THE NATIONAL ASSEMBLY FOR WALES

AUDIT COMMITTEE

Report presented to the National Assembly for Wales on 12 May 2005 in accordance with section 102(1) of the Government of Wales Act 1998

NHS Waiting Times in Wales

Contents **Paragraphs**

Summary

Recommendations 1-13

NHS waiting times in Wales

- the impact of long waiting times 14-15
- waiting time targets and their achievement 16-23
- comparisons with other parts of the United Kingdom 24-28
- waiting time variations within Wales 29-33

The causes of long waiting times 34

- level of demand for NHS services 35-39
- NHS Wales' capacity 40
- shortages of capacity in NHS Wales 41-42
- configuration of capacity 43-44
- utilisation of existing capacity 45-48
- delayed transfers of care 49-50

Improving waiting time performance

- leadership 51-53
- commissioning 54-56
- demand management and redesigning services 57-60
- strategy and performance management 61-65
- the use of waiting time initiatives, the Second Offer Scheme and the role of the private sector 66-70

- information and its management 71-72
- spreading best practice to improve waiting times 73-74

ANNEXES

Annex A – Relevant proceedings of the Committee – Minutes of evidence (Thursday 3 February, 10 February and 3 March 2005)

Annex B – Letter and supporting notes from Mrs Lloyd to the clerk to the Audit Committee, dated 16 March 2005

Annex C – Welsh Assembly Government press release, dated 17 March 2005, announcing revised waiting time targets

Annex D - Audit Committee

Summary

Many people in Wales have to wait for NHS treatment. Some of them have to wait for a very long time. At the end of February 2005, 368 people had waited over 18 months for inpatient/day case treatment (0.5 per cent of the total waiting for treatment), while 3,381 had waited over 18 months for a first outpatient appointment (2 per cent of the total waiting). Long waiting times give rise to widespread concern, impose human costs on patients and their carers, and can increase the ultimate cost of treatment.

On 3 and 10 February, on the basis of a report by the Auditor General for Wales, we took evidence about NHS waiting times from Mrs Ann Lloyd, Director of the Health and Social Care Department of the Welsh Assembly Government which is responsible for setting the overall policy framework, within which NHS waiting times are managed. On 3 March, we took further evidence from representatives from some of the local health organisations which are responsible for delivering the Welsh Assembly Government's waiting time targets and for developing local innovations and best practice to better serve their patients: Mr Geoff Lang, Chief Executive of Wrexham Local Health Board and Ms Bernadine Rees, Chief Executive of Pembrokeshire Local Health Board, and three NHS Trust chief executives - Ms Jane Perrin, Chief Executive of Swansea NHS Trust, Mr Paul Williams, Chief Executive of Bro Morgannwg NHS Trust and Mr Hugh Ross, Chief Executive of Cardiff and Vale NHS Trust. Consistently with the objectives of the National Assembly to conduct its business throughout Wales, this third evidence session took place in Swansea.

This report examines, in the light of the evidence we took, whether the position on waiting times can be improved. It concludes:

a. waiting times in Wales generally and especially in some areas have been and remain too long;

b. there is no single cause of long waiting times but rather a number of contributory factors acting on the whole health and social care system in Wales;

c. to improve the position, a strategic, whole system, framework is needed within which there is scope for numerous specific actions.

NHS waiting times in Wales are too long

The evidence before us leaves us in no doubt that the waiting time position in Wales has been and remains unacceptable:

a. long waiting times cause distress to patients and their carers, have wider economic and social costs and unnecessarily increase burdens on primary care;

b. the Welsh Assembly Government's 2001 targets for waiting times are not ambitious, yet even they are not being met. Shortly after our final evidence session, the Welsh Assembly Government announced new waiting time targets, to be achieved by 2009. Annex C contains the press release describing the revised targets;

c. health policy in Wales legitimately differs from that in England, but strikingly different waiting times as between Wales and England gives rise to practical problems as well as to no less legitimate concerns about equity;

d. within Wales there are very large variations in waiting times between different Local Health Board areas, between different NHS trusts, and between different specialties

There is no single cause of long waiting times

Long waiting times should be seen as a symptom of wider problems within the whole system of health and social care. Within that system numerous immediate causes can be identified:

a. **High demand for NHS services.** The ageing population of Wales increases demand relative to England, GP referral rates are increasing, and inappropriate referrals put pressure on waiting times. Wales has relatively higher accident and emergency attendances than any other part of the United Kingdom. Patients with chronic diseases generate a high demand for acute treatment: 55 per cent of beds in the acute sector are occupied by such patients.

b. **Capacity problems** (despite the existence of ample capacity overall). Some specialties suffer staff shortages. Within a low overall vacancy rate for consultants some key areas, such as accident and emergency have faced shortages. Access to diagnostic and therapy services varies, with particular problems in radiography, physiotherapy and podiatry. The physical capacity across the health and social care system is widely thought not to be arranged in the most effective way: for example, bed occupancy is high in acute hospitals but much lower in community hospitals. There is significant inefficiency in the way in which NHS Wales uses its existing capacity.

c. **Delayed transfers of care**, the so-called "blocking" of beds by patients who longer need to remain in beds in acute hospitals reduces the effective capacity of the system.

Improving waiting time performance requires a whole system approach

A very wide range of initiatives is underway within NHS Wales to tackle waiting times and their underlying causes, and we heard evidence from NHS Trust and Local Health Board chief executives about the actions taking place locally. This report sets out a number of measures that could be taken within a strategy to tackle waiting times. We highlight in particular the importance of treating the causes of long waiting times, rather than the symptoms. This report is intended to encourage the Welsh Assembly Government and local healthcare organisations to take a longer-term, more strategic

approach to tackling waiting times than they have previously. Their emphasis on waiting time initiatives has actually reinforced existing inefficiencies in the use of capacity and has failed to deliver sustainable reductions in waiting times.

This committee will monitor closely the impact of this report and the way the Welsh Assembly Government and NHS Wales proceed.

Recommendations

1. **Despite recent reductions, a significant minority of Welsh patients have still faced unacceptable waiting times of over 18 months. Waiting times in Wales compare badly with England and Scotland, although waiting times are longer in Northern Ireland.** Annex C provides the Welsh Assembly Government's announcement, two weeks after our final evidence session, of new waiting time targets intended to achieve a total waiting time of 6 months by 2009. The Welsh Assembly Government and trusts should develop systematic models of activity, demand and capacity to support the achievement of these targets.

2. **There are substantial variations in waiting times within Wales.** The Welsh Assembly Government should use the redistribution of resources arising from implementation of the Townsend Review to better meet health needs and, as a consequence, reduce the current regional variations in waiting times displayed in Figure 1 of this report.

3. **The absence of a clear overall strategy to reduce waiting times in Wales has contributed to the current level of waiting time performance. There have also been weaknesses in performance management, which have led to a perception that the Welsh Assembly Government has rewarded failure to meet targets, while there has been little incentive for better performing organisations to improve their performance.** We recognise that different organisations have differing starting points. The engagement of clinicians is critical in delivering better waiting times for patients, and there are particular dangers in targets which are imposed on clinicians without their ownership. Within a strategic framework, local organisations should then produce their own local targets, agreed and owned by clinical staff, for key measures of performance, including waiting times and their underlying causes. These local targets should reflect organisations' starting positions and should be subject to scrutiny, challenge and monitoring by Regional Offices. A strong framework of incentives and sanctions should support the delivery of these targets and reward good performance.

4. **NHS Wales has relatively little ring-fenced elective capacity compared to England and Scotland. New developments are in train but are overdue.** The Welsh Assembly Government and local health communities should further increase the amount of ring-fenced elective capacity available to improve the efficiency and speed with which NHS Wales treats patients from the waiting list. In particular, they

should, like England, take a strategic approach to the development of capacity on a regional basis, either through capital developments or redesignation of existing facilities.

5. **Local Health Boards' commissioning strategies can improve waiting time performance.** We recommend that commissioners use their commissioning strategies to change service models and minimise waiting times, particularly in commissioning by patient pathway and outcome, rather than traditional models of service delivery. Furthermore, Local Health Boards should collaborate to reduce duplication, share skills and maximise the impact of their commissioning strategies, both within their region and across the whole of Wales.

6. **It is essential that local health communities manage demand by providing services that are accessible to patients and reflect the way patients access and use services.** Consequently, we recommend that health communities seek to match services and patients' needs, for example by co-locating out of hours services with accident and emergency services; developing pathways to manage chronic diseases more appropriately; by developing or expanding medical assessment units; and by developing new roles such that the most appropriate healthcare professionals treat patients in the most appropriate setting. They should also establish systems to capture data about referrals and establish mechanisms to enable consultants to feed back to GPs about the quality of referrals and alternatives to referral to a consultant.

7. **There is evidence that the National Leadership and Innovation Agency for Healthcare, and its predecessor bodies, have supported effective innovation and modernisation within parts of NHS Wales, but that there is considerable scope to spread best practice further, particularly through the more effective engagement of all clinicians.** We recommend that the National Leadership and Innovation Agency for Healthcare engages with clinicians who are resistant to new ways of working, as well as those willing to act as champions of change, to improve patient care, efficiency and waiting times by spreading recognised best practice throughout NHS Wales.

8. **The extent of cancellations is unacceptable and reflects, in part, weaknesses in pre-operative assessment processes.** We recommend that trusts should reduce cancelled operations, for example by strengthening their pre-operative assessment processes and by seeking to extend booking systems to inpatient/day case treatments. Should there be no reduction in the current number of cancellations, the Welsh Assembly Government should include in next year's Service and Financial Framework a target for health communities to reduce cancellations.

9. **Patient throughput could be improved if trusts had more efficient and robust discharge processes which plan patients' discharge as soon as they are admitted.** We recommend that all trusts develop discharge processes and protocols to ensure that discharge is as timely as possible. These should include setting target discharge dates for patients as soon as they are admitted, modernising pharmacy

arrangements, expanding the range of healthcare professionals able to discharge patients and ensuring that ward rounds are timed to enable new patients to be admitted as soon as possible.

10. **The extent of delayed transfers of care, excluding mental health delays, is a serious drain on the secondary care sector, accounting for an average of 723 beds each day between November 2003 and June 2004.** Consequently, we recommend that health communities minimise the impact of delayed transfers of care arising from patient choice by developing and using staging posts in community settings, in which they can place patients while they wait for their chosen care home.

11. **Waiting times could be improved if NHS Wales made better use of its existing capacity, particularly by improving bed and operating theatre utilisation, and maximising rates of day surgery.** We therefore recommend that the Welsh Assembly Government should only provide additional funding to those organisations which can clearly demonstrate that they are making good use of the capacity they already have. Otherwise, additional funding simply reinforces existing poor use of capacity.

12. **The Welsh Assembly Government has made extensive use of additional non-recurrent funding to run 'waiting time initiatives' in the private sector or in the evening or at weekends in NHS facilities. Although non-recurrent funding can be beneficial in some circumstances, initiatives have taken place for too many years without delivering sustainable solutions to the waiting time problem. This is largely because they do not address the underlying causes of long waiting times.** The Welsh Assembly Government should permit the use of non-recurrent funding, not only to treat additional patients, but also to achieve sustainable change by addressing the underlying causes of long waiting times in their health communities. The Welsh Assembly Government should ensure that any non-recurrent funding is subject to specific targets to reduce waiting times and their underlying causes, with claw back where health communities fail to achieve such targets.

13. **The Second Offer Scheme has contributed to recent reductions in inpatient/day case waiting times, but has some inherent risks which need careful management.** In particular, we recommend that the Welsh Assembly Government implements controls to make sure that NHS Wales does not pay twice for treating the same patient as a result of referral to the Second Offer Scheme. The Welsh Assembly Government should consult Local Health Boards about proposed developments under the Second Offer Scheme so that they are consistent with local commissioning strategies.

NHS waiting times in Wales

The impact of long waiting times

14. Waiting times are important to patients and also have impacts across the system of health and social care. Primarily these impacts affect patients on the waiting lists, their families and carers. As well as these personal costs, waiting times have wider economic and social costs. Mrs Lloyd recognised that

patients, particularly in orthopaedics, experience particular problems with mobility and access if they have to wait over one year for treatment.[1] Given the 26 per cent increase in expenditure on the NHS in Wales between 2000-01 and 2003-04,[2] we cannot condone the deterioration of patients.

15. We were also concerned to find that long waiting times for treatment increase the burden on GPs and primary care more generally.[3] Patients who face long waiting times are likely to make repeat visits to their GP to manage their condition, thus reducing the capacity of primary care to provide a wider range of services by caring locally for patients, particularly those with chronic diseases, or to treat those who need minor procedures. We note that Mrs Lloyd has asked Local Health Boards to estimate the impact of long waiting patients on primary care.[4]

Waiting time targets and their achievement

16. As a result of the importance of the time patients wait for treatment, NHS waiting times and associated targets form an important element of health policy both in Wales and other parts of the United Kingdom. Waiting times measured by the Welsh Assembly Government, in common with other parts of the United Kingdom, relate only to particular parts of the patient's journey from first experiencing symptoms to receiving their final treatment. Figure 2 shows the component parts of most patients' journey through the healthcare system and that some periods of waiting – such as for diagnostic tests – do not currently count towards waiting time figures. The Welsh Assembly Government has set targets for and measures the following key elements of the patient journey through the healthcare system in Wales:

    - the waiting time for a first outpatient appointment after referral from a GP, another consultant, accident and emergency or other source – this is known as the **outpatient waiting time;** and

    - the time from a consultant's decision to place a patient on the inpatient/day case waiting list for treatment to the date of admission to hospital – the **inpatient/day case waiting time**.

17. The Welsh Assembly Government has set a number of waiting time targets, first set out in its NHS Plan of 2001. There are basic targets that no one should wait over 18 months for a first outpatient appointment or for inpatient/day case treatment, reducing to 12 months by March 2006. In addition, there are a number of specific targets for particular procedures, such as cataract surgery (four month maximum waiting time), routine cardiac surgery (12 month maximum waiting time, subsequently reduced to 10 and then eight months), angiography (six month maximum waiting time) and orthopaedic surgery (18 month maximum waiting time).5

[1] AGW report, volume 1, paragraphs 2.8-2.13 and figures 3 and 4; Q75
[2] Annex B
[3] AGW report, volume 1, paragraph 2.13 and figure 4
[4] Q104
[5] AGW report, volume 1, figure 7

18. Thus, even if current waiting time targets in Wales were achieved, some patients' total waiting time, even assuming that they move straight from the first outpatient appointment to the inpatient/day case waiting list without having to wait for diagnostic tests, could be three years.[6] This compares very unfavourably with the much more ambitious target in place in England, which is moving to a total waiting time – from GP referral to surgical treatment – of no more than 18 weeks by 2008.[7] In Scotland, the NHS is working to maximum waiting times for both outpatients and inpatient/day cases of 6 months by December 2005.[8] This Committee believes that the waiting time targets in Wales have lacked ambition, and agrees with Mr Williams, chief executive of Bro Morgannwg NHS Trust, who described the targets as 'somewhat conservative', with targets having a lower priority than those set in England.[9] Mr Williams emphasised his belief that targets can work, citing the impact of the four month target for cataract surgery as an example of a positive impact.[10]

19. The Welsh Assembly Government recently announced new waiting time targets: a total waiting time – first outpatient appointment, diagnostic test and inpatient/day case treatment - of 6 months by 2009, with interim targets of a total waiting time of no more than 16 months by March 2007, and 12 month maximum waiting times for each of a first outpatient appointment and inpatient/day case treatment by March 2006.[11]

20. The Welsh Assembly Government now appears to have understood the essential fact that the primary concern of patients is their total waiting time - from first experiencing symptoms to their eventual treatment. The artificial distinction between outpatient and inpatient/day case waiting times means little to patients. The existence of waiting times for diagnostic and therapy services, which are not measured and therefore add to the total waiting times, exacerbates this situation. The Welsh Assembly Government has taken steps to measure waiting times for diagnostic and therapy services in order to understand better how long patients wait for such services and to identify the causes of long waiting times. Mrs Lloyd told us that she was waiting for approval from the Statistical Directorate that the waiting time data on diagnostic and therapy services were sufficiently robust for publication.[12]

21. NHS Wales has so far failed to meet Welsh Assembly Government waiting time targets. At the end of June 2004, just over 7,000 patients had been waiting over 18 months for a first outpatient appointment; while just under 1,500 patients had been waiting over 18 months for inpatient/day case treatment.[13] By the end of February 2005, this had reduced to 3,381 for outpatients and 368 for inpatient/day

[6] AGW report, volume 1, figure 7
[7] Q45
[8] AGW report, volume 1, figure 7
[9] Q296
[10] Q324
[11] Annex C
[12] Qs 121-123
[13] AGW report, executive summary, paragraph 7

cases.14 The substantial reduction in inpatient/day case waiting times reflects the initial impact of the Second Offer Scheme.15 However, we agree with Mrs Lloyd that any waiting times of over 18 months, for a first outpatient appointment or for inpatient/day case treatment, are unacceptable, particularly when it is the total waiting time which matters most to patients.16 Mr Ross also recognised in his evidence to us that the overall patient journey is still far too long.17 Waiting times of over eighteen months, and indeed over twelve months, are unacceptable in a modern system of healthcare. Nevertheless, we recognise that long waiting times affect a minority of patients treated by NHS Wales, albeit a much larger minority than exists anywhere else in the United Kingdom other than Northern Ireland.18 The Auditor General found that 85 per cent of patients, treated across three key specialties between January and September 2003, received treatment within one year.19 Mr Ross informed us that Cardiff and Vale NHS Trust treated 84 per cent of patients from its waiting lists within 6 months in the last year.20 Thus those facing the longest waiting times represent a 'tail' at the end of the waiting list.

22. As well as setting overall maximum waiting time targets, the Welsh Assembly Government has set specific targets for particular priority procedures. Although performance has generally improved against all of these targets, NHS Wales has not yet achieved all of the Welsh Assembly Government's specific targets. We recognise that there have been recent reductions in cataract, cardiac surgery and orthopaedic waiting times, but that some specific targets have not been achieved and some patients are still waiting too long for some priority procedures.21

23. We note the assurances from Mrs Lloyd and the three Trust chief executives that it is imperative that all trusts achieve the new 12 month targets for first outpatient appointment and inpatient/day case treatment by March 2006 and that their trusts were confident that they would achieve their waiting time targets for the 2004-2005 financial year.22 There are concerns about the sustainability of such improvements in waiting times - Mr Lang and the Auditor General's report both highlighted a pattern, whereby waiting times fall as one financial year ends but 'bounce up' again at the start of the new financial year when non-recurrent funding has been exhausted.[23]

Comparisons between waiting times in Wales and those elsewhere in the United Kingdom

24. Devolution legitimately leads to differences in policy between the different parts of the United Kingdom. Mrs Lloyd emphasised the fact that Wales had adopted a broader health policy, focusing on

[14] NHS Waiting Times at the end of February 2005, National Assembly for Wales statistical bulletin, published March 2005
[15] Q195
[16] Qs 72 and 95
[17] Q323
[18] AGW report, volume 1, figures 17 and 18
[19] AGW report, volume 1, figure 21
[20] Q299
[21] AGW report, volume 1, figure 9
[22] Qs 18, 20, 289 and 291
[23] AGW report, volume 1,figure 12 and volume 2, paragraph 4.42; Q250

the determinants of ill-health and the overall public health agenda and had not given such a driving, laser-like concentration on waiting times, as had been the case in England.24 Mrs Lloyd estimated that it would take ten years for this broader policy to demonstrate its benefit,25 but observed that in England, the government was beginning to pursue the public health agenda, having dealt first with reducing waiting times.26 However, in our view these are not alternative policies: they go hand-in-hand and complement each other. We see no reason why the Welsh Assembly Government should not have been taking all possible steps to improve waiting times whilst at the same time paying attention to tackling the determinants of ill-health, since a focus on public health at the expense of waiting times could condemn a generation of patients to the pain and inconvenience of long waiting times.

25. Moreover, irrespective of the Welsh Assembly Government's attention to longer-term issues associated with the overall public health agenda, the people of Wales have a right to expect that they do not have to wait longer for treatment than people in England. We note the Auditor General's analysis which shows that people in Wales are waiting significantly longer for healthcare than those in England and Scotland, although waiting times are even longer in Northern Ireland.27

26. There are some differences in the numbers of people counted on the outpatient waiting list. Wales has a clearer idea of the number of people waiting for a first outpatient appointment because it counts a wider range of outpatients (estimated by the Auditor General to represent between 20 and 30 per cent more patients than those counted in England). Nonetheless, at the end of March 2004 there were only 18 people who had been waiting over 6 months for a first outpatient appointment in England, compared with 68,845 in Wales.28 For inpatient/day cases, there were over 8,000 patients waiting over one year in Wales at the end of March 2004, whereas in England and Scotland, waiting times of one year or more had been largely eradicated.29 Supplementary evidence provided by Mrs Lloyd showed that, despite broadly similar levels of expenditure per head of population, the percentage of patients who had been waiting more than six months at 31 March 2003 was twenty per cent higher in Wales than in north east England.30 Witnesses from the service confirmed that there are clear and material differences in waiting times between England and Wales. We consider that it is essential that the Welsh Assembly Government improves the relative waiting time position in Wales compared with other parts of the United Kingdom.

27. Furthermore, policy differences have real impacts for those patients living on the border between England and Wales. Some 30,000 patients each year travel from Wales for treatment in England, while

[24] Q182
[25] Q51
[26] Q45
[27] AGW report, volume 1, paragraphs 4.15-4.19 and figures 17-19
[28] AGW report, volume 1, paragraphs 4.12-4.14 and figure 17
[29] AGW report, volume 1, figure 18
[30] Annex B

between 15,000 and 18,000 travel in the opposite direction for treatment in Wales.31 The Auditor General's report commented on the impact of diverging health policy between Wales and England, particularly the financial risks facing Welsh commissioners of services from England if large volumes of patients are treated within English waiting time targets.32 Mr Lang confirmed that some residents of Wrexham were waiting longer for treatment in English trusts than English patients in the same trusts, as well as the difficulty for Welsh commissioners of keeping up with the rapid pace of change in England over the past two years. Mr Lang stressed the difficulties faced by clinicians in explaining and trying to justify to their Welsh patients that, because they happen to live in the wrong village, they must wait a further nine months for treatment.33

28. Mr Lang further expressed his concern that the ongoing reductions in waiting times and waiting time targets in England, particularly the drive to achieve a total waiting time of 18 weeks from referral to treatment by 2008, could severely diminish the influence of Welsh commissioners on English providers. This in turn may lead to additional financial risks, as further reductions in English waiting times may encourage GPs to alter their referral patterns away from Welsh providers with longer waiting times, thus destabilising those Welsh providers. For example, Mr Lang estimated that £1 million of North East Wales NHS Trust's income was at risk in this way.34 However, witnesses also suggested that there can be benefits from a more competitive environment, such as exists in north Wales, where the lower waiting times across the border in England appear to provide an incentive for Welsh trusts to keep their waiting lists as low as possible, to continue to attract referrals.[35]

Waiting time variations within Wales

29. As well as differences in waiting times between Wales and other parts of the United Kingdom, one of the most striking aspects of the analysis in the Auditor General's report was Figure 16 in Volume 1, which analysed waiting times of over 18 months per 1,000 head of population – both outpatient and inpatient/day case - in each of Wales' twenty-two Local Health Board areas at the end of December 2003. This very helpful indicator, shown in Figure 1 below, of performance revealed significant regional variations, such that the number of outpatients waiting over 18 months per 1,000 head of population varied by a factor of nearly twelve, with the position especially serious in Cardiff and the Vale of Glamorgan Local Health Board areas. For inpatient/day cases, Figure 1 shows that the number of people waiting over 18 months per 1,000 head of population varied by a factor of three between the Local Health Board areas. Waiting times were much longer in south Wales than they were in north

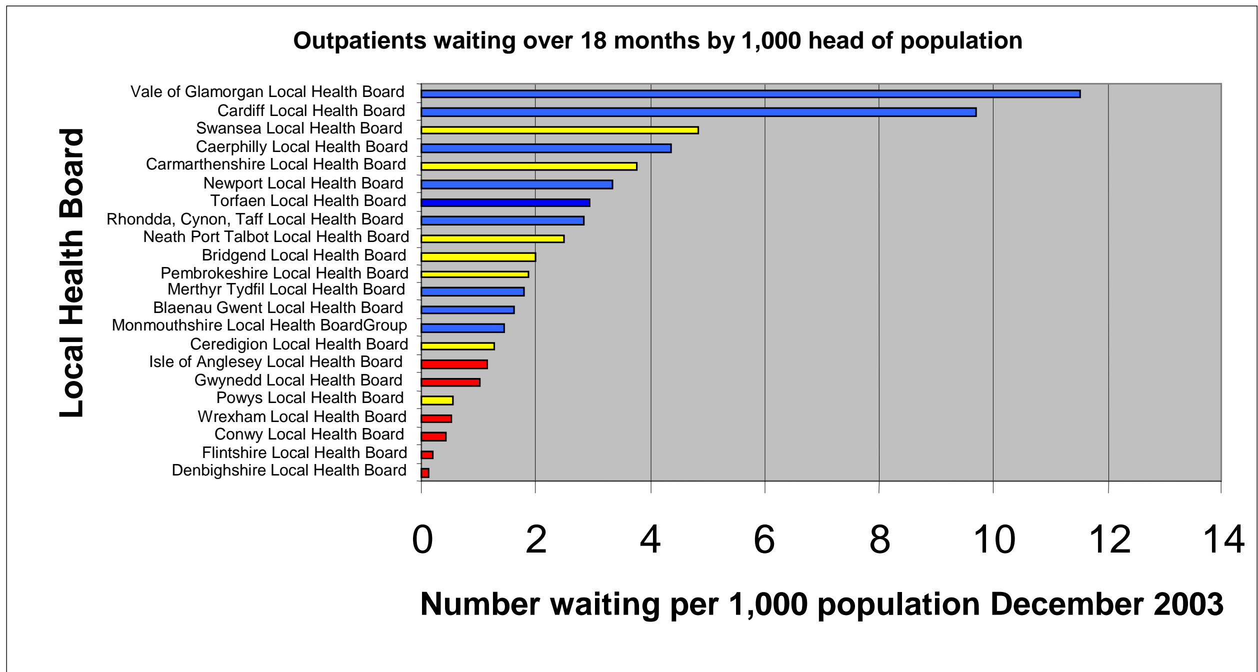
[31] Q206
[32] AGW report, volume 2, paragraphs 4.52-4.55
[33] Qs 235 and 273-274
[34] Q276
[35] Q234

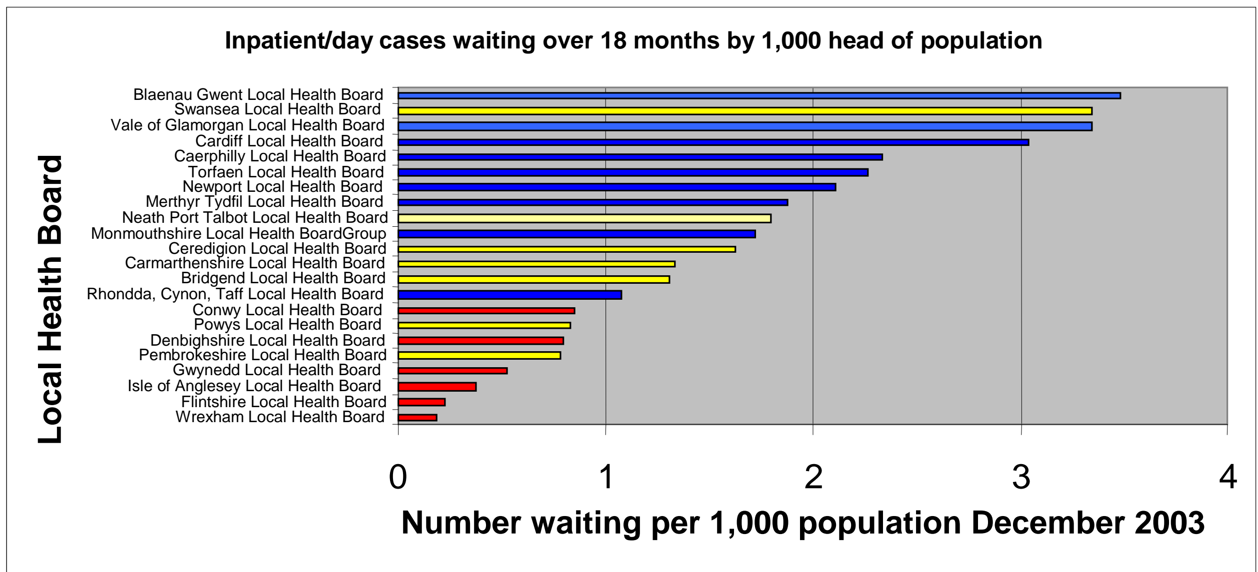
Wales, and represent a postcode lottery.[36] We agree with Mrs Lloyd's view that the problems arising from such inequalities of waiting times must be eradicated.[37]

30. Waiting times also vary by NHS Trust. While the majority of trusts have met the Welsh Assembly Government's maximum 18 month waiting time targets for outpatients and inpatient/day cases, the two tertiary trusts - Cardiff and Vale, and Swansea – accounted for over 80 per cent of all waiting times of 18 months or more.[38] Mr Williams said that, although Bro Morgannwg NHS Trust had exceeded all of the Welsh Assembly Government waiting time targets, it did not provide the specialist services, which Swansea and Cardiff and Vale NHS Trusts provide for emergency and elective patients from all over Wales, as well as some from England.[39] Mrs Lloyd referred to the fact that trusts in major urban conurbations can face greater demand from residents the nearer they live to the hospital. She informed us that the Welsh Assembly Government is working with trusts to unpick this issue.[40] Ms Perrin told us that Swansea's role as a national centre for Plastic Surgery services distorted their waiting time statistics, although there was additional pressure on the Trust because of the 50 per cent refusal rate in the locality under the Second Offer Scheme.[41]

Figure 1 – Numbers waiting over 18 months for a first outpatient appointment or inpatient/day case treatment per 1,000 head of population December 2003

[36] AGW report, volume 1, figure 16
[37] Q28
[38] AGW report, volume 1, paragraph 4.5
[39] Q291
[40] Q23
[41] Q293





Key to Figure 16

South East Wales Regional Office

Mid and West Wales Regional Office

North Wales Regional Office

Source: National Audit Office.

31. There are additional and significant variations in waiting times by specialty. We were particularly concerned by the fact that 62 per cent of those waiting for a first outpatient appointment in Plastic Surgery had been waiting over 12 months at the end of June 2004. 42 Mrs Lloyd attributed this to the

[42] AGW report, volume 1, paragraphs 4.3-4.4 and figure 15

fact that the list contained a number of patients with problems which England may not treat, or would direct to an alternative practitioner; and there was a legacy of health authorities failing to manage the waiting list with sufficient rigour. We are concerned that poor waiting list management, allied to an apparent absence of alternative practitioners, may distort the overall picture of outpatient waiting times in Wales. Mrs Lloyd assured us that her officials are working with Swansea NHS Trust to look very critically at the needs of these patients, and to see whether they need to be seen by a consultant and what alternatives could be provided for them.[43]

32. In addition, there are other specialties with long waiting times. For outpatients, over ten per cent of those waiting in plastic surgery, neurology, pain management, trauma and orthopaedics, other neurology, neurosurgery, rheumatology and ear, nose and throat had been waiting over 12 months at the end of June 2004. For inpatient/day cases, there were particular problems in neurosurgery, ear, nose and throat, trauma and orthopaedics, general surgery, plastic surgery and neurology.[44]

33. Such variations by speciality and Trust reflect the regional variations by Local Health Board, meaning that patients in particular regions and specialties can face extremely long waiting times. The fact that waiting times depend on a patient's condition and place of residence is inherently inequitable and requires urgent action from the Welsh Assembly Government. Mrs Lloyd assured us that the Welsh Assembly Government has conducted a significant volume of work to determine health needs, and has used the Townsend Review, which published its report in July 2001 and found that the allocation of resources did not adequately match the distribution of disease, to better match the allocation of resources with those health needs.[45]

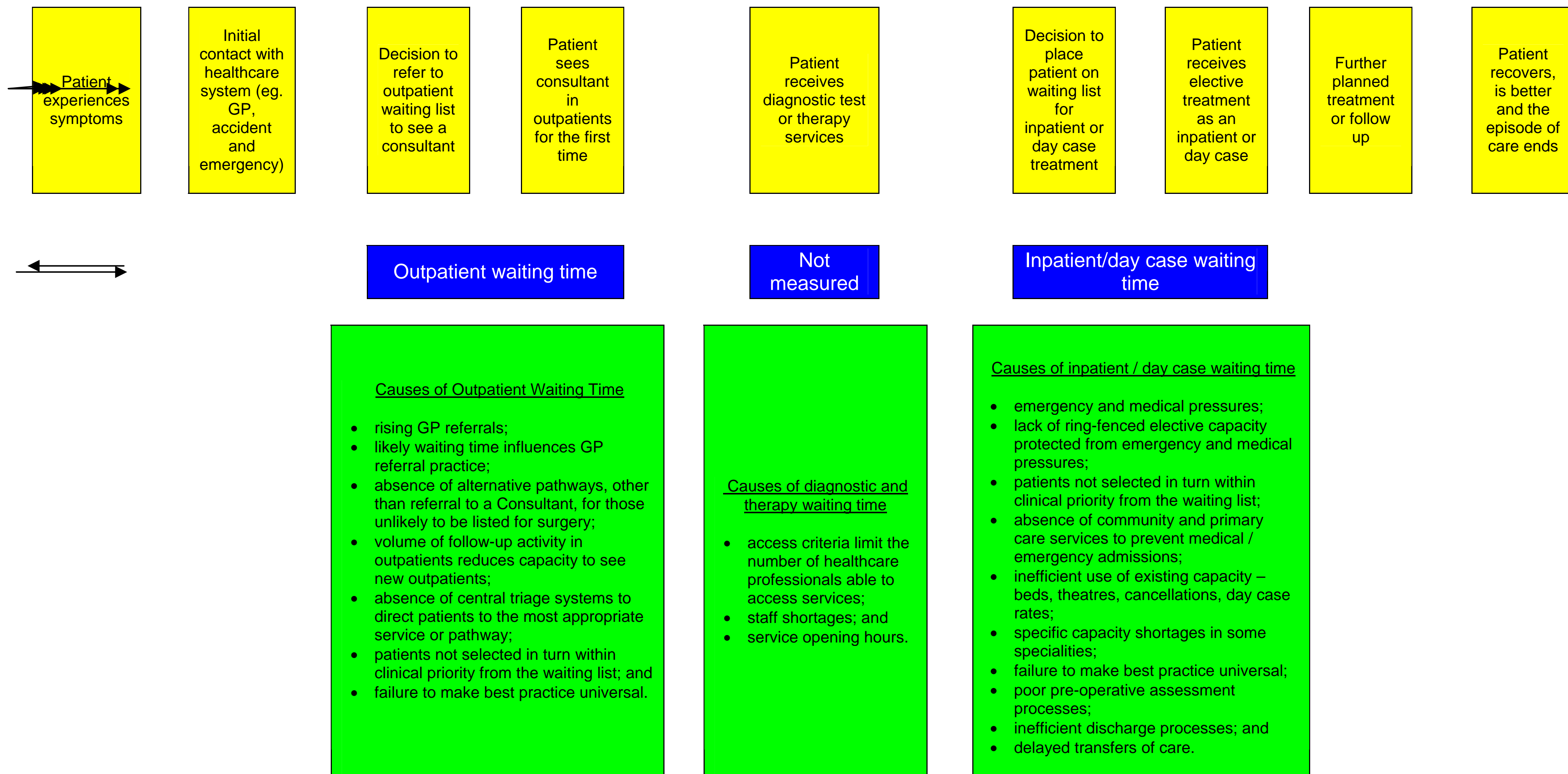
The causes of long waiting times

34. Waiting times are a symptom of wider problems within the whole system of health and social care. Treating the symptom – people facing long waiting times – does not address the underlying causes of long waiting times. The long waiting times, faced by many people in Wales, have numerous causes which vary at different stages of the pathway. The specific pressures which affect the different health communities also influence local waiting times. Figure 2 shows how the causes of long waiting times

[43] Q77
[44] AGW report, volume 1, figure 15
[45] Qs 23-27

vary at different stages of the patient’s journey through the healthcare system. We set out in more detail these main causes in the paragraphs that follow.

Figure 2 – waiting times and their causes at the different stages of the patient pathway



Level of demand for NHS services

35. Mrs Lloyd stressed the fact that Wales has an ill and ageing population, with many people suffering from more than one condition.[46] Mrs Lloyd's note shows that Wales has a higher percentage of its population aged 65 and over than any part of the United Kingdom other than south west England. Wales also has a higher standard mortality rate per 100,000 population than England, although some regions – such as north east and north west England, and Scotland – have higher standardised mortality rates than Wales. 47 Mrs Lloyd also indicated that the Welsh Assembly Government's focus on health inequalities and the causes of ill-health has lead to a short-term increase in demand.48

36. The principal cause of long outpatient waiting times is increasing demand, manifested by increasing GP referral rates. It is also important to note that there is a relationship between waiting times and GP referral practice, identified both by the Auditor General's report and Mrs Lloyd's evidence.49 GPs sometimes refer earlier in recognition of the likely long waiting time.50 While shorter waiting times may encourage earlier referral, they may also lead to GPs delaying a referral because they know that the patient will be able to access a consultation quickly should their circumstances change.51 The Auditor General's report showed that first outpatient appointments, which are counted on the waiting list, account only for one quarter of total outpatient activity.52 Consequently, Mrs Lloyd said that it was important to increase the number of first outpatient appointments, available to those waiting to get into the system from the waiting list, by developing alternatives to follow-up outpatient appointments with a consultant. 53 We welcome the fact that the Service and Financial Framework for 2005-06 includes efficiency targets which seek to increase the ratio of new to follow-up appointments.

37. Mrs Lloyd described the potential to send all referrals for triage by an expert team to ensure that they followed the most appropriate pathway, rather than placing all patients on a consultant's outpatient waiting list. This has great potential to improve patients' ability to access the services most appropriate to their needs, as well as reducing the time they have to wait for care or treatment. We were interested to hear Mrs Lloyd describe a scheme in Manchester, through which all GP referrals go to an expert team to be put into categories for referral to an extended scope practitioner or GP with a special interest.54 Mr Ross described a similar pilot in the Vale of Glamorgan, whereby all referrals to secondary care will be assessed by a referral centre within the Local Health Board itself, to ensure that patients follow the most appropriate pathway. Mr Ross indicated that such models, when used in

---

[46] Qs 51 and 134
[47] Annex B
[48] Qs 3 and 51
[49] AGW report, volume 2, paragraphs 2.4-2.5; Q103
[50] Q32
[51] AGW report, volume 2, paragraphs 2.4-2.5
[52] AGW report, volume 1, figure 5
[53] Q105
[54] Q31

England, had been shown to reduce secondary care referrals substantially by providing better alternatives.[55]

38. The major causes of long inpatient/day case waiting times are emergency and medical pressures, allied to the level of urgent work, which encroach upon elective capacity and crowd out NHS Wales' capacity to treat those on the elective waiting list.[56] Also, Mrs Lloyd and Mr Ross both informed us that many patients visit accident and emergency departments inappropriately,[57] but Mrs Lloyd was subsequently unable to produce detailed data to support this contention.[58] She did, however, provide a note which showed that Wales had relatively higher accident and emergency attendances than any other part of the United Kingdom other than Northern Ireland.[59] Trust chief executives described the difficulties they faced in balancing waiting time targets and the 'relentless' emergency pressures, which create daily dilemmas about cancelling elective treatments.[60] They emphasised the recent increase in emergency admissions, which was worrying and unsustainable, and linked it to recent changes in primary care out of hours GP provision[61] - Mr Ross indicated that anecdotal evidence supported his view that 20-30 per cent of patients, attending accident and emergency, should not be there and could be dealt with adequately in primary care. Further, Mr Ross believed that out of hours primary care services had failed adequately to command public confidence.[62]

39. Mrs Lloyd told us that NHS Wales faces pressures on its capacity to perform elective surgery from the waiting list, not only from emergency patients but also from those admitted because of medical conditions. Mrs Lloyd informed us that there was a 17 per cent increase in medical admissions between 2000 and 2004.[63] She also told us that there is an acute need to address chronic disease management since patients with an escalation of their chronic diseases occupy 55 per cent of beds in the acute sector, when their condition could have been managed effectively within the community to prevent the escalation that led to their admission to hospital.[64] The effective management of patients who have chronic diseases can have beneficial impacts on the quality of both care and life for those patients, as well as enabling NHS Wales to optimise its use of existing capacity. The Welsh Assembly Government has recognised the importance of chronic disease management by including a target within the 2005-06 Service and Financial Framework, whereby each health community must reduce emergency admissions by 5 per cent by developing chronic disease management pathways across five areas.[65]

---

[55] Q323
[56] AGW report, volume 2, paragraphs 3.2-3.7; Q134
[57] Qs 148-149 and 302
[58] Annex B
[59] Annex B
[60] Qs 290-292 and 302
[61] Q301
[62] Q302
[63] Annex B
[64] Q135
[65] Welsh Health Circular (2003) 083

NHS Wales' capacity

40. Overall, there is ample capacity – funding, beds, operating theatres and staff - within NHS Wales, reflected both by relatively high expenditure and bed numbers compared with other parts of the United Kingdom other than Scotland.66 However, Mr Ross described the financial pressures in the 2005-06 financial settlement as 'quite the tightest…for many years', with an increase in Wales of 5.2 per cent compared with 8 per cent in England. Mr Williams described 'a gap of at least 3 per cent if we stand still', while all three trust chief executives described the need for their Trust to achieve efficiencies of at least £10 million and expressed concern that the drive to make financial savings might distract health communities from developing capacity and reducing waiting times.67 However, we also note Mr Ross' optimism about the Welsh Assembly Government's decision to increase greatly the capital funding available to NHS Wales, and the provision of £32 million non-recurrent funding, although he expressed concern that there had been no detailed planning to identify the patients to be treated within this additional non-recurrent capacity, with the attendant risk that opportunities to use the funding effectively could be compromised.68 Local Health Board chief executives also emphasised their concern about the financial settlement for 2005-06 and its potential impact on the drive to tackle the waiting time problem.69 Mr Williams rightly emphasised the importance of avoiding overspends, since they distract organisations and prevent them from investing in technology and new buildings.[70] This part of the report looks at NHS Wales' capacity, and considers in turn:

- shortages of capacity in NHS Wales;
- configuration of capacity; and
- utilisation of capacity.

Shortages of capacity in NHS Wales

41. There are staff shortages in some specialties, such as orthopaedics, neurosurgery, and plastic surgery.[71] Although the overall vacancy rate for consultants in surgical specialties and anaesthetics has generally been relatively low at between 3.7 and 4.4 per cent,[72] there have been particular difficulties with staff shortages in key areas, such as accident and emergency consultants.[73]

42. Mrs Lloyd reiterated the Auditor General's finding that there were variable access criteria for health professionals to access diagnostic and therapy services for their patients, which can affect how long patients wait for important diagnostic tests. There are also particular shortages of radiographers,

---

[66] Annex B
[67] Q325
[68] Q326
[69] Q241
[70] Q299
[71] AGW report, volume 2, paragraph 3.6
[72] Q137
[73] AGW report, volume 2, paragraph 3.6; Qs 138-140

physiotherapists and podiatrists.[74] We welcome Mrs Lloyd's comments that the Welsh Assembly Government had worked with the Royal College of Radiologists to improve training and access to careers in radiology for medical students; and had committed part of the recently-announced £30 million investment to diagnostic equipment, such as MR scanners.[75] Despite this laudable activity, we share Mrs Lloyd's concern, given the waiting times for patients in orthopaedics, that some physiotherapists who had recently completed their training were unable to obtain positions within NHS Wales.[76]

Configuration of capacity

43. Wales spends more on health per head of population than England.[77] However, it does not produce the same results in terms of waiting times. This reflects a widespread perception that capacity across the health and social care systems is not arranged in the most effective way, with excessive pressures on the acute sector, which crowd out elective work.[78] Bed occupancy levels are high in acute hospitals in Wales but are much lower in community hospitals, although some hospitals make more use of their community facilities than others.[79] The way health services are currently set up in Wales, and the resulting unsustainable pressure on the acute sector, represents a very poor use of resources, both financially – each bed day costs £329[80] - and in terms of the opportunity cost for the many thousands of Welsh people languishing on waiting lists for long periods. The pressures on the acute sector manifest themselves through widespread cancellations of elective operations, medical patients occupying surgical beds, and dedicated elective facilities being used for non-elective patients.[81] Mr Ross provided graphic evidence of this – his Trust has invested in the largest elective ambulatory care unit in Europe, and is a tertiary centre employing some of Wales' leading surgeons, yet its effectiveness is being severely compromised by emergency patients.[82] Witnesses frequently described the benefits of ring-fencing elective capacity, as has been the policy in England, as a means of reducing waiting times by treating more patients more quickly. Ring-fenced elective capacity insulates trusts from the emergency and medical pressures, which so influence the ability of NHS Wales to treat patients from the waiting list, and allow them to predict the volume of patients they will be able to treat.[83]

44. NHS Wales has relatively little ring-fenced elective capacity compared with England and Scotland.[84] Mr Lang said that the NHS in England had strategically planned the additional capacity it needed through its network of treatment centres which had 'given those in England the ability to deliver' their

---

[74] AGW report, volume 2, paragraphs 2.32-2.33; Qs 34-37 and 120
[75] Qs 34, 120 and 121
[76] Q34
[77] Annex B
[78] The Welsh Assembly Government's *Review of health and social care in Wales: the report of the project team advised by Sir Derek Wanless*, June 2003, page 22
[79] Qs 151 and 303-304
[80] AGW report, volume 2, paragraph 3.13
[81] Qs 96, 297, and 301-302
[82] Q301
[83] Q302
[84] AGW report, volume 2, paragraphs 3.21-3.25

waiting time targets.[85] There is some dedicated elective capacity in Wales, such as the patient hotel and treatment centres at Bro Morgannwg NHS Trust and Ambulatory Care unit at Cardiff and Vale NHS Trust. Mr Williams described the beneficial impact of such protected facilities.[86] Mr Ross told us that the planned orthopaedic elective facility at Llandough Hospital would significant enhance the Trust's protected elective capacity, and that the new facility had been deliberately designed so that it will not be capable of taking emergency patients.[87] We welcome the Welsh Assembly Government's recent announcement of £30 million capital funding for four new day case facilities, as well as enhancements to diagnostic and therapy services and operating theatres.[88]

Utilisation of existing capacity

45. Despite capacity shortages in some areas and the problems for the acute sector arising from the way current capacity is set up, there is significant inefficiency in the way in which NHS Wales uses its existing capacity. Despite having a relatively high bed stock, beds are not used efficiently; rates of day surgery, which has huge potential to reduce waiting times, are poor compared with those in England; much more can be done to maximise the efficient utilisation of operating theatres and minimise cancelled operations; while trusts need to do much more to discharge patients proactively to free beds for other patients.[89] Mr Williams stated that his Trust had focused strongly on internal efficiency and had low waiting times, yet had the lowest number of doctors in Wales.[90] His Trust also demonstrates relatively good day case rates and high theatre utilisation.[91] This shows the importance of effective planning and management of existing capacity, to ensure that NHS Wales delivers better value for money than it currently does.

46. One of the key issues facing NHS Wales is the extent of cancelled surgery – the Auditor General found that over one thousand operations were cancelled each month, with eight per cent of all scheduled operations between April 2003 and January 2004 cancelled at short notice, either on the day of surgery or the day before surgery.[92] There are also high levels of cancellations by patients who do not turn up for surgery or decide that they no longer require treatment.[93] The loss of these operating theatre slots represents a high opportunity cost, both in terms of wasted resources and the personal costs for those patients on the waiting list whose surgery is cancelled. We welcome Mrs Lloyd's assurance that NHS Wales has tightened up on cancellations arising from clinicians taking leave at short notice. Mrs Lloyd also highlighted the importance of pre-operative assessment processes in reducing blockages in the system. Mrs Lloyd said that around 440 patients each month were unfit for scheduled treatment, which

---

[85] Q276
[86] Q296
[87] Q302
[88] Q184 and Welsh Assembly Government press release dated 15 November 2004
[89] AGW report, volume 2, paragraphs 3.8-3.20 and 3.41-3.42; Qs 135,155 and 312
[90] Q296
[91] Q312
[92] AGW report, volume 2, paragraph 3.9
[93] AGW report, volume 2, paragraph 3.10; Q99

represents a huge waste of theatre slots that NHS Wales simply cannot afford.[94] Mr Ross also highlighted the importance of effective pre-operative assessment in improving theatre utilisation.[95] We also welcome Mrs Lloyd's assurance that NHS Wales would be moving to a full booking system, similar to that already in place in England, which the Auditor General suggested has the potential to reduce the opportunity cost arising from patients failing to turn up for surgery and a similarly positive impact as partial booking for outpatients.[96]

47. The Auditor General's reported robust discharge processes were important in freeing up capacity to treat other patients from the waiting list.[97] Mrs Lloyd also emphasised the importance of ward teams focusing on better care planning from the outset of a patient's admission to develop a care path for the patient which results in the earliest safe discharge. She also stated that Innovations in Care has worked to reduce unnecessary process delays, such as in dispensing medicines to take home, discharge protocols and the timing of ward rounds. She told us that, rather than having regular ward rounds, protocols can allow non-consultant members of the care team to discharge patients.98 We were impressed by Mr Williams' description of the focus in his Trust on discharge at the 'magic hour' of 10am in the morning, 'rather like checking out of a hotel' to free up capacity for other patients.99 It is clear that robust discharge processes can contribute significantly to more efficient use of NHS capacity and therefore shorter waiting times.

48. We believe that it is difficult to justify providing additional capacity and resources until NHS Wales can clearly demonstrate acceptable efficiency levels, otherwise additional resources may simply support existing inefficiencies. Mr Ross said that the Auditor General was correct to highlight in his report the importance of process efficiency.100 Mrs Lloyd informed the Committee that the Welsh Assembly Government had, for the first time, included efficiency targets for local health communities in the Service and Financial Framework – the agreement about the resource inputs and service outputs which each health community must deliver in that financial year - for 2005-06, covering reductions in the average length of stay, improved day case rates, increased numbers of new outpatient consultations and improved operating theatre utilisation.[101] It is absolutely imperative that trusts take immediate steps to improve the way in which they use existing capacity, using the modernisation tools and support available from the National Leadership and Innovation Agency for Healthcare.

Delayed transfers of care

49. One of the most significant barriers to the efficient use of capacity is delayed transfers of care which, excluding mental health delays, accounted for a daily average of 723 "blocked" beds between

---

[94] Q99
[95] Q312
[96] AGW report, volume 2, paragraph 3.28; Q105
[97] AGW report, volume 2, paragraphs 3.41-3.42
[98] Qs 155 and 156
[99] Q312
[100] Q302

November 2003 and June 2004.[102] Witnesses emphasised that delayed transfers of care remain a very serious issue across the whole system of health and social care, and influence waiting times for inpatient treatment because of their impact on bed utilisation. In particular, Mr Ross described delayed transfers of care as the number one problem facing Cardiff and Vale NHS Trust, where there were over 200 delayed transfers when he gave evidence on 3 March, representing over 10 per cent of the Trust's beds. This problem is exacerbated by diminishing private sector care home capacity – in Cardiff, Mr Ross reported a 15 per cent reduction in care home bed capacity, with a further home due to close shortly. Mr Lang also described independent care home capacity in the Wrexham area as shrinking quite dramatically. Furthermore in Cardiff, 10 of the 13 remaining homes do not accept local authority rates, meaning that patients have to top-up fees themselves, which leads to long waiting lists for the three homes which accept local authority rates, thus reinforcing the widespread problem of delays arising from patient choice.[103] Mrs Lloyd informed us that the Welsh Assembly Government is establishing a formula which will provide the owners of private care homes with a sustainable income, allowing them to develop their staff and facilities and to ensure that such businesses, the availability of which has a major impact on secondary care capacity within NHS Wales, remain viable.[104] Further, Mrs Lloyd provided a note, which stated that the Welsh Assembly Government has issued statutory commissioning guidance to councils which requires them to commission in ways which take account of the effect on providers and the market, and is funding a Welsh Local Government Association initiative, 'the fees toolkit', to assist in making local fee negotiations more transparent.[105]

50. There are also major problems with delayed transfers of care relating to patient choice, reflecting the overall trend in Wales, whereby issues relating to patients, their families and carers represent the most common cause of delays.[106] Ms Perrin also reported that patients often remain in community hospital beds while they wait for their chosen care home.[107] Mrs Lloyd told us that patient choice must be respected, but reported that the Welsh Assembly Government had recently tightened its guidance on the definitions of choice, which also suggests alternative strategies if the patient's home of choice is not available. These include moving patients to community facilities or 'staging posts' for more active rehabilitation.[108]

---

[101] Q184; Welsh Health Circular (2004) 083
[102] AGW report, volume 2, paragraph 3.35
[103] Qs 251 and 314
[104] Q169
[105] Appendix 2
[106] AGW report, volume 2, paragraph 3.38; Qs 158 and 314
[107] Q303
[108] Q158

Improving waiting time performance in Wales

Leadership

51. Effective leadership at all levels is a key factor in improving waiting time performance. At a national level, given the widespread acceptance that the current configuration of NHS Wales is sub-optimal (see paragraphs 43-44), there needs to be effective leadership at various levels to support the change needed to deliver better access to elective services for the people of Wales. The Welsh Assembly Government provides an overall framework for the process of improving waiting times and the way in which NHS Wales' services are currently arranged. Mrs Lloyd described the intention of the Welsh Assembly Government to develop a model for the future of both health and social care services, against which local communities can test their reconfiguration proposals set out in their 'Wanless action plans' (responding to the review of health and social care, advised by Sir Derek Wanless).[109]

52. Ms Rees indicated that there are many changes in practice which do not require money but call for clinical and managerial leadership.[110] Consequently, leadership within health communities, from trust managers, commissioners and clinicians, is absolutely critical to gripping waiting times. Leaders set the priorities, vision and focus of their organisations, and need to take a strong lead on the waiting time issue. We were impressed by the organisational culture at Bro Morgannwg NHS Trust, described by Mr Williams, who emphasised the culture of trying to excel and continuously improve by benchmarking performance against English hospitals. He described a process whereby, if a Trust meets resistance to change or a target appears impossible, that Trust should seek to learn from other organisations which are doing better.[111] Similarly, Mrs Lloyd commended the importance of the stability and talents of the three chief executives of the north Wales trusts for their shared commitment and joint working at a regional level. She also focused on one of the chief executives, stating that they were determined that their organisation should be the best in Wales and ran a good organisation, which always met its targets.[112]

53. Leadership is also important across the separate but inter-connected systems of health and social care, an issue exemplified by the significant capacity problems arising from delayed transfers of care, 33 per cent of which arose from social care issues.[113] Mr Williams cited the example of developing a non-statutory partnership board - between Bro Morgannwg NHS Trust, its Local Health Board chairs and chief executives, and local authority leaders and chief executives - to develop joint priorities and a

---

[109] Q226; and the Welsh Assembly Government's *Review of health and social care in Wales: the report of the project team advised by Sir Derek Wanless*, June 2003
[110] Q241
[111] Q298
[112] Q23
[113] AGW report, volume 2, figure 13

shared commitment to their achievement, as well as generating senior ownership of a whole systems concept.[114]

Areas where there is scope to improve leadership

- the Welsh Assembly Government can provide clearer strategic leadership to support improvements in waiting times;
- health and social care organisations need to collaborate and work effectively together, which depends on joint leadership across the inter-related systems of health and social care; and
- engaging clinical staff in leading change is fundamental to the improvement of services and waiting times.

[114] Qs 312 and 315

Commissioning

54. Another critical function within the system of health and social care is that of commissioning, which Mrs Lloyd described as one of her three priorities to reduce waiting times.[115] Effective needs assessment and commissioning can and must shape change in service configuration and delivery, although we recognise the tension between effective commissioning and remaining within financial allocation, emphasised by Mr Lang and Ms Rees.[116] Mrs Lloyd emphasised the importance of effective commissioning, rather than block contracting, and indicated that Local Health Boards needed to become much more effective at commissioning to meet the needs of their populations, a need highlighted by the unacceptable variations in the index of long waiting times per 1,000 head of population in the Auditor General's report. Mrs Lloyd described her clear focus on the need to make commissioning more effective and the training planned for senior executives in Local Health Boards.[117]

55. There were diverging views about the impact of moving to a larger number of bodies commissioning health care services – the twenty two Local Health Boards and Health Commission Wales, which commissions specialist services on a national basis. Local Health Board representatives described the benefits of their coterminosity with local authority boundaries and their consequent local knowledge and focus in establishing alternatives to care in the acute sector by working closely with primary care.[118] Trust representatives had a slightly different perspective. Mr Williams said that the sheer number of providers and commissioners, all with 'a slightly different view of life', had made matters extremely complex. His Trust had developed an informal concordat with its five commissioners to negotiate jointly, but that this was sometimes difficult because each commissioner has its own local community with its particular pressures and nuances in how it wished to do things.[119] It is imperative, therefore, that commissioners and providers follow such an example to work more effectively in networks[120] and embrace the principles of working collaboratively, encapsulated in the Welsh Assembly Government's document, *Making the connections*.

56. Ms Rees confirmed that the Auditor General's report would be a 'useful platform to commission differently'.[121] Mr Lang and Ms Rees emphasised the importance of commissioning by pathway and output, rather than according to traditional models of service delivery.[122] Ms Rees and Mr Lang described existing joint regional commissioning, as well as giving examples of collaborative work in north Wales.[123] However, although the Local Health Board chief executives believed that each Local

---

[115] Q227
[116] Q231
[117] AGW report, volume 1, figure 16; Q208
[118] Qs 254 and 278
[119] Q309
[120] Q211
[121] Q236
[122] Q241
[123] Q278

Health Board needed individual directors of finance and commissioning in order to discharge their statutory responsibilities, particularly in terms of governance, they probably did not 'have an excess of skills'.[124] Given this situation, we believe that Local Health Boards should seek to collaborate and deliver services more effectively through models of joint working, which might include joint appointments at senior level.

Areas where there is scope to improve commissioning

- Local Health Boards can move increasingly towards genuine commissioning of services to meet local needs and improve waiting times, rather than block contracting according to historical patterns; and
- the twenty-two Local Health Boards need to collaborate more effectively to share skills, expertise and knowledge and to develop strategic regional solutions to health needs, such as clinical networks, as well as to reduce duplication and to simplify the commissioning process.

Demand management and redesigning services

57. Demand management is a crucial factor in increasing the efficiency with which NHS Wales uses its resources. Demand management requires health communities to focus on the needs of patients and shape the system such that patients are treated in the right place, by the right healthcare professional and at the right time. Local Health Boards need to understand clearly the health needs of their resident populations and the referral practices of GPs in their area. They then need to commission services, and redesign service models, to meet the needs of patients as effectively as possible. In doing so, they should recognise that patients on waiting lists could often be seen more appropriately by alternative healthcare professionals, such as extended scope physiotherapists or GPs with a special interest, rather than waiting to see a consultant.

58. The Auditor General reported that consultants estimated that between 20 and 30 per cent of referrals received in 2003 had been inappropriate.[125] While we accept that it is appropriate for a GP to make a referral if a patient's condition is beyond their clinical competence, the Auditor General's finding reflects the fact that there are insufficient alternatives available to GPs other than referral for a first outpatient appointment with a consultant. It is crucial that processes change to ensure that consultants are free to see the patients who most need consultant services and that alternatives exist for patients who need treatment, but not necessarily from a consultant. This is particularly apposite in Orthopaedics, where the majority of those on the outpatient waiting list will not require surgery, for example if they have back pain. Mrs Lloyd emphasised the significance of the seventy GPs with a special interest, who take referrals from other GPs, which would otherwise have gone onto the

[124] Q280
[125] AGW report, volume 2, paragraph 2.6

outpatient waiting list, citing in particular the example of a GP with a special interest in orthopaedics, who only refers 10 per cent of the patients they see to a consultant.[126]

59. Demand management is not simply a matter of reducing the number of patients trying to access health and social care services, but also includes the provision of integrated care pathways to better meet the needs of patients before they enter the secondary care system. Mr Ross said that alternative outpatient pathways are just as beneficial for the patient, but are more readily available than consultant-led outpatient services. Mr Ross told us that such pathways had been shown to work in England and described a musculo-skeletal pilot in Barry, which is focused entirely on long-waiting orthopaedic patients, some of whom had been waiting as outpatients for years. Within six months, 2,000 patients will have been seen at the centre, of whom only 300 or 400 will require further surgical referral. Mr Ross told us that patient satisfaction levels are among the highest he has ever seen for any such initiative.[127]

60. Examples of other demand management initiatives include rapid response teams, hospital at home services and other such community-based services, which seek to prevent patients from requiring secondary care services.[128] The effective management of emergency and medical pressures is another key facet of demand management. Mr Williams cited the example of the Fast Track Unit at Bro Morgannwg NHS Trust, which has reduced admissions by ten per cent and which has the potential to deliver a step change if it were to open twenty-four hours a day, seven days a week.[129]

Areas where there is scope to improve demand management and redesigning services

- health communities can further develop services led by alternative health professionals, rather than consultants, to provide more appropriate options for GPs than referral to the outpatient waiting list;
- to support such alternatives, health communities should consider the patient's pathway through the system of health and social care, remove unnecessary steps and ensure that pathways integrate primary and secondary care, as well as social care provision;
- there is scope for Local Health Boards to improve the quality of information available about GP referral patterns in order to better understand demand; and
- other new services which can reduce demand on the acute sector, and which should be common practice throughout Wales, include community-based rapid response teams, reablement teams, hospital at home services and medical assessment units.

[126] Qs 31-32
[127] Q323
[128] Q240
[129] Qs 296 and 305

Strategy and performance management

61. We also found a lack of a clear overall strategy for tackling waiting times, in stark contrast to England, whose focus on tackling waiting times Mrs Lloyd described as 'laser-like'.130 There has not been a strategic plan, similar to that operating in England, to reduce waiting times in NHS Wales. This lack of clarity has contributed to the current level of waiting time performance. We noted particularly the consistent emphasis by the three trust chief executives on the need for a clear, long-term 'whole-systems' based strategy, covering at least three years, which deals with genuine capacity problems (for example Orthopaedic outpatients at Cardiff and Vale NHS Trust) and, critically, the underlying causes of long waiting times within the whole system of health and social care. Mr Williams stressed his view that there is 'no substitute for a coherent, sustainable plan',131 and described the production of such a plan as 'a fairly simple management problem'.132 After our final evidence session, the Welsh Assembly Government announced revised waiting time targets for 2009, which are described in Annex C.

62. Performance management processes need to flow from, and support, a clear strategic framework. While the lack of a clear plan inhibited NHS Wales from improving waiting times, the weak arrangements for monitoring and ensuring the achievement of the 'conservative' targets already set have contributed to the waiting time position. 133 In addition, the Welsh Assembly Government has rewarded failure to deliver reduced waiting times through the provision of non-recurrent waiting time initiative funding to trusts that have breached minimum targets.[134] We accept to some extent that the Welsh Assembly Government should seek to avoid refusing to provide additional funding to organisations with long waiting times, because it might reduce access further or compromise patient care. [135] However, the Welsh Assembly Government should incentivise good waiting time performance by providing additional work to those trusts that have good waiting time performance and can demonstrate that they are using their capacity efficiently, to treat patients from those organisations which were not.

63. Mr Williams described the fact that the tolerance of breaches of waiting time targets undermines the incentive for already strong performers to further improve their waiting times.136 Mrs Lloyd agreed that it was unacceptable to institute differential targets for some organisations which exceeded Welsh Assembly Government maximum waiting times without informing those who used these services.137 While we note the assurances from Mrs Lloyd that performance management arrangements have been

[130] Q18
[131] Q317
[132] Q324
[133] AGW report, volume 2, paragraph 4.9; Q296
[134] AGW report, volume 2, paragraphs 4.14-4.17
[135] Qs 177 and 183
[136] Q320
[137] Q176

tightened over the last two years,[138] there needs to be a renewed focus on performance management to ensure that the 2009 target and interim milestones are achieved to avoid any perpetuation of the unacceptable waiting times which have faced Welsh patients in recent times. This should take account of the unsatisfactory historical patterns of 'quick fixes', whereby waiting time initiatives have been used to treat the symptom of long waiting times rather than the underlying causes, and have not resulted in sustainable solutions.

64. Mr Williams described the role of incentives and sanctions, and the fact that incentives have been slow in coming forward in Wales.[139] The Welsh Assembly Government should follow England's 'laser like focus' on improving waiting times for patients. Mr Lang and Ms Rees described the ultimate sanction of pulling resources out of the local trust to commission services from elsewhere. They admitted that they had so far made little use of existing sanctions but believed that they could make judicious use of long-term incentives to reduce waiting times.[140]

65. We are aware that an excessive focus on targets can lead to gaming or the existence of perverse incentives, which produce unintended consequences. We are particularly concerned that the focus of the Second Offer Scheme on inpatient/day case waiting times could draw the focus of organisations away from outpatient waiting times, and consequently we welcome Mrs Lloyd's assurances that 'we cannot allow the outpatient targets or the numbers to drift even further' and that 'flow-through has to be maintained'.[141]

Areas where there is scope to improve strategy and performance management

- the Welsh Assembly Government can develop a clear, medium-term strategy to support the achievement of waiting time targets by tackling their underlying causes;
- although there has been a focus on tightening performance management arrangements, there is scope to further enhance the incentives and sanctions that support them;
- there is a particular need to develop mechanisms which engage clinical staff in the process of setting, monitoring and achieving key targets, and leading the innovation which supports improvement;
- it is important that performance management arrangements focus not only on weaker performers, but also provide levers for the continuous improvement of performance where it is already strong; and
- in developing further its strategy and performance management systems, the Welsh Assembly Government should be mindful of the risks of perverse incentives, confusion arising from an excess of targets, and achieving alignment between the targets and priorities of local organisations.

[138] Qs 18 and 135
[139] Q317
[140] Qs 246 and 248

The use of waiting time initiatives, the Second Offer Scheme and the role of the private sector

66. Weaknesses in strategy and performance management have been exacerbated by the Welsh Assembly Government's widespread use of additional non-recurrent funding to provide additional treatments in the private sector or in marginal NHS capacity in the evenings or at weekends. The Auditor General reported that the Welsh Assembly Government spent £36 million in this way over the financial years 2002-03 and 2003-04.[142] Ms Perrin emphasised the frustration of her clinicians about the continuing use of waiting time initiatives without long-term, sustainable solutions to support them.[143] Mr Ross and Mr Williams supported the Auditor General's view that there were certain benefits of waiting time initiatives, particularly as 'a quick fix' and in treating individual patients, but that it is a 'no brainer' to provide money on a non-recurring basis for six years while nothing appears to be happening to address the underlying causes of long waiting times.[144] NHS Wales requires a sustainable medium to long-term plan to underpin the judicious use of waiting time initiatives for 'legitimate quick fixes'.[145] We share the concern of Mr Williams about the poor value for money achieved through 'expensive and inefficient' waiting time initiatives.[146] We are extremely concerned that, over the 2002-03 and 2003-04 financial year, £36 million was available to consultants participating in waiting time initiatives in Wales,[147] particularly at a time when the NHS is making such poor use of its existing capacity. Although witnesses did not believe that there was any direct evidence of perverse incentives,[148] the availability of such substantial sums of money to consultants may inevitably act as a barrier to improving the efficiency with which NHS Wales uses its capacity, a process which depends largely on the contribution of consultants.

67. The Welsh Assembly Government's Second Offer Scheme guarantees an offer of treatment by an alternative provider – in the NHS or private sector - to patients likely to breach inpatient/day case waiting time targets. The scheme, which was announced in November 2003 and introduced fully in April 2004, has already made a significant impact in reducing inpatient/day case waiting times and we welcome its potential to reduce costs and improve value for money through strategic central commissioning on a national basis. The scheme will also, from April 2005, involve the party deemed to be responsible for the breach of a Welsh Assembly Government target – either the Local Health Board responsible for commissioning the service, or the NHS Trust responsible for providing the service – will have to pay for the patient's treatment under the Second Offer Scheme. We note that the running costs of the Second Offer Scheme were £287,000 in 2004-05, or as low as £37 per patient

---

[141] Qs 44 and 197
[142] AGW report, volume 2, paragraph 4.21
[143] Q299
[144] AGW report, volume 2, paragraphs 4.41-4.44; Q322
[145] Q322
[146] AGW report ,volume 2, paragraphs 4.28-4.33; Q322
[147] Q189
[148] Q323

treated.[149] The scheme has certain inherent risks, highlighted by the Auditor General, in particular the risks of:

- disputes about responsibility for the breach of Welsh Assembly Government targets;
- impacts on the financial viability of individual Local Health Boards or NHS Trusts arising from responsibility for the costs of treatment under the scheme;
- a perverse incentive to avoid seeing outpatients because many of them will go onto inpatient/day case waiting lists;
- the reluctance of patients to travel for treatment under the scheme, which compromises benefits for patients and fails to relieve the pressure on trusts with long waiting times;
- confusion about responsibility for pre- and post-operative work;
- the ability of health communities to model demand, activity, capacity and waiting times to ensure that they avoid financial liabilities under the scheme and improve waiting times for their patients;[150] and
- Mrs Lloyd highlighted the further risk of NHS Wales paying twice for treating the same patient if trusts failed to meet the volumes of activity in their long-term agreements.[151]

68. Witnesses particularly highlighted the problems, which have arisen from the reluctance of some to travel for treatment with an alternative provider, which was particularly acute in the Swansea area, thus exacerbating the pressure on that Trust.[152] Most patients, surveyed in a recent MORI poll to explore this pattern, refused to say why they would not travel for treatment at an alternative provider.[153] Mr Williams said that people were prepared to travel miles to the shopping mall and should do so for high-quality healthcare.[154] We also noted the concern of Mr Lang that treatments offered through the Second Offer Scheme need to be connected to local commissioning strategies.[155] This mirrors the Auditor General's report, which found that 45 per cent of Local Health Board chief executives had not been consulted about the appropriateness of providing waiting time initiative funding to local trusts.[156]

69. We took evidence about the role and use of the private sector in NHS Wales. The Auditor General's report said that the cost of five common procedures, provided through waiting time initiatives in the

---

[149] Annex B – full year cost £278,000; patient numbers extrapolated from April 2004-January 2005 figures to produce an annual total of 7,667 patients
[150] AGW report, volume 2, paragraph 4.5
[151] Q197
[152] Qs 196 and 293
[153] Q300
[154] Q308
[155] Q264
[156] AGW report, volume 2, paragraph 4.37

private sector in 2002-03 and 2003-04, was between 17 and 78 per cent higher than the equivalent cost under the Department of Health tariff – a schedule of costs for each procedure carried out on behalf of the NHS in England and which supports the new system of payment by results.[157] Although providing treatment within the private sector has traditionally been more expensive than the NHS, there may be value in NHS Wales taking a pragmatic view of its relationship with the private sector, which Mr Lang said it should see as one of a number of potential suppliers of NHS-funded activity.[158] We believe that safeguards should be put in place to ensure that the involvement of the private sector does not weaken NHS Wales in the medium or long term. However, there is scope to develop a long-term partnership with the private sector to support NHS capacity when there is a shortfall and where commissioners can secure good value for money.[159] There is particular scope to use private sector capacity, or spare capacity from the English network of treatment centres, to provide treatments under the Second Offer Scheme. We note that 36 per cent of Second Offer Scheme treatments between April 2004 and January 2005 were provided by the private sector, while 61 per cent took place in marginal NHS capacity.[160]

70. The Health and Social Services Minister recently announced a further £32 million non-recurrent funding to tackle waiting times in 2005-06.[161] We are anxious that the provision of this non-recurrent funding could replicate the problems of value for money and sustainability in the use of previous non-recurrent funding, described by the Auditor General and witnesses.[162] We welcome the development of better control of the cost of initiatives through the fixed rate in the consultant contract and the use of the English tariff as a benchmark through which to drive down costs.[163]

[157] AGW report, volume 2, figure 23
[158] Q266
[159] Qs 187, 266 and 269
[160] Annex B
[161] Welsh Assembly Government press release, dated 23 February 2005
[162] AGW report, volume 2, paragraphs 4.28-4.44; Q322
[163] Q185

Areas where there is scope to improve the use of non-recurrent funding to reduce waiting times

- while the use of non-recurrent funding can be beneficial, it should be used in concert with developments to achieve sustainable reductions in waiting times;
- there is scope to align more effectively the use of waiting time initiatives and the Second Offer Scheme with local commissioning strategies;
- there is scope to tailor the Second Offer Scheme to develop solutions to patients' local needs, such as the reluctance of many patients to travel in the Swansea area; and
- there is considerable scope to reduce the costs of non-recurrent initiatives through central national commissioning through the Second Offer Scheme; the set rate for additional work in the consultant contract; and through the judicious use of the Department of Health's tariff as a benchmark of cost.

Information and its management

71. We remain concerned about the accuracy and robustness of the data available to NHS managers to support process change and improved performance. For example, Mrs Lloyd could not provide reliable or consistent data about the number of inappropriate attendances at accident and emergency departments.164 Mr Lang and Ms Rees confirmed that, although similar information is available in Wales as in England, the quality of information about referrals in both countries was poor and was only available at the level of the GP practice, rather than individual GP. 165 This makes it difficult to manage demand and provide feedback to GPs on referral practice, especially since GPs are not a homogeneous group.166 Mrs Lloyd emphasised the importance of the Welsh Assembly Government's *Informing Healthcare* strategy in providing clinical management information to support performance management, to allow GPs and consultants to exchange information and to ensure that there is a single record for each patient.167 Ms Rees stressed the importance of interrogating the data collected through the General Medical Services contract to look at key themes such as chronic disease management.168 Mr Ross described the weakness of the definitions used for day surgery, and observed that day surgery rates would be higher in his Trust if patients staying less than 24 hours, but who may stay overnight within that period, counted as day cases.169

72. Waiting list management processes are extremely important in reducing waiting times. Patients should only be on waiting lists if they require treatment and able to have immediate treatment. The Auditor

---

[164] Annex B
[165] Q282
[166] Q238
[167] Q8
[168] Q284

General found evidence that patients inappropriately remained on waiting lists.170 Mrs Lloyd described to us a good practice initiative, known as "treat in turn", which the Welsh Assembly Government requires NHS Trusts to implement. This reduces the number of clinical prioritisations from three to two – urgent and routine – and within each classification, treats patients strictly by the date they went onto the waiting list.171 We welcome this sensible initiative, which has considerable scope to equalise waiting times and shorten the tail of the waiting list, thereby avoiding long waiting times. Ms Perrin said that treating patients in turn can help to prevent consultants from picking and choosing what they wanted to do.[172]

Areas where there is scope to improve information and its management

- through its *Informing Healthcare* strategy, the Welsh Assembly Government can improve the quality and robustness of data at all levels of the NHS, particularly that available to clinicians, in order to support waiting list management and modelling waiting times, capacity, activity and demand; and

- there is scope for trusts to improve waiting list management, particularly by treating patients in turn within their clinical priority.

Spreading best practice to improve waiting times

73. NHS Wales, through Innovations in Care (now merged with the Centre for Health Leadership to form the National Leadership and Innovation Agency for Healthcare), has undertaken a considerable amount of work to spread best practice. Mrs Lloyd informed us that a number of Innovations in Care staff had come from the Modernisation Agency in England.173 Innovations in Care have been responsible for a number of positive changes, such as partial booking, which the Auditor General found had contributed to improved efficiency and patient choice.174

74. However, we were concerned that Mrs Lloyd believed that many extremely good initiatives undertaken by clinicians have not been implemented in all parts of NHS Wales.175 Consequently, she has asked Innovations in Care to conduct an audit of good practice in every trust and Local Health Board, to see whether such initiatives have been instituted and, if they have not, why this is. Similarly, Mr Williams said that it was important to consolidate successful initiatives to ensure that they become the norm. He also expressed concern that NHS Wales tends to implement initiatives on a piecemeal basis, rather than in a strategic manner. He described this as 'the thousand blooms' whereby, while little flowers may poke up through the lawn and start to bloom good ideas, they do not then make the whole lawn a carpet

---

[169] Q312
[170] AGW report, volume 1, paragraphs 4.28-4.31
[171] AGW report, volume 1, paragraph 4.27 and figure 23; Qs 92 and 323
[172] Q323
[173] Q2
[174] AGW report, volume 2, paragraphs 2.17-2.20; Q96
[175] Q127

of wonderful flowers.[176] The Auditor General's report highlighted one possible barrier - ongoing resistance to change among clinicians. As a result, Innovations in Care has tended to 'preach to the converted', who would have willingly embraced change, rather than working with those clinicians most resistance to change, who most need to be persuaded to change.[177]

Areas where there is scope to spread best practice more effectively

- change programmes need to engage fully with those clinicians resistant to change, as well as using the enthusiasm, skill and talent of those clinicians willing to champion modernisation; and
- the Welsh Assembly Government can use the National Leadership and Innovation Agency for Healthcare's audit of best practice to support the further spread of known best practice throughout NHS Wales.

Annex A

[176] Q308
[177] AGW report, volume 2, paragraph 4.61

Cynulliad Cenedlaethol Cymru
Pwyllgor Archwilio

The National Assembly for Wales
Audit Committee

Amseroedd Aros y GIG yng Nghymru
NHS Waiting Times in Wales

Cwestiynau 1-129
Questions 1-129

Dydd Iau, 3 Chwefror 2005
Thursday, 3 February 2005

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

Swyddogion yn bresennol: Gillian Body, Swyddfa Archwilio Genedlaethol Cymru; Rob Powell, Swyddfa Archwilio Genedlaethol Cymru; David Powell, Swyddog Cydymffurfio, Cynulliad Cenedlaethol Cymru.

Tystion: Ann Lloyd, Pennaeth Adran Iechyd a Gofal Cymdeithasol, Cynulliad Cenedlaethol Cymru;

Stuart Marples, Cyfarwyddwr Rhanbarth y Canolbarth a'r Gorllewin, Adran Gwasanaeth Iechyd

Gwladol Cymru, Cynulliad Cenedlaethol Cymru.

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

Officials present: Gillian Body, National Audit Office Wales; Rob Powell, National Audit Office Wales; David Powell, Compliance Officer, National Assembly for Wales.

Witnesses: Ann Lloyd, Head of Health and Social Care Department, National Assembly for Wales; Stuart Marples, Mid and West Wales Regional Director, National Health Service Wales Department, National Assembly for Wales.

Dechreuodd y cyfarfod am 9.29 a.m.
The meeting began at 9.29 a.m.

[1] **Janet Davies:** Good morning. I welcome the committee, the witnesses and members of the public to the first meeting of the spring term. I hope that it will be an interesting meeting, although it will perhaps be a lengthy one. Sir John Bourn could not be here today; he is in New Zealand at a conference of Commonwealth auditor generals. Auckland seemed too far away for us to ask him to come back for this meeting.

Two new members have joined the committee, namely Irene James and Catherine Thomas. I welcome Irene James, but Catherine Thomas is not here because she is, unfortunately, not feeling too well today.

The committee operates bilingually and we can use headsets to listen to a translation of Welsh. I point out to members of the public that using the headsets also helps you to hear the proceedings more clearly if you have problems in this regard. If people have their backs to you, it is not always easy to hear them. I ask everyone to turn off their mobile phones, pagers and all electronic devices because they interfere with the broadcasting

[1] **Janet Davies:** Bore da. Croesawaf y pwyllgor, y tystion ac aelodau'r cyhoedd i gyfarfod cyntaf tymor y gwanwyn. Gobeithio y bydd yn gyfarfod diddorol, er efallai y bydd yn un hir. Ni all Syr John Bourn fod yma heddiw; mae yn Seland Newydd mewn cynhadledd archwilwyr cyffredinol y Gymanwlad. Yr oedd Auckland yn rhy bell i ni ofyn iddo ddod yn ôl ar gyfer y cyfarfod hwn.

Mae dau aelod newydd wedi ymuno â'r pwyllgor, sef Irene James a Catherine Thomas. Croesawaf Irene James, ond nid yw Catherine Thomas yma oherwydd, yn anffodus, nad yw'n teimlo'n hwylus heddiw.

Mae'r pwyllgor yn gweithredu'n ddwyieithog a gallwn ddefnyddio clustffonau i wrando ar gyfieithiad i'r Gymraeg. Hoffwn ddweud wrth aelodau'r cyhoedd bod y clustffonau hefyd o bosibl yn eich cynorthwyo i glywed y trafodion yn fwy clir os oes gennych broblemau yn hyn o beth. Os yw pobl â'u cefnau tuag atoch, nid yw'n hawdd eu clywed bob tro. Gofynnaf i bawb droi eu ffonau symudol, teclynnau galw a phob dyfais

and translation systems. If there is an emergency, leave by the nearest exit, and the ushers will show you where to go.

electronig i ffwrdd oherwydd eu bod yn tarfu ar y systemau darlledu a chyfieithu. Mewn argyfwng, gadewch drwy'r allanfa agosaf, a bydd y tywyswyr yn dangos i chi lle i fynd.

We have received apologies from Denise Idris Jones. Do members have any declarations of interest? I see that they do not. Therefore, I ask the witnesses to introduce themselves.

Yr ydym wedi derbyn ymddiheuriadau gan Denise Idris Jones. A oes gan unrhyw aelodau ddatganiadau o fuddiannau? Gwelaf nad oes ganddynt. Felly, gofynnaf i'r tystion gyflwyno eu hunain.

Ms Lloyd: I am Ann Lloyd, head of the Health and Social Care Department.

Ms Lloyd: Fi yw Ann Lloyd, pennaeth yr Adran Iechyd a Gofal Cymdeithasol.

Mr Marples: I am Stuart Marples, regional director of the mid and west Wales regional office of the National Health Service Wales Department.

Mr Marples: Fi yw Stuart Marples, cyfarwyddwr rhanbarth y Canolbarth a'r Gorllewin, Adran Gwasanaeth Iechyd Gwladol Cymru.

[2] **Janet Davies:** Thank you. I will start the questions by looking at the scale of the problem in volume 1 and I will ask some general questions about achieving time targets. I am afraid that I will be dotting about a bit from one part to another, so I will give you plenty of notice of exactly which bit I am talking about, because it is a much longer report than we usually have and we need to take time over it. I start with paragraphs 4.12 to 4.19 on pages 31 to 32, and with figures 17 and 18. Mrs Lloyd, what do you see as being the main lessons that we in Wales can learn from the greater success that England and Scotland have had in reducing waiting times?

[2] **Janet Davies:** Diolch. Yr wyf am ddechrau'r cwestiynau drwy edrych ar faint y broblem yng nghyfrol 1 ac yr wyf am ofyn cwestiynau cyffredinol am fodloni'r targedau amser. Mae'n debyg y byddaf yn neidio o un rhan i'r llall, felly byddaf yn rhoi digon o rybudd i chi ynglŷn â pha ran y byddaf yn ei thrafod, oherwydd mae'n adroddiad llawer hwy na'r arfer ac mae angen i ni gymryd ein hamser. Yr wyf yn dechrau gyda pharagraffau 4.12 i 4.19 ar dudalennau 31 i 32, a chyda ffigurau 17 ac 18. Mrs Lloyd, beth yn eich tyb chi yw'r prif wersi y gallwn ni yng Nghymru eu dysgu o'r gwell llwyddiant a gafwyd yn Lloegr a'r Alban wrth ostwng amseroedd aros?

Ms Lloyd: We have learnt a considerable amount about what has been done in England, and I hope that someone will ask me about the policy context in Wales. We have had close contact with the people who have been driving the waiting times and lists changes in England, and, of course, both Mr Marples and I came from England during the course of the movement to shorter waiting times. There is no doubt at all that to achieve what has been achieved in England has required enormous effort in terms of the resource that was allocated to beating this problem, the concentration of effort from the

Ms Lloyd: Yr ydym wedi dysgu llawer am yr hyn sydd wedi'i wneud yn Lloegr, a gobeithio y bydd rhywun yn gofyn i mi am y cyd-destun polisi yng Nghymru. Yr ydym wedi bod mewn cysylltiad agos â'r bobl sydd wedi gorfodi'r newidiadau i amseroedd a rhestrau aros yn Lloegr, ac, wrth gwrs, daeth Mr Marples a minnau o Loegr yn ystod yr ymgyrch i leihau amseroedd aros. Nid oes amheuaeth o gwbl bod llwyddo i gyflawni'r hyn sydd wedi ei gyflawni wedi golygu ymdrech enfawr o ran yr adnoddau a ddyrannwyd i fynd i'r afael â'r broblem hon, yr ymdrech ddwys gan reolwyr ac, yn benodol, y clinigwyr o fewn y sefydliadau, adolygiad trylwyr iawn o'r holl systemau a phrosesau, a dealltwriaeth o anghenion iechyd y boblogaeth. Ni chredaf eu bod wedi mynd mor bell yn Lloegr ag yr ydym wedi'i wneud yng Nghymru o ran asesiadau anghenion iechyd a'r canlyniadau, oherwydd,

management and, in particular, the clinicians within the organisations, a very thorough review of all systems and processes, and an understanding of the population's health needs. I do not think that they have gone as far in England as we have in Wales in terms of health needs assessments and the consequences, because, as you will be aware, we have a much more frail and elderly population than they have in England, which I think is symptomatic of some of the problems that we have had with cancelled operations, with people not being fit enough because so many of them have co-morbidity. Nevertheless, there was a laser-like concentration on solving waiting times in England over the past, I would say, seven years. Certainly, in our experience, it started about seven years ago. Several modernisation agency staff members are now working with us. These are individuals who were chosen in the health service in England to shine a light on systems, processes and the different ways of working needed to beat some of these problems. A number of them have come to work for our innovations-in-care service in Wales, and they have brought with them very good practice, not that good practice did not already exist in Wales. The chief medical officer and I held a small conference of clinicians about three or four months ago to ensure that the good work that was being done in various parts of Wales by the clinical community was understood in the wider context and that the examples that they could share with us, which had been therefore evaluated and were evidence-based, could also be shared more widely.

fel y gwyddoch, mae gennym boblogaeth lawer mwy bregus a hŷn na Lloegr, sy'n symptomatig dybiaf i o rai o'r problemau yr ydym wedi'u hwynebu gyda chanslo triniaethau, gyda phobl ddim yn ddigon iach oherwydd bod gan gymaint ohonynt gyd-forbidrwydd. Fodd bynnag, canolbwyntiwyd ar ddatrys amseroedd aros yn Lloegr yn ystod, dywedwch, y saith mlynedd diwethaf. Yn sicr, o'n profiad ni, dechreuodd oddeutu saith mlynedd yn ôl. Mae llawer o aelodau staff yr asiantaethau moderneiddio yn gweithio gyda ni bellach. Unigolion yw'r rhain a ddewiswyd yn y gwasanaeth iechyd yn Lloegr i daflu goleuni ar systemau, prosesau a'r gwahanol ffyrdd o weithio sydd eu hangen i fynd i'r afael â rhai o'r problemau hyn. Mae llawer ohonynt wedi dod i weithio i'n gwasanaeth arloesi mewn gofal yng Nghymru, ac wedi dod ag arferion da iawn gyda hwy, nid nad oedd arferion da yn bodoli eisoes yng Nghymru. Cynhaliodd y prif swyddog meddygol a minnau gynhadledd fach o glinigwyr tua thri i bedwar mis yn ôl i sicrhau bod pobl yn deall y gwaith da sy'n cael ei wneud mewn rhannau amrywiol o Gymru gan y gymuned glinigol yn y cyd-destun ehangach ac y gallai'r enghreifftiau yr oeddent yn gallu eu rhannu gyda ni, a oedd wedi'u pwyso a'u mesur ac a oedd yn seiliedig ar dystiolaeth, gael eu rhannu'n fwy eang hefyd.

The concentration on this as a single problem that had to be solved, as a first, was important to remember in England. However, as Wanless reminded us, if Wales's systems were ever to improve substantially, if we were ever to get on the top of the causes and consequences of ill health, and if the demand that emerges from getting better at managing it was to be cracked in Wales, then constantly chasing that demand was not going to work. So, we have tried to balance this in Wales.

Yr oedd yn bwysig cofio canolbwyntio ar hyn fel problem unigol yr oedd yn rhaid ei datrys, fel cam cyntaf, yn Lloegr. Fodd bynnag, fel y cawsom ein hatgoffa gan Wanless, os oedd systemau Cymru i wella'n sylweddol o gwbl, os oeddem byth am allu mynd i'r afael ag achosion a chanlyniadau iechyd gwael, ac os oeddem byth am allu meistroli'r galw sy'n deillio o wella'r ffordd yr ydym yn rheoli yng Nghymru, yna ni fyddai mynd i'r afael â'r galw hwnnw'n barhaus yn gweithio. Felly, yr ydym wedi ceisio cydbwyso hyn yng Nghymru.

[3] **Janet Davies:** Thank you, Mrs Lloyd. Clearly, points have been raised that I know Members will want to pursue, and I will not pursue them myself at present unless, at the end, I feel that they have not been properly answered. I will return to page 7, paragraphs 2.4 to 2.6, if I may. Why do you think that the NHS has failed to fulfil the maximum 18-month waiting time target set by the Assembly Government for out-patients and in-patients? This target was set out in the 2001 plan, and, in itself, is considerably longer than the targets being pursued in England and Scotland.

[3] **Janet Davies:** Diolch, Mrs Lloyd. Yn amlwg, mae pwyntiau wedi'u codi y gwn y bydd Aelodau am eu trafod, ac nid wyf am eu trafod fy hun ar hyn o bryd os na fyddaf, yn y diwedd, yn credu nad ydynt wedi'u hateb yn iawn. Yr wyf am droi at dudalen 7, paragraffau 2.4 i 2.6, os caf fi. Pam yr ydych yn credu bod y GIG wedi methu bodloni'r targed amser aros hwyaf o 18 mis a osodwyd gan Lywodraeth y Cynulliad ar gyfer cleifion allanol a chleifion mewnol? Nodwyd y targed hwn yng nghynllun 2001, ac, yn ei hun, mae'n llawer hwy na'r targedau sy'n cael eu gosod yn Lloegr a'r Alban.

Ms Lloyd: There are a number of reasons why the service has failed to do this. One of them was that, as the King's Fund report said, you must have extremely good data before you really know the source and consequence of the issues that you are facing. Certainly, I do not believe that the data that was available

Ms Lloyd: Mae sawl rheswm pam mae'r gwasanaeth wedi methu gwneud hyn. Un rheswm, fel y dywedodd adroddiad Cronfa King, yw bod yn rhaid i chi gael data da iawn cyn i chi wybod yn iawn beth yw ffynhonnell a chanlyniad y materion sy'n eich wynebu. Yn sicr, nid wyf yn credu bod y data a oedd

to trusts, their purchasers or to the Welsh Assembly Government was sufficiently robust or comprehensive for anyone to understand the true nature of the problem. When you look at 2001, Wales was in the same situation that England was in 1996-97, when we believed that we knew the scale of the waiting times and lists problems. However, once we were faced with targets and challenges, the likes of which had not been known before, we found that waiting times escalated, as did waiting lists, which appeared out of nowhere supposedly, and you had to deal with them. Therefore, first, I think that the information was not sound enough.

ar gael i ymddiriedolaethau, eu prynwyr neu i Lywodraeth Cynulliad Cymru yn ddigon cadarn neu gynhwysfawr i unrhyw un ddeall union natur y broblem. Wrth edrych ar 2001, yr oedd Cymru yn yr un sefyllfa ag yr oedd Lloegr ym 1996-97, pan yr oeddem yn credu ein bod yn gwybod graddfa'r problemau amseroedd a rhestrau aros. Fodd bynnag, unwaith yr oeddem yn wynebu'r targedau a'r heriau, rhai o'r math nad oeddent wedi'u hwynebu o'r blaen, bu i ni ganfod bod amseroedd aros wedi dwysáu, fel y rhestrau aros, a ymddangosodd yn ddisymwth yn ôl pob sôn, ac yr oedd yn rhaid i chi ddelio â hwy. Felly, yn gyntaf, credaf nad oedd y wybodaeth yn ddigon cadarn.

Secondly, the performance management system was not robust enough either. When I came in mid-1991, there was no performance management system in place and, therefore, it has taken us time to construct one that will be sufficiently robust to be able to challenge organisations on the nature of their performance. In addition, at the time, although I would not say that this was a problem—this was a difference in policy—the Welsh Assembly Government had decided to pursue policy on a wider front, to look very much at the causes and consequences of ill health, to put an enormous effort into promotion and prevention, which is culminating in Health Challenge Wales, and to put an enormous effort, following Townsend's initial review, into tackling the whole issue of health inequalities. Health inequalities and success

Yn ail, nid oedd y system rheoli perfformiad yn ddigon cadarn ychwaith. Pan gyrhaeddais yng nghanol 1991, nid oedd system rheoli perfformiad ar waith ac, felly, mae wedi cymryd amser i ni adeiladu un a fydd yn ddigon cadarn i allu herio sefydliadau o ran natur eu perfformiad. Yn ogystal, ar y pryd, er na fyddwn yn dweud bod hyn yn broblem—yr oedd hwn yn wahaniaeth o ran polisi—yr oedd Llywodraeth Cynulliad Cymru wedi penderfynu gweithredu polisi ehangach, edrych yn ofalus ar achosion a chanlyniadau iechyd gwael, ymdrechu'n galed i hyrwyddo ac atal, sydd wedi cyrraedd penllanw gyda Her Iechyd Cymru, ac ymdrechu'n galed, yn dilyn adolygiad cyntaf Townsend, i fynd i'r afael â'r holl fater o anghydraddoldebau iechyd. Mae anghydraddoldebau iechyd a llwyddiant wrth fynd i'r afael â hwy yn peri cynnydd yn y

in combating them causes demand to rise. During the last year in particular, an enormous demand has been placed on the cardiology service, particularly for testing. That is possibly—and we are tracking it now—a consequence of the large number of health inequality schemes, which focus on the health needs of populations and the heart health needs of populations. So, I think that a number of problems beset Wales when it initially set its targets, which we have been steadily trying to manage and combat during the last three years.

galw. Yn ystod y flwyddyn ddiwethaf yn benodol, bu galw enfawr am y gwasanaeth cardioleg, yn arbennig ar gyfer profi. Mae hynny o bosibl—ac yr ydym yn mynd i'r afael â hyn yn awr—yn deillio o'r nifer mawr o gynlluniau anghydraddoldeb iechyd, sy'n canolbwyntio ar anghenion iechyd poblogaethau ac anghenion iechyd y galon poblogaethau. Felly, credaf fod Cymru wedi wynebu llawer o broblemau o ganlyniad i osod ei thargedau yn y lle cyntaf, ac yr ydym wedi bod yn ceisio'u rheoli gan bwyll a'u datrys yn ystod y tair blynedd diwethaf.

[4] **Janet Davies:** Before I go on, I would like to bring in Alun Cairns on this point.

[4] **Janet Davies:** Cyn i mi fynd ymlaen, hoffwn ofyn i Alun Cairns gyfrannu yma.

[5] **Alun Cairns:** Mrs Lloyd, I was quite shocked by one of your responses. You mentioned that management information was not robust and then said that, when you came in 1991, which is around 14 years ago—

[5] **Alun Cairns:** Mrs Lloyd, cefais gryn fraw o glywed un o'ch ymatebion. Bu i chi grybwyll nad oedd gwybodaeth reoli yn gadarn, a phan fu i chi ymuno yn 1991, sydd oddeutu 14 mlynedd yn ôl—

Ms Lloyd: I am sorry, I should have said 2001.

Ms Lloyd: Mae'n ddrwg gennyf, dylwn fod wedi dweud 2001.

[6] **Alun Cairns:** Well, that is still some time ago.

[6] **Alun Cairns:** Wel, mae hynny'n dal yn gryn amser yn ôl.

Ms Lloyd: Yes, of course it is.

Ms Lloyd: Ydy, wrth gwrs.

[7] **Alun Cairns:** How long would you expect it to take to introduce some robust management information?

[7] **Alun Cairns:** Faint fyddech chi'n disgwyl iddi gymryd i gyflwyno gwybodaeth reoli gadarn?

Ms Lloyd: Management information or performance?

Ms Lloyd: Gwybodaeth reoli neu berfformiad?

[8] **Alun Cairns:** An information structure.

[8] **Alun Cairns:** Strwythur gwybodaeth.

Ms Lloyd: You will know that the informing healthcare strategy is a key component of 'Improving Health in Wales'. That strategy, which looks very much at the improvement of clinical management information, which will drive a whole performance management system, has been instituted since 2003. That was important because there had been an information system back in the early 1990s, but it needed to be refreshed and renewed. We needed to be able to focus on the types of information that would be actively used by clinicians and ensure that they were shared between clinicians because, unless we get a system whereby general practitioners in particular can talk to consultants and exchange information on patients' needs and requirements, we will never be able to manage the whole of the system. As the King's Fund report also pointed out, waiting times and lists are part of a whole system, and you must try to manage the whole system, of which one component is waiting times. So, it did not mean that we did not do anything; the issue of not having sufficiently robust information was picked up in

Ms Lloyd: Byddwch yn gwybod bod y strategaeth hysbysu gofal iechyd yn elfen allweddol o 'Gwella Iechyd yng Nghymru'. Mae'r strategaeth honno, sy'n canolbwyntio ar wella gwybodaeth rheoli clinigol, sef y grym y tu ôl i system rheoli perfformiad gyfan, wedi'i gweithredu ers 2003. Yr oedd hynny'n bwysig oherwydd yr oedd system wybodaeth yn ôl yn yr 1990au cynnar, ond yr oedd angen ei hadfywio a'i hadnewyddu. Yr oedd angen i ni allu canolbwyntio ar y mathau o wybodaeth a fyddai'n cael eu defnyddio'n aml gan glinigwyr a sicrhau eu bod yn cael eu rhannu rhwng clinigwyr oherwydd, os nad ydym yn cael system lle y gall ymarferwyr cyffredinol yn arbennig siarad â meddygon ymgynghorol a chyfnewid gwybodaeth am anghenion a gofynion cleifion, ni fyddwn byth yn gallu rheoli'r system gyfan. Fel y nododd adroddiad Cronfa King hefyd, mae amseroedd a rhestrau aros yn rhan o system gyfan, ac mae'n rhaid i chi geisio rheoli'r system gyfan, a dim ond un elfen yw amseroedd aros. Felly, nid oedd hyn yn golygu ein bod wedi llaesu dwylo; nodwyd y mater o beidio â chael gwybodaeth

‘Improving Health in Wales’ and has been actioned. We have a very vigorous programme that looks at securing existing computer systems—we cannot allow them to crash—and making sure that they are fit for purpose, while building a whole new platform for information collection, monitoring and sharing, by having one single patient record, which is fundamental to improving the care that we can give to patients.

gadarn ddigonol yn ‘Gwella Iechyd yng Nghymru’ ac yr ydym wedi gweithredu ar hynny. Mae gennym raglen gadarn iawn sy’n ceisio diogelu systemau cyfrifiadur cyfredol—ni allwn adael iddynt fethu—a sicrhau eu bod yn addas ar gyfer eu diben, tra’n adeiladu llwyfan newydd sbon ar gyfer casglu gwybodaeth, ei monitro a’i rhannu, drwy gael un cofnod i bob claf, sy’n sylfaenol i wella’r gofal y gallwn ei roi i gleifion.

[9] **Alun Cairns:** Thank you for that information. I also wanted a little more evidence on health inequality. Do you mean the inequality between Wales and England, or do you mean inequality within Wales?

[9] **Alun Cairns:** Diolch am y wybodaeth honno. Yr oeddwn hefyd am gael ychydig mwy o wybodaeth ar anghydraddoldeb iechyd. A ydych yn golygu’r anghydraddoldeb rhwng Cymru a Lloegr, neu a ydych yn golygu’r anghydraddoldeb yng Nghymru?

Ms Lloyd: Inequality within Wales itself.

Ms Lloyd: Anghydraddoldeb yng Nghymru ei hun.

[10] **Janet Davies:** Irene and Mick have asked to come in on this, but I ask them to ensure that they refer to the current topic and do not go further into the report.

[10] **Janet Davies:** Mae Irene a Mick wedi gofyn am gael cyfrannu yma, ond gofynnaf iddynt sicrhau eu bod yn cyfeirio at y pwnc dan sylw ac nad ydynt yn treiddio ymhellach i’r adroddiad.

[11] **Irene James:** I want to ask what level of evidence we have for this report.

[11] **Irene James:** Yr wyf am ofyn pa lefel o dystiolaeth sydd gennym ar gyfer yr adroddiad hwn.

Ms Lloyd: For this report?

Ms Lloyd: Ar gyfer yr adroddiad hwn?

[12] **Irene James:** Yes.

[12] **Irene James:** Ie.

[13] **Janet Davies:** Perhaps Mrs Lloyd feels that the National Audit Office should answer that question. Could someone from the National Audit Office respond?

[13] **Janet Davies:** Efallai bod Mrs Lloyd yn credu y dylai'r Swyddfa Archwilio Genedlaethol ateb y cwestiwn hwnnw. A all unrhyw un o'r Swyddfa Archwilio Genedlaethol ymateb?

Ms Body: Yes. This report involves many months of detailed examination at six trusts and extensive survey work of trusts, local health boards, patients, general practitioners and consultants. We have received advice from an expert panel, which has advised us throughout the study. The membership of the panel is set out in appendix 2 of the report. Therefore, there is a very weighty volume of analysis underpinning a very detailed report, and the analysis is set out in the report.

Ms Body: Iawn. Mae'r adroddiad hwn yn golygu misoedd lawer o archwilio manwl mewn chwe ymddiriedolaeth a gwaith arolygu helaeth mewn ymddiriedolaethau, byrddau iechyd lleol, gyda chleifion, meddygon teulu a meddygon ymgynghorol. Yr ydym wedi derbyn cyngor gan banel o arbenigwyr, sydd wedi'n cynghori gydol yr astudiaeth. Nodir aelodau'r panel yn atodiad 2 yr adroddiad. Felly, mae gwaith dadansoddi swmpus iawn yn ategu adroddiad manwl iawn, ac mae'r dadansoddi wedi'i nodi yn yr adroddiad.

[14] **Irene James:** I would agree with that, but can you tell me what percentage was the level received for this evidence?

[14] **Irene James:** Byddwn yn cytuno â hynny, ond a allwch ddweud pa ganran oedd y lefel a dderbyniwyd ar gyfer y dystiolaeth hon?

Ms Body: Are you talking about the survey part of the work?

Ms Body: A ydych yn siarad am ran arolwg y gwaith?

[15] **Irene James:** Yes.

[15] **Irene James:** Ydw.

Ms Body: That is set out in appendix 1 of the report on page 56. You will see that our surveys of chief executives of Welsh trusts is 100 per cent. Our surveys of chief executives of local health boards was 100 per cent. Our survey of consultants in the three specialities that we looked at was 31 per cent. Our survey of chief officers of community health councils was 45 per cent. Our survey of general practitioners in Wales was 17 per cent. We also had 113 surveys returned from patients.

Ms Body: Mae hyn wedi'i nodi yn atodiad 1 yr adroddiad ar dudalen 56. Byddwch yn gweld bod ein harolygon o brif weithredwyr ymddiriedolaethau Cymru yn 100 y cant. Yr oedd ein harolwg o feddygon ymgynghorol yn y tri maes arbenigol yr edrychwyd arnynt yn 31 y cant. Yr oedd ein harolwg o brif swyddogion cynghorau iechyd cymuned yn 45 y cant. Yr oedd ein harolwg o ymarferwyr cyffredinol yng Nghymru yn 17 y cant. Dychwelodd cleifion 113 o arolygon hefyd.

[16] **Janet Davies:** Thank you, Gillian. Mrs Lloyd, has this been agreed as being correct before it was published?

[16] **Janet Davies:** Diolch, Gillian. Mrs Lloyd, a gytunwyd bod hyn yn gywir cyn ei gyhoeddi?

Ms Lloyd: Yes.

Ms Lloyd: Do.

[17] **Mick Bates:** Returning to the issue of data collection, which you described as 'robust', does this extend to hospitals in England that treat many patients who live on the border?

[17] **Mick Bates:** Gan ddod yn ôl at y mater o gasglu data, a ddisgrifiwyd gennych fel 'cadarn', a yw hyn yn wir hefyd am ysbytai yn Lloegr sy'n trin llawer o gleifion sy'n byw ar y ffin?

Ms Lloyd: It does. As you know, they have a slightly different information system in England. One of the challenges in our information strategy is to ensure that the two systems can talk together, and this is being addressed, so we know what is happening to

Ms Lloyd: Ydy. Fel y gwyddoch, mae ganddynt system wybodaeth ychydig yn wahanol yn Lloegr. Un o'r heriau yn ein strategaeth wybodaeth yw sicrhau bod y ddwy system yn gallu siarad gyda'i gilydd, ac yr ydym yn mynd i'r afael â hyn, felly

patients who are transferred to England.

gwyddom beth sy'n digwydd i gleifion sy'n cael eu symud i Loegr.

[18] **Janet Davies:** Thank you. You have talked about the things that you and the Assembly Government are doing to address the situation. How confident are you that you will be able to achieve the March 2006 targets?

[18] **Janet Davies:** Diolch. Yr ydych wedi siarad am y pethau yr ydych chi a Llywodraeth y Cynulliad yn eu gwneud i fynd i'r afael â'r sefyllfa. Pa mor hyderus ydych chi y byddwch yn gallu cyflawni targedau Mawrth 2006?

Ms Lloyd: The March 2006 targets are an absolute imperative. When we first had service and financial frameworks, we had a lot of targets for organisations to meet. However, they have now been refined to about 20, four of which focus on waiting times and the time that people have to wait for a variety of interventions. The performance management regime is now much more pertinent than it was. We no longer allow—[*Interruption.*]

Ms Lloyd: Mae targedau Mawrth 2006 yn gwbl orfodol. Pan gawsom fframweithiau gwasanaeth a chyllid am y tro cyntaf, yr oedd gennym lawer o dargedau i sefydliadau eu bodloni. Fodd bynnag, y maent wedi'u cwtogi bellach i oddeutu 20, ac mae pedwar ohonynt yn canolbwyntio ar amseroedd aros a'r amser sy'n rhaid i bobl aros am amrywiaeth o ymyriadau. Mae'r drefn rheoli perfformiad yn llawer mwy perthnasol bellach nag yr arferai fod. Nid ydym bellach yn caniatáu—[*Torri ar draws*.]

[19] **Leighton Andrews:** I cannot concentrate on the witness with all this chatter.

[19] **Leighton Andrews:** Ni allaf ganolbwyntio ar y tyst gyda chymaint o glebran.

[20] **Janet Davies:** Could all Members please listen carefully, because this is a very important session, and we really need to be on top of this issue. Sorry for the interruption, Mrs Lloyd.

[20] **Janet Davies:** A allai'r holl Aelodau wrando'n astud, oherwydd mae hon yn sesiwn bwysig iawn, ac mae'n rhaid i ni fynd at wraidd y mater hwn. Mae'n ddrwg gennyf am dorri ar eich traws, Mrs Lloyd.

Ms Lloyd: Let me think where I was. We need to make sure that the targets that we set are taken seriously by the service. This is why the Minister asked for the role of the regional office to be strengthened in terms of holding to account those organisations, and we are now doing this. There is a focus on improving the waiting and access experience for patients throughout the system. I am confident at the moment that there is a sharpened focus from the service to achieve these 2006 targets. We have done the modelling, and there is a robust model coming out, which Cardiff University has been working on for some time with us. It is in place for out-patients at the moment and will be piloted for in-patients in the next four months. I consider this to be a reasonable target that should be achieved by the service.

Ms Lloyd: Gadewch i mi gofio lle yr oeddwn. Mae angen i ni sicrhau bod y gwasanaeth yn ystyried o ddifrif y targedau yr ydym yn eu gosod. Dyma pam mae'r Gweinidog wedi gofyn am i rôl y swyddfa ranbarthol gael ei chryfhau o ran gwneud y sefydliadau hynny'n atebol, ac yr ydym yn gwneud hyn yn awr. Yr ydym yn canolbwyntio ar wella'r profiad aros a mynediad i gleifion drwy'r system gyfan. Yr wyf yn hyderus ar hyn o bryd bod y gwasanaeth yn canolbwyntio'n fwy dyfal nag erioed ar gyflawni'r targedau 2006 hyn. Yr ydym wedi gwneud y gwaith modelu, ac mae model cadarn yn cael ei gyflwyno, un y mae Prifysgol Caerdydd wedi bod yn gweithio arno am beth amser gyda ni. Mae ar waith ar gyfer ein cleifion allanol ar hyn o bryd a bydd yn cael ei dreialu ar gyfer cleifion mewnol yn y pedwar mis nesaf. Yr wyf yn ystyried bod hwn yn darged rhesymol ac y dylai'r gwasanaeth ei gyflawni.

[21] **Janet Davies:** Thank you. I would like to go over paragraphs 4.2 and 4.3, which are on page 26, and look at figure 16 on page 37. The report criticises the Assembly Government for its failure to state clearly the waiting time targets, and to set out a clear, medium-term plan for the staged reduction of waiting times. Why has this not been done, and why have the waiting time targets been so inconsistently stated in different documents? This is shown in figure 16.

[21] **Janet Davies:** Diolch. Hoffwn drafod paragraffau 4.2 a 4.3, sydd ar dudalen 26, ac edrych ar ffigur 16 ar dudalen 37. Mae'r adroddiad yn beirniadu Llywodraeth y Cynulliad am ei methiant i nodi'r targedau amser aros yn glir, a nodi cynllun tymor canolig, clir ar gyfer gostwng amseroedd aros fesul cam. Pam nad yw hyn wedi'i wneud, a pham i'r targedau amser aros gael eu datgan mor anghyson mewn gwahanol ddogfennau? Dangosir hyn yn ffigur 16.

Ms Lloyd: I have understood the question,

Ms Lloyd: Yr wyf wedi deall y cwestiwn,

Chair, but which paragraph are you referring to? I seem to be on the wrong page.

Gadeirydd, ond at ba baragraff yr ydych yn cyfeirio? Ymddengys fy mod ar y dudalen anghywir.

[22] **Janet Davies:** It is paragraphs 4.2 to 4.3. The figure is on the next page, I am sorry.

[22] **Janet Davies:** Paragraffau 4.2 i 4.3. Mae’r ffigur ar y dudalen ganlynol, mae’n ddrwg gennyf.

Ms Lloyd: That is okay, it is not a problem. It is figure 16 on page 29.

Ms Lloyd: Mae hynny’n iawn, nid yw’n broblem. Ffigur 16 ar dudalen 29 ydyw.

[23] **Janet Davies:** Basically, there seems to be an inconsistency between the local health boards.

[23] **Janet Davies:** Yn syml, ymddengys bod anghysondeb rhwng y byrddau iechyd lleol.

Ms Lloyd: Yes, there is. To deal with that inconsistency, there are a few factors that we need to consider. One is the traditional allocation of finance, which the Townsend allocation resource formula is trying to equalise. You will note that—and this is a possibility, I could not be 100 per cent certain about it—those that seem to be managing best at the moment are in north Wales. As you know, there is a redressing of the balance of resource between north and south Wales in terms of the inequalities agenda and the needs assessment of the population. So, it could be that that has allowed those organisations to be able to have a little more flexibility to meet targets.

Ms Lloyd: Oes, mae hynny’n wir. I ddelio â’r anghysondeb, mae angen i ni ystyried rhai ffactorau. Un yw dyraniad traddodiadol y cyllid, y mae fformiwla adnoddau dyrannu Townsend yn ceisio’i gyfartalu. Byddwch yn sylwi—a phosibilrwydd yw hyn, ni allaf fod yn 100 y cant yn sicr am hyn—fod y rhai hynny sydd i’w gweld yn ymdopi orau ar hyn o bryd yn y Gogledd. Fel y gwyddoch, mae angen cydbwyso’r fantol adnoddau rhwng y Gogledd a’r De o ran yr agenda anghydraddoldebau a’r asesiad o anghenion y boblogaeth. Felly, efallai bod hynny wedi caniatáu i’r sefydliadau hynny allu cael ychydig mwy o hyblygrwydd i fodloni targedau.

However, I would also say that, in defence of

Fodd bynnag, byddwn hefyd yn dweud, i

north Wales, there is a relatively stable group of trust chief executives in the region. One of them in particular is absolutely determined that his organisation shall be the best in Wales, and he has always met the challenges and targets placed in front of him. He runs a good organisation. The three work as a team to ensure that they focus on the real health needs of the population. It is quite a stable set of organisations up there, with determined chief executives.

amddiffyn y Gogledd, bod grŵp cymharol sefydlog o brif weithredwyr ymddiriedolaethau yn y rhanbarth. Mae un ohonynt yn arbennig yn hollol benderfynol mai ei sefydliad ef fydd y gorau yng Nghymru, ac mae wedi bodloni'r heriau a'r targedau y mae wedi'u hwynebu bob tro. Mae'n rhedeg sefydliad da. Mae'r tri yn gweithio fel tîm i sicrhau eu bod yn canolbwyntio ar wir anghenion iechyd y boblogaeth. Mae'n garfan gymharol sefydlog o sefydliadau i fyny yno, gyda phrif weithredwyr penderfynol.

As for the others, we now have, fortunately, very good needs assessment analyses throughout Wales, given the advent of the local health boards. They now need to think very carefully about how they physically manage to meet the demands placed upon them, given those needs. Some areas have many more problems than others, and they have to, through their commissioning, particularly this year—and this is one of the targets set for them, and the training is being provided—match the needs to the demands that are coming through the system. So, you will notice that the areas under the greatest pressure are very much in south-east Wales, with a couple in mid and west Wales. However, we are working with these organisations to ensure that they understand how their needs might match their ability to meet those needs.

O ran y gweddill, mae gennym yn awr, yn ffodus, ddulliau o ddadansoddi asesiadau anghenion da iawn ledled Cymru, o ystyried dyfodiad y byrddau iechyd lleol. Mae angen iddynt yn awr feddwl yn ofalus iawn ynglŷn â sut maent yn llwyddo'n ffisegol i fodloni'r gofynion a roddir arnynt, o ystyried yr anghenion hynny. Mae gan rai ardaloedd lawer mwy o broblemau nag eraill, ac mae'n rhaid iddynt, drwy eu comisiynu, yn arbennig eleni—a dyma yw un o'r targedau sydd wedi'u pennu iddynt, a darperir yr hyfforddiant—sicrhau bod yr anghenion yn cyd-fynd â'r gofynion a gyflwynir drwy'r system. Felly, byddwch yn sylwi bod yr ardaloedd sydd dan y pwysau mwyaf yn y De-ddwyrain, gydag un neu ddau yn y Canolbarth a'r Gorllewin. Fodd bynnag, yr ydym yn gweithio gyda'r sefydliadau hyn i sicrhau eu bod yn deall sut y gall eu hanghenion gyfateb i'w gallu i ddiwallu'r anghenion hynny.

The other problem is that there is evidence to show that, where individuals live within close proximity to a major secondary or tertiary care centre, the requirement from that population for access to that centre is greater. This is based on research that has been done throughout the UK—the demand escalates the nearer people are to recognised tertiary care centres. That is certainly one of the issues facing Cardiff and Swansea. It is also relevant to Newport, but to a lesser extent, because some of the population served is far more rural. However, that is another issue that must be borne in mind, and we are working with Cardiff University and these organisations to unpick this problem. It might mean that the referrals straight to a tertiary care centre are occurring as part of this halo effect, which surrounds all large cities that are home to eminent organisations.

Y broblem arall yw bod tystiolaeth i ddangos, lle mae unigolion yn byw'n agos i ganolfan gofal eilaidd neu drydyddol fawr, bod y gofyniad gan y boblogaeth honno i gael defnyddio'r ganolfan honno yn uwch. Mae hyn yn seiliedig ar ymchwil sydd wedi'i wneud ledled y DU—mae'r galw yn uwch po agosaf yw'r bobl i ganolfannau gofal trydyddol cydnabyddedig. Mae hyn yn sicr yn un o'r materion sy'n wynebu Caerdydd ac Abertawe. Mae hefyd yn berthnasol i Gasnewydd, ond i raddau is, oherwydd bod rhywfaint o'r boblogaeth a wasanaethir yn llawer mwy gwledig. Fodd bynnag, mae hwn yn fater arall sy'n rhaid i ni ei ystyried, ac yr ydym yn gweithio gyda Phrifysgol Caerdydd a'r sefydliadau hyn i ddatrys y broblem hon. Gall olygu bod y cyfeiriadau yn syth i ganolfan gofal trydyddol yn digwydd fel rhan o'r effaith leugylch hon, sy'n cwmpasu pob dinas fawr y mae sefydliadau amlwg wedi'u lleoli ynddynt.

[24] **Janet Davies:** That is a very interesting situation. I will bring you in in a minute, Leighton. I am really surprised that anybody would want to go to hospital because he or she lives nearby. Perhaps that needs looking at carefully.

[24] **Janet Davies:** Mae honno'n sefyllfa ddiddorol iawn. Cewch gyfrannu yn y man, Leighton. Yr wyf yn synnu y byddai unrhyw un am gael mynd i'r ysbyty oherwydd eu bod yn byw'n agos. Efallai bod angen edrych ar hynny'n ofalus.

I also wanted to ask you about the tertiary sector. In the South, in Cardiff and the Vale and in Swansea, you have a lot of tertiary treatment, whereas in north Wales people go

Yr oeddwn hefyd am ofyn i chi am y sector trydyddol. Yn y De, yng Nghaerdydd a'r Fro ac yn Abertawe, mae llawer o driniaeth drydyddol, tra yn y Gogledd mae pobl yn

to England, I believe. Do the waiting times in the north, therefore, reflect what is happening in England, because a certain sector will be going outside Wales?

mynd i Loegr, yn ôl pob tebyg. A yw’r amseroedd aros yn y Gogledd, felly, yn adlewyrchu’r hyn sy’n digwydd yn Lloegr, oherwydd bydd sector penodol yn mynd y tu allan i Gymru?

Ms Lloyd: No, not necessarily. Health Commission Wales, which looks after tertiary services and their commissioning, is finding that the referral rates diminish the further west you go in the north, and that, when you look at the issues facing some of the local health boards in the north—and I have asked for particular research to be undertaken on this, because it is not explicable—you find that, for example, for plastic surgery, which must go outside Wales in the north, the numbers waiting and the referrals for Ynys Môn and Gwynedd are well above what you would expect, and they have a major problem. Why is that? We must look with their secondary care providers to see whether the referrals are appropriate or could be managed differently. As the health needs become clearer in the communities, it enables you to tackle some of these anomalies in a more constructive way.

Ms Lloyd: Na, nid o reidrwydd. Mae Comisiwn Iechyd Cymru, sy’n gofalu am wasanaethau trydyddol a’u comisiynu, yn canfod bod y cyfraddau cyfeirio yn lleihau wrth fynd ymhellach i’r gorllewin yn y Gogledd, ac, wrth edrych ar y materion sy’n wynebu rhai o’r byrddau iechyd lleol yn y Gogledd—ac yr wyf wedi gofyn i ymchwil benodol gael ei chyflawni ar hyn, oherwydd ni ellir ei esbonio—yr ydych yn gweld, er enghraifft, gyda llawfeddygaeth gosmetig, sy’n gorfod mynd y tu allan i Gymru yn y Gogledd, mae’r niferoedd sy’n aros a’r cyfeiriadau ar gyfer Ynys Môn a Gwynedd yn llawer uwch na’r hyn y byddech yn ei ddisgwyl, ac mae’n broblem ddifrifol. Pam hynny? Mae’n rhaid i ni edrych gyda’u darparwyr gofal eilaidd i weld a yw’r cyfeiriadau yn briodol neu a ellid eu rheoli’n wahanol. Wrth i’r anghenion iechyd ddod yn fwy clir yn y cymunedau, mae’n eich galluogi i fynd i’r afael â rhai o’r anghysondebau hyn mewn ffordd fwy adeiladol.

With regard to the south, as you can see from some of the waiting-times figures, there have been big problems, particularly with neurosurgery, but that is UK wide as well, because of the heavy proportion of the work

O ran y de, fel y gwelwch o rai o’r ffigurau amseroedd aros, bu problemau mawr, yn arbennig gyda niwrolawfeddygaeth, ond mae hynny’n wir drwy’r DU hefyd, oherwydd bod cyfran uchel o waith niwrolawfeddygon yn

that neurosurgeons do that is emergency treatment. Health Commission Wales is undertaking a review of neurology services and neurosurgery services to see how it can better commission care and how the centres can work together better to maximise the skills that we have in Wales. So, there are problems there, too. Plastic surgery in Swansea has been tackled, and, as you know, the burns service is regarded as one of the pre-eminent services in the UK, and that has done very well indeed. We are, therefore, gradually going through the list of the real problems that have emerged over the last 18 months, given the needs assessment, to try to explain why these blips and escalating demands occur, and to discuss with communities how they might be managed better, including more locally, if necessary.

ymwneud â thriniaethau brys. Mae Comisiwn Iechyd Cymru yn cynnal adolygiad o wasanaethau niwroleg a gwasanaethau niwrolawfeddygaeth i weld sut y gall gomisiynu gofal yn well a sut y gall y canolfannau weithio gyda'i gilydd yn well i fanteisio i'r eithaf ar y sgiliau sydd gennym yng Nghymru. Felly, mae problemau yno, hefyd. Yr ydym wedi mynd i'r afael â llawfeddygaeth gosmetig yn Abertawe, ac, fel y gwyddoch, ystyrir y gwasanaeth llosgiadau fel un o wasanaethau gorau'r DU, ac mae hwnnw wedi gwneud yn dda iawn. Yr ydym, felly, yn mynd yn raddol drwy'r rhestr o broblemau gwirioneddol sydd wedi codi dros y 18 mis diwethaf, o ystyried yr asesiad anghenion, i geisio egluro pam mae'r camgymeriadau a'r gofynion cynyddol hyn yn digwydd, ac i drafod gyda chymunedau sut y gellir eu rheoli'n well, gan gynnwys yn fwy lleol, os oes angen.

[25] **Leighton Andrews:** I understand the point that you are making about Cardiff and Swansea and why they, in accord with other UK research, would be more in demand, as it were. However, that does not explain the situation in Blaenau Gwent, or, indeed, in Caerphilly. Would you like to respond to that?

[25] **Leighton Andrews:** Yr wyf yn deall y pwynt yr ydych yn ei wneud am Gaerdydd ac Abertawe a pham, yn unol ag ymchwil arall yn y DU, y byddai mwy o alw amdanynt, fel petai. Fodd bynnag, nid yw hynny'n egluro'r sefyllfa ym Mlaenau Gwent, neu, yn wir, yng Nghaerffili. A hoffech ymateb i hynny?

Ms Lloyd: We all have to remember that Caerphilly and Blaenau Gwent are among the areas of most extreme health inequalities. They are all major gainers under the Townsend formula, particularly Caerphilly, which is the worst and is furthest from target. Therefore, you are dealing with problems of a very disabled community that has many health needs. You will see that many of the

Ms Lloyd: Mae'n rhaid i ni gyd gofio bod Caerffili a Blaenau Gwent ymysg yr ardaloedd lle ceir yr anghydraddoldebau iechyd mwyaf eithafol. Maent i gyd ar eu hennill o dan fformiwla Townsend, yn arbennig Caerffili, sef y gwaethaf a'r pellaf o'r targed. Felly, yr ydych yn delio â phroblemau o gymuned anabl iawn sydd â llawer o anghenion iechyd. Byddwch yn gweld bod nifer o'r cynlluniau anghydraddoldebau-mewn-iechyd yn yr ardaloedd hynny, ac maent yn canfod galw cudd am wasanaethau. Mae hyn yn dda yn ei hun, ond mae'n rhaid ymdopi â'r sefyllfa. Yng Nghaerffili a Blaenau Gwent yn benodol, bydd llu o gynlluniau cyfalaf pwysig yn cael eu cyflwyno yn y blynyddoedd nesaf i wella mynediad i ofal ar gyfer unigolion ac i gryfhau'r gwasanaethau gofal

inequalities-in-health schemes are in those areas, and they are finding a latent demand for services. That is good in itself, but it must then be coped with. In Caerphilly and Blaenau Gwent in particular, you will see major capital schemes coming on stream in the next few years to improve access to care for individuals and to strengthen the community and primary care services to try to meet health demands at that primary care, very local level in order to take some of the pressure off in terms of the demand created on the secondary care services. You, no doubt, will know about the new Ebbw Vale community-focused units that are coming on stream, and the big proposals in Caerphilly for a complete reorganisation of its community and hospital services to meet its demands more effectively. This is to do with the concentration of effort exercised by the local health boards, and the trust currently responsible for the hospital care in those areas, on working together to devise a more sustainable solution for an underprivileged part of society up there.

sylfaenol a chymunedol i geisio diwallu gofynion iechyd ar y lefel gofal sylfaenol, lleol iawn honno er mwyn ysgafnhau ychydig ar y baich o ran y galw ar y gwasanaethau gofal eilaidd. Gwyddoch, mae'n siŵr, am yr unedau newydd yng Nglynebwy sy'n canolbwyntio ar gymunedau, a'r cynigion mawr yng Nghaerffili i ad-drefnu ei wasanaethau cymuned ac ysbyty yn llwyr i ddiwallu ei ofynion yn fwy effeithiol. Mae hyn yn ymwneud â'r ymdrech gan y byrddau iechyd lleol, a'r ymddiriedolaeth sy'n gyfrifol ar hyn o bryd am ofal ysbyty yn yr ardaloedd hynny, i weithio gyda'i gilydd ar lunio ateb mwy cynaliadwy ar gyfer rhan ddifreintiedig y gymdeithas yno.

[26] **Leighton Andrews:** I cannot find the right table in the report now, but, if I remember rightly, Merthyr also benefits. Is that right?

[26] **Leighton Andrews:** Nid wyf yn gallu gweld y tabl cywir yn yr adroddiad yn awr, ond, os cofiaf yn iawn, mae Merthyr hefyd yn elwa. A yw hynny'n gywir?

Ms Lloyd: Merthyr is better. On visiting these places, you would not automatically think that Merthyr was extremely different from the others in terms of the inequalities in health scheme. On Townsend gainers, Merthyr is well away from the others.

Ms Lloyd: Mae Merthyr yn well. Wrth ymweld â'r lleoedd hyn, ni fyddech yn meddwl yn awtomatig bod Merthyr yn wahanol iawn i'r lleill o ran y cynllun anghydraddoldebau iechyd. O ran y rhai sydd ar eu hennill o adroddiad Townsend, mae

Nevertheless, as you will know, we are concerned about the health needs of Merthyr and its surroundings, and some £150 million has been put aside in the capital programme over the next few years to resolve some of the infrastructure issues around Merthyr. The local health board and trust, together with its regional office, are looking carefully, with the community itself, at how best the resource might be expended to get more patient-focused access, particularly in mental health services, to ensure that we can move out of unsatisfactory, old-fashioned accommodation such as St Tydfil's. They are also looking at the Caerphilly model to see whether more local access can be provided in some of the more isolated communities to better serve their health needs. There is an active debate happening in Merthyr. However, in terms of Townsend gainers, it is, surprisingly, not in the top rank.

Merthyr ymhell ar y blaen o'i gymharu â'r lleill. Fodd bynnag, fel y gwyddoch, yr ydym yn bryderus ynghylch anghenion iechyd Merthyr a'r cyffiniau, ac mae oddeutu £150 miliwn wedi'i neilltuo yn y rhaglen gyfalaf dros y blynyddoedd nesaf i ddatrys rhai o'r materion seilwaith ym Merthyr. Mae'r bwrdd iechyd lleol a'r ymddiriedolaeth, ynghyd â'i swyddfa ranbarthol, yn edrych yn ofalus, gyda'r gymuned ei hun, ar y ffordd orau o ddefnyddio'r adnoddau er mwyn cael mynediad sy'n canolbwyntio mwy ar gleifion, yn arbennig gwasanaethau iechyd meddwl, i sicrhau y gallwn symud allan o safleoedd anfoddhaol, hen ffasiwn fel Tudful Sant. Maent hefyd yn edrych ar fodel Caerffili i weld a ellir darparu mynediad mwy lleol yn rhai o'r cymunedau mwyaf diarffordd i ddiwallu eu hanghenion iechyd yn well. Mae trafodaeth frwd ym Merthyr. Fodd bynnag, o ran y rhai sydd ar eu hennill yn sgil adroddiad Townsend, nid yw, er syndod, ar y brig.

[27] **Janet Davies:** I do not want to go down this road, but it is interesting how well Rhondda Cynon Taf is doing, particularly with regard to in-patients.

[27] **Janet Davies:** Nid wyf am ddilyn y trywydd hwn, ond mae'n ddiddorol gweld cystal y mae Rhondda Cynon Taf yn ei wneud, yn arbennig o ran cleifion mewnol.

Ms Lloyd: Rhondda Cynon Taf is a keen purchaser. It commissions well.

Ms Lloyd: Mae Rhondda Cynon Taf yn brynwr awyddus. Mae'n comisiynu'n dda.

[28] **Mark Isherwood:** I would like to pick up briefly on your comments about the north Wales trust chief executive who is very keen

[28] **Mark Isherwood:** Hoffwn drafod yn gryno eich sylwadau ar y prif weithredwr yn un o ymddiriedolaethau'r Gogledd sy'n

to compete across the border. I have discussed this with him and I am aware that commissioners are, effectively, working in a competitive market with a choice of trusts, particularly the further east you travel. Do you believe, therefore, that there should be an enhanced role for differential waiting time targets driven by the trusts—in this case, working with the local college to produce academic work to support their proposed programme?

awyddus iawn i gystadlu dros y ffin. Yr wyf wedi trafod hyn gydag ef ac yr wyf yn ymwybodol bod comisiynwyr, i bob pwrpas, yn gweithio mewn marchnad gystadleuol gyda dewis o ymddiriedolaethau, yn arbennig wrth i chi deithio ymhellach i'r dwyrain. A ydych yn credu, felly, y dylid cael gwell rôl ar gyfer targedau amseroedd aros gwahaniaethol a yrrir gan yr ymddiriedolaethau—yn yr achos hwn, sy'n gweithio gyda'r coleg lleol i gynhyrchu gwaith academaidd i ategu eu rhaglen arfaethedig?

Ms Lloyd: We must eradicate inequalities. This report highlights the problem caused through an inequality of waiting times. There is no doubt that in north Wales there are lower waiting times and better access rates than anywhere else. They have done extremely well to look at their relationship with the University of Wales, Bangor to see how they can combine academic posts better. They have a problem in north Wales that people might not wish to work quite so far west and, therefore, to maintain the interest of their clinicians, which is essential in delivering high-quality care, they have been very creative about how they can attract staff into their areas. They need to make absolutely sure that access to local services for the public up there is maintained, while providing good access. This should not be done in a competitive mode; they must collaborate. The whole of that north Wales area must collaborate more on the development of the active networks that need

Ms Lloyd: Mae'n rhaid i ni gael gwared ar anghydraddoldebau. Mae'r adroddiad hwn yn amlygu'r broblem a achosir yn sgil anghydraddoldeb amseroedd aros. Nid oes amheuaeth bod amseroedd aros is a gwell cyfraddau mynediad yn y Gogledd nag yn unrhyw le arall. Maent wedi gwneud yn dda iawn i edrych ar eu perthynas â Phrifysgol Cymru, Bangor i weld sut y gallant gyfuno swyddi academaidd yn well. Y broblem yn y Gogledd yw nad yw pobl o bosibl am weithio mor bell tua'r gorllewin ac, felly, i gynnal diddordeb eu clinigwyr, sy'n hanfodol wrth ddarparu gofal o ansawdd uchel, maent wedi bod yn greadigol iawn ynghylch sut y gallant ddenu staff i'w hardaloedd. Mae angen iddynt wneud yn hollol sicr bod mynediad y cyhoedd i wasanaethau lleol yn cael ei gynnal yno, tra'n darparu mynediad da. Ni ddylid gwneud hyn mewn dull cystadleuol; mae'n rhaid iddynt gydweithio. Mae'n rhaid i'r ardal gyfan honno yn y Gogledd gydweithio mwy ar ddatblygu'r rhwydweithiau

to be instituted in order to maintain good quality services. As you will know—as, no doubt, the chief executive will have told you—there is currently a north Wales planning forum which is about to appoint its project manager to do a great deal more work on the schemes that have been commissioned over the last year in north Wales, to look at how to maintain orthopaedic services, better access for cardiology and cardiac services, and what will be done about cancer and its management. There is an excellent system in Conwy and Denbighshire that has to serve a wide area. The future for north Wales is that, to maintain the high-quality services that they have there, they will have to collaborate more than they have ever done in the past. They are actively pursuing that through the network projects that they have commissioned as a whole community—the six LHBs, the three trusts and the regional offices—because, with the European working-time directive, it is quite difficult to maintain isolated services, particularly with quality standards being raised all the time.

gweithgar sydd angen eu sefydlu er mwyn cynnal gwasanaethau o ansawdd da. Fel y gwyddoch—bydd y prif weithredwr, yn sicr, wedi dweud wrthych—mae fforwm cynllunio gogledd Cymru yn bodoli ar hyn o bryd sydd ar fin penodi ei reolwr prosiect i wneud llawer mwy o waith ar y cynlluniau sydd wedi'u comisiynu dros y flwyddyn ddiwethaf yn y Gogledd, i edrych ar ffyrdd o gynnal gwasanaethau orthopedig, gwell mynediad i wasanaethau cardioleg a chardiaidd, a beth fydd yn cael ei wneud am ganser a'i reolaeth. Mae system ragorol yng Nghonwy a Sir Ddinbych sy'n gorfod gwasanaethu ardal eang iawn. I gynnal y gwasanaethau o ansawdd uchel sydd ganddynt yno, bydd yn rhaid i'r Gogledd yn y dyfodol, gydweithio mwy nag y maent erioed wedi'i wneud. Maent yn mynd at wraidd hynny'n ddiwyd drwy'r prosiectau rhwydwaith y maent wedi'u comisiynu fel cymuned gyfan—y chwe Bwrdd Iechyd Lleol, y tair ymddiriedolaeth a'r swyddfeydd rhanbarthol—oherwydd, gyda'r gyfarwyddeb oriau gwaith Ewropeaidd, mae'n eithaf anodd cynnal gwasanaethau ar wahân, yn arbennig wrth i safonau ansawdd gael eu codi drwy'r amser.

[29] **Carl Sargeant:** On that point, the waiting times in north Wales are particularly low, and that has not come about by chance. You are suggesting that there is particularly good management in north Wales across the trusts. Are you perhaps saying that the management in other areas is not quite as good?

[29] **Carl Sargeant:** Ar y pwynt hwnnw, mae'r amseroedd aros yn y Gogledd yn isel iawn, ac nid drwy hap y digwyddodd hynny. Yr ydych yn awgrymu bod rheolaeth arbennig o dda yn y Gogledd yn yr holl ymddiriedolaethau. A ydych o bosibl yn dweud nad oes rheolaeth gystal mewn ardaloedd eraill?

Ms Lloyd: No. We have some excellent managers throughout Wales. However, there has been a focus up there on being the best. There is quite a play here. However, they are also the furthest away from the Townsend targets, the other way from Caerphilly. Therefore, they might have had the benefit of more resources given the needs of their population. You must take the two things together. They possibly had the opportunity to be flexible.

Ms Lloyd: Na. Mae gennym rai rheolwyr rhagorol ledled Cymru. Fodd bynnag, maent wedi canolbwyntio i fyny yno ar fod y gorau. Mae yna dipyn o gystadleuaeth yno. Fodd bynnag, hwy hefyd sydd bellaf i ffwrdd o dargedau Townsend, y ffordd arall o Gaerffili. Felly, efallai eu bod wedi gallu elwa ar fwy o adnoddau o ystyried anghenion eu poblogaeth. Mae'n rhaid ystyried y ddau beth gyda'i gilydd. Yr oedd ganddynt y cyfle o bosibl i fod yn hyblyg.

[30] **Carl Sargeant:** The fundamental point in terms of the waiting times is that the LHBs must be the driver as they are ultimately responsible for driving down waiting times. North Wales is achieving this, but south Wales is not. Surely, good practice should be shared across Wales. You are saying that they are working collaboratively across north Wales. Why is that not happening in south Wales? Who is taking responsibility for that?

[30] **Carl Sargeant:** Y pwynt sylfaenol o ran yr amseroedd aros yw bod yn rhaid i'r BILlau yrru hyn ymlaen oherwydd mai hwy sy'n gyfrifol yn y pen draw am leihau amseroedd aros. Mae'r Gogledd yn cyflawni hyn, ond nid yw'r de. Oni ddylid rhannu arferion da ledled Cymru. Yr ydych yn dweud eu bod yn cydweithio ledled y Gogledd. Pam nad yw hynny'n digwydd yn y de? Pwy sy'n cymryd cyfrifoldeb am hynny?

Ms Lloyd: It is also working in south Wales, and I am sure that Mr Marples can tell you what has been going on in mid and west Wales. It is working. There is a collaborate feel now around south Wales. The number of people waiting and the times that they are waiting are reducing every month. They must work together. We have noticed, particularly with the new chief executive in north Glamorgan, that there is huge progress in terms of collaboration. He is now using

Ms Lloyd: Mae hefyd yn gweithio yn y de, ac yr wyf yn sicr y gall Mr Marples ddweud wrthych beth sydd wedi bod yn digwydd yn y Canolbarth a'r Gorllewin. Mae'n gweithio. Mae ymdeimlad o gydweithio bellach ledled y de. Mae nifer y bobl sy'n aros a'r amseroedd y maent yn aros yn gostwng bob mis. Mae'n rhaid iddynt weithio gyda'i gilydd. Yr ydym wedi sylwi, yn arbennig gyda'r prif weithredwr newydd yng ngogledd Morgannwg, bod cynnydd enfawr o ran

facilities in Brecon to serve the south Powys community and his own community. His trust is working much more collaboratively with those in Abergavenny, Pontypridd and Rhondda. They are all well aware that they must work together, and so are the local health board chief executives. The Gwent local health board chief executives have collaborated to the point at which, for immediate contact and interface with the Gwent trust, one of their number is nominated to deal with particular issues. One of them deals with the usual acute work and another deals with the cancer access times. Therefore, they are collaborating because they recognise that they are small organisations put there to look critically at their local needs and partnerships and to concentrate on the patients and their needs. However, in order to act in a co-ordinated manner, they need to work together. That is what is happening.

cydweithio. Mae bellach yn defnyddio cyfleusterau yn Aberhonddu i wasanaethu cymuned de Powys a'i gymuned ei hun. Mae ei ymddiriedolaeth yn cydweithio llawer mwy gyda rhai'r Fenni, Pontypridd a Rhondda. Maent i gyd yn gwbl ymwybodol bod yn rhaid iddynt weithio gyda'i gilydd, ynghyd â phrif weithredwyr y byrddau iechyd lleol. Mae prif weithredwyr bwrdd iechyd lleol Gwent wedi cydweithio i'r graddau, ar gyfer y cydgysylltiad a chysylltiad uniongyrchol ag ymddiriedolaeth Gwent, mae un o'u haelodau wedi'i enwebu i ddelio â materion penodol. Mae un ohonynt yn delio â'r gwaith acíwt arferol ac mae un arall yn delio â'r amseroedd mynediad canser. Felly, maent yn cydweithio oherwydd eu bod yn cydnabod eu bod yn sefydliadau bach sydd â'r dasg o edrych yn feirniadol ar eu hanghenion a phartneriaethau lleol a chanolbwyntio ar y cleifion a'u hanghenion. Fodd bynnag, er mwyn gweithredu mewn dull cydlynol, mae angen iddynt weithio gyda'i gilydd. Dyna beth sy'n digwydd.

[31] **Jocelyn Davies:** You started off this morning by saying that you hoped that you would be asked about the policy context in Wales. I will not disappoint you. Can you outline the policy context in Wales in terms of out-patient appointments?

[31] **Jocelyn Davies:** Bu i chi ddechrau'r bore yma drwy ddweud eich bod yn gobeithio y byddai rhywun yn gofyn i chi am y cyd-destun polisi yng Nghymru. Nid wyf am eich siomi. A allwch amlinellu'r cyd-destun polisi yng Nghymru o ran apwyntiadau cleifion allanol?

Ms Lloyd: We are taking a twin-track approach in terms of out-patients. The basic target is that no-one waits more than 18

Ms Lloyd: Mae gennym ddull deuol o ddelio â'n cleifion allanol. Y targed sylfaenol yw nad oes neb yn gorfod aros am fwy na 18

months. For the service and financial framework, that goes down to 12 months by 2006. However, we have also required the organisations to look critically at why people get on out-patient lists in the first place. You will see from this report, and from our own evidence, that a number of consultants are asking, 'Was I the best person for this person to see and wait to see?' Therefore, through 'Innovations in Care', we have made an enormous effort in terms of looking at the needs of people on the waiting lists and considering whether or not a consultant's opinion is required. There are a number of GP specialists or GPs with a special interest. We now have 70 in Wales who have been successful in having suites of patients referred to them by other GPs; patients who would otherwise have been on the out-patient waiting list, waiting to see a consultant. All those schemes, which were initiated through the interest of GPs themselves and through the innovations in care teams and the local health boards, are being evaluated. We are finding considerable success. Those GPs are all under the control of and work with the consultants, therefore there are clear protocols. We are finding good success with regard to appropriately directing patients, who otherwise would have been waiting a long time on out-patient waiting lists, to alternative care.

mis. Gyda'r fframwaith gwasanaeth a chyllid, bydd hyn yn mynd i lawr i 12 mis erbyn 2006. Fodd bynnag, yr ydym hefyd wedi mynnu bod sefydliadau yn edrych yn feirniadol ar pam mae pobl yn cael eu rhoi ar restrau cleifion allanol yn y lle cyntaf. Byddwch yn gweld o'r adroddiad hwn, ac o'n tystiolaeth ein hunain, bod nifer o feddygon ymgynghorol yn gofyn, 'Ai fi oedd yr unigolyn gorau i'r unigolyn hwn ei weld ac aros i'w weld?' Felly, drwy 'Arloesi mewn Gofal', yr ydym wedi ymdrechu'n galed iawn i edrych ar anghenion pobl ar y rhestrau aros ac ystyried a oes angen barn meddyg ymgynghorol ai peidio. Mae nifer o feddygon teulu arbenigol neu feddygon teulu gyda diddordeb arbennig. Mae gennym 70 bellach yng Nghymru sydd wedi llwyddo i gael carfanau o gleifion wedi'u cyfeirio atynt gan feddygon teulu eraill; cleifion a fyddai fel arall wedi bod ar restr aros cleifion allanol, yn aros i weld meddyg ymgynghorol. Mae'r holl gynlluniau hynny, a sbardunwyd o ganlyniad i ddiddordeb y meddygon teulu eu hunain a thrwy dimau arloesi mewn gofal a'r byrddau iechyd lleol, yn cael eu gwerthuso. Yr ydym yn gweld cryn lwyddiant. Mae'r meddygon teulu hynny i gyd yn cael eu rheoli ac yn gweithio gyda'r meddygon ymgynghorol, felly mae protocolau clir. Yr ydym yn gweld cryn lwyddiant o ran cyfeirio cleifion yn briodol, cleifion a fyddai fel arall wedi bod yn gwastraffu llawer o amser ar restrau cleifion allanol, at ofal amgen.

There are a number of these schemes. You know about the one in Cardiff, but there are

Mae llawer o'r cynlluniau hyn. Yr ydych yn gwybod am yr un yng Nghaerdydd, ond mae

back-pain teams throughout the rest of Wales, and musculoskeletal teams, so that people who might otherwise have been put on orthopaedic waiting lists with musculoskeletal problems, rather than pure bone problems, are being seen by GPs. Additionally, consultants are working with a much-expanded team of extended-role practitioners: physiotherapists who are able to do complicated work, and nurses too. Those multi-professional teams are triaging the patients who are coming through the system to make sure that they are not placed on lists, unless they have been through a screen, and can be seen. In neurosurgery, for years we have had physiotherapists who will take all the query microdiscectomies and triage them before the consultant sees them, to ensure that there is a faster flow through. That will have a much greater effect, as I think that we will see, over the next year, as these schemes become universalised and we put additional resources into training the general practitioners and the extended-role physicians. There is a lot that can be done.

timau poen cefn ledled gweddill Cymru, a thimau cyhyrysgerbydol, fel bod pobl a allai fel arall fod wedi'u rhoi ar restrau aros orthopedig gyda phroblemau cyhyrysgerbydol, yn hytrach na phroblemau esgyrn yn unig, yn cael gweld meddyg teulu. Yn ogystal, mae meddygon ymgynghorol yn gweithio gyda thîm eang iawn o ymarferwyr swyddogaeth estynedig: ffisiotherapyddion sy'n gallu gwneud gwaith cymhleth, a nyrsys hefyd. Mae'r timau amlbroffesiynol hynny yn dosbarthu'r cleifion hynny sy'n dod drwy'r system i sicrhau nad ydynt yn cael eu gosod ar restrau, oni bai eu bod wedi mynd drwy sgrin, ac y gellir eu gweld. Ym maes niwrollawfeddygaeth, yr ydym wedi cael ffisiotherapyddion ers blynyddoedd a fydd yn delio â'r holl ymholiadau microdiscectomiau a'u dosbarthu cyn i'r meddyg ymgynghorol eu gweld, er mwyn sicrhau eu bod yn cael eu trin ynghynt. Bydd hynny'n cael llawer mwy o effaith, fel y credaf y byddwn yn ei weld, dros y flwyddyn nesaf, wrth i'r cynlluniau hyn gael eu cyffredinoli ac wrth i ni roi adnoddau ychwanegol ar gyfer hyfforddi'r meddygon teulu ac ymarferwyr swyddogaeth estynedig. Mae llawer y gellir ei wneud.

As you know, what patients want is to know is what wrong with them and what is going to happen, and I think that just putting more and more people on waiting lists does not give them the answers to those questions. We are also evaluating the scheme that started in Manchester, which is quaintly called the Manchester Neck, through which all GP referrals go to an expert team so that they can

Fel y gwyddoch, yr hyn mae cleifion am ei wybod yw beth sy'n bod arnynt a beth fydd yn digwydd, a chredaf nad yw rhoi mwy a mwy o bobl ar restrau aros yn rhoi'r atebion i'r cwestiynau hynny. Yr ydym hefyd yn gwerthuso'r cynllun a ddechreuodd ym Manceinion, sydd â'r enw doniol Manchester Neck, lle bydd holl gyfeiriadau meddygon teulu yn mynd at dîm arbenigol er mwyn

be put into categories, as to whether they should be seen by a physiotherapist or a GP specialist. We are trying, throughout Wales, to ensure that the LHBs have the tools to effectively and safely redirect patients, but also to ensure that only those patients who really need to see a consultant get on those lists, so that the consultants can get through them in a much more expeditious manner.

iddynt allu eu dosbarthu i gategorïau, a phennu a ddylai ffisiotherapydd neu feddyg teulu arbenigol eu gweld. Yr ydym yn ceisio, ledled Cymru, sicrhau bod gan y BILlau yr offer i ailgyfeirio cleifion yn effeithiol ac yn ddiogel, ond hefyd i sicrhau mai dim ond y cleifion hynny sydd wir angen gweld meddyg ymgynghorol sy'n cael mynd ar y rhestrau hynny, er mwyn i'r meddygon ymgynghorol allu eu gweld i gyd yn llawer mwy hwylus.

[32] **Jocelyn Davies:** It is encouraging that patients would see someone who is appropriate, but what sort of percentage of the out-patient waiting lists has been inappropriately referred to the consultant? In fairness to the GPs, they only refer the patients whose treatment is beyond their competence, so they have had no choice but to refer people to the hospital consultant. What is the wait time for people to enter the screening initiatives that you mentioned? Are we sure that they will not be used as a way of holding back from the consultant waiting list people who will eventually go on it? Are we going to have several waiting lists before someone actually gets on a waiting list for treatment? Where have all these patients come from? The out-patient waiting lists have dramatically increased over the last couple of years. Where have all the patients come from?

[32] **Jocelyn Davies:** Mae'n galonogol meddwl y byddai cleifion yn cael gweld rhywun sy'n briodol, ond pa ganran o'r rhestrau aros cleifion allanol sydd wedi'i chyfeirio yn amhriodol at feddygon ymgynghorol? I fod yn deg gyda meddygon teulu, dim ond y cleifion nad ydynt yn gymwys i'w trin y maent yn eu cyfeirio, felly nid oes ganddynt ddewis ond cyfeirio pobl at feddygon ymgynghorol ysbyty mewn gwirionedd. Beth yw'r amser aros i bobl gael mynd ar y mentrau sgrinio y bu i chi eu crybwyll? A ydym yn sicr na fyddant yn cael eu defnyddio fel ffordd o ddal pobl yn ôl o'r rhestr aros i weld meddyg ymgynghorol er y byddant yn mynd arni'n hwyr neu'n hwyrach? A ydym yn mynd i gael sawl rhestr aros cyn i rywun gael mynd ar restr aros ar gyfer triniaeth? O ble mae'r holl gleifion hyn wedi dod? Mae rhestrau aros cleifion allanol wedi cynyddu'n sylweddol dros y flwyddyn neu ddwy ddiwethaf. O ble mae'r holl gleifion hyn wedi dod?

Ms Lloyd: To deal with the latter question

Ms Lloyd: I ateb y cwestiwn olaf i ddechrau,

first, it is possible that they have always been there and were never counted. There is evidence in this report, and other evidence that we know of, that the longer the wait time is perceived to be, the earlier people will refer patients. That is known, and it happened in England too. Also, the shorter the wait times are, the more GPs widen their access criteria—they start to refer more people who they think can truly be helped. We have all seen, over the past 10 years, an extension of the age range of the people who are being referred. We are getting lots of people aged between 85 and 90 who are being referred in for another hip replacement, and I do not think that we would have seen that trend 10 to 15 years ago—it would not have happened. It means that people are getting much more expert at managing frail and elderly people through, for example, hip disease to a better future. So, some of that is going on too. I think that we had a latent demand in Wales, which is being exposed, as it was in England.

mae'n bosibl eu bod wedi bod yno erioed ond nad oeddent wedi'u cyfrif. Mae tystiolaeth yn yr adroddiad hwn, a thystiolaeth arall y gwyddom amdani, yn dangos po hwyaf yw'r amser aros, cynharaf oll y bydd y bobl yn cyfeirio cleifion. Mae hynny'n cael ei gydnabod, a digwyddodd yn Lloegr hefyd. Hefyd, po fyrraf yw'r amseroedd aros, po fwyaf y mae meddygon teulu yn ehangu eu meini prawf mynediad—maent yn dechrau cyfeirio mwy o bobl y credant y gellir eu cynorthwyo. Yr ydym i gyd wedi gweld, yn ystod y 10 mlynedd diwethaf, ystod oed y bobl sy'n cael eu cyfeirio yn cael ei estyn. Yr ydym yn cael llawer o bobl rhwng 85 a 90 oed sy'n cael eu cyfeirio ar gyfer clun newydd arall, ac nid wyf yn credu y byddem wedi gweld y duedd hon 10 i 15 mlynedd yn ôl—ni fyddai wedi digwydd. Mae'n golygu bod pobl yn arbenigo llawer mwy ar reoli pobl fregus a hŷn drwy, er enghraifft, afiechyd clun ar gyfer dyfodol gwell. Felly, mae hyn yn digwydd hefyd. Credaf ein bod wedi gweld galw cudd yng Nghymru, sy'n cael ei ddatgelu, fel a ddigwyddodd yn Lloegr.

On whether we will have waiting lists on waiting lists, no, please, we cannot have that. These schemes must work expeditiously. They must assess the patients effectively and refer them to treatment so that the patients and their general practitioner, who still retains control of their overall care, knows what is happening to them, but it is a way of ensuring that those who do not have to see a consultant can access care.

O ran a fydd gennym restrau aros ar ben rhestrau aros, na, os gwelwch yn dda, ni allwn gael hynny. Mae'n rhaid i'r cynlluniau hyn weithio'n gyflym. Mae'n rhaid iddynt asesu'r cleifion yn effeithiol a'u cyfeirio at driniaeth fel bod y cleifion a'u meddygon teulu, sy'n parhau i reoli eu gofal cyffredinol, yn gwybod beth sy'n digwydd iddynt, ond mae'n ffordd o sicrhau bod y rhai hynny nad ydynt yn gorfod gweld meddygon

ymgynghorol yn gallu cael mynediad i ofal.

On the wait times for diagnostics in terms of, ‘Well, physio is long’ and so on, that is why we have commissioned far more physiotherapists and other allied health professionals to ensure that there will be sufficient numbers of those staff coming through to cope with the redirection of physiotherapists and other allied health professionals towards these more skilled jobs for the future. We cannot get into a situation whereby patients have to get through more hurdles than they do at present, because that is not the point of this and neither is it fair. The whole point of it—and we are watching this very carefully, as was the case in England—is to ensure that people get access to appropriate treatment faster and much earlier, and that they know what will happen to them.

Parthed yr amseroedd aros ar gyfer diagnosteg o ran, ‘Wel, mae ffisiotherapi yn cymryd llawer o amser’ ac ati, dyna pam ein bod wedi comisiynu llawer mwy o ffisiotherapyddion a gweithwyr iechyd proffesiynol cysylltiedig i sicrhau y bydd digon o’r staff hynny yn dod trwodd i ymdopi ag ailgyfeirio ffisiotherapyddion a gweithwyr iechyd proffesiynol cysylltiedig eraill tuag at y swyddi mwy medrus yn y dyfodol. Ni allwn fod mewn sefyllfa lle bydd yn rhaid i gleifion wynebu rhagor o rwystrau nag y maent yn eu hwynebu’n barod, oherwydd nad hynny yw diben hyn ac ni fyddai’n deg. Prif bwynt hyn—ac yr ydym yn cadw llygad manwl iawn ar hyn, fel a ddigwyddodd yn Lloegr—yw sicrhau bod pobl yn cael mynediad i driniaeth briodol yn gyflymach ac yn llawer cynharach, a’u bod yn gwybod beth fydd yn digwydd iddynt.

The first question, on how many people on the consultant out-patient waiting list should not be on there and could be dealt with separately, is difficult to answer, because that will vary between consultants and between specialties. However, we are finding that, for example, the GP specialist in orthopaedics in the vale is only referring 10 per cent of everyone now referred to him on to a consultant. If that was true of everybody, it would have a dramatic effect on out-patients, but it would also mean that you would have to completely redirect the services to support

Mae’r cwestiwn cyntaf, ynghylch faint o bobl sydd ar restr aros cleifion allanol meddyg ymgynghorol na ddylai fod arni ac y gellid delio â hwy ar wahân, yn un anodd i’w ateb, oherwydd bydd hynny’n amrywio rhwng meddygon ymgynghorol a meysydd arbenigol. Fodd bynnag, yr ydym yn canfod, er enghraifft, nad yw meddyg teulu sy’n arbenigwr orthopedeg yn y fro ond yn cyfeirio 10 y cant o bawb sy’n cael eu cyfeirio ato ymlaen at feddyg ymgynghorol. Pe bai hynny’n wir am bawb, byddai’n effeithio’n ddramatig ar ein cleifion allanol,

the alternatives. However, I would be cautious of doing that until we have done a little more research into the consequences, over, say, 12 to 15 months, of these various initiatives on the whole of the referrals from general practitioners, so that we can talk constructively with the whole of the clinical body about where the resources need to be placed, because we cannot get away from the fact that, although we might redirect loads of people off the out-patient waiting list for orthopaedics by providing alternatives in terms of back-pain management and so on, the number of people who are deemed suitable for surgery is also going up. So, it is redirecting in terms of getting better front-line access for the out-patients, but we still have the issue that lots of people need—

ond byddai hefyd yn golygu y byddai'n rhaid i chi ailgyfeirio'r gwasanaethau yn llwyr i ddarparu ar gyfer yr opsiynau eraill. Fodd bynnag, byddwn yn pwyllo cyn gwneud hynny tan i ni ymchwilio ymhellach i ganlyniadau, dros, dywedwch, 12 i 15 mis, y mentrau amrywiol hyn ar yr holl gyfeiriadau gan feddygon teulu, er mwyn i ni allu siarad yn adeiladol gyda'r corff clinigol cyfan am le ddylai'r adnoddau fod, oherwydd ni allwn anwybyddu'r ffaith, er y gallwn ailgyfeirio llawer o bobl oddi ar y rhestr aros cleifion allanol ar gyfer orthopedeg drwy ddarparu opsiynau eraill o ran rheoli poen cefn ac ati, mae nifer y bobl y tybir eu bod yn addas ar gyfer llawdriniaeth hefyd yn cynyddu. Felly, mae'n ailgyfeirio o ran cael gwell mynediad rheng flaen i'r cleifion allanol, ond mae'r broblem yn parhau i ni fod llawer o bobl angen—

[33] **Jocelyn Davies:** From what you are saying, the figure could be as high as 90 per cent, yet, when people do see the consultant, they end up going in for surgery.

[33] **Jocelyn Davies:** O'r hyn yr ydych yn ei ddweud, gallai'r ffigur fod mor uchel â 90 y cant, ond eto, pan fo pobl yn gweld meddyg ymgynghorol, maent yn gorfod mynd am lawdriniaeth.

Ms Lloyd: Exactly. So it is not the end of all ills, it is just a better way of managing a group of patients, but we still have a large number of patients coming through the system who actually need and deserve consultant intervention, and they all have to be coped with.

Ms Lloyd: Yn union. Felly nid yw'n ddiwedd pob gofid, yn hytrach mae'n ffordd well o reoli grŵp o gleifion, ond mae gennym gryn dipyn o gleifion o hyd yn dod drwy'r system sydd angen ac yn haeddu ymyriad gan feddyg ymgynghorol, ac mae'n rhaid delio â hwy i gyd.

[34] **Janet Davies:** On that point, Mrs Lloyd, you mentioned the need for sufficient numbers of allied health professionals to deal with this new way of working. I have read in the press that there is a shortage of physiotherapists. Is that true, and, if so, will you get enough trained, because physiotherapists have to train for a long time, do they not? Will you have enough to cope with carrying out this sort of system?

[34] **Janet Davies:** Ar y pwynt hwnnw, Mrs Lloyd, bu i chi grybwyll yr angen am ddigon o weithwyr iechyd proffesiynol cysylltiedig i ddelio â'r ffordd newydd hon o weithio. Yr wyf wedi darllen yn y wasg bod prinder ffisiotherapyddion. A yw hynny'n wir, ac os ydyw, a fyddwch yn gallu hyfforddi digon, oherwydd onid oes yn rhaid hyfforddi ffisiotherapyddion am gyfnod hir? A fydd gennych ddigon i allu ymdopi wrth weithredu system fel hon?

Ms Lloyd: We have commissioned a considerable increase in physiotherapy trainees, and they will be required to replace those very specialist practitioners who will take on the other work. I was very disturbed to find out, when I had the last workforce planning meeting, that there were trainees coming through the system and out at the end as qualified to take up basic grade posts, but that we had some in Wales who had not found posts. So, I have asked all the trusts to look at the reasons for this, because when you look at the physiotherapy waiting lists, there is an obvious need that we are not meeting, and given the changes that we need to pursue in terms of promoting extended-role practitioners, we need to ensure that the basic grades are coming through. It almost seems to me to defeat the object if we commission more, because we are told by the service, through its workforce planning, that it needs more, to find, at the end of three years, that people are coming through the training course and not being employed. So, I have asked my workforce department to track

Ms Lloyd: Yr ydym wedi comisiynu cynnydd sylweddol mewn hyfforddeion ffisiotherapi, a bydd gofyn iddynt gymryd lle'r ymarferwyr arbenigol hynny a fydd yn gwneud gweddill y gwaith. Yr oedd yn ofid calon i mi glywed, yn y cyfarfod cynllunio gweithle diwethaf, bod hyfforddeion yn dod drwy'r system gyda chymwysterau ar ei diwedd i weithio mewn swyddi gradd sylfaenol, ond bod rhai yng Nghymru nad oedd wedi dod o hyd i waith. Felly, yr wyf wedi gofyn i'r holl ymddiriedolaethau edrych ar y rhesymau dros hyn, oherwydd wrth edrych ar restrau aros ffisiotherapi, mae angen amlwg nad ydym yn ei ddiwallu, ac o ystyried y newidiadau y mae angen i ni eu cyflawni o ran hyrwyddo ymarferwyr swyddogaeth estynedig, mae angen i ni sicrhau bod y graddau sylfaenol yn dod trwodd. Bron yr ymddengys i mi bod hyn yn mynd yn groes i'n bwriad os ydym ym comisiynu mwy, am fod y gwasanaeth yn dweud wrthym, drwy ei waith cynllunio gweithlu, ei fod angen mwy, ac yna canfod, ar ddiwedd y tair blynedd, bod pobl yn

down where these people are—certainly, in September, there were a number that had not been successful in finding positions—and to ensure that the service was aware that these people were around, because the patients need them. They have been trained, we have invested heavily in them, and we will certainly need more for the future, which is why you will find, in the workforce plans and the commissioning that is done with the universities, that the numbers are going up.

cyflawni'r cwrs hyfforddi a ddim yn cael eu cyflogi. Felly, yr wyf wedi gofyn i'm hadran gweithlu ganfod lle mae'r bobl hyn—yn sicr, ym mis Medi, yr oedd nifer wedi methu â dod o hyd i waith—ac i sicrhau bod y gwasanaeth yn ymwybodol bod y bobl hyn ar gael, oherwydd mae'r cleifion eu hangen. Maent wedi'u hyfforddi, yr ydym wedi buddsoddi'n sylweddol ynddynt, a byddwn yn sicr angen mwy yn y dyfodol, a dyma yw'r rheswm y canfyddwch, yn y cynlluniau gweithlu a'r comisiynu sy'n cael ei wneud gyda'r prifysgolion, bod y niferoedd yn cynyddu.

It is not just physiotherapists; it is all others, particularly podiatrists, because podiatry waiting in Wales has the longest kind of drift out at the far end, and these people are really helpful in terms of orthopaedics, because they can now do minor operations themselves. Their screening of patients is also fundamental as part of tackling some of the orthopaedic problems. Therefore, this is what I have said to the workforce planning group is the number one priority. We must know why these people have not been employed, and what the service is going to do about it, because it will not meet these future challenges, where these successful projects are going on in Wales, if it does not get the basic grades in post so that they can step in as fully qualified people in a year to 18 months' time.

Nid ffisiotherapyddion yn unig sydd dan sylw; ond y lleill hefyd, podiatregwyr yn arbennig, oherwydd rhestrau aros podiatreg yng Nghymru sydd bellaf oddi wrthi tua'r diwedd, ac mae'r bobl hyn yn ddefnyddiol iawn o ran orthopedeg, oherwydd eu bod yn gallu gwneud mân lawdriniaethau eu hunain bellach. Mae eu gwaith sgrinio cleifion hefyd yn rhan sylfaenol o fynd i'r afael â rhai o'r problemau orthopaedig. Felly, dyma'r wyf wedi'i ddweud wrth y grŵp cynllunio'r gweithlu yw'r brif flaenoriaeth. Mae'n rhaid i ni wybod pam nad yw'r bobl hyn wedi'u cyflogi, a beth mae'r gwasanaeth yn mynd i'w wneud am hyn, oherwydd ni fydd yn diwallu'r heriau hyn yn y dyfodol, lle mae'r prosiectau llwyddiannus hyn yn digwydd yng Nghymru, os nad yw'n cael y graddau sylfaenol mewn gwaith er mwyn iddynt allu gweithio fel pobl cwbl gymwys mewn blwyddyn i 18 mis.

[35] **Janet Davies:** That certainly seems to me a matter of quite a lot of concern.

[35] **Janet Davies:** Mae hynny'n sicr i mi yn achos cryn ofid.

[36] **Alun Cairns:** I am pretty surprised by your statement that they are not being employed. Is it not the case that, because the health waiting lists for physiotherapy treatment are so long, there are greater incentives for these now-qualified physiotherapists to work in the private sector, because the cost of private treatment for physiotherapy is nowhere in the region, certainly in a large one-off outlay, of what it would be for an operation of some sort? Therefore, is it not self-perpetuating: because the waiting lists are so long, these people now qualifying can actually make a lot more money in the private sector, but they are only working in the private sector because the waiting lists are long?

[36] **Alun Cairns:** Yr wyf wedi fy syfrdanu braidd gyda'ch datganiad nad ydynt yn cael eu cyflogi. Onid yw'n wir, oherwydd bod y rhestrau aros am driniaeth ffisiotherapi mor hir, bod mwy o gymhelliannau i'r ffisiotherapyddion newydd hyn weithio yn y sector preifat, oherwydd nad yw cost triniaeth breifat ar gyfer ffisiotherapi yn ddim byd tebyg, yn sicr mewn un taliad mawr i'r hyn y byddai am lawdriniaeth o ryw fath? Felly, nid yw'n hunanbarhaol: oherwydd bod y rhestrau aros mor hir, gall y bobl hyn sy'n cymhwyso'n awr wneud llawer mwy o arian yn y sector preifat, ond yr unig reswm eu bod yn gweithio yn y sector preifat yw bod y rhestrau aros yn hir?

Ms Lloyd: That is an argument, but people who have only just qualified also need to get their certification. They need to have a period of experience within the NHS to be able to move to a more independent practitioner role such as you would find in the private sector. So, it is a nice argument, but I do not know that I believe that that is the whole issue. You will often find physiotherapists working in both sectors.

Ms Lloyd: Gellid dadlau felly, ond mae pobl sydd newydd gymhwyso hefyd angen eu hardystio. Maent angen profiad yn y GIG i allu symud i swydd ymarferwr mwy annibynnol fel sydd ar gael yn y sector preifat. Felly, mae'n ddadl ddymunol, ond wn i ddim a wyf yn credu mai dyna yw'r sefyllfa mewn gwirionedd. Byddwch yn aml yn gweld ffisiotherapyddion yn gweithio yn y ddau sector.

[37] **Alun Cairns:** If it is not the whole issue, what is the issue?

[37] **Alun Cairns:** Os nad dyna'r sefyllfa mewn gwirionedd, beth yw'r sefyllfa?

Ms Lloyd: The issue is that I do not believe that the service has yet understood that there are people out there who can help with some of its waiting times. The service has not accessed them, which is why I have sent out the message to the service that this has been the consequence this year—it has been absolutely unheard of before that unemployed people should come out of college. Given the waiting times for physiotherapy, they have a requirement to get those waiting times down. In addition, the whole rehabilitation strategy in Wales has been brought to pre-eminence particularly through the Wanless action plans, where re-ablement is on everybody's list—keeping people out of hospitals and ensuring that they can live successfully at their home means that more physiotherapists and more occupational therapists are required, which is why we have trained more of them. Therefore, there should not be any unemployment. People can choose what they like to do, but there is a solid job for them to do in the NHS. Dealing with out-patients' waiting lists in physiotherapy is not the whole job of physiotherapists—they have a huge job to do in terms of re-ablement and rehabilitation.

Ms Lloyd: Y sefyllfa yw nad wyf yn credu bod y gwasanaeth wedi deall eto bod pobl allan yno a all ei gynorthwyo gyda rhywfaint o'i amseroedd aros. Nid yw'r gwasanaeth wedi'u defnyddio, a dyma pam fy mod wedi dweud wrth y gwasanaeth fod hyn wedi digwydd eleni—byddai wedi bod yn anodd dirnad yn y gorffennol fod pobl wedi gadael y coleg yn ddi-waith. O ystyried yr amseroedd aros ar gyfer ffisiotherapi, mae'n ofynnol iddynt gael yr amseroedd aros hynny i lawr. Yn ogystal, mae'r holl strategaeth adsefydlu yng Nghymru wedi cael ei hamlygu yn arbennig drwy gynlluniau gweithredu Wanless, lle mae ailalluogi ar restr pawb—mae cadw pobl allan o ysbytai a sicrhau eu bod yn gallu byw'n llwyddiannus yn eu cartrefi yn golygu bod angen mwy o ffisiotherapyddion a mwy o therapyddion galwedigaethol, a dyna pam ein bod wedi hyfforddi mwy ohonynt. Felly, ni ddylid cael unrhyw ddiweithdra. Gall pobl ddewis yr hyn y maent am ei wneud, ond mae gwaith sefydlog iddynt ei wneud yn y GIG. Mae mwy i waith ffisiotherapyddion na delio â rhestrau aros ffisiotherapi cleifion allanol—mae ganddynt waith sylweddol i'w wneud o ran ailalluogi ac adsefydlu.

[38] **Alun Cairns:** Is there not perhaps a deep-rooted problem? Are the conditions and hours of work perhaps not conducive to the working environment of physiotherapists? They may be choosing to stay out of the

[38] **Alun Cairns:** Onid oes o bosibl broblem ag iddi wreiddiau dwfn? Onid yw'r amodau a'r oriau gwaith yn anffafriol i amgylchedd gwaith ffisiotherapyddion? Efallai eu bod yn dewis aros allan o'r proffesiwn ar ôl

profession after training, or something like that. I may be making a statement, rather than asking a question.

hyfforddi, neu rywbeth tebyg. Efallai fy mod yn gwneud datganiad, yn hytrach na gofyn cwestiwn.

Ms Lloyd: You will know that physiotherapists and some other allied health professionals are not required to work the hours that some others do. Speech and language therapists have always had fewer hours in their contracts—32 or 35 hours, rather than the 37.5 hours for a nurse. That will be equalised under the agenda for change. It depends what people want to do with their lifestyles, and I cannot answer for individuals. Certainly, the opportunities within the health service for constructive and creative work for allied health professionals has never been better, because they are being given more autonomy and control over the career path that they wish to follow. I actually think that it is a good career.

Ms Lloyd: Byddwch yn gwybod nad yw'n ofynnol i ffisiotherapyddion a rhai gweithwyr iechyd proffesiynol cysylltiedig weithio'r oriau y mae eraill yn ei wneud. Mae therapyddion lleferydd ac iaith wedi cael llai o oriau yn eu contractau erioed—32 neu 35 awr yn hytrach na 37.5 awr ar gyfer nyrs. Caiff hyn ei gyfartalu gyda'r agenda dros newid. Mae'n dibynnu beth mae pobl am ei wneud gyda'u ffyrdd o fyw, ac ni allaf ateb dros unigolion. Yn sicr, nid yw'r cyfleoedd yn y gwasanaeth iechyd ar gyfer gwaith adeiladol a chreadigol i weithwyr iechyd proffesiynol cysylltiedig erioed wedi bod yn well, oherwydd maent yn cael mwy o ymreolaeth a rheolaeth dros y llwybr gyrfa y maent am ei ddilyn. Credaf ei bod yn yrfa dda.

[39] **Alun Cairns:** Surely this is a management issue which needs to be addressed, rather than your being dismissive and saying that you cannot account for individuals. There must be a cultural issue in that people do not want to come work, or it might be conditions or salary levels—there is an issue that needs to be addressed, and it is for management to bring those people into the health service.

[39] **Alun Cairns:** Onid yw hyn yn sicr yn fater rheoli sydd angen mynd i'r afael ag ef, yn hytrach na'ch bod yn ddiystyriol ac yn dweud na allwch ateb dros unigolion. Mae'n rhaid bod mater diwylliannol o bobl ddim am ddod i weithio, neu gallai fod ynghylch amodau neu lefelau cyflog—mae mater y mae angen mynd i'r afael ag ef, a chyfrifoldeb rheolwyr yw dod â phobl fel hyn i'r gwasanaeth iechyd.

Ms Lloyd: Of course, and we must also be very clear about the way in which we employ all our staff, which is why the recruitment and retention strategy was rolled out a year ago. That is the reason why we are testing all our trusts on flexible working, to enable skilled staff, who we and the patients really need, to work more effectively for us. I found that there had not been enough take-up and creativity about the work balance that many of these individuals have to strike. That is why we had a new recruitment and retention policy with a great deal more emphasis on flexible working, so that we could ensure that people were enabled to work within the NHS for the future.

Ms Lloyd: Wrth gwrs, ac mae'n rhaid i ni hefyd fod yn glir iawn ynglŷn â'r ffordd yr ydym yn defnyddio ein staff i gyd, a dyna pam y cyflwynwyd y strategaeth recriwtio a chadw fesul cam flwyddyn yn ôl. Dyna'r rheswm pam ein bod yn profi ein hymddiriedolaethau i gyd o ran gweithio'n hyblyg, i alluogi staff medrus, sydd eu hangen arnom ni a'r cleifion, i weithio'n fwy effeithiol i ni. Gwelais na fu digon o ddefnydd a chreadigrwydd ynghylch y cydbwysedd gwaith y mae'n rhaid i lawer o'r unigolion hyn ei ganfod. Dyna pam ein bod wedi cael polisi recriwtio a chadw newydd gyda llawer mwy o bwyslais ar weithio'n hyblyg, er mwyn i ni allu sicrhau bod pobl yn gallu gweithio o fewn y GIG yn y dyfodol.

[40] **Janet Davies:** I will allow Carl to come in with a short question, because I do not want to get bogged down—I want to make progress.

[40] **Janet Davies:** Yr wyf am adael i Carl gyfrannu gyda chwestiwn cryno, oherwydd nid wyf am arafu pethau—yr wyf am fwrw ymlaen.

[41] **Carl Sargeant:** My question relates to a response that Mrs Lloyd gave to Jocelyn, which went straight over my head, but I have caught up with it now. It is fundamental to this whole issue. On the drive to reduce waiting lists, you said that they could possibly have been there before these patients. Can you qualify that statement? Are you happy that the data in this report is accurate? You say that we have high waiting lists, which we might have had before but which had not been recorded, so there may not have been a change. Therefore, the list is

[41] **Carl Sargeant:** Mae fy nghwestiwn yn ymwneud â'r ymateb a roddodd Mrs Lloyd i Jocelyn, nad oeddwn yn ei ddeall yn iawn ar y pryd, ond mae gennyf well syniad yn awr. Mae'n sylfaenol i'r holl fater hwn. O ran yr ymdrech i ostwng rhestrau aros, dywedasoch efallai eu bod wedi bod yno cyn y cleifion hyn. A allwch egluro'r datganiad hwnnw? A ydych yn fodlon bod y data yn yr adroddiad hwn yn gywir? Dywedasoch fod gennym restrau aros uchel, a allai fod wedi bodoli yn gynharach ond nad oeddynt wedi'u cofnodi, felly efallai na fu newid. Felly, mae'r rhestr

better than before because we are driving the agenda down. The change is happening.

yn well nag y bu oherwydd ein bod yn gyrru'r agenda i lawr. Mae'r newid yn digwydd.

Ms Lloyd: Our data quality has improved year on year. The data that the NAO produced is not unfamiliar. Nevertheless, the King's Fund said that you must have confidence in your data, which is why we have put so much effort into trying to ensure that the data is correct and authenticated. It is helpful that both the Audit Commission and the NAO have been helping us to externally scrutinise the data that is coming through. I do not say that more could not be done, and that is why the 'Informing Healthcare' strategy is so important to us in terms of getting accurate data. Unless you know the scale of issue that you are dealing with, it is hard to find the solutions that will be effective.

Ms Lloyd: Mae ansawdd ein data wedi gwella flwyddyn ar ôl blwyddyn. Nid yw'r data a gynhyrchwyd gan y Swyddfa Archwilio Genedlaethol yn anghyfarwydd. Fodd bynnag, dywedodd Cronfa King bod yn rhaid i chi gael hyder yn eich data, a dyma pam ein bod wedi ymdrechu cymaint i geisio sicrhau bod y data yn gywir ac yn ddilys. Mae'n ddefnyddiol bod y Comisiwn Archwilio a'r Swyddfa Archwilio Genedlaethol wedi bod yn ein cynorthwyo i archwilio'r data sy'n dod trwodd yn allanol. Nid wyf yn dweud na ellid gwneud mwy, a dyna pam fod y strategaeth 'Hysbysu Gofal Iechyd' mor bwysig i ni o ran cael data cywir. Oni bai eich bod yn gwybod maint y maes yr ydych yn ei drafod, mae'n anodd dod o hyd i'r atebion a fydd yn effeithiol.

[42] **Janet Davies:** Leighton, I believe you want to ask quite a few questions.

[42] **Janet Davies:** Leighton, credaf eich bod am ofyn rhai cwestiynau.

[43] **Leighton Andrews:** If we look at paragraph 3.12, principally, and figure 8, the number of out-patients waiting over six, 12 and 18 months more or less doubled between April 2000 and May 2004, which was against what was envisaged in the plan. According to paragraph 3.2 in volume 2, a higher minimum standard is accorded to in-patient and day-case targets compared with a lower continuous improvement target for out-patients. Does that tell us that in-patient, day-case waiting time targets have a higher priority than out-patient waiting time targets?

[43] **Leighton Andrews:** Os edrychwn ar baragraff 3.12, yn bennaf, a ffigur 8, dyblodd nifer y cleifion allanol a oedd yn aros dros chwech, 12 a 18 mis fwy neu lai rhwng Ebrill 2000 a Mai 2004, a oedd yn groes i'r hyn a ragwelwyd yn y cynllun. Yn ôl paragraff 3.2 yng nghyfrol 2, mae safon ofynnol uwch ynghlwm wrth dargedau cleifion mewnol ac achosion dydd o'i chymharu â'r targed

gwelliant parhaus is ar gyfer cleifion allanol. A yw hynny'n golygu bod gan dargedau amser aros cleifion mewnol, achosion dydd flaenoriaeth uwch na thargedau amser aros cleifion allanol?

Ms Lloyd: No, because that has been rectified in last year's and next year's service and financial frameworks. They are of equal importance.

Ms Lloyd: Na, oherwydd mae hynny wedi'i gywiro yn fframweithiau gwasanaeth a chyllid y llynedd a'r flwyddyn nesaf. Maent yr un mor bwysig.

[44] **Leighton Andrews:** Has that had an impact in the past? You say that you have rectified that in the service and financial framework, but has it had an impact in the past?

[44] **Leighton Andrews:** A yw hynny wedi cael effaith yn y gorffennol? Yr ydych yn dweud eich bod wedi cywiro hynny yn y fframwaith gwasanaeth a chyllid, ond a yw wedi cael effaith yn y gorffennol?

Ms Lloyd: The comment made by the NAO that there could be a drifting out of the out-patient targets because they did not want too many people converting over, has some merit. That is why we cannot allow the out-patient targets or the numbers to drift even further, which is why we have the target in the service and financial framework that attacks both parts of the wait that is currently measured.

Ms Lloyd: Mae peth rhinwedd i'r sylw a wnaed gan y Swyddfa Archwilio Genedlaethol, sef bod targedau cleifion allanol yn cael eu dileu yn raddol oherwydd nad oeddent am weld gormod o bobl yn trosi. Dyna pam na allwn adael i dargedau neu niferoedd cleifion allanol ddisgyn hyd yn oed ymhellach, a dyna pam ein bod wedi pennu'r targed yn y fframwaith gwasanaeth a chyllid, sy'n mynd i'r afael â'r ddwy elfen o aros a fesurir ar hyn o bryd.

[45] **Leighton Andrews:** I will move now to what is probably more important for patients, namely total waiting times. As we know, England is setting a target of 18 weeks by 2008. You said at the beginning of your evidence, in answer to questions from the Chair, that there had been a laser-like focus in England over something like seven years. Are you suggesting that there has not been a laser-like focus in Wales?

[45] **Leighton Andrews:** Yr wyf am symud yn awr at yr hyn sy'n bwysicach i gleifion yn ôl pob tebyg, sef cyfanswm amseroedd aros. Fel y gwyddom, mae Lloegr yn gosod targed o 18 wythnos erbyn 2008. Dywedasoch ar ddechrau eich tystiolaeth, wrth ateb cwestiynau gan y Cadeirydd, eu bod wedi canolbwyntio yn fanwl yn Lloegr ar hyn am oddeutu saith mlynedd. A ydych yn awgrymu na fu canolbwyntio cyffelyb yng Nghymru?

Ms Lloyd: The policy pursued by the Welsh Assembly Government has been over a broader field and what it did was to look very much at the causes of ill health and the eradication of those causes. At the same time, in terms of the consequences of the causes of ill health, it pursued a principle of attacking the resolution of those causes and looked at the real major needs of the population, which is why there has been a reduction in things like cataract waiting times, and particularly cardiac waiting times, which was a major source of concern in Wales. Those have been very successfully reduced, followed by orthopaedics, because that is such an issue in Wales. So, it has pursued an almost twin-track approach.

England has pursued the waiting-times approach and has recognised that the whole agenda on

Ms Lloyd: Mae'r polisi a weithredir gan Lywodraeth Cynulliad Cymru wedi bod dros faes ehangach a'r hyn a wnaeth oedd edrych ar achosion iechyd gwael a sut i gael gwared ar yr achosion hynny. Ar yr un pryd, o ran canlyniadau achosion iechyd gwael, aeth i'r afael ag egwyddor datrys yr achosion hynny ac edrych ar wir anghenion pwysig y boblogaeth, a dyna'r rheswm pam y bu gostyngiad mewn pethau fel amseroedd aros triniaethau cataract, ac amseroedd aros cardiaidd yn arbennig, a oedd yn achos pryder difrifol yng Nghymru. Mae'r rheiny wedi'u gostwng yn llwyddiannus iawn, ynghyd ag orthopedeg, oherwydd bod hynny'n fater mor bwysig yng Nghymru. Felly, mae wedi mynd ar drywydd dull deuol bron iawn.

Mae Lloegr wedi mynd i'r afael ag amseroedd aros ac wedi cydnabod bod yn rhaid codi'r holl

inequalities must be raised. It was pointed out in the Healthcare Commission report last year that there needed to be a focus in England on the eradication of ill health and inequality, and on the prevention of ill health. All these things need to be tackled. The service is like an amoeba—if you poke it at one end, something falls out of the other—so, in Wales, we concentrated on emergency access because we have higher number of emergencies. The number of people coming into the system in that way is higher here than in England. So, there was a threefold approach to the policy pursued at the time. The new Minister has made it clear that we have done a considerable amount of work on inequalities and health protection, and on the real needs of the population, ensuring that they have improved access, so we now have to tackle the rest of the waiting times.

agenda ar anghydraddoldebau. Nodwyd yn adroddiad y Comisiwn Gofal Iechyd y llynedd bod angen canolbwyntio yn Lloegr ar gael gwared ar iechyd gwael ac anghydraddoldeb, ac ar atal iechyd gwael. Mae angen mynd i'r afael â'r holl bethau hyn. Mae'r gwasanaeth fel ameba—os ydych yn ei brocio ar un pen, mae rhywbeth yn disgyn allan o'r pen arall—felly, yng Nghymru, bu i ni ganolbwyntio ar fynediad brys oherwydd bod gennym fwy o achosion brys. Mae nifer y bobl sy'n dod i mewn i'r system yn y dull hwnnw yn uwch yma nag yn Lloegr. Felly, yr oedd agwedd driphlyg at y polisi ar y pryd. Mae'r Gweinidog newydd wedi nodi'n glir ein bod wedi gwneud llawer o waith ar anghydraddoldebau a diogelu iechyd, ac ar wir anghenion y boblogaeth, felly mae'n rhaid i ni'n awr fynd i'r afael â gweddill yr amseroedd aros.

[46] **Leighton Andrews:** I do not want to be facetious, but I do not understand—has there been a twin-track approach or a threefold approach?

[46] **Leighton Andrews:** Nid wyf am fod yn gellweirus, ond nid wyf yn deall—a ddefnyddiwyd dull deuol neu ddull triphlyg?

Ms Lloyd: Threefold.

Ms Lloyd: Triphlyg.

[47] **Leighton Andrews:** England, as I think we all know, has started to focus on public health more recently, if you like. However, at the end of the day, England still has an 18-week target for, as I understand it, the entire patient journey by 2008. Have we given any consideration to moving to sharper targets such as those?

[47] **Leighton Andrews:** Mae Lloegr, fel y gwyddom i gyd yr wyf yn siŵr, wedi dechrau canolbwyntio mwy ar iechyd y cyhoedd yn ddiweddar, os dymunwch. Fodd bynnag, yn y pen draw, mae gan Loegr darged o 18 wythnos o hyd, fel y deallaf, ar gyfer holl siwrnai'r claf erbyn 2008. A ydym wedi ystyried symud i dargedau mwy uchelgeisiol fel y rhai hynny?

Ms Lloyd: That is something that you will have to ask the Minister.

Ms Lloyd: Mae hynny'n gwestiwn y bydd yn rhaid i chi ei ofyn i'r Gweinidog.

[48] **Janet Davies:** Jocelyn would like to come in on that point, if you do not mind, Leighton.

[48] **Janet Davies:** Hoffai Jocelyn gyfrannu ar y pwynt hwnnw, os yw hynny'n iawn, Leighton.

[49] **Jocelyn Davies:** On the healthy living agenda and this idea of a two or three-pronged approach to healthcare in Wales, when would you expect that to pay off in terms of people not falling ill and the waiting times being affected, through encouraging people to live more healthily? Is it a matter of two years, three years, 10 years, or 20 years?

[49] **Jocelyn Davies:** O ran yr agenda byw'n iach a'r syniad o agwedd ddeuol neu driphlyg at ofal iechyd yng Nghymru, pryd y byddech yn disgwyl i hynny lwyddo o ran pobl yn peidio â chael eu taro'n wael a hynny'n effeithio ar yr amseroedd aros, drwy annog pobl i fyw'n iachach? A yw'n fater o ddwy flynedd, tair blynedd, 10 mlynedd, neu 20 mlynedd?

Ms Lloyd: No, it is a longer-term approach. In the intermediate period, we will find a greater demand being created, which is why you have to ensure now that we purposefully tackle the consequences of the demand placed upon the service. So it is longer term.

Ms Lloyd: Na, mae'n agwedd tymor hwy. Yn y cyfamser, byddwn yn gweld galw cynyddol, a dyna pam mae'n rhaid i chi sicrhau yn awr ein bod yn mynd i'r afael yn fwriadol â chanlyniadau'r galw ar y gwasanaeth. Felly mae'n agwedd tymor hwy.

[50] **Jocelyn Davies:** As you say, England is only now just catching up with this idea, but its wait times have come down. You would not expect that. If England is not encouraging people to be healthier, even though it is tackling waiting lists and treating people who are ill, why are its wait

[50] **Jocelyn Davies:** Fel y dywedasoch, dim ond dechrau defnyddio'r syniad hwn y mae Lloegr, ond mae ei hamseroedd aros wedi disgyn. Ni fyddech yn disgwyl hynny. Os nad yw Lloegr yn annog pobl i fod yn iachach, er ei bod yn mynd i'r afael â rhestrau aros a thrin pobl sy'n wael, pam

times coming down?

mae ei hamseroedd aros yn disgyn?

Ms Lloyd: It is because of the fact that that was England's priority. England tackled the demand, and Wales determined—and this is just as an observer's point of view—

Ms Lloyd: Mae hyn oherwydd mai dyna oedd blaenoriaeth Lloegr. Aeth Lloegr i'r afael â'r galw, a phennodd Cymru—a safbwynt arsyllwr yn unig yw hwn—

[51] **Jocelyn Davies:** We understand that you do not decide the policy; we accept that entirely.

[51] **Jocelyn Davies:** Deallwn nad chi sy'n pennu'r polisi; yr ydym yn derbyn hynny'n llwyr.

Ms Lloyd: Wales decided to tackle the supply. I think that what Wanless said about us never getting the system right if we just chase demand was his own view.

Ms Lloyd: Penderfynodd Cymru fynd i'r afael â'r cyflenwad. Credaf mai dim ond barn bersonol Wanless oedd na fyddwn yn cael y system yn iawn drwy fynd i'r afael â'r galw yn unig.

[52] **Jocelyn Davies:** When you say that this will pay off in the longer term, how long is that?

[52] **Jocelyn Davies:** Drwy ddweud y bydd hyn yn talu yn y tymor hwy, pa mor hir yw hynny?

Ms Lloyd: I think that it is about 10 years. However, we should see some of the issues coming through. That is why, in some of the areas where we have focused on the real causes of ill health, we have seen a rise in demand for access to care, which is being tackled, and tackled effectively. So there will be these surges. You will know of the health-gain targets that are in place now for the next five years, which the chief medical officer is tracking as a sort of focus on trying to reduce the causes of ill health. We have a legacy; we have a large number of people in Wales who are over 75 and who are very frail—with dual diagnoses at the very minimum—and we must ensure that we can manage and treat them well. As a consequence, we get a larger percentage of emergency admissions.

Ms Lloyd: Oddeutu 10 mlynedd, dybiwn i. Fodd bynnag, dylem weld rhai o'r materion yn dod trwodd. Dyna pam, yn rhai o'r ardaloedd lle yr ydym wedi canolbwyntio ar wir achosion iechyd gwael, ein bod wedi gweld cynnydd mewn galw am fynediad i ofal, ac mae hyn yn cael ei ddatrys, a hynny'n effeithiol. Felly bydd ymchwyddiadau fel hyn. Byddwch yn ymwybodol o'r targedau cynnydd mewn iechyd sydd ar waith bellach ar gyfer y pum mlynedd nesaf, y mae'r prif swyddog meddygol yn eu holrhain fel rhyw fath o ffocws ar geisio gostwng achosion iechyd gwael. Mae gennym etifeddiaeth; mae gennym nifer sylweddol o bobl yng Nghymru sydd dros 75 oed ac sy'n fregus iawn—gydag o leiaf ddau ddiagnosis—ac mae'n rhaid i ni sicrhau ein bod yn eu rheoli a'u trin yn dda. O ganlyniad, cawn ganran uwch o dderbyniadau brys.

[53] **Janet Davies:** As England pursues a broader agenda, is there a danger that in England—I know that you cannot answer for England, but speaking theoretically—waiting lists will lengthen rather than become shorter?

[53] **Janet Davies:** Wrth i Loegr ddilyn agenda ehangach, a oes perygl yn Lloegr—gwn na allwch ateb dros Loegr, ond gan siarad yn ddamcaniaethol—y bydd rhestrau aros yn cynyddu yn hytrach na lleihau?

Ms Lloyd: As you say, I cannot answer for England. However, if it pursues its public health agenda, it is not inconceivable that it will find the same effects as are being found in Wales. Of course, it does not have the same level of ill health as Wales, but, nevertheless, it is a question of balance and, with all these systems, you have to keep your eye on the balance.

Ms Lloyd: Fel y dywedasoch, ni allaf ateb dros Loegr. Fodd bynnag, os yw'n dilyn ei agenda iechyd cyhoeddus, nid yw y tu hwnt i amgyffred y bydd yn canfod yr un effeithiau ag sydd i'w gweld yng Nghymru. Wrth gwrs, nid oes ganddi'r un lefel o iechyd gwael â Chymru, ond, fodd bynnag, mae'n fater o gydbwysedd a, gyda'r holl systemau hyn, mae'n rhaid i chi gadw llygad ar y cydbwysedd.

[54] **Alun Cairns:** You say that England does not have the same levels of ill health as Wales. What sort of evidence is there to substantiate that? I was under the impression that the Audit Commission published a report last year stating that there was little difference in health. That is why I asked specifically, in an earlier question on health inequality, whether you meant the UK or in Wales.

[54] **Alun Cairns:** Yr ydych yn dweud nad oes gan Loegr yr un lefelau o iechyd gwael â Chymru. Pa fath o dystiolaeth sydd i gadarnhau hynny? Yr oeddwn dan yr argraff bod y Comisiwn Archwilio wedi cyhoeddi adroddiad y llynedd yn datgan nad oedd llawer o wahaniaeth mewn iechyd. Dyna pam i mi ofyn yn benodol, mewn cwestiwn cynharach ar anghydraddoldeb iechyd, a oeddech yn cyfeirio at y DU neu Gymru.

Ms Lloyd: Given the health gain targets and the needs assessments that we are finding now throughout Wales, I would pursue an argument with the Audit Commission about whether, for the universality of England, they are dealing with the same scale of health need as Wales.

Ms Lloyd: O ystyried y targedau cynnydd mewn iechyd a'r asesiadau anghenion yr ydym yn eu canfod yn awr ledled Cymru, byddwn yn dadlau gyda'r Comisiwn Archwilio ynghylch a ydynt, yn Lloegr yn gyffredinol, yn delio â'r un raddfa o anghenion iechyd â Chymru.

[55] **Alun Cairns:** When we compare waiting times in England and Wales, would it be fairer to compare waiting times in, for example, the north east of England, which might have an economic history that is closer to that of Wales? What are the differences in waiting times between that region and this nation, and are its waiting lists shorter than ours?

[55] **Alun Cairns:** Wrth i ni gymharu amseroedd aros yn Lloegr a Chymru, a fyddai'n decach cymharu amseroedd aros, er enghraifft, yng ngogledd ddwyrain Lloegr, a allai fod â hanes economaidd sy'n debycach i un Cymru? Beth yw'r gwahaniaethau mewn amseroedd aros rhwng y rhanbarth hwnnw a'r genedl hon, ac a yw ei restrau aros yn llai na'n rhai ni?

Ms Lloyd: We have been finding that, in terms of health needs, even the north east of England is not absolutely comparable to Wales. However, I can provide you with the evidence on that. You will know that there are no let-outs in England in terms of waiting times, so the north east will be subject to the same waiting times as the rest of England.

Ms Lloyd: Yr ydym wedi bod yn gweld, o ran anghenion iechyd, na ellir cymharu gogledd ddwyrain Lloegr hyd yn oed â Chymru. Fodd bynnag, gallaf eich darparu gyda'r dystiolaeth ar gyfer hynny. Byddwch yn gwybod nad oes opsiwn arall yn Lloegr o ran amseroedd aros, felly bydd gan y gogledd ddwyrain yr un amseroedd aros â gweddill Lloegr.

[56] **Alun Cairns:** Finally, I have a brief question on a response given to Leighton Andrews. When Mr Andrews asked whether we have plans to have sharper targets, you rightly responded that that was a matter for the Minister. Do we currently have the capacity, should the Minister choose to

[56] **Alun Cairns:** Yn olaf, mae gennyf gwestiwn cryno ar ymateb a roddwyd i Leighton Andrews. Pan ofynnodd Mr Andrews a oes gennym gynlluniau i gael targedau mwy uchelgeisiol, yr oeddech yn llygad eich lle i ymateb mai mater i'r Gweinidog yw hwnnw. A oes gennym y

reduce the targets, to cope with the 2008 18-week target?

capasiti ar hyn o bryd, pe bai'r Gweinidog yn dewis gostwng y targedau, i ymdopi â'r targed o 18 wythnos erbyn 2008?

Ms Lloyd: It is for him to decide whether he wishes to pursue—

Ms Lloyd: Ei gyfrifoldeb ef yw penderfynu a yw am ddilyn—

[57] **Alun Cairns:** But—

[57] **Alun Cairns:** Ond—

Ms Lloyd: Hang on, I am coming to it. It is for him to decide what particular target he wishes to go for. The whole point of engaging Cardiff University to undertake the modelling for us has been to establish, given the level of demand coming through the system now, what capacity we are able to institute to cope with a variety of targets that Ministers and the Cabinet might wish to adopt in future. So, that work is coming to a conclusion in terms of out-patients and is being run as a pilot scheme in the next three to four months for in-patients. Once the Minister has had the outcome of that, I am sure that he and his Cabinet colleagues will come to a view.

Ms Lloyd: Daliwch eich gafael, yr wyf yn dod at hynny. Ei gyfrifoldeb ef yw penderfynu pa darged penodol y mae am ei ddilyn. Diben gofyn i Brifysgol Caerdydd gyflawni'r modelu ar ein cyfer yw pennu, o ystyried lefel y galw ar y system yn awr, y capasiti sydd gennym i ymdopi ag amrywiaeth o dargedau y gallai Gweinidogion a'r Cabinet ddewis eu mabwysiadu yn y dyfodol. Felly, mae'r gwaith hwnnw yn dirwyn i ben o ran cleifion allanol ac mae'n cael ei redeg fel cynllun peilot yn y tri i bedwar mis nesaf ar gyfer cleifion mewnol. Unwaith i'r Gweinidog gael canlyniad hynny, yr wyf yn sicr y bydd ef a'i gydweithwyr yn y Cabinet yn ffurfio barn.

[58] **Alun Cairns:** I am asking you, however, as accounting officer, whether we have the capacity, should the Minister decide to shift policy.

[58] **Alun Cairns:** Yr wyf yn gofyn i chi, fodd bynnag, fel swyddog cyfrifyddu, a oes gennym y capasiti, pe bai'r Gweinidog yn penderfynu newid y polisi.

Ms Lloyd: Capacity affects several areas, such as whether we have the resources, the

Ms Lloyd: Mae capasiti yn effeithio ar sawl maes, fel a oes gennym yr adnoddau, y staff

staff and the facilities, whether we have modernised sufficiently and, if that demand is managed, whether there is latent demand below it waiting to surface. At present, we are about to go into a budget planning round, so, unless we do the modelling, I cannot advise the Minister on the resource needed, on the staff needed or on the change of system needed. We might have a fair idea at the moment, but I would prefer to be accurate when I advise the Minister. We will be in that position in the next six to eight months.

a'r cyfleusterau, a ydym wedi moderneiddio ddigon ac, os rheolir y galw hwnnw, a oes galw dirgel dan y wyneb yn barod i godi. Ar hyn o bryd, yr ydym ar fin cynnal cylch cynllunio cyllideb, felly, os nad ydym yn gwneud y modelu, ni allaf gynghori'r Gweinidog ar yr adnoddau sydd eu hangen, ar y staff sydd eu hangen neu ar y newid system sydd ei angen. Efallai bod gennym syniad gweddol ar hyn o bryd, ond byddai'n well gennyf fod yn gywir wrth gynghori'r Gweinidog. Byddwn yn y sefyllfa honno yn y chwech i wyth mis nesaf.

[59] **Leighton Andrews:** Moving to targets for urgent cancer referrals, which are set at 10 days, none of the six trusts that the NAO looked at had data that was fully compliant with the target, although it seemed that, generally, GPs felt that the target had improved access to first out-patient appointments. Why have you not published data on compliance with the cancer target?

[59] **Leighton Andrews:** Gan symud at dargedau ar gyfer cyfeiriadau canser brys, sydd wedi'u gosod ar 10 diwrnod, nid oedd gan yr un o'r chwe ymddiriedolaeth yr edrychodd y Swyddfa Archwilio Genedlaethol arnynt ddata a oedd yn cydymffurfio'n llawn â'r targed, er ei bod yn ymddangos, ar y cyfan, bod meddygon teulu yn credu bod y targed wedi gwella mynediad i apwyntiadau cleifion allanol cyntaf. Pam nad ydych wedi cyhoeddi data ar gydymffurfio â'r targed canser?

Ms Lloyd: The whole point of compliance with the cancer target is that a definition of 'urgent' could never be agreed, and the way in which it was applied in organisations was insufficiently robust for us to be really sure that we were comparing like with like. For this, I have to depend on the advice that we get from the National Assembly for Wales's statistics unit, which is not within my ambit; it is independent and it will advise us. It has advised us very strongly about not publishing these. In the meantime, however, given research evidence, we found that what is more appropriate in terms of patient outcome is to start to move towards the time between referral and start of treatment. The

Ms Lloyd: Diben cydymffurfio â'r targedau canser yw na ellid byth gytuno ar ddiffiniad o 'frys', ac nid oedd y ffordd yr oedd yn cael ei ddefnyddio mewn sefydliadau yn ddigon cadarn i ni fod yn hollol sicr ein bod yn cymharu tebyg at ei debyg. Ar gyfer hyn, mae'n rhaid i mi ddibynnu ar y cyngor yr ydym yn ei gael gan uned ystadegau Cynulliad Cenedlaethol Cymru, nad yw o

December 2006 targets, which have now been set, mean that we will have one-month and two-month targets for that. That is the evidence given to us by our clinical teams and by researchers. Those are the types of targets in the SAFF this year. The trusts are currently conducting an exercise in gathering robust evidence that we will be able to publish on those targets. It is supposed to be a better clinical outcome measurement than the old target that we used, and which was also used by England.

fewn fy nghwmpas; mae'n annibynnol a bydd yn ein cynghori. Mae wedi'n cynghori'n gryf iawn ar beidio â chyhoeddi'r rhain. Yn y cyfamser, fodd bynnag, o ystyried tystiolaeth ymchwil, bu i ni ganfod mai'r hyn sy'n fwy priodol o ran canlyniadau cleifion yw cychwyn symud tuag at yr amser rhwng y cyfeirio a dechrau'r driniaeth. Mae targedau Rhagfyr 2006, sydd wedi'u gosod yn awr, yn golygu y bydd gennym dargedau mis a deufis ar gyfer hynny. Dyna'r dystiolaeth a roddwyd i ni gan ein timau clinigol a chan ymchwilwyr. Dyna'r mathau o dargedau yn y fframwaith gwasanaeth a chyllid eleni. Mae'r ymddiriedolaethau wrthi ar hyn o bryd yn cynnal ymarfer i gasglu tystiolaeth gadarn a byddwn yn gallu ei chyhoeddi ar y targedau hynny. Mae'n well dull o fesur canlyniad clinigol yn ôl pob sôn na'r hen darged yr oeddem yn ei ddefnyddio, ac a ddefnyddiwyd yn Lloegr hefyd.

[60] **Leighton Andrews:** You have therefore dropped the 10-day target?

[60] **Leighton Andrews:** Yr ydych felly wedi cael gwared ar y targed 10 niwrnod?

Ms Lloyd: Yes. It has been replaced by this clinically more robust target.

Ms Lloyd: Do. Mae'r targed clinigol mwy cadarn hwn wedi cymryd ei le.

[61] **Leighton Andrews:** For how long have you had the target?

[61] **Leighton Andrews:** Ers pryd yr ydych wedi cael y targed?

Ms Lloyd: It has just been published to be—

Ms Lloyd: Mae newydd gael ei gyhoeddi—

[62] **Leighton Andrews:** No, for how long have you had the 10-day target?

[62] **Leighton Andrews:** Na, ers pryd yr ydych wedi cael y targed 10 niwrnod?

Ms Lloyd: The 10-day target was established by the cancer networks two years ago. As I said, we were having terribly differential information from trusts, some of which we knew was simply not accurate. Our statistical colleagues advised us that it could not be published as it would be misleading.

Ms Lloyd: Penderfynodd y rhwydweithiau canser ar y targed o 10 niwrnod ddwy flynedd yn ôl. Fel y dywedais, yr oeddem yn cael gwybodaeth hollol wahanol gan ymddiriedolaethau, ac yr oeddem yn gwybod fod rhywfaint ohoni'n gwbl wallus. Dywedodd ein cydweithwyr ystadegau wrthym na allem ei chyhoeddi gan y byddai'n gamarweiniol.

[63] **Leighton Andrews:** Therefore, what are the one-month and two-month targets? What do they mean?

[63] **Leighton Andrews:** Felly, beth yw'r targedau mis a deufis? Beth maent yn ei olygu?

Ms Lloyd: The one-month target is for referral, and the two-month target is for treatment, from the GP (1). Those are the targets that the clinical advisers are asking us to adopt.

Ms Lloyd: Mae'r targed mis ar gyfer cyfeirio, a'r targed deufis ar gyfer triniaeth, gan y meddyg teulu (1). Dyna'r targedau y mae'r cynghorwyr clinigol yn gofyn i ni eu mabwysiadu.

[64] **Leighton Andrews:** Do you not have any concerns that the apparent message that you no longer have a 10-day target could lead to GPs finding that access to first out-patient appointments falls?

[64] **Leighton Andrews:** Onid oes gennych unrhyw bryderon y gallai'r neges nad oes gennych darged o 10 niwrnod bellach beri i feddygon teulu ganfod bod mynediad i apwyntiadau cleifion allanol cyntaf yn gostwng?

Ms Lloyd: No, I do not have that concern at present, although we will track it very carefully indeed. There has been great

Ms Lloyd: Na, nid wyf yn bryderus am hynny ar hyn o bryd, er y byddwn yn cadw llygad barcud ar y mater. Bu pryder mawr am

concern about this, publicly and also among management and clinical staff. Our clinicians tell us that this sort of target has a better outcome for patients, so we will pursue it. However, we will keep a very steely eye on whether or not this is leading to a drift out of people having access to a clinical opinion, if they are urgent cases.

hyn, yn gyhoeddus a hefyd ymhlith rheolwyr a staff clinigol. Mae ein clinigwyr yn dweud wrthym fod gan darged fel hyn well canlyniad i gleifion, felly byddwn yn ei ddilyn. Ond, byddwn yn cadw llygad barcud i weld a yw hyn yn arwain at atal pobl rhag cael barn glinigol, os ydynt yn achosion brys.

[65] **Leighton Andrews:** When will you measure compliance with the new 2006 target?

[65] **Leighton Andrews:** Pryd y byddwch yn mesur cydymffurfiaeth â'r targed 2006 newydd?

Ms Lloyd: We will start to measure it in September 2005. We need our colleagues to be quite clear that this is robust and accurate.

Ms Lloyd: Byddwn yn cychwyn ei fesur ym mis Medi 2005. Mae angen i'n cydweithwyr fod yn glir iawn bod hyn yn gadarn ac yn gywir.

[66] **Leighton Andrews:** If you are implementing new targets, which will potentially be very controversial, publicly—if they are seen in a different way—how will you ensure that the data is robust and how quickly will you be able to validate that data?

[66] **Leighton Andrews:** Os ydych yn gweithredu targedau newydd, a allai fod yn ddadleuol iawn, yn gyhoeddus—os ydynt yn cael eu gweld mewn ffordd wahanol—sut byddwch yn sicrhau bod y data yn gadarn a pha mor gyflym y gallwch ddilysu'r data hwnnw?

Ms Lloyd: My regional colleagues, who performance-manage these organisations, have been asked to pay particular attention to this and to work closely with the local health boards and the trusts to ensure that the target is well understood by the management—in terms of definition and application by the clinicians and the local health boards—and to

Ms Lloyd: Gofynnwyd i'm cydweithwyr rhanbarthol, sy'n rheoli perfformiad y sefydliadau hyn, roi sylw arbennig iawn i hyn a gweithio'n agos â'r byrddau iechyd lleol a'r ymddiriedolaethau i sicrhau bod y rheolwyr yn deall y targed yn iawn—o ran y ffordd y bydd yn cael ei ddiffinio a'i ddefnyddio gan y clinigwyr a'r byrddau iechyd lleol—ac

report back to us. They will also work with the statistics unit.

adrodd yn ôl i ni. Byddant hefyd yn gweithio gyda'r uned ystadegau.

[67] **Leighton Andrews:** Does that mean that, since the National Audit Office provided its report, you have not followed up the implementation of the 10-day target with any of the six trusts originally researched?

[67] **Leighton Andrews:** A yw hyn yn golygu, ers i'r Swyddfa Archwilio Genedlaethol ddarparu ei adroddiad, nad ydych wedi dilyn gweithrediad y targed 10 niwrnod gydag unrhyw un o'r chwe ymddiriedolaeth a ymchwiliwyd yn wreiddiol?

Ms Lloyd: Yes, we have followed it up through the regional offices.

Ms Lloyd: Ydym, yr ydym wedi'i ddilyn drwy'r swyddfeydd rhanbarthol.

[68] **Leighton Andrews:** Has it improved?

[68] **Leighton Andrews:** A yw wedi gwella?

Ms Lloyd: Yes. One of my colleagues had to follow this up—

Ms Lloyd: Ydy. Yr oedd yn rhaid i un o'm cydweithwyr fynd ar drywydd y mater hwn—

[69] **Leighton Andrews:** Would you like to elaborate on that?

[69] **Leighton Andrews:** A hoffech ymhelaethu ar hynny?

Mr Marples: As part of monitoring SAFF targets for 2004-05, the regions have had comparative tables of performance against the 10-day target—acknowledging the points already made about the vulnerability of the collection. On the other hand, if we take the hit because the targets were exceeded, and if they are improving against the same set of data, it is legitimate. They are all improving. The vast majority of cases now have

Mr Marples: Fel rhan o fonitro targedau'r fframwaith gwasanaeth a chyllid ar gyfer 2004-05, mae'r rhanbarthau wedi cael tablau perfformiad cymharol yn erbyn y targed o 10 niwrnod—gan gydnabod y pwyntiau sydd wedi'u gwneud eisoes am wendid y casgliad. Ar y llaw arall, os ydym yn ymdopi â'r ergyd oherwydd eu bod wedi perfformio'n well na'r targedau, ac os ydynt yn gwella yn erbyn yr un gyfres o ddata, mae'n ddilys. Maent i gyd

achieved greater than 95 per cent. At least one of the organisations is now regularly reporting 100 per cent compliance for all sites, whereas previously, compliance, as you have seen from reports, had been patchy. Therefore, there is some evidence of success in terms of the performance management regime, particularly around this area. The new target will be adopted just as rigorously.

yn gwella. Mae mwyafrif helaeth yr achosion bellach wedi perfformio'n well na 95 y cant. Mae o leiaf un o'r sefydliadau bellach yn adrodd cydymffurfiaeth o 100 y cant yn rheolaidd ar gyfer pob safle, lle'n flaenorol, bu cydymffurfiaeth, fel yr ydych wedi'i weld o'r adroddiadau, yn anghyson. Felly, mae peth tystiolaeth o lwyddiant o ran y drefn rheoli perfformiad, yn arbennig yn y maes hwn. Bydd y targed newydd yn cael ei fabwysiadu yn llawn mor drwyadl.

[70] **Leighton Andrews:** Do you think that those six are representative of all trusts?

[70] **Leighton Andrews:** A ydych yn credu bod y chwech hyn yn gynrychioliadol o'r holl ymddiriedolaethau?

Mr Marples: I cannot answer that.

Mr Marples: Ni allaf ateb hynny.

Ms Lloyd: Neither can I.

Ms Lloyd: Na minnau.

Mr Marples: The improvements that we have seen in our region are across all trusts, but I cannot speak for all regions.

Mr Marples: Mae'r gwelliannau yr ydym wedi'u gweld yn ein rhanbarth ar draws pob ymddiriedolaeth, ond ni allaf siarad ar ran pob rhanbarth.

[71] **Leighton Andrews:** I will move to targets for cardiac, orthopaedic and cataract treatment in particular. You have made progress in terms of meeting the cardiac and orthopaedic targets, but not the cataract surgery targets. Would you like to explain why?

[71] **Leighton Andrews:** Yr wyf am symud at dargedau ar gyfer triniaethau cardiaidd, orthopedig a chataract yn benodol. Yr ydych wedi gwneud cynnydd o ran bodloni'r targedau cardiac ac orthopedig, ond nid y targedau llawdriniaethau cataract. A hoffech egluro pam?

Ms Lloyd: Some trusts have had great problems in meeting the cataract target, particularly Carmarthen, which had several breaches. However, they are all making progress now. There has been a considerable drop in the numbers waiting.

Ms Lloyd: Mae rhai ymddiriedolaethau wedi cael problemau difrifol o ran bodloni'r targed cataract, yn arbennig Caerfyrddin, a oedd â llawer o doriadau. Fodd bynnag, maent i gyd yn gwneud cynnydd bellach. Cafwyd gostyngiad sylweddol yn y niferoedd sy'n aros.

[72] **Leighton Andrews:** Some of the evidence that we have been given by the NAO suggests that ophthalmology consultants had particular concerns about the impact that the cataract target was having on clinical priorities. Do you have any observations on that?

[72] **Leighton Andrews:** Mae rhywfaint o'r dystiolaeth a roddwyd i ni gan y Swyddfa Archwilio Genedlaethol yn awgrymu bod gan feddygon ymgynghorol offthalmoleg bryderon penodol ynghylch yr effaith yr oedd y targed cataract yn ei gael ar flaenoriaethau clinigol. A oes gennych unrhyw sylwadau ar hynny?

Ms Lloyd: That is a concern that they have expressed, which is why the cataract target has not been reduced further, as it has in England.

Ms Lloyd: Mae hynny'n bryder y maent wedi ei fynegi, a dyna pam na ostyngwyd y targed cataract ymhellach, fel a ddigwyddodd yn Lloegr.

[73] **Leighton Andrews:** Again, we come back to total waiting times as being the issue of most concern to patients. As I understand it, the four-month wait is after the first appointment. There may be a much longer out-patient waiting time before that. Are you making progress with that?

[73] **Leighton Andrews:** Eto, yr ydym yn dod yn ôl at gyfanswm yr amseroedd aros fel yr hyn sy'n achosi'r pryder mwyaf i gleifion. Fel y deallaf, mae'r cyfnod aros o bedwar mis yn digwydd ar ôl yr apwyntiad cyntaf. Efallai bod amser aros llawer hwy fel claf allanol cyn hynny. A ydych yn gwneud cynnydd gyda hynny?

Ms Lloyd: Yes, indeed. The initiative that has been pursued, in terms of optometrists referring straight in and doing the basework, has shortened any potential waiting time enormously. You will see in various organisations that the waiting time between the optometrist referring a patient and treatment being given—the Gwent scheme is an example of that—has reduced considerably and patients are being seen quickly.

Ms Lloyd: Ydym, yn wir. Mae'r fenter sydd ar waith, o ran optometryddion yn cyfeirio'n syth i mewn a gwneud y gwaith sylfaenol, wedi lleihau unrhyw amser aros posibl yn sylweddol. Byddwch yn gweld mewn gwahanol sefydliadau bod yr amser aros rhwng yr optometrydd yn cyfeirio claf a thriniaeth yn cael ei rhoi—mae cynllun Gwent yn enghraifft o hynny—wedi gostwng yn sylweddol ac mae cleifion yn cael eu gweld yn gyflym.

[74] **Alun Cairns:** I will refer to figure 15 in chapter 4 of volume 1, where it highlights the specific problems in terms of orthopaedic waiting times. What is the impact of the failure to reduce waiting times in this discipline, where there are specific issues?

[74] **Alun Cairns:** Yr wyf am gyfeirio at ffigur 15 ym mhennod 4 cyfrol 1, lle amlygir y problemau penodol o ran amseroedd aros orthopedig. Beth yw effaith y methiant i leihau amseroedd aros yn y ddisgyblaeth hon, lle mae materion penodol?

Ms Lloyd: In terms of in-patients?

Ms Lloyd: O ran cleifion mewnol?

[75] **Alun Cairns:** Yes. What is the impact of failure to reduce waiting times for orthopaedics in general, for both in-patients and out-patients?

[75] **Alun Cairns:** Ie. Beth yw effaith methu â gostwng amseroedd aros ar gyfer orthopedeg yn gyffredinol, ar gyfer cleifion mewnol a chleifion allanol?

Ms Lloyd: The impact is that there are more patients waiting. However, the number waiting more than 18 months is falling dramatically to single figures. They must get down to 12 months by the end of this year, which is being done.

Ms Lloyd: Yr effaith yw bod mwy o gleifion yn aros. Fodd bynnag, mae'r nifer sy'n aros am fwy na 18 mis yn disgyn yn ddramatig i ffigurau unigol. Mae'n rhaid eu cael i lawr i 12 mis erbyn diwedd y flwyddyn, ac mae hyn yn digwydd.

[76] **Alun Cairns:** I was primarily aiming at the impact on patients themselves rather than on the

[76] **Alun Cairns:** Yr oeddwn yn cyfeirio'n bennaf at yr effaith ar y cleifion eu hunain yn

numbers waiting.

hytrach na'r niferoedd sy'n aros.

Ms Lloyd: The research in this report shows that GPs are reporting that they have to see patients more frequently. We know from experience that patients will suffer problems in terms of access and mobility, which is why there has been a particular focus on reducing orthopaedic out-patient waits and producing access solutions that allow independent ambulatory care centres to be established throughout Wales.

Ms Lloyd: Mae'r ymchwil yn yr adroddiad hwn yn dangos bod meddygon teulu yn dweud eu bod yn gorfod gweld cleifion yn amlach. Gwyddom o brofiad y bydd cleifion yn dioddef problemau o ran mynediad a symudedd, a dyna pam ein bod wedi canolbwyntio'n benodol ar leihau amseroedd aros cleifion allanol a chanfod atebion i broblemau mynediad a fydd yn caniatáu i ganolfannau triniaethau dydd gael eu sefydlu ledled Cymru.

[77] **Alun Cairns:** Do you accept that conclusion, and particularly the comments made by the GPs in one of the appendices?

[77] **Alun Cairns:** A ydych yn derbyn y casgliad hwnnw, a'r sylwadau gan y meddygon teulu yn un o'r atodiadau yn arbennig?

Ms Lloyd: I do accept them. It has had such a high profile in order to try to solve this problem.

Ms Lloyd: Yr wyf yn eu derbyn. Mae wedi cael cymaint o sylw i geisio datrys y broblem hon.

[78] **Alun Cairns:** Turning to plastic surgery, why is there such a problem with the majority of patients waiting longer than 12 months in this discipline?

[78] **Alun Cairns:** Gan droi at lawdriniaeth gosmetig, pam mae cymaint o broblem gyda'r mwyafrif o gleifion yn aros yn hwy na 12 mis yn y ddisgyblaeth hon?

Ms Lloyd: I can give you my opinion on why that is a problem. When you look at the list for plastic surgery that is being held in Swansea, you will find a number of cases that, certainly in England, were either significantly reduced in terms of the numbers that the trusts could treat or were not done at all. This is the legacy of the health authorities that did not look rigorously enough at the types of patients that were being referred onto lists such as those for plastic surgery. There are also a number of cases that, in England, are dealt with by alternative practitioners. We have been working with Swansea, which manages plastic surgery for us, to look very critically at the requirements of the individuals on these lists, whether they need to be seen by a plastic surgeon and what alternatives could be provided for them. However, it is a complete outlier, as you can see. There is a very distinctive approach to plastic surgery in England—I know, because I had a plastic surgery department—which

Ms Lloyd: Gallaf roi fy marn ar pam mae hynny'n broblem. Pan edrychwch ar y rhestr ar gyfer llawdriniaeth gosmetig yn Abertawe, byddwch yn gweld nifer o achosion, yn sicr yn Lloegr, a oedd naill ai wedi'u gostwng yn sylweddol o ran y niferoedd y gallai'r ymddiriedolaethau eu trin neu na chawsant eu gwneud o gwbl. Dyma etifeddiaeth yr awdurdodau iechyd na edrychodd yn ddigon manwl ar y mathau o gleifion a oedd yn cael eu cyfeirio ar restrau fel y rhai hynny ar gyfer llawdriniaeth gosmetig. Mae llawer o achosion hefyd, yn Lloegr, yn cael sylw gan ymarferwyr amgen. Yr ydym wedi bod yn gweithio gydag Abertawe, sy'n rheoli llawdriniaeth gosmetig ar ein cyfer, i edrych yn feirniadol iawn ar ofynion unigolion ar y rhestrau hyn, a oes angen i lawfeddyg cosmetig eu gweld a pha opsiynau eraill y gellid eu darparu ar eu cyfer. Fodd bynnag, mae'n elfen ar wahân, fel y gwelwch. Mae agwedd unigryw iawn at lawdriniaeth gosmetig yn Lloegr—yr wyf yn gwybod,

does not seem to have been pursued by the health authorities. Therefore, they have this legacy, and some of these patients have been waiting for a very long time. That is why we have been working with the organisation and clinicians concerned on alternatives for patients.

oherwydd yr oedd gennyf adran lawdriniaeth gosmetig—nad yw'r awdurdodau iechyd wedi'i mabwysiadu yn ôl pob tebyg. Felly, mae ganddynt yr etifeddiaeth hon, a bu rhai o'r cleifion hyn yn aros am amser hir iawn. Dyna pam y buom yn gweithio gyda'r sefydliad a'r clinigwyr dan sylw ar opsiynau gwahanol ar gyfer cleifion.

[79] **Alun Cairns:** What are you specifically doing to overcome the problems?

[79] **Alun Cairns:** Beth yn benodol yr ydych yn ei wneud i oresgyn y problemau?

Ms Lloyd: Mr Marples deals with Swansea, and he will able to give you the nuts and bolts of it.

Ms Lloyd: Mae Mr Marples yn delio ag Abertawe, a gall roi'r manylion i chi.

Mr Marples: The service is nationally commissioned by Health Commission Wales. It has had one of its commissioners working solely on a plan for plastic surgery, which has been dealt with in detail with the individual clinicians, who have been extremely helpful. There are all sorts of initiatives, as Miss Lloyd has indicated, to deal with demand and the numbers on the lists. The numbers are falling considerably, as you have heard, and it is expected that they will reach the target by 31 March 2005.

Mr Marples: Mae'r gwasanaeth yn cael ei gomisiynu'n genedlaethol gan Gomisiwn Iechyd Cymru. Bu un o'i gomisiynwyr yn gweithio yn unig ar gynllun ar gyfer llawdriniaeth gosmetig, sydd wedi'i drafod yn fanwl gyda'r clinigwyr unigol, a fu'n gymorth mawr. Mae pob math o fentrau, fel y dywedodd Miss Lloyd, i ymdrin â'r galw a'r niferoedd ar y rhestrau. Mae'r niferoedd yn disgyn yn sylweddol, fel y clywsoch, ac mae disgwyl iddynt gyrraedd y targed erbyn 31 Mawrth 2005.

[80] **Alun Cairns:** On the regional variation in waiting lists across Wales, and figure 16 specifically, we have touched upon the differences between north and south Wales, and you highlighted Caerphilly, Merthyr

[80] **Alun Cairns:** O ran yr amrywiad rhanbarthol mewn rhestrau aros ledled Cymru, a ffigur 16 yn benodol, yr ydym wedi crybwyll y gwahaniaethau rhwng y Gogledd a'r De eisoes, ac yr ydych wedi sôn am

Tydfil, and Blaenau Gwent. However, looking at figure 16, the Vale of Glamorgan is one of the more economically prosperous parts of Wales, but it has more people per 1,000 population waiting more than 18 months for out-patient treatment. Why is that?

Gaerffili, Merthyr Tudful, a Blaenau Gwent. Fodd bynnag, wrth edrych ar ffigur 16, Bro Morgannwg yw un o rannau mwyaf llewyrchus Cymru yn economaidd, ond mae mwy o bobl fesul 1,000 o'r boblogaeth yn aros mwy na 18 mis ar gyfer triniaeth fel cleifion allanol. Beth yw'r rheswm am hynny?

Ms Lloyd: It could be the halo effect. However, we have asked the local health—

Ms Lloyd: Gallai fod oherwydd yr effaith lleugylch. Fodd bynnag, yr ydym wedi gofyn i'r bwrdd iechyd lleol—

[81] **Alun Cairns:** Sorry, would you expand on what you mean by 'the halo effect'?

[81] **Alun Cairns:** Mae'n ddrwg gennyf, a wnewch ymhelaethu ar ystyr 'yr effaith lleugylch'?

Ms Lloyd: Yes. Given that most of it is an economically wealthy area, the expectations of patients, as you know, will be higher. That has been proven by research. It is also proven by research that individuals who live near a large tertiary centre seek to access care in greater proportion than others. We have asked the Vale of Glamorgan Local Health Board to look carefully at its needs and to match its commissioning to meet the needs of the population. It must then look at what this large stream of people who are waiting per 1,000 population means, in terms of managing that demand, because the needs of the population may not actually map to this demand at all.

Ms Lloyd: Gwnaf. O ystyried bod y mwyafrif o'r ardal yn gyfoethog yn economaidd, bydd disgwyliadau cleifion, fel y gwyddoch, yn uwch. Mae ymchwil wedi profi hynny. Mae ymchwil wedi profi hefyd fod unigolion sy'n byw'n agos i ganolfan drydyddol fawr yn ceisio cael rhagor o fynediad i ofal nag eraill. Yr ydym wedi gofyn i Fwrdd Iechyd Lleol Bro Morgannwg edrych yn ofalus ar ei anghenion ac i sicrhau bod ei gomisiynu yn diwallu anghenion y boblogaeth. Mae'n rhaid iddo edrych wedyn ar beth y mae'r holl bobl hyn sy'n aros fesul 1,000 o'r boblogaeth yn ei olygu, o ran rheoli'r galw hwnnw, oherwydd efallai nad yw anghenion y boblogaeth yn cyfateb i'r galw hwn o gwbl.

[82] **Alun Cairns:** I do not quite understand why the halo effect would have such an impact because the neighbouring authorities, Bridgend to the west and Rhondda Cynon Taf to the north, are much lower down the scale, certainly at the mid point, broadly speaking, and they are primarily using the same services in the same trusts—obviously Cardiff on the eastern side is higher up. I fail to see how the halo effect would have such an impact on an area such as the Vale of Glamorgan, which is at the top of the list.

[82] **Alun Cairns:** Nid wyf yn deall yn iawn pam y byddai'r effaith lleugylch yn cael cymaint o effaith oherwydd mae'r awdurdodau cyfagos, Pen-y-bont ar Ogwr i'r gorllewin a Rhondda Cynon Taf i'r gogledd, yn llawer is ar y raddfa, yn sicr tua hanner ffordd, a siarad yn fras, ac maent yn defnyddio'r un gwasanaethau yn yr un ymddiriedolaethau i bob diben—yn amlwg mae Caerdydd i'r dwyrain yn uwch i fyny. Ni allaf weld sut y byddai'r effaith lleugylch yn cael cymaint o effaith ar ardal fel Bro Morgannwg, sydd ar frig y rhestr.

Ms Lloyd: It probably does. Bridgend is only accessed by a small proportion of the Vale of Glamorgan, and the economic differences between Rhondda Cynon Taf and the Vale of Glamorgan are quite stark. However, it may be—and this is what I have asked the local health board to confirm or not—that the previous health authority, or even itself in the first year, as it established, was not commissioning sufficiently to meet the demand or the needs of its population, and it is for the board to do that. It has to report back to us on what it is doing about it and how it will manage such a large number of people who are waiting in its area.

Ms Lloyd: Mae'n debyg ei fod. Dim ond cyfran fach o Fro Morgannwg sy'n defnyddio Pen-y-bont ar Ogwr, ac mae'r gwahaniaethau economaidd rhwng Rhondda Cynon Taf a Bro Morgannwg yn amlwg iawn. Fodd bynnag, efallai—a dyma'r hyn yr wyf wedi gofyn i'r bwrdd iechyd lleol ei gadarnhau ai peidio—nad oedd yr awdurdod iechyd lleol blaenorol, neu hyd yn oed y bwrdd ei hun yn y flwyddyn gyntaf, wrth iddo sefydlu, yn comisiynu'n ddigonol i ddiwallu'r galw neu anghenion ei boblogaeth, a chyfrifoldeb y bwrdd yw gwneud hynny. Mae'n gorfod adrodd yn ôl i ni ar yr hyn y mae'n ei wneud am y peth a sut y bydd yn rheoli y nifer fawr o bobl sy'n aros yn ei ardal.

[83] **Alun Cairns:** So, might it be that the commissioning in Swansea, Cardiff and the Vale of Glamorgan is much weaker than it is elsewhere in Wales, and that is why we have those three at the top?

[83] **Alun Cairns:** Felly, a allai'r comisiynu yn Abertawe, Caerdydd a Bro Morgannwg fod yn llawer gwannach nag y mae mewn mannau eraill yng Nghymru, a dyna pam mae gennym y tri hynny ar y brig?

Ms Lloyd: It may well be but, until it has finished its commissioning proposals for this year, given its needs assessment and the demand that is shown in this report, I will not give you a

Ms Lloyd: Efallai fod hynny'n wir ond, hyd nes iddo orffen ei gynigion comisiynu ar gyfer eleni, o ystyried ei asesiad o anghenion a'r galw sy'n cael ei ddangos yn yr adroddiad hwn, ni roddaf

definitive answer on that.

ateb terfynol i chi ar hynny.

[84] **Jocelyn Davies:** Janet, may I ask a question on this halo effect and the wealthier among us on these NHS waiting lists who live closer to the hospitals? Is it not the case that the wealthy often use the private sector as out-patients, both to see a consultant and to have their treatment? Given that the Vale of Glamorgan is quite a wealthy area, I would expect to see people using private treatment.

[84] **Jocelyn Davies:** Janet, a gaf fi ofyn cwestiwn ar yr effaith lleugylch a'r rhai cyfoethocaf ohonom ar y rhestrau aros GIG hyn sy'n byw'n agosach at yr ysbytai? Onid yw'n wir bod y bobl gyfoethocaf yn aml yn defnyddio'r sector preifat fel cleifion allanol, i weld meddygon ymgynghorol ac i gael eu triniaeth? O ystyried bod Bro Morgannwg yn ardal gymharol gyfoethog, byddwn yn disgwyl gweld pobl yn defnyddio triniaeth breifat.

Ms Lloyd: Well, they might do, but that is not shown in these figures.

Ms Lloyd: Wel, efallai, ond nid yw hynny'n cael ei ddangos yn y ffigurau hyn.

[85] **Jocelyn Davies:** No, it certainly is not shown, and that is why I am challenging this 'halo effect'.

[85] **Jocelyn Davies:** Na, yn sicr nid yw'n cael ei ddangos, a dyna pam fy mod yn herio'r 'effaith lleugylch' hon.

[86] **Janet Davies:** I find it a very odd effect, but the statistics seem to be there, and I do not think that there is much value in pursuing that at this particular moment.

[86] **Janet Davies:** Yr wyf yn ei ystyried yn effaith ryfedd iawn, ond ymddengys bod yr ystadegau yno, ac ni chredaf fod llawer o werth mewn dilyn y mater hwn ar hyn o bryd.

Gohiriwyd y cyfarfod rhwng 11.02 a.m. a 11.17 a.m.
The meeting was adjourned between 11.02 a.m. and 11.17 a.m.

[87] **Janet Davies:** I realise that this has not been mentioned to the witnesses but, during a discussion in the break, it was mentioned that we are going through this report very slowly. It is obviously a crucial report, so I have had a request that I approach the Business Committee to ask whether we can have another meeting on this report and that we aim to get a little more done now, as it is approaching 12 p.m. and we have other items on the agenda. I hope that the meeting will take place before we have our meetings with the local health boards and the national health service trusts. So, unless there are any really strong objections, we would hope to have another meeting to finish looking at this report with you, Mrs Lloyd, and, hopefully, with Mr Marples.

[87] **Janet Davies:** Sylweddolaf nad yw hyn wedi'i grybwyll wrth y tystion ond, mewn trafodaeth yn ystod yr egwyl, crybwyllwyd ein bod yn mynd drwy'r adroddiad hwn yn araf iawn. Mae'n amlwg yn adroddiad pwysig, felly gofynnwyd i mi gysylltu â'r Pwyllgor Busnes i ofyn a allwn gael cyfarfod arall ar yr adroddiad hwn a'n bod yn ceisio cyflawni ychydig mwy yn awr, gan ei bod yn agosáu at 12 p.m. a bod gennym eitemau eraill ar yr agenda. Gobeithiaf y bydd y cyfarfod yn cael ei gynnal cyn i ni gael ein cyfarfodydd gyda'r byrddau iechyd lleol ac ymddiriedolaethau'r gwasanaeth iechyd gwladol. Felly, os nad oes gwrthwynebiadau cryf iawn, gobeithio y byddwn yn cael cyfarfod arall i orffen edrych ar yr adroddiad hwn gyda chi, Mrs Lloyd, a, gobeithio, gyda Mr Marples.

Ms Lloyd: I have no strong objections to that.

Ms Lloyd: Nid oes gennyf wrthwynebiadau cryf i hynny.

[88] **Janet Davies:** Okay. Thank you very much.

[88] **Janet Davies:** Iawn. Diolch yn fawr iawn.

[89] **Mick Bates:** I think that that is a very sensible suggestion, Chair. However, I spoke to you in the interval about taking another question and I wonder whether it would be sensible to finish the questions on volume 1 and leave volume 2 until the other meeting?

[89] **Mick Bates:** Credaf fod hynny'n awgrym call iawn, Gadeirydd. Fodd bynnag, siaradais â chi yn ystod yr egwyl ynghylch gofyn cwestiwn arall a thybed oni fyddai'n ddoeth gorffen y cwestiynau ar gyfrol 1 a gadael cyfrol 2 tan y cyfarfod arall?

[90] **Janet Davies:** No. I think that we need to go on a little further than that.

[90] **Janet Davies:** Na. Credaf fod angen i ni fynd ymlaen rhywfaint pellach na hynny.

[91] **Mick Bates:** Okay.

[91] **Mick Bates:** Iawn.

[92] **Janet Davies:** We will try to look at the issues of the actual waiting times and the accuracy of the waiting lists and we will make a start on volume 2, on tackling the out-patient waiting times. I am sorry about this, but this is the biggest report that we have ever had and it is very important. I think that this is the best way of handling the situation that we have now reached. Irene James, will you take up the issue of waiting times and the accuracy of the waiting lists?

[92] **Janet Davies:** Yr ydym am geisio edrych ar faterion yr amseroedd aros gwirioneddol a chywirdeb y rhestrau aros a byddwn yn dechrau ar gyfrol 2, ar fynd i'r afael ag amseroedd aros cleifion allanol. Mae'n ddrwg gennyf am hyn, ond hwn yw'r adroddiad mwyaf i ni ei gael erioed ac mae'n bwysig iawn. Credaf mai dyma'r ffordd orau o ymdrin â'r sefyllfa sydd ohoni. Irene James, a wnewch chi drafod mater yr amseroedd aros a chywirdeb y rhestrau aros?

[93] **Irene James:** I would like to look at figure 21, which shows that the majority of

[93] **Irene James:** Hoffwn edrych ar ffigur 21, sy'n dangos bod y mwyafrif o gleifion

in-patient day cases wait less than 18 months but that six per cent of patients wait longer than that. That suggests that there is a tail at the end of the waiting list. Why does a significant minority of patients end up facing a waiting time that is longer than that experienced by the majority?

mewnol sy'n cael triniaeth fel achos dydd yn aros llai na 18 mis ond bod chwech y cant o gleifion yn gorfod aros yn hwy na hynny. Mae hynny'n awgrymu bod cynffon ar waelod y rhestr aros. Pam mae lleiafrif sylweddol o gleifion yn wynebu amser aros sy'n hwy na'r hyn y mae'r mwyafrif yn ei brofi?

Ms Lloyd: Well, of course, the targets and the actions that we have taken are trying to militate against that, but you will find—and I think that this is suggested in this report—that, because the waiting times are attenuated, general practitioners will naturally try to expedite their individual clients. What we have done about this—and this is one of the rules outlined in the King's Fund report as well as in others—is to manage people chronologically. We all understand the importance of the urgent cases being seen urgently and of clinical priority being adhered to at all times, but you tend to have a drift of patients that sometimes go over the limits and are not receiving the care that they should be receiving. Therefore, we have put into all trusts a scheme called 'Treat in Turn', which means that you take those patients who have been waiting the longest off the back of the lists, chronologically, while balancing those who are clinically urgent and not interfering with clinical priority. This is quite a stark piece of information here, which clearly shows that, for in-patients, the numbers being treated within those six months—the numbers no longer appearing on the list—are at about 64 per cent and, up to 12 months, it is another 25 per cent. So, the vast majority are being seen, but we must ensure that people who are waiting longer than that do not drift out. When you look at some trusts' profiles, you will see this flattening down and then a long tail of a few patients, but they must now come within the limits that have been proposed.

Ms Lloyd: Wel, wrth gwrs, mae'r targedau a'r camau gweithredu yr ydym wedi'u cymryd yn ceisio milwrio yn erbyn hynny, ond byddwch yn gweld—a chredaf fod hyn wedi'i awgrymu yn yr adroddiad hwn—oherwydd bod yr amseroedd aros wedi'u lleihau, y bydd meddygon teulu yn naturiol yn ceisio cyflymu eu cleientiaid unigol. Yr hyn yr ydym wedi'i wneud am hyn—a dyma un o'r rheolau a amlinellir yn adroddiad Cronfa King yn ogystal ag adroddiadau eraill—yw rheoli pobl yn gronolegol. Yr ydym i gyd yn deall pwysigrwydd gweld yr achosion brys yn gyflym a rhoi blaenoriaeth glinigol iddynt drwy'r amser, ond yr ydych yn tueddu i gael ton o gleifion sy'n mynd dros y terfynau o bryd i'w gilydd heb dderbyn y gofal y dylent ei dderbyn. Felly, yr ydym wedi cyflwyno cynllun o'r enw 'Trin yn eu Tro' ym mhob ymddiriedolaeth, sy'n golygu eich bod yn cymryd y cleifion hynny sydd wedi bod yn aros hwyaf oddi ar waelod y rhestrau, yn gronolegol, tra'n cydbwyso'r rhai hynny sy'n achosion brys o safbwynt clinigol ac nad ydynt yn ymyrryd â blaenoriaeth glinigol. Mae hon yn wybodaeth glir, sy'n dangos yn amlwg, ar gyfer cleifion mewnol, fod y niferoedd sy'n cael eu trin o

fewn y chwe mis hynny—y niferoedd nad ydynt yn ymddangos ar y rhestr bellach—tua 64 y cant a, hyd at 12 mis, mae'n 25 y cant arall. Felly, mae'r mwyafrif llethol yn cael eu gweld, ond mae'n rhaid i ni sicrhau nad yw pobl sy'n aros yn hwy na hynny yn cael eu hanghofio. Wrth ichi edrych ar broffiliau rhai ymddiriedolaethau, byddwch yn gweld y nifer yn mynd yn fwy gwastad ac wedyn cynffon hir o lond llaw o gleifion, ond mae'n rhaid iddynt bellach ddod o fewn y terfynau a gynigiwyd.

[94] **Irene James:** So, how do you propose to eradicate that tail?

[94] **Irene James:** Felly, sut ydych chi'n bwriadu cael gwared ar y gynffon?

Ms Lloyd: We have put 'Treat in Turn' in so that every trust is obliged to ensure that, in terms of chronology and not interfering with clinical priorities, patients come off the back of the lists and to ensure that people do not get jumped and pushed further back. We are monitoring that very carefully indeed.

Ms Lloyd: Yr ydym wedi cyflwyno 'Trin yn eu Tro' er mwyn iddi fod yn ofynnol i bob ymddiriedolaeth sicrhau, o ran cronoleg a pheidio ag ymyrryd â blaenoriaethau clinigol, fod cleifion yn dod oddi ar waelod rhestrau a sicrhau nad yw pobl yn cael eu gadael ar ôl a'u gwthio ymhellach yn ôl. Yr ydym yn monitro hynny'n ofalus iawn.

[95] **Irene James:** Do you believe that that will sustain the eradication of these people from those lists?

[95] **Irene James:** A ydych yn credu y bydd hynny'n parhau i gael gwared ar y bobl hyn oddi ar y rhestrau hynny?

Ms Lloyd: It has to, because we must go down to 12 months by the end of March, so we cannot have people who are now outliers.

Ms Lloyd: Mae'n rhaid iddo, oherwydd mae'n rhaid i ni fynd i lawr i 12 mis erbyn diwedd mis Mawrth, felly ni allwn gael pobl sy'n allgleifion ar hyn o bryd.

The other problem that we find, as has happened on the orthopaedic list and the cardiac list, is that some people in ones and twos are popping over the maximum wait, and some people will have been suspended from that list, either because of their clinical condition or because they have decided that they want more time to reflect on whether or not they want the operation—and that is fair enough—and then they come back onto the list as clinically able to be operated upon. That gives the trust too little time to actually get them treated either within the 18 months or within the 12 months. So, we have had a couple of breaches there, and we have instructed all trusts to tighten up their processes so that that does not occur.

Y broblem arall yr ydym yn ei chanfod, fel sydd wedi digwydd ar y rhestr orthopedig a'r rhestr gardiaidd, yw bod rhai pobl bob yn un neu ddau yn mynd y tu hwnt i'r cyfnod aros uchaf, a bydd rhai wedi'u gwahardd o'r rhestr honno, naill ai oherwydd eu cyflwr clinigol neu oherwydd eu bod wedi penderfynu eu bod am gael rhagor o amser i ystyried a ydynt am gael y llawdriniaeth ai peidio—ac mae hynny'n ddigon teg—ac yna maent yn dod yn ôl ar y rhestr fel pobl sy'n glinigol alluog i gael llawdriniaeth. Nid yw hynny'n rhoi digon o amser i'r ymddiriedolaeth eu trin naill ai o fewn y 18 mis neu o fewn y 12 mis. Felly, cafwyd ambell fethiant yma, ac yr ydym wedi rhoi cyfarwyddiadau i bob ymddiriedolaeth wella'u prosesau er mwyn sicrhau nad yw hynny'n digwydd.

[96] **Irene James:** Obviously, like the rest of us, you agree that waiting 18 months is totally

[96] **Irene James:** Yn amlwg, fel y gweddill ohonom, yr ydych yn cytuno bod aros 18 mis yn

unacceptable?

Ms Lloyd: It is not acceptable to wait 18 months.

[97] **Irene James:** I would like to move on now to paragraphs 4.27 to 4.31, where it states that a quarter of those patients who had waited over 18 months and who were contacted as part of the second offer scheme were actually removed from the waiting list. Why? We have put considerable investment into waiting list management, so how can we improve the accuracy of this list?

Ms Lloyd: That is due to validation. We have looked very critically at whether or not the patient still wants the operation and is still fit to have it, or whether alternative treatment should be offered. We have also found that patients have appeared on more than one list, so they have been double counted, and, over the last 18 months, there has been a very rigorous review of the nature of these waiting lists and whether patients are placed on them appropriately. Patients have also been exercising a choice, such as in terms of whether or not they still require their operation or treatment. It is interesting to note that one of the indicators that we collect is about cancelled operations and, when you look at the stories in the papers, one would imagine that the reasons for the vast majority of cancelled operations are because we are under huge pressure with emergencies and so on. However, although there are hospital cancellations, either because there has been an upsurge of emergencies or because there are no beds at all, and there are a number of those, then you find on the other hand that there are a large number—and I mean a large number—of cancelled operations.

The patient cancels because the waiting list slot is not convenient, they do not want it, or they do not turn up. So, to tackle that, we have instituted the partial booking scheme so that, in terms of new out-patients, we reduce the number of people who do not attend, which was at about 10 or 11 per cent. All trusts must do this, and those who have implemented partial booking, which gives patients a choice of when they want to attend, have found that the number of 'do not attends' has gone down to 5 per cent. We are extending that to follow-up appointments, where there is a greater number of patients coming through. That is currently at 12 per

hollol annerbyniol?

Ms Lloyd: Nid yw'n dderbyniol aros am 18 mis.

[97] **Irene James:** Hoffwn symud ymlaen yn awr at baragraffau 4.27 i 4.31, lle mae'n nodi bod chwarter o'r cleifion hynny a oedd wedi aros dros 18 mis ac y cysylltwyd â hwy fel rhan o gynllun yr ail gynnig wedi'u tynnu oddi ar y rhestr aros. Pam? Yr ydym wedi buddsoddi'n sylweddol mewn rheoli rhestrau aros, felly sut y gallwn wella cywirdeb y rhestr hon?

Ms Lloyd: Mae hynny oherwydd dilysiad. Yr ydym wedi edrych yn feirniadol iawn ar a yw'r claf eisiau'r llawdriniaeth o hyd ai peidio ac a yw'n ffit i'w chael, neu a ddylid cynnig triniaeth amgen. Yr ydym hefyd wedi canfod maent wedi'u cyfrif ddwywaith, a, dros y 18 mis diwethaf, bu adolygiad manwl iawn o natur y rhestrau aros hyn ac a yw cleifion yn cael eu rhoi arnynt yn briodol. Mae cleifion hefyd wedi bod yn ymarfer dewis, megis o ran a ydynt angen eu llawdriniaeth neu driniaeth o hyd ai peidio. Mae'n ddiddorol sylwi bod un o'r dangosyddion yr ydym yn ei gasglu ynghylch llawdriniaethau sydd wedi'u canslo a, phan edrychwch ar yr hanesion yn y papurau, byddai rhywun yn dychmygu mai'r rhesymau am y mwyafrif llethol o lawdriniaethau sydd wedi'u canslo yw ein bod dan bwysau enfawr gydag achosion brys ac ati. Fodd bynnag, er bod canslo yn yr ysbytai, naill ai oherwydd cynnydd cyflym mewn achosion brys neu oherwydd nad oes gwelyau o gwbl, ac mae nifer o achosion fel hynny, yna byddwch yn gweld ar y llaw arall bod llawer—ac yr wyf yn golygu llawer—o lawdriniaethau'n cael eu canslo.

Mae'r cleifion yn canslo oherwydd nad yw'r slot ar y rhestr aros yn gyfleus, nid ydynt am gael triniaeth, neu nid ydynt yn mynychu'r apwyntiad. Felly, er mwyn mynd i'r afael â hynny, yr ydym wedi sefydlu'r cynllun bwcio'n rhannol er mwyn i ni, o ran cleifion allanol newydd, ostwng nifer y bobl nad ydynt yn mynychu, sef tua 10 neu 11 y cant. Mae'n rhaid i bob ymddiriedolaeth wneud hyn ac mae'r rhai hynny sydd wedi gweithredu y drefn bwcio'n rhannol, sy'n gadael i gleifion ddewis pryd maent am fynychu, wedi canfod bod nifer yr achosion o 'heb fynychu' wedi gostwng i 5 y cant. Yr ydym yn ehangu hynny i apwyntiadau

cent, but we expect that to be reduced. It is a little more difficult to get partial booking for follow-up appointments at the moment because some of the patient administration systems are being changed and they need a solid base of information to do that. Nevertheless, progress is being made, but we are finding that that is a problem.

dilynol, lle mae mwy o gleifion yn dod trwodd. Mae hynny'n 12 y cant ar hyn o bryd, ond yr ydym yn disgwyl i hynny ostwng. Mae ychydig yn anoddach defnyddio'r drefn bwcio rhannol ar gyfer apwyntiadau dilynol ar hyn o bryd oherwydd bod rhai o'r systemau gweinyddu cleifion yn cael eu newid ac maent angen sylfaen wybodaeth gadarn i wneud hynny. Fodd bynnag, mae cynnydd yn cael ei wneud, ond yr ydym yn canfod bod hynny'n broblem.

On cancelled operations, we are also finding that patients are not fit in pre-assessment. A patient's condition, because of the morbidity, can vary from day to day. Sometimes, we find that quite a large number of patients per month are no longer fit for treatment and therefore have to be deferred. So, it is a complex system, but we are trying to ensure that those who have to manage the system—the clinicians and the managers together—have the right sort of information to help them to manage this large number of patients who need care and attention.

O ran canslo llawdriniaethau, yr ydym hefyd yn gweld nad yw cleifion yn ffit mewn cyn-asesiadau. Gall cyflwr claf, oherwydd y morbidrwydd, amrywio o ddydd i ddydd. O bryd i'w gilydd, yr ydym yn canfod nad yw llawer o gleifion y mis yn ddigon ffit bellach ar gyfer triniaeth ac felly mae'n rhaid eu gohirio. Felly, mae'n system gymhleth, ond yr ydym yn ceisio sicrhau bod gan y rhai hynny sy'n gorfod rheoli'r system—y clinigwyr a'r rheolwyr gyda'i gilydd—y math iawn o wybodaeth i'w cynorthwyo i reoli'r nifer mawr hwn o gleifion sydd angen gofal a sylw.

[98] **Irene James:** Do you think that the number of times that patients are contacted, while they are on the waiting list for a referral and other treatment, has any bearing on this?

[98] **Irene James:** A ydych yn credu bod gan y nifer o weithiau y cysylltir â chleifion, tra'u bod ar y rhestr aros i gael eu cyfeirio ac i gael triniaeth arall, unrhyw berthynas â hyn?

Ms Lloyd: Yes, I think so. Under the second offer scheme, patients are contacted at least

Ms Lloyd: Oes, yn fy marn i. O dan gynllun yr ail gynnig, cysylltir â chleifion o leiaf

twice. There are a large number of people in the second offer scheme from whom we have had no response. If they have been contacted twice by post and telephone—we insist that there is personal contact—and their GP has contacted them, then we must question whether or not that person still requires treatment. That judgment has to be made by the trusts. However, people will exercise their own decisions. Some people who have some fairly major surgery decisions in front of them—and we have found this from fairly anecdotal evidence coming through the second offer scheme—will say that they would like a little longer to think about it and discuss it with their consultant or GP, which is a pressure for us because they are still on the list. However, you must ensure that people are confident about the outcome of their care and that that is what they want.

ddwywaith. Mae llawer o bobl ar gynllun yr ail gynnig nad ydym wedi derbyn ymateb ganddynt. Os ydym wedi cysylltu â hwy ddwywaith drwy'r post ac ar y ffôn—yr ydym yn mynnu bod cysylltiad personol—a bod eu meddyg teulu wedi cysylltu â hwy, yna mae'n rhaid i ni ystyried a yw'r person angen triniaeth o hyd ai peidio. Penderfyniad yr ymddiriedolaeth fydd hynny. Fodd bynnag, bydd pobl yn penderfynu dros eu hunain. Bydd rhai unigolion sy'n gorfod gwneud penderfyniadau am lawdriniaethau eithaf mawr—ac yr ydym wedi canfod hyn o dystiolaeth gymharol anecdotaidd sy'n dod drwy gynllun yr ail gynnig—yn dweud eu bod am gael rhywfaint mwy o amser i feddwl am y peth a thrafod y mater gyda'u meddyg ymgynghorol neu feddyg teulu, sy'n ein rhoi dan bwysau oherwydd eu bod ar y rhestr o hyd. Fodd bynnag, mae'n rhaid i chi sicrhau bod pobl yn hyderus am ganlyniad eu gofal ac mai dyna y maent ei eisiau.

[99] **Jocelyn Davies:** On the issue of the cancelled operations, I am sure that all of us as Assembly Members have been contacted by people who have had their operations cancelled—sometimes on the day of the operation. Some operations have been cancelled after people have had their pre-meds. You said that some of this was down to the patient; what percentage of cancelled operations is down to the patient rather than any other factor?

[99] **Jocelyn Davies:** Ar y mater o ganslo llawdriniaethau, yr wyf yn siŵr ein bod i gyd fel Aelodau Cynulliad wedi clywed gan rywun y mae eu llawdriniaeth wedi'i chanslo—ar ddiwrnod y llawdriniaeth o bryd i'w gilydd. Mae rhai llawdriniaethau wedi'u canslo ar ôl i bobl gael eu rhagbrofion meddygol. Dywedasoch fod hyn yn rhannol oherwydd y claf; pa ganran o lawdriniaethau sy'n cael eu canslo sydd o ganlyniad i'r cleifion yn hytrach nag unrhyw ffactor arall?

Ms Lloyd: Can I give you the number,

Ms Lloyd: A gaf fi roi'r nifer i chi,

because I do not know that I can add up that fast?

oherwydd nid wyf yn gwybod a allaf adio mor gyflym â hynny?

[100] **Jocelyn Davies:** Yes.

[100] **Jocelyn Davies:** Iawn.

Ms Lloyd: Of the cancelled operations, there were 444 people who were clinically unfit, or whose operations were not necessary—and I have compared November 2002 with November 2004. On hospital cancellations, when there were no beds or increased emergencies—these terrible incidences where you have had your pre-med, you wake up and nothing has happened—there were 400 in November 2004. There were 160 cancellations because of lists overrunning and 350 because of staff absences—people going off sick and other reasons. There were 453 cases of patients cancelling, unwanted operations and 'did not attends', and there were 782 appointments that were 'inconvenient'.

Ms Lloyd: O'r llawdriniaethau a gafodd eu canslo, yr oedd 444 o bobl nad oeddynt yn glinigol ffit, neu nid oedd angen llawdriniaethau arnynt—ac yr wyf wedi cymharu Tachwedd 2002 gyda Thachwedd 2004. O ran canslo gan yr ysbytai, pan nad oedd gwelyau neu o ganlyniad i gynnydd mewn achosion brys—y digwyddiadau ofnadwy hyn pan yr ydych wedi cael eich rhagbrofion meddygol, ac yn deffro a dim byd wedi digwydd—yr oedd 400 yn Nhachwedd 2004. Yr oedd 160 achos o ganslo oherwydd bod rhestrau yn gor-redeg a 350 oherwydd absenoldebau staff—pobl i ffwrdd yn sâl a rhesymau eraill. Yr oedd 453 achos o gleifion yn canslo, llawdriniaethau nad oedd eu heisiau ac apwyntiadau na fynychwyd, ac yr oedd 782 o apwyntiadau a oedd yn 'anghyfleus'.

There is quite a balance. From the outside you would think that the reason was that there were no beds—that is only a small proportion. On all counts, the situation has improved considerably since November 2002. Certainly, the whole issue of patients being clinically unfit or staff not being available has been tightened up enormously. Clinicians must now give a fair degree of notice of when they will not be available. We

Mae tipyn o gydbwysedd. O'r tu allan byddech yn meddwl mai diffyg gwelyau oedd y rheswm—cyfran fach yn unig yw honno. Ar bob cyfrif, mae'r sefyllfa wedi gwella'n sylweddol ers Tachwedd 2002. Yn sicr, mae'r holl broblem o gael cleifion nad ydynt yn glinigol ffit neu bod dim staff ar gael wedi gwella'n sylweddol. Mae'n rhaid i glinigwyr yn awr roi cryn dipyn o rybudd i ddweud pryd na fyddant ar gael. Yr ydym yn monitro

monitor theatre staff sickness, and you have taken an Audit Committee report on that issue. We are ensuring that pre-operative assessment is done effectively, to try to reduce those blocks in the system. If people are unfit and they are scheduled for treatment, that is 440 slots a month being wasted, and with the volume of care that we provide, we cannot afford for that to happen.

salwch staff theatr, ac yr ydych wedi cael adroddiad Pwyllgor Archwilio ar y mater hwnnw. Yr ydym yn sicrhau bod yr asesiadau cyn llawdriniaeth yn cael eu gwneud yn effeithiol, i geisio gostwng y rhwystrau hynny yn y system. Os yw pobl heb fod yn ffit a'u bod i fod i gael triniaeth, mae hynny'n gwastraffu 440 slot y mis, a chyda'r holl ofal a ddarparwn, ni allwn fforddio gadael i hynny ddigwydd.

[101] **Jocelyn Davies:** If you are quite elderly when you go on the waiting list—I am from Gwent, where you could be waiting for two or three years—by the time you get to the top, you are that much older, and might not be fit. Therefore, it is the length of the waiting list that has affected your fitness.

[101] **Jocelyn Davies:** Os ydych yn eithaf hen pan fo'ch enw'n cael ei roi ar y rhestr aros—yr wyf fi o Went, lle gallech fod yn aros am ddwy neu dair blynedd—erbyn i chi gyrraedd y brig, yr ydych gymaint â hynny'n hŷn, ac efallai nad ydych yn ffit. Felly, hyd y rhestr aros sydd wedi effeithio ar eich ffitrwydd.

Ms Lloyd: It is not necessarily the length of the waiting list that is responsible. We know that once people reach the age of 75 that their clinical condition varies quite considerably, because it is not usually just one thing that is wrong with them. Their clinical condition can vary from week to week. We must ensure that the pre-assessment is accurate and of consequence.

Ms Lloyd: Nid hyd y rhestr aros sy'n gyfrifol o reidrwydd. Gwyddom fod cyflwr clinigol pobl yn amrywio'n sylweddol ar ôl cyrraedd 75 oed, oherwydd nid dim ond un peth sy'n bod arnynt fel arfer. Gall eu cyflwr clinigol amrywio o wythnos i wythnos. Rhaid i ni sicrhau bod y cyn-asesiad yn gywir ac yn bwysig.

[102] **Jocelyn Davies:** I have one more question on that issue. Do you know how many people turn to the private sector while they are waiting? Would you count those as people who no longer want treatment?

[102] **Jocelyn Davies:** Mae gennyf un cwestiwn arall ar y mater hwnnw. A wyddoch faint o bobl sy'n troi at y sector preifat tra'u bod yn aros? A fyddech yn cyfrif y rheini fel pobl nad oes arnynt angen

triniaeth mwyach?

Ms Lloyd: No, I am afraid I do not know. I cannot answer that question.

Ms Lloyd: Na, ni wn y mae arnaf ofn. Ni allaf ateb y cwestiwn hwnnw.

[103] **Alun Cairns:** With your permission, Chair, may I go back to the issue of people who are clinically unfit? One example quoted in the report is a patient who suffered a stroke while waiting for treatment; the wait for treatment could have contributed to that stroke, because of high blood pressure, excess stress and so on. I am a bit disturbed that this issue was almost dismissed, because the waiting time for an operation is a major factor in terms of people's general health, in causing other illnesses and ailments, and in preventing them from having the operation. It must be something significant, rather than a cold or flu or something else that is around at the time.

[103] **Alun Cairns:** Gyda'ch caniatâd, Gadeirydd, a gaf fi ddychwelyd at y mater o bobl nad ydynt yn glinigol ffit? Un enghraifft a ddyfynnir yn yr adroddiad yw claf a gafodd strôc tra'n aros am driniaeth; gallai'r aros am driniaeth fod wedi cyfrannu at y strôc honno, oherwydd pwysedd gwaed uchel, straen gormodol ac yn y blaen. Yr wyf ychydig yn bryderus i'r mater hwn bron â chael ei anwybyddu, oherwydd mae'r amser aros am lawdriniaeth yn ffactor pwysig o ran iechyd cyffredinol pobl, o ran achosi afiechydon ac anhwylderau eraill, ac o ran eu rhwystro rhag cael y llawdriniaeth. Rhaid iddo fod yn rhywbeth difrifol, yn hytrach nag annwyd neu'r ffliw neu rywbeth arall sydd o gwmpas ar y pryd.

Ms Lloyd: That is not what I was implying. You asked me a previous question about the consequences of waiting on the clinical condition of patients, which I acknowledged from the research that has been done. It is not the sole reason, but it is a reason.

Ms Lloyd: Nid dyna'r oeddwn yn ei awgrymu. Bu i chi ofyn cwestiwn blaenorol i mi am effeithiau aros ar gyflwr clinigol cleifion, y bu i mi ei ateb o'r ymchwil sydd wedi ei chynnal. Nid dyna'r unig reswm, ond mae yn rheswm.

[104] **Janet Davies:** Thank you. We now turn to the second volume, starting with paragraphs 2.4, 2.5 and 2.12, which are on pages 4 and 7, and are concerned with

[104] **Janet Davies:** Diolch. Trown yn awr at yr ail gyfrol, gan ddechrau gyda pharagraffau 2.4, 2.5 a 2.12, sydd ar dudalennau 4 a 7, ac sy'n ymwneud â mynd i'r afael ag amseroedd

tackling out-patient waiting times. The report points out in these paragraphs that long waiting times influence GP referrals—because of long waiting times, GPs put people on the list sooner than needed. Those practices can fill a waiting list with patients who technically should not be there, or leave some routine patients falling further down the list, facing a very long wait, which we have already talked about. What steps do you propose to take to avoid this vicious circle?

aros cleifion allanol. Mae'r adroddiad yn tynnu sylw yn y paragraffau hyn at y ffaith bod amseroedd aros hir yn dylanwadu ar gyfeiriadau meddygon teulu—oherwydd amseroedd aros hir, mae meddygon teulu yn rhoi pobl ar y rhestr yn gynt na'r angen. Gall y practisau hynny lenwi rhestr aros gyda chleifion na ddylent fod ar y rhestr mewn gwirionedd, neu adael i rai cleifion sy'n cael mân-driniaethau gwympo'n is ar y rhestr, gan wynebu arhosiad hir iawn, yr ydym eisoes wedi ei drafod. Pa gamau yr ydych yn cynnig eu cymryd i osgoi'r cylch dieflig hwn?

Ms Lloyd: We are taking steps to avoid this practice by getting shorter waiting lists, hence the drop to 12 months for out-patients by 2006. We are also implementing alternatives to which GPs can refer, such as the GP specialists and the back-pain teams and so on. We try to ensure that there is an alternative for GPs to which they might refer their patients. This seems to be quite successful at the moment.

Ms Lloyd: Yr ydym yn cymryd camau i osgoi'r arfer hwn drwy gael rhestrau aros byrrach, ac felly'r lleihad i 12 mis ar gyfer cleifion allanol erbyn 2006. Yr ydym hefyd yn gweithredu opsiynau eraill y gall meddygon teulu gyfeirio cleifion atynt, megis y meddygon teulu arbenigol a'r timau poen cefn ac ati. Ceisiwn sicrhau bod gan feddygon teulu opsiwn amgen y gallant gyfeirio eu cleifion ato. Mae'n ymddangos bod hyn yn eithaf llwyddiannus ar hyn o bryd.

[105] **Janet Davies:** Do you have any estimate of the impact of long waiting times on the primary care workload?

[105] **Janet Davies:** A oes gennych unrhyw amcangyfrif o effaith amseroedd aros hir ar lwyth gwaith gofal sylfaenol?

Ms Lloyd: As a consequence of this report, we are asking local health boards to try to estimate that impact, given the new general medical services contract, and to estimate the

Ms Lloyd: O ganlyniad i'r adroddiad hwn, yr ydym yn gofyn i fyrddau iechyd lleol geisio amcangyfrif yr effaith honno, o ystyried y contract gwasanaethau meddygol cyffredinol

consequences of these repeat visits to general practice, and whether or not there is a correlation between the length of the waiting time and the number of times people come back. We have asked them to undertake that work for us.

newydd, ac amcangyfrif canlyniadau'r ymweliadau lluosog hyn i ymarfer cyffredinol, ac a oes cydberthynas ai peidio rhwng hyd yr amser aros a sawl gwaith y mae pobl yn dod yn ôl. Yr ydym wedi gofyn iddynt ymgymryd â'r gwaith hwnnw ar ein rhan.

[106] **Mick Bates:** Paragraphs 2.7 and 2.8 state that patient behaviour affects the efficiency of out-patient departments through patients failing to attend, which you have already mentioned. It is worth recording the figures in those paragraphs—341,000 patients at a total cost of £37 million—which are significant. You have mentioned a reduction in this, but these figures are immensely significant. What are you doing, therefore, to reduce the impact of this wastage in the system?

[106] **Mick Bates:** Dywed paragraffau 2.7 a 2.8 bod ymddygiad cleifion yn effeithio ar effeithlonrwydd adrannau cleifion allanol oherwydd bod cleifion yn methu â mynychu apwyntiadau, sydd eisoes wedi ei grybwyll gennych. Mae'n werth cofnodi'r ffigurau yn y paragraffau hynny—341,000 o gleifion ar gyfanswm cost o £37 miliwn—sy'n sylweddol. Yr ydych wedi crybwyll lleihad yn hyn, ond mae'r ffigurau hyn yn hynod arwyddocaol. Beth yr ydych yn ei wneud, felly, i leihau effaith y gwastraff hwn yn y system?

Ms Lloyd: Paragraph 2.7 states that consultants have traditionally overbooked their clinics to cover the anticipated 'did not attend' rate. That is true—they have traditionally double booked patients, because there is a known 'did not attend' rate in every hospital throughout the United Kingdom, and there has been a traditional view that you therefore overbook. That also leads to huge frustrations among patients, because they find that they have come for a 9 a.m. appointment, and four other people have a 9 a.m. appointment. So, although that culture and behaviour will continue, and it gets a bit

Ms Lloyd: Dywed paragraff 2.7 fod meddygon ymgynghorol yn draddodiadol wedi gorfwcio eu clinigau i gwmpasu'r gyfradd 'heb fynychu' ragweledig. Mae hynny'n wir—yn draddodiadol maent wedi rhoi'r un apwyntiad i fwy nag un claf, oherwydd bod cyfradd 'heb fynychu' hysbys ym mhob ysbyty ledled y Deyrnas Unedig, a'r farn draddodiadol yw eich bod, felly, yn gorfwcio. Mae hynny hefyd yn achosi rhwystredigaeth enfawr ymysg cleifion, oherwydd maent yn canfod eu bod wedi dod i apwyntiad 9 a.m., a bod gan bedwar unigolyn arall apwyntiad 9 a.m. Felly, er y bydd y

more difficult to manage if we start to reduce these 'did not attend' rates, we have to change that behaviour at the same time. However, we have found that our partial booking schemes for out-patients, particularly with regard to new out-patients, have been successful in halving the 'did not attend' rate. Also, those trusts that have a sufficiently robust system, and which have instituted follow-ups, have also started to reduce their rate, but not by quite as much.

diwylliant a'r ymddygiad hwnnw'n parhau, ac mae'n mynd ychydig yn anoddach i'w reoli os ydym yn dechrau lleihau'r cyfraddau 'heb fynychu' hynny, mae'n rhaid i ni newid yr ymddygiad hwnnw ar yr un pryd. Fodd bynnag, yr ydym wedi canfod bod ein cynlluniau bwcio'n rhannol ar gyfer cleifion allanol, yn enwedig mewn perthynas â chleifion allanol newydd, wedi llwyddo i haneru'r gyfradd 'heb fynychu'. Yn ogystal, mae'r ymddiriedolaethau hynny sy'n meddu ar system ddigon cadarn, ac sydd wedi gweithredu camau dilynol, hefyd wedi dechrau lleihau eu cyfradd, ond ddim i'r un graddau.

We are also looking at the reasons for follow-up appointments, which are variable throughout the United Kingdom, to see whether or not, given the extended-scope practitioners, and given alternatives to having to come back to see a consultant, we are able to redirect some of the follow-up appointments, so that more new out-patient appointments can be given. We know that, given clinical governance requirements and improved standards, both the clinicians and the patients now anticipate having a longer out-patient appointment, and that there will be a longer interview between the clinicians and their clients. That is happening in general practice too. So we have to account for that in trying to balance the workload of consultants and their teams in clinics. That is why many clinicians have a whole multidisciplinary team working with them, to ensure that they are able to keep up the number of new out-

Yr ydym hefyd yn edrych ar y rhesymau dros apwyntiadau dilynol, sy'n amrywio ledled y Deyrnas Unedig, i weld, o ystyried yr ymarferwyr cwmpas estynedig, ac o ystyried yr opsiynau eraill heblaw gorfod dychwelyd i weld meddyg ymgynghorol, a allwn ailgyfeirio rhai o'r apwyntiadau dilynol ai peidio, fel y gellir rhoi mwy o apwyntiadau cleifion allanol newydd. Gwyddom, o gofio gofynion llywodraethu clinigol a safonau gwell, bod y clinigwyr a'r cleifion bellach yn disgwyl cael apwyntiad claf allanol hwy, ac y bydd cyfweliad hwy rhwng y clinigwyr a'u cleientiaid. Mae hynny'n digwydd ym maes ymarfer cyffredinol hefyd. Felly rhaid i ni ystyried hynny wrth geisio cydbwyso llwyth gwaith meddygon ymgynghorol a'u timau mewn clinigau. Dyna pam y mae gan gynifer o glinigwyr dîm amlddisgyblaeth cyfan yn gweithio gyda hwy, i sicrhau eu bod yn gallu cadw nifer y cleifion allanol newydd y maent

patients that they can see, by using appropriate alternative practitioners, as junior doctors do not now devote as much time to this as they did in the past. However, we are putting several proposals into place for this. England has now gone on to full booking, which means that general practitioners book patients straight onto lists, and that is the way that we will be going too.

yn eu gweld yn uchel, drwy ddefnyddio ymarferwyr amgen priodol, oherwydd nad yw meddygon dan hyfforddiant yn treulio cymaint o amser ar hyn ag yr oeddynt yn y gorffennol. Fodd bynnag, yr ydym yn rhoi sawl cynnig ar waith ar gyfer hyn. Mae Lloegr wedi troi at system bwcio'n llawn, sy'n golygu bod meddygon teulu yn rhoi cleifion ar restrau ar unwaith, a dyna'r trywydd y byddwn ni yn ei ddilyn hefyd.

[107] **Mick Bates:** Thank you for that rather lengthy answer. It was in your final sentence that I felt a sense of urgency and priority in terms of how to reduce this 10 to 12 per cent 'did not attend' rate. Am I correct then, from your answer, in saying that that is your number one priority—that GPs refer directly?

[107] **Mick Bates:** Diolch am yr ateb eithaf hir hwnnw. Yr oedd yn eich brawddeg olaf, yn fy marn i, ymdeimlad o frys a blaenoriaeth o ran sut i leihau'r gyfradd 'heb fynychu' 10 i 12 y cant hon. A ydwyf yn gywir felly, o'ch ateb, i ddweud mai dyma yw eich prif flaenoriaeth—bod meddygon teulu yn cyfeirio'n uniongyrchol?

Ms Lloyd: I think that it would be. We have found in England that that has been most effective in terms of reducing the number of 'did not attends' but, also, England started with partial booking and is now just going to full booking, and that is where we want to go too.

Ms Lloyd: Credaf mai dyna fyddai ein prif flaenoriaeth. Yr ydym wedi canfod yn Lloegr bod hynny wedi bod yn hynod effeithiol o ran lleihau nifer y cleifion a oedd 'heb fynychu' ond, hefyd, dechreuodd Lloegr gyda'r drefn bwcio'n rhannol ac mae'n troi at drefn bwcio'n llawn ar hyn o bryd, a dyna beth yr ydym am ei wneud hefyd.

[108] **Mick Bates:** To take you back, you said that that this figure is pretty constant over the years. It seems that there has been a lack of prioritisation of the reasons in order to reduce this figure and make significant savings, given that the cost is £37 million.

[108] **Mick Bates:** I fynd â chi yn ôl, dywedasoch fod y ffigur hwn yn eithaf cyson dros y blynyddoedd. Mae'n ymddangos na chafodd y rhesymau eu blaenoriaethu ddigon er mwyn lleihau'r ffigur hwn a gwneud arbedion sylweddol, o gofio fod y gost yn £37 miliwn.

Ms Lloyd: The figure has not been constant over the years. In 2001, the new 'did not attend' figure was 11 per cent: it is now 7.5 per cent. Of course we must reduce this figure, which is why these different initiatives have been instituted. That is why we put in partial booking, because we knew of the success achieved in reducing the number of people who did not attend.

Ms Lloyd: Nid yw'r ffigur wedi bod yn gyson dros y blynyddoedd. Yn 2001, yr oedd y ffigur 'heb fynychu' newydd yn 11 y cant; mae bellach yn 7.5 y cant. Wrth gwrs mae'n rhaid i ni leihau'r ffigur hwn, a dyna pam y mae'r mentrau gwahanol hyn wedi eu rhoi ar waith. Dyna pam y bu i ni weithredu'r drefn bwcio'n rhannol, oherwydd yr oeddem yn gwybod am y llwyddiant a gafwyd wrth leihau nifer y bobl a oedd heb fynychu.

[109] **Mick Bates:** These figures show that the NHS is not very customer friendly, do they not? You are changing the system, but what about the interface with the patient? What are you doing to make the patient feel more comfortable with the process?

[109] **Mick Bates:** Mae'r ffigurau hyn yn dangos nad yw'r GIG yn ystyriol iawn o gwsmeriaid, onid ydynt? Yr ydych yn newid y system, ond beth am y cydgysylltiad gyda'r claf? Beth yr ydych yn ei wneud i wneud i'r claf deimlo'n fwy cysurus gyda'r broses?

Ms Lloyd: That is the beauty of partial booking. When I implemented partial booking in my trust, five years ago, one of the main issues was to construct out-patient appointments and the running of the clinic around the needs of the people who we were seeing. So, we employed a set of patient advocates—we were among the first in the country to do so—and they were important in gathering, per specialty, a view from a range of patients or their carers on what would make, between the clinician and the patient, best sense in terms of the client group that they were serving. Traditionally, out-patient clinics have been held between 9 a.m. and 12 p.m., 1 p.m. and whatever, and some people

Ms Lloyd: Dyna fantais y drefn bwcio'n rhannol. Pan weithredais y drefn bwcio'n rhannol yn fy ymddiriedolaeth, bum mlynedd yn ôl, un o'r prif faterion oedd sicrhau bod apwyntiadau cleifion allanol a'r ffordd y rhedwyd y clinig yn seiliedig ar anghenion y bobl yr oeddem yn eu gweld. Felly, bu i ni gyflogi grŵp o eiriolwyr cleifion—yr oeddem ymhlith y cyntaf yn y wlad i wneud hynny—ac yr oeddent yn bwysig o ran casglu, yn ôl arbenigedd, safbwyntiau amrywiaeth o gleifion neu eu gofalwyr ar beth a fyddai'n gwneud, rhwng y clinigwr a'r claf, y synnwyr gorau o ran y grŵp cleientiaid yr oeddynt yn eu gwasanaethu. Yn draddodiadol, cynhaliwyd clinigau allanol

cannot get there, which is why they do not attend, or the ambulance takes longer than that to get there and you cannot use a hospital car service before 8 a.m. when your appointment is at 8 a.m. somewhere else. Partial booking has, therefore, helped us to be much more flexible, and it gives patients, within six weeks of when they are going to see somebody, an option of when it would be convenient for them to be seen, and it focuses on the needs and lifestyles of the patients.

rhwng 9 a.m. a 12 p.m., 1 p.m. a beth bynnag, ac ni all rai pobl gyrraedd yno, a dyna pam nad ydynt yn mynychu, neu mae'r ambiwlans yn cymryd yn hwy na hynny i gyrraedd yno ac ni allwch ddefnyddio gwasanaeth car ysbyty cyn 8 a.m. os yw'ch apwyntiad am 8 a.m. yn rhywle arall. Mae'r drefn bwcio'n rhannol, felly, wedi ein helpu i fod yn llawer mwy hyblyg, ac mae'n rhoi opsiwn i gleifion, o fewn chwe wythnos i'r dyddiad y byddant yn gweld rhywun, i ddweud pryd y byddai'n gyfleus iddynt gael eu gweld, ac mae'n canolbwyntio ar anghenion a ffordd o fyw cleifion.

[110] **Mick Bates:** Thank you. I have just one more question on this issue. I am still grappling with the concept that, five years ago, you implemented this system in whatever trust it was, yet that is not the case throughout Wales, is it?

[110] **Mick Bates:** Diolch. Mae gennyf un cwestiwn arall ar y mater hwn. Yr wyf yn dal i geisio dygymod â'r cysyniad eich bod, bum mlynedd yn ôl, wedi gweithredu'r system hon ym mha bynnag ymddiriedolaeth yr ydoedd, ond eto ni wnaethpwyd hynny ledled Cymru?

Ms Lloyd: No.

Ms Lloyd: Na.

[111] **Mick Bates:** So, why, after this time, do we not have a more robust system of reducing 'did not attends'?

[111] **Mick Bates:** Felly, pam, ar ôl yr amser hwn, nad oes gennym system fwy cadarn o leihau cyfraddau 'heb fynychu'?

Ms Lloyd: I think that we have that now. That is a massive improvement that means that many patients are now turning up for their appointments. Remember, the number of out-patients going through the system has

Ms Lloyd: Credaf fod gennym y system honno yn awr. Mae hynny'n welliant enfawr sy'n golygu bod llawer o gleifion bellach yn mynychu eu hapwyntiadau. Cofiwch, mae nifer y cleifion allanol yn y system wedi

risen hugely since 2001. That is an improvement, so there has been a focus on it, although we need to roll it out quickly.

cynyddu'n aruthrol ers 2001. Mae hynny'n welliant, felly bu ffocws arno, er bod angen i ni ei roi ar waith fesul cam yn gyflym.

[112] **Mick Bates:** Right, but what about the collection of information? Paragraphs 2.6 and 2.7, I believe, state that there are weaknesses in the recording system. Earlier, you told me that the data collection systems were all good, yet here we are identifying weaknesses in the recording system. What plans do you have to develop a more sophisticated measure to address the issue?

[112] **Mick Bates:** O'r gorau, ond beth am y gwaith o gasglu gwybodaeth? Dywed paragraffau 2.6 a 2.7, yn fy nhyb i, bod gwendidau yn y system gofnodi. Yn gynharach, dywedasoch wrthyf fod y systemau casglu data i gyd yn dda, ond eto dyma ni yn nodi gwendidau yn y system gofnodi. Pa gynlluniau sydd gennych i ddatblygu mesur mwy soffistigedig i fynd i'r afael â'r mater hwn?

Ms Lloyd: This is about the recording of activity, is it not?

Ms Lloyd: Mae hyn yn ymwneud â chofnodi gweithgarwch, onid ydyw?

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

[113] **Mick Bates:** Ydy.

Ms Lloyd: The recording of activity, before it ceased, was really not reflecting the modern practice prevalent in Welsh hospitals at all. It did not record such things as ward attenders, people coming in for small day-case procedures, or the work being done by the multi-disciplinary team—they were not being recorded properly. Therefore, we ceased to use that system, and, in the meantime, we have been working hard with the trusts and the information service to ensure that, when the information gathering system is relaunched in the next few months, we are able to gather all the information to

Ms Lloyd: Cyn iddo ddod i ben, nid oedd cofnodi gweithgarwch mewn gwirionedd yn adlewyrchu'r arferion modern a oedd yn gyffredin yn ysbytai Cymru o gwbl. Nid oedd yn cofnodi pethau megis mynychwyr wardiau, pobl yn dod am fân-driniaethau fel achosion dydd, neu'r gwaith a oedd yn cael ei wneud gan y tîm amlddisgyblaeth—nid oeddent yn cael eu cofnodi'n gywir. Felly, bu i ni roi'r gorau i ddefnyddio'r system honno, ac, yn y cyfamser, yr ydym wedi bod yn gweithio'n galed gyda'r ymddiriedolaethau a'r gwasanaeth gwybodaeth i sicrhau ein bod yn gallu casglu'r holl wybodaeth i

accurately reflect the activity being carried out in the Welsh health system. Now, that has taken longer than I wished, because the data systems have improved. I do not know or think that they are perfect or even very good yet, because some of these things are still not in the system to give us a very accurate picture of what we know is going on out there.

adlewyrchu'n gywir y gweithgarwch sy'n cael ei gyflawni yn system iechyd Cymru, pan gaiff y system casglu gwybodaeth ei hail-lansio yn ystod y misoedd nesaf. Mae hynny wedi cymryd yn hwy nag y byddwn wedi dymuno, oherwydd bod y systemau data wedi gwella. Nid wyf yn gwybod neu'n credu eu bod yn berffaith neu hyd yn oed yn dda iawn eto, oherwydd nid yw rhai o'r pethau hyn yn y system o hyd i roi i ni ddarlun manwl gywir o'r hyn y gwyddom sy'n digwydd yn y maes.

[114] **Mick Bates:** To return to this issue, earlier, you actually told me that the data systems were there and that you could ensure that data went through the system. Now you are telling me that they are not in place to make sure that we have accurate information about this activity.

[114] **Mick Bates:** I ddychwelyd at y mater hwn, yn gynharach, dywedasoch wrthyf mewn gwirionedd fod y systemau data yn eu lle ac y gallech sicrhau bod data'n mynd drwy'r system. Yn awr yr ydych yn dweud wrthyf nad ydynt ar waith i sicrhau bod gennym wybodaeth gywir am y gweithgarwch hwn.

Ms Lloyd: On activity, no. We have acknowledged that, which is why we have stopped gathering it as we did.

Ms Lloyd: Am weithgarwch, nac oes. Yr ydym wedi cydnabod hynny, a dyna pam yr ydym wedi rhoi'r gorau i gasglu'r wybodaeth fel y gwnaethom.

[115] **Mick Bates:** Therefore, who is responsible for that negligence, and for making sure that the data was there? We have known about this for some years.

[115] **Mick Bates:** Felly, pwy sy'n gyfrifol am yr esgeulustod hwnnw, ac am sicrhau bod y data ar gael? Yr ydym wedi gwybod am hyn am rai blynyddoedd.

Ms Lloyd: I do not think that I would be as unkind as to call it negligence. The information gathering system in Wales did

Ms Lloyd: Ni chredaf y byddwn mor angharedig â'i alw'n esgeulustod. Ni lwyddodd y system casglu data yng Nghymru

not keep pace with what was actually happening on the ground. We need to ensure that you and the clinicians who manage these systems have that accurate information. It is another step down the track.

i gadw i fyny â'r hyn a oedd yn digwydd yn y maes mewn gwirionedd. Mae angen i ni sicrhau bod gennych chi a'r clinigwyr sy'n rheoli'r systemau hyn y wybodaeth gywir honno. Mae'n gam arall ar hyd y ffordd.

[116] **Mick Bates:** With great respect, I accept that the time factor is important, but we have known for some time that the data collection on many levels is poor, particularly at the interfaces between different levels of management. Are you saying that that problem is addressed so that we will see 'did not attend' rates fall further?

[116] **Mick Bates:** Gyda phob parch, derbyniaf fod y ffactor amser yn bwysig, ond yr ydym wedi gwybod ers peth amser bod y gwaith casglu data ar sawl lefel yn wael, yn enwedig ar y rhyngwynebau rhwng lefelau rheoli gwahanol. A ydych yn dweud bod y broblem wedi ei datrys ac felly y byddwn yn gweld cyfraddau 'heb fynychu' yn lleihau ymhellach?

Ms Lloyd: I do not know whether or not it will affect 'did not attend' rates, but you will certainly know what the activity is, going through the hospitals.

Ms Lloyd: Ni wn a fydd yn effeithio ar gyfraddau 'heb fynychu' ai peidio, ond byddwch yn sicr yn gwybod beth yw'r gweithgarwch, o fynd drwy'r ysbytai.

[117] **Mick Bates:** Could you be more specific?

[117] **Mick Bates:** A allech fod yn fwy penodol?

Ms Lloyd: I do not think that the gathering of this activity will affect 'did not attend' rates, but it will, at least, allow us to see how the shape of the service and its provision is changing. The activity data largely showed us how many consultant episodes there were. It was not showing that consultants had appropriately handed on care to a vast suite of alternative practitioners. The organisations gathering it, such as Bro Morgannwg and

Ms Lloyd: Ni chredaf y bydd casglu'r gweithgarwch hwn yn effeithio ar gyfraddau 'heb fynychu', ond bydd, o leiaf, yn ein galluogi i weld sut mae siâp y gwasanaeth a'i ddarpariaeth yn newid. Dangosodd y data gweithgarwch i ni sawl cyfnod gofal meddyg ymgynghorol a fu i raddau helaeth. Nid oedd yn dangos bod meddygon ymgynghorol wedi trosglwyddo gofal yn briodol i ystod eang o ymarferwyr amgen. Ni ellid cymharu tebyg â

others, could not be compared like with like. When we have looked at the changing roles of the workforce within the NHS in Wales, we have found that there are already 100 new roles. There is no correlation between what is undertaken by those different roles, which is why we are bringing the title of the roles down to about 10, in terms of the Agenda for Change. They were all being named differently, so you could not look at a comparative analysis of what an individual practitioner called ‘x’ in one trust was doing compared with ‘y’ in another, because they were known by different names. Were they doing the same? Could they be accredited in the same regime? It sounds like ‘Why have you not got on with this?’, but these things had to be sorted out before we could produce accurate information, which would mean something to people.

thebyg y sefydliadau sydd yn casglu’r gweithgarwch, megis Bro Morgannwg ac eraill. Pan yr ydym wedi edrych ar swyddogaethau newidiol y gweithlu yn y GIG yng Nghymru, yr ydym wedi canfod bod 100 o swyddogaethau newydd eisoes. Nid oes cydberthynas rhwng yr hyn a gyflawnir gan y swyddogaethau gwahanol hynny, a dyna pam yr ydym yn lleihau teitlau’r swyddogaethau i tua 10, o ran yr Agenda ar gyfer Newid. Yr oeddynt oll yn cael eu henwi’n wahanol, felly ni allech edrych ar ddadansoddiad cymharol o beth yr oedd ymarferydd unigol o’r enw ‘x’ mewn un ymddiriedolaeth yn ei wneud o gymharu ag ‘y’ mewn ymddiriedolaeth arall, oherwydd eu bod yn cael eu hadnabod gan enwau gwahanol. A oeddynt yn gwneud yr un fath? A ellid eu hachredu o dan yr un drefn? Mae’n ymddangos fel ‘Pam nad ydych wedi bwrw iddi gyda hyn?’, ond yr oedd yn rhaid cael trefn ar y pethau hyn cyn i ni allu cynhyrchu gwybodaeth gywir, a fyddai’n golygu rhywbeth i bobl.

[118] **Mick Bates:** I wonder, Chair, in view of what we have just heard about the interfaces between 10 levels, whether we could have further information about it? The data collection is crucial. Activity rates are a separate issue, but, to me, it seems that the interfaces have not existed. There has been time to create them to reduce waiting times but, as yet, that has not been done. I would greatly appreciate having good information about the interfaces.

[118] **Mick Bates:** Ys gwn i, Gadeirydd, o ystyried yr hyn yr ydym newydd ei glywed am y rhyngwynebau rhwng 10 lefel, a allem gael gwybodaeth bellach amdano? Mae’r dreth casglu data yn hollbwysig. Mae cyfraddau gweithgarwch yn fater ar wahân, ond, i mi, mae’n ymddangos nad yw’r rhyngwynebau wedi bodoli. Bu amser i’w creu i leihau amseroedd aros ond, hyd yn hyn, nid yw hynny wedi digwydd. Byddwn yn gwerthfawrogi’n fawr cael gwybodaeth dda am y rhyngwynebau.

Ms Lloyd: Yes.

Ms Lloyd: Iawn.

[119] **Jocelyn Davies:** On a point of clarification on the 'did not attend' records that you have, the number of people who do not turn up for their appointments is quite alarming. Are you sure that they are people who did not turn up, or is there an administrative issue here or any inefficiency in the system that records such matters? Last week, for example, someone came to see me after having received four letters offering different dates for appointments with the same consultant. He cancelled three of the appointments, but, if he had not done so, it would have appeared that he had not turned up. I wonder how much inefficiency there is in the system. You mentioned some of the reasons why people do not turn up. How do you know these reasons? Do you assume that these are the reasons, or have you done some sort of evidence gathering where you have asked people why they did not attend?

[119] **Jocelyn Davies:** I fod yn eglur am y cofnodion 'heb fynychu' sydd gennych, mae nifer y bobl nad ydynt yn dod i'w hapwyntiadau yn eithaf dychrynllyd. A ydych yn siŵr eu bod yn bobl na wnaethant fynychu, neu a oes problem weinyddol yma neu unrhyw aneffeithlonrwydd yn y system sy'n cofnodi'r cyfryw faterion? Yr wythnos diwethaf, er enghraifft, daeth rhywun i'm gweld ar ôl cael pedwar llythyr yn cynnig dyddiadau gwahanol ar gyfer apwyntiadau gyda'r un meddyg ymgynghorol. Canslodd dri o'r apwyntiadau, ond, pe na bai wedi gwneud hynny, byddai'n ymddangos nad oedd wedi mynychu. Ys gwn i faint o aneffeithlonrwydd sydd yn y system. Soniasoch am rai o'r rhesymau pam nad yw pobl yn mynychu. Sut gwyddoch y rhesymau hyn? A ydych yn tybio mai dyma yw'r rhesymau, neu a ydych wedi mynd ati i gasglu tystiolaeth mewn rhyw fodd gan ofyn i bobl pam na wnaethant fynychu?

Ms Lloyd: The trusts have traditionally followed up in such cases. Your example is an alarming story and I shall take that back if you would provide me with the details.

Ms Lloyd: Mae gan yr ymddiriedolaethau hanes o wneud gwaith dilynol yn y cyfryw achosion. Mae eich enghraifft yn stori ddychrynllyd ac af â'r enghraifft honno yn ôl gyda mi os rhowch y manylion i mi.

[120] **Jocelyn Davies:** Yes, I will.

[120] **Jocelyn Davies:** Iawn, gwnaf.

Ms Lloyd: That would be helpful. It must undermine credibility, must it not?

Ms Lloyd: Byddai hynny'n ddefnyddiol. Mae'n rhaid ei fod yn tanseilio hygrededd, onid ydyw?

[121] **Carl Sargeant:** Following Mick's comments on the diagnostic and therapy waiting times, paragraphs 2.29, 2.32 and 2.33 show that part of the problem of long waits in the patient pathway was due to staff shortages and limitations on opening hours and the referral and access criteria. What are you doing specifically to tackle those issues?

[121] **Carl Sargeant:** Yn dilyn sylwadau Mick am yr amseroedd aros diagnostig a therapi, dengys paragraffau 2.29, 2.32 a 2.33 mai prinder staff a chyfyngiadau ar oriau agor a'r meini prawf cyfeirio a mynediad oedd wrth wraidd rhan o'r broblem o arosiadau hir ymysg cleifion. Beth yr ydych yn ei wneud yn benodol i fynd i'r afael â'r materion hynny?

Ms Lloyd: There are a number of issues here. First, we must analyse the diagnostic waits and what people are waiting for. Wales has been doing this, which I think is unique in the UK. We recognised that this was a problem for patients. In terms of radiology, we found that 71 per cent of patients were seen within three months, despite the drawn-out waiting times for GPs requesting MRIs, which has the highest number of patients waiting. Radiology is a particular problem. It is difficult to get radiologists throughout the UK and, as with other clinical specialists, they now sub-specialise. You have to have the right plan for the job. We have been talking to the Royal College of Radiologists and its counterparts in Wales about what we need to do to improve training and access to that career for our medical students. It has suggested some good ideas, which we are pursuing with it. We have considered increasing the number of radiologists in

Ms Lloyd: Mae nifer o faterion yn y fan hon. Yn gyntaf, rhaid i ni ddadansoddi'r arosiadau diagnostig a'r hyn y mae pobl yn aros amdano. Mae Cymru wedi bod yn gwneud hyn, sydd yn unigryw yn y DU yn fy nhyb i. Bu i ni gydnabod bod hyn yn broblem i gleifion. O ran radioleg, bu i ni ganfod bod 71 y cant o gleifion yn cael eu gweld o fewn tri mis, er gwaethaf yr amseroedd aros hir ar gyfer meddygon teulu a oedd yn gwneud cais am MRIs, sydd â'r nifer uchaf o gleifion yn disgwyl. Mae radioleg yn broblem arbennig. Mae'n anodd cael radiolegwyr ledled y DU ac, fel yn achos arbenigwyr clinigol eraill, maent bellach yn is-arbenigo. Mae'n rhaid i chi feddu ar y cynllun cywir ar gyfer y gwaith. Yr ydym wedi bod yn siarad â Choleg Brenhinol y Radiolegwyr a'i gymheiriaid yng Nghymru ynglŷn â beth sydd angen i ni ei wneud i wella hyfforddiant a mynediad i'r yrfa honno ar gyfer ein myfyrwyr meddygol. Mae wedi awgrymu

training and giving them the ability to extend their roles—there are consultant radiographers now and extended-scope practitioners—to try to see how we can use the whole workforce to manage this diagnostic problem. Therefore, that is one thing that we are doing.

rhai syniadau da, ac yr ydym yn eu datblygu gyda'r Coleg. Yr ydym wedi ystyried cynyddu nifer y radiolegwyr dan hyfforddiant a rhoi iddynt y gallu i ehangu eu swyddogaethau—mae radiolegwyr ymgynghorol erbyn hyn ac ymarferwyr cwmpas estynedig—i geisio gweld sut gallwn ddefnyddio'r gweithlu cyfan i reoli'r broblem ddiagnostig hon. Felly, dyna un peth yr ydym yn ei wneud.

Other diagnostic waiting times are much more variable, and we are working with trusts on considering the basis for the long waits for some diagnostic treatments. I am particularly concerned about podiatry, because many people are waiting a long time in that discipline. We are considering the access criteria for that specialty, how the patients are being managed and what alternatives there are for them. We must balance this now as diagnostic waits are important, and we must ensure that they are included in the equation of how soon patients can get access to treatment.

Mae amseroedd aros diagnostig eraill yn llawer mwy amrywiol, ac yr ydym yn gweithio gydag ymddiriedolaethau i ystyried sail yr arosiadau hir am rai triniaethau diagnostig. Yr wyf yn pryderu'n arbennig am bodiatreg, oherwydd mae llawer o bobl yn aros am gyfnod maith yn y maes hwnnw. Yr ydym yn ystyried y meini prawf mynediad ar gyfer yr arbenigedd hwnnw, sut caiff cleifion eu rheoli a pha opsiynau amgen sydd ar gael iddynt. Rhaid i ni gydbwyso hyn yn awr oherwydd mae arosiadau diagnostig yn bwysig, a rhaid i ni sicrhau eu bod yn cael eu hystyried o ran pa mor fuan y gall cleifion gael mynediad i driniaeth.

[122] **Carl Sargeant:** Further to that, we recognise that you are attempting to measure the waiting times in the diagnostic and therapy service. How much progress have you made on that and what do you intend to do with the information? It is good that you are creating a list, but what are you going to do about it?

[122] **Carl Sargeant:** Ymhellach, cydnabyddwn eich bod yn ceisio mesur yr amseroedd aros yn y gwasanaeth diagnostig a therapi. Faint o gynnydd yr ydych wedi ei wneud yn y gwaith hwnnw a beth y bwriadwch ei wneud â'r wybodaeth honno? Mae'n dda eich bod yn llunio rhestr, ond beth yr ydych yn bwriadu ei wneud yn ei chylch?

Ms Lloyd: First, we and our statistical colleagues feel that the information that we are getting through is robust, but we need to test one more month. It has at least allowed us to examine more critically which diagnostic tests are causing the major problem—it is obviously a problem in terms of accessing MR scanners. There are extremely long waits in some parts of Wales and far shorter waits in others. That is not necessarily an efficiency issues, because there are long waits for MR scans in Cardiff and the Vale, and yet the efficiency there is the second best in the country and is good. It is a volume and demand issue. As part of the £30 million for capital expenditure that the Minister announced recently, we have bought additional MR or diagnostic equipment to try to overcome some of the problems that the staff have been experiencing. Therefore, we have tried to ensure that there is sustainability in terms of reducing the large volume of patients. We also know that it has become more the norm for clinicians, in order to get more accurate diagnoses, to order MR scans than it was before. We must ensure that we have capable staff and the equipment to keep up with that demand, and exceed it if necessary.

Ms Lloyd: Yn gyntaf, yr ydym ni a'n cydweithwyr ystadegau o'r farn bod y wybodaeth yr ydym yn ei chael yn gadarn, ond mae angen i ni brofi un mis arall. Mae o leiaf wedi ein galluogi i archwilio'n fwy beirniadol pa brofion diagnostig sy'n achosi'r broblem fawr—mae'n amlwg yn broblem o ran cael mynediad i sganwyr MR. Mae'r aros yn eithriadol o hir mewn rhai rhannau o Gymru ac yn llawer byrrach mewn eraill. Nid problem effeithlonrwydd yw honno o reidrwydd, oherwydd mae'r aros yn hir am sganiau MR yng Nghaerdydd a'r Fro, ac eto honno yw'r ail ymddiriedolaeth orau yn y wlad o ran effeithlonrwydd ac mae'n dda yno. Mae'n fater maint a galw. Fel rhan o'r £30 miliwn ar gyfer gwariant cyfalaf a gyhoeddodd y Gweinidog yn ddiweddar, yr ydym wedi prynu offer MR neu offer diagnostig ychwanegol i geisio goresgyn rhai o'r problemau y mae staff wedi eu cael. Felly, yr ydym wedi ceisio sicrhau bod cynaliadwyedd o ran lleihau'r nifer fawr o gleifion. Gwyddom hefyd ei bod bellach yn fwy cyffredin nag yr oedd cynt i glinigwyr archebu sganiau MR, er mwyn cael diagnosis mwy cywir. Rhaid i ni sicrhau bod gennym staff galluog a'r offer i ateb y galw hwnnw, a mynd y tu hwnt iddo os oes angen.

[123] **Carl Sargeant:** Your answer suggests that you already have a grasp of the issues behind these waiting times. Am I right in saying that another month's data would give you more current information?

[123] **Carl Sargeant:** Mae eich ateb yn awgrymu bod gennych eisoes ddealltwriaeth o'r materion sydd wrth wraidd yr amseroedd aros hyn. A wyf yn gywir i ddweud y byddai data mis arall yn rhoi gwybodaeth fwy

cyfredol i chi?

Ms Lloyd: We very much hope that that will be the case.

Ms Lloyd: Yr ydym ym mawr obeithio mai dyna fydd yr achos.

[124] **Carl Sargeant:** On that basis, will you publish the information on the diagnostic and therapy waiting times and your strategy to deal with them?

[124] **Carl Sargeant:** Ar y sail honno, a fyddwch yn cyhoeddi'r wybodaeth am yr amseroedd aros diagnostig a therapi a'ch strategaeth i ddelio â hwy?

Ms Lloyd: The strategy will be for the Minister to announce. If our colleagues in statistics are secure in the fact that this is information, I see no reason not to publish it.

Ms Lloyd: Y Gweinidog a fydd yn cyhoeddi'r strategaeth. Os yw'n cydweithwyr yn y maes ystadegau yn sicr o'r ffaith mai gwybodaeth yw hon, ni allaf weld rheswm dros beidio â'i chyhoeddi.

[125] **Janet Davies:** Thank you. I know that both Alun and Mark want to ask questions on this.

[125] **Janet Davies:** Diolch. Gwn fod Alun a Mark am ofyn cwestiynau am hyn.

[126] **Alun Cairns:** Mrs Lloyd, I want to go back to your responses on activity. I appreciate many of the comments that you made about what is highlighted in paragraph 2.26 of the second volume—that those are not measured figures. It may be a crude measure, but it might also be a fair measure. If we refer to figure 5 in the first volume of the report, which identifies first out-patient appointments and total out-patient activity, there were 699,000 new out-patient appointments in 2000-01 and 737,000 in 2003-04, which is an increase of 5.4 per cent,

[126] **Alun Cairns:** Mrs Lloyd, hoffwn fynd yn ôl at eich ymatebion ar weithgarwch. Yr wyf yn gwerthfawrogi llawer o'r sylwadau a wnaethoch ynglŷn â'r hyn sydd wedi ei nodi ym mharagraff 2.26 yr ail gyfrol—nad ffigurau wedi eu mesur yw'r rheini. Efallai ei fod yn fesur bras, ond efallai ei fod hefyd yn fesur teg. Os cyfeiriwn at ffigur 5 yng nghyfrol gyntaf yr adroddiad, sy'n nodi apwyntiadau cleifion allanol cyntaf a chyfanswm gweithgarwch cleifion allanol, bu 699,000 o apwyntiadau cleifion allanol newydd yn 2000-01 a 737,000 yn 2003-04,

according to my calculations. That is despite a £2 billion or £3 billion increase in the health budget during that period. It might be crude, but is it not fair to say that, after all that investment, the increase in activity has only gone up by a relatively small amount—from 699,000 to 737,000?

sy'n gynnydd o 5.4 y cant, yn ôl fy nghyfrifiadau i. Mae hynny er gwaethaf cynnydd o £2 biliwn neu £3 biliwn yn y gyllideb iechyd yn ystod y cyfnod hwnnw. Efallai ei fod yn fras, ond onid yw'n deg i ddweud, ar ôl yr holl fuddsoddi hynny, mai cynnydd cymharol fach a welwyd mewn gweithgarwch—o 699,000 i 737,000?

Ms Lloyd: New out-patients only reflect a small proportion of the activity that is carried on in the NHS. I think that the analysis of the impact of an additional £2 billion going in—much of which will be spent on staff pay, which accounts for 80 per cent of our budget—should be offset against what these figures show. It would be relatively easy, I hope—my finance director will kill me—to provide you with an analysis of how much is spent against particular headings, such as out-patients and elective activities. We spend about 26 per cent of our budget on elective activity.

Ms Lloyd: Cyfran fach yn unig o'r gweithgarwch a gyflawnir yn y GIG a gaiff ei hadlewyrchu gan gleifion allanol newydd. Credaf y dylai'r dadansoddiad o effaith cyfraniad ychwanegol o £2 biliwn—y bydd y rhan fwyaf ohono'n cael ei wario ar gyflogau staff, sy'n cyfrif am 80 y cant o'n cyllideb—gael ei osod yn erbyn yr hyn y mae'r ffigurau hyn yn ei ddangos. Byddai'n gymharol hawdd, gobeithiaf—bydd fy nghyfarwyddwr cyllid yn fy lladd—rhoi dadansoddiad ichi o faint gaiff ei wario yn erbyn penawdau penodol, megis cleifion allanol a gweithgarwch dewisol. Gwariwn tua 26 y cant o'n cyllideb ar weithgarwch dewisol.

[127] **Alun Cairns:** That would be useful. However, that is 26 per cent of a £2 billion or £3 billion increase, and only a 5.4 per cent increase in the number of new out-patient appointments. I appreciate that there have been repeats for others, but I focus on the new out-patient appointments because those figures are much clearer as it is a new intervention.

[127] **Alun Cairns:** Byddai hwnnw'n ddefnyddiol. Fodd bynnag, mae hynny'n 26 y cant o gynnydd o £2 biliwn neu £3 biliwn, a dim ond cynnydd o 5.4 y cant yn nifer yr apwyntiadau cleifion allanol newydd. Yr wyf yn gwerthfawrogi y bu apwyntiadau dilynol ar gyfer eraill, ond yr wyf yn canolbwyntio ar yr apwyntiadau cleifion allanol newydd oherwydd bod y ffigurau hynny yn llawer mwy eglur gan ei fod yn ymyrraeth newydd.

Ms Lloyd: Yes, but we can provide you with detail of that.

Ms Lloyd: Iawn, ond gallwn ddarparu manylion hynny i chi.

[128] **Mark Isherwood:** We hear repeatedly about models of good practice that have not been shared. On therapy services, what consideration has been given to the model in the Conwy and Denbighshire NHS Trust of self-referral to local therapy services, which has driven down the waiting times substantially, against, I believe, a fair amount of established opposition?

[128] **Mark Isherwood:** Yr ydym yn clywed dro ar ôl tro am fodelau arferion da nad ydynt wedi eu rhannu. O ran gwasanaethau therapi, pa ystyriaeth sydd wedi ei rhoi i'r model yn Ymddiriedolaeth GIG Siroedd Conwy a Dinbych o hunangyfeirio at wasanaethau therapi lleol, sydd wedi lleihau'r amseroedd aros yn sylweddol, yn erbyn, credaf, cryn dipyn o wrthwynebiad sefydledig?

Ms Lloyd: Thank you for that. It has indeed had a very good effect on waiting times. What have we done about it? I was concerned that the many extremely good initiatives undertaken by clinicians in this country have not been universalised. Innovations in care have been informing trusts about these innovations, and they all have access to what the effects of these changes in practice have meant for patients and clinicians. We have asked the innovations in care team to audit, through every trust and LHB, whether the initiatives have been instituted, if they have not, why not, and what alternatives have been instituted instead. To my mind, if somebody has had a good idea, which has had a positive impact in terms of clinician workload and patient outcome, I would need a good reason why other people have not followed that initiative. For the first time, we will get a clear analysis of where all the initiatives have

Ms Lloyd: Diolch am hynny. Mae wedi cael effaith dda iawn yn wir ar amseroedd aros. Beth yr ydym wedi ei wneud yn ei gylch? Yr oeddwn yn poeni nad yw'r llu o fentrau hynod dda yr ymgymerwyd â hwy gan glinigwyr yn y wlad hon wedi eu cyffredinoli. Mae arloesi mewn gofal wedi bod yn hysbysu ymddiriedolaethau am yr enghreifftiau o arloesi hyn, ac mae gan bob un ohonynt fynediad i'r hyn y mae effeithiau'r newidiadau hyn i arfer wedi ei olygu i gleifion a chlinigwyr. Yr ydym wedi gofyn i'r tîm arloesi mewn gofal i archwilio, ym mhob ymddiriedolaeth a BILl, a yw'r mentrau wedi eu sefydlu, ac os nad ydynt, pam hynny, a pha fentrau amgen sydd wedi eu sefydlu yn eu lle. Yn fy marn i, os oes gan rywun syniad da, sydd wedi cael effaith gadarnhaol ar lwyth gwaith clinigwyr a chanlyniadau i gleifion, byddai arnaf angen rheswm da pam nad yw pobl eraill wedi dilyn

been instituted and mainstreamed.

y fenter honno. Am y tro cyntaf, byddwn yn cael dadansoddiad clir o ble mae'r holl fentrau wedi eu sefydlu a'u prif ffrydio.

For the future, we must not regard these as stand-alone initiatives. This has to be a mainstream activity for the way in which care is produced in Wales for patients. We have sufficient data for the vast majority of these initiatives, from the clinicians and the patients, to establish whether they worked. We will then look for an even better idea or implement those original good ideas throughout Wales. Therefore, again, you eradicate the inequalities and get a good standard across Wales.

Ar gyfer y dyfodol, rhaid i ni beidio ag ystyried y rhain fel mentrau annibynnol. Rhaid i hwn fod yn weithgarwch prif ffrwd ar gyfer y modd y caiff gofal ei gynhyrchu yng Nghymru ar gyfer cleifion. Mae gennym ddata digonol ar gyfer y mwyafrif helaeth o'r mentrau hyn, gan y clinigwyr a'r cleifion, i ganfod a wnaethant weithio ai peidio. Yna byddwn yn chwilio am syniad hyd yn oed yn well neu'n gweithredu'r syniadau da gwreiddiol hynny ledled Cymru. Felly, eto, gallwch ddileu'r anghydraddoldebau a sicrhau safon dda ledled Cymru.

[129] **Janet Davies:** Thank you very much. We will call a halt on this evidence session, Mrs Lloyd, and continue it as soon as possible. We will want to get a date that is as convenient as possible for everyone, but, on the other hand, it should not go so far forward that we all forget what we have learned today. Thank you for your appearance, and your full and helpful answers, and to Mr Marples as well. We look forward to seeing you again in the near future. I do not know whether you will look forward to seeing us. I should also mention that the verbatim record will be sent to you so that you can check it.

[129] **Janet Davies:** Diolch yn fawr iawn. Rhown derfyn ar y sesiwn tystiolaeth hwn, Mrs Lloyd, a pharhau ag ef cyn gynted â phosibl. Byddwn am gael dyddiad sydd mor gyfleus â phosibl i bawb, ond, ar y llaw arall, ni ddylid ei adael cyhyd fel ein bod i gyd yn anghofio'r hyn y bu i ni ei ddysgu heddiw. Diolch yn fawr am eich ymddangosiad, a'ch atebion llawn a defnyddiol, ac i Mr Marples hefyd. Edrychwn ymlaen at eich gweld eto yn y dyfodol agos. Ni wn a fyddwch yn edrych ymlaen at ein gweld ni. Dylwn hefyd ddweud y bydd y cofnod gair am air yn cael ei anfon atoch fel y gallwch ei wirio.

Daeth y sesiwn cymryd tystiolaeth i ben am 12.01 p.m.
The evidence-taking session came to an end at 12.01 p.m.

(1) Hoffai'r tyst egluro bod y targed mis ar gyfer cyfeirio cleifion y credir bod canser arnynt ac a gyfeirir o ran arall o'r system, ac mae'r targed deufis ar gyfer triniaeth sy'n gorfod dechrau o fewn deufis o dderbyn cyfeireb gan yr ymarferydd cyffredinol.

(1) The witness would like to make clear that the one-month target is for referral of patients who are thought to have cancer and are transferred from another part of the system, and the two-month target is for treatment that must commence within two months of receipt of a GP referral.

Annex A

Cynulliad Cenedlaethol Cymru
Y Pwyllgor Archwilio

The National Assembly for Wales

Audit Committee

Amseroedd Aros y GIG yng Nghymru
NHS Waiting Times in Wales

Cwestiynau 130-228
Questions 130-228

Dydd Iau, 10 Chwefror 2005
Thursday, 10 February 2005

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

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

Tystion: Ann Lloyd, Pennaeth Adran Iechyd a Gofal Cymdeithasol, Cynulliad Cenedlaethol Cymru,

John Hill-Tout, cyfarwyddwr, adran rheoli perfformiad ac ansawdd, Cynulliad Cenedlaethol Cymru.

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

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

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

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

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

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

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

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

Ms Lloyd: Volume 2?

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

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

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

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

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

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

Ms Lloyd: Cyfrol 2?

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

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

to be back.

bod yn ôl.

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

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

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

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

In terms of emergency activity, the actions that are being taken are to look very carefully at the reasons for emergency admissions escalating in this way. As I said last time, we have an ill and co-morbidity type of population. So, the frailty and the oldness of the individuals seeking emergency activity are greater here than you would expect throughout the whole of the UK. Nevertheless, we have undertaken extensive work, particularly with our innovations-in-care team, looking at emergency activity, and how it might be managed differently, and to look at alternatives to emergency admissions. That is why each trust in Wales now has a medical assessment unit, so that GPs will have easy access to an opinion about whether or not they are able to continue to manage patients at home, or whether the patient must

O ran gweithgarwch brys, y camau sy'n cael eu cymryd yw edrych yn ofalus iawn ar y rhesymau pam mae derbyniadau brys yn cynyddu fel hyn. Fel y dywedais y tro diwethaf, mae gennym boblogaeth lle mae salwch a chyd-forbidrwydd. Felly, mae'r unigolion sydd ag arnynt angen gweithgarwch brys yn fwy bregus a hen yma nag y byddech yn ei ddisgwyl ledled y DU gyfan. Serch hynny, yr ydym wedi gwneud gwaith helaeth, yn enwedig gyda'n tîm arloesi mewn gofal, gan edrych ar weithgarwch brys a sut gellid ei reoli'n wahanol, ac edrych ar ddewisiadau gwahanol yn lle derbyniadau brys. Dyna pam mae uned asesu meddygol gan bob ymddiriedolaeth yng Nghymru bellach, fel y bydd meddygon teulu yn hawdd yn gallu cael barn am y cwestiwn a allant barhau i reoli cleifion

be admitted. That is one of the things we have been doing.

gartref ai peidio, neu a oes angen i'r claf ddod i'r ysbyty. Dyna un o'r pethau yr ydym wedi bod yn eu gwneud.

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

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

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

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

tackled in terms of why we are treating people as in-patients, when they might be safely treated as day cases.

o ran pam yr ydym yn trin pobl fel cleifion mewnol, pan ellid eu trin yn ddiogel fel achosion dydd.

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

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

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

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

i fynd i'r afael â'r mater hwnnw hefyd?

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

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

The other issue relates to the management of chronic diseases. At least 55 per cent of

Mae'r mater arall yn ymwneud â rheoli clefydau cronig. Mae o leiaf 55 y cant o

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

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

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

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

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

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

Ms Lloyd: These targets are monitored on a regular basis by the regional offices. As you know, the Minister has asked that the regional offices be strengthened so that they are not only there to advise and facilitate, but

Ms Lloyd: Caiff y targedau hyn eu monitro'n rheolaidd gan y swyddfeydd rhanbarthol. Fel y gwyddoch, mae'r Gweinidog wedi gofyn i'r swyddfeydd rhanbarthol gael eu cryfhau er mwyn iddynt fod yno nid yn unig i roi cyngor

have the power to direct organisations to prove beyond reasonable doubt that they are maximising the use of the facilities and resources available to them in order to meet the needs of their population. The performance regime has tightened considerably, particularly over the last year. There are issues in this report surrounding incentives and sanctions and, as I think that I said in the last meeting, two of the organisations are already on an intervention protocol on a whole range of issues regarding the way in which they are using their assets and staff. Had I not been here today, I would have been seeing the Gwent Community on level 2 to oversee how it has progressed on a number of fronts. It has done quite well in terms of waiting-times reduction.

a hwyluso, ond er mwyn iddynt gael y pŵer i orchymyn sefydliadau i brofi y tu hwnt i amheuaeth resymol eu bod yn gwneud y defnydd gorau posibl o'r cyfleusterau a'r adnoddau sydd ar gael iddynt i ddiwallu anghenion eu poblogaeth. Mae'r drefn perfformiad wedi tynhau'n sylweddol, yn enwedig yn y flwyddyn ddiwethaf. Mae materion yn yr adroddiad hwn sy'n ymwneud â sancsiynau, ac fel y dywedais yn y cyfarfod diwethaf, mi gredaf, mae dau o'r sefydliadau eisoes ar brotocol ymyriad ynglŷn ag ystod gyfan o faterion yn ymwneud â'r modd y maent yn defnyddio eu hasedau a'u staff. Pe na bawn yma heddiw, byddwn wedi bod yn gweld Cymuned Gwent ar lefel 2 i oruchwylio sut y mae wedi gwneud cynnydd mewn llawer agwedd. Mae wedi gwneud yn eithaf da o ran lleihau amseroedd aros.

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

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

Ms Lloyd: That figure is not universally

Ms Lloyd: Nid yw'r ffigur hwnnw'n

applied to all specialties. If you look at the vacancies at the end of March 2004, in the surgical specialties and anaesthetics, which is most pertinent to what is wrong with the capacity to manage the waiting times, the percentage vacancy has varied between 3.7 per cent and 4.8 per cent, which is below the target that one would usually see within NHS employed staff. Our major problems are with psychiatry, some paediatrics, and a few of the medical specialties; dermatology is mentioned in the report, and that is currently at 27.3 per cent. You will know that the numbers of consultants that we have employed in Wales over the last few years have gone up year-on-year, so, for example, in 2003, an additional 40 were funded, and, since 2001, there have been an additional 170 employed in Wales. We have tried to increase the consultant workforce, knowing very well that, with the European working-time directive, and with the fact that it is being reported that the requirement for an out-patient consultation is taking longer—because there must be informed consent and good information—consultants' available time is being eaten into. However, as you know, we have increased the number of medical trainees over the past five years to ensure that we can keep pace with the situation. However, again, by increasing the number of trainees, you increase the call on the time of clinical tutors and trainers working to train them properly. It is a balance, and that is why you have seen an increase in the number of consultants being employed, but also in what they are being required to do, which is reflected in the

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

Welsh consultant contract.

ydych wedi gweld cynnydd yn nifer y meddygon ymgynghorol a gyflogir, a hefyd yn yr hyn y mae gofyn iddynt ei wneud. Mae hyn yn cael ei adlewyrchu yng nghontract meddygon ymgynghorol Cymru.

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

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

Ms Lloyd: Yes, it is 18 per cent.

Ms Lloyd: Ie, 18 y cant.

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

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

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

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

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

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

Ms Lloyd: We are still trying to recruit more accident and emergency consultants. We have been successful in some places that have had real problems: for example, in Pembrokeshire and Derwen NHS Trust, we have just recruited a new medical director,

Ms Lloyd: Yr ydym yn dal i geisio recriwtio mwy o feddygon ymgynghorol ar gyfer damweiniau ac achosion brys. Yr ydym wedi llwyddo mewn rhai mannau sydd wedi cael problemau gwirioneddol: er enghraifft, yn Ymddiriedolaeth GIG Sir Benfro a Derwen,

who happens to also be an accident and emergency consultant. Since he came on the scene, he has considerably reduced the waiting times in accident and emergency.

yr ydym newydd recriwtio cyfarwyddwr meddygol newydd, sydd hefyd yn digwydd bod yn feddyg ymgynghorol ym maes damweiniau ac achosion brys. Ers iddo gyrraedd, mae wedi lleihau'r amseroedd aros yn yr adran damweiniau ac achosion brys yn sylweddol.

Given that we know that the number of accident and emergency consultants is very tight throughout the UK and that it is a difficult speciality to recruit to, we are looking at the whole use of the accident and emergency workforce. We are doing this to ensure that there is effective triage, that we have good-quality nurse practitioners, and that we have physiotherapists and many different types of staff who can manage and help manage the work that comes through accident and emergency. However, as you know, the past two weeks have been particularly difficult in terms of the real pressures on accident and emergency medical admissions in Wales. We are trying to ensure that trusts are taking advantage of the skills that can be deployed by other members of staff to enhance the whole accident and emergency clinical team.

O ystyried ein bod yn gwybod bod nifer y meddygon ymgynghorol damweiniau ac achosion brys yn brin ledled y DU a'i fod yn arbenigedd anodd recriwtio iddo, yr ydym yn edrych ar yr holl ddefnydd a wneir o'r gweithlu damweiniau ac achosion brys. Gwnawn hyn i sicrhau bod yna wasanaeth effeithiol i flaenoriaethu cleifion, bod gennym ymarferwyr nyrsio o safon dda, a bod gennym ffisiotherapyddion a nifer o wahanol fathau o staff a all reoli a helpu rheoli'r gwaith a ddaw drwy'r adran damweiniau ac achosion brys. Fodd bynnag, fel y gwyddoch, mae'r pythefnos diwethaf wedi bod yn arbennig o anodd o ran y pwysau gwirioneddol ar dderbyniadau meddygol mewn adrannau damweiniau ac achosion brys yng Nghymru. Yr ydym yn ceisio sicrhau bod ymddiriedolaethau'n manteisio ar y sgiliau y gellir eu defnyddio gan aelodau eraill o'r staff i wella'r holl dîm clinigol damweiniau ac achosion brys.

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

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

Ms Lloyd: By having more consultants?

Ms Lloyd: Drwy gael rhagor o feddygon ymgynghorol?

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

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

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

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

cynllunio i gynyddu nifer y myfyrwyr meddygol a nifer y staff meddygol ymgynghorol, i sicrhau y gallwn gydbwyso'r gweithlu hwn, pa darged bynnag fydd y Gweinidog yn dewis ei osod.

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

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

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

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

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

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

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

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

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

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

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

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

[147] **Janet Davies:** No, you are not coming in just yet, Denise—you are asking question 19, which is a couple of questions ahead. I will bring

[147] **Janet Davies:** Na, nid eich tro chi yw hi eto, Denise—yr ydych yn gofyn cwestiwn 19, ac mae ychydig gwestiynau cyn hwnnw. Galwaf ar

Jocelyn in now, and I also have some confusion that I would like cleared up.

Jocelyn yn awr, ac y mae yna hefyd ychydig ddryswch yr hoffwn ei ddatrys.

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

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

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

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

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

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

Ms Lloyd: It is tracked carefully. We must try to educate the public as to what alternative is available. Triage at accident and emergency is very important in terms of redirecting patients, and you will see that many trusts have general practitioners working in their accident and emergency departments who can immediately see the category 4 patients, so that they do not have to wait for ages. Why should anyone want to go to accident and emergency with a minor ailment and have to wait for a considerable time, when those who are of higher priority are obviously seen before them? Therefore, it is about trying to ensure that the whole of accident and emergency provision is not clogged up unnecessarily by patients who do not need to be there, but that those people who have come, irrespective of whether they should have gone to their GP or not, also get good-quality care, and expeditiously too. However, I can send you the data.

Ms Lloyd: Caiff ei olrhain yn ofalus iawn. Rhaid i ni geisio addysgu'r cyhoedd am y dewis arall sydd ar gael. Mae blaenoriaethu mewn adrannau damweiniau ac achosion brys yn bwysig iawn o ran ailgyfeirio cleifion. Gwelwch fod gan nifer o ymddiriedolaethau ymarferwyr cyffredinol sy'n gweithio yn eu hadrannau damweiniau ac achosion brys ac sy'n gallu gweld y cleifion categori 4 ar unwaith, fel nad oes yn rhaid iddynt aros am amser maith. Pam fyddai unrhyw un yn dewis mynd i adran damweiniau ac achosion brys gyda mân anhwylder a gorfod aros am amser hir, pan fydd y rheini sydd â blaenoriaeth uwch yn amlwg yn cael eu gweld o'u blaen? Felly, mater yw hwn o geisio sicrhau nad yw'r holl ddarpariaeth damweiniau ac achosion brys yn cael ei thagu'n ddiangen gan gleifion nad oes angen iddynt fod yno. Mae'n fater lle mae'r bobl hynny sydd wedi dod, p'un a ddylent fod wedi mynd at eu meddyg teulu ai peidio, hefyd yn cael gofal o ansawdd da, ac yn gyflym hefyd. Fodd bynnag, gallaf anfon y data atoch.

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

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

Ms Lloyd: I do not have that data. We could

Ms Lloyd: Nid yw'r data hynny gennyf.

ask the trusts to find out, but I do not know whether the patients would tell you.

Gallem ofyn i'r ymddiriedolaethau holi, ond ni wn a fyddai'r cleifion yn dweud wrthych.

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

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

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

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

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

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

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

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

Ms Lloyd: Yes, that is part of it.

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

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

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

Ms Lloyd: Yes, indeed, and some of them do that already. However, we have been considering, with the problem of delayed transfers, how we can use the community resource better and, given the turnover intervals and the lengths of stay, at what

Ms Lloyd: Byddwn, yn wir, ac mae rhai ohonynt eisoes yn gwneud hynny. Fodd bynnag, yr ydym wedi bod yn ystyried, gyda'r broblem o oedi wrth drosglwyddo cleifion, sut gallwn ddefnyddio'r adnodd cymunedol yn well, ac o ystyried y cyfnodau

point it is safe to transfer patients back to a community resource for more active reablement and rehabilitation. We are certainly pressing the service on using the community resource in a much more proactive way.

trosiant a hyd arosiadau, pryd y mae'n ddiogel trosglwyddo cleifion yn ôl i adnodd cymunedol am ofal ail-alluogi ac adfer sy'n fwy gweithgar. Yr ydym yn sicr yn pwyso ar y gwasanaeth i ddefnyddio'r adnodd cymunedol mewn ffordd lawer mwy rhagweithiol.

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

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

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

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

Ms Lloyd: Again, the innovations team has been looking at this matter, and looking at the best ways of reducing these unnecessary delays. The teams are actively involved either in ensuring that ward rounds take place regularly or in ensuring that the care plan is so well developed—which it should be, anyway—that other staff members on that ward can take the decision to discharge. The other things that we have been doing in terms of the delays for to-take-home medicines concern how there should be much more

Ms Lloyd: Eto, mae'r tîm arloesi wedi bod yn edrych ar y mater hwn, ac yn edrych ar y ffyrdd gorau i leihau'r oedi diangen hwn. Mae'r timau'n ymwneud yn weithgar â'r gwaith o sicrhau naill ai bod meddygon yn mynd o amgylch wardiau yn rheolaidd neu bod y cynllun gofal wedi ei ddatblygu mor dda—fel y dylai fod, beth bynnag—fel y gall aelodau eraill o'r staff ar y ward honno wneud y penderfyniad i ryddhau claf. Mae'r pethau eraill yr ydym wedi eu gwneud o ran yr oedi gyda'r meddyginiaethau sydd i'w

constructive discussion about when it is likely, with the ward team, that a patient might be discharged and to pre-order what will be necessary to take home with him or her, so that you do not have the good news that you are going and then wait for three or four hours to get there.

cymryd gartref yn ymwneud â'r ffordd y dylid cael trafodaeth lawer mwy adeiladol, gyda thîm y ward, ynglŷn â phryd y mae'n debygol y gallai claf gael ei ryddhau. Ffordd arall yw archebu ymlaen llaw yr hyn fydd ei angen ar y claf i fynd adref, fel na fyddwch yn cael y newyddion da eich bod yn cael gadael ac yna'n aros am dair neu bedair awr cyn i hynny ddigwydd.

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

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

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

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

Ms Lloyd: I think that having better care planning and planning from the outset of the patient's admission is really the best way, so that the whole ward team is engaged, from the outset, in the care path for the individual patient. This gives confidence to the ward team that if the consultant or junior member of the medical team is not there, for whatever

Ms Lloyd: Credaf mai cynllunio gofal yn well a chynllunio o'r eiliad y caiff claf ei dderbyn yw'r ffordd orau mewn gwirionedd, fel y bydd tîm cyfan y ward yn ymwneud, o'r cychwyn cyntaf, â llwybr gofal y claf unigol. Mae hyn yn rhoi hyder i dîm y ward, os nad yw'r meddyg ymgynghorol neu aelod iau o'r tîm meddygol yno, am ba reswm bynnag—fe

reason—they might be in theatre—a senior member of the ward team will take, with confidence, the decision to discharge. That is the best way, because the patients know where they are and the ward team gains confidence, and it means that these in-built delays are stopped. This also improves the situation when equipment is required or when adaptations need to be made, because the patient is well aware of it from the outset, and that, again, can be activated at an earlier stage. With unified assessment to be implemented in April, the ways in which social care and the health service performs in terms of individual care should be improved quite dramatically.

allai fod yn y theatr—y bydd aelod uwch o dîm y ward yn gwneud y penderfyniad, yn hyderus, i ryddhau'r claf. Dyna'r ffordd orau, oherwydd mae'r cleifion yn gwybod beth yw'r sefyllfa a bydd tîm y ward yn magu hyder. Ac mae'n golygu bod yr oedi cynhenid hwn yn peidio. Mae hyn hefyd yn gwella'r sefyllfa pan fydd angen offer neu pan fydd angen gwneud addasiadau, oherwydd mae'r claf yn ymwybodol iawn ohono o'r cychwyn, a gall hynny, unwaith eto, gael ei gychwyn yn gynharach. Gan fod asesu unedig i ddod i rym ym mis Ebrill, dylai'r ffyrdd y mae gofal cymdeithasol a'r gwasanaeth iechyd yn perfformio o ran gofal unigol wella'n eithaf syfrdanol.

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

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

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

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

asesiad cymdeithasol ydynt. Felly, y nod yw uno hynny.

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

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

Ms Lloyd: Patient choice was really a method by which some families or patients decided that, having grown accustomed to their surroundings, that was where they wished to stay and that they did not want the alternative. I would say that that possibly happened because we did not offer sufficient alternatives for them, or because of all the financial issues that you will know about, which cause concern to individuals and their families. Patient choice has to be respected. However, we found that, with 41 per cent delays built into the system, some patients were fit to go to alternative accommodation, but were being retained in hospital for very

Ms Lloyd: Yr oedd dewis cleifion mewn gwirionedd yn ddull a ddefnyddiodd rhai teuluoedd neu gleifion i benderfynu, ar ôl cynefino â'u hamgylchedd, mai dyna lle yr oeddynt am aros ac nad oeddynt am fynd am y dewis arall. Byddwn yn dweud i hynny ddigwydd o bosibl oherwydd nad oeddem yn cynnig digon o ddewisiadau eraill iddynt, neu oherwydd yr holl faterion ariannol y byddwch yn gwybod amdanynt, sy'n peri pryder i unigolion a'u teuluoedd. Rhaid parchu dewis cleifion. Fodd bynnag, gydag oedi o 41 y cant yn gynhenid yn y system, gwelsom fod rhai cleifion yn ddigon da i fynd i lety amgen, ond yn cael eu cadw yn yr

long periods of time. If you are in a busy hospital and are fit to be somewhere else, it is a disconcerting experience as you will not receive the same level of care and attention as other people who are more acutely ill. Hospitals are not the most relaxing places to be in.

ysbyty am gyfnodau hir iawn. Os ydych mewn ysbyty prysur ac yn ddigon da i fod rywle arall, mae'n brofiad annifyr oherwydd ni fyddwch yn cael yr un lefel o ofal a sylw â phobl eraill sy'n fwy difrifol sâl. Nid yw ysbyty yn un o'r lleoedd mwyaf gorffwysol i fod.

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

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

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

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

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

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

Ms Lloyd: We do not have the latest figures yet; they come out at the end of the year. We are evaluating how people are using this guidance. The numbers since June and September 2004 have gone down, and we know that we have successfully placed some patients who have been in hospital for a long time. So, in that case, yes, it is starting to work, but we have to keep track of it. We have also encouraged local government and the health service to work together to look at the individual circumstances associated with named patients, rather than just deal with a mass of 20 numbers, and to look at the real needs of individuals. In that way, we have found that much better collective packages have been provided to people. So, they deal with the patient on a named basis and discuss them frequently to ensure that, wherever possible, they can be moved to more appropriate accommodation.

Ms Lloyd: Nid yw'r ffigurau diweddaraf gennym hyd yma; byddant yn dod allan ddiwedd y flwyddyn. Yr ydym yn gwerthuso sut mae pobl yn defnyddio'r canllawiau hyn. Mae'r niferoedd wedi gostwng ers mis Mehefin a mis Medi 2004, a gwyddom ein bod wedi llwyddo i gael lle i rai cleifion a fu yn yr ysbyty ers amser hir. Felly, yn yr achos hwnnw, ydynt, mae'r canllawiau'n dechrau gweithio, ond rhaid i ni gadw llygad arnynt. Yr ydym hefyd wedi annog llywodraeth leol a'r gwasanaeth iechyd i weithio gyda'i gilydd i edrych ar yr amgylchiadau unigol sy'n gysylltiedig â chleifion penodol, yn hytrach na delio â phentwr o 20 o rifau, ac i edrych ar anghenion gwirioneddol unigolion. Fel hynny, yr ydym wedi gweld bod pecynnau cyfunol llawer gwell wedi eu darparu i bobl. Felly, maent yn delio â'r claf wrth ei enw ac yn ei drafod yn aml i sicrhau y gellir ei symud i lety mwy priodol, ble bynnag mae hynny'n bosibl.

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

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

Beth sy'n rhwystro hynny?

Ms Lloyd: The barriers are money, priorities and focus. A number of things have been put into effect that will overcome some of those barriers. First, in order to facilitate better discharge and better alternatives, the Minister provided additional resources to local health boards to manage the problem of delayed transfers of care. We have tracked what has happened within communities to the levels of delayed discharges because they are not being transferred. I have met local government and health service representatives from individual localities where sufficient progress was not being made to find out what the real reasons were and what alternatives were being discussed by those communities together to effect a real improvement. One of the successes was Carmarthenshire, which, at one point around six or seven months ago, was doing really badly on its delayed transfers of care. So, we called in the local partners to ask them what was blocking care. One of the problems was that the trust said that the numbers were X and everyone else said they were Y. So, that was sorted out. We then challenged local government and the local health board together to come forward with a sustainable solution to this. They were gainers under the Townsend formula anyway, so a small amount of this £4 million went to them. Together, they have been very creative about designing and planning long-term solutions as well as managing the short-term problem. Carmarthenshire is now doing far better in

Ms Lloyd: Y rhwystrau yw arian, blaenoriaethau a ffocws. Mae nifer o bethau wedi eu rhoi ar waith a fydd yn goresgyn rhai o'r rhwystrau hynny. Yn gyntaf, er mwyn hwyluso trefniadau rhyddhau gwell a gwell dewisiadau gwahanol, darparodd y Gweinidog adnoddau ychwanegol i fyrddau iechyd lleol i reoli problem oedi wrth drosglwyddo gofal. Yr ydym wedi olrhain beth sydd wedi digwydd mewn cymunedau i lefelau oedi wrth ryddhau cleifion oherwydd nad ydynt yn cael eu trosglwyddo. Yr wyf wedi cyfarfod â chynrychiolwyr llywodraeth leol a'r gwasanaeth iechyd o ardaloedd unigol lle nad oedd cynnydd digonol yn cael ei wneud i ddarganfod beth oedd y gwir resymau a pha ddewisiadau gwahanol a oedd yn cael eu trafod gan y cymunedau hynny gyda'i gilydd i greu gwelliant gwirioneddol. Un o'r llwyddiannau oedd Sir Gaerfyrddin a oedd, ar un adeg tua chwech neu saith mis yn ôl, yn perfformio'n wael iawn o ran oedi wrth drosglwyddo gofal. Felly, galwyd y partneriaid lleol i mewn i ofyn iddynt beth oedd yn rhwystro gofal. Un o'r problemau oedd bod yr ymddiriedolaeth yn dweud mai X oedd y niferoedd a phawb arall yn dweud mai Y. Felly, cafodd hynny ei ddatrys. Yna, heriwyd llywodraeth leol a'r bwrdd iechyd lleol i ddod at ei gilydd i gyflwyno ateb cynaliadwy i hyn. Yr oeddynt ar eu hennill dan y fformiwla Townsend beth bynnag, felly, rhoddwyd cyfran fechan o'r £4 miliwn hwn iddynt. Gyda'i gilydd, maent wedi bod yn greadigol iawn wrth ddylunio a chynllunio

terms of managing delayed transfers of care successfully. So, this emphasis on the number people who are being held in the wrong environment has had some effect.

atebion hirdymor yn ogystal â rheoli'r broblem fyrdymor. Mae Sir Gaerfyrddin bellach yn gwneud yn well o lawer yn rheoli oedi wrth drosglwyddo gofal yn llwyddiannus. Felly, mae'r pwyslais hwn ar nifer y bobl sy'n cael eu cadw yn yr amgylchedd anghywir wedi cael rhywfaint o effaith.

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

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

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

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

Ms Lloyd: Yes.

Ms Lloyd: Oedd.

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

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

Ms Lloyd: That is right.

Ms Lloyd: Mae hynny'n gywir.

[163] **Jocelyn Davies:** Mrs Lloyd, looking at the table on page 31, there seems to be huge variation between local authorities. The variation is quite stark. Blaenau Gwent and Torfaen are right at the top, then, at the bottom, you have Bridgend doing very well, and Denbighshire, Pembrokeshire and the Isle of Anglesey. Can you account for the variation between those local authorities?

[163] **Jocelyn Davies:** Mrs Lloyd, o edrych ar y tabl ar dudalen 31, mae'n ymddangos bod amrywiad enfawr rhwng awdurdodau lleol. Mae'r amrywiad yn hollol amlwg. Mae Blaenau Gwent a Thor-faen ar y brig, yna, ar y gwaelod, mae Pen-y-bont ar Ogwr yn gwneud yn dda iawn, a Sir Ddinbych, Sir Benfro ac Ynys Môn. A allwch roi rhesymau dros yr amrywiad rhwng yr awdurdodau lleol hynny?

Ms Lloyd: There is a vast variety of reasons. Sometimes it is because alternatives are not available, and we all know that, around Cardiff, the reduction in the number of nursing home places that have been available has caused real pressures. At other times, it is because patients are exercising choice. In Torfaen, there was a big problem about gaining a single focus in health and social care to tackle the problem. That has now been overcome and you will see, from the December figures, that some of those big outliers are starting to reduce. However, there is a variety of reasons and, often, it is because the alternatives are not sufficient or there is such pressure coming through the system.

Ms Lloyd: Mae amrywiaeth eang o resymau. Weithiau mae'n digwydd am nad oes unrhyw ddewisiadau eraill, a gwyddom oll fod y gostyngiad yn nifer y lleoedd sydd ar gael mewn cartrefi nyrsio, o gwmpas Caerdydd, wedi achosi pwysau gwirioneddol. Bryd arall, mae'n digwydd am fod cleifion yn defnyddio eu hawl i ddewis. Yn Nhor-faen, bu problem fawr o ran cael un ffocws ym maes iechyd a gofal cymdeithasol i fynd i'r afael â'r broblem. Mae honno bellach wedi ei goresgyn a gwelwch, o ffigurau mis Rhagfyr, fod rhai o'r ffigurau allgleifion mawr hynny yn dechrau gostwng. Fodd bynnag, mae amrywiaeth o resymau, ac yn aml mae'n digwydd am nad yw'r dewisiadau gwahanol

Again, we have been looking at spreading good practice in terms of providing a range of alternatives that might be utilised by health services and local government, which includes looking at some of the successes in supportive housing, a greater move to using community staff to maintain people in their homes, and better assessment processes. We are working with all these communities, and with the regional offices, to ensure that the factors that cause such inequality are being tackled universally. It is a high priority for us to ensure that people are placed effectively and well.

yn ddigonol neu am fod cymaint o bwysau'n dod drwy'r system. Eto, yr ydym wedi bod yn edrych ar ledaenu arferion da wrth ddarparu amrywiaeth o ddewisiadau gwahanol y gellid eu defnyddio gan wasanaethau iechyd a llywodraeth leol, sy'n cynnwys edrych ar rai o'r llwyddiannau mewn tai cymorth, tuedd fwy i ddefnyddio staff cymuned i gynnal pobl yn eu cartrefi eu hunain, a phrosesau asesu gwell. Yr ydym yn gweithio gyda'r cymunedau hyn i gyd, a chyda'r swyddfeydd rhanbarthol, i sicrhau bod pob un yn mynd i'r afael â'r ffactorau sy'n achosi anghydraddoldeb. Mae'n flaenoriaeth bwysig i ni i sicrhau bod pobl yn cael eu lleoli'n effeithiol ac yn dda.

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

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

Ms Lloyd: I think that it is not just the health service; local government also talks about the squeeze and the difficulty of prioritisation. I think that we need to concentrate on looking at a range of alternatives, so that patients can have a better choice of where they wish to be placed. A lot of work is going on at the moment concerning making more use of sheltered housing, assistive technology and support for people in their homes, providing local-government alternatives to privately owned nursing homes, getting a better relationship with the private nursing home sector, and looking much more carefully at what alternatives are required to deliver good-quality care for individuals on a long-term basis, which will include rehabilitation and all sorts of things. It is not a simple one-shot answer. It is very much about looking at the needs of individuals in the community and how those needs might best be

Ms Lloyd: Credaf nad y gwasanaeth iechyd yn unig sydd dan sylw: mae llywodraeth leol hefyd yn sôn am ddiffyg arian ac anhawster blaenoriaethu. Credaf fod angen i ni ganolbwyntio ar edrych ar amrywiaeth o ddewisiadau gwahanol, fel y gall cleifion gael gwell dewis wrth benderfynu ble maent am gael eu lleoli. Mae llawer o waith ar droed ar hyn o bryd ynghylch gwneud mwy o ddefnydd o dai gwarchod, cefnogaeth a thechnoleg gynorthwyol i bobl yn eu cartrefi,

addressed, in a far more creative way than we were able to do in the past. That has grown from the need, and some of the mandatory requirements placed on local government and the health service, to work more effectively together.

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

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

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

[166] **Alun Cairns:** Yes, but I would like to pick up on Mrs Lloyd's response to Jocelyn Davies a few moments ago. She highlighted the reduction of the number of nursing homes in Cardiff, which was one reason for a delayed transfer. In view of the fact that that comes within the same Minister's responsibility, what guidance have you and your colleagues within the department issued to local authorities in seeking to resolve this issue? It is a critical issue that I am aware of within my region, and one that, I am sure, Assembly Members are familiar with in other

[166] **Alun Cairns:** Oeddwn, ond hoffwn drafod ymateb Mrs Lloyd i Jocelyn Davies rai munudau'n ôl. Pwysleisiodd y gostyngiad yn nifer y cartrefi nyrsio yng Nghaerdydd, sef un o'r rhesymau am yr oedi wrth drosglwyddo. O ystyried y ffaith bod hynny'n rhan o gyfrifoldeb yr un Gweinidog, pa ganllawiau yr ydych chi a'ch cydweithwyr yn yr adran wedi eu rhoi i awdurdodau lleol i geisio datrys y broblem hon? Mae'n fater hollbwysig yr wyf yn ymwybodol ohono yn fy rhanbarth, ac yn un, yr wyf yn siŵr, y mae Aelodau'r Cynulliad yn gyfarwydd ag ef

regions. In my mind, that is focused on funding issues, between what private-sector nursing homes say that they need in order to operate efficiently and to invest in staff, and what local authorities are prepared to pay. Therefore, I assume that the Welsh Assembly Government is in a position to negotiate, arbitrate, or certainly to issue guidance in order to resolve these disputes.

mewn rhanbarthau eraill. Yn fy marn i, mae hwnnw'n canolbwyntio ar faterion cyllid, rhwng yr hyn y dywed cartrefi nyrsio'r sector preifat fod ei angen arnynt i weithredu'n effeithlon a buddsoddi mewn staff, a'r hyn y mae awdurdodau lleol yn barod i'w dalu. Felly, cymeraf fod Llywodraeth Cynulliad Cymru mewn sefyllfa i negodi, cyflafareddu, neu'n sicr i roi canllawiau er mwyn datrys yr anghydfodau hyn.

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

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

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

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

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

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

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

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

by patients who could be discharged from hospital.

gyhoeddwyd yn dangos gostyngiad yn nifer y dyddiau gwelyau sy’n cael eu llenwi gan gleifion a allai gael eu rhyddhau o’r ysbyty.

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

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

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

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

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

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

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

[169] **Alun Cairns:** O’r gorau, dim ond mewn rhai ardaloedd y mae prinder, ond nid mater y prinder yn unig yw hyn, aie? Does bosibl, os ydym yn edrych ymlaen at ddyfodol mwy hirdymor y sector annibynnol, mae angen fformiwla a chyfradd sefydlog y gall y sector annibynnol eu defnyddio i fuddsoddi yn ei gyfleusterau ac i hyfforddi ei staff er mwyn rhoi dyfodol iddynt. Yn fy mhrofiad i—ac efallai mai tystiolaeth lafar ydyw, ond dyna yw fy mhrofiad yn fy rhanbarth i—mae cartrefi nyrsio yn cau oherwydd nad ydynt yn fodlon â’r gyfradd a gânt gan awdurdodau lleol. Maent yn cwyno wrth y Gweinidog, ond mae’r Gweinidog yn beio’r awdurdod lleol a’r cartrefi nyrsio’n cael eu dal rhwng y ddau sefydliad. Awgrymaf i chi y byddai’n well o lawer pe bai Llywodraeth Cynulliad Cymru yn manteisio ar y cyfle yng Nghymru—ni ellid gwneud hynny yn Lloegr am ei bod lawer yn rhy fawr—i ddyfeisio a hwyluso rhyw fath o fformiwla ariannol a fyddai’n bodloni pawb, gan ystyried y costau, y pwysau a’r buddsoddiad y mae ei angen yn y sefydliadau hynny.

Ms Lloyd: Some work has been done on establishing a formula for just that purpose. Unfortunately, the care sector is currently discussing the end figure with us, but I can give you details of how that formula was arrived at and the sorts of things that it addresses. This is a serious problem and that is why we need multiple answers to the

Ms Lloyd: Mae ychydig waith wedi ei wneud i bennu fformiwla at yr union ddiben hwnnw. Yn anffodus, mae’r sector gofal yn trafod y ffigur terfynol gyda ni ar hyn o bryd, ond gallaf roi manylion i chi am y ffordd y cyrhaeddwyd y fformiwla hwnnw a’r mathau o bethau y mae’n mynd i’r afael â hwy. Mae hon yn broblem ddifrifol, a dyna pam mae

problem of the future care that can be given to older populations, and the private nursing-home sector is only one part of that solution. I can send you what has been done on that.

arnom angen nifer o atebion i broblem y gofal y gellir ei roi i boblogaethau hŷn yn y dyfodol. Dim ond un rhan o'r ateb hwnnw yw'r sector cartrefi nyrsio preifat. Gallaf anfon atoch yr hyn sydd wedi ei wneud ynghylch hynny.

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

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

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

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

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

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

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

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

dderbyniol?

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

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

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

[173] **Alun Cairns:** Tybiaf y gallai'r ffaith i chi ddweud ei bod yn annerbyniol cael diwylliant lle mae'n dderbyniol methu targedau fy nghalonogi, ond hoffwn eich cyfeirio at baragraff 4.14 ar dudalen 41 yr ail

volume, which states clearly—I am reading halfway down that paragraph—that

gyfrol, sy’n nodi’n glir—darllenaf hanner ffordd i lawr y paragraff hwnnw—

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

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

It goes on to say that,

Mae’n mynd ymlaen i ddweud,

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

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

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

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

Ms Lloyd: Not necessarily.

Ms Lloyd: Ddim o reidrwydd.

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

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

Ms Lloyd: No, this is not inaccurate, but it is one side of a coin. The Minister said that progress had to be made to reduce waiting times, and that has been done. A judgment

Ms Lloyd: Na, nid yw hyn yn anghywir, ond un ochr o’r geiniog ydyw. Dywedodd y Gweinidog bod yn rhaid gwneud cynnydd i leihau amseroedd aros, ac mae hynny wedi ei

had to be made about the feasibility of that achievement and we had to ensure that there was a reasonable chance that organisations, if they maximised their efficiency and used their facilities well, could meet the targets that were being proclaimed, and adhered to that, so that the aspirations of the individual patients could be met. You will know of some of the action that we took, where we believed that organisations needed to be scrutinised very closely indeed. We felt that they could meet their targets and yet they seemed to be drifting off the necessary progress. The first thing that we did, particularly with Gwent, which has turned itself around, was that the Minister invited Brian Edwards to look very carefully at the way in which it was managing its very large waiting lists and the long tail of wait that was prevalent at that time. He reported and they actioned all the recommendations that he made, and Gwent has achieved its targets. It was important that both the deficit culture, and the culture of ‘we can miss this if we fancy’, was stopped once and for all once the new organisations were established.

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

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

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

Ms Lloyd: Yes.

Ms Lloyd: Ydy.

[176] **Alun Cairns:** I thought so. If we turn

[176] **Alun Cairns:** Dyna yr oeddwn yn ei

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

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

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

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

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

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

Ms Lloyd: In terms of the patients not being told, I think that that is a justifiable criticism. There will not be any tolerated breaches anymore, and that was made clear in the SAFF of 2004-05. A judgment had to be made about the balance between the activity that the organisations could legitimately be expected to deliver and the weight of the problem that was upon them, which is why,

Ms Lloyd: O ran nad yw'r cleifion yn cael eu hysbysu, credaf fod hynny'n feirniadaeth y gellir ei chyfiawnhau. Ni fydd unrhyw achosion o beidio â chyflawni targedau a ganiatawyd bellach, a gwnaed hynny'n glir yn fframwaith gwasanaeth a chyllid 2004-05. Yr oedd yn rhaid gwneud penderfyniad ar y cydbwysedd rhwng y gweithgarwch y gellid disgwyl i'r sefydliadau ei gyflawni mewn

in 2003-04, there were tolerated breaches. Those will not be tolerated anymore, and they have not been tolerated since this SAFF was produced for 2004-05. I should preface this by asking if you are asking whether or not we have rewarded the inefficient.

gwirionedd a phwysau'r broblem a oedd ganddynt, a dyna pam, yn 2003-04, yr oedd achosion o beidio â chyflawni targedau a ganiatawyd. Ni fydd y rheini'n cael eu goddef mwyach, ac nid ydynt wedi eu goddef ers cynhyrchu'r SAFF hwn yn 2004-05. Dylwn ragflaenu hyn drwy ofyn a ydych yn holi a ydym wedi gwobrwyo'r aneffeithlon ai peidio.

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

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

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

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

they can manage their patients. However, those people who have a mountain to climb and are not efficient are now under a scheme that intervenes in how they manage their services.

cleifion. Fodd bynnag, mae'r bobl hynny sydd â mynydd i'w ddringo ac nad ydynt yn effeithlon bellach yn rhan o gynllun sy'n ymyrryd yn y ffordd y maent yn rheoli eu cleifion.

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

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

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

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

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

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

Ms Lloyd: That is exactly what we have done.

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

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

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

Ms Lloyd: When this report was done, there was what I would call some sanctions, but of a facilitative nature, and there had been incentives. Incentives were paid in 2003-04 and 2004-05. Since this report stopped gathering its data, because it has only just been published, we have been working up a much tighter incentive and sanctions system—because we do listen to people—and it is something that we and the Minister are very wedded to, so that we do get a proper way of incentivising, and intervening when necessary, when trusts are proven to be inefficient and not managing the system well enough. Some have long waiting times and are really efficient: that is the burden of the demand that is coming through their door, which is another thing that we have to tackle.

Ms Lloyd: Pan wnaed yr adroddiad hwn, yr oedd yr hyn y byddwn yn ei alw'n rhai cosbau, ond cosbau a fyddai'n hwyluso, a bu cymhellion. Talwyd cymhellion yn 2003-04 a 2004-05. Ers i'r adroddiad hwn orffen casglu ei ddata, oherwydd mai dim ond newydd gael ei gyhoeddi y mae, yr ydym wedi bod yn creu system cymhellion a chosbau lawer mwy caeth—oherwydd ein bod yn gwrando ar bobl—ac mae'n rhywbeth yr ydym ni a'r Gweinidog yn ymrwymedig iawn iddi, fel ein bod yn cael ffordd gywir o gymell, ac ymyrryd pan fo angen, pan brofir bod ymddiriedolaethau yn aneffeithlon ac nad ydynt yn rheoli'r system yn ddigon da. Mae gan rai amseroedd aros hir ac maent yn effeithlon iawn: dyna faich y galw sydd wrth eu drws, sy'n rhywbeth arall y mae'n rhaid i ni fynd i'r afael ag ef.

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

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

Ms Lloyd: In terms of managing waiting times?

Ms Lloyd: O ran rheoli amseroedd aros?

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

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

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

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

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

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

Ms Lloyd: Yes, I think so.

Ms Lloyd: Gallent, yn fy marn i.

[184] **Jocelyn Davies:** Okay. Can we now turn to the waiting-time initiatives? I am looking at page 43, if that is any help. The report says that waiting-time initiatives have some positive benefits, certainly for those

[184] **Jocelyn Davies:** O'r gorau. A allwn droi yn awr at y mentrau amseroedd aros? Yr wyf yn edrych ar dudalen 43, os yw hynny o gymorth. Dywed yr adroddiad bod gan fentrau amseroedd aros rai buddiannau

patients who were treated—I am sure that they would say that they were of huge benefit—and in terms of clearing genuine backlogs and in supporting wider strategic development. The Auditor General’s report is critical of the use of waiting-time initiatives and it states here that there has been no clear overall strategy to reduce waiting times and that initiatives treat the symptom, that is, the patients waiting, rather than the causes of long waiting times. So, how will you ensure that additional funding provided to tackle waiting times delivers sustainable solutions and value for money in future?

cadarnhaol, yn sicr ar gyfer y cleifion hynny a gafodd eu trin—yr wyf yn siŵr y buasent yn dweud eu bod o fudd enfawr—ac o ran clirio ôl-groniadau achosion gwirioneddol ac wrth gefnogi gwaith datblygu strategol ehangach. Mae adroddiad yr Archwilydd Cyffredinol yn feirniadol o’r defnydd o fentrau amseroedd aros ac mae’n nodi yma na fu strategaeth gyffredinol amlwg i leihau amseroedd aros a bod mentrau’n mynd i’r afael â’r symptom, hynny yw, cleifion yn aros, yn hytrach nag achosion amseroedd aros hir. Felly, sut byddwch yn sicrhau bod cyllid ychwanegol a ddarperir i fynd i’r afael ag amseroedd aros yn rhoi atebion cynaliadwy a gwerth am arian yn y dyfodol?

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

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

In terms of sustainability, as you know, the Minister announced £30 million for capital, because, as we went around Wales, we found that the day-case rates in many of the organisations could not improve, because the day-case facilities were just hopeless. So,

O ran cynaliadwyedd, fel y gwyddoch, cyhoeddodd y Gweinidog £30 miliwn ar gyfer cyfalaf, oherwydd, wrth i ni fynd o amgylch Cymru, bu i ni ganfod na allai’r cyfraddau achosion dydd yn llawer o’r sefydliadau wella, oherwydd bod y

there is a huge amount of work going on to ensure that we modernise the accommodation, and that we have new equipment, so that they build up their capacity. That also includes diagnostics.

cyfleusterau achosion dydd mor anobeithiol. Felly, mae llawer iawn o waith yn cael ei wneud i sicrhau ein bod yn moderneiddio'r llety, a bod gennym offer newydd, fel eu bod yn adeiladu eu gallu. Mae hynny'n cynnwys diagnosteg hefyd.

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

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

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

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

solutions in terms of orthopaedics.

i’r ddau ranbarth arall ar gyfer atebion cynaliadwy o ran orthopaedeg.

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

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

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

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

Ms Lloyd: Obviously, it is not good value for money, and we recognised that. Up until 2003, the health authorities were managing this resource on our behalf, but, from 2003 onwards, it was clear that we had to institute much better control over the use made of money. We have done it in two ways, and I will give two sets of anecdotes. First, some trusts were paying very variable fees to their

Ms Lloyd: Yn amlwg, nid yw’n werth da am arian, a bu i ni gydnabod hynny. Tan 2003, yr oedd yr awdurdodau iechyd yn rheoli’r adnodd hwn ar ein rhan, ond, o 2003 ymlaen, yr oedd yn amlwg bod yn rhaid i ni sefydlu rheolaeth lawer gwell o’r defnydd a wnaed o’r arian. Yr ydym wedi ei wneud mewn dwy ffordd, a rhoddaf ddwy enghraifft i chi. Yn gyntaf, yr oedd rhai ymddiriedolaethau yn

consultants for waiting-lists initiatives, so there is a fixed rate contained within our consultants' contract. Although some chief executives are asking me to be lenient and to vary it, we will not—it will stay as it is.

talu ffioedd amrywiol iawn i'w meddygon ymgynghorol ar gyfer mentrau rhestrau aros, felly mae cyfradd sefydlog wedi ei chynnwys yn ein contract meddygon ymgynghorol. Er bod rhai prif weithredwyr yn gofyn i mi beidio â bod yn rhy llym ac i'w hamrywio, ni fyddwn yn gwneud hynny—bydd yn aros fel ag y mae.

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

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

yn cael ei ddefnyddio'n effeithiol.

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

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

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

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

[187] **Jocelyn Davies:** We know that patients faced with long waiting lists are more likely to turn to the private sector to spend their own money when they may not normally consider doing that. You accept that. What is the longer-term role for the private sector?

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

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

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

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

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

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

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

now be done by Healthcare Inspectorate Wales, so that we can ensure that the standards achieved by the private sector are the same as those achieved in the NHS.

hwnnw bellach yn cael ei wneud gan Arolygiaeth Gofal Iechyd Cymru, fel y gallwn sicrhau bod y safonau a gyflawnir gan y sector preifat yr un fath â'r rheini a gyflawnir yn y GIG.

[189] **Alun Cairns:** To pursue that further, when this money was being spent to use the private sector to bring the waiting list down, was that additional money offered to any trust, or was any request made by any trust for additional staff, or to recruit an additional consultant? I put it to you that one trust's chief executive told me that, if only he had the money to recruit an additional consultant, he could use the money far more efficiently than we could, because of the money going to the private sector. He said that the consequence was that that single consultant that they had was becoming a millionaire overnight—and that was the phrase that he used—because he was operating on NHS patients in the private sector. He said that if that money had been given to him to recruit another consultant, whom he thought he could have sourced from elsewhere, it would have been a much more effective use of the funds. Was any proposal along those lines made to you by any trust?

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

Mr Hill-Tout: We operate on the basis that, when additional work is being considered, whether it is work that will take place in the

Mr Hill-Tout: Yr ydym yn gweithredu ar y sail sef, pan fo gwaith ychwanegol yn cael ei ystyried, boed hwnnw'n waith a fydd yn

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

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

We, as the Welsh Assembly Government, are putting pump-priming money into this, and so the debate that you may have been told about when you had that discussion with that consultant is also an issue for the local health boards, as to whether they would consider making a permanent investment in that service. That is an issue for local deliberation. So, it may well be that that local health board did not wish to make an investment in that way and at that time. However, I can assure you that all of the work that we commission through the second offer scheme is offered to the NHS first, so that it gets ample opportunity to carry out this work. As you can see, 2,700 patients received their care through the NHS this year.

Yr ydym ni, fel Llywodraeth Cynulliad Cymru, yn buddsoddi arian sefydlu yn hyn, ac felly mae'r ddadl y cawsoch eich hysbysu amdani o bosibl pan gawsoch y drafodaeth honno gyda'r meddyg ymgynghorol hwnnw hefyd yn fater i'r byrddau iechyd lleol, ynglŷn ag a fyddent yn ystyried gwneud buddsoddiad parhaol yn y gwasanaeth hwnnw. Mae hwnnw'n fater i'w ddadlau'n lleol. Felly, mae'n dra phosibl nad oedd y bwrdd iechyd lleol hwnnw am wneud buddsoddiad yn y modd hwnnw ac ar yr adeg honno. Fodd bynnag, gallaf eich sicrhau bod yr holl waith yr ydym yn ei gomisiynu drwy gynllun yr ail gynnig yn cael ei gynnig i'r GIG yn gyntaf, fel ei fod yn cael digon o gyfle i gyflawni'r gwaith hwn. Fel y gwelwch, derbyniodd 2,700 o gleifion eu gofal drwy'r GIG eleni.

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

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

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

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

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

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

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

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

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

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

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

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

[194] **Alun Cairns:** I want to refer to the second offer scheme that is highlighted particularly on page 38 and in the box on that page that describes it. It also highlights that an extra £12 million is going in to pay for treatments under the scheme in 2004-05. Just before that, it also gives an explanation of

[194] **Alun Cairns:** Yr wyf am gyfeirio at gynllun yr ail gynnig sy'n cael sylw yn arbennig ar dudalen 38 a hefyd yn y blwch ar y dudalen honno sy'n ei ddisgrifio. Mae hefyd yn tynnu sylw at y ffaith bod £12 miliwn ychwanegol yn cael ei fuddsoddi i dalu am driniaethau dan y cynllun yn 2004-

what will happen thereafter, in terms of how funding will be resolved. It seems pretty bureaucratic to me. What estimates have you made of the costs of administrating it?

05. Cyn hynny, mae hefyd yn rhoi esboniad o'r hyn a fydd yn digwydd ar ôl hynny, o ran sut bydd y cyllid yn cael ei ddatrys. Mae'n ymddangos yn eithaf biwrocrataidd i mi. Pa amcangyfrifon a wnaethoch o'r costau o'i weinyddu?

Mr Hill-Tout: I do not have the exact figures with me, but we took the view that there would be considerable economies of scale if we could set up a second-offer commissioning team, which would operate on behalf of all 22 local health boards in Wales, and that suggesting that each LHB commissioned their second offers individually would not be cost-effective. The central commissioning team is provided, on behalf of the NHS in Wales, through Rhondda Cynon Taf Local Health Board, and its running costs are approximately £350,000 to £400,000 a year, but I could give you the exact figures.

Mr Hill-Tout: Nid oes gennyf yr union ffigurau gyda mi, ond bu i ni benderfynu y byddai arbedion maint sylweddol pe gallem sefydlu tîm comisiynu'r ail gynnig, a fyddai'n gweithredu ar ran pob un o'r 22 bwrdd iechyd lleol yng Nghymru, ac na fyddai awgrymu bod pob BILl yn comisiynu ei ail gynigion yn unigol yn gost-effeithiol. Darperir y tîm comisiynu canolog, ar ran y GIG yng Nghymru, drwy Fwrdd Iechyd Lleol Rhondda Cynon Taf, ac mae'n costio tua £350,000 i £400,000 y flwyddyn i'w gynnal, ond gallwn roi'r union ffigurau i chi.

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

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

Mr Hill-Tout: In two ways. First of all, the Welsh Assembly Government publishes waiting-time figures on a monthly basis and part of those publications specifically address patients who are the subjects of a second offer. So, our current target is to achieve a

Mr Hill-Tout: Mewn dwy ffordd. Yn gyntaf oll, mae Llywodraeth Cynulliad Cymru yn cyhoeddi ffigurau amseroedd aros yn fisol ac mae rhan o'r cyhoeddiadau hynny yn canolbwyntio'n benodol ar gleifion sy'n destun ail gynnig. Felly, ein targed cyfredol

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

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

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

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

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

Mr Hill-Tout: Credaf ei fod yn adlewyrchiad teg. Os edrychwn yn ôl at y rheswm dros gynllun yr ail gynnig ei hun, mae wedi ei ddylunio i roi cyfleuster i gleifion sydd mewn perygl o fethu'r targedau gofynnol a osodwyd gan y Llywodraeth. Nid yw wedi ei gynllunio i ddarparu ateb cynaliadwy i amseroedd aros;

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

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

The second issue is the point that I would single out as an issue, which is the reluctance to travel. It is certainly the case—and when we get into it, Chair, I have some figures on this, and the report picks this up—that several patients say that they would prefer not to travel, and they give a variety of reasons for this. That would mean that those patients

Yr ail fater yw'r pwynt y byddwn yn ei ddewis fel problem, sef yr amharodrwydd i deithio. Mae'n sicr yn wir—a phan awn ati i'w drafod, Gadeirydd, mae gennyf ffigurau am hyn, ac mae'r adroddiad yn sôn am hyn—bod llawer o gleifion yn dweud y byddai'n well ganddynt beidio â theithio, a rhoddant amrywiaeth o resymau dros hyn. Byddai

therefore need to be treated locally, so they add, effectively, to the total number of patients who must be treated locally. We have to manage that risk, and I think that we can do more. We have commissioned a MORI poll of 800 patients, who were asked their reasons as to why they refused a second offer. There were a range of reasons, but some of them included patients not being sure of what it means, and not necessarily being sure about what would happen to them and their relatives if they went to Bristol or Hereford. We can do much more, through the second offer commissioning team, to provide a more fulfilling experience for patients, giving them more information, helping them to understand, providing for patients' friends, and organising their travel and domestic arrangements to a greater extent than we do now. I am convinced that, if we can do more in that area, we can reduce that risk of those patients who decline their opportunity because they are unwilling to travel.

hynny'n golygu felly bod angen trin y cleifion hynny'n lleol, felly maent yn ychwanegu, i bob pwrpas, at gyfanswm y cleifion y mae'n rhaid eu trin yn lleol. Rhaid i ni reoli'r risg honno, a chredaf y gallwn wneud mwy. Yr ydym wedi comisiynu pôl MORI o 800 o gleifion, a gafodd eu holi am eu rhesymau dros wrthod ail gynnig. Yr oedd amrywiaeth o resymau, ond yr oedd rhai ohonynt yn cynnwys cleifion yn ansicr am beth y mae'n ei olygu, a ddim o reidrwydd yn siŵr beth fyddai'n digwydd iddynt a'u perthnasau pe baent yn mynd i Fryste neu Henffordd. Gallwn wneud llawer mwy, drwy'r tîm comisiynu ail gynnig, i ddarparu profiad llawer mwy boddhaus i gleifion, gan roi mwy o wybodaeth iddynt, eu helpu i ddeall, darparu ar gyfer ffrindiau cleifion, a threfnu eu trefniadau teithio a domestig i raddau helaethach nag y gwnawn ar hyn o bryd. Yr wyf yn argyhoeddedig, os gallwn wneud mwy yn y maes hwnnw, y gallwn leihau'r risg honno o gleifion sy'n gwrthod eu cyfle oherwydd eu bod yn amharod i deithio.

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

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

Ms Lloyd: There is now a target that is much tighter on out-patient treatment as well, so they have to balance it out; it is going down

Ms Lloyd: Mae targed bellach sy'n llawer mwy tynn ar driniaeth cleifion allanol hefyd, felly mae'n rhaid iddynt ei gydbwyso; mae'n

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

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

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

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

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

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

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

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

Mr Hill-Tout: In Bridgend?

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

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

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

Mr Hill-Tout: In Bridgend?

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

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

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

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

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

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

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

Mr Hill-Tout: That is the first time that I have been notified of any such instance, and I will certainly look into it. It is possible that

Mr Hill-Tout: Dyna’r tro cyntaf i mi gael fy hysbysu am unrhyw achos o’r fath, a byddaf yn sicr yn ymchwilio iddo. Mae’n bosibl y

those consultants who operate in their private time—which they are perfectly free to do—can be contracted to other hospitals. Was it a private hospital in England, or an NHS hospital?

gall y meddygon ymgynghorol hynny sy'n cynnal llawdriniaethau yn eu hamser preifat—sy'n rhywbeth y mae ganddynt berffaith hawl i'w wneud—gael eu contractio i ysbytai eraill. Ai ysbyty preifat ydoedd yn Lloegr, neu ysbyty'r GIG?

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

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

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

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

[204] **Alun Cairns:** I know that I have already said 'finally', but I have one further question to ask, if I may, which links to this point. Bearing in mind that we are making use of under capacity or free capacity in England, where we are told that, for example, MRSA rates, among other infections, may be

[204] **Alun Cairns:** Gwn fy mod eisoes wedi dweud 'yn olaf', ond mae gennyf un cwestiwn arall i'w ofyn, os caf, sy'n gysylltiedig â'r pwynt hwn. Gan gofio ein bod yn defnyddio gallu dros ben neu allu rhydd yn Lloegr, lle dywedir wrthym, er enghraifft, y gallai cyfraddau MRSA, ymhlith

higher, what risk is there of a claim against NHS Wales for contracting to a hospital in England if a patient contracts MRSA because of the potentially higher risks there? We could have a paper on that, if that is of any help.

heintiau eraill, fod yn uwch, beth yw'r risg o hawliad yn erbyn GIG Cymru am gontractio i ysbyty yn Lloegr os yw claf yn cael MRSA oherwydd y risgiau uwch o bosibl a geir yno? Gallem gael papur am hynny, os yw hynny o unrhyw gymorth.

Ms Lloyd: They are our patients—

Ms Lloyd: Ein cleifion ni ydynt—

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

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

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

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

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

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

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

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

the case—you are right in the sense that there must be an increased risk, if there is a greater prevalence of MRSA in England. However, to convert that into any financial issue is almost impossible to do.

yr ystyr bod yn rhaid i'r risg fod yn uwch, os yw MRSA yn fwy cyffredin yn Lloegr. Fodd bynnag, mae bron yn amhosibl troi hynny'n unrhyw fater ariannol.

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

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

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

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

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

[208] **Mark Isherwood:** Dechreuaf drwy ychwanegu at sylw a wnaed gan Mr Hill-Tout am effaith benodol y llif trawsffiniol yn y Gogledd, a chadarnhau mai dim ond un gwasanaeth iechyd sydd yn nhyb llawer o bobl yn y Gogledd, yn enwedig y Gogledd-ddwyrain. Nid oes gwasanaethau ar wahân ar gyfer Cymru a Lloegr, oherwydd màs critigol, oherwydd y ddarpariaeth gwasanaeth

for intensive care for children, and so on. Therefore, it is about how we manage that in a cohesive way.

hanesyddol yng Nglannau Merswy o ofal dwys i blant, ac ati. Felly, mae'n fater o sut yr ydym yn rheoli hynny mewn modd cydlynus.

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

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

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

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

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

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

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

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

The national leadership and innovation agency will undertake the additional training

Bydd yr asiantaeth arwain ac arloesi genedlaethol yn ymgymryd â'r gwaith o roi

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

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

Although Conwy and Denbighshire are not major winners under Townsend, there are major areas, as you know, of real deprivation that need to be tackled within communities, even when, overall, they look as if they will be finely balanced in terms of equality of access to care and good health outcomes. The local health boards need to become much more sophisticated about looking at the solutions to ill health in these pockets of deprivation within communities, and establishing alternative models of care to manage the requirements of those communities.

Er nad yw Siroedd Conwy a Dinbych yn cael budd mawr dan Townsend, mae ardaloedd mawr, fel y gwyddoch, o amddifadedd gwirioneddol y mae angen mynd i'r afael â hwy mewn cymunedau, hyd yn oed pan eu bod, ar y cyfan, yn ymddangos y byddant yn eithaf cytbwys o ran cydraddoldeb mynediad i ofal a chanlyniadau iechyd da. Mae angen i'r byrddau iechyd lleol ddod yn llawer mwy soffistigedig ynghylch edrych am yr atebion i afiechyd yn yr ardaloedd hyn o amddifadedd mewn cymunedau, a sefydlu modelau gofal amgen i reoli gofynion y cymunedau hynny.

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

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

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

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

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

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

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

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

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

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

gwnaethant hyd yma.

[211] **Mark Isherwood:** Right. Do you see different patterns of regional working, whereby the boards and trusts work together better in some areas than in others?

[211] **Mark Isherwood:** Iawn. A ydych yn gweld patrymau gwahanol o weithio rhanbarthol, lle mae rhai byrddau ac ymddiriedolaethau'n gweithio gyda'i gilydd yn well mewn rhai ardaloedd nag eraill?

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

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

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

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

English hospitals should face longer waits than English patients?

dylai cleifion o Gymru a gaiff eu trin yn ysbytai Lloegr orfod aros yn hwy na chleifion o Loegr?

Mr Hill-Tout: I think that the issue about whether it is reasonable or not is really a matter for the Government, because it sets the targets. On what can be done to mitigate the effect on the patient, a number of things are being done. First, it is open to the local health boards in Wales to commission from whom they choose, and we just talked about commissioning. Clearly, they must make decisions about how best to secure care for their patients and whether to secure it from a Welsh or an English hospital. They know the framework in which they are operating. What we have recognised is that disputes arise frequently as a consequence of this. So, I have met colleagues from the Department of Health over the last nine months, with the agreement of the Minister and the Minister in London, to set out a procedure document, if you like, which clarifies for commissioners on both sides of the border, how they should handle disputes. We have given guidance—in fact, it was issued as a Welsh health circular this month—to the service on both sides of the border and we have also set up a procedure whereby, if there is a difficulty and if any patient is at the heart of a difficulty, that the patient's care must come first. So, the patient must be treated, and then, if there is an issue about the cost, who bears the cost or the length of the waiting time, there is a disputes procedure that is effective, which goes up through the local health board and

Mr Hill-Tout: Credaf mai mater i'r Llywodraeth mewn gwirionedd yw a yw'n rhesymol ai peidio, oherwydd y Llywodraeth sy'n gosod y targedau. O ran beth y gellir ei wneud i liniaru'r effaith ar y claf, mae nifer o bethau yn cael eu gwneud. Yn gyntaf, mae hawl gan y byrddau iechyd lleol yng Nghymru i gomisiynu gan bwy bynnag y dewisant, ac yr ydym newydd drafod comisiynu. Yn amlwg, rhaid iddynt wneud penderfyniadau ar y ffordd orau o sicrhau gofal i'w cleifion ac a ddylid cael y gofal o ysbyty yng Nghymru neu yn Lloegr. Maent yn adnabod y fframwaith y maent yn gweithredu ynddo. Yr hyn yr ydym wedi ei nodi yw bod anghydfod yn codi'n aml yn sgil hyn. Felly, yr wyf wedi cyfarfod â chydweithwyr o'r Adran Iechyd dros y naw mis diwethaf, gyda chydsyniad y Gweinidog a'r Gweinidog yn Llundain, i greu dogfen weithdrefnau, os hoffwch, sy'n egluro i gomisiynwyr y naill ochr i'r ffin, sut y dylent ymdrin ag anghydfod. Yr ydym wedi rhoi canllawiau—a dweud y gwir, cawsant eu cyhoeddi fel cylchlythyr iechyd Cymru y mis hwn—i'r gwasanaeth ar ddwy ochr y ffin ac yr ydym hefyd wedi sefydlu gweithdrefn, sef os oes anhawster ac os yw unrhyw glaf yng nghanol anhawster, bod yn rhaid i ofal y claf gael blaenoriaeth. Felly, rhaid i'r claf gael ei drin, ac yna, os oes problem ynglŷn â'r gost, pwy sy'n talu'r gost neu hyd yr amser aros, mae gweithdrefn anghydfod effeithiol, sy'n

the primary care trust on the other side of the border up to the regional office level in Wales and the strategic health authority level in England, and, if necessary, but only in a very small number of cases, that dispute will be addressed at governmental level. We have agreed that procedure, over the last six or nine months, with our colleagues in London and it has been issued to the NHS on both sides of the border. So, my answer is that we know that there are different waiting times—that is a matter for the Governments—but, in terms of managing that, I think that the guidance that we have issued, including the disputes procedure, will allow patient care to be properly protected.

gweithio i fyny'r bwrdd iechyd lleol a'r ymddiriedolaeth gofal sylfaenol ar ochr draw'r ffin hyd at lefel swyddfa ranbarthol yng Nghymru a lefel yr awdurdod iechyd strategol yn Lloegr, ac, os oes angen, ond dim ond mewn nifer fach iawn o achosion, bydd yr anghydfod hwnnw'n cael ei ddatrys ar lefel llywodraeth. Yr ydym wedi cytuno ar y weithdrefn honno, dros y chwech i naw mis diwethaf, gyda'n cydweithwyr yn Llundain ac mae wedi ei chyhoeddi i'r GIG ar ddwy ochr y ffin. Felly, fy ateb yw ein bod yn gwybod bod amseroedd aros gwahanol—mae hynny'n fater i'r Llywodraethau—ond, o ran rheoli hynny, credaf y bydd y canllawiau a gyhoeddwyd gennym, gan gynnwys y weithdrefn anghydfod, yn caniatáu i ofal cleifion gael ei ddiogelu'n briodol.

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

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

On the knock-on effect, particularly in terms of cross-border commissioning, I know that the North East Wales NHS Trust, for

Ynglŷn â'r effaith ganlyniadol, yn enwedig o ran comisiynu trawsffiniol, gwn fod Ymddiriedolaeth GIG Gogledd Ddwyrain

example, is increasingly seeing itself in a competitive environment because of commissioning. It is working with the local higher education college to put forward its proposals to enable it to compete effectively with the targets in England. Would you endorse such initiatives, and how can we take that forward on a bottom-up model, where we are using the expertise that is available on the ground?

Cymru, er enghraifft, yn ystyried ei hun fwyfwy mewn amgylchedd cystadleuol oherwydd comisiynu. Mae'n gweithio gyda'r coleg addysg uwch lleol i gyflwyno ei chynigion i'w galluogi i gystadlu'n fwy effeithiol â'r targedau yn Lloegr. A fyddech yn cefnogi mentrau o'r fath, a sut gallwn ddatblygu hynny ar fodel o'r gwaelod i fyny, lle yr ydym yn defnyddio'r arbenigedd sydd ar gael ar lawr gwlad?

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

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

activity is going up'. It is a complex environment, and we would certainly encourage the Welsh trusts on the border to operate within that environment. We are saying to them that they are not compelled to offer anything other than Welsh waiting times.

ydych yn anfon mwy o'ch cyfeiriadau brys atom, felly mae angen i chi ein talu am y cyfeiriadau hynny oherwydd mae'r gweithgarwch hwnnw ar gynnydd'. Mae'n amgylchedd cymhleth, a byddem yn sicr yn annog ymddiriedolaethau Cymru ar y ffin i weithredu yn yr amgylchedd hwnnw. Yr ydym yn dweud wrthynt nad oes gorfodaeth arnynt i gynnig unrhyw beth heblaw amseroedd aros Cymru.

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

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

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

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

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

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

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

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

[215] **Mark Isherwood:** On that note, I will

[215] **Mark Isherwood:** Ar y nodyn hwnnw,

pass you back to the Chair for the final question.

hoffwn eich trosglwyddo yn ôl at y Cadeirydd am y cwestiwn olaf.

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

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

[217] **Mick Bates:** I refer you to volume 1, appendix 6. Mark raised some interesting points. I refer you to page 71, which shows the figures for the Powys Local Health Board, from which two questions arise. First, you have here an innovative solution. There is no trust, just the local health board, and it takes all the secondary care and the commissioning in Powys. It has achieved a great result, with no-one waiting over 18 months for in-patient care and only five waiting for out-patient care. Is it not unnecessary to retain this double structure of trusts and health boards? [*Interruption.*] The evidence is in this report—they are the most effective people of all at reducing waiting times.

[217] **Mick Bates:** Cyfeiriaf at gyfrol 1, atodiad 6. Cododd Mark bwyntiau diddorol. Cyfeiriaf at dudalen 71, sy'n dangos y ffigurau ar gyfer Bwrdd Iechyd Lleol Powys, sef testun y ddau gwestiwn. Yn gyntaf, mae gennych yn y fan hon ateb arloesol. Nid oes ymddiriedolaeth, dim ond y bwrdd iechyd lleol, ac ef sy'n gyfrifol am yr holl ofal eilaidd a'r comisiynu ym Mhowys. Mae wedi cyflawni canlyniad gwych, gyda neb yn aros dros 18 mis am ofal cleifion mewnol a dim ond pump yn aros am ofal cleifion allanol. Onid yw'n ddiangen cadw'r strwythur dwbl hwn o ymddiriedolaethau a byrddau iechyd? [*Torri ar draws.*] Mae'r dystiolaeth yn yr adroddiad hwn—hwy yw'r bobl fwyaf effeithiol wrth leihau amseroedd aros.

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

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

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

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

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

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

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

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

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

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

Ms Lloyd: It has good data.

Ms Lloyd: Mae ganddo ddata da.

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

[220] **Mick Bates:** Dim ond drwy frwydro ag

ysbytai Lloegr y mae hyn wedi digwydd.

Ms Lloyd: Yes.

Ms Lloyd: Ie.

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

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

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

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

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

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

[222] **Mick Bates:** O’r gorau.

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

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

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

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

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

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

[224] **Jocelyn Davies:** Mewn ymateb i gwestiwn gan Mark Isherwood, Mrs Lloyd, dywedasoch eich bod o’r farn bod y byrddau iechyd lleol yn atebol—yr oeddech yn bendant iawn am hynny. Gwn fod Leighton

raised this earlier. How is the local health board accountable to the public?

hefyd wedi crybwyll hyn yn gynharach. Sut mae’r bwrdd iechyd lleol yn atebol i’r cyhoedd?

Ms Lloyd: It has quite an extended board in terms of its representation, which is one way in which it extends its representation. Also, it has to meet in public, it has to disclose its strategies and its commissioning proposals to the public and discuss them with it, it has to have in place a system of public involvement to gather evidence from the general public, informed by health needs, and—in looking at the workings of local health boards as opposed to those of previous commissioners—possibly there is very much more active engagement in trying to ensure that it holds a good discussion with its own partners and with the general public about the issues facing it. That is one of the evaluations that is going on at the moment: how effectively have the local health boards engaged both with their partners and with their general public in the first two years, particularly in areas where there are these pockets of deprivation, which need to be addressed? We hope to have the results of that sort of evaluation in September, to see how well they have done that and what there is to learn.

Ms Lloyd: Mae ganddo fwrdd eithaf estynedig o ran ei gynrychiolaeth, sydd yn un ffordd y mae’n ymestyn ei gynrychiolaeth. Hefyd, mae’n rhaid iddo gyfarfod yn gyhoeddus, rhaid iddo ddatgelu ei strategaethau a’i gynigion comisiynu i’r cyhoedd a’u trafod gyda hwy, rhaid iddo fod â system o gynnwys y cyhoedd ar waith i gasglu tystiolaeth gan y cyhoedd, sydd wedi ei hysbysu gan anghenion iechyd, ac—wrth edrych ar weithredoedd byrddau iechyd lleol o gymharu â gweithredoedd comisiynwyr blaenorol—mae’n bosibl bod llawer mwy o ymgysylltu gweithredol i geisio sicrhau ei fod yn cynnal trafodaeth dda â’i bartneriaid ei hun a chyda’r cyhoedd am y materion sy’n ei wynebu. Dyna un o’r gwerthusiadau sy’n digwydd ar hyn o bryd: pa mor effeithiol y mae’r byrddau iechyd lleol wedi ymgysylltu â’u partneriaid a chyda’r cyhoedd yn y ddwy flynedd gyntaf, yn enwedig mewn ardaloedd lle mae’r llecynnau hyn o amddifadedd, y mae angen mynd i’r afael â hwy? Yr ydym yn gobeithio cael canlyniadau’r math hwnnw o werthusiad ym mis Medi, i weld pa mor dda y maent wedi gwneud hynny a gweld beth y gallwn ei ddysgu.

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

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

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

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

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

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

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

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

and getting sustained improvement?

sicrhau gwelliant cyson?

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

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

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

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

Ms Lloyd: Yes, of course.

Ms Lloyd: Iawn, wrth gwrs.

Daeth y sesiwn cymryd tystiolaeth i ben am 3.25 p.m.

The evidence-taking session ended at 3.25 p.m.

Cynulliad Cenedlaethol Cymru
Pwyllgor Archwilio

The National Assembly for Wales
Audit Committee

Amseroedd Aros y GIG yng Nghymru
NHS Waiting Times in Wales

Cwestiynau 229-329
Questions 229-329

Dydd Iau, 3 March 2005
Thursday, 3 March 2005

Aelodau Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Mark Isherwood, Irene James, Carl Sargeant, Catherine Thomas.

Swyddogion yn bresennol: Syr John Bourn, Archwilydd Cyffredinol Cymru; Gillian Body, Swyddfa Archwilio Genedlaethol Cymru; David Powell, Swyddog Cydymffurfio, Cynulliad Cenedlaethol Cymru.

Tystion: Geoff Lang, Prif Weithredwr, Bwrdd Iechyd Lleol Wrecsam; Jane Perrin, Prif Weithredwr, Ymddiriedolaeth GIG Abertawe; Bernadine Rees, Prif Weithredwr, Bwrdd Iechyd Lleol Sir Benfro; Hugh Ross, Prif Weithredwr, Ymddiriedolaeth GIG Caerdydd a'r Fro; Paul Williams, Prif Weithredwr, Ymddiriedolaeth GIG Bro Morgannwg.

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

Officials present: Sir John Bourn, Auditor General for Wales; Gillian Body, National Audit Office Wales; David Powell, Compliance Officer, National Assembly for Wales.

Witnesses: Geoff Lang, Chief Executive, Wrexham Local Health Board; Jane Perrin, Chief Executive, Swansea NHS Trust; Bernadine Rees, Chief Executive, Pembrokeshire Local Health Board; Hugh Ross, Chief Executive, Cardiff and Vale NHS Trust; Paul Williams, Chief Executive, Bro Morgannwg NHS Trust.

Dechreuodd y cyfarfod am 9.33 a.m.
The meeting began at 9.33 a.m.

[229] **Janet Davies:** Good morning. I welcome committee members, witnesses and members of the public to this meeting of the Audit Committee in Swansea.

[229] **Janet Davies:** Bore da a chroeso i aelodau'r pwyllgor, y tystion, a'r cyhoedd i'r cyfarfod hwn o'r Pwyllgor Archwilio yn Abertawe.

I remind everyone that the committee operates bilingually and that headsets are available for translation of Welsh into

Yr wyf yn atgoffa pawb fod y pwyllgor yn gweithredu'n ddwyieithog a bod clustffonau ar gael ar gyfer cyfieithu o'r Gymraeg i'r

English, and also to amplify the sound.

Saesneg, a hefyd i gynyddu'r sain.

I remind everyone to switch off their mobile telephones, pagers, and any other electronic equipment, as they interfere with the translation and broadcasting equipment.

Yr wyf yn atgoffa pawb i ddiffodd eu ffonau symudol, galwyr, ac unrhyw ddyfais electronig arall, gan eu bod yn ymyrryd ar yr offer cyfieithu a darlledu.

If we have to leave the room in an emergency, please leave by the nearest exit and follow the ushers' directions.

Os bydd angen gadael yr ystafell mewn argyfwng, dylid ymadael drwy ddefnyddio'r drws agosaf a dilyn cyfarwyddyd y tywyswyr.

In an attempt to increase the awareness of, and access to, the committee, we are meeting in Swansea today, rather than in Cardiff. I feel that it is important for the Audit Committee to meet away from Cardiff occasionally. As someone who represents Swansea, among other areas, I am pleased that we could come to Swansea.

Mewn ymgais i gynyddu ymwybyddiaeth o'r pwyllgor a mynediad iddo, yr ydym yn cyfarfod yn Abertawe heddiw, yn hytrach na Chaerdydd. Teimlaf ei bod yn bwysig i'r Pwyllgor Archwilio gyfarfod i ffwrdd o Gaerdydd o bryd i'w gilydd. Fel rhywun sy'n cynrychioli Abertawe, ymhlith ardaloedd eraill, yr wyf yn falch iawn ein bod wedi gallu dod i Abertawe.

We have received apologies from Denise Idris Jones. I also welcome members from Audit Scotland. Barbara Hirst, Angela Cullen and Neil Craig are here with us, and it is nice to see them.

Yr ydym wedi derbyn ymddiheuriadau gan Denise Idris Jones. Yr wyf hefyd yn croesawu aelodau o Audit Scotland. Mae Barbara Hirst, Angela Cullen a Neil Craig yma gyda ni, ac mae'n bleser eu gweld i gyd.

I now ask Members whether they have any declarations of interest. I see that there are none.

Gofynnaf i'r Aelodau a oes ganddynt unrhyw ddatganiadau o fuddiannau. Gwelaf nad oes ganddynt.

Before asking the witnesses to introduce themselves, I remind the committee that this is the last meeting of the Audit Committee at which Sir John Bourn will be present as Auditor General for Wales. We have been fortunate over nearly six years to have Sir John setting the scene for audit in Wales. He introduced us to a rigorous and searching line of inquiry on every subject that we have had. I know that we will all miss him very much, although we will also be welcoming Mr Jeremy Colman in April. Thank you, Sir John.

Cyn gofyn i'r tystion gyflwyno eu hunain, yr wyf yn atgoffa pawb mai dyma gyfarfod olaf Syr John Bourn ar y Pwyllgor Archwilio fel Archwilydd Cyffredinol Cymru. Yr ydym wedi bod yn ffodus dros ben am bron i chwe blynedd i gael Syr Jon yn arwain y maes archwilio yng Nghymru. Cyflwynodd ni i ddull ymchwilio cadarn a thrwyadl ar bob pwnc yr ydym wedi'i drafod. Gwn y byddwn i gyd yn ei golli'n fawr, er y byddwn hefyd yn croesawu Mr Jeremy Colman fis Ebrill. Diolch, Syr John.

Sir John Bourn: Thank you, Chair.

Syr John Bourn: Diolch, Gadeirydd.

[230] **Janet Davies:** I ask the two witnesses present to introduce themselves.

[230] **Janet Davies:** Gofynnaf i'r ddau dyst sy'n bresennol i gyflwyno eu hunain.

Ms Rees: I am Bernadine Rees, chief executive of Pembrokeshire Local Health Board.

Ms Rees: Fi yw Bernadine Rees, prif weithredwr Bwrdd Iechyd Lleol Sir Benfro.

Mr Lang: I am Geoff Lang, chief executive of Wrexham Local Health Board.

Mr Lang: Fi yw Geoff Lang, prif weithredwr Bwrdd Iechyd Lleol Wrecsam.

[231] **Janet Davies:** Thank you very much. As you know, we are taking evidence on the 'NHS Waiting Times in Wales' report, and this is the third of three oral evidence-taking sessions on this report, which is considerably longer than the reports that we normally

[231] **Janet Davies:** Diolch yn fawr. Fel y gwyddoch, yr ydym yn cymryd tystiolaeth ar adroddiad 'Amseroedd Aros y GIG yng Nghymru', a hon yw'r drydedd o dair sesiwn cymryd tystiolaeth lafar ar yr adroddiad hwn, sy'n llawer hwy na'r adroddiadau yr ydym yn

consider. So, we will be taking evidence from the local health boards first, and then, probably after coffee, from some NHS trusts. I will start by asking the first questions, which will be quite general. I will make sure, as I hope will other Members, that you know which parts of the report we are going through. As we have two hefty volumes, it is difficult to work out where you are sometimes. I ask for your answers to be as focused as possible, because the report is very long. Perhaps you would like to decide which of you answers first. However, unless someone says differently, the questions are addressed to you both.

eu trafod fel arfer. Felly, byddwn yn cymryd tystiolaeth gan y byrddau iechyd lleol yn gyntaf, ac yna, ar ôl coffi mae'n debyg, gan rai ymddiriedolaethau GIG. Yr wyf am ddechrau drwy ofyn y cwestiynau cyntaf, a fydd yn eithaf cyffredinol. Byddaf yn sicrhau, fel y bydd Aelodau eraill yn ei wneud gobeithio, eich bod yn gwybod pa rannau o'r adroddiad yr ydym yn eu trafod. Gan fod gennym ddwy gyfrol swmpus, mae'n anodd gwybod lle yr ydych o bryd i'w gilydd. Gofynnaf i chi gadw mor agos â phosibl at y mater yn eich ateb, oherwydd bod yr adroddiad yn hir iawn. Efallai yr hoffech ddewis pwy sy'n ateb gyntaf. Fodd bynnag, oni bai bod rhywun yn dweud yn wahanol, gofynnir y cwestiynau i'r ddau ohonoch.

First, I would like to ask a fairly general question. The NHS in Wales has consistently failed to meet Assembly waiting time targets. Can you explain what responsibility and accountability your particular local health boards have for waiting times?

Yn gyntaf, yr wyf am ofyn cwestiwn eithaf cyffredinol. Mae'r GIG yng Nghymru yn gyson wedi methu â bodloni targedau amseroedd aros y Cynulliad. A allwch egluro pa gyfrifoldeb ac atebolrwydd sydd gan eich byrddau iechyd lleol penodol o ran amseroedd aros?

Mr Lang: In terms of the responsibility of local health boards, clearly, we are held to account by Welsh Assembly Government officials in terms of delivering against the performance targets that are set out for us annually in the context of a clear financial allocation. Our challenge is to commission services that balance the financial resource with the aspirations to improve the quality of service and access to services, particularly

Mr Lang: O ran cyfrifoldeb y byrddau iechyd lleol, yn amlwg, yr ydym yn atebol i swyddogion Llywodraeth Cynulliad Cymru o ran cyflawni yn erbyn y targedau perfformiad a bennir i ni yn flynyddol yng nghyd-destun dyraniad ariannol clir. Ein her yw comisiynu gwasanaethau sy'n cydbwyso'r adnoddau ariannol gyda'r dyheadau i wella ansawdd gwasanaeth a mynediad i wasanaethau, yn arbennig amseroedd mynediad o ran rhestrau

access times in terms of waiting lists.

aros.

Ms Rees: I would only add that our accountability is to break even. So, within our financial situation, we have to meet the targets and break even.

Ms Rees: Yr wyf ond am ychwanegu mai'n cyfrifoldeb ni yw adennill costau. Felly, yn ein sefyllfa ariannol, mae'n rhaid i ni fodloni'r targedau ac adennill costau.

[232] **Janet Davies:** Right, thank you.

[232] **Janet Davies:** Iawn, diolch.

[233] **Jocelyn Davies:** I wish to ask a supplementary to that. Are you accountable to the public?

[233] **Jocelyn Davies:** Yr wyf am ofyn cwestiwn atodol i hynny. A ydych yn atebol i'r cyhoedd?

Mr Lang: Yes. We have to demonstrate public accountability in terms of the decisions that we make and report to the public in terms of our performance and our use of resources. That performance management accountability is very much backed through the Welsh Assembly Government.

Mr Lang: Ydym. Mae'n rhaid i ni ddangos atebolrwydd cyhoeddus o ran y penderfyniadau yr ydym yn eu gwneud ac adrodd i'r cyhoedd ar ein perfformiad a'n defnydd o adnoddau. Mae'r atebolrwydd rheoli perfformiad hwn yn cael ei gefnogi drwy Lywodraeth Cynulliad Cymru.

[234] **Janet Davies:** We see that there is regional variation in waiting times per head of the population. Can you tell me why it is so acute in different health boards? If you look at figure 16 on page 29 of volume 1, you will see this demonstrated fairly clearly.

[234] **Janet Davies:** Yr ydym yn gweld bod amrywiad rhanbarthol mewn amseroedd amser y pen o'r boblogaeth. A allwch ddweud wrthyf pam mae hyn mor ddifrifol mewn gwahanol fyrddau iechyd? Os edrychwch ar ffigur 16 ar dudalen 29 cyfrol 1, byddwch yn gweld bod hyn yn cael ei amlygu'n eithaf clir.

Mr Lang: Perhaps I could comment first. In

Mr Lang: Efallai y gallaf wneud sylw i

terms of regional variation rather than individual local health board variation, the regional variation is very much a reflection of former health authorities and the work that they did. Certainly, the report identifies, for example, that the north Wales area has some lower waiting times than other parts of Wales. That is a reflection of the fact that health boards in north Wales commission a lot of services in England as well as in Wales and, as a result, they have had a consistent focus on comparing waiting times over many years. Therefore, the boards have invested to try to achieve equity between residents who are accessing services in Wales and in England over a long period. So, part of it is about history, and part of it is about the way in which resources have been deployed in the past. The other dimension that affects trusts—and our colleagues may comment on this later in terms of north Wales—is the element of competition and the need to continue to attract referrals, in that, if referrals change and access times go up and general practitioners from England do not refer patients to hospitals in Wales for whatever reason, those hospitals lose resources. That is a real financial burden that they have to manage. Therefore there has been an incentive for trusts as well to keep their waiting lists as low as possible, and comparable with those of colleagues in England. So, from a north Wales context, that has always been a historic driver.

ddechrau. O ran amrywiad rhanbarthol yn hytrach nag amrywiad byrddau iechyd lleol unigol, mae’r amrywiad rhanbarthol yn adlewyrchiad o gyn awdurdodau iechyd a’r gwaith a wnaethant. Yn sicr, mae’r adroddiad yn nodi, er enghraifft, bod ardal y Gogledd wedi cael amseroedd aros is na rhannau eraill o Gymru. Mae hynny’n adlewyrchu’r ffaith bod byrddau iechyd yn y Gogledd yn comisiynu llawer o wasanaethau yn Lloegr yn ogystal ag yng Nghymru ac, o ganlyniad, maent wedi canolbwyntio’n gyson ar gymharu amseroedd aros dros sawl blwyddyn. Felly, mae’r byrddau wedi buddsoddi i geisio sicrhau tegwch rhwng preswylwyr sy’n defnyddio gwasanaethau yng Nghymru ac yn Lloegr dros gyfnod hir. Felly, mae rhan ohonno’n ymwneud â hanes, a rhan yn ymwneud â’r ffordd y defnyddiwyd adnoddau yn y gorffennol. Dimensiwn arall sy’n effeithio ar ymddiriedolaethau—ac efallai y bydd ein cydweithwyr am roi sylwadau ar hyn yn ddiweddarach o ran y Gogledd—yw’r elfen o’r gystadleuaeth a’r angen i barhau i ddenu cyfeiriadau, o ran, os yw cyfeiriadau yn newid ac amseroedd aros yn cynyddu ac nad yw meddygon teulu o Loegr yn cyfeirio cleifion at ysbytai yng Nghymru am ba bynnag reswm, mae’r ysbytai hynny’n colli adnoddau. Mae hynny’n faich ariannol gwirioneddol sydd yn rhaid iddynt ei reoli. Felly cafwyd cymhelliant i ymddiriedolaethau hefyd gadw eu rhestrau aros mor isel â phosibl, ac yn debyg i rai cydweithwyr yn Lloegr. Felly, yng nghyd-destun y Gogledd, mae hynny wedi bod yn rym hanesyddol erioed.

[235] **Janet Davies:** I will come back to you in a minute, Ms Rees.

[235] **Janet Davies:** Deuaf yn ôl atoch mewn munud, Ms Rees.

So, are you saying, Mr Lang, that competition is not helpful in achieving your targets?

Felly, a ydych yn dweud, Mr Lang, nad yw cystadleuaeth o gymorth i gyflawni'ch targedau?

Mr Lang: It has been helpful in the north Wales context, because there is a need to continue to attract the referrals and to ensure that patient flows remain consistent. Trusts have then had to focus on delivering waiting times, as have commissioners who wanted to deliver equity for residents. So, it has proved helpful and has maintained a sharp focus. Over the last couple of years, the differences in waiting times have grown considerably as the pace of change in England has accelerated, and commissioners in north Wales have not had the resources to be able to keep up with that pace against other priorities set by the Welsh Assembly Government.

Mr Lang: Mae wedi bod o gymorth yng nghyd-destun y Gogledd, oherwydd bod angen parhau i ddenu'r cyfeiriadau a sicrhau bod llif cleifion yn parhau'n gyson. Bu'n rhaid i ymddiriedolaethau wedi hynny ganolbwyntio ar fodloni amseroedd aros, yn union fel comisiynwyr a oedd am sicrhau tegwch i breswylwyr. Felly, mae wedi bod o gymorth ac wedi cynnal ffocws clir. Yn ystod yr ychydig flynyddoedd diwethaf, mae'r gwahaniaethau mewn amseroedd aros wedi cynyddu'n sylweddol wrth i'r newid yn Lloegr gyflymu, ac nid yw comisiynwyr yn y Gogledd wedi cael yr adnoddau i allu cadw i fyny â'r cyflymdra hwnnw yn erbyn blaenoriaethau eraill a osodir gan Lywodraeth Cynulliad Cymru.

Ms Rees: In many ways, from the Pembrokeshire point of view, it is history again. As the committee is aware, local health boards were set up two years ago, and we were commissioning at a 'steady state', which meant that we did not really make inroads into commissioning until up to 12 months or 18 months. The period that the

Ms Rees: Mewn sawl ffordd, o safbwynt sir Benfro, mae hanes yn cael ei ailadrodd. Fel y gŵyr y pwyllgor, sefydlwyd byrddau iechyd lleol ddwy flynedd yn ôl, ac yr oeddem yn comisiynu ar 'gyflwr sefydlog' a oedd yn golygu nad oeddem yn cychwyn comisiynu tan 12 mis neu 18 mis. Mae'r cyfnod y mae'r adroddiad archwilio yn ei drafod yn mynd â

audit report covers takes us to May 2004, by which time we were beginning to have information on the LHB position to enable us to be more proactive in terms of commissioning.

ni i fis Mai 2004, ac erbyn hynny yr oeddem yn dechrau cael gwybodaeth am sefyllfa'r BILl i'n galluogi i fod yn fwy rhagweithiol o ran comisiynu.

[236] **Janet Davies:** Of course, in Pembrokeshire, you are in a situation very different from north-east Wales, are you not?

[236] **Janet Davies:** Wrth gwrs, yn sir Benfro, yr ydych mewn sefyllfa wahanol iawn i'r Gogledd-ddwyrain, onid ydych?

Ms Rees: Yes, we are, but we still have our tensions and our difficulties in Pembrokeshire. Dyfed has three district general hospitals, and we commission separately. We need to be considering using the audit report as a platform to commission differently, safely and with quality from a wider perspective.

Ms Rees: Ydym, yr ydym, ond mae gennym ein tensiynau a'n hanawsterau o hyd yn sir Benfro. Mae tri ysbyty cyffredinol dosbarth yn Nyfed, ac yr ydym yn comisiynu ar wahân. Mae angen i ni ystyried defnyddio'r adroddiad archwilio fel llwyfan i gomisiynu'n wahanol, yn ddiogel a chydag ansawdd o safbwynt ehangach.

[237] **Catherine Thomas:** Moving to volume 2, I refer to paragraph 2.3 and paragraphs 2.10 to 2.12, which deal with the increasing demand for out-patient services, and the role of LHBs in managing that demand. We see that increasing demand for out-patient services as a key driver of long waiting times. With regard to your LHB, do you feel that it is working effectively with trusts to manage demand, particularly for out-patient services?

[237] **Catherine Thomas:** Gan symud at gyfrol 2, cyfeiriaf at baragraff 2.3 a pharagraffau 2.10 i 2.12, sy'n delio â'r galw cynyddol am wasanaethau cleifion allanol, a swyddogaeth y BILlau wrth reoli'r galw hwnnw. Yr ydym yn gweld y galw cynyddol am wasanaethau cleifion allanol fel un o achosion allweddol amseroedd aros. O ran eich BILl, a ydych yn teimlo ei fod yn gweithio'n effeithiol gydag ymddiriedolaethau i reoli'r galw hwnnw, yn arbennig ar gyfer gwasanaethau cleifion allanol?

Ms Rees: We have certainly started to make

Ms Rees: Yr ydym yn sicr wedi dechrau

inroads. Demand management is not an overnight solution; there needs to be investment, and we need to address particular issues regarding the unravelling of information to make sure that we know what the demands and referrals are made up of. Currently, and during the time to which this report refers, almost the only alternative for most general practitioners was referring patients to secondary care. In putting in alternative services and developing pathways, investment is required as well as re-routeing. We need to have the appropriate professionals able to treat appropriately along the pathway, and the acute provider is almost the last source for the individual to be able to access out-patient care.

ennill tir. Nid yw rheoli'r galw yn ateb dros nos; mae angen buddsoddiad, ac mae angen i ni fynd i'r afael â materion penodol o ran datrys gwybodaeth i sicrhau ein bod yn gwybod beth sy'n gysylltiedig â'r gofynion a'r cyfeiriadau. Ar hyn o bryd, ac yn ystod y cyfnod y mae'r adroddiad hwn yn cyfeirio ato, yr unig opsiwn arall bron iawn i'r mwyafrif o feddygon teulu oedd cyfeirio cleifion i ofal eilaidd. Wrth gyflwyno gwasanaethau amgen a datblygu llwybrau, mae angen buddsoddiad yn ogystal ag ail-lwybro. Mae arnom angen y gweithwyr proffesiynol priodol sy'n gallu trin yn briodol ar hyd y llwybr, a'r darparwr acíwt yw'r ffynhonnell olaf bron iawn i'r unigolyn allu cael mynediad i ofal cleifion allanol.

Mr Lang: What Bernie has outlined is entirely correct, and the other challenge that we have is reshaping the system so that clinicians in every part of the system, whether they be general practitioners, nurses or other professionals working in primary care, through to consultants working in specialist care, see themselves as part of that system. Wherever the patient needs to be, to access care, there needs to be a clinical pyramid focused on delivering for patients, rather than elements of the system looking at their individual responsibility. For example, if I were a general practitioner, I might see my responsibility as being in primary care, whereas it is not: it is in primary care and also right along the whole pathway to and from the consultant. Similarly, consultants need to view their role as providing advice outwards to primary care and intermediate settings so that, if a patient needs access to a consultant's expertise, that need not always be in a consultation room. That can be provided through a clinical network and a communication channel with other practitioners. That change of approach and philosophy is one that we have to foster and work with.

Mr Lang: Mae'r hyn y mae Bernie wedi'i amlinellu yn hollol gywir, a'r her arall sy'n ein hwynebu yw ail-lunio'r system i sicrhau bod clinigwyr ym mhob rhan o'r system, boed yn feddygon teulu, yn nyrsys neu'n weithwyr proffesiynol eraill sy'n gweithio mewn gofal sylfaenol, i feddygon ymgynghorol sy'n gweithio mewn gofal arbenigol, yn ystyried eu hunain yn rhan o'r system honno. Ble bynnag y mae angen i'r cleifion fod, i gael mynediad i ofal, mae angen pyramid clinigol sy'n canolbwyntio ar ddarparu i gleifion, yn hytrach nag elfennau o'r system yn edrych ar eu cyfrifoldebau unigol. Er enghraifft, pe bawn i yn feddyg teulu, efallai y byddwn yn ystyried mai gofal sylfaenol fyddai fy nghyfrifoldeb, ond nid yw hynny'n wir: mae mewn gofal sylfaenol a hefyd ar hyd y llwybr i ac o'r meddyg ymgynghorol. Yn yr un modd, mae angen i feddygon ymgynghorol ystyried mai eu swyddogaeth yw darparu cyngor i'r tu allan i ganolfannau gofal sylfaenol a chanolraddol er mwyn sicrhau, os oes angen barn arbenigol meddyg ymgynghorol ar glaf, nid oes yn rhaid i hynny fod mewn ystafell ymgynghori bob tro. Gellir darparu hynny drwy rwydwaith clinigol a sianel gyfathrebu gydag ymarferwyr eraill. Mae'r newid dull ac

athroniaeth hwnnw yn un y mae'n rhaid i ni ei feithrin a gweithio gydag ef.

[238] **Catherine Thomas:** Do you feel that your LHB is doing enough to ensure that it has the information needed to effectively monitor GP referral patterns?

[238] **Catherine Thomas:** A ydych yn credu bod eich BILl yn gwneud digon i sicrhau bod ganddo'r wybodaeth sydd ei angen arno i fonitro patrymau cyfeirio meddygon teulu yn effeithiol?

Mr Lang: We are working to improve the information that we have. At the moment, we have fairly crude information that will tell us the rate of referrals from any particular general practice group—which may be one general practitioner or it may be up to seven, eight or nine of them if they are in a partnership—to a specialty in a hospital. We can map that over time. It is crude, but it tells whether, for example, in general surgery, the referral rate is rising or not. What it does not tell us is what is being referred, namely the clinical analysis within that and the reasons for the referral. Referrals may be because a general practitioner's background, training and clinical experience means that he or she is not particularly equipped to deal with certain conditions. General practitioners are not homogenous beings; they all have different competencies and skills according to their training and background, so, whereas a general practitioner in one practice may refer a particular case, another general practitioner may feel totally confident and competent to deal with it. That is not a criticism of that doctor; it is a reflection of how doctors are trained and the way in which they work. We need to understand what drives the decision at the individual doctor

Mr Lang: Yr ydym yn gweithio i wella'r wybodaeth sydd gennym. Ar hyn o bryd, mae gennym wybodaeth eithaf bras a fydd yn dweud wrthym y gyfradd gyfeiriadau gan unrhyw grŵp ymarfer cyffredinol penodol—a allai fod yn un meddyg teulu neu a allai fod hyd at saith, wyth neu naw ohonynt os ydynt mewn partneriaeth—i adran arbenigol mewn ysbyty. Gallwn weld y patrwm hwn dros amser. Mae'n fras, ond mae'n dweud a yw, er enghraifft, y gyfradd gyfeirio mewn llawfeddygaeth gyffredinol yn codi ai peidio. Yr hyn nad yw'n ei ddweud wrthym yw'r hyn sy'n cael ei gyfeirio, sef y dadansoddiad clinigol o fewn hynny a'r rhesymau dros y cyfeirio. Gall cyfeiriadau ddigwydd oherwydd bod cefndir, hyfforddiant a phrofiad clinigol meddyg teulu yn golygu nad yw'n gymwys i ddelio â chyflyrau penodol. Nid yw meddygon teulu i gyd yr un fath; mae ganddynt i gyd wahanol alluoedd a sgiliau yn dibynnu ar eu hyfforddiant a'u cefndiroedd, felly, lle gallai meddyg teulu gyfeirio achos penodol, gallai meddyg teulu arall fod yn hollol hyderus a chymwys i ddelio â'r achos. Nid lladd ar y meddyg yr ydym yma; mae'n adlewyrchu'r ffordd y mae meddygon yn cael eu hyfforddi a'r ffordd y maent yn gweithio. Mae angen i ni ddeall yr hyn sydd wrth

level. That is what we do not currently have; we have it at practice level, but we do not have it at doctor level. We are working to improve the information, but it will require some investment and it needs better information systems than we currently have.

wraidd y penderfyniad gan y meddyg unigol. Nid ydym yn gwneud hyn ar hyn o bryd; mae'n digwydd ar lefel ymarfer, ond nid yw'n digwydd ar lefel meddyg. Yr ydym yn gweithio i wella'r wybodaeth, ond bydd gofyn am fuddsoddiad ac mae angen gwell systemau gwybodaeth na'r hyn sydd gennym ar hyn o bryd.

[239] **Catherine Thomas:** That ties in with my next question, namely, have you implemented any mechanisms to provide feedback to GPs on the quality of their referrals?

[239] **Catherine Thomas:** Mae hynny'n ymwneud â'm cwestiwn nesaf, sef, a ydych wedi gweithredu unrhyw fecanweithiau i roi ymateb i feddygon teulu ar ansawdd eu cyfeiriadau?

Ms Rees: Yes. We use a GP commissioning group and we look at this service by service. However, a couple of things means that it is not as smooth as we would like it to be: first, public acceptance that there is an alternative to secondary care; and, secondly, the fact that it is much easier for GPs to refer into secondary care than it is for us to provide alternatives. The information is sketchy and, as Geoff alluded to, being able to analyse the information will take some time and resource in terms of looking at how we do that. We also need to be able to benchmark each GP so that you almost have some peer management around how you use particular parts of pathways, and that requires clinical leadership from the acute sector and from our GP colleagues.

Ms Rees: Ydym. Yr ydym yn defnyddio grŵp comisiynu meddygon teulu ac yr ydym yn edrych ar hyn fesul gwasanaeth. Fodd bynnag, mae ambell beth yn golygu nad yw mor rhwydd ag yr hoffem iddo fod: yn gyntaf, y cyhoedd yn derbyn bod opsiwn arall yn hytrach na gofal eilaidd; ac, yn ail, y ffaith ei bod yn llawer haws i feddygon teulu gyfeirio at ofal eilaidd nag ydyw i ni ddarparu opsiynau eraill. Mae'r wybodaeth yn fras ac, fel y soniodd Geoff, bydd angen llawer o amser ac adnoddau i allu dadansoddi'r wybodaeth o ran edrych ar sut yr ydym yn gwneud hynny. Mae hefyd angen i ni allu meincnodi pob meddyg teulu fel bod gennych reolaeth gan gydweithwyr bron iawn ynghylch sut i ddefnyddio rhannau penodol o lwybrau, ac mae hynny'n gofyn am arweiniad clinigol gan y sector acíwt a gan ein cydweithwyr sy'n feddygon teulu.

[240] **Catherine Thomas:** I will move on to paragraphs 3.3, 3.4 and 4.48, which look at the main causes of long in-patient, day-case waiting times. A review into the split between elective and emergency surgery provision in Carmarthenshire is taking place at the moment. What are you doing, in relation to your LHB, to ensure that emergency pressures do not impact on elective surgery rates?

[240] **Catherine Thomas:** Yr wyf am symud ymlaen at baragraffau 3.3, 3.4 a 4.48, sy'n edrych ar brif achosion amseroedd aros achosion dydd, cleifion mewnol hir. Mae adolygiad o'r rhaniad rhwng darpariaeth llawdriniaeth ddewisol a brys yn sir Gaerfyrddin ar y gweill ar hyn o bryd. Beth yr ydych yn ei wneud, o ran eich BILl, i sicrhau nad yw pwysau brys yn effeithio ar gyfraddau llawdriniaethau brys?

Mr Lang: Perhaps I could comment in terms of work that we are undertaking in our area. We have put in place a range of activities, services and initiatives aimed at managing emergency demand or urgent care need more appropriately. That involves using initiatives such as rapid-response teams, where you will have nursing and other clinical professionals—teams are able to assess a patient and support them in their own home or residential setting, rather than admitting them to hospital. We have looked, with our trust, at refocusing the way in which it is assessed, on their arrival, as to whether patients need to be admitted to hospital. So, for example, two years ago, a patient who presented with a suspected deep vein thrombosis would have gone straight into a medical ward, but that is now dealt with on an out-patient basis; they are diagnosed, treated and managed in the community. Likewise with patients who may have chest pain: many can be diagnosed and managed on an out-patient basis rather than being

Mr Lang: Efallai y gallwn wneud sylw ar y gwaith yr ydym yn ei wneud yn ein hardal. Yr ydym wedi rhoi amrywiaeth o weithgareddau, gwasanaethau a mentrau ar waith sydd â'r nod o reoli galw brys neu anghenion gofal brys yn fwy priodol. Mae hynny'n golygu defnyddio mentrau fel timau ymateb cyflym, lle y bydd nyrsys a gweithwyr clinigol proffesiynol eraill—mae timau yn gallu asesu cleifion a'u cynorthwyo yn eu cartrefi eu hunain neu mewn lleoliad preswyl, yn hytrach na'u hanfon i'r ysbyty. Yr ydym wedi edrych, gyda'n hymddiriedolaeth, ar newid pwyslais y ffordd y mae'n cael ei asesu, wrth eu derbyn, o ran a oes angen anfon cleifion i'r ysbyty. Felly, er enghraifft, ddwy flynedd yn ôl, byddai claf y tybiwyd bod ganddo thrombosis gwythiennau dwfn wedi cael ei anfon yn syth i ward feddygol, ond byddai'n cael ei drin fel claf allanol erbyn hyn; maent yn cael eu diagnosio, eu trin a'u rheoli yn y gymuned. Mae'r un peth yn digwydd gyda chleifion a allai fod yn dioddef poenau yn eu brest: gellir

admitted to hospital. There is a range of initiatives of that nature and they are about looking at the patient's needs, asking where they can be managed and do they actually have to go into an acute hospital ward. Quite a lot of work on initiatives is going on around Wales, and we have checked with colleagues on similar kinds of things. I am sure that Bernadine can give examples of similar things that are ongoing in her patch.

diagnosio a rheoli llawer fel cleifion allanol yn hytrach na'u hanfon i'r ysbyty. Mae amrywiaeth o fentrau tebyg ac maent yn ymwneud ag edrych ar anghenion y cleifion, gofyn lle y gellir eu rheoli ac a oes yn rhaid iddynt fynd i ward ysbyty acíwt mewn gwirionedd. Mae cryn dipyn o waith yn cael ei wneud ar fentrau ledled Cymru, ac yr ydym wedi gwirio pethau tebyg gyda chydweithwyr. Yr wyf yn sicr y gall Bernadine roi enghreifftiau i chi o bethau tebyg sy'n digwydd yn ei hardal.

Ms Rees: Not to use the same examples, but on a strategic level, in terms of operational management within the trust, we are introducing benchmarking exercises that monitor lengths of stay. Pembrokeshire is very fortunate—it has a hospital at home, we have a joint discharge team with the local authority and we can move our delayed-transfers-of-care services fairly quickly. We are only really hampered by patient choice—that is the main barrier to delayed transfers of care in Pembrokeshire. This is almost a three-pronged attack, because what you are talking about is demand management creating huge emergency capacity issues in all of our general hospitals. If you look at it from a policy point of view, you have the wellbeing element of it, which will take longer to kick in, the demand management, which we have already talked about, and protecting elective capacity, which will be difficult while we have this surge in emergency admissions. However, in Pembrokeshire, our emergency admissions have decreased because of some

Ms Rees: Rhag defnyddio'r un enghreifftiau, ond ar lefel strategol, o ran rheoli gweithredol o fewn yr ymddiriedolaeth, yr ydym yn cyflwyno ymarferion meincnodi sy'n monitro hyd cyfnodau aros. Mae sir Benfro yn ffodus iawn—mae ganddi ysbyty gartref, mae gennym dîm rhyddhau o'r ysbyty ar y cyd gyda'r awdurdod lleol a gallwn symud ein gwasanaethau ar gyfer oedi wrth drosglwyddo gofal yn eithaf cyflym. Yr unig beth sy'n ein rhwystro yw dewis cleifion—dyna'r prif rwystr i oedi wrth drosglwyddo gofal yn sir Benfro. Mae hwn yn ddull triphlyg i bob pwrpas, oherwydd yr hyn yr ydych yn ei drafod yw rheoli galw yn creu problemau gallu brys enfawr yn ein holl ysbytai cyffredinol. Os edrychwch ar y sefyllfa o safbwynt polisi, mae gennych yr elfen les, a fydd yn cymryd rhagor o amser i fod yn effeithiol, rheoli'r galw, yr ydym wedi ei drafod yn barod, a diogelu'r gallu i ddewis, a fydd yn anodd pan fo gennym y cynnydd hwn mewn derbyniadau brys. Fodd bynnag, yn sir Benfro, mae ein derbyniadau brys wedi

of the initiatives to which Geoff and I have alluded.

gostwng oherwydd rhai o'r mentrau y cyfeiriodd Geoff a minnau atynt.

[241] **Catherine Thomas:** Finally, how can you ensure that providers deliver commissioned volumes of elective work, based on what you have just said?

[241] **Catherine Thomas:** I gloi, sut y gallwch sicrhau bod darparwyr yn cyflawni gwaith dewisol ar lefel wedi'i gomisiynu, ar sail yr hyn yr ydych newydd ei ddweud?

Ms Rees: We must move away from what we have dealt with historically, which is the long-term agreement against a financial amount. We must commission, both in the long-term and the short-term, to unravel some of the difficulties identified in the report. We should be commissioning on pathways and on outputs, so we should be looking at outcomes. I believe that the year ahead will be tremendously challenging, given the financial allocation. There will be a position where we talk about decommissioning, given the amounts of money that we have all been allocated across Wales. There are things that do not require money, which call for clinical and managerial leadership. However, the bottom line is that we have a great deal of work to do with patients and clinicians to work through what are appropriate pathways of care delivered by the appropriate professionals. I am very sorry, but it will take time to work through those pathways. There will be no overnight solution, and the financial challenge that we face will hinder some of this work.

Ms Rees: Mae'n rhaid i ni symud i ffwrdd o'r hyn yr ydym wedi bod yn ei wneud yn hanesyddol, sef y cytundeb hirdymor yn ôl swm ariannol. Mae'n rhaid i ni gomisiynu, yn yr hirdymor ac yn y tymor byr, i ddatrys rhai o'r anawsterau a nodwyd yn yr adroddiad. Dylem fod yn comisiynu ynghylch llwybrau ac ar allbwn, felly dylem fod yn edrych ar ganlyniadau. Credaf y bydd y flwyddyn nesaf yn un llawn her, o ystyried y dyraniad ariannol. Bydd sefyllfa lle y byddwn yn siarad am ddadgomisiynu, o ystyried y symiau o arian sydd wedi'u dyrannu ledled Cymru. Mae pethau nad oes angen arian amdanynt, sy'n gofyn am arweiniad clinigol a rheolaethol. Fodd bynnag, diwedd y gân yw bod gennym lawer o waith i'w wneud gyda chleifion a chlinigwyr i weithio drwy'r hyn sy'n llwybrau gofal priodol a ddarperir gan weithwyr proffesiynol priodol. Mae'n ddrwg iawn gennyf, ond bydd yn cymryd amser i weithio drwy'r llwybrau hynny. Ni fydd ateb dros nos, a bydd yr her ariannol sy'n ein hwynebu yn rhwystro rhywfaint ar y gwaith hwn.

Mr Lang: I will briefly add to that in terms

Mr Lang: Yr wyf am ychwanegu'n gryno at

of the very specific issue of elective surgery and how we try to ensure that that is delivered. Over the last couple of years, Welsh Assembly Government policy has moved forward in terms of performance management and the clarity that is now expected from NHS organisations, the planned workload that will take place, its profiling, and how it is monitored and managed throughout the system. We have an important part to play in ensuring that our plans with trusts are clear and realistic, and that they take account of the pressures in the system. We must also hold trusts to account in terms of delivering that activity. A couple of years ago, we would simply have had an agreement with a trust that said, 'You will do 2,000 operations this year in a particular speciality', but we are now in a position where that is profiled by month according to when that activity should take place. The impact on the waiting list is profiled by month, and we have a far more dynamic and assertive management of that situation. You asked how we ensure that that takes place, and the answer is that we have mechanisms to that end. Ultimately, we rely on efficient and effective management within trusts, and we work closely with our colleagues to ensure that that happens, but we are improving the mechanisms to ensure that we can hold trusts to account.

hynny ynghylch y mater penodol iawn o lawdriniaeth ddewisol a sut yr ydym yn ceisio sicrhau bod hynny'n cael ei gyflawni. Yn ystod y blynyddoedd diwethaf, mae polisi Llywodraeth Cynulliad Cymru wedi symud ymlaen o ran rheoli perfformiad a'r eglurder a ddisgwylir bellach gan sefydliadau GIG, y llwyth gwaith arfaethedig, ei broffilio, a sut y bydd yn cael ei fonitro a'i reoli ledled y system. Mae gennym ran bwysig i'w chwarae i sicrhau bod ein cynlluniau gydag ymddiriedolaethau yn glir ac yn realistig, a'u bod yn ystyried y pwysau yn y system. Mae'n rhaid i ni hefyd sicrhau bod yr ymddiriedolaethau yn atebol o ran cyflawni'r gweithgarwch hwnnw. Rai blynyddoedd yn ôl, byddem wedi cael cytundeb gydag ymddiriedolaeth a fyddai'n dweud, 'Byddwch yn cynnal 2,000 o lawdriniaethau eleni mewn maes arbenigol penodol', ond yr ydym mewn sefyllfa'n awr lle mae hyn yn cael ei broffilio bob mis yn ôl pryd y dylid cynnal y gweithgarwch hwnnw. Mae'r effaith ar y rhestr aros yn cael ei phroffilio fesul mis, ac yr ydym yn rheoli'r sefyllfa honno yn llawer mwy deinamig a phendant. Bu i chi ofyn sut yr ydym yn sicrhau bod hynny'n digwydd, a'r ateb yw bod gennym fecanweithiau i wneud hynny. Yn y pen draw, yr ydym yn dibynnu ar reolaeth effeithlon ac effeithiol o fewn ymddiriedolaethau, ac yr ydym yn gweithio'n agos gyda'n cydweithwyr i sicrhau bod hynny'n digwydd, ond yr ydym yn gwella'r mecanweithiau i sicrhau bod yr ymddiriedolaethau'n atebol.

[242] **Alun Cairns:** What sanctions can you take have against trusts if they do not fulfill their obligations under those agreements?

[242] **Alun Cairns:** Pa gosbau y gallwch eu defnyddio gydag ymddiriedolaethau os nad ydynt yn diwallu eu hymrwymiadau dan y cytundebau hynny?

Mr Lang: Ultimately, we can take the resources and commission services elsewhere.

Mr Lang: Yn y pen draw, gallwn fynd â'r adnoddau a chomisiynu gwasanaethau i fannau eraill.

[243] **Alun Cairns:** Bearing in mind the lack of capacity within the system, how realistic is that, and are trusts aware of it? Effectively, what sanctions do you have?

[243] **Alun Cairns:** O gofio'r diffyg capasiti o fewn y system, pa mor realistig yw hynny, ac a yw ymddiriedolaethau'n ymwybodol o hynny? Pa gosbau, yn bôn, sydd gennych?

Mr Lang: They are aware of it. There are options in terms of capacity in the system. Depending on which service you are looking at, it can be a problem, but if we take surgical services, for some fairly routine operative procedures, there are alternatives. They may be in the private sector, or in my context, they may be over the border in England, and those are options that we can use. We try to work with the trust to improve performance so that we do not reach that situation, because it is destabilising for the patients—they do not particularly like being referred to one hospital, only to be moved somewhere else for surgery. That is not ideal and is very much a second-choice option for us. However, we do have the ability, and we are charged with the accountability, of delivering for patients. If that means moving services, ultimately, as commissioners, that is something we have to do.

Mr Lang: Maent yn ymwybodol o hynny. Mae opsiynau o ran capasiti yn y system. Yn dibynnu ar ba wasanaeth yr ydych yn edrych arno, gall fod yn broblem, ond o edrych ar wasanaethau llawfeddygol, ar gyfer rhai gweithdrefnau llawdriniaeth gymharol reolaidd, mae opsiynau eraill ar gael. Hwyrach eu bod yn y sector preifat, neu yn fy nghyd-destun innau, hwyrach eu bod dros y ffin yn Lloegr, ac mae'r rheini yn opsiynau y gallwn eu defnyddio. Yr ydym yn ceisio gweithio gyda'r ymddiriedolaeth i wella perfformiad fel na fyddwn yn cyrraedd y sefyllfa honno, oherwydd ei bod yn ansefydlogi'r cleifion—nid ydynt yn or-hoff o gael eu cyfeirio at un ysbyty, dim ond iddynt gael eu symud i rywle arall am lawdriniaeth. Nid yw hynny'n ddelfrydol a dim ond ail ddewis ydyw i ni. Fodd bynnag, mae gennym y gallu i ddarparu ar gyfer cleifion, a ni sy'n atebol am hynny. Os yw

hynny'n golygu symud gwasanaethau, yn y pen draw, fel comisiynwyr, mae'n rhywbeth sydd yn rhaid i ni ei wneud.

[244] **Alun Cairns:** Thank you, Mr Lang. Mrs Rees, can I ask you the same question? In Pembrokeshire, you are clearly in a different position as you are not close to the English border. What sanctions do you have?

[244] **Alun Cairns:** Diolch, Mr Lang. Mrs Rees, a gaf fi ofyn yr un cwestiwn i chi? Yn sir Benfro, yr ydych yn amlwg mewn sefyllfa wahanol oherwydd nad ydych yn agos i ffin Lloegr. Pa gosbau sydd gennych?

Ms Rees: We have the same ones, actually. We would decommission and, in all probability, we will look at that over the next few months. What it does for Dyfed is to cause difficulties to some of the smaller providers, but I think that that is the only way we have to go now for the future. We are commissioning on outcomes, and we have to make it clear to our providers that we will be buying the outcomes that are in the best interests of the patients.

Ms Rees: Mae gennym yr un rhai mewn gwirionedd. Byddem yn dadgomisiynu, a'r tebygolrwydd yw y byddwn yn edrych ar hynny yn ystod y misoedd nesaf. Mae'n achosi problemau yn Nyfed i rai o'r darparwyr llai, ond credaf mai dyna'r unig ffordd sydd gennym yn awr ar gyfer y dyfodol. Yr ydym yn comisiynu yn ôl canlyniadau, ac mae'n rhaid i ni egluro i'n darparwyr y byddwn yn prynu'r canlyniadau sydd fwyaf buddiol ar gyfer y cleifion.

[245] **Alun Cairns:** To go back to the chart that the Chair highlighted at the outset, which shows the areas with the longest waiting times in local health board areas, the options in south Wales—Pembrokeshire is slightly different—are pretty limited. If you are looking to commission in other south Wales trusts, lack of capacity is a serious problem. So, is that an effective sanction?

[245] **Alun Cairns:** I fynd yn ôl at y siart y bu i'r Cadeirydd ei grybwyll yn y dechrau, sy'n dangos yr ardaloedd gyda'r amseroedd aros hiraf mewn ardaloedd byrddau iechyd lleol, mae'r opsiynau yn y De—mae sir Benfro ychydig yn wahanol—yn eithaf cyfyngedig. Os ydych yn meddwl comisiynu ymddiriedolaethau eraill yn y De, mae diffyg capasiti'n broblem ddifrifol. Felly, a yw hynny'n gosb effeithiol?

Ms Rees: I think that, from the patient's

Ms Rees: Credaf, o safbwynt y cleifion, ei

point of view, it is effective because it is the outcome that we are commissioning for the patients. It may cause political fallout in terms of what we do to providers—small providers, in particular—but I think that we can return some core activity to local providers that will release capacity in bigger tertiary centres. The future is in a clinical services strategy that can be commissioned at appropriate levels, in appropriate areas. We are currently talking about how the system is, but we are going to be commissioning on a new system.

fod yn effeithiol oherwydd mai dyma'r canlyniad yr ydym yn ei gomisiynu ar gyfer y cleifion. Gall arwain at anghydweld gwleidyddol o ran yr hyn yr ydym yn ei wneud i ddarparwyr—darparwyr bach, yn benodol—ond credaf y gallwn ddychwelyd rhywfaint o weithgarwch craidd i ddarparwyr lleol a fydd yn rhyddhau'r capasiti mewn canolfannau trydyddol mwy. Mae'r dyfodol yn gofyn am strategaeth gwasanaethau clinigol y gellir ei chomisiynu ar lefelau priodol, mewn ardaloedd priodol. Ar hyn o bryd yr ydym yn pwyso a mesur y system, ond byddwn yn comisiynu ar system newydd.

[246] **Jocelyn Davies:** Just to clear up this point, paragraph 4.11 of the Auditor General's report states that most local health boards have not developed incentives or sanctions. It would appear, therefore, Mr Lang, that your experience is exceptional, would it not?

[246] **Jocelyn Davies:** Er mwyn egluro'r pwynt hwn, mae paragraff 4.11 yn adroddiad yr Archwilydd Cyffredinol yn nodi nad yw'r mwyafrif o fyrddau iechyd lleol wedi datblygu cymhellion neu gosbau. Ymddengys, felly, Mr Lang, fod eich profiad yn un eithriadol, onid ydyw?

Mr Lang: The question that I responded to was: what sanctions are available. I think that very limited use is made of those sanctions at present. Sanctions are there as part of the governance arrangements that we have in local health boards. The point that the Auditor General has drawn to our attention is that the use of those sanctions—and actually managing their consequences—has been very limited. I would agree with his comment.

Mr Lang: Y cwestiwn a atebais oedd: pa gosbau sydd ar gael. Credaf nad oes llawer o ddefnydd yn cael ei wneud o'r cosbau hynny ar hyn o bryd. Mae cosbau ar gael fel rhan o'r trefniadau llywodraethu sydd ar waith mewn byrddau iechyd lleol. Y pwynt y mae'r Archwilydd Cyffredinol wedi'i ddwyn i'n sylw yw bod y defnydd o'r cosbau hynny—a rheoli eu canlyniadau mewn gwirionedd—wedi bod yn gyfyngedig iawn. Byddwn yn cytuno â'i sylw.

[247] **Jocelyn Davies:** Ms Rees, would you agree?

[247] **Jocelyn Davies:** Ms Rees, a fyddech yn cytuno?

Ms Rees: Yes, certainly, but we are talking about the past, whereas Geoff and I are actually representing the future.

Ms Rees: Byddwn, yn sicr, ond yr ydym yn siarad am y gorffennol, tra bod Geoff a minnau'n cynrychioli'r dyfodol mewn gwirionedd.

[248] **Jocelyn Davies:** I just wanted to clear up the point that sanctions or incentives are very rarely used. The implication then is that local health boards are simply provider funders.

[248] **Jocelyn Davies:** Yr oeddwn am gael cadarnhad ynghylch y pwynt nad yw cosbau neu gymhellion yn cael eu defnyddio'n aml. Mae hyn yn awgrymu mai cyllidwyr darparwyr yn unig yw byrddau iechyd lleol.

Mr Lang: I would say that the use of incentives has been greater, particularly in my own experience, in terms of delivery of the waiting lists. What we have tried to do is to put together plans with trusts that include an incentive—if clinicians engage and bring down waiting lists, we deliver other improvements around the system. For example, rather than purely looking at waiting-list initiatives to bring things down, we have looked at the sustainable development of services alongside the initiatives. So, if you like, the deal is that, if we can do the short-term work, we will invest for the long term. Clinicians and services will get a better infrastructure for the future that will allow us to continue that work. So, we have used some incentives in that way. The sanctions side of it, I think, is probably under-developed.

Mr Lang: Byddwn yn dweud y bu mwy o ddefnydd o gymhellion, yn arbennig yn fy mhrofiad i, o ran cyflawni'r rhestrau aros. Yr hyn yr ydym wedi ceisio'i wneud yw llunio cynlluniau gydag ymddiriedolaethau sy'n cynnwys cymhelliad—os yw clinigwyr yn cyfrannu ac yn gostwng rhestrau aros, yr ydym yn cyflawni gwelliannau eraill o gwmpas y system. Er enghraifft, yn hytrach nag edrych ar fentrau rhestrau aros i ddod ag amseroedd i lawr yn unig, yr ydym wedi edrych ar ddatblygiad cynaliadwy gwasanaethau law yn llaw â'r mentrau. Felly, os dymunwch, yr hyn a fydd yn digwydd, os gallwn wneud y gwaith tymor byr, yw y byddwn yn buddsoddi ar gyfer yr hirdymor. Bydd clinigwyr a gwasanaethau yn cael gwell seilwaith ar gyfer y dyfodol a fydd yn ein galluogi i barhau â'r gwaith hwnnw. Felly, yr ydym wedi defnyddio rhai cymhellion yn y ffordd honno. Nid yw'r elfen gosbau, credaf,

wedi'i datblygu'n ddigonol.

[249] **Jocelyn Davies:** Is it better to use incentives rather than sanctions?

[249] **Jocelyn Davies:** A yw'n well defnyddio cymhellion yn hytrach na chosbau?

Mr Lang: I believe so, but there is a place for both. Ultimately, we have to ensure that there is effective use of resources and good performance delivery and if, for whatever reason, an organisation cannot deal with that, our duty is to the patient—to get the best service for the patient—which might mean a sanction against an organisation.

Mr Lang: Ydy yn fy marn i, ond mae lle i'r ddau. Yn y pen draw, mae'n rhaid i ni sicrhau bod adnoddau'n cael eu defnyddio'n effeithiol a darpariaeth perfformiad da ac os, am ba bynnag reswm, na all sefydliad ddelio â hynny, mae ein dyletswydd ni i'r claf—i gael y gwasanaeth gorau ar gyfer y claf—a allai olygu cosb yn erbyn sefydliad.

[250] **Janet Davies:** I will follow up on that point. It seems to me that you can have a very difficult situation, with quite a lot of tensions. Would you recognise that there may be some contradiction between achieving short-term outcomes for the patient and ensuring, as you say, the sustainable viability of your particular hospitals in the health service in your area? There may be some contradiction there—if you pool money into one, perhaps by commissioning private care somewhere, that does not help the system that you need to strengthen.

[250] **Janet Davies:** Yr wyf am ddilyn y pwynt hwnnw. Ymddengys i mi y bydd gennych sefyllfa anodd iawn, gyda llawer o densiwn. A fyddech yn cydnabod bod rhywfaint o wrth-ddweud rhwng cyflawni canlyniadau tymor byr ar gyfer y claf a sicrhau, fel y dywedasoch, ddilysrwydd cynaliadwy eich ysbytai penodol yn y gwasanaeth iechyd yn eich ardal? Efallai bod rhywfaint o wrth-ddweud yno—os ydych yn cyfuno arian i un, efallai drwy gomisiynu gofal preifat yn rhywle, nid yw hynny'n cynorthwyo'r system y mae angen i chi ei chryfhau.

Mr Lang: Absolutely. One has to be mindful of the way in which short-term means are engaged. There is a place for engaging the private sector or NHS services on a short-

Mr Lang: Yn sicr. Rhaid cofio'r ffordd y defnyddir y modd tymor byr. Mae lle i gynnwys y sector preifat neu wasanaethau'r GIG ar sail tymor byr, ond efallai i ni fod â

term basis, but we have perhaps lacked a short-term approach in the context of a long-term direction, so that you are planning both bits at the same time. We have tended to have a short-term target with a short-term resource, and therefore you deal with the short term. For example, leading up to 31 March, you will see that the pattern is that waiting lists always drop, and in April they bounce back up again, because the short-term resource has run out, the short-term plan has finished, and the long-term provision is not in place. So it is about getting both together. They both have a place, and it is important that they are seen in context.

diffyg dull tymor byr yng nghyd-destun cyfeiriad hirdymor, a'ch bod felly'n cynllunio ar gyfer y ddwy elfen ar yr un pryd. Yr ydym wedi tueddu i osod targed tymor byr gydag adnoddau tymor byr, ac felly yr ydych yn ymdrin â'r tymor byr. Er enghraifft, wrth agosáu at 31 Mawrth, byddwch yn gweld bod amseroedd amser yn gostwng bob tro, ac maent yn codi eto ym mis Ebrill, oherwydd bod yr adnoddau tymor byr wedi dod i ben, mae'r cynllun tymor byr wedi gorffen, ac nid yw'r ddarpariaeth hirdymor ar waith. Felly mae'n rhaid dod â'r ddau at ei gilydd. Mae lle i'r ddau, ac mae'n bwysig eu hystyried yn eu cyd-destun.

[251] **Mark Isherwood:** I refer you to paragraphs 3.33 and 3.35 in relation to delayed transfers of care, which are highlighted as one of the key factors leading to inefficient use of hospital capacity, and indicating a quarter of a million bed days lost as a consequence each year. Could each of you answer, in respect of your own areas, what you believe to be the causes of these delays, and the impact on your area, particularly in relation to waiting times, and what you think should be done to tackle this problem?

[251] **Mark Isherwood:** Yr wyf yn cyfeirio at baragraffau 3.33 a 3.35 mewn perthynas ag oedi wrth drosglwyddo gofal, sy'n cael ei amlygu fel un o'r ffactorau allweddol sy'n arwain at y defnydd aneffeithlon o allu ysbyty, gan nodi bod chwarter miliwn o ddyddiau gwely wedi'u colli o ganlyniad i hyn bob blwyddyn. A all y ddau ohonoch ateb, mewn perthynas â'ch ardaloedd eich hunain, beth yw achosion yr oedi hyn yn eich barn chi, a'r effaith ar eich ardal, yn arbennig o ran amseroedd aros, a beth ddylai gael ei wneud yn eich barn chi i fynd i'r afael â'r broblem hon?

Ms Rees: In terms of the causes, Pembrokeshire has quite a small problem. However, the problem in terms of mental health is much larger, and, indeed, Pembrokeshire commissions mental health

Ms Rees: O ran yr achosion, problem gymharol fach sydd yn sir Benfro. Fodd bynnag, mae'r broblem o ran iechyd meddwl yn llawer mwy, ac, yn wir, mae sir Benfro yn comisiynu iechyd meddwl ar gyfer Dyfed.

for Dyfed. The acute delayed transfers of care in Pembrokeshire, in the main, are now down to patient choice about where they prefer to go and how we manage that. In mental health, a lot of it is around the elderly mentally ill and the capacity that we have to keep patients locally.

Mae'r oedi difrifol wrth drosglwyddo gofal yn sir Benfro, yn bennaf, yn deillio o ble mae cleifion yn dewis mynd a sut yr ydym yn rheoli hynny. Mewn iechyd meddwl, mae llawer ohono yn ymwneud â henoed sydd â salwch meddwl a'r gallu sydd gennym i gadw cleifion yn lleol.

I think that we have to build in mental health capacity, and work with patients on the choice issue. We have done a considerable amount of work jointly with the local authority in Pembrokeshire to maintain a level of delayed transfers of care. We have also purchased extra beds for an interim solution for some patients. Sometimes, this is accepted and sometimes it is not.

Credaf fod yn rhaid i ni sicrhau bod gennym allu iechyd meddwl, a gweithio gyda chleifion ar y mater dewis. Yr ydym wedi gwneud llawer o waith ar y cyd â'r awdurdod lleol yn sir Benfro i gynnal lefel o oedi wrth drosglwyddo gofal. Yr ydym hefyd wedi prynu gwelyau ychwanegol fel ateb dros dro i rai cleifion. Derbynnir hyn o bryd i'w gilydd ond nid bob tro.

Mr Lang: I will comment in terms of some of the causes and what we have been doing in Wrexham. There are several issues that sit behind the causes. One of the key issues, historically, in Wrexham, has been the resource availability to local government and the social services budget. Going back four or five years, that was a major issue in terms of delayed transfers, and although on the chart we do not have the highest rate per 1,000 population in terms of delayed transfers, we are still above the average in Wrexham. We had made a lot of progress before the audit was undertaken, and, indeed, have done so afterwards, so resourcing is a major issue in the local authority setting, as well as in the NHS setting. This target can only be delivered if those two systems work in

Mr Lang: Yr wyf am wneud sylw ar rai o'r achosion a'r hyn yr ydym wedi bod yn ei wneud yn Wrecsam. Mae llawer o faterion wrth wraidd yr achosion. Un o'r materion allweddol, yn hanesyddol, yn Wrecsam, yw'r adnoddau sydd wedi bod ar gael i lywodraeth leol a chyllideb gwasanaethau cymdeithasol. Gan edrych yn ôl bedair i bum mlynedd, yr oedd hynny'n fater pwysig o ran oedi wrth drosglwyddo, ac er ar y siart nad oes gennym y gyfradd uchaf fesul 1,000 o'r boblogaeth o ran oedi wrth drosglwyddo, yr ydym yn parhau yn uwch na'r cyfartaledd yn Wrecsam. Yr oeddem wedi gwneud llawer o gynnydd cyn cynnal yr archwiliad, ac, yn wir, yr ydym wedi gwneud llawer wedi hynny, felly mae adnoddau yn fater pwysig yn yr awdurdod lleol, yn ogystal ag yn y GIG. Dim

tandem, are interconnected and work very well.

ond os yw'r ddwy system yn gweithio gyda'i gilydd, wedi'u cydgysylltu ac yn gweithio'n dda iawn y gallwn gyflawni'r targed hwn.

There have also been issues in terms of independent sector care home capacity, which has been shrinking quite dramatically in the Wrexham area, and presents a tension in terms of social services options to provide care packages for patients. There is currently an issue in relation to the ability to recruit homecare staff. One of the unfortunate consequences of a very strong economy in north-east Wales is that homecare employment is not particularly attractive. There is a real workforce challenge for us in working with social services, in terms of how we make those roles attractive and rewarding in what is now quite a competitive employment market. So, that is a factor that is very much outside our control, but it is having a real impact this year in terms of the ability to put together home care packages.

Bu materion hefyd ynghylch gallu cartrefi gofal y sector annibynnol sydd wedi bod yn lleihau'n eithaf dramatig yn ardal Wrecsam, ac mae hyn yn arwain at densiwn o ran yr opsiynau gwasanaethau cymdeithasol i ddarparu pecynnau gofal i gleifion. Ar hyn o bryd mae mater ynghylch y gallu i recriwtio staff gofal cartref. Un o ganlyniadau anffodus economi cryf iawn yn y Gogledd-ddwyrain yw nad yw cyflogaeth gofal cartref yn atyniadol iawn. Mae gwir her yn ein hwynebu o ran gweithlu wrth i ni weithio gyda gwasanaethau cymdeithasol, o ran y ffordd orau o wneud y swyddi hynny yn atyniadol ac yn foddhaus mewn marchnad cyflogaeth sy'n gystadleuol iawn erbyn hyn. Felly, mae hynny'n ffactor sy'n sicr y tu hwnt i'n rheolaeth, ond mae'n cael effaith wirioneddol eleni o ran y gallu i lunio pecynnau gofal cartref.

It is not all about the independent sector and social services. I think that one of the causes was a focus within the NHS on the management of the patients throughout their episode of care. We had a tradition of a strong focus on the early acute part of the episode. However, the rehabilitative component, and the reablement to move the patient back into the community or home, was less developed and less focused. Some of what we have done in terms of delayed

Nid yw'n ymwneud yn llwyr â'r sector annibynnol a'r gwasanaethau cymdeithasol. Credaf mai un o'r achosion oedd ffocws o fewn y GIG ar reoli'r cleifion gydol eu gofal. Yn draddodiadol yr oedd gennym ffocws cryf ar ran acíwt cynnar y cyfnod. Fodd bynnag, nid oedd yr elfen adsefydlu, ac ailalluogi'r claf i symud yn ôl i'r gymuned neu'r cartref, wedi'i ddatblygu cymaint ac yr oedd llai o ffocws. Mae rhywfaint o'r gwaith yr ydym wedi'i wneud ym maes oedi wrth

transfers of care and workload has been around that end of the service: building up community services, having reablement teams, and establishing step-down care facilities that can be equally accessed by social care or the health service. That is some of what we have been doing. In terms of impact, it has had a heavy impact on the management of the acute sector capacity. We certainly struggle sometimes against a very significant challenge in north-east Wales, with the main hospital having many patients who could be more appropriately cared for elsewhere, which makes the challenge more difficult. Therefore, the management of the acute case becomes more complex, with patients moved around wards and transferred between wards. It then becomes more difficult to follow their care through. So it has a knock-on effect into the acute sector, which is quite damaging.

drosglwyddo gofal a llwyth gwaith wedi ymwneud â'r elfen hon o'r gwasanaeth: adeiladu gwasanaethau cymuned, sefydlu timau ailalluogi, a sefydlu cyfleusterau gofal llai dwys y gall gofal cymdeithasol neu'r gwasanaeth iechyd eu defnyddio y naill fel y llall. Dyna rywfaint o'r hyn yr ydym wedi bod yn ei wneud. O ran yr effaith, mae wedi cael effaith gadarn iawn ar reoli gallu'r sector acíwt. Yr ydym yn sicr yn cael cryn drafferth o bryd i'w gilydd gyda'r her sylweddol sy'n ein hwynebu yn y Gogledd-ddwyrain, gyda'r prif ysbyty yn cael llawer o gleifion y gellid rhoi gofal mwy priodol iddynt yn rhywle arall, sy'n gwneud yr her yn anoddach fyth. Felly, mae rheoli'r achos acíwt yn mynd yn fwy cymhleth, gyda chleifion yn cael eu symud o gwmpas wardiau ac yn cael eu trosglwyddo o un ward i'r llall. Mae'n anos wedyn i ddilyn eu gofal i'r diwedd. Felly mae'n cael effaith gynyddol i mewn i'r sector acíwt, sy'n eithaf niweidiol.

[252] **Mark Isherwood:** I will address the next question to Bernadine Rees first. The figures show that your delayed transfers of care fell by 83 per cent between November 2003 and June 2004. How was this achieved, and what lessons do you think this provided for other local health boards?

[252] **Mark Isherwood:** Yr wyf am ofyn y cwestiwn nesaf i Bernadine Rees yn gyntaf. Mae'r ffigurau'n dangos bod yr oedi wrth drosglwyddo gofal wedi disgyn o 83 y cant rhwng Tachwedd 2003 a Mehefin 2004. Sut y cyflawnwyd hyn, a pha wersi y mae hyn wedi'i ddysgu i fyrddau iechyd lleol eraill yn eich barn chi?

Ms Rees: We are smaller and are coterminous with the local authority; we only deal with one local authority. We have worked through, quite rigorously, joint

Ms Rees: Yr ydym yn llai ac yn gyffiniol â'r awdurdod lleol; dim ond ag un awdurdod lleol yr ydym yn ymdrin. Yr ydym wedi gweithio, yn eithaf trylwyr, gyda thimau

discharge teams, and through opportunities to use local authority provision as well as nursing homes. That has led us to try to keep the position—it does fluctuate, and has risen since then. The main issue for us, as I said earlier, is about choice. However, having seven patients in our acute provider gives us a problem in relation to bed numbers, and so I would not minimise the impact that it can have on us at times. However, it is tacked through joint working, and including patients and their relatives in determining where they go after their acute provision. Also, in Pembrokeshire, we have the hospital at home scheme, which allows us to give more acute support. Earlier discharge obviously avoids the inevitability of some patients becoming delayed transfers.

rhyddhau ar y cyd, a thrwy gyfleoedd i ddefnyddio darpariaeth awdurdod lleol yn ogystal â chartrefi nyrsio. Mae hynny wedi ein harwain at geisio cadw'r sefyllfa—mae'n amrywio, ac mae wedi codi ers hynny. Fel y dywedais yn gynharach, dewis yw'r prif beth i ni. Fodd bynnag, mae cael saith claf gyda'n darparwr acíwt yn peri problem i ni o ran niferoedd gwelyau, ac felly ni fyddwn yn bychanu'r effaith y gall ei chael arnom o bryd i'w gilydd. Fodd bynnag, yr ydym yn mynd i'r afael â'r sefyllfa drwy gydweithio, ac yn cynnwys cleifion a'u perthnasau yn y broses o bennu lle maent yn mynd ar ôl eu darpariaeth acíwt. Yn ogystal, yn sir Benfro, mae gennym y cynllun ysbyty yn y cartref, sy'n ein galluogi i roi rhagor o gymorth acíwt. Mae rhyddhau o'r ysbyty yn gynnar yn amlwg yn rhwystro oedi wrth drosglwyddo rhai cleifion.

[253] **Mark Isherwood:** I will address a similar question to Geoff: Wrexham has the sixth highest level of delayed transfers of care, and over a similar period—November 2003 to June 2004—there was an increase in Wrexham. Why is this, and what do you feel that you can do to rectify the situation?

[253] **Mark Isherwood:** Yr wyf am ofyn cwestiwn cyffelyb i Geoff. Mae gan Wrecsam y chweched lefel uchaf o oedi wrth drosglwyddo gofal, a thros gyfnod tebyg—Tachwedd 2003 i Fehefin 2004—bu cynnydd yn Wrecsam. Beth yw'r rheswm am hyn, a beth y gallwch ei wneud i geisio unioni'r sefyllfa?

Mr Lang: Many of the drivers and the reasons are those that I alluded to in my previous answer. We are working very closely with our local authority partners, as well as the local trust. There are a range of initiatives, similar to those that Bernie has

Mr Lang: Cyfeiriais at lawer o'r achosion a'r rhesymau yn fy ateb blaenorol. Yr ydym yn gweithio'n agos iawn gyda'n partneriaid awdurdod lleol, yn ogystal â'r ymddiriedolaeth leol. Mae amrywiaeth o fentrau, rhai tebyg i'r rhai y disgrifiodd

described. We are looking at home-from-hospital schemes, using the voluntary sector to support care, and at the flexible use of resources. We are establishing a pooled budget, for example, in elderly mental health services, where we have a significant capacity problem in the independent sector and nursing homes—where a lot of these patients will receive their future care—and we are not able to transfer those patients out on an individual basis. We are looking at trying to commission, strategically, capacity from the independent care sector that we can access on a routine basis, with the certainty that it is there for us, rather than having the traditional model of social care support and continuing care being dealt with on an individual basis. For every case that crops up, we then look for a place for that individual. We are trying to make it more systematic, so that we buy in the capacity to allow patients to move through that system. That has implications for choice, and, as Bernie said, choice is a big issue, and it is a big issue in Wrexham. In the general nursing home category, there are one or two highly favoured nursing homes in the Wrexham area, and they tend to be full and have waiting lists, and many of our patients are waiting to go into those nursing homes. There is a debate with the families and the patients themselves, as moving patients who may be frail and elderly twice compromises quality of life. It sets them back in terms of recovery, and we are trying to find ways around that. However, it is a very difficult issue to challenge and one that, in terms of social services policy, is outwith NHS control. The

Bernie. Yr ydym yn edrych ar gynlluniau gartref-o'r-ysbyty, defnyddio'r sector gwirfoddol i gefnogi gofal, ac ar ddefnyddio adnoddau'n hyblyg. Yr ydym yn sefydlu cyllideb gyfun, er enghraifft, mewn gwasanaethau iechyd meddwl yr henoed, lle mae gennym broblem gallu ddifrifol yn y sector annibynnol ac mewn cartrefi nyrsio—lle y bydd llawer o'r cleifion hyn yn derbyn eu gofal yn y dyfodol—ac nid ydym yn gallu trosglwyddo'r cleifion hynny ar sail unigol. Yr ydym yn ceisio comisiynu, yn strategol, gallu o'r sector gofal annibynnol y gallwn ei ddefnyddio'n rheolaidd, gyda'r sicrwydd ei fod yno i ni, yn hytrach nag ymdrin â'r model traddodiadol o gymorth gofal cymdeithasol a gofal parhaus ar sail unigol. Am bob achos sy'n codi, yr ydym wedyn yn chwilio am le ar gyfer yr unigolyn dan sylw. Yr ydym yn ceisio gwneud y broses yn fwy systematig, er mwyn i ni allu prynu'r gallu i alluogi cleifion i symud drwy'r system honno. Mae gan hynny oblygiadau o ran dewis, ac, fel y dywedodd Bernie, mae dewis yn fater pwysig, ac mae'n fater pwysig yn Wrecsam. Yn y categori cartrefi nyrsio cyffredinol, mae un neu ddau o gartrefi nyrsio poblogaidd iawn, ac maent yn tueddu i fod yn llawn a chyda rhestrau aros, ac mae llawer o'n cleifion yn aros i gael mynd i'r cartrefi nyrsio hynny. Mae trafodaeth gyda'r teuluoedd a'r cleifion eu hunain, oherwydd bod symud cleifion sy'n fregus ac yn hen ddwywaith yn gallu cyfaddawdu ansawdd byw. Mae'n gam yn ôl iddynt o ran adferiad, ac yr ydym yn ceisio dod o hyd i ffyrdd i fynd i'r afael â hyn. Fodd bynnag, mae'n fater anodd iawn i'w herio ac yn un, o ran polisi gwasanaethau

local authority's policy on choice is its policy, not ours.

cymdeithasol, sydd y tu hwnt i reolaeth y GIG. Polisi'r awdurdod lleol yw ei bolisi ar ddewis, nid ein polisi ni.

[254] **Mark Isherwood:** In respect of delays caused by social services, what helps and what hinders the joint working relationship between social services and health? How can we improve accountability? Can you expand, Geoff, on the points you made about local authority budgets and whether you feel that, on a national level, these should be more needs-focused in these areas?

[254] **Mark Isherwood:** O ran yr oedi a achosir gan wasanaethau cymdeithasol, beth sy'n cynorthwyo a beth sy'n rhwystro'r berthynas gydweithio rhwng gwasanaethau cymdeithasol ac iechyd? Sut allwn wella atebolrwydd? A allwch ymhelaethu, Geoff, ar y pwyntiau a wnaethoch ar gyllidebau awdurdod lleol ac a ydych yn credu, ar lefel genedlaethol, y dylai'r rhain ganolbwyntio mwy ar anghenion yn y meysydd hyn?

Mr Lang: In terms of what makes our relationship work, having worked for a health authority, and now working on a local health board, I would say that the very structure of a local health board and its focus on the coterminous arrangement with the local authority has helped tremendously. We now have far more dynamic relationships with local authorities than was the case with health authorities. So the very structure has helped. Obviously, that will only get you so far down the path.

Mr Lang: O ran beth sy'n gwneud i'n perthynas weithio, ar ôl gweithio i awdurdod iechyd, a bellach yn gweithio ar fwrdd iechyd lleol, byddwn yn dweud bod strwythur y bwrdd iechyd lleol a'i ffocws ar y cytundeb cyffiniol gyda'r awdurdod lleol wedi bod yn gymorth mawr. Mae gennym bellach gysylltiadau llawer mwy deinamig gydag awdurdodau lleol na chyda'r awdurdodau iechyd. Felly mae'r strwythur wedi'n cynorthwyo. Yn amlwg, bydd hynny ond yn mynd â chi beth o'r ffordd.

The resource issue is a major one. We have seen an increase in the resource going into this area of activity from the health sector, and, likewise, grants to local authorities. Ultimately, difficulties arise when the pressures on the social services budget in general rise, as happened to Wrexham

Mae'r mater adnoddau yn un pwysig. Yr ydym wedi gweld cynnydd yn yr adnoddau sy'n cael eu rhoi i'r maes gweithgarwch hwn gan y sector iechyd, ac, yn yr un modd, grantiau i awdurdodau lleol. Yn y pen draw, mae anawsterau yn codi pan fo'r pwysau ar gyllideb gwasanaethau cymdeithasol yn

council this year, for example. It was facing a £1 million overspend in its social services budget in total. When a local authority is in that position, it has to be accountable and has a statutory duty to balance its budget and take decisions. That is when the joint approach gets stretched and strained. We work hard to keep the joint approach going, and to ensure that, even when there is budgetary difficulty, hospital patients and patients requiring discharge to home are given priority. However, ultimately, local authorities have different accountability and performance systems than we do, and a different duty to perform. That is where the tension arises. Our job is to get the joint working cracked, and we are doing reasonably well at that, but when the financial pressures hit and cause tensions, if the two systems do not afford the same priority to the task at hand, then you will get a disjointed approach and problems will emerge. We have all experienced that to different degrees at different times.

gyffredinol yn codi, fel sydd wedi digwydd yng nghyngor Wrecsam eleni, er enghraifft. Yr oedd yn wynebu gorwariant o £1 miliwn yng nghyfanswm ei gyllideb gwasanaethau cymdeithasol. Pan fo awdurdod lleol yn y sefyllfa honno, mae'n rhaid iddo fod yn atebol ac mae ganddo ddyletswydd statudol i fantoli ei gyllidebau a gwneud penderfyniadau. Dyna pryd mae pwysau a straen ar y dull ar y cyd. Yr ydym yn gweithio'n galed i gynnal y dull ar y cyd, ac i sicrhau, hyd yn oed pan fo anhawster cyllidebol, bod cleifion ysbyty a chleifion y mae angen eu rhyddhau i'r cartref yn cael blaenoriaeth. Fodd bynnag, yn y pen draw, mae gan awdurdodau lleol wahanol atebolrwydd a systemau perfformiad i ni, a gwahanol ddyletswydd i berfformio. Dyna yw gwraidd y tensiwn. Ein gwaith ni yw mynd i'r afael â'r cydweithio, ac yr ydym yn gwneud yn gymharol dda gyda hynny, ond pan fo pwysau ariannol a'r rheini'n achosi tensiynau, os nad yw'r ddwy system yn rhoi'r un flaenoriaeth i'r dasg dan sylw, yna cewch ddull tameidiog a bydd problemau'n codi. Yr ydym i gyd wedi cael y profiad hwnnw i wahanol raddau ar wahanol adegau.

[255] **Mark Isherwood:** Do you have anything to add to that from your perspective, Ms Rees?

[255] **Mark Isherwood:** A oes gennych unrhyw beth i ychwanegu at hynny o'ch safbwynt chi, Ms Rees?

Ms Rees: Only to say that we use joint commissioning as a vehicle to reduce duplication, and that has a knock-on effect at all levels of commissioning, in terms of

Ms Rees: Dim ond i ddweud ein bod yn defnyddio comisiynu ar y cyd fel dull o ostwng yr achosion o gyflawni'r un gwaith drosodd a thro, ac mae hynny'n cael effaith

supporting patients from the social care perspective before they go in to hospital. The joint discharge team then helps us to help the patients in terms of their discharge and reconnecting them with social care.

ganlyniadol ar bob lefel o gomisiynu, o ran cynorthwyo cleifion o safbwynt gofal cymdeithasol cyn iddynt fynd i'r ysbyty. Yna, mae'r tîm rhyddhau ar y cyd yn ein cynorthwyo i gynorthwyo'r cleifion wrth iddynt adael yr ysbyty a'u hailgysylltu â gofal cymdeithasol.

[256] **Alun Cairns:** Mr Lang, I would like to ask you, in the first instance, what impact does the fact that different local authorities pay residential and nursing care homes different levels of fees for patients have on the problem of bed-blocking?

[256] **Alun Cairns:** Mr Lang, hoffwn ofyn i chi, yn y lle cyntaf, pa effaith y mae'r ffaith bod gwahanol awdurdodau lleol yn talu ffioedd gwahanol i gartrefi gofal preswyl a nyrsio ar gyfer cleifion yn ei chael ar y broblem o flocio gwelyau?

Mr Lang: I can share the experience of Wrexham, which is interesting in that some local authorities in England pay higher rates than those in Wales. What we have found is that there is an inward migration of residents from neighbouring local authorities into Wrexham, because the homes are keen to offer them places, as they are commercial enterprises at the end of the day. If they are good quality homes, that will bring in patients. That then shrinks the capacity that is available for local residents, so it is a problem. Generally, the homes have rehearsed their case very well in terms of the pressure that they face with the amount of resource that they get for core funding for social care cases, or even basic continuing NHS care cases. They are under a lot of pressure, and if they can see a more lucrative financial stream through taking one particular cohort of patients rather than another, then,

Mr Lang: Gallaf rannu profiadau Wrecsam, sy'n ddiddorol o ystyried bod rhai awdurdodau lleol yn Lloegr yn talu cyfraddau uwch na rhai Cymru. Yr ydym wedi canfod bod ymfudiad mewnol o breswylwyr o awdurdodau lleol cyfagos i Wrecsam, oherwydd bod y cartrefi yn awyddus i gynnig lleoedd iddynt, gan eu bod yn fentrau masnachol yn y pen draw. Os ydynt yn gartrefi o ansawdd da, bydd hynny'n denu cleifion. Mae hynny wedyn yn gostwng y lleoedd sydd ar gael i breswylwyr lleol, felly mae'n broblem. Yn gyffredinol, mae'r cartrefi wedi paratoi eu hunain yn dda iawn o ran y pwysau a wynebant gyda'r adnoddau y maent yn ei gael ar gyfer cyllid craidd i achosion gofal cymdeithasol, neu hyd yn oed achosion gofal GIG parhaus sylfaenol. Maent o dan gryn bwysau, ac os ydynt yn gallu gweld ffrwd ariannol fwy deniadol drwy gymryd un garfan benodol o gleifion yn

often, homes will choose to do that. There is not so much of an issue in my patch between Wrexham and Flintshire local authorities, but the difference between what Wrexham and Cheshire pay has been an issue. That has caused a cross-border issue.

hytrach nag un arall, yna, yn aml, bydd cartrefi yn dewis gwneud hynny. Nid oes cymaint o broblem yn fy ardal i rhwng awdurdodau lleol Wrecsam a sir y Fflint, ond mae'r gwahaniaeth rhwng yr hyn y mae Wrecsam a Swydd Gaer yn ei dalu wedi bod yn bwnc trafod. Mae hynny wedi achosi problem drawsffiniol.

Ms Rees: It is not an issue in residential homes, but it is an issue in nursing homes. That is on the health budget, because there is a variation in price in nursing homes in Pembrokeshire, hence it's the choice issue that we end up with, because it is usually the higher-priced homes that are the preferred choice.

Ms Rees: Nid yw'n berthnasol mewn cartrefi preswyl, ond mae'n berthnasol mewn cartrefi nyrsio. Mae hynny o ran y gyllideb iechyd, oherwydd mae amrywiad ym mhrisiau cartrefi nyrsio yn sir Benfro, a dyna'r rheswm am y dewis sydd gennym, oherwydd mai'r cartrefi drutaf yw'r dewis poblogaidd fel arfer.

[257] **Alun Cairns:** Various studies have been made on behalf of the independent sector and the social services department alike on what the levels should be. What view can you offer on those, because different fees in different areas often lead to a lack of capacity? Very near here in Neath Port Talbot, for example, many residential care homes closed very quickly. They claimed that this was due to lack of fees, which, had they been paid, would have enabled them to stay in business, and that put an awful lot of elderly residents in a difficult position. Also, given the ageing population, I suspect that, over time, the problem will become more acute, so what view can you offer as to how this can be best resolved, bearing in mind that you have to handle the

[257] **Alun Cairns:** Mae astudiaethau amrywiol wedi'u cynnal ar ran y sector annibynnol a'r adran gwasanaethau cymdeithasol yn yr un modd ar y lefelau y dylid eu gweithredu. Beth yw eich barn ar y rheini, oherwydd mae gwahanol ffioedd mewn gwahanol ardaloedd yn aml yn arwain at ddiffyg gallu? Yn agos iawn i ni yma yng Nghastell-nedd Port Talbot, er enghraifft, caeodd llawer o gartrefi nyrsio preswyl yn gyflym iawn. Honnent fod hyn oherwydd diffyg ffioedd, a fyddai, pe baent wedi'u talu, wedi'u galluogi i aros ar agor, a rhoddodd hynny lawer iawn o breswylwyr hŷn mewn sefyllfa anodd. Hefyd, o ystyried y boblogaeth sy'n heneiddio, tybiaf, gydag amser, y bydd y broblem yn mynd yn un fwy difrifol, felly beth yw'r ffordd orau o ddatrys

ultimate problem due to lack of capacity?

hyn yn eich barn chi, gan gofio eich bod yn gorfod mynd i'r afael â'r broblem oherwydd diffyg lleoedd?

Ms Rees: In terms of the tensions around fees in Pembrokeshire, we are working with all our nursing homes to try to understand what the criteria are and what we are paying for. The bottom line, however, is that our finances will only allow us to go to a certain level, and if we pay more money, we reduce the available capacity. We have just had an uplift that we can offer our nursing homes, but I still think that it is wanting in terms of the quality standard that we want from the private sector.

Ms Rees: O ran y tensiynau ynghylch ffioedd yn sir Benfro, yr ydym yn gweithio gyda'n holl gartrefi nyrsio i geisio deall beth yw'r meini prawf ac am beth yr ydym yn talu. Diwedd y gân, fodd bynnag, yw mai dim ond i lefel benodol y gallwn fynd gyda'n cyllid, ac os ydym yn talu rhagor o arian, yr ydym yn gostwng y gallu sydd ar gael. Yr ydym newydd gael cynnydd y gallwn ei gynnig i'n cartrefi nyrsio, ond credaf ei fod yn brin o ran y safon ansawdd yr ydym am ei chael gan y sector preifat.

Mr Lang: I have just to add that it is very difficult to offer a view on the absolute rate, but, in the context of our work for NHS-funded patients, we look at individual cases and their needs, and rates are adjusted according to those individuals' needs. So, if nursing homes are providing continuing healthcare, as opposed to basic care packages for social services, that is adjusted and is very much related to the clinical input that a patient requires. Therefore, it gives a more reflective financial package of the patient's needs than, perhaps, a basic local authority package. However, I would not be able to offer comment on what would be appropriate as an absolute rate for nursing homes.

Mr Lang: Yr wyf ond am ychwanegu ei bod yn anodd iawn cynnig barn ar gyfradd absoliwt, ond, yng nghyd-destun ein gwaith ar gyfer cleifion a gyllidir gan y GIG, yr ydym yn edrych ar achosion unigol a'u hanghenion, a chaiff cyfraddau eu haddasu yn ôl yr anghenion unigol hynny. Felly, os yw cartrefi nyrsio yn darparu gofal iechyd parhaus, yn hytrach na phecynnau gofal sylfaenol ar gyfer gwasanaethau cymdeithasol, mae hynny'n cael ei addasu ac yn gysylltiedig iawn â'r mewnbwn clinigol sydd ei angen ar y claf. Felly, mae'n cynnig pecyn ariannol sy'n adlewyrchu mwy ar anghenion y claf nag, efallai, pecyn awdurdod lleol sylfaenol. Fodd bynnag, ni fyddwn yn gallu gwneud sylwadau pellach ar yr hyn a fyddai'n briodol fel cyfradd absoliwt ar gyfer cartrefi nyrsio.

[258] **Jocelyn Davies:** Rather than this constant bargaining with the private sector, have you considered providing these places in the public sector?

[258] **Jocelyn Davies:** Yn hytrach na'r bargeinio cyson hyn â'r sector preifat, a ydych wedi ystyried darparu'r lleoedd hyn yn y sector cyhoeddus?

Ms Rees: Yes. However, Tenby is an illustration of public-sector commissioning of private-sector provision, where we have a pilot of 10 NHS beds in Tenby that will, however, be delivered by the private sector.

Ms Rees: Do. Fodd bynnag, mae Dinbych-y-pysgod yn enghraifft o sector cyhoeddus yn comisiynu darpariaeth sector preifat, lle mae gennym beilot o 10 gwely GIG yn Ninbych-y-pysgod a fydd, fodd bynnag, yn cael eu darparu gan y sector preifat.

Mr Lang: Likewise, we have commissioned services from the private, independent sector. We have not actually looked at bringing those services back in house, although it is fair to say that, in terms of some of the very high-cost continuing-care patients that we have, we face a challenge, as I mentioned earlier in relation to delayed transfers. Packages tend to be built around individuals at the time that their needs arise. In the early days of continuing healthcare responsibilities for the NHS, that was quite appropriate, and we were developing a relationship with the independent sector. What we now have, however, certainly on our patch, is a series of nursing homes that specialise in particular elements of care, and where we are placing and funding four or five patients in a particular nursing home, we as commissioners are asking whether we should have a more strategic relationship with that nursing home so that we do not pay for an

Mr Lang: Yn yr un modd, yr ydym wedi comisiynu gwasanaethau o'r sector preifat, annibynnol. Nid ydym wedi edrych mewn gwirionedd ar ddod â'r gwasanaethau hynny yn ôl yn fewnol, er y byddai'n deg dweud, o ran rhai o'r cleifion gofal parhaus cost uchel sydd gennym, yr ydym yn wynebu her, fel y soniais eisoes o ran oedi wrth drosglwyddo. Tueddir i adeiladu pecynnau o gwmpas unigolion wrth i'w hanghenion godi. Yn ystod dyddiau cynnar cyfrifoldebau gofal iechyd parhaus y GIG, yr oedd hynny'n eithaf priodol, ac yr oeddem yn datblygu perthynas â'r sector annibynnol. Yr hyn sydd gennym yn awr, fodd bynnag, yn sicr yn ein hardal ni, yw cyfres o gartrefi nyrsio sy'n arbenigo mewn elfennau gofal penodol, ac yr ydym yn lleoli a chyllido pedwar neu bump o gleifion mewn cartref nyrsio penodol, yr ydym fel comisiynwyr yn gofyn a ddylai fod gennym berthynas fwy strategol â'r cartref nyrsio dan sylw fel nad ydym yn talu am

individual. In an extreme case, five individuals placed on their own would need one-to-one nursing provision to ensure that nurses were present, but, when you have five in adjacent rooms, you can ask whether you need five nurses present, or whether you need three or even two to cover that need. What we are getting into now is a discussion that may involve thinking about NHS provision and asking whether—the cost of providing it in that model being what it is and financial resources being so tight—other models would deliver it more cost effectively. You must then weigh up the qualitative dimensions of that for the individual and the sort of provision that you would have to give. However, a more strategic view, and one that brings together clusters of skill and gets the economies of scale, is what we are looking at.

unigolyn. Mewn achos eithafol, byddai ar bum unigolyn wedi'u lleoli ar eu pen eu hunain angen darpariaeth nyrsio un-i-un i sicrhau bod nyrsys yn bresennol, ond, pan fo gennych bump mewn ystafelloedd cyfagos, gallwch ofyn a oes angen pum nyrs yn bresennol, neu a ydych angen tair neu hyd yn oed dwy i ddiwallu'r angen hwnnw. Yr hyn yr ydym yn ei wneud yn awr yw dechrau trafodaeth a all gynnwys meddwl am ddarpariaeth y GIG a gofyn—o ystyried beth yw'r gost o'i darparu yn y model hwnnw a bod adnoddau ariannol mor brin—a fyddai modelau eraill yn ei ddarparu yn fwy effeithiol. Mae'n rhaid i chi wedyn bwyso a mesur hyd a lled ansoddol hynny ar gyfer yr unigolyn a'r math o ddarpariaeth y byddai'n rhaid i chi ei rhoi. Fodd bynnag, barn fwy strategol, ac un sy'n dod â chlystyrau o sgiliau at ei gilydd ac sy'n cael yr arbedion maint, yw'r hyn yr ydym yn edrych arno.

[259] **Janet Davies:** Jocelyn, you wanted to ask some questions about commissioning, but they may have been partly covered.

[259] **Janet Davies:** Jocelyn, yr oeddech am ofyn cwestiynau am gomisiynu, ond efallai eu bod wedi'u hateb i ryw raddau.

[260] **Jocelyn Davies:** Yes, some of them have already been covered. I think it was Mark who wanted to ask something.

[260] **Jocelyn Davies:** Ydy, mae rhai ohonynt wedi'u hateb eisoes. Credaf fod Mark am ofyn rhywbeth.

[261] **Janet Davies:** I am sorry, Mark.

[261] **Janet Davies:** Mae'n ddrwg gennyf, Mark.

[262] **Mark Isherwood:** I have not asked

[262] **Mark Isherwood:** Nid wyf wedi gofyn

question no. 5 yet.

cwestiwn rhif 5 eto.

[263] **Janet Davies:** All right.

[263] **Janet Davies:** Iawn.

[264] **Mark Isherwood:** On the second offer scheme, paragraphs 4.4 and 4.5 highlight both potential and risk inherent in the second offer scheme. How will it impact in your own areas, and do you feel that it can deliver sustainable improvements?

[264] **Mark Isherwood:** O ran cynllun yr ail gynnig, mae paragraffau 4.4 a 4.5 yn trafod potensial a risgiau cynhenid cynllun yr ail gynnig. Sut y bydd yn effeithio ar eich ardaloedd chi, ac a ydych yn credu y bydd yn gallu cyflawni gwelliannau cynaliadwy?

Mr Lang: Maybe I can answer this in terms of how it has impacted in our area. The situation in which we have been means that we have used the funding of the second offer scheme, but we have not got into the position of giving second offers to patients to be transferred to other providers. In Wrexham, we have a situation where the north-east Wales trust has, for its problem with day-case orthopaedic waiting lists, which is quite significant, managed this in-house. For its in-patients, the trust has managed an arrangement with a local private hospital, but the process has been managed through the trust. There is continuity for the patient and it is not a cold contact, if you like, asking whether patients would like to transfer to another hospital to have treatment. It is a managed pathway. This has been okay, has worked quite well, and has allowed patients to have their operations.

Mr Lang: Efallai y gallaf ateb hyn o ran sut y mae wedi effeithio ar ein hardal ni. Mae’r sefyllfa yr ydym wedi bod ynddi yn golygu ein bod wedi defnyddio cyllid cynllun yr ail gynnig, ond nid ydym wedi bod yn y sefyllfa i roi ail gynnig i gleifion gael eu trosglwyddo i ddarparwyr eraill. Yn Wrecsam, yr ydym mewn sefyllfa lle mae ymddiriedolaeth y Gogledd-ddwyrain, gyda’i phroblemau gyda rhestrau aros orthopedig achos dydd, sy’n eithaf sylweddol, wedi rheoli hyn yn fewnol. Gyda’i chleifion mewnol, mae’r ymddiriedolaeth wedi dod i drefniant gydag ysbyty preifat lleol, ond mae’r broses wedi’i rheoli drwy’r ymddiriedolaeth. Mae dilyniant i’r claf ac nid yw’n gysylltiad oer, os dymunwch, gofyn a fyddai cleifion am gael eu trosglwyddo i ysbyty arall i gael triniaeth. Mae’n llwybr a reolir. Mae hyn wedi bod yn iawn, wedi gweithio’n eithaf da, ac wedi caniatáu i gleifion gael eu llawdriniaethau.

On a more fundamental point about the

Ar bwynt mwy sylfaenol am gynllun yr ail

second offer scheme, and referring to the point made through the chair, in relation to short-term and long-term connections between schemes, it is important that what happens with the second offer scheme is connected into local health board commissioning plans, and that we do not end up with local health boards trying to commission and deliver a model at one level, and the second offer scheme putting in something that may be complementary in the short term but could cause some conflict and difficulty between the two.

gynnig, a chan gyfeirio at y pwynt a wnaed gan y Cadeirydd, mewn perthynas â chysylltiadau tymor byr a hirdymor rhwng cynlluniau, mae'n bwysig bod yr hyn a fydd yn digwydd gyda chynllun yr ail gynnig yn gysylltiedig â chynlluniau comisiynu'r bwrdd iechyd lleol, ac na fydd y byrddau iechyd lleol yn ceisio comisiynu a darparu model ar un lefel, a chynllun yr ail gynnig yn cynnig rhywbeth a fyddai'n gyflenwol yn y tymor byr ond a allai achosi gwrthdaro ac anawsterau rhwng y ddau.

In terms of whether or not the second offer scheme has worked in north-east Wales, it has been very helpful, but it has not been the true second offer scheme, perhaps, as has been applied more in south Wales. Bernie may have a comment on that.

O ran a yw cynllun yr ail gynnig wedi bod yn llwyddiannus yn y Gogledd-ddwyrain ai peidio, mae wedi bod yn ddefnyddiol iawn, ond nid dyma gynllun yr ail gynnig mewn gwirionedd, o bosibl, fel sydd wedi'i weithredu i raddau mwy helaeth yn y De. Efallai y bydd Bernie am roi sylwadau ar hynny.

Ms Rees: We are working with the second offer scheme to ensure that the evaluation plays a key role in sustaining the activity that we buy. We also need the non-recurring money that has been announced for this year to become recurrent to be able to secure the capacity.

Ms Rees: Yr ydym yn gweithio gyda chynllun yr ail gynnig i sicrhau bod y gwerthusiad yn gwneud cyfraniad allweddol at gynnal y gweithgarwch yr ydym yn ei brynu. Yr ydym hefyd angen yr arian anghylchol sydd wedi'i gyhoeddi ar gyfer eleni i fod yn rheolaidd er mwyn gallu diogelu'r gallu.

[265] **Mark Isherwood:** Finally, how do you work with the trust in your area to avoid breaches of waiting-time targets and potential

[265] **Mark Isherwood:** Yn olaf, sut yr ydych yn gweithio gyda'r ymddiriedolaeth yn eich ardal i osgoi methu'r targedau

financial liabilities? Do you anticipate disputes, or have you encountered any disputes?

amseroedd aros a thorri'r rhwymedigaethau ariannol posibl? A ydych yn rhagweld achosion o anghydfod, neu a ydych wedi profi unrhyw anghydfod?

Ms Rees: The only issue that we have in Pembrokeshire is around visiting consultants. We work with other providers, rather than our home provider, because that is where the visitors come from in determining that we do not have an almost second-class service because we use a visiting consultant. We have done a lot of work on that, and I think that visiting consultants will be an issue for us in terms of commissioning with our other four providers over the next year.

Ms Rees: Yr unig fater yr ydym wedi'i wynebu yn sir Benfro yw un yn ymwneud â meddygon ymgynghorol ymweld. Yr ydym yn gweithio gyda darparwyr eraill, yn hytrach na'n darparwr cartref, oherwydd mai dyna'r agwedd sydd gan ymwelwyr wrth ddod i'r casgliad nad oes gennym wasanaeth eilradd bron iawn oherwydd ein bod yn defnyddio meddygon ymgynghorol ymweld. Yr ydym wedi gwneud llawer o waith ar hynny, a chredaf y bydd meddygon ymgynghorol ymweld yn bwnc trafod i ni o ran comisiynu gyda'n pedwar darparwr arall yn ystod y flwyddyn nesaf.

Mr Lang: We do not particularly envisage a problem in our area in hitting the targets. However, there is an issue for us. I alluded to the way in which orthopaedic waiting lists have been managed, and there is a major issue in terms of our strategic capacity to deliver lower orthopaedic waiting times, which we are working on. The sort of approaches that we currently use will not deliver that. We are trying to develop a plan that will do that, and there has been an announcement of recurring investment previously in other regions and, this year, in north Wales. Therefore, we believe that we will hit the targets this year, and that we are able to sustain them if we are able to use that

Mr Lang: Nid ydym yn rhagweld problem yn ein hardal i gyflawni'r targedau. Fodd bynnag, mae yna fater i ni. Cyfeiriais at y ffordd y mae rhestrau aros orthopedig wedi'u rheoli, ac mae mater pwysig o ran ein gallu strategol i gyflawni amseroedd aros orthopedig is, ac yr ydym yn gweithio ar hynny. Ni fydd y math o ddulliau yr ydym yn eu defnyddio ar hyn o bryd yn cyflawni hynny. Yr ydym yn ceisio datblygu cynllun a fydd yn gwneud hynny, a bu cyhoeddiad ynglŷn â buddsoddiad cylchol eisoes mewn rhanbarthau eraill ac, eleni, yn y Gogledd. Felly, credwn y byddwn yn cyflawni'r targedau eleni, ac y byddwn yn gallu eu cynnal os gallwn ddefnyddio'r adnoddau

resource in a properly planned fashion.

hynny yn drefnus.

[266] **Jocelyn Davies:** I have one or two questions about the role of the private sector, and I know that we touched on it earlier. However, what do you see as the role of the private sector, and what services do you commission within the private sector and why? Do you consider that to be good value for money?

[266] **Jocelyn Davies:** Mae gennyf ambell gwestiwn am rôl y sector preifat, a gwn ein bod wedi crybwyll hyn yn gynharach. Fodd bynnag, beth yn eich barn chi yw rôl y sector preifat, a pha wasanaethau yr ydych yn eu comisiynu yn y sector preifat a pham? A ydych yn ystyried bod hyn yn werth da am arian?

Mr Lang: If I could answer first, in terms of the private sector, in its purest sense, it is my view that it is one of the potential providers of care to the NHS. As long as that care is funded by the NHS and sticks with the principles of the NHS, it is a potential provider. I think that we have to view the private sector as having some skills and some qualities to offer in terms of the way that its services are organised, in that they do not suffer the pressures and difficulties of emergency admissions. The sector is very privileged in that way. It has planned care that is well managed and moves through the system in an orderly and managed fashion. That is good for patients.

Mr Lang: Os caf ateb gyntaf, o ran y sector preifat, yn ei hanfod, credaf ei fod yn un o'r darparwyr gofal posibl i'r GIG. Cyhyd â bod y gofal hwnnw'n cael ei gyllido gan y GIG ac yn cadw at egwyddorion y GIG, mae'n ddarparwr posibl. Credaf fod yn rhaid i ni gydnabod bod gan y sector preifat rai sgiliau a rhai rhinweddau i'w cynnig o ran y ffordd y mae ei wasanaethau wedi'u trefnu, fel nad ydynt yn dioddef pwysau ac anawsterau derbyniadau brys. Mae'r sector yn freintiedig iawn yn hynny o beth. Mae ganddo ofal wedi'i gynllunio sy'n cael ei reoli'n dda ac sy'n symud drwy'r system yn drefnus. Mae hynny'n dda i gleifion.

There is a reliability and a predictability about service in the private sector. Having said that, there are issues around value for money. We need to be conscious of the fact that we have to balance the assurance of delivery, which can often be higher within the private sector because it has this

Mae rhinweddau dibynadwy a disgwyliadwy yn perthyn i wasanaeth y sector preifat. Ond o ddweud hynny, mae materion ynghylch gwerth am arian. Mae angen i ni fod yn ymwybodol o'r ffaith bod yn rhaid i ni gydbwyso'r sicrwydd o ddarpariaeth, a all fod yn uwch yn aml yn y sector preifat

protective capacity, with value for money. The costs may not be identical between the NHS and the private sector. We are not using the tariffs that England is using, although I think that we can get a lot of benefit by using them as benchmarks in Wales and take advantage of the fact that the private sector has accepted in England that there is a standard price for doing things. That may be a bit of a two-edged sword, because, if the NHS in Wales says that it can do it cheaper, it will cost us more to do it through the private sector. However, we have a fixed benchmark there. So, that gives a lid on price and, to a certain degree, gives us a measure on value for money, because if the private sector has to deliver whatever service you ask it to deliver in an acute sense on the NHS tariff, then that is broadly comparable with value for money of the ongoing strategic capacity that the NHS would deliver in England, and likewise in Wales.

oherwydd bod ganddo'r gallu amddiffynnol hwn, gyda gwerth am arian. Efallai nad yw'r costau yr un fath rhwng y GIG a'r sector preifat. Nid ydym yn defnyddio'r tariffau y mae Lloegr yn eu defnyddio, er y credaf y gallem elwa o'u defnyddio fel meincnodau yng Nghymru a manteisio ar y ffaith bod y sector preifat wedi derbyn yn Lloegr bod pris safonol ar gyfer gwneud pethau. Gallai hynny fod yn dipyn o sefyllfa amhosibl i ni, oherwydd, os yw'r GIG yng Nghymru yn dweud ei fod yn gallu ei wneud yn rhatach, bydd yn costio mwy i ni i'w wneud drwy'r sector preifat. Fodd bynnag, mae gennym feincnod penodol yno. Felly, mae hynny'n rhoi terfyn ar bris ac, i ryw raddau, yn rhoi dull i ni fesur gwerth am arian, oherwydd os yw'r sector preifat yn gorfod darparu pa bynnag wasanaeth yr ydych yn gofyn iddo'i ddarparu a hynny ar sail acíwt ar dariff y GIG, gellir cymharu hynny'n fras gyda gwerth am arian y gallu strategol cyfredol y byddai'r GIG yn ei ddarparu yn Lloegr, a'r un fath yng Nghymru.

[267] **Jocelyn Davies:** What services do you commission from the private sector?

[267] **Jocelyn Davies:** Pa wasanaethau yr ydych yn eu comisiynu o'r sector preifat?

Mr Lang: At the moment, we commission very little from the private sector. We use the sector to help us to reduce waiting lists, which takes us back to this protected capacity issue, but we do not routinely commission a lot of care from that sector at the moment. There are odd bits here and there and individual packages of care. In terms of

Mr Lang: Ar hyn o bryd, nid ydym yn comisiynu llawer o'r sector preifat. Yr ydym yn defnyddio'r sector i'n cynorthwyo i ostwng y rhestrau aros, sy'n mynd â ni'n ôl at y mater o amddiffyn gallu, ond nid ydym yn comisiynu llawer o ofal yn rheolaidd o'r sector hwnnw ar hyn o bryd. Mae yna dameidiau yma ac acw a phecynnau gofal

patients with complex needs who may be supported in the community, the private sector will often work in that area. Obviously, the independent sector, or the nursing home sector, is a major sector that we commission from, but we commission very little from the private hospital sector. Having said that, as part of our forward view of how we deliver capacity in orthopaedics, I think that that has to be viewed as one of the options.

unigol. O ran cleifion gydag anghenion cymhleth sy’n cael eu cynorthwyo yn y gymuned o bosibl, bydd y sector preifat yn aml yn gweithio yn y maes hwnnw. Yn amlwg, mae’r sector annibynnol, neu’r sector cartrefi nyrsio, yn sector mawr yr ydym yn comisiynu ganddo, ond nid ydym yn comisiynu llawer o’r sector ysbytai preifat. Ond ar ôl dweud hynny, fel rhan o’n cynlluniau ar gyfer y dyfodol ar sut y byddwn yn darparu gwasanaethau orthopedig, credaf fod yn rhaid i ni ystyried hynny fel un o’r opsiynau.

Ms Rees: I do not have much to add to what Geoff has just said. We do not commission routinely in the private sector. It is a standby. If we do not unravel the systems and processes for new commissioning models, it may be that we rely more on the private sector. However, our service and commissioning plan, which we have just taken to the board, talks about the capacity within our NHS providers and not within the private sector.

Ms Rees: Nid oes gennyf lawer i ychwanegu at yr hyn a ddywedodd Geoff. Nid ydym yn comisiynu yn rheolaidd yn y sector preifat. Cynllun wrth gefn ydyw. Os nad ydym yn datrys y systemau a’r prosesau ar gyfer modelau comisiynu newydd, efallai y byddwn yn dibynnu mwy ar y sector preifat. Fodd bynnag, mae ein gwasanaeth a’n cynllun comisiynu, yr ydym newydd eu rhoi ar waith, yn trafod gallu ein darparwyr GIG ac nid y gallu yn y sector preifat.

[268] **Jocelyn Davies:** So, are you saying that, in the long term, you would choose the NHS rather than the private sector, and that you do not see a role for the private sector in the long term?

[268] **Jocelyn Davies:** Felly, a ydych yn dweud, yn yr hirdymor, y byddech yn dewis y GIG yn hytrach na’r sector preifat, ac nad ydych yn gweld bod gan y sector preifat rôl yn yr hirdymor?

Ms Rees: Yes.

Ms Rees: Ydwyf.

Mr Lang: I am open-minded about it. We are currently looking at plans that should weigh up the options. If the private sector is able to deliver value for money and guaranteed access to high-quality care for patients, I think that we should look at that and test it. I do not have a firm view on what the answer will be. However, I think that we should be open-minded about it.

Mr Lang: Yr wyf yn cadw meddwl agored am hynny. Ar hyn o bryd yr ydym yn edrych ar gynlluniau a ddylai bwyso a mesur yr opsiynau. Os yw'r sector preifat yn gallu darparu gwerth am arian a sicrwydd o fynediad i ofal o ansawdd uchel i gleifion, credaf y dylem edrych ar hynny ac arbrofi. Nid wyf yn sicr beth fydd yr ateb. Fodd bynnag, credaf y dylem gadw meddwl agored ynglŷn â hyn.

[269] **Alun Cairns:** In response to your last answer, Ms Rees, in view of the fact that the private sector is quite a dynamic environment where costs can rise or fall relatively sharply, depending on your band quite often, do you still not see a role for the private sector?

[269] **Alun Cairns:** Mewn ymateb i'ch ateb diwethaf, Ms Rees, gan ystyried y ffaith bod y sector preifat yn amgylchedd eithaf deinamig lle gall costau godi neu ddisgyn yn eithaf cyflym, yn dibynnu ar eich band yn eithaf aml, onid ydych yn gweld rôl i'r sector preifat?

Ms Rees: In terms of hospital care and provision, I think that our first choice in Pembrokeshire, because we work with five providers, is to look at the NHS capacity. It is about working through systems and processes from the demand management to the strategies that we are putting in to be able to deliver it in the NHS.

Ms Rees: O ran gofal ysbyty a darpariaeth, credaf mai'n dewis cyntaf yn sir Benfro, oherwydd ein bod yn gweithio gyda phum darparwr, yw edrych ar allu'r GIG. Mae'n ymwneud â gweithio drwy systemau a phrosesau i reoli'r galw i'r strategaethau yr ydym yn eu cyflwyno i allu ei ddarparu yn y GIG.

[270] **Alun Cairns:** Even if an operation costs more within the NHS than the private sector because of this dynamic environment that I talked about, do you still think that the commitment should be to commission within the NHS, although it is costing the public purse more money?

[270] **Alun Cairns:** Hyd yn oed os yw llawdriniaeth yn costio mwy yn y GIG na'r sector preifat oherwydd yr amgylchedd deinamig y bu i mi sôn amdano, a ydych yn dal i feddwl y dylid ymrwymo i gomisiynu o fewn y GIG, er ei fod yn defnyddio mwy o arian cyhoeddus?

Ms Rees: I think that we are limited in Pembrokeshire in terms of the geographical arrangements of private providers. So, we would be looking at home, to be able to deliver our own needs from an NHS establishment.

Ms Rees: Credaf ein bod yn cael ein cyfyngu yn sir Benfro o ran trefniadau daearyddol darparwyr preifat. Felly, byddwn yn troi ein golygon tuag adref, i allu diwallu ein hanghenion ein hunain o sefydliad GIG.

[271] **Alun Cairns:** Is that your view, despite the fact that the second offer scheme can potentially take people away?

[271] **Alun Cairns:** Ai hynny yw eich barn, er y gall cynllun yr ail gynnig fynd â phobl i ffwrdd o bosibl?

Ms Rees: I think that the second offer scheme, in terms of its evaluation, will identify what I have said—it's working as a barrier to benefits in terms of the number of refusals.

Ms Rees: Credaf y bydd cynllun yr ail gynnig, o ran ei werthuso, yn nodi yr hyn a ddywedais—mae'n gweitio fel rhwystr i fanteision o ran nifer y gwrthodiadau.

[272] **Leighton Andrews:** I wanted to ask Mr Lang about the issue of tariffs. You referred to the difference between England and Wales. Would you elaborate on that and say whether you think there is a role for them in Wales?

[272] **Leighton Andrews:** Yr oeddwn am holi Mr Lang am fater tariffau. Bu i chi gyfeirio at y gwahaniaeth rhwng Cymru a Lloegr. A allwch ymhelaethu ar hynny a dweud a ydych yn credu bod rôl iddynt yng Nghymru?

Mr Lang: Certainly. England is increasingly moving to a system whereby the rate at which primary-care organisations pay trusts for activity is predetermined. It is linked closely to the amount of activity undertaken and is a strict financial calculation. That has certain advantages for a commissioner in that, if you wish to commission extra capacity, you do not have to spend time worrying whether the tariff is right, whether other services are being loaded into it, or whether we are covering other costs. You know that, if you

Mr Lang: Yn sicr. Mae Lloegr yn symud fwyfwy at system lle pennir ymlaen llaw y gyfradd y mae sefydliadau gofal sylfaenol yn talu i ymddiriedolaethau am weithgarwch. Mae'n cael ei gysylltu'n agos â faint o weithgarwch a gyflawnir ac mae'n gyfrifiad ariannol caeth. Mae manteision penodol i hynny i gomisiynydd o ran, os ydych am gomisiynu gallu ychwanegol, nid oes yn rhaid i chi dreulio amser yn poeni a yw'r tariff yn iawn, a yw gwasanaethau eraill yn cael eu llwytho arno, neu a ydym yn talu'r

want to buy 20 hip replacements, you are going to have to pay a certain amount for them. Therefore, there is an advantage there. However, there are also some down sides to it. One particular issue for us in north-east Wales is that foundation trusts are guaranteed that income. The framework is that, if they do the operations, you will pay. As a commissioner, that can leave you slightly vulnerable to additional financial costs, because, if demands rise, you are not then in a position to manage them. So, there are tensions within it, but, as a framework, it is helpful.

costau eraill. Gwyddoch, os ydych am brynu 20 llawdriniaeth gosod clun newydd, y bydd yn rhaid i chi dalu swm penodol amdanynt. Felly, mae mantais yno. Fodd bynnag, mae anfanteision hefyd. Un mater penodol i ni yn y Gogledd-ddwyrain yw bod ymddiriedolaethau sefydledig yn cael sicrwydd o'r incwm hwnnw. Mae'r fframwaith yn golygu, os ydynt yn gwneud y llawdriniaethau, y byddwch yn talu. Fel comisiynydd, gall hynny eich gadael ychydig yn agored i gostau ariannol ychwanegol, oherwydd, os oes cynnydd yn y galw, nid ydych wedyn mewn sefyllfa i'w reoli. Felly, mae tensiynau yn hyn o beth, ond, fel fframwaith, mae'n ddefnyddiol.

In my view, I would not necessarily go so far as to say that we should implement a system in Wales where all the activity times the price equals the amount of money that you pay. The national health service is more sophisticated than that. Certainly, in the emergency services, you could introduce some extreme and perverse incentives. You could have a situation whereby a hospital would be looking to admit patients because every patient brings £3,000 with them, as opposed to our current strategy, which is to look at investing in infrastructure in the community and turning that tide to promote more independent living. So, there are benefits in the financial framework, in value for money, and in pushing efficiency issues, but there are also risks in wholeheartedly adopting a tariff-based structure.

Yn fy marn i, ni fyddwn o reidrwydd yn mynd mor bell â dweud y dylem weithredu system yng Nghymru lle mae pris amser yr holl weithgarwch yn gyfwerth â'r arian yr ydych yn ei dalu. Mae'r gwasanaeth iechyd gwladol yn fwy soffistigedig na hynny. Yn sicr, yn y gwasanaethau brys, gallech gyflwyno cymhellion eithafol a gwrthnysig. Gallech fod mewn sefyllfa lle byddai ysbyty yn ceisio derbyn cleifion oherwydd bod pob claf yn denu £3,000, yn hytrach na'n strategaeth bresennol, sef edrych ar fuddsoddi mewn seilwaith yn y gymuned a chynorthwyo pobl i fyw'n fwy annibynnol. Felly, mae manteision yn y fframwaith ariannol, o ran gwerth am arian, ac wrth geisio gwthio materion effeithlonrwydd, ond mae peryglon hefyd wrth fabwysiadu strwythur ar sail tariff yn llwyr.

[273] **Jocelyn Davies:** Mr Lang, it is interesting for you that you deal with both English and Welsh trusts, and you have explained to us some of the differences between them. However, are you aware of any patients in your area who are waiting for treatment in English trusts and who are waiting longer than English patients in the same English trusts?

[273] **Jocelyn Davies:** Mr Lang, mae'n ddiddorol eich bod yn delio gydag ymddiriedolaethau o Gymru a Lloegr, ac yr ydych wedi egluro rhai o'r gwahaniaethau rhyngddynt. Fodd bynnag, a ydych yn ymwybodol o unrhyw gleifion yn eich ardal sy'n aros am driniaeth mewn ymddiriedolaethau yn Lloegr ac sy'n aros yn hwy na chleifion o Loegr yn yr un ymddiriedolaethau o Loegr?

Mr Lang: Yes, I am.

Mr Lang: Ydwyf.

[274] **Jocelyn Davies:** Thank you for that. What, for you, are the main implications of the differences between health policy in England and in Wales?

274] **Jocelyn Davies:** Diolch am hynny. Beth, yn eich barn chi, yw prif oblygiadau'r gwahaniaethau rhwng polisi iechyd Cymru a Lloegr?

Mr Lang: I will start with the waiting-times issue; it is a key one. We find that there are

Mr Lang: Dechreuaf gyda'r amseroedd aros; mae'n fater allweddol. Yr ydym yn canfod

situations where patients wait longer; we have a significant arrangement with the Robert Jones and Agnes Hunt Orthopaedic and District Hospital in Oswestry, which serves many people, not just in north-east Wales, but across north Wales, because it also deals in specialist work. There are great difficulties, mainly at the patient/clinician interface, where consultants have to explain to patients that, because they happen to live in the wrong village, they must wait a further nine months for their surgery. It is not easy to explain to anybody that there is any justification for that. I understand that it is a matter of policy, we manage that and explain to patients that that is the reason for it. That is a very practical, on-the-ground difficulty. Where that also leads us, as commissioners, is to a situation where our influence, in terms of being able to commission services for our residents with those same hospitals, is diminishing as those gaps become bigger.

bod sefyllfaoedd lle mae cleifion yn aros yn hwy; mae gennym drefniant pwysig gydag Ysbyty Orthopedig a Dosbarth Robert Jones ac Agnes Hunt yng Nghroesoswallt, sy'n gwasanaethu llawer o bobl, nid yn unig yn y Gogledd-ddwyrain, ond ledled y Gogledd, oherwydd ei bod hefyd yn delio mewn gwaith arbenigol. Mae anawsterau mawr, yn bennaf o ran cydgysylltu'r claf/clinigwr, lle mae meddygon ymgynghorol yn gorfod egluro i gleifion bod yn rhaid iddynt aros naw mis pellach am eu llawdriniaeth, oherwydd eu bod yn byw yn y pentref anghywir. Nid yw'n hawdd egluro i unrhyw un bod unrhyw gyfiawnhâd dros hynny. Deallaf ei fod yn fater o bolisi, yr ydym yn rheoli hynny ac yn egluro i gleifion mai dyna yw'r rheswm amdano. Mae hynny'n anhawster ymarferol, cyffredinol iawn. Mae hynny hefyd yn ein rhoi ni, fel comisiynwyr, mewn sefyllfa lle mae ein dylanwad, o ran gallu comisiynu gwasanaethau ar gyfer ein preswylwyr gyda'r un ysbytai hynny, yn lleihau wrth i'r bylchau hynny gynyddu.

Hospitals such as the Robert Jones and Agnes Hunt hospital, the Countess of Chester Hospital, which is right on the border, and the hospitals in Hereford and Shrewsbury, both of which have a strong link to Powys, are focusing very hard on delivering the English targets. That is where their accountability lies, and they refer straight back to Westminster, ultimately, in terms of their performance. That means that it becomes increasingly frustrating, difficult and annoying for them to have to manage two different systems and, because of the resource constraints that we have, I, for example, can only commission an 18-month waiting time. I do not have the resources to commission it down to nine months, as England is doing. I would like to be able to do so, but then that would present a further inequity when we come back into Wales. So, there is an issue about how influential we will be with English providers for the future, and I think that that is being undermined. There is a major interdependence between Wales and England and, if you look at, in my case, north-east Wales, the interdependence is not equal—we depend on England more than England depends on us.

Mae ysbytai fel ysbyty Robert Jones ac Agnes Hunt, Ysbyty Iarlles Caer, sydd ar y ffin, ac ysbytai Henffordd a'r Amwythig, sydd â chysylltiad agos â Phowys, yn canolbwyntio'n galed iawn ar gyflawni targedau Lloegr. Yno mae eu hatebolrwydd, ac maent yn cyfeirio yn syth yn ôl at San Steffan, yn y pen draw, o ran eu perfformiad. Mae hynny'n golygu ei bod yn mynd yn gynyddol rhwystredig, anodd a blinderus iddynt orfod rheoli dwy system wahanol ac, oherwydd y cyfyngiadau adnoddau sydd gennym, ni allaf i, er enghraifft, ond gomisiynu amseroedd aros 18 mis. Nid oes gennyf yr adnoddau i'w gomisiynu i lawr i naw mis, fel y mae Lloegr yn ei wneud. Hoffwn allu gwneud hynny, ond byddai hynny wedyn yn ychwanegu annhegwch pellach wrth i ni ddod yn ôl i Gymru. Felly, mae mater yma am ba mor ddylanwadol y byddwn gyda darparwyr o Loegr yn y dyfodol, a chredaf fod hynny yn cael ei danseilio. Mae cyd-ddibyniaeth sylweddol rhwng Cymru a Lloegr, ac, os edrychwch, yn fy achos i, ar y Gogledd-ddwyrain, nid yw'r gyd-ddibyniaeth yn gyfartal—yr ydym yn dibynnu mwy ar Loegr nag y mae Lloegr yn dibynnu arnom ni.

[275] **Jocelyn Davies:** Do you have patients coming from England?

[275] **Jocelyn Davies:** A oes gennych gleifion yn dod o Loegr?

Mr Lang: We do indeed.

[276] **Jocelyn Davies:** For what kind of treatment?

Mr Lang: It is a mixture. Emergency-care patients come across the border, because, for example, Wrexham Maelor Hospital may be their nearest district general hospital, so there is a flow there. We also have elective-care patients across a range of services, mainly due to historic referral patterns. Sometimes it is down to the proximity of GP practices to particular hospitals, and sometimes it is down to clinical excellence. There are some excellent services that attract referrals. The issue emerging more and more is that of booking systems, because waiting times are so much longer and the choice agenda in England is being heightened. We have seen much in the press about this, and about how booking systems are, or are not, working. However, the theory of that exercise is that a GP will present to patients the options available to them, and they will book up the time. They must offer five providers and, if four of them can see the patient within 12 weeks and can perform the operation within three months, and the other provider will see the patient in maybe 12 months and the operation will take place another year after that, there is a strong potential for those referrals to change. That will financially destabilise hospitals on the border. The North East Wales NHS Trust will be destabilised. Probably around £1 million of that trust's income is at risk from those sorts of changes. So, that is a very real impact of the policy difference.

Mr Lang: Oes yn wir.

[276] **Jocelyn Davies:** Am ba fath o driniaeth?

Mr Lang: Mae'n gymysgedd. Mae cleifion gofal brys yn croesi'r ffin, oherwydd, er enghraifft, efallai mai Ysbyty Maelor Wrecsam yw'r ysbyty cyffredinol dosbarth agosaf, felly mae llif yno. Mae gennym hefyd gleifion gofal dewisol ar draws amrywiaeth o wasanaethau, yn bennaf oherwydd patrymau cyfeirio hanesyddol. O bryd i'w gilydd mae hyn oherwydd agosrwydd meddygfeydd meddygon teulu at ysbytai penodol, ac weithiau mae oherwydd rhagoriaeth glinigol. Mae rhai gwasanaethau rhagorol sy'n denu cyfeiriadau. Mae systemau bwcio yn fater sy'n codi dro ar ôl tro, oherwydd bod amseroedd aros cymaint hirach ac mae'r agenda ddewis yn Lloegr yn dwysáu. Yr ydym wedi gweld llawer yn y wasg am hyn, ac am sut mae systemau bwcio yn gweithio, neu sut maent yn methu â gweithio. Fodd bynnag, damcaniaeth yr ymarfer yw y bydd meddyg teulu yn cyflwyno'r opsiynau sydd ar gael i'r cleifion, a byddant yn bwcio'r amser. Mae'n rhaid iddynt gynnig pum darparwr ac, os yw pedwar ohonynt yn gallu gweld y claf o fewn 12 wythnos ac yn gallu cyflawni'r llawdriniaeth o fewn tri mis, ac efallai y bydd y darparwr arall yn gweld y claf mewn 12 mis o bosibl a bydd y llawdriniaeth yn cael ei chyflawni flwyddyn arall ar ôl hynny, mae potensial cryf i'r cyfeiriadau hynny newid. Bydd hynny'n ansefydlogi ysbytai ar y ffin yn ariannol. Bydd Ymddiriedolaeth GIG Gogledd-dwyrain Cymru yn cael ei ansefydlogi. Mae'n debyg bod tua £1 miliwn o incwm yr ymddiriedolaeth honno mewn perygl yn sgil y math hynny o newidiadau. Felly, dyna effaith wirioneddol y gwahaniaeth polisi.

The final point in terms of what I see as the policy difference is the impact of capacity, in terms of how England has approached its waiting-times problem and has strategically placed capacity. Whether that has been through independent treatment centres or treatment centres in NHS hospitals, it has recognised the need to have more theatres, more clinicians and wards to do the work, and has strategically planned that. It has not been left to local discretion to work up small schemes to give every hospital slightly more capacity; there has been a strategic drive. That has given those in England the ability to deliver and, to someone like me who sits on the board, that presents an opportunity to use that capacity, which also has implications for our local hospital. So, some very real issues emerge from the differences.

Y pwynt olaf o ran yr hyn y gwelaf fel y gwahaniaeth polisi yw effaith y gallu, o ran sut mae Lloegr wedi mynd i’r afael â’i phroblem amseroedd aros ac wedi gosod gallu yn strategol. Waeth a yw hynny wedi bod drwy ganolfannau triniaeth annibynol neu ganolfannau triniaeth mewn ysbytai GIG, mae wedi cydnabod yr angen i gael mwy o theatrau, mwy o glinigwyr a wardiau i wneud y gwaith, ac mae wedi cynllunio hynny’n strategol. Ni chafwyd rhyddid lleol i roi cynlluniau bach ar waith er mwyn rhoi ychydig mwy o allu i bob ysbyty; bu ymdrech strategol. Mae hynny wedi rhoi’r gallu i’r rheini yn Lloegr i gyflawni ac, i rywun fel minnau sydd ar y bwrdd, mae hynny’n rhoi cyfle i ddefnyddio’r gallu hwnnw, sydd hefyd ag iddo oblygiadau i’n hysbyty lleol ni. Felly, mae rhai materion gwirioneddol iawn yn deillio o’r gwahaniaethau.

[277] **Carl Sargeant:** I will be brief. I did not think that we were going to delve into the realms of Chester, so I did not declare this earlier: I am a non-executive member of the board of the Countess of Chester Hospital.

[277] **Carl Sargeant:** Byddaf yn gryno. Nid oeddwn yn credu ein bod am fynd ar drywydd Caer, felly ni ddatgelais hyn yn gynharach: yr wyf yn aelod anweithredol o fwrdd Ysbyty Iarlles Caer.

You made a point, Mr Lang, about dependency on cross-border services. A very important point is that cross-border hospitals, such as those in Chester and Shrewsbury and so on, are very dependent on income from the Welsh sector—I think that 20 per cent or 25 per cent of their business comes from the Welsh market—so we are significant in their

Bu i chi sôn, Mr Lang, am ddibyniaeth ar wasanaethau trawsffiniol. Pwynt pwysig iawn yw bod ysbytai trawsffiniol, fel y rheini yng Nghaer a’r Amwythig ac ati, yn ddibynnol iawn ar incwm o sector Cymru—credaf fod 20 y cant neu 25 y cant o’u busnes yn dod o farchnad Cymru—felly yr ydym yn bwysig o ran y ffordd y maent yn gweithredu.

operation.

Mr Lang: It is very much about interdependence, but the point, maybe, is that the balance of it is such that we depend more upon those providers than English commissioners depend on Welsh providers. However, you are right: that is a key part of their business.

Mr Lang: Mae'n ymwneud llawer iawn â chyd-ddibyniaeth, ond y pwynt, o bosibl, yw bod ei gydbwysedd yn golygu ein bod yn dibynnu mwy ar y darparwyr hynny nag y mae comisiynwyr Lloegr yn dibynnu ar ddarparwyr Cymru. Fodd bynnag, yr ydych yn gywir: mae hynny'n rhan allweddol o'u busnes.

[278] **Mick Bates:** Some of the issues that I wished to raise were touched on earlier. I will refer particularly to paragraph 4.52 in volume 2, and to figure 25. It is noted there that the revised commissioning arrangements have not yet fully bedded in because of the challenging agenda that the new local health boards face. Figure 25 identifies opportunities and risks inherent in the new commissioning arrangements. In his report, the Auditor General identifies several opportunities for new commissioning arrangements, set up in 2003, but he also identifies several risks. A question for you both is: in your view, do the 22 local health boards have the sufficient expertise and skills necessary to do an effective job?

[278] **Mick Bates:** Crybwyllwyd rhai o'r materion yr oeddwn am eu trafod yn gynharach. Cyfeiriaf yn benodol at baragraff 4.52 yng nghyfrol 2, ac at ffigur 25. Nodir yno nad yw'r trefniadau comisiynu diwygiedig wedi'u cyflwyno'n llawn eto oherwydd yr agenda llawn her sy'n wynebu'r byrddau iechyd lleol newydd. Mae ffigur 25 yn nodi cyfleoedd a risgiau sy'n gynhenid yn y trefniadau comisiynu newydd. Yn ei adroddiad, mae'r Archwilydd Cyffredinol yn nodi sawl cyfle ar gyfer trefniadau comisiynu newydd, a sefydlwyd yn 2003, ond mae hefyd yn nodi sawl risg. Cwestiwn i chi'ch dau: yn eich barn chi, a oes gan y 22 bwrdd iechyd lleol yr arbenigedd digonol a'r sgiliau sy'n angenrheidiol i wneud gwaith effeithiol?

Ms Rees: We are working together in terms of looking at how we jointly commission on a regional basis. The point on risk is well made and there is an issue around capacity. There is also the need to avoid duplication, and to ensure that patients get a good deal,

Ms Rees: Yr ydym yn gweithio gyda'n gilydd i edrych ar sut yr ydym yn cyd-gomisiynu yn rhanbarthol. Mae'r pwynt ar risgiau yn un da ac mae gallu yn bwnc trafod. Mae angen hefyd i sicrhau nad ydym yn gwneud yr un gwaith ac i sicrhau bod y

because we have the expertise to commission. So, there is more working together, and, certainly in mid and west Wales, we are looking at facilitated help in terms of determining commissioning patterns for the region.

cleifion yn cael bargen well, oherwydd bod gennym yr arbenigedd i gomisiynu. Felly, mae mwy o weithio gyda'n gilydd, ac, yn sicr yn y Canolbarth a'r Gorllewin, yr ydym yn edrych ar gymorth wedi'i hwyluso o ran pennu patrymau comisiynu ar gyfer y rhanbarth.

From a mental health point of view, as we have the lead in Pembrokeshire, we are working as a collegiate with others. So, if you want the best deal for patients, it does not matter what the organisational structure is, it is a matter of working together to ensure that you get the best deal.

O safbwynt iechyd meddwl, oherwydd mai ni sy'n arwain y maes yn sir Benfro, yr ydym yn cydweithio ag eraill. Felly, os ydych am gael y ddarpariaeth orau i gleifion, nid oes gwahaniaeth beth yw'r strwythur cyfundrefnol, mae'n fater o weithio gyda'n gilydd i sicrhau eich bod yn cael bargen well.

Mr Lang: I think that, to a degree, skills and competencies depend on the sort of service that you are commissioning and which element of it you are commissioning. Local health boards bring a very strong advantage in terms of an ability to work with primary care and to develop demand-management alternatives to acute sector care. So, if you look at the Wanless strategic agenda, which is about more community focus, and people taking more responsibility for their own health and therefore avoiding a dependence on hospitals, the skills in local health boards are extremely well equipped to deal with that agenda. They are, by their very nature, small organisations, and they have a dependence upon each other and on the trusts that work with clusters of local health boards, and there is no doubt that that brings complexity. It would be far easier if you had one

Mr Lang: Credaf, i raddau, bod sgiliau a chymwyseddau yn dibynnu ar y math o wasanaeth yr ydych yn ei gomisiynu a pha elfen ohono yr ydych yn ei gomisiynu. Mae byrddau iechyd lleol yn rhoi mantais gref iawn o ran y gallu i weithio gyda gofal sylfaenol a datblygu opsiynau rheoli galw amgen i ofal sector acíwt. Felly, os edrychwch ar agenda strategol Wanless, sy'n ymwneud â chanolbwyntio'n fwy ar y gymuned, a phobl yn cymryd rhagor o gyfrifoldeb am eu hiechyd eu hunain ac felly'n osgoi dibyniaeth ar ysbytai, mae gan y byrddau iechyd lleol ddigon o sgiliau i ddelio â'r agenda honno. Maent, o ran eu natur, yn sefydliadau bach, ac maent yn dibynnu ar ei gilydd ac ar yr ymddiriedolaethau sy'n gweithio gyda chlystyrau o fyrddau iechyd lleol, ac nid oes amheuaeth bod dryswch yn ei sgîl. Byddai'n llawer haws cael un

commissioner with one hospital or, even better, one commissioner with five hospitals, looking at the pattern across them. However, that is something that we can achieve. We are already, as Bernie says, working in regional groups. We have examples in north Wales of where one local health board commissions a particular service on behalf of everyone, and Bernie alluded to mental health services in Pembrokeshire. So, the skills are there; it is now a matter of how we harness them, dependent upon which service we are looking at, and we are maturing into that. I would not try to say to you that we have that sorted and that our collaborative arrangements are as well developed as they need to be, but we are aware of it and are working on it.

comisiynwr gydag un ysbyty neu, yn well byth, un comisiynydd gyda phum ysbyty, yn edrych ar y patrwm ar eu traws. Fodd bynnag, mae hynny'n rhywbeth y gallwn ei gyflawni. Yr ydym eisoes, fel y dywedodd Bernie, yn gweithio mewn grwpiau rhanbarthol. Mae gennym enghreifftiau yn y Gogledd lle mae un bwrdd iechyd lleol yn comisiynu gwasanaeth penodol ar ran pawb, a chyfeiriodd Bernie at wasanaethau iechyd meddwl yn sir Benfro. Felly, mae'r sgiliau yno; mae'n ymwneud yn awr â sut yr ydym yn eu defnyddio, yn dibynnu ar ba wasanaeth yr ydym yn edrych arno, ac yr ydym yn aeddfedu i wneud hynny. Ni fyddwn yn ceisio dweud ein bod wedi ymdrin â hynny'n llwyr a bod ein trefniadau cydweithredu wedi'u datblygu cymaint ag sy'n ofynnol, ond yr ydym yn ymwybodol o hynny ac yn gweithio arno.

[279] **Mick Bates:** In terms of Wrexham, with the cross-border issues which further complicate that, what steps are you taking to build strategic regional commissioning?

[279] **Mick Bates:** O ran Wrecsam, gyda'r materion trawsffiniol sy'n cymhlethu hynny ymhellach, pa gamau yr ydych yn eu cymryd i feithrin comisiynu rhanbarthol strategol?

Mr Lang: In terms of north Wales, we have what we refer to as the north Wales planning forum, which is a gathering of all local health board chief executives, the trust chief executives and the regional director of the Welsh Assembly Government Health and Social Care Department. That forum is looking at the key strategic issues, and it has been formed on the basis that we recognise that individual local health boards cannot

Mr Lang: O ran y Gogledd, mae gennym yr hyn yr hyn yr ydym yn cyfeirio ato fel fforwm cynllunio'r Gogledd, sef casgliad o holl brif weithredwyr y byrddau iechyd lleol, prif weithredwyr yr ymddiriedolaethau a chyfarwyddwr rhanbarthol Adran Iechyd a Gofal Cymdeithasol Llywodraeth Cynulliad Cymru. Mae'r fforwm hwnnw yn edrych ar y materion strategol allweddol, ac mae wedi'i sefydlu ar y sail ein bod yn cydnabod na all y

deal with all the challenges and, indeed, individual local health boards and trusts in their health community—and, for me, that means Wrexham, Flintshire and the north-east Wales trust—cannot deal with all the challenges. We are recognising that we must look at certain issues across north Wales, and the strategic solution to orthopaedic services, as an example, is one that we are taking a north-Wales view on. That will not necessarily be to up the capacity in three hospitals by the same factor and carry on with the same model. So, we are recognising that and learning to work with the system that we have.

byrddau iechyd lleol unigol ymdrin â'r holl heriau ac, yn wir, ni all byrddau iechyd lleol unigol ac ymddiriedolaethau yn eu cymunedau iechyd—ac, i mi, mae hynny'n golygu Wrecsam, sir y Fflint ac ymddiriedolaeth y Gogledd-ddwyrain—ymdrin â'r holl heriau. Yr ydym yn cydnabod bod yn rhaid i ni edrych ar faterion penodol ledled y Gogledd, ac mae'r ateb strategol i wasanaethau orthopedig, fel enghraifft, yn un yr ydym yn ei ystyried yn y Gogledd. Ni fydd hynny o reidrwydd yn golygu cynyddu'r gallu yn y tri ysbyty yn ôl yr un ffactor a pharhau gyda'r un model. Felly, yr ydym yn cydnabod hynny ac yn dysgu gweithio gyda'r system sydd gennym.

[280] **Mick Bates:** In that case, does every local health board really need a director of finance and a director of commissioning? If you are co-operating, as has been said, is it better, perhaps, to have just one director?

[280] **Mick Bates:** Os yw hynny'n wir, a oes angen cyfarwyddwr cyllid a chyfarwyddwr comisiynu ar bob bwrdd iechyd lleol? Os ydych yn cydweithio, fel sydd wedi'i grybwyll, oni fyddai'n well, o bosibl, i gael un cyfarwyddwr yn unig?

Mr Lang: Every local health board does need both a director of finance and a director of commissioning. We must reflect on two issues here: one is the management process that we have to deal with, and the other is the public accountability and stewardship that we must discharge. From the latter perspective, there is a very clear need for that. If you look at the resources and skills required, there is probably not an excess of skill among the local health boards. If you add it all up and ask 'Is it enough to do the job?', I do not

Mr Lang: Mae angen cyfarwyddwr cyllid a chyfarwyddwr comisiynu ar bob bwrdd iechyd lleol. Mae'n rhaid i ni ystyried dau fater yma: un ohonynt yw'r broses reoli y mae'n rhaid i ni ymdrin â hi, a'r llall yw'r atebolrwydd cyhoeddus a'r stiwardiaeth y mae'n rhaid i ni eu cyflawni. O safbwynt yr olaf, mae angen clir iawn am hynny. Os edrychwch ar yr adnoddau a'r sgiliau gofynnol, mae'n debyg nad oes gormodedd o sgiliau ymhlith y byrddau iechyd lleol. Os ydych yn ystyried yr holl waith a gofyn 'A

believe that we have more resource than we need to do the job. It is a matter of how we galvanise that. Having, in north Wales, six finance directors who can each lead on particular issues, move things forward and make them happen, is not inappropriate from a management perspective and, as I said, from a governance perspective, it is vital that those posts are in place to account to their board and to the public.

yw’n ddigon i wneud y gwaith?’, ni chredaf fod gennym fwy o adnoddau nag sydd eu hangen i wneud y gwaith. Mae’n ymwneud â sut yr ydym yn symbylu hynny. Nid yw cael chwe chyfarwyddwr cyllid yn y Gogledd sy’n gallu arwain ar faterion penodol, symud pethau ymlaen a gwneud iddynt ddigwydd yn amhriodol o safbwynt rheoli ac, fel y dywedais, o safbwynt llywodraethu, mae’n hanfodol bod y swyddi hynny yn eu lle i fod yn atebol i’w bwrdd ac i’r cyhoedd.

[281] **Mick Bates:** Thank you. Would you also like to comment on that, Ms Rees?

[281] **Mick Bates:** Diolch. A ydych hefyd am roi sylw ar hynny, Ms Rees?

Ms Rees: I would just say that you do need the team, because the LHBs are responsible for health and wellbeing, as well as for just health and, to do that, you need the spread of people with the expertise to be able to look at the full plethora of responsibilities from a local health point of view.

Ms Rees: Hoffwn ddim ond dweud bod angen y tîm arnoch, oherwydd mae’r BILlau yn gyfrifol am iechyd a lles, yn ogystal ag am iechyd yn unig ac, i wneud hynny, mae angen gwahanol bobl gyda’r arbenigedd i allu edrych ar yr amrywiaeth llawn o gyfrifoldebau o safbwynt iechyd lleol.

[282] **Mick Bates:** Earlier, you mentioned problems with cross-border issues, and you made an interesting comment about performance management and the way that incentivises the system. You also made a comment about data for individual GPs. How robust is the collection of data, so that you can move towards more effective performance management, both in terms of your own trust and the information that you gather from English providers?

[282] **Mick Bates:** Yn gynharach, bu i chi grybwyll problemau gyda materion trawsffiniol, a gwnaethoch sylw diddorol am reoli perfformiad a’r ffordd y mae hynny’n ysgogi’r system. Gwnaethoch sylw hefyd am ddata ar gyfer meddygon teulu unigol. Pa mor rymus yw’r casgliad o ddata, er mwyn i chi allu symud i reoli perfformiad yn fwy effeithiol, o ran eich ymddiriedolaeth eich hun a’r wybodaeth yr ydych yn ei chasglu gan ddarparwyr o Loegr?

Mr Lang: In terms of the data, the basic data are there in terms of the number of patients accessing and receiving care for particular conditions in particular hospitals. We have those data at individual patient level, and we can aggregate them. That is the same in Wales as it is in England; there is no difference. In terms of data with regard to referrals, for example, which I referenced earlier, that information is not available at an individual GP level either in Wales or in England. It is all at practice level, and therefore we have a common agenda. My experience in terms of accessing information from England is that it is no more difficult to get information from England than it is from Welsh providers, and you can usually get the same analysis. Some providers in England are far more attuned to it because, in some instances, their performance-management of waiting lists and their delivery of targets has been heightened to such a level that their information systems have followed that and they have had to do it. I have no real experience of problems in terms of accessing information from England. When we move forward with an information strategy, and start to look at issues such as automatic electronic referrals and booking of appointments into hospitals, whether in Wales or in England, there are issues at the interface about whether the systems will work with each other. That is not necessarily about data collection—that is how the systems will engage. As I say, I do not have experience of data difficulties, as such, with

Mr Lang: O ran y data, mae'r data sylfaenol yno o ran nifer y cleifion sy'n cael mynediad i ofal ac yn ei dderbyn am gyflyrau penodol mewn ysbytai penodol. Mae gennym y data hynny ar lefel cleifion unigol, a gallwn eu hagregu. Mae hynny yr un fath yng Nghymru ag y mae yn Lloegr; nid oes gwahaniaeth. O ran data mewn perthynas â chyfeiriadau, er enghraifft, y cyfeiriais ato'n gynharach, nid yw'r wybodaeth ar gael ar lefel meddyg teulu unigol yng Nghymru nac yn Lloegr. Mae hyn i gyd ar lefel ymarfer, ac felly mae gennym agenda gyffredin. O'm profiad o gael gafael ar wybodaeth o Loegr, nid yw'n anoddach i gael gwybodaeth o Loegr nag ydyw gan ddarparwyr o Gymru, oherwydd gallwch gael yr un dadansoddiad fel arfer. Mae rhai darparwyr yn Lloegr mewn cytgord â hyn i raddau mwy helaeth oherwydd, mewn rhai achosion, mae eu dulliau o reoli perfformiad amseroedd aros a chyflawni targedau wedi'u dwysáu i'r fath lefel fel bod eu systemau gwybodaeth wedi dilyn hynny ac maent wedi gorfod ei wneud. Nid oes gennyf brofiad gwirioneddol o broblemau o ran cael gafael ar wybodaeth o Loegr. Wrth i ni symud ymlaen gyda strategaeth wybodaeth, a dechrau edrych ar faterion fel cyfeiriadau electronig awtomatig a bwcio apwyntiadau i ysbytai, boed yn Lloegr neu yng Nghymru, mae materion cydgysylltu ynghylch a fydd y systemau yn gweithio gyda'i gilydd. Nid yw hynny o reidrwydd yn ymwneud â chasglu data—dyna sut y bydd y systemau yn ymgysylltu. Fel y dywedais, nid oes gennyf brofiad o anawsterau data, fel y cyfryw, gyda

England.

Lloegr.

[283] **Mick Bates:** What about Pembrokeshire?

[283] **Mick Bates:** Beth am sir Benfro?

Ms Rees: We must do a lot of work with the data that we have available. There is data available, but it needs rigorous analysis. ‘Informing Healthcare’ will help us in terms of some of the capacity that it will release, but there is a lot of work to do in terms of primary care data.

Ms Rees: Mae’n rhaid i ni wneud llawer o waith gyda’r data sydd ar gael i ni. Mae data ar gael, ond mae angen ei ddadansoddi’n drylwyr. Bydd ‘Hysbysu Gofal Iechyd’ yn ein cynorthwyo o ran rhywfaint o’r gallu y bydd yn ei ryddhau, ond mae llawer o waith i’w wneud gyda data gofal sylfaenol.

[284] **Mick Bates:** Could you expand a little on that, because, in my view, this data is absolutely essential if we are to deliver a more effective service, particularly in terms of reducing waiting times?

[284] **Mick Bates:** A allwch ymhelaethu ychydig ar hynny, oherwydd, yn fy marn i, mae’r data hwn yn gwbl hanfodol os ydym am ddarparu gwasanaeth mwy effeithiol, yn arbennig o ran gostwng amseroedd aros?

Ms Rees: On looking at how general practice works, picking out referrals and what they actually do from a chronic disease management point of view, we certainly need to interrogate the contract data submitted as an output of the new general medical services contract, to be able to look at how we can influence pathways and the commissioning of pathways.

Ms Rees: Wrth edrych ar sut mae ymarfer cyffredinol yn gweithio, dethol atgyfeiriadau a beth y maent yn ei wneud mewn gwirionedd o safbwynt rheoli clefyd cronig, yn sicr mae angen i ni archwilio’r data contract a gyflwynwyd fel allbwn o’r contract gwasanaethau meddygol cyffredinol newydd, i allu edrych ar sut y gallwn ddylanwadu ar lwybrau a chomisiynu llwybrau.

[285] **Mick Bates:** Thank you. Further, on the cross-border issues—

[285] **Mick Bates:** Diolch. Ymhellach, ar y materion trawsffiniol—

Janet Davies: We have run out of time, so could you be very brief please?

Janet Davies: Mae amser yn ein maeddu, felly a allwch fod yn gryno iawn, os gwelwch yn dda?

[286] **Mick Bates:** With the widening gap between English and Welsh targets, what sort of pressures are you going to face as a commissioner, given the self-reliance that exists? My LHB is the Powys Local Health Board, and I am quite familiar with the economic pressures, but, as times are reduced, those are going to get more critical, are they not? What sort of scale of increase will you need to keep pace with the competition target of 18 weeks, if we are still at 18 months?

[286] **Mick Bates:** Gyda'r bwlch yn ehangu rhwng targedau Cymru a Lloegr, pa fath o bwysau y byddwch yn ei wynebu fel comisiynydd, o ystyried yr hunan-ddibyniaeth sy'n bodoli? Bwrdd Iechyd Lleol Powys yw fy BILl i, ac yr wyf yn gymharol gyfarwydd â'r pwysau economaidd, ond, wrth i amseroedd gael eu gostwng, bydd y rheini yn bwysicach fyth, oni fyddant? Pa fath o raddfa gynnydd y bydd angen i chi ei dilyn gyda'r targed cystadleuaeth o 18 wythnos, os byddwn yn dal ar 18 mis?

Mr Lang: It is very difficult to give a precise answer on the scale of additional investment or capacity. That is work that we are currently looking at—what would it take to get Wales to that position? As I alluded to earlier, the issues for me are related to tariff and access. If referrals are into hospitals in England, particularly given that the rules of financial reimbursement in England are different to those in Wales, that is a risk. We must keep an eye on that.

Mr Lang: Mae'n anodd iawn rhoi ateb manwl gywir ar raddfa buddsoddiad neu gapasiti ychwanegol. Mae hwn yn waith yr ydym yn ei wneud ar hyn o bryd—beth a fyddai'n ei olygu i gael Cymru yn y sefyllfa honno? Fel y crybwyllais yn gynharach, mae'r pynciau llosg i mi yn ymwneud â thariff a mynediad. Os atgyfeirir cleifion i ysbytai yn Lloegr, yn arbennig o ystyried bod y rheolau ad-daliadau ariannol yn Lloegr yn wahanol i'r rhai yng Nghymru, mae hynny'n risg. Mae'n rhaid i ni gadw llygad ar hynny.

The issues about influence and strategic influence are important. As England moves on, delivers different targets and works in different ways, the hassle factor—for want of a better word—of dealing with Welsh

Mae'r materion ynghylch dylanwad a dylanwad strategol yn bwysig. Wrth i Loegr symud ymlaen, gan gyflawni targedau gwahanol a gweithio mewn gwahanol ffyrdd, mae'r ffwdan—yn niffyg gair gwell—o

commissioners becomes a big issue. That is particularly true if it is a small percentage—not 25 per cent of someone's business, but a smaller percentage. That also presents a problem. So, those are quite key issues.

ddelio â chomisiynwyr o Gymru yn dod yn fater pwysig. Mae hynny'n arbennig o wir os yw'n ganran fach—nid 25 y cant o fusnes rhywun, ond canran lai. Mae hynny hefyd yn achosi problem. Felly, mae rheini'n faterion eithaf allweddol.

[287] **Janet Davies:** We have come to the end of the first part of our hearing with local health board representatives. It is always helpful for this committee to be able to meet people who are operating systems on the ground. It gives us a far greater understanding when we are able to do that. So, thank you very much to both of you—Ms Rees and Mr Lang—for being so helpful today.

[287] **Janet Davies:** Yr ydym wedi cyrraedd diwedd rhan gyntaf ein gwrandawiad gyda chynrychiolwyr byrddau iechyd lleol. Mae'n ddefnyddiol bob tro i'r pwyllgor hwn allu cyfarfod pobl sy'n gweithredu systemau ar lawr gwlad. Mae'n rhoi llawer gwell dealltwriaeth i ni pan fyddwn yn gallu gwneud hynny. Felly, diolch yn fawr i chi'ch dau—Ms Rees a Mr Lang—am fod yn gymaint o gymorth i ni heddiw.

As you know, a verbatim transcript is being produced of this meeting; you will be sent the draft so that you can check it for accuracy. Please let us know if there are any inaccuracies in terms of what you said. Thank you again.

Fel y gwyddoch, mae trawsgrifiad gair am air yn cael ei gynhyrchu o'r cyfarfod hwn; byddwch yn derbyn y drafft er mwyn i chi allu gwirio ei gywirdeb. Rhowch wybod i ni os oes unrhyw wallau o ran yr hyn a ddywedasoch. Diolch eto.

Gohiriwyd y cyfarfod rhwng 10.49 a.m. and 11.08 a.m.

The meeting adjourned between 10.49 a.m. and 11.08 a.m.

[288] **Janet Davies:** We will now move on to talk to chief executives from three national health service trusts, to get the trusts' view on this report, and on the difficulties that they face. I ask the three chief executives to

[288] **Janet Davies:** Symudwn ymlaen yn awr i siarad â phrif weithredwyr tair ymddiriedolaeth gwasanaeth iechyd gwladol, i gael barn yr ymddiriedolaethau ar yr adroddiad hwn, ac ar yr anawsterau y maent yn eu hwynebu. Gofynnaf i'r tri phrif

introduce themselves.

weithredwr gyflwyno eu hunain.

Ms Perrin: I am Jane Perrin, chief executive of Swansea NHS Trust.

Ms Perrin: Fi yw Jane Perrin, prif weithredwr Ymddiriedolaeth GIG Abertawe.

Mr Williams: I am Paul Williams, chief executive of Bro Morgannwg NHS Trust.

Mr Williams: Fi yw Paul Williams, prif weithredwr Ymddiriedolaeth GIG Bro Morgannwg.

Mr Ross: I am Hugh Ross, chief executive of Cardiff and Vale NHS Trust.

Mr Ross: Fi yw Hugh Ross, prif weithredwr Ymddiriedolaeth GIG Caerdydd a'r Fro.

[289] **Janet Davies:** Headphones are available so that, if anyone wishes to speak in Welsh, they can do so and there will be simultaneous translation. The headphones also help with hearing difficulties if anyone is speaking particularly quietly. We will go straight into this issue, and I will ask the first question, but we will try to ensure that you know which volume of the report we are referring to at any particular time. I ask for answers that are as focused as possible, because we do not want to be here all day—this is a morning meeting. I will start by referring to paragraphs 2.5 and 2.6 in volume 1. The first question is aimed at all three trusts. From your point of view, why has the NHS failed to achieve the targets set by the Welsh Assembly Government?

[289] **Janet Davies:** Mae clustffonau ar gael felly, os oes unrhyw un am siarad Cymraeg, gallant wneud hynny a bydd cyfieithu ar y pryd. Mae'r clustffonau hefyd yn helpu gydag anawsterau clywed os oes rhywun yn siarad yn arbennig o dawel. Awn ati i drafod y mater hwn yn ddioed, ac yr wyf am ofyn y cwestiwn cyntaf, ond byddwn yn ceisio sicrhau eich bod yn gwybod pa gyfrol o'r adroddiad yr ydym yn cyfeirio ati ar unrhyw adeg arbennig. Gofynnaf am atebion sy'n glynu at y pwynt cymaint â phosibl, oherwydd nid ydym am fod yma drwy'r dydd—cyfarfod bore ydyw. Dechreuaf drwy gyfeirio at baragraffau 2.5 a 2.6 yng nghyfrol 1. Mae'r cwestiwn cyntaf wedi ei anelu at y tair ymddiriedolaeth. Yn eich barn chi, pam mae'r GIG wedi methu â chyflawni'r targedau a osodwyd gan Lywodraeth Cynulliad Cymru?

Ms Perrin: We would argue that we are working to deliver the targets set by the Welsh Assembly Government, and the report covers the period up until July 2004. From a Swansea perspective, we are on target to hit Welsh Assembly Government waiting-time targets by the end of March, the end of the calendar year.

Ms Perrin: Byddem yn dadlau ein bod yn gweithio i gyflawni'r targedau a osodwyd gan Lywodraeth Cynulliad Cymru, ac mae'r adroddiad yn cwmpasu'r cyfnod hyd at fis Gorffennaf 2004. O safbwynt Abertawe, yr ydym ar darged i gyrraedd targedau amseroedd aros Llywodraeth Cynulliad Cymru erbyn diwedd mis Mawrth, diwedd y flwyddyn galendr.

Mr Williams: I do not think I can speak for NHS Wales, but, in terms of my trust, we hit the targets during the period of the study.

Mr Williams: Ni chredaf y gallaf siarad ar ran GIG Cymru, ond, o ran fy ymddiriedolaeth i, bu i ni gyrraedd y targedau yn ystod cyfnod yr astudiaeth.

Mr Ross: From my relatively recent perspective in Wales, I can only add that Cardiff and Vale NHS Trust will also hit the ministerial targets at the end of March. On events before July 2004, when I took up post, I am afraid I cannot help.

Mr Ross: O'm profiad cymharol ddiweddar yng Nghymru, ni allaf ond ychwanegu y bydd Ymddiriedolaeth GIG Caerdydd a'r Fro hefyd yn cyflawni targedau'r gweinidogion ddiwedd mis Mawrth. O ran y digwyddiadau cyn mis Gorffennaf 2004, pan ddechreuais fy swydd, yr wyf yn ofni na allaf helpu.

[290] **Alun Cairns:** I appreciate that you are new in post, Mr Ross, but can you offer your perspective on why targets were not achieved until recently? We are discussing the end of the calendar year, which is fine, but can Mrs Perrin give a view on why targets were missed, because that is what we are trying to get at? We are looking at the contents of the report, which ended some time ago. We are trying to establish the root issues so that we can try to introduce policies to help overcome them.

[290] **Alun Cairns:** Yr wyf yn gwerthfawrogi eich bod yn newydd i'r swydd, Mr Ross, ond a allwch roi eich safbwynt ar pam na chafodd targedau eu cyflawni tan yn ddiweddar? Yr ydym yn trafod diwedd y flwyddyn galendr, sydd yn iawn, ond a all Mrs Perrin gynnig barn ar pam y methwyd targedau, oherwydd dyna beth yr ydym yn ceisio ei ganfod? Yr ydym yn edrych ar gynnwys yr adroddiad, a orffennodd beth amser yn ôl. Yr ydym yn ceisio canfod y materion gwaelodol fel y

gallwn geisio cyflwyno polisïau i helpu i'w goresgyn.

Mr Ross: My understanding, from what I have seen and heard, is that a broad range of issues and priorities were decided upon in Wales, which Mrs Lloyd outlined at a previous meeting of the committee. I believe that she referred to the very focused concentration, specifically on waiting times, that had taken place elsewhere and contrasted that approach with the broad-based public health promotion approach that had been taken in Wales. That is all I can offer.

Mr Ross: Fy nealltwriaeth i, o'r hyn yr wyf wedi ei weld a'i glywed, yw i amrywiaeth eang o faterion a blaenoriaethau gael eu penderfynu yng Nghymru, ac i Mrs Lloyd eu hamlinellu mewn cyfarfod blaenorol o'r pwyllgor. Credaf iddi gyfeirio at y ffocws pendant iawn, yn benodol ar amseroedd aros, a gafwyd mewn mannau eraill a chyferbynnu'r dull hwnnw â'r dull o hybu iechyd cyhoeddus eang ei sail a weithredwyd yng Nghymru. Dyna'r cyfan y gallaf ei gynnig.

Ms Perrin: If I could pick up on that, we are coming to the end of year 2 of the service and financial framework process, and it is fair to say that, until fairly recently, there was not the same focus on waiting time targets in Wales as there was, perhaps, in other parts of the United Kingdom. The focus has sharpened up considerably in the last couple of years. In terms of hitting targets, trusts have been working incredibly hard to deliver those. The challenge that a number of us across NHS Wales have is to balance the emergency workload, which has been increasing, with the challenge of delivering waiting-time targets. From the perspective of Swansea, which has a regional role in the context of mid and west Wales, it is a constant tightrope in terms of managing the emergency patients who turn up relentlessly through our doors, and hitting waiting-time

Ms Perrin: Pe gallwn ddilyn y trywydd hwnnw, yr ydym yn nesáu at ddiwedd blwyddyn 2 y broses fframwaith gwasanaeth a chyllid, ac mae'n deg dweud na fu, tan yn gymharol ddiweddar, yr un ffocws ar dargedau amseroedd aros yng Nghymru ag y bu, efallai, yn rhannau eraill o'r Deyrnas Unedig. Mae'r ffocws wedi cynyddu'n sylweddol yn yr ychydig flynyddoedd diwethaf. O ran cyrraedd targedau, mae ymddiriedolaethau wedi bod yn gweithio'n hynod galed i gyflawni'r rheini. Yr her sy'n wynebu nifer ohonom ledled GIG Cymru yw cydbwyso'r llwyth gwaith brys, sydd wedi bod ar gynnydd, gyda'r her o gyflawni'r targedau amseroedd aros. O safbwynt Abertawe, sydd â rôl ranbarthol yng nghyd-destun y Gorllewin a'r Canolbarth, mae'n her gyson o ran rheoli'r cleifion brys a ddaw drwy ein drysau byth a hefyd, a chyflawni'r

targets. In terms of the service and financial framework over the past couple of years, Swansea hit the targets, but we did not always sustain them month on month, which is obviously the service and financial framework challenge for next year.

targedau amseroedd aros. O ran y fframwaith gwasanaeth a chyllid dros yr ychydig flynyddoedd diwethaf, cyflawnodd Abertawe y targedau, ond ni wnaethom bob amser eu cynnal fis ar ôl mis, a dyma her y fframwaith gwasanaeth a chyllid ar gyfer y flwyddyn nesaf yn amlwg.

[291] **Alun Cairns:** Do you have anything to add, Mr Williams?

[291] **Alun Cairns:** A oes gennych unrhyw beth i'w ychwanegu, Mr Williams?

Mr Williams: The issue addressed by my colleagues, regarding the dilemma of how one deals with emergency and elective work, was the subject of a report called 'A Question of Balance', which I produced for the Assembly in 2002. My trust endeavours to implement many of the recommendations of that report. That has helped us to cope with the difficulties, and has enabled us to make significant improvements in the waiting times. Not only do I expect to achieve Government targets at the end of the year, but many of my waiting lists will be considerably shorter than the target length.

Mr Williams: Yr oedd y mater yr aethpwyd i'r afael ag ef gan fy nghydweithwyr, ynglŷn â'r cyfyng-gyngor o ran sut mae rhywun yn delio â gwaith brys a dewisol, yn destun adroddiad o'r enw 'Cadw Cydbwysedd', y bu i mi ei gynhyrchu ar gyfer y Cynulliad yn 2002. Mae fy ymddiriedolaeth i'n ymdrechu i weithredu llawer o argymhellion yr adroddiad hwnnw. Mae hynny wedi ein helpu i ymdopi â'r anawsterau, ac wedi ein galluogi i wneud gwelliannau sylweddol i'r amseroedd aros. Nid yn unig fy mod yn disgwyl cyflawni targedau'r Llywodraeth ddiwedd y flwyddyn, ond bydd llawer o'm rhestrau aros dipyn yn fyrrach na'r hyd targed.

My trust is different; I do not have the major tertiary specialties that must confuse the situation in terms of emergency and elective care in both my colleagues' trusts. Nevertheless, applying the principles of 'A Question of Balance', gives you the headroom to provide your elective

Mae fy ymddiriedolaeth i yn wahanol; nid oes gennyf yr arbenigeddau trydyddol pwysig sy'n siŵr o ddrysu'r sefyllfa o ran gofal brys a dewisol yn ymddiriedolaethau fy nau gydweithiwr. Serch hynny, mae gweithredu egwyddorion 'Cadw Cydbwysedd', yn gyfle i chi ddarparu eich trwybwn dewisol mewn

throughput in a more planned way.

ffordd sydd wedi ei chynllunio i raddau helaethach.

[292] **Leighton Andrews:** In her evidence, the chief executive of NHS Wales told us that there had been a laser-like focus on waiting lists in England. I think that Jane Perrin said that there had not been the same focus in Wales as in other parts of the UK. What was the focus in Wales, if not waiting lists?

[292] **Leighton Andrews:** Yn ei thystiolaeth, dywedodd prif weithredwr GIG Cymru y bu ffocws pendant ar restrau aros yn Lloegr. Credaf i Jane Perrin ddweud na fu'r un ffocws yng Nghymru ag yn rhannau eraill o'r DU. Beth oedd y ffocws yng Nghymru, os nad rhestrau aros?

Ms Perrin: The Welsh Assembly Government has put a different focus on health and wellbeing, and is starting to look at some of the broader implications for improving health. There has been a more holistic approach—certainly in my personal view—than has been the case in England until now, but it has spread more thinly some of the priorities that we are all working towards. The focus on waiting times and waiting lists has sharpened considerably in the last couple of years.

Ms Perrin: Mae Llywodraeth Cynulliad Cymru wedi rhoi ffocws gwahanol ar iechyd a lles, ac mae'n dechrau edrych ar rai o'r goblygiadau ehangach ar gyfer gwella iechyd. Bu ymagwedd fwy gyfannol—yn sicr yn fy marn bersonol i—nag yn Lloegr hyd yma, ond nid yw wedi canolbwyntio i'r un graddau ar rai o'r blaenoriaethau yr ydym i gyd yn gweithio tuag atynt. Mae'r ffocws ar amseroedd aros a rhestrau aros wedi cynyddu'n sylweddol yn yr ychydig flynyddoedd diwethaf.

[293] **Janet Davies:** Mrs Perrin, three months ago, your trust accounted for nearly three-quarters of all in-patient day-case treatment where people had to wait for more than 18 months. By the end of this month, you will get to grips with that. How did you achieve this?

[293] **Janet Davies:** Mrs Perrin, dri mis yn ôl, yn eich ymddiriedolaeth chi yr oedd bron i dri chwarter y triniaethau ar gyfer cleifion mewnol oedd yn cael eu trin fel achos dydd y bu'n rhaid i bobl aros mwy na 18 mis ar eu cyfer. Erbyn diwedd y mis hwn, byddwch yn mynd i'r afael â hynny. Sut gwnaethoch chi hyn?

Ms Perrin: In terms of context, it is important to note that Swansea provides plastic services for the whole of Wales. Therefore, in some ways, the size of our waiting times, overall, is slightly distorted by the fact that we have a big plastic surgery service that covers the population of Wales. The other issue to note is that Swansea is not sitting on lots of spare capacity. We do not have wards that are not used. We are running our full capacity, in terms of beds, theatres, and out-patient clinics. We did not have a lot of scope just to open up and staff new facilities to put through more work. We have managed the targets through a range of initiatives. Some have been managed locally within Swansea: we have doctors, nurses, therapists and support staff undertaking extra initiatives to put through more patients in the evenings and at weekends. We sourced additional capacity locally within the private sector at Sancta Maria Hospital in Swansea, and we have also out-sourced the treatment of some patients to the private sector in Cardiff, Bristol and further afield. One challenge for us, in Swansea, is the low take-up by patients of offers to travel for

Ms Perrin: O ran cyd-destun, mae'n bwysig nodi bod Abertawe yn cynnig gwasanaethau cosmetig i Gymru gyfan. Felly, mewn rhai ffyrdd, mae'r ffaith bod gennym wasanaeth llawfeddygaeth gosmetig fawr sy'n cwmpasu poblogaeth Cymru yn rhoi darlun ychydig yn gamarweiniol o faint ein rhestrau aros, ar y cyfan. Y mater arall i'w nodi yw nad oes gan Abertawe lawer o allu dros ben. Nid oes gennym wardiau nad ydynt yn cael eu defnyddio. Yr ydym yn defnyddio ein gallu llawn, o ran gwelyau, theatrau a chlinigau cleifion allanol. Nid oedd gennym gyfle mawr i fynd ati i agor a staffio cyfleusterau newydd i wneud mwy o waith. Yr ydym wedi rheoli'r targedau drwy amrywiaeth o fentrau. Mae rhai wedi eu rheoli'n lleol yn Abertawe: mae gennym feddygon, nyrsys, therapyddion a staff cefnogi yn cynnal mentrau ychwanegol i drin mwy o gleifion gyda'r nos ac ar benwythnosau. Bu i ni ganfod capasiti ychwanegol yn lleol yn y sector preifat yn Ysbyty Sancta Maria yn Abertawe, ac yr ydym hefyd wedi rhoi triniaeth rhai cleifion i'r sector preifat yng Nghaerdydd, Bryste, a thu hwnt. Un her i ni, yn Abertawe, yw'r ffaith nad yw llawer o gleifion

treatment. If you look at statistics relating to the second offer scheme, approximately 50 per cent of patients offered a second offer guarantee of treatment elsewhere declined, and this put further pressure on services locally.

yn manteisio ar gynigion i deithio am driniaeth. Os edrychwch chi ar ystadegau sy'n ymwneud â chynllun yr ail gynnig, gwrthododd tua 50 y cant o'r cleifion y cynigwyd gwarant o ail gynnig o driniaeth yn rhywle arall iddynt, a chynyddodd hyn y pwysau ar wasanaethau yn lleol.

[294] **Janet Davies:** Perhaps we can go into the second offer scheme in a little bit more detail later on. Mr Ross, your trust has achieved significant reductions in waiting times. Could you give us a flavour of how you have done this?

[294] **Janet Davies:** Efallai y cawn drafod cynllun yr ail gynnig ychydig yn fanylach yn nes ymlaen. Mr Ross, mae eich ymddiriedolaeth chi wedi llwyddo i leihau amseroedd aros yn sylweddol. A allech roi blas i ni o sut yr ydych wedi gwneud hyn?

Mr Ross: A number of the themes will be the same as in Swansea. The first is trying to use all existing capacity within the trust as effectively as possible, and ensuring that, where possible, elective surgery is protected. Cardiff and Vale's efforts to try to protect elective beds are commended in the report, although recent emergency pressures have made that difficult. Through the second offer scheme, the trust has been able to fund extra internal capacity to deal with waiting list issues. The orthopaedic 18-month target was hit some time ago. We have also availed ourselves of the second offer scheme using external capacity in Cardiff and elsewhere, and that has been helpful. We are now down to just 20 patients waiting over 18 months in neurosurgery, which is a complex and difficult area: we are one of only two specialist centres providing this service in Wales. There are genuine capacity problems with regard to what the service can do, but we are steadily working our way through them and we expect to treat all those patients by the end of this month.

Mr Ross: Bydd nifer o'r themâu yr un fath ag yn Abertawe. Y cyntaf yw ceisio defnyddio'r holl allu sy'n bodoli yn yr ymddiriedolaeth mor effeithiol â phosibl, a sicrhau, lle bo'n bosibl, bod llawdriniaeth ddewisol wedi ei diogelu. Caiff ymdrechion Caerdydd a'r Fro i ddiogelu gwelyau dewisol eu canmol yn yr adroddiad, er bod pwysau brys diweddar wedi gwneud hynny'n anodd. Drwy gynllun yr ail gynnig, mae'r ymddiriedolaeth wedi gallu ariannu gallu mewnol ychwanegol i ddelio â materion rhestrau aros. Cyflawnwyd y targed 18 mis ar gyfer triniaeth orthopedeg beth amser yn ôl. Yr ydym hefyd wedi defnyddio cynllun yr ail gynnig gan ddefnyddio gallu allanol yng Nghaerdydd a mannau eraill, ac mae hynny wedi bod yn ddefnyddiol. Yr ydym bellach mewn sefyllfa lle mai dim ond 20 claf sy'n aros dros 18 mis ym maes llawdriniaeth nerfol, sy'n faes cymhleth ac anodd: yr ydym yn un o ddim ond dwy ganolfan arbenigol sy'n darparu'r gwasanaeth hwn yng Nghymru. Mae problemau gallu gwirioneddol mewn perthynas â'r hyn y gall y gwasanaeth ei wneud, ond yr ydym yn gweithio ein ffordd drwyddynt gan bwyll a disgwyliwn drin yr holl gleifion hynny erbyn diwedd y mis hwn.

[295] **Janet Davies:** Again, that success on the orthopaedic target happened very quickly, since the end of last year, did it not?

[295] **Janet Davies:** Eto, digwyddodd y llwyddiant hwnnw ar y targed orthopedeg yn gyflym iawn, ers diwedd y llynedd, oni wnaeth?

Mr Ross: Yes, I think that the overall data will show that Cardiff and Vale is the most improved trust in Wales in terms of dealing with waiting times. I think that the data at the end of March will confirm that.

Mr Ross: Do, credaf y bydd y data cyffredinol yn dangos mai Caerdydd a'r Fro yw'r ymddiriedolaeth sydd wedi gwella orau yng Nghymru o ran delio ag amseroedd aros. Credaf y bydd y data ar ddiwedd mis Mawrth yn cadarnhau hynny.

[296] **Alun Cairns:** I apologise for interrupting your line of thought all the time. These achievements over recent months are commendable, and need to be recognised, but why were these actions not introduced months ago, when we could have had the same impact and the same people would not have waited for so long? That question is to all the witnesses.

[296] **Alun Cairns:** Mae'n ddrwg gen i am dorri ar draws eich trywydd meddwl drwy'r amser. Mae'r cyflawniadau hyn dros y misoedd diwethaf i'w canmol, ac mae angen eu cydnabod, ond pam na chafodd y camau gweithredu hyn eu cyflwyno fisoedd yn ôl, pan y gallem fod wedi cael yr un effaith ac ni fyddai'n rhaid i'r un bobl fod wedi aros cyhyd? Mae'r cwestiwn hwnnw i'r tystion i gyd.

Ms Perrin: When, at the beginning of this financial year, we saw the service and financial framework targets for what we had to deliver by the end of March, we worked hard, both within the trust and with partners in other parts of the NHS, to put a plan together. That plan was based on recruiting additional locum staff to help us achieve the targets, and some of that has a lead-in time, so it was not all going to happen within the

Ms Perrin: Pan welsom, ddechrau'r flwyddyn ariannol hon, y targedau fframwaith gwasanaeth a chyllid ar gyfer yr hyn yr oedd yn rhaid i ni ei gyflawni erbyn diwedd mis Mawrth, bu i ni weithio'n galed, yn yr ymddiriedolaeth a chyda partneriaid yn rhannau eraill o'r GIG, i greu cynllun. Yr oedd y cynllun hwnnw yn seiliedig ar recriwtio staff locwm ychwanegol i'n helpu i gyflawni'r targedau, ac mae angen amser i

first three months of this financial year. The plan was accepted by the Welsh Assembly Government in June or July of last year, and we have been implementing it in the knowledge that it would take us up to the end of March to deliver it. By and large, however, the plan that we set out last summer has been achieved.

gyflwyno rhywfaint o'r gwaith hwnnw, felly nid oedd popeth yn mynd i ddigwydd yn nhri mis cyntaf y flwyddyn ariannol hon. Derbyniwyd y cynllun gan Lywodraeth Cynulliad Cymru ym mis Mehefin neu fis Gorffennaf y llynedd, ac yr ydym wedi bod yn ei weithredu gan wybod y byddai'n cymryd tan ddiwedd mis Mawrth i ni i'w gyflawni. Ar y cyfan, fodd bynnag, mae'r cynllun y bu i ni ei nodi yr haf diwethaf wedi ei gyflawni.

Mr Ross: My knowledge of what has happened in years gone by, again, is second hand rather than personal. I can only say that it has been made clear to me since I took up my post that getting on top of waiting times, driving them down and ensuring that this is done as quickly as possible in the coming years is a very high priority. This has been made clear to me by all concerned and it is a culture with which I am familiar. Waiting times are clearly a matter of enormous public concern and interest. I think that we are on the right track and that NHS Wales is now making good progress, but there is still some way to go.

Mr Ross: Mae fy ngwybodaeth am yr hyn sydd wedi digwydd yn y gorffennol, eto, yn ail law yn hytrach nag yn bersonol. Ni allaf ond dweud ei bod wedi bod yn amlwg i mi ers i mi ddechrau fy swydd bod cael y gorau ar amseroedd aros, eu lleihau a sicrhau y gwneir hyn mor gyflym â phosib yn y blynyddoedd i ddod yn flaenoriaeth uchel iawn. Mae hyn wedi ei bwysleisio i mi gan bawb dan sylw ac y mae'n ddiwylliant yr wyf yn gyfarwydd ag ef. Mae amseroedd aros yn amlwg o bryder a diddordeb mawr i'r cyhoedd. Credaf ein bod ar y trywydd cywir a bod GIG Cymru yn awr yn gwneud cynnydd da, ond mae ffordd bell i fynd o hyd.

Mr Williams: My response is somewhat different, because my board has always prided itself on meeting its targets, and to some degree the set targets have been somewhat conservative, so we have tried to exceed them wherever possible. So there is a process in terms of commissioning, and if

Mr Williams: Mae fy ymateb braidd yn wahanol, oherwydd mae fy mwrdd bob amser wedi ymfalchïo mewn cyrraedd ei dargedau, ac i ryw raddau mae'r targedau a osodwyd wedi bod braidd yn geidwadol, felly yr ydym wedi ceisio rhagori arnynt lle bynnag y bo'n bosibl. Felly mae proses o ran comisiynu, ac

commissioning is not setting particularly challenging targets—that has to be related to the resources. In terms of the comments about ‘a laser-like approach’, target-setting has not been a high priority in Wales compared to England.

os nad yw comisiynu yn gosod targedau arbennig o anodd—rhaid i hynny fod yn gysylltiedig â’r adnoddau. O ran y sylwadau am ‘ffocws pendant’, nid yw gosod targedau wedi bod yn flaenoriaeth uchel yng Nghymru o gymharu â Lloegr.

In my trust we address waiting times with a three-pronged approach. First, in terms of process, you have to improve internal efficiency. Secondly, in terms of demand, you have to look at whether it is possible to control demand, to turn the tap off somehow, so that you have some more headroom. Thirdly, you have to ensure that you have sufficient capacity to deal with what is coming in through the doors.

Yn fy ymddiriedolaeth awn i’r afael ag amseroedd aros mewn ffordd driphlyg. Yn gyntaf, o ran proses, mae’n rhaid i chi wella effeithlonrwydd mewnol. Yn ail, o ran galw, rhaid i chi edrych ar a yw’n bosibl rheoli galw, troi’r tap i ffwrdd ryw ffordd, fel bod gennych fwy o le i anadlu. Yn drydydd, rhaid i chi sicrhau bod gennych allu digonol i ddelio â’r hyn sy’n dod i mewn drwy’r drysau.

Our approach has been to drive the internal efficiency of the organisation through performance management. It is interesting that I have some of the lowest waiting times in Wales and the lowest number of doctors. That may tell you something about the use of resources. Week in, week out, and month in, month out, we are looking at ways in which we can improve our internal efficiency.

Ein dull fu ysgogi effeithlonrwydd mewnol y sefydliad drwy reoli perfformiad. Mae’n ddiddorol bod gennyf rai o’r amseroedd aros byrraf yng Nghymru a’r nifer lleiaf o feddygon. Efallai fod hynny’n dweud rhywbeth wrthych am y defnydd o adnoddau. Wythnos ar ôl wythnos, a mis ar ôl mis, yr ydym yn edrych ar ffyrdd y gallwn wella ein heffeithlonrwydd mewnol.

On demand, and there is a reference in the report to our fast-track unit, we have been able to reduce the admissions coming in to the hospital by 10 per cent. That helped, as did developing our capacity using facilities such as, for example, the two NHS treatment centres that we have in the trust. We have a

Ar gais, ac mae cyfeiriad yn yr adroddiad at ein huned garlam, yr ydym wedi gallu lleihau’r derbyniadau sy’n dod i’r ysbyty 10 y cant. Helpodd hynny, fel y gwnaeth datblygu ein gallu gan ddefnyddio cyfleusterau megis, er enghraifft, y ddwy ganolfan driniaeth GIG sydd gennym yn yr

40-bed patients' hotel, which is 40 beds that are protected for intermediate elective surgery, and that has been a huge boon to us. Since the trust was established, we have two hospitals—Neath Port Talbot and Bridgend—that we describe as one hospital with an 18-mile corridor. That allows us to manage our elective care and our emergency care much more effectively, rather than having two hospitals competing against each other and duplicating services. That has partly been due to the way in which we work in partnership with our local health boards, which have been quite happy to see an interchange of patients across their boundaries, because they can see the benefits of short waiting times.

ymddiriedolaeth. Mae gennym westy cleifion 40 gwely, sef 40 gwely sydd wedi eu diogelu ar gyfer llawdriniaeth ddewisol ganolraddol, ac mae hwnnw wedi bod o fantais enfawr i ni. Ers sefydlu'r ymddiriedolaeth, mae gennym ddau ysbyty—Castell-nedd Port Talbot a Phen-y-bont ar Ogwr—yr ydym yn eu disgrifio fel un ysbyty gyda choridor 18 milltir. Mae hynny'n ein galluogi i reoli ein gofal dewisol a'n gofal brys yn llawer mwy effeithiol, yn hytrach na chael dau ysbyty yn cystadlu yn erbyn ei gilydd a dyblygu gwasanaethau. Mae hynny'n rhannol oherwydd y ffordd yr ydym yn gweithio mewn partneriaeth gyda'n byrddau iechyd lleol, sydd wedi bod yn ddigon bodlon gweld rhyngnewid cleifion ar draws eu ffiniau, oherwydd gallant weld manteision amseroedd aros byr.

Finally, there is the issue of delayed transfers of care. We have driven down delayed transfers of care, and I think that, in January, delayed transfers of care in the acute sector for Neath Port Talbot and Bridgend were fewer than 20. That obviously has a huge impact in terms of bed availability.

Yn olaf, mae'r mater o oedi wrth drosglwyddo gofal. Yr ydym wedi lleihau oedi wrth drosglwyddo gofal, a chredaf, ym mis Ionawr, y bu llai nag 20 achos o oedi wrth drosglwyddo gofal yn y sector acíwt ar gyfer Castell-nedd Port Talbot a Phen-y-bont ar Ogwr. Mae hynny'n amlwg yn cael effaith enfawr o ran y gwelyau sydd ar gael.

[297] **Alun Cairns:** Thank you, Mr Williams. Cadeirydd, I am trying to reconcile the difference between the experience that Mr Williams has offered and the experience of other trusts where, clearly, there have been some difficulties. I accept the issue about tertiary care, and that being a regional centre

[297] **Alun Cairns:** Diolch, Mr Williams. Gadeirydd, yr wyf yn ceisio cysoni'r gwahaniaeth rhwng y profiad y mae Mr Williams wedi ei gynnig a phrofiad ymddiriedolaethau eraill lle, yn amlwg, y bu rhai anawsterau. Derbyniaf y mater am ofal trydyddol, a bod bod yn ganolfan ranbarthol

complicates the issue. However, it seems that, as a very general statement, when management is very effective, and is planned properly, such as in the plan that Mrs Perrin highlighted as being introduced, it delivers. I just wish that a plan had been introduced some time ago, if there was that focus on waiting times. As was suggested by Mr Williams, it seems that they had thought through the planning stage and the capacity issues and all the other issues mentioned.

yn cymhlethu'r mater. Fodd bynnag, mae'n ymddangos, fel datganiad cyffredinol iawn, pan fo rheoli yn effeithiol iawn, ac yn cael ei gynllunio'n gywir, fel yn y cynllun y bu i Mrs Perrin dynnu sylw ato fel un a oedd wedi ei gyflwyno, mae'n llwyddo. Ni allaf ond dymuno y byddai cynllun wedi ei gyflwyno beth amser yn ôl, os oedd y ffocws hwnnw ar amseroedd aros. Fel yr awgrymwyd gan Mr Williams, mae'n ymddangos eu bod wedi ystyried yn fanwl y cam cynllunio a'r materion gallu a'r holl faterion eraill sydd wedi eu crybwyll.

[298] **Janet Davies:** Can I ask you to enlarge slightly on that point, Mr Williams? It seems that your trust has been very forward looking in foreseeing problems, perhaps even before NHS Wales did. Do you think this is true, and do you think that there are lessons from your trust for other trusts in Wales—not picking on any particular?

[298] **Janet Davies:** A gaf fi ofyn i chi ymhelaethu ychydig ar y pwynt hwnnw, Mr Williams? Mae'n ymddangos bod eich ymddiriedolaeth wedi meddwl yn flaengar iawn wrth ragweld problemau, efallai hyd yn oed cyn i GIG Cymru wneud hynny. A yw hyn yn wir yn eich tyb chi, ac a ydych o'r farn bod gan eich ymddiriedolaeth wersi ar gyfer ymddiriedolaethau eraill yng Nghymru—heb enwi unrhyw un yn benodol?

Mr Williams: It is not for me to suggest that what we do is transferable; it is just that we have a culture in the organisation of trying to excel. Something that we have done particularly is to benchmark our performance against that of English hospitals. We are one of the CHKSK's top 40 trusts. When we meet resistance to change, or if the target appears to be impossible, we then go out to see who is doing it better and ask why we cannot do it. There is a culture of continuous quality

Mr Williams: Nid fy lle i yw awgrymu bod modd trosglwyddo'r hyn a wnawn; y gwir yw bod gennym ddiwylliant yn y sefydliad o geisio rhagori. Rhywbeth yr ydym wedi ei wneud yn benodol yw meincnodi ein perfformiad yn erbyn perfformiad ysbytai Lloegr. Yr ydym ymhlith 40 ymddiriedolaeth orau'r CHKSK. Pan ddeuwn ar draws gwrthwynebiad i newid, neu os yw'r targed yn ymddangos yn amhosibl, yna yr ydym yn mynd allan i weld pwy sy'n ei wneud yn well

improvement that we have fostered in the organisation.

ac yn gofyn pam na allwn ni ei wneud. Mae diwylliant o wella ansawdd yn barhaus yr ydym wedi ei feithrin yn y sefydliad.

[299] **Irene James:** My question deals with the management of waiting lists, in paragraphs 4.27 to 44.31. Much of a trust's success in reducing waiting times depends on the contributions of the clinicians. How do you manage to engage clinical staff in the management of the key issues of waiting times in your trusts, and to what extent have they signed up to modernising their waiting lists, such as pooled waiting times and treating patients in turn?

[299] **Irene James:** Mae fy nghwestiwn yn ymwneud â rheoli rhestrau aros, ym mharagraffau 4.27 i 4.31. Mae llawer o lwyddiant ymddiriedolaeth wrth leihau amseroedd aros yn dibynnu ar gyfraniadau'r clinigwyr. Sut yr ydych yn gallu cynnwys staff clinigol yn y gwaith o reoli'r materion allweddol o amseroedd aros yn eich ymddiriedolaethau, ac i ba raddau y maent wedi ymrwymo i foderneiddio eu rhestrau aros, megis amseroedd aros cyfun a thrin cleifion yn eu tro?

Mr Ross: I have been very pleased by the degree of medical-clinical sign up in Cardiff and Vale NHS Trust to these very important issues. I have brought with me a mental check list, if you like, of all the good practice that I would expect to see in place, including some of the sorts of initiatives and principles that you mentioned, and I find that they are all in evidence in the trust and in use in the trust. I would not claim that they are 100 per cent in use in every area, and I think it is fair to say that the burden of the waiting-list issue weighs on the surgeons concerned as much as everybody else, and they are extremely keen to find some sustainable solutions that would mean that we could treat all our patients with the same speed as we treat the majority of them. It is worth making the point that, although we talk about waiting times, we are

Mr Ross: Yr wyf wedi bod yn fodlon iawn â graddau'r ymrwymiad meddygol-clinigol yn Ymddiriedolaeth GIG Caerdydd a'r Fro i'r materion hynod bwysig hyn. Yr wyf wedi dod â rhestr wirio yn fy mhen gyda mi, os hoffwch chi, o'r holl arferion da y byddwn yn disgwyl eu gweld ar waith, gan gynnwys rhai o'r mathau o fentrau ac egwyddorion y bu i chi eu crybwyll, ac yr wyf yn gweld eu bod i gyd yn amlwg yn yr ymddiriedolaeth ac ar waith yn yr ymddiriedolaeth. Ni fyddwn yn hawlio eu bod i gyd 100 y cant ar waith ym mhob maes, a chredaf ei bod yn deg dweud bod baich y mater rhestrau aros yn pwyso ar y llawfeddygon dan sylw cymaint â phawb arall, ac maent yn hynod awyddus i ganfod atebion cynaliadwy a fyddai'n golygu y byddem yn gallu trin ein holl gleifion yr un mor gyflym ag yr ydym yn trin y mwyafrif

always talking about the longest waiting times, and even with a trust like Cardiff and Vale, which is under great pressure, 84 per cent of our patients on waiting lists were treated within six months in the last year. We must always remember that. However, obviously, we want to see everybody treated within a very few months.

ohonynt. Er ein bod yn siarad am amseroedd aros, mae'n werth nodi ein bod bob amser yn siarad am yr amseroedd aros hiraf, a hyd yn oed gydag ymddiriedolaeth fel Caerdydd a'r Fro, sydd dan bwysau mawr, cafodd 84 y cant o'n cleifion ar restrau aros eu trin o fewn chwe mis yn y flwyddyn ddiwethaf. Rhaid i ni beidio ag anghofio hynny. Fodd bynnag, yn amlwg, yr ydym am weld pawb yn cael eu trin o fewn ychydig iawn o fisoedd.

We audit all the time, and the innovations-in-care team, and the good practice guidance that it has produced, is very helpful in ensuring that we can keep up to the mark with best practice elsewhere. We audit all the time how well we are doing against the various expectations of good practice, be it administrative management, validation, or making sure that we keep in touch with our patients on an appropriate basis to make sure that the surgery is still required and wished for, and, wherever possible, to look at alternative ways of demand management and keeping waiting lists down. It is a constant and never-ending theme, a bit like painting the Forth bridge, but you have to keep at it all the time. As I say, I have been pleased to find that it has a high profile in the trust. My job is to make sure that we improve it further.

Yr ydym yn archwilio drwy'r amser, ac mae'r tîm arloesi mewn gofal, a'r canllawiau arferion da y mae wedi eu cynhyrchu, yn ddefnyddiol iawn o ran sicrhau ein bod yn gallu bod yn gyson ag arferion da mewn mannau eraill. Yr ydym yn archwilio'n gyson o ran pa mor dda yr ydym yn perfformio yn erbyn disgwyliadau amrywiol arferion da, boed yn rheolaeth weinyddol, dilysu, neu sicrhau ein bod yn cadw mewn cysylltiad â'n cleifion yn briodol i sicrhau bod angen y llawdriniaeth o hyd a bod y claf eisiau'r llawdriniaeth, a, lle bynnag y bo'n bosibl, edrych ar ffyrdd amgen o reoli galw a chadw rhestrau aros i lawr. Mae'n thema gyson a di-ben-draw, ychydig fel paentio pont Forth, ond mae'n rhaid i chi ddal ati drwy'r amser. Fel y dywedaf, yr wyf wedi bod yn falch o ganfod bod ganddi broffil uchel yn yr ymddiriedolaeth. Fy swydd yw sicrhau ein bod yn ei gwella ymhellach.

Ms Perrin: Perhaps I could just add that I would agree that clinical engagement is key and I think that we owe a huge debt to our

Ms Perrin: Efallai y cawn ychwanegu y byddwn yn cytuno bod cyfraniad clinigwyr yn allweddol a chredaf ein bod yn fawr ein

clinicians—not just doctors, but other health professionals—in pulling out the stops to deliver the targets. The key for the future is around thinking about the whole system so that we are working with the trust's clinicians, working with primary care, to look at how we can avoid admission in the first place, how we can process the patients through the acute system as quickly as possible, and how we can put in place the other infrastructure issues back into the community, to get those patients discharged from our services as quickly as possible and cared for in the community.

dyled i'n clinigwyr—nid dim ond meddygon, ond gweithwyr iechyd proffesiynol eraill—am wneud eu gorau glas i gyflawni'r targedau. Mae'r allwedd ar gyfer y dyfodol yn ymwneud â meddwl am y system gyfan fel ein bod yn gweithio gyda chlinigwyr yr ymddiriedolaeth, yn gweithio gyda gofal sylfaenol, i edrych ar sut gallwn osgoi derbyniadau yn y lle cyntaf, sut gallwn brosesu'r cleifion drwy'r system acíwt cyn gynted â phosib, a sut gallwn roi ar waith y materion seilwaith eraill yn ôl yn y gymuned, fel bod y cleifion hynny'n cael eu rhyddhau o'n gwasanaethau cyn gynted â phosibl ac yn cael eu gofal yn y gymuned.

One of the challenges for us is that we have been doing non-recurrent waiting list initiatives for a number of years. I think that our clinicians, inevitably, become frustrated that they cannot see long-term sustainable recurrent solutions to some of this in terms of continuing to drive down waiting lists.

Un o'r heriau i ni yw ein bod wedi bod yn gwneud mentrau rhestrau aros afreolaidd am nifer o flynyddoedd. Credaf fod ein clinigwyr, yn anochel, yn mynd yn rhwystredig oherwydd ni allant weld atebion cyson cynaliadwy hirdymor i rywfaint o hyn o ran parhau i leihau rhestrau aros.

Mr Williams: I would like to add that the alignment of clinical staff—that is, all clinicians, as Jane says—is absolutely essential. I do not see how you can achieve what we need to do without that engagement. It starts for us in terms of good and regular communication with our colleagues so that there is an alignment of Government and trust objectives. We have very effective clinical directorates which have total responsibility for managing their day-to-day affairs. They are supported by effective

Mr Williams: Hoffwn ychwanegu bod cysoni staff clinigol—hynny yw, yr holl glinigwyr, fel y dywed Jane—yn gwbl hanfodol. Ni allaf weld sut gallwch gyflawni'r hyn sydd angen i ni ei wneud heb yr ymgysylltiad hwnnw. Mae'n dechrau i ni o ran cyfathrebu da a rheolaidd gyda'n cydweithwyr fel bod amcanion y Llywodraeth a'r ymddiriedolaeth yn gyson. Mae gennym gyfarwyddiaethau clinigol effeithiol iawn sy'n gwbl gyfrifol am reoli eu materion bob dydd. Cânt eu cefnogi gan

teams.

dimau effeithiol.

I meet those clinical directorates on a monthly basis, in what we call a management executive. We have effective performance management, whereby the executive team reviews the performance of each directorate every two months. My executive team will go through our critical success factors every month. We try to avoid overspend, and have always done so; overspend tends to distract an organisation. This gives one the freedom, particularly, to use whatever capital one has, and to plough back into the organisation. Organisations such as ours thrive on investment in technology and new buildings. This creates the incentives and a much more purposeful approach, and, from that, I find that clinical staff will innovate and drive improvement forward, because they want to make things better for patients. It is about management getting behind the clinicians, and doing what we all want to do, which is to ensure a better deal for patients.

Yr wyf yn cyfarfod â'r cyfarwyddiaethau clinigol hynny yn fisol, yn yr hyn a alwn yn weithrediaeth reoli. Yr ydym yn rheoli perfformiad yn effeithiol; mae'r tîm gweithredol yn adolygu perfformiad pob cyfarwyddiaeth bob dau fis. Bydd fy nhîm gweithredol yn mynd drwy ein ffactorau llwyddiant critigol bob mis. Yr ydym yn ceisio osgoi gorwario, a bob amser wedi gwneud hynny; mae gorwario yn tueddu i dynnu sylw sefydliad. Mae hwn yn rhoi rhyddid i rywun, yn arbennig, i ddefnyddio faint bynnag o gyfalaf sydd gan rywun, a'i fuddsoddi yn ôl yn y sefydliad. Mae sefydliadau fel ein un ni yn ffynnu ar y buddsoddi mewn technoleg ac adeiladau newydd. Mae hyn yn creu'r cymhellion ac ymagwedd lawer mwy pwrpasol, ac, o hynny, yr wyf yn canfod y bydd staff clinigol yn arloesi ac yn datblygu gwelliannau, oherwydd eu bod am wella pethau i gleifion. Mae'n fater o reolwyr yn cefnogi'r clinigwyr, a gwneud yr hyn yr ydym i gyd am ei wneud, sef sicrhau bargen well i gleifion.

[300] **Irene James:** Jane, we understand that refusal to participate in the second offer scheme has been especially high in the Swansea area. Do you have any explanation for that?

[300] **Irene James:** Jane, deallwn fod nifer arbennig o uchel yn gwrthod cymryd rhan yng nghynllun yr ail gynnig yn ardal Abertawe. A oes gennych unrhyw esboniad am hynny?

Ms Perrin: We have just seen the findings from a recent MORI poll that was conducted into why patients chose not to take up second offers. We had obviously done our own analysis, and the MORI poll shows that approximately 50 per cent of patients who have been offered alternative treatment elsewhere, turned it down. The interesting factor is of that 50 per cent who refused, between 60 and 70 per cent refused to tell the MORI people why they would not accept treatment elsewhere, which is quite interesting in terms of helping us in the service and the Welsh Assembly Government to better understand the reasons. Obviously,

Ms Perrin: Yr ydym newydd weld y canfyddiadau o arolwg diweddar gan MORI ar pam mae cleifion yn dewis peidio â derbyn ail gynigion. Yr oeddem yn amlwg wedi gwneud ein dadansoddiad ein hunain, ac mae arolwg MORI yn dangos bod tua 50 y cant o gleifion y cynigiwyd triniaeth arall iddynt yn rhywle arall, wedi ei gwrthod. Y ffactor diddorol yw o'r 50 y cant a wrthododd, gwrthododd rhwng 60 a 70 y cant ddweud wrth bobl MORI pam nad oeddent yn derbyn triniaeth yn rhywle arall, sy'n eithaf diddorol o ran ein cynorthwyo yn y gwasanaeth ac yn Llywodraeth Cynulliad Cymru i ddeall y rhesymau yn well. Yn amlwg, mae'r rhan

most of the second offer work has been sourced further down the M4 corridor, and I suspect that for many of our patients, it is further to travel. Many of our patients are elderly, and they worry about travel arrangements and so forth. However, until we can fully understand why, it is very difficult to make assumptions and plan for that for the future.

fwyaf o'r gwaith ail gynnig wedi'i sianelu i lawr coridor yr M4, a thybiaf i lawer o'n cleifion, ei fod yn bellach i deithio. Mae llawer o'n cleifion yn oedrannus, ac maent yn poeni am drefniadau teithio ac ati. Fodd bynnag, tan i ni ddeall yn iawn pam, mae'n anodd iawn i ni ragdybio a chynllunio ar gyfer hynny ar gyfer y dyfodol.

[301] **Irene James:** My next question relates to paragraphs 3.3 and 3.4, which state that the main causes of long in-patient case waiting times are emergency and medical pressures. How significantly do emergency and medical pressures impact on elective surgery, and how do you address that?

[301] **Irene James:** Mae fy nghwestiwn nesaf yn ymwneud â pharagraffau 3.3 a 3.4, sy'n nodi mai prif achosion amseroedd aros hir achosion cleifion mewnol yw pwysau brys a meddygol. I ba raddau y mae pwysau brys a meddygol yn effeithio ar lawdriniaeth ddewisol, a sut mae mynd i'r afael â hynny?

Ms Perrin: Yes, this does have an impact. Certainly, over the past couple of years in Swansea, we have seen a 10 per cent increase in the number of emergency patients admitted to hospital. I think that the challenge for us, as I think Mr Ross said earlier, is getting that balance between protecting sufficient beds to carry out the elective surgery and managing the emergencies. We work closely with the ambulance service in terms of trying to balance that. However, we walk a fine tightrope with that increase in emergency admissions. We have seen a further increase over the past few months as a result of the changes in general practice out-of-hours provision.

Ms Perrin: Oes, mae gan hyn effaith. Yn sicr, yn ystod yr ychydig flynyddoedd diwethaf yn Abertawe, yr ydym wedi gweld cynnydd o 10 y cant yn nifer y cleifion brys a dderbynnir i'r ysbyty. Credaf mai'r her i ni, fel y credaf i Mr Ross ddweud yn gynharach, yw cael y cydbwysedd hwnnw rhwng diogelu digon o welyau i gyflawni'r llawdriniaeth ddewisol a rheoli'r achosion brys. Yr ydym yn gweithio'n agos gyda'r gwasanaeth ambiwlans o ran ceisio cydbwyso hynny. Fodd bynnag, mae'n her gyson gyda'r cynnydd hwnnw mewn derbyniadau brys. Yr ydym wedi gweld cynnydd pellach dros yr ychydig fisoedd diwethaf o ganlyniad i'r newidiadau mewn darpariaeth tu allan i oriau ymarfer cyffredinol.

Mr Ross: The Cardiff and Vale experience is slightly different in that, although the percentage of overall admissions is gradually rising, the numbers have been relatively stable. I think that that is because the trust has put a huge amount of effort into avoiding emergency admissions. So, a whole range of schemes around acute response in the community, enhanced community support arrangements and discharging patients from medical admission examination units before they actually get into the system have helped to keep the emergency numbers much the same. Having said that, the emergency/elective split is a problem. We do not have enough protected capacity for elective care in the trust. Our ambulatory care unit is mentioned in the report, but that has been severely compromised in recent months by emergency patients who, frankly, have overflowed into a number of parts of the trust where we would not normally expect to find them. As of today, we have 108 patients who are outliers, that is, they are not in the ward that you would expect and wish them to be in. So, that is a difficult issue for us. I think that we could overcome that, with the exception of the delayed transfers of care and delayed discharges problem, which is at its most difficult in the Cardiff and Vale area. That is the No. 1 problem for us, because you can follow the chain all the way back to the ambulances at the front door. If we could sort out the delayed transfers of care problem, I think that we could manage the significant emergency pressures much more successfully

Mr Ross: Mae profiad Caerdydd a'r Fro rhywfaint yn wahanol oherwydd, er bod canran y derbyniadau cyffredinol yn codi'n raddol, mae'r niferoedd wedi bod yn eithaf sefydlog. Credaf fod hynny oherwydd bod yr ymddiriedolaeth wedi ymdrechu'n galed i osgoi derbyniadau brys. Felly, mae amrywiaeth cyfan o gynlluniau o gwmpas ymateb acíwt yn y gymuned, gwell trefniadau cymorth cymuned a rhyddhau cleifion o unedau archwilio derbyniadau meddygol cyn iddynt fynd i mewn i'r system wedi cynorthwyo i gadw'r niferoedd brys yn eithaf sefydlog. Ond wedi dweud hynny, mae'r rhaniad brys/dewisol yn broblem. Nid oes gennym ddigon o allu neilltuedig ar gyfer gofal dewisol yn yr ymddiriedolaeth. Crybwyllir ein huned triniaethau dydd yn yr adroddiad, ond mae honno wedi'i chyfaddawdu'n sylweddol yn y misoedd diwethaf gan gleifion brys sydd, yn blwmp ac yn blaen, wedi gorlifo i lawer o rannau o'r ymddiriedolaeth lle na fyddem yn disgwyl eu canfod fel arfer. Heddiw, mae gennym 108 o gleifion sy'n allgleifion, hynny yw, nid ydynt yn y ward y byddech yn disgwyl iddynt fod ynddi. Felly, mae hynny'n fater anodd i ni. Credaf y gallem oresgyn hynny, ar wahân i'r broblem oedi wrth drosglwyddo gofal ac oedi wrth ryddhau, sydd ar ei gwaethaf yn ardal Caerdydd a'r Fro. Dyna'r brif broblem i ni, oherwydd gallwch ddilyn y gadwyn yr holl ffordd yn ôl i'r ambiwlansys wrth y brif fynedfa. Pe gallem ddatrys y broblem oedi wrth drosglwyddo gofal, credaf y gallem reoli'r pwysau brys sylweddol yn llawer mwy

than we are able to do at the moment. Our experience with out-of-hours provision has been similar to that of colleagues in Swansea. We have seen significant increases in out-of-hours attendances in our accident and emergency department in recent months.

llwyddiannus nag y gallwn ei wneud ar hyn o bryd. Mae ein profiad gyda darpariaeth allan o oriau wedi bod yn debyg i brofiad ein cydweithwyr yn Abertawe. Yr ydym wedi gweld cynnydd sylweddol mewn derbyniadau allan o oriau yn ein hadran damweiniau ac achosion brys yn y misoedd diwethaf.

Mr Williams: If I can just build on that, our experience within Bro Morgannwg has been rather similar to that in Cardiff in the sense that, for the last two years or so, our emergency admissions and referrals have plateaued. I think that we need to remember that, in Wales, we have mainly integrated trusts. So, by developing an alternative response within the community through reablement teams, we can do a great deal to sustain patients in the community and to avoid their having to come to accident and emergency and getting into a cycle of admissions. Admission avoidance is important, and integrated trusts in Wales have a good opportunity to exploit that.

Mr Williams: Os caf ychwanegu at hynny, mae ein profiadau ym Mro Morgannwg wedi bod yn eithaf tebyg i rai Caerdydd o ran y ffaith, am y ddwy flynedd ddiwethaf, bod ein derbyniadau a chyfeiriadau brys wedi lefelu. Credaf fod angen i ni gofio bod gennym yng Nghymru ymddiriedolaethau integredig yn bennaf. Felly, drwy ddatblygu ymateb amgen o fewn y gymuned drwy dimau ailalluogi, gallwn wneud llawer i gadw cleifion yn y gymuned a gallant osgoi orfod dod i adran damweiniau ac achosion brys ac yn mynd i fewn i gylch derbyniadau. Mae’n bwysig osgoi derbyniadau, ac mae gan ymddiriedolaethau integredig yng Nghymru gyfle da i wneud hynny.

I described in my earlier response some of the issues in terms of how we have created the capacity within the organisation. However, I would just like to reiterate my comments. The upsurge in emergency admissions since October 2004 is worrying. They peaked at 16 per cent in my trust in January, converting to around a 6 per cent emergency admission rate. That will not be sustainable unless commissioners can tackle the demand issue, or we have more capacity.

Disgrifiais yn fy ateb cynharach rai o’r materion o ran sut yr ydym wedi creu’r gallu yn y sefydliad. Fodd bynnag, hoffwn ailadrodd fy sylwadau. Mae’r cynnydd mewn derbyniadau brys ers Hydref 2004 yn achos pryder. Bu iddo gyrraedd ei anterth o 16 y cant yn fy ymddiriedolaeth ym mis Ionawr, gan drawsnewid i gyfradd derbyn brys o tua 6 y cant. Ni fydd hynny’n gynaliadwy os nad yw comisiynwyr yn gallu mynd i’r afael â’r mater galw, neu fod gennym ragor o allu.

[302] **Irene James:** I wish to respond to Mr Ross and say that we have all seen the recent media coverage of the impact of emergency pressures on your trust. How are you addressing these issues, maintaining reasonable waiting times for those who are waiting for in-patient treatment and reducing your waiting lists?

[302] **Irene James:** Hoffwn ymateb i Mr Ross a dweud ein bod i gyd wedi gweld y sylw diweddar yn y wasg i effaith pwysau brys ar eich ymddiriedolaeth. Sut ydych yn mynd i'r afael â'r materion hyn, gan gynnal amseroedd aros rhesymol i'r rheini sy'n aros am driniaeth cleifion mewnol a gostwng eich rhestrau aros?

Mr Ross: First, we will continue to try to protect what elective capacity we can, as well as we can. However, every day, we face dilemmas regarding whether to cancel treatment for elective patients in order to bring in emergency admissions as reasonably quickly as we can. The builders are now on site at the new Llandough orthopaedic centre, which will be a significant enhancement to the trust's protected elective capacity, because it will not be capable of taking any emergency patients. It has been deliberately designed so that it will be properly protected. We must continue to try to develop these facilities, and I would wish to see that centre expanded to its full capacity, over and above what we can currently do, as quickly as possible.

Mr Ross: Yn gyntaf, byddwn yn parhau i geisio amddiffyn y gallu dewisol sydd gennym, cystal ag y gallwn. Fodd bynnag, bob dydd, yr ydym yn wynebu cyfyng-gyngor ynghylch a ddylid canslo triniaeth ar gyfer cleifion dewisol er mwyn dod â derbyniadau brys i mewn cyn gynted â phosibl. Mae'r adeiladwyr bellach yn gweithio ar safle canolfan orthopedig newydd Llandochau, a fydd yn welliant sylweddol i allu dewisol neilltuedig yr ymddiriedolaeth, oherwydd ni fydd yn gallu cymryd unrhyw gleifion brys. Mae wedi'i gynllunio'n fwriadol er mwyn ei neilltuo'n iawn. Mae'n rhaid i ni barhau i geisio datblygu'r cyfleusterau hyn, a hoffwn weld y ganolfan yn ehangu i'w gallu llawn, y tu hwnt i'r hyn y gallwn ei wneud ar hyn o bryd, cyn gynted â phosibl.

In terms of the emergency patient's journey through the system, it falls into three categories. First, what can we do to stop emergency patients coming to the hospital in the first place? How can we maximise

O ran symudiadau'r cleifion brys drwy'r system, mae'n disgyn i dri chategori. Yn gyntaf, beth y gallwn ei wneud i atal cleifion brys rhag dod i'r ysbyty yn y lle cyntaf? Sut allwn sicrhau'r cymorth mwyaf posibl yn y

support in the community? How can we encourage and incentivise primary care to take on as much as is possible? What alternative facilities can we provide in the community? Anecdotal evidence—and I am sure that we will prove this with our latest survey—shows that 20 or 30 per cent of our accident and emergency department patients should not be there. They could be dealt with adequately in primary care. This has been explored at great length recently. So, we have a very full, ongoing dialogue with local health boards and primary care about how we can, first of all, try to stem the flow. It is clear that, for whatever reason, the out-of-hours arrangements are not commanding the public confidence that we would wish, and that leads to some of the kinds of problems we have been describing. That is one aspect.

gymuned? Sut allwn annog a sbarduno gofal sylfaenol i gymryd cymaint ag sy'n bosibl? Pa gyfleusterau eraill y gallwn eu darparu yn y gymuned? Mae tystiolaeth anecdotaidd—ac yr wyf yn sicr y byddwn yn profi hyn gyda'n harolwg diweddaraf—yn dangos na ddylai 20 i 30 y cant o'n cleifion adran damweiniau ac achosion brys fod yno. Gellid delio â hwy'n ddigonol mewn gofal sylfaenol. Mae hyn wedi'i bwyso a'i fesur yn drylwyr yn ddiweddar. Felly, mae gennym drafodaeth lawn, barhaus gyda byrddau iechyd lleol a gofal sylfaenol ynglŷn â sut gallwn, yn y lle cyntaf, geisio rhwystro'r llif. Mae'n amlwg, am ba reswm bynnag, nad yw'r trefniadau allan o oriau yn ennyn hyder y cyhoedd fel yr hoffem, ac mae hynny'n arwain at rai o'r problemau yr ydym wedi'u disgrifio. Mae honno'n un agwedd.

Secondly, there is everything that happens from the time that we decide that a patient needs to be admitted, and what we do from then on. We then have to try to use best practice in streaming patients and making sure that we move them through the appropriate parts of the system as quickly as possible. The trust has put in place everything that you would expect to be put in place—all of the good practice and so on—in order to do that. The problem is, because we cannot progress patients through the system as quickly as we would like, there are delays at each stage of the process. The emergency patient is delayed in getting into the medical admissions unit, the medical-admissions-unit patient is delayed in getting onto a medical

Yn ail, mae popeth sy'n digwydd o'r amser yr ydym yn penderfynu bod angen derbyn claf, a beth yr ydym yn ei wneud o hynny allan. Mae'n rhaid i ni wedyn geisio defnyddio arferion gorau wrth ffrydio cleifion a sicrhau ein bod yn eu tywys drwy elfennau priodol y system cyn gynted â phosibl. Mae'r ymddiriedolaeth wedi gweithredu popeth y byddech yn disgwyl iddynt ei roi ar waith—yr holl arferion da ac ati—er mwyn gwneud hynny. Y broblem, oherwydd na allwn dywys cleifion drwy'r system mor gyflym ag yr hoffem, yw bod oedi ym mhob cyfnod o'r broses. Mae oedi wrth fynd â'r cleifion brys i'r uned derbyniadau meddygol, mae oedi wrth fynd â'r cleifion uned-derbyniadau-meddygol i'r

ward, for example, the medical-ward patient is delayed in moving to a convalescent, rehabilitation or intermediate-care bed, and the intermediate-care, rehabilitation patient is delayed in getting back into residential or nursing-home care in their community, or going there for the first time, if that is appropriate. The market in Cardiff is not providing us with anything like the capacity we need to get patients right through the system. So, I am afraid that, within the trust, I have a number of delays at all stages of the emergency patient's journey. That in itself has an impact right back at the front door and makes it difficult to achieve the emergency/elective split that we all want to see. I am envious of the separation of facilities that Paul has achieved in Bro Morgannwg. That is something that we should all be striving to do as much as possible, and it is something that we intend to take further, when we can.

ward feddygol, er enghraifft, mae oedi wrth fynd â'r cleifion ward feddygol i wely ymadfer, adsefydlu neu ofal canolraddol, ac mae oedi wth fynd â chleifion adsefydlu, gofal canolraddol yn ôl i ofal cartref preswyl neu nyrsio yn eu cymuned, neu wrth fynd yno am y tro cyntaf, os yw hynny'n briodol. Nid yw'r farchnad yng Nghaerdydd yn ein darparu ag unrhyw beth fel y gallu sydd ei angen arnom i dywys cleifion drwy'r system. Felly, yn anffodus, yn yr ymddiriedolaeth, mae gennyf sawl achos o oedi ym mhob cam o daith y claf brys. Mae hynny yn ei hun yn cael effaith ymhell yn ôl i'r brif fynedfa ac mae'n ei gwneud yn anodd i gyflawni'r rhaniad brys/dewisol yr ydym i gyd am ei weld. Yr wyf yn genfigennus o'r gwahaniad cyfleusterau y mae Paul wedi'i gyflawni ym Mro Morgannwg. Mae hynny'n rhywbeth y dylem i gyd geisio'i wneud cymaint â phosibl, ac mae'n rhywbeth yr ydym yn bwriadu ei ddatblygu, pan allwn.

So, I want to assure you that we are putting maximum effort into the pre-admission situation in primary care. We are working very closely with the local authorities and the local health boards to see what we can do to overcome this extremely difficult problem of delayed transfers. We have around 80 patients at the moment in the trust who are waiting for a place in the nursing home or residential home of their choice. We are also doing everything that we can to sort out our own internal processes and make them as

Felly, yr wyf am eich sicrhau ein bod yn gwneud ein gorau glas gyda'r sefyllfa cyn-derbyn mewn gofal sylfaenol. Yr ydym yn gweithio'n agos iawn gyda'r awdurdodau lleol a'r byrddau iechyd lleol i weld beth y gallwn ei wneud i ddatrys y broblem anodd iawn hon o oedi wrth drosglwyddo. Mae gennym oddeutu 80 claf ar hyn o bryd yn yr ymddiriedolaeth sy'n aros am le yn y cartref nyrsio neu'r cartref preswyl o'u dewis. Yr ydym hefyd yn gwneud popeth o fewn ein gallu i gael trefn ar ein prosesau mewnol ein

efficient and quick as possible. The report, quite rightly, draws attention across NHS Wales to a whole number of process delays that trusts need to be working on to sort out and eradicate those delays, and to make sure that internal flows work as well as possible. I am sorry to give such a lengthy answer, but it is a complex and difficult problem, and I want to reassure you that we are trying to address every step of the process with equal urgency.

hunain a'u gwneud mor effeithlon a chyflym â phosibl. Mae'r adroddiad, yn gywir, yn tynnu sylw ledled GIG Cymru at lawer o oedi prosesau y mae angen i ymddiriedolaethau fynd i'r afael â hwy i ddatrys a chael gwared ar yr oediadau hynny, ac i sicrhau bod y symudiadau mewnol yn gweithio cystal â phosibl. Mae'n ddrwg gennyf am roi ateb mor hirfaith, ond mae'n broblem gymhleth ac anodd, ac yr wyf am eich sicrhau ein bod yn ceisio mynd i'r afael â phob cam o'r broses gyda'r un brys.

[303] **Janet Davies:** Three weeks ago, Ms Ann Lloyd told us that there was a low occupancy rate in community hospitals and, when I asked her about this, she said that she felt that there was capacity there for dealing with some delayed transfers where appropriate, and also for diagnostic and day care. Do you see any problems in getting these cases moved into community hospitals, and could you give us some views on whether you think this is a viable proposition, within your area particularly?

[303] **Janet Davies:** Dair wythnos yn ôl, dywedodd Ms Ann Lloyd wrthym fod graddfa feddiannaeth isel mewn ysbytai cymuned a, phan y bu i mi ei holi am hyn, dywedodd ei bod yn credu bod gallu yno i ddelio â rhywfaint o'r oedi wrth drosglwyddo lle'n briodol, a hefyd ar gyfer gofal diagnostig a dydd. A ydych yn rhagweld unrhyw broblemau i symud yr achosion hyn i ysbytai cymuned, ac a ellwch roi eich barn i ni ynglŷn ag a ydych yn credu bod hwn yn gynnig ymarferol, yn eich ardal chi yn benodol?

Mr Ross: I think it may well be viable in certain parts of Wales. We only have two community hospitals associated with our trust—St David's Hospital in Cardiff and Barry Hospital. Their occupancy rates range between 85 and 90 per cent, which is what you would hope and expect to see. The occupancy rates in the medical wards in the University Hospital of Wales, for example,

Mr Ross: Credaf y gallai fod yn ymarferol mewn rhannau penodol o Gymru. Dim ond dau ysbyty cymuned sy'n gysylltiedig â'n hymddiriedolaeth—Ysbyty Dewi Sant yng Nghaerdydd ac Ysbyty'r Barri. Mae eu graddfeydd meddiannaeth yn amrywio rhwng 85 a 90 y cant, sef yr hyn y byddech yn ei ddisgwyl ac yn ei obeithio. Mae'r graddfeydd meddiannaeth yn y wardiau meddygol yn

are 98 per cent, which is desperately inefficient, because one thing goes wrong and many things ripple from that. I have read the report very carefully and I am aware that this is an issue for debate, but it is not an option that is available to any great degree to Cardiff and Vale NHS Trust, although there is more to be done for us to use the Barry and St David's hospitals as fully and as well as we possibly can.

Ysbyty Athrofaol Cymru, er enghraifft, yn 98 y cant, sy'n druenus o aneffeithlon, oherwydd mae un peth yn mynd o'i le ac mae llawer o bethau'n deillio o hynny. Yr wyf wedi darllen yr adroddiad yn ofalus iawn ac yr wyf yn ymwybodol bod hwn yn bwnc trafod, ond nid yw'n opsiwn sydd ar gael i unrhyw raddau helaeth yn Ymddiriedolaeth GIG Caerdydd a'r Fro, er bod mwy i'w wneud i ni ddefnyddio ysbytai'r Barri a Dewi Sant cymaint a chystal ag y gallwn.

[304] **Janet Davies:** Ms Perrin, perhaps you could tell us how this applies in Swansea.

[304] **Janet Davies:** Ms Perrin, hwyrach y gallwch ddweud wrthym sut mae hyn yn berthnasol yn Abertawe.

Ms Perrin: I think that we have very similar issues to those in Cardiff. We have four community hospitals within the Swansea trust and we run at similar occupancies to those in Cardiff. I am aware that, across Wales, there are differences in the occupancy of community hospitals, but we believe that we run ours reasonably efficiently. The problem that we have is that, as acute patients move into needing rehabilitation and care, we move them out of our two big acute hospitals and into the community hospitals, but then they sometimes get stuck there while we are waiting to move them on into homes—either back home or into homes in the community.

Ms Perrin: Credaf ein bod wedi wynebu materion tebyg iawn i'r rhai yng Nghaerdydd. Mae gennym bedwar ysbyty cymuned yn ymddiriedolaeth Abertawe ac mae gennym raddfeydd meddiannaeth tebyg i'r rhai yng Nghaerdydd. Yr wyf yn ymwybodol, ledled Cymru, bod gwahaniaethau yng ngraddfeydd meddiannaeth ysbytai cymuned, ond credwn ein bod yn cynnal ein rhai ni yn eithaf effeithlon. Y broblem sydd gennym yw, wrth i gleifion acíwt symud i fod angen adsefydlu a gofal, yr ydym yn eu symud allan o'n dau ysbyty acíwt mawr ac i'r ysbytai cymuned, ond o bryd i'w gilydd byddant yno am gyfnod maith tra ein bod yn aros i'w symud i gartrefi—naill ai yn ôl gartref neu i gartrefi yn y gymuned.

Mr Williams: Just to add to that, we manage our community hospitals—like Jane, I have four—as tightly as we do the main acute hospitals. However, one must appreciate that the complexity of the cases requires a significant investment in rehabilitation staff, and, where there is a less-than-optimum performance, that may be a reflection on insufficient investment in rehabilitation staff. We have had a degree of success with our commissioners on that, in that they recognise the good value that one can get from investing in the community hospitals to ensure that they play their full part in the chain of care.

Mr Williams: I ychwanegu at hynny, yr ydym yn rheoli ein hysbytai cymuned—fel Jane, mae gennyf bedwar—mor fanwl ag yr ydym yn rheoli'r prif ysbytai acíwt. Fodd bynnag, mae'n rhaid gwerthfawrogi bod cymhlethdod yr achosion yn gofyn am fuddsoddiad sylweddol mewn staff adsefydlu, ac, lle nad ydynt yn perfformio cystal â phosibl, efallai bod hynny'n adlewyrchu'r buddsoddiad annigonol mewn staff adsefydlu. Yr ydym wedi bod yn llwyddiannus i raddau gyda'n comisiynwyr ar hynny, o ran eu bod yn cydnabod y gwerth da y gall rhywun ei gael o fuddsoddi yn yr ysbytai cymuned i sicrhau eu bod yn chwarae eu rhan lawn yn y gadwyn ofal.

[305] **Irene James:** Could you describe the impact that the fast-track assessment unit has had on your trust and how effective the surgery and eye treatment centres in your trust have been in reducing waiting times?

[305] **Irene James:** A ellwch ddisgrifio'r effaith y mae'r uned asesu llwybr carlam wedi'i chael ar eich ymddiriedolaeth a pha mor effeithiol y bu'r canolfannau llawdriniaeth a thriniaeth llygad yn eich ymddiriedolaeth wrth ostwng amseroedd aros?

Mr Williams: On the fast-track unit—this is not a concept unique to our trust; we pinched the idea from elsewhere—having a very highly qualified consultant physician who can take a proportion of the patients who would come through the doors of the accident and emergency department, to quickly assess them and to have at his disposal the full panoply of diagnostic tests means that one can, with confidence, decide whether the patient needs to be admitted, and admitted appropriately, whether they can be returned to the community, or whether they need to come back to us as an out-patient. That has reduced our admissions by around 10 per cent. The problem is—and I think that, further on in the report, there is mention of issues around the roll-out of best practice—that some of these schemes start in a piecemeal way, in that we have either found the resources through our cost improvement programmes or we have had some money through the Wanless action plan or whatever, but we do not turn these good ideas into practice in terms of running them 24/7. So, if I had a fast-track unit running 24/7, for which I would probably need about three and a half consultants as opposed to one, we could probably see a step change. One of the debates that we

Mr Williams: O ran yr uned llwybr carlam—nid yw hwn yn gysyniad sy'n unigryw i'n hymddiriedolaeth ni; syniad rhywun arall ydoedd—mae cael meddyg ymgynghorol cymwys iawn sy'n gallu cymryd cyfran o'r cleifion a fyddai'n dod drwy ddrysau'r adran damweiniau ac achosion brys, i'w hasesu'n gyflym ac i gael y defnydd llawn o'r profion diagnostig yn golygu y gall rhywun, yn hyderus, benderfynu a oes angen derbyn y claf, a'i dderbyn yn briodol, a ellir eu gadael yn ôl i'r gymuned, neu a oes angen iddynt ddod yn ôl atom ni fel cleifion allanol. Mae hynny wedi gostwng ein derbyniadau o tua 10 y cant. Y broblem—a chredaf, yn nes ymlaen yn yr adroddiad, y crybwyllir materion ynghylch rhoi arferion gorau ar waith fesul cam—yw bod rhai o'r cynlluniau hyn yn dechrau mewn ffordd dameidiog, o ran ein bod naill ai wedi canfod yr adnoddau drwy ein rhaglenni gwella costau neu ein bod wedi cael rhywfaint o arian drwy gynllun gweithredu Wanless neu beth bynnag, ond nid ydym yn rhoi'r syniadau da hynny ar waith o ran eu gweithredu 24/7. Felly, pe bai gennyf uned llwybr carlam yn gweithredu 24/7, y byddwn angen tri a hanner meddyg ymgynghorol yn hytrach nag un ar ei chyfer mae'n debyg, gallem

must have is on why we cannot roll out things that we know to work. We have a very piecemeal approach to this and that is causing some of the difficulties.

weld newid sylweddol yn ôl pob tebyg. Un o’r trafodaethau sy’n rhaid i ni ei chael yw un ynghylch pam na allwn roi pethau y gwyddom sy’n gweithio ar waith fesul cam. Mae gennym agwedd dameidiog iawn at hyn ac mae hynny’n achosi anawsterau.

[306] **Janet Davies:** Alun, did you want to come in on this?

[306] **Janet Davies:** Alun, a oeddech am gyfrannu at hyn?

[307] **Alun Cairns:** I will come in at the end of this block of questions, if you like.

[307] **Alun Cairns:** Cyfrannaf ar ddiwedd y bloc o gwestiynau, os dymunwch.

[308] **Leighton Andrews:** Could you say a little more about why you see it as a piecemeal approach, Mr Williams?

[308] **Leighton Andrews:** A ellwch ymhelaethu pam eich bod yn ei hystyried yn agwedd dameidiog, Mr Williams?

Mr Williams: It is simply in terms of the way in which one can attract resources. As I said, if this is a new investment, you either have to convince the commissioners to provide the money, and it will come through one’s service and financial framework process and long-term agreement, or you try to save money within your organisation and reinvest it. There are difficulties with both in terms of priorities, and I think that, where things have been proven to work, we need to find a way to ensure that they are consolidated and become the norm. It is what I believe they call in England ‘the thousand blooms’—all these little flowers suddenly poke up through the lawn and start to bloom good ideas, but we do not then make the whole lawn a carpet of wonderful flowers. It is about how we grasp these things that do work and say, ‘that is what is going to happen’. Clinicians are struggling with all kinds of priorities and challenges, and we have probably moved on too many fronts at once. I always say that we need to do less but do it really well. If we did that, we could probably tackle some of these difficult issues.

Mr Williams: Yn syml o ran y ffordd y gall rhywun ddenu adnoddau. Fel y dywedais, os yw hwn yn fuddsoddiad newydd, yr ydych naill ai’n gorfod argyhoeddi’r comisiynwyr i ddarparu’r arian, a bydd yn dod drwy broses fframwaith gwasanaeth a chyllid a chytundeb hirdymor rhywun, neu yr ydych yn ceisio arbed arian yn eich sefydliad a’i ailfuddsoddi. Mae anawsterau gyda’r naill a’r llall o ran blaenoriaethau, a chredaf, lle mae pethau wedi gweithio, bod angen i ni ddod o hyd i ffordd o sicrhau eu bod yn cael eu hatgyfnerthu ac yn dod yn safon arferol. Dyma’r hyn y maent yn ei alw yn Lloegr yn ‘filoedd o flodau’—yr holl flodau bach hyn yn sydyn yn dechrau ymddangos ar y lawnt ac yn dechrau blodeuo yn syniadau da, ond nid ydym wedyn yn sicrhau lawnt cyfan o flodau hyfryd. Mae’n ymwneud â sut yr ydym yn manteisio ar y pethau hyn sy’n gweithio a dweud, ‘dyna beth sy’n mynd i ddigwydd’. Mae clinigwyr yn ymrafael gyda phob math o flaenoriaethau a heriau, ac yr ydym yn ôl pob tebyg wedi ceisio gwneud gormod o bethau ar unwaith. Yr wyf yn dweud bob amser bod angen i ni wneud llai ond ei wneud yn dda iawn. Pe baem yn gwneud hynny, gallem fynd i’r afael â rhai o’r materion anodd hyn.

That takes me on to the treatment centres. In

Mae hynny’n fy arwain at y canolfannau

the Bridgend area, we have had experience of two treatment centres for over 10 years and, over those 10 years, they have probably treated, throughout south Wales, over 10,000 patients. Therefore, in Bridgend, we have contributed to significantly reducing waiting times in other parts of south Wales but, again, it has never been rolled out or developed. Elective capacity works, and treatment centres in England clearly work. We just seem to have a block in terms of finding ways in which we can attract more patients to the idea that it is okay to travel if you get good access and good treatment. I have proven it time and time again, in fact, I have proven 10,000 times that people are prepared to travel, and it is a cultural issue that we need to work on. I have used the analogy that most of us are prepared to travel miles to the shopping mall; that has now become part of our culture. I do not see why patients cannot travel maybe 25 miles to get first-class treatment of their choice if we can demonstrate that it is of top quality, and we make that experience enjoyable.

triniaethau. Yn ardal Pen-y-bont ar Ogwr, mae gennym brofiad o ddwy ganolfan driniaethau yn ystod y 10 mlynedd diwethaf ac, yn ystod y 10 mlynedd hynny, mae'n debyg eu bod wedi trin, ledled y De, dros 10,000 o gleifion. Felly, ym Mhen-y-bont ar Ogwr, yr ydym wedi cyfrannu at ostwng amseroedd aros yn sylweddol yn y De ond, eto, nid yw wedi'i roi ar waith fesul cam na'i ddatblygu. Mae gallu dewisol yn gweithio, ac mae canolfannau triniaethau yn Lloegr yn amlwg yn gweithio. Ymddengys nad ydym yn gallu dod o hyd i ffordd o ddenu mwy o gleifion i'r syniad ei bod yn iawn teithio os ydych yn cael mynediad da a thriniaeth dda. Yr wyf wedi profi dro ar ôl tro, yn wir, yr wyf wedi profi 10,000 o weithiau bod pobl yn fodlon teithio, ac mae'n fater diwylliannol y mae'n rhaid i ni weithio arno. Yr wyf wedi defnyddio'r gyfatebiaeth bod y rhan fwyaf ohonom yn fodlon teithio milltiroedd i'r ganolfan siopau; sydd wedi dod yn rhan o'n diwylliant bellach. Ni allaf weld pam na all cleifion deithio 25 milltir o bosibl i gael triniaeth o'r radd flaenaf o'i dewis os gallwn ddangos ei bod o'r ansawdd gorau, a'n bod yn gwneud y profiad yn un pleserus.

[309] **Mick Bates:** I was fascinated by your reply on the piecemeal approach, and two things stem from that: first, who is responsible then for making this lawn bloom and, secondly, would it help if there was a strategic regional view of innovation, rather than what you described as the piecemeal approach, given the number of trusts and local health boards?

[309] **Mick Bates:** Yr oedd gennyf ddiddordeb yn eich ymateb i'r agwedd dameidiog, ac mae dau beth yn deillio o hynny: yn gyntaf; pwy sy'n gyfrifol am sicrhau bod y blodau hyn yn blodeuo, ac yn ail, a fyddai o gymorth pe bai barn ranbarthol strategol ar arloesedd, yn hytrach na'r hyn y bu i chi ei ddisgrifio fel yr agwedd dameidiog, o ystyried y nifer o

ymddiriedolaethau a byrddau iechyd lleol?

Mr Williams: When you have a number of providers and commissioners, and they all have a slightly different view of life, it makes matters extremely complex. I would have thought that there could be a role for some regional strategic view, in terms of how a programme is rolled out. What we have been lacking is an alignment of these issues of processes, demand and capacity into a plan that will clearly deliver. The co-ordination of those things is needed in order to get the maximum advantages, in terms of putting in resources. I deal with only five or so commissioners, and that makes life difficult, but what we have tried to do with our commissioners is to form a concordat so that, wherever possible, we all sit round the table and try to reach an agreement. It is difficult, however, because each has its own local community, its own pressures and its own nuances in how it wants to do things.

Mr Williams: Pan fo gennych nifer o ddarparwyr a chomisiynwyr, a bod ganddynt i gyd farn rywfaint yn wahanol am fywyd, mae'n gwneud materion yn gymhleth iawn. Byddwn wedi tybio y dylid bod rôl i rywfaint o farn strategol ranbarthol, o ran sut y rhoddir rhaglen ar waith fesul cam. Yr hyn na fu gennym oedd cynllun i dynnu ynghyd y materion hyn o brosesau, galw a gallu mewn cynllun a fydd yn amlwg yn cyflawni'r nod. Mae angen cydlynu'r pethau hyn er mwyn sicrhau'r manteision gorau posibl, o ran cyfrannu adnoddau. Yr wyf yn delio gyda thua phum comisiynydd yn unig, ac mae hynny'n gwneud bywyd yn anodd, ond yr hyn yr ydym wedi ceisio'i wneud gyda'n comisiynwyr yw ffurfio concordat sy'n golygu, pryd bynnag y bo hynny'n bosibl, ein bod yn eistedd gyda'n gilydd o amgylch bwrdd ac yn ceisio dod i gytundeb. Mae'n anodd, fodd bynnag, oherwydd mae gan bob un ei gymuned leol ei hun, ei bwysau ei hun a'i bwyslais ei hun ar y ffordd y mae am wneud pethau.

[310] **Alun Cairns:** Briefly, I have several questions that I wish to pursue with Mr Williams, but I know that time is precious, so I will return to one of Mr Ross's answers. I was pleased to hear his answers about the delayed processes within the hospital, when we were talking about emergency services. One initiative, particularly at Christmas time, was field hospitals. I happened to be at the

[310] **Alun Cairns:** Yn gryno, mae gennyf sawl cwestiwn yr wyf am fynd i'r afael â hwy gyda Mr Williams, ond gwn fod amser yn brin, felly yr wyf am ddod yn ôl at un o atebion Mr Ross. Yr oeddwn yn falch o glywed ei atebion am y prosesau a oedd yn cael eu hoedi yn yr ysbyty, wrth i ni siarad am wasanaethau brys. Un fenter, yn arbennig yn ystod y Nadolig, oedd ysbytai maes.

accident and emergency unit of the Princess of Wales Hospital at that time. I spent a night there as a fly on the wall, which also showed me the operations of trusts going around the country. However, you were still operating at risk 5 in the accident and emergency unit at the University Hospital of Wales on those occasions when you had the field hospitals. Were those gimmicks? Was the field hospital a gimmick to draw attention away from the difficulties of the accident and emergency unit, or did it add value to the service? I couple that with the positive comments that I made about the processes that appear, from your previous answer, to be looking up.

Digwydd i mi fod yn uned damweiniau ac achosion brys Ysbyty Tywysoges Cymru ar y pryd. Treuliais noswaith yno fel pryf ar y wal, a oedd hefyd yn dangos i mi sut yr oedd ymddiriedolaethau yn gweithredu ym mhob cwr o'r wlad. Fodd bynnag, yr oeddech yn dal i weithredu ar risg 5 yn yr uned damweiniau ac achosion brys yn Ysbyty Athrofaol Cymru ac ar yr adegau hynny yr oedd gennych yr ysbytai maes. Ai gimigau oeddent? A oedd yr ysbyty maes yn gimig i dynnu sylw oddi ar anawsterau'r uned damweiniau ac achosion brys, neu a oedd yn ychwanegu gwerth at y gwasanaeth? Cyfeiriaf at hynny ochr yn ochr â'r sylwadau positif y bu i mi eu gwneud am y prosesau sy'n ymddangos, o'ch ateb blaenorol, fel pe baent yn gwella.

Mr Ross: I would be disappointed if anyone thought that it was a gimmick. I certainly cannot claim credit for the idea; it is one that the trust and the ambulance service had. As I said earlier, it is about how we can ensure that people do not come to the accident and emergency unit at UHW if they do not need the level of treatment that the unit is kitted out to provide. We know that large events—be they sporting or other occasions—attract very large crowds of people and we can predict that there will be a certain number of minor casualties or people needing attention at such events. It seems to me to make sense to at least try a pilot scheme and see how it works. I believe that something similar is being done in Swansea to see whether we can take treatment to the people concerned rather

Mr Ross: Byddwn yn siomedig pe bai unrhyw un yn meddwl mai gimig ydoedd. Yn sicr, ni allaf gymryd y clod am y syniad; yr oedd yn syniad a gyflwynwyd gan yr ymddiriedolaeth a'r gwasanaeth ambiwlans. Fel y dywedais yn gynharach, mae'n ymwneud â sut gallwn sicrhau nad yw pobl yn dod i'r uned damweiniau ac achosion brys yn Ysbyty Athrofaol Cymru os nad oes arnynt angen y lefel o driniaeth y mae'r uned yn gymwys i'w rhoi. Gwyddom fod digwyddiadau mawr—boed yn chwaraeon neu'n achlysuron eraill—yn denu torfeydd mawr iawn o bobl a gallwn ragweld y bydd nifer penodol o fân anafiadau neu bobl y bydd arnynt angen sylw mewn digwyddiadau o'r fath. Ymddengys i mi ei bod yn gwneud synnwyr i o leiaf roi cynnig ar gynllun peilot

than have them turn up and, frankly, take up time and resources in the accident and emergency unit. So, I think that it has been worth trying on a number of occasions. It is being evaluated by the ambulance service and the trust, and we will then make a decision on whether it is something that we want to continue with in the longer term.

a gweld sut mae'n gweithio. Credaf fod rhywbeth tebyg yn cael ei wneud yn Abertawe i weld a allwn fynd â thriniaeth at y bobl dan sylw yn hytrach na'u bod yn troi fyny ac, i fod yn blaen, yn gwastraffu amser ac adnoddau yn yr uned damweiniau ac achosion brys. Felly, credaf ei bod wedi bod yn werth rhoi cynnig ar hyn o bryd i'w gilydd. Mae'n cael ei werthuso gan y gwasanaeth ambiwlans a'r ymddiriedolaeth, a byddwn wedyn yn penderfynu a yw'n rhywbeth yr ydym am ei barhau yn y tymor hwy.

[311] **Leighton Andrews:** On capacity usage, and looking at paragraphs 3.12 to 3.24 of the report, it is pretty clear that we are not making the most efficient use of existing capacity, so what are you doing in your trusts to address these issues? Mr Williams, you may want to tell us a bit about the short stay unit and, Mr Ross, a bit more about your ambulatory care unit.

[311] **Leighton Andrews:** O ran defnyddio gallu, a chan edrych ar baragraffau 3.12 i 3.24 yr adroddiad, mae'n eithaf clir nad ydym yn gwneud y defnydd mwyaf effeithlon o'r gallu sydd gennym, felly beth yr ydych yn ei wneud yn eich ymddiriedolaethau i fynd i'r afael â'r materion hyn? Mr Williams, efallai y byddwch am sôn rhywfaint wrthym am yr uned arhosiad byr a, Mr Ross, rhywfaint am eich uned triniaethau dydd.

Mr Williams: Would you like me to start?

Mr Williams: A hoffech i mi gychwyn?

[312] **Leighton Andrews:** Yes.

[312] **Leighton Andrews:** Hoffwn.

Mr Williams: I think that, in terms of capacity, first of all we took a very clear view on delayed transfers of care. One of the things that I would commend is the very close partnership working that we have in the

Mr Williams: Credaf, o ran gallu, i ni gymryd safbwynt clir iawn i ddechrau am oedi wrth drosglwyddo gofal. Un o'r pethau y byddwn yn eu canmol yw'r gweithio mewn partneriaeth agos iawn sydd gennym yn yr

area between Neath Port Talbot County Borough Council and Bridgend County Borough Council and the local health boards. Although they do not exist in law, we have what are called ‘partnership boards’, where the leader and the chief executive of the county council, and the chief executive and chair of the local health board, and my chair and I meet regularly to set policy within the context of our whole systems. One commitment that we made was to drive down delayed transfers of care. So, that is one good example of how we create capacity. I mentioned how we maximised the opportunities to run two hospitals in tandem; I think that that has been an excellent example. Again, we drive our community hospitals very hard.

ardal rhwng Cyngor Bwrdeistref Sirol Castell-nedd Port Talbot a Chyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr a’r byrddau iechyd lleol. Er nad ydynt yn bodoli yn llygad y gyfraith, mae gennym yr hyn a elwir yn ‘fyrddau partneriaeth’, lle mae arweinydd a phrif weithredwr y cyngor sir, a phrif weithredwr a chadeirydd y bwrdd iechyd lleol, fy nghadeirydd a minnau yn cyfarfod yn rheolaidd i bennu polisi o fewn cyd-destun ein systemau cyfan. Un o’n hymrwymiadau oedd gostwng oedi wrth drosglwyddo gofal. Felly, mae hynny’n un enghraifft dda o sut yr ydym yn creu gallu. Crybwyllais sut y bu i ni fanteisio i’r eithaf ar y cyfleoedd i gynnal dau ysbyty law yn llaw; credaf fod hynny wedi bod yn enghraifft ragorol. Eto, yr ydym yn gweithio’n hysbytai cymuned yn galed iawn.

The short stay unit, or the patients’ hotel, has been enormously helpful; it is a haven of 40 beds that can never be used for emergency treatment. That has proved its worth time and again. We can now treat patients within the short stay unit by having what we call a ‘second-stage recovery’, though that is limited. The patients’ hotel has single bedrooms with en-suite bathrooms where you have the opportunity to call a nurse, but you are not actually monitored by a nurse. Therefore, there have to be tight protocols that, once surgery has taken place, you go to your own room where you can have privacy, but you self-care for up to 24 hours.

Mae’r uned arhosiad byr, neu’r gwesty cleifion, wedi bod yn ddefnyddiol dros ben; mae’n hafan o 40 gwely na ellir byth eu defnyddio ar gyfer triniaethau brys. Mae wedi profi ei werth dro ar ôl tro. Gallwn yn awr drin cleifion yn yr uned arhosiad byr drwy gael yr hyn a elwir yn ‘wellhad ail gyfnod’, er bod hynny’n gyfyngedig. Mae gan y gwesty cleifion ystafelloedd sengl gydag ystafelloedd ymolchi en-suite lle mae gennych y cyfle i alw nyrs, ond nid ydych yn cael eich monitro mewn gwirionedd gan nyrs. Felly, mae’n rhaid cael protocolau llym eich bod, ar ôl y llawdriniaeth, yn mynd i’ch ystafell eich hun lle y cewch breifatrwydd, ond eich bod yn gofalu amdanoch chi eich hun am hyd at 24 awr.

We have now introduced what we call a second-stage recovery, where patients that have higher intermediate surgery will go to second-stage recovery first until they are deemed to be safe to self-care. The clinicians worked this idea through themselves; they came to me and said ‘We think that we can actually improve the way we use this system’.

Yr ydym bellach wedi cyflwyno’r hyn a elwir gennym yn wellhad ail gyfnod, lle mae cleifion sy’n cael llawdriniaeth ganolraddol uwch yn mynd i wellhad ail gyfnod i ddechrau hyd y pennir eu bod yn ddiogel, ac y gallant wedyn ofalu am eu hunain. Bu i’r clinigwyr weithio drwy’r syniad hwn ymhlith ei gilydd; daethant ataf a dweud ‘Credwn y gallwn wella’r ffordd yr ydym yn defnyddio’r system hon’.

We have driven our day surgery hard in terms of how we use it. We have now moved our day surgery rates up to 80 per cent. That obviously creates capacity on the in-patient side. We have also been working very hard in relation to down-time in theatres, or up-time, if you like, which means that we are now using our theatres 95 per cent. We are still working hard to see whether we can get that other 5 per cent back in the system.

Yr ydym wedi gyrru ein meddygfa dydd yn galed o ran y ffordd yr ydym yn ei defnyddio. Yr ydym bellach wedi cynyddu ein cyfraddau meddygfa dydd i fyny i 80 y cant. Mae hynny’n amlwg yn creu gallu o ran cleifion mewnol. Yr ydym hefyd wedi bod yn gweithio’n galed iawn mewn perthynas ag amser segur yn y theatrau, neu’r amser mynd os dymunwch, sy’n golygu ein bod bellach yn defnyddio ein theatrau 95 y cant. Yr ydym yn parhau i weithio’n galed i weld os gallwn gael y 5 y cant arall yn ôl yn y system.

We have also, as Mr Ross mentioned, been looking at our process, because the quicker that one can move the patients smoothly through the system, the better. That has included developing a discharge lounge. We are trying to get to what we call the ‘magic hour’, which means that by 10 a.m. every day, if patients are ready to go home, they are moved off the wards, rather like checking out of a hotel at a particular time. That then

Yr ydym hefyd, fel y crybwyllodd Mr Ross, wedi bod yn edrych ar ein proses, oherwydd gorau po gyntaf y gallwn symud y cleifion yn rhwydd drwy’r system. Mae hynny wedi cynnwys datblygu lolfa ryddhau. Yr ydym yn ceisio cyrraedd yr hyn a elwir yr ‘awr hud’, sy’n golygu erbyn 10 a.m. bob diwrnod, os yw cleifion yn barod i fynd gartref, eu bod yn cael eu symud oddi ar y wardiau, ychydig fel gadael gwesty ar amser penodol. Mae hynny

means that cleaners have time to come in and get the wards spruced up and ward teams can be ready to receive their next patients. So, a lot of work is going on around these kinds of issues to deal with these particular difficulties. I could go on, but those are just some examples.

wedyn yn golygu bod gan y glanhawyr amser i ddod i mewn a glanhau'r wardiau a gall timau ward fod yn barod i dderbyn eu cleifion nesaf. Felly, mae llawer o waith yn cael ei wneud ar y mathau hyn o faterion i ddelio â'r anawsterau penodol hyn. Gallwn fynd ymlaen, ond dim ond rhai enghreifftiau yw'r rhain.

Mr Ross: I will not repeat the kind of good-practice examples that Paul has given. We are also seeking to work on and improve our performance in all of those areas. There are a couple of things worth adding. First, traditional definitions of day surgery need to be rethought. For example, our ambulatory care unit can now work right through to the early evening, patients can be kept overnight and discharged early in the morning. The length of a patient's stay is now only 12, 13 or 14 hours but, because such patients stay overnight, they do not count as a day case. Therefore, they do not show up on one set of indicators, and so the traditional definitions are no longer keeping pace with changing clinical practice. In fact, if we include those kinds of patients in our figures, we are into the high 70s against the basket of procedures. There is still room for improvement in areas such as arthroscopies, but we are working on it all the time.

Mr Ross: Nid wyf am ailadrodd y math o enghreifftiau arferion da y mae Paul wedi'u rhoi. Yr ydym hefyd yn ceisio gweithio ar ein perfformiad a'i wella yn yr holl feysydd hynny. Mae un neu ddau o bethau sy'n werth eu hychwanegu. Yn gyntaf, mae angen ailystyried y diffiniadau traddodiadol o lawdriniaeth dydd. Er enghraifft, gall ein huned triniaethau dydd bellach weithio ymlaen i fin nos, gellir cadw cleifion dros nos a'u rhyddhau ben bore. Er mai dim ond 12, 13 i 14 awr yw hyd arhosiad claf, oherwydd bod y fath gleifion yn aros dros nos, nid ydynt yn cael eu cyfrif yn achosion dydd. Felly, nid ydynt yn ymddangos ar un gyfres o ddangosyddion, ac felly nid yw'r diffiniadau traddodiadol bellach yn berthnasol i arfer clinigol newidiol. Yn wir, o gynnwys y mathau hynny o gleifion yn ein ffigurau, yr ydym ymhell yn y 70au yn ôl y casgliad o weithdrefnau. Mae lle i wella o hyd mewn meysydd fel cymalsyllu, ond yr ydym yn gweithio ar hyn drwy'r amser.

Traditional issues, such as theatre utilisation and efficiency, are also very important. That is a particularly difficult issue for our trust

Mae materion traddodiadol, fel defnyddio ac effeithlonrwydd theatr, hefyd yn bwysig iawn. Mae hynny'n fater arbennig o anodd

because of the increasing complexity of the cancer work and so on that we do, where single operations can take up an operating theatre for an entire day. As our case mix changes, and as more and more specialist work comes to Cardiff and Vale from the district general hospitals across south-east Wales, the pressures on our theatre facilities for these lengthy and complex cases, and the knock-on effect on our critical-care facilities get greater and greater. That is a problem for us, because this is not necessarily a managed movement; it is a drift. The necessary resources to do all that we should be doing do not necessarily follow at the pace that I would wish. It is a constant debate that I have with commissioners and the regional office and so on. Nevertheless, theatre utilisation is very important, and we are spreading good practice in terms of good pre-operative assessment in all areas. We are still not at 100 per cent, but that is a way in which you can avoid patients cancelling operations or their operations being cancelled at short notice. Our figures are different from most of NHS Wales's figures, in that they show that most of our theatre cancellations are down to bed availability problems, rather than other issues. That suggests that we are doing our pre-operative assessments and other things well.

i'n hymddiriedolaeth oherwydd cymhlethdod cynyddol y gwaith canser ac ati a wnawn, lle gall llawdriniaethau unigol feddiannu theatr llawdriniaeth am ddiwrnod cyfan. Wrth i'n cymysgedd achosion newid, ac wrth i fwy a mwy o waith arbenigol ddod i Gaerdydd a'r Fro o'r ysbytai cyffredinol dosbarth ledled y De-ddwyrain, mae'r pwysau ar ein cyfleusterau theatr ar gyfer yr achosion hirfaith a chymhleth hyn, a'r sgil-effaith ar ein cyfleusterau gofal critigol yn cynyddu mwy a mwy. Mae hon yn broblem i ni, oherwydd nid yw hyn o reidrwydd yn symudiad a reolir; mae'n drifftio. Nid yw'r adnoddau sydd eu hangen i wneud yr holl bethau y dylem fod yn eu gwneud o reidrwydd yn dod ar y cyflymdra y byddem yn ei ddymuno. Mae'n drafodaeth gyson yr wyf yn ei chael gyda chomisiynwyr a'r swyddfa ranbarthol ac ati. Fodd bynnag, mae'r defnydd o'r theatr yn bwysig iawn, ac yr ydym yn lledaenu arferion da o ran asesiadau cyn-llawdriniaeth ym mhob maes. Nid ydym wedi cyrraedd 100 y cant eto, ond mae honno'n ffordd y gallwch osgoi bod cleifion yn canslo llawdriniaethau neu bod eu llawdriniaethau yn cael eu canslo ar fyr-rybudd. Mae ein ffigurau yn wahanol i ffigurau GIG Cymru ar y cyfan, oherwydd eu bod yn dangos mai problemau gyda'r gwelyau sydd ar gael sy'n gyfrifol am y rhan fwyaf o'r achosion o ganslo yn y theatr, yn hytrach na materion eraill. Mae hynny'n awgrymu ein bod yn gwneud ein hasesiadau cyn-llawdriniaeth a phethau eraill yn dda.

I do not think there is anything else I wish to

Ni chredaf fod unrhyw beth arall yr hoffwn ei

add, other than to supplement what Paul has said.

ychwanegu, ar wahân i ategu'r hyn y dywedodd Paul.

Ms Perrin: From a Swansea perspective, there are a lot of very similar initiatives. We are process-mapping the patient journey across a range of specialties to look at where we can take inefficiencies out of the system. There is also a range of work going on at the moment to improve the throughput of patients. Building work is under way at Morriston Hospital to create a new medical assessment unit by June or July, which will work in the way that Paul has discussed. At the moment, Singleton Hospital is the only general hospital in Wales that does not have a day-case unit, but it will have one that is up and running by this summer. So, there are capital developments going on to improve the way in which patients are treated in the system.

Ms Perrin: O safbwynt Abertawe, mae llawer o fentrau tebyg iawn. Yr ydym yn proses-fapio llwybr y claf ar draws amrywiaeth o feysydd arbenigol er mwyn edrych ar ymhle y gallwn waredu aneffeithlonrwydd o'r system. Mae amrywiaeth o waith yn cael ei wneud ar hyn o bryd hefyd i wella trwybwn cleifion. Mae gwaith adeiladu ar y gweill yn Ysbyty Treforys i greu uned asesu meddygol newydd erbyn Mehefin neu Orffennaf, a fydd yn gweithio yn y ffordd y trafododd Paul. Ar hyn o bryd, Ysbyty Singleton yw'r unig ysbyty cyffredinol yng Nghymru heb uned achosion dydd, ond bydd un ar waith yno erbyn yr haf. Felly, mae datblygiadau cyfalaf ar y gweill i wella'r ffordd y mae cleifion yn cael eu trin yn y system.

There are also some very simple examples—we have, physically, based a district nurse in the accident and emergency department at Morriston Hospital, and a number of patients who would otherwise have been admitted are able to be discharged straight from accident and emergency, because the district nurse is able to advise on the homecare packages available. So, there is a range of initiatives, ranging from the quite expensive, dependent on capital and revenue resource availability from our commissioners, to reorganising the way in which we work, which has a high impact.

Mae rhai enghreifftiau syml iawn hefyd—yr ydym, yn ffisegol, wedi lleoli nyrs ardal yn yr adran damweiniau ac achosion brys yn Ysbyty Treforys, ac mae nifer o gleifion a fyddai wedi'u derbyn fel arall yn gallu mynd gartref yn syth o'r adran damweiniau ac achosion brys, oherwydd bod y nyrs ardal yn gallu cynghori ar y pecynnau gofal cartref sydd ar gael. Felly, mae amrywiaeth o fentrau, yn amrywio o'r rhai eithaf drud, sy'n dibynnu ar yr adnoddau cyfalaf a refeniw sydd ar gael gan ein comisiynwyr, i ad-drefnu'r ffordd yr ydym yn gweithio, sy'n cael effaith sylweddol.

[313] **Leighton Andrews:** Delayed transfers of care are covered in paragraphs 3.33 to 3.35. I think that you have already commented on them, Mr Williams, although feel free to add any comments, should you wish. I ask Jane Perrin and Hugh Ross specifically what they see as the overall trends and impacts for delayed transfers of care in their communities, particularly in relation to waiting times, and what they are doing to tackle the problems that they are identifying.

[313] **Leighton Andrews:** Trafodir oedi wrth drosglwyddo gofal ym mharagraffau 3.33 i 3.35. Credaf eich bod wedi rhoi sylwadau arnynt eisoes, Mr Williams, er bod croeso i chi ychwanegu unrhyw sylwadau, os dymunwch. Gofynnaf i Jane Perrin a Hugh Ross yn benodol beth yn eu barn hwy yw tueddiadau ac effeithiau cyffredinol oedi wrth drosglwyddo gofal yn eu cymunedau, yn arbennig mewn cysylltiad ag amseroedd aros, a beth y maent yn ei wneud i fynd i'r afael â'r problemau y maent yn eu nodi.

Ms Perrin: As of the end of January, we had 83 patients that we would classify as delayed transfers of care. We started off last year with about 120 patients, and we came down to an all-time low of around 59 patients over the summer, but that figure has crept upwards in terms of how we are dealing with the issue. Of those 83 patients, 73 are acute patients, and 10 are patients with mental health problems, whom we are trying to move back into the community. We are working quite closely with our local health boards, social services and other trusts. I assume that the situation is the same in Cardiff but, because of the complex and tertiary workload that we undertake, a number of our patients are waiting for transfer back to their home locations, or back into community hospitals elsewhere in the NHS.

Ms Perrin: Ar ddiwedd mis Ionawr, yr oedd gennym 83 o gleifion y byddem yn eu dosbarthu fel rhai oedi wrth drosglwyddo gofal. Yr oedd gennym oddeutu 120 o gleifion ar ddechrau'r llynedd, a daethom i lawr i'r nifer isaf erioed o 59 o gleifion dros yr haf, ond mae'r ffigur hwnnw wedi cynyddu'n raddol o ran sut yr ydym yn delio gyda'r mater. O'r 83 o gleifion hynny, mae 73 yn gleifion acíwt, ac mae 10 yn gleifion gyda phroblemau iechyd meddwl, yr ydym yn ceisio'u symud yn ôl i'r gymuned. Yr ydym yn gweithio'n gymharol agos gyda'n byrddau iechyd lleol, gwasanaethau cymdeithasol ac ymddiriedolaethau eraill. Tybiaf fod y sefyllfa'r un fath yng Nghaerdydd ond, oherwydd y llwyth gwaith cymhleth a thrydyddol yr ydym yn ymgymryd ag ef, mae llawer o'n cleifion yn aros i gael eu trosglwyddo yn ôl i'w cartrefi, neu yn ôl i ysbytai cymuned mewn mannau eraill yn y GIG.

We are working closely in partnership, and more money has been made available to social services. However, in many ways, we are seeing the effect of market forces on care homes and must assess whether or not we are using that money as effectively as we might in order to crack delayed transfers of care. I do not think that we are currently maximising the impact of additional resources.

Yr ydym yn gweithio'n agos mewn partneriaeth, a neulltiwyd rhagor o arian i wasanaethau cymdeithasol. Fodd bynnag, mewn sawl ffordd, yr ydym yn gweld effaith grymoedd y farchnad ar gartrefi gofal ac mae'n rhaid i ni asesu a ydym yn defnyddio'r arian mor effeithiol ag y gallem er mwyn dileu oedi wrth drosglwyddo gofal. Ni chredaf ein bod yn gwneud y defnydd gorau o effaith adnoddau ychwanegol ar hyn o bryd.

[314] **Leighton Andrews:** Can you explain that, please?

[314] **Leighton Andrews:** A allwch egluro hynny, os gwelwch yn dda?

Ms Perrin: The extra money received by social services—certainly in Swansea—has been used to pay increased rates in care homes, rather than to focus on some of the true issues of ensuring better discharge planning and reducing those delayed transfers of care. That is not unique to Swansea.

Ms Perrin: Mae'r arian ychwanegol a dderbyniwyd gan wasanaethau cymdeithasol—yn sicr yn Abertawe—wedi'i ddefnyddio i dalu cyfraddau uwch mewn cartrefi gofal, yn hytrach na chanolbwyntio ar rai o'r materion gwirioneddol o sicrhau bod gwell cynllunio wrth ryddhau cleifion o'r ysbyty a bod yr oedi wrth drosglwyddo gofal yn cael ei ostwng. Nid yw hynny'n unigryw i Abertawe.

Mr Ross: Starting with the end of the question, there has been an impact on elective care, as substantial numbers of delayed transfers of care block beds, which means that a number of medical patients overspill into unprotected surgical capacity, which cannot then be used, as intended, for waiting-

Mr Ross: Gan ddechrau gyda diwedd y cwestiwn, cafwyd effaith ar ofal dewisol, gyda llawer o flocio gwelyau oherwydd oedi wrth drosglwyddo gofal, sy'n golygu bod nifer o gleifion meddygol yn defnyddio'r gallu llawdriniaethol diamddiffyn, na ellir ei ddefnyddio felly, yn unol â'r bwriad, ar gyfer

list patients. It ripples right back through the system, as I explained earlier. The situation in Cardiff and Vale is serious. The number of delayed transfers of care at the end of January was 203, which is back where the trust was a year ago, notwithstanding some good progress in the form of a downward trend earlier in the year. Of those 203 patients, 128 were general patients and some 75 were mental-health patients. Although mental-health patients might be considered a slightly separate issue, they sometimes, because they have mental-health and general-health problems, occupy acute general beds as opposed to mental-health facilities. Therefore, they too—and I do not want this to sound wrong—are part of the issue of elective care.

cleifion rhestrau aros. Mae hyn yn treiddio yn ôl drwy'r system, fel yr eglurais yn gynharach. Mae'r sefyllfa'n un ddifrifol yng Nghaerdydd a'r Fro. Yr oedd nifer yr achosion o oedi wrth drosglwyddo gofal ar ddiwedd Ionawr yn 203, sef lle yr oedd yr ymddiriedolaeth flwyddyn yn ôl, er gwaethaf peth cynnydd da o ganlyniad i duedd ddisgynnol yn gynharach yn y flwyddyn. O'r 203 o gleifion hynny, yr oedd 128 yn gleifion cyffredinol ac yr oedd 75 yn gleifion iechyd meddwl. Er y gellir ystyried cleifion iechyd meddwl yn fater ar wahân i raddau, oherwydd bod ganddynt broblemau iechyd meddwl ac iechyd cyffredinol, maent weithiau yn meddiannu gwelyau cyffredinol acíwt yn hytrach na chyfleusterau iechyd meddwl. Felly, maent hefyd—ac nid wyf am i hyn swnio'n anghywir—yn rhan o'r mater gofal dewisol.

What are we doing about this? For the first time, we have all five statutory agencies involved—two local authorities, two local health boards and the trust—working on a single action plan covering everything from primary care to demand management, right through to delayed transfers of care, so that we can all see the whole picture. That is something that I have developed in the last two or three weeks to ensure that everyone knows their role in this process. Local authorities are aware of the problem but, in Cardiff in particular, they are hugely handicapped by the continuing decline in capacity. Around 15 per cent of beds have been lost in the private sector in recent years,

Beth yr ydym yn ei wneud am hyn? Am y tro cyntaf, mae pob un o'r pum asiantaeth statudol yn cymryd rhan—dau awdurdod lleol, dau fwrdd iechyd lleol a'r ymddiriedolaeth—gan weithio ar gynllun gweithredu unigol sy'n cynnwys popeth o ofal sylfaenol i reoli gofynion, i oedi wrth drosglwyddo gofal, er mwyn i bob un ohonom allu gweld y darlun cyflawn. Mae hynny'n rhywbeth yr wyf wedi'i ddatblygu yn y pythefnos i dair wythnos ddiwethaf i sicrhau bod pawb yn ymwybodol o'u rôl yn y broses hon. Mae awdurdodau lleol yn ymwybodol o'r broblem ond, yng Nghaerdydd yn benodol, maent dan anfantais enfawr oherwydd y gostyngiad parhaus

and the trend is still downwards, and we expect another nursing home to close in Cardiff in the coming months.

mewn gallu. Collwyd oddeutu 15 y cant o welyau yn y sector preifat yn y blynyddoedd diwethaf, ac maent yn parhau i ostwng, ac yr ydym yn disgwyl i gartref nyrsio arall gau yng Nghaerdydd yn y misoedd nesaf.

Of the 13 general nursing homes in Cardiff, only three will accept the rates that are paid by Cardiff council. The other 10 homes demand that a top-up is paid by the patients or their relatives. Unsurprisingly, the queue for the three homes is very long, and those who exercise choice stay in our system for a considerable time. We have patients in our beds who have been waiting for their nursing home of choice for many months. When measured in bed days, as opposed to numbers of patients, it runs into the many thousands. We are trying to do all that we possibly can to develop imaginative ways of freeing up the system. We are considering possibilities such as using other local authority facilities that have become redundant or could be used for patient care for those who need continuing care and support, and we are looking at ways of providing intensive home support in a way that will enable people to be supported and maintained at home rather than having to go to a nursing or residential home. We have also considered ways for us to stimulate the marketplace to increase the capacity, which is extremely difficult. I have spent a great deal of time talking to colleagues in Cardiff council in particular, and the chairman of the trust and I are meeting them again next week to discuss this issue and others.

O’r 13 cartref nyrsio cyffredinol yng Nghaerdydd, dim ond tri a fydd yn derbyn y cyfraddau a delir gan gyngor Caerdydd. Mae’r 10 cartref arall yn mynnu bod ffi ychwanegol yn cael ei dalu gan y cleifion neu eu perthnasau. Nid yw’n syndod bod y ciw am y tri chartref yn hir iawn, ac mae’r rheini sy’n ymarfer dewis yn aros yn ein system am gryn amser. Mae gennym gleifion yn ein gwelyau sydd wedi bod yn aros am y cartref nyrsio o’u dewis ers misoedd lawer. Wrth fesur hyn mewn dyddiau gwely, yn hytrach na niferoedd y cleifion, mae’n filoedd ar filoedd. Yr ydym yn ceisio gwneud popeth o fewn ein gallu i ddatblygu ffyrdd llawn dychymyg o ryddhau’r system. Yr ydym yn ystyried posibiliadau fel defnyddio, neu o bosibl defnyddio, cyfleusterau awdurdod lleol eraill sy’n segur ar gyfer gofal i gleifion i’r rheini sydd angen gofal a chymorth parhaus, ac yr ydym yn edrych ar ffyrdd o ddarparu cymorth cartref dwys mewn modd a fydd yn galluogi pobl i gael cymorth a chynhaliaeth yn y cartref yn hytrach na gorfod mynd i gartref nyrsio neu breswyl. Yr ydym hefyd wedi ystyried ffyrdd o sbarduno’r farchnad i gynyddu’r gallu, sy’n anodd iawn. Yr wyf wedi treulio llawer o amser yn siarad â chydweithwyr yng nghyngor Caerdydd yn benodol, ac mae cadeirydd yr ymddiriedolaeth a minnau yn eu

cyfarfod eto yr wythnos nesaf i drafod y mater hwn ac eraill.

This inhibits our activity enormously. Over 10 per cent of our beds are occupied by delayed transfers of care. Some 70 patients in general-health beds are awaiting their nursing home of choice. If we could solve one problem in the trust in the next 12 months, this would be my No. 1 by some distance.

Mae hyn yn rhwystro ein gweithgarwch yn sylweddol. Mae dros 10 y cant o'n gwelyau yn cael eu meddiannu gan oedi wrth drosglwyddo gofal. Mae oddeutu 70 o gleifion mewn gwelyau iechyd cyffredinol yn aros am y cartref nyrsio o'u dewis. Pe gallem ddatrys un broblem yn yr ymddiriedolaeth yn y 12 mis nesaf, dyma fyddai fy mlaenoriaeth o bell ffordd.

[315] **Leighton Andrews:** Mr Williams, you mentioned your partnership board arrangement; could you comment on that as a model for others?

[315] **Leighton Andrews:** Mr Williams, bu i chi grybwyll eich trefniant bwrdd partneriaeth; a ellwch roi sylwadau ar hynny fel model ar gyfer eraill?

Mr Williams: I do not think that the model is unique. What happened, simply, is that when we reorganised the health service, the statutory partners were the local health boards and the local authorities. The trust was not part of those partnerships, but to the credit of both my LHBs and local authorities, they immediately invited the trust to be almost a full partner without the legal connotations associated with that. This has developed a real ownership of a 'whole systems' concept. If I have beds blocked, that harms the whole system, although the consequences for social services may not be such an immediate problem. By working together—saying that 'whole systems' means that everybody has to contribute, that we all

Mr Williams: Ni chredaf fod y model yn unigryw. Yr hyn a ddigwyddodd, yn syml, oedd wrth i ni ad-drefnu'r gwasanaeth iechyd, mai'r partneriaid statudol oedd y byrddau iechyd lleol a'r awdurdodau lleol. Nid oedd yr ymddiriedolaeth yn rhan o'r partneriaethau hynny, ond er clod i fy BILl a'm hawdurdodau lleol, bu iddynt ofyn yn syth i'r ymddiriedolaeth fod yn bartner llawn bron iawn heb yr arwyddocâd cyfreithiol sy'n gysylltiedig â hynny. Mae hyn wedi datblygu perchnogaeth wirioneddol o gysyniad 'systemau cyfan'. Os oes gennyf flocio gwelyau, mae hynny'n niweidio'r system gyfan, er na fydd y canlyniadau i'r gwasanaethau cymdeithasol yn broblem ar unwaith o bosibl. Drwy weithio gyda'n

have a part to play and that we all have to understand each other's problems—we can take really exciting approaches.

gilydd—gan ddweud bod 'systemau cyfan' yn golygu bod pawb yn gorfod cyfrannu, bod gennym i gyd ran i'w chwarae a bod yn rhaid i ni gyd ddeall problemau ein gilydd—gallwn gymryd camau cyffrous iawn.

The issues around choice for us are certainly a lot simpler than some of the difficulties in Cardiff. The spread of accommodation in Bridgend, for instance, is fairly attractive; that is not so much the case in Neath, but my colleagues in Neath Port Talbot County Borough Council—to their credit—saw the need to tackle improving the range of accommodation available, and over the last 18 months, they have acted on it, so we are now seeing a significant improvement. Even when our numbers are small, this issue of choice, with patients and families having a sanction on what is available, still causes many difficulties.

Mae'r materion ynghylch dewis i ni yn sicr yn llawer symlach na rhai o'r anawsterau yng Nghaerdydd. Mae'r amrywiaeth o lety ym Mhen-y-bont ar Ogwr, er enghraifft, yn eithaf dymunol; nid yw hynny'n wir yng Nghastell-nedd, ond gwelodd fy nghydweithwyr yng Nghyngor Bwrdeistref Sirol Castell-nedd Port Talbot—er mawr clod iddynt—yr angen i fynd i'r afael â gwella'r amrywiaeth o lety sydd ar gael, a thros y 18 mis diwethaf, maent wedi gweithredu ar hyn, felly yr ydym yn awr yn gweld gwelliant sylweddol. Hyd yn oed pan fo'n niferoedd yn isel, mae'r mater hwn o ddewis, gyda chleifion a theuluoedd yn cael cymeradwyo yr hyn sydd ar gael, yn parhau i achosi llawer o anawsterau.

[316] **Leighton Andrews:** My final questions are on waiting-times strategy and performance management, aimed at you all. Is it not true to say that a culture of missing waiting-time targets has developed within NHS Wales?

[316] **Leighton Andrews:** Mae fy nghwestiynau olaf ar strategaeth amseroedd aros a rheoli perfformiad, sydd ar eich cyfer i gyd. Onid yw'n wir dweud bod diwylliant o fethu targedau amseroedd aros wedi'i ddatblygu yn GIG Cymru?

Mr Williams: It is not a culture that I would acknowledge.

Mr Williams: Nid yw'n ddiwylliant y byddwn yn ei gydnabod.

Ms Perrin: I think that it is difficult to generalise. By and large, Swansea has hit the targets that have been set for it over the past couple of years. We are certainly on target to do so again this year.

Ms Perrin: Credaf ei bod yn anodd cyffredinoli hyn. Ar y cyfan, mae Abertawe wedi cyflawni'r targedau a osodwyd ar ei gyfer yn ystod yr ychydig flynyddoedd diwethaf. Yr ydym yn sicr ar y trywydd iawn i wneud hynny eto eleni.

Mr Ross: The report states that this culture existed in the past, but it is not one that I recognise. I have made it clear to everyone in the trust that hitting targets must be a top priority.

Mr Ross: Mae'r adroddiad yn nodi bod y diwylliant hwn wedi bodoli yn y gorffennol, ond nid yw'n un yr wyf yn ei adnabod. Yr wyf wedi nodi'n glir wrth bawb yn yr ymddiriedolaeth bod yn rhaid rhoi blaenoriaeth i gyflawni'r targedau.

[317] **Leighton Andrews:** Do you think that the Assembly Government should develop more effective incentives and sanctions to address this issue?

[317] **Leighton Andrews:** A ydych yn credu y dylai Llywodraeth y Cynulliad ddatblygu cymhellion a chosbau mwy effeithiol i fynd i'r afael â'r mater hwn?

Mr Ross: I would like to see long-term, clear targets set down by the Assembly. For example, it could say that it would take a three-year approach towards achieving a certain point by 2008. We would make sure that we drove the system to be as efficient and effective as possible, to get the absolute maximum out of every penny spent, but that we would think imaginatively about the extra capacity needed to drive down waiting times.

Mr Ross: Hoffwn weld y Cynulliad yn gosod targedau hirdymor, clir. Er enghraifft, gallai ddweud y byddai'n cymryd ymagwedd dair blynedd at gyflawni pwynt penodol erbyn 2008. Byddem yn sicrhau ein bod yn gweithredu'r system i fod mor effeithiol ac effeithlon â phosibl, i gael y gorau o bob ceiniog sy'n cael ei gwario, ond y byddem yn defnyddio'n dychymyg i feddwl am y gallu ychwanegol sydd ei angen i ostwng amseroedd aros.

The capacity issue is a genuine one. There is an example in the report of a trust which has an annual level of referrals twice what it is

Mae'r mater gallu yn un dilys. Mae enghraifft yn yr adroddiad o ymddiriedolaeth sydd â lefel cyfeiriadau blynyddol ddwywaith

paid to treat; that is my trust in orthopaedics. We currently have a significant gap between what commissioners are able to commission and what is required. We are going to require some imaginative approaches, as part of what I would like to see, which is a three-year strategy, to ensure that NHS Wales gets to the level of maximum waiting times that we would all wish to see. That is a personal view, but I sense that there is a growing consensus that that is the right way forward, and I sincerely hope that we can make significant progress along those lines in the next two or three years.

cymaint â'r hyn y telir iddi ei thrin; sef fy ymddiriedolaeth ym maes orthopedeg. Ar hyn o bryd mae gennym fwlch sylweddol rhwng yr hyn y gall comisiynwyr ei gomisiynu a'r hyn sy'n ofynnol. Bydd angen agweddau llawn dychymyg arnom, fel rhan o'r hyn yr hoffwn ei weld, sef strategaeth tair blynedd, er mwyn sicrhau bod GIG Cymru yn cyrraedd y lefel amseroedd aros uchaf bosibl yr ydym i gyd am ei gweld. Barn bersonol yw honno, ond credaf fod consensws cynyddol mai dyna'r ffordd iawn ymlaen, a gobeithiaf yn ddiffuant y gallwn wneud cynnydd sylweddol ar hyd y trywydd hwnnw yn y ddwy i dair blynedd nesaf.

Ms Perrin: I would agree with you about different incentives and levers. It is important that we look at that on a whole-system basis across trusts, local health boards and the whole health community, if you like, because they all have an impact on each other. As we pointed out earlier, we have been living with non-recurrent waiting-list initiatives for a number of years now. We need to find recurrent, sustainable solutions around capacity and working differently across NHS Wales.

Ms Perrin: Byddwn yn cytuno gyda chi am y gwahanol gymhellion a dulliau. Mae'n bwysig ein bod yn edrych ar hynny ar sail system gyfan ar draws ymddiriedolaethau, byrddau iechyd lleol a'r gymuned iechyd gyfan, os dymunwch, oherwydd maent i gyd yn effeithio ar ei gilydd. Fel y bu i ni sôn yn gynharach, yr ydym wedi bod yn byw gyda mentrau rhestrau aros anghylchol ers blynyddoedd bellach. Mae angen i ni ganfod atebion rheolaidd, cynaliadwy ynghylch gallu a gweithio'n wahanol ar draws GIG Cymru.

Mr Williams: I do not think that there is any substitute for a coherent, sustainable plan. If incentives have a place, then they have certainly been slow in coming in Wales. In fact, I enjoyed, for the first time, an incentive payment this year, but it is non-recurring and there is very little that I can do with it to

Mr Williams: Credaf nad oes unrhyw beth i gymryd lle cynllun cydlynol, cynaliadwy. Os oes gan gymhellion le, yna maent yn sicr wedi bod yn araf yn cyrraedd Cymru. Yn wir, derbyniais, am y tro cyntaf, gymelldaliad eleni, ond mae'n anghylchol ac ni allaf wneud llawer gydag ef i sbarduno neu roi'r

stimulate or roll-out the projects that we discussed earlier. So, it has been useful to put more equipment in the front line, but it has been quite modest. Incentives in England have been fairly substantial—£1 million for a three-star trust—but that sort of money has not been available in Wales. However, ultimately, we need an effective, coherent, sustainable plan.

prosiectau y bu i ni eu trafod yn gynharach ar waith fesul cam. Felly, mae wedi bod yn ddefnyddiol i roi rhagor o gyfarpar ar y rheng flaen, ond mae wedi bod yn gymharol ddi-nod. Mae'r cymhellion yn Lloegr wedi bod yn eithaf sylweddol—£1 miliwn ar gyfer ymddiriedolaeth tair seren—ond nid oes arian tebyg wedi bod ar gael yng Nghymru. Fodd bynnag, yn y pen draw, mae angen cynllun effeithiol, cydlynol a chynaliadwy arnom.

[318] **Leighton Andrews:** As Mr Ross and—

[318] **Leighton Andrews:** Fel Mr Ross a—

[319] **Janet Davies:** I am sorry, Leighton, but you only have another two minutes.

[319] **Janet Davies:** Mae'n ddrwg gennyf, Leighton, ond dim ond dau funud arall sydd gennych.

[320] **Leighton Andrews:** Okay. In that case, I will just ask Mr Williams one question. Some trusts were allowed to breach the Government's minimum targets on the 2003-04 service and financial framework—yours was not one of them. Does this not undermine the incentive for you as a better-performing trust to improve waiting times?

[320] **Leighton Andrews:** Iawn. Os felly, yr wyf am ofyn un cwestiwn i Mr Williams. Caniatawyd rhai ymddiriedolaethau i dorri targedau gofynnol y Llywodraeth yn fframwaith gwasanaeth a chyllid 2003-04—nid oedd eich un chi yn un ohonynt. Onid yw hyn yn tanseilio'r cymhelliant i chi fel ymddiriedolaeth sy'n perfformio'n well i wella amseroedd aros?

Mr Williams: Yes, it does. If we drive the organisation hard—and we do drive it hard—it stretches the loyalty of the clinical staff to extremes at times. They ask why we are doing this if other organisation are breaching. So, there are some sort of perverse incentives

Mr Williams: Ydy, mae hynny'n wir. Os ydym yn gweithio'r sefydliad yn galed—ac yr ydym yn ei weithio'n galed—mae'n rhoi straen enfawr ar deyrngarwch y staff clinigol o bryd i'w gilydd. Maent yn gofyn pam ein bod yn gwneud hyn os yw sefydliadau eraill

in that, if you get better, you are not necessarily rewarded. That is not about a personal reward for me, but about a way in which the clinical staff can relate to why we want to do these things. That is one of the subtle issues in terms of the incentivisation. You get into all sorts of issues of differential waiting times and all sorts of other things, but we must find a way of capturing people's imagination and get everybody behind this to drive it forward.

yn torri'r addewidion. Felly, mae rhyw fath o gymhellion gwrthnysig yn hynny sef, os ydych yn gwella, nid ydych yn cael eich gwobrwyo o bosibl. Nid yw hynny'n golygu gwobr bersonol i mi, ond mae'n golygu ffordd y gall staff clinigol uniaethu â pham ein bod am wneud y pethau hyn. Mae hynny'n un o'r materion cynnil o ran y cymhelliant. Yr ydych yn wynebu pob math o faterion o amseroedd aros gwahanol a phob math o bethau eraill, ond mae'n rhaid i ni ganfod ffordd o danio dychymyg pobl a chael pawb i gefnogi hyn i'w yrru ymlaen.

[321] **Janet Davies:** Thank you. You have five minutes, Alun.

[321] **Janet Davies:** Diolch. Mae gennych bum munud, Alun.

[322] **Alun Cairns:** I will ask questions of all three witnesses, Cadeirydd. I refer to paragraphs 4.21 in volume 2 and paragraphs 4.41 to 4.44, where the Auditor General's report is critical of the use of waiting-times initiatives, their management and their sustainability. What are your views on the effectiveness of waiting-time initiatives? From the perspective of the trusts, could the money be spent more effectively? I would like to couple that with the answer that Mr Williams just gave about non-recurring funding—maybe that could be included in the answer.

[322] **Alun Cairns:** Yr wyf am ofyn cwestiynau i'r tri thyst, Gadeirydd. Cyfeiriaf at baragraffau 4.21 yng nghyfrol 2 a pharagraffau 4.41 i 4.44, lle mae adroddiad yr Archwilydd Cyffredinol yn feirniadol o'r defnydd o fentrau amseroedd aros, eu rheolaeth a'u cynaliadwyedd. Beth yw eich barn ar effeithlonrwydd y mentrau amseroedd aros? O safbwynt yr ymddiriedolaethau, a ellid gwario'r arian yn fwy effeithiol? Hoffwn gyplysu hynny gyda'r ateb y mae Mr Williams newydd ei roi am arian anghylchol—efallai y gellid cynnwys hynny yn yr ateb.

Mr Ross: My personal view is that waiting-time initiatives can be very effective, and they can result in measurable reductions in

Mr Ross: Yr wyf o'r farn y gall mentrau amseroedd aros fod yn effeithiol iawn, a gallant arwain at ostyngiadau mesuradwy

waiting times, but they do not necessarily address the underlying causes. As has already been said by one of my colleagues, when you do something on a non-recurring basis for the sixth time, it is probably giving you a pretty clear steer that you should be doing it on a recurring basis. That has led to the sorts of frustrations in the systems that Paul referred to.

mewn amseroedd aros, ond nid ydynt o reidrwydd yn mynd i'r afael â'r achosion sylfaenol. Fel y dywedodd un o'm cydweithwyr eisoes, wrth wneud rhywbeth ar sail anghylchol am y chweched tro, mae'n debyg bod hyn yn rhoi arwydd eithaf clir y dylech ei wneud ar sail gylchol. Mae hynny wedi arwain at y mathau o rwystredigaethau yn y systemau y cyfeiriodd Paul atynt.

The report suggests that some of the waiting-time initiatives in Wales have not been as cost effective as should have been the case in the past. I do not have any knowledge of that, but I do know that a great deal of care and attention is being paid to ensuring that the purchasing power available is used as effectively as possible in the current year. There has been a real focus on making sure that, for example, English NHS tariffs were used as benchmarks and so on, to ensure that as much value for money as possible was procured. Having said that, frankly, the best investment of all, I think, would be to make the sort of investment in NHS Wales that we have had through the second offer scheme in the trusts. We have brought some additional surgical facilities on-line; we have run them effectively with our own staff, they are protected facilities, and all the second-offer money goes directly into those facilities rather than into a private facility, for example. So, they have had a place. I would prefer, as I indicated just now, to see them replaced by a sustainable and resourced programme. If that meant that innovative ways of increasing the capacity in the short

Mae'r adroddiad yn awgrymu nad yw rhai o'r mentrau amseroedd aros yng Nghymru wedi bod mor gost effeithiol ag y dylent yn y gorffennol. Nid oes gennyf unrhyw wybodaeth am hynny, ond gwn fod llawr o ofal a sylw yn cael ei roi i sicrhau bod y gallu prynu sydd ar gael yn cael ei ddefnyddio mor effeithiol â phosibl yn y flwyddyn bresennol. Bu gwir ganolbwyntio ar sicrhau, er enghraifft, bod tariffau'r GIG yn Lloegr yn cael eu defnyddio fel meincnodau ac ati, i sicrhau ein bod yn cael cymaint o werth am arian â phosibl. Ar ôl dweud hynny, a bod yn blaen, y buddsoddiad gorau un, yn fy marn i, fyddai gwneud y math o fuddsoddiad yn GIG Cymru yr ydym wedi ei gael drwy gynllun yr ail gynnig yn yr ymddiriedolaethau. Yr ydym wedi dod â rhai cyfleusterau llawfeddygol ychwanegol ar-lein; yr ydym wedi'u gweithredu'n effeithiol gyda'n staff ein hunain, maent yn gyfleusterau a ddiogelir, ac mae holl arian cynlluniau'r ail gynnig yn mynd yn syth i'r cyfleusterau hynny yn hytrach nag i gyfleuster preifat, er enghraifft. Felly, mae ganddynt le. Byddai'n well gennyf, fel y dywedais yn awr, weld rhaglen gynaliadwy ac iddi adnoddau yn cymryd eu

term had to be found, then that is all well and good.

lle. Pe bai hynny’n golygu bod angen canfod ffyrdd arloesol o gynyddu gallu yn y tymor byr, popeth yn iawn.

Mr Williams: I will just reinforce that message. We keep using the terms ‘sustainable capacity’ and ‘sustainable improvement’, but we cannot emphasise this sufficiently. There is a very legitimate place in management for what we call ‘putting in a quick fix’, provided that, at the same time, you put in a medium to long-term plan. Waiting-list initiatives have put a quick fix in, year after year, which is inexpensive and inefficient. It is inexpensive and inefficient, because we also have the financial obligation not to overspend. You cannot hire an expensive team of staff and say, ‘By the way, in six months’ time, you will not have a job’. You therefore start to use overtime or the private sector, or start to pay over the odds to encourage people to do the work.

Mr Williams: Yr wyf am atgyfnerthu’r neges honno. Yr ydym yn parhau i ddefnyddio’r termau ‘gallu cynaliadwy’ a ‘gwelliant cynaliadwy’, ond ni allwn bwysleisio hyn ddigon. Mae lle dilys iawn ym maes rheoli i’r hyn a ddisgrifir fel ‘defnyddio ateb cyflym’, os, ar yr un pryd, eich bod yn gweithredu cynllun tymor canolig neu hirdymor. Mae mentrau rhestrau aros wedi bod yn ateb cyflym, flwyddyn ar ôl blwyddyn, sy’n rhad ac yn annigonol. Mae’n rhad ac yn annigonol, oherwydd bod gennym hefyd y rhwymedigaeth ariannol i beidio â gorwario. Ni allwch gyflogi tîm drud o staff a dweud, ‘Gyda llaw, mewn chwe mis, ni fydd gennych swydd’. Yr ydych felly’n dechrau defnyddio goramser neu’r sector preifat, neu’n dechrau talu gormod i annog pobl i wneud y gwaith.

If that money had been provided recurringly—and, as Hugh said, that money seems to be have been provided recurringly on a non-recurring basis, which seems to be a bit of a no-brainer to me—you could then have had significantly more value for money in terms of having a sound return on the investment. For me, there is nothing wrong with a quick fix. What I cannot see is the sustainable medium to long-term plan, and I think that we can certainly compete on equal terms—if not better—with the private sector

Pe bai’r arian hwnnw wedi’i ddarparu’n gylchol—ac, fel y dywedodd Hugh, ymddengys bod yr arian hwnnw wedi’i ddarparu’n gylchol ar sail anghylchol, sy’n ymddangos rhywfaint yn dwp i mi—byddech wedyn wedi gallu cael llawer rhagor o werth am arian o ran cael adenillion da ar y buddsoddiad. I mi, nid oes unrhyw beth o’i le gydag ateb cyflym. Yr hyn na allaf ei weld yw’r cynllun tymor canolig i hirdymor cynaliadwy, a chredaf y gallwn yn sicr gystadlu ar delerau cyfartal—os nad yn

in delivering these services, as this is our core business.

well—gyda'r sector preifat wrth ddarparu'r gwasanaethau hyn, oherwydd mai dyma'n busnes craidd.

Ms Perrin: I do not have anything else to add. I totally support the comments made by Hugh and Paul.

Ms Perrin: Nid oes gennyf unrhyw beth arall i'w ychwanegu. Yr wyf yn cytuno'n llwyr â sylwadau Hugh a Paul.

[323] **Alun Cairns:** Mr Ross and Ms Perrin, I recognise the progress that the trust has made in tackling long in-patient day-case waiting times, and also, to a lesser extent, out-patient waiting times. The trusts clearly experience long waiting lists with long tails. Has the level of expenditure on waiting-times initiatives provided a perverse incentive to your consultants to maintain long tails on the waiting lists, because it then forces people to use the private sector far more, which potentially could be more lucrative to them?

[323] **Alun Cairns:** Mr Ross a Ms Perrin, yr wyf yn cydnabod y cynnydd y mae'r ymddiriedolaeth wedi'i wneud wrth fynd i'r afael ag amseroedd aros hir achosion dydd cleifion mewnol, a hefyd, i raddau llai, amseroedd aros cleifion allanol. Mae'r ymddiriedolaethau yn amlwg yn wynebu amseroedd aros hir gyda chynffonau hir. A yw'r lefel gwariant ar fentrau amseroedd aros wedi darparu cymhelliant gwrthnysig i'ch meddygon ymgynghorol i gadw'r cynffonau hyn ar yr amseroedd aros, oherwydd ei fod wedyn yn gorfodi pobl i ddefnyddio llawer mwy o'r sector preifat, a allai o bosibl fod yn fwy proffidiol iddynt?

Ms Perrin: I do not think that the private practice is an issue in this part of the world, as it is, perhaps, elsewhere in the UK. Good waiting-list and waiting-time management is around treating patients in turn according to clinical priority. Work is certainly ongoing in Swansea to make sure that we are taking patients from the end of the lists, so that we are not, if you like, allowing consultants to just pick and choose what they want to do. It is a managed process to ensure that we are

Ms Perrin: Ni chredaf fod yr ymarfer preifat yn fater yn y rhan hon o'r byd, fel y mae, o bosibl, mewn mannau eraill yn y DU. Mae rhestrau aros da a rheoli amseroedd aros yn golygu trin cleifion yn unol â blaenoriaeth glinigol. Mae gwaith yn sicr yn cael ei wneud yn Abertawe i sicrhau ein bod yn cymryd cleifion o waelod y rhestrau, fel nad ydym, os dymunwch, yn gadael i feddygon ymgynghorol ddethol a dewis yr hyn y maent am ei wneud. Mae'n broses a reolir i sicrhau

treating patients in turn, according to the clinical priority of the patient.

ein bod yn trin cleifion yn eu tro, yn unol â blaenoriaeth glinigol y claf.

Mr Ross: There is no evidence to suggest that there has been motivation to keep waiting lists long in the way that you suggest. Problems around out-patients, traditionally, across the NHS—not just in Wales, but elsewhere—have been because perhaps the issue was not afforded as much attention as in-patient to day-case lists. I think that that is changing rapidly. The sorts of good practice guides to which Jane referred are now widely used. There is a real focus on reducing those waiting times. I am delighted to see that the Assembly also has that in its sights. The sooner that we get on with the business of reducing those out-patient waiting times, the sooner we will reduce the overall patient journey, which is still far too long.

Mr Ross: Nid oes tystiolaeth i awgrymu y bu cymhelliant i gadw rhestrau aros yn hir yn y ffordd yr ydych yn awgrymu. Mae'r problemau ynghylch cleifion allanol, yn draddodiadol, ledled y GIG—nid yng Nghymru yn unig, ond mewn mannau eraill—wedi bodoli oherwydd na roddwyd cymaint o sylw o bosibl i'r mater ag a roddir i restrau cleifion mewnol i achosion dydd. Credaf fod hynny'n newid yn gyflym. Mae'r mathau o ganllawiau arferion da y cyfeiriodd Jane atynt yn cael eu defnyddio'n eang bellach. Canolbwyntir ar ostwng yr amseroedd aros hynny. Yr wyf yn falch iawn bod hynny o fewn golygon y Cynulliad hefyd. Po gyflymaf y byddwn yn mynd ati i ostwng yr amseroedd aros cleifion allanol hynny, y cynharaf y byddwn yn gostwng llwybr cyffredinol y claf, sy'n llawer yn rhy hir o hyd.

It seems to me that there are some really exciting initiatives now getting under way, and I will give you two examples of that. The first is a pilot referral centre in the Vale of Glamorgan Local Health Board, which will eventually lead to all GP referrals to secondary care being assessed by a referral centre in the local health board itself, to see whether that is the most appropriate pathway, or whether there are alternative pathways that would be just as beneficial for the patient but which are much more readily available. That

Ymddengys i mi bod rhai mentrau cyffrous iawn ar fin cychwyn yn awr, ac yr wyf am roi dwy enghraifft i chi o hynny. Y cyntaf yw'r ganolfan gyfeirio beilot ym Mwrdd Iechyd Lleol Bro Morgannwg, a fydd yn arwain yn y pen draw at asesu holl gyfeiriadau meddygon teulu at ofal eilaidd gan ganolfan gyfeirio yn y bwrdd iechyd lleol ei hun, i weld ai hwnnw yw'r llwybr mwyaf priodol, neu a oes llwybrau gwahanol a fyddai'r un mor fuddiol i'r claf ond sydd ar gael yn llawer haws. Mae hynny'n defnyddio model sydd wedi'i

is using a model which has been used in England and has been shown to reduce secondary care referrals substantially by providing better alternatives. We already have one running, in effect, for orthopaedics. We have been running a musculoskeletal treatment centre at Barry hospital, which is focused entirely on long-waiting orthopaedic patients, some of whom have been waiting as out-patients for years, and, within six months, over 2,000 patients will have been seen in that centre. If the current projections are maintained, only 300 or 400 of those patients will need to go for surgical consideration for surgical referral, and we will have found alternative ways to offer them treatment. Interestingly, patient satisfaction levels are among the highest that I have ever seen for any such initiatives. Therefore, there are different ways of managing the out-patient problem. Again, I think that it is about proper demand management, proper work on referrals, and secondary and primary care working together to make sure that only the most relevant and appropriate patients find their way through to the traditional out-patient list. Accepting that you will still have that list, and you have to manage it as tightly and as well as you possibly can. I think that if we can do that, we will also have the beginnings of a sustainable solution for out-patients.

ddefnyddio yn Lloegr ac sydd wedi gostwng cyfeiriadau gofal eilaidd yn sylweddol drwy ddarparu gwell opsiynau gwahanol. Mae gennym un ar waith yn barod, mewn gwirionedd, ar gyfer orthopedeg. Yr ydym wedi bod yn rhedeg canolfan driniaethau cyhyrysgerbydol yn ysbyty'r Barri, sy'n canolbwyntio'n llwyr ar gleifion orthopedig sydd wedi bod yn aros am hir, mae rhai wedi bod yn aros fel cleifion allanol am flynyddoedd, ac, o fewn chwe mis, bydd dros 2,000 o gleifion wedi'u gweld yn y ganolfan. Os cynhelir y rhagamcaniadau presennol, dim ond 300 neu 400 o'r cleifion hynny a fydd angen ystyriaeth lawdriniaethol ar gyfer cyfeiriadau llawdriniaethol, a byddwn wedi canfod ffyrdd gwahanol o gynnig triniaeth iddynt. Yn ddiddorol, mae lefelau boddhad cleifion ymhlith yr uchaf yr wyf erioed wedi'u gweld ar gyfer unrhyw fentrau o'u bath. Felly, mae gwahanol ffyrdd o reoli'r broblem cleifion allanol. Eto, credaf fod hyn yn ymwneud â rheoli galw yn iawn, gwaith iawn ar gyfeiriadau, a gofal eilaidd a chanolraddol yn gweithio gyda'i gilydd i sicrhau mai dim ond y cleifion mwyaf perthnasol a phriodol sy'n cyrraedd y rhestrau cleifion allanol traddodiadol. Gan dderbyn y bydd gennych y rhestr honno o hyd, a bod yn rhaid i chi ei rheoli mor gaeth a chystal â phosibl. Os gallwn wneud hynny, credaf y bydd gennym y sylfeini ar gyfer ateb cynaliadwy i'n cleifion allanol yn ogystal.

[324] **Alun Cairns:** Mr Williams, can you tell me, from a trust perspective, what interventions would really help you to make

[324] **Alun Cairns:** Mr Williams, a allwch ddweud wrthyf, o safbwynt ymddiriedolaeth, pa ymyriadau a fyddai'n eich cynorthwyo i

large in-roads into waiting times for in-patients and out-patients?

ostwng amseroedd aros cleifion mewnol a chleifion allanol yn sylweddol?

Mr Williams: It comes back to having this coherent plan, which brings together those three issues of tackling process, the demand and the capacity, and linking them to human, revenue and capital resources. To me, that is a fairly simple management problem. That is where we need the focus of all the organisations to achieve it. So, some organisations might have to spend more time internally improving their processes and efficiencies, while others might have to tackle the demand and the capacity issues more aggressively. It will vary in certain parts of Wales. However, coming back to my colleague's point, maybe some regional perspective would also help on that. I think that it will be possible within three years to perhaps approach some of the English targets if we address the problem in that particular way and focus on these issues. There is one good example of where targets can work: if we look back four or five years ago at where our cataract waiting list was, we said at the time that the wait would be four months, and we now have a four-month list. I do not see why you could not rack that up and say, 'Let us have another go and make it three months, and chip away at that one'. So, I think that a lot of exciting work is going on now, but it needs to have that concentration and to be delivering on a coherent plan. At the moment I have some difficulty in seeing that developing, because there are huge problems in terms of this year's financial settlement,

Mr Williams: Mae'n dod yn ôl at gael y cynllun cydlynol hwn, sy'n dod â'r tri achos ynghyd o fynd i'r afael â'r broses, y galw a'r gallu, a'u cysylltu ag adnoddau dynol, refeniw a chyfalaf. I mi, mae hynny'n broblem reoli gymharol syml. Ar hyn y mae angen i'r holl sefydliadau ganolbwyntio er mwyn ei gyflawni. Felly, hwyrach y bydd yn rhaid i rai sefydliadau dreulio mwy o amser yn fewnol yn gwella eu prosesau a'u heffeithlonrwydd, tra gallai eraill fynd i'r afael â'r materion galw a gallu yn fwy ffyrnig. Bydd yn amrywio mewn gwahanol rannau o Gymru. Fodd bynnag, gan ddod yn ôl at bwynt fy nghydweithwyr, hwyrach y byddai rhywfaint o safbwynt rhanbarthol yn cynorthwyo gyda hynny. Credaf, o fewn tair blynedd, y bydd modd dilyn rhai o dargedau Lloegr os ydym yn mynd i'r afael â'r broblem yn y ffordd benodol honno a chanolbwyntio ar y materion hyn. Mae un enghraifft dda o le gall targedau weithio: os edrychwn yn ôl bedair neu bum mlynedd ar ein rhestr aros cataractau, bu i ni ddweud ar y pryd y byddai'n rhaid aros pedwar mis, ac mae gennym restr aros pedwar mis yn awr. Ni allaf weld pam na ellwch edrych ar hynny a dweud, 'Beth am geisio ei gael i lawr i dri mis, a mynd ati i wneud hynny'. Felly, credaf fod llawer o waith cyffrous yn cael ei wneud yn awr, ond mae angen canolbwyntio fel hynny a chyflawni cynllun cydlynol. Ar hyn o bryd yr wyf yn cael trafferth gweld hynny'n datblygu, oherwydd mae problemau enfawr o

and we will be distracted in my trust as we may have to find £4 million for a cost-improvement programme. That is an enormous thing to ask, as well as trying to develop capacity and have sustainable plans.

ran setliad ariannol eleni, a bydd hyn yn ein rhwystro yn fy ymddiriedolaeth oherwydd efallai y byddwn yn gorfod dod o hyd i £4 miliwn ar gyfer rhaglen gwella costau. Mae hynny'n gofyn llawer, ynghyd â cheisio datblygu gallu a gweithredu cynlluniau cynaliadwy.

[325] **Alun Cairns:** Can you expand on that last answer about the financial settlement for this coming year, Mr Williams? What does that mean in your trust? If the Cadeirydd is willing, perhaps I could ask the same question to Mr Ross and Ms Perrin.

[325] **Alun Cairns:** A allwch ymhelaethu ar eich ateb diwethaf am y setliad ariannol ar gyfer y flwyddyn sydd i ddod, Mr Williams? Beth mae hynny'n ei olygu yn eich ymddiriedolaeth chi? Os yw'r Cadeirydd yn fodlon, efallai y gallaf ofyn yr un cwestiwn i Mr Ross a Ms Perrin.

Mr Williams: The figures published by the Assembly indicate that, compared with England, which will have a settlement of around 8 per cent, the settlement in Wales is around 5.2 per cent. With the already identified cost pressures in the system, there is a gap of at least 3 per cent if we stand still, before more capacity is built in. So, crudely at the moment, if we look at the Neath Port Talbot and Bridgend health community—the trust and the local health boards—we are thinking around how we are going to deal with perhaps a £10 million problem. It seems to me that England is powering ahead with capacity and, at the same time, putting higher levels of resources in. It could well be that the view is that we cannot manage the money that we already have. Nevertheless, there are issues regarding sustainable capacity and how will deal with these issues. Is it

Mr Williams: Mae'r ffigurau a gyhoeddwyd gan y Cynulliad yn dangos, o gymharu â Lloegr, a fydd yn cael setliad o tua 8 y cant, bod y setliad yng Nghymru tua 5.2 y cant. Gyda'r pwysau costau sydd wedi'u hamlygu eisoes yn y system, mae bwlch o 3 y cant o leiaf os ydym yn aros yn ein hunfan, cyn y gellir ychwanegu rhagor o gapasiti. Felly, yn fras ar hyn o bryd, os edrychwn ar gymuned iechyd Castell-nedd Port Talbot a Phen-y-bont ar Ogwr—yr ymddiriedolaeth a'r byrddau iechyd lleol—yr ydym yn ystyried sut byddwn yn delio â phroblem £10 miliwn o bosibl. Ymddengys i mi bod Lloegr ben ac ysgwydd o'n blaenau o ran capasiti ac, ar yr un pryd, yn cyfrannu rhagor o adnoddau. Efallai nad ydym yn gallu rheoli'r arian sydd gennym eisoes. Fodd bynnag, mae materion ynghylch capasiti cynaliadwy a sut byddwn yn delio â'r materion hyn. A yw'n briodol ein

appropriate that we should be spending all our time next year thinking about having to take money out, rather than about how we can be creatively developing our capacity?

bod yn treulio ein holl amser y flwyddyn nesaf yn meddwl am orfod tynnu arian allan, yn hytrach na meddwl am ffyrdd o ddatblygu ein capasiti yn greadigol?

Mr Ross: The situation in Cardiff and Vale NHS Trust is that the provisional plans that have gone to the trust board suggest that we will have to reduce our costs by around £15 million in the next financial year. Our turnover, as you will be aware, is a little over £500 million. We do not fully know yet what the implications of that will be. We are, as you would expect, benchmarking our performance against a whole range of other large teaching trusts across the UK to see where we can make efficiencies, be it in everything from procurement and supplies through to all aspects of clinical practice and the use of equipment, drugs, consumables and so on. I think that Paul is right to say that it is an extremely significant issue for NHS Wales. There is no doubt that it is quite the tightest financial settlement that I have faced at the beginning of a financial year for a good many years.

Mr Ross: Y sefyllfa yn Ymddiriedolaeth GIG Caerdydd a'r Fro yw bod y cynlluniau dros dro sydd wedi'u cyflwyno i fwrdd yr ymddiriedolaeth yn awgrymu y byddwn yn gorfod gostwng ein costau o tua £15 miliwn yn y flwyddyn ariannol nesaf. Mae ein trosiant, fel y gwyddoch, ychydig dros £500 miliwn. Nid ydym yn gwybod yn iawn eto beth fydd goblygiadau hynny. Yr ydym, fel y byddech yn disgwyl, yn meincnodi ein perfformiad yn erbyn amrywiaeth llawn o ymddiriedolaethau addysgu mawr eraill ledled y DU i weld lle gallwn wneud arbedion, boed hynny ym mhopeth o gaffael a chyflenwadau i bob agwedd ar ymarfer clinigol a'r defnydd o gyfarpar, cyffuriau, nwyddau traul ac ati. Credaf fod Paul yn llygad ei le yn dweud ei fod yn fater hynod bwysig i GIG Cymru. Nid oes amheuaeth ei fod yn un o'r setliadau ariannol caletaf yr wyf wedi'i wynebu ar ddechrau blwyddyn ariannol ers blynyddoedd maith.

Ms Perrin: We are in a similar position. Our income is around £320 million, so it is smaller than Cardiff's. However, we are approaching double figures in terms of what we believe to be the shortfall. That is made up, if you like, of the gap that Paul talked about in terms of standing still to continue to deliver what we are doing at the moment,

Ms Perrin: Yr ydym mewn sefyllfa debyg. Mae'n hincwm oddeutu £320 miliwn, felly mae'n llai nag incwm Caerdydd. Fodd bynnag, yr ydym yn agosáu at ffigurau dwbl o ran yr hyn yr ydym yn ei ystyried yn ddiffyg. Mae hynny'n cynnwys, os dymunwch, y bwlch y cyfeiriodd Paul ato o ran aros yn ein hunfan i barhau i wneud yr

plus the cost of achieving the tightened targets for next year. All NHS organisations make efficiencies year on year, but, as Hugh has said, we have an extremely difficult year ahead of us to sustain services and to hit the waiting-times targets. The challenge is going to be—and I think that we have picked this up throughout the morning—how we can do things differently, and how we can think differently. It is not just about doing more of the same. That, however, is going to require very strong partnership working across commissioners, providers and social services, and, as Wanless has said, looking at the sustainability and configuration of services across south Wales.

hyn yr ydym yn ei wneud ar hyn o bryd, yn ogystal â'r gost o gyflawni'r targedau caletach ar gyfer y flwyddyn nesaf. Mae pob sefydliad GIG yn gwneud arbedion flwyddyn ar ôl blwyddyn, ond, fel y dywedodd Hugh, mae blwyddyn anodd iawn o'n blaenau bob un i gynnal gwasanaethau ac i gyflawni'r targedau amseroedd aros. Yr her sy'n ein hwynebu—a chredaf ein bod wedi trafod hyn gydol y bore—yw sut gallwn wneud pethau'n wahanol, a sut gallwn feddwl yn wahanol. Nid yw'n golygu gwneud rhagor o'r un peth yn unig. Bydd hynny, fodd bynnag, yn gofyn am waith partneriaeth cryf iawn rhwng comisiynwyr, darparwyr a gwasanaethau cymdeithasol, ac, fel y dywedodd Wanless, edrych ar gynaliadwyedd a ffurfwedd gwasanaethau ledled y De.

[326] **Alun Cairns:** It seems to me that the position is extremely worrying for the next financial year, and I am grateful to each of you for being candid in this respect. Bearing in mind that many of the best practice initiatives that we have heard about will require additional capital in the short term, perhaps, in order to deliver them, what implication does this financial settlement have on those initiatives, which will provide that sustainable reduction in waiting times?

[326] **Alun Cairns:** Ymddengys i mi bod y sefyllfa'n destun pryder mawr ar gyfer y flwyddyn ariannol nesaf, ac yr wyf yn ddiolchgar i chi gyd am fod yn onest ynghylch hyn. O gofio y bydd llawer o'r mentrau arferion gorau yr ydym wedi clywed amdanynt yn gofyn am gyfalaf ychwanegol yn y tymor byr, efallai, er mwyn eu cyflawni, pa oblygiadau sydd gan y setliad ariannol hwn ar y mentrau hynny, a fydd yn darparu gostyngiad cynaliadwy mewn amseroedd aros?

Mr Ross: There are two possible developments: one is the Welsh Assembly Government's decision to greatly increase the capital available to the national health service

Mr Ross: Mae dau ddatblygiad posibl: y cyntaf yw penderfyniad Llywodraeth Cynulliad Cymru i gynyddu'r cyfalaf sydd ar gael i'r gwasanaeth iechyd gwladol yn

in coming years, and that will certainly help with some of the modernisation and improvement and changes in facilities that we need to see. The Llandough orthopaedic unit is a good example of how increased capital investment will help with waiting times. On revenue, the Minister has announced that there is £32 million available in the coming year—on a non-recurring basis—for in-patient and day-case waiting-time work, out-patient waiting-list work, and work on cardiac services. We do not know yet how that money will be distributed in detail, but we have been given some outlines about the procedures that will be used. My anxiety, as you would expect, is that the new year starts on 1 April, and if we are to have additional capacity running next year, which we must, I would like those patients to be already identified by this stage—which we are not in a position to do. I would like to hit the ground running on 1 April with the levels of work that are required. So, we are urging colleagues in the system to get cracking with that as quickly as possible.

sylweddol yn y blynyddoedd nesaf, a bydd hynny'n sicr yn cynorthwyo gyda rhywfaint o'r moderneiddio a'r gwelliannau a'r newidiadau mewn cyfleusterau sydd angen eu gwneud. Mae uned orthopedeg Llandochau yn enghraifft dda o sut bydd buddsoddiad cyfalaf cynyddol yn cynorthwyo gydag amseroedd aros. O ran refeniw, mae'r Gweinidog wedi cyhoeddi bod £32 miliwn ar gael yn y flwyddyn nesaf—ar sail anghylchol—ar gyfer gwaith amseroedd aros cleifion mewnol ac achosion dydd, gwaith rhestrau aros cleifion allanol, a gwaith ar wasanaethau'r galon. Nid ydym yn gwybod eto sut yn union y dosberthir yr arian hwnnw, ond yr ydym wedi derbyn ambell amlinelliad o'r gweithdrefnau a fydd yn cael eu defnyddio. Fy mhryder, fel y byddech yn ei ddisgwyl, yw bod y flwyddyn newydd yn dechrau ar 1 Ebrill, ac os ydym am gael capasiti ychwanegol ar waith y flwyddyn nesaf, sy'n hanfodol i ni, byddwn yn hoffi pe bai'r cleifion hynny wedi'u nodi eisoes—rhywbeth nad ydym mewn sefyllfa i'w wneud. Hoffwn pe baem yn dechrau ar y gwaith o ddifrif ar 1 Ebrill gyda'r lefelau o waith sy'n ofynnol. Felly, yr ydym yn annog cydweithwyr yn y system i dorchi llewys gyda hynny cyn gynted â phosibl.

Mr Williams: The question for me is, although the £32 million is welcome, what is the gap between the £32 million and what we need in order to maintain the existing capacity, plus the additional capacity that will need to go into the system as a result of reducing waiting times for out-patients to 12

Mr Williams: Y cwestiwn i mi yw, er ein bod yn croesawu'r £32 miliwn, beth yw'r bwlch rhwng y £32 miliwn a'r hyn yr ydym ei angen er mwyn cynnal y gallu sydd gennym eisoes, ynghyd â'r gallu ychwanegol a fydd ei angen ar gyfer y system o ganlyniad i ostwng amseroedd aros cleifion mewnol i

months and the conversion rate that will have on in-patients? The assumption is that that will somehow be sorted out between the commissioners and the trusts. That is the $64,000 question.

12 mis a'r gyfradd drosi y bydd hynny'n ei chael ar gleifion mewnol? Y rhagdybiaeth yw y bydd hynny rhywsut yn cael ei ddatrys rhwng y comisiynwyr a'r ymddiriedolaethau. Dyna'r cwestiwn hollbwysig.

[327] **Alun Cairns:** However, if the finance is not there, clearly that cannot be resolved.

[327] **Alun Cairns:** Fodd bynnag, os nad yw'r arian ar gael, yn amlwg ni ellir datrys hynny.

Mr Williams: Or one overspends.

Mr Williams: Neu mae rhywun yn gorwario.

Ms Perrin: The additional capital resources that have recently been announced are welcome, because if we are to stop the current dependence on the acute side of the NHS, we must have the facilities and infrastructure in place elsewhere in the health system. We are not yet clear how that capital is going to be used, or how it is going to be allocated. It is welcome, but we need to get cracking with using it.

Ms Perrin: Croesewir yr adnoddau cyfalaf ychwanegol a gyhoeddwyd yn ddiweddar, oherwydd os ydym am atal y ddibyniaeth sydd gennym ar hyn o bryd ar elfen acíwt y GIG, mae'n rhaid i ni gael y cyfleusterau a'r seilwaith ar waith yn rhywle arall yn y system iechyd. Nid ydym yn glir eto sut y byddwn yn defnyddio'r cyfalaf, neu sut y bydd yn cael ei ddyrannu. Yr ydym yn ei groesawu, ond mae'n rhaid i ni fynd ati i'w ddefnyddio.

[328] **Janet Davies:** I think that right at the end of this hearing we have come across a very serious problem. The amounts of money that you are talking about are very large amounts for your trusts to get to grips with. I am not downplaying this at all, but I will ask Mr Williams a specific question: you had a meeting for Assembly Members in your area—I think it was two years ago, before the reorganisation of the health service—

[328] **Janet Davies:** Credaf ar ddiwedd y gwrandawiad hwn ein bod wedi datgelu problem ddifrifol iawn. Mae'r symiau o arian yr ydych yn eu trafod yn symiau mawr iawn i'ch ymddiriedolaethau fynd i'r afael â hwy. Nid wyf yn bychanu hyn o gwbl, ond yr wyf am ofyn cwestiwn penodol i Mr Williams: cynhaliwyd cyfarfod i Aelodau'r Cynulliad yn eich ardal—credaf fod hyn ddwy flynedd yn ôl, cyn ad-drefnu'r gwasanaeth iechyd—

concerning £1 million, by which you felt that you would be adrift at that point. This was specifically connected with the neo-natal sector. How did you overcome that problem at that time?

ynghylch £1 miliwn, sef y swm yr oeddech yn credu y byddech ar ei hôl hi bryd hynny. Yr oedd hyn yn gysylltiedig yn benodol â'r sector newyddenedigol. Sut gwnaethoch ddatrys y broblem honno ar y pryd?

Mr Williams: As Jane says, year in, year out, we have to make efficiency savings and we remained within budget by setting ourselves a very stringent cost improvement, taking about £2 million out of the system by doing things differently. There is always that kind of challenge, always the requirement that we do those kinds of things. The problem is that often patient choice and technology drives the system harder than we can find the money. The neo-natal service is a very good example of that, whereby we are still working through, with Health Commission Wales, a review of neo-natal services, which has a substantial bill attached to it. I do not know what will happen if the review's findings are accepted, but the resources are not going to be there. At the moment, the way in which we are bridging that gap is by the trust, the LHB and the HCW putting in some money on a non-recurring basis. So, the problem is being handled, but we have yet to have a sustainable solution.

Mr Williams: Fel y dywedodd Jane, bob blwyddyn, mae'n rhaid i ni wneud arbedion effeithlonrwydd a bu i ni aros o fewn cyfyngiadau ein cyllideb drwy bennu gwelliant costau caeth iawn, gan gymryd oddeutu £2 filiwn allan o'r system drwy wneud pethau'n wahanol. Ceir her o'r fath drwy'r amser, ac mae'n ofynnol i ni wneud y mathau hynny o bethau drwy'r amser. Y broblem yn aml yw bod dewis cleifion a thechnoleg yn gweithio'r system yn galetach na'r arian sydd ar gael i ni. Mae'r gwasanaeth newyddenedigol yn enghraifft dda iawn o hynny, lle yr ydym yn parhau i weithio, gyda Chomisiwn Iechyd Cymru, drwy adolygiad o wasanaethau newyddenedigol, sy'n costio llawer o arian. Nid wyf yn gwybod beth fydd yn digwydd os derbynnir canfyddiadau'r adolygiad, ond ni fydd yr adnoddau yno. Ar hyn o bryd, y ffordd yr ydym yn pontio'r bwlch yw drwy gael yr ymddiriedolaeth, y BILl a Chomisiwn Iechyd Cymru i gyfrannu arian ar sail anghylchol. Felly, yr ydym yn delio â'r broblem, ond nid ydym wedi canfod ateb cynaliadwy eto.

[329] **Janet Davies:** Thank you for that reply. As I said, I was not trying to downplay your problems: I fully recognise that you have some major ones there.

[329] **Janet Davies:** Diolch am yr ateb. Fel y dywedais, nid oeddwn yn ceisio bychanu eich problemau: yr wyf yn cydnabod yn llawn eich bod yn wynebu problemau mawr.

I would like to thank the three of you very much for coming here today, and to point out that hearing of the problems directly from the people who operate on the ground is very helpful for this committee. It gives us a different view. Every time we have done this—and we only do it about once a year—it has always given us a lot to think about, and it has been very significant in the report that comes forward.

Hoffwn ddiolch yn fawr iawn i'r tri ohonoch am ddod yma heddiw, ac mae cael clywed am y problemau yn uniongyrchol gan y bobl sy'n gweithio yn y maes yn ddefnyddiol iawn i'r pwyllgor hwn. Mae'n taflu goleuni arall i ni ar y mater. Bob tro yr ydym wedi gwneud hyn—a dim ond tua unwaith y flwyddyn y gwnawn hynny—mae wedi rhoi digon i ni gnoi cil drosto, ac mae wedi bod yn bwysig yn yr adroddiad sy'n cael ei gyflwyno.

There will be a verbatim transcript of this meeting, and you will each be sent a copy of the draft transcript to correct any factual inaccuracies before it is published. Thank you for coming today.

Bydd trawsgrifiad gair am air o'r cyfarfod hwn, a bydd copi o'r drafft hwn yn cael ei anfon atoch er mwyn i chi allu cywiro unrhyw wallau ffeithiol cyn ei gyhoeddi. Diolch i chi am ddod heddiw.

Daeth y sesiwn cymryd tystiolaeth i ben am 12.35 p.m.

The evidence-taking session ended at 12.35 p.m.

Annex B

Kathryn Jenkins
Clerk to the Audit Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Mrs Ann Lloyd

Head, Health & Social Care Department

Chief Executive, NHS Wales

Pennaeth, Adran Iechyd a Gofal Cymdeithasol

Prif Weithredwraig, GIG Cymru

Eich cyf/ Your ref:
Ein cyf / Our ref: AJL/ BJ

16th March 2005

Dear Kathryn,

FURTHER INFORMATION RESULTING FROM ASSEMBLY AUDIT COMMITTEE EVIDENCE SESSIONS, 3 & 10 February 2005 - "NHS Waiting Times in Wales"

Further to the Committee's session on 3 February 2005, I undertook to write to you with further information on a number of aspects/issues.

- Further information regarding the health needs of Wales compared to that of North East England
- A note setting out in greater detail the interfaces between the differing levels of NHS Management and how this impacts on, and adds to the complexity of, the ability to collect activity data
- The percentage breakdown of budget spent against activity (eg new outpatients, elective activities etc)

Further to the Committee's session on 10 February 2005, I undertook to write to you with further information on a number of aspects/issues.

- the latest data on the number of inappropriate admissions (level 4 patients) to A&E
- further information on the development of the formula to set the level of charges to be paid to the independent care sector for nursing homes
- the disaggregated figures on the provision of treatment under the second offer scheme by (i) NHS Wales, (ii) NHS England and (iii) the private sector
- the exact figure on the running costs of the commissioning team set up to administer the second offer scheme on behalf of LHBs
- in relation to waiting time performance over time, further information on the different ways in which Trusts have used the information compared to Powys LHBs [Appendix 6, Volume 1]
- information on any associated financial or other risk to NHS Wales of its patients contracting MRSA in English hospitals.

In respect of each hearing, the information requested is attached hereto.

I am copying this letter to the Auditor General for Wales and the Assembly Compliance Office.

Yours sincerely

Mrs ANN LLOYD
Head, Health & Social Care Department
Chief Executive, NHS Wales

PENNAETH, ADRAN IECHYD A GOFAL CYMDEITHASOL

PRIF WEITHREDWRAIG, GIG CYMRU

c.c. Auditor General for Wales
Assembly Compliance Officer (ACO)

- Further information regarding the health needs of Wales compared to that of North East England

For many socio-economic indicators – including expenditure on private healthcare - Wales shares a striking similarity with the North East of England. There are, however, some differences. The North East has a slightly lower percentage of its population aged over 65 and a lower proportion in very sparsely populated areas. for most health expenditure.

In terms of some of the main socio-economic indicators, in comparison with Wales the North East has:

- Slightly lower GDP per head
- Lower disposable household income
- A similar proportion of households in receipt of incapacity or disablement benefits
- Similar rates of economic inactivity
- Mortality rates and self-reported long-term illness rates which are slightly higher than in Wales.

In 2002/03 spending per head on health was broadly similar in Wales and the North East.

Comparative indicators: Wales and the North East of England

Indicator	Wales	North East	Wales % above (+) or below (-) North East
GDP per head (£ per head index, 1999. UK=100)	79	76	+4
Disposable household income per head (£ per head index, 1999)	87.5	88.9	-2
% of households in receipt of incapacity or disablement allowance (2000-01)	26	24	+8
% economically inactive (working age, spring 2002)	72.9	73.5	-1
Average gross weekly earnings (£, April 2001): Males	412.3	418.6	-2
Females	327.4	318.4	+3
% with no qualification (working age, spring 2002)	19.2	18.1	+6

Sources: Regional Trends, 2002; 2001 Census of Population

Comparisons of health and social services between Wales and the North East are complicated by the fact that North East is not one of the regions of the NHS in England.

Health Comparisons 2002-03

	Context		Spending		Pressures			Efficiency					Waiting
	Age standardised mortality rates, 2001 per 100,00	Popuiuation aged 65 and over 2002 %	Health spending per head# (UK =100)	Increase in NHS spend 2000/1 to 2003/4^~	Inpatient admissions per 1000 population	Consultant outpatient attendances per person	Accidents & emerg. attendances per million population	Inpatient beds per 1000 population	Day cases per ten thousand population	Average length of stay (days)	Average list size per GP	Practice staff per 1000 pop	Example - less than 6 months at 31 March 2003 (%)
Wales	988	17.5	107	42%	174	0.91	3.5	5.0	4.6	6.8	1,704	2.07	63
North East	1,056	16.7	108	41%	190	1.05	3.1	4.7	10.0	7.2	1,745	1.47	83
North West	1,043	16.1	107	39%	183	1.05	3.2	4.2	8.0	7.1	1,851	1.39	81
Yorks and Humber	967	16.2	98	39%	175	0.96	3.3	4.0	8.9	8.2	1,772	1.37	82
South West	849	18.7	90	40%	158	0.79	2.8	3.9	8.6	8.0	1,597	1.45	81
England	935	15.9	98	42%	157	0.91	2.9	3.8	7.6	n/a	1,838	1.37	81
Scotland	1,085	16.1	114	n/a	188	0.93	3.1	6.0	8.3	7.0	1,392	1.42	75
Northern Ireland	977	13.4	109	n/a	194	0.86	4.0	4.9	7.7	6.4	1,651	n/a	60

Source:

Regional Trends 2004 (ONS), except: #Public Expenditure Statistical Analysis 2004 (HMT), ^DoH Dept Report 2004 and ~NFS(F) figures.

Note that the Regional Trends figure of 6.8 days for Average length of stay in Wales is in acute specialties and compares with data showing 8.4 days in all specialties.

- A note setting out in greater detail the interfaces between the differing levels of NHS Management and how this impacts on, and adds to the complexity of, the ability to collect activity data

Interfaces between different levels of NHS Management, with job titles varying by organisation, should be assisted by the simplification of the number of levels.

There are actually 9 levels, taken from a document called 'A Career Framework For The NHS' which was recently formally adopted by the NHS Workforce Development Sub Groups for use in Wales.

The 9 A4C levels are:-

1. Initial entry level eg. domestic, cadet.
2. Support workers eg. healthcare assistant/ porter.
3. Senior support workers eg. health care assistant/ technician.
4. Assistant practitioner eg. assistant mental health practitioner/ office manager.
5. Practitioner eg. newly qualified nurse/AHP.
6. Senior practitioner eg. district nurse/ HR officer.
7. Advanced practitioner eg. modern matron/ head of accounts.
8. Consultant practitioner eg. nurse consultant/ Deputy HR Director.
9. More senior staff eg. head of medical physics/ very senior manager below board level .

A 10th level equates to board level positions.

This means that, for example, that if health care support workers have multiple titles in different organisations such as, healthcare assistant, nursing assistant etc they could all be classed as 'level 2 healthcare assistant' from the above categories.

- The percentage breakdown of budget spent against activity (eg new outpatients, elective activities etc)

NHS expenditure, as reported in the NHS (Wales) Summarised Accounts, shows a 26% increase between 2000-1 and 2003-04.

	2000-01	**2001-02**	**2002-03**	**2003-04**
	£ billion	£ billion	£ billion	£ billion
Expenditure	2.880	3.144	3.450	3.627
% increase	-	9%	10%	5%
3 year increase	-	-	-	26%

Source: NHS (Wales) Summarised Accounts 2000-01 to 2003-04

An analysis of expenditure against particular areas is shown in the table below:

	2000-01	**2001-02**	**2002-03**	**2003-04**
Outpatients:				
First attendances	3%	3%	3%	3%
Total attendances	12%	12%	13%	14%
Inpatients:				
Elective	20%	18%	17%	17%
Emergency	43%	41%	40%	38%
Day cases	n/a	4%	4%	4%
Accident and emergency	3%	3%	3%	3%
Day care services	2%	2%	2%	2%
Community services	16%	17%	17%	18%
	100%	**100%**	**100%**	**100%**

Source: NHS trust annual accounts 2000-01 to 2003-04. TFR2 – specialty and programme cost return.

Note:

1. Daycases were not recorded separately prior to financial year 2001-02.
2. Figures may not add exactly due to rounding

- The latest data on the number of inappropriate admissions (level 4 patients) to A&E

Enquiries have been made but no data on the specific number of Level 4 admissions to A&E units in Wales can be obtained from a central source, and data of a reliable or consistent nature would not be obtainable from multiple alternative sources.

In the near future, a Change Agent Team are to carry out an anonymised snapshot audit to look at the reasons for increased A&E attendances. In the longer term, a research project is being commissioned to identify contributory factors for the increasing demand on A&E.

- Further information on the development of the formula to set the level of charges to be paid to the independent care sector for nursing homes

The Welsh Assembly Government has issued statutory commissioning guidance to councils which requires that, among other things, they commission in ways which take account of the effect on providers and of the market of their commissioning practices. As part of that, there is a WLGA initiative, "the fees toolkit", which we are funding and this is to assist in local fees negotiations . This will make the whole fee setting process more transparent in that there will be accurate data on how providers' costs have moved.

Separately, the Welsh Assembly Government sets the nursing element for NHS funded nursing care, which is an entitlement for those people in residential homes which are registered to provide nursing care.

- The disaggregated figures on the provision of treatment under the second offer scheme by (i) NHS Wales, (ii) NHS England and (iii) the private sector

Patients treated Apr 04 – Jan 05	
By NHS Wales	**3,891**
through in-house solutions 3,866	
through alternative providers 25	
By NHS England through alternative providers:	**195**
Weston NHS Trust 149	
Kidderminster Treatment Centre 46	
By the Private Sector through alternative providers in Wales and England:	**2,303**
Cardiff BUPA 1,266	
Sancta Maria (Swansea) 65	
St Josephs (Newport) 241	
Wrexham BUPA 66	
Werndale 156	
Nuffield Hospitals 257	
Worcester BUPA 51	
Bristol BUPA 201	
GRAND TOTAL	**6,389**

- The exact figure on the running costs of the commissioning team set up to administer the second offer scheme on behalf of LHBs

For 2004/05 the Second Offer Commissioning Team (SOCT) running costs total £278,000 full year cost.

- In relation to waiting time performance over time, further information on the different ways in which Trusts have used the information compared to Powys LHBs [Appendix 6, Volume 1]

Specific further information in relation to Appendix 6, which provides details about waiting time performance over time for each NHS Trust in Wales excluding Velindre, includes Powys LHB as a provider. In this role Powys LHB has 5 outpatients waiting over 18 months and no inpatients or daycases waiting more than 18 months.

Figure 16 shows figures for Powys LHB in its role as commissioner and here gives different over 18 month outpatient and inpatient/daycase waiting times for Powys residents.

- Information on any associated financial or other risk to NHS Wales of its patients contracting MRSA in English hospitals.

I am not aware of any specific information. However, the generally accepted financial risk associated with any healthcare associated infection is increased length of hospital stay. This leads to added drug costs (antibiotics) and a knock on effect of bed utilisation and thus waiting times. The risk is not peculiar to MRSA, indeed MRSA forms only a small part of all HCAI's. From historical data we know that about 9% patients going into hospital will get an infection. A new survey is expected 2005/06 led by the Hospital Infection Society. Wales will be participating. Using our bacteraemia data as a surrogate marker, we know that overall, the rate of infection appears static.

Plowman et al. reported on a study in 2000 and found in an average DGH that the additional costs per patient were £3,154 per infection. The table gives a breakdown:

Site of infection	Number	Additional costs (£)
Urinary tract	107	1327
Respiratory tract	48	2398
Surgical wound	38	1618
Blood stream	4	5397
Skin	25	1790
Other	30	2263
Multiple	57	9152
Any infection	**309**	**3154**

However, these risks are not peculiar to a burden arising from an English trust, the same figures would apply within Wales.

Annex C

Welsh Assembly Government press release, dated 17 March 2005 announcing revised waiting time targets.

Patients in Wales were today told that in 2009 the maximum total waiting time from referral by the GP to treatment would be 6 months, including waiting times for any diagnostic tests required.

First Minister Rhodri Morgan and Health Minister Dr Brian Gibbons today jointly announced this major step forward and gave their assurance to patients and their families that the downward trajectory seen over the last year in waiting times would continue downwards over the next four to five years.

The First Minister said: "This announcement today affirms our commitment to setting for the first time ever total waiting times for Welsh NHS patients. The success of our second offer guarantee scheme in bringing down long waiting times has shown the way forward on shortening long waits for in-patient treatment.

"What we have never done before is to combine into one all-in total waiting time, the outpatient wait, the diagnostic test wait and the inpatient or day cast treatment wait and to have one single maximum 6 month period for the whole process."

Dr Brian Gibbons said: "Over the past year patients have seen huge reductions in the length of time they have had to wait for treatment. Since January 2004 the number of people waiting over 18 months for treatment has fallen by over 3,500 (87%) and the number of people waiting over 18 months for a first out appointment has fallen by over 4,000.

"We have already set a target of no-one waiting over 12 months for their first outpatient appointment and 12 months for inpatient/day case treatment by March 2006 and as an interim target we are also announcing today that by March 2007 there will be a maximum wait of no more than 16 months for the total outpatient and inpatient wait.

"The targets we are setting today are tough but ring-fenced money will be set aside to help the NHS in Wales deliver these targets over the next 4 years."

"The targets we are announcing today will mean that from GP referral through the outpatient appointment and diagnostic test and finally to treatment no-one will wait more than a maximum of 6 months for an operation.

"Our second offer scheme has had a huge impact on waiting times and 6,389 people have been treated under it. As our maximum waiting times fall the second offer trigger time will also fall ensuring patients get treatment within our targets.

"NHS staff are working hard to meet our targets and I am sure this will continue. With extra funding over the next 4 years I am confident that these targets will be delivered across Wales."

Annex D

THE AUDIT COMMITTEE

The National Assembly's Audit Committee ensures that proper and thorough scrutiny is given to the Assembly's expenditure. In broad terms, its role is to examine the reports on the accounts of the Assembly and other public bodies prepared by the Auditor General for Wales; and to consider reports by the Auditor General for Wales on examinations into the economy, efficiency and effectiveness with which the Assembly has used its resources in discharging its functions**.** The responsibilities of the Audit Committee are set out in detail in Standing Order 12.

The current membership of the Committee is:

Janet Davies (Plaid Cymru) - Chair
Leighton Andrews (Labour)
Mick Bates (Liberal Democrat)
Alan Cairns (Conservative)
Jocelyn Davies (Plaid Cymru)
Irene James (Labour)
Denise Idris-Jones (Labour)
Mark Isherwood (Conservative)
Carl Sargeant (Labour)
Catherine Thomas (Labour)

Further information about the Committee can be obtained from:

Kathryn Jenkins
Clerk to the Audit Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA
Tel: 02920 898501
Email: Audit.comm@wales.gsi.gov.uk