Agenda – Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 3 – Senedd
Dyddiad: Dydd Iau, 17 Medi 2015
Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:
Llinos Madeley
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1 Cyflwyniadau, ymddiheuriadau a dirprwyon

(09.15)

2 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 6

(09.15 – 10.15) (Tudalennau 1 – 56)

Dr Rodney Berman, Cymdeithas Feddygol Prydain (Cymru)

Dr Stephen Monaghan, Cymdeithas Feddygol Prydain (Cymru)

Dr Jane Fenton-May, Coleg Brenhinol yr Ymarferwyr Cyffredinol Cymru

Egwyl (10.15 -10.30)

3 Bil Iechyd y Cyhoedd (Cymru): fideo o'r dystiolaeth a gasglwyd ynghylch Rhan 3 (Gweithdrefnau Arbennig)

(10.30 – 10.40)

4 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 7

(10.40 – 11.15) (Tudalennau 57 – 67)

Paul Burgess, Cymdeithas Nyrsys Cosmetig Prydain

Andrew Rankin, Cymdeithas Nyrsys Cosmetig Prydain

Ashton Collins, Save Face

Brett Collins, Save Face

Egwyl (11.15 – 11.25)

5 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 8

(11.25 – 12.00)

Dr Fortune Ncube, Epidemiolegydd Ymgynghorol ac Ymgynghorydd mewn Meddygaeth Iechyd Cyhoeddus

6 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 9

(12.00 – 12.30) (Tudalennau 68 – 70)

Nick Pahl, y Cyngor Aciwbigo Prydeinig

Cinio (12.20 – 13.15)

7 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 10

(13.15 – 14.00) (Tudalennau 71 – 75)

Sarah Calcott, Cymdeithas Prydain ar gyfer Tyllu'r Corff

Lee Clements, Ffederasiwn Prydain ar gyfer Artistiaid Tatŵ

8 Papurau i'w nodi

(14.00 – 14.05)

Cofnodion y cyfarfodydd ar 9 a 15 Gorffennaf 2015

(Tudalennau 76 – 81)

Bil Iechyd y Cyhoedd (Cymru): gwybodaeth ychwanegol gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

(Tudalennau 82 – 92)

Bil Iechyd y Cyhoedd (Cymru): yr ymatebion i'r ymgynghoriad

Bil Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru): ymateb y Gweinidog Iechyd a Gwasanaethau Cymdeithasol i adroddiad Cyfnod 1 y Pwyllgor

(Tudalennau 93 – 109)

Bil Lefelau Diogel Staff Nyrsio (Cymru): gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

(Tudalen 110)

Sesiwn graffu gyffredinol a chraffu ariannol gyda'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol a'r Dirprwy Weinidog Iechyd: gwybodaeth ychwanegol gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

(Tudalennau 111 - 116)

Arweinydd Proffesiynol Cenedlaethol ar gyfer Gofal Sylfaenol yng Nghymru: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

(Tudalen 117)

Rheoliadau Gofal a Chymorth (Cymhwystra) (Cymru) 2015: gohebiaeth gan Gomisiynydd Pobl Hŷn Cymru

(Tudalennau 118 - 119)

P-04-603 Helpu Babanod 22 Wythnos Oed i Oroesi: gohebiaeth gan y Prif Swyddog Meddygol

(Tudalen 120)

Cynlluniau tymor canolig integredig byrddau iechyd ac ymddiriedolaethau'r GIG: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

(Tudalennau 121 - 122)

Adolygiad o drefniadau neilltuo cyllid ar gyfer gwasanaethau iechyd meddwl yng Nghymru: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

(Tudalen 123)

Review of the financial ring fencing arrangements for arrangements for mental health services in Wales - Report to the Minister for Health and Social Services (PDF, 1.5MB) [Saesneg yn unig]

9 Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn ac o eitem 1 yn y cyfarfod ar 23 Medi 2015

(14.05)

10 Bil Iechyd y Cyhoedd (Cymru): ystyried y dystiolaeth

(14.05 - 14.20) (Tudalennau 124 - 129)

Mae cyfyngiadau ar y ddogfen hon

Y Gymdeithas Feddygol Brydeinig
Pumed Llawr
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BMA

Cymru Wales

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from BMA Cymru Wales – PHB 76 / Tystiolaeth gan BMA Cymru Wales – PHB 76

PUBLIC HEALTH (WALES) BILL – GENERAL PRINCIPLES

Consultation by the National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

4 September 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by the National Assembly for Wales' Health and Social Care Committee on the general principles of the Public Health (Wales) Bill.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

When the Welsh Government published the Public Health White Paper in 2014, BMA Cymru Wales expressed extreme concern that the proposals contained within it represented a significant step backwards from the more innovative high-level proposals that had been contained within the preceding Public Health Green Paper published in 2012.

We have therefore been further disappointed that the now-published Public Health (Wales) Bill currently contains a narrower set of proposals than even the White Paper.

Whilst we are nonetheless broadly supportive of many of the proposals that have been brought forward within the Bill as published, we do feel that it represents a missed opportunity to provide more ground-breaking legislation that could have made Wales an international exemplar in the field of public health.

Health Impact Assessment (HIA)

We are particularly disappointed by the absence of proposals within the Bill to place Health Impact Assessment (HIA) on a statutory footing.

As far back as 1999 the then Welsh Assembly Government committed to taking forward HIA, and set out its approach in a document entitled *'Developing Health Impact Assessments in Wales'*.

In the present Assembly term, the idea of introducing HIA in Wales on a statutory basis was also consulted upon by the Welsh Government in the Public Health Green Paper published in 2012. The subsequently published summary of responses to that Green Paper stated that *"there was a high level of support for the concept of using Health Impact Assessment as a method for ensuring health issues are considered as part of policy making."* It also stated that a clear majority of those who responded indicated that Welsh Ministers, Welsh Government departments and local authorities should be required to use HIA.

We also note that the Minister for Health and Social Services, Mark Drakeford, expressed support last year for undertaking HIA in relation to local authority planning and licensing applications. During a plenary debate on an update statement on the Public Health White Paper on 7 October 2014, he said: *"I would be very keen—I always have been—to be able to make the public health impact one of the considerations that local authorities are able to take into account in making planning and licensing determinations."*

The Chief Medical Officer for Wales, Dr Ruth Hussey, has also expressed her support for HIA, telling the Health and Social Care Committee on 8 October 2014: *"…we should be using health impact assessments at the beginning of a process to ask how we can get the most health benefit from whatever proposals, policies or services we are developing, and to ask whether we can get added value."*

Given this recent consideration and expression of support, we were extremely surprised and disappointed to see that the idea of legislating to require HIA in specific circumstances was dropped in the Public Health White Paper and has not been reinstated in the Bill as published.

Appendix 1 to this submission outlines in more detail our case for placing HIA on a statutory footing in Wales through incorporation of such a proposal within the Bill. We suggest a requirement for the use of HIA be placed on the face of the Bill, with regulations subsequently being brought forward to specify in exactly which circumstances a mandatory HIA would be required. In the first instance we would suggest that these regulations could require that HIA is made mandatory in relation to Strategic and Local Development Plans, certain larger scale planning applications, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

Minimum unit pricing for alcohol

In our responses to both the Public Health Green Paper and the Public Health White Paper, we expressed strong support for the proposal to introduce minimum unit pricing for alcohol in Wales. We are disappointed that, owing to the on-going legal challenge to a similar proposal in Scotland, it has not been possible to include this proposal in the current Bill. However, we recognise that the Welsh Government has recently published a draft Bill for consultation aimed at taking the initiative forward in future should the legal challenge in Scotland be appropriately resolved.

We are pleased that the Welsh Government therefore still intends, if possible, to introduce minimum unit pricing for alcohol at a later date, and we look forward to responding positively to the consultation on the Draft Public Health (Minimum Price for Alcohol) Bill in due course.

Obesity and nutritional standards

The Public Health White Paper sought views on introducing nutritional standards in certain public sector settings, as well as asking what other steps could be taken on these issues.

We are especially disappointed that those proposals have now been dropped and that there are no specific proposals within the Bill directed at tackling obesity. We believe this further weakens the impact that this Bill will have.

In our view, the proposals for introducing nutritional standards in both pre-school settings and care homes should be reinstated, as well as being extended to cover hospitals in Wales by way of an update to the implementation of the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2012).

Our members witness first-hand the effects of obesity on the health of their patients. We would therefore also like to see further measures brought forward aimed at assisting people in Wales to make healthier nutritional choices. While doctors have a key role in providing advice on dietary choices and physical activity patterns, we feel this needs to be supported by a comprehensive range of public health interventions to tackle the obesity epidemic. In our view, individual programmes alone are likely to have little effect and legislative measures are also required to help people make healthy choices as part of a comprehensive strategic approach.

We do, however, recognise that some of the legislative changes we would wish to see may be outside the competence of the Welsh Assembly. We have, for instance, repeatedly called for the introduction of a standardised, consistent approach to food labelling, calling for all pre-packaged products to have front of pack labelling based on a ‘traffic light’ colour coding system combined with information on guideline daily amounts (now known as reference intake). We have been disappointed that neither the EU nor the UK Government has backed mandatory ‘traffic light’ labels for food packaging.

We remain concerned that unhealthy food is positively marketed to a young audience and feel there should be a complete ban on the advertising and marketing of unhealthy foodstuffs. This should include product placement and inappropriate sponsorship programmes targeted at school children.

It should also be noted that a significant proportion of the UK population is consuming saturated fat, salt and added sugar at levels above recommended guidelines; and too little fruit, vegetables, oily fish, and fibre. More therefore needs to be done to promote healthy eating. One option that could be considered would be to subsidise the cost of fruit and vegetables.

Maternal obesity is associated with increased maternal and fetal risks in pregnancy, as well as increased intervention rates and an increased risk of major chronic disease for their offspring in adulthood. With rates of obesity in pregnancy rising across the UK, steps need to be taken to ensure that young people understand the importance of health and wellbeing before pregnancy – giving attention to their diet and optimal body weight before planning a pregnancy. This could include offering nutrition education and counselling, which have been shown to improve knowledge and behaviour. We also support the need to provide education and support aimed at promoting and prolonging the duration of breastfeeding.

We recognise that physical activity levels in Wales and the rest of the UK are very low and have been declining for the past 30 years, whilst sedentary activity is increasing. Promoting physical activity is therefore an important aspect to reducing levels of obesity in the UK. Initiatives such as the application of the Active Travel (Wales) Act 2013 can play a contributory role, alongside the promotion of other activities that involve physical exercise.

Other initiatives which could be taken forward would be to require all NHS premises to clearly display the healthcare risks involved with junk food and drinks, especially in catering areas and on vending machines; and for NHS premises to ban the sale of junk food and unhealthy drinks or offer subsidised healthier options.

Tobacco and nicotine products

BMA Cymru Wales is largely supportive of the proposals laid out in Part 2 of the Bill and would consider that on balance the available evidence favours their enactment. In particular, we support:

- creating a national register of retailers of tobacco and nicotine products;
- adding to the offences which contribute to a Restricted Premises Order (RPO);
- prohibiting the handing over of tobacco or nicotine products to people under the age of 18; and
- restricting the use of nicotine inhaling devices such as electronic cigarettes in enclosed and substantially enclosed public and work places, bringing the use of these devices in line with existing provisions on smoking.

E-cigarettes

While e-cigarettes have the potential to reduce tobacco-related harm, by helping smokers of convetional cigarettes to cut down and quit, we believe that a strong regulatory framework is required for their sale and use in order to:

- prohibit their use in workplaces and public places to limit second hand exposure to the vapour exhaled by the user, and to ensure their use does not undermine smoking prevention and cessation by reinforcing the normalcy of cigarette use;
- restrict their marketing, sale and promotion so that it is only targeted at smokers as a way of cutting down and quitting, and does not appeal to non-smokers, in particular children and young people; and
- ensure they are safe, quality assured and effective at helping smokers cut down or quit.

Emerging evidence suggests that e-cigarettes are predominantly used together with conventional cigarettes by current smokers, for the purposes of cutting down or quitting smoking or to circumvent smoke free legislation.[1] It is evident that the risks of using e-cigarettes with tobacco cigarettes (dual use) are likely to be much less beneficial than quitting smoking completely, or switching exclusively to e-cigarette use.

Current evidence suggests that e-cigarettes are primarily effective in helping smokers reduce the intensity of smoking (by cutting down), rather than the duration of smoking (by quitting). We support a regulatory framework that helps to ensure they are effective cessation aids.

Data from the 2011 International Tobacco Control Four Country Survey (Australia, Canada, UK, US) confirms that individuals report using e-cigarettes because they believe they are less harmful than cigarettes (79.8%), to reduce smoking (75.8%), and to help quit smoking (85.1%).[2,3]

E-cigarettes are no doubt less harmful than smoking tobacco and, while we welcome the recent research published by Public Health England,[4] we believe that there needs to be much more research into the safety of their long-term use.

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1 Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87

2 Adkinson SE, O'Connor RJ, Bansal-Travers M et al (2013) Electronic nicotine delivery systems: international tobacco control four country survey. American Journal of Preventative Medicine **3**:201

3 http://www.ash.org.uk/files/documents/ASH_891.pdf

4 Public Health England. E-cigarettes: an evidence update (2015) Available at: https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

While BMA Cymru Wales supports the use of licensed nicotine replacement therapies (NRT) as a smoking cessation aid, it should be recognised that the consumption of nicotine is not risk-free. Nicotine is a highly addictive substance and users can become physically dependent.[5] We are also concerned by the lack of regulation to ensure the efficacy, quality and safety of e-cigarettes including the variable concentration of nicotine in these devices.

Nicotine withdrawal is associated with craving, anxiety and stress.[6] Research suggests that nicotine may be an important mechanism by which tobacco promotes tumour development, progression and resistance to cancer treatment; this is a particular issue for dual-use of e-cigarettes and conventional cigarettes.[7] The physiological effects of nicotine include increased blood pressure, increased heart rate, transient tachycardia and vasoconstriction.[8,9,10]

Symptoms of nicotine toxic overdose include tremors, nausea, vomiting, convulsions, neuromuscular blockade, diarrhoea and gastrointestinal irritation.

Chronic exposure to nicotine is associated with an increased risk of stroke, hypertension, reproductive disorders, peptic ulcer disease and high total cholesterol.[11]

[5] Markou A (2008) Neurobiology of nicotine dependence. Philosophical Transactions of the Royal Society **363** (1507): 3159-68

[6] Benowitz NL (2010) Nicotine addiction. New England Journal of Medicine **362**(24): 2295-303

[7] Warren GW & Singh AK (2013) Nicotine and lung cancer. Journal of Carcinogenisis **12**:1

[8] Benowitz NL (2010) Nicotine addiction. New England Journal of Medicine **362**(24): 2295-303

[9] Institute of Medicine (2001) Clearing the smoke: assessing the science base for tobacco harm reduction. Washington: National Academy Press.

[10] Bhatnagar A, Whitsel LP, Ribisil KM et al (2014) Electronic cigarettes: a policy statement from the American Heart Association. Circulation (Epub ahead of print 24.08.14).

[11] Institute of Medicine (2001) Clearing the smoke: assessing the science base for tobacco harm reduction. Washington: National Academy Press.

In addition to nicotine, e-cigarettes have been found to contain a range of other substances with negative health implications.[12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29] Studies have also indicated that bystanders can be exposed to vapour emitted from e-cigarette use,[30,31,32,33] and the World Health Organisation (WHO) has warned of the potential adverse health effects of exposure to toxicants and particles contained within e-cigarette vapour.[34]

Despite the evidence of risk associated with using e-cigarettes, it is nonetheless worth emphasising that substituting tobacco with e-cigarettes is likely to substantially reduce exposure to tobacco-specific toxins and the potential health risks associated with exclusive e-cigarette use are therefore likely to be very much lower than the risks of smoking tobacco cigarettes.

On balance, however, whilst we believe that more research is required around the extent to which hand to mouth use of e-cigarettes either breaks or reinforces smoking behaviours – and the actual effectiveness of e-cigarettes in helping smokers to quit – from our overall view of the evidence that is currently available, we would agree that their use should be banned in enclosed public and work places as is currently the case for smoking tobacco.

In our view, it is vital that the use of e-cigarettes does not undermine the success of conventional tobacco control measures by reinforcing the normalcy of smoking behaviour in a way that other products containing nicotine do not. This specifically relates to the way these devices commonly resemble tobacco

[12] Etter JF (2010) Electronic Cigarettes: A survey of users. BMC Public Health **10:** 231.
[13] Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87
[14] Vardavas CI, Filippidis FT & Agaku IT (2014) Determinants and prevalence of e-cigarette use throughout the European Union: a secondary analysis of 26,566 youth and adults from 27 countries. Tobacco Control **10**: 1136.
[15] Cahn Z & Siegelb M (2011) Electronic cigarettes harm reduction strategy for tobacco control: a step forward or a repeat of past mistakes? Journal of Public Health Policy **32**: 16 – 31.
[16] Cheng (2014) Chemical evaluation of cigarettes. Tobacco Control **23**: ii1 1-7
[17] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[18] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[19] Vickerman KA, Carpenter KM, Altman T et al (2013) Use of electronic cigarettes among state tobacco cessation quitline callers. Nicotine and Tobacco Research **10:** 1787 - 91
[20] Cahn Z & Siegelb M (2011) Electronic cigarettes harm reduction strategy for tobacco control: a step forward or a repeat of past mistakes? Journal of Public Health Policy **32**: 16 – 31.
[21] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[22] Etter JF (2010) Electronic cigarettes: a survey of users. BMC Public Health **10**: 231.
[23] Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87
[24] Cahn Z & Siegelb M (2011) Electronic cigarettes harm reduction strategy for tobacco control: a step forward or a repeat of past mistakes? Journal of Public Health Policy **32**: 16 – 31.
[25] Goniewicz ML, Knysak J, Gawron M et al (2013) Levels of selected carcinogens and toxicants in vapour from electronic cigarettes. Tobacco Control **23**(2): 113-9
[26] Williams M, Villarreal A, Boshilow K et al (2013) Metal and Silicate particles including nanoparticles are present in electronic cigarette cartomizer fluid an aerosol. PLOS one **8**(3): e57987.
[27] Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87
[28] Farsalinos K, Romagna G, Allifranchini et al (2013) Comparison of the cytotoxic potential of cigarette smoke and electronic cigarette vapour extract on cultured myocardial cells. International Journal of Environmental Research and Public Health **10**(10): 5146-62.
[29] Vardavas CL, Anagnostopoulos N, Kougias M et al (2012) Short term pulmonary effects of using an electronic cigarette: Impact on respiratory flow resistance, impedance, and exhaled nitric oxide. Chest **(141**)6.
[30] Grana R, Benowitz N & Glants SA (2013) Background paper on e-cigarettes (electronic nicotine delivery systems) San Francisco: University of California.
[31] Schripp T, Makewitz D, Uhde E et al (2012) Does e-cigarette consumption cause passive vaping? Indoor Air **2**3(1) 25-31
[32] Pellegrino RM, Tinghino B, Mangiaracina G et al (2012) Electronic cigarettes: and evaluation of exposure to chemicals and fine oarticulate matter (PM) Annali di Igiene: Medicina Preventiva e di Comunita **24**:279 - 88
[33] McAuley TR, Hopke PK, Zhao J et al (2012) Comparison of the effects of e-cigarette vapour and cigarette smoke on indoor air quality. Inhalation Toxixology 24: 850-7
[34] World Health Organisation (2014) Electronic nicotine delivery systems. Geneva: World Health Organisation.

cigarettes, in terms of appearance, nomenclature and the way they are used, as well as features such as flavouring and styling that are potentially highly attractive to children, and may include cigarette brand reinforcement. And because e-cigarettes commonly resemble tobacco cigarettes, and may not be immediately distinguishable from them, we also believe that restricting their use in current smoke-free areas will aid the managers of such premises in their ability to enforce the current smoking ban.

It is our concern that the e-cigarette marketing methods used across a range of advertising media and locations are likely to appeal to children, young people and non-smokers. These include point-of-sale displays; advertising via television, radio, in-print media and online; on billboards near schools; at university freshers' fairs; and the marketing of flavoured e-cigarettes.[35]

BMA Cymru Wales is also concerned that e-cigarette marketing may have an adverse impact, reinforcing conventional cigarette smoking habits, as well as indirectly promoting tobacco smoking, increasing the likelihood of young people starting to smoke.[36,37,38]

The e-cigarette market increased by 340% in 2013, and is estimated to be worth £193 million.[39] There are now more than 450 brands of e-cigarette, and 7,700 unique flavours.[40]

E-cigarette promotion ranges from being advertised as 'a healthier alternative to smoking traditional tobacco products', to evocative advertising with phrases such as 'love your lungs', 'vape with style', 'smoking is so last season' and 'add flavour to your lifestyle'. The advertising and promotion also frequently makes positive associations with recreational activities, sports and youth culture, and can incorporate celebrity endorsements.[41] [42] [43] [44] The UK Advertising Standards Authority (ASA) has previously ruled that certain e-cigarette advertisements were considered misleading and made unsubstantiated claims relating to health.[45]

In terms of accessibility, e-cigarettes can be bought from a variety of high street outlets, ranging from newsagents, superstores, and pharmacies to pubs and specialist shops. E-cigarettes and liquid nicotine can also be purchased online, even in wholesale quantities.[46]

The legal status of e-cigarettes varies around the world. In some countries (eg Denmark, Canada, Israel, Singapore, Australia and Uruguay) the sale, import, or marketing of e-cigarettes is either banned, regulated in various ways, or the subject of health advisories by government health organisations. In others (eg New Zealand), e-cigarettes are regulated as medicines and can only be purchased in pharmacies.

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[35] English PM (2013) Re: EU policy on e-cigarettes is a "dog's dinner" says UK regulator (rapid response) BMJ **347**: f6871.

[36] Andrade M, Hastings G & Angus K (2013) Promotion of electronic cigarettes: tobacco marketing reinvented? BMJ **347**: f7473

[37] National Institute for Health and Care Excellence (2013) Tobacco: harm reduction approaches to smoking. Manchester National Institute for Health and Care Excellence.

[38] Cancer Research UK (2013) The marketing of electronic cigarettes in the UK. London: Cancer Research UK.

[39] Public Health England (2014) E-cigarette uptake and marketing. London: Public Health England.

[40] Zhu S-H, Sun JY, Bonnevie N et al (2014) Four hundred and sixty brands of e-cigarettes and counting: implications for product regulation. Tobacco Control **23**: iii3-9

[41] Andrade M, Hastings G & Angus K (2013) Promotion of electronic cigarettes: tobacco marketing reinvented? BMJ **347**: f7473

[42] Grana R, Benowitz N & Glants SA (2013) Background paper on e-cigarettes (electronic nicotine delivery systems) San Francisco: University of California.

[43] Cancer Research UK (2013) The marketing of electronic cigarettes in the UK. London: Cancer Research UK.

[44] US Senate report (14.4.14) Gateway to addiction? A survey of popular electronic cigarette manufacturers and targeted marketing to youth.

[45] www.asa.org.uk/Rulings/Adjudications/2013/5/Nicocigs-Ltd/SHP_ADJ_219974.aspx (Last accessed October 2014)

[46] Kamerow D (2014) The poisonous "juice" in e-cigarettes. BMJ **348**: g2504

In the UK, e-cigarettes are subject to regulation under the General Product Safety Regulations 2005, the Chemicals (Hazard Information and Packaging for Supply) Regulations 2009, and by trading standards.[47] Worryingly, there is no requirement for manufacturers of e-cigarettes to list the nicotine content of their products, to include childproof safety features, or to take measures to protect against accidental overdose.[48]

Laboratory analysis of e-cigarettes indicates that labelling of nicotine levels in e-cigarette liquid may be inconsistent and misleading.[49] The Trading Standards Institute and others have stated that safety concerns have come to light around some brands of e-cigarettes, including electrical safety, the need for proper labelling, and the provision of child resistant packaging.[50] [51]

BMA Cymru Wales would advocate the introduction of stringent guidelines in terms of appropriate labelling and childproof safety features.

Extending restrictions to non-enclosed spaces

We recognise that a clear case can be made that banning smoking in certain circumstances in open spaces will have a positive health benefit in the same way as it does within enclosed spaces. We note that whilst voluntary smoking bans have been effective in some areas when applied to open spaces, in others they remain largely ignored and extremely hard to enforce locally.

We therefore support the proposals in the Bill that create the provision to extend statutory restrictions on smoking and e-cigarettes to certain non-enclosed spaces which could include such locations as hospital grounds and children's playgrounds.

Careful consideration may, however, need to be given to how this is applied in order to take account of the impact on individuals using e-cigarettes if they are forced to share a defined combined 'smoking area' with users of tobacco cigarettes.

We note the approach that has been advocated in the Bill of enabling additional locations that could come under the scope of these restrictions to be subsequently specified in regulations, and welcome the stipulation that the addition of new locations can only be supported when Welsh Ministers are satisfied that doing so is likely to contribute towards the promotion of the health of the people of Wales.

National register and Restricted Premises Orders (RPOs)

BMA Cymru Wales welcomes the provisions within the Bill to establish a tobacco retailers' register. We believe it is a proportionate and reasoned measure which need not be overly bureaucratic or burdensome on retailers.

We believe that its establishment would be a pragmatic step that will help to prevent underage sales and sales of illegal tobacco. It will also assist in ensuring compliance with the point of sale display and advertising regulation.

The additional information that will be gathered as a consequence of the introduction of the register and the strengthened RPO regime, will assist local authority trading standards officers in identifying where tobacco is, or is not, permitted to be sold and thereby help in enforcing tobacco and nicotine offences.

[47] Trading Standards Institute (2010) Response of the Trading Standards Institute to MHRA consultation on the regulation of nicotine containing products. Basildon, Essex: Trading Standards Institute.
[48] Benowitz NL (2010) Nicotine addiction. New England Journal of Medicine **362**(24): 2295-303
[49] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[50] Trading Standards Institute (2010) Response of the Trading Standards Institute to MHRA consultation on the regulation of nicotine containing products. Basildon, Essex: Trading Standards Institute.
[51] North East Lincolnshire Council press release (05.01.12) Use e-cigarettes with care, warn trading standards officers.

Creating a new offence for knowingly handing over tobacco and nicotine produces to a person under the age of 18 is also something that we support.

Additional suggestions

To ensure successful and expedient implementation of the Public Health (Wales) Bill we would urge the Welsh Government to ensure an appropriate commensurate budget to ensure that the general public is made fully aware of the implications of the Bill coming in to force.

In addition to the Bill, BMA Cymru Wales would advocate regulating e-cigarettes as a licensed medicinal product to best reflect their use for harm reduction, bringing them in line with other existing NRT products, and ensure effectiveness, quality and safety. This form of regulation would also provide the necessary controls on their marketing and promotion.

Special procedures

The proposals in the bill to create a compulsory, national licensing system for practitioners of specified procedures in Wales – such as acupuncture, body piercing, electrolysis and tattooing – seem reasonable in our view.

We also support the proposal to give Ministers the power to amend the list of special procedures to which this licensing system will apply through regulations.

As we previously indicated in our response to the Public Health White Paper, we would suggest that consideration could also be given to including the following additional procedures under the proposed licensing system:

- laser hair removal;
- chemical peels;
- dermal fillers;
- scarification/branding; and
- sub-dermal implantation (or 3D implant).

Intimate piercing

We are supportive of the plan to prohibit the intimate piercing of anyone under the age of 16 in Wales. The proposals in this section of the Bill would therefore seem reasonable.

Pharmaceutical Services

The Bill includes provision to require each local health board to publish an assessment of the need for pharmaceutical services in its area with the aim of ensuring that decisions about the location and extent of pharmaceutical services are based on the pharmaceutical needs of local communities.

Whilst such a proposal seems superficially reasonable, we are concerned about the experience in England where the interpretation of a similar requirement for pharmaceutical need assessments has led to the withdrawal of dispensing rights for some GP practices, with potentially catastrophic impact on some rural communities if this were to be repeated in Wales. The experience in England is that there seems to be no mechanism whereby the pharmaceutical needs assessment considers the wider primary healthcare needs of a locality – particularly a rural one. As such, we would be concerned that the resultant provision of additional pharmaceutical services under section 81 of the National Health Service (Wales) Act 2006 would be unlikely to compensate for the closure of a local GP practice.

The *Cost of Service Inquiry*[52] conducted in 2010 by the Department of Health in England demonstrated the cross-subsidy of services provided under the General Medical Services (GMS) contract by dispensing

[52] http://www.pwc.co.uk/government-public-sector/publications/cost-of-service-inquiry-for-community-pharmacy.jhtml

in rural dispensing practices. Many of these dispensing practices rely on the additional profit from dispensing to remain viable when catering for often small and dispersed registered patient lists.

The additional pharmaceutical services mentioned in the Explanatory Notes which accompany the Bill – flu immunisation, smoking cessation and emergency contraception (and indeed many others) – are ones that are provided under GMS services already. However, there have been instances in England where, because such services have not been provided under a pharmaceutical contract, there has been a determination that there were unmet pharmaceutical needs and thus applications to provide additional pharmaceutical services were agreed. This led to the closure of dispensing services even in areas that have been defined as controlled localities (i.e. areas that have been designated as being 'rural in character' such that, in certain circumstances, doctors can provide pharmaceutical services to certain of their eligible patients.) This, in turn, can have a huge negative impact on the provision of GMS services in such localities. With current GP recruitment problems this could be devastating for rural areas and lead to directly to GP practice closures.

Ideally, we would therefore suggest that controlled localities be excluded from the proposed provisions of the Bill. Failing that, as an absolute minimum, GMS services similar to extended pharmaceutical services should be required to be considered in any pharmaceutical needs assessment, and all pharmaceutical needs assessments should include a risk assessment to existing GMS provision of any new approvals to provide pharmaceutical services.

In the light of these quite serious concerns, the view of BMA Cymru Wales is that we believe the provisions in this section of the Bill might improve the planning and delivery of pharmaceutical services, but only as narrowly defined and in isolation.

We further believe that the proposals will encourage existing pharmacies to adapt and expand services according to local need – an aim we can most certainly support.

However, it must be recognised that the proposals relating to pharmaceutical services in the Bill have the potential to seriously undermine public health in Wales if (as they have in England) they negatively impact on the provision of GMS GP services in rural areas and lead to the closure of existing GP practices.

Provision of toilets

We welcome the proposed provisions in this section of the Bill. These proposals seem both sensible and reasonable, and we are therefore happy to provide our support.

APPENDIX 1 – The case for Health Impact Assessment (HIA)

Introduction

Pre-assessing new policies, plans or programmes in order to avoid any unforeseen negative impacts on the environment or equalities is already well-established within decision-making by public bodies in Wales. However, there is clearly also a strong case to be made that we should be equally seeking to avoid or minimise any negative impacts on the health and well-being of the Welsh population, as well as promoting positive impacts. Indeed, this would appear to be both a logical and desirable development of an already well-established approach.

It also makes sense in light of the accepted recognition that health is, to a large extent, determined by factors outside of healthcare provision. Known as the wider determinants of health, these include social and community factors; access to services; and economic and environmental factors.

It can hopefully be taken as a given that public bodies in Wales would wish to avoid negative impacts on health that could arise from decisions they might be taking, or from the application of new policies they might be adopting. But if we are considering potential deleterious consequences that are neither

intended nor envisaged, it cannot simply be assumed that these will be obvious in the first instance and hence mitigated against automatically.

If such outcomes are therefore to be systematically avoided, it would seem logical that some form of pre-decision assessment needs to be undertaken before decisions are made, plans approved or new policies adopted. This would maximise the likelihood that something that might not otherwise be obvious can brought to the fore and properly considered in a timely manner.

HIA is a well-established tool that can fulfil this role. The World Health Organisation (WHO) defines HIA as '*a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques. HIA helps decision-makers make choices about alternatives and improvements to prevent disease/injury and to actively promote health*.'[53] A definition known as the Gothenburg Consensus describes HIA as a combination of procedures methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.[54]

As practiced in Wales, HIA assesses the implications for health and wellbeing through the broad lens of the wider determinants of health. It is a process which considers to what extent the health and well-being of a population may be affected, whether positively or negatively, by a proposed action – be it a policy, programme, plan or project. As such it can provide an opportunity to identify ways in which health benefits can be maximised as well as how health risks can be minimised. It can not only identify health impacts and health inequalities affecting the general population, but also those affecting vulnerable groups (e.g. children, young people, the elderly etc.). It can be used to identify opportunities for health improvement, as well as to fill identified gaps in service provision or delivery.

For as long as its application in decision-making by Welsh public bodies remains optional, however, its effectiveness in avoiding un-envisaged negative impacts on health – or in identifying ways in which health benefits might be maximised – will in our view be substantially reduced. It might only be through the undertaking of an HIA that an unforeseen negative impact on health might is in fact identified.

Relationship with existing policy and legislation

The use of HIA can also be seen as a logical progression of the current policy direction in Wales, complementing the aims of many recent developments in legislation.

For instance, the Active Travel (Wales) Act 2013 requires Welsh Government and Welsh local authorities to undertake continuous improvement through the development of transport infrastructure that can facilitate travel by active means – thereby helping people to undertake healthier travel options. However, whilst this will lead to a certain amount of new transport infrastructure being developed to further the aims of this Act, it is possible that other new transport infrastructure may also be developed alongside which is not assessed for its impact on health and which might therefore have an un-considered negative impact, or might not be developed in a manner which maximises the opportunities for promoting health benefits. In our view it therefore makes sense for all new transport infrastructure to be assessed for its impact on health so that health concerns can be brought to the fore whether or not the infrastructure in question is being specifically developed to further the aims of the Active Travel (Wales) Act 2013. That way Wales can adopt a more holistic approach to furthering this policy aim.

Another example of where HIA could provide added benefit can be highlighted in relation to planning considerations, where we would also argue that it might not be seen as sufficient to only require HIAs to be undertaken at the level of the over-arching Local Development Plan (LDP). Generalised land use allocations within an LDP will not necessarily reveal the impact on health that individual development

[53] http://www.who.int/hia/en/

[54] European Centre for Health Policy. Health impact assessment: main concepts and suggested approach. Gothenburg consensus paper. Brussels: WHO European Centre for Health Policy. 1999. Available at: http://www.euro.who.int/document/PAE/Gothenburgpaper.pdf

proposals, which are subsequently brought forward during the lifetime of the plan, might have. It may only become apparent once the specific details of individual planning applications are known what impacts they could have on a broad-range of public policy considerations, including health. It might therefore be considered that certain categories of planning applications – e.g. housing developments above a certain size – could be subject to HIA.

Application

HIAs need not be overly burdensome. This is often used as an argument against their use being made a requirement, but the first stage in the process should be a screening exercise which can determine whether an HIA would both be valuable and feasible within a particular decision-making context.

In our view, it would be too simplistic to just dismiss this as a tick box exercise. A methodology could be developed which would ensure those policies, plans and programmes which should be subject to an HIA could then go on to be subject to a suitably more rigorous assessment – but for those for which this would not be necessary, this can also be straightforwardly identified.

Additionally, HIA need not be undertaken as a stand-alone process but could also be undertaken as part of a wider, but integrated, impact assessment. An example of this is the approach which was employed in Tasmania[55] as a result of legislation introduced there in 1996. That legislation required all proposed developments requiring an environmental impact assessment (EIA) to also be subject to an HIA, with these being carried out as part of one integrated assessment.

Indeed it should be recognised that broad HIA can provide added benefits even in circumstances where EIA is already required. Even though there may be a requirement within EIA to consider human health, this may done in a manner which could be much narrower in scope than would be required in an HIA. At present, for instance, EIA undertaken in accordance with current EU regulation only looks at negative risks and implications for health, and only those which may be caused by environmental determinants.

Undertaking HIA alongside other assessments, as part of a wider integrated assessment, could be seen as a worthwhile adjunct to the recently passed Well-being of Future Generations (Wales) Act 2015 which seeks to promote a healthier Wales as one of its seven identified well-being goals. Whilst this Act requires public bodies in Wales to set objectives that will further each of these well-being goals, it does not however establish a specific requirement for Welsh public bodies to consider the impact on health of other decisions they may make, or of new policies they may adopt, when these are outside of those which are specifically being brought forward to further the aims of the Act. A mandatory application of HIA by Welsh public bodies could therefore ensure that the impact on health and wellbeing is considered more widely across the board, thereby more effectively delivering the intention of a health-in-all-policies approach.

HIA is an open and transparent process which promotes the active inclusion and participation of key stakeholders and communities affected. It can therefore ensure greater involvement of these groups in decisions that affect them. As such, it can bring reassurance in relation to certain decisions that potential impacts on health and well-being are properly understood.

Existing requirements for HIA use in Wales

It should be recognised that there are already circumstances in which HIA is referenced in existing guidance in Wales. Examples include the *Vibrant and Viable Places: New Regeneration Framework (2013)*[56] which includes the need for a HIA to be included in all Stage 2 bids for Welsh Government funding; the *Welsh Transport Appraisal Guidance (WelTAG), 2008*[57]; the *Collections, Infrastructure and*

[55] Ewan C, Young A, Bryant E, Calvert E, Calvert D. *National framework for environmental and health impact assessment.* Canberra: National Health and Medical Research Council, Australian Government Publishing Service, 1994. Available at: https://www.nhmrc.gov.au/guidelines-publications/eh10

[56] http://gov.wales/topics/housing-and-regeneration/regeneration/vibrant-and-viable-places/?lang=en

[57] http://gov.wales/topics/transport/planning-strategies/weltag/?lang=en

Markets Sector Plan[58] which covers the management of waste*;* and the *Minerals Technical Advice Note (MTAN) 2: Coal*[59], which provides planning advice in relation to facilities for coal extraction including open-cast mining. These include circumstances in which HIA has already been made a mandatory requirement in Wales.

Making HIA a statutory requirement

Given that there are already circumstances in which Welsh Government has specified that HIA should be undertaken, it could therefore be a logical progression to include a statutory requirement for HIA in certain defined circumstances. Indeed, such a provision could substantially strengthen the scope and impact of the Public Health (Wales) Bill, as well as being seen as an evolution of the existing approach.

The principle for HIA to be a requirement in specific situations could be incorporated on the face of the Public Health (Wales) Bill, with the intention that regulations would subsequently be produced which could then specify in exactly which particular situations a mandatory HIA would be required. That way the requirement for mandatory HIA could initially be applied in a number of discrete areas where it is most apparent that this would be of benefit, with scope for this to be easily broadened to further areas in the future. This would be a similar approach, for instance, to the manner in which the provisions of the Welsh Language (Wales) Measure 2011 are being applied.

In the first instance, we would suggest that regulations could require that HIA is made mandatory in relation to Strategic and Local Development Plans, certain larger scale planning application, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

Summary

We feel that a mandatory requirement for HIA in certain defined circumstances would be entirely in line with the wider Welsh Government policy direction and recent legislative developments.

It would ensure greater consideration within decision-making of ways in which negative impacts on health can be mitigated against and positive health benefits maximised, thereby ensuring unforeseen impacts are avoided at the same time as providing greater reassurance for communities in the way such decisions are reached.

Legislating for mandatory HIA could provide a significant contribution to improving the future health and well-being of the Welsh population, at the same time as helping Wales to become a World leader in the application of public health policy.

[58] http://gov.wales/topics/environmentcountryside/epq/waste_recycling/publication/cimsectorplan/?lang=en
[59] http://gov.wales/topics/planning/policy/mineralstans/2877461/?lang=en

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 1

Do you agree that the use of e-cigarettes should be banned in enclosed public and work places in Wales, as is currently the case for smoking tobacco?
Yes, we do. As the Bill states this should include all nicotine inhaling devices. It will be easier for organisations to manage a total ban on smoking tobacco and use of nicotine inhaling devices including e cigarettes. The actual vapour being exhaled by those "vaping" can be very annoying to others and it is also a poor example to children, who may follow the example and either vapour or smoke. There will also be some residual nicotine in the vapour which may have harmful effects on others. It has been known for many years that nicotine is addictive and it also has adverse medical effects so should not be encouraged in any manner.

Question 2

Do you believe the provisions in the Bill will achieve a balance between the potential benefits to smokers wishing to quit with any potential dis-benefits related to the use of e-cigarettes?
Yes. Those wishing to quit smoking need to gradually reduce their use of the e-cigarettes over time and restrictions on use will help enhance this behaviour. We are not aware of any dis-benefits.

Question 3

Do you have any views on whether the use of e-cigarettes re-normalises smoking behaviours in smoke-free areas, and whether, given their appearance in replicating cigarettes, inadvertently promote smoking?

|Yes, we feel that the use of e-cigarettes normalises the behaviour in smoke free zones and potentially encourages others to take up the habit. Some patients only used e-cigarettes in public areas, where they are accepted due to social pressures to conform. They were actually upset to learn that e-cigarettes contained nicotine as they thought they are was only steam or water. Some of the also shared the -cigarettes and were unaware of potential risk of spreading infections such as viral hepatitis. The same is also true of hocker or bubble pipes which should be made to include these into the Bill.

Question 4

Do you have any views on whether e-cigarettes are particularly appealing to young people and could lead to a greater uptake of their use among this age group, and which may ultimately lead to smoking tobacco products?
Yes we do have concerns about risks to young people as there is an increasing social trend to their use in these age groups partly due to social pressures.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
Yes This may need to be modified to include pharmacies if the law is changed to allow short term use of e cigarettes to be used for smoking cessation therapy.

Question 6

What are your views on creating a new offence for knowingly handing over tobacco and nicotine products to a person under 18, which is the legal age of sale in Wales?
We support this. This may need to be modified if the law is changed to enable the use of e-cigarettes to be used short term for smoking cessation on prescription as some of the patients may be under 18 years of age.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

What are your views on creating a compulsory, national licensing system for practitioners of specified special procedures in Wales, and that the premises or vehicle from which the practitioners operate must be approved?
We support this. People are very often unaware of the risks related to these procedures due to infection, allergy or potential carcinogens in some inks used for tattoos. They are also unaware of the potential for life long scaring resulting occasionally in disfiguring or disabling deformity from procedures which have complications. They are also unaware that it is difficult to remove evidence of piercing or tattooing, when they no longer want the associated affect.

Question 8

Do you agree with the types of special procedures defined in the Bill?
Yes

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
We support this

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
No

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

Do you believe an age restriction is required for intimate body piercing? What are your views on prohibiting the intimate piercing of anyone under the age of 16 in Wales?
Yes

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
We believe naval, lip, nose and tongue piecing should be added to the list. These have high risk of infection and complication and the implications of these need to be understood fully by the person having the procedure, hence the support to restrict this to over 16 year olds.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
Yes

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
We believe that if need is shown in an area potentially pharmacies will respond but there may be restrictions due to suitable premises or staff availability.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

What are your views on the proposal that each local authority in Wales will be under a duty to prepare and publish a local toilets strategy for its area?
We support this. Some people restrict their activity due to lack of available accessible public toilets in the area. The published data should include data on the current toilets including opening times and accessibility especially for disabled toilets.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
We hope that this will be the case but the strategy will need to be open to public comment

Question 17

Do you believe the provision in the Bill to ensure appropriate engagement with communities is sufficient to guarantee the views of local people are taken into account in the development of local toilet strategies?
Yes

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
These should be included but some may need to have restrictions to those using the settings for their prime purpose.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
Yes

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
Minimum alcohol pricing which is already being considered

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
No

British Association of Cosmetic Nurses

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from the British Association of Cosmetic Nurses – PHB 33 / Tystiolaeth gan Gymdeithas Nyrsys Cosmetig Prydain – PHB 33

Consultation – Public Health (Wales Bill) – Submission by the British Association of Cosmetic Nurses (BACN).

Introduction

1. The BACN is delighted to have been invited to comment on the above Bill as it passes through the Committee stages of the National Assembly for Wales. The format of our response will follow the guidelines that were sent with the invitation to provide evidence. We have also sent confirmation of our willingness to attend a meeting of the Committee on 17th September 2015 if required.

The BACN – An Introduction

2. The BACN was formed in 2009 by a small group of registered Nursing and Midwifery Council nurses who wanted to provide a forum for networking and mentoring in what was and still is the rapidly growing sector of non-surgical aesthetic treatments.
3. The BACN is now the largest Professional Association in the field of non-surgical aesthetic treatments and has over 600 members – a number of which practise in Wales. A detailed breakdown of our constitution, governance and activities can be found on our website at:

www.bacn.org.uk

Regulation in the UK – Non- Surgical/Aesthetic Treatments

4. It is worth reiterating that there is no regulation at all in England, Wales, Scotland or Northern Ireland for non-surgical aesthetic treatments. There is regulation by governing councils and statutory legislation for prescription medication. The problem is interpretation of regulation, the difficulty of enforcing it and the maintenance of best practice standards under the legislation (and of course, fillers are not prescription drugs therefore not regulated).

England

5. There is a lot of activity going on in England with regard to potential models of regulation following the publication of the Keogh Report on 'Non-Surgical Cosmetic Interventions' on 11th September 2014.
6. This report was commissioned by the Secretary of State for Health and looked in particular at the need for regulation in the non-surgical sector. The findings outlined a principle of self-regulation for England and initiated a consultative process amongst stakeholders led by Health Education England (HEE). The BACN was a member of the Expert Reference Group established by the HEE to review the findings of the Keogh Report.
7. The findings of the Expert Reference Group were published in December 2014 and final comments were provided to the Secretary of State for Health by 31st March 2015. The HEE is currently considering the responses prior to making recommendations to the Minister of Health.
8. The Keogh Report identified the absence of any regulation for dermal fillers. The Department of Health have expressed the desire to address this through the introduction of statutory legislation which focuses on dermal fillers and possibly other non-prescription treatments. This would have the effect of bringing these treatments under the jurisdiction of statutory regulated healthcare professionals which, we believe, is to be welcomed.

Scotland

9. The Scottish Executive is about to announce a licensing system for aesthetic businesses. The BACN has contributed to the development process and been invited to sit on the Health Inspection Service (HIS) which will inspect premises. They are now looking at establishing standards and have looked towards the BACN Competency Framework as a guide in this area. At the moment there are no plans to establish an overarching body to oversee standards or to look

at the assessment of competence. This function will be performed by the Chief Medical Officer for Scotland and as yet there are no proposals for review.

BACN Competency Framework

10. The BACN Competency Framework is the only set of standards published for the non-surgical aesthetic sector which is also accredited by the RCN. As part of the HEE process the Competency Framework was adapted to also include hair restoration and various laser treatments. We recommend the standards in the Competency Framework to the National Assembly for Wales as the basis for setting a national set of standards in this area either through primary or secondary legislation and to include non-surgical cosmetic interventions.

Joint Council Model

11. The BACN in its final submission to the HEE also recommended the establishment of an over- arching body, a 'Joint Council' that would own and update standards and take a strategic view on regulation in the sector. It also suggested that there is an Accreditation Body established under the wing of the Joint Council to review training programmes that are outside the usual remit of academic institutions and OFQUAL.
12. Detailed discussions are now taking place on the format, remit and financing of a Joint Council between the HEE and some of the key Professional Associations that oversee activity in the non-surgical sector. However, without legislation this process is subject to the industry and professional bodies agreeing an acceptable way of working which is proving very difficult.
13. One option that has been suggested is the establishment of a 'Voluntary Register' in England. It is the view of the BACN that this is fraught with difficulties in terms of who is required to register, who keeps the register and who polices it. It is also open to misinterpretation by the public if it is not clear what the register has been established to do. An approval to be on a register that is just based on premises inspection, availability of policies and procedures for the activity or hygiene gives no guarantees in relation to the competence of the persons providing treatments.

The Welsh Proposals – Comments

14. The BACN in this section respond to the key areas outlined in the 'Guidance Notes' for responders and the questions that are asked to be covered. The

single most important point to make here is that the proposals published in the Bill refer to licensing 'Special Procedures' and 'Cosmetic Procedures' but no reference is made to 'aesthetic procedures' (see para 107 in Guidance Notes). The BACN would support licensing however do not believe that a 'Public Health Bill' is the most appropriate route or vehicle to achieve the desired aims for the reasons set out below.

15. The risks associated with aesthetic procedures include serious facial scarring and blindness, which require rapid and expert identification and intervention. The importance of and need to identify competence is reflected by the serious complications that can occur in aesthetic procedures. In its current form we would question the extent to which the Bill refers to such competence and the ability of it to be measured and verified by the arrangements suggested.

16. Experience tells us that the public are frequently not judicious in determining the true meaning of any licence, kite mark or title. Any such annotation is usually perceived, without question, as competence in the broadest sense. Any move to license practitioners to all but the fullest measure is likely to cause confusion at best and misplaced trust at worst.

17. By virtue of the prescription status of certain popular treatments, unregulated practitioners cannot work in isolation, but are subject to the overview of regulated healthcare prescribers. Any move to license those who are unregulated would have to entertain the complexities of this impinging upon those who are regulated from another source. e.g. NMC or GMC.

18. The draft proposals do appear to discuss providing exemptions to 'members of specific professions' (see para 120 in Guidance Notes) who are overseen by 'Governing Councils'. Our position on this is with regard to nurses in particular where we would agree that such exemptions are appropriate. The alternative would seem to be a layering of regulation upon regulation. We would question the benefits as set against the complexities of such a measure.

19. The emphasis of the Bill appears be on 'Special Procedures' being carried out in 'an unhygienic fashion' (Para 108 of the Guidance Notes) and the need for practitioners to 'employ safe working practices' (Para 108 of the Guidance Notes). Para 115 of the Guidance Notes refers to the lack of a 'Competency Test' for practitioners and also to there being no requirement 'for consent forms, pre and post-procedure consultation, aftercare advice or record keeping' which are all critical points. However we refer to Para 14 in this submission which states that the suggested framework for licensing is inadequate to support the assessment of professional competence.

20. The principle of licensing individuals as well as premises (Para 117 of the Guidance Notes) is thoroughly endorsed by the BACN from its experience of the non-surgical sector in the UK. This is necessary to avoid large chains of

clinics or bodies providing 'Special Procedures' registering on bloc under the licensing system and then having a number of individuals carrying out 'Special Procedures' without a licence and redress for the patient.

21. Recognition in the Bill of the need to update various 'Special Procedures' via secondary legislation is also welcomed by the BACN from its experience of the rapidly changing 'non-surgical aesthetic sector' in the UK.
22. The BACN notes that it is local authorities in Wales who are being charged with the responsibility for licensing and enforcing the conditions of the licence (Para 122 of the Guidance Notes) and questions if they have the specialist expertise and resources to do this in respect of aesthetic treatments. If the area of 'non-surgical aesthetic treatments' did come under some kind of licensing procedure how would local authorities ensure that they have the relevant expertise to assess competence.
23. The power of local authorities to issue 'Stop Notices' to practitioners (Para 123 of the Guidance Notes) who have contravened the licensing rules is good in theory but may be very difficult to implement in practice. It also places the Licensing Authority in a position where 'loss of business income' could be part of a major counter claim.
24. It is suggested that the legislation will 'institute a system of mandatory licensing for those practitioners who provide special procedures in Wales, to which national standards will be attached and enforced by local authorities' (Para 125 of the Guidance Notes) however this is dependent on agreement being reached on national standards. It is our experience in the field of non-surgical aesthetic treatments that this is a major issue. As referred to earlier the BACN has developed its own 'Framework of Standards and Competencies' to meet this gap and this is now being incorporated into a broader framework by the HEE in England. It has taken over 18 months to agree this framework with numerous stakeholders participating.
25. Reference in Para 127 of the Guidelines to 'Public confidence and client understanding will be further enhanced by the requirement for practitioners to provide pre- and post - procedure consultations' is definitely recognised by the BACN with regard to non-surgical aesthetic procedures but only if the regulations and enforcement procedures deliver an effective process for monitoring.
26. The Bill talks about possible exemptions to the arrangements for persons carrying out 'Special Procedures'. In England this matter has been discussed in great depth with a number of 'Professional Bodies/Governing Councils' making the case that existing arrangements are adequate to cover any negligence by a practitioner or to deal with a complaint from a member of the public.

BACN – Concluding Statement

27. The BACN maintains that there is a need to regulate 'non-surgical cosmetic interventions' in Wales but does not believe it fits well within a 'Public Health Bill' that has not been designed for this purpose and concentrates on premises and hygiene regulation only. The extensive work done by the HEE in England provides an excellent backdrop to the issue of regulation in Wales. However the BACN is concerned about the length of time it has taken and the fact that there is still no clear set of proposals or structures agreed.

28. We consider that there are two options involved with regard to providing a regulatory framework for non-surgical cosmetic interventions in Wales:

Option 1

Adopting the framework currently being developed in England where considerable work has been undertaken to define the area and the standards/competency involved. However this is subject to agreements being reached and final proposals published.

Option 2

Reviewing what emerges from the process in England and then deciding if a more regulated framework via statute is necessary in Wales. This would enable Wales to make its own decision on regulation but could mean considerable delays which would not be in the interest of the general public or regulated medical professionals.

The BACN is happy to work with the Welsh Assembly whichever approach it decides to take with regard to the issue of regulating 'non-surgical cosmetic interventions' separately from this current Bill.

Sharon Bennett – Chair – on behalf of the BACN Board

Andrew Rankin – Vice Chair – on behalf of the BACN Board

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29th August 2015.

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t: [redacted] | e: [redacted] | w: bacn.org.uk

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from Save Face – PHB 46 / Tystiolaeth gan Save Face – PHB 46

What are your views on creating a compulsory, national licensing system for practitioners of specified special procedures in Wales, and that the premises or vehicle from which the practitioners operate must be approved?

'The principal purpose of regulation of any (healthcare) profession is to protect the public from unqualified or inadequately trained practitioners. The effective regulation of a therapy thus allows the public to understand where to look in order to get safe treatment from well-trained practitioners in an environment where their rights are protected. It also underpins the (healthcare) professions' confidence in a therapy's practitioners and is therefore fundamental in the development of all (healthcare) professions.'

We would question how the identified risks have undergone an appropriate assessment, and analysis of achievable, quantifiable and desirable outcomes which justifies the measures (and investment of public funds and resources) proposed.

In February 2011, the Government published the Command Paper 'Enabling Excellence – Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers'. This document sets out the current Government's policy on regulation, including its approach to extending regulation to new groups. In particular, it sets out the Government's policy that, in the future, statutory regulation will only be considered in 'exceptional circumstances' where there is a 'compelling case' and where voluntary registers, such as those maintained by professional bodies and other organisations, are not considered sufficient to manage the risk involved.
The paper also outlines a system of what is called 'assured voluntary registration'. The Health and Social Care Act 2012 has implemented a number of the policies described in the Command Paper. The Professional Standards Authority for Health and Social Care now has powers to accredit voluntary registers of people working in a variety of health and social care occupations. The idea behind this to provide assurance to the public that these registers are well run and that they require their registrants to meet high standards.

Has The Assembly considered supporting established Professional Associations to explore and develop more robust voluntary self regulatory frameworks (self-funded)? Well organised and appropriately focused professional bodies are better placed to establish;

- Standards of training and accreditation
- Codes of Conduct
- Standards of Practice
- Public and professional education
- Credible influence on both practitioner and consumer behaviour
- Appropriate expertise
- Flexibility to respond to public and professional concerns
- Hold, manage and publish registers of members
- Hold members accountable to Standards
- Manage complaints and report/refer to appropriate statutory regulators (e.g.Public/Environmental Health/MHRA)

The British Institute & Association of Electrolysis should be consulted and may prove to be the best vehicle to protect the public- sign posting consumers to properly trained professionals?

Alliance of Professional Tattooists
The Association of Professional Tattoo Artists
Association of Professional Piercers
Tattoo and Piercing Industry Union
The above (Tattoo) bodies should be brought together to collaborate, sharing experience and expertise to inform developing their own model for self regulation.

The British Acupuncture Council is a recognised body registered with The Professional Standards Authority. This model is one, other Associations should aspire to.

Do you agree with the types of special procedures defined in the Bill?

We trust that the list has been devised based on evidence of harm caused, high risk behaviour and poor practice related to these procedures. We would question how the measures proposed will impact on public health more effectively than encouraging and supporting more robust self regulation.
Acupuncture already has a model for registration and regulation, The British Acupuncture Council. We would question the need for this procedure to be included in the legislation, but perhaps the authorities should signpost the public to regulated practitioners (Registered members of The BAC).

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?

We are very pleased the Assembly has had the foresight to ensure provision for flexibility to respond and adapt in a timely fashion. Statutory regulation should only be imposed if Voluntary self or co-regulation fails to deliver improved standards of safety and practice. With the exception of Acupuncture, this model of self- regulation has not yet been explored. The problem always lies with a lack of recognised standards of practice, training and accreditation and inclusion on a register which is accessible to the public and holds practitioners accountable. In the interests of gathering information and data, we would ask of the assembly whether the licensing process could include a questionnaire on other potentially high risk procedures performed and by whom and facilitate some form of reporting for members of the public who wish to raise concerns or complaints, as a means of gathering data for risk assessment to inform decisions on whether ,and for what procedures the list should be extended. Also, if in the course of inspection, the officer observes anything which he or she sees as a risk to public health, they record and report to appropriate authority/regulator.

The Bill includes a list of specific professions that are exempt from needing a licence to practice special procedures. Do you have any views on the list?

We appreciate the exempted professionals are accountable to their own statutory regulators, but the procedures included do not fall within their recognised scope of practice, and we feel it would be appropriate, in the interests of clarity for the public, that ALL those providing these procedures should be subject to the same mandatory licensing and inspection. It is our experience that regulated healthcare professionals are capable of unsafe practice in inappropriate environments. Their regulators do not inspect premises, would not be in a position to manage complaints and the process for appraisal and revalidation would not include any of these procedures.

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?

Effective enforcement requires more than the process of licensing; application, verification, inspection and publication on a register. It must be supported with education, motivation and deterrent.

Education

The public must be familiar with the regulation and actively seek licensed providers.

- This can best be achieved by providing license holders with materials to promote their licensed status- badge, poster, logo for website and social media. The website and social media 'badge' should have an embedded link to the register- so that consumers can verify their license, and provide feedback on the service. The logo could say, 'click to verify'. Display should be compulsory.
- Articles about the licensing and regulation should be published in all trade and specialist magazines. It may be possible to require trade/specialist publications to include a statement about licensing wherever services are advertised. Not unlike the 'Drink Aware Campaign'.
- The register itself should also provide a platform for public education and should include advice and information to support the consumer to make safe choices and be aware of risks.
- The licensing process itself affords the opportunity to educate the practitioners, establish standards and provide guidelines. Save Face has provided model templates and guidelines on patient information, consent, complaints management, adverse event reporting, confidentiality/data protection, record keeping, infection control etc. which have been welcomed by our registrants and provide a clear bench mark for our inspectors to measure against.

Motivation

In a competitive market, providers will recognise the 'marketing value' of the logo/license. If the process is supportive, providers will see added value to obtaining a license.

Deterrent

- With the necessity of online presence, it is not difficult, with routine searches (Google, Facebook and Twitter) to identify providers and check they are licensed. This pro active activity, if neglected, allows unscrupulous providers to practice with impunity. They need to know they cannot fly, 'under the radar'.
- Fixed penalties, escalating for persistent offenders must be applied without exception. The penalty should be sufficient to act as a deterrent and should not be preceded with a warning.
- Advertising of unlicensed services (print media) should be prohibited, with fixed penalties applied.
- Reporting process must be accessible and responsive. To identify issues, to monitor and audit success/failure, to inform continuous improvement and to promote public confidence in the regulation.

Clearly, Education and motivation could be provided through self regulatory models, the deterrent aspects would be weak, without legislation to enable enforcement, but perhaps the Assembly could consider a model for co-regulation- when standards are breached, there is enforcement by local authorities?

Problems:

Lack of appropriate knowledge/expertise exploited by practices
Enforcement officers applying standards not applicable to specialism.
Reluctance of public to report/ or lack of understanding- who to report to and for what?
Lack of public/consumer engagement
Lack of engagement with trainers and professional bodies
Lack of targeted resources to prevent harm, rather than act retrospectively to punish when harm is caused.
Poor data collection for audit
Lack of consistency across regions.
Safe practices will be more inclined to register, whilst high risk services go 'underground'. It is our experience that the public who use unsafe services are less likely to raise concerns or make complaints, for a variety of reasons.

- There is none who will take responsibility
- They don't know who to complain to
- They are embarrassed
- They have been intimidated/ threatened

THIS needs to be addressed as a matter of priority. Current licensing models tend to cling to the four corners of the legislation (has the practitioner/premises breached the terms of the licensing?) This fails the consumer.

Do you believe the proposals relating to special procedures contained in the Bill will contribute to improving public health in Wales?

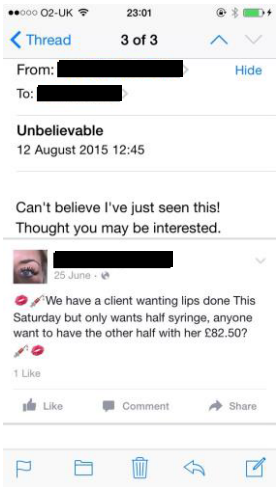
We believe the proposals have the potential to contribute to public health in Wales. Lessons might be learned from similar regulations applied in London Boroughs and Nottingham. This must not be perceived, either by the licensees or the public as 'just another income generator'. The officers must be well trained, well informed, understand the wider regulatory framework and be clear on their public protection responsibilities which may at times, go beyond the four corners of this Act, and require referral to or collaboration with other statutory or executive bodies.
Complaints must be recorded, resolved and audited. 360 degree feedback must be encouraged and published to inform continuous improvement.

It is our opinion that **effective** regulation would be more expensive and complicated than anticipated. It is currently estimated that the cost of fully implementing this licensing bill would cost in excess of £6m of public funding and is the second most expense item on the health bill. This would place an additional burden on already challenged public services at a time when there must be higher priorities. Local Authorities are not best placed to implement the measures proposed and

do not have sufficient resources to do so. However, when practice breaches standards and legislation already in place (Health and Safety Legislation) they should have clear responsibilities and publicly accessible processes to act and prosecute; this is already assumed and expected.

Save Face propose it is not in the public's interest to allocate such a significant amount of public funding to such services. These are elective procedures and there are other forms of introducing more stringent standards across the board that would be cost neutral to the tax-payer but would be income generate for the local authorities who would still have ownership of applying legislation where standards have been breached to apply enforcement action. Save Face propose that it would it would be more appropriate cost effective and efficient to contract the ownership and management to a third party scheme. To Contract the development of standards, assessment model and audit to a third party organization who would submit a competitive tender for the contract. This would facilitate business growth and job creation in Wales whist mitigating risk and cost to each authority. The appointed origination would have the existing infrastructure and training framework to implement the model at a far greater pace and would have access to the areas of specialism required to create a fit for purpose set of standards to assess both the suitability of the practitioner and the environment in which the treatments are performed. It would also have the necessary experience and infrastructure to develop and raise consumer awareness of the register, a vital element of successful licensing which other public facing registers have failed to do.

This model has proven significantly more effective in other cases of accreditation that are managed on an outsourced basis on behalf of the government in other areas requiring the application of a stringent set of standards. For example there are several of government appointed health and safety accreditation schemes including; Safecontractor, Altius, Constructionline and in utilities; Gas Safe which is managed by Capita PLC on behalf of the UK government.



Case History (Not Wales)

I reported to Public Health England.
I was referred to the local Authority
I was contacted and spoke to a nurse who understood and acknowledged my concerns
The Inspectors established the salon was not licensed to provide IPL hair removal or permanent makeup and did an unannounced inspection, but did not find the provision of dermal fillers as within their scope, so declined to take any action or any investigation of my complaint!
The full name of the nurse is not published, the salon will not provide it to me, therefore I cannot complain to The NMC (Nursing and Midwifery Council-) in any case, they would require more 'evidence'. There is no regulator who can take any action without further evidence, and no regulator who will use their authority (and resources) to investigate, based on my complaint….Presumably we will have to wait for a member of the public to contract Hep B or Hep C and be able to trace it to a shared syringe of dermal filler or botulinum toxin, before any action is taken, This is unacceptable,

We are happy to provide further and better particulars, upon request ,on any of the comments we have made.

Save Face

Eitem 6

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from British Acupuncture Council – PHB 15 / Tystiolaeth gan Y Cyngor Aciwbigo Prydeinig – PHB 15

British Acupuncture Council

Response to Consultation on Public Health (Wales) Bill

What are your views on creating a compulsory, national licensing system for practitioners of specified special procedures in Wales, and that the premises or vehicle from which the practitioners operate must be approved?

The British Acupuncture Council (BAcC) believes that the introduction of a new compulsory national licensing scheme for special procedures will remove many of the anomalies which have arisen in the enforcement of Local Government Miscellaneous Provisions Act (1982) as amended by the Local Government Act 2003. The existence of non-mandatory model byelaws has not always led to consistent adoption of similar models by local authorities, and the BAcC's experience is that local enforcement across the UK as a whole has been variable, with many authorities blurring the distinction between legal requirements and best practice advice in enforcement. A standardised system across Wales will both eradicate idiosyncratic interpretations of the law and create a single reference point for discussion and consultation on any variations which might be required in line with developments in health and safety requirements.

It follows that the BAcC supports any provision to approve the premises or vehicles in which or from which special procedures are performed. The provision of clear guidance as outlined in the consultation document would set down a standard which would enable practitioners to ensure their premises were satisfactory, and as above, make very clear what upgrades and updates may be required in future.

In summary, the BAcC supports these proposals, with the caveat that the advantages of a centralised system could be undermined unless suitable consultation procedures are in place for future development of the licensing conditions. The BAcC was heavily involved in the drafting of the model byelaws by the Department of Health in 2005/6 and was able to bring important practitioner concerns to the fore when the national guidelines were created. The special procedures covered by this proposal range from the minimally invasive to the necessarily near-surgical, and it is important to enshrine a level of proportionality into guidelines affecting a range of techniques to avoid an unnecessary and unfair levelling up of requirements. This has to involve input from the professions, and the BAcC hopes that this will be taken into account if these proposals become law.

Do you agree with the types of special procedures defined in the Bill?

The types of procedure outlined in the Bill are consistent with those in primary legislation elsewhere in the UK, except Greater London where 'special treatments' has a wider definition under the London Local Authorities Act 1991. The BAcC would not wish to see any changes to this list at this stage.

However, the emergence of variations on the standard theme has been considerable over the last forty years, and there are a number of techniques used in Traditional East Asian medicine, for example, which are proscribed by regulatory bodies like the BAcC but may actually be used by practitioners who choose not to register with a voluntary association. The example of 'wet cupping', a procedure widely used in China, demonstrates how there may well be variations to any of the named disciplines in the Bill which could be advertised and used without reference to the provisions of the Bill for want of inclusion within the definitions. The BAcC would welcome further discussion during the implementation of the Bill about the scopes of practice of the various techniques and what a local authority could reasonably claim to hold jurisdiction over.

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?

The BAcC believes that such a provision is essential to avoid unnecessary expense or unnecessary delay in extending the range of procedures covered by the legislation. As noted above, however, the BAcC would welcome explicit rules for consultation if secondary powers are invoked in this way.

The Bill includes a list of specific professions that are exempt from needing a licence to practice special procedures. Do you have any views on the list?

The BAcC is pleased to see that registration under the Professional Standards Authority's AVR scheme has been accepted as a basis for exemption. Its experience of submitting itself to this new scheme has been that the requirements for accreditation have been onerous and robustly enforced, and have demonstrated this this is not a 'soft option.'

The only cautionary note which the BAcC would like to sound is in relation to the exemption granted to registrants of professions regulated by statute. Its experience is that while most doctors and physiotherapists who undertake acupuncture belong to the relevant special interest bodies within their professions (the British Medical Acupuncture Society and Acupuncture Association of Chartered Physiotherapists), many other registered professionals like osteopaths and chiropractors go 'off the radar' in the absence of equivalent special interest bodies within their professions. This has meant that neither safety nor training standards of such practitioners are vetted, and the BAcC does not believe that this is entirely adequate. Set against the argument that the threat of loss of title ensures compliance with appropriate rules is the counter argument that you can't know what you don't know, and that it is not satisfactory to find out that something has gone wrong after it has gone wrong.

The BAcC would favour some form of explicit statement that there were powers within the Bill to inspect the premises of exempted practitioners where concerns has been raised about their standards of practice, and would be happy to see this enforced in relation to its own members. The logic applied in Greater London is that the exemption is granted on the assumption of maintaining exemplary standards, and therefore failure to maintain standards

should set aside the veil of exemption. Given that there are several published and readily accessible standards for safe acupuncture practice and recognised training, the BAcC believes that a local authority should have powers within the Bill to inspect and enforce precisely as it does with other licensees.

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?

The BAcC is generally satisfied that the system as outlined in the Bill can be enforced effectively by local authorities, and believes that the clarity of the national statements and guidelines will eradicate those problems which it has met elsewhere. These have primarily been the generation of idiosyncratic rules by local Environmental Health Officers based on their personal beliefs, and the turnover of staff which has meant that incoming officers have not been properly inducted into the system, and have applied it somewhat arbitrarily. The new licensing arrangements should ensure that the reference material Is available and consistently applied across the principality.

Do you believe the proposals relating to special procedures contained in the Bill will contribute to improving public health in Wales?

There is no doubt that a clear statement of standards and enforcement will be of benefit to public health in Wales, not least because an increasingly well-informed public used to electronic access to information will be able to find out easily what the relevant standards are and have confidence that anyone licensed within the new system has met and continues to meet them. This will also benefit the practitioners themselves, whose profile will be enhanced by demonstrating that the public can have trust that they are safe and competent.

The BAcC is grateful for having been invited to participate in the consultation, and would welcome any future invitations to be involved in the drawing up of detailed guidelines for acupuncture and acupuncture practitioners.

4th August 2015

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from British Body Piercing Association – PHB 08 / Tystiolaeth gan Cymdeithas Prydain ar gyfer Tyllu'r Corff – PHB 08

Public Health (Wales) Bill: Consultation questions

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

What are your views on creating a compulsory, national licensing system for practitioners of specified special procedures in Wales, and that the premises or vehicle from which the practitioners operate must be approved?
The British Body Piercing Association has set in place codes of practice and ethics which all members have adopted and use these in their work place. (please find attached) We have the most up to date training and follow the guide lines set by local boroughs. Body piercers need to be more regulated within their premises and have a recognised body in which they can rely on for support and further training.

Question 8

Do you agree with the types of special procedures defined in the Bill?
Yes, all of these areas of work are those of great skill and performed incorrectly can result in emergency medical treatment. Which in turn has consequences? The ability of the body piercer is defined not only by the teachings of the body piercer but confidence and ongoing support.

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?

By being able to amend current special procedures and aim to put in place newer protocol fits with keeping in with what consumers want. They want to know the best place to have a body piercing, and to know that the studio is certified.

Body piercing is something that has been used for years and does hold a rite of passage to not be regulated, but a huge percentage of body piercers do no withhold a basic understanding of body piercing. By bringing a standard of body piercing there would be far lesser impact on consumers not achieving the desired outcome and incounter problems.

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
By enforcing new licensing systems it brings the industry to a professional standing, Currently there are two candidates that have been working within the body piercing industry outside of EHO, TPIU and The Association of Professional Piercers, (APP) neither of these organisation warrant the merit of the body piercer you can simply fill in a form and make a payment, The memberships are not built to aid the body piercer. By bringing new regulations that are within a workable ability for piercing professionals I believe this will only impact in a positive light. Local authorities should be able to rely on potential training and associations to give help and guidance, but also be able to liaise with local business to keep them up to date with new requirements. By having more understand of the job that a body piercer does I believe will help to encourage people to want to push forward and become the industry recognised people they are.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

Do you believe an age restriction is required for intimate body piercing? What are your views on prohibiting the intimate piercing of anyone under the age of 16 in Wales?
The use of age restrictions is something that needs to come in to affect more, especially with in intimate areas of the body. The BBPA do use an age restriction within the codes of practices and ethics, Which is highly regarded with in the studios of our members. Prohibiting intimate piercings for under the age of 16 will give moral standing. Being able to allow a parent or guardian to stand guardian of the person I feel will be adequately sufficient for above the waist piercings. Female's nipples should be considered for piercing over 18 only. However anything below the waist I believe should only be in performed by someone who has adequate knowledge of the anatomy of the genitals and has had further training with in this specific area and should not be performed on anyone under the age of 18. Actively working with the in industry allows me to be in constant communication with piercers and pierce'es on average the majority of under 16's are already aware that they will need a parent or guardian to be present when having their piercing performed.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
Yes, in my opinion the list is correct. I believe that the environment that the intimate piecing is taking place should be performed in a stricter platform. An utilised area which can be designated to the use of genital piercings only. Their also needs to be more information and advise based around these piercing for the general public. The basis of body piercing is training and consultation, the tool book creates a

really good basis to go forward with however it does not promote the ability's of the body piercer.

Weather a body piercer is piercing an ear, an belly button or a nipple the client knows they will have to be contact made in that particular area.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
Yes. There is a huge potential to be able to create an better environment for every one today.

Eitem 8.1

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 3 – Senedd**
Dyddiad:	**Dydd Iau, 9 Gorffennaf 2015**
Amser:	**09.17 – 11.52**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://senedd.tv/cy/3026

Cofnodion Cryno:

Aelodau'r Cynulliad:	**David Rees AC (Cadeirydd)** **Alun Davies AC** **John Griffiths AC** **Altaf Hussain AC** **Elin Jones AC** **Lynne Neagle AC** **Gwyn R Price AC** **Lindsay Whittle AC** **Kirsty Williams AC**
Tystion:	**Dr Julie Bishop, Iechyd Cyhoeddus Cymru** **Dr Quentin Sandifer, Iechyd Cyhoeddus Cymru** **Dr Gillian Richardson, Bwrdd Iechyd Aneurin Bevan** **Dr Sara Hayes, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg**
Staff y Pwyllgor:	**Llinos Madeley (Clerc)** **Helen Finlayson (Ail Glerc)** **Catherine Hunt (Ail Glerc)** **Sian Giddins (Dirprwy Glerc)** **Rhys Morgan (Dirprwy Glerc)** **Gareth Howells (Cynghorydd Cyfreithiol)**

Amy Clifton (Ymchwilydd)
Philippa Watkins (Ymchwilydd)

Trawsgrifiad
Gweld trawsgrifiad o'r cyfarfod.

1 Y Bil Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru): trafodaeth ar drefn ystyried trafodion Cyfnod 2

1.1 Cytunodd y Pwyllgor ar drefn ystyried trafodion Cyfnod 2 y Bil Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru) mewn egwyddor.

2 Cyflwyniadau, ymddiheuriadau a dirprwyon

2.1 Cafwyd ymddiheuriadau gan Darren Millar.

3 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 2

3.1 Cafwyd ymddiheuriadau gan yr Athro Mark Bellis.

3.2 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

3.3 Cytunodd y tystion i ddarparu nodyn ar yr eitemau a ganlyn i'r Pwyllgor:

- y cydweithio rhwng Iechyd Cyhoeddus Cymru, Chwaraeon Cymru a Llywodraeth Cymru er mwyn annog gweithgarwch corfforol i wella iechyd pobl leol;
- eu barn ar p'un a ddylid cynnig cymhelliant ariannol er mwyn helpu awdurdodau lleol i ddarparu toiledau cyhoeddus;
- eu barn ar gyflwyno cyfyngiad oedran gofynnol ar gyfer tyllu rhannau o'r corff;
- unrhyw fesurau rheoli tybaco ychwanegol y dylid ystyried eu cynnwys yn y Bil; ac
- unrhyw dystiolaeth sy'n dangos effaith anweddau gweddilliol ac anweddau trydydd-law o e-sigaréts.

4 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 3

4.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

5 Papurau i'w nodi

5.1 Cofnodion y cyfarfodydd ar 17 a 25 Mehefin 2015

5.1a Nododd y Pwyllgor gofnodion y cyfarfodydd a gynhaliwyd ar 17 a 25 Mehefin 2015.

6 Cynnig o dan Reolau Sefydlog 17.42 (vi) a (ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

6.1 Derbyniwyd y cynnig.

7 Bil Iechyd y Cyhoedd (Cymru): trafod y dystiolaeth

7.1 Trafododd y Pwyllgor y dystiolaeth a ddaeth i law.

8 Blaenraglen waith y Pwyllgor.

8.1 Cytunodd y Pwyllgor ar yr amlinelliad o'r flaenraglen waith ar gyfer mis Medi i fis Hydref 2015, a chytunodd i ddychwelyd at yr eitem hon yn y dyfodol.

8.2 Yn sgil sylw'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol ei fod yn bwriadu cynnig penderfyniad ariannol ar gyfer y Bil Lefelau Diogel Staff Nyrsio (Cymru) yn nechrau tymor yr hydref, cytunodd y Pwyllgor i ysgrifennu at y Pwyllgor Busnes i ofyn am estyniad i'r dyddiad cau ar gyfer cwblhau trafodion Cyfnod 2.

8.3 Trafododd y Pwyllgor ei flaenraglen waith ar gyfer mis Tachwedd 2015 i fis Mawrth 2016, a chytunodd i ddychwelyd at yr eitem hon yn y dyfodol.

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 3 – Senedd**
Dyddiad:	**Dydd Mercher, 15 Gorffennaf 2015**
Amser:	**09.18 – 11.55**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://senedd.tv/cy/3013

Cofnodion Cryno:

Aelodau'r Cynulliad:	**David Rees AC (Cadeirydd)** **Alun Davies AC** **John Griffiths AC** **Altaf Hussain AC** **Elin Jones AC** **Darren Millar AC** **Lynne Neagle AC** **Gwyn R Price AC** **Lindsay Whittle AC** **Kirsty Williams AC**
Tystion:	**Julie Barratt, Sefydliad Siartredig Iechyd yr Amgylchedd** **Robert Hartshorn, Cyfarwyddwyr Diogelu'r Cyhoedd Cymru** **Paul Mee, Cyfarwyddwyr Diogelu'r Cyhoedd Cymru** **Naomi Alleyne, Cymdeithas Llywodraeth Leol Cymru** **Simon Wilkinson, Cymdeithas Llywodraeth Leol Cymru**
Staff y Pwyllgor:	**Llinos Madeley (Clerc)** **Christopher Warner (Clerc)** **Helen Finlayson (Ail Glerc)** **Catherine Hunt (Ail Glerc)** **Sian Giddins (Dirprwy Glerc)**

Rhys Morgan (Dirprwy Glerc)
Gareth Howells (Cynghorydd Cyfreithiol)
Amy Clifton (Ymchwilydd)
Elfyn Henderson (Ymchwilydd)
Victoria Paris (Ymchwilydd)
Philippa Watkins (Ymchwilydd)

Trawsgrifiad
Gweld trawsgrifiad o'r cyfarfod.

1 Cyflwyniadau, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd ymddiheuriadau.

2 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 4

2.1 Ymatebodd y tyst i gwestiynau gan yr Aelodau.
2.2 Cytunodd y tyst i ddarparu'r canlynol i'r Pwyllgor:

- nodyn ar ddigwyddiad a nodwyd gan Iechyd Cyhoeddus Lloegr yn ymwneud ag aciwbigo; a
- manylion am astudiaeth ar blant yn defnyddio sigaréts melys yn trosglwyddo i ysmygu.

3 Bil Iechyd y Cyhoedd (Cymru): sesiwn dystiolaeth 5

3.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

4 Papurau i'w nodi

4.1 Cofnodion y cyfarfodydd a gynhaliwyd ar 1 Gorffennaf 2015
4.1a Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 1 Gorffennaf 2015.

4.2 Ymchwiliad i gamddefnyddio alcohol a sylweddau: gwybodaeth ychwanegol gan y Dirprwy Weinidog Iechyd
4.2a Nododd y Pwyllgor y wybodaeth ychwanegol.

4.3 Bil Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru): gohebiaeth gan y Comisiynydd Pobl Hŷn Cymru
4.3a Nododd y Pwyllgor yr ohebiaeth.

5 Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn

5.1 Derbyniwyd y cynnig.

6 Bil Iechyd y Cyhoedd (Cymru): trafod y dystiolaeth

6.1 Ystyriodd y Pwyllgor y dystiolaeth a ddaeth i law.

7 Ymchwiliad i gamddefnyddio alcohol a sylweddau: trafod yr adroddiad drafft

7.1 Bu'r Pwyllgor yn trafod yr adroddiad drafft, a chytunodd arno yn amodol ar fân newidiadau.

8 Gwaddol Pwyllgorau'r Pedwerydd Cynulliad: trafod y dull gweithredu

8.1 Bu'r Pwyllgor yn trafod ei ddull gweithredu o ran ei waddol yn y Pedwerydd Cynulliad, a chytunodd arno.

Eitem 8.2

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: LF/MD/0688/15

David Rees AM
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
Caerdydd
CF99 1NA

4 Medi 2015

Annwyl David

Bil Iechyd y Cyhoedd (Cymru)

Hoffwn ddiolch i chi a'r Pwyllgor am y cyfle i drafod Bil Iechyd y Cyhoedd (Cymru) ar 1 Gorffennaf 2015.

Rwyf yn falch o ddarparu mwy o wybodaeth i'r Pwyllgor am y materion canlynol, a godwyd yn ystod y sesiwn:

a) barn Llywodraeth Cymru ar gymhwysedd deddfwriaethol Cynulliad Cenedlaethol Cymru i osod cyfyngiadau ar werthu cynhyrchion siwgr uchel ac alcohol, ac i wahardd gwerthu sigaréts confensiynol yng Nghymru;

b) manylion am gymorth meddygol a geisir o ganlyniad i gael unrhyw un o'r triniaethau arbennig a gynhwysir yn y Bil, gan gynnwys y gost o ddarparu triniaeth;

c) manylion y dystiolaeth y cyfeiriais ati fod y rhan fwyaf o ddefnyddwyr e-sigaréts hefyd yn defnyddio sigaréts tybaco confensiynol;

ch) gwybodaeth am y gyfradd llwyddiant o ran defnyddio e-sigaréts fel dull o roi'r gorau i smygu o'i gymharu â dewisiadau eraill; a

d) mwy o wybodaeth am y materion hawliau dynol sy'n ymwneud â'r Bil o ran ysmygu a'r defnydd o e-sigaréts mewn anheddau preifat sydd hefyd yn weithleoedd, ac am y darpariaethau pwerau mynediad a gynhwysir yn y Bil.

Cyflwynir y wybodaeth hon isod.

Cymhwysedd deddfwriaethol Cynulliad Cenedlaethol Cymru i osod cyfyngiadau ar werthu cynhyrchion siwgr uchel ac alcohol, ac i wahardd gwerthu sigaréts confensiynol yng Nghymru

Mae Llywodraeth Cymru yn parhau i adolygu'r buddion posibl i iechyd y cyhoedd o ganlyniad i osod cyfyngiadau ar werthiant cynhyrchion siwgr uchel neu ar sut y mae manwerthwyr yn arddangos alcohol. Nid yw'n bolisi gan Lywodraeth Cymru i gyflwyno gwaharddiad ar werthu sigaréts confensiynol yng Nghymru. Fel y cyfryw, nid oes cynigion polisi manwl wedi eu datblygu nac wedi bod yn destun ymgynghoriad, ac nid oes darpariaethau deddfwriaethol wedi eu drafftio. Bydd y Pwyllgor yn gwerthfawrogi'r ffaith fod unrhyw asesiad o gymhwysedd yn unol ag adran 108 o Ddeddf Llywodraeth Cymru 2006 yn ymwneud â darpariaethau gwirioneddol Deddfau'r Cynulliad, nid polisïau cyffredinol, ac nad yw'n bosibl, heb ddarpariaethau drafft, i fynegi barn derfynol ar gymhwysedd. Fodd bynnag, er mwyn cynorthwyo'r Pwyllgor, nodir isod restr o ffactorau a fyddai'n debygol o gael eu hystyried yn ystod unrhyw ddadansoddiad o gymhwysedd darpariaethau drafft.

Mae Adran 108 o Ddeddf Llywodraeth Cymru 2006 yn nodi terfynau cymhwyster y Cynulliad. Mae adran 108(4) yn darparu bod darpariaeth o fewn cymhwyster os yw'n ymwneud ag un neu fwy o bynciau a restrir dan y penawdau yn Rhan 1 o Atodlen 7 y Ddeddf ac nad yw'n dod o dan unrhyw un o'r esemptiadau yn y Rhan honno. O ganlyniad, byddai angen ystyried pa un a fyddai'r darpariaethau'n ymwneud â phynciau Atodlen 7, o ystyried diben ac effaith y darpariaethau. Mae'r pynciau yn Atodlen 7 a allai fod yn berthnasol i'r ddau destun yn cynnwys 'hyrwyddo iechyd', 'atal, trin a lliniaru clefydau, salwch, anaf, anabledd ac anhwylder meddyliol', ac 'amddiffyn a llesiant plant'. Gallai 'bwyd a chynhyrchion bwyd' hefyd fod yn berthnasol i gyfyngiadau ar gynhyrchion siwgr uchel ac alcohol.

Fodd bynnag, byddai hefyd angen ystyried pa un a fyddai'r darpariaethau'n dod o dan esemptiadau Atodlen 7. O ran gosod cyfyngiadau ar werthu cynhyrchion siwgr uchel ac alcohol, gallai nifer o esemptiadau fod yn berthnasol, gan gynnwys yr esemptiad 'diogelu defnyddwyr' dan bennawd 4 a'r esemptiad 'trwyddedu' dan bennawd 12. O ran gwahardd tybaco, byddai angen ystyried pa un a fyddai'r darpariaethau'n dod o dan yr esemptiad 'safonau a diogelwch cynhyrchion' neu'r esemptiadau 'eiddo deallusol' dan bennawd 4.

Mae Adran 108(6)(c) o Ddeddf Llywodraeth Cymru 2006 yn darparu ymhellach pan fo darpariaeth yn dod o dan adran 108(4), bydd y tu allan i gymhwysedd y Cynulliad os yw'n anghydnaws â hawliau Confensiwn neu gyfraith yr Undeb Ewropeaidd. Mae'n debygol iawn y byddai unrhyw ddarpariaethau sy'n ceisio lleihau'r defnydd o gynhyrchion siwgr uchel ac alcohol yn golygu ymyrryd â meddiannau, sy'n dod dan gwmpas Erthygl 1 y Protocol Cyntaf, ac o bosibl, yn ymyrraeth â'r hawl i ryddid mynegiant y darperir ar ei gyfer gan Erthygl 10 y Confensiwn. Heb gael mwy o fanylion am y cynigion penodol, mae'n anodd asesu pa un a fyddent o fewn cymhwysedd. O ran gwaharddiad ar werthu tybaco, byddai angen rhoi ystyriaeth ofalus i ba un a fyddai unrhyw ddarpariaethau'n mynd yn groes i'r egwyddor symud nwyddau yn rhydd, yn benodol, y ffaith fod gwahardd cyfyngiadau a mesurau meintiol yn cael yr un effaith â chyfyngiadau o'r fath yn Erthygl 34 y Cytuniad ar Weithrediad yr Undeb Ewropeaidd.

Ar wahân i broblemau cymhwysedd, byddai angen i unrhyw welliannau sy'n cael eu hawgrymu i Fil Iechyd y Cyhoedd (Cymru) gydymffurfio â Gorchymyn Sefydlog 26.61.

Manylion am gymorth meddygol a geisir o ganlyniad i gael unrhyw un o'r triniaethau arbennig a gynhwysir yn y Bil, gan gynnwys y gost o ddarparu triniaeth

Mae'r dystiolaeth sydd ar gael yn awgrymu mai'r rhan fwyaf o gymhlethdodau sy'n gysylltiedig â thriniaethau arbennig yw heintiau y croen, ond gall amrywiaeth o gymhlethdodau o ddifrifoldeb amrywiol godi. Nid yw systemau casglu data presennol y GIG yn darparu gwybodaeth am nifer y bobl y mae angen cymorth meddygol arnynt oherwydd cymhlethdodau o'r fath, ac o ganlyniad, nid yw Llywodraeth Cymru mewn sefyllfa i ddarparu'r data y gofynnwyd amdano.

Mae pob un o'r pedair triniaeth a gynhwysir yn y Bil yn ymwneud â thyllu drwy'r croen, ac felly maent yn achosi risg posibl i iechyd os gwneir hyn mewn modd anhylan. O ganlyniad, rwyf yn fodlon fod rheoleiddio cymesur o'r triniaethau hyn yn briodol, er mwyn amddiffyn y cyhoedd yn effeithiol rhag y posibilrwydd o niwed.

I ddangos y math o niweidiau a all gael eu hachosi, a'u heffaith ar y GIG, canfu astudiaeth yn Lloegr yr adroddwyd am gymhlethdodau ynghylch 27.5% o driniaethau tyllu'r corff, a phroblemau digon difrifol i chwilio am gymorth ychwanegol mewn 12.9% o achosion. Ymysg pobl ifanc 16-24 mlwydd oed, arweiniodd 5.1% o'r triniaethau tyllu'r corff at ofyn am gymorth gan fferyllydd, 3% gan Feddyg Teulu, a 0.6% gan adran Damweiniau ac Achosion Brys, ac roedd angen i 0.9% gael eu derbyn i'r ysbyty. Er nad ydym ni wedi canfod data cyffelyb ar gyfer y triniaethau arbennig eraill, mae tystiolaeth o Unol Daleithiau America, er enghraifft, yn awgrymu cyfradd cymhlethdodau o 2-3% ar gyfer tatŵs. Darperir mwy o wybodaeth ym mharagraffau 541-556 o Femorandwm Esboniadol y Bil.

Fel y gŵyr y Pwyllgor, rydym ni hefyd wedi dod i wybod am achosion penodol, diweddar o niwed yn cael ei achosi yng Nghymru oherwydd arfer gwael. Anfonwyd naw unigolyn i'r ysbyty ac roedd angen llawdriniaeth arnynt a oedd yn ymwneud â'r haint pseudomonas yn dilyn tyllu'r cyrff a gafodd ei gynnal mewn un sefydliad yng Nghasnewydd. Fel yr eglurodd Dr Gill Richardson yn ei thystiolaeth i'r Pwyllgor ar 9 Gorffennaf 2015, bydd y digwyddiad hwn wedi costio oddeutu £0.25 miliwn i Fwrdd Iechyd Prifysgol Aneurin Bevan, Iechyd Cyhoeddus Cymru a'r awdurdod lleol.

Tystiolaeth fod y rhan fwyaf o ddefnyddwyr e-sigaréts hefyd yn defnyddio sigaréts tybaco confensiynol

Mae'r rhan fwyaf o'r defnyddwyr e-sigaréts yn "ddefnyddwyr deuol" sy'n parhau i ysmygu cynhyrchion tybaco confensiynol. Mae amrywiol awgrymiadau wedi eu gwneud ynghylch cyfran debygol ysmygwyr deuol, sef o dair rhan o bump o'r holl ddefnyddwyr sy'n oedolion yn 2015, yn ôl arolwg gan ASH UK,[1] hyd at 85% o'r holl ddefnyddwyr, yn ôl y Smoking Toolkit Study[2]. Ceir mwy o fanylion am yr astudiaethau hyn isod:

[1] ASH factsheet 33: Use of electronic cigarettes in Great Britain. May 2015
http://www.ash.org.uk/information/facts-and-stats/fact-sheets
[2] Smoking Toolkit Study. Trends in electronic cigarette use in England. Updated 23rd April 2015
http://www.smokinginengland.info/latest-statistics/

ASH factsheet 33: Use of electronic cigarettes in Great Britain. April 2014 and 20 October 2014, ar gael yn http://www.ash.org.uk/information/facts-and-stats/fact-sheets: Roedd y canfyddiadau'n cynnwys:-

- Mae amcangyfrif o 2.1 miliwn o oedolion ym Mhrydain Fawr yn defnyddio e-sigaréts ar hyn o bryd; ac
- Mae oddeutu traean o'r defnyddwyr yn gyn-ysmygwyr, ac mae dwy ran o dair yn ysmygu ar hyn o bryd.

Cyfanswm maint y sampl oedd 12,269, a gwnaed y gwaith maes rhwng 5 a 14 Mawrth 2014. Cynhaliwyd yr holl arolygon ar-lein. Hon yw'r ffynhonnell a ddefnyddiwyd yn yr Asesiad o Effaith Rheoleiddio ar gyfer Bil Iechyd y Cyhoedd (Cymru), a gymesurwyd ar gyfer Cymru.

ASH factsheet 33: Use of electronic cigarettes (vapourisers) among adults in Great Britain. May 2015 – ar gael yn http://www.ash.org.uk/information/facts-and-stats/fact-sheets. Roedd y canfyddiadau'n cynnwys:

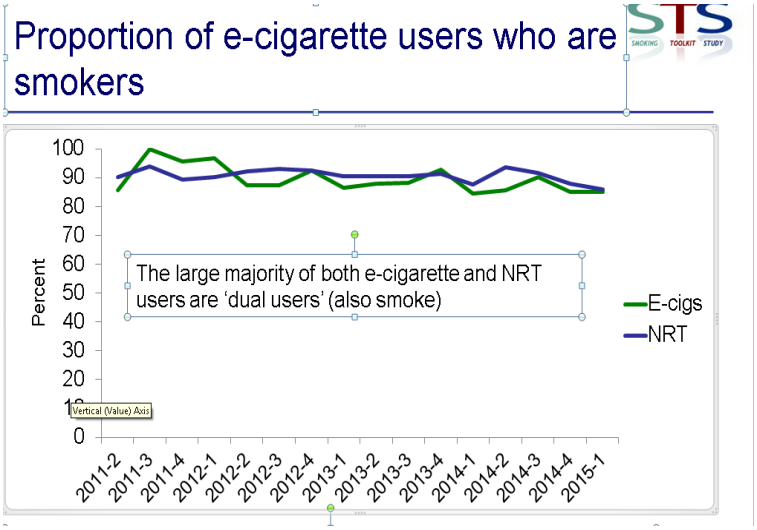
- Mae amcangyfrif o 2.6 miliwn o oedolion ym Mhrydain Fawr yn defnyddio e-sigaréts ar hyn o bryd; ac
- Mae bron i ddau allan o bump o'r defnyddwyr yn gyn-ysmygwyr, ac mae tri allan o bump yn ysmygwyr ar hyn o bryd.

Cyfanswm maint y sampl ar gyfer yr astudiaeth hon oedd 12,055, a gwnaed y gwaith maes rhwng 26 Chwefror a 12 Mawrth 2015. Cynhaliwyd yr holl arolygon ar-lein.

Smoking Toolkit Study. Trends in electronic cigarette use in England. Updated 23 April 2015 – ar gael yn http://www.smokinginengland.info/latest-statistics/

Roedd yr astudiaeth hon yn ymwneud ag arolygon misol o aelwydydd, gyda sampl gynrychiadol newydd bob mis o oddeutu 1,800 o ymatebwyr ac oddeutu 450 ohonynt yn ysmygwyr.

Dangosir y canfyddiadau yn y graff isod.



Nid oedd data 2015 ASH ar gael ar adeg paratoi yr Asesiad o Effaith Rheoleiddio ar gyfer y Bil. O ganlyniad, defnyddiwyd data 2014 ASH yn yr Asesiad o Effaith Rheoleiddio, er mwyn inni allu gwneud ein hasesiad cyfredol gorau o gostau a manteision, gan eu bod yn darparu amcangyfrif o nifer presennol yr oedolion sy'n defnyddio e-sigaréts ym Mhrydain Fawr, yn ogystal â'r gyfran o ddefnyddwyr e-sigaréts sy'n parhau i ysmygu ar hyn o bryd (y 'defnyddwyr deuol', fel y'u gelwir). Adolygir yr Asesiad o Effaith Rheoleiddio yn ystod Cyfnod 2 o broses y Bil, ac ystyrir ailedrych ar y costau a manteision ar sail y dystiolaeth a data newydd fydd ar gael ar adeg yr adolygiad.

Trwy ddefnyddio data 2014 ASH, amcangyfrifir bod oddeutu 100,800 o ddefnyddwyr e-sigaréts yng Nghymru, a bod dwy ran o dair o'r defnyddwyr e-sigaréts yn eu defnyddio ochr yn ochr â chynhyrchion tybaco. Mae "defnyddwyr deuol" o'r fath yn parhau i wneud eu hunain yn agored i'r niweidiau iechyd a geir wrth ysmygu tybaco[3], a allai fod â goblygiadau negyddol i unigolion ac i iechyd y cyhoedd. Mae parhau i ysmygu unrhyw sigaréts confensiynol yn achosi'r risg gardiofasgwlaidd lawn yn y pen draw, ac efallai mai dim ond effaith gymedrol a fyddai ar y risg o ganser, oherwydd bod hyd y cyfnod ysmygu yn bwysicach na'r dwyster.[4] Mae NICE yn dangos y gallai fod rhai manteision lleihau niwed o ddefnyddio llai o dybaco os nad yw rhoi'r gorau iddi yn ddewis[5].

Yn seiliedig ar yr union ffynonellau hyn, nododd Iechyd y Cyhoedd Lloegr yn ei adroddiad 2015 fod oddeutu dwy ran o dair o ddefnyddwyr e-sigaréts hefyd yn ysmygu. O dderbyn y ffigur hwn, mae'n awgrymu bod angen data ar dafl-lwybr naturiol 'defnydd deuol', hynny yw, pa un a yw defnydd deuol yn fwy tebygol o arwain at roi'r gorau i ysmygu yn ddiweddarach ynteu at ddal ati i ysmygu.[6]

[3] http://www.nhs.uk/chq/Pages/2344.aspx?CategoryID=53
[4] Background Paper on E-cigarettes (Electronic Nicotine Delivery Systems). Rachel Grana, PhD MPH; Neal Benowitz, MD; Stanton A. Glantz, PhD. Center for Tobacco Control Research and Education University of California, San Francisco WHO Collaborating Center on Tobacco Control. Prepared for World Health Organization Tobacco Free Initiative December 2013.
[5] https://www.nice.org.uk/guidance/ph45
[6] E-cigarettes: an evidence update: A report commissioned by Public Health England. Public Health England. August 2015

Defnyddio e-sigaréts fel dull o roi'r gorau i ysmygu o'i gymharu â dewisiadau eraill

Er bod llawer o ysmygwyr yn rhoi'r gorau iddi heb droi at wasanaethau a chynhyrchion rhoi'r gorau i ysmygu, cydnabyddir y gall cynhyrchion nicotin wneud cyfraniad pwysig i gynorthwyo ysmygwyr i roi'r gorau iddi'n gyfan gwbl, neu i leihau eu defnydd o gynhyrchion tybaco.
Mae cynhyrchion tybaco yn cynnwys ffurfiau traddodiadol ar therapi disodli nicotin (NRT) trwyddedig, megis patsys nicotin, gymiau a losenni nicotin. Mae tystiolaeth ar gael i awgrymu nad yw'r defnydd tymor hir o NRT ar y cyd ag ysmygu yn cael ei gysylltu ag achosion cynyddol o niwed, gan gynnwys problemau cardiofasgwlaidd neu ganser, yn ôl y dadansoddiad diweddaraf o'r canlyniadau 12.5 mlynedd o ddechrau'r astudiaeth[7].

Nid yw effeithiau iechyd tymor hir y defnydd o e-sigaréts wedi eu profi hyd yma[8].
Mae'r dystiolaeth gryfaf yn dod o Adolygiad Cochrane[9] o 13 o astudiaethau a gwblhawyd ynghylch rhoi'r gorau i ysmygu, a gyhoeddwyd ym mis Rhagfyr 2014. Nodwyd yn yr adolygiad hwn bod peth tystiolaeth ar gael o ddau arbrawf fod e-sigaréts sy'n cynnwys nicotin yn cynorthwyo ysmygwyr i roi'r gorau i ysmygu yn y tymor hir neu'n lleihau'r nifer a ysmygir, o'u cymharu ag e-sigaréts nad ydynt yn cynnwys nicotin. Fodd bynnag, daeth adolygwyr Cochrane i'r casgliad fod ansawdd y dystiolaeth yn isel ar y cyfan oherwydd ei bod wedi ei seilio ar nifer bychan o astudiaethau. Canfu'r un astudiaeth[10] a oedd yn cymharu e-sigaréts â phatsys nicotin nad oedd unrhyw wahaniaeth sylweddol yn y cyfraddau ymwrthod dros chwe mis. Er hynny nododd yr awduron nad oedd digon o rym ystadegol i'r astudiaeth, ac felly ni ellir diystyru gwahaniaeth clinigol pwysig.

Mae Memorandwm Esboniadol y Bil yn rhoi manylion am rai astudiaethau perthnasol, ac rydym yn parhau i fonitro'r deunydd darllen. Rydym yn ymwybodol o astudiaethau a dadansoddiadau mwy diweddar, er enghraifft, astudiaeth sy'n dangos bod y defnydd dyddiol o e-sigaréts ac ysmygu ar y cyd yn gysylltiedig â chynnydd yn yr ymdrechion i roi'r gorau i ysmygu a lleihau'r nifer o sigaréts a ysmygir, ond nid â rhoi'r gorau iddi. Fodd bynnag, canfu yr un astudiaeth nad yw'n ymddangos bod peidio â defnyddio e-sigaréts bob dydd, a pharhau i ysmygu, yn cynyddu'r ymdrechion i roi'r gorau i ysmygu, nac yn lleihau'r nifer a ysmygir[11]. Roedd dogfen ddiweddar arall, a oedd yn edrych ar 11 o astudiaethau cyhoeddedig, yn awgrymu bod ysmygwyr sy'n defnyddio e-sigaréts oddeutu 30% llai tebygol o roi'r gorau i ysmygu nag ysmygwyr nad ydynt yn defnyddio e-sigaréts[12].

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[7] https://www.nice.org.uk/guidance/PH45/chapter/9-The-evidence
[8] Pisinger Charlotta, Døssing Martin, A systematic review of health effects of electronic cigarettes, *Preventive Medicine* (2014), doi:10.1016/j.ypmed.2014.10.009
[9] Electronic cigarettes for smoking cessation and reduction (Review). 2014. The Cochrane Collaboration. Published by John Wiley & Sons, Ltd. Ar gael yn: http://www.cochrane.org/features/new-cochrane-evidence-shows-electronic-cigarettes-facilitate-smoking-cessation
[10] Bullen C, Howe C, La ugesen M, McRobbie H, Parag V, Williman J, et al.Electronic cigarettes for smoking cessation:a randomised controlled trial. Lancet 2013;382(9905):1629–37.

[11] Is the use of electronic cigarettes while smoking associated with smoking cessation attempts, cessation and reduced cigarette consumption? A survey with a 1-year follow-up. Leonie S. Brose, Sara C. Hitchman, Jamie Brown, Robert West and Ann McNeill. Addiction Volume 110, Issue 7, pages 1160–1168, July 2015
[12] https://tobacco.ucsf.edu/meta-analysis-all-available-population-studies-continues-show-smokers-who-use-e-cigs-less-likely-quit-smoking March 2015

Mae llawer iawn wedi ei ddysgu ar draws y DU am ddarparu cymorth effeithiol ar gyfer rhoi'r gorau i ysmygu ers cyflwyno gwasanaethau arbenigol yn 2000. Edrychodd astudiaeth o ddata gan wasanaethau rhoi'r gorau i ysmygu arbenigol yn Lloegr[13] ar 126,890 o gyfnodau triniaeth mewn 24 o wasanaethau rhoi'r gorau i ysmygu yn 2009/10 er mwyn asesu'r cysylltiad rhwng nodweddion ymyrraeth a chyfraddau llwyddiant. Roedd amrywiaeth sylweddol mewn cyfraddau llwyddiant ar draws nodweddion ymyrraeth ar ôl addasu ar gyfer nodweddion ysmygwyr:

- Roedd NRT a ddefnyddiwyd ar ei ben ei hun yn gysylltiedig â chyfraddau llwyddiant uwch na dim triniaeth o gwbl;
- Roedd NRT, ar y cyd â Varenicline (meddyginiaeth presgripsiwn a ddefnyddir i drin caethiwed i nicotin), yn fwy llwyddiannus na defnyddio NRT ar ei ben ei hun;
- Roedd cymorth grŵp yn gysylltiedig â chyfraddau llwyddiant uwch na chymorth un i un;
- Roedd lleoliadau gofal sylfaenol (megis meddygfeydd ac ysbytai) yn llai llwyddiannus na chlinigau arbenigol.

Dywedir yn aml bod ysmygwyr hyd at bedair gwaith yn fwy tebygol o lwyddo i roi'r gorau i ysmygu trwy gael cymorth gan wasanaethau rhoi'r gorau i ysmygu. Daw tystiolaeth i ategu'r datganiad hwn o astudiaethau a ganfu'r canlynol:

- Wrth gymharu mathau cyfatebol o ysmygwyr, oddeutu tri neu bedwar y cant yw cyfradd llwyddiant y rhai hynny sy'n rhoi'r gorau iddi heb unrhyw gymorth[14];
- Canfu un astudiaeth fawr yn Lloegr fod cyfraddau rhoi'r gorau i ysmygu a ddilyswyd trwy brawf anadl ar ôl 12 mis yn 15 y cant ar gyfer gwasanaethau rhoi'r gorau i ysmygu, ac yn 20 y cant ar gyfer gwasanaethau arbenigol[15].

Yng Nghymru, cynorthwyir ysmygwyr i roi'r gorau i ysmygu trwy amrywiaeth o wasanaethau, gan gynnwys gwasanaeth Dim Smygu Cymru a darpariaeth gynyddol o wasanaethau rhoi'r gorau i ysmygu mewn fferyllfeydd cymunedol. Yn ddiweddar, dywedodd Dr Julie Bishop, cyfarwyddwr gwella iechyd ar gyfer Iechyd Cyhoeddus Cymru, fod Dim Smygu Cymru eisoes wedi dechrau gweithio i sicrhau bod ysmygwyr sy'n dewis defnyddio e-sigaréts i'w helpu i roi'r gorau i ysmygu hefyd yn gallu cael gafael ar gymorth ymddygiadol arbenigol[16].

Materion hawliau dynol ynghylch ysmygu a'r defnydd o e-sigaréts mewn anheddau preifat sydd hefyd yn weithleoedd

<u>Y gyfraith bresennol ar ysmygu mewn anheddau preifat sydd hefyd yn weithleoedd</u>

[13] Brose, West, McDermott, Fidler, & McEwan (2011). What makes for an effective stop-smoking service
[14] Hughes JR, Keely J, Naud S (2004). Shape of the relapse curve and long-term abstinence among untreated smokers. Addiction. 2004;99 29-38
[15] Ferguson J, Bauld L, Chesterman J, Judge K. (2005) The English smoking treatment services: one-year outcomes. Addiction. 100 Suppl 2:59-69.
[16] Page 4, The I newspaper 19 August 2015

Gweithredir y polisi di-fwg presennol dan Ddeddf Iechyd 2006 a Rheoliadau Mangreoedd Di-fwg etc. (Cymru) 2007 ("Rheoliadau 2007"). Mae Rheoliad 3 o Reoliadau 2007 yn cynnwys nifer o esemptiadau i ofynion di-fwg Deddf Iechyd 2006 o ran anheddau a ddefnyddir hefyd fel gweithleoedd. Sail resymegol y polisi i'r esemptiadau hyn oedd na ddylai fyth fod yn ofynnol i annedd breifat unigolyn fod yn ddi-fwg yn unig yn rhinwedd y ffaith bod unigolyn yn mynd i'r annedd i ddarparu gwasanaethau penodol ("y gwasanaethau wedi'u heithrio").

Dyma'r "gwasanaethau sydd wedi'u heithrio":

(i) darparu gofal personol neu ofal iechyd i berson sy'n byw yn yr annedd;
(ii) cynorthwyo gyda gwaith domestig yr aelwyd yn yr annedd;
(iii) cynnal strwythur neu adeiladwaith yr annedd: a
(iv) gosod, arolygu, cynnal, neu symud unrhyw wasanaeth a ddarperir i'r annedd er budd y personau sy'n byw ynddi.

Cyflawnodd Rheoliadau 2007 nod y polisi cyffredinol hwn trwy gyfuniad o ddwy ddarpariaeth:

(i) Rheoliad 3(1)(b), sy'n datgan na all rhan o annedd breifat fyth fod yn ddi-fwg heblaw ei fod yn cael ei ddefnyddio ar gyfer dibenion gwaith *yn unig* (neu os y'i rhennir gydag annedd breifat arall – Rheoliad 3(1)(a)); a
(ii) Rheoliad 3(3), sy'n datgan hyd yn oed os oes rhannau o annedd breifat a ddefnyddir ar gyfer dibenion gwaith yn unig, nid yw'n ofynnol i'r rhannau hynny fod yn ddi-fwg os yw'r gwaith yn cynnwys y gwasanaethau wedi'u heithrio yn unig.

Bydd y rhan fwyaf o'r rhannau o anheddau a ddefnyddir ar gyfer darparu gwasanaethau wedi'u heithrio yn cael eu defnyddio'n *rhannol* yn unig at y dibenion hynny. Mae Rheoliad 3(1)(b) yn datgan nad yw'n ofynnol i'r rhannau hynny fod yn ddi-fwg. Mae Rheoliad 3(3) yn sicrhau nad oes unrhyw rannau o'r annedd a ddefnyddir *yn unig* at ddibenion y gwasanaethau wedi'u heithrio yn cael eu dal trwy amryfusedd i fod yn ofynnol ddi-fwg (er enghraifft, ystafell a ddefnyddir yn unig fel man lle y mae ffisiotherapyddion yn mynd iddi i roi ffisiotherapi i breswyliwr, neu ystafell mewn annedd a ddefnyddir yn unig gan wasanaethydd domestig i gadw offer glanhau ac ati).

Mae'r sail resymegol i'r polisi o beidio â'i gwneud hi'n ofynnol fyth i ran o annedd breifat fod yn ddi-fwg dim ond oherwydd y darperir gwasanaethau wedi'u heithrio yno yn gysylltiedig â'r gofyniad i fangreoedd di-fwg fod yn ddi-fwg bob amser (hynny yw, 24 awr y dydd)[17], ac nid yn unig pan y'u defnyddir fel gweithle. Mae natur y gwasanaethau wedi'u heithrio yn golygu eu bod, fel arfer, yn cael eu darparu ar brydiau yn unig (er enghraifft, yn wythnosol, yn fisol neu'n flynyddol). Fel y cyfryw, ystyrir y byddai'n anghymesur i wneud y meddiannydd yn droseddwr pe byddai ef neu hi'n digwydd bod yn ysmygu wrth fynd heibio trwy'r rhan berthnasol o'r annedd, er gwaetha'r ffaith na fyddai'r rhan honno o'r annedd, efallai, yn cael ei defnyddio at ddibenion gwaith am, er enghraifft, chwe mis.

Yn hyn o beth, gellid gwahaniaethu rhwng y gwasanaethau wedi'u heithrio, pan nad yw meddiannydd yr annedd wedi dewis rhedeg busnes o'r cartref a'i fod ond yn derbyn mathau arbennig o wasanaethau o bryd i'w gilydd, a phan fo'r meddiannydd wedi dewis rhedeg busnes o'r cartref, a'i fod yn defnyddio rhan o'r cartref at y diben hwnnw yn unig. Yn yr olaf, gwnaed penderfyniad ymwybodol i wneud rhan o'r cartref yn weithle, ac yn

[17] Mae adran 2(2) yn darparu ei bod yn ofynnol i fangreoedd di-fwg fod yn ddi-fwg bob amser.

gyffredinol, byddai'r gweithle hwnnw'n cael ei ddefnyddio'n fwy rheolaidd nag y byddai'r gwasanaethau wedi'u heithrio yn cael eu darparu. Fel y cyfryw, ystyrir ei bod yn gymesur i'w gwneud hi'n ofynnol i rannau o anheddau, a ddefnyddir fel gweithleoedd yn unig (hynny yw, lleoedd lle y rhedir busnes oddi yno), fod yn ddi-fwg bob amser.

E-sigaréts ac anheddau preifat

Ystyrir y sefyllfa bresennol a amlinellir uchod ymhellach yng nghyd-destun Bil Iechyd y Cyhoedd (Cymru), yn enwedig o ystyried y bydd y Bil yn ei gwneud hi'n ofynnol i unrhyw rannau o anheddau a ddefnyddir yn rhannol neu'n unig fel gweithleoedd fod yn ddi-fwg, ond dim ond pan y'u defnyddir fel gweithle. Gan nad oes unrhyw esemptiadau perthnasol yn y rheoliadau a wnaed dan adran 10 y Bil, bydd adran 6 yn ei gwneud hi'n ofynnol i rannau o anheddau preifat sy'n weithleoedd fod yn ddi-fwg pan y'u defnyddir fel gweithle. Yn y cyd-destun hwn, mae 'di-fwg' yn golygu y bydd ysmygu a defnyddio dyfeisiau mewnanadlu nicotin yn cael eu gwahardd.

Wrth ddatblygu ein polisi ynghylch defnyddio dyfeisiau mewnanadlu nicotin mewn anheddau a ddefnyddir fel gweithleoedd, ystyriwyd tri dewis:

(i) caniatáu'r defnydd o ddyfeisiau mewnanadlu nicotin bob amser;
(ii) gwahardd y defnydd o ddyfeisiau mewnanadlu nicotin (ac ysmygu) bob amser; a,
(iii) gwahardd ysmygu a'r defnydd o ddyfeisiau mewnanadlu nicotin pan ddefnyddir y rhan berthnasol o'r annedd fel gweithle (h.y. yr ymagwedd a gymerwyd yn y Bil).

Wrth benderfynu ar yr ymagwedd i'w chymryd yn y Bil, ystyriwyd Erthygl 8 o Gonfensiwn Ewrop ar Hawliau Dynol yn llawn. Rwyf yn fodlon bod y Bil yn taro'r cydbwysedd cywir rhwng hawliau meddiannydd i ddefnyddio dyfeisiau mewnanadlu nicotin yn ei gartref ei hun, a'r manteision iechyd sy'n codi o ganlyniad i gyfyngu ar eu defnydd.

Mae sail y dystiolaeth dros wahardd y defnydd o ddyfeisiau mewnanadlu nicotin mewn rhannau o anheddau sy'n weithleoedd yr un fath ag ar gyfer cyfyngu ar y defnydd o ddyfeisiau mewnanadlu nicotin yn fwy cyffredinol. Ystyrir bod y defnydd o ddyfeisiau mewnanadlu nicotin yn normaleiddio ymddygiad ysmygu. Mae dyfeisiau mewnanadlu nicotin megis e-sigaréts yn dynwared yr ymdeimlad a'r ymddangosiad o ysmygu sigarét[18] ac yn darparu rhai o'r awgrymiadau ymddygiadol ychwanegol y gwyddys eu bod yn bwysig o ran bod yn ddibynnol ar dybaco gan gynnwys yr ystum 'o'r llaw i'r geg'. Yn y cyd-destun hwn, ystyrir bod manteision iechyd y cyhoedd sylweddol i'w cael o wahardd y defnydd o ddyfeisiau mewnanadlu nicotin mewn anheddau sy'n weithleoedd, yn enwedig lle y gallai plant fod yn bresennol. Dyma enghreifftiau o sefyllfaoedd gweithle o'r fath:

- gwasanaethau gwarchod plant a gynigir o annedd breifat unigolyn;
- gwasanaethau trin gwallt a gynigir o annedd breifat (h.y. pan fo pobl, gan gynnwys plant, yn dod i'r annedd i gael torri eu gwallt);
- gwersi cerdd neu iaith neu wersi preifat eraill a gynigir o annedd breifat (h.y. lle y mae pobl, yn enwedig plant, yn mynd i'r annedd breifat am wers / hyfforddiant);

[18] Public Health England. Electronic Cigarettes: A report commissioned by Public Health England. Professor John Britton and Dr Ilze Bogdanovica. UK Centre for Tobacco and Alcohol Studies Division of Epidemiology and Public Health, University of Nottingham. 2014

- gwasanaethau ffisiotherapi a ddarperir mewn annedd breifat (h.y. lle y mae pobl, gan gynnwys plant, yn mynd i'r annedd breifat i gael triniaeth ffisiotherapi); a
- gwasanaethau parti addurno teisennau cwpan i blant a ddarperir o gegin annedd breifat (h.y. y plentyn a'i ffrindiau yn mynd i'r annedd breifat ar gyfer parti pen-blwydd).

Ystyrir hefyd y bydd gwahardd y defnydd o ddyfeisiau mewnanadlu nicotin mewn rhannau o anheddau sy'n weithleoedd yn diogelu'r amgylchedd aer gwell sydd wedi deillio o Ddeddf Iechyd 2006. Mae dyfeisiau mewnanadlu nicotin yn cynnwys gwahanol gemegion sy'n cael eu hanweddu a'u rhyddhau i'r aer, ac mae astudiaethau wedi awgrymu y gall erosol e-sigarét gynnwys rhai o'r gwenwynau sy'n bresennol mewn mwg tybaco, er ar lefelau sy'n llawer is[19] [20]Eto, fy marn i yw bod gan yr ymagwedd a gymerwyd yn y Bil fanteision iechyd arbennig o ran gweithleoedd yn gyffredinol, yn enwedig y rhai hynny y mae'n debygol y bydd plant a phobl ifanc yn mynd iddynt.

Wrth ddatblygu'r polisi, rhoddwyd ystyriaeth hefyd i'r ffaith mai bach iawn fydd effaith y gwaharddiad, yn ymarferol. Yn ystod oriau gwaith yn unig y bydd y gwaharddiad ar waith, ac hyd yn oed bryd hynny, bydd gan y meddiannydd hawl i ddefnyddio dyfais mewnanadlu nicotin mewn ystafell gyfagos. I gyfeirio at yr enghraifft a roddwyd yn Atodiad A eich llythyr, ni fyddai'r gwaharddiad rhannol ar yr hawl i ddefnyddio dyfais mewnanadlu nicotin yn atal Mr A rhag gadael yr ystafell fyw i fynd, er enghraifft, i'r gegin, i ddefnyddio ei ddyfais mewnanadlu nicotin.

Hoffwn nodi hefyd y bydd y pwerau a ddarperir yn adran 10 y Bil yn caniatáu i Weinidogion Cymru lunio rheoliadau ar gyfer eithrio mangreoedd, neu ardaloedd penodol mewn mangreoedd, o'r gofyniad i fod yn ddi-fwg. Gallai unrhyw esemptiadau o'r fath fod ynghylch ysmygu a'r defnydd o ddyfeisiau mewnanadlu nicotin, ysmygu yn unig, neu'r defnydd o ddyfeisiau mewnanadlu yn unig. Rhoddir ystyriaeth i ba un a ddylid gweithredu'r pwerau hyn i ddarparu esemptiad, ynghylch dyfeisiau mewnanadlu nicotin, ar gyfer anheddau preifat sy'n fathau arbennig o weithleoedd a lle nad yw plant fyth yn bresennol.

Pwerau mynediad

Mae'r pwerau mynediad yn y Bil yn ymwneud ag awdurdodau lleol ac awdurdodau gorfodi eraill. Ni ragwelir y bydd unrhyw awdurdodau nad ydynt yn rhai cyhoeddus yn cael eu dirprwyo fel awdurdodau gorfodi. Mae awdurdodau cyhoeddus a'r Llysoedd yn ddarostyngedig i Gonfensiwn Ewrop ar Hawliau Dynol, yn unol ag adran 6 o Ddeddf Hawliau Dynol 1998.

Mae'r darpariaethau yn y Bil sy'n ymwneud â phwerau mynediad yn darparu'r diogelwch mai ond yn dilyn ystyriaeth a chymeradwyaeth o warant gan Ynad Heddwch y ceir rhoi'r pwerau ar waith. Oherwydd hynny, rwyf yn fodlon fod y pwerau mynediad i anheddau preifat gyda gwarant yn gymesur, a bod y diogelwch a gyflwynwyd, trwy i Ynad Heddwch

[19] Electronic cigarettes: review of use, content, safety, effects on smokers and potential for harm and benefit. Hajek et al. 2014. Addiction, 109, 1801-1810 doi:10.1111/add.12659

[20] Safety evaluation and risk assessment of electronic cigarettes as tobacco cigarette substitutes: a systematic review. Farsalinos and Polosa. Therapeutic Advances in Drug Safety. Apr 2014; 5(2): 67–86. doi: 10.1177/2042098614524430 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4110871/

ystyried a chymeradwyo'r warant, yn ddigonol i sicrhau nad oes unrhyw ymyrraeth ddigyfiawnhad â hawliau dynol â ddiogelir yr unigolyn.

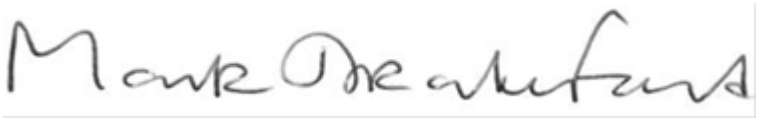
Ni ddylai Ynad Heddwch lofnodi gwarant yn awdurdodi Swyddog Awdurdodedig i ymddwyn mewn modd a fyddai'n creu ymyrraeth â hawliau dynol â ddiogelir unigolyn. Pe byddai'r Ynad Heddwch o'r farn fod angen gwneud hynny o dan yr amgylchiad unigol, caiff ef neu hi hefyd osod amodau i'r warant, megis amseriadau neu gyfyngiadau eraill.

O ran cyflwyno hysbysiad mynediad, mewn nifer o amgylchiadau, byddai hynny'n mynd yn groes i ddiben mynd i mewn i'r fangre. Pe byddai hysbysiad mynediad yn cael ei gyflwyno, gallai unigolyn guddio neu gael gwared ag unrhyw dystiolaeth neu ddogfennau a oedd yn yr annedd cyn i'r Swyddog Awdurdodedig fynd yno ar y dyddiad penodol.

Rwyf yn ymwybodol fod Adran Iechyd Llywodraeth y DU wedi cyhoeddi adroddiad ym mis Rhagfyr 2014 yn dilyn adolygiad o'r pwerau mynediad iechyd a gofal, er mwyn sicrhau eu bod yn cyflawni'r cydbwysedd cywir rhwng yr angen i barchu hawliau unigolion a'r angen i weithredu'r gyfraith ar gyfer amddiffyn iechyd y cyhoedd. Nodwyd pum deg pedwar o bwerau mynediad mewn deddfwriaeth sylfaenol ac is-ddeddfwriaeth yng ngyd-destun iechyd a gofal. Canfu'r adolygiad fod y rhan fwyaf o'r rhain yn hanfodol a chymesur. Yn unol â hynny, cadwyd pedwar deg un o bwerau mynediad. Pan gadwyd pwerau mynediad, gweithiodd yr Adran Iechyd gyda'r Swyddfa Gartref i sicrhau bod yr amddifyniadau priodol wedi eu sefydlu, a oedd yn cynnwys dewis 'ataliad hir' i gyrff geisio cael gwarant. Nid yw Llywodraeth Cymru wedi cynnal adolygiad ar wahân o bwerau mynediad.

Rwyf yn gobeithio bod y wybodaeth a ddarparwyd yn y llythyr hwn yn ateb y cwestiynau a godwyd gan aelodau o'r Pwyllgor, ac rwyf yn edrych ymlaen at ateb unrhyw gwestiynau eraill oddi wrth yr aelodau maes o law.

Yn gywir



Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol

Minister for Health and Social Services

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: LF/MD/0774/15

David Rees AM
Chair of the Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
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8 September 2015

Dear David.

Regulation and Inspection of Social Care (Wales) Bill

You will recall, during the General Principles debate on the Bill on 14 July, I confirmed that I would provide a detailed response to your Committee's Stage 1 report and its 46 recommendations. Whilst there is no strict requirement to provide a response to every single one of the recommendations, I felt it was important to answer them under the same headings that your report provided to help you understand the consideration that I have given them. My detailed response is included with this letter.

I am copying this letter to Jocelyn Davies AM, chair of the Finance Committee, as I am aware that she provided her Committee's response to you for inclusion in your report.

Best wishes,

Mark.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
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Recommendations from the Health and Social Care Committee Stage 1 Report into the Regulation and Inspection of Social Care (Wales) Bill.

I would like to thank the Committee for their support for the Regulation and Inspection of Social Care (Wales) Bill and for the detailed scrutiny of its provisions that has been undertaken. I am pleased that the Committee has recognised that this Bill takes positive steps to provide much needed accountability, transparency and stability to the social care sector in Wales. I am reassured to see that the Committee has acknowledged and welcomed a number of our proposals including those for a responsible individual and market stability reporting.

I welcome the vast majority of recommendations made by the Committee and provide further detail on each recommendation below.

General Principles and the Need for Legislation

I am grateful for the Committee's support for the general principles of the Bill

In terms of **recommendation 2**, the Committee will understand that the First Minister has indicated he will provide a response to the Flynn Review later this month. That response will cover the key policy responses to Dr Flynn's review, and I will therefore be able to provide further detail after that point. In terms of this Bill, the Committee will be aware of Dr Flynn's comments within the Executive Summary of her report, where she acknowledged the ongoing dialogue as the Bill had been developed. She noted how that dialogue had

'considered how emergent findings might be reflected: by ensuring that those who own and gain from the provision of services, that is, Board members, are held accountable; by allowing regulators to take action against a corporate body rather than a single service; and by ensuring that information about services providing care and support is accessible to individuals receiving care and to their families'

These three priority findings are, I believe, strongly reflected within this Bill. For example, the new requirements around Responsible Individuals are a significant new approach to accountability of providers in our sector. The move to a service model will allow action by the regulator at a series of levels. The new requirements about published annual reports will transform the information available to the public about care services in Wales.

In addition, Dr Flynn set what she described as an 'ambitious' list of ideas in terms of the new regulatory regime. These will be important contributors to the process of implementation and the regulations that will flow from the Bill. I will ensure that the technical groups we will establish to take forward regulations will consider how these ideas could be taken forward.

However, after reading Dr Flynn's report and considering her ideas I have decided to seek to amend the Bill in one very important way. I will be proposing an amendment on the face of the Bill that establishes in primary legislation the criteria by which we will establish whether someone is fit to register to deliver services in our sector.

I have provided additional information in response to **recommendation 3** as appendices to this letter.

I have sought further advice in response to the concerns raised by both the Committee and stakeholders in respect of amending the Bill to require all those exercising functions under the Bill to have due regard to the United Nations Conventions on the Rights of the Child, the Rights of the Disabled People and the United Nations Principles for Older Persons (**recommendation 4)**. Based on this advice I am satisfied that such an amendment is not required and I am **rejecting** this recommendation. The protection of protect vulnerable individuals' rights. This is best achieved I believe through the creation of a framework of regulation which ensures that regulators have appropriate functions at their disposal to promote and maintain high standards in the provision of social care services and, where necessary, intervene to safeguard vulnerable individuals from harm. In my view the Bill creates this framework. The Bill adopts an approach which is designed to ensure that the interests of vulnerable individuals are protected; this will occur through the imposition of detailed duties on providers of social care services, and the conferral of tailored powers upon regulators established for the purposes of safeguarding the interests of the vulnerable. The relevance of the Conventions and Principles lies in informing policy development by the Welsh Government and I am confident that that system of regulation created by the Bill has been informed by those Conventions and Principles. I would re-iterate what I said to the Committee when I gave evidence, that if the Committee is of the view that there are gaps or weaknesses in the regulatory systems established by the Bill that could be resolved by bringing forward amendments to the Bill I would be happy to consider those further.

Moving on to **recommendation 5**, I am happy to **accept** this in part and thank the Committee and stakeholders for drawing this issue to my attention. I have again sought further advice in respect of the United Nations Convention on the Rights of Disabled People and I am of the view that the obligation to provide detail in the annual report on the public sector equality duty will necessarily cover the principles contained in the Convention on the Rights of Disabled People. However, I will bring forward an amendment ensuring that duties under the United Nations Principles for Older People are reported on by the Care and Social Services Inspectorate Wales (CSSIW) in its annual report.

Engagement with the Public

I was very pleased to see the duties to engage the public within the Bill recognised by both the Committee and stakeholders. I am satisfied that the Bill as it stands sets out very clearly the Welsh Government's expectation that CSSIW and Social Care Wales (SCW) must work closely with citizens in carrying out their work. However, in acknowledgement of the views expressed by both the Committee and stakeholders I am happy to provide more detail on those expectations in response to **recommendation 6 below**. I believe very strongly that the precise ways in which the public should be involved in the work of both CSSIW and SCW should not be dictated by Government but should be developed in conjunction with the sector, stakeholders and the public.

Whilst I remain unconvinced about the need to specify the requirement for CSSIW to engage lay inspectors, I am certainly of the view that the public should play an active role in the inspection process. I will bring forward an amendment to ensure that this expectation is met. As such I am **accepting recommendation 7** and **partially accepting recommendation 9** in that the amendment will be a general requirement rather than a specific one.

CSSIW has taken significant steps forward over the past few years in improving its engagement and involvement of users, carers and citizens. I would expect this development to continue. The National Advisory Board and its developing regional presence can continue to provide a voice for citizens and to retain oversight of and challenge to the work of CSSIW. Beyond this I will expect CSSIW to develop strong community links in order to ensure that those closest to care can inform and shape its work. I expect CSSIW to take on board the important wider perspectives that those involved in the sector, and those who are not, can bring. In respect of SCW, I am firmly of the view that public involvement and engagement should extend beyond the presence of its lay-led board and the lay-led requirements this Bill establishes for workforce regulation. With its role leading improvement in our sector, Social Care Wales must stand as an exemplar as to how engagement with and involvement of citizens can make a positive difference to the outcomes for people in Wales.

I am happy to **accept recommendation 8** and agree that the Bill could be strengthened in respect of carers in certain sections and will bring forward amendments accordingly.

Accountability and Transparency

I **accept recommendation 10** in principle; I have made clear my intention to work with the sector in the development of these regulations and also my intention to consult on these regulations prior to introduction. However to add clarity I will bring forward an amendment providing more detail as to the content of the annual return on the face of the Bill. I will also bring forward an amendment specifying that the first set of regulations drafted in relation to annual returns must follow the affirmative procedure.

In **recommendation 11** the committee has asked for an outline of how the provisions relating to Responsible Individuals (RIs) apply to UK-wide or multinational organisations which provide social care services within Wales. The requirements for a RI are a central part of this Bill, they cement the link between the front line and the Boardroom. As such whilst some flexibility in the system is essential the fundamental premise of this provision must be retained i.e. those gaining from the social care sector in Wales must hold primary responsibility and accountability for the quality and safety of the care being provided. In applying these principles it is clear that the RI provisions contained within section 19 of the Bill must apply to large organisations in exactly the same way as to smaller organisations.

The prevention of unsuitable individuals providing social care services in Wales is a fundamental aspect of this Bill. I have decided, following the Flynn Review, that this is an aspect of the Bill that represents a clear opportunity to strengthen our regulatory regime by being absolutely clear about who can and who cannot register to deliver services. I therefore **accept recommendation 12 in principle** as more clarity could be added on the face of the Bill regarding the fit and proper person test that must be satisfied before registration is granted to deliver social care services in Wales. I will bring forward an amendment accordingly.

In my previous letter to the Committee I set out my intention to use the regulation making powers in sections 26 and 27 of the Bill, and the powers to issue guidance set out in section 28 of the Bill, to require providers and/or Responsible Individuals to have appropriate whistle-blowing policies and procedures in place. On this basis I am **rejecting recommendation 13** as I am reluctant to bring forward an amendment of this nature. There

are a range of other very important requirements upon which regulations and guidance could be drafted using the powers contained in sections 26, 27 and 28 of the Bill, and there is no intention to list any of these on the face of the Bill. An indicative list could have the effect of being interpreted as an exhaustive list, thus potentially limiting the extent of areas in which regulations and guidance could be brought forward. The powers in sections 26 and 27 are wide and are intended to be so. That is why the affirmative procedure has been ascribed to these powers so that the Assembly will have the opportunity to scrutinise the necessity and appropriateness of each of the requirements.

I note the Committee's **recommendation 14** and **accept** this on the basis that I will keep sections 19, 21 and 24 of the Social Services and Well-being (Wales) Act under review.

Regulated Services

Recommendation 15 refers to the placing of advocacy services as a regulated service on the face of the Bill. We discussed this issue in Committee and I have given this recommendation further thought. However, my views have not changed from those expressed previously. Although children's advocacy services are well-established my intention is not to take a piecemeal approach but to bring all advocacy services within the regulatory regime at the same time, once full and proper discussions have taken place with the entire sector. However, whilst I am **rejecting** this amendment I am happy to re-iterate my commitment that advocacy will be first in line to become a new regulated service in the first relevant tranche of regulations made under section 2(h) of the Bill.

The Committee has asked for further detail in **recommendation 16** outlining how I will monitor and assess whether the requirement to register should be extended to preventative services and innovative service delivery models emerging under the Social Services and Well-being Act 2014. I **accept** this and can advise the Committee that the relevant duties at section 15 of the 2014 Act will be commenced in April 2016. Once those provisions are commenced it will take time for such services and models to emerge. During that period I will be receiving updates and intelligence from both CSSIW and local authorities themselves. As is currently the case I will be continuing to meet CSSIW on a regular basis and to receive advice on a range of regulatory issues. There will be a continued expectation that CSSIW will advise me of any changes in the sector requiring my attention including new services requiring regulation.

Recommendation 17 concerns outlining the arrangements and support that will be put in place for social care providers during the transition to the service-based model of registration. I am happy to **accept** this recommendation. I have asked CSSIW to undertake an exercise looking into transition planning to include training requirements, dissemination of information and communication of key messages. I envisage that this planning may include the establishment of tools to assist providers during transition such as a support helpline.

The Committee raised concerns regarding how the Bill will deliver a culture of regulation and inspection in which the support and improvement strands of CSSIW's work do not compromise the delivery of robust and effective regulatory activity and enforcement and asked for further detail regarding this in **recommendation 18,** which I **accept**. I do not consider that there is a conflict of the nature described and sections 4 and 67 of the Bill specifically refer to the roles of both CSSIW and SCW being to promote and maintain high

standards. In fact the Bill will, for the first time, make adherence to quality standards a regulatory requirement and provide CSSIW with a range of strengthened enforcement powers and offences with stronger penalties. It is these factors that will ensure robust and effective regulatory activity and enforcement and the involvement of service users and lay people will provide the additional layer of scrutiny which I described in Committee.

Definition of Care

The Committee and stakeholders have expressed concerns that the definition of care in section 3 of the Bill does not take into account the definition of well-being in the 2014 Act. This is reflected in **recommendation 19** which I am **accepting** in principle. Having considered this issue further I am still of the view that the regulatory requirements imposed by section 26 of the Bill, which specifically refer to the well-being outcomes, ensure that well-being is taken into account in the Bill, and the direct correlation to the definition of well-being between both the Bill and the 2014 Act is achieved by section 187. As such I do not intend to bring forward an amendment to the Bill itself but I will be amending the Explanatory Notes for the Bill to make this clearer. I will be bringing forward an amendment to the Explanatory Notes to include examples of what we intend "care" and "support" to relate to, and these will l be along the lines of those included in the Public Services Reform (Scotland) Act 2010 which establishes a similar regime.

With reference to **recommendations 20 and 21** I have reflected further and am happy to say I **accept** both recommendations and will bring forward appropriate amendments.

Inspections

Recommendation 22, which I **accept**, refers to the Committee receiving more information on the outcomes-based inspections which will be undertaken by CSSIW and raises concerns regarding resource and capacity implications following the introduction of a new system. Representatives from CSSIW who gave evidence to Committee were clear that work on outcomes-based inspections had already commenced and so this will not be a completely new system for them or service providers. There will clearly be implications once the new system is fully operational and I anticipate that this will be examined in far more detail in the work on transition which I have asked CSSIW to undertake. Once that information is to hand I would be happy to make a statement.

Recommendations 23, 24 and 25 I **accept** and will bring forward relevant amendments. In respect of 23 and 25, I will ensure that the requirement for appropriate training for inspectors is included in the relevant code that must be prepared pursuant to section 32 and section 161A. I also **accept recommendation 26** and agree that it is essential for regulations to make clear rights and processes for re-inspections.

Power to Charge Fees

I note both the comments from Committee and stakeholders however I feel it is clear under section 185 of the Bill as drafted that the regulations to be made under section 38 relating to the charging of fees, will be subject to the affirmative procedure. I am therefore not minded to bring forward an amendment to section 38 to add that a statement of consultation will be required as the provision of information on the consultation undertaken is included in the Explanatory Memorandum that will be laid alongside the regulations as part of the current established legislative process, as such I **reject recommendation 27.**

Local Authority Social Services

I acknowledge the comments of both the Committee and stakeholders regarding the commissioning of social care services by local authorities and agree wholeheartedly that effective commissioning practices lie at the heart of the delivery of excellent social services. I agree that there is scope to clarify the role of CSSIW in this area on the face of the Bill so **accept recommendation 28** and I will bring forward an amendment to achieve this at stage 2. I am unable to extend this amendment to include local health boards (LHBs) as CSSIW's powers under this Bill do not extend to LHBs. However I do expect an increasingly integrated approach to be taken to commissioning and will look towards producing appropriate guidance.

Market Stability and Financial Sustainability

I have reflected on both the views of the Committee and stakeholders in respect of **recommendations 29, 30, 31 and 33** and am happy to **accept** all four recommendations. I will bring forward an amendment to section 62 of the Bill to make clear that an analysis of commissioning should be included in market stability reports. I cannot imagine a situation where consultation would not take place prior to the introduction of regulations, however as it is felt that this requires clarification, I will bring forward amendments to sections 55, 58 and 62 of the Bill to make clear that consultation will take place prior to the introduction of regulations under these sections. In addition, I will bring forward a further amendment to section 55 to ensure that local authorities must consult with a LHB with which it carried out a population needs assessment pursuant to section 14 of the 2014 Act.

Recommendations 32 and 35 refer to ensuring appropriate resourcing and support for both local authorities and CSSIW in the preparation of market stability reports and the oversight of the regime itself. I **accept** both recommendations and re-iterate my comments to the Committee; the Regulatory Impact Assessment prepared for the Bill identifies the resource requirements for all market oversight related work. This has been arrived at in consultation with stakeholders. In respect of **recommendation 34**, section 58 contains a regulation making power which provides flexibility should the need arise to change the criteria for those subject to market stability reporting. However it remains the case that the primary responsibility for ensuring the due diligence for contractual arrangements remains with local authorities rather than the Welsh Government.

Social Care Wales

I am happy to **accept recommendation 36**. I am reassured that the Committee found the majority of stakeholders to be broadly in favour of extended functions for Social Care Wales. I believe that combining the regulation and service improvement functions to be a logical and progressive approach which can result in shared learning and added value. This view was also endorsed in a report produced for my consideration by the Strategic Improvement Steering Group which provided advice on the establishment of Social Care Wales.

However, I am mindful of the need to put in place measures aimed at mitigating against any perceived conflict of interest that might arise as a result of combining functions. The Bill itself establishes, importantly, a new statutory role for the regulator of Registrar, ensuring there is clear accountability for the regulatory functions of Social Care Wales. I have also established a Transition to Social Care Wales Advisory Panel to develop a transition plan

for my consideration by March next year. As one of its priorities, I have asked the panel to consider governance options for Social Care Wales and specifically to explore and recommend an approach designed to mitigate against any conflict of interest. The panel, which includes stakeholders from across the sector, is currently considering this very important issue so I don't want to pre-empt any recommendations that the panel might make, however I will ensure that Members are updated on the work of this group as it develops its recommendations.

I also **accept recommendation 37** to provide further detail about why there is a need to rebrand the Care Council for Wales as Social Care Wales. The Transition to Social Care Wales Advisory Panel is also considering issues around communications and branding for Social Care Wales which I will update you on as part of my commitment to keep members informed of progress in that work.

Essentially, the case for rebranding centres around the need to convey the significance of the shift to Social Care Wales and the prominence of the service improvement function in particular. The organisation will have responsibility for demonstrating clear leadership to driving improvement across the sector. I therefore believe a modest level of rebranding to be necessary in order to raise awareness of this significant development and to ensure that Social Care Wales can successfully be positioned at the heart of change

Social Care Workforce

I have listened carefully to the range of expression and views from stakeholders and the Committee on the matter of workforce regulation. It has been a rich discussion about a key area of the Bill, given its direct impact upon public assurance. The Bill builds on the foundation of workforce regulation put in place over the last 15 years and paves the way forward for an approach that continues to strengthen the workforce and provide public assurance for the future.

I have signalled that I am in favour of strengthening public assurance in relation to domiciliary care staff and further to that, adult residential care workers. I commit to registration of the domiciliary workforce within the lifetime of the next Welsh Government. In this way I therefore accept the principle behind **recommendation 38**. However it is not viable to move immediately to registration of this workforce without significant risk to service continuity. I will therefore use the medium term to develop the workforce, and our understanding of it, to allow an effective transition to formal registration in due course. I will work with the providers of such services to ensure that the public has access to information about the workforce, its background, qualifications, training and other important information. Using the registration requirements from the service regulator, the Welsh Government will ensure that citizens will have an unprecedented understanding of the staff that are delivering care in people's homes. This will significantly enhance public assurance. But it will also be an opportunity to make a step change in the capabilities and skills of this workforce. I will use the levers at the Welsh Government's disposal, including funding, to prioritise the development of domiciliary workers. A clear and ambitious programme to support career and skill development will be put in place, as part of our wider commitment to the care workforce across health and social care.

On the matter of foster carers, the white paper opened up the question of potential registration and responses were ambivalent, acknowledging the comprehensive vetting processes already operated by local authorities and fostering agencies. Work is taking place with relevant stakeholders to develop a national approach to fostering services in Wales, as part of our wider strategy for looked after children. The aim is to set a new direction for fostering services, linked to the Social Services and Well-being (Wales) Act and this Bill. In this context, I **accept recommendation 39** to explore the potential benefits of applying registration to foster carers.

The Committee also recommended in **recommendation 40** that I reconsider whether the Bill is flexible enough to respond to the regulatory needs of the future workforce. I **accept** this recommendation and have given this matter further consideration. I have reached the conclusion that the Bill upholds the key principles of rigorous lay-led regulation whilst at the same time enabling flexibility of process through regulations and then rules determined by Social Care Wales.

It is vital that the Bill provides clarity to the sector on the relevance of the various provisions to the different elements of the workforce. The committee recommended that I ensure that the terminology used in the Bill achieves this. I **accept recommendation 41** and have looked again at the language of the Bill. I am of the view that the Bill, in following the well-established approach of the Care Standards Act, is already sufficiently clear in how it applies to the social care workforce, including how it relates to the various professions who make a valuable contribution to it. I think it is understood by those working in the sector and moving away from this approach could cause confusion. In order to provide an additional safeguard against any misinterpretation of the Bill, I have asked my officials to look again at the Explanatory Notes to see if they can be further developed to provide greater clarity. I will also ensure that the implementation of the Bill is supported by awareness raising events and publicity material to ensure that all of those affected have a clear understanding of its implications.

Regulation will also be strengthened by relevant bodies and regulators co-operating with each other to ensure coherent workforce regulation and development across sectors and jurisdictions. I therefore **accept recommendation 42 in principle**. The Bill requires Social Care Wales and CSSIW to co-operate with each other and with those relevant authorities listed in section 175. There is a strong history of positive cooperation between regulators across the UK and we are in dialogue with the UK government to explore if this can be formalised on the face of the Bill.

Part 7 of the Bill brings provides the basis for a distinct addition to workforce regulation which would have wide ranging implications for workers, employers and the public at large. In view of this, I **accept recommendation 43** that these regulations should be taken forward through full consultation with the sector and a regulatory impact assessment. I am happy to place this commitment on the face of the Bill.

Cooperation and Joint Working

On the issues of cooperation and joint working, I welcome the broad support that these provisions received. These are new and, I believe, important parts of the Bill. I note the shared view across stakeholders and the Committee that it is important to provide as much opportunity as possible for cooperation and joint working across public services, and for the

law to enable rather than limit these behaviours. The Bill therefore seeks to set out clearly and constructively the expectation and powers for such cooperation. It provides powerful new duties on regulators to share information when well-being is at risk, a provision I was pleased to see endorsed by many stakeholders including WLGA and ADSS Cymru.

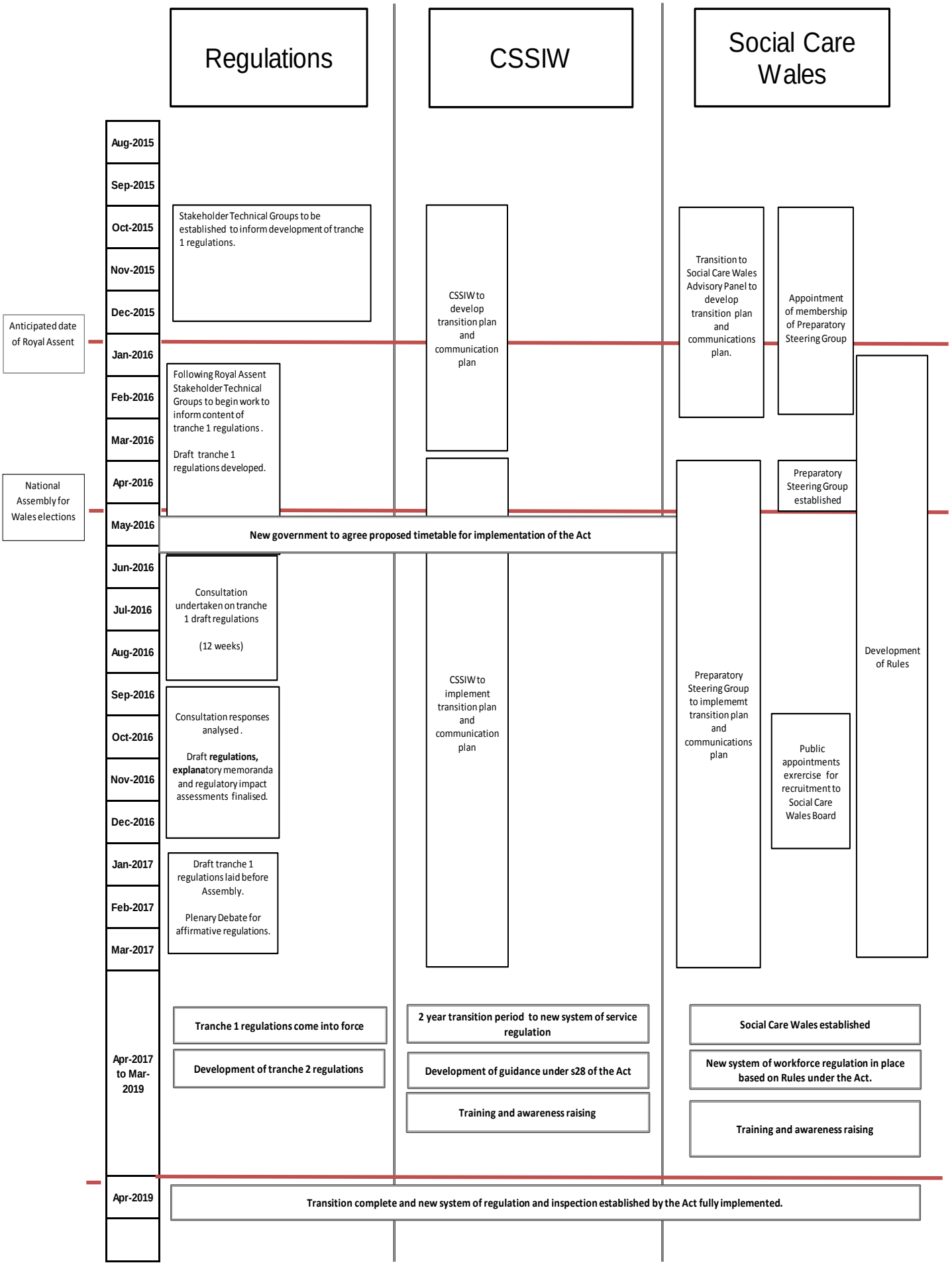
The Committee and stakeholders rightly raised the lack of non-Welsh bodies in the list of authorities in section 175 of the Bill. As I said in Committee, it is my firm intention that this list will include such bodies when it comes into force, but I have been working with officials and the UK Government to establish how that can be achieved most appropriately. In **recommendation 44**, the Committee ask me to set out the non-Welsh bodies I would intend to add to the list. Discussions are ongoing regarding this list of bodies and it would not be appropriate at this time for me to pre-empt the outcome of those discussions by including a list of non-Welsh bodies in this response so I am **unable to accept** this recommendation at this stage.

I also **accept recommendation 45**, although as in this case, it is not always possible to guarantee such consent when it often relies on external factors and the actions of organisations outside the control of the Welsh Government.

The Committee also reported on their considerations regarding the integration of health and social care, and specifically the opportunities for joint working between the relevant regulators - HIW and CSSIW. As both of these bodies reported in their evidence to the Committee, and as I said in scrutiny, there is no legislative barrier to working together given that the functions they both carry out are on behalf of Welsh Ministers. In **recommendation 46** the Committee asks me to set out how the Bill provides a basis for joint working, and whether the Bill is suitably flexible to respond to the outcomes of the green paper on NHS Quality currently out to consultation. Again I am happy to **accept** this recommendation. The Bill sets out clear powers and duties on regulators to share information, work together and to cooperate. It allows for regulators to carry out functions, such as inspections, jointly and it allows regulators to delegate functions in some circumstances. In section 180 it establishes a powerful new duty on such regulators to share information where that is necessary or expedient to protect the well-being of an individual in Wales.

In terms of the future, the Bill sets out functions in relation to Welsh Ministers, and not structures. This means that if and / or when the regulatory landscape is changed following the current consultation, these functions will remain and will apply to the new systems. If some of these regulatory functions were to be required to be passed onto a body other than Welsh Ministers this could be achieved through the legislation that would be required by the other changes.

Appendix A – Timeline for Implementation



Appendix B – Proposed Timings of Legislation Based on Implementation Timeline

Tranche 1 (by April 2017)

Section	Description
2 (1)(h) - Regulated Services	Regulation of additional services: advocacy.
6(1)(d) & (2) – Application for Registration as a service provider	Form and content of application for registration to provide a regulated service.
9(2); 9(3)(a)(ii); 9(3)(b) – Application for variation of registration as a service provider	Form, content and time limit for application to vary registration as a service provider.
19(6) – Responsible Individuals	The specific circumstances in which an individual may be designated as a responsible individual by the Welsh Ministers.
26(1) – Regulations about regulated services	Standards & requirements to be placed upon on service providers.
27(1) - Regulations about responsible individuals	Duties of responsible individuals
29(1) – Service providers who are liquidated.	Requirement for an appointed person to notify the Welsh Ministers of their appointment
30(1) – Service providers who have died	Provision relating to a service provider who has died.
43 – Failure by service provider to comply with requirements in regulations	Offence of failing to comply with provisions of regulations made under section 26.
44 – Failure by responsible individual to comply with requirements in regulations	Offence of failing to comply with regulations made under section 27
51(b) – Penalty Notices	Detail of fixed penalty notice scheme.
78(2)(b) – Meaning of "social care worker"	Provide that persons are to be treated as social care workers.
79 (1)(b) – The register	Register maintained by SCW to include managers, children's home workers, social work students
90(1)(c) and (d) – Content of register	Information required in an entry in the register.
109(6) – List of persons removed from the register	Form and content of the list; publication; circumstances in which an entry may be removed from the list.
173(1) – Proceedings before panels	Proceedings before (a) registration appeals panels; (b) interim orders panels; and (c) fitness to practise panels.
172(5)(b) – Duty to establish panels etc.	Persons who may not be members of a panel.

Appendix B – Proposed Timings of Legislation Based on Implementation Timeline

Tranche 2 (by April 2018)

Section	Description
8(2) & 8 (3) – Annual returns	Form, content and time limit for annual return by service providers.
32/56(2) - Service Inspections	Code of practice about manner in which inspections are carried out, including the frequency of inspections.
55 – 144A of Act - Annual report by local authorities	Form and content of annual reports by local authorities.
55 – 144B of Act – Local Market Stability Reports	Form, timing and content of local market stability reports
58(1); (4) – Specifying criteria for application of market oversight regime	Criteria for determining whether, and extent to which, s60 applies to a service provider.
60(6); (7) – Assessment of financial sustainability of service provider	Obtaining appropriate information and the making of assessments.
62(1); (3) – National Market Stability Report	Timing, publication and content of the national market stability.
110(5) – Use of title 'social worker' etc.	Organisations who may maintain a 'relevant register' – *subject to changes elsewhere in the UK.*
118(4)(d) – Preliminary consideration	Persons who may not carry out preliminary consideration - *subject to changes elsewhere in the UK.*
124(5)(d) – Duty to investigate	Persons who may not carry out investigations - *subject to changes elsewhere in the UK.*

Section 28 – Guidance about regulations under sections 26 & 27 to be developed by CSSIW once regulations have been developed.

Remaining regulations will be developed by April 2019 or as and when required.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: LF/MD/0775/15

David Melding AM
Chair of the Constitutional and Legislative Affairs Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear David,

8 September 2015

Regulation and Inspection of Social Care (Wales) Bill

You will recall, during the General Principles debate on the Bill on 14 July, I confirmed that I would provide a detailed response to your Committee's Stage 1 report and its 14 recommendations. Whilst there is no strict requirement to provide a response to every single one of the recommendations, I feel that it is important to help you understand the consideration that I have given to each of them.

I am copying this letter to David Rees AM, Chair of the Health and Social Care Committee.

Best wishes,

Mark

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Recommendations from the Constitutional and Legislative Affairs Committee Stage 1 Report into the Regulation and Inspection of Social Care (Wales) Bill.

I thank the Constitutional and Legislative Affairs Committee for their detailed consideration of the Regulation and Inspection of Social Care (Wales) Bill. I have considered each of your recommendations and am responding accordingly.

Recommendations 2, 3 and 4 call for a number of amendments to be made to the Bill, I am happy to confirm that I **accept** all three recommendations and will bring forward amendments in response to all three recommendations at stage two. My response to recommendation 2 will take the form of amending a number of sections to ensure a duty to consult applies, for example to sections 35 and 38.

In respect of recommendation 3 I accept the principle of this recommendation, however I will not be bringing forward an amendment to change the procedure for regulations introduced under section 6(1)(d) of the Bill. I will however bring forward amendments to put more detail directly on the face of the Bill regarding the fitness test to provide services and be nominated as a Responsible Individual. I believe this goes beyond the intention for this recommendation so trust the Committee will be satisfied by this approach.

I will bring forward an amendment to put extra detail regarding the content of the annual return directly on the face of the Bill, this will set out some of the standard information that will be required. I will also propose amendments to the Bill at stage two so that the first set of regulations drafted under this section will be subject to the affirmative procedure.

As previously indicated I have considered **recommendation 5** in further detail, I remain of the view that it would not be helpful to list on the face of the Bill some of the potential circumstances in which Welsh Ministers may designate a Responsible Individual. Such an amendment would not in my view enhance the Bill and could instead have the unintended consequence of the list being interpreted as exhaustive and tie the hands of Welsh Ministers in dealing with unlisted and unexpected circumstances. On this basis I am **rejecting** this recommendation.

I have reviewed sections 26-30 of this Bill in response to **recommendation 6** and noted the views of the Committee but am of the view that there is inherent risk in placing further detail on the face of the Bill. I intend the power to be wide so that the things that providers may be required to do may be many and varied. The Assembly will have the opportunity to review the appropriateness of each of the requirements that may be imposed via the affirmative procedure. There is further detail in the Explanatory Notes which accompany the Bill. I am happy to commit to review that information to see if additional detail can be provided, however I am **rejecting** this amendment.

Recommendations 7, 8, 9 and 10 call for amendments to be made to the Bill to apply the super affirmative procedure to a number of sections of the Bill relating to ratings, offences, penalty notices and financial sustainability. I am happy to accept the principle behind the recommendations, which would require a 12 week consultation on the draft regulations themselves with a statement from the Minister regarding the consultation and detailing what the regulations change. I will give effect to this recommendation by making amendments to the Explanatory Notes detailing that it would be our intention to follow the procedure set out

in section 33 of the Social Services and Well-being (Wales) Act 2014 for substantive regulations.

The committee recommended in **recommendation 11** that the affirmative procedure is applied to section 110(5) relating to protection of title. Protecting titles of social care workers is a significant regulatory intervention and because of this I have already considered that the affirmative procedure should apply to section 110(2) where the titles of other social care workers, in addition to social workers are protected. However, I am not of the view that the affirmative procedure is needed in relation to section 110(5) as this will only need to be used if there are changes to those relevant regulators listed in subsection (4). Such changes will only be made to keep the Bill up to date. The regulation making power will not therefore substantially affect the provisions of the Bill. I am therefore **rejecting** this recommendation.

Recommendation 12 calls for an amendment to the Bill to apply the affirmative procedure to the making of regulations under section 124(5)(d). The Committee's report refers to the fact that this is because section 124 relates to the right to a fair trial under the European Convention on Human Rights and this could therefore potentially be compromised by the composition of a fitness to practise panel. Section 124(5) deals with those persons who are precluded from carrying out an investigation. Provision in relation to the composition of the panel adjudication decisions is set out in section 172. This is to ensure that there is a separation between those carrying out investigations into a person's fitness to practise and those adjudicating on those issues. The regulation making power in section 125(5)(d) enables persons to be added to that list of persons who cannot carry out an investigation. It does not allow the Welsh Ministers to 'take away' from that list. Therefore the separation between investigation and adjudication required by Article 6 of the European Convention on Human Rights will always be maintained irrespective of whether regulations are made or not. As such, this detail is relatively minor in the overall legislative scheme and I am concerned that applying the affirmative procedure in line with **recommendation 12** would tie up National Assembly and Government resources. I am therefore **rejecting** this recommendation.

The power in section 135(2) is included in order to enable the lists of persons to whom Social Care Wales is required to disclose details of undertakings agreed with a registered person to be kept up to date and adjusted if the key organisations or structures within social care change. The disclosure of undertakings is a significant feature of public protection and as such, it is important that the list of persons to whom disclosure must be made is carefully and thoroughly considered. I therefore **accept** the **recommendation 13** that these regulations should be subject to the affirmative procedure.

Recommendation 14 calls for an amendment to apply the negative procedure commencement orders that include transitory, transitional or saving provisions in accordance with section 254(3). I am **rejecting** this recommendation as the making of commencement orders is not normally subject to any procedure, as they bring into force what the National Assembly has already approved, I see no reason to therefore deviate from the current convention in relation to commencement orders.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf: LF/MD/0600/15

David Rees AC
Cadeirydd
Pwyllgor Iechyd a Gofal Cymdeithasol
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
Caerdydd
CF99 1NA

17 Gorffennaf 2015

Annwyl David,

Bil Lefelau Diogel Staff Nyrsio (Cymru)

Yn fy llythyr atoch ar 25 Mehefin ynglŷn â'r Bil Lefelau Diogel Staff Nyrsio (Cymru), mynegais fy mwriad i gyflwyno gwelliannau Llywodraeth Cymru cyn toriad yr haf.

Llythyraf atoch er mwyn rhoi gwybod am y cynnydd. Gwneir gwaith pellach ar y gwelliannau ac rwy'n parhau i weithio gyda'r Aelod sy'n Gyfrifol.

Cyflwynir y gwelliannau cyn diwedd toriad yr haf.

Parhaf i roi gwybod ichi am y cynnydd.

Mark Drakeford

Mark Drakeford AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/2115/15

David Rees AC
Cadeirydd, Pwyllgor Iechyd a Gofal Cymdeithasol

17 Gorffennaf 2015

Annwyl David,

Diolch i chi am eich llythyr dyddiedig 24 Mehefin 2015 yn gofyn cyfres o gwestiynau yn dilyn fy ymddangosiad yn eich Pwyllgor ar 17 Mehefin. Ceir atebion i bob cwestiwn isod.

Manylion y dyraniadau ychwanegol o £6.8 miliwn ar gyfer perfformiad gofal wedi'i gynllunio a £6.8 miliwn ar gyfer pwysau'r gaeaf ar Fyrddau Iechyd a ddarparwyd yn ystod 2014-15 (manylion a amlinellwyd ym mharagraff 8 o'ch papur ysgrifenedig), fesul bwrdd unigol.

Gwelir manylion y dyraniadau pwysau'r gaeaf ychwanegol gan bob sefydliad yn y GIG yn y tabl isod:

Bwrdd Iechyd Lleol	**Pwysau'r gaeaf ar YGAC**	**Pwysau'r gaeaf ar Ofal Heb Ei Drefnu**	**Pwysau'r gaeaf - gofal wedi'i gynllunio a gollwyd**	**Cyfanswm**
	£m	**£m**	**£m**	**£m**
BI Aneurin Bevan		0.5	0.4	0.9
BI Abertawe BM		3.4	0.4	3.8
BI Betsi Cadwaladr		0.0	3.0	3.0
BI Caerdydd a'r Fro		0.0	1.1	1.1
BI Cwm Taf		2.9	0.5	3.5
BI Hywel Dda		0.0	0.9	0.9
BI Powys		0.0	0.4	0.4
YGAC	8.0			8.0
Cyfanswm	**8.0**	**6.8**	**6.8**	**21.6**

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Manylion cynnwys cyffredinol y cyllidebau gofal sylfaenol ac eilaidd, i gynnwys gwybodaeth am:

- **y dyraniadau i ofal sylfaenol ac eilaidd yn 2014-15;**

Mae'r tabl isod yn manylu ar y dyraniadau ar ffurf adnoddau refeniw a roddwyd i Fyrddau Iechyd Lleol yng Nghymru ar gyfer 2014-15.

Dyraniadau Adnoddau Refeniw 2014-15	**£m**
Gwasanaethau Meddygol Cyffredinol	469.1
Gwasanaethau Deintyddol Cyffredinol	143.7
Gwasanaethau Fferyllol	158.9
Gwasanaethau Ysbytai a Gofal Iechyd Cymunedol	4,856.5
	5,628.2

Sail y cyfrif - deillio o rannu cyfyngiadau adnoddau terfynol i Fyrddau Iechyd ar gyfer 2014-15, yn unol â Chofnodion Cyllid Grŵp Cefnogi'r System Iechyd

Dylai'r Pwyllgor nodi y bydd y "dyraniadau adnoddau" uchod yn eithrio cyllid arall sy'n cael ei ddarparu i Fyrddau Iechyd Lleol neu i gyrff allanol at bwrpas gofal sylfaenol neu eilaidd a reolir drwy gyllidebau iechyd canolog heb eu dirprwyo i sefydliadau'r GIG. Bydd y rhain yn cynnwys gwasanaethau a gaiff eu had-dalu naill ai ar sail costau gwirioneddol, er enghraifft, gwasanaethau offthalmig, prosiectau a gyllidir drwy grantiau a chyllidebau ar gyfer addysg a chyllidebau hyfforddi staff y GIG.

Dylid nodi hefyd bod dyraniad y Gwasanaethau Ysbytai ac Iechyd Cymunedol o £4,856.5 miliwn yn cynnwys cyllid ar gyfer darparu rhai gwasanaethau gofal sylfaenol penodol nad ydynt yn cael dyraniadau adnoddau gofal sylfaenol ar wahân. Ymhlith yr enghreifftiau mae cyffuriau a chyfarpar gofal sylfaenol a roddir ar bresgripsiwn.

- **cyfran y gorwariant yn 2014-15 y gellid ei briodoli i ofal sylfaenol a hefyd gofal eilaidd; a**

Nid wyf yn cofio'r cwestiwn hwn yn cael ei ofyn yn y pwyllgor ac nid yw'n rhywbeth y gellir ei nodi'n rhwydd am y rhesymau a nodir uchod. Yn gyffredinol, mae byrddau iechyd yn gyfrifol am ddarparu gwasanaethau gofal sylfaenol ac eilaidd. Ceir monitro ac adrodd yn ôl ar berfformiad ar lefel gyffredinol ac nid ar wahân ar draws y penawdau gofal sylfaenol ac eilaidd.

Byddai unrhyw gyfrif i rannu'r uchod ar lefel genedlaethol yn galw am lefel o ddyrannu yn lleol ac yn genedlaethol; rhannu cyllidebau canolog a chyfateb gwybodaeth rhwng dyraniadau a'r cyfrifon a gyhoeddwyd er mwyn ceisio adnabod y gwahanol amrywiaethau. Nid wyf wedi gofyn i swyddogion gyfrif hwn am yn ol oherwydd byddai'n rhaid rhybuddio ynghylch anwadalrwydd y ffigurau am y rhesymau a nodwyd uchod.

- **y cynnydd/gostyngiad mewn cyllidebau gofal sylfaenol ac eilaidd ar gyfer pob un o'r pum mlynedd diwethaf, yn enwedig fel cyfran o'r gyllideb adrannol gyffredinol.**

Mae'r tabl isod yn manylu ar y dyraniadau adnoddau refeniw a ddarparwyd i Fyrddau Iechyd Lleol yng Nghymru ar gyfer 2010-11 i 2014-15, a'r cynnydd canran dros y cyfnod o bum mlynedd.

	2010-11	2011-12	2012-13	2013-14	2014-15	Cynnydd canran yn ystod y 5 mlynedd
	£m	£m	£m	£m	£m	%
Dyraniadau Gofal Sylfaenol	729	740	754	766	772	5.9%
Dyraniadau Gwasanaethau Ysbytai ac Iechyd Cymunedol	4,624	4,740	4,768	4,672	4,856	5.0%
Cyfanswm	**5,353**	**5,480**	**5,522**	**5,438**	**5,628**	**5.2%**

**O 2011-12 ymlaen, cafodd y dyraniad blynyddol ar gyfer presgripsiynau ei drosglwyddo i ddyraniad y Gwasanaethau Ysbytai ac Iechyd Cymunedol, mae 2010-11 wedi cael ei ailgyflwyno ar sail gyson er mwyn darparu cymhariaeth.*
Sail y cyfrif - deillio o rannu cyfyngiadau adnoddau terfynol i Fyrddau Iechyd ar gyfer pob blwyddyn, yn unol â Chofnodion Cyllid Grŵp Cefnogi'r System Iechyd

Esbonio'r dyddiad pryd cafodd byrddau iechyd yng Nghymru wybod na fyddai'n rhaid ad-dalu gorwariant a chyllid broceriaeth a ddarparwyd ar ddiwedd 2013-14 cyn i Ddeddf Cyllid y Gwasanaeth Iechyd Gwladol (Cymru) 2014 ddod i rym.

Rwyf yn siŵr y bydd y pwyllgor yn deall nad yw perfformiad alldro'r GIG bob blwyddyn yn derfynol nes bod yr holl gyfrifon terfynol, gan gynnwys cyfrifon cryno'r GIG, wedi'u cyflwyno ger bron yr Archwilydd Cyffredinol yn y Cynulliad. Roedd hyn ym mis Gorffennaf 2014 ar gyfer blwyddyn ariannol 2013/14. Daeth gofynion newydd Deddf Cyllid y GIG (Cymru) 2014 i rym cyn cwblhau alldro 2013/14 h.y. mis Ebrill 2014.

Yn fy natganiadau ysgrifenedig ym misoedd Mai a Mehefin 2014, ar gyfer y trefniadau cynllunio newydd a gyflwynwyd ar y 1af Ebrill, esboniais yn glir bod y drefn newydd yn arwydd o newid sylweddol mewn trefniadau rheoli ariannol. Fel rhan o'r trefniadau newydd, roeddwn yn glir na fyddem yn dal ati i ddarparu cyllid ychwanegol i sefydliadau oedd heb gynlluniau cadarn yn eu lle ac a oedd yn parhau i brofi diffygion ariannol flwyddyn ar ôl blwyddyn. Mae'r ymrwymiad hwn wedi'i fodloni ers cyflwyno'r drefn newydd.

Yn fy natganiad ysgrifenedig ym mis Mehefin 2004, amlinellais mai dim ond cynlluniau a fyddai'n llwyddiannus mewn proses fanwl y byddwn yn eu cymeradwyo, er mwyn sicrhau ein bod yn rhoi terfyn ar unrhyw gysyniad o ddiwylliant o ddiffygion ariannol. Dim ond dau gynllun, sef cynlluniau Byrddau Iechyd Caerdydd a'r Fro a Phrifysgol Cwm Taf, oedd yn cynnwys ad-dalu diffygion 2013/14, ond yn y ddau achos roedd y taliad ymlaen llaw wedi'i gynllunio ar gyfer blwyddyn tri eu cynlluniau (2016/17). Yn ystod y broses gymeradwyo, dywedodd swyddogion wrth y ddau fwrdd y byddai cadarnhad o'r trefniadau ynghylch peidio ag ad-dalu diffygion 2013/14 yn cael ei roi yn nes ymlaen yn ystod y flwyddyn ac y dylent ganolbwyntio ar weithredu eu cynlluniau cymeradwy yn llawn cyfamser. Ni chafodd hyn unrhyw

effaith ar eu cynlluniau yn 2014/15 oherwydd nid oedd yr ad-daliadau wedi'u cynllunio tan flwyddyn 3 yn eu cynlluniau unigol.

Yn fy natganiad ysgrifenedig ym mis Mehefin hefyd dywedais y byddwn yn gweithio gyda'r Gweinidog Cyllid dros yr haf i edrych ar sut byddai'r cyllid gofynnol a amlinellwyd yn Adroddiad annibynnol Ymddiriedolaeth Nuffield a gyhoeddwyd ym mis Mehefin yn cael ei ddarparu. Pan gyhoeddwyd cyllideb 2015/16 (gan gynnwys y cyllid ychwanegol ar gyfer 2014/15) ddiwedd mis Medi, cadarnhaodd fy swyddogion na fyddai'n rhaid ad-dalu gorwariant 2013/14, drwy gyfrwng cyflwyniadau i Gadeiryddion a Phrif Weithredwyr ar ôl cyhoeddi'r gyllideb. Rhannwyd cynnwys y cyflwyniadau a chadarnhawyd y dull o weithredu gydag archwilwyr hefyd, cyn gynted ag yr oedd hynny'n ymarferol, yn ystod cyfarfod diweddaru rheolaidd ar ôl cyhoeddi'r gyllideb.

Er bod y bwriad o ran peidio â gofyn am ad-daliad yn glir o ddechrau'r hydref, dylid nodi mai 2014/15 oedd y flwyddyn gyntaf i'r ddeddfwriaeth a'r dull archwilio gyda'r drefn newydd gael eu rhoi ar waith. Gweithiodd fy swyddogion yn agos â staff ACC ar y gweithredu ymarferol ac ar y dehongliad o'r ddeddfwriaeth yn ystod y misoedd a oedd yn arwain at ddiwedd y flwyddyn. Nododd y swyddogion yn glir yr angen am ddod â'r hen drefn i ben yn ystod y trafodaethau hyn.

Ar ôl y gwaith a amlinellwyd uchod, gofynnwyd am i'r esboniad terfynol o beidio ag ad-dalu ar gyfer 2013/14 gael ei nodi'n ysgrifenedig gan yr archwilwyr a'r byrddau iechyd fel rhan o'r broses diwedd blwyddyn, er mwyn ei ddatgan yn glir yn y cyfrifon a gyhoeddwyd. Gwnaeth y swyddogion hyn ar 5ed Mai 2015 mewn llythyr a oedd yn datgan na fyddai angen ad-dalu diffygion a broceriaeth 2013/14 ond y byddai'n rhaid adfer unrhyw ddiffygion o dan y drefn ariannol newydd.

Mae'r uchod wedi cael sylw wedyn yng nghyfrifon cryno sylfaenol y byrddau iechyd a'r GIG a gyhoeddwyd, er mwyn adlewyrchu'n gywir y gofynion adrodd yn ôl y cytunwyd arnynt o dan y drefn ariannol newydd ac yn fy natganiad ysgrifenedig ar alldro 2014/15.

Diweddariad ar y gwaith y mae Llywodraeth Cymru yn ei wneud ar lif ariannol ar draws ffiniau byrddau iechyd.

Mae Llywodraeth Cymru wedi bod yn gweithio gyda GIG Cymru ar lif ariannol ar draws ffiniau byrddau iechyd ers peth amser ond nid yw'r egwyddorion wedi cael eu llunio'n derfynol oherwydd y newidiadau gwasanaeth sylweddol arfaethedig y mae'n rhaid eu gweithredu.

Adolygwyd y mecanwaith llif ariannol cyfredol am y tro cyntaf ddwy flynedd yn ol gan y Cyfarwyddwr Cyllid, gyda'r egwyddorion yn cael eu cyflwyno ar gyfer eu hystyried. Cytunwyd bod raid i'r gwaith hwn gael ei adolygu gan Brif Weithredwyr ac eraill er mwyn adlewyrchu'r newidiadau arfaethedig o ganlyniad i'r trefniadau llif cleifion sy'n newid ac a fyddai'n codi drwy raglen De Cymru a chynlluniau ad-drefnu eraill.

Mae'r gwaith hwn yn cael ei arwain yn awr gan Gyfarwyddwr Cydweithredol y GIG, Bob Hudson. Cytunwyd y bydd y gwaith hwn yn cael ei ddiweddaru ar gyfer y cyfarfod nesaf o'r Prif Weithredwyr ym mis Medi, ble bydd posib ystyried yr egwyddorion newydd ar gyfer llif incwm ac ariannol ar gyfer rhaglenni sy'n dechrau yn 2016/17.

Pa dechnegau ystadegol a ddefnyddir gan Lywodraeth Cymru a'r byrddau iechyd i geisio rhagweld pwysau'r gaeaf ac a yw hyn yn cael ei adlewyrchu mewn dyraniadau blynyddol cyffredinol i fyrddau iechyd?

Ceir dealltwriaeth dda o'r newidiadau mewn patrymau cyffredinol o alw mewn perthynas â'r gwahanol dymhorau ac mae posib ei ragweld i raddau helaeth. Er enghraifft, bob blwyddyn mae mwy yn dod i mewn i'r Adran Gwasanaethau Brys dros fisoedd yr haf nag yn ystod y gaeaf. Mae Llywodraeth Cymru, Byrddau Iechyd Lleol ac Iechyd Cyhoeddus Cymru yn adolygu ac yn dadansoddi tueddiadau dros amser yn rheolaidd er mwyn deall beth sy'n sbarduno galw cyffredinol, patrymau galw ac oedran y cleifion sy'n defnyddio'r gwasanaethau.

Er bod dealltwriaeth o bwysau tymhorol, ni ellir fyth rhagweld y rhain yn fanwl gywir o ddydd i ddydd yn rhy bell ymlaen llaw. Mae'r dystiolaeth yn dangos y gellir cael amrywiaeth sylweddol o ran galw dyddiol a phwysau ym mhob tymor, a achosir gan newidiadau yn y tywydd. Mae hyn yn cael effaith annheg yng Nghymru o ystyried ei phroffil oedran, yn enwedig y gyfran uchel o henoed. Y ffactor bwysig arall sy'n arwain at newidiadau mewn galw, yn enwedig dros y gaeaf, yw amlygrwydd afiechydon heintus sy'n cael effaith sylweddol ar wasanaethau gofal heb eu trefnu ac unwaith eto mae hyn yn gysylltiedig ag oedran.

Mae'r GIG yn datblygu cynlluniau penodol ar gyfer y gaeaf sy'n cynnwys rhagfynegi galw a chynlluniau wrth gefn ar gyfer y tywydd, gyda £40 miliwn ychwanegol yn cael ei neilltuo ar gyfer pwysau'r gaeaf yn 2014/15. Mae'r dyraniad blynyddol i fyrddau iechyd yn adlewyrchu galw a gwariant drwy gydol y flwyddyn.

Esboniad ynghylch pryd daeth swyddfa'r Archwilydd Cyffredinol yn ymwybodol na fyddai'n rhaid i sefydliadau'r GIG ad-dalu broceriaeth a gorwariant 2013-14, yng ngoleuni datganiad yn Adroddiad yr Archwilydd Cyffredinol ar GIG Cymru: Trosolwg o Berfformiad Ariannol a Gwasanaeth 2013-14 "bydd yr Adran nid yn unig yn gofyn am ad-daliad unrhyw gyllid broceriaeth ar gyfer 2013-14 yn 2014-15, ond hefyd ad-daliad o unrhyw 'ddiffyg' gan y cyrff yn y GIG nad ydynt yn cyrraedd eu targedau ariannol".

Rwyf yn siŵr bod y Pwyllgor yn gwerthfawrogi bod cyfarfodydd rheolaidd yn cael eu cynnal rhwng yr archwilwyr a'm swyddogion i. Fel y nodwyd eisoes, rwyf wedi cael gwybod y byddai rhai trafodaethau ar fwriad wedi cael eu trafod drwy gydol 2014/15 ond daeth hyn yn fwy ffurfiol ar ôl cyhoeddi'r gyllideb ym mis Medi a hyd at ddiwedd y flwyddyn. Rwyf yn deall bod adroddiad ACC wedi'i gyhoeddi ar 14eg Hydref ac efallai nad oedd y trafodaethau cadarnhau ar ôl cyhoeddi'r gyllideb wedi'u cynnal mewn pryd i gadarnhau unrhyw gyfeiriadau yn adroddiad ACC, yn enwedig pan oedd gweithredu'r ddeddfwriaeth am y tro cyntaf, a'i goblygiadau, yn cael eu trafod hyd at gyhoeddi cyfrifon 2014/15.

Pa ddata a gesglir i ddangos y cynnydd yng nghymhlethdod achosion cleifion a'i effaith ar gapasiti gwasanaethau iechyd yng Nghymru? Byddai'r Pwyllgor yn arbennig yn croesawu ffigurau misol am hyd yr arhosiad a'r capasiti o ran gwelyau mewn ysbytai, os oes rhai ar gael, am y pum mlynedd diwethaf.

Mae Cronfa Ddata Cyfnodau Gofal Cleifion Cymru yn casglu data amrywiol am dderbyn i ysbytai. Gellir defnyddio'r data hyn yn unigol ac yn gasgliadol i ganfod y cynnydd yng nghymhlethdod cleifion. Mae'r canlynol yn enghreifftiau nodweddiadol o eitemau o ddata sy'n cael eu dadansoddi'n rheolaidd gan Lywodraeth Cymru a darparwyr y GIG er mwyn dangos y newidiadau yn y llwyth achosion.

- Diagnosis Cleifion - mae'n nodi'r prif ddiagnosis ac yn cyflwyno cydforbidrwydd drwy gyfrwng codio ICD10;
- Gweithdrefn Weithredol - casglu unrhyw ymyriad(au) a gweithdrefn(au) gweithredol a gyflawnir gan ddefnyddio dosbarthiad codio OPCS4;
- Oedran Cleifion - er enghraifft, dadansoddi effaith poblogaeth sy'n heneiddio ar arhosiad mewn ysbyty;
- Hyd Arhosiad mewn Ysbyty - a ddefnyddir i adnabod newidiadau mewn amrywiaeth i ddosbarthiad arhosiad mewn ysbyty yn gysylltiedig ag oedran a chymysgedd o achosion;
- Canlyniadau Marwolaethau - er enghraifft, i fonitro'r effaith ar adnoddau gofal lliniarol yn sgil newidiadau yn nifer y marwolaethau;
- Grwpiau Adnoddau Gofal Iechyd - defnyddio grwpiau safonol o driniaethau tebyg yn glinigol sydd â lefelau cyffredin o adnoddau gofal iechyd;
- Dyddiadau Derbyn - defnyddir i ddadansoddi'r newidiadau mewn amrywiad tymhorol mewn cydweithrediad â ffactorau eraill.

Mae data pellach i ddangos newidiadau i gymhlethdod achosion ar gael o ystod o gasgliadau a chyfresi data. Er enghraifft, mae hyn yn cynnwys data mynediad gan Wasanaethau Brys a data galwadau gan y gwasanaethau Ambiwlans.

Mae'r daenlen sydd wedi'i hatodi'n cynnwys tablau a siartiau sy'n dangos tueddiadau pum mlynedd ar gyfer hyd arhosiad ar gyfartaledd. Mae'r siart dewisol ar gyfer hyd arhosiad ar gyfartaledd (prif arbenigeddau llawfeddygol) ar gyfer Cymru'n dangos gostyngiad o ryw 0.4 diwrnod dros y pum mlynedd. Mae hyn yn arbennig o arwyddocaol o ystyried bod cyfraddau'r achosion dydd wedi cynyddu 9% yn ystod yr un cyfnod. Ar ei ben ei hun, byddai hyn yn cynyddu hyd arhosiad ar gyfartaledd. I'r gwrthwyneb, mae hyd arhosiad brys ar gyfartaledd wedi cynyddu ryw 0.2 diwrnod yn ystod y cyfnod, wrth i ostyngiadau mewn effeithlonrwydd gael eu niwtraleiddio gan effaith poblogaeth sy'n heneiddio. Mae dargyfeirio cleifion a dderbyniwyd i ysbyty'n flaenorol (cyfnod byr) i unedau asesu yn ffactor sy'n cyfrannu at gynyddu canlyniadau hyd arhosiad ar gyfartaledd hefyd. Hefyd mae'r siart hyd arhosiad brys ar gyfartaledd yn tynnu sylw at yr amrywiad tymhorol o ran aros mewn ysbytai, yn enwedig yn ystod y cyfnodau brig dros y gaeaf ac ar ôl y gaeaf.

Darperir capasiti o ran gwelyau mewn ysbytai yn y ddogfen sydd wedi'i hatodi hefyd, ond dim ond yn chwarterol mae data cyn 2013 ar gael. Mae hyn yn dangos bod gostyngiad o 1,088 wedi bod rhwng 2010/11 a 2014/15 yn nifer y gwelyau sydd ar gael ledled Cymru, gostyngiad o 9%. Mae cynnydd mewn meddygfeydd dydd, ac unedau asesu newydd a mentrau eraill i osgoi derbyn i ysbytai, wedi cyfrannu'n sylweddol at lai o alw am welyau.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref MB/MD/1761/15

David Rees AC
Cadeirydd
Y Pwyllgor Iechyd a Gofal Cymdeithasol
Cynulliad Cenedlaethol Cymru

Annwyl David,

17 Gorffennaf 2015

Mae'n bleser gen i eich hysbysu bod Dr Richard Lewis we cael ei benodi yn Arweinydd Proffesiynol Cenedlaethol ar gyfer Gofal Sylfaenol yng Nghymru, yn dilyn cystadleuaeth agored. Bydd Dr Lewis yn rhoi arweiniad clinigol i helpu i sicrhau bod gofal iechyd yn cael ei gynllunio a'i ddarparu'n lleol.

Ar hyn o bryd, Dr Lewis yw Ysgrifennydd Cymdeithas Feddygol Prydain yng Nghymru ac mae hefyd yn Feddyg Teulu yng Nghymoedd y De. Fel Meddyg Teulu sydd â dros 25 mlynedd o brofiad ac sydd wedi gweithio mewn rôl arweiniol gyda Chymdeithas Feddygol Prydain am dros 10 mlynedd, mae'n meddu ar wybodaeth, profiad a dealltwriaeth fanwl o gryfderau a heriau presennol y system gofal sylfaenol yn y GIG yng Nghymru.

Byddaf yn cyhoeddi'r penodiad hwn heddiw yn lansiad cynllun y gweithlu ar gyfer gofal sylfaenol. Mae cynllun y gweithlu, a fydd yn destun chwe-wythnos o ymgysylltiad, wedi cael ei ddatblygu o ganlyniad i gam gweithredu a nodwyd yn y cynllun cyffredinol ar gyfer gwasanaethau gofal sylfaenol yng Nghymru. Mae'n rhoi camau gweithredu ar waith ar gyfer y tymor uniongyrchol a'r tymor-canolig i adeiladu sylfeini cryfach ar gyfer cynllunio'r gweithlu sydd ei angen arnom ar gyfer y dyfodol, er mwyn helpu i ddatblygu clystyrau yn y dyfodol ac ar gyfer buddsoddi yn y gweithlu gofal sylfaenol ehangach drwy addysg a hyfforddiant. Mae hefyd yn cynnwys cymryd camau i gefnogi adrannau allweddol o'r gweithlu presennol, mewn ymateb i'r pwysau amlwg sy'n parhau i effeithio ar rannau o Gymru wrth i fodelau gofal newydd gael eu datblygu.

Mae'r llythyr hwn yn cael ei gopïo i lefarwyr y gwrthbleidiau.

Yn gywir,
Mark.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol
Y Swyddfa Ddeddfwriaeth
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
CF99 1NA

31 Gorffennaf 2015

Annwyl Gadeirydd

Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014 – Cod Ymarfer ar Eiriolaeth

Gan ystyried argymhellion y Pwyllgor ar ôl craffu ar Reoliadau Gofal a Chymorth (Cymhwysedd) (Cymru) 2015, roeddwn yn meddwl y byddai'n ddefnyddiol amlinellu'r prif bwyntiau rwyf wedi'u codi wrth ymateb i ymgynghoriad Llywodraeth Cymru ar y Cod Ymarfer ar Eiriolaeth, fel rhan o'm swyddogaeth statudol i adolygu a yw'r gyfraith sy'n effeithio ar fuddiannau pobl hŷn yng Nghymru yn ddigonol ac yn effeithiol.

1. Mae'r Ddeddf yn rhoi ymrwymiad penodol i alluogi pobl i wneud eu penderfyniadau eu hunain a rheoli eu bywyd eu hunain, ac i roi help i sicrhau bod llais pobl yn gryf, yn glir, yn cael ei glywed ac yn cael sylw priodol. Bydd **eiriolaeth annibynnol** yn hanfodol i bobl sy'n ei chael yn anodd gwneud yn siŵr bod eu llais yn cael ei glywed. Mae eiriolaeth annibynnol yn allweddol i lwyddiant y ddeddfwriaeth newydd hon. Mae'n **ymrwymiad pwysig ac mae'n rhaid iddo gael ei gynnwys** yn holl reoliadau a chodau ymarfer y Ddeddf. Nid wyf yn fodlon eto fod hyn wedi'i wireddu'n llwyr.

2. Mae'n rhaid sicrhau bod **dull gweithredu sy'n seiliedig ar hawliau** yn sail i'r modd y mae gwasanaethau cyhoeddus yn cael eu darparu. Er bod llawer o rethreg ynglŷn â dyletswydd unigolion i gydlunio eu hatebion eu hunain i sicrhau eu canlyniadau o ran lles, nid yw'r hawl i eiriolaeth annibynnol yn cael yr un sylw. Bydd cydlunio go iawn yn digwydd pan mae pawb ar yr un lefel, felly rwy'n bryderus ynglŷn â'r ffaith bod y Cod Ymarfer ar Eiriolaeth, ar hyn o bryd, yn cynnig prawf sy'n dibynnu ar benderfyniad y gweithiwr proffesiynol ac sy'n rhoi cydlunio yn y fantol. Mae angen newid patrwm er mwyn

gweddnewid gwasanaethau cymdeithasol go iawn, a bydd hyn yn cynnwys mynd i'r afael â'r anghydbwysedd presennol mewn pŵer a allai atal y rheini sydd angen mynediad at eiriolaeth annibynnol rhag cael hynny. Er fy mod yn deall bod awdurdodau lleol yn wynebu cyfyngiadau ariannol, mae defnydd da o wasanaethau eiriolaeth annibynnol yn dda i unigolion, yn dda ar gyfer diogelu ac yn dda i'r pwrs cyhoeddus.

3. Bydd **newid diwylliant** awdurdodau lleol yn hanfodol er mwyn rhoi bwriad y Ddeddf ar waith, ac mae gofyn bod gan y rheini sy'n cyflawni eu dyletswyddau o dan y Ddeddf ymwybyddiaeth dda o'r hawl i eiriolaeth annibynnol. Dylid edrych ar eiriolaeth annibynnol nid yn unig fel ffordd allweddol o wireddu dyheadau'r Ddeddf o ran llais a rheolaeth, ond hefyd fel rhywbeth hanfodol a hollbwysig wrth sicrhau gwasanaethau cyhoeddus effeithiol ac o safon. Fodd bynnag, nid yw'r angen i newid diwylliant mewn awdurdodau lleol wedi'i gynnwys yn y Cod Ymarfer ar Eiriolaeth a'r rhannau cysylltiedig ar hyn o bryd. Mae'n rhaid i staff awdurdodau lleol edrych yn gadarnhaol ar eiriolaeth annibynnol er mwyn iddo gael ei wreiddio mewn ymarfer o ddydd i ddydd. Felly bydd gweld sut bydd hyn yn cael sylw o ddiddordeb i mi.

Er fy mod yn siomedig nad yw fy argymhellion yn yr adroddiad '*Achos Busnes dros Eiriolaeth yng Nghymru'*[1] wedi cael eu datblygu, rwyf wedi ymrwymo o hyd i wneud yn siŵr bod pobl hŷn yn gallu cael gafael ar wasanaethau eiriolaeth effeithiol, gan gynnwys eiriolaeth annibynnol, pan fydd angen[2]. I bob golwg, nid yw'r Cod Ymarfer ar gyfer Mesur Perfformiad Gwasanaethau Cymdeithasol yn cynnig unrhyw ddangosyddion a fydd yn cofnodi lefel y mynediad at wasanaethau eiriolaeth annibynnol. Rwyf wedi nodi bod hyn yn bryder, a byddaf yn cadw golwg ar y mater wrth i'r Ddeddf gael ei rhoi ar waith.

Yn gywir

Sarah Rochira

Sarah Rochira
Comisiynydd Pobl Hŷn Cymru

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[1] Achos Busnes dros Eiriolaeth, Mai 2014, Comisiynydd Pobl Hŷn Cymru

[2] Blaenoriaeth pump: Mynd i'r afael â rhagfarn, anghydraddoldeb a gwahaniaethu, Fframwaith Gweithredu 2013-17, Comisiynydd Pobl Hŷn Cymru

Eitem 8.9

Dr Ruth Hussey OBE
Prif Swyddog Meddygol/Cyfarwyddwr Meddygol, GIG Cymru
Chief Medical Officer/Medical Director NHS Wales

Llywodraeth Cymru
Welsh Government

David Rees AC
Cadeirydd, y Pwyllgor Iechyd a Gofal Cymdeithasol

11 Awst 2015

Annwyl David,

Deiseb P-04-603 Helpu babanod 22 wythnos oed i oroesi

Diolch am eich llythyr dyddiedig 14 Gorffennaf, yn gofyn am ragor o wybodaeth am amserlenni'r gwaith sy'n cael ei wneud ar y cyd gan y Rhwydwaith Mamolaeth a'r Rhwydwaith Newyddenedigol.

Mae disgwyl i'r ddogfen Mamolaeth a Newyddenedigol ar y cyd ynghylch gofal i fabanod sydd â siawns o oroesi, gael ei chyflwyno yng nghyfarfodydd y pwyllgorau llywio ar y rhwydwaith mamolaeth a rhwydwaith newyddenedigol ym mis Medi a mis Hydref, a bydd y ddogfen derfynol yn cael ei chyflwyno yng nghyfarfod y Grŵp Llywio Newyddenedigol ar 6 Tachwedd 2015.

Bydd y canllawiau hyn yn seiliedig ar ganllawiau presennol Cymdeithas Meddygaeth Amenedigol Prydain sy'n defnyddio tystiolaeth o ddogfennau meddygol a chonsensws broffesiynol.

Fel rhan o'r gwaith hwn, rydym hefyd am gael adborth gan rieni a BLISS (elusen sy'n gweithio i ddarparu'r gofal a'r cymorth gorau posibl i bob babi sâl a rhai sy'n cael eu geni'n gynnar a'u teuluoedd), ar y canllawiau a thaflenni gwybodaeth i rieni.

Ar ôl cwrdd â Ms Emma Jones, y deisebydd, ar 18 Chwefror 2015, bydd Dr Heather Payne, Uwch Swyddog Meddygol ar gyfer iechyd mamolaeth ac iechyd plant yn cynnig cyfarfod â Ms Jones eto er mwyn casglu ei sylwadau ar y ddogfen ddrafft. Yna, caiff yr adborth ei gyflwyno i'r Rhwydwaith Mamolaeth a'r Rhwydwaith Newyddenedigol sy'n gyfrifol am gyhoeddi'r canllawiau.

Cofion gorau

Ruth Hussey

PRIF SWYDDOG MEDDYGOL / CYFARWYDDWR MEDDYGOL GIG CYMRU

cc: William Powell AC, Cadeirydd y Pwyllgor Deisebau

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Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/MD/1929/15

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CF99 1NA

12 Awst 2015

Annwyl David

Rwy'n cyfeirio at fy natganiad ysgrifenedig ar 10 Mehefin ynghylch cymeradwyo cynlluniau tymor canolig integredig byrddau iechyd ac ymddiriedolaethau'r GIG. Fel y cofiwch adeg pasio Deddf Cyllid y GIG (Cymru) 2014 a Fframwaith Cynllunio GIG Cymru, rhoddais sicrwydd y byddai archwiliadau priodol yn cael eu gosod i sicrhau bod cynlluniau tymor canolig integredig yn gadarn a bod modd eu cyflawni.

Cymeradwyais bum cynllun ym mis Mehefin (byrddau iechyd prifysgol Cwm Taf ac Aneurin Bevan, Bwrdd Addysgu Iechyd Powys, Iechyd Cyhoeddus Cymru ac Ymddiriedolaeth GIG Felindre) a dywedais y byddai fy swyddogion yn parhau i weithio gyda byrddau iechyd prifysgol Abertawe Bro Morgannwg a Chaerdydd a'r Fro i ddatblygu ymhellach a phrofi manylder eu cynlluniau. Cwblhawyd y gwaith hwn a chymeradwywyd cynlluniau tymor canolig integredig y ddau sefydliad yn 2015-16.

Fodd bynnag, cymeradwywyd yn amodol ar nifer o delerau ac amodau, a fydd yn destun craffu agos dros y misoedd nesaf. Mae'r amodau hyn yn cynnwys:

- Dangos tystiolaeth o berfformiad gwell ar draws targedau haen un a sicrhau y caiff safonau ansawdd eu cynnal a'u gwella ym mhob gwasanaeth;

- Sicrhau rheolaeth ariannol dda ar y cynllun.

Caiff perfformiad yn erbyn yr amodau hyn ei olrhain drwy drafodaethau rhwng prif weithredwyr a chadeiryddion, cyfarfodydd ansawdd, diogelwch a chyflawni, a chyd-gyfarfodydd timau gweithredol. Lle ceir amrywiadau annerbyniol o'r cynllun y cytunwyd arno, bydd sefydliad yn destun mwy o drefniadau monitro, herio, cymorth ac uwchgyfeirio, a gallai golli'r breintiau sy'n gysylltiedig â bod yn rhan o'r drefn cynllunio tymor canolig.

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Mae fy mhenderfyniad yn arwydd o'r trylwyrder parhaus sydd ei angen i weithredu'r trefniadau a amlinellir yn Fframwaith Cynllunio GIG Cymru a Deddf Cyllid y GIG (Cymru) 2014.

Anfonwyd copi o'r llythyr hwn at Elin Jones AC, Kirsty Williams AC a Darren Millar AC a rhoddwyd copi yn llyfrgell y Cynulliad Cenedlaethol.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Mark Drakeford AC / AM
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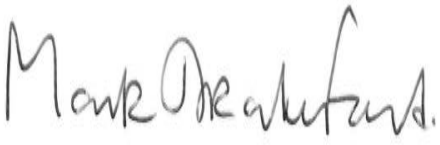
17 Awst 2015

Annwyl gyfaill,

Mae'n bleser gen i amgáu copi o'r adolygiad o drefniadau neilltuo cyllid ar gyfer gwasanaethau iechyd meddwl yng Nghymru.

Daw'r adolygiad i'r casgliad bod diben gwreiddiol y trefniadau neilltuo cyllid – i ddiogelu gwariant ar wasanaethau iechyd meddwl – wedi cael ei gyflawni ar y cyfan. Mae'n gwneud cyfres o gynigion ar gyfer gwella'r system yn y dyfodol, a byddaf yn ystyried y cynigion hyn.

Anfonaf gopi o'r llythyr hwn at lefarwyr y gwrthbleidiau hefyd.



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Mae cyfyngiadau ar y ddogfen hon