

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 1 - Y Senedd

Dyddiad:
Dydd Iau, 22 Medi 2011

Amser:
09:30

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales



I gael rhagor o wybodaeth, cysylltwch a:

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Agenda

1. Ymddiheuriadau a dirprwyon

2. Ymchwiliad i leihau'r risg o strôc - tystiolaeth gan y Gymdeithas Ffibriliad Atriaidd (09.30 - 10.30) (Tudalennau 1 - 15)

HSC(4)-03-11 papur 1

- Jo Jerome, Cyfarwyddwr Cynorthwyol

3. Ymchwiliad i leihau'r risg o strôc - tystiolaeth gan y Gymdeithas Strôc (10.30 - 11.30) (Tudalennau 16 - 22)

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- Ana Palazòn, Cyfarwyddwr Cymru
- Paul Underwood, Dirprwy Cyfarwyddwr Cymru
- Lowri Griffiths, Pennaeth Cyfathrebu a Materion Allanol

4. Craffu ar Gyllideb Ddrafft 2012-13 - ystyried y dull gweithredu (11.30 - 11.40) (Tudalennau 23 - 25)

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5. Ymchwiliad i ofal preswyl i oedolion - papur cwmpasu (11.40 - 11.50) (Tudalennau 26 - 33)

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6. Ymchwiliad y Pwyllgor Plant a Phobl Ifanc i Iechyd y Geg mewn Plant yng Nghymru - llythyr gan y Cadeirydd (11.50 - 11.55)

(Tudalennau 34 - 35)

HSC(4)-03-11 papur 5

7. Papur i'w nodi: Blaenraglen waith y Pwyllgor - Hydref 2011 (11.50 - 12.00) (Tudalennau 36 - 38)

HSC(4)-03-11 papur 6



Atrial Fibrillation Association (AFA) is a registered charity.

Internationally, AFA works closely with patients, carers, medical professionals, service providers, service payers affiliated groups and allied professionals to:

- provide support and information
- advance the education of the medical professionals
- raise awareness amongst the general public
- promote research into the management of Atrial Fibrillation

In Wales, many thousands of preventable strokes occur every year leading to thousands of early deaths and a devastating burden on individuals, families and society in terms of disability, medical and social care costs, and loss of working hours and tax revenues.

Atrial fibrillation (AF) is a common heart rhythm disorder associated with deadly and debilitating consequences including heart failure, stroke, poor mental health, reduced quality of life and death.ⁱ

Key points of AFA evidence

1. AF patients suffer a disproportionate number of strokes which are, in turn, disproportionately fatal, debilitating, expensive and likely to recur.
2. AF detection and diagnosis is low, leaving an estimated 50% of patients undiagnosed. **Opportunistic screening**, has been shown to be both effective and cost efficient at finding AF patients, however it is not widely used.
3. **Guidance and guideline adherence** is poor and consequently leaves AF patients at risk of avoidable strokes.
4. The main current therapy option, warfarin, which can effectively prevent many of these strokes is actually effective in only 18-21% of AF patients, due to under prescribing especially in those at high risk of stroke.
5. Too often, those at most risk, frequently the elderly, are prescribed aspirin, which only reduces the risk of stroke by 22% and increases their risk of a bleed to equal that of warfarin.
6. For those who often fall out of therapeutic levels (> 60% outside of target therapeutic range), warfarin is of little or no benefit.
7. The Inquiry Committee may wish to consider seeking evidence from all relevant professionals, including heart rhythm specialists.

Supporting evidence

AFA is mindful that budgetary pressures are ever-present and inevitable, and as a result, cost effectiveness has to be a reasonable expectation when comparing guidance it is important to consider both cost and effectiveness. This difference is probably best summarised but the QIPP, Right Care programme, 'Commissioning for Value':

'...value must also be measured by outputs, not inputs. Hence it is patient health results that matter...'

The AFA has amassed and documented many thousands of experiences that have been shared with us by patients, their caregivers and health care providers. These accounts are an excellent representation of the "health results" of patients suffering from AF in the UK today. In light of this amassed patient feedback and respected published data we have formulated the following response on behalf of patients suffering from AF.

1. AF is the most powerful independent risk factor for stroke and results in strokes that are more severe, more likely to disable, more likely to kill and more likely to recur.

Atrial Fibrillation (AF) is a common heart rhythm disorder associated with deadly and debilitating consequences including heart failure, stroke, poor mental health, reduced quality of life and death. [26] Today, more than 51,000 of the Welsh population have been diagnosed with AF, [28] yet experts suggest that up to half of all AF patients have not yet been detected. Among many damaging and debilitating consequences, AF increases an individual's risk of suffering a stroke by five times. [31] This effect alone results in considerable disability and death, [27,32] not to mention avoidable millions in healthcare expenditure [28] that NHS Wales cannot afford. For example, patients with primary or secondary diagnosis of AF occupied almost 308,000 bed days in 2008, at a cost to NHS Wales of £100 million [265]. Strokes kill about 1325 people in Wales each year. AF is known to be responsible for almost one quarter of these strokes, the health and social care costs of AF-related strokes in Wales are expected to reach £46.3 million per year [266]. These figures exclude the economic burden on NHS Wales and the Welsh economy.

Atrial Fibrillation is known to be responsible for 45% of all embolic strokes, resulting in more than 12,500 strokes per year in England and Wales. The strokes suffered by people with AF are also more severe, [82] they are more frequently fatal [83 84] and they are more likely to lead to disability, [83 85 86 82] increased healthcare costs [89] and extended hospital care than strokes in patients without AF. [82] Moreover, AF-related strokes are more likely to happen again [89], adding not just to the risk of future strokes, but also to the potential for increased patient anxiety and a further reduction in quality of life. AF-related strokes kill nearly twice as frequently as non-AF strokes. [82,83,84]

The medical cost of a stroke in first year is £9,500 - £14,000 per stroke. Embolic, and hence AF related, strokes are likely to be represented at the high end of this range. [93,98,100,103,104] These costs do not include continuing costs after first year, nor do they include costs associated with long term disability or the human cost, which is incalculable.

2. AF detection and diagnosis is low, leaving an estimated 50% of patients undiagnosed

Without effective detection and diagnosis of AF up to half the patients affected will never be identified. If a lack of detection and diagnosis continues, then many patients will be denied the opportunity to benefit from treatments that can dramatically reduce their risk of stroke. Existing research suggests that routine pulse screening has a role to play, as does public education on the need to investigate an irregular pulse.

Opportunistic screening, has been shown to be both effective and cost efficient at finding AF patients, however it is not widely used.

The role and value of screening programmes following the positive results of the SAFE study [266] illustrate the value of this in both finding patients with AF and reducing stroke risk, and ultimately stroke events. This has been more recently shown in Wrexham [268] where The Wrexham primary care AF model pilot launched on 1st May 2007 in four general practice surgeries under the Local Health Boards and ran for six months with positive results and findings. The audit of the pilot evaluated the view of existing patients on the AF registers in the surgeries as well as those patients that were identified through the routine screening using the manual pulse check. Seven new AF patients were found during opportunistic checks as part of the pilot and 68 patients were found to be on inappropriate or no thromboprophylaxis, which prompted further review by the GPs. Four

years since the start of the pilot the team are still reaping the benefits of the work undertaken in primary care.

NICE also recommends that all patients with an irregular pulse receive an ECG to make a diagnosis. However, The SAFE study found that GP and practice nurse performance in interpreting ECGs was not encouraging, identifying another potential challenge to the effective diagnosis of AF in primary care.

The need for routine, opportunistic screening, especially amongst those at greater risk of developing AF is essential if lives are to be saved and costs due to stroke events, reduced.

3. Guidance adherence is poor and consequently leaves AF patients at risk of avoidable strokes

There remains poor adherence to authoritative and national guidelines. Even NICE's own data shows that of all those with AF who should be on warfarin, almost half are not. Yet, when asked, physicians demonstrate both awareness of the guidelines and agreement with them. One study documented the medications being taken by AF patients when they suffered an ischemic stroke. It found that only 10% of these patients had been taking an effective dose of an anticoagulant. Nearly a third were on no antithrombotic treatment at all (29%). A further 29% were on aspirin and another 29% were on a non-therapeutic dose of warfarin.

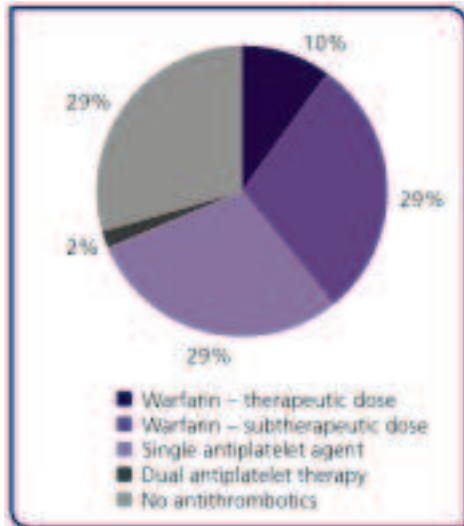


Figure 10. Medications received before admission to hospital by patients with known atrial fibrillation who suffered an acute ischaemic stroke: only 10% of patients had received warfarin at a therapeutic dose. Adapted with permission from Gladstone

Adherence to Guidelines for the prevention of stroke in patients with AF may be low for several reasons. These include difficulties in maintaining INR within the therapeutic range and physicians' concerns about bleeding risk, particularly in the elderly. [35]

Quality Outcomes Framework (QOF) was designed to reward GPs for the quality of the care that they provided, instead of for how many patients they treated. Currently, GPs can work to secure up to 1,000 QOF points by meeting predetermined performance targets in four broad areas: Clinical, Organisational, Patient Experience, and Additional Services. A total haul of 1,000 points represents an additional payment to GPs of over £13,000.

Specifically for AF, within the current QOF scheme, up to 12 points are available for GPs achieving a high percentage of 'patients with atrial fibrillation who are currently treated with anticoagulation drug therapy or antiplatelet therapy.'

It is reasonable to expect that many patients diagnosed with AF will already be taking aspirin for another condition. It is also relatively simple to start and manage a patient on aspirin (antiplatelet

therapy) compared to warfarin (anticoagulation therapy). Consequently, the way the target is written enables GPs to receive the maximum QOF reward just by having AF patients on aspirin, even if none of them is on warfarin.

Consequently, QOF today provides virtually no incentive for GPs to put patients on warfarin in accordance with the NICE 2006 or the ESC 2010 guidelines.

AFA would suggest that guidelines and rewards encourage

- An increase in the percentage of patients with Atrial Fibrillation in whom stroke risk has been assessed using the CHADS₂ risk stratification scoring system in the previous 15 months
- In those patients with Atrial Fibrillation in whom there is a record of a CHADS₂ score of ≥ 1 , an increase the percentage of patients who are receiving anticoagulants

Adherence to agreed guidance is essential if AF patients are to be properly assessed and treated to reduce stroke.

4. Aversion to warfarin leaves thousands of patients at unnecessarily high risk of stroke

In clinical trials warfarin has been associated with a stroke risk reduction in AF patients of 50%-70%. However, this potential is not being realised in routine clinical practice, leaving thousands at risk of preventable strokes.

Warfarin is currently recommended in UK and European guidelines as first-line therapy in patients with AF and a moderate or high risk of developing stroke. [138 139] Despite evidence that following the guidelines results in improved patient outcomes, [166] there is significant under-use of warfarin. Thus, many patients with AF and a moderate-to- high risk of stroke do not receive anticoagulant therapy and therefore remain at high risk for stroke. [156 153]

NICE data shows that of all those with AF who should be on warfarin, almost half are not. [179]. In a study conducted in seven European countries, it was found that only 8.4% of patients with AF who had a stroke were receiving anticoagulants at the time of their stroke, and the proportion decreased by 4% per year with increasing age. [181] A review of the scientific literature from 2000 indicated that only 15–44% of eligible patients with AF were receiving warfarin.[180] Yet, when asked, physicians demonstrate both awareness of the guidelines and agreement with them, despite not treating patient in accordance with those guidelines. [182] This further highlights the discrepancy that is often found between trial results and what happens in clinical practice. Another study documented the medications being taken by AF patients when they suffered an ischemic stroke. It found that only 10% of these patients had been taking an effective dose of an anticoagulant. Nearly a third were on no antithrombotic treatment at all (29%). A further 29% were on aspirin and another 29% were on a non-therapeutic dose of warfarin. According to recent surveys in different parts of Europe, the proportion of patients with AF at high risk of stroke who are receiving adequate anticoagulation is most commonly around 54–61% [185,172]

Warfarin is under-prescribed for many reasons including the complexity of dosing and patient management as well as fear of the associated bleeding risks. Consequently, almost half the AF patients for whom warfarin is indicated are not on warfarin and remain at extremely high risk of severe, debilitating and expensive strokes.

Management of warfarin is complex and time-consuming for primary care physicians. It is also recognised that those at greatest risk, the elderly, are less likely to be given warfarin because of perceived fear of complications.

In centres where clinicians with a special interest in AF have set up clinics and outreach support, such as Prince Philip Hospital, Llanelli, commitment of a truly multidisciplinary team, has led to a

successful "one-stop service" service for those referred with AF. When started, only 22% of the patients referred to Dr Izzat with a CHADS₂ of more than 1 were adequately anti-coagulated with warfarin, this has now improved to just over 40% and plans to improve this further are in hand. Knowledge of and adherence to current guidance, effective use of validated risk assessment schema and appropriate use of anticoagulation has lead to successful stroke prevention – and with no extra finance.

5. Too often, those at most risk, frequently the elderly, are prescribed aspirin, which only reduces the risk of stroke by 22% and increases their risk of bleed to equal that of warfarin.

Many physicians resist the use of warfarin in the elderly, largely on grounds of safety. Research has demonstrated repeatedly that physicians over-estimate the risk of bleeding associated with the use of warfarin and under-estimate its benefits in preventing thromboembolism and stroke; conversely, they have been shown to under-estimate the bleeding risk of aspirin therapy and over-estimate its benefits. [196,188,201] As a result, eligible patients are not receiving therapy that could prevent strokes. [18] For many physicians, bleeding risk is a particular concern in the elderly, who are more prone to falls, more likely to have suffered previous major bleeds, and who are subject to many additional problematic factors associated with old age. [202,204] While the bleeding risk with warfarin is no worse than that with aspirin, physician experience of major bleeding events associated with warfarin can profoundly reduce prescription of warfarin. [205] A study investigated the behaviour of physicians treating AF patients who had bleeds while on warfarin. Patients treated in the 90 days after the physician had encountered a bleeding event were significantly less likely to receive a prescription for warfarin than patients treated before the bleed. [205] In contrast, having a patient who experienced a Stroke while not receiving warfarin did not influence prescribing behaviour with subsequent patients. [205] In other words, a bleeding event may make a physician less likely to prescribe an anticoagulant but a stroke does not increase the likelihood that a physician will prescribe an anticoagulant. There are large numbers of younger patients who according to guidance should be prescribed anticoagulants including 'those with a history of stroke and those aged 65 years or over with one of the following: diabetes, coronary artery disease, or hypertension', but who simply are not receiving it, whether this be through their choice or physician assessment. **AFA would propose that guidelines recommending that patients be assessed for risk using the CHADS₂ and the CHADS₂VASc₂ system should be adopted.**

6. For those patients on warfarin large numbers of patients are difficult to control and spend >60% outside the target therapeutic range – rendering warfarin of no benefit.

Research has shown that AF patients in routine clinical care were able to maintain a target INR for over half the time (56%). Of the considerable remaining time, patients were above the target range for 30%, and below the target range for 14%. [184]. If around half of all patients in need of anticoagulation aren't prescribed warfarin [179] and if those who are have either ineffective or unsafe blood levels of warfarin for nearly half of the time, [184] then perhaps only a quarter of patients at any one time receive the therapy they need to safely lower their risk of stroke. This becomes ever more worrisome when considering experts' estimates that only about half of all AF patients are actually diagnosed. The vast majority of these undiagnosed patients would be expected to be at moderate or high risk of stroke, [190] and, hence, in need of warfarin therapy according to

the ESC 2010 guidelines. Yet perhaps only a fifth of patients in need of warfarin to reduce risk of stroke are actually receiving safe and effective anticoagulation treatment at any time.

-Effective monitoring is essential if at risk AF patients are to be protected.

-An education programme, in line with recommended guidance is required to increase awareness and understanding of the importance of appropriate anticoagulation therapy in AF patients.

7. The Inquiry Committee may wish to consider seeking evidence from all relevant professionals, including heart rhythm arrhythmia specialists.

AF is largely managed in primary care, but cardiologist who are arrhythmia specialists also play a key role in local training, referrals and care of more challenging AF patients. Cardiac Networks and cardiology arrhythmia specialists are also instrumental in informing and supporting local guideline adherence in order to PREVENT stroke in AF patients.

AFA has worked with the Cardiac Networks and Arrhythmia specialist in Wales, and suggests that the Inquiry would benefit from seeking expert advice from these sources. AFA would be very happy to highlight Welsh centres where specialist clinicians are working to reduce both the burden of AF and the risk of stroke amongst the AF population.

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Atrial fibrillation—so what?

Changing clinical practice

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The arrhythmia nurse practitioner's role has many different titles, from specialist nurse to arrhythmia care co coordinator, with the different titles comes the diverse yet rewarding workload. The role of the British Heart Foundation (BHF) arrhythmia nurse is underpinned with three key elements

- ♦ Ensuring that all patients with arrhythmias receive an effective and holistic assessment and a package of care, to ensure that all the patients' medical and emotional needs are discussed.
- ♦ All those who are included in the care pathways including patients, families and carers receive education and support as needed.
- ♦ Ongoing monitoring and auditing of the arrhythmia service takes place. These elements ensure that the quality requirements of chapter 8 of the National Service Framework (NSF) for Coronary Heart Disease (CHD) (Department of Health, 2005) and the Welsh equivalent standard 5 of the Welsh NSF (Welsh Assembly Government, 2008) are met.

Arrhythmia nurse practitioners service

In October 2006 two experienced cardiac nurses were appointed to the arrhythmia nurse practitioners (ANPs) service based in a district general hospital, one with additional experience in primary care with knowledge of the local area. These roles had been created to develop a service that would bridge the gap between primary, secondary and tertiary care for patients who suffer from arrhythmias.

The day-to-day work load now is very varied and can include answering telephone enquires from the advice line, pre-assessing patients for procedures such as elective direct current cardioversion, permanent pacemaker implants, educating other health professionals about the management of patients with arrhythmias, visiting patients, families or carers at home or in hospital to discuss arrhythmias and their management, liaising with other health professionals to improve patient care, audit, and developing patient pathways to improve access to services. Nevertheless the majority of our work load centres around the management of patients with atrial fibrillation (AF).

Atrial fibrillation

Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia, if left untreated it is a significant risk

factor for stroke and other morbidities (National Collaborating Centre for Chronic Conditions (NCC-CC), 2006). The annual risk of stroke increases by around 4-5% for patients with atrial fibrillation, however this is not relative and the risk increases with age and other co-morbidities. This risk can be reduced with appropriate and timely thromboprophylaxis (NCC-CC, 2006). The effects of AF on the patient can range from none to many side effects such as reduced quality of life, breathlessness, fatigue, palpitations, and angina. The screening for atrial fibrillation in the elderly (SAFE) study (Hobbs et al, 2005) identified that when GPs record manual pulses during routine consultations the incidence of AF diagnosis is significantly increased, ultimately leading to a reduction in the incidence of stroke.

Based on experience as a practice nurse prior to taking the post as an arrhythmia nurse practitioner, it was felt that GP surgeries and practice nurses play a vital role in the care of patients with chronic diseases and are therefore

ABSTRACT

Atrial fibrillation (AF) is the most common sustained cardiac arrhythmia, if left untreated it is a significant risk factor for stroke and other morbidities. Approximately 12 500 strokes each year are attributable to AF and the annual cost to the NHS and personal social services budget is estimated to be around £148 million. The SAFE study identified that when GPs record manual pulses during routine consultations the incidence of AF diagnosis is significantly increased, ultimately leading to a reduction in the incidence of stroke.

On 1 May 2007 the Wrexham primary care AF model pilot was launched. Working in partnership across organizational boundaries, changes were made to existing templates in some GP surgeries. A manual pulse check was added to all chronic disease management templates, and a stroke risk stratification tool was added to AF templates to ensure patients are correctly stratified for appropriate use of a thromboprophylactic agent, which in turn would reduce the incidence of stroke. Seven new AF patients were found by opportunistic checks during the pilot and 68 patients found to be on inappropriate or no thromboprophylaxis, which prompted further review by the GPs.

KEY WORDS

- ♦ Manual pulse checks
- ♦ Atrial fibrillation
- ♦ Screening
- ♦ Stroke risk assessment

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ideally situated to initiate a screening service for atrial fibrillation within local primary care settings.

The hospital is based on the borders of Wales and England, serving patients from both countries, and the same region is also served by two other hospitals. To reduce inequalities in services between the different hospital that serve the local area, we chose to facilitate other health care professionals in the community to undertake screening for AF by integrating manual pulse checks into routine clinical assessments i.e. chronic disease management in GP surgeries, district nurse assessments, community matron or long-term condition nurse assessments.

Facilitating AF screening in GP surgeries

The model for screening is not complex, nor ingenious, quite the opposite. It is simple, requires no funding, and can be adapted into any general practice setting that conducts chronic disease management reviews. The model aims for each individual to be assessed, to create a treatment plan that is centred on their own exclusive needs.

Before piloting the model we delivered several educational workshops for local practitioners (including GPs, practice nurses and district nurses) to reach as many health professionals in primary care as possible in order to highlight the implications of AF. Emphasis was placed on the need for manual pulse and blood pressures monitoring, as the use of automated machines can give inaccurate readings for patients with irregular pulses.

The arrhythmia nurse practitioner service worked in partnership across organizational boundaries and made changes to existing templates in some GP surgeries (who volunteered to take part). These included the addition of a manual pulse check to all chronic disease management templates, which instigates opportunistic and routine screening not only for those who are at high risk for AF but also for the wider population.

In addition, the model used a stroke risk stratification tool—CHADS₂ (Valentin et al, 2006)—and recorded the results using the read code 388I in an AF template to ensure patients were correctly stratified for the appropriate thromboprophylactic agent, which in turn would reduce the incidence of stroke.

The CHADS₂ stroke risk stratification is a clinical prediction tool used for estimating the risk of stroke in patients with nonrheumatic, or nonvalvular, AF. Points are assigned for chronic heart failure (C), hypertension (H), age 75 years or over (A), diabetes mellitus (D) and history of stroke or transient ischaemic attack (S—2 points). The higher a person's CHADS₂ score, the greater the risk of stroke.

An annual diary date was created to prompt annual review, which is a component missing from the clinical indicators of the quality outcome framework (QOF) for atrial fibrillation (British Medical Association/NHS Employers 2006).

Implementing the tool and annual check was supported by the development of internet-based guidelines and cardiac network guidelines that GPs can access.

AF primary care pilot

The Wrexham primary care AF model pilot launched on 1st May 2007 in four general practice surgeries under the local health boards, and ran for six months with positive results and findings. The audit of the pilot evaluated the review of existing patient on the AF registers in the surgeries as well as those patients that were identified through the routine screening using the manual pulse check. Seven new AF patients were found during opportunistic checks as part of the pilot and 68 patients were found to be on inappropriate or no thromboprophylaxis, which prompted further review by the GPs.

Nearly two years since the start of the pilot the team are still reaping the benefits of the work undertaken in primary care. Although four practices were initially recruited into the pilot, the arrhythmia nurse practitioners wrote to every practice in the catchment area and asked to set up a meeting to discuss the basis of the pilot.

It seems a key reason that practices were not keen to take part in the pilot was that the pilot scheme used paper audit forms, whereas most GP surgeries operate a paperless policy. This appeared to be an obstacle that could not be overcome at the time, and the additional time needed to complete the form was seen to be problematic.

In one surgery one of the ANPs personally performed an audit of all the patients on the AF register, highlighting any patients that appeared to be on inappropriate therapy or thromboprophylaxis. This allowed her to gain a better understanding of the extent of problems that could be discovered, and appreciate the time it took to perform this audit and the impact it would have on GP and practice nurses' workload. This method of auditing patients was also used in other surgeries by GPs and practice nurses, whereas some practices chose to invite all patients on the AF register in for a review.

The ANP service now see on many referral letters that the patient was found to be in AF during a routine blood pressure check or during an annual chronic disease management review. Hopefully, this is a direct effect of the educational events the service continues to provide and also a result of those surgeries that made the changes to their chronic disease management templates.

Award winning service.

In April 2008 the team's work in this area was recognized nationally with an award at the Cardiac Nursing Awards in London for 'Excellence or innovation in arrhythmia management'. This award would not have been possible if it were not for the continued support of our manager, consultants, GPs, practice nurses, cardiac lead nurses in the community and last but not least the BHF. Our idea was simple but has proved to be effective.

The future

Other initiatives undertaken by the team include a collaboration with the local health board lead nurse for cardiovascular disease on developing part of a cardiology local enhanced service (LES) for GPs (DH, 2008)).

The option in the LES relating to AF included raising awareness of AF, the significance of taking a manual pulse and the importance of using the stroke risk stratification tool to identify those who needed interventions to reduce the risk of stroke. GP practices agreeing to take part in this option were asked to attend an ECG study day on arrhythmias and an AF study session provided by the two ANPs. The session included the importance of the stroke risk stratification tool and thromboprophylaxis. Following this, the practices involved were encouraged to adapt all their chronic disease management computer templates to include taking a manual pulse.

It is recognized that ongoing education is required in primary care and working closely with local health boards the ANP service aims to provide further education.

In addition, the service is in the process of organizing a 'Know your Pulse' educational event for Arrhythmia Awareness Week 2009. The event is to be hosted with the support of the occupational health department of a large local employer who has approximately 8500 permanent and contract staff. The event will start with an internal television campaign highlighting the importance of 'know your pulse' followed by site tours educating staff on how to check their own pulse and the importance of seeking medical advice if an abnormal pulse is found. Due to the enormity of the site three days have been scheduled for this event over the summer months, alongside night visits to ensure night staff benefit from this event.

KEY POINTS

- ◆ Atrial fibrillation is the most common arrhythmia and if left untreated can lead to an increased risk of stroke
- ◆ Undetected AF cannot be treated, making screening important
- ◆ Studies have shown that when GPs record manual pulses during routine consultations the incidence of AF diagnosis is significantly increased
- ◆ By providing education and support to primary care colleagues to assist them in identifying and appropriately treating patients with AF, future complications may be reduced

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Eitem 3

Health and Social Care Committee

HSC(4)-03-11 paper 2

Inquiry into Stroke Risk Reduction - Evidence from the Stroke Association in Wales

Y GYMDEITHAS
STRÔC



The Stroke Association in Wales welcomes the opportunity to provide written evidence to the Health, and Social Care Committee on the Inquiry into Stroke Risk Reduction.

The Stroke Association in Wales is the leading third sector provider of Life After Stroke Services. We aim to reach at least nine out of ten stroke survivors and their families within two weeks of the stroke. We are at the forefront of raising awareness of stroke and promoting the right of stroke survivors. We help people to reduce their risk of having a stroke and lobby for improvements in stroke services across the whole care pathway.

1. What is the current provision of stroke risk reduction services and how effective are the Welsh Government policies in addressing any weaknesses in these services?

1.1 Around 11,000 people in Wales have a stroke each year. However, stroke is both preventable and treatable. Preventing a stroke from happening in the first place should be at the forefront of health promotion policy. Smoking, excessive intake of alcohol, obesity, poor diet and lack of exercise are all conclusively linked to stroke.

1.2 The Welsh Government has funded a number of stroke prevention campaigns including Weigh up your Risk of Stroke, the F.A.S.T campaign and most recently with the Stroke Association; Ask First – to help prevent a stroke later campaign which focussed on the risks of having a stroke associated with having a condition called AF and / or high blood pressure.

1.3 As well as ensuring continued awareness about healthy lifestyles, The Welsh Assembly Government must aim to tackle the inequalities in health which continue to lead to less favourable health outcomes for those with a lower socio – economic background.

1.4 The Welsh Assembly Government needs to take a wider view to implementing successful health promotion campaigns and integrate thinking

with the social inequalities that come about as a result of the wider determinants of ill health which exist across parts of Wales.

1.5 The Stroke Association welcomes its continued partnership with the Welsh Government in delivering stroke prevention campaigns. However, these should be delivered more strategically. This can be achieved by allowing longer planning periods and more collaboration across organisations and functionalities, as well as ensuring that adequate levels of funding are available to deliver integrated campaigns.

2. What are your views on the implementation of the Welsh Government's Stroke Risk Reduction Action Plan and whether action to raise public awareness of the risk factors for stroke has succeeded?

2.1 Whilst the Stroke Association cannot comment on the implementation on some of the actions attributed to other organisations, we can offer comment on how we see the overall implementation. Last year the Stroke Association welcomed the Health, Wellbeing and Local Government's Inquiry into Stroke and the resulting publication of "Promoting Cardiovascular Health: the Stroke Risk Reduction Action Plan". However, following publication, we have not had any further correspondence regarding implementation despite being attributed as an organisation to deliver key actions in partnership with others.

2.2 However, The Stroke Association has worked with the Health Improvement Division of the Welsh Government to implement action point 37: Conduct an awareness raising campaign 'know your blood pressure, know your pulse; including targeted action for BME groups at greater risk.

2.3 At the Stroke Association our focus turned to AF in September 2010 when we were in the process of developing our UK wide Stroke Association AF campaign. In Wales we were given the opportunity to jointly launch "Keeping our Finger on the Pulse: why Wales must address the personal, clinical and economic impact of Atrial Fibrillation" funded through an educational grant by Sanofi Aventis and in partnership with the Atrial Fibrillation Association. This document outlined a case for action and offered analysis on the devastation that AF causes in Wales each year.

2.4 At the same time, The Welsh Government was launching "Promoting Cardiovascular Health: the Stroke Risk Reduction Action Plan" and one of the actions was to carry out an awareness raising campaign around both high blood pressure and irregular heartbeat. This coincided with our UK wide strategic drive to raise awareness of AF as a risk factor for stroke.

2.5 We decided to form a partnership to deliver a joint campaign. Ours was an AF specific campaign at UK level; however the Welsh Health Minister wanted a dual purpose approach to include high blood pressure. We set to work to integrate the requirements of The Welsh Government with our own strategic priorities and we planned and implemented a successful campaign called Ask First: to help prevent a stroke later, in March this year.

2.6 The partnership has been hugely successful and we hope to be able to work with the Welsh Government to deliver further awareness and prevention campaigns along these lines in the future.

2.7 With regard to delivery of the remaining actions, we would welcome a report on progress and an open dialogue to ensure that the actions are implemented. A review and refresh of this action plan is needed to ensure the best possible outcome for promoting good cardiovascular health and therefore a reduction of strokes in Wales.

3. What are the particular problems in the implementation and delivery of stroke risk reduction actions?

3.1 We believe the main problem with the implementation has been ownership. Despite being attributed actions, no further communication has been forthcoming to facilitate these actions to ensure delivery.

3.2 With a focus on working to remedy the failure of Wales to meet standards set out in the RCP National Stroke Audit which has been critical of Wales in terms of its delivery of stroke services within the acute setting; the work around stroke prevention has had less focus and resource, and yet it is vitally important if we are to prevent some of the 11,000 strokes which happen in Wales each year.

3.3 Whilst it is right and proper that stroke patients are given good quality interventions within hospital to ensure the best possible outcome, the whole stroke pathway needs to be taken into consideration. This pathway should not start with the onset of stroke symptoms; rather stroke prevention should carry equal weight. This is why the Stroke Association in Wales continues to call for an overarching All Wales Stroke Strategy which would incorporate prevention, acute intervention and life after stroke rehabilitation and reablement services placing the citizen and his or her carer at the very centre of the stroke journey.

3.4 The work being done by the 1000 Lives+ initiative and supported by the NHS Delivery and Support Unit to drive up standards in stroke services has been fundamental in improving the performance of acute stroke care across Wales. The Stroke Association wholeheartedly welcomes the development of

Intelligent Targets for acute, TIA, early rehabilitation stages of the stroke pathway. The implementation of these targets has been hugely successful and praise needs to be given to clinicians in the stroke community across Wales for their determination to implement this programme.

3.5 The Stroke Association is pleased to be able to support this programme and is looking forward to the work being developed on the Life After Stroke Intelligent Target and in particular any work that is going to be done to develop a Stroke Prevention Target.

3.6 Vital to implementing a successful programme of stroke improvement is the engagement of all strategic partners. The work around improving stroke services has to date centred on the clinical intervention of stroke and is firmly embedded within health. Yet, acute intervention is one part (though crucial) of the journey of a stroke survivor and the role of Local Authorities in ensuring that effective prevention strategies are embedded into local strategic planning is all too often missing as stroke is seen as a “medical” problem and not a social problem with opportunity for improvement through solutions that lie within social care.

3.7 Whilst this is an issue which affects Life After Stroke Services more so than prevention services, we would like it stated as part of this inquiry that the role of Local Government as a strategic partner in promoting preventative and early intervention programmes is vital and we would expect to see the role of Local Authorities being bolstered in a renewed and invigorated action plan for stroke prevention and risk reduction.

4. What evidence exists in favour of an atrial fibrillation screening programme being launched in Wales?

4.1 AF affects about 750,000 people in the UK and is more common in older people. AF is the most common heart rhythm disorder in Wales and it is said that AF related strokes cost in the region of £46.3 million a year.

4.2 AF means the heart is not pumping as well as it should do. The upper chambers of the heart contract and relax in an uncoordinated and irregular way because of erratic electrical activity. Irregular and fast heartbeats mean the heart does not have a chance to relax and empty properly before filling up with blood again. Blood can collect and pool and this increases the risk of blood clots forming in the blood. As a result, blood clots are more likely to form in the heart. If a clot dislodges itself from the heart it can then travel through the blood stream to the brain and can cause a stroke.

4.3 The risk of stroke is five times greater in people with AF than in people with normal heart rhythm, and one of every six strokes occurs in a person

with AF. Strokes due to AF are twice as likely to be fatal as non-AF stroke, more severe and have a greater need for long-term care.

4.4 AF can cause symptoms such as palpitations, breathlessness, chest pain or fatigue, but can also have no obvious symptoms.

4.5 The Stroke Association is actively campaigning to improve awareness of AF and its link to stroke. We believe that routine screening for AF should be introduced across Wales. This should not be onerous and the following existing opportunities should be considered as a way of identifying more people with AF:

- Flu clinics. Since older people are routinely called in each year for the annual flu vaccination, a simple pulse check would identify new cases of AF.
- Chronic disease clinics. The people who attend for monitoring of chronic cardiovascular conditions, diabetes etc. are at a higher risk of developing AF and will also carry a higher stroke risk. The addition of a routine pulse check to the assessment would increase the identification of AF.
- Flagging applied to records of all patients over 65 known not known to have AF would prompt routine checking of pulse.

4.6 The role nurses can play in detecting AF is crucial. The Stroke Association recently ran an event with the Royal College of Nursing to raise awareness regarding the role of the nurses in identifying AF. By ensuring that each local health board establishes a nurse who champions AF and its link to stroke, AF would be seen as a risk factor for stroke, not merely as a heart rhythm disorder. Primary Care nurses also have a role to play in detecting people who have AF and promptly referring for treatment. Many options are available to increase the role of nursing in this area, and training to carry out manual pulse checks could easily be integrated into the clinics listed above at little or no extra cost to the NHS.

4.7 The existing Quality and Outcomes Framework (QOF) indicators may be one possible reason why fewer than expected AF patients are identified as they do not adequately encourage the detection of unrecognised AF. The Stroke Association recommends that pulse checks are introduced into an overall Health Check programme and we support the call for the inclusion of a new QOF indicator 'the percentage of patients aged 65 or over who have undergone pulse assessment in the last 15 months.'

4.8 As blood clots are more likely to form in the heart in AF, stroke may occur if a clot travels to the brain. While not everyone who has AF will have a stroke, some are at more risk than others. Some simple tools have been

validated that help health professionals identify those most at risk of stroke, and a tool has been developed in England called GRASP-AF for the easy use in GP practices. The Stroke Association would like to see the use of this tool or a similar tool in GP practices in Wales.

4.9 NICE guidelines already exist for the stratification of patients with AF for risk of stroke, using validated tools. However, adherence to these guidelines is low and we recommend that a risk assessment for stroke, using a recognised tool recommended in the ESC guidelines, to be carried out on all patients with AF, and that this is reviewed at regular intervals. We call for a new QOF indicator that states 'the percentage of patients with AF in whom stroke risk has been assessed using a validated tool'.

4.10 Anti-coagulant treatments are available for at-risk individuals. Despite the existence of NICE guidelines, and the availability of treatments to reduce the risk of stroke, many AF patients at risk of stroke are not treated in accordance with the guidelines.

4.11 The Stroke Association calls for NICE guidelines to be urgently updated, and for clinicians to adhere to the most recent guidance on the treatment of AF and reduce the risk of stroke by appropriate treatment. We also want to see the inclusion of a new QOF indicator 'The percentage of patients at high risk of stroke who are receiving anticoagulants (unless a contra-indication or side-effects are recorded)'.

5. Final Remarks

5.1 The Stroke Association in Wales wholeheartedly welcomes this Inquiry into Stroke Risk Reduction and in particular the focus on Atrial Fibrillation as a risk factor for stroke. Mitigating the devastation that stroke can have on people's lives is the basis of our work and we wholeheartedly support further attention being given to raise the awareness of the importance of stroke prevention and risk reduction.

5.2 Prevention work need not be resource heavy as we have demonstrated. Including simple pulse checks into already existing clinics and introducing new QOF indicators will help save lives and prevent people falling into disability as a result of stroke.

For further information please contact Lowri Griffiths, Head of Communications and External Affairs at the Stroke Association in Wales lowri.griffiths@stroke.org.uk or ring 029 20524400

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Y Pwyllgor Iechyd a Gofal Cymdeithasol

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CRAFFU AR GYLLIDEB 2012/13

Diben

1. Un o swyddogaethau'r Pwyllgor Iechyd a Gofal Cymdeithasol ("y Pwyllgor") yw craffu ar gyllideb flynyddol Llywodraeth Cymru. Mae portffolio'r Pwyllgor yn cynnwys tri maes o fewn y gyllideb, sef iechyd, iechyd meddwl a gwasanaethau cymdeithasol.
2. Mae'r papur hwn yn ceisio barn y Pwyllgor ar y dull arfaethedig o graffu ar y gyllideb.

Y broses o graffu ar y gyllideb

3. Y Pwyllgor Cyllid yw'r unig bwyllgor a all argymhell newidiadau i gyllideb y Llywodraeth.¹ Fodd bynnag, gall unrhyw bwyllgor arall ystyried y gyllideb ddrafft a chyflwyno adroddiad i'r Pwyllgor Cyllid.² Fel arfer, caiff hyn ei wneud mewn adroddiad pwyllgor neu lythyr at y Pwyllgor Cyllid.
4. Lansiodd y Pwyllgor Cyllid ymgynghoriad cyhoeddus ar y gyllideb yn ystod yr haf. Roedd yr alwad am dystiolaeth³ yn un eang, ac aeth i amrywiaeth eang o randdeiliaid, gan gynnwys sefydliadau iechyd, iechyd meddwl a gwasanaethau cymdeithasol.
5. Mae'r amser sydd ar gael i'r Pwyllgor graffu ar y gyllideb yn gyfyngedig:

4 Hydref	Llywodraeth yn gosod y gyllideb ddrafft
12 Hydref	Cyfarfodydd pwyllgor ar gael i gymryd dystiolaeth ar y gyllideb.
20 Hydref	

¹ Rheol Sefydlog 20.11

² Rheol Sefydlog 20.10

³ <http://senedd.cynulliadcymru.org/documents/s2247/Galwad%20am%20-%20wybodaeth%20Cynigion%20cyllideb%20ddrafft%20Llywodraeth%20Cymru%20ar%20gyfer%202012-13.pdf>

26 Hydref	Rhaid gosod adroddiadau pwyllgor erbyn y dyddiad hwn er mwyn i'r Pwyllgor Cyllid ystyried barn pwyllgorau yn ei adroddiad ar y gyllideb ddrafft.
8 Tachwedd	Y dyddiad olaf ar gyfer cyhoeddi adroddiad y Pwyllgor Cyllid ar y gyllideb ddrafft.

Craffu ar waith y Gweinidog

6. Mae'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol ar gael i ddod i gyfarfod y Pwyllgor ar 20 Hydref i graffu ar y gyllideb.

Trafodaeth

7. Gofynnir i'r Pwyllgor ystyried cynnig i gynnal sesiwn drafod gyda chynrychiolwyr o bob un o'r tri maes o fewn y gyllideb. Disgwylir mai sesiwn fer fyddai hon (tua 1 awr) ar 12 Hydref. Diben y drafodaeth fyddai canfod y prif faterion i'w hystyried wrth graffu ar y gyllideb ddrafft a llywio'r gwaith o graffu ar waith y Gweinidog a'r Dirprwy Weinidog yr wythnos ganlynol.
8. Gan mai diben y sesiwn hon fyddai casglu gwybodaeth, ni fyddai nodiadau briffio manwl yn cael eu darparu. Byddai'r Aelodau yn cael eu hannog i archwilio'r meysydd hynny gyda'r tystion sydd angen eu harchwilio ymhellach gyda'r Gweinidog a'r Dirprwy Weinidog.
9. Oherwydd natur y sesiwn, efallai y byddai'r Aelodau yn teimlo mai cyrff ymbarél fyddai yn y sefyllfa orau i roi trosolwg o'r prif faterion sydd angen eu harchwilio gyda'r Gweinidog a'r Dirprwy Weinidog. Yn ogystal â'r cyrff ymbarél, efallai yr hoffai'r pwyllgor ystyried gwahodd tyst a allai roi trosolwg cyffredinol ar y sefyllfa ariannol sy'n wynebu'r sector, er enghraifft economegydd iechyd neu academydd.
10. Gallai'r tystion posibl gynnwys:
 - Confederasiwn y GIG

- Y Gymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol
- Y Bwrdd Rhaglen Genedlaethol ar gyfer Iechyd Meddwl Oedolion
- Academydd

Craffu ar y gyllideb yn y dyfodol

11. Mae craffu ar y gyllideb yn un o gyfrifoldebau parhaus y Pwyllgor, a gellir gwneud mwy o waith ar hyn drwy gydol y flwyddyn. Er mwyn cynorthwyo'r Pwyllgor i wneud mwy o waith craffu, efallai yr hoffai'r Aelodau ystyried canfod 'cynghorwyr arbenigol' a allai helpu i graffu ar y gyllideb yn y dyfodol.⁴ Byddai hyn yn helpu i leddfu'r anawster o ran recriwtio tystion sy'n meddu ar y cydbwysedd cywir o arbenigedd ym maes cyllid a pholisi ac nad ydynt eisoes yn darparu cymorth o fewn Cymru.
12. Gofynnir i'r Aelodau awgrymu darpar ymgeiswyr i gynorthwyo yn y gwaith o graffu ar y gyllideb yn y dyfodol. Gallai'r bobl hyn fod yn academyddion / arbenigwyr o'r tu allan i Gymru, a fydd yn cytuno i roi cyngor i'r pwyllgor ar gyfer cylch cyllideb 2013-14.

Camau gweithredu ar gyfer y Pwyllgor

13. Gwahoddir y Pwyllgor i:
 - gytuno ar y ffordd o graffu ar gyllid ar gyfer 2012-13 (paragraffau 6 - 10); a
 - ystyried ymhellach y dull o graffu ar y gyllideb yn y dyfodol (paragraffau 11 a 12)

⁴ Mae Rheol Sefydlog 17.55 yn caniatáu i bwyllgorau benodi cynghorwyr i roi cyngor arbenigol.



HSC(4)-03-11 papur 4

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Gofal Preswyl i Oedolion

Papur cwmpasu ar gyfer ymchwiliad i ofal preswyl i oedolion yng Nghymru

Dyddiad y cyfarfod:

22 Medi 2011

Cynhyrchwyd y papur briffio hwn gan y Gwasanaeth Ymchwil i'w ddefnyddio gan y Pwyllgor Iechyd a Gofal Cymdeithasol.

I gael rhagor o wybodaeth, cysylltwch â Stephen Boyce yn y Gwasanaeth Ymchwil

Est. 8095

E-bost: Stephen.boyce@wales.gov.uk

Members'
Research
Service



1. Cyflwyniad

Yn ei gyfarfod ar 13 Gorffennaf 2011, cytunodd y Pwyllgor i gynnal ymchwiliad i ofal preswyl yng Nghymru, a chytunodd hefyd y byddai ei aelodau'n ystyried papur cwmpasu yn ei gyfarfod ar 22 Medi 2011. Mae'r papur hwn yn gosod allan gwmpas posibl ymchwiliad o'r fath.

Cefndir

Mae'r gwasanaethau gofal cymdeithasol wedi bod yn destun sylw ers tro, yn enwedig y problemau sydd ynghlwm wrth ariannu gwasanaethau i boblogaeth sy'n heneiddio. Yn ogystal â hyn, mae'r digwyddiadau yn Southern Cross wedi hoelio sylw ar sefydlogrwydd a chynaliadwyedd y sector gofal preswyl.

Yn gynharach eleni, cyhoeddodd Llywodraeth Cymru bapur polisi¹ yn gosod allan ei chynlluniau ar gyfer gofal cymdeithasol am y deng mlynedd nesaf, sy'n cynnwys cyhoeddi Bil Gofal Cymdeithasol yn y Pedwerydd Cynulliad.

Mae'r Dirprwy Weinidog dros Blant a Gwasanaethau Cymdeithasol yn sefydlu Grŵp Gorchwyl a Gorffen i archwilio materion yn ymwneud ag anghenion gofal a llety pobl hŷn. Cyhoeddir aelodaeth y Grŵp hwn yn ystod hydref 2011.

Mae'n bosibl y bydd y Pwyllgor am gytuno i gynnal ymchwiliad i gynaliadwyedd y sector gofal preswyl a'i allu i ddiwallu anghenion pobl hŷn yng Nghymru ar hyn o bryd, ac yn y dyfodol, ac i ystyried dulliau eraill o ddarparu gofal.

Ymchwiliad i anghenion pobl hŷn yn unig fyddai hwn, ond gellid ei ehangu i gynnwys oedolion iau.

Gallai'r Ymchwiliad ymdrin â'r agweddau a ganlyn ar ofal preswyl.

2. Llwybrau gofal preswyl

Ers cryn amser, mae polisi gofal cymdeithasol wedi ceisio rhoi llai o bwyslais ar ofal sefydliadol a chynnig darpariaeth i helpu pobl i gadw'u hannibyniaeth ac i barhau i fod â rheolaeth dros eu bywydau'u hunain. Dyma yw sylfaen y polisi presennol o hyd: mae papur polisi gwasanaethau cymdeithasol Llywodraeth Cymru² yn rhagweld y bydd gwasanaethau i bobl hŷn yn 'trawsnewid' wrth i ragor o gynlluniau ailalluogi a gwasanaethau cymorth arloesol gael eu darparu yn y gymuned.

Mae cost uchel gofal preswyl, ynghyd â'r problemau sy'n codi wrth i bobl ddatblygu meddylfryd sefydliadol, yn golygu bod nifer gynyddol o bobl ag anghenion sylweddol yn cael gwasanaethau gofal yn y cartref. Mae dulliau newydd o ddarparu gofal, fel Rhaglen Llesgedd Gwent, a datblygiadau ym myd technoleg, fel Teleofal, wedi ehangu'r posibiliadau

¹ Llywodraeth Cymru [Gwasanaethau Cymdeithasol Cynaliadwy: Fframwaith Gweithredu](#) (2011) [fel ar 5 Medi 2011]

² Ibid



ar gyfer gofal yn y gymuned. Er hyn, araf fu'r broses o symud y pwyslais oddi ar ofal sefydliadol i ofal yn y gymuned³ ac mae'r cydbwysedd rhwng comisiynu gofal preswyl a gofal dibreswyl yn amrywio o'r naill awdurdod i'r llall⁴.

Mae proses asesu awdurdodau lleol (a gaiff ei adolygu gan Lywodraeth Cymru cyn bo hir) ac, yn enwedig yn achos pobl sy'n talu ffioedd, y wybodaeth a'r cyngor sydd ar gael i ddefnyddwyr gwasanaethau a'u teuluoedd, yn effeithio ar benderfyniadau ynghylch y math o ofal a gânt.

Mae'n bosibl y bydd y Pwyllgor am ystyried y broses sy'n arwain pobl i dderbyn gofal preswyl, y gwasanaethau eraill sydd ar gael, a pha mor hawdd yw hi i bobl gael y gwasanaethau hynny.

3. Adnoddau a chomisiynu

Y sectorau preifat a gwirfoddol⁵ sy'n rhedeg y rhan fwyaf o gartrefi gofal i bobl hŷn yng Nghymru (87 y cant), er mai awdurdodau lleol yw prif brynwyr gwasanaethau gofal preswyl. Mae penderfyniadau cynllunio a chomisiynu awdurdodau lleol felly'n dylanwadu'n drwm ar farchnadoedd gofal lleol. Mae Llywodraeth Cymru yn bwriadu cyflwyno cytundeb amlinellol cenedlaethol ar gyfer gofal preswyl.

Mae ambell anghydfod⁶ rhwng darparwyr gofal ac awdurdodau lleol Cymru ynghylch cost gofal preswyl, wedi amlygu'r anawsterau sy'n wynebu comisiynwyr a darparwyr mewn cyfnod lle mae cyfyngiadau ar wariant cyhoeddus⁷. Mae memorandwm dealltwriaeth i annog darparwyr gofal cymdeithasol a Chymdeithas Llywodraeth Leol Cymru i gydweithredu mwy wedi bod dan gryn bwysau'n ddiweddar wedi i ddarparwyr gofal gymryd camau cyfreithiol yn erbyn awdurdodau lleol mewn ambell ardal yng Nghymru, ac mae tystiolaeth⁸ yn dangos bod nifer o ddarparwyr gofal wedi mynd i ddwylo gweinyddwyr.

Gan fod nifer y bobl mewn cartrefi gofal yng Nghymru wedi gostwng ar gyfartaledd, mae'r pwysau ariannol ar ddarparwyr gofal wedi cynyddu⁹, er bod y rhagolygon hirdymor yn awgrymu y bydd y galw'n cynyddu ac mae cryn alw o du cwsmeriaid preifat, sy'n prynu 40% o ofal preswyl.

³ Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru [Adroddiad Blynyddol y Prif Arolygwr 2009-10](#) t17 [fel ar 7 Medi 2011]

⁴ Gweler Ystadegol SDR Llywodraeth Cymru 155/2011 [Asesiadau a Gwasanaethau Cymdeithasol ar gyfer Oedolion 2010-11](#) Medi 2011, Tabl A1 [fel ar 7 Medi 2011]

⁵ Llywodraeth Cymru *Gofal Preswyl: papur briffio ar gyfer cyfarfod iechyd a gofal cymdeithasol 28 Gorffennaf 2011* paragraff 4 [fel ar 2 Medi 2011].

⁶ Community Care [Welsh Government bids to cool social care fee row](#) 22 Mehefin 2011 [fel ar 5 Medi 2011] (Saesneg yn unig)

⁷ Gweler Guardian.co.uk [Firms going bust in social care sector up by 50% amid spending cuts](#) 4 Gorffennaf 2011 [fel ar 10 Gorffennaf 2011] (Saesneg yn unig)

⁸ Community Care [More care homes on the brink of closure as fees fall](#) 14 Gorffennaf 2011 [fel ar 2 Medi 2011] (Saesneg yn unig)

⁹ Gweler Llywodraeth Cymru *Gofal Preswyl: papur briffio ar gyfer cyfarfod iechyd a gofal cymdeithasol 28 Gorffennaf 2011* paragraff 5 [fel ar 2 Medi 2011].

Mae awdurdodau lleol yn rhoi cyngor a gwybodaeth i breswylwyr cartrefi gofal sy'n talu drostynt eu hunain. Gall rhai o'r rhain fod yn gymwys i dderbyn arian cyhoeddus yn ddiweddarach wrth i'w hadnoddau ariannol leihau.

Bu cryn dipyn o ymgynghori a thrafod yng nghyswllt talu am ofal cymdeithasol yng Nghymru ac yn y DU. Cyhoeddwyd *adroddiad Dilnot*¹⁰ yn ddiweddar yn ymwneud ag ariannu gofal cymdeithasol yn Lloegr gan gyfrannu at y ddadl ar y trefniadau yn y dyfodol yn Lloegr a Chymru.

Mae'n bosibl y bydd y Pwyllgor am ystyried y modd y mae awdurdodau lleol yn comisiynu lleoedd mewn cartrefi gofal preswyl a gallu'r sector i fodloni'r galw o ystyried y cyfyngiadau ar adnoddau.

Mae'n bosibl y bydd y Pwyllgor am ystyried y cymorth a gynigir gan awdurdodau lleol i'r rhai sy'n talu'n breifat am ofal preswyl.

4. Gallu'r sector gofal preswyl

Gan fod gwasanaethau iechyd a gofal wedi'u lleoli mwy yn y gymuned yn ddiweddar, mae anghenion y rhai sy'n mynd i gartrefi gofal preswyl yn dueddol o fod yn fwy dwys nag y buont yn y gorffennol. Mae tystiolaeth gwaith ymchwil¹¹ yn dangos bod angen buddsoddi i roi rhagor o hyfforddiant i staff er mwyn ymdopi â'r anghenion hyn, a bod rhoi rhagor o hyfforddiant i staff yn gwella ansawdd bywyd y preswylwyr.

Mae Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Gofal Cymru¹² wedi nodi bod rhai cartrefi gofal wedi derbyn pobl â dementia er nad oedd ganddynt y gallu na'r staff i ddiwallu eu hanghenion. Mewn crynodeb¹³ o adroddiadau Blynyddol Cyfarwyddwyr Gwasanaethau Cymdeithasol, nodwyd bod angen datblygu rhagor o wasanaethau i bobl â dementia, ac yn yr adroddiad, *Preliminary Analysis of Dementia in Wales*, nodwyd:

A significant finding of the preliminary analysis is that there are wide variations in what is available across Wales and that this variability doesn't seem to be related to need. Crucial gaps have also been identified. This means that the needs of people with dementia and their families and carers are not being adequately or equitably met by social care and social services (p.3)¹⁴.

Mae'n bosibl y bydd y Pwyllgor am ystyried gallu'r sector gofal preswyl i fodloni'r galw am wasanaethau i bobl sydd ag anghenion cynyddol, gan gynnwys pobl â dementia, o ran nifer y lleoedd sydd ar gael, y cyfleusterau a gwybodaeth a sgiliau staff.

¹⁰ Y Comisiwn ar Ariannu Gofal a Chymorth *Fairer Care Funding. The Report of the Commission on Funding of Care and Support* Gorffennaf 2011 [fel ar 5 Gorffennaf 2011]

¹¹ Sefydliad Joseph Rowntree *Residential care home workforce development: the rhetoric and reality of meeting older residents' future care needs* (2010) [fel ar 2 Medi 2011] (Saeseng yn unig)

¹² Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru *Adroddiad Blynyddol y Prif Arolygwr 2009-10* t17 [fel ar 5 Medi 2011]

¹³ Asiantaeth Gwella Gwasanaethau Cymdeithasol *Adroddiadau Blynyddol gan 22 Gyfarwyddwyr Statudol Gwasanaethau Cymdeithasol Cymru - Dadansoddiad o Lwyddiant a Heriau*. (2011) t10 [fel ar 5 Medi 2011]

¹⁴ Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru *Dadansoddiad Rhaagarweiniol o Dementia yng Nghymru* Gorffennaf 2010 [fel ar 5 Medi 2011]



5. Safon gwasanaethau mewn cartrefi gofal preswyl

Mae profiadau a sylwadau'r rhai sy'n derbyn gofal mewn cartref preswyl, a'u teuluoedd, yn rhoi syniad i ni o safon y gwasanaethau a ddarperir gan y sector hwn. Yn ôl astudiaethau ymchwil¹⁵ mae gwahanol ffactorau'n effeithio ar lefel bodlonrwydd preswylwyr ac mae'r rhain yn cynnwys lefelau staffio, trosiant staffio, ymglymiad teuluoedd, prydau bwyd, rheolaeth bersonol, gweithgareddau hamdden ac amgylchedd y cartref. Mae'r ymchwil hefyd yn awgrymu bod cefnogaeth y teulu a chyfoedion yn effeithio ar ansawdd bywyd, yn ogystal â gallu'r preswylwyr i ddewis, a faint o rym sydd ganddynt. Mae trefniadau rheoleiddio ac arolygu, adnoddau a hyfforddiant hefyd yn effeithio ar safon y gwasanaeth.

Mae gallu gwasanaethau i ddiwallu anghenion grwpiau penodol o bobl hŷn, fel siaradwyr Cymraeg a phobl Dduon a Lleiafrifoedd Ethnig hefyd yn effeithio ar brofiadau'r rhai sy'n cael gofal mewn cartref preswyl.

O ystyried ansefydlogrwydd presennol y farchnad gofal preswyl, mae parhad gwasanaethau dan fygythiad pan fydd darparwyr yn trosglwyddo neu'n cau cartrefi gofal, gan beri gofid i ddefnyddwyr y gwasanaethau a'u teuluoedd. Mae Comisiynydd Pobl Hŷn Cymru wedi mynegi pryder¹⁶ am yr effaith a gaiff penderfyniad i gau cartrefi gofal ar bobl hŷn. Mae'r Comisiynydd ar hyn o bryd yn ystyried defnyddio'i phwerau mewn perthynas â darparu eiriolaeth ddigonol i bobl hŷn sy'n cael gofal preswyl.

Mewn adroddiadau a gyhoeddwyd yn ddiweddar, amlygwyd bod angen gwella gofal iechyd i bobl hŷn mewn cartrefi gofal preswyl¹⁷, gan gynnwys y rhai y mae angen gofal lliniarol neu ofal iechyd meddwl arnynt¹⁸.

Mae Llywodraeth Cymru yn diwygio'r trefniadau ar gyfer gwella gwasanaethau gofal cymdeithasol er mwyn cyflawni amcanion y Fframwaith Canlyniadau Cenedlaethol newydd. Caiff cynnydd ei fesur drwy ddefnyddio 'cyfres ddiwygiedig o ddangosyddion lefel uchel'¹⁹.

Mae'n bosibl y bydd y Pwyllgor am ystyried safon gwasanaethau gofal preswyl a phrofiadau defnyddwyr gwasanaethau a'u teuluoedd, gan gynnwys ystyried i ba raddau y mae gwasanaethau'n ymdopi ag anghenion amrywiol pobl hŷn.

Mae'n bosibl y bydd y Pwyllgor hefyd am ystyried y trefniadau ar gyfer sicrhau bod pobl hŷn yn parhau i gael gofal pan fydd cartref gofal yn cau.

¹⁵ Sefydliad Joseph Rowntree [Improving care in residential care homes: a literature review](#) (2008) [fel ar 2 Medi 2011] (Saesneg yn unig)

¹⁶ Comisiynydd Pobl Hŷn Cymru [Datganiad ar Gau Cartrefi Gofal](#) 1 Rhagfyr 2010 [fel ar 10 Gorffennaf 2011]

¹⁷ British Geriatrics Society [Quest for Quality. British Geriatrics Society Joint Working Party Inquiry into the Quality of Healthcare Support for Older People in Care Homes: A Call for Leadership, Partnership and Quality Improvement](#) (Mehefin 2011) [fel ar 2 Medi 2011] (Saesneg yn unig)

¹⁸ Sefydliad Joseph Rowntree [Improving care in residential care homes: a literature review](#) (2008) t3 [fel ar 2 Medi 2011] (Saesneg yn unig)

¹⁹ Llywodraeth Cymru [Gwasanaethau Cymdeithasol Cynaliadwy i Gymru: Fframwaith Gweithredu](#) (2011) paragraff 3.14 [fel ar 5 Medi 2011]



6. Rheoleiddio ac arolygu

Diben y trefniadau ar gyfer rheoleiddio ac arolygu cartrefi gofal yw sicrhau cysondeb yn safon y ddarpariaeth drwy'r holl sector gofal preswyl, sy'n sector mawr ac amrywiol. Mae'r trefniadau presennol ar waith ers i *Ddeddf Safonau Gofal 2000* ddod i rym, ac ers hynny, mae'r galw am wasanaethau wedi cynyddu ac mae modelau gofal newydd wedi ymddangos.

Mae anawsterau ariannol Gofal Iechyd Southern Cross, a ddaeth i'r amlwg yn ddiweddar, wedi tynnu sylw at y darparwr mawr hwn (sydd â 34 o gartrefi gofal yng Nghymru) ac at y sector gofal preswyl yn gyffredinol. Awgrymwyd bod angen monitro sefyllfa ariannol darparwyr gofal preifat mawr²⁰.

Mewn Datganiad Ysgrifenedig gan y Cabinet²¹ ar 25 Gorffennaf 2011 dywedodd y Dirprwy Weinidog dros Blant a Gwasanaethau Cymdeithasol, Gwenda Thomas AC, wrth gyfeirio at broblemau Southern Cross:

Gofynnwyd i mi a wyf yn ystyried y mesurau angenrheidiol sydd angen eu cymryd er mwyn atal sefyllfaoedd tebyg rhag codi eto. Ystyrir opsiynau ar gyfer rheoleiddio ariannol neu fesurau eraill yn rhan o ddatblygiad y Mesur Gwasanaethau Cymdeithasol arfaethedig.

Mae Llywodraeth Cymru wedi amlinellu cynlluniau i ddiwygio trefniadau i reoleiddio ac arolygu gwasanaethau cymdeithasol. Mae ei phapur polisi ar wasanaethau cymdeithasol yn dangos bod y pwyslais yn symud o arolygu cartrefi gofal unigol i ofynion cofrestru'r cyrff sy'n darparu gwasanaethau; 'trwydded i weithredu'. Mae'n nodi:

Dyma'r amser i newid y pwyslais ym maes rheoleiddio ac arolygu o'r pwynt lle caiff gwasanaethau eu darparu i'r cyrff sy'n darparu'r gwasanaethau hynny ac i weithwyr proffesiynol penodol o fewn y gweithlu. Bydd hyn yn ein galluogi ni i leihau'r baich rheoleiddio ac i leihau faint o reoleiddio sy'n digwydd.

Mae Llywodraeth Cymru hefyd wedi penderfynu peidio â bwrw ymlaen â chynlluniau i gofrestru staff gofal cymdeithasol ar wahân i weithwyr cymdeithasol a rheolwyr gofal.

Mae'n bosibl y bydd y Pwyllgor am ystyried pa mor effeithiol yw'r trefniadau ar gyfer rheoleiddio ac arolygu gofal preswyl, gan gynnwys y posibilrwydd o graffu'n fanylach ar sefyllfa ariannol y cyrff sy'n darparu gwasanaethau.

7. Cydgysylltu ac integreiddio gwasanaethau gofal preswyl a gwasanaethau iechyd a gofal cymdeithasol eraill.

Dim ond un elfen o'r gwasanaethau iechyd a gofal cymdeithasol rhyngddibynnol yw gofal preswyl; felly nid yw'n gweithredu'n annibynnol arnynt. Mae gwasanaethau fel rhaglenni ail-alluogi sy'n ceisio cynnal annibyniaeth pobl hŷn, yn rhyngweithio'n agos â gwasanaethau gofal preswyl, ac yn effeithio ar y galw am y gwasanaethau hynny. Gall cydweithredu

²⁰ Community Care [Southern Cross crisis prompts call for regulator](#) 2 Mehefin 2011 [fel ar 10 Gorffennaf 2011]. (Saesneg yn unig)

²¹ Llywodraeth Cymru, Gwenda Thomas AC, Y Dirprwy Weinidog dros Blant a Gwasanaethau Cymdeithasol [Southern Cross - Diweddariad ar Ailstrwythuro](#) Datganiad Ysgrifenedig y Cabinet, 25 Gorffennaf 2011 [fel ar 1 Medi 2011]



effeithiol rhwng y gwasanaethau ddylanwadu ar brofiadau defnyddwyr gwasanaethau ac ar effeithiolrwydd y gwasanaethau rhyngddibynnol. Er enghraifft, gall gofal cymdeithasol gwael arwain at gynnydd yn nifer y bobl sy'n cael eu trosglwyddo o ofal lleoliadau gofal iechyd aciwt.

Un o amcanion polisi hirsefydlog Llywodraeth Cymru yw integreiddio gwasanaethau fwyfwy, yn enwedig gwasanaethau iechyd a gofal cymdeithasol; mae ei phapur polisi ar ofal cymdeithasol a gyhoeddodd yn ddiwedd, yn atgyfnerthu'r amcan hwn²².

Mae'n bosibl y bydd y Pwyllgor am ystyried trefniadau i gydgyssylltu a/neu integreiddio gofal preswyl â gwasanaethau iechyd a gofal cymdeithasol eraill.

8. Darpariaeth yn y dyfodol

Mae'r pwyslais parhaus ar ddatblygu modelau gwasanaeth sy'n hyrwyddo annibyniaeth, rhagor o newidiadau ym mhroffil demograffig poblogaeth hŷn Cymru, a disgwyliadau uwch o ran safon gwasanaethau, yn debygol o olygu bod angen dulliau newydd o ddarparu gofal i'r bobl sydd â'r anghenion mwyaf.

Mae'n bosibl y bydd angen modelau gofal yn y dyfodol sy'n ddigon hyblyg i ymdopi ag anghenion pobl hŷn, wrth i'r anghenion hynny newid, heb orfod eu symud o'r naill le i'r llall. Mae cartrefi Gofal ychwanegol, er enghraifft, yn cynnig gofal sy'n caniatáu i breswylwyr fyw'n annibynnol, ac mae darpariaeth debyg ar gael hefyd mewn pentrefi ymddeol ar raddfa ehangach.

Mae'n bosibl y bydd y Pwyllgor am ystyried y modelau newydd o ofal sy'n datblygu, fel Gofal ychwanegol, pentrefi gofal a modelau eraill sy'n hyrwyddo annibyniaeth ac sy'n cynnig gofal hyblyg.

Bu newid sylweddol ym maes gofal preswyl ers 1980 wrth i gartrefi gofal gael eu trosglwyddo o ddwylo adurdodau lleol i'r sector preifat ac erbyn hyn mae 84 y cant o gartrefi gofal dan reolaeth perchnogion preifat.

Fodd bynnag, o gofio problemau ariannol Gofal Iechyd Southern Cross yn ddiweddar, mae'n bosibl y bydd angen ystyried modelau ariannu a pherchnogaeth gwahanol. Gall cyrff dielw fel Landlordiaid Cymdeithasol Cofrestredig, er enghraifft, helpu i greu amrywiaeth gynyddol yn economi'r sector gofal drwy ymwneud mwy â'r ddarpariaeth. Mewn rhai gwledydd, fel Canada, mae'r sector cydweithredol yn rhan bwysig o'r gwasanaethau tai a gofal.

Yn ei phapur polisi ar wasanaethau cymdeithasol²³ mae Llywodraeth Cymru yn nodi: "Mae gofal cymdeithasol yn faes parod ar gyfer datblygu mentrau cymdeithasol". Ymrwymodd Llywodraeth flaenorol Cymru (2007-11) i ddatblygu cartrefi nyrsio di-elw²⁴.

²² Llywodraeth Cymru [Gwasanaethau Cymdeithasol Cynaliadwy i Gymru: Fframwaith Gweithredu](#) (2011) paragraff 3.21 [fel ar 5 Medi 2011]



Mae'n bosibl y bydd y Pwyllgor am ystyried y cyfleoedd sydd ar gael i ddatblygu modelau ariannu a pherchnogaeth eraill fel y rhai a gynigir gan y sector cydweithredol a chydfuddiannol.

²³ Llywodraeth Cymru [Gwasanaethau Cymdeithasol Cynaliadwy i Gymru:Fframwaith Gweithredu](#) (2011) paragraff 3.18 [fel ar 5 Medi 2011]

²⁴ Llywodraeth Cymru *Cymru'n Un, Rhaglen Flaengar ar gyfer Llywodraethu Cymru* (2007) t12 [fel ar 7 Medi 2011]

Eitem 6

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-03-11 papur 5

Ymchwiliad y Pwyllgor Plant a Phobl Ifanc i iechyd y geg mewn plant - Llythyr gan y Cadeirydd

Ynglwm fel atodiad i'r papur hwn, ceir llythyr gan Gadeirydd y Pwyllgor Plant a Phobl Ifanc ynglyn â'r ymchwiliad i iechyd y geg mewn plant.

Gwasanaeth y Pwyllgorau



**Y Pwyllgor Plant a Phobl Ifanc
Children and Young People Committee**

Mark Drakeford AM
Chair, Health and Social Care Committee

21 July 2011

Dear Mark

Children and Young People Committee - Inquiry into Children's Oral Health

I am writing to inform you that, at its last meeting, the Children and Young People's Committee agreed to launch a short inquiry into children's oral health. Full details of the inquiry will be published on the Committee's website in due course—

<http://www.senedd.assemblywales.org/mgCommitteeDetails.aspx?ID=224>

Whilst the subject matter of the inquiry falls within the remit of the Children and Young People's Committee, I appreciate it is something that members of the Health and Social Care Committee may be interested in. With that in mind, I am happy to share any evidence we receive with your Committee, and would welcome any members of your Committee who would like to participate in our oral evidence sessions early in the autumn term. Do get in touch with me, or with the Clerk, Sarah Beasley, if you would like to discuss further.

Yours sincerely

Christine Chapman
Chair

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

E-bost / Email: sarah.beasley@wales.gov.uk

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

Eitem 7

Y Pwyllgor Iechyd a Gofal Cymdeithasol

HSC(4)-03-11 : Papur 6

Blaenraglen Waith y Pwyllgor Iechyd a Gofal Cymdeithasol – Hydref 2011

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 hyd at doriad mis Hydref 2011.

3. Fe'i cyhoeddwyd ar gyfer Aelodau'r Cynulliad ac unrhyw aelod 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 disgrisiwn y Pwyllgor pan fydd busnes perthnasol yn codi.

Argymhelliad

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

Gwasanaeth y Pwyllgorau

ATODIAD A

Dydd Iau 22 Medi (bore yn unig)

Ymchwiliad i leihau'r risg o strôc

Sesiwn tystiolaeth lafar

- Y Gymdeithas Ffibriliad Atriaidd
- Y Gymdeithas Strôc

Blaenraglen Waith

Ymchwiliad i Ofal Preswyl i Oedolion: papur cwmpasu

Craffu ar y gyllideb: ystyried y dull o weithio

Ymchwiliad y Pwyllgor Plant a Phobl Ifanc i iechyd y geg mewn plant:

Ilythyr gan y Cadeirydd, Christine Chapman AC

Dydd Mercher 28 Medi (bore yn unig)

Ymchwiliad i fferylliaeth gymunedol

Sesiwn tystiolaeth lafar

- Y Gymdeithas Fferyllol Frenhinol
- Fferylliaeth Gymunedol Cymru

Dydd Iau 6 Hydref (bore a phrynhawn)

Ymchwiliad i leihau'r risg o strôc (bore)

Sesiwn tystiolaeth lafar

- Iechyd Cyhoeddus Cymru
- Cynrychiolwyr o'r GIG
- Coleg Brenhinol y Nyrsys
- Cymdeithas Feddygol Prydain / Cymdeithas y Ffisigwyr Strôc

Craffu ar adroddiad blynyddol Comisiynydd Pobl Hŷn Cymru (prynhawn)

Sesiwn tystiolaeth lafar

- Ruth Marks MBE, Comisiynydd Pobl Hŷn Cymru

Dydd Mercher 12 Hydref (bore yn unig)

Ymchwiliad i fferylliaeth gymunedol

Sesiwn tystiolaeth lafar

Craffu ar y gyllideb

Trafodaeth gyhoeddus ar y gyllideb gydag arbenigwyr allanol (i'w gadarnhau yn ddibynol ar ystyriaeth y Pwyllgor ar 22 Medi)

ATODIAD A

Dydd Iau 20 Hydref (bore yn unig)

Craffu ar y gyllideb

Sesiwn tystiolaeth lafar

- Lesley Griffiths AC, y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
- Gwenda Thomas AC, y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol

Dydd Llun 24 Hydref – Dydd Gwener 28 Hydref: Toriad hanner tymor

Gwybodaeth ychwanegol

- Fe fydd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol yn ymddangos gerbron y Pwyllgor ar 2 Tachwedd i gwblhau'r broses o gasglu tystiolaeth ar gyfer yr ymchwiliad ar leihau y risg o strôc.
- Disgwylir i'r sesiynau tystiolaeth ar gyfer yr ymchwiliad ar fferylliaeth gymunedol ddod i ben cyn toriad y Nadolig.