Agenda - Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:

Ystafell Pwyllgora 5, Tŷ Hywel

Dyddiad: Dydd Mercher, 10 Mai 2023

Amser: 09.00

I gael rhagor o wybodaeth cysylltwch a:

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Clerc y Pwyllgor

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Rhag-gyfarfod preifat

(09.00 - 09.15)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau.

(09.15)

2 Canserau gynaecolegol: Panel 3

(9.15-10.30) (Tudalennau 1 - 40)

Lowri Griffiths, Cadeirydd, Cynghrair Canser Cymru a Chyfarwyddwr Cymorth, Polisi a Mewnwelediad, Gofal Canser Tenovous

Rachel Downing, Pennaeth Polisi ac Ymgyrchoedd, Target Ovarian Cancer

Claire O'Shea, Un y mae canser wedi effeithio arni

Papur briffio gan Ymchwil y Senedd

Papur 1: Gofal Canser Tenovus

Papur 2: Target Ovarian Cancer

Papur 3: Claire O'Shea

Egwyl

(10.30-10.45)

Senedd Cymru
Welsh Parliament

3 Canserau gynaecolegol: Panel 4

(10.45-11.45) (Tudalennau 41 - 43)

Dr Shanti Karupiah, Coleg Brenhinol y Meddygon Teulu

Dr Zohra Ali, Cymdeithas Feddygol Islamaidd Prydain

Papur 4: Coleg Brenhinol y Meddygon Teulu

4 Papurau i'w nodi

(11.45)

4.1 Llythyr ar y cyd at y Gweinidog Iechyd a Gwasanaethau Cymdeithasol gan y Pwyllgor Iechyd a Gofal Cymdeithasol a'r Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus ynghylch Bwrdd Iechyd Prifysgol Betsi Cadwaladr

(Tudalennau 44 - 45)

4.2 Llythyr at y Dirprwy Weinidog Gwasanaethau Cymdeithasol ynghylch y polisi Cymru gyfan ar ryddhau cleifion o'r ysbyty a chanllawiau cysylltiedig.

(Tudalennau 46 - 47)

4.3 Llythyr at y Pwyllgor Cyllid ynghylch tystiolaeth a ddarparwyd gan Lywodraeth Cymru fel rhan o'r gwaith craffu ar y gyllideb ddrafft ar gyfer 2023-24

(Tudalennau 48 - 50)

4.4 Llythyr gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ynghylch Gwasanaethau Endosgopi: ymchwiliad dilynol

(Tudalennau 51 - 55)

4.5 Llythyr gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ynghylch y Rheoliadau Gofal Iechyd (Trefniadau Rhyngwladol) (Ymadael â'r UE) 2023

(Tudalennau 56 - 58)

4.6 Llythyr at y Pwyllgor Cyllid ynghylch cynaliadwyedd a chydbwysedd ariannol byrddau iechyd

(Tudalennau 59 - 60)

4.7 Llythyr gan y Pwyllgor Cyllid ynghylch cynaliadwyedd a chydbwysedd ariannol byrddau iechyd

(Tudalennau 61 - 62)

5 Cynnig o dan Reol Sefydlog 17.42(vi) a (ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn, ac o bob eitem ac eithrio Eitem 1 i Eitem 3 y cyfarfod a gaiff ei gynnal ar 25 Mai 2023.

6 Canserau gynaecolegol: trafod y dystiolaeth

(11.45-12.00)

7 Bil Caffael y Gwasanaeth Iechyd (Cymru): Cyfnod 2

(12.00-12.05) (Tudalennau 63 - 66)

Papur 5: Bil Caffael y Gwasanaeth Iechyd (Cymru): Cyfnod 2

8 Gwasanaethau endosgopi: Ymateb Llywodraeth Cymru

(12.05-12.15) (Tudalennau 67 - 70)

Papur briffio gan Ymchwil y Senedd (Saesneg yn unig)

Yn rhinwedd paragraff(au) vi o Reol Sefydlog 17.42

Eitem 2

Mae cyfyngiadau ar y ddogfen hon

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Canserau gynaecolegol

This response was submitted to the Health and Social Care Committee consultation on Gynaecological Cancers

GC 14

Ymateb gan: Tenovus | Response from: Tenovus

Response to Gynaecological Cancers Inquiry Call for Evidence

March 2023

Tenovus Cancer Care is one of Wales's leading cancer charities, with a long and distinguished history of providing practical and emotional support to everyone affected by cancer in their community.

We are committed to working alongside people affected by cancer to champion their needs, raise awareness of the issues faced and ultimately improve cancer outcomes.

General comments

Thank you for this opportunity to provide evidence to the Health and Social Care Committee (the Committee) concerning gynaecological cancers in Wales. Tenovus Cancer Care does not represent or prioritise any one type of cancer over any other, we are a generalist cancer charity providing support services to anyone with any kind of cancer. Our response reflects this position. For specific tumour-related responses we defer to those tumour-site specific charities and their particular areas of expertise and insight.

Where web-based resources are referred to, we have supplied a hyperlink towards the end of this response.

We welcome the steps taken by the Committee to capture the testimonies of women across Wales with a gynaecological cancer experience. Through the course of this evidence-gathering period we have heard concerning, and at times harrowing, stories from women who have felt ignored, their dignity compromised and left with distressing feelings at an already overwhelming time of their lives.

Where we have been able to do so, we have referred women onto the Senedd's engagement team who have managed the capturing of stories on film. We trust that Committee members will reflect on these testimonies with compassion and are able to reach findings that will help to ensure that women found in similar situations in the future do not experience similar outcomes.

We encourage Members to speak to clinicians involved in the diagnosis, treatment and care of women affected by gynaecological cancers, in particular the clinical lead

of the gynaecological cancers site group[i], Dr Louise Hanna at Velindre Cancer Centre.

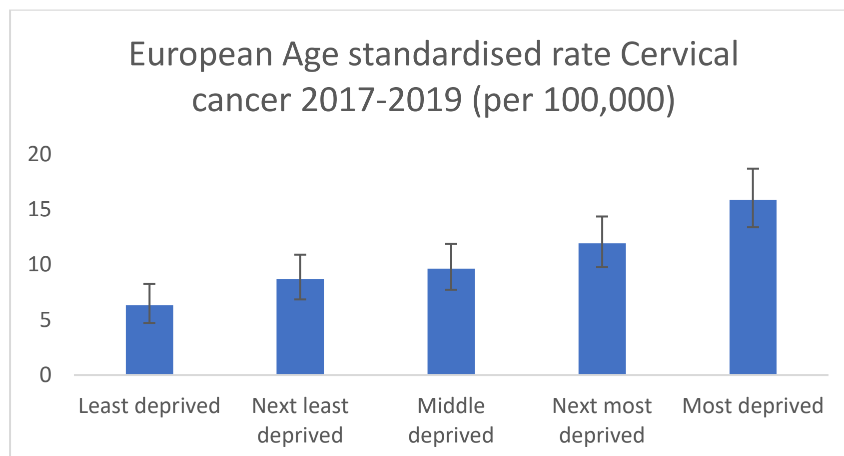
Incidence of gynaecological cancers in Wales

2019 (most recent data):
There were 981 cases of gynaecological cancers in Wales, 145 of which were cervical cancers, 306 ovarian and 530 uterine.

Together these cancers accounted for 10% of all cancers in women in Wales in 2019 (981/9515). This makes gynaecological cancers (as a group) the 4th most common cancer type amongst women.

Betsi Cadwaladr UHB had the highest incidence numbers of all gynaecological cancers, due to the size of the health board and it also had the highest European age standardised rate of cervical cancer (due to deprivation links).

Although there is a trend for increased incidence rates for ovarian and uterine cancers associated with increased deprivation, these trends are not statistically significant, whilst cervical cancer incidence rates are significantly affected by deprivation.



Cancer mortality

Sadly in 2021, 373 women in Wales lost their lives to gynaecological cancers, this was made up of 50 deaths from cervical cancer, 203 from ovarian cancer and 120 from uterine cancer, making ovarian cancer the deadliest of the gynaecological cancers.

Gynaecological cancers accounted for 9% of cancer deaths in women in Wales in 2021 making it the 4th most common cause of cancer death in women.

Deprivation and gynaecological cancers

As mentioned, cervical cancer is strongly associated with deprivation, due in part to smoking rates, earlier onset of sexual activity (and potential HPV exposure) and obesity.

When the mortality rates for the least deprived areas in Wales are applied to the numbers of deaths in the other areas in Wales, it is apparent that as many as 28 cervical cancer deaths a year in Wales are associated with deprivation.

However, as cervical cancer is largely preventable through the detection of pre-cancerous cells during cervical screening, much of this inequality is to do with screening uptake.

Response to the Committee's Terms of Reference

> *The information available and awareness about the risk factors for gynaecological cancers across the life course and the symptoms associated with gynaecological cancers.*

We believe there needs to be more information available at every stage of a woman's life to better inform them of the signs and symptoms of gynaecological cancers over the course of their lifetime. There are many contact points throughout a women's life that could be used to educate about symptoms or encourage a woman to act upon vague symptoms that might lead to referral to a rapid diagnostic centre or diagnostic hub of the future.

> *The barriers to securing a diagnosis, such as symptoms being dismissed or confused with other conditions.*

> *Whether women feel they are being listened to by healthcare professionals and their symptoms taken seriously.*

While most women with a gynaecological cancer report a positive NHS experience (Wales Cancer Patient Experience Survey [WCPES] 2021[ii], NHS care rated as 8.5 out of 10, n=388), a concerning number of women (around 6%) rate their NHS care as below average. A single poor experience is one poor experience too many. The WCPES website does not contain the reasons behind those poor experiences, but barriers to diagnosis, and communication with healthcare professionals will very likely feature.

Tenovus Cancer Care wishes to express our concern at the testimonies we have heard from women with gynaecological cancers who have received very poor cancer experiences in the recent past and wish to share those experiences to ensure that no-one must endure the same indignities, pain – both physical and emotional, and stress. We encourage Members to reflect on these testimonies with compassion and reach findings that will help to ensure that women found in similar situations in the future do not experience similar outcomes.

> *HPV vaccination and access to timely screening services including consideration of the inequalities and barriers that exist in uptake among different groups of women and girls.*

Moving forward, the biggest indicator of cervical cancer risk will soon become uptake of the HPV vaccine during the teenage years. Vaccine uptake in children in Wales is

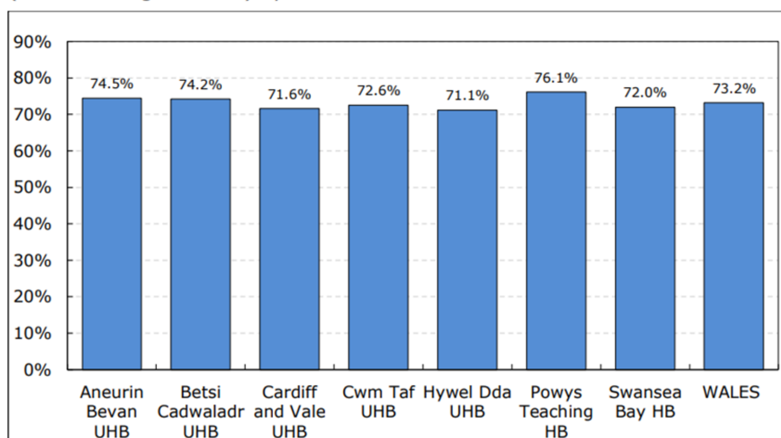
around 79% for first dose, although there appears to be large variation between health boards. The World Health Organisation's (WHO) cervical cancer elimination initiative sets a target of 90% of girls fully vaccinated by 2030[iii].

The Committee might want to ask NHS managers responsible for the HPV vaccine programme why there is variation in uptake of HPV vaccine between health boards. The HPV vaccine is the closest thing we've ever had to a "cure" for cervical cancer and Wales appears to experience a deprivation gap, an increasing inequality that will contribute to avoidable discomfort, suffering and death in the future. The uptake of the second dose is also unreasonably low, why is this the case?

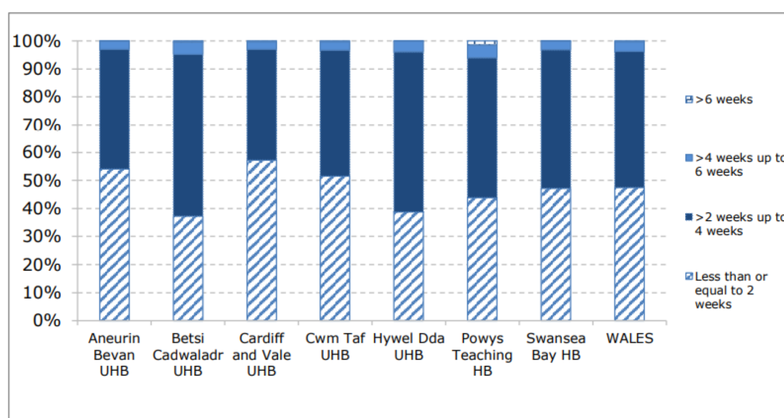
A research paper looking at HPV vaccine uptake in South-West England in 2021[iv] indicated that written consent from parents was a barrier to uptake that could increase the deprivation gap but could be overcome by allowing parents to verbally consent and adolescents to self- consent.

The cervical screening uptake rate in Wales is around 73% according to the most recent annual statistical report (Graph 1b, below). Although deprivation levels were not examined here, there were small amounts of variation in uptake observed between health boards, and the speed of processing and reporting results was variable between health boards (Graph 4, below).

Graph 1b: Combined cervical screening coverage of target age group (individuals aged 25-64) by health board



Graph 4: Time from date sample was taken to issue of result letter, by health board



We understand that there is very little support for victims of sexual abuse to uptake cervical screening in Wales, nothing we are aware of is offered through the invite. Since up to 1 in 4 women will have experienced some kind of sexual assault this seems to be a significant oversight.

NHS recovery of screening and diagnostic services, specifically the level of extra capacity that has been provided for services to recover from the impact of the COVID-19 pandemic.

Prior to the pandemic cancer services were in a worrying state, with known issues concerning the cancer workforce, waiting times and diagnostic services. The COVID-19 pandemic exacerbated and compounded these existing issues and created new pressures through the suspension of services to prioritise COVID-19 resilience.

We are aware of at least one gynaecological cancer clinic that was cancelled due to the pandemic that has yet to resume, an unacceptable situation. Recovery, if it is to mean anything, must mean the resumption of all oncology activity that was postponed/paused for the pandemic.

The prioritisation of pathways for gynaecological cancers as part of NHS recovery, including how gynaecological cancer waiting lists compare to other cancers and other specialities.

Whether there are local disparities in gynaecological cancer backlogs (addressing inequalities so that access to gynaecological cancer care and treatment is not dependent on where women live).

From the conversations we have had with clinicians we understand that there is no prioritisation of pathways for gynaecological cancers, and that oncologists and other clinicians involved with the treatment and care of these cancers are subject to the pressures and resource constraints of any other cancer. That's not withstanding our understanding that at least one gynaecological cancer clinic has not resumed post-pandemic.

We welcome the development of national optimal pathways for cervical[v], endometrial[vi], ovarian[vii] and vulval[viii] cancers by the gynaecological cancers site group of the Wales Cancer Network, with their aims to standardise care, reduce unwarranted variation and drive improvement and quality.

The comparably poor waiting times for women with gynaecological cancers are extremely concerning. Over the last couple of years around 40% of women have started treatment within the 62-day wait. This has fallen to 25% in December 2022 – during the period this call for evidence has been open. This is extremely disappointing, and strongly suggests systematic pressures that need greater attention and prioritisation across Wales.

The extent to which data is disaggregated by cancer type (as opposed to pooling all gynaecological cancers together) and by other characteristics such as ethnicity.

There are significant issues regarding the collection and use of cancer data in Wales that impacts what we are capable of understanding as a nation.

For example, reports from the USA indicate that black women are slightly less likely to get gynaecological cancer but 1.3 times more likely to die of it. We do not know if that is the case in Wales because we do not collect ethnicity data through the cancer informatics system. The new system, now available across the NHS, and in use by healthcare professionals, has the technological means of collecting ethnicity data, but we understand that that is a low priority, and unlikely to be acted upon for some time.

Tenovus Cancer Care wants to see that rectified, and the collection of ethnicity data prioritised by the NHS.

> *Whether adequate priority is given to gynaecological cancers in the forthcoming Welsh Government/NHS Wales action plans on women and girls' health and cancer, including details of who is responsible for the leadership and innovation needed to improve cancer survival rates for women.*

Gynaecological cancers are not singled out to any extent within the Cancer Improvement Plan but given the poor waiting times experienced by women with a diagnosis we would expect Health Boards to explain what they are doing to rectify issues within their Integrated Medium-Term Plans (IMTPs). Improvements to cancer waiting times cannot come at the expense of gynaecological cancer waiting times.

The gynaecological cancers site group (the CSG) plays an important role in the development and delivery of gynaecological cancer services. The Wales Cancer Networks describes CSGs as[ix]:

- a single clinical structure providing advice and expertise to the Wales Cancer Network and the Cancer Network Board.
- contributing to policy development and supporting the delivery of the Quality Statement for Cancer. They also provide clinical teams an opportunity to address any site-specific challenges identified at a national level.
- forming the clinical structure of the Wales Cancer Network. They have a diverse membership drawn from the associated multidisciplinary teams that span primary, secondary and tertiary care who care for patients within individual cancer sites across Wales.
- a resource for consultation and advice on clinical guidelines and a support to the national work programme, aiming to enhance patience experience through collaboration, sharing best practice and highlighting areas of service improvement.

It is important to note that clinical input on a CSG is done on a voluntary basis, and with minimal administrative and project support. We believe that the current issues facing gynaecological cancer services warrants additional support for the CSG to enable the identification and co-ordination of activity across and between health boards.

The extent to which gynaecological cancers, and their causes and treatments (including side-effects), are under-researched; and the action needed to speed up health research and medical breakthroughs in diagnosing and treating gynaecological cancers.

The priority given to planning for new innovations (therapy, drugs, tests) that can improve outcomes and survival rates for women.

We understand anecdotally that there is “huge unmet need for gynaecological cancer research” in Wales, but since this is not our area of expertise and we defer to other contributors.

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[i] https://collaborative.nhs.wales/networks/wales-cancer-network/clinical-hub/cancer-site-groups/gynaecological-cancer/
[ii] https://wcpes.co.uk/scorecard following application of the Gynaecological cancers filter.
[iii] https://www.who.int/initiatives/cervical-cancer-elimination-initiative
[iv] https://bmjopen.bmj.com/content/11/7/e044980
[v] https://collaborative.nhs.wales/networks/wales-cancer-network/wcn-documents/clinician-hub/csg-pathways-and-associated-documents/gynae-nop-cervix-pdf/
[vi] https://collaborative.nhs.wales/networks/wales-cancer-network/wcn-documents/clinician-hub/csg-pathways-and-associated-documents/gynae-nop-endometrial-pdf/
[vii] https://collaborative.nhs.wales/networks/wales-cancer-network/wcn-documents/clinician-hub/csg-pathways-and-associated-documents/gynae-nop-ovary-pdf/
[viii] https://collaborative.nhs.wales/networks/wales-cancer-network/wcn-documents/clinician-hub/csg-pathways-and-associated-documents/gynae-nop-vulva-pdf/
[ix] https://collaborative.nhs.wales/networks/wales-cancer-network/clinical-hub/cancer-site-groups/

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Canserau gynaecolegol

This response was submitted to the Health and Social Care Committee consultation on Gynaecological Cancers

GC 06

Ymateb gan: | Response from: Target Ovarian Cancer

Welsh Health and Social Care Committee- Gynaecological cancers Consultation

Information available and awareness of risk factors and symptoms associated with gynaecological cancers.

Over 300 women are diagnosed with ovarian cancer each year in Wales and more women die as a result of ovarian cancer in the UK than all other gynaecological cancers combined.[i] As there is currently no screening tool for ovarian cancer, to improve early diagnosis it is vital that women are not only aware of the symptoms but also the importance of family history so they can contact their GP as soon as they begin experiencing symptoms.

Target Ovarian Cancer found that awareness of the key ovarian cancer symptoms remains worryingly low in Wales, with just 33 per cent of women able to name abdominal pain as a symptom, 27 per cent able to name bloating, 5 per cent able to name feeling full and just 1 per cent able to recognise urinary urgency[ii].

Approximately 13 per cent of ovarian cancers are caused by a mutation of the BRCA1 or 2 gene[iii]. However, there is poor awareness among women across the UK of the importance of family history of cancer with only a third of women recognising that family history could be a risk factor for ovarian cancer.

Target Ovarian Cancer welcomed the development of a NICE guideline on inherited ovarian cancers, but a key area not covered in the guideline will be awareness of the risk. We need to see awareness campaigns alongside investment into better prevention options and access to genetic counselling so that those with a family history can make an informed decision about genetic testing.

The most effective way of achieving greater awareness is government funded symptom awareness campaigns. We must ensure that everyone is aware of the key symptoms of ovarian cancer. Concerningly, awareness of feeling full has declined from 5 per cent of women recognising this as a symptom in 2016 to just 3 per cent[iv]. We urgently need to see government funded awareness campaigns across Wales that highlight the symptoms of ovarian cancer. In 2017 the Welsh Assembly Petitions Committee produced a report calling for a public facing ovarian cancer awareness campaign in Wales. To date there have been no specific awareness campaigns on ovarian cancer symptoms. The case for symptoms awareness is clear as our research also found that just 6 per cent of women in Wales said that they were very confident in naming ovarian cancer symptoms.[v]

Awareness of symptoms is key to improving early diagnosis, however, we must also address the misconceptions around ovarian cancer. Target Ovarian Cancer found that 42 per cent of women in Wales wrongly believe that cervical screening detects ovarian cancer[vi]. We need to ensure that the information provided at cervical screening appointments makes clear that it does not test or screen for other gynaecological cancers and include the symptoms of other gynaecological cancers.

Recommendations

- We need to see Government funded awareness campaigns across Wales that highlight the symptoms of ovarian cancer
- There needs to be campaigns that educate the public on the importance of knowing their family history so they can investigate preventive action
- Consideration should be given to ensuring that materials related to cervical screening are clear that it does not test for the other gynaecological cancers.

The barriers to securing a diagnosis, such as symptoms being dismissed or confused with other conditions

Whether women feel they are being listened to by healthcare professionals and their symptoms taken seriously.

If diagnosed at an earliest stage (Stage I), 93 per cent of women in Wales can survive five years or more, compared to just 13 per cent of women diagnosed at stage IV.[vii] Currently just over a third of women are diagnosed at an early stage in Wales[viii].

Once a woman has been referred by her GP for tests, it is vital that either ovarian cancer is diagnosed or ruled out as soon as possible. However, there can still be unnecessary delays in diagnosis. Ovarian cancer is diagnosed using a CA125 blood test, followed by an ultrasound if the levels are raised. The CA125 protein is elevated in 80 per cent of women with advanced disease, but no more than 50 per cent of women diagnosed with stage I ovarian cancer will have a raised CA125[ix]. Having a CA125 as a standalone test can mean that women with early-stage disease are not referred.

We have also found that there are delays in waiting for test results despite GPs being able to access these tests directly. Target Ovarian Cancer found that one third of women in Wales reported waiting more than three months from their first appointment with their GP to receiving their diagnosis. Given the time taken to get the results of the CA125 blood test and an ultrasound, there is an urgent need to shorten the ovarian cancer diagnostic pathway

We need to see a reduction in the time it takes to get a diagnosis and ensure that more women with an early-stage cancer are identified. By carrying out the CA125 blood test and ultrasound concurrently as is currently done in Scotland, it would allow women to be diagnosed faster and begin treatment as soon as possible.

GP awareness is also key to early diagnosis. However, too many women experience misdiagnosis and delays as a result of GPs not being appropriately educated or supported to diagnose ovarian cancer. Target Ovarian Cancer found that 43 per cent of GPs in Wales believe that symptoms only present in the late stages of disease and one quarter of those diagnosed with ovarian cancer report visiting their GP three or more times before being referred for tests[x].

This is concerning, as symptoms are often present in those with early-stage disease. Appropriate training must be in place at primary care level if we want to ensure more people receive an early diagnosis.

Recommendations

- Shorten the diagnostic pathway for ovarian cancer so that a CA125 blood test and ultrasound are carried out at the same time
- Ensure that GPs are well supported with access to training, Advice and Guidance services vague symptoms pathways and support to use NICE guidance

NHS recovery of screening and diagnostic services, specifically the level of extra capacity that has been provided for services to recover from the impact of the COVID-19 pandemic.

The prioritisation of pathways for gynaecological cancers as part of NHS recovery, including how gynaecological cancer waiting lists compare to other cancers and other specialities.

Target Ovarian Cancer welcomed the introduction of the Suspected Cancer Pathway in Wales and the 62-day target to receive a diagnosis and begin treatment. The pandemic had a drastic impact on urgent referrals for suspected cancer from GPs and treatment wait times. Early diagnosis and beginning treatment as soon as possible are key in increasing the survival rates among women with ovarian cancer.

In 2022 just 34 per cent of gynaecological cancers met the single cancer pathway target, when comparing this to those diagnosed with lung cancer 54 per cent of those diagnosed met the cancer pathway, starting their treatment within 62 days of first being suspected with cancer[xi]. Understanding why we continue to see delays in diagnosis for gynaecological cancers is crucial. We know that there are many barriers to an early diagnosis for ovarian cancer, such as misdiagnosis and a lack of GP awareness. We must see the pathways for gynaecological cancers prioritised to ensure more people meet the single cancer pathway target and are able to start treatment as soon as possible. Urgent action must be taken to ensure everyone diagnosed with ovarian cancer and other gynaecological cancers have the best possible chance of survival.

Recommendations:

- Prioritise gynaecological cancer diagnostic pathways. Consider reviewing and shortening the diagnostic pathway for ovarian cancer to ensure that it meets the single cancer pathway target.

Whether there are local disparities in gynaecological cancer backlogs (addressing inequalities so that access to gynaecological cancer care and treatment is not dependent on where women live)

This audit will play a crucial role in transforming diagnosis and access to treatment for everyone diagnosed, irrespective of their age or where they live.

Target Ovarian Cancer welcomed the announcement that the full clinical audit to improve ovarian cancer care and treatment across England and Wales. It is vital that the commissioned audit provides in-depth analysis of the diagnosis and treatment of ovarian cancer so that progress can be tracked.

Where you live should not affect your treatment options or outcomes. It is vital that the NHS in Wales proactively identifies ways of tacking any disparity identified in the audit when it reports.

The extent to which data is disaggregated by cancer type (as opposed to pooling all gynaecological cancers together) and by other characteristics such as ethnicity.

Ovarian cancer is often reported as part of a larger set on gynaecological cancers. However, this is unhelpful as the diagnostic and treatment pathways for individual cancers, ovarian, cervical, womb, vulval and vaginal are different so it is difficult to make meaningful assessments of performance in ovarian cancer diagnosis and treatment using aggregated data sets.

Recommendation

- Datasets should be disaggregated by tumour type to ensure we can better understand how services are currently performing and plan interventions.

Whether adequate priority is given to gynaecological cancers in the forthcoming Welsh Government/NHS Wales action plans on women and girls' health and cancer, including details of who is responsible for the leadership and innovation needed to improve cancer survival rates for women.

We welcome the focus the Welsh Government is placing on women and girls' health and gynaecological cancers. However, the Cancer Quality Statement lacks detail on how the Government/NHS will specifically address symptom awareness and the variation in access to diagnostics and treatment for gynaecological cancers in Wales.

It is concerning that just 34 per cent of gynaecological cancers met the single cancer pathway target in Wales. To ensure 75 per cent of people diagnosed with cancer meet the 62-day target we need to see the current diagnostic pathway for ovarian cancer reviewed and shortened, this would allow women to be diagnosed faster and begin treatment as soon as possible.

The focus placed on screening will significantly help other gynaecological cancers such as cervical, however for ovarian cancer there is currently no viable screening programme. To see accelerated progress and achieve earlier diagnosis for everyone diagnosed with ovarian cancer in Wales the action plan needs to consider symptom awareness campaigns that feature the symptoms of ovarian cancer and other less common cancers.

Recommendations

- We need to see continued commitment to improve early diagnosis and treatment of gynaecological cancers
- Ensure that GPs are well supported with access to training and symptom awareness, helping more women presenting with symptoms get diagnosed earlier

The extent to which gynaecological cancers, and their causes and treatments (including side-effects), are under-researched; and the action needed to speed up health research and medical breakthroughs in diagnosing and treating gynaecological cancers.

Research is vital to improving the outcomes for everyone diagnosed with ovarian cancer. However, in recent years we have seen a worrying decline in the UKs spend on ovarian cancer research. Public spend on ovarian cancer research across the UK has decreased by 27 per cent in ten years, from £12.9m in 2010/11 to £10.3m in 2020/2, which is just 3 per cent of site-specific research. This is concerning as the outbreak of coronavirus also saw many medical research charities struggling to retain their funding with £270 million cut from charitable research spend.

One in ten women are diagnosed with a less common tumour type[xii], however, rarer sub-types of ovarian cancer have fewer treatment options. When considering how we can improve the treatment offered to everyone with cancer, we must ensure that rarer tumours along with other rare and less common gynaecological cancer types receive the focus and funding they need, so everyone has the best possible chance of survival.

Clinical trials offer those diagnosed with cancer the opportunity to access new cancer drugs and treatment options. This is particularly important for those diagnosed with rarer tumours

or incurable ovarian cancer. Our recent Pathfinder study highlighted that there has been a 10 per cent decline in women being asked about clinical trials between 2016 and 2022. This is despite there being a clear desire to take part in clinical trials with 61 per cent of women who took part in our study and who were not asked to take part in a clinical trial, saying they would have liked the opportunity to take part in a trial[xiii]. We must ensure that the decline in opportunities to take part in trials is reversed and information about clinical trials is shared.

Target Ovarian Cancer welcomes the commitment outlined in the Cancer Quality Statement that all eligible patients will be offered access to research trials and that Wales will provide supporting infrastructure for cancer research. This is crucial if we are to continue developing lifesaving treatment and new diagnostic tools.

Recommendations

- Patients must be empowered to ask about clinical trials, with signposting to information on clinical trials embedded into interactions between patients and their clinical team.
- We need to see urgent investment in post pandemic studies that will lead to better treatments.

The priority given to planning for new innovations (therapy, drugs, tests) that can improve outcomes and survival rates for women.

No matter where they live or their personal circumstances everyone diagnosed with ovarian cancer must have access to specialist support and the best treatment. We welcome the commitment made in the Cancer Quality Statement to ensure more evidence-based surgical techniques, radiotherapies and genomic testing are routinely available. Everyone with ovarian cancer must be able to access the best possible treatment, targeted to their needs.

Surgery is the treatment that offers the best prognosis. Ovarian cancer surgery is a complex, major operation so it is vital that surgery is undertaken at a specialist multidisciplinary disciplinary diagnostic centre. Research has shown that treatment at specialist centres improves survival by 45 per cent[xiv].

Genomic testing

The availability of PARP inhibitors to treat the most common type of ovarian cancer is dependent on the presence of a BRCA variation or HRD status which is determined through genomic testing. The presence of a BRCA germline variant also has implications for family members as they may also have the gene, so women need the right support when undergoing BRCA germline testing.[xv]

We found that there is good access to genomic testing in Wales of those we surveyed:

- 79 per cent had BRCA germline testing
- 42 per cent had BRCA somatic testing
- 8 per cent report HRD testing (available across the whole UK from December 2021)

However, 65 per cent said they weren't offered specialist counselling to help them decide if they wanted to be tested.

Recommendations

- Everyone that would benefit from specialist surgery must be able to access it regardless of age or geographical location.

- There must be a consistent approach to consenting for genomic testing, with access, where required, to genetic counselling maintained for those having BRCA germline

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[i] Cancer Incidence in Wales, 2002-2019 - Public Health Wales (NHS, Wales)
[ii] Target Ovarian Cancer, Awareness Measure. (2022)
[iii] Pathfinder 2016: Transforming futures for women with ovarian cancer.
[iv] Target Ovarian Cancer, Awareness Measure. (2022)
[v] Target Ovarian Cancer, Awareness Measure. (2022)
[vi] Target Ovarian Cancer, Awareness Measure. (2022)
[vii] Welsh Cancer Intelligence and Surveillance Unit Cancer survival by stage of diagnosis. Available at: www.wcisu.wales.nhs.uk/cancer-survival-by-stage-at-diagnosis-in-1
[viii] Pathfinder Wales 2022: Faster, Further, Fairer (2022). Target Ovarian Cancer.
[ix] Scottish Intercollegiate Guidelines Network (2013) SIGN 135. Management of epithelial ovarian cancer. Revised 2018. Available at: www.sign.ac.uk/sign-135-management-of-epithelial-ovarian-cancer.html
[x] Pathfinder Wales 2022: Faster, Further, Fairer (2022). Target Ovarian Cancer.
[xi] StatsWales: Cancer Waiting Times. https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Cancer-Waiting-Times/Monthly/suspectedcancerpathwayclosedpathways-by-localhealthboard-tumoursite-agegroup-gender-measure-month
[xii] Target Ovarian Cancer's data briefing on Ovarian Cancer. 2018. Available at: https://targetovariancancer.org.uk/sites/default/files/2020-07/Target%20Ovarian%20Cancer%27s%20data%20briefing%20for%20ovarian%20cancer%20in%202018.pdf
[xiii] Pathfinder Wales 2022: Faster, Further, Fairer (2022). Target Ovarian Cancer.
[xiv] Khoja, L., et al. 'Improved Survival from Ovarian Cancer in Patients Treated in Phase III Trial Active Cancer Centres in the UK'. Clinical Oncology (Royal College of Radiologists (Great Britain)), vol. 28, no. 12, Dec. 2016, pp. 760–65. PubMed, https://doi.org/10.1016/j.clon.2016.06.011.
[xv] Pathfinder Wales 2022: Faster, Further, Fairer (2022). Target Ovarian Cancer.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Canserau gynaecolegol

This response was submitted to the Health and Social Care Committee consultation on Gynaecological Cancers

GC 11

Ymateb gan: Claire O'Shea | Response from: Claire O'Shea

13th January 2023

Ref: Gynaecological cancer consultation

Dear Chair,

I am submitting evidence as an individual who at 40 years old had a diagnosis of Uterine Leiomyosarcoma (uLMS) in November 2022. The resulting treatment was a full hysterectomy in December. I am currently under the care of the Women's Cancer Centre for Wales at University Hospital Wales.

For the purposes of brevity, I have attempted to link my experiences to research and wider issues for people diagnosed with uLMS. There are many more significant issues to cover, and I would be very happy to develop these further in writing or in person, if the committee would find it useful. Uterine Leiomyosarcoma is a rare and aggressive cancer; because of this it is often diagnosed late, leading to devastating consequences. If awareness, attention and research were achieved, many cases could potentially be prevented or cured. Too many patients end up having palliative care soon after diagnosis.

Background

In July 2021 I began suffering with symptoms of Uterine Leiomyosarcoma, a rare and aggressive cancer that has a poor prognosis and a high recurrence rate. It makes up less than 2% of all cancers; around 5300 people a year are diagnosed in the UK. The 5-year survival rate is 50%–55% for patients with early uterine sarcoma and 8%–12% for advanced cases. Due to lack of awareness of this cancer by both medical professionals and people presenting with symptoms, many cases are diagnosed late; this combined with low levels of research lead to extremely poor outcomes.

Since August 2021, I have struggled to get a diagnosis and timely treatment. When I first presented with symptoms; including a lump in my abdomen, my GP diagnosed me with Irritable Bowel Syndrome, as a result of a narrow set of questions about my symptoms. This resulted in months of delay. When dealing with sarcoma, fast diagnosis is one of the most important factors in reducing mortality. This is a common experience with Sarcoma, most GPs will only see one sarcoma in their career. The later sarcoma is diagnosed, the worse the outcomes, despite this, on average sarcomas are diagnosed when they are the size of a can of beans.

Over a few months, I made several attempts to get a follow up appointment; as the medication I was prescribed wasn't working. My symptoms were developing and it became

clear to me that the lump I had been able to feel in my abdomen was located in my uterus. I was increasingly alarmed. Eventually, I insisted on seeing a woman GP having heard a discussion on research that concluded patients who were treated by women healthcare professionals had significantly better outcomes. Following a consultation with the new GP, I was referred urgently to University Hospital Wales where, following scans, I was diagnosed with a suspected fibroid. I had several appointments to discuss treatments and to receive hormone injections to induce chemical menopause aimed at shrinking the 'fibroid' (which was now so large it was visible protrusion from my abdomen). Following the hormone injections, I was scheduled for surgery in July 2022, however due to the 'non-urgent' nature of a fibroid and the pressures experienced by the NHS my surgery was eventually performed at the end of September 2022.

Following my surgery (open myomectomy) I was advised that I would be contacted within 3 weeks if my biopsy results showed anything of concern. After 3 weeks, I assumed I had a clean bill of health and returned to work. However, again, due to the current pressures on the Welsh NHS I didn't get my results for 6 weeks. Sadly, on the 18th November 2022, I received the results of my biopsy, which showed the fibroid was uLMS. I was immediately sent for a CAT scan to see if the disease had spread to my lungs or other areas of the abdomen. The scans showed no evidence of tumours anywhere else in my abdomen. Shortly after the scans, I underwent a full hysterectomy on the 2nd December 2022. Although there were no signs of the cancer having spread, it was vital to have the procedure as a preventative measure due to the recurrence rates.

To date, I have only had surgery, as this is the most effective way of treating sarcoma. I am now under a three-monthly regime of x-rays, scans and a consultant appointment, as recurrence rates are between 53% and 71%. Alongside this I am still waiting on the results of whether the cancer cells were hormone receptive, if this is the case I will need another procedure to remove my ovaries; which I was reluctant to do without establishing the histology of the cancer, due to the negative impact of early menopause.

Through my experience as summarised above and in reference to some of the specific areas the committee are interested in receiving evidence on, I consider the following evidence and information to be of particular importance.

Awareness and information

- Information and awareness are very low. 75% of people surveyed by Sarcoma UK said they didn't know what sarcoma was. My symptoms presented as a fibroid, an extremely common condition in women. Personally, I wasn't aware of fibroids as a condition despite considering myself to be well informed and educated on women's health. My GP misdiagnosed me with IBS due to the impact the fibroid was having on my digestive system, even with an abdominal exam where the growth was easy to feel. If I had better awareness of the condition, I would have been better able to advocate for myself, and link the developing symptoms to specific conditions.

- 40% of sarcoma patients do not receive an accurate diagnosis, and on average sarcoma patients wait an average of 92 weeks between spotting symptoms and being referred for investigation. This can be longer in the case of uterine sarcoma, as other soft tissue sarcomas appear in the extremities and can be more obvious due to the proximity to the surface. I waited for approximately 66 weeks, but my consultant said that was largely due to the fact I didn't carry excess weight on my abdomen and the growth was visible at an earlier stage.

Primary Care

- There were many issues with primary care, alongside the initial incorrect diagnosis. I was given blood tests at my initial consultation. When they came back as negative, I was not contacted, and had to call my GP surgery a few weeks later. I was not offered further diagnostics, despite my symptoms worsening and the medication for IBS not improving the situation. Over the phone I was simply offered a prescription for a new medication.
- I was unable to secure appointments as the econsult system my surgery has employed did not give me the opportunity to connect some of the symptoms I was experiencing together. Initially I had not recognised it as a gynaecological condition, as the main impact was on my digestive system and bladder. This often bounced me between calling my pharmacist or attending A&E depending on the pathway of symptoms This led to frustration and giving up due to the time-consuming nature of it.
- I was made to feel like I was being neurotic. Despite being very concerned about my health, I was met with indifference at every phone call and appointment. On one occasion I called about a 'growing lump' and was told to monitor it and get in touch if I felt like it was growing. The basis of the phone call was that I already knew it was growing. It is nearly impossible to personally monitor the growth of an internal lump in an accurate way. My experience is not unique, Sarcoma UK research says 27% of patients who visited their GP were started on treatment for another condition or told that their symptoms were not serious.
- When I finally had an appointment with a GP, who referred me for an ultrasound, I cried with relief having finally felt my concerns were taken seriously. She was empathetic and clearly concerned, and I ended up in hospital for scans two working days later. Feeling relief at getting a standard of care that should be available as standard is also something that other women have spoken to me about.
- I do not know what my long-term prognosis is at this stage, uLMS is under researched and unpredictable. Regardless, my mental health has been severely impacted, knowing how high recurrence is, and how long it was left to grow in my body and that it was staged as aggressive as a result. My GP has not contacted me since my diagnosis or offered me support outside of the hospital treatment I have received.

Diagnostics and cancer backlogs

- uLMS is commonly misdiagnosed as fibroids, as there is little to no difference when viewed on MRI or Ultrasound. Most cases of Uterine Sarcoma are discovered as a result of a routine hysterectomy or myomectomy to remove a fibroid. This was my experience and is very common as there are no reliable preoperative diagnostics. I waited from February 2022 until the end of September 2022 until I was able to have surgery. This was an additional 8/9 months where the sarcoma had an opportunity to spread and progress to Stage III.
- Fibroid surgery is considered 'non-urgent' (despite them having an enormous impact on wellbeing) and while this is understandable, without being able to differentiate between a sarcoma and a fibroid, the delay can have a catastrophic impact for women who are eventually diagnosed with uLMS (and other gynaecological sarcomas)
- Many people are offered other treatments for fibroids including uterine artery embolization. Indeed, I was offered this as the preferred treatment by my consultant. If I had taken this option the sarcoma would have been left in my body undiagnosed. Many women find themselves in this situation; research shows that it can postpone diagnosis by an additional 13-15 months. While uLMS is rare, the risk and impact of sarcoma cannot be understated when women are advised on their treatment options. I opted for surgery following personal research based on the need for more frequent reinterventions after UAE and long-term studies on the women's reported wellbeing following both procedures. However, I was nervous about expressing this decision against my consultant's recommendation. She was, however, very supportive and pleased that I had undertaken research from credible sources.
- Despite the significantly better treatment I received in hospital, there were still delays and dismissal of my experiences. I had two hormone injections to put me into chemical menopause to shrink the 'fibroid' to improve the outcomes at surgery. When the hormone injections wore off, the fibroid grew back rapidly. I called the obs-gynae department 79 times over 3 days to report my concern, but the phone was not answered. I made an official complaint in writing, expressing my concerns about the rapid growth and the lack of communication about my surgery. When someone eventually called me back, I was made to feel like I was lying about the rapid growth in order to secure a surgery date (after my original slot had been missed) At no point was I able to speak to a medical professional or asked to return to clinic to establish whether my 'fibroid' had grown rapidly. My concerns were 'dealt with' by administration staff. This was another occasion when I ended up crying to an administrator about the pain and impact on my wellbeing. The rapid growth should have also been a 'red flag' and potentially my surgery should have been changed from a myomectomy to remove a fibroid, to a hysterectomy due to risk of uLMS.

Research and breakthroughs

- Most charities and professionals working on sarcoma will tell you that research and breakthroughs on sarcoma are inadequate. It is a rare cancer, and even rarer when it appears in the reproductive organs. I have had to make life changing decisions based on research with 75 participants which hasn't been updated for years. On issues like keeping my ovaries in to prevent the conditions associated with early menopause, I have had to do it with an inconclusive research base and against the advice of my medical team, who ultimately were concerned with the immediate threat to life my cancer poses, as opposed to my long-term wellbeing should I survive the current diagnosis.
- If surgery for uLMs isn't successful and the cancer spreads, research into effective chemotherapy and radiotherapy has yet to lead to a consistently-effective standardised treatment pathways So in most cases the cancer is treatable rather than curable.
- Basic research hasn't established conclusive knowledge and is widely debated. Having been diagnosed with a fibroid (a common pathway to discovering sarcoma); there isn't conclusive research to say whether fibroids become cancerous, or whether the growth is cancerous from the start. This speaks volumes about the priority given to women's health. The 5-year survival rate for testicular cancer is 95% It is hard not to consider how the gap in research has led to such radically different outcomes.
- Recurrence levels are high, as is metastasis. This is both because of delays in diagnosis, but recurrence can happen many years after the primary tumour and it is not clear why this happens. With other cancers there are blood tests and other ways of monitoring, with uLMS it is visual monitoring on a 3-monthly basis, to ensure surgery can be deployed early as surgery is the most reliable method of controlling the disease.

Personal Impact

Several opportunities to diagnose me early and offer me timely treatment were missed. At the conclusion of my treatment at the end of December, the cancer cells appeared to be limited to my uterus. However, this is not reassuring. uLMS is under researched and as a result recurrence levels are high and prognosis once it has metastasized is extremely poor. It is very isolating to read about the lack of research and treatment for a condition that is likely to recur.

It is a rare cancer, but unfortunately the consequences are catastrophic. The current approach to diagnosing this condition always feels though it focuses on 'most likely; and 'best case' scenarios, to the extent that indicators of seriousness that should have set alarm bells ringing were ignored or weren't understood as significant.

I have had two major surgeries in 3 months, I am no longer able to have children, I am likely to experience early menopause and need to deal with the trauma of the last few months. I have taken significant amounts of time off work, and this will be ongoing as I am on a regime of a scan, x-ray and consultant appointment every three months for the next two years. At the two year point my scans will be done on a 6-monthly basis. I have no peace of mind and the constant looming of check-ups, means I have to plan my life accordingly and try to avoid

‘scan-xiety’. I have been reassured that I will be treated with priority due to the nature of the cancer and the care provided to me by the gynae-oncology nurses and the consultant team has been personal and empathetic. I can’t criticise their professionalism at all. However, due to the enormous pressure the Welsh NHS is under, I am still struggling to contact staff at University Hospital Wales to arrange appointments. I have called for results of the histology report on my cancer, and even though the original procedure was on the 30th September I do not know whether my cancer is hormone responsive - which would entail another procedure.

I live with the knowledge that due to the length of time I have had this condition and the speed at which the Welsh NHS is currently operating, my chances of dying of this cancer are high. It is hard not to feel completely isolated, as well as having my trust in the process eroded. I spend a great deal of my time thinking about the very real prospect that even with the radical surgery I have undergone at 40, the probability of me dying of this cancer still remains high.

Recommendations

Recommendations for further research and service provision can be found via charities like Sarcoma UK and Cancer Research UK. I would recommend reading their policy positions, as it will be systemic and focus on wider experiences. As a person experiencing this cancer in Wales my recommendations would include.

- Improvement of early diagnosis through primary care education; early diagnosis is key to better outcomes.
- Increased public awareness of uLMS in order that people present with symptoms much earlier.
- National Standards for Sarcoma Services were published in 2009, I have been unable to find a copy as all online links are broken, including in the Service Specification CP149 Soft Tissue Sarcoma. These should be reviewed and updated with current research.
- Diagnosis of uLMS must be improved. The risks of assuming a fibroid is benign are catastrophic. All fibroid surgery should be treated with urgency if outcomes are to be improved. In order to achieve a solution, proportionate to the risk, research into pre-operative diagnosis should be funded and prioritised as a matter of urgency.
- Resources should be channelled towards general research into sarcoma. Diagnosis rates are increasing and with little understanding of the causes, it is hard to ensure rates do not continue to increase.
- There should be a cultural shift within the NHS (and wider society) into how women are treated when they present with symptoms. I was dismissed on more occasions than I care to remember. I began to refer to it as ‘medical gaslighting’ My worst fears were eventually realised. My experience since then has not improved and there has been little contrition or a process to educate and reform practice. My GP has yet to get in touch despite my serious diagnosis in November. Alongside a better response to women and their health concerns, primary care must have better mechanisms for learning from mistakes, which involve the patient.

I am pleased to see the attention of the committee being turned towards gynaecological cancers, it has been helpful to channel some of my experiences into this response. I hope as a result there are improvements for people experiencing the impact of gynaecological cancers in Wales.

Yours faithfully.

Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Canserau gynaecolegol

This response was submitted to the Health and Social Care Committee consultation on Gynaecological Cancers

GC 04

Ymateb gan: | Response from: Coleg Brenhinol Meddygon Teulu | Royal College of General Practitioners

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Gynaecological Cancer Consultation Response
RCGP Cymru Wales

In response to the Senedd's request for comment regarding gynaecological cancers, RCGP Cymru Wales has consulted with its GP members and patient representatives to ascertain the present position on this topic in general practice. The issues raised related to awareness, screening, women's health, onward referrals, and the impact of COVID-19.

1. Awareness

Both patient representatives and GP members agree that awareness on the topic of gynaecological cancer is not at desired levels. Patients in particular note that they have access to information regarding cervical cancer but are not aware of any symptoms of other cancers such as ovarian cancer. GPs also do not feel patients presenting with symptoms know that they may be symptoms of these cancers.

2. Screening programmes

The prevention strategy with which GPs have greatest involvement with is the cervical smear. GP members note there is confusion within the public regarding who is entitled to a smear test how often. RCGP Cymru Wales is aware that some members of the public believe a smear test is only for people with symptoms, while the differences between the age of patients who qualify for smears and the regularity of the tests between the four nations means that well-meaning publicity often adds to the confusion.

GPs report an anecdotal decline in women booking themselves in for smear tests. They report reasons ranging from embarrassment, busy lifestyles and cultural beliefs.

RCGP Cymru Wales is aware of public campaigns to normalise the discussion and process surrounding a smear test however, the risks are not highly publicised. Since the introduction of HPV vaccine and the waning of the 'Jade Goody effect' there is a concern that cervical cancer is not as prominent as it could be in the public perception[1]. A Public Health Wales study in 2014 reported that women who have received the HPV vaccine are less likely to attend a screening[2], it seems further research into the uptake in Wales is needed.

3. Women's health

Patients also raise concerns that, while much has been done to promote women's health, particular training regarding all aspects is still needed to ensure that health professionals

[1] Sky News, 2019, Cervical Smear Campaign Launched: https://news.sky.com/story/cervical-smear-campaign-launched-as-jade-goody-effect-wears-off

[2] Public Health Wales, Study of the HPV Immunisation 2014, https://ncphwr.org.uk/portfolio/hpv-immunisation-wales/

understand that presentation of serious conditions in women. They draw parallels with discoveries regarding late diagnosis of endometriosis, which has been recently publicised. [3]

4. Referral to secondary care

When asked about referrals for gynaecological cancer symptoms, GPs note that referral times vary hugely between geographic locations and are often thought to be less urgent than other, more widely publicised cancers such as breast and lung.

5. Impact of COVID-19

GPs also raise the impact of COVID-19 on both the screening and referral process, noting the backlog. One GP states that prior to COVID-19 women presenting with post-menopausal would be seen in a matter of weeks, while now that wait is likely to take months. Our members also note that patients are now out the habit of booking routine screenings due to the postponement of them during COVID-19.

[3] NIHR, Why do women feel unheard, November 2022: https://evidence.nihr.ac.uk/collection/womens-health-why-women-feel-unheard/

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

Y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus
—
Public Accounts and Public Administration Committee

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Eluned Morgan AS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

19 Ebrill 2023

Annwyl Eluned

Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Yn ein cyfarfodydd ddydd Iau 30 Mawrth, trafododd y Pwyllgor Iechyd a Gofal Cymdeithasol a'r Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus faterion yn ymwneud â Bwrdd Iechyd Prifysgol Betsi Cadwaladr ac unrhyw gamau posibl y gallai'r Pwyllgor eu cymryd. Er bod y sefyllfa yn peri pryder i'r ddau Bwyllgor, rydym am sicrhau y bydd unrhyw gamau y bydd y Pwyllgorau'n eu cymryd yn amserol ac yn ychwanegu gwerth. Rydym yn awyddus i osgoi dyblygu gwaith, a byddwn yn gweithio gyda'n gilydd lle bo'n briodol i sicrhau hynny. Rydym hefyd yn ymwybodol o effaith y sefyllfa bresennol ar y staff a'r bwrdd iechyd.

Rydym wedi cytuno i ailystyried y mater hwn, ac unrhyw gamau y gallai'r Pwyllgor eu cymryd, yn ein cyfarfod cydamserol ar 25 Mai. Er mwyn hwyluso'n trafodaethau, byddem yn ddiolchgar pe gallech ddarparu'r wybodaeth a amlinellir yn yr atodiad i'r llythyr hwn. Byddem yn ddiolchgar hefyd pe baech yn ymateb erbyn 12 Mai 2023.

Yn gywir

Russell George AS
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

Mark Isherwood AS
Cadeirydd y Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Senedd Cymru
Welsh Parliament

Atodiad: Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Yn dilyn cyfarfod y Pwyllgor Iechyd a Gofal Cymdeithasol a'r Pwyllgor Cyfrifon Cyhoeddus a Gweinyddiaeth Gyhoeddus pan drafodwyd y sefyllfa ym Mwrdd Iechyd Prifysgol Betsi Cadwaladr, byddem yn ddiolchgar pe gallech ddarparu gwybodaeth am y materion isod, a hynny erbyn 12 Mai 2023.

1. Gwybodaeth ychwanegol am y Tîm Ymyrraeth a Chymorth gan gynnwys ei benodiad, ei gylch gorchwyl, ei ddulliau o weithio, ei ymrwymiad o ran amser, ac ei berthynas â Llywodraeth Cymru a Gweithrediaeth newydd y GIG.

2. Y wybodaeth ddiweddaraf am y gwaith a'r cynnydd a wnaed o ran cyflawni'r amcanion a bennwyd o dan y drefn mesurau arbennig newydd a gyflwynwyd yn y Bwrdd Iechyd.

3. Amserlen ar gyfer y gwaith o geisio gwella atebolrwydd, yn ogystal â'r gwaith o ddiwygio a diweddaru'r fframwaith ymyrryd ac uwchgyfeirio.

Mewn perthynas â phwyntiau 2. a 3. uchod, byddai'r Pwyllgorau'n ddiolchgar pe gallech ein diweddaru bob chwe mis am y cynnydd a wneir yn y meysydd hyn.

Y Pwyllgor Iechyd a
Gofal Cymdeithasol
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Health and Social Care
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Julie Morgan AS
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Llywodraeth Cymru

21 Ebrill 2023

Annwyl Julie

Polisi rhyddhau o'r ysbyty Cymru gyfan a'r canllawiau cysylltiedig

Roedd argymhelliad 3 yn ein hadroddiad ar gyllideb ddrafft Llywodraeth Cymru 2023-24 yn gofyn am wybodaeth am ba mor hir y disgwylir i'r canllawiau diwygiedig a gyhoeddwyd ar 30 Rhagfyr 2022, sy'n datgan y gellir rhyddhau cleifion tra'n aros am asesiad gofal cymdeithasol neu heb fod pecyn gofal yn ei le, barhau mewn grym.

Yn eich ymateb i'n hargymhelliad, egluroch chi fod y llythyr a gyhoeddwyd ym mis Rhagfyr 2022 "yn cefnogi'r canllawiau presennol ar ryddhau cleifion o'r ysbyty sydd eisoes ar gael yn y system", ac felly y byddai'n "parhau ar waith hyd y gellir rhagweld".

Rydym yn nodi bod y canllawiau 'Cyflawni'r canlyniadau a'r profiad gorau i bobl yn yr ysbyty', sy'n rhan o'r Rhaglen Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng, yn nodi:

> *"Mae polisi rhyddhau Cymru gyfan yn cael ei ddiweddaru (2022) a dylid ei ddefnyddio i ategu'r broses o drosglwyddo cleifion pan fyddant wedi'u hoptimeiddio'n glinigol ac y gallant symud i le gofal mwy addas. Dylai cam nesaf eu gofal gael ei nodi gan y llwybr D2RA y maent arno.*
>
> *Bydd dau ganllaw newydd ar gael a fydd yn ategu'r fframwaith hwn ac yn dod yn rhan o'r polisi rhyddhau diwygiedig:*

Senedd Cymru
Welsh Parliament

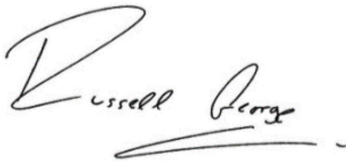
- *Canllawiau ar gyfer Rôl Aseswr Dibynadwy*
- *Canllawiau Rhyddhau Cleifion Anfodlon."*

Byddem yn ddiolchgar pe gallech wneud y canlynol:

1. Darparu wybodaeth ynghylch pryd y bydd y polisi Cymru gyfan wedi'i ddiweddaru, a phryd y caiff y canllawiau newydd ynghylch Rôl Aseswr Dibynadwy a Rhyddhau Cleifion Anfodlon eu cyhoeddi.
2. Ymrwymo i ddarparu copïau o bob un o'r tair dogfen i ni pan fyddant ar gael.

Byddem yn ddiolchgar o gael ymateb erbyn 9 Mehefin 2023.

Yn gywir



Russell George AS
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

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Peredur Owen Griffiths AS
Cadeirydd
Y Pwyllgor Cyllid

28 Ebrill 2023

Annwyl Peredur,

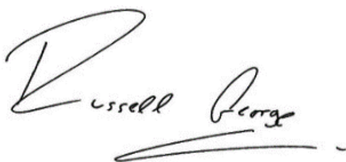
Craffu ar y Gyllideb Ddrafft ar gyfer 2023-24: Tystiolaeth a ddarparwyd gan Lywodraeth Cymru

Diolch am eich llythyr dyddiedig 8 Mawrth 2023, a'r cyfle i roi sylwadau ar y dogfennau cyllidebol a ddarparwyd gan Lywodraeth Cymru i lywio gwaith craffu'r Senedd ar y Gyllideb Ddrafft ar gyfer 2023-24.

Buom yn trafod eich llythyr yn ein cyfarfod ar 30 Mawrth 2023, a gobeithiwn y bydd y myfyrdodau ar ein profiad o graffu ar gyllideb ddrafft Llywodraeth Cymru ar gyfer 2023-34 a nodir yn yr atodiad i'r llythyr hwn o gymorth wrth fwrw ymlaen â gwelliannau ar gyfer y dyfodol.

Rhowch wybod i ni os bydd angen rhagor o wybodaeth arnoch.

Yn gywir



Russell George AS
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Atodiad: barn y Pwyllgor Iechyd a Gofal Cymdeithasol ar ddogfennau Cyllideb Ddrafft Llywodraeth Cymru ar gyfer 2023-24 a thystiolaeth ysgrifenedig ddilynol gan y Gweinidog

Y cefndir

1. Cynhaliwyd gwaith craffu'r Pwyllgor ar gyllideb ddrafft Llywodraeth Cymru 2023-24 ar 11 Ionawr 2023. Yn unol â'n harfer arferol, fe wnaethom ysgrifennu at y Gweinidogion sy'n gyfrifol am iechyd a gofal cymdeithasol ar 28 Hydref 2022, yn gofyn am wybodaeth ysgrifenedig i lywio ein gwaith craffu. Y dyddiad cau ar gyfer derbyn cyflwyniadau oedd 14 Rhagfyr 2022. Cawsom y dogfennau terfynol yn Saesneg ar 21 Rhagfyr 2022. Ni chafwyd y dogfennau Cymraeg tan 9 Ionawr 2023 (roedd ein papurau cyfarfod wedi'u cyhoeddi ar 6 Ionawr 2023). Hefyd, ar 9 Ionawr 2023, cawsom gais i ddisodli rhan o'r cyflwyniad Saesneg gwreiddiol (a oedd eisoes wedi'i gyhoeddi) gyda fersiwn ddiwygiedig.

Amseroldeb tystiolaeth

2. Mae angen derbyn papurau'n ddwyieithog pan ofynnir amdanynt, gyda'r holl atodiadau perthnasol. Dylent hefyd fod yn gywir ac ni ddylid bod angen eu disodli gan fersiynau wedi'u diweddaru neu eu diwygio. Roedd cael tystiolaeth wythnos yn hwyr, a dim ond ychydig cyn gwyliau'r Nadolig, wedi lleihau'r amser a oedd ar gael i'r Aelodau a'n swyddogion ystyried y dystiolaeth a pharatoi ar gyfer y sesiwn dystiolaeth lafar gyda'r Gweinidogion.

Ffocws y dystiolaeth

3. Hoffai'r Pwyllgor pe bai Llywodraeth Cymru yn rhoi y refeniw, a'r negeseuon allweddol i ni; a sut mae'r dyraniadau yn adlewyrchu'r negeseuon hynny; y canlyniadau y maent yn eu disgwyl a sut y byddant yn mesur y canlyniadau hynny. Er ein bod wedi ysgrifennu at Lywodraeth Cymru ymlaen llaw i nodi rhai materion, roedd y dystiolaeth ysgrifenedig yn hir iawn ac nid oedd yn cynnwys manylion penodol.

4. Yn y dyfodol, hoffem gael crynodeb o'r prif negeseuon allweddol, o'r newidiadau allweddol ac arwyddocaol (e.e. cynnydd chwyddiant o ran byrddau iechyd, cynnydd o ran cyllid gofal cymdeithasol), pwysau allweddol, amcanion neu flaenoriaethau newydd allweddol, a newidiadau o'u cymharu â'r flwyddyn flaenorol. Dylai'r prif gorff fod wedi'i olygu'n dda a chanolbwyntio'n benodol. Dylai ddangos yn union beth sy'n cael ei wario, ym mha feysydd, yr amserlen ar gyfer y gwariant, a pha effaith/canlyniadau a sicrheir o ran y gwariant hwnnw. Ar gyfer cynlluniau cyfalaf, dylai fod yn benodol ynghylch pa gynlluniau sy'n cael eu hariannu, a beth fydd yn cael ei brynu ac erbyn pryd. Mae diffyg manylion gronynnog yn y dystiolaeth eleni, ac mewn blynyddoedd blaenorol.

5. Rhoddir cyfran sylweddol o'r cyllid iechyd yn uniongyrchol i'r byrddau iechyd. Mae angen i'r Pwyllgor gael gwybodaeth am flaenoriaethau'r Gweinidogion ac unrhyw gyfarwyddiadau sy'n ymwneud â'r cyllid hwn, a hynny yn llawer cynharach. Ni allwn weld fod unrhyw reswm pam na

ddylem gael y wybodaeth hon yr un amser â'r byrddau iechyd, ac o leiaf ymhell cyn unrhyw sesiynau tystiolaeth lafar.

Anghydraddoldebau iechyd a gwariant ataliol

6. Mae angen i Lywodraeth Cymru fod yn gliriach yn naratif ei chyllideb a'i dogfennau o ran sut mae gwariant mewn DELau eraill yn cyfrannu at fynd i'r afael ag anghydraddoldebau iechyd. Dylai hyn fod yn glir o ran negeseuon, ac o ran arian, canlyniadau a chamau a nodir.

7. Mae hyn hefyd yn wir o ran gwariant ataliol.

Ymateb Llywodraeth Cymru i adroddiad y Pwyllgor:

8. Mae angen i ymateb Llywodraeth Cymru i adroddiad y Pwyllgor ddod i law ymhellach ymlaen llaw i'r ddadl yn y Cyfarfod Llawn er mwyn galluogi Aelodau a rhanddeiliaid i'w ystyried cyn cymryd rhan yn y ddadl a phleidleisio ar y gyllideb. Eleni, cawsom y fersiwn Saesneg y noson cyn y ddadl, a'r fersiwn Gymraeg a'r llythyr eglurhaol ychydig oriau cyn i'r ddadl gael ei chynnal.

Gwybodaeth am y gyllideb derfynol

9. Pan fydd y gyllideb derfynol yn cael ei gosod, dylai gwybodaeth glir am yr hyn sydd wedi newid ers y gyllideb ddrafft gydfynd â hi. Dylai Gweinidogion ysgrifennu at Bwyllgorau sydd wedi gwneud gwaith craffu ar y gyllideb, naill ai i gadarnhau bod dyraniadau'r gyllideb ddrafft wedi'u hadlewyrchu yn y gyllideb derfynol, neu i nodi ble y bu newidiadau.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George AS
Cadeirydd,
Y Pwyllgor Iechyd a Gofal Cymdeithasol

Seneddlechyd@senedd.cymru

25 Ebrill 2023

Annwyl Russell

Diolch ichi am eich llythyr dyddiedig 10 Mawrth ynghylch camau dilynol y Pwyllgor i'w ymchwiliad i endosgopi.

Mae cynaliadwyedd ac achrediad proffesiynol gwasanaethau endosgopi yn parhau i fod yn flaenoriaeth i Lywodraeth Cymru. Fel y nodais yn fy ymateb blaenorol i'r Pwyllgor ar y mater hwn, bu tarfu sylweddol ar y rhaglen waith genedlaethol i gefnogi sefydliadau'r GIG. Er hynny, rydym yn parhau i weithio gyda'r GIG i wneud cynnydd ac i gysoni'r gwaith hwn â'r Bwrdd Diagnostig. Yn gynharach heddiw, cyhoeddais y Strategaeth Adfer a Thrawsnewid Diagnosteg sy'n ceisio gwella mynediad at brofion diagnostig a chefnogi datblygiad ein gweithlu diagnostig. Bydd y Strategaeth newydd hon yn adeiladu ar waith y Rhaglen Endosgopi Genedlaethol, ac yn mewngorffori'r gwaith hwn, gan roi cyfleoedd i gyd-fynd â datblygiadau ehangach hanfodol fel y ganolfan ddiagnostig ranbarthol arfaethedig ar gyfer de-ddwyrain Cymru.

Rwyf wedi ymateb i argymhellion eich Pwyllgor isod.

Argymhelliad: Dylai Llywodraeth Cymru ddarparu rhagor o wybodaeth am sefydlu Gweithrediaeth y GIG. Dylai hyn gynnwys manylion ei threfniadau llywodraethu, ei rôl a'i chyfrifoldebau mewn perthynas â dwyn byrddau iechyd i gyfrif a sicrhau bod newid yn cael ei weithredu, a'r amserlenni ar gyfer ymgymryd â'r rolau a'r cyfrifoldebau hynny.

Fel y byddwch yn gwybod, daeth Gweithrediaeth GIG Cymru i rym o 1 Ebrill 2023: Hafan – Gweithrediaeth GIG Cymru. Mae'r Rhaglen Endosgopi Genedlaethol yn rhan o'r Rhaglen Diagnosteg Genedlaethol gyffredinol a bydd y trefniadau llywodraethu rhwng rhaglenni cenedlaethol a Gweithrediaeth GIG Cymru yn cael eu penderfynu gan yr uwch dîm arwain.

Gan weithio ar ran Llywodraeth Cymru, swyddogaeth Gweithrediaeth GIG Cymru yw sicrhau arweinyddiaeth gryf a chyfeiriad strategol, a galluogi, cefnogi a, lle bo angen,

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Correspondence.Eluned.Morgan@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

ymyrryd i sicrhau bod blaenoriaethau a safonau cenedlaethol yn cael eu cyflawni a diogelu a gwella ansawdd a diogelwch gofal. Bydd Gweithrediaeth GIG Cymru yn rhoi capasiti ychwanegol ar lefel genedlaethol i oruchwylio a chefnogi darparu'r blaenoriaethau hyn drwy ddod â Chydweithrediaeth Iechyd GIG Cymru, Uned Gyflawni GIG Cymru, Uned Cyflawni Ariannol GIG Cymru a Gwelliant Cymru ynghyd. Bydd Gweithrediaeth GIG Cymru yn gweithredu o dan uwch dîm arweinyddiaeth penodedig ac yn parhau i gyflawni nifer o'r swyddogaethau a oedd yn cael eu cyflawni'n wreiddiol gan y sefydliadau hyn ond mewn ffordd fwy effeithiol, effeithlon a chydweithredol. Bydd Gweithrediaeth GIG Cymru yn:

- Cryfhau arweinyddiaeth a chefnogaeth genedlaethol i sicrhau gwell ansawdd
- Darparu cyfeiriad mwy canolog i sicrhau dull cyson a theg o gynllunio yn seiliedig ar ganlyniadau yn genedlaethol ac yn rhanbarthol.
- Galluogi trefniadau rheoli perfformiad cryfach, gan gynnwys y gallu i herio a chefnogi sefydliadau nad ydynt yn gweithredu yn ôl y disgwyl.
- Ysgogi ac ymateb i'r datblygiadau mewn technoleg a gwyddorau meddygol i sicrhau GIG modern yng Nghymru.

Ni fydd sefydlu Gweithrediaeth GIG Cymru yn newid mecanweithiau atebolrwydd statudol. Mae holl gyrff y GIG eisoes yn uniongyrchol atebol i Weinidogion, a Llywodraeth Cymru, a bydd hyn yn parhau. Bydd Gweinidogion yn parhau i osod blaenoriaethau, targedau a mesurau canlyniadau ar gyfer y GIG ar ffurf Fframwaith Cynllunio'r GIG. Mae hwn wedi'i drosi gan y Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/Prif Weithredwr GIG Cymru yn Fandad i Weithrediaeth GIG Cymru, gan amlinellu ei rôl, ffyrdd o weithio a swyddogaethau o ran cyflawni'r disgwyliadau a nodwyd mewn Llythyr Cylch Gwaith blynyddol.

Yn ystod 2023, y bwriad yw adeiladu ar gam cyntaf ei sefydlu a chryfhau'r trefniant hwn drwy gynnwys swyddogaethau ychwanegol fel rhan o raglen cam 2. Bydd Ebrill 2023 - Mawrth 2024 yn flwyddyn bontio ar gyfer Gweithrediaeth GIG Cymru ac rydym yn derbyn y bydd rhai elfennau o'i ddatblygiad a'i effeithiolrwydd llawn yn parhau i esblygu dros amser wrth iddo aeddfedu a setlo i'r system iechyd a gofal cymdeithasol ehangach.

Argymhelliad: Dylai Llywodraeth Cymru roi diweddariad i ni erbyn mis Gorffennaf 2023 am ddatblygu academi endosgopi clinigol, yn benodol er mwyn nodi a yw'r gwaith ar y trywydd iawn i fodloni'r amserlenni a ragwelwyd yng nghynllun gwella gwasanaethau canser ar gyfer GIG Cymru 2023-2026.

Mae byrddau iechyd yn y de-ddwyrain yn parhau i ddatblygu cynigion ar gyfer cyfleusterau endosgopi sy'n gallu darparu ar gyfer y galw cynyddol ar y gwasanaeth clinigol hwn. Mae trafodaethau ar y gweill gyda chydweithwyr clinigol, gan gynnwys Uwchgynhadledd Endosgopi Clinigol a drefnwyd ar gyfer 21 Ebrill i ystyried y model mwyaf effeithiol ar gyfer darparu'r gwasanaeth yn y dyfodol. Ochr yn ochr â hyn, mae Addysg a Gwella Iechyd Cymru yn ystyried sut y gellir sefydlu model Academi Hyfforddiant Sgiliau Clinigol ar gyfer endosgopi i gynorthwyo gyda recriwtio a chadw endoscopyddion clinigol.

Argymhelliad: Dylai Llywodraeth Cymru nodi pa gamau fydd yn cael eu cymryd, a phryd, i symud gwasanaethau endosgopi o'r sefyllfa bresennol, sy'n dibynnu ar fesurau tymor byr fel contractio gwaith ar sail mewnol ac ar sail allanol i ymateb i'r galw, ac i ryddhau arian i fuddsoddi mewn gweithlu mwy cynaliadwy a datrysiadau o ran capasiti.

Mae Llywodraeth Cymru'n parhau i weithio gyda byrddau iechyd o ran datblygu eu capasiti endosgopi. Mae'r rhaglen endosgopi genedlaethol wedi cefnogi byrddau iechyd i ddatblygu eu modelu o ran y galw a'r capasiti. Mae'r byrddau iechyd yn cynllunio eu gwasanaethau mewn ymateb i hyn, ac rydym yn adolygu eu cynlluniau lleol a rhanbarthol. Mae'r rhain yn cynnwys cymysgedd o atebion, megis cynllunio swyddi diwygiedig, recriwtio ychwanegol, hyfforddi staff presennol, a datblygu cyfleusterau newydd. Hoffwn dynnu sylw at fuddsoddiad cyfalaf Llywodraeth Cymru mewn theatrau endosgopi newydd ac wedi'u hadnewyddu yng Nghaerdydd a Chasnewydd fel enghraifft o gymorth Llywodraeth Cymru, ond bydd yn cymryd llawer o flynyddoedd i gyrff y GIG recriwtio, hyfforddi a defnyddio'r capasiti gweithlu ychwanegol angenrheidiol.

Bydd y mwyafrif o fyrddau iechyd yn parhau i ddibynnu ar atebion staffio nad ydynt yn rhai craidd i ddiwallu angen cyffredinol eu poblogaeth. Mae'n debygol y bydd hyn yn parhau ochr yn ochr â datblygu capasiti craidd ychwanegol am gryn amser, a bydd hyn yn dibynnu ar ba mor gyflym y gellir recriwtio neu hyfforddi staff – yn ogystal â newidiadau yng nghydbwysedd y galw/capasiti yn y dyfodol a'r rhagolygon ariannol y dyfodol ar gyfer GIG Cymru. Y bwriad yw lleihau dibynnu gymaint â phosibl ar gyflenwyr allanol ac i ryw raddau ar drefnu yn fewnol a mentrau rhestri aros. Er hynny, bydd angen defnydd mwy cyfyngedig o'r gallu hwn bob amser i fodloni ymchwydd yn y galw neu i gyflymu'r gwaith o leihau'r ôl-groniad.

Y bwriad yw datblygu capasiti'r gwasanaeth craidd i'r pwynt lle gall hyn fodloni'r rhan fwyaf o'r galw rheolaidd. Fel rhan o hyn, mae'r rhaglen endosgopi genedlaethol yn cydweithio ag Addysg a Gwella Iechyd Cymru (AaGIC) i hyfforddi carfannau o endosgopyddion clinigol. Hyd yn hyn mae AaGIC wedi darparu tair carfan lwyddiannus ac wyth endosgopydd clinigol wedi cwblhau'r hyfforddiant. Mae tri endosgopydd clinigol yn cael eu hyfforddi ar hyn o bryd, gyda charfan bellach i ddechrau ym mis Medi. Mae'r rhaglen endosgopi genedlaethol hefyd wedi lansio ymgyrch ledled y DU i ddenu gweithwyr gofal iechyd proffesiynol i weithio ym maes endosgopi yng Nghymru. Mae'r Rhaglen wrthi'n cynnal arolwg cadw o holl staff endosgopi GIG Cymru ar hyn o bryd i gael gwell dealltwriaeth o'u profiad yn y gweithle ac i ganfod y rhesymau dros ddewis rhai i adael neu i aros yn y proffesiwn. Bydd y Rhaglen yn cydweithio'n agos ag AaGIC i ddatblygu cynllun cadw penodol i endosgopi er mwyn mynd i'r afael ag unrhyw faterion a nodir yn yr arolwg. Rydym hefyd yn ymchwilio i'r potensial ar gyfer cyflwyno academi endosgopi i gefnogi'r gwaith o ddatblygu gweithlu'r dyfodol yn gyflymach.

Argymhelliad: Yn ei hymateb i'r llythyr hwn, dylai Llywodraeth Cymru nodi pa waith sy'n cael ei wneud i ddeall a mynd i'r afael â'r rhwystrau sy'n gysylltiedig ag amrywiadau neu bolisïau adnoddau dynol gor-gyfyngol a allai atal staff y GIG rhag gweithio neu hyfforddi mewn bwrdd iechyd heblaw'r bwrdd iechyd y maent wedi'i leoli ynddo. Os oes angen mwy o amser i ymateb, dylai Llywodraeth Cymru ymrwymo i roi'r wybodaeth hon erbyn mis Gorffennaf 2023.

Yn y Cynllun Gweithredu Cenedlaethol ar gyfer y Gweithlu a gyhoeddwyd ym mis Ionawr, rydym wedi ymrwymo i fynd i'r afael â'r rhwystrau sydd ar hyn o bryd yn atal staff rhag cael eu defnyddio yn hyblyg ar draws rhwystrau sefydliadol. Yn benodol, rydym wedi nodi camau i gefnogi Cydwasanaethau GIG Cymru i ddatblygu dull 'pasbort' er mwyn galluogi'r gweithlu i gael ei defnyddio ar draws sefydliadau GIG Cymru yn fwy hyblyg. Rydym hefyd yn ymrwymo yn y cynllun i gefnogi'r angen i gynllunio a darparu gwasanaethau yn rhanbarthol wrth i fodelau gwasanaeth newydd a chynaliadwy gael eu datblygu.

Argymhelliad: Yn yr ymateb i'r llythyr hwn, dylai Llywodraeth Cymru nodi pa gamau sy'n cael eu cymryd, a phryd, i arwain, annog a hwyluso'r defnydd o dechnolegau arloesol a ffyrdd o weithio mewn gwasanaethau endosgopi yng Nghymru.

Mae arloesi mewn gofal endosgopig yn elfen bwysig ar wella gwasanaethau. Yn ystod y blynyddoedd diwethaf, mae gwasanaethau endosgopi wedi integreiddio llawer o arloesiadau megis delweddu gwell, hyblygrwydd, goleuadau, a galluoedd megis echdoriad endosgopig sy'n creu archoll mor fach â phosibl yn lle echdoriad llawfeddygol. Mae'n bwysig ystyried gwerthuso dyfeisiau newydd a thechnegau sy'n esblygu. Mae angen cydbwyso hyn ag anghenion y cleifion a'r boblogaeth a thystiolaeth am eu diogelwch a'u heffeithiolrwydd clinigol, a chost-effeithiolrwydd o'u cymharu â'r technegau presennol. Ar hyn o bryd mae gan dimau clinigol adnoddau, capasiti, ac amser cyfyngedig i brofi a gwerthuso technegau newydd, ac felly mae angen ymdrechion cydgysylltiedig i gefnogi gwerthuso ac integreiddio arloesedd.

Mae arloesi'n cynnwys cyfuniad o synthesis tystiolaeth genedlaethol, arweiniad a chefnogaeth, a gwerthuso lleol ac ymarferoldeb gweithredu. Mae'r rhaglen endosgopi genedlaethol yn canolbwyntio ar ddatblygu gwasanaethau addas i'r diben, cynaliadwy, ac achrededig. Mae arloesi mewn technegau yn berthnasol i'r agenda hon gan y gallai technegau newydd, ar gyfer rhai cleifion â gofynion penodol, fod yn llawer gwell neu'n llai dwys i'w darparu o ran adnoddau. Mae'r rhaglen wedi ystyried nifer o arloesiadau megis endosgopi capsiwl colon ac yn gweithio gyda nifer o fyrddau iechyd i brofi cymhwyso'r dechneg hon. Mae rhaglenni cenedlaethol perthynol, megis canser, hefyd wedi cefnogi profi technegau newydd megis endosgopi drwy'r trwyn. Bydd sefydliadau cenedlaethol yn parhau i gefnogi mabwysiadu technolegau sydd wedi profi eu gwerth.

Er hynny, cyfrifoldeb sefydliadau'r GIG yw penderfynu pa dechnegau a dyfeisiau sy'n cyflawni'r gofynion ar gyfer eu poblogaethau lleol yn y ffordd orau, ar yr amod eu bod yn cydymffurfio â safonau gofal cenedlaethol.

Argymhelliad: Yn ei hymateb i'r llythyr hwn, dylai Llywodraeth Cymru roi rhagor o wybodaeth am y gofal cofleidiol a'r cymorth (gan gynnwys cymorth iechyd meddwl) sydd ar gael i bobl sydd wedi cael diagnosis o gyflyrau genetig fel Syndrom Lynch yng Nghymru. Dylai hyn gynnwys gwybodaeth am sut y caiff gofal a chymorth o'r fath eu teilwra i anghenion grwpiau penodol, er enghraifft menywod o oedran cael plant, pobl o gymunedau lleiafrifoedd ethnig, neu bobl anabl.

Mae Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (WHSSC) yn comisiynu profion Lynch fel y disgrifiwyd yn ei Sefyllfa Bolisi Profi Genomig PP184. Mae'r prawf genomig hwn

wedi'i gomisiynu gan Wasanaeth Genomeg Feddygol Cymru gyfan (AWMGS). Mae AWMGS yn darparu gwasanaethau genomig ar gyfer poblogaeth Cymru sy'n cael ei chynnal gan Fwrdd Iechyd Prifysgol Caerdydd a'r Fro. Mae tua 2,000 o samplau'r flwyddyn yn dod i law oddi wrth bob un o'r saith bwrdd iechyd. Mae AWMGS wedi cael ei roi ar waith yn llwyddiannus ledled Cymru, gan sicrhau bod cleifion yng Nghymru'n gallu cael mynediad at brofion a argymhellir, yn deg ar draws Cymru. Rydym yn disgwyl i fyrddau iechyd ddarparu gofal cyfannol sy'n gweddu i'r unigolyn.

Mae AWMGS yn cwnsela ac yn cefnogi pob person sy'n cael ei brofi am syndrom Lynch, cyn profi, ac wedi hynny os cadarnheir bod ganddynt y cyflwr. Nod y gwasanaeth yw cefnogi cleifion i ddeall eu hopsiynau a phenderfynu sut i symud ymlaen. Bydd hyn yn ystyried amgylchiadau unigol pob person ac yn cynnwys unrhyw benderfyniadau y gall fod angen eu gwneud ynghylch opsiynau atgenhedlu, sgrinio neu wyliadwriaeth, triniaeth, a chyffuriau atal canser.

Gobeithio y bydd yr wybodaeth hon o gymorth i chi.

Yn gywir

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Eitem 4.5

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George AS
Cadeirydd
Y Pwyllgor Iechyd a Gofal Cymdeithasol

SeneddIechyd@senedd.cymru

25 Ebrill 2023

Annwyl Russell

Ysgrifennaf i hysbysu’r Pwyllgor fod Llywodraeth y DU yn bwriadu gwneud a gosod Rheoliadau Gofal Iechyd (Trefniadau Rhyngwladol) (Ymadael â’r UE) 2023 ("y Rheoliadau HIA”).

Rwyf wedi derbyn llythyr oddi wrth Will Quince AS, y Gweinidog Gwladol dros Iechyd a Gofal Eilaidd ynglŷn â’r Rheoliadau HIA, y mae Llywodraeth y DU yn bwriadu eu gosod yng ngwanwyn 2023. At hynny, mae swyddogion Llywodraeth y DU wedi dweud mai eu bwriad yw gosod y Rheoliadau ddechrau mis Mehefin.

Bydd y Rheoliadau HIA yn ymestyn i'r DU gyfan. Byddant yn cael eu gwneud drwy arfer pwerau a roddir i'r Ysgrifennydd Gwladol gan Ddeddf Gofal Iechyd (Trefniadau Rhyngwladol) 2019 ("y Ddeddf") (a arferai gael ei galw yn Ddeddf Gofal Iechyd (Trefniadau’r Ardal Economaidd Ewropeaidd a'r Swistir) 2019 ond sy’n cael ei hailenwi gan adran 162 o Ddeddf Iechyd a Gofal 2022). Pan ddaw adran 162 i rym, bydd yn peri i’r prif bŵer galluogi ar gyfer y Rheoliadau HIA gychwyn. Bydd y prif bŵer galluogi yn cael ei gynnwys yn adran 2 o'r Ddeddf. O dan adran 2A o'r Ddeddf, caiff Gweinidogion Cymru hefyd wneud darpariaeth benodol drwy reoliadau sy'n cyfateb i'r hyn y gall yr Ysgrifennydd Gwladol ei wneud drwy ddefnyddio adran 2, ond nid yr holl ddarpariaeth a dim ond pan fo'r ddarpariaeth o fewn cymhwysedd datganoledig.

Bydd y Rheoliadau HIA yn disodli fframwaith cyfreithiol y DU ar gyfer gweithredu trefniadau gofal iechyd y darperir ar eu cyfer mewn rheoliadau presennol, sef Rheoliadau Gofal Iechyd (Trefniadau’r Ardal Economaidd Ewropeaidd a’r Swistir) (Ymadael â’r UE) 2019 ("Rheoliadau HEEASA"), a wneir mewn perthynas â darparu gofal iechyd cilyddol yng ngwladwriaethau’r Ardal Economaidd Ewropeaidd (AEE) a'r Swistir, gan gynnwys gwneud taliadau. Mae’r Rheoliadau HEEASA hefyd yn gosod dyletswyddau ar awdurdodau cyhoeddus yng Nghymru i roi effaith i drefniadau gofal iechyd cilyddol gyda'r Undeb Ewropeaidd (UE), Gwledydd yr Ardal Economaidd Ewropeaidd a'r Swistir.

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

Mae'r Rheoliadau HIA yn debyg i'r Rheoliadau HEEASA i raddau helaeth, ond maent yn ehangu cwmpas y fframwaith cyfreithiol i gynnwys cytundebau gofal iechyd rhwng Llywodraeth y DU a gwledydd Gweddill y Byd. Mae'r Rheoliadau HIA yn:

- galluogi i daliadau gael eu gwneud yn unol â chytundeb gofal iechyd cilyddol gan yr Ysgrifennydd Gwladol ar sail y DU gyfan;
- galluogi i daliadau gael eu gwneud gan yr Ysgrifennydd Gwladol mewn amgylchiadau eithriadol ar sail y DU gyfan;
- gorfodi gofyniad i roi effaith i rwymedigaethau ac ymrwymiadau'r DU o dan gytundebau gofal iechyd perthnasol, gan gynnwys prosesu swyddogaethau triniaeth mamolaeth a gynlluniwyd, ar Awdurdod Gwasanaethau Busnes GIG y DU (NHSBSA);
- gorfodi swyddogaethau gwybodaeth a chyngor ar NHSBSA;
- rhestru Gwledydd Gweddill y Byd sy'n rhan o gytundebau gofal iechyd rhyngwladol â'r DU;
- gorfodi swyddogaethau triniaeth a gynlluniwyd S2 ar GIG Lloegr, Byrddau Iechyd Lleol Cymru a byrddau iechyd yr Alban (hy, gwneud penderfyniadau clinigol mewn perthynas â cheisiadau a phennu a chyhoeddi gweithdrefnau ar gyfer gwneud penderfyniadau mewn perthynas â cheisiadau S2, sy'n cynnwys darpariaeth ar gyfer proses adolygu).

Gellid gwneud rhai agweddau ar y Rheoliadau HIA yn gyfan neu'n rhannol drwy ddarpariaeth sydd wedi'i chynnwys mewn rheoliadau a wnaed gan Weinidogion Cymru o dan adran 2A o'r Ddeddf.

Egwyddor gyffredinol Llywodraeth Cymru yw mai yng Nghymru y dylai'r gyfraith sy'n ymwneud â materion datganoledig gael ei gwneud a'i diwygio, ond, ar yr achlysur hwn, rwyf wedi ystyried ei bod yn briodol i'r Ysgrifennydd Gwladol ddeddfu mewn perthynas â Chymru.

Mae'r sefyllfa o ran cymhwysedd yn y maes hwn yn gymhleth. Er bod gan Weinidogion Cymru rywfaint o bŵer i wneud rheoliadau yn y maes hwn mewn perthynas â Chymru, mae'r fframwaith cyfreithiol sydd ar waith ar gyfer darparu gofal iechyd cilyddol wedi'i gydblethu hefyd ag agweddau nad ydynt o fewn cymhwysedd datganoledig. Felly, byddai rheoliadau Llywodraeth y DU a rheoliadau Cymru yn unig ar wahân yn gyd-ddibynnol ar ei gilydd. Gan fod y maes hwn wedi'i gydblethu cymaint, rwyf o'r farn y byddai'n ddarbodus pennu'r fframwaith cyfreithiol yng Nghymru mewn un set o reoliadau, yn hytrach na rhannu hyn rhwng rheoliadau Cymru yn unig a Rheoliadau'r DU. Mae hyn hefyd yn golygu bod y ddeddfwriaeth yn fwy hygyrch, yn unol ag egwyddorion cyfraith dda.

Mae'r ddarpariaeth ddeddfwriaethol amnewid a wneir gan y Rheoliadau HIA mewn perthynas â chyfundrefn y DU ar gyfer gofal iechyd cilyddol yn cadw'r status quo yn fras o dan y Rheoliadau HEEASA cyfredol. Golyga hyn y byddai'r ddarpariaeth y byddai'r Ysgrifennydd Gwladol yn ei gwneud yn y Rheoliadau HIA mewn perthynas â Chymru ac mewn meysydd datganoledig yn cyfateb i'r ddarpariaeth y byddem ninnau yn ei gwneud mewn rheoliadau Cymru yn unig. Felly, ni fyddai'n niweidiol i'r safbwynt polisi yn y maes hwn pe bai Llywodraeth y DU yn gwneud y ddarpariaeth hon i Gymru. Nid yw'r dull gweithredu hwn ychwaith yn atal Gweinidogion Cymru rhag gwneud rheoliadau i Gymru yn unig o dan adran 2A o'r Ddeddf yn y dyfodol.

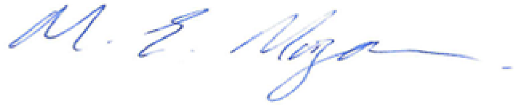
Rhestrir gwledydd a gwmpesir gan Gytundebau Gofal Iechyd Rhyngwladol mewn Atodlen i'r Rheoliadau HIA. O ystyried bod Llywodraeth y DU am geisio cytundebau â nifer o wledydd yn y blynyddoedd sydd i ddod, a bydd angen diwygio'r Atodlen gan ddefnyddio'r weithdrefn gadarnhaol bob tro y bydd gwledydd yn cael eu rhestru, rwy'n ystyried ei fod yn fwy ymarferol ac effeithlon bod Llywodraeth y DU yn gwneud y gwaith hwn ar ein rhan.

Nid yw'r dull yn y Rheoliadau HIA fel y'u drafftiwyd yn gwrthdaro â'r Rhaglen Lywodraethu nac ychwaith y Cytundeb Cydweithio.

Nid oes gan y Rheoliadau hyn oblygiadau ar gyfer y Rhaglen Lywodraethu.

Rwyf wedi ysgrifennu yn yr un modd at Huw Irranca-Davies AS, Cadeirydd y Pwyllgor Deddfwriaeth, Cyfiawnder a'r Cyfansoddiad.

Yn gywir



Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Y Pwyllgor Iechyd a Gofal Cymdeithasol
–
Health and Social Care Committee

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Peredur Owen Griffiths AS
Cadeirydd
Y Pwyllgor Cyllid

24 Ebrill 2023

Annwyl Peredur

Byrddau iechyd: cynaliadwyedd a chydbwysedd ariannol

Yn ein cyfarfod ar 30 Mawrth 2023, trafododd y Pwyllgor Iechyd a Gofal Cymdeithasol ymateb Llywodraeth Cymru i'n hadroddiad diweddar ar gyllideb ddrafft Llywodraeth Cymru ar gyfer 2023-24. Mae gennym rai pryderon parhaus am berfformiad ariannol byrddau iechyd, a hoffem ofyn ichi ystyried cynnwys craffu ariannol ar fyrddau iechyd yn eich rhaglen waith.

Rydym wedi ystyried sefyllfa ariannol byrddau iechyd yn ystod ein gwaith craffu ar gyllidebau drafft Llywodraeth Cymru ar gyfer 2022-23 a 2023-24, gan gynnwys i ba raddau y maent yn cyflawni eu cyfrifoldebau statudol o dan Ddeddf Cyllid y Gwasanaethau Iechyd Gwladol (Cymru) 2014, h.y. eu dyletswyddau i reoli eu hadnoddau o fewn terfynau cymeradwy dros gyfnod treigl o dair blynedd; ac i baratoi Cynllun Tymor Canolig Integredig dros gyfnod treigl o dair blynedd a gymeradwyir gan Weinidogion. Yn ystod tystiolaeth lafar ar y gyllideb ddrafft ym mhob blwyddyn, rydym wedi trafod y sefyllfa â'r Gweinidogion, gan gynnwys sut y mae Llywodraeth Cymru yn gweithio gyda byrddau iechyd ac yn eu cefnogi.

Fodd bynnag, rydym yn pryderu bod ein gwaith craffu ar gyllideb ddrafft 2023-24 yn awgrymu bod sefyllfa ariannol y byrddau iechyd wedi gwaethygu yn hytrach na gwella. Yn ôl y ffigurau diweddaraf sydd ar gael i lywio ein gwaith craffu, mae byrddau iechyd, gyda'i gilydd, yn nodi diffyg yn ystod y flwyddyn hyd yma o £98.6 miliwn a diffyg diwedd blwyddyn a ragwelir o £159.9 miliwn ar gyfer 2022-23. Bryd hynny, roedd chwech o'r saith bwrdd iechyd yn rhagweld gorwariant diwedd blwyddyn. Mae

Senedd Cymru
Welsh Parliament

hyn yn arbennig o bryderus gan fod dyraniadau i fyrddau iechyd yn gyfran sylweddol o gyllideb gyffredinol Llywodraeth Cymru bob blwyddyn.

Yn ein hadroddiad, gwnaethom argymell:

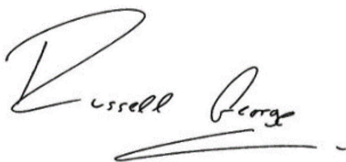
> *"[D]ylai Llywodraeth Cymru roi sicrwydd pellach ynghylch sut bydd yn sicrhau bod pob bwrdd iechyd yng Nghymru yn cyflawni cynaliadwyedd ariannol a'r cydbwysedd o fewn cylch cynllunio tymor canolig integredig 2023-24 i 2025-26. Dylai hyn gynnwys amserlenni clir o ran lle mae Llywodraeth Cymru yn rhagweld y bydd pob bwrdd iechyd yn sicrhau cydbwysedd ariannol, a sut bydd cynnydd yn cael ei fonitro."*

Derbyniodd Llywodraeth Cymru yr argymhelliad hwn mewn egwyddor. Yn ei hymateb, tynnodd Llywodraeth Cymru sylw at y "pwysau eithriadol" ar gyllid byrddau iechyd. Ni nododd amserlenni i bob bwrdd iechyd gyflawni cydbwysedd ariannol; yn hytrach, nododd na fyddai modd i'r "rhan fwyaf o fyrddau iechyd" gyflwyno cynllun tymor canolig integredig wedi'i fantoli ym mis Mawrth 2023. Ychwanegodd:

> *"Mae angen gwneud gwaith i gwmpasu a datblygu cyfleoedd i wella effeithlonrwydd ac adfer sefydlogrwydd ariannol a'u rhoi ar waith. Gwneir hyn mewn partneriaeth rhwng Llywodraeth Cymru ac uwch-swyddogion y GIG. Byddwn yn rhannu'r wybodaeth ddiweddaraf â'r Pwyllgor wrth i'r gwaith hwnnw fynd rhagddo."*

Nid ydym wedi ein sicrhau eto y bydd hyn yn ddigonol o ystyried y dirywiad a welsom a'r pwysau parhaus ar ein gwasanaethau iechyd. Mae gennym bryderon hefyd ynghylch lefel y capasiti sydd ar gael gan Lywodraeth Cymru i ddarparu'r cymorth sydd ei angen. Byddem yn ddiolchgar, felly, pe baech yn ystyried cynnwys craffu ariannol ar fyrddau iechyd yn eich rhaglen waith, gan gynnwys a yw byrddau iechyd a Llywodraeth Cymru yn ymdrechu digon i adennill cynaliadwyedd a chydbwysedd ariannol byrddau iechyd, ac a oes capasiti digonol ar gael ar gyfer hyn.

Yn gywir



Russell George AS
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Senedd Cymru
Y Pwyllgor Cyllid
—
Welsh Parliament
Finance Committee

Russell George AS

Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol

2 Mai 2023

Annwyl Russell,

Craffu ar Fyrddau Iechyd

Diolch am eich llythyr dyddiedig 24 Ebrill.

Rwy'n croesawu'n fawr y ffaith eich bod chi wedi dod â'r materion pwysig hyn i'n sylw. Mae byrddau iechyd yn cael symiau sylweddol o arian cyhoeddus, ac o'r herwydd mae'n hanfodol bod y Senedd yn craffu'n drylwyr arnynt er mwyn sicrhau gwerth am arian a defnydd priodol o adnoddau cyhoeddus.

Fel y gwyddoch, mae'r rhain yn faterion y mae'r Pwyllgor Cyllid wedi'u hystyried o'r blaen, yn fwyaf diweddar drwy ein gwaith craffu ar Ail Gyllideb Atodol Llywodraeth Cymru ar gyfer 2022-23. Gwnaeth ein hadroddiad, a gyhoeddwyd ym mis Mawrth, yr argymhelliad a ganlyn mewn perthynas â pherfformiad ariannol byrddau iechyd, a fydd o ddiddordeb i'ch Pwyllgor:

> *"**Argymhelliad 5**. Mae'r Pwyllgor yn argymell fel a ganlyn:*
>
> - *Bod mesurau'n cael eu cymryd gan Lywodraeth Cymru i sicrhau nad yw pob bwrdd iechyd lleol yng Nghymru yn mynd y tu hwnt i'w gyllid dros y cyfnodau treigl o dair blynedd, fel sy'n ofynnol gan Ddeddf Cyllid y Gwasanaeth Iechyd Gwladol (Cymru) 2014; a*
> - *lle mae Byrddau Iechyd Lleol yn gorwario mewn un flwyddyn, dylai'r rhain gael eu hariannu o gyllideb bresennol yr adran iechyd a gwasanaethau cymdeithasol."*

Yn ei hymateb, dywedodd y Gweinidog Cyllid a Llywodraeth Leol:

> *"Mae Deddf Cyllid y Gwasanaeth Iechyd Gwladol (Cymru) 2014 yn cynnwys y cyfrifoldeb i bob Bwrdd Iechyd Lleol adennill costau dros gyfnod cyfrifyddu o dair blynedd a pharatoi cynlluniau i wneud hynny. Mae'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'i swyddogion yn monitro perfformiad yn rheolaidd o ran y ddyletswydd hon ac yn gweithredu mesurau uwchgyfeirio pan fo*

angen. Mae cyfrifon wedi'u harchwilio pob corff yn cynnwys adrodd am berfformiad o ran y cyfrifoldeb hwn.

Mae Llywodraeth Cymru yn disgwyl bod pob Prif Grŵp Gwariant, pan fo'n bosibl, yn cwrdd ag unrhyw bwysau ariannol sy'n codi yn y flwyddyn, yn y lle cyntaf, o'u cyllidebau presennol. Pan nad yw hyn yn bosibl, neu pan wneir diwygiadau eraill i gyllidebau, byddwn yn cyhoeddi newidiadau yn unol â'n proses y cytunwyd arni ar gyfer cyllidebau atodol."

Yn ogystal â'r dull strategol a fabwysiadwyd gan y Pwyllgor mewn perthynas â chraffu ar gynigion cyllidebol Llywodraeth Cymru, mae'n egwyddor sydd wedi'i hen sefydlu bod pwyllgorau unigol yn parhau i graffu ar faterion ariannol sy'n dod o fewn eu cylchoedd gorchwyl.

Mae hyn wedi gweithio'n effeithiol yn ystod y Chweched Senedd hyd yma, gan alluogi pwyllgorau polisi i ymchwilio i feysydd penodol tra'n caniatáu i'r Pwyllgor Cyllid ddefnyddio dull lefel uchel ac ystyried cynigion cyllidebol Llywodraeth Cymru yn eu cyfanrwydd.

Byddwn felly yn parhau i fynd ar drywydd materion sydd o bwysigrwydd strategol fel y rhain fel rhan o'n rhaglen waith, yn enwedig yn ystod ein gwaith craffu ar gynigion Cyllideb Ddrafft a Chyllideb Atodol Llywodraeth Cymru. Hyderaf y byddwch hefyd yn cynnal gwaith craffu ar fyrddau iechyd, yn ogystal â materion ariannol allweddol eraill yn eich cylch gorchwyl, pan ddaw'r amser.

Yn gywir

Peredur Owen Griffiths AS
Cadeirydd y Pwyllgor Cyllid

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

Mae cyfyngiadau ar y ddogfen hon

Eitem 8

Mae cyfyngiadau ar y ddogfen hon