Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 – y Senedd

Dyddiad:
Dydd Mercher, 18 Gorffennaf 2012

Amser:
08:30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

Polisi: Llinos Dafydd / Deddfwriaeth: Fay Buckle
Clerc y Pwyllgor
029 2089 8403/8041
PwyllgorIGC@cymru.gov.uk

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon

2. Ystyried gohebiaeth a gyhoeddwyd yn ddiweddar rhwng swyddogion Llywodraeth Cymru a'r Athro Marcus Longley (08:30 – 10:00) (Tudalennau 1 – 63)

HSC(4)-23-12 papur 1a : Gwybodaeth a gyhoeddwyd ar log datgelu Llywodraeth Cymru

HSC(4)-23-12 papur 1b : Y Trefniant Gorau ar gyfer Gwasanaethau Ysbytai Cymru: Adolygiad o'r Dystiolaeth (ysgrifennwyd gan yr Athro Longley)

HSC(4)-23-12 papur 1c : Gwybodaeth gan Gonffederasiwn GIG Cymru

08:30 – 09:15 – sesiwn 1
Yr Athro Marcus Longley

09:15 – 10:00 – sesiwn 2
Lesley Griffiths AC, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
David Sissling, Cyfarwyddwr Cyffredinol, Iechyd, Gwasanaethau Cymdeithasol a Phlant, Llywodraeth Cymru a Prif Weithredwr, GIG Cymru
Dr Chris Jones, Cyfarwyddwr Meddygol, GIG Cymru a Dirprwy Brif Swyddog Meddygol Cymru, Llywodraeth Cymru

3. Bil Sgorio Hylendid Bwyd (Cymru): Cyfnod 1 – Sesiwn dystiolaeth 4 (10:00 – 10:30)

Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

Lesley Griffiths AC, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Christopher Brereton - Pennaeth Deddfwriaeth Iechyd y Cyhoedd yr Amgylchedd, Llywodraeth Cymru
Christopher Humphreys - Yr Adran Gwasanaethau Cyfreithiol, Llywodraeth Cymru

4. Bil Sgorio Hylendid Bwyd (Cymru): Cyfnod 1 – Sesiwn dystiolaeth 4 (10:30 - 11:30) (Tudalennau 64 - 87)

Cymdeithas y Siopau Cyfleus
Shane Brennan - Cyfarwyddwr Cysylltiadau Cyhoeddus, Cymdeithas y Siopau Cyfleus
HSC(4)-23-12 papur 2

Cymdeithas Cwrw a Thafardnai Prydain
Brigid Simmonds – Prif Weithredwr, Cymdeithas Cwrw a Thafarndai Prydain
HSC(4)-23-12 papur 3

Cymdeithas Lletygarwch Prydain
John Dyson – Cynghorydd Bwyd a Materion Technegol, Cymdeithas Lletygarwch Prydain
HSC(4)-23-12 papur 4

5. Papurau i'w nodi (Tudalennau 88 - 91)

Cofnodion y cyfarfodydd a gynhaliwyd ar 28 Mehefin a 4 Gorffennaf

5a. Yr ymchwiliad i ofal preswyl i bobl hŷn: nodiadau o'r cyfarfodydd o'r grwpiau cyfeirio a gynhaliwyd ar 24 Mai a 12 Mehefin (Tudalennau 92 - 104)
Nodyn o'r cyfarfod o'r grŵp cyfeirio a gynhaliwyd ar 24 Mai
HSC(4)-23-12 papur 5

Nodyn o'r cyfarfod o'r grŵp cyfeirio a gynhaliwyd ar 12 Mehefin
HSC(4)-23-12 papur 6

6. Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol: (11:30)

7. Bil Sgorio Hylendid Bwyd (Cymru): y prif faterion (11:30 – 12:15)

8. Yr ymchwiliad i ofal preswyl i bobl hŷn: y prif faterion (12:15 – 13:00)

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-23-12 papur 1a

Ystyried gohebiaeth a gyhoeddwyd yn ddiweddar rhwng swyddogion Llywodraeth Cymru a'r Athro Marcus Longley.

Mae atodiad i'r papur hwn yn cynnwys yr ohebiaeth rhwng swyddogion Llywodraeth Cymru a'r Athro Marcus Longley, a gyhoeddwyd yn ddiweddar ar wefan Llywodraeth Cymru.

Atodiad

Ffynhonnell – log datgelu Llywodraeth Cymru

http://wales.gov.uk/publications/accessinfo/disclogs/dr2012/julsep/health1/dlhlth161/?skip=1&lang=cy [cyrchwyd 12 Gorffennaf 2012]

Hlth161 Communications with Prof Marcus Longley regarding the Case for Change document

4 July 2012. You asked for copies of correspondence and records of discussions between Professor Marcus Longley, the NHS Confederation Wales and the Welsh Government regarding the Case for Change document over the last six months

4 July 2012

Dear

Thank you for your email of 29 May asking for the following information:

Details of discussions/correspondence between Professor Marcus Longley, the NHS Confederation Wales and the Welsh Government regarding the Case for Change document over the last six months.

We have identified information which falls within scope of your request. The relevant extracts are attached to this reply.

In responding to your request for information, I think it is important that we set out the context for the "Case for Change" document and the process for its production.' Together for Health – a Five Year Vision for the NHS in Wales' sets out the challenges facing the health service in Wales and the changes needed to ensure Wales has high quality services. Together for Health is clear that retaining the status quo is not an option. As part of their response to the challenge set in Together for Health, Health Board Chief Executives and the NHS Confederation commissioned the Wales Institute for Health and Social Care (WIHSC) to articulate a “National Case for Change” against the available evidence base.

The report produced by Professor Longley is owned by the Health Boards and the NHS Confederation, and its purpose is to articulate the reasons why Health Boards need to change services, and to help Health Boards in engaging with their communities about the future of hospital services in Wales. During its production, Welsh Government officials responded to requests for statistical and other information from Professor Longley and the Confederation. Given the importance and high level of public,

political and media interest in any proposed changes to NHS services, officials in Department of Health, Social Services and Children; the Minister for Health and Social Services and Welsh Government's Cabinet were, of course, updated on progress in developing the Case for Change and on the timing and plans for its publication. The Cabinet were informed of the content of the Professor Longley's report in a Cabinet paper which was made public on 27April 2012 and is available here (see spotlight). Throughout its production, the Welsh Government did not seek to influence or amend the content of the report, as that was entirely a matter for the NHS Confederation and for Professor Longley.

If you believe that I have not followed the relevant laws, or you are unhappy with this response, you may request an internal review by writing to:
Joanna Jordan
Director
Department for Health, Social Services and Children
Cathays Park
Cardiff
CF10 3NQ

When dealing with any concerns, we will follow the principles set out in the Welsh Government's Code of Practice on Complaints which is available on the Internet at www.wales.gov.uk or by post.

You also have the right to complain to the Information Commissioner. Normally, however, you should provide us with an opportunity to undertake an internal review before you complain to the Information Commissioner. The Information Commissioner can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 01625 545 745
Fax: 01625 524 510
Email: casework@ico.gsi.gov.uk

Also, if you think that there has been maladministration in dealing with your request then you may make a complaint to the Public Services Ombudsman for Wales who can be contacted at:
Public Services Ombudsman for Wales
Ffordd yr Hen Gae
Pencoed
Bridgend
CF35 5LJ

Yours sincerely,

Department for Health, Social Services and Children
Welsh Government

Note of meeting with NHS Confederation held on Monday 23 January 2012 at Ty Hywel, Cardiff Bay.

Present:

Lesley Griffiths AM	Minister for Health and Social Services
Helen Birtwhistle	Director of Welsh NHS Confederation
Alice Attenborough	Welsh NHS Confederation Policy & Public Affairs Officer
Grant Duncan	Deputy Director, Medical Directorate
Jonathan Davies	Special Advisor
Dominic Worsey	Medical Directorate

Information redacted – not in scope

Engagement on "Together for Health" and update on University of Glamorgan Research

10. The Confederation and the University have been working to develop a suite of papers on the national case for change, which will support *Together For Health*. These will be finalised by the end of February, and an engagement plan is also being developed to highlight the work to key stakeholders. An AM centred event will be organised in Cardiff, and the Health Committee will also be kept fully abreast of developments.

Information Redacted - not in Scope

Dominic Worsey
24 January 2012

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 14 February 2012 08:16
To: Jones, Chris (DHSSC - Medical Directorate); Peter Bradley (Public Health Wales); 'John Watkins (Public Health Wales)'; Bowen, Richard (DHSSC - Directorate of Operations); 'Jeff.James@wales.nhs.uk'
Cc: 'Andrew Carruthers (Cardiff and Vale UHB - Service Planning)'; Ponton M (HESAS - WIHSC)
Subject: National Case for Change Safety and Quality paper final draft

Colleagues – please find attached the final draft of the Safety and Quality paper. **Very grateful for any comments, ideally by 20 February**. NB this paper does not contain the clinical outcomes data which you have helpfully been sending through – that will be in the 'overarching' paper.

To remind you… this is one of 4 papers (other drafts to follow in the next few days!):

- Overarching paper (inc summaries of other 3, clinical outcomes data, and 'the narrative')
- Quality and safety (attached)
- Workforce
- Access

Please give me a ring if that would be helpful.

Many thanks for your continuing help in this.

Marcus

Marcus Longley
Professor of Applied Health Policy and
Director, Welsh Institute for Health and Social Care
Lower Glyntaf Campus, University of Glamorgan, Pontypridd, CF37 1DL
Tel 01443 483070 Fax 01443 403070

http://wihsc.glam.ac.uk/

Subject	Service Change Group	Date	17/04/2012
Chair	David Sissling	Time	13:30
Location	Cathay's Park	Scribe	Leon Rees

Key Points Discussed		
	Topic	**Highlights**
	Case for Change Report	• Launch in early May • Media plan – important to create broader context so we do not unintentionally re-enforce a hospital focus.

Yr Adran Iechyd, Gwasanaethau Cymdeithasol a Phlant
Cyfarwyddwr Cyffredinol • Prif Weithredwr, GIG Cymru

Department for Health, Social Services and Children
Director General • Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

Prof Marcus Longley
Welsh Institute for Health and Social Care
University of Glamorgan
Glyntaff Campus
Pontypridd
Wales
CF37 1DL

Our Ref : DS/LR

9 March 2012

Marcus

Just a quick note to thank you for your work on the Case for Change. I am aware that certain aspects are still subject to some revision, but overall it is looking good. I am sure it will help to change the tone and terms of the debate.

Regards

David Sissling

From: Bowen, Richard (DHSSC - Directorate of Operations)
Sent: 24 January 2012 09:20
To: 'Longley M J (HESAS - WIHSC)'
Subject: RE: Stats for 'statement for change'

As I said - just a start as I'm not sure what exactly you're after but let me know either way.
The McKinsey work is not at least 2.5 yrs old but we'll have a look through the key areas and get back to you.
There may be some nuggets worth flagging again.
R

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 24 January 2012 08:42
To: Bowen, Richard (DHSSC - Directorate of Operations)
Subject: RE: Stats for 'statement for change'

Richard – many thanks for this, just the job! Will go through now in detail, and get back to you as necessary.

It would also be helpful to have sight of the McKinsey stuff, where you think this is still current. Would that be possible?

In the meantime … I'd be very grateful for your comments on the attached, which is a (still incomplete) draft of the first of the papers we are producing. The aim is to produce a total of 4 papers:

- Quality and Safety (attached)
- Workforce (which I'll send through on Thursday)
- Access
- Over-arching paper, which summarises the above 3, and pulls together all the threads – this will be self-standing, but will direct readers to the above 3 if they want to follow up the evidence on any particular points.

They should summarise the key evidence, in an objective but accessible way, with a view to allowing the interested lay reader to draw their own conclusions on the key aspects of the argument for service re-configuration.

That's the aim… but do they succeed?! The drafts are still work in progress, but should be complete enough for you to get a sense of the whole.

I'd be very grateful for any comments, ideally by next Tuesday (31st) if possible.

Marcus

Director of WIHSC and Professor of Applied Health Policy

Tel. 01443 483070 http://wihsc.glam.ac.uk/ http://twitter.com/marcuslongley

From: Bowen, Richard (DHSSC - Directorate of Operations) [mailto:Richard.Bowen@Wales.GSI.Gov.UK]
Sent: 23 January 2012 18:33
To: Longley M J (HESAS - WIHSC)
Subject: FW: Stats for 'statement for change'

Marcus
Apologies for delay. Starter for 10.
Come back to me on some of this.
you can also have the latest CEO performance paper if any help - good bit on mortality for the first time e.g. weekend effect.
R

Information Redacted – out of scope

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 17 January 2012 20:52
To: Bowen, Richard (DHSSC - Directorate of Operations)
Subject: RE:

Thanks Richard.

(Confusingly, the health stats stuff is for a presentation to the Bevan Commission on Thursday on something else... but clearly all roads lead to your team!)

Marcus

Marcus Longley
Director of the Welsh Institute for Health and Social Care and Professor of Applied Health Policy
University of Glamorgan
Lower Glyntaf Campus
Pontypridd CF37 1DL
01443 483070
http://wihsc.glam.ac.uk/
http://twitter.com/marcuslongley

From: Bowen, Richard (DHSSC - Directorate of Operations) [Richard.Bowen@Wales.GSI.Gov.UK]
Sent: 17 January 2012 19:54
To: Longley M J (HESAS - WIHSC)
Subject: RE:

Marcus
Just spoken to colleagues in Health Stats (Welsh Gov) and Terry Gill (my team centrally) who have also been asked to furnish you with the same information? We will link to see what

there is available on this and get back to you.
R
Richard Bowen
Director of Operations / Cyfarwyddwr Gweithrediadau
Directorate of Operations / Cyfarwyddiaeth Gweithrediadau
***Department for Health, Social Services and Children* / Cyfarwyddiaeth Gyffredinol lechyd & Gwasanaethau Cymdeithasoll**
Welsh Government / Llywodraeth Cynulliad Cymru
Tel/ Ffon: 029 2082 5850
Fax / Ffacs: 029 2082 3907
e-mail / e-bost: Richard.Bowen@wales.gsi.gov.uk

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 17 January 2012 10:41
To: Bowen, Richard (DHSSC - Directorate of Operations)
Subject:

Richard - many thanks for the helpful chat last week.

To confirm, we'd be most grateful to have sight of any material of which you're aware which bears on the workforce, safety and access dimensions of the case for change. We'll pick up material via parallel discussions with colleagues on stroke service, workforce (NLIAH), primary care and public health, but any other relevant evidence (the 'killer facts') would be really useful.

It would be good if we could receive any material by early next week, if possible.

I'm very happy to talk to colleagues if any of this need clarification.

Many thanks once again

From BlackBerry

Marcus Longley
Director, WIHSC and Professor of Applied Health Policy
01443 483070

Information Redacted – out of scope

From: Bowen, Richard (DHSSC - Directorate of Operations) <Richard.Bowen@Wales.GSI.Gov.UK>
To: Andrew Carruthers (Cardiff and Vale UHB - Service Planning); Harris, Abigail (DHSSC Strategy and Planning) <Abigail.Harris4@Wales.GSI.Gov.UK>; Helen Birtwhistle <helen.birtwhistle@welshconfed.org>; Gill, Terry (DHSSC - Directorate of Operations) <Terry.Gill@Wales.GSI.Gov.UK>
Cc: Jones, Chris (DHSSC - Medical Directorate) <Chris.Jones@Wales.GSI.Gov.UK>
Sent: Thu Mar 22 19:19:26 2012
Subject: RE: Case for Change

Thanks Andrew - will ask Terry to see what he can forward to Marcus.

Terry's presentation highlighted the need to be extremely careful when comparing the mortality data however the Regional comparison is extremely useful and gives the context of the argument. Bottom line does indicate the excess deaths debate but when to take all factors into account....

Terry - please can you link with Andrew C as appropriate.

Many thanks

Richard

Information Redacted – out of scope

From: Harris, Abigail (DHSSC Strategy and Planning) [mailto:Abigail.Harris4@Wales.GSI.Gov.UK]
Sent: 22 March 2012 17:06
To: Helen Birtwhistle; Andrew Carruthers (Cardiff and Vale UHB - Service Planning)
Cc: Jones, Chris (DHSSC - Medical Directorate); Hands, David (DHSSC - Corporate Services and Partnerships)
Subject: Case for Change

Helen,

I know you are expecting comments back in from the LHBs today on the Case for Change report. I know there has been concern in particular about the RAMI data - we had a presentation today from Terry Gill on mortality which highlighted more explicitly the differences between the Welsh and English data (the most signficance being the community hospital data which are included for Wales but not for England). There was a suggestion today that inclusion of regioal comparisons might be useful in however the mortality data are presented in the final version of the slides for next week and the report.

I understand that Marcus has had all of the information that was presented today from Richard Bowen's team.

Helen, look forward to receiving the updated comms plan. David was chasing today for feedback from LHBs on their assessment of comms capacity and capability.

Abi

From: Harris, Abigail (DHSSC Strategy and Planning)
Sent: 22 March 2012 17:40
To: 'Helen Birtwhistle'; Jones, Chris (DHSSC - Medical Directorate); Andrew Carruthers (Cardiff and Vale UHB - Service Planning); Hands, David (DHSSC - Corporate Services and Partnerships); Sissling, David (Director General, Health, Social Services & Children)
Subject: RE: Case for Change - publication of independent WIHSC research

All,

I have just had a conversation with Helen - due to the work being done with the health boards to finalise the report, the closeness to recess, and the practicalities of organising at short notice, the briefing planned with AMs won't go ahead next week. Therefore suggest it takes place in early May once Easter recess is over and local elections are out of the way. The health boards have all seen the presentation so the key messages can be used in local engagement work.

The timetable below will therefore need to be updated to reflect the changes and all parties have more time to prepare.
Hope this is helpful.

Abi

From: Helen Birtwhistle [mailto:helen.birtwhistle@welshconfed.org]
Sent: 22 March 2012 17:19
To: Harris, Abigail (DHSSC Strategy and Planning); Jones, Chris (DHSSC - Medical Directorate); Andrew Carruthers (Cardiff and Vale UHB - Service Planning)
Cc: Hands, David (DHSSC - Corporate Services and Partnerships); Jane Green; Alice Attenborough; Sian Pugh
Subject: Case for Change - publication of independent WIHSC research
Importance: High

Prynhawn da, bawb.

Further to yesterday's Team Wales event and to our brief follow-up meeting, please find below my recommendations for the publication of Marcus Longley's evidence-based research, and a summary of our actions.

A key element of what we discussed yesterday was whether the briefing for AMs could and/or should go ahead next Wednesday (28 March 2012). While we agreed that the presentation that Marcus Longley gave yesterday at Team Wales would be appropriate and would start to get the debate opened up, the fact that we're now only three working days before the event is problematic. You may recall that only two out of sixty Assembly Members had said they would attend when we arranged the event for this week, 21st March, and that was when we gave them two weeks' notice. Ideally, we would have given them the new date when we postponed/cancelled initially. We have had no adverse reaction to the cancellation but run the risk now, at such a late stage, of rearranging at very short notice for the last week of term and then possibly cancelling again, which could prompt questions. Our intelligence from the workings of the Assembly tells us that AMs will not be impressed with the short notice. We also are not in possession yet of the Chairs' feedback, which may impact on Marcus' presentation.

I do, however, appreciate the alternative arguments, about having some outlet for the general tenor of the findings before the Easter Recess. It's a difficult balance but, because of the logistics, and developments this week, it could simply be too late now to go ahead. Having said that, I have put the following summary together on the basis that there could still be an event on 28 March. A possible alternative would be for us to offer the Wednesday 28th briefing slot to Mark Drakeford, whose office has been incredibly co-operative throughout this whole process. As Chair of the Health and Social Care Committee, it would be entirely appropriate to give him an early indication of the findings and to discuss next steps.

March 2012

Thursday 22nd: NHS Chairs submit their feedback to the draft research report to Helen Birtwhistle (HB), Welsh NHS Confederation (Confed), by close of play.

Thursday 22nd: Welsh Government informs Confed of decision on whether presentation to AMs can go ahead on 28 March (recommend that this takes form of Marcus Longley (ML) presentation to Team Wales)

Friday 23rd: (If AMs' briefing to go ahead) Confed confirms arrangements, issues invites etc

Friday 23rd: HB works with lead Chair, Chris Martin, to review the individual feedback and create a summary, which will be shared with Chairs and Chief Executives. This feedback can then be shared with ML.

Friday 23rd, prov. 3.30pm: HB meets ML(and others – Andrew Carruthers (AC), Jane Green (JG)) to hand over feedback and discuss.

Week beg, Monday 26th: ML reviews feedback and produces further draft/indicates extent of any additional work and probable timescale

Monday 26th: Confed finalises media holding position/key messages to be used in the event that research gets into public domain before formal publication.

Confed shares key messages etc with David Hands (DH) and liaises re handling

Confed alerts and informs Health Board and Trust comms teams about event, key messages, holding position etc

Tuesday 27th: Confed chases AM attendance for next day's breakfast event and briefs Mark Drakeford, AM, Chair of Health and Social Care Committee, who is sponsoring/chairing event

Wednesday 28th , 8-9am: ML delivers presentation on Case for Change. Also present AC, HB, JG. Introductory message is that this research is still to be finalised but wanted to share themes with AMs before Recess in order to stimulate and inform ongoing debate. No materials available to take away.

Ongoing: AC to lead on preparation of the NHS response to the independent research findings

AC to work with Confed team, who will prepare detailed media handling for publication of research

Confed to work with its members on ensuring key stakeholders etc are representative of local audiences

Confed to brief key NHS spokespeople (including clinical voice) on key messages and publication plan

Confed to prepare Communications toolkit and provide to NHS Comms teams

Monday 2 – Sunday 22 April inclusive: Assembly Recess

April 2012

Tuesday 17th: Update briefing at Chief Exec peer group meeting

Friday 20th: Confed convenes briefing meeting of all-Wales NHS Comms teams for full briefing

Dates to be confirmed: ML to advise on when Research report will be finalised and ready for publication

Allow one week for translation into Welsh

Report sent to Chief Execs and Confed

Confed to send report on behalf of the NHS in Wales to the Minister, Lesley Griffiths AM (unless delayed beyond this, recommend report is formally sent to Minister week beg. 23 or 30 April, for potential publication week beg. 7 May)

May 2012

?Tues 8th, :Weds 9th, Thurs 10th:

Publication of independent research, to take form of pre-briefings for media, development of story packages, proactive identification of interview opportunities etc. Communications to be led by Confed, in discussion with WG comms.
If AMs' pre-briefing has not taken place already (just before Recess) then incorporate briefing for AMs into publication handling plan (to coincide with or take place just before media embargo)

Dates to be confirmed: Series of stakeholder discussion events throughout Wales (using Universities as venues to reinforce that this is an independent report, setting the national context).

Ongoing: Media plan in place to maximise key issues raised in independent Report and in the response from NHS Wales.

I think this covers what we discussed yesterday and gives a robust planning outline to which we can all work. If I've missed anything, however, please don't hesitate to say.

Grateful if Abi could confirm the position re 28th March and the AMs' briefing. If it is to take place we will endeavour to re-make arrangements immediately.

Look forward to continuing to work with you all on this really interesting initiative.

Cofion gorau,

Helen

Helen Birtwhistle
Director Welsh NHS Confederation
Welsh NHS Confederation
Unit 3
Waterton Park
Bridgend
CF31 3PH

DDI: 01656 643800
Fax: 0844 7744299
www.welshconfed.org

From: Harris, Abigail (DHSSC Strategy and Planning)
Sent: 16 March 2012 14:12
To: 'Helen Birtwistle (helen.birtwhistle@welshconfed.org)'; Hands, David (DHSSC - Corporate Services and Partnerships); 'Andrew.carruthers2@wales.nhs.uk'
Subject: E-mail

Dear Helen, Andrew and David,

I thought it might be useful to catch up on the various conversations today about the Case of Change (CfC) publication planned for 28th.

I know, Helen, that you are working on the communications plans for this. It is recognised that there is nervousness about the state of preparedness to be on the front foot with the management of communication for the publication and the period building up to it and following it.

I have had a brief discussion with David. There is support for the CfC being launched on 28th if the comms plans are right and the Minister will want to be assured of this. We recognise the importance of keeping the momentum going over this critical period.

David is therefore looking for sight of the comms plan which sets out clearly the comms activity planned within local health boards and nationally - with an indication of who is fronting the activity. David has a series of meetings with the Minister (including one with the LHB and Trust Chairs) on Monday afternoon and so would like sight of the plans to inform those discussions.

This follows on from the broader discussions this week about the need to strengthen the planning and delivery of the communication support to the TfH process. As you confirmed this morning, Andrew, you have received the detailed engagement and communications plans from each organisation along with the overarching plans and you are pulling these together at the moment.

Hope this helps to clarify the position and the expectations.

Thanks Abi

Abigail Harris
Director of Strategy and Policy
Department of Health, Social Services and Children
Welsh Government
Cathays Park
Cardiff

Direct telephone line: 029 2082 6103
Abigail.Harris4@wales.gsi.gov.uk

Note of meeting with NHS Confederation held on Monday 23 January 2012 at Ty Hywel, Cardiff Bay.

Present:

Lesley Griffiths AM	Minister for Health and Social Services
Helen Birtwhistle	Director of Welsh NHS Confederation
Alice Attenborough	Welsh NHS Confederation Policy & Public Affairs Officer
Grant Duncan	Deputy Director, Medical Directorate
Jonathan Davies	Special Advisor
Dominic Worsey	Medical Directorate

Information redacted – not in scope

Engagement on "Together for Health" and update on University of Glamorgan Research

10. The Confederation and the University have been working to develop a suite of papers on the national case for change, which will support *Together For Health*. These will be finalised by the end of February, and an engagement plan is also being developed to highlight the work to key stakeholders. An AM centred event will be organised in Cardiff, and the Health Committee will also be kept fully abreast of developments.

Information Redacted - not in Scope

Dominic Worsey
24 January 2012

Subject	**Ministerial update meeting with NHS Confederation**	**Date**	**02/05/12**
Chair	**Minister for Health and Social Services**	**Time**	**10:00**
Location	**Minister's Office, Ty Hywel**	**Scribe**	**Dominic Worsey, Medical Directorate**
Attendees	**Helen Birtwhistle** — **Director of Welsh NHS Confederation** **Alice Attenborough** — **Welsh NHS Confederation Policy & Public Affairs Officer** **Jonathan Davies** — **Special Advisor** **Claire Habberfield** — **Workforce & OD** **Dominic Worsey** — **Medical Directorate**		
Apologies	**None**		

Information Redacted – Out of Scope

2.	Engagement on "Together for Health" and update on University of Glamorgan Research	• Professor Marcus Longley's Case for Change report will be published on 9 May. This will coincide with an event for AMs, being hosted by Mark Drakeford at the Senedd, when Professor Longley will present the findings of his study. • The Minister confirmed she had received a draft of the report, and had forwarded a copy to the First Minister's office. • It was acknowledged the report might contain some unpalatable messages about the current state of the Welsh NHS , but this is necessary if we are to be open and honest with the public. • Four roadshows were planned, starting during the week commencing 7 May, in Carmarthen, Aberystwyth, Llandudno and Cardiff. The target audience will be county councilors, CHCs, academics, charities and local action groups (such as Sosspan and aBer). • The Confed will also 'piggyback' onto other suitable events where possible, and a full action plan had been submitted to David Sissling's office.

Information Redacted – Out of Scope

Subject	**Ministerial update meeting with NHS Confederation**	**Date**	**23/01/12**
Chair	**Minister for Health and Social Services**	**Time**	**13:30**
Location	**Minister's Office, Ty Hywel**	**Scribe**	**Dominic Worsey, Medical Directorate**
Attendees	**Helen Birtwhistle** — **Director of Welsh NHS Confederation** **Alice Attenborough** — **Welsh NHS Confederation Policy & Public Affairs Officer** **Grant Duncan** — **Deputy Director, Medical Directorate** **Jonathan Davies** — **Special Advisor**		
Apologies	**None**		

Information Redacted – Out of scope

3.	Engagement on "Together for Health" and update on University of Glamorgan Research	• The Confederation and the University have been working to develop a suite of papers on the national case for change, which will support *Together For Health*. These will be finalised by the end of February, and an engagement plan is also being developed to highlight the work to key stakeholders. An AM centred event will be organised in Cardiff, and the Health Committee will also be kept fully abreast of developments.

Information Redacted – Out of scope

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 26 January 2012 16:07
To: Davis, Liz (DHSSC - Director for Workforce & OD)
Subject: NCfC Workforce Technical Document

Dear Liz

Following on from your recent discussion with Mike Ponton about the 'National Case for Change', I am attaching herewith as promised the latest draft of the workforce paper, and would be most grateful for your comments.

We are aiming to produce a total of 4 papers:

- Quality and Safety
- Workforce (attached)
- Access
- Over-arching paper, which summarises the above 3, and pulls together all the threads – this will be self-standing, but will direct readers to the above 3 if they want to follow up the evidence on any particular points.

They should summarise the key evidence, in an objective but accessible way, with a view to allowing the interested lay reader to draw their own conclusions on the key aspects of the argument for service re-configuration.

That's the aim… but does it succeed?! The draft is still work in progress, but should be complete enough for you to get a sense of the whole.

I'd be very grateful for any comments, ideally by early-ish next week if possible…

Please give me a ring if further clarification would be helpful

Kind regards

Marcus

Director of WIHSC and Professor of Applied Health Policy

Tel. 01443 483070 http://wihsc.glam.ac.uk/ http://twitter.com/marcuslongley

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 22 February 2012 13:51
To: Jones, Chris (DHSSC - Medical Directorate)
Subject: National Case for Change

Dear Chris WORKFORCE Final Draft .doc

I attach the latest draft of the Workforce Paper which is part of the suite of papers we are preparing for the forthcoming debate on the National Case for Change.

We have used material from the Deanery, NLIAH and other published papers, including the impact of medical workforce issues such as the European Working Time Directive, the shortage of junior/middle grades in some places and the possible changes in training. However, on reflection the evidence as presented does not seem to be as incisive as we might have hoped.

Is there any further evidence that you could provide to sharpen up the document and its impact in supporting the case for change.

If you are attending the Clinical Forum later, perhaps we could have a quick chat about this.

Regards
Marcus

Marcus Longley
Professor of Applied Health Policy and
Director, Welsh Institute for Health and Social Care
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Tel 01443 483070 Fax 01443 403070
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From: Jones, Chris (DHSSC - Medical Directorate)
Sent: 05 February 2012 17:14
To: 'Longley M J (HESAS - WIHSC)'; 'Andrew.Carruthers2@wales.nhs.uk'
Cc: Coley, Michelle (DHSSC - Medical Directorate); Eley, Carl R (DHSSC - Medical Directorate); Chainey, Shaun (DHSSC - Medical Directorate); White, Cathy (DHSSC - Medical Directorate); Hanson, Jane (DHSS - CPCHSD); Bowen, Richard (DHSSC - Directorate of Operations); Perks, Roger (DHSSC - Directorate of Operations); Duncan, Grant (DHSSC - Medical Directorate)
Subject: RE: Clinical Outcomes data

Hi Marcus,

Yes absolutely agree the National Clinical Audit data shows us exactly where we are on many important services. We have all this in WG, held by Carl Eley's branch, and we will share with you.

Cancer survival data are held by Cathy White via the National Cancer Team.

CHKS data is held in Richard Bowen's directorate (Roger Perks) and again we re happy to share anything we can that would help.

I am copying to relevant colleagues and hope to catch up with you shortly,

Best Wishes,

Chris

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 03 February 2012 11:11
To: Jones, Chris (DHSSC - Medical Directorate); Andrew.Carruthers2@wales.nhs.uk
Cc: Coley, Michelle (DHSSC - Medical Directorate)
Subject: Clinical Outcomes data
Importance: High

Chris/Andrew - we've been trying to track down data from the various audit-type sources to include in the National Case for Change papers - as we've discussed, a crucial piece in the jigsaw is the argument 'we cant stay as we are: just look at outcomes'. So far, so elusive! I've approached Peter Bradley and Richard Bowen, who have been most helpful with other data, but nothing of this sort.

I guess I'm thinking of cancer, cardiology, mental health...? The CHKS database, for example...?

Can you help? It would be a real shame not to include it...

(PS did you hear Bruce Keogh on the radio this morning, on the back of the recent stuff about weekend care - very good on the 'moral case' for change...)
Marcus

Marcus Longley
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From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 20 February 2012 17:35
To: andrew.goodall@wales.nhs.uk; mary.burrows@wales.nhs.uk; jan.williams7@wales.nhs.uk; allison.williams4@wales.nhs.uk; trevor.purt@wales.nhs.uk; andrew.cottom@wales.nhs.uk; Bob.hudson@wales.nhs.uk; simon.dean@wales.nhs.uk; elwyn.price-morris@wales.nhs.uk; paul.roberts@wales.nhs.uk
Cc: Davis, Liz (DHSSC - Director for Workforce & OD); Galton, Bernard (DG People Places and Corporate Services); Jones, Chris (DHSSC - Medical Directorate); peter.bradley@wales.nhs.uk; Bowen, Richard (DHSSC - Directorate of Operations); Jeff James (Cardiff and Vale UHB - Whitchuch Headquarters); andrew.carruthers@wales.nhs.uk; PAT & MICHAEL PONTON
Subject: SUBJECT National Case for Change in Service Configuration: Papers 2 and 3

Dear Colleague

Please find attached the final drafts of the 2nd and 3rd papers, on Workforce and Access issues. The overarching paper – which sets out 'the case for change' succinctly, in one place – will be prepared following your feedback on these.

As always, very grateful for any comments, ideally be the end of this week. Please do not distribute widely at this stage

Please give me a ring if you think that would be helpful.

Many thanks, as always

Marcus

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From: Jones, Chris (DHSSC - Medical Directorate)
Sent: 04 March 2012 17:31
To: 'Longley M J (HESAS - WIHSC)'
Cc: 'Andrew.Carruthers2@wales.nhs.uk'
Subject: RE: ABMU Changing for the Better - Results of Voting 29th Feb

Hi Marcus,

This is interesting and pretty clear as you describe. Encouraging overall.

Andrew will brief you on last Friday. Helpful meeting between MDs and planners. I think there was a general feeling that the CfC needs to be more positive if possible I.e. describing a persuasive vision of how things could be better. People seemed to think there was a gap where a blueprint in response could exist and Andrew is thinking about this.

There was an excellent presentation on the emergency response service covering the west of Scotland and a feeling that we need something similar in Wales. This is a positive new service that needs to go in.

I wonder also if we could provide a list of new services and technologies that must be delivered and examples of other systems producing better outcomes and experience than us.

I was pleased to have been able to meet Rachel on Friday. It was a great evening.

Best Wishes,

Chris

From: Longley M J (HESAS - WIHSC) [mailto:mlongley@glam.ac.uk]
Sent: 03 March 2012 17:01
To: Jones, Chris (DHSSC - Medical Directorate)
Cc: Andrew.Carruthers2@wales.nhs.uk
Subject: FW: ABMU Changing for the Better - Results of Voting 29th Feb

Chris - have a look at the attached. Quite interesting snapshot of leaders' opinions of case for change and its chances...

On Wednesday, we did some electronic voting with 170 leaders in ABMU, based on the Case for Change presentation. Andrew was there. Interesting results:

1. theyre positive about the need for change, especially re the workforce (slide 3), and
2. positive about the chnaces of success (slide 9)
3. think the biggest obstacles to be overcome are attitudes of the workforce, money and political will (in that order) (sldie 10)

Marcus

Marcus Longley

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Information Redacted – out of scope

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-23-12 papur 1b

Ystyried gohebiaeth a gyhoeddwyd yn ddiweddar rhwng swyddogion Llywodraeth Cymru a'r Athro Marcus Longley

Wedi'i atodi i'r papur hwn mae crynodeb o adroddiad yr Athro Marcus Longley, *Y Trefniant Gorau ar gyfer Gwasanaethau Ysbytai Cymru: Adolygiad o'r Dystiolaeth.*

Hefyd wedi'u hatodi mae'r lincs i dair dogfen - sy'n ymwneud â mynediad, y gweithlu ac ansawdd a diogelwch - a gyhoeddwyd i ategu'r adroddiad:

- Dogfen ar **fynediad** (Saesneg yn unig)
- Dogfen ar **y gweithlu** (Saesneg yn unig)
- Dogfen ar **ansawdd a diogelwch** (Saesneg yn unig)

Y TREFNIANT GORAU AR GYFER GWASANAETHAU YSBYTAI CYMRU:

ADOLYGIAD O'R DYSTIOLAETH

CRYNODEB

Yr Athro Marcus Longley

Sefydliad Iechyd a Gofal Cymdeithasol Cymru · Prifysgol Morgannwg

Ebrill 2012

Welsh Institute for Health and Social Care
Sefydliad Iechyd a Gofal Cymdeithasol Cymru

DIOLCHIADAU

Seilir y crynodeb hwn ar dri adolygiad manylach o'r dystiolaeth ar Ansawdd a Diogelwch, Y Gweithlu a Mynediad a ymchwiliwyd ac ysgrifennwyd gan fy nghydweithwyr Mike Ponton a Katie Norton, gyda chymorth Amy Simpson a Susan Kimani. Rydyn ni i gyd yn ddiolchgar iawn i staff Llywodraeth Cymru, GIG Cymru a Deoniaeth Cymru a ddarparodd ddata ar agweddau allweddol o'r gwaith hwn ar ein cyfer, ac i gydweithwyr eraill y buon ni'n trafod y dystiolaeth gyda nhw ac a adolygodd fersiynau drafft cynharach o'r papurau. Comisiynwyd y gwaith gan Fyrddau Iechyd Lleol Cymru.

Yr awdur

Mae'r Athro Marcus Longley MA (Oxon), MSc Econ, PhD, FFPH, AHSM yn Gyfarwyddwr Sefydliad Iechyd a Gofal Cymdeithasol Cymru ac Athro Polisi Iechyd Gymhwysol ym Mhrifysgol Morgannwg. mlongley@glam.ac.uk http://wihsc.glam.ac.uk/

CYNNWYS

CRYNODEB

Mae'r papur hwn yn adolygu'r hyn y mae'r dystiolaeth yn ei awgrymu am y nifer optimaidd o wasanaethau ysbytai, eu maint a'u dosbarthiad yng Nghymru. Fe'i ysgrifennwyd ar gyfer cynulleidfa anfeddygol: dinasyddion Cymru sy'n dymuno penderfynu drostyn nhw eu hunain sut dylai eu hysbytai gael eu trefnu. Ceir gwybodaeth bellach am dair rhan y drafodaeth hon – ansawdd a diogelwch, y gweithlu a mynediad – mewn tri phapur cysylltiedig.

Bwriad y papur hwn ydy helpu'r darllenydd i ateb pedwar cwestiwn:

C: Ar Ddiogelwch ac Ansawdd: **Beth sydd o'i le ar batrwm presennol ein gwasanaethau ysbytai?**

A: Mae corff cynyddol o dystiolaeth sy'n awgrymu nad ydy cleifion yng Nghymru bob amser yn cael y canlyniadau gorau posibl o'u gofal ysbyty, ac nad ydy'r modd y trefnir gwasanaethau mewn rhai meysydd arbenigol allweddol yng Nghymru– megis prif drawma, trawma cyffredinol a gofal brys, gofal strôc, gofal mamolaeth a'r newydd anedig a phediatreg – y gorau posibl o bell ffordd yn ôl y dystiolaeth.

C: Ar y Gweithlu: **Mae mwy o staff nag erioed gyda ni, felly beth ydy'r broblem?**

A: Erbyn hyn mae pwysau dybryd ar staffio meddygol ym maes pediatreg, meddygaeth argyfwng, hyfforddiant llawfeddygol craidd a seiciatreg, ac yn fwy cyffredinol yn rhai o'r mannau mwyaf anghysbell o Gymru. Mae 'storom berffaith ' wedi datblygu, gyda mwy o feddygon yn ein hysbytai, ond mewn gwirionedd llai ar gael o'i gymharu â'r galw am eu gwasnaeth.

C: Ar Fynediad: **Ydy gwaeth mynediad yn anochel er mwyn sicrhau ansawdd a diogelwch da?**

A: Mae canoli gwasanaethau yn anorfod yn golygu bod rhaid i rai pobl deithio ymhellach. Fodd bynnag gellir gwneud llawer i liniaru effaith canoli rhai gwasanaethau. Yn arbennig, gellid gostwng y risgiau sy'n gysylltieidig â theithio ymhellach yn sylweddol petai gwasanaethau argyfwng cyn mynd i ysbyty hefyd yn cael eu hail-drefnu.

C: Ac o roi'r elfennau at ei glydd: **Beth ydy'r ddadl dros newid?**

A: Erbyn hyn mae dadl gref dros ail-drefnu rhai gwasanaethau ysbytai, yng Nghymru fel mewn mannau eraill yn y DU. Mae agwedd bositif i hyn o beth - gellid gwella canlyniadau i gleifion – ac agwedd negyddol – bydd rhai gwasanaethau yn chwalu oherwydd prinder staff allweddol , os na wneir y newidiadau'n rhagweithiol. Er bod y problemau hyn wedi bod yn datblygu tros gyfnod, bellach mae'r angen i newid yn un dirfawr mewn rhai meysydd allweddol arbenigol, wrth i lefelau staffio meddygol fynd yn fwy difrifol.

Mae'n naturiol i'r dystiolaeth hon weithiau i fod yn rhwystredig o aneglur, yn amhendant, yn gwrthddweud ei hunan, neu beidio bodoli o gwbl ac heb fod bob amser yn cynnig un ateb penodol. Fodd bynnag, fel y dengys y crynodeb hwn a'r papurau atodol, mae yna bellach dystiolaeth argyhoeddiadol nad ydy gwasanaethau ysbyty yng Nghymru ddim bob amser wedi eu trefnu yn optimaidd, ac y gallai gofal cleifion fod yn dioddef, a bod rhai grwpiau o staff allweddol, mewn rhai ysbytai, yn anghynaliadwy, gyda'r risg o weld y gwasanaeth yn chwalu'n llwyr a hynny'n fuan. Felly rhaid i'r darllenwyr bwyso a mesur y dystiolaeth drostyn nhw eu hunain, gan ystyried y dehongliad i'w roi arni a defnyddio'u synnwyr cyffredin. Yn aml, pethau fel hyn ydy penderfyniadau polisi iechyd - yn rhannol ym ymwneud â dyfarniadau gwerth, ac y mae dod i gyfaddawd derbyniol rhwng gwahanol amcanion yn rhywbeth arall y mae'n rhaid i ddarllenwyr ei wneud drostyn nhw eu hunain. Dyna pam bod angen trafodaeth gyhoeddus o ddifrif am y materion hyn. Mewn rhai agweddau allweddol, fodd bynnag, mae digon o dystiolaeth i bryderu a ydyn ni wir yn cael y gofal gorau posibl gan yr adnoddau yr ydyn ni'n buddsoddi ynddyn nhw.

'Here now is the opportunity to build a hospital service equal to any in the world and matched, I would think, by very few… the intention of the Government and of the Hospital Service [is] to rise to that opportunity… This Plan is nothing less than a plan for the modernisation of our hospital system… to make clear the sort and size of hospitals which we ought to have if we are to make the best use of the specialist techniques of our time, together with the general practitioner services and the domiciliary services.'

Yr Arglwydd Newton, yn cyflwyno *Cynllun Ysbytai ar gyfer Lloegr a Chymru* i Dŷ'r Arglwyddi yn 1962

1. CYFLWYNIAD

I. PWRPAS Y PAPUR HWN

Gofynnwyd am farn pobl ar draws Cymru ar sut y dylid newid eu gwasanaethau iechyd. Lluniwyd y papur hwn i helpu pobl i benderfynu drostyn nhw eu hunain. Mae'n adolygu'r dystiolaeth am yr hyn ydy'r ffordd 'orau' ar gyfer darpariaeth ysbytai, ac asesu cryfderau a goblygiadau'r dystiolaeth. Mae'n canolbwyntio ar yr hyn y mae'r dystiolaeth yn ei awgrymu am y **nifer optimaidd o wasanaethau ysbytai, eu maint a'u dosbarthiad yng Nghymru.** Mae'n ddi-duedd, yn seiliedig yn unig ar y dystiolaeth a adolygwyd ac mae unrhyw ddyfarniad a wneir ar sail y dystiolaeth yn eglur a phendant. Ysgrifennwyd y papur yn bennaf ar gyfer cynulleidfa leyg: pobl sydd yn poeni am ddyfodol eu gwasanaethau iechyd, ac yn dymuno penderfynu drostyn nhw eu hunain rhwng y gwahanol safbwyntiau sydd weithiau'n groes i'w gilydd a gyflwynir ar y cyfryngau a mannau eraill.

Dydy'r papur ddim yn ystyried cynlluniau *lleol*: ond yn hytrach mae'n adolygu'r hyn y mae'r dystiolaeth yn ei ddweud *yn gyffredinol* am newidiadau i'r patrwm o wasanaethau ysbytai. Mae'n canolbwyntio'n bennaf ar ysbytai aciwt, ond mae'n gwneud y pwynt mai rhan yn unig ydy'r ysbytai hyn o rwydwaith cymhleth o wasanaethau GIG Cymru, a'u bod yn dibynnu ar y gwasanaethau o'u cwmpas. Mae hefyd yn gweithio ar y sail y gall y dystiolaeth *helpu* pobl ddod i benderfyniad, *ond ddim yn rhoi'r ateb i chi*. Wrth wraidd y materion anodd hyn mae set o ddyfarniadau gwerth: mae angen i bobl benderfynu drostyn nhw eu hunain ar yr hyn sydd o fwyaf bwys yn eu tyb nhw mewn gofal iechyd a pha gyfaddawdu y maen nhw'n barod i'w dderbyn.

Mae'r papur hwn yn seiliedig ar dair dogfen 'dechnegol' gysylltiedig sy'n disgrifio'r dystiolaeth yn fwy manwl:

I. Ansawdd a Diogelwch
II. Y Gweithlu
III. Mynediad

Os ydy'r darllenydd am gael rhagor o wybodaeth ar unrhyw fater arbennig, gall droi at y dogfennau technegol hyn.

II. ATEBION AR EU PEN I GWESTIYNAU SYML

Mae llawer o'r dadlau ynglyn ag unrhyw ddarpar aildrefnu gwasanaethau iechyd unrhywle yn y DU yn deillio o gynigion i newid yr hyn y mae ysbytai yn ei gynnig, ac yn enwedig i dynnu gwasanaethau oddiar

ysbytai lleol. Yn llawer rhy aml, mae'n ymdangos, dydy'r ddadl ddim wedi'i seilio ar y dystiolaeth ac mae hyn yn drysu pobl (neu'n eu gwneud yn amheus) am yr hyn sy'n digwydd. Rydyn ni wedi seilio'r adolygiad hwn o'r dystiolaeth ar rai o'r cwestiynau syml - ond dwys – y mae pobl yn eu gofyn dro ar ôl tro am ddyfodol eu hysbytai ac yn cael trafferth weithiau i gael atebion sy'n eu hargyhoeddi:

- Ar Ddiogelwch ac Ansawdd: **Beth sydd o'i le ar batrwm presennol ein gwasanaethau ysbytai?**
- Ar y Gweithlu: **Mae mwy o staff nag erioed gyda ni, felly beth ydy'r broblem**
- Ar Fynediad: **Ydy gwaeth mynediad yn anochel er mwyn sicrhau ansawdd a diogelwch da**

Ac o roi'r elfennau at ei gilydd: **Beth ydy'r ddadl dros newid?**

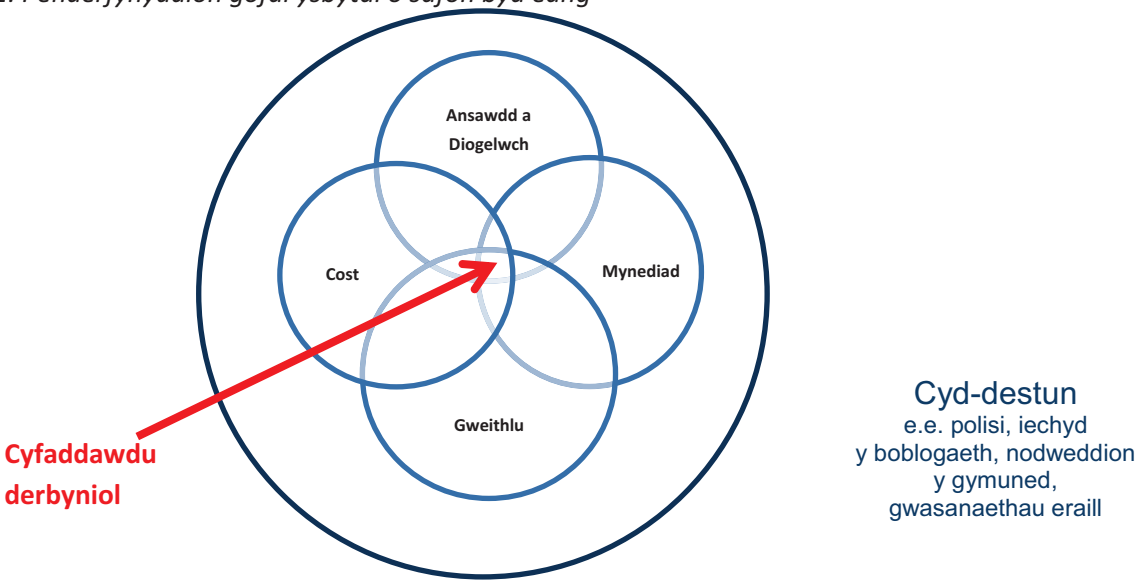
Mater arall sy'n codi'n aml yn y trafodaethau hyn ydy arian: **Allwn ni fforddio gwella'r gwasanaeth?** Dydyn ni ddim yn adolygu'r dystiolaeth ar hyn yn y fan yma ond ceir trafodaeth am yr hyn allai'r cwestiwn ei olygu.

2. Y CYD-DESTUN

I. MAE YSBYTAI O SAFON BYD EANG YN DIBYNNU AR...

Argymhellodd Comisiwn Bevan i Lywodraeth Cymru y dylai gofal iechyd yng Nghymru *'fod yn addas i anghenion Cymru ac yn un cyffelyb i'r gorau unrhywle'.* Sef: 'safon byd eang'. Mae diffiniadau o'r hyn yw gofal ysbyty o 'safon byd eang' yn amrywio o le i le, o berson i berson, ond ceir mesur o gytundeb ar y pedwar set o faterion penodol sydd wrth wraidd llwyddiant cyffredinol: ansawdd a diogelwch y gofal a ddarperir yn yr ysbyty; pa mor hygyrch ydy'r gofal; a ydy'r gweithlu'n ddigonol o ran ansawdd, eu nifer a'u dosbarthiad; ac a ellir fforddio'r system. Mae rhaid i bob un o'r rhain fod yn gynaliadwy i'r dyfodol. Does dim un system yn y byd wedi gallu cyflawni pob un o'r meysydd hyn yn berffaith, na chwaith fyth yn gallu: mae 'safon byd eang' yn golygu canfod set o gyfaddawadau sy'n dderbyniol i ddinasyddion a'r gweithredwyr proffesiynol (Ffigwr 1):

Ffigwr 1: Penderfynyddion gofal ysbytai o safon byd eang



Mae'r papur hwn yn cyfeirio at wasanaethau ysbytai aciwt ac mae ffocws cul i'r dystiolaeth a adolygwyd yma. Ond mae'r ffactorau yn eu cyd-destun yn hanfodol i lwyddiant ysbytai. Maen nhw'n troi'n gyfres o amcanion sy'n gyffredin i fwyafrif o systemau gofal iechyd y byd datblygedig, gan gynnwys Cymru ac eisoes yn destun amrywiaeth o fentrau eraill:

- Helpu pobl a chymunedau i ofalu amdanyn nhw eu hunain – i atal afiechyd a chadw pobl yn iach
- Rheoli'r baich cynyddol o glefydau cronig - er mwyn lleihau effaith cyflyrrau hirdymor sydd eisoes yn cyfrif am fwyafrif y gofal iechyd yng Nghymru
- Rhagor o gapasiti GIG a chydgysylltu tu allan i'r ysbyty – er mwyn symud cydbwysedd yr adnoddau tuag at y gymuned
- Atal derbyniadau diangen i'r ysbyty – i sicrhau mai dim ond cael eu derbyn i'r ybyty y bydd pobl pan fo hwnnw'r dewis gorau iddyn
- Gwell cydlynu rhwng holl ddarparwyr gwasanaethau – er mwyn darparu gwaith tîm effeithiol ar draws ystod cymhleth o wasanaethau sydd eu hangen ar bobl
- Mabwysiadu mesurau effeithiolrwydd o safon fyd eang - er mwyn parhau â'r dasg ddiddiwedd o wneud y system i weithio mor effeithlon â phosibl
- Dilyn yr arferion clinigol gorau – er mwyn sicrhau bod pob gwasanaeth yn dilyn arferion da cydnabyddedig
- Osgoi oedi rhag ryddhau o'r ysbyty – er mwyn sicrhau bod pobl yn gadael yr ysbyty i fynd i'r mannau priodol heb unrhyw oedi
- Gwasanaethau a gynlluniwyd ar gyfer gwahanol gymunedau – er mwyn sicrhau bod gwasanaethau'n cael eu trefnu'n briodol a'u cymhwyso i'w hardal
- Partneriaeth rhwng gwasanaethau a chleifion – er mwyn sicrhau bod yr holl gleifion yn cymryd rhan yn eu gofal eu hun, yn gwneud penderfyniadau a derbyn y gofal sy'n addas ar eu cyfer
- Adnoddau digonol – er mwyn sicrhau bod gwasanaethau'n gweithio'n effeithlon ac yn derbyn yr arian a'r adnoddau sydd eu hangen arnyn nhw.

Mae cyflawni gwasanaethau ysbytai o safon fyd eang yn golygu cyflawni darpariaeth o safon fyd eang ar gyfer pob un o'r agweddau hyn yn ogystal â threfnu gwasanaethau ysbytai eu hunain i'r safon gorau posibl. Yng Nghymru, mae cyflawni'r trydydd nod – sef gwella gwasanaethau iechyd a gwasanaethau cysylltiedig yn ddramatig *tu allan i* ysbytai – yn arbennig o bwysig i ddyfodol gwasanaethau ysbytai. Mae wedi bod yn amlwg ers cryn amser bod gan Gymru fwy o welyau ysbyty na Lloegr – 3.90 o welyau am bob 1,000 o boblogaeth yng Nghymru o'i gymharu â 2.64 o welyau am bob 1,000 o boblogaeth yn Lloegr (Rhagfyr 2011). Rhaid i gynnydd yn y maes hwn (a amlinellir yn *Gosod y Cyfeiriad,* polisi Llywodraeth Cymru) gydsymud yn union â datblygiad gwasanaethau ysbytai os nad ydy hwnnw'n cael ei adael i lenwi bylchau yn y ddarpariaeth ar gyfer y gymuned a derbyn pobl y dylid gofalu amdanyn nhw yn y gymuned.

II. 50 MLWYDD OED OND YN NEWID YN BARHAUS

Sefydlwyd patrwm cyfredol gwasanaethau ysbytai yn Lloegr a Chymru 50 mlynedd yn ôl yn *The Hospital Plan for England and Wales*, cynllun Enoch Powell, AS, y Gweinidog Iechyd bryd hynny. Mae ei nod yn hynod o fodern: creu gofal ysbyty o safon fyd eang drwy ddatblygu system gydlynol o fewn yr ysbyty a thu allan, gan ddefnyddio'r dechnoleg ddiweddaraf ac ystod llawn o sgiliau ac arbenigedd y staff. Gallai

geiriau'r Arglwydd Newton a ddyfynwyd ar ddechrau'r papur hwn fod yn eiriau fyddai Gweinidog Cymru yn yn eu llefaru yn y Senedd wythnos yn ôl!

Esgorodd *The Hospital Plan* ar rwydwaith o 'Ysbytai Cyffredinol Dosbarth' yn cynnwys rhwng 600 ac 800 o welyau i wasanaethau poblogaethau rhwng 100,000 a 150,000. Mae'r sylfeini allweddol hyn yn dal i fodoli ar draws Cymru 50 mlynedd yn ddiweddarach, ond mae'r gofal maen nhw'n ei ddarparu wedi newid a'i addasu i gwrdd ag amgylchiadau sydd wedi newid:

Er enghraifft...	*... sy'n golygu*
Mae gofal sylfaenol yn canfod cleifon sydd mewn perygl ac yn eu rheoli'n rhagweithiol	Roedd cleifion â chlefyd siwgr yn arfer mynd i mewn i'r ysbyty i gychwyn ar eu hinsiwlin… nawr caiff ei wneud yn y gymuned
Mae hyd arhosiad mewn ysbyty yn fyrrach o lawer	Mae llawer o lawdriniaethau'n cael eu gwneud fel achosion dydd
Mae technoleg yn caniatâu i gleifion gael gofal arbenigol yn nes adref	Mae llawer o ofal canser a mwyafrif o wasanaethau iechyd meddwl nawr yn digwydd yn y gymuned
Mae staff wedi datblygu rolau newydd	Llawer o wasanaethau nawr yn cael eu harwain gan staff anfeddygol

Rhaid i newidiadau yn y meysydd hyn a meysydd eraill barhau ar y cyd ag unrhyw newidiadau yng nhrefniant gwasnaethau ysbytai.

3. YSBYTAI O SAFON FYD EANG

I. DIOGELWCH AC ANSAWDD

Mae nifer o ffyrdd y gellir diffinio diogelwch ac ansawdd gwasanaethau ysbytai. Ystyrir tystiolaeth dau o'r ffyrdd pwysicaf yma. Canlyniadau clinigol ydy'r mesurau gwrthrychol llwyddiant hynny sydd bwysicaf i gleifion, megis marwolaeth ac anabledd y mae modd eu hosgoi. Mae modelau gwasanaeth yn disgrifio'r modd y darperir rhannau o'r gwasanaeth – er enghraifft, mathau o lawdriniaethau, gofal strôc, genedigaeth. Mae ystyried y ddau yn ein helpu i ateb y cwestiwn: **Beth sydd o'i le ar batrwm presennol ein gwasanaethau ysbytai?**

Ceir gwybodaeth bellach ar y data a grynhoir yn y ddogfen hon yn y papur cysylltiedig, Ansawdd a Diogelwch. Dylid darllen y drafodaeth hon ar ddiogelwch ac ansawdd ar y cyd â'r adran nesaf, sef y Gweithlu, sy'n ystyried a all prinder grwpiau penodol ynddo'i hun fod yn fygythiad i ansawdd a diogelwch.

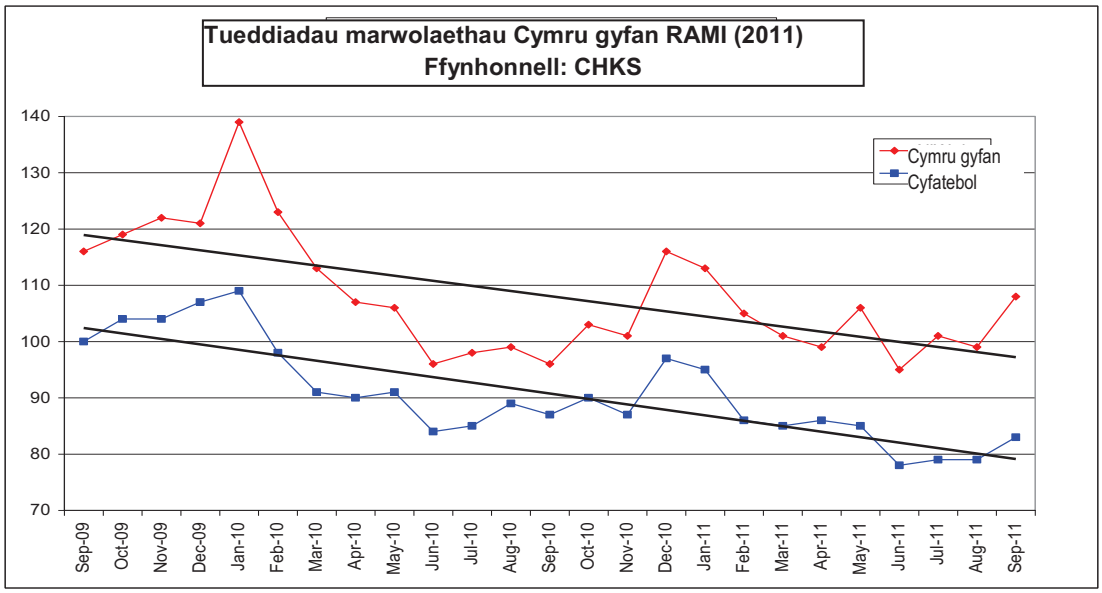
A. Canlyniadau clinigol

Defnyddir data ar farwolaethau yn ysbytai Cymru i lunio Mynegai Marwolaethau wedi'u haddasu yn ôl Risg (RAMI). Mae hwn yn ceisio addasu cyfraddau 'syml' marwolaethau ar gyfer y gwahaniaethau rhwng cleifion sydd ddim o ganlyniad i ofal mewn ysbyty – er enghraifft, oed, rhyw, neu ddifrifoldeb cyflwr wrth fynd i mewn i ysbyty. Mae'r rhain wedyn yn cael eu cymharu'n fras â grŵp tebyg o ysbytai Lloegr i sefydlu a oes gwahaniaeth rhwng y canlyniadau a allai fod o achos y gofal ysbyty ei hun. Yn union fel unrhyw

dechneg ystadegol, dydy'r broses o asesiad risg ddim yn berffaith, ac mae'n bosibl bod o leiaf rhai o'r gwahaniaethau a welwyd yn ganlyniad i ffactorau dieithr megis y gwahaniaethau yn y mathau o ysbytai a gymharwyd, neu argaeledd gofal hospis yn lleol. Felly, dylid defnyddio'r data a gyflwynir yma yn ofalus. Mae'r data hwn hefyd yn cuddio'r gwahaniaethau rhwng y rhanbarthau yn Lloegr.

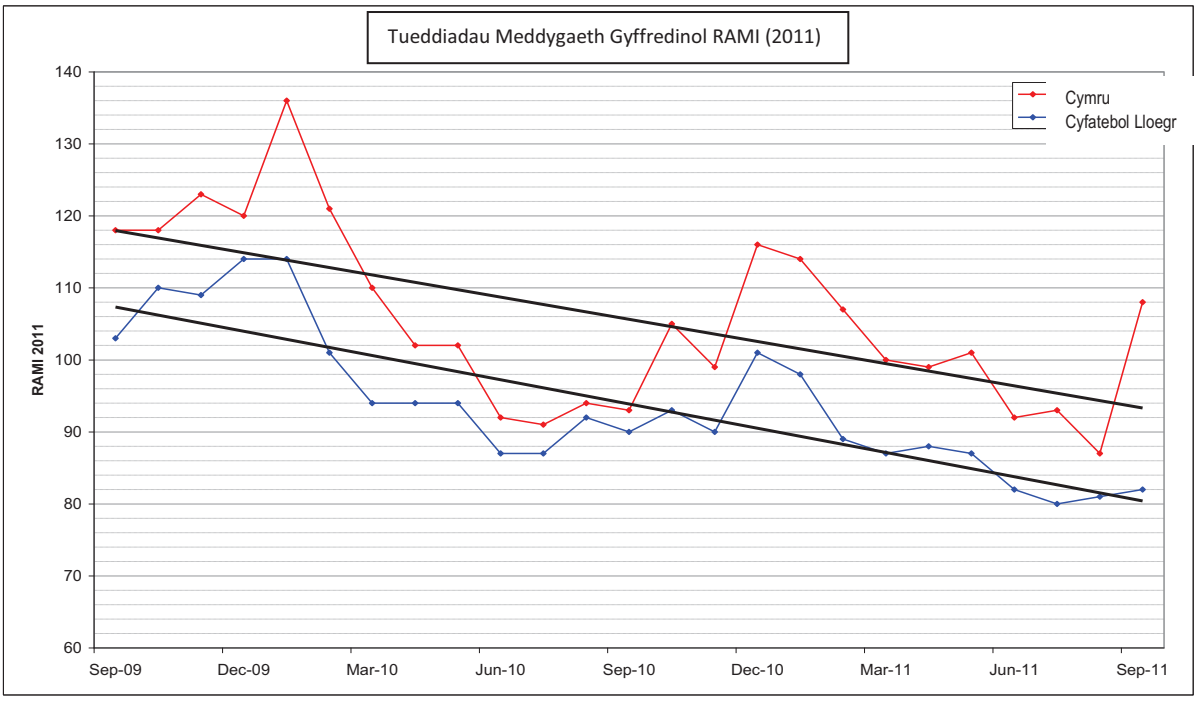
Mae Ffigwr 2 yn dangos y gymhariaeth gyffredinol rhwng ysbytai Cymru a Lloegr, a gwelwn fod patrwm hynod o debyg (gwelliant) rhwng y ddwy wlad, ond bod perfformiad Cymru yn gyson waeth:

Ffigwr 2: Tueddiadau marwolaethau a addaswyd yn ôl risg 2009-11, Cymru a Lloegr



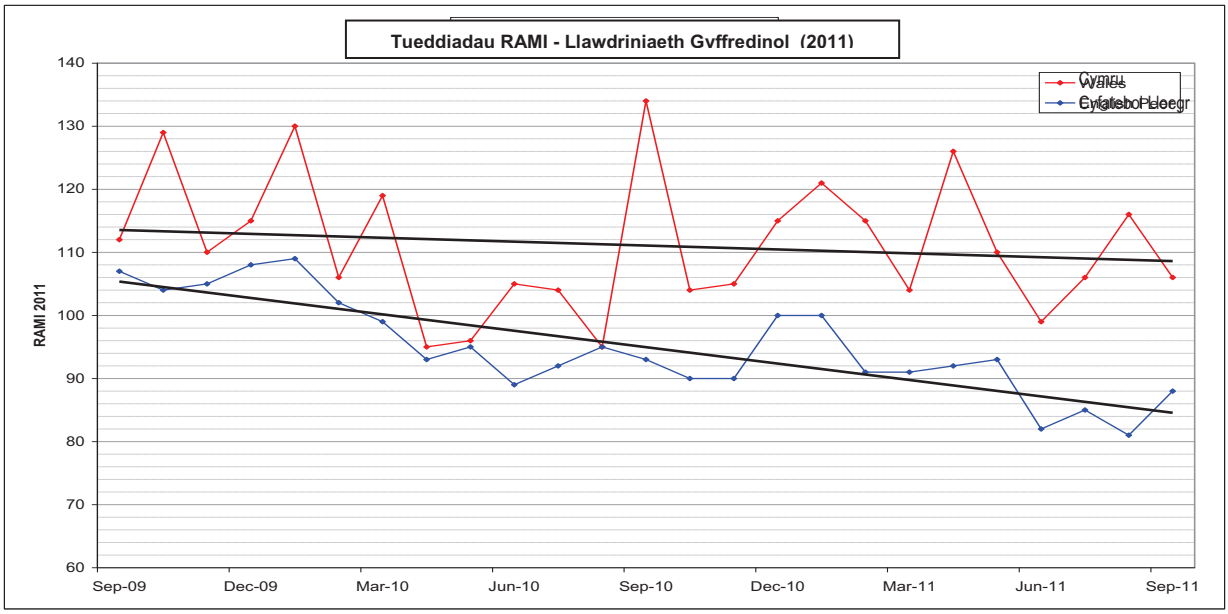
O ystyried yn fwy gofalus yr arbenigeddau ehangach o fewn y darlun cyffredinol, mae'n ymddangos bod meddygaeth gyffredinol yn dilyn patrwm tebyg (Ffigwr 3):

Ffigwr 3: Tueddiadau marwolaethau Meddygaeth Gyffredinol a addaswyd yn ôl risg, 2009-11, Cymru a Lloegr



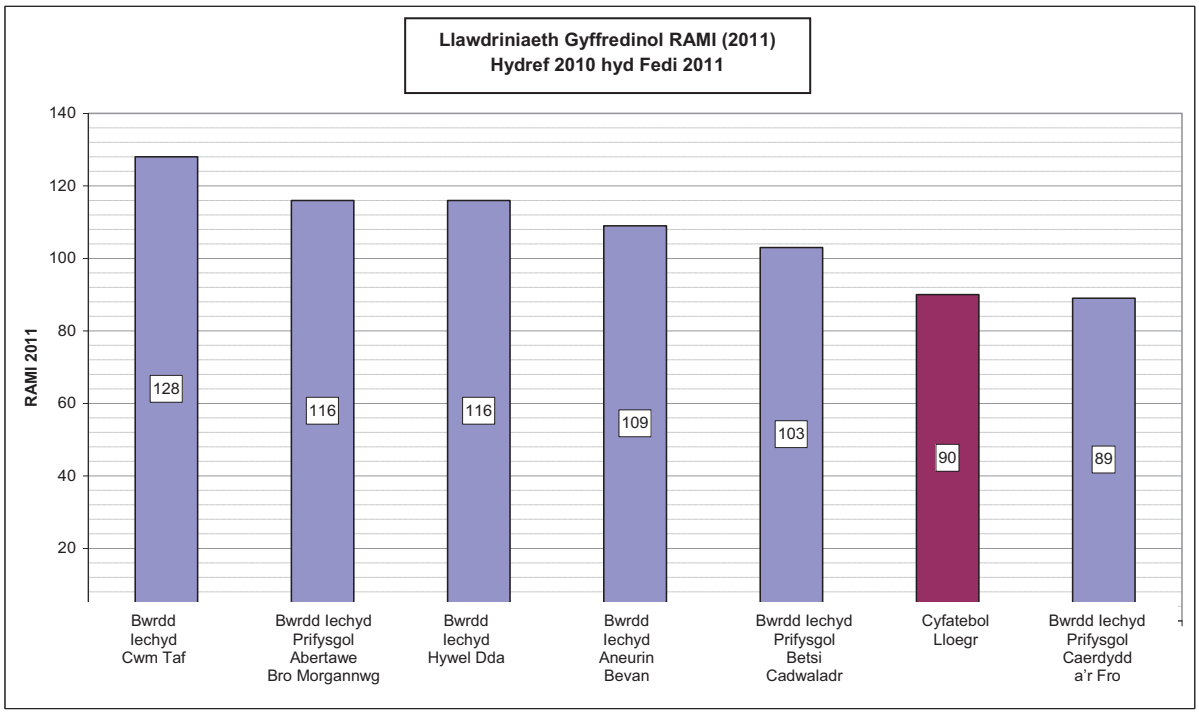
Ym maes llawdriniaeth gyffredinol, mae'r bwlch rhwng Lloegr a Chymru i'w weld yn ehangu (Ffigwr 4):

Ffigwr 4: Tueddiadau marwolaethau Meddygaeth Gyffredinol a addaswyd yn ôl risg, 2009-11, Cymru a Lloegr



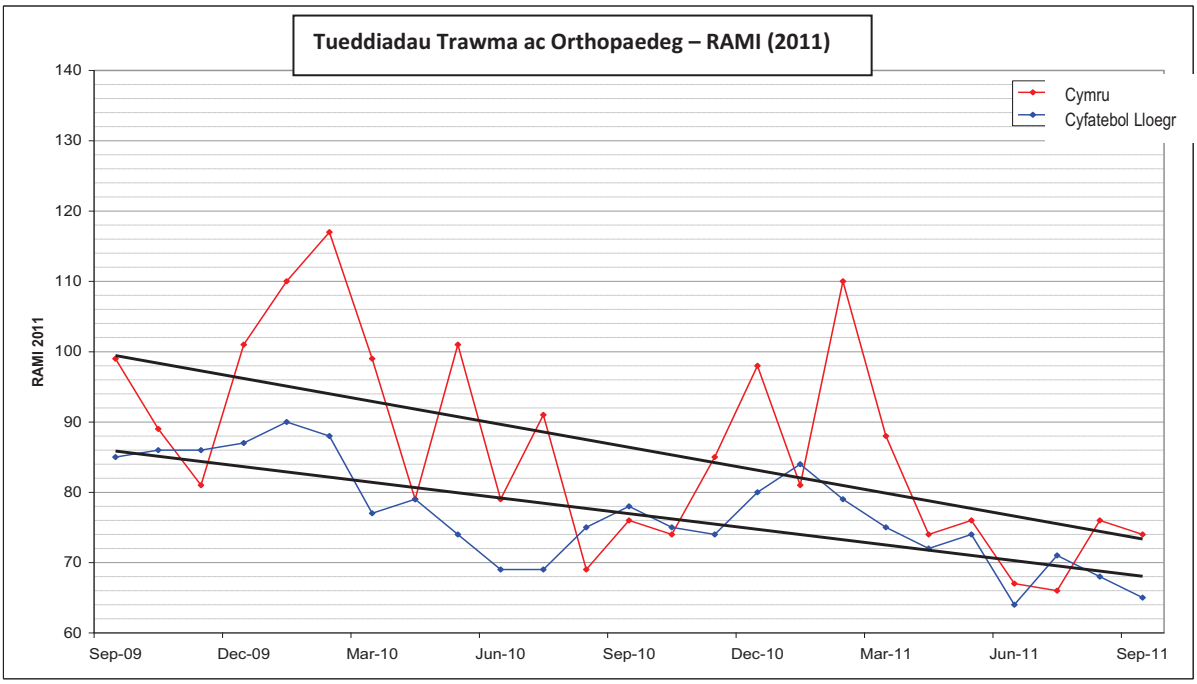
Ac y mae amrywiaethau sylweddol rhwng gwahanol Fyrddau Iechyd Cymru (Ffigwr 5):

Ffigwr 5: Marwolaethau a Addaswyd yn ôl Risg, Llawdriniaeth Gyffredinol, Byrddau Iechyd Cymru a hefyd Lloegr, 2010/11



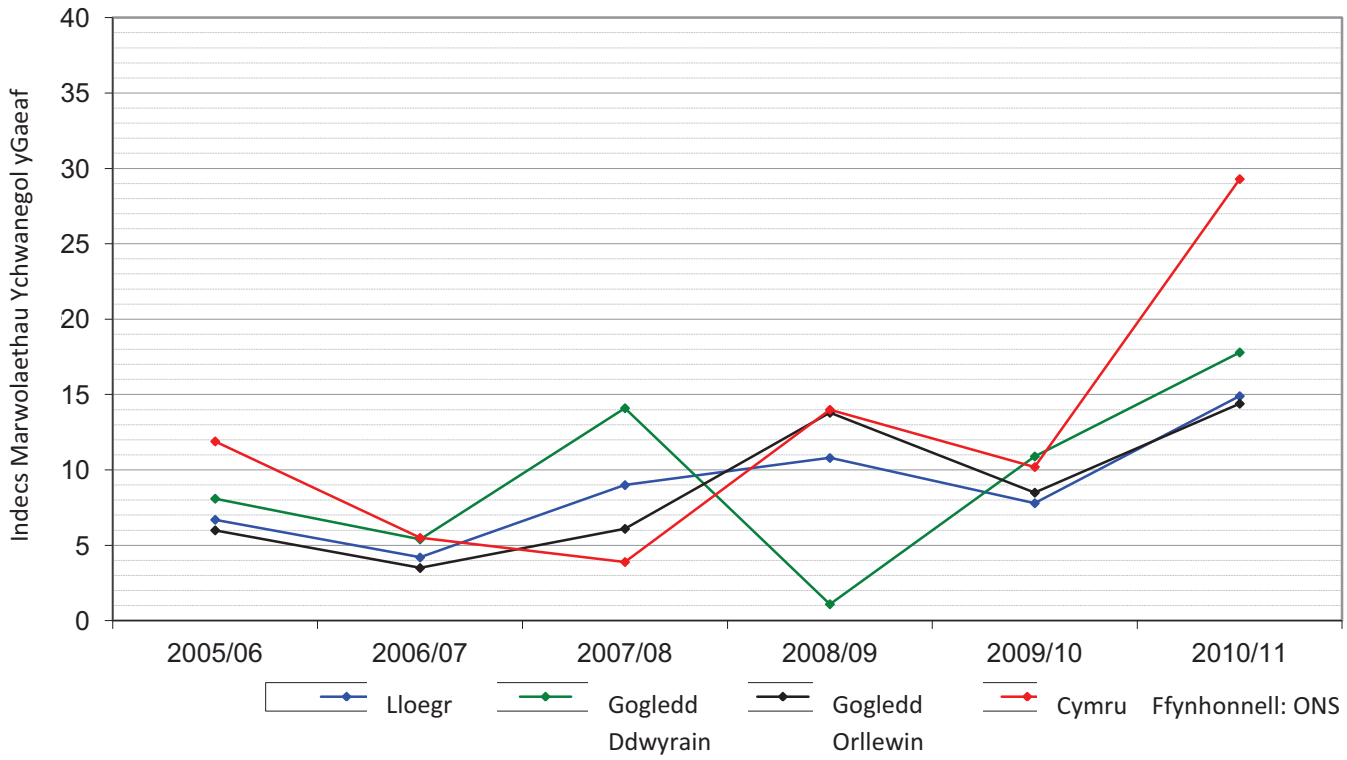
Ym maes trawma ac orthopaedeg, mae'r bwlch rhwng y ddwy wlad yn ymddangos ei fod yn culhau (Ffigwr 6). Fodd bynnag, mae'n ymddangos bod Cymru'n cael anhawster i gynnal safonau diogel pan fydd galwadau tymhorol ar eu hanterth:

Ffigwr 6: Tueddiadau marwolaethau Trawma ac Orthopaedeg a addaswyd yn ôl risg, 2009-11, Cymru a Lloegr



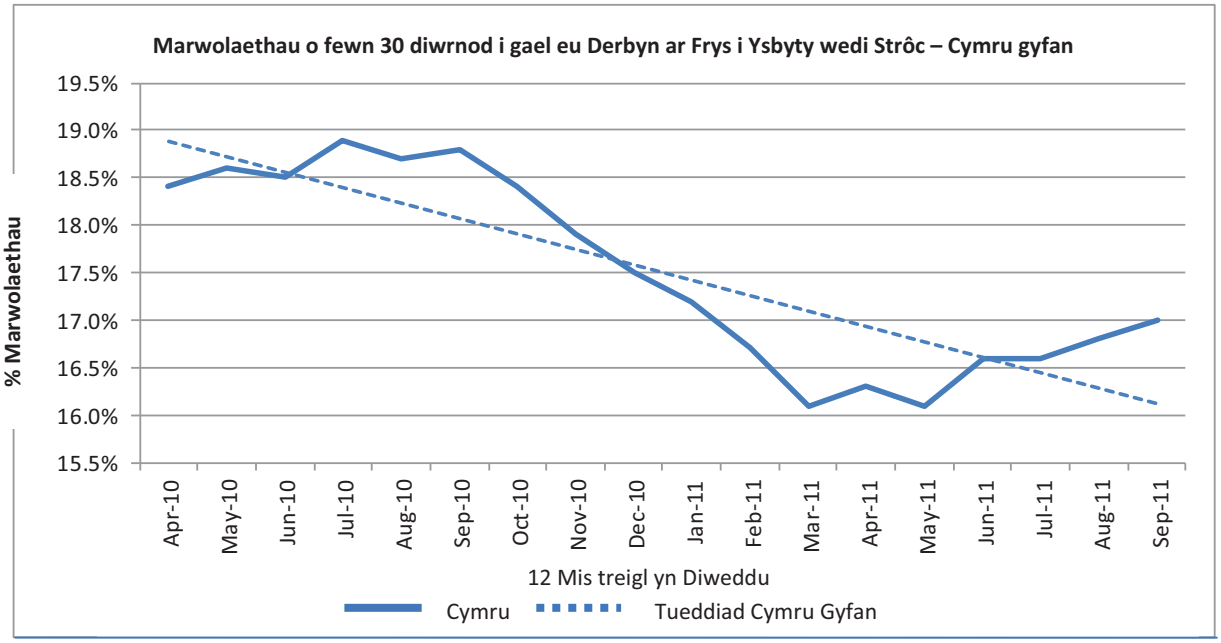
Mae hyn hefyd yn cael ei adlewyrchu yn amcangyfrifiad 'mynegai marwolaethau ychwanegol y gaeaf', sy'n dangos bod Cymru'n aml yn perfformio'n waeth nag ardaloedd tebyg yn Lloegr (Ffigwr 7):

Ffigwr 7: Mynegai marwolaethau ychwanegol y gaeaf*, oed 0-64, yn ôl ardal, o 2005/6 at 2010/11*



Ym maes gofal strôc, cafwyd gwelliant amlwg yn y canlyniadau ers i Goleg Brenhinol y Meddygon gynnal archwiliad seminaidd (Ffigwr 8):

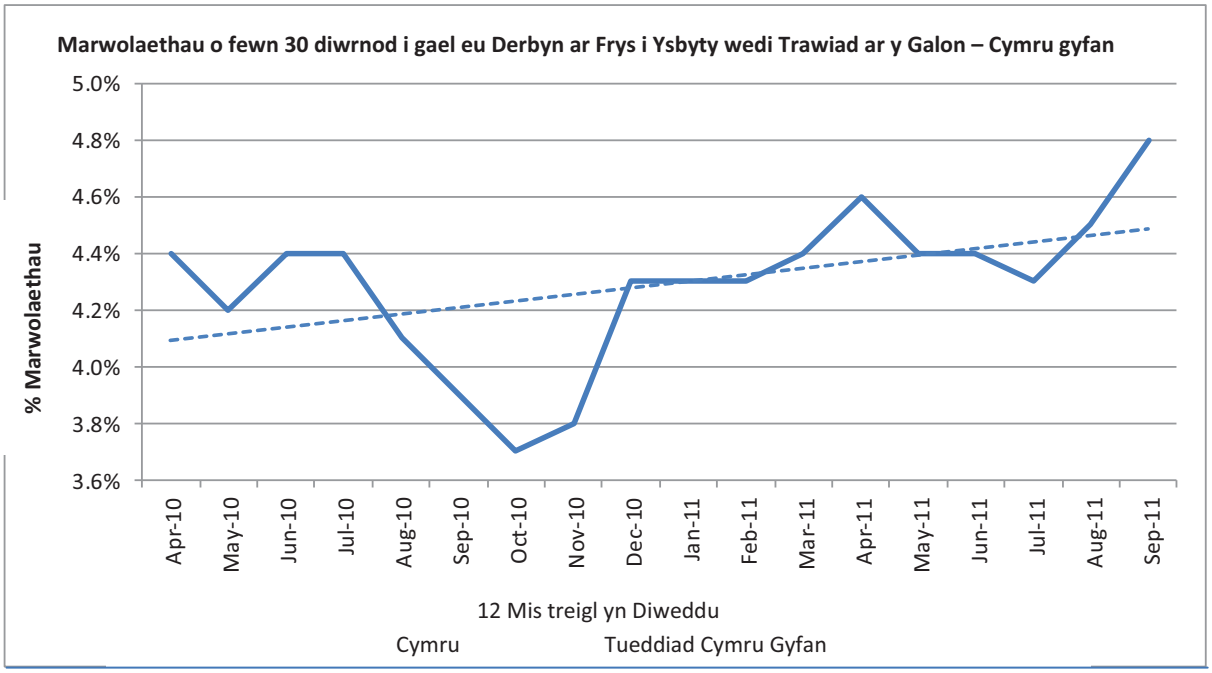
Ffigwr 8: Marwolaethau mewn ysbytai o fewn 30 diwrnod i dderbyn brys ar gyfer Strôc, Cymru, 2010-11



Fodd bynnag, mae data mis Rhagfyr 2011 yn dangos amrywiaeth eang mewn perfformiad rhwng ysbytai o ran cydymffurfio â'r safonau y cytunwyd arnyn nhw ar gyfer diwrnod cyntaf hollbwysig ôl ofal strôc. Mae'r rhain yn amrywio o dros 95% o gydymffurfiad mewn pedair o'r pymtheg ysbyty sy'n darparu gofal strôc yng Nghymryu hyd at o dan 50% o gydymffurfiad mewn dwy ysbyty.

Mae'n ymddangos bod marwolaethau ar ôl derbyn ar frys ar ôl trawiad yng Nghymru (Ffigwr 9):

Ffigwr 9: Marwolaethau mewn ysbyty o fewn 30 diwrnod i gael eu derbyn ar frys oherwydd trawiad, Cymru, 2010-11



Seilir ffurf arall o ddata canlyniadau ar archwilio adrannau unigol a chymharu'r hyn y maen nhw wedi'i gyflawni gydag unedau tebyg mewn rhywle arall. Un o'r mwyaf ydy bas data Rhwydwaith Ymchwil

Archwiliad Trawma (TARN) sy'n darparu gwybodaeth fanwl am berfformiad a chanlyniadau ar gyfer adrannau Damweiniau ac Achosion Brys. Yn anffodus, dim ond chwech o'r 13 Adran Ddamweiniau ac Achosion Brys a ddarparodd ddata ar gyfer Bas data TARN. Mae Ffigwr 10 yn darparu crynodeb o fesur y rhai a oroesodd yn annisgwyl neu farwolaethau rhwng 2008 a 2011 lle mae 0 yn awgrymu perfformiad cyfartalog a nifer positif yn well na'r cyfartaledd. Mae'r data hyn yn gyffredinol dda, ond yn anffodus does dim data ar gael ar gyfer dros hanner unedau Cymru:

Ffigwr 10: Canlyniadau cymharol Adrannau Damweiniau ac Achosion Brys, Cymru, 2008-11

Bwrdd Iechyd Lleol	Ysbyty	Cyfradd Goroesi
Caerdydd a'r Fro	Ysbyty Prifysgol Cymru	2.9 ychwanegol a oroesodd/100 o gleifion
Betsi Cadwaladr	Glan Clwyd	0.2 ychwanegol a oroesodd/100
	Wrecsam Maelor	1.6 ychwanegol a oroesodd/100
	Ysbyty Gwynedd	2.7 ychwanegol a oroesodd/100
Abertawe Bro Morgannwg	Treforys	1.7 ychwanegol a oroesodd/100
	Tywysoges Cymru	0.7 mwy o farwolaethau/100
Aneurin Bevan	Nevill Hall	Dim data
	Brenhinol Gwent	
Cwm Taf	Brenhinol Morgannwg	
	Tywysog Cymru	
Hywel Dda	Bronglais	
	Ysbyty Cyffredinol Gorllewin Cymru	
	Llwynhelyg	

Dimensiwn arall a gafodd lawer o sylw yn Lloegr a Chymru fel ei gilydd yn ddiweddar ydy effaith pa ddiwrnod o'r wythnos y derbynnir cleifion. Yn y ddwy wlad, mae tystiolaeth sy'n peri pryder bod cleifion sy'n cael eu derbyn yn ystod y penwythnos – ac yn enwedig ar Ddydd Sul – yn fwy tebygol o farw na'r rhai a dderbyniwyd rhwng Ddydd Llun a Dydd Gwener (Ffigwr 11):

Ffigwr 11: Marwolaethau mewn ysbyty fesul dydd y derbyn, Cymru, 2010-11

Tabl 3: Graddfa Marwolaethau heb gyfri Pediatreg, Obstetreg a Bydwreigiaeth yn ol Dydd Derbyn ac Ysbyty

Ysbyty Derbyn	Llun	Mawrth	Mercher	Iau	Gwener	Sadwrn	Sul	Cymhareb Perygl
Ysbyty Bronglais	4.99%	5.59%	4.41%	7.86%	6.53%	6.72%	4.15%	1.89
Ysbyty Glan Clwyd	6.13%	6.10%	6.26%	5.87%	5.30%	6.03%	6.39%	1.21
Ysbyty Gyffredinol Gorllewin Cymru	5.63%	5.15%	5.67%	4.92%	5.75%	6.94%	6.00%	1.41
Ysbyty Treforys	4.62%	5.13%	5.41%	4.93%	5.93%	5.23%	6.00%	1.30
Ysbyty Nevill Hall	4.76%	4.51%	4.32%	5.15%	5.73%	5.00%	6.86%	1.59
Ysbyty Tywysog Siarl	5.50%	4.69%	4.97%	4.58%	5.36%	5.24%	6.48%	1.42
Ysbyty Tywysoges Cymru	7.60%	7.06%	6.82%	8.06%	7.18%	8.41%	8.06%	1.23
Ysbyty Frenhinol Morgannwg	6.00%	6.32%	5.94%	6.75%	5.41%	7.21%	7.68%	1.42
Ysbyty Frenhinol Gwent	3.97%	4.50%	4.82%	4.85%	4.36%	5.56%	5.65%	1.42
Ysbyty Prifysgol Cymru	5.56%	5.56%	5.21%	5.55%	6.13%	5.02%	5.90%	1.22
Ysbyty Llwynhelyg	5.63%	5.88%	5.19%	6.66%	5.56%	7.25%	6.63%	1.40
Ysbyty Maelor Wrecsam	4.71%	5.28%	5.15%	5.53%	5.37%	5.86%	6.01%	1.28
Ysbyty Gwynedd	6.44%	5.59%	5.29%	4.79%	4.86%	4.97%	4.80%	1.34
Cyfanswm	**5.35%**	**5.36%**	**5.32%**	**5.54%**	**5.49%**	**5.90%**	**6.22%**	**1.17**

Nodiadau: Mae'r data'n cyfeirio at ryddhau o'r ysbyty rhwng Medi 2010 ac Awst 2011 yn gynwysedig
Mae'r data yn ymweud â derbyn ar frys i'r ysbyty yn unig
Mae'r data yn ymdrin â chleifion oedd angen triniaeth arbenigol ac eithrio Pediatreg, Obstetreg a Bydwreigiaeth
Mae 'Ysbyty Freninol Morgannwg' yn cynnwys marwolaethau ym maes 'Gwasanaethau iechyd meddwl yn Ysbyty Frenhinol Morgannwg'
Mae Ysbyty Gwynedd yn cynnwys marwolaethau yn 'Ysbyty Gwynedd (seiciatrig)'
Mae'r dydd o'r wythnos lle gwelir y raddfa uchaf o farwolaethau ym mhob ysbyty yn cael eu nodi mewn llwyd tywyll a'r dydd â'r raddfa isaf mewn glas golau
Cymhareb Perygl ydy cymhareb graddfa uchaf o farwolaethau ar y diwrnod gyda'r raddfa isaf o farwolaethau ar y diwrnod

Ffynhonnell : NWIS

Mae'r patrwm yn amrywio o arbenigedd i arbenigedd, ond prin ydy'r rhai sy'n sicrhau cysondeb drwy'r wythnos. Mae'n amrywio mewn mewn rhai arbenigeddau a hyd yn oed yn fwy amlwg na'r darlun cyffredinol – er enghraifft, marwolaethau cleifion sydd wedi torri pen y glun yn ardal asgwrn eu morddwyd yn seiliedig ar y diwrnod y cafodd y claf ei dderbyn (Ffigwr 12):

Ffigwr 12 Marwolaethau cleifion sydd wedi torri pen y glun yn ardal asgwrn eu morddwyd yn seiliedig ar y diwrnod y cafodd y claf ei dderbyn, Cymru, Medi 2010-Hydref 2011

Graddfa marwolaethau	Sul	Llun	Maw	Merch	Iau	Gwen	Sad	Cyfan	Cymhareb Perygl
Betsi Cadwaladr	6.0%	6.6%	5.9%	4.0%	7.9%	8.3%	4.9%	6.2%	2.1
Hywel Dda	2.4%	4.3%	4.4%	6.1%	5.9%	8.5%	5.7%	5.4%	3.6
Abertawe Bro Morgannwg	13.4%	4.0%	13.6%	6.2%	10.4%	10.9%	7.5%	9.2%	3.4
Caerdydd a'r Fro	14.9%	15.1%	9.1%	6.4%	5.5%	13.5%	7.8%	10.3%	2.7
Cwm Taf	5.7%	8.0%	9.4%	4.1%	8.8%	3.2%	13.2%	7.7%	4.1
Aneurin Bevan	7.9%	9.0%	3.8%	10.1%	4.3%	6.7%	9.0%	7.2%	2.6
Powys	0.0%	20.0%	3.7%	3.6%	4.0%	0.0%	0.0%	4.5%	
Cymru gyfan	8.0%	7.7%	7.0%	6.0%	7.2%	8.6%	7.5%	7.4%	1.4

Noder: i ddeall effaith y niferoedd foliwm dylid ystyried y graddfeydd marwolaethau ynghyd â nifer y marwolaethau/nifer y rhai dderbynnir i'r ysbyty.

Yn dynodi'r dydd â'r raddfa uchaf o farwolaethau
Yn dynodi'r dydd â'r raddfa isaf o farwolaethau
* Mae'r Cymhareb Perygl yn cymharu'r dydd gwaethaf gyda'r dydd gorau – e.e. mae cleifion Cwm Taf bedair gwaith yn fwy tebygol o farw ar y Sadwrn o'i gymharu â'r dydd Gwener.

Mae materion diffinio ac ansawdd yn peryglu'r holl ddata hwn a dylid eu trin i gyd gyda gofal. Fodd bynnag, maen nhw'n awgrymu bod yna achos i bryderu am ganlyniadau clinigol mewn arbenigeddau allweddol, ac yn ôl y diwrnod derbyn i'r ysbyty.

Nawr, ystyriwn y dystiolaeth sy'n cysylltu'r modelau gwasanaeth â chanlyniadau clinigol.

B. Modelau Gwasanaeth

Er bod data canlyniadau yn werthfawr i amlygu problemau, dydyn nhw ddim o anghenrhaid yn dangos achosion y problemau hyn, a gellir dehongli faint o ddylanwad mae trefniant yr ysbytai wedi cael arnyn nhw (o'u cyferbynnu â ffactorau eraill a adolygir yn Adran 3.1.C isod). Dull arall o fynd ati ydy ystyried sut mae gwasnaethau'n cael eu trefnu a gofyn cwestiynau: ydy modelau gwasanaeth ysbytai Cymru yn dilyn tystiolaeth am arferion da?

Neges fwyaf amlwg y dystiolaeth am fodelau gwasanaeth ydy ei bod yn amhosibl i gyffredinoli ar draws gwahanol arbenigeddau gofal iechyd cyfoes: mae'r materion yn aml yn wahanol, felly mae angen ystyried pob un yn unigol.

Yr ail ganlyniad, a'r un mwyaf rhwystredig, ydy nad oes gennym ddigon o dystiolaeth yn aml, i fod yn sicr am y trefniant perffaith. Mae gwneud ymchwil yn y maes hwn – sefydlu cyswllt argyhoeddiadol rhwng y modd y mae gwasanaethau yn cael eu darparu a chanlyniadau - yn wirioneddol anodd, yn bennaf oherwydd bod cymaint o elfennau mewn model gwasanaeth, a bod cymaint o ffactorau eraill a allai ddylanwadu ar ganlyniadau. Mae ystod o dystiolaeth o amryfal o hapdreialon graddfa fawr wedi'u rheoli (y dystiolaeth gryfaf), os ydy ymchwilwyr wedi ceisio ystyried yr holl newidynnau hyd at gonsensws barn arbenigwyr yn seiliedig ar dystiolaeth a fyddai'n amhendant. Yr un cyntaf ydy'r agosaf at 'brawf' a allwn ei

gael, ond yn eitha prin; mae'r un olaf yn llawer mwy cyffredin ac yn sicr yn werthfawr, ond dydy arbenigwyr ddim bob amser yn gywir a dylid trin eu barn yn ofalus. Yn y canol, mae corff cynyddol o astudiaethau sy'n chwilio am gysylltiadau ystadegol rhwng modelau a chanlyniadau, gan wneud ymgais i reoli newidynnau dryslyd.

Mae '*caveat'* arall: dydy prinder tystiolaeth am niwed ddim yn dystiolaeth bod prinder niwed. Mewn geiriau eraill, oherwydd na allwn 'brofi' bod model yn niweidiol, dydy hynny ddim yn golygu y dylwn gymryd yn ganiataol ei fod yn ddiogel. Mae angen rhagor o ymchwil bob amser!

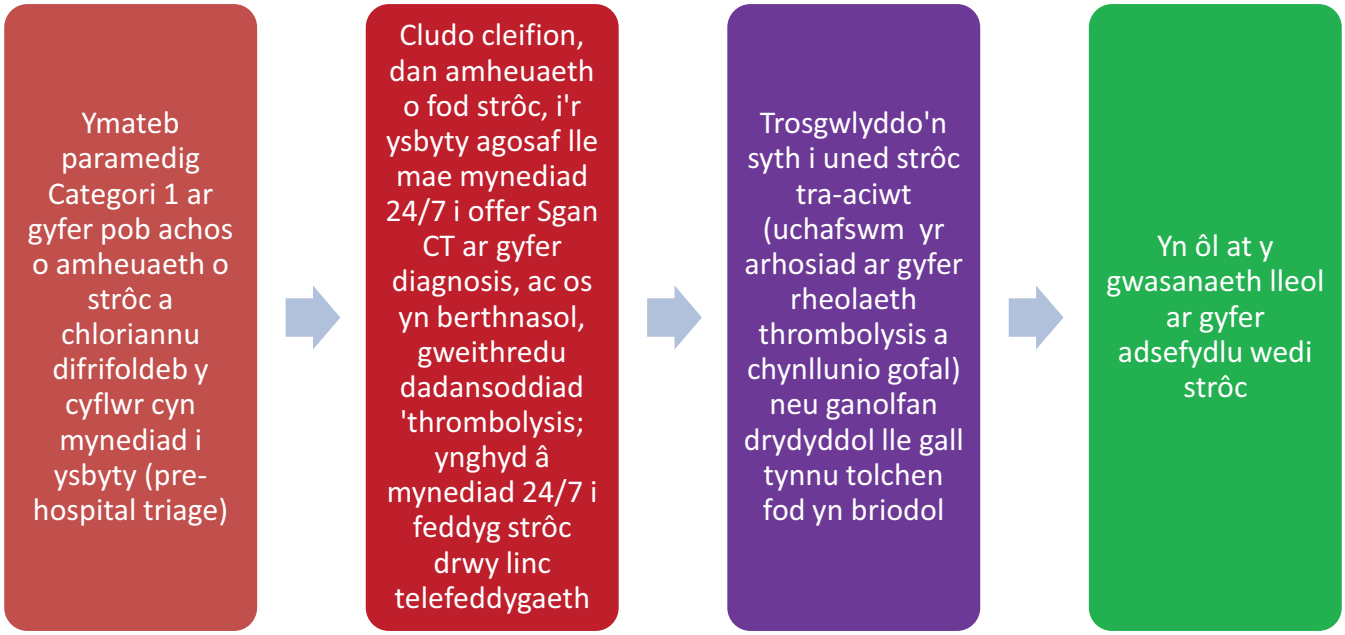
Ar sail y dystiolaeth sydd ar gael fodd bynnag, mae nifer o arbenigeddau lle gallwn fod yn rhesymol sicr eim bod yn gwybod sut i drefnu gwasanaethau:

1. **Gwasanaethau Trawma Difrifol** (h.y. anafiadau niferus i wahanol feinweoedd a systemau organau sy'n peryglu bywyd neu a allai beryglu bywyd). Mae tystiolaeth o ganlyniadau buddiol pan gaiff cleifion trawma difrifol eu trin mewn canolfan sy'n arbenigo mewn trawma difrifol. Mewn blwyddyn arferol mae tua 1000 o gleifion yng Nghymru yn dioddef trawma difrifol:
    - Mae datganoli'r gofal i ganolfannau trawma arbenigol rhanbarthol yn gostwng cyfradd y marwolaethau o 25% a hyd yr arhosiad o 4 diwrnod
    - Mae canolfannau sy'n delio â swmp mawr o drawma yn gostwng cyfradd marwolaethau o anafiadau difrifol hyd at 50%
    - Yn anad dim, yr amser a gymer rhwng yr anaf yn digwydd a chael y llawdriniaeth derfynol sy'n penderfynu'r canlyniad mewn trawma difrifol (nid yr amser i gyrraedd yr adran argyfwng agosaf)
    - Mae cleifion trawma difrifol a gafodd eu trin yn y lle cyntaf mewn ysbytai lleol yn 1.5 hyd at 5 gwaith mwy tebygol o farw na chleifion a gafodd eu cludo'n uniongyrchol i ganolfannau trawma.
    - Gallai un ganolfan fel arfer wasanaethau poblogaeth o 3-4 miliwn.

2. **Trawma Cyffredinol a Gofal Mewn Argyfwng –** mae tystiolaeth ar gael ar gyfer rhai cleifion (megis cleifion yn dioddef o ymlediad toredig aortaidd yn yr abdomen) o ganlyniadau'n gwella wrth i faint yr uned gynyddu, ond nid yw'n ystadegol arwyddocaol. Yr hyn sy'n gwneud y mwyaf o wahaniaeth ydy gwasanaethau sy'n cwrdd â safonau clinigol ac yn dilyn llwybrau argymelledig yn gyson, waeth beth fo maint yr uned. Mae mwy a mwy o dystiolaeth bod canlyniadau'n well pan fo uwch feddygon yn bresennol 24/7 ac mae hyn yn mynd yn fwyfwy anodd i'w gyflawni mewn unedau llai:
    - Ceir canlyniadau gwell pan fo uwch feddyg ar gael ac wrth law 24/7
    - Ychydig o dystiolaeth (gwan) bod canlyniadau'n gwella ar gyfer rhai llawdriniaethau (e.e. ymlediad toredig aortaidd yn yr abdomen) yn ôl maint yr uned.
    - Mae cydymffurfio â safonau a llwybrau clinigol yn bwysicach na maint (yn aml mae ysbytai llai yn cydymffurfio'n well)
    - Gellir gostwng yr amser cyn i'r claf gael ei drin drwy ddarpariaeth symudol mewn rhai achosion.

3. **Gofal Strôc** – Mae'r dystiolaeth yn awgrymu bod cleifion sy'n dod i mewn i adran 'uned strôc tra-aciwt') sy'n cydymffurfio â safonau gofal strôc aciwt yn fwy tebygol o gael gwell canlyniadau. Mae'n bwysig sicrhau mynediad diymdroi i ganolfan niwro lawdriniaethol ar gyfer nifer fechan iawn o gleifion a aseswyd eu bod yn addas ar gyfer tynnu clot. Byddai'r trefniant perffaith yn sicrhau'r canlynol (Ffigwr 13):

Ffigwr 13 Llwybr Strôc



4. **Gwasanaethau Gofal Mamolaeth a'r Newydd anedig –** Does dim tystiolaeth o gysylltiad cyson rhwng canlyniadau a maint uned ac fel y cyfryw, ni ellir dod i unrhyw gasgliad o'r ymchwil sydd wedi'i gyhoeddi. I ferched a aseswyd eu bod yn isel eu risg, mae unedau bydwreigiaeth yn ymddangos yn ddiogel i'r babi ac yn cynnig manteision i'r fam ac mae'r un peth yn wir am eni yn eu cartref i ferched sy'n cael eu hail neu eu trydydd plentyn. Y cyngor proffesiynol y mae Canllawiau Coleg Brenhinol yr Obstetryddion a Gynaecolegwyr yn ei gynnig ydy y dylai unedau sy'n cynnig gofal obstetreg sicrhau lleiafswm oriau o bresenoldeb obstetryddion ymgynghorol pwrpasol ar y wardiau obstetreg bob wythnos. Byddai cwrdd â'r safon hwn yn debygol o arwain at lai o unedau obstetreg yng Nghymru o gofio'r nifer o obstetryddion sy'n ymarfer yng Nghymru.

5. **Gwasanaethau Pediatreg –** Does dim tystiolaeth o gysylltiad cyson rhwng canlyniadau a maint uned, ac fel y cyfryw, ni ellir dod i unrhyw gasgliad o'r ymchwil sydd wedi'i gyhoeddi. Mae'r cyfarwyddyd a geir yn Safonau Coleg Brenhinol Pediatreg ac Iechyd Plant yn argymell na ddylai unedau pediatreg bychan sy'n derbyn llai na 1800 o blant bob blwyddyn barhau i fodoli, onibai eu bod mewn lleoedd anghysbell. Byddai cwrdd â'r safon hwn yn arwain at lai o unedau pediatreg ar gyfer cleifion preswyl yng Nghymru er bod yr hyn mae'n ei olygu i wasanaethau pediatreg mewn ysbytai heb uned bediatreg breswyl yn llai eglur.

O ran arbenigeddau eraill, mae'r cyswllt rhwng maint uned/niferoedd cleifion ac ansawdd y gofal yn llai eglur. Er enghraifft, yn achos arbenigeddau llawdriniaethol, ceir tystiolaeth dda sy'n cysylltu canlyniadau cleifion â foliwm y *llawfeddyg unigol* yn hytrach na foliwm *yr ysbyty.* Daeth Gweithgor Ail-drefnu o Goleg Brenhinol Llawfeddygon Lloegr 2006 i'r casgliad y gellid, yn achos llawer o lawdriniaeth gyffredinol gyflawni'r cyfansymiau hyn drwy rwydweithio clinigol yn hytrach na thrwy ganolbwyntio ar safleodd ysbytai unigol.

Mewn achosion eraill, cysylltir canoli gyda gwelliant dramatig yn y canlyniadau. Yng Ngogledd Cymru, er enghraifft, yn flaenorol, cynhaliwyd rhai llawdriniaethau arbenigol ar y llwnc a'r stumog ('oesophagectomi'

a ‘gastrectomi’) mewn pedair Ysbyty Cyffredinol Dosbarth, ond bum mlynedd yn ôl, fe’u canolwyd mewn un ysbyty a chafwyd gwelliant sylweddol ym maes y llwnc - ‘oesophagectomi’:

- erbyn hyn mae ffigyrau goroesi pedair mlynedd yn dangos bod marwolaethau yn yr ysbyty yn 3% o’u cymharu â chyfartaledd y DU o 4.5%
- mae cyfraddau ail-lawdrinaieth yn 6% o’u cymharu â chyfartaledd y DU o 10%

ac ar gyfer maes gastrectomi:

- roedd marwolaethau yn yr ysbyty yn 5% o’i gymharu â chyfartaledd y DU o 6%
- mae cyfraddau ail-lawdriniaeth nawr yn 1% o’u cymharu â chyfartaledd y DU o 7%

Mae teuluoedd cleifion yn cael cynnig llety mewn gwesty os ydyn nhw wedi teithio o bell, yn enwedig yn ystod y dyddiau cynnar ar ôl llawdriniaeth.

Fodd bynnag, mae’r fffaith bod rhai o’r arbenigeddau yn dibynnu ar ei gilydd yn cymhlethu pethau ymhellach. Y syniad oedd wrth wraidd ysbytai Dosbarth yn 1962 oedd ceisio sefydlu clwstwr o arbenigeddau yn dibynnol ar ei gilydd mewn un lle. Yn y 50 mlynedd canlynol, mae’r manylion wedi newid, ond mae’r egwyddor yn parhau. Er enghraifft, yn achos gofal mewn argyfwng, nawr derbynnir yn gyffredinol bod angen lleiafswm set o wasanaethau aciwt ar y safle i ddarparu adran gwasanaeth diogel ar gyfer argyfwng. (Ffigwr 14):

Ffigwr 14 Gwasanaethau sydd eu hangen i gynorthwyo adran argyfwng

Cymorth Ar y Safle drwy Fynediad 24 Awr ar gyfer:
Meddygaeth Aciwt
Gofal Critigol Lefel Dau
Uned Gofal Coronari Heb fod yn Driniaeth drwy’r Croen
Labordy Gwasanaethau Hanfodol (biocemeg, haematoleg, trallwysiad gwaed, rheoli haint a gwasanaethau mortiwari)
Radioleg Diagnostig (Pelydr-X, uwchsain a Sgan CT)
Cymorth Mynediad Rhwydwaith 24 Awr i Drefn o Ysbytai Lleol sy’n Cyd-rannu Gwasanaethau (ddim o anghenraid ar y safle) ar gyfer:
Llawdriniaeth Frys
Trawma & Orthopaedeg
Pediatreg
Obstetreg & Gynaecoleg
Iecdyd Meddwl
Llawdriniaeth a Oruchwylir
Radioleg sy’n golygu triniaeth drwy’r croen

Felly, hwyrach bydd rhaid i rai arbenigeddau newid neu ail-leoli, nid oherwydd bod eu model gofal yn annigonol ond er mwyn dilyn arbenigeddau eraill sy’n ddibynnol arnyn nhw.

C. Penderfynyddion eraill ar ansawdd a diogelwch

Mae’r drafodaeth hyd yn hyn wedi canolbwytnio ar y cysylltiad posibl rhwng foliwm ac ansawdd/diogelwch y gofal, oherwydd profwyd taw hwn ydy un o’r elfennau lle ceir mwyaf o ddadlau yn ei gylch wrth aildrefnu gwasanaethau iechyd ar daws y DU. Ond ceir nifer o benderfynyddion eraill am ansawdd a diogelwch gwasanaethau ysbytai, sydd o leiaf wedi’u seilio yr un mor gryf ar dystiolaeth.

O fewn yr ysbytai eu hunain , rydyn ni'n gwybod er enghraifft bod y canlynol yn bwysig:

- Lefelau, cymhwysterau, hyfforddiant a'r defnydd o staff – mae llawer o waith wedi'i wneud ar staffio nyrsio, er enghraifft
- Yr adnoddau sydd ar gael ar gyfer elfennau allweddol y system
- Cadw at y canllawiau a llwybrau gofal yn seilieidig ar dystiolaeth
- Cymhwyso tystiolaeth ymchwil

ac mae ansawdd a diogelwch y gofal mewn ysbyty yn cael ei effeithio'n uniongyrchol gan yr hyn sy'n digwydd tu allan, er enghraifft:

- Maint, ansawdd a threfniant gwasnaethau sylfaenol a chymunedol
- Yr adnoddau sydd ar gael yn y gymuned leol i ofalu am ei iechyd a'i les ei hun.

Mae llawer o'r ffactorau hyn yn amherthnasol i faint ysbyty; gellir sefydlu cydberthynas rhwng ffactorau eraill â maint ysbyty, weithiau'n gwbl groes. Yn fyr, gallai trefnu ysbytai fod yn elfen anghenrheidiol i sicrhau ansawdd a diogelwch, fydd e byth yn ddigonol ynddo'i hun.

D. Casgliadau

Er gwaetha'r holl 'caveats' angenrheidiol am y dystiolaeth, mae'n eglur:

- Na all cleifion mewn ysbytai yng Nghymru fod yn hyderus y bydd eu canlyniadau bob amser yn rhai 'cystal â'r goreuon yn unrhyw le', fel yr awgrymodd Comisiwn Bevan y dylai pethau fod
- Nad ydy rhannau allweddol o'r gwasanaeth ysbyty wedi eu trefnu fel dylen nhw fod

Bydd angen i'r GIG ystyried sawl math o ysbytai o wahanol fathau y gallan nhw eu cynnal os ydyw am sicrhau bod y canlyniadau i'r cleifion i fod y gorau posibl, ym mhob ysbyty, ar bob adeg yn ystod yr wythnos.

II. Y GWEITHLU

Mae'r adran hon yn adolygu lefelau staffio cyfredol elfennau allweddol o wasanaeth ysbytai Cymru, ar hyn o bryd a chyhyd i'r dyfodol ac y gellir ei ragweld, i weld os ydyn nhw'n creu unrhyw fygythiad i ansawdd a diogelwch y gwasanaethau. Yn y broses, y nod ydy helpu i ateb y cwestiwn: **Mae ganddon ni fwy o staff nag erioed, felly beth ydy'r broblem?** Mae'r ffocws yn bennaf ar y staff meddygol, oherwydd mai yno, yn ôl yr honiad, mae'r problemau mwyaf i'w cael, ond caiff rhai o'r materion allweddol sy'n effeithio ar staff eraill yn y sector ysbytai hefyd eu hadolygu'n fras. Ceir rhagor o wybodaeth yn y papur atodol ar Y Gweithlu.

A. Staffio Meddygol: Y Storom Berffaith

Wrth ystyried lefelau staffio meddygol mewn ysbytai yng Nghymru, yn syth y mae yna baradocs: mae gennym fwy o feddygon ysbytai yng Nghymru nag erioed o'r blaen (yn y deng mlynedd diwethaf, mae niferoedd meddygon ysbytai yng Nghymru wedi cynyddu 49% (+1,807 o swyddi llawn amser cyfwerth), yn

cynnwys cynnydd o 66% o ymgynghorwyr (+836)), ac eto mae llawer o sôn am brinder difrifol mewn ardaloedd allweddol. Sut gall y ddau beth fod yn wir?

Erys yr ateb yn y 'storom berffaith' lle gostyngir argaeledd a chynyddir y galw:

- Gostyngiad yn y mewnbwn meddygol sydd ar gael: er bod cyfanswm y niferoedd wedi cynyddu, mae'r amser clinigol a ddarperir gan bob meddyg wedi gostwng wrth i effaith y canlynol gael ei weithredu:
  - Y Gyfarwyddeb Oriau Gwaith Ewropeaidd: rhwng 2007 a 2011, cynyddodd nifer y doctoriaid oedd yn hyfforddi yng Nghymru o 2748 hyd at 2810, ond gostyngodd nifer yr oriau gwaith wythnosol o 134,206 i 126,651; a
  - newidiadau i'r contract i feddygon ymgynghorol: yn 2004, ar gyfartaledd roedd ymgynghorwyr yn gweithio cyfanswm o 11.5 sesiwn yr wythnos, gyda 9.3 yn rhai clinigol; erbyn 2010 roedd hyn wedi gostwng i fod yn 10.4, gyda 7.9 yn rhai clinigol.

  Cymhlethir hyn fwy-fwy gan fod
  - meddygon dan hyfforddiant (yn arbennig merched) yn gynyddol yn dewis gweithio llai o oriau er mwyn sefydlu gwell cydbwysedd rhwng gwaith a bywyd: ar hyn o bryd mae 7.5% (203) o feddygon dan hyfforddiant yn gweithio llai na llawn amser.
- Cynnydd yn y lleiafswm sy'n ddisgwyliedig ar gyfer meddygon:
  - O ganlyniad i'r newidiadau nodwyd uchod, bu adolygiad yn nifer yr ymgynghorwyr sydd eu hangen ar gyfer rotas y staff: mewn meysydd arbenigedd mawr, megis trawma a llawdriniaeth cyffredinol, bellach mae angen 8 ymgynghorydd i gynnal rota weithredol.
  - Mae'r dystiolaeth a nodir yn yr adran flaenorol am effaith niweidiol prinder staff hŷn i weithredu 24/7 wedi cynyddu rhagor yn y galw am uwch staff.
- Problemau recriwtio mewn rhai meysydd arbenigedd, yn aml drwy'r holl DU, wedi ei gymhlethu weithiau gan batrymau hyfforddi annymunol, (e.e. lle mae meddygon iau yn teimlo nad ydyn nhw'n cael digon o oruchwyliaeth) a thrwy gyflenwad cyfnewidiol o ddoctoriaid tramor.
- Tuedd tymor hir i gael rhagor o is-arbenigedd – ar un adeg, disgwylid i arbenigwyr wneud llawdriniaethau ar amrywiaeth o rannau o'r corff – i drin pob math o gyflyrau. Dros gyfnod, fodd bynnag, daeth nifer o feysydd arbenigol i'r amlwg. Er enghraifft, ar hyn o bryd, dyma rai o'r meysydd arbenigol sydd heb fod yn rhai llawfeddygol: Cardiothorasig; Llawfeddygaeth Niwro; Llawfeddygaeth y genau a'r wyneb; Otolaryngoleg (ENT); Llawfeddygaeth Pediatrig; Llawfeddygaeth Blastic; Trawma ac Orthopaedeg (T&O); Wroleg; Llawfeddygaeth Gyffredinol. O fewn Llawfeddygaeth Gyffredinol mae nifer o 'Feysydd o Ddiddordeb Cyffredinol', gan gynnwys Gastroberfeddol Uchaf; Colorectal; Fasgiwlar; Brest ac Oncoplastig; Trawsblaniadau; Endocrin. gwelir patrwm tebyg ym maes meddygaeth. Mae hyn yn gwneud ysbytai bach yn llai deniadol i lawer o ddarpar ymgynghorwyr, ac yn cynyddu'r galw cyffredinol am ymgynghorwyr.

Gwelir effaith y newidiadau cydamserol hyn yn y trafferthion recriwtio ar hyd a lled Cymru. Dengys ffigwr 15 y meysydd arbenigol lle mae Byrddau Iechyd Lleol yn cael trafferthion recriwtio. Nid yr oedi sy'n aml yn dod yn sgil prosesau biwrocrataidd penodi mo'r rhain: Mae'r rhain yn broblemau parhaus, lle bydd adrannau'n ceisio llanw bylchau gyda staff dros-dro, ac yn aml yn cael prinderau staff difrifol a llawn stres – ac weithiau'n llawn risg:

Ffigwr 15: Problemau recriwtio staff meddygol yn ôl Arbenigedd: Cymru

Arbenigedd	Nifer Byrddau Iechyd â thrafferthion recriwtio	Prinder Cenedlaethol?
Damweiniau&Argyfwng (A&E)	6	Oes
Pediatreg	6	Oes
Iechyd Meddwl/CAMHS	6	Oes
Radioleg Clinigol	4	Na
Meddygol/Geriatreg*	4	?
Anaestheteg	3	Oes
Microbioleg	3	Oes
Obstetreg a Gynaecoleg	3	Oes

*Ffynhonnell: Cynlluniau gweithlu Byrddau Iechyd Lleol 2010/11 *Yr is-arbenigedd heb fod yn eglur*

Mae hefyd effaith ariannol ar y prinderau hyn. Mae costau staff meddygol o asiantiaethau, er enghraifft, yn uchel ac yn cynyddu yng Nghymru (Ffigwr 16):

Ffigwr 16 Dadansoddiad Asiantaethau yn y 6ed mis 2011/12

	Blwyddyn Lawn 2010/11	2011/12 hyd at fis Medi
Abertawe Bro Morgannwg	£3.282 m	£2.023 m
Aneurin Bevan	£2.031 m	£1.027 m
Betsi Cadwaladr	£13.351 m	£7.083 m
Caerdydd a'r Fro	£2.67 m	£1.296 m
Cwm Taf	£3.977 m	£2.085 m
Hywel Dda	£5.275 m	£3.357 m
Powys	£0.217 m	£0.062 m
Iechyd Cyhoeddus	£0.017 m	£0 m
Felindre	£0.146 m	£0.003 m
Ambiwlans Cymru	£0 m	£0 m
Cyfanswm	**£30.966 miliwn**	**£16.936 miliwn**
Rhagfynegiad i ddiwedd y flwyddyn		£33.872 miliwn

B. Arbenigedd dan bwysau

Gyda'r cefndir hwn o'r 'storom berffaith', mae rhai meysydd arbenigedd a hyfforddiant wedi eu heffeithio'n arw iawn, ynghyd â rhai o'r mannau mwy diarffordd o Gymru. Gall tensiynau godi rhwng anghenion i GIG i feddygon dan hyfforddiant i gadw'r gwasanaethau i fod yn hyfyw, ac oblygiadau'r Ddeoniaeth Ôl-radd, Y Cyngor Meddygol Cyffredinol, y Colegau Brenhinol ac eraill i sicrhau lefelau digonol o hyfforddiant a phrofiad perthnasol a dilyniant proffesiynol. Mewn marchnad recriwtio sy'n agored i'r DU, gall dymuniadau'r hyfforddai eu hunain fod yn arf pwerus i newid pethau. Mae'r pedwar maes isod yn dangos ble mae'r pwysau yn ei anterth yng Nghymru:

1. **Pediatreg –** Mae recriwtio ym maes Pediatreg wedi bod yn isel dros y 2-3 blynedd diwethaf, a does dim argoelion yng Nghymru na thrwy'r DU y bydd y sefyllfa'n cael ei datrys yn y tymor byr na chanolig. Fel dengys Ffigwr 15, mae pob un o Fyrddau Iechyd Cymru yn cael trafferthion recriwtio parhaus yn y maes arbenigol hwn. Mae hyn yn creu problemau penodol gan fod yna ormod o unedau pediatrig i gleifion preswyl, ac felly gormod o rotas staff meddygol, ar gyfer y niferoedd o ddoctoriaid sydd ar gael. Mae nifer o rotas na ellir bellach eu staffio mewn modd sy'n cydymffurfio a dyma'r broblem sydd ar y funud yn gorfod cael ei hwynebu mewn tri o'r byrddau iechyd. Yn y rownd recriwtio ddiweddaraf penodwyd 11 lle roedd 20 swydd wag. Mae arolwg y GMC yn dangos bod baich gwaith hyfforddai Pediatrig yng Nghymru ymhlith yr uchf yn y DU, ac yng Nghymru mae'r esiamplau isaf a'r ail isaf yn y DU o gydymffurfio â'r Gyfarwyddeb Oriau Gwaith. Mae hyn i gyd wedi arwain i'r Coleg Brenhinol Pediatreg ac Iechyd Plant yng Nghymru i ddatgan *'nad oes modd i'r ddarpariaeth pediatrig i gleifion preswyl yng Nghymru fod yn gynaliadwy drwy lawn weithredu'r Gyfarwyddeb Oriau Gwaith yn 2009. Mae gan Gymru ormod o unedau pediatreg cleifion preswyl gyda gormod o rotas graddfeydd canolig. Mae dirfawr angen gostwng nifer yr unedau pediatreg cleifion preswyl a chynyddu'n sylweddol y nifer o Ymgynghorwyr yng Nghymru'.*

2. **Meddygaeth argyfwng** – mae hyn yn broblem drwy'r DU i gyd. Mae'r GMC ar y funud yn cynnal adolygiad o'r 'cover' ym maes Meddygaeth Argyfwng ym mhob adran ar hyd a lled y DU. Mae gofid penodol am arolygaeth Doctoriaid Sylfaen dros nos yn yr adrannau Damwain ac Argyfwng. Mae'r Ddeoniaeth wedi ceisio lleihau hyn yng Nghymru, ond bod angen adolygiad ar fyrder o'r mannau lle gosodir yr hyfforddiant, gan ei fod wedi ei daenu'n rhy denau rhwng gormod o adrannau. Mae pob un o Fyrddau Iechyd Cymru yn cael trafferthion recriwtio parhaus yn yr arbenigedd hwn (Ffigwr 15). Dengys arolwg y GMC bod baich gwaith Damweiniau ac Argyfwng (A&E) yng Nghymru yr uchaf yn y DU. Dydy hyn ddim yn help i'r broses recriwtio. Mae Cymru tua'r hanner isaf o ran cydymffurfio â'r Gyfarwyddeb Oriau Gwaith. Eleni mae hanner y nifer o ddoctoriaid graddfa ganol yn y broses benodi a dim ond 11 penodiad a wnaed lle roedd 20 swydd wag.

3. **Hyfforddiant Llawfeddygol Craidd** yng Nghymru - mae hyn wedi bod yn broblem ers amser maith. Yn wahanol i faes pediatreg, mae gormodedd o Hyfforddai Llawfeddygol Craidd heb obaith o fynd ymlaen i hyfforddiant uwch gan nad oes yna ddigon o swyddi ymgynghorol ar eu cyfer. Caiff hyn effaith ar y recriwtio i'r swyddi hynny, ond mae'r gwasanaeth yn ymddangos yn ddibynnol ar eu presenoldeb. Mae canlyniadau'r arholiadau ym maes Hyfforddiant Llawfeddygol Craidd ac mae cymhareb y gystadleuaeth ymhlith y rhai sy'n ceisio mynd ymlaen am hyfforddiant uwch ymhlith y rhai uchaf yn y DU. Dengys arolwg y GMC mai Cymru ydy'r gwaethaf yn y DU am foddhad cyffredinol ac ymhlith yr isaf o ran profiad digonol. Mae'r Ddeoniaeth yn gostwng niferoedd yr Hyfforddai Llawfeddygol Craidd dros y ddwy flynedd nesaf er mwyn lleihau'r gymhareb gystadleuol, gwella ansawdd yr ymgeiswyr a lleihau nifer y mannau y gall yr Hyfforddai Craidd weithio. Fodd bynnag, fydd y Ddeoniaeth ddim yn gostwng niferoedd yr hyfforddai uwch felly bydd Cymru'r parhau i gynhyrchu'r un nifer o lawfeddygon cymwysedig.

4. **Seiciatreg –** Mae hyfforddiant seiciatrig yn ofid arall drwy'r cyfan o'r DU gyda'r niferoedd wedi gostwng drwy'r DU, ac yn arbennig o argyfyngus yng Nghymru. Unwaith eto, gyda'r arbenigedd hwn, mae gormod o leoliadau lle gwelir Meddygon Iau'n gweithredu heb oruchwyliaeth 'allan o oriau'. Bydd y Ddeoniaeth yn adolygu'r rhain yn y misoedd nesaf ac yn tynnu Meddygon Iau o'r gwasanaeth 'allan o

oriau'. Bydd hyn, yn anochel, yn effeithio ar ddarpariaeth y gwasanaeth, ond y mae yn gyson â gofynion y GMC. Dengys arolwg y GMC o'r hyfforddai foddhad cyffredinol isel, gyda rhai'n cofnodi diffyg profiad digonol â goruchwyliaeth addysgol wael.

Bydd peidio â datrys y problemau hyn yn achosi bylchau mewn staffio, a bydd hyn, yn ei dro, yn bygwth diogelwch ac ansawdd y gwasanaeth, a'i gynaliadwyedd.

Tu allan i'r ysbytai, mae'r sefyllfa gyda'r meddygon teulu hefyd yn creu trafferthion. Mae llawer o feddygon teulu Cymru'n debygol o ymddeol dros y blynyddoedd nesaf, ac mae recriwtio ar gyfer swyddi hyfforddi meddygon teulu eisoes yn achosi problemau mewn rhannau o Gymru (maes lle bu Cymru unwaith yn gryf ynddo). Bydd hyn hefyd yn achosi her i wasanaethau ysbytai, lle mae'r nod ydy trosglwyddo rhai gwasanaethau i'r gymuned.

C. Staff Anfeddygol

Canolbwyntiwyd hyd yma ar y staff meddygol, gan mai dyma lle gwelir y pwysau ar ei waethaf, ac mewn rhai mannau'n bygwth y dilyniant gofal dros y misoedd nesaf. Ond mae gofal diogel ac o safon uchel hefyd yn dibynnu ar yr holl staff arall – y nyrsus, bydwragedd, y staff proffesiynol gofal iechyd perthynol, gwyddonwyr gofal iechyd, ac eraill – ac y maen nhw hefyd yn wynebu cyfres o sialensiau a chyfleoedd.

Mae'r GIG wedi bod yn brysur yn creu swyddogaethau newydd i lawer o'r grwpiau staff hyn. Er enghraifft, caiff y presgripsiwn ar gyfer rhai cleifion bellach ei roi gan nyrsus a fferyllwyr, tra bo cleifion eraill yn mynychu adrannau mân niweidiau lle mae'r nyrsus yn darparu'r cyfan o'r gofal. Ceir uwch ymarferwyr yn y mwyafrif o broffesiynau gofal iechyd, yn gweithio ar lefelau uchel iawn o ofal arbenigol ac yn cymryd cyfrifoldeb dros yr holl wasanaeth a ddarperir. Wrth i elfennau o'r gwasanaeth gael eu trosglwyddo yn gynyddol o ysbytai i'r gymuned, mae staff ysbytai yn caffael lefel newydd o sgiliau a darparu modelau gofal.

Mae rheolwyr lleol hefyd yn ystyried yn ofalus y gymysgedd fwyaf addas o sgiliau mewn timoedd clinigol. O ganlyniad, mae staff yn cymryd cyfrifoldebau oedd yn flaenorol yn cael eu hysgwyddo gan eraill: nyrsys yn cymryd lle meddygon, staff cymorth yn cymryd lle pobl broffesiynol gofrestredig y gwahanol ddisgyblaethau a staff yn darparu ystod ehangach o wasanaethau ar gyfer eu cleifion er mwyn gostwng nifer y bobl broffesiynol y mae rhaid i bob claf ryngweithio â nhw. Mae potensial i newidiadau o'r fath ddarparu gofal o'r ansawdd flaenaf y mae cleifion yn ei werthfawrogi'n fawr, ond hefyd potensial i liniaru'r broblem o brinder meddygon – er enghraifft mewn unedau mân anafiadau.

Yn gyffredinol, mae gweithlu gofal iechyd yn heneiddio, ac yn fuan bydd hyn yn achosi sialensiau mewn meysydd penodol. Mae rhai o'r meysydd darpariaeth mwy arbenigol yn ei chael hi'n anodd recriwtio ac mae'r gystadleuaeth am staff yn cynyddu o du gwledydd tramor sydd yn cael anhawsterau recriwto eu hunain.

Mae mwyafrif o'r newidiadau hyn â goblygiadau i addysg a hyfforddiant staff anfeddygol, ac mae rhaid i gomisiynu'r mewnbwn addysgol hwn gyd-symud gyda'r newidiadau. Mae'r niferoedd a recriwtiwyd ar gyfer addysg cyn-cofrestru wedi codi a gostwng dros y degawdau diwethaf ac mae hyn yn ei gwneud hi'n

anodd cynllunio gweithlu cyson. Mae cyfran sylweddol o holl addysg broffesiynol yn digwydd ar ôl y cymhwyso cychwynnol ac mae angen cydweithredu agos rhwng y GIG a'r Prifysgolion er mwyn cyflenwi datblygiad proffesiynol parhaus o'r fath – i ryddhau staff ar gyfer rolau newydd tra roedden nhw'n dal dan bwysau yn eu rolau cyfredol ac i ragweld pa sgiliau newydd fydd eu hangen.

Bydd y darpar newidiadau i ail-drefnu ysbytai yn dibynnu ar y broses barhaus hon o addasu a datblygu ymhlith y gweithlu anfeddygol a dull cydgysylltiol o fynd ati i ddelio ag addysg, darparu gwasanaeth a sicrhau ansawdd.

D Casgliadau

Mae rhai rhannau o'r gwasanaeth ysbytai yng Nghymru'n wynebu prinder difrifol o staff meddygol. Mae hyn yn deilliaw o newidiadau tymor hir mewn patrymau gwaith sy'n gyffredin ar draws y DU, sydd wedi ei waethygu mewn rhai meysydd arbenigedd yng Nghymru oherwydd bod adnoddau meddygol prin yn cael eu taenu rhwng llawer o ysbytai. Gall hyn hefyd olygu nad oes staff ar gael ym mhobman i sicrhau safon uchel o ofal dros 24 y dydd, 7 diwrnod yr wythnos. Gall recriwtio staff ychwanegol helpu mewn rhai ardaloedd, ond o wybod bod yr un pwysau ar ysbytai drwy'r DU, mae'n anhebygol y bydd hyn yn datrys y mater. Gallai sefydlu rol newydd i staff a modelau gwasanaeth newydd liniaru'r mater, ond mae'r broblem bellach yn fater o frys, gan y bydd meddygon dan hyfforddiant yn debygol o gael eu symud o rai adrannau mewn ysbytai yn 2012. Mae sialensiau eraill yn wynebu'r gweithlu ehangach o fewn y GIC, gan gynnwys y ddibyniaeth ar staff sy'n debygol o ymddeol yn y degawd nesaf a'r angen i fatsio hyfforddiant i anghenion y gwasanaeth yn y dyfodol.

III. MYNEDIAD

Bu cryn drafod yr angen i ganoli rhai o agweddau mwy arbenigol gofal ysbyty mewn nifer llai o ysbytai – ac felly i lawer o bobl ysbytai mwy anghysbell. Hyd yn hyn, yn y papur hwn, rydyn ni wedi ystyried cryfder y dystiolaeth ar gyfer hyn, o safbwynt diogelwch/ansawdd ac o safbwynt y pwysau ar weithluoedd. Mae'r adran hon yn ysytired yr hyn mae 'mynediad' yn ei olygu, y risgiau posibl o gael gwasanaethau ymhellach i ffwrdd a'r hyn y gellid ei wneud i leihau effaith ar gleifion drwy gael gwasanaethau mwy anghysbell. Mae'n help i ateb ein trydydd cwestiwn: **Ydy gwaeth mynediad yn anochel er mwyn sicrhau ansawdd a diogelwch da?** Ceir gwybodaeth bellach yn y papur cysylltieidig ar Fynediad.

A. Beth ydyn ni'n ei olygu wrth 'Fynediad'?

Ar yr olwg gyntaf, mae hwn yn gwestiwn pedantig: ai pa mor *hawdd* a *chyflym* ydy hi i gael y gofal *sydd ei angen arnon ni* pan fyddwn ni ei angen ydy'r ystyr? Er enghraifft:

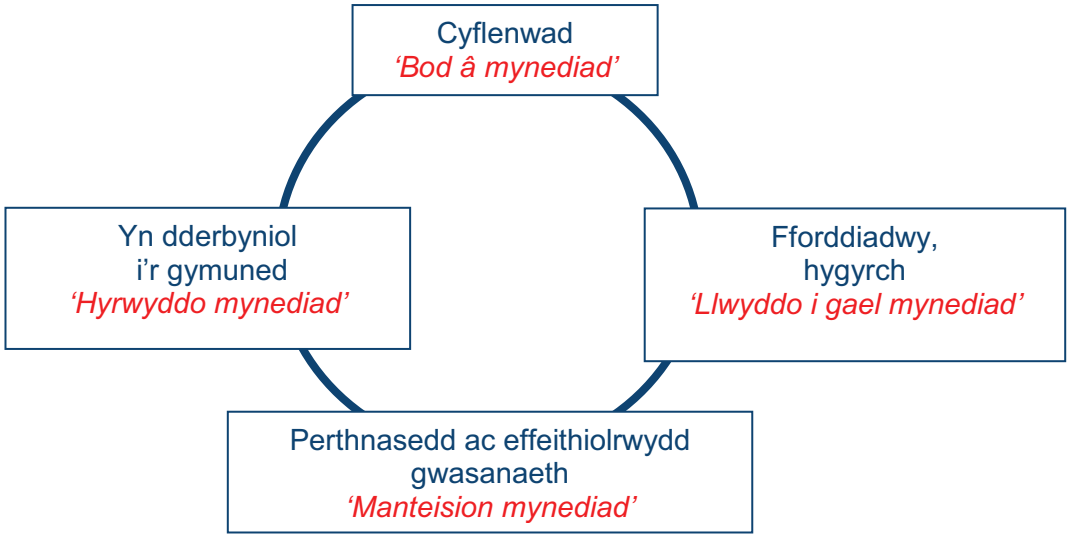
- Mae **pa mor hawdd** ydy cael mynediad yn golygu gwahanol bethau mewn gwahanol amgylchiadau: gallai pobl ddisgwyl mynediad gwahanol ar gyfer un ymweliad i weld ymgynghorydd ysbyty o'i gymharu ag ymweliadau misol, cyson dros nifer o flynyddoedd;
- Mae **mynediad cyflym** hefyd yn dibynnu ar amgylchiadau: mae'n gynyddol bosibl i symud gofal argyfwng ar ei union at y bobl, yn hytrach na'u cludo nhw i'r ysbyty.

Ac yn bwysicach fyth:

- Mae'r **gofal sydd ei angen arnon ni** yn ddimensiwn critigol – dydy mynediad syth i ofal gwael ddim o werth i neb.

Rydyn ni'n gwybod bod pobl yn disgwyl lefelau gwahanol o fynediad, yn dibynnu ar lefel eu hangen a natur eu cyflwr. Felly, mae angen i wasanaethau sicrhau mynediad yn y modd graddedig hwn, ac mae hyn yn golygu llawer mwy na lleoliad y gwasanaethau ('cael mynediad' yn Ffigwr 17):

Ffigwr 17: Dimensiwn Mynediad



B. Ydy amseroedd teithio hirach yn golygu canlyniadau gwaeth?

Mae lleoliad y gwasanaethau – ac felly'r amser teithio – yn bwysig er hynny ac i bobl yn dioddef o gyflyrau sy'n bygwth eu bywyd, gallai fod yn fater o fywyd neu farwolaeth. Mae rhai astudiaethau wedi dangos bod cyswllt rhwng amser teithio a chanlyniadau diffygiol, er enghraifft geni plentyn, problemau anadlu difrifol ac asthma, mae eraill wedi methu â dod o hyd i unrhyw gysylltiad. Mewn rhai achosion y broblem ydy'r pellter i wasanaethau Meddyg Teulu (a hynny'n golygu oedi yn y diagnosis) yn hytrach nag ysbytai; y broblem mewn achosion eraill ydy pa mor anghysbell mae gwasanaethau'r ysbytai eu hunain.

Fodd bynnag, ymhob achos, y broblem ydy'r amser mae'n ei gymryd i gael *mynediad i'r gofal priodol*. Mewn llawer o achosion, oherwydd y dull mae gwasanaethau wedi'u trefnu ar hyn o bryd, mae hyn yr un amser ac mae'n ei gymryd i fynd i'r ysbyty. Ond y rheswm dros hyn yn aml, ydy nad ydy'r gofal cyn mynd i'r ysbyty ddim wedi'i ddatblygu'n dda a'r unig opsiwn ydy rhuthro pobl i'r ysbyty. Mewn gwledydd eraill, sefydlwyd gwasanethau o ofalu am bobl, yn hytrach na'u symud i ofal, yn aml gan ddefnyddio rhwydwaith ddatblygedig o gyfleusterau symudol ar gyfer triniaeth, ar y ffordd (cyfleusterau clinigol symudol datblygedig) a'r awyr (hofrennydd ac awyren).

Yn yr Alban, er enghraifft, yn y rhan fwyaf o'r wlad – gan gynnwys yr ardaloedd mwyaf anghysbell – gellir cyrraedd pobl yn dioddef o argyfyngau sy'n bygwth eu bywyd o fewn 45 munud ymhob tywydd ar wahân i'r tywydd mwyaf gerwin a darparu dulliau sefydlogi o safon fyd eang a'u trosglwyddo i'r ysbyty yn ôl yr angen. Byddai dibynnu'n unig ar wasanaethau ambiwlans confensiynol yn golygu amser llawer hirach a

chanlyniadau gwaeth. O gymhwyso'r un model i Gymru awgrymir na fyddai'r amser aros am fynediad ddim mwy nag 20-30 munud ar draws y wlad.

I grynhoi, yr hyn sy'n cyfrif ydy'r **amser o gychwyn y driniaeth briodol** yn hytrach na'r amser a gymer i fynd i'r ysbyty. Yn gynyddol, nid yr un peth ydy'r rhain.

C. Beth a ellir ei wneud i leihau effaith gwasanaeth mwy anghysbell?

Fel yr ydyn ni wedi gweld, mae mynediad yn golygu llawer mwy nag amser teithio. Gall y GIG leihau effaith cael gwasandethau anghysbell mewn nifer o ffyrdd.

Yn gyntaf, gall technoleg fod o help. Rydyn ni'n dechrau ystyried potensial technoleg mewn pedwar maes:

- Cynorthwyo hunan ofal – e.e. telefonitro yn y cartref ar gyfer pobl yn dioddef o gyflyrau hirdymor, mynediad haws i wybodaeth ar hunan ofal
- Cynorthwyo cyflenwi gofal mwy diogel – e.e. cofnodi iechyd electronig a fyddai'n galluogi i ddata ar gleifion gael ei gyfleu rhwng pobl broffesiynol
- Galluogi cyflenwi gwasanaethau yn fwy lleol – e.e. rhith dimoedd gofal iechyd, yn cynnwys pobl broffesiynol gofal iechyd sy'n cydweithio a rhannu gwybodaeth am gleifion yn ddigidol
- Cynorthwyo effeithiolrwydd – e.e. datrys amseroedd apwyntiadau, rheoli data cleifion, gweithio symudol

Yn ail, mae corff sylweddol o dystiolaeth yn dangos gwahanol ffyrdd o leihau'r angen am wasanaethau ysbyty. Ymhlith y rhain mae sicrhau dilyniant gofal sylfaenol, darparu gwasanaethau ysbyty yn y cartref, rheoli achos â phendantrwydd ym maes iechyd meddwl, uwch adolygiad cynnar yn yr Adran Ddamweiniau ac Achosion Brys, ymyriadau aml-ddisgyblaethol a thelemonitro diffyg y galon, integreiddio gofal sylfaenol ac eilradd, cynllunio rhyddhau strwythuredig a rhaglenni gofal iechyd wedi'u personoli.

Yn drydydd, mae'r math o ddatblygiad mewn gofal argyfwng cyn mynd i'r ysbyty a ddisgrifiwyd uchod yn lleihau'r angen i dderbyn cleifion i'r ysbyty mewn rhai achosion.

Yn olaf, y broblem sy'n effeithio fwyaf ar y rhan fwyaf o gleifion ydy pa mor ddigonol ydy cludiant di-frys i'r ysbyty ac o'r ysbyty, ar gyfer cleifion ac (yn achos cleifion preswyl) ar gyfer eu hymwelwyr. Ceir amrywiaeth o fesurau gan gynnwys gwell cyfathrebu, effeithiolrwydd y ddarpariaeth a thargedu cludiant a gomisiynwyd gan y GIG a all wella gwasanaethau – gafodd eu tanlinellu'n ddiweddar yn Adolygiad Griffiths. Ar ben hyn cafwyd nifer o ymdrechion i wella cludiant cyhoeddus a pharcio ceir, weithiau'n llwyddiannus. Gall cynnig llety gwesty i berthnasau cleifion os ydyn nhw'n gorfod teithio'n bell (cyn belled â Gogledd Cymru yn yr enghraifft a ddyfynwyd yn gynharach) liniaru rhai o effeithiau bod yn anghysbell.

D Casgliadau

Mae cael mynediad rhwydd ac amserol i ofal yn bwysig, i arbed bywydau, ac i leihau'r anhwylustod i gleifion a'u hymwelwyr, yn arbennig y rhai heb fod â defnydd rhwydd o gar. Gall technoleg newydd a dulliau newydd o weithio ostwng effaith gwasanaethau ysbyty sydd ymhell i ffwrdd – drwy wella cludiant argyfwng a di-argyfwng, a thrwy fwy o ddefnydd o ddulliau tele-ofal. Mewn achosion brys, y mater

pwysicaf yn aml ydy'r amser y derbynnir y gofal, sydd yn gynyddol heb fod yr un peth a'r amser i gyrraedd yr ysbyty. Ar gyfer gofal achosion heb fod yn rhai argyfwng, cafodd llawer ei gyflawni – a gellid gwneud rhagor – i symud y gofal o'r ysbytai, ond bydd niferoedd sylweddol o bobl yn parhau i fod angen teithio, ac i'r rhain, gall mynediad fod yn anodd.

IV. COST

Mae'r GIG yn hen gyfarwydd â bod dan bwysau ariannol. Mae dau fath o bwysau: effaith hirdymor y cynnydd mewn disgwyliadau a phoblogaeth sy'n heneiddio gyda phroblemau cronig difrifol; a chyfyngiadau cyllidebol tymor byr dros y blynyddoedd nesaf. O ran y cyntaf, mae'r Swyddfa Cyfrifoldeb Cyllidebol yn amcangyfrif y bydd angen i'r GIG, oherwydd goblygiadau poblogaeth sy'n heneiddio, gynyddu ei ran o gynnyrch mewnwladol crynswth o 8.0% yn 2009/10 i 10.2% yn 2039/40 dim ond er mwyn aros yn ei unfan. Mae problem gynyddol o ordewdra ymhlith y boblogaeth ac yng Nghymru amcangyfrifwyd bod problem gordewdra ac alcohol yn costio £140miliwn i'r GIG yn 2008/09. Yn ychwanegol at ymateb i'r ffactorau hyn, mae pwysau'r costau ar yr ochr cyflenwi: cost cynyddol moddion newydd a chost cyflogi staff yn ddwy enghraifft bwysig. Yn y tymor byr, mae goblygiadau cyllidol yr argyfwng bancio wedi treiddio i GIG Cymru erbyn hyn. Mae Swyddfa Archwilio Cymru yn amcangyfrif y bydd bwlch cyllido (h.y. y gwahaniaeth rhwng yr hyn fyddai angen ar GIG Cymru i aros yn ei unfan a'r hyn fydd yn ei dderbyn) o rhwng £252m a £445m erbyn 2013/14.

Ni fu erioed bwysau cyllidol tebyg yn hanes GIG yn y byrdymor na'r hirdymor. Nid yn unig bydd rhaid i'r GIG wella'u effeithiolrwydd drwy wneud i'w wasanaethau cyfredol weithio'n well, ond hefyd bydd rhaid iddo newid y gwasanaethau hynny'n sylweddol os ydyn nhw am fod yn gynaliadwy. Felly ai arbed arian ydy pwrpas ail-drefnu ysbytai?

Dydy'r dystiolaeth ar effaith cost ail-drefnu ysbytai ddim yn derfynol: weithiau mae'n arbed arian, weithiau mae'n niwtral o ran cost, bryd arall mae'n cynyddu'r gost. Mae'r darlun yn aml yn cael ei ddrysu gan oblygiadau cost newid na ellir ei ragweld a gan gyd-ddigwyddiad newidiadau eraill i'r gwasanaeth. Oherwydd y cymhlethdod hwn, mae'n anhebygol y bydd unrhyw ail-drefnu gwasanaeth yn arwain i *gynnydd* net mewn costau – yn wahanol i newidiadau blaenorol i'r gwasanaeth – oherwydd y pwysau ariannol y crybwyllwyd uchod.

Yn gyffredinol, mae'r pwysau demograffig a chyllidol yn ail-bwysleisio pwysigrwydd mynd i'r afael â phenderfynyddion gofal iechyd o safon fyd eang a amlinellwyd yn adran 2.1 uchod, gan gynnwys helpu pobl i ofalu amdanyn nhw eu hunain yn well a symud gofal o'r ysbytai a thriniaeth i'r gymuned ac ataliad. I ateb ein cwestiwn gwreiddiol, **A allwn ni fforddio gwella'r gwasanaeth?** mae'r ateb yn amodol: ni allwn ei fforddio, os ydy gwelliant yn golygu gwario llawer mwy o arian. Ar y llaw arall, mae digon o bethau amlwg aneffeithiol yn y gwasanaeth presennol i fod yn optimistaidd. Arhoswn am y costiadau manwl.

4. CASGLIADAU

Bwriad y papur hwn oedd ceisio rhoi atebion gonest i rai cwestiynau syml. Ar sail y dystiolaeth a geir yma – sef crynodeb o'r hyn sydd yn y tair ddogfen gysylltiol – pa gasgliadau gallwn ni eu cynnig?

Ar Ddiogelwch ac Ansawdd, y cwestiwn oedd: **Beth sydd o'i le ar batrwm presennol ein gwasanaethau ysbytai?** Yr ateb ydy bod ein canlyniadau, o ran llawer o bethau yn ymddangos yn waeth na mannau eraill. Mae'r rhesymau dros y perfformiad hwn yn amrywio, a dydyn nhw ddim bob amser yn eglur. Ar y llaw arall, gallwn fod yn rhesymol sicr nad ydy nifer o'n modelau gwasanaeth (yn arbennig ym maes trawma difrifol, gofal argyfwng cyffredinol, agweddau o ofal strôc, ychydig o lawdriniaethau arbenigol) yn cyrraedd safon fyd eang o bell ffordd a byddai'n rhesymol i ddod i'r casgliad bod pobl felly yn dioddef anabledd diangen a hyd yn oed yn marw o ganlyniad.

Am y Gweithlu, y cwestiwn oedd: **Mae mwy o staff nag erioed gyda ni, felly beth ydy'r broblem?** Yr ateb ydy ein bod wedi cyrraedd sefyllfa beryglus o ran nifer o grwpiau staff meddygol ac mae nawr yn bosibl rhagweld y bydd rhaid i wasanaethau gael eu cau mewn modd heb ei gynllunio yn y dyfodol agos os na weithredir yn ddioed. Does dim digon uwch staff gyda ni, lle mae eu hangen i sicrhau gofal o'r ansawdd uchaf i bawb, ac mae gwasanaethau sydd ddim yn gallu recriwtio staff allweddol o dan bwysau sylweddol ac mewn mwy o berygl. Datblygodd y sefyllfa hon dros amser gan ein bod yn mynnu mwy gan ein meddygon, yn arbennig pan fydd eu hamser clinigol yn lleihau ac yn gynyddol yn mynd yn fwy arbenigol. Mae meddygon dan hyfforddiant yn rhan allweddol o'r gwasanaeth, ond i rai, mae eu hyfforddiant yn annigonol ac ni all barhau. Mae llawer o'r problemau hyn yn gyffredin ar draws y DU ac mae rhaid i wasanaethau ymhob man ymateb mewn modd tebyg.

Ar Fynediad, y cwestiwn oedd: **Ydy gwaeth mynediad yn anochel er mwyn sicrhau ansawdd a diogelwch da?** Yr ateb i hynny ydy ei fod yn anochel mewn rhai achosion. Ond ym mwyafrif o achosion gellir gwneud llawer i liniaru'r broblem hon – gostwng yr angen am ofal ysbyty, defnyddio technolegau newydd, gwella cludiant a mynediad di-argyfwng a thrwy wella capasiti gofal argyfwng cyn cyrraedd yr ysyby. Effaith net yr holl fesurau hyn fyddai gwella mynediad i ofal argyfwng o'r ansawdd uchaf ac i gyfyngu problemau ysbytai anghysbell i nifer fechan o bobl sydd angen gofal arbenigol iawn ac i'r rhan fwyaf aciwt o'u 'llwybr'.

Ac o roi'r elfennau at ei gilydd: **Beth ydy'r ddadl dros newid?** Mewn gwirionedd, mae'r ddadl yn un gref iawn, yng Nghymru fel mewn mannau eraill yn y DU dros ail-drefnu gwasanaethau rhai ysbytai aciwt. Mae agweddau positif a negyddol i hyn. Ar yr ochr bositif, gallai ysbytai Cymru ddarparu gofal gwell mewn rhai agweddau allweddol, gostwng y risg o anabledd diangen a hyn yn oed marwolaeth. Ar yr ochr fwy negyddol, erbyn hyn gallai'r pwysau ar sicrhau argaeledd staff meddygol allweddol mewn nifer fechan o arbenigeddau mor fawr olygu chwalfa mewn rhai gwasanaethau. Gellir yn aml, liniaru effaith ail-drefnu a hefyd mae potensial i gynyddu'r mynediad i ofal argyfwng i bobl ar draws Cymru, hyd yn oed yn y cymunedau mwyaf anghysbell.

Drwy'r adolygiad hwn, mae dwy thema yn codi'u pen. Yn gyntaf, anaml y mae'r dystiolaeth yn ddigon eglur i arwain at ateb pendant. Felly, mae angen ei dehongli a'i chymhwyso i amgylchiadau arbennig ac mae angen i'w gosod yng nghyd-destun y cyd-ddibyniaethau cymhleth sy'n nodweddiadol o'r maes gofal iechyd modern. Yn ail, fel arfer mae polisi iechyd yn ymwneud â sefydlu cyfaddawdau derbyniol rhwng amcanion sy'n cystadlu yn erbyn ei gilydd – ansawdd a diogelwch, hygyrchedd, cost.

Felly, dyma'r papur hwn i chi – ymgais i gyflwyno crynodeb i ddarllenwyr an-arbenigol o'r hyn mae'r dystiolaeth yn ei gefnogi, fel y gallan nhw benderfynu drostyn nhw eu hunain.

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THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

Health and Social Care Committee

HSC(4)-23-12 paper 1c

Consideration of recently published correspondence between Welsh Government officials and Professor Marcus Longley – Information from the Welsh NHS Confederation

16 July 2012

National Assembly for Wales Health and Social Care Committee
Submission of information from the Welsh NHS Confederation

The Welsh NHS Confederation represents the seven Local Health Boards and three NHS Trusts that make up the NHS in Wales. We are a membership organisation, with charitable status.

In November 2011, The Minister for Health and Social Services published 'Together for Health,' the Welsh Government's five-year vision for the NHS in Wales. Later that month, the Welsh NHS Confederation held its annual conference, on the theme of 'Transformational Change – what does it take.'

Throughout the course of this fourth National Assembly, since it came into being in May 2011, the Confederation has been unequivocal in its core message; that the NHS must change if it is to provide high-quality and safe services and if the people of Wales are to have the improved health and healthcare services they deserve.

Together with our members, we have always recognised that there are difficult and potentially unpopular decisions ahead. Indeed we have already seen vehement public opposition when Health Boards have outlined potential options – even before plans have been drawn up.

We also recognised that the NHS in Wales has a responsibility to explain what it needs to do and why, at the same time as demonstrating the remarkable improvements already made by shifting some services from hospitals into local communities and even people's own homes.

It is of vital importance that the public has access to clear and independent information. The overarching purpose of commissioning information from the Welsh Institute for Health and Social Care (WIHSC) was to have the existing evidence collected in one place in an attempt to promote discussions and to inform the debate. The research presented an overall picture of why the NHS in Wales needs to change.

In summary:

- The research was commissioned from WIHSC by the seven Health Board Chief Executives in NHS Wales.
- The National Director for Together for Health liaised with WIHSC on behalf of the Chief Executives to facilitate access to information, and to monitor delivery of the research.
- The National Director for Together for Health was appointed to co-ordinate activity across NHS Wales. The Director is based at Cardiff and Vale University Health Board.
- Following discussions between the Chief Executives at their regular Peer Group meetings (facilitated by the Welsh NHS Confederation), the Confederation circulated (on 21 December 2011) a proposed scoping paper for the research (prepared by WIHSC) to the Chief Executives for their feedback by 6 January 2012. (Attachment 1).
- Following that feedback, work commenced at a cost of £29,000. The invoice from WIHSC was paid by Cardiff and Vale University Health Board (host Board for the National Director) on behalf of the other Health Boards.
- The first twenty copies of the final printed summary document were ready for collection by the Welsh NHS Confederation on 23 April. Bulk printing for the engagement and communications activity was ordered on 25 April.
- The research report(s) 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence' was presented at a briefing for Assembly Members in Ty Hywel on Wednesday 9 May 2012. This was followed by a media briefing and a number of stakeholder meetings throughout Wales, in the following days and weeks.
- The publication of the final report, the response to it from the NHS in Wales and associated communications activity was co-ordinated by the Welsh NHS Confederation.

Conclusion

The report 'The Best Configuration of Hospital Services for Wales: A Review of the Evidence' was commissioned by the NHS in Wales (specifically the Health Board Chief Executives through the National Director of Together for Health) to provide an independent overview of what the clinical evidence says about the best configuration for hospital services in Wales. Local Health Boards felt it was important that the public have ready access to clear and independent information to help them examine forthcoming service plans.

As Health Boards prepare to publish detailed options for healthcare services throughout Wales, it is even more important that information is readily available to the public as well as patients, their families and carers, and staff. This WIHSC piece of work, and its publication, represented a real and genuine attempt by Health Boards to inform a range of audiences and invite them to become involved in the debate.

At the Welsh NHS Confederation, we are deeply disappointed that the focus appears to have shifted from that important debate. The stark fact is that the NHS in Wales

has to change – something that is widely acknowledged in all quarters. The more authentic and well-informed the debate is about change, the better it will be for the future of healthcare services, and for the people of Wales.

From: Tegan Williams
Sent: 21 December 2011 15:21
To: All NHS Chief Executives
Subject: National case for Change

Prynhawn da, bawb.

Further to the Chief Executives' Peer Group meeting on Monday, I am pleased to forward to you the summary from Marcus Longley of the Welsh Institute for Health and Social Care on the proposed work around the national case for change. This sets out potential key headings – workforce, safety and access – on which the study will focus. The WIHSC team would be grateful for your comments by 6 January please (we can collate through the Welsh NHS Confederation here) as the timescale is quite tight.

In addition, to highlight the research, we are currently working on a programme of engagement with AMs/MPs which we expect to include a series of regional roundtable stakeholder events, a specific event for Assembly Members in Cardiff and 1-2-1 briefings with Opposition spokespeople and special advisers.

We look forward to receiving your feedback.

Cofion gorau – a Nadolig Llawen!

Helen

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THE NATIONAL CASE FOR CHANGE:
PROPOSED SCOPE OF DISCUSSION PAPERS AND ENGAGEMENT PROCESS

'Services best suited to Wales, but comparable with the best anywhere'.

1. Introduction

Two elements are proposed for this programme of work: a suite of discussion papers; and an engagement process (organised and facilitated by the Welsh NHS Confederation and WIHSC) to explore the material discussed in the papers, and other issues of interest. The purpose is to help provoke and inform a dispassionate and evidence-based discussion of the key issues relating to the national case for change, amongst both NHS staff and also external stakeholders (other statutory sector organisations, third sector, and interested 'lay' people, including elected representatives, media etc.). In this way, attention will be focused on principles and evidence, rather than the future of particular local elements of service provision. The discussion papers will provide a impartial and independent synthesis of the most important evidence relating to the key issues on which the national case for change hinges, and the engagement events will offer people an independently-facilitated, honest and structured opportunity to understand and challenge the evidence and arguments.

While the development of primary and community care services is an essential part of the future vision for the NHS and its strategies, the focus of this paper is primarily concerned with the changes affecting the future hospital infrastructure in Wales.

2. The Synthesis Framework

The framework used for the synthesis will bring together:

a) The range of the clinical and diagnostic services and the overall related proposals and implications that are central to the case for change
b) The key issues that are agreed as fundamental to the case for change: the workforce, quality and safety, access and sustainability
c) The context in which service change will be designed: current Welsh Government vision, strategy, policy and the health care standards that are a core requirement in the management and delivery of health care and relevant to the key issues that are the focus of this discussion paper.
d) The evidence with which to support the national case for change and on which to base the discussion within this paper including: current service and associated data, literature, best practice and service reviews, Inspector and Regulator Reports.

3. Scope of the discussion papers

Four discussion papers are proposed, to address the following:

Overview Paper

Using the framework set out above, this first paper will provide an overview of all the issues which are driving change, and briefly rehearse the main evidence. It will be accompanied by three other papers which will each explore one key issue in more depth:

The Workforce

Getting the right people with the right skills and competences in the right place at the right time:

- Consider current numbers (in post, vacancies, recruitment), longer-term trends, future projections.
- Overall review of the factors relevant to ensuring that the professional staff groups have the skills they need to work in a complex, changing NHS: team working, flexible working, streamlined workforce planning and development, maximizing the contribution of all staff to patient care, education and training, developing new and more flexible careers, developing the workforce to meet future demands.
- Review of the particular issues relating to the recruitment, training, deployment and retention of the medical workforce.
- Conclusions for discussion.

Safety

Will – we must want to improve; Ideas – we must know what to try; and Execution – we must know how to change. (Berwick, 2003 and Nolan, 2007).

- The clinical case for change: critical mass, range and depth of cover, clinical integration, scale of risk, etc.
- Clinical evidence base and Wales' overall performance.
- Conformance with clinical, professional and service standards.
- Evidence of best practice.
- Evidence of benefits/disbenefits of service change and rationalization.
- Conclusions for discussion

Access

Getting people to services or services to people.

- Access to secondary care including emergency, unscheduled and elective care including tertiary care and cross border services.
- Waiting times.
- Outreach - where and how services can be brought closer to local people when it is safe to do so.
- Use of new technology e-health, telemedicine and telecare - bringing services and information closer to people.
- Emergency and non-emergency transport.
- Conclusions for discussion.

Issues of Sustainability will be considered in each of the papers.

Professor Marcus Longley, Director, and Michael Ponton, Senior Fellow
Welsh Institute for Health and Social Care, University of Glamrogan

WIHSC, University of Glamorgan
20 December 2011

Food Hygiene Rating (Wales) Bill
Evidence from the Association of Convenience Stores

1. ACS (the Association of Convenience Stores) welcomes the opportunity to provide evidence to the Committee. ACS represents 33,500 local shops across the UK, the vast majority of which sell food products and are subject to food hygiene regulations. ACS recognises the importance of food hygiene regulations which prevent the contamination of food and the spread of disease, and continues to provide information and advice to members on this important area of the law.

2. However, ACS believes that these important measures must be proportionally implemented. New regulations should only be introduced in cases where there is clear public risk to customers, or where the outcomes justify the additional burden being placed on the food industry.

3. ACS outlines below the key reasons we do not believe it is necessary to introduce a compulsory Food Hygiene Rating Scheme (FHRS), which would create additional regulatory burden at a time when central Government is committed to reducing the amount of red tape faced by business.

Aim of the Bill

4. The consultation document on the draft Bill stated that the aim of the Bill is to reduce incidence of food-borne illness. However the Bill does not propose any measures which will strengthen food hygiene standards in stores. The Bill focuses on achieving two aims, firstly to create a compulsory FHRS, and secondly to require all food businesses to display their rating.

5. ACS argues that a compulsory scheme is unnecessary as the consultation's own Regulatory Impact Assessment (RIA) highlights that the current voluntary scheme is being operated by all 22 Local Authorities in Wales. As the current scheme has universal coverage, and there is no suggestion that any Authorities plan to withdraw from the scheme, further regulation is not required to achieve this aim.

6. The primary focus of the Bill, therefore, is to require premises to display their Food Hygiene Rating, in order to ensure customers have equal access to information and are better informed. While we understand the aim, this will not have any direct impact on the stated aim to reduce incidence of food-borne illness.

7. As a result, the estimated cost of £225,000 per year for the sector appears to be a disproportionate burden on businesses during what are already difficult economic times.

Impact on small firms

8. The consultation's own RIA acknowledged that this financial burden will be felt significantly more by small firms, many of whom may already be struggling due to the current economic climate. Much of the cost of the scheme will come from the reassessment of business ratings in cases where improvement works have been carried

out, or where ownership and food preparation and handling practices have been changed. While larger stores can more easily absorb these costs, for small businesses such fixed costs can signify a much greater hurdle. The result would be that larger stores would be able to afford to obtain and promote their newer ratings, which could constitute a commercial advantage over their smaller competitors.

Practical application

9. There are also likely to be practical considerations which would limit the intended result, even if the Bill were to be passed. The Bill states that a sticker showing the Food Hygiene Rating must be displayed in a prescribed location on the premises where it would be visible to customers. Due to the nature of some food businesses, this could prove problematic.

10. For shops, the key issue would be where the 'prescribed location' would be sited, and how prominent it must be. Convenience retailing involves the sale of many highly regulated products, most notably alcohol and tobacco. As a result, there is already a plethora of signage at the point of sale and throughout stores, from information highlighting that it is illegal to sell restricted products to those below the age of 18, to information on schemes such as Challenge 25, and educational material to promote how many units are in your drink.

11. While it may appear straight forward to require information to be publicly displayed, there is a real risk of the message getting lost amongst the existing signage, or worse, diluting the messages of the existing material displayed in store.

12. For these reasons, ACS does not believe that the Bill will be able to achieve its aims, and will instead place an unnecessary burden on convenience store retailers in Wales.

Alternative options

13. ACS believes there may be other solutions which should be explored before legislation is introduced. As the issue is predominantly the availability and use of Food Hygiene Ratings, the role of Government, Local Authorities, and the potential role of technology should be considered as a means of increasing the flow of information.

14. The Welsh Assembly or Local Authorities could maintain and distribute information on local amenities and their ratings as part of existing communications (such as tourism information). Technology could also play a role in making this information more accessible, through means such as mobile phone applications, which are able to identify local premises, and could include information as to their Food Hygiene Rating.

15. These measures are indicative of potential alternative solutions which would not place an additional regulatory or financial burden on the food industry in Wales.

The Draft Bill

17. Despite opposing the introduction of the Bill, ACS aims to also provide constructive comment on the proposed Draft Bill, in order to minimise the extent of the burden to the food industry should the Bill be enacted.

18. ACS outlines below a number of areas we feel would require improvement should the Bill be formally adopted.

Resourcing

19. The Bill makes no provision for additional resourcing. Local Authorities have assessed 13,500 premises to date, since the voluntary scheme came in in October 2010. In order to roll out this scheme to all 30,000 premises, and to ensure that all would be rated within a reasonable time and on a regular basis, ACS believes additional resources would be required. Without this, there is concern that re-ratings, which would provide a revenue stream for Local Authorities, could be prioritised over the day to day needs of businesses.

20. In order to ease the burden while the scheme was being rolled out, ACS believes a phased roll-out may also be appropriate. This would start with high priority establishments such as schools and hospitals, moving down to butchers, restaurants, stores etc. as appropriate. A phased roll-out would ease the pressure on resources and mean that the highest priority premises were covered as soon as possible.

Training of Food Authority (FA) officers

21. ACS is concerned of reports of inconsistencies in the application of the existing voluntary scheme, even within the same FA. ACS believes the Bill should contain a requirement for all officers receive standardised training, which would continue at suitable intervals during their employment. A sample of ratings should also be independently reviewed on an annual basis to ensure standards are applied consistently across the scheme.

Rating system and the need for public education

22. Members have expressed some concerns over the public understanding of Food Hygiene ratings. Customers who are not familiar with the ratings may consider that ratings reflect the public health risk of premises, rather than an officers view of legal compliance. The ratings also do not reflect the varying levels of risk between a small retail store compared to a busy high risk food restaurant or takeaway.

23. ACS believes that further work should be carried out to ensure the scoring criteria take account of these factors, and that the Welsh Government and Local Authorities should work together to create and provide materials to educate the public as to the meaning of the ratings.

Publication of inspection report summaries

24. ACS believes that inspection report summaries should only be published on condition that this would not further increase the costs and burden of this regulation on businesses.

Display of invalid stickers

25. The Bill would make it an offence to display an invalid Food Hygiene Rating sticker, however does not state how it could be identified as invalid. Would stickers carry an

expiry date, or date of next inspection? If not, administrative or postal errors could result in businesses inadvertently failing to comply with the regulations. Without a means of identifying invalid stickers, the public would also have no way of knowing if the rating displayed was still genuine or how old it was.

Right to reply

26. ACS does not believe comments made under the right to reply terms should only be made available on the FSA website. This information is an explanation by the business of any and all relevant circumstances at the time the assessment was carried out.

27. The consultation's underlying assumption is that simply publishing information online is not an adequate means of ensuring customers have access, hence the proposed requirement for the display of Food Hygiene Ratings at all premises. ACS believes that, if this logic is to hold, it must also apply to ensuring customers have access to all relevant information, including that contained in the right to reply.

28. ACS therefore believes that retailers should be permitted to display this additional information alongside their rating in store, and Local Authorities should be required to include this information as part of any publication of Food Hygiene Ratings.

Re-rating inspections

29. The consultation does not state how Local Authorities will determine whether it is 'reasonable' to conduct a reassessment of premises, or how they would calculate what the 'reasonable costs' are to be incurred for that inspection. Clear guidance would be required to ensure a consistent approach was adopted across all Local Authorities, and clear criteria, or a set fee, should be introduced so businesses are aware up front of how much the process may cost them.

30. The consultation also makes reference to the possibility of some premises, such as schools and hospitals, being exempt from re-rating costs. If this were to be introduced, safeguards must be put in place to ensure that these costs were not passed on to the rest of the food sector.

Power of entry

31. ACS agrees that FAs need power of entry to ensure compliance with food hygiene and safety standards. However, as such visits often cause disruption, premises should be given time to implement plans to minimise the impact on their business.

32. ACS therefore believes that regulations should include a requirement on FAs for prior notification of visits, except in cases where an imminent risk of harm has been identified.

Offence by body corporate

33. The Bill also states that, where a business is run by a corporate body, an individual within the premises will also be liable under the proposed regulations. Clarity is needed over how the individual would be identified as being liable, for example whether it would be a store manager, a health and safety officer, or store assistant who had accidentally removed information from display? This information would be needed for in store training as well as for clarity on individual responsibilities under the Bill.

27 June 2012

Health and Social Care Committee of the National Assembly for Wales

Consultation on the Food Hygiene Rating (Wales) Bill

Introduction

The British Beer and Pub Association (BBPA), is the leading trade association representing the interests of over half of the 52,000 pubs in the UK. There are 52,000 public houses in the UK, of which 3,200 are in Wales. Nationally, the pub sector contributes over £19bn to the economy, representing 2% of GDP and employing almost 600,000 people in full and part-time jobs. Pubs are vital to our economy, at the heart of our communities, and are central to society. We are an industry with the potential to create many more much-needed jobs and investment throughout the country. However, in order to do this we need a tax and regulatory regime that supports our sector.

Only 10% or so of the 3,200 pubs in Wales are branded or chain outlets operated by a parent company. The pub sector provides 32,000 direct jobs in Wales, with 46,000 direct and indirect jobs being supported overall by the beer and pub sector. Since the vast majority of catering businesses, including pubs, are small, independent businesses, we believe the costs of introducing a mandatory food hygiene rating scheme will fall disproportionately on SMEs, inhibiting their ability to create new employment opportunities and much needed economic growth.

The Association has devoted significant resources and expertise to assist in the development of a voluntary national scheme that has been agreed and successfully implemented across England and Wales. Additional regulatory burdens will have a debilitating effect on Welsh food businesses which will place them at an economic disadvantage to their counterparts in other regions of the UK.

We welcome this opportunity to respond to the questions raised by the Health and Social Care Committee of the National Assembly for Wales below and hope that our views will be taken into account.

British Beer & Pub Association, Brewers' Hall, Aldermanbury Square, London EC2V 7HR. 020 7627 9199

Consultation Questions

BBPA Response

General

1. Is there a need for a Bill to introduce a statutory food hygiene rating scheme in Wales? Please explain your answer.

The BBPA is a member of the FSA Food Hygiene Rating Scheme Steering Group, which has overseen the development of the national scheme over the last three years, and has been instrumental in ensuring local authority and business acceptance of the voluntary national scheme. We are very disappointed, therefore, that the Welsh Government is proposing to introduce the Food Hygiene Rating (Wales) Bill which will inevitably place additional bureaucracy and cost on small pub businesses in Wales, at a time when the scheme is just beginning to gain national recognition and credibility. We do not, therefore, believe that there is any need for a successful voluntary initiative such as the national voluntary Food Hygiene Rating Scheme to be made compulsory in Wales or any other part of the UK. The voluntary national scheme was only launched on 30th November 2010, and we would much prefer that it is given sufficient time to become established, and that some form of national evaluation of its impact is carried out before any consideration is given to introducing the scheme on a statutory basis in any part of the UK.

The proposals will also place a significant cost burden on pubs and other catering businesses, the vast majority of which are SMEs, which we believe is out of step with the UK Government's overall commitment to reducing burdens on business. The BBPA and the BHA were recently successful in opposing proposals for the compulsory display of ratings from the London (Local Authorities) Bill. Parliament, by rejecting the provisions of this Bill, signified its firm support for the voluntary display of hygiene ratings.

The Welsh Government consultation earlier this year suggested that a mandatory Food Hygiene Rating Scheme would help to avoid serious food poisoning incidents in the future. While we recognise the devastating impact of the outbreaks of E.coli O157 in Wales in 2005 and E.coli O104 in Germany last year, it is clear, contrary to the suggestion in the consultation, that the display of food hygiene ratings in catering businesses would not have prevented either of these. The source in the case of the Welsh outbreak was identified as a butcher (already operating under a licensing scheme) who was ultimately responsible for supplying contaminated meat, and in Germany, an organic vegetable farm was pinpointed as the origin of the problem. The food hygiene rating in a restaurant relates purely to compliance with food hygiene legislation and represents a "snapshot" based on an inspection at a given moment in time, and in neither case would hygiene ratings of restaurants have prevented the outbreaks and their consequences.

2. Do you think the Bill, as drafted, delivers the stated objectives as set out in the Explanatory Memorandum? Please explain your answer.

While we accept that it is not the Welsh Government's intention to depart significantly from the FSA Scheme in establishing a statutory food hygiene rating scheme for Wales, unfortunately the Bill will introduce additional requirements and mechanisms which do not form part of the voluntary national scheme.

Once legislation is introduced, then it will also be possible in the future to adapt the scheme further, which would cause further issues for businesses, particularly those operating across borders, and could also give rise to confusion amongst consumers. In our response to the Welsh Government's consultation earlier this year, we requested that should a statutory food hygiene rating scheme be introduced in Wales, that it should be in accordance with the requirements of the voluntary national scheme, to avoid imposing additional burdens on businesses and local authorities.

3. Are the sections of the Bill appropriate in terms of introducing a statutory food hygiene rating scheme in Wales? If not, how does the Bill to need to change?

We welcome a number of the amendments which have been made to the Bill following the public consultation, particularly with regard to the timescales for appeals and the clarification of the provisions relating to the right to reply. However, overall, the proposals will still create additional bureaucracy, penalties and costs for businesses.

We remain concerned about the following sections of the Bill in particular, which we also highlighted in our response to the Welsh Government:

1 - Overview

We do not support Clause 1(6) and Clause 1(7) in particular since these requirements depart from the national scheme and will create burdens on businesses, which we simply do not believe are necessary. We would prefer that the national voluntary scheme is given sufficient time to become established, and that some form of national evaluation of its impact is carried out before any consideration is given to introducing the scheme on a statutory basis. While we support the scheme itself, and in the interests of consistency, would accept that it could be made compulsory across local authorities in Wales, we believe that it would be better to retain the flexibility for businesses with regard to display of the signage and avoid imposing unnecessary burdens.

Technology is also constantly moving on, and the assumption in the Explanatory Memorandum is short sighted, as it does not appear to recognise that the situation with regard to internet usage and access to smart phones will be very different in just a few years time, even among those aged over 65, and that the web-based ratings will be even more widely available. This is not, in our view, sound evidence upon which to introduce a statutory requirement affecting over 3,000 pub businesses in Wales, which will have a lasting effect.

4 – Rating Criteria

We believe that the rating criteria and the scoring system should be a matter for guidance rather than primary or secondary legislation. A consistent approach to rating, as detailed in the FSA brand standard for the national scheme, is crucial to ensuring fair treatment for businesses and securing the credibility of the scheme. Prior to the development of the national brand standard, businesses were subject to inconsistent inspection criteria, which were not based on legal compliance with food hygiene law, but went beyond this to include a level of good practice which many smaller businesses were simply unable to achieve and which precluded them from achieving the top rating, even though they were legally compliant. The Food Hygiene Rating Scheme must remain a legal compliance scheme, and the Bill should reflect this and not introduce any scope to depart from this approach and gold-plate existing legislation.

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7 – Requirement to display food hygiene rating stickers

As stated above, we do not support any mandatory requirement for the display of the FHRS sticker. We believe that it would be better to retain the flexibility for businesses with regard to display of the signage and avoid imposing unnecessary burdens. In our view, the level of display of the FHRS stickers nationally has made good progress considering the relatively short time that the scheme has been running (since November 2010), and especially as a significant number of local authorities (including London Boroughs) have only agreed to come on board with the national scheme in recent months, following an arrangement between the FSA and Transparency Data on the website platform for ratings. We were confident that the overall percentages for signage display would have increased over the coming months due to this important development.

As with any voluntary system, it is inevitably that not everyone will join in; in this case not all businesses will choose to display their rating, especially if it is below three stars. Feedback from our membership suggests that even companies achieving the top rating choose not to display the score for various reasons, not least because there are a number of other signs and stickers that are also jostling for priority space in pubs, such as National Pubwatch stickers, Unit Awareness Information, Best Bar None, local or national food awards, Good Beer Guide, BII etc). Sometimes, there are also aesthetic reasons for not displaying the stickers, as the design of the stickers does not always sit well with corporate branding.

However, the fact that the food hygiene ratings now reflect legal compliance rather than gold plating food hygiene law has meant that businesses have been increasingly happy to display their scores, and this will continue to grow over time.

Another relevant factor is that the voluntary FHRS in England and Wales is more complex in structure due to the six rating tiers compared to Scotland where there is a simpler approach which means businesses either pass their inspection or are rated as “improvement required”. While a requirement to display the stickers would not have a detrimental effect on those venues achieving a three, four or five star rating, previous consumer research by the Food Standards Agency has indicated that those venues with ratings of less than three stars could see a dramatic fall in custom, despite the fact that they are still compliant with food hygiene law, but could improve overall practice. The mandatory requirement will force such businesses to display their rating and as a result they could potentially lose trade, even though they are still legally compliant. Where a food business is not compliant with food hygiene law and poses a danger to public health, enforcement officers should, of course, close that outlet down.

In our view, in the event of a statutory scheme being introduced in Wales or in any of the UK regions, serious consideration should be given to legislating along the lines of the Scottish model which is simpler and fairer for both businesses and consumers.

The Association successfully petitioned against the proposals contained in the recent 10th London Local Authorities Bill which proposed the compulsory display of food hygiene ratings, on the grounds that this would create further legislative burdens on businesses which would undermine the efforts of the Food Standards Agency to reduce such burdens as part of its Simplification Plan,

and pre-empt the development of the voluntary national scheme. The House of Commons Committee supported our position, removing the requirement from the Bill.

We firmly believe that it is unacceptable to seek to codify something in law which is in need of further refinement and has not, as yet, been subject to proper evaluation. We remain concerned that the Welsh Government's proposals will result in enforcement efforts being diverted away from promoting good standards of compliance with food hygiene law, with enforcement officers focusing instead on the minutiae of valid stickers being properly displayed.

9 – Offences

We remain concerned about the creation of unnecessary bureaucracy and burdens on catering businesses such as the introduction of the proposed offences under law for failing to display valid food hygiene rating stickers, in the right place etc. These are minor failings, best dealt with by a good enforcement regime and dialogue with businesses. We are also disappointed that an additional offence has been introduced for failing to comply with a request by a person to be informed verbally of the food hygiene rating.

It is not clear how this would be enforced, and it also has the potential to be anecdotal and therefore difficult to prove. It could put operators at risk of vexatious or fictitious claims against them which they would equally find difficult to defend.

The removal of the requirement for businesses to display the stickers would negate the need to create a range of offences and fines, which ultimately will place unnecessary administrative and financial burdens on businesses.

12 – Payment of the costs of re-rating

This was not proposed by the Food Standards Agency (FSA) in its original consultation on "Scores on the Doors" in 2008 and the issue is still under discussion with the FSA in respect of the national voluntary scheme. The FSA has developed a robust national framework in the interests of consistency and transparency of operation and we do not think that the Bill should be going beyond the parameters set by the national scheme in this respect.

We have previously suggested to the FSA that it should provide guidance to local authorities setting out the circumstances in which re-inspections, re-visits, and documentary evidence would generally be acceptable.

In the absence of any legal framework, local authorities are able to retain an element of discretion to extend this to circumstances not specified in any guidance from the Agency. A mandatory food hygiene rating scheme in Wales will undermine the voluntary national scheme and leave no room for local discretion on the part of local authorities.

19 – Penalties

We remain very much opposed to the introduction of fines for what are essentially minor misdemeanors involving the display of food hygiene rating stickers.

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A Level 3 fine (£1,000) is excessive in view of the type of offences outlined in Clause 9, and we suggest that a maximum fine at Level 1 (£200) would be a sufficient deterrent for catering businesses, the vast majority of which are SMEs. It appears that the proposals have taken the current position in relation to the display of smoking signage as its benchmark. The BBPA has always maintained that the penalties in respect to failing to display the correct "No Smoking" signage are too high, and indeed questioned the need to require this signage once the legislation was firmly established. Following the Government's "Red Tape Challenge" last year, we are delighted that the Government is now reviewing the need for "No Smoking" signage, and we are hopeful that this particular burden, and the related penalties, will be repealed. It follows, therefore, that the existing rules around "No Smoking" signage are not a suitable template for these penalties.

20 – Fixed penalties

We do not support the introduction of Fixed Penalty Notices (FPNs) and comment further on this issue in relation to the Schedule to the Bill (below).

21 – Use of fixed penalty receipts

We do not support the provision that, in the event of FPNs being introduced, the receipts should be paid to the Welsh Ministers to retain for the improvement of food hygiene in Wales. We do not think this would be the most efficient use of funds, and would prefer the Bill to allow receipts to be retained by local authorities in order to focus locally on those premises which would benefit from more intensive support.

Schedule (Section 20) – Fixed Penalty Notices

As stated above, we do not support the introduction of FPNs, but in the event that they are introduced, we do not support the proposed fine of £200, with a discounted penalty of £150 if the FPN is paid within a certain period.

This is far too high, given the nature of the offences it will cover. Current FPNs for traffic offences such as speeding, traffic light contraventions, failing to comply with yellow box junctions and no right/left turns, are £60 plus three points on the driving licence of the individual concerned. These offences are more serious than the failure to display a sticker, and yet the fine is much less. Similarly, FPNs for disorder are currently set at £50 for lower tier offences and £80 for higher tier offences. Again, we would argue that these cover more serious offences, but attract a lower rate. Parents who fail to ensure their child attends school regularly can be issued with FPNs for truancy which range from £50 to £100.

Again, the reference point for the FPN level is probably the offences related to "No Smoking" signage, but as we have pointed out above, this is not appropriate as the Government is currently committed to reviewing this in the light of its drive to reduce burdens on business.

In the event FPNs are introduced, then we suggest that they should be in the region of £50 with a reduction of 25% for early payment. If they are set any higher than this, then early payment should reduce the fine by 50%, as is the case with parking fines for example.

4. How will the proposed Measure change what organisations do currently and what impact will such changes have, if any?

As previously stated, businesses which do not currently display the FHRS stickers will need to do so, and, as far as pubs are concerned, may have to do so at the expense of displaying signage for other initiatives. Businesses will have to manage the display of the sticker, ie. ensure that it is displayed and has not fallen down, that it is in date, properly visible and so on. In the event of issues arising with managed venues, companies may also need to provide additional staff training and introduce disciplinary procedures in the event of offences being committed at unit level. Again, as referred to above, those businesses with lower ratings will be forced to display their stickers and may suffer detriment to trade, despite still being compliant with food hygiene legislation.

5. What are the potential barriers to implementing the provisions of the Bill (if any) and does the Bill take account of them?

The Food Standards Agency considered a report on the "Food Hygiene Rating Scheme and Food Hygiene Information Scheme – increasing provision of information to consumers on the hygiene standards of food premises" at its open meeting on Tuesday 22 May, and agreed that:

- a mandatory approach to display of ratings/inspection results will strengthen the FHRS and FHIS and increase their potential to improve public health protection; and
- the FSA, in consultation with other relevant Government Departments and with stakeholders, should assess the impact of introducing parallel legislation to give a statutory basis to the FHRS/ FHIS in England, Northern Ireland and Scotland once local authority uptake of the schemes is complete.

We believe it would be sensible for the Food Hygiene Rating (Wales) Bill to be part of this overall review, in order to ensure a co-ordinated approach to the introduction of any resulting legislation which will safeguard the consistency of the national scheme.

The Association believes it is essential that the Welsh Assembly consider the potential burdens on the tens of thousands of small catering businesses that the introduction of a statutory FHRS will impose, in the context of the Government's public commitment to reduce such burdens following the "Red Tape Challenge" last year. In the event that legislation is introduced, then consideration must also be given to removing burdens elsewhere, as part of the "one in, one out" principle.

Powers to make subordinate legislation

6. What are your views on powers in the Bill for Welsh Ministers to make subordinate legislation (i.e. statutory instruments, including regulations, orders and directions)?

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Notwithstanding our concerns about the Bill per se, we agree with the powers in the Bill enabling secondary legislation. We remain concerned about any amendment of the definition of "food business establishment" (Clause 2(6)(a)) as explained above.

Financial Implications

7. What are your views on the financial implications of the Bill?

The Association does not agree with the preferred Option 4 as detailed in Regulatory Impact Assessment, contained in Part 2 of the Explanatory Memorandum, and remains opposed to proposals to introduce a mandatory food hygiene rating scheme in Wales. We believe that this will undermine the voluntary national scheme, which has been developed by the Food Standards Agency in collaboration with local authorities and business representatives, including ourselves.

The voluntary national scheme has been the positive result of a successful partnership, resulting in an initiative which has wide ranging support, even from local authorities who had initially wanted to continue with their own "scores on the doors" schemes. The fact that the food hygiene ratings now reflect legal compliance rather than gold plating food hygiene law has meant that businesses are increasingly happy to display their scores.

Our preference is for Option 2, which we believe would drive up food hygiene standards, as this would become a point on which businesses would have to compete more than they do currently. Much more could be done to raise consumer awareness of the purpose of food hygiene ratings, as we believe that there is still a tendency on the part of some consumers to confuse the ratings with "quality" as opposed to legal compliance with food hygiene law. We would certainly like to see more work done on consumer understanding of the scheme. The aims of Consumer Focus Wales could also be met through greater consumer awareness of the voluntary national scheme, increasing the demand for food hygiene ratings to be displayed at premises.

The original consultation on the RIA stated in paragraph 22 that of the 13,500 food businesses in Wales which have a food hygiene rating, 3,000 have a score of less than "3" and are therefore less likely to be displaying their scores. This is just 22% of the total number of businesses. It should be possible to target this minority and work with them to raise their food hygiene standards to a level where they would be happy to display their score voluntarily. Where businesses have received higher scores but have not displayed them, there is no consumer detriment which would justify the introduction of mandatory display of food hygiene ratings. We are concerned that a Bill of this nature has been introduced to target an increasing minority of premises.

Compared with the current voluntary national scheme which is working well, we are naturally concerned at the imposition of any costs as a result of these proposals. It is difficult to assess whether the projected £690,000 for re-visits (Summary Table of additional costs of Option 4) is an

accurate assessment of the costs on food businesses, the vast majority of which are SMEs, but it is clear that business is shouldering half of the overall costs, the remainder being shared across local authorities, the FSA and the Welsh Government. We would suggest that these are costs that could be avoided in the spirit of the Government's commitment to reducing costs on businesses.

The RIA does not appear to take into account the costs of the associated bureaucracy that will also be introduced as a result of a mandatory food hygiene rating scheme in order to avoid committing an offence and receiving the associated penalty.

This will require businesses to monitor the state of their stickers to ensure their display remains valid, to put measures in place to raise staff awareness and introduce structures for possible disciplinary action. These additional burdens are difficult to quantify, but exist nonetheless.

Other comments

8. Are there any other comments you wish to make about specific sections of the Bill?

We would take this opportunity to make additional comments about the following sections of the Bill:

2 – Programme of food hygiene inspections

We understand the rationale behind the decision to include businesses that supply food to other businesses within the scope of the scheme, but would take this opportunity to repeat our original observation that in many cases these will already governed by other legislation requiring high standards of hygiene, such as the licensing regime for butchers for example.

We do not support the proposal in Clause 2(8)(a) which would allow for definitions of "a food business establishment" to be altered, since this has the potential to lead to further divergence between the voluntary national scheme and the statutory Welsh scheme which would not be helpful to either business or consumers.

13 – Duties of the Food Standards Agency

We note the requirement for a formal evaluation of the FHRS within three years of the commencement of the scheme, and subsequently every three years. We would reiterate our concern that such a formal evaluation of the voluntary national scheme should have been carried out prior to the consideration of any statutory requirement.

16 – Power of entry

We question the need for this clause. The food hygiene rating is ultimately the outcome of a food hygiene inspection, which is facilitated under existing food hygiene law. There should be no need for any separate power in this Bill to enable enforcement officers to enter food business establishments for the purpose of producing a food hygiene rating or re-rating (the latter being likely to have been requested by the food business in the first

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place). We are concerned, therefore, that the inclusion of these requirements risk gold-plating existing requirements.

17 – Obstruction of authorised officers

18 – Offences by bodies corporate

We reiterate our concerns about potentially gold-plating existing legislation, as per Clause 16 above.

BBPA/RK
28.06.12

British Beer & Pub Association, Brewers' Hall, Aldermanbury Square, London, EC2V 7HR. 020 7627 9199

British Hospitality Association response the consultation on the Food Hygiene Rating (Wales) Bill

About the British Hospitality Association (BHA)

The British Hospitality Association represents the hotel, restaurant and catering industry, which employs 112,000 people directly and contributes £1.88 billion in annual gross value added (wages and profits) in Wales (*Source: Oxford Economics 2011*). The BHA Wales Committee brings together our members to represent their views to the National Assembly and the Welsh Government.

Introduction

The BHA has made a significant contribution to the development of the National Food Hygiene Rating Scheme through membership of the FSA national Steering Group and the various working groups which developed the scheme. We were also instrumental in the development of the Food Hygiene Information scheme in Scotland and have clearly stated on many occasions that we would have preferred a UK wide scheme which would be simple for consumers to understand and preferably based on the Scottish scheme. We recognised the FSA Board decision to develop a six tier scheme and therefore decided to assist its development and part of our consideration was that there would be a brand standard for the scheme which would be imposed on all participating Local Authorities in an effort to produce a consistent approach. We therefore do not see how the proposals in the Food Hygiene Rating (Wales) Bill will add value to the scheme and indeed are likely to result create confusion for businesses with associated added costs and potentially confusion for consumers.

1 Is there a need for a Bill to introduce a statutory food hygiene rating scheme in Wales? Please explain your answer.

We do not believe that there is a need for a statutory Food Hygiene Rating Scheme in Wales because:

1.1 The voluntary Food Hygiene Rating Scheme in Wales has not been given sufficient time to settle down since its introduction in October 2010. Many operators who have by now received scores 3 and above will be happy to display their scores as research indicates that 3 and above is where consumers are happy to eat. There are however significant differences in the rating scores between England Wales and Northern Ireland as follows:

Wales-**30%** of premises rated 0,1,2,
Northern Ireland- **9%** of premises rated 0,1,2,
England- **15%** of premises rated 0,1,2, (Source FSA Board Paper 12/05/04)

This suggests significant inconsistency in the way the schemes are being administered.

1.2 A major justification for compulsory display is claimed to be the opinion poll from Consumer Focus Wales, indicating that 94 per cent of consumers want to see FHRS scores displayed compulsorily. However, the research failed to ask the preliminary question: do you understand the ratings? Since only 50 per cent of respondents had even heard of the scheme, then 44 per cent were asking for something they had never heard of. Even if they were among the 50 per cent who had heard of the scheme, we suspect that very few will understand the significance of the scoring system, beyond the point made above that consumers will intuitively be happy to eat if the score is 3 or abovee

2. Do you think the Bill, as drafted, delivers the stated objectives as set out in the Explanatory Memorandum? Please explain your answer.

2.1 The local authorities in Wales are already operating the FSA National Food hygiene rating scheme and have been provided with funding by the FSA to implement the scheme. In addition the FSA in Wales carries out audits of Local authorities to ensure that they are carrying out their functions in relation to enforcement of food safety legislation in a competent manner. Therefore in our opinion there is no need for a statutory scheme in Wales and the Bill can only be seen as over Regulation.

3. Are the sections of the Bill appropriate in terms of introducing a statutory food hygiene rating scheme in Wales? If not, how does the Bill to need to change?

3.1 While we welcome some of the changes which have been made to the Bill following the consultation we do however believe that there should be any variation in Wales whatsoever from the FHRS branded scheme which has been developed by the FSA and the UK Steering Group which covers issues such as re inspection, appeals, scoring, application to food premises etc. Any variation will add to the costs of multi-site businesses that operate not only in Wales but also England and will cause confusion for consumers who have had to deal with a plethora of different schemes run by local authorities.

3.2 The proposal to extend the Food Hygiene Rating Scheme to businesses who supply food to other businesses but not directly to the consumer is not part of the FSA scheme and therefore in our view conflicts with the stated aim of the Bill which is to inform consumers about the hygiene standards of the premises they visit.

3.3 In particular we do not agree with Clauses 1(6) and 1(7) which introduce the statutory requirements those food businesses must inform members of the public of the food hygiene rating and to display stickers as these requirements fall outside the FSA scheme. In deed there are practical difficulties in some premises which have more than one entrance e.g. a hotel may have a separate entrance to a banqueting room to that of the restaurant or it may have a main external entrance (maybe 2) and the internal entrance to the restaurant. Some quick service restaurants have a restaurant and often a drive through. In our view food businesses should be provided with a sticker but then given flexibility where or whether they display that sticker. The requirement for verbal information with respect to the Food hygiene rating to be provided creates an unnecessary burden on businesses in ensuring that every member of staff has all the relevant information and will be difficult to enforce for local authorities. There is potential for time consuming investigations of frivolous complaints.

3.4 The payment of costs for re-rating in our opinion is an unnecessary burden on small businesses. Businesses should be encouraged to improve by working with the local authority Environmental Health Officer and the introduction of payments could result in a change to the relationship between the business and the EHO.

3.5 We oppose the introduction of fines for failure to display Food hygiene rating stickers and believe that the proposal for a level 3 fine is excessive. If such a fine is to be imposed then a level 1 fine should be the maximum. Similarly we believe that the level of fixed penalty notices is far too high for this offence and suggest a lower amount e.g. £50 with a discount of 25% for early payment.

4. How will the proposed Measure change what organisations do currently and what impact will such changes have, if any?

4.1 There will be an increases in costs for businesses with respect to the management of display of Food Hygiene Rating Stickers i.e. ensuring that the sticker is permanently on display, in date, and properly visible.

5. What are the potential barriers to implementing the provisions of the Bill (if any) and does the Bill take account of them?

5.1 The Food Standards agency has recently agreed to carry out an assessment of the impact of introducing parallel legislation in England, Scotland and Northern Ireland with respect to introducing a mandatory approach to the display of Food hygiene ratings and we believe that the Food Hygiene Rating (Wales) Bill should be included in that assessment to ensure consistency with the national scheme.

5.2 The commitment by the Government to reduce the burden of regulation following the "Red Tape Challenge" should be considered by the Welsh Assembly Government and therefore if the Bill is to be made law in Wales then the removal of a burden on small businesses on the basis of "one in, one out" should be introduced.

Powers to make subordinate legislation

6. What are your views on powers in the Bill for Welsh Ministers to make subordinate legislation (i.e. statutory instruments, including regulations, orders and directions)? In answering this question, you may wish to consider Section 5 of the Explanatory Memorandum, which contains a table summarising the powers delegated to Welsh Ministers in the Bill to make orders and regulations, etc.

6.1 We have no concerns about the powers to make subordinate legislation which are appropriate.

Financial Implications

7. What are your views on the financial implications of the Bill? In answering this question you may wish to consider Part 2 of the Explanatory Memorandum (the Regulatory Impact Assessment), which estimates the costs and benefits of implementation of the Bill.

7.1 We believe that the voluntary scheme has had a positive effect on businesses and that the competitive nature of business means that many businesses will wish to display ratings as consumers become increasingly aware of the scheme. The our preferred option as decribed in the Regulatory Impact Assessment would be "option 2 " We would support moré action in raising awareness of consumers to the voluntary scheme.

Other comments

8. Are there any other comments you wish to make about specific sections of the Bill?

8.1 No

Our response to the initial consultation on the Wales Food Hygiene Rating Bill is attached to this document.

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British Hospitality Association response to the Welsh Government Consultation Document

Proposals for a Food Hygiene Rating (Wales) Bill

About the British Hospitality Association

The British Hospitality Association represents the hotel, restaurant and catering industry, which employs 112,000 people directly and contributes £1.88 billion in annual gross value added (wages and profits) in Wales. The BHA Wales Committee brings together our members to represent their views to the National Assembly and the Welsh Government.

Response to Consultation questions

Question 1: Do you have any comments on the first clause in the Bill (Welsh Food Hygiene Rating Scheme)?

We do not believe that the Food Hygiene Rating Scheme in Wales should require the compulsory display of the Food Hygiene ratings because:

- The voluntary FHRS scheme in Wales has not been given sufficient time to settle down since its introduction in October 2010. Many operators who have by now received scores 3 and above will be happy to display their scores as research indicates that 3 and above is where consumers are happy to eat. Given that 3 and above is likely to cover 80% of food businesses and the remainder will be subject to closer scrutiny/enforcement by EHO's then we believe that additional regulation is totally unnecessary. We are aware of the FSA research currently being carried out into whether compulsory display of Food hygiene ratings is necessary and therefore we believe that the decision to proceed with the Bill should be delayed until the results of that consumer research is known. Hence we oppose the clauses relating to criminal offences, fines etc.
- A major justification for compulsory display is claimed to be the opinion poll from Consumer Focus Wales, indicating that 94 per cent of consumers want to see FHRS scores displayed compulsorily. However, the research failed to ask the preliminary question: do you understand the ratings? Since only 50 per cent of respondents had even heard of the scheme, then 44 per cent were asking for something they had never heard of. Even if they were among the 50 per cent who had heard of the scheme, we suspect that very few will understand the significance of the scoring system, beyond the point made above that consumers will intuitively be happy to eat if the score is 3 or above

- We do believe that Local Authorities should be compelled to follow the national scheme to ensure a consistent approach and less confusion for consumers. However, we would much have preferred that Wales adopted the 'pass'/ 'improvement required' Food Hygiene Information Scheme operating in Scotland, which is simpler for both consumers and operators to understand."

- We also believe that there should be no variation in Wales whatsoever from the FHRS branded scheme which has been developed by the FSA and the UK Steering Group which covers issues such as re inspection, appeals, scoring, application to food premises etc. Any variation will add to the costs of multi site businesses who operate not only in Wales but also England and will cause confusion for consumers who have had to deal with a plethora of different schemes run by local authorities.

- We do not believe that operators should be required to pay for re inspection. Encouraging small to medium enterprises to improve their standards without additional cost burdens should be inherent in the scheme.

Question 2 Do you agree that assessments of the food hygiene standards of an establishment carried out prior to the commencement of this Act can be used as the basis of a rating under the mandatory scheme?

We do not agree with mandatory display but it makes sense for all businesses who are inspected under FHRS to be able to display their ratings.

Question 3: Do you agree that all food businesses supplying food directly to consumers should be included in the scope of the FHRS?

Yes

Question 4: Are there any food business establishments that provide food directly to consumers that you think should be exempt from the FHRS?

Very low risk premises selling wrapped confectionery, sweets etc

Question 5: Should those businesses involved in food business-to-business trade be included in the scope of the FHRS?

Yes

Question 6: Do you have any comments on the appeals process including the timescales? Please provide details of how the appeals process could be strengthened. Comments:

See answer to Q1

Question7: Do you think summary inspection reports (in addition to the Food Hygiene Rating Scores) should be routinely published on an FSA's website or otherwise made available?

No, summary reports can be misleading

Question8: Do you think the operator should be required to display the FHRS sticker at their establishment in a place where consumers can see it easily? Or you have any suggestions on where this location should be?"

No, some premises have more than one entrance e.g. a hotel may have a separate entrance to a banqueting room to that of the restaurant or it may have a main external entrance (maybe 2) and the internal entrance to the restaurant. Some quick service restaurants have a restaurant and often a drive through. In our view food businesses should be provided with a sticker but then given flexibility where or whether they display that sticker.

Question 9: Are the requirements in relation to the duty to remove out of date or invalid food hygiene rating stickers from display practical and reasonable

Yes

Question 10: Do you think that the list of offences is reasonable?

See answer to Q1

Question 11: Should all operators be required to display the food hygiene rating certificate at the premises in addition to the food hygiene rating sticker?

See answer to Q1

Question 12: Do you think the publication of the "right of reply" gives sufficient voice to the operator?

See answer to Q1

Question 13: Do you agree that operators that have actively taken steps to improve their food hygiene rating should be allowed to apply for a re-rating, rather than have to wait until their next planned inspection?

Yes

Question 14: Do you agree that food authorities should be required to charge operators the reasonable cost of undertaking a re-rating inspection?

No

Question 15: Should any food establishments be excluded from the charge for re-rating inspections?

No see answer to Q14

Question 16: Do you have any comments on the duties of the FSA? Are there any omissions? If so, please provide details:

No

Question 17: Do you think it is useful for a sticker to be displayed which informs customers that a food hygiene rating has not yet been issued to the food business establishment?

YES

Question 18: Is a level 3 fine (currently £1000) in relation to offences committed under the legislation appropriate?

See Answer to Q1

Question 19: Do you think food authorities should have the ability to issue Fixed Penalty Notices

See answer to Q1

Question 20: Do you consider the discounted penalty (£150) for early payment (within 14 days) of a Fixed Penalty Notice provides an appropriate discount for early payment?

See answer to Q1

Question 21: Do you agree with the preferred option in the Regulatory Impact Assessment (option 4 – Introduce the mandatory scheme with cost recovery for food hygiene re-rating inspections)?

No see answer to Q1

Question 22: Do you agree with the estimated costs/benefits regarding the implementation of this Bill?

No see answer to Q1

Question 23: Do you have any comments on the expected costs to food businesses and food authorities? :

See answer to Q1

Question 24: Please provide your comments on the impact that the introduction of a mandatory food hygiene rating scheme will have on: small businesses, the voluntary sector, equality, sustainable development, rural issues and the Welsh Language:

The proposal for charging for re inspection will disproportionally affect SME's and the voluntary sector and therefore damage their sustainability from an economic point of view. Many SME's are already subject to a high level of regulation in comparison to their size and the vast majority desire a supportive culture rather than that of regulation, enforcement and prosecution.

Wales has the opportunity to reinforce a "Welcome Culture" through communication, cooperation and commitment.

We should be pleased to discuss this response further with you. I confirm that we have no objection to it being made publicly available.

John Dyson

Food and Technical Affairs Adviser

British Hospitality Association

Eitem 5 Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 28 Mehefin 2012**
Amser:	**09:00 – 15:25**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_28_06_2012&t=0&l=cy
http://www.senedd.tv/archiveplayer.jsf?v=cy_200002_28_06_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Mr Phil Banfield, BMA Cymru** **Mr Bryan Beattie, Coleg Brenhinol yr Obstetryddion a'r Gynaecolegwyr** **Julia Chandler, Coleg Brenhinol y Bydwragedd** **Elizabeth Duff, Ymddiriedolaeth Genedlaethol Geni Plant** **Polly Ferguson, Llywodraeth Cymru** **Professor Jason Gardosi, Sefydliad amenedigol Gorllewin Canolbarth Lloegr** **Fiona Giraud, Bwrdd Iechyd Prifysgol Betsi Cadwaladr** **Shirley Gittoes, Sands** **Dr Alexander Heazell, Canolfan gwyddorau iechyd academaidd Manceinion** **Angela Hopkins, Bwrdd Iechyd Cwm Taf** **Dr Siobhan Jones, Iechyd Cyhoeddus Cymru** **Isobel Martin, Cronfa ymchwil marw-enedigaeth Holly Martin** **Dr Shantini Paranjothy, Arolwg Amenedigol Cymru gyfan** **Dr Heather Payne, Prif Swyddog Feddygol,**

	Llywodraeth Cymru **Janet Scott, Sands** **Prof Gordon Smith, Y Gynghrair Marw-enedigaethau Rhyngwladol** **Dr Mark Temple, BMA Cymru** **Marilyn Wills, Ymddiriedolaeth Genedlaethol Geni Plant** **Dr Jean White, Llywodraeth Cymru**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Mike Lewis (Dirprwy Glerc)** **Victoria Paris (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Darren Millar ar gyfer y sesiynau a gynhaliwyd yn y bore a'r prynhawn, a chan Lindsay Whittle ar gyfer y sesiwn a gynhaliwyd yn y bore.

2. Ymchwiliad un-dydd i farw-enedigaethau yng Nghymru - Tystiolaeth lafar

2.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor ar farw-enedigaethau yng Nghymru.

2.2 Cytunodd Siobhan Jones i gadarnhau a yw Iechyd Cyhoeddus Cymru wedi ymgysylltu â chymunedau lleiafrifol ethnig ar y mater o farw-enedigaethau, ac i ddarparu enghreifftiau o'r gwaith hwnnw os felly.

3. Papurau i'w nodi

3.1 Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 14 Mehefin.

4. Cynnig dan Reol Sefydlog 17.42(vi) i benderfynu atal y cyhoedd o'r cyfarfod ar gyfer eitem 5 ac ar gyfer y cyfarfod ar 4 Gorffennaf ar gyfer eitem 1

4.1 Cytunodd y Pwyllgor ar y cynnig.

5. Ymchwiliad un-dydd i farw-enedigaethau yng Nghymru - Trafod y dystiolaeth

5.1 Bu'r Pwyllgor yn trafod y dystiolaeth a gafwyd ar farw-enedigaethau yng Nghymru.

TRAWSGRIFIAD

Trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – y Senedd**
Dyddiad:	**Dydd Mercher, 4 Gorffennaf 2012**
Amser:	**09:15 – 11:00**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_04_07_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Lesley Griffiths, Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol** **Dr Chris Jones, Llywodraeth Cymru** **David Sissling, Cyfarwyddwr Cyffredinol dros Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cymru**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Victoria Paris (Ymchwilydd)**

1. Ymchwiliad i ofal preswyl i bobl hŷn – trafod y prif faterion

1.1 Trafododd y Pwyllgor y prif faterion sy'n codi ar gyfer yr ymchwiliad i ofal preswyl i bobl hŷn.

2. Cyflwyniad, ymddiheuriadau a dirprwyon

2.1 Croesawodd y Cadeirydd bawb i'r cyfarfod. Ni chafwyd unrhyw ymddiheuriadau.

3. Craffu ar waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

3.1 Croesawodd y Cadeirydd y Gweinidog a'i swyddogion i'r cyfarfod. Holodd yr Aelodau y Gweinidog.

3.2 Cytunodd y Gweinidog i ddarparu'r wybodaeth ychwanegol a ganlyn ar gais y Pwyllgor:

- Enghreifftiau o ysbytai cyffredinol dosbarth yn y DU lle ni ddarperir gwasanaethau aciwt;
- Copi o'r asesiad annibynnol o'r ymarfer ar ymgysylltiad y cyhoedd a gynhaliwyd gan Fwrdd Iechyd Hywel Dda fel rhan o'i gynlluniau ailgyflunio.

4. Papurau i'w nodi

4.1 Nododd y Pwyllgor gofnodion y cyfarfod ar 20 Mehefin.

TRAWSGRIFIAD

Trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-23-12 papur 5

Ymchwiliad i Ofal Preswyl i Bobl Hŷn – Nodyn o gyfarfod y Grŵp Cyfeirio ar 24 Mai 2012

Cefndir

1. Sefydlodd y Pwyllgor Iechyd a Gofal Cymdeithasol grŵp cyfeirio ar gyfer ei ymchwiliad i ofal preswyl i bobl hŷn yn ystod gwanwyn 2012. Mae'r grŵp yn cynnwys y rhai a fu'n cynorthwyo ffrindiau neu aelodau o'r teulu mewn lleoliadau gofal preswyl yn ddiweddar, sy'n gwneud hynny ar hyn o bryd, neu sy'n wynebu gwneud hynny yn y dyfodol.

2. Rôl y grŵp cyfeirio allanol yw rhoi barn i'r Pwyllgor ynghylch y prif faterion a fynegwyd yn ystod yr ymchwiliad. Mae hyn yn cynnwys eu barn ynghylch y graddau y mae'r wybodaeth a ddarperir yn y dystiolaeth yn adlewyrchu eu profiadau personol eu hunain, a'r graddau y maent yn cytuno â'r cyfeiriad polisi presennol ym maes gofal preswyl i bobl hŷn.

3. Bydd y grŵp cyfeirio yn cyfarfod bob mis yn ystod y cyfnod o gasglu tystiolaeth lafar, gan ystyried y dystiolaeth a gyflwynwyd eisoes a chynnig mathau o gwestiynau y gellid eu gofyn mewn sesiynau tystiolaeth yn y dyfodol. Bydd y grŵp cyfeirio yn cytuno ar bob nodyn a lunnir o'i gyfarfodydd cyn eu cyhoeddi.

Crynodeb

4. Cyfarfu'r grŵp ar 24 Mai 2012 i drafod y prif themâu a ddaeth i'r amlwg yn sesiynau tystiolaeth y Pwyllgor Iechyd a Gofal Cymdeithasol ar 26 Ebrill a 2 Mai 2012. Yn ystod y ddau sesiwn hyn, ystyriwyd rôl darparwyr y trydydd sector a modelau amgen ar gyfer darparu.

5. Bu'r grŵp hefyd yn ystyried materion yn ymwneud â rheoleiddio ac arolygu gofal, a chwestiynau y gellid eu gofyn yn y sesiwn dystiolaeth gydag Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru (AGGCC), Arolygiaeth Gofal Iechyd Cymru (AGIC) a Chyngor Gofal Cymru ar 30 Mai.

Y prif themâu

6. Cytunodd y grŵp cyfeirio mai dyma'r prif themâu a ddaeth i'r amlwg yn y sesiynau tystiolaeth ffurfiol a gaiff eu crybwyll ym mharagraff 4:

   - **Gofal sy'n canolbwyntio ar yr unigolyn** ddylai fod wrth wraidd darparu gwasanaethau. Mae angen ystyried pobl mewn modd cyfannol, a dylai fod cymorth ar gyfer yr unigolyn cyfan, gan

sicrhau bod pob cyflwr sydd ganddynt a chyflyrau posibl yn cael eu canfod a'u trin.

- Dylai gwasanaethau **ailalluogi** a gwasanaethau tebyg fod **ar gael i bawb**, **ym mhob cam** o'r broses gofal preswyl. Mae annog pobl i fod mor annibynnol â phosibl yn rhan allweddol o'r broses o adfer. Dylid gweithio i **godi ymwybyddiaeth** o bob gwasanaeth sydd ar gael.

- Mae angen **gweithio mewn partneriaeth yn well a rhannu arfer da ac arbenigedd**. Dylai fod mwy o weithio hyblyg a llai o seilos yn y sectorau iechyd a gofal cymdeithasol. Dylai fod cyfathrebu gwell rhwng sefydliadau, yn enwedig yng nghyswllt cadw cofnodion, er mwyn sicrhau dilyniant yn nhriniaeth y claf.

- Mae angen **digon o gyllid** ar gyfer gwasanaethau, ac **isafswm taliadau** ar gyfer gwasanaethau gofal, p'un a ydynt yn wasanaethau a ddarperir yn y cartref neu mewn cartrefi gofal preswyl. Gall comisiynu ar sail cost yn hytrach nag ansawdd gael effaith andwyol, o bosibl, ar y gwasanaethau y mae pobl yn eu cael.

- **Mae angen gwybodaeth well, fwy hygyrch ynghylch y mathau o ofal sydd ar gael**. Bydd hyn yn helpu i ateb cwestiynau fel beth sy'n nodweddu gofal o safon. Dylid diffinio ailalluogi yn glir, a fydd yn helpu i sicrhau cysondeb o ran yr hyn sy'n nodweddu ailalluogi, ynghyd â chyfarwyddyd yn hynny o beth, i'r rheini sy'n ei ddarparu.

- **Dylai hyfforddiant ar faterion fel dementia a chlefyd Parkinson ymwneud â mwy na chodi ymwybyddiaeth yn unig**; dylai ymwneud hefyd â sut y dylid ymdrin â'r cyflyrau hyn, a dylai anelu at wella sgiliau staff yn gyffredinol, mewn wardiau ysbytai, meddygfeydd, a chartrefi gofal.

- Dylid **gweld mwy o werth mewn staff sy'n gweithio yn y sector gofal**. Mae gan weithwyr gofal mewn cartrefi gofal a'r rheini sy'n darparu gofal yn y cartref nifer o gyfrifoldebau, yn ogystal â bod wedi'u cyfyngu arnynt yn aml gan bwysau ariannol a phwysau o ran eu hamser, a dylid cydnabod hyn mwy.

7. Wrth drafod y prif themâu a'r dystiolaeth a glywyd, mynegodd y grŵp y pwyntiau a ganlyn:

   - Dylid cynnal **trafodaethau am anghenion gofal pobl yn y dyfodol ar adeg briodol**, gyda'r holl bobl berthnasol. Fel arfer, dylid gwneud hyn mor fuan ag y bo modd – ond bydd hyn yn amrywio yn ôl y sefyllfa a'r

bobl dan sylw. Mae angen cymorth ac eiriolaeth i sicrhau bod hyn yn effeithiol.

- Rhaid i'r **broses asesu** ar gyfer y rheini sy'n cael gofal neu'r rheini y canfyddir y bydd angen gofal arnynt, o bosibl, **fod yn barhaus**, ac ni ddylai fod yn rhywbeth a wneir unwaith yn unig. Gall pobl ymddangos yn glir eu meddwl mewn un asesiad, ond mae modd meithrin dealltwriaeth fwy cynhwysfawr o les unigolyn os cynhelir asesiadau parhaus. Ar ben hynny, gall anghenion pobl fod yn fwy neu'n llai gan ddibynnu ar eu cyflyrau a'r driniaeth y maent yn ei chael, a dylid monitro hyn drwy'r broses asesu.

- Teimlai'r grŵp y dylai **mwy o wybodaeth am ailalluogi** fod ar gael. Buont yn trafod nodweddion ailalluogi a pha mor anodd ydyw i'w diffinio. Roedd hwn yn faes yr oedd angen ei egluro, yn eu barn hwy, ac roedd angen hefyd am ddata sylfaenol am wasanaethau ailalluogi, er mwyn gallu symud ymlaen yn y maes hwn. Teimlai'r grŵp nad oedd y gwasanaethau a ddarperir, fel ailalluogi, wedi'u ffurfioli'n iawn ar hyn o bryd, a'u bod yn cael eu darparu mewn modd ad hoc. Teimlent y dylai fod mwy o ymwybyddiaeth o'r gwasanaethau hyn, a darpariaeth safonol i bawb.

- Bu'r grŵp yn trafod y ffaith bod **unigedd yn broblem** i bobl yng nghefn gwlad ac mewn ardaloedd trefol. Teimlent ei bod yn werthfawr iawn bod y trydydd sector yn cymryd rhan drwy gyfrwng prosiectau fel cyfeillio. Teimlent hefyd fod **nifer o heriau ynghlwm wrth ddarparu gofal yn y cartref yng nghefn gwlad**, oherwydd yn aml nid oedd contractau'n darparu ar gyfer amseroedd teithio a chost. Gall hyn beri i'r contractau beidio â bod yn hyfyw neu'n atyniadol i gyflenwyr.

- **Mae angen mynd i'r afael â natur gwrth-risg gweithwyr proffesiynol ym maes iechyd**. Teimlai'r grŵp fod angen newid agweddau a bod angen canolbwyntio llai ar bethau a allai ddigwydd. Teimlent y byddai hyn o gymorth wrth alluogi pobl i fod yn fwy annibynnol, ac y gallai helpu i leihau costau yn y tymor hir.

- Teimlai'r grŵp fod **taliadau uniongyrchol** i bobl hŷn yn rhy isel i alluogi pobl i brynu gwasanaethau wedi'u rheoleiddio, sy'n golygu eu bod yn anhyfyw ar hyn o bryd. Ymddengys nad yw'r system yn dymuno rhoi cymorth i bobl hŷn yn eu cartrefi.

- Teimlai'r grŵp y byddai gwell rheoleiddio ar y system gofal yn y cartref yn gam cadarnhaol.

- **Yn aml, nid yw'r amser a gaiff ei neilltuo ar gyfer ymweliadau gofal â'r cartref, a'r cymorth ar gyfer yr ymweliadau hyn, yn ddigon** ar gyfer y tasgau y mae gofyn iddynt ymgymryd â hwy. Mae

hynny'n wir yn arbennig lle y gallai fod gan y claf ddementia, ac efallai y bydd yn cymryd amser i gael mynediad i'r tŷ ac i ennyn hyder y cleient. Mae'r taliadau yswiriant ac atebolrwydd y mae eu hangen er mwyn i staff gofal yn y cartref roi meddyginiaeth yn rhwystro'r mwyafrif o ddarparwyr rhag gallu cynnig y gwasanaeth hwn.

- Mae **cynllunio da**, gan ystyried elfennau fel colli synhwyrau a dementia, yn hanfodol wrth ddatblygu lleoliadau gofal newydd. Dylai'r gwaith o ddatblygu tai newydd hefyd ystyried bod anghenion y boblogaeth yn newid, a dylid sicrhau y byddant yn addas i'r henoed yn y dyfodol. Teimlai'r grŵp, heb grantiau digonol ar gyfer addasu cartrefi pobl, fod rhywfaint o'r dewis o ran aros gartref yn cael ei ddileu.

- Bu'r grŵp yn trafod y ffaith ei bod yn aml **yn anodd siarad ag aelodau o'r teulu am eu hanghenion gofal**, yn enwedig os nad oeddent am gydnabod eu cyflwr. Teimlai'r grŵp fod llawer o'r materion mewn perthynas â diffyg gwybodaeth a'r anawsterau o ran trafod ag aelodau hŷn o'r teulu yn ymwneud â'r cenedlaethau, a theimlai'r grŵp y byddent hwy a chenedlaethau'r dyfodol wedi'u paratoi'n well ar gyfer y dewisiadau a'r trafodaethau y byddai angen ymgymryd â hwy.

- Teimlai'r grŵp na ddylid ystyried dementia a'r angen am ofal **yn stryd unffordd tuag at ddirywiad**, a'i bod yn hanfodol **fod gan bobl ddewis ac annibyniaeth**. Mae hyn yn hanfodol er mwyn sicrhau bod gan bobl bwrpas yn eu bywydau.

- Roedd aelodau'r grŵp wedi cymryd yn ganiataol fod pob aelod o'r staff nyrsio mewn lleoliadau gofal preswyl wedi'u hyfforddi i ymdrin â dementia. Gwnaethant nodi nad oeddent wedi meddwl am yr angen i gadarnhau pa hyfforddiant yr oedd staff wedi'i gael wrth ddewis cartref.

- Yn aml, nid yw'r **math o iaith a gaiff ei defnyddio yng nghyd-destun trin cleifion sydd â dementia yn ddefnyddiol** – er enghraifft, teimlai'r grŵp ei bod yn bosibl fod unigolyn y dywedir ei fod yn "ystyfnig" yn cael trafferth cyfathrebu, mewn gwirionedd.

Cwestiynau ar gyfer sesiynau'r dyfodol

8. Bu'r grŵp yn trafod meysydd sy'n destun pryder ynghylch yr ymchwiliad o ran arolygu a rheoleiddio. Gwnaethant awgrymu hefyd y dylid cyflwyno'r sylwadau a'r cwestiynau a ganlyn i AGGCC/AGIC a Chyngor Gofal Cymru:

   - Rhaid i'r broses arolygu gynnwys treulio digon o amser gyda phreswylwyr a'u teuluoedd.

- Beth sy'n cael ei wneud i sicrhau bod profiadau preswylwyr o'r cartref preswyl yn cael mwy o sylw?

- O brofiad y grŵp, ymddengys na chaiff adroddiadau arolygu gwael eu gorfodi, ac nad oes canlyniadau yn deillio ohonynt. Mae angen camau gweithredu clir ar gyfer gorfodi – ymddengys fod pethau tebyg yn codi flwyddyn ar ôl blwyddyn.
    - Beth sy'n cael ei wneud i gryfhau'r broses o orfodi canfyddiadau'r gyfundrefn arolygu?
    - A oes unrhyw broses ddilynol ynghylch sicrhau nad yw rheolwyr a staff cartrefi gofal yn edrych am waith mewn cartrefi gofal eraill ar ôl iddynt gael eu diswyddo?

- Mae nifer o weithiwyr proffesiynol yn gweithio mewn cartrefi gyda phreswylwyr, gan gynnwys gweithwyr cymdeithasol ac aseswyr gofal cymhleth (os caiff y claf ei gyllido gan y gwasanaeth iechyd).
    - A yw AGGCC yn gweithio gyda'r bobl hyn cyn arolygu i ganfod unrhyw feysydd sy'n destun pryder? A oes proses o gysylltu â hwy'n barhaus ynghylch y prif bryderon sy'n dod i'r amlwg mewn cartrefi?

- Teimlai'r grŵp cyfeirio fod cartrefi gofal yn gwybod pryd yr oedd yn debygol y byddai arolygiadau'n cael eu cynnal, gan eu bod yn tueddu i ddilyn yr un patrwm ar draws rhanbarthau. Teimlent fod angen mwy o hapwiriadau ac arolygwyr lleyg.
    - Beth sy'n cael ei wneud i ddod ag arolygwyr lleyg yn ôl i mewn i'r system? [Barn y grŵp yw bod angen defnyddio mwy o weithdrefnau ac i fwy o bobl gymryd rhan, gan gynnwys arolygwyr lleyg.]
    - Mae AGIC yn cynnal arolygiadau heb rybudd mewn ysbytai o safbwynt urddas – a yw'r rhain yn cael eu cyflwyno mewn cartrefi gofal hefyd?

- Dylid rheoleiddio yn achos staff islaw rheolwyr – ni ddylai cost cofrestru cael ei chrybwyll fel rhwystr.

- Mynegodd y grŵp bryderon ynghylch pam y bu cynnydd yn nifer y cartrefi sy'n hunanasesu – a hwythau'n berthnasau i breswylwyr, roeddent yn pryderu'n fawr am hyn.

- Defnyddiodd y grŵp yr adroddiadau arolygu ysgrifenedig fel ffynhonnell wybodaeth ar gyfer penderfynu i ble y dylai aelodau o'r teulu fynd – maent o'r farn y gellid gwella'r adroddiadau hyn, ac y gallent gynnwys gwybodaeth fwy hygyrch, defnyddiol, ac sy'n rhoi

darlun cliriach o realiti bywyd preswylydd mewn lleoliad preswyl penodol. At hynny, roedd y grŵp o'r farn

- bod angen mwy o ystyriaeth o gynulleidfa bosibl adroddiadau, ac y dylai'r adroddiadau egluro materion mewn termau cyffredin;
- y dylai'r arolygiaeth ystyried cynnwys pethau fel ffeithiau a ffigurau diddorol am y cartrefi;
- y dylai'r adroddiadau fod ar gael yn eang, ac nid ar y we yn unig;
- bod gormod o sylw yn cael ei roi i weithdrefn a gwaith papur yn yr adroddiadau, ac y dylid gwneud mwy o waith i glywed barn y bobl sy'n ymwneud â'r cartref gofal drwy gysylltu'n uniongyrchol â hwy; nid yw holiaduron yn ddigon;
- y dylid ystyried cyfarfodydd preswylwyr yn ffynonellau gwybodaeth defnyddiol ar gyfer arolygwyr.

- Gofynnodd y grŵp beth yr oedd AGGCC yn ei wneud i sicrhau bod data yn cael ei ddiogelu mewn cartrefi. Roedd enghreifftiau a grybwyllwyd gan y grŵp cyfeirio yn cynnwys lluniau teuluol yn cael eu defnyddio at ddibenion hysbysebu cartrefi, er na roddwyd caniatâd ar gyfer gwneud hynny. Mae'n bwysig bod preifatrwydd preswylwyr yn cael ei gynnal.

- O ystyried nifer yr achosion o rai cyflyrau, fel colli synhwyrau / dementia / salwch meddwl, roedd y grŵp am gael gwybod pa lefel o hyfforddiant y mae arolygwyr wedi'i chael yn y meysydd hyn, er mwyn gallu nodi a ydynt yn cael sylw digonol yn y cartrefi.

- Roedd y grŵp am gael gwybod a oes unrhyw fonitro'n cael ei wneud o nifer a mathau'r achosion o syrthio mewn lleoliadau preswyl, ac, os felly, i ba raddau yr eir i'r afael â hyn.

- Roedd y grŵp am gael gwybod ym mha fodd y mae morâl staff yn cael ei gynnwys mewn adroddiadau arolygu. Mae hyn yn cynnwys i ba raddau:
  - y gwneir addasiadau ar gyfer holi'r rheini nad yw'r Gymraeg neu'r Saesneg yn famiaith iddynt.
  - yr ystyrir pethau fel y llety byw a ddarperir i staff; roedd y grŵp o'r farn y gall y llety hwn fod o ansawdd isel iawn, ac y gallai effeithio ar allu gweithwyr gofal i gyflawni eu swyddi.

- Roedd y grŵp o'r farn y dylid monitro'r hyfforddiant a ddarperir i staff, ac y dylid cynyddu nifer yr elfennau gorfodol o hyfforddiant, e.e. hyfforddiant gorfodol ar ddementia.

9. Cytunodd y grŵp i ystyried cwestiynau posibl ar gyfer sesiwn y Pwyllgor gyda'r darparwyr gofal, a fydd yn cael ei gynnal ar 14 Mehefin 2012.

10. Cytunodd y grŵp i ystyried materion yn ymwneud â chyllid a disgrifiad o swydd gweithiwr gofal yn y cyfarfod nesaf.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-23-12 papur 6

Ymchwiliad i Ofal Preswyl i Bobl Hŷn – Nodyn o gyfarfod y Grŵp Cyfeirio ar 12 Mehefin 2012

Cefndir

1. Sefydlodd y Pwyllgor Iechyd a Gofal Cymdeithasol grŵp cyfeirio ar gyfer ei ymchwiliad i ofal preswyl i bobl hŷn yn ystod gwanwyn 2012. Mae'r grŵp yn cynnwys y rhai a fu'n cynorthwyo ffrindiau neu aelodau o'r teulu mewn lleoliadau gofal preswyl yn ddiweddar, sy'n gwneud hynny ar hyn o bryd, neu sy'n wynebu gwneud hynny yn y dyfodol.

2. Rôl y grŵp cyfeirio allanol yw rhoi barn i'r Pwyllgor ynghylch y prif faterion a fynegwyd yn ystod yr ymchwiliad. Mae hyn yn cynnwys eu barn ynghylch y graddau y mae'r wybodaeth a ddarperir yn y dystiolaeth yn adlewyrchu eu profiadau personol eu hunain, a'r graddau y maent yn cytuno â'r cyfeiriad polisi presennol ym maes gofal preswyl i bobl hŷn.

3. Bydd y grŵp cyfeirio yn cyfarfod bob mis yn ystod y cyfnod o gasglu tystiolaeth lafar, gan ystyried y dystiolaeth a gyflwynwyd eisoes a chynnig mathau o gwestiynau y gellid eu gofyn mewn sesiynau tystiolaeth yn y dyfodol. Bydd y grŵp cyfeirio yn cytuno ar bob nodyn a lunnir o'i gyfarfodydd cyn eu cyhoeddi.

Crynodeb

4. Cyfarfu'r grŵp ar 12 Mehefin 2012 i drafod y prif themâu a ddaeth i'r amlwg yn sesiwn dystiolaeth y Pwyllgor Iechyd a Gofal Cymdeithasol ar 16 Mai 2012 gyda gweithwyr proffesiynol a sefydliadau staff.

5. Bu'r grŵp hefyd yn ystyried materion yn ymwneud â chyllido gofal preswyl, proffil staff ar gyfer y rheini sy'n gweithio ym maes gofal, a chwestiynau y gellid eu gofyn yn y sesiynau tystiolaeth gyda darparwyr annibynnol ar 14 Mehefin, a chyda'r Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol ar 20 Mehefin.

Y prif themâu

6. Cytunodd y grŵp cyfeirio mai dyma'r prif themâu a ddaeth i'r amlwg yn y sesiwn dystiolaeth ffurfiol a gaiff ei chrybwyll ym mharagraff 4:

   - Mae **terminoleg** fel *'digonol' neu 'waith ychwanegol'*, a gaiff ei defnyddio gan y staff a chyrff proffesiynol, yn rhy amwys.

- Rhaid gwneud mwy i fynd i'r afael â'r materion sy'n ymwneud â **recriwtio a chadw staff ar bob lefel ym maes gofal**. Dylid ystyried gweithio ym maes gofal yn broffesiwn, sydd â llwybr gyrfa clir a graddfeydd cyflog sy'n adewyrchu profiad.

- Yr **angen am hyfforddiant addas ac ymarferol ar gyfer staff sy'n gweithio ym maes gofal**. Rhaid i hyn fod yn fwy nag ymarfer ticio blychau, a rhaid i'r hyfforddiant fod yn ystyrlon ac yn berthnasol i'r rheini sy'n darparu gofal.

- Rhaid **cynllunio'n ehangach ar gyfer y dyfodol**, gan ystyried newidiadau yn nemograffeg Cymru.

- Yr angen am **isafswm o ran lefelau staffio** mewn cartrefi gofal, er mwyn sicrhau bod bob amser nifer briodol o aelodau staff yn gweithio, yn enwedig dros nos.

7. Wrth drafod y prif themâu a'r dystiolaeth a glywyd, mynegodd y grŵp y pwyntiau a ganlyn:

   - Ymddengys fod nifer o fwriadau da, a rhethreg am wahanol sefydliadau yn cydweithio; fodd bynnag, ymddengys na chefnogwyd hyn gan weithredu cadarnhaol a gwaith i symud ymlaen.

   - Ymddengys fod y **sefydliadau proffesiynol yn diystyru gwaith a chyfraniad posibl y trydydd sector**. Er eu bod yn cydnabod pwysigrwydd gwirfoddolwyr, mae gwaith y trydydd sector yn cael effaith a dylanwad llawer mwy eang na hyn.

   - Drwy gydol yr holl sesiynau tystiolaeth, ymddengys **na chyfeiriwyd fawr at y Bil Gwasanaethau Cymdeithasol** a'r effaith y gallai ei chael ar nodweddion gofal preswyl.

   - Mae **tuedd mewn ysbytai, wrth ofalu am yr henoed, i ganolbwyntio ar y diffygion** a'r hyn na all pobl ei wneud, yn hytrach na'r galluoedd sydd ganddynt o hyd. Gall hyn beri i gleifion ddirywio.

   - Drwy gydol y sesiynau tystiolaeth, **nid oes yr un tyst wedi cyfeirio at y mater pwysig o brofedigaeth**. Yn aml, mae ar bobl angen galaru am y perthnasau hynny nad ydynt wedi marw ond y cafwyd bod ganddynt ddementia, clefyd Parkinson, neu gyflyrau tebyg, yn enwedig pan fyddant yn mynd i ofal preswyl. Mae datblygu a rhannu cynlluniau diwedd bywyd â theuluoedd yn gysylltiedig â hyn.

   - Dylai fod **ffyrdd gwell o sicrhau bod cartrefi'n rhannu arferion da**. Gellid gwneud hyn drwy'r gyfundrefn arolygu, o bosibl, a gallai

arolygwyr geisio annog y cartrefi hynny na fu'n perfformio cystal i gymryd rhan, drwy awgrymu enghreifftiau o arfer da.

- Os yw'r tâl a gewch mewn cartref gofal yn llai na'r hyn y byddwch yn ei gael am weithio mewn archfarchnad, bydd y swydd yn parhau'n anatyniadol. Mae hyn yn broblem arbennig o gofio nad oes llwybr gyrfa clir yn y sector.

- Mynegodd y grŵp bryder, os nad oedd gweithio mewn gofal yn atyniadol i'r bobl hynny mewn swyddi proffesiynol â chyflog uwch, fel seiciatryddion, y byddai hyd yn oed yn llai tebygol o ddenu'r rheini sy'n mynd i swyddi â chyflog is, fel gweithwyr gofal.

- **Ni all e-ddysgu gymryd lle dysgu ymarferol**. Wrth drafod y ddarpariaeth gofal, gofynnodd y grŵp a ystyriwyd cynnwys trosglwyddo gwybodaeth ac ymweld â chartrefi gofal eraill, o bosibl, mewn rhaglenni hyfforddiant.

- **Dylai bywydau pobl fod yn werth y gost o reoleiddio a chofrestru** staff ar bob lefel ym maes gofal.

- Arweinyddiaeth dda yw'r sail i reoleiddio da.

- Mae Cyngor Gofal Cymru wedi gwneud llawer o waith da ynghylch camau cychwynnol cofrestru staff. Dylid datblygu hyn yn awr, ac ni ddylai Cymru fod ar ei hôl hi.

- Rhaid i weithwyr proffesiynol, gan gynnwys nyrsys a therapyddion galwedigaethol, sy'n gofalu am bobl hŷn wybod mwy am ba wasanaethau a chymorth sydd ar gael yn y gymuned.

- Roedd y grŵp o'r farn ei bod yn bwysig ystyried dewisiadau unigol o ran ble y mae pobl yn dymuno byw. Yn enwedig, teimlent ei bod yn bwysig cydnabod pam mae pobl yn dymuno aros gartref a bod yn annibynnol, ac y gellid defnyddio hyn i ddatblygu'r sector gofal.

- Roedd y grŵp **yn pryderu bod sefydliadau proffesiynol yn tueddu i wneud penderfyniadau sy'n osgoi risg** yng nghyswllt pobl hŷn. Hoffai'r grŵp weld y grwpiau hyn yn cael mwy o rym ac arweinyddiaeth, er mwyn sicrhau eu bod yn gwneud y penderfyniad gorau ar gyfer y claf ac nid y penderfyniad sydd â'r risg leiaf o'u safbwynt hwy.

- Dylid cynnal arolwg hydredol ymysg pobl sy'n 60 oed er mwyn cynllunio ar gyfer y dyfodol. Mae'n bwysig bod y Llywodraeth yn cyfathrebu â'r rheini a fydd yn defnyddio ac yn cyllido'r system gofal preswyl yn y dyfodol wrth ddatblygu modelau gofal newydd.

- Roedd y grŵp o'r farn bod **hyfforddiant yn elfen allweddol o ddarparu gwasanaeth gwell ym maes gofal preswyl**, yn enwedig mewn meysydd fel dementia, lle y gall hyd yn oed ychydig bach o hyfforddiant drawsnewid y gofal a ddarperir mewn cartref. Fodd bynnag, teimlai'r grŵp fod materion yn ymwneud ag ansawdd yn codi'n aml pan fo hyfforddiant yn cael ei ddarparu'n fewnol gan gartrefi, ac yn electronig.

- Yn aml, gall hyfforddiant mewn lleoliadau gofal fod yn ymarfer ticio blychau, yn enwedig yng nghyswllt iechyd a diogelwch a chodi a chario, er enghraifft, nad oes ganddo fawr o gyswllt â'r hyn sy'n digwydd mewn gwirionedd. Pan ofynnir i'r staff am hyfforddiant, ni allant weld cyswllt rhwng yr hyn a ddysgwyd a'u profiadau yn y swydd.

- Mynegodd y grŵp bryder y gallai preswylwyr ddioddef os aethpwyd â'r staff oddi ar y safle i'w hyfforddi a chyflogwyd staff asiantaeth yn eu lle nad oeddent yn gwybod am anghenion preswylwyr.

- Credai'r grŵp fod y cysyniad o gael pwynt canolog ar gyfer gwybodaeth yn un da, ac y byddai'n ddefnyddiol cael ffordd o arwain pobl drwy'r broses o ddewis gofal preswyl a mynd i ble y caiff ei ddarparu. Fodd bynnag, teimlwyd y byddai angen cefnogaeth pawb sy'n ymwneud â darparu gofal preswyl ac y byddai angen i'r adnoddau priodol fod ar gael er mwyn sicrhau y gallai pobl gael gafael ar y wybodaeth mewn pryd. Awgrymodd y grŵp y dylid ystyried modelau sy'n bodoli eisoes wrth ddatblygu unrhyw adnodd o'r fath, er mwyn dysgu o arferion gorau.

- Mae llawer o'r dystiolaeth a gafwyd wedi awgrymu bod preswylwyr yn cael profiad negyddol mewn cartrefi mwy, o'u cymharu â chartrefi llai. Fodd bynnag, pwysleisiodd y grŵp fod rhai manteision yn gysylltiedig â chartrefi gofal mwy, gan y gallant ddarparu dewis ehangach o weithgareddau, ynghyd â mwy o gyfle i gymdeithasu ac i barhau'n fwy gweithgar yn gyffredinol.

- Ym marn y grŵp, roedd honiad yr undebau llafur bod diffyg hyfforddiant a datblygiad ar gyfer staff, cyflogau isel, a diffyg proffesiynoli yn y sector gofal yn adlewyrchu sut y caiff staff eu gweld, ac yn pwysleisio bod angen dyrchafu'r alwedigaeth.

8. Yn ychwanegol at ystyried y materion a ddaeth i'r amlwg yn y sesiynau tystiolaeth, bu'r grŵp hefyd yn ystyried nifer o bwyntiau yn ymwneud â themâu sy'n codi'n aml, sef cyllid a phroffil y staff:

Cyllid

- Nid yw cael lleiafswm o gyllid yn ddigon; bydd yn arwain at lai a llai o

arian. Ni ddylai'r ffaith bod rhywun yn cael ei gyllido drwy'r awdurdod lleol olygu o reidrwydd na all ond fynd i gartref o ansawdd is.

- Rhaid ystyried y system ar gyfer taliadau ychwanegol.

- Rhaid gwneud mwy o waith ynghylch taliadau gofal parhaus, gan eu bod yn cael eu dyfarnu mewn modd anghyson ar hyn o bryd. Teimlai'r grŵp fod loteri o ran cael y taliadau hyn, ac mai'r ffordd yr ydych yn ateb cwestiynau'r asesiad sy'n bwysig, yn hytrach na bod gwerthusiad gwirioneddol o angen. Ymddengys fod cleifion yng Nghymru (yn enwedig y rheini sydd â dementia neu gyflyrau gwybyddol) o dan anfantais o'u cymharu â chleifion yn Lloegr, a hynny o ganlyniad i'r dull a ddefnyddir i asesu.

Proffil y Staff

- Mae'r sgiliau a'r gofynion y mae eu hangen ar staff sy'n gweithio ym maes gofal preswyl yn llawer uwch nag sy'n cael ei gydnabod. Er enghraifft, mae angen i staff wybod am nifer o gyflyrau, gan gynnwys clefyd Alzheimer, clefyd Parkinson, a nam ar y synhwyrau, a rhaid iddynt allu gweithredu o ganlyniad i arwyddion y cyflyrau hyn.

- Mae angen gwneud mwy o waith i godi proffil gweithwyr gofal, ac i wella agweddau tuag at staff.

- Roedd y grŵp o'r farn y gellid crynhoi'r nodweddion y mae eu hangen ar y rheini sy'n gweithio ym maes gofal preswyl drwy ddefnyddio'r pedwar 'S': ***Sicr*** (i allu ymdrin ag unrhyw heriau); ***Sensitif*** (o ran urddas); ***Synnwyr digrifwch***; a ***Stumog gref***.

- Dylid ystyried gweithio ym maes gofal yn alwedigaeth, a dylid gweithio i sicrhau bod strwythur gyrfa clir ynddi.

- Dylid hyrwyddo gweithio yn y sector gofal a'r manteision a'r gwobrwyon sy'n gysylltiedig ag ef. Eto i gyd, byddai angen i hyn gynnwys pob agwedd ar yr hyn y mae'n rhaid ei wneud yn y swydd, er mwyn helpu i fynd i'r afael â'r gyfradd cadw staff.

- Awgrymodd y grŵp y byddai'n ddefnyddiol pe bai manyleb safonol y person i weithwyr gofal ar gael, y gallai'r arolygiaeth ei defnyddio i sicrhau bod y sgiliau priodol mewn cartref, a bod gan staff asiantaethau gymwysterau priodol.

Cwestiynau ar gyfer sesiynau'r dyfodol

9. Awgrymodd y grŵp y meysydd a ganlyn y byddai'r Pwyllgor efallai am eu trafod â'r Dirprwy Weinidog Plant a Gofal Cymdeithasol yn y cyfarfod ar

20 Mehefin 2012:

- Yr angen am fodelau ariannol gwahanol wrth ddarparu gofal preswyl, er mwyn sicrhau hyfywedd gwasanaethau gofal yn y dyfodol ac i sicrhau y gall unigolion ddewis i ble y maent yn mynd. Dylai hyn gynnwys dewisiadau a fyddai'n galluogi unigolion i fuddsoddi yn eu gofal fel rhanddeiliad.

- Talu am ofal a chanfod beth yw safbwynt Cymru ynghylch Comisiwn Dilnot.

- Sicrhau bod tryloywder yng nghyswllt gwybodaeth am gartrefi preswyl preifat, mewn meysydd fel hyfywedd ariannol, nifer y staff, a hyfforddiant/cymwysterau, a fydd yn galluogi pobl i wneud dewisiadau gwybodus.

- Gwaith cynllunio'r Llywodraeth ar gyfer anghenion gofal yn y dyfodol– teimlai'r grŵp fod angen cynnal arolwg o bobl yn eu 50au/60au i weld sut y gallai'r proffil anghenion iechyd/gofal fod yn y dyfodol.

- Ffyrdd i fynd i'r afael â chanfyddiad gwael y cyhoedd o gartrefi gofal a gwaith gofal.

- Yr angen i symud i ffwrdd o 'gartrefi' preswyl/ymddeol ac ehangu'r gorwel i gwmpasu pentrefi ymddeol, lle y gellid ymdrin ag anghenion gwahanol.

Unrhyw fater arall

10. Cytunodd y grŵp i gynnal cyfarfod arall tua diwedd mis Gorffennaf neu ar ddechrau mis Awst er mwyn trafod y prif themâu ac argymhellion a ddaeth i'r amlwg o'r ymchwiliad; bydd hynny'n cyfrannu at yr adroddiad drafft.