Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio

The National Assembly for Wales
Audit Committee

Amseroedd Aros y GIG yng Nghymru
NHS Waiting Times in Wales

Cwestiynau 130-228
Questions 130-228

Dydd Iau, 10 Chwefror 2005
Thursday, 10 February 2005

Aelodau o'r Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Irene James, Mark Isherwood.

Swyddogion yn bresennol: Gillian Body, Swyddfa Archwilio Genedlaethol Cymru, Swyddog Cydymffurfio, Cynulliad Cenedlaethol Cymru, Ian Gibson, Pennaeth Dros Dro Cangen Llywodraethu Corfforaethol y GIG.

Tystion: Ann Lloyd, Pennaeth Adran Iechyd a Gofal Cymdeithasol, Cynulliad Cenedlaethol Cymru, John Hill-Tout, cyfarwyddwr, adran rheoli perfformiad ac ansawdd, Cynulliad Cenedlaethol Cymru.

Assembly Members present: Janet Davies (Chair), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Irene James, Mark Isherwood.

Officials present: Gillian Body, National Audit Office Wales, Rob Powell, National Audit Office Wales, Ian Gibson, acting head of the NHS corporate governance branch.

Witnesses: Ann Lloyd, Head of the Health and Social Care Department, National Assembly for Wales, John Hill-Tout, director of performance, quality and regulation division, National Assembly for Wales.

Dechreuodd y cyfarfod am 1.32 p.m.
The meeting began at 1.32 p.m.

[130] **Janet Davies:** Good afternoon. I welcome the witnesses and members of the public to this extra meeting of the Audit Committee, which continues with volume 2 of the report: 'NHS Waiting Times in Wales'. As you all know, the committee operates bilingually and, if you have difficulties hearing, please use the headphones. Please turn off mobile phones, pagers or any other electronic equipment, as they interfere with the headphones and the broadcasting and translation systems. If there is an emergency, the ushers will show us out. Do Members have any declarations of interest to make?

[130] **Janet Davies:** Prynhawn da. Croesawaf y tystion ac aelodau'r cyhoedd i'r cyfarfod ychwanegol hwn o'r Pwyllgor Archwilio, sy'n parhau â chyfrol 2 yr adroddiad: 'Amseroedd Aros y GIG yng Nghymru'. Fel y gwyddoch i gyd, mae'r pwyllgor yn gweithredu'n ddwyieithog, ac os ydych yn cael trafferth clywed, defnyddiwch y clustffonau. Diffoddwch ffonau symudol, blipwyr neu unrhyw offer electronig arall, os gwelwch yn dda, gan eu bod yn amharu ar y clustffonau a'r systemau darlledu a chyfieithu. Os bydd argyfwng, bydd y tywysyddion yn ein tywys allan. A oes gan Aelodau unrhyw ddatganiadau o fuddiannau i'w gwneud?

[131] **Jocelyn Davies:** I am on an in-patient waiting list, but I do not know whether or not I should declare it.

[131] **Jocelyn Davies:** Yr wyf ar restr aros cleifion mewnol, ond ni wn a ddylwn ei ddatgan ai peidio.

[132] **Janet Davies:** Okay, thank you.

[132] **Janet Davies:** O'r gorau, diolch.

I welcome Ann Lloyd and John Hill-Tout to this meeting. We will start with the part of the report that tackles in-patient day-case waiting times. Mick Bates will start off today.

Croesawaf Ann Lloyd a John Hill-Tout i'r cyfarfod hwn. Dechreuwn gyda'r rhan o'r adroddiad sy'n mynd i'r afael â'r amseroedd aros ar gyfer achosion dydd ymhlith cleifion mewnol. Mick Bates sydd am ddechrau heddiw.

Ms Lloyd: Volume 2?

[133] **Janet Davies:** Yes, volume 2, paragraphs 3.3 and 3.8.

[134] **Mick Bates:** Paragraph 3.3 is on page 17, for your assistance. Thank you, Chair; it is good to be back.

Paragraphs 3.3 to 3.8 state that the main causes of long in-patient and day-case waiting times are emergency medical pressures, which encroach upon elective capacity. In addition, paragraphs 3.12 and 3.15 show that there are a number of inefficiencies in how NHS Wales uses its existing capacity, such as bed utilisation, which also affects in-patient and day-case waiting times. Such inefficiency is also expensive given that the daily cost of an acute bed is £229. Why are emergency and medical pressures so significant in crowding out elective surgery and increasing waiting times? How will you address this issue?

Ms Lloyd: As you will see from one of the figures in the report, which I cannot precisely put my finger on at the moment, there has been a significant increase in emergency activity in surgery and medicine over the past few years. For example, between 2000 and 2004, the number of emergency surgery admissions increased by 3,000 and in medicine it increased by much more—from 142,000 admissions to 166,000 admissions. I will deal with this in chunks.

In terms of emergency activity, the actions that are being taken are to look very carefully at the reasons for emergency admissions escalating in this way. As I said last time, we have an ill and co-morbidity type of population. So, the frailty and the oldness of the individuals seeking emergency activity are greater here than you would expect throughout the whole of the UK. Nevertheless, we have undertaken extensive work, particularly with our innovations-in-care team, looking at emergency activity, and how it might be managed differently, and to look at alternatives to emergency admissions.

Ms Lloyd: Cyfrol 2?

[133] **Janet Davies:** Ie, cyfrol 2, paragraffau 3.3 a 3.8.

[134] **Mick Bates:** Mae paragraff 3.3 ar dudalen 17, i'ch helpu. Diolch, Gadeirydd; mae'n dda cael bod yn ôl.

Dywed paragraffau 3.3 i 3.8 mai'r prif achosion dros amseroedd aros hir i gleifion mewnol ac achosion dydd yw pwysau meddygol brys, sy'n lleihau'r gallu i wneud gwaith dewisol. Yn ogystal, dengys paragraffau 3.12 a 3.15 fod llawer o aneffeithlonrwydd yn y ffordd y mae GIG Cymru yn defnyddio'r gallu sydd ganddo, megis defnyddio gwelyau, sydd hefyd yn effeithio ar amseroedd aros ymhlith cleifion mewnol ac achosion dydd. Mae aneffeithlonrwydd felly hefyd yn ddrud o gofio bod gwely gofal acíwt yn costio £229 y dydd. Pam mae pwysau brys a phwysau meddygol mor arwyddocaol o ran lleihau llawdriniaeth ddewisol a chynyddu amseroedd aros? Sut byddwch yn mynd i'r afael â'r mater hwn?

Ms Lloyd: Fel y gwelwch o un o'r ffigurau yn yr adroddiad, na allaf roi fy mys arno'n union ar hyn o bryd, cafwyd cynnydd sylweddol mewn gweithgarwch brys mewn llawfeddygaeth a meddygaeth dros yr ychydig flynyddoedd diwethaf. Er enghraifft, rhwng 2000 a 2004, bu cynydd o 3,000 yn nifer y derbyniadau am lawfeddygaeth frys, a bu llawer mwy o gynnydd mewn meddygaeth—o 142,000 o dderbyniadau i 166,000 o dderbyniadau. Af i'r afael â hyn fesul darn.

O ran gweithgarwch brys, y camau sy'n cael eu cymryd yw edrych yn ofalus iawn ar y rhesymau pam mae derbyniadau brys yn cynyddu fel hyn. Fel y dywedais y tro diwethaf, mae gennym boblogaeth lle mae salwch a chyd-forbidrwydd. Felly, mae'r unigolion sydd ag arnynt angen gweithgarwch brys yn fwy bregus a hen yma nag y byddech yn ei ddisgwyl ledled y DU gyfan. Serch hynny, yr ydym wedi gwneud gwaith helaeth, yn enwedig gyda'n tîm arloesi mewn gofal, gan edrych ar weithgarwch brys a sut gellid ei reoli'n wahanol, ac edrych ar ddewisiadau gwahanol

That is why each trust in Wales now has a medical assessment unit, so that GPs will have easy access to an opinion about whether or not they are able to continue to manage patients at home, or whether the patient must be admitted. That is one of the things we have been doing.

yn lle derbyniadau brys. Dyna pam mae uned asesu meddygol gan bob ymddiriedolaeth yng Nghymru bellach, fel y bydd meddygon teulu yn hawdd yn gallu cael barn am y cwestiwn a allant barhau i reoli cleifion gartref ai peidio, neu a oes angen i'r claf ddod i'r ysbyty. Dyna un o'r pethau yr ydym wedi bod yn eu gwneud.

We have also instituted work on looking at the avoidance of admission in the first instance—things such as re-ablement teams, to ensure that a careful eye is kept on the health and wellbeing of patients by GPs in the community. There are steps that we have taken to try to ensure that the emergencies that enter hospitals are appropriate. You will also see that the numbers coming through accident and emergency departments have not diminished either, even though medical assessment units have been established. There is a case, and it is argued in the report, about whether or not individual organisations should ring-fence their surgical beds, and that is a discussion that we are having with them. However, you raised the important issue of capacity, and how well we use our capacity, and that is an extremely valid point.

Yr ydym hefyd wedi cychwyn gwaith i edrych ar osgoi derbyn cleifion i'r ysbyty yn y lle cyntaf—pethau megis timau ail-alluogi, i sicrhau bod meddygon teulu yn y gymuned yn cadw llygad gofalus ar iechyd a lles cleifion. Mae yna gamau yr ydym wedi eu cymryd i geisio sicrhau bod yr achosion brys sy'n dod i'r ysbyty yn rhai priodol. Gwelwch hefyd nad yw'r niferoedd sy'n cael eu derbyn drwy adrannau damweiniau ac achosion brys wedi lleihau ychwaith, er bod unedau asesu meddygol wedi eu sefydlu. Mae yna achos, a chaiff ei ddadlau yn yr adroddiad, dros ofyn a ddylai sefydliadau unigol neilltuo eu gwelyau llawfeddygol ai peidio, ac yr ydym yn trafod hynny gyda hwy. Fodd bynnag, yr oeddech yn codi mater pwysig gallu, a pha mor dda yr ydym yn defnyddio'n gallu, ac mae hwnnw'n bwynt hynod ddilys.

When you read the service and financial framework for this year and next year, you will see the efficiency targets that we have put in place for the service, including that we would like to see a reduction in the turnover intervals, that is, the spare time between discharge and the admission of the next patient. Also, the lengths of stay must be reduced to the mean for those who are outliers—there are some very considerable variances in the lengths of stay—and things like the day-case rates, and so on, need to be tackled in terms of why we are treating people as in-patients, when they might be safely treated as day cases.

Pan ddarllenwch y fframwaith gwasanaeth a a chyllid am eleni a'r flwyddyn nesaf, gwelwch fod y targedau effeithlonrwydd yr ydym wedi eu gosod ar gyfer y gwasanaeth, gan gynnwys y targed yr hoffem weld lleihad mewn cyfnodau trosiant, hynny yw, yr amser rhydd rhwng rhyddhau un claf a derbyn y claf nesaf. Hefyd, rhaid lleihau hyd yr arhosiad i'r cymedr ar gyfer y rheini sy'n allgleifion—mae yna rai amrywiaethau sylweddol iawn yn hyd arosiadau. Ac mae angen mynd i'r afael â phethau fel cyfraddau achosion dydd, ac ati, o ran pam yr ydym yn trin pobl fel cleifion mewnol, pan ellid eu trin yn ddiogel fel achosion dydd.

So, there are a variety of targets that have been included in those service and financial frameworks for the past two years, to try to use our capacity, or to ensure the service can use the capacity, far better than has been done in the past. Much of this is because we are now getting the information that allows us to help the service, and the innovations-in-care teams have also been undertaking a variety of performance improvement studies,

Felly, mae amrywiaeth o dargedau wedi eu cynnwys yn y fframweithiau gwasanaeth a chyllid hynny am y ddwy flynedd diwethaf, i geisio defnyddio ein gallu, neu i sicrhau y gall y gwasanaeth ddefnyddio'r gallu, lawer yn well nag a wnaed yn y gorffennol. Mae llawer o hyn oherwydd ein bod bellach yn cael y wybodaeth sy'n ein galluogi i helpu'r gwasanaeth. Ac mae'r timau arloesi mewn gofal hefyd wedi bod yn ymgymryd ag

which are being shared with the service to ensure that they can access best practice.

amrywiaeth o astudiaethau gwella perfformiad, sy'n cael eu rhannu gyda'r gwasanaeth i sicrhau y gallant gael mynediad i arfer gorau.

[135] **Mick Bates:** Thank you. There are a lot of points there. I am very pleased that you again noted the importance of collecting data in order to address the issue. However, in Wales we have 33 per cent more beds per head than in England, so in terms of the utilisation of this capacity it is still, to me, slightly unclear as to why our waiting times are much longer than those in England. I would like a little more detail on what you are doing to address that. I have the figures here. However, it is not a new problem. We have known about good utilisation of bed capacity for some time, and I also note that there is an under-utilisation of beds in community hospitals. What are you doing to address that issue also?

[135] **Mick Bates:** Diolch. Mae nifer o bwyntiau yn hyn. Yr wyf yn falch iawn i chi unwaith eto sôn am bwysigrwydd casglu data er mwyn mynd i'r afael â'r mater. Fodd bynnag, mae gennym 33 y cant yn fwy o welyau y pen yng Nghymru nag yn Lloegr. Felly, o ran defnyddio'r gallu hwn, i mi mae'n dal braidd yn aneglur pam mae ein hamseroedd aros ni lawer yn hwy na'r rheini yn Lloegr. Hoffwn gael ychydig mwy o fanylion am yr hyn yr ydych yn ei wneud i fynd i'r afael â hynny. Mae'r ffigurau gennyf yma. Fodd bynnag, nid yw'n broblem newydd. Gwyddom ers cryn amser am ddefnyddio gwelyau'n dda, a sylwaf hefyd nad oes digon o ddefnyddio gwelyau mewn ysbytai cymuned. Beth yr ydych yn ei wneud i fynd i'r afael â'r mater hwnnw hefyd?

Ms Lloyd: Community hospitals, and the use of those beds, is particularly addressed in the guidance that we are giving to the service. As you know, many of the beds within community hospitals were traditionally managed by general practitioners, and the turnover intervals in some of the GP community beds have been very long. However, they have also been used for respite care, and we must ensure that we can establish whether or not there are alternative models that would prevent the need for respite care where people come in for two weeks every three months to give a legitimate break to their carers, and whether there is something more effective that can be done within the community. The guidance that the innovations-in-care teams have produced has begun to have an effect. However, as part of the audit that they are currently undertaking on the Government's behalf, they will provide us with a report on which organisations have taken up the best practice guidelines that have been disseminated throughout the service, and, if they have not taken them up, what they have done about it. It has been a problem for a number of years, and it must be tackled. With the advent of the improved performance management regime, we are able to keep a better grip on the seamlessness of access to care.

Ms Lloyd: Mae ysbytai cymuned, a defnyddio'r gwelyau hynny, yn cael sylw penodol yn y canllawiau yr ydym yn eu rhoi i'r gwasanaeth. Fel y gwyddoch, yn draddodiadol byddai nifer o'r gwelyau mewn ysbytai cymuned yn cael eu rheoli gan ymarferwyr cyffredinol, ac mae'r cyfnodau trosiant yn rhai o welyau cymuned meddygon teulu wedi bod yn hir iawn. Fodd bynnag, maent hefyd wedi eu defnyddio ar gyfer gofal seibiant, a rhaid i ni sicrhau y gallwn sefydlu a oes yna fodelau amgen a fyddai'n atal yr angen am ofal seibiant lle mae pobl yn dod i mewn am bythefnos bob tri mis i roi saib gwirioneddol i'w gofalwyr, ac a oes rhywbeth mwy effeithiol y gellir ei wneud yn y gymuned. Mae'r canllawiau y mae'r timau arloesi mewn gofal wedi eu cynhyrchu wedi dechrau cael effaith. Fodd bynnag, fel rhan o'r archwiliad y maent yn ei wneud ar hyn o bryd ar ran y Llywodraeth, byddant yn darparu adroddiad inni i ddweud pa sefydliadau sydd wedi mabwysiadu'r canllawiau arfer gorau sydd wedi eu dosbarthu drwy'r gwasanaeth cyfan, ac os nad ydynt wedi eu mabwysiadu, beth y maent wedi ei wneud ynglŷn â'r peth. Mae'n broblem ers llawer blwyddyn, a rhaid mynd i'r afael â hi. Gyda dyfodiad y drefn well o reoli perfformiad, gallwn gael gwell gafael ar fynediad i ofal di-dor.

The other issue relates to the management of chronic diseases. At least 55 per cent of hospital beds in Wales are occupied by people who are suffering from an escalation of their chronic disease. Over the last three to four years, there have been good schemes, both in Wales and throughout the UK, to manage chronic diseases better. We need to ensure that we universalise the practice. Throughout Wales, organisations have tried different ways of managing chronic diseases within the community in order to prevent this escalation.

Mae'r mater arall yn ymwneud â rheoli clefydau cronig. Mae o leiaf 55 y cant o welyau ysbytai yng Nghymru yn cael eu defnyddio gan bobl sydd â chlefyd cronig sydd wedi gwaethygu. Dros y tair neu'r pedair blynedd diwethaf, mae yna gynlluniau da wedi bod, yng Nghymru a ledled y DU, i reoli clefydau cronig yn well. Mae angen i ni sicrhau ein bod yn cyffredinoli'r arfer. Ledled Cymru, mae sefydliadau wedi profi gwahanol ffyrdd i reoli clefydau cronig yn y gymuned er mwyn atal y gwaethygu hwn.

In November, the Minister announced that, by April 2006, five chronic disease pathways must be instituted and effective in every organisation within Wales and that the minimum target for a reduction in emergency admissions has to be 5 per cent. I think that this target will be exceeded in some parts of Wales.

Ym mis Tachwedd, cyhoeddodd y Gweinidog bod yn rhaid sefydlu a gweithredu pum llwybr clefydau cronig ym mhob sefydliad yng Nghymru erbyn mis Ebrill 2006, a bod yn rhaid i'r targed ar gyfer lleihau derbyniadau brys fod yn 5 y cant o leiaf. Credaf y bydd rhai rhannau o Gymru yn rhagori ar y targed hwn.

[136] **Mick Bates:** I am aware of the targets that you have set, and these improvement standards are important. However, what will you do if these targets are not met? For example, 7 per cent bed occupancy in community hospitals. Let us say that you do not reach the 5 per cent target, what will you do?

[136] **Mick Bates:** Yr wyf yn ymwybodol o'r targedau yr ydych wedi eu gosod, ac mae'r safonau gwella hyn yn bwysig. Fodd bynnag, beth fyddwch yn ei wneud os na chyrhaeddir y targedau hyn? Er enghraifft, llenwi 7 y cant o welyau ysbytai cymuned. Beth fyddwch yn ei wneud os na fyddwch, dywedwch, yn cyrraedd y targed o 5 y cant?

Ms Lloyd: These targets are monitored on a regular basis by the regional offices. As you know, the Minister has asked that the regional offices be strengthened so that they are not only there to advise and facilitate, but have the power to direct organisations to prove beyond reasonable doubt that they are maximising the use of the facilities and resources available to them in order to meet the needs of their population. The performance regime has tightened considerably, particularly over the last year. There are issues in this report surrounding incentives and sanctions and, as I think that I said in the last meeting, two of the organisations are already on an intervention protocol on a whole range of issues regarding the way in which they are using their assets and staff. Had I not been here today, I would have been seeing the Gwent Community on level 2 to oversee how it has progressed on a number of fronts. It has done quite well in

Ms Lloyd: Caiff y targedau hyn eu monitro'n rheolaidd gan y swyddfeydd rhanbarthol. Fel y gwyddoch, mae'r Gweinidog wedi gofyn i'r swyddfeydd rhanbarthol gael eu cryfhau er mwyn iddynt fod yno nid yn unig i roi cyngor a hwyluso, ond er mwyn iddynt gael y pŵer i orchymyn sefydliadau i brofi y tu hwnt i amheuaeth resymol eu bod yn gwneud y defnydd gorau posibl o'r cyfleusterau a'r adnoddau sydd ar gael iddynt i ddiwallu anghenion eu poblogaeth. Mae'r drefn perfformiad wedi tynhau'n sylweddol, yn enwedig yn y flwyddyn ddiwethaf. Mae materion yn yr adroddiad hwn sy'n ymwneud â sancsiynau, ac fel y dywedais yn y cyfarfod diwethaf, mi gredaf, mae dau o'r sefydliadau eisoes ar brotocol ymyriad ynglŷn ag ystod gyfan o faterion yn ymwneud â'r modd y maent yn defnyddio eu hasedau a'u staff. Pe na bawn yma heddiw, byddwn wedi bod yn gweld Cymuned Gwent ar lefel 2 i oruchwylio sut y mae wedi gwneud cynnydd

terms of waiting-times reduction.

[137] **Mick Bates:** Thank you. I think that other Members will pick that up. Paragraph 3.6 notes that 8.8 per cent of consultant posts in Wales are vacant. The pressure on staff and resources will be exacerbated by the European working-time directive, which is highlighted in the box above paragraph 23.4, and the new deal for junior doctors and the new consultant contracts. The NHS depends on skilled professionals, so what action are you taking to fill these important vacant posts?

Ms Lloyd: That figure is not universally applied to all specialties. If you look at the vacancies at the end of March 2004, in the surgical specialties and anaesthetics, which is most pertinent to what is wrong with the capacity to manage the waiting times, the percentage vacancy has varied between 3.7 per cent and 4.8 per cent, which is below the target that one would usually see within NHS employed staff. Our major problems are with psychiatry, some paediatrics, and a few of the medical specialties; dermatology is mentioned in the report, and that is currently at 27.3 per cent. You will know that the numbers of consultants that we have employed in Wales over the last few years have gone up year-on-year, so, for example, in 2003, an additional 40 were funded, and, since 2001, there have been an additional 170 employed in Wales. We have tried to increase the consultant workforce, knowing very well that, with the European working-time directive, and with the fact that it is being reported that the requirement for an out-patient consultation is taking longer—because there must be informed consent and good information—consultants' available time is being eaten into. However, as you know, we have increased the number of medical trainees over the past five years to ensure that we can keep pace with the situation. However, again, by increasing the number of trainees, you increase the call on the time of clinical tutors and trainers working to train them properly. It is a balance, and that is why you have seen an increase in the number of consultants being

mewn llawer agwedd. Mae wedi gwneud yn eithaf da o ran lleihau amseroedd aros.

[137] **Mick Bates:** Diolch. Credaf y bydd Aelodau eraill yn holi am hynny. Mae paragraff 3.6 yn nodi bod 8.8 y cant o swyddi meddygon ymgynghorol yng Nghymru yn wag. Bydd y pwysau ar staff ac adnoddau yn gwaethygu yn sgîl y gyfarwyddeb Ewropeaidd ar amser gweithio, sydd wedi ei nodi yn y blwch uwchlaw paragraff 23.4, a'r fargen newydd ar gyfer meddygon iau a'r contractau meddygon ymgynghorol newydd. Mae'r GIG yn dibynnu ar weithwyr proffesiynol medrus, felly, pa gamau yr ydych yn eu cymryd i lenwi'r swyddi gwag pwysig hyn?

Ms Lloyd: Nid yw'r ffigur hwnnw'n berthnasol yn gyffredinol i bob maes arbenigol. Os edrychwch ar y swyddi gwag ar ddiwedd mis Mawrth 2004, yn yr arbenigeddau llawfeddygol ac anaestheteg, sy'n fwyaf perthnasol i'r hyn sydd o'i le â'r gallu i reoli'r amseroedd aros, mae canran y swyddi gwag wedi amrywio rhwng 3.7 y cant a 4.8 y cant, sy'n is na'r targed y byddai rhywun fel rheol yn ei weld ymysg staff a gyflogir gan y GIG. Ein problemau mawr yw seiciatreg, rhai meysydd mewn paediatreg, ac ychydig o'r arbenigeddau meddygol; caiff dermatoleg ei grybwyll yn yr adroddiad, ac mae hwnnw'n 27.3 y cant ar hyn o bryd. Byddwch yn gwybod bod nifer y meddygon ymgynghorol yr ydym wedi eu cyflogi yng Nghymru yn yr ychydig flynyddoedd diwethaf wedi cynyddu flwyddyn ar ôl blwyddyn. Felly, er enghraifft, yn 2003 ariannwyd 40 yn ychwanegol, ac ers 2001, mae 170 yn ychwanegol wedi eu cyflogi yng Nghymru. Yr ydym wedi ceisio cynyddu'r gweithlu meddygon ymgynghorol, gan wybod yn iawn, gyda'r gyfarwyddeb Ewropeaidd ar amser gweithio, a'r ffaith fod y gofyniad ar gyfer ymgynghoriad claf allanol yn cymryd mwy o amser, yn ôl y sôn—oherwydd rhaid cael caniatâd deallus a gwybodaeth dda—fod yr amser sydd ar gael gan feddygon ymgynghorol yn lleihau. Fodd bynnag, fel y gwyddoch, yr ydym wedi cynyddu nifer yr hyfforddeion meddygol dros y pum mlynedd diwethaf i sicrhau ein bod yn gallu ddelio â'r sefyllfa. Fodd bynnag, eto trwy gynyddu nifer yr hyfforddeion, yr ydych yn cynyddu'r galw ar amser tiwtoriaid a

employed, but also in what they are being required to do, which is reflected in the Welsh consultant contract.

hyfforddwyr clinigol i'w hyfforddi'n briodol. Mater o gydbwysedd ydyw, a dyna pam yr ydych wedi gweld cynnydd yn nifer y meddygon ymgynghorol a gyflogir, a hefyd yn yr hyn y mae gofyn iddynt ei wneud. Mae hyn yn cael ei adlewyrchu yng nghontract meddygon ymgynghorol Cymru.

[138] **Mick Bates:** That is good. Could you give me some more information on accident and emergency, which is in the news a great deal at the moment? In the report, I think that it is 18 per cent of consultant posts were vacant—

[138] **Mick Bates:** Mae hynny'n beth da. A allwch roi rhagor o wybodaeth i mi am ddamweiniau ac achosion brys, sy'n cael llawer o sylw yn y newyddion ar hyn o bryd? Yn yr adroddiad, credaf fod 18 y cant o swyddi meddygon ymgynghorol yn wag—

Ms Lloyd: Yes, it is 18 per cent.

Ms Lloyd: Ie, 18 y cant.

[139] **Mick Bates:** Has that situation improved since this report?

[139] **Mick Bates:** A yw'r sefyllfa wedi gwella ers yr adroddiad hwn?

Ms Lloyd: No, because this report was at that time.

Ms Lloyd: Nac ydyw, oherwydd yr oedd yr adroddiad hwn ar yr adeg honno.

[140] **Mick Bates:** So, what are you doing to address the particular issue of accident and emergency consultants?

[140] **Mick Bates:** Felly, beth yr ydych yn ei wneud i fynd i'r afael â phroblem benodol meddygon ymgynghorol ym maes damweiniau ac achosion brys?

Ms Lloyd: We are still trying to recruit more accident and emergency consultants. We have been successful in some places that have had real problems: for example, in Pembrokeshire and Derwen NHS Trust, we have just recruited a new medical director, who happens to also be an accident and emergency consultant. Since he came on the scene, he has considerably reduced the waiting times in accident and emergency.

Ms Lloyd: Yr ydym yn dal i geisio recriwtio mwy o feddygon ymgynghorol ar gyfer damweiniau ac achosion brys. Yr ydym wedi llwyddo mewn rhai mannau sydd wedi cael problemau gwirioneddol: er enghraifft, yn Ymddiriedolaeth GIG Sir Benfro a Derwen, yr ydym newydd recriwtio cyfarwyddwr meddygol newydd, sydd hefyd yn digwydd bod yn feddyg ymgynghorol ym maes damweiniau ac achosion brys. Ers iddo gyrraedd, mae wedi lleihau'r amseroedd aros yn yr adran damweiniau ac achosion brys yn sylweddol.

Given that we know that the number of accident and emergency consultants is very tight throughout the UK and that it is a difficult speciality to recruit to, we are looking at the whole use of the accident and emergency workforce. We are doing this to ensure that there is effective triage, that we have good-quality nurse practitioners, and that we have physiotherapists and many different types of staff who can manage and help manage the work that comes through accident and emergency. However, as you know, the past two weeks have been

O ystyried ein bod yn gwybod bod nifer y meddygon ymgynghorol damweiniau ac achosion brys yn brin ledled y DU a'i fod yn arbenigedd anodd recriwtio iddo, yr ydym yn edrych ar yr holl ddefnydd a wneir o'r gweithlu damweiniau ac achosion brys. Gwnawn hyn i sicrhau bod yna wasanaeth effeithiol i flaenoriaethu cleifion, bod gennym ymarferwyr nyrsio o safon dda, a bod gennym ffisiotherapyddion a nifer o wahanol fathau o staff a all reoli a helpu rheoli'r gwaith a ddaw drwy'r adran damweiniau ac achosion brys. Fodd bynnag,

particularly difficult in terms of the real pressures on accident and emergency medical admissions in Wales. We are trying to ensure that trusts are taking advantage of the skills that can be deployed by other members of staff to enhance the whole accident and emergency clinical team.

fel y gwyddoch, mae'r pythefnos diwethaf wedi bod yn arbennig o anodd o ran y pwysau gwirioneddol ar dderbyniadau meddygol mewn adrannau damweiniau ac achosion brys yng Nghymru. Yr ydym yn ceisio sicrhau bod ymddiriedolaethau'n manteisio ar y sgiliau y gellir eu defnyddio gan aelodau eraill o'r staff i wella'r holl dîm clinigol damweiniau ac achosion brys.

[141] **Mick Bates:** I have two final issues with regard to that. Would you say that by putting more consultants in post, you will reduce waiting times?

[141] **Mick Bates:** Mae gennyf ddau fater olaf mewn perthynas â hynny. A fyddech yn dweud y byddwch yn lleihau amseroedd aros drwy benodi rhagor o feddygon ymgynghorol?

Ms Lloyd: By having more consultants?

Ms Lloyd: Drwy gael rhagor o feddygon ymgynghorol?

[142] **Mick Bates:** Yes.

[142] **Mick Bates:** Ie.

Ms Lloyd: We are certainly hoping that the new consultant contract in Wales will give us a clear picture of the capacity of the clinical and medical team to deliver. Our contract is unique: it clearly states how much time consultants need for their continuous professional development, for their other administrative-type work, that is teaching, training, research and so on, and it looks for between seven and eight clinical sessions a week, or more, if that is what people are doing. It is up to the trusts to ensure that that is good working practice for a clinician. Additionally, at our behest, two trusts have undertaken an analysis with their clinical teams of what is a reasonable work-programme for consultants and, depending on the speciality, how many new out-patients they should be seeing, and how long their case-mix—the type of patients that are coming through—should take in terms of theatre time. The idea is that we get a descriptor of what achievement it is reasonable to expect from a clinician in Wales. Obviously, the clinicians sign up to this. That is crucial work, because we can then review the proposals that are already planned for an increase in the number of medical students and in the number of consultant medical staff, to ensure that we can balance this workforce, given whatever target the Minister chooses to set.

Ms Lloyd: Yr ydym yn sicr yn gobeithio y bydd y contract meddygon ymgynghorol newydd yng Nghymru yn rhoi i ni ddarlun clir o allu'r tîm clinigol a meddygol i lwyddo. Mae ein contract yn unigryw: mae'n dweud yn glir faint o amser y mae ar feddygon ymgynghorol ei angen ar gyfer eu datblygiad proffesiynol parhaus, ar gyfer eu gwaith arall o fath gweinyddol, hynny yw, addysgu, hyfforddi, ymchwil, ac ati. Ac mae'n anelu at rhwng saith ac wyth sesiwn glinigol yr wythnos, neu fwy, os mae pobl yn ei wneud. Cyfrifoldeb yr ymddiriedolaethau yw sicrhau bod hynny'n arfer gweithio da i glinigydd. Yn ogystal, ar ein cais, mae dwy ymddiriedolaeth wedi gwneud dadansoddiad gyda'u timau clinigol o'r hyn sy'n rhaglen waith resymol i feddygon ymgynghorol, a chan ddibynnu ar yr arbenigedd, faint o gleifion allanol newydd y dylent fod yn eu gweld, a pha mor hir ddylai eu cyfuniad o achosion—y math o gleifion sy'n cael eu gweld—ei gymryd o ran amser yn y theatr. Y syniad yw i ni gael disgrifydd o'r gwaith y mae'n rhesymol ei ddisgwyl gan glinigydd yng Nghymru. Yn amlwg, mae'r clinigwyr yn cytuno â hyn. Mae hwnnw'n waith hollbwysig, oherwydd wedyn gallwn adolygu'r cynigion sydd eisoes wedi eu cynllunio i gynyddu nifer y myfyrwyr meddygol a nifer y staff meddygol ymgynghorol, i sicrhau y gallwn gydbwyso'r gweithlu hwn, pa darged bynnag fydd y Gweinidog yn dewis ei osod.

[143] **Mick Bates:** Thank you for that. Finally, several positive innovations are mentioned in the report, which, it is suggested, will help to reduce waiting times. Many of these require flexibility in the operation of clinical issues and management. How will you train people to become more flexible, which is a key factor in all these innovations?

[143] **Mick Bates:** Diolch am hynny. Yn olaf, caiff nifer o gynlluniau arloesol cadarnhaol eu crybwyll yn yr adroddiad, a fydd, yn ôl yr awgrym, yn helpu lleihau amseroedd aros. Mae nifer o'r rhain yn gofyn am hyblygrwydd wrth weithredu materion clinigol a rheolaeth. Sut byddwch yn hyfforddi pobl i fod yn fwy hyblyg, sy'n ffactor allweddol yn yr holl fentrau hyn?

Ms Lloyd: Clinical engagement is critical, and we need creative, flexible management as well. I recently established the national innovation and leadership agency in Wales. That has been commissioned by the chief medical officer and me particularly to take a very active part in engaging better the clinical communities, and to ensure that the very good and creative work that is done in many parts of Wales by clinicians is shared, and that we can train for the new skills that are required. Therefore, if you take the major personnel contracts that have been developed over the past year—both nationally, and locally to Wales—we are looking to use 'Agenda for Change', the consultants' contract and the general medical services contract to give our staff opportunities to develop their skills and to ensure that they can match the growing requirements of patients, keep their skills up to date, and maximise their potential.

Ms Lloyd: Mae ymwneud clinigol yn allweddol, ac mae arnom angen rheolaeth greadigol a hyblyg hefyd. Sefydlais yr asiantaeth genedlaethol arloesi ac arwain yng Nghymru yn ddiweddar. Mae wedi ei chomisiynu gennyf fi a'r prif swyddog meddygol yn arbennig i gymryd rhan weithgar iawn yn y gwaith o wella cysylltiadau â'r cymunedau clinigol, a sicrhau bod y gwaith creadigol a da iawn a wneir mewn llawer rhan o Gymru gan glinigwyr yn cael ei rannu, ac y gallwn hyfforddi ar gyfer y sgiliau newydd sydd eu hangen. Felly, os cymerwch y contractau personél mawr sydd wedi eu datblygu dros y flwyddyn ddiwethaf—yn genedlaethol, ac yn lleol yng Nghymru—bwriadwn ddefnyddio 'Agenda ar gyfer Newid', y contract meddygon ymgynghorol a'r contract gwasanaethau meddygol cyffredinol i roi cyfle i'n staff ddatblygu eu sgiliau ac i sicrhau y gallant ddiwallu gofynion cynyddol cleifion, diweddaru eu sgiliau, a gwneud y mwyaf o'u potensial.

[144] **Mick Bates:** I have just one further point on that. You mentioned innovation in Wales—what if it is somewhere else, such as England, would you take that on as good practice?

[144] **Mick Bates:** Mae gennyf un pwynt arall ar hynny. Yr oeddech yn sôn am arloesi yng Nghymru—beth os yw'n digwydd rywle arall, megis Lloegr, a fyddech yn mabwysiadu hwnnw fel arfer da?

Ms Lloyd: Yes, of course. As you know, most of my innovations-in-care team have come from the English NHS Modernisation Agency, and we have very good links with it. I do not mind who I pinch ideas from.

Ms Lloyd: Byddem, wrth gwrs. Fel y gwyddoch, daeth y rhan fwyaf o'm tîm arloesi mewn gofal o Asiantaeth Moderneiddio'r GIG yn Lloegr, ac mae gennym gysylltiadau da iawn â honno. Nid wyf yn poeni oddi wrth bwy y byddaf yn dwyn syniadau.

[145] **Mick Bates:** Watch this space for developments.

[145] **Mick Bates:** Cadwch eich llygad ar agor am ddatblygiadau.

[146] **Denise Idris Jones:** Do you want me to ask the next question, Chair?

[146] **Denise Idris Jones:** A ydych am i mi ofyn y cwestiwn nesaf, Gadeirydd?

[147] **Janet Davies:** No, you are not coming in just yet, Denise—you are asking question 19, which is a couple of questions ahead. I will bring Jocelyn in now, and I also have some confusion that I would like cleared up.

[147] **Janet Davies:** Na, nid eich tro chi yw hi eto, Denise—yr ydych yn gofyn cwestiwn 19, ac mae ychydig gwestiynau cyn hwnnw. Galwaf ar Jocelyn yn awr, ac y mae yna hefyd ychydig ddryswch yr hoffwn ei ddatrys.

[148] **Jocelyn Davies:** Mrs Lloyd, Mick Bates asked you about data. He often reminds us that you must have robust data if you hope to improve things. On the accident and emergency admissions, do you have any information about what sort of percentage of those admissions, or people attending, should not be at accident and emergency at all? We all hear stories of people dialling 999 when they need not—perhaps some of these people would be better served by the out-of-hours service or by their own GP. Do you have any idea about that?

[148] **Jocelyn Davies:** Mrs Lloyd, gofynnodd Mick Bates i chi am ddata. Mae'n aml yn ein hatgoffa bod yn rhaid i chi gael data cadarn os ydych yn gobeithio gwella pethau. O ran derbyniadau damweiniau ac achosion brys, a oes gennych unrhyw wybodaeth pa ganran o'r derbyniadau hynny, neu'r bobl sy'n mynychu, na ddylent fod mewn adrannau damweiniau ac achosion brys o gwbl? Yr ydym i gyd yn clywed straeon am bobl yn deialu 999 pan nad oes angen iddynt—efallai y byddai'n well i rai o'r bobl hyn ddefnyddio'r gwasanaeth sydd ar gael pan fydd adrannau ar gau, neu gan eu meddyg teulu eu hunain. A oes gennych unrhyw syniad ynglŷn â hynny?

Ms Lloyd: It varies from trust to trust. However, we collect data on what are technically known as level 4 patients—patients who could be seen by general practice or by the out-of-hours service, and did not need to attend an accident and emergency department. If you would like me to send in a copy of those latest returns, if that would help—

Ms Lloyd: Mae'n amrywio o ymddiriedolaeth i ymddiriedolaeth. Fodd bynnag, byddwn yn casglu data am yr hyn a elwir yn dechnegol yn gleifion lefel 4—cleifion a allai gael eu gweld gan bractis cyffredinol neu gan y gwasanaeth pan fydd meddygfeydd ar gau, ac nad oedd angen iddynt fynd i adran damweiniau ac achosion brys. Os hoffech i mi anfon copi o'r canlyniadau diweddaraf hynny, pe bai hynny o gymorth—

[149] **Jocelyn Davies:** Yes, that would be very helpful.

[149] **Jocelyn Davies:** Iawn, byddai hynny'n ddefnyddiol iawn.

Ms Lloyd: It is tracked carefully. We must try to educate the public as to what alternative is available. Triage at accident and emergency is very important in terms of redirecting patients, and you will see that many trusts have general practitioners working in their accident and emergency departments who can immediately see the category 4 patients, so that they do not have to wait for ages. Why should anyone want to go to accident and emergency with a minor ailment and have to wait for a considerable time, when those who are of higher priority are obviously seen before them? Therefore, it is about trying to ensure that the whole of

Ms Lloyd: Caiff ei olrhain yn ofalus iawn. Rhaid i ni geisio addysgu'r cyhoedd am y dewis arall sydd ar gael. Mae blaenoriaethu mewn adrannau damweiniau ac achosion brys yn bwysig iawn o ran ailgyfeirio cleifion. Gwelwch fod gan nifer o ymddiriedolaethau ymarferwyr cyffredinol sy'n gweithio yn eu hadrannau damweiniau ac achosion brys ac sy'n gallu gweld y cleifion categori 4 ar unwaith, fel nad oes yn rhaid iddynt aros am amser maith. Pam fyddai unrhyw un yn dewis mynd i adran damweiniau ac achosion brys gyda mân anhwylder a gorfod aros am amser hir, pan fydd y rheini sydd â blaenoriaeth uwch yn

accident and emergency provision is not clogged up unnecessarily by patients who do not need to be there, but that those people who have come, irrespective of whether they should have gone to their GP or not, also get good-quality care, and expeditiously too. However, I can send you the data.

amlwg yn cael eu gweld o'u blaen? Felly, mater yw hwn o geisio sicrhau nad yw'r holl ddarpariaeth damweiniau ac achosion brys yn cael ei thagu'n ddiangen gan gleifion nad oes angen iddynt fod yno. Mae'n fater lle mae'r bobl hynny sydd wedi dod, p'un a ddylent fod wedi mynd at eu meddyg teulu ai peidio, hefyd yn cael gofal o ansawdd da, ac yn gyflym hefyd. Fodd bynnag, gallaf anfon y data atoch.

[150] **Janet Davies:** Thank you. From that data, Mrs Lloyd, are you aware of how many of those patients are told by their GP to go to accident and emergency and are still level 4?

[150] **Janet Davies:** Diolch. O'r data hynny, Mrs Lloyd, a wyddoch faint o'r cleifion hynny sy'n cael eu hanfon i adrannau damweiniau ac achosion brys gan eu meddyg teulu ac sy'n dal yn gleifion lefel 4?

Ms Lloyd: I do not have that data. We could ask the trusts to find out, but I do not know whether the patients would tell you.

Ms Lloyd: Nid yw'r data hynny gennyf. Gallem ofyn i'r ymddiriedolaethau holi, ond ni wn a fyddai'r cleifion yn dweud wrthych.

[151] **Janet Davies:** Right, thank you. I am slightly confused about community hospitals, going back to what Mick was talking about. We know that there is quite low occupancy of community hospitals and that bed turnover is low. I have heard people mention two possible uses in this regard in that community hospitals may be valuable in tackling day cases and giving blood transfusions and so on, as well as being useful as a convalescence base. Do you see them going one way or the other, or would they have a role in doing both?

[151] **Janet Davies:** O'r gorau, diolch. Yr wyf wedi drysu braidd am ysbytai cymuned, gan fynd yn ôl at yr hyn yr oedd Mick yn siarad amdano. Gwyddom fod defnyddio gwelyau mewn ysbytai cymuned yn ddigon isel a bod y trosiant gwelyau yn isel. Yr wyf wedi clywed pobl yn sôn am ddau ddefnydd posibl mewn perthynas â hyn, sef y gallai ysbytai cymuned fod yn werthfawr i ddelio ag achosion dydd a thrallwyso gwaed, ac yn y blaen, yn ogystal â bod yn ddefnyddiol fel lle i gleifion wella. A ydych yn eu gweld yn mynd y naill ffordd neu'r llall, neu a fyddai ganddynt rôl yn y ddau beth?

Ms Lloyd: I think that the role of community hospitals will alter in the next couple of years. When we asked local communities to produce their Wanless local action plans—and now the regional teams are coming forward with the secondary care reconfigurations strategies—the guidance that we put out about what a community resource could look like for the future did just what you suggested, which is to use the resource much more flexibly to ensure that people can access local care more reasonably. There is much work that can be done on an out-patient or day-case basis in local hospitals, and, working with general practitioners, there are better ways of dealing with the emergencies that arise in local hospitals other than having to put somebody in an ambulance to take him or her from a

Ms Lloyd: Credaf y bydd swyddogaeth ysbytai cymuned yn newid yn y flwyddyn neu ddwy nesaf. Pan ofynnwyd i gymunedau lleol gynhyrchu eu cynlluniau gweithredu lleol Wanless—ac mae'r timau rhanbarthol nawr yn cyflwyno'r strategaethau ar gyfer ail-gyflunio gofal eilaidd—yr oedd y canllawiau a ddosbarthwyd gennym am yr hyn y gallai adnodd cymunedol fod ar gyfer y dyfodol yn gwneud yn union yr hyn a awgrymech, sef defnyddio'r adnodd lawer yn fwy hyblyg i sicrhau bod pobl yn gallu cael gofal lleol yn fwy rhesymol. Mae llawer o waith y gellir ei wneud ar sail cleifion allanol neu achosion dydd mewn ysbytai lleol. A thrwy weithio gydag ymarferwyr cyffredinol, mae yna ffyrdd gwell i ddelio â'r achosion brys sy'n codi mewn ysbytai cymuned na gorfod rhoi rhywun mewn ambiwlans i'w

community hospital to the nearest district general hospital—the sort of cover arrangements that can be possible. So, we are testing the proposals, which will come in in the summer, against the guidelines that we outlined to the service to ensure that it is using these valuable resources, most of which are liked by local communities, much more creatively to take the pressure away from secondary care, and also to provide more responsive local access for people. Again, there is some good practice in the UK that we have shared with the service on that.

gludo ef neu hi o ysbyty cymuned i'r ysbyty cyffredinol dosbarth agosaf—y math o drefniadau darparu a all fod yn bosibl. Felly, yr ydym yn profi'r cynigion, a fydd yn dod i rym yn yr haf, yn erbyn y canllawiau a amlinellwyd gennym i'r gwasanaeth. Gwnaethom hynny i sicrhau bod y gwasanaeth yn defnyddio'r adnoddau gwerthfawr hyn - ac mae'r rhan fwyaf ohonynt yn boblogaidd ymhlith cymunedau lleol - mewn ffordd lawer mwy creadigol i leddfu'r pwysau ar ofal eilaidd, a hefyd i ddarparu mynediad lleol i bobl sy'n ymateb yn well. Eto, mae yna ychydig arfer da ar hynny yn y DU, ac yr ydym wedi ei rannu gyda'r gwasanaeth.

[152] **Janet Davies:** So, do you see them as having a role in convalescence and respite care or as a staging post between an acute hospital and a nursing home?

[152] **Janet Davies:** Felly, a ydych yn credu bod ganddynt ran mewn gofal seibiant a gwella, neu fel arhosfan rhwng ysbyty acíwt a chartref nyrsio?

Ms Lloyd: Yes, that is part of it.

Ms Lloyd: Ydw, mae hynny'n rhan ohono.

[153] **Janet Davies:** You would see that as well, would you?

[153] **Janet Davies:** Byddech yn gweld hynny hefyd?

Ms Lloyd: Yes, indeed, and some of them do that already. However, we have been considering, with the problem of delayed transfers, how we can use the community resource better and, given the turnover intervals and the lengths of stay, at what point it is safe to transfer patients back to a community resource for more active reablement and rehabilitation. We are certainly pressing the service on using the community resource in a much more proactive way.

Ms Lloyd: Byddwn, yn wir, ac mae rhai ohonynt eisoes yn gwneud hynny. Fodd bynnag, yr ydym wedi bod yn ystyried, gyda'r broblem o oedi wrth drosglwyddo cleifion, sut gallwn ddefnyddio'r adnodd cymunedol yn well, ac o ystyried y cyfnodau trosiant a hyd arosiadau, pryd y mae'n ddiogel trosglwyddo cleifion yn ôl i adnodd cymunedol am ofal ail-alluogi ac adfer sy'n fwy gweithgar. Yr ydym yn sicr yn pwyso ar y gwasanaeth i ddefnyddio'r adnodd cymunedol mewn ffordd lawer mwy rhagweithiol.

[154] **Janet Davies:** Okay, thank you very much. Leighton?

[154] **Janet Davies:** O'r gorau, diolch yn fawr iawn. Leighton?

[155] **Leighton Andrews:** I turn to page 30 and paragraphs 3.41 and 3.42 on process inefficiencies. I am sure that we have all had experience of family members being in hospital and waiting for a ward round to be completed before they can be released and so on. Although this may sound in some way trivial, these are ways in which release can be speeded up, therefore what is being done to tackle process matters such as this?

[155] **Leighton Andrews:** Trof i dudalen 30 a pharagraffau 3.41 a 3.42 ynglŷn ag aneffeithlonrwydd prosesu. Yr wyf yn siŵr ein bod i gyd wedi cael y profiad pan fydd aelodau'r teulu yn yr ysbyty ac yn aros tan i'r meddyg fynd o amgylch y ward cyn y gellir eu rhyddhau, ac ati. Er y gall hyn ymddangos braidd yn ddibwys, hwryach, mae'r rhain yn ffyrdd i allu cyflymu'r broses ryddhau. Felly, beth sy'n cael ei wneud i fynd i'r afael â materion prosesu fel hwn?

Ms Lloyd: Again, the innovations team has been looking at this matter, and looking at the best ways of reducing these unnecessary delays. The teams are actively involved either in ensuring that ward rounds take place regularly or in ensuring that the care plan is so well developed—which it should be, anyway—that other staff members on that ward can take the decision to discharge. The other things that we have been doing in terms of the delays for to-take-home medicines concern how there should be much more constructive discussion about when it is likely, with the ward team, that a patient might be discharged and to pre-order what will be necessary to take home with him or her, so that you do not have the good news that you are going and then wait for three or four hours to get there.

Ms Lloyd: Eto, mae'r tîm arloesi wedi bod yn edrych ar y mater hwn, ac yn edrych ar y ffyrdd gorau i leihau'r oedi diangen hwn. Mae'r timau'n ymwneud yn weithgar â'r gwaith o sicrhau naill ai bod meddygon yn mynd o amgylch wardiau yn rheolaidd neu bod y cynllun gofal wedi ei ddatblygu mor dda—fel y dylai fod, beth bynnag—fel y gall aelodau eraill o'r staff ar y ward honno wneud y penderfyniad i ryddhau claf. Mae'r pethau eraill yr ydym wedi eu gwneud o ran yr oedi gyda'r meddyginiaethau sydd i'w cymryd gartref yn ymwneud â'r ffordd y dylid cael trafodaeth lawer mwy adeiladol, gyda thîm y ward, ynglŷn â phryd y mae'n debygol y gallai claf gael ei ryddhau. Ffordd arall yw archebu ymlaen llaw yr hyn fydd ei angen ar y claf i fynd adref, fel na fyddwch yn cael y newyddion da eich bod yn cael gadael ac yna'n aros am dair neu bedair awr cyn i hynny ddigwydd.

We are also discussing the issue of transport delays with the hospital car services and the ambulance service, to see whether or not we can find alternatives for those patients who do not have their own transport, or relatives' transport, to ensure that they can be taken home safely. Therefore, a great deal of work has been going on in terms of trying to ensure that we do not build even more delay into the system, particularly with the pressure on acute-sector beds.

Yr ydym hefyd yn trafod y mater o oedi o ran cludiant gyda'r gwasanaethau ceir ysbyty a'r gwasanaeth ambiwlans, i weld a allwn ddod o hyd i ddewisiadau eraill i'r cleifion hynny nad oes ganddynt eu cludiant eu hunain, neu gludiant perthnasau, er mwyn sicrhau y gellir mynd â hwy adref yn ddiogel. Felly, mae llawer iawn o waith wedi bod yn mynd ymlaen i geisio sicrhau nad ydym yn achosi rhagor o oedi yn y system, yn enwedig gyda'r pwysau sydd ar welyau yn y sector acíwt.

[156] **Leighton Andrews:** Which policies do you find as the most effective in reducing delays in routine discharge, and can you spread those?

[156] **Leighton Andrews:** Pa bolisïau dybiwch chi sydd fwyaf effeithiol i leihau oedi yn y drefn reolaidd o ryddhau cleifion, ac a allwch ledaenu'r rheini?

Ms Lloyd: I think that having better care planning and planning from the outset of the patient's admission is really the best way, so that the whole ward team is engaged, from the outset, in the care path for the individual patient. This gives confidence to the ward team that if the consultant or junior member of the medical team is not there, for whatever reason—they might be in theatre—a senior member of the ward team will take, with confidence, the decision to discharge. That is the best way, because the patients know where they are and the ward team gains confidence, and it means that these in-built delays are stopped. This also improves the

Ms Lloyd: Credaf mai cynllunio gofal yn well a chynllunio o'r eiliad y caiff claf ei dderbyn yw'r ffordd orau mewn gwirionedd, fel y bydd tîm cyfan y ward yn ymwneud, o'r cychwyn cyntaf, â llwybr gofal y claf unigol. Mae hyn yn rhoi hyder i dîm y ward, os nad yw'r meddyg ymgynghorol neu aelod iau o'r tîm meddygol yno, am ba reswm bynnag—fe allai fod yn y theatr—y bydd aelod uwch o dîm y ward yn gwneud y penderfyniad, yn hyderus, i ryddhau'r claf. Dyna'r ffordd orau, oherwydd mae'r cleifion yn gwybod beth yw'r sefyllfa a bydd tîm y ward yn magu hyder. Ac mae'n golygu bod yr oedi cynhenid hwn yn peidio. Mae hyn hefyd yn

situation when equipment is required or when adaptations need to be made, because the patient is well aware of it from the outset, and that, again, can be activated at an earlier stage. With unified assessment to be implemented in April, the ways in which social care and the health service performs in terms of individual care should be improved quite dramatically.

gwella'r sefyllfa pan fydd angen offer neu pan fydd angen gwneud addasiadau, oherwydd mae'r claf yn ymwybodol iawn ohono o'r cychwyn, a gall hynny, unwaith eto, gael ei gychwyn yn gynharach. Gan fod asesu unedig i ddod i rym ym mis Ebrill, dylai'r ffyrdd y mae gofal cymdeithasol a'r gwasanaeth iechyd yn perfformio o ran gofal unigol wella'n eithaf syfrdanol.

[157] **Leighton Andrews:** Would you like to say a little more about that?

[157] **Leighton Andrews:** A hoffech ddweud ychydig mwy am hynny?

Ms Lloyd: In many areas, unified assessment has been working for years. Again, that has not been universal, and this is throughout the UK. From 1 April, all teams, with their social work teams, and the hospital-based teams with the community teams, have to plan the care of patients, to ensure that they really are risk-assessed and will have the full spectrum of care that they require for their clinical condition or social circumstances. This makes the process far more coherent, and means that one part does not have to wait for the other to do its assessment, which sometimes occurs. This is the case with some of the delayed transfers—they are people waiting for social assessment. Therefore, the aim is to unify that.

Ms Lloyd: Mewn llawer maes, mae asesu unedig wedi bod ar waith ers blynyddoedd. Eto, nid yw hynny wedi digwydd benbaladr, ac mae hynny ledled y DU. Ar ôl 1 Ebrill, mae'n rhaid i bob tîm, gyda'u timau gwaith cymdeithasol, a'r timau yn yr ysbyty gyda'r timau cymuned, gynllunio gofal cleifion, i sicrhau eu bod yn cael eu hasesu'n wirioneddol o ran risg ac y cânt y sbectrwm gofal llawn y mae arnynt ei angen ar gyfer eu cyflwr clinigol neu eu hamgylchiadau cymdeithasol. Mae hyn yn gwneud y broses lawer yn fwy cydlynol, ac mae'n golygu nad oes yn rhaid i un rhan aros i'r rhan arall wneud ei hasesiad, fel sy'n digwydd weithiau. Dyna sy'n digwydd gyda rhywfaint o'r oedi wrth drosglwyddo—pobl yn aros am asesiad cymdeithasol ydynt. Felly, y nod yw uno hynny.

[158] **Denise Idris Jones:** Tackling delayed transfers is key to improving patient throughput and, therefore, reducing waiting times. Despite the 23 per cent reduction in delayed transfers of care between November 2003 and June 2004, there is still room for improvement. In June 2004, 41 per cent of delayed transfers of care were due to patients, their families or carers. In September 2004, the Welsh Assembly Government issued revised guidance about its approach to patient choice. Why is the impact of patient choice so significant, and what has the revised guidance of September 2004 achieved?

[158] **Denise Idris Jones:** Mae mynd i'r afael ag oedi wrth drosglwyddo yn allweddol i wella trwybwn cleifion, ac felly wrth leihau amseroedd aros. Er gwaethaf y gostyngiad o 23 y cant yn nifer yr achosion o oedi wrth drosglwyddo gofal rhwng mis Tachwedd 2003 a mis Mehefin 2004, mae lle i wella o hyd. Ym mis Mehefin 2004 cleifion, eu teuluoedd neu eu gofalwyr oedd wrth wraidd 41 y cant o achosion o oedi wrth drosglwyddo gofal. Ym mis Medi 2004, cyhoeddodd Llywodraeth Cynulliad Cymru ganllawiau diwygiedig ar ei ymagwedd tuag at ddewis cleifion. Pam mae dewis cleifion yn cael cymaint o effaith, a beth mae canllawiau diwygiedig mis Medi 2004 wedi ei gyflawni?

Ms Lloyd: Patient choice was really a method by which some families or patients decided that, having grown accustomed to their surroundings, that was where they

Ms Lloyd: Yr oedd dewis cleifion mewn gwirionedd yn ddull a ddefnyddiodd rhai teuluoedd neu gleifion i benderfynu, ar ôl cynefino â'u hamgylchedd, mai dyna lle yr

wished to stay and that they did not want the alternative. I would say that that possibly happened because we did not offer sufficient alternatives for them, or because of all the financial issues that you will know about, which cause concern to individuals and their families. Patient choice has to be respected. However, we found that, with 41 per cent delays built into the system, some patients were fit to go to alternative accommodation, but were being retained in hospital for very long periods of time. If you are in a busy hospital and are fit to be somewhere else, it is a disconcerting experience as you will not receive the same level of care and attention as other people who are more acutely ill. Hospitals are not the most relaxing places to be in.

oeddynt am aros ac nad oeddynt am fynd am y dewis arall. Byddwn yn dweud i hynny ddigwydd o bosibl oherwydd nad oeddem yn cynnig digon o ddewisiadau eraill iddynt, neu oherwydd yr holl faterion ariannol y byddwch yn gwybod amdanynt, sy'n peri pryder i unigolion a'u teuluoedd. Rhaid parchu dewis cleifion. Fodd bynnag, gydag oedi o 41 y cant yn gynhenid yn y system, gwelsom fod rhai cleifion yn ddigon da i fynd i lety amgen, ond yn cael eu cadw yn yr ysbyty am gyfnodau hir iawn. Os ydych mewn ysbyty prysur ac yn ddigon da i fod rywle arall, mae'n brofiad annifyr oherwydd ni fyddwch yn cael yr un lefel o ofal a sylw â phobl eraill sy'n fwy difrifol sâl. Nid yw ysbyty yn un o'r lleoedd mwyaf gorffwysol i fod.

You need to get on with reablement and rehabilitation. So, it is not good to retain people in hospitals when they could be somewhere else getting the next type of care that they need. However, if patients choose to stay there, it is very difficult to do anything about it.

Mae angen i chi fynd i'r afael â gofal ail-alluogi ac adfer. Felly, nid yw'n beth da cadw pobl mewn ysbytai pan allent fod rywle arall yn cael y math nesaf o ofal y mae arnynt ei angen. Fodd bynnag, os yw cleifion yn dewis aros yno, mae'n anodd iawn gwneud unrhyw beth yn ei gylch.

The new guidance tightens up the definitions of what choice is about, but also provides alternatives to the service, if somebody does not want to go to nursing home X or their home is not ready for them to be taken back, to use the option of moving them to community-type facilities where they can get more active rehabilitation so that their care plan can be pursued more vigorously. So, the service must use the facilities that it has available at its disposal much more constructively. In that way, it is a staging post for the patients, so they cannot say that they do not want to go there because it is a suitable alternative. It might not be the last place that they will be discharged to. So, they must use the staging posts.

Mae'r canllawiau newydd yn tynhau'r diffiniadau o'r hyn y mae dewis yn ei olygu. Ond maent hefyd yn darparu dewisiadau gwahanol i'r gwasanaeth, os nad yw rhywun yn dymuno mynd i gartref nyrsio X neu os nad yw ei gartref yn barod iddo symud yn ôl, fel y gall y gwasanaeth ddefnyddio'r dewis o symud y claf i gyfleusterau cymunedol, lle gall gael gofal adferol mwy gweithgar fel y gellir gweithredu ei gynllun gofal yn fwy egnïol. Felly, rhaid i'r gwasanaeth ddefnyddio'r cyfleusterau sydd ar gael iddo lawer yn fwy adeiladol. Fel hynny, mae'n arhosfan i'r cleifion, fel na allant ddweud nad ydynt yn dymuno mynd yno, oherwydd mae'n ddewis arall addas. Efallai nad hwnnw fydd y lle olaf iddynt gael eu hanfon iddo. Felly, rhaid iddynt ddefnyddio'r arosfannau.

[159] **Denise Idris Jones:** Has this been effective? Are people doing this?

[159] **Denise Idris Jones:** A yw hyn wedi bod yn effeithiol? A yw pobl yn gwneud hyn?

Ms Lloyd: We do not have the latest figures yet; they come out at the end of the year. We are evaluating how people are using this guidance. The numbers since June and September 2004 have gone down, and we know that we have successfully placed some

Ms Lloyd: Nid yw'r ffigurau diweddaraf gennym hyd yma; byddant yn dod allan ddiwedd y flwyddyn. Yr ydym yn gwerthuso sut mae pobl yn defnyddio'r canllawiau hyn. Mae'r niferoedd wedi gostwng ers mis Mehefin a mis Medi 2004, a gwyddom ein

patients who have been in hospital for a long time. So, in that case, yes, it is starting to work, but we have to keep track of it. We have also encouraged local government and the health service to work together to look at the individual circumstances associated with named patients, rather than just deal with a mass of 20 numbers, and to look at the real needs of individuals. In that way, we have found that much better collective packages have been provided to people. So, they deal with the patient on a named basis and discuss them frequently to ensure that, wherever possible, they can be moved to more appropriate accommodation.

bod wedi llwyddo i gael lle i rai cleifion a fu yn yr ysbyty ers amser hir. Felly, yn yr achos hwnnw, ydynt, mae'r canllawiau'n dechrau gweithio, ond rhaid i ni gadw llygad arnynt. Yr ydym hefyd wedi annog llywodraeth leol a'r gwasanaeth iechyd i weithio gyda'i gilydd i edrych ar yr amgylchiadau unigol sy'n gysylltiedig â chleifion penodol, yn hytrach na delio â phentwr o 20 o rifau, ac i edrych ar anghenion gwirioneddol unigolion. Fel hynny, yr ydym wedi gweld bod pecynnau cyfunol llawer gwell wedi eu darparu i bobl. Felly, maent yn delio â'r claf wrth ei enw ac yn ei drafod yn aml i sicrhau y gellir ei symud i lety mwy priodol, ble bynnag mae hynny'n bosibl.

[160] **Denise Idris Jones:** It sounds like a much better system to give people individual attention. A total of 33 per cent of delayed transfers of care arose because of social care reasons. We need to ensure that social services and the health service are working in effective partnership. However, it still does not seem to be happening as well as we would have liked. What are the barriers to that?

[160] **Denise Idris Jones:** Mae'n ymddangos bod rhoi sylw unigol i bobl yn system lawer iawn gwell. Rhesymau gofal cymdeithasol a oedd wrth wraidd cyfanswm o 33 y cant o'r achosion o oedi wrth drosglwyddo gofal. Mae angen i ni sicrhau bod gwasanaethau cymdeithasol a'r gwasanaeth iechyd yn gweithio mewn partneriaeth effeithiol. Fodd bynnag, mae'n ymddangos nad yw eto'n digwydd cystal ag y byddem wedi dymuno. Beth sy'n rhwystro hynny?

Ms Lloyd: The barriers are money, priorities and focus. A number of things have been put into effect that will overcome some of those barriers. First, in order to facilitate better discharge and better alternatives, the Minister provided additional resources to local health boards to manage the problem of delayed transfers of care. We have tracked what has happened within communities to the levels of delayed discharges because they are not being transferred. I have met local government and health service representatives from individual localities where sufficient progress was not being made to find out what the real reasons were and what alternatives were being discussed by those communities together to effect a real improvement. One of the successes was Carmarthenshire, which, at one point around six or seven months ago, was doing really badly on its delayed transfers of care. So, we called in the local partners to ask them what was blocking care. One of the problems was that the trust said that the numbers were X and everyone else said they were Y. So, that was sorted out. We then challenged local

Ms Lloyd: Y rhwystrau yw arian, blaenoriaethau a ffocws. Mae nifer o bethau wedi eu rhoi ar waith a fydd yn goresgyn rhai o'r rhwystrau hynny. Yn gyntaf, er mwyn hwyluso trefniadau rhyddhau gwell a gwell dewisiadau gwahanol, darparodd y Gweinidog adnoddau ychwanegol i fyrddau iechyd lleol i reoli problem oedi wrth drosglwyddo gofal. Yr ydym wedi olrhain beth sydd wedi digwydd mewn cymunedau i lefelau oedi wrth ryddhau cleifion oherwydd nad ydynt yn cael eu trosglwyddo. Yr wyf wedi cyfarfod â chynrychiolwyr llywodraeth leol a'r gwasanaeth iechyd o ardaloedd unigol lle nad oedd cynnydd digonol yn cael ei wneud i ddarganfod beth oedd y gwir resymau a pha ddewisiadau gwahanol a oedd yn cael eu trafod gan y cymunedau hynny gyda'i gilydd i greu gwelliant gwirioneddol. Un o'r llwyddiannau oedd Sir Gaerfyrddin a oedd, ar un adeg tua chwech neu saith mis yn ôl, yn perfformio'n wael iawn o ran oedi wrth drosglwyddo gofal. Felly, galwyd y partneriaid lleol i mewn i ofyn iddynt beth oedd yn rhwystro gofal. Un o'r problemau oedd bod yr ymddiriedolaeth yn dweud mai

government and the local health board together to come forward with a sustainable solution to this. They were gainers under the Townsend formula anyway, so a small amount of this £4 million went to them. Together, they have been very creative about designing and planning long-term solutions as well as managing the short-term problem. Carmarthenshire is now doing far better in terms of managing delayed transfers of care successfully. So, this emphasis on the number people who are being held in the wrong environment has had some effect.

X oedd y niferoedd a phawb arall yn dweud mai Y. Felly, cafodd hynny ei ddatrys. Yna, heriwyd llywodraeth leol a'r bwrdd iechyd lleol i ddod at ei gilydd i gyflwyno ateb cynaliadwy i hyn. Yr oeddynt ar eu hennill dan y fformiwla Townsend beth bynnag, felly, rhoddwyd cyfran fechan o'r £4 miliwn hwn iddynt. Gyda'i gilydd, maent wedi bod yn greadigol iawn wrth ddylunio a chynllunio atebion hirdymor yn ogystal â rheoli'r broblem fyrdymor. Mae Sir Gaerfyrddin bellach yn gwneud yn well o lawer yn rheoli oedi wrth drosglwyddo gofal yn llwyddiannus. Felly, mae'r pwyslais hwn ar nifer y bobl sy'n cael eu cadw yn yr amgylchedd anghywir wedi cael rhywfaint o effaith.

Also, we have been tracking the health, social care and wellbeing strategies that each health board and local government has to produce, to ensure that they can operate together on blockages in the system and have solid plans for removing them. When the next lot of Wanless plans comes in, we will evaluate how effectively they are moving along the track of their health, social care and wellbeing strategies to meet the objectives that they have set themselves. Quite a lot is being done, and the working together has certainly been very positive during the last year.

Yn ogystal, buom yn olrhain y strategaethau iechyd, gofal cymdeithasol a lles y mae gofyn i bob bwrdd iechyd a llywodraeth leol eu cynhyrchu, i sicrhau y gallant weithredu gyda'i gilydd mewn perthynas â rhwystrau yn y system, a chael cynlluniau cadarn ar gyfer eu gwaredu. Pan ddaw'r grŵp nesaf o gynlluniau Wanless i law, byddwn yn gwerthuso pa mor effeithiol y maent yn cadw at eu strategaethau iechyd, gofal cymdeithasol a lles i gyflawni'r amcanion y maent wedi eu gosod iddynt eu hunain. Mae cryn dipyn yn cael ei wneud, ac mae'r cydweithio yn sicr wedi bod yn gadarnhaol iawn yn ystod y flwyddyn ddiwethaf.

[161] **Denise Idris Jones:** That sounds promising. However, if you are saying that there was this in Carmarthenshire, it is possible that the same problem was not seen in one of the hospitals in north Wales. Might there not have been a lack of communication?

[161] **Denise Idris Jones:** Mae hynny'n argoeli'n addawol. Fodd bynnag, os ydych yn dweud bod hyn wedi digwydd yn Sir Gaerfyrddin, mae'n bosibl na welwyd yr un broblem yn un o ysbytai'r Gogledd. Onid oedd yma ddiffyg cyfathrebu o bosibl?

Ms Lloyd: Yes.

Ms Lloyd: Oedd.

[162] **Denise Idris Jones:** I think that we need to work absolutely in partnership throughout the whole of Wales.

[162] **Denise Idris Jones:** Credaf fod angen i ni weithio mewn partneriaeth lwyr drwy Cymru gyfan.

Ms Lloyd: That is right.

Ms Lloyd: Mae hynny'n gywir.

[163] **Jocelyn Davies:** Mrs Lloyd, looking at the table on page 31, there seems to be huge variation between local authorities. The variation is quite stark. Blaenau Gwent and Torfaen are right at the top, then, at the

[163] **Jocelyn Davies:** Mrs Lloyd, o edrych ar y tabl ar dudalen 31, mae'n ymddangos bod amrywiad enfawr rhwng awdurdodau lleol. Mae'r amrywiad yn hollol amlwg. Mae Blaenau Gwent a Thor-faen ar y brig, yna, ar

bottom, you have Bridgend doing very well, and Denbighshire, Pembrokeshire and the Isle of Anglesey. Can you account for the variation between those local authorities?

y gwaelod, mae Pen-y-bont ar Ogwr yn gwneud yn dda iawn, a Sir Ddinbych, Sir Benfro ac Ynys Môn. A allwch roi rhesymau dros yr amrywiad rhwng yr awdurdodau lleol hynny?

Ms Lloyd: There is a vast variety of reasons. Sometimes it is because alternatives are not available, and we all know that, around Cardiff, the reduction in the number of nursing home places that have been available has caused real pressures. At other times, it is because patients are exercising choice. In Torfaen, there was a big problem about gaining a single focus in health and social care to tackle the problem. That has now been overcome and you will see, from the December figures, that some of those big outliers are starting to reduce. However, there is a variety of reasons and, often, it is because the alternatives are not sufficient or there is such pressure coming through the system. Again, we have been looking at spreading good practice in terms of providing a range of alternatives that might be utilised by health services and local government, which includes looking at some of the successes in supportive housing, a greater move to using community staff to maintain people in their homes, and better assessment processes. We are working with all these communities, and with the regional offices, to ensure that the factors that cause such inequality are being tackled universally. It is a high priority for us to ensure that people are placed effectively and well.

Ms Lloyd: Mae amrywiaeth eang o resymau. Weithiau mae'n digwydd am nad oes unrhyw ddewisiadau eraill, a gwyddom oll fod y gostyngiad yn nifer y lleoedd sydd ar gael mewn cartrefi nyrsio, o gwmpas Caerdydd, wedi achosi pwysau gwirioneddol. Bryd arall, mae'n digwydd am fod cleifion yn defnyddio eu hawl i ddewis. Yn Nhor-faen, bu problem fawr o ran cael un ffocws ym maes iechyd a gofal cymdeithasol i fynd i'r afael â'r broblem. Mae honno bellach wedi ei goresgyn a gwelwch, o ffigurau mis Rhagfyr, fod rhai o'r ffigurau allgleifion mawr hynny yn dechrau gostwng. Fodd bynnag, mae amrywiaeth o resymau, ac yn aml mae'n digwydd am nad yw'r dewisiadau gwahanol yn ddigonol neu am fod cymaint o bwysau'n dod drwy'r system. Eto, yr ydym wedi bod yn edrych ar ledaenu arferion da wrth ddarparu amrywiaeth o ddewisiadau gwahanol y gellid eu defnyddio gan wasanaethau iechyd a llywodraeth leol, sy'n cynnwys edrych ar rai o'r llwyddiannau mewn tai cymorth, tuedd fwy i ddefnyddio staff cymuned i gynnal pobl yn eu cartrefi eu hunain, a phrosesau asesu gwell. Yr ydym yn gweithio gyda'r cymunedau hyn i gyd, a chyda'r swyddfeydd rhanbarthol, i sicrhau bod pob un yn mynd i'r afael â'r ffactorau sy'n achosi anghydraddoldeb. Mae'n flaenoriaeth bwysig i ni i sicrhau bod pobl yn cael eu lleoli'n effeithiol ac yn dda.

[164] **Leighton Andrews:** In answer to Mrs Idris Jones, you said that one of the problems was money, yet a lot of money has gone into the health service in Wales in recent years. What, specifically, would you want that money to be spent on?

[164] **Leighton Andrews:** Wrth ateb Mrs Idris Jones, dywedasoch mai un o'r problemau oedd arian, ond eto mae llawer o arian wedi ei fuddsoddi yn y gwasanaeth iechyd yng Nghymru yn y blynyddoedd diwethaf. Ar beth, yn benodol, y byddech am i'r arian hwnnw gael ei wario?

Ms Lloyd: I think that it is not just the health service; local government also talks about the squeeze and the difficulty of prioritisation. I think that we need to concentrate on looking at a range of alternatives, so that patients can have a better choice of where they wish to be placed. A lot of work is going on at the moment concerning making more use of

Ms Lloyd: Credaf nad y gwasanaeth iechyd yn unig sydd dan sylw: mae llywodraeth leol hefyd yn sôn am ddiffyg arian ac anhawster blaenoriaethu. Credaf fod angen i ni ganolbwyntio ar edrych ar amrywiaeth o ddewisiadau gwahanol, fel y gall cleifion gael gwell dewis wrth benderfynu ble maent am gael eu lleoli. Mae llawer o waith ar

sheltered housing, assistive technology and support for people in their homes, providing local-government alternatives to privately owned nursing homes, getting a better relationship with the private nursing home sector, and looking much more carefully at what alternatives are required to deliver good-quality care for individuals on a long-term basis, which will include rehabilitation and all sorts of things. It is not a simple one-shot answer. It is very much about looking at the needs of individuals in the community and how those needs might best be addressed, in a far more creative way than we were able to do in the past. That has grown from the need, and some of the mandatory requirements placed on local government and the health service, to work more effectively together.

droed ar hyn o bryd ynghylch gwneud mwy o ddefnydd o dai gwarchod, cefnogaeth a thechnoleg gynorthwyol i bobl yn eu cartrefi, darparu dewisiadau gwahanol gan lywodraeth leol yn lle cartrefi nyrsio sydd mewn dwylo preifat, cael perthynas well â'r sector cartrefi nyrsio preifat, ac edrych lawer yn fwy gofalus ar y dewisiadau gwahanol y mae eu hangen i ddarparu gofal o ansawdd da i unigolion dros gyfnod hir, a fydd yn cynnwys gofal adferol a phob math o bethau. Nid ateb syml o un elfen yn unig yw hyn. Mae'n ymwneud i raddau helaeth ag edrych ar anghenion unigolion yn y gymuned a sut orau i fynd i'r afael â'r anghenion hynny, mewn ffordd lawer mwy creadigol nag yr oedd modd i ni ei wneud yn y gorffennol. Mae hynny wedi deillio o'r angen, a rhai o'r gofynion gorfodol sydd wedi eu gosod ar lywodraeth leol a'r gwasanaeth iechyd, i weithio'n fwy effeithiol gyda'i gilydd.

[165] **Janet Davies:** Alun, you wanted to look at the waiting-time strategy and performance management.

[165] **Janet Davies:** Alun, yr oeddech am edrych ar y strategaeth amseroedd aros a rheoli perfformiad.

[166] **Alun Cairns:** Yes, but I would like to pick up on Mrs Lloyd's response to Jocelyn Davies a few moments ago. She highlighted the reduction of the number of nursing homes in Cardiff, which was one reason for a delayed transfer. In view of the fact that that comes within the same Minister's responsibility, what guidance have you and your colleagues within the department issued to local authorities in seeking to resolve this issue? It is a critical issue that I am aware of within my region, and one that, I am sure, Assembly Members are familiar with in other regions. In my mind, that is focused on funding issues, between what private-sector nursing homes say that they need in order to operate efficiently and to invest in staff, and what local authorities are prepared to pay. Therefore, I assume that the Welsh Assembly Government is in a position to negotiate, arbitrate, or certainly to issue guidance in order to resolve these disputes.

[166] **Alun Cairns:** Oeddwn, ond hoffwn drafod ymateb Mrs Lloyd i Jocelyn Davies rai munudau'n ôl. Pwysleisiodd y gostyngiad yn nifer y cartrefi nyrsio yng Nghaerdydd, sef un o'r rhesymau am yr oedi wrth drosglwyddo. O ystyried y ffaith bod hynny'n rhan o gyfrifoldeb yr un Gweinidog, pa ganllawiau yr ydych chi a'ch cydweithwyr yn yr adran wedi eu rhoi i awdurdodau lleol i geisio datrys y broblem hon? Mae'n fater hollbwysig yr wyf yn ymwybodol ohono yn fy rhanbarth, ac yn un, yr wyf yn siŵr, y mae Aelodau'r Cynulliad yn gyfarwydd ag ef mewn rhanbarthau eraill. Yn fy marn i, mae hwnnw'n canolbwyntio ar faterion cyllid, rhwng yr hyn y dywed cartrefi nyrsio'r sector preifat fod ei angen arnynt i weithredu'n effeithlon a buddsoddi mewn staff, a'r hyn y mae awdurdodau lleol yn barod i'w dalu. Felly, cymeraf fod Llywodraeth Cynulliad Cymru mewn sefyllfa i negodi, cyflafareddu, neu'n sicr i roi canllawiau er mwyn datrys yr anghydfodau hyn.

Ms Lloyd: I will ask Mr Hill-Tout to answer this, as he was involved in issuing the guidance.

Ms Lloyd: Gofynnaf i Mr Hill-Tout ateb hyn, oherwydd bu'n ymwneud â chyhoeddi'r canllawiau.

Mr Hill-Tout: There are a number of issues

Mr Hill-Tout: Mae nifer o faterion yn y fan

here. First, the targets for both the health service and local government are set uniformly. In other words, there is an expectation on both health organisations and local authorities to hit targets that are jointly agreed and set by Government. So, there is an expectation that they will work together to look at the local facilities that are available within their community. As Mrs Lloyd has said, there could be a range of facilities, revolving through the hospital service into facilities that are available in the community and facilities that may be available within the independent sector, either nursing or residential accommodation. The Government approaches this by requiring local government and the health service to work together to meet those targets jointly.

hon. Yn gyntaf, caiff y targedau ar gyfer y gwasanaeth iechyd a llywodraeth leol eu gosod yn unffurf. Hynny yw, mae disgwyl i sefydliadau iechyd ac awdurdodau lleol gyrraedd targedau sy'n cael cytuno a'u gosod ar y cyd gan y Llywodraeth. Felly, mae disgwyl y byddant yn gweithio gyda'i gilydd i edrych ar y cyfleusterau lleol sydd ar gael yn eu cymuned. Fel y dywedodd Mrs Lloyd, gallai fod amrywiaeth o gyfleusterau, o'r gwasanaeth ysbyty i gyfleusterau sydd ar gael yn y gymuned a chyfleusterau a all fod ar gael yn y sector annibynnol, naill ai'n llety nyrsio neu'n llety preswyl. Mae'r Llywodraeth yn mynd i'r afael â hyn drwy ei gwneud yn ofynnol i lywodraeth leol a'r gwasanaeth iechyd weithio gyda'i gilydd i gyrraedd y targedau hynny gyda'i gilydd.

[167] **Alun Cairns:** With the greatest respect, Mr Hill-Tout and Mrs Lloyd, I do not really think that we have achieved that in any way. Many of us read regularly of nursing homes closing. I can appreciate that, if this problem existed in England—and it may well do so, I do not know—it is such a large geographical and populous area that it would be very difficult to manage or facilitate negotiations between authorities on an England-only basis. However, we have devolution in Wales, and one of its key benefits is that a Minister can take a holistic approach on an all-Wales basis in terms of addressing such issues. The first step is to recognise that there is a problem, and it seems that we are doing that, which is good news. The second step is to get your hands dirty, in knocking heads together or certainly in facilitating, or in putting oil on the wheels to ensure that nursing homes do not close because you have a problem. Otherwise, in 10 years' time, with an ageing population, I suggest that we will have an even bigger problem.

[167] **Alun Cairns:** Gyda phob parch, Mr Hill-Tout a Mrs Lloyd, nid wyf wir yn credu i ni gyflawni hynny mewn unrhyw fodd. Bydd nifer ohonom yn darllen yn rheolaidd am gartrefi nyrsio yn cau. Gallaf werthfawrogi, pe bai'r broblem hon yn bodoli yn Lloegr—ac efallai ei bod yn wir, ni wn—mae'n ardal boblog a daearyddol mor fawr fel y byddai'n anodd iawn rheoli neu hwyluso trafodaethau rhwng awdurdodau ar sail Lloegr yn unig. Fodd bynnag, mae gennym ddatganoli yng Nghymru, ac un o'i brif fanteision yw y gall Gweinidog ddefnyddio dull cyfannol ar sail Cymru gyfan o ran mynd i'r afael â'r cyfryw faterion. Y cam cyntaf yw cydnabod bod problem, ac mae'n ymddangos ein bod yn gwneud hynny, sy'n newyddion da. Yr ail gam yw torchi'ch llewys, wrth daro pennau yn erbyn ei gilydd, neu'n sicr wrth hwyluso neu iro olwynion i sicrhau nad yw cartrefi nyrsio yn cau oherwydd bod gennych broblem. Fel arall, ymhen 10 mlynedd, gyda phoblogaeth sy'n heneiddio, awgrymaf y bydd gennym broblem fwy fyth.

Mr Hill-Tout: First of all, regarding performance, we must look at the progress that has been made in relation to delayed transfers of care, and Mrs Lloyd referred to this. At the December census, the figures had gone down to 738, so we have moved from a position of 1,150 delayed transfers to 738 in December 2004. Also, if you look at the material that shows the bed days that that relates to, the published figures show a

Mr Hill-Tout: Yn gyntaf oll, o ran perfformiad, rhaid i ni edrych ar y cynnydd a wnaed mewn perthynas ag oedi wrth drosglwyddo gofal, a chyfeiriodd Mrs Lloyd at hyn. Yng nghyfrifiad mis Rhagfyr, yr oedd y ffigurau wedi gostwng i 738, felly yr ydym wedi symud o sefyllfa o 1,150 o achosion o oedi wrth drosglwyddo i 738 ym mis Rhagfyr 2004. Hefyd, os edrychwch ar y deunydd sy'n dangos y dyddiau gwelyau y mae

reduction in the number of bed days occupied by patients who could be discharged from hospital.

hynny'n cyfeirio atynt, mae'r ffigurau a gyhoeddwyd yn dangos gostyngiad yn nifer y dyddiau gwelyau sy'n cael eu llenwi gan gleifion a allai gael eu rhyddhau o'r ysbyty.

Therefore the first point is that there is considerable evidence of a systematic and downward trend, through a combination of the measures that are being put in place by local authorities and those being put in place by the health service. You asked what role the Government could take to intervene in situations such as when there is an acknowledged shortfall in accommodation in the nursing or residential-home sector. Through the partnership forum and other mechanisms, the Minister has ways of holding dialogue with both the NHS, local government and the independent sector to address those specific problems, to facilitate and to achieve change. Mrs Lloyd and myself meet representatives of the independent sector on a twice-yearly basis to discuss these sorts of issues, so that, where there is an acknowledged problem, Government can intervene and facilitate where necessary.

Felly, y pwynt cyntaf yw bod tystiolaeth sylweddol o duedd systematig a thuedd o ostwng, drwy gyfuniad o'r mesurau sy'n cael eu rhoi ar waith gan awdurdodau lleol a'r rheini sy'n cael eu rhoi ar waith gan y gwasanaeth iechyd. Yr oeddech yn goyn pa rôl fyddai'r Llywodraeth yn ei chymryd i ymyrryd mewn sefyllfaoedd fel pan fydd prinder cydnabyddedig o lety yn y sector cartrefi nyrsio neu gartrefi preswyl. Drwy'r fforwm partneriaeth a mecanweithiau eraill, mae gan y Gweinidog ffyrdd i gael deialog â'r GIG, llywodraeth leol a'r sector annibynnol i fynd i'r afael â'r problemau penodol hynny, er mwyn hwyluso a sicrhau newid. Bydd Mrs Lloyd a minnau'n cyfarfod cynrychiolwyr y sector annibynnol ddwywaith y flwyddyn i drafod y mathau hyn o faterion, ac felly, lle mae yna broblem gydnabyddedig, gall y Llywodraeth ymyrryd a hwyluso lle bydd angen.

[168] **Alun Cairns:** I am grateful for that; it partly helps. I apologise, Cadeirydd, for pursuing this matter, but I think that it is pretty fundamental. Mr Hill-Tout, you just mentioned the acknowledged shortfall in residential care.

[168] **Alun Cairns:** Yr wyf yn ddiolchgar am hynny; mae'n helpu'n rhannol. Ymddiheuraf, Gadeirydd, am barhau â'r mater hwn, ond credaf ei fod yn eithaf allweddol. Mr Hill-Tout, yr ydych newydd grybwyll y prinder cydnabyddedig mewn gofal preswyl.

Mr Hill-Tout: There is a shortfall in some areas.

Mr Hill-Tout: Mae yna brinder mewn rhai ardaloedd.

[169] **Alun Cairns:** Granted, it is only in some areas, but it is not only a question of the shortfall, is it? Surely, if we are looking forward to the longer-term future of the independent sector, there needs to be a formula and a stable rate from which it can invest in its facilities and train its staff in order to give them prospects. My experience is—and it might well be anecdotal, but it is my experience in my region—that nursing homes are closing because they are not satisfied with the rate that they receive from local authorities. They complain to the Minister, but the Minister blames the local authority and the nursing homes are caught between the two organisations. I put it to you that it would be far better if the Welsh Assembly Government took the opportunity

[169] **Alun Cairns:** O'r gorau, dim ond mewn rhai ardaloedd y mae prinder, ond nid mater y prinder yn unig yw hyn, aie? Does bosibl, os ydym yn edrych ymlaen at ddyfodol mwy hirdymor y sector annibynnol, mae angen fformiwla a chyfradd sefydlog y gall y sector annibynnol eu defnyddio i fuddsoddi yn ei gyfleusterau ac i hyfforddi ei staff er mwyn rhoi dyfodol iddynt. Yn fy mhrofiad i—ac efallai mai tystiolaeth lafar ydyw, ond dyna yw fy mhrofiad yn fy rhanbarth i—mae cartrefi nyrsio yn cau oherwydd nad ydynt yn fodlon â'r gyfradd a gânt gan awdurdodau lleol. Maent yn cwyno wrth y Gweinidog, ond mae'r Gweinidog yn beio'r awdurdod lleol a'r cartrefi nyrsio'n cael eu dal rhwng y ddau sefydliad. Awgrymaf i chi y byddai'n well o lawer pe

within Wales—this could not be done in England, because it is much too big—to come up with and to facilitate some sort of financial formula that would satisfy everyone, bearing in mind the costs, pressures and investment needed in those organisations.

bai Llywodraeth Cynulliad Cymru yn manteisio ar y cyfle yng Nghymru—ni ellid gwneud hynny yn Lloegr am ei bod lawer yn rhy fawr—i ddyfeisio a hwyluso rhyw fath o fformiwla ariannol a fyddai'n bodloni pawb, gan ystyried y costau, y pwysau a'r buddsoddiad y mae ei angen yn y sefydliadau hynny.

Ms Lloyd: Some work has been done on establishing a formula for just that purpose. Unfortunately, the care sector is currently discussing the end figure with us, but I can give you details of how that formula was arrived at and the sorts of things that it addresses. This is a serious problem and that is why we need multiple answers to the problem of the future care that can be given to older populations, and the private nursing-home sector is only one part of that solution. I can send you what has been done on that.

Ms Lloyd: Mae ychydig waith wedi ei wneud i bennu fformiwla at yr union ddiben hwnnw. Yn anffodus, mae'r sector gofal yn trafod y ffigur terfynol gyda ni ar hyn o bryd, ond gallaf roi manylion i chi am y ffordd y cyrhaeddwyd y fformiwla hwnnw a'r mathau o bethau y mae'n mynd i'r afael â hwy. Mae hon yn broblem ddifrifol, a dyna pam mae arnom angen nifer o atebion i broblem y gofal y gellir ei roi i boblogaethau hŷn yn y dyfodol. Dim ond un rhan o'r ateb hwnnw yw'r sector cartrefi nyrsio preifat. Gallaf anfon atoch yr hyn sydd wedi ei wneud ynghylch hynny.

[170] **Janet Davies:** On that general point, Mrs Lloyd, one of the problems is that there has been a loss of local government residential accommodation in recent years. I am very aware that the finances may not add up to this, but do you see any room for public-sector accommodation to come back, either in the way of new build, which I realise would be very expensive, or possibly in the way of the conversion of any appropriate build that may be spare?

[170] **Janet Davies:** Ar y pwynt cyffredinol hwnnw, Mrs Lloyd, un o'r problemau yw bod llety preswyl llywodraeth leol wedi ei golli yn y blynyddoedd diwethaf. Gwn yn iawn nad yw'r cyllid efallai yn galluogi hyn, ond a ydych yn gweld unrhyw gyfle i lety sector cyhoeddus ddychwelyd, naill ai drwy adeiladu cyfleusterau newydd, a fyddai'n ddrud iawn, fel yr wyf yn sylweddoli, neu o bosibl drwy addasu unrhyw adeiladau priodol a all fod yn segur?

Ms Lloyd: That is one of the options that are being actively discussed at the moment.

Ms Lloyd: Dyna un o'r dewisiadau sy'n cael eu trafod ar hyn o bryd.

[171] **Janet Davies:** Thank you. Sorry about that, Alun; you wanted to come in again.

[171] **Janet Davies:** Diolch. Mae'n ddrwg gen i am hynny, Alun; yr oeddech am ofyn rhagor o gwestiynau.

[172] **Alun Cairns:** Mrs Lloyd, on waiting-times strategy and performance management, I suppose that it would be easy for me to ask which is the more important element, because I am sure that every element is important, but can you tell me why a culture has developed whereby missing targets within the health service is acceptable?

[172] **Alun Cairns:** Mrs Lloyd, mewn perthynas â strategaethau amseroedd aros a rheoli perfformiad, tybiaf y byddai'n hawdd i mi ofyn pa un yw'r elfen bwysicaf, oherwydd yr wyf yn siŵr bod pob elfen yn bwysig, ond a allwch ddweud wrthyf pam mae diwylliant wedi datblygu lle mae methu â chwrdd â thargedau yn y gwasanaeth iechyd yn dderbyniol?

Ms Lloyd: It is not acceptable, and has not been for the past two years. One of the

Ms Lloyd: Nid yw'n dderbyniol, ac nid yw wedi bod am y ddwy flynedd ddiwethaf. Un

problems with the targets, and why we have differential targets for some places, was just the sheer scale of the problem that was affecting some of the organisations. We started to set targets early on. Before April 2003, the targets were being managed through the health authorities. That changed in April 2003, when the establishment of the targets and then their more active management was being addressed by the regional offices, which allowed us to keep a much tighter grip on how organisations were performing, and on the problems that they were facing. Some of those organisations did, and still do, face an enormous uphill job in trying to manage down either the demand that is placed on them or the history of the number of people who were on their lists in the first place. It is not acceptable, and that is why an incentive and sanction scheme has become of real importance in Wales, and why we are getting renewal teams in to help those organisations, throughout Wales, which are having a real problem managing both the demand and the legacy that they find themselves with. So, it is important.

o'r problemau gyda'r targedau, a pham y mae gennym dargedau gwahaniaethol ar gyfer rhai lleoedd, oedd maint y broblem a oedd yn effeithio ar rai o'r sefydliadau. Bu i ni ddechrau gosod targedau yn gynnar. Cyn Ebrill 2003, yr oedd y targedau'n cael eu rheoli drwy'r awdurdodau iechyd. Newidiodd hynny yn Ebrill 2003, pan yr oedd y swyddfeydd rhanbarthol yn gyfrifol am y gwaith o osod y targedau ac yna eu rheoli'n fwy gweithredol, a oedd yn ein galluogi i gadw llygad llawer craffach ar sut yr oedd sefydliadau yn perfformio, ac ar y problemau yr oeddynt yn eu hwynebu. Mae llawer o'r sefydliadau hynny wedi, ac yn parhau i, wynebu tasg hynod ddyrys wrth geisio lleihau naill ai'r pwysau a roddir arnynt neu hanes y nifer o bobl a oedd ar eu rhestrau yn y lle cyntaf. Nid yw'n dderbyniol, a dyna pam mae cynllun cymhellion a chosbau wedi dod yn hynod bwysig yng Nghymru, a pham yr ydym yn galw ar dimau adnewyddu i helpu'r sefydliadau hynny, ledled Cymru, sy'n cael problem wirioneddol gyda rheoli'r galw a'r hyn y maent wedi ei etifeddu. Felly, mae'n bwysig.

[173] **Alun Cairns:** I suppose that I could be heartened by your saying that it is unacceptable to have a culture in which it is acceptable to miss targets, but I refer you to paragraph 4.14 on page 41 of the second volume, which states clearly—I am reading halfway down that paragraph—that

[173] **Alun Cairns:** Tybiaf y gallai'r ffaith i chi ddweud ei bod yn annerbyniol cael diwylliant lle mae'n dderbyniol methu targedau fy nghalonogi, ond hoffwn eich cyfeirio at baragraff 4.14 ar dudalen 41 yr ail gyfrol, sy'n nodi'n glir—darllenaf hanner ffordd i lawr y paragraff hwnnw—

'this meant that the SAFF for some health communities included a specific number of tolerated breaches of minimum targets'.

'Roedd hyn yn golygu bod y SAFF ar gyfer rhai cymunedau iechyd yn cynnwys nifer penodol o achosion o beidio â chyflawni targedau gofynnol a ganiatawyd.'

It goes on to say that,

Mae'n mynd ymlaen i ddweud,

'the number of tolerated breaches of maximum waiting times target was not publicised'.

'Ni chyhoeddwyd nifer yr achosion o beidio â chyflawni targedau amseroedd aros gofynnol a ganiatawyd'.

That means that people on these waiting lists would have expected treatment within a relevant waiting time against the target. It seems that there is a culture of saying, 'Well, you know this is the target, but we know you won't achieve it'. Is that the case?

Mae hynny'n golygu y byddai pobl ar y rhestrau aros hyn wedi disgwyl triniaeth o fewn amser aros perthnasol yn erbyn y targed. Mae'n ymddangos bod diwylliant o ddweud, 'Wel, yr ydych yn gwybod mai dyma'r targed, ond gwyddom na fyddwch yn ei gyflawni'. Ai dyna'r achos?

Ms Lloyd: Not necessarily.

Ms Lloyd: Ddim o reidrwydd.

[174] **Alun Cairns:** Is this inaccurate then?

Ms Lloyd: No, this is not inaccurate, but it is one side of a coin. The Minister said that progress had to be made to reduce waiting times, and that has been done. A judgment had to be made about the feasibility of that achievement and we had to ensure that there was a reasonable chance that organisations, if they maximised their efficiency and used their facilities well, could meet the targets that were being proclaimed, and adhered to that, so that the aspirations of the individual patients could be met. You will know of some of the action that we took, where we believed that organisations needed to be scrutinised very closely indeed. We felt that they could meet their targets and yet they seemed to be drifting off the necessary progress. The first thing that we did, particularly with Gwent, which has turned itself around, was that the Minister invited Brian Edwards to look very carefully at the way in which it was managing its very large waiting lists and the long tail of wait that was prevalent at that time. He reported and they actioned all the recommendations that he made, and Gwent has achieved its targets. It was important that both the deficit culture, and the culture of 'we can miss this if we fancy', was stopped once and for all once the new organisations were established.

[175] **Alun Cairns:** Is it fair to say that there are 15 trusts in Wales?

Ms Lloyd: Yes.

[176] **Alun Cairns:** I thought so. If we turn to appendix seven, we see that five trusts had significant tolerance to breaching waiting targets. So, it is not as though it is just one or two—five separate trusts have had agreement in different areas, and some of them have had pretty significant agreements, such as the Swansea NHS trust. Couple that with paragraph 4.15, which reads,

'improvement targets are difficult to enforce

[174] **Alun Cairns:** A yw hyn yn anghywir felly?

Ms Lloyd: Na, nid yw hyn yn anghywir, ond un ochr o'r geiniog ydyw. Dywedodd y Gweinidog bod yn rhaid gwneud cynnydd i leihau amseroedd aros, ac mae hynny wedi ei wneud. Rhaid oedd gwneud penderfyniad ar ddichonolrwydd y cyflawniad hwnnw a bu'n rhaid i ni sicrhau bod cyfle rhesymol y gallai sefydliadau, pe baent yn sicrhau eu bod mor effeithlon â phosibl ac yn defnyddio'u cyfleusterau'n dda, gyrraedd y targedau a oedd yn cael eu cyhoeddi, ac yn cadw at hynny, fel y gellid diwallu dyheadau'r cleifion unigol. Byddwch yn gwybod am rai o'r camau y bu i ni eu cymryd, lle yr oeddem yn credu bod angen archwilio sefydliadau yn fanwl iawn. Yr oeddem o'r farn y gallent gyrraedd eu targedau ac eto yr oeddynt yn ymddangos fel pe baent yn gwyro i ffwrdd oddi wrth y cynnydd angenrheidiol. Y peth cyntaf a wnaethom, yn enwedig gyda Gwent, sydd wedi troi ei sefyllfa ben i waered, oedd i'r Gweinidog wahodd Brian Edwards i edrych yn ofalus iawn ar y ffordd yr oedd yn rheoli ei restrau aros hir iawn a'r amserau aros hir a oedd yn gyffredin bryd hynny. Bu iddo adrodd a bu iddynt weithredu pob un o'r argymhellion a wnaeth, ac mae Gwent wedi cyflawni ei thargedau. Yr oedd yn bwysig bod y diwylliant diffyg, a'r diwylliant o 'gallwn fethu hwn os ydym eisiau', yn cael ei ddileu unwaith ac am byth ar ôl i'r sefydliadau newydd gael eu sefydlu.

[175] **Alun Cairns:** A yw'n deg dweud bod 15 o ymddiriedolaethau yng Nghymru?

Ms Lloyd: Ydy.

[176] **Alun Cairns:** Dyna yr oeddwn yn ei feddwl. Os trown at atodiad saith, gwelwn i bum ymddiriedolaeth fod â goddefgarwch sylweddol at fethu targedau aros. Felly, nid yw fel pe bai dim ond un neu ddau—mae pum ymddiriedolaeth wahanol wedi cael cytundeb mewn ardaloedd gwahanol, ac mae rhai ohonynt wedi cael cytundebau eithaf arwyddocaol, megis ymddiriedolaeth GIG Abertawe. Cyplyswch hynny gyda pharagraff 4.15, sy'n dweud,

'mae targedau gwelliant parhaus o'r fath yn

in an environment where some organisations receive additional funding for less stringent targets after breaching minimum waiting times'.

anodd eu gorfodi mewn amgylchedd lle y mae rhai sefydliadau yn derbyn arian ychwanegol a thargedau llai llym ar ôl peidio â chyflawni safonau amseroedd aros gofynnol'.

Does that not introduce confusion at the very best, and chaos at the very worst, and patients waiting longer than the times they have been promised, when the previous paragraph tells us that even when these tolerances are accepted, the patients are not even told?

Onid yw hynny'n cyflwyno dryswch ar y gorau, ac anhrefn ar y gwaethaf, a chleifion yn aros yn hwy na'r amseroedd a addawyd iddynt, pan fo'r paragraff blaenorol yn dweud wrthym hyd yn oed pan gaiff yr achosion hyn o oddefgarwch eu derbyn, na chaiff cleifion hyd yn oed eu hysbysu?

Ms Lloyd: In terms of the patients not being told, I think that that is a justifiable criticism. There will not be any tolerated breaches anymore, and that was made clear in the SAFF of 2004-05. A judgment had to be made about the balance between the activity that the organisations could legitimately be expected to deliver and the weight of the problem that was upon them, which is why, in 2003-04, there were tolerated breaches. Those will not be tolerated anymore, and they have not been tolerated since this SAFF was produced for 2004-05. I should preface this by asking if you are asking whether or not we have rewarded the inefficient.

Ms Lloyd: O ran nad yw'r cleifion yn cael eu hysbysu, credaf fod hynny'n feirniadaeth y gellir ei chyfiawnhau. Ni fydd unrhyw achosion o beidio â chyflawni targedau a ganiatawyd bellach, a gwnaed hynny'n glir yn fframwaith gwasanaeth a chyllid 2004-05. Yr oedd yn rhaid gwneud penderfyniad ar y cydbwysedd rhwng y gweithgarwch y gellid disgwyl i'r sefydliadau ei gyflawni mewn gwirionedd a phwysau'r broblem a oedd ganddynt, a dyna pam, yn 2003-04, yr oedd achosion o beidio â chyflawni targedau a ganiatawyd. Ni fydd y rheini'n cael eu goddef mwyach, ac nid ydynt wedi eu goddef ers cynhyrchu'r SAFF hwn yn 2004-05. Dylwn ragflaenu hyn drwy ofyn a ydych yn holi a ydym wedi gwobrwyo'r aneffeithlon ai peidio.

[177] **Alun Cairns:** That is what I am building up to because that would be my next question—paragraph 4.9 talks about rewarding failure. That is clearly quoted by a trust board chief executive.

[177] **Alun Cairns:** Dyna'r hyn yr wyf yn dod ato oherwydd dyna fyddai fy nghwestiwn nesaf—mae paragraff 4.9 yn sôn am wobrwyo methiant. Caiff hynny ei ddyfynnu'n glir gan brif weithredwr bwrdd ymddiriedolaeth.

Ms Lloyd: Yes. On the question of rewarding failure, we must bear in mind the most important person in this equation, and that is the patient, and his or her access to care. Again, a judgment had to be made about whether or not to penalise organisations that were not performing well, or were breaching and the two things are not necessarily the same. By penalising them and taking money away from them we would therefore be reducing access for patients even further. I do not think that that is the judgment that we would wish to adopt. So, that had to be borne in mind. However, it is important that those people who are efficient and have made good

Ms Lloyd: Caiff. O ran y mater o wobrwyo methiant, rhaid i ni gofio'r unigolyn pwysicaf oll yn yr hafaliad hwn, a'r claf yw hwnnw, a'i fynediad ef neu hi i ofal. Eto, rhaid oedd penderfynu a ddylid cosbi ai peidio sefydliadau nad oeddynt yn perfformio'n dda, neu a oedd yn mynd yn groes i ofynion, ac nid yw'r ddau beth yr un peth o reidrwydd. Drwy eu cosbi a mynd ag arian oddi wrthynt byddem felly yn lleihau mynediad i gleifion hyd yn oed ymhellach. Ni chredaf mai hwnnw yw'r penderfyniad y byddem am ei fabwysiadu. Felly, rhaid oedd cofio hynny. Fodd bynnag, mae'n bwysig bod gan y bobl hynny sy'n effeithlon ac wedi gwneud

progress, have an incentive to go even further on behalf of Wales, and that those people who are struggling with a legitimate burden are given help and support to improve how they can manage their patients. However, those people who have a mountain to climb and are not efficient are now under a scheme that intervenes in how they manage their services.

cynnydd da gymhelliant i fynd hyd yn oed ymhellach ar ran Cymru, a bod y bobl hynny sydd â baich gwirioneddol yn cael cymorth a chefnogaeth i wella sut gallant reoli eu cleifion. Fodd bynnag, mae'r bobl hynny sydd â mynydd i'w ddringo ac nad ydynt yn effeithlon bellach yn rhan o gynllun sy'n ymyrryd yn y ffordd y maent yn rheoli eu cleifion.

[178] **Alun Cairns:** Does not your answer go completely against the principles of Wanless that we are trying to introduce into the hospitals, in other words, rewarding more efficient hospitals?

[178] **Alun Cairns:** Onid yw'ch ateb yn mynd yn gwbl groes i'r egwyddorion Wanless yr ydym yn ceisio eu cyflwyno yn yr ysbytai, hynny yw, gwobrwyo ysbytai mwy effeithlon?

Ms Lloyd: No, it does not. What I have said is what Wanless said. I am sorry, I may not have explained myself sufficiently.

Ms Lloyd: Nac ydyw. Yr hyn yr wyf wedi ei ddweud yw'r hyn a ddywedodd Wanless. Mae'n ddrwg gen i, efallai na eglurais fy hun yn ddigonol.

[179] **Alun Cairns:** No, that is okay, but let me add to the question. Why then in figure 17, do 100 per cent of trust chief executives and 74 per cent of local health board chief executives say that performance management arrangements would be more effective if they included stronger incentives and sanctions—so that would mean stronger sanctions—for achieving waiting-times targets, although I assume that the sanctions would be for those who have missed those targets?

[179] **Alun Cairns:** Na, mae hynny'n iawn, ond gadewch i mi ychwanegu at y cwestiwn. Pam felly, yn ffigur 17, y mae 100 y cant o brif weithredwyr ymddiriedolaethau a 74 y cant o brif weithredwyr byrddau iechyd lleol yn dweud y byddai trefniadau rheoli perfformiad yn llawer mwy effeithiol pe baent yn cynnwys cymhellion a chosbau cryfach—felly byddai hynny'n golygu cosbau cryfach—ar gyfer cyflawni targedau amseroedd aros, er y tybiaf y byddai'r cosbau ar gyfer y rheini sydd wedi methu'r targedau hynny?

Ms Lloyd: That is exactly what we have done.

Ms Lloyd: Dyna'n union beth yr ydym wedi ei wneud.

[180] **Alun Cairns:** But that seems to be calling for stronger sanctions and/or incentives.

[180] **Alun Cairns:** Ond mae'n ymddangos bod hynny'n galw am gosbau a/neu gymhellion cryfach.

Ms Lloyd: When this report was done, there was what I would call some sanctions, but of a facilitative nature, and there had been incentives. Incentives were paid in 2003-04 and 2004-05. Since this report stopped gathering its data, because it has only just been published, we have been working up a much tighter incentive and sanctions system—because we do listen to people—and it is something that we and the Minister are very wedded to, so that we do get a proper way of incentivising, and intervening when necessary, when trusts are proven to be

Ms Lloyd: Pan wnaed yr adroddiad hwn, yr oedd yr hyn y byddwn yn ei alw'n rhai cosbau, ond cosbau a fyddai'n hwyluso, a bu cymhellion. Talwyd cymhellion yn 2003-04 a 2004-05. Ers i'r adroddiad hwn orffen casglu ei ddata, oherwydd mai dim ond newydd gael ei gyhoeddi y mae, yr ydym wedi bod yn creu system cymhellion a chosbau lawer mwy caeth—oherwydd ein bod yn gwrando ar bobl—ac mae'n rhywbeth yr ydym ni a'r Gweinidog yn ymrwymedig iawn iddi, fel ein bod yn cael ffordd gywir o gymell, ac ymyrryd pan fo angen, pan brofir bod

inefficient and not managing the system well enough. Some have long waiting times and are really efficient: that is the burden of the demand that is coming through their door, which is another thing that we have to tackle.

ymddiriedolaethau yn aneffeithlon ac nad ydynt yn rheoli'r system yn ddigon da. Mae gan rai amseroedd aros hir ac maent yn effeithlon iawn: dyna faich y galw sydd wrth eu drws, sy'n rhywbeth arall y mae'n rhaid i ni fynd i'r afael ag ef.

[181] **Alun Cairns:** I have a final question, with your permission, Cadeirydd. Considering that waiting-times targets are far tighter and more stringent in England than they are in Wales, how would you contrast its approach, which is highlighted in paragraph 4.17, in comparison to the approach that we have taken here?

[181] **Alun Cairns:** Mae gennyf gwestiwn olaf, gyda'ch caniatâd, Gadeirydd. Gan ystyried bod targedau amseroedd aros yn llawer tynnach ac yn llymach yn Lloegr nag y maent yng Nghymru, sut byddech yn gwrthgyferbynnu ei dull, sydd wedi ei nodi ym mharagraff 4.17, o gymharu â'r dull yr ydym wedi ei ddefnyddio yma?

Ms Lloyd: In terms of managing waiting times?

Ms Lloyd: O ran rheoli amseroedd aros?

[182] **Alun Cairns:** Waiting-times targets.

[182] **Alun Cairns:** Targedau amseroedd aros.

Ms Lloyd: As I said last time, the waiting-times targets in England were established some considerable time ago and have been tightened year on year. England had a laser-like concentration on that being the goal that simply had to be achieved, irrespective of everything else, right back as far as 1997. In Wales, as you know, the policy agenda was different; it was very much about looking at ill health and its causes and how we could overcome that to remove inequalities, so the policy balance was different.

Ms Lloyd: Fel y dywedais y tro diwethaf, sefydlwyd y targedau amseroedd aros yn Lloegr gryn amser yn ôl ac maent wedi eu tynhau flwyddyn ar ôl blwyddyn. Yr oedd Lloegr yn hollol sicr mai dyna oedd y nod yr oedd yn rhaid ei chyflawni heb os, heb ystyried popeth arall, mor bell yn ôl ag 1997. Yng Nghymru, fel y gwyddoch, yr oedd yr agenda polisi yn wahanol; yr oedd yn canolbwyntio'n helaeth ar edrych ar salwch a'i achosion a sut y gallem ei oresgyn i ddileu anghydraddoldebau, felly yr oedd y cydbwysedd polisi yn wahanol.

[183] **Jocelyn Davies:** Just on that point on sanctions, Mrs Lloyd, just to clear this up—you would consider that financial sanctions might adversely affect patients in those areas?

[183] **Jocelyn Davies:** Ar y pwynt hwnnw am gosbau, Mrs Lloyd, i egluro hyn—byddech yn ystyried y gallai cosbau ariannol effeithio'n andwyol ar gleifion yn yr ardaloedd hynny?

Ms Lloyd: Yes, I think so.

Ms Lloyd: Gallent, yn fy marn i.

[184] **Jocelyn Davies:** Okay. Can we now turn to the waiting-time initiatives? I am looking at page 43, if that is any help. The report says that waiting-time initiatives have some positive benefits, certainly for those patients who were treated—I am sure that they would say that they were of huge benefit—and in terms of clearing genuine backlogs and in supporting wider strategic development. The Auditor General's report is critical of the use of waiting-time initiatives

[184] **Jocelyn Davies:** O'r gorau. A allwn droi yn awr at y mentrau amseroedd aros? Yr wyf yn edrych ar dudalen 43, os yw hynny o gymorth. Dywed yr adroddiad bod gan fentrau amseroedd aros rai buddiannau cadarnhaol, yn sicr ar gyfer y cleifion hynny a gafodd eu trin—yr wyf yn siŵr y buasent yn dweud eu bod o fudd enfawr—ac o ran clirio ôl-groniadau achosion gwirioneddol ac wrth gefnogi gwaith datblygu strategol ehangach. Mae adroddiad yr Archwilydd

and it states here that there has been no clear overall strategy to reduce waiting times and that initiatives treat the symptom, that is, the patients waiting, rather than the causes of long waiting times. So, how will you ensure that additional funding provided to tackle waiting times delivers sustainable solutions and value for money in future?

Cyffredinol yn feirniadol o'r defnydd o fentrau amseroedd aros ac mae'n nodi yma na fu strategaeth gyffredinol amlwg i leihau amseroedd aros a bod mentrau'n mynd i'r afael â'r symptom, hynny yw, cleifion yn aros, yn hytrach nag achosion amseroedd aros hir. Felly, sut byddwch yn sicrhau bod cyllid ychwanegol a ddarperir i fynd i'r afael ag amseroedd aros yn rhoi atebion cynaliadwy a gwerth am arian yn y dyfodol?

Ms Lloyd: This year, that is what has been happening. We have had an approach where we must reduce the backlog that has built up. The Minister changed the target down to 12 months, and instituted the second offer scheme, in order to focus on removing the backlog while the service builds up sustainable solutions. A third of the second offer scheme is being undertaken within the NHS in Wales, so that it is consolidating what it has.

Ms Lloyd: Eleni, dyna'r hyn sydd wedi bod yn digwydd. Yr ydym wedi cael dull lle mae'n rhaid i ni leihau'r ôl-groniadau achosion sydd wedi pentyrru. Newidiodd y Gweinidog y targed i lawr i 12 mis, a sefydlodd gynllun yr ail gynnig, er mwyn canolbwyntio ar waredu'r ôl-groniadau achosion tra bod y gwasanaeth yn datblygu atebion cynaliadwy. Mae traean o gynllun yr ail gynnig yn cael ei gynnal o fewn y GIG yng Nghymru, fel ei fod yn cyfnerthu'r hyn sydd ganddo.

In terms of sustainability, as you know, the Minister announced £30 million for capital, because, as we went around Wales, we found that the day-case rates in many of the organisations could not improve, because the day-case facilities were just hopeless. So, there is a huge amount of work going on to ensure that we modernise the accommodation, and that we have new equipment, so that they build up their capacity. That also includes diagnostics.

O ran cynaliadwyedd, fel y gwyddoch, cyhoeddodd y Gweinidog £30 miliwn ar gyfer cyfalaf, oherwydd, wrth i ni fynd o amgylch Cymru, bu i ni ganfod na allai'r cyfraddau achosion dydd yn llawer o'r sefydliadau wella, oherwydd bod y cyfleusterau achosion dydd mor anobeithiol. Felly, mae llawer iawn o waith yn cael ei wneud i sicrhau ein bod yn moderneiddio'r llety, a bod gennym offer newydd, fel eu bod yn adeiladu eu gallu. Mae hynny'n cynnwys diagnosteg hefyd.

We are auditing the modernisation of the service, to ensure that everyone is held to account to ensure that they are using the most modern techniques, but that requires a real engagement of the clinical teams, and each trust and local health board is being urged to ensure that the ideas of their clinicians are brought to the fore, to try to tackle the management of the demand and how patients coped with it. We have put in efficiency targets to try to ensure that the capacity within the NHS in Wales is used more effectively.

Yr ydym yn archwilio'r gwaith o foderneiddio'r gwasanaeth, i sicrhau bod pawb yn cael eu dal yn gyfrifol i sicrhau eu bod yn defnyddio'r technegau mwyaf modern, ond mae hynny'n gofyn am gyfraniad gwirioneddol gan y timau clinigol, ac mae pob ymddiriedolaeth a bwrdd iechyd lleol yn cael eu hannog i sicrhau bod syniadau eu clinigwyr yn cael lle blaenllaw, i geisio mynd i'r afael â'r gwaith o reoli'r galw a sut ymdopodd cleifion ag ef. Rhaid i ni weithredu targedau effeithlonrwydd i geisio sicrhau bod y gallu yn y GIG yng Nghymru yn cael ei ddefnyddio'n fwy effeithiol.

In terms of sustainability, a considerable resource has now gone into the service, particularly in orthopaedics and plastics, to

O ran cynaliadwyedd, mae adnodd sylweddol bellach wedi ei roi yn y gwasanaeth, yn enwedig mewn orthopaedeg a llawfeddygaeth

ensure that there is a sustainable solution. We are currently discussing how the 'one-off' nature of waiting-time initiatives can be eradicated forever. We have had to rely on end-year flexibility money for the past couple of years, but much more money has been focused on the sustainability of the solutions, particularly in orthopaedics. That is why the schemes in Llandough and St Woollos are going ahead, and money has been given to the other two regions for sustainable solutions in terms of orthopaedics.

blastig, i sicrhau bod ateb cynaliadwy. Yr ydym yn trafod ar hyn o bryd sut gellir dileu natur 'unigryw' mentrau amseroedd aros am byth. Yr ydym wedi gorfod dibynnu ar arian hyblygrwydd diwedd blwyddyn am yr ychydig flynyddoedd diwethaf, ond mae llawer mwy o arian wedi ei ganolbwyntio ar gynaliadwyedd yr atebion, yn enwedig ym maes orthopaedeg. Dyna pam mae'r cynlluniau yn Llandochau a St Woollos yn mynd yn eu blaenau, ac mae arian wedi ei roi i'r ddau ranbarth arall ar gyfer atebion cynaliadwy o ran orthopaedeg.

So, we are trying to ensure that the whole system is covered. If you are just chasing demand, as you rightly say, we will not produce a sustainable system. So, it is not just about chucking more money at it, although that is always helpful. It is very much about ensuring that we use our capacity to the maximum, and that we look at the demand that is coming through, to see whether or not that could be managed differently.

Felly, yr ydym yn ceisio sicrhau bod y system gyfan wedi ei chwmpasu. Os ydych yn canolbwyntio ar alw yn unig, fel y dywedwch yn gywir, ni fyddwn yn cynhyrchu system gynaliadwy. Felly, nid yn unig mater o daflu rhagor o arian ato ydyw, er bod hynny bob amser yn ddefnyddiol. Mae'n ymwneud i raddau helaeth â sicrhau ein bod yn defnyddio ein gallu i'r eithaf, a'n bod yn edrych ar y galw sy'n dod trwodd, i weld a ellid rheoli hwnnw'n wahanol ai peidio.

[185] **Jocelyn Davies:** I am pleased to hear about the investment in the NHS in Wales, but could I just ask you one or two questions about the use of the private sector, which the report covers? It says that the expenditure in the private sector grew by 120 per cent compared with 7 per cent in NHS facilities from 2002-04. Do you think that that was good value for money?

[185] **Jocelyn Davies:** Yr wyf yn falch o glywed am y buddsoddiad yn y GIG yng Nghymru, ond a allwn ofyn cwestiwn neu ddau i chi am y defnydd o'r sector preifat, sy'n codi yn yr adroddiad? Dywed i'r gwariant yn y sector preifat gynyddu 120 y cant o gymharu â 7 y cant yng nghyfleusterau'r GIG o 2002-04. A ydych o'r farn i hynny fod yn werth da am arian?

Ms Lloyd: Obviously, it is not good value for money, and we recognised that. Up until 2003, the health authorities were managing this resource on our behalf, but, from 2003 onwards, it was clear that we had to institute much better control over the use made of money. We have done it in two ways, and I will give two sets of anecdotes. First, some trusts were paying very variable fees to their consultants for waiting-lists initiatives, so there is a fixed rate contained within our consultants' contract. Although some chief executives are asking me to be lenient and to vary it, we will not—it will stay as it is.

Ms Lloyd: Yn amlwg, nid yw'n werth da am arian, a bu i ni gydnabod hynny. Tan 2003, yr oedd yr awdurdodau iechyd yn rheoli'r adnodd hwn ar ein rhan, ond, o 2003 ymlaen, yr oedd yn amlwg bod yn rhaid i ni sefydlu rheolaeth lawer gwell o'r defnydd a wnaed o'r arian. Yr ydym wedi ei wneud mewn dwy ffordd, a rhoddaf ddwy enghraifft i chi. Yn gyntaf, yr oedd rhai ymddiriedolaethau yn talu ffioedd amrywiol iawn i'w meddygon ymgynghorol ar gyfer mentrau rhestrau aros, felly mae cyfradd sefydlog wedi ei chynnwys yn ein contract meddygon ymgynghorol. Er bod rhai prif weithredwyr yn gofyn i mi beidio â bod yn rhy llym ac i'w hamrywio, ni fyddwn yn gwneud hynny—bydd yn aros fel ag y mae.

Secondly, particularly through the second offer scheme, we applied the tariffs that had been prepared and promoted in England. However, there has been a debate in England regarding whether or not these tariffs are sufficiently flexible for some specialties, which, in some of the more specialised fields, is a reasonable point, but they are still quite a good benchmark for the general specialties. That changed behaviour considerably and changed our relationship with the private sector. We first negotiated centrally, and drove down the costs to the tariff price. We also drove down the costs of trusts that were bidding, as some of them were coming in well above the tariff cost for routine surgery. That has allowed us to drive down the costs of care, which is important given the backlog that we have to deal with. So, we have taken action on making sure that we get better value for money, but we are testing the system all the time. We are becoming much more sophisticated about the type of case-mix and the cost attached to that case-mix to make sure that that resource that we do have, when we manage it centrally, is being applied effectively.

Yn ail, yn enwedig drwy gynllun yr ail gynnig, bu i ni roi ar waith dariffau a oedd wedi eu paratoi a'u hyrwyddo yn Lloegr. Fodd bynnag, bu dadl yn Lloegr ynglŷn ag a yw'r tariffau hyn yn ddigon hyblyg ai peidio ar gyfer rhai arbenigeddau, sydd, yn rhai o'r meysydd mwy arbenigol, yn bwynt rhesymol, ond maent yn dal i fod yn feincnod da ar gyfer yr arbenigeddau cyffredinol. Newidiodd hynny ymddygiad yn sylweddol a bu iddo newid ein perthynas â'r sector preifat. Bu i ni negodi'n ganolog yn gyntaf, a lleihau'r costau i'r pris tariff. Bu i ni hefyd leihau costau ymddiriedolaethau a oedd yn cynnig, oherwydd yr oedd costau rhai ohonynt yn llawer uwch na'r gost dariff ar gyfer llawfeddygaeth gyffredin. Mae hynny wedi ein galluogi i leihau costau gofal, sy'n bwysig o gofio'r ôl-groniad achosion sydd gennym i ddelio ag ef. Felly, yr ydym wedi gweithredu i sicrhau ein bod yn cael gwerth gwell am arian, ond yr ydym yn rhoi'r system ar brawf drwy'r amser. Yr ydym yn dod yn llawer mwy soffistigedig am y math o gymysgedd achosion a'r gost sy'n gysylltiedig â'r cymysgedd achosion hwnnw i sicrhau bod yr adnodd hwnnw sydd gennym, pan y byddwn yn ei reoli'n ganolog, yn cael ei ddefnyddio'n effeithiol.

[186] **Jocelyn Davies:** Did the initiatives represent a huge opportunity for consultants who were working both within the NHS and the private sector? They made enormous sums of money from the public purse while the NHS made poor use of the facilities.

[186] **Jocelyn Davies:** A oedd y mentrau yn gyfle enfawr i feddygon ymgynghorol a oedd yn gweithio yn y GIG ac yn y sector preifat? Bu iddynt ennill symiau enfawr o arian o'r coffrau cyhoeddus tra bod y GIG yn gwneud defnydd gwael o'r cyfleusterau.

Ms Lloyd: I can only speculate on that; you would have to ask them. However, there is anecdotal evidence to support this view. Some of the prices that were paid did not represent value for money, but that is not universally true. A lot of the guys who were doing the waiting-list initiatives were very reasonable. One downside of working on these initiatives was that we had to ensure that our clinicians were not working outside the European working-time directive. That was also a disbenefit for them. It is a balance. I do not know what consultants do in their private lives.

Ms Lloyd: Ni allaf ond dyfalu am hynny; byddai'n rhaid i chi ofyn iddynt. Fodd bynnag, mae tystiolaeth anecdotaidd i gefnogi'r farn hon. Nid oedd rhai o'r prisiau a dalwyd yn cynrychioli gwerth da am arian, ond nid yw hynny'n wir am bob achos. Yr oedd llawer o'r bobl a oedd yn gwneud y mentrau rhestrau aros yn rhesymol iawn. Un anfantais o weithio ar y mentrau hyn oedd bod yn rhaid i ni sicrhau nad oedd ein clinigwyr yn gweithio y tu allan i'r gyfarwyddeb amser gweithio Ewropeaidd. Yr oedd hynny o anfantais iddynt hefyd. Cydbwysedd ydyw. Ni wn beth y gwna meddygon ymgynghorol yn eu bywydau preifat.

[187] **Jocelyn Davies:** We know that patients

[187] **Jocelyn Davies:** Gwyddom fod

faced with long waiting lists are more likely to turn to the private sector to spend their own money when they may not normally consider doing that. You accept that. What is the longer-term role for the private sector?

cleifion sy'n wynebu rhestrau aros hir yn fwy tebygol o droi at y sector preifat i wario'u harian eu hunain pan na fyddent fel arfer yn ystyried gwneud hynny o bosibl. Yr ydych yn derbyn hynny. Beth yw'r rôl fwy hirdymor ar gyfer y sector preifat?

Ms Lloyd: I think that it is part of a partnership. If we get value for money from the private sector, and the cost to the service is the same as the cost of using the private sector, then, as long as the clinicians stay within a 48-hour week, it is an added capacity for us. That is why we are using some of the extra capacity in England. As long as we have good quality and high standards, patients are happy to use the facilities, both in the NHS in England and the private sector in Wales. If the outcomes are also good and we get value for money, then we should maximise the use of what is available to us. I would, however, look to the NHS first to improve its capacity management.

Ms Lloyd: Credaf ei fod yn rhan o bartneriaeth. Os cawn werth am arian gan y sector preifat, a bod y gost i'r gwasanaeth yr un fath â'r gost o ddefnyddio'r sector preifat, yna, cyn belled nad yw clinigwyr yn gweithio mwy na 48 awr yr wythnos, mae'n allu ychwanegol i ni. Dyna pam ein bod yn defnyddio peth o'r gallu ychwanegol yn Lloegr. Cyn belled â bod gennym safonau uchel ac ansawdd da, mae cleifion yn fodlon defnyddio'r cyfleusterau, a hynny yn y GIG yn Lloegr a'r sector preifat yng Nghymru. Os yw'r canlyniadau yn dda hefyd a'n bod yn cael gwerth am arian, yna dylem wneud y defnydd mwyaf posibl o'r hyn sydd ar gael i ni. Byddwn, fodd bynnag, yn edrych ar y GIG yn gyntaf i wella ei reolaeth o allu.

[188] **Janet Davies:** Do you not see a possibility that increasing use of the private sector could cause problems for the NHS as years go by?

[188] **Janet Davies:** Onid ydych yn gweld posibilrwydd y gallai cynyddu'r defnydd o'r sector preifat achosi problemau ar gyfer y GIG wrth i flynyddoedd fynd heibio?

Ms Lloyd: Our first priority has to be to use NHS capacity well; that is what we are paying for and that is our fundamental rationale. Where the capacity is insufficient—given rises in demand or whatever—and we can get good quality services at a good price, similar to that which you would expect to find in the NHS, then we should use the capacity that is available to us. The standards have got to be the same. The Care Standards Inspectorate for Wales used to review the standards and inspect the private sector in Wales, but that work will now be done by Healthcare Inspectorate Wales, so that we can ensure that the standards achieved by the private sector are the same as those achieved in the NHS.

Ms Lloyd: Defnyddio gallu'r GIG yn dda ddylai fod yn flaenoriaeth gyntaf i ni; dyna'r hyn yr ydym yn talu amdano a dyna ein sail resymegol sylfaenol. Lle mae'r gallu yn annigonol—o gofio cynnydd mewn galw neu beth bynnag—a lle gallwn gael gwasanaethau o ansawdd da am bris da, yn debyg i hynny y byddech yn disgwyl ei gael yn y GIG, yna dylem ddefnyddio'r gallu sydd ar gael i ni. Rhaid i'r safonau fod yr un fath. Yr oedd Arolygiaeth Safonau Gofal Cymru yn arfer adolygu'r safonau ac archwilio'r sector preifat yng Nghymru, ond bydd y gwaith hwnnw bellach yn cael ei wneud gan Arolygiaeth Gofal Iechyd Cymru, fel y gallwn sicrhau bod y safonau a gyflawnir gan y sector preifat yr un fath â'r rheini a gyflawnir yn y GIG.

[189] **Alun Cairns:** To pursue that further, when this money was being spent to use the private sector to bring the waiting list down, was that additional money offered to any trust, or was any request made by any trust for additional staff, or to recruit an additional

[189] **Alun Cairns:** I ymhelaethu ar hynny, pan yr oedd yr arian hwn yn cael ei wario ar ddefnyddio'r sector preifat i leihau'r rhestr aros, a gafodd yr arian ychwanegol hwnnw ei gynnig i unrhyw ymddiriedolaeth, neu a wnaeth unrhyw ymddiriedolaeth unrhyw gais

consultant? I put it to you that one trust's chief executive told me that, if only he had the money to recruit an additional consultant, he could use the money far more efficiently than we could, because of the money going to the private sector. He said that the consequence was that that single consultant that they had was becoming a millionaire overnight—and that was the phrase that he used—because he was operating on NHS patients in the private sector. He said that if that money had been given to him to recruit another consultant, whom he thought he could have sourced from elsewhere, it would have been a much more effective use of the funds. Was any proposal along those lines made to you by any trust?

am staff ychwanegol, neu i recriwtio meddyg ymgynghorol ychwanegol? Dywedaf wrthych i brif weithredwr un ymddiriedolaeth ddweud wrthyf, pe bai ganddo'r arian i recriwtio meddyg ymgynghorol ychwanegol, gallai ddefnyddio'r arian yn llawer mwy effeithlon nag y gallem ni, oherwydd yr arian sy'n mynd i'r sector preifat. Dywedodd mai'r canlyniad oedd bod yr un meddyg ymgynghorol hwnnw a oedd ganddynt yn dod yn filiwnydd dros nos—a dyna'r geiriau a ddefnyddiodd—oherwydd ei fod yn cynnal llawdriniaethau ar gleifion y GIG yn y sector preifat. Dywedodd pe bai'r arian hwnnw wedi ei roi iddo i recriwtio meddyg ymgynghorol arall, y credai y gallai fod wedi ei gael o rywle arall, byddai wedi bod yn ddefnydd llawer mwy effeithiol o'r arian. A wnaeth unrhyw ymddiriedolaeth gynnig tebyg i chi?

Mr Hill-Tout: We operate on the basis that, when additional work is being considered, whether it is work that will take place in the NHS or in the private sector, it has to be judged competitively. I can give you the figures for the numbers of second offers that have been carried out since April 2004, when the scheme started: 2,778 patients had their treatment within the NHS in Wales funded though the second offer scheme, and 4,607 patients have been referred to a provider outside the NHS in Wales. That could be the NHS in England or it could be the independent and the private sector. You can see, therefore, that there is a strong balance between the amount of work that we commission inside the NHS and the amount of work that we commission from the independent sector.

Mr Hill-Tout: Yr ydym yn gweithredu ar y sail sef, pan fo gwaith ychwanegol yn cael ei ystyried, boed hwnnw'n waith a fydd yn digwydd yn y GIG neu yn y sector preifat, bod yn rhaid ei feirniadu'n gystadleuol. Gallaf roi i chi'r ffigurau ar gyfer niferoedd yr ail gynigion sydd wedi eu cyflawni ers Ebrill 2004, pan ddechreuodd y cynllun: cafodd 2,778 o gleifion eu triniaeth yn y GIG yng Nghymru a oedd wedi ei hariannu gan gynllun yr ail gynnig, ac mae 4,607 o gleifion wedi eu cyfeirio at ddarparwr y tu allan i'r GIG yng Nghymru. Gallai hwnnw fod y GIG yn Lloegr neu gallai fod y sector annibynnol neu breifat. Gallwch weld, felly, bod cydbwysedd cryf rhwng faint o waith yr ydym yn ei gomisiynu y tu mewn i'r GIG a faint o waith yr ydym yn ei gomisiynu gan y sector annibynnol.

We, as the Welsh Assembly Government, are putting pump-priming money into this, and so the debate that you may have been told about when you had that discussion with that consultant is also an issue for the local health boards, as to whether they would consider making a permanent investment in that service. That is an issue for local deliberation. So, it may well be that that local health board did not wish to make an investment in that way and at that time. However, I can assure you that all of the work that we commission through the second offer scheme is offered to the NHS first, so

Yr ydym ni, fel Llywodraeth Cynulliad Cymru, yn buddsoddi arian sefydlu yn hyn, ac felly mae'r ddadl y cawsoch eich hysbysu amdani o bosibl pan gawsoch y drafodaeth honno gyda'r meddyg ymgynghorol hwnnw hefyd yn fater i'r byrddau iechyd lleol, ynglŷn ag a fyddent yn ystyried gwneud buddsoddiad parhaol yn y gwasanaeth hwnnw. Mae hwnnw'n fater i'w ddadlau'n lleol. Felly, mae'n dra phosibl nad oedd y bwrdd iechyd lleol hwnnw am wneud buddsoddiad yn y modd hwnnw ac ar yr adeg honno. Fodd bynnag, gallaf eich sicrhau bod yr holl waith yr ydym yn ei gomisiynu drwy

that it gets ample opportunity to carry out this work. As you can see, 2,700 patients received their care through the NHS this year.

gynllun yr ail gynnig yn cael ei gynnig i'r GIG yn gyntaf, fel ei fod yn cael digon o gyfle i gyflawni'r gwaith hwn. Fel y gwelwch, derbyniodd 2,700 o gleifion eu gofal drwy'r GIG eleni.

[190] **Janet Davies:** Alun, before you go into the second offer scheme, Leighton will ask a question.

[190] **Janet Davies:** Alun, cyn i chi drafod cynllun yr ail gynnig, bydd Leighton yn gofyn cwestiwn.

[191] **Leighton Andrews:** I just wanted to be clear on the figures. Was the first figure that you gave for the NHS referring to the NHS in Wales?

[191] **Leighton Andrews:** Yr oeddwn am fod yn glir am y ffigurau. A oedd y rhif cyntaf y bu i chi ei roi ar gyfer y GIG yn cyfeirio at y GIG yng Nghymru?

Mr Hill-Tout: Yes, that was for the NHS in Wales.

Mr Hill-Tout: Oedd, yr oedd hwnnw ar gyfer y GIG yng Nghymru.

[192] **Leighton Andrews:** Then the second figure was for the NHS in England plus the private sector. Can you disaggregate that?

[192] **Leighton Andrews:** Felly yr oedd yr ail ffigur ar gyfer y GIG yn Lloegr ynghyd â'r sector preifat. A allwch ddadgyfuno'r ffigur hwnnw?

Mr Hill-Tout: I cannot, I can let you have that on a separate occasion, but I do not have that disaggregation with me.

Mr Hill-Tout: Na allaf, gallaf roi hwnnw i chi rywbryd arall, ond nid oes gennyf y dadgyfuniad hwnnw gyda mi.

[193] **Janet Davies:** If we could have a note on that it would be helpful.

[193] **Janet Davies:** Byddai'n ddefnyddiol pe gallem gael nodyn ar hwnnw.

[194] **Alun Cairns:** I want to refer to the second offer scheme that is highlighted particularly on page 38 and in the box on that page that describes it. It also highlights that an extra £12 million is going in to pay for treatments under the scheme in 2004-05. Just before that, it also gives an explanation of what will happen thereafter, in terms of how funding will be resolved. It seems pretty bureaucratic to me. What estimates have you made of the costs of administrating it?

[194] **Alun Cairns:** Yr wyf am gyfeirio at gynllun yr ail gynnig sy'n cael sylw yn arbennig ar dudalen 38 a hefyd yn y blwch ar y dudalen honno sy'n ei ddisgrifio. Mae hefyd yn tynnu sylw at y ffaith bod £12 miliwn ychwanegol yn cael ei fuddsoddi i dalu am driniaethau dan y cynllun yn 2004-05. Cyn hynny, mae hefyd yn rhoi esboniad o'r hyn a fydd yn digwydd ar ôl hynny, o ran sut bydd y cyllid yn cael ei ddatrys. Mae'n ymddangos yn eithaf biwrocrataidd i mi. Pa amcangyfrifon a wnaethoch o'r costau o'i weinyddu?

Mr Hill-Tout: I do not have the exact figures with me, but we took the view that there would be considerable economies of scale if we could set up a second-offer commissioning team, which would operate on behalf of all 22 local health boards in Wales, and that suggesting that each LHB commissioned their second offers individually would not be cost-effective. The central commissioning team is provided, on behalf of the NHS in Wales, through

Mr Hill-Tout: Nid oes gennyf yr union ffigurau gyda mi, ond bu i ni benderfynu y byddai arbedion maint sylweddol pe gallem sefydlu tîm comisiynu'r ail gynnig, a fyddai'n gweithredu ar ran pob un o'r 22 bwrdd iechyd lleol yng Nghymru, ac na fyddai awgrymu bod pob BILl yn comisiynu ei ail gynigion yn unigol yn gost-effeithiol. Darperir y tîm comisiynu canolog, ar ran y GIG yng Nghymru, drwy Fwrdd Iechyd Lleol Rhondda Cynon Taf, ac mae'n costio tua

Rhondda Cynon Taf Local Health Board, and its running costs are approximately £350,000 to £400,000 a year, but I could give you the exact figures.

£350,000 i £400,000 y flwyddyn i'w gynnal, ond gallwn roi'r union ffigurau i chi.

[195] **Alun Cairns:** That is fine, thank you. Can you tell me how you would evaluate the impact of the second offer scheme so far?

[195] **Alun Cairns:** Mae hynny'n iawn, diolch. A allwch ddweud wrthyf sut byddech yn gwerthuso effaith cynllun yr ail gynnig hyd yn hyn?

Mr Hill-Tout: In two ways. First of all, the Welsh Assembly Government publishes waiting-time figures on a monthly basis and part of those publications specifically address patients who are the subjects of a second offer. So, our current target is to achieve a 12-month maximum or minimum target by the end of March. That information is then published and the publication demonstrates how many people have received care through the second offer scheme. One level of evaluation is whether we are going to achieve the target. We are on track to achieve it, so, in that sense, the second offer scheme is evaluated in terms of outcome. In terms of its efficiency, we have set up a central overseeing agency, which is chaired by the director, which will be called the second offer board. To ensure that we get value for money, when proposals come forward from the commissioning team as to how patients should be allocated their care—either in-house within the NHS in Wales, or in the independent or NHS sector in England—all those decisions are taken by that board so that we can compare and contrast, and ensure that we are getting good value for money.

Mr Hill-Tout: Mewn dwy ffordd. Yn gyntaf oll, mae Llywodraeth Cynulliad Cymru yn cyhoeddi ffigurau amseroedd aros yn fisol ac mae rhan o'r cyhoeddiadau hynny yn canolbwyntio'n benodol ar gleifion sy'n destun ail gynnig. Felly, ein targed cyfredol yw sicrhau targed uchafswm neu isafswm o 12 mis erbyn diwedd mis Mawrth. Yna caiff y wybodaeth honno ei chyhoeddi ac mae'r cyhoeddiad yn dangos faint o bobl sydd wedi derbyn gofal drwy gynllun yr ail gynnig. Un o lefelau'r gwerthuso yw a ydym yn mynd i gyrraedd y targed. Yr ydym ar y trywydd i'w gyrraedd, felly, ar yr ystyr hwnnw, caiff cynllun yr ail gynnig ei werthuso o ran canlyniadau. O ran ei effeithlonrwydd, yr ydym wedi sefydlu asiantaeth oruchwylio ganolog, a gaiff ei chadeirio gan y cyfarwyddwr, a fydd yn cael ei alw yn fwrdd yr ail gynnig. I sicrhau ein bod yn cael gwerth am arian, pan gyflwynir cynigion gan y tîm comisiynu ar sut dylid dyrannu eu gofal i gleifion—naill ai'n fewnol yn y GIG yng Nghymru, neu yn y sector annibynnol neu GIG yn Lloegr—gwneir yr holl benderfyniadau hynny gan y bwrdd fel y gallwn gymharu a gwrthgyferbynnu, a sicrhau ein bod yn cael gwerth da am arian.

[196] **Alun Cairns:** Paragraph 4.5 talks about the risks that are inherent within the second offer scheme. Is that a fair reflection, what are the main risks in your view, and what are you doing to manage them?

[196] **Alun Cairns:** Mae paragraff 4.5 yn sôn am y risgiau sy'n gynhenid yng nghynllun yr ail gynnig. A yw hwnnw'n adlewyrchiad teg, beth yw'r prif risgiau yn eich barn chi, a beth yr ydych yn ei wneud i'w rheoli?

Mr Hill-Tout: I think that it is a fair reflection. If we look back to the reason for the second offer scheme itself, it is designed to provide a facility for patients who are at risk of breaching the minimum targets set by the Government. It is not designed to provide a sustainable solution to waiting times; it is one part of that strategy. Therefore, to that extent, wherever the Minister sets the target, the second offer scheme will apply for those

Mr Hill-Tout: Credaf ei fod yn adlewyrchiad teg. Os edrychwn yn ôl at y rheswm dros gynllun yr ail gynnig ei hun, mae wedi ei ddylunio i roi cyfleuster i gleifion sydd mewn perygl o fethu'r targedau gofynnol a osodwyd gan y Llywodraeth. Nid yw wedi ei gynllunio i ddarparu ateb cynaliadwy i amseroedd aros; mae'n un rhan o'r strategaeth honno. Felly, i'r graddau hynny, ble bynnag y mae'r Gweinidog yn gosod y targed, bydd cynllun

patients, whether it is 18 months, 12 months, nine months, or whatever. There are risks, and those risks are around the fact that we would expect the NHS to budget adequately to pick up the costs of second offers. In other words, once the Government's pump-priming money is used, we say quite clearly that it is a matter for the NHS, through its baseline funding, to make decisions, on the part of local health boards and trusts together, as to how well it can treat patients so as to avoid second offers, because the purpose of this exercise is to ensure that people are treated locally. Therefore, second offers should be a last resort, not a first resort. There is a risk of financial pressure on the local NHS, but that is part of the principles of the second offer scheme, to drive efficiency and to ensure that the NHS can treat patients locally, rather than resort to this scheme. So that is a risk, but I think that it is a risk that we have to take, because it drives change.

yr ail gynnig yn berthnasol i'r cleifion hynny, boed yn 18 mis, 12 mis, naw mis, neu beth bynnag. Mae risgiau, ac mae'r risgiau hynny yn gysylltiedig â'r ffaith y byddem yn disgwyl i'r GIG gyllidebu'n ddigonol i dalu costau ail gynigion. Mewn geiriau eraill, unwaith y mae arian sefydlu y Llywodraeth wedi ei ddefnyddio, dywedwn yn eithaf clir mai mater i'r GIG, drwy ei gyllid llinell sylfaenol, yw gwneud penderfyniadau, ar ran byrddau iechyd lleol ac ymddiriedolaethau gyda'i gilydd, ynglŷn â pha mor dda y mae'n gallu trin cleifion er mwyn osgoi ail gynigion, oherwydd pwrpas yr ymarfer hwn yw sicrhau bod pobl yn cael eu trin yn lleol. Felly, dylai ail gynigion gael eu defnyddio pan aiff pethau i'r pen, ac nid ar y dechrau'n deg. Mae risg o bwysau ariannol ar y GIG lleol, ond mae hwnnw'n rhan o egwyddorion cynllun yr ail gynnig, i annog effeithlonrwydd a sicrhau y gall y GIG drin cleifion yn lleol, yn hytrach na throi at y cynllun hwn. Felly mae hynny'n risg, ond credaf fod honno'n risg y mae'n rhaid i ni ei chymryd, oherwydd mae'n ysgogi newid.

The second issue is the point that I would single out as an issue, which is the reluctance to travel. It is certainly the case—and when we get into it, Chair, I have some figures on this, and the report picks this up—that several patients say that they would prefer not to travel, and they give a variety of reasons for this. That would mean that those patients therefore need to be treated locally, so they add, effectively, to the total number of patients who must be treated locally. We have to manage that risk, and I think that we can do more. We have commissioned a MORI poll of 800 patients, who were asked their reasons as to why they refused a second offer. There were a range of reasons, but some of them included patients not being sure of what it means, and not necessarily being sure about what would happen to them and their relatives if they went to Bristol or Hereford. We can do much more, through the second offer commissioning team, to provide a more fulfilling experience for patients, giving them more information, helping them to understand, providing for patients' friends, and organising their travel and domestic arrangements to a greater extent than we do now. I am convinced that, if we can do more in that area, we can reduce that risk of those

Yr ail fater yw'r pwynt y byddwn yn ei ddewis fel problem, sef yr amharodrwydd i deithio. Mae'n sicr yn wir—a phan awn ati i'w drafod, Gadeirydd, mae gennyf ffigurau am hyn, ac mae'r adroddiad yn sôn am hyn—bod llawer o gleifion yn dweud y byddai'n well ganddynt beidio â theithio, a rhoddant amrywiaeth o resymau dros hyn. Byddai hynny'n golygu felly bod angen trin y cleifion hynny'n lleol, felly maent yn ychwanegu, i bob pwrpas, at gyfanswm y cleifion y mae'n rhaid eu trin yn lleol. Rhaid i ni reoli'r risg honno, a chredaf y gallwn wneud mwy. Yr ydym wedi comisiynu pôl MORI o 800 o gleifion, a gafodd eu holi am eu rhesymau dros wrthod ail gynnig. Yr oedd amrywiaeth o resymau, ond yr oedd rhai ohonynt yn cynnwys cleifion yn ansicr am beth y mae'n ei olygu, a ddim o reidrwydd yn siŵr beth fyddai'n digwydd iddynt a'u perthnasau pe baent yn mynd i Fryste neu Henffordd. Gallwn wneud llawer mwy, drwy'r tîm comisiynu ail gynnig, i ddarparu profiad llawer mwy boddhaus i gleifion, gan roi mwy o wybodaeth iddynt, eu helpu i ddeall, darparu ar gyfer ffrindiau cleifion, a threfnu eu trefniadau teithio a domestig i raddau helaethach nag y gwnawn ar hyn o bryd. Yr wyf yn argyhoeddedig, os gallwn

patients who decline their opportunity because they are unwilling to travel.

wneud mwy yn y maes hwnnw, y gallwn leihau'r risg honno o gleifion sy'n gwrthod eu cyfle oherwydd eu bod yn amharod i deithio.

[197] **Alun Cairns:** How would you address the risk that the second offer scheme might incentivise trusts to concentrate on in-patient day-case treatment, rather than, and maybe to the cost of, out-patient treatment?

[197] **Alun Cairns:** Sut byddech yn mynd i'r afael â'r risg y gallai cynllun yr ail gynnig gymell ymddiriedolaethau i ganolbwyntio ar driniaeth achosion dydd cleifion mewnol, yn hytrach na, ac efallai ar draul, triniaeth cleifion allanol?

Ms Lloyd: There is now a target that is much tighter on out-patient treatment as well, so they have to balance it out; it is going down to 12 months now. We are well aware of that risk, which is why the flow-through has to be maintained. I would put another risk down here that has not been picked up by the Auditor General, and that is the risk of paying twice under the second offer scheme, because, unless we audit carefully the long-term agreements between local health boards and trusts, then it might be that they are declaring a number of people that might breach, and therefore will come under the second offer, who should have been treated as part of the long-term agreement. So, we had to put in an audit trail on that as well to make sure that we are not paying twice.

Ms Lloyd: Mae targed bellach sy'n llawer mwy tynn ar driniaeth cleifion allanol hefyd, felly mae'n rhaid iddynt ei gydbwyso; mae'n lleihau i 12 mis yn awr. Yr ydym yn llwyr ymwybodol o'r risg honno, sef pam mae'n rhaid cynnal y llif drwodd. Byddwn yn ychwanegu risg arall yn y fan hon nad yw wedi ei chrybwyll gan yr Archwilydd Cyffredinol, a honno yw'r risg o dalu ddwywaith dan gynllun yr ail gynnig, oherwydd, oni bai ein bod yn archwilio'n ofalus y cytundebau hirdymor rhwng byrddau iechyd lleol ac ymddiriedolaethau, yna efallai eu bod yn datgan nifer o bobl a allai fethu targed, ac a fydd felly'n rhan o'r ail gynnig, a ddylai fod wedi eu trin fel rhan o'r cytundeb hirdymor. Felly, bu'n rhaid i ni roi trywydd archwilio ar waith mewn perthynas â hynny i sicrhau nad ydym yn talu ddwywaith.

[198] **Alun Cairns:** Finally, if I may, Cadeirydd, in the last week a constituent contacted me who, having needed to receive treatment under the second offer scheme, travelled to the Midlands and had the operation there. However, the consultant who performed the operation was the very same consultant who works in my constituent's district general hospital. I sought to test that, and it was all clarified when I went back to that person to confirm that that was the case. How could that have happened? Surely that is not very efficient use of public money, bearing in mind that we are paying for accommodation costs and everything else in another hospital in the Midlands, when the same consultant happens to work there.

[198] **Alun Cairns:** Yn olaf, os caf, Gadeirydd, yn yr wythnos diwethaf cysylltodd etholwr â mi a oedd, o ganlyniad i orfod cael triniaeth dan gynllun yr ail gynnig, wedi teithio i Ganolbarth Lloegr a chael y llawdriniaeth yno. Fodd bynnag, y meddyg ymgynghorol a gynhaliodd y llawdriniaeth oedd yr union feddyg ymgynghorol sy'n gweithio yn ysbyty cyffredinol ardal fy etholwr. Euthum ati i wirio hynny, a daeth popeth yn eglur pan euthum yn ôl at yr unigolyn hwnnw i gadarnhau mai dyna oedd yr achos. Sut gallai hynny fod wedi digwydd? Siawns nad yw'n ddefnydd effeithlon iawn o arian cyhoeddus, o gofio ein bod yn talu costau llety a phopeth arall mewn ysbyty arall yng Nghanolbarth Lloegr, pan fo'r un meddyg ymgynghorol yn digwydd gweithio yno?

Mr Hill-Tout: May I ask about one point on that matter? Where was the patient living? What was the local district general hospital

Mr Hill-Tout: A gaf fi ofyn am un pwynt ar y mater hwnnw? Ble'r oedd y claf yn byw? O ba ysbyty cyffredinol dosbarth lleol y cafodd

from which the patient was referred?

[199] **Alun Cairns:** The Princess of Wales.

Mr Hill-Tout: In Bridgend?

[200] **Alun Cairns:** Bearing in mind where the person lives, I would assume that it was the Princess of Wales.

Mr Hill-Tout: In Bridgend?

[201] **Alun Cairns:** Yes.

Mr Hill-Tout: And the patient was referred to a hospital in England, where the same consultant operated on the patient, presumably under contract to that hospital in England?

[202] **Alun Cairns:** Yes.

Mr Hill-Tout: That is the first time that I have been notified of any such instance, and I will certainly look into it. It is possible that those consultants who operate in their private time—which they are perfectly free to do—can be contracted to other hospitals. Was it a private hospital in England, or an NHS hospital?

[203] **Alun Cairns:** I do not have that detail.

Mr Hill-Tout: It is possible, but I would say to you, and Mrs Lloyd referred to this earlier, that the second offer scheme is based on our paying for care based on the tariff. So, we are ensuring that we get value for money in the payments that we make wherever the patient is treated. That hospital is obviously paying that consultant a fee to treat that patient, but what we are charged is a value-for-money tariff rate. I am certainly convinced that we are achieving that value for money now with that methodology. However I agree that it does not imply a particularly efficient system, if a consultant can go and work in England and do that.

[204] **Alun Cairns:** I know that I have

y claf ei gyfeirio?

[199] **Alun Cairns:** Ysbyty Tywysoges Cymru.

Mr Hill-Tout: Ym Mhen-y-bont ar Ogwr?

[200] **Alun Cairns:** Gan ystyried ble mae'r unigolyn yn byw, tybiwn mai Ysbyty Tywysoges Cymru ydoedd.

Mr Hill-Tout: Ym Mhen-y-bont ar Ogwr?

[201] **Alun Cairns:** Ie.

Mr Hill-Tout: A chafodd y claf ei gyfeirio i ysbyty yn Lloegr, lle bu'r un meddyg ymgynghorol yn rhoi llawdriniaeth i'r claf, dan gontract i'r ysbyty hwnnw yn Lloegr, mae'n debyg?

[202] **Alun Cairns:** Do.

Mr Hill-Tout: Dyna'r tro cyntaf i mi gael fy hysbysu am unrhyw achos o'r fath, a byddaf yn sicr yn ymchwilio iddo. Mae'n bosibl y gall y meddygon ymgynghorol hynny sy'n cynnal llawdriniaethau yn eu hamser preifat—sy'n rhywbeth y mae ganddynt berffaith hawl i'w wneud—gael eu contractio i ysbytai eraill. Ai ysbyty preifat ydoedd yn Lloegr, neu ysbyty'r GIG?

[203] **Alun Cairns:** Nid oes gennyf y wybodaeth honno.

Mr Hill-Tout: Mae'n bosibl, ond byddwn yn dweud wrthych, a chyfeiriodd Mrs Lloyd at hyn yn gynharach, bod cynllun yr ail gynnig yn seiliedig arnom yn talu am ofal ar sail y tariff. Felly, yr ydym yn sicrhau ein bod yn cael gwerth am arian yn y taliadau a wnawn ble bynnag y caiff claf ei drin. Mae'r ysbyty hwnnw'n amlwg yn talu ffi i'r meddyg ymgynghorol hwnnw am drin y claf hwnnw, ond yr hyn a godir arnom yw cyfradd dariff gwerth am arian. Yr wyf yn sicr yn argyhoeddedig ein bod bellach yn cael gwerth am arian gyda'r fethodoleg honno. Fodd bynnag cytunaf nad yw'n awgrymu system arbennig o effeithlon, os gall meddyg ymgynghorol fynd a gweithio yn Lloegr a gwneud hynny.

[204] **Alun Cairns:** Gwn fy mod eisoes wedi

already said ‘finally’, but I have one further question to ask, if I may, which links to this point. Bearing in mind that we are making use of under capacity or free capacity in England, where we are told that, for example, MRSA rates, among other infections, may be higher, what risk is there of a claim against NHS Wales for contracting to a hospital in England if a patient contracts MRSA because of the potentially higher risks there? We could have a paper on that, if that is of any help.

dweud ‘yn olaf’, ond mae gennyf un cwestiwn arall i’w ofyn, os caf, sy’n gysylltiedig â’r pwynt hwn. Gan gofio ein bod yn defnyddio gallu dros ben neu allu rhydd yn Lloegr, lle dywedir wrthym, er enghraifft, y gallai cyfraddau MRSA, ymhlith heintiau eraill, fod yn uwch, beth yw’r risg o hawliad yn erbyn GIG Cymru am gontractio i ysbyty yn Lloegr os yw claf yn cael MRSA oherwydd y risgiau uwch o bosibl a geir yno? Gallem gael papur am hynny, os yw hynny o unrhyw gymorth.

Ms Lloyd: They are our patients—

Ms Lloyd: Ein cleifion ni ydynt—

[205] **Alun Cairns:** That is the point that I was making.

[205] **Alun Cairns:** Dyna’r pwynt yr oeddwn yn ei wneud.

Ms Lloyd: They are our patients, and they will be covered by our risk pool, wherever they are treated.

Ms Lloyd: Ein cleifion ni ydynt, a byddant yn cael eu diogelu dan ein cronfa risg, ble bynnag y cânt eu trin.

[206] **Alun Cairns:** The point I am making is, does that pose an additional risk to NHS Wales, financially?

[206] **Alun Cairns:** Y pwynt yr wyf yn ceisio ei wneud yw, onid yw hynny’n rhoi risg ychwanegol i GIG Cymru, yn ariannol?

Mr Hill-Tout: Well, there could be a risk. If I can set it in context, before the second offer scheme was put into effect, the general flows of patients between England and Wales—and these are approximate figures—were that around 30,000 patients a year went from Wales to England, and about 15,000 to 18,000 came from England to Wales. The traffic, particularly in north Wales, between the two countries is constant and quite widespread. So, the issue that you raised about whether, on average, the MRSA rate is higher in England than in Wales—which is the case—you are right in the sense that there must be an increased risk, if there is a greater prevalence of MRSA in England. However, to convert that into any financial issue is almost impossible to do.

Mr Hill-Tout: Wel, mae hynny’n bosibl. Os caf roi hyn mewn cyd-destun, cyn i gynllun yr ail gynnig ddod i rym, y llif cyffredinol o gleifion rhwng Lloegr a Chymru—a ffigurau bras yw’r rhain—oedd bod tua 30,000 o gleifion y flwyddyn yn mynd o Gymru i Loegr, a bod tua 15,000 i 18,000 yn dod o Loegr i Gymru. Mae’r llif, yn enwedig yn y Gogledd, rhwng y ddwy wlad yn gyson ac yn eithaf cyffredin. Felly, mae’r mater y bu i chi ei godi ynglŷn ag a yw’r gyfradd MRSA, ar gyfartaledd, yn uwch yn Lloegr nag yng Nghymru—sy’n wir—yr ydych yn gywir ar yr ystyr bod yn rhaid i’r risg fod yn uwch, os yw MRSA yn fwy cyffredin yn Lloegr. Fodd bynnag, mae bron yn amhosibl troi hynny’n unrhyw fater ariannol.

Ms Lloyd: We are applying the same standards, wherever the patient is treated, and there are equivalent standards between England and Wales for quality of care, outcomes, infection rates and so on. Wherever a patient is treated in England, whether it is through a second offer or just at their normal treatment centre, there will be data available on the outcomes of care, irrespective of where the patient is managed.

Ms Lloyd: Yr ydym yn gweithredu’r un safonau, ble bynnag y caiff y claf ei drin, ac mae safonau cyfatebol rhwng Cymru a Lloegr ar gyfer ansawdd gofal, canlyniadau, cyfraddau heintio ac yn y blaen. Ble bynnag y caiff claf ei drin yn Lloegr, boed hynny drwy ail gynnig neu yn ei ganolfan driniaeth arferol, bydd data ar gael ar ganlyniadau gofal, waeth ble y rheolir y claf. Tan yn ddiweddar, dim ond un arolygiaeth oedd ar

Until recently, there was just one inspectorate for England and Wales. Even now, there is a common core set of standards between England and Wales for access to care and outcome.

gyfer Cymru a Lloegr. Hyd yn oed yn awr, mae cyfres o safonau craidd cyffredin rhwng Cymru a Lloegr ar gyfer mynediad i ofal a chanlyniadau.

[207] **Janet Davies:** We are approaching the end, but Mark has been waiting very patiently and has some questions to ask about commissioning. I think that we will be dodging between volume 2 and volume 1 on this one.

[207] **Janet Davies:** Yr ydym yn nesáu at y diwedd, ond mae Mark wedi bod yn aros yn amyneddgar iawn ac mae ganddo gwestiynau i'w holi am gomisiynu. Credaf y byddwn yn cyfeirio yn ôl a blaen rhwng cyfrol 2 a chyfrol 1 ar gyfer hyn.

[208] **Mark Isherwood:** I will just start by building on a comment by Mr Hill-Tout about the particular impact in north Wales of the cross-border traffic, and endorse that for many people in north Wales, particularly the north-east, there is only one health service. There are not separate English and Welsh services, because of critical mass, because of the historical service provision in Merseyside for intensive care for children, and so on. Therefore, it is about how we manage that in a cohesive way.

[208] **Mark Isherwood:** Dechreuaf drwy ychwanegu at sylw a wnaed gan Mr Hill-Tout am effaith benodol y llif trawsffiniol yn y Gogledd, a chadarnhau mai dim ond un gwasanaeth iechyd sydd yn nhyb llawer o bobl yn y Gogledd, yn enwedig y Gogledd-ddwyrain. Nid oes gwasanaethau ar wahân ar gyfer Cymru a Lloegr, oherwydd màs critigol, oherwydd y ddarpariaeth gwasanaeth hanesyddol yng Nglannau Merswy o ofal dwys i blant, ac ati. Felly, mae'n fater o sut yr ydym yn rheoli hynny mewn modd cydlynus.

Moving back to volume 1, figure 16, we see that there are substantial variations in waiting times per head of population between the different local health boards. Also, on page 30 of volume 1, reference is made to the Townsend review of needs-based resource allocation. There is an interesting observation there, that one of the best performers is the Flintshire Local Health Board, although I understand that it will be a net winner under the Townsend formula. Conwy is still a good performer, but I understand that it will be a net loser, despite Conwy and Denbighshire having the highest percentage of older people in Wales, which will obviously result in a more profound cost in the future. Therefore, there are issues there. However, the key point is that volume 2, paragraph 4.46 indicates that long waiting times can also result from inadequate commissioning, particularly by local health boards.

Gan droi'n ôl at gyfrol 1, ffigur 16, gwelwn fod amrywiadau sylweddol mewn amseroedd aros y pen rhwng y byrddau iechyd lleol gwahanol. Hefyd, ar dudalen 30 cyfrol 1, cyfeirir at adolygiad Townsend o ddyrannu adnoddau ar sail anghenion. Mae arsylw diddorol yn y fan honno, sef mai Bwrdd Iechyd Lleol Sir y Fflint yw un o'r perfformwyr gorau, er caf ar ddeall y bydd ar ei ennill dan fformiwla Townsend. Mae Conwy yn dal i berfformio'n dda, ond deallaf y bydd ar ei golled, er gwaethaf y ffaith mai Siroedd Conwy a Dinbych sydd â'r ganran uchaf o bobl hŷn yng Nghymru, a fydd yn amlwg yn arwain at gost fwy difrifol yn y dyfodol. Felly, mae materion yn y fan honno. Fodd bynnag, y pwynt allweddol yw bod cyfrol 2, paragraff 4.46 yn nodi y gall amseroedd aros hir hefyd ddeillio o gomisiynu annigonol, yn enwedig gan fyrddau iechyd lleol.

Local health boards are new bodies with many challenges, so it is not easy for them. However, are they minimising waiting times in the most effective way, or is there evidence that they are maintaining and funding local providers—whomsoever they

Cyrff newydd sy'n wynebu llawer o heriau yw byrddau iechyd lleol, felly nid yw'n hawdd iddynt. Fodd bynnag, a ydynt yn lleihau amseroedd aros yn y modd mwyaf effeithiol, neu a oes tystiolaeth eu bod yn cynnal ac yn ariannu darparwyr lleol—pwy

may be—even where their performance is poor?

bynnag ydynt—hyd yn oed os ydynt yn perfformio'n wael?

Ms Lloyd: I think that we are dealing with the latter at present. I think that there is still a lot of what I would describe as block contracting, rather than commissioning, happening in Wales. However, I think that we will see two important changes over the next 18 months. The effective commissioning of care by local health boards has been made a real priority and we are providing them with additional training to ensure that they can do that.

Ms Lloyd: Credaf ein bod yn ymdrin â'r olaf ar hyn o bryd. Credaf fod llawer o'r hyn y byddwn i'n ei ddisgrifio fel contractio bloc, yn hytrach na chomisiynu, yn digwydd yng Nghymru o hyd. Fodd bynnag, credaf y byddwn yn gweld dau newid pwysig dros y 18 mis nesaf. Gwnaed comisiynu gofal yn effeithiol gan fyrddau iechyd lleol yn flaenoriaeth wirioneddol ac yr ydym yn rhoi hyfforddiant ychwanegol iddynt i sicrhau y gallant wneud hynny.

Over the past year, the National Public Health Service has been developing the needs assessment for each local health board. Obviously, without that, you cannot even start to commission effectively. Yesterday, I met the director of the National Public Health Service, whom I see on a regular basis. In addition to the needs assessment, I have now asked her to ensure that the work on clinical epidemiology is also progressed, to establish what treatments are effective, what treatments should be developed in each area, and how to better commission on the basis of the evidence of clinical epidemiology and research. Therefore, that is her top priority for this year. She has done the needs assessment; now this needs to be done.

Dros y flwyddyn ddiwethaf, mae'r Gwasanaeth Iechyd Cyhoeddus Cenedlaethol wedi bod yn datblygu asesiad o anghenion ar gyfer pob bwrdd iechyd lleol. Yn amlwg, heb hwnnw, ni allwch hyd yn oed ddechrau comisiynu yn effeithiol. Ddoe, bu i mi gyfarfod â chyfarwyddwraig y Gwasanaeth Iechyd Cyhoeddus Cenedlaethol, yr wyf yn ei gweld yn rheolaidd. Yn ogystal ag asesu anghenion, yr wyf bellach wedi gofyn iddi sicrhau bod y gwaith ar epidemioleg glinigol yn cael ei ddatblygu, i bennu pa driniaethau sy'n effeithiol, pa driniaethau y dylid eu datblygu ym mhob ardal, a sut i gomisiynu'n well ar sail tystiolaeth o epidemioleg glinigol ac ymchwil. Felly, dyna yw ei phrif flaenoriaeth ar gyfer eleni. Mae wedi gwneud yr asesu anghenion; yn awr mae angen gwneud hyn.

The national leadership and innovation agency will undertake the additional training and development of the local health board executive directors to ensure that they can use this information well. Currently, I think that it is very much a case of—'well, we have always given them 'x' amount of money, and we get 'y' amount of service, and we will do it like that'. They must become much better at commissioning effectively to meet the needs of the population.

Bydd yr asiantaeth arwain ac arloesi genedlaethol yn ymgymryd â'r gwaith o roi hyfforddiant a datblygiad ychwanegol i gyfarwyddwyr gweithredol y byrddau iechyd lleol i sicrhau y gallant ddefnyddio'r wybodaeth hon yn dda. Ar hyn o bryd, credaf fod hwn, i raddau helaeth, yn achos o—'wel, yr ydym bob amser wedi rhoi 'x' o arian iddynt, a chawn 'y' o wasanaeth, a dyna sut y byddwn yn ei wneud'. Rhaid iddynt allu comisiynu'n effeithiol yn llawer gwell i ddiwallu anghenion y boblogaeth.

Although Conwy and Denbighshire are not major winners under Townsend, there are major areas, as you know, of real deprivation that need to be tackled within communities, even when, overall, they look as if they will be finely balanced in terms of equality of access to care and good health outcomes. The

Er nad yw Siroedd Conwy a Dinbych yn cael budd mawr dan Townsend, mae ardaloedd mawr, fel y gwyddoch, o amddifadedd gwirioneddol y mae angen mynd i'r afael â hwy mewn cymunedau, hyd yn oed pan eu bod, ar y cyfan, yn ymddangos y byddant yn eithaf cytbwys o ran cydraddoldeb mynediad

local health boards need to become much more sophisticated about looking at the solutions to ill health in these pockets of deprivation within communities, and establishing alternative models of care to manage the requirements of those communities.

i ofal a chanlyniadau iechyd da. Mae angen i'r byrddau iechyd lleol ddod yn llawer mwy soffistigedig ynghylch edrych am yr atebion i afiechyd yn yr ardaloedd hyn o amddifadedd mewn cymunedau, a sefydlu modelau gofal amgen i reoli gofynion y cymunedau hynny.

So this is a major issue for the NHS in Wales at the moment. We have resourced it now in terms of expertise and skills to be able to take better commissioning decisions and also to look at the sorts of demands that are coming from the local population and how to manage them better, and find what the real priorities are.

Felly mae hwn yn fater pwysig i'r GIG yng Nghymru ar hyn o bryd. Yr ydym wedi darparu adnoddau iddo yn awr o ran arbenigedd a sgiliau i allu gwneud penderfyniadau comisiynu gwell a hefyd i edrych ar y math o alw a ddaw gan y boblogaeth leol a sut i'w reoli'n well, a chanfod beth yw'r gwir flaenoriaethau.

[209] **Mark Isherwood:** Is there a geographical factor at work here, because I know, having visited health boards in north Wales, that they normally talk about commissioning from only one or two trusts, for example. However, in Flintshire, because they are dealing with the Countess of Chester Hospital, Wrexham Maelor Hospital and Glan Clwyd Hospital, they are thinking about three commissioners immediately and considering the patients' needs first. So, is that not to an extent driven by geography?

[209] **Mark Isherwood:** A oes ffactor daearyddol ar waith yma, oherwydd gwn, o ymweld â byrddau iechyd yn y Gogledd, eu bod fel arfer yn sôn am gomisiynu o un neu ddwy ymddiriedolaeth yn unig, er enghraifft. Fodd bynnag, yn Sir y Fflint, oherwydd eu bod yn ymdrin ag Ysbyty Iarlles Caer, Ysbyty Maelor Wrecsam ac Ysbyty Glan Clwyd, maent yn meddwl am dri chomisiynydd ar unwaith ac yn ystyried anghenion y cleifion yn gyntaf. Felly, onid daearyddiaeth sydd wrth wraidd hynny i raddau?

Ms Lloyd: I think that it is driven by history more than geography. These traditional relationships have been established and have not broken yet. I think that there has to be a much more balanced discussion between the providers of care and those who commission about what, given the needs of that population, is really required that providers must aim to deliver. So, I think that it is the historical links between the organisations that are holding sway at the moment.

Ms Lloyd: Credaf mai hanes sydd wrth wraidd hynny yn fwy na daearyddiaeth. Mae'r cysylltiadau traddodiadol hyn wedi eu sefydlu ac nid ydynt wedi torri hyd yn hyn. Credaf fod angen trafodaeth lawer mwy cytbwys rhwng darparwyr gofal a'r rheini sy'n comisiynu ynglŷn ag, o ystyried anghenion y boblogaeth honno, yr hyn y mae ei angen mewn gwirionedd ac y mae'n rhaid i ddarparwyr anelu at ei gyflenwi. Felly, credaf mai'r cysylltiadau hanesyddol rhwng y sefydliadau sydd â'r dylanwad mwyaf ar hyn o bryd.

[210] **Mark Isherwood:** Has the creation of 23 commissioning bodies confused accountability?

[210] **Mark Isherwood:** A yw creu 23 o gyrff comisiynu wedi drysu atebolrwydd?

Ms Lloyd: I do not think so. No, not at all. I think that they have to share their skills and expertise better than they have up to now.

Ms Lloyd: Ni chredaf hynny. Na, ddim o gwbl. Credaf fod yn rhaid iddynt rannu eu sgiliau a'u harbenigedd yn well nag y gwnaethant hyd yma.

[211] **Mark Isherwood:** Right. Do you see

[211] **Mark Isherwood:** Iawn. A ydych yn

different patterns of regional working, whereby the boards and trusts work together better in some areas than in others?

gweld patrymau gwahanol o weithio rhanbarthol, lle mae rhai byrddau ac ymddiriedolaethau'n gweithio gyda'i gilydd yn well mewn rhai ardaloedd nag eraill?

Ms Lloyd: Yes, and, certainly, that again will be a matter of history. It is obvious from looking at secondary care services, and accreditation of services, that there must be much better joint-working in future, because we will have to work more in networks to ensure that a high-quality service is available to all.

Ms Lloyd: Ydym, ac, yn bendant, mater o hanes fydd hwnnw eto. Mae'n amlwg o edrych ar wasanaethau gofal eilaidd, ac achrediad gwasanaethau, bod yn rhaid cael gweithio ar y cyd llawer gwell yn y dyfodol, oherwydd bydd angen i ni weithio mwy mewn rhwydweithiau i sicrhau bod gwasanaeth ansawdd uchel ar gael i bawb.

[212] **Mark Isherwood:** Right. I wish to move on to specific cross-border issues and the challenges facing commissioners who face different waiting-time targets in England. This can lead to cost pressures where English hospitals are trying to treat Welsh patients according to English targets. It can also lead to differential performance, and even indirect discrimination, where English hospitals are treating Welsh patients according to Welsh targets while treating English patients according to English targets. What are the Assembly Government and the Department of Health doing to manage these risks created by cross-border differences in targets? I think that I know the answer to the second bit, but would you consider it reasonable that Welsh patients treated in English hospitals should face longer waits than English patients?

[212] **Mark Isherwood:** Iawn. Yr wyf am symud ymlaen at faterion trawsffiniol penodol a'r heriau sy'n wynebu comisiynwyr sy'n wynebu targedau amseroedd aros gwahanol yn Lloegr. Gall hyn arwain at bwysau costau lle mae ysbytai Lloegr yn ceisio trin cleifion o Gymru yn unol â thargedau Lloegr. Gall hefyd arwain at berfformiad gwahaniaethol, a hyd yn oed gwahaniaethu anuniongyrchol, lle mae ysbytai Lloegr yn trin cleifion o Gymru yn unol â thargedau Cymru tra'n trin cleifion o Loegr yn unol â thargedau Lloegr. Beth mae Llywodraeth y Cynulliad a'r Adran Iechyd yn ei wneud i reoli'r risgiau hyn a grëir gan wahaniaethu trawsffiniol mewn targedau? Credaf fy mod yn gwybod yr ateb i'r ail ran, ond a fyddech yn ei ystyried yn rhesymol y dylai cleifion o Gymru a gaiff eu trin yn ysbytai Lloegr orfod aros yn hwy na chleifion o Loegr?

Mr Hill-Tout: I think that the issue about whether it is reasonable or not is really a matter for the Government, because it sets the targets. On what can be done to mitigate the effect on the patient, a number of things are being done. First, it is open to the local health boards in Wales to commission from whom they choose, and we just talked about commissioning. Clearly, they must make decisions about how best to secure care for their patients and whether to secure it from a Welsh or an English hospital. They know the framework in which they are operating. What we have recognised is that disputes arise frequently as a consequence of this. So, I have met colleagues from the Department of Health over the last nine months, with the agreement of the Minister and the Minister in London, to set out a procedure document, if

Mr Hill-Tout: Credaf mai mater i'r Llywodraeth mewn gwirionedd yw a yw'n rhesymol ai peidio, oherwydd y Llywodraeth sy'n gosod y targedau. O ran beth y gellir ei wneud i liniaru'r effaith ar y claf, mae nifer o bethau yn cael eu gwneud. Yn gyntaf, mae hawl gan y byrddau iechyd lleol yng Nghymru i gomisiynu gan bwy bynnag y dewisant, ac yr ydym newydd drafod comisiynu. Yn amlwg, rhaid iddynt wneud penderfyniadau ar y ffordd orau o sicrhau gofal i'w cleifion ac a ddylid cael y gofal o ysbyty yng Nghymru neu yn Lloegr. Maent yn adnabod y fframwaith y maent yn gweithredu ynddo. Yr hyn yr ydym wedi ei nodi yw bod anghydfod yn codi'n aml yn sgil hyn. Felly, yr wyf wedi cyfarfod â chydweithwyr o'r Adran Iechyd dros y naw mis diwethaf, gyda chydsyniad y Gweinidog

you like, which clarifies for commissioners on both sides of the border, how they should handle disputes. We have given guidance—in fact, it was issued as a Welsh health circular this month—to the service on both sides of the border and we have also set up a procedure whereby, if there is a difficulty and if any patient is at the heart of a difficulty, that the patient's care must come first. So, the patient must be treated, and then, if there is an issue about the cost, who bears the cost or the length of the waiting time, there is a disputes procedure that is effective, which goes up through the local health board and the primary care trust on the other side of the border up to the regional office level in Wales and the strategic health authority level in England, and, if necessary, but only in a very small number of cases, that dispute will be addressed at governmental level. We have agreed that procedure, over the last six or nine months, with our colleagues in London and it has been issued to the NHS on both sides of the border. So, my answer is that we know that there are different waiting times—that is a matter for the Governments—but, in terms of managing that, I think that the guidance that we have issued, including the disputes procedure, will allow patient care to be properly protected.

a'r Gweinidog yn Llundain, i greu dogfen weithdrefnau, os hoffwch, sy'n egluro i gomisiynwyr y naill ochr i'r ffin, sut y dylent ymdrin ag anghydfod. Yr ydym wedi rhoi canllawiau—a dweud y gwir, cawsant eu cyhoeddi fel cylchlythyr iechyd Cymru y mis hwn—i'r gwasanaeth ar ddwy ochr y ffin ac yr ydym hefyd wedi sefydlu gweithdrefn, sef os oes anhawster ac os yw unrhyw glaf yng nghanol anhawster, bod yn rhaid i ofal y claf gael blaenoriaeth. Felly, rhaid i'r claf gael ei drin, ac yna, os oes problem ynglŷn â'r gost, pwy sy'n talu'r gost neu hyd yr amser aros, mae gweithdrefn anghydfod effeithiol, sy'n gweithio i fyny'r bwrdd iechyd lleol a'r ymddiriedolaeth gofal sylfaenol ar ochr draw'r ffin hyd at lefel swyddfa ranbarthol yng Nghymru a lefel yr awdurdod iechyd strategol yn Lloegr, ac, os oes angen, ond dim ond mewn nifer fach iawn o achosion, bydd yr anghydfod hwnnw'n cael ei ddatrys ar lefel llywodraeth. Yr ydym wedi cytuno ar y weithdrefn honno, dros y chwech i naw mis diwethaf, gyda'n cydweithwyr yn Llundain ac mae wedi ei chyhoeddi i'r GIG ar ddwy ochr y ffin. Felly, fy ateb yw ein bod yn gwybod bod amseroedd aros gwahanol—mae hynny'n fater i'r Llywodraethau—ond, o ran rheoli hynny, credaf y bydd y canllawiau a gyhoeddwyd gennym, gan gynnwys y weithdrefn anghydfod, yn caniatáu i ofal cleifion gael ei ddiogelu'n briodol.

[213] **Mark Isherwood:** One of my constituents who came to see me recently has been seeing the same consultant for 15 years in Gobowen hospital. She is now on four 18-month waiting lists in Gobowen, but does not want to go somewhere else because that consultant is her consultant. That is the human side. How can we provide a service for that person, take away the pain, and remove the possible need for home care because that person can no longer sustain themselves?

[213] **Mark Isherwood:** Mae un o'm hetholwyr a ddaeth i'm gweld yn ddiweddar wedi bod yn gweld yr un meddyg ymgynghorol am 15 mlynedd yn ysbyty Gobowen. Mae bellach ar bedair rhestr aros 18 mis yng Ngobowen, ond nid yw am fynd i rywle arall oherwydd y meddyg ymgynghorol hwnnw yw ei meddyg ymgynghorol hi. Dyna'r ochr ddynol. Sut gallwn ddarparu gwasanaeth ar gyfer yr unigolyn hwnnw, gwaredu'r boen, a dileu'r angen posibl am ofal cartref oherwydd na all yr unigolyn hwnnw gynnal ei hun mwyach?

On the knock-on effect, particularly in terms of cross-border commissioning, I know that the North East Wales NHS Trust, for example, is increasingly seeing itself in a competitive environment because of commissioning. It is working with the local higher education college to put forward its proposals to enable it to compete effectively

Ynglŷn â'r effaith ganlyniadol, yn enwedig o ran comisiynu trawsffiniol, gwn fod Ymddiriedolaeth GIG Gogledd Ddwyrain Cymru, er enghraifft, yn ystyried ei hun fwyfwy mewn amgylchedd cystadleuol oherwydd comisiynu. Mae'n gweithio gyda'r coleg addysg uwch lleol i gyflwyno ei chynigion i'w galluogi i gystadlu'n fwy

with the targets in England. Would you endorse such initiatives, and how can we take that forward on a bottom-up model, where we are using the expertise that is available on the ground?

effeithiol â'r targedau yn Lloegr. A fyddech yn cefnogi mentrau o'r fath, a sut gallwn ddatblygu hynny ar fodel o'r gwaelod i fyny, lle yr ydym yn defnyddio'r arbenigedd sydd ar gael ar lawr gwlad?

Mr Hill-Tout: I think that we would endorse that. I think that you were right when you said in your opening remarks that, in north Wales, the health community straddles the border, therefore those trusts are operating in a complex environment. We are saying to them, 'If you are a trust in north Wales, the targets that you must offer are the Welsh waiting times, so you cannot be subjected to any approach by an English commissioner that says that you must offer an English waiting time'. The Welsh trusts must offer Welsh waiting times. However, I recognise that there are areas in which Welsh trusts can, and do, compete well. I do not have the figures with me, but there is some evidence to suggest that the number of emergency referrals to hospitals in north Wales is increasing. It could well be that as English trusts experience pressure to hit their waiting-time targets, there will be a movement of emergency patients into Welsh hospitals. If that is sustained, that will be an opportunity for the Welsh trusts to say, 'You are sending us more of your emergency referrals, so you need to pay us for those referrals because that activity is going up'. It is a complex environment, and we would certainly encourage the Welsh trusts on the border to operate within that environment. We are saying to them that they are not compelled to offer anything other than Welsh waiting times.

Mr Hill-Tout: Credaf y byddem yn cefnogi hynny. Credaf eich bod yn llygad eich lle pan ddywedasoch yn eich sylwadau agoriadol fod y gymuned iechyd, yn y Gogledd, ar y naill ochr a'r llall i'r ffin, felly mae'r ymddiriedolaethau hynny yn gweithredu mewn amgylchedd cymhleth. Yr ydym yn dweud wrthynt, 'Os ydych yn ymddiriedolaeth yn y Gogledd, amseroedd aros Cymru yw'r targedau y mae'n rhaid i chi eu cynnig, fel na all comisiynydd o Loegr ddod atoch gan ddweud bod yn rhaid i chi gynnig amser aros Lloegr'. Rhaid i ymddiriedolaethau Cymru gynnig amseroedd aros Cymru. Fodd bynnag, yr wyf yn cydnabod bod meysydd lle mae ymddiriedolaethau Cymru yn gallu, ac yn, cystadlu'n dda. Nid yw'r ffigurau gyda fi, ond mae peth tystiolaeth i awgrymu bod nifer y cyfeiriadau brys i ysbytai yn y Gogledd yn cynyddu. Mae'n dra phosibl, wrth i ymddiriedolaethau Lloegr ddod o dan bwysau i gyflawni eu targedau amser aros, y bydd llif o gleifion brys i ysbytai Cymru. Os caiff hwnnw ei gynnal, bydd hynny'n gyfle i ymddiriedolaethau Cymru ddweud, 'Yr ydych yn anfon mwy o'ch cyfeiriadau brys atom, felly mae angen i chi ein talu am y cyfeiriadau hynny oherwydd mae'r gweithgarwch hwnnw ar gynnydd'. Mae'n amgylchedd cymhleth, a byddem yn sicr yn annog ymddiriedolaethau Cymru ar y ffin i weithredu yn yr amgylchedd hwnnw. Yr ydym yn dweud wrthynt nad oes gorfodaeth arnynt i gynnig unrhyw beth heblaw amseroedd aros Cymru.

[214] **Mark Isherwood:** I think that they appreciate that they are not being compelled in that regard. Nonetheless, they do not want to be prevented by the policy on differential waiting times in Wales from providing a service that will allow their commissioners to send patients to them on a long-term basis, rather than seeing a growing haemorrhage across the border. I will leave that with you.

[214] **Mark Isherwood:** Credaf eu bod yn gwerthfawrogi nad ydynt yn cael eu gorfodi yn hynny o beth. Serch hynny, nid ydynt am gael eu rhwystro gan y polisi ar amseroedd aros gwahaniaethol yng Nghymru rhag darparu gwasanaeth a fydd yn galluogi eu comisiynwyr i anfon cleifion atynt ar sail hirdymor, yn hytrach na gweld colled gynyddol dros y ffin. Gadawaf hynny gyda chi.

Finally, I think that you mentioned briefly the

Yn olaf, credaf i chi sôn yn fyr am y system

new tariff system that is operating in England and the impact that that might have on commissioners in Wales. What do you believe will be the financial implications of that tariff system for commissioners in Wales using English services?

dariff newydd sydd ar waith yn Lloegr a'r effaith y gallai honno ei chael ar gomisiynwyr yng Nghymru. Beth yn eich barn chi fydd goblygiadau ariannol y system dariff honno i gomisiynwyr yng Nghymru sy'n defnyddio gwasanaethau yn Lloegr?

Mr Hill-Tout: I referred earlier to the ongoing discussion that we are having with officials from the Department of Health, and although it covers waiting times and cross-border responsibility, it also covers differences in the financial regime. At the moment, as you know, there is a tariff in England, but not in Wales—there may be one in the future, but that is a matter for ministerial agreement. What we have said to England, and secured, is that there must be protection and a neutral position for Welsh commissioners who are commissioning work from England. It would be unfair if there was an impact on Welsh commissioners as a consequence of a tariff being issued in England. That must be neutralised, and the Department of Health has said that it recognises that and will fulfil that request.

Mr Hill-Tout: Cyfeiriais yn gynharach at y drafodaeth yr ydym yn ei chael â swyddogion o'r Adran Iechyd sy'n dal i fynd rhagddi, ac er ei bod yn cwmpasu amseroedd aros a chyfrifoldeb trawsffiniol, mae hefyd yn cwmpasu gwahaniaethau yn y drefn ariannol. Ar hyn o bryd, fel y gwyddoch, mae tariff yn Lloegr, ond nid yng Nghymru—efallai y bydd un yn y dyfodol, ond mae hwnnw'n fater i Weinidogion gytuno arno. Yr hyn yr ydym wedi ei ddweud wrth Loegr, ac wedi sicrhau, yw bod yn rhaid bod amddiffyniad a sefyllfa niwtral ar gyfer comisiynwyr o Gymru sy'n comisiynu gwaith gan Loegr. Byddai'n annheg pe bai effaith ar gomisiynwyr Cymru o ganlyniad i gyflwyno tariff yn Lloegr. Rhaid dirymu hynny, ac mae'r Adran Iechyd wedi dweud ei bod yn cydnabod hynny ac y bydd yn cyflawni'r cais hwnnw.

Ms Lloyd: One of the problems that has been found with the exercise of the tariff by the new foundation trust—as it was allowed to go first—was that where it was, say, 90 per cent of tariff, the commissioners had to pay 100 per cent. So, it gained that 10 per cent to underpin its balance sheet. That could be destabilising, which is why we have asked for there to be a neutral effect in Wales. We are tracking the use of the tariff very carefully in England at the moment to see its net effects across the community, before we provide any advice to Ministers.

Ms Lloyd: Un o'r problemau a ganfuwyd pan weithredwyd y tariff gan yr ymddiriedolaeth sefydledig newydd—gan iddi gael mynd yn gyntaf—oedd lle yr oedd yn 90 y cant o dariff, dywedwch, yr oedd yn rhaid i'r comisiynwyr dalu 100 y cant. Felly, yr oedd yn ennill y 10 y cant hwnnw ar gyfer ei mantolen. Gallai hynny greu ansefydlogrwydd, sef y rheswm pam yr ydym wedi gofyn am effaith niwtral yng Nghymru. Yr ydym yn cadw llygad barcud ar y defnydd o'r tariff yn Lloegr ar hyn o bryd i weld ei effeithiau net ledled y gymuned, cyn i ni roi unrhyw gyngor i Weinidogion.

[215] **Mark Isherwood:** On that note, I will pass you back to the Chair for the final question.

[215] **Mark Isherwood:** Ar y nodyn hwnnw, hoffwn eich trosglwyddo yn ôl at y Cadeirydd am y cwestiwn olaf.

[216] **Janet Davies:** Not quite the final question. Mick, you wanted to come in on this.

[216] **Janet Davies:** Nid y cwestiwn olaf un. Mick, yr oeddech am gyfrannu mewn perthynas â hyn?

[217] **Mick Bates:** I refer you to volume 1, appendix 6. Mark raised some interesting points. I refer you to page 71, which shows the figures for the Powys Local Health

[217] **Mick Bates:** Cyfeiriaf at gyfrol 1, atodiad 6. Cododd Mark bwyntiau diddorol. Cyfeiriaf at dudalen 71, sy'n dangos y ffigurau ar gyfer Bwrdd Iechyd Lleol Powys,

Board, from which two questions arise. First, you have here an innovative solution. There is no trust, just the local health board, and it takes all the secondary care and the commissioning in Powys. It has achieved a great result, with no-one waiting over 18 months for in-patient care and only five waiting for out-patient care. Is it not unnecessary to retain this double structure of trusts and health boards? [*Interruption*.] The evidence is in this report—they are the most effective people of all at reducing waiting times.

sef testun y ddau gwestiwn. Yn gyntaf, mae gennych yn y fan hon ateb arloesol. Nid oes ymddiriedolaeth, dim ond y bwrdd iechyd lleol, ac ef sy'n gyfrifol am yr holl ofal eilaidd a'r comisiynu ym Mhowys. Mae wedi cyflawni canlyniad gwych, gyda neb yn aros dros 18 mis am ofal cleifion mewnol a dim ond pump yn aros am ofal cleifion allanol. Onid yw'n ddiangen cadw'r strwythur dwbl hwn o ymddiriedolaethau a byrddau iechyd? [*Torri ar draws*.] Mae'r dystiolaeth yn yr adroddiad hwn—hwy yw'r bobl fwyaf effeithiol wrth leihau amseroedd aros.

The second point relates to the cross-border situation and competition. The differential and the competitive element has, I believe, been the major contributing factor in our getting to this position in Powys. The reason for that is that good data have been collected. Are you convinced that all these other trusts and health boards have robust data to allow them to resolve the waiting-time problem?

Mae'r ail bwynt yn ymwneud â'r sefyllfa a'r gystadleuaeth drawsffiniol. Mae'r elfen wahaniaethol a chystadleuol, yn fy marn i, wedi bod yn ffactor cyfrannol pwysig i sicrhau ein bod yn y sefyllfa hon ym Mhowys. Y rheswm am hynny yw bod data da wedi ei gasglu. A ydych yn argyhoeddedig bod gan yr holl ymddiriedolaethau a byrddau iechyd eraill hyn ddata cadarn i'w galluogi i ddatrys y broblem amser aros?

Ms Lloyd: First, on whether or not we should restructure, we have finished the first part of the evaluation of the effectiveness of Powys. There are a number of targets and methods of working that it has to achieve. We have done the first part, which will inform the announcement that the Minister made about whether or not there are other combinations between local health boards and trusts, or parts of trusts, which might benefit patient care. The guidance on this will be issued shortly. So, the jury is out on that matter.

Ms Lloyd: Yn gyntaf, ynglŷn ag a ddylem ailstrwythuro ai peidio, yr ydym wedi cwblhau'r rhan gyntaf o'r gwerthusiad o effeithiolrwydd Powys. Mae nifer o dargedau a dulliau gweithio y mae'n rhaid iddo eu cyflawni. Yr ydym wedi gwneud y rhan gyntaf, a fydd yn hysbysu'r cyhoeddiad a wnaeth y Gweinidog ynglŷn ag a oes cyfuniadau eraill ai peidio rhwng byrddau iechyd lleol ac ymddiriedolaethau, neu rannau o ymddiriedolaethau, a allai fod o fudd i ofal cleifion. Bydd y canllawiau ar hyn yn cael eu cyhoeddi'n fuan. Felly, mae'r mater hwnnw yn destun trafod o hyd.

[218] **Mick Bates:** It is there, is it not?

[218] **Mick Bates:** Mae yno, onid ydyw?

Ms Lloyd: This is only one part of a very complex situation in Powys; it is also a complex organisation. I look forward to reading its management letter, which will cover a few more bases than just the waiting times. Although, this is a very good performance. I have forgotten the rest of your question.

Ms Lloyd: Dim ond un rhan yw hon o sefyllfa gymhleth iawn ym Mhowys; mae hefyd yn sefydliad cymhleth. Edrychaf ymlaen at ddarllen ei lythyr rheoli, a fydd yn cwmpasu rhagor o elfennau yn hytrach nag amseroedd aros yn unig. Er, mae hwn yn berfformiad da iawn. Yr wyf wedi anghofio gweddill eich cwestiwn.

[219] **Mick Bates:** It was about whether the reason for this is that Powys has collected robust data.

[219] **Mick Bates:** Yr oedd ynglŷn ag ai'r ffaith bod Powys wedi casglu data cadarn yw'r rheswm dros hyn.

Ms Lloyd: It has good data.

[220] **Mick Bates:** This has come about only by battling with English hospitals.

Ms Lloyd: Yes.

[221] **Mick Bates:** That is why it was able to delve into every case. Do the other trusts and health boards have the same quality of data, which I believe would enable them to get to the Powys position?

Ms Lloyd: The type of information that is available to the others is the same. What might vary is the way in which they use it.

[222] **Mick Bates:** Right.

Ms Lloyd: That is why we are performance managing them.

[223] **Mick Bates:** I would like to hear more about the use of these data by the other trusts and health boards, if possible.

Ms Lloyd: I will ask the regional directors for a note on that.

[224] **Jocelyn Davies:** In answer to a question from Mark Isherwood, Mrs Lloyd, you said that you felt that the local health boards are accountable—you were very definite about that. I know that Leighton also raised this earlier. How is the local health board accountable to the public?

Ms Lloyd: It has quite an extended board in terms of its representation, which is one way in which it extends its representation. Also, it has to meet in public, it has to disclose its strategies and its commissioning proposals to the public and discuss them with it, it has to have in place a system of public involvement to gather evidence from the general public, informed by health needs, and—in looking at the workings of local health boards as opposed to those of previous commissioners—possibly there is very much more active engagement in trying to ensure that it holds a good discussion with its own partners and with the general public about the

Ms Lloyd: Mae ganddo ddata da.

[220] **Mick Bates:** Dim ond drwy frwydro ag ysbytai Lloegr y mae hyn wedi digwydd.

Ms Lloyd: Ie.

[221] **Mick Bates:** Dyna pam y bu modd iddo archwilio pob achos. A oes gan ymddiriedolaethau a byrddau iechyd eraill ddata o'r un ansawdd a fyddai, fe gredaf, yn eu galluogi i fod yn yr un sefyllfa â Phowys?

Ms Lloyd: Mae'r math o wybodaeth sydd ar gael i'r lleill yr un fath. Yr hyn a allai amrywio yw'r modd y maent yn ei defnyddio.

[222] **Mick Bates:** O'r gorau.

Ms Lloyd: Dyna pam yr ydym yn rheoli eu perfformiad.

[223] **Mick Bates:** Hoffwn glywed mwy am y defnydd o'r data hwn gan yr ymddiriedolaethau a'r byrddau iechyd eraill, os yw'n bosibl.

Ms Lloyd: Gofynnaf i'r cyfarwyddwyr rhanbarthol am nodyn ar hynny.

[224] **Jocelyn Davies:** Mewn ymateb i gwestiwn gan Mark Isherwood, Mrs Lloyd, dywedasoch eich bod o'r farn bod y byrddau iechyd lleol yn atebol—yr oeddech yn bendant iawn am hynny. Gwn fod Leighton hefyd wedi crybwyll hyn yn gynharach. Sut mae'r bwrdd iechyd lleol yn atebol i'r cyhoedd?

Ms Lloyd: Mae ganddo fwrdd eithaf estynedig o ran ei gynrychiolaeth, sydd yn un ffordd y mae'n ymestyn ei gynrychiolaeth. Hefyd, mae'n rhaid iddo gyfarfod yn gyhoeddus, rhaid iddo ddatgelu ei strategaethau a'i gynigion comisiynu i'r cyhoedd a'u trafod gyda hwy, rhaid iddo fod â system o gynnwys y cyhoedd ar waith i gasglu tystiolaeth gan y cyhoedd, sydd wedi ei hysbysu gan anghenion iechyd, ac—wrth edrych ar weithredoedd byrddau iechyd lleol o gymharu â gweithredoedd comisiynwyr blaenorol—mae'n bosibl bod llawer mwy o ymgysylltu gweithredol i geisio sicrhau ei fod yn cynnal trafodaeth dda â'i bartneriaid ei

issues facing it. That is one of the evaluations that is going on at the moment: how effectively have the local health boards engaged both with their partners and with their general public in the first two years, particularly in areas where there are these pockets of deprivation, which need to be addressed? We hope to have the results of that sort of evaluation in September, to see how well they have done that and what there is to learn.

hun a chyda'r cyhoedd am y materion sy'n ei wynebu. Dyna un o'r gwerthusiadau sy'n digwydd ar hyn o bryd: pa mor effeithiol y mae'r byrddau iechyd lleol wedi ymgysylltu â'u partneriaid a chyda'r cyhoedd yn y ddwy flynedd gyntaf, yn enwedig mewn ardaloedd lle mae'r llecynnau hyn o amddifadedd, y mae angen mynd i'r afael â hwy? Yr ydym yn gobeithio cael canlyniadau'r math hwnnw o werthusiad ym mis Medi, i weld pa mor dda y maent wedi gwneud hynny a gweld beth y gallwn ei ddysgu.

[225] **Jocelyn Davies:** I look forward to seeing that.

[225] **Jocelyn Davies:** Edrychaf ymlaen at weld hynny.

[226] **Janet Davies:** Lastly, in the executive summary, the Auditor General describes the need for the Assembly Government to develop a clear strategic vision on the proper configuration of services, regionally and nationally. Do you have plans, Mrs Lloyd, to review this configuration to bring the system of health and social care back into balance? This would be one of the most important ways of doing that.

[226] **Janet Davies:** Yn olaf, yn y crynodeb gweithredol, mae'r Archwilydd Cyffredinol yn disgrifio'r angen i Lywodraeth y Cynulliad ddatblygu gweledigaeth strategol glir ar gyflunio gwasanaethau yn briodol, yn rhanbarthol ac yn genedlaethol. A oes gennych gynlluniau, Mrs Lloyd, i adolygu'r cyflunio hwn i sicrhau cydbwysedd yn y system iechyd a gofal cymdeithasol unwaith eto? Dyma fyddai un o'r ffyrdd pwysicaf o wneud hynny.

Ms Lloyd: The health and wellbeing strategies indicate where the balances are out of kilter at the moment and the actions that local communities will be striving to take to redress that balance. In the secondary reconfiguration proposals and the Wanless proposals—and we are just about to put forward a paper describing social care for the future too, so that local communities can start to test their current configuration against a model for the future—these are all being brought together to describe for each locality and, in some cases, across a whole region, what the future model of care should look like and how it will be evaluated. So, quite a lot of work has been done on putting the guidelines into place for a different model of care, which can be scrutinised against the outcomes and the removal of the blockages that we find at the moment.

Ms Lloyd: Mae'r strategaethau iechyd a lles yn nodi lle nad oes cydbwysedd ar hyn o bryd a'r camau gweithredu y bydd cymunedau lleol yn ymdrechu i'w cymryd i unioni'r fantol honno. Yn y cynigion ailgyflunio eilaidd a chynigion Wanless—ac yr ydym ar fin cyflwyno papur yn disgrifio gofal cymdeithasol ar gyfer y dyfodol hefyd, fel y gall cymunedau lleol ddechrau profi eu cyflunio cyfredol yn erbyn model ar gyfer y dyfodol—mae y rhain oll yn cael eu dwyn ynghyd i ddisgrifio ar gyfer pob ardal leol ac, mewn rhai achosion, ledled rhanbarth cyfan, sut dylai model y dyfodol o ofal ymddangos a sut caiff ei werthuso. Felly, mae cryn dipyn o waith wedi ei wneud ar roi canllawiau ar waith ar gyfer model gofal gwahanol, y gellir ei archwilio yn erbyn y canlyniadau a dileu'r rhwystrau yr ydym yn eu canfod ar hyn o bryd.

[227] **Janet Davies:** So, what do you think are the three most important tasks facing you in terms of building on recent improvements and getting sustained improvement?

[227] **Janet Davies:** Felly, beth, yn eich barn chi, yw'r tair tasg bwysicaf sy'n eich wynebu o ran adeiladu ar welliannau diweddar a sicrhau gwelliant cyson?

Ms Lloyd: I think that they are good

Ms Lloyd: Credaf mai'r rhain yw comisiynu

commissioning that really reflects the population's needs, improved effectiveness in terms of outcomes for patients and the outcome of care and treatment, and an improved balance between performance management, together with the financial management, and the release of the energy within the service, given much more coherent clinical engagement in the solutions, so that we can ensure that we are using all the talent that we have in the service to address these problems and others.

da sy'n adlewyrchu anghenion y boblogaeth mewn gwirionedd, effeithiolrwydd gwell o ran canlyniadau ar gyfer cleifion a chanlyniadau gofal a thriniaeth, a chydbwysedd gwell rhwng rheoli perfformiad, ynghyd â'r rheoli ariannol, a rhyddhau'r egni o fewn y gwasanaeth, o gael ymgysylltiad clinigol llawer mwy cydlynol yn yr atebion, fel y gallwn sicrhau ein bod yn defnyddio'r holl dalent sydd gennym yn y gwasanaeth i fynd i'r afael â'r problemau hyn ac eraill.

[228] **Janet Davies:** Thank you very much, Mrs Lloyd and Mr Hill-Tout. As you know, the verbatim transcript will be sent to you so that you can check it for accuracy. Would it be possible to receive at least the notes from last week's meeting before we have our meeting on 3 March? As you know, we will be looking at the same report, but we will be interviewing two national health service trust chief executives and two local health board executives, so it would be very helpful if you could manage to do that.

[228] **Janet Davies:** Diolch yn fawr iawn, Mrs Lloyd a Mr Hill-Tout. Fel y gwyddoch, anfonir y trawsgrifiad gair am air atoch fel y gallwch wirio ei fod yn gywir. A fyddai'n bosibl derbyn o leiaf y nodiadau o gyfarfod yr wythnos diwethaf cyn ein cyfarfod ar 3 Mawrth? Fel y gwyddoch, byddwn yn edrych ar yr un adroddiad, ond byddwn yn cyfweld â dau brif weithredwr ymddiriedolaeth y gwasanaeth iechyd gwladol a dau swyddog gweithredol bwrdd iechyd lleol, felly byddai'n ddefnyddiol iawn pe gallech wneud hynny.

Ms Lloyd: Yes, of course.

Ms Lloyd: Iawn, wrth gwrs.

Daeth y sesiwn cymryd tystiolaeth i ben am 3.25 p.m.
The evidence-taking session ended at 3.25 p.m.