Gwell Iechyd Gwell Cymru

Better Health Better Wales

Cyflwynwyd gerbron y Senedd gan Ysgrifennydd Gwladol Cymru drwy Orchymyn Ei Mawrhydi
Mai 1998

Presented to Parliament by the Secretary of State for Wales by command of Her Majesty
May 1998

Gorch 3922 12.30 Cm 3922 12.30

published by The Stationery Office

CYNNWYS

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RHAGAIR

Mae ein maniffesto ar gyfer yr etholiad, a'r gwaith yr ydym wedi rhoi blaenoriaeth iddo fel Llywodraeth, yn amlygu ein hymrwymiad i wella iechyd yng Nghymru. Ein gweledigaeth yw gwella iechyd a lles pobl Cymru drwy strategaethau sy'n hybu ac yn diogelu iechyd, yn lleihau anghydraddoldebau mewn iechyd ac mewn mynediad i wasanaethau iechyd, a darparu gwasanaethau iechyd effeithiol ac effeithlon.

Cydnabyddwn fod yna amgylchiadau arbennig yng Nghymru sydd wedi creu amrywiadau eang ym mhrofiadau iechyd y naill gymuned a'r llall. Mae'r dystiolaeth bod anghydraddoldebau iechyd yng Nghymru ar gynnydd yn drawiadol, a rhaid cymryd camau pendant i fynd i'r afael hwy, a'r camau hynny yn edrych ar y tymor byr a'r tymor hir ill dau.

Mae cydadwaith cymhleth rhwng ffordd o fyw a ffactorau amgylcheddol yn dylanwadu ar iechyd a rhaid cymryd y rhain i ystyriaeth os bwriedir sicrhau gwir welliannau. Her at yr hir dymor yw hon, a bydd yn golygu cydweithredu ar draws gwasanaethau cyhoeddus, y sectorau gwirfoddol a phreifat, a chymunedau.

Mae gennym lawer i adeiladu arno, ac mae llawer o sectorau eisoes yn cynllunio camau wedi'u seilio ar bolisau'r Llywodraeth newydd, a fydd yn cyfrannu at welliannau iechyd - megis y rhai sy'n mynd i'r afael dieithrwch cymdeithasol, datblygu economaidd a rheoli'r amgylchedd. Mae'r NHS yng Nghymru'n cael ei ailstrwythuro er mwyn ymateb yn well i anghenion lleol, yn enwedig drwy greu Grwpiau Iechyd Lleol (GILl) gyda chyfrifoldeb dros gomisiynu gwasanaethau sylfaenol, yn ogystal gwasanaethau cymunedol a gwasanaethau ysbyty, a gofynion cryfach ynghylch cydweithredu ag Awdurdodau Lleol a chyrff eraill.

Cydnabyddwn fod rhaid gwneud rhagor i godi lefelau iechyd Cymru i gyrraedd lefel y goreuon yn Ewrop. Gwahoddwn unigolion, cynrychiolwyr cymunedol, llywodraeth leol, diwydiant a grwpiau gwirfoddol i ymateb i'r cyfleoedd newydd i feddwl yn greadigol ac ymuno phartneriaethau newydd er gwell iechyd.

Ron Davies
YSGRIFENNYDD GWLADOL CYMRU

Win Griffiths
IS-YSGRIFENNYDD SENEDDOL
Y SWYDDFA GYMREIG

Peter Hain
IS-YSGRIFENNYDD SENEDDOL
Y SWYDDFA GYMREIG

1. NODI YMAGWEDD NEWYDD

Mae'r bennod hon yn gosod nodau ar gyfer iechyd cynaliadwy drwy gydweithredu.

1.1. Mae'r Llywodraeth am fynd i'r afael ag achosion is-orweddol iechyd drwy ymagwedd newydd sy'n cydnabod y ffactorau sy'n effeithio ar iechyd ac yn mynd i'r afael hwy. Yr ydym wedi addo gwella iechyd a lles pobl Cymru. Mae *Gwell Iechyd - Gwell Cymru* yn nodi'r sylfaen ar gyfer ein hymagwedd newydd ac yn gofyn am sylwadau ar sut i fwrw ymlaen hi.

1.2. Mae'r papur yn cynnig ystod eang o feysydd lle gallai camau newydd a chydgysylltiedig wneud gwahaniaeth sylweddol i iechyd a lles. Tynnwyd ar gyngor gan y Swyddfa Gymreig ac ystod eang o'r cyrff allweddol yn y sector cyhoeddus a'r sector gwirfoddol. Diben ymgynghori yw cynnwys pawb yn y drafodaeth am y ffyrdd gorau o wella iechyd pobl. Gobeithio y bydd unigolion, arweinwyr cymunedol, cyflogwyr a'r rhai sy'n gyfrifol am wasanaethau yn ymateb. Bydd yr ymatebion yn bwydo gwaith i ddatblygu Cynllun Gweithredu a gyhoeddir yn yr Hydref ym 1998.

Nodau

1.3. Mae'r cyfnod nesaf hwn yn holl-bwysig er mwyn ein galluogi i lunio polisau cydweithredol a fydd yn cyfrannu at y canlynol:

- nodi strategaeth ar gyfer camau cenedlaethol, rhanbarthol a lleol a gaiff ei symud ymlaen gan Gynulliad Cenedlaethol Cymru;
- atal clefyd a gwella'n sylweddol ar iechyd a lles pobl Cymru;
- codi lefel y rhai 'r iechyd gwaethaf i lefel y rhai 'r iechyd gorau;
- gwella iechyd a lles plant;
- hybu cyfrifoldeb unigol dros iechyd;
- gwella iechyd a diogelwch pobl yn y gwaith;

  a hynny drwy gyfrwng:

  - sicrhau bod yr effaith ar iechyd yn ystyriaeth ar agenda pawb wrth ddatblygu a gweithredu polisau;
  - defnyddio mathau newydd o gydweithredu i sicrhau gwell canlyniadau a gwell gwerth am arian;
  - cyfeirio'r ymdrechion ar y lefel leol at sicrhau y cymerir penderfyniadau ar ofal iechyd a gofal cymdeithasol gyda'i gilydd gan gynrychiolwyr, proffesiynolion a gweinyddwyr lleol,
  - trefnu bod gwell gwybodaeth am iechyd ar y lefel leol ar gael i'r cyhoedd ac eraill er mwyn bwydo dewisiadau iach;
  - cyfeirio rhaglenni ymchwil i roi sylw i'r cysylltiadau rhwng iechyd gwael a ffactorau eraill sy'n cyfrannu at iechyd a lles yng Nghymru.

1.4. Dyma'r gwerthoedd sy'n sail i'r ymagwedd newydd hon:

tegwch - dylai pawb gael cyfle i gael triniaeth a gwasanaethau yn l eu hanghenion - ni ddylai iechyd a lles ddibynnu ar ble yr ydych yn byw;

effeithiolrwydd - dylai polisi iechyd y llywodraeth gael ei seilio ar y wybodaeth a'r arferion diweddaraf er mwyn atal clefydau a hybu iechyd;

effeithlonrwydd - dylai'r sectorau cyhoeddus, preifat a gwirfoddol ddefnyddio'u hadnoddau i sicrhau'r gwerth gorau am arian er mwyn lleihau afiechyd y gellir ei osgoi;

ymatebolrwydd - dylai unigolion allu cael y wybodaeth y mae arnynt ei hangen i wneud dewisiadau gwybodus am iechyd a gofal cymdeithasol;

integreiddio - dylai cydweithredu rhwng yr asiantaethau drwy rannu penderfyniadau wella iechyd a lles unigolion a chymunedau;

atebolrwydd - dylai pob corff fod yn atebol am ei gyfrifoldebau dros iechyd a lles;

hyblygrwydd - rhaid i systemau rheoli fod yn ddigon ystwyth i ymateb i amgylchiadau ac anghenion lleol tra'n galluogi cyrff preifat, cyhoeddus ac eraill i sicrhau gwelliannau mewn iechyd.

Iechyd a lles

1.5. Hwyrach nad yw iechyd da yn bosibl ym mhob cyfnod o'n bywydau. Bydd yna adegau pan fyddwn yn fwy agored i niwed, o bosibl ym mlynyddoedd cynnar ein bywyd, neu fel pobl oedrannus. Ni allwn osgoi afiechyd neu anabledd bob amser. Er hynny, fe allwn anelu at les, hynny yw byw ein bywyd mor llawn ag y dewiswn. Pan fyddwn yn sl, gall fod arnom angen gwasanaethau iechyd a gofal cymdeithasol. Yn ddiweddar nododd y Swyddfa Gymreig ei chynigion ar gyfer gwasanaethau yn yr NHS newydd yng Nghymru yn *Rhoi Cleifion yn Gyntaf (Ionawr 1998)*.[cm]

Iechyd cynaliadwy

1.6. Un o gonglfeini ein hymagwedd newydd yw sefydlu partneriaethau a chydweithredu go iawn a anelir at **iechyd a lles cynaliadwy**. Ar y lefel leol, dylai pob un o benderfynyddion iechyd y mae'r polisi cyhoeddus yn effeithio arnynt - amgylchedd, cyflogaeth, tai, mynediad i hamdden, iechyd a gofal cymdeithasol, addysg a gwasanaethau eraill - gael eu hystyried ar y cyd yn hytrach nag fel polisau ar wahn, gan gymryd eu heffaith bosibl ar iechyd i ystyriaeth.

1.7. Un ffordd o sicrhau hyn fyddai cyflwyno **asesiad effaith iechyd**. Er enghraifft, gallai datblygiadau tai gymryd gofynion diogelwch cymunedol i ystyriaeth. Ni ddylai ystadau diwydiannol newydd a datblygu economaidd beryglu amgylchedd gln. Dylid cynllunio twristiaeth er mwyn lleihau cymaint phosibl ar niwsans, straen a pheryglon yn sgil cynnydd mewn traffig, swn a sbwriel. Dylai amgylcheddau sydd wedi'u difrodi a'u halogi gael eu hadfer mewn ffyrdd sy'n cymryd cynhaliaeth ddiogel i ystyriaeth.

1.8. Cynhwysir yr amcanion hyn ac eraill yn ymrwymiad y Llywodraeth a'i phenderfyniad i hyrwyddo **datblygu cynaliadwy**. Mae papur ymgynghori y Llywodraeth *Cyfleoedd ar gyfer newid (1998)*[at] yn gofyn am ystod eang o sylwadau gan bob sector o'r gymdeithas i baratoi ar gyfer Strategaeth Datblygu Cynaliadwy newydd i'r DU i'w chyhoeddi erbyn diwedd 1998. Mae'r papur yn nodi bod datblygu cynaliadwy yn golygu sicrhau gwell ansawdd bywyd yn awr ac i'r cenedlaethau sydd i ddod. Seilir gweledigaeth y Llywodraeth o ddatblygu cynaliadwy ar bedwar amcan allweddol:

- cynnydd cymdeithasol sy'n cydnabod anghenion pawb;
- dulliau effeithiol o ddiogelu'r amgylchedd;
- defnydd doeth ar adnoddau naturiol; a
- chynnal lefelau uchel a sefydlog o dwf economaidd a chyflogaeth.

1.9. Ar y lefel leol, mae strategaethau **Agenda Leol 21** (gweler yr Eirfa) yn ffocws ar gyfer defnyddio a chyflwyno datblygu cynaliadwy. Mae'r rhain yn dechrau cynnwys pobl leol mewn gwella a chynnal ffabrig amgylcheddol, cymdeithasol ac economaidd cymunedau; dylai iechyd cynaliadwy cymunedau gael ei gymryd i ystyriaeth hefyd. Y nod i ni yw sicrhau bod pob polisi yn cyfrannu at iechyd a lles, ac yn osgoi niwed.

Cydweithio a Buddsoddiadau Cydweithredol

1.10. Mae *Gwell Iechyd - Gwell Cymru* yn nodi ymagwedd newydd at atal clefyd a hybu iechyd a lles drwy gydweithio. Mae hyn yn ymddangos yn hawdd o ran egwyddor, ond bu'n fwy anodd ei sicrhau yn ymarferol. Mae gan bawb ran i'w chwarae - unigolion, cymunedau, busnes, gwasanaethau cyhoeddus a gwirfoddol. Er mwyn gwneud hyn, bydd angen sicrhau newidiadau yn ein hymagwedd at lawer o faterion cymdeithasol ac economaidd sy'n effeithio ar iechyd.

1.11. Seilir rhan allweddol o'r strategaeth ar fuddsoddiadau cydweithredol rhwng asiantaethau gwirfoddol, llywodraeth leol a'r NHS. Mae gwaith integredig eisoes ar gael ar lawer lefel, ond nid yn unffurf ar draws y gwasanaethau cyhoeddus. I sicrhau y bodlonir nodau'r strategaeth newydd, mae'r Llywodraeth yn cynnig dyletswydd newydd o gydweithredu ar gyfer awdurdodau lleol a chyrff iechyd fel ei gilydd. Rhaid cael cyfrifoldebau ac atebolrwyddau cytn ar gyfer hybu gwelliannau mewn iechyd. Mae hyn yn golygu y dylai asiantaethau gytuno, a chyd-fonitro, sut y dylai eu gwahanol swyddogaethau gynnal iechyd a lles unigolion a chymunedau.

1.12. Anogir cyflogwyr ar bob lefel, gan gynnwys yr NHS a llywodraeth leol, i hybu gweithleoedd iach. Bydd cyd-ddealltwriaeth o'r hyn y gellir ei wneud i leihau anghydraddoldebau iechyd, gyda chymorth ymchwil a gwell hyfforddiant ac addysg, yn hanfodol er mwyn gwneud gwelliannau.

Dewisiadau Gwybodus

1.13. Ar yr un pryd, dylai fod gwybodaeth ar gael yn hwylus i alluogi unigolion a theuluoedd i wneud dewisiadau gwybodus am eu hiechyd. Dylid datblygu ymhellach ar waith hybu iechyd yn yr ysgolion a'r colegau i sicrhau bod pobl ifanc yn deall dewisiadau ynglyn ffordd o fyw a'u canlyniadau ar gyfer iechyd. Dylai Awdurdodau Lleol, Awdurdodau Iechyd, cyrff gwirfoddol ac asiantaethau eraill sicrhau y caiff cymunedau lleol eu hysbysu, ac yr ymgynghorir hwy, ynghylch datblygiadau a allai effeithio ar eu hiechyd.

1.14. Mae'r Swyddfa Gymreig yn bwriadu adeiladau ar y ffynonellau presennol o wybodaeth am statws iechyd a materion cysylltiedig drwy gyfrwng **System Wybodaeth Iechyd Cymru (HOWIS)** gynhwysfawr. Yn ychwanegol at ddarparu gwybodaeth werthfawr ar gyfer cynllunio a datblygu gwasanaethau, bydd hefyd yn gyfrwng angenrheidiol iawn ar gyfer cysylltu data sy'n ymwneud ag iechyd, salwch a gwasanaethau iechyd, ac i wella'r ystod o wybodaeth sydd ar gael i unigolion a chymunedau.

Rhaglen Ymchwil Gweithredu ar Iechyd Cynaliadwy

1.15. Yr allwedd i leihau salwch a gwella disgwyliad oes ymhlith y rhai 'r iechyd gwaethaf fydd targedu adnoddau lle y gallant fod yn fwyaf effeithiol. Er hynny, ni wyddom ddigon eto am y cysylltiadau rhwng iechyd gwael ac amodau byw gwael i gael gweithredu rhaglenni newydd gyda hyder. Y cam cyntaf y mae'n rhaid ei gymryd yw sicrhau gwybodaeth uniongyrchol am yr hyn sy'n gweithio'n effeithiol. Gan hynny mae'r Swyddfa Gymreig yn bwriadu sefydlu rhaglen ymchwil gweithredu 5-mlynedd i roi sylw i'r cysylltiadau rhwng iechyd gwael a ffactorau eraill sy'n cyfrannu at iechyd a lles yng Nghymru (gweler paragraff 8.5-8.6).

Cynnydd mewn Iechyd

1.16. Nid ydym yn dechrau thudalen wag. Mae'r NHS eisoes yn gweithio tuag at 15 **targed cynnydd mewn iechyd** at y 5 mlynedd nesaf a gyhoeddwyd gan y Swyddfa Gymreig ym Mehefin 1997 (gweler yr Eirfa). O'u cymryd ynghyd, mae'r rhain

yn dargedau cynhwysfawr ac uchelgeisiol y gallwn eu defnyddio fel mesur cyffredinol o gynnydd tuag at well iechyd yng Nghymru. Er hynny, ni allwn bwyso ar yr hyn y gall yr NHS yn unig ei wneud. Mae sicrhau cynnydd hir-dymor mewn iechyd a lles yn mynd yn llawer ehangach. Mae'n gofyn am ymateb gwybodus gan unigolion, grwpiau cymunedol, asiantaethau gwirfoddol, asiantaethau eraill, llywodraeth leol a chanolog.

Y Strategaeth

1.17. Mae'r Llywodraeth o'r farn bod strategaeth ar gyfer y tymor canol i hir yn hanfodol er mwyn mynd i'r afael ag achosion anghydraddoldebau mewn statws iechyd. Bydd y strategaeth yn gofyn am nodau at y tymor byr, canol a hir gyda dangosyddion a thargedau priodol i fonitro cynnydd ac amlygu'r cyraeddiadau. Dyma fydd y man cychwyn:

- cynllunio gwelliannau iechyd y tu hwnt i'r 5 mlynedd nesaf;
- adeiladu ar y targedau cynnydd mewn iechyd presennol;
- ymchwilio i'r cysylltiadau rhwng amodau byw gwael ac iechyd gwael;
- datblygu dangosyddion/targedau ychwanegol yn gysylltiedig ag anghydroddoldebau a phenderfynyddion iechyd;
- partneriaeth a chydweithredu ar lefel gymunedol, lleol a chanolog;
- defnydd arloesol ar yr adnoddau sydd ar gael ar draws ffiniau;
- hybu hyfforddiant, ymchwilio a datblygu, a rhannu gwybodaeth broffesiynol ar y cyd;
- datblygu strwythurau a chyrff yn briodol.

Caiff unrhyw bwysau am adnoddau ychwanegol yn sgil strategaeth iechyd cyhoeddus Cymru eu hariannu oddi fewn i'r adnoddau presennol.

1.18. Caiff y strategaeth hon ei symud ymlaen o dan drefniadau Cynulliad Cenedlaethol Cymru o 1999 ymlaen. I gynnig y sylfaen ar gyfer gweithredu, bydd y Swyddfa Gymreig yn cyhoeddi Cynllun Gweithredu ym mis Medi 1998 wedi'i seilio ar y fframwaith a amlinellir yn y ddogfen hon ac wedi'i fwydo gan yr ymatebion i'r ymgynghoriad.

2. ETIFEDDIAETH AFIECHYD

Mae'r bennod hon yn disgrifio'r prif anghydraddoldebau mewn statws iechyd o fewn Cymru a rhwng Cymru a gwledydd eraill.

Yr achos o blaid gwell iechyd yng Nghymru

2.1. Er gwaethaf gwelliannau yn ddiweddar, gwael yw iechyd pobl Cymru o'i gymharu ag iechyd yn y mwyafrif o wledydd Ewrop a rhannau eraill o'r DU. Yng Nghymru, mae cyfran sylweddol o'r boblogaeth yn dal o dan anfantais fawr yn nhermau disgwyliad oes ac ansawdd bywyd sy'n gysylltiedig ag iechyd, ac mae amrywiadau eang i'w gweld rhwng y rhai 'r iechyd gwaethaf a'r rhai 'r iechyd gorau.

2.2. Yn y 25 mlynedd diwethaf, cafwyd gostyngiad cyson yng nghyfraddau marwolaeth clefydau y gellir eu hosgoi a chynnydd mewn disgwyliad oes. Ar draws Ewrop, mae **disgwyliad oes** adeg eu geni yn achos dynion a menywod wedi cynyddu tua 5 mlynedd. Drwy gydol y cyfnod hwnnw, mae disgwyliad oes yng Nghymru wedi bod ymhlith y gwaethaf yn Ewrop, sef rhyw dair i bedair blynedd yn llai nag yn y gwledydd gorau. Mae disgwyliad oes mewn rhai mannau yng Nghymoedd y De tua phum mlynedd yn llai nag mewn rhai rhannau eraill o Gymru.cl

2.3. Cafwyd gostyngiad o ryw chwarter i draean yn y **cyfraddau marwoldeb** cyffredinol (gweler yr Eirfa) ar draws Ewrop, ond unwaith eto gwael yw Cymru o'i chymharu 'r mwyafrif o wledydd eraill. O'i chymharu Lloegr, mae'r bwlch marwoldeb yng Nghymru wedi ehangu dros y degawd diwethaf o 5% i 9%.cl

2.4. Mae **marwoldeb babanod** (marwolaethau yn y flwyddyn gyntaf o fywyd) yng Nghymru, er ei bod wedi gostwng dros hanner yn yr ugain mlynedd diwethaf, yn dal yn uwch nag yn y mwyafrif o wledydd Ewrop.cl

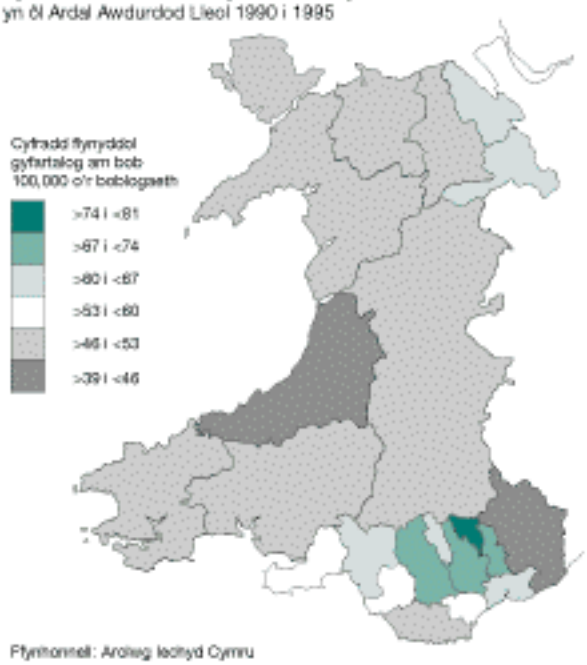
2.5. **Clefyd y galon** yw prif achos marwolaeth yng Nghymru. Er bod cyfraddau marwolaeth yng Nghymru wedi gostwng yn sylweddol yn y blynyddoedd diweddar, mae'n dal yn sylweddol uwch yng Nghymru a'r DU nag mewn llawer o wledydd yn Ewrop, yn arbennig Ffrainc, lle gwelir cyfraddau sydd tua thraean y cyfraddau yng Nghymru.cl

2.6. Mae Cymru ymhlith y cyfraddau uchaf o gofrestriadau **canser** yn yr Undeb Ewropeaidd, gyda chyfraddau tua 50% yn uwch na rhai gwledydd eraill.cl

2.7. Mae'r marwolaethau cynamserol o wahanol achosion yn amrywio'n fawr rhwng ardaloedd yr Awdurdodau Lleol. Gwelir iechyd gwael cyson yng Nghymoedd y De yn arbennig. Ym Mlaenau Gwent, mae'r gyfradd farwolaeth o glefyd y galon ymhlith pobl o dan 65 oed ddwywaith yn uwch na chyfradd Ceredigion. Yn achos canser yr ysgyfaint, mae'r gyfradd farwolaeth ymhlith dynion o dan 75 oed ym Mlaenau Gwent tua dwywaith yn uwch nag ym Mhowys.[bm]

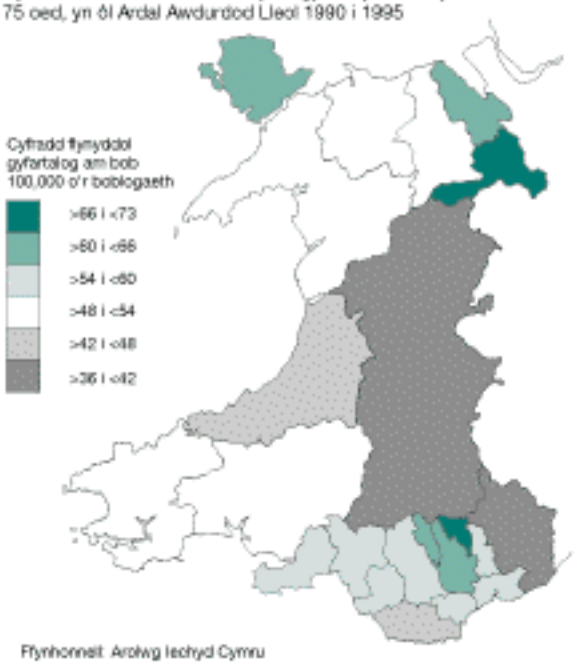
Ffigur 2.1

Cyfraddau Marwoldeb Clefyd Coronaidd y Galon o dan 65 oed, yn ôl Ardal Awdurdod Lleol 1990 i 1995



Ffynhonnell: Arolwg Iechyd Cymru

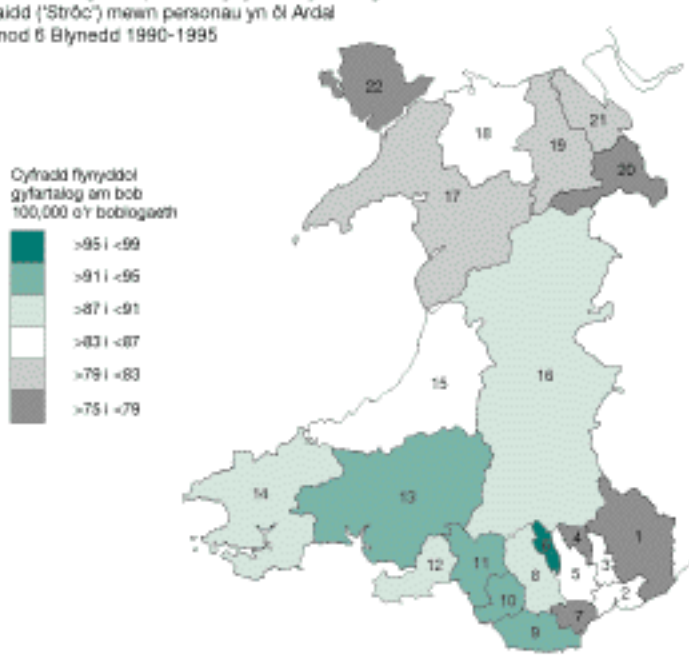
Cyfraddau Marwoldeb Canser yr Ysgyfaint ymhlith dynion o dan 75 oed, yn ôl Ardal Awdurdod Lleol 1990 i 1995



Ffynhonnell: Arolwg Iechyd Cymru

Ffigur 2.2

Cyfraddau Marwoldeb Oed-Safonedig Ewropeaidd Blynyddol Cyfartalog am Glefyd Serebro-fasgwlaidd ('Strôc') mewn personau yn ôl Ardal Awdurdod Lleol dros y cyfnod 6 Blynedd 1990-1995



Awdurdod Lleol

1 Sir Fynwy
2 Casnewydd
3 Tor-faen
4 Blaenau Gwent
5 Caerffili
6 Merthyr Tudful
7 Caerdydd
8 Rhondda Cynon Taf
9 Bro Morgannwg
10 Pen-y-bont ar Ogwr
11 Castell-nedd Port Talbot
12 Abertawe
13 Sir Gaerfyrddin
14 Sir Benfro
15 Sir Ceredigion
16 Powys
17 Gwynedd
18 Conwy
19 Sir Ddinbych
20 Wrecsam
21 Sir y Fflint
22 Sir Ynys Môn

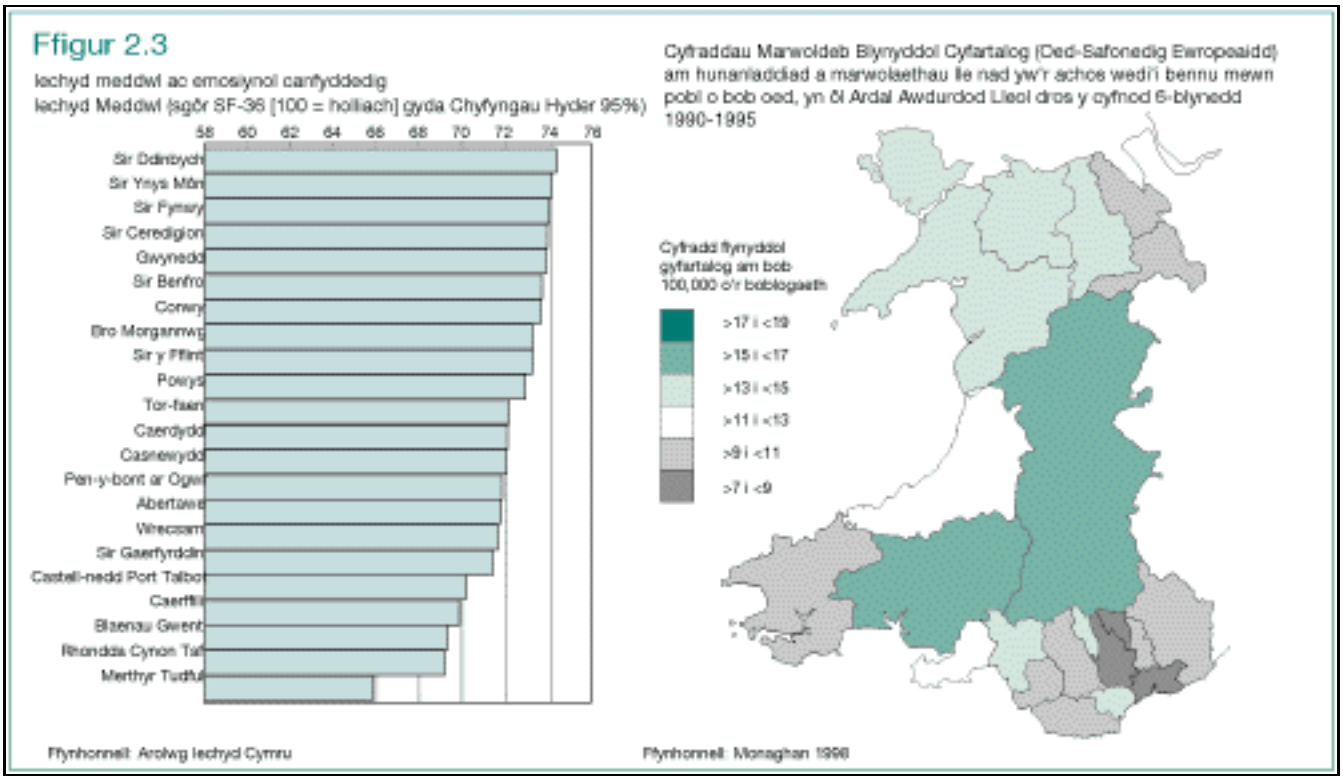
Ffynhonnell: Monaghan 1998

2.8. O'i chymharu rhanbarthau Lloegr, mae gan Gymru lefelau uwch o bobl y mae arnynt angen triniaeth am **bwysau gwaed uchel** - ffactor sylweddol mewn llawer o achosion o drawiad ar y galon a strc. Unwaith eto, mae'r cyfraddau'n amrywio rhwng ardaloedd yr Awdurdodau Lleol, gyda chyfradd farwolaeth o'r strc tua chwarter yn uwch ym Merthyr Tudful nag yn Ynys Mn.[bm]

2.9. Mae un ym mhob naw o bobl yn dioddef problemau **iechyd meddwl** ac mae gan un ym mhob dau gant salwch difrifol y gall fod angen gofal iechyd a gofal cymdeithasol sylweddol ar ei gyfer. Tueddir i weld sgoriau iechyd meddwl is ym Merthyr Tudful, Blaenau Gwent a Rhondda Cynon Taf nag mewn rhannau eraill o Gymru er enghraifft Sir Fynwy, Ynys Mn a Sir Ddinbych.bm

2.10. Gall anhwylder meddyliol a chamddefnyddio sylweddau gynyddu'r risg o hunan-laddiad. Er hynny, nid pob

marwolaeth yn sgil **hunan-laddiad** a hunan-anaf sy'n digwydd ymhlith pobl sy'n dioddef salwch meddwl. Cofnodwyd 240 o farwolaethau ymhlith gwrywod a 52 o farwolaethau ymhlith menywod oherwydd hunan-laddiad a hunan-anaf yng Nghymru ym 1996. Gwelir cynnydd yn y risg mewn rhai grwpiau galwedigaethol hefyd, megis ffermwyr. Mae awdurdodau gwledig, lle mae'r dwysedd poblogaeth yn is na chyfartaledd Cymru, yn tueddu i weld cyfraddau hunan-laddiad uwch na'r cyfartaledd.bm



3. IECHYD A LLES CYNALIADWY

Mae'r bennod hon yn ystyried ffactorau sy'n atal afiechyd ac yn hybu iechyd a lles

3.1. Caiff iechyd cynaliadwy ei sicrhau pan all pobl a chymunedau gymryd rheolaeth ar eu bywydau a byw eu bywyd yn llawn. Mae'r ffactorau sy'n cyfrannu at les yn cynnwys teimlo'n ddiogel, cael sicrwydd cartref a digon i fyw arno, perthnasoedd boddhaol, gweithgareddau difyr ac amrywiol, ac ymdeimlad eich bod yn symud yn eich blaen.

3.2. Mae'n debyg mai amgylchiadau cymdeithasol ac economaidd rhywun yw'r dylanwad cryfaf ar iechyd, salwch y gellir ei osgoi a marwolaeth gynamserol. Ceir cysylltiadau cryf rhwng y patrwm o amddifadedd a'r patrwm o afiechyd a chlefyd. Mae ble'r ydych yn byw, ac a ydych mewn swydd neu beidio, yn dylanwadu ar ddeiet, ysmygu, straen a ffordd o fyw. Gall ble'r ydych yn gweithio, pa mor dda yw'r rheolaeth ar y peryglon yn y gwaith, ac i ryw raddau ble'r ydych yn byw, ddylanwadu ar ddatguddiad i beryglon amgylcheddol, gan gynnwys peryglon yn yr amgylchedd gwaith.

3.3. Gellir gweld patrwm amlwg o afiechyd, salwch ac absenoliaeth yng Nghymru, a esbonnir yn rhannol o bosibl gan hanes y diwydiannau trwm. Yn y gorffennol, yn sgil dibyniaeth ar ddiwydiannau megis glo a dur, gwelwyd gwahaniaethau mewn addysg, medrau a dyheadau. Pan gaeodd y diwydiannau, nid oedd y bobl wedi'u paratoi'n dda i gymryd swyddi eraill ac nid oedd diwydiannau newydd yn gweld y cyn-ardaloedd glofaol yn fannau da ar gyfer buddsoddi. Mae strategaeth adfywio'r economi ar gael ers blynyddoedd lawer, ond nid yw'r cydadwaith rhwng materion cymdeithasol, economaidd, amgylcheddol ac iechyd bob amser wedi'i ddeall.

3.4. Mae angen cymryd camau at y tymor-hir i fynd i'r afael ag achosion anghydraddoldeb mewn iechyd ac yn yr economi. Gallai hyn olygu ymagwedd newydd at gynnal iechyd ac at ddefnyddio gwasanaethau gofal iechyd a gofal cymdeithasol fel adnoddyn cymunedol. Gall fod angen cyflwyno asesiadau effaith iechyd, gwaith hybu iechyd sy'n rhoi sylw i'r pwysau a geir mewn rhai cymunedau yn sgil anfanteision niferus, ac ail-ffocysu cyfrifoldebau proffesiynol. Un o'r prif flaenoriaethau yw cydnabod pwysigrwydd iechyd cynaliadwy wrth adfywio'r economi a'r gymdeithas.

Cyflogaeth

3.5. Ar y cyfan, mae bod mewn gwaith yn iachach na bod yn ddi-waith. Mae gwaith ystyrlon, am dl neu beidio, yn diogelu iechyd y meddwl ac yn hybu ymdeimlad o hunan-werth ac o berthyn. Mae ar gyflogwyr ddyletswydd gyfreithiol i sicrhau bod gweithleoedd ac arferion gwaith yn ddiogel ac iach. Gall cyflogwyr ddylanwadu'n sylweddol hefyd ar iechyd cyffredinol gweithwyr.

Oddi ar Fudd-daliadau i mewn i Waith

3.6. Mae'r sicrwydd yn sgil chwarae rhan fuddiol ym mywyd y gymuned, drwy weithio fel arfer, yn ganolog i ymdeimlad pawb o les ac yn ganolog i greu cymunedau cynaliadwy. Diben y Fargen Newydd ar gyfer pobl ddi-waith hir-dymor yw gwella gallu pobl i gael eu cyflogi a'u helpu i mewn i gyflogaeth gynaliadwy. Dyluniwyd y cynllun oddi ar Fudd-daliadau i mewn i Waith i ffocysu'r cymorth sydd ar gael ar anghenion unigolion; meithrin ymdeimlad o berchnogaeth ymhlith ei gleientau a gwireddu ei amcanion drwy weithio mewn partneriaeth. Bydd cymorth pellach ar gael ym Mharth Cyflogi Prototeip y Gogledd-orllewin. Un o 5 prototeip yw hwn, lle bydd partneriaethau lleol yn anelu at dynnu ynghyd wahanol linynnau cymorth er mwyn creu pecyn mwy cynhwysfawr, yn ffocysu ar yr unigolyn.

Gweithleoedd Iach

3.7. I bobl sy'n gweithio, mae amgylchedd y gwaith yn ddylanwad pwysig ar eu hiechyd. I lawer, mae mynd i'r gwaith yn rhan bositif o'u bywyd, ac mae'n ei helpu i aros yn iach. Ond mae angen sicrhau nad yw gwaith yn gwneud pobl yn sl, a'u bod yn ymadael 'r gwaith ar ddiwedd y dydd o leiaf mor iach phan ddaethant i mewn. Mae ffactorau megis pa mor dda yw'r rheolaeth ar beryglon y gweithle, yn unol chyfraith iechyd a diogelwch, yn chwarae eu rhan mewn creu gweithleoedd iach. Mae'r Comisiwn (HSC) a'r Awdurdod Gweithredol (HSE) Iechyd a Diogelwch wrthi'n datblygu *Strategaeth Genedlaethol ar Iechyd Galwedigaethol* a disgwylir gweld papur trafod yn cael ei gyhoeddi yn ystod 1998. Bydd y strategaeth yn cydategu ac yn cyfrannu at y strategaeth ar gyfer Cymru iachach.

3.8. Yn ddiweddar cyhoeddodd yr Awdurdod Gweithredol Iechyd a Diogelwch ganlyniadau arolwg o salwch cysylltiedig gwaith a hunan-adroddwyd.[as] Amcangyfrifir bod 100,000 o bobl yng Nghymru (4.7 am bob 100 o bobl sydd wedi bod mewn cyflogaeth erioed, o'i chymharu 4.8 am bob 100 ym Mhrydain Fawr) yn dioddef salwch sy'n gysylltiedig 'u gwaith. Er hynny, cymerodd pobl yng Nghymru fwy o ddyddiau i ffwrdd o'u gwaith am bob gweithiwr o ganlyniad i'r salwch hwn (0.84 dydd y gweithiwr, o'i gymharu 0.71 dydd y gweithiwr ar gyfer Prydain Fawr yn ei chrynswth). Fe allai'r dioddef personol hwn, a'r gost economaidd i Gymru yn sgil yr 1.1 miliwn o ddyddiau a gollir bob blwyddyn, gael eu lleihau.

3.9. Mae ymgyrch yr HSE *Good Health is Good Business* yn ceisio codi ymwybyddiaeth o beryglon i iechyd yn y gwaith a helpu cwmnau i reoli'r peryglon iechyd yn eu gweithleoedd. Mae gan ymgyrchoedd fel hyn ran bwysig i'w chwarae wrth sicrhau iechyd da yng Nghymru. Mae mentrau cenedlaethol cyfredol, megis *Health at Work: The Corporate Standard* a ddatblygwyd gan Hybu Iechyd Cymru, yn cynnig cymorth ymarferol a chanllawiau ar yr arferion gorau. Mae'r HSC yn edrych hefyd ar ffyrdd o fwrw ymlaen fframwaith hyblyg o wasanaethau iechyd galwedigaethol a fydd yn rhoi sylw i anghydraddoldebau posibl mewn mynediad i gyngor ar iechyd galwedigaethol.

3.10. Yn olaf, gall cyflogwyr fod yn ddylanwadol wrth hybu iechyd drwy ddarparu amgylchedd cefnogol i bobl sydd am roi'r gorau i ysmygu, dewisiadau iach o fwydydd yn y cyfleusterau arlwyo a hybu seiclo, cerdded a chludiant cyhoeddus yn lle teithio i'r gwaith yn y car. Gall hybu iechyd yn y gweithle wella cynhyrchedd, codi'r ysbryd, lleihau absenoliaeth a throsiant staff, gwella delwedd y sefydliad a helpu i ddenu staff o'r radd uchaf.

Sut gall mwy o gyflogwyr, gweithwyr a chyrff megis cymdeithasau masnach ac undebau llafur wneud cyfraniadau mwy effeithiol byth i reoli peryglon yn y gweithle a sicrhau iechyd cynaliadwy yn y gweithle?

Diogelwch Cymunedol

3.11. Mae amgylchedd diogel yn rhydd rhag trosedd (neu ofn trosedd) yn cyfrannu'n sylweddol at ymwybod yr unigolyn o les. Mae'r rhai sy'n dioddef troseddau treisiol (sydd, yn ffodus, yn beth prin) yn dioddef effeithiau sylweddol ar eu hiechyd. Yr oedd un ym mhob pum oedolyn a holwyd yn *Arolwg Troseddau Prydain (1996)* yn bryderus iawn am ddioddef bwrgleriaeth, cael eu mygio, neu ddwyn eu car. Mae'n bwysig lleihau troseddau ac ofn troseddau. I fynd i'r afael throseddau, mae angen cydweithio ar lawer lefel er mwyn lleihau ymddygiad troseddol ac atal ail-droseddu. Mae'n arwyddocaol bod y tri-chwarter o bobl ifanc a gollfernir am y troseddau mwyaf treisiol a difrifol wedi dioddef camdriniaeth gorfforol, rhywiol neu emosiynol eu hunain.

3.12. Bydd Deddf Troseddau ac Anhrefn (1998) yn gosod rhwymedigaethau newydd ar yr awdurdodau lleol a'r heddlu (yr awdurdodau cyfrifol'):

- i adolygu lefelau a phatrymau troseddau ac anhrefn;
- cyhoeddi adroddiad i ddadansoddi goblygiadau'r archwiliad ar gyfer strategaeth lleihau troseddau;
- i ymgynghori phartneriaid a bennir gan yr Ysgrifennydd Gartref (awdurdodau heddlu, awdurdodau iechyd a phwyllgorau profiannaeth) ac eraill sydd diddordeb:
- i lunio a chyhoeddi strategaeth ar gyfer lleihau troseddau ac anhrefn.

Cyhyd ag y caiff sl bendith y Senedd, deddfir darpariaethau'r Mesur o 1 Medi 1998 ymlaen. Disgwylir i'r partneriaethau

ddechrau gwaith ar y strategaeth a'r archwiliad diogelwch cymunedol ar unwaith, gan sefydlu strategaethau, ar sail archwiliadau, erbyn 1 Ebrill 1999. Yn yr Hydref ym 1998 bydd y Swyddfa Gartref yn cyhoeddi *Strategaeth ar Drais yn erbyn Menywod* hefyd.

3.13. Mae'r ffyrdd posibl o dorri'r cylch o ymddygiad gwrth-gymdeithasol a mynd i'r afael pheryglon hysbys ar gyfer troseddau yn cynnwys:

- lleihau beichiogrwyddau yn yr arddegau a beichiogrwyddau diangen a datblygu cynlluniau i wella medrau rhieni;
- canolbwyntio gwasanaethau ar ardaloedd amddifad i helpu pobl ifanc sy'n hawdd eu niweidio a'u hannog i gymryd rhan mewn gweithgareddau a fydd yn hybu hunan-barch a medrau cymdeithasol;
- sicrhau bod blaenoriaeth yn cael ei rhoi i driniaeth i atal camddefnyddio cyffuriau ac alcohol ac i adsefydlu yn eu sgil;
- sicrhau bod gan wasanaethau iechyd meddwl plentyndod a glasoed arbenigedd wrth ymdrin ag anhwylderau ymddygiad a phlant treisgar neu or-weithgar.

Sut gallai targedau gwella iechyd gryfhau strategaeth lleihau troseddau?

Cymorth Personol a Theuluol

3.14. Gall rhwydweithiau o deuluoedd, cyfeillion a sefydliadau cymdeithasol (e.e. eglwysi, clybiau, cyfleusterau chwaraeon, cyrff gwirfoddol) fod yn bwysig wrth feithrin hunan-barch a hyder ac wrth roi cymorth. Mae'r rhwydweithiau traddodiadol hyn wedi mynd yn llai effeithiol dros y blynyddoedd diwethaf gyda phatrymau cyflogaeth ac adloniant yn newid.

3.15. Gall rhieni newydd gael cymorth drwy siarad rhieni eraill, drwy gyfrwng cysylltiadau 'r teulu ehangach ac o gynlluniau i helpu i gynyddu eu gwybodaeth a'u medrau fel rhieni; gallai'r rhain ddod o amrediad o asiantaethau.

3.16. Gwyddys bod perthynas o ymddiriedaeth agos phartner a chyfaill agos yn ffactor sy'n diogelu yn erbyn salwch meddwl. Mae tor-perthynas ac ysgaru yn creu canlyniadau dwfn ar gyfer yr unigolion o dan sylw. Mae'r rhain yn cynnwys gostyngiad mewn incwm a llai o weithgarwch economaidd, yn arbennig ymysg menywod. Mae plant perthnasoedd o'r fath yn debycach o amlygu aflonyddwch emosiynol ac ysgaru wedyn fel oedolion.

3.17. Gallai ymyriadau effeithiol yn y meysydd hyn gynnwys:

- cymorth ar gyfer gwasanaethau cwnsela a chymodi priodasol;
- hybu addysg ar gyfer rhieni, rhaglenni cymorth a chynlluniau sy'n creu cyfeillion ymhlith rhieni unig;
- gorfodi rhieni dibriod a rhieni sydd wedi gwahanu i ysgwyddo mwy o hawliau a chyfrifoldebau rhiant;
- lleihau nifer y beichiogrwyddau diangen;
- cefnogi grwpiau ieuenctid a grwpiau teuluol ar lefel gymunedol;
- cryfhau rl Ymwelwyr Iechyd a bydwragedd wrth roi cymorth i deuluoedd a rhieni;
- rhoi sylw i gwestiynau dinasyddiaeth, bod yn rhiant, addysg rhyw a pherthnasoedd yn yr ysgol;
- mynd i'r afael thrais domestig a digartrefedd;
- hybu gwyliau i rieni ac arferion cyflogaeth sy'n gydnaws 'r teulu;
- hybu rhwydweithiau cymorth cymunedol.

Plant

3.18. Mae iechyd plant yn ddangosydd pwysig o iechyd yn nes ymlaen yn eu bywyd. Mae lefelau uchel o iechyd gwael ymhlith oedolion yn niweidio iechyd eu plant. Heintiadau byr-dymor ar yr anadl ac anhwylderau'r glust yw prif achosion salwch mewn plant. Damweiniau yw'r prif achos marwolaeth. Caiff niferoedd cymharol uchel o blant eu hatgyfeirio i gael triniaeth am ddamweiniau ac achosion brys.

3.19. Mae'r Swyddfa Gymreig yn bwriadu canolbwyntio ar iechyd a lles plant fel buddsoddiad yn y dyfodol. Bydd y Swyddfa Gymreig yn adeiladu ar *Iechyd Plant yng Nghymru (1997)*[cn] er mwyn datblygu strategaeth gynhwysfawr i wella iechyd plant.

Sut dylai polisi cyhoeddus ddiogelu plant a theuluoedd a sut gall pob sector o'r gymuned feithrin rl ofalgar?

Dieithrwch Cymdeithasol

3.20. Gall diweithdra, medrau isel, incwm isel, tai gwael, amgylchedd o droseddau uchel a chwalfa deuluol, yn ogystal ag iechyd gwael, olygu bod unigolion a chymunedau yn methu chymryd rhan gyflawn mewn cymdeithas.

3.21. Mae rhai cymunedau a theuluoedd yn ynysig oherwydd hil, lliw neu grefydd. Mae eraill yn methu manteisio ar ystod gyflawn o gyfleoedd am eu bod mewn ardaloedd anghysbell. Amgylchiadau, ac nid problemau unigol, sy'n golygu bod y rhain wedi'u cau allan o'r gymdeithas. Wrth fynd i'r afael ag anghydraddoldebau iechyd drwy bolisau cynhwysfawr ac integredig, rhaid cynnwys persbectif grwpiau lleiafrifoedd ethnig a grwpiau eraill.

3.22. Mae'r Swyddfa Gymreig yn datblygu rhaglen i nodi a, lle bo'n bosibl, i wella mentrau polisi sy'n rhoi sylw i ddieithrwch cymdeithasol. Bydd y cynigion yn cymryd i ystyriaeth y partneriaethau a'r cydweithredu o fewn yr Awdurdodau Lleol ac asiantaethau eraill. Mae'r gwaith hwn yn cydategu gwaith yr Uned Dieithrwch Cymdeithasol yn Lloegr a'r strategaeth iechyd cyhoeddus yng Nghymru.

Sut dylai grwpiau lleiafrifol gael eu cynnwys mewn polisau ar gyfer gwella iechyd a lles?

4. FFORDD IACH O FYW

Mae'r bennod hon yr nodi'r ffyrdd o fyw sy'n brif benderfynyddion iechyd.

4.1. Mae penderfyniad person i ysmygu, ymarfer corff yn aml, neu ddilyn deiet iach, yn effeithio ar iechyd a lles. Nid mater o wybodaeth a dewis yn unig yw ffordd o fyw - mae'r dystiolaeth yn awgrymu y dylanwadir yn gryf arno gan ffactorau ehangach sy'n gysylltiedig sefyllfaoedd lleol a phersonol, gan gynnwys lefel addysgol, medrau personol, pwysau cyfoedion, a ffactorau cymdeithasol, economaidd a diwylliannol.

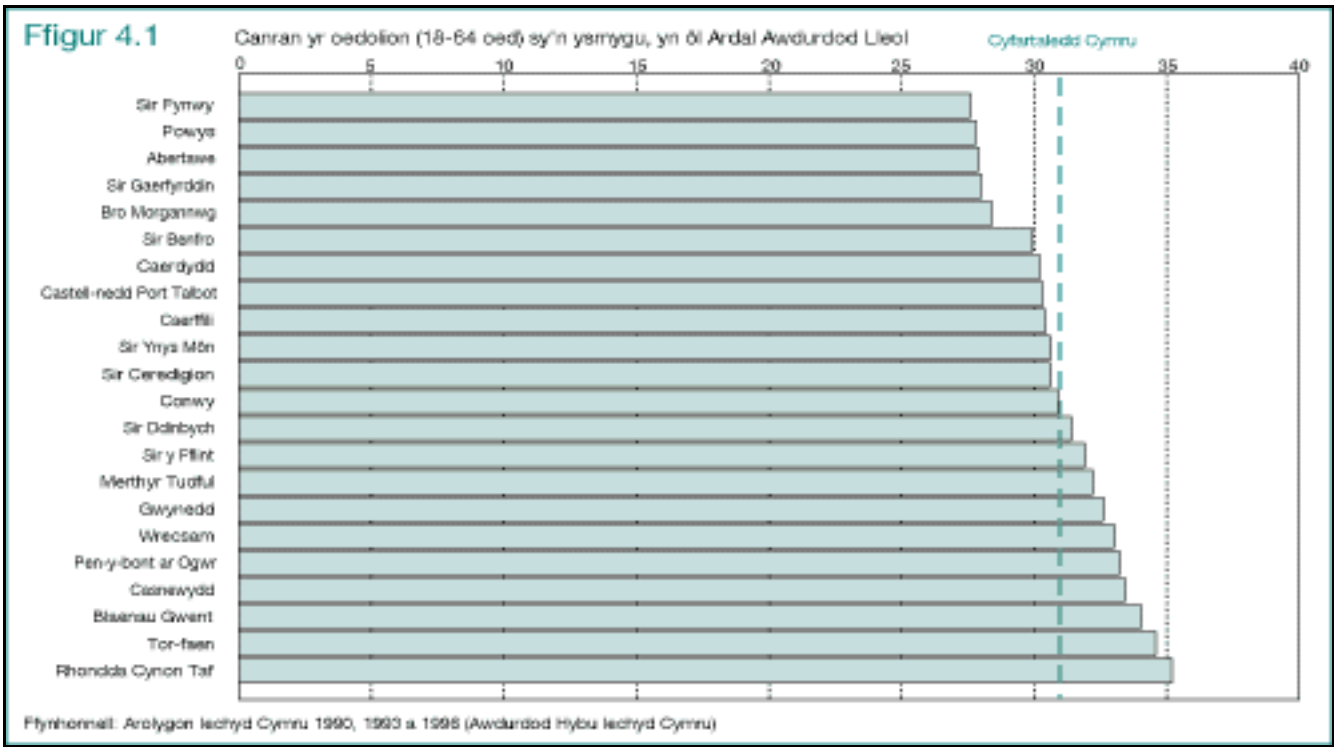
4.2. Mae mynediad i wybodaeth briodol am ffyrdd iach o fyw yn helpu pobl i wneud dewisiadau, ond hwyrach na fydd gwybodaeth ar ei phen ei hun yn ddigon i ategu newid. Mae hyn yn gofyn bod unigolion a chymunedau yn cymryd rhan mewn penderfyniadau sy'n effeithio ar eu bywydau. Yr unig ffordd o sicrhau newid o'r fath yw gweithio gydag unigolion a chymunedau mewn ffordd sy'n golygu bod y problemau a'r atebion yn perthyn iddynt.

Ysmygu

4.3. Defnyddio tybaco yw'r achos unigol mwyaf o farwolaeth gynamserol ac afiechyd y gellir ei atal yng Nghymru. Ysmygu yw prif achos canser yr ysgyfaint ac mae hefyd yn cynyddu'n sylweddol ar y perygl o ganserau'r geg, y stumog, yr arennau, y bledren a'r cefndedyn. Mae ysmygwyr yn debycach o ddioddef clefyd y galon a broncitis cronig. Mae'r rhai nad ydynt yn ysmygu ond sydd mewn cysylltiad ag ysmygwyr hefyd yn dioddef perygl uwch o ganser yr ysgyfaint a chlefyd y galon.

4.4. Mae mamau beichiog sy'n ysmygu yn debycach o gael babanod llai, sydd hwythau'n debycach o brofi iechyd gael. Mae marwolaethau yn y crud ymhlith babanod mamau a fu'n ysmygu yn ystod beichiogrwydd yn fwy cyffredin nag ymhlith babanod mamau nad ydynt yn ysmygu. Ceir perygl uwch o anhwylderau'r anadl ymhlith plant ysmygwyr.

4.5. Yng Nghymru, rhwng 1985 a 1996, gostyngodd y gyfran o ddynion a oedd yn ysmygu bob dydd o 35% i 28%, ac o 30% i 26% yn achos menywod. Codi a disgyn fu hanes cyfraddau ysmygu ymhlith arddegwyr dros y 10 mlynedd diwethaf. Ymhlith arddegwyr 15 oed, y gyfran o fechgyn a oedd yn ysmygu oedd 16% ym 1986, gan ostwng i 12% ym 1988 a chodi i 23% ym 1996. Ymhlith merched yn eu harddegau mae'r ffigurau yn uwch, ond yr un yw'r patrwm. Ym 1986 y lefel oedd 20%, gan ostwng i 19% ym 1988 a chodi i 29% ym 1996.aq Mae strategaethau effeithiol i leihau lefelau ysmygu yn hanfodol ar gyfer iechyd yn y dyfodol.



4.6. Gallai'r camau i leihau cyffredinolrwydd ysmygu gynnwys:

- gorfodi'r ddeddfwriaeth ar werthu tybaco;
- polisau di-fwg yn y gweithle a mannau cyhoeddus;
- atal pobl rhag dechrau - rhaglenni addysg iechyd yn yr ysgolion, clybiau mygu mwg, ysgolion di-fwg;
- helpu pobl i stopio - rhaglenni rhoi'r gorau i ysmygu;
- negeseuon hybu iechyd cryfach;
- rhoi sylw i'r cwestiwn pam mae mwy o ferched nag o fechgyn yn ysmygu.

Mygu Mwg Cymru **Rhaglen genedlaethol yw Mygu Mwg Cymru ac mae'n anelu at hybu delwedd bositif o fod yn ddi-fwg ymhlith y rhai 9-13 oed. Mae gan y clwb, sy'n agored i unrhyw berson ifanc sy'n addo peidio dechrau ysmygu, yn prysur agosu at 20,000 o aelodau. Cydgysylltir Mygu Mwg Cymru yn genedlaethol gan Awdurdod Hybu Iechyd Cymru ac mae'n cael ei redeg yn lleol gan weithwyr hybu iechyd.**

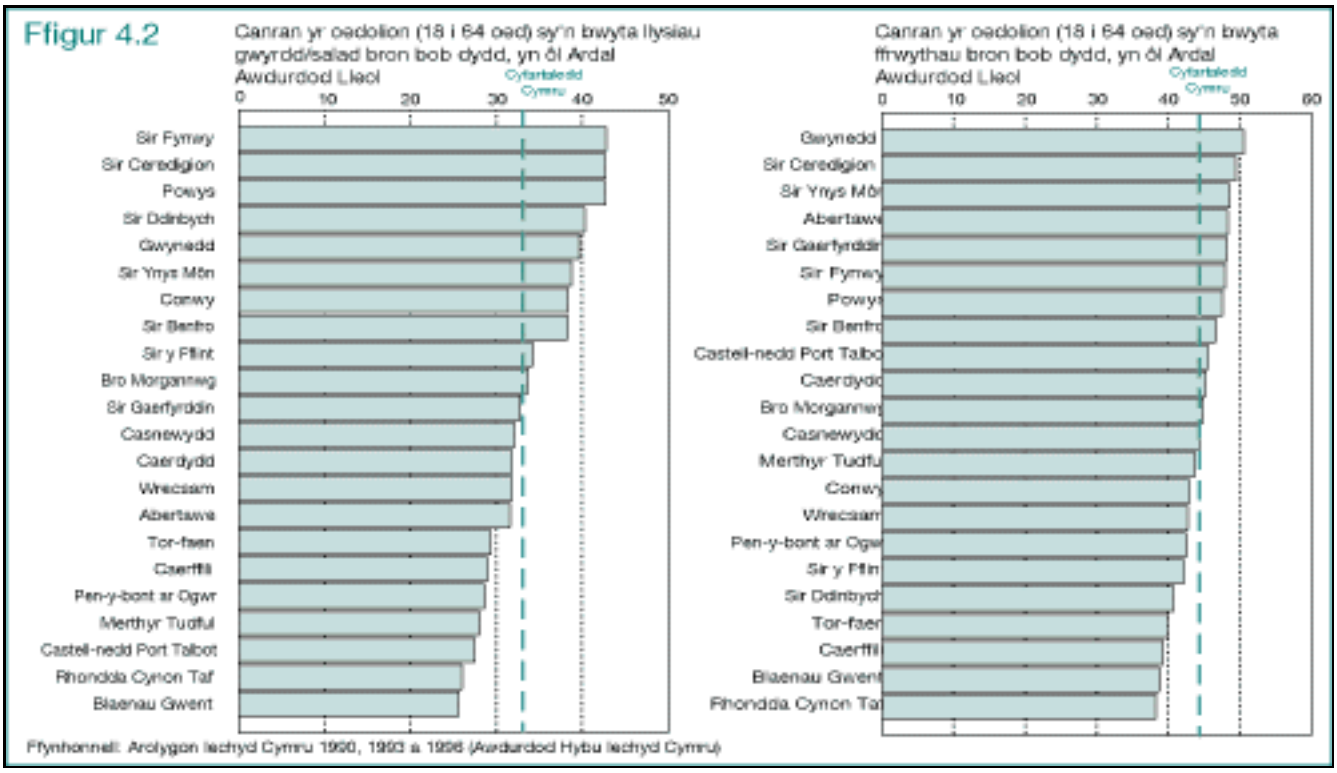
4.7. Yng Ngorffennaf 1997, addawodd y Canghellor godi'r trethi ar dybaco 5% mewn termau real bob blwyddyn. Mae'r Llywodraeth wedi cymryd camau pendant hefyd i sicrhau diwedd ar hysbysebion a nawdd tybaco, gan gynnig amser i bob camp ddod o hyd i ffynonellau eraill o nawdd. Sicrhawyd cytundeb yn y Cyngor Iechyd Ewropeaidd ar Gyfeireb Hysbysebu Tybaco i wahardd hysbysebu a nawdd o fewn yr Undeb Ewropeaidd. Bydd y Llywodraeth yn cyhoeddi Papur Gwyn ym 1998 gyda chynigion ar fwrw ymlaen 'r gwaharddiad o fewn y DU fel rhan o ystod gynhwysfawr ac integredig o fesurau i fynd i'r afael ag ysmygu a lleihau'r afiechyd a'r marwolaethau cynamserol cysylltiedig.

4.8. Lansiwyd *Adroddiad y Pwyllgor Gwyddonol ar Dybaco ac Iechyd (SCOTH)* ar 11 Mawrth 1998. Mae'n cynnig negeseuon allweddol ar feysydd megis ysmygu gweithredol, ysmygu goddefol a chaethineb i nicotin. Mae hefyd yn cynnwys argymhellion ar gyfer mynd i'r afael meysydd megis cyfyngiadau ar ysmygu mewn mannau cyhoeddus a gweithleoedd, diogelu pobl ifanc rhag hybu a hysbysebu tybaco, addysg iechyd a darparu mwy o wasanaethau rhoi'r gorau i ysmygu.

Maethiad a Deiet

4.9. Mae deiet iach a chytbwys yn ffactor o bwys wrth gynnal iechyd. Ceir fitaminau a ffibr mewn llysiau a ffrwythau, a chredir bod y rhain yn diogelu rhag clefydau'r coluddyn a chanserau yn gyffredinol. Mae lefelau uchel o asidau brasterog irlawn yn achosi clefyd y galon a'r strc, ac mae cymeriant halen uchel yn cyfrannu at lefelau pwysau gwaed uchel, sydd yn eu tro yn arwain at strc. Mae cymeriant braster irlawn yn y DU dros y 10 mlynedd diwethaf, fel canran o'r egni o fraster wedi aros tua 40% ac nid yw'n argoeli ei fod yn gostwng i'r lefel a argymhellir, sef 35% o egni bwyd. Dangosodd *Arolwg Iechyd Cymru (1995)*[ct] fod pobl Cymoedd y De yn bwyta lle o ffrwythau a llysiau a mwy o floneg nag mewn mannau eraill yng Nghymru. Cynyddu mae lefelau pobl rhy drwm a gor-dew yng Nghymru, gyda 51% o fenywod a 53% o wrywod ym 1996 yn rhy drwm neu'n or-dew.

4.10. Mae deiet iach yn ffordd bwysig o hybu twf a datblygiad. Gall maethiad priodol helpu plant a phobl ifanc i ganolbwyntio yn yr ystafell ddosbarth yn ogystal helpu i atal afiechyd yn nes ymlaen mewn bywyd. Nodwyd bwriad y Llywodraeth yn y Papur Gwyn *Adeiladu Ysgolion Ardderchog Gyda'n Gilydd* i gyflwyno safonau maethol ar gyfer cinio yn yr ysgol. Bydd y rhain yn adeiladu ar yr arferion da sy'n bodoli eisoes ynghylch y fframwaith i ddarparwyr lle mae modd i arlwywyr gynnig cinio ysgol sy'n iach ac yn ddymunol.



4.11. Mae'n bwysig bod pawb yn cael cyfle hawdd i gael amrywiaeth eang o fwydydd sy'n faethlon ac yn rhesymol eu pris er mwyn i bawb fforddio bwyta i fod yn iach'. Yn ogystal 'r deunyddiau crai, mae ar bobl angen cyfle i gael cyngor ynghylch dulliau paratoi bwyd sy'n cadw ei werth maethiadol ac yn ddiogel. Mae hyn yn arbennig o wir i grwpiau sy'n hawdd ei niweidio megis plant (e.e. drwy wersi yn yr ysgol), mamau beichiog (e.e. dosbarthiadau cyn-genhedlu a dosbarthiadau rhieni') a phobl oedrannus.

5. AMGYLCHEDD IACH
Mae'r bennod hon yn nodi prif benderfynyddion amgylcheddol iechyd.

5.1. Mae'r amgylchedd ffisegol yn benderfynydd iechyd pwysig. Gall ble'r ydym yn byw, a ble'r ydym yn gweithio, ein datguddio i amrywiaeth o beryglon amgylcheddol. Bydd ymrwymiad y Llywodraeth i weithio tuag y nod o ddatblygu cynaliadwy lle gwelir anghenion economaidd, amgylcheddol a chymdeithasol fel anghenion sy'n cyd-berthyn, yn cyfrannu at iechyd a lles yn y tymor hirach.

5.2. Trafodir llawer o'r ffactorau amgylcheddol sy'n effeithio ar iechyd yn y DU yn ei chrynswth yn y Cynllun Gweithredu Cenedlaethol ar gyfer Iechyd yr Amgylchedd a luniwyd o dan adain Mudiad Iechyd y Byd, y mae'r Llywodraeth yn bwriadu ei adolygu cyn Cynhadledd nesaf y WHO ar gyfer Gweinidogion ar yr Amgylchedd ac Iechyd yn Llundain ym 1999.

Cartrefi Iach

5.3. Mae'r cysylltiad rhwng amodau tai gwael ac iechyd gwael wedi'i gydnabod ers amser maith. At ei gilydd, mae'r rhai sy'n byw mewn tai da mewn gwell iechyd corfforol a meddyliol na'r lleill. Mae tai llaith, oer, heb ddigon o awyr, yn creu amodau sy'n creu afiechyd. Yn aml bydd gwres annigonol a diffyg awyr yn effeithio'n fwyaf ar bobl oedrannus a gallant arwain at hypothermia a chynnydd mewn problemau anadlu. Mae ymchwil wedi dangos bod y peryglon iechyd mwyaf arwyddocaol oherwydd tai gwael yn gysylltiedig ag oerfel a lleithder: o Ionawr hyd Fawrth mae yna ryw 40,000 yn fwy o farwolaethau yn y DU na'r gyfradd gyfartalog ar gyfer gweddill y flwyddyn. Mae angen mesurau effeithlonrwydd ynni, yn arbennig yng nghartrefi pobl oedrannus a'r hawsaf i'w niweidio. Ceir mynychder llawer uwch o afiechyd meddwl ymhlith pobl sy'n byw mewn tai wedi'i gordyrru, a mwy o drais domestig hefyd. Gall safle tai a gwasanaethau eraill wella mynediad neu olygu bod mwy o geir yn cael eu defnyddio i fynd phlant i'r ysgol ac ar siwrneiau dyddiol eraill. Gall dyluniad tai, yn arbennig ceginau, leihau damweiniau.

Ardal Adnewyddu Tai Oakdale	**Mae Awdurdod Lleol yr Ardal Adnewyddu, asiantaethau cyhoeddus eraill, y sector preifat a'r gymuned yn cydweithio i ddatblygu ymagwedd strategol i wella tai ynghyd 'r amodau amgylcheddol, cymdeithasol ac economaidd. Mae gweithredu cydgysylltiedig yn rhoi sylw i dlodi tanwydd a pheryglon tn, troseddau, lleithder, llifoedd traffig, ffabrig tai gwael a mannau hamdden.**

5.4. Mae'r Awdurdodau Lleol yn gyfrifol am weinyddu grantiau adnewyddu tai ac mae ganddynt gyfrifoldebau statudol penodol tuag at bobl ddigartref. Mae gan Gymru gyfran uwch na'r cyfartaledd o berchen-feddianwyr yn byw yn nhai sy'n dyddio o'r 19eg ganrif, yn aml mewn ardaloedd o ddiweithdra uchel lle mae'r perchnogion yn llai abl i fforddio adnewyddu a chynnal eu cartrefi. Yn Arolwg Cyflwr Tai Cymru (1993)[bs] gwelwyd bod 13% o'r cartrefi o dan y safon isaf ar gyfer gwres ac awyr. Mae adolygiad cynhwysfawr y Llywodraeth o wariant wrthi'n ystyried costau tai gwael i wasanaethau iechyd a gwasanaethau eraill a sut y gallai'r adnoddau gael eu targedu'n well.

Tai Cymdeithasol

5.5. Gall tai cymdeithasol wneud cyfraniad pwysig at iechyd. Mae'r Awdurdodau Lleol yn landlordiaid ar 204,000 o gartrefi, 16% o'r holl anheddau a 57% o'r farchnad ar rent. Landlordiaid cymdeithasol cofrestredig sy'n rheoli 48,000 o gartrefi - rhyw 12% o'r farchnad ar rent.[bq] Dyrennir y mwyafrif mawr o'r tai i deuluoedd phlant neu i'r rhai sy'n hawdd eu niweidio. Mae dros 80% o'r tenantiaid newydd yn derbyn budd-daliadau tai.[bo] Mae'r Swyddfa Gymreig a Thai Cymru yn

annog landlordiaid cymdeithasol i gael eu tenantiaid i gymryd rhan yn rheolaeth eu hystadau.

Tai Cymru **Mae cynlluniau tai safonol Tai Cymru, eu manylebau adeiladu a'u canllawiau ar arferion da yn sicrhau bob dylunwaith tai cymdeithasol yng Nghymru yn adlewyrchu ymroddiad i iechyd a diogelwch, ac yn cynnig cyfleoedd ar gyfer addasu yn y dyfodol wrth i anghenion y deiliaid newid. Dylunnir y tai er mwyn lleihau perygl damweiniau mewn mannau peryglus ee ceginau a grisiau, ac i fod yn ddarbodus o ran eu gwresogi. Mae'r anheddau a'r ystadau o'u cwmpas yn cynnig lefelau uchel o hygyrchedd i ymwelwyr gydag amrediad eang o anableddau ac maent yn ymgorffori ystod gynhwysfawr o fesurau atal trosedd.**

Sut y gall landlordiaid cymdeithasol a chyrff tenantiaid ddatblygu eu rl mewn cryfhau cymunedau?

Sut y gallant greu effaith fwy cadarnhaol ar iechyd a lles pobl?

Digartrefedd

5.6. Mae pobl sy'n cysgu allan, yn arbennig am gyfnodau hir, mewn perygl arbennig o iechyd gwael. Yng Nghymru, mewn arolwg ciplun gan Shelter Cymru a'r Gwasanaeth Ymgynghorol Tai Anghenion Arbennig, a ariannwyd gan y Swyddfa Gymreig, cafwyd bod 77% o'r rhai a oedd yn cysgu allan o dan 35 oed. Dywedodd 44% fod ganddynt broblemau iechyd corfforol neu feddyliol, gan gynnwys camddefnyddio cyffuriau ac alcohol. Mae mynediad i wasanaethau iechyd a gwasanaethau eraill yn arbennig o anodd i bobl ddigartref, neu sydd heb gartref sefydlog.

5.7. Mae pobl ddigartref ifanc yn debyg o fod wedi dioddef profiadau bywyd andwyol o'r blaen, gan gynnwys cyfnodau mewn gofal. Maent mewn mwy o risg oherwydd camddefnyddio cyffuriau ac alcohol, puteindra a chlefydau a drosglwyddir yn rhywiol. Mae plant sy'n byw gyda rhieni mewn hosteli i'r digartref mewn perygl hefyd o ddioddef datblygiad gohiriedig a phroblemau ymddygiad. Caiff dynion a menywod digartref eu gwthio i ymylon y gymdeithas. Rhan yn unig o'r rheswm dros digartrefedd yw diffyg tai addas; mae'r gwreiddiau yn gorwedd yn niffyg perthnasoedd teuluol a pherthnasoedd eraill, neu yn chwalfa'r rheiny.

Sut dylai polisau tai gael eu datblygu i gymryd i ystyriaeth ddiogelwch cymunedol ac iechyd cynaliadwy, yn arbennig lle ceir crynodiadau o dai is-safonol?

Aer Gln

5.8. Mae ansawdd aer wael yn gwaethygu anhwylderau megis asthma, broncitis cronig, ac emffysema. Mae'r Llywodraeth wedi ymrwymo i leihau llygredd atmosfferig o gludiant a ffynonellau diwydiannol ac mae'n cymryd amrywiaeth o gamau i wella ansawdd aer, gan gynnwys:

- adolygiad carlam o'r Strategaeth Genedlaethol Ansawdd Aer i'w gwblhau erbyn diwedd y flwyddyn;
- Amcanion Statudol Ansawdd Aer a gyflwynwyd yn Rhagfyr 1997;
- system newydd o wybodaeth gyhoeddus ynghylch llygredd aer a gyhoeddwyd ar 19 Tachwedd 1997;
- rhaglen ymchwil gynhwysfawr ar aer yn yr awyr agored gan yr Adran Iechyd/Adran yr Amgylchedd, Trafnidiaeth a'r Rhanbarthau/y Cyngor Ymchwil Feddygol.

5.9. Mae gan yr Awdurdodau Lleol ran o bwys i'w chwarae, gyda chefnogaeth *Fforwm Ansawdd Aer Cymru*, sy'n coladu gwybodaeth ledled Cymru. Ers Rhagfyr 1997, mae'n ofynnol i'r Awdurdodau Lleol fonitro ansawdd aer eu hardal a chymryd camau priodol pan na chaiff amcanion penodedig eu bodloni.

5.10. Mae gan y Llywodraeth ddiddordeb mewn dulliau effeithiol ac arloesol o fynd i'r afael thagfeydd a llygredd. Mae'n

ddigon posibl y bydd yr Awdurdodau Lleol yn elwa drwy gymryd rhan ym mhroject *Dinasoedd Heb Geir*, neu gynlluniau tebyg eraill. Ond y lefel leol yw'r lle gorau i gymryd penderfyniadau o'r fath, wrth i'r awdurdodau ystyried y ffordd orau o fodloni eu dyletswyddau statudol o dan Ddeddf yr Amgylchedd 1995.

5.11. Mae ansawdd aer wael mewn adeiladau, yn y gwaith, mewn hamdden ac yn y cartref yn cyfrannu at afiechyd. Er enghraifft, gall croniad nwyon fel carbon monocsid greu goblygiadau difrifol ar gyfer iechyd. Mae radon yn nwy sy'n digwydd yn naturiol mewn llawer rhan o Gymru. Credir mai dyma'r ail achos pwysicaf o farwolaeth yn y DU o ganser yr ysgyfaint ar l ysmygu, sef rhyw 5% o'r marwolaethau o ganser yr ysgyfaint bob blwyddyn yn y DU.[bn] Erbyn hyn gorffennwyd mapio mynychder radon ac mae arolygon pellach yn cael eu cynnal i ddod o hyd i'r anheddau a'r lefelau radon uchaf. Dynodir ardaloedd ychwanegol ym 1998. Bydd y Swyddfa Gymreig yn hybu ymwybyddiaeth o ardaloedd radon a'r mathau o gymorth sydd ar gael i ddeiliaid tai i ddiogelu yn erbyn allyriannau.

Dwr Diogel

5.12. Cyflenwad eang o garthffosiaeth a dwr gln oedd y cyflawniad pwysicaf ym maes iechyd y cyhoedd yn y 100 mlynedd diwethaf. Mae cynnal y systemau hyn yn dal yn holl-bwysig heddiw. Er bod safonau ansawdd dwr yn uchel at ei gilydd, ni ellir llaesu dwylo. Yn ogystal pharhau i ddiogelu yn erbyn y bygythiadau traddodiadol i ddiogelwch dwr, rhaid i gyflenwyr ymateb i fygythiadau sydd newydd eu nodi megis organeb cryptosporidiwm. Mae gan ddiwydiant, gan gynnwys amaethyddiaeth, gyfrifoldeb dros osgoi llygru cyflenwadau dwr.

5.13. Er bod camau wedi'u cymryd i leihau lefelau plwm yn yr amgylchedd, er enghraifft o bibellau gwacu cerbydau a phaent, gall plwm o unrhyw ffynhonnell fod yn niweidiol. Er enghraifft, mae astudiaethau wedi dangos y gall hyd yn oed ychydig iawn o blwm greu effaith niweidiol ar ddatblygiad meddyliol plant. Mae'r Llywodraeth yn benderfynol o barhau i fynd i'r afael a lefelau plwm mewn dwr yfed. Rhaid i ddarparwyr dwr drin cyflenwadau dwr i leihau ei allu i doddi plwm ac yn y mwyafrif o adeiladau bydd hyn yn sicrhau nad yw'r lefelau wrth y tap - hynny yw ar l unrhyw lygredd o bibellau plwm a gynhelir gan berchnogion yr eiddo - yn fwy na 25 microgram y litr. Mae'r Llywodraeth yn bwriadu gosod safon lem o 10 microgram y litr o ddwr yfed a ddarperir ar gyfer cartrefi, i'w chyrraedd mewn 15 mlynedd, a bydd yn paratoi cyngor i ddeiliaid tai i'w helpu i wneud penderfyniad gwybodus ynghylch amnewid pibellau plwm yn eu cartrefi.

5.14. Yn y blynyddoedd diwethaf cafwyd gwelliant dramatig yn ansawdd dyfroedd ymdrochi ar arfordir Cymru ac, ym 1997, llwyddodd 60 o'r 64 sy'n cael eu monitro o dan y Gyfeireb Ewropeaidd i gyrraedd y safonau gorfodol. Disgwylir gweld y gwelliant yn parhau. Mae *Menter y Mr Glas* yn anelu at 50 o draethau Baner Las yng Nghymru (o'i gymharu 9 ym 1997) ac fel rhan o'r fenter bydd angen i ansawdd y dwr ar y traethau hyn gyrraedd y safonau llawer llymach yn y canllawiau a bennir gan Ewrop. Y llynedd, llwyddodd 31 o ddyfroedd ymdrochi Cymru i fodloni'r safonau Ewropeaidd llymach hyn. Fel rhan o *Fenter y Mr Glas*, mae Dwr Cymru/Welsh Water yn bwriadu dechrau trin yr holl ollyngiadau carthion ar yr arfordir diheintydd. Ond os bwriedir gweld 50 o Faneri Glas yng Nghymru, bydd angen i eraill chwarae eu rhan yn llawn, er enghraifft, trwy gadw'r traethau'n rhydd rhag sbwriel a gwastraff, gan gynnwys gwastraff cwn.

Defnyddio Tir

5.15. Mae yna lawer ardal lle ceir tir diffaith a halogedig yng Nghymru, gyda'r perygl o halogi dyfroedd wyneb a dyfroedd daear. Enghreifftiau penodol yw dwr yn gollwng o hen fwyngloddiau glo a metel. Bu Awdurdod Datblygu Cymru ar flaen y gad wrth adfer tir yn Ewrop ac, ers 1976, wedi buddsoddi dros 300 miliwn yn adfer dros 17,300 o erwau o dir, gan ddarparu tir ar gyfer ffatroedd, cartrefi, ysbytai, parciau gwledig a meysydd chwarae. Mae'r gwaith hwn yn bwysig iawn gan yr Awdurdod a fydd yn parhau 'i raglen sylweddol o adfer tir.

5.16. Mae'r dirywiad yn y diwydiant glo dwfn yng Nghymru wedi arwain at gynnydd mewn glo o lofeydd brig. Dylai ceisiadau am ddatblygu glofeydd newydd gael eu hystyried yng nghyd-destun polisau cynllunio y Swyddfa Gymreig a'r polisau mewn cynlluniau datblygu lleol. Dylai'r materion gael eu trafod yn llawn gyda'r cymunedau lleol. Rhaid i Asiantaeth yr Amgylchedd, yr Awdurdodau Lleol a'r diwydiant gydweithio i sicrhau a gweithredu unrhyw ddulliau rheoli sy'n angenrheidiol i ddiogelu'r cymunedau cyfagos a'r amgylchedd.

5.17. Caiff swm sylweddol o wastraff soled ei gynhyrchu a rhaid ei waredu'n ddiogel. I safleoedd tirlenwi yr aiff llawer ohono ar hyn o bryd ac mae hyn yn arwain yn aml at ddadleuon ynghylch diogelwch arferion o'r fath ond mae'r dewisiadau

eraill yn aml yn codi cynifer o wrthwynebiadau. Mae dulliau ar gyfer cynllunio gwlad a thref yn cynnig cyfeiriad cyffredinol ar gyfer rheoli defnyddio tir. Dylai'r Awdurdodau Lleol ystyried agweddau iechyd cynllunio fel rhan o'u strategaeth gyffredinol.

5.18. Un ffordd bwysig o leihau deunyddiau sy'n gorfod mynd ar gyfer tirlenwi neu losgi yw ailgylchu, gan leihau felly y baich ar safleoedd gwaredu a gwneud y defnydd gorau ar yr adnoddau presennol. Mae ailgylchu hefyd yn agor cyfleoedd ar gyfer arloesi a chyflogaeth drwy ddatblygu technoleg newydd. Bydd gwelliannau cyfatebol yn yr amgylchedd yn hwb i nodau datblygu cynaliadwy ac yn gyfraniad at wella iechyd y cyhoedd.

5.19. Mae hefyd yn bwysig lleihau swm y gwastraff a gynhyrchir yn y lle cyntaf. Mae'r Swyddfa Gymreig yn hybu ailgylchu ac fe hoffai glywed sylwadau ar ddefnydd ehangach cynhyrchion wedi'u hailgylchu a chynlluniau ailgylchu cymunedol arloesol. Mae angen i'r Awdurdodau Lleol, diwydiant, busnesau bach a theuluoedd ddod o hyd i ffyrdd i leihau gwastraff. Mae'r Swyddfa Gymreig yn croesawu sylwadau ar y dulliau a ddefnyddir i waredu gwastraff ac ar sut y gellir datblygu technoleg i ymdrin hyn yn y dyfodol.

Lleihau Gwastraff Diwydiannol yng Nghymru	**Mae Cambrian Stone Cyf. yn ailbrosesu'r slag o ffwrneisiau chwyth a gynhyrchir fel sgil-gynnyrch wrth i ddur gael ei wneud. Caiff y slag ei ailgylchu a'i ddefnyddio i wneud amrywiaeth o ddeunyddiau diwydiannol gan gynnwys sment amnewid, blociau wedi'u hinswleiddio'n thermol neu inswleiddiad croglofftydd. Mae gwneud sment amnewid, er enghraifft, yn lleihau ar faint o gerrig a ddefnyddir o chwareli, gan gyfrannu felly at gadw'r amgylchedd.**

Digwyddiadau Cemegol a Pheryglus

5.20. Yn fwy ac yn fwy mae defnydd a symudiadau sylweddau peryglus yn codi cwestiynau ynghylch diogelwch ac iechyd y cyhoedd, y gweithredwyr a'r gwasanaethau brys. Yr Awdurdod Gweithredol Iechyd a Diogelwch yw'r awdurdod ar gyfer gorfodi iechyd a diogelwch ar safleoedd y prif beryglon ac wrth gludo sylweddau peryglus, a rhaid ymgynghori hwy ynghylch materion cynllunio defnyddio tir o gwmpas safleoedd y prif beryglon. Bydd nifer o gyrff hefyd yn adnoddau ardderchog i'r Cynulliad Cenedlaethol er mwyn sicrhau bod Cymru'n rheoli'r agweddau iechyd ar ddigwyddiadau brys a digwyddiadau hir-dymor sy'n cynnwys sylweddau peryglus. Mae'r rhain yn cynnwys y *Ffocws Cenedlaethol Digwyddiadau Cemegol* yng Nghaerdydd, sy'n gwasanaethu'r DU gyfan, *Canolfan Cydweithredol Digwyddiadau Cemegol Mudiad Iechyd y Byd (WHO)*, sydd hefyd wedi'i lleoli yng Nghaerdydd ac sy'n chwarae rhan ryngwladol, ac *Uned Gymorth Rheoli Digwyddiadau Cemegol* yng Nghymru. Mae'r Swyddfa Gymreig yn bwriadu adeiladu ar waith sydd eisoes wedi'i sefydlu a, drwy ymgynghori 'r Awdurdodau Lleol, yr Awdurdodau Iechyd a'r gwasanaethau brys, dylunio fframwaith strategol ar gyfer canllawiau a gwaith monitro.

Sut mae datblygu'n blaenoriaethau i sicrhau cydbwysedd cynaliadwy rhwng diogelu iechyd y cyhoedd a'r amgylchedd?

6. PARTNERIAETHAU AR GYFER IECHYD

Mae'r bennod hon yn ceisio tynnu ynghyd themu sy'n uno'r cyfan, a nodi ar ba lefel y mae angen cymryd camau.

6.1. Mae angen gweithredu ar draws ffrynt eang sy'n ymestyn ymhell y tu hwnt i'r NHS i fynd i'r afael 'r anghydraddoldebau iechyd a'r iechyd gwaelach a brofir gan Gymru o'i chymharu 'r goreuon yn Ewrop. Bydd angen strategaeth hir-dymor ac ymagwedd strwythuredig er mwyn penderfynu yr hyn y mae angen ei wneud a phwy ddylai ei wneud. Bydd yn fwyaf priodol rhoi sylw i rai agweddau ar lefel y Llywodraeth ganolog, rhai ar lefel Cymru gyfan, a rhai ar lefel leol.

6.2. Ni fydd yn hawdd datblygu polisau priodol a mynd i'r afael 'r problemau. Bydd gan bawb gyfraniad i'w wneud, yn arbennig i annog unigolion i gymryd camau i hybu eu hiechyd a'u lles eu hunain. Bydd yn hanfodol meithrin partneriaethau effeithiol newydd ar draws ystod eang o asiantaethau, gan gynnwys y Llywodraeth ganolog a Llywodraeth leol, masnach a diwydiant a chyrff gwirfoddol.

Sut dylai'r cyfrifoldebau dros nodi a gweithredu ar anghydraddoldebau statws iechyd gael eu rhannu gan wahanol asiantaethau?

Unigolion

6.3. Mae gan bob ohonom gyfrifoldeb dros gadw'n hiechyd ac osgoi ffactorau sy'n achosi salwch. Mae afiechyd y gellir ei osgoi yn gwastraffu bywydau, adnoddau'r NHS ac yn lleihau'n ffyniant a'n lles economaidd. Mae'r Swyddfa Gymreig o'r farn y dylai fod yn hawdd i unigolion a theuluoedd gael gwybodaeth dda am ffyrdd iach o fyw ac y dylent gael eu cefnogi mewn cymunedau, yn y gweithle, mewn ysgolion a sefydliadau cyhoeddus o bob math i wneud y gorau o'r cyfleoedd ar gyfer iechyd a lles.

Beth yw'r ffordd orau i unigolion gael eu hannog i ofalu am eu hiechyd eu hunain o fewn cymunedau, gweithleoedd, ysgolion ac amgylcheddau eraill?

Cyrff Cymunedol a Gwirfoddol

6.4. Bydd swyddogaeth yr eglwysi, grwpiau ieuenctid a phlant, grwpiau chwaraeon a hamdden, a chyrff gwirfoddol yn bwysig i lwyddiant a fframwaith newydd ar gyfer iechyd a lles. Mae perthnasoedd a chymorth cymdeithasol yn allweddol er mwyn sicrhau y gall pawb fyw bywyd gweithgar.

6.5. Yn ysbryd y compact sy'n cael ei ddatblygu rhwng y Swyddfa Gymreig a'r sector gwirfoddol yng Nghymru, dylai partneriaethau cynhyrchiol rhwng y gwasanaethau statudol a chyrff cymunedol a gwirfoddol wneud y gorau o'r holl adnoddau mewn cymuned. Mae gan y Swyddfa Gymreig ddiddordeb mewn cynlluniau gwirfoddoli arloesol sy'n rhoi cymorth i bobl leol pan fydd ei hangen. Rhaid i gynlluniau o'r fath gael eu monitro'n iawn a'u gwerthuso a rhaid i'r aelodau gael eu hyfforddi a chael cymorth proffesiynolion priodol.

Sut gall cyrff gwirfoddol chwarae rhan gyflawn wrth wella iechyd a lles eu cymunedau, mewn partneriaeth phroffesiynolion a gwasanaethau eraill?

Awdurdodau Lleol

6.6. Yr Awdurdodau Lleol sy'n gyfrifol am wasanaethau mawr megis gwasanaethau cymdeithasol, tai, trafnidiaeth a chynllunio. Maent hefyd yn cyflawni swyddogaethau pwysig ym maes iechyd y cyhoedd, gan gynnwys rheoli iechyd galwedigaethol ac amgylcheddol, hylendid bwyd a chlefydau heintus. Mae gan yr ardaloedd morol gyfrifoldebau dros iechyd porthladdoedd hefyd. Mae'r Awdurdodau Lleol hefyd yn gyflogwyr o bwys.

6.7. Mae gan yr Awdurdodau Lleol swyddogaeth mewn llywodraethu cymunedau, yn aml drwy ariannu cyrff gwirfoddol a datblygu strategaethau corfforaethol. Mae rl yr aelodau etholedig yn bwysig, oherwydd eu gwybodaeth leol o'u cymuned yn y ward, eu harbenigedd penodol e.e. Cadeiryddion Pwyllgorau Iechyd yr Amgylchedd/Diogelu'r Cyhoedd, a'u cyfraniad at agendu strategol corfforaethol.

6.8. I helpu i ddatblygu cyd-gyfrifoldeb dros welliannau bras yn iechyd pobl, a lles y cymunedau lleol, cyflwynir dyletswydd newydd i ymwneud phartneriaethau ar yr Awdurdodau Lleol a'r NHS fel ei gilydd. Bydd yr Awdurdodau Lleol yn bartneriaid o bwys yn natblygiad a chyflwyniad rhaglenni gwella iechyd.

6.9. Mae'r Llywodraeth yn ystyried cyflwyno gofyniad bod **Asesiad Effaith Iechyd** yn cael ei gynnal pan ddatblygir gwasanaethau newydd o bwys, gan gynnwys y rhai sy'n gyfrifoldeb i lywodraeth leol. Mae hefyd yn bwriadu adolygu dyraniad presennol y swyddogaethau rhwng yr Awdurdodau Iechyd a'r Awdurdodau Lleol ynghylch rheoli clefydau trosglwyddadwy.

6.10. Mae'r Awdurdodau Lleol yn chwarae rhan eithriadol o bwysig ym mywydau ystod eang o bobl. Gall Adrannau Gwasanaethau Cymdeithasol wneud cyfraniad o bwys at gefnogi pobl gartref a hybu eu hannibyniaeth, yn aml drwy bartneriaeth gwasanaethau iechyd.

6.11. Gall cydweithredu effeithiol ar y lefel hon sicrhau manteision sylweddol i unigolion a sicrhau bod yr holl adnoddau sydd ar gael yn cael eu defnyddio'n effeithlon, er enghraifft drwy atal yr angen i dderbyn pobl i'r ysbyty a chynnal cleifion pan gnt eu rhyddhau. Drwy gysylltiadau llawer o'r bobl hawsaf eu niweidio o ddydd i ddydd, gall y gwasanaethau cymdeithasol chwarae rhan bwysig wrth nodi problemau'n gynnar. Gallant helpu pobl i gael y gwasanaethau priodol a dod o hyd i'w ffordd o amgylch y system. Fe allant:

- helpu gyda mynediad i wasanaethau iechyd;
- sicrhau bod pobl yn cael y budd-daliadau a'r gwasanaethau y maent yn gymwys i'w cael;
- gweithio gyda'r gwasanaethau addysg a'r NHS i hybu lles plant a theuluoedd;
- cefnogi pobl i fyw'n annibynnol cyn belled phosibl yn eu cartrefi eu hunain yn y gymuned;
- cydnabod gwerth gofalwyr a hybu gwasanaethau i'w cynnal.

6.12. Bydd y Swyddfa Gymreig yn ystyried pa newidiadau sy'n angenrheidiol mewn **canllawiau cynllunio** i sicrhau y cymerir yr effaith ar iechyd i ystyriaeth mewn cynlluniau datblygu cymdeithasol ac economaidd lleol.

6.13. Mae'r mathau eraill o gydweithredu y gellid eu hystyried yn cynnwys:

- cyd-gyrff ffurfiol wedi'u strwythuro ar fodelau presennol, gan gynnwys cynrychiolwyr o'r sector gwirfoddol;
- cydweithredu mwy effeithiol i ddiffinio ac i gyflwyno cynlluniau gofal cymdeithasol statudol yn ardal pob Awdurdod Lleol, er enghraifft drwy sicrhau cyd-gyfnewid rhwng staff Awdurdodau Iechyd ac Awdurdodau Lleol;
- cyd-ymgynghori 'r cymunedau lleol i gynnwys y bobl leol wrth ddatblygu cynlluniau'r Awdurdodau Iechyd a'r Awdurdodau Lleol, gan gynnwys y cynlluniau cymunedol eang y mae'r Cynghorau'n debyg o gael pwer i'w paratoi;
- Swyddogion Diogelu'r Cyhoedd ac Iechyd Amgylchedd yr Awdurdodau Lleol i gynghori Awdurdodau Lleol a Grwpiau Iechyd Lleol;
- Cyfarwyddwyr Iechyd y Cyhoedd i ddatblygu eu rl wrth roi cyngor annibynnol i Awdurdodau Iechyd ac

Awdurdodau Lleol;

- Asesiad o Effaith datblygiadau mawr ar Iechyd i gael cyfraniad gan ystod o broffesiynolion;

- cyd-benodiadau gan Awdurdodau Iechyd ac Awdurdodau Lleol, gan gynnwys recriwtio arbenigwyr iechyd y cyhoedd i weithio gyda'r Awdurdodau Lleol.

Beth yw'r ffordd orau i'r Awdurdodau Lleol chwarae rhan gyflawn wrth wella iechyd a lles eu poblogaethau, yn benodol cyfrifoldebau dros nodi a gweithredu ar benderfynyddion iechyd, megis tai, sy'n effeithio ar iechyd?

Yr NHS

6.14. Yn *Rhoi Cleifion yn Gyntaf (1998)*[cm] nodir fframwaith ar gyfer gosod system o ofal integredig yn lle'r farchnad fewnol yn NHS Cymru. Bwriad y strwythur newydd yw canolbwyntio adnoddau ar ofal uniongyrchol i gleifion a galluogi pob proffesiynolyn i gyfrannu at wasanaethau cydlynus. Bydd meddygon, nyrsys a phroffesiynolion gofal iechyd eraill lleol yn cymryd yr awenau wrth lunio gwasanaethau lleol i fodloni anghenion cleifion.

6.15. Ffocws newydd NHS Cymru fydd cydweithredu yn hytrach na chystadlu, a gwella iechyd yn ogystal thrin salwch. Ar gyfer iechyd cynaliadwy mae angen gwasanaethau integredig gan gynnwys ystod o broffesiynolion iechyd, gan gynnwys nyrsys, meddygon, fferyllwyr, gwasanaethau iechyd ysgol, deintyddion, optegwyr ac amrediad o wasanaethau arbenigol.

6.16. Mae angen cryfhau rl NHS Cymru ym maes iechyd y cyhoedd, i sicrhau bod pob rhan o'r gwasanaeth iechyd yn canolbwyntio'n fwy ar atal afiechyd drwy gyfrwng y canlynol:

- mynd i'r afael ag anghydraddoldeb drwy sicrhau bod gwasanaethau'n cyrraedd yr ardaloedd lle mae'r angen mwyaf, a bod y gwasanaethau sydd ar gael o well ansawdd;

- sicrhau'r cymysgedd cywir o wasanaethau lleol;

- sicrhau bod yr NHS yn gosod esiampl fel cyflogydd da, gan ddangos ei fod o ddifrif ynglyn ag iechyd amgylcheddol ac iechyd a diogelwch galwedigaethol.

Sut dylai'r dyletswyddau hyn gael eu cyflawni, yn arbennig y cyfrifoldebau dros nodi a gweithredu ar anghydraddoldebau mynediad i wasanaethau byr-dymor a chanlyniadau amrywiol i gleifion?

Awdurdodau Iechyd

6.17. Mae gan yr Awdurdodau Iechyd rl o bwys wrth atal clefydau a gwella iechyd, a dal ysbytai a darparwyr gofal iechyd yn gyfrifol am eu cyfraniad at wneud pobl yn iachach. Mae Cyfarwyddwyr Iechyd y Cyhoedd yn gyfrifol am reoli clefydau trosglwyddadwy, rhaglenni effeithiol o imwneiddio, brechu a sgrinio, ac am adroddiadau annibynnol am iechyd eu poblogaethau. Mae angen cryfhau'r arbenigedd yn iechyd y cyhoedd ym mhob sector. Mae hybu cynnydd yn yr ymwybyddiaeth o faterion iechyd y cyhoedd yn sylfaenol ar gyfer yr ymagwedd newydd, fel bod y rhain yn ymdreiddio i ddealltwriaeth a diwylliant proffesiynolion iechyd ac eraill.

6.18. Bydd gan Gyfarwyddwyr Iechyd y Cyhoedd rl allweddol wrth hwyluso perthnasoedd newydd llywodraeth leol ac asiantaethau lleol. Er mwyn cryfhau'n sylfaen bresennol o wybodaeth, bydd y Llywodraeth yn esemptio proffesiynolion iechyd y cyhoedd o'r diffiniad o gostau rheoli Awdurdodau Iechyd, fel na fydd ymdrechion i leihau biwrocratiaeth yn yr NHS yn creu cam-gymhelliant i wanhau'r arbenigedd mewn iechyd y cyhoedd ar y lefel leol. Buddsoddiad at y tymor hir yw iechyd y cyhoedd, ac nid gorben gweinyddol.

6.19. Bydd ar yr Awdurdodau Iechyd ddyletswyddau newydd o bartneriaeth, yn arbennig gyda'r Awdurdodau Lleol a'r sector gwirfoddol, i wella iechyd eu poblogaeth. Drwy ymgynghori rheolwyr gwasanaethau, bydd y Swyddfa Gymreig yn datblygu fframweithiau ar gyfer cydweithredu a mecanweithiau ar gyfer enwi a mynnu camau yngln ag anghydraddoldebau iechyd. Yn benodol, bydd angen i'r fframwaith ar gyfer dyrannu adnoddau rhwng yr Awdurdodau Iechyd ac o fewn yr

ardaloedd a wasanaethir gan yr Awdurdod Iechyd gymryd i ystyriaeth waith i fynd i'r afael ag anghydraddoldebau mewn statws iechyd a mynediad i wasanaethau. Rhaid nodi ar wahn anghenion penodol menywod a grwpiau arbennig yn y gymuned a mynd i'r afael hwy.

6.20. Bydd blaenoriaethau newydd yr Awdurdodau Iechyd yn ei gwneud yn ofynnol iddynt fynd yn fwy strategol a chanolbwyntio'n fwy ar wella iechyd. Cedwir llawer o'u cyfrifoldebau presennol nad oeddynt yn gysylltiedig 'r farchnad fewnol. Oni chnt eu diwygio fel arall, mae'r rhain yn cynnwys cytuno ar yr hyn y mae angen ei wneud i wella iechyd a gofal iechyd pobl leol, mesur statws iechyd ac epidemioleg a chyflwyno adroddiadau arnynt, darparu cyngor meddygol, deintyddol, fferyllol a chyngor nyrsio annibynnol, ac ystod o swyddogaethau i ddiogelu iechyd y cyhoedd ac ymateb i achosion o glefydau.

Grwpiau Iechyd Lleol

6.21. Bydd gweithredu *Rhoi Cleifion yn Gyntaf (1998)* yn arwain at sefydlu **Grwpiau Iechyd Lleol**, wedi'u seilio ar ffiniau'r Awdurdodau Lleol. Grwpiau Iechyd Lleol fydd y cyfrwng ar gyfer cydweithredu lleol rhwng y gwasanaethau sy'n effeithio ar iechyd y cyhoedd. Bydd ar y Grwpiau gynrychiolwyr o wasanaethau cyhoeddus y tu allan i iechyd a byddant yn gallu ysgogi gwasanaethau ac adnoddau ar gyfer ystod eang o wasanaethau. Bydd yn bwysig i'r Grwp Iechyd Lleol gael gafael ar wybodaeth am statws iechyd, yn arbennig lle bo hwnnw o dan y cyfartaledd cenedlaethol, a'r adnoddau i wneud gwahaniaeth go iawn dros gyfnod o amser.

6.22. Er y bydd y Grwpiau Iechyd Lleol yn dod phenderfyniadau'n nes at y bobl leol, byddant yn rhy fawr i gynrychioli materion iechyd ardaloedd bach. Bwriedir defnyddio profiad **Rhaglenni Ymchwil Gweithredu Iechyd Cynaliadwy** i ddatblygu ffyrdd o greu sylfaen effeithiol ar gyfer gwaith cynllunio a phwerau penderfynu y Grwpiau Iechyd Lleol.

Beth yw'r ffordd orau o baratoi'r Grwpiau Iechyd Lleol i wneud y gwaith hwn, yn arbennig cyfrifoldebau dros nodi a gweithredu ar anghydraddoldebau statws iechyd a mynd ati i hybu gwelliannau mewn iechyd?

Ymddiriedolaethau NHS

6.23. Fel prif gyflogwyr staff yr NHS, mae ar Ymddiriedolaethau NHS gyfrifoldeb penodol dros osod esiampl fel cyflogwyr da a sicrhau gwasanaethau iechyd galwedigaethol o safon uchel (hyn fel cyflogwyr staff ac fel darparwyr gwasanaethau iechyd galwedigaethol i eraill). Mae ganddynt gyfrifoldeb hefyd dros sicrhau bod ysbytai yn lleoedd iach, drwy gyfrwng mesurau trwyadl i atal traws-heintiadau.

Gofal Sylfaenol

6.24. gwasanaethau gofal sylfaenol megis ymarferwyr cyffredinol, nyrsys cymunedol, ymwelwyr iechyd a bydwragedd y gwneir 90% o gysylltiadau 'r NHS. Mae ymarferwyr cyffredinol, nyrsys practis ac aelodau eraill y t"m gofal sylfaenol mewn sefyllfa ddelfrydol i weithredu fel eiriolydd i'r cleifion, gan eu helpu drwy'r system, eu gosod ar y ffordd gywir, a gwneud y cysylltiadau iawn. Drwy gyd-leoli gwasanaethau iechyd a gwasanaethau cymunedol eraill, gellir sicrhau mynediad hawdd a siopau pob peth' er mwyn i bobl drafod materion megis budd-daliadau gyda chynrychiolwyr y gwasanaethau cymdeithasol, gofal cymdeithasol i blant ac oedolion hawdd eu niweidio gyda staff gwasanaethau cymdeithasol, a gofyn am gyngor ar faterion eraill gan bersonl y Canolfannau Gynghori, fel rhan o ofal iechyd ehangach.

6.25. Mae ymarferwyr cyffredinol yn rhoi gwybodaeth benodol hefyd am statws iechyd cleifion at ddibenion mynediad i dai, trafnidiaeth (DVLA), yswiriant, a budd-daliadau (e.e. Budd-dl Analluedd a Lwfans Anabledd). Maent yn chwarae rl arbennig o arwyddocaol mewn perthynas Thl Salwch Statudol a Budd-Daliadau Analluedd byr-dymor y wladwriaeth, gan mai'r dystiolaeth feddygol a roddant i'w cleifion yw'r llwybr cychwynnol i mewn i fudd-daliadau fel arfer. Maent yn chwarae rhan o bwys hefyd wrth asesu cleifion ar gyfer lleoliad mewn gofal hir-dymor (yn arbennig pobl oedrannus) a nodi anghenion gofalwyr ynghyd gwasanaethau iechyd lleol eraill. Mae cyd-reoli gwasanaethau i gleifion rhwng gwasanaethau iechyd a gwasanaethau cymdeithasol, megis cymorth integredig i gleifion wrth ymadael 'r ysbyty, yn holl-bwysig ar gyfer cynnal iechyd a lles ac ar gyfer defnyddio adnoddau'n effeithiol. Mae'r Swyddfa Gymreig yn bwriadu ymgynghori ag

Awdurdodau Iechyd, Ymddiriedolaethau NHS, Awdurdodau Lleol ac unigolion eraill sydd diddordeb ynghylch ffyrdd o sicrhau mwy o gymorth ac integreiddio.

Project Cymuned Iach Meddygfa Crosshands

Sefydlwyd Project Cymuned Iach Meddygfa Crosshands i roi sylw i anghenion cymunedol ym mhen uchaf Cwm Gwendraeth, drwy ddefnyddio model cydgysylltydd cymunedol. Nodweddion allweddol y project yw nodi anghenion iechyd lleol a datblygu cysylltiadau rhwng asiantaethau er mwyn diwallu'r anghenion hynny.

Ar gyfer y fenter penodwyd cydgysylltydd iechyd cymunedol ym mhractis pob un o'r ymarferwyr cyffredinol lleol. Rl y cydgysylltydd yw nodi anghenion cymunedau lleol a rhoi sylw i'r anghenion hynny drwy weithio mewn partneriaeth ag aelodau'r cymunedau lleol, proffesiynolion iechyd ac eraill ac asiantaethau gwirfoddol.

6.26. Mae ymarferwyr cyffredinol, nyrsys, ymwelwyr iechyd, bydwragedd, deintyddion a fferyllwyr hefyd yn darparu addysg ar gyfer cleifion ynghylch materion ffordd o fyw sy'n ymwneud yn benodol ag atal clefyd gymaint rheoli clefyd. Mae cyngor ar ymarfer corff, rhyw ddiogel, deiet, ysmygu, diogelwch a pharatoi bwyd yn berthnasol yma. Ceir tystiolaeth gref (e.e. rhoi'r gorau i ysmygu) bod cyngor ac ymyriadau hybu iechyd gan broffesiynolion iechyd yn cael ymateb da ac yn effeithiol.

Canolfannau Byw'n Iach

Caiff Cymru bron 20 miliwn ar gyfer sefydlu rhwydwaith o ganolfannau byw'n iach dros y blynyddoedd 2001-02. Darperir 300 miliwn ar draws y DU ar gyfer Canolfannau Byw'n Iach o Arian y Loteri drwy gyfrwng y Gronfa Cyfleoedd Newydd. (Nodwyd y ci'r Gronfa ei sefydlu yn y Papur Gwyn The People's Lottery, a gyhoeddwyd yng Ngorffennaf 1997). Mae'r arian ar gyfer Canolfannau Byw'n Iach yn gyfle aruthrol i wella iechyd pobl Cymru. Anelir Canolfannau Byw'n Iach at y cymunedau hynny, yn y trefi a chefn gwlad, sy'n profi'r iechyd gwaethaf.

Bydd Canolfannau Byw'n Iach yn helpu pobl i wneud y gorau o'u hiechyd a'u lles beth bynnag fo'u gallu ar gyfer ffitrwydd' yn yr ystyr draddodiadol. Ond bydd Canolfannau Byw'n Iach yn fwy na chanolfannau ffitrwydd. Canolbwyntir ar iechyd fel nodwedd bositif sy'n helpu pobl i gael y mwyaf o'u bywyd, gan ymgorffori lles corfforol a meddyliol. Bydd y canolfannau'n berthnasol i bobl o bob oed: dechrau iach mewn bywyd i blant, bywyd iach i oedolion o oedran gweithio, ac ymddeoliad iach i eraill. Ceir llawer o enghreifftiau eisoes o fentrau lleol arloesol wedi'u dylunio i wella pobl ar draws Cymru ac mae'r rhain yn llwyfan cadarn ar gyfer datblygu rhwydwaith o Ganolfannau Byw'n Iach.

Bydd angen i Ganolfannau Byw'n Iach greu partneriaethau rhwng cymunedau lleol, cyrff gwirfoddol, a chyrff statudol megis Awdurdodau ac Ymddiriedolaethau Iechyd, ac Awdurdodau Lleol, gan gynnwys eu hadrannau gwasanaethau cymdeithasol ac addysg. Gall fod angen hefyd gynnwys arbenigwyr hybu iechyd, ymarferwyr cyffredinol a gwasanaethau gofal sylfaenol, prifysgolion, ysgolion a chyrff yn y sector preifat.

Bydd Canolfannau Byw'n Iach yn lleol, gan anelu at fodloni'r amgylchiadau lleol penodol. Rhaid cael y bobl leol i gymryd rhan drwy gyfrwng ymdrechion gwirfoddol, ac i arddel perchnogaeth, er mwyn sicrhau bod Canolfannau Byw'n Iach yn adnoddyn cymunedol gwerthfawr a all ddenu pobl nad ydynt o bosibl yn defnyddio'r gwasanaethau presennol.

Hybu Iechyd

6.27. Mae gwaith effeithiol i hybu iechyd ar bob lefel yn elfen allweddol arall ar yr ymagwedd newydd. Mae gan lawer o asiantaethau ran i'w chwarae wrth ddarparu gwybodaeth, cyngor a rhaglenni newid diwylliant a anelir at wella iechyd. Mae'r Awdurdodau Iechyd a'r Ymddiriedolaethau NHS yn darparu unedau hybu iechyd arbenigol. Mae proffesiynolion iechyd mewn llawer cefndir yn ffynonellau pwysig o gyngor a chymorth ar agweddau ar ffordd iach o fyw. Mae gan Lywodraeth Leol rl gref mewn hybu iechyd. Yn y dyfodol, disgwylir i Grwpiau Iechyd Lleol gydgysylltu mentrau lleol i hybu iechyd ar draws ystod o wasanaethau, o fewn strategaeth genedlaethol.

6.28. Rhieni, gyda chymorth ysgolion, sydd 'r rhan bwysicaf wrth addysgu plant am fyw'n iach, osgoi niwed a sylweddau peryglus, a byw'n ddiogel. Mae adolygiad o'r cwricwlwm Addysg Bersonol, Cymdeithasol ac Iechyd ar y gweill i ystyried sut y gellir addysgu plant ar gyfer iechyd a lles.

6.29. Yn ychwanegol at Addysg, mae llawer agwedd arall ar wasanaethau'r awdurdodau lleol yn hybu iechyd a lles, drwy gyfrwng eu gwaith ar ddiogelwch bwyd, diogelwch ffyrdd, safonau masnachu, diogelu'r amgylchedd a gwasanaethau cymdeithasol personol.

6.30. Mae Awdurdod Hybu Iechyd Cymru (HPAW) yn rhedeg rhaglenni cenedlaethol ac yn gweithio mewn partneriaeth chyrff eraill yn y gwasanaeth iechyd ac mewn mannau eraill i hybu iechyd a lles. Mae'r Ysgrifennydd Gwladol wedi gofyn i Hybu Iechyd Cymru, o dan gyfarwyddyd grwp llywio aml-asiantaeth, adolygu'r gweithgareddau hybu iechyd presennol yng Nghymru i baratoi ar gyfer strategaeth genedlaethol y bwrir ymlaen hi gan y Cynulliad Cenedlaethol. Bydd yr adolygiad a'r strategaeth yn cymryd i ystyriaeth rl llywodraeth leol, y sector gwirfoddol ac eraill sy'n gysylltiedig hybu iechyd a'r angen am fwy o gydweithredu:

- datblygu cyfraniad hybu iechyd at wella iechyd a mynd i'r afael ag anghydraddoldebau mewn statws iechyd drwy'r canlynol:
- cysylltu polisi cyhoeddus gwella iechyd;
    - gwella medrau pobl i wella'u hiechyd a'u lles;
    - cryfhau gallu cymunedau i sicrhau cynnydd mewn iechyd;
    - cynnal amodau byw a gweithio sy'n hybu iechyd;
    - cyfeirio gwasanaethau iechyd a gofal cymdeithasol tuag at wella iechyd a lles.

6.31. Ymgynghorir yn eang ar yr adolygiad, gan arwain at strategaeth gytn i'w chyhoeddi fel rhan o *Gynllun Gweithredu Gwell Iechyd - Gwell Cymru* ym Medi 1998.

Ymchwilio a Datblygu

6.32. Rhaid i iechyd a lles cynaliadwy ar gyfer unigolion a chymunedau, ochr yn ochr darparu gofal iechyd a gofal cymdeithasol priodol, gael eu seilio ar y dystiolaeth orau sydd ar gael o bolisi ac arferion cyhoeddus effeithiol. I wneud hyn, rhaid i'r strategaeth gael ei bwydo gan yr arferion gorau mewn mannau eraill yn y DU ac yn rhyngwladol drwy gysylltiadau academaidd a chysylltiadau ymchwil cryf ag Ewrop.

6.33. Yn sgil sefydlu Swyddfa Cymru ar gyfer Ymchwilio a Datblygu (WORD) ym 1995, mae Cymru wrthi'n datblygu safonau ac arferion wedi'u seilio ar dystiolaeth a ddylunnir i fod yn sylfaen ar gyfer gofal iechyd a gofal cymdeithasol. Bydd ailffocysu'r ymchwil ar faterion iechyd y cyhoedd yn bwysig er mwyn sicrhau gwelliannau mewn iechyd. Mae'r Ysgrifennydd Gwladol wedi gofyn i WORD, o dan gyfarwyddyd grwp llywio aml-asiantaeth, ddatblygu fframwaith strategol ar gyfer hybu ymchwilio a datblygu o ansawdd uchel i ategu ymagweddau at wella iechyd sydd wedi'u seilio ar dystiolaeth. Bydd y fframwaith yn cynnwys argymhellion ar gyfer blaenoriaethau a rhaglen gymorth y bwrir ymlaen hi gan y Cynulliad Cenedlaethol. Bydd y fframwaith strategol a'r rhaglen gymorth yn ystyried y cyfraniad y gall ymchwilio a datblygu ei wneud at wella iechyd a mynd i'r afael ag anghydraddoldebau mewn statws iechyd; a gofal iechyd a gofal cymdeithasol effeithiol, drwy gymorth wedi'i seilio ar dystiolaeth ar gyfer:

- ailffocysu polisi cyhoeddus tuag at wella iechyd;
- darparu rheolaeth a thriniaeth briodol ac effeithiol ar gyfer afiechyd ac anabledd;
- gwella medrau pobl i wella'u hiechyd a'u lles eu hunain;
- cryfhau gallu cymunedau i sicrhau cynnydd mewn iechyd;

- cynnal amodau byw a gweithio sy'n hybu iechyd;
- cyfeirio gwasanaethau gofal iechyd a gofal cymdeithasol tuag at wella iechyd a lles;
- nodi anghenion iechyd gwahanol menywod.

6.34. Mae'r agenda hon ar gyfer yr adolygiad yn adlewyrchu trefniadau unigryw yng Nghymru sy'n dod ag ymchwil iechyd ac ymchwil gofal cymdeithasol yn agos at ei gilydd. Ymgynghorir yn eang ynglyn 'r adolygiad, gan arwain at strategaeth gytn i'w chyhoeddi fel rhan o *Gynllun Gweithredu Gwell Iechyd - Gwell Cymru* ym Medi 1998.

Rhwydweithiau Cydweithredol

6.35. Mae Agenda newydd ar gyfer Gwell Iechyd - Gwell Cymru yn gofyn am gydweithredu ar draws ffrynt eang. Ceir cydweithredu eisoes mewn amrywiaeth o sefydliadau; dyma rai enghreifftiau o rwydweithio:

- grwpiau cyd-sectoraidd a chyd-ddisgyblaeth megis Rhwydwaith Iechyd Cyhoeddus Cymru, Cydweithrediad Iechyd ac Amgylchedd Cymru, Fforwm Microbiolegol Bwyd Cymru a Fforwm Ansawdd Aer Cymru; a
- grwpiau proffesiynol megis Cymdeithas Cyfarwyddwyr Diogelu'r Cyhoedd yng Nghymru, Cyfarwyddwyr Meddygaeth Iechyd y Cyhoedd, Meddygon Dynodedig (Amddiffyn Plant), Nyrsys a Bydwragedd Dynodedig (Amddiffyn Plant), Cydgysylltwyr Imwneiddio, Panel Prif Swyddogion Tai Cymru Gyfan, Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol, Cymdeithas Prif Weithredwyr yr Awdurdodau Lleol.

6.36. Mae'r Swyddfa Gymreig wrthi'n ystyried yr angen am rwydwaith cydweithredol ar lefel y Cynulliad Cenedlaethol y disgwylid i bob cyfranddaliwr gyfrannu ato. Yn ychwanegol at y rhai a restrwyd yn 6.35, ceir nifer o sefydliadau addysgol, rhwydweithiau ymchwil a chyrff gwirfoddol sydd llawer i'w gyfrannu at y drafodaeth, at ddatblygu polisi a'i weithredu. Gallai Cynulliad Cenedlaethol Cymru fod ar ei ennill o gael trefniant a fyddai'n hwyluso cydweithrediad yr holl grwpiau hyn, ar sail system gynhwysfawr o wybodaeth iechyd megis HOWIS. Dyddiau cynnar yw hi ar y trafodaethau ac mae croeso i awgrymiadau ar sut y gallai rhwydwaith o'r fath gael ei ddatblygu ac ar yr aelodaeth bosibl.

Sut gall grwpiau proffesiynol chwarae rhan gyflawn mewn cydweithredu ystyrlon a fydd yn gwella iechyd a lles cymunedau, mewn partneriaeth grwpiau gwirfoddol a chymunedol?

Cynulliad Cenedlaethol Cymru

6.37. Cyhyd ag y bydd y Senedd yn ei gymeradwyo, bydd sefydlu Cynulliad Cenedlaethol Cymru ym 1999 yn gweddnewid bywyd cyhoeddus yng Nghymru gan gyflwyno rheolaeth ddemocrataidd ar adnoddau iechyd am y tro cyntaf. Amlinellwyd swyddogaethau iechyd arfaethedig y Cynulliad yn y Papur Gwyn, Llais dros Gymru:

- monitro iechyd a lles poblogaeth Cymru ac ymateb pholisau i hybu iechyd a mynd i'r afael ag afiechyd;
- penderfynu graddfa'r adnoddau ariannol ar gyfer iechyd o fewn ei gyllideb gyffredinol;
- nodi a hybu arferion da mewn gwasanaethau iechyd a dal cyrff yr NHS yng Nghymru yn atebol am eu perfformiad;
- holi a gweithredu ar farn cleifion, staff a gofalwyr ar ansawdd gwasanaethau'r NHS;
- sicrhau bod gan NHS Cymru weithlu o staff hyfforddedig.

6.38. Wrth bennu fframwaith strategol ar gyfer gwella iechyd Cymru, bydd ar y Cynulliad angen y canlynol:

- gwybodaeth am iechyd pobl Cymru ar lefel genedlaethol, lefel ranbarthol a lefel yr awdurdodau lleol;
- canllawiau a chyfarwyddiadau i bennu safonau ar gyfer tai, rhwydweithiau trafnidiaeth, rheolau amgylcheddol,

gofal iechyd a hybu iechyd, a mynediad i wasanaethau iechyd;

- adborth ar lefel a chyraeddiadau gwasanaethau cyhoeddus yn nhermau cynnydd mewn iechyd;

- gwasanaethau Cymru gyfan megis ymchwilio a datblygu ar gyfer iechyd a gofal cymdeithasol; a hybu iechyd.

6.39. Yr amcan fydd gwella iechyd ledled Cymru a mynd i'r afael ag anghydraddoldebau mewn statws iechyd ac mewn mynediad i wasanaethau priodol. Mae'r Llywodraeth o'r farn y gellir gwneud hyn drwy sicrhau bod effeithiau ar iechyd yn cael eu cymryd i ystyriaeth mewn agendu eraill, a thrwy gyfrwng mathau newydd o gydweithredu. Nid syniad newydd mo hwn a gwyddom oll pa mor anodd ydyw yn ymarferol. Yr hyn sy'n newydd yw hybu polisau cynhwysol sy'n gweithredu gyda chyfraniad gweithgar gan unigolion, asiantaethau lleol a'r Llywodraeth.

6.40. I ddechrau chwalu'r rhwystrau i gydweithredu yng nghraidd y Llywodraeth, mae'r Prif Weinidog wedi penodi Gweinidog newydd dros iechyd y cyhoedd ac wedi penodi Pwyllgor Cabinet pwysig ar gyfer Iechyd y Cyhoedd gyda chynrychiolwyr o 12 o Adrannau. Gweinidog Iechyd y Swyddfa Gymreig sy'n bwrw ymlaen 'r gwaith hwn yng Nghymru. Cyfrifoldeb yr Uned Dieithrwch Cymdeithasol yw rhoi sylw i'r anghydraddoldebau sy'n effeithio ar y grwpiau hawsaf eu niweidio yn ein cymdeithas.

6.41. I baratoi ar gyfer y Cynulliad Cenedlaethol, mae'r Swyddfa Gymreig yn cynnal adolygiad sylfaenol o strwythur y Grwp Iechyd, gan edrych yn benodol ar gylch gwaith y Cynulliad dros wella iechyd a mynd i'r afael ag anghydraddoldebau. Mae mecanweithiau ar gyfer gweithio ar draws y Swyddfa yn cael eu datblygu drwy amsugno Tai Cymru i mewn i Adran Tai newydd a thrwy drefnu bod rhannau o Awdurdod Gwasanaethau Cyffredin Iechyd Cymru a Hybu Iechyd Cymru yn dod i mewn i'r Cynulliad.

Sut dylai cydweithredu yng nghyd-destun Cynulliad Cenedlaethol Cymru gael ei gryfhau i sicrhau mai gwell iechyd sy'n ysgogi'r polisau pwysicaf?

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7. MESUR CYNNYDD

Yn y bennod hon trafodir targedau a dulliau mesur cynnydd mewn iechyd.

7.1. Rhaid i'r strategaeth ar gyfer *Gwell Iechyd - Gwell Cymru* osod cerrig milltir ar gyfer asesu cynnydd. Ystyr asesu cynnydd yw meintoli, mesur, a phennu nodau ar gyfer cynnydd tuag at wella iechyd a lles a lleihau anghydraddoldebau. Yr ydym yn dymuno adeiladu ar y **Targedau Cynnydd mewn Iechyd** i fesur cynnydd (gweler yr Eirfa), a chynnig fframwaith ar gyfer datblygu targedau lleol sy'n sensitif i'r amrywiaeth o amgylchiadau lleol ar draws Cymru.

Meini prawf ar gyfer pennu targedau

7.2. Wrth ddethol set o dargedau ar gyfer y strategaeth, mae'r Swyddfa Gymreig yn credu y dylai'r targedau:

- mesur meysydd arwyddocaol a fydd yn symud gwaith i wireddu'r strategaeth ymlaen;
- defnyddio ffynonellau data sefydledig;
- bod yn ymestynnol, ond yn gyraeddadwy;
- cael eu hystyried nid fel mesur manwl-gywir o gynnydd, ond fel arwydd o'r cynnydd sydd ym marn y Swyddfa Gymreig yn bosibl.

Datblygu targedau

7.3. Mae'r Swyddfa Gymreig yn bwriadu sefydlu grwp o arbenigwyr i roi ystyriaeth bellach i ddatblygu:

- targedau cenedlaethol ar gyfer lleihau anghydraddoldebau iechyd;
- targedau cenedlaethol ar gyfer gwella penderfynyddion iechyd.

7.4. Mae'r Swyddfa Gymreig yn cynnig y dylai'r Cyfarwyddwyr Iechyd y Cyhoedd, gan gydweithredu 'r Awdurdodau Lleol, adrodd bob blwyddyn i'r Prif Swyddog Meddygol ar gynnydd tuag at dargedau cenedlaethol a lleol; dylai'r adroddiadau hyn fod wedi'u seilo ar Raglenni treigl 3-blynedd ar gyfer Gwella Iechyd. Yn unol hynny bydd y Prif Swyddog Meddygol yn adrodd ar gynnydd ledled Cymru i Gynulliad Cenedlaethol Cymru. Bydd Adroddiadau Blynyddol Cyfarwyddwyr Iechyd y Cyhoedd yn parhau yn gyfrwng ar gyfer monitro ar y lefel leol.

7.5. Bydd Adroddiad Blynyddol y Prif Swyddog Meddygol yn cynnig gorolwg o'r cynnydd ar wella iechyd a lleihau anghydraddoldebau iechyd.

Targedau cenedlaethol cynnydd mewn iechyd

7.6. Cyhoeddodd y Swyddfa Gymreig set o bymtheng **Targed Cynnydd mewn Iechyd** ar gyfer Cymru ym Mehefin 1997 (DGM (97)50). Disgwylir i'r Awdurdodau Iechyd weithio gydag asiantaethau lleol eraill i ddatblygu cynlluniau gwella iechyd sy'n ymdrin 'r targedau, ac sy'n rhoi sylw i'r anghydraddoldebau rhwng iechyd poblogaethau'r Awdurdodau Lleol o fewn pob Awdurdod Iechyd. Mae'r targedau yn ymdrin 'r canlynol:

canser yr ysgyfaint
canser y fron
canser ceg y groth
clefyd y galon
strociau
damweiniau
hunan-laddiad
pwysau geni isel
poen yn y cefn
arthritis
iechyd meddwl
ysmygu
bwyta ffrwythau a llysiau
yfed alcohol
pydredd dannedd

Ceir rhestr lawn o'r targedau, ynghyd 'r manylebau technegol, yn yr Eirfa.

7.7. Datblygwyd y set hon o dargedau i roi sylw i ystod eang o anhwylderau sy'n cynnwys marwolaeth gynamserol, ansawdd bywyd, a ffyrdd o fyw sydd o bwys yng Nghymru; lle credid bod gwelliant yn realistig; ac sy'n fesuradwy, gyda gwaelodlin hysbys. Mae lefelau'r targedau yn cymryd profiad y gorffennol yng Nghymru, mewn rhannau eraill o'r DU, ac mewn gwledydd tebyg eraill yng Ngorllewin Ewrop, i ystyriaeth. Mae'r cymariaethau hyn yn cynnig syniad realistig o'r cyfle i wella ac o'r raddfa amser y gellir disgwyl gwelliannau o'i mewn.

7.8. Nid yw'n rhestr gynhwysfawr o anhwylderau pwysig, ac nid yw'n rhestr o flaenoriaethau - nac i'r gwasanaeth iechyd, nac i asiantaethau eraill. Yr hyn a gynigir, o'i gymryd fel pecyn, yw'r set orau sydd ar gael o ddangosyddion a thargedau ar gyfer gwelliant cyffredinol yn iechyd a lles Cymru. Pennwyd y mwyafrif o'r targedau ar gyfer y flwyddyn 2002, ynghlwm wrth raglen weithredu pum-mlynedd.

7.9. Gan gydnabod y gwaith sydd ar y gweill, mae'r Swyddfa Gymreig wedi penderfynu canolbwyntio ar y 15 **Targed Cynnydd mewn Iechyd**, gan ychwanegu targedau ar gyfer iechyd a lles plant, ar gyfer y tymor canolig, gan gydnabod y bydd nod hir-dymor y strategaeth yn ymestyn ymhell y tu hwnt i 2002.

Targedau cenedlaethol ar gyfer lleihau anghydraddoldebau iechyd

7.10. Mae'r Swyddfa Gymreig yn awyddus nid yn unig i wella iechyd y boblogaeth yn ei chrynswth, ond hefyd i fynd ar drywydd polisau a fydd yn creu'r effaith fwyaf posibl ar y rhannau hynny o'r boblogaeth sy'n dioddef yr iechyd gwaethaf. Drwy ymgynghori ag asiantaethau allweddol, bwriedir datblygu nifer o dargedau blaenoriaeth er mwyn lleihau anghydraddoldebau iechyd yng Nghymru.

Targedau cenedlaethol ar gyfer gwella penderfynyddion iechyd

7.11. Er bod iechyd y boblogaeth yn ei grynswth yn gwella'n gyson, lledu y mae'r anghydraddoldebau mewn iechyd. Yn yr amgylchedd cymdeithasol, economaidd a ffisegol y gwelir yr achosion isorweddol, ac mae'r rhain yn cymryd amser i'w newid, ac felly realiti'r sefyllfa yw na welir y duedd hon o fwy o anghydraddoldeb iechyd yn cael ei gwrth-droi am nifer o flynyddoedd. Dyna pam y bwriedir datblygu, yng ngoleuni'r sylwadau a ddaw i law yn ystod y cyfnod ymgynghori, nifer o dargedau cenedlaethol ar gyfer gweithredu ar benderfynyddion iechyd, i fod yn arwyddion canolradd o gynnydd gyda'r strategaeth.

Targedau lleol

7.12. Bwriedir i'r targedau cenedlaethol fonitro cynnydd ar y lefel genedlaethol. Ar y lefel leol, ceir hyblygrwydd drwy gyfrwng Rhaglenni Gwella Iechyd i ddatblygu strategaethau lleol a thargedau lleol ar gyfer bodloni'r targedau cenedlaethol, yn ogystal hyblygrwydd i ddatblygu targedau ychwanegol i fynd i'r afael blaenoriaethau lleol.

Rhaglenni Gwella Iechyd

7.13. Bydd Rhaglenni Gwella Iechyd ar gael yn ardal pob awdurdod iechyd erbyn diwedd 1999. Rhagwelwn y bydd Rhaglenni Gwella Iechyd:

- yn cynnig disgrifiad clir o sut yr eir i'r afael yn lleol nodau, blaenoriaethau a thargedau cenedlaethol ar gyfer iechyd a lles;
- yn nodi amrediad o flaenoriaethau a benderfynir yn lleol, gyda phwyslais penodol ar sylw i feysydd lle ceir anghydraddoldeb iechyd mawr yn y cymunedau lleol;
- yn pennu rhaglenni gweithredu cytn i roi sylw i'r blaenoriaethau cenedlaethol a lleol hyn ar gyfer gwella iechyd;
- yn dangos bod y camau arfaethedig wedi'u seilio ar dystiolaeth o'r hyn y gwyddys ei fod yn effeithiol;
- yn dangos pa fesurau o gynnydd lleol a ddefnyddir, gan gynnwys y mesurau sy'n angenrheidiol at ddibenion monitro cenedlaethol;
- yn nodi pa gyrff lleol sydd wedi cymryd rhan wrth lunio'r cynllun, beth fydd eu cyfraniad a sut y byddant yn gyfrifol am wireddu'r cynllun;
- yn sicrhau bod y cynllun yn hawdd i'w ddeall ac ar gael yn rhwydd i'r cyhoedd;
- yn gyfrwng ar gyfer pennu strategaethau i lunio gwasanaethau iechyd lleol;
- drwy ddefnyddio proses o asesu risg, yn penderfynu ar flaenoriaethau lleol ym maes iechyd a diogelwch galwedigaethol.

7.14. Bydd y trefniadau newydd yn golygu y gellir ystyried ymagwedd gydweithredol rhwng gwelliannau tai, cynlluniau integredig trafnidiaeth a gwell gwasanaethau lleol o fewn yr un fframweithiau lleol ag iechyd a gofal cymdeithasol. Ar ochr llywodraeth leol, tanlinellir yr ymagwedd hon gan fwriad y Llywodraeth i orfodi dyletswydd i sicrhau'r Gwerth Gorau ar draws yr ystod lawn o wasanaethau, gan gynnwys y rhai a gyflwynir gan y Cynghorau fel rhan o Raglenni Gwella Iechyd. Caiff grwpiau cymunedol a gwirfoddol gyfleoedd pwysig hefyd i ddylanwadu ar Raglenni Gwella Iechyd a'u gwerthuso. Dyma fydd y prif offeryn cynllunio ar gyfer gwella iechyd a thargedu anghydraddoldebau iechyd.

Sut dylai Rhaglenni Gwella Iechyd gael eu cyflawni?

Yn benodol sut y gellir defnyddio'r cyfrifoldebau dros ddarganfod a gweithredu ar anghydraddoldebau iechyd yn effeithiol?

8. BUDDSODDI YN Y DYFODOL

Mae'r bennod hon yn disgrifio cynigion ar gyfer bwrw ymlaen 'r agenda fras ynghylch cynnydd yn iechyd y cyhoedd.

8.1. Er gwaethaf y gostyngiad sylweddol mewn marwoldeb gynamserol ar draws y boblogaeth yn ei chrynswth, lledu y mae'r bwlch rhwng y rhai 'r iechyd gorau a'r rhai 'r iechyd gwaethaf. Mae'n debyg mai polisi economaidd, cymdeithasol, amgylcheddol a pholisi iechyd y cyhoedd, yn hytrach na gwasanaethau meddygol neu wasanaethau gofal iechyd personol eraill fydd y cyfrwng ar gyfer gwella iechyd a lleihau'r anghydraddoldebau iechyd rhwng grwpiau cymdeithasol.

8.2. Dylai'r dystiolaeth nad yw cyfraddau marwolaeth ymhlith lleiafrif sylweddol o boblogaeth Cymru yn gostwng mor gyflym chyfraddau'r mwyafrif fod yn destun pryder a thrafod cyhoeddus. Yn hytrach na chyrraedd targed Mudiad Iechyd y Byd (1995) o leihau 25% ar anghydraddoldeb iechyd erbyn y flwyddyn 2000, mae'n debyg mai cynnydd o 25% mewn anghydraddoldeb a welir.

8.3. Mae parhad y gwahaniaethau economaidd yng Nghymru yn awgrymu y gallai'r bwlch marwoldeb rhwng ardaloedd tlawd a chyfoethog gynyddu, oni bai bod camau pendant yn cael eu cymryd i wella'r cydbwysedd.

8.4. Nod *Gwell Iechyd - Gwell Cymru* yw gwella rhagolygon iechyd ein plant a'n pobl ifanc ac ymestyn bywyd gweithgar a chynhyrchiol pawb. Mae hyn yn golygu amgylcheddau diogel, tai, ysgolion, gweithleoedd a mannau cyhoeddus iach a ffyrdd iach o fyw, gan gynnwys cyfleoedd ar gyfer gwaith a hamdden. Pa nad yw hyn yn bosibl, dylem sicrhau y darperir y gofal gorau, sy'n ychwanegu ansawdd at fywyd yn ogystal ag ymestyn bywyd.

Rhaglenni Ymchwil Gweithredu Iechyd Cynaliadwy

8.5. Mae'r Swyddfa Gymreig yn bwriadu sefydlu project ymchwil gweithredu 5 mlynedd a ddylunnir i ddangos y ffyrdd mwyaf effeithiol o dorri'r cylch o iechyd gwael yng Nghymru. Bydd y project yn canolbwyntio ar gymunedau lle ceir y mynychder mwyaf o afiechyd a marwolaeth gynamserol, dieithrwch cymdeithasol a chyfleoedd gwael mewn bywyd. Dewisir yr ardaloedd i adlewyrchu materion trefol a gwledig. Bydd y gweithredu'n canolbwyntio ar ddysgu gwersi ynghylch yr hyn sy'n gweithio wrth roi sylw i'r tai effeithiau a gaiff diweithdra, trallod cymdeithasol a mynediad gwael i wasanaethau mewn amrywiaeth o gefndiroedd ar iechyd. Caiff y wybodaeth a sicrheir ei defnyddio, wrth iddi ddod i'r amlwg, i fwydo penderfyniadau am ddyraniad adnoddau a datblygiadau yn y dyfodol.

8.6. Bydd meini prawf y project:

- yn cynnwys ymchwil weithredu ledled Cymru;
- yn canolbwyntio ar gymunedau bach gydag afiechyd sylweddol;
- yn cynnwys camau graddfa-fach y gellir eu hailadrodd mewn amrywiaeth o gefndiroedd;
- yn cymryd diwylliant a daearyddiaeth Cymru i ystyriaeth;
- yn adeiladu ar gynlluniau llwyddiannus i adfywio cymunedau;
- yn cynnwys menywod a dynion lleol, asiantaethau a phroffesiynolion lleol wrth ddylunio a chyflwyno'r project;
- yn cynnwys asiantaethau a phroffesiynolion lleol;
- yn profi amrywiaeth o ragdybiaethau am yr hyn sy'n gweithio i adeiladu cymunedau iach.

Sut dylai Rhaglenni Ymchwil Gweithredu Iechyd Cynaliadwy gael eu dylunio i harneisio medrau ar bob lefel a gwneud y defnydd gorau ar adnoddau wrth leihau anghydraddoldeb?

Asesiad Effaith Iechyd

8.7. Bydd pob polisi yn effeithio ar fywyd pobl, rhai yn fwy ac yn gynt nag eraill. Gall profiad iechyd y boblogaeth, ar lefel genedlaethol neu leol, adlewyrchu effaith polisau o'r fath. Ac eithrio mewn cymharol ychydig o enghreifftiau, anaml y bydd y berthynas achosol rhwng polisau ac iechyd neu les y boblogaeth yn uniongyrchol a syml. Er hynny, drwy gymharu effeithiau polisau ar iechyd dros gyfnod o amser ac mewn cyd-destunau gwleidyddol gwahanol, gellir pwyso a mesur canlyniadau posibl dewisiadau polisi.

8.8. Syniad cymharol newydd yw Asesiad Effaith Iechyd. Dylunnir yr asesiadau i fod yn gefnogol ond beirniadol, ac i fwydo'r broses o wneud polisi. Dros y degawd diwethaf, mabwysiadwyd Asesiadau Effaith Iechyd yn yr Undeb Ewropeaidd, Canada, Awstralia, Seland Newydd a gwledydd yn y byd sy'n datblygu. Yn Lloegr, yn sgil asesiad ffurfiol o effaith ail redfa arfaethedig maes awyr Manceinion ar iechyd, gweithredwyd yr holl argymhellion ynglyn diogelu iechyd tra'n gwireddu manteision economaidd y datblygiad.

8.9. Hanfod Asesiad Effaith Iechyd yw:

- defnyddio meini prawf sgrinio i helpu i ddewis polisau neu brojectau ar gyfer Asesiad Effaith Iechyd;
- proffilio'r ardaloedd a'r cymunedau yr effeithir arnynt;
- defnyddio model iechyd a ddiffiniwyd ymlaen llaw i ragfynegi'r effeithiau posibl;
- gwerthuso pwysigrwydd, graddfa a thebygrwydd yr effeithiau hynny;
- pwyso a mesur y dewisiadau a gwneud argymhellion ar gyfer gweithredu.

8.10. Nid rhwystro ond yn hytrach hwyluso polisi yw'r diben a hynny drwy nodi, yn y dyddiau cynnar, effeithiau andwyol posibl ar iechyd a sut i'w goresgyn. Ar ei symlaf gall hyn olygu arolygu'r effeithiau hir-dymor ar iechyd gyda mecanweithiau ar gyfer cymryd mesurau cynnar i ddatrys problemau.

8.11. Gall Asesiad Effaith Iechyd fod yn offeryn buddiol hefyd i ddiffinio effaith debygol polisau ar iechyd poblogaethau. Mae'r fethodoleg wedi'i diffinio a'i phrofi'n helaeth a gellir ei gweithredu yn rhwydd.

Sut dylai asesiad effaith iechyd gael ei ddefnyddio wrth bennu polisi cyhoeddus yng Nghymru?

Gwybodaeth a Chyfathrebu

8.12. I helpu i ategu a gwella iechyd, bydd cleifion ac unigolion yn fwy ac yn fwy yn mynnu ac yn disgwyl gwybodaeth am y canlynol:

- materion iechyd cyffredinol, hybu iechyd, osgoi afiechyd a hunan-ofal;
- anhwylderau penodol;
- y mathau o wasanaethau sydd ar gael o dan yr NHS, a sut a phryd y byddai orau i ddefnyddio'r gwasanaethau hynny;
- y dewis o wasanaethau sydd ar gael gyda gwybodaeth am ansawdd, effeithiolrwydd, amserau aros etc.

8.13. Byddant hefyd yn disgwyl bod y wybodaeth yn cael ei chyflwyno mewn nifer o wahanol ffyrdd ond mewn modd

cyson, hawdd ei defnyddio, a deniadol. Bydd hyn yn eu helpu i gael gafael ar wasanaethau a'u defnyddio'n fwy effeithiol ac mae'n rhoi mwy o reolaeth iddynt dros eu hamgylchiadau.

8.14. Mae'n bwysig sicrhau hefyd fod cymuned yr NHS ei hun yn wybodus. Mae cael y wybodaeth fwyaf priodol a'r orau sydd ar gael wrth law wrth wneud penderfyniadau yn helpu i sicrhau bod y penderfyniadau hynny'n gywir a phriodol, o'r driniaeth orau ar gyfer claf penodol gyda phroblem benodol drwodd i'r wybodaeth sy'n angenrheidiol i helpu i leihau amrywiadau mewn iechyd ac i sicrhau bod gwasanaethau priodol ar gael yn unol ag anghenion a statws iechyd y boblogaeth leol.

8.15. Mae llawer o gyrff ac unigolion yn chwarae rhan wrth ddarparu'r wybodaeth hon gan gynnwys y llywodraeth, y cyfryngau, grwpiau gwirfoddol, ysgolion, gwasanaethau gwybodaeth iechyd dros y ffn, a'r rhai sy'n gweithio yn yr NHS. Daw'r wybodaeth o amrywiaeth o ffynonellau, gan gynnwys:

- gwybodaeth sy'n berthnasol i anghenion gwasanaethau ac sy'n cael ei chasglu'n lleol;
- data wedi'i seilio ar ddyfyniadau o wybodaeth leol a ffynonellau allanol eraill sy'n cael ei choladu'n ganolog;
- toreth o gronfeydd data, arolygon a systemau: megis System Gwybodaeth Iechyd Cymru (HOWIS) a gynigiwyd yn y Papur Gwyn Rhoi Cleifion yn Gyntaf (Gorch 3841),cm a fydd yn cynnig mynediad i ddata dienw agregedig mewn fformatau hawdd eu deall; neu'r arolwg cenedlaethol newydd o brofiad cleifion a defnyddwyr a gyflwynir ar lefel yr Awdurdodau Iechyd o 1998 ymlaen.

8.16. Mae swm y wybodaeth sydd ar gael i'r cyhoedd a'r NHS yn llethol eisoes. Er hynny, amheus yw ansawdd llawer ohoni ac mae yn aml yn gwrth-ddweud ei hun. Mae angen i'r NHS gydgysylltu ei adnoddau gwybodaeth yn fwy effeithiol, gan wneud y defnydd gorau ar fathau newydd o gyfathrebu megis y rhyngrwyd a gwasanaethau cyfathrebu digidol, er mwyn darparu'r wybodaeth mewn ffurf a all gael ei defnyddio gan ddinasyddion unigol, proffesiynolion gofal iechyd, darparwyr gwasanaethau a gwneuthurwyr polisi fel ei gilydd.

8.17. Nid yw gwybodaeth ar ei phen ei hun yn ddigon. Mae angen strategaeth gyfathrebu a fydd yn sicrhau:

- y defnyddir data i ddarparu gwybodaeth sy'n berthnasol i ddarparwyr gwasanaethau, comisiynwyr, defnyddwyr/cleientau/cleifion, mewn fformat cyfleus wedi'i addasu ar gyfer syniadau ac anghenion y derbynnydd' penodol;
- y ceir cydweithredu 'r cyfryngau - i ddatblygu'r cynllun gweithredu', i gadw llygad ar gynnydd a mynegi'r negeseuon iechyd allweddol i'r cyhoedd;
- strategaeth farchnata' effeithiol - papurau lleol (gan gynnwys papurau di-dl/ radio/teledu), y Rhyngrwyd, canolfannau siopa, llyfrgelloedd;
- y caiff risgiau eu cyfleu'n effeithiol - sut mae cyfleu risgiau i iechyd mewn ffordd glir, hawdd ei deall, sy'n galluogi unigolion a chymunedau i gymryd camau priodol i wella'u statws iechyd?

8.18. Er mwyn i strategaeth iechyd y cyhoedd lwyddo, rhaid cael mynediad i wybodaeth gywir. I wneud hyn bydd angen ymagwedd gorfforaethol a chydgysylltiedig fwy effeithiol. Heb fynediad i wybodaeth o ystod eang o ffynonellau addysgol a chymdeithasol, bydd yn anodd iawn asesu iechyd y boblogaeth ac effeithiolrwydd strategaeth iechyd y cyhoedd wrth fynd i'r afael phroblemau.

Pa wybodaeth fyddai'n eich gwneud chi'n fwy gwybodus am iechyd a sut hoffech ei chael?

Pa wybodaeth y mae ei hangen i helpu i greu gwelliannau yn iechyd pobl Cymru?

Pa wybodaeth y mae ei hangen i helpu i fwydo'r trafod ar faterion iechyd y cyhoedd yng Nghymru?

Crynodeb

8.19. Mae angen felly datblygu strategaeth gwella iechyd sy'n cymryd i ystyriaeth yr anghydraddoldebau dwfn mewn iechyd o fewn Cymru, a'r amrywiad mewn penderfynyddion iechyd sydd wedi arwain at y rheiny; strategaeth sy'n wirioneddol adlewyrchu cyd-ymdrechion y gymdeithas'. Byddai methu mynd i'r afael 'r pwnc llosg hwn yn wastraff cyfle i roi sylw i'r gwahaniaethau sylweddol yn y cyfleoedd a'r problemau sydd ar gael yng Nghymru.

GEIRFA A THERMAU TECHNEGOL

Targedau Cynnydd mewn Iechyd

Datblygwyd y rhain gan grwp arbenigol a'u cyhoeddi gan Ysgrifennydd Gwladol Cymru ym Mehefin 1997. Gyda'i gilydd, bwriedir iddynt fesur cynnydd tuag at well iechyd yng Nghymru. Disgwylir i'r NHS ddatblygu cynlluniau i fynd i'r afael 'r targedau hyn dros y 5 mlynedd nesaf.

Dangosydd	Targed
1. Canser y tracea, broncws, ysgyfaint. ICD 162	a. Gostwng y gyfradd marwoldeb safonedig Ewropeaidd am ganser yr ysgyfaint mewn dynion o dan 75 oed 54% o leiaf erbyn 2010 (o 49.2 ym mhob 100,000 ym 1995 i ddim mwy na 22.6 yn 2010). b. Gostwng y gyfradd marwoldeb safonedig Ewropeaidd am ganser yr ysgyfaint mewn menywod o dan 75 oed 21% o leiaf erbyn 2010 (o 23.0 ym mhob 100,000 ym 1995 i ddim mwy na 18.2 yn 2010). *Yn ogystal, mae'r targedau ysmygu 12(a) a 12(b) i'w trin fel mesuriadau dros dro o gynnydd yn 2002.*
2. Canser y fron i fenywod. ICD 174	Gostwng y gyfradd marwoldeb safonedig Ewropeaidd am ganser y fron mewn menywod rhwng 50 a 74 oed 30% o leiaf erbyn 2002 (o 83.9 ym mhob 100,000 ym 1995 i ddim mwy na 58.7).
3. Canser ceg y groth. ICD 180	Gostwng y gyfradd cofrestru safonedig Ewropeaidd am ganser ymledol yng ngheg y groth mewn menywod 50% o leiaf erbyn 2002 (o 21.9 ym mhob 100,000 ym 1990 i ddim mwy nag 11.0). *Caiff y targed a bennwyd ei adolygu yng ngoleuni data mwy diweddar a ddilyswyd gan Gofrestrfa Canser Cymru, pan fydd ar gael.*
4. Clefyd coronaidd y galon (Clefyd isgemig y galon). ICD 410-414	a. Gostwng y gyfradd marwoldeb safonedig Ewropeaidd am glefyd coronaidd y galon ar gyfer pobl o dan 65 oed 50% o leiaf erbyn 2002 (o 50.3 ym mhob 100,000 ym 1995 i ddim mwy na 25.2). b. Gostwng y gyfradd marwoldeb safonedig Ewropeaidd am glefyd coronaidd y galon ar gyfer pobl rhwng 65 a 74 oed 25% o leiaf erbyn 2002 (o 820 ym mhob 100,000 ym 1995 i ddim mwy na 615).
5. Clefyd Serebo-fasgwlaidd (strociau). ICD 430-438	a. Gostwng y gyfradd marwoldeb safonedig Ewropeaidd o strc mewn pobl o dan 65 oed 20% o leiaf erbyn 2002 (o 11.5 ym mhob 100,000 ym 1995 i ddim mwy na 9.2). b. Gostwng y gyfradd marwoldeb safonedig Ewropeaidd o strc mewn pobl rhwng 65 a 74 oed 25% o leiaf erbyn 2002 (o 218.4 ym mhob 100,000 ym 1995 i ddim mwy na 163.8).
6. Damweiniau. ICD E800-949	Gostwng y gyfradd marwoldeb safonedig am ddamweiniau ar gyfer pob oedran, 15%

	o leiaf erbyn 2002 (o 20.7 ym mhob 100,000 i ddim mwy na 17.6). *Caiff y posibilrwydd o ddefnyddio System Arolygu Anafiadau Cymru Gyfan i bennu a monitro'r targed am fynychder anafiadau difrifol o ganlyniad i ddamweiniau ei adolygu'n rheolaidd.*
7. Hunanladdiad a marwolaethau lle nad yw'r achos wedi'i bennu. ICD E950-959, E980-989	Gostwng y gyfradd marwoldeb safonedig Ewropeaidd am hunanladdiad (gan gynnwys marwolaethau lle nad yw'r achos wedi'i bennu) 10% o leiaf erbyn 2002 (o 12.3 ym mhob 100,000 ym 1995 i ddim mwy nag 11.1).
8. Pwysau geni isel.	Gostwng cyfradd y babanod phwysau geni isel (yn is na 2,500gram) i lai na 6% erbyn 2002. *Caiff y posibilrwydd o wahanu'r babanod phwysau geni isel iawn (llai na 1,500 gram) o'r gweddill ei adolygu'n rheolaidd.*
9. Poen cefn.	Erbyn 2002 gostwng 10% o leiaf ar y gyfran o bobl o dan 65 oed sy'n adrodd eu bod yn dioddef poen yn y cefn sydd wedi'i drin gan feddyg, yn l yr hyn a fesurwyd gan Arolwg Iechyd Cymru o 27.4% ym 1995 i ddim mwy na 24.7%.
10. Llid y Cymalau.	Codi Sgr Gryno gymedrig y Gydran Gorfforol mewn pobl 65 oed a throsodd sy'n adrodd bod ganddynt lid y cymalau sydd wedi'i drin gan feddyg i 34.9 erbyn 2002 (o 32.4 ym 1995), fel y'i mesurwyd gan Arolwg Iechyd Cymru.
11. Iechyd Meddwl.	Codi Sgr Gryno gymedrig y Gydran Feddyliol yng Nghymru i 50 (yn gyfartal ffigur UDA) erbyn 2002 (o 49.5 ym 1995), fel y'i mesurwyd gan Arolwg Iechyd Cymru.
12. Ysmygu.	a. Gostwng y gyfran o oedolion rhwng 18 a 64 oed sy'n ysmygu (pob dydd ac yn achlysurol) i ddim mwy nag 20% ar gyfer dynion a menywod erbyn 2002 (o 31.5% ar gyfer dynion a 28.1% ar gyfer menywod ym 1993). b. Gostwng y gyfran o blant 15 oed sy'n ysmygu (o leiaf yn wythnosol) i ddim mwy nag 16% ar gyfer bechgyn ac 20% ar gyfer merched (o 23% mewn bechgyn a 29% mewn merched ym 1996). c. Cynyddu'r gyfran o fenywod sy'n rhoi'r gorau i ysmygu wrth ddisgwyl baban i 33% o leiaf. *Caiff y targed ar gyfer ysmygu yn ystod beichiogrwydd ei ddatblygu fel ymarfer peilot gyda Grwp Cydlynu'r Awdurdodau Iechyd, lle ceisir cytundeb ar ddiffiniad manwl, a ffynonellau data.*
13. Bwyta ffrwythau a llysiau.	a. Cynyddu'r gyfran o oedolion rhwng 18 a 64 oed sy'n bwyta llysiau gwyrdd neu salad bron bob dydd i 40% o leiaf erbyn 2002 (o 32.8% ym 1993). b. Cynyddu'r gyfran o oedolion rhwng 18 a 64 oed sy'n bwyta ffrwythau ffres bron bob dydd i 55% o leiaf erbyn 2002 (o 44.3% ym 1993).
14. Yfed alcohol.	Lleihau'r ganran o ddynion rhwng 18 a 64 oed sy'n yfed mwy nag 21 uned o alcohol yr wythnos i 18% erbyn 2002 (o 26.4% ym 1993), a menywod rhwng 18 a 64 oed sy'n yfed mwy na 14 uned yr wythnos i 7% erbyn 2002 (o 8.5% ym 1993).
15. Pydredd dannedd.	Lleihau'r gyfran o blant sy'n dioddef pydredd dannedd (DMFT o 1 neu fwy) o 5 pwynt canrannol fel y'i mesurwyd gan Arolygon Cydgysylltiedig BASCD, o 53% o blant 5 oed ym 1995 i 48% erbyn 2002, ac o 64% o bobl ifanc 14 oed ym 1994 i 59% erbyn 2002.

Yn Sesiwn Arbennig y Cenhedloedd Unedig ym Mehefin 1997, anogodd y Prif Weinidog holl Awdurdodau Lleol y DU i fabwysiadu strategaethau Agenda Leol 21. Mae'r rhain yn cymhwyso egwyddorion datblygu cynaliadwy o fewn eu hardaloedd eu hunain. I helpu yn y broses, cyhoeddodd y Swyddfa Gymreig Cymunedau Cynaliadwy yng Nghymru ar gyfer yr 21ain Ganrif - Pam a Sut i Baratoi Strategaeth Effeithiol Agenda Leol 21 yn Ionawr 1998, sef arweiniad i annog yr Awdurdodau Lleol, gydag ymglymiad pob rhan o'u cymunedau, i fwrw ymlaen 'u strategaethau.

Cyfradd farwoldeb

Cymhareb cyfanswm y marwolaethau i'r cyfanswm mewn unrhyw boblogaeth benodol.

Dosbarthiad Galwedigaethol Safonol

Dosbarth	**Galwedigaeth**	***Er enghraifft:***
I	proffesiynol	*ffisegydd, ficer, deintydd*
II	rheoli a thechnegol	*llyfrgellydd, nyrs, newyddiadurydd*
III(N)	medrus, heb fod llaw	*ffotograffydd, clerc, swyddog gwerthu*
III(M)	medrus, llaw	*briciwr, oriadurwr, trydanydd*
IV	lled-fedrus	*gofalydd, gweinydd garddwr*
V	difedr	*glanhawr, llafurwr, negesydd*

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HOLIADUR

IECHYD A LLES CYNALIADWY

Gweithleoedd Iach

1. Sut gall mwy o gyflogwyr, gweithwyr a chyrff megis cymdeithasau masnach ac undebau llafur wneud cyfraniadau mwy effeithiol byth i reoli peryglon yn y gweithle a sicrhau iechyd cynaliadwy yn y gweithle?

Diogelwch Cymunedol

2. Sut gallai targedau gwella iechyd gryfhau strategaethau lleihau troseddau?

Cymorth Personol a Theuluol

3. Sut dylai polisi cyhoeddus ddiogelu plant a theuluoedd a sut gall pob sector o'r gymuned feithrin rl ofalgar?

Dieithrwch Cymdeithasol

4. Sut dylai grwpiau lleiafrifol gael eu cynnwys mewn polisau ar gyfer gwella iechyd a lles?

FFORDD IACH O FYW

5. Sut y gallwn hybu ffordd iach o fyw gyda phobl yn gwneud dewisiadau sy'n cynnal ac yn gwella'u hiechyd a'u lles?

Iechyd Rhywiol

6. A ydym yn fodlon chwalu'r rhwystrau i gyfathrebu effeithiol ar y pynciau hyn er mwyn rhoi sylw i'r gyfradd annerbyniol o uchel o feichiogrwydd ymhlith arddegwyr a rheoli lledaeniad heintiadau a drosglwyddir yn rhywiol?

Iechyd y Geg

7. Yn wyneb y dystiolaeth gref fod fflworideiddio yn atal pydredd dannedd, a ddylai'r Llywodraeth ei gwneud yn ofynnol i'r Cwmnau Dwr fflworideiddio'r cyflenwadau, os bydd y mwyafrif o'r bobl o blaid hyn?

Atal Clefydau

8. A oes ffyrdd i wneud rhaglenni sgrinio ac atal yn fwy effeithiol?

Ysgolion Iach

9. Sut y gellid defnyddio addysg a hyfforddiant yn well i hysbysu pobl am iechyd ac i annog pobl i ofalu am eu hiechyd eu hunain?

Gwasanaethau Iechyd Ysgolion

10. Sut gallai ymagwedd partneriaeth newydd fod o les i iechyd plant yn yr ysgol?

Damweiniau

11. Sut y gallwn gynyddu safonau diogelwch ac atal damweiniau?

AMGYLCHEDD IACH

Tai Cymdeithasol

12. Sut y gall landlordiaid cymdeithasol a chyrff tenantiaid ddatblygu eu rl mewn cryfhau cymunedau?

13. Sut y gallant greu effaith fwy cadarnhaol ar iechyd a lles pobl?

Tai

14. Sut dylai polisau tai gael eu datblygu i gymryd i ystyriaeth ddiogelwch cymunedol ac iechyd cynaliadwy, yn arbennig lle ceir crynodiadau o dai is-safonol?

Digwyddiadau Cemegol a Pheryglus

15. Sut mae datblygu'n blaenoriaethau i sicrhau cydbwysedd cynaliadwy rhwng diogelu iechyd y cyhoedd a'r amgylchedd?

PARTNERIAETHAU AR GYFER IECHYD

16. Sut dylai'r cyfrifoldebau dros nodi a gweithredu ar anghydraddoldebau statws iechyd gael eu rhannu gan wahanol asiantaethau?

Unigolion

17. Beth yw'r ffordd orau i unigolion gael eu hannog i ofalu am eu hiechyd eu hunain o fewn cymunedau, gweithleoedd, ysgolion ac amgylcheddau eraill?

Cyrff Cymunedol a Gwirfoddol

18. Sut gall cyrff gwirfoddol chwarae rhan gyflawn wrth wella iechyd a lles eu cymunedau, mewn partneriaeth phroffesiynolion a gwasanaethau eraill?

Awdurdodau Lleol

19. Beth yw'r ffordd orau i'r Awdurdodau Lleol chwarae rhan gyflawn wrth wella iechyd a lles eu poblogaethau, yn benodol cyfrifoldebau dros nodi a gweithredu ar benderfynyddion iechyd, megis tai, sy'n effeithio ar iechyd?

Yr NHS

20. Sut dylai'r dyletswyddau hyn gael eu cyflawni, yn arbennig y cyfrifoldebau dros nodi a gweithredu ar anghydraddoldebau mynediad i wasanaethau byr-dymor a chanlyniadau amrywiol i gleifion?

Grwpiau Iechyd Lleol

21. Beth yw'r ffordd orau o baratoi'r Grwpiau Iechyd Lleol i wneud y gwaith hwn, yn arbennig cyfrifoldebau dros nodi a gweithredu ar anghydraddoldebau statws iechyd a mynd ati i hybu gwelliannau mewn iechyd?

Rhwydweithiau Cydweithredol

22. Sut gall grwpiau proffesiynol chwarae rhan gyflawn mewn cydweithredu ystyrlon a fydd yn gwella iechyd a lles cymunedau, mewn partneriaeth grwpiau gwirfoddol a chymunedol?

Cynulliad Cenedlaethol Cymru

23. Sut dylai cydweithredu yng nghyd-destun Cynulliad Cenedlaethol Cymru gael ei gryfhau i sicrhau mai gwell iechyd sy'n ysgogi'r polisau pwysicaf?

MESUR CYNNYDD

24. Sut dylai Rhaglenni Gwella Iechyd gael eu cyflawni?

25. Yn benodol sut y gellir defnyddio'r cyfrifoldebau dros ddarganfod a gweithredu ar anghydraddoldebau iechyd yn effeithiol?

BUDDSODDI YN Y DYFODOL

Rhaglenni Ymchwil Gweithredu Iechyd Cynaliadwy

26. Sut dylai Rhaglenni Ymchwil Gweithredu Iechyd Cynaliadwy gael eu dylunio i harneisio medrau ar bob lefel a gwneud y defnydd gorau ar adnoddau wrth leihau anghydraddoldeb?

Asesu Effaith Iechyd

27. Sut dylai asesiad effaith iechyd gael ei ddefnyddio wrth bennu polisi cyhoeddus yng Nghymru?

Gwybodaeth a Chyfathrebu

28. Pa wybodaeth fyddai'n eich gwneud chi'n fwy gwybodus am iechyd a sut hoffech ei chael?

29. Pa wybodaeth y mae ei hangen i helpu i greu gwelliannau yn iechyd pobl Cymru?

30. Pa wybodaeth y mae ei hangen i helpu i fwydo'r trafod ar faterion iechyd y cyhoedd yng Nghymru?

Eich sylwadau chi

Maer Swyddfa Gymreig yn croesawu sylwadau ar y materion a godwyd yn y papur hwn a chymerir y rhain i ystyriaeth wrth ddatblygu **Cynllun Gweithredu** iw gyhoeddi ym Medi 1998. Anfonwch eich sylwadau at:

Nicola Rodgers
Adran Iechyd y Cyhoedd
Y Swyddfa Gymreig
Parc Cathays
CAERDYDD
CF1 3NQ

Dylaich sylwadau ddod i law erbyn **31 Gorffennaf 1998**.

Os na chnt eu marcio cyfrinachol, gall eich sylwadau gael eu cyhoeddi yn gyfan gwbl, neu ar ffurf crynodeb, a gall copau gael eu gosod yn Llyfrgelloedd dau Dyr Senedd.

Mae rhagor o gopau o Gwell Iechyd - Gwell Cymru ar gael oddi wrth yr Uned Cymorth Proffesiynolion Iechyd, Y Swyddfa Gymreig, Parc Cathays, CAERDYDD CF1 3NQ. Ffn 01222 825417. Maer ddogfen ar gael hefyd ar:

http://www.official-documents.co.uk/document/cm39/3922/3922.htm

FOREWORD

Our election manifesto and the work we have made a priority in Government, make plain our commitment to improving health in Wales. Our vision is to improve the health and well-being of people in Wales through strategies which promote and protect health, reduce inequalities in health and inequities in access to health services, and provide effective and efficient health services.

We recognise that there are special circumstances in Wales which have generated wide variations in health experience from one community to another. The evidence of growing inequalities in Wales is stark and must be addressed with decisive action which has both an immediate and long term perspective.

Health is influenced by a complex interaction of lifestyle and environmental factors which must be taken into account if real improvement is to be achieved. This is a long term challenge, which will involve collaboration across public services, voluntary and private sectors, and communities.

We have much to build upon, and many sectors are already planning action based on new government policies, which will contribute to health improvements - such as those which address social exclusion, economic development and environmental controls. The NHS in Wales is being restructured in order to enable it to be more responsive to local needs, in particular through the creation of Local Health Groups (LHG) with commissioning responsibilities for primary as well as community and hospital-based services, and strengthened requirements for co-operation with Local Authorities and other organisations.

We recognise that more must be done to bring the levels of health in Wales to match those of the best in Europe. We invite individuals, community representatives, local government, industry and voluntary groups to respond to the new opportunities to think creatively and join new partnerships for better health.

Ron Davies
Secretary of State
for Wales

Win Griffiths
Parliamentary Secretary
Welsh Office

Peter Hain
Parliamentary Secretary
Welsh Office

1. SETTING OUT A NEW APPROACH

This chapter sets out aims for sustainable health through collaborative action.

1.1. The Government wishes to tackle the underlying causes of ill-health through a new approach which recognises and addresses the factors which impact on health. We are pledged to improve the health and well-being of the people of Wales. *Better Health - Better Wales* sets out the basis of our new approach and seeks views on how this can be taken forward.

1.2. This paper proposes a broad range of areas where new and concerted action could make a significant difference to health and well-being. This has drawn on advice from both the Welsh Office and a wide range of key organisations in the public and voluntary sectors. The purpose of this consultation is to engage everyone in the debate about the best ways to improve people's health. We hope that individuals, community leaders, employers and those responsible for services will respond. Those responses will inform the development of an Action Plan which will be published in Autumn 1998.

Aims

1.3. This next stage is of crucial importance to enable the formulation of collaborative policies which will contribute to:

- setting a strategy for national, regional and local action which will be taken forward by the National Assembly for Wales;
- preventing disease and substantially improving the health and well-being of people in Wales;
- bringing the level of those with the poorest health up to the level of those with the best health;
- improving the health and well-being of children;
- encouraging individual responsibility for health;
- improving the health and safety of people at work;

  by:

  - ensuring that health impact is a consideration on everyone's agenda in policy development and implementation;
  - using new forms of collaboration to achieve better results and better value for money;
  - directing efforts at local level to ensure health and social care decisions are taken together by local representatives, professionals and administrators;
  - making better information on health at local levels available to the public and others to inform healthy choices;
  - directing research programmes to address the links between poor health and other factors which contribute to health and well-being in Wales.

1.4. The values under-pinning this new approach are:

fairness - everybody should have access to treatment and services according to their needs - health and well-being should not depend on where you live;

effectiveness - health policy should be based on the most up-to-date information and practice in order to prevent disease and promote health;

efficiency - the public, private and voluntary sectors should use their resources to achieve best value for money to reduce avoidable ill-health;

responsiveness - individuals should have access to the information they need to make informed choices about health and social care;

integration - inter-agency collaboration through shared decision-making should improve the health and well-being of individuals and communities;

accountability - each organisation should be accountable for its responsibilities for health and well-being;

flexibility - management systems must be flexible enough to respond to local circumstances and needs while also enabling private, public and other organisations to deliver health improvements.

Health and well-being

1.5. Good health may not be possible at every stage in our lives. There will be times when we are more vulnerable, perhaps in the early years of life, or as older people. We cannot always avoid ill-health or disability. However, we can aim for **well-being**, that is to live life as fully as we choose. When we are ill, we may need access to health and social care services. The Welsh Office recently set out its proposals for services in the new NHS in Wales in *Putting Patients First (January 1998)*.[cm]

Sustainable health

1.6. A cornerstone of our new approach is to put in place new partnerships and real collaboration aimed at **sustainable health and well-being**. At the local level, each of the determinants of health affected by public policy - environment, employment, housing, access to leisure, health and social care, education and other services - should be considered together rather than as separate policies, taking into account their potential impact on health.

1.7. One way of achieving this would be the introduction of **health impact assessment**. For example, housing developments could be designed to take account of community safety requirements. New industrial estates and economic development should not jeopardise a clean environment. Tourism should be planned to minimise nuisance, stress and hazards from increased traffic, noise and litter. Damaged and contaminated environments should be reclaimed in ways which take account of safe maintenance.

1.8. These and other objectives are encompassed with the Government's promotion of, and commitment to, **sustainable development**. The Government's consultation paper *Opportunities for change (1998)*[at] seeks views from all sectors in preparation for a UK Sustainable Development Strategy to be published by the end of 1998. The paper identifies that sustainable development is about ensuring a better quality of life now and for generations to come. The Government's vision of sustainable development is based around four key objectives:

- social progress which recognises the needs of everyone;
- effective protection of the environment;
- prudent use of natural resources; and
- maintenance of high and stable levels of economic growth and employment.

1.9. At a local level **Local Agenda 21** (see Glossary) strategies provide a focus for application and delivery of sustainable development. These are starting to involve local people in improving and maintaining the environmental, social and economic fabric of communities; the sustainable health of communities should also be taken into account. Our aim is to ensure that all policies contribute to health and well-being, and avoid harm.

Integrated Working and Collaborative Investment

1.10. *Better Health - Better Wales* sets out a new approach to preventing disease and promoting health and well-being through working together. It appears easy in principle but has proved difficult to achieve in practice. Everyone has a part to play - individuals, communities, business, public and voluntary services. In order to do this, it will be necessary to bring about changes in our approach to many social and economic issues which affect health.

1.11. A key part of the strategy will be based on collaborative investment between voluntary agencies, local government and the NHS. Integrated working already occurs at many levels, but not uniformly across public services. To ensure the aims of the new strategy are met, the Government is proposing a new duty of collaboration on both Local Authorities and on health bodies. There must be agreed responsibilities and accountabilities for promoting improvements in health. This means that agencies should agree, and monitor together, how their separate functions should support the health and well-being of individuals and communities.

1.12. Employers at all levels, including the NHS and local government, will be encouraged to promote healthy workplaces. A shared understanding of what can be done to reduce health inequalities, backed by research and improved training and education will be essential to making improvements.

Informed Choices

1.13. At the same time, information should be readily available to enable individuals and families to make informed choices about their health. Health promotion work should be further developed in schools and colleges to ensure that young people understand lifestyle choices and their health consequences. Local Authorities, Health Authorities, voluntary organisations and other agencies should ensure that local communities are informed and consulted on developments which might impact on their health.

1.14. The Welsh Office proposes to build on existing sources of information about health status and related issues through a comprehensive **Health of Wales Information System (HOWIS)**. In addition to providing valuable information for planning and developing services, it will also provide the means to link data related to health, illness and health services, and to improve the range of information available to individuals and communities.

Sustainable Health Action Research Programme

1.15. The key to reducing illness and improving life expectancy for those with the poorest health will be targeting resources where they can be most effective. However, we do not yet know enough about the links between poor health and poor living conditions to be able to implement new programmes with confidence. A first step must be to obtain first-hand information on what works effectively. The Welsh Office therefore proposes to set up a 5 year action research programme to address the links between poor health and other factors which contribute to health and well-being within Wales (see paragraphs 8.5 - 8.6).

Health Gains

1.16. We are not starting from scratch. The NHS is already working towards 15 **health gain targets** for the next 5 years published by the Welsh Office in June 1997 (see Glossary). Taken together, these are comprehensive and ambitious targets by which we can gain an overall measure of progress towards better health in Wales. However, we cannot rest only on what

the NHS can do. Achieving long-term gains in health and well-being goes much wider. It involves an informed response from women and men, community groups, voluntary agencies, other agencies, and local and central Government.

The Strategy

1.17. The Government believes that a medium to long-term strategy is essential to tackle the causes of inequalities in health status. The strategy will require short, medium and long-term aims with appropriate indicators and targets to monitor progress and demonstrate achievements. The starting point will be:

- planning health improvement beyond the next 5 years;
- building on existing health gain targets;
- researching the links between poor living conditions and poor health;
- developing additional indicators/targets relating to inequalities and health determinants;
- partnership and collaboration at community, local and central levels;
- innovative use of available resources across boundaries;
- promotion of joint professional training, research and development, and information sharing;
- appropriate structural and organisational development.

Any additional resource pressures resulting from the Welsh public health strategy will be funded from within existing resources.

1.18. This strategy will be taken forward under the arrangements for the National Assembly for Wales from 1999. To provide the basis for action, the Welsh Office will publish an Action Plan in September 1998 based on the framework outlined in this document and informed by responses to the consultation.

2. THE LEGACY OF ILL-HEALTH

This chapter describes the major inequalities in health status within Wales and between Wales and other countries.

The case for better health in Wales

2.1. Despite recent improvements, the health of people in Wales is poor compared with that in the majority of European countries and in other parts of the UK. Within Wales a significant proportion of the population remain deeply disadvantaged in terms of expectation of life and health-related quality of life, and there are wide variations between those with the poorest health and those with the best.

2.2. In the last 25 years, death rates from avoidable diseases have fallen steadily and life expectancy has increased. Across Europe, **life expectancy** at birth for both men and women has increased by about 5 years. Throughout that period, life expectancy in Wales has been amongst the worst in Europe at approximately three to four years less than in the best countries. Life expectancy in some areas of the South Wales Valleys is about five years less than in some other parts of Wales.[cl]

2.3. There has also been a reduction across Europe of about a quarter to a third in overall **mortality rate** (see Glossary), but again Wales compares poorly with most other countries. Compared with England, the mortality gap in Wales has widened over the last decade from 5% to 9%.[cl]

2.4. **Infant mortality** (deaths in the first year of life) in Wales, although having declined by over a half over the last twenty years, remains higher than in the majority of European countries.[cl]

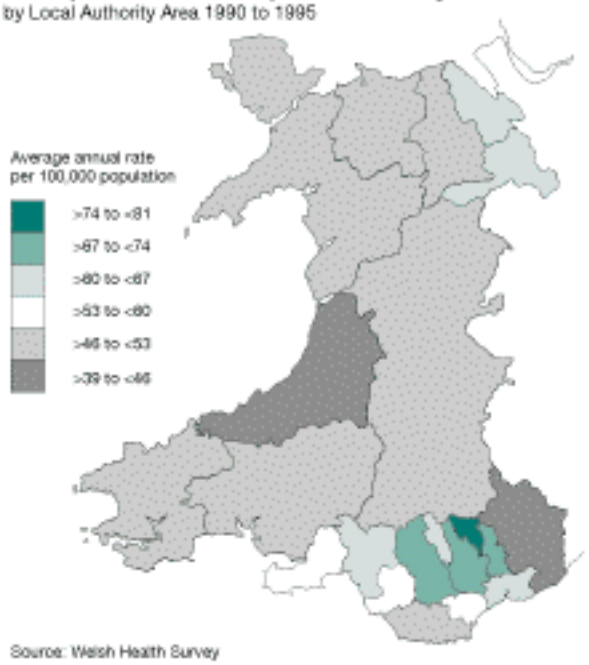
2.5. **Heart disease** is the major cause of death in Wales. Although the death rate in Wales has declined considerably in recent years, it remains substantially higher in Wales and the UK than in many European countries, particularly France, where the rate is approximately one third that in Wales.[cl]

2.6. Wales has amongst the highest rate of **cancer** registrations in the European Union, with rates about 50% higher than some other countries.cl

2.7. Premature deaths from various causes vary widely between Local Authority areas. Consistent poor health is seen particularly in the South Wales Valleys. In Blaenau Gwent the death rate for heart disease for people under 65 is twice the rate in Ceredigion. For lung cancer, the death rate in Blaenau Gwent for men under 75 years is around twice that in Powys.bm

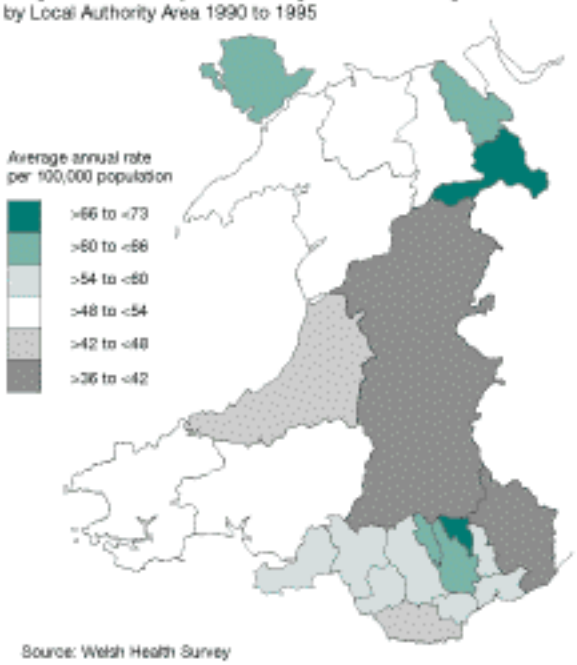
Figure 2.1

Coronary Heart Disease Mortality Rates under the age of 65, by Local Authority Area 1990 to 1995



Source: Welsh Health Survey

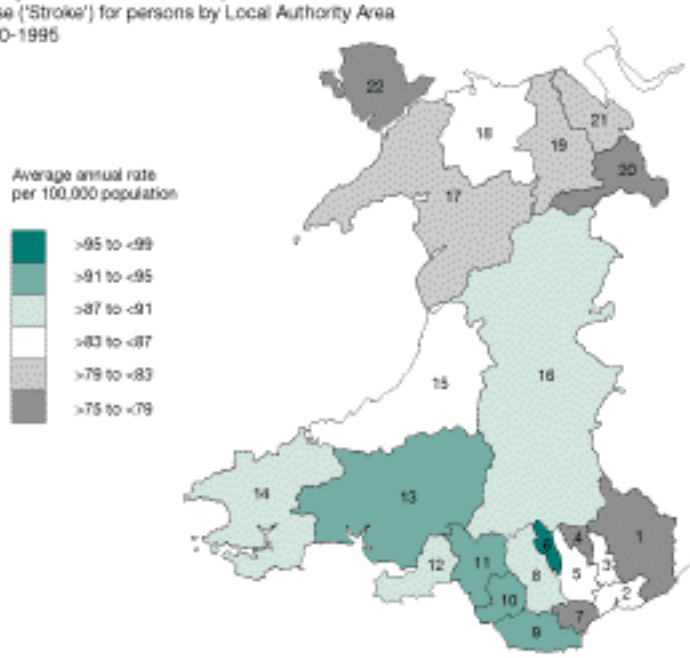
Lung Cancer Mortality Rates among men under the age of 75, by Local Authority Area 1990 to 1995



Source: Welsh Health Survey

Figure 2.2

Average Annual European Age-Standardised Mortality Rates for Cerebrovascular Disease ('Stroke') for persons by Local Authority Area over the 6 year period 1990-1995



Local Authority

1 Monmouthshire
2 Newport
3 Torfaen
4 Blaenau Gwent
5 Caerphilly
6 Merthyr Tydfil
7 Cardiff
8 Rhondda Cynon Taff
9 The Vale of Glamorgan
10 Bridgend
11 Neath Port Talbot
12 Swansea
13 Carmarthenshire
14 Pembrokeshire
15 Ceredigion
16 Powys
17 Gwynedd
18 Conwy
19 Denbighshire
20 Wrexham
21 Flintshire
22 Isle of Anglesey

Source: Monaghan 1998

2.8. Compared with English regions, Wales has higher levels of people needing treatment for **high blood pressure** - a significant factor in many cases of heart attack and stroke. Again, rates vary between Local Authority areas with the death rate from strokes being around a quarter higher in Merthyr Tydfil than in Anglesey.[bm]

2.9. One in nine people suffer from **mental health** problems and one in two hundred has a severe mental illness which may require substantial health and social care. Merthyr Tydfil, Blaenau Gwent and Rhondda Cynon Taff tend to have lower mental health scores than other parts of Wales for example, Monmouthshire, Anglesey and Denbighshire.[bm]

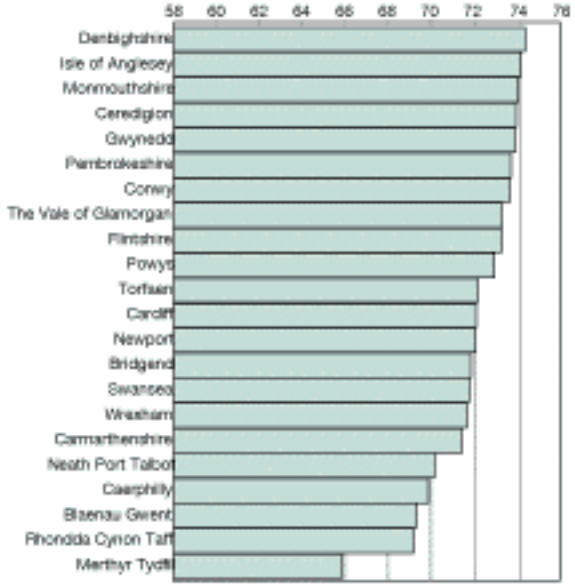
2.10. Mental disorder and substance misuse can increase the risk of **suicide**, however, not all deaths due to suicide and self-inflicted injury occur in people suffering from a mental illness. There were 240 male and 52 female deaths recorded as due to

suicide and self-inflicted injury in Wales in 1996. An increased risk is also seen in some occupational groups, such as farmers. Rural authorities whose population densities are lower than the Wales average, tend to have higher than average suicide rates.[bm]

Figure 2.3

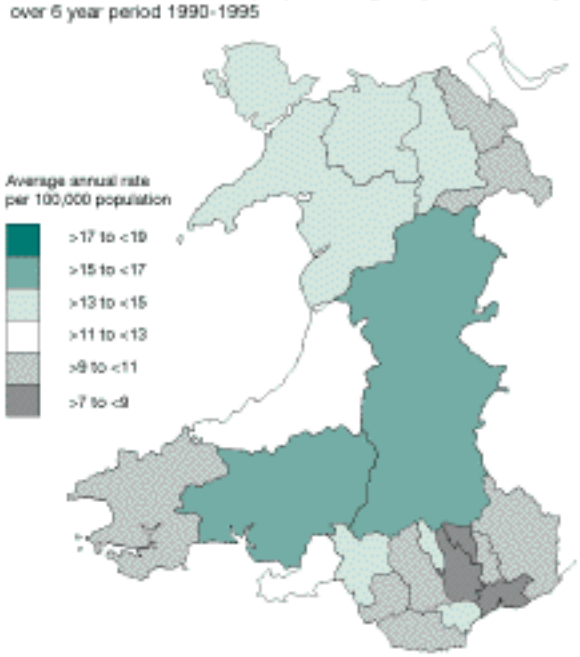
Perceived mental and emotional health

Mental Health (SF-36 score [100 = perfect health] with 95% CIs)



Source: Welsh Health Survey

Average Annual Mortality Rates (European Age Standardised) for suicide and undetermined deaths in people of all ages, by Local Authority Area over 5 year period 1990-1995



Source: Monaghan 1998

3. SUSTAINABLE HEALTH AND WELL-BEING

This chapter considers factors which prevent illness and promote health and well-being.

3.1. Sustainable health is achieved when people and communities can take control of their lives and are able to live their lives to the full. The factors contributing to a state of well-being include feeling safe, having the security of a home and enough to live on, satisfying relationships, interesting and varied activities, and having a sense of moving forward.

3.2. A person's social and economic circumstances are probably the strongest influence on health, avoidable sickness and premature death. There are strong links between the pattern of deprivation and the pattern of ill-health and disease. Where you live and whether you are in work, influences diet, smoking, stress and lifestyle. Where you work, how well the risks at work are controlled, and to some extent where you live, can influence exposure to environmental hazards, including hazards in the working environment.

3.3. A marked pattern of ill-health, sickness and absenteeism can be seen in Wales and may be partly explained by a history of heavy industry. In the past, reliance on industries such as coal and steel made for differences in education, skills and aspirations. When the industries closed down, people were not well-equipped to take other jobs and the former mining areas were not seen as good places for investment by new industries. An economic regeneration strategy has been in place for many years, but the interaction between social, economic, environmental and health issues is not always well understood.

3.4. Long-term action is needed to tackle the root causes of health and economic inequality. This may mean a new approach to maintaining health and to using health and social care services as a community resource. The introduction of health impact assessment, health promotion that addresses the pressures of multiple disadvantage in some communities, and refocused professional responsibilities may all be needed. A major priority is to recognise the importance of sustainable health in economic and social regeneration.

Employment

3.5. On the whole, being in work is healthier than being unemployed. Meaningful work, whether paid or unpaid, is protective of mental health and fosters a sense of self worth and belonging. Employers have a legal duty to ensure work places and work practices are safe and healthy. Employers can also have considerable influence on the overall health of employees.

Welfare to Work

3.6. Central to everyone's sense of well-being and to the creation of sustainable communities is the assurance that comes from playing a useful part in the life of the community, usually through work. The New Deal for the long-term unemployed is about improving people's employability and helping them into sustainable employment. Welfare to Work is designed to focus the help available on the needs of individuals; to foster a sense of ownership among its clients and to deliver its objectives through partnership working. Further help will be available in the North West Wales Prototype Employment Zone. This is one of 5 prototypes in which local partnerships aim to draw together various strands of help to create a more coherent package, focused on the individual.

Healthy Workplaces

3.7. For people who work, the working environment is an important influence on their health. For many people, going to work is a positive part of their lives, and it helps them to stay healthy. But we need to make sure that work doesn't make people ill, and that they leave work at the end of the day at least as healthy as when they arrived. Factors such as how well workplace risks are controlled in accordance with health and safety law play their part in creating healthy workplaces. The Health and Safety Commission (HSC) and Executive (HSE) are developing a *National Occupational Health Strategy* and expect to issue a discussion paper during 1998. This strategy will complement and contribute to the strategy for a healthier Wales.

3.8. The Health and Safety Executive recently published the results of a survey of self-reported work-related illness.[as] This estimates that 100,000 people in Wales (4.7 per 100 people who have ever been in employment compared to 4.8 per 100 in Great Britain) suffer from work-related illness. However people in Wales took more days off work per worker as a result of these illness (0.84 days per worker, compared with 0.71 days per worker for Great Britain as a whole). The personal suffering that this represents, and the economic cost to Wales of the 1.1 million days lost annually, could be reduced.

3.9. HSE's Good Health is Good Business campaign seeks to raise awareness of health risks at work and to help small firms control the health risks in their workplaces. Campaigns such as this have an important role to play in ensuring good health in Wales. Current national initiatives, such as *Health at Work: The Corporate Standard* developed by the Health Promotion Authority for Wales, provide practical assistance and guidance on best practice. HSC is also looking at ways of driving forward a flexible framework of occupational health services that will address possible inequalities of access to occupation health advice.

3.10. Employers can be influential in promoting health through providing a supportive environment for people who want to give up smoking, healthy choices of foods in catering facilities and promoting cycling, walking and public transport as alternatives to car travel to work. Health promotion in the workplace can improve productivity, improve morale, reduce absenteeism and staff turnover, improve organisational image and help to attract high-calibre staff.

How can more employers, employees and organisations such as trade associations and trade unions make even more effective contributions to controlling workplace risks and ensuring sustainable health in the workplace?

Community Safety

3.11. A safe environment free from crime (or fear of crime) contributes significantly to an individual's sense of well-being. Victims of violent crime (which, fortunately, is rare) experience significant health effects. One in five adults questioned in the *British Crime Survey (1996)* were very worried about being burgled, mugged or having their car stolen, and one in three women continue to be anxious about rape. Reducing crime and the fear of it is important. Combating crime requires joint working at many levels in order to reduce offending behaviour and to prevent re-offending. It is significant that three-quarters of young people convicted of the most violent and serious crimes have themselves been victims of physical, sexual or emotional abuse.

3.12. The Crime and Disorder Act (1998) will place new obligations on local authorities and the police, ('the responsible authorities') to:

- review levels and patterns of crime and disorder;
- publish a report analysing the audit's implications for a crime reduction strategy;
- consult with partners prescribed by the Home Secretary (police authorities, Health Authorities and probation committees) and others with an interest:
- formulate and publish a strategy for the reduction of crime and disorder.

Subject to parliamentary approval, provisions of the Act will be enacted from 1 September 1998. Partnerships are expected to start work on the community safety strategy and audit immediately, with strategies in place, supported by audits, by 1 April 1999. In Autumn 1998, the Home Office will also publish a *Strategy On Violence against Women*.

3.13. Possible ways of breaking into the cycle of anti-social behaviour and tackling known risk factors for offending

include:

- reducing teenage and unwanted pregnancies and developing schemes to improve parenting skills;
- focusing services on areas of deprivation to help vulnerable young people and to encourage them to take part in activities that will promote self-esteem and social skills;
- ensuring that preventative treatment of, and rehabilitation from, drug and alcohol misuse is a priority;
- ensuring child and adolescent mental health services have expertise in dealing with conduct disorders and aggressive or hyperactive children.

How could action to improve health strengthen crime reduction strategies?

Personal and Family Support

3.14. Networks of families, friends and social institutions (e.g. churches, clubs, sports facilities, voluntary organisations) can be important in developing self esteem and confidence and in providing support. These traditional networks have become less effective over recent years with the changing patterns of employment and entertainment.

3.15. New parents can gain support from talking to other parents, from links with the wider family and from schemes to help increase their knowledge and skills in parenting; these can come from a range of agencies.

3.16. An intimate confiding relationship with a partner or close friend is a known protective factor against mental illness. Breakdown of relationships and divorce have profound consequences for the individuals concerned. These include reduced income and diminished economic activity, particularly for women. The children of such relationships are more likely to show emotional disturbance and subsequently to divorce as adults.

3.17. Effective interventions in these areas might include:

- support for marriage counselling and mediation services;
- promoting education for parenting, support programmes and befriending schemes for isolated parents;
- making unmarried and separated parents assume greater parental rights and responsibilities;
- reducing the number of unwanted pregnancies;
- supporting youth and family groups at the community level;
- strengthening the role of Health Visitors and midwives in supporting families and parents;
- addressing issues of citizenship, parenthood, sex and relationship education in schools;
- tackling domestic violence and homelessness;
- promoting parental leave and family-friendly employment practices;
- encouraging community support networks.

Children

3.18. Children's health is an important indicator of health in later life. High levels of poor health among adults has a damaging effect on their children's health. The major causes of illness in children are acute respiratory infections and ear disorders. Accidents are the major cause of death. Relatively high numbers of children are referred for accident and

emergency treatment.

3.19. The Welsh Office intends to focus on children's health and well-being as an investment in the future. The Welsh Office will build on *The Health of Children in Wales (1997)*[cn] to develop a comprehensive strategy to improve children's health.

How should public policy protect children and families and how can all sectors of the community develop caring roles?

Social Exclusion

3.20. Unemployment, poor skills, low incomes, poor housing, high crime environments and family breakdown, as well as bad health or disability, can lead to individuals and communities failing to participate fully in society.

3.21. Some communities and families are isolated by their race, colour or religion. Others are unable to access a full range of opportunities because they are in remote areas. These are socially excluded not because of individual problems, but because of circumstances. Addressing health inequalities through comprehensive and integrated policies must include the perspective of ethnic and other minority groups.

3.22. The Welsh Office has announced funding for co-ordinators to work with communities to devise Local Action Plans which address social exclusion. Proposals must take account of the partnership and collaborative working within Local Authorities and other agencies. This work complements the Social Exclusions Unit's work in England and the public health strategy in Wales.

How should minority groups be included in policies for improving health and well-being?

4. HEALTHY LIFESTYLE

This chapter identifies major lifestyle determinants of health.

4.1. Whether a person chooses to smoke, exercise frequently, or follow a healthy diet, affects health and well-being. Lifestyle is not only a matter of knowledge and choice - evidence suggests that it is strongly influenced by wider factors related to local and personal situations including educational level, personal skills, peer pressure, and social, economic and cultural factors.

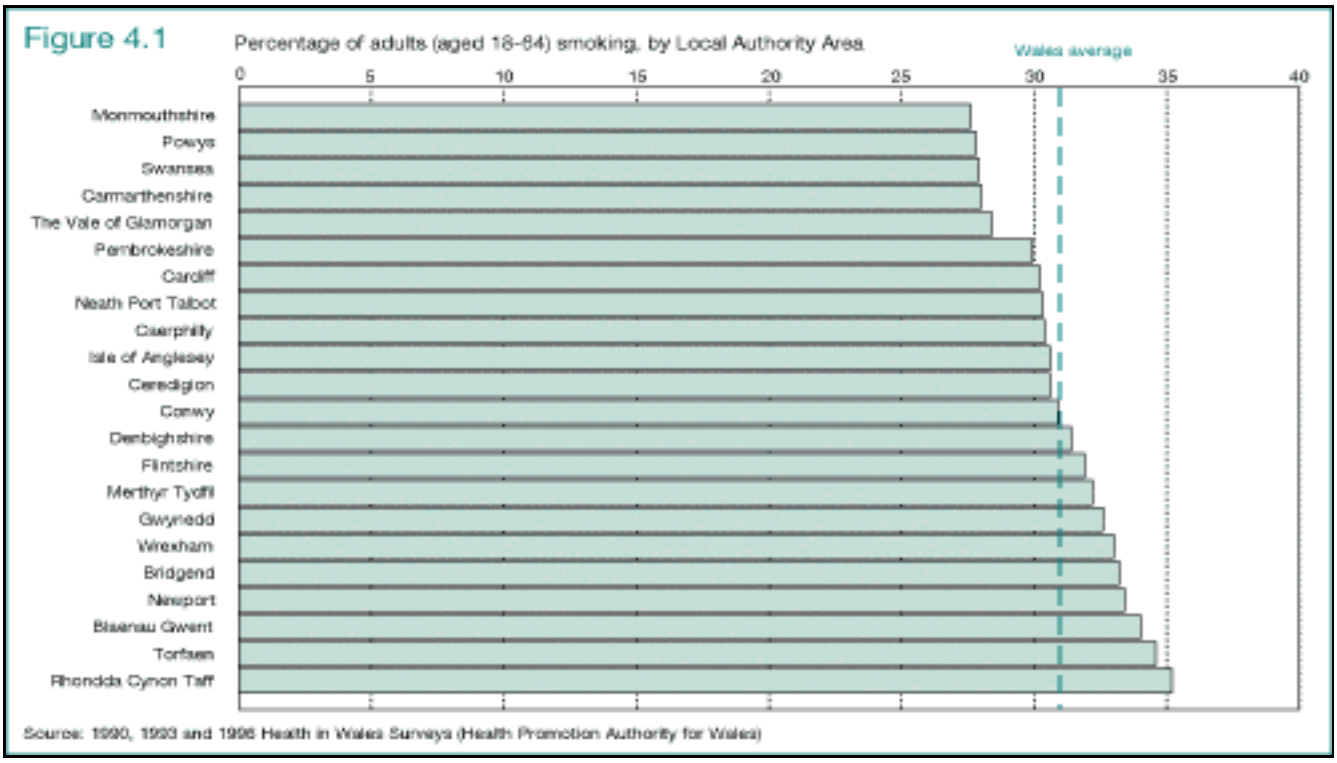
4.2. Access to appropriate information about healthy lifestyles helps people to make choices, but information on its own may not be sufficient to support change. This requires individuals and communities to participate in decisions affecting their lives. Such change can only be brought about by working with individuals and communities in such a way that the problems and solutions are owned by them.

Smoking

4.3. Tobacco use is the single largest cause of premature death and preventable ill-health in Wales. Smoking is the predominant cause of lung cancer and also increases significantly the risk of mouth, stomach, kidney, bladder and pancreatic cancers. Smokers are more likely to suffer heart disease and chronic bronchitis. Non-smokers who are in contact with smokers also suffer an increased risk of lung cancer and heart disease.

4.4. Pregnant mothers who smoke are more likely to have smaller babies, who are more likely to experience poor health. Cot deaths in infants of mothers who smoked in pregnancy are more common than in babies of non-smoking mothers. Children of smokers have a higher risk of respiratory complaints.

4.5. In Wales, between 1985 and 1996, the proportion of men who smoked every day declined from 35% to 28% and from 30% to 26% for women. Smoking rates among teenagers have peaked and troughed over the last 10 years. For teenagers aged 15, the proportion of boys who smoke was 16% in 1986, fell to 12% in 1988 and rose to 23% in 1996. For teenage girls the figures are higher, but the pattern is the same. The level in 1986 was 20%, falling to 19% in 1988 and rising to 29% in 1996.[aq] Effective strategies to reduce smoking levels are essential to future health.



4.6. Action to reduce the prevalence of smoking could include:

- enforcement of legislation on sales of tobacco;
- smoke-free policies in the workplace and public places;
- stopping people from starting - school health education programmes, smokebusters' clubs, smoke-free schools;
- helping people to stop - smoking cessation programmes;
- stronger health promotion messages;
- addressing the issue of why more girls than boys smoke.

Smokebusters **Smokebusters is a national programme which aims to promote a positive image of being smoke-free among 9-13 year olds. Membership of the club, which is open to any young person who pledges to remain a non-smoker, is fast approaching 20,000.**

Smokebusters is co-ordinated nationally by the Health Promotion Authority for Wales and run locally by health promotion workers.

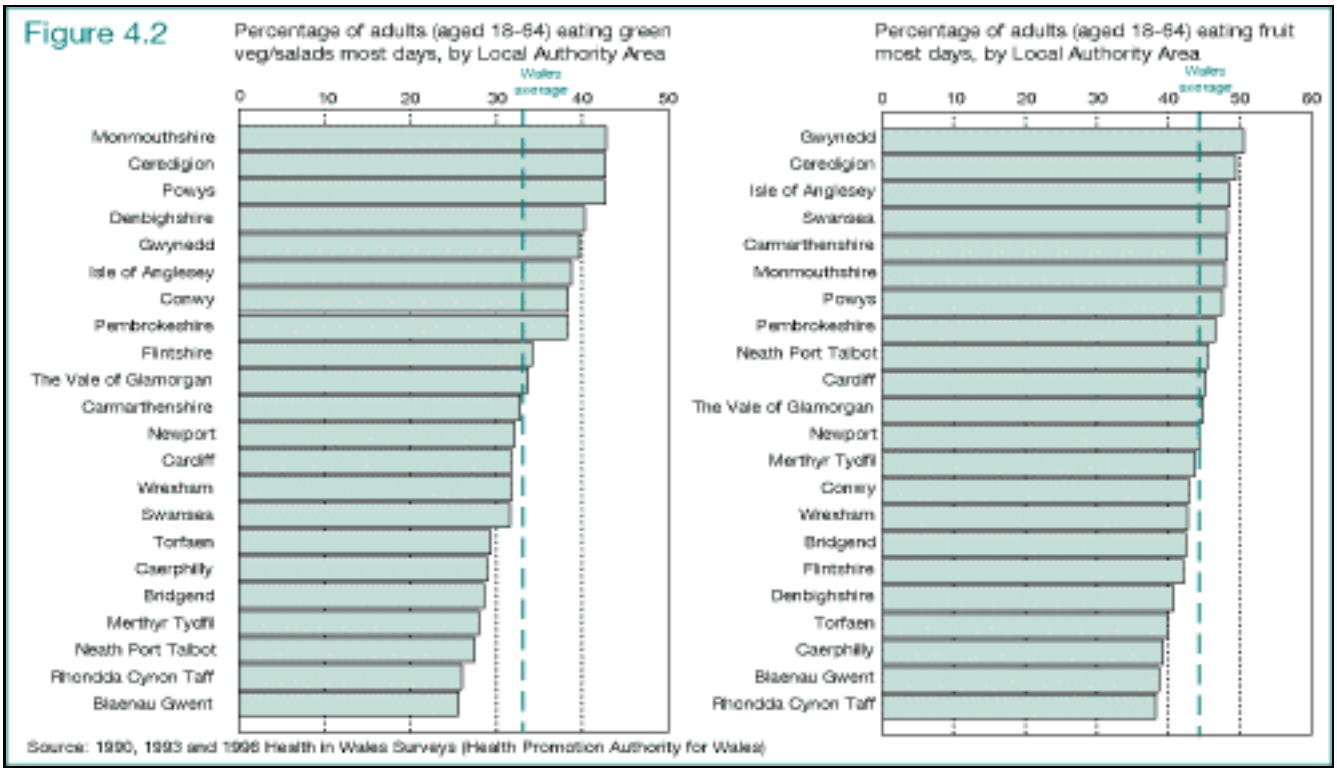
4.7. In July 1997 the Chancellor pledged to increase taxes on tobacco by 5% in real terms each year. The Government has also taken decisive action to secure an end to tobacco advertising and sponsorship, whilst providing time for all sports to find alternative sources of sponsorship. Agreement has been secured at the European Health Council on a Tobacco Advertising Directive banning both advertising and sponsorship within the European Union. The Government will publish a White Paper in 1998 with proposals for taking forward this ban within the UK as part of a comprehensive and integrated range of measures to combat smoking and reduce associated ill-health and premature death.

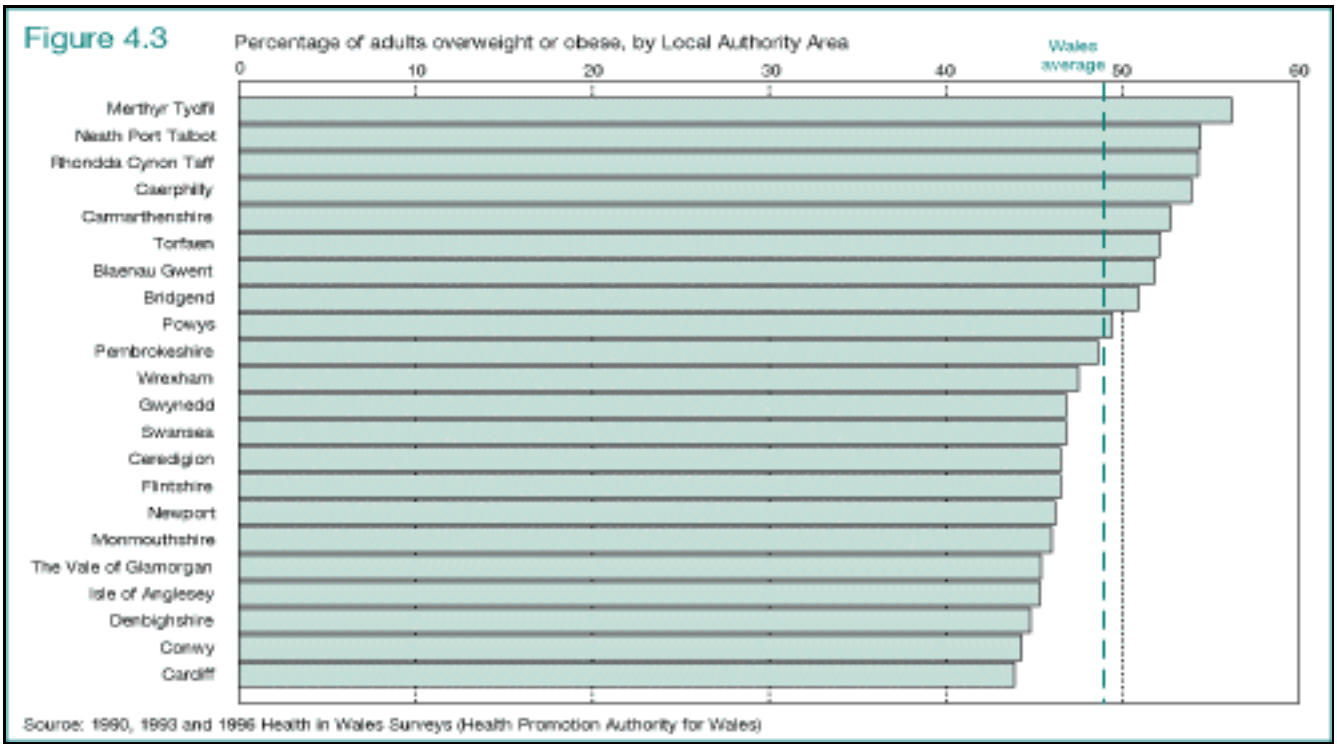
4.8. The *Scientific Committee on Tobacco and Health (SCOTH) Report* was launched on 11 March 1998. It provides key messages on active smoking, passive smoking and nicotine addiction. It also contains recommendations to address areas such as restrictions on smoking in public areas and work places, the protection of young people from tobacco promotion and advertising, health education and the provision of increased smoking cessation services.

Nutrition and Diet

4.9. A healthy, balanced diet is a major factor in maintaining health. Vegetables and fruit provide vitamins and fibre and are thought to be protective against bowel diseases and cancers in general. High levels of saturated fatty acids cause heart disease and strokes, and high salt intake contributes to high blood pressure levels, which in turn lead to strokes. Saturated fat intake in the UK over the last 10 years, as a percentage of energy from fat, has remained around 40% and shows no signs of declining to the recommended level of 35% of food energy. The *Welsh Health Survey (1995)*[ct] showed that the people in South Wales Valleys areas ate less fruit and vegetables and more lard than in other areas of Wales. Overweight and obesity levels in Wales are increasing with 51% of females and 53% of males classified as overweight or obese in 1996.

4.10. A healthy diet is an important way of promoting growth and development. Proper nutrition can help children and young people's concentration in the classroom as well as helping to prevent ill-health in later life. The White Paper *Building Excellent Schools Together* stated the Government's intention to introduce nutritional standards for school lunches. These will build on existing good practice on provider framework in which caterers can offer school lunches which are both healthy and enjoyable.





4.11. It is important that everyone has easy access to sources of a wide variety of food that is both nutritious and reasonably-priced so that everyone can afford to 'eat for health'. As well as the raw ingredients, people need access to sources of advice regarding food preparation methods that maintain nutritional value and safety. This is particularly important for vulnerable groups such as children (e.g. through school lessons), expectant mothers (e.g. pre-conception and 'parenting' classes) and older people.

5. HEALTHY ENVIRONMENT

This chapter identifies major environmental determinants of health.

5.1. The physical environment is an important determinant of health. Where we live, and where we work, can expose us to a variety of environmental hazards. The Government's commitment to working towards the goal of sustainable development where economic, environmental and social needs are seen as inter-related, will contribute to health and well-being in the longer term.

5.2. Many of the environmental factors affecting health in the UK as a whole are discussed in the National Environmental Health Action Plan drawn up under the auspices of the World Health Organisation, which the Government intends to review ahead of the next WHO Ministerial Conference on Environment and Health to be held in London in 1999.

Healthy Homes

5.3. The association between poor housing conditions and poor health has long been recognised. Generally, those living in good housing are in better physical and mental health than those who are not. Houses that are damp, cold and poorly-ventilated create conditions which generate ill-health. Insufficient heating and poor ventilation often impact most on older people and may lead to hypothermia and an increase in respiratory problems. Research has shown that the most significant health risks from poor housing are associated with cold and damp: from January to March there are typically about 40,000 more UK deaths than the average rate for the rest of the year. Energy efficiency measures are necessary, particularly in the homes of older people and the most vulnerable. People in overcrowded houses have greater incidence of mental illness and domestic violence is more prevalent. Siting of housing and other services can enhance access or may lead to greater use of cars to take children to school and other daily journeys. The design of houses, particularly kitchens, can reduce accidents.

Oakdale Housing Renewal Area	**Here the Renewal Area Local Authority, other public agencies, the private sector and the community work together to develop a strategic approach to improve housing together with environmental, social and economic conditions. Co-ordinated action addresses fuel poverty and fire risks, crime, damp, traffic flows, poor housing fabric and recreation areas.**

5.4. Local Authorities are responsible for administering home renovation grants and have certain statutory responsibilities towards homeless people. Wales has a higher than average proportion of owner-occupiers living in 19th century houses, often in areas of high unemployment where owners are less able to afford to renovate and maintain their houses. The *Welsh Housing Condition Survey (1993)*[bs] found that 13% of homes failed to meet the fitness standard. The Government's comprehensive spending review is considering the costs to health and other services of poor housing and how resources might be better targeted.

Social Housing

5.5. Social housing can make an important contribution to health. Local Authorities are landlords for 204,000 homes, 16% of all dwellings and 57% of the rented market. Registered social landlords manage 48,000 homes - approximately 12% of the rented market.[bq] The majority of housing allocations are to families with children or to those who are vulnerable. Over 80% of new tenants of registered social landlords receive housing benefit.[bo] The Welsh Office and Tai Cymru encourage all social landlords to involve their tenants in the management of their estates.

Tai Cymru's **Tai Cymru's standard house plans, building specification and good practice guidance ensure that social housing design in Wales reflects a commitment to health and safety, and provides opportunities for future adaptation as the needs of occupants change. Houses are designed to minimise risk of accidents in hazardous areas e.g. kitchens and stairs, and to be economical to heat. Both the dwellings and their surrounding estates provide high levels of accessibility to visitors with a wide range of disabilities and incorporate a comprehensive range of crime prevention measures.**

How can social landlords and tenants' organisations develop their role in strengthening communities?

How can they make a more positive impact on the health and well-being of people?

Homelessness

5.6. People sleeping rough, especially for long periods, are particularly at risk from poor health. In Wales, a snapshot survey by Shelter Cymru and the Special Needs Housing Advisory Service, funded by the Welsh Office, found that 77% of those sleeping rough were under the age of 35. 44% said that they had physical or mental health problems, including drug and alcohol misuse. Access to health services and other services is a particular difficulty for those who sleep rough regularly, or who do not have settled home.

5.7. Young homeless people are likely to have had previous adverse life experience including periods in care. They are more at risk from drug and alcohol misuse, prostitution and sexually transmitted diseases. Children living with parents in hostels for the homeless are also at risk of delayed development and behavioural problems. Homeless men and women are marginalised from society. Lack of suitable housing only partly accounts for homelessness; it is firmly rooted in the lack, or breakdown, of family and other relationships.

How should housing policies be developed to take account of community safety and sustainable health, particularly where there are concentrations of sub-standard houses?

Clean Air

5.8. Poor air quality aggravates conditions such as asthma, chronic bronchitis and emphysema. The Government is committed to reducing atmospheric pollution from transport and industrial sources and is undertaking a range actions to improve air quality, including:

- an accelerated review of the National Air Quality Strategy to be completed by the end of the year;
- Statutory Air Quality Objectives introduced in December 1997;
- a new public information system for air pollution announced on 19 November 1997;
- a comprehensive Department of Health/Department of the Environment Transport and the Regions/Medical Research Council research programme on outdoor air.

5.9. Local Authorities have a major role to play, supported by the *Welsh Air Quality Forum*, which collates information across Wales. Since December 1997, Local Authorities have been required to monitor air quality in their area and to initiate appropriate action where specified objectives are not met.

5.10. The Government is interested in effective and innovative approaches to tackling congestion and pollution. Local Authorities may well benefit from participating in the *Car Free Cities* project, or other similar schemes. But such decisions are best taken at the local level, as Authorities consider how best to meet their statutory duties under the Environment Act 1995.

5.11. Poor air quality inside buildings, at work, leisure and at home contributes to ill-health. The build up of gases such as carbon monoxide, for example, can have serious implications for health. Radon is a naturally-occurring gas in many parts of Wales. It is thought to be the second most important cause of death in the UK from lung cancer after smoking, around 5% of annual lung cancer deaths in the UK.[bn] Mapping the incidence of radon is now complete and further surveys are being carried out to identify the dwellings with highest radon levels. Additional areas will be designated in 1998. The Welsh Office will promote awareness of radon areas and of the forms of assistance available to householders to protect against emissions.

Safe Water

5.12. The widespread provision of sewerage and of clean water supplies was the most important public health achievement of the last 100 years. The maintenance of these systems remains crucial today. Although standards of water quality are generally high, there is no room for complacency. As well as continuing to protect against traditional threats to water safety, suppliers have to respond to newly identified threats such as the cryptosporidium organism. Industry, including agriculture, has responsibility for preventing pollution of water supplies.

5.13. Although action has been taken to reduce lead levels in the environment, for instance from vehicle exhausts and paints, lead from any source can be harmful. For example, studies have shown that even small amounts of lead can have a harmful effect on the mental development of children. The Government is determined that levels of lead in drinking water should continue to be tackled. Water providers must treat water supplies to reduce its ability to dissolve lead and for most properties this will ensure that levels at the tap - that is after contamination by lead plumbing maintained by property owners - do not exceed 25 micrograms per litre. The Government intends to set a stringent standard of 10 micrograms per litre of drinking water provided to homes, to be met in 15 years, and will prepare advice to householders to help them take an informed decision on whether to replace lead pipes in their homes.

5.14. Over recent years there has been a dramatic improvement in the quality of bathing waters on the Welsh coastline and, in 1997, 60 of 64 monitored under the European Directive met its mandatory standards. This improvement is set to continue. The *Green Sea Initiative* is aiming for 50 Blue Flag beaches in Wales (compared to 9 in 1997) and, as part of this, water quality at these beaches will need to meet the much more stringent guidelines set by Europe. Last year, 31 Welsh bathing waters met these much tougher European standards. As part of the *Green Sea Initiative*, Dwr Cymru/Welsh Water intends to introduce disinfection treatment at all its coastal sewage discharges. But if we are to have 50 Blue Flags in Wales, others will need to play their full part, for example in keeping beaches free of litter and waste, including from dogs.

Land Use

5.15. There are many areas of derelict and contaminated land in Wales, with the risk of contamination of surface and ground waters. Particular examples are water discharges from abandoned coal and metal mines. The Welsh Development Agency has been at the forefront of land reclamation in Europe and, since 1976, has invested over 300 million reclaiming over 17,300 acres of land, providing land for factories, homes, hospitals, country parks and playing fields. The Agency attaches high priority to this work and will continue its substantial land reclamation programme.

5.16. The decline in the deep-mine coal industry in Wales has led to an increased demand for coal from open-cast mines. Applications to develop new mines should be considered in the context of Welsh Office planning policies and those in local development plans. The issues should be fully debated with local communities. The Environment Agency, Local Authorities and the industry must work together to secure and implement any necessary controls to protect surrounding communities and the environment.

5.17. A considerable amount of solid waste is generated and must be disposed of safely. Currently much of this goes to landfill sites. This often leads to controversy about the safety of such practices but alternatives often raise as many objections. Town and country planning schemes provide an overall direction for the regulation of land use. Local Authorities should consider the health aspects of planning as part of their overall strategy.

5.18. Recycling is an important way of reducing material that has to go to landfill or incineration, thereby reducing the burden on disposal sites and making best use of existing resources. Recycling also opens up opportunities for innovation and

employment through the development of new technology. Commensurate improvements to the environment will further the aims of sustainable development and contribute to improvements in public health.

5.19. It is also important to minimise the amount of waste generated in the first place. The Welsh Office encourages recycling and would like to hear views on the wider use of recycled products and innovative community recycling schemes. Local Authorities, industry, small businesses and households all need to find ways to reduce waste. The Welsh Office welcomes views on the methods used to dispose of waste and on how technology can be developed to deal with this in the future.

Reducing Industrial Waste in Wales	**Cambrian Stone Ltd. reprocesses the blast furnace slag which is produced as a by-product of the manufacture of steel. The slag is recycled and used to make a variety of industrial materials including replacement cement, thermally insulated blocks and loft insulation. The manufacture of replacement cement, for example, minimises the use of quarried stones which contributes to the preservation of the environment.**

Chemical and Hazardous Incidents

5.20. The use and movement of dangerous substances increasingly poses questions about the safety and health of the public, operators and emergency services. The Health and Safety Executive is the health and safety enforcing authority for major hazard sites and the transport of dangerous substances, and a consultee on land-use planning issues around major hazard sites. A number of organisations will also provide the National Assembly for Wales with excellent resources to ensure that Wales manages well the health aspects of emergency and long-term incidents involving dangerous substances. These include the *National Focus for Chemical Incidents* which is based in Cardiff, but serves the UK, the *World Health Organisation (WHO) Collaborating Centre for Chemical Incidents*, which is also based in Cardiff and has an international role, and the *Chemical Incident Management Support Unit* in Wales. The Welsh Office intends to build on work already in place and, in consultation with Local Authorities, Health Authorities and emergency services, to design a strategic framework for guidance and monitoring.

How can we develop our priorities to ensure a sustainable balance between the protection of public health and the environment?

6. PARTNERSHIPS FOR HEALTH

This chapter draws together some unifying themes to identify levels at which action needs to be taken.

6.1. Action is needed across a broad front extending well beyond the NHS to tackle the inequalities in health and poorer health experienced by Wales relative to the best in Europe. This will require a long-term strategy and a structured approach to decide what needs to be done and who should do it. Some aspects will be addressed more appropriately by central Government, some at the all-Wales level, and some at local level.

6.2. Developing appropriate policies and tackling the problems will not be easy. Everyone will have a contribution to make particularly to encourage individuals to take action to promote their own health and well-being. Forging new effective partnerships across a wide range of agencies, including central and local Government, commerce, industry and voluntary organisations will be essential.

How should responsibilities for identifying and acting upon inequalities in health status be shared by different agencies?

Individuals

6.3. Each of us has a responsibility to maintain our health and avoid factors which cause illness. Avoidable ill-health wastes lives, squanders NHS resources and reduces our economic prosperity and well-being. The Welsh Office believes that individuals and families should have ready access to good information on healthy lifestyles and should be supported in communities, in the workplace, in schools and in public settings of all kinds to make the best of the opportunities for health and well-being.

How best can individuals be encouraged to look after their own health within communities, workplaces, schools and other environments?

Community and Voluntary Organisations

6.4. The role of the churches, women's, youth and children's groups, sports and activity groups, and voluntary organisations (in which women are particularly active) will be important to the success of the new framework for health and well-being. Social relationships and support are key to ensuring that everyone is able to enjoy an active life.

6.5. In the spirit of the compact which is being developed between the Welsh Office and the voluntary sector in Wales, productive partnerships between statutory services and community and voluntary organisations should maximise all the resources in a community. The Welsh Office is interested in innovative volunteering schemes which provide help to local people when they need it. Such schemes must be properly monitored and evaluated and participants must be trained and have the support of appropriate professionals.

How can voluntary organisations play a full part in improving the health and well-being of their communities, in partnership with professionals and other services?

Local Authorities

6.6. Local Authorities are responsible for major services such as social services, housing, transport and planning. They also exercise important public health functions. These include controls on occupational and environmental health, food hygiene and infectious disease. Maritime districts also have port health responsibilities. Local Authorities are also a major employers.

6.7. Local Authorities have a community governance role, often through the funding of voluntary organisations and the development of corporate strategies. The role of elected members is important, both because of their local knowledge of their ward community, their specific expertise e.g. Chairs of Environmental Health/Public Protection Committees, and their contribution to corporate strategic agendas.

6.8. To help the development of shared responsibility for broad improvements to people's health, and the well-being of local communities, a new duty to engage in partnerships will be introduced for both Local Authorities and the NHS. Local Authorities will be significant partners in the development and delivery of health improvement programmes.

6.9. The Government is considering the introduction of a requirement for **Health Impact Assessment** to be conducted for major new service developments, including those which are the responsibility of local government. It also intends to review the present allocation of functions between Health Authorities and Local Authorities for the control of communicable disease.

6.10. Local Authorities play an extremely important part in the lives of a wide range of people. Social Services Departments can make an important contribution to supporting people at home and promoting their independence, frequently through partnership with health services.

6.11. Effective joint working at this level can achieve substantial benefits for individuals and ensure the efficient use of all the available resources, for example, by preventing the need for admission to hospital and by supporting patients on their discharge from hospital. Through their day to day contact with many of the most vulnerable people, social services can play an important part in identifying problems early. They can help people to access the appropriate services and find their way round the system. They can:

- assist with access to health services;
- ensure people receive benefits and services for which they are eligible;
- work with education services and the NHS to promote the well-being of children and families;
- support people to live independently as far as possible in their own homes in the community;
- recognise the value of carers and promote services to support them.

6.12. The Welsh Office will consider what changes are necessary to **planning guidance** to ensure that health impact is taken account of in local social and economic development plans.

6.13. Other forms of collaboration which could be considered include:

- formal joint bodies structured on existing models, including representatives of the voluntary sector;
- more effective joint working both to define and to deliver statutory social care plans in each Local Authority area, for example by ensuring an interchange of Health and Local Authority staff;
- joint consultation with local communities to involve local people with the development of plans of both Health and Local Authorities, including the wide-ranging community plans which Councils are likely to be empowered to prepare;
- Local Authority Public Protection and Environmental Health Officers to advise Health Authorities and Local Health Groups;
- Directors of Public Health to develop their role in providing independent advice to both Health Authorities and

Local Authorities;

- Health Impact Assessment of major developments to have input from a range of professionals;

- joint appointments by Health and Local Authorities, including recruitment of public health specialists to work with Local Authorities.

How best can Local Authorities play a full part in improving the health and well-being of their populations, in particular responsibilities for identifying and acting upon health determinants, such as housing, which impact on health?

The NHS

6.14. *Putting Patients First (1998)*[cm] sets out a framework for replacing the internal market in NHS Wales with a system of integrated care. The new structure is intended to concentrate resources on direct patient care and enable each professional to contribute to cohesive services. Local doctors, nurses and other healthcare professionals will take the lead in shaping local services to meet patients' needs.

6.15. The new focus of NHS Wales will be on collaboration rather than competition and on improving health as well as treating sickness. Sustainable health requires integrated services involving a range of health professionals including nurses, doctors, pharmacists, school health services, dentists, opticians and a range of specialist services.

6.16. The public health role of NHS Wales needs to be strengthened to ensure that all parts of the health service become more focused on preventing ill-health by:

- tackling inequality by ensuring that services reach areas of greatest need and that the services available are of a better quality;

- ensuring the right mix of local services;

- ensuring the NHS sets an example as a good employer, showing that it is serious about environmental health and occupational health and safety.

How should these duties be carried out, in particular responsibilities for identifying and acting upon inequalities in access to acute services and differing outcomes for patients?

Health Authorities

6.17. Health Authorities have a major role in preventing disease and health improvement, and holding hospitals and other health care providers to account for their contribution to making people healthier. Directors of Public Health are responsible for communicable disease control, effective immunisation, vaccination and screening programmes, and for independent reports on the health of their populations. Expertise in public health needs to be strengthened in all sectors. It is fundamental to the new approach to promote an increased awareness of public health issues so that they permeate health professionals' and non-professionals' understanding and culture.

6.18. Public Health Professionals have a key role in facilitating new relationships with local government and local agencies. In order to strengthen our existing knowledge base, the Government will exempt public health professionals from the definition of Health Authority management costs, so that efforts to curb bureaucracy in the NHS do not create a perverse incentive to weaken public health expertise at local level. Public health is a long-term investment, not an administrative overhead.

6.19. Health Authorities will have new duties of partnership, particularly with Local Authorities and the voluntary sector, to improve the health of their populations. The Welsh Office, in consultation with service managers, will develop frameworks for collaboration and mechanisms for identifying and requiring action on health inequalities. In particular, the framework for

allocating resources between Health Authorities and within areas served by the Health Authority, will need to take account of work to tackle inequalities in health status and access to services. The particular needs of women and of special groups within the community must be separately identified and addressed.

6.20. The new priorities for Health Authorities will require them to become more strategic and more focused on improving health. They will retain many of their existing responsibilities which were not associated with the internal market. Unless otherwise revised, these include agreeing to what needs to be done to improve the health and health care of local people, the measurement and public reporting of health status and epidemiology, the provision of independent medical, dental, pharmaceutical and nursing advice and a range of functions to protect public health and to respond to outbreaks of disease.

Local Health Groups

6.21. Implementation of *Putting Patients First (1998)* will lead to the setting up of **Local Health Groups**, based upon Local Authority boundaries. Local Health Groups will be the vehicle for local collaboration between services affecting public health. The Groups will have representation from public services outside health and will provide real leverage on services and resources for a wide range of services. It will be important that the Local Health Group has access to information about health status, particularly where this is below the national average, and the resources to make a real difference over time.

6.22. Although Local Health Groups will bring decision-making closer to local people, they will be too large to represent small-area health issues. It is intended to use the experience of the **Sustainable Health Action Research Programmes** to develop ways of effectively under-pinning the planning and decision-making powers of Local Health Groups.

How best can Local Health Groups be equipped to undertake this work, in particular responsibilities for identifying and acting upon inequalities in health status and actively promoting health improvements?

NHS Trusts

6.23. NHS Trusts as the main employers of NHS staff have a particular responsibility for setting an example as good employers and ensuring high quality occupational health services (both as employers of staff and as providers of occupational health services for others). They also have responsibility for ensuring hospitals are healthy places, through rigorous measures to prevent cross-infection.

Primary Care

6.24. 90% of contacts with the NHS are made with primary care services such as general practitioners, community nurses, health visitors and midwives. GPs, practice nurses and other members of the primary care team, are in an ideal position to act as the patients' advocate, helping them through the system, pointing them in the right direction, making the right contacts. The co-location of health and other community services can provide easy access and 'one stop shops' so that people can discuss issues such as benefits with social security representatives, social care for vulnerable children and adults with social service staff, and seek advice on other issues from Citizen's Advice Bureaux personnel, as part of wider health care.

6.25. GPs also provide specific information on the health status of patients for the purposes of access to housing, transport (DVLA), insurance, and benefits (e.g. Incapacity Benefit and Disablement Allowance). They play a particularly significant role in relation to Statutory Sick Pay and short-term state Incapacity Benefit since the medical evidence they provide to their patients usually acts as the initial entry route to benefit. They also play an important role in the assessment of patients for placement in long-term care (particularly older people) and the identification of the needs of carers along with other local health services. Joint management of services to patients between health and social services, such as integrated support for patients leaving hospital, is crucial both to sustaining health and well-being and to the effective use of resources. The Welsh Office intends to consult Health Authorities, NHS Trusts, Local Authorities, other interested bodies and individuals on ways of achieving greater support and integration.

Crosshands Surgery Healthy Community Project

The Crosshands Surgery Healthy Community Project was set up to address community needs in the Upper Gwendraeth Valley using a community co-ordinator model. The identification of local health needs and the development of inter-agency alliances to meet those needs are key features of the project.

The initiative involved the appointment of a health community co-ordinator based at one of the local GP practices. The role of the co-ordinator is to identify the needs of local communities and address the needs by working in partnership with members of local communities, health and other professionals and voluntary agencies.

6.26. GPs, nurses, health visitors, midwives, dentists and pharmacists also provide patient education on lifestyle matters that has as much to do with disease prevention as disease management. Advice on exercise, safe sex, diet, smoking, safety and food preparation are relevant here. There is strong evidence (e.g. smoking cessation) that advice and health promotion interventions given by health professionals are well received and effective.

Healthy Living Centres

Wales will receive nearly 20 million for the establishment of a network of healthy living centres spread over the years to 2001-02. 300 million will be provided across the UK for Healthy Living Centres from Lottery Funding via the New Opportunities Fund. (The establishment of the Fund was set out in the White Paper The People's Lottery, published in July 1997.) The funding for Healthy Living Centres is a massive opportunity to improve the health of the people of Wales. Healthy Living Centres will be aimed at those communities, both urban and rural, which experience the poorest health.

Healthy Living Centres will help people to maximise their health and well-being whatever their capacity for fitness' in the traditional sense. But Healthy Living Centres will not just be fitness centres. Their focus will be on health as a positive attribute which helps people to get the most out of life, embracing both physical and mental well-being. They will be relevant to people of all ages: a healthy start in life for children, a healthy life for adults of working age, and a healthy retirement for others. There are already many examples of innovative local initiatives designed to improve people's health across Wales and they provide a solid platform for the development of a network of Healthy Living Centres.

Healthy Living Centres will need to create partnerships between local communities, voluntary organisations, and statutory bodies such as Health Authorities and Trusts, Local Authorities, including their social services and education departments. They may also need to involve, health promotion specialists, GPs and primary care services, universities, schools and private sector organisations.

Healthy Living Centres will be locally based, aimed at meeting specific local circumstances. Active local participation through volunteer effort, and a sense of ownership by local people will be essential to make Healthy Living Centres a valued community resource which can attract people who may not be accessing existing services.

Health Promotion

6.27. Effective health promotion at every level is another key element of the new approach. Many agencies have a role to play in providing information, advice and cultural change programmes aimed at improving health. Health Authorities and NHS Trusts provide specialist health promotion units. Health professionals in many settings are important sources of advice and support on aspects of a healthy lifestyle. Local Government has a strong health promotion role. In future, local health promotion initiatives should be co-ordinated across a range of services, within a national strategy.

6.28. Parents, with the support of schools, have the major role in educating children about healthy living, avoidance of harm and dangerous substances, and living safely. A review of the Personal, Social and Health Education curriculum is underway to consider how children can be educated for health and well-being.

6.29. In addition to Education, many other aspects of local authority services promote health and well-being through their work on food safety, road safety, trading standards, environmental protection and personal social services.

6.30. The Health Promotion Authority for Wales (HPAW) runs national programmes and works in partnership with other organisations in the health service and elsewhere to further the promotion of health and well-being. The Secretary of State has asked the Health Promotion Authority for Wales, under the guidance of a multi-agency steering group, to review existing health promotion activity in Wales in preparation for a national strategy to be taken forward by the National Assembly. The review and strategy will take into account the role of local government, the voluntary sector and others involved in health promotion and the need for greater collaboration:

- developing the contribution of health promotion to health improvement and tackling inequalities in health status through:
    - relating public policy towards improving health;
    - enhancing people's skills to improve their health and well-being;
    - strengthening the capacity of communities to achieve health gains;
    - maintaining living and working conditions which promote health;
    - orientating health and social care services towards enhancing health and well-being.

6.31. The review will be subject to wide consultation, leading to an agreed strategy to be published as part of the *Better Health - Better Wales Action Plan* in September 1998.

Research and Development

6.32. Sustainable health and well-being for individuals and communities, alongside the provision of appropriate health and social care, must be based on the best available evidence of effective public policy and practice. To do this, the strategy must be informed by best practice elsewhere in the UK and internationally through strong academic and research links with Europe.

6.33. Following the establishment in 1995 of the Wales Office for R&D (WORD), Wales is developing standards and evidence-based practice designed to underpin health and social care. Refocusing research on public health issues will be important to achieving improvements in health. The Secretary of State has asked WORD, under the guidance of a multi-agency steering group, to develop a strategic framework for promoting high quality research and development to support evidence-based approaches to health improvement. The framework will include recommendations for priority-setting and a support programme to be taken forward by the National Assembly. The strategic framework and support programme will consider the contribution research and development can make to health improvement and tackling inequalities in health status, and effective health and social care, through evidence-based support for:

- refocusing public policy towards improving health;
- providing appropriate and effective management and treatment of ill-health and disability;
- enhancing people's skills to improve their own health and well-being;
- strengthening the capacity of communities to achieve health gains;
- maintaining living and working conditions which promote health;
- orientating health and social care services towards enhancing health and well-being;
- identifying the separate health needs of women.

6.34. This agenda for the review reflects unique arrangements in Wales which bring health and social care research closely together. The review will be subject to wide consultation, leading to an agreed strategy to be published as part of the *Better*

Health - Better Wales Action Plan in September 1998.

Collaborative Networks

6.35. A new agenda for *Better Health - Better Wales* needs collaborative action across a broad front. Collaboration already exists in a wide variety of settings; examples of networking are:

- inter-sectoral and interdisciplinary groups such as the Welsh Public Health Network, Welsh Collaboration for Health and Environment, Welsh Food Microbiological Forum and the Welsh Air Quality Forum; and

- professional groups such as the Society of Directors of Public Protection in Wales, Directors of Public Health Medicine, Designated Doctors (Child Protection), Designated Nurses and Midwives (Child Protection), Immunisation Co-ordinators, All-Wales Chief Housing Officers' Panel, Association of Directors of Social Services, Society of Local Authority Chief Executives.

6.36. The Welsh Office is considering the need for a collaborative network at National Assembly level to which all stakeholders would be expected to contribute. In addition to those listed at 6.35 there are a number of educational establishments, research networks and voluntary organisations who have much to contribute to the debate, the development of policy and its implementation. The National Assembly for Wales could benefit from an arrangement which facilitated the active collaboration of all these groups, underpinned by a comprehensive health information system such as HOWIS. Discussions are at an early stage and suggestions of how such a network might be developed and possible membership are welcome.

How can professional groups play a full part in meaningful collaboration which will improve the health and well-being of communities, in partnership with voluntary and community groups?

The National Assembly for Wales

6.37. Subject to Parliamentary approval, the establishment of the National Assembly for Wales in 1999 will transform public life in Wales and introduce for the first time democratic control of the resources for health. The White Paper, *A Voice for Wales*, outlined the Assembly's intended health functions:

- to monitor the health and well-being of the Welsh population and respond with policies to promote health and tackle ill-health;

- to decide the scale of financial resources for health within its overall budget;

- to identify and promote good practice in health services and hold NHS bodies in Wales to account for their performance;

- to canvass and act upon the views of patients, staff and carers on the quality of NHS services;

- to ensure that NHS Wales has a workforce of well-trained staff.

6.38. In setting the strategic framework for the improvement of health in Wales, the Assembly will require the following:

- information about the health of people in Wales at a national, regional and local authority level;

- guidance and directions to set standards for housing, transport networks, environmental controls, health care and health promotion, and access to health services;

- feedback on the level and achievements of public services in terms of health gains;

- all-Wales services such as research and development for health and social care; and health promotion.

6.39. The objective will be to improve health across Wales and tackle inequalities in health status and in access to appropriate services. The Government believes that this can be achieved by ensuring that health effects are taken into account in other agendas, and by new forms of collaboration. This is not a new idea and we all know how difficult it is in practice. What is new is the encouragement of inclusive policies which operate with the active participation of individuals, local agencies and Government.

6.40. To start to break down the barriers to collaboration at the heart of Government, the Prime Minister has appointed a new Minister for Public Health and appointed a senior Cabinet Committee for Public Health with representatives of 12 Departments. The Welsh Office health minister takes forward this work in Wales. The Social Exclusion Unit is charged with taking action to address inequalities affecting the most vulnerable groups in our society.

6.41. The Welsh Office, in preparation for the National Assembly, is undertaking a fundamental review of the structure of the Health Group, looking specifically at the Assembly's remit for health improvement and tackling inequalities. Mechanisms for cross-departmental working are being developed with the absorption of Tai Cymru Housing for Wales into a new Housing Department and parts of the Welsh Health Common Services Authority and the Health Promotion Authority for Wales coming into the Assembly.

How should collaboration in the context of the National Assembly for Wales be strengthened to ensure that better health drives major policies?

7. MEASURING PROGRESS

This chapter discusses targets and ways of measuring health gain.

7.1. The strategy for *Better Health - Better Wales* must set milestones by which progress can be assessed. This is the issue of quantifying, measuring, and setting goals for, progress towards improving health and well-being and reducing inequalities. We wish to build on the **Health Gain Targets** to measure progress (see Glossary), and to provide a framework against which local targets can be developed that are sensitive to the variety of local circumstances across Wales.

Criteria for setting targets

7.2. In selecting a set of targets for this strategy, the Welsh Office considers that targets should:

- measure significant areas which will progress the achievement of the strategy;
- use established data sources;
- be challenging, but achievable;
- be seen not as a precise measure of progress, but as an indication of the progress that the Welsh Office considers to be possible.

Development of targets

7.3. The Welsh Office intends to establish an expert group to consider further the development of:

- national targets for reducing health inequalities;
- national targets for improving the determinants of health.

7.4. The Welsh Office proposes that Directors of Public Health, in collaboration with Local Authorities, should report to the Chief Medical Officer on progress towards national and local targets, annually; these reports should be based on 3-year rolling Health Improvement Programmes. The Chief Medical Officer will report accordingly on progress throughout Wales to the National Assembly for Wales. The Reports of the Directors of Public Health will continue to provide a means of monitoring at a local level.

7.5. The Chief Medical Officer's independent Annual Report will provide an overview of progress on improving health and reducing health inequalities.

National health gain targets

7.6. The Welsh Office published a set of fifteen **Health Gain Targets** for Wales in June 1997 (DGM (97)50). Health Authorities are expected to work with other local agencies to develop plans for health improvement that cover the targets, and which address inequalities in health between Local Authority populations within each Health Authority. The targets cover:

lung cancer	back pain
breast cancer	arthritis
cervical cancer	mental health
heart disease	smoking
strokes	consumption of fruit and vegetables
accidents	consumption of alcohol
suicides	dental caries (tooth decay)
low birth weight	

A full list of the targets, with their technical specifications, is included in the Glossary.

7.7. This set of targets was developed to include: a broad range of conditions that cover premature death, quality of life, and lifestyles; that are of importance in Wales; where improvement was thought to be realistic; and which are measurable, with a known baseline. The target levels take account of past experience in Wales, in other parts of the UK, and in other comparable countries in Western Europe. These comparisons give a realistic idea of the scope for improvement and of the time-scale over which improvements can be expected.

7.8. It is not a comprehensive list of important conditions, and is not a list of priorities - either for the health service, or for other agencies. What it does represent, taken as a package, is the best available set of indicators and targets for overall improvement of health and well-being in Wales. Most of the targets were set for the year 2002, tied to a five year action programme.

7.9. Recognising the work in progress, the Welsh Office has decided to focus on the 15 **Health Gain Targets**, with the addition of targets for children's health and well-being, for the medium term, recognising that the long-term aim of the strategy will extend well beyond 2002.

National targets for reducing health inequalities

7.10. The Welsh Office is concerned not only with improving the health of the population as a whole, but also in pursuing policies that will have maximum impact on those sections of the population that suffer the worst health. It is proposed to develop, in consultation with key agencies, a number of priority targets for the reduction of inequalities in health in Wales.

National targets for improving the determinants of health

7.11. Although the health of the population as a whole is improving steadily, inequalities in health are widening. This is because the underlying cause of health inequalities lie in the social, economic, and physical environment, and they take time to change. The reality is that a reversal of this trend of widening inequality in health will not become apparent for a number of years. For this reason it is proposed to develop, in the light of comments received during the consultation period, a number of national targets for action on the determinants of health, to act as intermediary indicators of progress with the strategy.

Local targets

7.12. The national targets are intended to monitor progress at the national level. At the local level, there is flexibility through Health Improvement Programmes to develop local strategies and local targets for meeting the national targets, as well as flexibility to develop additional targets to tackle pressing local priorities.

Health Improvement Programmes

7.13. Health Improvement Programmes in each Health Authority area will be in place by late 1999. We envisage that Health Improvement Programmes will:

- give a clear description of how the national aims, priorities and targets for health and well-being will be tackled locally;
- set out a range of locally-determined priorities, with a particular emphasis on addressing areas of major health inequality in local communities;
- specify agreed programmes of action to address these national and local health improvement priorities;
- show that the action proposed is based on evidence of what is known to be effective;
- show what measures of local progress will be used, including those required for national monitoring purposes;
- indicate what local organisations have been involved in drawing up the plan, what their contribution will be and how they will be held accountable for delivering it;
- ensure that the plan is easy to understand and accessible to the public;
- be a vehicle for setting strategies for the shaping of local health services;
- using a process of risk assessment, decide local priorities for occupational health and safety.

7.14. The new arrangements will mean that a collaborative approach to housing improvements, integrated transport schemes and improved local services can be considered within the same local frameworks as health and social care. On the local government side, this approach will be underlined by the Government's intention to impose a duty to achieve Best Value across the full range of services, including those which Councils deliver as part of Health Improvement Programmes. Community and voluntary groups will also be given important opportunities to influence and evaluate Health Improvement Programmes. These will be the main planning tool for improving health and targeting health inequalities.

How should Health Improvement Programmes be carried out?

In particular how should responsibilities for identifying and acting upon inequalities in health status be used effectively?

8. INVESTING IN THE FUTURE

This chapter describes proposals for taking the broad public health gain agenda forward.

8.1. Despite the considerable reduction in premature mortality across the whole population, the gap between those with the best health and those with the worst is widening. Health improvement and narrowing of health inequalities between social groups is likely to be achieved primarily by economic, social, environmental and public health policy rather than by medical or other personal health care services.

8.2. The evidence that death rates in a substantial minority of the Welsh population are not declining as fast as those in the majority should be a matter of public concern and debate. Instead of achieving the World Health Organisation (1995) target of reducing health inequality by 25% by the year 2000, it is likely that there will have been an increase of 25% in inequality.

8.3. The continuing economic differences in Wales suggests that the mortality divide between poor and wealthy areas may increase, unless decisive action is taken to redress the balance.

8.4. The aim of *Better Health - Better Wales* is to improve the health prospects for our children and young people and to extend the active and productive lives of everyone. This means safe environments, healthy housing, schools, workplaces and public places and healthy lifestyle, including access to work and leisure opportunities. When this is not possible, we should ensure that the best care is provided that adds quality to life as well as extending life.

Sustainable Health Action Research Programmes

8.5. The Welsh Office proposes to set up a 5 year action research project designed to show the most effective ways of breaking the cycle of poor health in Wales. The project will focus on communities with the highest incidence of ill-health and premature death, social exclusion and poor life chances. Areas will be chosen to reflect urban and rural issues. Action will focus on learning lessons about what works in addressing the effects on health of housing, unemployment, social distress and poor access to services in a variety of settings. The information gained will be used, as it becomes available, to inform decisions about resource allocation and future development.

8.6. The criteria for the project will:

- include Wales-wide action research;
- focus on small communities with significant poor health;
- include small-scale actions which are replicable in a variety of settings;
- take account of the culture and geography of Wales;
- build on successful community regeneration schemes;
- involve local women and men, local agencies and professionals in the design and delivery;
- involve local agencies and professionals;
- test a range of assumptions about what works to build healthy communities.

How should Sustainable Health Action Research Programmes be designed to harness skills at every level and make the

best use of resources in reducing inequality?

Health Impact Assessment

8.7. All policies impact on people's lives, some to a greater extent and with more immediacy than others. The health experience of a population, at national or local level, can reflect the impact of such policies. Except in a relatively few examples the causal relationship between policies and health or well-being of a population is rarely direct and simple. Nevertheless comparisons of the health effects of policies over time and in differing political contexts enables judgements to be made on the possible outcomes of policy choices.

8.8. Health Impact Assessment is a relatively recent idea which is designed to be supportive but critical, and to inform the policy making process. Over the past decade Health Impact Assessment has been adopted in the European Union, Canada, Australia, New Zealand and by countries in the developing world. In England a formal health impact assessment of Manchester's proposed second runway led to the implementation of all the recommendations made to safeguard health while realising the economic benefits of the development.

8.9. The essence of Health Impact Assessment is:

- applying screening criteria to help select policies or projects for Health Impact Assessment;
- profiling the areas and communities affected;
- applying a pre-defined model of health to predict potential impacts;
- evaluating the importance, scale and likelihood of those impacts;
- option appraisal and recommendations for action.

8.10. The purpose is not to obstruct but to facilitate policy creation by identifying, early on, possible adverse health impacts and how to overcome them. At its simplest, this may mean long-term surveillance of health effects with mechanisms for early and corrective measures to be taken.

8.11. Health Impact Assessment can also be a useful tool to define the likely effect of policies on the health of populations. The methodology is well-defined and tested and can be readily implemented.

How should health impact assessment be used in setting public policy in Wales?

Information and Communication

8.12. To help support and improve health, patients and individuals will increasingly demand and expect information about:

- general health matters, health promotion, ill-health avoidance and self care;
- specific conditions;
- types of NHS services available, and how and when best to access these services;
- choice of services available with information on quality, effectiveness, waiting time etc.

8.13. They will also expect the information to be presented through a number of different ways but in a consistent, accessible and attractive manner. This will help them to access and use services more effectively and give them more control over their circumstances.

8.14. It is also important to ensure that the NHS community itself is well informed. Having the most appropriate and best

available information to hand when making decisions helps ensure that these decisions are correct and appropriate, from the best treatment for a particular patient with a specific problem through to the information needed to help reduce variations in health and ensure appropriate services are made available according to the health needs and status of local populations.

8.15. Many organisations and individuals play a part in providing this information, including government, the media, voluntary groups, women's organisations, school, telephone health information services, and those working in the NHS. The information comes from a variety sources, including:

- locally-collected information relevant to service needs;
- centrally-collated data based on extracts from locally-captured information and other external sources;
- multiple data bases, surveys and systems: such as the Health of Wales information system (HOWIS) proposed in the White Paper *Putting Patients First (Cm 3841)*,[cm] which will give access to aggregated anonymous data in easily understandable formats; or the new national survey of patient and user experience which will be introduced at Health Authority level from 1998.

8.16. There is already a bewildering amount of information available to the public and the NHS. However, much of it is of questionable quality and is often conflicting in nature. The NHS needs to co-ordinate its information resource more effectively, making best use of new forms of communication such as the Internet and digital communications services, to provide the information in a form that can be used by individual citizens, healthcare professionals, service providers and policy makers alike.

8.17. Information on its own is not enough. We need a communication strategy which will ensure:

- use of data to provide information relevant to service providers, commissioners, users/clients/patients, in a user-friendly format adjusted for particular 'receiver's' perceptions and needs;
- collaborative work with the media - developing the 'action plan', monitoring progress and getting key health messages across to the general public;
- an effective 'marketing' strategy - local newspapers (including the free newspapers/radio/TV), the Internet, shopping centres, libraries;
- effective risk communication - how do we communicate risks to health in a clear and easily understood way which enables individuals and communities to take appropriate action to improve their health status?

8.18. If the public health strategy is to be successful it will depend upon access to accurate information. This will require a more effective corporate and co-ordinated approach. Without access to information from a wide range of sources it will be very difficult to assess the health of the population and the effectiveness of the public health strategy in addressing problems.

What information would make you more informed about health and how would you wish to see it provided?

What information is needed to help bring about improvements in the health of the people of Wales?

What information is needed to help inform debate about public health issues in Wales?

Summary

8.19. There is a need then, to develop a health improvement strategy that takes account of the profound inequalities in health within Wales, and of the variation in health determinants that have led to them; a strategy which truly reflects the 'organised efforts of society'. Failing to tackle this issue would be a wasted opportunity to address the significant differences in the opportunities and problems existing in Wales.

GLOSSARY AND TECHNICAL TERMS

Health Gain Targets

These were developed by an expert group and announced by the Secretary of State for Wales in June 1997. Together they are intended to measure progress towards improved health in Wales. The NHS are expected to develop plans to address these targets over the next 5 years.

Indicator	Target
1. Cancer of trachea, bronchus, lung. ICD 162	a. Reduce European standardised mortality rate for lung cancer in men under the age of 75 by at least 54% by 2010 (from 49.2 per 100,000 in 1995 to no more than 22.6 in 2010). b. Reduce European standardised mortality rate for lung cancer in women under the age of 75 by at least 21% by 2010 (from 23.0 per 100,000 in 1995 to no more than 18.2 in 2010). *In addition, the smoking targets 12(a) and 12(b) are to be regarded as interim measures of progress in 2002.*
2. Cancer of female breast. ICD 174	Reduce the European standardised mortality rate from breast cancer in women age 50 to 74 by at least 30% by 2002 (from 83.9 per 100,000 in 1995 to no more than 58.7).
3. Cervical cancer. ICD 180	Reduce the European standardised registration rate for invasive cervical cancer in women by at least 50% by 2002 (from 21.9 per 100,000 in 1990 to no more than 11.0). *The target set will be reviewed in the light of more up-to-date and validated data from the Wales Cancer Registry, when they become available.*
4. Coronary heart disease (Ischaemic heart disease). ICD 410-414	a. Reduce the European standardised mortality rate from coronary heart disease for people aged under 65 by at least 50% by 2002 (from 50.3 per 100,000 in 1995 to no more than 25.2). b. Reduce the European standardised mortality rate from coronary heart disease for people aged 65 to 74 by at least 25% by 2002 (from 820 per 100,000 in 1995 to no more than 615).
5. Cerebrovascular disease (strokes). ICD 430-438	a. Reduce the European standardised mortality rate from stroke in people aged under 65 by at least 20% by 2002 (from 11.5 per 100,000 in 1995 to no more than 9.2). b. Reduce the European standardised mortality rate from stroke in people aged 65 to 74 by at least 25% by 2002 (from 218.4 per 100,000 in 1995 to no more than 163.8).
6. Accidents. ICD E800-949	Reduce the European standardised mortality rate for accidents, for all ages, by at least 15% by 2002 (from 20.7 per 100,000 in 1995 to no more than 17.6). *The possibility of using the All-Wales Injuries Surveillance System to set and monitor a target for the incidence of serious injuries resulting from accidents will be kept under regular*

review.

7. Suicide and undetermined deaths. ICD E950-959, E980-989	Reduce the European standardised mortality rate from suicide (including undetermined deaths) by at least 10% by 2002 (from 12.3 per 100,000 in 1995 to no more than 11.1).
8. Low birth weight.	Reduce to below 6% the proportion of babies of low birth weight (below 2,500 gms) by 2002. *The possibility of separating out the very low birth weight babies (below 1,500 gms) from the rest will be kept under regular review.*
9. Back pain.	Reduce by at least 10% by 2002 the proportion of people aged under 65 who report that they have back pain which has been treated by a doctor, as measured by the Welsh Health Survey, from 27.4% in 1995 to no more than 24.7%.
10. Arthritis.	Increase the mean Physical Component Summary Score in people aged 65 and over who report that they have arthritis, which has been treated by a doctor to 34.9 by 2002 (from 32.4 in 1995), as measured by the Welsh Health Survey.
11. Mental health.	Increase the mean Mental Component Summary Score for Wales to 50 (equal to that of the USA) by 2002 (from 49.5 in 1995), as measured by the Welsh Health Survey.
12. Smoking.	a. Reduce the proportion of adults age 18 to 64 who smoke (daily + occasionally) to no more than 20% for both men and women by 2002 (from 31.5% in men and 28.1% in women in 1993). b. Reduce the proportion of 15 year old children who smoke (at least weekly) to no more than 16% for boys and 20% for girls (from 23% in boys and 29% in girls in 1996). c. Increase the proportion of women who give up smoking during their pregnancy to at least 33%. *The target for smoking in pregnancy will be taken forward as a pilot exercise with the Health Authority Co-ordinating Group, where agreement on a precise definition, and on data sources, will be sought.*
13. Consumption of fruit and vegetables.	a. Increase the proportion of adults aged 18 to 64 who eat green vegetables or salads most days to at least 40% by 2002 (from 32.8% in 1993). b. Increase the proportion of adults aged 18 to 64 who eat fresh fruit most days to at least 55% by 2002 (from 44.3% in 1993).
14. Alcohol consumption.	Reduce the percentage of men aged 18 to 64 consuming more than 21 units of alcohol per week to 18% by 2002 (from 26.4% in 1993), and of women aged 18 to 64 consuming more than 14 units per week to 7% by 2002 (from 8.5% in 1993).
15. Dental caries.	Reduce the proportion of children experiencing dental caries (DMFT of 1 or more) by 5 percentage points as measured in BASCD Co-ordinated Surveys, from 53% of 5-year-olds in 1995 to 48% by 2002, and from 64% of 14-year-olds in 1994 to 59% by 2002.

Local Agenda 21

At a UN Special Session in June 1997 the Prime Minister urged all Local Authorities in the UK to adopt Local Agenda 21 strategies. These apply the principles of sustainable development within their own areas. To assist in this process the Welsh Office published Sustainable Communities in Wales for the 21st Century Why and How to Prepare an Effective Local Agenda 21 Strategy in January 1998: this is a guide to encourage Local Authorities, with the involvement of all sections of their communities, to press ahead with their strategies.

Mortality rate

The ratio of the total numbers of deaths to the total in any particular population.

Standard Occupational Classification

Class	Occupation	*For example:*
I	professional	*physicist, vicar, dentist*
II	managerial and technical	*librarian, nurse, journalist*
III(N)	skilled, non-manual	*photographer, clerk, salesperson*
III(M)	skilled, manual	*bricklayer, watchmaker, electrician*
IV	partly skilled	*caretaker, waiter, gardener*
V	unskilled	*cleaner, labourer, messenger*

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QUESTIONNAIRE: YOUR VIEWS ON IMPROVING HEALTH AND WELL BEING

SUSTAINABLE HEALTH AND WELL-BEING

Healthy Workplaces

1. How can more employers, employees and organisations such as trade associations and trade unions make even more effective contributions to controlling workplace risks and ensuring sustainable health in the workplace?

Community Safety

2. How could action to improve health strengthen crime reduction strategies?

Personal and Family Support

3. How should public policy protect children and families and how can all sectors of the community develop caring roles?

Social Exclusion

4. How should minority groups be included in policies for improving health and well-being?

HEALTHY LIFESTYLE

5. How can we encourage a healthy lifestyle with people making choices that sustain and improve their health and well-being?

Sexual Health

6. Are we prepared to take down the barriers to effective communication on these subjects in order to address the unacceptably high rate of teenage pregnancy and to control the spread of sexually acquired infection?

Oral Health

7. In view of the strong evidence that fluoride prevents tooth decay, should the Government require Water *Companies to*

fluoridate supplies, if this is supported by the majority of people?

Preventing Disease

8. Are there ways in which screening and prevention programmes can be made more effective?

Healthy Schools

9. How could education and training be used better to inform people about health and encourage people to look after their own health?

School Health Services

10. How could a new partnership approach benefit the health of children in schools?

Accidents

11. How can we increase safety standards and prevent accidents?

HEALTHY ENVIRONMENT

Social Housing

12. How can social landlords and tenants' organisations develop their role in strengthening communities?

13. How can they make a more positive impact on the health and well-being of people?

Housing

14. How should housing policies be developed to take account of community safety and sustainable health, particularly where there are concentrations of sub-standard houses?

Chemical and Hazardous Incidents

15. How can we develop our priorities to ensure a sustainable balance between the protection of public health and the environment?

PARTNERSHIPS FOR HEALTH

16. How should responsibilities for identifying and acting upon inequalities in health status be shared by different agencies?

Individuals

17. How best can individuals be encouraged to look after their own health within communities, workplaces, schools and other environments?

Community and Voluntary Organisations

18. How can voluntary organisations play a full part in improving the health and well-being of their communities, in partnership with professionals and other services?

Local Authorities

19. How best can Local Authorities play a full part in improving the health and well-being of their populations, in particular responsibilities for identifying and acting upon health determinants, such as housing, which impact on health?

The NHS

20. How should these duties be carried out, in particular responsibilities for identifying and acting upon inequalities in access to acute services and differing outcomes for patients?

Local Health Groups

21. How best can Local Health Groups be equipped to undertake this work, in particular responsibilities for identifying and acting upon inequalities in health status and actively promoting health improvements?

Collaborative Networks

22. How can professional groups play a full part in meaningful collaboration which will improve the health and well-being of communities, in partnership with voluntary and community groups?

The National Assembly for Wales

23. How should collaboration in the context of the National Assembly for Wales be strengthened to ensure that better health drives major policies?

MEASURING PROGRESS

24. How should Health Improvement Programmes be carried out?

25. In particular how should responsibilities for identifying and acting upon inequalities in health status be used effectively?

INVESTING IN THE FUTURE

Sustainable Health Action Research Programmes

26. How should Sustainable Health Action Research Programmes be designed to harness skills at every level and make the best use of resources in reducing inequality?

Health Impact Assessment

27. How should health impact assessment be used in setting public policy in Wales?

Information and Communication

28. What information would make you more informed about health and how would you wish to see it provided?

29. What information is needed to help bring about improvements in the health of the people of Wales?

30. What information is needed to help inform debate about public health issues in Wales?

Your Views The Welsh Office welcomes views on the issues raised in this paper and will take these into account in developing an Action Plan to be published in September 1998. Please send comments to:

Nicola Rodgers
Public Health Division
Welsh Office
Cathays Park
CARDIFF
CF1 3NQ

Comments should be received by **31 July 1998**.

Unless marked confidential your views may be published in whole, or in summary form, and copies may be placed in the Libraries of the Houses of Parliament.

Further copies of Better Health - Better Wales are available from the Health Professionals Support Unit, Welsh Office, Cathays Park, CARDIFF CF1 3NQ. Telephone 01222 825417.

Tlodi, amddifadedd ac afiechyd

2.11. Ceir cyfatebiaeth agos rhwng patrymau amddifadedd a salwch a chlefyd. Ceir gwahaniaeth o 5 mlynedd mewn disgwyliad oes rhwng dynion proffesiynol a dynion sy'n gwneud gwaith llaw difedr. Tair blynedd yw'r ffigur cyfatebol yn achos menywod.cl Mae'r bwlch hwn yn mynd yn lletach. Mae gweithwyr llaw difedr yn debycach na phroffesiynolion o ddioddef salwch cyfyngus hir-dymor, marwoldeb uwch ymhlith babanod yn eu teuluoedd ac mae eu plant yn debycach o ddioddef salwch cronig a phydredd dannedd.

2.12. Yn *Arolwg Iechyd Cymru (1995)* gwelwyd lefelau uwch na'r cyfartaledd o glefyd y galon, clefyd yr anadl, salwch meddwl, arthritis a phoen ymhlith pobl yn gwneud gwaith difedr. Maent yn debycach hefyd o gael damweiniau neu anafiadau y mae angen eu trin yn yr ysbyty; o ddioddef problemau heb eu cywiro gyda'u golwg a'u clyw; o ymweld yn llai aml 'r deintydd a'r optegydd; o ymarfer corff yn llai ac maent yn debycach o fod yn or-dew. Mae mynychder poen yn y cefn a salwch cyfyngus hir-dymor ymhlith pobl sy'n gwneud gwaith difedr bron dwbl yr hyn a welir ymhlith dynion a menywod proffesiynol o'r un oedran.

2.13. Mae gan Gymru ganran lawer uwch o bobl o oedran gweithio sy'n adrodd **salwch cyfyngus hir-dymor** (12.5%) nag ym Mhrydain Fawr yn ei chrynswth (8.5%) (Cyfrifiad Poblogaeth 1991). Gwelir y patrwm rhanbarthol yn amlwg o fewn Cymru yn nhermau diffyg gweithgarwch economaidd a salwch hunan-adroddedig. Nid yw'n syndod mai yn hen ardaloedd diwydiannol Cymoedd y De y gwelir y lefelau uchaf. Yn yr ardaloedd hyn, dywed 17.7% o'r boblogaeth o oedran gweithio fod arnynt salwch cyfyngus hir-dymor, o'i gymharu 12.5% o Gymru yn ei chrynswth.

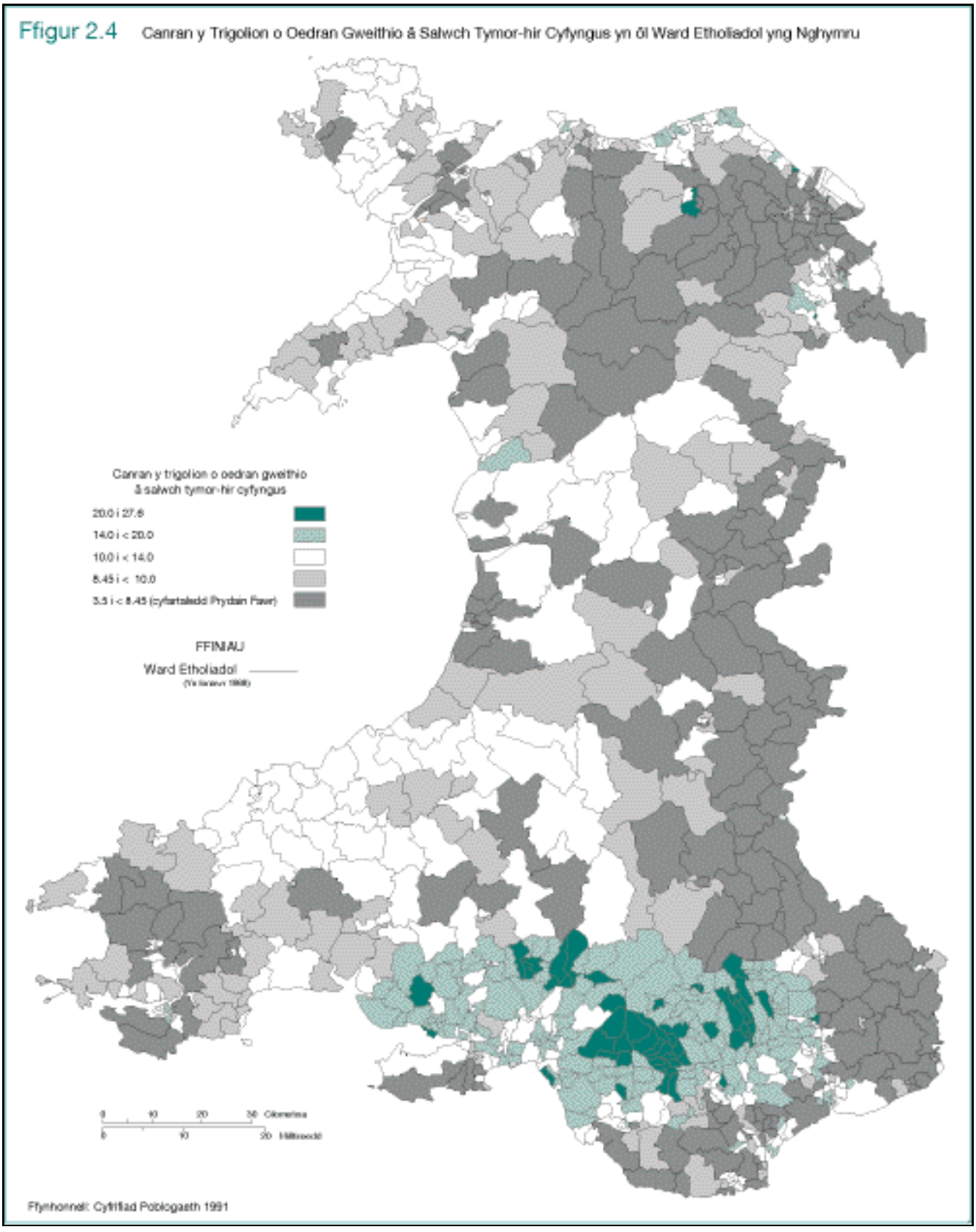
2.14. Gwelir y patrwm sefydledig a hysbys hwn o afiechyd, salwch ac absenoliaeth mewn ardaloedd eraill hefyd lle bu'r diwydiannau echdynnu trwm yn arfer ffynnu - megis Gogledd Lloegr. Gan hynny mae'r lefelau uwch o afiechyd yn y Cymoedd yn ymddangos yn gyson hanes galwedigaethol y diwydiannau trwm a'r mwyngloddiau, ac amodau cymdeithasol ac economaidd gwael.

2.15. Ond nid yw hyn yn esboniad cyflawn ar y lefel o ddiffyg gweithgarwch economaidd a welir yng Nghymoedd y De. Mae'r dystiolaeth yn dangos bod y lefelau hyn i'w gweld ymhlith dynion sydd heb weithio yn y diwydiannau hyn o'r blaen, ac mewn mannau eraill, gan gynnwys y Gorllewin. Ymhellach, nid yw'r lefel analluedd, yn l pob tebyg, yn fwy na lefel dynion o'r un oedran mewn rhannau eraill o'r DU, ond ar gyfer unrhyw lefel benodedig o analluedd yng Nghymru, ceir mwy o duedd o fod wedi cofrestru fel person parhaol sl, yn hytrach na bod mewn gwaith. Mae'n debyg bod hyn yn deillio yn rhannol o ddiffyg swyddi a hyfforddiant addas i bobl ar ddiwedd eu hoedran gweithio gyda mn anabledd corfforol.

2.16. Mae diweithdra a diffyg gweithgarwch economaidd yn effeithio ar hunan-barch ac iechyd meddwl ac yn cynyddu straen, yn ogystal ag effeithiau tlodi cymharol ar dai, deiet a mynediad i weithgareddau hamdden. Mae effaith gymdeithasol diweithdra drwy gyfrwng afiechyd yn sylweddol a gall y tlodi sy'n deillio o hynny waethygu ffactorau megis troseddau a chamddefnyddio sylweddau sy'n ychwanegu at y cylch o amodau gwael ac afiechyd.

2.17. Mae'r rhai sy'n dweud eu bod yn dioddef salwch hir-dymor yn tueddu i fod dros 45 oed ac yn debycach o fod yn wrywod na benywod. Y duedd yw bod ganddynt ychydig yn unig o gymwysterau, eu bod yn byw mewn teuluoedd sy'n dibynnu ar fudd-daliadau gydag incwm isel ac mae llawer yn hawlio Budd-dl Analluedd. Y problemau iechyd mwyaf cyffredin yw poen yn y cefn a'r gwddf, arthritis a chryd cymalau, problemau'r galon a'r frest ac iselder.[cl]

2.18. Nid oes ateb hawdd i broblemau o'r fath, ond y ffaith amdani yw bod grwp sylweddol o'r boblogaeth - difedr, canol oed, mewn iechyd gwael a gwrywod yn bennaf - wedi datgysylltu oddi wrth y farchnad lafur. Mae angen cymryd camau yn y tymor hir felly i fynd i'r afael ag achosion gwreiddiol y broblem. Mae'r Llywodraeth wedi dechrau ar hyn drwy gynnig newidiadau eang i foderneiddio'r system les; i gyflwyno isafswm cyflog cenedlaethol y bwriedir iddo godi safonau byw y rhai ar y tl isaf; a'r rhaglenni newydd i gael pobl oddi ar Fudd-daliadau i mewn i Waith, gan gynnig hyfforddiant a chymorth i helpu pobl yn l i'r gwaith.



Crynodeb

2.19. Mae iechyd cymharol wael pobl Cymru yn dangos bod angen ailwampio'r ffordd yr ymgodymir materion iechyd. Mae mynychder afiechyd sylweddol yn creu canlyniadau pellgyrhaeddol ar gyfer yr economi, ac ar gyfer strwythur cymdeithasol a lles y cymunedau. Rhaid i gymdeithas fodern fynd i'r afael materion cydraddoldeb a thegwch a amlygir pan fo statws iechyd yn dibynnu ar ddosbarth cymdeithas, neu ar a ydych mewn gwaith, neu ar ble'r ydych yn byw.

Bwyd Diogel

4.12. Mae'r Llywodraeth wedi ymrwymo i roi'r flaenoriaeth uchaf i ddiogelu iechyd y cyhoedd ym maes diogelwch a safonau bwyd. Mae bwriad y Llywodraeth i sefydlu Asiantaeth Safonau Bwyd yn ganolog i'r polisi. Cyhyd ag y bydd y Senedd yn ei chymeradwyo, sefydlir yr Asiantaeth cyn diwedd 1999. Un o rolau allweddol yr Asiantaeth fydd hybu'r safonau uchaf o ddiogelwch bwyd a sicrhau y caiff defnyddwyr y wybodaeth y mae arnynt ei hangen i wneud dewisiadau gwybodus am eu deiet.

4.13. Bydd yr Asiantaeth Safonau Bwyd yn gweithredu drwy gyfrwng gweithrediaeth yng Nghymru. Bydd y Cynulliad Cenedlaethol yn goruchwylio ac yn ariannu ei gwaith. Bydd gweithrediaeth Cymru a'r Awdurdodau Lleol yn cydweithio i wella cysondeb mewn gweithgareddau i orfodi'r gyfraith ar fwyd a, lle bo'n angenrheidiol, i gywiro unrhyw ddiffygion. Caiff yr Asiantaeth ddigon o bwerau i sicrhau y gall ddwyn gwir ddylanwad dros weithgareddau'r awdurdodau unigol. Bydd yr Asiantaeth hefyd yn darparu gwybodaeth proffil-uchel i'r cyhoedd ac yn ymestyn y cysylltiadau diogelwch bwyd sydd eisoes wedi'u datblygu gan y Swyddfa Gymreig.

4.14. Ar wahn, mae'r Llywodraeth yn adolygu'r ddeddfwriaeth ynghylch rheoli ac arolygu clefydau trosglwyddadwy, gan gynnwys clefyd a ddygir mewn bwyd, er mwyn sicrhau ei bod yn bodloni anghenion iechyd y cyhoedd yn ddigonol.

4.15. Mae'r Cod Ymarfer ar arolygiadau hylendid bwyd wedi'i ddiwygio yn ddiweddar i fynnu arolygiadau amlach ar safleoedd lle ceir perygl uchel. Cydnabuwyd hyn yn setliad refeniw yr awdurdodau lleol ar gyfer 1998-99.

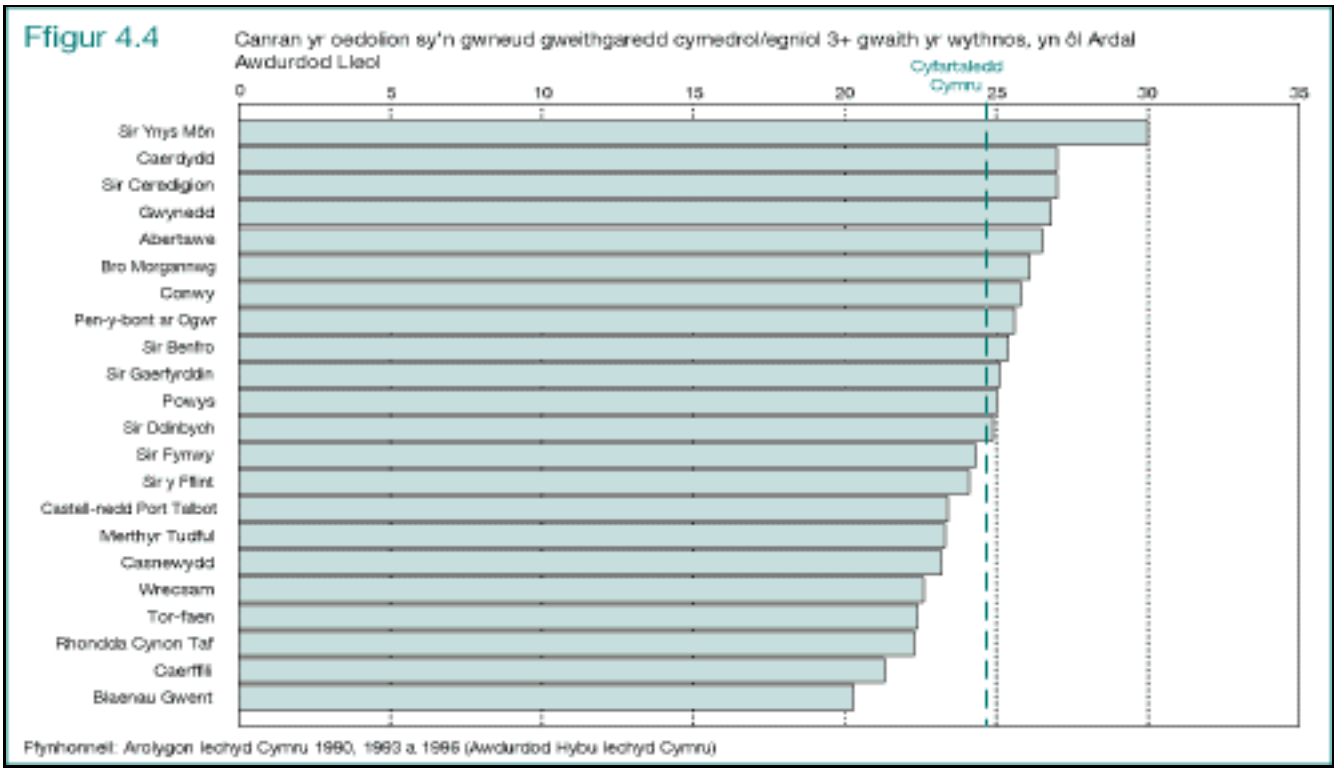
4.16. Yng Nghymru, mae'r Awdurdodau Lleol wedi derbyn adnoddau ychwanegol i fonitro a chynghori manwerthwyr bwyd. Mae'r gweithgareddau'n cynnwys: gwella systemau hylendid mewn siopau cig; darparu deunyddiau addysgol ar gyfer ysgolion; diogelu grwpiau hawdd eu niweidio; a chynghori gweithredwyr safleoedd bwyd anghofrestredig (megis neuaddau eglwys etc). Bydd yr Asiantaeth Safonau Bwyd yn cefnogi'r gwaith hwn.

4.17. Mae'r Llywodraeth yn cymryd yr awenau yn ystod ei Llywyddiaeth ar yr Undeb Ewropeaidd i weithio dros labeli clir, syml a llawn gwybodaeth ar gynhyrchion bwyd. Mae'r Llywodraeth yn ymwybodol o bryder y cyhoedd ynghylch bwydydd a newidiwyd yn genetig a bwydydd newydd eraill ac mae'n gweithio gyda'i phartneriaid Ewropeaidd i sicrhau bod labeli clir ar y cynhyrchion hyn er mwyn i'r defnyddwyr gael dewis defnyddio bwydydd o'r fath neu beidio.

Ymarfer Corff

4.18. Nid yw dros 70% o oedolion Cymru'n ymarfer corff digon i fod o les i'w hiechyd.[aq] Mae lefelau isel o weithgarwch corfforol yn gysylltiedig chlefyd y galon, gorbwysedd, clefyd siwgr nad yw'n ddibynnol ar inswlin, gordewdra, osteoporosis ac iselder ysbryd. Mae'r dystiolaeth yn awgrymu mai mwyaf o ymarfer corff a wneir, lleiaf yw'r perygl o gael yr anhwylderau hyn.

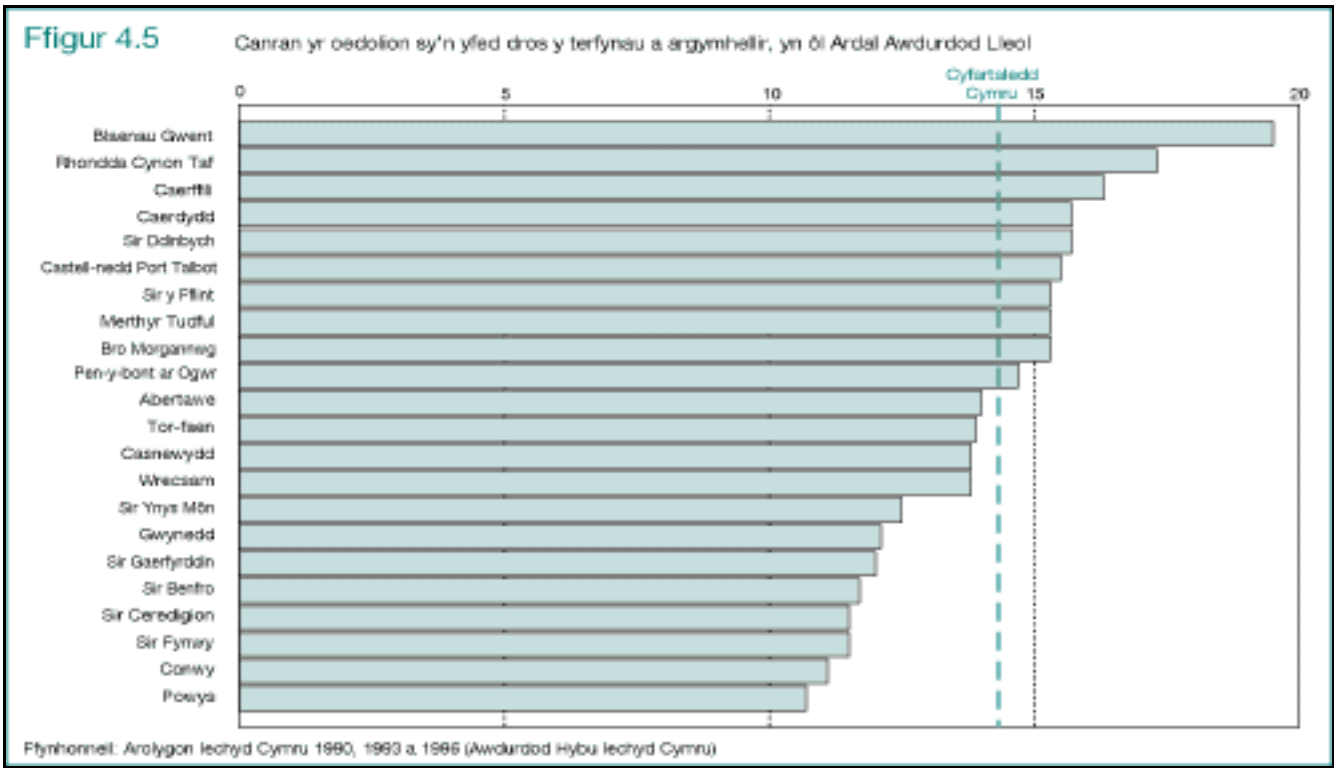
Ymarfer Corff ar Bresgripsiwn **O dan y rhaglen Presgripsiynau Iechyd a Hamdden, gall ymarferwyr cyffredinol a phroffesiynolion iechyd atgyfeirio'u cleifion at gampfeydd lleol, lle caiff rhaglen o ymarferion ei dyfeisio ar gyfer pob unigolyn er lles eu hiechyd. Ar hyn o bryd, ceir 12 rhaglen gyfeirio at ymarfer corff yng Nghymru. Mae'r rhain yn cynnwys adrannau gwasanaethau hamdden lleol, practisau ymarferwyr cyffredinol ac yn aml gwasanaethau hybu iechyd. Mae'r mwyafrif o'r cynlluniau'n rhedeg am ryw 12 wythnos, gyda chyrsiau dilynol yn aml. Gellir cael gwybodaeth am raglenni atgyfeirio yng Nghymru a chyngor ar sefydlu cynlluniau oddi wrth Awdurdod Hybu Iechyd Cymru. Hefyd, mae Tystysgrif Atgyfeirio Ymarfer Corff, ar gyfer hyfforddwyr ffitrwydd sy'n ymdrin chleifion sydd wedi'u hatgyfeirio, wedi'i sefydlu gan Awdurdod Hybu Iechyd Cymru mewn cydweithrediad Ffitrwydd Cymru a Phrifysgol Cymru, Caerdydd.**



Sut y gallwn hybu ffordd iach o fyw gyda phobl yn gwneud dewisiadau sy'n cynnal ac yn gwella'u hiechyd a'u lles?

Alcohol a Chyffuriau

4.19. Mae effeithiau andwyol yfed gormod o alcohol a chamddefnyddio cyffuriau yn hysbys iawn ac wedi'u dogfennu'n helaeth. Sefydlwyd cysylltiad rhwng yfed trwm cyson a rhai canserau, strc, gorbwysedd, clefyd yr iau ac iselder, a rhwng camddefnyddio cyffuriau a phroblemau iechyd meddwl. Mae'r ddau yn gysylltiedig ag amrediad eang o broblemau cymdeithasol ac economaidd gan gynnwys chwalfa deuluol, damweiniau, troseddau ac amhariadau ar berfformiad yn y gwaith. Er bod y gyfran o oedolion sy'n mynd y tu hwn i'r terfynau yfed doeth wedi gostwng, mae *Arolwg Iechyd Ieuenctid Cymru 1996*[ap] yn dangos bod lefelau yfed ymhlith pobl ifanc o dan 16 oed (sydd eisoes ymhlith yr uchaf yn Ewrop) yn parhau i godi. Mae'n ymddangos bod cyflwyniad alcopops wedi creu effaith ar batrymau yfed arddegwyr ifanc, yn arbennig merched. Mae angen ffrynt unedig, rhwng y llywodraeth, y cyfryngau, yr heddlu, iechyd, diwydiant a manwerthwyr, er mwyn gwrth-droi'r duedd.



4.20. Yn yr un modd, gwelwyd cynnydd yn y gyfran o bobl ifanc 15-16 oed sy'n dweud eu bod yn defnyddio cyffuriau anghyfreithlon. Ym 1990, yr oedd 20% o ferched, a 25% o fechgyn, wedi arbrofi ag o leiaf un cyffur anghyfreithlon. Erbyn 1996, yr oedd y ffigurau wedi dyblu i 40% o ferched a 50% o fechgyn.[aq]

4.21. Mae angen i iechyd, addysg, gwasanaethau cymdeithasol, asiantaethau cosb ac asiantaethau gwirfoddol gydweithio i gyrraedd y nodau o atal camddefnyddio cyffuriau ac alcohol, yn arbennig ymhlith pobl ifanc, a darparu triniaeth, cefnogaeth ac adsefydlu i'r rhai sy'n eu camddefnyddio. Dangoswyd bod gwasanaethau triniaeth, sy'n cael eu rhedeg yn effeithiol, yn cael dylanwad cadarnhaol ar iechyd camddefnyddwyr cyffuriau: mae cyfnewid nodwyddau, rhagnodi a rhaglenni addysg wedi helpu i gadw cyfradd heintiad HIV ymhlith camddefnyddwyr cyffuriau sy'n chwistrellu yn gyfradd isel yn y wlad hon, ac mae rhaglenni adsefydlu yn gwella iechyd cyffredinol eu cleientau, yn ogystal chyfrannu at ostyngiadau mewn troseddau sy'n gysylltiedig chyffuriau, gostyngiadau sy'n gwneud cyfraniad sylweddol at ddiogelwch cymunedol.

4.22. Galwodd Strategaeth Cyffuriau ac Alcohol Cymru, *Ymlaen Gyda'n Gilydd*, a lansiwyd ym Mai 1996, am gydweithredu i fynd i'r afael chamddefnyddio cyffuriau ac alcohol a phwyslais newydd ar atal camddefnyddio, yn arbennig ymhlith pobl ifanc. Sefydlwyd Pwyllgor Ymgynghorol ar Gamddefnyddio Cyffuriau ac Alcohol yng Nghymru i gynghori'r Ysgrifennydd Gwladol ar faterion cyffuriau ac alcohol. Sefydlwyd Uned Cyffuriau ac Alcohol Cymru, o dan gontract i'r Swyddfa, i helpu i weithredu'r strategaeth ledled Cymru. Sefydlwyd pum T"m Gweithredu ar Gyffuriau ac Alcohol ar lefel yr Awdurdodau Iechyd i ddatblygu a gweithredu strategaethau lleol ar sail aml-ddisgyblaeth. Mae Timau Ymgynghorol Lleol gyda chynrychiolwyr o lawer o asiantaethau ar waith ar lefel yr Awdurdodau Lleol.

4.23. Mae angen ymagwedd gydgysylltiedig i sicrhau bod rhieni a phobl ifanc yn deall peryglon camddefnyddio cyffuriau ac alcohol a bod ganddynt y medrau a'r wybodaeth i wrthsefyll. Cafodd yr ymagwedd hon ei hybu gan y *Cynllun Gweithredu Atal Strategol* a gynhyrchwyd gan Uned Cyffuriau ac Alcohol Cymru a'i lansio fis Tachwedd diwethaf. Gellir gwneud hyn drwy gyfrwng y Cwricwlwm Cenedlaethol ac addysg iechyd mewn ysgolion, asiantaethau ieuenctid, y system gosb a'r gweithle. Mae'n bwysig bod oedolion yn ymwybodol o'r terfynau yfed doeth. Gall ymwybyddiaeth o beryglon meddwi a dibyniaeth ar gyffuriau ac alcohol leihau'r posibilrwydd o ddamweiniau, anhwylder meddyliol a thrais. Mae angen pwysleisio'r peryglon i'r teulu, i gyflogaeth ac i amgylchiadau cymdeithasol yn sgil dibyniaeth ddifrifol ar sylweddau a gamddefnyddir.

4.24. Mae gwaith y Llywodraeth yn erbyn camddefnyddio cyffuriau wedi cael hwb newydd yn sgil penodi Cydgysylltydd Gwrth-Gyffuriau cyntaf y DU, Keith Hellawell, fis Hydref diwethaf. Y dasg iddo yw datblygu strategaeth gynhwysfawr yn erbyn cyffuriau. Mae Ysgrifennydd Gwladol Cymru ymhlith y Gweinidogion sydd wedi llofnodi'r strategaeth deng-mlynedd newydd hon ar gyfer mynd i'r afael chamddefnyddio cyffuriau, *Tackling Drugs to Build a Better Britain*, a lansiwyd ar 27 Ebrill. Canolbwyntio ar Loegr yn bennaf a wna'r strategaeth hon, ond mae'n berthnasol i Gymru hefyd, a byddwn yn myfyrio

ar oblygiadau'r strategaeth ar gyfer gweithgareddau gwrth-gyffuriau yng Nghymru, gan gyflwyno adroddiad ar ddatblygiadau diweddar i Gydgysylltydd Gwrth-Gyffuriau y DU erbyn Chwefror 1999.

Iechyd Rhywiol

4.25. Mae pobl yn ifanc yn mynd yn rhywiol weithredol yn gynharach ac ni welir unrhyw ostyngiad amlwg yn y cyfraddau beichiogi ymhlith pobl ifanc o dan 16 oed, a hyd yn oed cynnydd mewn rhai rhannau o Gymru. Mae ar blant angen addysg rhyw glir a diamwys gan eu rhieni, yn yr ysgol, neu sefydliadau eraill a all fod yn fwy derbyniol iddynt, megis clybiau ieuenctid. Mae llawer o rieni yn teimlo mai eu cyfrifoldeb hwy yw hyn, tra bo eraill yn teimlo'n anabl i drafod materion o'r fath yn adeiladol gyda'u plant. Mae ymchwil wedi dangos y byddai'r mwyafrif o rieni yn croesawu gweld y pwnc yn cael ei addysgu yn yr ysgol ond mae rhai plant yn teimlo bod hyn yn lletchwith ac nad yw'n cynnig gwybodaeth.[w] Cnt lawer o wybodaeth gan eu cyfoedion neu'r cyfryngau. Gall y wybodaeth honno fod yn anghywir ac arwain at gamddeall.

4.26. Ble bynnag y darperir y wybodaeth, mae angen ei rhoi heb beri lletchwithdod ac mewn modd llawn gwybodaeth, gan gymryd sensitifrwyddau diwylliannol a chrefyddol i ystyriaeth. Mae'r profiad yn Netherlands,[bt] lle mae addysg rhyw yn llawer mwy eglur nag yn y DU, wedi dangos y gall hyn fod yn ffordd effeithiol o ymdrin 'r angen am wybodaeth sy'n gywir ac yn dderbyniol i'r grwpiau yr ydym yn ceisio'u haddysgu. Byddai hyn yn golygu cyflwyno darpariaethau newydd i ddileu feto llywodraethwyr ysgol, i ganiatu i'r addysgu fod yn fwy eglur (e.e. dangos i blant sut i ddefnyddio condom yn iawn) a bod yn fwy agored ynghylch peryglon ymddygiad rhywiol anghyfrifol.

4.27. Gall rhyw heb ddiogelwch arwain at afiechyd neu farwolaeth o glefydau a drosglwyddir yn rhywiol. Nid oes brechlyn o hyd yn erbyn HIV na gwellhad ar gyfer AIDS. Mae ar bobl sydd mewn perygl o gael **clefydau a drosglwyddir yn rhywiol** angen gwybodaeth gywir wedi'i thargedu mewn ffordd sy'n dderbyniol iddynt, ac ar yr adeg briodol. Mae olrhain cysylltiadau yn fecanwaith pwysig ar gyfer cyfyngu lledaeniad clefydau. Er hynny, dim ond pan fydd y rhai o dan sylw yn teimlo'n hyderus bod y wybodaeth a roddant yn mynd i gael ei thrin yn gyfrinachol y mae'n effeithiol.

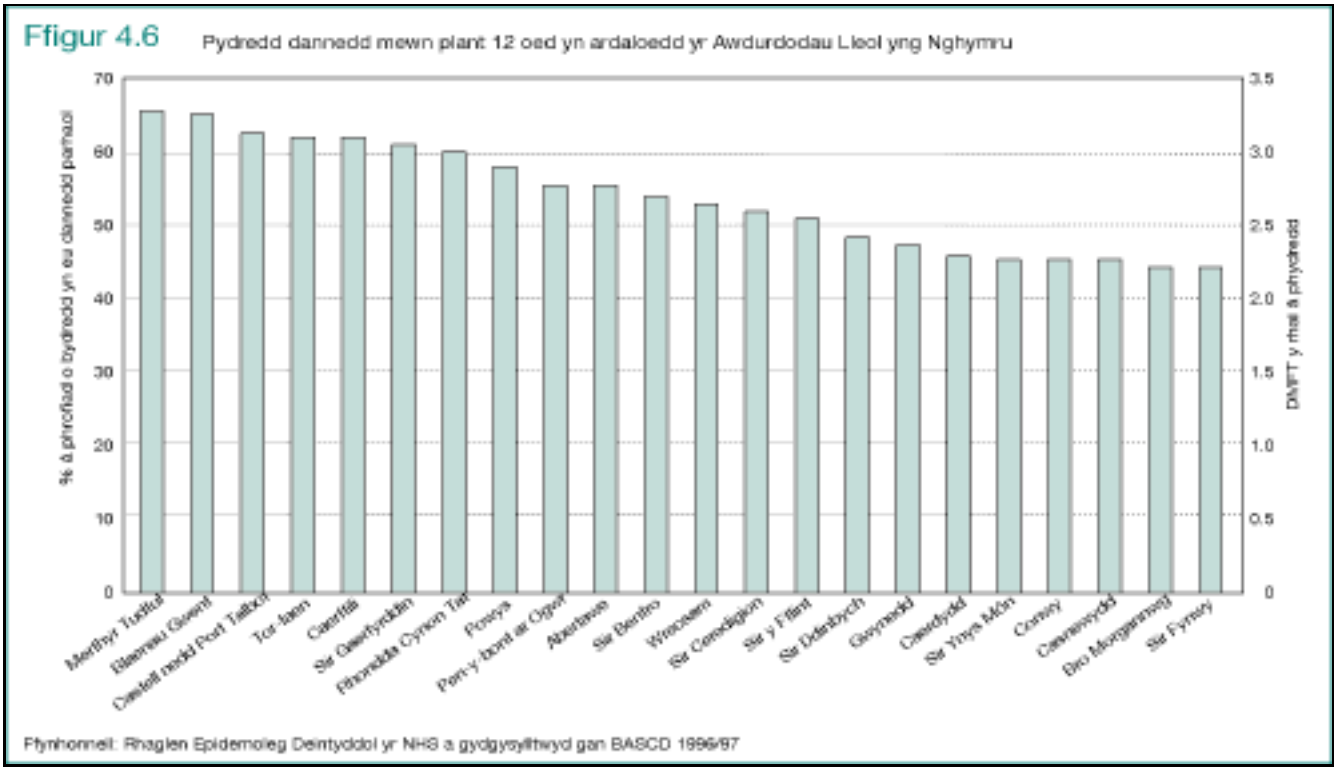
4.28. Mae anghenion pobl sy'n HIV positif yn newid wrth i therapau gyda chyffuriau newydd gynyddu disgwyliad oes yn sylweddol. Gall fod ar unigolion angen cymorth seicolegol wrth ddilyn trefn y cyffuriau, a bydd llawer yn ddigon da i ddymuno dychwelyd i gyflogaeth.

A ydym yn fodlon chwalu'r rhwystrau i gyfathrebu effeithiol ar y pynciau hyn er mwyn rhoi sylw i'r gyfradd annerbyniol o uchel o feichiogrwydd ymhlith arddegwyr a rheoli lledaeniad heintiadau a drosglwyddir yn rhywiol?

Iechyd y Geg

4.29. Bydd canser y geg yn lladd bron cymaint o bobl chanser ceg y groth ac mae'n gysylltiedig ag ysmygu a gorddefnyddio alcohol. Mae damweiniau i'r dannedd, yn arbennig ymhlith pobl ifanc a'r rhai sy'n cymryd rhan mewn chwaraeon, yn broblem gynyddol. Mae pydredd dannedd yn amrywio'n eang ar draws Cymru. Mae gan blant 5 oed ym Mhenderi (Abertawe) bron chwe gwaith a hanner yn fwy o ddannedd pwdr, coll neu wedi'u llenwi na phlant Rhiwbeina (Caerdydd).[bm]

4.30. Mae ymchwil ddiweddar sy'n cysylltu amryfal ddangosyddion amddifadedd drwy gyfrwng codau post data o arolygon deintyddol yn dangos bod pydredd dannedd yn fwy ac yn fwy yn glefyd sy'n gysylltiedig thlodi cymharol.



Ffynhonnell: Rhaglen Epidemoleg Deintyddol yr NHS a gydgysylltwyd gan BASCD 1996/97

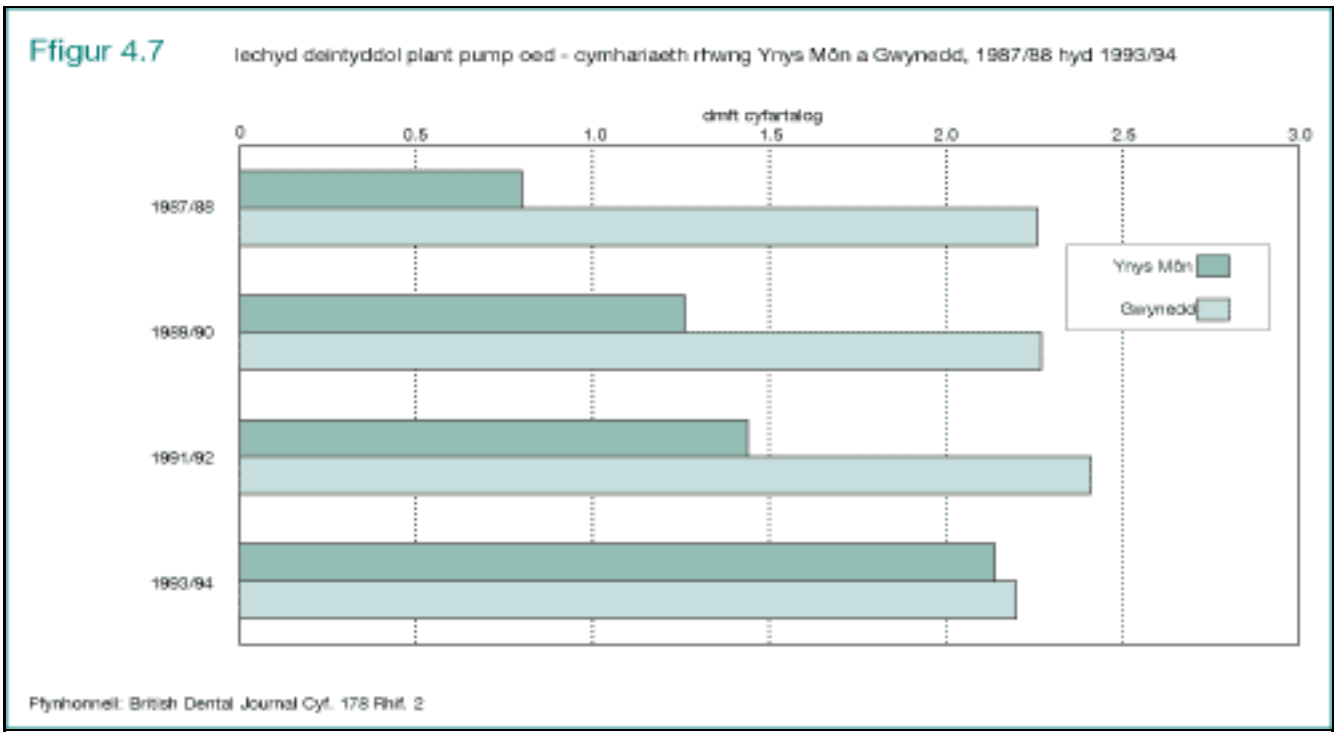
4.31. Gall pydredd dannedd gael ei leihau'n sylweddol, drwy addasiad i greu'r lefelau gorau posibl o fflworid mewn cyflenwadau dwr. Ceir fflworid ym mhob cyflenwad o ddwr domestig, ond mewn rhai ardaloedd yn unig y mae'n digwydd ar lefel a all ddiogelu dannedd yn naturiol. Nid oes effeithiau andwyol profedig ar iechyd pan godir lefelau fflworid i ryw 1 rhan ym mhob miliwn, ac er y gellir cael ychydig o afliwio, nid arwydd o unrhyw effaith andwyol yw hyn ac mae'r fantais gyffredinol i iechyd y geg yn drech nag ef.

4.32. Gwelwyd cynnydd sylweddol (168%) mewn pydredd dannedd yn Ynys Mn ymhlith plant 5 oed yn sgil penderfyniad unochrog Dwr Cymru i roi'r gorau yn raddol i fflworideiddio ychwanegol ym 1987, gan ddod i ben yn llwyr ym 1991. Mewn arolwg o'r farn gyhoeddus a gynhaliwyd ar yr ynys ym 1995, cytunodd 69% o'r rhai a holwyd y dylai'r cwmni dwr ychwanegu fflworid at y dwr os gofynnid iddo wneud hynny - yn genedlaethol (y DU) ceir mwyafrif o 75% o blaid fflworideiddio. Ar hyn o bryd, nid oes unrhyw gyflenwad yng Nghymru ar y lefel fflworideiddio orau posibl.

4.33. Gall cwmnau dwr weithredu cynlluniau fflworideiddio pan ofynnir iddynt wneud hynny gan yr Awdurdodau Iechyd, yn sgil ymgynghori eang 'r cyhoedd, ond mae'r ddeddfwriaeth bresennol yn gadael y diwydiant dwr mewn sefyllfa lle gall ddewis cytuno cheisiadau o'r fath neu beidio. Mae'r Llywodraeth yn credu bod angen adolygu hyn ond yn cydnabod y safbwyntiau cryf a arddelir ar gwestiwn fflworideiddio dwr.

Fflworideiddio Dwr

Yn y 1980au, cafwyd treial yn y DU o fflworideiddio artiffisial, ac yng Nghymru Ynys Mn a ddewiswyd fel yr ardal i'w phrofi. Yn Ffigur 4.7, cymherir iechyd deintyddol plant pump oed yn Ynys Mn phlant yng Ngwynedd dros y cyfnod 1987/88 i 1993/94. Rhoddwyd y gorau i fflworideiddio ym 1989/90. Mae'r lefel gynyddol o bydredd dannedd yn Ynys Mn ar l rhoi'r gorau i ychwanegu fflworid yn dangos manteision fflworideiddio.



Yn wyneb y dystiolaeth gref fod fflworideiddio yn atal pydredd dannedd, a ddylai'r Llywodraeth ei gwneud yn ofynnol i'r Cwmnau Dwr fflworideiddio'r cyflenwadau, os bydd y mwyafrif o'r bobl o blaid hyn?

Atal Clefydau

4.34. Gall rhaglenni sgrinio, megis imwneiddio yn ystod plentyndod a sgrinio babanod newydd-anedig atal clefydau yn y boblogaeth, ac mae sgrinio cyn-geni, sgrinio canser y fron a sgrinio ceg y groth yn elfennau allweddol wrth ddod o hyd i glefydau yn gynnar er mwyn eu trin yn effeithiol.

4.35. Mae *Bron-Brawf Cymru* yn cynnal rhaglen genedlaethol o sgrinio'r fron, gan sgrinio dros 60,000 o fenywod bob blwyddyn. Bydd y Swyddfa Gymreig yn cyflwyno Fframwaith Gwasanaeth Cenedlaethol ar gyfer Sgrinio Ceg y Groth ym 1999. Bydd hwn yn sicrhau safonau uchel ym mhob elfen o'r gwasanaeth sgrinio.

4.36. Imwneiddio yw un o'r ymyriadau mwyaf cost-effeithiol sydd ar gael ar hyn o bryd. Gall sicrhau diogelwch gydol eich oes yn erbyn nifer o glefydau heintus a fu unwaith yn achos pwysig o salwch a hyd yn oed marwolaeth. Pan gaiff cyfran ddigon uchel o'r boblogaeth ei himwneiddio, caiff trosglwyddiad o berson i berson ei atal a gall clefydau gael eu dileu (e.e. y frech wen).

4.37. Er hynny, mae clefydau heintus newydd yn dal i ddod i'r amlwg a hen glefydau wedi ailymddangos. Er enghraifft, mae achosion o wenwyn bwyd (gan gynnwys E coli 0157), llid yr ymennydd, a hepatitis firol, ar gynnydd yng Nghymru, a gwelwyd organebau sy'n gwrthsefyll gwrthfiotigau yn dod i'r amlwg. Mae rhai o'r rhesymau am hyn yn cynnwys teithio rhyngwladol haws, gordyrru a gorddefnyddio gwrthfiotigau. Mae'r datblygiadau hyn yn tanlinellu pwysigrwydd parhau i wella'r gyfran a imwneiddir; yr angen i gynnal a datblygu ymhellach ar systemau arolygu; mireinio cynlluniau rhyng-asiantaethol ar gyfer ymdrin ag achosion; a chynnal a gwella medrau proffesiynol ar bob lefel.

A oes ffyrdd i wneud rhaglenni sgrinio ac atal yn fwy effeithiol?

Addysg ar gyfer Bywyd

4.38. Mae addysg a chyfleoedd hyfforddi yn bwysig er mwyn bodloni'n hanghenion economaidd a darparu'r sylfaen ar gyfer gweithgareddau diwylliannol a chymdeithasol. Mae'n bwysig hybu dysgu gydol eich oes a'r ymateb i gyfleoedd i ddysgu beth bynnag fo'ch oedran. Bydd hyn yn cyfrannu at gymell a herio pobl a chreu'r teimlad eu bod yn rheoli eu bywydau eu hunain. Yn benodol, mae gan fenywod anghenion arbennig os ydynt am gael manteisio ar gyfleoedd addysg a hyfforddiant e.e. menywod sy'n dychwelyd i fyd addysg a mamau y mae arnynt angen trefniadau gofal plant neu fynediad arbennig yn ystod oriau'r ysgol.

Ysgolion Iach

4.39. Y blynyddoedd ysgol yw'r adeg pan enillir medrau cymdeithasol y tu allan i'r teulu a phan fydd cysylltiadau sy'n hybu medrau cymdeithasol da, hunan-barch ac ymwybyddiaeth gymunedol yn bwysig. Mae darparu addysg rhyw effeithiol, gan gynnwys sut i ddeall a rheoli perthnasoedd emosiynol, a dysgu am ymddygiad cymdeithasol, hawliau a chyfrifoldebau yn eithriadol o bwysig os bwriedir torri'r cylch o amddifadedd a dieithrwch.

4.40. Mae triwantiaeth, bwlian, cymryd cyffuriau (gan gynnwys alcohol), ysmygu a beichiogrwydd yn yr arddegau i gyd yn dod yn fwy cyffredin. Mae angen i bolisau ac arferion yn yr ysgol helpu pobl ifanc i ddewis ymddygiad a fydd yn gwella'u hiechyd a'u lles yn y tymor byr a'r tymor hir.

4.41. Mae'r Swyddfa Gymreig wedi dechrau ar yr agenda hon yn y Papur Gwyn *Adeiladu Ysgolion Ardderchog Gyda'n Gilydd (Gorch 3701)*.[co] Mae hwn yn tanlinellu:

- bod yn rhiant - dylai pob ysgol uwchradd chwarae rhan mewn addysgu pobl ifanc am fedrau bod yn rhiant da;
- addysgu maethiad ac iechyd a hybu iechyd;
- addysg bersonol a chymdeithasol - gofynnwyd i Awdurdod Cymwysterau, Cwricwlwm ac Asesu Cymru (ACCAC) ailasesu diffiniadau, gwella perthnasedd a chynghori ar y Cwricwlwm Addysg Bersonol a Chymdeithasol;
- chwaraeon yn yr ysgol - anelir at ymestyn cyfleoedd mewn chwaraeon ym mhob ysgol, gwella cysylltiadau chyrff chwaraeon a chynyddu gweithgareddau y tu allan i'r ysgol;
- cydnabod bod llawer o broblemau iechyd mewn plant o oedran ysgol sy'n effeithio ar eu gallu i fanteisio ar addysg yn gysylltiedig phroblemau emosiynol ac ymddygiadol;
- pwyslais cryfach ar adnabod plant ag AAA yn gynharach, ymyriadau mwy priodol a gwell cynllunio rhanbarthol a chydweithredu rhwng asiantaethau wrth gyflwyno gwasanaethau plant, fel a danlinellwyd yn y Papur Gwyrdd cysylltiedig ar AAA Y Gorau ar gyfer Addysg Arbennig (Gorch 3792);
- gwella presenoldeb ac ymddygiad drwy hybu partneriaeth cartref-ysgol effeithiol, gan gynnwys cytundebau cartref-ysgol ynghylch disgwyliadau ynglyn phresenoldeb, disgyblaeth, gwaith cartref, safon yr addysg, ac ethos yr ysgol;
- atgoffa ysgolion ei bod yn bwysig ymdrin yn effeithiol bwlian a chynnwys holl gymuned yr ysgol (gan gynnwys y disgyblion) wrth ddefnyddio strategaethau i'r perwyl hwnnw. Parhau i roi cymorth i'r awdurdodau lleol ar gyfer projectau triwantiaeth a disgyblaeth o dan Grantiau Cynnal Addysg a Hyfforddiant y Swyddfa Gymreig (GCAH).

Sut y gellid defnyddio addysg a hyfforddiant yn well i hysbysu pobl am iechyd ac i annog pobl i ofalu am eu hiechyd eu hunain?

Menter Ysgolion Iach **Cyd-broject peilot yw'r Rhwydwaith Ewropeaidd o Ysgolion sy'n Hybu Iechyd (ENHPS) ac erbyn 1996 yr oedd yn cynnwys 40 o wledydd.**

Yng Nghymru, gweinyddir y project gan Awdurdod Hybu Iechyd Cymru (HPAW). Mae 12 o ysgolion wrthi ar hyn o bryd, sef 6 ysgol gynradd a 6 ysgol uwchradd. Mae'r ysgolion sy'n cymryd rhan yn y project yn mynd i'r afael ag ystod o faterion iechyd, gan gynnwys bwlian, dewisiadau bwyd, ysmygu a diogelu rhag yr haul. Dull HPAW yw gweithio mewn partneriaeth staff a disgyblion yr ysgolion, ynghyd 'r gwasanaethau iechyd ac addysg lleol. Mae'r project yn edrych ar ffyrdd i'r ysgolion gyfrannu at iechyd a disgyblion, athrawon a'r gymuned ehangach drwy ddatblygu amgylchedd sy'n hybu iechyd yn yr ysgol.

Gwasanaethau Iechyd Ysgolion

4.42. Darperir Gwasanaethau Iechyd Ysgolion gan wasanaethau iechyd o fewn cyd-destun polisi'r Swyddfa Gymreig o wella iechyd plant yn ogystal gwella presenoldeb yn yr ysgol a chwblhau addysg amser-llawn. Mae gwasanaethau iechyd ysgolion yn targedu'r plentyn a'r person ifanc yn eu grwp cyfoedion gan eu galluogi i ystyried dewisiadau iach a all wella'u hiechyd yn eu blynyddoedd fel oedolyn. Mae'r gwasanaethau y mae ar yr ysgolion eu hangen yn cynnwys:

- addysg iechyd a chyngor cyfrinachol i blant ysgol (yn arbennig glasoedion) e.e. addysg rhyw;
- cyngor i staff ysgol a theuluoedd i'w galluogi i ymdopi'n fwy effeithiol phlant phroblemau iechyd corfforol ac emosiynol/seiciatrig;
- sgrinio (meddygol a deintyddol), arolygu iechyd a gwasanaethau imwneiddio.

Sut gallai ymagwedd partneriaeth newydd fod o les i iechyd plant yn yr ysgol?

Damweiniau

4.43. Damweiniau yw'r prif achos marwolaeth ymhlith plant. Ym 1996, cafwyd pump ar hugain o farwolaethau yn sgil damweiniau plant o dan bymtheg oed yng Nghymru. Cafwyd tair ar ddeg o'r rhain yn sgil damweiniau cludiant, tair yn sgil tn, un yn sgil gwenwyno, un yn sgil cwymp a saith oherwydd achosion damweiniol eraill.

Damweiniau ar y Ffyrdd

4.44. Byddai sefydlu llwybrau diogel i'r ysgol a gwneud ffyrdd trefol, yn arbennig ffyrdd preswyl, yn fwy diogel i blant a defnyddwyr eraill sy'n hawdd eu niweidio yn lleihau damweiniau. Mae hyn yn gofyn am gyfuniad o addysg diogelwch ffyrdd, dylunwaith ffyrdd, mesurau tawelu traffig a lleihau cyflymder. Rhaid ystyried y cynlluniau hyn ar y cyd mesurau i leihau llygredd aer o draffig. Ni ddylai cynlluniau tawelu traffig greu problemau iechyd drwy gynyddu llygredd cefndir i lefelau a allai beri niwed. Mae'r Swyddfa Gymreig wedi sefydlu *Grwp Ymgynghorol Trafnidiaeth Cymru* i gynghori ar ddatblygu a gweithredu polisi trafnidiaeth integredig a chynaliadwy ar gyfer Cymru. Ar 27 Ebrill, cyhoeddodd Mr Hain, Gweinidog Trafnidiaeth Cymru, y ci hyd at 500,000 y flwyddyn ei ddyrannu ar gyfer *Menter Llwybrau Diogel i'r Ysgol yng Nghymru*. Bydd y fenter yn cefnogi'r Awdurdodau Lleol wrth iddynt gyflwyno cynlluniau yn anelu at greu amgylchedd diogel i annog mwy o blant i gerdded, seiclo, neu defnyddio cludiant cyhoeddus i fynd i'r ysgol.

4.45. Mae angen i ni godi ymwybyddiaeth o'r peryglon i'r unigolyn ac i ddefnyddwyr eraill y ffordd yn sgil yfed o dan ddylanwad alcohol neu gyffuriau. Mae'r Llywodraeth wedi comisiynu astudiaeth 3 blynedd a ddechreuodd ym mis Hydref 1996, ar bresenoldeb cyffuriau yn y rhai a leddir mewn damweiniau traffig ffyrdd. Mae'r ddogfen ymgynghori *Combating Drink Driving - Next Steps (1998)* yn anelu at ddatblygu pecyn o fesurau i leihau damweiniau yfed a gyrru ymhellach. Mae'r cynigion yn cynnwys:

- gwella gorfodaeth - cynnydd posibl ym mhwerau'r heddlu i gynnal profion anadl;

- gwella'r system o droseddau a chosbau - o bosibl gostwng y terfyn yfed a gyrru i 50mg o alcohol mewn 100ml o waed, ynghyd mwy o gyrsiau adsefydlu; ac

- addysg, cyhoeddusrwydd a gwybodaeth - gan gynnwys addysg cyn-gyrru a chyhoeddusrwydd wedi'i dargedu ar yfwyr-gyrwyr penderfynol.

4.46. Caiff damweiniau ymhlith beicwyr modur eu lleihau drwy hyfforddiant a phrofi, a gorfodaeth i wisgo helmed. Mae angen hybu hyfforddiant seiclo i blant a gwisgo helmedau seiclo. Mae pob seiclwr ar ei ennill yn sgil mesurau sy'n gwella breciau a goleuadau cerbydau modur, a gwarchodwyr ar ochrau cerbydau HGV. Mae llwybrau ar wahn i feiciau, gwell cyffyrdd a mesurau tawelu traffig yn gwneud seiclo'n fwy diogel.

4.47. Gall safonau cerbydau helpu i leihau'r perygl o ddamweiniau drwy fesurau diogelwch sylfaenol megis gwella breciau, goleuadau a gwella llywio, a mesurau diogelwch eilaidd yngln gwregysau seddi, bagiau awyr, strwythurau cerbydau a phadiau mewnol sy'n lleihau'r perygl o anafiadau i'r teithwyr (ac weithiau i gerddwyr a defnyddwyr ffyrdd eraill sy'n hawdd eu niweidio). Bydd y Llywodraeth yn parhau i annog gwelliannau drwy brojectau gydag arian ysgogi, drwy bennu safonau a thrwy gyflwyno gofynion diogelwch ychwanegol.

Osteoporosis

4.48. Osteoporosis yw un o brif achosion damweiniau ymhlith pobl oedrannus. Mae'r clefyd yn peri bod esgyrn mor sych nes eu bod yn torri'n hawdd iawn. Mae dros hanner o'r bobl 65 oed a throsodd sy'n marw mewn damweiniau yn gwneud hynny ar l cwympo. Mae osteoporosis yn arwain at dorri rhyw 60,000 o gluniau y flwyddyn yn y DU, gan arwain at fwy na 40 marwolaeth gynamserol y dydd: bydd 50% o'r bobl sy'n torri'r glun yn anabl yn barhaol ac yn methu byw yn annibynnol, a bydd 20% yn marw o fewn 6 mis. Mae gan 22% o fenywod dros 50 oed lefelau dwysedd isel yn eu hesgyrn. Bydd bron hanner o'r holl fenywod wedi torri asgwrn erbyn cyrraedd 70 oed. Amcangyfrifir bod osteoporosis wedi costio 742 miliwn i'r NHS ym 1994.[v]

4.49. Mae atal a thrin osteoporosis yn cynnwys perswadio pobl o bob oedran i newid eu ffordd o fyw, a thargedu'r rhai sydd mewn perygl uchel. Mae'r nodweddion ffordd o fyw y gwyddys eu bod yn dylanwadu ar berygl colled asgwrn a thor-asgwrn yn cynnwys: ysmygu, yfed llawer o alcohol, seguryd corfforol, a chymeriant isel o galsiwm a Fitamin D yn y deiet, yn arbennig ymhlith pobl oedrannus. Ceir tystiolaeth sylweddol bod therapi amnewid hormonau yn atal colled asgwrn a thor-asgwrn ymhlith menywod ar l y newid bywyd.

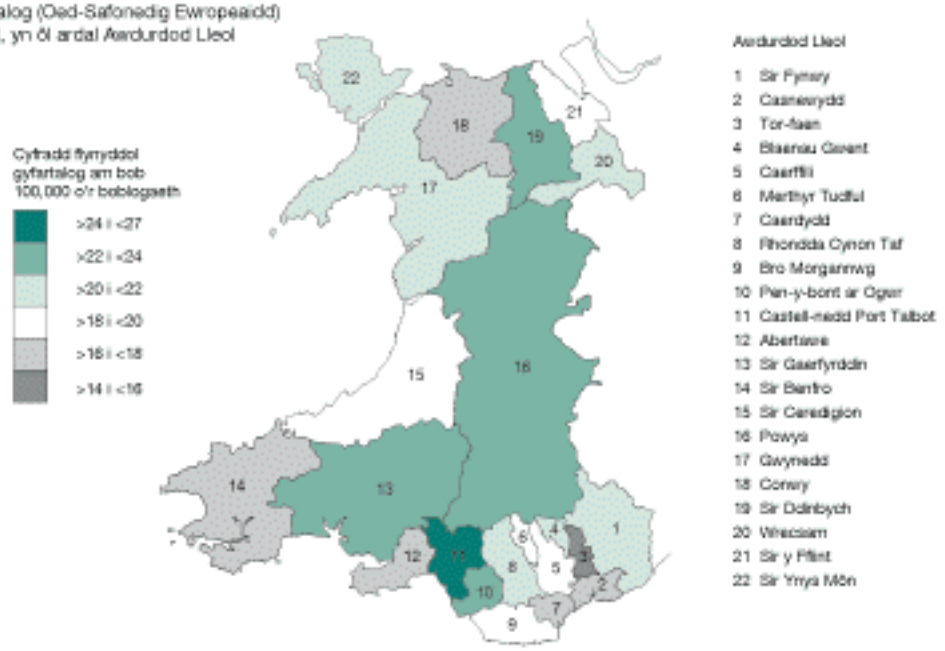
Y Gweithle

4.50. Mae'r gweithle yn achos pwysig o ddamweiniau. Yn ystod 1996-97 yng Nghymru, rhoddwyd gwybod i'r Awdurdod Gweithredol Iechyd a Diogelwch (HSE), am 34 o farwolaethau yn y gweithle, a thros 7,000 o ddamweiniau yn y gweithle.[ar] Cymharol fn oedd y mwyafrif o'r damweiniau (sigiadau, straeniau a chleisiau yn bennaf), er bod rhyw 1,800 wedi'u dosbarthu yn anafiadau mawr (tor-asgwrn yn bennaf). Mae'n debyg bod gwir nifer y damweiniau yn y gweithle gryn dipyn yn uwch na hyn, gan fod yr HSE yn amcangyfrif mai dim ond rhyw 40% o ddamweiniau sy'n cael eu hadrodd.

4.51. Mewn cymunedau gwledig mae damweiniau ar y fferm yn achos mawr o anafiadau a marwolaethau. Mewn arolwg diweddar yn y Canolbarth, ar y fferm y digwyddodd 61% o'r anafiadau damweiniol yn y gwaith, a 39% mewn diwydiannau eraill. Yr oedd yr anafiadau mwyaf cyffredin ar y fferm yn gysylltiedig 'r tractor (65% ar offer o ryw fath) tra oedd anifeiliaid yn gysylltiedig 34%. Buasai'n fuddiol defnyddio dillad diogelu mewn 28% ond mewn 6% yn unig y cawsant eu defnyddio. Credid y gellid bod wedi atal 80% o'r damweiniau a adroddwyd.[ak] Mae'r HSE yn gweithio gydag undebau amaethwyr a cholegau amaethyddol, gan ddefnyddio deunyddiau dwyieithog i hysbysu ac addysgu pobl am achosion damweiniau a sut i'w hatal.

Ffigur 4.8

Cyfraddau Marwoldeb Blynyddol Cyfartalog (Oed-Safonedig Ewropeaidd) am ddamweiniau mewn pobl o bob oed, yn ôl ardal Awdurdod Lleol dros y cyfnod 6-blynedd 1990 i 1995



Ffynhonnell: Monaghan 1998

Sut y gallwn gynyddu safonau diogelwch ac atal damweiniau?

Poverty, deprivation and ill-health

2.11. There is a close correlation between the patterns of deprivation and of illness and disease. There is a 5 year difference in life expectancy between professional men and men who do unskilled manual work. The corresponding figure for women is 3 years.[cl] This gap is widening. Unskilled manual workers are more likely than professionals to have long-term limiting illness, higher infant mortality in their families, and their children are more likely to suffer from chronic sickness and tooth decay.

2.12. The *Welsh Health Survey (1995)* found that people doing unskilled work have higher than average levels of heart disease, respiratory disease, mental illness, arthritis and back pain. They are also more likely to have accidents or injuries needing hospital treatment; have more uncorrected eyesight and hearing problems; visit the dentist and optician less frequently; exercise less and are more likely to be obese. The prevalence of back pain and limiting long-term illness for people doing unskilled work is almost double that for professional men and women of the same ages.

2.13. Wales has a much higher percentage of people of working age who report a **limiting long-term illness** (12.5%) than in Great Britain as a whole (8.5%) (1991 Census of the Population). A marked regional pattern can be seen within Wales in terms of economic inactivity and self-reported sickness. Unsurprisingly the highest levels of both are in the older industrial areas of the South Wales Valleys. In these areas, 17.7% of the population of working age report a limiting long-term illness, compared to 12.5% for Wales as a whole.

2.14. This long-established and well-documented pattern of ill-health, sickness and absenteeism can also be seen in other areas where heavy extractive industries used to thrive - such as the North of England. Thus the higher levels of ill-health in the Valleys seem to be consistent with the occupational history of heavy industry and mining, and poor socio-economic conditions.

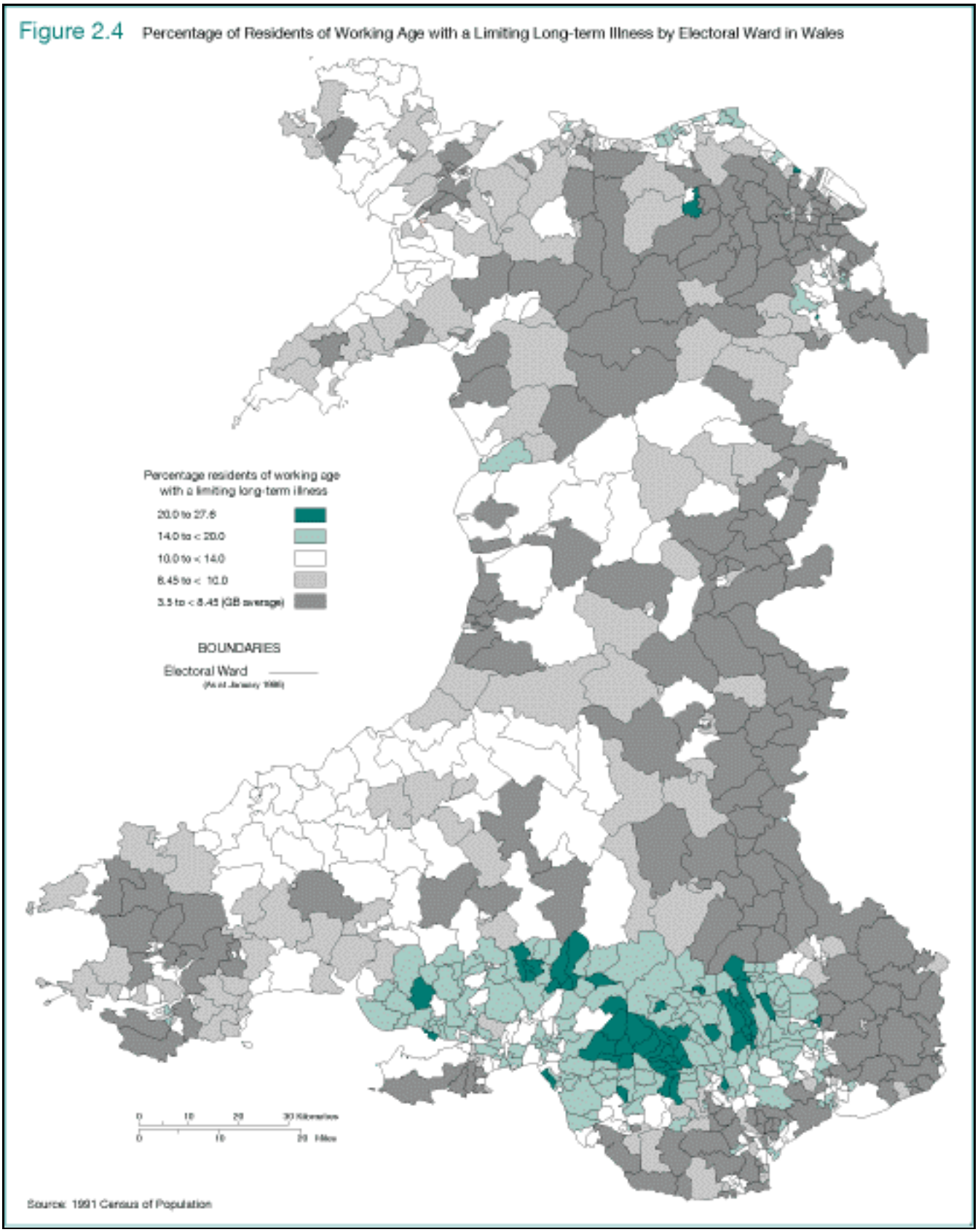
2.15. But this does not fully account for the level of economic inactivity found in the South Wales Valleys. The evidence shows that these levels exist in men who have not previously worked in those industries, and in other areas, including West Wales. Furthermore, the level of incapacity is probably no greater than that of men of the same age in other parts of the UK, but for any given level of incapacity in Wales, there is a greater tendency to be registered as permanently sick, rather than being in work. This is probably due, in part, to lack of suitable jobs and training for people of late working age with mild physical disability.

2.16. Unemployment and economic inactivity affect self-esteem and mental health and increase stress, in addition to the effects of relative poverty on housing, diet and access to leisure activities. The social effect of unemployment through ill-health is substantial and the resulting poverty can aggravate such factors as crime and substance misuse which add to the cycle of poor conditions and ill-health.

2.17. Those who report long-term illness tend to be over 45 years old and are more likely to be male than female. They tend to have few qualifications, live in households dependent on benefit with low incomes and many claim Incapacity Benefit. The most common health problems are back and neck pains, arthritis and rheumatism, heart and chest problems and depression.[cl]

2.18. There is no easy solution to such problems, but the fact is that a significant group of the population - unskilled, middle-aged, in poor health and predominantly male have become detached from the labour market. Long-term action is therefore needed to tackle the root causes of the problem. The Government has made a start in proposing wide ranging changes to modernise the welfare system; to introduce a national minimum wage which is intended to raise the living standards of the lowest paid; and the new Welfare to Work programmes which offer training and support to help people into work.

Figure 2.4 Percentage of Residents of Working Age with a Limiting Long-term Illness by Electoral Ward in Wales



Summary

2.19. The relatively poor health of people in Wales signals the need for a radical overhaul of the way we tackle health issues. The prevalence of significant ill-health has far reaching consequences for the economy, social structure and well-being of communities. A modern society must address the issues of equity and fairness demonstrated by health status being dependent on social class, or whether you are in work, or where you live.

Safe Food

4.12. The Government is committed to giving top priority to the protection of public health where food safety and standards are concerned. Central to this policy is the Government's intention to establish a Food Standards Agency. Subject to Parliamentary approval, the Agency will be established before the end of 1999. A key role of the Agency will be to promote the highest standards of food safety and to ensure that consumers have the information they need to be able to make informed choices about their diet.

4.13. The Food Standards Agency will operate through an executive in Wales. The National Assembly will oversee and fund its work. The Wales executive and Local Authorities will work together to improve consistency in food law enforcement activity and, where necessary to remedy any deficiencies. Sufficient powers will be provided to the Agency to ensure that it is able to exercise real influence over individual Authorities' activities. The Agency will also provide high profile information to the public and will extend the food safety communications activities already developed by the Welsh Office.

4.14. Separately, the Government is reviewing legislation concerning the control and surveillance of communicable disease, including food-borne disease, in order to ensure that it adequately meets public health needs.

4.15. The Code of Practice on food hygiene inspections has been recently amended to require increased frequency of inspection of high risk premises. This was recognised in the Local Authority revenue settlement for 1998-99.

4.16. In Wales, Local Authorities have received additional resources to monitor and advise food retailers. Activities include: improving hygiene systems in butchers shops; providing education materials to schools; safeguarding vulnerable groups; and advice to operators of non-registered food premises (such as church halls etc.). The Food Standards Agency will support this work.

4.17. The Government is taking the lead during its Presidency of the European Union to press for clear, simple and informative labelling of food products. The Government is aware of public concern about genetically-modified and other novel foods and is working with its European partners to ensure that such products are clearly labelled so that consumers have the choice of using such foods or not.

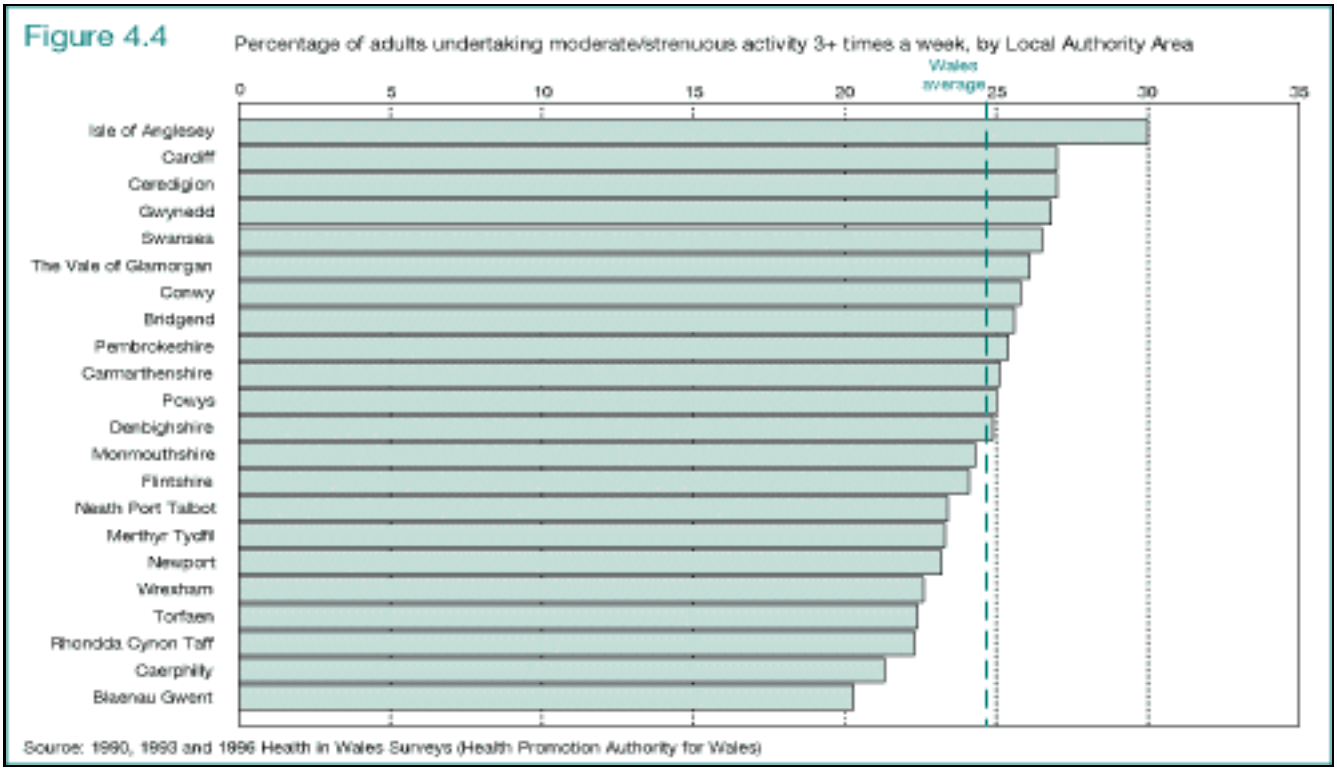
Exercise

4.18. Over 70% of the Welsh adult population do not take enough exercise to benefit their health.[aq] Low levels of physical activity are linked to heart disease, hypertension, non-insulin dependent diabetes, obesity, osteoporosis and depression. Evidence suggests that the greater the amount of exercise, the lower the risk of these disorders occurring.

Exercise on Prescription

Under the Prescription for Health and Leisure programme, GPs and health professionals are able to refer their patients to local exercise gyms to have a programme of exercise devised for each individual to benefit their health. There are currently at least 12 exercise referral programmes throughout Wales. These involve leisure services departments, GP practices and often health promotion services. Most schemes run for approximately 12 weeks, often with follow-up courses.

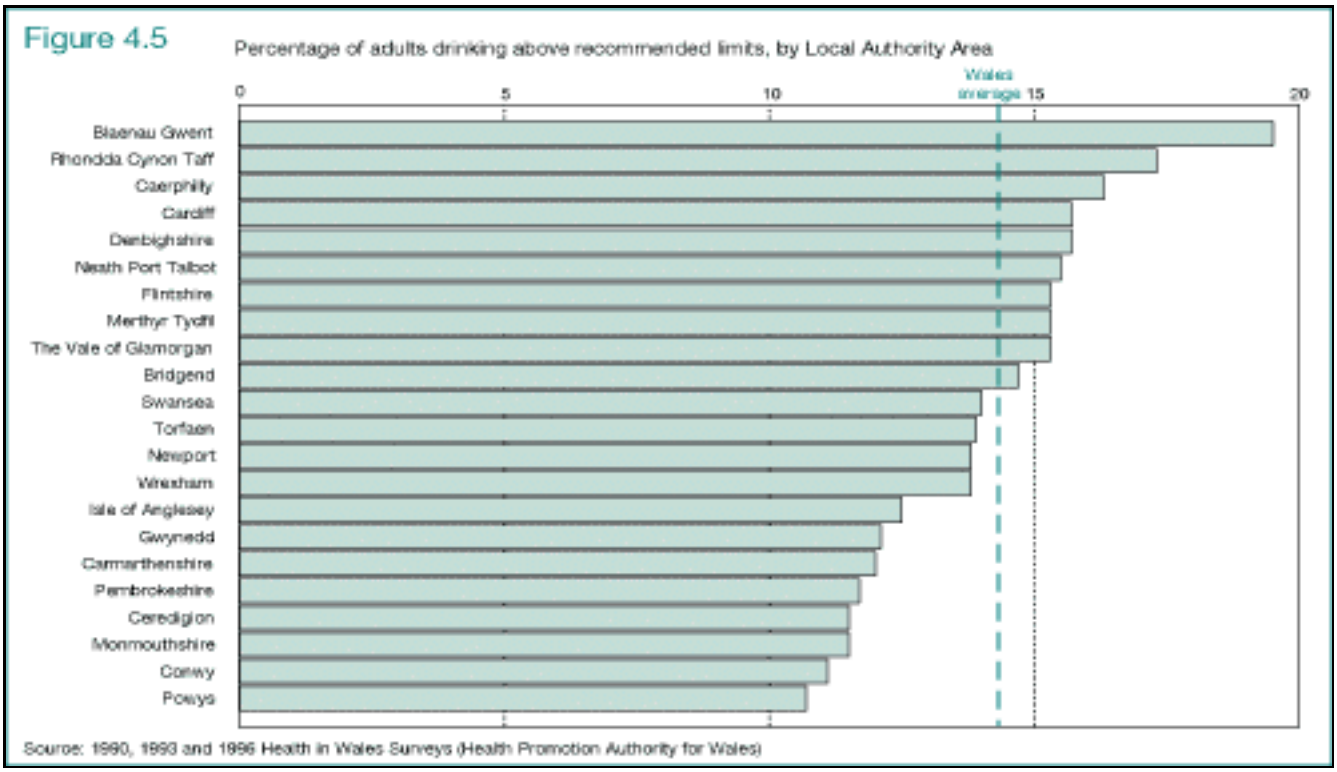
Information on exercise referral programmes in Wales and advice on setting up schemes can be obtained from the Health Promotion Authority for Wales. In addition, a Certificate in Exercise Referral for fitness instructors dealing with referral patients has been established by the Health Promotion Authority for Wales in collaboration with Fitness Wales and the University of Wales, Cardiff.



How can we encourage a healthy lifestyle with people making choices that sustain and improve their health and well-being?

Alcohol and Drugs

4.19. The adverse effects of excessive alcohol consumption and drug misuse are widely-recognised and well-documented. A link has been established between sustained heavy drinking and certain cancers, stroke, hypertension, liver disease and depression. Similarly, there is clearly a link between drug misuse and other mental health problems. Those who inject drugs run the risk of contracting and passing on infection such as HIV and several forms of hepatitis. Both are associated with a wide range of social and economic problems including family breakdown, accidents, crime and impaired work performance. Although the proportion of adults who exceed sensible drinking limits has decreased, the 1996 *Welsh Youth Health Survey*[ap] shows that the levels of drinking among under 16s (already among the highest in Europe) are continuing to rise. The introduction of alcopops appears to have had an impact on the drinking patterns of younger teenagers, particularly girls. A united front, with the government, media, police, health, industry and retailers is needed to reverse this trend.



4.20. Similarly there has been an increase in the proportion of 15 -16 year olds reporting that they use illicit drugs. In 1990, 20% of girls, and 25% of boys, had experimented with at least one illicit drug. By 1996, the figures had doubled to 40% of girls, and 50% of boys.[aq]

4.21. Health, education, social services, penal and voluntary agencies need to work together to achieve the goals of preventing the misuse of drugs and alcohol, particularly among younger people and providing treatment, support and rehabilitation for those misusing them. Effectively-run treatment services have been shown to impact positively on the health of drug misusers: needle exchange, prescribing and education programmes have helped to keep the rate of HIV infection amongst injecting drug misusers low in this country, and rehabilitation programmes improve the general health of their clients, as well as contributing to reductions in drug-related crime which contributes significantly to community safety.

4.22. The Welsh Drug and Alcohol Strategy, *Forward Together*, launched in May 1996, called for joint action to combat drug and alcohol misuse and a new emphasis on the prevention of misuse, especially among young people. A Welsh Advisory Committee on Drug and Alcohol Misuse has been established to advise the Secretary of State on drug and alcohol issues. A Welsh Drug and Alcohol Unit has been set up, under contract to the Department, to assist in the implementation of the strategy throughout Wales. 5 Drug and Alcohol Action Teams at Health Authority level have been established to develop and implement local strategies on a multi-disciplinary basis. Local Advisory Teams with multi-agency representation are active at a Local Authority level.

4.23. A co-ordinated approach is required to ensure parents and young people understand the risks of drug and alcohol misuse and have the skills and knowledge to resist. *The Strategic Prevention Action Plan* produced by the Welsh Drug and Alcohol Unit and launched last November, encouraged this approach. This can be done through the National Curriculum and health education in schools, youth agencies, the penal system and the workplace. It is important for adults to be aware of sensible drinking limits. Awareness of the risks of intoxication and dependence on drugs and alcohol may reduce the possibility of accidents, mental disorder and violence. The risks to family, employment and social circumstances of severe dependence on abusive substances need to be emphasised.

4.24. The Government's work against drug misuse has been given a new impetus by the appointment last October of the first UK Anti-Drugs Co-ordinator, Keith Hellawell, who was tasked with developing a comprehensive anti-drugs strategy. The Secretary of State for Wales is one of the signatories to this new ten-year strategy for tackling drugs misuse, *Tackling Drugs to Build a Better Britain*, which was launched on 27 April. Although this strategy focuses mainly on England, it is also relevant to Wales, and we will reflect on the implications for anti-drug activity in Wales and report back to the UK Anti-Drugs Co-ordinator on relevant developments by February 1999.

Sexual Health

4.25. Young people are becoming sexually active at an earlier age, with the rates of conception among under 16 year olds showing no marked decline and even rising in some parts of Wales. Children need clear, unambiguous sex education from parents, in school or in other settings which may be more acceptable to them, such as youth clubs. Many parents feel that this is their responsibility whilst others feel unable to discuss such matters constructively with their children. Research has shown that most parents would welcome the subject being taught in school but some children find this embarrassing and uninformative.[w] Much information is acquired from their peers or the media. Such information may be inaccurate and lead to misunderstanding.

4.26. Wherever the information is provided it needs to be given in an un-embarrassing and informative manner, taking account of cultural and religious sensitivities. Experience in the Netherlands,[bt] where sex education is far more explicit than in the UK, has shown that this can be an effective way of dealing with the need for information that is accurate and acceptable to the groups we are trying to reach. This would mean introducing new provisions to remove the veto of the school governors, to allow teaching to be more explicit (e.g. show children how to use condoms properly) and to be more open about the risks of irresponsible sexual behaviour.

4.27. Unprotected sex can lead to ill-health or death from sexually transmitted diseases. There is still no vaccine against HIV nor a cure for AIDS. People at risk of acquiring **sexually transmitted diseases** require accurate and targeted information in a way that is acceptable to them, and at the appropriate time. Contact tracing is an important mechanism for limiting the spread of disease but is effective only when those involved feel confident that the information they give will be treated confidentially.

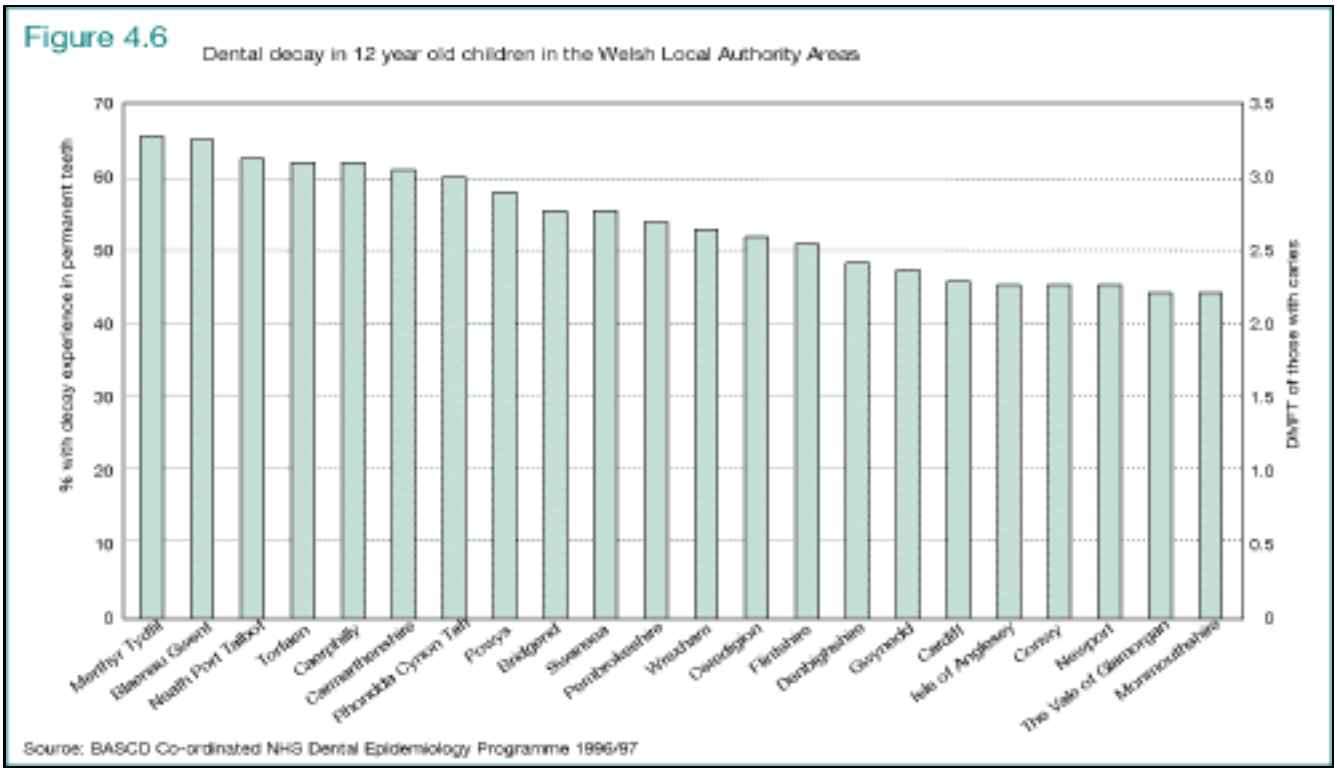
4.28. The needs of HIV positive people are changing as new drug therapies are increasing life expectancy significantly. Individuals may need psychological support in following the drug regimen, and many will be well enough to want to get back into employment.

Are we prepared to take down the barriers to effective communication on these subjects in order to address the unacceptably high rate of teenage pregnancy and to control the spread of sexually acquired infection?

Oral Health

4.29. Oral cancer kills nearly as many people as cervical cancer and is linked to smoking and excessive alcohol use. Accidents to teeth, especially amongst young people and those engaged in sports, are an increasing problem. Tooth decay varies widely across Wales. 5 year olds in Penderry (Swansea) have nearly six and a half times as many decayed, missing or filled teeth as those in Rhiwbina (Cardiff).[bm]

4.30. Recent research linking various deprivation indicators via postcodes to dental survey data shows that dental decay is increasingly becoming a disease of relative poverty.

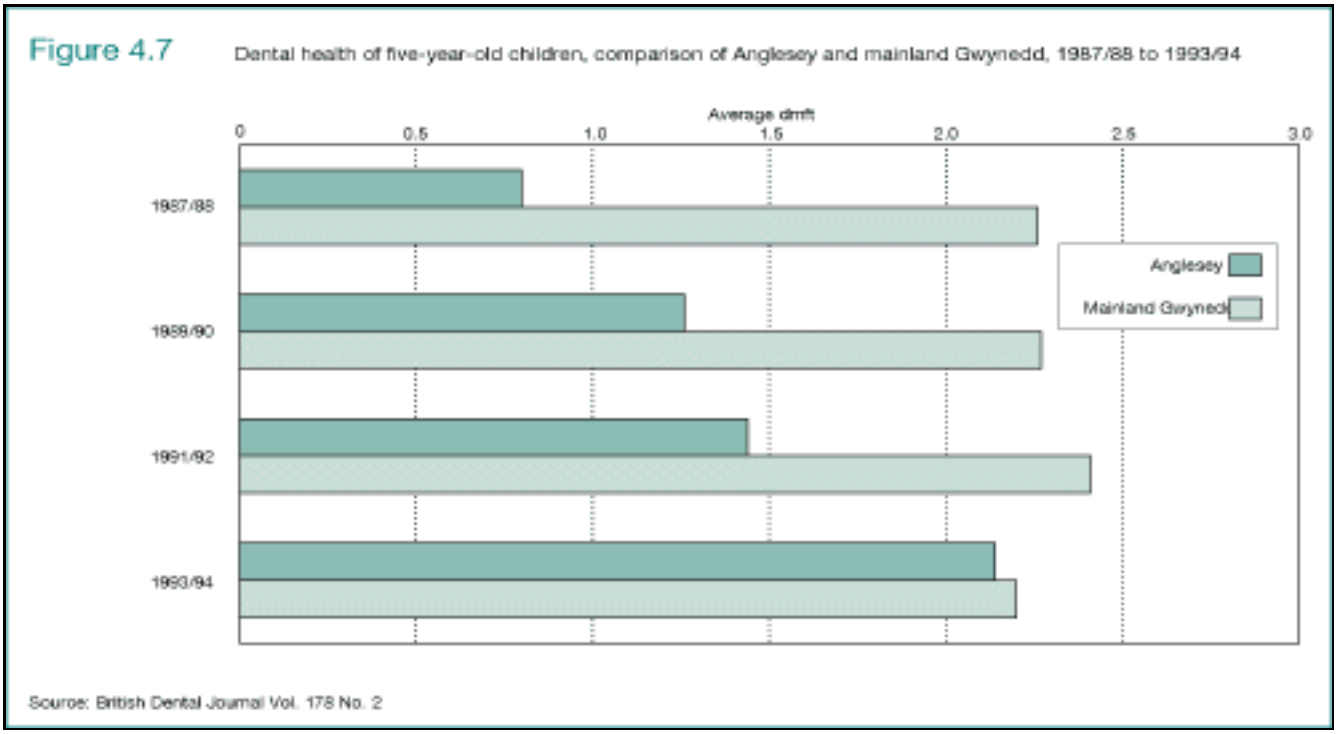


4.31. Dental decay can be reduced substantially by the adjustment to an optimum, of levels of fluoride in water supplies. Fluoride is found in all domestic water supplies but only occurs naturally at a level which can protect teeth in some areas. There are no proven adverse health effects when fluoride levels are topped up to around 1 part per million. Slight colour variations which are rarely noticeable can occur, but this is not a sign of any ill effect and is outweighed by the overall benefit on oral health.

4.32. Tooth decay in Anglesey five year olds increased significantly (by 168%) following the unilateral decision by Welsh Water to gradually withdraw additional fluoridation in 1987 with final cessation in 1991. In a public opinion survey, conducted on the island in 1995, 69% of those questioned agreed that the water company should add fluoride to water if asked to do so - nationally (UK) the majority supporting fluoridation is around 75%. Currently no supplies in Wales are at optimum fluoridation levels.

4.33. Water companies may implement fluoridation schemes when asked to do so by Health Authorities, following wide public consultation, but the current legislation leaves the water industry in a position of deciding whether or not to agree to such requests. The Government believes this needs to be reviewed but acknowledges the strongly-held views on the water fluoridation issue.

Water Fluoridation **In the 1980s a UK trial of artificial fluoridation took place, and in Wales Anglesey was chosen as the test area. Figure 4.7 compares the dental health of five year olds in Anglesey to mainland Gwynedd over a period from 1987/88 to 1993/94. Fluoridation was withdrawn in 1989/90. The increasing level of dental decay in Anglesey after fluoride was withdrawn, demonstrates the benefits of fluoridation.**



In view of the strong evidence that fluoride prevents tooth decay, should the Government require Water Companies to fluoridate supplies, if this is supported by the majority of people?

Preventing Disease

4.34. Screening programmes, such as neonatal screening can prevent disease in the population, and ante-natal, breast and cervical cancer screening are key elements in detecting early disease which enables effective treatment.

4.35. *Breast Test Wales* operates a national breast screening programme which screens over 60,000 women each year. The Welsh Office will introduce a National Service Framework for Cervical Screening in 1999. This will ensure high standards in all elements of the screening service.

4.36. Immunisation represents one of the most cost-effective interventions currently available. Immunisation can achieve life-long protection against a number of infectious diseases which were once an important cause of illness and even death. When sufficiently high coverage of the population is achieved, transmission from person to person is prevented and diseases can be eliminated (e.g. smallpox).

4.37. Nevertheless, new infectious diseases are still emerging and old ones have re-emerged. For example, cases of food poisoning (including E coli 0157), meningitis, and viral hepatitis are increasing in Wales, together with the emergence of antibiotic resistant organisms. Some of the reasons for this include easier international travel, overcrowding and over-use of antibiotics. These developments emphasise the importance of continued improvement in immunisation coverage; the need for maintenance and further development of surveillance systems; the refinement of inter-agency planning for dealing with outbreaks; and the maintenance, and enhancement of, professional skills at all levels.

Are there ways in which screening and prevention programmes can be made more effective?

Education for Life

4.38. Education and training opportunities are important to satisfy our economic needs and provide the foundation for cultural and social activities. It is important to foster lifelong learning and encourage the take-up of learning opportunities at any age. These contribute towards people feeling motivated, empowered and in charge of their own lives. Women, in particular, have special needs if they are to be able to take advantage of education and training opportunities e.g. women returners and mothers needing childcare or special access arrangements during school hours.

Healthy Schools

4.39. School years are the time when social skills outside the family are acquired and where contacts which promote good social skills, self esteem and a sense of community are important. Provision of effective sex education, including how to understand and manage emotional relationships, and learning about social behaviour, rights and responsibilities is extremely important if the cycle of deprivation and exclusion is to be broken.

4.40. Reports of truancy and bullying, as well as drug-taking (including alcohol), smoking and teenage pregnancy are becoming more frequent. Policies and practice in the school environment need to help young people choose behaviour which will improve their health and well-being in both the short and long term.

4.41. The Welsh Office has made a start on this agenda with the *BEST (Building Excellent Schools Together) White Paper (Cm 3701)*.[co] This highlights:

- parenting - all secondary schools should have a role in teaching young people the skills of good parenting;
- teaching nutrition and health and health promotion;
- personal and social education - the *Qualifications, Curriculum Assessment Authority (ACCAC)* have been asked to reassess definitions, enhance relevance and advise on the Personal and Social Education Curriculum;
- school sport - aims to extend sporting opportunities in all schools, improve links with sporting organisations and increase out-of-school activities;
- recognising that many health problems in school age children which affect ability to benefit from education relate to emotional and behavioural problems;
- a stronger emphasis on early identification of children with Special Educational Needs, more appropriate intervention and better regional planning and multi-agency collaboration in the delivery of children's services, as highlighted in the associated SEN Green Paper *The BEST for Special Education (Cm 3792)*;
- improving attendance and behaviour by promoting effective home-school partnership including home-school agreements covering expectations about attendance, discipline, homework, the standard of education, and the ethos of school;
- reminding schools of the importance of dealing effectively with bullying and involving the whole school community (including pupils) in the application of strategies to this end. Continuing to provide support to Local Authorities for truancy and discipline projects under the Welsh Office Grants for Education Support and Training (GEST).

How could education and training be used better to inform people about health and encourage people to look after their own health?

Healthy **The European Network of Health Promoting Schools (ENHPS), is a joint pilot project which by 1996 had**

Schools Initiative **involved 40 countries.**

In Wales the project is administered by the Health Promotion Authority for Wales (HPAW). Twelve schools are currently involved, 6 primary and 6 secondary. The schools working on the project are tackling a range of health issues, including bullying, food choices, smoking and protection from the sun.

HPAW's approach is to work in partnership with staff and pupils of the schools, together with local health and education services. The project looks at ways in which schools can contribute to the health of pupils, teachers and the wider community through the development of a health promoting school environment.

School Health Services

4.42. School Health Services are provided by health services within the context of Welsh Office policy to improve the health of children as well as to improve school attendance and completion of full-time education. School health services target the child and young person in their peer group and enable them to consider healthy choices which may improve health in their adult years. Services required by schools include:

- health education and confidential advice to school children (particularly adolescents) e.g. sex education;
- advice to school staff and families to enable them to cope more effectively with children with physical and emotional/psychiatric health problems;
- screening (medical and dental), health surveillance and immunisation services.

How could a new partnership approach benefit the health of children in schools?

Accidents

4.43. Accidents are the major cause of death in children. In 1996, there were twenty-five deaths from accidents of children under the age of fifteen in Wales. Thirteen of these were due to motor vehicle transport accidents, three to fires, one to poisoning, one to a fall and seven to other accidental causes.

Road Accidents

4.44. Establishing safe routes to schools and making urban roads, especially residential ones, safer for children and other vulnerable road users would reduce accidents. This requires a combination of road safety education, road design, traffic calming measures and reduced speed. These schemes must be considered in conjunction with measures to reduce air pollution from traffic. Calming schemes should not create health problems by increasing background pollution to potentially damaging levels. The Welsh Office has established the *Welsh Transport Advisory Group* to advise on the development and implementation of an integrated and sustainable transport policy for Wales. On 27 April, Mr Hain, the Welsh Transport Minister, announced that up to 500,000 per annum would be allocated to a *Welsh Safe Routes to School Initiative*. The initiative will support Local Authorities in bringing forward schemes aimed at creating safe environments to encourage more children to walk, cycle or use public transport to travel to school.

4.45. We need to raise awareness of the risks to the individual and other road users of driving under the influence of alcohol or drugs. The Government has commissioned a 3 year study started in October 1996, into the presence of drugs in road traffic fatalities. The consultation document *Combating Drink Driving - Next Steps (1998)* aims to develop a package of measures to reduce drink-drive casualties further. Proposals include:

- improving enforcement - possible increase in police breath-testing powers;
- improving the system of offences and penalties - possibly lowering the drink-drive limit to 50mg of alcohol in 100ml of blood, together with more rehabilitation courses; and

- education, publicity and information - including pre-driver education and publicity targeting hardened drink-drivers.

4.46. Accidents involving motorcyclists are reduced by training and testing, and compulsory helmet wearing. We need to encourage child cycle training and the wearing of cycle helmets. All cyclists benefit from measures which improve motor vehicle braking and lighting, and from HGV side-guards. Segregated cycle routes, improved junctions and traffic calming also make cycling safer.

4.47. Vehicle standards can help reduce the risk of accidents through primary safety measures such as improvements to brakes, lights and steering and secondary safety measures relating to seat belts, airbags, vehicle structures and internal padding which reduce the risks of injuries to occupants (and in some cases pedestrians and other vulnerable road users). The Government will continue to encourage improvements by pump-priming projects, standard setting and the introduction of additional safety requirements.

Osteoporosis

4.48. One of the main causes of accidents in older people is osteoporosis. This disease makes bones so porous that they break very easily. Over half the people aged 65 and over who die from accidents do so from falls. Osteoporosis results in approximately 60,000 hip fractures a year in the UK, resulting in more than 40 premature deaths a day: 50% of people with hip fractures are left permanently disabled and unable to live independently and 20% die within six months. 22% of women over 50 years of age have low bone density levels. Almost half of all women will have experienced a fracture by the time they are 70 years of age. It is estimated that osteoporosis cost the NHS 742 million in 1994.[v]

4.49. Prevention and treatment of osteoporosis include persuading people of all ages to change their lifestyle, and targeting those at high risk. Lifestyle characteristics known to influence bone loss and fracture risk include: smoking, heavy alcohol consumption, physical inactivity, and low dietary intake of calcium and Vitamin D, particularly in older people. There is significant evidence that hormone replacement therapy prevents bone loss and fracture in post-menopausal women.

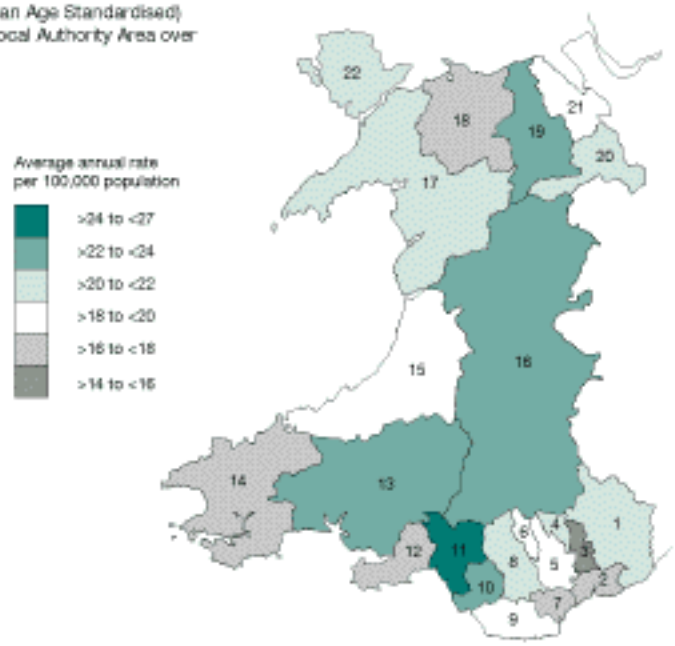
Workplace

4.50. The workplace is an important cause of accidents. During 1996-97 in Wales, 34 workplace deaths were reported to the Health and Safety Executive (HSE), and over 7,000 workplace accidents.[ar] The majority of the accidents were relatively minor (mainly sprains, strains and contusions), though about 1,800 were classified as major injuries (mainly fractures). It is likely that the real number of workplace accidents is considerable higher than this, as HSE estimates that in England and Wales, only about 40% of accidents are reported.

4.51. In rural communities farm accidents are a major cause of injuries and deaths. In a recent survey in mid-Wales 61% of accidental injuries at work were on farms whilst 39% occurred in other industries. The most common farm injuries involved the tractor (65% on implements of some kind) whilst animals were involved in 34%. Protective clothing could have been used beneficially in 28% but was only used in 6%. 80% of the accidents recorded were thought to be preventable.[ak] HSE works with farming unions and agricultural colleges, using bilingual materials to inform and educate people about the causes of accidents and how they can be prevented.

Figure 4.8

Average Annual Mortality Rates (European Age Standardised) for accidents in people of all ages, by Local Authority Area over the six year period 1990 to 1995



Local Authority

1 Monmouthshire
2 Newport
3 Torfaen
4 Blaenau Gwent
5 Caerphilly
6 Merthyr Tydfil
7 Cardiff
8 Rhondda Cynon Taff
9 The Vale of Glamorgan
10 Bridgend
11 Neath Port Talbot
12 Swansea
13 Carmarthenshire
14 Pembrokeshire
15 Ceredigion
16 Powys
17 Gwynedd
18 Conwy
19 Denbighshire
20 Wrexham
21 Flintshire
22 Isle of Anglesey

Source: Monaghan 1998

How can we increase safety standards and prevent accidents?