Pecyn dogfennau cyhoeddus

# Y Pwyllgor Iechyd a Gofal Cymdeithasol

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Lleoliad:
**Ystafell Bwyllgora 1 - Y Senedd**

Dyddiad:
**11 Ionawr 2012**

Amser:
**09:45**

I gael rhagor o wybodaeth, cysylltwch â:


**Llinos Dafydd**
Clerc y Pwyllgor
029 2089 8403
PwyllgorIGC@cymru.gov.uk


## Agenda

**1. Cyflwyniad, ymddiheuriadau a dirprwyon**

**2. Ymchwiliad i ofal preswyl i bobl hŷn - trafod amserlen yr ymchwiliad a phenodi cynghorydd arbenigol (09.45 - 10.15)**
HSC(4)-01-12 papur 1a - Amserlen yr ymchwiliad
HSC(4)-01-12 papur 1b - Penodi cynghorydd arbennigol

**3. Y Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru) - trafod y dull o ystyried y Bil drafft (10.15 - 10.30)**
HSC(4)-01-12 papur 2

**4. Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - tystiolaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (10.30 - 11.30)**
HSC(4)-01-12 papur 3
Lesley Griffiths AC, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Dr Gwyn Thomas, y Prif Swyddog Gwybodaeth
Andrew Evans, Uwch-gynghorydd Polisi
Roger Walker, y Prif Gynghorydd Fferyllol

**5. Papurau i'w nodi** (Tudalennau 1 - 2)
Cofnodion y cyfarfod a gynhaliwyd ar 8 Rhagfyr
HSC(4)-13-11 cofnodion

**Ymchwiliad i ofal preswyl i bobl hŷn - llythyr gan y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol**
HSC(4)-01-13 papur 4

**Llythyr gan y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol - rhoi'r pecyn gwella camau cyntaf ar waith**
HSC(4)-01-12 papur 5

**Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - tystiolaeth ysgrifenedig ychwanegol**

Llythyr gan y Cadeirydd at y Gymdeithas Fferyllol Frenhinol a Fferylliaeth Gymunedol Cymru
HSC(4)-01-12 papur 6

Y Gymdeithas Fferyllol Frenhinol
HSC(4)-01-12 papur 7

Fferylliaeth Gymunedol Cymru
HSC(4)-01-12 papur 8

Y Gymdeithas Cynllunio Teulu - gwybodaeth yn dilyn y sesiwn tystiolaeth lafar ar 16 Tachwedd
HSC(4)-01-12 papur 9

# Y Pwyllgor Iechyd a Gofal Cymdeithasol

**HSC(4)-01-12 Papur 1a**

**Ymchwiliad i Ofal Preswyl i Bobl hŷn - Amserlen a themâu allweddol**

**At:** Y Pwyllgor Iechyd a Gofal Cymdeithasol

**Gan:** Y Gwasanaeth Pwyllgorau

**Dyddiad:** Ionawr 2012

## Diben

1. Mae'r papur hwn yn cynnig amserlen amlinellol ar gyfer ymchwiliad y Pwyllgor Iechyd a Gofal Cymdeithasol i ofal preswyl i bobl hŷn.

## Cefndir

2. O gofio cwmpas eang yr ymchwiliad, cytunodd y Pwyllgor y byddai'n ddefnyddiol ystyried cynllun gwaith i fwrw ymlaen â chasglu tystiolaeth lafar. Cytunwyd dull o weithredu ar 8 Rhagfyr 2011 (Papur: HSC(4)-13-11 papur 2)

3. I sicrhau bod y Pwyllgor yn ymdrin â'r holl faterion a restrir yng nghylch gorchwyl yr ymchwiliad, cytunodd y Pwyllgor i gasglu tystiolaeth lafar yn unol â dwy egwyddor:
   (i) Sesiynau tystiolaeth lafar i'w trefnu ar sail grwpiau buddiant; a
   (ii) Dewis themâu penodol, fel y nodir yng nghylch gorchwyl yr ymchwiliad, i'r gwahanol Aelodau ymdrin â nhw yn ystod yr ymchwiliad.

## Amserlen

4. I sicrhau bod y Pwyllgor yn ystyried amrywiaeth eang o safbwyntiau wrth gynnal yr ymchwiliad, cytunwyd y byddai tystion yn cael eu gwahodd i ddod i'r Pwyllgor ar sail y grŵp buddiant y maent yn perthyn iddo. Atodir amserlen sesiynau drafft a rhestr o dystion posib yn Atodiad A, a seilir gan fwyaf ar y dystiolaeth lafar a dderbyniwyd hyd yma. Efallai yr hoffai Aelodau awgrymu tystion ychwanegol neu wahanol.

## Rhannu themâu allweddol ymhlith yr Aelodau

5. I sicrhau bod y Pwyllgor yn ymdrin â phob agwedd ar yr ymchwiliad hwn, cytunwyd y byddai aelod(au) penodol o'r Pwyllgor yn gyfrifol am

bob un o'r pwyntiau bwled a restrir yn y cylch gorchwyl (hynny yw, pob thema allweddol).

6. Yn ymarferol, byddai hyn yn golygu y byddai'r Pwyllgor yn gofyn i Aelod A ac Aelod B ganolbwyntio ar gasglu gwybodaeth yn ymwneud â'r pwynt bwled cyntaf yn y cylch gorchwyl drwy gydol yr ymchwiliad; byddai Aelod C ar y llaw arall yn gyfrifol am faterion yn ymwneud â phwynt bwled dau etc.

   *Ni fyddai hyn yn atal yr Aelodau mewn unrhyw ffordd rhag gofyn cwestiynau am bynciau oddi allan i'w themâu penodol nhw, ond byddai'n sicrhau bod pob thema'n cael ei hystyried, mewn perthynas â'i gilydd.*

7. Atodir cylch gorchwyl yr ymchwiliad (h.y. rhestr o'r themâu allweddol) yn Atodiad B.

**Y cynnig**

8. Gwahoddir y Pwyllgor i:

   – ystyried a chytuno amserlen drafft y dysiolaeth lafar a'r tystion a awgrymir (Atodiad A);

   – ystyried a chytuno pa Aelodau fydd yn arwain ar bob un o'r themâu allweddol a nodir yng nghylch gorchwyl yr ymchwiliad (Atodiad B).

## ATODIAD A

**Amserlen tystiolaeth lafar yr ymchwiliad i ofal preswyl i bobl hŷn**

Cynigir bod y seisynau isod yn cael eu hamserlenni rhwng Chwefror a Gorffennaf 2012. Fe fydd cyfleuon ar gyfer gwaith arall y Pwyllgor hefyd yn cael eu hamserlenni yn ystod y cyfnod hwn, gan gynnwys amser i Aelodau ymgymryd â gwaith sy'n ennyn diddordeb y cyhoedd yn yr ymchwiliad hwn.

**Sesiwn 1: Cyflwyno'r cefndir**

- Arbenigwr wedi'i apwyntio gan y Pwyllgor
- Y Sefydliad Gofal Cymdeithasol er Rhagoriaeth / Canolfan Bolisi ar Heneiddio / Sefydliad Joseph Rowntree
- OPAN Cymru (Ymchwil Heneiddio Cymru)

**Sesiwn 2: Defnyddwyr, eu teuluoedd a'u gofalwyr**

- Fforymau pobl hŷn e.e. Fforwm Pensiynwyr Cymru
- Grwpiau Age Cymru
- Grwpiau gofalwyr a sefydliadau sy'n eu cynrhychioli e.e. Cynghrair Gofalwyr Cymru
- Comisiynydd Pobl Hŷn Cymru

**Sesiwn 3: Cyrff yn y sector cyhoeddus**

- Awdurdodau lleol / Cymdeithas Llywodraeth Leol Cymru / Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol
- Byrddau Iechyd Lleol / Conffederasiwn y GIG
- Yr Asiantaeth Gwella Gwasanaethau Cymdeithasol / Asiantaeth Genedlaethol Arwain ac Arloesi mewn Gofal Iechyd

**Sesiwn 4: Darparwyr yn y sector preifat**

- Fforwm Gofal Cymru
- Cymdeithas Gofal Cymdeithasol
- Darparwr gofal mawr e.e BUPA

**Sesiwn 5: Cyrff a darparwyr yn y trydydd sector**

- Gofal Croesffyrdd
- Age Cymru / Cynghrair Henoed Cymru
- Cartrefi Cymunedol Cymru / Care and Repair Cymru
- Canolfan Cydweithredol Cymru

**Sesiwn 6: Cyrff proffesiynol a chyrff staff**

- Cymdeithas Gweithwyr Cymdeithasol Prydain yng Nghymru
- UNSAIN / Fforwm Gwasanaethau Cymdeithasol Unsain Cymru
- Proffesiynwyr iechyd e.e. Coleg Brenhinol y Seiciatryddion
- Coleg Therapyddion Galwedigaethol

**Sesiwn 7: Rheoleiddiwyr ac arolygwyr**

- Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru / Arolygiaeth Iechyd Cymru
- Cyngor Gofal Cymru

**Sesiwn 8: Llywodraeth Cymru**

- Y Dirprwy Weinidog dros Blant a Gwasanaethau Cymdeithasol
- Prif swyddogion

**ATODIAD B**

**Cylch gorchwyl yr ymchwiliad i ofal preswyl i bobl hŷn.**

Dyma gylch gorchwyl yr ymchwiliad, fel y'i cytunwyd gan y Pwyllgor ar 20 Hydref 2011:

Ymchwilio i ddarpariaeth gofal preswyl yng Nghymru a'r ffyrdd y gall fodloni anghenion presennol pobl hŷn a'u hanghenion ar gyfer y dyfodol, gan gynnwys:

- y broses a ddilynir gan bobl hŷn wrth iddynt fynd i ofal preswyl ac argaeledd a hygyrchedd gwasanaethau amgen yn y gymuned, gan gynnwys gwasanaethau ailalluogi a gofal yn y cartref.

- gallu'r sector gofal preswyl i fodloni'r galw am wasanaethau gan bobl hŷn o ran adnoddau staffio, gan gynnwys y sgiliau sydd gan staff a'r hyfforddiant sydd ar gael iddynt, nifer y lleoedd a'r cyfleusterau, a lefel yr adnoddau.

- ansawdd gwasanaethau gofal preswyl a phrofiadau defnyddwyr gwasanaethau a'u teuluoedd; effeithiolrwydd gwasanaethau o ran bodloni'r amrywiol anghenion ymhlith pobl hŷn; a rheolaeth ar gau cartrefi gofal.

- effeithiolrwydd trefniadau rheoleiddio ac archwilio gofal preswyl, gan gynnwys y cwmpas ar gyfer craffu mwy ar hyfywdra ariannol darparwyr gwasanaethau.

- y modelau gofal newydd sy'n dod i'r amlwg.

- y cydbwysedd rhwng darpariaeth yn y sector cyhoeddus a'r sector annibynnol, a modelau ariannu, rheoli a pherchnogaeth amgen, fel y rheini a gynigir gan y sector gydweithredol a chydfuddiannol, y trydydd sector, a landlordiaid cymdeithasol cofrestredig.

# Y Pwyllgor Iechyd a Gofal Cymdeithasol

**HSC(4)-01-12 papur 1b**

**Ymchwiliad i ofal preswyl i bobl hŷn – Penodi cynghorydd arbenigol**

| | |
|---|---|
| **At:** | Y Pwyllgor Iechyd a Gofal Cymdeithasol |
| **Oddi wrth:** | Gwasanaeth y Pwyllgorau |
| **Dyddiad:** | Ionawr 2012 |

## CYNGHORYDD ARBENIGOL AR GYFER YR YMCHWILIAD I OFAL PRESWYL I BOBL HŶN — MANYLEB Y SWYDD

### Diben

1. Ar 8 Rhagfyr, cytunodd Pwyllgor Iechyd a Gofal Cymdeithasol Cynulliad Cenedlaethol Cymru i benodi cynghorydd arbenigol ar gyfer ei ymchwiliad i ofal preswyl i bobl hŷn.

2. Mae Atodiad A i'r papur hwn yn amlinellu manyleb ar gyfer swydd cynghorydd arbenigol. Mae Atodiad B yn rhestru'r ymgeiswyr posibl ar gyfer ymgymryd â'r gwaith hwn.

### Cefndir

3. Mae Rheolau Sefydlog Cynulliad Cenedlaethol Cymru yn caniatáu i bwyllgorau benodi pobl i roi cyngor arbenigol iddynt.[1] I hwyluso hyn, mae'r Cynulliad yn cynnig y cyfle i unrhyw arbenigwr neu ymchwilydd gofrestru fel cynghorydd arbenigol allanol ar gyfer contractau ymchwil tymor byr drwy'r wefan.

4. Diben y cyngor arbenigol yw:
   - ategu arbenigedd mewnol Gwasanaeth Ymchwil Cynulliad Cenedlaethol Cymru; ac
   - ychwanegu gwerth at ystyriaeth Pwyllgor o unrhyw faes penodol.

   Cyflawnir hyn drwy ddarparu ffynhonnell ychwanegol o wybodaeth, cyngor a chapasiti dadansoddol i bwyllgor gan barti allanol sydd ag arbenigedd penodol ac wedi'i brofi yn y maes y mae'r pwyllgor yn ei ystyried.

[1] Cynulliad Cenedlaethol Cymru, Rheol Sefydlog 17.55 [fel ar 15 Rhagfyr 2011]

**Manyleb y swydd**

5. Er mwyn sicrhau bod y Pwyllgor yn cael y cymorth arbenigol ychwanegol sydd ei angen arno, drafftiwyd manyleb sy'n nodi'r prif dasgau y dylai'r cynghorydd arbenigol eu cyflawni. Atodir y fanyleb yn Atodiad A.

6. Mae'n rhaid i'r Pwyllgor gytuno ar y fanyleb hon cyn penodi cynghorydd arbenigol er mwyn sicrhau:
   - bod yr unigolyn iawn yn cael ei ddewis i ymgymryd â'r gwaith; a
   - bod gan yr ymgeisydd llwyddiannus ddealltwriaeth glir o'r rôl y mae disgwyl iddo ei chyflawni mewn perthynas â'r ymchwiliad a'r ymrwymiad cysylltiedig o ran amser.

**Yr ymgeiswyr**

7. Mae ysgrifenyddiaeth y Pwyllgor, ar y cyd â'r Cadeirydd, wedi nodi dau ymgeisydd posibl i fod yn gynghorydd arbenigol, a hynny'n seiliedig ar y fanyleb yn Atodiad A.

8. Trafodwyd y cyfle i fod yn ymgeisydd gyda'r Athro Judith Phillips (Athro Gerontoleg a Gwaith Cymdeithasol, Canolfan Heneiddio Arloesol, Prifysgol Abertawe), yr Athro Ann Netten (Athro Lles Cymdeithasol a Chyfarwyddwraig yr Uned Ymchwil ar Wasanaethau Cymdeithasol Personol ym Mhrifysgol Caint) a'r Athro Martin Knapp (Athro Polisi Cymdeithasol a Chyfarwyddwr yr Uned Ymchwil ar Wasanaethau Cymdeithasol Personol yn y London School of Economics). Yn sgil yr ymrwymiad amser a fyddai ei angen ar gyfer y gwaith hwn, nid oedd modd iddynt gynnig eu henwau fel ymgeiswyr posib.

9. Petai'r Pwyllgor am newid y fanyleb neu'r rhestr o ymgeiswyr posib, gellid ceisio dod o hyd i ymgeiswyr eraill. Fodd bynnag, dylai Aelodau fod yn ymwybodol y gallai hynny arwain at oedi cyn penodi cynghorydd ar gyfer yr ymchwiliad ac y gallai gyfyngu ar ei (g)allu i gyflawni rhai o'r tasgau a restrir yn y fanyleb.

10. Mae gwybodaeth am bob ymgeisydd ar gael yn Atodiad B.

**Penderfyniad**

11. Gwahoddir y Pwyllgor i:

- ystyried a chytuno ar y fanyleb ar gyfer swydd cynghorydd arbenigol ar gyfer ei ymchwiliad i ofal preswyl i bobl hŷn (gweler Atodiad A); ac

- ystyried yr ymgeiswyr a awgrymir (gweler Atodiad B), penodi cynghorydd ac awgrymu rhywun wrth gefn.

**ATODIAD A — MANYLEB Y SWYDD**

Bydd gofyn i'r unigolyn a gaiff ei benodi'n gynghorydd arbenigol:

- **Roi un sesiwn friffio gyflwyniadol i'r Pwyllgor ddydd Iau 2 Chwefror 2012**
  *Ymrwymiad amser disgwyliedig (paratoi a chyflwyno): 1 diwrnod*

  Diben y sesiwn gyflwyniadol hon fydd rhoi cyflwyniad i'r ymchwiliad a'i gylch gorchwyl a thrafod y dystiolaeth ysgrifenedig sydd wedi dod i law.

- **Gweithio gydag ysgrifenyddiaeth y Pwyllgor drwy gydol yr ymchwiliad i baratoi ar gyfer (ac, yn ôl y gofyn, fynychu) sesiynau tystiolaeth lafar** *Ymrwymiad amser disgwyliedig (gan gynnwys yr holl sesiynau tystiolaeth): 5 diwrnod*

  Bydd hyn yn cynnwys cynorthwyo i baratoi – neu adolygu – briff cefndir a meysydd posibl ar gyfer cwestiynau ar y dyddiadau a gytunir gan y Pwyllgor.

- **Gweithio gydag ysgrifenyddiaeth y Pwyllgor drwy gydol yr ymchwiliad er mwyn nodi'r themâu sy'n codi o'r ymchwiliad**
  *Ymrwymiad amser disgwyliedig: 5 diwrnod*

  Mae nodi'r themâu sy'n codi o ymchwiliad, yn enwedig cyn cynnal unrhyw sesiwn graffu gyda'r Gweinidog perthnasol ar ddiwedd yr ymchwiliad, yn allweddol er mwyn sicrhau bod y Pwyllgor yn dwyn y Llywodraeth i gyfrif ar y prif faterion sy'n deillio o'i waith. Bydd disgwyl i'r cynghorydd arbenigol weithio gydag ysgrifenyddiaeth y Pwyllgor i nodi a chrynhoi'r prif faterion sy'n deillio o'r sesiynau tystiolaeth lafar.

- **Rhoi sylwadau ar – a chyfrannu at – bapur yn nodi prif faterion yr ymchwiliad wrth i'r ymchwiliad dynnu tua'r terfyn**
  *Ymrwymiad amser disgwyliedig: 1 diwrnod*

  Mae nodi prif faterion yr ymchwiliad yn sail i'r gwaith o ddrafftio adroddiad terfynol, casgliadau ac argymhellion y Pwyllgor. Bydd disgwyl i'r cynghorydd arbenigol ddefnyddio'i arbenigedd i gynorthwyo'r Pwyllgor i grynhoi'r wybodaeth a gasglwyd yn ystod yr ymchwiliad yn themâu clir a phendant ynghyd â nodi materion ar gyfer craffu a / neu adroddiad pellach.

- **Adolygu a rhoi sylwadau ar adroddiad terfynol drafft y Pwyllgor, gan gynnwys prif gasgliadau ac argymhellion y Pwyllgor**
  *Ymrwymiad amser disgwyliedig: 1 diwrnod*

  Un o brif arfau pwyllgorau'r Cynulliad yw'r gallu i gyflwyno adroddiad ar ymchwiliad. Disgwylir i'r Llywodraeth ymateb i bob adroddiad Pwyllgor ac, yn wir, mae'n ymateb i bob adroddiad – oherwydd hynny, mae'n rhaid i gynnwys, casgliadau ac argymhellion adroddiad fod yn ddigon cadarn a dylanwadol i sicrhau canlyniad mor gadarnhaol â phosibl i'r ymchwiliad.

- **Rhoi cyngor ychwanegol i ysgrifenyddiaeth a Chadeirydd y Pwyllgor yn ôl y gofyn**
  *Cytunir ar yr ymrwymiad amser yn ôl yr angen, ac o fewn y telerau sydd wedi'u derbyn ar gyfer y penodiad.*

  Trafodir a chytunir ar hyn yn ôl yr angen rhwng ysgrifenyddiaeth y Pwyllgor a'r cynghorydd arbenigol a gaiff ei benodi.

## ATODIAD B — YR YMGEISWYR

**Dr Diane Seddon**
*Uwch Gymrawd Ymchwil, Canolfan Ymchwil Gymhwysol a Gwyddorau Gwerthuso (CYGGG), Prifysgol Bangor*

Mae diddordebau ymchwil Dr Seddon yn cynnwys: gofalwyr a rhoi gofal; asesu a rheoli gofal; dementia; y berthynas rhwng iechyd a gofal cymdeithasol; a'r ddarpariaeth o gartrefi gofal preswyl a nyrsio. Mae wedi bod yn rhan o'r gwaith o ddatblygu rhaglen ymchwil lwyddiannus mewn perthynas â gofalwyr, sydd wedi denu grantiau ymchwil gan ystod eang o gyrff ariannu, gan gynnwys yr Adran Iechyd, Llywodraeth Cymru a'r Gronfa Loteri Fawr. Mae Diane wedi cynghori ar ddatblygu polisi cenedlaethol, gan gynnwys bod yn gynghorydd arbenigol ar ofal cartref i'r Pwyllgor Dethol ar Faterion Cymreig yn Nhŷ'r Cyffredin. Mae hefyd wedi arwain adolygiadau o roi polisïau cenedlaethol ar waith, gan gynnwys gwerthuso strategaethau gofalwyr cenedlaethol yn Lloegr i'r Adran Iechyd ac yng Nghymru i Lywodraeth y Cynulliad, yn ogystal â'r gwerthusiad Cymru gyfan o'r Broses Asesu Unedig.

*Rolau eraill:*

- Cydlynydd modiwl, Gwerthuso Ymchwil ac Ymarfer Ymchwil ar sail Tystiolaeth, BA Gwaith Cymdeithasol, Prifysgol Bangor.
- Cadeirydd ac Ymddiriedolwr, Ymddiriedolaeth y Dywysoges Frenhinol i Ofalwyr, Gwasanaeth Allgymorth i Ofalwyr, Gogledd Cymru.
- Cynrychiolydd adran, y Coleg Bancio, Pwyllgor Moeseg Ymchwil y Gwyddorau Cymdeithasol a'r Gyfraith, Prifysgol Bangor.
- Cynghorydd arbenigol, Pwyllgor Dethol ar Faterion Cymreig, Tŷ'r Cyffredin (2009).
- Aelod:
  - Grŵp Llywio Gweithredol, NEURODEM Cymru.
  - Grŵp Datblygu Ymchwil Gofal Cymdeithasol a Thai Cymru.
  - Pwyllgor Grantiau Ymchwil Gogledd Cymru.

*Bywgraffiad y Brifysgol:*

http://www.bangor.ac.uk/so/staff/seddon.php.cy?

**Dr Catherine Robinson**
*Cyfarwyddwr, Canolfan Ymchwil Gymhwysol a Gwyddorau Gwerthuso (CYGGG), Prifysgol Bangor*

Mae diddordebau ymchwil Dr Robinson yn cynnwys: polisi gofal cymdeithasol a gofal iechyd; gweithredu polisïau a datblygu ymarfer; asesu, rheoli gofal a darparu gwasanaethau; y berthynas rhwng gofal iechyd a gofal cymdeithasol; gofal teulu; gwerthuso.

Catherine Robinson yw Cyfarwyddwr y ganolfan sydd newydd ei sefydlu, Canolfan Ymchwil Gymhwysol a Gwyddorau Gwerthuso. Cyn hynny roedd y tîm ymchwil hwn yn rhan o Gynghrair Cymru Gyfan ar gyfer Ymchwil a Datblygiad mewn Iechyd a Gofal Cymdeithasol (AWARD).

Mae ei phrosiectau ymchwil presennol yn cynnwys:

- *Carers for people with mental health problems: needs assessment to service provision (Robinson, C.A., Seddon, D. and Bowen, S.)*

  Mae'r astudiaeth hon yn mynd i'r afael â'r bylchau yn y ddealltwriaeth o anghenion, amgylchiadau ac anghenion cymorth gofalwyr sy'n gofalu am bobl sydd â phroblemau iechyd meddwl.

- *Unified assessment in Wales: older people with complex needs and their families (Seddon, D., Robinson, C.A., Tommis, Y and Woods, R).*

  Bydd yr astudiaeth hon yn astudio'n hydredol brofiadau defnyddwyr gwasanaethau a gofalwyr o'r broses Asesu Unedig a'r canlyniadau dilynol. Mae Rhodri Morgan yn aelod o'r tîm ymchwil hwn.

*Rolau eraill:*

- Grŵp Ymgynghorol Gofal Cymdeithasol Llywodraeth Cynulliad Cymru (2007- )

  Cydweithrediad Ymchwil Clinigol Cymru, Grŵp Llywio Gweithredol (2006- )
- Cydweithrediad Iechyd Meddwl Cymru, Grŵp Llywio (2005 – )
- Rhwydwaith Ymchwil Iechyd a Gofal Cymdeithasol i Blant (2006 – )
- Grŵp Llywio Rhwydwaith Ymchwil Dementia ac Anhwylderau Niwroddirywiol Cymru (2006 – )
- Cyd-fwrdd Polisi Cydweithrediad Gogledd Cymru ar gyfer Iechyd a Gofal Cymdeithasol (2005- )
- Pwyllgor Strategol a Phwyllgor Grantiau Ymchwil Gogledd Cymru (2001 – )

- Cadeirio gweithgor a gynullwyd i ystyried anghenion therapyddion lleferydd ac iaith sy’n gweithio gyda phlant ac oedolion Cymraeg eu hiaith a dwyieithog (2005).

*Bywgraffiad y Brifysgol:*

http://www.bangor.ac.uk/so/staff/robinson.php.cy?

Eitem 3

## Y Pwyllgor Iechyd a Gofal Cymdeithasol

**HSC(4)-01-12 papur 2**

**Y Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru) – Y dull o ystyried y Bil drafft**

**Diben**

1. Mae'r papur hwn yn tynnu sylw'r pwyllgor at y Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru) ac yn amlinellu'r opsiynau posibl pe byddai'r pwyllgor yn dymuno craffu ar y Bil drafft cyn deddfu.

**Cefndir**

2. Cyhoeddwyd y Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru) ar gyfer ynghynghoriad 12 wythnos gan y Gweinidog Iechyd a Gwasanaethau Cyhoeddus ar 14 Rhagfyr 2011.

3. Bydd y Bil yn ei gwneud yn orfodol i fusnesau bwyd yng Nghymru arddangos gwybodaeth am eu safonau hylendid (eu sgôr hylendid bwyd) mewn safle lle mae'r wybodaeth honno'n weledol i gwsmeriaid yn rhwydd. Bydd y Bil hefyd yn ei gwneud yn ofynnol i awdurdodau lleol orfodi'r cynllun gorfodol yn eu hardaloedd, a sicrhau bod y sgoriau yn cael eu harddangos yn gywir.

4. Nid yw'r mater a drafodir yn y Bil drafft yn berthnasol i gylch gwaith pwyllgor penodol. Caiff penderfyniad ar ba bwyllgor y cyfeirir y mater ato ei wneud gan y Pwyllgor Busnes unwaith i'r Bil gael ei gyflwyno'n ffurfiol.

**Trafodaeth**

*Defnyddio Biliau drafft*

5. Defnyddir Biliau drafft gan y Llywodraeth i ymgynghori â'r cyhoedd neu grŵpiau sydd â diddordeb arbennig ar gynigion deddfwriaethol penodol. Ni nodwyd dyletswydd ar bwyllgorau'r Cynulliad i ystyried neu graffu ar Filiau drafft yn Rheolau Sefydlog y Cynulliad.

6. Mae Biliau drafft wedi dod yn gyffredin yn Senedd y Deyrnas Unedig yn ystod y blynyddoedd diweddar, ac mae Pwyllgor Dethol yn aml yn craffu arnynt cyn iddynt gael eu cyflwyno'n ffurfiol. Fodd bynnag, mae'r arfer hwn wedi datblygu'n rhannol oherwydd nad oes proses graffu Cyfnod 1 yn cael ei dilyn yn San Steffan, ac mae'n bosibl na fydd y cyfnod craffu gan bwyllgor hwyrach yn cynnwys Aelodau'r Pwyllgor Dethol gwreiddiol. Yn yr Alban, er bod Llywodraeth yr Alban yn ymddangos fel petai'n cyhoeddi Biliau drafft, nid yw'n ymddangos bod llawer o waith craffu arnynt gan bwyllgorau Seneddol.

7. Er y gallai ymddangos yn wrth-gynhyrchiol i'r pwyllgor beidio ag ystyried Biliau drafft, mae perygl y byddai ceisio ystyried y Bil drafft yn fanwl yn ystod y cyfnod hwn yn gallu cael effaith negyddol neu ddryslyd ar ystyriaeth gan y pwyllgor yn ystod Cyfnod 1.

8. Hefyd, gallai ymateb yn ffurfiol i ymgynghoriad gymylu rôl y pwyllgor, yn ogystal â rhoi pwysau annigonol i'w rôl ffurfiol.

*Opsiynau*

9. Yn y cyd-destun hwn, cynigir yr opsiynau a ganlyn ar gyfer gwaith y gellid ei wneud gan y pwyllgor:

i. gwneud dim – fel y nodwyd uchod, ni nodwyd dyletswydd ar bwyllgorau i graffu ar Filiau cyn deddfu yn y Rheolau Sefydlog, ac mae Cyfnod 1 yn rhoi cyfle i graffu ar y Bil a gyflwynwyd yn ffurfiol.

ii. gwahodd y Gweinidog i gyflwyno tystiolaeth i'r pwyllgor fel cefndir ar gyfer cyflwyno'r Bil yn hwyrach yn y flwyddyn; fodd bynnag, yn y cyd-destun hwn, bydd y pwyllgor yn dymuno bod yn ymwybodol o'r ohebiaeth ddiweddar rhwng y Prif Weinidog a'r Llywydd (gweler Atodiad 1) ynghylch galw ar Weinidogion i ymddangos gerbron pwyllgorau mewn perthynas â Biliau drafft.

iii. Gwahodd swyddogion y Llywodraeth i friffio'r pwyllgor ar y Bil fel modd o esbonio'r cefndir iddo a sicrhau bod y pwyllgor yn cael y wybodaeth ddiweddaraf am ddatblygiadau er mwyn iddo fod yn barod ar gyfer gwaith craffu Cyfnod 1;

iv. rhoi opsiynau ii. neu iii. ar waith gyda phwyllgorau eraill sy'n debygol o fod â diddordeb yn y Bil, sef y Pwyllgor Cymunedau, Cydraddoldeb a Llywodraeth Leol a'r Pwyllgor Menter a Busnes. Gallai hyn ddigwydd ar yr un pryd neu o bosibl drwy is-bwyllgorau.

**Cam i'w gymryd**

10. Gwahoddir y Pwyllgor i ystyried pa un o'r opsiynau a amlinellir ym mharagraff 9 y mae'n dymuno ei ddewis mewn perthynas â'r Bil Drafft ynghylch Sgorio Hylendid Bwyd (Cymru).

Y Swyddfa Deddfwriaeth
Ionawr 2012

**Y Gwir Anrh/Rt Hon Carwyn Jones AC/AM**
**Prif Weinidog Cymru/First Minister of Wales**

**Ein cyf/Our Ref: LF/FM/5121/11**

Rosemary Butler AC
Llywydd
Cadeirydd y Pwyllgor Busnes
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
CF99 1NA

17 Hydref 2011

Annwyl Rosemary

Rwyf yn ysgrifennu atoch er mwyn rhoi eglurhad o safbwynt Llywodraeth Cymru mewn perthynas â'r ffordd mae'n trin ei hymgynghoriadau ar Bapurau Gwyn a Biliau Drafft.

Mae Llywodraeth Cymru wedi ymrwymo i ymgynghori cyn cyflwyno deddfwriaeth, p'un ai ar adeg ffurfio polisi, adeg Papur Gwyn neu drwy Fil Drafft. Rydym eisoes wedi cyhoeddi Papur Gwyn mewn perthynas â'r Bil Safonau a Threfniadaeth Ysgolion, a chyn bo hir byddwn yn cyhoeddi Papur Gwyn ar Roi Organau. Yn ddiweddarach eleni byddwn hefyd yn cyhoeddi nifer o Filiau Draft ar gyfer ymgynghori arnynt.

Tra fy mod yn ystyried mai ymgynghoriadau'r Llywodraeth yn bennaf yw Papurau Gwyn a Biliau Drafft, rwyf wedi gofyn i Weinidogion i sicrhau bod Aelodau'r Cynulliad yn cael gwybod amdanynt cyn eu cyhoeddi drwy Ddatganiad Ysgrifenedig Gweinidogol. Serch hynny, gwrando a thrafod gyda rhanddeiliaid a'r cyhoedd yn fwy eang yw swyddogaeth yr ymgynghoriadau yma.

Byddem wrth gwrs yn croesawu unrhyw farn a all fod gan y Cynulliad mewn perthynas â'r cynigion a amlinellir yn yr ymgynghoriadau yma, p'un ai gan Aelodau unigol neu gan Bwyllgor o'r Cynulliad.

Serch hynny, yr amser priodol i'r Cynulliad graffu ar gynigion Gweinidogion ynghylch cynigion deddfwriaethol Llywodraeth Cymru yw yn ystod y camau craffu ffurfiol, unwaith y caiff y Bil ei gyflwyno'n ffurfiol. Ni fyddem am danseilio gwaith y Cynulliad o graffu ar ddeddfwriaeth y Llywodraeth drwy beidio â dilyn y gweithdrefnau hyn.

Fel y cyfryw, ni fyddem yn disgwyl i Weinidogion gael eu galw i ymddangos gerbron Pwyllgorau yn ystod yr ymgynghoriadau yma i drafod Papur Gwyn neu Fil Drafft. Serch hynny byddem yn hapus i drefnu i swyddogion roi briffiadau technegol i Bwyllgorau ar Bapurau Gwyn neu Filiau Drafft unigol.

Mater i'r Pwyllgorau wrth gwrs yw penderfynu y ffordd orau o ystyried yr ymgynghoriadau yma, os ydynt yn dymuno gwneud hynny, ac efallai y byddant yn dymuno gwahodd rhanddeiliaid i gyflwyno tystiolaeth. Caiff safle'r Llywodraeth ei osod allan yn glir ymhob Papur Gwyn neu Fil Drafft, yr ydym yn ceisio barn rhanddeiliaid arno.

Gobeithiaf fod y llythyr hwn yn egluro safle'r Llywodraeth am y mater yma.

Carwyn Jones

Y Gwir Anrhydeddus Carwyn Jones AC
Prif Weinidog Cymru
Llywodraeth Cymru
Bae Caerdydd
CF99 1NA

Eich cyf: LF/FM/5121/11
Ein cyf: RB/AC/CJN/PO143

18 Hydref 2011

Annwyl Carwyn,

Diolch am eich llythyr ynghylch safbwynt Llywodraeth Cymru ar drin ymgynghoriadau ar Bapurau Gwyn a Biliau Drafft.

Mae ymgynghori ar gynigion y Llywodraeth am ddeddfwriaeth yn ddatblygiad i'w groesawu a gobeithiaf yn ddidwyll y bydd yn arwain at gyfranogaeth fwy eang yn y broses o wneud deddfwriaeth ac, yn y pen draw, at well deddfwriaeth.

Rwyf yn falch eich bod yn cydnabod pwysigrwydd gweithdrefnau craffu ffurfiol y Cynulliad ac yn rhannu'ch dymuniad na ddylai'r rhain gael eu tanseilio neu eu trechu gan y broses ymgynghori deddfwriaethol. Diolch i chi hefyd am fynegi parodrwydd y Llywodraeth i'w swyddogion ddarparu briffiau technegol i Bwyllgorau. Rwyf yn siŵr y bydd hyn yn cael ei werthfawrogi.

Byddaf yn rhannu'r pwyntiau yma gyda Chadeiryddion y pwyllgorau ac aelodau'r Pwyllgor Busnes er gwybodaeth, ond mae arnaf ofn na allaf warantu na fydd Pwyllgorau byth yn gwahodd Gweinidogion i fynychu Pwyllgorau i drafod Papurau Gwyn neu Filiau Drafft. Nid mater i mi yw arddweud wrth bwyllgorau sut y dylent fynd o gwmpas eu gwaith ac mae'n ddigon posibl y bydd achlysuron pryd y bydd hi'n berffaith briodol iddynt glywed gan Weinidogion pan fo cynigion polisi pwysig yn cael eu ffurfio. Wedi dweud hynny, cytunaf y byddai'n annymunol i Weinidogion gael eu galw gerbron Pwyllgorau fel mater o arfer yn ystod cyfnodau ymgynghori ac wedyn i fynd dros yr union dir hwnnw eto yn ystod Cam 1 o'r broses graffu.

Rosemary Butler AC, Llywydd

## Pwyllgor Iechyd a Gofal Cymdeithasol

**HSC(4)-01-12 papur 3**

**Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru - Tystiolaeth ysgrifenedig gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol**

i) Mae'r papur hwn yn rhoi i'r Pwyllgor fy ymateb i'r cwestiynau a ofynnwyd yn y llythyr dyddiedig 16 Awst 2011 a anfonodd Mr Drakeford ataf.

### Cyflwyniad

ii) Mae 708 o fferyllfeydd cymunedol yng Nghymru; mae 64% o'r rhain yn fferyllfeydd cadwyn, h.y. mae ganddynt 6 neu ragor o ganghennau ledled y wlad. Caiff 15 o fferyllfeydd cymunedol eu cynnal gan y Cynllun Fferyllfeydd Bach Hanfodol. Nod y Cynllun hwnnw yw sicrhau bod gwasanaethau fferyllol yn cael eu darparu'n briodol ar gyfer unigolion mewn ardaloedd gwledig, a fyddai fel arall yn ei chael yn anodd cyrraedd fferyllfa gymunedol.

iii) Mae nifer yr eitemau a ddosberthir gan fferyllfeydd cymunedol yn parhau i gynyddu bob blwyddyn, a chododd y nifer o 53.1 miliwn yn 2005-06 i 65.2 miliwn yn 2010-11[1].

iv) Mae buddsoddiad gan Lywodraeth Cymru i gefnogi datblygu gwasanaethau fferyllfeydd cymunedol wedi cynyddu'n sylweddol ers cyflwyno'r fframwaith contract newydd ar gyfer fferylliaeth yn 2005. Mae'r gyllideb gyfredol ar gyfer 2011-12 yn £145 miliwn, sy'n gynnydd o 51% o'i gymharu â'r swm o £96 miliwn a ddarparwyd yn 2005; nid yw hynny'n cynnwys cyllid ar gyfer costau meddyginiaethau a ragnodir. Yn ogystal, mae gan Lywodraeth Cymru gyllideb ar wahân i fynd i'r afael â chamddefnyddio sylweddau[2]; yn 2010-11 defnyddiwyd £2.3 miliwn o'r gyllideb honno i gyllido gwasanaethau cyfnewid nodwyddau a gwasanaethau rhoi meddyginiaeth gyfnewid dan oruchwyliaeth i'r sawl sy'n gaeth i opiadau. Yn ogystal, caiff cyllideb o £4.3 miliwn ar gyfer fferylliaeth yn benodol ei darparu er mwyn addysgu israddedigion a hyfforddi fferyllwyr (cyfeirier at baragraffau 4.16 - 4.17).

**1. Pa mor effeithiol yw'r contract fferylliaeth gymunedol i wella cyfraniad fferylliaeth gymunedol i wasanaethau iechyd a lles.**

[1] Ystadegau Llywodraeth Cymru: Community Pharmacy Services in Wales 2010-11 (Saesneg yn unig) – 26 Hydref 2011.

[2] Y Gronfa Weithredu ar Gamddefnyddio Sylweddau (Refeniw a Chyfalaf) a ddyrennir i Bartneriaethau Diogelwch Cymunedol y mae Byrddau Iechyd Lleol yn bartner statudol iddynt.

1.1 Cafodd fframwaith contract newydd ar gyfer fferylliaeth gymunedol ei gyflwyno yn 2005, ac roedd yn arwydd o newid sylweddol yn rôl fferyllwyr cymunedol. Cyflwynodd y fframwaith ddatblygiadau pwysig i wasanaethau fferylliaeth gymunedol, a oedd yn cynnwys y canlynol:

- Cydnabod am y tro cyntaf y cyfraniad arbennig y gall fferylliaeth gymunedol ei wneud yng nghyswllt ystod o faterion ym maes iechyd;

- Cyflwyno Adolygiadau o'r Defnydd o Feddyginiaethau i gydnabod yr arbenigedd y gall fferyllwyr cymunedol ei gyfrannu i wella'r defnydd y mae cleifion yn ei wneud o feddyginiaethau; a

- Sefydlu fframwaith archwilio a llywodraethu clinigol a gyflwynodd safonau cyffredin er mwyn hyrwyddo gwasanaethau proffesiynol, diogel ac effeithiol o safon a gweithdrefnau safonol gorfodol ar gyfer gweithredu.

1.2 Roedd y nodweddion allweddol yn cynnwys safoni gwybodaeth ar gyfer y cyhoedd am y gwasanaethau a gynigir, cyflwyno arolygon bodlonrwydd cleifion, ymestyn oriau agor i leiafswm o 40 awr dros gyfnod o 5 diwrnod, ymgorffori gwasanaethau hunanofal a threfniadau cyfeirio at wasanaethau eraill yn y fframwaith contract, a chyflwyno camau gorfodol i fonitro digwyddiadau'n ymwneud â diogelwch cleifion ac adrodd yn eu cylch. Mae pob un o'r rhain wedi'u cyflawni.

1.3 I ategu dyheadau'r fframwaith contract newydd, buddsoddodd Llywodraeth Cymru yn helaeth mewn datblygu seilwaith Technoleg Gwybodaeth fferyllfeydd cymunedol.

1.4 Ers 2005 rydym wedi darparu £12.1 miliwn yn benodol i hybu gwybodeg am iechyd mewn gwasanaethau fferylliaeth gymunedol. Amcanion allweddol y buddsoddiad hwn yw hwyluso'r broses o drosglwyddo gwybodaeth rhwng darparwyr gofal iechyd a fferylliaeth gymunedol a gwella diogelwch cleifion. Mae'r nodweddion allweddol yn cynnwys:

- Mynediad diogel i rwydwaith y GIG;
- Hawliadau electronig yng nghyswllt presgripsiynau; a
- Fframwaith llywodraethu electronig i hwyluso gwaith asesu a monitro gwasanaethau ledled Cymru mewn modd cyson a chynhwysfawr.

1.5 Roedd fframwaith contract 2005 yn effeithiol o ran safoni gwasanaethau a chodi proffil rôl ehangach fferyllwyr cymunedol; hebddo mae'n amheus a fyddai unrhyw gynnydd wedi'i wneud, a byddai fferyllwyr cymunedol yn dal i ganolbwyntio bron yn gyfan gwbl ar ddosbarthu meddyginiaethau heb gael eu cydnabod yn bobl a all

chwarae rôl bwysig yn yr agenda ehangach o ran iechyd. Fodd bynnag, ni fu'r cynnydd yn ddigon cyflym. I ddeffro a blaenoriaethu'r agenda ar gyfer fferylliaeth gymunedol, sefydlodd y Gweinidog blaenorol dros Iechyd a Gwasanaethau Cymdeithasol Grŵp Cyflawni Strategol. Roedd y grŵp hwn yn cynnwys aelodau uwch o staff y GIG, a châi ei gadeirio gan Gadeirydd Bwrdd Iechyd Lleol Hywel Dda. Gofynnwyd i'r Grŵp adnabod y meysydd allweddol ar gyfer newid. Mae ei argymhellion wedi eu symud ymlaen, a chânt eu hadlewyrchu yn y gwaith sydd wedi dechrau i adolygu'r Rheoliadau Gwasanaethau Fferyllol a'r newidiadau i'r fframwaith contract a ddaeth i rym ar 1 Tachwedd 2011. Caiff rhagor o fanylion am y datblygiadau eu hamlinellu ym mharagraffau 3.6 – 3.9 a 6.1 – 6.2.

**2. Y graddau y mae Byrddau Iechyd Lleol wedi cymryd y cyfleoedd a ddarparwyd trwy'r contract i ymestyn gwasanaethau fferylliaeth drwy ddarparu gwasanaethau 'gwell', ac enghreifftiau o gynlluniau llwyddiannus.**

2.1 Cafodd gwasanaethau gwell eu cynnwys yn fframwaith contract 2005 i roi cyfle i gomisiynu ystod eang o wasanaethau oddi wrth fferyllwyr cymunedol, yn ogystal â gwasanaethau hanfodol craidd megis gwasanaethau dosbarthu meddyginiaethau. Bwriad y cyfle i ddarparu gwasanaethau gwell oedd galluogi Byrddau Iechyd Lleol i gyflwyno gwasanaethau ar sail asesiad o angen lleol o ran gofal iechyd, a defnyddio fferyllfeydd cymunedol pan welid mai nhw oedd y darparwyr mwyaf priodol.

2.2 Y gwasanaethau gwell a ddarperir gan amlaf gan fferyllfeydd cymunedol yw gwasanaeth cyfnewid nodwyddau, gwasanaeth rhoi meddyginiaeth gyfnewid dan oruchwyliaeth i'r sawl sy'n gaeth i opiadau, a gwasanaeth rhoi'r gorau i ysmygu. Mae gwasanaethau rhoi'r gorau i ysmygu, yn enwedig, wedi helpu nifer galonogol o bobl i roi'r gorau i ysmygu, fel y dangoswyd gan Iechyd Cyhoeddus Cymru wrth werthuso'r gwasanaethau sydd yng Ngogledd Cymru, Powys a Merthyr Tudful.

2.3 Ym mis Ebrill 2011, lansiodd Llywodraeth Cymru y gwasanaeth gwell cenedlaethol cyntaf dan gyfarwyddyd ar gyfer atal cenhedlu hormonaidd brys. Ers cyflwyno'r gwasanaeth, mae 18,500 o unigolion wedi defnyddio'r gwasanaeth a ddarperir yn awr gan 386 o fferyllfeydd cymunedol.

2.4 Caiff data blynyddol ynghylch darparu gwasanaethau gwell ei gasglu oddi wrth Fyrddau Iechyd Lleol a'i gyhoeddi ar wefan StatsCymru Llywodraeth Cymru[3].

[3] http://wales.gov.uk/topics/statistics/?skip=1&lang=cy

2.5 Ym mis Tachwedd 2011, lansiodd Partneriaeth Cydwasanaethau GIG Cymru gronfa ddata newydd, sef Cronfa Ddata Fferylliaeth Cymru Gyfan, i gasglu gwybodaeth am wasanaethau a ddarperir gan bob fferyllfa gymunedol yng Nghymru. Mae'r Gronfa Ddata yn sicrhau bod un ffynhonnell ganolog o wybodaeth fanwl gywir ar gael am wasanaethau fferylliaeth gymunedol. Yn y dyfodol, bydd hawliadau a anfonir yn electronig gan fferyllwyr cymunedol yn cael eu cysylltu â'r gronfa ddata hon er mwyn gwirio eu statws achredu unigol a statws achredu'r fferyllfa lle darparwyd y gwasanaeth. Bydd y Gronfa Ddata hefyd yn darparu gwybodaeth ar gyfer Galw Iechyd Cymru er mwyn diweddaru'r wybodaeth a welir gan y cyhoedd.

2.6 Ym mis Ebrill 2011, i gyd-daro â lansiad y gwasanaeth cenedlaethol dan gyfarwyddyd ar gyfer darparu dulliau atal cenhedlu hormonaidd brys, cafodd y Ffurflen Hawlio ac Archwilio Electronig Genedlaethol ei lansio. Roedd y Ffurflen yn disodli hawliadau ar bapur ac yn symleiddio'r trefniadau ar gyfer fferyllwyr cymunedol wrth gyflwyno hawliadau am ddarparu gwasanaethau atal cenhedlu hormonaidd brys. Mae'r Ffurflen wedi lleihau'r baich gweinyddol ar fferyllwyr gan roi mwy o amser iddynt ganolbwyntio ar ofal cleifion. Yn bwysig iawn, am y tro cyntaf, mae'n darparu gwybodaeth gynhwysfawr am ddarpariaeth o ran gwasanaethau mewn modd amserol, a bydd yn cefnogi gwaith asesu anghenion a chynllunio gwasanaethau yn y dyfodol.

2.7 I gynorthwyo Byrddau Iechyd Lleol i ddatblygu gwasanaethau gwell, mae Iechyd Cyhoeddus Cymru wedi cynnal adolygiad llenyddiaeth i adnabod y sylfaen dystiolaeth a chynorthwyo Byrddau Iechyd Lleol i ddatblygu gwasanaethau gwell. Mae hefyd wedi bod yn gweithio gyda Byrddau Iechyd Lleol i gwblhau asesiadau o anghenion fferyllol, gan ddarparu rhagor o wybodaeth y gellir ei defnyddio i lywio gwaith cynllunio gwasanaethau.

2.8 I hybu'r broses o ddarparu gwasanaethau gwell sy'n gyson ac o safon ledled Cymru, rydym wrthi hefyd yn llunio fersiynau terfynol manylebau cenedlaethol ar gyfer gwasanaethau rhoi'r gorau i ysmygu, cyfnewid nodwyddau a rhoi meddyginiaeth gyfnewid dan oruchwyliaeth i'r sawl sy'n gaeth i opiadau. Bydd y manylebau hyn yn ychwanegol at y fanyleb ar gyfer gwasanaethau atal cenhedlu hormonaidd brys sydd eisoes ar waith.

**3. Graddfa'r gwasanaethau 'uwch' a ddarperir gan fferyllfeydd cymunedol a pha mor ddigonol ydynt.**

3.1 Mae gwasanaethau uwch yn gynlluniau cenedlaethol y mae'n ofynnol cael achrediad ar eu cyfer cyn y gellir darparu'r gwasanaeth. Cyn y setliad contract yn 2011, yr Adolygiad o'r Defnydd o Feddyginiaethau oedd y prif wasanaeth uwch a ddarperid, a châi pob fferyllfa gymunedol ddarparu hyd at 400 o Adolygiadau'r flwyddyn.

3.2 Mae Adolygiad o'r Defnydd o Feddyginiaethau yn golygu adolygu'r modd y mae cleifion yn defnyddio eu meddyginiaethau, er mwyn gwella eu dealltwriaeth o sut y dylent eu cymryd, adnabod y problemau y gallent fod yn eu cael, a chynnig help i'r sawl a allai fod mewn perygl o fethu â gwneud defnydd effeithiol o'u meddyginiaethau. Yn ogystal, mae Adolygiadau o'r Defnydd o Feddyginiaethau wedi rhoi cyfle i fferyllwyr ymgysylltu'n ffurfiol â chleifion, ac maent yn darparu rôl a gydnabyddir o safbwynt cynorthwyo unigolion i ddefnyddio eu meddyginiaethau yn y modd mwyaf effeithiol.

3.3 Ceir enghreifftiau da lle caiff Adolygiadau o'r Defnydd o Feddyginiaethau eu defnyddio i helpu cleifion i reoli cyflyrau megis asthma, trwy wella'u techneg defnyddio pwmp a gwella'r modd y maent yn rheoli eu hasthma.[4] Cyhoeddodd Iechyd Cyhoeddus Cymru adolygiad llenyddiaeth ynghylch Adolygiadau o'r Defnydd o Feddyginiaethau ym mis Mehefin 2011, a helpodd i bennu cyfeiriad y newidiadau a wnaed yn 2011 i'r fframwaith contract.

3.4 Mae lefelau cyfranogiad wedi cynyddu o'r naill flwyddyn i'r llall, gydag 88% o fferyllfeydd cymunedol yn darparu gwasanaethau Adolygiadau o'r Defnydd o Feddyginiaethau yn 2010-11. Mae nifer yr Adolygiadau a gyflawnir wedi cynyddu hefyd ac ar gyfartaledd cynhaliwyd 208 ohonynt gan bob fferyllfa yn 2010-11.

3.5 Yn rhan o ystod o newidiadau i'r fframwaith contract, a ddaeth i rym ar 1 Tachwedd 2011, cafodd y gwasanaeth Adolygiadau o'r Defnydd o Feddyginiaethau ei ddiwygio i dargedu grwpiau penodol o gleifion. Rhaid i hanner yr holl Adolygiadau a gynhelir gael eu cyflawni gyda'r grwpiau canlynol:

- Cleifion sy'n cymryd meddyginiaeth i ostwng pwysedd gwaed
- Cleifion sy'n cymryd meddyginiaethau i drin afiechyd anadlu
- Cleifion sy'n cymryd meddyginiaethau risg uchel, h.y. meddyginiaethau y gwyddys eu bod yn gysylltiedig â phroblemau'n ymwneud â diogelwch cleifion
- Cleifion y nodwyd bod perygl eu bod yn gwastraffu eu meddyginiaethau.

3.6 Mae'r grwpiau hyn yn adlewyrchu ymrwymiad Llywodraeth Cymru, a nodir yn y Rhaglen Lywodraethu, i wella canlyniadau o ran iechyd ymhlith y sawl sydd ag afiechyd yn ymwneud â chylchrediad y gwaed, cefnogi'r agenda 1000 o Fywydau a Mwy yng nghyswllt meddyginiaethau risg uchel, mynd i'r afael ag afiechyd anadlu (y cyflwr y mae pobl yng Nghymru yn sôn amlaf eu bod yn dioddef ohono, ar

[4] Price A, PCA 2009: Effectiveness of MURs in Asthma – South Wales & the South West.

wahân i afiechyd yn ymwneud â chylchrediad y gwaed[5]) a chyflawni ymrwymiadau maniffesto Llywodraeth Cymru i weithio gyda fferylliaeth gymunedol. Yn ogystal, bydd yr Adolygiadau o'r Defnydd o Feddyginiaethau yn ceisio:

- Codi ymwybyddiaeth o'r risg o strôc, a hybu'r defnydd cywir o feddyginiaeth i ostwng pwysedd gwaed; a
- Lleihau'n sylweddol y meddyginiaethau a wastreffir, gan gwtogi ar y modd y gwastreffir adnoddau gwerthfawr y GIG.

Bydd yr Adolygiadau newydd o'r Defnydd o Feddyginiaethau, a fydd yn canolbwyntio ar agweddau penodol, hefyd yn cynnig cyfle i'r fferyllydd ddarparu cyngor ynghylch hunanofal, mynd i'r afael â materion sy'n ymwneud â ffordd o fyw, a chyfeirio cleifion at wasanaethau eraill.

3.7 Ym mis Tachwedd 2011 lansiwyd gwasanaeth uwch newydd, sef y gwasanaeth Adolygu Meddyginiaethau adeg Rhyddhau. Mae'r gwasanaeth hwn wedi'i fwriadu ar gyfer cleifion sy'n cael eu rhyddhau i'r gymuned o ysbytai neu leoliadau gofal eraill. Mae'n cynnwys ymyriad ac iddo ddwy ran. Mae'r rhan gyntaf yn ei gwneud yn ofynnol i'r fferyllydd cymunedol wirio bod y meddyginiaethau a ragnodwyd yn y lleoliad gofal (e.e. yr ysbyty) yn cyd-fynd â'r rhai a gymerir gan y claf pan fydd yn dychwelyd adref. Mae'r ail ran yn adeiladu ar y gwasanaeth Adolygiadau o'r Defnydd o Feddyginiaethau cyfredol, ac mae'n darparu cyfle i'r fferyllydd drafod y modd y mae'r claf yn defnyddio ac yn deall ei feddyginiaethau.

3.8 Ceir tystiolaeth bod gwahaniaethau rhwng y meddyginiaethau a ragnodir ar gyfer unigolyn pan gaiff ei ryddhau o'r ysbyty a'r feddyginiaeth a ragnodir ar ei gyfer wedyn ym maes gofal sylfaenol. Fel rheol bydd hynny'n digwydd oherwydd problemau'n ymwneud â llif gwybodaeth amserol a manwl am ei feddyginiaethau.

Dylai cynnwys fferyllwyr cymunedol yn weithredol yn y broses hon helpu i sicrhau bod cleifion yn cael y meddyginiaethau a fwriadwyd, a dylai wella diogelwch cleifion a chanlyniadau o ran iechyd.

3.9 Bydd parhad y gwasanaeth Adolygu Meddyginiaethau adeg Rhyddhau ar ôl mis Ebrill 2013 yn amodol ar gwblhau gwerthusiad a dangos ei fod o fantais sylweddol i gleifion.

## 4. Y posibilrwydd o ddarparu rhagor o wasanaethau gan fferyllfeydd cymunedol yn ychwanegol at roi meddyginiaethau a dyfeisiau'r GIG, gan gynnwys y posibilrwydd o gael cynlluniau ar gyfer mân anhwylderau.

[5] Arolwg Iechyd Cymru 2010. Ar gael ar: http://wales.gov.uk/topics/statistics/headlines/health2011/1105191/?skip=1&lang=cy

**Darparu gwasanaethau newydd**

4.1 Fel yr amlinellwyd uchod, cafodd gwasanaeth Adolygu Meddyginiaethau adeg Rhyddhau ei gyflwyno ym mis Tachwedd 2011 i gyd-fynd â'r gwasanaeth Adolygiadau o'r Defnydd o Feddyginiaethau a ailstrwythurwyd, sy'n rhoi mwy o bwyslais yn awr ar dargedu grwpiau penodol o unigolion sy'n cymryd meddyginiaethau. Mae'r datblygiadau hyn wedi digwydd yn dilyn cyflwyno'r Gwasanaeth Gwell Cenedlaethol cyntaf ym mis Ebrill 2011 ar gyfer darparu dulliau atal cenhedlu hormonaidd brys. Yn ogystal, bwriedir cyflwyno tair manyleb ychwanegol ar gyfer Gwasanaethau Gwell Cenedlaethol newydd yn 2012, sef:

- Rhaglen cyfnewid nodwyddau a chwistrellau mewn fferyllfeydd cymunedol;
- Gwasanaeth rhoi meddyginiaeth gyfnewid dan oruchwyliaeth i'r sawl sy'n gaeth i opiadau, e.e. methadon; a
- Gwasanaeth rhoi'r gorau i ysmygu.

4.2 Wrth symud ymlaen mae angen cydnabod cymhlethdod cynyddol meddyginiaethau newydd a'r patrymau triniaeth y mae'n rhaid i gleifion eu dilyn i gael budd o'r meddyginiaethau a ragnodwyd ar eu cyfer. Gall fferyllwyr cymunedol gyflawni rôl allweddol o ran cynorthwyo cleifion i gael y budd mwyaf posibl, lleihau sgil-effeithiau a lleihau'r meddyginiaethau a wastreffir. Gyda'u harbenigedd ym maes rheoli meddyginiaethau, mae angen i fferyllwyr fod wrth wraidd datblygiadau newydd o ran gwasanaethau yn y gymuned, a chymryd rhagor o gyfrifoldeb a pherchnogaeth dros gynorthwyo cleifion sydd ag anhwylderau hirdymor a phobl hŷn sy'n agored i niwed.

4.3 Ar unrhyw adeg[6] gall fferyllfa gymunedol nodweddiadol fod yn darparu meddyginiaethau i:

- 8 o bobl â cholostomi
- 20 o bobl â chanser
- 50 o bobl sydd wedi'u rhyddhau'n ddiweddar o'r ysbyty
- 50 o bobl â diabetes
- 150 o bobl ag asthma
- 500 o bobl â phwysedd gwaed uwch na'r arfer
- 600 o ofalwyr
- 750 o bensiynwyr

4.4 Mae'r bobl uchod i gyd yn cael budd o gymorth ac ymyriad gan fferyllydd cymunedol. Mae angen rhwydwaith fferyllfeydd cymunedol ar GIG Cymru, sy'n gost-effeithiol, sydd wrth wraidd y gymuned ac sy'n cynorthwyo cleifion, y cyhoedd a gofalwyr. Mae gwasanaethau

[6] Moddion i lwyddo: strategaeth ar gyfer fferylliaeth yng Nghymru. Llywodraeth Cynulliad Cymru 2002

fferylliaeth gymunedol wedi datblygu ers 2005, ac erbyn hyn maent yn darparu ystod fwy o lawer o wasanaethau na gwasanaeth dosbarthu'n unig - er bod hwnnw'n bwysig hefyd. Mae Llywodraeth Cymru wedi ymrwymo i atgyfnerthu gofal sylfaenol a chymunedol, ac mae gan fferyllwyr cymunedol gyfraniad gwerthfawr i'w wneud ochr yn ochr â meddygon teulu a gweithwyr proffesiynol eraill ym maes gofal iechyd. Mae'n bwysig bod cyfraniad fferyllwyr cymunedol yn cael ei ystyried yn y cyd-destun hwn yn hytrach nag ar wahân iddo. Mae'r holl opsiynau'n cael eu harchwilio, a byddwn yn ymgynghori'n eang â gweithwyr proffesiynol ym maes gofal iechyd, ac yn bwysicach na neb, â chleifion.

**Mân anhwylderau**

4.5 Bob blwyddyn bydd nifer fawr o sesiynau ymgynghori meddygon teulu yn ymwneud ag anhwylderau y gall fferyllydd eu diagnosio, ac nad oes arnynt angen ymyriad gan feddyg teulu neu feddyginiaeth y mae'n rhaid cael presgripsiwn ar ei chyfer. Mae mân anhwylderau megis tarwden y traed, rhwymedd, peswch, dolur rhydd, y llindag, dafadennau, dolur gwddf, y llyngyren edau, llau pen, cur pen, clefyd y gwair a diffyg traul i gyd yn anhwylderau y gall fferyllydd ddarparu triniaeth ar eu cyfer.

4.6 Fodd bynnag, dangosodd ymchwil gan Gymdeithas Cyffuriau Siop Prydain Fawr[7] fod hyd at 40% o amser meddyg teulu'n cael ei dreulio'n ymdrin â chleifion sy'n dioddef o fân anhwylderau. Mae hynny'n lleihau nifer yr apwyntiadau sydd ar gael i gleifion ag anhwylderau mwy cymhleth, a gall ymestyn yr amser aros ar gyfer cleifion y mae angen iddynt weld meddyg teulu. Yn ogystal, nododd yr ymchwil farn y cleifion eu hunain am y rhwystrau sy'n eu hatal rhag defnyddio fferyllfa gymunedol i drin mân anhwylderau. Roedd y rhwystrau hynny'n cynnwys preifatrwydd, yr angen am gysur gan eu meddyg teulu, a'r gost a oedd yn gysylltiedig â meddyginiaeth na ragnodir.

4.7 Cydnabyddir bod rhoi cyngor ynghylch mân anhwylderau'n un o swyddogaethau craidd fferylliaeth, ac mewn llawer o achosion mae'n haws i unigolyn fynd at fferyllydd nag at feddyg teulu, o safbwynt amser teithio ac amser aros. Yn gyffredinol, mae ymarferion gwerthuso cynlluniau ar gyfer mân anhwylderau[8][9][10] wedi dod i'r casgliad eu bod yn wasanaethau diogel ac effeithiol a bod cleifion yn eu croesawu'n gyffredinol.

[7] Making the case for the self care of minor ailments – Awst 2009
[8] Vohra S. A community pharmacy minor ailment scheme-effective, rapid and convenient. Pharmaceutical Journal 2006; 276: 754-756.
[9] Blenkinsopp A; Noyce P. Minor illness management in primary care: a review of community pharmacy NHS schemes - Keele University 2002.
[10] Implementing a community pharmacy minor ailment scheme - National Pharmaceutical Association, 2003

4.8 Rydym yn archwilio nifer o faterion gyda rhanddeiliaid o bob cwr o Gymru, gan gynnwys y materion canlynol:

- Yr ystod bosibl o feddyginiaethau a ddylai fod ar gael gan y GIG yn rhan o wasanaeth ar gyfer mân anhwylderau;

- Y manteision cymharol pe bai gwasanaeth ar gyfer mân anhwylderau ar gael yn ystod oriau agor arferol neu pe bai'n gyfyngedig i'r penwythnosau ac adegau y tu allan i oriau agor arferol.

**Natur wledig**

4.9 Yn ein Rhaglen Lywodraethu, rydym wedi ailddatgan ein hymrwymiad i sicrhau cymuned wledig fywiog sy'n gallu cael mynediad i wasanaethau iechyd o safon. Mae cymunedau gwledig yn elwa o rwydwaith cynaliadwy, dibynadwy ac effeithiol o fferyllfeydd cymunedol. Ceir enghreifftiau da o fferyllfeydd sy'n darparu ystod o wasanaethau gofal iechyd yn ein cymunedau gwledig: gwasanaeth rhoi'r gorau i ysmygu (Powys), sicrhau'r driniaeth orau ar gyfer pall ar y galon (Hywel Dda) a darparu therapi ymddygiad gwybyddol ar gyfer iselder ysbryd yng Ngwynedd.

4.10 Fodd bynnag, mae angen adeiladu gwasanaethau newydd o hyd ar sail dealltwriaeth glir o angen fferyllol sy'n adlewyrchu arfer da. Ar hyn o bryd rydym wrthi'n archwilio'r agwedd hon ymhellach gydag Iechyd Cyhoeddus Cymru, ac yn archwilio'n benodol yr effaith bosibl y gallai gwasanaethau ehangach ym maes fferylliaeth gymunedol, megis Adolygiadau o'r Defnydd o Feddyginiaethau a gwasanaethau ar gyfer mân anhwylderau, ei chael ar gynyddu mynediad i wasanaethau mewn ardaloedd gwledig.

**Iechyd cyhoeddus**

4.11 Mae lleoliad, hygyrchedd a nifer y bobl sy'n ymweld â fferyllfeydd cymunedol yn golygu eu bod mewn sefyllfa allweddol i hyrwyddo'r agenda o ran iechyd cyhoeddus. Er y dylai cyfraniad fferyllwyr o ran iechyd cyhoeddus barhau i ganolbwyntio ar eu cyfraniad i waith rheoli meddyginiaethau, gan mai cymryd meddyginiaeth yw'r ymyriad mwyaf cyffredin ym maes gofal iechyd, mae ganddynt rôl i'w chwarae hefyd o ran atal afiechyd, sgrinio, monitro, trin a chynorthwyo'r boblogaeth.

4.12 Nid ydym eto wedi gwireddu'r holl effaith y gellir ei chael wrth gynnwys fferylliaeth gymunedol yn yr agenda o ran iechyd cyhoeddus. Fodd bynnag, gwnaed cynnydd eleni. Ym mis Mehefin 2011, cafodd pob fferyllfa gymunedol yng Nghymru gyfle i gymryd rhan yn yr ymgyrch genedlaethol gyntaf ym maes iechyd cyhoeddus. Yn ystod yr ymgyrch a barodd bythefnos, cafodd 17,507 o bobl eu sgrinio a

gwelwyd bod 1,478 mewn perygl mawr o ddatblygu diabetes. Roedd pawb a gymerodd ran yn yr ymgyrch o'r farn ei bod yn llwyddiannus, ac roedd yn ganlyniad cydweithredu rhwng Iechyd Cyhoeddus Cymru, Fferylliaeth Gymunedol Cymru, Diabetes UK a Byrddau Iechyd Lleol. Mae angen i ni sicrhau bod pob fferyllfa yn cymryd rhan mewn ymgyrchoedd cenedlaethol yn y dyfodol; mae'r ymgyrchoedd ar gyfer 2012-13 wedi'u nodi'n barod a byddant yn ymdrin ag afiechyd cardiofasgwlaidd, y rhaglen cleifion arbenigol ac afiechyd anadlu.

4.13 Bydd fferyllwyr cymunedol yn amlwg hefyd mewn rolau eraill yng nghyswllt iechyd cyhoeddus, a fydd yn cynnwys y rhaglen archwiliadau iechyd blynyddol, gwaith darparu cyngor a chymorth ynghylch ffordd o fyw, dulliau atal cenhedlu brys, gwasanaeth cyflenwi methadon, rhaglenni cyfnewid nodwyddau a chwistrellau, gwaith lleihau'r meddyginiaethau a wastreffir, a'r rhaglen frechu rhag y ffliw.

**Brechu rhag y ffliw**

4.14 Mae Llywodraeth Cymru wedi ymrwymo i sicrhau bod brechiadau rhag y ffliw ar gael yn eang i bawb y mae arnynt eu hangen. Mae lleoliad, hygyrchedd, hyfforddiant ac arbenigedd fferyllydd yn y gymuned yn ddelfrydol ar gyfer darparu brechiad rhag y ffliw. Er bod llawer o fferyllwyr yn darparu brechiadau i unigolion fel gwasanaeth preifat y tu allan i'r GIG, hyd yma nid ydynt wedi bod yn darparu gwasanaeth dan nawdd y GIG. Felly, mae'n siomedig bod cynlluniau i dreialu rhaglen frechu rhag y ffliw dan nawdd y GIG mewn fferyllfeydd cymunedol mewn dau Fwrdd Iechyd Lleol ar gyfer gaeaf 2011/12 wedi methu. Fodd bynnag, roedd angen i'r Byrddau Iechyd Lleol dan sylw ystyried y ffaith bod meddygon teulu wedi archebu eu brechiadau fisoedd lawer yn gynharach, a'u bod mewn perygl o gael stoc ar ôl a oedd heb ei defnyddio. Bydd defnyddio fferyllwyr cymunedol i frechu pobl rhag y ffliw yn fater a fydd yn cael ei symud yn ei flaen yn 2012/13, gan ymgysylltu'n gynnar â phob parti perthnasol.

**Rhagnodi gan bobl heblaw meddygon**

4.15 Ar hyn o bryd, prin yw'r rhagnodi sy'n digwydd gan bobl heblaw meddygon mewn fferylliaeth gymunedol, er bod gan lawer o fferyllwyr cymunedol gymwysterau priodol i wneud hynny. Mae'r rhan fwyaf o'r gwaith rhagnodi gan bobl heblaw meddygon ar gyfer anhwylderau cronig yn digwydd mewn practisiau meddygon teulu a chanolfannau gofal sylfaenol mewn clinigau a arweinir gan fferyllfeydd, ac mae'n adlewyrchu mor ddymunol yw cael gwahaniaeth clir rhwng rhagnodi meddyginiaeth a dosbarthu meddyginiaeth. Yn ogystal, mae fferyllwyr cymunedol yn rhagnodi ac yn cyflenwi meddyginiaethau dros y cownter fel mater o drefn, yn cyflenwi meddyginiaethau yn unol â Chyfarwyddeb Grwpiau Cleifion, neu'n darparu cyflenwadau brys fel rheol i gleifion y mae eu meddyginiaeth wedi gorffen. Mae angen sgiliau rhagnodydd i gyflawni pob un o'r rhain.

**Addysg**

4.16 Mae datblygu'r gweithlu yn rhan annatod o ddarparu gwasanaethau proffesiynol o safon. Mae Llywodraeth Cymru wedi buddsoddi'n helaeth mewn cefnogi addysg a hyfforddiant cyn ac ar ôl cofrestru ym maes fferylliaeth. At ei gilydd, caiff £4.3 miliwn ei fuddsoddi bob blwyddyn i gefnogi cyfres o gyfleoedd addysg, cyfleoedd hyfforddiant ac adnoddau drwy Ganolfan Addysg Broffesiynol Fferylliaeth Cymru (sy'n uned weithredol yn Ysgol Fferylliaeth Cymru ym Mhrifysgol Caerdydd) a'r Asiantaeth Genedlaethol Arwain ac Arloesi mewn Gofal Iechyd. Mae'r swm hwnnw'n cynnwys £3.2 miliwn i gefnogi myfyrwyr i gael hyfforddiant yn yr ysbyty a'r gymuned cyn cofrestru, a £1.1 miliwn i gyllido gwaith datblygu a chyflwyno datblygiad proffesiynol parhaus i fferyllwyr cymunedol, a ddefnyddir yn rhannol i'w galluogi i ddarparu gwasanaethau gwell. Gellir cael mynediad i'r ystod o hyfforddiant, a ddarperir gan Ganolfan Addysg Broffesiynol Fferylliaeth Cymru ac a gefnogir gan Lywodraeth Cymru, ar www.wcppe.org.uk.

4.17 Rydym hefyd wedi dechrau trafod cyflwyno cwrs gradd newydd 5 mlynedd ar gyfer fferylliaeth, a fydd yn integreiddio hyfforddiant clinigol ac ymarferol ochr yn ochr ag astudiaethau academaidd. Bydd hynny'n cynhyrchu fferyllwyr sydd â'r sgiliau a'r wybodaeth glinigol y mae eu hangen ar y GIG ac ar ddinasyddion Cymru.

**5. Effaith bresennol ac effaith bosibl ehangu gwasanaethau fferylliaeth gymunedol ar y galw am wasanaethau'r GIG mewn sefyllfaoedd gofal sylfaenol a gofal eilaidd, ac unrhyw arbedion cost y gallant eu cynnig.**

5.1 Bydd gwasanaeth gofal sylfaenol a chymunedol cryfach o safon yng Nghymru, a ddarperir gan dimau amlddisgyblaethol sy'n gweithio ar draws sectorau, yn cael effaith gadarnhaol ar y sector gofal eilaidd ac yn caniatáu i'r sector hwnnw ganolbwyntio ar yr hyn a wna orau. Mae gan wasanaethau fferyllfeydd cymunedol gyfraniad pwysig i'w wneud i'r agenda hon, ac maent mewn sefyllfa dda i helpu i gyflawni hynny gyda meddygon teulu, gweithwyr proffesiynol eraill ym maes gofal iechyd, a gwasanaethau cymdeithasol.

5.2 Mae sicrhau y caiff meddyginiaethau eu defnyddio'n effeithiol ac yn briodol, darparu cyngor arbenigol ynghylch hunanofal ar gyfer anhwylderau hirdymor a phroblemau iechyd eraill, cyfeirio cleifion at ffynonellau cymorth o ran gofal iechyd, ac adnabod problemau iechyd yn gynnar ymhlith rhai enghreifftiau'n unig o'r cyfraniad y gall fferyllydd cymunedol ei wneud i leihau achosion y gellir eu hosgoi o dderbyn neu ailddderbyn cleifion i'r ysbyty, gan arbed costau i'r GIG felly hefyd.

5.3 Fferylliaeth gymunedol yw un o'r ychydig ddarparwyr gofal iechyd sy'n ymwneud â phobl pan fyddant yn iach, a gellir defnyddio hynny i dargedu grwpiau a allai fod yn agored i niwed. Fferyllfeydd cymunedol yw canolfannau cymorth hygyrch y GIG yng nghanol trefi a dinasoedd ledled Cymru. At hynny, pan fydd pobl oddi cartref, maent yn gwybod y gallant gerdded i mewn i unrhyw fferyllfa a chael cyngor dibynadwy ynghylch iechyd neu gael meddyginiaeth hyd yn oed, mewn argyfwng, os ydynt wedi gadael eu meddyginiaeth gartref neu wedi'i cholli, a hynny heb beri i'r GIG yn ehangach fynd i ragor o gost sylweddol.

5.4 Ceir gofyniad clir a chynyddol i fferylliaeth gymunedol ddarparu rhagor o wasanaethau'n gost-effeithiol mewn cyd-destun lle mae nifer y presgripsiynau a roddir yn cynyddu. Rwy'n hyderus y gall fferyllfeydd cymunedol ddarparu'r gwasanaethau hyn, ac yn setliad fframwaith contract mis Tachwedd 2011 gofynnais i fferylliaeth gymunedol dargedu meysydd penodol ar gyfer gwella, e.e. y gwasanaeth Adolygiadau o'r Defnydd o Feddyginiaethau a ailstrwythurwyd a'r gwasanaeth Adolygu Meddyginiaethau adeg Rhyddhau, sy'n wasanaeth newydd, a sicrheais fod yr arian angenrheidiol ar gael. Dros y 15 mis nesaf byddaf yn monitro'n agos y cyfraniad y bydd y gwasanaethau newydd hyn yn ei wneud i ofal cleifion, a byddaf yn disgwyl i fferylliaeth gymunedol ddangos tystiolaeth gadarn o fudd.

## 6. Hynt y gwaith a wneir ar hyn o bryd i ddatblygu gwasanaethau fferylliaeth gymunedol.

6.1 Mae'r papur hwn yn disgrifio'r cynnydd y mae Llywodraeth Cymru wedi'i wneud o ran datblygu gwasanaethau fferylliaeth gymunedol, ac mae'n egluro ein rhaglen waith heriol ar gyfer y flwyddyn sydd i ddod. Byddai popeth a gyflawnwyd hyd yma wedi bod yn amhosibl heb ymrwymiad fferyllwyr cymunedol yng Nghymru a Byrddau Iechyd Lleol, a hoffwn ddiolch i bawb am eu cyfraniad i'r agenda hon. I grynhoi, mae'r meysydd allweddol yr ydym yn eu hybu ym maes gofal iechyd fel a ganlyn:

- Ymgyrch Iechyd Cyhoeddus 2012-13 sy'n targedu blaenoriaethau Llywodraeth Cymru o ran iechyd, sef afiechyd cardiofasgwlaidd, y rhaglen cleifion arbenigol ac afiechyd anadlu;

- Cyflwyno Adolygiadau o'r Defnydd o Feddyginiaethau a gwasanaethau Adolygu Meddyginiaethau adeg Rhyddhau sydd wedi'u targedu ac sy'n canolbwyntio ar gynorthwyo ein dinasyddion mwyaf agored i niwed;

- Sicrhau bod y gwasanaeth atal cenhedlu hormonaidd brys ar gael ym mhob fferyllfa gymunedol lle mae ei angen;

- Cyflwyno manylebau gwasanaethau gwell cenedlaethol newydd ar gyfer rhaglen cyfnewid nodwyddau a chwistrellau, gwasanaeth rhoi meddyginiaeth gyfnewid dan oruchwyliaeth i'r sawl sy'n gaeth i opiadau, a gwasanaeth rhoi'r gorau i ysmygu mewn fferyllfeydd cymunedol;

- Cynnwys fferyllwyr cymunedol yn y broses o ddarparu'r archwiliadau iechyd blynyddol newydd i bawb sy'n 50 oed neu'n hŷn;

- Datblygu a hyrwyddo fferyllfeydd cymunedol fel y man cyntaf y dylai'r sawl sydd â mân anhwylderau fynd iddynt; a

- Sefydlu rhaglen frechu rhag y ffliw dan nawdd y GIG mewn fferyllfeydd cymunedol ar gyfer gaeaf 2012.

6.2 I gefnogi'r datblygiadau hyn, bydd Llywodraeth Cymru yn ymgynghori'n fuan ynghylch newidiadau i'r rheoliadau fferyllol er mwyn symleiddio'r broses ymgeisio, cymeradwyo ac apelio sy'n ymwneud â "Rheoli Mynediad". Rydym hefyd yn bwriadu atgyfnerthu ac integreiddio gwaith cynllunio gwasanaethau fferyllol yng nghyd-destun gwaith cynllunio gofal cynradd a gofal cymunedol ar lefel Byrddau Iechyd Lleol ac ardaloedd. Yn y dyfodol mwy hirdymor, byddwn drwy ddeddfwriaeth yn ceisio sicrhau mai'r cynlluniau hyn yw'r sail y bydd Byrddau Iechyd Lleol yn ei defnyddio i wneud penderfyniadau ynghylch ceisiadau i agor fferyllfeydd newydd.

# Y Pwyllgor Iechyd a Gofal Cymdeithasol

| | |
|---|---|
| Lleoliad: | **Ystafell Bwyllgora 3 – Y Senedd** |
| Dyddiad: | **Dydd Iau, 8 Rhagfyr 2011** |
| Amser: | **09:30 - 11:20** |

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_400000_08_12_2011&t=0&l=cy

## Cofnodion Cryno:

| | |
|---|---|
| Aelodau'r Cynulliad: | **Mark Drakeford (Cadeirydd)**<br>**Mick Antoniw**<br>**Rebecca Evans**<br>**Vaughan Gething**<br>**William Graham**<br>**Elin Jones**<br>**Lynne Neagle**<br>**Lindsay Whittle** |
| Tystion: | **Dr Chris Jones, Llywodraeth Cymru**<br>**Grant Duncan, Llywodraeth Cymru** |
| Staff y Pwyllgor: | **Sarah Beasley (Clerc)**<br>**Llinos Dafydd (Clerc)**<br>**Naomi Stocks (Clerc)**<br>**Catherine Hunt (Dirprwy Glerc)**<br>**Joanest Jackson (Cynghorydd Cyfreithiol)**<br>**Gregg Jones (Ymchwilydd)**<br>**Stephen Boyce (Ymchwilydd)**<br>**Victoria Paris (Ymchwilydd)** |

### 1. Cyflwyniadau, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Darren Millar a Kirsty Williams.  Nid oedd dirprwyon.

### 2. Y wybodaeth ddiweddaraf am faterion polisi yr Undeb Ewropeaidd sy'n berthnasol i'r Pwyllgor Iechyd a Gofal Cymdeithasol

2.1 Bu'r Pwyllgor yn trafod y papur â Gregg Jones o'r Gwasanaeth Ymchwil.

2.2 Gofynnodd y Pwyllgor am ragor o wybodaeth am anghydraddoldebau iechyd, gan gynnwys gwybodaeth ynghylch unrhyw ddeddfwriaeth arfaethedig, cymeradwyo cyffuriau ledled yr UE, a modelau gofal i'r henoed yng ngwledydd yr UE.

2.3 Cytunodd y Pwyllgor i ystyried materion polisi'r UE eto fel rhan o drafodaeth ehangach ar ei flaenraglen waith yn y dyfodol.

## 3. Ymchwiliad i ofal preswyl i bobl hyn - Cynllun gwaith y Pwyllgor

3.1 Cytunodd y Pwyllgor ar ei gynllun gwaith ar gyfer ei ymchwiliad i ofal preswyl i bobl hŷn.

## 4. Papur Gwyn ar Roi Organau - Sesiwn friffio ar y materion technegol gan swyddogion Llywodraeth Cymru

4.1 Ymatebodd y swyddogion i gwestiynau gan aelodau'r Pwyllgor ynghylch y Papur Gwyn ar Roi Organau.

4.2 Cytunodd y swyddogion i ddarparu'r wybodaeth ychwanegol a ganlyn, y gofynnodd y Pwyllgor amdani:

- rhestr o sefydliadau yn y trydydd sector sydd wedi'u cynnwys yn yr ymgynghoriad ar y Papur Gwyn;
- manylion am gyfarfodydd cyhoeddus ar y Papur Gwyn a fydd yn cael eu cynnal yn y dyfodol;
- eglurhad ynghylch a yw'r trefniadau presennol ar gyfer rhoi organau a meinweoedd yn gymwys yng Nghymru a Lloegr yn unig, neu hefyd yn cynnwys yr Alban a Gogledd Iwerddon.

4.3 Cytunodd y Pwyllgor i gynnal sesiwn debyg ar ddiwedd y broses o ymgynghori ar y Papur Gwyn.

## 5. Papurau i'w nodi

5.1 Nododd y Pwyllgor gofnodion y cyfarfodydd a gynhaliwyd ar 16 a 24 Tachwedd.

5.2 Nododd y Pwyllgor y papurau i'w nodi.

## 6. Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitemau 7 ac 8

6.1 Cytunodd y Pwyllgor ar y cynnig i benderfynu gwahardd y cyhoedd o weddill y cyfarfod ar gyfer eitemau 7 ac 8.

## 7. Ymchwiliad i Leihau'r Risg o Strôc - Adroddiad drafft

7.1 Bu'r Pwyllgor yn ystyried yr adroddiad drafft ar ei ymchwiliad i leihau'r risg o strôc.

## 8. Paratoi ar gyfer y sesiwn graffu ar waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

8.1 Bu'r Pwyllgor yn ystyried y materion y byddai'n eu crybwyll wrth y Gweinidog Iechyd a Gwasanaethau Cymdeithasol yn y sesiwn graffu ar 25 Ionawr 2012.

**TRAWSGRIFIAD**

Trawsgrifiad o'r cyfarfod.

**Gwenda Thomas AC / AM**
**Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol**
**Deputy Minister for Children and Social Services**

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MBGT/7504/11

Mark Drakeford AM
Chair
Health & Social Care Committee
National Assembly for Wales
Cardiff Bay
Cardiff CF99 1NA

2nd December 2011

Dear Mark,

I have seen your letter of 24 October confirming that the Committee is to hold an inquiry into residential care for older people and which outlined the terms of reference of this inquiry.

I read with interest the wide-ranging nature of this inquiry, which I think the Committee should be congratulated upon. I note that you have also issued an invitation for evidence for this. For my part I am more than happy to provide written and/or oral evidence to the Committee to help inform this process when you feel this would be helpful.

As you will be aware I had intended to establish a task group that would consider over the next year the care and accommodation needs of older people. However, given the comprehensive terms of reference of the Committee's inquiry I have decided to hold this proposal in abeyance. As there would be a strong possibility of duplication I have concluded, on reflection, that it would be sensible to await the outcome of your inquiry before considering this proposal further.

Yours sincerely,
Gwenda.

**Gwenda Thomas AC / AM**
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

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Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Gwenda.Thomas@wales.gsi.gov.uk

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**Gwenda Thomas AC / AM**
**Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol**
**Deputy Minister for Children and Social Services**

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/GT/6989/11

Mark Drakeford AM
Chair
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
Cardiff

12 December 2011

Dear Mark,

**Update on the Monitoring of the Implementation of the First Steps Improvement Package**

You will recall that during the Committee's scrutiny on 20 October of the Assembly's draft budget, I promised to write to share the outcome of the first half yearly monitoring exercise that I had put in place on the implementation of the First Steps Improvement Package. That Package was to introduce more consistency where local authorities decided to charge for the non-residential social services they provide, or for which they arranged the provision. This was in light of the wide variations in the level of charges and calculation of charges that operated across local authorities in Wales, often for the same services.

As part of my post implementation monitoring of this Package, during the first year of implementation two half yearly monitoring exercises are being undertaken to assess its impact. The first of these concluded recently and I am now able to share with the Committee the main outcomes from this. In providing these I should stress that given the limited nature of this first return (ie covering just the initial 6 months of implementation) these can only represent a snapshot of what has occurred to date and will need to be verified further by the second exercise to be undertaken at the end of the financial year.

The good news is that due to the legislation we introduced authorities are reporting that no service user in Wales is paying more than £50 per week for the non-residential social services they receive provided under the service provision powers referred to in the Social Care Charges (Wales) Measure 2010. This is a substantial benefit for some service users who, depending upon their financial means, would have been paying several hundred pounds per week for their services. This is especially so where their local authority had no maximum charge previously for these services. In terms of those receiving a service, authorities report that around 30,000 individuals are receiving a service for which a charge could be levied, but that only around 18,000 are charged. Some authorities also report an increase in those seeking a service for the first time, although depending upon their care needs and the authority's eligibility criteria for services, it is not always the case that this results in an increase in the overall number of service users an authority has. This is

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something to be expected on the implementation of such an initiative as this. Nevertheless it will be interesting to see from the end year exercise whether this issue is still occurring then or whether requests for services have levelled off.

As a result a minority of authorities are at present reporting an above average increase over their original estimate of the income they will forego as a direct result of implementing the Package. That original estimate they provided last year to inform the £10.117 million p.a. that we included from 2011-12 in the RSG to local government to reimburse authorities for this lost income. Working with those authorities who have reported such increases to establish the nature of these, inconsistencies have been found in some authorities' calculations, leading in those cases to reductions in their estimates of income foregone provided.

Nevertheless it is important that we have a true reflection of the income that authorities are foregoing as a result of the Package's implementation. As a result I am asking authorities who continue to identify an increase in their income foregone in the second monitoring exercise to be undertaken at the end of the financial year to verity this with their section 151 officer. This is to ensure that authorities have calculated these estimates in the correct manner and that we have reliable data upon the full year financial effect on authorities in order to base decisions upon. (Under section 151 of the Local Government Act 1972 every authority is to make arrangements for the proper administration of their financial affairs and requires one officer to be nominated within the authority to take responsibility for this. This officer is usually the authority's treasurer and must be a qualified accountant belonging to one of the recognised chartered accountancy bodies). We will then, on the basis of this end year exercise, be able to take stock as to full impact of the Package's implementation and what further action, if any, we may need to take.

I trust the Committee will find this summary of the current monitoring exercise undertaken with local authorities informative.

Yours sincerely

**Gwenda Thomas AC / AM**
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

## Y Pwyllgor Iechyd a Gofal Cymdeithasol

**HSC(4)-01-12 papur 6**

**Ymchwiliad i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru – Cais am wybodaeth bellach gan Fferylliaeth Gymunedol Cymru a'r Gymdeithas Fferyllol Frenhinol**

Ynghlwm fel atodiadau i'r papur hwn ceir llythyrau gan Gadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol i Fferylliaeth Gymunedol Cymru a'r Gymdeithas Fferyllol Frenhinol yn gofyn am wybodaeth bellach fel rhan o ymchwiliad y Pwyllgor I'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru.

Gwasanaeth y Pwyllgorau

**Y Pwyllgor Iechyd a Gofal Cymdeithasol**

**Health and Social Care Committee**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Russell Goodway
Chief Executive
Community Pharmacy Wales

8 December 2011

Dear Russell,

As you will be aware, the Health and Social Care Committee's inquiry into the contribution of community pharmacy to health services in Wales will draw to a close shortly. The final oral evidence session will take place on Wednesday 11 January 2012 when we will scrutinise the Minister for Health and Social Services on this subject.

The Committee is grateful for the evidence you have provided for this inquiry to date. As you appeared before the Committee during its first oral evidence session on community pharmacy, we would like to seek your views on a number of points which have been raised in subsequent sessions. These points are listed in Annex A to this letter.

It would be most helpful to receive your response by **Friday 23 December** so that the information you provide can be considered when we scrutinise the Minister early in the new year. Please could you contact the Clerk on the details below should you foresee any problems with providing the information by this date.

Cofion gorau,

Mark Drakeford

**Mark Drakeford AM**
**Chair of the Health and Social Care Committee**

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Croesewir gohebiaeth yn y Gymraeg a'r Saesneg / We welcome correspondence in both English and Welsh

During the Health and Social Care Committee's gathering of evidence for the inquiry into the contribution of community pharmacy to health services in Wales, issues in relation to the four points below have been raised. The Committee would be grateful to know the views of CPW in relation to each of these points.

1. **"Hard to reach" groups and MURs**

Community Pharmacy Wales's 2011 manifesto states that:

> "Community pharmacies are especially well placed to capture those hard to reach groups and to work with them to address these challenges."[1]

The manifesto also says:

> "...community pharmacies operate at the heart of the community, and yet provide healthcare services to people who are often hardest to reach but who need it the most."[2]

Public Health Wales (PHW) told us, however, that the uptake of MURs, for example, is lower in areas where one would expect it to be higher,[3] citing a study in England that suggests lower take-up in poorer areas.[4] PHW noted that community pharmacy colleagues would have a better understanding of what drives uptake of such services (e.g. whether it is an issue of patients not coming forward, or not being encouraged to do so; whether pharmacists are not in a position to encourage uptake because of other pressures they face).

**Question 1**

Given the information provided by PHW, do you have any additional information to support your assertion that community pharmacy can provide healthcare services to people who are often hardest to reach but who need it the most?

*This would assist the Committee in understanding the extent to which the community pharmacy network could be utilised to engage hard to reach groups, and what services could be best used to do this.*

[1] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 24 – Community Pharmacy Wales, page 9 of the manifesto document [accessed 7 December 2011]
[2] Ibid, page 11 of the manifesto document
[3] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 28], 10 October 2011
[4] Bradley F et al. *Determinants of the uptake of medicines use reviews (MURs) by community pharmacies in England: A multi-method study*. Health Policy 2008; 88: 258-68

## 2. Community pharmacy capacity

Figures on the uptake for the national diabetes campaign delivered via the community pharmacy network indicated that a quarter of the network did not provide an evaluation of their work on this campaign, suggesting that some may not have participated at all.[5] The figure for non-responders rises to 40% in Pembrokeshire and Ceredigion.[6]

When asked about this during the oral evidence session, CPW rejected the notion that there are fewer locally enhanced services because pharmacists simply do not wish to provide them. Instead, you argued that this is attributable, in the main, to a lack of commissioning on the part of local health boards.[7]

When talking about the future potential for community pharmacy, however, Mr Chris Martin, Chair of the Hywel Dda Local Health Board and a pharmacist by profession, told us that:

> "…[his] greatest fear is that [his] profession will not deliver on this expanding role in sufficient numbers to provide fair and equitable service provision."[8]

**Question 2**

The evidence above suggests that, although there may have been limited commissioning of services by LHBs, where services are commissioned, community pharmacy may not be taking the opportunities being offered. Do you have any data which indicates what levels of uptake there are for services already commissioned locally and nationally?

*This would assist the Committee in understanding whether the alleged lack of additional pharmacy services is attributable in its entirety to a lack of commissioning activity, or whether there is a lack of interest or capacity on the part of pharmacists to deliver such services.*

[5] Nuala Brennan, Public Health Wales, Community pharmacy diabetes risk health promotion campaign, 24.8.11, page 5 [accessed 7 December 2011]
[6] Ibid, page 6
[7] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [paras 140 - 141], 28 September 2011
[8] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 199], 2 November 2011

## 3. Provision of services at a national level

CPW's supplementary written evidence on the Scottish contract states that:

> "...the national nature of the Scottish contract makes it more akin to there being a range of national enhanced services. This is what CPW has supported for many years."[9]

RPS's written evidence also welcomes national service provision via the community pharmacy network.[10] Representatives from local health boards told the Committee on 2 November that the national approach to commissioning services adopted in Scotland "...is definitely the way in which we should be going."[11]

**Question 3**

Do you have any further evidence of work underway amongst key bodies in Wales in relation to the commissioning of services on a national basis?

**Question 4**

What issues in particular do you think would be addressed by commissioning more services at a national level? Would there be any challenges if such an approach were adopted?

*This would assist the Committee in understanding the extent to which the commissioning of national services could address some of the issues raised during the inquiry, and what challenges could arise.*

## 4. Community pharmacy contractual framework

During the oral evidence session on 28 September,[12] Community Pharmacy Wales told the Committee that you believed "...that part of the problem is the contractual arrangements that exist". RPS also told us in their written evidence that "...the community pharmacy contractual framework has the potential to support a more integrated and clinical role

[9] National Assembly for Wales, Health and Social Care Committee, HSC(04)-12-11 - Paper 4: Inquiry into the contribution of community pharmacy to health services in Wales - Additional evidence from Community Pharmacy Wales, 24 November 2011 [accessed 7 December 2011]
[10] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 6 [accessed 7 December 2011]
[11] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 228], 2 November 2011
[12] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 162], 28 September 2011

for this workforce"[13], but that there have been missed opportunities and barriers to its utilisation, including a lack of synergy with other primary care contracts.[14]

LHB representatives also told us there is a need to scope out the capacity and resource needed to develop a new Welsh contract for community pharmacy.[15] This, they argued, was due to the fact that the current contract is volume-based[16] and means that medicines in Wales are delivered "in silos".[17]

Despite these alleged contractual limitations, evidence also suggests that opportunities already provided via the existing contract are not being utilised (cf. section 2 of this Annex).

**Question 5**

In your view, are the challenges which have arisen in relation to rolling out enhanced and advanced services via the community pharmacy network attributable to the current contractual framework?

- If so, what changes would you wish to see to the contract?
- If not, to what would you attribute the main challenges facing the expansion of enhance and advanced services?
- Do you have any further comments on the relationship between the community pharmacy contractual framework and other primary care contracts?

*This would assist the Committee in understanding the extent to which changes to the contractual framework might address the challenges of expanding the role of community pharmacy.*

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If there is any additional information of relevance to the inquiry which is not mentioned in this letter but you would like to raise, please feel free to include this in your response.

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[13] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 2 [accessed 7 December 2011]
[14] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 5.1.1 [accessed 7 December 2011]
[15] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 198], 2 November 2011
[16] Ibid, para 209
[17] Ibid, para 210

**Y Pwyllgor Iechyd a Gofal Cymdeithasol**

**Health and Social Care Committee**

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales

Mair Davies
Chair, Welsh Pharmacy Board
Royal Pharmaceutical Society

8 December 2011

Annwyl Mair,

As you will be aware, the Health and Social Care Committee's inquiry into the contribution of community pharmacy to health services in Wales will draw to a close shortly. The final oral evidence session will take place on Wednesday 11 January 2012 when we will scrutinise the Minister for Health and Social Services on this subject.

The Committee is grateful for the evidence you have provided for this inquiry to date. As you appeared before the Committee during its first oral evidence session on community pharmacy, we would like to seek your views on a number of points which have been raised in subsequent sessions. These points are listed in Annex A to this letter.

It would be most helpful to receive your response by **Friday 23 December** so that the information you provide can be considered when we scrutinise the Minister early in the new year. Please could you contact the Clerk on the details below should you foresee any problems with providing the information by this date.

Cofion gorau,

Mark Drakeford

**Mark Drakeford AM**
**Chair of the Health and Social Care Committee**

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Croesewir gohebiaeth yn y Gymraeg a'r Saesneg / We welcome correspondence in both English and Welsh

During the Health and Social Care Committee's gathering of evidence for the inquiry into the contribution of community pharmacy to health services in Wales, issues in relation to the four points below have been raised. The Committee would be grateful to know the views of RPS in relation to each of these points.

### 5. "Hard to reach" groups and MURs

During the oral evidence session on 28 September[18] and in written evidence,[19] RPS told the Committee that community pharmacy delivers services to - and engages with – cohorts of the population who were previously difficult to reach. It was suggested that this was due not only to the location of community pharmacies but to the accessibility and openness of community pharmacy services.[20]

Public Health Wales (PHW) told us, however, that the uptake of MURs, for example, is lower in areas where one would expect it to be higher,[21] citing a study in England that suggests lower take-up in poorer areas.[22] PHW noted that community pharmacy colleagues would have a better understanding of what drives uptake of such services (e.g. whether it is an issue of patients not coming forward, or not being encouraged to do so; whether pharmacists are not in a position to encourage uptake because of other pressures they face).

**Question 1**

Given the information provided by PHW, do you have any additional information to support your assertion that community pharmacy can engage a range of groups and communities, particularly those groups deemed "hard-to-reach"?

*This would assist the Committee in understanding the extent to which the community pharmacy network could be utilised to engage hard to reach groups, and what services could be best used to do this.*

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[18] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [paras 8 – 12], 28 September 2011
[19] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 3 [accessed 7 December 2011]
[20] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 10], 28 September 2011
[21] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 28], 10 October 2011
[22] Bradley F et al. *Determinants of the uptake of medicines use reviews (MURs) by community pharmacies in England: A multi-method study.* Health Policy 2008; 88: 258-68

## 6. Community pharmacy capacity

In your written evidence, you state that RPS's vision for community pharmacy would include community pharmacies as "the walk-in health care centres for great public health service provision".[23]

When talking about the future potential for community pharmacy, however, Mr Chris Martin, Chair of the Hywel Dda Local Health Board and a pharmacist by profession, told us that:

> "…[his] greatest fear is that [his] profession will not deliver on this expanding role in sufficient numbers to provide fair and equitable service provision."[24]

In addition, figures on the uptake for the national diabetes campaign delivered via the community pharmacy network indicated that a quarter of the network did not provide an evaluation of their work on this campaign, suggesting that some may not have participated at all.[25] The figure for non-responders rises to 40% in Pembrokeshire and Ceredigion.[26]

**Question 2**

The evidence above suggests that, although there may have been limited commissioning of services by LHBs, where services are commissioned, community pharmacy may not be taking the opportunities being offered. Do you have any data which indicates what levels of uptake there are for services already commissioned locally and nationally?

*This would assist the Committee in understanding whether the alleged lack of additional pharmacy services is attributable in its entirety to a lack of commissioning activity, or whether there is a lack of interest or capacity on the part of pharmacists to deliver such services.*

## 7. Provision of services at a national level

RPS's written evidence welcomes national service provision via the community pharmacy network.[27] Representatives from local health boards also told the Committee on 2 November that the national approach to

[23] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 7 [accessed 7 December 2011]
[24] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 199], 2 November 2011
[25] Nuala Brennan, Public Health Wales, Community pharmacy diabetes risk health promotion campaign, 24.8.11, page 5 [accessed 7 December 2011]
[26] Ibid, page 6
[27] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 6 [accessed 7 December 2011]

commissioning services adopted in Scotland "…is definitely the way in which we should be going."[28]

**Question 3**

Do you have any further evidence of work underway amongst key bodies in Wales in relation to the commissioning of services on a national basis?

**Question 4**

What issues in particular do you think would be addressed by commissioning more services at a national level? Would there be any challenges if such an approach were adopted?

*This would assist the Committee in understanding the extent to which the commissioning of national services could address some of the issues raised during the inquiry, and what challenges could arise.*

## 8. Community pharmacy contractual framework

During the oral evidence session on 28 September,[29] Community Pharmacy Wales told the Committee that they believed "…that part of the problem is the contractual arrangements that exist". RPS also told us in your written evidence that "…the community pharmacy contractual framework has the potential to support a more integrated and clinical role for this workforce"[30], but that there have been missed opportunities and barriers to its utilisation, including a lack of synergy with other primary care contracts.[31]

LHB representatives also told us there is a need to scope out the capacity and resource needed to develop a new Welsh contract for community pharmacy.[32] This, they argued, was due to the fact that the current contract is volume-based[33] and means that medicines in Wales are delivered "in silos".[34]

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[28] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 228], 2 November 2011
[29] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 162], 28 September 2011
[30] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 2 [accessed 7 December 2011]
[31] National Assembly for Wales, Health and Social Care Committee, Consultation response: CP 6 - Royal Pharmaceutical Society, section 5.1.1 [accessed 7 December 2011]
[32] National Assembly for Wales, Health and Social Care Committee, Record of Proceedings, [para 198], 2 November 2011
[33] Ibid, para 209
[34] Ibid, para 210

Despite these alleged contractual limitations, evidence also suggests that opportunities already provided via the existing contract are not being utilised (cf. section 2 of this Annex).

**Question 5**

In your view, are the challenges which have arisen in relation to rolling out enhanced and advanced services via the community pharmacy network attributable to the current contractual framework?

- If so, what changes would you wish to see to the contract?
- If not, to what would you attribute the main challenges facing the expansion of enhance and advanced services?
- Do you have any further comments on the relationship between the community pharmacy contractual framework and other primary care contracts?

*This would assist the Committee in understanding the extent to which changes to the contractual framework might address the challenges of expanding the role of community pharmacy.*

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If there is any additional information of relevance to the inquiry which is not mentioned in this letter but you would like to raise, please feel free to include this in your response.

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Mr Mark Drakeford AM
Chair, Health and Social Care Committee
National Assembly for Wales
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23 December 2011

Annwyl Mark,

**Inquiry into the contribution of community pharmacy to health and well being in Wales**

Thank you for your letter dated 8th December requesting additional information on points raised during the inquiry into the contribution of community pharmacy in Wales.

I am pleased to provide the attached information which I trust will support you and your Committee colleagues in your final deliberations.

Cofion gorau,

**Mair Davies**
**Chair, RPS Wales**



Patron: Her Majesty The Queen Chief Executive: Helen Gordon Member enquiries T 0845 257 2570 E support@rpharms.com

ROYAL PHARMACEUTICAL SOCIETY Wales
CYMDEITHAS FFERYLLOL FRENHINOL Cymru

**Inquiry into the contribution of community pharmacy to health and well being in Wales**

**Additional information from the Royal Pharmaceutical Society**

23rd December 2011

**Hard to reach groups**

***Question 1: Given the information provided by PHW, do you have any additional information to support your assertion that community pharmacy can engage a range of groups and communities, particularly those groups deemed "hard-to-reach"?***

Wales' 708 community pharmacies receive over 35 million visits each year[1] which we believe provides significant opportunities for community pharmacists to engage with the general public, including those who are considered 'hard to reach'[2].

Evidence is available which underpins the opportunities provided by community pharmacy. For instance, a study in 2009 analysed the characteristics and risks of Coronary Heart Disease of people who accessed the free Healthy Heart Assessment (HHA) operated by a large UK pharmacy chain between 2004 and 2006[3] and concluded that people from 'hard-to-reach' sectors of the population, men and people from less advantaged communities, accessed the HHA service and were more likely to return moderate-to-high CHD risk. It was also found that pharmacists prioritised the provision of lifestyle information above the sale of a product, clearly illustrating the public health role that community pharmacy can play.

Studies such as this support the notion that pharmacies can serve as suitable environments for the delivery of opportunistic screening services and that community pharmacy provides

[1] Community Pharmacy Wales (2011) *Good Health. Community Pharmacy: The Best Medicine for Healthy Lives in Wales*.
[2] We consider that hard to reach groups in this context relates to two distinct cohorts of people; those who require ongoing care but experience social exclusion such as the homeless, travellers, asylum seekers, refugees, people with disabilities, people living in deep rural areas, those living in deprivation and prisoners for example; and those who are able to access services but rarely engage with any health services due to their attitudes about health. Men traditionally fall into this second category.
[3] P Donyai, M Van Den Berg (2009) Coronary heart disease risk screening: the community pharmacy Healthy Heart Assessment Service *Pharmacy World and Science*, Vol. 31, no. 6, p. 643-647

opportunities to identify health risks among individuals who do not regularly access health services, such as men of working age.

**Community pharmacy capacity**

| ***Question 2: Do you have any data which indicates what levels of uptake there are for services already commissioned locally and nationally?*** |
|---|

No recent data is available to us so we are unable to accurately indicate levels of uptake of community pharmacy services already commissioned locally and nationally – these figures will be held by Local Health Boards.

Recent research, together with feedback from our members, indicates however that there is an appetite among the pharmacy profession for the development of new community pharmacy services and we would challenge the sentiments that the pharmacy profession may not deliver on their expanding role in sufficient numbers to allow the general public to access to equitable services across Wales. The introduction of local enhanced community pharmacy smoking cessation services in North Wales between 2006 and 2007 provides a good example of how community pharmacists can mobilise themselves to deliver services and an enhanced contribution to local health service developments. Public Health Wales' retrospective evaluation of this enhanced service recorded an initial uptake of 78 pharmacies in the then five LHB areas which illustrates the positive attitude and willingness of community pharmacists to deliver new services[4].

Despite the eagerness to deliver more patient-centred care through community pharmacy, our members have indicated that they have a number of concerns about the longevity of new services that are not part of formal contractual enhanced services. Previous experience of short lived projects and short term local enhanced services can deter some community pharmacists getting involved in new services. Some of our members have expressed concerns about inconsistency in commissioning across and between Health Board areas, poor communication about the development of new services and lack of support locally from Health Boards in implementing new services. Changes to the community pharmacy contractual framework in November 2011 and the introduction of new services provide a good example of this. We found that many of our members were ill informed about the implementation of the new services and therefore unable to support the new services on its implementation date. As the professional body we have supported our members working in community and hospital to find local solutions

[4] National Public Health Service for Wales (2009) Evaluation report: North Wales local enhanced community pharmacy smoking cessation services, NPHS.

to deliver the new medicine discharge service, our members concern being that their professional body was not involved in the planning of this service and thus unable to provide them with the necessary advice and support they needed to deliver the exciting new service.

Feedback from our members also indicates that current planning and commissioning activity is confusing in terms of which services their LHB are prioritising and consequently where they should be focusing their efforts. The default position as a result is to concentrate on dispensing medicines on the basis that income can be obtained under the current community pharmacy contract on the basis of volume of prescriptions dispensed – a position which we believe impedes the expansion and development of community pharmacy services. We advocate that imaginative and creative planning and commissioning activity at national and local levels is the key to getting the best from the community pharmacy contractual framework and from community pharmacists who are eager to deliver a range of new services.

In addition, it is also becoming clear that the general public, as well as other health professionals, are not aware of the range of NHS services that can be accessed from community pharmacies across Wales. Furthermore we are concerned that community pharmacy services are often not recognised as a part of the NHS family by the general public, health professionals and even health service planners and commissioners, and we are concerned that this may act as a significant barrier to the successful expansion of pharmacy services.

A recent study into the view of the general public on the role of pharmacy in public health for instance found that there is little awareness of pharmacy's involvement in providing services designed to improve public health[5]. This study also recommended that more effective marketing is needed to help the general public understand what these services are. The Welsh Government is aware that any service change must be supported locally by patients and other NHS service providers and new service models delivered through community pharmacy are no exception to this. Hence we believe that national and local campaigns should be undertaken to increase awareness of community pharmacy services.

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[5] J Krska, CW Morecroft (2010) Views of the general public on the role of pharmacy in public health *Journal of Pharmaceutical Health Services Research* Mar 2010;1(1):33-38

**Provision of services at a national level**

***Question 3: Do you have any further evidence of work underway amongst key bodies in Wales in relation to the commissioning of services on a national basis?***

We are aware that some discussions are underway in Wales with regard to the development of national community pharmacy services but we have not been invited to these discussions and would be unable to comment further. We are disappointed in general however that there appears to be little work being taken forward formally by key bodies in Wales in relation to national commissioning.

***Question 4: What issues in particular do you think would be addressed by commissioning more services at a national level? Would there be any challenges if such an approach were adopted?***

We believe that national commissioning could address a number of key challenges to the delivery of community pharmacy services across Wales. The development of nationally commissioned community pharmacy services in Wales should help:

- standardise the delivery of specific services within a clear national framework
- ensure a common educational framework is developed by post graduate education providers
- improve governance arrangements for the delivery of specific services by creating and maintaining a centrally held database of community pharmacists who have the relevant competencies to deliver specific new services
- integrate and establish community pharmacy services as an important part of the broader NHS family
- ensure community pharmacists are well informed prior to the introduction of new services
- reduce variance in service delivery and the potential of post code lotteries of care.
- Inform members of the public which services they can access consistently at community pharmacies wherever they live in Wales (provided this is supported by an effective national public awareness raising campaign).

Our colleagues in Scotland have indicated that the development of the National Minor Ailment Service has helped, not only to standardise the role of community pharmacy in delivering minor ailment services across Scotland, but has provided increased opportunities for patients and the general public to access health services and professional advice in the most appropriate setting.

Similarly the development of a national pharmacy patient group direction (PGD) in Scotland for out of hours emergency supply of medication has increased opportunities for patients to access their community pharmacist who can prescribe the full cycle of the patient's repeat medication when their GP is not available out of hours. We believe that this kind of service innovation on a national basis can vastly improve access to a health professional and has the potential to help reduce pressures on other parts of the health system as a result.

**Community pharmacy contractual framework**

***Question 5: In your view, are the challenges that have arisen in relation to rolling out enhanced and advanced services via the community pharmacy network attributable to the current contractual framework?***

We believe that the current contractual framework for community pharmacy has not been used creatively by Government or Local Health Boards and as a result opportunities have been missed to deliver improved and integrated care for patients. This has meant the contract is still proving to be a volume based supply model rather than one based on outcome focussed clinical services. Our colleagues in Scotland indicated in their submissions and oral evidence that by placing the patient at the centre of care, not the product or prescription, the key performance indicator was no longer the prescription issued/dispensed but the care received thus taking the role of pharmacist further. To place the patient at the centre of the contract may require changes in planning and financial management of the contract and supporting frameworks.

In devising a viable community pharmacy contractual framework there must be founding principles, namely an underpinning infrastructure and making patient pharmaceutical care needs a priority.

Firstly, we believe that in order to provide the best clinical pharmaceutical care for patients, a more formalised relationship should be adopted between patients and the pharmacy of their choice; this formalised relationship would not restrict access to pharmaceutical care in another pharmacy, but it would enable pharmacists to provide a more structured pharmaceutical care plan, particularly for those patients with chronic conditions, enabling continuity of care for these patients. This is an example of where a contractual change is not needed to improve care but where the NHS would need to be creative and develop a new service model for delivery.

Secondly, NHS IT systems in Wales need to be planned to underpin all new services. There needs to be appropriate access from community pharmacy to patient records, and mechanisms to be able to transmit and share information between different healthcare providers.

In order for relationships between the different primary care contracts to be improved, the planning of services needs to be based on a whole-systems approach rather than one which focuses on individual professions or contracts. Pharmaceutical care should feature more prominently in Local Health Board planning with models of care developed that make use of community pharmacy services through the provisions of the contractual framework.

3 January 2011

Mark Drakeford AM
Chair, National Assembly Health & Social Care Committee
National Assembly for Wales
**CARDIFF**
CF99 1NA

Dear Mark

**INQUIRY INTO THE CONTRIBUTION OF COMMUNITY PHARMACY TO HEALTH SERVICES IN WALES**

I refer to your letter dated 8 December 2011 in the above connection and seeking CPW's response to some of the points that have been raised during the various sessions at which the Committee has taken oral evidence. A detailed response to your specific questions is attached.

In addition, I would like to take the opportunity to draw the Committee's attention to two issues which were raised whilst the Committee was taking evidence but which were included in your specific questions.

First, the BMA Cymru Chair referred to CPW as the "trade union" of community pharmacy. That is not the case. Instead, CPW is a body recognised in statute - the National Health Services (Wales) Act 2006 - as the only organisation responsible for representing all of the 710 community pharmacies in Wales on all matters relating to NHS community pharmacy services. Like the Welsh Local Government Association, which acts on behalf of the collective body of Welsh county and county borough councils, CPW acts on behalf of the collective body of all Wales based community pharmacy contractors and works with Government and its agencies, such as local Health Boards, to help protect and develop high quality community pharmacy services and to shape the NHS community pharmacy contract and its associated Regulations. This removes the need for Government and its agencies to consult and negotiate with several hundred individual contractors.

Secondly, during the session with the BMA, it was suggested that the minor ailments service operated by community pharmacy required users of the service to pay for the medicines received. This is not the case. In Wales prescribed medicines are free to the patients irrespective of the NHS prescriber, which also applies to items prescribed as part of the minor ailments service such as the one operating in the Torfaen locality of Aneurin Bevan Health Board.

I trust that the information provided will be of assistance to your Committee during its final deliberations. I look forward to receiving a copy of the Committee Report in due course.

Yours ever

**RUSSELL GOODWAY**
**CHIEF EXECUTIVE**

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## 1. “Hard to reach” groups and MURs

**Question**

Given the information provided by PHW, do you have any additional information to support your assertion that community pharmacy can provide healthcare services to people who are often hardest to reach but who need it the most?

*This would assist the Committee in understanding the extent to which the community pharmacy network could be utilised to engage hard to reach groups, and what services could be best used to do this.*

**Response:**

Community pharmacy provides healthcare services to the harder to reach groups in four key ways:

a) **Structural tendency towards serving disadvantaged communities built into Community Pharmacy Contractual Framework**:

The current contractual mechanisms for remunerating community pharmacies for the services they provide result in contractors receiving the greater part of their income from the dispensing of prescriptions. This remuneration mechanism obviously results in a concentration of pharmacies where the flow of prescriptions is higher. Welsh Government data shows that prescribing per head of population is higher in areas where health needs are greater, for example in 2006-2007 there were 22.9 prescriptions per head of population in Merthyr Tydfil compared to 15.1 in Cardiff.

The most disadvantaged people tend to be less receptive to public health messages making them amongst the hardest to reach groups. The greater concentration of pharmacies in areas of deprivation where health needs are greatest, therefore provides Health Boards with significantly greater opportunities to offer additional community pharmacy based services to residents of those communities should the Health Board choose to do so. It is disappointing that, to date, most Health Boards have chosen not to do so.

b) **Rural communities**

The particular challenge of delivering services in rural locations is well documented in the Welsh Government‟s Rural Health Plan. In rural areas people have to travel longer distances to access healthcare support and often with little or no public transport assistance. The nature of that support is often different to that available in more built up areas. In small rural communities the pharmacy is an integral part of the social fabric in

the community and the most regular interface with NHS Wales. The advice of the community pharmacist is regularly sought and valued, particularly in small isolated communities.

The numbers of patients accessing any particular rural pharmacy may be small but overall the pharmacy service constitutes the main NHS interface for such areas. Successive Welsh Governments have recognised the value of this healthcare facility b choosing to retain the Essential Small Pharmacies Scheme, which was abolished in England some years ago. This provides additional support for rural pharmacies where the local economy would not otherwise enable the business to be viable.

Other care organisations readily recognise community pharmacies as an outlet capable of reaching elements of Welsh society that they themselves find the least accessible. For example, Age Cymru is currently working with community pharmacy contractors in rural areas to distribute free thermometer leaflets as part of the Welsh Government"s *Keep Well This Winter* campaign. Age Cymru have suggested that pharmacies "fill in the gaps" in the locations that they have not been able to cover. If this partnership proves effective in reaching such areas this winter then it may be extended as part of the 2012/13 Keep Well This Winter campaign.

c) **People not engaged with GP services**

Many of the NHS commissioned healthcare services are centred on the GP surgery. As a result, those hardest to reach are the significant section of the general population who do not engage with GP services on a regular basis. A number will not be even registered with a GP practice. As community pharmacies enjoy a high footfall and are visited on a regular basis by both those who are well and not just those who are ill, there is no better location to provide population screening and healthy living support. The recent trend towards locating GP practices from town centre locations to the outskirts of town, coupled with frequently reported complaints of people encountering difficulties in obtaining a GP appointment, creates additional barriers to people needing to access health services, particularly public health services. This is in marked contrast to the location of community pharmacies on every Welsh High Street and in locations where people live, work and travel.

d) **Busy people:**

Many people, particularly those of working age, find the opening hours and appointment arrangements in GP practices inconvenient. A number of pharmacies, particularly larger pharmacies and supermarket pharmacies offer more convenient opening hours providing significant additional opportunities for NHS Wales to roll out services. An example

of this in action, comes from a patient survey of over 2,500 patients receiving a flu vaccination in community pharmacy, where 50% of patients indicated that the pharmacy was more convenient than their previous provider and 37% would not have had the vaccination if it was not available at the community pharmacy.

e) **Specific services**

There are some services that are provided through community pharmacy precisely because it enables the services to be available to target groups in the population who have not been accessed by existing, traditional service design and locations. Two prime examples in Wales are (1) the Emergency Hormonal Contraception (Morning After Pill) services which started in April 2011 and where local pharmacies have proved to be a more than acceptable location for young women seeking emergency contraception, and (2) those involved in substance misuse seeking clean syringes and needles. .

f) **Other**

Other examples of the use of community pharmacy to reach out to hard to reach populations include the role of health trainers in Healthy Living Pharmacies in improving health literacy, outreach services from community pharmacy, such as the Healthy Heart initiative in Birmingham where pharmacy took health screening to local football grounds and community pharmacists delivering services to work places and schools. In addition evidence from the National Chlamydia Screening Service in England has demonstrated that the percentage of males that accessed the service through community pharmacy was noticeably higher than the percentage of males that accessed the service from other traditional service providers.

Community pharmacy provides services to all ages and all sections of the population. These factors make community pharmacy undeniably unique in its ability to deliver services to harder to reach groups.

## 6. Community pharmacy capacity

**Question**

The evidence above suggests that, although there may have been limited commissioning of services by LHBs, where services are commissioned, community pharmacy may not be taking the opportunities being offered. Do you have any data which indicates what levels of uptake there are for services already commissioned locally and nationally?

*This would assist the Committee in understanding whether the alleged lack of additional pharmacy services is attributable in its entirety to a lack of commissioning activity, or whether there is a lack of interest or capacity on the part of pharmacists to deliver such services.*

**Response:**

CPW believes it is completely disingenuous to argue that a lack of NHS services provided by pharmacies is due to lack of desire or interest by pharmacies in delivering the services rather than by lack of commissioning of these services by NHS Wales as a whole or by individual Health Boards. In addition, there are often other barriers in the way of the effective delivery of the services even where they are commissioned. There are many examples which prove this since the 2005 contract.

a) The Welsh Government has channelled all commissioning of pharmacy services through Health Boards and has therefore created a situation where the commissioning of pharmacy services requires the active engagement and support of the Health Board. Yet, as pharmacy is not represented on the Management Board of Health Boards, it does not have a direct voice in top level decision making.

b) Health Boards have a tendency to commission within the NHS and along traditional boundaries especially when financial resources are under pressure. This often precludes commissioning services from community pharmacy contractors even when overall costs will be lower for the public purse.

c) When new pharmacy initiatives are initiated by Health Boards they are often piecemeal and financed through small allocations of funds which for one reason or another has become available during the course of the year. All too often these initiatives take the form of very short term pilot projects which are not turned into sustainable services that patients can understand and rely on and on which pharmacies can plan ahead to build expertise and specialisms.

Community pharmacy therefore suffers badly from „pilotitis" where one pilot follows another and where despite robust outcomes the pilot funding invariably dries up and there is a period of time before the next pilot raises its head. A patient may be able to access a service at one time that is not available a few months later or in the next town. This piecemeal approach adds costs to pharmacies in establishing a service then winding it down. It also builds scepticism amongst pharmacies that Health Boards are not driven by sustainable healthcare for patients.

Contractors are often expected to undertake additional accreditation which is complex and way over what is reasonably required to provide the service, which is not always guaranteed. This is a requirement that is demanded of community pharmacists at their own cost and is not required of other healthcare professionals. For instance, many pharmacies across Wales invested heavily in accreditation for independent prescribing. But there are very few instances of Health Boards delivering any services that used these skills. Pharmacies were keen to use this skill and provide the services to patients but Health Boards failed to commission them.

d) Community pharmacies are independent contractors and, as such, any investment in premises and staff training is borne by the contractor. As with all businesses, there is a reasonable expectation that an investment by the business produces a reasonable return. Without this, the community pharmacy network would simple not exist.

While it is excellent for NHS Wales, that the risk is borne by the contractor, it is perhaps understandable that contractors are sometimes not enthusiastic to make the investment when the funding available is transient in nature. In order to invest in their business, contractors require a degree of confidence about future revenue streams and if this is available will happily make a personal and business investment into the successful delivery of the service. This has been clearly demonstrated by the launch of the Medicines Use Review Service (MUR), where from a standing start community pharmacies across Wales are delivering over 130,000 MUR interventions each year. For a contractor to deliver the MUR service they were required to take away sales floor space and to use that space for the establishment of private consultation areas and to undertake significant additional accreditation to provide the service. The fact that the vast majority of contractors across Wales fully embraced this service demonstrates, beyond any reasonable doubt, that when the commissioning arrangements are appropriate and a degree of stability is ensured, community pharmacy will rise to the occasion.

e) Arrangements for national enhanced services are a step in the right direction and where there is an improved degree of security of service. In the case of national enhanced services many more contractors are willing to provide the services when their Health Boards provided the opportunity. For example CPW have periodically registered with Cardiff & Vale Health Board a list of contractors wanting to deliver substance misuse services if the Health Board commissions them. However, this HB still declines to commission this service. Thus, despite well recognised gaps in substance misuse service provision in the Health Board area, a substance misuse client cannot access clean syringes and needles from community pharmacy in the capital city of Wales. This is due to lack of willingness by the Health Board not by the community pharmacy contractors.

f) In relation to the level of uptake of services across Wales this data is now captured on the All Wales Pharmacy Database. CPW assumes the committee research team has obtained reports in whatever format they require from the NHS Wales Shared Services Partnership. CPW would draw to the Committee‟s attention that this public data is not highlighted or distributed in the Welsh Government Stats service and so does not receive the level of transparency or publicity that other NHS funded services receive. The Committee may wish to address this in their recommendations.

## 7. Provision of services at a national level

**Question 3**

Do you have any further evidence of work underway amongst key bodies in Wales in relation to the commissioning of services on a national basis?

**Question 4**

What issues in particular do you think would be addressed by commissioning more services at a national level? Would there be any challenges if such an approach were adopted?

*This would assist the Committee in understanding the extent to which the commissioning of national services could address some of the issues raised during the inquiry, and what challenges could arise.*

**Response:**

The two main groups of private contractors with NHS are GPs and community pharmacy. It would be reasonable, and easier for the public to understand, for these two groups of contractors to be funded on an equal basis. The provision of services from GP practices is via additional and enhanced services and although the provision of these services by any GP practice is voluntary, where they are provided by the GP practice they are commissioned against a national service specification, with national standards and a nationally agreed remuneration rate.

This approach contrasts with the arrangements for the commissioning of pharmacy services where variations in commissioning, service design and payments are common place. This approach to commissioning is confusing and operationally difficult especially as pharmacies often operate across Health Board boundaries. In all the Plenary Session debates during the Third National Assembly the point was made by speakers from all political parties that they did not support one set of services being available for the population of, say, Swansea and a completely different set for the population of say, Llandudno. The fact that Level 3 smoking cessation services are available to patients in North Wales and Powys, or that a minor ailments service is only available in one part of one Health Board in South East Wales, or that NHS Emergency Contraception was only available in the nation‟s capital when it became a national service is unacceptable.

It is also inappropriate from a professional standpoint as each service specification purports to be based on best practice and there simply cannot be seven versions of best practice.

The recently launched Welsh Government *'Together for Health'* strategy clearly lays out the need for consolidated and integrated services based on the best available evidence and this is what CPW is seeking in terms of community pharmacy services.

CPW were hopeful that the recently launched EHC service would be commissioned on this basis. Disappointingly despite considerable movement in the right direction even this recent service implementation has not been introduced as a Directed Enhanced Service and is, as a result, open to a degree of local interpretation and variation in commissioning. This is confusing for patients. One of the advantages of national services is that the overall national messages and communication about the service can be made very clear and is more effective – patients find out what they are entitled to and are able to request a service. This fits well with the information and web savvy patients of today. But if there is still local variation to what has been officially publicised as a standard national service, then patient confidence in NHS information is undermined.

CPW has recently been working constructively with Welsh Government and its officials to put community pharmacy services on a national footing. However, the ultimate barrier would appear to be the lack of ring-fenced funding for community pharmacy services. Thus, in times of budget stringency it is too tempting for Health Boards to use the money released to them by Welsh Government for community pharmacy services either for other work in their area or just to offset their deficits. While Health Boards are allowed to do this for community pharmacy services, such as for the new hospital Discharge Medicines Service, they are likely to continue to do so. Community pharmacy therefore becomes a source of income for Health Boards rather than also a source of health care provision. This contrasts with GP services, the funding for which is ring fenced by Welsh Government and so cannot be dispersed elsewhere by Health Boards. The Committee may want to look at this is considering its recommendations.

## 8. Community pharmacy contractual framework

**Question 5**

In your view, are the challenges which have arisen in relation to rolling out enhanced and advanced services via the community pharmacy network attributable to the current contractual framework?

– If so, what changes would you wish to see to the contract?

– If not, to what would you attribute the main challenges facing the expansion of enhance and advanced services?

– Do you have any further comments on the relationship between the community pharmacy contractual framework and other primary care contracts?

*This would assist the Committee in understanding the extent to which changes to the contractual framework might address the challenges of expanding the role of community pharmacy.*

**Response**:

The Community Pharmacy Contractual Framework, as introduced in Wales in 2005, was designed to support the development of community pharmacy through the Enhanced and Advanced Services elements of the contract. There is nothing in the current contract structure that would prevent the development, commissioning and roll-out of any potential new community pharmacy service. The tools have been there since 2005, albeit Regulations have been introduced in a rather “heath robinson” fashion that often require some ingenuity to implement smoothly.

The failure to take the opportunity for the development of new Welsh Community Pharmacy Service has rather been due to a lack of a clear strategic view of the roll that the Welsh Government wishes community pharmacy to undertake in the medium to long-term, coupled with the lack of a clear delivery vehicle, no dedicated funding and the inability for national policy to be effectively delivered through apparently semi-autonomous local structures.

The Committee has seen that in Scotland over the same period the opportunities have not been missed as there has been a clear national policy in the role to be played by community pharmacy in delivering health to the nation. CPW noted the irony of Community Pharmacy Scotland saying in their oral evidence to the Committee that Scotland is too small a country for community pharmacy services to be delivered effectively at less than national level. Scotland is twice the size of Wales.

However, it is now too late to seek for the Welsh government to produce the promised consolidated regulations to implement the 2005 agreement. The direction of Government policy in England will have a significant impact on the ability to deliver community pharmacy services through the existing Wales – England contract. England"s Secretary of State for Health has declared his intention in the Health & Social Care Bill to produce a separate community pharmacy contract for England based on a national commissioning arrangement. It is important to understand the Welsh Government intentions in response to that announcement. CPW would support the future development of the contract in Wales so that it is a more effective framework tool for the delivery of Welsh Government policy and so mirrors the focus and priorities of NHS Wales.

## Health and Social Care Committee

**HSC(4)-01-12 paper 9**

**Inquiry into the contribution of community pharmacy to health services in Wales - Additional information from the Family Planning Association**

*December 2011*

## Health and Social Care Committee Inquiry into Community Pharmacy – Additional Information from FPA

FPA is one of the UK's leading sexual health charities. Melanie Gadd, Project Co-ordinator for Jiwsi in North Wales appeared before the Committee to give oral evidence on Wednesday 16 November 2011. This is our briefing on additional information the Committee asked for.

**Figures on the number of pharmacies across Wales that are participating in the Emergency Hormonal Contraception (EHC) scheme**

**Community Pharmacy Services that offer emergency hormonal contraception (EHC) 2010 – 11[1]**

| Local Health Board (LHB) | Number of services that offer EHC |
|---|---|
| Betsi Cadwaladar University LHB | 101 |
| Powys Teaching LHB | 13 |
| Hywel Dda LHB | 67 |
| ABM LHB | 86 |
| Cwm Taf LHB | 41 |
| Aneurin Bevan LHB | 78 |

[1] Source: Statswales Community Pharmacy Services 2010-11
http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx?ReportId=26599

| Cardiff and Vale LHB | 0 |
| --- | --- |
| | **TOTAL IN WALES:** 386 |