



Multilingual Manchester



NHS North, Central and  
South Manchester CCGs

## Language provisions in access to primary and hospital care in central Manchester

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# Summary & key findings

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Central Manchester health services draw on many years of experience in engaging with communities of diverse backgrounds, and show a robust system of language provisions that caters for a large variety of languages through different modes of delivery. Practitioners and patients are generally aware of these provisions and make use of them. The system is by and large flexible, responsive, and affordable. The pilot research was undertaken in order to establish whether there are any barriers to the use of language provisions that affect, potentially, access to health care. We relied on data of interpreter requests at Manchester's GP surgeries and Central Manchester University Hospitals (CMFT) from 2013-2015, and on interviews with medical practitioners, interpreters, and users of health care services from a variety of backgrounds.

The findings suggest that clients with limited English proficiency often encounter difficulties in communicating with administrative staff. This poses potential obstacles in procedures such as registration and booking appointments. There is generally a high level of satisfaction with the interpreter provisions that are available to medical staff. However, General Practitioners sometimes adopt a lax attitude toward relying on ad hoc, 'casual' interpreting by patients' friends or family members without full awareness of the risks. In the hospital environment, guidelines on good practice seem to be applied much more strictly.

We found no evidence to suggest that lack of adequate interpreter provisions is driving patients with lower levels of English to turn to emergency or other hospital services rather than to primary care. The majority of patient interviewees felt that there was no considerable difference in the accessibility of language provisions at A&E and GP practices. The interviews suggest that not all participants regard professional interpreting as an effective or satisfactory way to overcome language barriers. However, hesitance toward interpreting services was usually not caused by the patients' own experience. This indicates a need to increase awareness among patients of the quality of professional interpretation, as well as of the most efficient way to access the service. We found that there was low awareness of, and low use especially of provisions for translation of written documents.

There is also no evidence that particular language groups either engage, or fail to engage, disproportionately with individual services. However, there is some indication that there may be insufficient understanding of the system among some groups of patients. Differences in the level of demand for interpreter services by language generally reflect differences in age (high demand for health care in general among ageing populations, such as speakers of Hakka, Gujarati, and Cantonese) and relative period of arrival and settlement in the UK

(lower levels of English among recent arrivals such as speakers of Pashto, Kurdish, and Arabic). Historical fluctuations in the level of demand, even within the short observation period, provide evidence that the need for interpretation services tends to be transitional, at least among the younger population: We see a sharp rise in demand for eastern European languages in the beginning of the observation period, which is then followed by a fall in demand. This can be taken, in all likelihood, to reflect users' gradual period of adjustment and integration, as well as rising levels of English proficiency (even when considering that other factors, such as movement away from the area under consideration, may also impact on the level of demand).

In order to fill key gaps in existing provisions, steps should be taken to ensure that information about language needs that is provided by patients upon registration is drawn on not just for appointments but also for written communication with patients, and that it is also attached to referrals. There is room for improvement of standards in identifying and labelling languages and including multilingual options at the registration stage. Initiatives such as *Choose Well Manchester* have the potential to deliver even greater impact if their content and language selection are expanded and if greater effort is made to promote them among specific target groups. We have also identified a series of questions for further research, to address aspects of quantitative data evaluation and assessment of trends, levels of awareness of provisions among specific groups, and the interaction between practitioners, patients, and professional as well as 'casual' interpreters.

The delivery of interpreter and translation services relies heavily on partnerships between public health sector outlets and private contractors. At present there seem to be no procedures in place to share good practice on language provisions among outlets, either in relation to delivery methods or to data compilation and data monitoring. Some outlets show serious gaps in the compilation of data, to the extent that it is sometimes difficult to identify and assess trends. This poses a serious obstacle to the planning of service provision and potentially to an effective allocation of resources. There is also no procedure in place for quality assurance of interpreter and translation provisions that are offered at GP surgeries, and no procedure to validate suppliers and contractors; there seems to be little awareness of the risks posed by the absence of such quality assurance mechanism.

Interpreter and translation provisions are an essential instrument toward ensuring integration. The evidence suggests that patients' reliance on language provisions is transitional, and that over time, both increased confidence and familiarity with the system, and individuals' rising

level of proficiency in English, will reduce their dependency on such provisions. At the same time, the dynamics of constant population changes in a global city such as Manchester mean that the availability in principle of interpreter provisions in the health care system is a permanent necessity. For this reason, it is essential to ensure that the highest possible standards are adopted and maintained both for quality assurance and quality monitoring of services, and for data compilation and data assessment, as the latter are a key to understanding trends and planning provisions in a targeted and cost-effective manner.

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# Introduction

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Between the financial years 2013/2014 and 2015/2016, Manchester's CMFT (Central Manchester University Hospitals – NHS Foundation Trust) has seen a 10% increase in requests for interpreter services. Local medical practitioners are also faced with the need to respond to difficulties in accessing and using health care, as experienced by an increasingly diverse population. Discussions of *Superdiversity* – a concept introduced by Steven Vertovec (2007: 1024) to “underline a level and kind of complexity surpassing anything the country has previously experienced” – emphasise how globalisation has given rise to new needs. Phillimore (2015: 568) points out that “[t]he population complexity associated with superdiversity brings a wide range of challenges for social welfare providers”. These challenges were addressed by representatives of service providers from Greater Manchester and researchers at a recent event.<sup>1</sup> Health care professionals emphasised the need for new ways of providing services and for closer collaboration between researchers and service providers, as traditional models of dealing with diversity in health care provision were no longer fully applicable.

Difficulties in accessing and using health care services have often been linked to communication difficulties (Phillimore 2015; NHS 2015a; Bischoff & Hudelson 2010; Shi et al. 2009; Bischoff et al. 2003). A recent NHS initiative on *Improving the quality of interpreting in primary care* reports that “language barriers in the health care setting can lead to problems such as delay or denial of services, issues with medication management, and underutilisation of preventive services” (NHS 2015a: 3). Taylor et al. (2013) find that “language and literacy barriers adversely affect clinical effectiveness, medical decision making, medication adherence, and patients’ understanding of and access to services” (2013: 36).

It has been suggested that language difficulties may at times encourage patients to contact the Accident and Emergency (A&E) department, even when primary care services would have been available and more appropriate (Campbell 2013; Hanssens et al. 2016; Ford et al. 2012; Peters et al. 2015: 7; Taylor et al. 2013: 39; Jacobs et al. 2004). Based on local audits from southwest London, Ford et al. (2012) report that patients from migrant communities “were least likely to be registered with a GP and more likely to use A&E”.

The 2014 Health Scrutiny Review Report of A&E services in the London borough of Tower Hamlets links the documented increase in the use of A&E services over the past

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<sup>1</sup> Discussions on service provision and Superdiversity took place at the event ‘Superdiversity: A research and policy agenda for Manchester?’ on 7 March 2016, organised by the University of Manchester’s Multilingual Manchester project.

decade to language barriers in the GP environment (Tower Hamlets Health Scrutiny Panel 2014: 13). Reportedly, accessing emergency services was often perceived as “more convenient” and “quicker” than seeing one’s GP by prior appointment (Tower Hamlets Health Scrutiny Panel 2014: 14, 4; see also Sempere-Selva et al. 2001: 568). Moreover, there was a general feeling among patients that they would receive a “better” service and “more advanced” treatment at A&E departments as compared to GP practices (Tower Hamlets Health Scrutiny Panel 2014: 14). There was also an impression that insufficient understanding of the UK health care system might lead people with relatively minor problems to contact A&E (Tower Hamlets Health Scrutiny Panel 2014: 9).

Similar findings have been reported for health care provision outside the UK. Leman & Williams (1999) argue for the United States that patients with limited English proficiency tended to rely on A&E departments as they seemed to be “otherwise unable to access health care” (1999: 271). Jacobs et al. (2004: 866) find that “[p]ersons who have limited English proficiency are less likely to have a regular source of primary care and are less likely to receive preventive care” (see also Shi et al. 2009; Weinick & Krauss 2001; Woloshin et al. 1997; Derose & Baker 2000). Manson (1988) argues that patients “were slightly more likely to be noncompliant with their medication, miss an appointment” and use A&E services instead of scheduled appointments if they did not speak the same language as their health professionals (1988: 1123, 1125). In a study of health care access among Roma migrants in Ghent, Belgium, Hanssens et al. (2016: 1) find that communication difficulties may lead to patients “not being able to reach health care and having problems to get through the complexity of the system”. As a result, they observe, Roma patients “often wait too long [...] to seek regular care, which makes small problems urgent on the long term” and may lead to “unnecessary use of emergency care” (Hanssens et al. 2016: 5). The authors argue that “healthcare professionals and policy makers need to continue to address access-related problems to reduce health care avoidance”, emphasising that “access to health care is still a crucial point in the health care process, especially for socially disadvantaged groups” (Hanssens et al. 2016: 8).

Ford, de Silva & Archer (2012) have suggested that facilitating access to GP services for patients with limited English proficiency may be a way to reduce usage of A&E services. Jacobs et al. (2001: 472) find that patients who used interpreter services had a significant increase in office visits, prescription writing, prescription filling and exams.

In Manchester, bottom-up approaches have been taken by minority language communities to identify and overcome barriers in access to health care. A study conducted by Manchester’s Somali Adult Social Care Agency (SASCA 2014) explores the language

difficulties met by patients with limited English proficiency, and reports that people from the Somali community found it difficult to access interpretation services.

The present report presents the results of our pilot study into language difficulties in the access to and use of medical services in Manchester. We draw on data of interpreter requests from Manchester's CMFT and GP practices covering the period between 2013 and 2015, and on the views that participants in a number of focus groups expressed on their experiences with language provisions in medical settings in Manchester. Our interest was in the following questions:

- Which language provisions exist in the healthcare sector?
- Do language barriers affect use of and access to primary care, in comparison with hospital services?
- How do patients, medical staff and interpreters assess communication difficulties and existing language provisions?

The following section (Section 2) outlines Manchester's linguistic profile and discusses the rationale for choosing the 'CMFT catchment area' as the focus for this study. Section 3 offers an overview of existing language provisions in access to healthcare in Manchester. Section 4 presents quantitative data on interpreter requests in Manchester's GP practices and CMFT departments, in comparison with other datasets (Census 2011, School Census 2015) and M-Four (Manchester City Council Translation and Interpreting Service) interpreter request data (2012-2013). In Section 5 we present participants' views of language provisions, based on the findings from the focus groups. We then offer conclusions, recommendations for the improvement of services, and suggestions for further research.

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# Manchester's multilingualism

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Home to more than 150 languages, Manchester is characterised by a linguistically and culturally diverse population (Matras & Robertson 2015; MLM 2013a). Manchester has been a centre of immigration since the industrial revolution, attracting population of different background in different periods, including Commonwealth migrants, refugees, and EU migrants. In the decade between 2001 and 2011, Manchester saw a growth rate of 19%, the highest in the country outside of London, compared to 7% nationally and only 4% for the North West in general (Matras & Robertson 2015: 2).

Manchester is now home to a variety of languages originating from South and East Asia, West and East Africa, the Middle East and central and eastern Europe (MLM 2013a). In the 2011 Census, 16.6% of Manchester's adult population declared a language other than English to be their 'main language', which compares to only 8% of the UK population. The self-reported Census data further suggest that more than 25% of Manchester's population were born outside the UK, with 15.8% having lived in the city for less than ten years.

On the 2011 Census, more than 13,000 Manchester residents identified Urdu as their "main language", making Urdu the most frequently reported "main language" in the city after English. Urdu is followed by Arabic (7037 speakers), Polish (6447 speakers), Chinese (5878 speakers), Panjabi (4719 speakers) and Bengali (3114 speakers) in the city's list of top frequently reported main languages in the Census 2011. Other major community languages include Somali, Yoruba, Persian, Pashto, Gujarati, French, Portuguese, Kurdish, Spanish and Greek, as well as various African languages.

Speakers of some languages are geographically concentrated in certain areas in the city, whereas others are dispersed across the city. Urdu tends to be widely dispersed, with some clusters in Levenshulme, Crumpsall and Cheetham (MLM 2013a: 2). Speakers of Somali are found in Moss Side and Hulme; Arabic is concentrated in Hulme and Cheetham, and speakers of Kurdish cluster in Moss Side. Romani is concentrated in Gorton South and Longsight (MLM 2013a: 2).

There is no centralised policy on language provision in the city, but the various public institutions within Manchester take measures to facilitate access to their services for those whose English proficiency is limited (MLM 2013a). Greater Manchester Police make use of external interpretation services to communicate with clients whose English proficiency is limited, and Greater Manchester Fire and Rescue Services provide fire prevention support in several languages. The City Council use both face-to-face interpretation and written translation services.

The city's GP practices and Central Manchester Hospitals offer a wide range of language provisions to their patients and staff. The Central Manchester University Hospitals NHS Foundation Trust (CMFT) comprises eight major hospitals that serve the Central Manchester catchment area, and which see around one million patients every year. Five of the Trust's hospitals are located close to the linguistically diverse areas of Rusholme, Moss Side, Levenshulme and Longsight, serving patients from a variety of language backgrounds. It is widely accepted among practitioners that central Manchester is a 'gold standard' in the Northwest region, and perhaps beyond, in providing language services, a product of many years of experience with migrant communities. For these reasons, we have selected the CMFT, and Central GP practices that are located roughly within the presumed CMFT catchment area, as the focus of our study.

The CMFT keeps records of interpreter requests according to hospital department, which are used to assess and respond to language demand. We had access to these data as well as to GP interpreter request data for the entire city of Manchester. Triangulation of these data with the Census (2011), School Census (2015) and M-Four interpreter requests provides a differentiated picture of the area's linguistic profile and language needs (see Section 4).

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# Overview of language provisions in access to health care in Manchester

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### 3.1 Interpreter services at CMFT: Provisions and Guidelines

The CMFT’s brochure “Best Practice Guidance Interpretation Service” defines the Trust’s aim to facilitate “fair and easy access for patients to CMFT healthcare services whose preferred language is not English” and people who are Deaf (CMFT 2011: 4). One of the central ways to overcome language barriers is the use of face-to-face and telephone interpreters. NHS England funds interpretation and translation services within Primary Care, Secondary Care and A&E services. Unlike other countries like Germany (Langer & Wirth 2013) or Switzerland (Bischoff & Hudelson 2010), there is a legal obligation in the UK for health care providers to offer interpretation services to patients (cf. Phillimore 2015: 574). However, CMFT guidelines make reference to the Human Rights Act 1998, which “establishes rights and entitlements to the assistance of an interpreter if needed” (CMFT 2011: 4).

CMFT has been offering face-to-face interpretation services since 1989. The service was first offered in Saint Mary’s Hospital on an ad hoc basis, and it has since expanded considerably. At present, CMFT makes use of both internally based and external interpreters to facilitate communication during consultations, for obtaining informed consent, and for administration matters. Combined, the in-house interpreters and external interpreters can provide interpretation services for more than 100 languages. In addition, patients who are Deaf can access interpreting services for British Sign Language (BSL).

Trust interpreters typically provide interpretation services for pre-booked appointments, but may also be available for last minute and emergency cases. The in-house team currently has nine permanent staff who handle face-to-face interpretation and are employed by CMFT. They can respond to the following eighteen “most commonly used community languages” (CMFT 2011: 8) and sub-varieties of those languages:

- Urdu
- Arabic
- Panjabi
- Mirpur Panjabi
- Bengali (Sylheti)
- Bengali (Non-Sylheti)
- Farsi
- Dari
- Hindi
- Somali
- Cantonese Chinese
- Mandarin Chinese
- Polish
- Kurdish
- Gujarati
- Swahili
- Malay
- Vietnamese

Mirpur Panjabi and Malay were only added to the language portfolio of in-house interpreters in 2011 (cf. CMFT 2011).

CMFT has a strategy to respond to language needs in an effective and cost-efficient way: Seven of the nine internal interpreters can provide services for more than one language: There is one interpreter who offers interpretation for Arabic and Kurdish, and two interpreters provide interpreting services for both Cantonese and Mandarin. Urdu, Hindi, Mirpuri and Panjabi are covered by just two interpreters.

Ten bank staff support the in-house team in the languages listed above, but bank staff are not contracted to a fixed number of hours. Yet, this group of professional interpreters is regarded as a core part of the interpreting team and is usually favoured over external interpretation, as bank staff have extensive experience in interpreting in the hospital environment (MLM 2013a: 8). Also, use of external interpretation services is more expensive than the in-house provision (CMFT 2011: 9).

To supplement its in-house team, both in order to support high demand and to cover additional languages, CMFT contracts the interpretation agencies Pearl Linguistics Ltd and D.A. Languages Ltd. In addition, the interpreting agencies The Big Word and LanguageLine Solutions also provide language services for the CMFT. Notice of 24 hours is typically sufficient to arrange face-to-face interpreters for major languages outside the scope of the internal team. Securing an interpreter for languages that are less frequently spoken can take up to five days, and short-notice appointments are not always possible.

To book an interpreter, staff members contact the Trust Interpretation & Translation Service and submit a booking request form. There is also the possibility to book urgent requests during out of office hours. CMFT requires staff members to specify whether a patient prefers a female or male interpreter, and the interpreter booking form also offers the possibility to advise “if a preferred interpreter [...] is required, i.e. to offer continuity of care” (CMFT 2011: 11). The Trust encourages continuous use of the same interpreter to follow the patient’s journey through the health care system for the entire duration of treatment. Some practitioners report, however, that this can be problematic, and that patients may face difficulties if for some reason they would like to change interpreters. It has also been pointed out that continuity of interpreter care may create a form of dependency, with the risk that interpreters might feel a duty to advocate on behalf of patients on the basis of having established a continuous working relationship with them.

In addition to face-to-face interpreting, external providers also offer telephone interpretation. These are instant services that do not require pre-booking. At the CMFT,

telephone interpretation services are provided mainly for short interactions, such as confirmation of appointments with patients (CMFT 2011: 9). Typically, health professionals call one of the contracted interpretation agencies to request an interpreter for a particular language, and the caller is normally connected with the interpreter within a few minutes. In most cases, patients are already present in the consultation room, so that speakers can be used to facilitate communication between practitioner, patient and interpreter. In other cases, a three-way telephone conversation is established.

CMFT guidelines state that all health practitioners and NHS staff are required to use professional interpreters when dealing with clinical issues, emphasising that the use of qualified interpreters is essential to ensure “confidential impartial and accountable interpretation” (CMFT 2011: 9). The use of untrained interpreters is not considered to be a reliable way to communicate clinical information and may even “put the patient at risk” (CMFT 2011: 6). Normally, multilingual health practitioners or the patients’ family members and friends are expected not to act as interpreters for issues related to the patient’s treatment. In emergency cases, they may act as interpreters with the patient’s consent, provided that they possess native speaker proficiency in the relevant language. However, this applies “only when a qualified Interpreter is not available and the need to interpret is urgent” (CMFT 2011: 20). With respect to multilingual medical students, the University of Manchester’s Medical School and the CMFT do “not endorse the use of students on clinical placement to interpret for patients with whom they share a language without formal demonstration of adequate competence” (Farrington 2013). Children, “i.e. anyone under the age of 16 years”, or other patients are never to be used for interpreting (CMFT 2011: 18).

CMFT guidelines also state that staff must report cases where an unqualified interpreter is inappropriately used to interpret (CMFT 2011: 20), though we are not aware of cases where this has actually happened or of the consequences if and when such incidents are reported. On the other hand, multilingual staff members are always encouraged to use the patient’s preferred language for non-clinical matters and for welcoming and accommodation gestures. The CMFT keep a staff languages database that records which staff member can speak which language(s). Patients cannot bring their own (trained) interpreter, and it is the responsibility of CMFT staff to book a professional interpreter through the Trust. CMFT guidelines emphasise that “the health professional may need to make a decision on using an interpreter even when the patient, family member or carer may not want this” (CMFT 2011: 6).

The cost of face-to-face interpretation delivered by external agencies is £27.03 per hour, or £0.45 per minute. For telephone interpretation services, the agency The Big Word

charges £0.53 per minute. BSL interpretation is considerably more expensive, at £71 per hour. This is important to note that sign language interpretation is a permanent necessity for clients, while lack of English proficiency is, more often than not, a transitional state.

### 3.2 Interpretation services at Central Manchester's GP practices

Manchester's GP practices organise face-to-face interpretation and telephone interpretation services through external providers, which are able to provide services for "over 200 languages" (LanguageLine 2016). Not all practices make use of face-to-face interpreters, with some surgeries offering only telephone interpretation to patients and GP staff. The decision on which types of interpreter service are used is taken by the individual practice. Some practices prefer the instant telephone interpretation service for convenience, as it saves administration time and the effort that is required to pre-book face-to-face interpreters.

Patients are not expected to bring their own interpreter; instead, professional interpreters must be arranged through the GP practice, if required. As in CMFT, the patient's family members or friends are not expected to replace qualified interpreters. It should be noted that 'expected' implies a culture rather than a rule, and we are not aware of the extent to which these norms are enforced, or of the consequences in the event that incidents are identified where there has been a departure from the norm.

### 3.3 Translation services

Translation services for written documents are provided by external agencies and are available to CMFT and GP staff as well as patients. Upon request, translators can be commissioned to translate information leaflets, patient letters, patient medication leaflets, user experience questionnaires and public documents for specific communities. In addition, health professionals may require translations of discharge records or medical records of patients who had been treated outside the UK. The costs of using these external translation services depend on the individual language requested. In 2011, CMFT estimated that "more popular languages could cost around £15.00 per 100 English words; the more rare languages could be considerably higher" (CMFT 2011: 9).

A small number of posters and other printed material displayed around the hospital contain translations into other languages. We understand that the selection of languages is usually based on a general assessment of demand based on the number of interpreter requests. Requests from patients for translation of particular materials are also considered. CMFT also

provides *Language Identification Cards*, intended to help staff members identify a patient's language. The cards display a range of languages, listed next to a corresponding flag of the country where the language is spoken, as well as a simple phrase in the language and script. Patients can point to their preferred language if they recognise it on this card, and staff members can consult an interpreter accordingly.

### 3.4 Choose Well Manchester website

*Choose Well Manchester* is an online resource provided by NHS North, Central and South Manchester CCGs to help patients choose the right care and obtain self-care advice. The website gives general information on NHS web and telephone health care services, it lists medical services for selected geographical areas, and offers advice on when to use hospital or emergency services. In addition, there are videos and downloadable documents that inform about a range of illnesses and symptoms. Based on Google Translate a machine translation service is available for more than 50 languages for the main text. *Choose Well Manchester* additionally offers a small number of information videos in nine languages (<http://www.choosewellmanchester.org.uk/>). The videos give general guidance on how to register with a GP, and inform about the role of pharmacists and how to make a dentist appointment. The selection of languages draws on input from the University of Manchester's Multilingual Manchester project provided in 2010. The videos are available in Urdu/Hindi, Romanian, Polish, Kurdish, Arabic, Farsi, Cantonese, Somali and Bengali.

However, the Romanian versions of the videos on the *Choose Well Manchester* website are labelled 'Romani', which is actually the language originally suggested by Multilingual Manchester. The Somali version of the video appears to be using a nonstandard variety of the language that may not be intelligible to all Somali speakers. *Choose Well Manchester* also features a video with local GPs and nurses, offering self-care advice.

Alongside English, this video is available in Urdu, Arabic, Bengali and Panjabi.

### 3.5 Additional language provisions

Patient feedback screens around CMFT and check-in machines in many of the city's GP practices allow patients to select the display language, offering a choice of languages (usually Arabic, Mandarin, Hindi, Bengali, Polish, Urdu, French). CMFT guidelines refer to *multilingual phrasebooks* produced by the Red Cross, the Department of Health and the Ambulance Service Association, which can be accessed online (CMFT 2011: 21). These contain basic sentences in almost 40 languages, which can be used by staff members "as a

first line of enquiry or while waiting for an interpreter” (CMFT 2011: 21). Some phrases are represented pictorially to facilitate basic communication of frequently occurring issues.

In order to help patients with limited English proficiency understand when their next appointment is, the Department of Health and the NHS support the use of *Multilingual Appointment Cards*, which are facilitated by the HARPweb website (Health for Asylum Seekers and Refugees Portal Social Inclusion Research Programme). Health care staff members fill in an electronic appointment card in English, indicating the patient’s language or dialect. The appointment letter will then be translated and, together with the usual English-language appointment letters, sent to the patients. However, at the time of the research, the URL ([harpweb.org.uk](http://harpweb.org.uk)) provided in a CMFT brochure (CMFT 2011: 21) did not allow to access these services, and we were unable to find such a service for the UK that was accessible.

The CMFT has implemented a text messaging system for appointment booking, which is intended to facilitate health care access to patients who are Deaf or have hearing problems.

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# Use of provisions: scale and extent

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## 4.1 Datasets and research questions

Several datasets provide information on languages in Manchester. The 2011 Census is based on self-reported data: Respondents were asked to indicate their ‘main language’, yet no definition of the term was provided. Due to the potential ambiguity of the question, the Census (2011) may not provide a full picture of Manchester’s linguistic diversity (see Matras & Robertson 2015: 5). However, it can still offer some insights into the overall presence of language communities in the city. The School Census is the “principal instrument used by local authority to gather data on languages” (Matras & Robertson 2015). The format allows school staff to enter only a single language for each student, resulting potentially in a less differentiated overall picture, which, nonetheless, like the Census 2011, can provide general insights into the spatial distribution of languages in the city. Schools enter data on pupils, including the children’s ‘first language’, on an annual basis; below we draw on the dataset from January 2015. M-Four is Manchester City Council’s in-house unit offering face-to-face interpretation and written translation, and data on their interpreter requests were available to us for the period April 2012 to March 2013.

As far as we have been able to ascertain, CMFT is the only hospital trust in Greater Manchester that systematically collects and stores data on interpreter use, broken down by language. We have had access to data for the financial years 2013/2014, 2014/2015 and 2015/2016, covering the following information:

- Use of agency face-to-face interpretation services (Number of jobs and hours of interpretation by language; expenditure)
- Use of The Big Word telephone interpretation services (Number of calls and minutes of interpretation by language; expenditure)
- Use of Internal Staff interpretation services (Number of jobs and hours of interpretation by language)
- Overall expenditure

In addition, we had access to data on the use of face-to-face interpretation at the CMFT from April 2013 to November 2014, which lists individual interpreter requests, jobs that have been carried out, and chargeable hours by date and month, by CMFT hospital department, and by language and source of the service (Agency, Bank, Internal); and to data on face-to-face interpreter use at CMFT’s Accident & Emergency Department, which lists the total number of interpreting jobs and hours by language for the period from April 2014 to June 2015.

Data on interpreter use at Manchester's GP practices are collected by the Manchester Integrated Care Gateway (MICG), a service that has been implemented by NHS North, Central and South Manchester CCGs to manage referrals from GPs in the city. It also manages requests for interpretation provision for GP practices. We had access to data on interpreter requests at Manchester's GP practices, compiled by MICG for the period March 2014 to February 2015. The data are broken down by each Clinical Commissioning Group in Manchester, by individual GP practices, and by language. We also used the regional tag 'Central' to help identify the location of GP practices that are relevant to our study.

In assessing these datasets, we are interested in the scale and extent of the use of interpreting services at the CMFT, the spread of demand by language and key departments that may provide insights into population demographics, and any changes in demand in the three-year period from 2013/2014 to 2015/2016. We are also interested in similar questions pertaining to the demand for interpretation among GP practices in approximately the same area, to the extent that these are represented by the data for the Central Manchester Clinical Commissioning Group, and the way this compares with demand at CMFT. When giving consideration to these data, one must remember that data on interpreter use in hospital and GP environments capture instances where people need to access medical services, and as such they are not representative of the language needs or abilities (i.e. preference for use of the home language or lack of proficiency in English) of the language group as a whole. In general, we expect that interpreter requests represent the needs primarily of an elderly population and of new arrivals, both groups that are typically less proficient in English.

## 4.2 Language terminology

Terms used to designate individual languages and dialects vary both across, and sometimes within individual datasets. The Census (2011), which captures designations provided by respondents, distinguishes between 'Cantonese' and 'Mandarin' for Chinese, whereas Hakka and other Chinese varieties are grouped together as 'all other Chinese'. The Census does not distinguish between individual varieties of Kurdish (Kurmanji, Sorani, Bahdini) or between varieties of Persian (Farsi, Dari). The School Census (2015) does not distinguish sub-varieties of either Kurdish or Chinese. The overview of M-Four interpreter requests (2012/2013) lists Cantonese and Mandarin separately, but does not distinguish between Kurdish varieties.

In most CMFT datasets, the three Kurdish varieties Sorani, Kurmanji and Bahdini are recorded separately; in addition, however, there are also records for 'Kurdish'. Cantonese,

Mandarin and Hakka are recorded separately, and a distinction is made between Dari and Farsi. The GP dataset records ‘Kurdish’ with sub-labels for Sorani, Kurmanji and Bahdini. Cantonese, Mandarin and Hakka are recorded separately; again, however, there are also records for ‘Chinese’. Dari and Farsi are recorded separately.

For consistency and to facilitate comparison across datasets, we have grouped the various varieties of Kurdish together under ‘Kurdish’ for our analysis. Other languages were grouped where several terms were used to refer to the same language or sub-variety: ‘Edo’ and ‘Benin’ were combined together, as were ‘Tigrinya’ and ‘Tigrini’, ‘Ibo’ and ‘Igbo’, and ‘Uzbek’ and ‘Uzbekistan’. Cantonese, Mandarin and Hakka were listed separately where this was possible based on the original datasets.

### 4.3 General profile

In the 2011 Census, 16.6% of Manchester’s population indicated a language other than English as their ‘main language’; this represents 79,852 individuals. The School Census data from January 2015 indicates an even greater proportion of speakers of other languages among Manchester’s younger population: For 36% of pupils, or more than 27,000 school children, a language other than English was indicated as ‘first language’.

The total number of interpreter jobs at CMFT, including Internal, Bank and External interpreter services, for the period April 2014 to May 2015, was 48,425. The number of interpreter requests at Manchester’s GP practices between March 2014 and February 2015 was 18,246. Of those, a total of 9,593 represent Central Manchester surgeries. These numbers indicate a considerably higher use of interpretation services at the CMFT than at GP practices, with the CMFT reporting more than five times as many requests as Central Manchester’s GP practices, which are the surgeries located in the ‘assumed catchment area’ of the CMFT. For a similar time period, CMFT has seen three times as many requests as GP practices citywide. This, of course, reflects primarily the effect of hospitalization and the need for repeated services for in-patients.

A range of 99 different languages were requested at the CMFT between April 2014 and March 2015 (including BSL), with the top three languages being Urdu, Arabic and Cantonese. Only 53 different languages were requested at Central Manchester’s GP practices (including BSL) between March 2014 and February 2015, with Arabic, Urdu and Romanian being the top languages. Considering all surgeries in the entire city, there were interpreter requests for 86 different languages in the same time period. The top three languages requested at GP

surgeries in the city as a whole, for the period of March 2014 to February 2015, were Arabic, Urdu and Polish.

There is no evidence of disproportionate engagement or disengagement with GP or hospital services among any individual language group, and there is no evidence of any disproportionate representation of any particular language group at A&E. Interpreter demand for individual languages is by and large consistent across health care outlets, and the proportions of interpreter demand for individual languages also appears to be consistent with the presence of speakers in the city as reflected in other language datasets such as the 2011 Census and the School Census from January 2015. There is some evidence of frequent reliance on A&E among new arrival groups (Arabic, Romanian, Hungarian), but there is no indication that this is due to limited access to GP services, as these groups also show high demand for interpretation in GP practices.

## 4.4 Linguistic profile of Manchester

Table 4.4.1 lists the 20 most frequently reported languages across three datasets: the 2011 Census, M-Four interpreter requests (April 2012 - March 2013), and the School Census for January 2015.

Census (2011): Individuals identifying a language as their 'main language'			M-Four interpreter requests (April 2012 – March 2013)			School Census (Jan. 2015): School Pupils' 'first language'		
	N	%		N	%		N	%
Urdu	13,095	16.3%	Urdu and Panjabi	2245	17.7%	Urdu	6950	25.7%
Arabic	7037	8.8%	Bengali	910	7.1%	Arabic	3010	11.1%
Polish	6447	8.0%	Polish	904	7.1%	Somali	2126	7.9%
All other Chinese	5878	7.4%	Arabic	870	6.9%	Panjabi	1868	7.0%
Panjabi	4719	5.9%	Persian	753	6.0%	Bengali	1380	5.1%
Bengali	3114	3.9%	Somali	648	5.1%	Polish	1180	4.4%
Somali	2958	3.7%	Portuguese	429	3.38%	French	811	3.0%
Persian	2660	3.3%	Pashto	414	3.3%	Yoruba	763	2.9%
French	2351	2.9%	Kurdish	405	3.2%	Portuguese	494	1.8%
Kurdish	1886	2.4%	Romanian	404	3.2%	Chinese	482	1.7%
Spanish	1869	2.3%	Czech	387	3.0%	Pashto	424	1.6%
Cantonese	1739	2.2%	Mandarin	359	2.8%	Kurdish	411	1.5%
Greek	1588	1.9%	Lithuanian	357	2.8%	Spanish	380	1.4%
Portuguese	1458	1.8%	Russian	348	2.7%	Italian	364	1.3%
Pashto	1147	1.4%	Cantonese	262	2.0%	Malayalam	309	1.4%
German	936	1.2%	BSL	235	1.9%	Czech	289	1.0%
Czech	933	1.2%	French	218	1.7%	Romanian	246	0.9%
Mandarin	851	1.0%	Tigrinya	197	1.6%	Persian/Farsi	235	0.8%
Malayalam	849	1.0%	Amharic	191	1.5%	German	180	0.7%
Russian	844	1.0%	Gujarati	158	1.2%	Dutch/Flemish	175	0.6%
<b>Total 'main language other than English'</b>	<b>79,852 (16.6% of residents)</b>	<b>100%</b>	<b>Total requests</b>	<b>12,687</b>	<b>100%</b>	<b>Total 'first language' other than English</b>	<b>27,008 (36% of pupils)</b>	<b>100%</b>

Table 4.4.2 lists the top 20 most frequently reported languages in the 2011 Census and the School Census (2015) for the ‘assumed catchment area of the CMFT’.<sup>2</sup>

<b>Table 4.4.2 ‘assumed CMFT catchment area’ top 20 languages; N= number of speakers</b>					
Census (2011): Individuals identifying a language as their ‘main language’ in assumed CMFT catchment area			School Census (Jan. 2015): School Pupils’ first language in assumed CMFT catchment area		
	N	%		N	%
Urdu	9561	16.5%	Urdu	4632	26.4%
Arabic	5444	9.4%	Arabic	2080	11.9%
All other Chinese	5020	8.7%	Somali	1806	10.32%
Polish	3316	5.7%	Bengali	1221	7.0%
Panjabi	3139	5.4%	Panjabi	1078	6.1%
Bengali	2986	5.1%	Polish	524	3.0%
Somali	2654	4.6%	Yoruba	451	2.6%
Persian	1758	3.0%	French	414	2.3%
French	1662	2.9%	Kurdish	292	1.7%
Spanish	1590	2.7%	Portuguese	282	1.6%
Greek	1505	2.6%	Pashto	277	1.6%
Kurdish	1446	2.5%	Spanish	251	1.4%
Cantonese Chinese	1163	2.0%	Italian	230	1.3%
Portuguese	960	1.7%	Chinese	241	1.4%
Pashto	926	1.6%	Czech	197	1.12%
German	736	1.3%	Malayalam	157	0.9%
Mandarin Chinese	729	1.3%	Romanian	182	1.0%
Romanian	588	1.0%	Persian	134	0.5%
Italian	587	1.0%	German	128	0.73%
Swahili	582	1.0%	Dutch	117	0.6%
<b>Total ‘main language other than English’ 2011</b>	<b>57,985</b>	<b>100%</b>	<b>Total ‘first language’ other than English 2015</b>	<b>17,498 (39.9% of pupils)</b>	<b>100%</b>

A comparison of Table 4.4.2 with Table 4.4.1 shows the relatively high linguistic diversity of the sample area. For the ‘assumed CMFT catchment area’, almost 19% of residents regarded a language other than English as their ‘main language’ in the 2011 Census, compared to 16.6% for all of Manchester. The School Census (2015) shows a similar picture: Almost 40%

<sup>2</sup> Based on the geographical location of the CMFT, and considering the presence of other comparable hospital in the city, the ‘assumed catchment area of the CMFT’ included the wards City Centre, Ancoats, Beswick and Clayton, Bradford, Gorton North, Gorton South, Ardwick, Hulme, Moss Side, Rusholme, Longsight, Levenshulme, Fallowfield, Whalley Range, Chorlton, Chorlton Park, Old Moat, Withington, Burnage, Didsbury East, Didsbury West.

of pupils in the sample area were identified as having a language other than English as their ‘first language’, compared to 36% of all Manchester pupils.

Table 4.4.2 reflects the disproportionately high presence of some language communities in the assumed CMFT catchment area as compared to the city as a whole, notably speakers of Bengali and Somali, and indication of their strong spatial concentration. The Polish community, on the other hand, has a disproportionately low presence in the sample area compared to Manchester as a whole, an indication of its tendency toward greater spatial dispersion.

## 4.5 Use of interpreter services at the CMFT

### 4.5.1 Changes over a three-year period

Table 4.5.1 presents the number of interpreter jobs at CMFT by type of interpretation (face-to-face interpretation internal, face-to face interpretation external, or telephone interpretation external) and by year, showing data for the financial years 2013/2014 and 2014/2015 as well as for the time period between 1 April 2015 and 29 February 2016.

	April 2013 – March 2014	April 2014 – March 2015	April 2015 – Feb 2016
Total N requests internal face-to-face	9228	9195	8866
Total N requests agency face-to-face	29,364	31,015	31,648
Total N calls The Big Word	7343	8216	8279
<b>Total N</b>	<b>45,935</b>	<b>48,426</b>	<b>48,793</b>

Over the three-years time period between 2013/2014 and 1 April 2015 – 29 Feb 2016, there is an increase of around 6% in the total number of requests, most of it between the financial years 2013/2014 and 2014/2015.

For interpreting jobs requested from external agencies, there is a 5.6% increase from 2013/2014 to 2014/2015, and another slight increase by 2%. This increased use of interpreting services provided by external agencies may be attributable to the contracts awarded to Pearl Linguistic Ltd and DA Languages Ltd in 2014. The data for Big Word telephone interpretation show an 11.9% increase from 2013/2014 to 2014/2015, and a

continuation of this trend between 2014/2015 and 2015/2016. The number of requests handled by the internal interpretation services shows a decrease between 2014/2015 and 2015/2016 (by 3.6%).

Overall, there are no significant differences in the distribution of requests among the three sources of interpretation services, with external agencies covering 64% of all requests in 2013/2014 and 2014/2015, and 68% of all requests in the period from 1 April 2015 – 29 February 2016.

With a rising number of interpreter jobs, the total expenditure increases by 2.3% from £1,149,186 in 2013/2014 to £1,175,225 in 2014/2015. CMFT has seen another 6.8% increase in expenditure for interpreter jobs from 2014/2015 to April 2015/February 2016, with costs amounting to £1,261,019 for the latter eleven-month period. This amounts to an increase of 9.7% in expenditure across the three years.

The proportion of face-to-face interpretation, compared to telephone interpretation services, shows no significant fluctuation across the three time periods (see Table 10.1 in the appendix). Face-to-face interpretation accounts for over 83% of the total of interpretation jobs.

#### **4.5.2 CMFT interpreter requests: Seasonal fluctuations**

Media reports have often alluded to additional pressures on hospitals and particularly A&E departments during the winter months (BBC News 2015; The Health Foundation Newsletter 2015; The Independent 2014; The Telegraph 2014). The British Medical Association reports that “within the healthcare system, winter public health pressures often impact most markedly on emergency departments” (BMA 2013: 6). The Tower Hamlets Scrutiny Review found a rise in A&E use in the winter for this London borough (Tower Hamlets Health Scrutiny Panel 2014: 7, 9). For Manchester, too, the CMFT Annual Report 2014/2015 mentions increased demand for CMFT’s A&E services during the “winter pressure period” (CMFT 2015: 158; cf. Central Manchester CCG 2015: 9). However, an NHS England report on winter pressure maintains that “it is not simply about A&E attendances, which are at their lowest in the winter months. The major issue centres on emergency admissions and the number of people requiring hospital care” (NHS 2014: 1).

Table 4.5.2.1 shows numbers of interpreter requests at the CMFT hospital-wide in the period from December 2013 to November 2014, by month and season of the year. The data cover all face-to-face interpretation requests to Agency, Bank and Internal interpreters.

<b>Table 4.5.2.1 CMFT face-to-face interpretation (2013/2014) by month and season; colour codes indicate 10% or more above (red) or below (green) average</b>			
<b>N = number of requests by month</b>		<b>N = number of requests by season</b>	
	N		N
June 2013	3101	Summer 2013	9443
July 2013	3414		
August 2013	2928		
September 2013	3094	Autumn 2013	10063
October 2013	3567		
November 2013	3402		
December 2013	2934	Winter 2013/2014	9412
January 2014	3424		
February 2014	3054		
March 2014	3222	Spring 2014	9548
April 2014	3049		
May 2014	3277		
<i>Average N per month</i>	3205	<i>Average N per season</i>	9612
<b>Total</b>	<b>38,466</b>	<b>Total</b>	<b>38,466</b>

There is no evidence of increased demand for interpreting services during the winter period. In fact, the seasonal total of interpreter requests for the winter period is the lowest of the four seasons of the year. While the number of interpreter requests for January 2014 is above the monthly average, CMFT interpreter requests for December 2013 and February 2014 are significantly below average.

Table 4.5.2.2 shows the number of face-to-face interpretation requests at the CMFT's A&E department from June 2014 to May 2015, by month and season of the year.

<b>Table 4.5.2.2 CMFT A&amp;E face-to-face interpretation (2014/2015) by month and season; colour codes indicate 10% or more above (red) or below (green) average</b>			
<b>N = number of requests by month</b>		<b>N = number of requests by season</b>	
	N		N
June 2014	613	Summer 2014	1936
July 2014	647		
August 2014	676		
September 2014	686	Autumn 2014	2009
October 2014	686		
November 2014	637		
December 2014	574	Winter 2014/2015	1988
January 2015	724		
February 2015	690		
March 2015	682	Spring 2015	1769
April 2015	427		
May 2015	660		
<i>Average N per month</i>	<i>642</i>	<i>Average N per season</i>	<i>1926</i>
<b>Total</b>	<b>7702</b>	<b>Total</b>	<b>7702</b>

There is no indication of seasonal fluctuation in interpreter use at the A&E department, and no evidence of additional pressures on A&E in the winter.

We also looked for possible seasonal fluctuations in the numbers of interpreter requests by season for a selection of individual languages, namely Urdu, Arabic, Polish and Romanian. Both at the CMFT hospital-wide and at CMFT's A&E department, there is no evidence of increased demand during any of the four seasons by particular language groups (see Tables 10.2.1 – 10.2.4 in the appendix).

### 4.5.3 CMFT interpreter requests by language

The total number of languages requested for face-to-face interpretation at CMFT between April 2014 and March 2015 is 99, including BSL. This compares to 95 different languages requested at the CMFT in the preceding year (April 2013 to March 2014). Six languages were requested in the previous period for which there was no demand between April 2014 and March 2015: Ndebele (3 requests), Uzbek (2 requests), Afrikaans (1 request), Tumbuka (1 request), and Kazakh (1 request). The nine 'new' languages requested between April 2014 and March 2015 are Kinyarwanda (9 requests), Luganda (9 requests), Tibetan (7 requests), ChiChewa (3 requests), Bangla (2 requests), Guru (1 request), Norwegian (1 request) and

Pulaar (1 request) (see Appendix 10.3 for information on lesser-known languages). The low demand for some of these languages shows how CMFT’s Interpretation and Translation Service and their external suppliers are able to cover a wide range of language and respond to the needs of individual patients.

Table 4.5.3 shows the top 20 languages requested at CMFT between April 2014 and March 2015. The numbers include both face-to-face interpretation and telephone interpretation delivered by Agency, Bank and Internal interpreters.

	N	%
Urdu	9382	19.3%
Arabic	5764	11.9%
Cantonese	3346	6.9%
Polish	3316	6.8%
Bengali	3094	6.4%
Panjabi	2452	5.0%
Mandarin	2284	4.7%
Somali	2238	4.6%
Farsi	1796	3.7%
Romanian	1540	3.1%
Czech	1362	2.8%
Kurdish	1082	2.2%
BSL Sign	1009	2.1%
Portuguese	819	1.7%
Pashto	755	1.6%
Hungarian	640	1.3%
Spanish	575	1.2%
Italian	562	1.2%
French	546	1.1%
Gujarati	501	1.0%
Other languages	5363	11%
<b>Total</b>	<b>48,426</b>	<b>100 %</b>

These top languages requested for interpretation at the CMFT mirror the top languages in the Census (2011) and School Census (2015) (see Table 4.4.1 and Table 4.4.2). Of the 12 most frequently requested languages at the CMFT, 10 are also among the top twenty of the Census (2011), and 18 of the top 20 languages requested at the CMFT are also among the top 20 languages in the School Census (2015).

The relatively high demand for Urdu (19.3%) and Arabic (11.9%) compared to other languages reflects their strong presence in Manchester, particularly in the sample area (see Table 4.4.1 and Table 4.4.2).

#### **4.5.4 Distribution of languages by service provider**

The data in Tables 4.5.4.1 and 4.5.4.2 below give the number of requests by language covered at CMFT by external interpretation service providers for the periods April 2013/March 2014, April 2014/March 2015 and April 2015/February 2016.<sup>3</sup>

The data in Table 4.5.4.1 refer to the numbers of face-to-face interpretation services requested from external interpretation agencies for selected languages.

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<sup>3</sup> We have not considered interpretation jobs delivered by the CMFT's in-house team, as it can be assumed that internal staff work full-time. Therefore, interpreter demand reflects capacity rather than demand for interpretation services for individual languages, and any excessive demand is picked up by Agency interpreters.

<b>Table 4.5.4.1 Agency face-to-face interpretation; N = number of requests; colour codes indicate noteworthy increased (red) and decrease (green)</b>			
	1 April 2013 – 29 March 2014	1 April 2014 – 29 March 2015	1 April 2015 – 29 Feb 2016
	N	N	N
Urdu	5526	5516	6707
Arabic	2894	3769	3980
Polish	2657	2743	2374
Panjabi	1605	1570	1699
Bengali	1480	1337	1324
Cantonese	1331	1303	1397
Somali	1139	1210	1134
Farsi	1119	1150	926
Mandarin	1069	925	910
Romanian	1059	1046	1190
Czech	984	1092	813
Kurdish	829	731	788
Portuguese	625	585	679
Hungarian	461	410	337
Russian	445	329	366
Pashto	381	642	400
Spanish	348	397	531
Slovak	278	231	214
Italian	173	510	325
Latvian	133	117	203
Albanian	104	176	110
Nepali	75	91	40
N requests other languages	4649	5135	5201
<b>Total</b>	<b>29364</b>	<b>31015</b>	<b>31648</b>

Across the three years, the level of requests for Panjabi, Cantonese, Polish, Somali, and Kurdish remains relatively stable. Other languages show a significant increase: Urdu is stable in the period from 2013/2014 to 2014/2015, but shows a 22% increase in demand from 2014/2015 to 2015/2016. Similarly, Romanian remains stable in the first two years, but shows an increase by 18.8% from 2014/2015 to 2015/2016. Spanish and Latvian are also stable in the first two years and then show an increase in 2014/2015, of 33.7% and 42.4%

respectively. The rise in demand may reflect growth of the respective communities through immigration, but possibly also an increase in awareness of language provisions. Arabic shows an increase in interpreter requests by 30% from 2013/2014 to 2014/2015, and another slight increase by 6% in the following year. This is likely to reflect the recent increase of Arabic speakers in the sample area, which is in part attributable, we assume, to the arrival of refugees from Syria, Iraq, and Kuwait (Bidoonis). Practitioners also report on significant numbers of Egyptian, Sudanese and North African patients.

There is a decrease in CMFT face-to-face interpreter requests particularly for Eastern European languages: Interpreter requests for Russian show a 26% decrease from 2013/2014 to 2014/2015. The number of interpreter requests for Hungarian decreases by 17.8% from 2014/2015 to 2015/2016. Slovak shows a decrease by 16.9% from 2013/2014 to 2014/2015, and another slight decrease to 2015/2016. These numbers may in some cases reflect Eastern European migrants leaving the city, but also, we assume, increasing English proficiency among community members as the communities establish themselves in Manchester.

There is a 13.5% decrease in demand for Mandarin from 2013/2014 to 2014/2015, while for Bengali we see a decrease by 9.7% from 2013/2014 to 2014/2015. Nepali shows a significant decrease by 56% from 2014/2015 to 2015/2016, and Farsi shows a 19.5% decrease in the same period.

Pashto, Albanian, Czech and Italian are curious cases: They first show a significant increase in interpreter use from 2013/2014 to 2014/2015, which is followed by a significant decrease from 2014/2015 to 2015/2016. Pashto first shows a significant increase by 40.6% from 2013/2014 to 2014/2015, and then decreases from 2014/2015 to 2015/2016 by 37.6%. Albanian increases by 69% from 2013/2014 to 2014/2015, which is followed by a decrease from 2014/2015 to 2015/2016 by 37.5%. Similarly, Italian shows a significant increase in interpreter demand from 2013/2014 to 2014/2015, but decreases again by 36.3% 2015 to 2015/2016).

<b>Table 4.5.4.2 The Big Word Telephone interpretation; N = number of calls; colour codes indicate noteworthy increased (red) and decrease (green)</b>			
	1 April 2013 – 29 March 2014	1 April 2014 – 29 March 2015	1 April 2015 – 29 Feb 2016
	N	N	N
Arabic	1084	1419	1675
Urdu	863	1043	1126
Mandarin	673	609	674
Polish	549	573	571
Romanian	526	494	543
Czech	340	270	227
Somali	327	362	359
Cantonese	321	329	288
Bengali	314	406	445
Hungarian	230	230	136
Kurdish	215	255	263
Russian	203	77	99
Portuguese	150	234	221
Farsi	148	218	125
Panjabi	146	166	176
Slovak	142	132	62
Spanish	124	178	199
Pashto	52	113	95
Albanian	65	77	34
Latvian	45	23	28
Italian	27	52	90
Nepali	26	12	0
N calls other languages	2751	3406	3644
<b>Total</b>	<b>7374</b>	<b>8216</b>	<b>8279</b>

Table 4.5.4.2 shows the use of (external) telephone interpretation services for the same time periods. Mandarin, Cantonese, Panjabi, Polish, Somali, and Kurdish do not show any significant changes in interpreter use across the three-year period. Except for Mandarin, these were also the languages that remained stable in the data for face-to-face interpretation (see Table 4.5.4.1). Polish and Somali are in between long-established and recent arrivals to Manchester, having arrived in the city over the past two decades. It can be assumed that the

stable demand in interpreter requests for these languages reflects that there were no significant fluctuations in population size in recent years.

There is some increase in demand for Arabic, Urdu, Bengali, Pashto, Italian, and Spanish. The telephone-interpreter use for both Arabic and Urdu show a significant increase from 2013/2014 to 2014/2015, and another slight increase from 2014/2015 to 2015/2016. Comparing the first two time periods, the demand for Arabic rose by 40%, and for Urdu by 20%. Bengali shows an increase of 34% from 2014/2015 to 2015/2016. There is a very significant increase in interpreter demand for Pashto from 2013/2014 to 2014/2015 (117%), which, we assume, is attributable to the arrival of Afghan refugees. There is also a steady increase in interpreter demand for Italian and Spanish, which, based on information from the School Census for the sample area, we attribute to the arrival of immigrants of Pakistani origin who came to Manchester recently via these European countries and who may, especially in the younger generation, prefer to use the languages of their recent countries of residence over their heritage language Urdu.

As with the face-to-face interpretation data presented in Table 4.5.4.1, the number of telephone interpretation jobs across the three-year period offers some evidence of a decrease in demand for Eastern European languages. Telephone interpretation for Czech decreases by 21% from 2013/2014 to 2014/2015, with a further slight fall from 2014/2015 to 2015/2016. Hungarian and Slovak are stable in the first two years, but then fall by 41% and 53%, respectively. Demand for telephone-interpretation for Russian falls significantly by 62% from 2013/2014 to 2014/2015, but it then remains stable. Similarly, Latvian shows a 40% decrease in the first two years and remains unchanged from 2014/2015 to 2015/2016. The demand for Albanian falls by more than 50% in the third year. Nepali shows a 53% decrease from 2013/2014 to 2014/2015, but no interpreter requests are recorded for this language in 2015/2016.

Sinhala is a 'new' language, which was requested in 2014/2015 and 2015/2016, but not in 2013/2014. Afar, Bahasa Indonesian, Malay, Malayalam, Mandinka, and Rwandan were requested in 2015/2016 but not in the years prior to that (see Appendix 10.3 for information on lesser-known languages).

Both Agency face-to-face interpretation and telephone interpretation data show a rise in demand for those languages that are also provided by the CMFT's in-house interpreter team, such as Arabic, Urdu and Pashto. This confirms the rationale of CMFT's strategy of distributing jobs for certain languages among internal staff and external providers.

#### 4.5.5 Distribution of indicator languages across hospital departments

Table 4.5.5.1 compares total hours of face-to-face interpretation at the CMFT with hours of face-to-face interpretation at the CMFT's A&E department. We chose to focus on a number of 'indicator languages' that represent distinct settlement histories and demographics. Manchester's Urdu, Panjabi, Arabic, Gujarati, Vietnamese, Hakka, and Cantonese speaking communities are well established in the city. With the exception of Urdu and Arabic, which are also the languages of more recent arrivals, these languages tend to be spoken by elderly residents. By contrast, Pashto, Kurdish, Romanian, Spanish, Hungarian, and Mandarin are spoken primarily by more recent arrivals, and by and large by younger residents. We can assign an intermediate position to Somali and Polish, speakers of which have been settling in Manchester over the past 15-20 years.

	CMFT hospital-wide April 2013 – Nov 2014		CMFT A&E April 2014 – March 2015	
	N	%	N	%
Urdu	16709	20%	1701	20.4%
Arabic	7689	9.2%	1040	12.4%
Cantonese	6072	7.2%	455	5.4%
Polish	5714	6.8%	508	6%
Panjabi	5449	6.5%	363	4.3%
Somali	3754	4.4%	393	4.7%
Mandarin	3544	4.2%	375	4.5%
Romanian	2065	2.4%	310	3.7%
Kurdish	2069	2.4%	245	2.9%
Gujarati	1272	1.5%	38	0.4%
Hungarian	967	1.1%	179	2.1%
Pashto	970	1.1%	144	1.7%
Spanish	859	1%	79	0.9%
Vietnamese	829	0.9%	60	0.7%
Hakka	439	0.5%	83	0.9%
<b>Total</b>	<b>83512</b>	<b>100%</b>	<b>8333</b>	<b>100%</b>

Table 4.5.5.1 compares CMFT hospital-wide demand for interpreters for the indicator languages (April 2013 to November 2014) with the demand for the same languages at A&E (April 2014 to March 2015). There are no significant differences among the individual

languages. The proportion of A&E demand by language closely mirrors that of the general, hospital-wide demand. There is thus no evidence of disproportionate engagement or disengagement with A&E services by individual language communities, and hence no indication that a lack of language provision in primary care or a lack of understanding of the system motivate patients to turn to emergency services. A gap is only noticeable among some new arrival groups, namely Arabic, Romanian, and Hungarian, which show slightly higher demand in A&E. However, for Arabic and Romanian there is also high demand for interpretation services in Central Manchester GP practices (see Table 4.6.3 below), which indicates these groups' intensive engagement with language provisions across service outlets in general rather than frequent use of A&E due to limited GP access.

Certain hospital departments can be generally indicative of the age range of their patient population. Tables 4.5.5.2–4.5.5.5 compare CMFT hospital-wide interpreter requests for the indicator languages with requests at the CMFT's Maternity and Antenatal, Paediatrics, Sexual Health, and Cataract departments during the period from April 2013 to November 2014. The data confirm the trends that were identified for CMFT interpreter data for the year 2012/2013 (cf. Matras & Robertson 2015: 7). Numbers that deviate by more than 100% from the general proportion of hospital-wide requests for the same language are colour coded (green indicating lower, red indicating higher).

<b>Table 4.5.5.2 Hours of face-to-face interpretation at CMFT hospital-wide, CMFT Maternity and CMFT Antenatal; N = hours of interpretation</b>						
	CMFT hospital-wide April 2013 – Nov 2014		CMFT Maternity April 2013 – Nov 2014		CMFT Antenatal April 2013 – Nov 2014	
	N	%	N	%	N	%
Urdu	16709	20%	2	3%	144.5	29.9%
Panjabi	5449	6.5%	0	0%	13	2.6%
Gujarati	1272	1.5%	0	0%	4	0.8%
Hakka	439	0.5%	0	0%	0	0%
Cantonese	6072	7.2%	1	1.5%	4.25	0.9%
Vietnamese	829	0.9%	0	0%	8	2%
Bosnian	63	0.07%	0	0%	0%	0%
Somali	3754	4.4%	1	1.5%	45.5	9.4%
Arabic	7689	9.2%	16	25.9%	123.25	25.5%
Polish	5714	6.8%	4.25	6.6%	55.75	11.5%
Pashto	970	1.1%	1	1.5%	5	1%
Kurdish	2069	2.4%	5	7.5%	26	5.2%
Romanian	2065	2.4%	6	6%	25	5.1%
Spanish	859	1%	0	0%	10	2%
Hungarian	967	1.1%	1	1.5%	11	2.2%
Mandarin	3544	4.2%	2	3%	41.5	8.6%
<b>Total</b>	<b>83512</b>	<b>100%</b>	<b>64</b>	<b>100%</b>	<b>482</b>	<b>100%</b>

The relatively high demand of interpreter jobs for Arabic (25.9%; 25.5%), Kurdish (7.5%; 5.2%) and Romanian (6%; 5.1%) within Maternity Services and Antenatal compared to the CMFT total for these languages (Arabic: 9.2%; Kurdish: 2.4%; Romanian: 6%) reflects the younger age profile of these language communities. There are disproportionately high levels of interpreter requests within Antenatal for Somali (9.4% as compared to 4.4%), Spanish (2% as compared to 1%) and Mandarin (8.6% as compared to 4.2%), all of which are similarly languages spoken by younger populations.<sup>4</sup>

Languages with disproportionately low levels of interpreter requests within Maternity and Antenatal departments in comparison with CMFT totals are Panjabi and Cantonese, while there is minimal demand for Gujarati and Hakka, reflecting the ageing populations of

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<sup>4</sup> Vietnamese is an exception.

these communities. For Urdu, a significant gap stands out between Antenatal and Maternity, for which we are not able at present to offer an explanation.

<b>Table 4.5.5.3 Hours of face-to-face interpretation at CMFT hospital-wide and CMFT Paediatrics; N = hours of interpretation</b>				
	CMF hospital-wide April 2013 – Nov 2014		CMFT Paediatrics April 2013 – Nov 2014	
	N	%	N	%
Urdu	16709	20%	203	21.6%
Panjabi	5449	6.5%	44.5	4.7%
Gujarati	1272	1.5%	3	0.3%
Hakka	439	0.5%	0	0%
Cantonese	6072	7.2%	28	0.2%
Vietnamese	829	0.9%	3	0.3%
Bosnian	63	0.07%	0	0%
Somali	3754	4.4%	41.5	4.2%
Arabic	7689	9.2%	106.75	11.3%
Polish	5714	6.8%	42	4.4%
Pashto	970	1.1%	54	5.7%
Kurdish	2069	2.4%	28.5	3%
Romanian	2065	2.4%	33	3.5%
Spanish	859	1%	13	1.3%
Hungarian	967	1.1%	6	0.6%
Mandarin	3544	4.2%	42	4.4%
<b>Total</b>	<b>83512</b>	<b>100%</b>	<b>937</b>	<b>100%</b>

The pediatric services (Table 4.5.5.3) show high demand for Pashto, a language spoken by a rather young population of new arrivals, while low demand is recorded for ageing populations such as Cantonese, Hakka, Vietnamese and Gujarati speakers.

<b>Table 4.5.5.4 Hours of face-to-face interpretation at CMFT hospital-wide and CMFT Sexual Health; N = hours of interpretation</b>				
	CMF hospital-wide April 2013 – Nov 2014		CMFT Sexual Health April 2013 – Nov 2014	
	N	%	N	%
Urdu	16709	20%	371	41.5%
Panjabi	5449	6.5%	39	4.3%
Gujarati	1272	1.5%	1	0.1%
Hakka	439	0.5%	1	0.1%
Cantonese	6072	7.2%	88.75	9.9%
Vietnamese	829	0.9%	26.5	2.9%
Bosnian	63	0.07%	0	0%
Somali	3754	4.4%	47.5	5.3%
Arabic	7689	9.2%	390.25	43.6%
Polish	5714	6.8%	215	24%
Pashto	970	1.1%	51	5.7%
Kurdish	2069	2.4%	71	7.9%
Romanian	2065	2.4%	131	14.6%
Spanish	859	1%	73	8.1%
Hungarian	967	1.1%	72	8%
Mandarin	3544	4.2%	136.25	15.2%
<b>Total</b>	<b>83512</b>	<b>100%</b>	<b>893</b>	<b>100%</b>

Table 4.5.5.4 shows interpreter hours at CMFT's Sexual Health Department. Here too we find disproportionately high demand among younger age groups. Languages commonly requested are Urdu, and the group of recent arrivals: Arabic, Polish, Pashto, Kurdish, Romanian, Spanish, Hungarian and Mandarin.<sup>5</sup>

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<sup>5</sup> Vietnamese is again an exception.

<b>Table 4.5.5.5 Hours of face-to-face interpretation at CMFT hospital-wide and CMFT Cataract; N = hours of interpretation</b>				
	CMFT hospital-wide April 2013 – Nov 2014		CMFT Cataract April 2013 – Nov 2014	
	N	%	N	%
Urdu	16709	20%	926.5	29.3%
Panjabi	5449	6.5%	768	24.2%
Gujarati	1272	1.5%	195	6.1%
Hakka	439	0.5%	44	1.3%
Cantonese	6072	7.2%	315	9.9%
Vietnamese	829	0.9%	64	2%
Bosnian	63	0.07%	0	0%
Somali	3754	4.4%	232.5	7.3%
Arabic	7689	9.2%	198	6.2%
Polish	5714	6.8%	42	1.2%
Pashto	970	1.1%	0	0%
Kurdish	2069	2.4%	4	0.1%
Romanian	2065	2.4%	9	0.2%
Spanish	859	1%	22	0.6%
Hungarian	967	1.1%	11	0.3%
Mandarin	3544	4.2%	54	1.7%
<b>Total</b>	<b>83512</b>	<b>100%</b>	<b>3162</b>	<b>100%</b>

The reverse pattern can be observed in Table 4.5.5.5, which shows the number of hours of face-to-face interpretation by indicator language at the CMFT's Cataract department. The Cataract unit generally caters for an elderly population, which is reflected in the disproportionately high numbers of interpreter requests among the generally ageing populations of Panjabi, Gujarati and Hakka speakers. Other communities with different demographics, which showed high demand for interpreter service in the Maternity, Paediatric and Sexual Health departments, have disproportionately low levels of requests within the Cataract department: There is low demand for Polish, Kurdish, Romanian, Hungarian and Mandarin, and a moderate demand for Arabic, which reflects the relatively young populations of more recent immigrants in Manchester.

<b>Table 4.5.5.6 Hours of face-to-face interpretation at CMFT hospital-wide and CMFT ‘Access, Booking and Choice’; N = hours of interpretation</b>				
	CMFT hospital-wide April 2013 – Nov 2014		CMFT ‘Access, Booking and Choice’ April 2013 – Nov 2014	
	N	%	N	%
Urdu	16709	20%	145	26.7%
Panjabi	5449	6.5%	54	9.9%
Gujarati	1272	1.5%	26	4.7%
Hakka	439	0.5%	3	0.5%
Cantonese	6072	7.2%	79	14.5%
Vietnamese	829	0.9%	0	0%
Bosnian	63	0.07%	0	0%
Somali	3754	4.4%	15	2.7%
Arabic	7689	9.2%	40	7.3%
Polish	5714	6.8%	160	29.5%
Pashto	970	1.1%	0	0%
Kurdish	2069	2.4%	13	2.3%
Romanian	2065	2.4%	4	0.7%
Spanish	859	1%	5	0.9%
Hungarian	967	1.1%	1	0.1%
Mandarin	3544	4.2%	22	4.0%
<b>Total N of hours overall</b>	<b>83512</b>	<b>100%</b>	<b>542</b>	<b>100%</b>

Table 4.5.5.6 compares the number of hours of face-to-face interpretation for the selected indicator languages at CMFT with interpreter requests listed in the CMFT interpreter dataset under ‘Access, Booking and Choice’, a department that arranges appointment bookings and provides support to patients who have difficulties making appointments and choosing the right care. High demand for Cantonese and Gujarati may reflect the ageing profile of these groups, while the high demand for Polish seems to point to a need within this population for particular support in booking appointments, possibly indicating insufficient information on the procedures for accessing care and treatment. The reasons behind this trend require further research.

## 4.6 Use of interpreter services in Central Manchester GP practices ('assumed CMFT catchment area')

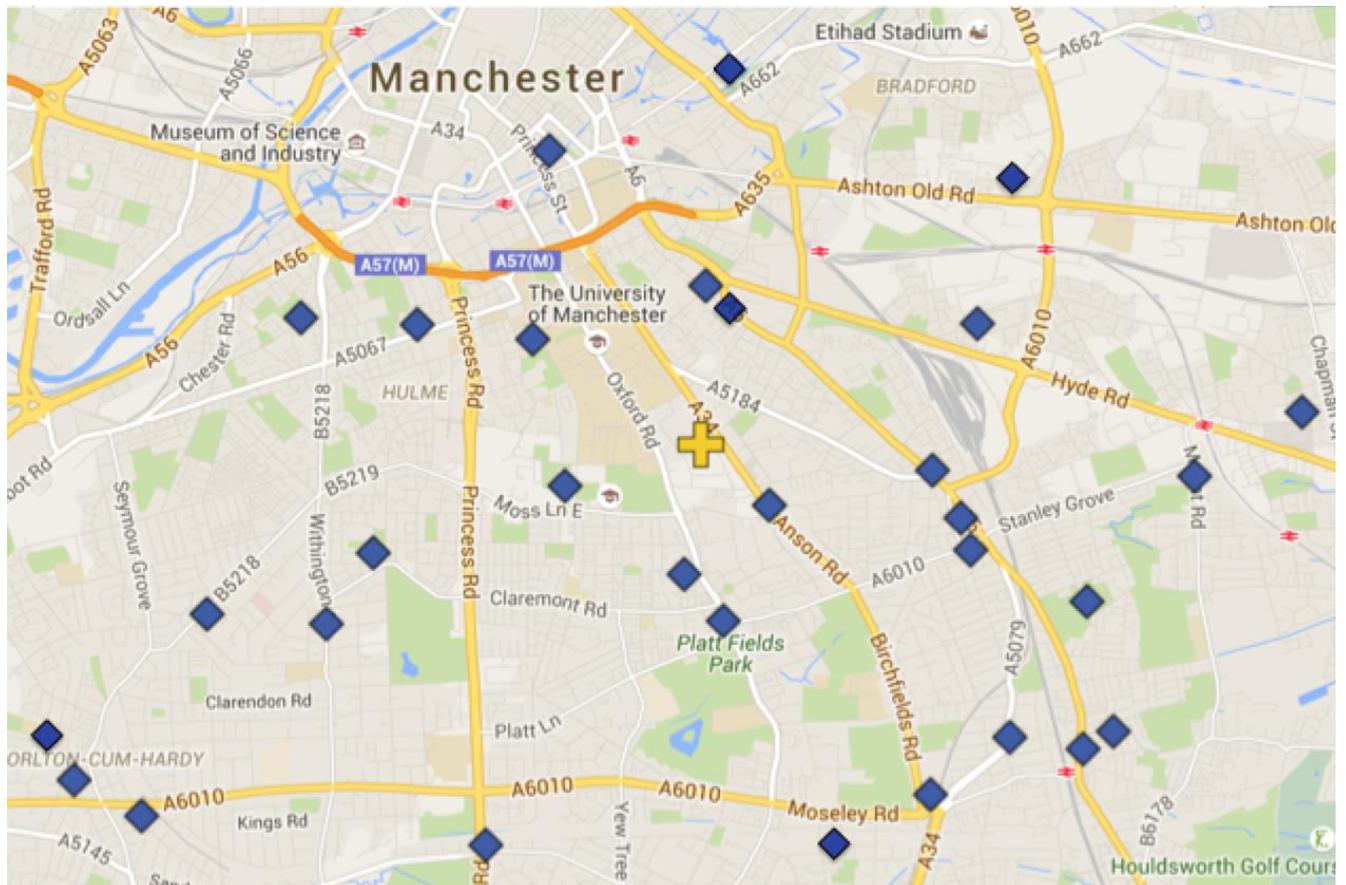
### 4.6.1 Location information for Central Manchester GP practices

Table 4.6.1 lists all GP practices categorised as 'GP Central' in the available dataset, together with their wards and postcodes. The spread of locations can be seen on Map 1 below.

<b>Practice</b>	<b>Ward</b>	<b>Postcode</b>
Ashcroft Surgery	Gorton South	M19 3BS
Ashville Surgery	Whalley Range	M16 9RT
Beacon Medical Practice	Blackley	M9 0FN
Bodey Medical Centre	Fallowfield	M14 6WP
Boundary Medical Practice	Hulme	M15 6PR
Chorlton Health Centre	Chorlton	M21 9NJ
City Road Surgery	Hulme	M15 4EA
Conran Medical Centre	Harpurhey	M9 5BH
Corkland Road Medical Practice	Chorlton Park	M21 8UP
David Medical Centre	Chorlton	M21 8HA
Dickenson Road Medical Centre	Longsight	M13 0WQ
Dr. Bokhari	Cheetham Hill	M8 8UP
Five Oaks Family Practice	Beswick	M11 3BB
Florence House Medical Practice	Higher Openshaw	M11 1JG
Gorton Medical Centre	Gorton North	M18 8LJ
Hawthorn Medical Centre	Levenshulme	M14 6FS
Ladybarn Group Practice	Withington	M20 4SS
Levenshulme Health Centre	Gorton South	M19 3BX
Longsight Medical Practice	Ardwick	M13 0RR
Manchester Medical	Moss Side	M14 4GP
Mount Road Surgery	Gorton North	M18 7BQ
New Bank Health Centre	Ardwick	M12 4JE
New Collegiate Medical Centre	Cheetham Hill	M8 0DA
Northenden Group Practice	Northenden	M22 4DH
Parkside Surgery	Gorton South	M12 5RU
Princess Road Surgery	Withington	M20 1BH
Shiv Lodge Medical Centre	Longsight	M13 0WQ

Surrey Lodge Group Practice	Ardwick	M14 5BY
The Arch Medical Practice	Hulme	M15 5TJ
The Docs Surgery	City Centre	M1 3LY
The Kaya Practice	Chorlton	M21 9NJ
The Range Medical Centre	Whalley Range	M16 8EE
The Robert Darbishire Practice	Rusholme	M14 5NP
The Vallance Centre	Ardwick	M13 9UJ
The Whitswood Practice	Moss Side	M16 7AP
Urban Village Medical Practice	Ancoats	M4 6EE
Victoria Mill Medical Practice	Miles Platting	M40 7LH
Wellfield Medical Centre	Ardwick	M12 5LH
West Point Medical Centre	Levenshulme	M19 2AF
Wilmslow Road Medical Centre	Rusholme	M14 5LQ

Map 1. Location of GP practices in catchment area



#### 4.6.2 Interpreter requests at Central Manchester GP practices

Tables 4.6.2a and 4.6.2b below show the total number of interpreter requests at individual GP practices in Manchester for the period between March 2014 and February 2015. The table also includes an index relating to requests per 100 patients by GP practice. We lack data on the duration of individual interpreter jobs, and so we are unable to estimate the cost incurred to individual practices to cover interpreter provisions. The interpretation agency LanguageLine Solutions generally charges between £0.93 per minute and £1.35 per minute for interpreter services, depending on the service user's demand per month. At the CMFT, the cost for using an external provider ranges between £29.00 - £49.50 per hour (considerably more for BSL) (CMFT 2011: 5). At a rough estimate, based on consulting a number of different sources, we expect the cost to be £25 per hour. This would suggest to us that GP practices that have to accommodate 200 requests per year would face a cost of upwards of around £2,300 per year for interpreter provisions.

<b>Practice</b>	<b>N</b>	<b>Registered patients Oct. 2015</b>	<b>Requests per 100 patients</b>
The Robert Darbishire Practice	1928	18098	10.65
Ashcroft Surgery	1487	7887	18.85
Mount Road Surgery	706	7326	9.64
West Point Medical Centre	595	7193	8.27
Levenshulme Health Centre	584	7021	8.32
Longsight Medical Practice	560	4789	11.69
Gorton Medical Centre	486	8345	5.82
Urban Village Medical Practice	464	10047	6.41
The Arch Medical Practice	384	12823	2.99
Bodey Medical Centre	377	17067	2.21
Shiv Lodge Medical Centre	331	6559	0.05
The Range Medical Centre	329	8179	4.02
Ladybarn Group Practice	288	10381	2.8
The Vallance Centre	254	18948	1.34
West Gorton Medical Centre	245	6398	3.83
Ashville Surgery	231	8088	2.86
Dickenson Road Medical Centre	226	6474	3.49
Hawthorn Medical Centre	216	4348	4.97
The Docs Surgery	199	6479	3.07

City Road Surgery	188	10444	1.8
The Whitswood Practice	164	3531	4.64
Boundary Medical Practice <sup>6</sup>	152	-	-
Parkside Medical Centre	138	3967	3.48
Manchester Medical	104	6552	1.59
Wilmslow Road Medical Centre	85	4592	1.85
David Medical Centre	72	4150	1.73
Dr. Bokhari	42	10221	0.41
Chorlton Health Centre	40	10172	0.39
Princess Road Surgery	18	4422	0.4
Surrey Lodge Group Practice	18	4536	0.4
New Bank Health Centre <sup>7</sup>	11	4800	0.23
Five Oaks Family Practice	10	8916	0.11
Wellfield Medical Centre	7	6459	0.11
Corkland Road Medical Practice	6	7037	0.09
The Kaya Practice	5	10172	0.1
Florence House Medical Practice	2	8276	0.02
Victoria Mill Medical Practice	2	2425	0.01
Beacon Medical Practice	1	3777	0.02
Conran Medical Centre	1	5311	0.02
New Collegiate Medical Centre	1	13186	0.01
Northenden Group Practice	1	10760	0.01
<b>Total</b>	<b>9593</b>	<b>329956</b>	<b>2.90</b>

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<sup>6</sup> No data available for number of registered patients.

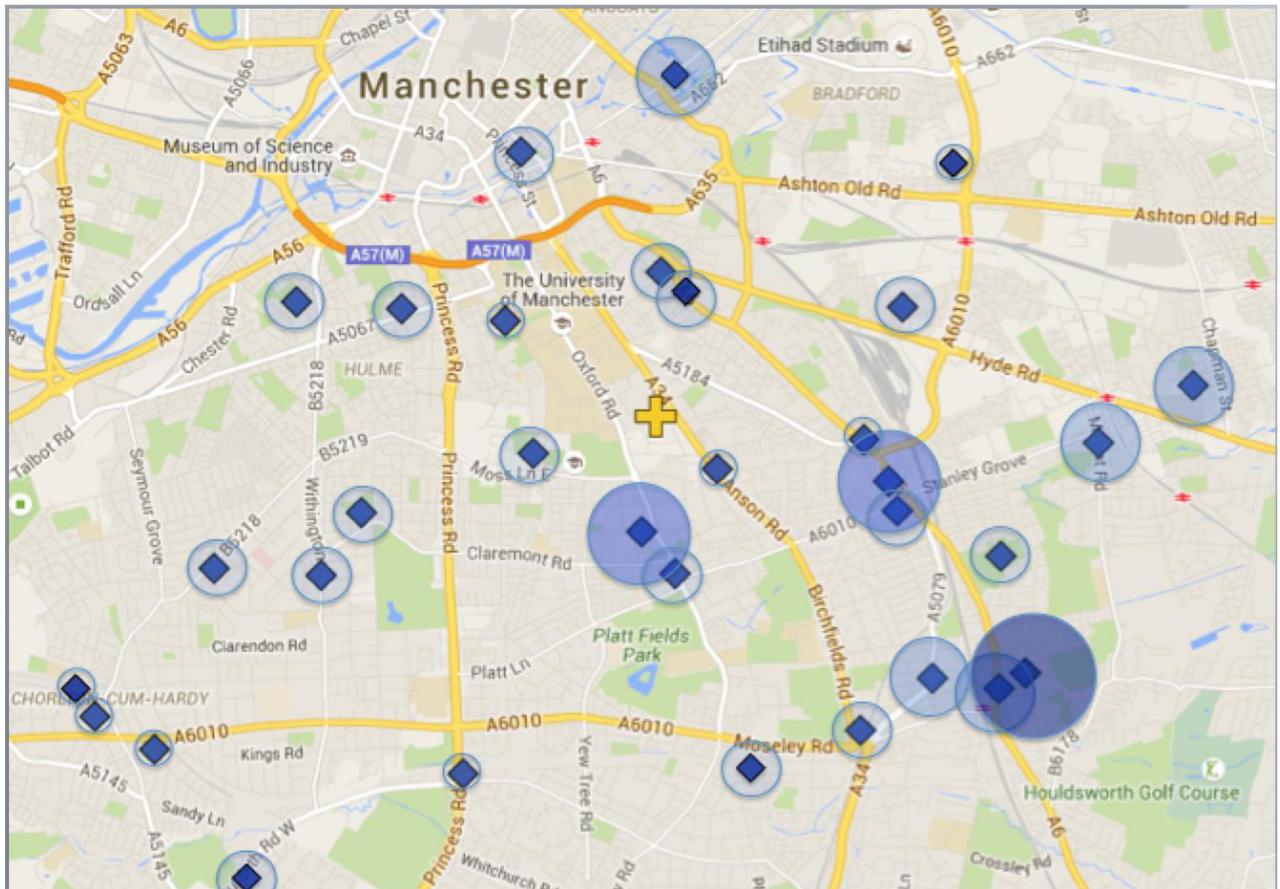
<sup>7</sup> Insufficient data available: Number of total requests represents exclusively requests for BSL.

<b>Table 4.6.2b Interpreter requests Central Manchester GPs (March 2014 – February 2015), by rate of demand; N = number of requests</b>			
<b>Practice</b>	<b>N</b>	<b>Registered patients Oct 2014</b>	<b>Requests per 100 patients</b>
Ashcroft Surgery	1487	7887	18.85
Longsight Medical Practice	560	4789	11.69
The Robert Darbishire Practice	1928	18098	10.65
Mount Road Surgery	706	7326	9.64
Levenshulme Health Centre	584	7021	8.32
West Point Medical Centre	595	7193	8.27
Urban Village Medical Practice	464	10047	6.41
Gorton Medical Centre	486	8345	5.82
Hawthorn Medical Centre	216	4348	4.97
The Whitswood Practice	164	3531	4.64
The Range Medical Centre	329	8179	4.02
West Gorton Medical Centre	245	6398	3.83
Dickenson Road Medical Centre	226	6474	3.49
Parkside Surgery	138	3967	3.48
The Docs Surgery	199	6479	3.07
The Arch Medical Practice	384	12823	2.99
Ashville Surgery	231	8088	2.86
Ladybarn Group Practice	288	10381	2.8
Bodey Medical Centre	377	17067	2.21
Wilmslow Road Medical Centre	85	4592	1.85
City Road Surgery	188	10444	1.8
David Medical Centre	72	4150	1.73
Manchester Medical	104	6552	1.59
The Vallance Centre	254	18948	1.34
Dr. Bokhari	42	10221	0.41
Princess Road Surgery	18	4422	0.4
Surrey Lodge Group Practice	18	4536	0.4
Chorlton Health Centre	40	10172	0.39

New Bank Health Centre	11	4800	0.23
Five Oaks Family Practice	10	8916	0.11
Wellfield Medical Centre	7	6459	0.11
The Kaya Practice	5	10172	0.1
Corkland Road Medical Practice	6	7037	0.09
Shiv Lodge Medical Centre	331	6559	0.05
Beacon Medical Practice	1	3777	0.02
Conran Medical Centre	1	5311	0.02
Florence House Medical Practice	2	8276	0.02
New Collegiate Medical Centre	1	13186	0.01
Boundary Medical Practice	152	-	-
Northenden Group Practice	1	10760	0.01
Victoria Mill Medical Practice	2	2425	0.01
<b>Total</b>	<b>9593</b>	<b>329956</b>	<b>2.90</b>

As Map 2 illustrates, most GP practices with the highest rates of interpreter use per patient are located in the linguistically diverse areas of Rusholme, Longsight and Levenshulme. Practices with the lowest rates of interpreter requests per patient are located in the Chorlton-area in South West Manchester.

Map 2. Interpreter request demand density at Central Manchester GP practices



>15 requests per 100 patients	
10 – 15 requests per 100 patients	
5 – 9 requests per 100 patients	
1 – 4 requests per 100 patients	
<1 request per 100 patients	

### 4.6.3 Central Manchester GP interpreter requests by language

Table 4.6.3 lists the top 20 languages with numbers of interpreter requests at Central Manchester GP surgeries between March 2014 and February 2015.

	N	%
Arabic	1828	19.0%
Urdu	1666	17.3%
Romanian	796	8.2%
Somali	703	7.3%
Bengali	587	6.1%
Czech	579	6.0%
Farsi	399	4.2%
Polish	382	3.9%
Kurdish	336	3.5%
Cantonese	304	3.1%
Mandarin	282	2.9%
Panjabi	174	1.8%
BSL	158	1.6%
Portuguese	149	1.6%
Pashto	110	1.1%
Spanish	105	1.0%
Hungarian	94	0.9%
Vietnamese	41	0.4%
Italian	37	0.4%
Gujarati	6	0.06%
Other languages	857	8.9%
<b>Total</b>	<b>9593</b>	<b>100%</b>

The top languages requested in Manchester's GP practices are consistent with the top languages in the Census (2011), which suggests that there is no disproportionate engagement or disengagement with language provisions at GP practices by particular language groups. Ageing populations, for example speakers of Gujarati or Panjabi, are lower than in the Census (2011). The disproportionately low number of requests for Panjabi in comparison with the Census (2011) may also be related to residential patterns, as Panjabi speakers can be found mainly in North Manchester.

### 4.6.4 Interpreter requests by language at selected GP surgeries

For a sample of three GP practices within the Central area, we examine the distribution of the main languages (top 20) in interpreter demand languages in relation to the presence of

principal languages in the immediate, presumed respective catchment areas of each surgery, by looking at first language data from School Census, for the schools in each surgery's immediate vicinity. The selected GP practices are Ashcroft Surgery in Levenshulme, Longsight Medical Practice, and The Robert Darbishire Practice in Rusholme. We compare requests per patient in the period March 2014 to February 2015, with the results of the School Census (2015). The aim of the comparison is to identify patterns of engagement of local community groups with the GP practices in their immediate area of residence.

#### 4.6.4.1 Ashcroft Surgery (Levenshulme)

	N	%
Urdu	502	33.8%
Romanian	389	26.2%
Arabic	146	9.8%
Czech	145	9.8%
Kurdish	72	4.8%
Bengali	43	2.9%
Pashto	25	1.7%
Polish	24	1.6%
Panjabi	24	1.6%
Farsi	16	1.0%
Hungarian	12	0.8%
Mandarin	10	0.6%
Russian	10	0.6%
Somali	10	0.6%
Russian	10	0.6%
Albanian	8	0.5%
Tigrinya	7	0.5%
Cantonese	6	0.4%
French	6	0.4%
Turkish	6	0.4%
Other languages	16	1.0%
<b>Total N requests</b>	<b>1487</b>	<b>100%</b>

<b>Table 4.6.4.1b Ashcroft Surgery vicinity:  School Census Data (Jan. 2015) Top 20 ‘first language’ at:  Alma Park, Cringle Brook Primary School, Chapel Street Primary School,  St. Mary’s RC Primary School, Levenshulme High School  N = of speakers by school pupils’ first language (other than English)</b>		
	N	%
Urdu	739	46.2%
Bengali	173	10.8%
Arabic	111	6.9%
Pashto	69	4.3%
Somali	45	2.8%
Czech	28	1.7%
Italian	26	1.6%
Polish	24	1.5%
Romanian	20	1.2%
Kurdish	18	1.2%
French	9	0.6%
BSL	7	0.4%
Dutch	7	0.4%
Slovak	6	0.3%
Wolof	6	0.3%
Albanian	5	0.3%
Cantonese	5	0.3%
Hungarian	5	0.3%
Romani	4	0.2%
Finnish	2	0.1%
Other languages	298	18.6%
<b>Total ‘first language’ other than English 2015</b>	<b>1601</b>	<b>100%</b>

The top 20 languages requested at Ashcroft Surgery generally mirror the top 20 languages recorded as ‘first languages’ other than English by school children in the area. The high numbers of interpreter requests for Urdu at Ashcroft Surgery (Table 4.6.1a) can be related to a high presence of Urdu speakers in Levenshulme, which is also mirrored in the School Census Data for the area (Table 4.6.1b). Romanian shows a disproportionately high demand for interpreters (26.2%) when compared with the presence of Romanian-speaking school children in the area (1.2%). This would seem to suggest that school-aged children make up

only a small proportion in relation to adults or infants, or may indeed point to a density of health issues in this particular community. We assume that much of the demand for Romanian interpreters in this area stems from the local community of Romanian Roma migrants (some of whose children are identified by the schools as speakers of Romani rather than Romanian as ‘first language’).

#### 4.6.4.2 Longsight Medical Practice (Longsight)

<b>Table 4.6.4.2a Top 20 languages requested at Longsight Medical Practice (March 2014 – Feb 2015); N= number of requests</b>		
	N	%
Arabic	136	24.2%
Bengali	66	11.8%
Farsi	51	9.1%
Romanian	49	8.8%
Czech	40	7.1%
Urdu	39	7.0%
Kurdish	23	4.1%
Polish	11	2.0%
Mandarin	10	1.8%
Dari	9	1.6%
Russian	8	1.4%
Lithuanian	8	1.4%
Hungarian	7	1.3%
Pashto	5	0.9%
Somali	5	0.9%
Tigrinya	5	0.9%
Azerbaijani	5	0.9%
French	5	0.9%
Spanish	4	0.7%
Albanian	4	0.7%
Other languages	70	12.5%
<b>Total N requests</b>	<b>560</b>	<b>100%</b>

<b>Table 4.6.4.2b Longsight Medical Practice vicinity</b> <b>School Census Data (Jan. 2015) Top 20 ‘first language’ at:</b> Stanley Grove Primary School, St. Agnes C.E. Primary School, St. Joseph RC Primary School, St. Peters RC High School <b>N = of speakers by school pupils’ first language (other than English)</b>		
	N	%
Urdu	465	29.0%
Bengali	254	15.8%
Panjabi	103	6.4%
French	55	3.4%
Somali	45	2.8%
Arabic	37	2.3%
Pashto	33	2.1%
Portuguese	32	2.0%
Chinese	27	1.7%
Polish	27	1.7%
Malayalam	26	1.6%
Kurdish	16	1.0%
German	13	0.8%
Italian	13	0.8%
Dutch	11	0.7%
Romanian	11	0.7%
Lithuanian	10	0.6%
Akan	9	0.6%
Swahili	9	0.6%
Spanish	9	0.6%
Other languages	397	24.8%
<b>Total ‘first language’ other than English 2015</b>	<b>1602</b>	<b>100%</b>

Many of the languages for which interpreting services were requested at Longsight Medical Practice are also listed among the top 20 languages in the School Census (2015) for the schools located closest to the surgery. The absence of some European languages in the top 20 interpreter requests (e.g. German and Dutch), which are present among the top 20 from the School Census for the relevant area, may be explained on the grounds that the school children’s parents are likely to be educated professionals who are proficient in English and do not need interpreter services. The high demand for Arabic and Persian is likely to reflect the

presence of recent refugees, mainly single young men, who are recent arrivals and who do not have children registered in the schools. Once again we see high demand for Romanian, reflecting, possibly, particular health issues in this community.

#### 4.6.4.3 The Robert Darbishire Practice (Rusholme)

<b>Table 4.6.4.3a Top 20 languages requested at Robert Darbishire Medical Practice, (March 2014 – Feb 2015); N= number of requests</b>		
	N	%
Arabic	765	39.7%
Somali	309	16%
Urdu	182	9.4%
Romanian	97	5.0%
Bengali	95	4.9%
Farsi	70	3.6%
Kurdish	57	3.0%
Mandarin	41	2.1%
Panjabi	34	1.8%
Brava	31	1.6%
Tigrinya	26	1.3%
Czech	25	1.3%
Hungarian	23	1.2%
Pashto	20	1.0%
Cantonese	17	0.9%
Russian	16	0.8%
Spanish	16	0.8%
Polish	14	0.7%
Amharic	12	0.6%
Portuguese	12	0.6%
Other languages	66	3.4%
<b>Total N requests</b>	<b>1928</b>	<b>100%</b>

<b>Table 4.6.4.3b The Robert Darbishire Practice vicinity: School Census Data (Jan. 2015) Top 20 'first language' at: Heald Place Primary School N of speakers by school pupils' first language (other than English)</b>		
	N	%
Urdu	137	25.1%
Arabic	117	21.5%
Somali	117	21.5%
Bengali	72	13.2%
Romanian	13	2.4%
Kurdish	12	2.2%
Panjabi	11	2.0%
Czech	9	1.6%
Swahili	8	1.5%
Italian	5	0.9%
Farsi	5	0.9%
Spanish	4	0.7%
Fula	3	0.5%
German	3	0.5%
Hindi	3	0.5%
Pashto	3	0.5%
Hungarian	2	0.4%
Javanese	2	0.4%
Polish	2	0.4%
Portuguese	1	0.2%
Other languages	15	2.8%
<b>Total 'first language' other than English 2015</b>	<b>544</b>	<b>100%</b>

The top languages requested in The Robert Darbishire Practice are consistent with the languages represented in the School Census for the local school. The high proportion of requests for Somali (16%) at the Rusholme GP surgery as compared with Central Manchester GP practices overall (7.3%, cf. Table 4.6.3) is due to the high concentration of Somali-speakers in the area. This is reflected also in the School Census for the nearest school, with Somali speaking children constituting, alongside Arabic speakers, the second largest language group in the school. In addition, both tables reflect the relatively low presence of

Romanian speakers in the area as compared to the Levenshulme and Longsight (see Tables 4.6.4.1a and 4.6.4.2a). The high demand for Arabic at the practice is likely to stem here too from the presence of refugees in the area.

#### 4.7 Comparison of interpreter requests at CMFT and Manchester's GP practices

Tables 4.7.1 – 4.7.3 compare interpreter requests across health care outlets. Table 4.7.1a ranks the top 20 languages according to the number of requests at GP practices and the CMFT, i.e. Manchester's GP practices (March 2014 – February 2015), the CMFT hospital-wide (April 2014 – March 2015) and Central Manchester GP practices (March 2014 – February 2015). Table 4.7.1b lists the same data, ranked by language.

Manchester GP March 2014 – February 2015			CMFT April 2014 – March 2015 (incl. Agency, Bank, Internal)			Central Manchester GP March 2014 – February 2015		
	N	%		N	%		N	%
Arabic	3019	16.5%	Urdu	9382	19.3%	Arabic	1828	19%
Urdu	2288	12.5%	Arabic	5764	11.9%	Urdu	1666	17.3%
Polish	1488	8.2%	Cantonese	3346	6.9%	Romanian	796	8.2%
Czech	1186	6.5%	Polish	3316	6.8%	Somali	703	7.3%
Cantonese	1185	6.5%	Bengali	3094	6.4%	Bengali	587	6.1%
Farsi	1094	6.0%	Panjabi	2452	5.0%	Czech	579	6%
Romanian	925	5.1%	Mandarin	2284	4.7%	Farsi	399	4.2%
Mandarin	841	4.6%	Somali	2238	4.6%	Polish	382	3.9%
Somali	819	4.5%	Farsi	1796	3.7%	Kurdish	336	3.5%
Bengali	632	3.5%	Romanian	1540	3.1%	Cantonese	304	3.1%
Kurdish	532	2.9%	Czech	1362	2.8%	Mandarin	282	2.9%
Portuguese	458	2.5%	Kurdish	1082	2.2%	Panjabi	174	1.8%
BSL	358	2.0%	BSL	1009	2.1%	BSL	158	1.6%
Panjabi	357	2.0%	Portuguese	819	1.7%	Portuguese	149	1.6%
Russian	339	1.9%	Pashto	755	1.6%	Pashto	110	1.1%
Spanish	282	1.6%	Hungarian	640	1.3%	Spanish	105	1.0%
Vietnamese	265	1.5%	Spanish	575	1.2%	Hungarian	94	0.9%
Hungarian	231	1.3%	Italian	562	1.2%	Vietnamese	41	0.4%
French	202	1.1%	French	546	1.1%	Italian	37	0.4%
Tigrinya	175	1.0%	Gujarati	501	1.0%	Gujarati	6	0.06%
Other	1570	8.6%	Other	5363	11%	Other	857	8.9%
<b>Total</b>	<b>18246</b>	<b>100%</b>	<b>Total</b>	<b>48426</b>	<b>100%</b>	<b>Total</b>	<b>9593</b>	<b>100%</b>

<b>Table 4.7.1b Top 20 languages: interpreter requests 2014/2015, ranked by language;</b>								
<b>N = number of requests</b>								
Manchester GP March 2014 – February 2015			CMFT April 2014 – March 2015 (incl. Agency, Bank, Internal)			Central Manchester GP March 2014 – February 2015		
	N	%		N	%		N	%
Arabic	3019	16.5%	Arabic	5764	11.9%	Arabic	1828	19%
Urdu	2288	12.5%	Urdu	9382	19.3%	Urdu	1666	17.3%
Polish	1488	8.2%	Polish	3316	6.8%	Polish	382	3.9%
Czech	1186	6.5%	Czech	1362	2.8%	Czech	579	6%
Cantonese	1185	6.5%	Cantonese	3346	6.9%	Cantonese	304	3.1%
Farsi	1094	6.0%	Farsi	1796	3.7%	Farsi	399	4.2%
Romanian	925	5.1%	Romanian	1540	3.1%	Romanian	796	8.2%
Mandarin	841	4.6%	Mandarin	2284	4.7%	Mandarin	282	2.9%
Somali	819	4.5%	Somali	2238	4.6%	Somali	703	7.3%
Bengali	632	3.5%	Bengali	3094	6.4%	Bengali	587	6.1%
Kurdish	532	2.9%	Kurdish	1082	2.2%	Kurdish	336	3.5%
Portuguese	458	2.5%	Portuguese	819	1.7%	Portuguese	149	1.6%
BSL	358	2.0%	BSL	1009	2.1%	BSL	158	1.6%
Panjabi	357	2.0%	Panjabi	2452	5.0%	Panjabi	174	1.8%
Russian	339	1.9%	Pashto	755	1.6%	Pashto	110	1.1%
Spanish	282	1.6%	Spanish	575	1.2%	Spanish	105	1.0%
Vietnamese	265	1.5%	Italian	562	1.2%	Vietnamese	41	0.4%
Hungarian	231	1.3%	Hungarian	640	1.3%	Hungarian	94	0.9%
French	202	1.1%	French	546	1.1%	Italian	37	0.4%
Tigrinya	175	1.0%	Gujarati	501	1.0%	Gujarati	6	0.06%
Other	1570	8.6%	Other	5363	11%	Other	857	8.9%
<b>Total</b>	<b>18246</b>	<b>100%</b>	<b>Total</b>	<b>48426</b>	<b>100 %</b>	<b>Total</b>	<b>9593</b>	<b>100%</b>

The top languages requested at Manchester’s GP practices, at the CMFT and at Central Manchester GPs are consistent across health care outlets. As Table 4.7.1b shows, 14 of the top languages requested for interpretation are among the top 20 at Manchester GP practices, CMFT and Central Manchester GPs. The top 20 languages across health care outlets are also consistent with other language datasets. The interpreter data presented in Tables 4.7.1a and 4.7.1b indicate that all language communities included in the list of top languages in the Census (2011) and School Census (2015) access health care services (cf. Table 4.4.1). The list of top languages in demand for CMFT and GP interpreter services also matches the distribution of demand for M-Four interpreter services. There is no evidence of significant overuse or underuse of interpreter service in health care settings for any language group in Manchester.

The high demand for Arabic and Romanian for interpreting at Central Manchester’s GP practices is likely to be due to the high presence of speakers of these languages in the sample area, and it also shows intensive engagement with primary care. The fact that these groups show disproportionately low use of interpreter services at the CMFT can, at least for Romanian, be attributed to the fact that this is a rather young population. The high levels of interpreter use for Cantonese at the CMFT (6.9%) compared to Central Manchester GP practices (3.1%) seems to reflect increased use of hospital services of the rather elderly population of Cantonese speakers.

Table 4.7.2 presents hours of interpretation at the CMFT (April 2013 – November 2014) and numbers of requests at Central Manchester GP practices (March 2014 – February 2015) by indicator languages.

<b>Table 4.7.2 Hours of interpretation at CMFT hospital-wide and numbers of requests GP Central by indicator languages</b>				
	CMFT April 2013 – Nov 2014		GP Central March 2014 – Feb 2015	
	N hours	%	N requests	%
Urdu	16709	20%	1666	17.3%
Panjabi	5449	6.5%	174	1.8%
Gujarati	1272	1.5%	6	0.06%
Hakka	439	0.5%	5	0.05%
Cantonese	6072	7.2%	304	3.1%
Vietnamese	829	0.9%	41	0.4%
Bosnian	63	0.07%	0	0%
Somali	3754	4.4%	703	7.3%
Arabic	7689	9.2%	1828	19%
Polish	5714	6.8%	382	3.9%
Pashto	970	1.1%	110	1.1%
Kurdish	2069	2.4%	336	3.5%
Romanian	2065	2.4%	796	8.2%
Spanish	859	1%	105	1.0%
Hungarian	967	1.1%	94	0.9%
Mandarin	3544	4.2%	282	2.9%
<b>Total</b>	<b>83512</b>	<b>100%</b>	<b>9593</b>	<b>100%</b>

As shown for Cantonese above, seemingly low demand at Central Manchester GP practices for Panjabi, Gujarati, Hakka, Cantonese and Vietnamese is likely to be a reflection of disproportionately high demand for hospital services (especially admission, i.e. hospitalisation) among the ageing communities, combined with their geographical distribution, which is not concentrated in the Central catchment area. Arabic and Romanian are, by contrast, over-represented in GP practices compared to the hospital, for the reasons stated above (high concentration in the sample area, and a young population that is less likely to need hospitalisation).

Table 4.7.3 lists the top 20 languages at the CMFT hospital-wide, the CMFT's A&E department, and the GP practices located in the CMFT's assumed catchment area.

**Table 4.7.3: Top 20 languages across GP and hospital environments;****N = number of requests**

CMFT Hospital-Wide April 2014 – March 2015 (incl. Agency, Bank, Internal)			CMFT A&E April 2014 – March 2015			Central Manchester GP March 2014 – Feb 2015		
	N	%		N	%		N	%
Urdu	9382	19.3%	Urdu	1569	20.8%	Arabic	1828	19%
Arabic	5764	11.9%	Arabic	967	12.8%	Urdu	1666	17.3%
Cantonese	3346	6.9%	Bengali	504	6.7%	Romanian	796	8.2%
Polish	3316	6.8%	Polish	450	6.0%	Somali	703	7.3%
Bengali	3094	6.4%	Cantonese	428	6.7%	Bengali	587	6.1%
Panjabi	2452	5.0%	Somali	387	5.1%	Czech	579	6.0%
Mandarin	2284	4.7%	Panjabi	352	4.7%	Farsi	399	4.2%
Somali	2238	4.6%	Mandarin	332	4.4%	Polish	382	3.9%
Farsi	1796	3.7%	Romanian	269	5.6%	Kurdish	336	3.5%
Romanian	1540	3.1%	Kurdish	221	2.9%	Cantonese	304	3.1%
Czech	1362	2.8%	Farsi	210	2.8%	Mandarin	282	2.9%
Kurdish	1082	2.2%	Czech	183	2.4%	Panjabi	174	1.8%
BSL Sign	1009	2.1%	Hungarian	142	1.9%	BSL	158	1.6%
Portuguese	819	1.7%	BSL	125	1.7%	Portuguese	149	1.6%
Pashto	755	1.6%	Pashto	123	1.6%	Pashto	110	1.1%
Hungarian	640	1.3%	Portuguese	100	1.3%	Spanish	105	1.0%
Spanish	575	1.2%	Hakka	75	1%	Hungarian	94	0.9%
Italian	562	1.2%	Russian	74	1%	Vietnamese	41	0.4%
French	546	1.1%	Spanish	70	0.92	Italian	37	0.4%
Gujarati	501	1.0%	Tigrinya	47	0.6%	Gujarati	6	0.06%
Other languages	5363	11%	Other languages	925	12.2%	Other languages	857	8.9%
<b>Total</b>	<b>48426</b>	<b>100 %</b>	<b>Total</b>	<b>7553</b>	<b>100%</b>	<b>Total</b>	<b>9593</b>	<b>100%</b>

The comparison of interpreter requests at the CMFT's A&E department with interpreter requests at Central Manchester GP practices confirms the findings stated above: There is no evidence of significant overuse or underuse of interpreter service by any language group. Those language groups that show high or moderate levels of interpreter use at the CMFT's A&E department, e.g. Urdu, Arabic and Romanian, show high demand for interpreting also in Central Manchester GP practices. There is no language group that has disproportionately high levels of use of interpreter services at the A&E department as compared to GP

environments. Thus, there is no obvious indication that frequent reliance on A&E is due to limited GP access.

The low demand for Cantonese (3.1%) and Panjabi (1.8%) in Central Manchester's GP practices compared to CMFT hospital-wide (6.9% and 5.0%, respectively) and CMFT A&E (6.7% and 4.7%, respectively) reflects, we assume, the disproportionately high demand for hospital and emergency services among these ageing populations.

The quantitative data on interpreter use in Manchester hospital environments and GP practices have offered an overview of the use and demand for interpreting services across language communities. The data suggest that the interpreter services offered at the CMFT and at Manchester's GP practices are flexible and responsive to individuals' language needs. The general picture underlines the importance of the interpreter services that are available in both health care outlets.

5

# Participants' perception of language provisions

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The following sections present the findings from our interviews and focus groups with members from principal groups that are involved in the access, use and provision of health care.

## 5.1 Method and rationale of data collection

We interviewed health professionals who work at CMFT, and staff at GP practices within the relevant geographical area. We conducted interviews and focus groups with patients with limited English proficiency from different linguistic backgrounds, and spoke to interpreters and translators who have worked in health care related contexts. The interviews and focus groups were carried out between May and December 2015. Individual interviews took between 10 and 15 minutes, and the focus groups took approximately one hour each. All interviews were semi-structured, with different sets of core questions specific for each of the three sectors (medical staff, patients, interpreters). Our questions addressed awareness of and engagement with interpretation services in health care settings, as well as participants' views of and experiences with existing language provisions. In addition, the interviewees were invited to add anything that they considered relevant to the topic. With consent from the participants, all interviews were audio-recorded and transcribed.

Our focus groups included staff from the Robert Darbishire Practice in Rusholme, Dickenson Road Medical Centre in Longsight, and Manchester Medical in Moss Side.

Tables 5.1a and 5.1b show data on interpreter requests for two of those for the period between March 2015 and February 2015. They show demand for a relatively small range of different languages, which represent the languages with particularly strong presence in the respective areas.

### 5.1a Dickenson Road Medical Centre (Longsight)

<b>Table 5.1a Languages requested at  Dickenson Road Medical Centre  (March 2014 – Feb 2015);  N= number of requests</b>		
	N	%
Urdu	81	35.8%
Bengali	64	28.3%
Arabic	29	12.8%
Spanish	10	4.4%
Polish	6	2.7%
Panjabi	6	2.7%
Somali	6	2.7%
Czech	5	2.6%
Italian	4	1.8%
Farsi	3	1.3%
Mandarin	3	1.3%
Vietnamese	3	1.3%
Kurdish	2	0.9%
Lingala	2	0.9%
Hungarian	1	0.4%
Pashto	1	0.4%
<b>Total N requests</b>	<b>226</b>	<b>100%</b>

## 5.1b Manchester Medical (Moss Side)

<b>Table 5.1b Languages requested at Manchester Medical Practice, (March 2014 – Feb 2015); N= number of requests</b>		
	N	%
Arabic	32	30.8%
Somali	30	28.8%
Kurdish	7	6.7%
Urdu	6	5.8%
Farsi	6	5.8%
Romanian	5	4.8%
Portuguese	4	3.8%
Lithuanian	4	3.8%
Spanish	3	2.9%
Chinese (incl. Mandarin)	2	1.9%
French	2	1.9%
Malay	1	1.0%
Panjabi	1	1.0%
Tigrinya	1	1.0%
<b>Total N requests</b>	<b>104</b>	<b>100%</b>

### 5.1.1 Health care professionals and other CMFT staff

We conducted interviews with a total of eight General Practitioners and two practice managers. To obtain varied perspectives, we interviewed health professionals whose surgeries serve very diverse communities, as well as GPs working in areas of the city where language difficulties may be less evident, yet present. Four out of the eight GPs work in practices located in Rusholme (The Robert Darbshire Practice), Moss Side (Manchester Medical), and Longsight (Dickenson Road Medical Centre, New Bank Health Centre). One of the GPs works at the CMFT's Manchester Royal Infirmary. Two GPs work at the University of Manchester's Medical School alongside their work as health practitioners. One of the two interviewees is Clinical Lecturer at the Medical School and works at a GP surgery in Sale. The other is Director of Student Experience at the Medical School, and works as a GP in a Wythenshawe practice. In the past, the interviewee had worked in the Whitehouse Centre in Huddersfield, a surgery that provides GP health services to asylum seekers, refugees, migrants and other vulnerable groups in the area. This person also had experience

with teaching at an education centre for refugee health professionals, which offered additional perspectives.

As this pilot study aimed at gaining an insight into possible language barriers in different areas of medical care, we also considered health care outside the hospital and GP environments. We interviewed a dentist and an optician, as well as three pharmacists working at CMFT. In addition, we interviewed a speech and language therapist who had worked with children from different minority language communities in Rochdale; at the time of the study, our interviewee was working as a senior lecturer for Speech and Language at the Faculty of Medical & Human Sciences at the University of Manchester.

We also spoke to the Interpreting and Translation Service manager at CMFT, and to a staff member from the CMFT Patient Advice and Liaison Service (PALS). PALS provide confidential advice and support for patients, families and carers who have questions or concerns about their care or NHS services in general.

### 5.1.2 Patient interviewees

We spoke to 32 individuals from seven different language communities about their experience of health care services and language provisions in Manchester (see Table 5.1.2 below).

<b>Number of interviewees</b>	<b>Home language (and origin) of interviewees</b>	<b>Area in which interviewees access GP services</b>
6	Arabic (Kuwait)	Rusholme
1	Arabic (Iraq)	Rusholme
1	Arabic (Sudan)	Longsight
2	Bengali (Bangladesh)	Stockport, Longsight
1	Kurdish Kurmanji (Syria)	Fallowfield
3	Mirpuri (Kashmir)	Eccles
8	Romani (Romania)	Longsight
4	Somali & Arabic (Somalia)	Rusholme, Hulme
6	Urdu (Pakistan)	Longsight

We conducted two focus groups, one with the four Somali speakers and a second one with the Arabic speaking members of the Kuwaiti-Bidooni community and the participant from Iraq. The remaining interviews were carried out with individual participants.

The groups include major and more established languages such as Arabic and Urdu, and the languages of smaller immigrant populations such as Romani and Kurdish, which represent more recent arrivals. Our sample includes members of communities that have a sizeable presence within the relevant area, namely Urdu, Arabic and Romani. We addressed issues that had been flagged by practitioners, other local authorities, or in previous research. In Manchester, the Roma community has been identified as a community whose members tended to show delays in GP registration, or not register with a GP at all. Roma have in general been described as a vulnerable population, which, according to Hanssens et al. (2016), often experience problems accessing health care. Hanssens et al. (2016:6) argue that this may be linked to a general lack of interpreters who can speak Romani.

The Somali-speaking participants in the focus group are all members of SASCA, Manchester's Somali Adult Social Care Agency, an organisation which in the past has published its own reports on their community members' difficulties in accessing and using medical services (SASCA 2014).

The interviewees' English proficiency varied, and an interpreter was present where interviewees did not have sufficient knowledge of English. At the beginning of our conversations, we aimed to gain a rough idea of the participants' levels of English proficiency, since an individual's level of English obviously has a direct impact on accessing and using health care. The main part of our interviews focused on whether patients were registered with a GP, on the process of GP registration itself, and on the use of GP services. Further questions pertained to potential communication difficulties at the GP surgery and interviewees' engagement with language provisions. A final set of questions focused on the patients' experience of using A&E services, as well as their general experience with GP and A&E services.

To supplement these data, we analysed notes from drop-in consultation sessions for Roma in Manchester, with a focus on issues related to community members' access to and use of health care in the city. The weekly drop-in sessions are offered by the MigRom project in partnership with the Manchester City Council and SureStart Longsight and provide advice and support with any issues that members of Manchester's Roma community may encounter (MigRom Project 2016). The data analysed consisted of anonymised notes taken during and after the drop-in sessions by outreach workers leading at the drop-in consultation, who are employed by the University of Manchester's MigRom project. These notes give a general overview of the clients' cases, the difficulties they encounter and the steps taken.

The data cover the years 2013, 2014 and 2015 and were obtained from the MigRom project.<sup>8</sup>

### 5.1.3 Interpreters and Translators

In the doctor-patient interaction, interpreters take the role of a neutral third party (Crushing 2003; Tribe 1998), which is why their experiences and perspective were crucial to our investigation of language barriers in health care. We conducted interviews with five professional interpreters and translators who have worked for the major interpretation agencies that provide services for the NHS. Four interviewees had experience in both face-to-face and telephone interpretation in medical settings, and two of these had also done translations of written material. The remaining interviewee had focused on written translations of health care-related documents. Our questions pertained to the interviewees' experiences, qualifications and attitudes about the effectiveness of the services for patients and health professionals.

## 5.2 Recording of patients' language at the CMFT and health care surgeries

CMFT guidelines state that staff members have a responsibility to record language-related patient information, which "must be communicated to other colleagues if the patient moves to another ward or service and for booking follow-up appointments" (CMFT 2011: 19). At the CMFT, patients are asked to indicate their preferred language or dialect on arrival at the hospital, and this information is recorded on the Patient Administration System and in the patient notes for future reference.

Likewise, all GPs we interviewed stated that they recorded language-related patient information during the patient's registration. Typically, registration forms require patients to indicate their 'main spoken language' and to state whether they had 'any problems reading' or 'speaking English'. In addition, some GP practices enquire during patient registration whether a patient generally needs an interpreter for appointments, and what the required language or dialect is. This information is then added to patient records and will be flagged when patients make an appointment, prompting staff members to book an interpreter if appropriate. We have, however, heard concerns from practitioners that reception staff may sometimes take it upon themselves not to book an interpreter if they have the impression that the patient is able to book an appointment in English and derive from that that the patient will also be able to communicate in English with the doctor. The issue of self-reported competency has also been flagged to us: Some patients may not want to lose face by

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<sup>8</sup> For an overview of the project, including briefings and reports, see <http://migrom.humanities.manchester.ac.uk/>

admitting that they have difficulties communicating in English effectively, or may feel that they might not be respected if they admit to a low level of competence in English.

The procedure at GP practices is similar to the recording of language-related patient information at Speech and Language Therapy centres, as reported by the speech and language therapist we interviewed. In addition to recording the needs for interpreting and the required language, our interviewee highlighted that the centres aim to maintain consistency in the use of individual interpreters. When making appointments, patients are offered the possibility to indicate the names of interpreters they had used in the past, which will be taken into account when staff members make the booking request.

The Speech and Language therapist emphasised difficulties related to the recording of language-related patient information. It was reported that about half of the clients reported a “wrong language”. This may illustrate the under-reporting of lower-status languages and over-reporting of higher-status languages: Multilingual patients may prefer to indicate the official (ex-colonial) language of their home countries (for example French or Portuguese) rather than their minority or regional languages, as has been argued in the context of Census (2011) data collection (Matras & Robertson 2015; MLM 2013a).

According to the Speech and Language therapist, another reason for incorrect recording of language needs may be that patients believe medical staff will not have heard of their particular language or dialect. Together with his colleagues from a Speech and Language Therapist Service in Rochdale, our interviewee encouraged the implementation of patient registration forms that offer a choice of languages and dialects. The selection of languages was based on a range of languages that our interviewee knew were spoken in the catchment area of the Speech and Language Therapy Centre.

However, across health care outlets, there seems to be no systematic, uniform way of recording language-related patient information, and there is no evidence of explicit sharing of good practice in relation to the recording of these data.

### 5.3 Use of GP and A&E Services

All patients interviewed were registered with a GP, and were aware of the differences between A&E and GP services. When asked about the ways people learned about the UK healthcare system and the process of GP registration, nine participants responded that they had used information available online, such as the *Choose Well Manchester* website. The majority of patient interviewees (27 out of 32) said they received help from friends and family members who had been living in England for a longer period of time. This supports

the conclusions of Hanssens et al. (2016), who found that much of the information patients from minority groups received came from family or friends. Hanssens et al. (2016: 6) report that “[w]hile most of the time this is helpful or harmless, in some cases wrong information from their social network led to difficult situations for health care workers”.

Across language groups, all patients reported to have registered with a GP shortly after they moved to the UK. Comparing A&E and GP services, the large majority of patient interviewees felt that there was no considerable difference in accessing the two services, or in accessibility of language provisions at A&E and GP practices. Four interviewees said they preferred to see their GP, as they knew they had a fixed appointment rather than long waiting times ahead at the health care outlet. Only a small number of interviewees said they found it easier to access A&E services due to language-related issues. The health professionals interviewed did not regard language barriers as a huge factor leading patients to use emergency services. Instead, they related inappropriate use of A&E services to insufficient awareness of existing out-of-hours services such as NHS Walk-In Centres. Both patients and medical staff expressed the view that differences between health systems in the patients’ home countries and the NHS have the potential to cause difficulties in choosing the right care. As our interviewees from Somalia and Bangladesh noted, patients in these countries are not required to book appointments when they want to see a health professional. The Somali focus group participants suggested that Somali patients in the UK tended to go to the pharmacy instead of making a GP appointment or contacting A&E, as this procedure resembled the one they would follow in Somalia.

Those patients who experienced language difficulties when making GP appointments or at GP registration reported that rather than present themselves at A&E, they sought ways to overcome these barriers – such as the use of family members or friends as interpreters.

#### **5.4 Engagement with interpretation services (face to face, telephone interpreting)**

All patient interviewees across language groups perceived communication difficulties as their biggest barriers in accessing and using health care, which confirms the observations reported by Elderkin et al. (2001). Practitioners were highly aware of the potential relevance of language difficulties in complicating access and use of medical services, and they acknowledged the specific scale of the problem in Manchester. Our interviewee from PALS at the CMFT reported that a large proportion of patient complaints were related to communication difficulties. At the same time, the PALS staff member suggested that patients with limited English were generally less confident and more hesitant to formally complain

through PALS, which in turn suggests that language-related difficulties experienced by patients are likely to remain unreported. We have heard concerns from medical practitioners and, in connection with a separate research project, from Greater Manchester Police and the Greater Manchester Police and Crime Commissioner's Office, that there is a 'hidden problem' specifically around asylum seekers not wanting to report hate crime or indeed to put forward any complaints to authorities for fear that this might disadvantage them in some way.

Language barriers may complicate all stages in the patient's journey: booking of appointments, communication during consultations, giving informed consent, or contacting out-of-hours doctors. As the I&T Service Manager at the CMFT noted, language difficulties may preclude patients who do not speak one of the 'major' languages from attending health interventions. One of the pharmacists emphasised the difficulties met by practitioners themselves, as communication problems can be a huge impediment in delivering high quality health care.

There is high awareness of the existing range of language provisions, both among CMFT staff and GP practice staff. Our interviewees regarded interpretation and translation services as relatively easy to access. The I&T Service manager reported that complaints about interpretation services are very rare, and that 98% of requests at CMFT were fulfilled without incident. Particularly the use of in-house interpreters had been without major complications.

Most practitioners were satisfied with the effectiveness of the booking system. They were also content with the option of using telephone interpretation services if a face-to-face interpreter for the required language was not immediately available, in urgent cases or for lesser-known languages. Yet, a number of issues were raised concerning the delivery and effectiveness of interpreting services. Three GPs emphasised logistical problems around whether an interpreter for the required language or dialect was actually available for a certain day or time. One GP argued that it is sometimes difficult to find an interpreter for certain dialects of Somali. The I&T Service Manager at the CMFT reported occasional non-attendance of external interpreters or cases in which the interpreter sent was not competent in the required language or dialect, which was confirmed by three GPs in our interviews. Two GPs had experienced situations in which the interpreter and the patient spoke different dialects of Kurdish, which had caused considerable difficulties since the dialects were not mutually intelligible.

## 5.5 Use of language provisions at GP surgeries and the CMFT

Across language communities, there is general awareness of and satisfaction with the language provisions offered at Manchester's GP practices. The majority of our interviewees were aware of the fact that professional interpreters are available for GP consultations, and they knew how to access these services. Most patients reported that they were offered interpreters every time they booked a GP appointment, and our interviewees generally reported that it was easy to arrange an interpreter for consultations. Nonetheless, three patients from the Urdu community and the Mirpuri speakers reported that they had never been offered interpretation services in health care.

While arranging an interpreter for consultations was described as unproblematic by most patients, the principal obstacle seems to be access to the health care system itself. The majority of our interviewees (25 out of 32) had not registered with their GPs on their own but had received help from English speaking family members or friends who were able to communicate with practice staff and help fill in GP registration forms. Most interviewees reported that, at the time of GP registration, they were not aware of the possibility to arrange interpretation services through their GP practice. A Kurdish speaker relied on support from outside the NHS to register with his GP; our interviewee reported that the *Manchester Advice* service, enabled by government funding (Migrant Impact Fund), had arranged an interpreter to accompany him to GP registration. *Manchester Advice* ceased to operate in 2010.

In addition to language barriers during registration, patients expressed difficulties booking GP appointments. The majority of interviewees required help from English speaking family members or friends to make appointments with their GPs. There is thus general agreement that language barriers may complicate interaction with administrative staff as well as communication with medical staff.

The drop-in session notes from the MigRom consultations for Roma in Manchester confirm our finding that access to health care is problematic for people with limited English proficiency. Between 2013 and 2015, there were several cases in which members of the Romani community asked for support with GP registration; others needed help with making appointments and arranging interpreters. There are records of one case in which an entire family was not registered with a GP for 6 months due to language difficulties. In another case, a woman who was eight months pregnant had not seen a doctor for the entire duration of her pregnancy. She approached the MigRom consultation to ask for help with GP registration. Others attended the drop-in sessions to ask for assistance with translating written documents that they had received from their GP, reflecting insufficient awareness of translation services.

The fact that Roma attend the MigRom consultations to seek support with access to health care indicates that people make use of supplementary advice provisions to be able to properly access and use health care services. These Manchester cases confirm Hanssens et al.'s (2016) findings for Ghent, where reportedly "inequities in health experienced by Roma are, at least partially, caused by access-related problems" (Hanssens et al. 2016: 1).

A large number of the interviewees decided against using professional interpreters for their GP appointments, although they were aware of the free language provisions. Only half of the interviewees reported to have used professional interpreters for their GP appointments, and only some of them reported that they used interpreters consistently when they saw health professionals. Some interviewees stated that they had used professional interpreters in the past, but did not need this service since their English has improved. Other interviewees said they arranged interpreters only when dealing with more serious health issues.

Several patients reported that they did not want to use professional interpreters, despite their low levels of English proficiency and their need for assistance when communicating in English. However, across language communities, the most common reason for not using professional interpreters does not seem to be lack of awareness of or poor access to language provisions. Our interviewees raised a number of issues explaining why they did not want to make use of the interpretation services. First, most interviewees argued that they did not feel comfortable having an unfamiliar third party in the consultation room, emphasising that they did not want to discuss their health problems with people they did not know. Health professionals noted that the presence of an interpreter could potentially lead patients to withhold information. Several practitioners and patients were critical of the need to use different interpreters throughout their treatment, which might lead to increased feelings of insecurity among patients.

Second, patient interviewees from the Romani, Kurdish and Bengali communities addressed issues of confidentiality. This was confirmed by several medical practitioners and our interviewee from PALS, who stated that particularly members of language communities with a relatively small presence in Manchester had expressed concerns about the disclosure of sensitive information and the spreading of rumours in their community.

Third, cultural issues may lead to a reluctance to use professional interpreters. Our Mirpuri speaking interviewees said they were used to discussing health issues with close relatives only, which is why they preferred using family members or friends as interpreters. Furthermore, as emphasised by one of the GPs, women are in some cultures not used to making health care related decisions without male approval. Therefore, they generally

preferred to be accompanied by their husbands or male family members rather than an interpreter booked through their GP. Patients may specify gender preferences when booking an interpreter, but the majority of patients we interviewed were not aware of this possibility.

Finally, some interviewees were critical about the quality and effectiveness of interpretation services. However, these views were expressed primarily by participants who had never used professional interpreters. Several participants feared that the process of booking an interpreter might delay treatment, although they had never actually experienced this themselves. The I&T Service Manager at the CMFT reported that some patients, even before they had accessed the service, expressed concerns about the quality of interpreter services and whether the interpreter would actually attend the appointment.

The interviews suggest that not all participants regard professional interpreting as an effective or satisfactory way to overcome language barriers. However, hesitance toward interpreting services was usually not caused by the patients' own experience. This indicates a need to increase awareness among patients of the quality of professional interpretation, as well as of the most efficient way to access the service.

All interviewees who had accessed health care services at CMFT or used A&E services said that they had been offered professional interpreters at the hospital. Also, all patients said that they had actually made use of interpretation services on these occasions.

A pattern emerges when comparing interviewees' engagement with professional interpreters in hospital environments with the use of interpreters in GP practices: The proportion of patients who used professional interpreters when accessing A&E or other hospital services is markedly higher than the proportion of patients who accessed interpretation services at their GP surgeries. However, as stated above (section 4.5.5), these impressions gained from the focus groups are not necessarily supported by the quantitative data, which provide no evidence that patients from particular communities turn to A&E or other hospital departments rather than to primary care because of difficulties with language provisions in GP practices.

## 5.6 Translated documents and written communication with patients

Four of the eight GP practices involved in our research displayed translated NHS information leaflets about particular illnesses or self-care advice in a small range of languages, usually including Arabic and Urdu. One of the practice managers said in the interview that they were about to add posters in additional languages, aiming to expand their portfolio of written non-English material, as she had realised the majority of patients did not read English.

Several health professionals emphasised that language difficulties may considerably affect written communication with patients. The speech and language therapist reported that patient letters were generally confusing. Patients who have a basic level of English and might not require interpreters for oral communication may have low English literacy skills and may not be able to understand documents written in English. The interviewee reported that patients had repeatedly arrived at the wrong location for their appointment, as the information given on patient letters had been unclear to them.

The effectiveness of translating written information materials was evaluated differently by different health professionals. Two pharmacists said that translation of health care written information was very important, since much of the pharmacists' communication with patients was based on written medication instructions and patient leaflets. On the other hand, most GPs interviewed did not regard the translation of written documents as a central or very effective way to overcome language barriers. Four interviewees emphasised that patients may be illiterate in their home language. Some languages or dialects, such as Mirpuri, do not have a standardised written form, which makes it difficult to provide written material. One of the GPs argued that, from his own experience, translated information material was not really used by the patients. Several interviewees therefore questioned whether translation services were a valuable use of resources (cf. Matras & Robertson 2015: 10).

The health practitioners interviewed also expressed concerns about the lack of communication with external providers of translation services. A pharmacist reported that in the past it had taken up to three weeks to have documents translated. There have also been occasions when information leaflets were translated into a language different from the one requested.

Most of the patients did not regard translation of written documents as a key way to overcome language barriers. The only exception was GP registration forms: GP registration forms are available in English only, which complicates the GP registration process for patients with limited English proficiency.

There seems to be insufficient awareness among both patients and practitioners of the translation services, which can be used upon request. None of the patients interviewed were aware that they are entitled to access these services. Two Arabic speaking interviewees reported to have received patient letters in English, although both had clearly indicated at the hospital that they were not proficient in English and that their preferred language was Arabic. There seem to be gaps in the implementation of language related patient information for written communication with patients, and/or lack of communication between other health care outlets and hospital departments. Language related patient information is used to arrange interpreters for oral communication, but these language preferences are not necessarily considered when issuing letters.

As mentioned above, many GP practices across Manchester provide electronic appointment registration machines to facilitate the patients' check-in process at the surgery. However, it appears that this service is not widely used. None of our interviewees used the check-in computers when they arrived at their practice, as they preferred to communicate with the practice staff directly. Although they were aware that the software was available in several languages, they were unable to say whether their own language was provided.

## **5.7 Alternative language provisions**

In addition to interpretation and translation services, a variety of unofficial yet often effective measures are taken by patients and practitioners to overcome language barriers in access to and use of Manchester's health care services.

### **5.7.1 Multilingual staff members as interpreters**

Both patients with limited English proficiency and health professionals emphasised the value of multilingual staff members. Two of our Mirpuri-speaking interviewees said they were registered with a GP who spoke their language, so they could go to the practice on their own if none of their English-speaking relatives had time to accompany them. The Urdu speakers also reported that they made use of multilingual staff members at their GP practice. One interviewee noted that he was "dependent" on Urdu speaking receptionists and doctors, as he was otherwise unable to make appointments.

Two GPs, who reported that the majority of their patients were of South Asian background, stated that their practices were staffed by speakers of Urdu/Hindi, Panjabi and Bengali. This was not due to targeted staff recruitment; however, having practitioners and administrative staff who can communicate in the patients' first languages turned out to be a very efficient way to overcome language barriers. A GP emphasised in our interview that he

saw it as a great advantage to use the patients' language, as this was the easiest and most effective way to communicate with patients who are not very proficient in English. Another GP similarly stressed the convenience of using multilingual staff members to overcome language difficulties, but argued that professional interpreters should be used during consultations for reasons of quality assurance. At this interviewee's practice, only reception staff were encouraged to use their languages to facilitate appointment booking or discuss other administrative matters. Another GP reported in our interview that multilingual practice staff occasionally supported patients to complete patient registration forms. Our interviewees emphasised the advantages of having multilingual staff members for administrative matters, which confirms the need to flag the use of professional interpreters for the first stages of accessing health care. At the same time, practitioners flagged that GPs are often reluctant to use home languages with patients because they feel that this changes patients' expectations of their behaviour and may therefore influence the outcome of consultations in a negative way: The home language may be regarded as informal and might therefore weaken the GP's authority in the eyes of the patient. The conflicting motivations also pertain to the cost of interpreting and the temptation to rely on staff language skills in order to reduce external cost. It appears that there are no uniform guidelines or procedures in place as to who takes a decision, and on what basis, in cases where the option to rely on staff language skills during the consultation is available.

### **5.7.2 Family members and friends as interpreters**

All health professionals we interviewed were aware that using untrained ad hoc interpreters violates CMFT and NHS guidelines (CMFT 2011). Particularly those interviewees working in hospital environments emphasised the risks involved when using untrained interpreters, such as uncontrolled quality and lack of accreditation. The interviewee from PALS reported that there have been several cases in which patients with limited English proficiency had complained about not being allowed to use family members as interpreters during their treatment at the hospital. However, at least in Manchester's GP practices, the use of the patients' family members or friends as interpreters seems to be very frequent. Our interviewees' statements confirm that there are communication difficulties with administration staff: Especially in the first stages of accessing health care, i.e. GP registration and making appointments, many patients rely on the assistance of relatives or fellow community members who are proficient in English and familiar with the workings of the NHS.

Several patients stated that they also relied on such ‘casual provisions’ for communication during consultations. Most patient interviewees emphasised that they preferred using family members or friends to professional interpreters, for the reasons mentioned in 5.4 above. We have heard that parents especially are usually proud of their children’s language skills and ad hoc interpreting abilities, and that practitioners are reluctant to disappoint patients by turning down the offer to rely on their children for interpreting. The patient interviewees reported that they had never been urged by their GPs or administrative staff member to use professional interpreters instead of family members, indicating that both patients and practitioners are insufficiently aware of the risks involved when using untrained interpreters.

Our interviews with GPs suggest that practitioners may accept the use of family members or friends as interpreters, on condition that both patient and the ad hoc interpreter explicitly consented to this before the consultation. Several GPs reported that the use of ‘casual provisions’ was a common way to overcome language barriers in GP surgeries. Three out of the eight GP interviewees emphasised the convenience of using the patients’ family members or friends as interpreters as it saved the trouble of booking face-to-face interpreters. One GP maintained that the use of the patients’ family members or friends as interpreters was a way to avoid telephone interpretation, which was regarded as a disruption of the conversation. Another GP explicitly stated that she preferred using ‘casual provisions’, arguing that booking professional interpreters was “a huge cost to the NHS” and emphasising the risk that patients may not attend the appointment and the cost would then be incurred without the benefit. A further aspect is the need, in principle, to book a ‘double’ consultation slot when relying on professional interpreters in order to accommodate the time of the interpreting. Since this, as far as we understand, rarely happened, patients who require interpretation are potentially disadvantaged by not receiving the time allocation that they would otherwise be entitled to.

There are several indications that, with respect to the use of ‘casual provisions’, stricter standards are imposed at the CMFT than in GP surgeries (cf. Section 5.5). Several patients reported to have used professional interpreters when they accessed hospital services, but the same patients tended to use family members and friends for their GP appointments. A focus group participant from the Somali community, who had worked at CMFT as a student nurse, confirmed this observation. She reported that the use of family members or friends as interpreters is more likely to be accepted in GP practices than in hospital environments.

### 5.7.3 Ad hoc creative solutions to overcome language barriers

One GP recalled a situation when a patient with limited English proficiency had difficulties to understand what was written on the patient registration form. A face-to-face interpreter was unavailable and the patient refused to use telephone interpreters, which is why the patient asked practice staff to call one of his English-speaking friends to resolve the difficulties. The GP emphasised in our interview that she felt very uncomfortable in the situation, but it was perceived as the only way to proceed with the patient's registration.

Several interviewees – both practitioners and patients – emphasised the effectiveness and convenience of Google Translate, which they used during consultations to translate individual words or phrases.

Some staff members have created their own solutions to reduce communication difficulties, and two creative examples of how health professionals have taken active steps to overcome language barriers deserve special mention:

One of the GPs we interviewed created a video to explain the basics of how to properly use the NHS, which was published in 2012 on YouTube and is available in 10 languages.<sup>9</sup> The GP decided to produce the video after she had worked at the Whitehouse Centre in Huddersfield, a surgery providing health services to asylum seekers, refugees and migrants of non-English backgrounds. The aim of the video is to introduce the UK health system to recent arrivals and other patients who may not be familiar with the differences between GP and A&E services or the processes of making GP appointments. The video also addresses the inappropriateness of using the patients' family members or friends as interpreters.

The video is available in Arabic, Cantonese, Farsi/Dari, French, Sorani Kurdish, Mandarin, Polish, Somali, Sylheti and Urdu. The choice of languages for the voiceovers was based on the languages that were most prevalent in our interviewee's practice in Huddersfield. A version of Mandarin was later produced at the request of the Black Health Agency, a local charity. According to our interviewee, the Black Health Agency had noted an increase in the number of Manchester's Mandarin-speaking residents in the past decade and provided funding to add the additional version. The range of languages has not been updated since. In February 2016, the English version of the video had 800 views; for the video's versions in other languages, the views ranged from around 20 (Farsi/Dari) to 200 (Kurdish and Arabic).

Another example of steps taken by practitioners to overcome language barriers was given by one of the pharmacists we interviewed. When treating an entire family who had

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<sup>9</sup> The video "How to use the NHS" is available at <https://www.youtube.com/watch?v=7U14Z8gihQc>

recently arrived in the UK and had been diagnosed with Tuberculosis, he used pictorial explanations to explain to the patients when and how to take medication. The family had very limited English proficiency and poor literacy skills in their home language and written translations of the rather complex medication instructions would not have been helpful. The patients had been provided instructions with the help of face-to-face interpreters, but they asked for more clarification. Together with a nurse specialist, our interviewee decided to create a step-by-step guide, using pictures and symbols to illustrate medication instructions. The pharmacist explained in our interview that this decision was based on his own efforts to ensure effective communication, as the patients' difficulties in understanding the processes of treatment did not fall under anyone's particular remit. Our interviewee reported that their solution was the only effective way to overcome language barriers, emphasising that conventional language provisions cannot always resolve practical communication difficulties.

The ad hoc measures taken by health practitioners illustrate their motivation to reflect on the potential influence of language barriers on patient safety and quality of service.

## **5.8 Staff training and awareness-raising measures**

CMFT has taken measures to actively promote the use of existing language provisions, through information stalls and PowerPoint presentations for staff and patients. Between two and three staff training sessions per year offer information on how best to make use of interpretation and translation services. Additional sessions on how to access interpretation and translation services may be arranged upon request. CMFT staff are offered basic BSL classes, and the Trust is currently investigating the possibility of introducing further e-learning classes that focus on issues of particular relevance to Deaf people.

The CMFT brochure "Best Practice Guide Interpretation Service" (CMFT 2011) offers information for staff members on when and how to book and use an interpreter. It provides general guidance on how to best record language-related patient information and how to work with interpreters, and offers advice for situations in which patients with limited English proficiency refuse the support of a professional interpreter. It must be noted, however, that no guidance is given on how to use telephone interpreters.

CMFT also aims to ensure the quality of translation and interpretation services. "Providing high quality interpretation and translation services is an important part of ensuring that patients receive the right care, with informed consent, and have improved health outcomes" (NHS 2015b: 1). Staff members from the CMFT I&T team hold quarterly meetings with representatives of external interpretation and translation partner agencies to

discuss patient complaints related to interpretation and possible ways to improve the services. As part of a volunteer scheme set up in partnership with the University of Manchester's Multilingual Manchester project, student volunteers accompany interpreters to speak to patients with limited English proficiency and record patient feedback about medical treatment and communication with CMFT staff.

The CMFT I&T Services homepage states that “[o]ur interpreters go through strict recruitment procedures, are trained professionals, and follow a code of practice and observe strict confidentiality” (CMFT 2016). The I&T Service Manager at the CMFT reported that the NHS had recently tightened regulations regarding the qualifications of interpreters. Accordingly, interpreters have to be formally qualified in their language or prove 100 hours’ experience interpreting in health service contexts.

However, there is no evidence for the existence of structured and uniform quality assurance of the services provided by external interpreters and translators, who often use part-time and free-lance staff. While a University degree or state examination are required to work as a professional interpreter in other countries such as Germany (BDÜ 2016), this is not a requirement for UK interpreting agencies. The interpreters and translators reported in our interviews that standard online courses such as those provided by DPSI online are sufficient to be able to work as a professional interpreter. Health care specific training is not required for interpretation or translation in medical settings. None of the interpreters or translators we interviewed had taken part in training that would have prepared them specifically for interpreting in hospital environments or GP surgeries.

Except for two universities (Middlesex University London and Glyndŵr University in Wales), universities in the UK that offer degrees in Interpreting and Translation do not offer modules that focus specifically on medical interpreting or translation. These degrees do, however, usually involve modules in Public Service Interpreting, which typically includes the field of ‘Health’ among other subject areas.

## 5.9 Quality of interpretation services

Interviewees from all sectors– health professionals, interpreters and translators, as well as patients with limited English proficiency – expressed concerns about the training and quality assessment of interpreters and translators. Several interpreters pointed out that, while they were trained in confidentiality and consent, they did not feel well prepared for interpreting in medical settings. It was emphasised that interpreting in these contexts may involve specific challenges. Emphasising the difficulties of translating medical terminology across cultures,

one GP noted in our interview that certain concepts, such as ‘depression’, do not necessarily exist in other cultures or languages. This may complicate the interpretation process significantly. An interpreter argued in our interview that translation equivalents could not always capture the measurement of gravity of the situation. Other interviewees addressed the great responsibility they had when interpreting in medical settings. This confirms Price-Wise’s (2008) findings, which show that errors in interpretation may have medical consequences. Our interviewees pointed out that, due to the additional challenges posed to interpreting in health care scenarios, more specialist training and a better system of interpreter qualification and certification was needed.

In addition, interpreters argued that also medical staff should be trained specifically for their work with interpreters. Communicating through a third party rather than directly with the patient has a considerable influence on the nature of the conversation, and it might require GPs to adapt the way they usually structure their consultations. In addition, several interviewees indicated that the three parties involved – patient, health professional and interpreter – often have different conceptions of the role of the interpreter. Our findings indicate the necessity to clearly set out the participants’ roles before consultations.

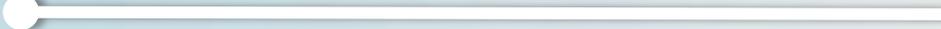
Concerns related to the efficiency and quality of interpretation services emerged in several cases:

1. One of the researchers, a native German speaker, was given the opportunity to witness a case of telephone interpretation in a GP practice. It took approximately two minutes to establish a connection with the German speaking interpreter, which is a noticeable time considering that GP consultations are usually limited to ten minutes per patient. However, the interpreter’s German proficiency level was limited and did not allow the conversation to run smoothly. The translation sounded artificial and was often difficult to understand, which may cause discomfort on the part of the patient in real-life situations. This single case does not, of course, allow for general conclusions about the quality of interpreting services offered in Manchester’s GP practices. Yet, it can certainly be taken as an indication that quality assurance procedures for professional interpreters working in health care settings require some attention.
2. The website [translatorscafe.com](http://translatorscafe.com) is a platform for self-declared “professional” interpreters and translators to advertise their services. There is a search function that allows users to search for interpreters and translators according to language and location. We did a test search for selected, lesser-known languages and found that

several Manchester interpreters who claimed to have worked in health care settings did not present any formal qualification in interpreting, but merely flagged their native speaker language skills as proof of quality. In some cases, specialised keywords were attached to their personal profiles, such as “Medicine - Public Health Education and Promotion; Medicine - Social Psychology; Medicine - Toxicology, Medicine (General)”, but again with no reference to any formal qualification.

6

# Findings



Our findings provide no indications that a lack of language provisions is impacting patients' choice of service outlet. There is no evidence of disproportionate engagement or disengagement with individual services by particular language groups. However, there is some evidence that there is insufficient understanding of the system among some patients from migrant populations.

We generally found a high level of awareness of language provisions among our interviewees. There is also general satisfaction among patients and medical staff with existing provisions, which are available in a variety of forms and allow tailored selection of medium and mode. In principle, health care providers and interpreting and translation agencies are aware of the dynamic changes of language needs and the need to maintain a flexible and responsive language provision portfolio. By and large there is a wide availability of languages, including sub-varieties of the same languages, and the system is able to respond to the language needs of individual patients.

However, at the same time, there are few safeguards in place to ensure that interpreting and translation staff have proper training and experience. This is the case especially for smaller or lesser-known languages, with which we mean languages that constitute minority or regional languages in the country of origin, and which often lack institutional support and standard written conventions. For these languages, the staff pool is smaller and training opportunities are limited (in the absence of a standard language, or a public health care system in the regional and minority language), while demand for such languages is not necessarily lower (and sometimes it is high locally due to residential clustering). No obvious facilities or procedures exist for quality assurance of interpreter and translation provisions that are offered at GP surgeries.

The principal obstacle for most patients is obtaining access, i.e. GP registration and appointments making. Communication with administrative rather than medical staff seems to create major difficulties for people with limited English proficiency.

There seems to be a lack of awareness on the part of both practitioners and patients of the risk of relying on 'casual' provisions (family members and friends as interpreters), despite the fact that practitioners tend to recognise the discrepancy between NHS guidelines and the practical convenience in respect of 'casual' provisions. Stricter standards are imposed with respect to 'casual' provisions in the hospital environment as compared to the GP environment, inasmuch as information is available. In general, there is insufficient awareness among patients, and among practitioners outside the hospital environment, of the risks of uncontrolled interpreting or lack of accreditation.

There are gaps in the standards of data compilation and data monitoring in individual outlets. There is no evidence of systematic, explicit sharing of good practice in relation to provisions, preferences, or data compilation methods, or monitoring and analysis of data. In addition, there are gaps in the implementation of patient language information for written communication with patients. Language-related patient information recorded at GP registration or upon arrival at the hospital may be used to contact interpreters, but usually no use is made of such information when issuing letters.

There is no evidence that residential patterns affect access to language service, but the lack of data from other hospital trusts means that we are unable to carry out a systematic comparative analysis.

Finally, there seems to be a high motivation on the part of practitioners to reflect on issues of language difficulties, and there is general awareness of the potential relevance of language barriers to patient safety and quality of service.

7

# Recommendations

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It is necessary to increase awareness among patients of interpreter provisions at GP surgeries, and of the accessibility of such provisions. Particular focus should be placed on ensuring more widespread awareness of language support during GP registration and appointment making, i.e. communication with administrative staff.

To this end, we recommend to expand and promote the *Choose Well Manchester* website. We recommend expanding the range of material available in languages other than English. In addition, we suggest targeted promotion of *Choose Well* services that are available in several languages, specifically addressing individual communities. Furthermore, we recommend creating a portal on the *Choose Well* website that allows users to group existing information material according to language. Gaps in content and presentation, as well as further pathways and channels for promotion should be identified.

There is a need to flag the existence of telephone interpretation services (to patients who have concerns about confidentiality), and to optimise the effectiveness of these services. GP practices need to ensure that their equipment allows for effective and comfortable use of telephone interpretation services (e.g. telephones with speaker phone). In addition, guidance for medical staff on how to use telephone interpreters, which is currently missing in the CMFT's guidance brochure on using interpreter services, (CMFT 2011), would be helpful.

Steps should be taken to increase awareness of translation services among patients and staff. Additionally, it must be ensured that a patient's registered language of communication is followed up for both appointments and written communication.

There is a need for quality assurance of interpreting services. We recommend setting standards for the training of interpreters, regular assessment of the service, and quality control through independent agencies. Moreover, there is a need to introduce explicit validation of contractors based on their ability to prove quality assurance specifically for medical consultation.

In order to raise medical staff members' awareness of working in a linguistically diverse environment, we recommend expanding relevant training for medical professionals on the job and as part of professional training courses (medical degree), of the kind that is already being offered at the University of Manchester's undergraduate programme.

Language-related patient information recorded at GP registration should be communicated to hospital staff as soon as a patient is referred to the hospital, so that health professionals and administrative staff working at the hospital are aware of a patient's language needs on the patient's arrival at the hospital.

There is a need to review the practice of relying on ‘casual’ interpreting by family members and friends. Attention needs to be called to the contradiction between recommended and actual practice, which is reinforced by the convenience to both GPs and patients, and to the risks involved. We recommend setting up channels for the sharing of good practice among hospital trusts and primary care.

There is a need for systematic and continuous data monitoring on language needs, data sharing among institutions, and the implementation of more uniform standards of data compilation. Close partnership with research can allow regular data monitoring and data sharing with other sectors in order to be able to assess localised trends and to help plan provisions, including quality assurance and training on specific communities. We have experienced in our own research that it was often difficult to obtain quantified data, which illustrates the need for stricter data compilation norms.

In order to maximise the benefits of monitoring patient language information, it is important to systematically and uniformly record language information in as much detail as possible. To avoid incorrect recording of patient languages, patient registration forms should offer a (comprehensive and updated) selection of languages and relevant sub-varieties of languages. Here too there is scope for close and ongoing collaboration with researchers, both in order to identify languages, and in order to be able to triangulate datasets across different sectors, which will allow to recognise trends such as fluctuations in the size of different communities, or residential clustering. Mutual intelligibility among some languages (Dari and Farsi; Hindi and Urdu in speech; etc.) might be taken into consideration more systematically when working with patient language data to inform language provision.

There is a need to facilitate GP registration and appointment making for patients with limited English proficiency. This could take the form of offering GP registration forms in several languages, which would however require closer collaboration with translation services to have these forms translated back into English.

Greater efforts should be undertaken to raise awareness among patients of their right to express a preference in regard to the choice of interpreter, in relation both to general preferences such as a gender preference, and the choice of individuals. Where appropriate, continuity should be encouraged. But patients must not feel under pressure to continue to use the same interpreter if they are unhappy with their service, or because they may feel a personal responsibility toward a particular interpreter knowing that the interpreter depends on the income from the booking.

We support the recommendations resulting from SASCA’s research looking at health issues in Manchester’s Somali community (SASCA 2014). That report emphasises the need for better two-way communication between the community and health professionals, arguing that difficulties in accessing health care was often caused by insufficient understanding of the UK health system and the roles of the different parts of the NHS (SASCA 2014:20). Based on our findings, we also agree with the conclusions of the NHS report on “Improving the Quality of Interpreting and Translation Services in Primary Care” (NHS 2015b).

# Suggestions for further research

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The data considered in this report focuses primarily on those who do access health care. There is a potential risk that targeted research will lead to self-selection of respondents. In order to gain a more in-depth understanding of problems of accessibility of health care services among linguistic minority groups, we need long-term participant observation within communities, and longitudinal or at least short term longitudinal studies especially among groups of recent arrivals such as asylum seekers and refugees, to observe the gradual process of gaining access and the difficulties that this entails directly.

Both the quantitative and qualitative data considered in this report show evidence of a continuum between the state of complete or near complete lack of English proficiency, and the gaining of confidence that enables clients (and the practitioners who provide care for them) to release themselves from the dependency on interpreter and translation services. On the quantitative side, the evidence is historical, pertaining to the low level of demand for interpreter services in languages of the communities that are well established in Manchester, and especially among the younger generations within these communities.

On the qualitative side, the evidence is apparent from the personal histories of respondents who reported having used interpreter services in the past but no longer requiring them now that their English language skills have improved. This underlines the need for more longitudinal qualitative data, to be gained through more systematic middle- and long-term participant observations, and for more comprehensive and longitudinal assessment of quantitative data, for which setting and enforcing strict standards on data compilation within the services is a requirement. There is also a need to identify and better understand various thresholds of patient language skills in regard to different types of consultation and treatment: While patients who are learning English may require less time to acquire the skills to express pain, for example, more time and greater immersion are likely to be needed before a patient can adequately speak about emotional matters. Impact-oriented research is needed into ways of empowering patients to be able to ask for interpreter services for some issues even if they are able to communicate in English on other health matters, and to build confidence among practitioners to interrupt a consultation session, if necessary, and to re-schedule it with an interpreter if a certain threshold of communication difficulties is encountered.

Systematic participant observation is also needed to better understand the effects and risks of 'casual' interpreting practices, and to gain an understanding of why patients and medical staff choose to opt for these, as well as of attitudes and obstacles in using professional interpreters. Such participant observation should ideally cover both hospital and

primary care environments in order to identify the differences in practice standards and the ways in which they are enforced, the way in which they are aligned with the specific environment, and the possible consequences of such differences.

We require a better understanding of the reasons for which some patient groups appear to be having difficulties making appointments and registering. This pertains especially to groups that showed high levels of interpreter use in the CMFT department ‘Access, Booking and Choice’. More qualitative research is also needed to investigate the slightly increased use of A&E among new arrival groups who also showed intensive engagement with primary care; here there is a need to expand the use of targeted focus groups in order to gain further insights. We have also identified a need to explore the level of awareness of language provisions among practitioners who work in those areas of Manchester that generally have lower levels of language diversity, and where traditionally there has not been a need for interpretation; this too can be achieved through targeted focus groups.

Some short-term, and smaller scale research in close collaboration with practitioners and practitioner organisations can have immediate benefits for practice in Manchester. The *Choose Well Manchester* resource has the potential to fill crucial information gaps. We are aware that it has received a high number of page views, and that there has been a 10% rise in page views in 2016, with 88% of views coming from new people. Clearly, *Choose Well Manchester* already plays a key role in raising awareness of language provisions and general health care provisions among new arrival populations. It would therefore be useful to learn more about the users’ experience of the resource, and we would recommend consulting targeted focus groups and systematic collaboration with community groups to that end.

In collaboration with the relevant agencies, training packages for medical staff on working in a multilingual environment might be designed and piloted. Researchers are in a position to identify and draw on international experience in this area, through existing links with a number of national and international projects.

There is also a need to explore existing international validation procedures for quality assurance. On this basis, procedures for quality assurance of interpreting in Manchester’s health care settings can be further developed. Pilot studies should be carried out to evaluate the effectiveness and feasibility of such procedures.

Finally, in order to allow continuous and systematic monitoring of changes in language profiles, as well as the level of responses to individual patients’ language needs, we recommend creating protocols for data compilation and sharing through the sharing of existing good practice, and cross-sector collaboration.

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10

# Appendix: Additional tables

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## 10.1 CMFT interpreter requests by type of interpretation and year

	<b>April 2013 – March 2014</b>		<b>April 2013 – March 2014</b>		<b>April 2015 – February 2016</b>	
	N	%	N	%	N	%
Face-to-face requests	38,592	84%	40,210	83%	40,514	83%
Telephone requests	7343	16%	8215	17%	8279	17%
<b>Total</b>	<b>45,935</b>	<b>100%</b>	<b>48,425</b>	<b>100%</b>	<b>48,793</b>	<b>100%</b>

## 10.2 Seasonal fluctuation by selected languages: Number of interpreter requests CMFT by month

Tables 10.2.1 – 10.2.4 show interpreter use at the CMFT and at the CMFT's A&E department for a selected number of individual language groups. The data include interpretation services delivered by Agency, Bank and Internal interpreters.

### 10.2.1 Seasonal fluctuation Urdu at CMFT and CMFT's A&E department

	N
December 2013	585
January 2014	757
February 2014	639
March 2014	648
April 2014	630
May 2014	702
June 2014	684
July 2014	644
August 2014	599
September 2014	734
October 2014	767
November 2014	681
<i>Average N per month</i>	<i>673</i>
<b>Total</b>	<b>8070</b>

<b>Table 10.2.1b CMFT A&amp;E face-to-face interpretation requests for Urdu by month; N = number of requests</b>	
	N
June 2014	133
July 2014	112
August 2014	121
September 2014	126
October 2014	135
November 2014	118
December 2014	132
January 2015	173
February 2015	154
March 2015	143
April 2015	98
May 2015	140
<i>Average N per month</i>	<i>132</i>
<b>Total</b>	<b>1585</b>

### 10.2.2 Seasonal fluctuation Arabic at CMFT and CMFT's A&E department

<b>Table 10.2.2a CMFT interpreter requests for Arabic by month; N = number of requests</b>	
	N
December 2013	308
January 2014	301
February 2014	265
March 2014	336
April 2014	317
May 2014	350
June 2014	360
July 2014	352
August 2014	316
September 2014	362
October 2014	381
November 2014	366
<i>Average N per month</i>	<i>335</i>
<b>Total</b>	<b>4014</b>

<b>Table 10.2.2b CMFT A&amp;E face-to-face interpretation requests for Arabic by month; N = number of requests</b>	
	N
June 2014	85
July 2014	73
August 2014	63
September 2014	91
October 2014	76
November 2014	96
December 2014	77
January 2015	95
February 2015	80
March 2015	98
April 2015	57
May 2015	87
<i>Average N per month</i>	81.5
<b>Total</b>	<b>978</b>

### 10.2.3 Seasonal fluctuation Polish at CMFT and CMFT's A&E department

<b>Table 10.2.3a CMFT interpreter requests for Polish by month; N = number of requests</b>	
	N
December 2013	199
January 2014	274
February 2014	384
March 2014	352
April 2014	224
May 2014	223
June 2014	222
July 2014	225
August 2014	190
September 2014	223
October 2014	243
November 2014	210
<i>Average N per month</i>	247.4
<b>Total</b>	<b>2969</b>

<b>Table 10.2.3b CMFT A&amp;E face-to-face interpretation requests for Polish by month; N = number of requests</b>	
	N
June 2014	37
July 2014	34
August 2014	40
September 2014	32
October 2014	40
November 2014	33
December 2014	31
January 2015	50
February 2015	58
March 2015	44
April 2015	21
May 2015	31
<i>Average N per month</i>	37.6
<b>Total</b>	<b>451</b>

#### 10.2.4 Seasonal fluctuation Romanian at CMFT and CMFT's A&E department

<b>Table 10.2.4a CMFT interpreter requests for Romanian by month; N = number of requests</b>	
	N
December 2013	68
January 2014	85
February 2014	90
March 2014	73
April 2014	78
May 2014	67
June 2014	78
July 2014	75
August 2014	41
September 2014	81
October 2014	98
November 2014	102
<i>Average N per month</i>	78
<b>Total</b>	<b>936</b>

<b>Table 10.2.4b CMFT A&amp;E face-to-face interpretation requests for Romanian by month; N = number of requests</b>	
	N
June 2014	18
July 2014	18
August 2014	15
September 2014	20
October 2014	32
November 2014	33
December 2014	24
January 2015	27
February 2015	25
March 2015	30
April 2015	23
May 2015	24
<i>Average N per month</i>	24
<b>Total</b>	<b>289</b>

### 10.3 Information on lesser-known languages

<b>Table 10.3 Information on lesser-known languages</b>		
	<b>Language Family</b>	<b>Countries where spoken</b>
Afar	Afroasiatic	Djibouti, Eritrea, Ethiopia
Afrikaans	West Germanic (Indo-European)	South Africa, Namibia
Bahasa Indonesian	Malayo-Polynesian (Austronesian)	Indonesia
Bangla	Indo-Aryan (Indo-European)	Bangladesh
ChiChewa	Bantu (Indo-European)	Zambia, Malawi, Mozambique, Zimbabwe
Guru	Bantu (Niger-Congo)	Republic of South Sudan
Kazakh	Turkic	Kazakhstan, Russia
Kinyarwanda	Bantu (Niger-Congo)	Rwanda, Burundi, Uganda
Malayalam	Dravidian	India
Mandinka	Mande (Niger-Congo)	Senegal, the Gambia, Guinea-Bissau
Luganda	Bantu (Niger-Congo)	Uganda
Ndebele	Bantu (Niger-Congo)	South Africa, Zimbabwe
Pulaar	Fula (Niger-Congo)	Senegal, Mauritania, the Gambia, Mali
Tumbuka	Bantu (Niger-Congo)	Malawi, Zambia