National Assembly for Wales
Culture, Welsh Language and Communications Committee

The Welsh Language Standards (No. 7) Regulations 2018:

Report of the Culture, Welsh language and Communications Committee under Standing Order 27.8

March 2018

Background

1. The Welsh Language Commissioner carried out a "standards investigation" from November 2014 to February 2015. The conclusions of that investigation were presented to the Welsh Government, which subsequently held a public consultation on draft Regulations (the draft Regulations) from July to October 2016.

2. Following this, the "Welsh Language Standards (No. 7) 2018 Regulations" (the Regulations) were laid before the Assembly on 27 February 2018 by the Minister for Welsh Language and Lifelong Learning.

Purpose of the Regulations

3. The Welsh Language (Wales) Measure 2011 makes provision for the specification of standards of conduct in relation to the Welsh language. These replace the system of Welsh language schemes provided for by the Welsh Language Act 1993.

4. The Regulations specify standards of conduct in relation to the Welsh Language for Local Health Boards, National Health Service Trusts in Wales,

Community Health Councils and the Board of Community Health Councils in Wales.

5. The Regulations also authorise the Welsh Language Commissioner (subject to certain exceptions set out in regulation 3(2)) to give a compliance notice to those bodies, in relation to standards specified by the Regulations.

6. Further information about the purpose and effect of the Regulations are set out in the accompanying Explanatory Memorandum and Notes.

Committee Consideration

7. The Committee agreed that the Regulations were likely to give rise to issues of public policy likely to be of interest to the Assembly. It agreed that it should scrutinise the Regulations when they were laid before the Assembly. The Committee gave notice to the Welsh Government of its intention to report on the Regulations, as required under Standing Order 27.8.

8. The Committee also agreed that it should provide an opportunity for stakeholders to submit written evidence and for the Committee to hear oral evidence.

Written Evidence

9. The Committee invited a number of organisations with an interest in this field to submit written evidence and issued a more general call for written evidence. The following organisations submitted written comments as a result:

- The NHS Confederation;
- BMA Cymru Wales;
- Cymdeithas yr Iaith Gymraeg;
- Meddwl.org;
- Royal College of General Practitioners.

10. The full written evidence received is in Annexe 1 to this report. A summary of some of the key points made is set out below.

NHS Confederation

11. The NHS Confederation was broadly supportive of the Regulations. It recognised the importance for patient-centred care of delivering services through the Welsh Language. It also pointed to a range of good practice already in place. It believed the Regulations would provide greater clarity but also pointed to a range of challenges including financial constraints, the environment in which the NHS operates and the difficulty of attracting and training suitable staff.

12. The Confederation welcomed the changes in the Regulations from the draft Regulations in relation to clinical consultations. This had previously required support for Welsh speakers at clinical consultations. Instead, there is a requirement for NHS Bodies to publish a 5-year improvement plan setting out the extent to which clinical consultations can be carried out in Welsh.

13. The Confederation also welcomed changes in relation to primary care. Other than the specific standards for primary care that have been retained (see standards 65-68), the Regulations now only apply standards to primary care services provided directly by Local Health Boards.

14. The Confederation noted a number of other concerns and concluded that while it agreed with the wider objectives of the standards, its members had a number of serious reservations about their practical application and their impact on other services.

BMA Cymru Wales

15. BMA Cymru Wales also supported the use of the Welsh language in health care settings and recognised that this can help doctors in diagnosis and in providing care. However, BMA Cymru Wales also pointed to practical issues around the availability of Welsh speaking medical staff.

16. BMA Cymru Wales supported the changes in relation to clinical consultations in secondary care. However, they also pointed out that there were differences of view among their members and some had expressed support for the standard in the draft Regulations.

17. BMA Cymru Wales also supported the approach set out in the Regulations in relation to primary care.

Cymdeithas yr Iaith Gymraeg [The Welsh Language Society]

18. Cymdeithas yr Iaith Gymraeg did not support the Regulations, which it believes are wholly inadequate to meet people's right to use the Welsh Language in the Health Service.

19. Their two main concerns were the exclusion of most primary healthcare providers from the Regulations and that there would be no right to receive face-to-face healthcare and clinical consultations in Welsh or with translation support.

20. Cymdeithas yr Iaith Gymraeg asked that the Regulations be amended to:

- place a duty on Local Health Boards to impose conditions within their agreements with independent primary healthcare providers to provide services through the medium of Welsh; and
- entitle individuals to receive face-to-face healthcare, including clinical consultations, in Welsh.

Meddwl.org

21. Meddwl.org is a voluntary organisation providing information and advice about mental health, and space to share experiences, through the medium of Welsh.

22. Meddwl.org was mainly concerned at the lack of rights to clinical consultations in Welsh or with Welsh language support. It was also concerned that the standards will not apply for the most part to the primary care sector.

Royal College of General Practitioners (RCGP)

23. The RCGP pointed out that most primary care services are run independently from Local Health Boards and will not be subject to the Regulations. The RCGP supports this approach and points to a number of practical difficulties, particularly financial and recruitment difficulties, in providing services in Welsh.

Oral Evidence

24. The Committee also took oral evidence on 14 March 2018 from:

- Representatives of Aneurin Bevan University Health Board, Powys Teaching Health Board and Hywel Dda University Health Board;
- Representatives of BMA Cymru Wales;

- Mrs Gwerfyl Wyn Roberts, Former Senior Lecturer in Health at Bangor University; and
- Dr Emyr Humphreys, Consultant Rheumatologist, Prince Charles Hospital, Cwm Taf University Health Board

25. The Committee also received a private technical briefing from Welsh Government officials. The transcript of the meeting and of the public evidence given is available on the Committee's web pages. However, some of the key points are set out below.

Local Health Boards

26. Representatives of Local Health Boards were supportive of the Regulations and reiterated many of the key themes in the NHS Confederation's written evidence.

27. In answer to questions, LHB witnesses indicated that:

- approximately 3 out of every 50 GP practices are managed directly by local health boards;
- the practical steps that Local Health Boards are taking to improve services for Welsh speakers;
- it might have been helpful to have included some priority areas for face-to-face services (e.g. dementia services) in the standards;

BMA Cymru Wales

28. Representatives of BMA Cymru Wales also reiterated a number of the themes in their written evidence:

- they pointed in particular to recruitment issues and the limited size of many GP practices;
- they also expressed concern that applying different standards to different areas could create a "post code lottery";
- they would not be happy with any element of compulsion on GP practices to provide Welsh language services.

Gwerfyl Wyn Roberts and Dr Emyr Humphreys

29. Gwerfyl Wyn Roberts and Dr Emyr Humphreys expressed concern about the Regulations and argued that they did not go far enough in providing clear rights to use Welsh in face-to-face situations or in primary care. Among other points made in evidence were:

- it was crucial that Welsh speaking patients were able to communicate in their language of choice. There were "dangers" if they were unable to do so;
- that the Regulations do not take account of the "patient journey" for Welsh speaking patients;
- that the Regulations were inconsistent between the rights for outpatients and patients in primary care, compared to those for inpatients in secondary care;
- that there is a need to plan to increase the number of Welsh speaking staff in the NHS; and
- that the number of clinical staff able to speak Welsh was increasing and that concerns about the "technical" standard of Welsh needed were overstated.

Conclusions

Time Available for Scrutiny

30. Just 21 days have been allowed on this occasion from the Regulations being laid before the Assembly until they are to be debated in Plenary. This has allowed us to carry out a very basic written consultation and to arrange oral evidence at one meeting of the Committee.

31. We accept that a longer period for scrutiny would delay implementation of the Regulations. However, given the significance of these Regulations, and the very considerable time they have been in gestation, (it has been over three years since the process first started) we do not believe there has been sufficient time to scrutinise them as thoroughly as we would have wished.

32. Beyond delaying implementation somewhat, there does not seem to be any specific reason why the Plenary debate could not be delayed to allow time for

further scrutiny. We agree that there is merit in the Minister considering doing so on this occasion.

33. Even if consideration of these Regulations goes ahead on the current timetable, the Government should consider whether it should allow more time for scrutiny of Welsh language standards regulations in the future. It could do this by making it clear in the Explanatory Memorandum that it will not seek approval of regulations until a longer period of time than the minimum of 20 days has elapsed. A period of 40 days would in most circumstances allow reasonable Committee scrutiny (including by other Committees with an interest) while not holding up work unduly on implementation.

Need for Regulations

34. We agree that these Regulations have been too long in the making and that there is a pressing need to put in place robust Welsh language standards for the health service. We have heard no evidence that standards are not needed to move the health service forward in this area.

35. We note that it is not possible for the Assembly to amend the Regulations at this stage and that if they are rejected it is unlikely that revised regulations can be brought forward for approval for some considerable time.

36. We have also heard considerable concerns around aspects of the Regulations and calls for them to be amended to address these concerns. It is a matter for debate and consideration by the Assembly whether the Regulations as drafted should be agreed.

37. However, irrespective of whether the Assembly agrees or disagrees the Regulations, we agree that at the earliest possible opportunity the Minister should bring additional regulations before the Assembly that will address the concerns set out below.

Right to Face-to-Face Services in Welsh

38. The lack of any right to receive face-to-face clinical services in Welsh or with Welsh language support is one of the greatest concerns we have about the Regulations. We accept that there are practical reasons why a right to receive these services cannot be absolute. The Committee recognise that there will be times and situations when it will not be reasonable or proportionate to provide such services. It may also be that specific services (such as dementia care or children's services) should be prioritised.

39. Nevertheless, we have heard evidence of the importance of language in clinical diagnosis and care. More than that, the right to receive a service in your language of choice should be an established principle in the public sector in Wales, even if there are occasions when this right has to be tempered by the practicalities of what can be provided. In many ways, the Health Service is the most important public service that most people will use. The idea that this basic principle should not also apply to the Health Service is in our view unacceptable.

Primary Care Services

40. The other major area of concern about the Regulations is that they do not apply for the most part to primary care service providers. Given that primary care services are the ones most often used by the public, this is also a clear area of concern.

41. We recognise that many GP practices may be small, that recruiting sufficient numbers of suitably qualified Welsh speakers can be problematic and that, unlike much of the public sector, primary healthcare providers do not currently have Welsh language schemes or operate under any Welsh language duties. Nevertheless, the absence of any standards is a clear weakness.

42. We are not convinced that it is unreasonable to place duties on Local Health Boards, which make them responsible for seeking to achieve compliance with standards by independent primary care providers. The fact that they cannot compel individual providers ignores the fact that they have considerable influence with them and we would expect the Welsh Government to empower and support Local Health Boards to enable primary care service providers to comply with standards and develop services.

43. We note that the Government proposes placing a "small number of Welsh language duties" on independent primary care providers using the primary care contract. This will create contractual obligations between the Local Health Board and the independent provider enforceable by the Local Health Bboard. We welcome this approach but without knowing what these duties will be it is difficult to know whether they will be sufficient to drive genuine improvements in Welsh language services.

44. Given the Government's proposed approach, it is not clear why the specific duties that will be placed in contracts cannot be specified in standards for Local Health Boards, which creates a route for complaints to the Commissioner. Local Health Boards can then monitor these standards and support their implementation in co-operation with their primary care contractors. Nor is it clear

why other standards, particularly those that require collaborative working, cannot be placed on health boards for them to support implementation by independent primary care providers.

Wider Provision and Policies for the Welsh Language

45. A theme running through the evidence we heard was the need to improve the recruitment and relevant skills of Welsh speaking staff in the health services. We agree that this is a concern. However, improvements in this area are to a considerable extent dependent on the progress of broader policies to support the Welsh language. It is important that the Welsh Government ensures that these broader policies are pursued with pace and ambition to help address some of the practical issues that witnesses have drawn to our attention.

CONCLUSIONS

Conclusion 1. The Government should consider allowing more time for Committee scrutiny of these regulations and should commit to this for future Welsh language standards regulations.

Conclusion 2. The Minister should consider bringing forward as soon as practicable additional regulations, which establish clearer rights to receive face-to-face healthcare services in Welsh.

Conclusion 3. The Minister should bring forward as soon as practicable revised regulations, which will introduce clearer standards for developing Welsh language services in the primary care sector.

Annex – Written Evidence Received

- 1. The NHS Confederation (English only)
- 2. BMA Cymru Wales (English only)
- 3. Cymdeithas yr Iaith Gymraeg (Welsh only)
- 4. Meddwl.org (Welsh Only)
- 5. Royal College of General Practitioners (English only)

Annex 1

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

	The Welsh NHS Confederation response to Culture, Welsh Language and Communications Committee scrutiny of the Welsh Language Standards (No 7) Regulations 2018.
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation
Date created:	5 March 2018

Introduction

1. The Welsh NHS Confederation, which represents the seven Health Boards and three NHS Trusts in Wales, welcomes the opportunity to respond to the Culture, Welsh Language and Communications Committee scrutiny of the Welsh Language Standards (No 7) Regulations 2018 for health services.

2. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work.

Summary

3. The delivery of bilingual NHS services is crucial to the provision of person-centred care. To deliver care and treatment in a patient's preferred language allows NHS bodies to establish a closer relationship with patients, enhances their ability to place the needs of the patient at the heart of the treatment process, and allows the patient to engage more positively in their treatment process by increasing their understanding of the treatment they receive. Health Boards and NHS Trusts have made significant progress in providing bilingual services in recent years and are committed to deliver a truly bilingual NHS for the people of Wales.

4. Throughout Wales, the Welsh language is used across a range of communication platforms. Examples include face to face consultations and providing care across the whole system (acute, primary and community); online and social media platforms; and administrative support, including Executive Board papers and minutes. Our members are using the Welsh language in all parts of their respective organisations and these new Standards will increase the organisations' understanding of the demand for Welsh language services, plan for services now and in future, and improve their capacity to offer services in Welsh.

5. We welcome the progress that has been achieved over the past 18 months and the greater degree of clarity afforded by the Welsh Language Standards (No.7) Regulations 2018 (the Regulations), but significant challenges remain. The Standards must be considered against the challenging backdrop that the NHS is working in, including rising demand, workforce recruitment challenges, finances and the fact that the NHS is a 24/7

service. Health Boards experience different challenges, and in more Welsh speaking population areas it will be easier for those Health Boards to attract and train Welsh speaking workers in lower banded posts than in areas where there are less people speaking Welsh, both in relation to attracting the workforce but also the need for Welsh speaking services in areas where the population of Welsh speakers is low. However, recruitment problems and shortages are the same across all Health Boards when it comes to nurses and specialist areas.

6. While we have highlighted a number of challenges below, we must emphasise that not all concerns highlighted within our submission are relevant to all Health Boards and Trusts. Across Wales, due to local demographics, some Health Boards have already implemented Schemes that address some of the issues that will face other Health Boards going forward.

Achieving a bilingual healthcare system

7. The Welsh NHS Confederation and our members recognise the importance of providing Welsh language services to patient. The Welsh NHS Confederation Policy Forum recently published *'One Workforce: Ten actions to support the health and social care workforce in Wales'*, which highlights the importance of investing in Welsh language provision across the health and social care workforce to ensure that patients and their families receive individual, person-centred care in their chosen language.

8. As highlighted within the Explanatory Memorandum, under the arrangements set out in the NHS Wales Planning Framework and the NHS Finance (Wales) Act 2014, Health Boards and NHS Trusts are under a duty to prepare Integrated Medium-Term Plans (IMTPs). Within current IMTPs, the NHS is required to demonstrate '*that services are planned and delivered in line with the strategic framework for health and social care in Wales 'More than just word…;' and the Welsh Government's response to the 'Welsh Language Commissioner's Primary Care Inquiry Report'*. In addition, Health Boards and Trusts' commitment to the Welsh language is further outlined by the responsibilities to the '*More than just Words…*' framework and the Well-being of Future Generations (Wales) Act 2015.

9. Our members welcome the growing recognition of the importance of meeting language needs and the impact this can have on the delivery of safe, high quality care and a positive patient experience. In particular, our members support the concept of the 'active offer' in relation to Welsh services and agree that the move from Welsh Language Schemes to a workable set of Welsh Language Standards has the potential to bring about the positive change required. Moreover, our members believe that the Welsh Language Standards should provide greater clarity for both organisations and members of the public on what provision they can expect to be provided in Welsh upon the Standards coming into force over time.

10. The Welsh Language Standards are also sufficiently clear in terms of their purpose in delivering the new legislative framework for NHS Wales. They provide the certain regulatory factors required to ensure that the Welsh language is not treated any less

favourably than English. In this regard at least, our members are fully supportive of the policy intent and the direction of travel towards a truly bilingual NHS for Wales.

Reduction in the number of Standards

11. We welcome the Welsh Governments' preferred option to reform the current standards system, particularly the removing or amendment of those Standards that did not appear to contribute directly to improving services or would have been costly to implement with little benefit or value. We are pleased that this has resulted in 64 fewer Standards than had originally been proposed. As highlighted in our previous written responses, some Standards included in the draft Regulations were unclear, overly onerous and bureaucratic.

12. While there have been substantial changes to Schedule 4 (Record Keeping Standards) and Schedule 5 (Standards which deal with supplementary matters), we are glad that some aspects of Schedule 4 have been retained e.g. those that require the body to keep a record of complaints they receive relating to their compliance with Standards, the Welsh language skills of their staff and the Welsh language skills required for new and vacant posts are recorded. We believe that retaining these Standards will be important for workforce planning, especially in relation to the duty to produce a 5-year improvement plan, and that complaints are considered an important and valuable indicator of the public perception of the quality of Welsh language services provided and where services can make improvements. As our response to *'Review of concerns (complaints) handling within NHS Wales*' highlights, when care does not meet the high standards which patients deserve and expect, we must make sure action is taken to put things right and the feedback and experiences of patients, their families and staff are critical in helping the NHS in Wales to provide the high standards of care that staff strive to deliver on a daily basis.

13. We are pleased also that the Standards relating to specific types of documents being produced and published have been deleted in favour of a more measured approach. We support that the Standard which requires the Health Board/ Trust to base their decision whether to produce the document in Welsh is done on an assessment of the subject matter and the anticipated audience has been retained. This will ensure that Welsh information will be produced or published only if there is an obligation to do so.

Comments relating to specific Standards

Schedule 1: Service Delivery Standards

Clinical consultations

14. We had previously expressed particular concern regarding Standard 25 namely the ambiguity and impracticality of the provision of Welsh language support at a clinical consultation. We support the new approach set out in the Regulations tabled requiring

NHS bodies to publish a 5-year improvement plan setting out the extent to which they are able to offer to carry out clinical consultations in Welsh, the actions they will take to increase their ability to offer clinical consultations in Welsh and a timetable for those actions. The 5- year improvement plan will support the NHS to set out the key milestones on how they will work towards implementing the active offer during clinical consultations and assess the extent to which they have complied with their plan. We consider this to be a much more practical approach that is reasonable and proportionate.

15. In our response to the draft Standards, specifically draft Standard 25 which dealt with the provision of Welsh in clinical consultations, our members suggested that were this Standard to be implemented this could lead to vital information being lost in translation, perhaps in terms of the outcome of the consultation or the severity of what was being discussed. Even in instances where there are Welsh-speaking members of staff working within Health Boards and Trusts, it is likely that a number of these individuals would not feel comfortable delivering care, treatment or a diagnosis in Welsh for fear that their own Welsh language capabilities are not of a sufficient standard to adequately convey information, especially given the complicated nature of medical terminology.

Active offer

16. We support the number of Standards within the Regulations that put forward the principle of an active offer and will sit within the policy infrastructure of '*More than just words…..*' as this will continue to play an important part in the understanding and promotion of the 'active offer' as the Standards become embedded e.g. Standard 2, which relates to NHS organisations asking individuals who correspond with them whether they wish to receive correspondence in Welsh, to keep a record of the individuals wish and ensure forms and future correspondence is in Welsh; Standard 19, which relates to telephone calls; Standards 23-24, which require bodies to ask inpatients on the first day of admission whether they wish to use Welsh to communicate; and Standard 25, which relates to case conferences.

17. These Standards build on good practice developed by a number of Health Boards/ Trusts to identify the language choice of inpatients and is a natural progression from existing Welsh Language Schemes and '*Mwy na Geiriau (More than just words)….'.* We are pleased that the active offer principle is embedded in the Standards because it is recognised that there is more to do to consistently implement the active offer advocated in '*More than just Words…'.* The proposed Standards mean that Health Boards and Trusts will be required to take a more proactive and strategic approach to mainstreaming the Welsh language and promoting the active offer.

18. The Standards would ensure a patient's language choice is made clear to staff, thus increasing opportunities between patients and (Welsh speaking) staff to interact in Welsh and for the active offer to be implemented. However, while we support the Standards in principle, it must be highlighted that not all patient administration systems currently have the facility to record language choice.

19. While we support that telephone and correspondence should be bilingual, currently it would be difficult to implement fully as there are several data systems within Health Boards and Trusts which are not compatible with each other. Some departments/clinics also record their data exclusively via paper systems, which would make language choice onerous and difficult to transfer.

20. In addition, the Data Protection Act 1998 prohibits some individuals accessing some systems. All complaints are recorded on a Datix system; however, not all staff have access to this system for confidential reasons and therefore even though language of choice can be recorded on Datix, it is unlikely that this choice will be communicated quickly.

21. The principles of Standards 23, 23A and 24 in relation to inpatients are currently being implemented across Health Board areas. The main concern is scaling up - will this be achievable when trying to implement on a large scale? There is also the challenge of ensuring that computer systems function in such a way that the patient's language choice is clear to staff members even when the patient receives treatment in more than one clinical department.

Primary Care

22. Overall, we support Standards 65 – 68 and the amendments to the draft Standards. The Standards now mean that only primary care services provided directly by Health Boards will be subject to the same standards as the other services provided by the Health Board. This means that the Regulations treat primary care services provided directly by Heath Boards in the same way as secondary care services. This will make it easier for Health Boards to plan and organise Welsh language provision across services. Moreover, implementing the Standards within managed practices and encouraging the implementation of Standards within independent primary care providers should lead to improvements for service users.

23. We recognise the need for Welsh language provision within primary care and welcome the flexibility that the Regulations is showing. Our members acknowledge and support the recommendations put forward by the Welsh Language Commissioner in her report '*My Language, My Health: The Welsh Language Commissioner's Inquiry into the Welsh Language in Primary Care*' and our members have taken forward a number of these recommendations.

24. We agree that it is not reasonable to place duties on Health Boards that would make them responsible for any failure to comply with Standards by one of its independent primary care providers as they do not have any direct influence over the way individual providers deliver services. However, we acknowledge and support that in future, awareness and improved Welsh language services could be introduced through prescribing a small number of Welsh language duties on independent primary care providers through primary care contracts or terms of service agreed between the Health Board and primary

care provider. However, whilst supporting their inclusion in the Standards, we remain concerned that the particular workforce challenges in this area will in some cases make some of the Standards impossible to deliver. With reference to the proposed enforcement of Standards for independent primary care providers through the contractual arrangements in place, it is difficult to envisage how this might work in practice. If a particular Standard was not enforced, despite it being included in agreed contractual arrangements, it is not clear whether the compliance action from the Commissioner's Office and potential financial penalty of up to £5,000 would be applied to the Health Board, or the independent primary care contractor.

Websites and on-line services

25. While currently all our members websites, apps and publications are available in Welsh, there needs to be consideration in relation to putting up bilingual information on social media, particularly in instances when a message needs to be conveyed urgently e.g. the unforeseen closure of a GP practice, or the cancellation of outpatient appointments due to unsafe weather conditions.

26. As well as a delay in providing information via social media in Welsh, there will also be translation costs incurred. Not all Health Boards and Trusts have in house translation services and translation work is contracted to external freelance translators which means that the turnaround of translation requests is dependent on the translators' capacity.

Schedule 2: policy making Standards

27. We support the Standards within Schedule 2, which ensure that all policy decisions, strategic plans, consultation documents and research are communicated in Welsh. We particularly support Standard 78 which requires Health Boards to publish an explanatory note for all decisions around Welsh language primary care service, as well as an explanatory note, published and made available via the organisations' website every five years after the implementation of the Standard, that sets out the extent to which the organisation has complied with that Standard. While this will raise awareness, and improve Welsh language provision in primary care, it is important to note that the workforce recruitment and retention challenges that the NHS faces is considered as part of the policy and the assessment.

28. As part of its current requirements under the Welsh Language Scheme, Health Boards/ Trusts assesses all policies, new or revised, for effects on the Welsh language. We do however acknowledge that the scrutiny levels currently in existence require strengthening to ensure policies are also assessed for the opportunity or lack of opportunity to use the Welsh language, as well as treating the Welsh no less favourably.

Schedule 3: Operational Standards

Internal administration

29. Generally, we support the Standards within Schedule 3 because they build on good current practice and work towards producing an improvement plan. This appears to present a more practical and achievable option over a longer period. It also provides the NHS with the tools to monitor and assess the current structure. However, some challenges still need to be considered before coming into force.

30. While we support that a number of operational Standards have been amalgamated e.g. the Standards placing a duty on a body to provide different types of documents to staff in Welsh, we are pleased that our feedback on internal administration has been considered, which is reflected by Standards 79 – 82. As previously highlighted in our response to the draft Standards, while our members felt that they would be able to provide some basic correspondence in Welsh, such as letters informing staff members of changes to their working hours, annual leave application forms and translating more complex letters would incur considerable costs given the fact that each piece of correspondence is likely to be specific for each employee, thereby leading to considerable delays in responses to Welsh-speaking members of staff.

31. Furthermore, our members are positive about adopting a central approach to the implementation of a revised version of the operational Standards if this was to be co-ordinated by the NWSSP (NHS Wales Shared Service Partnership). Our members believe that ensuring compliance with the Standards would be more achievable if they were encouraged to work collaboratively with the NWSSP towards a number of innovative implementation strategies e.g. using All-Wales recruitment templates.

Standards relating to a body disciplining staff

32. In relation to HR issues around complaints and disciplinary matters, as outlined under Standards 82 – 88, offering disciplinary meetings or correspondence in Welsh could cause delay if the organisation does not have Welsh-speaking individuals within their HR team. There are very clear timeframes within employment law practices that employers and employees must comply with, so concerns still remain that the availability of simultaneous translation might delay some processes which have statutory or set timescales. In addition, some meetings to record the initial assessment of facts and/or suspensions might have to be held as soon as possible to manage any risks - it may not be possible therefore to provide simultaneous translation. Situations that could fall in this category include a member of staff turning up for a shift under the influence of alcohol, or a member of staff being abusive to a patient. In both such instances, an immediate/instant removal from the workplace would be required and there would not be time to source a Welsh speaker.

33. In relation to disciplinary issues, meetings in relation to concerns and disciplinaries are conducted within various departments and services, with some requiring specialist

knowledge and expertise. In these circumstances, there would also be a requirement that Trade Union representatives be present at these meetings. It would be impossible to conduct these meetings without the assistance of simultaneous translation. This would prove to be a costly alternative – for example, one of our members stated that they hold approximately 16 Public Forum Meetings a year. Should the Health Board be requested to provide simultaneous translation services for each meeting, this would mean a cost of approximately £5,000 a year on top of the translation costs for the written materials, for which no extra funds are available. Numerous other 'meetings' also take place across the Health Board which would incur similar associated costs.

34. In relation to HR, consideration needs to be given to the fact that the National Electronic Staff Register (ESR), where annual leave requests are made, is an all-English NHS system. There has been work ongoing in updating and developing a Welsh section within ESR which is still in the development stages and has been negotiated as part of the new Contract with IBM, however, this will be difficult to implement until sufficient processes are in place. Consideration would also need to be given to the national e-rostering as nursing staff request annual leave through this system.

Intranet

35. Similarly, Standards 89 – 95 are problematic. These Standards specify that an organisation's intranet systems must be entirely bilingual. Firstly, there is concern because these pages contain large amount of technical information and there would be significant translation costs if all pages were required to be translated. For example, one Health Board has an estimated 1,300 intranet pages with an estimate of 750 words per page, this equates to approximately 975,000 words in total. If the translation team was to translate at the average of 300 words per hour, in an average 37.5 hour week, this would take 86 weeks to complete, with a dedicated translator. Another Health Board has appointed additional translators over the past 18 months, and even with additional resources, they would struggle to achieve these Standards due to the volume of information. However, some of the functionality to deliver this Standard is outside of the NHS control; there are national suppliers of the Content Management System through NHS Wales Informatics Service (NWIS) and the NHS may be reliant on their support to achieve this Standard, especially if a new Intranet is developed.

36. From a functionality viewpoint, a new wireframe would have to be designed, produced and installed across every Health Board and Trust in Wales to ensure that all IT systems were thoroughly bilingual. Associated costs would relate not only to the setting up of an entirely new IT network, but also the employing of managers and technicians to service and maintain the new system. Even if such a system could be developed, the costs involved would far outstrip our members' financial budgets, rendering them both impractical and unfeasible. Moreover, some of our members employ over 200 devolved editors with full access to uploading content to their individual sites – this reflects the sheer volume of content that is uploaded to these pages on an hourly basis. Thus, the implementation of such Standards would not only put immense pressure on our

members' IT and Communication teams, but also limit the pace at which new content could be uploaded. However, draft Standard 110 does appear to be more reasonable and proportionate in terms of making improvements to the delivery of bilingual services in the long term.

Standards relating to workforce planning and training

37. The Regulations involve the publication of a five-year plan setting out the extent to which they are able to offer and carry out clinical consultations in Welsh, the actions to increase the ability of clinical consultation in Welsh, and a timetable for those actions to be completed (Standards 96 – 105 and 110 – 110A). We are supportive of this as a way forward.

38. Currently there are significant challenges and pressures on the NHS in Wales workforce and it is therefore important that we prioritise the services that must be provided in Welsh. This will require a pragmatic approach that takes on board what actions are achievable and practical at a time of austerity and rising service demands.

39. There are current recruitment challenges across the NHS, especially within certain speciality posts. The health sector operates in an international recruitment market and healthcare workers are sought across the world. Although the demand for Welsh language support in clinical consultations may be lower in some areas in line with the local demographics, it is also known that there are fewer Welsh speaking members of staff, which would make it more difficult to ensure appropriate numbers are available to implement this Standard. Staff availability in clinical settings can prove problematic, and therefore there would need to be reliance on non-clinical staff at times which raises the issue of clinical safety.

40. In relation to Standards relating to training (specifically Standard 97), overall we believe that this Standard is neither reasonable or achievable. Furthermore, demand for this type of training in Welsh is, generally speaking, very low across Health Board areas and would undoubtedly result in significant delays in delivering specific training courses, as well as incurring significant costs. For example, in terms of health and safety training, it is required that specific training is delivered by subject experts, and this is an area of concern in ensuring there are Welsh speakers available to deliver sessions on a regular basis as health and safety is part of the mandatory training programme for all staff. In addition, one of our members highlighted that if induction is used as an example, and the Health Board was to deliver the Standard as suggested, the cost to the Health Board would be circa £20,947.20. However, if the induction was held in Welsh only, once a month, for all new staff who would prefer the session delivered in Welsh, the cost would be circa £2,618.40. This would result in a delay of three weeks in getting staff in post through induction, which would result in additional backfill costs at service level in wards and departments. For example, the cost of filling a Band 2 post for three weeks would be £1,180 and for a Band 5 post would be £5,734. On the basis that there are generally 20 places on a programme, if we calculate 50% support worker and 50% Band 5 backfill for 1

programme a month, the cost would amount to circa £69,140. The first option would not be considered reasonable during this time of austerity and therefore if this Standard remained, the Health Board would have to review the number of induction programmes held throughout the year. This would impact significantly on the turnaround time to secure staff into post, which is not practical or reasonable in the current recruitment environment.

Schedule 4: Record Keeping Standards.

41. We support Standards 115 – 117 in relation to keeping a record each financial year of the number of complaints, assessment of employees Welsh language skills and the number of new and vacant posts that were catagorised as Welsh language essential. This will help with workforce planning in the future and the skills required within the workforce having considered the population needs of the Health Board area.

Schedule 5: Supplementary Matters

42. We support the Standards within Schedule 5 because it will ensure that the public are aware of the Standards which the organisation is under a duty to comply with and that an annual report will be produced in each financial year, which ensures transparency and accountability.

Other comments

NHS Planning Guidance

43. It is not clear if the current NHS Planning Framework 2018/21 will be amended to reflect the new Standards. We would suggest that this would be very helpful.

Monitoring the Standards.

44. As highlighted in our previous responses to the draft Standards, a balance is needed between the Commission's ability to support and enforce when necessary. Our members note that some of these Standards are immeasurable, which means that it is extremely difficult for Health Boards and Trusts to monitor the extent to which the Standards are being implemented across such a large, diverse and multidisciplinary organisation across a range of services. Monitoring the Standards could also prove to be difficult to achieve as to ensure consistency across the organisations due to the complexity of the organisational infrastructure. Countless numbers of interactions between staff members, patients, administrators and various others take place every day across a variety of healthcare settings, all of which would require an altogether new and extensive level of bureaucracy to police and monitor. Thus, it would be an almost impossible task for our members to ensure that every one of these interactions complied with the Standards at all times. Indeed, the only way our members would become aware of any potential breach of the Standards would be as the result of a complaint or feedback stating so, whereupon an official investigation and possible penalty would follow. Given that the total NHS Wales

workforce currently stands at approximately 90,000, such an undertaking would inevitably incur significant financial costs as well as being extremely time-consuming.

Process of negotiation after Compliance Notice

45. It is not useful in the context of this response, which requires general views, to comment on each of the proposed 121 Standards. It is worth noting, however, that despite the amendments and deletions made to the original draft Standards following consultation, there remain some Standards in place that within the current resources and context will not be possible to achieve without a disproportionate investment, for example Standards 90 - 95 translation of the Intranet.

46. We recognise that there will be the opportunity for Health Boards and Trusts to express their concerns and negotiate with the Commissioner following the issuing of the Compliance Notice and we will be interested to understand the process for this. The regulations are long and complex and despite the explanatory memorandum are still open to some interpretation. It would be helpful to be assured that the process for negotiation regarding which Standards will be applied will allow for face to face discussions and not solely a written submission.

Recruiting and staffing implications:

47. Our members have highlighted the willingness and ability of the existing workforce and labour market to provide Welsh language services at the levels envisaged in the future. However, the NHS in Wales faces many recruitment and retention challenges, including the recruitment and retention of Welsh language professionals, clinicians and administrative staff (e.g. receptionists, HR, communication professionals such as media and digital etc). The solutions to these challenges often go beyond the remit of Health Boards and Trusts, with the importance of having a truly bilingual education system at the core of the issue.

48. Our members also point out that the Standards relating to increasing the number of Welsh-speaking staff within their specific Health Board or Trust is not solely an organisational or recruitment challenge – making the ability to correspond in Welsh an essential job requirement, for example, will have little or no effect if there is not a sufficiently sizeable Welsh-speaking population within the relevant geographical area in the first place. Achieving this involves sustained, targeted and multidisciplinary Welsh Government approaches that extend far beyond the remit of Health Boards and Trusts and have at their core a truly bilingual education system in Wales. This in itself represents an altogether new policy debate beyond the mandate of our members.

Financial costs of implementing the Welsh Language Standards.

49. Throughout the development of the Standards we have highlighted the range of possible cost implications when the Standards are introduced and we are therefore concerned that

the Explanatory Memorandum states that the "*current uncertainty surrounding which of the Standards each organisation will need to comply with means that it is not possible to produce a robust assessment of the costs and benefits associated with the Regulations at this stage*".

50. As referenced within the Explanatory Memorandum, our members, provided information on the cost of their current Welsh Language Schemes and an estimate of the cost of complying with the Welsh Language Standards. We acknowledge the concerns highlighted within the Explanatory Memorandum around the data received from organisations and whether it is suitable to produce a robust and accurate Regulatory Impact Assessment (RIA) and the fact that providing estimations for compliance with Welsh language Standards proved challenging. We share this concern and reiterate the difficulty in providing accurate data when Health Boards and Trusts were not aware which of the draft Standards they would be expected to comply with. It is not possible to accurately estimate the cost implications of the Standards until after Health Boards/ Trusts have received their Compliance Notice from the Commissioner informing them of which Standards they have to comply with. This highlights the difficulties both NHS organisations and the Welsh Government have to quantify the cost of implementing the Standards in the future, and with only a six-week consultation period, the timescale to produce this is challenging.

51. While it has not yet been decided which of the Standards will apply to each organisation, it is likely that there will be additional one-off and recurrent costs incurred by the organisations to comply with the Standards. Our members share the view that while they support the general principle of achieving a truly bilingual NHS in the long term, and while they remain committed to doing all they can to support and encourage the improvement of the Welsh language in all matters of service provision, this must only be considered a priority to the extent that it is financially feasible to do so. There is the inherent assumption among our members that the costs involved would be so great that they simply could not be met without a massive financial and human resource investment that is out of the control of the Health Board or Trust, or even the wider health sector either in the short or long term. More specifically, our members highlight a number of areas where they consider the costs involved to be excessive and subsequently unfeasible.

52. The requirement that every correspondence between Health Boards, Trusts and their patients be entirely bilingual is one example of the sort of resource challenge the Standards would bring about. Our members are unanimous in their affirmations that they do not possess the sufficient translation resource provision within their organisations to ensure that every piece of correspondence with patients would be produced and distributed in both Welsh and English.

53. It must be remembered that while the requirement to hire external contractors to translate all correspondence between Health Boards/Trusts and patients brings with it huge financial implications, this problem is brought about in the first instance by the fact that very few staff members within Health Boards and Trusts are professionally competent in Welsh. To train and support the existing non-Welsh-speaking workforce into

a workforce that is professionally competent in Welsh to provide professional medical advice is simply not feasible given the tight financial restrictions Health Boards and Trusts are already experiencing on a daily basis. Even if funds were available, our members point out that the willingness and aptitude of staff members to undertake an extensive and thorough Welsh language teaching programme, whether it takes place at staff members' usual place of work or not, is likely to be extremely diverse. Investment is required not only for the purposes of improving care for patients, but also for ensuring that those who work within the health and social care sectors are adequately supported, thereby making a career in health and social care an attractive prospect for young people.

Conclusion

54. On behalf of our members, the Welsh NHS Confederation welcomes the growing recognition of the importance of meeting language need in the Welsh NHS and the impact this can have on the delivery of safe, high quality healthcare for patients. We continue to support the importance of meeting language need and the 'active offer'. We remain in agreement that it is appropriate and timely to move from Welsh Language Schemes to a reasonable and proportionate set of Welsh language Standards. However, the process of negotiation to achieve this will be critical to success.

55. We encourage the Culture, Welsh Language and Communications Committee to note the significant progress made in recent years by our members in providing services in a patient's chosen language. However, while our members welcome these positive steps and agree wholeheartedly with the wider objectives of the Welsh Language Standards, it is evident that our members' have a number of serious reservations about the practical application of these Standards and their impact on other areas of service provision within their Health Board or Trust given the current financial and recruitment climate.

Annex 2

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THE WELSH LANGUAGE STANDARDS (NO. 7) REGULATIONS 2018

Inquiry by the National Assembly for Wales Culture, Welsh Language and Communications Committee

Response from BMA Cymru Wales

07 March 2018

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly for Wales Culture, Welsh Language and Communications Committee into the proposed Welsh Language Standards (No. 7) Regulations 2018.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of approximately 160,000. BMA Cymru Wales represents over 7,100 members in Wales from every branch of the medical profession.

RESPONSE

As we stated in our response to the Welsh Government's 2016 consultation on an earlier, draft version of these Regulations (which we have attached as Appendix 1 to this response), BMA Cymru Wales believes as a general principle that we must support the use of the Welsh language within health care settings in Wales for the benefit of Welsh-speaking patients. We very much recognise that it benefits patients to have the ability to communicate with medical practitioners in their first language.

We recognise that being able to communicate directly with a patient in their first language can be helpful for a doctor in reaching a better diagnosis whatever language is involved. We would note that a major factor for a doctor in arriving at a diagnosis is determining the history conveyed by a patient, and such history can be best relayed by patients in the language in which they are most fluent. As such, if a doctor is able to provide a consultation with sufficient competency through the medium of Welsh to patients who are first language Welsh speakers this can lead to better diagnoses and care, and may also prevent increased costs for diagnostics and secondary care referrals. We would also note that being able to communicate in Welsh to Welsh-speaking patients may be of greater importance to doctors when dealing with young children or more elderly patients, including those with dementia.

However, as we previously acknowledged, in the interests of receiving timely or appropriate clinical care, we recognise that it is not always possible or practical for a Welsh-speaking patient to have a consultation with a doctor, or other health care professional, who is able to undertake a consultation with them through the medium of Welsh.

Within our membership, however, it is only fair to point out that there are differing views regarding the precise standards that should be implemented, as might also be expected amongst the wider population. Our response to the proposed Regulations is therefore provided within this context. In addition, we would point out that we did not respond to all the questions posed by the Welsh Government on the earlier version of the Regulations as we concentrated on those aspects of the proposals which are of most direct relevance to our members. We therefore confine this follow-up response only to aspects of the Regulations on which we have previously commented.

Standards relating to clinical consultations in secondary care

When the initial version of the proposals was consulted upon by the Welsh Government in 2016, we pointed out our support for the potential benefits that can be derived from providing Welsh language support for clinical consultations, depending on the circumstances involved, but we also noted a number of practical difficulties. For instance, we referred to certain circumstances where undertaking doctor-patient interactions through translation might particularly impact on the ability to reach a successful diagnosis, or to effectively discuss very sensitive and emotive issues such as those relating to palliative care.

We understand that the Welsh Government has now concluded, taking on board feedback from ourselves and others, that its original proposed standards for clinical care consultations in secondary care settings are beyond what can currently be achieved or be provided either universally or consistently.

We note the proposed replacement standards will allow longer term planning by local health boards and trusts towards the provision of clinical consultations through the medium of Welsh over a 3-5-year period. We further note that there will also be a new standard to identify and convey to staff the language preference for in-patients, as well as new standards covering the provision of training opportunities for staff to help them improve their Welsh language skills and for health boards and trusts to assess the Welsh language skills amongst their workforce.

These new proposed standards seem to us to be an eminently more practical way forward which we are happy to support. We also feel this more pragmatic approach will help the NHS in Wales to take on board some of the issues and concerns that we previously raised, allowing realistic longer term planning and achievable objectives.

We would reiterate, however, that there are diverse views amongst our membership and it is therefore only fair to point out that some of our members previously told us they were in favour of the original proposed standard. Due to the tight timeframe in which we are having to produce this response to the revised Regulations, however, it has not been possible for us to extensively assess the level of support that exists amongst our wider membership and to determine how that compares to the views they previously expressed regarding the initial proposals.

Standards relating to case conferences

We previously noted that, depending on the circumstances involved, there could be benefit from the provision of translation facilities from Welsh to English, as well as from English to Welsh, for case conferences. However, we also expressed concern about the practicalities of arranging and undertaking case conferences around clinical commitments, and that consideration would need to be given to how the requirement for translation facilities could be delivered without causing further delays to when case conferences can be held.

We therefore welcome the change which the Welsh Government has now introduced to this proposed standard, by resolving that it should only apply to case conferences which are arranged at least five working days in advance of them being undertaken. This would appear to be a very sensible amendment to the proposed Regulations which we again are happy to support.

In our response to the earlier consultation, we noted that case conferences are often undertaken early in the morning or at lunchtime between clinical sessions and are often, by necessity, rushed as a result. Since adding a requirement for translation could lead to case conferences being lengthened, we questioned whether there would necessarily be time for this to be done. We note that this concern has not been addressed by the revised proposal, and therefore our concern about the practicality of this remains.

Standards relating to primary care

We recognise and support the pragmatic approach taken in relation to primary care within the standards.

In relation to primary care services provided directly by local health boards (i.e. managed practices) we would concur with the rationale that the same obligations are placed upon organisations for all the services they provide. We believe it is entirely appropriate that primary care sites are able to benefit from use of health board resources in terms of translation facilities and training for health board employed staff.

The different approach to clinical consultations described in the new draft of the standards somewhat alleviates concerns we previously expressed regarding the practicalities of providing bilingual access to all interactions of that nature, particularly given the long-term recruitment challenges in primary care. However, it remains the case that any negative perceptions relating to how the standards are implemented, and described externally, could further hamper the recruitment of GPs and GP trainees into Wales.

BMA Cymru Wales, in particular the Welsh GP Committee (GPC Wales), looks forward to discussing how Welsh language duties on independent contractors in primary care can be delivered within the GMS (General Medical Services) contract with Welsh Government officials during 2018. We are reassured that the standards relating to primary care retained within the present draft relate to obligations on local health boards to provide translation services, language capability badges and access to training courses for primary care providers and their staff. However, it is as important that the related cost of complying with any changes stemming from the standards should be funded by Health Boards (for instance, including covering the costs of access to training) and not GP practices.

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WELSH LANGUAGE STANDARDS (HEALTH SECTOR) REGULATIONS

Consultation by Welsh Government

Response from BMA Cymru Wales

14 October 2016

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by the Welsh Government on the proposed Welsh Language Standards (Health Sector) Regulations.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow every year. BMA Cymru Wales represents over 7,500 members in Wales from every branch of the medical profession.

RESPONSE

As a general principle BMA Cymru Wales believes that we must support the use of the Welsh language within health care settings in Wales for the benefit of Welsh-speaking patients. We very much recognise that it benefits patients to have the ability to communicate with medical practitioners in their first language.

We recognise that being able to communicate directly with a patient in their first language can be helpful for a doctor in reaching a better diagnosis whatever language is involved. We would note that a major factor for a doctor in arriving at a diagnosis is determining the history conveyed by a patient, and such history can be best relayed by patients in the language in which they are most fluent. As such, if a doctor is able to provide a consultation with sufficient competency through the medium of Welsh to patients who are first language Welsh speakers this can lead to better diagnoses and care, and may also prevent increased costs for diagnostics and secondary care referrals. We would also note that being able to communicate in Welsh to Welsh-speaking patients may be of greater importance to doctors when dealing with young children or more elderly patients, including those with dementia.

However, we recognise that it is not always possible or practical for a Welsh-speaking patient to have a consultation with a doctor, or other health care professional, who is able to undertake a consultation with them through the medium of Welsh. This has clearly also been recognised within the proposals that are now being put forward and which are the subject of this consultation and we are happy to provide a view on these proposals on behalf of the profession.

Within our membership, however, it is only fair to point out that there are differing views regarding the specific proposals being consulted on, as might also be expected amongst the wider population. We therefore respond to the questions that have been posed within this context. It should also be noted that we are not providing a response to every question that has been asked within the consultation document and concentrate on those issues on which we feel able to convey a representative view.

Is the proposed standard 25 (clinical consultation) practical in the various scenarios described in the consultation document? Do you agree with the concept of Welsh language support during clinical consultations?

Taking these two questions together, we would firstly recognise that providing such Welsh language support can be beneficial for consultations, depending on the circumstances involved. As we have touched upon earlier, the benefit may be greater when clinicians are undertaking consultations with both young children and elderly patients who are first language Welsh speakers, including for elderly patients with dementia, as those patients may have the greatest difficulty in communicating effectively in English.

It may also be beneficial for Welsh-speaking patients at times of stress and illness, enabling such patients to feel more comfortable and therefore better able to communicate their problems and symptoms. This may enable a clinician to obtain more accurate information from a patient, but this may be dependent on the quality of the translation or Welsh language support that is able to be provided and the competency of the individual providing this translation or support.

In some circumstances, however, we feel that the proposal may prove less practical and this could risk diminishing the effectiveness of consultations. For instance a non-Welsh speaking psychiatrist undertaking a consultation through a third party translator may find they then have less ability to effectively assess the way in which a patient answers any questions posed, as nuances in the way a patient's responses are expressed could be lost when translated. Indeed many doctors, and not just psychiatrists, would be clear that nuances in the way patients describe their problems can be key to arriving at successful diagnoses.

Another situation where undertaking a consultation through a third-party translator might be detrimental to the quality of the consultation is in the case of palliative care. To undertake a successful consultation in such circumstances, it would be necessary to be fully trained in advanced communication skills as the consultations involved can often be of a very sensitive and emotional nature. A palliative care clinician is trained to deal with the enormity, and emotional nature of such situations. Another member of staff assisting with translation may not possess the necessary skills to undertake that role effectively.

A concern which many of our members have raised is whether or not sufficient Welsh-speaking staff might be available in different health care settings to provide any required Welsh language support. Whilst the consultation document indicates that the intention would be to utilise Welsh language skills within the existing workforce, sufficient staff with such skills may not always be readily available in certain parts of Wales and this may lead to greater dependence on the provision of formal translators.

This, of course, would not come without any cost and some of our members have expressed concern regarding the impact that might have on overall service provision given that resources are already extremely tight and many aspects of health service provision are already suffering directly from a lack of sufficient resources. The extent to which this could be an issue would however depend on what the level of demand might be amongst patients for Welsh language support during clinical consultations, should

this proposal go ahead. That may be difficult to quantify in advance of any decision to implement the proposed regulations.

Some of our members have also raised a concern that greater use of translation, or other Welsh language support, during clinical consultations can have an impact on the time that may then be required for an individual consultation where this is provided. This could mean that fewer consultations are then able to be undertaken during a specific time period and this might have a knock-on effect on waiting times.

Again, we would note that the extent to which this might be a problem of notable significance will be very much dependent on the level of demand for Welsh language support should the proposal go ahead. The concern also needs to be balanced against the fact that in some circumstances providing Welsh language support, such as where it aids a patient in more effectively expressing the nature of their problems and symptoms, may lead to more accurate diagnoses and less time wasted undertaking inappropriate treatments or unnecessary diagnostic tests. We would therefore recognise that the issue is not clear cut, and may vary from circumstance to circumstance.

Do you agree that case conferences should be treated differently to clinical consultations and other meetings?

We would accept that a case conference involving an individual, in order to discuss heath related provision for that individual, could benefit from the provision of translation facilities from Welsh to English, and English to Welsh, depending on the circumstances involved.

Again, though, many of our members have expressed concern that this should be balanced against the practicalities of undertaking such case conferences. Some have noted, for instance, that there can often be delays at present in undertaking case conferences due to difficulties in being able to get different professionals together at the same time. It would need to be considered how any requirements for the provision of translation facilities at case conferences could be delivered without causing any further delays in them being undertaken. Others have pointed out that currently such case conferences may take place early morning or at lunchtime between clinical sessions and are often, by necessity, rushed as a result. Adding a requirement for translation could lengthen such meetings but there may not be the time available for this to happen. The practicality of the proposal therefore needs to be properly considered.

Some members have also raised concerns that the use of translation facilities may risk greater incidence of misunderstanding. Nuances in the way an individual expresses their needs may be lost through translation in the same way that they might during a clinical consultation. However, it also needs to be recognised some that for some individuals who are first language Welsh speakers, they may be better able to express their needs through the medium of Welsh in the first place. As a result, such concerns may vary depending on the individual involved and the quality of any translation being provided.

Do you agree with the proposed exemptions and the reasons why, e.g. responding to Civil contingencies and emergencies, excluding private hospitals and hospitals outside Wales?

We would generally support the proposed list of exceptions. It certainly seems sensible to us that in emergency situations other considerations have to take precedence. Some members have, however, queried why it is being proposed that exemptions should apply to private hospitals in Wales if the standards are to be applied to NHS hospitals.

Do you agree that contracted primary care services and services of a similar type provided directly by the local health board should be treated in the same way? Do you agree with the proposed new standards that place duties on local health boards in relation to primary care services, both contracted and those provided directly?

We agree with the Welsh Government's view that primary care providers should not be subject to the same standards as those being proposed for secondary care. We would concur with the conclusion that

the bureaucracy involved in the approach would not be justified and acknowledge the Welsh Government's belief that it would not achieve the anticipated outcome of the Welsh Language (Wales) Measure 2011.

Given that many Welsh GP practices are under severe strain due to a number of factors – such as increasing workload as a result of an ageing population and an increasing prevalence of chronic disease, funding increases not having kept pace with the rising costs of practice expenses in recent years, and severe and increasing challenges in recruitment and retention – we support the view that it would simply not be practical to apply the same requirements in relation to the Welsh language as those which may be being proposed for secondary care settings.

Given the extent of the problems we have referred to, it would also seem sensible that a common approach is adopted across primary care – regardless of whether services are provided by independent contractors or directly by local health boards.

The proposals which are being suggested in relation to primary care, which place a number of responsibilities upon local health boards, would therefore appear to our members to be a pragmatic, and hence sensible, way forward.

We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them.

As the Welsh Government will be very much aware, there are already recognised recruitment and retention challenges amongst the medical workforce in Wales – including within a number of secondary care specialties which have been the driver for various service reconfiguration proposals in recent years. A key challenge in addressing such recruitment challenges will be to counter any negative perceptions which could result from the application of the proposed Welsh language standards, particularly those being proposed for secondary care. If this is not done effectively, there is a risk that their implementation could further exacerbate current difficulties in attracting sufficient doctors to work in Wales. This is a concern which has been raised by many BMA Cymru Wales members in relation to these proposals.

Annex 3

Rheoliadau Safonau'r Gymraeg (Rhif 7)

Ymateb Cymdeithas yr Iaith

1.Cyflwyniad

1.1. Mae Cymdeithas yr Iaith Gymraeg yn fudiad sy'n ymgyrchu'n ddi-drais dros y Gymraeg a holl gymunedau Cymru.

1.2. Gofynnwn i'r pwyllgor roi sylw penodol i'r gymhariaeth rhwng y rheoliadau arfaethedig hyn a:

(i) Rheoliadau Safonau'r Gymraeg (Rhif 1) 2015 ar gyfer awdurdodau lleol, parciau cenedlaethol a Llywodraeth Cymru;

(ii) Rheoliadau ymgynghorol Safonau'r Gymraeg ar gyfer y maes iechyd a gyhoeddwyd gan y Llywodraeth yn 2016;

(iii) Argymhellion adroddiad ymchwiliad Safonau Comisiynydd y Gymraeg ar gyfer y maes iechyd (Mehefin 2015);

(iv) Adroddiad Comisiynydd y Gymraeg "Fy Iaith, Fy Iechyd" (2014); ac

(v) Egwyddorion strategaeth 'Mwy na Geiriau...' Llywodraeth Cymru

1.3. Mae Safonau'r Gymraeg ar gyfer sectorau eraill eisoes wedi gwneud gwahaniaeth sylweddol o ran gwella darpariaeth Gymraeg cyrff megis cynghorau sir. Oherwydd potensial y system Safonau i wella'r ddarpariaeth Gymraeg yn sylweddol, credwn y dylai'r Llywodraeth flaenoriaethu'r gwaith o'u hymestyn i'r holl sectorau y mae ganddi rym i wneud dan Fesur y Gymraeg 2011, gan gynnwys cwmnïau trên, ynni a thelathrebu.

1.4. Pryderwn, fodd bynnag, y bydd penderfyniadau Gweinidog y Gymraeg o ran union fanylion y set benodol hon o Safonau – gan ei bod wedi ildio i hunan-fuddiannau cyrff yn hytrach na blaenoriaethu anghenion defnyddwyr y gwasanaeth – yn golygu colli cyfle unigryw i wella hawliau pobl ar lawr gwlad i wasanaethau iechyd.

2. Crynodeb

2.1 Credwn fod y rheoliadau'n gwbl annigonol i fodloni hawliau pobl i ddefnyddio'r Gymraeg wrth ddelio â'r gwasanaeth iechyd. Mae'r rheoliadau wedi'u gwanhau'n sylweddol o gymharu â'r Safonau sydd eisoes yn weithredol ar gyfer awdurdodau lleol, a hyd yn oed y rheoliadau ymgynghorol ar gyfer y maes iechyd a gyhoeddwyd yn 2016. Credwn ymhellach fod y rheoliadau yn anwybyddu argymhellion Comisiynydd y Gymraeg ynghyd ag egwyddorion strategaeth 'Mwy na Geiriau...'.

2.2. Hoffem dynnu sylw'r pwyllgor at y ddau brif wendid yn y Rheoliadau arfaethedig:

(i) Mae gofal iechyd sylfaenol wedi'i eithrio o'r rheoliadau (paragraff 9, tudalen 9) – mae darparwyr fel fferyllfeydd a meddygfeydd, yn cael eu heithrio o'r Safonau er mai nhw yw prif bwynt cyswllt – ac yn aml, unig bwynt cyswllt – y cyhoedd â'r gwasanaeth iechyd;

(ii) Ni fydd hawl gan bobl i dderbyn gofal iechyd wyneb yn wyneb, gan gynnwys ymgynghoriadau clinigol, yn Gymraeg mewn ysbytai – boed drwy wasanaeth cymorth cyfieithu neu staff sy'n medru'r iaith – sef y prif wasanaeth a ddarperir gan wasanaethau iechyd;

2.2. Nid yw'r Safonau felly yn creu unrhyw hawl i dderbyn gofal iechyd wyneb yn wyneb, gan gynnwys ymgynghoriadau clinigol, yn Gymraeg yn unrhyw ran o'r gwasanaeth iechyd, a byddai unrhyw ddarpariaeth Gymraeg yn parhau i fod yn hollol wirfoddol. Byddai hynny'n golygu colli cyfle unigryw, unwaith-mewn-degawd o bosibl, i gynyddu defnydd o'r Gymraeg o fewn y gwasanaeth iechyd mewn ffordd a fyddai'n gwneud gwir wahaniaeth i gleifion.

2.3. Mae llawer o gymalau yn y Safonau y byddai'r Gymdeithas yn dymuno eu gwella, ond mewn ysbryd adeiladol, gofynnwn i'r pwyllgor argymell bod y Llywodraeth yn diwygio'r rheoliadau presennol drwy ychwanegu Safonau penodol a fyddai'n:

(i) gosod dyletswydd ar Fyrddau Iechyd i osod amodau o fewn eu cytundebau gyda chyrff gofal iechyd sylfaenol annibynnol i ddarparu gwasanaethau trwy'r Gymraeg. Mae'r Memorandwm Esboniadol yn dangos bod y Llywodraeth wedi derbyn yr egwyddor o osod amodau mewn cytundebau eisoes, ond byddai gosod hyn fel Safon yn sicrhau cydymffurfiaeth go iawn wedi'i reoleiddio gan Gomisiynydd y Gymraeg yn hytrach nag addewid penagored ac aneglur y Llywodraeth i gynnig gweithredu y tu allan i gyfundrefn y Safonau;

(ii) rhoi hawl i unigolion dderbyn gofal iechyd wyneb yn wyneb, gan gynnwys ymgynghoriadau clinigol, yn Gymraeg;

3. Sylwadau

Gwanhau'n sylweddol ar setiau a drafftiau blaenorol y Safonau

3.1. Mae'r Safonau yn wannach o lawer na Rheoliadau Safonau'r Gymraeg (Rhif 1) 2015, yn ogystal â'r drafft ymgynghorol ar gyfer y maes iechyd a gyhoeddwyd gan y Llywodraeth yn 2016.

3.2. Mae'r Safonau wedi'u gwanhau'n sylweddol mewn sawl ffordd, yn benodol gan eu bod:

(i) Yn dileu'r hawl i gymorth Cymraeg mewn ymgynghoriadau clinigol yn gyfan gwbl[1], felly er y bydd rhaid cofnodi dewis iaith y claf, ni fydd rhaid gwneud unrhyw drefniant i'w trin yn Gymraeg;

(ii) Yn dileu hawl y Comisiynydd i osod Safon i sicrhau gwasanaeth ffôn cyflawn Cymraeg, hyd yn oed mewn rhai ardaloedd neu sefyllfaoedd yn unig[2];

(iii) Yn dileu unrhyw hawliau i'r cyhoedd dderbyn dogfennau neu daflenni yn Gymraeg[3], megis manylion ymgynghoriadau, taflenni gwybodaeth, canllawiau, cardiau a llyfrynnau. Ymddengys bod y gwanhau hwn yn seiliedig ar gasgliadau ymgynghoriad ar Fil arfaethedig y Gymraeg nad ydynt yn gyhoeddus eto;

(iv) Yn gwanhau'r hawl i gyrsiau addysg a hyfforddiant drwy'r Gymraeg gan ragdybio y bydd pob cwrs yn Saesneg ac mai eithriadau'n unig fydd cyrsiau Cymraeg lle bo 'angen', sy'n gwbl groes i egwyddor y 'cynnig rhagweithiol' a argymhellir yn 'Mwy na Geiriau...' a hysbysiadau cydymffurfio cyrff eraill lle mae rhagdybiaeth y bydd cwrs yn Gymraeg. Mae'r Safonau hefyd yn lleihau ymhellach y nifer o gyrsiau sy'n ddarostyngedig i'r hawl hon[4];

(v) Yn eithrio cyrff iechyd o unrhyw ddyletswyddau i ohebu yn Gymraeg ynghylch ymgynghoriad clinigol[5];

(vi) Yn atal cyrff allanol rhag gweithredu yn Gymraeg drwy ddileu unrhyw hawliau cyrff i wasanaethau Cymraeg[6];

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1 c.f. Safon 25(c) yn Rheoliadau ymgynghorol 2016

2 c.f.: Safon 10 yn Rheoliadau ymgynghorol 2016

3 c.f . Safon 37-44 yn Rheoliadau ymgynghorol 2016 a Safon 82 Rheoliadau 2018 arfaethedig sy'n rhestru hawliau i ddogfennau i weithwyr dderbyn dogfennau penodol

4 gweler paragraff 56, tudalen 45

5 gweler paragraff 33, tudalen 37

(vii) Yn eithrio gwasanaethau gofal sylfaenol a gwasanaethau cartref gofal yn benodol o unrhyw ddyletswydd i ddarparu gwasanaethau yn Gymraeg[7];

Gofal Iechyd Sylfaenol – eithriad cwbl annerbyniol

3.3. Er bod sôn yn y memorandwm esboniadol am ba mor bwysig yw Gofal Sylfaenol, ac er gwaetha'r pryder a fynegwyd yn yr ymatebion i'r ymgynghoriad nad yw Gofal Sylfaenol wedi'i gynnwys, mae'r modd y mae'r Llywodraeth wedi ymateb i hynny yn y rheoliadau yn gwbl annigonol. Mae'r safonau hyn yn diystyru hawliau siaradwyr Cymraeg yn llwyr mewn perthynas â gofal sylfaenol. Mae angen safonau sy'n gwarchod hawliau defnyddwyr ar hyd eu llwybr gofal – o'r cysylltiad cyntaf â'r gwasanaeth iechyd. Meddygon teulu, optegwyr, deintyddion a fferyllwyr yw prif gyswllt y cyhoedd, ac yn aml ein hunig gyswllt, â'r gwasanaeth iechyd, felly byddai creu dyletswyddau iaith ym maes iechyd heb osod dyletswyddau ar y gwasanaethau hyn yn hollol annerbyniol.

3.4. Mae cwynion di-ri am ddiffyg gwasanaethau Cymraeg elfennol ym maes gofal sylfaenol, o ddiffyg gwasanaeth derbynfa Cymraeg, diffyg staff sy'n siarad Cymraeg i ddiffyg arwyddion a gwefannau Cymraeg. Fel dywedodd Comisiynydd y Gymraeg yn ei hymholiad swyddogol cyntaf "Fy iaith, fy iechyd: ymholiad i'r Gymraeg mewn gofal sylfaenol":

> *"Rwyf wedi fy mrawychu o glywed rhai profiadau dirdynnol siaradwyr Cymraeg ac aelodau o'u teuluoedd o fethu â chael gwasanaeth iechyd addas i'w hanghenion."*

3.5. Cafwyd argymhelliad clir gan Gomisiynydd y Gymraeg ar sail ei hymholiad i faes iechyd:

"Casgliad 14: Gan mai gofal sylfaenol yw cyswllt cyntaf mwyafrif aelodau'r cyhoedd gyda'r gwasanaeth iechyd, cred Comisiynydd y Gymraeg ei bod yn hanfodol sicrhau cysondeb ymddygiad ieithyddol ar draws y gwasanaeth iechyd yng Nghymru yn ei gyfanrwydd. O ganlyniad, rhaid i ddarparwyr gwasanaethau gofal sylfaenol fod yn ddarostyngedig i safonau'r Gymraeg o dan yr un fframwaith statudol â'r sefydliadau iechyd a fu'n destun i'r ymchwiliad safonau hwn. Daw'r Comisiynydd felly i'r casgliad bod angen safonau ychwanegol er mwyn galluogi hyn i ddigwydd."

ond mae'r Llywodraeth wedi anwybyddu'r argymhelliad yn llwyr wrth lunio ac ail-lunio'r rheoliadau.

3.6. Rydyn ni fel mudiad yn derbyn ymholiadau a chwynion gan ddefnyddwyr gwasanaethau iechyd a gofal cymdeithasol, am eu bod wedi methu â derbyn gwasanaeth yn Gymraeg. Mae'n anodd iawn i bobl gwyno am ddiffyg hawl i wasanaeth yn Gymraeg oherwydd maent gan amlaf yn ceisio cefnogaeth y gwasanaethau yma pan fyddant mewn angen ac yn teimlo'n fregus ac mewn perygl.

3.7. Mae sawl astudiaeth a darn ymchwil yn dangos pa mor bwysig yw gallu cyfathrebu yn eich dewis iaith, yn enwedig mewn sefyllfa o geisio cyfleu problem neu anhawster. Yn wir, mewn cyd-destun fel iechyd, mater o angen yn hytrach na dewis yw gwasanaeth yn eich iaith mewn gwirionedd. Mae sawl enghraifft anffodus o asesiad anghywir a thriniaeth anaddas yn digwydd oherwydd nad yw'r person sy'n ymateb i angen y claf neu'r defnyddiwr gwasanaeth wedi gallu darparu'r gwasanaeth yn Gymraeg. Gall gwasanaeth iechyd yn Gymraeg arwain at fudd sylweddol i iechyd y claf.

3.8. Mae iaith yn elfen allweddol o ofal. Mae pobl yn defnyddio'r gwasanaeth iechyd pan fônt ar eu mwyaf bregus, felly mae'n hanfodol bwysig eu bod yn medru cyfathrebu yn yr iaith maent yn teimlo'n fwyaf cyfforddus yn ei siarad. Dylai'r Safonau gydnabod y ffaith bod gwasanaethau Cymraeg yn y maes hwn yn hawl sylfaenol i bobl Cymru.

3.9. Mae tystiolaeth ein haelodau yn awgrymu bod mwyafrif y darparwyr gofal sylfaenol ledled Cymru yn gweithredu fel pe na bai unrhyw orfodaeth na chanllawiau yn eu cymell i weithredu gydag

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6 gweler para 34, tuadlen 38

7 gweler paragraffau 9 a 10, tudalen 9, Rheoliadau 2018 arfaethedig

ystyriaeth i anghenion iaith siaradwyr Cymraeg. Yn aml iawn nid oes staff dwyieithog yn cael eu penodi, ac nid yw arwyddion sylfaenol yn ddwyieithog hyd yn oed.

3.10. Prin bod y Safonau'n gwneud unrhyw beth i newid y sefyllfa o ran gwasanaeth wyneb yn wyneb, oherwydd y penderfyniad i wanhau'r rheoliadau presennol sydd eisoes yn weithredol ar gyfer cynghorau, parciau cenedlaethol a Llywodraeth Cymru.

3.11. Noder bod Safonau'r Gymraeg (Rhif 1) a basiwyd gan y Cynulliad yn unfrydol yn 2015 ac sydd bellach yn weithredol ar bob un awdurdod lleol, parc cenedlaethol a Llywodraeth Cymru yn datgan bod trydydd parti sy'n gweithredu ar ran corff, megis cwmni yn gweithredu ar ran cyngor, yn gorfod cydymffurfio â'r Safonau yn yr un ffordd â'r corff sy'n ddarostyngedig i'r Safonau ei hunan[8]. Yn gwbl groes i'r egwyddor hon, mae'r Rheoliadau hyn ym maes iechyd yn eithrio darparwyr gofal sylfaenol o'r un gofyniad sylfaenol. Felly, mae cwmni preifat sy'n gwneud gwaith ar ran neu drwy gytundeb gyda chyngor sir, megis un sy'n darparu gofal yn y cartref, yn gorfod cydymffurfio â'r Safonau. Fodd bynnag, ni fyddai cwmni sy'n darparu gofal iechyd ar ran Bwrdd Iechyd yn gorfod cydymffurfio gan fod eithriad penodol yn Safonau arfaethedig y Gymraeg (Rhif 7). Credwn fod rhaid newid y cam gwag hwn cyn pasio'r rheoliadau yn y Senedd.

3.12. Erbyn hyn, ymddengys fod y Llywodraeth wedi derbyn ei bod yn gyfreithiol bosibl gosod dyletswyddau cyfreithiol ar ddarparwyr gofal sylfaenol, gan fod eu cyfiawnhad dros beidio â'u cynnwys wedi newid. Yn 2016, dywedasant mewn cyfarfod gyda ni y byddai cynnwys darparwyr gofal sylfaenol fel trydydd parti yn y rheoliadau yn 'anghyfreithlon'[9], gan na all Byrddau Iechyd fod yn gyfreithiol gyfrifol am y cytundebau na'r meddygfeydd. Yn ogystal, nodwyd y canlynol mewn dogfen ymgynghori yn 2016:

> *"Gallai'r dull hwn arwain at ddiffyg eglurder i'r cyhoedd a darparwyr gofal sylfaenol gan na fyddai safonau'r Gymraeg ond yn berthnasol i wasanaethau y mae darparwyr gofal sylfaenol yn eu darparu ar ran y byrddau iechyd lleol. Gan fod llawer o ddarparwyr hefyd yn ymgymryd â gwaith preifat, ni fyddai'r amgylchiadau pan fyddai disgwyl iddynt gydymffurfio â safonau yn glir bob amser – gallai unigolyn gael cymysgedd o wasanaethau'r GIG a gwasanaethau preifat yr un pryd."*

3.13. Erbyn hyn, nid yw'r Llywodraeth yn defnyddio'r un dadleuon cyfreithiol. Mae'r memorandwm esboniadol yn datgan: "*Nid ydym o'r farn y byddai'n rhesymol gosod dyletswyddau ar fyrddau iechyd lleol a fyddai'n eu dal yn gyfrifol am fethiant ar ran un o'r darparwyr gofal sylfaenol annibynnol i gydymffurfio â'r safonau."*

3.14. Ymhellach, mae'r Llywodraeth bellach yn cynnig gwneud yr hyn roeddent yn dadlau y byddai'n 'anghyfreithlon' ei wneud drwy ddadlau dros: *"nifer fach o ddyletswyddau ... drwy gontractau gofal sylfaenol neu gytundeb telerau gwasanaeth rhwng darparwr gofal sylfaenol a bwrdd iechyd lleol."* Maent yn cynnig gwneud hynny y tu allan i'r gyfundrefn Safonau, gan arwain at ansicrwydd ac anallu i sicrhau'r hawliau mewn cyfundrefn ddeddfwriaethol.

3.15. Y cwestiwn amlwg sy'n codi felly yw: nawr bod y Llywodraeth yn derbyn bod modd i Fwrdd Iechyd Lleol osod amod o ran darpariaeth Gymraeg drwy gontract gyda darparwyr gofal sylfaenol a'u gorfodi, beth yw'r ddadl yn erbyn gwneud hynny drwy gyfundrefn y Safonau?

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8 paragraff 5, tudalen 6, Rheoliadau Safonau'r Gymraeg (Rhif 1) 2015: "*mae cyfeiriadau at unrhyw weithgaredd sy'n cael ei gyflawni gan gorff, neu at unrhyw wasanaeth sy'n cael ei ddarparu gan gorff, i'w darllen fel pe baent yn cynnwys cyfeiriad at y gweithgaredd hwnnw yn cael ei gyflawni ar ran y corff, neu at y gwasanaeth hwnnw yn cael ei ddarparu ar ran y corff, gan drydydd parti o dan drefniadau a wneir rhwng y trydydd parti a'r corff."*

9 http://cymdeithas.cymru/dogfen/safonaur-gymraeg-ym-maes-iechyd

3.16. **Argymhellwn fod y pwyllgor yn gofyn i'r Llywodraeth ddiwygio'r Safonau er mwyn cynnwys Safon benodol ychwanegol sy'n gosod dyletswydd gyfreithiol ar bob Bwrdd Iechyd Lleol i osod amodau darpariaeth Gymraeg mewn cytundebau gyda darparwyr gofal sylfaenol.** Heb y sicrwydd hwnnw, ni fyddwn yn cefnogi'r rheoliadau oherwydd:

- Bydd hawl cleifion i dderbyn gwasanaethau gofal iechyd sylfaenol drwy'r Gymraeg yn gwbl ddibynnol ar gamau gwirfoddol ar ran y cyrff iechyd, ac felly mewn gwirionedd ni fydd y mwyafrif yn cael gwasanaethau o'r fath yn Gymraeg.
- Na fydd yn rhoi'r gallu i amddiffyn hawliau cleifion i wasanaethau gofal sylfaenol yn nwylo cyfundrefn reoleiddio annibynnol sy'n cael ei chynnal gan Gomisiynydd y Gymraeg;
- Nad oes eglurder ynghylch beth fydd yr amodau yn y cytundebau arfaethedig hyn;
- Nad oes amserlen ynghylch pryd y daw'r cytundebau mae'r Llywodraeth yn sôn amdanynt i rym;
- Nad ydym yn ymddiried yn y Llywodraeth na'r Byrddau Iechyd i weithredu ar y mater.

3.17. Nid yw Safonau 65–68 yn creu unrhyw hawl i unigolyn dderbyn gwasanaeth gofal iechyd sylfaenol o unrhyw fath, er enghraifft mewn meddygfa teulu, drwy'r Gymraeg.

3.18. Noder ymhellach bod y memorandwm esboniadol yn datgan y bydd disgwyl i ddarparwr gofal sylfaenol gydymffurfio â'r Safonau os ydynt yn cael 'eu darparu'n uniongyrchol gan fyrddau iechyd'. Er bod hwn yn gam bach yn y cyfeiriad cywir, prin iawn yw'r enghreifftiau o'r gwasanaethau hyn yn cael eu darparu'n uniongyrchol gan fyrddau iechyd (e.e. nyrsys ardal a meddygfeydd dros dro) ond byddai cynnwys gofal sylfaenol yn gyffredinol yn cael effaith gadarnhaol iawn ar brofiadau cleifion ledled Cymru.

3.19. Mae eithrio cyrff annibynnol sy'n darparu gofal sylfaenol yn gosod gormod o risg i gleifion o ran:

- Asesu effeithiol a dibynadwy
- Pennu archwiliadau
- Cyfeirio
- Cynnal diagnosis
- Penderfyniadau o ran triniaethau / gofal
- Dilyniant

3.20. Yn ogystal, mae angen ystyried effaith colli cyfle hanesyddol a gynigir gan y set hon o Safonau, wedi i gynlluniau iaith fethu â chreu'r hawliau hyn ers chwarter canrif. Drwy fethu â chynnwys gwasanaethau gofal iechyd sylfaenol y tro hwn, caiff gwasanaethau Cymraeg eu dal yn ôl am flynyddoedd eto i ddod. Byddai creu hawliau i gleifion drwy gyfundrefn y Safonau wrth ymwneud â meddygfa, hyd yn oed ar lefel eithaf sylfaenol, yn cael effaith gadarnhaol iawn ar newid agweddau yn y maes.

Gofal Iechyd Wyneb yn Wyneb mewn Ysbytai – Dim Hawliau (Safonau 23–24 a 110–110A)

3.21. Ymddengys fod arwyddocâd iaith fel rhan o ofal iechyd ac egwyddor y 'cynnig rhagweithiol' wedi'u hanghofio yn y rheoliadau hyn. Mae cyfundrefn y Safonau'n rhoi cyfle i ddarparu platfform cryfach ar gyfer adeiladu gwasanaethau cyfrwng Cymraeg ar hyd y llwybr gofal, ond nid yw'r Llywodraeth wedi manteisio ar y cyfle yn y rheoliadau arfaethedig.

3.22. Mae cynghorau sir, parciau cenedlaethol a Llywodraeth Cymru yn ddarostyngedig i Safonau sy'n rhoi'r hawl i bobl gael cyfarfodydd yn Gymraeg os yw'r "cyfarfod hwnnw yn ymwneud â llesiant"[10] –

10 Safonau 25-26B, tudalen 14-15, Rheoliadau Safonau'r Gymraeg (Rhif 1) 2015

boed hynny drwy drwy gyfieithu ar y pryd neu staff sy'n medru'r iaith. Roedd y rheoliadau ymgynghorol ar gyfer y maes iechyd a gyhoeddwyd yn 2016 yn cynnwys Safon a oedd yn gwarantu, wedi i unigolyn fynegi dymuniad i ddefnyddio'r Gymraeg, "*darparu cymorth Cymraeg i A mewn ymgynghoriadau clinigol o hynny ymlaen (oni bai eich bod yn cynnal neu'n darparu'r ymgynghoriad clinigol yn Gymraeg)*".

3.23. Mewn gwrthgyferbyniad trawiadol â'r Safonau hynny ar gyfer cynghorau a chyrff cyhoeddus eraill, nid yw Safonau 23, 23A a 24 yn y rheoliadau arfaethedig ar gyfer y gwasanaeth iechyd yn creu'r un hawl i glaf dderbyn gofal iechyd wyneb yn wyneb yn Gymraeg. Nid bai cyfundrefn y Safonau yw hyn, ond diffyg ewyllys gwleidyddol y Gweinidog sy'n gyfrifol amdanynt.

3.24. Noder bod Safon 23A yn gosod dyletswydd i gofnodi dewis iaith claf, ond mewn nifer fawr o achosion, dylai dewis iaith y claf eisoes fod wedi'i gofnodi gan ddarparwr gofal sylfaenol. Dylid adnabod dewis neu angen iaith claf cyn iddo gael ei dderbyn i'r ysbyty er mwyn cael trefnu ar ei gyfer. Mae strategaeth 'Mwy na Geiriau...' yn rhoi dyletswydd ar feddygon teulu i gofnodi dewis iaith wrth gyfeirio cleifion at wasanaethau eilaidd. Dylid gosod y ddyletswydd o fewn y cytundebau felly.

3.25. Cyfeirir drwyddi draw at gleifion mewnol, ond nid oes sôn am gleifion allanol, felly ymddengys na fyddai gan gleifion allanol unrhyw hawliau i dderbyn gwasanaeth yn Gymraeg.

3.26. Argymhellwn y dylid ychwanegu Safon benodol sy'n cadarnhau hawliau cleifion, mewnol ac allanol, i gael derbyn ymgynghoriad clinigol, triniaeth a gofal drwy'r Gymraeg.

3.27. Nid yw Safon 110 yn rhoi hawl i gleifion gael ymgynghoriad drwy'r Gymraeg ychwaith. Yn hytrach, yr unig ofyniad yw gofyn i gyrff amlinellu eu cynlluniau o ran gweithio tuag at hynny. Mae ychwanegu dyletswydd i gyhoeddi cynllun i osod allan sut y bydd Bwrdd Iechyd yn darparu ymgynghoriadau clinigol yn Gymraeg yn waith papur ychwanegol nad yw'n creu dim hawliau i'r unigolyn. Yn ogystal, mae'n gwbl groes i rethreg y Llywodraeth ynghylch y Bil arfaethedig ar y Gymraeg sy'n honni ei bod am 'leihau biwrocratiaeth'. Pe bai'r Llywodraeth yn creu'r hawl fel rydym yn ei argymell ym mhwynt 3.17 uchod, gellid cadw Safon debyg i Safon 110 – sy'n ymdrin â chynnig cynnal ymgynghoriad yn y Gymraeg – er mwyn esbonio ***sut*** y dylai corff fynd ati i gynllunio ar gyfer rhoi'r dewis ar waith, er enghraifft drwy gyfeirio'r claf at staff sy'n siarad Cymraeg.

3.28. Yn fwy cyffredinol, mae diffyg manylder o fewn y Safonau Cyflenwi Gwasanaethau o ran asesu, cofnodi a lledaenu gwybodaeth ynghylch dewis neu angen iaith cleifion a rhoi'r cynnig rhagweithiol ar waith. Wedi'r cyfan, dyma'r man allweddol i ddefnyddwyr gwasanaeth sy'n fregus.

Sylwadau Eraill

3.29. Mae llawer iawn o fanylion yn y memorandwm esboniadol am gostau. Fodd bynnag, nid oes dim cyfeiriad at y gwerth sy'n cael ei ychwanegu tuag at y gwasanaeth wrth allu cyfathrebu â phobl yn eu dewis iaith (gan gyfeirio at adroddiad y Comisiynydd o brofiadau pobl).

3.30. Mae'r memorandwm esboniadol yn datgan bod Gofal Cymdeithasol Cymru wedi eu hychwanegu at Atodlen 6, ond nid ydynt i'w gweld yn Atodlen 6 y rheoliadau sydd wedi'u cyflwyno gerbron y Cynulliad.

3.31. Nid ydym wedi gweld esboniad ynghylch pam y dilëwyd "Awdurdod Gwasanaethau Busnes y GIG" o Atodlen 6 ac felly o unrhyw ddyletswydd i gydymffurfio â'r Safonau.

4. Hyfforddiant i wella cynllunio gweithlu'r gwasanaethau iechyd

4.1. Mae nifer o faterion sydd y tu hwnt i sgôp y rheoliadau hyn ond sy'n effeithio ar allu'r gwasanaeth iechyd i ddarparu drwy gyfrwng y Gymraeg, ac fe hoffem dynnu sylw'r pwyllgor atynt.

4.2. Er y bydd effaith gadarnhaol yn deillio o'r Safonau ynghylch recriwtio, nid ydynt yn mynd i'r afael â'r systemau hyfforddi. Dylai'r pwyllgor ystyried y darlun ehangach a'r angen am hyfforddi gweithlu sy'n medru'r Gymraeg.

4.3. Argymhellwn felly y dylid:

- Gosod cwotâu ar ysgolion meddygol a cholegau hyfforddi eraill o ran hyfforddi meddygon, nyrsys a gweithwyr iechyd eraill sy'n medru'r Gymraeg
- Sefydlu Ysgol Feddygol ym Mangor i gynyddu darpariaeth hyfforddiant meddygol yn Gymraeg

5. Casgliadau

5.1. Mae'n amlwg bod y Safonau wedi cael eu hysgrifennu o safbwynt y rhai sy'n rhoi'r gwasanaeth, nid y rhai sy'n eu derbyn. Nid yw'r rhain yn dderbyniol i gleifion, ond maent yn dderbyniol iawn i ddarparwyr gwasanaeth gan eu bod mor wan. Mae'n warthus bod pryderon y cyrff a nodir yn y memorandwm esboniadol wedi cael eu derbyn, tra bod pryderon y cyhoedd, sef defnyddwyr y gwasanaeth, wedi cael eu hanwybyddu.

5.2. Ni allwn gefnogi'r rheoliadau hyn yn eu ffurf bresennol gan nad ydynt yn creu hawliau i bobl mewn dau faes sy'n gwbl greiddiol i ddarpariaeth iechyd drwy'r Gymraeg, sef gofal iechyd sylfaenol a gofal iechyd wyneb yn wyneb mewn ysbytai.

5.3. Mae nifer o fân newidiadau pellach yn y Safonau sy'n gwanhau hawliau pobl ar lawr gwlad nad ydym wedi cyfeirio atyn nhw yn ein hymateb, ond maen nhw bron yn ddieithriad yn gwanhau hawliau pobl i'r Gymraeg o gymharu â Safonau sydd eisoes mewn grym ac o gymharu â'r Safonau drafft ar gyfer y gwasanaeth iechyd a gyhoeddwyd yn 2016.

5.4. Am y rhesymau hyn, credwn y byddai pasio'r Safonau annigonol hyn yn colli cyfle unigryw, efallai unwaith-mewn-degawd, i gryfhau hawliau pobl i'r Gymraeg mewn maes cwbl hanfodol. Argymhellwn fod y pwyllgor yn gofyn i'r Llywodraeth ychwanegu Safonau penodol at y rheoliadau presennol sydd:

> **(i) yn gosod dyletswydd ar Fyrddau Iechyd i osod amodau o fewn eu cytundebau gyda chyrff gofal iechyd sylfaenol annibynnol i ddarparu gwasanaethau trwy'r Gymraeg**
>
> **(ii) yn rhoi hawl i unigolion dderbyn gofal iechyd wyneb yn wyneb, gan gynnwys ymgynghoriadau clinigol, yn Gymraeg;**

5.5. Oherwydd y newid yn nadleuon y Llywodraeth, mae'n amlwg nad oes rheswm cyfreithiol bellach dros beidio â derbyn ein hargymhellion uchod; diffyg ewyllys gwleidyddol yn unig fyddai'n gyfrifol. Erfyniwn arnoch i sicrhau'r newidiadau hyn er lles cleifion a'u hawliau i driniaeth yn Gymraeg ac i sicrhau gwell gwasanaethau iechyd i bobl Cymru yn y dyfodol.

Is-Grŵp Iechyd, Cymdeithas yr Iaith

Mawrth 2018

Annex 4

meddwl.org

meddyliau ar iechyd meddwl

Bethan Jenkins AC
Cadeirydd
Pwyllgor Diwylliant, y Gymraeg a Chyfathrebu
Cynulliad Cenedlaethol Cymru
BAE CAERDYDD
CF99 1NA

Annwyl Gadeirydd,

Cyflwynwn drwy'r llythyr hwn dystiolaeth ysgrifenedig ar ran tîm rheoli meddwl.org mewn ymateb i'ch ymgynghoriad byr ar Reoliadau Safonau'r Gymraeg (Rhif 7) 2018 arfaethedig (rheoliadau rhif 7).

Mudiad gwirfoddol yw meddwl.org â'i waith pennaf yn ymwneud â rhedeg y wefan gyntaf i ddarparu gwybodaeth a chyngor am iechyd meddwl, a gofod i rannu profiadau, yn gyfan gwbl drwy'r Gymraeg. Mae'r gwaith hefyd yn ymestyn yn gynyddol i gymryd rhan mewn trafodaethau a chodi ymwybyddiaeth ymysg eraill ar fater pwysigrwydd gofal iechyd meddwl Cymraeg.

Ers blynyddoedd lawer, mae academyddion ar draws y byd ac yng Nghymru wedi amlygu'r cysylltiad rhwng gallu ieithyddol a'r gallu i fynegi emosiwn. Wrth gwrs, rydym yn cydnabod bod rôl hanfodol gan iaith i'w chwarae mewn cyd-destunau iechyd o bob math, ond o ystyried bod y gallu i gyfathrebu a mynegi emosiwn yn glir ac effeithiol yn gwbl greiddiol mewn triniaethau iechyd meddwl, mae'n wybyddus bellach bod pwysigrwydd cryfach fyth i'r Gymraeg yn y cyd-destun hwn.

Roeddem felly yn awyddus iawn i weld y rheoliadau safonau ar gyfer y sector iechyd yn cael eu gosod er ein bod, wrth reswm, yn effro i'r ffaith na fyddai'r safonau ar eu pennau eu hunain yn mynd i'r afael â'n holl ofnau nac yn sicrhau gweithrediad llawn o fframwaith strategol hanfodol y Llywodraeth, *Mwy na Geiriau....* Fodd bynnag, dylid nodi nad oes unrhyw bŵer cyfreithiol i'r fframwaith hwnnw ac yn hynny o beth, Mesur y Gymraeg (Cymru) 2011 (y Mesur) yw'r unig offeryn â'r gallu i ddwyn i gyfrif y rheiny sydd, ers blynyddoedd lawer, yn diystyru rhwystrau ieithyddol a'u hymrwymiadau cynllun iaith. Yn anffodus, rydym yn teimlo bod ffaeleddau amlwg i'w gweld yn rheoliadau rhif 7 sy'n golygu na fyddent yn ymateb i brif egwyddor a nod y Mesur o beidio â thrin y Gymraeg yn llai ffafriol na'r Saesneg yng Nghymru.

Mawr groesawn y ffaith fod eich pwyllgor wedi galw'r rheoliadau i mewn a gobeithiwn y bydd ystyriaeth drylwyr a theilwng o'r holl faterion hanfodol. Isod, amlinellir ein prif bryderon mewn perthynas â chynnwys y rheoliadau er eich ystyriaeth.

Dileu safonau'n ymwneud â darparu cymorth Cymraeg mewn ymgynghoriadau clinigol

Yn y rheoliadau drafft y cynhaliwyd ymgynghoriad arnynt yn ôl yn 2016, roedd safon 25 yn ymwneud â darparu cymorth Cymraeg mewn ymgynghoriadau clinigol:

> "Pan fydd unigolyn ("A") yn mynychu ymgynghoriad clinigol a gyflawnir neu a ddarperir gennych am y tro cyntaf rhaid ichi—
>
> (a) gofyn i A a yw A yn dymuno cael cymorth Cymraeg yn yr ymgynghoriad clinigol,
>
> (b) os yw A yn eich hysbysu bod A yn dymuno cael cymorth Cymraeg yn yr ymgynghoriad clinigol, gadw cofnod o'r dymuniad hwnnw, ac
>
> (c) darparu cymorth Cymraeg i A mewn ymgyngoriadau clinigol o hynny ymlaen (oni bai eich bod yn cynnal neu'n darparu'r ymgynghoriad clinigol yn Gymraeg)."

Darparwyd diffiniad yn y rheoliadau blaenorol hynny mai "*ystyr "ymgynghoriad clinigol" yw rhyngweithio rhwng unigolyn a chorff ynghylch darpariaeth iechyd."* Awgryma'r dehongliad hwn na fyddai'r safon yn berthnasol i'r ddarpariaeth iechyd ei hun, dim ond y drafodaeth a geir amdani. Mae'r dehongliad pellach a geir o'r term 'darpariaeth iechyd' sef *"darparu gwasanaethau iechyd fel rhan o'r gwasanaeth iechyd i unigolyn ac mae'n cynnwys asesu, diagnosio, neu drin yr unigolyn hwnnw"* hefyd yn cadarnhau hynny gan wahaniaethu yn gwbl glir rhwng 'ymgynghoriadau clinigol' a 'darpariaeth iechyd'. Yr hyn fyddai'r safon a ddyfynnir uchod wedi'i ganiatáu felly fyddai hawl i unigolion drafod eu hanghenion cychwynnol yn y Gymraeg.

Er nad oedd y safon hon yn caniatáu'r ddarpariaeth Gymraeg llawn, roeddem yn cytuno bod y cyfathrebu'n ystod ymgynghoriad clinigol yn allweddol gan mai ar yr adeg honno y byddai penderfyniad yn cael ei wneud ynghylch anghenion meddygol yr unigolyn. Rydym yn bendant ein safbwynt bod galluogi unigolion i fynegi eu hunain yn y Gymraeg yn hanfodol i sicrhau gwasanaeth o ansawdd ymhob sefyllfa, ond gan hefyd dderbyn yr anawsterau recriwtio cenedlaethol, roeddem yn cydnabod na fyddai'r gallu gan y Byrddau i sicrhau hynny ar hyn o bryd. O'r herwydd, roeddem yn croesawu bod mater y cyfathrebu cychwynnol hwnnw a fyddai'n llywio'r ddarpariaeth gofal am beth amser i ddod wedi cael sylw.

Pryder enbyd i ni fel mudiad felly oedd gweld yr hawl hon wedi'i diddymu yn rheoliadau rhif 7. Ymddengys mai'r safonau sydd wedi'u cynnwys yn lle'r safon uchod yn rheoliadau rhif 7 yw:

"Safon 23: Rhaid ichi ofyn i glaf mewnol ("A") ar ddiwrnod cyntaf ei dderbyniad claf fel claf mewnol a yw A yn dymuno defnyddio'r Gymraeg i gyfathrebu â chi yn ystod y derbyniad hwnnw fel claf mewnol.

Safon 23A: Os yw'r claf mewnol ("A") yn eich hysbysu fod A yn dymuno defnyddio'r Gymraeg i gyfathrebu â chi yn ystod derbyniad fel claf mewnol, rhaid ichi roi gwybod i'ch staff sy'n debygol o gyfathrebu ag A, fod A yn dymuno defnyddio'r Gymraeg i gyfathrebu â chi yn ystod y derbyniad hwnnw fel claf mewnol."

Er ein bod yn croesawu'r bwriad i ddarganfod ac ymateb i ddewis iaith mewn ysbytai, nodwn yn gyntaf oll fod y safonau uchod wedi eu cyfyngu i gleifion mewnol yn unig. Mae'r rheoliadau yn cadarnhau mai ystyr 'claf mewnol' ar gyfer dibenion y safonau hyn yw "*unigolyn sy'n cael ei dderbyn i'r ysbyty am o leiaf un noson".*

Mae safonau eraill yn y rheoliadau sy'n gwneud darpariaethau mewn perthynas â chynadleddau achos a chyfarfodydd rhwng corff ac unigolion. Yn ôl y rheoliadau, ystyr 'cynhadledd achos' yw *"rhyngweithio a'i brif bwrpas yw trafod darpariaeth unigolyn ("A") sy'n ymwneud ag iechyd ac sydd rhwng- (a) A, (b) un neu ragor o gyrff, a (c) un neu ragor o bersonau pan fo o leiaf un o'r personau hynny yn gyngor sir neu'n gyngor bwrdeistref sirol yng Nghymru".* Ymhellach, cedwir y diffiniad blaenorol a nodwyd uchod o 'ddarpariaeth iechyd' sydd, eto, yn gwahaniaethu gan awgrymu nad yw'r safonau sy'n ymwneud â chyfarfodydd rhwng corff ac unigolion (safonau 21-22CH) yn berthnasol chwaith i'r ddarpariaeth iechyd a thriniaeth.

Golyga hyn oll nad oes gan gleifion allanol nad ydynt wedi treulio o leiaf noson yn yr ysbyty unrhyw hawliau mewn perthynas â derbyn unrhyw elfen o'r ddarpariaeth yn Gymraeg, ac yn wahanol i'r rheoliadau drafft blaenorol, nid oes ganddynt bellach hyd yn oed yr hawl i gymorth Cymraeg mewn ymgynghoriadau clinigol. O ystyried mai cleifion allanol yw mwyafrif yr unigolion sy'n derbyn gwasanaethau iechyd yng Nghymru, ac yng ngoleuni'r prinder gwelyau sydd wedi bod (ac felly'r amharodrwydd cynyddol i dderbyn claf yn fewnol os nad oes rhaid), bydd y diffyg hwn yn y gyfundrefn safonau yn cael effaith anffafriol iawn ar siaradwyr Cymraeg. Rydym yn rhagweld y bydd hyn yn effeithio'n arbennig ar y rheiny sydd yn ei gweld hi'n llawer anoddach cyfathrebu am faterion personol a sensitif mewn unrhyw iaith ond y Gymraeg.

Ymhellach na hynny, rydym yn pryderu y bydd y diffyg hwn yn cael effaith gwirioneddol andwyol ar gleifion iechyd meddwl Cymraeg eu hiaith. Unedau arbenigol iawn yw'r rheiny lle y bydd cleifion iechyd meddwl yn dod yn rhai mewnol, ac yn gyffredinol dim ond pan fydd unigolion yn wirioneddol fregus y byddant yn mynd i unedau o'r fath. Hyd yn oed petaent yn cyrraedd y pwynt hwnnw, byr yw eu harhosiad gan amlaf, gyda'r gofal dilynol yn digwydd fel cleifion allanol neu yn y gymuned. Mewn gwirionedd felly, nifer fechan iawn o gleifion iechyd meddwl fydd ag unrhyw hawl i nodi eu dewis iaith. Nodir nad yw'r hawliau uchod yn pennu hawl cyflawn i gyfathrebiad yn Gymraeg fel claf mewnol chwaith ond yn hytrach hawl i gael mynegi'r dewis a sicrhau fod staff yn ymwybodol ohono'n unig.

Mae ymchwil wedi amlygu nad yw cleifion yn gallu mynegi eu hunain mor rhwydd os nad ydynt yn gallu gwneud hynny yn eu hiaith gyntaf, ac o ganlyniad eu bod weithiau'n mynegi eu hunain mewn ffordd nad yw wir yn cyfleu'r hyn a fwriadwyd. Adroddir fod hyn yn cael effaith ar hyder unigolion; ar y 'balans pŵer' lle mae'r claf yn teimlo islaw'r ymarferydd; ar y berthynas therapiwtig a'r gallu i sefydlu cydberthynas a hyd yn oed ar y parodrwydd neu'r 'amynedd' i ymhelaethu a cheisio egluro'r cysyniadau a'r meddyliau dwysaf a mwyaf cymhleth. O'r herwydd felly, mae'r penderfyniad i ddileu cymorth Cymraeg mewn ymgynghoriad clinigol yn galluogi i gyrff iechyd yng Nghymru esgeuluso anghenion y rheiny nad oes 'sgan' na 'thriniaeth amlwg' ar gyfer eu cyflyrau, a lle mae cyfathrebu clir yn gwbl allweddol wrth sicrhau diagnosis cywir, triniaeth effeithiol a gwellhad.

<u>Penderfyniad nad yw'r safonau a osodir ar gyrff iechyd yn berthnasol i unrhyw wasanaethau gofal sylfaenol a ddarperir ar eu rhan gan drydydd parti</u>

Nodwn fod rheoliadau rhif 7 yn datgan:

> "*Pan fo'r trydydd parti yn ddarparwr gofal sylfaenol... yna nid yw unrhyw safonau yn gymwys.*"

Cadarnheir mai 'darparwr gofal sylfaenol' yw *"person sy'n darparu gwasanaeth gofal sylfaenol ar ran Bwrdd Iechyd Lleol"* a bod 'gwasanaeth gofal sylfaenol' yn cynnwys gwasanaethau meddygol sylfaenol, gwasanaethau deintyddol, gwasanaethau offthalmig a gwasanaethau fferyllol.

Bydd nifer o gleifion iechyd meddwl sy'n mynd yn eu blaen i dderbyn gwasanaethau arbenigol yn dod i gyswllt â gwasanaethau iechyd am y tro cyntaf drwy ddarparwr gofal sylfaenol, megis eu meddyg teulu. Wrth reswm felly, mae'n bryder na fydd hawl gan yr unigolyn i unrhyw beth yn Gymraeg wrth ddefnyddio gwasanaeth gofal sylfaenol.

Eglura'r memorandwm esboniadol a gyhoeddwyd gan y Gweinidog Eluned Morgan AC ar y cyd â rheoliadau rhif 7 fod y safonau penodol yn ymwneud â dogfennau, gwefannau, apiau a chyfryngau cymdeithasol mewn perthynas â gofal sylfaenol wedi eu dileu gan y bydd safonau cyflenwi gwasanaethau eraill yn berthnasol. Wrth gwrs, mae'r eithriad a ddyfynnir uchod yn cadarnhau na fydd gwasanaethau gofal sylfaenol a ddarperir drwy gytundeb ar ran Byrddau Iechyd yn dod o fewn cwmpas y safonau. Rydym yn ymwybodol fod hyn oherwydd y tybiwyd y byddai'n afresymol gosod dyletswyddau ar fyrddau iechyd lleol a fyddai'n eu dal yn gyfrifol am fethiant darparwyr gofal sylfaenol annibynnol i gydymffurfio â'r safonau, gan nad oes ganddynt ddylanwad uniongyrchol dros y ffyrdd y mae darparwyr unigol yn darparu gwasanaethau.

O ganlyniad, noda'r memorandwm:

> *"cynigir y bydd nifer fach o ddyletswyddau sy'n ymwneud â'r Gymraeg yn cael eu gosod ar ddarparwyr gofal sylfaenol annibynnol drwy gontractau gofal sylfaenol neu gytundeb telerau gwasanaeth rhwng darparwr gofal sylfaenol a bwrdd iechyd lleol. Bydd hyn yn creu rhwymedigaethau contractiol rhwng byrddau iechyd lleol a'r darparwyr annibynnol y gall y bwrdd iechyd lleol eu gorfodi."*

O ystyried nifer y darparwyr gofal sylfaenol yng Nghymru, byddai disgwyl i Gomisiynydd y Gymraeg allu gosod a monitro safonau ar bob un yn gofyn am adnoddau eang iawn, ac felly mewn egwyddor, nid ydym yn anghytuno â'r syniad mai mewn rhwymedigaethau contractiol rhwng y bwrdd iechyd a'r sawl sy'n darparu gwasanaeth ar ei ran y dylid delio â'r materion hyn. Wedi dweud hynny, er mwyn caniatáu i'r rheoliadau arfaethedig hyn gael cymeradwyaeth y Pwyllgor, teimlwn fod angen i bob aelod fod yn wir hyderus y bydd hyn yn ddigonol ac yn llwyddiannus.

Ar ddechrau'r memorandwm esboniadol, nodir bod yr holl gyrff yn Atodlen 6 rheoliadau rhif 7 eisoes yn gyfarwydd â chydymffurfio â dyletswyddau iaith wrth iddyn nhw weithredu eu Cynlluniau Iaith o dan Ddeddf yr Iaith Gymraeg 1993. Fodd bynnag, credwn yn gryf mewn gwirionedd mai nifer fechan iawn oedd yn cydymffurfio ag ymrwymiadau eu cynlluniau iaith, ac o ystyried diffyg grym Bwrdd yr Iaith Gymraeg doedd dim ffordd bendant i fynd i'r afael â'r broblem.

Er mwyn i'r cynnig newydd mewn perthynas â darpariaeth gofal sylfaenol lwyddo, bydd angen cymhelliant ar y bwrdd iechyd lleol i sicrhau'r rhwymedigaethau yn y man cychwyn, ac i'w gorfodi wedi hynny. I'r rhai hynny sy'n cydnabod pwysigrwydd iaith mewn gofal ac sydd wedi cydymffurfio â'u cynlluniau iaith, gellir awgrymu y byddent yn gwneud eu gorau yn hynny o beth. I'r mwyafrif helaeth fodd bynnag (h.y.

y rheiny nad oedd yn parchu ymrwymiadau eu cynlluniau iaith), mae'n bryder i ni nad oes cymhelliant iddynt sicrhau bod eu darparwyr gofal sylfaenol yn cytuno ac yn cydymffurfio. Os nad oes gan y Comisiynydd yr hawl i ddal y byrddau iechyd hyn yn atebol am eu methiant i sicrhau bod eu darparwyr gofal sylfaenol trydydd parti yn cydymffurfio, ni allwn weld fod ganddynt unrhyw gymhelliant o gwbl.

Nid yw'n glir ychwaith o'r memorandwm nac o reoliadau rhif 7 y bydd unrhyw oblygiadau i'r byrddau iechyd hyn os nad ydynt yn cymryd y cyfrifoldeb hwn mewn perthynas â gofal sylfaenol o ddifri. Rydym yn gwerthfawrogi bod cyfrifoldeb ar y bwrdd iechyd i ystyried sut y byddant yn mynd i'r afael â hyn yn unol â'r safonau llunio polisi, ond ymddengys bod y modd mae disgwyl iddynt wneud hynny'n ddibynnol ar eu dehongliad eu hunain. A fydd unrhyw allu cyfreithiol i ganiatáu'r Comisiynydd (neu'r Tribiwnlys hyd yn oed) i fynd i'r afael â hyn?

Gofynnwn i'r Pwyllgor sicrhau eu bod yn gwbl hyderus bod trefniadau priodol mewn lle er mwyn bod yn siŵr bod y rheoliadau hyn yn cyflawni eu potensial i'r eithaf ac yn cael cymaint o effaith bositif ag sy'n bosib ar siaradwyr Cymraeg bregus.

<u>Safonau ynghylch corff yn llunio ac yn cyhoeddi dogfennau a ffurflenni</u>

1. Dogfennau

Yn rheoliadau rhif 7, mae'r Gweinidog wedi cynnwys safon sy'n nodi mai dim ond (a) os yw pwnc y ddogfen yn awgrymu y dylid ei llunio yn Gymraeg, neu (b) os yw'r gynulleidfa a ragwelir, a'u disgwyliadau, yn awgrymu y dylid llunio'r ddogfen yn Gymraeg y mae'n rhaid i gorff lunio'r ddogfen yn Gymraeg. Nid yw'r Gweinidog wedi cadw unrhyw un o'r safonau eraill oedd yn ymwneud â llunio dogfennau. Nid yw'r Comisiynydd wedi gosod y safon hon (sydd hefyd ar gael ymhob set o reoliadau) ar unrhyw sefydliad eto gan ei bod o'r farn ei bod yn rhy wan, ond hefyd yn rhy amwys i'r defnyddwyr gwasanaeth.

Mae ymchwil wedi dangos bod nifer o gleifion iechyd meddwl sy'n siaradwyr Cymraeg iaith gyntaf ac sy'n ffafrio defnyddio'r Gymraeg yn amharod i ofyn, neu hyd yn oed derbyn gwasanaeth Cymraeg pan gynigir ef iddynt. Mae sawl rheswm am hyn, ond y rhwystr pennaf yw'r ofn o dderbyn triniaeth llai ffafriol drwy orfod aros yn hirach, teithio ymhellach neu hyd yn oed cael eu hystyried yn lletchwith.

Rydym yn pryderu felly y gallai bwrdd iechyd, er enghraifft, ddadlau nad oes angen llunio dogfen sy'n rhoi gwybodaeth hanfodol i gleifion iechyd meddwl am gyflyrau yn y Gymraeg gan nad oes unrhyw glaf wedi mynegi'r dymuniad i dderbyn gwasanaeth yn yr iaith honno. Ymhellach, pe bai aelod o'r cyhoedd neu ddefnyddiwr gwasanaeth

yn ymweld â gwefan y bwrdd iechyd perthnasol neu'r Comisiynydd er mwyn darganfod a oes ganddynt hawl i ddogfen yn Gymraeg, ac felly a oes ganddynt achos i wneud cwyn nad yw ar gael yn Gymraeg, does dim ateb pendant o gwbl ar eu cyfer. Mae hyn yn debygol o leihau'r nifer o bobl sy'n cwyno gan nad yw'n glir iddynt a ddylent fedru cael y ddogfen honno'n Gymraeg ai peidio. Gellir dadlau y byddai'r diffyg cwynion hwnnw wedyn yn rhoi sail bellach i gyrff ddod i'r casgliad nad oes angen llunio dogfen yn Gymraeg.

Ym mhob set arall o reoliadau safonau mae safon gadarn i'w chael sy'n nodi bod rhaid i unrhyw ddogfen a lunnir ac a gyhoeddir gan gorff fod yn y Gymraeg. Rydym yn ymwybodol i'r Comisiynydd osod 'amgylchiadau penodol' ar y safonau hynny ar gyfer rhai cyrff yn dilyn trafodaethau am resymoldeb a chymesuredd y safon. Lle bo hynny wedi digwydd, mae'r Comisiynydd wedi gosod testun ychwanegol mewn hysbysiad cydymffurfio i egluro hynny'n glir i unrhyw aelod o'r cyhoedd. Rydym o'r farn mai dyma'r ffordd mwyaf effeithiol o sicrhau hawliau ac eglurder i ddefnyddwyr gwasanaeth, gan sicrhau bod y gofynion ar gyrff yn rhesymol a chymesur yn unol â darpariaethau'r Mesur.

Credwn felly y dylai'r gallu i osod safon nad yw'n rhoi rhwydd hynt i gyrff benderfynu a ddylid llunio dogfen yn Gymraeg ai peidio barhau yn rheoliadau rhif 7. Bydd hyn hefyd yn cyfrannu at y brif weledigaeth o normaleiddio'r Gymraeg a sicrhau bod pobl yng Nghymru yn gallu byw eu bywydau yn gyfan gwbl drwy'r Gymraeg petaent yn dymuno gwneud hynny.

2. Ffurflenni

Ym mharagraff 46 yr adran ddehongli ar gyfer y safonau hyn, nodir nad yw'r safonau'n gymwys *"pan fydd ffurflen neu ddogfen a lunnir gan y corff yn darparu gwybodaeth mewn perthynas ag unigolyn a enwir.*"

Yn aml, bydd ffurflenni meddygol yn cael eu hanfon at gleifion gyda rhywfaint o'u manylion personol wedi eu mewnosod ar eu rhan yn barod a'r gweddill yn wag er mwyn iddyn nhw eu cwblhau.

Rydym yn pryderu bod yr eithriad hwn yn berthnasol i ffurflenni o'r fath ac felly gofynnwn i'r pwyllgor ymchwilio i hyn. Mewn rheoliadau blaenorol, roedd safon wedi'i drafftio a oedd yn ymwneud yn benodol â mewnosod gwybodaeth ar ffurflen a chredwn fod yr elfen hon yn hanfodol i sicrhau bod defnyddwyr gwasanaeth yn gallu llywio drwy'r system yn y Gymraeg cymaint â phosib. Yn ogystal, o ystyried y cyfrifoldeb a ddaw yn sgil safonau 2 a 3 (cofnodi dewis iaith a gweithredu'n unol â hynny o'r pwynt hwnnw ymlaen), ni allwn weld rheswm dilys na fyddai modd

defnyddio'r cofnod hwnnw i sicrhau bod manylion a fewnosodir ar ffurflen yn gweithredu'n unol hefyd.

I grynhoi, felly, ein prif bryderon gyda'r rheoliadau yw:

1. Bod safonau'n ymwneud â darparu cymorth Cymraeg mewn ymgynghoriadau clinigol wedi eu dileu o'r rheoliadau arfaethedig. Golyga hyn oll nad oes gan gleifion allanol, nad ydynt wedi treulio o leiaf noson yn yr ysbyty, unrhyw hawliau i dderbyn unrhyw elfen o'r ddarpariaeth yn Gymraeg, ac yn wahanol i'r rheoliadau drafft blaenorol, nid oes ganddynt bellach hyd yn oed yr hawl i gymorth Cymraeg mewn ymgynghoriadau clinigol.

2. Penderfyniad i eithrio gwasanaethau gofal sylfaenol o'r cymal 'trydydd parti' yn llwyr.

Gofynnwn fod y pwyllgor yn eu hystyried yn llawn wrth iddynt graffu ar gynnwys rheoliadau rhif 7. Wrth reswm, rydym yn croesawu bod safonau yn gweld golau dydd ar gyfer y sector yma, ond rydym yn awyddus iawn bod y Cynulliad yn defnyddio'r cyfle gwerthfawr hwn i wneud y mwyaf o'r gyfundrefn werthfawr a gyflwynwyd gan y Mesur a chyflawni ei photensial.

Er gwybodaeth, mae'r holl ddeunydd sydd ar ein gwefan sy'n ymwneud ag iechyd meddwl a'r Gymraeg wedi eu cofnodi yma: https://meddwl.org/tag/iaith/.

Edrychwn ymlaen at ddilyn trafodaethau a chasgliadau'r pwyllgor. Mae pob croeso i chi gysylltu â ni am drafodaeth bellach ar y mater hwn, neu yn y dyfodol ynghylch cynyddu gwasanaethau iechyd meddwl Cymraeg yn gyffredinol.

Yn gywir iawn,
Hedd, Manon a Sophie

Tîm rheoli meddwl.org

Annex 5

Welsh Language Standards for Health Services

Royal College of General Practitioners Wales response to the Culture, Welsh Language and Communications Committee

Monday 05 March 2018

RCGP Wales welcomes the opportunity to respond to the Welsh Government's recently published Welsh Language Standards for Health Services.

The Royal College of General Practitioners Wales represents a network of around 2,000 GPs, aiming to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

We note that primary care services will only be subject to these regulations if they are directly run by a health board. In general practice this could include managed practices, out of hours services, and services delivered in settings such as a prison.

We hope due consideration is given to the potential of recruitment to these services being hindered by the need to comply to the regulations. General practice is facing severe recruitment difficulties, and if these standards are seen as a barrier to working as a GP these difficulties will be magnified. We need to attract the best GPs to work in Wales, rather than selecting doctors on their ability to speak Welsh.

The majority of primary care services are run independently from a local health board, and these services will not be subject to the regulations. We are supportive of this approach; as outlined in the Explanatory Memorandum local health boards do not have direct influence over individual providers. The Welsh Government has proposed that a small number of Welsh language duties on independent primary care providers will be prescribed through contracts or terms of service agreements.

RCGP Wales welcomes attempts to support the Welsh language in general practice, and would like patients to be able to speak the language of their choice. There is already significant effort in many practices across Wales to ensure this is the case.

Clear communication is key to consultancy which means patients speaking in their first language can be beneficial. The converse of this, however, is that GPs must have a strong grasp on the language to be able to consult professionally in Welsh. Some GPs who have Welsh as a first language can find doing consultations in Welsh difficult, as they do not have the technical words in Welsh.

We believe attempts to increase its use in general practice will be most effective if the pressures on the profession are kept in mind. There are many practical barriers in primary care that may limit the availability of the Welsh language. A shortage of GPs will inevitably limit the number of Welsh speaking GPs, and workload pressures can make it difficult for non-Welsh speaking GPs to learn the language. Any prescribed duties will need to recognise these factors.

Tacking the pressures on general practice may provide an opportunity to enhance Welsh language provision. For example, a constructive solution would be measures to attract more Welsh speaking GPs to the profession.

We also believe there is scope for the Welsh language in primary care to be enhanced through multidisciplinary working. Working collaboratively with other healthcare professionals should be able to expand Welsh language provision. This can be done outside of these regulations, as multidisciplinary working remains in a relatively early stage of development and we do not want to see any perceived barriers that prevent the transfer of professionals into primary care. This is particularly pertinent for recruitment from other areas in the UK and areas where Welsh is not traditionally spoken.