Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 3 - Senedd

Dyddiad:
Dydd Iau, 10 Ionawr 2013

Amser:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

**Deddfwriaeth: Steve George (Y Bil Asbestos) /
Fay Buckle (Y Bil Gwasanaethau Cymdeithasol)**

Clercod y Swyddfa Deddfwriaeth 029 2089 8242/8041

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

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon

2. Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Sesiwn dystiolaeth 1 (09:00-09:45)

Mick Antoniw AC, yr Aelod sy'n gyfrifol am y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru)
Vaughan Gething AC
Paul Davies, Aelod Cyswllt o Athrofa Iechyd a Gofal Cymdeithasol Cymru

Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru) fel y'i cyflwynwyd

Memorandwm Esboniadol

3. Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol: (09:45)

Eitemau 4, 7,8 & 12

Sesiwn breifat

4. Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): trafod tystiolaeth yr Aelod sy'n gyfrifol am y Bil (09:45-10:00)

Sesiwn gyhoeddus

5. Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Sesiwn dystiolaeth 2 (10:00-10:45) (Tudalennau 1 - 6)

HSC(4)-01-13 papur 1
HSC(4)-01-13 papur 2

Ymwybyddiaeth Asbestos a Chefnogaeth Cymru

Joanne Barnes-Mannings, Swyddog Allgymorth Cymunedol
Lorna Johns, Swyddog Ymchwil a Datblygu Strategol

Fforwm Grwpiau Cymorth Dioddefwyr Asbestos y DU

Tony Whitston, Cadeirydd, Fforwm Grwpiau Cymorth Dioddefwyr Asbestos y DU
Marie Hughes, Cymorth Mesothelioma (Grŵp Cymorth Dioddefwyr Manceinion Fwyaf)

6. Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Sesiwn dystiolaeth 3 (10:45 - 11:30) (Tudalennau 7 - 11)

HSC(4)-01-13 papur 3

Undebau Llafur
Uno'r Undeb a GMB Cymru a De Orllewin Lloegr

Hannah Blythyn, Cydgysylltydd Ymgyrchoedd a Pholisi Uno'r Undeb
Mike Payne, Swyddog Rhanbarthol, GMB

Sesiwn breifat

7. Y Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru): barn y cynghorwyr arbenigol (11:30 - 11:45) (Tudalennau 12 - 21)

HSC(4)-01-13 papur 4

Sesiwn breifat

8. Y Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru): Briff Ffeithiol (11:45 - 12:15)

Rob Pickford - Cyfarwyddwr Gwasanaethau Cymdeithasol a Phlant, Llywodraeth

Cymru

Julie Rogers - Dirprwy Gyfarwyddwraig Is-adran Deddfwriaeth a Polisi Gwasanaethau Cymdeithasol, Llywodraeth Cymru

(Egwyl 12:15-13:30)

Sesiwn gyhoeddus

9. Cynlluniau i ad-drefnu byrddau iechyd - tystiolaeth gan Ddeoniaeth Cymru (13.30 - 14.15) (Tudalennau 22 - 28)

HSC(4)-01-13 papur 5

Yr Athro Derek Gallen, Deon Uwchraddedigion
Yr Athro Peter Donnelly, Dirprwy Ddeon Uwchraddedigion
Dr Helen Fardy, Arweinydd Ad-drefnu Gwasanaethau Pediatrig
Dr Jeremy Gasson, Arweinydd Ad-drefnu Gwasanaethau Obstetreg a Gynaecoleg

10. Cynlluniau i ad-drefnu byrddau iechyd - tystiolaeth gan y Fforwm Clinigol Cenedlaethol (14.15 - 15.00) (Tudalennau 29 - 41)

HSC(4)-01-13 papur 6

Yr Athro Michael Harmer, Cadeirydd
Mary Burrows, Prif Weithredwr Arweiniol GIG Cymru

11. Papurau i'w nodi (Tudalennau 42 - 46)

Cofnodion y cyfarfodydd a gynhaliwyd ar 29 Tachwedd a 5 Rhagfyr 2012

Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Llythyr o'r Llywydd (Tudalennau 47 - 51)
HSC(4)-01-13 paper 7
HSC(4)-01-13 paper 7 (atodiad)

Y Blaenraglen Waith - mis Ionawr i fis Chwefror 2013 (Tudalennau 52 - 54)
HSC(4)-01-13 papur 8

Sesiwn breifat

12. Y Bil Sgorio Hylendid Bwyd (Cymru): trafod y rheoliadau drafft

Consultation on the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill.

Evidence of Asbestos Awareness & Support Cymru

Introduction

1. This evidence is submitted by Asbestos Awareness and Support Cymru (AASC), a support group for victims of asbestos related diseases and their families. It has a web presence plus Facebook and Twitter and offers a signposting service to improve access to the best services available within Wales.

2. It is a registered charity and is a member of the National Asbestos Victims Support Forum.

3. The overall aim is to be the leading connected community within Wales to enhance the quality of life for those victims of asbestos exposure and their families.

4. Financial compensation awarded to families who have lived and died from an asbestos related disease as a consequence of the negligence of employers has made a significant impact upon lives. The move to secure compensation has also strengthened the message that breaches of Health and Safety Law and putting workers lives at risk is not be to be tolerated. Human life is precious.

5. The Recovery of Medical Costs for Asbestos Diseases (Wales) Bill is welcomed as it is demonstrating not only a concern for the welfare of patients but also highlighting the costs incurred by the NHS for what has been negligent behaviour by employers.

Executive Summary

6. AASC welcomes this move to improve care to victims of exposure to asbestos related disease but also sees that financial resources could be used to enhance the care already being provided by the NHS.

7. As a health measure the financial compensation secured through the Bill create positive health outcomes for families affected by asbestos exposure.

8. There has been complacency around the dangers of asbestos exposure which heightens the risk that numbers diagnosed with illnesses such as mesothelioma are going to increase and this will naturally impact upon levels of NHS care provided.

9. The Bill will have the effect of improving care and support provided to asbestos victims.

10. The Bill will demonstrate to the rest of the UK and to the world that Wales does recognise the damaging effect asbestos has had upon workers.

11. The Bill illustrates a Wales wide responsibility for the NHS and that financial resources are needed to ensure that our high quality of care can continue but has been compromised by employers continuing to shirk responsibilities for their employees.

Financial Support

12. Care to victims of asbestos exposure requires financial resourcing, from the initial consultation with the General Practitioner to Consultant, nurse specialist, and other health specialists called upon to provide advice on mobility and breathing exercises such as physiotherapists and occupational therapists. Each of these professions requires payment and on top of that is the need to cover drug and surgical treatment costs.

13. Support to victims of asbestos related diseases and their families continues outside the NHS through the Third Sector with one to one meetings and group sessions, and hand holding through emotionally traumatic stages of an illness. Emotional support through the Third sector groups such as AASC is crucial not only for the victims but also the informal family carers. Any financial compensation acquired through this Bill and made available to the Third sector would be valued.

14. Extra financial resources secured through the implementation of the Bill could help in the development of increased telephone helpline support, more face to face meetings and improved collaboration between victims, carers and health professionals. Enhancing connections between the 'care givers' and the 'care receivers' will bring about 'piece of mind'. Pathways of care will be strengthened thus minimising the sense of despair, distress, pain, suffering and isolation and replacing with confidence, respect and knowledge that someone does care.

15. It is recognised that administrative costs will be incurred through the processing of compensatory payments and it is hoped that these will not be too onerous and eat into the compensation secured.

Summary.

- AASC welcomes the opportunity to comment on the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill and recognises that this is s brave move for the Welsh Government to undertake but it is a move undertaken on behalf of the many who have fallen prey to evils of asbestos dust.

- We hope that the Bill continues successfully through the legislative process to secure extra financial resources which will be made available for improved care.

- The world is watching Wales for what will be an historic step forward in supporting asbestos victims.

Asbestos Awareness & Support Cymru

18 December 2012.

www.asbestosforum.org.uk

Submission to the Health and Social Care Committee

National Assembly for Wales

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill

The Forum is a national organisation representing asbestos victims support groups throughout the UK. The groups provide a dedicated service to asbestos victims including: home visits for benefits and compensation advice; representation at tribunals; support meetings for mesothelioma sufferers and their families. The Forum campaigns for: improved services and treatment for asbestos victims; justice and full compensation, and; a ban on the trade and use of asbestos world-wide.

Submission

We have addressed the consultation questions below which come within the scope of our work, knowledge and expertise.

1. Is there a need for a Bill to recover medical costs?

We think there is a need for the Bill for the following reasons:

To properly fulfil the 'polluter pays principle' by meeting the full societal cost of asbestos-related diseases.

The established principle that the polluter pays is only fully complied with in respect of asbestos-related diseases where: the full societal costs of asbestos disease is met by those employers who negligently caused damage to health or loss of life through exposure to asbestos, and; where appropriate, by those who insured negligent employers.

The exigencies of life result in many people suffering many different diseases, incurring costs of medical treatment within the NHS, which are rightly funded through National Insurance. However, asbestos diseases, in the majority of cases, are caused by negligence and could, and should, have been prevented. The cost to society of fully meeting the treatment and care needs of asbestos victims resulting from negligence should be borne by the guilty party, or their insurers, not through National Insurance.

To fulfil unmet medical needs, the costs of which fall on the wider society

Often, medical costs are met by asbestos victims and their families who try to make up for unmet medical needs, as shown in the two examples below.

Mesothelioma sufferers and their families provide an enormous amount of funding for research into the treatment of mesothelioma, which attracts very little funding from the Department of Health. The Mick Knighton Mesothelioma Research fund has donated over £1 million, supporting many research projects, as has the June Hancock Mesothelioma Research Fund. Since Action Mesothelioma Day was inaugurated in 2006 over £110,000

has been donated to these research funds by mesothelioma sufferers and their families in Greater Manchester. A similar sum has been collected by other Forum members.

Insurers have acknowledged this unmet need by donating £3 million for mesothelioma research. However, we ask the Committee to understand that insurers received a huge windfall from the tax payer through recovery of state lump sum payments for over a decade. The compensation insurers paid to successful claimants was reduced by the amount of the state lump sum payment until 2008 when the Government finally decided to recover those payments, ending the tax payers' subsidy to insurers. The DWP recovered £23,953,961.00 in 2011[1], which is the amount that insurers would have recovered in that year. It is clear that over a decade, insurers received a windfall from the tax payer of well over £100 million.

It is our view that the insurers' donation to research came from the tax payer, not the insurers. Notwithstanding that view, we believe that the unmet need for research could be supported by recovery of NHS costs as set out in the Bill, which provides for certain and dependable income based on the polluter pays principle, and not reliant on goodwill (sic).

Mesothelioma Nursing posts. The charity Mesothelioma UK has, to date, funded three specialist mesothelioma nursing posts. Funding has come from a wide source of charitable donations to provide more specialist care for mesothelioma sufferers. The cost to society of specialist care of mesothelioma sufferers could be met by those who negligently caused this disease through the recovery of NHS costs as set out in the Bill.

To relieve the cost of occupational ill health as well as injury, which falls mainly on those affected and by their families.

The HSE estimate[2] that in 2011, 54% of the cost of occupational injury and ill health (excluding cancer) was borne by individuals, with employers bearing 24% and Government 23%. The HSE Executive Board (22 Aug. 2012) indicated that the cost to society of occupational cancer is in the region of 'double billion figures'.

The cost of ill-health, injury and cancer places an unacceptable burden on individuals and their families: over double the burden on the rest of society. This Bill goes a small, but significant way in reducing that burden.

8. Does the Bill deliver the stated objectives?

The Bill seeks to recover NHS costs of treating asbestos victims negligently exposed to asbestos to Welsh Ministers for the general benefit of asbestos victims and their families. As set out, we believe that the Bill does deliver those objectives by providing for the recovery of NHS costs in cases of negligent exposure to Welsh Ministers (S2) in accordance with the National Health Service (Wales) 2006 for the purposes of treatment of, or other services relating to, asbestos-related diseases (S16).

4. How will the Bill change what organisations do? What will the impact be?

[1] http://www.dwp.gov.uk/other-specialists/compensation-recovery-unit/2008-diffuse-mesothelioma/

[2] HSE Costs to Britain of workplace injuries and work-related ill health: 2010/2011

A compensation system which reflects the true cost to society of employer negligence properly fulfils an important objective common to all compensations systems: the prevention of further injury and disease. In 2002, an HSE report[3] concluded that '*UK employers only bear a minority of the tangible costs of occupational ill health and injury through insurance premiums, and an even smaller fraction if non-tangible costs are included.*' It is unsurprising that the Report further concluded that employers did not cite the reduction of the cost of insurance premiums as a reason for improving standards of health and safety management.

In making employers and insurers more responsible for the cost to society of asbestos disease, the Bill will encourage better prevention, affirming the view that employer negligence should not be a cheap option. This is especially important as the failure of duty holders to comply with the Control of Asbestos Regulations, especially in respect of asbestos in schools, has caused public dismay, particularly in Wales. Moreover, the HSE has asked that the asbestos Hidden Killer Campaign is urgently reinstated because of their deep-felt concerns about the lack of worker awareness of the hazards of asbestos and the failure of duty holders to comply with the law.

8. Financial implications of the Bill

We support option 2i for the reasons set out in paragraph 123 of the Explanatory Memorandum.

With reference to paragraph 129 of the Explanatory Memorandum, we do not think that the proposed tariff scheme for mesothelioma untraced insurance, as announced by Lord Freud on the 25 June 2012, will impact on the number of mesothelioma claimants in Wales which will allow for recovery of NHS costs. This is because the tariff scheme is to be funded by a levy on insurers, which is likened to a 'tax', so that payments to mesothelioma sufferers successful in a claim on the scheme will be paid by public funds. Furthermore, payments are envisioned to be paid at approx. 75% of average mesothelioma awards and will not conform to the usual civil law rules for payment, e.g. payment to the deceased's estate.

Had the Government adopted the main, and only costed option, in the consultation i.e. an Employers Liability Insurance Bureau (ELIB), similar to the Motor Insurers' Bureau (MIB), then mesothelioma sufferers would be treated no less favourably than injured drivers and would receive a payment from an insurance fund which could be vulnerable to recovery of NHS costs.

Tony Whitston

Forum Chair

20 December 2012

[3] HSE Report 436/2002. 'Changing business behaviour – would bearing the true cost of poor health and safety performance make a difference?'

Consultation – Recovery of Medical Costs for Asbestos Diseases (Wales) Bill

Joint response from Unite Wales and GMB Wales & South West trade unions

General

1. **Is there a need for a Bill to allow recovery of costs of NHS treatment for asbestos related diseases in Wales? Please explain your answer.**

Yes. We believe that there is a compelling case for a Bill to allow recovery of costs of NHS treatment of asbestos related diseases in Wales. Hundreds of Welsh workers die every year from asbestos related disease and exposure to asbestos at work has caused suffering and hardship for thousands of others over the past decades. Many of Unite and GMB's current membership have been exposed to asbestos. Our members who have worked in the insulation industry, ship building, power stations, manufacturing and construction are among the occupational groups most at risk of developing asbestos related disease.

What must not be overlooked here is the incalculable human suffering asbestos disease inflicts on Welsh workers and the devastating effect on their families. Those who suffer most are the estimated 100 people who will die each year in Wales from mesothelioma, the fatal asbestos cancer. There is no known cure for mesothelioma. The average life expectancy of a mesothelioma patient is 12 -18 months from the onset of symptoms with many dying in less than a year from diagnosis. HSE reports that most people who develop mesothelioma were exposed to asbestos at work.

We note from the Regulatory Impact Assessment that the treatment of patients diagnosed with asbestos related diseases has cost and continues to cost the Welsh NHS an average of £23,000 per patient, placing a considerable financial burden on the already financially hard pressed NHS in Wales. At diagnosis of the disease, there will be attendances to GPs, referral to consultants for radiology, biopsies, radiotherapy, and chemotherapy and in many cases, palliative care.

We believe that in cases where there is a clearly identifiable negligent employer and a civil compensation settlement is due it is only right that the negligent party (or their insurer) should reimburse the NHS for the cost of medical treatment paid for by NHS Wales. We believe that the 'polluter pays' principle should apply. The Bill will achieve this socially desirable outcome by requiring the negligent employer, or the insurer of the negligent employer, to contribute towards the

costs to society of providing medical treatment and support to Welsh workers who develop asbestos disease.

The Bill will displace the financial burden from the Wales NHS, which currently bears the cost of providing medical care and treatment, and transfer it to the negligent employer which caused the disease, or their insurer. The view of our members and, we believe, of Welsh working people generally, is that the aim of the Bill is entirely consistent with progressive social policy.

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

Yes. The Bill, as drafted, delivers the stated objectives as set out in the Explanatory Memorandum. It makes clear the intended purpose of the Bill and the mechanism for recovery of NHS costs.

3. Are the sections of the Bill appropriate in terms of introducing a regime to allow the recovery of costs of NHS treatment for asbestos related diseases in Wales? If not, what changes need to be made to the Bill?

We believe the sections of the Bill are appropriate, internally consistent and proportionate to the aims of the Bill. The Bill is clear in terms of introducing a regime to allow the recovery of costs of NHS treatment for asbestos related diseases in Wales. This is further expanded and illustrated in the Explanatory Memorandum. We therefore do not consider that any changes need to be made to the Bill.

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

Clearly the Bill will have a positive impact on the NHS in Wales in that it will reimburse the NHS in Wales for the significant costs for treatment of patients diagnosed with asbestos related diseases. In addition, as outlined by the Bill, the costs recovered will be of benefit to both the services provision of the NHS in Wales and the future treatment of victims of asbestos related diseases.

The establishment of an administrative process for the recovery of costs of the treatment of patients diagnosed with asbestos related diseases to the NHS in Wales will, of course, involve some initial change. However, we believe that the Explanatory Memorandum clearly outlines the available options. We support the proposed use of the existing injury compensation scheme coordinated by the CRU at the Department of Work and Pensions. We believe this would achieve the most cost effective balance by using established CRU structures and procedures, automated systems, data links to compensators and NHS bodies with the advantages of a single point of contact for data collection and administration of recovery of NHS treatment costs from compensators.

Moreover, the positive impact of these changes and the cost to society in the long term significantly outweigh any potential organisational adjustment at the outset.

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

We believe the Bill and the related Explanatory Memorandum make clear the provisions of the Bill and the mechanism of implementation.

We are aware that the Association of British Insurers (ABI) have indicated in their initial consultation response that they object to the Bill. We believe that the commercial interests of insurers should not take precedence over the principle of social justice which the Bill aims to deliver. Insurers who may claim that the impact of the Bill will result in the increased cost of insurance to employers in the current marketplace should be reminded that those insurers have already received, invested, reserved and profited from the premiums they were paid by employers in the past whose negligence is the cause of Welsh workers currently developing asbestos disease.

We also reject the specious objection from ABI that the NHS in Wales has already received the cost of treatment in the form of National Insurance Charges paid by workers – and that the Bill would result in duplication of payment. This ignores the obvious fact that if the insured employer had not negligently exposed Welsh workers to asbestos those workers who develop asbestos disease would not have done so and the substantial cost to the NHS in Wales of treating those patients would never have arisen. The ABI objection to the Bill offends the 'polluter pays' principle.

6. **Do you have any views on the way in which the Bill falls within the legislative competence of the National Assembly for Wales?**

We believe the Bill falls within the legislative competence of the National Assembly for Wales, under subject heading 9 of Part 1 of Schedule 7 to the Government of Wales Act 2006. This specifically includes the prevention, treatment and alleviation of disease, illness, injury, disability and mental disorder; and the organisation and funding of National Health Service. The purpose of this Bill is relevant to the 'treatment of disease, illnesses under this subject heading and the proposal of the Bill fits within 'organisation and funding of National Health Service.'

<u>Powers to make subordinate legislation</u>

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

In answering this question, you may wish to consider Section 5 of the Explanatory Memorandum, which contains a table summarising the powers delegated to Welsh Ministers in the Bill to make orders and regulations, etc.

The Bill strikes an effective balance between provision outlined in the Bill itself and the provision that will be made by subordinate legislation. This is similar to the

Health and Social Care (Community Health and Standards) Act 2003. Much of the procedure of the Bill in practice will be administrative, technical and incredibly detailed. Parts of provision of the Bill will also necessitate flexibility. This is therefore more suitable to subordinate legislation rather than the Bill itself.

Financial implications

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

In answering this question you may wish to consider Part 2 of the Explanatory Memorandum (the Regulatory Impact Assessment), which estimates the costs and benefits of implementation of the Bill.

It is estimated that the cost of care of victims of asbestos related diseases to the NHS in Wales is £2 million a year. The recovery of the costs of the treatment of asbestos related diseases in Wales would be significant to the NHS in Wales at a time when it is financially hard pressed.

The scale of the costs associated with the administration of the scheme are dependent on the administrative system used, the level of charges agreed within the tariff system and the amount of cases processed. However, the Explanatory Memorandum clearly outlines a number of options at varying initial and recurrent costs per annum. We refer to our response to Q4 outlining support for making the most effective use of existing CRU procedures for recovery of NHS treatment costs in order to minimise the administrative and business costs and maximise the net return.

We believe it is necessary and desirable to keep the administrative and business costs of the recoupment process to a minimum. We support the introduction of a tariff system for the calculation and recovery of NHS treatment costs. We note from the Explanatory Memorandum that there is a close correlation between the average cost in the proposed standard tariff (£25,361) with the average figure for the actual cost of treatment (£23,299) although we appreciate that there is potential for wider variation due to the relatively small sample of cases that formed the basis of the treatment cost analysis. In principle we consider that a form of capped tariff system is a reasonable and proportionate means of delivering the objectives of the Bill whilst minimising the operational costs.

We also believe that the combination of a capped standard tariff system with a CRU based recovery mechanism will provide an efficient means of dealing with any appeals and challenges by compensators or other parties and should minimise the scope for challenges due to the simplicity and clarity of a tariff based approach.

In addition, in relation to the costs for organisations liable for paying NHS charges the Bill does not create any new entitlement to compensation where a claim would not already exist. Successful claims arise when it is proven that a party such as the employer has been negligent. The status quo means that the NHS in Wales and therefore the public purse and the taxpayer must pick up the tab for the negligent party. We believe that this Bill is necessary, just and would ensure that the right party, or their insurer, is held responsible for their wrongdoing.

Other comments

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

It is important to GMB and Unite that the Bill binds the Crown so as to achieve parity of treatment between the recovery of NHS costs from commercial sector employers and insurers as well as government departments and former nationalised industries where many of our members worked and were negligently exposed to asbestos. It would be inequitable that a Crown employer who would also have made provision for risk, and who was as negligent as any private sector employer, should not bear the same responsibility to pay the same dues to society.

We reiterate our full support for the Bill which we believe is representative of Wales leading the way on matters of political substance and principle and delivering on the practicalities of implementing social justice. GMB and Unite in Wales commend this Bill for the benefits it confers on the NHS in Wales and the improved level of support and treatment it will generate for the people of Wales who will suffer the devastating effects of asbestos disease due to the legacy of employer negligence.

For further information please contact:

Unite - Hannah Blythyn on 07980 237694 or hannah.blythyn@unitetheunion.org
GMB – Mike Payne on 07980 753124 or mike.payne@gmb.org.uk

Yn rhinwedd paragraff(au) ix o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

Wales Deanery
Deoniaeth Cymru

Tystiolaeth Ysgrifenedig gan Ddeoniaeth Cymru i'r Pwyllgor Iechyd a Gofal Cymdeithasol

1. **Safbwynt y Ddeoniaeth ar y materion staffio sy'n wynebu'r GIG yng Nghymru ar hyn o bryd:**

Hwyrach ei bod yn bwysig gosod rôl Deoniaeth Cymru ('y Ddeoniaeth') yn ei chyd-destun cyn rhoi sylwadau ar y cwestiynau fel y'u hamlinellwyd yn yr ohebiaeth â'r Pwyllgor Iechyd a Gofal Cymdeithasol. Diben y Ddeoniaeth yw cefnogi, comisiynu a sicrhau ansawdd addysg a hyfforddiant hyfforddeion, Meddygon Teulu, Deintyddion a gweithwyr Gofal Deintyddol Proffesiynol yng Nghymru. Mae hyn yn cyfrif am tua 2700 o feddygon dan hyfforddiant a 330 o hyfforddeion deintyddol yng Nghymru.

Mae'r Ddeoniaeth yn atebol i'r Cyngor Meddygol Cyffredinol (y GMC) a rhaid iddi sicrhau ei bod yn cyflawni ei hymrwymiadau tuag at les ei hyfforddeion a chleifion yng Nghymru. Bellach, mae un gyfres o safonau ar gyfer y llwybr hyfforddi meddygol ôl-raddedig cyfan, o'r Rhaglen Sylfaen hyd at ddyfarnu'r Dystysgrif Cwblhau Hyfforddiant (CCT). Mae'r ddogfen 'The Trainee Doctor,'[1] a gyhoeddwyd yn 2011, yn ymgorffori'r safonau y bydd y GMC yn dal y deoniaethau ôl-raddedig yn atebol amdanynt yn unol â'r Ddeddf Meddygaeth 1983.

Mae'r Ddeoniaeth yn rhoi tystiolaeth i'r GMC yn rheolaidd bod cydymffurfiaeth â'r safonau hyn, er enghraifft Adroddiadau Blynyddol a Ffurflenni Data. Yn ogystal, mae'r GMC yn cynnal Ymweliad Arolygu Sicrwydd Ansawdd â phob deoniaeth yn y DU; cynhaliwyd yr ymweliad diweddaraf â Chymru ym mis Tachwedd 2011. Yn ogystal, mae'r GMC yn cymeradwyo cwricwla a systemau asesu, a ddyfeisiwyd gan Golegau Brenhinol Arbenigeddau, rhaglenni hyfforddi a swyddi.

Yn dilyn methiant y Medical Training Application Service (MTAS) yn 2007, mae recriwtio ar gyfer swyddi Hyfforddiant Arbenigol yn parhau i ddatblygu. Mae'r broses wedi cael ei symleiddio ar draws y DU. Ar gyfer pob arbenigedd, mae hyfforddeion bellach yn gwneud cais i un porth mynediad ac yn rhoi'r rhanbarth o'u dewis. Mae'r broses hon wedi gostwng yn sylweddol nifer y ceisiadau y mae pob Deoniaeth yn eu rheoli; fodd bynnag, mae hyn bellach yn cynnig golwg fwy realistig o nifer yr ymgeiswyr sy'n dymuno gwneud cais i Gymru am arbenigedd neu radd benodol.

Ar draws y DU, mae anawsterau o ran recriwtio i arbenigeddau penodol, sef Paediatreg, Seiciatreg a Meddygaeth Brys. Felly nid yw Cymru ar ei phen ei hun o ran cael anawsterau'n llenwi rotâu yn yr arbenigeddau hyn; fodd bynnag, dylid nodi bod y cyfraddau llenwi ar gyfer Cymru yn is o lawer na'r rhai ar draws Lloegr.

Arbenigedd	Cyfradd lenwi 2012 Lloegr	Cyfradd lenwi 2012 Cymru	Cyfradd lenwi 2011 Cymru
Paediatreg (diwedd rownd 1)	99%	87%	76%
Seiciatreg	68%	38%	56%
Hyfforddiant Meddygol Craidd	99%	72%	82%

1. *Y Cyngor Meddygol Cyffredinol (2011) The Trainee Doctor, GMC*

Wales Deanery Deoniaeth Cymru

Enghraifft bellach yw'r ffaith bod Cymru yn y 3 blynedd diwethaf, er ei bod wedi hysbysebu dros 15 swydd, wedi recriwtio 4 hyfforddai yn unig i Feddygaeth Brys.

Mae bylchau mewn recriwtio yn effeithio'n sylweddol ar rotâu sydd yna'n rhoi pwysau gwasanaeth gormodol ar yr hyfforddeion, er drwg i'w profiad addysgol. Mae'r Ddeoniaeth yn argymell, ar sail canfyddiadau Adroddiad Temple [2], y dylai rotâu fod ag 11 cyfranogai i atal effaith negyddol oherwydd bylchau mewn recriwtio, hyfforddiant llai nag amser llawn (LTFT), absenoldeb oherwydd salwch, cyfleoedd hyfforddi y tu allan i'r rhaglen ac absenoldeb mamolaeth. Bydd y dull hwn yn cynnig rhaglenni hyfforddi cynaliadwy i Gymru ar gyfer y dyfodol.

Ar gyfer y rhan fwyaf o arbenigeddau, caiff hyfforddeion eu gosod ar draws 15 Uned yng Nghymru lle mae'r rotâu'n cynnwys llai nag 11 o bobl. Felly, mae hyn yn golygu bod ein hyfforddeion yn yr arbenigeddau hyn yn cael eu gwasgaru'n rhy denau ar draws gormod o ysbytai.

Er mwyn cydymffurfio â safonau'r GMC ar gyfer hyfforddi a gofynion y Cwricwla Arbenigeddau unigol, mae angen i hyfforddeion gael y cysylltiad perthnasol â chleifion, gan weld holl ehangder cyflwyniadau a rheolaeth ar gleifion sâl. Mae hyn golygu nad yw'n bosibl rhoi hyfforddeion ym mhob adran ym mhob ysbyty ar draws Cymru, gan fod y cyfleoedd hyfforddi a roddir iddynt yn ystod eu cyfnod hyfforddi cymharol fyr yn annigonol i fodloni gofynion y cwricwla. Os na all hyfforddeion fodloni gofynion y cwricwlwm, byddant yn methu symud ymlaen i'r flwyddyn nesaf, maent yn fwy tebygol o fethu arholiadau'r Coleg Brenhinol ac mae hyn yn ei dro yn arwain at enw gwael i Gymru o ran hyfforddiant.

Mae tensiwn bob amser rhwng darparu gwasanaeth ac addysg yn y GIG ac mae'n hanfodol bwysig ein bod yn taro'r cydbwysedd cywir rhwng yr hyfforddeion yn dysgu yn y gweithle a chyfrannu at ddarparu gwasanaeth, ond gan sicrhau yn y bôn eu bod yn cael yr hyfforddiant gorau posibl. I sicrhau bod darpariaeth yn y dyfodol o feddygon o safon uchel sy'n cynnig gofal diogel i gleifion yng Nghymru, mae angen amser neilltuedig ar hyfforddeion ar gyfer eu haddysg i'w galluogi i gyflawni'r llwyddiant gofynnol yn arholiadau'r Coleg Brenhinol a dilyniant llyfn drwy eu rhaglen hyfforddi.

2. Sut caiff anawsterau staffio eu hesbonio orau:

Y peth gorau yw parhau i ganolbwyntio ar yr anawsterau a gawn wrth recriwtio meddygon iau, yng Nghymru yn y lle cyntaf. Mae'r GIG yng Nghymru wedi bod yn gorddibynnu ar bresenoldeb meddygon iau i ddarparu gwasanaeth, yn dyddio'n ôl sawl blwyddyn. Lleihaodd y Gyfarwyddeb Oriau Gwaith Ewropeaidd yn 2005 nifer yr oriau y gallai meddygon eu gweithio i 56 awr yr wythnos, a'r unig ffordd yr oedd modd i'r gwasanaeth reoli'r gostyngiad hwn oedd cynyddu nifer y meddygon iau. Yn anffodus, yng Nghymru, bu cynnydd amlwg yn nifer y swyddi Uwch-swyddog Preswyl (a elwir nawr yn hyfforddiant craidd) ar draws bob Ymddiriedolaeth er mwyn sicrhau bod y rotâu yn cydymffurfio. Mae hyn wedi cael effaith niweidiol ganlyniadol ar recriwtio i hyfforddiant arbenigedd uwch yng Nghymru gan ei fod wedi golygu nad oedd ein cymarebau cystadlu wrth fynd o hyfforddiant craidd i hyfforddiant uwch yn cyd-fynd â gweddill y DU.

2. Temple, J (2010). Time for Training. A review of the impact of EWTD on the quality of training

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Pan fyddant yn penderfynu pa arbenigedd ac ardal i wneud cais ar ei gyfer, caiff ymgeiswyr fanteisio ar wybodaeth o amryw ffynonellau bellach. I ymgeiswyr heddiw, mae cyfleoedd am ddilyniant gyrfaol yn ffactor pwysig. Po fwyaf o swyddi craidd sydd ar gael o gymharu â'r swyddi uwch, y lleiaf tebygol yw hi y bydd hyfforddai'n symud ymlaen o hyfforddiant craidd i hyfforddiant uwch. Er enghraifft, yn 2009, cyrhaeddodd y cymarebau o ymgeiswyr i swyddi ar gyfer arbenigeddau llawdriniaethol uchafswm o 58 ymgeisydd i bob swydd a hysbysebwyd. Mae'r wybodaeth hon yn hysbys i hyfforddeion, gellir ei holrhain ac mae ar gael ar y we.

Fe wnaeth hyn ynddo'i hun beri nad oedd Cymru'n lle deniadol i ddod iddo gan fod ymdeimlad bod cymarebau'r gystadleuaeth yn ormod o risg i gyfiawnhau gwneud cais. O ganlyniad i flynyddoedd olynol gyda swyddi gwag, mae paneli recriwtio wedi gostwng y trothwy derbynioldeb, ac o ganlyniad, mae'r rhai sy'n cael eu penodi o safon is. Mae'r meddygon hyn yn cael anhawster llwyddo yn arholiadau'r Coleg Brenhinol, ac mae tablau cynghrair ar y rhain yn cael eu cyhoeddi ac maent ar gael ar y we ar draws y DU. Eto, dyma ffactor negyddol o ran gwneud cais i ardal sydd â chyfraddau llwyddo isel. Mae tystiolaeth o'r arolwg blynyddol o adolygiadau cynnydd hyfforddeion yn ategu hyn. Yn 2012, cynyddodd nifer yr hyfforddeion yr oedd angen estyniad ffurfiol i hyfforddiant arnynt o ganlyniad i fethu 35%, a chynyddodd nifer yr hyfforddeion a dynnwyd yn ôl o hyfforddiant 44%.

Newidiodd y rheolau mewnfudo yn 2007 a wnaeth atal nifer sylweddol o raddedigion meddygol rhyngwladol rhag dod i Gymru. Yn flaenorol, roedd Cymru wedi cael gwasanaeth da gan nifer fawr o raddedigion meddygol rhyngwladol a oedd yn gymorth mawr yn bennaf wrth ddarparu gwasanaeth ac nad oeddent mewn swyddi hyfforddi. Yn 2008, cafodd Cymru geisiadau gan 1466 o raddedigion meddygol rhyngwladol; yn 2012, cafodd y DU yn ei chyfanrwydd geisiadau gan 1777. Wrth droi'r ffynhonnell draddodiadol hon o feddygon ymaith, roedd Cymru yn orddibynnol unwaith eto ar bresenoldeb hyfforddeion i ddarparu gwasanaeth.

Mae materion eraill nad ydynt yn gwneud Cymru'n lle deniadol i wneud cais i weithio a hyfforddi; mae daearyddiaeth yn un amlwg. Mae ymgeiswyr yn pryderu y gall fod yn rhaid iddynt symud dros bellteroedd sylweddol er mwyn cwblhau eu hyfforddiant, pan fyddant yn symud i Gymru. Er nad oes trafferth llenwi'r ysbytai ar hyd coridor yr M4 i raddau helaeth, mae gennym anawsterau cynyddol yn recriwtio i orllewin a gogledd Cymru. Rydym wedi ymdrechu i fynd i'r afael â'r mater hwn yng ngogledd Cymru trwy lunio cysylltiad â Deoniaeth Mersi er mwyn cael cyfnodau hyfforddi nad ydynt yn gofyn mwyach i'r hyfforddeion deithio i dde Cymru i gael y profiadau angenrheidiol i ateb anghenion y cwricwlwm. Felly rydym yn ystyried cynnal cyfnodau hyfforddi ar draws gogledd Cymru, ond bydd hyn yn cymryd cryn amser i ymsefydlu.

Mae amgyffredion eraill gan hyfforddeion ac yn wir staff eraill o ran dod i Gymru. Un yw camddealltwriaeth ynghylch yr angen i allu siarad Cymraeg ac, yn wir, cafwyd adroddiadau bod rhai pobl o dan yr argraff bod gennym arian gwahanol i weddill y DU.

Mae'r gronfa staff meddygol yn datblygu. Cynyddodd nifer graddedigion y DU 76% yn y 10 mlynedd hyd 2006, yr oedd dau o bob tri o'r rhain yn fenywaidd. Ar hyn o bryd, mae 53% o'r holl hyfforddeion yng Nghymru yn fenywaidd. Mae'r galw am

hyfforddiant LTFT, naill ai ar gyfer salwch neu anabledd neu o ganlyniad i gyfrifoldebau gofalu naill ai am blant neu ddibynyddion, wedi codi o 87 yn 2007 i 173 yn 2011. Ar hyn o bryd yn 2012, 203 yw'r nifer hwn a rhagwelir y bydd 48 arall yn dechrau erbyn diwedd 2012. Mae hyn yn cyfateb i ryw 10% o'r hyfforddeion yng Nghymru.

Yn 2011, aeth 100 o hyfforddeion ar absenoldeb mamolaeth ac fe wnaeth 50% o'r rhain gais am hyfforddiant LTFT ar ôl dychwelyd i'r gwaith. Yn ystod rhaglen hyfforddi gyfartalog, gall hyfforddeion fynd ar absenoldeb mamolaeth fwy nag unwaith a gallant newid rhwng cyflogaeth amser llawn a chyflogaeth LTFT.

Mae data gweithlu GIG Cymru yn dangos nad yw benyweiddio'r gweithlu wedi effeithio'n llawn ar y GIG eto ac mae mwy o fenywod o hyd i gyrraedd blynyddoedd gwasanaeth hyfforddiant y radd ganol.

O ran strategaeth farchnata, mae'n hynod annhebygol y byddai gan fwyafrif y bobl sy'n gwneud cais am swyddi unrhyw ddealltwriaeth wirioneddol o union leoliadau Bwrdd Iechyd Prifysgol Betsi Cadwaladr nac yn wir Bwrdd Iechyd Hywel Dda yn ddaearyddol. Mae'r ddau ohonynt yn cynnig cyfleoedd addysg rhagorol ac maent yn fannau prydferth i fyw a gweithio ynddynt er mwyn cael cydbwysedd rhagorol rhwng bywyd a gwaith, ond ni wnaed y gorau o fanteision y lleoliadau hyn.

Mae'n bwysig amlygu bod recriwtio a chadw hyfforddeion Meddygaeth Teulu yn broblem yng Nghymru. Mae hyn yn digwydd ar adeg pan fo darpariaeth Meddygaeth Teulu yn fwyfwy allweddol i wasanaeth iechyd modern, integredig. Mae patrymau tebyg yn bodoli lle nad yw dewisiadau hyfforddeion yn cynnwys gogledd neu orllewin Cymru.

3. Y ffordd orau o fynd i'r afael ag anawsterau staffio yng Nghymru:

Yr agwedd bwysicaf ar gyfer denu a chadw meddygon dan hyfforddiant i Gymru yw gwella'r profiad hyfforddi iddynt pan fyddant yn y wlad. Mae hyn yn golygu llai o ddibyniaeth arnynt ar gyfer darparu gwasanaeth a chontractau addysgol cytûn gyda'u hawdurdodau cyflogi, yn hytrach na'r contract presennol sydd â mwy o gysylltiad â darparu gwasanaeth. Mae angen amser wedi'i ddiogelu ar hyfforddeion am addysg yn ystod yr wythnos waith i fynd i'r theatr neu i glinigau cleifion allanol ac i gael amser astudio.

Mae angen proffesiynoli rôl goruchwylwyr addysgol. Gellir cyflawni hyn gan y cytundeb Tridarn y cynhaliodd y Ddeoniaeth gynllun peilot ohono ar draws nifer o Fyrddau Iechyd. Mae'n cyflwyno cytundeb rhwng goruchwylwyr addysgol, Byrddau/Ymddiriedolaethau Iechyd a'r Ddeoniaeth gan ddiffinio rolau a chyfrifoldebau ar gyfer darparu goruchwyliaeth addysgol. Bydd cynnwys goruchwyliaeth addysgol yn y broses arfarnu, gyda goruchwylwyr addysgol yn ymrwymo i wella'u sgiliau trwy ddatblygiad proffesiynol parhaus yn y rôl, yn arwain at brofiadau addysgol gwell i hyfforddeion.

Mae'r Ddeoniaeth hefyd o'r farn y dylid cynnal hyfforddiant ar lai o safleoedd er mwyn galluogi más critigol o hyfforddeion. Bydd hyn yn sicrhau bod hyfforddeion yn cael profiad clinigol digonol, bod eu rotâu ar gyfer gwasanaeth y tu allan i oriau yn gadarn gyda lleiafswm o 1 mewn 11 o ran ymrwymiad y tu allan i oriau, ac y byddant yn cael amser wedi'i ddiogelu yn ystod y diwrnod gwaith ar gyfer addysg,

presenoldeb mewn clinig cleifion allanol ac amser theatr ar gyfer arbenigeddau'r grefft. Yn ein tyb ni, bydd hyn yn gwella'u profiad, gwella cyfraddau llwyddo mewn arholiadau a gwella gofal i gleifion.

Hyd yn hyn, mae'r Ddeoniaeth wedi cyflwyno nifer o fentrau i gynorthwyo â recriwtio a chadw ar draws Cymru. Mewn rhai arbenigeddau, mae'r Ddeoniaeth wedi lleihau nifer y swyddi cyfnod penodol. Mae'r swyddi anatyniadol hyn wedi'u troi'n swyddi hirdymor cynaliadwy sy'n cynnig y sicrwydd y mae ar hyfforddeion ei angen.

Mae'r Ddeoniaeth wedi datblygu Hyfforddiant Academaidd Clinigol Cymru sy'n darparu rhaglen 8 mlynedd unigryw gyda ffocws cyfartal ar hyfforddiant clinigol ac academaidd. Mae diddordeb mawr yn y rhaglen hon, ac mae wedi denu a chadw hyfforddeion o safon uchel yng Nghymru.

Mewn rhai arbenigeddau, rydym wedi cychwyn a chynnal cynlluniau peilot o flynyddoedd ychwanegol er mwyn rhoi cyfleoedd i feddygon atgyfnerthu eu profiad hyfforddiant a'u paratoi'n well ar gyfer cystadleuaeth mewn hyfforddiant uwch.

Hefyd, mae'r Ddeoniaeth wedi ymrwymo i leihau nifer y swyddi hyfforddi craidd mewn arbenigeddau sydd â chymarebau cystadlu arbennig o uchel fel eu bod yn cyd-fynd yn well â chyfleoedd i fynd ymlaen i hyfforddiant uwch. Mae'r swyddi hyn naill ai wedi'u trosi'n hyfforddiant uwch yn yr arbenigedd hwnnw neu defnyddiwyd y cyllid i ddatblygu swyddi mewn arbenigeddau newydd sy'n dod i'r amlwg, fel Meddygaeth Brys Cyn Ysbyty, Meddygaeth Gofal Dwys, Meddygaeth Strôc a datblygiad rhaglen y Cymrawd Arwain Clinigol a fydd yn cefnogi dilyniant gyrfaol a dysgu gydol oes ar gyfer darpar arweinwyr meddygol a deintyddol. Mae'r Ddeoniaeth o'r farn y bydd buddsoddi yn yr arbenigeddau hyn yn dangos Cymru mewn goleuni cadarnhaol mewn perthynas â gweddill y DU.

Mae mentrau eraill yn cynnwys Prosiect iDoc Rhaglen Sylfaen Cymru Gyfan sy'n rhoi dyfais Smartphone i feddygon dan hyfforddiant i'w galluogi i gael at wybodaeth feddygol gywir i gynorthwyo â darparu gwybodaeth glinigol a dysgu mewn union bryd.

Yn 2009, lansiodd y Ddeoniaeth Wobrau'r Goruchwyliwr a Hyfforddwr Addysgol Gorau (BEST) gyda'r nod o sicrhau rhagoriaeth mewn hyfforddiant meddygol trwy ddatblygiad a chefnogaeth goruchwylwyr addysgol a chlinigol o safon uchel ledled Cymru. Mae'r gwobrau hyn wedi mynd o nerth i nerth ac maent yn fodel a ddilynir gan ddeoniaethau eraill ar draws y DU.

Mae Gwasanaethau Gwybodaeth Iechyd ac Estyniad Llyfrgelloedd Cymru Gyfan (AWHILES), sy'n unigryw i Gymru, yn galluogi pob meddyg a deintydd ar radd hyfforddi i gael at gyfleusterau a chymorth addysgol ôl-raddedig o safon uchel fel y gallant gyflawni eu potensial wrth ddarparu gwasanaeth i'r GIG yng Nghymru.

Mae'r Ddeoniaeth yn cydnabod y dylid amlygu'r agweddau cadarnhaol niferus ar hyfforddiant yng Nghymru i ddarpar ymgeiswyr. Dechreuodd y gwaith hwn yn 2010 trwy gyflwyno'r ymgyrch farchnata 'Y Dewis Doeth' gyda Llywodraeth Cymru ac mae gwaith ar hyn yn parhau ar y cyd â Chonffederasiwn y GIG. Mae'r Ddeoniaeth yn mynd rhagddi i hyrwyddo 'Hyfforddiant yng Nghymru' mewn ffeiriau gyrfaoedd meddygol amrywiol ar draws y wlad. Mae'r Ddeoniaeth yn cydnabod, fodd bynnag, bod angen mwy o waith i bwysleisio'r cyfleusterau ymchwil rhagorol ac uchel eu

parch, yr hyfforddwyr rhagorol a'r cyfleusterau addysgu a hyfforddi rhagorol sydd ar gael ar draws Cymru.

Yn 2012, roedd Uned Cymorth Proffesiynol y Ddeoniaeth, y mae ei gwaith yn cefnogi datblygiad meddygon a deintyddion, ymhlith y goreuon yng Ngwobrau Rhagoriaeth yr Healthcare People Management Association (HPMA) yn y categori: Gwobr Perfformiad Gofal Iechyd ar gyfer y strategaeth hyfforddi a datblygiad personol orau. Cafodd yr Uned Cymorth Proffesiynol ei chanmol am mai dyma oedd y cynnig cyntaf gan Ddeoniaeth yn y DU i wobrau HPMA.

Mae'r Ddeoniaeth yn parhau i roi cymaint o gyhoeddusrwydd ag y gall i ansawdd hyfforddiant yng Nghymru, ac yn ddiweddar, enillodd wobr y Medical Women's Federation ar gyfer y Ddeoniaeth Fwyaf Cyfeillgar i'r Teulu yn y DU. Dyma'r ail flwyddyn yn olynol i ni ennill y wobr honno ac mae'n adlewyrchu ein hymrwymiad nid yn unig i ddarparu'r hyfforddiant gorau posibl i hyfforddeion yma yng Nghymru, ond hefyd cydbwysedd cadarnhaol rhwng bywyd a gwaith er mwyn hyrwyddo cadw meddygon sy'n dod i Gymru.

Mae'r Ddeoniaeth yn gweithio'n agos ag Ysgolion Meddygol a Chlinigol yng Nghymru. Ar y cyd ag Ysgol Feddygaeth Prifysgol Caerdydd, mae'r Ddeoniaeth yn chwarae rôl arweiniol yn unioni blwyddyn olaf y cwrs meddygaeth israddedig â blwyddyn gyntaf y Sylfaen. Nod y fenter hon yw sicrhau bod meddygon newydd gymhwyso, wedi iddynt raddio, yn addas at y diben ar gyfer eu rôl yn y GIG a'u bod yn gymwys ac yn hyderus yn glinigol.

4. I ba raddau y mae'r cynigion presennol ar gyfer ad-drefnu'r gwasanaeth yn cael eu gyrru gan yr angen i ymateb i heriau staffio?

Mae'r Ddeoniaeth wedi gweithio'n agos gyda'r holl Fyrddau Iechyd mewn perthynas â'u cynlluniau ad-drefnu gwasanaethau. Dechreuodd cynlluniau ad-drefnu hyfforddiant y Ddeoniaeth ei hun ar 1 Mawrth 2010 a dechreuont cyn yr ystyriaethau ad-drefnu gwasanaethau yr ydym yn eu hwynebu nawr. Mae'r rhesymeg wrth wraidd ad-drefnu hyfforddiant eisoes wedi'i amlinellu mewn perthynas â llai o safleoedd, rotâu cynaliadwy, amser addysgu wedi'i ddiogelu a llai o ddibyniaeth ar yr hyfforddeion i ddarparu gwasanaeth.

Wrth reswm, yn sgil nifer y meddygon sy'n hyfforddi, maent yn parhau i wneud cyfraniad sylweddol at ddarparu gwasanaeth. Yr hyn sy'n allweddol i Gymru yw cael y cydbwysedd cywir, sy'n anhawster ar draws y DU. Er bod y Ddeoniaeth wedi amlygu'r angen i gynnal hyfforddiant ar lai o safleoedd, nid ydym erioed wedi rhoi cyfarwyddyd i unrhyw rai o'r Byrddau Iechyd ynghylch pa safleoedd y dylid cynnal yr hyfforddiant arnynt gan mai cyfrifoldeb y gwasanaeth yw penderfynu ar union drefn y ddarpariaeth gwasanaeth i Gymru.

Mae cysylltiad y Ddeoniaeth â'r Byrddau Iechyd a'r cynlluniau presennol yr ydym wedi'u gweld (cynhaliwn ddeialog barhaus gyda Bwrdd Iechyd Prifysgol Betsi Cadwaladr a Bwrdd Iechyd Hywel Dda, ac mae gennym gynrychiolaeth ar Fwrdd Rhaglen De Cymru a'r Fforwm Clinigol Cenedlaethol) yn awgrymu y bydd mantais fawr i ofal cleifion a chyflwyno gofal yn sgil ad-drefnu'r gwasanaeth. Mae'r Ddeoniaeth o'r farn y bydd hyn yn cael effaith gadarnhaol ar hyfforddi, recriwtio a chadw meddygon y gobeithiwn eu cadw yng Nghymru fel gweithlu'r dyfodol, gan gyflwyno gofal o'r ansawdd gorau posibl i'n cleifion.

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Er ein bod yn sylweddoli bod Byrddau Iechyd yn gweithio yn ôl amserlen benodol, rydym o'r farn bod ad-drefnu hyfforddiant mewn rhai arbenigeddau yn debygol o ddigwydd yn gynt na'r amserlen a bennwyd ar gyfer ad-drefnu'r gwasanaeth. Mae hyn yn arbennig o berthnasol mewn Paediatreg, Meddygaeth Brys a Seiciatreg, y mae nifer y meddygon sy'n hyfforddi yn annigonol ar hyn o bryd naill ai i gydymffurfio â'r holl rotâu neu yn wir i sicrhau eu bod yn cael yr hyfforddiant gorau posibl yn y safleoedd gorau posibl ar draws Cymru.

Rydym yn ymrwymo i weithio gyda'r Byrddau Iechyd, yn enwedig pan fydd eu cynlluniau ad-drefnu gwasanaeth wedi'u seilio ar bresenoldeb hyfforddeion, er mwyn sicrhau y gall yr hyfforddeion fanteisio ar yr addysgu a'r hyfforddiant gorau posibl a'n bod yn cyflwyno'r gofal gorau posibl i gleifion.

Rydym yn ddiolchgar iawn am y cyfle i gyflwyno'n cynlluniau a'n syniadau ynghylch anghenion hyfforddi meddygon a deintyddion yng Nghymru a'r effaith gadarnhaol y gall y rhain eu cael ar gyflwyno'r gwasanaeth nawr ac yn y dyfodol er mwyn sicrhau'r safonau gofal gorau posibl i'n cleifion.

HEALTH AND SOCIAL CARE COMMITTEE CONSIDERATION OF LHB SERVICE RECONFIGURATION PLANS

THE ROLE OF THE NATIONAL CLINICAL FORUM IN THE RECONFIGURATION PROCESS

EVIDENCE SUBMISSION BY THE NATIONAL CLINICAL FORUM

1. Introduction and Background

The National Clinical Forum (NCF) was established at the request of the NHS Wales Chief Executives in November 2011 to provide expertise, advice and challenge to service change plans developed by NHS organisations that would impact on populations in Wales. Initially it was established to run for one year from November 2011 to November 2012. In September 2012, due to the ongoing service change planning processes, the NHS Wales Chief Executives asked the Forum to continue for a further year.

The NCF has its own formal Terms of Reference. Given the Forum will continue for a further year, these Terms of Reference are in the process of being reviewed by members of the Forum and will be discussed at the Forum's January meeting. **The original Terms of Reference are attached as Appendix 1**.

The NCF is made up of healthcare professionals from across Wales who are experts within their own field and are generally part of the national advisory structure. Professor Mike Harmer was appointed as an independent Chair of the Forum for two days per month and in this role is responsible for both chairing the meetings and coordinating the views of the Forum in responding to LHB plans.

Whilst the majority of members of the NCF work within NHS Wales, the Forum itself is autonomous of both Welsh Government and Local Health Boards and Trusts. This enables the Forum to provide impartial advice based upon expert knowledge to assist LHBs in scrutinising and developing plans to deliver safe, high quality, effective and sustainable clinical services. Where individual members are commenting on plans developed by their employer organisations, interests are declared and due diligence applied.

2. Governance Arrangements

The Chair of the Forum reports to the LHB Chief Executive (the 'lead Chief Executive') who chairs the LHB Chief Executive peer group and therefore represents the LHBs in Wales.

The official views and opinion of the NCF are only communicated by the Chair or Vice-Chair, or through the National Director, Together for Health, at the request of the Chair.

The official views and opinion of the NCF will be communicated in writing to the relevant LHB or LHB's. In order to facilitate the Forum assessing all plans it is asked to consider against the same criteria, the NCF has established a set of Evaluation Criteria. These Evaluation Criteria will be used to formally assess all plans that are put forward by LHB's for formal Public Consultation. **The Evaluation Criteria are attached as Appendix 2.**

At any time, via the lead Chief Executive, LHBs or the NHS Wales Chief Executive can request a progress update or an overview commentary from the NCF.

Any costs and expenses incurred by the NCF are split equally between the LHB's.

All publically available documents of the NCF can be found on the National Clinical Forum website.

3. The Role Of The NCF In The Reconfiguration Process

As part of change management plans within and across LHBs, the NCF is a key stakeholder in the engagement and consultation process and has the unique ability to provide impartial clinical advice to Boards.

This is a new arrangement in Wales and, as such, the NCF's working is evolving as the process progresses, within the scope of its Terms of Reference. One of the benefits of the Forum is that it can provide advice and scrutiny of the changes being proposed by NHS organisations and it is also able to provide challenge and commentary on any issues that may be yet to be fully considered by the LHB(?).

The NCF hopes to establish an ongoing relationship with all LHBs and Trusts through the service planning process, and is there to be used as frequently as those organisations feel it is necessary to obtain expertise, advice and guidance on their emerging plans. As a minimum though, it has been agreed by the LHBs with the NCF, that they will attend a meeting with the NCF at the pre-engagement and pre-consultation stages of the process. The NCF then provides its formal public response to the LHB consultation process as any other stakeholder would do during the formal consultation period.

The NCF is purely advisory in function, and has no right or power of veto over any of the proposals or plans it considers.

In providing feedback to LHBs, it has been determined by the NCF that it will do so in two distinct parts:

1. Formally respond to those issues that the LHB is engaging and/or consulting upon including advising on any critical dependencies that the Forum considers have been omitted from the process;
2. Formally advise, under separate cover, on those issues the Forum considers the LHB must also address but which are not yet part of any ongoing engagement and consultation.

The NCF has determined that in future these two distinct parts will be issued separately, but simultaneously. It is important that these responses are given equal importance but are issued separately so that they do not cut across any formal consultation processes.

The NCF uses its meetings with the respective LHB's, and any other information that the LHB submits to it to develop its views and opinions on proposed plans. During those meetings, members of the Forum have the opportunity to question LHB's as to their thinking, rationale and evidence behind advancing any given proposal.

The NCF's Evaluation Criteria are used to help formulate the formal responses. Each member of the NCF is asked to respond on each plan using the criteria as a template for assessment. This ensures consistency of approach to the evaluation by all, and ensures the Chair can co-ordinate the response to a standard format. This is usually done outside of the meetings and submitted to the Chair due to the considered comments members wish to make. This process will be commenced after a broad discussion on the proposals, both with and without the presence of the presenting LHB at scheduled NCF meeting. Members are provided the opportunity to comment on the drafts of the co-ordinated response prior to formal submission, as it is very much an iterative process.

4. Lifespan Of The National Clinical Forum

As stated previously, the NCF was initially established by the NHS Wales Chief Executives, for one year from November 2011 until November 2012. This was extended to November 2013 by the NHS Wales Chief Executives due to the ongoing service change planning, engagement and consultation processes happening across Wales.

During the course of its second year, the NHS Wales Chief Executives will again consider the future lifespan of the NCF, and any role it might have, if any, in providing LHB's and Trusts with impartial expert clinical advice beyond November 2013.

The NCF believes it is adding value to the current service change planning process, and could see how such a role might be of benefit in the longer term. However, it is the NHS Wales Chief Executives that will determine what role may be required going forward.

APPENDIX 1

NATIONAL CLINICAL FORUM

Terms of Reference and Operating Arrangements

Introduction

All NHS Organisations are developing service plans to improve quality, responsiveness and accessibility of care across Wales. These plans will develop new sustainable models of care that integrate the NHS in Wales as a whole system, encompassing primary, community, secondary and specialist care services. The focus is on locally - based services wherever possible maximising the opportunities highlighted in *Setting the Direction*, with access to high quality specialist services when needed, through a network of specialist centres and centres of excellence.

This may involve some significant change to the current pattern of healthcare delivery in Wales. Although it is for the Local Health Boards and Trusts (LHBs) to plan, lead and implement any service changes required, there is a need for them to be supported nationally. This will ensure a consistent approach to service standards and models of care across Wales.

Purpose

The National Clinical Forum (NCF), hereafter referred to as "the Forum" will be an advisory task and finish group. **The NCF therefore has no decision making powers or right of Veto over any proposals/plans it considers**. Its role will be to advise LHBs if as a result of their service change plans, standards and policy requirements will be met, improved outcomes can be achieved and patients will be better served.

The Forum will consider if proposals for service change:

- are appropriately influenced by relevant evidence and best practice;
- provide a basis for sustainable delivery of services; and
- combine to create a realistic and ambitious way forward for healthcare in Wales.

In undertaking this role, the Forum may also be asked to consider any external/international expert advice the LHBs may decide to commission to support their plans.

Its role does not include consideration of professional terms and conditions of service.

Scope and Duties

The Forum will, in respect of its provision of advice to LHBs:

- offer advice and feedback to LHBs on an individual organisation, regional or all-Wales basis on any aspect of all service change plans that will impact across Health Board Boundaries or have impacts for Wales as a whole;
- Offer advice and feedback to LHBs on any local service change plans they request the Forum to review;
- Offer advice to LHBs on the development and content of the national narrative describing the clinical case for change.
- Offer advice to LHBs on the adoption of best practice service models and innovative practice across Wales, inclusive of best practice in training and education across all professions;

The Forum may provide advice to the LHBs:

- at Chief Executive Officer Group meetings, through the attendance of the Forum's Chair or a nominated representative;
- in written advice; and
- in any other form agreed with the LHBs.

The Forum may determine if it requires to be supported by any subgroups or additional sources of specialist advice to assist it in the conduct of its work, and may itself, determine any such arrangements.

Membership

Membership of the Forum will comprise clinicians from within NHS Wales, but will be independent of individual organisations. Any member of the Forum should not therefore be an executive or independent member of any LHB/Trust. Its membership will be drawn from a wide range of multi-disciplinary clinical specialists.

Chair
The Forum will be Co-Chaired by an independent Chair from Wales identified by the NHS Wales Chief Executives, and a Co-Chair identified within another UK health system, and who has experience of significant service reconfiguration.

The Chairmanship of each meeting will alternate from meeting to meeting between the two co-chairs.

Vice Chair
One of the Co-Chairs will always have to be present for the Forum to proceed, and so there is no requirement to appoint a formal vice chair. The Co-Chairs will provide cover and support to each other in the absence of one of them.

Members

The following clinical groups will be represented:

- Public Health
- Ambulance Services
- Members drawn from WMC NSAG, representing the following specialties:
    - child health
    - women's health
    - mental health
    - medicine
    - surgery
    - anaesthesia / critical care
    - general practice
- NJPAC, Welsh Scientific Advisory Committee
- NJPAC, Welsh Therapies Advisory Committee
- NJPAC, Welsh Nursing and Midwifery Committee
- NJPAC, Welsh Pharmaceutical Committee
- Welsh Dental Committee
- General Practitioner (nominated by BMA)
- Nurse (nominated by RCN)
- Heads of Midwifery Advisory Group
- Postgraduate Dean
- Academy of Medical Royal Colleges in Wales
- The Rural Health Plan Implementation Group
- The Institute of Rural Health

Members will be invited to nominate a named deputy in the event that they are unavailable for a forum meeting.

Secretariat

As determined by the National Director, *Together for Health*.

In attendance

- National Director, *Together for Health*
- The Medical Director, NHS Wales, Nurse Director, NHS Wales and Director of Therapies and Health Sciences, NHS Wales may be in attendance as observers. The Forum may also determine that other Welsh Government officials or LHB/Trust staff be in attendance.
- The Forum Chair may also request the attendance, from time to time, of Board members or LHB/Trust staff, subject to the agreement of the relevant Chief Executive.
- The Forum Chair may, from time to time, invite external/international experts to aid discussion and review of specific service change issues.

Terms and Length of Office

Appointments to the Forum will be made through the National Director, *Together for Health* on behalf of the LHB Chief Executives. Members will either be invited on to the Forum in their role as Chair of an All Wales Professional Group/Committee, or as a nomination from such a group, committee or stakeholder organisation. The Forum is a task and finish group which is anticipating needing to meet for a minimum of one year. The need for the continued role of the group will be reviewed regularly. In the interests of consistency in discussion and review of plans/information, Members will serve for the duration of the Forums' work, even if during the life of the Forum, they cease to be Chair of the Group or Committee that led to the original invitation. In this situation the Co-Chairs will have the option to invite the new Chair of that Committee to the Forum, if it is felt that the Committee concerned is no longer appropriately represented.

The appointed Co-Chairs of the Forum will hold those positions for the life of the Forum.

Members Responsibilities and Accountability

The Chair is responsible for the effective operation of the Forum:

- chairing meetings;
- ensuring all business is conducted in accordance with its agreed operating arrangements;
- developing positive and professional relationships amongst the Forum's membership and between the Forum and LHB/Trust Chief Executives and any other relevant groups;
- ensuring that any formal feedback to LHB's and notes of meetings accurately record the decisions taken and where appropriate, the views of individual members.

The Co- Chairs will cover for their colleague co-Chair in their absence for any reason.

Members – all members shall function as a coherent advisory group, all members being full and equal members and sharing responsibility for any advice agreed by the Forum. All members are accountable to the Forum Chair for their performance as group members and to their nominating body or group for the way in which they represent the views of their body or group at the Forum.

The role of the Forum will necessarily mean that Members will, from time to time, receive highly sensitive and confidential information about health services across Wales from LHB's. The highly confidential nature of this information must be respected.

Resignation and removal of members

A member of the Forum may resign office at any time during the period of appointment by giving notice in writing to the Forum Chair.

If the Forum Co-Chairs and the nominating body or group, considers that:

- it is not in the interests of the health service that a person should continue to hold office as a member; or
- it is not conducive to the effective operation of the Forum. (This could include an attendance rate considered to be poor by the Co-Chairs, or evidence that confidential information has been shared outside of the forum without explicit permission to do so).

it shall terminate the membership of that person by giving notice in writing to the person and the relevant nominating body or group.

A nominating body or group may request the removal of a member appointed to the Forum to represent their interests by writing to the Co-Chairs setting out an explanation and full reasons for removal.

Handling Conflicts of Interest

All members should declare any personal or business interest which may or may be perceived (by a reasonable member of the public) to influence their judgement. A register of interests will be established, kept up to date, and be open to the public. A declaration of any interest should also be made at any Forum if it relates specifically to a particular issue under consideration, for recording in the notes of the meeting.

Relationship with LHBs Chief Executives

The Forum's main link with the LHBs Chief Executives is through the Co-Chairs.

The Co-Chairs and Lead Chief Executive shall determine the arrangements for any joint meetings between the LHBs and the Forum, should it be required.

The lead Chief Executive shall put in place arrangements to meet with the Forum Co-Chair as required to discuss the Forum's activities and operation.

Relationship with Local Healthcare Professionals Fora

The Forum Co-Chairs will liaise with local Fora as he/she deems appropriate. It is expected that the Local Healthcare Professionals Fora would be an integral part of any local "continuous engagement" during the development of service change proposals, as per the National Guidance on Engagement and Formal Public Consultation. Therefore, the Forum would not anticipate being asked to consider plans that hadn't yet been advised upon locally by the Local Healthcare Professionals Fora.

The Forum may delay review of any LHB Service Change Plans, until it has received assurance that the Local Fora have been consulted, and their advice taken into account.

Support to the Forum

The National Director, *Together for Health*, will ensure that the Forum is properly equipped to carry out its role by:

- ensuring the provision of governance advice and support to the Forum Co-Chairs on the conduct of its business and its relationship with the LHBs and others;
- ensuring the provision of secretariat support for Forum meetings;
- ensuring that the Forum receives the information it needs on a timely basis; and
- facilitating effective reporting to the LHBs Chief Executives.

Forum meetings

At least one Co-Chair plus 50% of the agreed membership must be present to ensure the quorum of the Forum.

Meetings should be held no less than monthly and otherwise as the Chair deems necessary. The requirement to meet and frequency of meetings will be reviewed on a regular basis.

To facilitate attendance, Video Conferencing Facilities will be made available at all meetings.

The LHBs commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others which advise it. Meeting dates, agendas and minutes should therefore be publically available unless there are any specific, valid reasons for not doing so.

Following each Meeting, the Co-Chairs will produce a report summarising the items taken, discussions held and any advice being provided to the Health Boards. This will be available to the Public, and Members may use it to brief their respective committees.

Withdrawal of those on attendance

The Forum may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussions of particular matters.

8th December 2011.

Appendix 2

National Clinical Forum

Evaluation of Service Reconfiguration Plans

Introduction

The National Clinical Forum (NCF) was established at the request of the Local Health Boards (LHBs) to provide an independent group to evaluate the clinical aspects of the various reconfiguration plans. In considering the proposals put forward by the various LHBs, the NCF has attempted to view them in the light of the brief given to them by Welsh Government through a number of criteria.

The criteria are not intended to be totally inclusive of the many factors that may influence service delivery plans, but are based around the clinical delivery potential of such plans.

The Forum appreciates that the individual LHBs may face issues over public and political acceptance of plans but feels that its role is to concentrate on the clinical feasibility and sustainability of the service plan proposed.

The responses given from the NCF to the LHBs prior to and during the public consultation period will be based upon the application of the evaluation criteria outlined below. These evaluation criteria will be made available to the LHBs and any other interested parties prior to the completion of the consultation process.

Criteria for the Evaluation of Service Reconfiguration Plans

The key underpinning of the evaluation is based on the following components of the proposals:–

- Are the aims and objectives set out in the plan SMART (specific, measurable, achievable, realistic, and timely)?
- Do they specify what you want to achieve?
- Will it be possible to measure whether or not the objectives are being met?
- Is the plan going to be able to achieve these objectives? Are they attainable?
- Can they be realistically achieved with the resources you have available? Do they show value for money/ cost effectiveness?
- When should the objectives be met? Has timescale been set out?

Evaluation Criteria

Questions are set out to test the robustness and practicality of the Plans

Access and Integration of Services

- Is the Plan based on population needs with particular emphasis on addressing any known inequalities of provision?

- Does the plan show evidence-based practice as the main underpinning component of the revised care proposals, including where appropriate National guidance?

- Is there evidence that structures are/will be be in place to facilitate and develop integration between specialist, general and community services for all aspects of healthcare?

- Will the proposed service configurations provide timely and appropriate access to care?

- Is there an appreciation in the plan that primarily clinical need rather than the current estate configuration (service rather than hospital site) should be the founding basis?

- Has the plan been submitted to a process of 'rural-proofing' using a suitable tool such as that developed by the Institute of Rural Health?

- Has sufficient consideration been shown for distance and travel time from point of care and the transport implications for both routine and emergency care? This is particularly important for those Boards with a large rural population.

- Is the plan 'patient-centred' taking into account the 'patient journey' and the impact on relatives, especially for children?

- Does the plan include consideration of local public transport infrastructure?

- Is there evidence of appropriate collaboration with adjoining LHBs and other statutory bodies to consider fully the best care pathway for patients?

- Does the plan demonstrate evidence of working with other relevant services such as Local Authorities, Social Services and the Third Sector?

- Are Plans for increasing the community care of patients based on sound logistic and financial considerations?

- Is there evidence of pilot work or sharing of good practice for solutions in these areas?

- Is there clear and realistic evidence that there is sufficient capacity, both in terms of staff and ability to allow such change?

- Where appropriate, are the role of 'telemedicine' and other IT support mechanisms included?

Workforce

There must be evidence of a cohesive workforce plan.

- Is the workforce planning consistent with UK National and WG policies?

- Is it sustainable e.g. does it consider the availability of trainee staff in the future? Failure to address this matter may lead to training recognition being withdrawn centrally by Colleges, deanery and training committees with serious consequences.

- Are training plans aligned to National regulations and requirements of professional bodies (Royal Colleges, etc)?

- Does the plan take account that the positioning of trainees, in all fields of healthcare, is based on the experience available to the trainee in a particular setting rather than the service requirement? This must be taken into account in any plans. This might also include 'context experience' to ensure a broad breadth of experience.

- Is the provision of services by non-trainee, non-consultant clinicians considered in the light of the suitability and availability of the proposed workforce?

- Where appropriate, does the plan meet the training needs of existing staff in new developments and changing configuration? In particular, moving services to the community will impact upon the training needs of primary care professionals?

- Has consideration been given to the potential for extended roles for health professionals in the provision of care and have the training implications for such been given due consideration along with the necessary shift of resources?

- Is the timescale of such developments laid out and are they feasible?

Quality and Safety

Safety in patient care must be the priority in plan development.

- Is there clear evidence of patient involvement and consultation in the development of plans?

- Is there evidence of how the principles of ‘Dignity in Care’ underpin the strategy?

- Are all areas of care provision based upon accepted standards provided by appropriate bodies e.g. Statutory Professional Organisations, Royal Colleges, other professional bodies, advisory boards, etc?

- Is there sufficient assurance that services will be delivered in facilities that provide appropriate environments and support to ensure safety of patients and staff?

- Has sufficient emphasis been placed on the potential impact on configuration of integrating services, as appropriate?

- Does the plan maximise the potential for prevention and admission avoidance?

- Linked with the workforce plan, have governance issues relating to changing and enhanced staff roles, and working with joint agencies been considered.

Buildings and Facilities

- Has consideration been given to the appropriateness and sustainability of current estate and facilities to provide both current and projected care modalities?

- Is the strategy for the future of community hospitals clearly set out and to a timeline?

Compatibility across Wales

- How do the proposals for a specific LHB fit within an overall structure for NHS Wales its partner services?

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 29 Tachwedd 2012**
Amser:	**09:15 – 12:30**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200000_29_11_2012&t=0&l=cy

Cofnodion Cryno:

Aelodau'r Cynulliad:	**Mark Drakeford (Cadeirydd)** **Mick Antoniw** **Rebecca Evans** **Vaughan Gething** **William Graham** **Elin Jones** **Darren Millar** **Lynne Neagle** **Lindsay Whittle** **Kirsty Williams**
Tystion:	**Nicola Davis-Job, Coleg Brenhinol Nyrsio Cymru** **Dr Chris Jones, Llywodraeth Cymru** **David Sissling, Llywodraeth Cymru** **Lisa Turnbull, Coleg Brenhinol Nyrsio Cymru** **Dr Phil Evans, Y Grŵp Cynghori Arbenigol Cenedlaethol ar Ddiabetes ac Endocrinoleg** **Dr David Millar Jones, Y Grŵp Cynghori Arbenigol Cenedlaethol ar Ddiabetes ac Endocrinoleg** **Julie Lewis, Y Grŵp Cynghori Arbenigol Cenedlaethol ar Ddiabetes ac Endocrinoleg** **Dr Mike Page, Y Grŵp Cynghori Arbenigol Cenedlaethol ar Ddiabetes ac Endocrinoleg** **Richard Roberts, Y Grŵp Cynghori Arbenigol Cenedlaethol ar Ddiabetes ac Endocrinoleg**
Staff y Pwyllgor:	**Llinos Dafydd (Clerc)** **Lara Date (Clerc)** **Catherine Hunt (Dirprwy Glerc)** **Philippa Watkins (Ymchwilydd)**

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Nid oedd unrhyw ymddiheuriadau na dirprwyon.

2. Ymchwiliad i'r gwaith o weithredu'r fframwaith gwasanaeth cenedlaethol ar gyfer diabetes yng Nghymru a'i ddatblygiad yn y dyfodol – Tystiolaeth lafar

Y Grŵp Cynghori Arbenigol Cenedlaethol ar Ddiabetes ac Endocrinoleg

2.1 Atebodd y tystion gwestiynau gan aelodau'r Pwyllgor.

2.2 Cytunodd Dr Evans i ddarparu copi o'r ddogfen a gyflwynwyd i Lywodraeth Cymru yn 2010 ar argaeledd addysg strwythuredig am ddiabetes math 1 yng Nghymru.

Gwasanaeth Sgrinio ar gyfer Retinopathi Diabetig Cymru

2.3 Atebodd Mr Roberts gwestiynau gan aelodau'r Pwyllgor.

Coleg Brenhinol Nyrsio Cymru

2.4 Atebodd y tystion gwestiynau gan aelodau'r Pwyllgor.

2.5 Cytunodd y tystion i ddarparu tystiolaeth ysgrifenedig ychwanegol ar y lleihad honedig yn nifer y nyrsys diabetes arbenigol mewn blynyddoedd diweddar a rôl y nyrsys diabetes arbenigol ar y Grwpiau Cynllunio a Chyflenwi ar gyfer Diabetes.

Swyddogion Llywodraeth Cymru

2.6 Atebodd Mr Sissling and Dr Jones gwestiynau gan aelodau'r Pwyllgor.

2.7 Cytunodd Dr Jones i ddarparu tystiolaeth ysgrifenedig ychwanegol ar wasanaethau podiatreg ledled Cymru a chopïau o'r llythyron a anfonwyd at fyrddau iechyd ar ôl yr Archwiliad Diabetes Cenedlaethol.

3. Cynnig o dan Reol Sefydlog 17.17 i sefydlu Is-bwyllgor i gymryd tystiolaeth ar y Rheoliadau Mangreoedd etc. Di-fwg (Cymru) (Diwygio) 2012

3.1 Cytunodd y Pwyllgor â'r cynnig.

4. Papurau i'w nodi

4.1 Nododd y Pwyllgor gofnodion y cyfarfodydd a gynhaliwyd ar 15 a 21 Tachwedd.

TRAWSGRIFIAD
Gweld trawsgrifiad o'r cyfarfod.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Mercher, 5 Rhagfyr 2012**
Amser:	**09:30 – 11:20**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://www.senedd.tv/archiveplayer.jsf?v=cy_200002_05_12_2012&t=0&l=cy

Cofnodion Cryno:

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

1. Cyflwyniad, ymddiheuriadau a dirprwyon

1.1 Nid oedd unrhyw ymddiheuriadau na dirprwyon.

2. Craffu ar waith y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

2.1 Atebodd y Gweinidog a'i swyddogion gwestiynau gan aelodau'r Pwyllgor.

2.2 Cytunodd y Gweinidog i ddarparu rhagor o wybodaeth ysgrifenedig am brosiectau cyfalaf sydd heb eu cyflawni, y manylion fesul bwrdd iechyd o sut byddai'r £82 miliwn ychwanegol ar gyfer y GIG yn cael ei ddyrannu, sut bydd Llywodraeth Cymru yn cyfrannu at yr adolygiad o'r cydbwysedd o ran cymhwysedd rhwng y DU a'r UE, a'r ddarpariaeth o wasanaethau iechyd meddwl ar gyfer staff yn y lluoedd arfog a'r gwasanaethau brys.

3. Papurau i'w nodi

Y Wybodaeth Ddiweddaraf am Faterion Ewropeaidd

3.1 Nododd y Pwyllgor y papur.

Llythyr gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol: Camau gweithredu yn deillio o'r cyfarfod ar 17 Hydref a oedd yn craffu ar y gyllideb

3.2 Nododd y Pwyllgor y llythyr.

4. Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru): Ystyried penodi Cynghorydd Arbenigol i gynorthwyo'r gwaith o graffu ar y Bil

4.1 Trafododd y Pwyllgor yr opsiwn o benodi cynghorydd arbenigol i'w gynorthwyo â'r gwaith o graffu ar y Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru) yng nghyfnod 1.

4.2 Cytunodd y Pwyllgor mewn egwyddor y byddai cymorth o'r maes polisi perthnasol yn ddefnyddiol a bod gwerth ymchwilio i'r opsiwn. Cytunodd y Pwyllgor y gallai fod o fudd chwilio am gyngor gan nifer o gynghorwyr, a allai ei gynorthwyo i ystyried materion penodol, yn hytrach na phenodi un cynghorydd arbenigol.

4.3 Holodd y Pwyllgor y tîm clercio i ymchwilio ymhellach a dod ag enwau ymgeiswyr posibl i'r Aelodau yn y cyfarfod nesaf.

5. Bil Trawsblannu Dynol (Cymru) – Cyfnod 1: y dull o graffu

5.1 Cytunodd y Pwyllgor ar y cylch gorchwyl a'r dull o graffu ar y Bil Trawsblannu Dynol (Cymru) a chytunodd i lansio ymgynghoriad cyhoeddus yn fuan.

6. Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Cyfnod 1 – y dull o graffu

6.1 Cyfeiriodd Cadeirydd y Pwyllgor at lythyr diweddar a gafodd oddi wrth y Llywydd yn nodi, yn ei barn hi, bod y Bil o fewn cymhwysedd deddfwriaethol y Cynulliad. Fodd bynnag, nododd hefyd fod ei barn ar fin y gyllell o ran rhai rhannau o'r Bil. Amlinellodd y Cadeirydd y rhannau hynny o'r Bil a dywedodd y byddai'r llythyr yn cael ei anfon at Aelodau'n fuan.

6.2 Cytunodd y Pwyllgor y dylid ystyried y materion a godwyd gan y Llywydd adeg y broses graffu yng Nghyfnod 1. Holwyd cynghorwyr cyfreithiol y Pwyllgor i ddarparu rhagor o wybodaeth am y materion a gododd y Llywydd er mwyn gallu llunio cwestiynau i gynorthwyo'r Pwyllgor i ymchwilio i'r materion hynny gyda'r tystion perthnasol.

6.3 Trafododd y Pwyllgor ei ddull o graffu ar y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru) yng Nghyfnod 1.

6.4 Roedd y Pwyllgor yn fodlon â'r dull cyffredinol o graffu a awgrymwyd ym mhapur y Pwyllgor ond cytunodd y dylid ychwanegu cwestiwn am gymhwysedd deddfwriaethol y Cynulliad Cenedlaethol at y llythyr ymgynghoriad.

6.5 Cytunwyd hefyd y dylid ystyried cynrychiolwyr o elusennau canser, byrddau iechyd, y diwydiant adeiladu a sefydliadau sy'n cynhyrchu asbestos fel tystion llafar ychwanegol.

7. Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru): Cyfnod 1 – sesiwn dystiolaeth 1 – GOHIRIWYD

TRAWSGRIFIAD
Gweld y trawsgrifiad o'r cyfarfod

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Mark Drakeford AC
Cadeirydd
Pwyllgor Iechyd a Gofal Cymdeithasol
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
CF99 1NA

Eich cyf:
Ein cyf: PO/RB/SG

3 Rhagfyr 2012

Annwyl Mark

Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru)

Rwyf wedi ysgrifennu at Mick Antoniw heddiw i gadarnhau fy marn, yn unol ag adran 110(3) o Ddeddf Llywodraeth Cymru 2006, fod y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru) yn dod o fewn cymhwysedd deddfwriaethol y Cynulliad, ac rwy'n bwriadu gwneud datganiad i'r perwyl hwnnw pan gyflwynir y Bil.

Fodd bynnag, nid oedd fy mhenderfyniad yn yr achos hwn yn un syml. Rwyf wedi cael cyngor y gellir cyflwyno dadleuon dilys nad yw nifer o'r darpariaethau yn y Bil yn dod o fewn cymhwysedd deddfwriaethol y Cynulliad, o bosibl. Mae'r penderfyniad yr wyf wedi'i wneud o ran y meysydd hyn wedi golygu llawer o bwyso a mesur i sicrhau cydbwysedd.

Yn y cyfamser, rwy'n cynnwys, er gwybodaeth i chi, grynodeb o'r materion a ystyriwyd gennyf wrth ddod i benderfyniad ar gymhwysedd deddfwriaethol. Teimlaf ei bod yn briodol ac yn bwysig rhannu'r cyngor hwn gyda chi, er mwyn cydnabod a hwyluso rôl Aelodau'r Cynulliad ar eich Pwyllgor wrth graffu ar y Bil hwn. Bydd y cyfreithiwr a'r Clerc sy'n cefnogi'r Pwyllgor yn y gwaith craffu hwnnw yn gallu darparu gwybodaeth fwy manwl am y materion hyn.

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Dyma'r tro cyntaf i ni ddatgelu'r materion anodd ynghylch cymhwysedd a ystyriwyd gennyf. Hefyd, dyma'r achos cyntaf sydd wedi peri i faterion o'r fath godi ers y dyfarniad diweddar yn y Goruchel Lys. Nid oes amheuaeth bod materion sensitif yn codi o ran sut y mae'r Cynulliad yn trafod materion o gymhwysedd deddfwriaethol wrth i Fil fynd drwy'r broses ddeddfwriaethol. Bydd y staff sy'n cefnogi eich pwyllgor yn gallu rhoi cyngor ar y materion hyn a byddaf, wrth gwrs, yn hapus iawn i'w trafod â chi wyneb yn wyneb.

Yn y cyfamser, byddaf yn anfon llythyr tebyg at David Melding fel Cadeirydd y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol.

Rhaid i mi bwysleisio mai'r cyngor yr wyf wedi'i gael, ac yr wyf wedi seilio fy mhenderfyniad arno, yw y gellir datgan yn ddilys fod darpariaethau'r Bil yn dod o fewn cymhwysedd deddfwriaethol y Cynulliad. Fodd bynnag, rwyf am sicrhau bod y materion yr wyf wedi eu hystyried yn cael eu rhannu gyda'r Pwyllgorau er mwyn iddynt allu cael eu hystyried ymhellach wrth graffu ar y Bil, os yw Aelodau'n dymuno gwneud hynny.

Memorandwm Ariannol

Mae'r Rheolau Sefydlog hefyd yn ei gwneud yn ofynnol fy mod yn penderfynu a fydd angen penderfyniad ariannol ar gyfer y Bil hwn ai peidio. Ar ôl ystyried y Memorandwm Esboniadol sy'n cydfynd â'r Bil, credaf y bydd angen penderfyniad ariannol ar ei gyfer, yn unol â Rheolau Sefydlog 26.69(ii) a 26.70.

Rosemary

Rosemary Butler AC, Llywydd

Mae'n bosibl bod y ddogfen hon yn cynnwys cyngor cyfreithiol a roddwyd yn gyfrinachol i Gynulliad Cenedlaethol Cymru ac mae'n bosibl ei fod yn ddarostyngedig i fraint proffesiynol cyfreithiol.

Y Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru)

Crynodeb o Faterion sy'n ymwneud â Chymhwysedd Deddfwriaethol

Cefndir

1. Mae'r Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru) wedi'i gyflwyno i'r Llywydd gan Mick Antoniw AC, yr Aelod sy'n gyfrifol am y Bil, i alluogi'r Llywydd i ddatgan ei barn ynghylch a yw'r Bil yn dod o fewn cymhwysedd deddfwriaethol y Cynulliad. Yn unol ag adran 110(3) o Ddeddf Llywodraeth Cymru 2006 ("y Ddeddf"), a Rheol Sefydlog 26.4, rhaid gwneud y datganiad hwn pan gyflwynir y Bil, neu cyn hynny.

2. Ar ôl cael cyngor gan gynghorwyr cyfreithiol y Cynulliad, mae'r Llywydd wedi penderfynu bod y Bil, yn ei barn hi, yn dod o fewn y cymhwysedd deddfwriaethol. Fodd bynnag, mae'r Llywydd o'r farn ei bod yn briodol dwyn rhai materion sy'n ymwneud â chymhwysedd, y bu'n eu hystyried wrth ddod i farn, i sylw'r Pwyllgor a fydd yn craffu ar y Bil, fel y gall benderfynu a ddylid archwilio'r materion hyn ymhellach fel rhan o'r broses graffu.

Trosolwg o'r Bil

3. Diben y Bil yw sicrhau bod person sy'n talu iawndal i ddioddefwr clefyd sy'n ymwneud ag asbestos hefyd yn gorfod ad-dalu, i Weinidogion Cymru, y costau a ddaeth i ran y GIG yng Nghymru wrth ddarparu gofal i'r dioddefwr. Rhaid gwneud hyn hefyd os caiff yr iawndal ei dalu gan rywun arall ar ran y person sy'n gyfrifol am y niwed i'r dioddefwr, gan gynnwys cwmnïau yswiriant.

Materion o ran cymhwysedd y bu'r Llywydd yn eu hystyried

4. Mae'r mater cyntaf yn ymwneud ag adran 15 o'r Bil. Mae'r adran hon yn ymdrin â rhwymedigaeth yswirwyr i dalu'r taliadau newydd a gyflwynir gan y Bil. Mae Atodlen 7 i'r Ddeddf yn cynnwys eithriad i'r cymhwysedd deddfwriaethol sydd wedi'i ddrafftio fel a ganlyn: "Gwasanaethau ariannol, gan gynnwys...yswiriant". Nodir yr eithriad hwn o dan Bennawd 4, "Datblygu Economaidd", tra bo darpariaethau'r Bil yn ymwneud â Phynciau a restrir o dan Bennawd 9, sef "Iechyd a Gwasanaethau Iechyd". Fodd bynnag, mae eithriadau i'r cymhwysedd deddfwriaethol yn berthnasol yn yr un modd i bob Pwnc a restrir yn Atodlen 7.

Mae'n bosibl bod y ddogfen hon yn cynnwys cyngor cyfreithiol a roddwyd yn gyfrinachol i Gynulliad Cenedlaethol Cymru ac mae'n bosibl ei fod yn ddarostyngedig i fraint proffesiynol cyfreithiol.

5. Ar ôl pwyso a mesur, mae'r Llywydd o'r farn fod adran 15 yn dod o fewn y cymhwysedd deddfwriaethol, oherwydd bod yr adran hon yn atodol i ddarpariaethau eraill y Bil, neu'n briodol er mwyn sicrhau bod y Bil yn gwbl effeithiol.

6. Mae'r ail fater yn ymwneud ag adran 17 o'r Bil. Mae'r adran hon yn nodi bod y Bil yn rhwymo'r Goron. O ganlyniad, bydd yn effeithio ar Adrannau Llywodraeth y DU. Mae'r cwestiwn yn codi ynghylch a fydd y Bil, wrth wneud hynny, yn addasu un o swyddogaethau Gweinidog y Goron, neu'n gosod swyddogaeth newydd ar Weinidog o'r fath, ynteu ai'r oll y bydd yn ei wneud yw creu rhwymedigaeth y bydd Gweinidogion o'r fath yn ddarostyngedig iddi mewn amgylchiadau penodol.

7. Mae paragraff 1 o Ran 2 o Atodlen 7 i Ddeddf Llywodraeth Cymru 2006 yn gwahardd Bil rhag addasu swyddogaeth cyn-cychwyn Gweinidog y Goron. Swyddogaethau yw'r rhain y bu Gweinidog y Goron yn meddu arnynt ers cyn 5 Mawrth 2011. Mae'r paragraff hefyd yn gwahardd Bil rhag gosod swyddogaeth ar Weinidog y Goron. Fodd bynnag, gall Bil wneud unrhyw un o'r pethau hyn os bydd yr Ysgrifennydd Gwladol yn cydsynio iddynt. Fel arall, gall Bil addasu swyddogaeth (ond ni all osod swyddogaeth) os bydd gwneud hynny yn atodol i ddarpariaeth ddilys arall yn y Bil, neu'n ganlyniad iddi.

8. Mae'r Llywydd o'r farn na ddylid ystyried bod adran 17 y tu allan i'r cymhwysedd deddfwriaethol, o gofio bod dadleuon credadwy sy'n nodi nad yw'n diwygio swyddogaeth Gweinidog y Goron nac yn gorfodi swyddogaeth newydd ar Weinidog o'r fath; neu, os yw'n diwygio swyddogaeth Gweinidog y Goron, fod y diwygiad yn atodol i ddarpariaethau eraill y Bil.

9. Mae'r trydydd mater yn ymwneud â p'un a yw adran 2, sef darpariaeth graidd y Bil, yn ymwneud yn ddigon agos ag un neu fwy o'r pynciau a restrir yn Atodlen 7 i'r Ddeddf.

10. Mae paragraff 4 o Ran 2 o'r Memorandwm Esboniadol yn nodi bod pennawd 9 (Iechyd a gwasanaethau iechyd) yn Atodlen 7 i'r Ddeddf yn darparu'r cymhwysedd deddfwriaethol i ganiatáu i'r Cynulliad Cenedlaethol basio'r Bil hwn. Y pynciau sy'n ymddangos o dan y pennawd hwnnw sydd o bosibl yn berthnasol i'r Bil yw:

    "Atal, trin a lleddfu afiechyd, salwch, anaf [ac] anabledd ... Darparu gwasanaethau iechyd … t[h]refnu ac ariannu'r gwasanaeth iechyd gwladol."

11. Mae'r penderfyniad ynghylch a yw darpariaeth Bil yn ymwneud â phwnc i'w wneud yn bennaf drwy gyfeirio at ddiben y ddarpariaeth.

12. Nid yw'r diben "Atal, trin a lleddfu afiechyd (ac ati)" yn cael ei nodi fel diben unrhyw rai o ddarpariaethau'r Bil. Mae'r un peth yn wir am y pwnc "darparu gwasanaethau iechyd".

Mae'n bosibl bod y ddogfen hon yn cynnwys cyngor cyfreithiol a roddwyd yn gyfrinachol i Gynulliad Cenedlaethol Cymru ac mae'n bosibl ei fod yn ddarostyngedig i fraint proffesiynol cyfreithiol.

13. Fodd bynnag, mae'r Llywydd o'r farn bod holl ddarpariaethau'r Bil, at ei gilydd, yn ymwneud â'r pwnc "t[h]refnu ac ariannu'r gwasanaeth iechyd gwladol". Mae hyn oherwydd mai diben adran 2, ac felly yr holl Fil, yw addalu arian i Weinidogion Cymru - sy'n ariannu GIG Cymru - am y gost o ariannu rhai o wasanaethau'r GIG sy'n gysylltiedig ag asbestos. Mae hon yn berthynas ddigon agos â'r pwnc i ddod âg adran 2, ac felly'r holl Fil, o fewn y cymhwysedd deddfwriaethol.

14. Wrth wneud ei phenderfyniad bod darpariaethau'r Bil yn dod o fewn y cymhwysedd deddfwriaethol, bu i'r Llywydd hefyd ystyried yr holl brofion cymhwyso eraill a nodir yn y Ddeddf: a ydynt yn gydnaws â hawliau'r Confensiwn; a ydynt yn gydnaws â chyfraith yr UE; a gaiff rhai deddfiadau eu gwarchod; a gaiff swydd y Rheolwr ac Archwilydd Cyffredinol ei gwarchod; a'r prawf sy'n nodi fod yn rhaid i'r Bil beidio â chael effaith waharddedig ar Gronfa Gyfunol Cymru. Roedd yn fodlon bod y Bil yn amlwg yn pasio'r holl brofion hyn.

15. Yn olaf, ystyriodd y Llywydd a fyddai angen cael cydsyniad Ei Mawrhydi y Frenhines a Dug Cernyw er mwyn i'r Cynulliad allu pasio'r Bil. Penderfynodd ei bod yn bosibl y bydd angen y cydsyniad hwn a gofynnwyd i'r Aelod sy'n gyfrifol fynd i'r afael â'r mater hwn cyn Cyfnod 3 y Bil. Nid yw hwn yn fater o gymhwysedd deddfwriaethol fel y cyfryw.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-01-13 papur 8

Blaenraglen Waith y Pwyllgor Iechyd a Gofal Cymdeithasol: Ionawr - Chwefror 2013

At: Y Pwyllgor Iechyd a Gofal Cymdeithasol

Gan: Gwasanaeth y Pwyllgorau

Dyddiad y cyfarfod: 10 Ionawr

Diben

1. Mae'r papur hwn yn gwahodd yr Aelodau i nodi amserlen y Pwyllgor Iechyd a Gofal Cymdeithasol, sydd wedi'i atodi fel Atodiad A.

Cefndir

2. Yn Atodiad A, ceir copi o amserlen y Pwyllgor Iechyd a Gofal Cymdeithasol hyd at doriad hanner tymor mis Chwefror.

3. Fe'i cyhoeddwyd i gynorthwyo Aelodau'r Cynulliad ac unrhyw aelodau o'r cyhoedd a hoffai wybod am flaenraglen waith y Pwyllgor. Bydd y Pwyllgor yn cyhoeddi dogfen o'r fath yn gyson.

4. Gall yr amserlen newid a gellir ei diwygio yn ôl disgresiwn y Pwyllgor pan fydd busnes perthnasol yn codi.

Argymhelliad

5. Gwahoddir y Pwyllgor i nodi'r rhaglen waith yn Atodiad A.

ATODIAD A

DYDD IAU 10 IONAWR 2013

Bore a phrynhawn

Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru)
Sesiynau tystiolaeth lafar

Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru)*
Briffio ffeithiol
Ystyried cyngor gan arbenigwyr

Cynlluniau i ad-drefnu gwasanaethau Byrddau Iechyd Lleol
Sesiynau tystiolaeth lafar

Bil Sgorio Hylendid Bwyd (Cymru) – rheoliadau drafft
Briffio preifat

DYDD MERCHER 16 IONAWR 2013

Bore yn unig

Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru)
Sesiynau tystiolaeth lafar

Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru)*
Ystyried cyngor gan arbenigwyr

DYDD IAU 24 IONAWR 2013

Bore a phrynhawn

Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru)
Sesiynau tystiolaeth lafar

Bil Trawsblannu Dynol (Cymru)
Sesiynau tystiolaeth lafar

DYDD MERCHER 30 IONAWR 2013

Bore yn unig

ATODIAD A

Bil Gwasanaethau Cymdeithasol a Llesiant (Cymru)*
Cyfnod 1 – Y dull o graffu

Bil Trawsblannu Dynol (Cymru)
Sesiynau tystiolaeth lafar

DYDD IAU 7 CHWEFROR 2013

Bore a phrynhawn

Bil Adennill Costau Meddygol ar gyfer Clefydau Asbestos (Cymru)
Ystyried y materion allweddol (preifat)

Bil Trawsblannu Dynol (Cymru)
Sesiynau tystiolaeth lafar

Dydd Llun 11 Chwefror – Dydd Sul 17 Chwefror 2013: Toriad yr hanner tymor

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*Noder fod yr eitemau hyn yn dibynnu ar ddeddfwriaeth yn cael ei chyflwyno gan yr Aelodau priodol sy'n gyfrifol ac yn cael ei hail-gyfeirio gan y Pwyllgor Busnes i'r Pwyllgor Iechyd a Gofal Cymdeithasol fel rhan o'r gwaith o graffu yng Nghyfnod 1.