Agenda - Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Lleoliad:
Ystafell Bwyllgora 3 - Y Senedd
Dyddiad: Dydd Iau, 17 Ionawr 2019
Amser: 09.15

I gael rhagor o wybodaeth cysylltwch a:
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Rhag-gyfarfod anffurfiol (09.15-09.30)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

(09.30)

2 Hepatitis C: Sesiwn dystiolaeth gydag Ymddiriedolaeth Hepatitis C

(09.30-10.15) (Tudalennau 1 - 36)

Rachel Halford, Prif Weithredwr, Hepatitis C Trust

Stuart Smith, Cyfarwyddwr, Hepatitis C Trust

Aidan Rylatt, Cynghorwr Polisi a Seneddol, Hepatitis C Trust

Ymatebion i'r ymgynghoriad

Brif Ymchwil

Papur 1 - Hepatitis C Trust

Egwyl (10.15-10.20)

3 Hepatitis C: Sesiwn dystiolaeth gyda Choleg Brenhinol yr Ymarferwyr Cyffredinol a'r Coleg Nyrsio Brenhinol

(10.20-11.05) (Tudalennau 37 - 40)

Dr Mair Hopkin, Cyd-Gadeirydd, Coleg Brenhinol yr Ymarferwyr Cyffredinol

Dr Peter Saul, Cyd-Gadeirydd, Coleg Brenhinol yr Ymarferwyr Cyffredinol

Delyth Tomkinson, Nyrs Glinigol Arbenigol Hepatoleg, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Lisa Turnbull, Cynghorwr Polisi a Materion Cyhoeddus, Coleg Nyrsio Brenhinol Cymru

Papur 2 – Coleg Brenhinol yr Ymarferwyr Cyffredinol
Papur 3 – Coleg Nyrsio Brenhinol Cymru

Egwyl (11.05-11.15)

4 Hepatitis C: Sesiwn dystiolaeth gyda Grŵp Gweithredu Clefyd yr Afu Llywodraeth Cymru

(11.15-12.00) (Tudalennau 41 - 60)

Dr Brendan Healy, Cadeirydd Blood Borne Viruses Network, Ymgynghorydd Microbioleg a Chlefydau Heintus, Arweinydd Cenedlaethol ar Hepatitis
Dr Ruth Alcolado, Dirprwy Gyfarwyddwr Meddygol, Bwrdd Iechyd Prifysgol Cwm Taf
Gavin Hardcastle.Hepatitis, Nyrs Glinigol Arbenigol Hepatitis, Bwrdd Iechyd Prifysgol Aneurin Bevan
Dr Chinlye Ch'ng, Gastroenterolegydd Ymgynghorol, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg

Papur 4 – Brendan Healy, Arweinydd Cenedlaethol ar Hepatitis
Papur 5 – Bwrdd Iechyd Prifysgol Cwm Taf
Papur 6 – Bwrdd Iechyd Prifysgol Aneurin Bevan

Egwyl (13.15-13.20)

5 Hepatitis C: Sesiwn dystiolaeth gydag Iechyd Cyhoeddus Cymru

(12.30-13:15) (Tudalennau 61 - 69)

Dr Giri Shankar, Prif Ymgynghorydd ar gyfer Diogelwch Iechyd a Rheoli Clefydau Trosglwyddadwy, Iechyd Cyhoeddus Cymru

Dr Jane Salmon, Ymgynghorydd ar gyfer Diogelwch Iechyd, Iechyd Cyhoeddus Cymru

Dr Jane Perrett, Nyrs Arweiniol ar gyfer Iechyd a Chyfiawnder, Rhaglenni Diogelu Iechyd, Iechyd Cyhoeddus Cymru

Papur 7 – Iechyd Cyhoeddus Cymru

6 Is-ddeddfwriaeth mewn perthynas ag iechyd a gofal cymdeithasol

(13.15 - 13.20) (Tudalennau 70 - 74)

Rheoliadau Gwasanaethau Eirioli Rheoleiddiedig (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019
Memorandwm esboniadol

Rheoliadau Gwasanaethau Maethu Rheoleiddiedig (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019
Memorandwm esboniadol

Rheoliadau Gwasanaethau Eirioli Rheoleiddiedig (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019
Memorandwm esboniadol

Nodyn Cyngor Cyfreithiol

7 Papurau i'w nodi

(13.20)

7.1 **Deintyddiaeth yng Nghymru: Gwybodaeth ychwanegol gan Ddeintyddfa Belgrave ar Brototeip Contract Deintyddol**

(Tudalennau 75 - 79)

7.2 **Bil Awtistiaeth (Cymru): Llythyr gan Paul Davies AC i Gadeiryddion y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon; y Pwyllgor Cyllid; a'r Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol**

(Tudalennau 80 - 86)

8 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod hwn

(13:20)

9 Hepatitis C: Trafod y dystiolaeth

(13.20-13.30)

10 Cynnig Cydsyniad Deddfwriaethol ar Fil Gofal Iechyd (Trefniadau Rhyngwladol): Trafod yr adroddiad drafft

(13.30-13.40) (Tudalennau 87 - 91)

11 Gofal Lliniarol: Trafod y llythyr drafft

(13.40 - 13.45) (Tudalennau 92 - 94)

Mae cyfyngiadau ar y ddogfen hon

Hepatitis C inquiry – Evidence from The Hepatitis C Trust

Background

Hepatitis C is a blood-borne virus affecting the liver. Four-fifths of those infected develop chronic hepatitis C, which can cause fatal cirrhosis and liver cancer if untreated. Around 210,000 people are chronically infected with hepatitis C in the UK[1], with 12,000-14,000 of these in Wales[2].

Hepatitis C disproportionately affects disadvantaged and marginalised communities, with almost half of people who attend hospital for hepatitis C coming from the poorest fifth of society, and with the latest figures showing that 50% of injecting drug users in Wales have hepatitis C antibodies[3]. Other groups who are disproportionately affected include homeless people and migrant communities from countries with a high prevalence of hepatitis C, such as Pakistan and Poland.

With direct acting antiviral (DAA) treatments available without restriction through the NHS in Wales, offering high cure rates with very few side effects, achieving the elimination of hepatitis C by 2030, in line with the Welsh Government's commitment, is an achievable goal. However, with Wales currently falling significantly short of its target to treat 900 patients per year, efforts to find the roughly 50% of patients who remain undiagnosed must become a public health priority to ensure the opportunity of achieving elimination is seized.

Action being taken to meet the requirements of the Welsh Health Circular and 2030 elimination target

There is some encouraging progress being made towards meeting the requirements of the Welsh Health Circular and the elimination target of 2030.

The Hepatitis C Trust welcomes the variety of community outreach pilot projects that have been trialled across Wales, including assessing the effectiveness of testing in GP clinics and within specific populations, such as image and performance enhancing drug users, the homeless community, sex workers and asylum seekers. Initiatives such as these are a valuable way of determining how to most effectively target testing campaigns. The implementation of opt-out testing in prisons has also increased testing rates, and it is to be expected that these rates will continue to increase as the policy is further embedded.

A further positive development is Public Health Wales' ongoing roll-out of a re-engagement exercise for patients diagnosed with hepatitis C in the past but never treated. As noted in the Welsh Health Circular, there is an urgent need to refer these individuals for further testing and treatment to minimise ongoing liver damage, and The Hepatitis C Trust has been pleased to contribute to planning meetings for the exercise to provide the perspective of a patient organisation.

[1] Public Health England, *Hepatitis C in the UK: 2018 report*, August 2018
[2] National Assembly for Wales, *Written Assembly Questions tabled on 14 January 2015 for answer on 21 January 2015*, January 2015
[3] Public Health England, Health Protection Scotland, Public Health Wales, and Public Health Agency Northern Ireland, Shooting Up: Infections among people who inject drugs in the UK, 2017, November 2018

The ambition to increase the level of testing and treatment in community pharmacies will be greatly enhanced by the recent appointment of a National Pharmacy Lead. Pharmacies are a particularly effective setting to test for hepatitis C, with many current or former injecting drug users who may not be attending substance misuse services accessing them to collect clean injecting equipment or opioid substitution therapy (OST). Increasing testing in this setting is therefore likely to lead to greater numbers of patients being diagnosed and referred for treatment.

Despite this encouraging progress, there are evidently still challenges that remain if elimination is to be achieved by 2030. Whilst some Local Health Boards are meeting their treatment targets, most are not and there is a significant shortfall in meeting the national annual target. Diagnosis and treatment rates will have to increase significantly if elimination is to be achieved by 2030.

The release of the Welsh Health Circular was a very welcome step but The Hepatitis C Trust believes this must now be followed be a comprehensive national elimination strategy, with clear targets and allocated areas of responsibility, to ensure coordination of the various actors and actions needed to achieve elimination by 2030.

With Scotland having committed to releasing a dedicated hepatitis C elimination plan in the near future and NHS England having set a more ambitious target of elimination by 2025, Wales must continue to take an ambitious approach to avoid being left behind.

Increasing awareness of hepatitis C

Knowledge and awareness of hepatitis C among the public and some health professionals remains low, reflected in the roughly 50% of undiagnosed patients and continuing stigma around the virus.

To mark World Hepatitis Day 2018, The Hepatitis C Trust commissioned a UK-wide poll of members of the public to assess awareness of hepatitis C. Despite 80% of respondents stating that they were aware of what hepatitis C is, less than 40% knew that it infects the liver, and less than 30% knew the virus is curable. Awareness of symptoms was also low, with only a third of respondents accurately identifying tiredness, loss of appetite, vomiting and abdominal pains as signs of infection, and less than half aware that symptoms are not always obvious and can go unnoticed for many years. When asked how hepatitis C is transmitted, 30% incorrectly said it was through exchanging saliva.

This lack of public knowledge contrasts markedly with awareness of HIV, which saw huge increases in public awareness following government-backed awareness campaigns and campaigning activity by high-profile individuals. The Hepatitis C Trust would like to see the Welsh Government work with other key stakeholders to develop a nationally coordinated series of local awareness-raising campaigns, including messaging tailored to specific at-risk groups highlighting transmission risks, the importance of testing and the availability of the new treatments. Increasing awareness also helps to reduce stigma, which enables people to feel more comfortable about coming forward to get tested or access treatment. With Public Health Wales implementing a patient re-engagement exercise in late 2018/early 2019 and the UK-wide Infected Blood Inquiry also due to begin hearing evidence in April 2019, a series of awareness campaigns in the first half of 2019 would be well-timed to capitalise on a window of opportunity to raise attention to hepatitis C.

Low knowledge and awareness of hepatitis C is not just an issue among the general public, with myths and outdated messages still often prevalent even among particularly at-risk groups. For example, while injecting drug users are more likely than the general population to be aware of hepatitis C, many are unaware of the availability of the newer DAA treatments, with outdated information related to the significant side effects associated with the older interferon treatments often passed on. Such misinformation can have serious consequences, with some patients choosing not to access healthcare services due to fear of the old treatments.

Peer-to-peer support and peer groups are a particularly effective way of addressing such myths and improving knowledge and awareness among at-risk groups. Peer-to-peer support involves people who have themselves had experience of hepatitis C delivering awareness-raising talks to people with backgrounds similar to their own, as well as encouraging and supporting people to access testing and/or treatment. Expanding the use of peers in Wales would be an effective way of increasing knowledge and awareness of hepatitis C among at-risk groups.

Low knowledge and awareness among some health professionals is also an ongoing issue. During interviews and focus groups The Hepatitis C Trust conducted with patients prior to the publication of our *Hepatitis C in Wales: Perspectives, challenges and solutions* report, we were told that they often encountered low levels of knowledge of hepatitis C among health professionals. While the excellent care provided by specialist hepatology teams was emphasised, patients reported less positive experiences with other health professionals, such as GPs and non-specialist nurses.

Many patients told us they had been visiting their GP for years with symptoms consistent with hepatitis C infection but had never been offered a test. Others were given incorrect advice and information, such as being told that the virus is transmitted through sexual contact, which contributed to stigma encountered by patients.

There have been various initiatives to improve this situation, with Public Health Wales carrying out valuable work to improve professional awareness, HCV Action (coordinated by The Hepatitis C Trust) holding a hepatitis C good practice roadshow for healthcare professionals in Cardiff, and the British Liver Trust running a Liver Disease Event for GPs. However, there is a need for GPs and other primary care workers to be provided with regular information about hepatitis C and presented with opportunities to undertake training on hepatitis C as part of continued professional development to ensure increased levels of awareness and knowledge.

Scope to increase community-based activity

As referred to above, a range of community outreach activity has already been rolled out in Wales, particularly in relation to testing. However, there is a need for increased community-based activity to ensure the 2030 elimination target is met.

For example, dried blood spot (DBS) testing must become routine in settings such as substance misuse services and sexual health clinics, where prevalence rates among clients are likely to be higher than among the general public. The imminent introduction of routine opt-out BBV testing in substance misuse services is a very welcome development and is a

significant opportunity to diagnose and treat more patients. However, with substance misuse services facing significant financial challenges, it is essential that the policy is adequately resourced to ensure sustainability. The Hepatitis C Trust would also encourage more frequent testing in other community-based settings, including pharmacies, homeless hostels, and mosques.

With the simplicity of the DAA treatments for hepatitis C making them highly suitable for delivery in the community, there should be a move towards treatment being made available in any setting where testing takes place. Making treatment available in settings which patients access regularly and removing the need for referral to secondary care is likely to increase treatment uptake. If elimination is to be achieved by 2030, it is essential that Local Health Boards support community outreach work by funding appropriate staffing to support the delivery of treatment in a range of community settings. Welsh Government support is also likely to be required to facilitate the delivery of treatment in certain community settings, such as pharmacies, where there are unresolved issues regarding how treatments are funded.

An increase in community-based activity can also be supported by making use of peers. Peers are well placed to deliver testing and treatment in community settings and to provide the support and encouragement needed to help patients through the care pathway. For example, between October 2017 and December 2018, The Hepatitis C Trust's Peer Support Lead in South East London made contact with 44 hepatitis C positive patients considered 'hard to reach'. Of the 44 individuals, 42 were successfully supported to engage with treatment (95%). Peer support programmes should be commissioned to take place in a range of community services to ensure this support is in place.

Long-term viability of treatment programmes

The Hepatitis C Trust welcomes the Welsh Government's commitment to providing access to DAA treatments for hepatitis C for all who need them. This approach contrasted favourably with the approach adopted in England, whereby restrictions were placed on the number of patients able to access treatment, which initially resulted in waiting lists in some areas.

However, with treatment targets not being met despite this approach, more must be done to support patients to access treatment. With the cost of DAA treatments having reduced significantly since they came onto the market, it is important that these savings are reinvested back into hepatitis C care. The Hepatitis C Trust would like to see Local Health Boards reinvesting money saved on treatment cost reductions into finding individuals living with an undiagnosed infection, providing funding for designated staff and/or peers to support the delivery of testing and treatment in community services, and ensuring adequate staffing in secondary care hepatology teams. As testing rates increase in pharmacies and substance misuse services, there is likely to be a consequent rise in referrals into treatment, which secondary care services must be prepared for.

It is also vital that Local Health Boards understand that the national hepatitis C treatment targets are a minimum which they should be aiming to exceed. Anecdotally, The Hepatitis C Trust has heard of Local Health Board Finance Directors discouraging hepatology teams

from exceeding the treatment target due to financial concerns. The Welsh Government must make it clear to Local Health Boards that this approach will result in greater financial costs to Local Health Boards in the long run and is not compatible with Wales achieving elimination by 2030. Indeed, even if the current target of 900 patients being treated per year was being met – which it is not currently – the elimination target would be missed by 18 months. At the current rate of treatment, the elimination target will be missed be a substantial distance. It is therefore essential that Local Health Boards adopt an ambitious approach to treatment, with encouragement from the Welsh Government.

The Welsh Government should also consider developing a new funding arrangement for hepatitis C treatment, which allows for a longer-term, strategic approach and incentivises case finding. With NHS England currently in negotiations with the pharmaceutical industry over a new procurement deal, there may be an opportunity for Wales to follow England's example if such a deal is agreed. The proposed funding deal in England is expected to result in longer-term budget certainty for the NHS, introduce a role for the pharmaceutical industry in finding undiagnosed patients and incentivise higher treatment numbers. There would therefore be considerable benefits to Wales in considering such an approach.

Key recommendations

- The Welsh Government to produce a comprehensive national elimination strategy, with clear targets and allocated areas of responsibility, to ensure coordination of the various actors and actions needed to achieve elimination by 2030.

- The Welsh Government to work with other key stakeholders to develop a nationally coordinated series of local awareness-raising campaigns for hepatitis C.

- Peer support programmes to be commissioned in community services.

- GPs and other primary care workers to be provided with regular information about hepatitis C and presented with opportunities to undertake training on hepatitis C as part of continued professional development to ensure increased levels of awareness and knowledge.

- The opt-out blood borne virus testing policy in substance misuse services to be backed with adequate resource to ensure sustainability.

- The Welsh Government to work with all relevant stakeholders to facilitate the delivery of treatment in community settings, including pharmacies.

- Local Health Boards to reinvest money saved on treatment cost reductions into case finding and funding for staff personnel and/or peers to support the delivery of testing and treatment in community services.

- The Welsh Government to write to Local Health Board Finance Directors and Chief Executives to emphasise that treatment targets should be considered a minimum to

be exceeded, rather than a cap not to be exceeded.

- The Welsh Government to consider developing a new funding arrangement for hepatitis C treatment, which allows for a longer-term, strategic approach and incentivises case finding.

Further reading

- The Hepatitis C Trust, *Hepatitis C in Wales: Perspectives, challenges & solutions*, October 2016.
- HCV Action, *Summary report: Hepatitis C good practice roadshow, Cardiff*, December 2017.
- All-Party Parliamentary Group on Liver Health, *Eliminating Hepatitis C in England*, March 2018 [focused on England but has many recommendations also applicable to Wales].

RCGP Wales response: Hepatitis C

Royal College of General Practitioners Wales welcomes the opportunity to respond to the Welsh Assembly's Health, Sport and Social Care Committee's consultation on Hepatitis C.

RCGP Wales represents a network of around 2,000 GPs, aiming to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on resources, education, training, research and clinical standards.

The following response provides comments on the sections of the consultation we feel able to provide meaningful thoughts on. It therefore does not provide answer to each point in turn.

Point one: The action being taken to meet the requirements of the Welsh Health Circular (**WHC/2017/048[Opens in a new browser window]**) published in October 2017 and subsequently meet the World Health Organization target to eliminate Hepatitis B and Hepatitis C as significant public health threats by 2030

1) No comment

Point two: How the knowledge and awareness of the public and health professionals of the Hepatitis C virus can be increased.

2) Knowledge and awareness of the Hepatitis C virus is crucially important, not only for healthcare professionals but also for the public.

3) GPs are in a unique position within society to engage with groups at risk of contracting Hepatitis C infection and encourage them to get tested for the virus.

4) RCGP, in conjunction with the British Liver Trust, has developed a Liver Disease toolkit which provides specific guidance on Hepatitis C and its management in primary care. The toolkit is available as an online resource for primary care practitioners and is accessible here.

Point three: The scope to increase community-based activity e.g. the role of community pharmacies.

5) RCGP Wales recognises that there is a cohort of the public who are less likely to approach their GP practice for an appointment to help with issues of addiction management, for instance prescription of Methadone. We therefore acknowledge that community pharmacies are well placed to reach these groups and promote public health messages.

Point four: The long-term viability of treatment programmes.

6) No comment

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

January 2019

Response from the Royal College of Nursing Wales to the Health, Social Services & Sport Committee's inquiry into Hepatitis C

The Royal College of Nursing Wales is grateful for the opportunity to respond to this consultation and would like to raise a number of points in relation to the inquiry:

1) The action being taken to meet the requirements of the Welsh Health Circular and the target set by the World Health Organisation to eliminate Hepatitis B and Hepatitis C as significant public health threats by 2030

There are several initiatives operating in Wales which are helping to meet this aim:

- The Wales Liver Disease Delivery Plan through which Health Boards aim to improve and review their liver services using six themes:
  - Preventing liver disease & promoting liver health
  - Timely detection of liver disease
  - Fast & effective care
  - Living with liver disease
  - Improving information
  - Targeting research
- There are highly functional blood-borne viruses (BBV) networks across Wales which have a clear national vision.
- Routine opt-out BBV screening operates across Wales. A systematic approach is also taken to BBV testing across 'at risk' population, and re-engagement for those previously diagnosed. Further investment is required in BBV teams however to ensure equitable and transparent access.
- Rates of sustained virological response (SVR) are high, with effective treatment available in tablet form – these have minimal side-effects and above a 97% chance of eradicating the disease.

2) How the knowledge & awareness of the public and health professionals of Hepatitis C can be increased

- Education, across the public sphere and within the health profession, is needed to help overturn negative messaging and dispel some of the myths about testing and treatment. Better education and awareness raising is also important in helping to reach those most at risk, especially the vulnerable groups such as the homeless and rough sleepers, who do not always engage with any healthcare sectors.
- Increased collaboration with a number of different services/agencies would help increase knowledge and awareness. Some of these include; correctional services, substances misuse units, asylum seeker services, community pharmacies, primary care (GP surgeries), specialist secondary care (e.g. Haemophilia unit) and tier 3 services - for example, charitable organisations.
- Health Boards should engage with and promote initiatives such as 'World

Hepatitis Day' in conjunction with the World Hepatitis Alliance's annual themes.

- It is essential, in order to increase knowledge of health care professionals to have BBV training included in their pre & post graduate syllabus and induction for all new staff starting in all Welsh health boards.
- Other examples of good practice which could be further invested and/or replicated across Wales:
    - Cardiff Hepatitis Support Network was launched in July 2017, providing an online information hub, along with an e-form for self-referral.
    - The Annual All Wales Hepatology Nurse Forum (AWHNF) testing and awareness raising roadshow which operates across Wales.
    - BBV training days held on a monthly basis and open to all staff across all sectors of health & social care who want to be involved in BBV testing in Cardiff & Vale.
    - All Wales Hepatology Nurse Forum annual conference, which is aimed at health professionals across wales.
    - The Cardiff & Vale UHB Hepatitis C social media campaign #GetTestedGetCured which has been effectively supported by the Health Board's communications and media team. This is a long-term campaign which involves infographics being displayed on media screens across Cardiff & Vale UHB.
- Increased awareness raising of BBVs amongst younger people is needed, for instance in schools, colleges and universities. This is vitally important as understanding the risks before embarking on risky behaviours may prevent the spread of infection.

3) The scope to increase community-based activity

There are many positive aspects relating to existing community-based activity such as:

- A complete map of community pharmacies across Wales that carry out needle exchange and 'Opiate Substitute Therapy' (OST) has been established. A BBV Pharmacist lead for Wales has been recruited to oversee and coordinate the national pharmacy projects in BBV screening & treatment. Cardiff have already performed some pilot projects in some community pharmacies with some positive outcomes.
- The Harm Reduction Database developed by Public Health Wales as part of their Substance Misuse Programme captures Hepatitis (BBV) activity and risks in the community. Substance misuse services are required to complete these online database forms each time a client/individual is screened for BBVs. This is an ongoing project with progress still to be made but improvements have been seen following biannual Wales network meetings.

The scope to increase community-based activity includes:

- Increasing access to portable fibroscanners; one fibroscanner is used and shared by the specialist nursing team across all the community services in Cardiff and Vale for instance. Having access to additional fibroscanners would enable more community clinics to use the technology in patient assessments.
- 'Point of care testing' (for example via Oraquick mouth swab) can enable teams

to provide Hepatitis C antibody results within 30 minutes and initiate diagnosis or further testing and treatment options where required. A virology point of care testing lead based at University Hospital Wales has been able to oversee the roll-out of the scheme across Cardiff & Vale.

- Working with homeless people, rough sleepers and other vulnerable groups such as the pilot project run in Cardiff in 2017 in conjunction with the Salvation Army & Cardiff Council night bus. A double-decker bus provided temporary shelter as well as equipment and volunteers to enable screening for BBVs and fibroscans with a view to improving liver health. Having specialist nursing teams with a presence in homeless shelters and hostels, drug and alcohol units, and prisons is also worthwhile.
- Harm reduction advice is key to the prevention of acquiring BBVs and individuals at risk should be aware that following eradication, they can be re-infected with the virus if exposed to further risks.

4) The long-term viability of treatment programmes

- Treatment has evolved hugely over recent years and is considered to be highly effective in the eradication of the Hepatitis C virus. There are many treatment options with Directly Acting Anti-viral (DAA) treatments all having an efficacy exceeding 97%.
- The long-term viability of treatment programmes is dependent on several factors:
  - Cross-party political support in working towards eradication 2030 must be maintained, and Welsh Government funding for BBV services, medication and awareness raising programmes are essential if the eradication target is to be met.
  - Adherence to the DAAs is imperative as the risk of treatment failure and/or developing resistance may rise in the future. This can be a challenge in small groups of patients who are already vulnerable.
  - Annual All Wales Hepatology Nurse Forum (AWHNF) to continue to provide a link between the BBV services across the health boards in order to efficiently liaise when patients geographically move between treatment centres.

<u>About the Royal College of Nursing</u>

The RCN is the world's largest professional union of nurses, representing over 430,000 nurses, midwives, health visitors and nursing students, including over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

Submission of written evidence to Health, Social Care and Sport committee on Hepatitis C consultation, January 2019 by Dr Brendan Healy, National Lead for Hepatitis.

This submission is provided to the Committee through my role as National Lead for Hepatitis, which I am commissioned to provide by the Liver Disease Implementation Group at the request of Welsh Government. The views expressed in this submission are my own and reflect opinions formed as a result of that position. They do not necessarily reflect the views of my employing organisation (Public Health Wales) or any other organisation that I work for (Cardiff and Vale University Health Board and Abertawe Bro Morgannwg University Health Board).

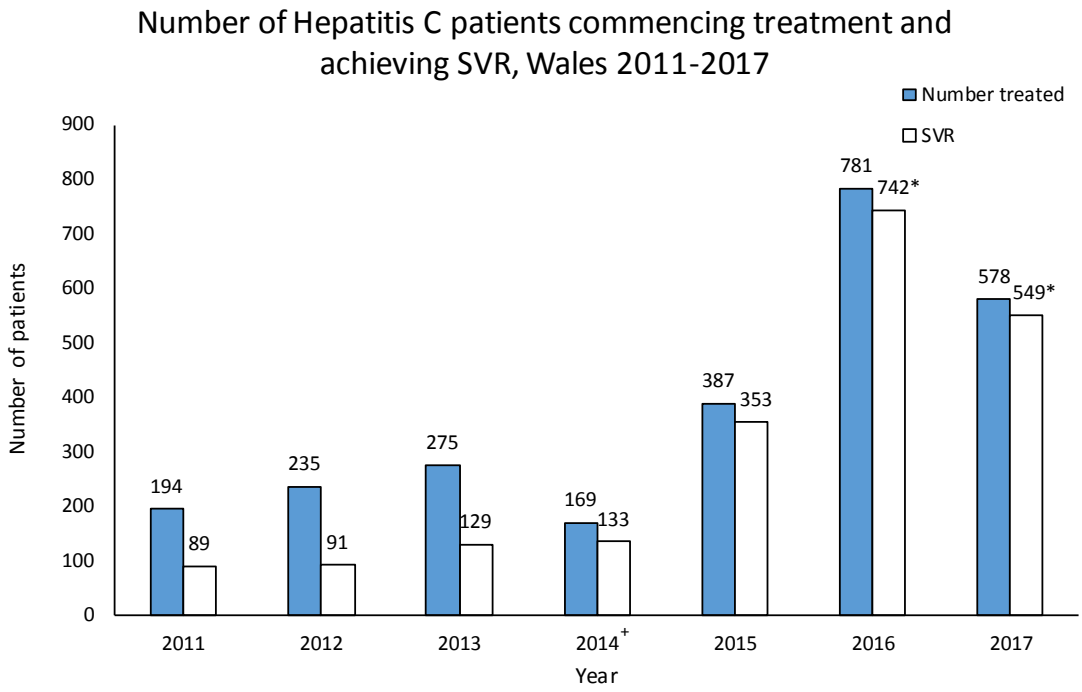
Current situation

See figure 1 below for treatment and cure (SVR) rates since 2011.

Prior to 2014 patients were treated with a combination of drugs called pegylated interferon (which had to be given by injection) and ribavirin. This treatment was difficult to take and had low cure rates of 40-80% in the small number of people who could tolerate it. Treatments using directly acting antiviral medications without the need for interferon have been available since 2015. These treatments are all in tablet form, are easy to take, well tolerated, can be taken by almost all people infected with hepatitis C and have high cure rates (>90% in all patients and >95% in most patients). In 2015, patients with the most advanced disease were treated with directly acting antivirals using a Welsh Government central fund. In 2016, patients that were accessing care, most of whom had been accessing care for some time, were treated (i.e. backlog of patients waiting for treatment was cleared). From 2017 onwards, the number of patients being treated reflects the number of patients being diagnosed and treated each year.

SVR = Sustained Virological Response which is an undetectable viral load in the blood taken 12 weeks after treatment has been completed which equates to a cure.

Figure 1



Notes on interpretation

i) Data obtained from health board returns. Data are unavailable for one health board in 2014+

ii) Data collection systems have been under development and therefore figures should be interpreted with caution, and may be subject to change. It is possible that some individuals may have been counted more than once.

iii) Year of SVR (sustained virological response) may not be the same as year of starting treatment for years 2011 to 2014.

*iv) *SVR in 2016/2017 is estimated based on 2015 SVR rates. Work on the exact SVR for those years is currently underway.*

Each Health Board was assigned a minimum treatment target at the end of 2015. This target was based on data available at that time which was used to predict the approximate prevalence of infection in each area and to provide treatment targets that would facilitate equitable and transparent access to treatment across Wales. The Viral Hepatitis Subgroup of the Liver Disease Implementation Group (LDIG) is aware that these figures will need to be refined when a more robust estimate of prevalence becomes available. The group anticipates being able to recalculate these minimum treatment targets at the beginning of 2020 when data from increased testing in the prisons, community pharmacies and drug and alcohol services is available. Delivery of increased testing in these environments is critical in facilitating a refinement of these figures and a refinement of the elimination modelling, which is currently based on data that may not accurately depict the current situation in Wales.

Attainment of minimum treatment targets:

Year 2017/2018

In 2017/2018 only one Health Board achieved the minimum treatment target. This was to be expected as there was a requirement for Health Boards to change the way the services were being run in order to meet the target. Health Boards had to change services to increase testing in at risk

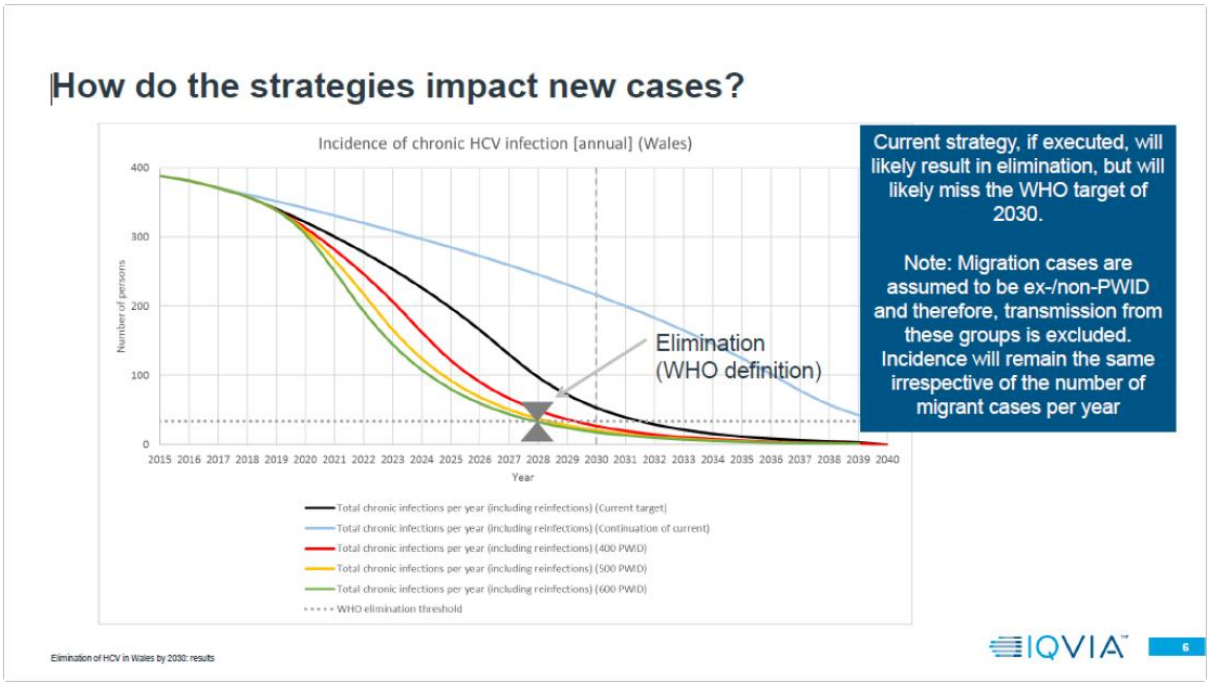
populations. The services also needed to be changed so that patients who tested positive could access treatment.

Year 2018/2019

Only two Health Boards are on target to treat the recommended minimum number of patients that need to be treated per year to achieve elimination. If the current trajectory (based on end of November figures, two thirds of the way through the year) is maintained, 638 patients will be treated by year-end (262 patients short of the minimum target).

Modelling (provided by an independent company funded by a pharmaceutical company), based on the most up to date data, suggests that if we treated 900 patients per year we would miss the WHO elimination date of 2030 by 1-2 years. Based on the current treatment numbers (2015/16 and 2016/17) elimination would not be achieved until 2040 (see figure below). It is imperative, therefore, that the number of at risk individuals being tested and treated is increased rapidly if elimination is to be achieved. This requires investment in a number of services and for Health Boards and BBV teams from each Health Board to work together to ensure that the teams in each area are appropriately resourced to deliver the necessary increase in testing and treating.

Figure 2:



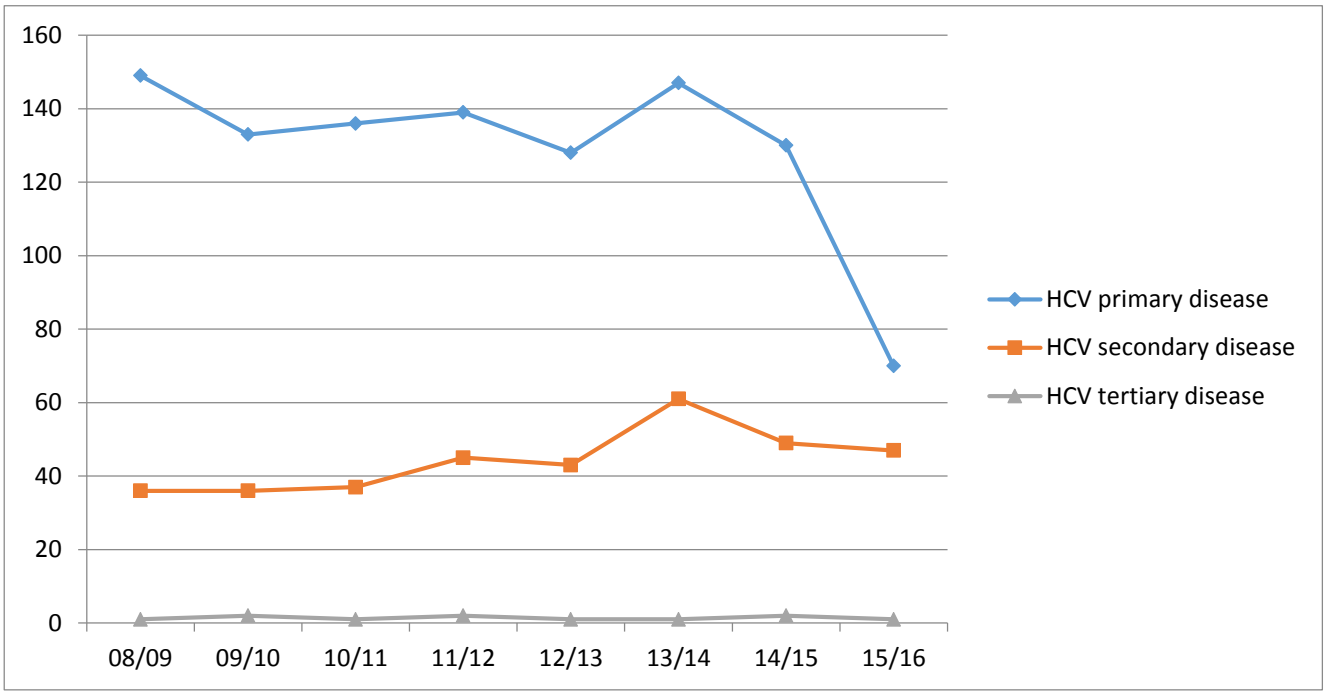
The graph demonstrates modelling of prevalence of hepatitis C in Wales based on current estimates of prevalence. The light blue line demonstrates the trajectory for elimination based on actual current treatment numbers across Wales. The black line demonstrates the trajectory of elimination based on 900 patients in Wales receiving treatment each year (current minimum target). The other lines demonstrate the trajectory for elimination if the number of people who are injecting drugs is altered within the model. Because people who inject drugs are responsible for most of the ongoing transmission of hepatitis C, treatment in this group has the potential to increase the speed with which elimination can be achieved without altering the overall annual treatment numbers. It also

has the potential to reduce the overall number of people that need to be treated to achieve elimination and reduce the total cost of the programme as a result.

The treatment programme in Wales has delivered significant clinical success which will be cost saving to NHS Wales in the long run because patients who have been cured of hepatitis C will not then develop hepatitis C related liver disease which is costly to manage (for example through the costs of the management of liver failure and liver transplantation - which is also a scarce and precious resource). Cure rates in the region of 95% were achieved in 2015, which is at least equivalent to other major international centres. Data on cure rates for 2016 – 2018 will be available in 2019 (work ongoing currently).

National (UK) statistics demonstrate that the new medications are having a significant impact on the outcomes of advanced liver disease – namely the reduced demand on liver transplantation and reduction in the number of hepatitis C related deaths (see graphs below).

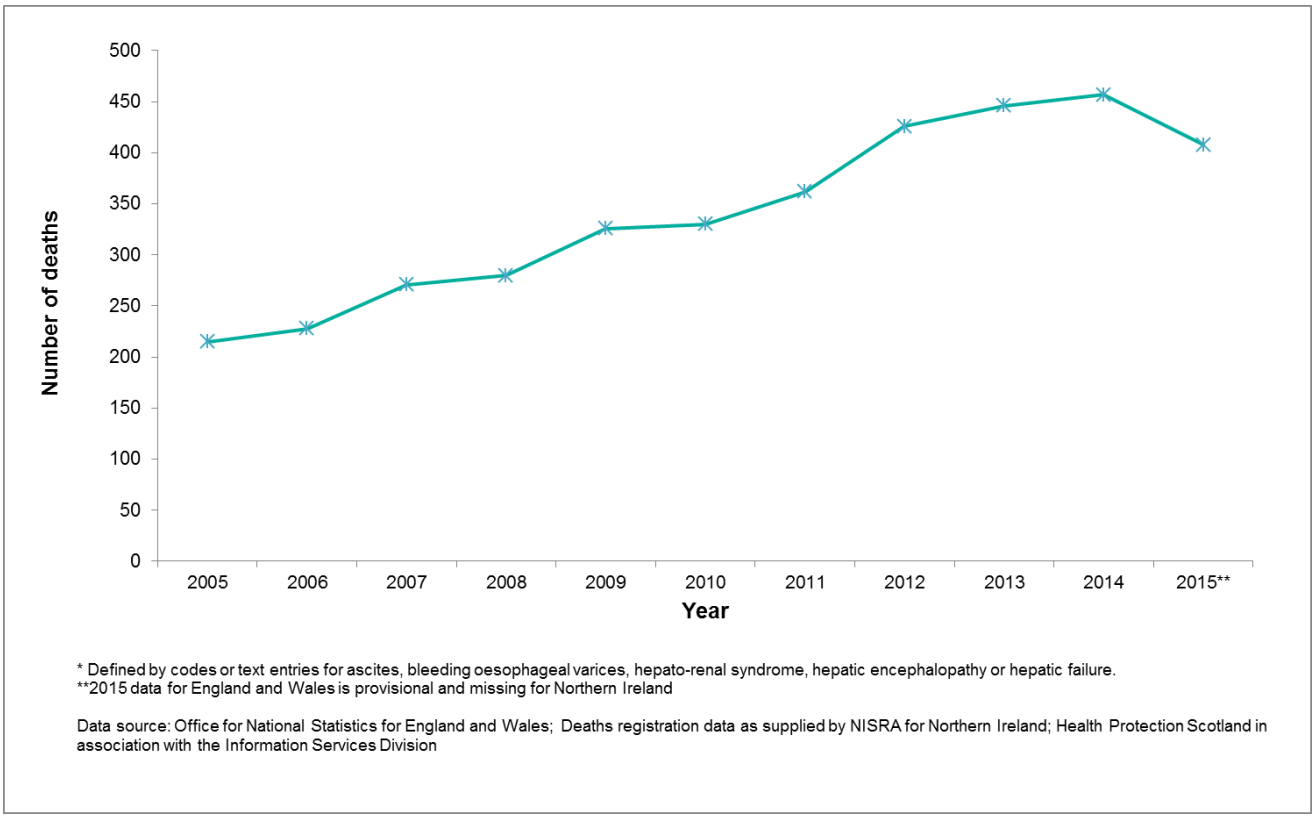
Figure 3: Patients Listed for First Liver Transplant with a Primary, Secondary and Tertiary Diagnosis of HCV 2008-2016 (UK Transplant Data)



This graph demonstrates that the number of people requiring a Liver transplant for hepatitis C (where hepatitis C is the main cause of liver disease – "HCV primary disease") dropped significantly following the introduction of directly acting antiviral agents. In this year, it most likely reflected treatment of patients with advanced disease who improved following treatment and could be delisted as a result. As liver transplant is a precious resource, this reduction in demand is a very positive outcome of the new treatments.

In the graph there is no change in the number of patients requiring liver transplantation where hepatitis C is not the main cause of liver disease ("HCV secondary disease" and "HCV tertiary disease") suggesting that this decline in the need for transplantation in the "HCV primary disease" group is related to treatment with the directly acting antiviral agents.

Figure 4: Death certificates with HCV



The National (UK) figures for deaths caused by hepatitis C as listed on death certificates also fell in 2015 following the introduction of the directly acting antiviral treatments. This is another positive sign that the treatments are having a beneficial effect at a national level.

Section 1: The action being taken to meet the requirements of the Welsh Health Circular (WHC/2017/048) published in October 2017 and subsequently meet the World Health Organization target to eliminate Hepatitis B and Hepatitis C as significant public health threats by 2030.

1. The World Health Organisation (WHO) has announced a global health sector strategy on viral hepatitis which sets out to eliminate hepatitis B (HBV) and hepatitis C (HCV) as significant public health threats by 2030. The WHO target is a 90% reduction in occurrence of new cases (incidence) and 65% reduction in death (mortality) due to hepatitis B and C by 2030. Wales is signed up to this strategy.
2. The Welsh Health Circular (WHC/2017/048, issued in October 2017) highlights the three key areas where action is needed in Wales to progress toward the 2030 elimination target. Those three areas are:-
    a. Reduce and ultimately prevent ongoing transmission of HCV within Wales;
    b. Identify individuals who are currently infected with HCV including those who have acquired HCV outside the UK and are now resident in Wales; and
    c. Test and treat individuals currently infected with HCV who are actively engaged in behaviours likely to lead to further transmission.

Reduce and ultimately prevent ongoing transmission of HCV within Wales

3. Over 90 per cent of ongoing transmission of hepatitis C is via injecting drug use. As such, the most effective way of reducing transmission is through a reduction in the number of individuals injecting and through provision of effective needle and syringe programmes (NSPs).
4. Reduction in HCV in these individuals is reliant on increased testing in appropriate settings (prisons, drug and alcohol services, needle exchange services, opiate substitution services, criminal justice services, third sector agencies, community pharmacies). Testing rates in all of these settings is currently sub-optimal. Work is being carried out to improve uptake of testing in these settings (e.g. community pharmacy national specification for testing, testing now a key performance indicator (KPI) for drug and alcohol services, catch-up vaccination for hepatitis B of staff who will be involved in testing, opt out in prisons). However, these initiatives need to be matched by an appropriate investment in the services so that they have sufficient staff and equipment to facilitate testing of all at risk clients.
5. Once tested positive individuals need to be able to access treatment. Each Health Board needs to have a robust mechanism in place that enables individuals to access treatment easily. This will most likely be provided by secondary care services. All Health Boards (except Powys) have a Blood Borne Virus team that delivers treatment for hepatitis C. Treatment and management of hepatitis C in Powys is supported by the Blood Borne virus teams of neighbouring Health Boards. It is imperative that these teams are appropriately resourced so that they are able to deliver treatment to positive individuals in a setting that they are willing and able to access. This will most likely be in the community where they are already accessing another service (e.g. community pharmacy, drug and alcohol services, needle exchange services, prison etc.). I think the BBV teams in all Health Boards require some investment to ensure that they have the appropriate staff in place to enable this to happen.
6. Treatment in community pharmacy setting is another means for achieving this aim. Work will start on a specification for this in the near future. This work is being carried out by the National Pharmacy Lead for BBV. This post is funded until 2020 through Liver Disease Implementation Group money. The delivery and roll out of a specification for treating in community pharmacies is complicated. For this to be achieved the funding for this post needs to run beyond 2020. Some of the decisions in relation to delivering treatment in this setting will need to be made at senior level and so engagement from individuals in a variety of settings is required to achieve this goal (e.g. Health Board finance directors, Senior Pharmacy staff at National level, Community Pharmacy Wales).
7. Delivery of appropriate harm reduction services is also a key component of the elimination strategy. It will reduce the number of people that require treatment, will reduce the risk of re-introduction of the infection once the prevalence has been significantly reduced, will reduce the risk of transmission of resistant virus and have other health benefits by preventing transmission of other infections. These services therefore require appropriate investment / funding. The Viral Hepatitis Subgroup of the Liver disease Implementation Group works with the Substance Misuse Programme, Health Protection, Public Health Wales in this regard and strategy in this

context is taken forward by them in conjunction with relevant individuals in Welsh Government. Substance Misuse Area Planning Boards / Heath Boards should have in place appropriate, comprehensive and effective harm reduction groups and local action plans, in line with the Welsh Government strategy, accompanying substance misuse treatment frameworks and best practice guidance.

Identify individuals who are currently infected with HCV including those who have acquired HCV outside the UK and are now resident in Wales

8. Public Health Wales with the Viral Hepatitis Subgroup of the Liver Disease Implementation Group is leading the co-ordination and implementation of a national patient re-engagement exercise. This work is looking to identify individuals with a historical diagnosis of Hepatitis C who, for whatever reason(s), have not completely engaged with treatment services and is seeking to bring them back into the service. The yield from this strategy is yet to be determined but pilot work has suggested that a high return in percentage terms is unlikely. Further work to try and identify individuals on this database at ongoing risk will probably be required.
9. Testing and treating patients at high risk of infection and at high risk on onward transmission is the first priority of the BBV subgroup. As such most work to date has concentrated on identifying infected individuals through testing in settings that provide services to individuals who inject drugs (see section above for more detail). Testing and treating individuals in this setting is the fastest way to reduce the overall prevalence, will be the key to achieving WHO elimination targets and will reduce the overall cost of reaching the elimination target (each individual successfully treated can reduce the overall number of individuals that need treatment as onward transmission is prevented). Success in this regard is being monitored through the harm reduction database. Measures in place to increase testing in these groups include the KPI for drug and alcohol services, opt out in prisons, national specification for testing in community pharmacies. As previously mentioned this needs to be matched with services that are able to offer treatment to these individuals when identified as positive.
10. Strategies to identify positive individuals from high risk countries, those that injected in the past but are no longer accessing services and those with other risk factors are not yet well established. There is still uncertainty with regards to the best way to identify these people and further work will be required on this in due course. It is the intention of the Viral Hepatitis Subgroup to turn its attention to these groups of people once the testing and treating of people in high risk groups already accessing services as outlined above is operating successfully. That said work has been carried out in asylum services and testing is now routinely offered to individuals accessing these services. Work is also being carried out to encourage testing of at risk pregnant women. It is yet to be determined whether targeted testing can be effective in this setting. I understand that previous attempts at targeted testing in this environment (e.g. HIV) were not successful. Some pilot work of testing individuals and raising awareness in individuals from high risk countries has also been carried out.

Test and treat individuals currently infected with HCV who are actively engaged in behaviours likely to lead to further transmission

11. As previously mentioned the three main areas of development in this regard relate to opt out testing in prisons (testing has increased from approximately 8% to 32% as a result), development of a KPI for drug and alcohol services related to BBV testing and development of a national specification for testing in community pharmacies.
12. All of these developments now need to be made operational and it is the appropriate investment and adequate resourcing of services that will make this possible.
13. Development of appropriate services to facilitate treatment of positive individuals identified in these settings is also required with adequate resourcing for medication should the number of patients accessing treatment dramatically increase. As previously mentioned this requires development of the BBV teams in secondary care to ensure treatment is delivered at the point of need and engagement from senior members of the Health Board such as the Finance Directors to ensure budgeting and adequate allocation of funding is achieved.

Developments so far

14. In my role as National Lead for Hepatitis I have worked with members of Public Health Wales, Welsh Government colleagues, other members of the BBV network, the Liver Disease Implementation Group, the microbiology / virology laboratory Cardiff, the National Point of Care testing lead, in developing roles, services and protocols to support elimination. Most of this work is carried out through the Viral Hepatitis Subgroup of the Liver disease Implementation Group.
15. The following has been delivered

    - Appointment of a National Pharmacy Lead for Hepatitis (funding secured to 2020)
    - Appointment of a National Project and Research Lead for Hepatitis (funding secured to 2020)
    - Appointment of a National Point of Care Testing Lead (funding due to expire 2019)
    - Development of a national protocol for testing for hepatitis in a community pharmacy setting
    - Obtaining funding to develop reflex PCR testing from dried blood spot tests that will facilitate and increase speed of access to a confirmed diagnosis which in turn can speed up access to treatment in some settings (e.g. community pharmacy)
    - Funding, and administration for a variety of projects on testing and treatment strategies for hepatitis C
    - Development of a protocol and plan including administrative support for delivery of a programme designed to re-engage patients with hepatitis C that

may have been lost to follow-up or may never have been offered treatment for hepatitis C (e.g. diagnosed when no treatment was available historically)

- Development of the national Hepatitis C treatment pathway and treatment recommendation protocol.
- Co-ordination of the blood-borne virus network.
- Running of two national network meetings per year made possible through unrestricted educational grants provided by pharmaceutical industry.
- Development of an elimination model using an independent company funded through non restricted grant by pharmaceutical industry
- Support for the national tendering process
- Delivery of equitable and transparent access to treatment.
- Construction of a map of all community pharmacies involved in provision of opiate substitution and needle exchange services
- Administration of the virtual panel that enables discussion of complicated patients to ensure most appropriate treatment options are given to these individuals
- Administration and collection of national figures on treatment numbers on a monthly basis
- Reporting of appropriate statistics on a regular basis to Welsh government, health boards and national bodies as appropriate
- Development of a hepatitis C electronic form that will facilitate live collection of national treatment data in the future
- Working with other agencies as appropriate to develop and support increased testing and treatment in a variety of settings including prisons, drug and alcohol services, third sector services and community pharmacies
- Regular reports of activity and routine reporting to the Liver Disease Implementation Group
- Collection of data to ensure appropriate governance of the blood borne virus section of the National Liver plan
- Regular review of the national plan for elimination with expert advice and recommendations for development as and when appropriate.
- Delivery of significant savings to the NHS in Wales through national procurement, adherence to the principles of prudent Healthcare, use of cheapest possible treatment options when appropriate, taking senior decisions to delay treatment in patients who could afford to wait for newer cheaper options in the early days of management of hepatitis C.
- Significant savings were delivered through a number of strategies that include strong clinical leadership, prudent use of available medications, national procurement and use of home care. In 2017 Wales was shown to

have the lowest acquisition costs in the UK for the new hepatitis medications as a result of these factors.

16. From October 2015 to 2017 the total saving to NHS Wales are estimated to be of the order of £29 Million, with £15.9 Million of this realised through direct action of the BBV group (home care delivery of medication and holding patients back for treatment). Breakdown of savings:

    - National procurement – significant savings against list price - £6M in 2015/2016, £8.5M in 2016/2017, Total £14.5M
    - Use of home care – £2.5M in 2015/2016, £2.3M in 2016/2017, Total £4.8M
    - Prudent prescribing – use of cheapest appropriate product – savings in 2015 £2M, 2016 £5M, Total £7M
    - Prudent prescribing – in 2016 patients with a certain genotype (genotype 3) disease that could wait were held back for treatment early in the financial year until a newer cheaper alternative became available – £3.1M (204 patients treated with the cheaper medication @ £15,623 saving per patient)
    - This figure does not include further savings achieved in 2017-2018 when treatment of patients with a certain genotype (genotype 3) infection who were willing and able to wait were delayed until a cheaper alternative became available, delivering a saving of approximately £13,000 per patient.

Section 2: How the knowledge and awareness of the public and health professionals of the Hepatitis C virus can be increased.

17. Increasing awareness of the public and health professionals is one of the most challenging areas of the elimination plan.

18. The British Liver Trust (BLT) (as part of their work with the Liver Disease Implementation Group) is working in Wales to raise public and professional awareness of liver health including the need for at risk individuals to be tested and treated.

19. In December 2017, a good practice hepatitis C roadshow was held in Cardiff. This event was organised by HCV Action and Public Health Wales, and aimed to bring together professionals working with hepatitis C in a variety of contexts, identify challenges and solutions for tackling hepatitis C locally, and showcase and share examples of good practice in prevention, testing, and treatment. The summary report from the roadshow is available on the HCV action website at http://www.hcvaction.org.uk/resource/summary-report-hepatitis-c-good-practice-roadshow-cardiff-december-2017 [accessed 27/12/2018]

20. In addition, I have organised with the blood borne virus network national network meetings (two in 2018 and two planned for 2019), to help share learning between teams and health boards. These were made possible through unrestricted educational grants provided by the pharmaceutical industry.

21. Local education and awareness raising is currently dependent on the enthusiasm and work of the local BBV teams. Whilst there has been some success in this regard, it is

fair to say that public awareness raising / advertising is not the skill set of these teams.

22. To date the following local awareness raising initiatives have been carried out (list not exhaustive)
    - Education of primary care teams
    - Awareness raising on World Hepatitis Day
    - Engagement with media when Hepatitis C is in the news
    - Support for Hepatitis C awareness raising events
    - Project to test and raise awareness in a mosque
23. Impact of these initiatives is uncertain but there is no evidence of a significant impact so far.
24. Consideration should be given to ways in which awareness raising could be increased although I also appreciate that this is not as easy to achieve as it sounds. In this particular instance targeted messaging is required.
25. Consideration could be given to using learning from other Public Health Campaigns such as the stop smoking campaign but we may require a very different approach to public messaging and engagement to that which has been used previously because the individuals at risk of hepatitis C infection come from groups in society that may not respond to traditional methods.
26. Consideration should be given to funding a focussed awareness raising campaign designed to specifically target the groups in society who are at risk of infection. A campaign of this sort could be particularly important in finding patients who are not easily identified (e.g. individuals from high prevalence countries, people who used to inject drugs or dabbled in early life but are no longer accessing support services, those at risk through blood transfusion etc.).

Section 3: The scope to increase community-based activity e.g. the role of community pharmacies.

27. I have worked with the Viral Hepatitis Subgroup of the Liver Disease Implementation Group, Community Pharmacy Advisor, Lead Pharmacist - Community Pharmacy & Primary Care, CTUHB, other BBV pharmacy colleagues, the Chief Pharmaceutical Officer for Wales and Community Pharmacy Wales to develop a national specification for delivery of testing for hepatitis C in the community pharmacy setting. The specification has now been approved by National Pharmacy Wales.
28. The National Pharmacist for Hepatitis C was appointed in October 2018. He has been involved in the completion of the national specification and is now working on rolling out testing in community pharmacies across Wales (making the specification / service operational).
29. Funding for a pilot project to test the protocol in the live environment has been secured and will run in January.

30. Blood borne virus teams from across Wales are aware of the protocol and are in position to support the roll out of testing in this environment.

31. A map of all pharmacies that carry out needle exchange and opiate substitution therapy has been constructed from data extracted from the Harm reduction database and this will be used to facilitate roll out. This has been provided by the Head of Substance Misuse Programme, Health Protection, Public Health Wales.

32. The National Pharmacist for Hepatitis C is also tasked with developing a national specification for treatment of positive patients in the community pharmacy setting. There are a number of hurdles to overcome in relation to this development. Earliest start date for this specification is 2020. Development of this specification requires engagement and support from a number of key decision makers including Health Board Finance Directors and senior members of the pharmacy teams in both secondary care and the community.

Section 4: The long-term viability of treatment programmes.

33. Treatment programmes are currently supported by a combination of Health Board level Blood Borne Virus teams and national roles (National Pharmacist, National Lead for Hepatitis, National Project and Research Lead, National Point of Care Testing Lead).

34. The national roles are supported by the Liver Disease Implementation Group. Funding for those roles is uncertain beyond 2020. At the current trajectory elimination will not be achieved until after 2030. If testing and treating is to be up-scaled to the point that elimination by 2030 is to be achieved then it is imperative that these roles are sustained beyond 2020.

35. Funding for treatment is currently secured through Health Boards. However, as treatment numbers increase this could create a cost pressure. If elimination is to be achieved it is imperative that Health Boards support treatments of hepatitis C and do not put any cap on treatment numbers at any stage.

36. Blood borne virus teams are variably resourced across Wales. It is imperative that all Health Boards ensure that their BBV teams are adequately resourced to deal with the challenge of elimination and this includes sufficient staff to support testing and treating in the community setting. As National Lead for Hepatitis, I am concerned that the BBV teams are not sufficiently resourced in this regard at this time.

37. There are many developments designed to increase the testing of at risk individuals and link them to care (e.g. increased testing in prisons, drug and alcohol services, third sector agencies, community pharmacies). It is imperative that these initiatives are appropriately resourced so that the increase in testing in these environments is sustainable.

38. The developments to increase testing and treatment of at risk individuals need to be appropriately matched with investment to promote harm reduction messages to reduce the risk of re-infection and make the delivery of elimination as cost effective as possible.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf University Health Board

Cwm Taf HB response to: The Health, Social Care and Sport Committee Enquiry into Hepatitis C

Author:
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Deputy Medical Director CTUHB

Targeting HCV with a view to eradication in Wales

There are number of factors which will affect our ability to eradicate HCV in Wales.

1) Baseline prevalence
2) Transmission rates
3) Detection of new and old cases
4) Engagement with the treatment services
5) Compliance with medication

1) And 2) As a HB CTUHB does not have pockets of very high prevalence in the same way that some large urban areas do but we know the prevalence of disease in our actively IV drug using community is moderate (18.6%) and that if we can make inroads into treating, particularly in the active IVDU group we can make a difference to rates of ongoing transmission.
Data below is from the Harm Reduction Database 2017-18 and first two quarters of 2018/19. This shows that some HBs have particularly high levels (ABMU). Some HBs however have lower testing rates recorded on HRD and results therefore may not show prevalence accurately.

	Total individuals tested for anti-HCV	% Results Recorded (n=1,452)	% anti-HCV Reactive
ABMU	230	97.6	39.7
Aneurin Bevan	386	99.2	8.6
BCU	334	89.6	17.1
Cardiff and Vale*	38	73.2	22.2
Cwm Taf	471	93.5	18.6
Hywel Dda*	97	81.0	7.7
Powys Teaching	10	20.0	0.0
Wales	**1566**	**92.7**	**18.4**

2) As above

3) Detection of new and old cases:
In CTUHB since April 2018 we have had approx. 68 new referrals for patients with HCV.
35 referrals have come direct from GPs or hospital based services including GUM(2), these are people generally not actively using drugs but often being picked up due to screening for reasons for abnormal LFT.
22 are from the HB CDAT team. These people are generally people with complex MH and dependency issues who have not been able to be managed in the third sector community addiction services. Many of these patients have been seen in third sector commissioned addiction services prior to referral in to Health based CDAT services due to case complexity.
2 referrals have been from Barod, one of our community based addiction services. Given the prevalence of Hepatitis C positivity in our local IVDU population this is a very low number of referrals in the first 8 months of the financial year 18/19. Of those who are tested in community services there is a high number of HCV antibody positive people who are already know to have or have previously had HCV treated. On the HRD data base this is reflected by the high level (43%) of patients tested who are RNA negative: compared with ABMU where only 27% of the clients positive for anti HCV are RNA negative. This suggests that testing is focussing on those who have known previous disease which has been treated rather than on those who are likely to have new active disease. It is reassuring that the individuals are RNA negative and annual retesting for those continuing high transmission risk behaviours is recommended but it also suggests we are not targeting patients with risk taking behaviours who have no history of HCV.
6 referrals are through our self-referral pathway which enables friends, families and contacts of people already in our service to refer themselves in for testing and treatment.
3 were other routes including patients transferring into our HB from another HB.
Looking at the referral source it appears that we are picking up old cases opportunistically which is the majority of GP and consultant testing, the only downside of this approach is that these people are more likely to have established liver damage.
We fall down in the area of testing and referring people who are actively using drugs or are early in their engagement with community drug services. These are people who could be benefited most as not only could they be cured before they develop established liver disease from their hepatitis C. The people who are referred to the Viral hepatitis treatment services are those who have complex addictions, dual diagnosis or physical illness from their addictions who are managed by CDAT rather than community services such as Barod and whilst these patients do need to be seen they are often in a more difficult to treat category due to co-morbidities.

4) Engagement with treatment services is something we need to work on. Our service model of bring people to a hospital base for their first appointment results in a 50% DNA rate for first appointments and of those just over 50% DNA a second appointment which means only 74% are actually seen for a first appointment.

5) Compliance with treatment. Once patients are established in the service and they feel they are ready to embark on treatment compliance is good. New treatments of short duration and many fewer side effects have meant that this is no longer the issue that it has been in years gone by. We have good arrangements with pharmacy and nationally agreed drug costs so that we can ensure there is no barrier to patients receiving the most appropriate treatment.

Our target in CTUHB is to treat 85 patients in each financial year. This target is set for our population taking into account population size, and prevalence rates, if we manage to hit this target we should start to have an impact on infection rates.
As we have not had enough referrals and our DNA rate is 26% we have not treated enough so far this year to be able to hit our target.
We have treated 29 patients in the first 8 months of the year, leaving 56 to treat in the last 4 months of the year. We have not had enough referrals to enable us treat another 56 even if all the patients we had been referred were treated we would not hit our target of 85 for 2018/19.

Actions we are looking to take:

1) We in the Health based services need to work more closely with our third sector community based third sector partners to understand the barriers they are experiencing to testing and referring patients for treatment. A new service provider is being commissioned and we need to ensure close partnership working form the start of the new service.

2) The new opt out testing as opposed to opt in may help increase testing rates but only if we ensure tests are offered and framed in a positive light. Ensuring those offering testing have up to date information on the new treatment options is essential as treatment has changed dramatically in the past 5 years becoming much simpler, moving from injections to oral and with reduced durations of treatment.

3) We need to look at the model of treatment services. Whilst services are provided in local community hospitals we could look at the treatment service going to the patient rather than the other way round.
For patients already engaged with health services it may be less of an issue to come up to a local DGH or community hospital but if we can increase testing

in community settings and this is the only point of contact for clients found to be positive, we may need to start looking at holding clinic consultations in community/third sector/local pharmacy/needle exchange premises. Visits to hospital bases should be kept for limited numbers of appointments where hospital based investigations are needed e.g. fixed fibroscan and only once a therapeutic relationship has been built between patient and treatment service..

Aneurin Bevan University Health Board's Evidence to the Health, Social Care and Sport Committee Enquiry into Hepatitis C

Background

Wales is signed up to a World Health Organisation global health sector strategy, which sets out to eliminate Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) by 2030 (90% reduction in incidence and 65% reduction in mortality). New directly acting anti-viral medications have revolutionised the treatment of HCV so that the disease is now essentially curable in the early stages.

The Welsh Health Circular WHC/2017/048 outlined a series of expected measures from multiple organisations and partnerships to contribute to the elimination target:

1. Reduce and ultimately prevent ongoing transmission of HCV within Wales

2. Identify individuals who are currently infected with HCV including those who have acquired HCV outside the UK and are now resident in Wales

   2.1 individuals infected with HCV who were not linked to care

   2.2 identifying individuals infected with HCV, who have never been tested and are unaware of the infection

3. Test and treat individuals currently infected with HCV who are actively engaged in behaviours likely to lead to further transmission

The Health, Social Care and Sport Committee will be undertaking a one-day inquiry into Hepatitis C. This paper provides a written evidence to the questions raised in the Committee's terms of reference of the inquiry.

Current situation

Given the availability of the new directly acting antiviral medication in 2015, each health board was assigned treatment targets. In 2017-18, only one health board achieved the minimum treatment target with Aneurin Bevan University Health Board (ABUHB) being ranked third among all health boards. In 2018-19, only two health boards are on target whereas others are falling behind including ABUHB. Based on the current treatment numbers ABUHB is unlikely to meet the 2018-19 target. The key issue is that not enough people have been referred to our Blood Bourne Virus (BBV) service to enable the required number of Hep C cases to be treated.

The ABUHB Blood Bourne Virus (BBV) team provides treatment services across Gwent and also covers Brecon and Llandrindod Wells. The current service model includes provision of treatment clinics in both hospital and community health care settings. Regular clinics are held in the Royal Gwent Hospital in Newport, Gwent Drug and Alcohol Services (GDAS) in Tredegar, Gwent Specialist Substance Misuse Service (GSSMS) in Newport and Caldicot GP Practice. Ad hoc clinics are provided in Caerphilly, Blackwood, Ebbw Vale, Blaenavon and various GP surgeries across Gwent. The BBV team also offers an outreach service, home visits and treatment clinics in two prisons, on mental health wards, and at the Wallich drop in centre in Newport for homeless people.

The actions being taken to meet the requirements of the Welsh Health Circular (WHC/2017/048) published in October 2017 and subsequently meet the World Health Organization target to eliminate Hepatitis B and Hepatitis C as significant public health threats by 2030 are:

- ABUHB has been engaged with Public Health Wales led national HCV re-engagement exercise. This involves identifying and offering assessment/treatment to individuals with historical tests indicating exposure to Hepatitis C who may still be infected, but they were not linked to care.

- ABUHB has been working with GDAS to increase Blood Bourne Virus (BBV) testing. There are around 2100 patients accessing GDAS services. In 2017-18, only 18% were tested for BBV, 6% declined the offer, and 66% were not offered the BBV test. The key barrier identified for this low BBV testing was lack of Hep B vaccination for the GDAS staff. ABHUB has agreed

funding to offer Hep B vaccination to 50 staff members. This will help to increase BBV testing in GDAS in 2019-20.

- Gwent Specialist Substance Misuse Service (GSSMS) of ABUHB also offers BBV testing and Hep B vaccine to service users. However, the uptake has been very low. The BBV team have been working with GSSMS staff to identify barriers and ABUHB will be putting measures in place to increase uptake.

- People who inject drugs and the homeless population are at high risk of contracting BBV infection. However, due to the chaotic and transient nature of their lifestyles they many go untested for BBV's. ABUHB is setting up a Dried Blood Spot (DBS) Testing Incentive Scheme for service users of the Needle Exchange service in Newport and the Wallich Homeless drop in centre. The scheme is waiting for the addition of Hep C Polymerase Chain Reaction (PCR) test to the DBS test to enable a complete diagnosis.

- Gwent has an established problem of use of steroid and image enhancing drugs (SIEDs) in Gwent. To address this problem the BBV team have set up a steroid clinic. This clinic offers harm reduction advice, general health screening, ECG and BBV testing.

- ABUHB provide health care services to the two Gwent prisons. BBV testing is offered to all new prisoners. Wherever indicated HCV treatment and Hep B vaccination is offered in the prisons.

- ABUHB provides BBV treatment clinics in both hospital and community health settings across Gwent. This ensures good engagement with service users and the Did Not Attend (DNA) rate is less than 25%. The BBV team has plans to further strengthen provision of treatment clinics in community health care settings to minimise the DNA rates.

- Given the short treatment course for Hepatitis C and few side effects, the compliance with the treatment is good.

How the knowledge and awareness of the public and health professionals of the Hepatitis C virus can be increased?

- Newport has the third highest ethnic minority community behind Cardiff and Swansea. It has a population of 147,400, of these 12,900 (8.8 %) are from an ethnic minority background. In recent years, there have been a small number of projects around the UK to try to engage with the south Asian community. The projects that are integrated with the mosques seemed to bring the better results. Working in collaboration with a local GP, the ABUHB BBV Team has been running BBV awareness and testing campaign at the local mosques. Two events have been held at two mosques so far.

Further events are planned to revisit theses mosques on a rolling basis twice yearly. Other communities have also expressed interest in the project.

- The ABUHB BBV team undertakes the following activities to raise BBV awareness among the professionals

  - Annual Liver Conference
  - Talks at GP annual training days
  - Training for the ABUHB clinical staff
  - Training for the GDAS and GSSMS clinical staff

The scope to increase community-based activity e.g. the role of community pharmacies

- ABUHB is aware of developments at the national level to involve community pharmacies in BBV testing.

- There have been discussions going on locally to run a pilot project in Newport using the national service specification and protocols.

The long-term viability of treatment programmes

- The ABUHB BBV team provides the ABUHB HCV treatment service. It comprises of two full time hepatology clinical nurse specialists. A hepatology consultant supervises the clinical work.

- The funding ABUHB receives to provide a BBV treatment service is sufficient for the current number of patients being treated. However, the anticipated rise in treatment rates could pose a cost pressure and to achieve the WHO elimination target it is imperative that BBV testing and treatment services are adequately resourced to ensure long-term sustainability.

Eitem 5

Tystiolaeth ysgrifenedig Iechyd Cyhoeddus Cymru i ymgynghoriad y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon i Hepatitis C, Ionawr 2019

Adran 1: Y camau sy'n cael eu cymryd i fodloni gofynion Cylchlythyr Iechyd Cymru (WHC/2017/048) a gyhoeddwyd ym mis Hydref 2017 a chyrraedd targed Sefydliad Iechyd y Byd, wedi hynny, i ddileu hepatitis B a hepatitis C fel bygythiadau sylweddol i iechyd y cyhoedd erbyn 2030.

1. Mae Sefydliad Iechyd y Byd wedi cyhoeddi strategaeth fyd-eang i'r sector iechyd ar hepatitis feirysol gyda'r nod o ddileu hepatitis B (HBV) a hepatitis C (HCV) fel bygythiadau sylweddol i iechyd y cyhoedd erbyn 2030. Targed Sefydliad Iechyd y Byd yw gostyngiad o 90% yn nifer yr achosion newydd (mynychder) a gostyngiad o 65% mewn marwolaethau oherwydd hepatitis B ac C erbyn 2030. Mae Cymru wedi ymrwymo i'r strategaeth hon. Cafodd y nod hwn ei gynnwys yn strategaeth tymor hir newydd hyd at 2030 Iechyd Cyhoeddus Cymru, a gyhoeddwyd yn 2018.

2. Mae Cylchlythyr Iechyd Cymru (WHC/2017/048, a gyhoeddwyd ym mis Hydref 2017) yn tynnu sylw at dri maes allweddol lle mae angen gweithredu yng Nghymru er mwyn symud tuag at darged dileu 2030. Y tri maes yw:
    a. Lleihau ac atal HCV rhag cael ei drosglwyddo ymlaen yng Nghymru;
    b. Adnabod unigolion sydd wedi'u heintio â HCV ar hyn o bryd, yn cynnwys y rhai sydd wedi cael eu heintio â HCV y tu allan i'r Deyrnas Unedig ac sydd nawr yn byw yng Nghymru; a
    c. Phrofi a thrin unigolion sydd wedi'u heintio â HCV sydd ar hyn o bryd yn ymddwyn mewn ffyrdd sy'n debygol o arwain at drosglwyddo pellach.
3. Yng Nghymru, mae 'Law yn Llaw at Iechyd – Cynllun Cyflawni ar gyfer Clefyd yr Afu' wedi adeiladu ar y gwaith da a hwyluswyd gan y cynllun, Blood Borne Viral (BBV) Hepatitis Action Plan for Wales 2010-2015. Mae'r cynllun hwn yn cael ei roi ar waith

gyda chymorth y Grŵp Gweithredu ar Glefyd yr Afu, sy'n cael ei gadeirio gan y Cyfarwyddwr Gweithredol Gwasanaethau Iechyd Cyhoeddus yn Iechyd Cyhoeddus Cymru ac mae'n cynnwys cynrychiolwyr o bob bwrdd iechyd yng Nghymru, Ymddiriedolaeth Afu Prydain a'r Children's Liver Disease Foundation. Nododd y Grŵp Gweithredu ar Glefyd yr Afu hepatitis feirysol a gludir yn y gwaed fel un o'r meysydd blaenoriaeth allweddol.

4. I helpu i symud yr agenda hon ymlaen, cafodd yr Is-grŵp Hepatitis Feirysol ei sefydlu. Mae'r is-grŵp hwn, sy'n cael ei gadeirio gan yr arweinydd cenedlaethol ar gyfer hepatitis, yn darparu arweinyddiaeth strategol a chefnogaeth i'r byrddau iechyd i symud ymlaen yn y maes hwn. Ceir cynrychiolaeth amlddisgyblaethol ar yr is-grŵp, yn cynnwys cynrychiolaeth o Ymddiriedolaeth Hepatitis C. Darperir cymorth epidemiolegol a gweinyddol i'r grŵp gan Iechyd Cyhoeddus Cymru.

5. Mae'r Is-grŵp Hepatitis Feirysol hwn yn adrodd yn rheolaidd i'r Grŵp Gweithredu ar Glefyd yr Afu a chaiff diweddariadau ar waith yr is-grŵp eu cynnwys yn y datganiad cynnydd blynyddol sy'n cael ei gyflwyno gan y Grŵp Gweithredu i Lywodraeth Cymru. Mae'r grŵp wedi hwyluso nifer o ddatblygiadau gan weithio gydag asiantaethau eraill fel sy'n briodol i ddatblygu a chefnogi mwy o brofion a thriniaeth mewn amryw o sefydliadau, yn cynnwys carchardai, gwasanaethau cyffuriau ac alcohol, gwasanaethau trydydd sector a fferyllfeydd cymunedol.

6. Gwnaeth yr Is-grŵp Hepatitis Feirysol helpu hefyd i sicrhau arian a gwasanaeth gweinyddol ar gyfer amryw o brosiectau yn ymwneud â strategaethau profi a thrin ar gyfer hepatitis C, e.e. arian i ddatblygu profion adwaith cadwynol polymerasau o brofion smotiau gwaed wedi sychu, gan roi diagnosis wedi'i gadarnhau yn gyflymach, a hynny yn ei dro yn gallu golygu mynediad cyflymach at driniaeth mewn rhai sefydliadau (e.e. fferyllfeydd cymunedol); a phenodi arweinydd profion pwynt gofal ar gyfer Canolfan Feiroleg Arbennig Cymru i ddatblygu'r gwasanaethau hyn mewn gwahanol sefydliadau ar draws Cymru.

7. Mae'r Is-grŵp Hepatitis Feirysol hefyd yn cyd-drefnu'r casglu data i sicrhau bod y cynllun cenedlaethol yn cael ei lywodraethu'n briodol a bod gwybodaeth berthnasol yn cael ei bwydo'n ôl i Lywodraeth Cymru, y byrddau iechyd a rhanddeiliaid

perthnasol eraill. Hefyd, mae'r is-grŵp wedi bod yn gweithio gyda Gwasanaeth Gwybodeg GIG Cymru i ddatblygu ffurflen hepatitis C electronig a fydd yn hwyluso'r gwaith o gasglu data trin cenedlaethol byw yn y dyfodol. Mae'r is-grŵp hefyd wedi cyfrannu tuag at ddatblygu model dileu gan ddefnyddio cwmni annibynnol, a ariannwyd drwy grant heb gyfyngiadau arno oddi wrth y diwydiant fferyllol.

8. Mae'r Is-grŵp Hepatitis Feirysol yn cefnogi'r adolygiadau rheolaidd o'r cynllun cenedlaethol drwy ddarparu cyngor arbenigol ac argymhellion ynglŷn â datblygu, fel a phan y mae hynny'n briodol. Bu'r is-grŵp yn holl-bwysig hefyd yng ngweinyddiaeth y rhith banel sy'n fodd i drafod cleifion cymhleth er mwyn sicrhau bod yr opsiynau trin mwyaf priodol yn cael eu rhoi i'r unigolion hyn.

Lleihau HCV a'i atal rhag cael ei drosglwyddo ymlaen yng Nghymru

9. Mae dros 90 y cant o'r trosglwyddo hepatitis C ymlaen yn digwydd drwy chwistrellu cyffuriau. Felly, y ffordd fwyaf effeithiol o atal trosglwyddo yw drwy ostwng nifer yr unigolion sy'n chwistrellu a thrwy ddarparu Rhaglenni Nodwyddau a Chwistrellau effeithiol. Mae Iechyd Cyhoeddus Cymru yn darparu cymorth i bob un o'r 270 Rhaglen Nodwyddau a Chwistrellau yng Nghrymu, drwy (yn 2017/18) ddatblygu canllawiau, polisi a monitro. Mae Rhaglenni Nodwyddau a Chwistrellau statudol a gwirfoddol a'r rhai sydd wedi'u lleoli mewn fferyllfeydd cymunedol i gyd yn cofnodi gweithgarwch unigol ar fodiwl y Gronfa Ddata Lleihau Niwed, sy'n fodd o ddarparu tystiolaeth o natur a graddfa'r defnydd o gyffuriau drwy chwistrellu, yn ogystal â chofnodi'r nodwyddau a'r chwistrellau sy'n cael eu darparu. Caiff adroddiad blynyddol ei gyhoeddi gan Iechyd Cyhoeddus Cymru i fonitro'r cynnydd, (ar gael ar wefan Iechyd Cyhoeddus Cymru ar http://www.wales.nhs.uk/sitesplus/documents/888/HRD%20Report%202017-18%20-%20Final%20.pdf).
10. Yn 2017/18 roedd cyfanswm o 14,000 o ddefnyddwyr yn defnyddio'r gwasanaethau nodwyddau a chwistrellau yn rheolaidd, a thros y pum mlynedd diwethaf bu gostyngiad yng nghyfradd y bobl ifanc sy'n chwistrellu cyffuriau ac yn manteisio ar wasanaethau, o 5.5% yn 2013/14 i 2.7% yn 2017/18.
11. Arweiniodd Iechyd Cyhoeddus Cymru, gyda Llywodraeth Cymru, ar broses gomisiynu genedlaethol yn 2016-7. Dechreuodd y fframwaith nodwyddau a chwistrellau

newydd ym mis Gorffennaf 2017 ac mae wedi arwain at gyflwyno ‘paciau chwistrellu unwaith’ yn ardal pob rhaglen nodwyddau a chwistrellau.

Adnabod unigolion sydd wedi’u heintio â HCV ar hyn o bryd, yn cynnwys y rhai sydd wedi cael eu heintio â HCV y tu allan i’r Deyrnas Unedig ac sydd nawr yn byw yng Nghymru

12. Gyda dyfodiad meddyginiaethau newydd, hynod effeithiol, y mae’r corff yn gallu’u goddef yn dda, i drin hepatitis C, mae Iechyd Cyhoeddus Cymru yn arwain y gwaith o gyd-drefnu ymarferiad cenedlaethol i ymgysylltu o'r newydd â chleifion, a’i roi ar waith. Nod yr ymarferiad yw canfod unigolion sydd â diagnosis hanesyddol o Hepatitis C nad ydynt, am ba reswm/resymau bynnag, wedi cydweithio’n llwyr â gwasanaethau trin a cheisio dod â nhw yn ôl i mewn i’r gwasanaeth a chynnig triniaeth iddynt gyda’r therapïau newydd sydd ar gael rŵan (fel sy’n briodol).
13. Mae’r gwaith hwn yn cael ei gefnogi gan grŵp gweithredu sy’n cynnwys cynrychiolwyr o Ymddiriedolaeth Hepatitis C, Ymddiriedolaeth Afu Prydain a Phwyllgor Ymarferwyr Cyffredinol Cymru yn ogystal â phob bwrdd iechyd yng Nghymru.
14. Gan ddefnyddio data profi hanesyddol o’r labordy fel man cychwyn, gwnaed gwaith i adnabod yr unigolion hyn. O wanwyn 2019, byddir yn cysylltu â nhw ac yn cynnig iddynt y cyfle i gydweithio o’r newydd â gwasanaethau a chael eu hasesu am driniaeth.
15. Mae’r Is-grŵp Hepatitis Feirysol hefyd wedi cefnogi nifer o gynlluniau/prosiectau peilot i helpu i adnabod a thrin unigolion sydd wedi’u heintio â hepatitis C. Mae hyn yn cynnwys gwerthusiad o wasanaethau cleifion allanol mewn un bwrdd iechyd, a chanfod achosion mewn gofal sylfaenol mewn bwrdd iechyd arall. Hefyd, mae arweinydd prosiect ac ymchwil cenedlaethol wedi cael ei benodi ar gyfer hepatitis i helpu i ddatblygu dulliau gweithredu a rhannu'r dysgu ar draws y byrddau iechyd.

Profi a thrin unigolion sydd wedi’u heintio â HCV sydd ar hyn o bryd yn ymddwyn mewn ffyrdd sy’n debygol o arwain at drosglwyddo pellach

16. Mae Iechyd Cyhoeddus Cymru wedi datblygu Modiwl Feirysau a Gludir yn y Gwaed yn y Gronfa Ddata Lleihau Niwed, sydd wedi’i roi ar waith ym mhob gwasanaeth camddefnyddio sylweddau arbenigol ar draws Cymru ac mewn nifer o safleoedd

fferyllfeydd cymunedol peilot. Rhagwelir y bydd rhaglen genedlaethol i gyflwyno'r modiwl ar draws pob fferyllfa gymunedol berthnasol yn cychwyn yn y blynyddoedd nesaf. O ystyried bod nifer achosion a mynychder haint HCV yn fwyaf uchel ymysg unigolion sydd un ai'n camddefnyddio sylweddau ar hyn o bryd neu wedi gwneud hynny yn y gorffennol, mae'n hanfodol fod y poblogaethau hyn yn cael eu profi fel mater o drefn a'u cyfeirio am driniaeth cyn gynted ag y cânt eu hadnabod. Mae modiwl feirysau a gludir yn y gwaed y Gronfa Ddata Lleihau Niwed yn darparu system i gofnodi profion arferol, yn unol â'r drefn profion arferol optio-allan sydd ar waith ym mhob gwasanaeth camddefnyddio sylweddau yng Nghymru (https://gov.wales/docs/dhss/publications/160906substance-missuse-2016-2018cy.pdf). Hefyd, mae'r gronfa ddata yn galluogi'r profion a'r cofnod canlyniadau i ddilyn y claf ble bynnag y mae yng Nghymru, a hynny dros amser. Mae'r gronfa ddata yn darparu mecanwaith ar gyfer sgrinio, diagnosio, cyfeirio a cherrig milltir trin, yn cynnwys dyddiad cychwyn, Ymateb Firolegol Cyson (SVR) ac ailheintio. Mae Iechyd Cyhoeddus Cymru yn cyhoeddi adroddiad blynyddol i fonitro'r cynnydd (ar gael ar wefan Iechyd Cyhoeddus Cymru ar : http://www.wales.nhs.uk/sitesplus/documents/888/BBV%20Annual%20report%202017-18%20FOR%20PUBLICATION.pdf) .

17. Profwyd mwy na 1600 o unigolion a oedd mewn cysylltiad â gwasanaethau camddefnyddio sylweddau yn 2017, ac mae hyn wedi cynyddu dros draean hyd yn hyn yn 2018. Fodd bynnag, mae cyfran sylweddol o unigolion yn dal heb eu profi ac mae'n bwysig bod adnoddau priodol ar gael fel bod modd profi pob cleient sydd 'mewn perygl' yn flynyddol.
18. Yn ychwanegol, mae Iechyd Cyhoeddus Cymru wedi cefnogi Llywodraeth Cymru wrth iddi ailgyflwyno Dangosydd Perfformiad Allweddol (DPA) ar gyfer pob gwasanaeth camddefnyddio sylweddau. Bydd hyn yn hwyluso'r gwaith o brofi pob unigolyn sydd mewn cysylltiad â gwasanaethau o leiaf unwaith y flwyddyn tan na fyddant mewn perygl o heintiau HCV. Bydd y Dangosyddion yn cael eu monitro ar gyfer pob safle drwy'r Gronfa Ddata Lleihau Niwed, sy'n sicrhau cofnod claf unigol o brofion, diagnosis a thriniaeth. Mae'r system hefyd yn lleihau'r tebygolrwydd y bydd gwasanaethau'n colli profion unigol sy'n adweithiol i HCV, neu'n 'syrthio drwy'r rhwyd', sydd wedi bod yn broblem yn y gorffennol.

19. Ers 2010, mae profion feirysau a gludir yn y gwaed wedi dod yn rhan arferol o ddarpariaeth iechyd carchardai. Ym mis Tachwedd 2016, cyhoeddodd Llywodraeth Cymru newid polisi ffurfiol i optio allan o brofion ar gyfer feirysau a gludir yn y gwaed ar gyfer pawb sy'n cael eu derbyn i'r carchar. Mae pob carchar yng Nghymru yn cynnig sgrinio feirysau a gludir yn y gwaed er bod y lefelau cyflawni yn parhau'n amrywiol. Mae Tabl 1 yn dangos nifer yr unigolion a ddefnyddiodd wasanaethau feirysau a gludir yn y gwaed ym mhob carchar yng Nghymru rhwng 2015 a 2017. Mae'r tabl yn dangos cynnydd yn nifer y dynion a brofwyd ers mis Tachwedd 2016 pan gyflwynwyd y broses sgrinio optio allan. Cyfartaledd cymedrig gwrthgyrff hepatitis C oedd 10% yn 2015, 7% yn 2016 a 10% yn 2017.

Tabl 1 Nifer yr unigolion a ddefnyddiodd wasanaethau feirysau a gludir yn y gwaed ym mhob carchar yng Nghymru 2015-2017

Y safle a wnaeth gais	Unigolion yn bresennol, fesul blwyddyn			
	2015	2016	2017	Cyfanswm
CARCHAR BERWYN	0	0	264	**264**
CARCHAR CAERDYDD	238	885	1290	**2413**
CARCHAR Y PARC	398	857	1463	**2718**
CARCHAR PRESCOED	98	114	196	**408**
CARCHAR ABERTAWE	0	4	162	**166**
CARCHAR BRYNBUGA	70	255	71	**397**
Cyfanswm	**804**	**2115**	**3446**	**6366**

20. Mae pob carchar yng Nghymru yn cynnig triniaeth ar gyfer feirysau a gludir yn y gwaed. Mae nyrsys arbenigol yn cynnal clinigau ym mhob carchar i weld y rhai sy'n cael prawf cadarnhaol o wrthgyrff hepatitis C. Mae sganwyr symudol a ddefnyddir o fewn carchardai yn golygu y gall unigolion drosglwyddo o brofion i driniaeth heb yr angen i adael y carchar yn y rhan fwyaf o achosion.
21. Roedd cynnydd yn nifer y dynion a sgriniwyd ar gyfer feirysau a gludir yn y gwaed yn amlwg yn dilyn cyflwyno'r polisi sgrinio optio allan. Er gwaethaf hyn, mae gweithredu'r profion optio allan ar draws carchardai yn parhau'n amrywiol ac ymddengys nad yw llawer o ddynion wedi cael eu profi. Mae'r syniad o bennu targed dros gyfnod ar gyfer sgrinio feirysau a gludir yn y gwaed mewn carchardai yn cael ei ystyried. Hyd yn hyn, mae carchardai yng Nghymru wedi cynyddu cyfraddau profi heb adnoddau uniongyrchol ychwanegol. Mae angen ystyried sicrhau bod gan

garchardai adnoddau digonol i ddygymod â chynnydd parhaus mewn profion mewn carchardai.

Adran 2: Sut gellir cynyddu gwybodaeth ac ymwybyddiaeth y cyhoedd a gweithwyr iechyd proffesiynol o firws Hepatitis C.

22. Mae Ymddiriedolaeth yr Afu Prydain (BLT) (fel rhan o'i gwaith gyda Grŵp Gweithredu Clefydau'r Afu) yn gweithio yng Nghymru i godi ymwybyddiaeth y cyhoedd o iechyd yr afu, tynnu sylw at brif achosion clefyd yr afu a pha ddewisiadau ffordd o fyw ac atal sydd eu hangen i gynnal iechyd da'r afu. Mae'r Ymddiriedolaeth hefyd yn cyflwyno digwyddiadau sgrinio a sganio *'Love Your Liver'* ledled Cymru, a chynhaliodd sioe deithiol *'Love Your Liver'* ym mis Tachwedd 2018, gyda'r Uned Sganio Symudol yn ymweld â Bangor, Wrecsam, Caerdydd, Pen-y-bont ar Ogwr ac Abertawe.
23. Fel rhan o raglen flaenoriaeth glinigol clefyd yr afu Coleg Brenhinol yr Ymarferwyr Cyffredinol (RCGP) a ariennir gan yr Ymddiriedolaeth, ym mis Gorffennaf 2018, cynhaliodd Cymru un o bedwar digwyddiad addysg gofal sylfaenol rhanbarthol yn y Deyrnas Unedig rhwng y Coleg Brenhinol a'r Ymddiriedolaeth.
24. Ym mis Rhagfyr 2017, cynhaliwyd sioe deithiol arferion da hepatitis C yng Nghaerdydd. Trefnwyd y digwyddiad hwn gan HCV Action ac Iechyd Cyhoeddus Cymru, gyda'r nod o ddod â gweithwyr proffesiynol sy'n gweithio gyda hepatitis C mewn amrywiaeth o gyd-destunau at ei gilydd, nodi heriau ac atebion o ran mynd i'r afael â hepatitis C yn lleol, a dangos a rhannu enghreifftiau o arfer da o ran atal, profi, a thriniaethau. Mae'r adroddiad cryno o'r sioe deithiol ar gael ar wefan HCV action: http://www.hcvaction.org.uk/resource/summary-report-hepatitis-c-good-practice-roadshow-cardiff-december-2017 [cyrchwyd 27/12/2018].
25. Yn ogystal, mae'r arweinydd cenedlaethol ar gyfer hepatitis wedi arwain dau gyfarfod rhwydwaith cenedlaethol y flwyddyn, i helpu i rannu gwersi a ddysgwyd rhwng timau a byrddau iechyd. Gwnaed y rhain yn bosibl drwy grantiau addysgol anghyfyngedig a ddarperir gan y diwydiant fferyllol.
26. Mae'r timau feirysau a gludir yn y gwaed yn rhoi cymorth ar gyfer mentrau codi ymwybyddiaeth. Mae'r rhain yn cynnwys enghreifftiau fel addysgu timau gofal sylfaenol, codi ymwybyddiaeth ar Ddiwrnod Hepatitis y Byd, ymgysylltu â'r cyfryngau

ynghylch digwyddiadau codi ymwybyddiaeth, a phrosiect i brofi a chodi ymwybyddiaeth mewn mosg. Fodd bynnag, nid yw'n glir hyd yma beth fu effaith y mentrau hyn.

27. Mae cynyddu ymwybyddiaeth y cyhoedd a gweithwyr iechyd proffesiynol yn un o feysydd heriol y cynllun dileu. Byddai croeso i gymorth ar gyfer ymgyrch codi ymwybyddiaeth benodol. Mae hyn yn arbennig o bwysig o ran dod o hyd i'r cleifion hynny nad oes modd eu hadnabod yn hawdd (e.e. unigolion o wledydd â nifer uchel o achosion, pobl a oedd yn arfer chwistrellu cyffuriau neu a fu'n arbrofi yn gynnar yn eu bywydau, a'r rhai mewn perygl yn sgil trallwysiad gwaed).

Adran 3: Y cwmpas i gynyddu gweithgarwch cymunedol e.e. rôl fferyllfeydd cymunedol.

28. Mae Is-grŵp Hepatitis Firaol LDIG wedi datblygu protocol cenedlaethol ar gyfer cyflwyno profion hepatitis C yn y gymuned, a gymeradwywyd gan Fwrdd Fferylliaeth Cymru.
29. Gyda chyllid gan LDIG, penodwyd arweinydd fferyllol cenedlaethol ar gyfer hepatitis ac mae bellach yn gweithio ar gyflwyno profion mewn fferyllfeydd cymunedol. Mae map o'r holl fferyllfeydd sy'n cynnal cyfnewidfeydd nodwyddau a therapi amnewid opiad wedi cael ei lunio ar sail data a dynnwyd o'r Gronfa Ddata Lleihau Niwed, a bydd hyn yn cael ei ddefnyddio i hwyluso'r gwaith o gyflwyno. Sicrhawyd cyllid ar gyfer prosiect peilot i brofi'r protocol yn yr amgylchedd byw, a bydd yn cael ei gynnal ym mis Ionawr 2019.
30. Mae timau feirysau a gludir yn y gwaed o bob cwr o Gymru yn ymwybodol o'r protocol ac maent mewn sefyllfa i gynorthwyo'r gwaith o gyflwyno profion yn yr amgylchedd hwn.
31. Mae'r arweinydd fferyllwyr cenedlaethol erbyn hyn yn dechrau gweithio ar lwybr triniaethau a gytunwyd yn genedlaethol mewn fferyllfa gymunedol i'w ddatblygu a'i gyflwyno yn 2020.

Adran 4: Hyfywedd hirdymor rhaglenni triniaeth.

32. Mae'r Is-grŵp Hepatitis Firaol, drwy'r arweinydd cenedlaethol ar gyfer hepatitis, wedi darparu cymorth gyda'r broses dendro genedlaethol a chyflwyno mynediad teg a thryloyw at driniaethau. Mae hyn wedi arwain at gyflawni arbedion sylweddol i'r

GIG yng Nghymru drwy gaffael cenedlaethol, gan gadw at egwyddorion gofal iechyd darbodus, y defnydd o ddewisiadau triniaeth rhatach posibl lle bo'n briodol, a chymryd penderfyniadau ar lefel uwch i oedi triniaeth mewn cleifion lle gellid fforddio aros ar gyfer dewisiadau rhatach mwy diweddar yn ystod dyddiau cynnar rheoli hepatitis C.

33. Datblygwyd y protocol cenedlaethol ar gyfer triniaethau a llwybrau triniaeth Hepatitis C drwy gydlynu'r rhwydwaith feirysau a gludir yn y gwaed ac arweinyddiaeth glinigol.
34. Mae rhaglenni triniaethau'n cael eu hategu ar hyn o bryd gan gyfuniad o dimau feirysau a gludir yn y gwaed ar lefel byrddau iechyd a rolau cenedlaethol (arweinydd fferyllol, arweinydd prosiect ac ymchwil, arweinydd profion pwynt gofal). Mae Grŵp Gweithredu Clefydau'r Afu yn cefnogi'r rolau cenedlaethol hyn. Mae cyllid ar gyfer y rolau hynny yn ansicr y tu hwnt i 2020. Ni fydd dileu'n digwydd ar y llwybr presennol tan ar ôl 2030. Os yw'r broses brofi a thrin am gael ei huwchraddio i'r pwynt y gellir cyflawni'r gwaith o'i ddileu erbyn 2030, yna mae'n hanfodol bod y rolau hyn yn cael eu cynnal y tu hwnt i 2020.
35. Mae llawer o ddatblygiadau wedi eu cynllunio i gynyddu profion unigolion sydd mewn perygl a'u cysylltu â gofal (e.e. rhagor o brofion mewn carchardai, gwasanaethau cyffuriau ac alcohol, asiantaethau'r trydydd sector, fferyllfeydd cymunedol). Mae'n hollbwysig bod adnoddau priodol yn cael eu darparu ar gyfer y mentrau hyn fel bod cynnydd mewn profion yn yr amgylcheddau hyn yn gynaliadwy.
36. Mae angen i'r datblygiadau i gynyddu profion a thriniaeth ar gyfer unigolion mewn perygl gydweddu'n briodol â buddsoddiad i hyrwyddo negeseuon lleihau niwed er mwyn lleihau'r risg o ailheintio a sicrhau bod y broses ddileu mor gost-effeithiol â phosibl.

Y PWYLLGOR IECHYD, GOFAL CYMDEITHASOL A CHWARAEON

CRYNODEB Y GWASANAETHAU CYFREITHIOL O DAIR SET O REOLIADAU GOFAL CYMDEITHASOL A OSODWYD GERBRON Y CYNULLIAD:

1. Rheoliadau Gwasanaethau Lleoli Oedolion (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019
2. Rheoliadau Gwasanaethau Maethu Rheoleiddiedig (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019
3. Rheoliadau Gwasanaethau Eirioli Rheoleiddiedig (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019

Y cefndir

Gwneir y **Rheoliadau** hyn oll o dan Ddeddf Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru) 2016 ("y Ddeddf"). Cyflwynodd Rhan 1 o Ddeddf 2016 system newydd o reoleiddio gwasanaethau gofal a chymorth yng Nghymru, gan ddisodli'r system a sefydlwyd o dan Ddeddf Safonau Gofal 2000.

Gosodwyd y Rheoliadau hyn ar 10 ac 11 Ionawr 2019. Maent yn Rheoliadau penderfyniad cadarnhaol a threfnwyd y ddadl a'r bleidlais yn y Cyfarfod Llawn ar y tair set o Reoliadau ar gyfer 22 Ionawr 2019.

Rheoliadau Gwasanaethau Lleoli Oedolion (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019

Crynodeb

Mae Adran 2 o Ddeddf 2016 yn diffinio "gwasanaeth rheoleiddiedig" fel gwasanaeth sy'n cynnwys lleoli oedolion. Mae paragraff 6 o Atodlen 1 i Ddeddf 2016 yn diffinio "gwasanaeth lleoli oedolion" fel gwasanaeth a gynhelir (pa un ai er elw ai peidio) gan awdurdod lleol neu berson arall at ddibenion lleoli oedolion gydag unigolyn yng Nghymru o dan gytundeb gofalwr (ac mae'n cynnwys unrhyw drefniadau ar gyfer recriwtio, hyfforddi a goruchwylio unigolion o'r fath).

Mae'r Rheoliadau hyn yn gosod gofynion ar ddarparwyr gwasanaethau mewn perthynas â gwasanaethau lleoli oedolion, gan gynnwys gofynion ynghylch safon y gofal a'r gefnogaeth sydd i'w darparu i unigolyn sy'n cael ei leoli o dan gytundeb gofalwr. Mae paragraff 6 o Atodlen 1 i Ddeddf 2016 yn diffinio "cytundeb gofalwr" fel

cytundeb ar gyfer darparu gan unigolyn lety yng nghartref yr unigolyn ynghyd â gofal a chymorth ar gyfer hyd at dri oedolyn.

Pwyntiau i gyflwyno adroddiad yn eu cylch gan y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol:

Ni chynhwyswyd unrhyw bwyntiau adrodd yn adroddiad drafft y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol ar y Rheoliadau hyn.

Rheoliadau Gwasanaethau Maethu Rheoleiddiedig (Darparwyr Gwasanaethau Ac Unigolion Cyfrifol) (Cymru) 2019

Crynodeb

Mae "gwasanaeth maethu" yn wasanaeth rheoleiddiedig, sydd wedi ei ddiffinio yn Neddf 2016 i olygu unrhyw wasanaeth a ddarperir yng Nghymru gan berson ac eithrio awdurdod lleol sy'n gwneud y naill neu'r llall o'r canlynol neu sy'n cynnwys y naill neu'r llall o'r canlynol, sef lleoli plant gyda rhieni maeth neu arfer swyddogaethau mewn cysylltiad â lleoliad o'r fath.

Mae'r Rheoliadau hyn yn gosod gofynion ar ddarparwr gwasanaeth mewn perthynas â gwasanaethau maethu. Er enghraifft, o dan y Rheoliadau, rhaid i ddarparwyr gwasanaeth sicrhau bod y gwasanaethau maethu'n cael eu darparu â gofal, cymhwysedd a sgìl digonol, gan gymryd camau rhesymol i sicrhau bod y gwasanaeth yn gynaliadwy yn ariannol.

Pwyntiau i gyflwyno adroddiad yn eu cylch gan y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol:

Mae'r tri phwynt canlynol wedi'u cynnwys yn adroddiad drafft y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol ar y Rheoliadau hyn. Ar adeg ysgrifennu hyn, nid oedd Llywodraeth Cymru wedi ymateb yn ffurfiol i'r pwyntiau adrodd.

1. Rheol Sefydlog 21.2(v) - bod angen eglurhad pellach ynglŷn â'i ffurf neu ei ystyr am unrhyw reswm penodol

Mae'r Rheoliadau yn cyfeirio at "darpar rieni maeth" mewn chwe lle. Fodd bynnag, nid yw'n glir beth yw ystyr "darpar rieni maeth" na phwy sy'n cael ei gwmpasu gan y term.

Mae'r diffyg eglurder yn destun pryder penodol o gofio bod y term "darpar rieni" yn gymwys mewn perthynas â throseddau. Er enghraifft, mae'n drosedd i ddarparwr gwasanaeth fethu â llunio canllaw ar y gwasanaeth ar gyfer darpar rieni maeth, ymysg eraill (gweler rheoliad 12(2)(c)(ii)).

Dyma godi drachefn bryder a godwyd gennym o'r blaen, sef bod angen eglurder llwyr wrth greu troseddau.

2. Rheol Sefydlog 21.2(v) - bod angen eglurhad pellach ynglŷn â'i ffurf neu ei ystyr am unrhyw reswm penodol

O dan y Rheoliadau, rhaid i ddarparwyr gwasanaethau wneud amrywiol hysbysiadau. Er enghraifft, rhaid i ddarparwyr gwasanaethau hysbysu'r heddlu am unrhyw "honiad bod plentyn sydd wedi ei leoli gyda rhieni maeth wedi cyflawni trosedd ddifrifol" (gweler rheoliad 40(5) a pharagraff 40 o Atodlen 3). Mae'n drosedd i ddarparwr gwasanaeth fethu â gwneud hynny.

Fodd bynnag, nid yw'n glir beth yw "honiad" a beth yw "trosedd ddifrifol".

Dyma godi drachefn ein pryder bod angen eglurder llwyr wrth ddiffinio troseddau newydd.

3. Rheol Sefydlog 21.2(vi) – ei bod yn ymddangos bod gwaith drafftio'r offeryn neu'r drafft yn ddiffygiol neu ei fod yn methu â bodloni gofynion statudol

Yn y diffiniad o "datganiad o ddiben" yn y testun Cymraeg, mae cyfeiriad at "Reoliadau Cofrestru 2018". Fodd bynnag, dylai'r cyfeiriad fod at "Reoliadau Cofrestru 2017".

Yn y cyd-destun, nodwn nad yw'r gwall hwn yn debygol o beri dryswch sylweddol yn ymarferol.

Rheoliadau Gwasanaethau Eirioli Rheoleiddiedig (Darparwyr Gwasanaethau ac Unigolion Cyfrifol) (Cymru) 2019

Crynodeb

Mae'r Rheoliadau hyn yn nodi'r gofynion rheoleiddiol a'r ddarpariaeth gysylltiedig ar gyfer darparwyr gwasanaethau eirioli rheoleiddiedig a'r personau hynny sydd wedi eu dynodi'n unigolion cyfrifol ar gyfer gwasanaethau o'r fath.

Mae'r Rheoliadau hyn yn gosod gofynion ar ddarparwyr gwasanaethau ac ar unigolion cyfrifol mewn perthynas â gwasanaethau eirioli. Er enghraifft, o dan y Rheoliadau, rhaid i'r darparwr gwasanaeth sicrhau bod trefniadau effeithiol yn eu lle ar gyfer monitro, adolygu a gwella ansawdd yr eiriolaeth a ddarperir, a rhaid iddynt sicrhau bod ganddynt bolisïau mewn perthynas â disgyblu staff a diogelu, er enghraifft.

Pwyntiau i gyflwyno adroddiad yn eu cylch gan y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol:

Mae'r tri phwynt canlynol wedi'u cynnwys yn adroddiad drafft y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol ar y Rheoliadau hyn. Mae ymateb Llywodraeth Cymru i bob pwynt wedi'i gynnwys.

1. Rheol Sefydlog 21.2(v) - bod angen eglurhad pellach ynglŷn â'i ffurf neu ei ystyr am unrhyw reswm penodol

Os nad yw'r unigolyn cyfrifol yn gallu cyflawni ei ddyletswyddau, o dan reoliad 6(4)(c), rhaid i ddarparwyr gwasanaethau sicrhau bod trefniadau yn eu lle ar gyfer cydymffurfedd y gwasanaeth â gofynion y Rheoliadau yn Rhannau 3 i 15.

Fodd bynnag, mae gofynion pwysig hefyd yn Rhan 2 o'r Rheoliadau. Nid yw'n glir pam nad yw rheoliad 6(4)(c) yn gwneud cydymffurfedd â Rhan 2 o'r Rheoliadau yn ofynnol.

Mae'r un mater yn codi mewn perthynas â rheoliad 7(3)(c).

Ymateb Llywodraeth Cymru i bwynt adrodd 1:

"Er bod llawer o'r dyletswyddau yn Rhan 2 yn fwy cyffredinol eu natur, ac felly o gymhwysiad mwy cyfyngedig yng nghyd-destun trefniadau interim yn ystod absenoldeb dros dro unigolyn cyfrifol (neu ddarparwr unigol), cydnabyddir y gall fod adegau pan fydd y dyletswyddau o dan Ran 2 yn berthnasol ac y dylai'r cyfeiriadau yn rheoliadau 6(4)(c) a 7(3)(c) gyfeirio at Rannau 2 i 15 o'r Rheoliadau. Gwneir diwygiad ar y cyfle nesaf sydd ar gael."

2. Rheol Sefydlog 21.2(v) - bod angen eglurhad pellach ynglŷn â'i ffurf neu ei ystyr am unrhyw reswm penodol

Mae rheoliad 10 yn gosod dyletswydd gonestrwydd ar ddarparwyr gwasanaethau - rhaid i ddarparwyr gwasanaethau weithredu mewn ffordd agored a thryloyw gydag:

- unigolion (h.y. personau y mae'r darparwr gwasanaeth yn darparu neu wedi darparu eiriolaeth ar eu cyfer, neu bersonau y gallai'r darparwr gwasanaeth ddarparu eiriolaeth ar eu cyfer), ac
- unrhyw gynrychiolwyr yr unigolion hynny.

Fodd bynnag, nid oes dyletswydd i weithredu mewn modd agored a thryloyw gyda chomisiynwyr gwasanaethau (h.y. awdurdodau lleol sy'n gyfrifol am wneud trefniadau gyda darparwr gwasanaeth i ddarparu cymorth i blentyn neu berson o dan adran 178(1) o Ddeddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014).

Gofynnwn pam nad oes dyletswydd o'r fath?

Ymateb Llywodraeth Cymru i bwynt adrodd 2:

"Rhoddwyd ystyriaeth benodol i'r mater hwn wrth ddrafftio'r rheoliadau ac i'r ffaith bod y ddyletswydd gonestrwydd yn gymwys i berthynas darparwr gwasanaeth â chomisiynwyr gwasanaethau ar gyfer mathau eraill o wasanaeth rheoleddiedig. Fodd bynnag, ar gyfer darparwr gwasanaeth eirioli, comisiynydd y gwasanaeth yw'r corff y mae'r plentyn neu'r person ifanc yn dymuno cyflwyno sylwadau yn ei erbyn hefyd. Wrth ddarparu eiriolaeth i blentyn neu berson ifanc, mae'n bwysig mai prif swyddogaeth darparwr y gwasanaeth eirioli yw cynrychioli safbwyntiau'r person hwnnw i'r awdurdod lleol sy'n comisiynu. Gallai dyletswydd i fod yn agored ac yn dryloyw gyda'r awdurdod lleol sy'n comisiynu wrthdaro â chyfarwyddiadau'r plentyn neu'r person ifanc a gwrthdaro â'r ddyletswydd hon. Am y rheswm hwn, eithriwyd comisiynwyr gwasanaethau yn benodol o gwmpas y ddyletswydd hon ar gyfer y math penodol hwn o wasanaeth."

3. Rheol Sefydlog 21.2(v) - bod angen eglurhad pellach ynglŷn â'i ffurf neu ei ystyr am unrhyw reswm penodol

Mae rheoliad 15 yn ei gwneud yn ofynnol i ddarparwyr gwasanaethau lunio canllaw ysgrifenedig ar y gwasanaeth eirioli. Rhaid i'r canllaw wedyn gael ei roi i "awdurdodau comisiynu" (gweler rheoliad 15(2)(d)).

Fodd bynnag, nid oes diffiniad o "awdurdodau comisiynu".

Mae'r diffyg eglurder yn bryder penodol o gofio bod torri'r ddyletswydd yn rheoliad 15(2)(d) yn drosedd, ac mae angen eglurder llwyr wrth greu troseddau.

Ymateb Llywodraeth Cymru i bwynt adrodd 3:

"Er bod y term hwn yn debygol o gael ei ddeall yn y cyd-destun oherwydd bydd gwasanaethau, yn y mwyafrif helaeth o achosion, yn cael eu comisiynu gan awdurdodau lleol, ac er bod llys, yn ein barn ni, i'r graddau y bo ansicrwydd, yn debygol ran amlaf o lawer o ddehongli'r ymadrodd yn yr un ffordd, derbynnir y byddai'r ddarpariaeth yn gliriach pe bai'r ymadrodd "comisiynwyr gwasanaethau" yn cael ei roi yn lle'r ymadrodd "awdurdodau comisiynu". Diffinnir yr ymadrodd "comisiynydd y gwasanaeth" yn rheoliad 2. Gwneir diwygiad ar y cyfle nesaf sydd ar gael."

Gareth Howells
Gwasanaethau Cyfreithiol y Cynulliad
10 Ionawr 2019

Feedback for the Health, Social Care and Sports Committee on the impact of the General Dental "Prototype" Contract on Belgrave Dental Centre, Swansea

By Huw Hopkins B.D.S. Principal Dentist/Director at Belgrave Dental Centre and Pontardawe Dental Centre

Introduction

We have been involved in General Dental Service (GDS) contract reform at Belgrave Dental Centre since 2011. As a Dental Provider we are in an unique position within Wales in that we have two GDS contracts at two different sites, one of which is the GDS Prototype (Belgrave) and the other is the standard GDS "Unit of Dental Activity (UDA)" based contract (Pontardawe).

The background of the contract reform process has been covered in a separate document supplied by ABMU Health Board. It is a comprehensive and accurate account so I shall not duplicate its information here. I would like to thank ABMU Health Boards continued support of the Prototype Contract.

I would like to quickly outline the important issues that relate to the last two NHS Dental Services Contracts, the pre 2006 "fee per item" contract and the 2006 UDA contract.

Pre 2006 "Fee per item" Contract

Previously, under the pre-2006 "fee per item" contract NHS Dentists were paid depending on the complexity of the treatment delivered and time spent delivering those treatments to patients. There was an extensive, complicated and very prescriptive "menu" of different fees for different items of dental treatment. Long and complicated treatment plans where attributed proportionally higher fees compared to shorter, simpler treatments. There was patient registration and practices also received a separate monthly capitation payment depending on how many patients it had registered on its list. There was little in the way of payment for preventive care but there was some provision for prevention in the contract.

The Fee per item contract was far from ideal. The treatment list was vastly complex and difficult for patients to understand. High value complicated courses of treatment were sometimes delivered to patients who had a high risk of dental

caries resulting in many repeated courses of treatment that was ultimately a waste of NHS funds.

Many years of under-inflationary increases to the fees meant that dentists had to work harder and harder, see more and more patients per day as the years passed, to generate the fees that would cover their ever-increasing practice running costs. Whilst the open-ended nature of the contract allowed practices to expand when they wanted to (there was no fixed contract value for each practice) most dentists complained that they felt like they were on a treadmill, having to run faster and faster just to keep still.

2006 UDA Contract

Whilst initially the "New Contract" appeared to simplify things for both Dentists and patients it soon became apparent that the UDA contract had dramatic unintended consequences.

As dentists got paid the same for carrying out one filling as they did for twenty, most practices stopped accepting new patients as they didn't want to take the risk that the newly accepted patients needed time consuming, long treatment plans i.e. the same payment no matter how many patient visits needed to complete a course of treatment. Whilst this would be feasible if the fee was set to cover the cost of five to ten fillings, it was in reality set for roughly one and a half!

Contracts were now limited with set annual contract values for a set number of UDAs delivered. There was a dramatic variation in the UDA rate across Wales, with some Practices receiving double the UDA rate of others! Patients were no longer registered with the practice and responsibility of out of hours care was removed from practices and transferred to LHBs.

Practices would plan their expenditure for the year with regard to the total Contract Value, however failure to deliver the UDAs resulted in "claw-back" equal to the value of the undelivered UDAs. One quick and easy way to have to give a large percentage of your contract back to the Health Board is to accept new high-need patients. Many dentists feel that this is perverse, as it prevents those that need NHS dentistry the most accessing it.

The top value BAND3 course of treatment, that was meant to cover the cost of the most complex dental treatment, involving laboratory fees e.g. crowns and bridgework or CoCr dentures, was set too low to carry out all but the most simple of acrylic dentures or single crowns. This has resulted in complex or high need patients being referred to secondary care and has also de-skilled Primary Care dentists. Younger GDPs that have qualified since the UDA contract started have not had the clinical experience of many treatments that were previously regarded as pretty routine for GDS Dentists under the fee per item contract.

The impact of the Prototype Contract on Belgrave

Clinical Freedom

The working environment of the Practice was instantly transformed once the clinicians were "freed" from the constraints of the UDA. Whilst the UDA system drives clinicians to try and finish courses of treatment in the least amount of time possible the Prototype allows Dentists and their teams to exercise clinical freedom and stage treatment appropriately.

Patients that are experiencing urgent problems (e.g. dental pain) get their problems managed appropriately as a matter of urgency. With the patients consent we then build them a tailored "**Care-Pathway**" based on the patients **Risk** and **Need**, which is assessed via the ACORN template.

Patients move through the care-pathway with the aim of progressing through treatment complexity. The prototype allows proper foundations to support the patient's journey.

The principles of Prudent Health-Care underpin the planning of treatment. No longer are complicated, expensive treatments delivered to patients who can't maintain them. High cost treatments are delivered on patients who have lower risk of developing dental decay so that NHS funds are spent more appropriately and have the least risk of premature failure with an emphasis on quality.

Prevention

Prevention is the core to the Prototype way of working. The practice team fosters relationships with patients based on Co-production in which we motivate and support them to help maintain their oral health and progress along a **RED-AMBER-GREEN** traffic light system.

Skill Mix

The Prototype really does give the practice the freedom to utilize Dental Care Professionals (DCPs) within the practice. Dental Nurses, who have been trained to be Oral Health Educators, deliver preventive advice to patients. They also have enhanced skills that enable them to apply topical fluoride as a caries preventive measure.

Clinicians are able to delegate appropriate treatments to Dental Therapists and Dental Hygienists. All clinicians working at the top of their competency increases efficiency and enables increased capacity to see more patients.

Flexibility of services

We have the flexibility to respond to requests from the LHB to deliver targeted services within the prototype contract such as dedicated appointment slots to deliver much needed dental care to those seeking Asylum in the UK. We also deliver in-hours access sessions and offer those access patients a risk based care plan.

A Transformative effect

The Prototype really has transformed both the working environment for the staff within the practice and also the experience of patients receiving care. We would all hate to revert back to the UDA way of working. It would be devastating for the whole practice and for patients.

Since the Prototype it is not uncommon to hear the following comments from patients: -

" For the first time in 30 years I really understand how to look after my mouth"

"Having had one child with dental pain and decay, I now feel confident that I know how to look after my children's dental health as well as my own!"

"I'm happy for you to refer me for help" (smoking cessation)

But what about the Pontardawe Practice ?

Our second practice has unfortunately been left behind with:

- UDAs
- High needs population
- Frustration attempting to treat patients based on a target, not the clinical need/risk/coproduction and prudent healthcare principles
- Staff retention issues – high turnover of Dentist performers who become disillusioned with the UDA system.
- Annual Clawback – funds being sucked out of the practice and local practice population from missing targets due to trying to treat a high needs population under UDA GDS contract and low UDA rate. Funding that would otherwise be used for capital investment/improving facilities.

However …

Pontardawe has begun its Contract reform journey by being accepted in the WAG 2017 Contract Reform process. At present **PHASE 1** involves only a 10%

reduction in the annual UDA target. I can assure you from personal experience that this has minimal effect of the day-to-day experience of staff and patients but it is a starting point. We have implement as much of what we have learned at Belgrave as we can at Pontardawe, even though we still have to hit our UDA target. We are told that further UDA% reduction is planned for **PHASE 2** of the process but as yet no date is planned for its implementation. I can't wait until the fantastic patients and hard working staff at our Pontardawe practice sees the real benefits of a UDA free GDS contract.

Eitem 7.2

Paul Davies AM/AC
Aelod y Ceidwadwyr Cymreig dros Breseli Penfro
Conservative Member for Preseli Pembrokeshire

Dai Lloyd AC
Cadeirydd y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

Mick Antoniw AC
Cadeirydd y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol

Llyr Gruffydd AC
Cadeirydd y Pwyllgor Cyllid

10 Ionawr 2019

Annwyl Gadeiryddion,

Bil Awtistiaeth (Cymru)
Hoffwn ddiolch i chi ac i aelodau'ch pwyllgorau am eich gwaith manwl yn trafod y Bil Awtistiaeth (Cymru) a'ch adroddiadau a gyhoeddwyd ar 7 Rhagfyr 2018. Ar ôl eu hystyried yn ofalus, hoffwn fanteisio ar y cyfle hwn i ymateb i'r argymhellion a wnaed yn y ddau adroddiad cyn y ddadl yn y Cyfarfod Llawn ynghylch egwyddorion cyffredinol y Bil ar 16 Ionawr.

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Argymhelliad 8: Rydym yn argymell, os bydd y Bil yn mynd yn ei flaen i Gyfnod 2, y dylid cyflwyno gwelliant i sicrhau nad Adolygiad Barnwrol yw'r unig lwybr sydd ar gael i unigolion weithredu eu hawliau.

Rwy'n derbyn yr egwyddor y tu ôl i'r argymhelliad hwn, ond ar ôl ystyried y materion perthnasol yn ofalus, yn anffodus iawn ni allaf ei weithredu ar hyn o bryd.

Diben cyffredinol y Bil hwn yw sicrhau y caiff anghenion plant ac oedolion ag anhwylder y sbectrwm awtistiaeth yng Nghymru eu diwallu, a diogelu a hyrwyddo'u hawliau. Byddai'n peri pryder mawr imi felly, os na fydd y rheini y mae'r Bil hwn yn

ceisio'u helpu yn gallu cael rhwymedïau priodol os na chaiff eu hanghenion eu diwallu. Ar hyn o bryd, mae'r Bil yn rhoi dyletswyddau clir ar Weinidogion Cymru a chyrff perthnasol sy'n galluogi'r rheini sydd eisiau cael iawn i wneud hynny drwy adolygiad barnwrol; fodd bynnag, rwy'n cydnabod pryderon nad yw bob amser yn hawdd mynd drwy'r broses hon.

Yn y dystiolaeth, fe wnes i a fy swyddogion sylwadau ynghylch y gwahaniaeth rhwng camau gorfodi ar ran y Weithrediaeth, a rhwymedïau uniongyrchol sydd ar gael i'r dinesydd. Er bod modd mynd i'r afael â'r cyntaf o'r rhain mewn sawl ffordd (er enghraifft, pwerau cyfarwyddyd ac ymyrraeth), mae'r opsiynau i fynd i'r afael â'r ail o'r rhain mewn deddfwriaeth o'r fath yn llawer mwy cyfyngedig. Ni fyddai rhwymedïau ariannol yn briodol yn yr achos hwn, ac ni fyddwn am ddeddfu ar gyfer rhwymedïau y mae gan y dinesydd yr hawl i gael mynediad atynt eisoes (fel cwynion drwy weithdrefnau presennol y GIG a'r awdurdodau lleol, ac atgyfeirio at yr Ombwdsmon Gwasanaethau Cyhoeddus). Fodd bynnag, fel y Pwyllgor, rwy'n cefnogi'r nod o sicrhau bod gan ddinasyddion fwy o hawliau i rwymedïau addas lle bo'n ymarferol ac, i'r perwyl hwn, rwyf wedi rhoi cryn ystyriaeth wrth ddatblygu'r Bil ynghylch sut y gellid ei ddiwygio er mwyn cyflawni'r nod hwn.

Ond yn anffodus am y rhesymau rwyf wedi'u hamlinellu, nid wyf wedi gallu dod o hyd i ddatrysiad ymarferol, felly ni allaf dderbyn yr argymhelliad hwn ar hyn o bryd. Wedi dweud hynny, rwy'n parhau i lwyr gefnogi rhesymau'r Pwyllgor dros wneud yr argymhelliad hwn, a gallaf sicrhau'r Aelodau, os cytunir ar yr egwyddorion cyffredinol, y byddwn yn hapus i weithio gyda'r Aelodau, neu ystyried unrhyw welliannau a gyflwynir yn ystod y cyfnodau diwygio, gyda'r nod o gryfhau'r Bil yn hyn o beth.

Mae'r argymhellion sy'n weddill a wneir gan y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yn ymwneud â Llywodraeth Cymru. Rwy'n rhannu'r pryderon y mae'r Pwyllgor wedi'u mynegi yn ei adroddiad ac yn cytuno'n llwyr â'r Pwyllgor bod angen gwelliannau brys i wasanaethau cymorth anhwylderau'r sbectrwm awtistig.

Y Pwyllgor Cyllid

Argymhelliad 2: Mae'r Pwyllgor yn nodi'r camgyfrifiad yn yr Asesiad Effaith Rheoleiddiol ac yn argymell y dylid mynd i'r afael â hyn, pe bai'r Bil yn symud ymlaen i gyfnod 2.

Derbyn.

Ysgrifennais at y Pwyllgor Cyllid ar 31 Hydref 2018 yn amlinellu camgyfrifiad yn yr Asesiad Effaith Rheoleiddiol o ran yr arbedion y gellid eu gwneud pe bai'r Bil yn arwain at ostyngiad o 1 y cant mewn gwariant anhwylderau'r sbectrwm awtistig. Os cytunir ar egwyddorion cyffredinol y Bil, gallaf gadarnhau y bydd yr Asesiad Effaith Rheoleiddiol, a gaiff ei lunio ar ôl cwblhau trafodion Cyfnod 2, yn adlewyrchu'r ffigur diweddaraf.

Rwy'n rhannu'r rhwystredigaeth y mae'r Pwyllgor Cyllid yn ei fynegi ynghylch diffyg cydweithrediad gan Lywodraeth Cymru â mi wrth i mi ofyn am ddata cywir ynghylch y gwariant cyfredol ar wasanaethau anhwylderau'r sbectrwm awtistig ledled Cymru. Byddai rhywun yn disgwyl bod Llywodraeth Cymru yn casglu data o'r fath er mwyn sicrhau bod ei gwasanaethau ei hun ar gyfer anhwylderau'r sbectrwm awtistig yn cael eu cynllunio a'u darparu'n briodol, a gallaf ddweud yn ddigamsyniol y byddai hyn wedi fy ngalluogi i roi mwy fyth o fanylion ynghylch costau'r Bil. Rwy'n llwyr gefnogi argymhelliad 1 y Pwyllgor bod Llywodraeth Cymru yn ymrwymo i ddarparu gwybodaeth i helpu Aelodau i lunio costau cywir ar gyfer memoranda esboniadol a gyflwynir gyda Biliau sy'n cael eu cyflwyno yn unol â Rheol Sefydlog 26.91.

Y Pwyllgor Materion Cyfansoddiadol a Deddfwriaethol

Argymhelliad 1: Dylai'r Aelod sy'n gyfrifol am y Bil gyflwyno gwelliant i'r Bil i'w gwneud yn ofynnol bod y strategaeth awtistiaeth o dan adran 1 o'r Bil yn dod o dan y weithdrefn negyddol.

Derbyn.
Rwy'n derbyn yr argymhelliad hwn ac, os bydd y Bil yn mynd ymlaen i Gyfnod 2, rwy'n ymrwymo i gyflwyno gwelliant i'r perwyl hwn er mwyn sicrhau bod gwaith craffu gan y Cynulliad yn digwydd ar y lefel hon yn achos y strategaeth hon.

Argymhelliad 2: Dylai'r Aelod sy'n gyfrifol am y Bil drafod gyda'r Ysgrifennydd Cabinet amserlen addas ar gyfer cwblhau'r strategaeth awtistiaeth a chyflwyno gwelliant i adran 1(4) o'r Bil i gynyddu'r cyfnod o 6 mis yn unol â'r trafodaethau hynny.

Derbyn.
Rwy'n ymwybodol bod Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol wedi mynegi pryder ynghylch yr amserlen y mae'r Bil yn ei phennu ar gyfer cwblhau'r strategaeth awtistiaeth. Rwy'n fodlon ailystyried yr amserlen ac yn

ymrwymo i weithio gyda Llywodraeth Cymru i gytuno ar amserlen addas a chyflwyno gwelliant i'r Bil i'r perwyl hwnnw.

Argymhelliad 3: Dylai'r Aelod sy'n gyfrifol am y Bil ailystyried a yw'r rhwymedïau sydd ar gael i ddinasyddion o dan y Bil yn briodol, ac os oes angen hynny, cyflwyno gwelliannau yng Nghyfnod 2 i ddarparu ffordd fwy effeithiol o orfodi darpariaethau'r Bil.

Derbyn.
Mae hyn yn debyg i argymhelliad 8 gan y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon. Fel y nodir yn fy ymateb uchod i'r argymhelliad hwnnw, rwy'n cefnogi'r syniad o roi mwy o hawliau i ddinasyddion o dan y Bil lle bo modd, ac rwyf wedi ystyried yr holl opsiynau ymarferol yn ofalus er mwyn cyflawni'r nod o gryfhau'r rhwymedïau sydd ar gael iddynt. Yn anffodus, fel yr wyf wedi esbonio, nid wyf wedi llwyddo i ddod o hyd i ffordd ystyrlon o ddiwygio'r Bil yn hyn o beth.

Fodd bynnag, rwy'n pwysleisio fy ymrwymiad i sicrhau bod y Bil yn darparu ar gyfer hawliau adferol lle bo'n ymarferol, ac fel y dywedais uchod, rwy'n hapus i weithio gyda'r Aelodau ac arbenigwyr eraill, neu ystyried unrhyw welliannau a gyflwynir yn ystod y cyfnodau diwygio, gyda'r nod o gryfhau'r rhwymedïau sydd ar gael o dan y Bil.

Argymhelliad 4: Dylai'r Aelod sy'n gyfrifol am y Bil gyflwyno gwelliant i'r Bil yn nodi'r data y mae'n rhaid i'r awdurdodau lleol ei gasglu, gan ychwanegu pŵer i Weinidogion Cymru ragnodi mewn rheoliadau, yn amodol ar y weithdrefn gadarnhaol, gategorïau eraill o ddata (gan ddyblygu'r ddarpariaeth yn adran 6(6)(j) i bob pwrpas).

Derbyn.
Mae Adran 6 y Bil yn nodi'r data penodol sydd i'w gasglu gan gyrff y GIG i gynorthwyo gyda diagnosis a darparu gwasanaethau i bobl ag anhwylderau'r sbectrwm awtistig. Bernir bod y categorïau penodol o ddata yn cyrraedd yr isafswm gofynnol ar gyfer bodloni swyddogaethau diagnosis, a chynllunio a datblygu gwasanaethau. Cafodd y ddarpariaeth hon ei llywio'n helaeth drwy ymgynghori â Dr Dawn Wimpory, sy'n rheoli treial ar gasglu data anhwylderau'r sbectrwm awtistig ar gyfer Bwrdd Iechyd Prifysgol Betsi Cadwaladr, ac sy'n ymarferydd clinigol ei hun. Ategwyd hyn ymhellach gan yr ymgynghoriad cyhoeddus am yr agwedd hon ar y Bil.

Rwy'n cydnabod, er bod awdurdodau lleol wedi'u pennu fel un o'r cyrff perthnasol y byddai rhannau o adran 6 yn gymwys iddynt, nad yw hyn ond yn ymwneud â'u rhwymedigaethau cyffredinol i gynorthwyo Gweinidogion Cymru i gyflawni eu dyletswyddau casglu data eu hunain o dan adran 6(1). Dyletswyddau Gweinidogion Cymru yw caffael, llunio a chadw data dibynadwy diweddar i gefnogi eu swyddogaethau o dan y Bil – ac mae rhyddid iddynt benderfynu pa ddata y mae'n rhaid iddynt ei gasglu i gyflawni hyn. Er bod y rhwymedigaethau data penodol sydd ar gyrff y GIG yn adran 6(6) o'r Bil wedi'u cynnwys i fynd i'r afael ag angen penodol a phwysig, ni ddaeth unrhyw dystiolaeth i law yn nodi bwlch mewn perthynas â chasglu data mewn awdurdodau lleol yn gyffredinol. Ymhellach, mae tystiolaeth y Gweinidog yn nodi bod gan Lywodraeth Cymru bwerau helaeth eisoes i gasglu data, ac nad oes angen pwerau na rhwymedigaethau pellach arni yn hyn o beth.

Efallai y bydd gan y Pwyllgor ddiddordeb nodi y bydd System Wybodaeth Gofal Cymunedol Cymru, sydd ar y gweill ac y cyfeiriais ati yn y Memorandwm Esboniadol, yn golygu ei bod yn haws i weithwyr proffesiynol iechyd a gofal cymdeithasol gofnodi a rhannu gwybodaeth bwysig sy'n cwmpasu ystod o weithgareddau fel nyrsio cymunedol, ymweliadau iechyd a gofal cymdeithasol, iechyd meddwl, anableddau dysgu, camddefnyddio sylweddau, anghenion gofal cymhleth neu therapi gofal cymdeithasol.

Gan ystyried hyn i gyd, ryw'n fodlon gofyn am gyngor arbenigol am y mathau o ddata y gallai fod yn ddefnyddiol i awdurdodau lleol eu casglu i helpu o safbwynt diagnosis a darparu gwasanaethau, ac, os yw'n briodol, cyflwyno gwelliannau yn unol â hynny.

Argymhelliad 5: Dylai'r Aelod sy'n gyfrifol am y Bil gyflwyno gwelliant i adran 9(1) o'r Bil i ddileu paragraff (b) o'r diffiniad o anhwylder sbectrwm awtistiaeth.

Derbyn.
Prif ffocws y Bil yw gwella gwasanaethau anhwylderau'r sbectrwm awtistig yng Nghymru. Fodd bynnag, fel y'i drafftiwyd ar hyn o bryd, mae adran 9(1) yn caniatáu i Weinidogion Cymru ragnodi anhwylderau niwroddatblygiadol eraill drwy reoliadau. Mae hyn yn golygu, pe bai Gweinidogion Cymru yn y dyfodol yn credu y dylid cymhwyso darpariaethau'r Bil hwn i bobl ag anhwylderau niwroddatblygiadol eraill, y byddai ganddynt y pŵer i wneud hynny.

Cafodd y ddarpariaeth hon ei chynnwys yn y Bil gan fod adborth o'r ymarferion ymgynghori y cynhaliais yn cefnogi'n gryf y defnydd o ddiffiniad Sefydliad Iechyd y Byd o anhwylderau'r sbectrwm awtistig a chynnwys pŵer i bennu anhwylderau niwroddatblygiadol eraill. Y rheswm dros gynnwys y ddarpariaeth hon oedd sicrhau bod modd ymestyn manteision deddfu ar gyfer anhwylderau'r sbectrwm awtistig i'r rheini â chyflyrau eraill. Fodd bynnag, diben y Bil yn fwy na dim yw gwella gwasanaethau anhwylderau'r sbectrwm awtistig yng Nghymru, a dyma yw ei brif ffocws.

Rwyf wedi ystyried yn ofalus y rhesymeg y tu ôl i argymhelliad y Pwyllgor ac rwy'n dod i'r casgliad fy mod yn fodlon cyflwyno'r gwelliant angenrheidiol i roi'r argymhelliad hwn ar waith.

Ni waeth a fydd darpariaeth i ymestyn cwmpas y Bil hwn i gynnwys cyflyrau eraill, rwy'n credu y bydd pasio a rhoi fy Mil ar waith o fudd i'r rheini y mae ganddynt ystod ehangach o gyflyrau.

Bydd y Bil yn gwella sgiliau staff sy'n gweithio gyda phobl ag anhwylderau'r sbectrwm awtistig, a phobl â chyflyrau eraill hefyd. Mae'r broses ddiagnostig ar gyfer awtistiaeth yn cynnwys ystyried cyflyrau cysylltiedig neu sy'n cyd-ddigwydd (e.e. anhwylder diffyg canolbwyntio a gorfywiogrwydd), sy'n golygu bod angen sgiliau o ran adnabod a gwahaniaethu rhwng y cyflyrau eraill hyn. Bydd y ddarpariaeth yn y Bil ar gyfer diagnosis cynharach yn sicrhau bod pobl yn cael y cymorth cywir yn gynt, p'un a oes ganddynt awtistiaeth neu gyflwr arall. Yn ogystal, gall gwella safonau gwasanaeth a chasglu data, ac annog ymchwil ac arloesedd, helpu i hyrwyddo arfer gorau ar draws gwasanaethau a sicrhau bod lefelau diagnosis priodol yn cael eu mesur yn erbyn data perthnasol am nifer yr achosion.

Argymhelliad 6: Dylai'r Aelod sy'n gyfrifol am y Bil gyflwyno gwelliant i'r Bil i alluogi'r gofynion ynghylch casglu data ar gyfer cyrff perthnasol newydd a ragnodir o dan adran 9(1) i gael eu nodi mewn rheoliadau sy'n dod o dan y weithdrefn gadarnhaol.

Derbyn.
Mae hyn yn cyd-fynd â fy ymateb i argymhelliad 4 y Pwyllgor. Rwy'n derbyn, os bydd angen ymestyn y gofynion casglu data i gynnwys corff neu sefydliad

ychwanegol, y dylai'r rheoliadau bennu'r gofynion casglu data sydd ar y corff hwnnw lle mae tystiolaeth arbenigol yn nodi bod hyn yn angenrheidiol. Os bydd cytundeb ynghylch egwyddorion cyffredinol y Bil, byddaf yn ymrwymo i gyflwyno gwelliant i'r Bil i'r perwyl hwnnw.

Rwy'n ddiolchgar i bob un o'r pwyllgorau am roi o'ch amser i drafod y Bil Awtistiaeth (Cymru) ac am eich adroddiadau manwl. Nod y Bil hwn o'r cychwyn yw gwella gwasanaethau i ddiwallu anghenion pobl ag anhwylderau'r sbectrwm awtistig a'u teuluoedd ledled Cymru, ac rwy'n credu'n gryf mai'r mesurau yn y Bil hwn yw'r ffordd fwyaf effeithiol o gyflawni'r gwelliannau sydd eu hangen.

Yn gywir,

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Preseli Penfro
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Mae cyfyngiadau ar y ddogfen hon

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