Ombwdsmon Ombudsman
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PUBLIC SERVICES OMBUDSMAN FOR WALES

An Own Initiative Investigation issued under s23 of the Public Services Ombudsman (Wales) Act 2019 against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202002273

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019 ("the Act").

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted.

Summary

During another investigation into concerns raised by Mr Y, the Ombudsman received evidence from the Health Board which indicated that, at the time Mr Y was placed on the urgent list for prostate cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate). As I had reasonable suspicion there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list, I commenced an investigation using my own initiative power of investigation to consider whether the Health Board exceeded the Referral to Treatment Time ("RTT" – the waiting time management rules) target for cancer waiting times for treatment of prostate cancer in respect of the 16 patients who were awaiting prostatectomies.

My investigation found that, in August 2019, the Welsh policy position in accordance with Welsh Government guidance was that, only patients treated in Wales were reported against the Welsh cancer waiting time targets. The Health Board therefore only produced "breach reports" and undertook harm reviews for the patients it treated. This did not apply to patients referred by the Health Board for treatment in England. Of the 16 patients on the waiting list in August 2019, 8 were referred to England for treatment. If they had been treated in Wales, the breaches of the target timescales would have been reported for all 8 patients because the amount of time they waited for treatment exceeded the 62 and 31-day target for cancer RTT (the target times relate to whether a patient had been designated as urgent suspected cancer or non-urgent suspected cancer). Four of the patients on the waiting list who were treated by the Health Board had exceeded the cancer waiting time target and these breaches of the target timescales were reported and harm reviews were completed.

While the Welsh policy position at the time meant there was no requirement to produce breach reports to the Welsh Government or to carry out harm reviews for Health Board patients treated in England, the geographical location of treatment should not have left these 8 patients in the position where they were denied the harm review process because

they were treated outside Wales. Regardless of the Welsh policy position at the time, the Health Board was obliged to undertake appropriate monitoring of the care and treatment of its patients under its commissioning and contracting arrangements. It should also have considered the impact of the delay in treatment. These failures amounted to maladministration.

The new Single Cancer Pathway ("SCP") which has replaced all previous cancer targets, has addressed the anomaly of the previous approach and all patients now referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times monitoring arrangements and all patients not treated within the target should have an internal breach report completed. However, to remedy the injustice to the 8 patients, in line with my approach to remedy, I recommended that the Health Board should return these patients to the position they would have been in had they been treated in Wales and carry out a harm review for each patient. I also recommended that the Health Board reviewed its harm review process to ensure it was in line with the requirements of the SCP.

I have reported on the Health Board's urology service several times and I am concerned that issues relating to capacity and succession planning within the urology department seems to be longstanding. I therefore recommended that the Health Board refers the report to its Board to consider capacity and succession planning for the urology department. The Health Board accepted my recommendations.

My jurisdiction

1. Under Section 4 of the Public Services Ombudsman (Wales) Act 2019 ("the Act"), I may carry out an investigation using my own initiative power of investigation. I am required, under section 5 of the Act, to publish criteria for own initiative investigations. The criteria allow me, where I have already commenced an investigation, to embark on an own initiative investigation into matters that have a "substantial connection" with the matter already being investigated. I can therefore begin an extended investigation using my own initiative power. Such investigation may be carried out where a complaint about 1 element of a service and / or 1 service provider is closely linked to another possible incidence of service failure.

The background

2. In December **2019** I received a complaint from an individual ("Mr Y") about the prostate cancer care and treatment he received from Betsi Cadwaladr University Health Board ("the Health Board"). Mr Y was concerned that the Health Board failed to meet the guidelines for cancer diagnosis which led to him seeking private treatment due to concerns about the impact of the wait for treatment. I commenced an investigation into Mr Y's complaint in January **2020**.[1] The investigation considered the following:

- "that the Health Board exceeded the referral-to-treatment target for cancer waiting times for treatment of prostate cancer. Mr Y was concerned that following a biopsy which confirmed this diagnosis, there was a delay in providing him with an appointment for treatment. As Mr Y was concerned about the impact of the delay, he sought private treatment".

3. During the course of the investigation into Mr Y's concerns, I received evidence from the Health Board which indicated that, at the time Mr Y was placed on the urgent list for cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate).

[1] Case reference: 201905373

4. As I had a reasonable suspicion that there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list, I commenced an investigation on my own initiative on 22 September 2020. The investigation considered whether the Health Board exceeded the Referral to Treatment target ("RTT") for cancer waiting times (this sets out the waiting time management rules, including cancer waiting time targets) for treatment of prostate cancer in respect of the other 16 patients with urgent clinical priority awaiting prostatectomies in August 2019. I was satisfied that the own initiative criteria had been met as there was a "substantial connection" with Mr Y's investigation, namely, a possible incidence of service failure linked to the Health Board's urology service in terms of RTT breaches in relation to provision of urology cancer care. I was concerned that there was a possibility that these 16 patients may have waited beyond the 62-day wait for treatment with potential consequences for their prognosis / treatment. Additionally, previous investigations by my office also highlighted concerns about the Health Board's prostate cancer care management.

5. On 3 December 2020 I published a public interest report against the Health Board in relation to the investigation of Mr Y's complaint.[2] The Health Board had breached the RTT in Mr Y's case; it acknowledged that it had done so and apologised for this. Based on the evidence, I found that Mr Y would not realistically have received his treatment until at least 168 days after receipt of the urgent suspected cancer ("USC") referral.[3] The Health Board would therefore, at a minimum, have missed the 62-day target by 106 days. Given that advice from my professional adviser, indicated that early radical treatment was essential in high-risk disease (and Mr Y was deemed high-risk), the wait for treatment was unacceptable and a service failure. As Mr Y had opted to receive private treatment, the actual impact of the delay was mitigated in Mr Y's case and the delay was not as significant as it would have been, had he waited for treatment by the Health Board. However, when Mr Y sought private treatment, he was concerned that the cancer would spread if he waited for NHS treatment. The delay caused Mr Y distress and anxiety, and the decision to seek private treatment, rather than wait for the Health Board to

[2] https://www.ombudsman.wales/wp-content/uploads/2020/12/CASE_201905373_231.pdf
[3] USC referral – a referral where a suspicion of cancer is stated by the GP and confirmed by the specialist.

provide treatment, did not lessen the impact of the Health Board's service failure on him at a very worrying time. I found that Mr Y suffered an injustice as a consequence.

Relevant guidance

My guidance

6. The "Principles of Remedy" outlines my approach to remedying injustice. My aim is to secure suitable and proportionate remedies. I am satisfied that these principles are relevant to my investigations using my own initiative power. A key driver in my approach to remedy is to return a complainant, and where appropriate, others who have suffered injustice and been treated unfairly, to the position they would have been in or, if not possible, to take remedial action. I advocate that people should be treated consistently.

7. The "Principles of Good Administration and Good Records Management" elaborates on the above points, and relevant to this investigation is the principle of acting fairly and proportionately. In seeking to achieve this, public service providers should ensure that people are treated fairly and consistently so that those in similar circumstances are dealt with in a similar way. Additionally, public service providers should seek to address the unfairness if applying the law, regulations or procedures strictly would lead to an unfair result for an individual.

Welsh Government and Health Board guidance

8. The Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules"), which was in place at the time of the events under investigation, set out the waiting time management rules, including cancer waiting time targets. The guiding principles included the values that, "all patients should wait the shortest possible time for treatment"

and that “RTT targets are maximum acceptable waits and urgent patients should be treated as their clinical need dictates”. In relation to cancer target times, there were 2 targets – the 62 day and 31-day targets:

- Newly diagnosed cancer patients that have been referred as USC, and confirmed as urgent by the specialist, to start definitive treatment within 62 days from receipt of referral at the Local Health Board (“LHB”).

- Newly diagnosed cancer patients not included as USC referrals (“NUSC” – non urgent suspected cancer)[4] to start definitive treatment within 31 days of a decision to treat.[5]

In relation to accountability for monitoring, performance and reporting of the RTT target, the RTT Rules stated:

- “When a referral is made to an English provider, the LHB commissioning the pathway is accountable for monitoring of that patient’s pathway. LHBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately”.

- “Where NHS activity is commissioned from an English provider, the accountability for performance against the targets lies with the LHB commissioning the activity”.

- “When a referral is made to an English provider, that provider is responsible for reporting performance against the target. LHBs must ensure that requirements for reporting are contractually included in commissioning agreements”.

- “The LHB with clinical responsibility for the patient…is responsible for reporting performance against the open pathway waiting time target”.

[4] Any patient diagnosed as having cancer who was not referred by their GP as a USC or upgraded by the specialist on analysis of the GP referral.
[5] Decision to treat - the date upon which the decision to treat was confirmed between a designated member of the multi-disciplinary team and the patient.

9. Cancer specific additional guidance to support revised RTT Guidance (issued April 2017) – the guidance provided by the Health Board and which it said it followed at the time of the events being investigated - repeated the 62 and 31-day targets.

10. Welsh Health Circular (2019) 028 ("the WHC") The Consolidated Rules for Managing Cancer Waiting Times (September 2019) was circulated to the Chief Executives of all Welsh health boards in September 2019; this was noted as the final version of the updated rules for managing cancer waiting times ("CWT") which would replace all previous guidance with effect from 1 December 2019. The document provided guidelines relating to the management of CWT and the reporting of performance against the cancer targets.

11. The guiding principles stated that the guidance, "is to ensure that the patients' wait for suspected cancer diagnosis and treatment are measured and reported in a consistent and fair manner. The guiding principles of CWT clearly reflect the prudent health principles. Patients should be managed with the aim of starting treatment at the earliest clinically appropriate time rather than against any performance measures".

12. The WHC, when published, indicated in relation to Welsh patients treated in England that:

- "At a later date, our intention is to report on Welsh patients treated in England. At present (August 2019) this is not possible. Discussions are taking place with NHS Digital to explore how this might be achieved. Until a solution is agreed, patients treated in England will be treated in line with the English cancer standards".

- "When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and CWTs are measured accurately. The Welsh targets need to be communicated as part of any contracts with other NHS providers (England and Wales). It is the responsibility of the commissioning Welsh health board to ensure they have processes in place to monitor and performance

manage their contracts for cancer provision, ensuring targets are met. It is our intention to capture patients treated in England on the SCP,[6] however systems and process do not allow this at present. Discussions are underway with NHS Digital and this guidance will be updated when the systems to allow this are in place".

- "Where NHS activity is commissioned from an English provider, the accountability for manging the patient wait lies with the health board commissioning the activity. The commissioning health board will need to ensure data is shared with the reporting health board, if different, as the reporting of the patients' pathway remains with the health board who received the original patient referral".

13. In terms of reporting, the WHC stated that:

- "All patients who are not treated within the NUSC and USC targets should have a breach report completed detailing their pathway journey and outlining the lessons learnt and remedial actions taken within the health board".

14. The 'Consolidated Guidelines for Managing Patients on the Suspected Cancer Pathway' (December 2020, Version 2.0) ("the Guidelines for SCP") provides guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target. The updated guidance introduces new rules around the management of patients on a suspected cancer pathway and includes the reporting of patients treated outside of NHS Wales when referred from secondary care in NHS Wales. In terms of CWT targets, a new single cancer pathway replaces the previous 2 standards - the USC and the NUSC. In relation to patients treated outside Wales, it states:

- "Those patients who are referred from NHS Wales secondary care to have their further investigation, and/or first definitive treatment undertaken outside of NHS Wales must be included in cancer waiting times reporting but those referred directly from primary care will not".

[6] Single Suspected Cancer Pathway – measures CWTs from the point of suspicion of cancer until start of first definitive treatment for all newly diagnosed patients.

- "When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and CWTs are measured accurately. The Welsh targets need to be communicated as part of any contracts with other NHS providers. It is the responsibility of the commissioning Welsh health board to ensure they have processes in place to monitor and performance manage their contracts for cancer provision, ensuring targets are met. All patients referred for treatment outside NHS Wales from secondary care will be included in CWT reporting".

- "Where NHS activity is commissioned from outside NHS Wales, the accountability for managing the patient's wait lies with the health board commissioning the activity. The commissioning health board will need to ensure data is shared with the reporting health board, if different, as the reporting of the patient's pathway remains with the health board who received the original patient referral".

15. In relation to patients not treated within target, it states:

- "All patients who are not treated within the target should have an internal breach report completed detailing their pathway journey and outlining the lessons learnt and remedial actions taken within the health board. All patients who have waited too long from POS[7] for their treatment and are suspected of coming to harm should have a clinical review undertaken and submitted to Welsh Government".

16. The Health Board's "Cancer 104 Day Harm Review Group" Terms of Reference (April 2020 – "the Harm Review Group") aim to review the care of cancer patients with a waiting time of over 104 days to identify any avoidable clinical and non-clinical factors. The Harm Review Group will consider whether harm has been caused by the wait, and the process will be used for patients presenting to and treated by the Health Board. If a

[7] Point of suspicion – the waiting time for patients on the suspected cancer pathway starts at the point which cancer is suspected (i.e. the point of suspicion).

patient's pathway starts and remains outside of the Health Board, the Health Board's commissioning team "will request harm reviews be completed by treating organisations".

The Health Board's evidence

17. I obtained comments and copies of relevant documents from the Health Board. In summary, the Health Board confirmed:

- That it was working to the Welsh Government Policy in terms of the 62/31-day cancer target times.

- In line with Welsh Government policy at the time of the events under investigation, only patients treated in Wales were reported against Welsh cancer waiting time targets which is why breach reports and harm reviews were only completed for patients treated by the Health Board. The Welsh Government changed this position with effect from January 2021 to include patients treated in England. This was following requests to include reporting of these patients treated in England from the Health Board and others (the Health Board referred to the relevant sections in the WHC and the Guidelines for SCP outlining these guideline changes – see paragraphs 10 - 15).

- Of the 17 patients (including Mr Y), there were 2 NUSC breaches reported, harm reviews were completed for both patients and no harm was identified; 2 USC breaches were reported, harm reviews were completed for both patients and no harm was identified; 8 patients were treated in England (a mixture of USC/NUSC patients); 2 NUSC where there were no breaches; 2 USC patients where there were no breaches and 1 patient who was not reportable against the Welsh cancer waiting times target.

- That harm reviews are completed for all cancer patients treated by the Health Board over day 104 on their cancer pathway (see paragraph 16) and that this was not mandated by Welsh Government in 2019 but completed by the Health Board as good practice.

- It would only complete harm reviews for patients treated by the Health Board. It will review this decision in line with the Guidelines for SCP and when it reviews the harm review process at the next harm review panel.

- The 4 harm reviews completed identified action points for learning including placing prostatectomy capacity on the Health Board risk register (added 24 July 2018 - current risk is scored as high) and to review how patients are counselled over treatment options for prostate cancer (an agreement was made to develop a protocol at the urology clinical advisory group in October 2020).

- A risk register entry (updated on 16 September 2020) identified risk relating to urology surgical capacity impacting on the ability to deliver RTT targets for urology. To address this risk, the Health Board identified the need to move forward with service remodelling and that there were short term contracts in place with 2 English Trusts to support with the delivery of prostate surgery and other urological cancers.

- It wrote to the Welsh Government Health and Social Services Group in September 2020 in response to the WHC, and amongst other things, noted that there was no mention in the document of reporting waiting times for patients treated in England. It said that it did not, at that time, report waits for those patients which it said "appears to be an anomaly".

- It had contracts with 2 English Hospital Trusts ("the First Trust" and the "Second Trust" respectively): with the exception of the contract with the Second Trust for 2018/2019, they were unsigned. The contracts were implied by performance given the contracts were issued to both providers. The contracts' operational standards in terms of cancer waiting times indicated that any breach of the 62-day USC wait target would lead to formal escalation of performance reporting to the Health Board; a breach of the 31-day target NUSC resulted in a financial penalty.

- The arrangement for the First Trust to treat prostatectomy patients is an ongoing historical one. A contract with another English Hospital Trust ("the Third Trust") started in February 2020 for prostatectomies.

- It holds regular weekly access meetings to discuss the performance of English providers in relation to RTT Rules.

18. A urology service update report in September 2020 identified recruitment and contractual capacity concerns.

Welsh Government comments

19. I obtained comments from the Welsh Government relating to cancer treatment time targets. In summary:

- It clarified that, since the introduction of RTT Rules, Welsh policy has been to report on the performance of Welsh health boards as providers only; it does not formally report, or performance manage their commissioning arrangements.

- It said there was a very clear expectation that the Health Board through its own commissioning policy ensures that patients are treated in a timely manner in line with Welsh standards; the performance with English providers is discussed at the regular quality and delivery meetings between each health board and the Welsh Government and any issues or concerns are raised in that forum. Health boards report to their board on the effectiveness of their commissioning strategies and performance of Welsh patients treated in England.

- It would expect, as a minimum, that the Health Board had a policy regarding delayed treatment with their providers to mirror Welsh standards that included formal reviews, breach reports, harm reviews and serious incidents on all patients who breach cancer waiting times.

- From January 2021 all patients will be managed on the new single cancer pathway and the other cancer pathways will no longer be managed and reported on. In introducing the pathway, it has decided

that all patients referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times.

- Guidelines (i.e. before the single cancer pathway) required all health boards to produce a breach report for any patient who did not start treatment within 62 or 31 days, depending on the pathway they were on, but it did not appear that breach reports were always used in a systemic manner to drive improvements and highlight service issues. It is currently reviewing whether health boards need to formally submit breach reports to the Welsh Government in future, but its expectation is clear that these need to continue within each health board and be used for service improvement and peer review.

- In response to the Health Board stating that only patients treated in Wales are reported against Welsh cancer waiting times targets, which is why breach reports and harm reviews have only been completed for patients treated by the Health Board (which it said was in line with Welsh Government policy), it said that it expected this to be embedded in health boards' commissioning contracts and that the health boards would have requested this from their English providers who currently operate a harm review process.

Analysis and conclusions

20. I commenced this investigation on my own initiative to consider whether the Health Board had exceeded the RTT target for cancer waiting times for treatment of prostate cancer in respect of 16 patients who, in August 2019, were awaiting prostatectomies. The Health Board told me during my investigation into Mr Y's complaint that all 16 patients had an urgent clinical priority. My own initiative power allowed me, in this case, to extend my investigation of Mr Y's complaint to consider whether there were systemic issues within the Health Board's urology service in terms of delivery of prostate cancer treatment (particularly prostatectomies) within Welsh cancer targets.

21. In August 2019 only patients treated in Wales were reported against Welsh cancer waiting time targets, the Health Board only produced breach reports and harm reviews for patients treated by the Health Board; this did not apply to patients referred by it for treatment in England. My guidance is clear, good administration requires that public service providers need to ensure that people are treated fairly and consistently so that those in similar circumstances are dealt with in a similar way.

22. Of the 16 patients, 8 were referred to England for treatment. If these 8 patients had been treated in Wales, all 8 would have been reported because they breached the 62 and 31-day target for RTT. Additionally, each of these 8 patients would have received a harm review to determine if the breach in waiting time had any clinical impact on their treatment or prognosis; harm reviews were completed for the 4 patients who were treated by the Health Board who breached the RTT target.

23. Whilst I accept that the Welsh policy position at the time meant there was no requirement to produce breach reports to the Welsh Government or to carry out harm reviews for Health Board patients being treated in England, in terms of fairness and consistency of patient treatment, the geographical location of treatment should not have left these 8 patients in the position where they were denied the harm review process because they were treated outside Wales. Regardless of the Welsh policy position at the time, the Health Board was obliged to undertake appropriate monitoring of the care and treatment of its patients under its commissioning and contracting arrangements. It should also have considered the impact of the delay in treatment. These failures amounted to maladministration which caused injustice to those 8 patients who were treated differently to the patients who were treated by the Health Board. My guidance is clear that if applying procedures strictly would lead to an unfair result for an individual, then a public service provider should seek to address this unfairness.

24. The rules in place in August 2019 stipulated that when a referral was made to an English provider, the Health Board commissioning the pathway was accountable for monitoring the patient's pathway and that accountability for performance against the targets lay with the commissioning Health Board. The Health Board had responsibility for

monitoring compliance of its commissioning arrangements and the contracts I have seen indicated that the Health Board had escalation processes in place for breaches of the 62 and 31-day target. The information I received confirms general high-level oversight of commissioned services was undertaken, with concerns being expressed about the need for extra provision of urology services. However, I have seen no evidence that the Health Board proactively monitored these contracts specifically in line with its contractual operational standards or had regard to the impact of delayed services on the individual patients.

25. The Guidelines for SCP has now addressed the inconsistency of the previous approach; all patients referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times (with the exception of those referred directly from primary care) and all patients not treated within the target should have an internal breach report completed, including identifying any lessons learnt and remedial action to be taken. In addition, all patients who have waited too long from POS for their treatment and are suspected of coming to harm, should have a clinical review. Whilst I welcome this change which now addresses the anomaly of the previous approach, the inequity of not carrying out harm reviews for the patients treated in England meant there was a loss of opportunity to ensure harm to individuals did not go unremedied, for potential learning and for improvement. Harm reviews provide health boards with the opportunity to identify service issues and to contribute towards service delivery improvements. In line with my approach to remedy, the Health Board should return these patients to the position they would have been had they been treated in Wales in terms of carrying out a harm review.

26. I have reported on the Health Board's urology services several times, and I am concerned that, even in September 2020, it identified recruitment and contractual capacity concerns. This is not a new issue. Healthcare Inspectorate Wales ("HIW") carried out a Urological Cancer Peer Review of the Health Board in February 2014. Whilst good practice was identified, several serious concerns were highlighted, including:

- A lack of clinically or management led consensus for the delivery model of urological cancer services in North Wales.

- The Multi-Disciplinary Teams ("MDT") stated that patients had been lost or delayed to follow-up and have deteriorated while waiting for their appointment.

- A lack of succession planning for the service "compounded by the lack of strategic direction from management on the delivery of urological services for the population of [the Health Board]".

- The Peer Review team were very concerned that they had not been reassured that high quality and safe urological cancer services would be provided in the future.

- Outpatient and Inpatient capacity.

- Lack of key worker support in general across the Health Board.

27. Additionally, the HIW report stated that "All MDTs stated that it is common practice for patients, who are due to breach, to be invited to have their surgery in centres in England, however the Health Board has had difficulty in finding nearby centres with the capacity to undertake this work. The Review team were informed that this practice was not clearly communicated to medical and specialist nursing staff and has led to some anxiety and confusion". This is concerning, and whilst I am unable to reach a finding that the 8 patients treated in England were referred outside the Health Board in order to avoid breaching the cancer waiting times target, the fact it was recognised that this was its approach in 2014, does raise the question whether this was still happening 5 years later.

28. I am also concerned that capacity issues continue to be a problem and the impact of this on patient care. I am currently investigating another complaint against the Health Board's Urology service. The fact that locum consultants were engaged to support the only 2 employed consultants at that time appears to have led to inconsistent follow up of patients. I will be reporting on this case separately, but it appears that capacity and succession planning for the Urology department is still an issue.

Recommendations

29. I **recommend** that the Health Board, within **3 months** of the date of this report:

a) Carries out harm reviews for the 8 patients treated in England. If the reviews identify that harm was caused, the Health Board should write to the patient explaining this and consider the individual cases under the Putting Things Right Process.

b) Asks the Harm Review Group to review the Guidelines for SCP and review the harm review process to ensure that the terms of reference are updated and in line with the requirements of the Guidelines for SCP.

c) Refers the report to the Board to consider capacity and succession planning in the urology department.

30. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Nick Bennett 26 August 2021
Ombwdsmon/Ombudsman

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Ymchwiliad yr Ombwdsmon ar ei Liwt ei Hun o dan adran 23 o Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019 yn erbyn Bwrdd Iechyd Prifysgol Betsi Cadwaladr

Adroddiad gan
Ombwdsmon Gwasanaethau Cyhoeddus Cymru
Achos: 202002273

Cynnwys	Tudalen

Cyflwyniad

Cyhoeddir yr adroddiad hwn o dan adran 23 o Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019 (“y Ddeddf”).

Yn unol â darpariaethau’r Ddeddf, mae’r adroddiad yn ddienw ac felly, cyn belled ag y bo modd, mae unrhyw fanylion a allai achosi i unigolion gael eu hadnabod wedi cael eu newid neu eu hepgor.

Crynodeb

Yn ystod ymchwiliad arall i bryderon a godwyd gan Mr Y, derbyniodd yr Ombwdsmon dystiolaeth gan y Bwrdd Iechyd a oedd yn awgrymu, pan roddwyd Mr Y ar y rhestr frys i gael triniaeth ar gyfer canser y prostad ym mis Awst 2019, fod cyfanswm o 16 o gleifion eraill gyda'r un flaenoriaeth glinigol frys yn aros am yr un driniaeth (prostadectomi – llawdriniaeth i dynnu'r prostad). Gan fod gen i amheuaeth resymol ynghylch achosion posibl eraill o gamweinyddu a methiant ar ran y gwasanaeth mewn perthynas â'r cleifion eraill ar y rhestr aros, cychwynnais ymchwiliad drwy ddefnyddio fy mhŵer i ymchwilio ar fy liwt fy hun. Bwriad hyn oedd ystyried a oedd y Bwrdd Iechyd wedi mynd dros y targed Amser Rhwng Atgyfeirio a Thriniaeth ("RTT" – y rheolau rheoli amseroedd aros) ar gyfer amseroedd aros am driniaeth canser y prostad yr 16 claf a oedd yn aros am brostadectomi.

Canfu fy ymchwiliad, ym mis Awst 2019 – wrth ystyried y polisi yng Nghymru, yn unol â chanllawiau Llywodraeth Cymru – mai dim ond cleifion oedd yn cael eu trin yng Nghymru oedd yn cael eu hadrodd yn erbyn targedau amser aros canser yng Nghymru. Felly, dim ond ar gyfer y cleifion yr oedd wedi'u trin yr oedd y Bwrdd Iechyd yn llunio "adroddiadau toramod" ac yn cynnal adolygiadau o niwed. Nid oedd hyn yn berthnasol i gleifion wedi'u hatgyfeirio gan y Bwrdd Iechyd ar gyfer triniaeth yn Lloegr. O'r 16 claf ar y rhestr aros ym mis Awst 2019, cafodd 8 eu hatgyfeirio i Loegr i gael triniaeth. Pe baent wedi cael eu trin yng Nghymru, byddai'r achosion o fynd dros yr amseroedd targed wedi cael eu hadrodd ar gyfer pob un o'r 8 claf gan fod yr amser yr oeddent wedi aros am driniaeth yn fwy na'r targed, sef 62 a 31 diwrnod ar gyfer RTT canser (mae'r amseroedd targed yn gysylltiedig â p'un a oedd claf wedi cael ei ddynodi'n achos brys lle'r amheuir canser neu'n achos llai brys lle'r amheuir canser). Roedd pedwar o'r cleifion ar y rhestr aros a gafodd eu trin gan y Bwrdd Iechyd wedi mynd dros y targed amser aros ar gyfer canser. Lluniwyd adroddiadau am yr achosion hyn a chwblhawyd adolygiadau o niwed ar eu cyfer.

Er bod polisi Cymru ar y pryd yn golygu nad oedd yn rhaid cyflwyno adroddiadau toramod i Lywodraeth Cymru na chynnal adolygiadau o niwed ar gyfer cleifion y Bwrdd Iechyd a oedd wedi cael eu trin yn Lloegr,

ni ddylai lleoliad daearyddol y driniaeth fod wedi gadael yr 8 claf hyn mewn sefyllfa lle nad oeddent yn cael eu cynnwys yn y broses adolygu niwed, dim ond am eu bod wedi cael eu trin y tu allan i Gymru. Beth bynnag oedd polisi Cymru ar y pryd, yn unol â'i drefniadau comisiynu a chontractio, roedd yn rheidrwydd ar y Bwrdd Iechyd i fonitro gofal a thriniaeth ei gleifion yn briodol. Dylai hefyd fod wedi ystyried effaith yr oedi yn y driniaeth. Arweiniodd y methiannau hyn at gamweinyddu.

Mae'r Llwybr Canser Sengl newydd, sydd wedi disodli'r holl dargedau canser blaenorol, wedi mynd i'r afael ag anghysondeb y dull blaenorol. Erbyn hyn, rhaid i bob claf sy'n cael ei atgyfeirio o ofal eilaidd ar gyfer triniaeth canser y tu allan i Gymru gael ei gynnwys yn y trefniadau monitro ar gyfer amseroedd aros canser, a dylid cwblhau adroddiad toramod mewnol ar gyfer pob claf nad yw'n cael triniaeth o fewn y targed. Fodd bynnag, er mwyn unioni'r anghyfiawnder i'r 8 claf, yn unol â'm dull o unioni camau, argymhellais y dylai'r Bwrdd Iechyd ddychwelyd y cleifion hyn i'r sefyllfa y byddent wedi bod ynddi pe baent wedi cael eu trin yng Nghymru, a chynnal adolygiad o niwed ar gyfer bob claf. Argymhellais hefyd fod y Bwrdd Iechyd yn adolygu ei broses adolygu niwed i sicrhau ei fod yn cyd-fynd â gofynion y Llwybr Canser Sengl.

Rwyf wedi adrodd am wasanaeth wroleg y Bwrdd Iechyd sawl gwaith ac rwy'n poeni bod materion yn ymwneud â chapasiti a chynllunio dilyniant yn yr adran wroleg yn hen. Argymhellais felly y dylai'r Bwrdd Iechyd gyfeirio'r adroddiad at ei Fwrdd er mwyn ystyried capasiti a chynllunio dilyniant ar gyfer yr adran wroleg. Derbyniodd y Bwrdd Iechyd fy argymhellion.

Fy awdurdodaeth

1. O dan adran 4 o Ddeddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019 ("y Ddeddf"), gallaf gynnal ymchwiliad drwy ddefnyddio fy mhŵer ymchwilio ar fy liwt fy hun. O dan adran 5 o'r Ddeddf, mae'n ofynnol i mi gyhoeddi'r meini prawf ar gyfer ymchwiliadau y byddaf yn eu cynnal ar fy liwt fy hun. Mae'r meini prawf yn caniatáu i mi – lle'r ydw i eisoes wedi cychwyn ymchwiliad – ddechrau ymchwilio ar fy liwt fy hun i faterion sydd â "chysylltiad sylweddol" â'r mater sy'n destun ymchwiliad yn barod. Felly, gallaf ddechrau ymchwiliad estynedig ar fy liwt fy hun. Gellir cynnal ymchwiliad o'r fath os oes cysylltiad agos rhwng cwyn am 1 elfen o wasanaeth a / neu 1 darparwr gwasanaeth ac achos posibl arall o fethiant gwasanaeth.

Y cefndir

2. Ym mis Rhagfyr **2019** derbyniais gŵyn gan unigolyn ("Mr Y") am y gofal a'r driniaeth a gafodd ar gyfer canser y prostad gan Fwrdd Iechyd Prifysgol Betsi Cadwaladr ("y Bwrdd Iechyd"). Roedd Mr Y yn poeni nad oedd y Bwrdd Iechyd wedi bodloni'r canllawiau ar gyfer diagnosis canser, a arweiniodd at ei benderfyniad i chwilio am driniaeth breifat oherwydd pryderon ynghylch yr effaith o orfod aros am driniaeth. Dechreuais ymchwilio i gŵyn Mr Y ym mis Ionawr **2020**.[1] Roedd yr ymchwiliad yn ystyried y canlynol:

- "bod y Bwrdd Iechyd wedi mynd dros y targed amseroedd aros canser rhwng atgyfeirio-a-thriniaeth ar gyfer canser y prostad. Roedd yn bryderus yn dilyn biopsi a oedd yn cadarnhau diagnosis o ganser y prostad, y bu oedi cyn rhoi apwyntiad iddo gael triniaeth. Gan fod Mr Y yn bryderus ynghylch effaith yr oedi, aeth am driniaeth breifat".

3. Yn ystod yr ymchwiliad i bryderon Mr Y, derbyniais dystiolaeth gan y Bwrdd Iechyd a oedd yn nodi, pan roddwyd Mr Y ar y rhestr frys i gael triniaeth ar gyfer canser ym mis Awst 2019, fod cyfanswm o 16 o gleifion eraill gyda'r un flaenoriaeth glinigol frys yn aros am yr un driniaeth (prostadectomi – llawdriniaeth i dynnu'r prostad).

[1] Cyfeirnod achos: 201905373

4. Gan fod gennyf le rhesymol i amau fod achosion eraill posibl o gamweinyddu a methiant ar ran y gwasanaeth mewn perthynas â'r cleifion eraill ar y rhestr aros, cychwynnais ymchwiliad ar fy liwt fy hun ar 22 Medi 2020. Roedd yr ymchwiliad yn ystyried a oedd y Bwrdd Iechyd wedi mynd dros y targed Rhwng Atgyfeirio a Thriniaeth ("RTT") ar gyfer amseroedd aros canser (sy'n nodi'r rheolau ar gyfer amseroedd aros, gan gynnwys targedau amseroedd aros canser) o ran trin canser y prostad yr 16 claf arall â blaenoriaeth glinigol frys oedd yn aros prostadctomi ym mis Awst 2019. Roeddwn yn fodlon bod y meini prawf ar gyfer cynnal ymchwiliad ar fy liwt fy hun wedi cael eu bodloni gan fod "cysylltiad sylweddol" gydag ymchwiliad Mr Y, sef achos posibl o fethiant gwasanaeth oedd yn gysylltiedig â gwasanaeth wroleg y Bwrdd Iechyd, o ran torri amodau RTT mewn perthynas â darparu gofal canser wroleg. Roeddwn yn bryderus fod posibilrwydd y gallai'r 16 claf hyn fod wedi aros y tu hwnt i'r 62 diwrnod am driniaeth, a bod hynny wedi arwain at ganlyniadau posibl o ran eu prognosis / triniaeth. Ar ben hyn, roedd ymchwiliadau blaenorol gan fy swyddfa wedi tynnu sylw at bryderon ynghylch y ffordd yr oedd y Bwrdd Iechyd yn rheoli gofal canser y prostad.

5. Ar 3 Rhagfyr 2020 cyhoeddais adroddiad budd y cyhoedd yn erbyn y Bwrdd Iechyd mewn perthynas â'r ymchwiliad i gŵyn Mr Y.[2] Roedd y Bwrdd Iechyd wedi torri'r RTT yn achos Mr Y; roedd yn cydnabod ei fod wedi gwneud hynny ac wedi ymddiheuro. Ar sail y dystiolaeth, deuthum i'r casgliad na fyddai Mr Y yn realistig wedi cael ei driniaeth tan o leiaf 168 diwrnod ar ôl yr atgyfeiriad brys lle'r amheuir canser ("USC").[3] Mae hynny'n golygu y byddai'r Bwrdd Iechyd wedi methu'r targed 62 diwrnod o 106 diwrnod fan leiaf. Gan ystyried bod fy nghynghorydd proffesiynol yn datgan bod triniaeth radical gynnar yn hanfodol ar gyfer clefydau risg uchel (ac roedd Mr Y yn cael ei ystyried yn risg uchel), roedd yr amser aros am driniaeth yn annerbyniol ac yn fethiant ar ran y gwasanaeth. Gan fod Mr Y wedi dewis cael triniaeth breifat, roedd effaith wirioneddol yr oedi yn llai yn ei achos ef, ac nid oedd yr oedi mor sylweddol ag y byddai pe bai wedi aros am driniaeth gan y Bwrdd Iechyd. Fodd bynnag, pan benderfynodd Mr Y fynd am driniaeth breifat, roedd yn poeni y byddai'r canser yn ymledu pe bai'n aros am driniaeth gan y GIG. Achosodd yr oedi ofid a phryder i Mr Y,

[2] https://www.ombwdsmon.cymru/wp-content/uploads/sites/2/2020/12/CASE_201905373_247-Cym-1.pdf
[3] Atgyfeiriad USC – atgyfeiriad lle mae'r Meddyg Teulu'n nodi bod amheuaeth o ganser a bod yr arbenigwr yn cadarnhau hynny.

ac ni wnaeth y penderfyniad i fynd am driniaeth breifat, yn hytrach nag aros i'r Bwrdd Iechyd ddarparu triniaeth, leihau'r effaith a gafodd methiant gwasanaeth y Bwrdd Iechyd arno yn ystod y cyfnod llawn pryder hwn. Deuthum i'r casgliad bod Mr Y wedi dioddef anghyfiawnder o ganlyniad i hyn.

Canllawiau perthnasol

Fy nghanllawiau i

6. Mae'r "Egwyddorion Unioni Cam" yn amlinellu sut rydw i'n mynd ati i wneud iawn am anghyfiawnder. Fy nod yw sicrhau atebion addas a chymesur. Rwy'n fodlon bod yr egwyddorion hyn yn berthnasol i'm hymchwiliadau gan ddefnyddio fy mhŵer i ymchwilio ar fy liwt fy hun. Un o'r ffactorau allweddol yn fy null o wneud iawn yw dychwelyd y sawl sydd wedi cyflwyno cwyn (a lle bo'n briodol, unigolion eraill sydd wedi dioddef anghyfiawnder ac wedi cael eu trin yn annheg) i'r sefyllfa y byddent wedi bod ynddi, neu os nad yw hynny'n bosibl, cymryd camau unioni. Rwy'n dadlau'n gryf y dylai pobl gael eu trin yn gyson.

7. Mae'r "Egwyddorion Gweinyddiaeth Dda a Rheoli Cofnodion yn Dda" yn ymhelaethu ar y pwyntiau uchod, ac mae'r egwyddor o weithredu'n deg ac yn gymesur yn berthnasol i'r ymchwiliad hwn. Wrth geisio cyflawni hyn, dylai darparwyr gwasanaethau cyhoeddus sicrhau bod pobl yn cael eu trin yn deg ac yn gyson fel bod y rheini sydd mewn amgylchiadau tebyg yn cael eu trin mewn ffordd debyg. Ar ben hynny, dylai darparwyr gwasanaethau cyhoeddus geisio mynd i'r afael â'r annhegwch pe bai dilyn y gyfraith, y rheoliadau neu'r gweithdrefnau'n llym yn arwain at ganlyniad annheg i unigolyn.

Canllawiau Llywodraeth Cymru a Byrddau Iechyd

8. Mae "Rheolau ar gyfer Rheoli Amseroedd Aros Rhwng Atgyfeirio a Thriniaeth" ("Rheolau RTT") Llywodraeth Cymru – a oedd ar waith adeg y digwyddiadau yr ymchwiliwyd iddynt – yn amlinellu'r rheolau ar gyfer rheoli amseroedd aros, gan gynnwys targedau amseroedd aros canser. Roedd yr egwyddorion arweiniol yn cynnwys gwerthoedd fel: "dylai cleifion aros cyn lleied o amser â phosibl am driniaeth" ac mai'r targedau RTT yw'r

amseroedd aros mwyaf sy'n dderbyniol ac y dylai cleifion brys gael eu trin yn unol â'u hanghenion clinigol. O ran amseroedd targed canser, roedd 2 darged – 62 diwrnod a 31 diwrnod:

- Cleifion canser sydd newydd gael diagnosis ac sydd wedi cael eu hatgyfeirio fel USC, ac sydd wedi cael eu cadarnhau fel achosion brys gan yr arbenigwr, i ddechrau triniaeth ddiffiniol o fewn 62 diwrnod ar ôl derbyn atgyfeiriad gan y Bwrdd Iechyd Lleol.

- Cleifion canser sydd newydd gael diagnosis ond heb gael eu hatgyfeirio fel USC ("NUSC" – achosion llai brys lle'r amheuir canser)[4] i ddechrau triniaeth ddiffiniol o fewn 31 diwrnod i benderfyniad i gael triniaeth.[5]

O ran atebolrwydd am fonitro, perfformiad ac adrodd yn ôl ar y targed RTT, roedd y Rheolau RTT yn dweud:

- Pan wneir atgyfeiriad at ddarparwr yn Lloegr, y Bwrdd Iechyd Lleol sy'n comisiynu'r llwybr sy'n atebol am fonitro llwybr y claf hwnnw. Rhaid i'r Byrddau Iechyd Lleol sicrhau bod protocolau cyfathrebu'n cael eu defnyddio fel bod gwybodaeth briodol yn cael ei rhannu, a bod amseroedd aros canser yn cael eu mesur yn gywir.

- Pan gaiff gweithgarwch y GIG ei gomisiynu gan ddarparwr yn Lloegr, y Bwrdd Iechyd Lleol sy'n comisiynu'r gweithgarwch sy'n atebol am berfformiad yn erbyn y targedau.

- Pan gaiff atgyfeiriad ei wneud i ddarparwr yn Lloegr, y darparwr hwnnw sy'n gyfrifol am adrodd am berfformiad yn erbyn y targed. Rhaid i'r Byrddau Iechyd Lleol sicrhau bod y gofynion ar gyfer adrodd yn cael eu cynnwys ar ffurf contract mewn cytundebau comisiynu.

- Y Bwrdd Iechyd Lleol sydd â chyfrifoldeb clinigol dros y claf...sy'n gyfrifol am adrodd am berfformiad yn erbyn y targed amser aros llwybr agored.

[4] Unrhyw glaf sydd wedi cael diagnosis o ganser na chafodd ei atgyfeirio gan ei feddyg teulu fel USC neu ei uwchraddio gan yr arbenigwr ar ôl dadansoddi atgyfeiriad y meddyg teulu.
[5] Penderfyniad i drin – y dyddiad y cadarnhawyd y penderfyniad i drin rhwng aelod dynodedig o'r tîm amlddisgyblaethol a'r claf.

9. Roedd canllawiau ychwanegol penodol i ganser i gefnogi'r Canllawiau RTT diwygiedig (a gyhoeddwyd ym mis Ebrill 2017) – y canllawiau a ddarparwyd gan y Bwrdd Iechyd, y dywedodd ei fod yn eu dilyn adeg yr ymchwiliad – yn ailadrodd y targedau 62 a 31 diwrnod.

10. Cylchlythyr Iechyd Cymru (2019) 028 – Cafodd y Rheolau wedi'u Cydgrynhoi ar gyfer Rheoli Amseroedd Aros Canser (Medi 2019) eu dosbarthu i Brif Weithredwyr holl fyrddau iechyd Cymru ym mis Medi 2019; nodwyd mai dyma fersiwn derfynol y rheolau diweddaraf ar gyfer rheoli amseroedd aros canser a fyddai'n disodli'r holl ganllawiau blaenorol o 1 Rhagfyr 2019 ymlaen. Roedd y ddogfen yn darparu canllawiau ar gyfer rheoli amseroedd aros canser ac adrodd ar berfformiad yn erbyn y targedau canser.

11. Yn ôl yr egwyddorion arweiniol, nod y canllawiau yw sicrhau bod amseroedd aros y cleifion am ddiagnosis posibl o ganser a thriniaeth ar gyfer hynny yn cael eu mesur a'u hadrodd mewn modd cyson a theg. Mae egwyddorion arweiniol amseroedd aros canser yn adlewyrchu'r egwyddorion iechyd darbodus yn glir. Dylid rheoli cleifion gyda'r nod o ddechrau triniaeth ar yr adeg gynharaf sy'n briodol yn glinigol yn hytrach nag yn erbyn unrhyw fesurau perfformiad.

12. Roedd Cylchlythyr Iechyd Cymru, pan gafodd ei gyhoeddi, yn nodi, mewn perthynas â chleifion o Gymru sy'n cael eu trin yn Lloegr:

- "Yn y dyfodol, rydym yn bwriadu adrodd ar gleifion o Gymru sy'n cael eu trin yn Lloegr. Nid yw hyn yn bosibl ar hyn o bryd (Awst 2019). Rydym yn trafod gyda GIG Digidol i weld sut y gellid cyflawni hyn. Hyd nes y byddwn yn cytuno ar ateb, bydd cleifion sy'n cael eu trin yn Lloegr yn cael eu trin yn unol â safonau canser Lloegr".

- "Pan wneir atgyfeiriad at ddarparwr GIG yn Lloegr, darparwr y GIG yn Lloegr sy'n atebol am fonitro llwybr y claf hwnnw. Rhaid i ddarparwyr y GIG yn Lloegr sicrhau bod protocolau cyfathrebu'n cael eu defnyddio fel bod gwybodaeth briodol yn cael ei rhannu, a bod amseroedd aros canser yn cael eu mesur yn gywir. Mae angen i dargedau Cymru gael eu rhannu fel rhan o unrhyw gontract â darparwyr eraill y GIG (Cymru a Lloegr). Cyfrifoldeb y bwrdd iechyd Cymreig sy'n comisiynu

yw sicrhau bod ganddynt brosesau i fonitro a rheoli perfformiad eu contractau ar gyfer darpariaeth ganser, gan sicrhau bod targedau'n cael eu bodloni. Ein bwriad yw cofnodi cleifion sy'n cael eu trin yn Lloegr ar y SCP, ond nid yw systemau a phrosesau'n caniatáu hyn ar y funud. Mae trafodaethau ar droed gyda GIG Digidol a bydd y canllawiau hyn yn cael eu diweddaru pan fydd y systemau i alluogi hyn ar waith".

- "Lle comisiynir gweithgarwch y GIG gan ddarparwr yn Lloegr, y Bwrdd Iechyd sy'n comisiynu'r gweithgarwch sy'n gyfrifol am faint mae'r claf yn ei aros. Bydd angen i'r bwrdd iechyd sy'n comisiynu sicrhau bod data'n cael eu rhannu â'r bwrdd iechyd sy'n adrodd, os yw'n wahanol, gan fod y cyfrifoldeb o adrodd yn ôl am lwybr y claf yn aros gyda'r bwrdd iechyd a dderbyniodd yr atgyfeiriad gwreiddiol".

13. O ran adrodd, roedd Cylchlythyr Iechyd Cymru yn dweud:

- "Dylid cwblhau adroddiad tramgwydd ar gyfer pob claf nad yw'n cael ei drin o fewn targedau NUSC ac USC, yn rhoi manylion ei daith ar y llwybr ac yn amlinellu'r gwersi a ddysgwyd a chamau gweithredu adferol a gymerwyd o fewn y bwrdd iechyd."

14. Mae'r ddogfen 'Canllawiau wedi'u Cydgrynhoi ar gyfer Rheoli Cleifion ar Lwybr Canser a Amheuir' (Rhagfyr 2020, Fersiwn 2.0) ("y Canllawiau ar gyfer y Llwybr Canser Sengl") yn rhoi canllawiau ar gyfer rheoli cleifion ar lwybr lle'r amheuir canser ac adrodd am berfformiad yn erbyn y targed canser. Mae'r canllawiau diweddaraf yn cyflwyno rheolau newydd ar gyfer rheoli cleifion ar lwybr lle'r amheuir canser ac mae'n sôn am adrodd am gleifion sy'n cael eu trin y tu allan i GIG Cymru pan gânt eu hatgyfeirio o ofal eilaidd GIG Cymru. O ran targedau amseroedd aros canser, mae llwybr canser sengl newydd yn disodli'r 2 safon flaenorol – USC ac NUSC. Yng nghyswllt cleifion sy'n cael eu trin y tu allan i Gymru, mae'n dweud:

- "Rhaid i'r cleifion hynny sy'n cael eu hatgyfeirio o ofal eilaidd GIG Cymru i gael eu hymchwiliad pellach, a/neu eu triniaeth ddiffiniol gyntaf y tu allan i GIG Cymru, gael eu cynnwys mewn adroddiadau amseroedd aros canser, ond ni fydd hynny'n wir am y rheini sy'n cael eu hatgyfeirio'n uniongyrchol o ofal sylfaenol".

- “Pan wneir atgyfeiriad at ddarparwr GIG yn Lloegr, darparwr y GIG yn Lloegr sy’n atebol am fonitro llwybr y claf hwnnw. Rhaid i ddarparwyr y GIG yn Lloegr sicrhau bod protocolau cyfathrebu’n cael eu defnyddio fel bod gwybodaeth briodol yn cael ei rhannu, a bod amseroedd aros canser yn cael eu mesur yn gywir. Mae angen i dargedau Cymru gael eu rhannu fel rhan o unrhyw gontract â darparwyr eraill y GIG. Cyfrifoldeb y bwrdd iechyd Cymreig sy’n comisiynu yw sicrhau bod ganddynt brosesau i fonitro a rheoli perfformiad eu contractau ar gyfer darpariaeth ganser, gan sicrhau bod targedau’n cael eu bodloni. Bydd pob claf sy'n cael ei atgyfeirio ar gyfer triniaeth y tu allan i GIG Cymru o ofal eilaidd yn cael ei gynnwys mewn adroddiadau am amseroedd aros canser”.

- “Lle comisiynir gweithgarwch y GIG o’r tu allan i GIG Cymru, y Bwrdd Iechyd sy’n comisiynu’r gweithgarwch sy’n gyfrifol am faint mae'r claf yn ei aros. Bydd angen i’r bwrdd iechyd sy’n comisiynu sicrhau bod data’n cael eu rhannu â’r bwrdd iechyd sy’n adrodd, os yw’n wahanol, gan fod y cyfrifoldeb o adrodd yn ôl am lwybr y claf yn aros gyda’r bwrdd iechyd a dderbyniodd yr atgyfeiriad gwreiddiol”.

15. Yng nghyswllt cleifion nad ydynt yn cael eu trin o fewn y targed, mae’n dweud:

- “Dylid cwblhau adroddiad torri amodau mewnol ar gyfer pob claf nad yw’n cael ei drin o fewn y targed. Dylai’r adroddiad hwn roi manylion am eu llwybr, gan amlinellu’r gwersi a ddysgwyd a’r camau unioni a gymerwyd o fewn y bwrdd iechyd. Dylid cynnal adolygiad clinigol ar gyfer pob claf sydd wedi aros yn rhy hir o’r pwynt amheuaeth am eu triniaeth ac yr amheuir eu bod wedi cael eu niweidio, a’i gyflwyno i Lywodraeth Cymru”.

16. Nod Cylch Gorchwyl “Grŵp Adolygu Niwed 104 Diwrnod Canser” y Bwrdd Iechyd (Ebrill 2020 – “y Grŵp Adolygu Niwed”) yw adolygu gofal cleifion canser gydag amser aros o fwy na 104 diwrnod i ganfod unrhyw ffactorau clinigol ac anghlinigol y gellid eu hosgoi. Bydd y Grŵp Adolygu Niwed yn ystyried a yw’r aros wedi achosi niwed, a bydd y broses yn cael ei defnyddio ar gyfer cleifion sy’n cael eu cyflwyno i’r Bwrdd Iechyd ac yn

cael eu trin ganddo. Os yw llwybr claf yn dechrau ac yn parhau y tu allan i'r Bwrdd Iechyd, bydd tîm comisiynu'r Bwrdd Iechyd yn gofyn i sefydliadau sy'n trin gwblhau adolygiadau o niwed.

Tystiolaeth y Bwrdd Iechyd

17. Cefais sylwadau a chopïau o ddogfennau perthnasol gan y Bwrdd Iechyd. Yn gryno, cadarnhaodd y Bwrdd Iechyd y canlynol:

- Ei fod yn gweithio'n unol â Pholisi Llywodraeth Cymru o ran yr amseroedd targed ar gyfer canser, sef 62/31.

- Yn unol â pholisi Llywodraeth Cymru adeg y digwyddiadau sy'n destun ymchwiliad, dim ond cleifion wedi'u trin yng Nghymru a adroddwyd yn erbyn targedau amser aros canser Cymru. Dyna pam mai dim ond ar gyfer cleifion a gafodd eu trin gan y Bwrdd Iechyd y cwblhawyd adroddiadau toramod ac adolygiadau o niwed. Newidiodd Llywodraeth Cymru hyn ym mis Ionawr 2021 fel bod cleifion sy'n cael eu trin yn Lloegr hefyd yn cael eu cynnwys. Roedd hyn yn dilyn ceisiadau i gynnwys adrodd am y cleifion hyn a gafodd eu trin yn Lloegr gan y Bwrdd Iechyd ac eraill (cyfeiriodd y Bwrdd Iechyd at yr adrannau perthnasol yng Nghylchlythyr Iechyd Cymru a'r Canllawiau ar gyfer y Llwybr Canser Sengl, a oedd yn amlinellu'r newidiadau hyn – gweler paragraffau 10–15).

- O'r 17 claf (gan gynnwys Mr Y), adroddwyd bod 2 achos o dorri amodau mewn perthynas ag achosion NUSC – cwblhawyd adolygiadau o niwed ar gyfer y ddau glaf ac ni nodwyd unrhyw niwed; adroddwyd 2 achos o dorri amodau mewn perthynas ag achosion USC, cwblhawyd adolygiadau o niwed ar gyfer y ddau glaf ac ni nodwyd unrhyw niwed; cafodd 8 claf driniaeth yn Lloegr (cymysgedd o gleifion USC/NUSC); 2 glaf NUSC heb unrhyw achos o dorri amodau; 2 glaf USC heb unrhyw achos o dorri amodau; ac 1 claf nad oedd yn destun adrodd yng nghyswllt targedau amseroedd aros canser Cymru.

- Bod adolygiadau o niwed yn cael eu cwblhau ar gyfer yr holl gleifion canser sy'n cael eu trin gan y Bwrdd Iechyd ar ôl diwrnod 104 ar eu llwybr canser (gweler paragraff 16) – nid oedd hyn yn orfodol gan Lywodraeth Cymru yn 2019 ond roedd y Bwrdd Iechyd yn gwneud hyn fel arfer da.

- Dim ond adolygiadau o niwed ar gyfer cleifion sy'n cael eu trin gan y Bwrdd Iechyd y byddai'n eu cwblhau. Bydd yn adolygu'r penderfyniad hwn yn unol â'r Canllawiau ar gyfer y Llwybr Canser Sengl a phan fydd yn adolygu'r broses adolygu niwed yn y panel adolygu niwed nesaf.

- Roedd y 4 adolygiad o niwed a gwblhawyd wedi nodi pwyntiau gweithredu ar gyfer dysgu, gan gynnwys rhoi capasiti ar gyfer prostatectomi ar gofrestr risg y Bwrdd Iechyd (ychwanegwyd ar 24 Gorffennaf 2018 – mae gan y risg bresennol sgôr uchel) ac adolygu sut mae cleifion yn cael cyngor am y triniaethau sydd ar gael ar gyfer canser y prostad (cytunwyd i ddatblygu protocol yng ngrŵp cynghori clinigol y gwasanaeth wroleg ym mis Hydref 2020).

- Roedd cofnod ar y gofrestr risg (a ddiweddarwyd ar 16 Medi 2020) yn nodi risg yn ymwneud â chapasiti llawfeddygol yn yr adran wroleg, a oedd yn effeithio ar y gallu i gyflawni targedau RTT ar gyfer wroleg. Er mwyn mynd i'r afael â'r risg hon, nododd y Bwrdd Iechyd yr angen i symud ymlaen gyda'r gwaith o ailfodelu'r gwasanaeth, ac roedd contractau tymor byr ar waith gyda 2 Ymddiriedolaeth yn Lloegr i helpu i gyflawni llawdriniaethau ar gyfer canser y prostad a chanserau wrolegol eraill.

- Roedd wedi ysgrifennu at Grŵp Iechyd a Gwasanaethau Cymdeithasol Llywodraeth Cymru ym mis Medi 2020 mewn ymateb i Gylchlythyr Iechyd Cymru, ac ymhlith pethau eraill, wedi nodi nad oedd sôn yn y ddogfen am adrodd am amseroedd aros ar gyfer cleifion a oedd wedi cael eu trin yn Lloegr. Dywedodd nad oedd, bryd hynny, yn adrodd am amseroedd aros ar gyfer y cleifion hynny, a bod hynny i bob golwg yn anghysondeb.

- Roedd ganddo gontractau gyda 2 Ymddiriedolaeth Ysbyty yn Lloegr (“yr Ymddiriedolaeth Gyntaf” a’r “Ail Ymddiriedolaeth” yn y drefn honno): ac eithrio’r contract gyda’r Ail Ymddiriedolaeth ar gyfer 2018/2019, nid oeddent wedi’u llofnodi. Roedd y contractau’n seiliedig ar berfformiad o ystyried bod y contractau’n cael eu rhoi i’r ddau ddarparwr. Roedd safonau gweithredol y contractau o ran amseroedd aros canser yn dweud y byddai mynd dros y targed aros o 62 diwrnod ar gyfer achosion USC yn arwain at uwchgyfeirio’n ffurfiol adroddiadau perfformiad i’r Bwrdd Iechyd; byddai mynd dros y targed 31 diwrnod ar gyfer achosion NUSC yn arwain at gosb ariannol.

- Mae’r trefniant i’r Ymddiriedolaeth Gyntaf drin cleifion prostadectomi yn un hanesyddol sy'n parhau. Cychwynnodd contract gydag Ymddiriedolaeth Ysbyty arall yn Lloegr (“y Drydedd Ymddiriedolaeth”) ym mis Chwefror 2020 ar gyfer llawdriniaethau prostadectomi.

- Mae’n cynnal cyfarfodydd mynediad wythnosol i drafod perfformiad darparwyr yn Lloegr mewn perthynas â’r Rheolau RTT.

18. Roedd adroddiad diweddaru gan y gwasanaeth wroleg ym mis Medi 2020 yn nodi pryderon ynghylch recriwtio a chapasiti cytundebol.

Sylwadau Llywodraeth Cymru

19. Cefais sylwadau gan Lywodraeth Cymru ynglŷn â thargedau amser triniaethau canser. Yn gryno:

- Roedd yn egluro, ers cyflwyno’r Rheolau RTT, mai polisi Cymru fu adrodd ar berfformiad byrddau iechyd Cymru fel darparwyr yn unig; nid yw’n adrodd yn ffurfiol, nac yn rheoli perfformiad trefniadau comisiynu.

- Dywedodd fod disgwyliad clir iawn bod y Bwrdd Iechyd, drwy ei bolisi comisiynu ei hun, yn sicrhau bod cleifion yn cael eu trin yn amserol yn unol â safonau Cymru; mae’r perfformiad gyda darparwyr yn Lloegr yn cael ei drafod yn y cyfarfodydd ansawdd a darparu rheolaidd rhwng pob bwrdd iechyd a Llywodraeth Cymru,

ac mae unrhyw broblemau neu bryderon yn cael eu codi yn y fforwm hwnnw. Mae byrddau iechyd yn adrodd i'w bwrdd ar effeithiolrwydd eu strategaethau comisiynu a pherfformiad cleifion o Gymru sy'n cael eu trin yn Lloegr.

- Byddai'n disgwyl, fan leiaf, i'r Bwrdd Iechyd gael polisi ynghylch oedi cyn triniaeth gyda'i ddarparwyr, a hwnnw'n adlewyrchu safonau Cymru, gan gynnwys adolygiadau ffurfiol, adroddiadau toramod, ac adolygiadau o niwed a digwyddiadau difrifol ar gyfer pob claf lle mae'r amseroedd aros ar gyfer canser yn cael eu torri.

- O fis Ionawr 2021 ymlaen, mae pob claf yn cael ei reoli ar y llwybr canser sengl. Ni fydd y llwybrau canser eraill yn cael eu rheoli mwyach ac ni fydd neb yn adrodd arnynt. Wrth gyflwyno'r llwybr, mae wedi penderfynu ei bod yn rhaid i'r holl gleifion sy'n cael eu hatgyfeirio o ofal eilaidd i gael triniaeth canser y tu allan i Gymru gael eu cynnwys mewn amseroedd aros ar gyfer canser.

- Roedd y canllawiau (h.y. cyn y llwybr canser sengl) yn ei gwneud yn ofynnol i bob bwrdd iechyd lunio adroddiad toramod ar gyfer unrhyw glaf nad oedd wedi dechrau triniaeth o fewn 62 neu 31 diwrnod, yn dibynnu ar y llwybr yr oedd arno. Fodd bynnag, nid oedd yn ymddangos bod adroddiadau toramod bob amser yn cael eu defnyddio mewn ffordd systemig i sicrhau gwelliannau a thynnu sylw at broblemau yn y gwasanaeth. Ar hyn o bryd, mae'n adolygu a oes angen i fyrddau iechyd gyflwyno adroddiadau toramod yn ffurfiol i Lywodraeth Cymru yn y dyfodol, ond mae disgwyliad pendant bod angen i'r rhain barhau ym mhob bwrdd iechyd a chael eu defnyddio i wella gwasanaethau ac i adolygu cymheiriaid.

- Mewn ymateb i ddatganiad y Bwrdd Iechyd mai dim ond cleifion sy'n cael eu trin yng Nghymru sy'n cael eu hadrodd yn erbyn targedau amseroedd aros canser Cymru – sy'n egluro pam mai dim ond ar gyfer cleifion sydd wedi cael eu trin gan y Bwrdd Iechyd y mae adroddiadau toramod ac adolygiadau o niwed wedi cael eu cwblhau (i gyd-fynd â pholisi Llywodraeth Cymru), dywedodd y byddai'n disgwyl i hyn fod wedi'i wreiddio yng nghontractau comisiynu byrddau

iechyd ac y byddai'r byrddau iechyd wedi gofyn am hyn gan eu darparwyr yn Lloegr sy'n gweithredu proses adolygu niwed ar hyn o bryd.

Dadansoddiad a chasgliadau

20. Dechreuais yr ymchwiliad hwn ar fy liwt fy hun er mwyn ystyried a oedd y Bwrdd Iechyd wedi mynd dros y targed RTT ar gyfer amseroedd aros canser ar gyfer trin canser y prostad mewn 16 o gleifion a oedd, ym mis Awst 2019, yn disgwyl prostadectomi. Yn ystod fy ymchwiliad i gŵyn Mr Y, dywedodd y Bwrdd Iechyd wrthyf fod pob un o'r 16 claf yn destun blaenoriaeth glinigol frys. Yn yr achos hwn, roedd fy mhŵer ar fy liwt fy hun yn caniatáu i mi ymestyn fy ymchwiliad i gŵyn Mr Y i ystyried a oedd problemau systemig yng ngwasanaeth wroleg y Bwrdd Iechyd o ran darparu triniaeth canser y prostad (yn enwedig llawdriniaethau prostadectomi) yn unol â thargedau canser Cymru.

21. Ym mis Awst 2019, dim ond cleifion oedd wedi cael eu trin yng Nghymru oedd yn cael eu hadrodd yn erbyn targedau amser aros canser Cymru. Dim ond ar gyfer cleifion a oedd wedi cael eu trin gan y Bwrdd Iechyd yr oedd y Bwrdd Iechyd wedi llunio adroddiadau toramod ac adolygiadau o niwed; nid oedd hyn yn berthnasol i gleifion a oedd wedi cael eu hatgyfeirio ganddo i gael triniaeth yn Lloegr. Mae fy arweiniad yn glir. Er mwyn sicrhau gweinyddiaeth effeithiol, mae angen i ddarparwyr gwasanaethau cyhoeddus sicrhau bod pobl yn cael eu trin yn deg ac yn gyson fel bod y rheini sydd mewn amgylchiadau tebyg yn cael eu trin mewn ffordd debyg.

22. O'r 16 claf ar y rhestr aros, cafodd 8 eu hatgyfeirio i Loegr i gael triniaeth. Pe bai'r 8 claf hyn wedi cael eu trin yng Nghymru, byddai pob un o'r 8 wedi cael eu hadrodd am beidio â chyrraedd y targed 62 a 31 diwrnod ar gyfer RTT. Ar ben hynny, byddai pob un o'r 8 claf wedi cael adolygiad o niwed i weld a oedd methu bodloni'r amseroedd aros wedi cael unrhyw effaith glinigol ar eu triniaeth neu'u prognosis; cafodd adolygiadau o niwed eu cwblhau ar gyfer y 4 claf a gafodd eu trin gan y Bwrdd Iechyd lle'r oedd wedi methu cyrraedd y targed RTT.

23. Er fy mod yn derbyn bod polisi Cymru ar y pryd yn golygu nad oedd yn rhaid cyflwyno adroddiadau toramod i Lywodraeth Cymru na chynnal adolygiadau o niwed ar gyfer cleifion y Bwrdd Iechyd a oedd wedi cael eu trin yn Lloegr, o ran trin cleifion yn deg ac yn gyson, ni ddylai lleoliad daearyddol y driniaeth fod wedi gadael yr 8 claf hyn mewn sefyllfa lle nad oeddent yn cael eu cynnwys yn y broses adolygu niwed, dim ond am eu bod wedi cael eu trin y tu allan i Gymru. Beth bynnag oedd polisi Cymru ar y pryd, yn unol â'i drefniadau comisiynu a chontractio, roedd yn rheidrwydd ar y Bwrdd Iechyd i fonitro gofal a thriniaeth ei gleifion yn briodol. Dylai hefyd fod wedi ystyried effaith yr oedi yn y driniaeth. Roedd y methiannau hyn yn cynnwys camweinyddu a achosodd anghyfiawnder i'r 8 claf a gafodd eu trin yn wahanol i'r cleifion a gafodd eu trin gan y Bwrdd Iechyd. Mae fy nghanllawiau'n glir – os bydd dilyn gweithdrefnau'n llym yn arwain at ganlyniad annheg i unigolyn, yna dylai darparwr gwasanaeth cyhoeddus fynd i'r afael â'r annhegwch hwn.

24. Yn ôl y rheolau a oedd ar waith ym mis Awst 2019, pan fyddai achos yn cael ei gyfeirio at ddarparwr yn Lloegr, y Bwrdd Iechyd oedd yn comisiynu'r llwybr oedd yn gyfrifol am fonitro llwybr y claf, a'r Bwrdd Iechyd oedd yn comisiynu oedd yn atebol am berfformiad yn erbyn y targedau. Roedd y Bwrdd Iechyd yn gyfrifol am fonitro i wneud yn siŵr bod ei drefniadau comisiynu'n cydymffurfio, ac mae'r contractau rwyf wedi'u gweld yn dangos bod gan y Bwrdd Iechyd brosesau uwchgyfeirio ar waith ar gyfer achosion o fynd dros y targed 62 a 31 diwrnod. Mae'r wybodaeth a gefais yn cadarnhau y cynhaliwyd arolwg lefel uchel yn gyffredinol o wasanaethau a gomisiynwyd, a bod pryderon wedi'u mynegi ynghylch yr angen am ddarpariaeth ychwanegol o wasanaethau wroleg. Fodd bynnag, nid wyf wedi gweld unrhyw dystiolaeth bod y Bwrdd Iechyd wedi mynd ati'n rhagweithiol i fonitro'r contractau hyn yn benodol yn unol â'i safonau gweithredu dan gontract nac wedi ystyried effaith oedi o ran gwasanaethau ar y cleifion unigol.

25. Erbyn hyn, mae'r Canllawiau ar gyfer y Llwybr Canser Sengl wedi mynd i'r afael ag anghysondeb y dull blaenorol. Rhaid i bob claf sy'n cael ei atgyfeirio o ofal eilaidd ar gyfer triniaeth canser y tu allan i Gymru gael ei gynnwys yn yr amseroedd aros canser (ac eithrio'r rheini sy'n cael eu hatgyfeirio'n uniongyrchol o ofal sylfaenol) a dylid cwblhau adroddiad toramod mewnol ar gyfer pob claf nad yw'n cael triniaeth o fewn y targed,

gan nodi unrhyw wersi a ddysgwyd a chamau adferol i'w cymryd. Yn ogystal â hyn, dylid cynnal adolygiad clinigol ar gyfer pob claf sydd wedi aros yn rhy hir o'r POS am eu triniaeth ac yr amheuir eu bod wedi dioddef niwed. Er fy mod yn croesawu'r newid hwn sydd bellach yn mynd i'r afael ag anghysondeb y dull gweithredu blaenorol, drwy beidio â chynnal adolygiadau o niwed ar gyfer y cleifion a dderbyniodd driniaeth yn Lloegr, collwyd cyfle i sicrhau bod iawn yn cael ei wneud, ac i ddysgu a gwella pethau. Mae adolygiadau o niwed yn rhoi cyfle i fyrddau iechyd nodi problemau sy'n ymwneud â gwasanaeth a chyfrannu at wella'r gwasanaeth hwnnw. Yn unol â'm dull o wneud iawn, dylai'r Bwrdd Iechyd ddychwelyd y cleifion hyn i'r sefyllfa y byddent wedi bod ynddi pe baent wedi cael eu trin yng Nghymru o ran cynnal adolygiad o niwed.

26. Rwyf wedi adrodd ar wasanaethau wroleg y Bwrdd Iechyd sawl gwaith, ac rwy'n bryderus bod pryderon o ran recriwtio a gallu contractiol – hyd yn oed ym mis Medi 2020. Dydy hwn ddim yn fater newydd. Cynhaliodd Arolygiaeth Gofal Iechyd Cymru ("AGIC") Adolygiad gan Gymheiriaid o Ganser Wrolegol yn y Bwrdd Iechyd ym mis Chwefror 2014. Er bod arferion da wedi'u nodi, tynnwyd sylw at nifer o bryderon difrifol, gan gynnwys:

- Diffyg consensws oedd yn cael ei arwain yn glinigol neu gan reolwyr ynghylch y model cyflenwi ar gyfer gwasanaethau canser wrolegol yng Ngogledd Cymru.

- Yn ôl y Timau Amlddisgyblaeth, roedd cleifion wedi cael eu colli neu eu dal yn ôl ac wedi dirywio wrth aros am eu hapwyntiad.

- Diffyg cynllunio ar gyfer dilyniant yn y gwasanaeth, oedd yn cael ei ddwysáu gan ddiffyg cyfarwyddyd strategol gan y rheolwyr ar gyflenwi gwasanaethau wrolegol ar gyfer poblogaeth [y Bwrdd Iechyd].

- Roedd y tîm a gynhaliodd yr adolygiad gan gymheiriaid yn bryderus iawn nad oeddent wedi cael sicrwydd y byddai gwasanaethau canser wrolegol diogel ac o ansawdd uchel yn cael eu darparu yn y dyfodol.

- Capasiti Cleifion Allanol ac Mewnol.

- Roedd prinder sylweddol o gymorth yn gyffredinol ar draws y Bwrdd Iechyd.

27. Roedd adroddiad AGIC hefyd yn dweud bod pob tîm amlddisgyblaethol wedi nodi ei bod yn arfer cyffredin i gleifion sydd ar fin mynd dros y targedau amser aros gael gwahoddiad i gael llawdriniaeth mewn canolfannau yn Lloegr, ond mae'r Bwrdd Iechyd wedi cael trafferth wrth ddod o hyd i ganolfannau cyfagos gyda'r capasiti i ymgymryd â'r gwaith hwn. Hysbyswyd y tîm adolygu nad oedd yr arfer hwn wedi cael ei gyfathrebu'n eglur i staff nyrsio meddygol ac arbenigol a'i fod wedi arwain at rywfaint o bryder a dryswch. Mae hyn yn peri pryder, ac er nad wyf yn gallu dod i gasgliad bod yr 8 claf a gafodd eu trin yn Lloegr wedi cael eu hatgyfeirio y tu allan i'r Bwrdd Iechyd er mwyn osgoi torri'r targed amseroedd aros canser, mae'r ffaith y cydnabyddir mai dyma oedd yn digwydd yn 2014 yn codi'r cwestiwn a oedd hyn yn dal i ddigwydd 5 mlynedd yn ddiweddarach.

28. Rwyf hefyd yn pryderu bod problemau capasiti'n parhau i fod yn broblem, ac yn poeni am effaith hyn ar ofal cleifion. Rwyf wrthi'n ymchwilio i gŵyn arall yn erbyn gwasanaeth Wroleg y Bwrdd Iechyd ar hyn o bryd. Mae'n ymddangos bod y ffaith bod ymgynghorwyr meddygol locwm wedi'u cyflogi i gefnogi'r unig 2 ymgynghorydd cyflogedig ar y pryd wedi arwain at anghysondeb yng nghamau dilynol y cleifion. Byddaf yn adrodd am yr achos hwn ar wahân, ond mae'n ymddangos bod capasiti a chynllunio dilyniant yn dal yn broblem yn yr adran Wroleg.

Argymhellion

29. Rwy'n **argymell** bod y Bwrdd Iechyd, o fewn **3 mis** i ddyddiad yr adroddiad hwn:

a) Yn cynnal adolygiadau o niwed ar gyfer yr 8 claf a gafodd eu trin yn Lloegr. Os bydd yr adolygiadau'n dangos bod niwed wedi'i achosi, dylai'r Bwrdd Iechyd ysgrifennu at y claf yn egluro hyn ac ystyried yr achosion unigol o dan y Broses Gweithio i Wella.

b) Yn gofyn i'r Grŵp Adolygu Niwed adolygu'r Canllawiau ar gyfer y Llwybr Canser Sengl ac edrych yn ofalus ar y broses adolygu niwed i sicrhau bod y cylch gorchwyl yn cael ei ddiweddaru, yn unol â gofynion Canllawiau'r Llwybr Canser Sengl.

c) Yn cyfeirio'r adroddiad at y Bwrdd i ystyried capasiti a chynllunio dilyniant yn yr adran wroleg.

30. Rwy'n falch o nodi bod y Bwrdd Iechyd, wrth gyflwyno sylwadau ar ddrafft yr adroddiad hwn, wedi cytuno i roi'r argymhellion hyn ar waith.

Nick Bennett 26 Awst 2021
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