



**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

**Y Pwyllgor Iechyd a Gofal Cymdeithasol
The Health and Social Care Committee**

**Dydd Mercher, 22 Hydref 2014
Wednesday, 22 October 2014**

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Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac o Eitem 1 y Cyfarfod ar 6 Tachwedd 2014
Motion under Standing Orders 17.42(vi) and (ix) to Resolve to Exclude the Public from the Remainder of the Meeting and for Item 1 of the Meeting on 6 November 2014

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

**Aelodau'r pwyllgor yn bresennol
Committee members in attendance**

Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
John Griffiths	Llafur Labour

Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales

**Eraill yn bresennol
Others in attendance**

Dr Grant Duncan	Pennaeth yr Is-Adran Polisi Gofal Iechyd, Llywodraeth Cymru Head of Healthcare Policy Division, Welsh Government
Dr Ruth Hussey	Prif Swyddog Meddygol Cymru Chief Medical Officer for Wales
Dr Chris Jones	Pennaeth yr Is-adran Ansawdd Gofal Iechyd, Llywodraeth Cymru Head of Healthcare Quality Division, Welsh Government

**Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance**

Sian Giddins	Dirprwy Glerc Deputy Clerk
Martin Jennings	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk
Rhys Morgan	Dirprwy Glerc Deputy Clerk

*Dechreuodd y cyfarfod am 09:34.
The meeting began at 09:34.*

**Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions**

[1] **David Rees:** Good morning. I welcome Members to this morning's session of the Health and Social Care Committee. The meeting, remember, is bilingual. You have the facilities for translation from Welsh to English on channel 1 or amplification on channel 0 of your headsets. You do not have to worry about the microphones. They automatically come on. If there is a fire alarm this morning, we are not expecting one, so please follow the directions of the ushers. We have received apologies from Kirsty Williams and Alun Davies this morning, with no substitutes identified. Finally, I remind all Members to please turn off any electronic equipment that may interfere with the broadcasting equipment. If you have mobile phones, please make sure that they are on 'silent'. Thank you very much.

09:35

Sesiwn Graffu Gyffredinol gyda'r Prif Swyddog Meddygol
General Scrutiny Session with the Chief Medical Officer

[2] **David Rees:** I welcome Dr Ruth Hussey to this morning's session, along with Dr Grant Duncan, head of the healthcare policy division, and Dr Chris Jones, who is the head of the healthcare quality division and also the deputy chief medical officer. I welcome you all and thank you for your report, which you submitted in the early part of this month. Thank you very much for that.

[3] This is a session, Members will remember, of the normal scrutiny of chief officers, commissioners and inspectorates. We are able, obviously, to focus on the report, because that has been submitted as well. So, there may be areas of the report that we wish to investigate further, as well as our other areas. If that is okay, we will go straight into questions. Gwyn, you have the first question.

[4] **Gwyn R. Price:** Good morning. What has the CMO identified as her key priority or priorities for the year ahead? What short, medium and long-term action will be taken to tackle these priorities?

[5] **Dr Hussey:** Thank you very much for the question. The report is my second report, and it builds on an analysis of the issues facing us in Wales in terms of the health of the population. There are three broad areas that we need to continue to focus on relentlessly, I think: one is prevention; secondly, tackling the inequality that underlies much of the health pattern that we have in Wales; and thirdly, quality and safety. The report tries to draw out specific areas to look at. Each year, I pick a few themes to draw upon. What you will see in the report is the importance this year that I have attached to really talking about primary and community services. My concern there was that we tend to be drawn into talking about hospitals, and yet there is a whole panoply of services in the community that we sometimes do not have as much knowledge about and clarity about what they offer. So, the report was really trying to get us in to knowing more about those services and planning for the future.

[6] In terms of specific things that, in the next 12 to 18 months, are areas that I want to work on, clearly, legislation is a key part of the role of my team, to support the Minister. There are two strands of legislation, which I was here a few weeks ago talking about: the public health White Paper, but also the Well-being of Future Generations (Wales) Bill. Those are two key elements of paving the way for health improvement and prevention.

[7] There are other areas that I am working on. Obviously, we are maintaining progress on some key health protection issues, not least immunisation—and we might come back to that, I do not know. Then there are specific lifestyle issues, working with Public Health Wales and the health boards, to strengthen our approach to prevention in a holistic way, using the three-year planning guidance as a means to drive a stronger focus through the work of the NHS.

[8] On inequalities, there are two areas. One is the fundamental service of primary care, and making sure that it matches services to needs. The second area within that is the inverse care work that we have started with two health boards. We are really trying to push that on to see whether we can make inroads in terms of the health of the local population. There are a couple of areas within the inequality agenda that I want to focus on this year. One is the Healthy Child Programme, and the other is smoking in pregnancy. Those two areas, I think, really do need a further push, and I am happy to come back, if you want to, to those.

[9] Thirdly, on quality and safety, the overarching programme of work that you will be familiar with is the concept of prudent healthcare, the first principle of which being 'do no

harm'. So, this is very much building on the quality and safety monitoring that we do, the quality system that we have in Wales, to really try to drive improvements, learning from a number of reports that we have had and making sure that they are coming into practice. Really, I think that the package of those things will then help to come together to focus on the key points that come from the report, namely the burden of preventable poor health that we have in Wales and what we can do, through all of the different elements of public service systems, to try to reduce that burden of preventable poor health.

[10] **David Rees:** Okay, Gwyn?

[11] **Gwyn R. Price:** Yes.

[12] **David Rees:** John, on this question?

[13] **John Griffiths:** Yes. In terms of what you said about understanding the wider determinants of health and ill-health, there are obviously various organisations involved in work that could address, and does address, these issues of how we get more strongly onto the preventative agenda. I am quite interested in physical activity and sport. There is a lot of concern at the moment around local authority budgets, and a lot of change in terms of outsourcing to trust models, and so on. There are various organisation and various players who will have a strong view that the connections between physical activity, sport, health and wellbeing need to be made more strongly, and somebody needs to have an overview, really, and take a lead. In terms of the work that you mentioned on trying to understand this better, I wonder whether there is anything that you could say as to how we can marry up the effort more effectively and have a more strategic and effective approach, to understand how we get people more physically active, and how that can really benefit the preventative health agenda.

[14] **Dr Hussey:** Yes. Physical activity is an absolutely key area for us to focus on. You will know from the report that about a third of the population pretty much does no physical activity or is inactive. We have to work at multiple levels to try to shift that pattern. I am working with my colleagues across the UK, looking at the guidelines—not to rewrite them, but to see whether we can communicate them in a way that helps people to understand that just starting is important, and getting them on to a ladder of engagement with physical activity. Building it into daily life is key, so legislation plays a role, such as the Active Travel (Wales) Act 2013, in creating the conditions that prompt us to be active. The small things matter. Everything that we do needs to be prompting us to take an extra 10 minutes, 15 minutes and 20 minutes of activity. The context-setting is important. Green space is important. People who exercise in green space get extra benefit. So, again, it is about the planning system taking that into account. Every single Government department has a role to play in creating the conditions that expect us to want to be physically active. It is not a single solution. We have a cross-Government group looking at physical activity. We are working on a plan as to what else we can do to create those conditions. That is one element.

[15] The other area that we are working on is whether we can use a mass change approach—'large-scale change', to use the jargon. We are working with one health board to try to develop an approach that uses multiple ways of prompting people to be physically active. It has to be reinforced over and over again in many different ways. Underpinning that is work with the local population to know what it is that is going to help that particular population to be more active. What is stopping people? We need to understand that very carefully. You can generalise, but you really have to understand what makes a third of the population inactive, what the prompt is to make them active, and how you make a shift with that particular group.

[16] So, there are multiple ways. As I say, we are working with one health board to try to test out a different way of approaching this so that every organisation plays its part. It is

important through simple things like role modelling in the health service. Are we prompting people to recognise the importance of physical activity? We have a new learning resource for general practice, Motivate 2 Move, which is something that GPs and practice teams can use to motivate, and seeing that as part of the consultation advice. So, there are lots of different ideas to try to get us all as a society recognising that physical activity matters.

[17] The evidence that we have from the Caerphilly study shows that the four healthy lifestyle things matter, but physical activity is a key one. So, we are hoping to bring forward some work from the physical activity executive group. The plan tries to bring all these ideas together to drive this forward. We are hoping to work with Sport Wales and Public Health Wales to put some leadership into this to really push on this in the next 12 months.

[18] **David Rees:** Elin, is your question on this particular topic?

[19] **Elin Jones:** Yes. I just wanted to ask whether you were content that your ways of influencing various Government departments on the importance of physical activity and green spaces have been successful enough. I draw your attention to the Planning (Wales) Bill going through at the moment, which in terms of building on green space in communities is going to make it more difficult for communities to keep green spaces and village greens, rather than make it easier for them to keep them. I would like you to respond on how you think Government departments are really engaging in this issue of helping communities to keep green spaces within urban and village communities.

09:45

[20] **Dr Hussey:** Thank you. On the methods that I have to influence, one is my report that is received across all Government departments—Ministers do receive the report. I have communicated the report to senior civil servants in the organisation and the Minister does have conversations with other Ministers about specific issues. I think that there are multiple ways in which we can try to influence legislation. We are working with the team on the Well-Being of Future Generations (Wales) Bill to look at how we can bring together the considerations. There are always choices to be made, are there not? One of the positive things about having health as one of the goals within the Well-Being of Future Generations (Wales) Bill is the explicit opportunity to weigh up the challenges and choices. None of these choices are easy choices. If you look at transport planning and how much you weight the importance of commuters being able to get to a place of work versus the local community having access to safe roads, there are tough choices to be made there. I think that the Well-being of Future Generations (Wales) Bill gives us a chance to be very explicit about the evidence and what we know and what we do not know. I am clear that we must make sure that the health impacts are explicit in that decision making and in the choices that are made. At the end of the day, they are still choices that people have to weigh up as to what matters, in the balance, to local communities. However, I will clearly continue to talk about the importance of green space and continue to talk about things like air pollution, which I refer to in the report as part of the picture of creating holistic solutions.

[21] If we look at physical activity, which we were talking about before, and if you link that with air pollution from industrial processes and also from traffic, you can ask whether there are ways in which you can bring a number of policy areas together and say, 'Actually, these add up; these impacts now add up to growing interest in different approaches to transport and so on'. My job is to keep pushing that conversation.

[22] **Elin Jones:** So, just in terms of process then, on all Government legislation, would you be formally consulted and would you provide a formal view to a Government Minister on the health impact of a particular piece of legislation—on all pieces of legislation then?

[23] **Dr Hussey:** I would not say that I was personally involved in every single piece. My team are often asked for advice on specific aspects. Sometimes, it is about raising awareness of new evidence, which I bring to people to say, 'Are you aware this is now changed?' I have had sessions with my senior civil service colleagues on health inequalities, which is very much a cross-Government issue. So, I bring evidence to them proactively. Again, I see in the Well-Being of Future Generations (Wales) Bill the opportunity for collaboration. I think the proposition is that the role of the chief medical officer will have a more formal contribution to that process, and I think that the idea of locking in health impact assessments and a consideration of health in all policies are really important ways of bringing that health dimension to all the other decision making. Equally, it is about bringing other considerations to the health dimension too; it is a two-way conversation.

[24] **David Rees:** Okay, thank you. Before we move on, you mentioned the inverse care law. Obviously, Dr Julian Hart put that together in 1971 and we are now talking about pilot schemes in one area. What type of timescale are we talking about in relation to evaluating that pilot scheme and whether we can actually roll it out across the areas that are clearly affected by that?

[25] **Dr Hussey:** Thank you for that. You are absolutely right. Julian Tudor Hart described this decades ago. We are not alone. This is a feature of systems, if you like, that we need to pay attention to. What we are doing is trying to put in place a better understanding of what it is that would help to shift local communities' approach and access to primary healthcare. What I am looking for is for the health boards to be able to quantify, as they develop it, what is having an impact, so that they change it as they go along, rather than saying, 'Here's a project; we will do three years and have a look at it in three years and see if it worked'. So, at this point in time, it is about getting all of the data together, working out what the scale of the problem is, putting additional resource in to try to then match the services to what the local population needs and what they are talking about as their needs. So, over the next two to three years, we should be starting to see whether those methods had an impact. However, I would not want to wait for three years to see the results. I want them to try to demonstrate and change what they are doing, so that we get more people into services. Particularly in Aneurin Bevan, they are focusing on coronary heart disease. It remains one of the key issues underpinning the pattern of inequalities. So, it is about really getting down to that almost individual level—neighbourhood level—to understand what they can do differently. We will be working with them to try to see what is coming out of that, as they go through that process.

[26] **David Rees:** We have questions now from Lindsay Whittle and Janet Finch-Saunders on engaging the public, and then Lynne Neagle on child healthcare.

[27] **Lynne Neagle:** And inequalities.

[28] **David Rees:** And inequalities.

[29] **David Rees:** Do you want to start on inequalities, then, because we are on that topic?

[30] **Lynne Neagle:** I wanted to ask about what you said about child health, but, linked to that, health inequalities more generally. I recently helped launch the report 'Why Children Die' for the Royal College of Paediatrics and Child Health. That report had some really powerful messages about the adversity that is faced by children in deprived communities, and the role that that plays in actually meaning that many more of them are likely to die in childhood, which is a pretty powerful message. So, I wanted to ask what you are doing specifically to tackle that link between child health problems and deprivation, but also to broaden that out to health inequalities more generally, because, as we know, they are still very pronounced in Wales.

[31] **Dr Hussey:** I will start with the inequalities, and then drill down into the subject of children specifically. Tackling health inequalities has been a lifelong passion of mine—the injustice that we see, or the unfairness, if you like. What I have seen over several decades now is the growing evidence base, not just describing the problem, but actually trying to understand what the drivers are underneath it. So, in Wales, Public Health Wales has published significant information on this. Two or three years ago, Professor Michael Marmot, who is internationally renowned, looked at the issue globally, at European level, and in parts of the UK. He came over in the summer to talk to us, again trying to look at whether we are doing all the right things—from the evidence base that we now have, what else can we do to really drive and tackle health inequalities?

[32] He had six policy recommendations, which he has not varied from, having looked at all that evidence base. The first one—and this is why I wanted to start generally—is giving children the best start in life. That is absolutely critical; the first three years is a critical phase in setting children on their lifetime journey. The second one is helping children and young people, as they develop, to have opportunities and control of their lives. The third one is good employment—you know, healthy employment. The fourth is ensuring a healthy standard of living. The fifth is sustainable communities—places where people feel safe and supported. The final one is the role of health prevention, if you like—specific programmes on things like tobacco, which we know is very much socially graded in terms of the pattern of smoking. So, they are the broad policy areas.

[33] I have been looking at the Healthy Child programme. Obviously, Welsh Government starts in a very strong place, because it has a track record of investing in the early years, looking at a range of programmes—Families First, Flying Start, and a number of different initiatives—and really trying to focus on those areas. So, what I have been looking at is: what else? What else could we really be trying to do? The area that I have staff working on at this point in time is the Healthy Child programme.

[34] If you look at the nought to five years, the universal access that parents have—and that that child has—is through the health service, so it is the midwife and the antenatal care services and health visitors. For those first few years, the NHS is the service that should provide universal access to those families. So, what we have in train is a piece of work to look at what the evidence base is, about what should be in the Healthy Child programme, comparing that to where we are, and then coming forward with plans to consolidate, develop and improve that programme. The key thing for me is driving 100% universal access—can we make sure that nobody is slipping through the net, and that, with the very children who we really need to tailor the support and the intervention to, are we getting there?

[35] We also have a plan to invest in a community child health information system—or a community system—so we can better track and help health visitors, and the NHS generally, to know whether we are actively managing to contact the people who may need the most support. We are working with education colleagues on that as well. For me, and this is in the evidence that Michael Marmot promotes, school readiness is a key one. Did all of that intervention add up to children being able to come to school, ready to learn, and safe and secure in the home? We have got a key role to look at whether we are doing enough and to the right standard. So, that is my focus, to unpick all of that and come forward with a programme of work. I have some staff working on that now.

[36] **Lynne Neagle:** May I just ask a couple of other questions? You mentioned the crossover with other departments. How effective do you think your department is in engaging with other key departments like education, which obviously also have a key role to play? I have one final point. I am sure that I am not alone in seeing people for the first time, because of the UK Government's reforms, who are actually destitute, and there is an increasing dependence on food banks. To what extent have you got an eye on the increasing pressure

that is on families because of those changes and the impact that that will have on their health?

[37] **Dr Hussey:** On the first question, on working with education in particular, I think that it is fair to say that when I have looked at the staff that I have and what they have been working on, one of the areas identified about nine months ago was whether I had enough resource targeted at children, so that we could be good partners with other Government departments, and whether we had enough skills and capacity there. So, I have strengthened that part of the team. I have recently appointed people to lead more strongly on the children's agenda. So, I hope that my education colleagues would say that we now have sufficient resource to be able to support and further develop the thinking around that. We are meeting regularly with colleagues now. So, I recognise that as an area that I wanted to major on.

[38] On the impact on children's lives, there is a concern. I think that it is a significant concern. If you look at the pattern of things like obesity, you will see that it is heavily socially graded. I then look at what resources families have in order to have an affordable diet that is high quality. I know that food banks play an important part, but access to vitamins and fresh fruit and so on is not something that they can meet the need for. So, I am very concerned about that area, clearly. The policies that Professor Marmot sets out to tackle inequalities are across the board and we have to keep majoring on whether everybody has a fair chance to have a healthy life and a healthy diet and to feel safe and secure. So, it has to underpin all of the work that we do.

[39] **David Rees:** Lindsay Whittle is next.

[40] **Lindsay Whittle:** Thank you, Chair. Good morning. There cannot be many people out there now who do not realise that smoking excessively every day, drinking every day and eating the totally wrong food every day is bad for you and will give you problems in later life. So, have you done any research into the challenges as to why people are not taking heed of the advice? I write a column for three newspapers in my region and I wrote about healthy eating and healthy living styles, and letters to the newspapers followed, criticising me and saying, 'Mind your own business'. They implied that I was the fascist police, telling the public what to eat. If adults want to drink and eat their way to death, that is fine, but I am more concerned about young children. Do you have any evidence of good practice that we could use for that?

[41] **Dr Hussey:** This is a complex set of issues. The area that I want to pick up on, first of all, is whether people know the consequences. Have people added it all up and realised? Secondly, does it matter enough to people in their daily lives to invest in something that might happen 20 or 30 years away? The Caerphilly study is incredibly powerful and demonstrates that if you do all four, as I mentioned, you will prevent dementia and diabetes at a very high rate. I think that this came to a head in a sense, because my report came out immediately after the budget conversation, and I was on the radio the day that the budget changes around local government and the NHS were being discussed, and I think that the realisation that the impact that this is having on public services became suddenly very obvious to a lot more people. Suddenly people were saying, 'I really see now; this is preventable poor health'. So, the general understanding, I think, is improving that this does add up to a real measured impact on public services.

10:00

[42] A simple example is the prevalence of diabetes going up from 5% to 7%. It does not sound like a lot, but when you turn that into real numbers of population, it is roughly, on the back of an envelope, about 60,000 people with more diagnoses, access to treatment, support and so on. The message is that, increasingly, people are realising the importance of it. That is one thing.

[43] The second thing is: does it actually change individual behaviour? Does it become personalised? There are different issues in different elements of lifestyle choices. Smoking, for instance; yes, we are down to 21% now. There has been a major impact on that; having a big push on whether we can go further on a single issue. The more difficult ones are physical activity, obesity and alcohol consumption; they are more embedded in society. What you are saying to society is, 'You have to reign back on some of this, it is actually adding up to harm'. There are some promising areas of work—aside from creating an environment that does not promote poor health choices—like the Active Travel (Wales) Act 2013 and the proposals on restricting tobacco further, and so on, in the public health White Paper.

[44] Aside from changing the environment, what can you do to change people's motivation and personalise that change? There is very interesting work emerging. There is a report from the King's Fund on something called patient activation. What it starts to do is bring it down to, 'Do people have the knowledge, the skills and the confidence to make the changes to see them through?' There is lots of evidence in there, from all parts of the world, on different initiatives and different programmes that bring it down to, 'Do you realise, on an individual basis, that these things are actually contributing to your poor health?'

[45] I have seen research from another part of the UK, which I was involved in some years ago, which was very much about people not realising that it was anything to do with anybody else. They did not realise the connection between their personal lifestyle choices and the impact it is having on other services. So, where we need to focus on is building on this concept of prudent healthcare. The prudent patient needs to be part of taking responsibility for the choices people are making. The Government has a role in making it easy to make those choices, but we also have to really work on this concept of patient activation. I met yesterday with the Royal College of Physicians, which is doing a lot of work on shared decision making, which is another type of co-production approach, which is one of our prudent healthcare principles. It was talking about how you start with the patient understanding what is driving their health, what they can do differently, and how they can work together with a health professional to change their health for the future.

[46] Again, it is a bit like the answer to physical activity; there is not one magic thing we can do. The important thing is that we all share the commitment and say, 'We have to prevent this burden of preventable illnesses'. We have to prevent it. Secondly, do all the policy initiatives add up to pushing in that direction? Thirdly, how do we directly work with people to help them be part of that solution?

[47] **Lindsay Whittle:** Do you think we should be more hard-hitting? I do not smoke, but I can see on cigarettes, which are now hidden, when I see people buying them, that it clearly says 'smoking kills'. On a bottle of wine or a can of beer, in minute writing, it says 'drink responsibly'. There is nothing at all outside a cake shop or a takeaway or a beef burger stall. Nothing at all. There is nothing wrong with cakes and—

[48] **Elin Jones:** What about the expensive restaurant?

[49] **Lindsay Whittle:** Indeed, yes. There is nothing there at all. These things should be treats not everyday occurrences.

[50] **Dr Hussey:** To pick up on this question of knowledge and information and signalling to the population, generally, the importance of looking at those things, I will just pick up on the point you made about restaurants. There was research this week about how many calories we consume outside the home and the trend of eating away from home and how you do not know what is in the food. Again, can we, collectively, help us all to make those choices conscious? There are some places that show calorie counts on their cakes and things, and it is

quite shocking to realise some of that. More prompting and more of those things help. *[Interruption.]* Yes. Can we help to create the environment, without nagging too much, of prompting people to say, ‘No, I’m not going to do that, because I hadn’t realised it was a quarter of my daily intake if I have that cake’? We should be promoting more of those things.

[51] You will know from my report that I also talk about whether or not we need to be doing more about the promotion of food—junk food advertising and so on—and those sorts of areas. Obviously, it is not in the gift of Welsh Government, but collectively, should we be working on some of those issues? So, it is multiple things, such as prompts and knowledge of when you have illnesses, doing more to stop them deteriorating and creating an environment where the healthy choice is the obvious and easy choice to make.

[52] **Lindsay Whittle:** I realise that, by asking that question, I can never eat a cake in this building again.

[53] **Dr Hussey:** No. *[Laughter.]*

[54] **Elin Jones:** Not on a 500-calorie day.

[55] **David Rees:** Okay. Let us move on.

[56] **Janet Finch-Saunders:** Good morning. My question is about engaging with the public in terms of reconfiguration of services. I think that it is fair to say, in my own constituency, when people become ill, they imagine that they will be treated at the nearest point, but we know—those of us who enter into dialogue with our local health boards—that there is a major reconfiguration of services going on across the whole of Wales. That, in itself, brings its own tensions and pressures, but there is also a need to educate our Welsh patients.

[57] I am not certain how the Welsh Government, NHS Wales and, indeed, our own local health boards are actually taking people with them. For instance, if one realises that, by travelling 25 extra miles if you have a vascular problem or a cardiac problem, you are going to get the best treatment, then, obviously, you are informed and you want to do that. I find that a lot of concerns are raised with me, as an AM, because suddenly, people realise and ask, ‘How am I going to get to this hospital?’ and ‘How is my family going to come and see me?’ It is that panic and fear of not knowing. However, if people were more aware that Wrexham Maelor is the specialist hospital for that and Ysbyty Gwynedd is—. If they are told, ‘This is what our plans are; that is where you go if you have that particular specialist condition that needs treating’—. I find that health boards are a bit precious about sharing that kind of information. It is shared with us as politicians and those overseeing these changes will be fully aware, but why are we not getting that message out to people so that, as and when something happens and they are taken ill, they know exactly where they are likely to go with that condition, so that it does not become a problem or an issue at the time?

[58] How can you influence health boards to trust the people they will be treating and actually bring them forward as part of the strategic plans, and also explain where there is a shortage of particular consultants and let people know? When I deal with casework, the biggest problem has been that people have just been left in limbo. When someone has needed a particular consultant—and they have been fairly thin on the ground up in north Wales and people have had to look around in other hospitals in England to try to get that particular—. People really need to know where the pressures are and start to inform, so that it does not become a major shock at the time. How can you influence that?

[59] **Dr Hussey:** On a number of levels, I think is the answer. The first is to help a better understanding of what is actually available in communities and how it all fits together. So,

coming back to the report that we are discussing, there is a chapter on primary community care, and it is about asking, ‘Do you realise that actually, all of this is available, locally?’ The second thing is whether we can do more to deliver more locally, so that the need to travel for the highly specialised treatment is diminished. I know, in north Wales, there is some work under way to try to push on some telehealth ideas. I was really pleased to hear about work that is just starting that involves talking to older people first to find out whether some of these ideas would be used by them.

[60] Therefore, the underpinning principle for me is this concept of co-production and a prudent healthcare approach, which is about listening to what people are talking about, listening to the worries and working out solutions that bring services as close as possible to as many people as possible, but also explaining why certain services need to meet a certain standard. That is a live discussion.

[61] As you know, the mid Wales study is due to be published shortly and that has been looking at the challenges, particularly in rural communities where this is a very real consideration for people—travelling long distances for services. So, I am looking forward to that being published and a discussion about how we get sufficient general services in the local area that are generally meeting need but be more explicit about the ones that absolutely must be centralised because they are more highly specialised.

[62] **Janet Finch-Saunders:** We realise at the moment that health is very much a subject topic in the media; sometimes for all the wrong reasons. Why is there no engagement so that, again, we are educating the public about where the good stuff is happening and how those services are being reconfigured? I truly believe that we tend to—from my perspective—reconfigure and redefine services and then just expect people to slot into those models rather than actually taking people. I think that more work needs to be done in terms of engagement with those who are going to be using those services.

[63] **Dr Hussey:** I strongly endorse that. We have had a piece of work over the summer looking at outcomes that people are looking for. There has been quite a detailed engagement process to work with people to say what outcomes matter to the public and how we can measure the right things for them and what matters to them. That work has drawn very much on public engagement and public views on some of that. The other area to consider is really surfacing quality information. We have been working very strongly—Chris might want to come in on this and on the work that we have been doing—to publish more quality information. Do you want to comment on the push that we have had on that?

[64] **Dr C. Jones:** I think that your question does raise the more general issue about what we are doing to try to help health boards and trusts to be more transparent in their dealings with the public. The health boards that have been engaged in service reconfiguration probably feel that they have done a great deal to try to engage and to inform, and perhaps will be disappointed to hear the reflection that they have not always succeeded. It is hard to reach everyone.

[65] I chaired a ministerial task and finish group on transparency, which published a statement earlier this year, with some advice for health boards about how to be more open. This is starting with individual interactions and being very open about quality issues as they arise in individual situations, but also organisations as a whole being very open—and the annual quality statements that have recently been published are a sign of that—and also the reporting that follows the delivery plans, the reports of achievement and the plans for next year are all part of this transparency, which we expect. We are publishing a lot more indicators on quality for the public all of the time. However, I agree with you that there needs to be a kind of compelling narrative to bring it all together into some sense of meaning for people on the street in Wales. I think that that is difficult, because people are very wedded to

the idea that everything is available locally. Having said that, I think that people do accept that they have to travel for neurosurgery and cardiac surgery. What is sometimes not always clear to people is that the evidence base is extending beyond those few very super specialist areas now to a wider range of specialist areas and that, actually, they may have to travel for more specialist type of care, but not for the main part of their hospital admission—perhaps just for the intervention or the point at which this very specialised environment brings most benefit.

[66] **Janet Finch-Saunders:** My point is that they do not find that out until they need the service. It is about educating people beforehand so that they are not concerned about that because they are expecting it, almost. I have raised it with the health board over many years, and I think that they do need to be—. People would see it more as a proactive stance rather than reactive.

[67] **David Rees:** Are you working with the health boards to ensure that the proactive approach is being taken?

[68] **Dr C. Jones:** I recently chaired the taskforce again at a further meeting, and we have decided now that we are going to follow up the recommendations that we made in March to see what change is happening. Some of the recommendations were for Welsh Government as well as for health boards, so we are going to follow that work through to see what traction those recommendations have had and what changes have happened in response.

[69] **David Rees:** Thank you. John, do you have a question?

[70] **Dr Hussey:** Chair, I could also just add that the review of the reconfiguration process is also coming to fruition. So, there may be lessons that we can reflect on there as well.

[71] **David Rees:** Thank you for that.

[72] **Janet Finch-Saunders:** May I just ask when that will be?

[73] **Dr Hussey:** I do not have a date for that yet, but I know that it is actively in progress.

[74] **David Rees:** We look forward to seeing that. John, do you have a question on this topic?

[75] **John Griffiths:** Yes. [*Inaudible.*]—lively debate at the moment around health services. I think that that is very relevant in terms of public expectations and public understanding. We know that we are in the run-up to a general election, and there is a lively political debate, but it is different in nature at the moment, I think, as far as Wales is concerned. Wales seems to be at the centre of the storm, and there seems to be a concerted effort to undermine and, indeed, attack the Welsh national health service. I can see that you are beginning to intervene, Chair, so—

10:15

[76] **David Rees:** I want to try to ensure that we do not get into a difficult exchange of views.

[77] **John Griffiths:** Let me say that this is obviously a political storm, as it were, and a political debate, and politicians are engaging in it. However, looking at the chief medical officer's annual report, it is partly about how you engage with the Welsh public and make sure that people have a proper understanding of health services in Wales and that you engage effectively with people in terms of their expectations. There are roles for the chief medical

officer in terms of leading the medical profession in Wales and there are issues around the morale of the health service as part of this debate. Also, the report and the duties of the chief medical officer and officials are shot through with building partnerships—partnerships with the UK Department of Health, for example. Those are key to public health and many different activities and strategies. So, my question—

[78] **David Rees:** *[Inaudible.]*

[79] **John Griffiths:** —not at a political level but at official level, really, with regard to working with the other departments of health across the UK is whether we can be assured—because there are questions about politicisation, for example, of the health department in the UK and, again, those are political issues—

[80] **David Rees:** No, we are not discussing that.

[81] **John Griffiths:** In terms of working relations and the effectiveness of those working relations between departments at official level and the chief medical officer level, I think that it is a time when we need some reassurance, really, that those relationships are not being damaged to the extent that it is really going to have an impact on health services for our people here in Wales.

[82] **Dr Hussey:** Partnership, as a general point, is absolutely the key to everything I do. With regard to all of the questions this morning, there has been an element of working in partnership with the public, working in partnership with other agencies, and working in partnership with other Government departments. It is a requirement, is it not? We are only going to make real inroads on the health of the population if we work in partnership. So, the question at the UK level is: what are those areas that we need to work together on? I meet regularly with my UK counterparts. We have a good working relationship. A recent example is preparedness for Ebola and regular communication on those issues. We have a track record of identifying issues. Sometimes, another administration will identify a health concern and we look at it together. We have got one that we are working on at the moment. So, I have good professional contact and good working relationships with my counterparts. That is something that is really important to me.

[83] **David Rees:** Okay. Thank you. Elin is next.

[84] **Elin Jones:** Diolch, Gadeirydd. Roeddwn eisiau gofyn i chi—. Rwyf yn falch o weld bod eich adroddiad yn bod yn rhagweithiol o ran lle mae'r Llywodraeth yn y cwestiwn ac ymyrryd yn y farchnad rydd yng nghyd-destun y diwydiant bwyd, y diwydiant alcohol a sigarêts—

Elin Jones: Thank you, Chair. I wanted to ask you—. I am pleased to see that your report is being proactive in terms of where the Government is in the question and intervening in the free market in the context of the food industry, the alcohol industry and cigarettes—

[85] **Dr Hussey:** Nid wyf yn gallu eich clywed chi—. O, diolch. Mae'n iawn 'nawr.

Dr Hussey: I am not able to hear you—. Oh, thanks. It is fine now.

[86] **Elin Jones:** Rwyf jest eisiau dweud fy mod yn falch bod eich adroddiad yn edrych i gadarnhau fod yna le i Lywodraethau ymyrryd yn y farchnad rydd o ran y diwydiannau bwyd ac alcohol ac yn y blaen. Mae hynny'n batrwm weddol o gyffredin lle mae alcohol a sigarêts yn y cwestiwn. Mae eich adroddiad hefyd yn

Elin Jones: I just want to say that I am pleased that your report is looking to confirm that there is a place for Governments to intervene in the free market in relation to the food and alcohol industries and so on. That is quite a common pattern where alcohol and cigarettes are concerned. Your report also draws attention to the increasing problem of

tynnu sylw at y broblem gynyddol o siwgr a dylanwad siwgr ar ordewdra, ac yn cyfeirio at y ffaith bod yna consensws yn datblygu 'nawr y gellid edrych ar drethu diodydd meddal. Rwy'n derbyn nad oes gan Lywodraeth Cymru y pŵer ar hyn o bryd i gyflwyno treth o'r fath, ond a allaf ofyn i chi pa waith yr ydych yn ei wneud wedyn gyda'r prif swyddogion meddygol eraill? Gwn fod hon yn farn y mae'r prif swyddog meddygol Lloegr yn ei rhannu. Pa waith a ydych chi'n ei wneud ar y cyd, mewn partneriaeth, i ddylanwadu ar y Llywodraeth sy'n gallu myrryd yn y modd hwnnw, sef Llywodraeth y Deyrnas Gyfunol ar hyn o bryd, er mwyn edrych ar gyflwyno treth o'r fath?

sugar and the influence of sugar on obesity, and it refers to the fact that there is a consensus developing now that we could look at taxing soft drinks. I accept that the Welsh Government does not have the power at the moment to introduce such a tax, but may I ask you what work you are undertaking then with the other chief medical officers? I know that this is a view that the chief medical officer for England shares. What work are you undertaking jointly, in partnership, to influence the Government that can intervene, that is, the UK Government at the moment, in order to look at introducing such a tax?

[87] **Dr Hussey:** Diolch yn fawr. I wanted to raise the issue of taxation in the report because I think that there is now a growing evidence base. Up until recently, the modelling and the testing had not been fully developed. We are at the stage where a number of research groups and interest groups are starting to be able to quantify the likely impact of sugar taxation, so I think that we are now at a point—and the purpose of putting it in my report was to highlight the issue—to start to follow that up with my colleagues. Obviously, each administration will have its own views, but, I think, building on the sense of the evidence that is emerging, our role as the UK's CMOs is to look at whether there are some areas where there is a growing interest and a growing evidence base that we can start to bring forward as specific areas of policy consideration. Obviously, it is for each CMO to decide on how to do that in their own countries, but it is an area that I want to start exploring, which is why I wanted to highlight it in the report this year. Now, clearly, as you rightly say, Wales does not have the powers to do that now—

[88] **Elin Jones:** Now.

[89] **Dr Hussey:** Now. [*Laughter.*]

[90] **Elin Jones:** Post 2016, it will be different.

[91] **Dr Hussey:** In a sense, the situation that I think that we are in at the moment is that we are paving the way for consideration, building the evidence base, understanding what the evidence is saying, and then helping policy makers consider at what point this becomes something that people would want to consider, that has sufficient merit and sufficient impact to consider as a policy. That is the stage that I think we are at: bringing that evidence forward as it starts to emerge.

[92] **David Rees:** May I just clarify one point? Are you looking simply at drinks or are you looking at sugar in all forms of food?

[93] **Elin Jones:** [*Inaudible.*]

[94] **Dr Hussey:** Some of the work that has been done is looking at fizzy drinks in particular, at the sweetened drinks, if you want to call them that—[*Interruption.*—]—or a range of sweetened drinks, but, again, people are looking at different elements of this, so I think it is for us to watch the evidence, the literature, and bring the science together to ask whether it is now giving us a case for change. So, I think that we are at that stage of the discussion.

[95] **David Rees:** Okay. Thank you. Did you have more questions, Elin?

[96] **Elin Jones:** No, I am fine.

[97] **David Rees:** Darren is next.

[98] **Elin Jones:** Lindsay just mentioned a tax on eclairs to me, so that distracted me, sorry. [*Laughter.*]

[99] **Darren Millar:** May I thank you for your report? It is pleasing to see the significant progress that is being made into aspects of care and it is very good to see that condensed into the report before us. However, of course, the NHS is not without its challenges in Wales, as in other parts of the UK, and we know that some challenges, in particular, appear to be more acute in some parts of Wales than in other parts of Wales, as well. So, within Wales, there is a difference from one part to the next in terms of some of the pressures. You are obviously responsible for the workforce and making sure that there are sufficient numbers of qualified people coming through to replace those who are exiting. Can you tell me—? There was not a great deal in your report about the challenges faced by the GP workforce in Wales, and we know that Wales has a lower number of GPs per 1,000 population than England or Scotland, and that is beginning to manifest itself more and more acutely now, with people having challenges getting appointments with their GP despite the fact that the Welsh Government, to be fair, is trying to open up GP access and make sure that GPs comply with their contractual obligations in terms of core contracted hours. What action, specifically, are you recommending that the Welsh Government take in order to address some of those problems?

[100] **Dr Hussey:** The reason I wanted to highlight primary healthcare in the report was to really shine a spotlight on it, and it is very encouraging, I think, that there is a growing awareness now that all the evidence base from developed countries, looking at all their health systems, shows that they all are starting to focus on a strong primary healthcare system. I think we are pushing in that direction. The Minister is considering a primary care plan, which we are working on at the moment, and Grant may want to comment a bit more on that. One of the strands in there is the workforce that is needed, both now—what practical things we can do now for the commissions and for the workforce coming through in the next 12 months—and also for the medium term, in terms of what else we need to do to consider the skill mix. I do not know, Grant, whether you want to talk a bit about that.

[101] **Dr Duncan:** I think the really important thing is what the skill mix is that is needed now and into the future. The model is actually changing. For example, in terms of trying to alleviate some of the pressures, the Minister has announced £3.5 million to primary care, and some of those grants are being finalised. That is encouraging new ways of working, such as more advanced practitioner nurses, more care workers and finding different ways. Rather than just saying, 'a GP', it is about the multi-skilled nature of it. Underpinning that, I think, is then for the—. We have been working hard with the primary care community this year over their cluster-development plans, with smaller localities. More and more, the thinking is about making sure that you plan locally, for 25,000 to 100,000 people, so we have GP clusters and primary care clusters. They have done some of their own development plans, and, in fact, today the health boards and the leads are working on what that needs. From that, we can get better analysis of what the local needs are and can start to build up and do better overall planning of the shape of the workforce needed. Ruth has mentioned a primary care plan, which the Minister will be considering. Part of that will also be identifying that we do need to do more work on a general workforce plan that looks in the round at GPs, at nurses, at therapists, and the whole range of what is actually needed. So, I think the model is actually changing, and the model of how we respond is going to be populated by local needs reflected in the health boards' three-year plans.

[102] **Darren Millar:** Is there not, though, a challenge that is much more immediate that we are facing in terms of the GP workforce? GPs have described it themselves as a ‘crisis’ in some parts of Wales, because they are failing to recruit into vacant posts, they cannot find new people to come into their practices, there is a dearth of Welsh-speaking GPs to serve Welsh-speaking rural parts of Wales, and, even in places that are very close to the border—big urban centres like Wrexham—there appear to be big challenges manifesting themselves. So, it is all very well having a three-year plan, but it takes a number of years to train a GP and to bring them up to a point where they can be embedded within the Welsh health service. We have to deal with this much more immediately than that, do we not? So, what sort of advice are you giving about perhaps recruiting people into Wales from elsewhere in order to plug these gaps in the short term, so that the longer-term plans, in terms of redeveloping, if you like, the suite of services within primary care facilities and perhaps bringing in different staff, who are not GPs, in order to do some of the work that GPs would have previously had to do, can be made?

[103] **Dr Hussey:** Absolutely. I am acutely aware that there are pockets of concerns. I have actually been to meet the GPs in Llŷn earlier this year. I went to Powys in the summer. I am actually going to a practice on Friday to hear about challenges that they have, and opportunities in terms of how they want to develop, so I am actively involved in trying to understand the different elements of that. This really is about trying to create ways of working whereby the workforce will want to come in. Looking at the model that is available, there is a very mixed picture of new doctors coming forward, in terms of what type of practice that they want to work in. Some of the resource that has come forward in the last few weeks will look at whether we can train some advanced nurse practitioners quickly to get them in place. There is some practical work around the locum list, the principal list, and whether you can fast track some of that to get people into the workplace. We know that there are obstacles when a GP retires that get in the way of them coming back into practice part time. So, we are looking at really practical things, and at whether there are ways in which we can work in the next few months and in the next 12 months to work out solutions to the immediate issues. The important thing, however, and the thing that the plan tries to look at, is what the choices are going forward. What is important is that I do not think we have a single model that says, ‘Everybody in Wales will have this model’. We have to have flexibility. The challenge for the population in a rural summer and winter pattern like that of Llŷn is that we need to create sufficient opportunity for a different mix of staff to be able to respond to those particular pressures. So, we really want the health boards—. This year, in the guidance that will be coming out shortly, we will be very strong in saying, ‘We want you to build up, and show us how you are creating sufficient capacity in local communities’, and then our role is to make sure that, if there are regulations that we need to change or consider, or practical things that Welsh Government can do to help make that easier, then we can help with that. The key thing, however, is really working with those practices, anticipating concerns, and trying to find solutions. I know that there is active recruitment going on, looking at what would help groups of staff wanting to come into practice, so there are a lot of different areas where we can help.

10:30

[104] **Darren Millar:** May I ask something on a separate subject? I appreciate the response that you have given there, because it does help to give a little bit more clarity about the level of activity that is going on in Welsh Government at the moment about that. May I just ask about the mortality case note reviews? Obviously, in the wake of Francis, the Minister established a piece of work to ensure that case notes were reviewed for all hospital deaths in all parts of Wales, which is a very welcome move indeed. Since then, the Minister has suggested that there is going to be a move away from looking at the risk-adjusted mortality indices, in terms of them being a marker of performance in the Welsh NHS, despite the fact that, just 12 months ago, you were celebrating the fact that this was the right measure to be

able to use and that it was going to be the standard by which performance was going to be marked—or one measure of performance.

[105] Those case note reviews, of course, were undertaken within the individual health boards themselves, rather than having anyone to independently verify the work. Of course, it is very difficult for a health board to acknowledge if there has been a failure in an area so that it can learn from it, because people, naturally, are very protective of the organisations within which they work. As human beings, we do not like to admit that we have sometimes made mistakes—particularly politicians. What assurances can you provide us today, as the chief medical officer, to demonstrate that those case note reviews were robust and that, in terms of the problems that were identified—in the small number of cases where problems were identified—lessons are being learned from those? How are you, as chief medical officer, following that up to ensure that feet are being held to the fire in every health board in Wales, so that mistakes that have been made previously are not made again in the future?

[106] **Dr Hussey:** I will bring Chris in on this, but I will just say a few words. What I wanted to try to do in my report this year was to make the connection with the population level avoidable mortality pattern to then ask how we can bring that back down to what I think is pioneering work around mortality case note reviews—you know, a 100% systematic approach to this—and absolutely learn from the themes that are coming out of those reviews. Yes, there may be individual cases where things could have been done better, but the big prize is to create learning and action that follows from it. Sepsis is an example that Chris might talk about and, in terms of child death reviews, I have requested a rapid review on themes in child deaths, coming back to the point that Lynne Neagle made earlier about the importance of drilling into some of these things. So, my role is very much to make sure that the system is working and, then, when things come to my attention—adverse events—absolutely follow them up.

[107] **Darren Millar:** So, what sorts of themes are emerging, then?

[108] **Dr Hussey:** I am going to ask Chris to talk about the process that we have put in place, where it has got to and what is emerging.

[109] **Dr Jones:** Before I come directly to that, I think there is a strong story here, actually. It is quite difficult to introduce a new clinical process and, actually, we have made tremendous progress in a very short period of time. So, what we have now is an embedded process for all deaths across all health boards. It is a two-stage process, which is agreed. There is consistent embedding of the first stage, which is the universal mortality review, or UMR, which asks a number of questions about the death, and then, in a proportion of cases, there will be the second stage, which is a more detailed root-cause analysis type of review.

[110] These processes were implemented at health board level with some variation initially, and now we are pulling them together into a more consistent approach. We do recommend that the reviews are undertaken by multidisciplinary teams, and that it is not just individuals marking their own homework. There is a very strong quality improvement element to this. It is a reflective practice. We expect, when themes arise, that there will be change—change occurring to fix any risk that that case note review has identified.

[111] Relatively early on in the process, through conversations with medical directors, they were all reporting that one issue that came up on occasion was the response to the deteriorating patient. There is no real surprise in that; a number of those will have sepsis. As a result of that, we have been able to strengthen our procedures around the sepsis screening tool. So, we know that we already have an advantage in that we have rolled out a national early warning score system throughout all of our acute hospitals.

[112] **Darren Millar:** That is the NEWS system.

[113] **Dr Jones:** That is the NEWS system. That is a strength in Wales. We know then that for people who trigger on the NEWS system, there should be the use of the sepsis screening tool, and then the sepsis six bundle for treatment. So, we have been able to embed those processes much more strongly, and, in fact, that position that we are in, which is a relatively strong position, was reflected in the recent patient safety alert that we sent out on sepsis. It was a different alert from that in England. We are, actually, in quite a strong position—as a result of the learning from the mortality case note reviews, in part.

[114] One of the other issues that I know has cropped up on a thematic basis has been place of death. That is, is it appropriate that someone is in hospital? Is it appropriate that someone has been on a critical care unit? These end-of-life, care pathway type of issues, I think crop up as well. Otherwise, there is a lot of richness in the learning, and my understanding is that the culture is changing because people know that the care is going to be looked at, but I think that there is more to be done about ensuring more consistency, particularly around the second stage. Ruth has appointed a national clinical lead to oversee this process. He is Dr Jason Shannon, who is a pathologist from Cwm Taf Local Health Board. He is supported by the 1000 Lives Plus improvement programme, which, of course, again is an all-Wales programme, and they are putting in place a steering group to oversee the process now, which first meets in November.

[115] **Darren Millar:** Thank you for that. Obviously, I think it is a strength that people can—.

[116] **David Rees:** This is the last question, as time is getting on.

[117] **Darren Millar:** I think it is important; I know Members are anxious to move on. I think it is a strength that we have a system in place where every death is reviewed. I welcome that—very much so. You talked about transparency earlier. Are you going to be publishing a report that collates all of these things together on a regular basis in the future?

[118] **Dr Jones:** Yes. The first thing is that we expect these processes to be reported to boards. That is obviously public, and we will then be publishing, on an annual basis, a summary of where we think we are in Wales.

[119] **Darren Millar:** When is the annual basis going to start?

[120] **Dr Jones:** I am not sure exactly when that will be. The Minister, as you know—.

[121] **David Rees:** Perhaps you would like to write to us and let us know when you have an indication as to what the date is.

[122] **Dr Jones:** Finally, if I may briefly just say that, from the independence point of view, this system that we have put in place makes us very well suited now to the implementation of the medical examiner role in two or three years' time, because that medical examiner role will, very likely, become the first-stage process on an independent basis, and we will be entirely ready for that.

[123] **Darren Millar:** Okay. Thank you.

[124] **David Rees:** I am very conscious of the time. We have overstepped our time a little bit, so thank you for the extra information that you have provided for us. Thank you for the evidence session you have given this morning. It has been very helpful. So, once again, thank you very much for your attendance.

[125] **Dr Hussey:** Thank you very much. Diolch yn fawr.

10:37

**Papurau i'w Nodi
Papers to Note**

[126] **David Rees:** We have one paper to note, which is from the Chair of the Children, Young People and Education Committee, which was placed in front of you last week for the discussion in the budget session, but we need to formally note it. Is it okay if we note it? It is.

10:38

**Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y
Cyhoedd o Weddill y Cyfarfod ac o Eitem 1 y Cyfarfod ar 6 Tachwedd 2014
Motion under Standing Orders 17.42(vi) and (ix) to Resolve to Exclude the
Public from the Remainder of the Meeting and for Item 1 of the Meeting on 6
November 2014**

[127] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 6 November 2014 in accordance with Standing Order Nos. 17.42(vi) and (ix).

[128] Are all Members content? You are. Thank you.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 10:38.
The public part of the meeting ended at 10:38.*