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# The investigation of a complaint against Swansea Bay University Health Board

A report by the  
Public Services Ombudsman for Wales  
Case: 202407678

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## Introduction

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

We have taken steps to protect the identity of the complainant and others, as far as possible. The names of the complainant and others have been changed as well.

## Summary

Mr W complained about a delay in receiving a total knee replacement surgery from Swansea Bay University Health Board, which he had been waiting for since August 2019. The investigation considered whether Mr W's waiting time for surgery was appropriately managed in line with the Welsh Government's Rules for Managing Referral to Treatment Waiting Times, specifically when his waiting time clock was re-set in October 2023.

The investigation found that Mr W's waiting time clock was inappropriately re-set in October 2023. It found no evidence that a clinician had documented that Mr W was medically unfit to proceed with surgery. Mr W required a repeat scan, due to the amount of time he had been waiting, which confirmed his fitness to proceed. The decision to re-set the waiting time clock was also not communicated to Mr W and he only became aware when he made a complaint. As a result of the delay, Mr W had experienced pain, reduced mobility and ongoing frustration. Further to this, he is now in a position where he is not able to proceed with surgery and this opportunity has been lost.

In January 2024, this office published 3 reports in the public interest in relation to the Health Board's management of the waiting list for orthopaedic treatment. These reports found that in all 3 cases the complainants had been treated unfairly because of errors in the way the waiting lists for orthopaedic surgery were managed. One of the recommendations contained within those reports was that the Health Board should carry out an audit of its waiting list to establish whether any other errors had been made relating to the resetting of waiting list times or improper removal from the list. It is concerning that further errors have subsequently been found despite this audit having taken place. This raises concern about the reliability of the audit the Health Board undertook previously.

The Health Board agreed to the following recommendations:

- a) Arrange for the Chief Executive to make an apology to Mr W for the failings identified in the management of his waiting time for surgery.
- b) Share this report with relevant staff and reflect on the failings identified, in particular the need for there to be a well documented clinical decision before a patient is deemed unfit for surgery.
- c) Appoint an independent person to re-audit its orthopaedic waiting list to establish if any other patients have been treated incorrectly in the same way as Mr W, including incorrect waiting time re-set date and/or not being informed of their waiting time clock being re-set. If any are identified, the Health Board should apologise to those patients and ensure the correct waiting list date is recorded. The Health Board should propose a scope for the audit that should be agreed by this office before the audit commences.
- d) Given that the Health Board remained of the view, during the course of my investigation, that it was appropriate to reset the clock in Mr W's case, it should ensure its training for staff on the application of the RTT guidance includes this type of scenario, to ensure that its approach to waiting list management is in keeping with the RTT guidance.
- e) Share the report with its Board which should nominate a Committee to maintain oversight and monitoring of the Health Board's compliance with these recommendations.

## The Complaint

1. Mr W complained about a delay in receiving total knee replacement surgery from Swansea Bay University Health Board (“the Health Board”). The investigation considered whether Mr W’s waiting time for surgery was appropriately managed in line with the Welsh Government’s Rules for Managing Referral to Treatment Waiting Times, specifically when his waiting time clock was re-set in October 2023.

## Investigation

2. My Investigation Officer obtained comments and copies of relevant documents from the Health Board and considered these in conjunction with the evidence provided by Mr W. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

3. Both Mr W and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

## Relevant legislation and national guidance

4. Welsh Government’s Rules for Managing Referral to Treatment Waiting Times (“RTT guidance”) Version 7, October 2017:

- In March 2005 the First Minister and Minister for Health and Social Services announced that, by December 2009, no patient in Wales will wait more than 26 weeks from GP referral to treatment including waiting times for any diagnostic tests or therapies required. The achievement of the 26 week RTT target is the responsibility of health boards.
- A maximum 26 week wait would be allowed for clinically complex patients, and different targets apply to certain types of treatment, such as diagnostic test (for example X-rays) and treatment for cancer. The wait time begins on receipt of a referral by a healthcare professional to a consultant and is the start of the waiting time clock. The clock can start or stop at certain designated points explained within the RTT guidance.

- Paragraph 76 includes “....Within a RTT period, the clock continues to tick until a clinical decision to stop is reached...”
- Paragraph 78 states “All referrals within an RTT period to diagnostic services, therapy assessments or anaesthetic assessment, will continue the clock.”
- Paragraph 88 states “When a patient is transferred between consultants for reasons of clinical necessity that prevents the current pathway being completed, the clock will stop. When this is simply a request for advice, this must be managed within the 26 week RTT period. The date on which it is explained to the patient that clinical responsibility for their care is being transferred to another consultant will be the clock stop date.”
- Paragraph 95 states “If, in the opinion of a suitably qualified healthcare professional, a patient has a medical condition which will not be resolved within 21 days, the patient should be returned to the referring clinician, or to another clinician who will treat the condition, and the clock will stop.”

5. The Health Board’s Patient Access Policy (2017). This states that patients may be removed from the waiting list when unfit to proceed for more than 3 weeks. Patients will be reinstated to the waiting list on notification that they are now fit. A new pathway will start and patients should be booked in taking into consideration their previous wait.

### **The background events**

6. On 13 August **2019** Mr W was added to the Health Board’s waiting list for a left total knee replacement. Mr W was determined to be a category 3 patient (the Health Board uses 4 types of category – 4 is routine, 3 is urgent, 2 is very urgent and 1 is cancer or emergency care).

7. On 14 September **2020** Mr W underwent a pre-operative assessment and was declared fit for surgery.

8. Mr W was listed for surgery on 17 September in Neath Port Talbot Hospital. However, this surgery could not go ahead as it was identified that Mr W required his surgery in Morriston Hospital (“the Hospital”), due to his other underlying health conditions.

9. During the COVID-19 pandemic orthopaedic surgery was suspended at the Hospital. This caused a significant backlog of patients and increased waiting times, including for Mr W.

10. In November **2022** orthopaedic surgery at the Hospital recommenced.

11. On 2 October **2023** Mr W underwent tests with a nurse to inform a pre-operative assessment. On 6 October Mr W met with an orthopaedic surgeon who confirmed he was happy to proceed with surgery to Mr W’s knee. On 14 October the pre-operative assessment results were reviewed by a consultant anaesthetist (“the Anaesthetist”). The Anaesthetist requested an echocardiogram (“ECHO” – a scan used to create images of the heart and surrounding blood vessels). They also wrote to a consultant cardiothoracic surgeon to request a computerised tomography scan (“CT scan – the use of X-rays and a computer to create an image of the inside of the body) of Mr W’s heart, as it had been over 2 years since this was last performed. The pre-operative assessment form did not state anywhere on it that Mr W had specifically been assessed as unfit to proceed with surgery.

12. On 14 October Mr W’s waiting time clock was re-set. The reason given for this was that he was unfit to proceed with surgery at that time. Mr W was not informed of this decision.

13. On 3 November Mr W underwent an ECHO. A consultant cardiothoracic surgeon also wrote to the Anaesthetist and advised that a CT scan had been completed in November 2022 and therefore a repeat was not required.

14. On 2 February **2024** Mr W’s ECHO results were reviewed by the Anaesthetist and the pre-operative assessment form was updated. He was deemed medically fit to proceed with surgery.

15. On 25 November Mr W complained to the Health Board about his wait for surgery.
16. On 29 November Mr W underwent a further pre-operative assessment. A “frank” discussion about Mr W’s risks of surgery took place. Mr W was noted as wishing to proceed with surgery.
17. During November Mr W was upgraded to category 2 (very urgent).
18. On 12 December the Health Board issued a response to Mr W’s complaint in which it explained that his waiting time clock had been re-set in October 2023. It explained that Mr W was only suitable for surgery at the Hospital which was going through a period of sustained pressure. Mr W wrote back and stated that he had not previously been aware that his waiting time clock had been re-set.
19. On 17 December the Health Board wrote to Mr W again. It explained that as he required further investigations to ensure his fitness for surgery, he had been considered medically unfit for over 21 days, in line with the RTT guidance. It apologised that he had not been notified of this. It said Mr W’s pathway was correct and at that point, he had waited just over 60 weeks.
20. On 3 January **2025** Mr W complained to my office about his ongoing wait for surgery.
21. On 21 March Mr W attended a review with a consultant orthopaedic surgeon. It was decided that Mr W now lacked sufficient rehabilitation potential to undertake the intensive physiotherapy required to achieve a good pain-free result from the surgery. He was removed from the waiting list and a plan was made for pain management.

### **Mr W’s evidence**

22. Mr W complained that he had been waiting over 5 years for surgery on his left knee. He said that it was only when he received a response from his complaint to the Health Board, in December 2024, that he found out that his waiting time clock had been re-set. He believed the Health Board was “cooking the books”.

23. Mr W had seen in the media the investigations carried out by this office which had identified patients being treated unfairly by the Health Board and that the Health Board reported that by the end of March 2024 no patient would have waited more than 3 years. However, he had been waiting 5 years and 4 months. He said the Health Board was now saying he had only been waiting 60 weeks, when in fact it was 276 weeks.

24. Mr W questioned how the Health Board could say he had been medically unfit for surgery for more than 21 days as he had not had any tests or consultations, other than pre-op assessments, following which he was told he was fine.

### **The Health Board's evidence**

25. The Health Board said that it was appropriate to stop Mr W's clock in October 2023 as he was deemed unfit to proceed with surgery and required intervention and investigations from cardiac services before being confirmed fit to proceed. It said this was in line with paragraph 88 of the RTT guidance. It said it had previously apologised that this information was not appropriately communicated to Mr W.

26. The Health Board said that it was unable to provide a copy of the correspondence sent to the Anaesthetist from a consultant cardiothoracic surgeon confirming that the CT scan had been completed in November 2022, as this could not be located. The Health Board also said that there was no documentation to support the change in Mr W's category, from 3 to 2, as this may have been done during a phone call.

27. The Health Board stated that, due to administrative error, Mr W's new clock was restarted the same day (14 October 2023). However, the new clock should have started from when he was deemed medically fit for surgery in February 2024. It said, therefore, Mr W had been advantaged by 4 months on the waiting list, as a result of this error.

28. The Health Board said that, in February 2025, while Mr W was awaiting further cardiac investigations following a pre-operative assessment, Mr W's waiting list remained open. The Health Board said that he should have been removed from the waiting list, in line with RTT

guidance. However, it said discretion had been used following discussions with the Health Board's Chief Operating Officer, based on the length of time Mr W had already waited. Unfortunately, following a subsequent review, it had been decided that Mr W was no longer medically fit to proceed with surgery, and he had been removed from the list.

29. The Health Board said that it endeavoured to ensure all patients are kept informed of pathway changes but, due to staff turnover, it had been unable to identify if any staff members were asked to inform Mr W of his pathway change. It said that there was learning to be had, and it would ensure this was reinforced to the administrative teams. It said that staff were documenting, in the notes section of patient referrals, the date of contact with patients to ensure this was captured.

30. The Health Board said that in October 2023 the waiting time for surgery was 3-4 years and the target of no patient waiting more than 3 years for treatment by March 2024 was achieved. Therefore, it said that, had Mr W's waiting time clock not been reset in October 2023, he would have received his surgery by March 2024.

31. In commenting on the draft investigation report, the Health Board said that relevant senior members of staff had reviewed Mr W's waiting list pathway. It said that it had applied the RTT guidance correctly in removing Mr W from the waiting list as only patients considered ready for treatment should be actively waiting. When a patient could not be signed off by the pre-operative assessment as ready for treatment, as was the case for Mr W, and their care passed to another consultant then the original pathway is stopped and a new pathway begins. In providing its comments, the Health Board said it had applied paragraph 95 of the RTT guidance which states:

“If, in the opinion of a suitably qualified healthcare professional, a patient has a medical condition which will not be resolved within 21 days, the patient should be returned to the referring clinician, or to another clinician who will treat the condition, and the clock will stop. The clock stop date will be the date the patient is determined to be medically unavailable for this period.”

32. The Health Board said that it fully appreciated that improved and transparent communication with Mr W would have improved his patient experience, which was always of the utmost importance to the Health Board.

33. The Health Board subsequently further commented that, once it was known that Mr W did not require a repeat CT scan, the clock stop on his pathway should have been removed. The Health Board then confirmed that it accepted the draft report fully and its recommendations.

### **Previous investigations**

34. In January 2024, I issued 3 public interest reports (202200425, 202201496 and 202200361) in relation to the Health Board's management of waiting lists for orthopaedic treatment. These reports detailed reasons for long waiting times for orthopaedic surgery at the Health Board. This included a lack of facilities, insufficient staff numbers, unclear management arrangements and unclear processes for these operations. The reports also detailed the action the Health Board was taking to address the waiting times. I have therefore not repeated this information here.

35. These investigations identified that in all 3 cases the complainants had been treated unfairly because of errors in the way the waiting lists for orthopaedic surgery were managed. As a result of these findings the Health Board agreed to audit the whole of its waiting list to establish whether errors had been made with the waiting list times, or if there had been any improper removals. The Health Board confirmed to my office that it had completed the audit of waiting times from April 2023. This found that patients had either been correctly managed in line with the RTT guidance or, where it identified errors, it stated they had not had a detrimental impact on the waiting time for any patient and in fact had put them ahead.

36. In commenting on the draft report, the Health Board provided further detail of the actions it had taken since these previous investigation reports were issued. It said that it had introduced safeguards to safety net patients who are removed from the waiting list

and require optimisation, to ensure that they are not disadvantaged when they re-commence their wait when they are medically fit to proceed with their surgery. This included coding the patients with a specific code when they are removed from the waiting list so that they are visible to waiting list staff, tracked and regularly reviewed. Patients who are returned to the list have a specific priority to ensure they are visible and treated in line with their original waiting list date. The Health Board said it recognised its communication with patients required improvement and it had introduced a project group to address this. It said all calls to the Waiting List Department are now recorded so that there is a record of what was discussed. It also said that monthly waiting list audits are undertaken and reviewed to monitor patient pathways and appropriate application of the RTT guidance. Finally, the Health Board said it had introduced a “Planned Care Academy” to provide regular training and review of the RTT guidance and it had been chosen to host an all-Wales task and finish group for all health boards in Wales to work collaboratively to improve waiting lists. It will also be developing a system to address how the outcome of pre-operative assessments are communicated.

## **Analysis and conclusions**

37. Mr W was added to the waiting list for orthopaedic surgery in August 2019. Without his knowledge, his waiting time clock was re-set in October 2023. The Health Board has already acknowledged that Mr W should have been informed of this decision and apologised for this. It must have been a huge shock for Mr W to read in the complaint response that his waiting time was recorded as being just over 60 weeks when he considered he had been waiting over 5 years.

38. During the pre-operative assessment in October 2023, it was decided that Mr W required further assessments to determine if he was fit to proceed with surgery. Mr W had previously been deemed fit for surgery but, as pre-operative assessments are only valid for 6 months, due to the length of time Mr W had needed to wait, further assessment was required.

39. The Health Board has said that it was appropriate to re-set Mr W's clock at this time as he was unfit to proceed with the procedure. However, the Health Board has not provided any evidence of a clinician documenting that Mr W was medically unfit to proceed at this point.

40. The Anaesthetist's pre-operative assessment in October 2023 noted that the last ECHO and CT scan were more than 2 years ago. The assessment then noted that an ECHO was requested, and a consultant was contacted about a repeat CT scan. It did not state that Mr W was medically unfit for surgery. The same document was subsequently updated in February 2024. The decision noted on the document was "Fit To Proceed".

41. I do not accept the Health Board's position that Mr W was clinically assessed as medically unfit to proceed with surgery. Instead, it was assessed that further information was required to determine his fitness to proceed. It was then found that a repeat CT was not necessary, and an ECHO was done 3 weeks later, although the results were not reviewed for a further 3 months. On the date that the information was assessed, he was found to be fit to proceed.

42. It is deeply concerning that, following my previous investigations into the Health Board's management of orthopaedic waiting lists, it carried out a full audit but did not identify this error. In addition, the Health Board reviewed Mr W's case when providing its complaint response and when providing comments to my office and yet it still did not recognise this error. The Health Board maintained its position that it was appropriate for a patient, who had already been waiting 4 years for surgery, to have his waiting time clock re-set. This was despite pre-operative assessments and tests needing to be repeated as a result of the Health Board's backlog of patients. These assessments and tests subsequently confirmed Mr W's fitness. This raises further concerns about whether other patients have also had their waiting time clock inappropriately re-set and calls into question the reliability of the audit undertaken as a result of the recommendations contained in my previous report.

43. The re-setting of Mr W's waiting time clock in October 2023 was incorrect and amounts to maladministration. This resulted in Mr W not receiving his surgery, during which time he experienced pain, reduced mobility and ongoing frustration on a daily basis. Further to this, he is now in a position where he is not able to proceed with the surgery and this opportunity has been lost. This was, and continues to be, a significant and ongoing injustice to him. Mr W has expressed a wish for the Health Board to improve the service it provides, "to take the best care of the health of the people that they are responsible for." Mr W is not seeking financial redress.

44. In addition, the Health Board itself identified errors in the management of this case. An administrative error occurred when re-setting the clock, although it considered this benefited Mr W by 4 months on the waiting list. It also acknowledged it should have informed Mr W of the change in his waiting time. It is very concerning that multiple errors have occurred in the management of Mr W's case. The RTT guidance is clear that patients should be involved in decisions and these decisions be communicated to them. In fact, paragraph 88 of the RTT guidance, which the Health Board stated it applied in this case, is clear that the date the clock is stopped is the date that it is explained to the patient. Therefore, even if a stop at this point had been appropriate, it should not have been applied until this was explained to Mr W, which in this case did not happen. The failings identified in this case have led me to conclude that there are systemic failures in the Health Board's management of its waiting lists and its understanding of the RTT guidance.

45. For the reasons outlined above, I **uphold** this complaint.

46. In view of the significant and systemic failings identified in this report, I am sharing my report with the Cabinet Secretary for Health and Social Care and Healthcare Inspectorate for Wales.

47. I was also concerned that, during this investigation, the Health Board was unable to provide copies of some evidence that was requested. In January 2022, my predecessor issued "[Good Records Management Matters](#)". This detailed the importance of good record

keeping, to create confidence in decision making, accountability and to enable others to verify what has been done. I **invite** the Health Board to consider this guidance and the importance of accurate record keeping.

## Recommendations

48. I **recommend** that, within **4 weeks** of the final report being issued, the Health Board should:

- a) Arrange for the Chief Executive to make an apology to Mr W for the failings identified in the management of his waiting time for surgery.
- b) Share this report with relevant staff and reflect on the failings identified, in particular the need for there to be a well documented clinical decision before a patient is deemed unfit for surgery.

49. I **recommend** that, within **12 weeks** of the final report being issued, the Health Board should:

- c) Appoint an independent person<sup>1</sup> to re-audit its orthopaedic waiting list to establish if any other patients have been treated incorrectly in the same way as Mr W, including incorrect waiting time re-set date and/or not being informed of their waiting time clock being re-set. If any are identified, the Health Board should apologise to those patients and ensure the correct waiting list date is recorded. The Health Board should propose a scope for the audit that should be agreed by this office before the audit commences.
- d) Given that the Health Board remained of the view during the course of my investigation, that it was appropriate to reset the clock in Mr W's case, it should ensure its training for staff on the application of the RTT guidance includes this type of scenario, to ensure that its approach to waiting list management is in keeping with the RTT guidance.

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<sup>1</sup> A suitably qualified individual not employed by the Health Board

e) Share the report with its Board which should nominate a Committee to maintain oversight and monitoring of the Health Board's compliance with these recommendations.

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

20 November 2025

**Michelle Morris**

Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

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Yr ymchwiliad i gŵyn yn erbyn  
Bwrdd Iechyd Prifysgol Bae Abertawe

Adroddiad gan  
Ombwdsmon Gwasanaethau Cyhoeddus  
Cymru  
Achos: 202407678

<b>Cynnwys</b>	<b>Tudalen</b>
Cyflwyniad	1
Crynodeb	2
Y gŵyn	4
Yr ymchwiliad	4
Deddfwriaethau a chanllawiau cenedlaethol perthnasol	4
Y digwyddiadau cefndir	5
Tystiolaeth Mr W	7
Tystiolaeth y Bwrdd Iechyd	8
Ymchwiliadau blaenorol	10
Dadansoddiad a chasgliadau	11
Argymhellion	14

## Cyflwyniad

Cyhoeddir yr adroddiad hwn o dan adran 23 Deddf Ombwdsmon Gwasanaethau Cyhoeddus (Cymru) 2019.

Rydym wedi cymryd camau i ddiogelu hunaniaeth yr achwynydd ac eraill, cyn belled ag y bo modd. Mae enw'r achwynydd ac eraill wedi'u newid hefyd.

## Crynodeb

Cwynodd Mr W ynglŷn â'r oedi wrth aros i gael llawdriniaeth i gael pen-glin newydd gan Fwrdd Iechyd Prifysgol Bae Abertawe, yr oedd wedi bod yn aros i'w chael ers Awst 2019. Bu'r ymchwiliad yn ystyried a gafodd amser aros Mr W ar gyfer y llawdriniaeth ei reoli'n briodol yn unol â Rheolau Rheoli Amseroedd Aros Rhwng Atgyfeirio a Thriniaeth Llywodraeth Cymru, yn benodol pan gafodd ei gloc amser aros ei ailosod ym mis Hydref 2023.

Canfu'r ymchwiliad bod cloc amser aros Mr W wedi'i ailosod yn amhriodol ym mis Hydref 2023. Ni chanfuwyd unrhyw dystiolaeth bod clinigydd wedi cofnodi nad oedd Mr W yn ffit yn feddygol i fwrw ymlaen â'r llawdriniaeth. Roedd angen cynnal sgan arall ar Mr W oherwydd yr amser yr oedd wedi bod yn aros, a gadarnhaodd ei ffitrwydd i gael y llawdriniaeth. Ni chafodd y penderfyniad i ailosod y cloc amser aros ei gyfleu i Mr W a daeth ond yn ymwybodol o hyn pan wnaeth gŵyn. O ganlyniad i'r oedi, roedd Mr W wedi profi poen, llai o symudedd a rhwystredigaeth barhaus. Yn ogystal â hyn, mae bellach mewn sefyllfa lle nad yw'n gallu bwrw ymlaen â'r llawdriniaeth ac mae'r cyfle hwn wedi'i gollu.

Ym mis Ionawr 2024, cyhoeddodd y swyddfa hon 3 adroddiad er budd y cyhoedd mewn cysylltiad â'r ffordd yr oedd y Bwrdd Iechyd yn rheoli'r rhestr aros ar gyfer triniaeth orthopedig. Canfu'r adroddiadau hyn, ym mhob un o'r 3 achos, bod yr achwynwyr wedi derbyn triniaeth annheg oherwydd camgymeriadau yn y ffordd yr oedd y rhestrau aros ar gyfer llawdriniaethau orthopedig yn cael eu rheoli. Un o'r argymhellion yn yr adroddiadau hynny oedd y dylai'r Bwrdd Iechyd gynnal archwiliad o'u rhestrau aros er mwyn sefydlu a wnaed unrhyw gamgymeriadau eraill mewn cysylltiad ag ailosod amseroedd rhestrau aros neu dynnu enwau'n amhriodol oddi ar y rhestr. Mae'n destun pryder bod gwallau pellach wedi'u canfod er bod yr archwiliad hwn wedi'i gynnal. Mae hyn yn codi pryder ynghylch dibynadwyedd yr archwiliad a gynhaliwyd gan y Bwrdd Iechyd yn flaenorol.

Cytunodd y Bwrdd Iechyd i'r argymhellion canlynol:

- a) Trefnu i'r Prif Weithredwr wneud ymddiheuriad i Mr W am y methiannau a nodwyd yn y ffordd y rheolwyd ei amser aros ar gyfer llawdriniaeth.
- b) Rhannu'r adroddiad hwn gyda'r staff perthnasol a myfyrio ar y methiannau a nodwyd, yn arbennig yr angen am benderfyniad clinigol wedi'i ddogfennu'n dda cyn ystyried nad yw claf yn ffit ar gyfer llawdriniaeth.
- c) Penodi person annibynnol i ail-archwilio eu rhestr aros orthopedig i sefydlu a yw unrhyw gleifion eraill wedi derbyn triniaeth anghywir yn yr un ffordd â Mr W, gan gynnwys ailosod dyddiad amser aros anghywir a/neu beidio cael eu hysbysu ynglŷn â'r ffaith bod eu cloc amser aros wedi'i ailosod. Os nodir unrhyw rai, dylai'r Bwrdd Iechyd ymddiheuro i'r cleifion hynny a sicrhau bod y dyddiad rhestr amser cywir yn cael ei gofnodi. Dylai'r Bwrdd Iechyd gynnig cwmpas ar gyfer yr archwiliad, i'w gytuno gyda'r swyddfa hon, cyn dechrau'r archwiliad.
- ch) O ystyried bod y Bwrdd Iechyd wedi cynnal y safbwynt, yn ystod fy ymchwiliad, ei bod yn briodol ailosod y cloc yn achos Mr W, dylent sicrhau bod eu hyfforddiant i staff ar gymhwyso'r canllawiau Atgyfeirio i Driniaeth (AiD) yn cynnwys y math hwn o senario, i sicrhau bod eu proses o reoli rhestrau aros yn cydymffurfio â'r canllawiau AiD.
- d) Rhannu'r adroddiad gyda'i Fwrdd a ddylai enwebu Pwyllgor i oruchwylio a monitro cydymffurfiaeth y Bwrdd Iechyd â'r argymhellion hyn.

## Y Gŵyn

1. Cwynodd Mr W ynglŷn â'r oedi wrth aros i gael llawdriniaeth i gael pen-glin newydd gan Fwrdd Iechyd Prifysgol Bae Abertawe ("y Bwrdd Iechyd"). Bu'r ymchwiliad yn ystyried a gafodd amser aros Mr W ar gyfer y llawdriniaeth ei reoli'n briodol yn unol â Rheolau Rheoli Amseroedd Aros Rhwng Atgyfeirio a Thriniaeth Llywodraeth Cymru, yn benodol pan gafodd ei gloc amser aros ei ailosod ym mis Hydref 2023.

## Yr Ymchwiliad

2. Casglodd fy Swyddog Ymchwilio sylwadau a chopïau o ddogfennau perthnasol gan y Bwrdd Iechyd ac rwyf wedi ystyried y rhain ochr yn ochr â'r dystiolaeth a ddarparwyd gan Mr W. Nid wyf wedi cynnwys yr holl fanylion yr ymchwiliwyd iddynt yn yr adroddiad hwn, ond rwy'n fodlon nad oes unrhyw beth arwyddocaol wedi'i ddiystyru.

3. Rhoddwyd cyfle i Mr W a'r Bwrdd Iechyd weld copi drafft o'r adroddiad hwn a rhoi eu sylwadau arno cyn cyhoeddi'r fersiwn derfynol.

## Deddfwriaethau a chanllawiau cenedlaethol perthnasol

4. Rheolau Rheoli Amseroedd Aros Rhwng Atgyfeirio a Thriniaeth Llywodraeth Cymru ("canllaw AiD") Fersiwn 7, Hydref 2017:

- Ym mis Mawrth 2005 cyhoeddodd Prif Weinidog Cymru a'r Gweinidog Iechyd a Gwasanaethau Cymdeithasol na fyddai unrhyw glaf yng Nghymru, erbyn Rhagfyr 2009, yn aros mwy na 26 wythnos o gael eu hatgyfeirio gan feddyg teulu ar gyfer triniaeth, gan gynnwys amseroedd aros ar gyfer unrhyw brofion diagnostig neu therapïau angenrheidiol. Byrddau iechyd sy'n gyfrifol am gyflawni targed 26 wythnos AiD.
- Byddai uchafswm arhosiad o 26 wythnos yn cael ei ganiatáu ar gyfer cleifion sy'n gymhleth yn glinigol, ac mae gwahanol dargedau yn berthnasol i fathau penodol o driniaethau, er enghraifft prawf diagnostig (er enghraifft pelydr X) a thriniaeth ar gyfer canser. Mae'r amser aros yn dechrau wrth dderbyn atgyfeiriad gan weithiwr gofal iechyd proffesiynol at feddyg ymgynghorol a dyma yw

dechrau'r cloc amser aros. Gall y cloc ddechrau neu stopio ar adegau dynodedig sy'n cael eu hesbonio yn y canllawiau AiD.

- Mae paragraff 76 yn cynnwys “...O fewn cyfnod AiD, bydd y cloc yn parhau i dician nes gwneir penderfyniad clinigol i stopio...”
- Mae paragraff 78 yn datgan “Bydd pob atgyfeiriad o fewn llwybr AiD at brofion diagnostig, asesiadau therapi neu asesiadau anesthetig yn gwneud i'r cloc barhau.”
- Mae paragraff 88 yn datgan “Pan gaiff claf ei drosglwyddo rhwng meddygon ymgynghorol gwahanol oherwydd anghenraid clinigol, sy'n atal y llwybr presennol rhag cael ei gwblhau, bydd y cloc yn stopio. Fodd bynnag, os mai cais am gyngor yw hyn yn syml rhaid rheoli hyn o fewn y cyfnod AiD 26 wythnos. Y dyddiad yr esbonnir bod y cyfrifoldeb clinigol am eu gofal yn cael ei drosglwyddo i feddyg ymgynghorol arall fydd y dyddiad stopio'r cloc.”
- Mae paragraff 95 yn datgan “Os bydd gweithiwr gofal iechyd proffesiynol cymwysedig o'r farn bod gan glaf gyflwr meddygol na chaiff ei ddatrys o fewn 21 diwrnod, dylai'r claf gael ei ddychwelyd at ei glinigydd atgyfeirio, neu glinigydd arall a wnaiff drin y cyflwr, a bydd y cloc yn stopio..”

5. Polisi Mynediad Cleifion y Bwrdd Iechyd (2017). Mae'r polisi hwn yn datgan y gellir tynnu cleifion oddi ar y rhestr aros os nad ydynt yn ffit i fwrw ymlaen am fwy na 3 wythnos. Bydd enwau cleifion yn cael eu hadfer i'r rhestr aros ar ôl cael gwybod eu bod bellach yn ffit. Bydd llwybr newydd yn dechrau a dylid trefnu cleifion gan ystyried eu cyfnod aros blaenorol.

## Y digwyddiadau cefndir

6. Ar 13 Awst **2019** ychwanegwyd Mr W at restr aros y Bwrdd Iechyd i gael pen-glin chwith gyflawn newydd. Roedd Mr W yn benderfynol o fod yn glaf categori 3 (mae'r Bwrdd Iechyd yn defnyddio 4 math o gategori – 4 yw arferol, 3 yw brys, 2 yw brys iawn ac 1 yw canser neu ofal argyfwng).

7. Ar 14 Medi **2020** cafodd Mr W asesiad cyn llawdriniaeth ac aseswyd ei fod yn ffit i gael y llawdriniaeth.

8. Rhoddwyd enw Mr W ar y rhestr ar gyfer llawdriniaeth ar 17 Medi yn Ysbyty Castell-nedd Port Talbot. Fodd bynnag, ni fu'n bosibl cynnal y llawdriniaeth hon oherwydd nodwyd bod angen i Mr W gael y llawdriniaeth yn Ysbyty Treforys ("yr Ysbyty"), oherwydd ei gyflyrau iechyd isorweddol eraill.

9. Yn ystod y pandemig COVID-19, aseswyd bod llawdriniaethau orthopedig wedi'u hatal yn yr Ysbyty. Achosodd hyn ôl-groniad sylweddol o gleifion a chynnydd i amseroedd aros, gan gynnwys i Mr W.

10. Ym mis Tachwedd **2022** ail-ddechreuodd llawdriniaethau orthopedig yn yr Ysbyty.

11. Ar 2 Hydref **2023** cafodd Mr W brofion gyda nyrs i hysbysu asesiad cyn llawdriniaeth. Ar 6 Hydref, cyfarfu Mr W â llawfeddyg orthopedig a gadarnhaodd ei fod yn fodlon bwrw ymlaen â'r llawdriniaeth ar ben-glin Mr W. Ar 14 Hydref, adolygwyd canlyniadau'r asesiad cyn llawdriniaeth gan anesthetydd ymgynghorol ("yr Anesthetydd"). Gofynnodd yr Anesthetydd am echocardiogram ("ECHO" – sgan a ddefnyddir i greu delweddau o'r galon a'r rhydweliâu gwaed amgylchynol). Fe wnaethant ysgrifennu hefyd at lawfeddyg cardiothorasig ymgynghorol i ofyn am sgan tomograffeg gyfrifiadurol ("sgan CT – y defnydd o sganiau pelydr x a chyfrifiadur i greu delwedd o'r tu mewn i'r corff) o galon Mr W, oherwydd bod dros 2 flynedd wedi bod ers cynnal yr un diwethaf. Nid oedd y ffurflen asesu cyn llawdriniaeth yn nodi yn unman fod Mr W wedi derbyn asesiad penodol a oedd yn dangos nad oedd yn ffit i fwrw ymlaen â'r llawdriniaeth.

12. Ar 14 Hydref, ailosodwyd cloc amser aros Mr W. Y rheswm a roddwyd am hyn oedd nad oedd yn ffit i fwrw ymlaen â'r llawdriniaeth ar y pryd. Ni chafodd Mr W wybod am y penderfyniad hwn.

13. Ar 3 Tachwedd, cafodd Mr W ECHO. Ysgrifennodd llawfeddyg cardiothorasig ymgynghorol at yr Anesthetydd hefyd yn cynghori bod sgan CT wedi'i gynnal ym mis Tachwedd 2022 ac felly nid oedd angen cynnal un arall.

14. Ar 2 Chwefror **2024** cafodd canlyniadau ECHO Mr W eu hadolygu gan yr Anesthetydd a diweddarwyd y ffurflen asesiad cyn llawdriniaeth. Ystyriwyd ei fod yn ffit yn feddygol i gael y llawdriniaeth.

15. Ar 25 Tachwedd cwynodd Mr W wrth y Bwrdd Iechyd ynglŷn â'i gyfnod aros ar gyfer y llawdriniaeth.
16. Ar 29 Tachwedd derbyniodd Mr W asesiad cyn llawdriniaeth pellach. Cafwyd trafodaeth "onest" ynglŷn â risgiau'r llawdriniaeth i Mr W. Nodwyd bod Mr W wedi datgan ei fod yn dymuno bwrw ymlaen â'r llawdriniaeth.
17. Yn ystod mis Tachwedd, symudwyd Mr W i gategori 2 (brys iawn).
18. Ar 12 Rhagfyr, cyflwynodd y Bwrdd Iechyd ymateb i gŵyn Mr W, lle esboniwyd bod ei gloc amser aros wedi'i ailosod ym mis Hydref 2023. Esboniwyd bod Mr W ond yn addas ar gyfer llawdriniaeth yn yr Ysbyty a oedd yn profi cyfnod o bwysau parhaus. Ysgrifennodd Mr W yn ôl a datgan nad oedd yn ymwybodol cyn hyn bod ei gloc amser aros wedi'i ailosod.
19. Ar 17 Rhagfyr, ysgrifennodd y Bwrdd Iechyd at Mr W eto. Esboniwyd y bu'n rhaid cynnal ymchwiliadau pellach arno i sicrhau ei ffitrwydd ar gyfer y llawdriniaeth, ystyriwyd nad oedd yn ffit yn feddygol am fwy na 21 diwrnod, yn unol â'r canllawiau AiD. Ymddiheurodd nad oedd wedi'i hysbysu ynglŷn â hyn. Dywedwyd bod llwybr Mr W yn gywir ac ar yr adeg honno, roedd wedi bod yn aros am ychydig dros 60 wythnos.
20. Ar 3 Ionawr **2025** cwynodd Mr W i fy swyddfa ei fod yn parhau i aros am ei llawdriniaeth.
21. Ar 21 Mawrth, mynychodd Mr W adolygiad gyda llawfeddyg orthopedig. Penderfynwyd nad oedd gan Mr W ddigon o botensial adsefydlu bellach i ymgymryd â'r ffisiotherapi dwys sy'n ofynnol i sicrhau canlyniad da di-boen o'r llawdriniaeth. Cafodd ei dynnu oddi ar y rhestr aros a gwnaed cynllun ar gyfer rheoli poen.

## Tystiolaeth Mr W

22. Cwynodd Mr W ei fod wedi bod yn aros am dros 5 mlynedd am llawdriniaeth ar ei ben-glin chwith. Dywedodd ei fod ond wedi canfod bod ei gloc amser aros wedi'i ailosod pan dderbyniodd ymateb i'w gŵyn i'r Bwrdd Iechyd, ym mis Rhagfyr 2024. Roedd yn credu bod y Bwrdd Iechyd yn "ffugio'r amseroedd aros".

23. Roedd Mr W wedi gweld yn y cyfryngau yr ymchwiliadau hynny sydd wedi'u cynnal gan y swyddfa hon a nododd bod cleifion yn cael eu trin yn annheg gan y Bwrdd Iechyd a bod y Bwrdd Iechyd wedi datgan na fyddai unrhyw glaf wedi gorfod aros mwy na 3 blynedd erbyn diwedd mis Mawrth 2024. Fodd bynnag, roedd ef wedi bod yn aros am 5 mlynedd a 4 mis. Dywedodd bod y Bwrdd Iechyd yn dweud yn awr ei fod ond wedi bod yn aros am 60 wythnos, ond mewn gwirionedd roedd yn 276 wythnos.

24. Cwestiynodd Mr W sut y gallai'r Bwrdd Iechyd ddweud nad oedd yn ffit yn feddygol i gael llawdriniaeth am fwy na 21 diwrnod gan nad oedd wedi cael unrhyw brofion nac ymgynghoriadau, heblaw am asesiadau cyn llawdriniaeth, ac wedi hynny dywedwyd wrtho ei fod yn iawn.

### **Tystiolaeth y Bwrdd Iechyd**

25. Dywedodd y Bwrdd Iechyd ei bod yn briodol stopio cloc Mr W ym mis Hydref 2023 oherwydd ystyriwyd nad oedd yn ffit i gael y llawdriniaeth a bod angen ymyrraeth ac ymchwiliadau gan y gwasanaethau cardiaidd cyn cadarnhau ei fod yn ffit i fwrw ymlaen. Dywedodd bod hyn wedi'i wneud yn unol â pharagraff 88 y canllawiau AiD. Dywedodd eu bod wedi ymddiheuro'n gynharach nad oedd y wybodaeth hon wedi'i chyfleu'n briodol i Mr W.

26. Dywedodd y Bwrdd Iechyd na allai ddarparu copi o'r ohebiaeth a anfonwyd at yr Anesthetydd gan lawfeddyg cardiothorasig ymgynghorol bod sgan CT wedi'i gwblhau ym mis Tachwedd 2022, am na lwyddwyd i'w leoli. Dywedodd y Bwrdd Iechyd hefyd nad oedd unrhyw ddogfennaeth i gefnogi'r newid i gategori Mr W, o 3 i 2, oherwydd mae'n bosibl i hyn gael ei wneud yn ystod galwad ffôn.

27. Dywedodd y Bwrdd Iechyd, o ganlyniad i gamgymeriad gweinyddol, y cafodd cloc newydd Mr W ei aildechrau'r un diwrnod (14 Hydref 2023). Fodd bynnag, dylai'r cloc newydd fod wedi dechrau pan ystyriwyd ei fod yn ffit yn feddygol i gael y llawdriniaeth ym mis Chwefror 2024. Dywedodd felly bod Mr W wedi derbyn mantais o 4 mis ar y rhestr aros, o ganlyniad i'r camgymeriad hwn.

28. Dywedodd y Bwrdd Iechyd, ym mis Chwefror 2025, wrth i Mr W aros am ymchwiliadau cardiaidd pellach yn dilyn asesiad cyn llawdriniaeth, bod rhestr aros Mr W wedi parhau i fod ar agor. Dywedodd y Bwrdd Iechyd y

dylid bod wedi tynnu ei enw oddi ar y rhestr aros, yn unol â'r canllawiau AiD. Fodd bynnag, dywedwyd eu bod wedi defnyddio disgresiwn yn dilyn trafodaethau gyda Phrif Swyddog Gweithredu'r Bwrdd Iechyd. Yn anffodus, yn dilyn adolygiad dilynol, penderfynwyd nad oedd Mr W yn ffit yn feddygol mwyach i fwrw ymlaen â'r llawdriniaeth, a bod ei enw wedi'i dynnu oddi ar y rhestr.

29. Dywedodd y Bwrdd Iechyd eu bod yn ymdrechu i sicrhau bod pob claf yn cael eu hysbysu ynghylch newidiadau i'w llwybr ond, oherwydd trosiant staff, ni fu'n bosibl canfod a ofynnwyd i unrhyw aelod o staff hysbysu Mr W am y newid i'w lwybr. Dywedwyd bod gwersi i'w dysgu, ac y byddent yn sicrhau bod hyn yn cael ei bwysleisio i'r timau gweinyddol. Dywedodd bod staff yn dogfennu, yn adran nodiadau atgyfeiriadau claf, dyddiadau cysylltu â chleifion er mwyn sicrhau bod hyn yn cael ei gofnodi.

30. Dywedodd y Bwrdd Iechyd mai'r amser aros ar gyfer llawdriniaeth ym mis Hydref 2023 oedd 3-4 mlynedd a bod y targed o sicrhau nad oedd unrhyw glaf yn aros mwy na 3 blynedd am driniaeth erbyn mis Mawrth 2024 wedi'i gyflawni. Felly, dywedodd, pe na fyddai cloc amser aros Mr W wedi'i ailosod ym mis Hydref 2023, y byddai wedi derbyn ei lawdriniaeth erbyn mis Mawrth 2024.

31. Wrth roi sylwadau ar adroddiad drafft yr ymchwiliad, dywedodd y Bwrdd Iechyd bod uwch aelodau o staff perthnasol wedi adolygu llwybr rhestr aros Mr W. Dywedodd eu bod wedi cymhwyso'r canllawiau AiD yn gywir, wrth dynnu enw Mr W oddi ar y rhestr aros, oherwydd dim ond cleifion sy'n barod am driniaeth ddylai fod yn aros yn weithredol. Pan na fydd yr asesiad cyn llawdriniaeth yn gallu cymeradwyo claf eu bod yn barod am driniaeth, fel yn achos Mr W, a bod eu gofal yn cael ei drosglwyddo i feddyg ymgynghorol arall yna mae'r llwybr gwreiddiol yn cael ei atal ac mae llwybr newydd yn dechrau. Wrth ddarparu ei sylwadau, dywedodd y Bwrdd Iechyd ei fod wedi cymhwyso paragraff 95 y canllawiau AiD sy'n datgan:

“Os bydd gweithiwr gofal iechyd proffesiynol cymwysedig o'r farn bod gan glaf gyflwr meddygol na chaiff ei ddatrys o fewn 21 diwrnod, dylai'r claf gael ei ddychwelyd at ei glinigydd atgyfeiriol, neu glinigydd arall a wnaiff drin y cyflwr, a bydd y cloc yn stopio. Dyddiad stopio'r cloc fydd y dyddiad y tybir nad yw'r claf ar gael yn feddygol ar gyfer y cyfnod hwn.”

32. Dywedodd y Bwrdd Iechyd ei fod yn gwerthfawrogi'n llwyr y byddai cyfathrebu gwell ac agored gyda Mr W wedi gwella ei brofiad fel claf, a oedd bob amser o'r pwys mwyaf i'r Bwrdd Iechyd.

33. Aeth y Bwrdd Iechyd ymlaen i ddatgan ymhellach, unwaith yr oedd yn hysbys nad oedd angen sgan CT arall ar Mr W, y dylid bod wedi tynnu'r cloc stopio o'i lwybr. Yna cadarnhaodd y Bwrdd Iechyd eu bod yn derbyn yr adroddiad drafft yn llwyr a'i argymhellion.

## **Ymchwiliadau blaenorol**

34. Ym mis Ionawr 2024, cyhoeddais 3 adroddiad budd y cyhoedd (202200425, 202201496 a 202200361) mewn cysylltiad â dulliau'r Bwrdd Iechyd o reoli rhestrau aros ar gyfer triniaeth orthopedig. Roedd yr adroddiadau hyn yn manylu ar resymau dros amseroedd aros hir ar gyfer llawdriniaeth orthopedig yn y Bwrdd Iechyd. Roedd hyn yn cynnwys diffyg cyfleusterau, niferoedd staff annigonol, trefniadau rheoli aneglur a phrosesau aneglur ar gyfer y llawdriniaethau hyn. Roedd yr adroddiadau hefyd yn manylu ar y camau yr oedd y Bwrdd Iechyd yn eu cymryd i fynd i'r afael â'r amseroedd aros. Felly nid wyf wedi ailadrodd y wybodaeth hon yma.

35. Canfu'r ymchwiliadau hyn bod yr achwynwyr wedi'u trin yn annheg ym mhob un o'r 3 achos oherwydd camgymeriadau yn y ffordd yr oedd y rhestrau aros ar gyfer llawdriniaethau orthopedig yn cael eu rheoli. O ganlyniad i'r canfyddiadau hyn, cytunodd y Bwrdd Iechyd i archwilio eu rhestrau aros yn eu cyfanrwydd i sefydlu a wnaed camgymeriadau gyda'r amseroedd aros, neu a dynnwyd unrhyw enwau yn amhriodol. Cadarnhaodd y Bwrdd Iechyd i fy swyddfa eu bod wedi cwblhau'r archwiliad o'r amseroedd aros o fis Ebrill 2023. Canfu'r archwiliad hwn bod cleifion wedi'u rheoli'n gywir yn unol â'r canllawiau AiD neu, pan nododd gamgymeriadau, dywedodd na chafodd hyn effaith niweidiol ar yr amser aros ar gyfer unrhyw glaf ac yn wir roedd wedi eu rhoi ymhellach ymlaen.

36. Wrth roi sylwadau ar yr adroddiad drafft, darparodd y Bwrdd Iechyd fanylion pellach o'r camau yr oedd wedi'u cymryd ers cyhoeddi'r adroddiadau ymchwiliadau blaenorol. Dywedodd eu bod wedi cyflwyno mesurau diogelwch i ddiogelu cleifion sy'n cael eu tynnu oddi ar y rhestr aros ac y mae angen eu hoptimeiddio, er mwyn sicrhau

nad ydynt dan anfantais pan fyddant yn ailddechrau aros pan fyddant yn feddygol ffit i fwrw ymlaen â'u llawdriniaeth. Roedd hyn yn cynnwys codio'r cleifion â chod penodol pan fyddant yn cael eu tynnu oddi ar y rhestr aros er mwyn sicrhau eu bod yn weladwy i staff rhestrau aros, a'u bod yn cael eu holrhain a'u hadolygu'n rheolaidd. Mae gan gleifion sy'n cael eu dychwelyd i'r rhestr flaenoriaeth benodol i sicrhau eu bod yn weladwy a'u bod yn cael eu trin yn unol â'u dyddiad rhestr aros wreiddiol. Dywedodd y Bwrdd Iechyd eu bod yn cydnabod bod angen gwella'r ffordd yr oeddent yn cyfathrebu gyda chleifion, a'u bod wedi cyflwyno grŵp prosiect i fynd i'r afael â hyn. Dywedodd bod pob galwad i'r Adran Rhestr Aros yn cael eu recordio yn awr er mwyn cael cofnod o'r hyn a drafodwyd. Dywedodd hefyd bod y rhestrau aros yn cael eu harchwilio'n fisol a'u hadolygu i fonitro llwybrau cleifion a defnydd priodol o'r canllawiau AiD. Yn olaf, dywedodd y Bwrdd Iechyd eu bod wedi cyflwyno "Academi Gofal Cynlluniedig" i ddarparu hyfforddiant rheolaidd ac adolygu'r canllawiau AiD a'u bod wedi'u dewis i gynnal grŵp gorchwyl a gorffen Cymru Gyfan ar gyfer yr holl fyrddau iechyd yng Nghymru i gydweithio er mwyn gwella rhestrau aros. Bydd hefyd yn datblygu system i fynd i'r afael â'r broses o gyfathrebu canlyniad asesiadau cyn llawdriniaeth.

## **Dadansoddiad a chasgliadau**

37. Ychwanegwyd enw Mr W i'r rhestr aros ar gyfer llawdriniaeth orthopedig ym mis Awst 2019. Heb yn wybod iddo, ailosodwyd ei gloc amser aros ym mis Hydref 2023. Mae'r Bwrdd Iechyd eisoes wedi cydnabod y dylai Mr W fod wedi cael gwybod am y penderfyniad hwn ac ymddiheurodd am hyn. Rhaid ei fod wedi bod yn sioc enfawr i Mr W ddarllen yn yr ymateb i'r gŵyn fod ei amser aros wedi'i gofnodi fel ychydig dros 60 wythnos pan oedd yn ystyried ei fod wedi bod yn aros dros 5 mlynedd.

38. Yn ystod yr asesiad cyn llawdriniaeth ym mis Hydref 2023, penderfynwyd bod angen asesiadau pellach ar Mr W i benderfynu a oedd yn ffit i fwrw ymlaen â'r llawdriniaeth. Roedd Mr W wedi cael ei ystyried yn ffit ar gyfer llawdriniaeth yn flaenorol ond, gan mai dim ond am 6 mis y mae asesiadau cyn llawdriniaeth yn ddilys, oherwydd yr amser y bu'n rhaid i Mr W aros, roedd angen asesiad pellach.

39. Dywedodd y Bwrdd Iechyd y bu'n briodol i ailosod cloc Mr W ar yr adeg hon am nad oedd yn ffit i fwrw ymlaen â'r driniaeth. Fodd bynnag, nid yw'r Bwrdd Iechyd wedi darparu unrhyw dystiolaeth o glinigydd yn dogfennu nad oedd Mr W yn ffit yn feddygol i fwrw ymlaen ar yr adeg hon.

40. Nododd asesiad cyn llawdriniaeth yr Anesthetydd ym mis Hydref 2023 bod y sganiau ECHO a CT wedi'u cynnal mwy na 2 flynedd yn gynharach. Yna nododd yr asesiad y gwnaed cais am ECHO, ac y cysylltwyd â meddyg ymgynghorol ynglŷn â sgan CT arall. Nid oedd yn nodi pam nad oedd Mr W yn ffit yn feddygol ar gyfer y llawdriniaeth. Diweddarwyd yr un ddogfen yn ddiweddarach yn Chwefror 2024. Y penderfyniad a nodwyd yn y ddogfen oedd "Ffit i Fwrw Ymlaen".

41. Nid wyf yn derbyn safbwynt y Bwrdd Iechyd bod Mr W wedi'i asesu fel claf nad oedd yn ffit yn feddygol i fwrw ymlaen â'r llawdriniaeth. Yn hytrach, aseswyd bod angen gwybodaeth bellach i benderfynu ar ei ffitrwydd i fwrw ymlaen. Yna canfuwyd nad oedd angen sgan CT arall, a chynhaliwyd ECHO 3 wythnos yn ddiweddarach, er na chafodd y canlyniadau eu hadolygu am 3 mis arall. Ar y diwrnod yr aseswyd y wybodaeth, canfuwyd ei fod yn ffit i fwrw ymlaen.

42. Mae'n destun pryder mawr, yn dilyn fy ymchwiliadau blaenorol i ddulliau'r Bwrdd Iechyd o reoli rhestrau aros orthopedig, ei fod wedi cynnal archwiliad llawn ond na chanfu'r gwall hwn. Yn ogystal, adolygodd y Bwrdd Iechyd achos Mr W wrth ddarparu eu hymateb i'r gŵyn a phan ddarparwyd sylwadau ganddynt i'm swyddfa ac eto ni chydnabu'r gwall hwn o hyd. Cynhaliodd y Bwrdd Iechyd eu safbwynt ei bod yn briodol i glaf, a oedd eisoes wedi bod yn aros 4 blynedd am llawdriniaeth, gael ei gloc amser aros wedi'i ailosod. Roedd hyn er gwaethaf yr angen i ailadrodd asesiadau a phrofion cyn llawdriniaeth o ganlyniad i ôl-groniad o gleifion y Bwrdd Iechyd. Cadarnhaodd yr asesiadau a'r profion hyn ffitrwydd Mr W wedi hynny. Mae hyn yn codi pryderon pellach ynghylch a yw cleifion eraill hefyd wedi cael eu cloc amser aros wedi'i ailosod yn amhriodol ac mae'n codi cwestiwn ynghylch dibynadwyedd yr archwiliad a gynhaliwyd o ganlyniad i'r argymhellion a gynhwysir yn fy adroddiad blaenorol.

43. Roedd ailosod cloc amser aros Mr W ym mis Hydref 2023 yn anghywir ac mae gyfystyr â chamweinyddu. Golygodd hyn na dderbyniodd Mr W ei lawdriniaeth, ac yn ystod y cyfnod hwn profodd boen, llai o symudedd a rhwystredigaeth barhaus yn ddyddiol. At hynny, mae mewn sefyllfa yn awr lle nad yw'n gallu bwrw ymlaen â'r llawdriniaeth ac mae'r cyfle hwn wedi'i golli. Roedd hyn, ac mae'n parhau i fod, yn anghyfiawnder arwyddocaol a pharhaus iddo. Mae Mr W wedi mynegi dymuniad i'r Bwrdd Iechyd wella'r gwasanaeth maent yn ei ddarparu, "i ofalu orau am iechyd y bobl y maent yn gyfrifol amdanynt." Nid yw Mr W yn ceisio iawn ariannol.

44. Yn ogystal, mae'r Bwrdd Iechyd ei hun wedi nodi camgymeriadau yn y broses o reoli'r achos hwn. Bu camgymeriad gweinyddol wrth ailosod y cloc, er yr ystyriwyd bod Mr W wedi elwa ar hynny o 4 mis ar y rhestr aros. Roedd hefyd yn cydnabod y dylent fod wedi hysbysu Mr W o'r newid yn ei amser aros. Mae'n bryderus iawn bod sawl camgymeriad wedi digwydd wrth reoli achos Mr W. Mae'r canllaw AiD yn datgan yn glir y dylai cleifion fod yn rhan o'r penderfyniadau ac y dylid cyfathrebu'r canlyniadau hyn iddyn nhw. Yn wir, mae paragraff 88 y canllawiau AiD, y dywedodd y Bwrdd Iechyd eu bod wedi'u cymhwyso yn yr achos hwn, yn datgan yn glir mai'r dyddiad y mae'r cloc yn cael ei stopio yw'r dyddiad y caiff ei egluro i'r claf. Felly, hyd yn oed pe bai stopio ar y pwynt hwn wedi bod yn briodol, ni ddylid bod wedi'i gymhwyso nes i hyn gael ei egluro i Mr W, ac ni ddigwyddodd hyn yn yr achos hwn. Mae'r methiannau a nodwyd yn yr achos hwn wedi fy arwain i'r casgliad bod methiannau systemig yn rheolaeth y Bwrdd Iechyd o'i restrau aros a'u dealltwriaeth o'r canllawiau AiD.

45. Am y rhesymau a amlinellwyd uchod, rwy'n **cynnal** y gŵyn hon.

46. O ystyried y methiannau arwyddocaol a systemig a nodwyd yn yr adroddiad hwn, rwy'n rhannu fy adroddiad gydag Ysgrifennydd y Cabinet dros Iechyd a Gofal Cymdeithasol ac Arolygiaeth Gofal Iechyd Cymru.

47. Roeddwn yn bryderus hefyd na allai'r Bwrdd Iechyd ddarparu copiâu o rywfaint o dystiolaeth y gofynnwyd amdani yn ystod yr ymchwiliad hwn. Yn Ionawr 2022, cyhoeddodd fy rhagflaenydd "[Materion yn Ymwneud â Chadw Cofnodion yn Dda](#)". Roedd hyn yn pwysleisio pwysigrwydd cadw cofnodion da, er mwyn meithrin hyder yn y

penderfyniadau a wneir, atebolrwydd a galluogi eraill i ddilysu beth sydd wedi'i wneud. Rwy'n **gwahodd** y Bwrdd Iechyd i ystyried y canllaw hwn a phwysigrwydd cadw cofnodion cywir.

## Argymhellion

48. Rwy'n argymell y dylai'r Bwrdd Iechyd, o fewn **4 wythnos** i gyhoeddi'r adroddiad terfynol:

- a) Trefnu i'r Prif Weithredwr wneud ymddiheuriad i Mr W am y methiannau a nodwyd yn y ffordd y rheolwyd ei amser aros ar gyfer llawdriniaeth.
- b) Rhannu'r adroddiad hwn gyda'r staff perthnasol a myfyrio ar y methiannau a nodwyd, yn arbennig yr angen am benderfyniad clinigol wedi'i ddogfennu'n dda cyn ystyried nad yw claf yn ffit ar gyfer llawdriniaeth.

49. Rwy'n **argymell** y dylai'r Bwrdd Iechyd, o fewn **12 wythnos** o gyhoeddi'r adroddiad terfynol:

- c) Penodi person annibynnol<sup>1</sup> i ail-archwilio eu rhestr aros orthopedig i sefydlu a yw unrhyw gleifion eraill wedi derbyn triniaeth anghywir yn yr un ffordd â Mr W, gan gynnwys ailosod dyddiad amser aros anghywir a/neu beidio cael eu hysbysu ynglŷn â'r ffaith bod eu cloc amser aros wedi'i ailosod. Os nodir unrhyw rai, dylai'r Bwrdd Iechyd ymddiheuro i'r cleifion hynny a sicrhau bod y dyddiad rhestr amser cywir yn cael ei gofnodi. Dylai'r Bwrdd Iechyd gynnig cwrmpas ar gyfer yr archwiliad, i'w gytuno gyda'r swyddfa hon, cyn dechrau'r archwiliad.
- ch) O ystyried bod y Bwrdd Iechyd bod y Bwrdd Iechyd yn parhau i fod o'r farn yn ystod fy ymchwiliad, ei bod yn briodol ailosod y cloc yn achos Mr W, dylent sicrhau bod eu hyfforddiant i staff ar gymhwyso'r canllawiau AiD yn cynnwys y math hwn o senario, er mwyn sicrhau bod eu dull o reoli rhestrau aros yn cydymffurfio â'r canllawiau AiD.

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<sup>1</sup> Unigolyn cymwys addas nad yw'n cael ei gyflogi gan y Bwrdd Iechyd

d) Rhannu'r adroddiad gyda'i Fwrdd a ddylai enwebu Pwyllgor i oruchwylio a monitro cydymffurfiaeth y Bwrdd Iechyd â'r argymhellion hyn.

50. Mae'n bleser gennyf nodi, wrth roi eu sylwadau ar yr adroddiad drafft hwn, bod y **Bwrdd Iechyd** wedi cytuno i weithredu'r argymhellion hyn.

20 Tachwedd 2025

**Michelle Morris**

Ombwdsmon Gwasanaethau Cyhoeddus | Public Services Ombudsman

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