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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.