Agenda - Y Pwyllgor Cyfrifon Cyhoeddus

Lleoliad:

Ystafell Bwyllgora 3 - y Senedd

Dyddiad: Dydd Llun, 20 Mai 2019

Amser: 13.15

I gael rhagor o wybodaeth cysylltwch a:

Fay Bowen

Clerc y Pwyllgor

0300 200 6565

SeneddArchwilio@cynulliad.cymru

(Rhag-gyfarfod preifat)

(13.15 - 13.30)

1 Cyflwyniad, ymddiheuriadau, dirprwyon a datgan buddiannau

(13.30)

2 Papur(au) i'w nodi

(13.30- 13.40)

2.1 Gwariant ar staff asiantaeth gan GIG Cymru: Llythyr gan Lywodraeth Cymru (25 Ebrill 2019)

(Tudalennau 1 - 8)

2.2 Rheoli Apwyntiadau Dilynol Cleifion Allanol ar ar Draws Cymru: Llythyrau gan Goleg Brenhinol y Meddygon a'r BMA

(Tudalennau 9 - 19)

3 Cynllun Llywodraeth Cymru i gynnig tocynnau bws rhatach i bobl ifanc - FyNgherdynTeithio: Sesiwn dystiolaeth gyda Llywodraeth Cymru

(13.40 - 15.10) (Tudalennau 20 - 43)

Papur briffio gan y Gwasanaeth Ymchwil

PAC(5)-13-19 Papur 1 - Llywodraeth Cymru

Andrew Slade - Cyfarwyddwr Cyffredinol, Grŵp yr Economi, Sgiliau a Chyfoeth Naturiol, Llywodraeth Cymru

Simon Jones - Cyfarwyddwr, Seilwaith yr Economi, Llywodraeth Cymru

Cynulliad Cenedlaethol Cymru

National Assembly for Wales

Sheena Hague - Dirprwy Gyfarwyddwr Rheoli'r Rhwydwaith, Llywodraeth Cymru

4 Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y mater a ganlyn:

(15.10)

Eitem 5

5 Cynllun Llywodraeth Cymru i gynnig tocynnau bws rhatach i bobl ifanc – FyNgherdynTeithio: Trafod y dystiolaeth a ddaeth i law

(15.10 - 15.30)

Eitem 2.1

**Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol**

**Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group**

Nick Ramsay AC
Cadeirydd
Y Pwyllgor Cyfrifon Cyhoeddus

Ein cyf: AG/SOT

25 Ebrill 2019

Annwy Mr Ramsay,

Gwariant GIG Cymru ar staff asiantaeth

Rwy'n ysgrifennu mewn ymateb i'r llythyr y gwnaethoch ei anfon ar 28 Mawrth 2019.

Mae Llywodraeth Cymru yn croesawu adroddiad Swyddfa Archwilio Cymru (SAC), Ionawr 2019, ar wariant ar staff asiantaeth gan Wasanaeth Iechyd Gwladol Cymru (GIG Cymru) a fydd yn llywio gweithgareddau i'r dyfodol yng Nghymru. Roeddem eisoes wedi dechrau gwneud gwaith sylweddol yn genedlaethol i reoli'r gwariant hwn, a gwnaethom rannu hyn gyda SAC wrth iddynt gwblhau eu hadroddiad. Mae'n galonogol bod yr arsylwadau a wnaed gan SAC ar ddatblygu ffynhonnell sengl o gasgliad data cyson a chryfhau arweiniad i lywio'r gwaith a darparu effeithlonrwydd i'r dyfodol yn cyd-fynd â'n ffocws ar gyfer ail gyfnod y rhaglen waith hon.

Gwnaethom gyflwyno fframwaith rheoli cenedlaethol newydd ym mis Tachwedd 2017 a gymeradwywyd gan y Gweinidog i leihau'r defnydd o asiantaethau a'r gwariant arnynt, gan ein galluogi i leihau gwariant cymaint â £30 miliwn mewn 12 mis rhwng 2016-17 a 2017-18. Mae hyn yn welliant o 17% mewn gwariant sylfaenol ac mae wedi gwrthdroi patrwm o gynnydd blynyddol.

Roedd y lleihad hwn o ganlyniad i waith ar y cyd rhwng Llywodraeth Cymru a sefydliadau'r GIG i weithredu nifer o reolaethau a phrosesau rheoli a gyflwynwyd gan Gylchlythyr Iechyd Llywodraeth Cymru WHC 2017-042 ym mis Tachwedd 2017 i leihau'r defnydd o staff asiantaeth a staff locwm yn sefydliadau GIG Cymru.

Ochr yn ochr â'r rheolaethau ar leoli staff asiantaeth a locwm, rydym hefyd wedi gweithredu ystod o fesurau mwy strategol i adeiladu gweithlu sylweddol a chynaliadwy yn erbyn y

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gwariant uchaf a gofnodwyd erioed ar weithlu, gan gynnwys ein hymgyrch Hyfforddi, Gweithio, Byw llwyddiannus.

Bu cynnydd wrth recriwtio'r gweithlu, gyda'r nifer uchaf erioed o staff yn gweithio yn GIG Cymru. Ym mis Medi 2017 (yr ystadegau swyddogol diweddaraf sydd ar gael) roedd 77,917 o staff GIG cyfwerth â llawn amser (FTE) yn cael eu cyflogi yn uniongyrchol yng Nghymru. Roedd hyn 2.1% (1,629) yn uwch nag yn 2016 a dyma'r nifer uchaf erioed.

Hefyd, ym mis Tachwedd 2018, cyhoeddodd y Gweinidog Iechyd a Gwasanaethau Cymdeithasol becyn buddsoddi o £114m i gefnogi rhaglenni addysg a hyfforddiant ar gyfer gweithwyr gofal iechyd proffesiynol yng Nghymru. Mae hyn yn cynrychioli cynnydd o £7m o gymharu â 2018/19.

Rydym wedi cyflawni lleihad sylweddol a chyflym yn ein gwariant ar staff asiantaeth a locwm drwy ein fframwaith rheoli newydd. Mae'r casgliad gwybodaeth sy'n sylfaen i'r fframwaith rheoli hwn, ochr yn ochr â dadansoddiad a sylwadau SAC, wedi ein galluogi i adnabod y camau nesaf ar gyfer ail gyfnod y gwaith i leihau dibyniaeth y GIG ymhellach ar staff asiantaeth a locwm, a pharhau â'r cynnydd da hwn.

Er bod potensial sylweddol i reoli'r defnydd o staff asiantaeth a locwm ymhellach, mae rhai sefydliadau wedi gwneud gwell cynnydd nag eraill. Felly, mae swyddogion Llywodraeth Cymru yn gweithio gyda'r byrddau iechyd unigol i rannu arfer da a chraffu ar eu camau gweithredu. Maent hefyd yn archwilio manteision posibl y sefydliadau, gan gynnwys dewisiadau masnachol, sy'n cynnig ystod o wasanaethau sy'n ceisio lleihau'r gwariant ar staff asiantaeth a locwm.

Mae dadansoddiad o'r gwariant ar leoli staff asiantaeth a locwm ym mhob grŵp staff yn y GIG yng Nghymru ar gyfer 2018-19 wedi'i gynnwys yn Atodiad 1.

Yours sincerely

Dr Andrew Goodall CBE

Staff Group	2018/19 Agency & Locum (paid at a premium) Expenditure (M11 Actual + M12 Forecast)											Staff Category as a % of Total Expenditure
	ABM	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf	Hywel Dda	Powys	PHW	Velindre	WAST	Total	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Admin & Clerical & Board Members	1,223	269	1,672	421	993	239	70	763	1,093	160	**6,902**	4.9%
Medical & Dental	9,737	10,334	13,809	144	13,909	4,308	1,286	673	-	-	**54,200**	38.5%
Nursing & Midwifery Registered	11,575	7,358	12,428	9,442	6,741	14,216	2,074	-	4	-	**63,839**	45.3%
Prof Scientific & Technical	8	86	300	5	50	22	710	-	-	-	**1,181**	0.8%
Additional Clinical Services	851	48	25	15	342	138	368	-	101	-	**1,888**	1.3%
Allied Health Professionals	1,006	1,438	2,293	591	808	1,222	409	48	522	-	**8,337**	5.9%
Healthcare Scientists	201	716	213	164	296	168	-	642	44	-	**2,444**	1.7%
Estates & Ancillary	679	736	21	347	1	-	237	2	62	12	**2,097**	1.5%
Students	-	-	-	-	-	-	-	-	-	-	**-**	0.0%
Total NHS Wales	**25,280**	**20,985**	**30,761**	**11,129**	**23,139**	**20,313**	**5,154**	**2,127**	**1,826**	**172**	**140,887**	**100.0%**
As a % of Total	**17.9%**	**14.9%**	**21.8%**	**7.9%**	**16.4%**	**14.4%**	**3.7%**	**1.5%**	**1.3%**	**0.1%**	**100.0%**	
Total Forecast Pay Expend	**670,203**	**537,896**	**739,998**	**613,540**	**355,679**	**414,727**	**78,626**	**82,838**	**159,508**	**131,237**	**3,784,252**	
As a % of Total Pay Expend	**3.8%**	**3.9%**	**4.2%**	**1.8%**	**6.5%**	**4.9%**	**6.6%**	**2.6%**	**1.1%**	**0.1%**	**3.7%**	

Reasons for expenditure Agency/ Locum (paid at a premium)	2018/19 Agency & Locum (paid at a premium) Expenditure (M11 Actual + M12 Forecast)											% spend by Category
	ABM	Aneurin Bevan	Betsi Cadwaladr	Cardiff & Vale	Cwm Taf	Hywel Dda	Powys	WAST	Velindre	WAST	Total	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Vacancy	17,275	16,073	26,256	6,046	17,205	18,675	2,557	2,127	1,782	172	**108,168**	**76.8%**
Maternity/Paternity/Adoption Leave	-	174	533	650	114	49	73	-	-	-	**1,593**	**1.1%**
Special Leave (Paid) – inc. compassionate leave, interview	-	151	-	81	-	4	-	-	-	-	**236**	**0.2%**
Special Leave (Unpaid)	-	-	-	-	-	1	-	-	-	-	**1**	**0.0%**
Study Leave/Examinations	-	-	-	-	91	-	99	-	-	-	**190**	**0.1%**
Additional Activity (Winter Pressures/Site Pressures)	4,677	2,150	581	2,657	1,855	996	1,173	-	44	-	**14,134**	**10.0%**
Annual Leave	-	34	1,889	23	1,309	-	286	-	-	-	**3,541**	**2.5%**
Sickness	3,328	1,348	1,502	1,672	2,550	588	971	-	-	-	**11,958**	**8.5%**
Restricted Duties	-	-	-	-	15	-	-	-	-	-	**15**	**0.0%**
Jury Service	-	-	-	-	-	-	-	-	-	-	**-**	**0.0%**
WLI	-	818	-	-	-	-	-	-	-	-	**818**	**0.6%**
Exclusion (Suspension)	-	236	-	-	-	-	-	-	-	-	**236**	**0.2%**
Total NHS Wales	**25,281**	**20,985**	**30,761**	**11,129**	**23,139**	**20,313**	**5,158**	**2,127**	**1,826**	**172**	**140,892**	**100.0%**

Archwilydd Cyffredinol Cymru
Auditor General for Wales

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Mr Nick Ramsay AC
Cadeirydd y Pwyllgor Cyfrifon Cyhoeddus
Cynulliad Cenedlaethol Cymru
Bae Caerdydd
Caerdydd
CF99 1NA

Cyfeirnod: AC/144/caf
Dyddiad cyhoeddi: 13 Mai 2019

Annwyl Nick

Gwariant GIG Cymru ar staff asiantaeth

Diolch i chi am rannu gyda mi y llythyr dyddiedig 25 Ebrill 2019 oddi wrth Dr Andrew Goodall at y Pwyllgor, oedd yn mynegi ymateb Llywodraeth Cymru i'm hadroddiad ym mis Ionawr 2019 ar 'Gwariant GIG Cymru ar Staff Asiantaeth'.

Mae'n dda gennyf nodi sylwadau cadarnhaol Dr Goodall ar f'adroddiad. Fodd bynnag, meddyliais y dylwn dynnu sylw'r Pwyllgor at y ffaith fod y ffigurau sydd wedi eu cynnwys yn yr atodiad i lythyr Dr Goodall yn dangos bod gwariant ar staff asiantaeth wedi cynyddu unwaith eto yn 2018-2019, ar ôl gostwng yn y flwyddyn flaenorol. Nid oes sôn am y cynnydd hwn yn y llythyr.

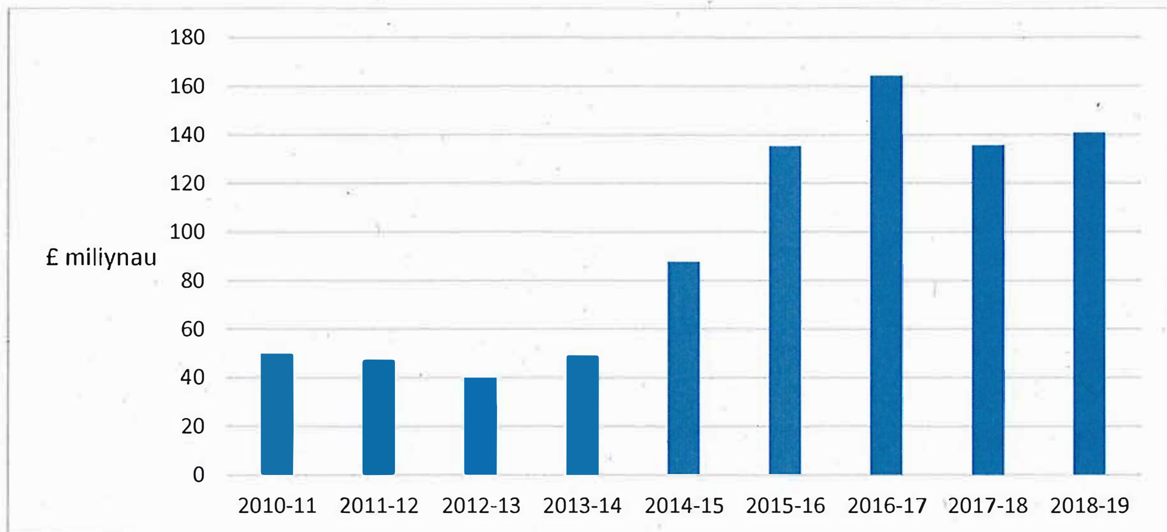
Nodaf hefyd y caiff y Pwyllgor y cyfle i holi tystion o fyrddau iechyd lleol ac o Lywodraeth Cymru ynglŷn â'r materion hyn yn ei sesiynau tystiolaeth cyn bo hir ar Gyllid y GIG.

Ar ôl gostyngiad yn 2017-18, cododd gwariant asiantaeth cyffredinol eto yn 2018-19

Fel y mae Dr Goodall yn nodi, roedd fy adroddiad i'n datgan bod gwariant cyffredinol ar staff asiantaeth rhwng 2016-17 a 2017-18 wedi gostwng o £30 miliwn (17 y cant), gan wrthdroi patrwm o gynyddiadau blynyddol sylweddol oedd wedi digwydd ers 2012--13.

Fodd bynnag, ac fel y dangosir yn Arddangosyn 1 isod, dengys y data a roddir yn llythyr Dr Goodall fod y gwariant asiantaeth cyffredinol yn ystod 2018-19 wedi cynyddu mewn gwirionedd o £5.2 miliwn (4 y cant), i £141 miliwn.

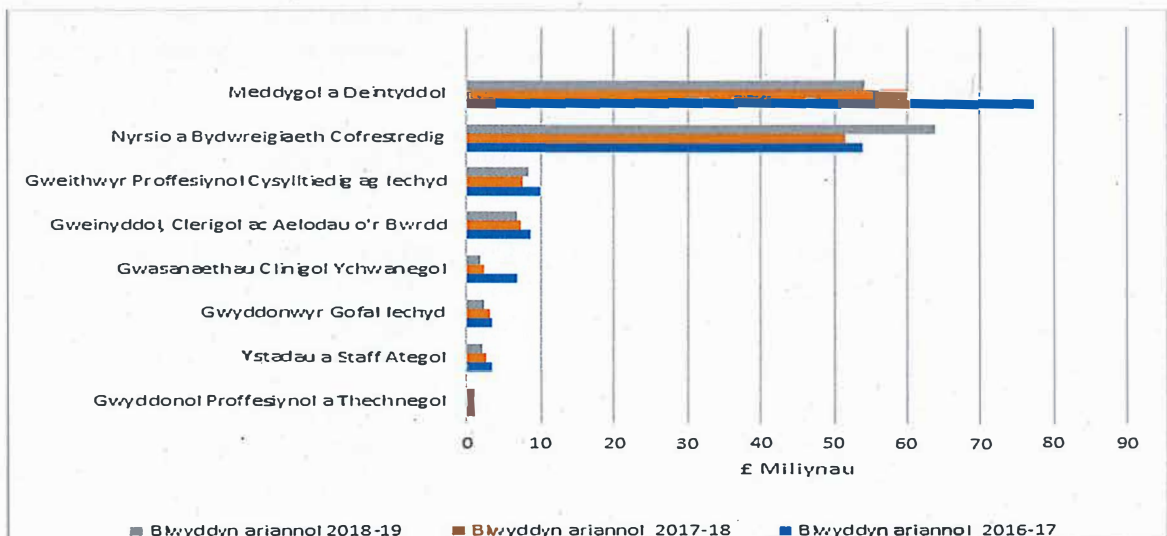
Arddangosyn 1: cyfanswm gwariant y GIG yng Nghymru ar staff asiantaeth rhwng 2010-11 a 2018-29



Y ffynonellau ar gyfer yr holl arddangosion: 2010-11 i 2017-18 Gweithlu, Gwasanaethau Addysg a Datblygiad, Partneriaeth Cyd-wasanaethau GIG Cymru; 2018-19: Llywodraeth Cymru.

Rhydd Arddangosyn 2 ddadansoddiad manylach o'r codiad hwn yng nghyfanswm blynyddol costau staff asiantaeth. Dengys fod gwariant wedi gostwng ym mhob categori o staff asiantaeth ond dau yn ystod 2018-19, a bod y codiad o fewn y flwyddyn bron yn gyfan gwbl oherwydd gwariant sylweddol fwy ar staff asiantaeth Nyrsio a Bydwreigiaeth.

Arddangosyn 2: Gwariant y GIG yng Nghymru ar staff asiantaeth fesul grŵp staff rhwng 2016-17 a 2018-19



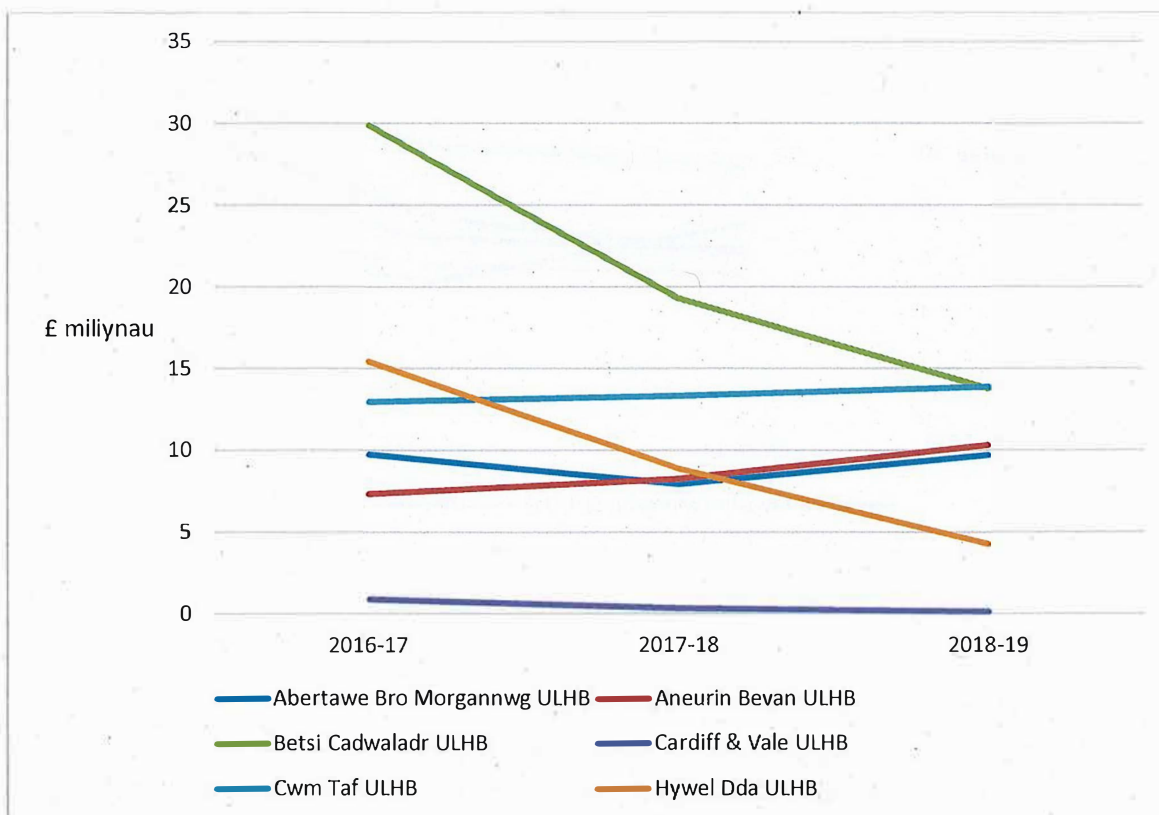
Daeth costau staff asiantaeth Meddygol i lawr o bron i 10 y cant.

Canolbwyntiai ein hadroddiad ni ar fentrau Cymru gyfan i gael rheolaeth ar gost defnyddio staff asiantaeth (i) meddygol a (ii) nyrsio. Mae'r gostyngiad mwyaf mewn gwariant asiantaeth o 2017-28 i 2018-29 yng nghategori staff asiantaeth Meddygol a Deintyddol, sydd wedi lleihau o £5.8 miliwn (9.7 y cant).

Roedd Cylchlythyr Iechyd Cymru WHC 2017-042, a gyflwynwyd ym mis Tachwedd 2017, yn ei gwneud yn ofynnol i gyrff GIG Cymru weithredu dulliau rheoli a phrosesau rheoli i leihau'r defnydd a gwariant ar staff asiantaeth ar gyfer staff meddygol a deintyddol. Yn galonogol, cafwyd o ganlyniad gwymp o 30 y cant (£23 miliwn) mewn gwariant ar staff asiantaeth meddygol a deintyddol rhwng 2016-17 a 2018-19.

Fodd bynnag, mae'n bwysig nodi mai lleol yw'r gostyngiad hwn mewn gwariant asiantaeth meddygol a deintyddol - fel y dangosir yn Arddangosyn 3, mewn tri yn unig allan o'r chwe chorff iechyd mwyaf y cafwyd gostyngiad.

Arddangosyn 3: gwariant ar staff asiantaeth Meddygol a Deintyddol yn y chwe chorff iechyd mwyaf rhwng 2016-17 a 2018-19



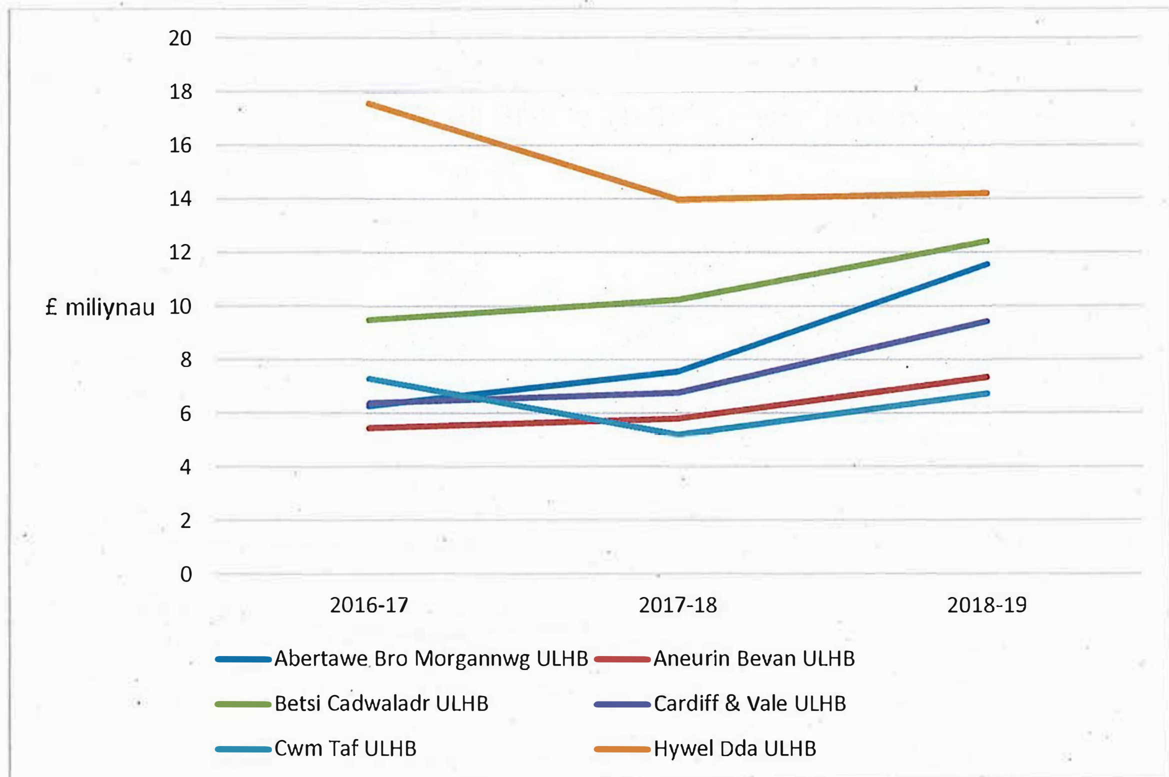
Bu gostyngiadau sylweddol yn ystod 2018-19 yn BIP Betsi Cadwaladr (£5.5 miliwn) a BIP Hywel Dda (£4.6 miliwn) ond codiadau yn BIP Aneurin Bevan (£2.1 miliwn) a BIP Abertawe Bro Morgannwg (£1.8 miliwn). Y symudiadau o fewn y

flwyddyn yn BIP Cwm Taf a BIP Caerdydd a'r Fro oedd codiad o £0.5 miliwn a chwymp o £0.2 miliwn yn y drefn honno.

Cododd costau staff asiantaeth Nyrsio a Bydwreigiaeth o 24 y cant

Cododd gwariant ar staff asiantaeth Nyrsio a Bydwreigiaeth o 24 y cant i £63.8 miliwn yn 2018-19, ar ôl cwympo o'r blaen i £51.4 miliwn yn 2017-18. Fel y dangosir yn Arddangosyn 4, mae pob un o'r chwe chorff iechyd mwyaf wedi adrodd am gynyddiadau mewn gwariant asiantaeth ar gyfer y categori hwn o staff, gyda graddfa'r cynnydd yn amrywio o 1.6 y cant (£0.2 miliwn) yn BIP Hywel Dda i 52.9 y cant (£4 miliwn) yn BIP Abertawe Bro Morgannwg.

Arddangosyn 4: gwariant ar staff asiantaeth cofrestredig Nyrsio a Bydwreigiaeth yn y chwe chorff iechyd mwyaf rhwng 2016-17 a 2018-19



Cyfnod Dau o raglen waith Llywodraeth Cymru

Mae llythyr Dr Goodall hefyd yn cyfeirio at ail gyfnod rhaglen waith Llywodraeth Cymru i leihau dibyniaeth ar staff asiantaeth a staff dros dro ar draws GIG Cymru. Ar adeg ein hadolygiad archwilio y llynedd, nid oedd eto'n glir beth y byddai'r ail gyfnod hwn yn ei olygu a'r mentrau y byddai'n eu cynnwys. Cymharol ychydig a rydd llythyr Dr Goodall o ran gwybodaeth bellach am fanylion rhaglen cyfnod dau.

Yn ei sesiwn dystiolaeth ar Gyllid y GIG gyda Llywodraeth Cymru felly, hwyrach y bydd y Pwyllgor yn dymuno hefyd edrych gyda'r tystion ar y modd y mae'r ail

gyfnod gwaith hwnnw yn ymateb i'r ddwy brif her a nodwyd gennym yn Rhan 4 ein hadroddiad.

Mae niferoedd aelodau o staff GIG Cymru yn parhau i godi

Wrth ystyried y wybodaeth ddiweddar hon am gostau staff Asiantaeth, efallai y bydd y Pwyllgor hefyd yn dymuno cadw mewn cof yr ystadegau swyddogol diweddaraf sydd ar gael ar nifer y staff sy'n gweithio yn GIG Cymru.

Dengys y datganiad ystadegol diweddaraf gan Lywodraeth Cymru fod yna 79,054 o staff yn cyfateb i amser llawn yn cael eu cyflogi'n uniongyrchol gan y GIG yng Nghymru ar 30 Medi 2018. Mae hyn yn cynrychioli codiad o 1.4 y cant (1,083 o staff) yn y flwyddyn o fis Medi 2017. Cododd staffio meddygol a deintyddol o 2.4 y cant (156 o staff), tra y daeth staffio nyrsio, bydwreigiaeth ac ymwelwyr iechyd i lawr o 0.1 y cant (47 o staff).

Hyderaf y bydd y wybodaeth ychwanegol hon a'r dadansoddiad o gymorth i'r Pwyllgor wrth baratoi ar gyfer ei sesiynau tystiolaeth ar Gyllid y GIG yn ddiweddarach y tymor hwn.

Yn gywir

ADRIAN CROMPTON
Archwilydd Cyffredinol Cymru

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Eitem 2.2

Inquiry into the management of follow up outpatients across Wales

RCP Cymru Wales response

About us

Our 36,000 members worldwide (including 1,300 in Wales) work in hospitals and the community across 30 different clinical specialties, diagnosing and treating millions of patients with a huge range of medical conditions, including stroke, care of older people, cardiology and respiratory disease. We campaign for improvements to healthcare, medical education and public health. We work directly with health boards, NHS Wales trusts and HEIW; we carry out regular 'local conversation' hospital visits to meet patients and front-line staff; and we collaborate with other organisations to raise awareness of public health challenges.

We organise high-quality conferences, teaching and workshop events that attract hundreds of doctors every year. Our work with the Society of Physicians in Wales aims to showcase best practice in Wales through poster competitions and trainee awards. In July 2018, we hosted the inaugural and highly successful RCP membership (MRCP(UK)) and fellowship (FRCP) ceremony for Wales.

To help shape the future of medical care in Wales, visit our website:
www.rcplondon.ac.uk/wales

To tell us what you think – or to request more information – email us at:
wales@rcplondon.ac.uk

Tweet your support:
@RCPWales
#MedicineisBrilliant
#MeddygaethynWych

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Public Accounts Committee
National Assembly for Wales
Cardiff CF99 1NA
SeneddPAC@Assembly.Wales

3 May 2019

Inquiry into the management of follow up outpatients across Wales

Thank you for the opportunity to respond to your inquiry into the management of follow up outpatients across Wales. The Royal College of Physicians (RCP) has worked with consultant physicians, trainee and specialty doctors, and members of our patient carer network in Wales to produce this response. We have also included a statement from colleagues at the Royal College of Ophthalmologists.

Both royal colleges would be happy to organise further written or oral evidence if that would be helpful.

Our response

The RCP recognises that the management of follow up outpatients in Wales poses a major clinical risk and we welcome the Wales Audit Office report and its recommendations. We agree that reform of the outpatient system is needed – while those with genuine problems need to be seen, many follow up appointments are unnecessary and take up clinical time which could be spent helping other patients. The system is also affected by widespread vacancies, rota gaps and a shortage of clinical staff. Technology could be used more widely and much more effectively, but its development has been slow.

> ***'Most clinics [are] heavily booked with new patients as this was a "target" – [this is] an example of distorting clinical practice to avoid penalties [and] has resulted in a huge number of patients waiting a long time for review … It will undoubtedly have added to medical assessment unit and emergency department attendances.'*** (Consultant physician, NHS Wales)

In the **Aneurin Bevan University Health board neurology service**, using a 'see on symptoms' approach, patients with certain long-term conditions (eg epilepsy, neuropathy, Parkinson's disease, MS) are responsible for liaising with the service, often through clinical nurse specialists. Advice is given over the phone, or by email or letter, which avoids unnecessary six month or annual reviews. For complex or urgent problems, a clinic appointment is scheduled. Some patients are naturally anxious that they will be lost in the system, so the process has built-in capacity to see patients at short notice, and recognises that the clinic appointment schedule must allow sufficient time to assess more complex cases.

The recent RCP report, *Outpatients: the future – adding value through sustainability*, found that the traditional model of outpatient care is no longer fit for purpose.[1] It places unnecessary financial and time costs on patients, clinicians, the NHS and the public purse. Its findings align with those of the Wales Audit Office in their 2018 report, *Management of follow up outpatients across Wales*.

***'Outpatient care represents the largest proportion of NHS contact with the public in the hospital setting.'*[1]**

We know that the traditional one-model-fits-all approach to outpatient care is not able to keep up with growing demand and fails to minimise disruption to patient lives. Clinicians are increasingly frustrated with, and fatigued by, growing pressures from waiting lists and overbooked clinics. Patients are frustrated by poor communication and long waiting times.

> ***'Outpatient follow up is an interesting area. In many specialties, secondary care follow up is much needed but has huge resource limitations and in many instances, GP services are not able to cope with the follow up needs of patients. Recently one of our consultants retired, and a lot of his patient workload has been distributed between the rest of us, which has had an impact on the patients that we would normally follow up from our wards, the medical assessment unit and community care. I suspect it is the same for most specialist services.'*** (Consultant physician, NHS Wales)

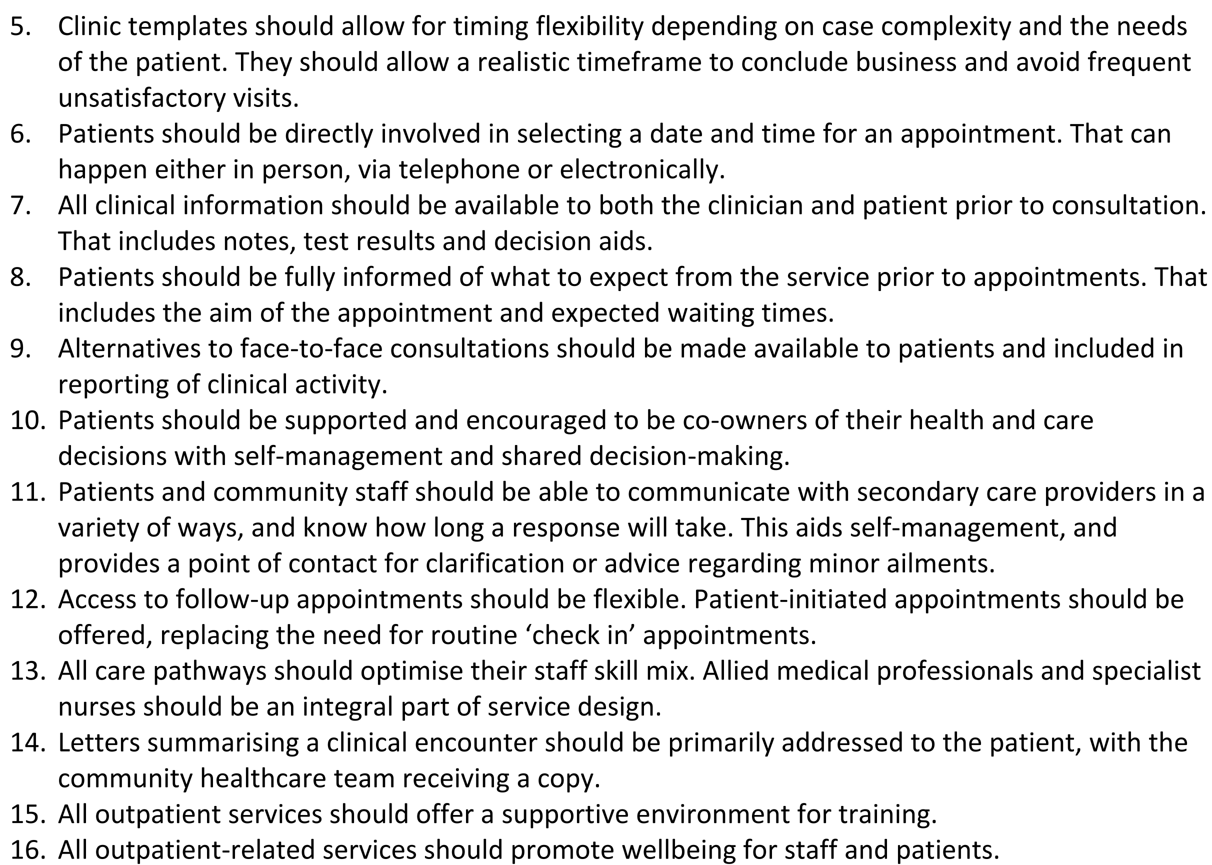
Health boards need to think differently about how they provide healthcare – for example, identifying the balance between cost and outcomes (value) and the long-term impact of the way they work (sustainability). This means taking into account all the costs related to an intervention, including loss of income to a patient attending an appointment and the impact of transport on public health.

The time has come to re-evaluate the purpose of outpatient care and align those objectives with modern-day living and expectations. This will require health boards to be more flexible, and allow patients more control over when and how they receive care. A key element of the redesign process is better use of the technology already available. It is up to the Welsh government to provide clear guidance and support to enable this transformation.

CARTREF (**CAR**e delivered with **T**elemedicine to support **R**ural **E**lderly and **F**rail patients) – is a telemedicine project that aims to improve access to care for frail older patients in rural north Wales. It was part of the RCP Future Hospital Programme which was established to implement innovative clinical changes across sites in England and Wales.[2] The Betsi Cadwaladr UHB project enables patients, especially those with chronic illnesses to have follow-up outpatient reviews closer to home. By using video clinics in primary care and community hospitals around Dolgellau, patients and relatives are able to meet specialists without travelling. The team worked with patients and carers to design the service model and can demonstrate patient satisfaction rates of 80%.

Principles for good outpatient care[1]

1. Demand for an outpatient service should be met by the available capacity. Capacity should take into consideration fluctuations in demand and staff availability throughout the year.
2. Interventions to reduce new patient demand should be targeted at all referral sources. They must not deter necessary referrals or damage professional working relationships.
3. Generic referrals should be pooled to minimise waiting times for appointments. Local consultants should review an agreed mix of generic and sub-specialty referrals according to demand.
4. All outpatient care pathways should aim to minimise disruption to patients' and carers' lives.



5. Clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient. They should allow a realistic timeframe to conclude business and avoid frequent unsatisfactory visits.
6. Patients should be directly involved in selecting a date and time for an appointment. That can happen either in person, via telephone or electronically.
7. All clinical information should be available to both the clinician and patient prior to consultation. That includes notes, test results and decision aids.
8. Patients should be fully informed of what to expect from the service prior to appointments. That includes the aim of the appointment and expected waiting times.
9. Alternatives to face-to-face consultations should be made available to patients and included in reporting of clinical activity.
10. Patients should be supported and encouraged to be co-owners of their health and care decisions with self-management and shared decision-making.
11. Patients and community staff should be able to communicate with secondary care providers in a variety of ways, and know how long a response will take. This aids self-management, and provides a point of contact for clarification or advice regarding minor ailments.
12. Access to follow-up appointments should be flexible. Patient-initiated appointments should be offered, replacing the need for routine 'check in' appointments.
13. All care pathways should optimise their staff skill mix. Allied medical professionals and specialist nurses should be an integral part of service design.
14. Letters summarising a clinical encounter should be primarily addressed to the patient, with the community healthcare team receiving a copy.
15. All outpatient services should offer a supportive environment for training.
16. All outpatient-related services should promote wellbeing for staff and patients.

'Action is needed now to preserve our most precious sense before more patients come to harm'

Ophthalmology is one of the busiest outpatient specialties in the UK. The needs of an ageing population and the increase in chronic eye disease requiring long term treatment and follow up care have put the hospital eye service under unprecedented pressure. The current workforce is stretched to meet a predicted increase in demand of 40% over the next 20 years. However, ophthalmology continues to develop efficient and effective models of outpatient care; working in partnership with optometrists in and out of the hospital setting can decrease the number of false positive referrals into secondary care, the use of the multidisciplinary teamwork that optimises efficiency and value in the hospital setting, and the use of virtual clinics in the treatment of glaucoma.

The Royal College of Ophthalmologists welcomes the Senedd Public Accounts Committee inquiry into the management of outpatients, especially the focus placed on ophthalmology. It is important that the committee recognises the very real risk of loss of sight if follow up patients are not seen as indicated by the consultant in a time-appropriate manner. In 2017 the RCOphth British Ophthalmology Surveillance Unit found up to 22 patients per month losing sight as a result of hospital initiated delays to follow up appointments.[3] Action is needed now to preserve our most precious sense before more patients come to harm.

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‘One in four potential outpatient appointments in Wales are cancelled or reported as ‘did not attend’ (DNA).’[1]

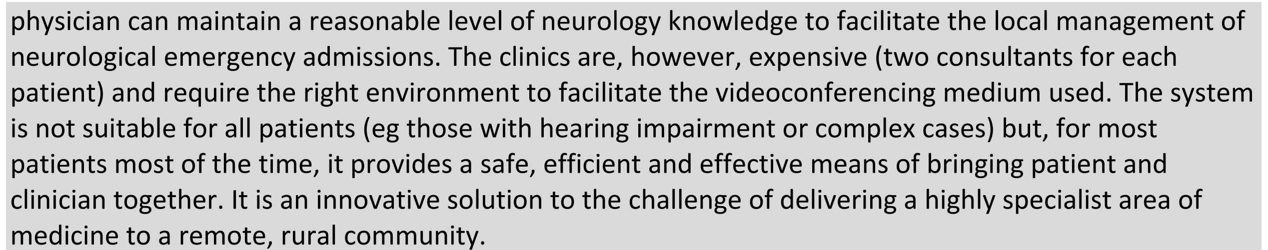
Next steps[1]

1. The Welsh government and NHS Wales should consider commissioning an external clinically-led whole system invited service review. This could take a cross-college approach.[4]
2. The NHS should support clinicians to deliver more specialist medical care in the community – the hospital without walls – and using new technology.
3. The wider healthcare team has a vital contribution to make – eg clinical nurse specialists, physiotherapists, and physician associates – and should be supported to play a key role in the management of patients with long term conditions.
4. Clinicians should think creatively about how they can support trainee doctors and medical undergraduate students to learn effectively from follow-up outpatients and their conditions.
5. Quality improvement (QI) projects should report on value as a whole, recognising the population and system effects of change as well as individual clinical outcomes.
6. Health boards should be appraised on the basis of clinical value, not units of physical interaction or activity.
7. National guidance for the oversight of outpatients as part of local governance structures should be developed and integrated in all health boards alongside mortality and morbidity reviews.
8. Specialist organisations and charities should work collaboratively to oversee the development of signposting to resources that support outpatient consultations, eg patient decision aids, preventing duplication of efforts locally.
9. NHS Wales, the Welsh government and local government need to work together to provide clear and structured guidance on how to build partnerships with the voluntary and community sectors. This should be created and supported by case studies.

‘An innovative solution to the challenge of delivering a highly specialist area of medicine to a remote, rural community’

In the more rural areas of Wales, the challenge of providing high-quality specialist services is not insignificant. Bronglais Hospital serves a population of around 150,000 across Ceredigion, north Powys and south Gwynedd – our patients may travel for 2 hours or more to reach this site. Our tertiary referral centre for neurology is in Swansea – a round trip of about 150 miles. The road infrastructure is poor and, at many points in the year, the roads are full of heavy goods vehicles and holiday traffic. The consultant contract in Wales recognises travel from base to clinic time as a direct clinical care element; therefore, this round trip adds substantially to the allocation of direct clinical care time. To combat this, we have worked with colleagues in Swansea to establish a teleneurology clinic, which has been running for a number of years now. Initially, we linked with one neurologist every 6 weeks and now we link with two neurologists roughly every fortnight. To date, two patients have also had an emergency teleneurology consultation. The service is appreciated by patients (who do not have to travel), by their carers (who do not have to take time off work) and by clinicians (who no longer have to spent clinical time travelling between hospitals).

An early survey to judge acceptability of this model showed that, of 36 patients on the waiting list who responded, 90% accepted and 10% declined – 5% preferring to travel and 5% preferring to see their own GP. After the service was established, a further survey of 24 patients who had used the service showed that, of 19 respondents, 100% were happy with the consultation and would use the service again. From a local perspective, the service provides an invaluable educational opportunity. It means that a general



physician can maintain a reasonable level of neurology knowledge to facilitate the local management of neurological emergency admissions. The clinics are, however, expensive (two consultants for each patient) and require the right environment to facilitate the videoconferencing medium used. The system is not suitable for all patients (eg those with hearing impairment or complex cases) but, for most patients most of the time, it provides a safe, efficient and effective means of bringing patient and clinician together. It is an innovative solution to the challenge of delivering a highly specialist area of medicine to a remote, rural community.

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[1] Royal College of Physicians. *Outpatients: the future – adding value through sustainability*. London: RCP, 2018. https://www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability
[2] RCP Future Hospital Programme. https://www.rcplondon.ac.uk/projects/future-hospital-programme
[3] Royal College of Ophthalmologists. *BOSU report shows patients losing sight to follow-up appointment delays.* https://www.rcophth.ac.uk/2017/02/bosu-report-shows-patients-coming-to-harm-due-to-delays-in-treatment-and-follow-up-appointments/
[4] RCP invited reviews. https://www.rcplondon.ac.uk/invited-reviews

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MANAGEMENT OF FOLLOW UP OUTPATIENTS ACROSS WALES

Inquiry by the National Assembly for Wales Public Accounts Committee

Response from BMA Cymru Wales

10 May 2019

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the inquiry by the National Assembly's Public Accounts Committee into the findings of the Auditor General for Wales' report entitled 'Management of follow up outpatients across Wales'.

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

RESPONSE

BMA Cymru Wales welcomes the opportunity to respond to this inquiry, as it touches on a significant area of concern that we have been highlighting in recent years with both the Welsh Government and Welsh NHS employers. During this time, we have been raising this issue as a major concern at both national and local meetings.

We remain deeply troubled at the lack of tangible progress which has been made in addressing the extent to which follow up outpatient appointments are delayed since the Auditor General's first report which looked at the situation as it was in 2015-16. Regrettably, the Auditor General's 2018 report validates the stance we have been taking in continuing to raise concerns, as it echoes the observation of many of our members. We take no pleasure in the fact that the situation has appreciably worsened, as

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Y Gymdeithas Feddygol Brydeinig
British Medical Association

highlighted in the findings of the 2018 report. This highlights the failure of Welsh NHS organisations to take the issue sufficiently seriously.

We can only hope that this second report by the Auditor General will now lead to an escalation of the efforts being made to address the problem. There is a clear need in our view for appropriate resources to be allocated by health boards and trusts to addressing this issue. This needs to involve the allocation of funding as well as an appropriate staffing resource, but we would also note that not all solutions to the problem necessarily require additional expenditure.

In compiling this evidence, we have sought views from our members based on their own experience. We hope this can provide some pointers as to how the situation might be more effectively addressed.

We would certainly endorse all the recommendations in the report, including that "*health boards need to get better at assessing and managing the clinical risks to patients from delays in follow-up appointments*" and that there "*needs to be a greater focus on the management of follow-up outpatient appointments within national and local performance management arrangements*." These two issues are, to a large extent, interlinked in our view.

A huge part of the problem lies in the way the that formal target arrangements currently operate as this often takes precedence over clinical judgment as to when a patient needs to be seen. This is often down to the fact there is a target for when patients should be seen for their first outpatient appointment after being referred by their GP (known as the referral to treatment target, or RTT) but there is no equivalent target for when they should be seen for a follow-up appointment. This sometimes creates a perverse incentive for health boards to prioritise first appointments over follow-up appointments to ensure they meet their targets, which might be achieved only at the expense of delaying follow-up appointments.

We would recommend that how this system works must be reviewed. We need to move away from the problem that currently exists where the need to meet Welsh Government-set targets can over-ride informed clinical judgement on when patients should be seen.

We further note that when follow-up appointments are delayed in this way by health boards, the consultant overseeing the care of the patient in question is often not informed that this has happened and may only become aware the appointment was delayed when they next see the patient in question. As highlighted in the Auditor General's report, in worst-case scenarios a patient's health might have deteriorated irreversibly during the time their follow-up appointment was delayed – something that may have been avoided had the appointment taken place within the time-frame originally specified by the clinician who requested it.

The report notes the risk that this can pose to ophthalmology patients who could potentially even lose their sight as a result of a delayed follow-up appointment, but as the report acknowledges there can be similar risks in relation to other specialties. For instance, one of our members who is an ear, nose and throat (ENT) surgeon has pointed out that for his patients the potential exists for delayed follow-up appointments to lead to a permanent loss of hearing, an irreversible loss of balance or the development of facial palsy.

One concern our members highlight is a lack of consistent practice in dealing with follow-up outpatient appointments, which can vary between health boards, between specialties and between individual clinicians. Thus, whilst there are plenty of examples of good practice being employed, they are not being done so consistently. We are aware for instance that some consultants make a point of regularly assessing their own lists and initiate action themselves to ensure their follow-up appointments are not being delayed by addressing any backlog they might have. However, this is not something that happens routinely across the board.

Whilst some consultants regularly obtain their own figures for how many 'follow-up not booked' (FUNB) appointments they have on their list as a matter of routine, this is not universal. We would therefore

suggest that consideration is given to putting in place a mandatory requirement for health boards and trusts to supply every consultant who manages a list with details of how many FUNB appointments they have on either a monthly or quarterly basis.

One of our consultant members has highlighted the challenges he has had in ensuring he has no outpatient appointments classed as FUNB, as well as maintaining such a position once it has been achieved. After taking up his post, it took him four years to eliminate FUNB appointments from his list. However, events outside of his control have meant that he has not always been able to fully maintain such a position on a continuous basis. On one occasion, for instance, a software change introduced by his health board led to 150 patients being lost from his list. When this was discovered at a later date, and they were then added back to his list, he found himself with a backlog of 150 FUNB appointments which it took him 18 months to eliminate once again. On another occasion, he inherited 40 FUNB appointments from a colleague who had retired.

We would suggest that there is a clear need to ensure best practice is shared and that consultants are facilitated in adopting changes that would ameliorate this adverse position. The consultant referred to in the previous paragraph adopted a system for managing appointments that he had previously observed another consultant using, but we need to consider how such best practice sharing could be better promoted and adopted. One suggestion would be to hold a forum, or one-day conference, specifically about strategies for dealing with follow-up outpatient appointments – something that could potentially be undertaken on an annual basis.

Another suggestion that we support within the Auditor General's report is to review the need for so many patients to receive a follow-up outpatient appointment automatically after surgery. In the experience of our members, this is also an area in which there appears to be quite inconsistent practice between different hospitals and health boards.

A consultant dermatologist has pointed out that in her department patients are only seen after surgery if it is deemed that they require further treatment or assessment, but in a neighbouring hospital the practice there is to give every patient who has received a biopsy a follow-up appointment even when a carcinoma has been fully excised and needs no further treatment.

We note the necessity to ensure that outcomes are monitored and that feedback about quality and safety are essential, but there are many ways to collate such data using IT, telephone, or other means. One consultant gynaecologist reported that, due to cuts in staffing, their successful efficient nurse-led 'gynae reunion' session was stopped so patients are now followed up instead in consultant clinics. Health boards must be tasked with moving the service forwards – all too often our members report regression due to cost or staff constraints.

An ENT surgeon has noted that is now standard accepted practice not to see all patients automatically following surgery for tonsil removal, and that similar practice is now also being adopted in relation to patients who have had simple nose surgeries, e.g. septoplasty and simple functional endoscopic sinus surgery (FESS). Patients can however phone to request an appointment up to eight weeks following their surgery should a problem arise.

This surgeon has also pointed out that a consultant should be able to judge to a high level of accuracy (i.e. around 96%) whether or not a patient will need to be seen again following surgery. Through the use of such clinical judgment to determine whether or not patients will need to be seen in such circumstances, capacity can therefore be freed up to enable other patients to be seen in a more timely manner.

The key point here is that greater use of clinical judgement can help to minimise the risk that might exist to patients, as well as ensuring fewer patients who need a follow-up appointment have that appointment delayed. This can help reduce such delays without necessarily needing greater financial resource.

We note the emphasis that is placed on improving quality through better outcomes – be they clinical or patient-reported – so it also remains vital that follow-up data are collected, collated and utilised effectively in driving up standards and quality.

A further concern raised by a consultant oral and maxillofacial surgeon is that when he is scheduling a review appointment for a patient, he will not normally have any available appointments that are less than four months into the future because his clinics prior to this time will already be fully booked. On occasions when he judges he needs to see a patient again more quickly, e.g because the patient needs a scan or other investigation for suspected cancer or other serious conditions, he therefore has no choice but to overbook an earlier clinic. This can put other patients at risk who are already booked to be seen in these clinics, but whose appointments may then have to be delayed.

Some of our GP members have expressed concern regarding the frustration that delayed follow-up appointments cause to their patients. This in turn has workload implications for GP practices, as patients often contact them when they have been left waiting and are lacking information about what is happening. Again, we would point to the impact of differential practice. Some hospital departments will advise a patient of an alternative date for their appointment at the same time as letting them know it has been delayed, but others just advise patients to wait until they hear from them again before they will be given an alternative date whilst some require such patients to ring in to book an alternative date for their appointment.

GP practices are often asked to assist patients who have difficulty rearranging outpatient appointments that they are unable to make. Patients often find that the contact numbers provided on the letters they have received are permanently engaged, meaning they struggle to inform a hospital department they can't attend on the date offered. This can mean they are then being classed as DNA (did not attend) rather than CNA (could not attend), and this can then lead them to be discharged from the waiting list.

We are also aware of patients who have received letters advising them that their outpatient appointment has been rescheduled for an earlier date than their original appointment, but the letters advising them of this fact have not reached them until after their new appointment date has already passed.

Another concern GPs have highlighted is that patients are often asked by hospital departments to confirm that they are consenting to their referral, even though they have already opted in to being referred at the GP appointment they attended when it was agreed the referral should be made. We are further aware of instances where patients who have been referred for an assessment are then asked to confirm they consent to a procedure being undertaken, even though it may not be known at that stage if a procedure is in fact needed. Such patients may understandably be reluctant to do so until they have actually had their secondary care assessment. It is hard to see what the benefit of such confirmation requirements are, other than to remove patients from waiting lists that GPs have determined should be seen. This may help reduce waiting lists, but only in a manner which may be detrimental to the health of patients.

One suggestion put forward by a GP member is that there could be a dedicated person (or team) within each health board with responsibility for managing the situation for each patient. This person could act as an 'ongoing hospital care navigator', be a point of contact for patients and have responsibility for liaising with relevant specialty departments within the hospital. By acting as a channel for such communications, this could reduce the current multiplicity of calls to secretaries within hospital departments and contacts at GP surgeries. They could also have a role in requesting that follow-up appointments be expedited and chasing when responses are not being received, although clearly there would be a need to also ensure they were undertaking their roles with appropriate clinical input.

Another of our GP members has advised us of his experience as a member of the Dyfed Powys Local Medical Committee (LMC) in working with Hywel Dda University Health Board to address problems there around delayed follow-up outpatient appointments. Three years ago, he approached the health board's deputy chief executive with a proposal that the health board could commission GPs to look at cases once

appointments had reached six months delay compared to when a patient was supposed to have been seen. The idea was for GPs to review such cases to determine if the patients in question still needed a follow-up appointment, or if they could instead be discharged from the list to free up capacity and reduce waits for others. A subsequent meeting was held which also involved the chair of the LMC to further develop the proposal, draw up a potential service level agreement and consider an appropriate fee for the work as it would not be covered by existing contractual arrangements. The discussions considered five different specialties which it was felt should initially be targeted, because this is where the LMC felt the most difference could be made.

A pilot was subsequently undertaken for urology patients. It led to 6% of cases being immediately referred back to the clinic as being in need of urgent review, 54% being identified as suitable to be discharged from the list, with the remaining 40% of patients being recommended to remain on the list for a follow-up appointment. It is greatly disturbing that more than one in 20 patients were judged to be in need of urgent review when on a waiting list.

Regrettably, although funding to take this work forward was written in to the health board's RTT plan for 2019-20, it was not subsequently approved by the health board's executive team. This is clearly a deeply disappointing outcome, particularly given the fact that it is possible significant sums for negligence may have to be paid out for patients who have suffered deterioration to their health as a result of delayed follow-up appointments. Whilst the health board should of course be concerned about this, we would note that such payments come from the Wales Risk Pool rather from the health board's own budget. This is something the Welsh Government should perhaps seek to address, as it would surely be more cost effective, and significantly better for patients, for funding to be allocated to such initiatives rather than see much greater sums paid out in negligence claims.

In summary

We would reiterate our view that efforts to tackle this problem must now be appropriately escalated and that the issue needs to be given significantly greater priority by health boards, including at board level. More consistent practice needs to be adopted across health boards and hospital departments, as well as by individual clinicians. Where required, appropriate resources should be allocated, and initiatives should be supported across health boards that can address the underlying issues. More also needs to be done to facilitate the sharing of best practice.

Part of the solution involves reviewing the need for some patients to remain on lists awaiting follow-up appointments and for a change in adopted practice so that certain categories of patients aren't routinely seen for follow-up appointments when there may not be a clinical need. In addition, there are undoubtedly ways in which the current system for managing such outpatient appointments can be reformed to ensure it is more appropriately based on ensuring patients are seem in accord with assessed clinical need at the time a clinician has judged they should be seen. Perverse incentives in the way Welsh Government targets are currently applied need to be addressed to ensure that adhering to such targets does not over-ride clinical judgement.

We can only hope that this second report from the Auditor General will lead to this issue now being treated with the seriousness it deserves at health board level. It is deeply regrettable that the problem has significantly worsened overall since concerns we contributed to raising led to the first report being undertaken in 2015-16. We would therefore suggest that National Assembly committees should play a role in monitoring progress. We cannot afford to wait until another report is produced by the Auditor General in a few years' time only to discover that the situation has worsened yet again to the detriment of patients.

Mae cyfyngiadau ar y ddogfen hon

Papur Tystiolaeth cyn Sesiwn Graffu'r Pwyllgor Cyfrifon Cyhoeddus – 20.05.2019

Adroddiad Archwilydd Cyffredinol Cymru ar gynllun tocynnau bws rhatach Llywodraeth Cymru ar gyfer pobl ifanc - 'FyNgherdynTeithio'

Diben y papur hwn yw rhoi Tystiolaeth Ysgrifenedig i'r Pwyllgor Cyfrifon Cyhoeddus ar Adroddiad ffeithiau'n unig Archwilydd Cyffredinol Cymru ar 'Gynllun tocynnau bws rhatach Llywodraeth Cymru ar gyfer pobl ifanc - FyNgherdynTeithio'.

Adran 1: Canfyddiadau allweddol

Adran 2: Datblygu a chyflwyno FyNgherdynTeithio

Adran 3: Gweithredu FyNgherdynTeithio rhwng mis Medi 2015 a mis Mawrth 2017

Adran 4: Gweithredu FyNgherdynTeithio ers mis Ebrill 2017

Adran 1: Canfyddiadau allweddol

Yn absenoldeb deddfwriaeth sy'n galluogi Llywodraeth Cymru i'w gwneud yn ofynnol i gwmnïau bysiau gymryd rhan, cafodd cynllun FyNgherdynTeithio ei gyflwyno fel trefniant gwirfoddol rhwng Llywodraeth Cymru a mwy na 80 o gwmnïau bysiau annibynnol, ac erys felly.

Mae Adroddiad ffeithiau'n unig Swyddfa Archwilio Cymru yn cydnabod bod swm y cyllid a ddyrannwyd i'r cynllun yn 2105-16 (£5m ar gyfer mis Medi 2015 hyd at fis Mawrth 2016) a 2016-17 (£9.75m ar gyfer y flwyddyn ariannol lawn) wedi'i gyhoeddi fel rhan o gytundeb gwleidyddol rhwng Llafur Cymru a Democratiaid Rhyddfrydol Cymru ar gyfer cyllideb 2015-16.

Cafodd y swm ei gyhoeddi cyn i Lywodraeth Cymru drafod â chwmnïau bysiau am yr iawndal a fyddai'n daladwy iddynt am gludo pobl ifanc 16 i 18 oed am bris rhatach. Cynhaliwyd y trafodaethau hynny rhwng Llywodraeth Cymru a'r diwydiant bysiau, wedi'i gynrychioli gan y Cydffederasiwn Cludiant Teithwyr (y Cydffederasiwn) mewn cyd-destun lle roedd y Cydffederasiwn yn mynnu bod y symiau llawn o gyllid a gyhoeddwyd eisoes yn cael eu talu iddynt er mwyn sicrhau bod y cwmnïau bysiau'n cymryd rhan.

Serch hyn, llwyddodd swyddogion i ddod i gytundeb ar gynllun a oedd yn gwireddu'r cyhoeddiad gwreiddiol, ac yn rhagori arno, heb fod angen mwy o gyllid na'r hyn a gyhoeddwyd eisoes. Roedd y gwelliannau hynny'n sicrhau disgownt o 33%, nid yn unig i bobl ifanc 16 ac 17 oed ar siwrneiau bws yn ôl ac ymlaen o hyfforddiant a chyflogaeth, ond i bob person ifanc 16, 17 ac 18 oed, ac ar gyfer siwrneiau o unrhyw fath.

Roedd y trafodaethau hyn hefyd yn sicrhau bod y cyllid a gyhoeddwyd eisoes yn cael ei ddefnyddio i dalu costau gweinyddol cysylltiedig Traveline Cymru (FyNgherdynTeithio), ac ar gyfer gwaith marchnata a hyrwyddo.

Mae Adroddiad Archwilydd Cyffredinol Cymru yn nodi'n gywir ddigon bod llai o bobl ifanc na'r disgwyl wedi manteisio ar FyNgherdynTeithio i ddechrau. Ar y pryd, nid oedd unrhyw gynllun cyfatebol a thrwy gyflwyno cynnig newydd ac arloesol i annog mwy o bobl ifanc i deithio ar fysiau, roedd brasamcanion Llywodraeth Cymru yn eang iawn wrth reswm.

Gan fod y cynllun yn un gwirfoddol ac nad oedd ymrwymiad i'w ariannu y tu hwnt i 31 Mawrth 2017, roedd y gweithredwyr yn gyndyn i gael gwared ar eu cynlluniau tocynnau rhatach i bobl ifanc masnachol eu hunain, gan ofni y byddent yn colli cysylltiad â charfan allweddol o gwsmeriaid presennol a chwsmeriaid y dyfodol, o bosibl.

Roedd cadw cynlluniau'r gweithredwyr eu hunain yn golygu bod pobl ifanc yn gallu cael tocynnau rhatach ar gyfer siwrneiau ar wasanaethau'r gweithredwyr hynny, ac nad oedd unrhyw gymhelliant uniongyrchol iddynt gael cerdyn FyNgherdynTeithio - oni bai eu bod yn teithio'n rheolaidd ar fysiau mwy nag un gweithredwr. Mae'r Adroddiad yn cydnabod bod cynnydd sylweddol yn nifer cardiau FyNgherdynTeithio a gyflwynwyd pan oedd gweithredwr yn rhoi'r gorau i gynnig ei gynhyrchion ei hun i'r grŵp oedran hwn.

Yn ogystal â thrafodaethau Archwilydd Cyffredinol Cymru â Gwasanaeth Archwilio Mewnol Llywodraeth Cymru, gofynnodd Llywodraeth Cymru am i'r Gwasanaeth Archwilio Mewnol adolygu trefniadau FyNgherdynTeithio ar gyfer 2017-18, ar ôl i'r cynllun beidio â bod yn gynllun peilot. Cwblhawyd adroddiad y Gwasanaeth Archwilio Mewnol ym mis Tachwedd 2018 i'w ddefnyddio gan Lywodraeth Cymru'n unig. Roedd yr adroddiad yn nodi'n glir y gallai gwersi gael eu dysgu, ac aeth Llywodraeth Cymru ati'n gyflym i roi nifer o gamau gweithredu ar waith - gan gynnwys ad-dalu'r cwmnïau bysiau ar sail y nifer wirioneddol o siwrneiau a deithiwyd. Mae Llywodraeth Cymru'n parhau i gydymffurfio ag adroddiad y Gwasanaeth Archwilio Mewnol ac yn monitro'r broses o roi'i argymhellion ar waith, ac mae swyddogion yn gweithio'n agos gyda Swyddfa Archwilio Cymru a'r Gwasanaeth Archwilio Mewnol i nodi cyfleoedd pellach i wella'r gwaith o reoli'r cynllun, a'u rhoi ar waith.

Mae'r Cydffederasiwn wedi croesawu cyflwyno'r cynllun peilot 16 i 18, a'r ffaith iddo gael ei ehangu i gynnwys pobl ifanc 19 i 21 oed. Mae'r Cydffederasiwn yn cydnabod bod tocynnau bws rhatach i bobl ifanc yn gymhelliant gwych i gwsmeriaid ddewis teithio ar fws dros fynd yn y car, gyda'r holl fanteision o ran yr amgylchedd a theithio llesol yn ychwanegu mwy fyth o werth i'r cynllun gwych hwn i bobl ifanc yng Nghymru.

Adran 2: Datblygu a chyflwyno FyNgherdynTeithio

Mae Adroddiad Archwilydd Cyffredinol Cymru yn nodi bod Democratiaid Rhyddfrydol Cymru wedi cyhoeddi adroddiad “A concessionary fare Scheme for Young People in Wales” ym mis Mawrth 2014. Roedd yr adroddiad hwn yn argymell cynllun tocynnau teithio rhatach cenedlaethol i bobl ifanc yn seiliedig ar gyfradd tocynnau gostyngedig gyffredinol i bobl 16-18 oed a myfyrwyr er mwyn helpu i leihau costau trafnidiaeth gyhoeddus a gwella mynediad i gyfleoedd addysg, cyflogaeth a hyfforddiant. Roedd yr adroddiad yn amcangyfrif y byddai menter o'r fath yn costio rhwng £2.4m a £40.6m gan ddibynnu ar lefel y gostyngiad a gynigir a'r grwpiau oedran a fyddai'n cael eu cynnwys.

Cyhoeddodd y Gweinidog Cyllid a Busnes y Llywodraeth ar y pryd ym mis Medi 2014 ymrwymiad i gyflwyno cynllun tocynnau bws rhatach i bobl ifanc 16 ac 17 oed i deithio yn ôl ac ymlaen i'r gwaith neu hyfforddiant, a hynny erbyn mis Medi 2015. Swm y cyllid a gyhoeddwyd oedd £5m yn 2015-16 (mis Medi 2015 i fis Mawrth 2016) a £9.75m yn 2016-17 (ar gyfer y flwyddyn ariannol lawn).

Cyn y cyhoeddiad hwnnw, ym mis Mehefin 2014, roedd y Grŵp Cynghori ar Bolisi Bysiau wedi rhoi argymhellion i Weinidog yr Economi, Gwyddoniaeth a Thrafnidiaeth ar y pryd ar wasanaethau trafnidiaeth cynaliadwy yng Nghymru, gan gynnwys y dylai polisi tocynnau rhatach i bobl ifanc gan ei ddatblygu drwy ymchwil ac ymgynghori pellach.

Ym mis Medi 2015, cafodd yr ymrwymiadau a wnaed gan Weinidogion Cymru ym mis Medi 2014 eu bodloni'n llwyr, gan gynnwys llwyddo i gytuno ar welliannau a oedd yn cynnwys ymestyn y cynnig i bob person ifanc 16, 17 ac 18 oed, ac ar gyfer pob siwrnai ar fws, waeth at ba ddiben bynnag, ac ar gyfer gweinyddu a marchnata'r cynllun.

Yn sgil y trafodaethau hyn, bu modd i Lywodraeth Cymru ddefnyddio'r cyllid a gyhoeddwyd ar gyfer 2015-16 a 20-16-17 i weinyddu a marchnata'r cynllun. Yn y trafodaethau hynny, cadarnhaodd y Cydffederasiwn ei fod yn disgwyl i'r swm cyfan a gyhoeddwyd gael ei roi i'r diwydiant bysiau am gymryd rhan yn wirfoddol yn y cynllun peilot.

Er mwyn sicrhau bod cynllun a oedd yn cydymffurfio ar waith erbyn 1 Medi 2015, archwiliodd y swyddogion, ynghyd â swyddogion awdurdodau lleol a'r Cydffederasiwn Cludiant Teithwyr, amrywiaeth o ffyrdd o gyflawni ac ymestyn amcanion gwreiddiol y Gweinidogion. Roedd ymestyn y cyhoeddiad i gynnwys pob siwrnai a wneir gan bobl ifanc 16 i 18 oed yn goresgyn y trafferthion posibl i yrwyr bysiau wrth gadarnhau bod deiliaid y cerdyn yn teithio at ddibenion hyfforddiant neu waith mewn gwirionedd. Gallai ceisio gwneud hynny fod wedi arwain at anghydfodau ac oedi, gan amharu at fanteision y cynnig a phrofiadau teithwyr eraill i raddau.

Cynhaliwyd y trafodaethau hyn gyda'r diwydiant bysiau ar ddwy lefel - yn strategol rhwng rheolwyr gyfarwyddwr cwmnïau bysiau Cymru (a oedd hefyd yn cynrychioli'r Cydffederasiwn) ac aelodau o uwch wasanaeth sifil Llywodraeth Cymru, a grŵp technegol a oedd yn cynnwys staff gweithredol cwmnïau bysiau yng Nghymru, cynrychiolwyr Cymdeithas Swyddogion Cydlynu Cludiant Cymru (corff cynrychioli swyddogion cludiant arweiniol o bob awdurdod lleol yng Nghymru) ac aelodau o dîm Llywodraeth Cymru a gafodd y dasg o roi'r fenter ar waith.

Yn absenoldeb unrhyw gynlluniau presennol, bu'n rhaid i'r swyddogion, yn anochel, wneud tybiaethau penodol am y niferoedd posibl a fyddai'n manteisio ar y cynllun ac yn defnyddio FyNgherdynTeithio, yn seiliedig ar y cynllun tocynnau bws am ddim gorfodol. Er ein bod yn sylweddoli nad oedd y cynllun ieuenctid am ddim, ac yn rhoi gostyngiad o 33% ar docynnau teithio, yn hytrach na siwrneiau am ddim, rydym yn dal i fod yn fodlon bod y brasamcanion yn rhesymol ar yr adeg honno ac yn absenoldeb unrhyw gynllun tebyg mewn mannau eraill o'r DU. Dysgwyd o brofiad bod gan bobl ifanc lai o ddiddordeb mewn teithio rhatach ar fysiau nag y tybiwyd yn wreiddiol, a bod y nifer ohonynt a oedd yn teithio ar wasanaethau mwy nag un gweithredwr yn gymharol fach.

Fel y nodwyd eisoes, wrth drafod, roedd y Cydffederasiwn yn benderfynol o sicrhau bod y cronfeydd i gyd a gyhoeddwyd gan Weinidogion yn cael eu defnyddio i gefnogi'r rhwydwaith bysiau o dan yr hyn a oedd, ac sydd o hyd, yn drefniant gwirfoddol.

Adran 3: Gweithredu FyNgherdynTeithio rhwng mis Medi 2015 a mis Mawrth 2017

Ni fu unrhyw gyfaddawd yn argyhoeddiad cadarn y cwmnïau bysiau bod yn rhaid i'r rhwydwaith bysiau elwa ar ddyraniad cyfan y cyllid a gyhoeddwyd yn ystod cyfnod peilot y fenter.

Yn absenoldeb peiriannau tocynnau addas yn ystod y peilot, ni fu'n bosibl cofnodi pob siwrnai'n electronig, a thrwy hynny, gysylltu pob siwrnai â thaliad priodol. O dan yr amgylchiadau hyn, daeth trafodaethau â'r Cydffederasiwn i'r casgliad y dylai'r cyllid gael ei ddyrannu i bob gweithredwr yn unol â dau ffactor:

- yn gyntaf, nifer y teithiau bws am ddim; ac
- yn ail, y milltiroedd cofrestredig a weithredir gan bob cwmni bysiau.

Yn y ffordd hon, dyrannwyd cyfrannau o gyfanswm y cyllid a oedd ar gael ar gyfer iawndal i'r gweithredwyr yn gymesur â'r rhan roedd pob un yn ei chwarae yn rhwydwaith bysiau Cymru.

Am y rhesymau a ddisgrifir eisoes, parhaodd y gweithredwyr i gynnal eu cynlluniau tocynnau teithio rhatach eu hunain i bobl ifanc hefyd, gan leihau nifer y cardiau FyNgherdynTeithio a ddosbarthwyd a nifer y siwrneiau o dan y cynllun. Yn ogystal, gwrthododd y cwmnïau bysiau rannu manylion am nifer y bobl ifanc a gofrestrodd â'u cynlluniau hwy a'u defnyddio, gan nodi sensitifrwydd masnachol y data hynny fel y rheswm dros beidio â'u rhannu.

Mae Llywodraeth Cymru wedi cydnabod y dylai Gweinidogion fod wedi cael gwybod yn ffurfiol am y dull manwl ar gyfer talu'r cwmnïau bysiau yn ystod y cynllun peilot a ddatblygwyd ac a gytunwyd gyda'r Cydffederasiwn. Nid oedd unrhyw beth yng nghyhoeddiad gwreiddiol y Gweinidogion a oedd yn pennu sut yn union y byddai cyllid Llywodraeth Cymru yn cael ei ddyrannu, ac felly nid oedd defnyddio nifer milltiroedd a siwrneiau rhatach yn mynd yn groes i unrhyw beth roedd y

Gweinidogion wedi'i ddweud. Er nad oedd unrhyw beth am y trefniant hwn yn anghyson, byddai wedi bod yn arfer gwell i roi gwybod i'r Gweinidog am yr union ddull a ddefnyddiwyd ar gyfer dosbarthu'r cyllid.

Wrth i'r cynllun peilot dynnu at ei derfyn, dywedodd y Gweinidogion yn glir eu bod am iddo barhau i gynnig disgownt o draean pris tocynnau i bobl ifanc rhwng 16 a 18 oed ar gyfer pob siwrnai, nes y gallai cynllun newydd a gwell gael ei lunio. Yna, cafwyd ymgynghoriad manwl yn ystod 2017-18 yn ceisio barn ar yr hyn y gallai cynllun newydd ei gynnwys.

Er bod cyfanswm y cyllid a ddyrannwyd yn 2015-16 ac yn 2016-17 yn uwch o lawer nag yn 2017-18, mae'r diwydiant bysiau wedi nodi bod y lefel gyffredinol o gyllid a ddyrannwyd o dan gynllun peilot FyNgherdynTeithio wedi "helpu gweithredwyr i sefydlogi'r rhwydwaith bysiau, gan ei wneud yn fwy deniadol i deithwyr newydd a phresennol". Ychwanegodd y Cydffederasiwn nad oedd unrhyw sail i gredu bod cwmnïau bysiau wedi gwneud elw ychwanegol, na'u bod ar unrhyw gyfrif wedi mynd ag elw o Gymru a'i ddefnyddio i gystadlu'n annheg mewn mannau eraill yn Ewrop". Yn ystod 2016, aeth tri chwmni bysiau i ddwylo'r gweinyddwyr: un o'r ffactorau a oedd y tu ôl i gynllun pum pwynt Ysgrifennydd y Cabinet dros yr Economi a Thrafnidiaeth i gefnogi'r diwydiant bysiau yng Nghymru.

Dywedodd y Cydffederasiwn "Pe bai'r cynllun peilot wedi dangos bod lefel y cyllid a ad-dalwyd i gwmnïau bysiau'n ddigonol, ni fyddem wedi cael yr hawl i ofyn am fwy yn ôl-weithredol. Mae'n anorfod y bydd mentrau mawr fel FyNgherdynTeithio yn cynnwys elfen o risg ar y naill ochr a'r llall, o ystyried yr ansicrwydd amrywiol sydd ynghlwm wrthynt, a'r ffaith ei bod hi'n gwbl amhosibl diffinio'r "gwrthffeithiol" yn fanwl gywir".

Adran 4: Gweithredu FyNgherdynTeithio ers mis Ebrill 2017

Mae'r newid yn lefel y swm ar gyfer digolledu, marchnata a gweinyddu i £1m o 1 Ebrill 2017 ymlaen ar ôl y cyfnod peilot a thrafodaethau cysylltiedig Gweinidogion ynghylch y lefelau cyllido, yn adlewyrchu'r defnydd o'r data a gasglwyd yn ystod y cynllun peilot, a gadarnhaodd bod llai o bobl ifanc na'r disgwyl wedi manteisio ar FyNgherdynTeithio ac y bu llai o siwrneiau na'r disgwyl.

Mae hefyd yn adlewyrchu'r gwelliannau yn narpariaeth a galluogrwydd peiriannau tocynnau electronig sy'n gweithredu yn fflyd bysiau Cymru. Yn sgil y gwelliannau hyn, bu modd i Lywodraeth Cymru a chwmnïau bysiau gytuno y byddai hawliadau am gyllid digolledu yn seiliedig ar nifer wirioneddol y siwrneiau a gofnodwyd.

Ar gyfer marchnata'r cynllun yn ystod 2017-18, penderfynodd Ysgrifennydd y Cabinet ar y pryd mewn ymateb i feirniadaeth y Cydffederasiwn o'r ymdrechion marchnata hyd yna y dylid gwahodd y Cydffederasiwn ei hun (sy'n cynrychioli sefydliadau sy'n marchnata gwasanaethau bysiau i ddenu teithwyr) gael ei wahodd i gymryd cyfrifoldeb dros farchnata'r cynllun am y cyfnod rhwng 1 Ebrill 2017 i 31 Mawrth 2018 gan ddefnyddio cyllid gan Lywodraeth Cymru.

Trefnodd y swyddogion drafodaethau rhwng y Cydffederasiwn a Traveline Cymru ar gynnwys yr ymgyrch farchnata newydd, a chytunodd y Cydffederasiwn â'r swyddogion i weithio tuag at darged o ddyblu nifer deiliaid y cardiau a dyblu nifer y siwrneiau bob blwyddyn, ac ar y ffordd y byddai'r cyllid yn cael ei hawlio. Roedd y trefniant cytundebol ar gyfer marchnata a'r cynllun hyrwyddo a'r cynnwys rhwng y Cydffederasiwn a Traveline Cymru yn unig.

Yn ystod 2018-19, tra bod yr ymatebion i'r ymgynghoriad yn cael eu hystyried, dim ond lefel isel o weithgarwch marchnata a gynhaliwyd. Yn dilyn penderfyniad Ysgrifennydd y Cabinet i ehangu'r ystod oedran i gynnwys pobl ifanc 19, 20 a 21 oed, ac i'r gwaith marchnata gael ei wneud yn fewnol, cafodd ymgyrch hyrwyddo a chyfryngau cymdeithasol sylweddol ei datblygu i gyd-ddigwydd â lansio'r cynllun estynedig.

Efallai yr hoffai'r Pwyllgor nodi, ers i'r cynllun gael ei ehangu yn fwy diweddar i gynnwys pobl ifanc 19 - 21 oed ar 14 Chwefror 2019, roedd 1,554 o geisiadau i law erbyn 22 Ebrill 2019.

Mae Llywodraeth Cymru'n parhau i gydweithio'n agos â'r Cydffederasiwn a'n partneriaid mewn awdurdodau lleol i annog mwy o bobl ifanc i ddefnyddio bysiau ar gyfer mwy o'u siwrneiau. Mae'r trafodaethau i roi'r peilot ar waith, a'r gwersi a ddysgwyd ohono, wedi bod yn rhan o'r broses o sefydlu sail hirdymor deg i'r cynllun. Mae Llywodraeth Cymru wedi cyflawni cynllun poblogaidd, sy'n tyfu ac sy'n dangos manteision gweithio gyda'n partneriaid ac sy'n cydymffurfio â chanfyddiadau adroddiadau Swyddfa Archwilio Cymru a'r Gwasanaeth Archwilio Mewnol.