



Cynulliad Cenedlaethol Cymru The National Assembly for Wales

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

**Dydd Mercher, 10 Gorffennaf 2013
Wednesday, 10 July 2013**

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynndi 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

Leighton Andrews	Llafur (yn dirprwyo ar ran Vaughan Gething) Labour (substitute for Vaughan Gething)
Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (yn dirprwyo ar ran Kenneth Skates) Labour (substitute for Kenneth Skates)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Helen Bedford	Uwch-ddarlithydd Iechyd Plant, UCL Institute of Child Health Senior Lecturer in Children's Health, UCL Institute of Child Health
John Burge	Prif Swyddog Llywodraethu Ysgolion, Cyngor Bwrdeistref Sirol Castell-nedd Port Talbot Principal School's Governance Officer, Neath Port Talbot County Borough Council
Mark Drakeford	Aelod Cynulliad, Llafur (y Gweinidog Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Dr Sara Hayes	Cyfarwyddwr Iechyd y Cyhoedd, Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Director of Public Health, Abertawe Bro Morgannwg University Health Board
Dr Ruth Hussey	Prif Swyddog Meddygol, Llywodraeth Cymru Chief Medical Officer, Welsh Government
Andrew Jones	Cyfarwyddwr Iechyd y Cyhoedd, Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr Director of Public Health, Betsi Cadwaladr University Health Board
Dr Marion Lyons	Cyfarwyddwr Diogelu Iechyd, Iechyd Cyhoeddus Cymru Director of Health Protection, Public Health Wales
Joff McGill	Pennaeth Gwybodaeth, Cyngor ac Ymchwil a'r arweinydd o ran imiwneiddio a rwbel, Sense Head of Information, Advice, and Research and lead on immunisation and rubella, Sense
Dr Ian Millington	Ysgrifennydd Meddygol, Pwyllgor Meddygol Lleol Morgannwg Medical Secretary to Morgannwg Local Medical Committee

Nick Morris	Swyddog Polisi ac Ymgyrchoedd (Cymru), Sense Policy and Campaigns Officer (Cymru), Sense
Dr Gillian Richardson	Cyfarwyddwr Iechyd y Cyhoedd, Bwrdd Iechyd Lleol Aneurin Bevan
Dr Andrew Riley	Director of Public Health, Aneurin Bevan Health Board Uwch-swyddog Meddygol, Llywodraeth Cymru
Dr Quentin Sandifer	Senior Medical Officer, Welsh Government Cyfarwyddwr Gweithredol Gwasanaethau Iechyd y Cyhoedd
Dr Andy Williams	Executive Director of Public Health Services Ysgol Newyddiaduraeth Caerdydd Cardiff School of Journalism

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

Catherine Hunt	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

*Dechreuodd y cyfarfod am 9.30 a.m.
The meeting began at 9.30 a.m.*

Cynnig i Ethol Cadeirydd Dros Dro Motion to Elect Temporary Chair

[1] **Ms Madeley:** Bore da a chroeso i gyfarfod y Pwyllgor Iechyd a Gofal Cymdeithasol. Fel clerc y pwyllgor, ac yn unol â Rheol Sefydlog Rhif 17.22, rwy'n galw am enwebiadau ar gyfer Cadeirydd dros dro ar gyfer cyfarfod heddiw.

Ms Madeley: Good morning and welcome to this meeting of the Health and Social Care Committee. As committee clerk, and in accordance with Standing Order No. 17.22, I call for nominations for a temporary Chair for today's meeting.

[2] **Leighton Andrews:** I nominate David Rees.

[3] **Ms Madeley:** Gwelaf nad oes enwebiadau eraill, felly rwy'n datgan mai David Rees sydd wedi'i benodi'n Gadeirydd dros dro.

Ms Madeley: I see that there are no other nominations and I therefore declare that David Rees has been appointed temporary Chair.

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[4] **David Rees:** Thank you. I welcome Members to the meeting of the Health and Social Care Committee. The meeting will be bilingual and headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification on channel 0. I ask everyone to please switch off their mobile phones and other electronic equipment, apart from your electronic computers, so that they do not interfere with the broadcasting system. There is no fire drill scheduled for this morning, so, if there is an alarm, please follow the directions of the ushers.

[5] We have received apologies from Darren Millar and Elin Jones this morning. We

obviously also have the appointments of Vaughan Gething and Ken Skates to the Government and Leighton Andrews and I are here on their behalf as substitutes. Are there any declarations of interest before we commence the meeting today?

[6] **Leighton Andrews:** I should declare, Chair, that I am an honorary professor at Cardiff University's School of Journalism, Media and Cultural Studies, given that we are taking evidence from one of its lecturers.

[7] **David Rees:** Thank you.

9.31 a.m.

Ymchwiliad i'r Achosion o'r Frech Goch 2013—Tystiolaeth ar Lafar Inquiry into Measles Outbreak 2013—Oral Evidence

[8] **David Rees:** I thank the witnesses this morning for the written evidence that they provided. Could you introduce yourselves, please, to the Members?

[9] **Dr Millington:** I am Ian Millington, general practitioner and secretary of Morgannwg local medical committee, representing all the GPs in Neath Port Talbot, Bridgend and Swansea.

[10] **Dr Hayes:** I am Sara Hayes, director of public health for Abertawe Bro Morgannwg University Local Health Board.

[11] **Mr Jones:** I am Andrew Jones. I am the director of public health for Betsi Cadwaladr University Local Health Board.

[12] **Dr Richardson:** I am Dr Gill Richardson. I am the director of public health for Aneurin Bevan Local Health Board.

[13] **Mr Burge:** Good morning. I am John Burge from Neath Port Talbot County Borough Council and the schools governance officer.

[14] **David Rees:** Thank you very much and good morning and welcome. Normally, you would have an opportunity to give an opening statement, but because we have a tight schedule today, we will go straight into questions, if that is okay. We will start with William.

[15] **William Graham:** Thank you, Chair. Thank you for your evidence. I have a more general question to ask you, if I may. I think that I saw published that, in the years before, the actual numbers of people who had measles were relatively small—literally in the hundreds. So, could you give the committee an idea of why, in this particular year, the numbers were so great? Was there a particular vector that caused that?

[16] **Dr Hayes:** I think that if we look back over the last few years, Wales has been very good at keeping the level of measles down. There was an outbreak in 2012 in north Wales that Andrew might want to talk about, but by and large, we were measles-free. If we imported a case, there was an extensive case control investigation and lots of MMR vaccinations were given, so we managed to contain it.

[17] However, measles is endemic in England and it is inevitable that we will import cases from England and elsewhere—it is not just England; it is endemic in parts of Europe. So, what has happened over the last six months is that, rather than us being able to contain it, it just spread. We can talk about that later on. Our level of measles has been very low in Wales,

because we have had very active contact tracing, and very active MMR vaccination programmes.

[18] **Mr Jones:** In relation to north Wales in 2012, there was a small outbreak, if you like, which was in a more rural community. That was identified very quickly and a similar sort of response to what you have seen in Swansea, but proportionate to the risk, was put in place very quickly, with an outbreak control team. Again, as Sara said, if I can use north Wales as an example, we have been persistently looking at a planned approach to increasing the amount of immunisation among children, particularly in terms of MMR. That helped in relation to being able to bring an outbreak, when it happened, under control and to keep raising the level of uptake. I think that we will have some discussion around that this morning and I am pleased to say that in north Wales, and elsewhere, we are continuing to increase that level of immunity in the community, which has been a challenge, as you know.

[19] **Dr Richardson:** I will just add that we have been very successful at small-scale outbreak control. We have responded well to clusters of children, but the pace of this outbreak was such that—I do not know if it was a particularly virulent strain; I do not know the reasons for it, but it seemed to be a very infectious agent. I am sure that there will be further studies into that aspect by the scientists.

[20] **William Graham:** Are you confident that the level of preparedness was available at the time, and that it was just other factors, as you tried to describe, that caused this particular incident to be so widespread?

[21] **Dr Hayes:** In the context of Swansea, we had a vulnerable population in the high school age group, and that was part of the problem. However, we have taken measures to address that, which I can talk about now, if you want me to.

[22] **David Rees:** No. May I ask one question on that? In the experience of Swansea, was a large proportion of cases in that age group?

[23] **Dr Hayes:** Yes, they were.

[24] **William Graham:** So, we could say that it was a localised outbreak in essence.

[25] **Dr Hayes:** It started as a localised outbreak, but it involved Swansea, Neath Port Talbot, Carmarthen and Pembrokeshire. However, the peak was seen in Swansea.

[26] **Mr Jones:** In relation to the preparedness of the response, I think that you can say that north Wales, for example, was evidence that we have robust plans to respond. You have seen how they can be escalated in relation to a larger problem. However, our objective is to keep immunity levels growing so that we are not exposed to that type of risk.

[27] **David Rees:** With regard to some of that information, there were a lot of comments in your papers—and thank you very much for those papers—about the incompatibility of IT systems and the need to get accurate child health service records. Was that a problem at the start of the outbreak?

[28] **Dr Hayes:** The quality of the records was not as good as it should have been. It is a complex system. Vaccination is given in a variety of settings and, when it is given, we currently rely on paper records being submitted to the child health system in Swansea. For some reason or other, the records in the child health system were not up to date. That could partly be because of children moving around, and so the children's movements had not been tracked. Children had moved into and out of the area, and our records were not up to date. So, it was a problem.

[29] We overcame it by working very closely with general practice in Swansea, Neath Port Talbot and Bridgend. We submitted the records that we had of children who were under-vaccinated, and asked the GPs to check those against their records and to send back any amendments. That worked very well. It meant that we could update our child health system, but that was just a short-term fix to get through the outbreak. We clearly need to do something more complete looking forward. I do not know what that would look like, but we need to work on that.

[30] **David Rees:** Andrew, is it the same in north Wales?

[31] **Mr Jones:** The child health record system is one of the best record systems in the NHS; that is important to recognise. Ongoing data reconciliation is really important. We are part of a complex system that comes in to support each other, as I am sure you will hear from GP colleagues. So, it is something that, in north Wales, we are constantly doing, as, I am sure, are my colleagues. I think that what we have highlighted as part of this is whether we can do more to make that system more beneficial for everybody—for GPs and patients—and to make it work more efficiently.

[32] **David Rees:** What about the arrangements for Gwent?

[33] **Dr Richardson:** There is always a lag between having the vaccination and having that piece of paper come from the school nursing system into the child health office. The child health office is also dealing with various submissions from general practice. So, the records are always a little out of date. We found some problems, in that some children who lived in Monmouthshire had been immunised over the border by English GPs with whom they were registered, and perhaps we were not aware of all of those immunisations on our system. So, we certainly did the same exercise as Andrew and Sara described, namely asking GPs to submit their understanding of the childhood vaccination status for their populations. We then saw where the individual gaps were, so that we knew exactly which school and which child was vulnerable or not.

[34] **Lynne Neagle:** I want to explore some of the issues around following up on parents. The cohort of kids that is particularly vulnerable would have been missed out when it was covered by health visitors and baby clinics when the MMR scare was at its highest. What exactly are the procedures? You get a slip through the post telling you that your child has to have the MMR vaccine. What happens if the parent does not go to the appointment? What follow-up process is in place, and how consistent is it across Wales?

[35] **Dr Millington:** It is a very active part of what we do in general practice. Most of the people who have not had their children immunised have been invited to do so between 10 and 15 times. In my practice, not only did we have a system to do that but we had a flag on the screen for every contact with the patients, through a health visitor, a practice nurse et cetera. We have written to patients. There was a refusal to have immunisation in the cohort that has not been immunised, despite very considerable effort. Having said that, we have offered immunisation whenever and wherever we can.

[36] To comment on general practitioner records, they are updated in real time, whereas everything else is data that have to be entered later. The most accurate record is probably, therefore, the GP record. Child health records are good, but we need some way of reconciling, which should be electronic.

[37] **Lynne Neagle:** You said that some parents had about 10 contacts. Was that the same contact? Was the same letter generated, or would a health visitor, perhaps, get in touch and say, 'You have not had your child immunised'? How would that work in practice?

[38] **Dr Millington:** We see our patients quite often in Wales. Every meeting is an opportunity to remind people and invite them to have the MMR vaccine. Some of the responses that we get are really quite difficult. I have people who say, 'Every time I come here, you ask me about my child's immunisation status; why do you not mind your own business?' That is a very difficult conversation to have, but I think that we have tried everything else.

[39] Once the outbreak started, I think that things were different. Different methods were used, and I think that they were effective; Sara will probably be able to tell you more about that. However, it is surprising how many people did not listen to the message, and it is surprising how many people have still not listened to it; they do not want to hear it.

[40] **Dr Hayes:** To reinforce the point, back in the times when confidence in the MMR vaccine was low, these children would have had at least one call and two recalls for each MMR dose. They would have had that again at their pre-school booster; they would have had a discussion with the nurse on entering school; they would also have had a discussion on entering high school, or at least the nurse would have informed the family that the child needed the MMR vaccine.

[41] In addition to that, some of these high-school children will have gone through an outbreak of mumps in 2005, when there was a big catch-up campaign. We also had a national catch-up campaign in 2008, I believe—the dates escape me at the moment. That campaign invited these children again and again. These are children whose parents have not responded. What is new this time around is not only that parents are more confident in MMR, but that children want it. I think that there is a big debate about giving children a choice and involving them in immunisation decisions, which would be really helpful to take forward.

[42] **Mr Jones:** We mentioned the school nursing service and the health visitor service, and I would like to take this opportunity to thank them.

[43] **David Rees:** We are coming to the schools; do not worry.

[44] **Mr Jones:** Those services have done a fantastic job. In relation to the committee member's question on letters, I think that what you are hearing is that some of this contact has been personal. It has been about contact on many occasions with a nurse who knows the family, not just in relation to immunisation. That is certainly the case in north Wales, where all such opportunities have been taken. In the written submission, we share the strategy that we use to try to take every opportunity to give every child the opportunity of having the vaccine. It has changed the situation; there is no doubt about that.

[45] **David Rees:** Rebecca, did you have a follow-up question?

[46] **Rebecca Evans:** It was on a different area.

[47] **David Rees:** We will turn to Gwyn at this point, because he has a question on schools.

[48] **Gwyn R. Price:** It is impressive that there is one school here with a 100% immunisation rate, while one school has a rate of 99% and other schools have a rate of 95%. I congratulate you all on working in partnership. Tackling this is all about having a partnership approach. Well done to all of you on that. What further work is needed to ensure that all schools reach the 95% vaccination rate target? Could you expand on that?

9.45 a.m.

[49] **David Rees:** We will turn to Sara first; we will go through the three health boards, and I will then ask John how it works.

[50] **Dr Hayes:** At the moment, the MMR status of children is reviewed on entry to primary school and high school. A new schedule is coming in for schools, with flu vaccinations for year 7. There is a new vaccination coming in for meningitis group C, with a teenage booster. All of a sudden, the vaccination opportunities in schools are doubling. We need to ensure that the MMR records are checked at each one of those vaccinations, and that the family is given the opportunity to have the MMR. We cannot make policy today, but I will look in my local patch to see whether we can offer the MMR at the same time as we offer other vaccinations in schools. I think that that would be much easier for the children. We have quite a good response rate for other vaccinations, so let us build on that.

[51] The other thing that we need to do is check the child's health record against the GP record and the school record, maybe annually, so that our records are much more up-to-date on a routine basis. Those would be the two things that I would be looking to do on a local basis, while, perhaps, having the discussion nationally. We need to look at these things. Maybe some of them will not happen, but those are the things that I will be looking at.

[52] **Mr Jones:** Thank you for acknowledging the partnership. We need to relay that back to our local partners, because it really felt like partnership. Everybody recognised the different risks that were around—north Wales was in a different position to Swansea. Our response was very much to provide a general approach but also to target. We were working with the education authorities to go—particularly with the school nurses—to the schools where we knew there were perhaps more children who were more at risk. That is one of the lessons that we had learned from the Gwynedd outbreak, and that we are learning again from this one. One of our next steps is to continue working with education, not offering to everybody, but trying to work with those areas where we know that there are still some children who need vaccination. I will give you an example from a border point of view. There was an outbreak in Powys as well, which was close to the north Wales border. Our immediate response was to go to the schools in that catchment. Even though some of their uptake was very high—one of the schools was at 98%—we looked to have further conversation to get it up to 100%, because that is the objective.

[53] **Dr Richardson:** We will also be looking to increase the availability of MMR through school nurses. We learned that young people who were 16 or older could easily give their own consent and make their own health decision on immunisation. Many of them self-consented. The other thing to note is that our school nurses are going to be required to deliver meningitis C and intra-nasal flu vaccinations from this year. So, they will be having ever-increasing contact with schools. The capacity of school nurses is crucial to this.

[54] **David Rees:** John, could you comment on this from the schools' perspective?

[55] **Mr Burge:** By all means. Mr Price, you acknowledged the partnership working between the health board and the local authority at the beginning of your question, and you thanked us for our contribution. I would like to take this opportunity to give thanks to the schools for their partnership working. I am expressing Neath Port Talbot's point of view, where the partnership working was at its best at the beginning of the outbreak. Our schools, our headteachers and the administrative staff, on week one of what we call the school response to the outbreak, were tremendous. They gave up their school holidays. During the Easter break, they came into school, started to put the logistics into place, contacted parents, and decided what they were going to do on the first day back after half-term. It was brilliant. I could not ask for anything more. I am sure that, later on, you will come to the lessons learned and what we could do better. I am not sure that I could do anything better in respect of our

schools. That partnership approach was great, and so was the partnership approach with the health board. We were invited to attend meetings. We were included on distribution lists and given all of the information that everyone else was given during the outbreak. We really felt that we were being included in everything. It was a great partnership approach.

[56] **Gwyn R. Price:** I will touch on that, if I may. Not all schools have access to parental text messaging. If the Welsh Government could take this up, would it be an advantage to take this forward?

[57] **Mr Burge:** Absolutely, yes. I mentioned that in my written evidence. This was a fantastic demonstration of technology, and how we were targeting hundreds of parents and pupils at the same time through different media, including the texting service that is in the majority of schools, but not all our schools. I did not know that until a certain time, because I do not have much involvement in the texting side of things, but I did on this occasion and therefore learned how well schools were using it and how they can target the whole school population, year groups and individual classes. Nearly everybody has a mobile phone these days. Most of the pupils have mobile phones, and the simplicity of how they can send messages directly, instantly, is a feature. I think that there is an opportunity to roll out this programme to include all schools, and it is possibly an initiative that the Welsh Government could look at.

[58] **David Rees:** Dr Millington, would you like to give a perspective from a GP point of view in relation to the schools?

[59] **Dr Millington:** Basically, we work closely through the health board on the schools. They took the lead on it. We provided back-up where people were not immunised in schools, when they missed the sessions et cetera. The effort from general practice was magnificent in our area. Over 16,000 vaccines were delivered at a time of quite a heavy workload anyway, and once we got going—and it did not take very long to get going—I do not think anybody was turned away. People said that they could not get their immunisation, but when they were analysed, it was seen that that was when they turned up and demanded it immediately, and that is quite difficult when you have sick people in the waiting room. However, the response from general practice was excellent and the numbers speak for themselves. The whole thing was a team approach. I represented the GPs on the outbreak control group and we worked very hard to do that, and I think that it was an example where we have learned from flu. The flu planning, which Sara and I were involved in, was a good starter-for-10 on this. We had things in place. We had an outbreak enhanced service ready to go, which had come from a previous outbreak. So, the pieces of the jigsaw were there. We just put them together, and it worked very quickly.

[60] **Dr Hayes:** Primary care did have an impact on the schools programme as well, because we had practice nurses supporting immunisation sessions. So, it really was an integrated response.

[61] **Kirsty Williams:** Obviously, there was a huge amount of communication going on. People were being bombarded with messages, either from their GP surgery or via their school. In some ways, I guess, you picked off the low-hanging fruit—the people who wanted to engage and were, therefore, demanding their vaccine. What analysis, if any, were you able to carry out of why people continue to refuse to take up those opportunities, because, even in the face of all the publicity and the apparent risk, there were people still not wanting to engage in that? How does that then affect any future plans that we have? If we try to produce a message, we will have to be able to respond to the underlying beliefs people have about why they have refused to date. I wonder what analysis you have been able to carry out about why people were refusing in the face of all the publicity and effort to get people vaccinated.

[62] **Dr Richardson:** We were working very closely through this with Public Health Wales, and this was exactly one of the issues raised during the outbreak response. Public Health Wales offered to help Sara's area and mine—particularly the Monmouthshire area, which I was concerned about—and to call in the evenings parents and children who had not consented, so that we could get a good idea whether it was just that there was a letter in the bottom of the school bag or whether a parent had taken their child for immunisation but that it was over the border and we did not have that information, and then to have a conversation with those who were true decliners about the reasons why they did not want this. Further work will need to be done to address some of those issues. Some of it is still related to the Andrew Wakefield scare and the fact that a well-respected medical journal published that research. Therefore, from the point of view of the public, there must have been some truth in that, even though, later, the same journal published other studies that refuted it.

[63] So, some of it is still catch-up from the scientific evidence point of view. For others, it is, possibly, more about an anti-interventionist view that things should be natural. Some parents perhaps have a short memory as to what happened before routine child immunisation. They were not alive at the time of mass polio outbreaks and iron lungs. So, there is, perhaps, an ethos that we should be having natural food and organic products and that immunisation is an external agent that is introducing something into our systems that should not be there. There is more work to be done, definitely, in trying to understand those true decliners for some of those reasons. However, with a lot of people, it was just that they had not realised that the research evidence had come full circle.

[64] **David Rees:** May I ask, we have a tight time schedule, so if you want to comment on additional issues, please do so, but otherwise—

[65] **Mr Jones:** I will comment briefly, Chairman, because I think that we also need to acknowledge that we have a 95% uptake in probably all age cohorts as a result of what we have done. So, that is really good, but there is still more to do. It is complex, as Gill said, but I also highlight, Chairman, that you will see from our action plans and those of the other health boards that particular actions were taken for particular groups as well. I am thinking of looked-after children and those people who, for what might be a range of reasons, were treated specially, or there was a special direction in relation to them. However, it is an area where we need to understand a little bit more in relation to the resistance that is there among those who remain.

[66] **Dr Millington:** I have not done a detailed analysis. I can certainly give you some anecdotal evidence. I was in practice all the way through the Andrew Wakefield information and the active campaign by the *South Wales Evening Post* and a few very vociferous families, who are a small number of people who will not have any immunisations. That often relates to the Travelling population and, as was said, the natural approach to health. There was a much bigger number who were uncertain as to what was going on. I think that, at the time of the *Evening Post*-Andrew Wakefield information, it was not balanced, and people still hear 'MMR' and think of autism. Those are the people who, if in doubt, do nothing. That is, in effect, what they are doing: they are doing nothing.

[67] I think that it is interesting that we also had a population who had never seen measles. I certainly had colleagues who had never seen measles, and they did not know how bad it could be. We had parents who had never seen measles, and we actually had grandparents who had never seen measles. I think that that was the issue. We lost an opportunity at the time of Wakefield. We needed to indicate just how awful these illnesses are and, from there onwards, we had been fighting a losing battle with that element of the population, until we had the outbreak, and now we are winning. The younger cohort has been immunised and the older cohort was immunised. It is the group in-between that we have had to really target and work hard at. We could add things like travel vaccination—why do we not suggest that that is part

of mandatory travel vaccination? After all, you have more chance of catching measles abroad than you have any of the other diseases.

[68] **David Rees:** Thank you for that. I might come back to the training issue later, but, Rebecca, you have a question.

[69] **Rebecca Evans:** It follows on from what Dr Millington was saying about colleagues not having seen measles much in recent years. The charity Sense Cymru has suggested to us that, because it was not seen in surgeries, young doctors particularly might have missed opportunities to diagnose it. The BMA has said that myths around the MMR vaccine were shared by some health professionals and were communicated both directly and indirectly to patients, which also contributed to a low uptake of the MMR vaccine. Do you recognise those concerns, and what can you do about them?

[70] **Dr Millington:** I do recognise them. I think that the need for training has now probably passed; I do not think that there are many GPs in Wales who have not seen measles, so I think that that issue has gone. On the idea of negative images, we have all had to search our hearts to decide what to do with our children. I am absolutely convinced about where we are on this. I looked after a fever hospital for the first five years of my career. I am definite about it. So, I think that the answer is that we now have a population of health professionals who are convinced. We are going through the same thing with flu; not all the health professionals are convinced about flu immunisation. We do have some work to do on it. I am not sure where you do that work, because it is about hearts and minds, not education.

10.00 a.m.

[71] **Rebecca Evans:** I have another hearts-and-minds question, I suppose. Aneurin Bevan health board, in its evidence, said that uptake of the MMR vaccine among healthcare staff themselves has been disappointing, despite a proactive approach to promoting it. What can be done to encourage healthcare staff to take up this vaccine, and the flu vaccine, to protect themselves and patients?

[72] **Dr Richardson:** Our healthcare staff obviously have free will and choice in this. It is not the same as it is in some other countries in Europe, or America, where, if you are not immunised, you would not be allowed into work. While I sympathise with everybody having a choice, when there are healthcare professionals who are treating people who are vulnerable, I believe that they have an ethical duty, as part of their post, to be immunised. We push quite strongly not just the MMR, but, every year, the flu vaccine, among our staff, because they could be somebody who transmits flu from one patient to the next, and they could actually be a source of infection within the hospital. So, it is really important that we win their hearts and minds as well, and put their anxieties to rest as regards the research. It is very difficult. Healthcare workers are often very busy looking after their charges, and their own health is the last thing on their mind. They often neglect their own health, but our occupational health departments are really trying to make it easy, taking vaccination to the wards and making it easy for people to access drop-in clinics at any time of the day. It is part of our response as a health service to encourage our staff. However, personally, I would really favour a health passport for organisations. That is something that we would strongly welcome in public health.

[73] **David Rees:** I am conscious of the time and we still have a couple of questions to go. Leighton Andrews is first on this point, and then another question, please.

[74] **Leighton Andrews:** I am interested in what you said about all health workers having to prove that they have immunisation. Would you have to change people's contracts to ensure that that happened?

[75] **Dr Richardson:** That would be necessary.

[76] **David Rees:** Leighton now has questions on communications, and then we will have Lindsay.

[77] **Leighton Andrews:** I will start with Abertawe Bro Morgannwg. You gave us your strategic immunisation and vaccination action plan for 2011-12. There are a number of objectives that you set out: seasonal flu, HPV and all routine childhood vaccinations, but the initials that do not appear in your immunisation and vaccination action plan are 'MMR'.

[78] **Dr Hayes:** That is because one of the aims was to have all vaccinations completed by age four or age five. That would have included the two doses of MMR. What it did not include was the catch-up side, which was not part of the programme that year.

[79] **Leighton Andrews:** You have an action plan here for 2011-12, and you have known that you have a historical problem in your health board, but MMR was not in your action plan.

[80] **Dr Hayes:** Yes.

[81] **Leighton Andrews:** Has that been changed for future years?

[82] **Dr Hayes:** Definitely. We look at MMR very closely now. We will be pushing to get 95% coverage with the two doses from now—we are very close to it. It is the case that we were not looking at the catch-up part of MMR at that stage.

[83] **Leighton Andrews:** As you communicate with the health board, what kind of conversations, meetings and discussions do you have around the immunisation and vaccination plan with the communications team in your health board?

[84] **Dr Hayes:** I personally did not have communication with it on the plan. I have obviously done extensive work with it on the outbreak, but that is a separate issue. Going forward, however, we are looking to do quite a lot of work on the issue of measles, mumps and rubella, so we are going to have a campaign locally on those issues with the communications team on board.

[85] **Leighton Andrews:** I have no issue with the communications once the outbreak had started, which, as far as I can see, seem to have been excellent, but I want to ask each of the boards: to what extent do you, as the medical directors, engage with your communications teams on a formal basis in planning the communications for immunisation and vaccination during the course of any year?

[86] **Dr Hayes:** May I come back on that point? There would be formal communications whenever there is a change or whenever there is something to announce. So, for any programme, there would have been communications. On the introduction of new vaccines, my communications team did a lot of local work on the rotavirus vaccine coming in, for instance. So, for the routine changes, there is a lot of communication.

[87] **Leighton Andrews:** Okay, let me be very precise in my question, then, to each of the boards. Do you have regular meetings with your head of communications to discuss the overall communications strategy in the area of immunisation and vaccination?

[88] **David Rees:** Please give short answers.

[89] **Mr Jones:** Yes, in relation to a whole range of public health issues. It is really important. This is an opportunity to raise the profile of prevention and early intervention. So, in relation to immunisation, from the north Wales perspective, perhaps because we had had an outbreak, we had ongoing communications in relation to that. By that, I do not just mean outward media communications, but to GPs and to other bits of the system, because we were in the place we were. However, I really do think it is an opportunity to raise the profile of communicating immunisation generally and routinely, and other public health early intervention issues.

[90] **Dr Richardson:** We have a group called STRIVE, strategies to raise immunisation and vaccination for everyone, and that is mainly about communications. Also, at the centre, at Public Health Wales, there is a vaccine-preventable diseases programme. Dr Richard Roberts has a lot of national materials that he would like us to roll out on a local basis. So, there is usually quite a lot of interaction between what is coming out centrally—on new vaccines, say—and what is happening locally on reinforcing the programmes that are there.

[91] **David Rees:** Lindsay is next.

[92] **Lindsay Whittle:** Good morning to some familiar faces. We heard earlier about the schools, and there we have quite a captive audience—I think it is called ‘herding’, which is not a word I like, but I fully understand that word. However, I want to talk about hard-to-reach groups. We have had some evidence about prisons, Gypsy and Traveller communities, ethnic minorities, and looked-after children have just been mentioned. I am particularly interested in the work that all of the health boards did with those hard-to-reach groups. No-one is talking about students and homeless young people, whom I am concerned about as well. All too often, we see many younger homeless people on our streets. We have had one death, of a young man, so this is clearly a young person’s illness, is it not? What about festivals? Are there any public awareness campaigns at festivals? We have the Urdd Eisteddfod and the Green Man Festival, and there will be other festivals throughout the summer. Will there be any public awareness campaigns at those festivals?

[93] **David Rees:** Can we start with ABMU, Sara, and then we will move across?

[94] **Dr Hayes:** At our first outbreak meeting, we invited in the homelessness nurse from Swansea. She came in and she got fully briefed, she went off and vaccinated, and she continued vaccinating relentlessly. I have asked a colleague for the numbers, and I have not had the numbers back yet, but I know that she was still vaccinating a month later because of correspondence I had with her in relation to a certain case. So, we did target homeless groups. We had a very strong campaign in our prisons, which is in the report. We did hundreds of vaccinations in our two prisons, and that was for staff as well as for prisoners. That programme is ongoing. We linked with our universities and colleges in our patch and, in particular, we encouraged students coming to Swansea University to have their MMR vaccination before they started their next year. However, we have also asked the university itself to promote the MMR and direct students either to go to their own GP on site, or the GP where they were working. So, we had contact with all of those groups.

[95] **Mr Jones:** The same happened with both universities in north Wales, and, indeed, a number of tertiary sixth-form colleges. With regard to the at-risk groups, as they were described by the committee member, and the action plan—we do not have time for it now, Chairman, but we can provide further detail—there was absolutely contact with those groups, including contact through the substance misuse service, where we know there are people who find it difficult sometimes to reach healthcare services. So, as I described earlier, there was a deliberate approach to those cohorts.

[96] **Dr Richardson:** There were Twitter and Facebook campaigns aimed at students. We

also worked with Newport university, and some bars that students frequented were even able to publicise the drop-in clinics.

[97] **Lindsay Whittle:** It is a tough job, but someone has to do it. [*Laughter.*]

[98] **Dr Richardson:** So, it was comprehensive. With regard to the emergency response by the Gypsies and Travellers, we found that parents in the travelling community were quite welcoming of health professionals. Whereas in the past we have perhaps had reticence, they welcomed the health visitors they knew to do these immunisations.

[99] **Lindsay Whittle:** There are some phenomenal figures on Facebook, which are really interesting. There are phenomenal figures in this evidence.

[100] **Mr Jones:** To add to that, even though we were in a very difficult position in relation to doing things swiftly—and I know that colleagues did the same—we also went to schools and had some focus groups with young people to understand what messages they might best like to receive. That is a key part of listening, in relation to being given messages via technology, namely to be informed by the receiver.

[101] **Dr Hayes:** We also related the message to all children going to the eisteddfod. We reminded people to have the MMR vaccine before the event.

[102] **David Rees:** Thank you very much for attending this morning and for giving us your evidence. It is very much appreciated. I have a final question before you go. We are looking at the future as well, and we understand that there could be a measles outbreak anywhere and that there could be consequences. This question is for the three health boards: are you in a position to deal with the next outbreak far better than this one, because 1,000 plus cases is clearly a large number?

[103] **Dr Hayes:** Our MMR uptake rate is so much higher and we are less likely to have such a big outbreak. We have mobilised immunisation staff very quickly, so we are confident that we could deal with it very quickly next time.

[104] **Mr Jones:** As you saw from the north Wales outbreak, there will be lessons to learn. I am sure that there will be a formal structured debrief nationally, led by Public Health Wales, and also locally. As I mentioned earlier, we are at 95% for the first dose, and the health board has committed to doing the next step, which is getting 95% for the two doses.

[105] **Dr Richardson:** The anti-viral flu distribution plans and the clinical emergency response plans that we had have been built on, as has been said earlier. This outbreak operationalised that. The fact that public health, primary care and secondary care were all in the same organisation meant that we could mobilise resources quickly with our partners in local government. It means that we have tested it out, and that we are in a strong position to respond to future threats, be they measles or anything else.

[106] **David Rees:** Thank you very much, and thank you again for attending. A copy of the transcript will be sent to you to check for any factual inaccuracies. Thank you very much; we appreciate your time.

10.13 a.m.

Tystiolaeth ar Rôl y Cyfryngau Evidence on the Role of the Media

[107] **David Rees:** I welcome Dr Andy Williams from the Cardiff School of Journalism, Media and Cultural Studies to the meeting. Thank you for the written evidence that you provided to the committee in advance of the meeting. Given our tight schedule, we will not offer you the opportunity of making an opening statement; we will just go straight into questions. Leighton Andrews will start with a question on communications.

[108] **Leighton Andrews:** Andy, can you give us your views on the *South Wales Evening Post's* coverage?

[109] **Dr Williams:** I think that the situation in Swansea was made worse by the fact that the *South Wales Evening Post* took a critical line on MMR. It gave quite a lot of prominence in its coverage to concerned local parents who, it turned out, wrongly believed that their children were at risk from the MMR vaccine. *The Guardian* pointed out that the *South Wales Evening Post* was earlier than the rest of the UK press in reporting MMR in a sustained way. Its coverage started in 1997, and a key news source for it was a solicitor called Richard Barr, who later commissioned Dr Wakefield to do the notorious *Lancet* study. So, it is important for us to bear in mind that there were anti-vaccination vested interests behind the scenes in Swansea years before the national media scare took off in 2001-02 and 2003. It should also be borne in mind that Swansea journalists were not alone in, essentially, misinforming the public on MMR. The defence that some have mounted recently is, I think, quite surprising. The ex-editor of the newspaper, George Edwards, claimed that they reported MMR like they did because their readers were concerned about it. He even said that they would do the same again in the same way if it were to happen today.

10.15 a.m.

[110] It is true that one of the things that newspapers should do is to reflect public debate and concerns among their readership. That is not all that they should be doing. They also have a responsibility to check their facts, to check the evidence behind what they report, and when that evidence is too complex to understand or too jargonistic, they should consult relevant experts to ask them for help in interpreting the findings and putting them into some context. Edwards also said, and I quote, that

[111] ‘Newspapers listen to their readers, report what they say, and then they go to the relevant people and say “what have you got to say about this?”’

[112] I can understand that sentiment, too. He talked about reflecting public debate before, and now he is talking about the watchdog function of the press. I think that the *South Wales Evening Post* too often took the wrong information to the wrong people. It should have been debunking, far more than it did, the claims that were made about MMR and the clever spin that accompanied those claims. There were many public health experts on hand who were willing to do that. In fact, the *South Wales Evening Post* did quote them on numerous occasions, but it balanced those quotes too often, which is part of the problem. Instead, it too often took shoddy evidence and bashed politicians and doctors over the head with it. This was the wrong call and it had consequences. Too much of the media scepticism in Swansea was directed at officials, and not much of it, and not enough of it, was directed at the claims that were being made. The *South Wales Evening Post*, specifically, spent too much time reporting the fears of scared parents—who are not to blame in all of this, I do not think—and not enough time putting those fears into context, checking them out and calming things down.

[113] **David Rees:** May I ask a question, before we go into an attack on the *South Wales*

Evening Post, which I do not want to do? Is it fair to say, therefore, that this approach is generic to local newspapers rather than to national newspapers—as in the approach that they take in expressing opinions and views on national issues such as this?

[114] **Dr Williams:** Campaigning journalism is very popular on a local level and on a national level, too. I do not know whether this was widespread or whether it happened in any other areas in the UK. I have not been alerted to many instances where a local newspaper took the lead on MMR reporting in the late 1990s.

[115] **David Rees:** So, the only evidence that you have is the *South Wales Evening Post*?

[116] **Dr Williams:** Yes.

[117] **Leighton Andrews:** I think that you have established that the position of the *South Wales Evening Post* at the time was morally repugnant, frankly. May I just—

[118] **Dr Williams:** I do not think that it was morally repugnant. I think that it backed the wrong horse.

[119] **David Rees:** May I ask a question? You say that it ‘backed the wrong horse’. Is that because it had not undertaken the investigative journalism that you would have expected it to have done to balance it out?

[120] **Dr Williams:** I do not even think that it takes sustained investigative journalism, uncovering all sorts of—investigative journalism implies a sustained effort to investigate something. This is more about making the calls, checking them out, and putting the claims of readers into context. That was not done. Well, it was done, but it was balanced. The issue of balance in the reporting of MMR in the national media and in the local journalism of the *South Wales Evening Post* was pretty much the problem here. The story should have been spiked early on. There was no evidence. Even when the evidence that later sparked the health scare at a national level emerged, there was no evidence. I am sure that you have all read the Wakefield paper, which said, ‘We’ve found no link between the MMR and autism’.

[121] You asked why that happened, and the reasons for it, I think, lie partly in the news values, so controversy, scientific conflict are attractive to journalists. Another sure-fire hit with local news audiences are editorial campaigns. They can boost sales considerably. A journalistic prize, I think, was won for the campaign that was run on this in the late 1990s. So, the reason was partly, probably, financial—boosting sales and boosting readership. It is also very possible that the journalists at the *South Wales Evening Post* simply made a mistake. We have seen real cuts for decades to local media, as you all know, and this has put huge pressure on journalists to produce more copy in the same amount of time, and so the squeeze from those cuts was already being felt.

[122] **Leighton Andrews:** Can I come in on that, Andy, if you do not mind? You make the point about cuts and you talk in language that I understand about information subsidies that are provided to news outlets by well-resourced PR operatives, but, arguably, there are quite significant PR resources being directed at the truth here. There are substantial charities, public health budgets and so on that are providing information subsidies to inform in terms of the reality. What does that say to us about the effectiveness of public health campaigns on this?

[123] **Dr Williams:** I do not think that it really says much about the effectiveness of the public health campaigns. It tells us a lot about the priorities of what makes a good story. The attractiveness of this story, the conflict between different social groups and the controversy that it caused, and the politicised nature later on when Tony Blair was involved, makes this story very attractive to news journalists. That gathered a momentum of its own in the later

national health scare, and it became a story that was too difficult to ignore.

[124] **Leighton Andrews:** I am not sure about that. How, then, do you evaluate the effectiveness of public health campaign budgets?

[125] **Dr Williams:** I do not have any research evidence to evaluate that.

[126] **Rebecca Evans:** Is there any evidence to suggest that the public trusts what it reads in a newspaper more than, for example, information through the door from a public health campaign or from politicians on the television and so on?

[127] **Dr Williams:** I am not aware that there is anything that directly compares public trust in news media with public trust in health officials. However, public trust in journalists of all sorts is quite low and has been for a number of years, although local journalists retain higher levels of trust than many of their national counterparts.

[128] **Kirsty Williams:** You say in your paper that one of the ways in which the news media messed up when reporting MMR was by balancing the news sources they quoted in their stories. It is difficult to understand from your paper whether you make a distinction between print media and broadcast media. Have you had an opportunity to look at whether reporting via the print media was particularly prone to this and that the broadcast media were perhaps more balanced in their approach, or does your statement cover both sides?

[129] **Dr Williams:** It covers both sides. The evidence on which I am drawing was carried out by Tammy Boyce at the School of Journalism, Media and Cultural Studies at Cardiff University, where I work. She found that that balance was a dominant way of reporting MMR across platforms, across the newspapers and across broadcasting. You are right that there is a political difference to some of the reporting; the right-leaning Conservative press was more likely to report only the anti-MMR views and evidence. However, on the whole, the broadcast media and newspaper journalists were equally to blame, if you like, for using this false balance, as it has become known among the science journalists.

[130] It is very clear when you look at the evidence about how MMR was reported that balance was an issue, and in Tammy Boyce's study, she found that around 30% of stories in the national media—in broadcasting and in newspapers—included only anti-MMR information. So, 30% backing Wakefield, if you like, and that was mostly in the right-leaning press. Around 20% contained only pro-MMR information. So, the public health message was there on its own in only 20% of the coverage. That left around half of the coverage that balanced the evidence presented on both sides. The problem when you balance science news, as opposed to when you balance political news, is that you are often not balancing opinion, rhetoric or the strength of people's arguments in convincing something; you are giving the impression, when you talk about science news in a balanced way, that the evidence is equally weighted on both sides. In this case, it was not. There was no evidence on the anti-MMR side, but there were very clever media manipulators who played a very clever PR game, and they did very well.

[131] **Kirsty Williams:** Obviously, at the height of this furore, *The Lancet* went on to rubbish the Wakefield study. Were you and your colleagues able to carry out any analysis of media coverage of MMR, once the research had been debunked and once Wakefield had been exposed for what he was. From the last guests, it seemed that we almost sat back. The response once the measles outbreak happened was exemplary, but there were years in between when not a lot went on. I just wonder whether you looked at any of the media coverage and that gap between the height of the scandal, the scare stories, and the outbreak, and what happened in between that in terms of media reporting of MMR.

[132] **Dr Williams:** I do not have any comprehensive evidence. I should state that at the start. But, I do teach about this and I lecture about it year on year, so I have followed the story over the past five to six years and I am familiar with some of the coverage. It got better. The idea of false balance, especially among specialist science reporters, is now regarded as a trap to be aware of, but less so among generalist reporters, it has to be said. That said, there continued to be a drip, drip association between MMR and autism in some quarters of the press and some quarters of the broadcast media. There was a very notorious talk radio show on LBC Radio that was broadcast by Jenni Murray a few years back that sparked a certain amount of controversy and criticism, but that is by no means an isolated example, and things got better, broadly speaking. That is my impression.

[133] **David Rees:** Dr Williams, you say that they got better. I think that you used the words, 'People—scientific journalists—got to realise that a balanced argument had to be addressed properly'. Was it therefore fair to say that, when it originally happened, they were not aware of the implications of a balanced argument, even though the evidence was not there?

[134] **Dr Williams:** Balance is a dominant notion in contemporary journalism. It is still taught as best practice in journalism schools across the country—mine included. It is commonly regarded by journalists as a signifier that the story is fair—seen as proof that the journalism is not biased. That is an ingrained part of the way that journalists work and their practice, training and ideas about what their profession should be doing. So, it took a long time for the research base about balancing science news to filter through. Some of it was done around MMR, and some of it was done around climate change, because that is an issue as well, where the overwhelming amount of evidence is on one side and there is very little on the other, but the sceptics get a lot of media coverage. It took a while for that to filter into the journalistic practice of specialist science journalists. There is a lot of awareness of it now among specialist science journalists, but it took, I would say, until after MMR for this to become talked about among those professional circles. It is still not seen as a huge issue by journalists who do not report science routinely, or very often. That is a problem, because most science news is still reported by generalist journalists, but that is a long-term issue that should be addressed with training, I think, and perhaps professional guidelines. Training is the key.

[135] **Rebecca Evans:** You referred to climate change as one of those areas where the weight of evidence is certainly on one side. Could you give us any other examples within the health field where one side of an argument is given almost equal coverage to another, despite the fact that it does not have the evidence base?

[136] **Dr Williams:** I mentioned the classic examples; I am struggling to mention any others off the top of my head. When I write my lectures about this, those are the ones that I draw on. I am sure that there are others, but they are the biggies. An example of a field of scientific inquiry where things are quite split, and where balance probably is needed, is the medical effects of cannabis. That is an example that I have heard given to prove the other point. But, it is all about communicating the balance of the evidence and you cannot do that simply by quoting people from both sides. You have to convey, discursively, where most of the evidence lies as well. That is being done more and more by specialist science journalists.

[137] **William Graham:** Dr Wakefield came here to the Assembly and gave quite an interesting talk. I should say that he made no particular claim about his research and I have to say that, at that time, there were two Members who were practising GPs who were not convinced in any way, and made their opinions known. Part of that meeting was about the great sympathy with what Dr Wakefield was saying, with those parents who had autistic children, who are, as you know, a fairly vociferous group. Do you think that they have any influence, even a subtle influence, within the *South Wales Evening Post* that could explain why that story was given prominence, and in one aspect prominently?

10.30 a.m.

[138] **Dr Williams:** Can you rephrase that, Mr Graham? Sorry. Was it whether the parents themselves had any influence?

[139] **William Graham:** As a group.

[140] **Dr Williams:** Yes, they had influence, but as members of that community. I think that—

[141] **William Graham:** Right, but you do not think that they had any other influence, because it does seem strange—

[142] **Dr Williams:** Not that I know of.

[143] **William Graham:** I think that it does seem strange that that newspaper had this irresponsible story, really. Although you have given reasons for why it might have occurred, it does seem exceptional.

[144] **Dr Williams:** It is difficult to look behind the scenes. I was not there at the time, and I do not really know. My reading of it is that they simply made a mistake by not checking the facts, and by not bottoming out the evidence behind what these parents were claiming. There seems to be some prima facie evidence at least that the solicitor who was preparing a case for these parents had some kind of influence; he was quoted a lot back then. Aside from that, it is difficult for me to say.

[145] **William Graham:** That is interesting. When Andrew Wakefield was here, he made himself out—this would have been 12 years ago—to be very much the victim. He had already warned us that he was about to be struck off and that the power and influence of the drug companies would be brought to bear against him with great effect. That was part of his story. I will just ask you this: you mentioned the part of CJD in the BSE affair, but that was pretty quickly knocked on the head, was it not, despite some fairly virulent campaigns, at least in some of the red tops? That never got any credence in either local or national papers.

[146] **Dr Williams:** I cite the BSE affair as the backdrop to this. It is a mitigating circumstance for the press, in that they were given bad advice and information from public health officials and the politicians who were backing them. So, you have to understand the importance of it, and I think that that is its importance: it happened, and the press, largely speaking, did take the Government line and the public health line, and it turned out to be wrong. There was John Gummer, feeding the burger to his daughter, and that is the backdrop to Blair refusing to say whether he had Leo vaccinated not, which was a huge story. When you look at the volume of coverage, something like 30% of the stories were quoting that stuff. There are not many occasions when I have felt sympathy for Blair over the past 20 years, but that is one of them, you know. He seemed to do the ethical thing and not politicise his family in that case. It turned out later—I think that it was in Cherie's autobiography—that they did have him vaccinated, but they did not want to politicise that family issue.

[147] **Lynne Neagle:** I just want to make a point on what you just said. The issue with BSE is that it highlights that there is a key role for the media in scrutinising Government. They are a key part of our democracy, and the Government was wrong about BSE, so that was an important context. However, we are still seeing anti-vaccination stories in the press. The *Daily Mail* and the *Daily Express* regularly run anti-vaccination stories from an ideological position of not liking the nanny-state, public-health input thing. However, we also saw a front page of Andrew Wakefield, in the middle of the outbreak, from *The Independent*, which is a

paper that we all thought should have known better. Do you have any suggestions for anything that Government and public health agencies can do to try to improve communication with responsible publishers such as *The Independent*, and with the tabloids, which have their own agenda, to try to get these messages over in a more effective way?

[148] **Dr Williams:** I wonder if there is anything that can be done about the ideological motivations behind the tabloids that you cite, and I share that analysis completely. It is part of their business model, as well as their ideological model, to splash sensationalist and exaggerated health stories all over their front pages. I think that it is hard to reach and to affect that side of our media system.

[149] As for *The Independent*, its reporters were among the most responsible during the scare, although they did balance their stories too much in the way that I have talked about. I really do not know what is going on there; I would see that as a blip, to be honest. I know that specialist science journalists and editors at all of the serious broadsheets now work very closely with the Science Media Centre, for example. So, that is something that has been done since the MMR affair. The Science Media Centre was launched as a kind of public relations office for science, for when science hits the headlines. It is the controversial, firefighting side of public health and scientific media management. It does a largely good job in many respects and, for me, that is the main thing that has been done.

[150] In terms of what is to be done more broadly, there have been a few attempts recently to come up with some guidelines for journalists to follow when covering controversial science, and the best of them was actually written by the Science Media Centre in collaboration with a bunch of specialist science journalists in the national media when they gave evidence for the Leveson report. They came up with a 10-point set of guidelines. I can forward them to committee if you like. They are very good. I will mention the ones that relate most to MMR. First, state the source of the story, ideally with enough information for readers to look it up or a web link, if it is online, so that we can check out ourselves whether these claims are justified. Secondly, specify the size and nature of the study and mention major limitations, which would have been key in the Wakefield claim—it was a case series study, it was 12 children, and you cannot make any claims based on that. Thirdly, when reporting a link between two things, indicate whether or not there is evidence that one causes another, which is obviously really key in this instance. Fourthly, especially on a story with public health implications, try to frame new findings in the context of other evidence—does it reinforce or conflict with previous studies? If there are concerns, they should not be ignored. Fifthly, if there is space, quote both the researchers themselves and external sources with appropriate expertise—be wary of scientists and press releases over-claiming for studies. Sixthly, distinguish between findings, interpretation and extrapolation by scientists: the findings are where the evidence is, the interpretation and extrapolation is where the arguments are. Finally, headlines should not mislead the reader about a story's context, which is another thing that happened an awful lot with this.

[151] It is not rocket science, is it? It is good solid advice about areas where the news media, and particular elements of the news media, consistently underperform and misrepresent science. That gives me heart, in that these guidelines would be quite easy to follow, but it also worries me, because if they are easy to follow, why are they not being followed by everybody? Your previous question gives us an indication of that. There are serious ideological and, I think, financial reasons why these guidelines are not followed. Sensationalist, controversial and exaggerated public health coverage seems to sell papers better than measured, evidence-based, myth-busting public health coverage. That is something that is just very difficult to get around.

[152] **Kirsty Williams:** However, it is not just the papers. It is not so long ago that I listened to a Radio Wales phone-in programme about the HPV vaccine, and the guest on the

programme was a religious campaigner who was objecting to the science from a religious and personal perspective. That person was the main guest on the phone-in, so it is easy to blame the tabloid press—

[153] **Dr Williams:** It is not just the tabloids.

[154] **Kirsty Williams:** Mainstream, licence-fee-funded media can also fall into these traps.

[155] **Dr Williams:** I am talking mainly about news coverage here, and the kind of science reporting that gets done by journalists at all news institutions. You are absolutely right—the BBC did not have clean hands on this. It balanced its stories a lot and has to share part of the responsibility.

[156] **William Graham:** Could we have those guidelines in evidence?

[157] **David Rees:** Will you be able to provide a copy of those guidelines?

[158] **Dr Williams:** Yes. It is a one-pager.

[159] **David Rees:** Lindsay, you had a short question.

[160] **Lindsay Whittle:** It is just a very small question. Clearly, relationships between Government and the media are good and bad at times. If it is a good story and your name is in it, the politician is happy, but if it is a bad story and your name is in it, you are not happy, and that is the end of it, is it not? It is as simple as that, really.

[161] **Kirsty Williams:** Leighton thrives on both. [*Laughter.*]

[162] **Lindsay Whittle:** Maybe. I am concerned that we have heard evidence from Dr Hillier—I think that was his name—that patients are coming into his surgery saying, ‘Mind your own business’, when asked about vaccination. That frightens me.

[163] **David Rees:** Dr Millington.

[164] **Lindsay Whittle:** I am sorry; I got his name totally wrong. I do apologise. They are saying, ‘Mind your own business’. If you are telling a health professional that, I wonder why you are even bothering to walk into the surgery itself. We had other written evidence that Facebook has had nearly half a million hits on this. Is Facebook the future? I am sorry to put journalists out of work, but there are journalists working on Facebook anyway. How could the Welsh Government work with the media, not just newspapers, but radio, television and Facebook, to get the message across that vaccination is necessary for the future to prevent another outbreak?

[165] **Dr Williams:** I would recommend that, in terms of the mainstream media—the countable media—you work with groups like the Science Media Centre in London, which really has this down pat. It has good relationships with the news media in London and I am sure that it would be willing to work with the Welsh national and regional news media as well. In terms of Facebook and social media, there is very little you can do when it is not a journalist doing this; there is not much you can do when it is a journalist writing about public health or science in this way, but when it is individuals—you might want to call them ‘citizen journalists’—I am at a loss to give you any practical advice, I am afraid.

[166] **David Rees:** Time has caught up with us. Dr Williams, thank you very much for your evidence and for attending today. It has been very helpful to give us an indication of where

we have come from, in the sense of how this was reported many years ago. Thank you very much for that. You will receive a copy of the transcript to check for any factual inaccuracies.

[167] I adjourn the meeting, under Standing Order No. 17.47, for a short break of five minutes.

*Gohiriwyd y cyfarfod rhwng 10.41 a.m. a 10.49 a.m.
The meeting adjourned between 10.41 a.m. and 10.49 a.m.*

[168] **David Rees:** Welcome back. I welcome our witnesses for the next session. I ask you to introduce yourselves and tell us which body you represent.

[169] **Dr Bedford:** I am Helen Bedford, and I am a senior lecturer at the Institute of Child Health at University College London.

[170] **Mr Morris:** I am Nick Morris; I am responsible for policy and campaigns work for Sense Cymru.

[171] **Mr McGill:** I am Joff McGill; I work for Sense and I take a lead on rubella and rubella immunisation issues.

[172] **David Rees:** Thank you for coming this morning. Normally, we would give you an opportunity to present your introductions, but we have a very tight schedule today, so we will go straight into questions, if that is okay.

[173] I will start. This morning, we heard from the health boards about a lack of understanding, perhaps, by some younger health professionals in relation to the impacts of measles and rubella. What are your views? I will start with Sense and move on to Dr Bedford. What are your views in relation to the understanding of the implications of measles and rubella, and where do we go from here?

[174] **Mr McGill:** In terms of an understanding of rubella, I think that it is different to measles and mumps. It is not the disease itself that we are protecting against but the impact of the disease on a woman who is pregnant. It is not the individual themselves who we are solely protecting; it is all of the people around that young person, particularly pregnant women, to whom they might pass on the disease. It is a different protection issue and a different public health message.

[175] Now that we are in an era when, thankfully, there is not a lot of rubella around and we have, largely, curtailed congenital rubella syndrome, it is important that people still remember why we are protecting against these diseases and why there is an 'R' in MMR. That is, obviously, very difficult in the middle of an outbreak of measles, when all of the focus has to be on measles. However, going forward, we need to remind children, parents and young people who need to be protected with MMR what it is we are protecting them against and why that is incredibly important. Through vaccination, we can prevent babies from being born deafblind and profoundly disabled; it is really important that we stay focused on that.

[176] **David Rees:** Is there a general underestimation of the implications and consequences of not having the MMR vaccine and contracting those illnesses?

[177] **Mr McGill:** That is the impact of a successful vaccination programme, is it not? We do not see the diseases, we forget how serious they are and we do not understand their impact. As a young man starting at Sense 20 years ago, I probably did not really know much about rubella, because it was not an issue and it was not surrounding us. As the threat of the disease diminishes, we forget why it is important. Some of the complexities around the rubella

message make that even harder. We still get questions at Sense, such as ‘Why should I immunise boys against rubella?’ There is a simple answer, which is that boys can pass rubella on to a pregnant woman just as easily as girls can pass it on. However, we are still asked that question again and again. We forget about the impact of these diseases, and it is important to remember.

[178] **Dr Bedford:** It is a challenge keeping people’s perceptions of the severity of these diseases high. They are almost seen as Victorian diseases now, because of the success of the immunisation campaign, as Joff said. If you are not seeing these diseases every day, you tend to forget how serious they can be. However, there has always been a sort of myth even around measles, namely that it is a natural part of growing up. Some people believe that having a dose of measles is good for you and strengthens the immune system, which is not the case at all.

[179] **Gwyn R. Price:** Good morning to you all. I congratulated the previous witnesses on working in partnership, and I congratulate you, too, because the Minister has recognised that Sense and the voluntary sector have made a big effort in this latest outbreak. In terms of working in partnership, what can be learned from this outbreak, in your opinion?

[180] **Mr Morris:** I think that one thing that was important in this particular outbreak was that there came a point when the coverage had almost reached saturation and people were seeing the word ‘measles’ coming up again and again. As Joff was saying, this is not just about measles, but mumps and rubella as well. Something that we were able to add there was to approach Public Health Wales to talk about rubella and then do some joint work on it. The key issue here is that you have three diseases that you want to tackle, not just one. There is, perhaps, a way that you can keep things fresh that way, and that was one of the lessons from this outbreak. I think that people will almost switch off after a while—they will stop listening—so refreshing the message and using the knowledge that exists and using the expertise that we have built up in the voluntary sector over the years in supporting deafblind people and their families, was something that we were able to bring to the table. I am sure that there are other partners that could do similar things in different areas.

[181] **William Graham:** I was interested in what Dr Bedford was saying, having been born slightly before the introduction of MMR. The majority survived, did they not? There were about half a million cases a year, or something like that, and not many reported fatalities. It is difficult to get the numbers of those who had very debilitating effects from those diseases. It is a wonderful invention, is it not? More people should take advantage of it. Why is there still a hard core of people who are most reluctant to do so? It cannot just be religious objection.

[182] **Dr Bedford:** Obviously, uptake rates of immunisation are very impressive. The overwhelming majority of people get their children immunised. That needs to be underlined. It is, as you say, a very small proportion—of the order of 1% or 2%—who are totally anti-vaccination. These are people who may have a completely different view about what causes ill health: that it is not caused by bacteria and viruses, but by something internal. We have also developed a population who have been taught to question things and who have been offered choices. They may think that immunisation is something that they can also choose, in the same way that they can choose other things, such as the way that they give birth and those sorts of things. Of course, the power of the internet is quite extraordinary. If you have a slight doubt in your mind about something like immunisation, it does not take very long to find information that will support your view. So, this is about teaching people earlier on about how to assess science and the validity of information, to see what is robust and what is not.

[183] **Mr Morris:** The other concerning thing there is that, as we saw in the Swansea area, when you get clusters of people who have not been vaccinated, for whatever reason, that is when the danger comes. We know that there are other clusters. In written evidence to the

committee, the Minister for Health and Social Services has stated that there are other clusters of which his agencies are aware. So, this is about trying to understand where the clusters are and the reasons why people are in those clusters, such as in the Swansea area, or people in particular age cohorts or ethnic groups. It is about trying to go back not just to maintain the current high rate, but also to address gaps that we know exist and that have arisen from the past.

[184] **William Graham:** We heard in evidence given earlier—and you have obviously seen things in the press—that a number of these infectious diseases are becoming rarer by their very nature. Therefore, it becomes more difficult to diagnose them accurately. I note that you have made some recommendations here. Would you suggest that there should be some form of continuous assessment, so that trainees are made aware of this? Otherwise, it could easily pass again.

[185] **Mr McGill:** It is difficult. Rubella is a difficult disease to diagnose. You may be asymptomatic. You may never know that you have the condition. You might not have some of the common signs, but you might still have the virus. Laboratory testing is the only way to confirm whether you have it, which is one of the reasons why vaccination is so important. You can never think, ‘Oh, that person has or has not got rubella; I will avoid them’. So, it is important that we protect people. The ongoing education of health professionals and others about these diseases, their implications, how to spot them, and—most importantly—what to do if you think that a person may have them, is incredibly important.

[186] **Kirsty Williams:** I wish to look at where we are now. Dr Bedford, your paper seems to suggest that, these days, parents just regard MMR as just one of a suite of vaccines. However, attitudes regarding children born in the years 2000 to 2002 were very different. I note that girls were less likely to be immunised than boys. Is there any useful linkage that could be made in trying to reach those girls who are now teenagers, or who are about to enter their teenage years, in respect of the issue of rubella, and messages to parents about risks to unborn children? When you have a small baby girl, the prospect of her being a parent herself is a very long way away. However, as a teenager, those issues are perhaps more to the mind. As a mother of girls, the issue of rubella and of trying to explain to a daughter why I had not vaccinated her and something happening, such as her catching rubella during pregnancy, was a big motivation for me. Is there anything useful that we could do now with that particular group of pre-teen and teenage girls? Would drawing linkages with rubella be a more useful way of convincing parents and children to get vaccinated, rather than concentrating on the measles aspect of the diseases?

11.00 a.m.

[187] **Mr McGill:** One of implications of the last 15 or 20 years has been that it is no longer a childhood issue; it is a teenage issue and a young-adult-women issue. So, we do need to target all of those groups. I suspect that the message for the teenagers is slightly different to the message for the group of people who are actively planning on getting pregnant. That will be different again for the group of people who just had their first baby but might not be sure of their immunisation status, and I think that there is something that we can do for all three of those groups. As I said earlier, I think that rubella does add something to those public health messages, and we need to get it across.

[188] **Dr Bedford:** There are important opportunities, because we have the HPV vaccine programme, and I think that the teenage years are a period when we will see more vaccines coming in. We are introducing a booster meningococcal C vaccine with the school-leavers booster. So, there are opportunities, but, at all stages in life, whether it is very young children or older children, we need to take the opportunities to remind people. So, when children are entering play groups, nursery schools and pre-school, we need to remind them, because a lot

of it is about people forgetting to get the immunisation. Equally, as they enter the teenage years, we need to remind them of these opportunities and then when they go on to college or university. It is about taking those opportunities that are there; they just need to be used.

[189] **Lynne Neagle:** I have a couple of questions for Dr Bedford. We know that there is a drop-off rate in that some parents give their children the MMR, but do not give them the second booster, and that is highlighted in your paper. We also know that these are parents who are not afraid of the MMR in any way, because they have had the first immunisation. Your paper highlights some social or family pressures that may mean that they do not get round to completing the course. Do you have any more information on what the obstacles were to parents going back for that second jab?

[190] **Dr Bedford:** Again, it is about reminding the people, because the second jab often comes at the same time as the pre-school booster, which immunises against diphtheria, tetanus et cetera. However, often, people do not have such regular contact with health visitors, for example, as they do in the early years. Often, all the information about immunisation is given very early on in a child's life and then they are expected to remember it until the pre-school booster is due at three years and four months. So, again, it is about taking opportunities when children are entering nurseries, pre-school groups and primary school to remind them that it is important, to ask them, 'Has your child had these vaccinations?' and to give them information about where to get them. However, we also need to take immunisation, perhaps, into those locations as well.

[191] **Lynne Neagle:** You do get a letter calling you for the pre-school jabs, with, as you say, the five-in-one jab, and the MMR is on there as well. So, why are people coming to have the diphtheria and the tetanus booster, but not having their MMR?

[192] **Dr Bedford:** Uptake of the pre-school booster is also not optimal. So, we need to improve that as well. They work hand in hand.

[193] **Lynne Neagle:** You referred to various policies that could help with this issue, including the NICE guidance from 2009. I wonder if you have any comments on the level of compliance with the NICE guidance in Wales, or whether you think that there is anything the Welsh Government could do to re-enforce delivery on the ground.

[194] **Dr Bedford:** It is important to take the NICE guidance on board. I cannot comment on the level of uptake on it in Wales. I would imagine that Public Health Wales has been taking it seriously. It has recently been reviewed to see whether it needs to be updated, and it has come to the conclusion that there is no further evidence that needs to go into that guidance. So, it will be reviewed again in a few years. However, with all the guidance that is issued by the Health Protection Agency about training, it is a question of people taking them seriously and looking at them.

[195] **David Rees:** Dr Bedford, you focused on parental attitudes towards immunisation. We heard previously from the communication side of the issues and the impact that local and national newspapers and other forms of media had on the MMR uptake in the 1990s. Is that still a major influence and factor in people's attitudes as to whether they take up immunisation, whether it is MMR or other forms of immunisation?

[196] **Dr Bedford:** It is difficult to take it out of the mix of influences that will inform a particular parent about immunisation. It is difficult to take out anything, for that matter, because the power of your friends, your mum and relatives will also be very influential. So, it is about a number of people all saying the same story, if you like, giving the positive messages about the value of immunisation. However, since the MMR controversy, we have really seen a lift off in the use of social media and of things like Twitter and Facebook. They

are enormously influential, I believe, in informing parents, because, especially with Twitter, you just need to have one anti-vaccine message posted and it is around the world in seconds. So, perhaps we need to be using our immunisation advocates more to get the good messages out there and, instead of sitting back, we should be constantly promoting the importance of immunisation.

[197] **David Rees:** In that sense, once again the question arises of the attitude of individuals to messages from public servants and their confidence in the message they receive. Would a tweet from a public health body, for example, be recognised as equally important as a tweet from social friends or others who may be advocating the good use of immunisation?

[198] **Dr Bedford:** It probably works both ways. Some people would take notice of it. I suppose that it is a matter of how it is phrased. If it is big brother-ish, then people are not going to like it. So, it has to be a bit closer to the public. However, it is a combination of all things. If you have positive messages coming out from all places, then it will have an impact on some people. Having said that, there is a very resistant, hard-core group, with whom we need to get much better at communicating. I do not think that that would work for people who are already resistant. It is about the hesitant population, the people who may have concerns and doubts and who just need the right sort of information to make them take up immunisation. For the hard-core resisters, if you like, we need to be a bit cleverer in how we communicate with them, because it can be very challenging.

[199] **Lindsay Whittle:** On this issue, it is the impact that the loss of two or more senses has on the family that would be the most powerful message. I know, because, thanks to Sense, I have visited families who have suffered this. You have a powerful message to send. Is it possible, perhaps, not to use the families, as that is the wrong word, but to ask the families—that is a better word—whether they can put their personal experience on these public media? People do not trust politicians and we heard earlier that they do not trust medical professionals, sometimes, which is rather sad. However, they certainly trust their friends and other people on Facebook. I have seen on Facebook—because I am a member of Facebook and have friends in this room, in fact, although not many—some posts achieving a million hits. I am not on Twitter, but I understand that that is more powerful. Those are surely the media to work with, are they not?

[200] **Mr McGill:** Families have a very powerful story to explain, and there is an independent voice that organisations like Sense bring to the debate. You are right in terms of social media, such as Facebook and Twitter; those are very powerful mechanisms and we can use them. However, we are one of the voices. That needs to be backed up by sound science and a really good explanation of that science and evidence. People also need to be willing to listen. It has been fascinating for me, having been involved 15 years ago in this story, that, in the last few months, it has been very easy to get that story about rubella across, and it has been very encouraging to get that story about rubella across, and people have been willing to listen.

[201] We were trying to do the same thing 15 years ago and they were more interested in the views of the anti-vaccination parents than they were in a parent saying, ‘We think you should listen to the Government and the scientists because we think that they have got it right’. Back then, that was not as powerful a story. Sometimes, it was purely an emotive thing. I plainly remember being asked, ‘Do you have a three-year-old who has congenital rubella syndrome, because we have a three-year-old who we think is autistic because of the vaccine?’. We said, ‘No, we’ve got a spotty 16-year-old, if you’re lucky, because we’ve got rid of congenital rubella syndrome; that is the point’. We were told, ‘Oh, we’re only interested in three-year-olds, so we will come back later when you’ve got a three-year-old’. So, it is sometimes quite difficult to get that message across, particularly in a very fast-moving media world where people have a particular story that they want to tell. However, it is

a very powerful voice, and that independent voice is very strong.

[202] **Dr Bedford:** To pick up on your comment about people not trusting doctors, they trust their individual GP and their individual health visitor. I think that it is a lack of trust in the powers that be. BSE went a long way with regard to doing that. If you look at the evidence about MMR, parents say ‘Look what happened with BSE—how do we know that we can trust the Department of Health?’ However, at the ground level, they trust their individual health professional, which is where the solution to all of this lies. It is about having well-informed, confident health professionals who can talk to parents.

[203] **David Rees:** Turning to Sense, the current situation highlights the problems that we face because of a lack of immunisation. How do you see us moving forward? Has this recent outbreak given us the opportunity to raise the profile of immunisation, and perhaps involve third sector organisations in taking that even further?

[204] **Mr Morris:** I think that there has been a positive effect in terms of an increased stimulus to take up MMR, but it has also given a platform to clinics such as that set up in the Swansea area to offer single vaccines. Also, during the outbreak, there was something in *The Independent* from Andrew Wakefield. It runs both ways, because it also gives a platform for debate to the anti-vaccination lobby.

[205] As Joff alluded to earlier, there is also a danger around people seeing this as just a measles issue, when it is a measles, mumps and rubella issue—thus an MMR issue.

[206] In terms of the way forward, we do not want it to be played out in a sensationalised way. We want it to be played out in an informed way, which lends itself, as Dr Bedford said, to people trusting their individual GP. You want it to be done at that level—surgery level and individual level—rather than it being played out in a sensational way.

[207] **Mr McGill:** I would add to that that there is an opportunity to move from dealing with an outbreak of a particular disease to a long-term commitment to eliminate measles, rubella and mumps. We know what we need to do—we have got the vaccination programmes in place; we just need people to use them. It is all the things that you have been talking about this morning, and all the conversations that we have been having now. It is about using every opportunity as young people grow older. It is about the powerful messages. It is about explaining the science. That is the opportunity that we have—from one of managing outbreaks, to one, with the right political, social and public commitment to this, of eliminating and preventing these diseases for the long-term.

[208] **Rebecca Evans:** My question is for Dr Bedford. I am interested in finding out if there is good practice from other countries that we can learn from. You mention in your paper that there is a requirement in the USA for children to be immunised before entering school. I know that they had a recent outbreak of measles in New York city, and politicians there have suggested that people should be able to sue parents who do not vaccinate their children if they pass on measles. I am not advocating that approach, but are there examples of good practice that we could take from other countries?

[209] **Dr Bedford:** Actually, we are one of the best countries in the world in terms of immunisation uptake, partly as a result of good policies and well-trained health professionals making immunisation relatively easy. We have these occasional unfortunate incidents, but as a general rule, we do extremely well. Countries such as Sweden and Finland get a very high uptake without recourse to the law, but they come from a different cultural background. We do not need to look very far to see good practice in terms of immunisation; we have very high uptake rates without any legal obligation to have children immunised.

[210] **David Rees:** Following on from that, you say that we have one of the best examples, so where can we go from here to ensure that we improve our immunisation rates? We are not at the levels that we want to be yet. You have identified that there is about 1% to 2% that we are never going to convince, but how do we get the others, to take it up to the level that we want?

[211] **Dr Bedford:** We need to have a number of things in place. The first thing is that we need very good information systems, because very often, when you go to an area where there is poor uptake and you clean up the data and have a good information system, that puts the rates up to begin with. So, the first thing is about knowing your population—who is immunised, who is not immunised—and then knowing the reasons why those groups are as they are. They do differ. Some of it is about access, and that is about increasing opportunities for immunisation, offering it in places other than the obvious places like GP surgeries, but in places where young families go—perhaps in hospital; perhaps, for some groups, they need to have domiciliary immunisation offered. So, it is about taking the opportunities that are already there and making the most of them, and getting other groups equally on board. So, as well as health and social care, we need to have early years practitioners, teachers and educationalists to see that it is all our responsibility, not just the responsibility of health and social care. Of course, we need to use the official guidance as a starting place to know what we need to do. We also need to be looking at whether there are other interventions that are necessary for particular groups, such as travelling communities or looked-after children.

[212] **Mr McGill:** I would agree with all of that, and I would add that I think that there is some particular activity that we can do around the messages about rubella with people who are planning on getting pregnant—reaching those people, checking their immunisation status and, if needs be, ensuring that they are vaccinated. Also, with people who have just been pregnant and have had their baby, if their vaccination status means that they need to receive MMR before they leave hospital or as they are discharged, then that should happen. We need really strong systems in place to make sure that that happens every time, rather than sometimes, as I suspect is the case at the moment. Ethnic minority groups are another group that is of some concern, with regard to rubella, particularly.

[213] **Rebecca Evans:** You talked about certain areas and different hard-to-reach communities and so on, so to what extent would you agree that vaccination is actually an issue about health inequalities?

[214] **Dr Bedford:** Yes, it is very linked to inequalities in health, but there are two groups. For one group, which has limited access or difficulties accessing, for whatever reason, it is about improving the ability to access the service. For the other group, the inequalities work in a different way: the people who reject immunisation outright are often the more highly educated, older mothers, and this is, perhaps, a more challenging group in many ways to address. How do we educate them more about the importance of immunisation and the fact that it is not harmful for their children, but it is actually important to protect them from these diseases?

[215] **Rebecca Evans:** There are issues, as you say, about inequalities in access to services; are there issues about inequalities in access to information? Presumably, information or good information now is pretty easily accessible online, in terms of the Public Health Wales website, which during the outbreak was updated twice a week and so on. Is information still hard to come by for some communities or some individuals, who perhaps do not have internet access, cannot read and so on? Sense might have a view on this as well.

[216] **Mr McGill:** I think that you are right. The information exists, and we can always do more to make it accessible and to make sure that it is in the right format, but it is about marrying the information up to the opportunities that we have been talking about earlier. So,

there is a particular opportunity and a particular time when you want to access that information. Just because it exists somewhere does not mean that you are going to get hold of it when you want it. That is the challenge, to make sure that, at the opportunity to talk to somebody about immunisation, we have the information to hand, we have someone who understands that information and is able to explain it and respond carefully to the genuine questions, and sometimes genuine fears, that people may have, in a way that reassures and convinces and explains. I think that that is the important thing.

[217] **David Rees:** Do Members have any other questions? There is just one final question from me. In the build up to the outbreak, we saw progression of immunisation. We have figures showing that it has been steadily increasing over the years again. Was the message prior to the outbreak appropriate, in your opinion, to get that immunisation level up? In other words, do we need to do better than we were before the outbreak?

[218] Silence. [*Laughter.*]

[219] **Mr McGill:** From Sense's point of view, we would always want to be talking about rubella—we are very keen and passionate about talking about rubella. I think that it is an important part of the message. As I think that I have explained, it is a more complex message and it is a harder message to get across. Measles tends to be a very immediate concern and the one that people want to talk about, naturally. So, there is more that we can do to explain rubella and mumps. There are lots of myths about mumps, but let us not forget that it is a significant cause of hearing loss and hearing impairment. It is about explaining all of the diseases and all of the reasons why we are immunising. It is something that we would be keen to do and it is that ongoing commitment to eliminate these diseases that I think is really important.

[220] **Dr Bedford:** It is extremely challenging. We knew that something like this was going to happen, because if immunisation levels fall at the rate that they did, it is inevitable that there will be outbreaks of measles, particularly, because it is so infectious. It is very difficult in the absence of disease to bring home the message that it is really important that you are immunised, because people think that there is no disease, so, what is the problem? So, this outbreak was extremely unfortunate, and we would not wish it to have happened, but, in terms of what it has done for the uptake of vaccination, it has been incredibly powerful.

[221] **David Rees:** I thank you for attending this morning and for your evidence. A copy of the transcript will be sent to you for correction of any factual inaccuracies. Thank you for coming today. We will move on quickly. Our next witnesses are here.

[222] Welcome to the meeting and to this session of our inquiry into the measles outbreak. Could you introduce yourselves, please?

[223] **Dr Lyons:** I am Marion Lyons, director of health protection, Public Health Wales.

[224] **Dr Sandifer:** I am Dr Quentin Sandifer, executive director of public health services, Public Health Wales.

[225] **David Rees:** Thank you for attending this morning, and for the written evidence that you have provided to the committee on the measles outbreak. Normally, we would ask for an opening statement, but we have limited time this morning, so we will go straight into question, if that is okay with you. We will start with William Graham.

[226] **William Graham:** Thank you, Chair. As you can imagine, so far, we have heard quite a lot of evidence about communication—you have been stretched on that from your own appearances on television, for example. In 2000, the MMR myth buster was published and it

was available at all GP practices, so we are told. Yet, looking at the figures in Swansea, that was hardly a success, was it? The number of immunised children went down dramatically.

[227] **Dr Sandifer:** The number of children immunised did fall following the adverse media campaign that we have discussed earlier in this committee. That effect ran for a period of about five years, in reality. The myth busters publication was developed in the wake of that campaign in the late 1990s and was distributed, as you say, in 2000. It was part of a package of activities that were taking place, but at the time, we were dealing with a considerable tide of negative publicity and the backwash from all of that. The truth was that it was about five years before we started to get traction on the positive messages around public health. I think that the evidence is clear now, that from about 2003 onwards, thanks to the efforts of public health services and the NHS more broadly, including primary care, of which the application of myth busters was a part, we began to turn the corner.

[228] **William Graham:** In looking to the future, in terms of these lists of unvaccinated and partially vaccinated children from the child health office—clearly, that is very important—were these only distributed in Swansea, or throughout Wales?

[229] **Dr Sandifer:** The outbreak was centred on the Swansea, Neath Port Talbot and Llanelli areas. However, outbreaks, unfortunately, do not restrict themselves to administrative boundaries, and yes, we did see a spread into Powys, and further afield into west Wales, and we had a discrete outbreak up in north-east Powys. For those reasons, we reported across the Hywel Dda, ABMU and Powys health board boundaries.

[230] **William Graham:** How helpful do you think this information was? Did GPs really listen to what you are saying about identifying unvaccinated and vaccinated children? We heard earlier that a lot of contact was met with complete refusal. Do you think that it was a worthwhile campaign within itself?

[231] **Dr Sandifer:** I think that the response from the whole of the health service was really impressive. Let us just be clear about this: 75,909 unscheduled vaccines were given during the period from March through to the end of June. Over 46,500 of those were given in primary care. I would like to place on record that the response from primary care across Wales, and especially in the Swansea and Neath Port Talbot area, was outstanding. So, yes, they were very receptive, they responded very positively and they contributed actively to the response in a whole host of ways, at a local level and at a national level.

[232] **David Rees:** We now have questions from Gwyn, followed by Lynne.

[233] **Gwyn R. Price:** Good morning to you both. You talk about partnerships, and I want to touch on that subject, really, because I congratulated the other witnesses on it. It is a team effort, the way you have all got together to tackle this issue. However, were there any concerns about resources in all of this?

[234] **Dr Sandifer:** Public Health Wales convened its senior response team, and its clear objective in doing so was to ensure that we were able to mobilise and co-ordinate most efficiently the use of resources. As far as I am concerned, we deployed all the resources that we needed to respond efficiently to the outbreak, and that was done within Public Health Wales and also by providing support and assistance to the local health boards, where appropriate, with the resources that they might need—for example, administrative support, additional support with data collection and analysis, the provision of guidance and advice, and so on.

[235] **Gwyn R. Price:** Do you have any specific concerns about the public health specialists required—or the lack of them—to help with any further outbreaks?

[236] **Dr Sandifer:** In the course of the outbreak, we had an excellent response from the public health community. We were able to mobilise all the specialists in public health that we needed to man the measles co-ordination centre that we established at the Welsh National Temple of Peace and Health, including the provision of evening and weekend cover. People did so on a voluntary basis, and I would like to commend all the staff for their efforts in responding so magnificently to this outbreak.

[237] **Lynne Neagle:** We heard this morning from the health boards that there are rigorous procedures in place to follow up parents who do not respond to the notification that their child is due for immunisation, which includes not just letters, but individual contact from the health boards to chase those parents up. Do you have any comment to make on how rigorous those procedures are and whether they are consistently applied across Wales? If the procedures are as rigorous as we were told they are, why are we still seeing the drop-off in terms of parents bringing their children for their second MMR booster?

[238] **Dr Sandifer:** If I may, I will take your question in two parts. Through the period since the catastrophic fall in immunisation in the late 1990s, particularly from 2003 onwards, I think that we began to win the hearts and minds battle, if you like, with parents. One of the actions of the mid-2000s that the Welsh Government supported us with was the publication of a circular that suggested an amendment to the routine, so that we began to ask on entry at both primary and secondary school level, to check that children had been immunised. That has been applied consistently and rigorously since that time.

11.30 a.m.

[239] We have continued since then to encourage children at those two school entry points and in the teenage booster campaigns, and we will certainly look at further opportunities, as has been mentioned, with the introduction of meningitis C vaccination in the teenage years as another opportunity, and we will use all those opportunities. So, I think that we have been consistent in our application to this time. I would also say that the results speak for themselves. We have surveyed parents during the course of this outbreak and parental anxiety about the vaccine is extremely low now. Less than 3% of parents in a focused survey that we conducted—a survey of parents who had not, for whatever reason, responded to our initial invitation—cited concerns about the vaccine. I think that that is evidence that we have won the battle with parents about their anxieties over the vaccine.

[240] **Lynne Neagle:** In terms of the pre-school boosters, you said that there is going to be rigorous follow-up when children go to school. Is that going to be consistently applied across Wales? For example, what exactly will happen if a parent fills in the entry form for the school and says that their child has not been immunised? What action will then follow?

[241] **Dr Sandifer:** There is a general approach across Wales. One of the advantages of Wales is that we can co-ordinate our actions and efforts across the country. As you have heard from previous witnesses, in north Wales they have demonstrated by their efforts their success in getting the message across and reaching parents and successfully getting a response from them. We have a good basis now for moving forward and building on the success to date. You are absolutely right that we cannot be complacent. We have to continue reaching out and communicating to parents, and using every means possible. We also need to use modern communications to reach out to young people themselves. I have been interested in references to the potential opportunities of social media. This is an area that we are keen to explore further as we go forward.

[242] **David Rees:** We now have questions from Leighton and Kirsty followed by Rebecca.

[243] **Leighton Andrews:** Abertawe Bro Morgannwg health board gave us a copy of its action plan on immunisation and vaccination for 2011-12, and despite the history in that area of the adverse coverage to which you referred earlier, there was no specific reference to a need for a campaign around MMR. Do you find that surprising?

[244] **Dr Sandifer:** We have met the directors of public health from all the health boards in the last few days—

[245] **Leighton Andrews:** No, let us just focus on Abertawe Bro Morgannwg. Do you find that surprising?

[246] **Dr Sandifer:** Abertawe Bro Morgannwg has MMR clearly in its forward plans.

[247] **Leighton Andrews:** But, did it in recent years?

[248] **Dr Sandifer:** Yes.

[249] **Leighton Andrews:** Why was it not in its immunisation and vaccination action plan then?

[250] **Dr Sandifer:** I am not able to comment on the content of that particular plan, but what I would absolutely say is that the efforts of public health have been directed consistently at improving MMR uptake in the Abertawe Bro Morgannwg area ever since the late 1990s. There has been no let-up in that, and I can assure this committee from what I have seen that it has good, clear plans for building on its success recently going forward.

[251] **Kirsty Williams:** To build upon that, it seems to me that the response to the outbreak was exemplary and people have worked very hard, and I appreciate that in the early 2000s it was very difficult to get public health messages across in the face of all the negative publicity, but I am interested in the intervening years. I am very surprised that Swansea did not have a specific mention of MMR in its vaccination plans, and actually, when asked to detail what actions it took between 1998 and the outbreak, the evidence supplied by the health board was scant indeed. It even resorts to saying that, in 2009, the chief executive reported to the board. That is one of their actions to demonstrate what they were doing in the intervening years. Can you explain what your relationship was with Abertawe Bro Morgannwg in particular, given the low uptake in that particular health board area, in the intervening years from the height of the scandal or scare to the outbreak? What was your relationship with the health boards in those years around MMR?

[252] **Dr Sandifer:** Until 2009, and from 2003, the National Public Health Service existed and that, of course, became Public Health Wales. I can confirm and we set out in our evidence submission, as we have in previous briefings that we have provided to the Welsh Government and Assembly Members, the detail of all the actions. However, in essence, public health at a national level and the Welsh Government, working with the local public health team—which, at that time, would have been Iechyd Morgannwg Health Authority's public health team—first of all, as we have already discussed, developed the myth buster programme. I can confirm that, throughout the period from 2003, when the National Public Health Service was in existence, it worked closely with local public health staff in Iechyd Morgannwg Health Authority, across Swansea and Neath Port Talbot, working with primary care, and we have documented that also in our response. There was a significant nationally directed campaign in 2005-06, and over 58,000 children were successfully immunised in that period, including—

[253] **Kirsty Williams:** How many of those were children in the Swansea area?

[254] **Dr Sandifer:** We will have to go away and get that figure for you. I do not know that

figure, but there is no suggestion, from my examination of the historic record, that public health action in Swansea Neath Port Talbot was any less than in other parts of Wales. I would also draw attention to the fact that, although they suffered the greatest fall off, they demonstrably showed through that period the greatest recovery up to the start of the outbreak period, in terms of recovery of immunisation rates.

[255] **Kirsty Williams:** In 2008, you carried out an audit of your circular, and it said that there was consequent correspondence between the Welsh Government and health boards in 2009. Do you know what the content of the correspondence was between the Welsh Government and this particular geographical area? I am interested in what the audit told us about what was happening in the Swansea Neath Port Talbot area.

[256] **Dr Sandifer:** I am not able to comment on the specifics of correspondence with that particular health board. However, what happened as a result of the audit was a recognition that we needed to continue to push hard on the changes that I have described in terms of the routine for the follow-up of children—the primary, secondary and teenage boosters. In addition, one action that the Welsh Government gave its support to was an agreement that, over and above that, it would be helpful to establish immunisation co-ordinator posts in local health boards. That policy was implemented, I believe, in 2009, and all health boards now employ immunisation co-ordinators who liaise with the vaccine-preventable disease team in Public Health Wales, and we work very closely with them.

[257] **David Rees:** Is that okay, Kirsty?

[258] **Kirsty Williams:** I have just one last one, if I may. In earlier evidence, witnesses referred to the 2009 NICE guidance, ‘Reducing differences in the uptake of immunisations’, and I am wondering what consideration, if any, was given to what your role was in ensuring that that guidance from NICE was implemented consistently.

[259] **Dr Sandifer:** I can confirm that the vaccine-preventable disease programme that I have just referred to has adopted NICE guidance and worked with all the health boards to ensure that the actions and recommendations in that guidance are being followed.

[260] **Kirsty Williams:** Are you confident that that guidance is being followed?

[261] **Dr Sandifer:** Yes, I am.

[262] **Dr Lyons:** There are elements of the guidance that we can measure numerically, such as the number of babies born to hepatitis B mothers who are vaccinated. We audited ours last year, and we had 100% across Wales because we developed a single database. So, what is measurable we can measure. Much of it is around improving access, and that is not as easy to quantify.

[263] **Kirsty Williams:** Sure. Thank you.

[264] **Rebecca Evans:** We have talked a lot this morning about engagement with parents and about parental responsibility. However, I wonder what efforts you made to engage with the children and young people themselves in the recent outbreak, particularly teenagers, because older teens would have been able to take themselves to the doctor to be vaccinated, if they had not been already, and younger teens could also potentially challenge their parents as to why they had not been immunised. Did you make any efforts to have that conversation with young people and children?

[265] **Dr Sandifer:** Our communications team at Public Health Wales worked very closely with the local communications teams in the health boards. I think that you heard from the

health boards earlier that they used a variety of approaches to engage with young people in particular. I think that the evidence submitted by Abertawe Bro Morgannwg University Local Health Board demonstrates an exemplary application of social media, and I know that social media were also used in the Aneurin Bevan Local Health Board area.

[266] We work closely with the local communications team to help it tailor the messages that could be effectively applied at local level through a variety of media, including social media. That is not just with parents; you are right, and it has been referenced earlier, that one of the early lessons that we took from this is that we could, if we were able to make direct contact with young people, provided that they were of appropriate age, accept their consent for immunisation without having to refer to their parents.

[267] **Rebecca Evans:** I note the survey that you did back in May of parents who had not taken the opportunity to have their children vaccinated at the sessions that were provided for them in schools. Can you update us on the barriers that you have found as a result of that survey? I know that you found that some people did not have English or Welsh as a first language, so they could not understand the communications from the school, and so on. What can we learn about the barriers from your work?

[268] **Dr Sandifer:** I think that the most striking message was that most parents thought that their children had already been vaccinated. Earlier in this session, we heard some debate about how well the child health records held by the health boards reflect the up-to-date position of immunisations given in primary care. We think that there is an opportunity to look at what, I think, are already very good systems. However, over the course of this outbreak, we have seen a number of opportunities to strengthen further some of our data systems, such as linking the GP record of vaccines given to the child health record system, so that we can get direct connectivity between the giving of vaccines in the primary care system and the child health record. We could then avoid some of the issues that were described earlier by ABMU about having to do post-immunisation validation.

[269] So, that was the most striking message, and the need, therefore, for us to get our records up to date has been a key part of the latter stages of our outbreak management. We are grateful to all of the child health departments and primary care for the work that they have done to try to clean up the data so that we can get the most accurate current position. Our intention is to convey that information back to the health boards, when we are satisfied that it is as complete as it can be, to give them the basis for knowing what they need to do next. The job is not done; we know that we need to do more, and we are keen to try to get that information back as quickly as possible.

[270] **David Rees:** In relation to records being up to date, earlier, we heard that there were some concerns that records were not, initially, up to date on the systems and that the information had to be found to ensure that they were up to date. Are you confident that records are now up to date, not just for children, but for all patients, so that, if another outbreak occurs, we will have the relevant information to hand, without having to go and dig for it?

11.45 a.m.

[271] **Dr Sandifer:** We certainly invested a great deal of time and effort, as I have just mentioned, in working with the local health boards and encouraging the local health boards to work with primary care to achieve that. However, this is an opportunity to think about how we could further strengthen that. I have just mentioned one potential opportunity. It would be helpful if GPs had read-only electronic access to child health records. That way, they could look directly online for evidence of vaccination, which would avoid sending parents unnecessary vaccination invitations, would provide a more accurate count, and would avoid

some of the data-sharing problems that we know already exist within Wales, across some of the internal administrative boundaries. So, yes, there is certainly more that we can do. Can I say with absolute confidence that those records are complete and fully accurate? No, of course, I cannot. However, a great deal of effort has gone in in recent weeks to bringing them up to date, as far as we are able to do so.

[272] **David Rees:** I have a further question on that. We have heard that private clinics were involved in giving single immunisation injections. This is a technical question: is that information recorded, so that that immunisation record is known?

[273] **Dr Lyons:** No, we do not add that to the records. To do that would validate the single vaccine, and we would have no way of measuring its safety or impact. It is not part of our NHS supply system, so the cold chain and all of the other controls that are in place for our MMR vaccine might apply, but we would not know. So, we could not guarantee any child that they would be protected, and to put that information on the child health system would suggest that they are protected. What is on the child health system is a record for life. It tells you that you have had two MMRs and that you know you are safe. So, we do not add that.

[274] **David Rees:** You mentioned that over 70,000 vaccines were issued over this period of time. However, you also indicated that around 3% parents are still concerned about the vaccine. That leaves 97%, but our figures have not reached those levels yet. How do we expect to reach the target figures?

[275] **Dr Lyons:** I will answer that one. In the second survey that we did in Monmouth to support Gwent's uptake rates, we had clinical staff to support the individuals doing the survey. So, if parents expressed concern, we would have someone there at the time, rather than saying that someone would call them back. On the evenings that I did it, we must have interviewed 180 parents or so. About six parents expressed concern, but, having spoken to them, the concern was more about their children's health than about the safety of the vaccine. For the most part, there were specific issues around their child that were making them wonder whether it was safe for their child, because they had X, Y or Z. I can honestly say that, of the parents to whom I spoke, there was only one parent who was not happy to go to the drop-in clinic that was being held on the Saturday to have their children vaccinated after we had talked through the issues with them. This is why I think that there are opportunities, moving forward, to engage again with these parents, whether that is when we give them meningitis C at age 14, or when they go in to school. For those parents who say that they are worried, we can discuss the issues around their particular child that make them worried, rather than the safety of the vaccine. For the most part, nobody questions that MMR is safe. For individuals, though, there is that debate.

[276] **Lynne Neagle:** I suppose that good training, then, is absolutely crucial in being able to talk to parents. You have referred in your evidence to the vaccine-preventable disease programme. Could you tell us how that has been rolled out throughout Wales? Also, what assurances can you give that training for front-line staff across Wales is being delivered consistently?

[277] **Dr Sandifer:** Perhaps I could just start by saying what our plans are, led by the vaccine-preventable disease programme. Marion might then want to add something to that. The vaccine-preventable disease programme, as I said, is currently updating its information on the current uptake. You heard earlier that MMR1 and MMR2 figures are now at their highest level ever. We will feed back the data at health board level to local health boards to enable them to plan for taking action to build on the success of the campaign, going forward. The vaccine programme will continue to work closely with the health boards to ensure that all the available measures, the application of guidance, and any support they need on collection, analysis and interpretation of data, are available to them to inform their planning. We are also

working through the immunisation co-ordinators, with whom we have regular contact, helping them to identify the hard-to-reach groups and to ensure that MMR is offered. As an organisation, Public Health Wales will work, as I said earlier, with the local health boards now to revisit our communication strategy, build on our experience and learning from the outbreak, and see what more we can do to try to convey those messages. Staff training has always been a key part of the delivery and I believe that the immunisation co-ordinators at health board level are critical to the successful delivery of training to healthcare professionals, and we will continue to do that. I do not know whether Marion has anything to add to that.

[278] **Dr Lyons:** There is training that is required of all new immunisers and there are regular update training sessions for people who do it every day. It is co-ordinated by the immunisation co-ordinators. Much of it is delivered by health protection staff.

[279] **Lynne Neagle:** Are all health visitors included, because they are the ones who are usually having the discussion with the parents?

[280] **Dr Lyons:** Yes, and school nurses are also key to this.

[281] **David Rees:** There is a time lapse between MMR1 and MMR2. Clearly, some of those people who were not immunised would have just had MMR1 in the recent outbreak. What actions will you take to ensure that those are followed up and that they complete the MMR2?

[282] **Dr Sandifer:** That is part of the action planning that local health boards will now develop. The committee will be aware that the Welsh Government has published new tier-1 targets, and health boards will now be held to account for the delivery of 95% immunisation with all scheduled vaccines for children to age four. That will be a key part of the local planning, and we will work with the local health boards to give them support and advice to enable them to develop robust plans to achieve those tier-1 targets.

[283] **David Rees:** I appreciate that that is a tier-1 target, but, as you said, it is up to age four, and the group in the Swansea-Neath Port Talbot area was the 10 to 18 age group.

[284] **Dr Sandifer:** Absolutely. There is still a pool of up to 30,000 children across Wales that we need to continue to reach out to, to invite and give opportunities to receive the vaccine. There are a number of approaches. We will continue to reinforce it at school entry, the teenage booster and the meningitis C points in time, and we will use any other opportunities that we can to try to reach out to those children in that period.

[285] **Dr Lyons:** Throughout this outbreak, supported by audit plus the GP system, we have been able to monitor by age—nine-year-olds, 10-year-olds, five-year-olds—who has had a first dose and who has had a second dose of vaccine. We continue to gather that information in real time. So, every night it is updated as to how many received it yesterday, or whatever, and I am pleased to say that we are still getting hundreds of second doses done in primary care, which is what you would expect, because these are the older children who had one dose six weeks ago, or a month ago, and are now having the second one. We will now, over the summer, be feeding back to the local health boards, reminding them that there will be a cohort of children who had the first dose and need the second, because it is crucial that they get the full protection of the two doses. However, we are measuring that in real time for the health boards.

[286] **Leighton Andrews:** Once the outbreak started, it seems to me that the crisis plans that you had worked very well, and the communications, particularly, were very well handled. However, can you tell me how you, as Public Health Wales, will plan for the future communication and marketing of the need for the MMR vaccine, and to what extent you will

have direct conversation with your communications teams to take that forward?

[287] **Dr Sandifer:** We are in constant dialogue with our communications teams. The communications director in Public Health Wales sits at a desk less than 50 ft from me, and we have that discussion on an everyday basis.

[288] Our plan in terms of reviewing and taking forward the lessons learned is that we are planning an internal debrief in Public Health Wales on all aspects of the response management. We will do that in the next couple of weeks. By the beginning of September, we will have had a formal, structured evaluation with all other partners involved in the response management, and we are proposing to bring in some independent external audit as well. I am committed to taking an outbreak management report to the Public Health Wales board by the end of this calendar year. In that, we will set out all of the lessons learned. As I have already said when giving evidence to you earlier, we see a real opportunity here now to revisit our communications strategy, working with the local health boards. It cannot just be a Public Health Wales one; this has to be a whole-systems communication strategy.

[289] **David Rees:** I assume that that strategy would include targeting the harder-to-reach groups as well.

[290] **Dr Sandifer:** Yes, absolutely. We will certainly do that. We will look at as wide a variety of platforms and media for engaging all people who might be vulnerable, going forward.

[291] **David Rees:** Are there any other questions from Members? I see that there are not. Therefore, I thank you for your evidence this morning. You will receive a copy of the transcript, which you can check for factual inaccuracies. Thank you very much for your attendance this morning.

[292] We will move on, because the witnesses for our next session are here. I welcome the Minister and his officials to the meeting. Obviously, we have a tight time schedule this morning. Please introduce yourself and your officials.

[293] **The Minister for Health and Social Services (Mark Drakeford):** I am Mark Drakeford, and you will be familiar with Dr Ruth Hussey, the chief medical officer, and Dr Andrew Riley, who is the senior medical officer.

[294] **David Rees:** Thank you for attending this morning and for the written evidence that you have provided to the committee. We do not have sufficient time to allow you the opportunity to give an introduction, so we will move straight into questions. We will start with Lynne Neagle.

[295] **Lynne Neagle:** I have a question on communication and on the strategic role of the Welsh Government. Mark, your paper highlights the good relationships that existed throughout the outbreak and the way in which this enabled clear information to be provided to the public. In that positive picture, are there any areas in which you had outstanding concerns or where you felt that things could have been improved?

[296] **Mark Drakeford:** Chair, I guess that my starting point is that things can always be improved. So, we should always be looking at what we have done, even when we have had a successful campaign, to see if there are things that could be done better. There will be a big piece of work undertaken to review the whole way in which the outbreak was responded to. If I was to pick one thing that I look back on and wonder whether there was more that we could have done—but, it is an open question, rather than knowing for sure—it would be that, if you think of the work that was done on Saturday mornings, for example, outside the main

outbreak area, in Cardiff, Gwent, and so on, you see that there is a striking difference in the number of people who presented themselves or their children for vaccination in those clinics compared with those that were directly in the outbreak area. I am left asking whether there was more that we could have done to try to persuade people a bit further afield that it was as much in the interests of their children as it would be for a child in Neath Port Talbot or Swansea to have had a vaccination at that point, and we did not quite get that across to them in the way that we might have done.

12.00 p.m.

[297] **Lynne Neagle:** Thank you. The programme for government contains a commitment to measure the percentage of children aged two who have received their MMR vaccine, yet we know that it is two doses of the MMR that confers the necessary immunity to eliminate the diseases. In view of the difficulties that we had with the outbreak, are you planning to review the programme for government commitment?

[298] **Mark Drakeford:** I am sure that, as part of the general review of the experience, we will look at that to see whether it needs to be amended. It is important to remember that Public Health Wales reports on these things, not just against those ages, but also against the ages of one, two, three, four, five, eight, nine, 15 and 16. We do that every quarter, and we do it for every health board and local authority. So, although the programme for government focuses on one part of the measuring system, it does not mean that the system itself is not measuring uptakes on a much wider scale all the time. However, the simple answer to the question is 'Yes, of course; we will look at that as part of the overall review'.

[299] **Gwyn R. Price:** The voluntary sector and partnerships this morning said that working together in this outbreak was a real advantage, and I know, Minister, that you have congratulated many organisations on their efforts on a voluntary basis by working on weekends and in schools and hospitals across the piece. What are your short, medium and long-term priorities on immunisation and preventable diseases?

[300] **Mark Drakeford:** Thank you, Gwyn, for that. I will start, and the chief medical officer might want to add something to this. Our immediate priority in the MMR field is to go on driving up the level of vaccination so that we get to the 95% target for both doses of vaccination. That is an immediate priority to do what we can to make that happen. In the medium-term, there is, as you will know, a wider programme of new immunisations being introduced into the NHS in Wales. This month, we started rotavirus inoculation for infants. In September, we will introduce the vaccination for shingles among those aged between 70 and 79, and a new pattern of vaccination for meningitis C. During the autumn, we will introduce a further new inoculation programme for flu among two-year-olds and children in year 9 of school. So, in the medium term, a whole new package of vaccinations is coming through that we will implement in the Welsh NHS.

[301] In the longer run, we have very close contact with the Joint Committee on Vaccination and Immunisation, which is the UK committee responsible for validating new forms of vaccination that become available. We are part of that landscape, and there is no doubt that further opportunities for vaccination and immunisation will come out of that work. In the longer run, my ambition for Wales is that we continue to be able to provide the vaccinations in Wales that are available in other parts of the United Kingdom.

[302] **Lindsay Whittle:** Good afternoon, Minister, and to your officials. That leads nicely to my question, because viruses know no borders. We heard in earlier evidence from Sense that the Swansea outbreak was initially contracted by children who had been visiting friends and relatives or who had been holidaying in England. I understand that the other three British countries are playing catch-up with the Welsh Government's vaccination programme. How

are you engaging with UK health officials to prevent further outbreaks of not just this disease, but other diseases as well? Are our airports and ports sufficiently signposted with all of the diseases that you can probably catch? There are probably too many posters to put up, I would guess.

[303] **Mark Drakeford:** Thank you, Lindsay. Just to confirm what you said in the beginning, these are diseases that know no geographical boundaries. I also confirm that the chief medical office in Wales announced on 17 April that we would have an immediate and rapid campaign of extra vaccinations in schools. Scotland announced that it would do the same on 24 April; England followed on 25 April; and Northern Ireland followed on 28 May. There is a sense that by responding to the outbreak in the way that we did, we alerted other parts of the United Kingdom of the need for them to be doing a similar catch-up campaign. I will ask the chief medical officer to explain some of the detail of the way that we engage in those things.

[304] **Dr Hussey:** I think it is very important—forgive me, I have brought my own virus this morning—that the working relationship across the UK on threats to health that are infectious in nature is well established. We have official-level communication regularly on a range of issues. On vaccination, as the Minister said, we are observers on the Joint Committee on Vaccination and Immunisation, so we work together to look at new opportunities to introduce vaccination programmes. I alerted my fellow chief medical officers to the situation in Wales, followed up with formal communication at permanent secretary level as well. We continue to do that. We will look to also share the lessons from the situation in Wales with the wider audience. Colleagues in Public Health Wales have been invited to speak on a number of international platforms, to talk about what we can learn from the situation here, and what we can adopt as further best practice as we look forward. So, we have to keep looking outside of Wales to manage threats to health, but also to learn from each other as well.

[305] **Rebecca Evans:** Good afternoon, Minister. You mentioned a big piece of work that will look at how the outbreak was handled. I assume that this is the Public Health Wales inquiry that you have referred to in your document. Could you give us an idea what the terms of reference might be for that and when it would be likely to report to you?

[306] **Mark Drakeford:** Again, I will probably ask Ruth to give you the specifics of the terms of reference, but it is a piece of work by Public Health Wales. It will be a report on the outbreak. The work will be completed in this calendar year, but it may be in the second half of the autumn, rather than the first half. As well as reporting on the outbreak, it will also see whether we need to update our outbreak control plan, which is the more general plan that we have to respond to all outbreaks of this sort, whether it be a flu epidemic or whatever. There are at least two components to it—the very specific piece of work on what we learned from this experience, and whether this experience needs to feed into a wider updating of the more general plans that we have for this sort of incident.

[307] **Dr Hussey:** Just to echo that, there is a standard approach to any outbreak. It is custom and practice to reflect afterwards and look at any lessons learned. There is a plan for an internal debrief very quickly, in a matter of weeks now. There is a commitment to take a report to the Public Health Wales board before the end of the calendar year. I am in discussion with colleagues about involving external peer review and audit of what has happened, to make sure that there is good challenge externally to this as well. So, there is a real opportunity to make sure that we have thoroughly looked at every possible angle here. As I said in answer to the previous question, there is international interest in the approach that was taken and the lessons that could be learned from elsewhere. So, I think that this will be a well-regarded piece of work that people will want to use and learn from. We will make sure that we get scrutiny and challenge into that.

[308] **Rebecca Evans:** Thank you. Does the Welsh Government think that there is a case to examine the economic impact of the outbreak? We have had evidence from the BMA that suggests that,

[309] ‘Economically the area has taken a hit, with anxiety remaining in many parts of the UK and abroad about travelling to Wales and Swansea.’

[310] Is this something that you will look at with your Government colleagues?

[311] **Mark Drakeford:** I am certainly prepared to do that. I am sure that there is a case for having a look at it. We are a bit close, I think, to being able to do that at the moment. My memory from the foot-and-mouth disease outbreak was that there was an economic impact analysis carried out, but you need a bit of distance between yourselves and the event in order to be able to allow you to be able to disentangle the impact of different strands. Who knows what the impact of three weeks of sunny weather will have on the economy of the Gower, for example. Compare that with what the impact of measles might be. If you try to do it when you are right on top of it, you risk not being able to see the relative salience of different factors. In all of that, the health aspect will have a part to play in an economic impact assessment, but I doubt that we will be the lead part of the Welsh Government to do that.

[312] **David Rees:** I would like to ask a question on the review. You mentioned it is going to look at the outbreak and how it was handled. Are you also going to look at whether appropriate action was taken prior to the outbreak that might have prevented it from happening in the first place?

[313] **Dr Hussey:** The expectation is that the outbreak review will be very much about the handling of the outbreak and what actions were taken. Obviously, looking back on the actions that were happening throughout the last decade, a strong history of a whole range of activities, such as communication efforts and catch-up campaigns, can be seen. There is evidence of further vaccinations being taken up at different points in the last decade. If you look at the MMR uptake in 2005, you will see that it was 82%. By 2012, it was 92%. So, there was evidence of an accumulative building up of impact in terms of willingness to take up the vaccine, and there were specific efforts during that decade to target the group that might have declined the vaccine in response to the fears and anxieties with the publicity around the Wakefield case. There is a well-documented account of efforts made during that period. The normal practice with an outbreak is to look at the handling of it, and that is the focus of the debrief that is planned at the moment.

[314] **David Rees:** Kirsty has a point on this.

[315] **Kirsty Williams:** I am interested in the effectiveness of those interventions between 2000 and the outbreak. I appreciate that different people were in post at the time, but did the Welsh Government ever ask for an analysis to be carried out of the effectiveness of the MMR myth busters pack that was sent to primary care? Can you account for the differences in figures with regard to the number of children who were immunised during the campaign in 2005-06? Public Health Wales figures are 7,000 below what you are quoting in your paper, and so I am interested in why there is a discrepancy between the figures. With regard to the correspondence between the Welsh Government and health boards following the circular audit, was that generic correspondence—the same going to each health board—or did the Welsh Government write to each health board individually about their own plans? Also, has the Welsh Government ever carried out any work to consider compliance with the 2009 NICE guidance?

[316] **David Rees:** Four questions in one.

[317] **Dr Hussey:** Yes, there were a few there. In terms of the approach that was taken in the early 2000s, and the information and the catch-up process, the question is whether the uptake improved over time, and, clearly, there was a growing trend of improved uptake during that period. That was the objective of the process. I would have to look back into the history of this to know exactly what communications evaluation was done around the myth buster programme.

[318] On the question of data reconciliation with Public Health Wales, I would need to look into that. I know that we rely on the same data, so I will have to come back to you as to why there may be a discrepancy in those figures. On the NICE guidance, my understanding is that NICE guidance is adopted and used and is therefore part of practice in Wales.

[319] **Kirsty Williams:** Whoa. I have sat on this committee, as has the Minister, for long enough to know that just because NICE says that you have to do it does not mean that clinicians actually do it. Is it your role or the Welsh Government's role to ensure that that NICE guidance is being followed, because I have a lot of evidence of other guidance that is not followed?

[320] **Dr Hussey:** We do follow up from time to time to ensure that guidance is being used, and I am assured by colleagues in Public Health Wales that part of the conversation that they have about best practice, peer review, support to local areas, and so on is about ensuring that we use effective guidance and the evidence base that is available.

[321] **Kirsty Williams:** With regard to the correspondence between the Ministers and local health boards following the circular, was that generic or did that focus on individual local situations?

[322] **Dr Hussey:** My understanding is that, again going back over the records, clear expectations were raised with all health boards about the importance of vaccination. These were raised at a senior level.

12.15 p.m.

[323] **Kirsty Williams:** My question was whether it was generic, or whether it was geographically specific.

[324] **Dr Hussey:** I would have to come back to you on that.

[325] **David Rees:** I would be grateful if you could write to the committee with confirmation of that information.

[326] **Mark Drakeford:** It is just worth saying, while Ruth gets her voice back a bit, that there are two different sorts of activities going on over this period. There is the effort to bolster the take-up of MMR with regard to children who are newly born and coming into the system for the first time, and there is work that is going on to try to move that figure upwards. It is generally successful; there is a clear trend—it is moving up throughout the period. Then there are efforts at different points to try to catch up with those people who missed out on vaccination during the height of the scare, if we are going to call it that. The 2005 campaign, which was a co-ordinated national take-up campaign—I do not know why the figures are different; I imagine it will turn out to be something as simple as that it was counted over a different time period—succeeded in having about 61,000 people in the catch-up group vaccinated. There is something fairly remarkable about that, because that happened in a year where there was not a single laboratory-confirmed case of measles in Wales.

[327] We know that, in many ways, what has driven people into the clinics in this outbreak

has been the fact that they can see that measles is happening around them, and that reminds them to go. In 2005, over 60,000 young people were vaccinated in the catch-up, in a year when there was nothing like that going on. In fact, there was not a single case of measles in the whole of Wales in that year, and yet we managed to get hold of that number of people. Undoubtedly, that has had an impact on the outbreak this time. If those 60,000 people were still unvaccinated, it would have made this outbreak much more difficult.

[328] **Leighton Andrews:** One of the earlier witnesses suggested that all health workers should have appropriate vaccination and immunisations before they are allowed to work in the health service. Do you have a view on that?

[329] **Mark Drakeford:** My view is that it is the professional and ethical responsibility of people who work in the health service to protect themselves and the people who they work with against diseases that are preventable, and, therefore, they ought to ensure that they are immunised. Do I take the next step and say that if they do not do that, they ought not to work in the health service? I do not think that I am at that point yet, and I do not know whether I ever would be. There is quite a lot more that we can do simply to persuade, educate and put people in a position where they do the thing that we think they ought to do. Ruth can say something about the extra steps that are being taken to make sure that that happens.

[330] **Dr Hussey:** While it is very encouraging that so many healthcare workers took up the MMR vaccination in this period, my ambition is to ensure that this is a given, if you like. I recognise that there is an opportunity with flu as well. It is about finding a way of ensuring that we systematically check and encourage healthcare workers to do everything they can to protect the spread of infection to patients, which includes being fully protected themselves. Conversations need to take place around that responsibility, with regard to being up-to-date with the evidence and making sure that they are able to give the evidence to patients on a whole range of vaccinations. So, there are a number of steps like that that need to be followed up, I think. That was certainly an observation that I picked up and wanted to pursue, and steps have already started to be taken towards having conversations about how we might find a way of ensuring that, more systematically and more regularly, we are asking people to make sure that they are up-to-date with all their vaccinations.

[331] **Leighton Andrews:** Can I ask about some of the prior planning? Abertawe Bro Morgannwg University Local Health Board gave us its immunisation and vaccination and action plan for 2011-12. It did not have in it a specific objective around MMR, but it did talk about routine childhood vaccinations. Given the history in that area, do you find that surprising?

[332] **Dr Hussey:** Looking back, as I have done, at all the steps that were taken, it is evident that there was a lot of work happening there throughout that period. There is now communication, and I think that you have heard from professionals and colleagues who have said that there is personal communication as well. It seems to me that there is consistent year-on-year evidence that people were raising these issues and attempting to try to keep pushing up the vaccination uptake throughout that period.

[333] **Leighton Andrews:** Do you find it surprising that there was no specific reference to MMR in its immunisation and vaccination action plan?

[334] **Dr Hussey:** Recognising that it was trying to improve all of the vaccinations, the evidence suggests that it was doing things around these things—whether or not it specifically referred to MMR in that period. As for whether it should have written it into the plan, perhaps it should have done. Looking at the catalogue of actions that were going on in Wales throughout that period, we can see that things were already happening on a number of occasions.

[335] **David Rees:** We have heard some evidence this morning particularly in relation to health professionals perhaps not being fully aware of the implications of measles being contracted, or sometimes being unable to identify measles as a condition. What actions will the Welsh Government take to ensure that the training will be appropriate? Just because we believe that we have eradicated something does not mean to say that it has gone, and it means that we still need to identify it to avoid another outbreak.

[336] **Dr Hussey:** You are absolutely right. There is a sense that people had forgotten what measles was like as an illness because we have successfully not had it for a long time. The same applies to diseases that may re-emerge. We need to make sure that, in training, people are vigilant to expecting that these diseases may appear from time to time. We are now in a position where people do know what measles looks like and are aware of it. An essential part of general training is to keep that vigilance up and to incorporate it into all training programmes that infectious diseases can come back at any time and that we need to be aware and mindful of that.

[337] **Mark Drakeford:** It is also the case that we seem to forget outbreaks fairly fast. There was an outbreak in Wales in 2009, to which I have seen almost no reference at all in the literature surrounding this outbreak. Yet, there was an outbreak that centred in Porthmadog; it occurred in north and west Wales. My predecessor Minister at the time, Edwina Hart, made an oral Plenary statement in May of that year; she issued a written statement in June; she answered written Assembly questions; and she wrote to all Assembly Members in September when they came back. So, at the time, it was an issue that people were alert to and noticed. However, when an outbreak goes, we tend to forget that it was there. So, there is a need for continuous training and to make people aware of the fact that, if we are lucky and we get another couple of years when we do not have something of this scale, we cannot act as though it could not happen again.

[338] **David Rees:** How do we ensure, therefore, that unintended complacency does not repeat itself?

[339] **Mark Drakeford:** My guess is that it is through the obligation that professional workers in this field have to make sure that they are aware of, alert to, and trained sufficiently to be able to respond to things. That is done as part of their continuous professional responsibility.

[340] **Dr Hussey:** Increasingly, there is a means through electronic training methods, if you like, to alert people when something emerges again. There are opportunities now to very quickly make material available through the web and other methods to bring it to people's attention instantly. So, it is a matter of being alert to it generally in all training programmes, and then, when there are situations emerging, being alert that something is happening that is changing. It is also a matter of using all modern methods to remind people. So, it is about having timely information at the point when they actually need to use it, in terms of diagnosis, investigation, treatment and follow-up. There are examples of working with other professionals as well. We have regular packages of training done for pharmacists, for instance. It is a matter of thinking about all of the possible audiences for information when something like this emerges, and linking the surveillance of disease with the right actions. Tailoring information that is very timely is also a key to this and a lesson that we will take forward.

[341] **David Rees:** Following on from your point on timely information, can we go back to a point that has been raised by other groups this morning on the data being held on IT systems? At the start of the outbreak, it seemed as though the data were not complete, and therefore that there was a delay in getting sufficient information. What action will the Welsh

Government take to ensure the continual updating of data, and that it is effectively done in real time, to ensure that any future outbreaks are handled with the relevant information to hand?

[342] **Dr Hussey:** The child health system is a very comprehensive system, and what it was experiencing was a surge in the need to bring information in as vaccinations were being given rapidly. It does highlight the opportunity to look at the connectedness between that information system and other information systems. Looking at how we might be able to improve information handling electronically, there is a real opportunity for us to make that even faster and more accurate, in a timely way. That is definitely an area that I would look at and say that we might be able to improve on that substantially if we can look at an electronic process that cuts out some of the need to input data.

[343] **David Rees:** I will ask another question. We have focused very much on children, but the biggest group that we have been talking about in one sense is 10 to 18-year-olds. Of course, as time goes on, they will be in their 20s and beyond. How will we manage that group of individuals as they progress if they have not been immunised at this point in time?

[344] **Dr Hussey:** Public Health Wales and colleagues are very actively looking at every single opportunity that we can look at to get to the target group, if you like. I am very concerned that we still have a group of the population in Wales that is not fully protected. Conversations are already happening about what other opportunities might arise. We have new programmes fitting in to the teenage years in schools; can we find a way of double-checking each time that they are up-to-date with all their vaccinations? Equally, thinking laterally, are there other services that people might be using as they enter the young adult years—for example, sexual health services—and can we build in checks and balances in any type of encounter where that group might be using services as it leaves the education system? I am clear that we need to carry on doing everything that we can. These young people are now entering their reproductive years—or will do before too long—and mumps and rubella are serious conditions, and particularly of concern around fertility and harm to the unborn child. I do not think that we should stop. We need to carry on thinking of other ways in which we can keep having that conversation. As people go through their lives, they change their approach, and the reasons for taking up a vaccine might change as well. We have to keep building in a failsafe system that keeps asking. At the end of the day, though, it is still a personal choice. I think that you have heard evidence of people persistently asking; our job is to keep trying.

[345] **Mark Drakeford:** May I reinforce one point that the chief medical officer made? We focus a lot on measles, and obviously that is the focus of the inquiry, but the MMR vaccine protects people against more than that. We have been very lucky in Wales: we have not had a case of rubella for many years now, but there were 65 cases in England last year, and as we have seen with measles, these diseases travel across the border on an entirely chance basis. If someone happened to be in contact with a case across our border and came back into Wales, we are not in any way immune to that. There are 179 cases of mumps so far this year in Wales. There were 88 last year and 77 the year before. There is a considerable upturn in mumps in the Welsh population. It affects young people in exactly the age group that you referred to, with all the consequences that Ruth has mentioned. A quarter of those cases are in Cardiff. There is, in its own way, a mini outbreak there, so we have to go on reminding people that the reason for having MMR is beyond just measles. These are really important things. As the cohort gets into this age, maybe reminding them about some of those other things will have an extra relevance to them that will persuade them to come forward and be vaccinated.

[346] **David Rees:** Thank you for that, Minister. My mother-in-law was diagnosed with mumps in her 50s, so it does not hit just young people. May I ask one question on the media? You have highlighted the good work done with the media during the outbreak. How does the

Welsh Government review the role of the media in this process, and how do you wish to take it forward in progressing the immunisation programme?

12.30 p.m.

[347] **Mark Drakeford:** We have learned some important things about the way that public health messages can successfully be communicated through the media. I have said before and I will say again that I think that the Welsh media have played an important and responsible role in doing that difficult job that journalists, when they succeed, do very well, of taking complicated, often technical, material and turning it into messages that people can understand readily. That has been done successfully this time.

[348] Among the lessons are that you have to get in early with people, before the news frame, as it is called, gets set. Once the media decide the way that a story will be reported, they tend to use any new material against the frame that they have already set. So, being in early is important in order to try to shape the story; providing good, accurate and reliable technical information that journalists will have confidence in using has been important; and keeping up the contact throughout the period. Public Health Wales issued over 50 press releases during the outbreak period, it responded to more than 500 media inquiries from far beyond Wales and the UK, and people gave more than 100 interviews. There is a lesson for us in that part of it, too. I am quite sure that there will be people in this room who have had many invitations and opportunities to do media interviews during the outbreak period. On the whole, politicians at the Assembly responded properly, too, by trying to keep out of the media gaze and allowing those messages to be communicated by people who would be received as being authoritative and having things to say that people would take seriously and act upon. By and large, those are clinicians, who are experts in the field, rather than, certainly, Ministers. I did my very best not to do interviews and so on, because one of the messages from the media handling of all of this is that you need the right person giving the right message, and then you are effective.

[349] **Dr Hussey:** May I add a comment? What we have also seen in this period is an outbreak in a modern communications age. Underpinning that has been an opportunity to engage with the public. Rather than being about messaging, it has also been about listening to the concerns that were coming up and responding to that in shaping the next stage of the communication and the information sharing—both in very real time through social media, but then using that to inform the next public mainstream media approach. There is a lot to learn about that, both in terms of what is bothering people, what is concerning people, and identifying the questions that people are asking, but also the gearing up of a public health service response in a way that enables it to respond quickly. Once again, there have been great examples of how that has been done in this situation, but there are also real lessons in terms of how we gear up for future events like this.

[350] **David Rees:** Do any Members have any further questions? I see not. Therefore, we thank you, Minister, and your officials for attending this morning's meeting and for giving us the information. You will be given a copy of the transcript to check for any factual inaccuracies. Once again, thank you very much for attending today.

12.33 p.m.

Papurau i'w Nodi Papers to Note

[351] **David Rees:** Under this item are the minutes of the meetings held on 6, 12, 20 and 26 June, and 1 July; written evidence from the British Medical Association Cymru in relation to this inquiry; and written evidence from the Royal College of Nursing in relation to this

inquiry. Is everyone happy to agree those minutes? I see that you are. We also note the additional written evidence.

[352] I thank Members for their contributions to this morning's meeting. We will next meet formally on 18 July, next Thursday, at 9.30 a.m., when we will undertake a general and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Social Services.

[353] The committee has now agreed its report on Stage 1 of the Social Services and Well-being (Wales) Bill, which will be published in time for the 19 July deadline. I now close the meeting. Thank you very much.

Daeth y cyfarfod i ben am 12.34 p.m.
The meeting ended at 12.34 p.m.