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 and translation systems. If there is an

[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 electronig i ffwrdd oherwydd eu bod yn tarfu

emergency, leave by the nearest exit, and the ushers will show you where to go.

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 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

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

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.

anghenion iechyd a'r canlyniadau, oherwydd, 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

[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

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.

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 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.

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 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 in combating them causes demand to rise. During the last year in particular, an enormous demand has been placed on the

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 galw. Yn ystod y flwyddyn ddiwethaf yn benodol, bu galw enfawr am y gwasanaeth cardioleg, yn arbennig ar gyfer profi. Mae

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.

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

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

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 '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.

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 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

Ms Body: Iawn. Mae'r adroddiad hwn yn golygu misoedd lawer o archwilio manwl mewn chwe ymddiriedolaeth a gwaith

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.

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 patients who are transferred to England.

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 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

[21] **Janet Davies:** Diolch. Hoffwn drafod paragraffau 4.2 a 4.3, sydd ar dudalen 26, ac

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.

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

Ms Lloyd: Yr wyf wedi deall y cwestiwn, 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 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.

Fodd bynnag, byddwn hefyd yn dweud, i 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 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?

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 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 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

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 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

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.

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 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.

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 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

[26] **Leighton Andrews:** Nid wyf yn gallu gweld y tabl cywir yn yr adroddiad yn awr,

remember rightly, Merthyr also benefits. Is that right?

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. 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.

[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.

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

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

ond, os cofiaf yn iawn, mae Merthyr hefyd yn elwa. A yw hynny'n gywir?

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

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

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 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.

gwaith academaidd i ategu eu rhaglen arfaethedig?

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 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 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

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 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,

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.

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 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

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 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

alternative care.

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 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.

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

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 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

[32] **Jocelyn Davies:** Mae'n galonogol

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?

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 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.

Ms Lloyd: I ateb y cwestiwn olaf i ddechrau, 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

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

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.

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 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,

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, 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

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—

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

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

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 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.

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 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

[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

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?

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

[40] **Janet Davies:** Yr wyf am adael i Carl gyfrannu gyda chwestiwn cryno, oherwydd

want to get bogged down—I want to make progress.

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

[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 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.

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.

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

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

[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

two years, three years, 10 years, or 20 years?

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 times coming down?

[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 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

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

percentage of emergency admissions.

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

Ms Lloyd: Yr ydym wedi bod yn gweld, o ran anghenion iechyd, na ellir cymharu gogledd ddwyrain Lloegr hyd yn oed â

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.

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

[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 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 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

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

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 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.

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 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?

Ms Lloyd: It has just been published to be—

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

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.

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

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.

[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?

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

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

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.

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

Ms Lloyd: Mae newydd gael ei gyhoeddi—

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

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:** Felly, beth yw'r targedau mis a deufis? Beth maent yn ei olygu?

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:** 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: 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 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:** Pryd y byddwch yn mesur cydymffurfiaeth â'r targed 2006 newydd?

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

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 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 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.

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 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,

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.

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

[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.

out-patient waiting time before that. Are you making progress with that?

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 numbers waiting.

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

[77] **Alun Cairns:** A ydych yn derbyn y casgliad hwnnw, a'r sylwadau gan y

made by the GPs in one of the appendices?

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 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.

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, 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

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

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.

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 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?

[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 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

[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

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.

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 definitive answer on that.

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 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

[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

that we have now reached. Irene James, will you take up the issue of waiting times and the accuracy of the waiting lists?

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 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?

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

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.

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

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.

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.

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

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

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

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.

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:** Yn amlwg, fel y gweddill ohonom, yr ydych yn cytuno bod aros 18 mis yn 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

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 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.

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 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 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.

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

[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

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?

Ms Lloyd: Can I give you the number, because I do not know that I can add up that fast?

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

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'.

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 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.

[101] **Jocelyn Davies:** If you are quite elderly when you go on the waiting list—I

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: A gaf fi roi'r nifer i chi, oherwydd nid wyf yn gwybod a allaf adio mor gyflym â hynny?

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

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'.

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 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:** Os ydych yn eithaf hen pan fo'ch enw'n cael ei roi ar y rhestr

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.

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

[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

pages 4 and 7, and are concerned with 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?

sy'n ymwneud â mynd i'r afael ag amseroedd 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 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.

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 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

[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,

wastage in the system?

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 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.

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 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-patients that they can see, by using

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 yn eu gweld yn uchel, drwy ddefnyddio

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.

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

Ms Lloyd: Dyna fantais y drefn bwcio'n

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 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.

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

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 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

[112] **Mick Bates:** O'r gorau, ond beth am y gwaith o gasglu gwybodaeth? Dywed

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?

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 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.

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 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

[115] **Mick Bates:** Felly, pwy sy'n gyfrifol

responsible for that negligence, and for making sure that the data was there? We have known about this for some years.

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 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.

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

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 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

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.

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 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.

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 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

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

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.

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, 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?

[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, 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 been instituted and mainstreamed.

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 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

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

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.

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.