Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
Thursday, 9 July 2015

Meeting time:
09.15

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

At its meeting on 1 July 2015 the Committee resolved under Standing Order 17.42(vi) to exclude the public for item 1 of the meeting on 9 July 2015

1 Regulation and Inspection of Social Care (Wales) Bill: discussion on order of consideration for Stage 2 proceedings (09.15 - 09.30) (Pages 1 - 3)

Note: Stage 2 proceedings on this Bill will only go ahead if the General Principles are agreed to on 14 July 2015.

2 Introductions, apologies and substitutions (09.30)

3 Public Health (Wales) Bill: evidence session 2 (09.30 - 10.30) (Pages 4 - 45)

Professor Mark Bellis, Public Health Wales
Dr Julie Bishop, Public Health Wales
Dr Quentin Sandifer, Public Health Wales

Break (10.30 - 10.50)

4 Public Health (Wales) Bill: evidence session 3 (10.50 - 11.50) (Pages 46 - 64)

Dr Gill Richardson, Aneurin Bevan University Health Board
Sara Hayes, Abertawe Bro Morgannwg University Health Board

5 Papers to note (11.50)

Minutes of the meetings on 17 and 25 June 2015 (Pages 65 - 69)

6 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from the remainder of the meeting (11.50)

7 Public Health (Wales) Bill: consideration of evidence (11.50 - 12.05)

8 The Committee's forward work programme (12.05 - 12.30)

Agenda Item 1

Document is Restricted

By virtue of paragraph(s) vi of Standing Order 17.42

Document is Restricted

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from Public Health Wales – PHB 03 / Tystiolaeth gan Iechyd Cyhoeddus Cymru – PHB 03

Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill

Date: June 2015	**Version:** 1b

1 Overview

Public Health Wales welcomes the opportunity to comment on the draft Public Health (Wales) Bill. The Welsh Government has taken a number of steps in ensuring health is considered across Governmental agendas in respect of legislation such as the Active Travel (Wales) Act and the Wellbeing of Future Generations Act. The Public Health (Wales) Bill, although relatively narrow in scope adds to the legislative framework for health improvement and health protection.

Previously, Public Health Wales advised that the proposed public health legislation should steer away from addressing specific - though pertinent - issues (i.e. restrictions on sales of tobacco and alcohol, use of sun beds, etc.) which could be set out in secondary legislation, regulations or other statutory instruments. There is a risk that in establishing such a list of specific matters to be addressed, the underpinning element of good mental health and well-being, essential to the achievement of many desired public health outcomes, is missed. We have acknowledged however, the approach being taken by Government in this regard and that the specific matters addressed in the White Paper are important public health issues in their own right and Public Health Wales looks forward to working with the Welsh Government to progress the actions described.

Public Health Wales recognises that the Wellbeing of Future Generations Act includes within it provision for a 'health in all policies' approach which will raise the profile of public health in society and increase awareness and knowledge of public health issues across government departments (national and local) and among those who develop and implement policy. This approach in tackling the wider determinants of health is pivotal to achieving the types of improvement in health and wellbeing and the reduction in health inequalities that are required in Wales. We will continue to work closely with Welsh Government and other partners in developing the Statutory Guidance that will support implementation of the Act to ensure that this potential is achieved.

It is critical that the wider influences of health and wellbeing are recognised within policy and legislation and Public Health Wales will continue to support and monitor the implementation of the Wellbeing of Future Generations Act and the extent to which the stated intention of a 'health in all policies' approach is being achieved in practice. If our assessment over time is that this is not the case we will engage constructively with Government and public services to identify either within the scope of the Wellbeing of Future Generations Act or through other legislation how this can be strengthened.

In our response to the White Paper we identified the need to define 'wellbeing' and that it was not appropriate for the only definition and use of 'wellbeing' to be in the Social Services and Well-being (Wales) Bill. The Public Health Bill must clearly define wellbeing within its provisions.

The sections that follow contain Public Health Wales' initial response to each of the questions raised in the Public Health White Paper consultation exercise. We have had little time to consider in detail some of the specific proposals within the Bill or to consult with key partners in formulating our response. We would like to submit further supplementary written evidence for consideration by the Committee prior to its deadline in September.

1.1 Minimum Unit Pricing Alcohol

Public Health Wales strongly supports the introduction of minimum unit pricing, alongside a range of other measures, to reduce the substantial harm associated with excess alcohol consumption in Wales. This was articulated in some detail in our submission to the consultation on the White Paper, we have attached this for information as Appendix 1.

We note that the intention is to introduce this measure through an alternative legislation and would welcome the opportunity to support Welsh Government in bringing this legislation into effect at the earliest opportunity.

1.2 Nutritional Standards

Public Health Wales strongly supported the proposals to extend nutritional standards within Pre-School settings and Care Homes as proposed within the White Paper. We note the intention to introduce these measures via secondary legislation or other means.

Poor nutrition is among the leading causes of avoidable ill health and premature death in Wales currently. It is essential that these measures are introduced at the earliest opportunity and that they have the necessary statutory basis to ensure that implementation is comprehensive and can be 'enforced'.

2 Part 2: Tobacco and Nicotine Products

2.1 Do you agree that the use of e-cigarettes should be banned in enclosed public and work places in Wales, as is currently the case for smoking tobacco?

Public Health Wales strongly supports this action.

2.2 What are your views on extending restrictions on smoking and e-cigarettes to some non-enclosed spaces (examples might include hospital grounds and children's playgrounds)?

Restrictions on the use of tobacco in public places serve two functions. The first is to restrict exposure to environmental tobacco smoke (ETS) to smokers and non-smokers. The second is to support the creation of an environment in which non-smoking is the norm, in which children in particular are exposed as infrequently as possible to adults smoking. The introduction of smoking restrictions in outdoor environments such as those listed above would support the second of these. While voluntary bans may have merit, we believe that the strong signal sent through legislation has more potential impact and supports local authorities, health boards and others in implementation. It also assists members of the public who can be certain as to whether or not they may smoke in a setting regardless of where in Wales they are.

We would suggest priority should be given to outdoor spaces used for leisure and recreation that may be frequented by children and the grounds of healthcare premises. Discussion on the classification of outdoor space is required, for example, whether beaches are regarded within the description of 'outdoor spaces used for leisure and recreation that may be

frequented by children' and if so, whether this would be seasonal or all year round.

2.3 Do you believe the provisions in the Bill will achieve a balance between the potential benefits to smokers wishing to quit with any potential dis-benefits related to the use of e-cigarettes?

Public Health Wales acknowledges the potential role of e-cigarettes in helping those smokers who wish to quit smoking or particularly those who, while not able to quit at the current time, wish to reduce the harm from using tobacco.

There is no evidence that the introduction of measures to restrict the use of electronic cigarettes in enclosed public places would undermine the potential benefits of harm reduction. There is no evidence that this will deter people from switching to a less harmful product. Smokers of tobacco currently are unable to smoke when and where they please and are well used to restrictions, if they switch to e-cigarettes then they will still gain in health terms. Those who would oppose restrictions argue that it suggests that using e-cigarettes is as harmful as smoking, however, it might reasonably be argued that an adult can more readily understand the rationale for the restriction than, a young child can distinguish between an adult using an e-cigarettes and a normal cigarette. A further argument used against this proposal, is that it will mean that the e-cigarette user is exposed to second hand smoke. In practice, if they use cigarettes they will also be exposed to second hand smoke so their overall risk is still substantially reduced.

It is important that the focus on e-cigarettes as a potential means to quit smoking does not overshadow other evidence based approaches and that smokers who wish to quit receive accurate information about the options available to them in making a quit attempt. Current evidence suggests that use of e-cigarettes in broadly in line with the use of nicotine replacement therapy bought over the counter.

We acknowledge that mode of use of e-cigarettes is different to tobacco in that users inhale much more frequently and that could lead to the need to take more frequent smoking breaks. However, current best practice in regard to smoking cessation would recommend the use of 'dual therapy' for nicotine replacement, that is the use of a long term produce such as a patch supplemented by more immediate acting products. The same approach can be utilised to assist smokers in coping within tobacco during the working day.

In conclusion, we believe that the proposals strike the appropriate balance between meeting the needs of smokers who wish to quit and avoidance of potential harm through normalisation of smoking behaviour. We believe this is entirely consistent with the principle outlined within the Wellbeing of Future Generations Act of '*balancing short term needs with the need to*

safeguard the ability to meet long term needs, especially where things done to meet short term needs may have detrimental long term effect'

2.4 Do you have any views on whether the use of e-cigarettes re-normalises smoking behaviours in smoke-free areas, and whether, given their appearance in replicating cigarettes, inadvertently promote smoking?

The UK and International Tobacco Control Policy has included a number of core, inter-related approaches. One of the key elements has been efforts to 'de-normalise' smoking as a behaviour. The underpinning rationale of this approach has been twofold:

- To create an environment in which young children were not routinely exposed to smoking as a normal behaviour of adults
- To support those smokers who are attempting to quit by providing environments which reduce cues to smoking behaviour or reduce the opportunity to smoke.

The widespread use of e-cigarettes in public places is likely to undermine these attempts.

2.5 Do you have any views on whether e-cigarettes are particularly appealing to young people and could lead to a greater uptake of their use among this age group, and which may ultimately lead to smoking tobacco products?

The presentation of e-cigarettes as a safe way to smoke may provide a route to nicotine addiction for children and young people. This in itself is clearly not something to be encouraged, a fact that seems to be overlooked in much of the debate and discussion about e-cigarettes. They may be preferable to smoking tobacco but their use is not something to be encouraged – regardless of whether this leads to use of other nicotine products. In addition it is possible that, once established, nicotine addiction could lead to tobacco use. However, it will be some time before reliable evidence is available that either supports or refutes these concerns.

There is very little information available on the use of e-cigarettes among young people. Given that the product is still relatively new to the market and the rapid growth in their use has been within the last two to three years, it is almost certainly too soon to draw conclusions.

The most recent published information from Wales, the CHETS 2 study[1], confirms findings of other studies internationally, that e-cigarette

experimentation is widespread but that regular use among previous non tobacco users is rare. However, this study does not provide conclusive evidence that there is no risk and raises concerns about the use of e-cigarettes in those vulnerable to tobacco use. The study found that among non-smoking children who reported having used an e-cigarette, 14% reported they might start smoking within the next two years (compared to 2% of those who had not used an e-cigarette) and although intention to smoke within two years was relatively low, children who had used an e-cigarette were substantially less likely to say they definitely will not smoke, and more likely to say that they might.

Action on Smoking and Health (ASH) has conducted a regular survey of use of e-cigarettes among adults in the UK since 2010 and has extended this to young people aged 16 – 18 years in 2013[2]. This survey found that awareness of e-cigarettes among children and young people was high at 83 per cent but that use in this group was low at 7 per cent, the majority of whom were current smokers.

A survey in the Cheshire and Merseyside area by North West Trading Standards[3] in students aged 14 – 17 years asked if they had ever bought or tried e-cigarettes. A total of 5,845 young people responded to the survey and 12.7 per cent stated they had accessed e-cigarettes. The majority were current or ex-smokers but 2.4 per cent had never smoked tobacco. Use was also associated with having a parent or guardian who smoked which would reflect known risk factors for smoking.

While these surveys do not suggest widespread use of e-cigarettes it would be inappropriate to draw too much reassurance from this data at this time. There is evidence of use and there is evidence of the conditions (i.e. promotion and widespread use in public), that would encourage increased use. It would seem inappropriate to wait to act until there is clear evidence of a problem. The awareness of children in the ASH survey[4] that e-cigarettes are safer than tobacco (79 per cent) is a potential concern as this could lead to adoption of the habit because it is perceived to be safe.

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[1] http://bmjopen.bmj.com/content/5/4/e007072.full

[2] ASH. Electronic Cigarettes. ASH Briefing, March 2014. www.ash.org.uk (last accessed 16/06/14)

[3] E-cigarette access among young people in Cheshire and Merseyside. Centre for Public Health, Liverpool John Moores University. March 2014. www.cph.org.uk (accessed 16/06/14)

[4] ASH. Electronic Cigarettes. ASH Briefing, March 2014. www.ash.org.uk (last accessed 16/06/14)

2.6 Do you have any views on whether restricting the use of e-cigarettes in current smoke-free areas will aid managers of premises to enforce the current non-smoking regime?

Currently, as there are a number of products which clearly mimic cigarettes in their appearance, the ability of enforcement officers and the managers/owners of these premises to rapidly determine the difference would be difficult. Legislation on the use of these products would provide much needed clarity and ensure a consistent message across Wales.

We are aware from evidence provided by our public health colleagues in local authorities that there are clear examples of where prosecution in relation to the Smoking Ban has been challenged on the grounds that it was an e-cigarette that was being used. This potential defence clearly undermines existing anti-tobacco legislation.

2.7 Do you have any views on the level of fines to be imposed on a person guilty of offences listed under this Part?

It is clearly important that the level of fine is sufficient to act as a meaningful deterrent. We have no specific information currently that would enable us to comment on whether the proposed level is sufficient but will provide a further response following discussions with enforcement colleagues and more detailed consideration of the literature on this subject.

2.8 Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?

Public Health Wales strongly supports this action, which is in line with Welsh Government and local Tobacco Control Action Plans to reduce smoking prevalence through prevention of uptake of smoking in young people.

2.9 **Do you believe the establishment of a register will help protect under 18s from accessing tobacco and nicotine products?**

Enforcement of underage sales is a key component of a strategy to prevent smoking uptake. Supporting enforcement, in this case through a register, would strongly enhance current measures. It is likely that the measure will also support enforcement of display regulations. Identifying locations where the sale of tobacco is permitted may help with the identification of premises where tobacco is sold illicitly.

We also believe that the measure contributes to the denormalising of tobacco as a product i.e. it is not the same as other consumer products and should not be available for sale in the same way. The introduction of

registration re-enforces this position. We also believe that over time it may be possible to use a register to monitor systematically trends in illegal sales to young people – the current important enforcement and intelligence based approach used by local authorities does not enable Government of public health agencies to understand whether there is a declining trend in likelihood of non-compliance which would be a key goal of tobacco control policy. We also believe that it would offer potential to consider density of tobacco control outlets and their control by local authorities as a public health measure in future.

We consider it appropriate to extend the provision to e-cigarettes and limit their sale to registered retailers. This would support enforcement of proposed legislation on making sale of these products to those under age illegal.

2.10 Do you believe a strengthened Restricted Premises Order regime, with a national register, will aid local authorities in enforcing tobacco and nicotine offences?

Public Health Wales would support the proposal to enable local authority enforcement officers to introduce a restricted premises order (RPO). However, as prosecutions for non compliance with under age sales regulations are infrequent, it seems unlikely in practice that retailers would be identified as having repeated infringement of the regulations. We would suggest that consideration be given to a 12 month order following a single infringement or at least the powers to make an application to a magistrate to grant an RSO or RPO. We would suggest that repeated infringement should carry a longer term restriction.

Our review of the international evidence in this field supports the view that while the introduction of legislation is important it will only be effective if accompanied by active enforcement and a meaningful deterrent.

2.11 What are your views on creating a new offence for knowingly handing over tobacco and nicotine products to a person under 18, which the is legal age of sale in Wales?

The growth of online shopping would suggest the need to revisit all age restricted sales in this way. The introduction of this new offence is supported by Public Health Wales to ensure that all tobacco products are received only by an adult.

2.12 **Do you believe the proposals relating to tobacco and nicotine products contained in the Bill will contribute to improving public health in Wales?**

Public Health Wales fully supports the proposals relating to tobacco and nicotine products contained in the Bill.

3 Part 3: Special Procedures

3.1 What are your views on creating a compulsory, national licensing system for practitioners of specified special procedures in Wales, and that the premises or vehicle from which the practitioners operate must be approved?

Public Health Wales supports the proposal for a National Special Procedures Register to ensure the provision of consistent standards in respect of infection control, cleanliness and hygiene for all practitioners and businesses operating any of the listed treatments.

There is some older evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare.[15-17] A recent review suggests there is a significant risk of transmission through piercing and tattooing procedures which are not done under sterile conditions, such as at home or in prison.[18] However, in our view, the risk of transmission is the same in commercial parlours where sterile conditions and infection control measures are not in place. Scarring from complications following such procedures can also have long-term psychological impacts.[19-21] Anecdotal evidence suggests that individuals with localised infections associated with such procedures often present in GP practices and Accident and Emergency departments, particularly following tongue piercings. All of the nine cases identified in the look back exercise self-presented to healthcare, often multiple times.

The Register should also consider requiring practitioners of special procedures to have received a course of Hepatitis B vaccinations and routine testing for blood borne viruses.

The current legislation does not adequately protect the public and these procedures have the potential to cause harm if not carried out safely. In a recent look back exercise in Wales, nine people were identified as needing hospital admission due to severe *Pseudomonas aureaginosa* infection, eight of whom required surgical intervention (including incision, drainage, reconstruction and stitching), following body piercing at a tattoo and body piercing premises. The individuals needed weeks of hospital treatment and follow-up care, and some are permanently disfigured. More minor problems for other clients included swelling and trauma around the site, scarring, local skin infections, and allergic reactions which were more prevalent. A lack of good hygiene and infection control can lead to blood poisoning (sepsis) or transmission of blood-borne infections through contaminated equipment, such Hepatitis B, Hepatitis C or HIV.

3.2 Do you agree with the types of special procedures defined in the Bill?

Public Health Wales agrees with the types of procedures included within the Bill and the acknowledgement that this is a changing field and the need to include provision to amend the regulations accordingly. In our initial response we had identified other procedures that might be included within the scope of the Bill which have not been included e.g. injections or fillers. This Bill also presents an opportunity to regulate the administration of the following procedures: body modification (to include stretching, scarification, sub-dermal implantation/3D implants, branding and tongue splitting), injection of any liquid into the body e.g. Botox or dermal fillers, dental jewellery, chemical peels, and laser treatments such as used for tattoo removal or in hair removal.

We note that these have not been included within the Bill, it is possible that this will be encompassed within specific requirements for cosmetic procedures in line with those proposed by the UK Government for England following the Keogh Review in 2013[5].

3.3 What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?

Public Health Wales is of the opinion that the ability to amend the Register to enable the inclusion and removal of specific procedures would enable the Welsh Government to adapt and change legislation in accordance with new trends and patterns in body modification.

3.4 The Bill includes a list of specific professions that are exempt from needing a licence to practice special procedures. Do you have any views on the list?

The exemptions proposed include all of the registered health professions, Further consideration would be required as to whether all of the professions included within the scope of this definition would have the necessary competence by virtue of their professional registration to undertake these procedures.

3.5 Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?

No specific observations at this time.

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5 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf

3.6 Do you believe the proposals relating to special procedures contained in the Bill will contribute to improving public health in Wales?

The proposals will certainly improve the protection of public health. Recent experience within Wales relating to a 'look back' exercise conducted by Aneurin Bevan Health Board in relation to potential infection risk in Tattoo Parlours in the area has highlighted the potential risk to Public Health from these procedures. We are currently reviewing the learning from this exercise with colleagues in Health Boards and Local Authorities and will provide additional evidence to the Committee should this highlight additional measures that may be of benefit.

4 Part 4: Intimate Piercing

4.1 Do you believe an age restriction is required for intimate body piercing? What are your views on prohibiting the intimate piercing of anyone under the age of 16 in Wales?

Public Health Wales supports these proposals.

4.2 Do you agree with the list of intimate body parts defined in the Bill?

Yes, however we would propose that the risks posed by piercing of the tongue and lip also offer significant risks to the health of children and that the scope of the proposed regulations should be extended to include this area of the body.

4.3 Do you have any views on the proposals to place a duty on local authorities to enforce the provisions, and to provide local authorities with the power to enter premises, as set out in the Bill?

Public Health Wales agrees with these proposals.

4.4 Do you believe the proposals relating to intimate piercing contained in the Bill will contribute to improving public health in Wales?

Public Health Wales agrees that these proposals will strengthen the protection of public health in Wales.

5 Part 5: Pharmaceutical Services

Part 5 of the Bill includes provision to require each local health board to publish an assessment of the need for pharmaceutical services in its area

with the aim of ensuring that decisions about the location and extent of pharmaceutical services are based the pharmaceutical needs of local communities.

Public Health Wales is supportive of the proposals outlined with the Bill in relation to Pharmaceutical Services. We have attached our response to the White Paper consultation which provides further information on this issue (Appendix 2).

6 Part 6: Provision of Toilets

6.1 What are your views on the proposal that each local authority in Wales will be under a duty to prepare and publish a local toilets strategy for its area?

Public Health Wales is in no doubt that the provision of toilets for public use should be regarded as an important public health issue. We fully recognise the challenges of safeguarding the existing provision or improving provision in the current economic climate. Whilst the preparation of a strategy that considers the need for and plans for the future provision of toilets for public use would provide clarity at the local level (for elected members, officers and the public) the real issue of making resources available to address this issue remains. The writing of a strategy alone will not automatically improve provision.

Public Health Wales recognises that access to toilet facilities when away from home is an important public health issue, but precise quantitative evidence of need is often lacking. Publicly accessible toilets are a necessity to maintain population health for everyone, but some groups have specific needs. These groups include people with disability, parents with babies and young children, pregnant women, older people and those with specific conditions including incontinence, inflammatory bowel disease, irritable bowel syndrome, multiple sclerosis, and people who have been prescribed diuretics. If toilet provision is inadequate, people can become afraid or reluctant to go out away from the home for periods of time, leading to poor mobility, isolation and depression.

6.2 Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?

Public Health Wales is cognisant of the financial pressures experienced by local authorities at this time. This presents challenges in local authorities' ability to safeguard existing provision and to promote new facilities. The statutory duty to write a strategy will have little impact on actual provision, unless resources can be identified to put such a strategy in place. A requirement to undertake health impact assessment of changes

to service provision and policy decisions would permit the consideration of the adequacy of public toilet provision in an area.

6.3 Do you believe the provision in the Bill to ensure appropriate engagement with communities is sufficient to guarantee the views of local people are taken into account in the development of local toilet strategies?

Section 92 of the Bill refers not only to communities but includes "any person it considers likely to be interested in the provision of toilets in its area". This should include not only local communities but also, for example, those representing specific age groups, people with disabilities or impairments or those with medical problems. Consultation should also include the needs of homeless people, mobile workers and visitors to the area. It is essential that toilet provision should be adequate at transport hubs and in city centres where local communities will be a minority of potential users.

6.4 Do you have any views on whether the Welsh Ministers' ability to issue guidance on the development of strategies would lead to a more consistent approach across local authorities?

Guidance on the development of strategies is likely to lead to a more consistent approach across local authorities.

6.5 What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?

It would be useful if toilet facilities could be made available in settings such as leisure centres, libraries, subsidised theatres, arts centres, galleries and museums. This is already the case in some of these venues but may not be widely known by some members of the public. However, this would not be a complete answer to provision for public use due to restricted opening hours.

6.6 Do you believe including changing facilities for babies and for disabled people within the term 'toilets' is sufficient to ensure that the needs of all groups are taken into account in the development of local toilet strategies?

Including changing facilities for babies and for disabled people within the term 'toilets' is insufficient to ensure that the needs of all groups are taken into account in the development of local toilet strategies.

6.7 Do you believe the proposals relating to toilet provision in the Bill will contribute to improving public health in Wales?

Provision of more toilets for public use should contribute to improving public health, but only if they are well designed and appropriately located with high standards of maintenance and cleaning. Different categories of user and their specific needs should be considered when making provision, as set out above.

Additional Material from Public Health Wales NHS Trust Response to the Consultation on the Public Health White Paper – Listening to You Your Health Matters

Appendix 1 – Minimum Unit Pricing Alcohol

Public Health Wales shares the Welsh Government's concerns regarding the levels of alcohol related harm in Wales. We support the view that the consideration of public health should be one of the statutory licensing objectives under the Licensing Act 2003 and that all other available controls should be maximised at the local level. Most notably, the opportunities of the local development planning process should be promoted to ensure that health impacts are taken into account during local decision making. The Public Health Wales evidence based position on the issue of Minimum Unit Price is reproduced in full in our response, for completeness and accuracy, recognising that there is a notable overlap with the evidence presented in the White Paper.

Minimum Unit Pricing

15. Given the evidence base and public health considerations, do you agree that the Welsh Government should introduce a Minimum Unit Price for alcohol?

There is compelling evidence that introducing a minimum unit price in Wales would lead to significant improvements in health and well-being. Recent decades have seen increases in alcohol consumption and health harms associated with alcohol across Wales. These increases are linked with real terms reductions in the cost of alcohol. A minimum unit price is a targeted measure that will impact beneficially on the heaviest drinkers and other groups particularly at risk from alcohol related harms – such as young people. Moderate drinkers will experience relatively little change in the amount they have to pay for alcohol. The evidence for this is presented below and as a result of this compelling evidence Public Health Wales strongly supports implementation of the minimum unit price for alcohol in Wales.

Minimum Unit Price (MUP) sets a floor price for a unit of alcohol[6], meaning that alcohol could not legally be sold below that price. This would not increase the price of every drink, only those that are sold below the minimum price; for example very cheap spirits, beer and wine. MUP is based on two fundamental principles that are widely supported by scientific evidence:[7,8,9]

[6] 25ml spirit (40%) is one unit, 175ml of wine (13%) 2.3 units, a pint of cider (4.5%) 2.6 units, a pint of beer (4%) 2.3 units;

[7] Stockwell and Thomas, (2013) Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol. Institute of Alcohol Studies Report

[8] Wagenaar AC, Salois MJ, and Komro KA (2009) Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction*, *104*, 179-90

[9] Wagenaar, A., Tobler, A. and Komro, K. (2010) Effects of alcohol tax and price policies on morbidity and mortality: A systematic review. *American Journal of Public Health*, published online September 23, 2010 at: http://ajph.aphapublications.org/cgi/content/abstract/AJPH.2009.186007v1

- When the price of alcohol increases consumption by most drinkers goes down including, critically, consumption by hazardous and harmful drinkers (i.e. heavier drinkers)
- When alcohol consumption in a population declines, rates of alcohol-related harms also decline

Drinking alcohol increases the risk of developing over 60 different health problems[10] including a range of cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions. It also increases the risk of causing harms to the health of others.

UK Government guidelines for the consumption of alcohol recommend that to limit the harms from alcohol to their health: men should not regularly (every day or most days of the week) drink more than the lower risk guidelines of 3-4 units of alcohol (equivalent to a pint and a half of 4 per cent alcohol by volume [ABV] beer) and women more than 2-3 units (equivalent to a 175 ml glass of wine).

The 2011 General Lifestyle Survey (GLS[11]) showed that the percentage of persons that drank more than 3-4 units on at least one day in Wales (28 per cent) was similar to Scotland (31 per cent) and England (31 per cent). Those drinking more than 6-8 units on at least one day was the same in Wales (15 per cent) as in England (15 per cent) and similar to Scotland (16 per cent). Residents of England and Wales (13 per cent and 12 per cent respectively) were more likely than men in Scotland (7 per cent) to have had an alcoholic drink on at least five days in that week.

The Welsh Health Survey[12] (2012) reported that around two in five (42 per cent) adults reported drinking above the recommended guidelines on at least one day in the past week, including 26 per cent who reported binge drinking (drinking more than twice the daily guidelines). Men were more likely than women to report drinking above the recommended guidelines on at least one day in the past week (48 per cent of men compared with 36 per cent of women) and to report binge drinking (31 per cent of men, 21 per cent of women).

Importantly, social surveys consistently record lower levels of consumption than would be expected from data on alcohol sales, partly because people often underestimate how much alcohol they consume.

Although alcohol sales data are not available for Wales, 2012 sales data for the UK show that consumption was estimated at 22 units per person

[10] World Health Organisation (2009) Harmful Use of Alcohol http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf
[11] Office for National Statistics, (2011) *'General Lifestyle Survey'* [online] Available at: http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/index.html
[12] Welsh Government (2012) *'Welsh Health Survey'* [online] Available at: http://wales.gov.uk/statistics-and-research/welsh-health-survey/?lang=en WHO. Alcohol policy in the WHO European Region: current status and the way forward.

per week. This is a much greater level than recorded in surveys and suggests that more people exceed weekly guidelines than surveys would suggest.

The past four decades have seen a rise in alcohol consumption and although the reasons behind this are complex and multi-factorial, affordability is a key factor.

It has been reported that alcohol is 45 per cent more affordable than in 1980 and the increase in affordability of alcohol has been linked with increased alcohol consumption and related health harms[13,14,15,16].

Men and women in the UK can now exceed recommended daily limits for about £1 if they purchase inexpensive alcohol from supermarkets or other off-trade outlets[17].

A 2005 review by the World Health Organisation (WHO)[18] of 32 European alcohol strategies found that the most effective measures to curb alcohol related health harms include changes to price and availability.

By comparison other measures (public service campaigns, education initiatives, and voluntary self regulation preferred by the alcohol industry) have more limited impacts on drinking patterns and problems.

This evidence has led several countries to consider MUP policy[19].

16. Do you agree that a level of 50 pence per unit is appropriate? If not, what level do you think would be appropriate?

Based on the evidence provided here, Public Health Wales regards a level of 50 pence per unit MUP as an appropriate level at which to initially establish a MUP. Sufficient modelling has already been undertaken in England and elsewhere to estimate the benefits that a 50 pence MUP would have on alcohol consumption and related health harms. However, this is based on current levels of affordability of alcohol (2014), and we consider that MUP should be linked to an inflationary measure to ensure it remains an effective measure to reduce alcohol health harms. Should the introduction of MUP be delayed the initial MUP should be adjusted from 50p to account for inflationary trends up to the point of its introduction.

[13] Institute for Social Marketing: University of Stirling (2013) '*Health First: An evidence-based strategy for the UK'* [online] Available at: http://www.stir.ac.uk/management/about/social-marketing/
[14] Home Office (2012) *A minimum unit price for alcohol: impact assessment 1A*. Home Office, London, UK.
[15] Anderson, P., Chisholm, D. and Fuhr, D. (2009) Alcohol and Global Health 2: Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet, 373,* 2234–46.
[16] Gallet, C.A. (2007) The demand for alcohol: a meta-analysis of elasticities. *Australian Journal of Agriculture and Resource Economics*, *51*, 121-35.
[17] Institute for Social Marketing: University of Stirling (2013) '*Health First: An evidence-based strategy for the UK'* [online] Available at: http://www.stir.ac.uk/management/about/social-marketing/
[18] WHO fact sheet. 2005. www.parpa.pl/download/fs1005e2.pdf.
[19] Holmes, J., Meng, Y., Meier, P.S., Brennan, A., Angus, C., Campbell-Burton, A., Guo, Y., Hill-McManus, D. and Purshouse, R.C. (2014) Eff ects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. *Lancet, 383,* 1655-1664

Both US and UK data show that the heaviest drinkers gravitate towards the cheapest alcohol[20,21]. As a result MUP affects heavy drinkers' consumption much more than light or moderate drinkers. Consequently, MUP is a targeted measure which primarily impacts heavy drinkers.

In England, modelling suggests that a 50 pence MUP would result in:

- a harmful drinker drinking 368 fewer units per year
- a moderate drinker drinking 11 fewer units per year
- an annual reduction in alcohol related deaths of 12.3 per cent and in alcohol related hospital admissions of 10.3 per cent

Concerns around the possibility of a hard-hitting impact on those with low incomes have been a critical consideration of MUP debate,[22,23] however, for the majority of people on low incomes who are abstainers, light or moderate drinkers, the financial impacts of MUP are very small.

While a moderate drinker may see a small increase in costs of alcohol per year with a MUP of 50 pence (around £43.17- £55.57[24], however, this figure is based on the average drinker per annum), this should be seen in the context of national costs from alcohol related harms (health, social, economic and criminal justice) being equivalent to around £900 per family. These harm-related costs could be substantially reduced if a MUP was introduced.

Work in Scotland suggests that an MUP of 50 pence per unit would reduce alcohol-related hospital admissions in Scotland by 8,900 annually and would reduce alcohol related criminal offences by 4,200, with a total value of an estimated saving of £1.3 billion over 10 years.[25]

The inclusion of impacts of MUP on crime is an important health and well-being consideration. Therefore, as well as harm to the individual who is drinking, alcohol consumption can also impact the wellbeing of wider society through reducing alcohol-related crime, including those relating to violent, anti-social and disorderly behaviour, acquisitive crime and criminal damage.

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[20] Kerr, W. C. and T. K. Greenfield (2007). "Distribution of alcohol consumption and expenditures and the impact of improved measurement on coverage of alcohol sales in the 2000 National Alcohol Survey." *Alcoholism: Clinical and Experimental Research*, *31,* 1714-1722.

[21] Meier, P., Brennan, A., Purshouse, R., Taylor, K., Raffia, R., Booth, A., O'Reilly, D., Stockwell, T., Sutton, A., Wilkinson, A. and Wong, R. (2008) *Independent review of the effects of alcohol pricing and promotion, Part B. Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model, Version 2008(1-1)*. University of Sheffield, Sheffield, UK. Report commissioned by the UK Department of Health.

[22] Hansard. House of Commons Debate 14 March 2013. *Hansard* 2013; **560:** 451–91.

[23] Duffy, J.C. and Snowdon, C. (2012) The minimal evidence for minimum pricing: the fatal flaws in the Sheffield alcohol policy model. http:// www.adamsmith.org/blog/liberty-justice/the-minimal-evidence-forminimum- pricing (accessed July 2, 2013).

[24] Purhouse, R., Brennan, A., Latimer, N., Meng, Y., Rafia, R., Jackson, R. and Meier, P. (2009) Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0) http://www.nice.org.uk/nicemedia/live/11828/45668/45668.pdf

[25] School of Health and Related Research, University of Sheffield. Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland. www.shef.ac.uk/polopoly_fs/1.95608!/file/scottishadaptation.pdf.

The Crime Survey for England and Wales reports that within the year 2011/12 there was 917,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47 per cent of violent offences that year. Alcohol routinely accounts for over 40 per cent of all violent crimes committed[26] and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide)[27].

In Scotland 50 per cent of people reported one or more harms as a result of someone else's drinking in the last year[28].

Modelling undertaken for England and Scotland suggest a MUP of 50 pence would reduce alcohol related violence.

A MUP of 50 pence would not impact the cost of alcohol in licensed settings (e.g. pubs) but would increase the cost of the cheapest alcohol sold in off-licences settings (e.g. supermarkets). This is an important affect as the difference in costs between the two settings is driving health harming behaviours such as pre-loading with alcohol especially in young people, before going out for a night[29].

17. Do you agree that enforcing Minimum Unit Pricing for alcohol would support the reduction in alcohol related harms? Please provide evidence to support your answer, if available.

Public Health Wales agrees that enforcing a MUP for alcohol would reduce alcohol related harms. We have presented much of the evidence to support this position in the above sections. We have provided some additional information below.

MUP in Canada has proved a successful measure for reducing alcohol-related harms; including reducing alcohol-related deaths.[30]

In British Columbia with a population of 4.6million, a 10 per cent increase in the average minimum price of all alcoholic beverages was associated with a 9 per cent decrease in acute alcohol-attributable admissions and a 9 per cent reduction in chronic alcohol-attributable admissions two years later[31]. It was estimated from this that a 10 cent (approximately 6 pence)

[26] British Crime Survey, ONS; http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales
[27] World Health Organisation (2006) Interpersonal violence and alcohol. http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf
[28] Alcohol Focus Scotland (2013) Unrecognised and under-reported: the impact of alcohol on people other than the drinker in Scotland. http://www.alcohol-focus-scotland.org.uk/alcohol-harm-to-others
[29] Barton, A. and Husk, K. (2012) Controlling pre-loaders: alcohol related violence in an English night time economy, *Drugs and Alcohol Today, 12,* 89-97.
[30] Zhao, J., Stockwell, T., Martin, G., Macdonald, S., Valance, K., Treno, A., Ponicki, W., Tu, A. and Buxton, J. 2013. The relationship between changes to minimum alcohol price, outlet densities and alcohol-related death in British Columbia, 2002-2009. *Addiction*. URL:http://onlinelibrary.wiley.com/doi/10.1111/add.12139/pdf.
[31] Stockwell, T., Zhao, J., Martin,G. Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A. And Buxton, J. (2013) Minimum alcohol prices and outlet densities in British Columbia, Canada: estimated impacts on alcohol-attributable hospital admissions. *American Journal of Public Health, 103,* 2014-20.

increase in average minimum price was associated with 2 per cent (166) fewer acute admissions in the first year and 3 per cent (275) fewer chronic admissions two years later. Canada is one of six countries that have introduced some form of MUP and in every case the observed impacts on reducing consumption (and consequently preventing related harms) have been larger than those estimated.

The estimated costs to the health service in Wales of alcohol-related harm are between £70 and £85 million each year.[32] These costs have increased since the 1970s, as alcohol has become more affordable and alcohol-related deaths and disease have risen. Therefore, Wales appears to be price sensitive to alcohol with harms increasing as alcohol becomes more affordable.

Thus, the number of alcohol-related deaths[33] for males in Wales from alcohol increased from 236 in 2002 to 311 in 2012. The corresponding increase for females was 34 per cent from 127 to 193 deaths. The number over the last five years has declined slightly from 541 in 2008 to 504 in 2012 but actually rose again between 2011 and 2012.[34]

Wales's (episode-based) rates for hospital admissions caused solely by alcohol (e.g. alcoholic liver disease or alcohol poisoning) has increased consistently from 2001/02 to 2011/12. Among females, alcohol-specific admissions per 100,000 population increased from 2001/02 (274.4) to 2011/12 (335.5), with a comparable increase among males (537.5 in 2001/02 to 675.5 in 2011/12).

When considering alcohol specific conditions plus alcohol related conditions (those that are caused by alcohol in some, but not in all cases; e.g. stomach cancer and unintentional injury) in the past 10 years, the overall rate in Wales has increased (1,280.9 in 2001/02 to 1,643.7 in 2011/12). This increase has been observed among females (951.6 to 1,185.4) and males (1,650.5 to 2,158.0).

Many of the health harms associated with alcohol fall disproportionately on the most deprived communities, with levels of alcohol related deaths across Wales increasing from the most affluent to the most deprived quintile. Consequently, tackling alcohol related ill health is an important element in reducing inequalities in health[35].

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[32] Welsh Assembly Government (2008) 'Working Together to Reduce Harm, The Substance Misuse Strategy for Wales 2008-2018'.

[33] 'Alcohol-related deaths' follow the Office for National Statistics (ONS) definition of alcohol-related deaths (which includes causes regarded as most directly due to alcohol consumption). ONS has agreed with the GROS and NISRA that this definition will be used to report alcohol-related deaths for the UK. In January 2011, the software used by the Office for National Statistics (ONS) for cause of death coding was updated from the ICD–10 v2001.2 to v2010. The main changes in ICD-10 v2010 are amendments to the modification tables and selection rules, which are used to ascertain a causal sequence and consistently assign underlying cause of death from the conditions recorded on the death certificate. Overall, the impact of these changes is small although some cause groups are affected more than others. Please refer to Results of the ICD-10 v2010 bridge coding study, England and Wales - 2009 . Please note that these mortality figures have NOT been adjusted in any way to compensate for these changes.

[34] PEDW; NWIS https://www.healthmapswales.wales.nhs.uk/IAS/dataviews/report/multiple?reportId=60&viewId=117&geoTypeId=7,2

[35] A Profile of alcohol and health in Wales (2009)

Based on evidence from Canada and elsewhere, MUP would help substantially in reversing these health harming trends relating to alcohol consumption in Wales.

18. Do you think any level of Minimum Unit Pricing set by the Welsh Government should be reviewed and adjusted over time? Please provide evidence to support your answer, if available.

See response to question 17.

19. As the Welsh Government cannot legislate on the licensing of the sale and supply of alcohol, what enforcement and/or penalty arrangements do you think should be in place to introduce Minimum Unit Pricing for alcohol in Wales?

Public Health Wales is not currently in a position to provide specialist legal advice on the implementation of a Minimum Unit Price for alcohol across Wales. However, we would suggest the points below are taken into consideration:

- We are aware the issue of compatibility between European law and MUP has been raised as an issue. We understand that certain articles prohibit quantitative restrictions between Member States on the Union's founding principle that goods must be able to move freely between Member States

- Opponents to MUP argue that if goods are subjected to minimum prices in one Member State this could act as a barrier to the free movement of such goods

- However, European law stipulates that such articles do not preclude consideration of public morality, public policy or the protection of health and the lives of humans. In other words measures such as MUP could be introduced when the public health case is sufficiently strong

- Any measures implemented on the basis of Public Health must be proportionate. In other words it is important to demonstrate that public health benefits sought justify the measures implemented and that the same outcome would not be achievable by a less intrusive measure

- Public Health Wales believes that there is a strong case across Wales that MUP is a measure proportionate to expected reductions in health harms and numbers of lives saved

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http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/0400558233b1c95c802576ea00407a33/$FILE/Alcohol%20and%20health%20in%20Wales_WebFinal_E.pdf

- Further, we understand that when raised by the Association of Greater Manchester Authorities, their legal advice refuted the claim that minimum pricing imposed at the sole instigation of a public authority would be an infringement of national and EU competition law

- As the measure that is likely to at least involve consideration of law changes and how they would impact public health, Public Health Wales is keen to work with Welsh Government on the possible options to implement MUP

- Public Health Wales would suggest the implementation of bye laws across Wales be explored alongside the use of existing licensing legislation that allows conditions to be attached to alcohol licenses

- As well as legislative measures, it may also be worth considering opportunities to allow additional freedoms and incentives to those who operate a MUP policy on the basis that they are not contributing to the costs resulting from sales of cheap alcohol that fall on health, criminal justice, education systems and the broader economy

- A number of local authorities in England and Wales have taken steps towards implementing MUP. Wales would be well placed to bring these players together to share learning and provide leadership for authorities wishing to tackle alcohol related harms to health through MUP. Public Health Wales would be keen to support such a forum with the support of the Welsh Government

20. Do you think there are other measures that should be pursued in order to reduce the harms associated with excessive alcohol consumption?

Public Health Wales recommends a range of other evidence based measures should be considered in order to reduce the harms caused by alcohol to Welsh citizens. None of these require MUP so are not dependent on MUP being in place but would work in synergy to reduce alcohol harms to health. Not all of these measures can be unilaterally implemented in Wales as devolved powers do not allow their introduction. However, we believe Wales can still act as a powerful advocate for creating a culture where people are better informed about the harms associated with alcohol consumption and the real costs of alcohol are reflected in the price at which it is sold. Further work is required to identify the best way of delivering these through action and advocacy within existing devolved powers. While provision of evidence to support all the actions suggested below would be inappropriate in this consultation we believe there is sufficient evidence already available to support[7]:

- Public health and community safety should be given priority in all public policy-making about alcohol

- At least one third of every alcohol product label is an evidence based health warning from an independent regulatory body
- Sales in shops should be restricted to specific times of the day and designated areas with no promotion outside these areas
- Tax on alcohol products should be proportionate to volume of alcohol to incentivise sales of lower strength products
- Licensing authorities should be empowered to tackle alcohol-related harm by controlling total availability in their area
- Alcohol advertising should be strictly limited to newspapers and other adult press while its content should be limited to factual information
- There should be an independent body to regulate alcohol promotion, including product and packaging design for public health and community safety
- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
- Graduated driver licensing should be introduced, restricting the circumstances in which young and novice drivers can drive
- All health and social care professionals should be trained to provide early identification and brief alcohol advice
- People who need support for alcohol problems should be routinely referred to specialist alcohol services for assessment and treatment
- Existing laws to prohibit the sale of alcohol to individuals who are already heavily intoxicated should be enforced in order to reduce acute and long term harms to their health and that of the individuals around them

Appendix 2 – Part 5 Pharmaceutical Services

Public Health Wales agrees that there is considerable public health benefit to be gained by ensuring that health boards have a stronger role in planning pharmaceutical services in their areas.

Public Health Wales is pleased to note that the pharmaceutical profession is increasingly recognising the important role that pharmacists can play in improving the health and wellbeing of the public, as manifested in the recent development of professional standards that reflect public health competences. Whilst not all pharmacists will be required to meet all nine of these standards, this development does demonstrate that the profession is preparing to take on a greater role in public health.

Public Health Wales would highlight that the introduction of pharmaceutical needs assessments will have resource implications for our teams in Pharmaceutical Public Health, the Public Health Wales Public Health Observatory and the local public health teams.

24. Do you agree community pharmacies can play a stronger role in promoting and protecting the health of individuals, families and local communities as part of a network of local health care services?

Public Health Wales agrees that community pharmacies should play a stronger role in promoting and protecting the health of individuals, families and local communities as part of a network of local health care services.

We recognise that pharmacies are found in the heart of communities and are more likely to be located in the most deprived areas of Wales[36] and therefore, have a reach into those communities which could benefit most from greater support to promote and protect health.

The ability of pharmacies to deliver healthy lifestyle messages has been demonstrated in the evaluations of a number of national public health campaigns[37,38,39]. The campaigns were co-ordinated on behalf of health boards by Public Health Wales, and delivered in collaboration with Community Pharmacy Wales and third sector organisations.

[36] Hinchliffe A. (2012) Distribution of pharmacies and deprivation in Wales v1 Available at http://www2.nphs.wales.nhs.uk:8080/pharmaceuticalphtdocs.nsf/61c1e930f9121fd080256f2a004937ed/db81e21d6dd7e3a38025798900523f74?OpenDocument

[37] Evans A. (2014) Eye health campaign final report 2014 Available at http://www2.nphs.wales.nhs.uk:8080/pharmaceuticalphtdocs.nsf/61c1e930f9121fd080256f2a004937ed/53f5fc99bc39a12480257c85003c5ca5?OpenDocument&AutoFramed

[38] Evans A. (2013) Love your lungs evaluation final report Available at http://www2.nphs.wales.nhs.uk:8080/pharmaceuticalphtdocs.nsf/61c1e930f9121fd080256f2a004937ed/b967d8e3607cba2880257b430035c43f?OpenDocument&AutoFramed

[39] Brennan N. (2012) Education programmes for patients. Community pharmacy public health campaign report Available at http://www2.nphs.wales.nhs.uk:8080/pharmaceuticalphtdocs.nsf/61c1e930f9121fd080256f2a004937ed/6767e0d54074f12680257a48004ee581?OpenDocument

The introduction of essential, advanced and enhanced services in the community pharmacy contractual framework (2005) signalled the intention to broaden the range of services community pharmacies provide, increase access and make health service provision more flexible.

Community pharmacy has already shown its effectiveness in delivering enhanced services such as smoking cessation, substance misuse harm reduction and emergency hormonal contraception[40]. Other services which have been introduced more recently and been positively evaluated include flu vaccination[41] and the North Wales early years pharmacy scheme[42].

Conversely there are some services, such as repeat dispensing, which are already highlighted in the contractual framework and which are not being used to their full potential. Maximising the outcomes from existing services is important as well as making further developments.

Addressing medicines waste and improving medicines safety are complex issues and require a joined up response from care providers. Issues such non-adherence with medicines, poor health literacy, reducing harm from high risk medicines, reducing unnecessary polypharmacy, delivering pharmaceutical care for housebound and care home residents, and securing medicines reconciliation at the interface, are all areas where community pharmacy could have a greater role in future.

If community pharmacy is to have a greater role in promoting and protecting health needs, it needs a contractual framework that matches the priorities of NHS Wales. The current contractual framework drives pharmacy contractors to prioritise dispensing above other activities as dispensing is rewarded with a fee whereas other activities, for example signposting, public health, counselling patients on their medicines etc. do not attract additional fees or remuneration.

Pharmacists can play an important part in the health boards efforts to deliver prudent health care, through their role in medications review and the opportunity to support general practice and the public in understanding the most effective use of medications.

Access to patient information is another pre-requisite for pharmacists to significantly enhance their contribution. For example, medicines use reviews were introduced to support patient adherence with their medicines. However, for pharmacists to help patients understand and take their medicines effectively, they need to know the indication for the medicine. (Increasingly medicines have multiple indications which can be

[40] Fajemsin F. (2013) Community pharmacy and public health SPH Available at http://www.sph.nhs.uk/sph-documents/community-pharmacy-and-public-health-final-report/?searchterm=community%20pharmacy
[41] Welsh Government (2013) Community pharmacy influenza vaccination 2012-13 Cardiff
[42] Public Health Wales Observatory North Wales early years pharmacy scheme a success Available at http://www.wales.nhs.uk/sitesplus/888/news/news/31458

as varied as depression, epilepsy or pain relief). Information technology solutions are needed that allow connectivity between GPs and pharmacists and permit pharmacists to view, and write in the patient's summary record. Access to patient information would also enable advancements in referral to certain programmes and services directly from the community pharmacy, for example National Exercise Referral Service, in line with Every Contact Counts philosophy.

25. Do you agree with the proposal to require Local Health Boards to complete periodically an assessment of the pharmaceutical needs of its population?

Public Health Wales agrees with the proposal to require health boards to complete periodically an assessment of the pharmaceutical needs of its population.

In the context of this consultation two types of pharmaceutical need can be identified and throughout this response reference to type A and type B needs are made:

Type A

Needs matched by services that are delivered predominantly through community pharmacies or could potentially be cost effectively delivered through community pharmacy as part of system re-design. Examples include; supplying medicines on prescription including hospital initiated prescriptions; encouraging self-care for minor ailments through the provision of advice and sale of over-the-counter medicines; supporting medicines adherence and; minimising medicines waste.

Type B

Needs matched by services which community pharmacy can deliver safely and effectively, where community pharmacy is one amongst a range of service providers e.g. smoking cessation services, sexual health services, substance misuse harm reduction services.

Factors influencing the decision to choose a pharmacy delivered service will include; patient access (location and opening hours), providing patient choice, service capacity, willingness to provide the service, clinical effectiveness and cost effectiveness of a pharmacy model compared with alternative providers.

In public health, need implies a capacity to benefit i.e. there must be an effective intervention to match the identified problem. As the evidence base improves for the effectiveness of pharmacy interventions addressing a wider range of health problems the scope of the pharmaceutical needs assessment will need to widen. For example, in the future it could include management of patients with pre-diabetes or palliative care support, if

effective pharmacy interventions were demonstrated that could match these patients' health needs.

26. In respect of question 25 what are your views on such assessments being completed as a discrete part of their assessment of local health and wellbeing needs?

Public Health Wales is of the opinion that the pharmaceutical needs assessment should be undertaken and reported with minimal duplication with the local health and well being needs assessment.

- Where a joint approach can effectively deliver the requirements for the health and well being needs assessment and the pharmaceutical needs assessment this would seem desirable

- Whether the pharmaceutical needs assessment is reported separately or integrated into the local health and well being assessment report is a matter to be debated

- However, both type A and type B pharmaceutical needs should be clearly identifiable within the report, alongside existing service provision

- Unmet needs should be stated and consideration given to prioritising them

- Strategic plans developed from the health and well being needs assessment should clearly identify planning intent relevant to community pharmacy

Requiring health boards to complete an assessment of the pharmaceutical needs of its population is a step towards integrating pharmaceutical care and pharmaceutical services into the planning processes of the Health Board. This is vital if community pharmacies are to play a stronger role in promoting and protecting health, as suggested in question 24.

Type B services, as described in response to question 25, require pharmacy provision to be considered as an option when the need is identified and in the round with other service providers. It would therefore make sense to complete the pharmaceutical needs assessment at the same time as the local health and wellbeing needs assessment.

Historically there has been limited patient and public engagement in identifying and prioritising pharmaceutical needs. Stakeholder engagement is an important part of undertaking a health and wellbeing needs assessment. Exploring stakeholder views on pharmaceutical needs as part of the health and wellbeing stakeholder engagement strategy would be an efficient way to improve stakeholder engagement regarding pharmaceutical needs.

The current pharmaceutical services regulations require a health board to approve an application for a pharmacy contract if the applicant can demonstrate the pharmacy is 'necessary and expedient' to meet the dispensing needs in the neighbourhood[43]. Whilst reference to the pharmaceutical needs assessment will be important in determining whether an application meets the 'necessary and expedient' test, NHS Wales is unlikely to have sufficient resources to meet every health need identified in the health and well being needs assessment, including all type B pharmaceutical needs. Clear guidance will therefore be needed for health boards about the use of pharmaceutical needs assessment when making control of entry and service planning decisions. There should be a measured approach to developing the pharmaceutical needs assessment process in Wales, learning lessons from England and Scotland, as there are specific legal considerations for health boards in ensuring there is a robust process in place as part of control of entry decision making arrangements.

27. Please comment on what information you think Local Health Boards should incorporate in its pharmaceutical needs assessment and the frequency with which such assessments should be updated.

If undertaken alongside the health and well being needs assessment demographic, epidemiological, topographical, deprivation, rurality and disease specific information will already be provided. The health and wellbeing needs assessment will also identify future planning needs e.g. new housing estate, closure of health services etc.

The pharmaceutical needs assessment should describe current pharmacy/pharmaceutical service provision and evaluate whether current services meet the pharmaceutical needs of the population. This will include:

- Location of community pharmacies and dispensing doctors within and on the borders with the health board; controlled localities
- Other providers of pharmaceutical services e.g. appliance contractors, mail order pharmacies, long distance suppliers (e.g. supplies to care homes from pharmacies in England), out-of-hours, A&E department, hospital pharmacy
- Location of outlets selling general sales list (GSL) medicines

[43] The National Health Service (Pharmaceutical Services) (Wales) Regulations 2013. No 898 (W.102) Available at The National Health Service (Pharmaceutical Services) (Wales) Regulations 2013

- Information about the range of pharmacy services available in different localities within the health board, particularly enhanced services

- Availability of a private consultation area at the pharmacy

- Factors/patient groups known to have a significantly increased need for pharmaceutical care

- Pharmacy opening hours, contracted and actual, including those open at lunchtimes, evenings and weekends. Hours of availability for services that are not offered continuously during opening hours

- Identification of pharmaceutical issues raised by patients and citizens following formal and informal engagement with them

- Identification of pharmaceutical issues raised by health professionals/managers

- Reference to evidence of effectiveness of enhanced pharmacy services (either local evidence to support existing services or from further afield to support proposed/ potential services)

Public Health Wales recommends that as a minimum, the pharmaceutical needs assessment should be updated at the same time as the health and well being needs assessment, which is currently every three years- next due 2015/16. In the event of significant changes during the lifetime of the pharmaceutical needs assessment the Health Board should have the right to update the pharmaceutical needs assessment sooner, i.e. within three years.

Health boards should be provided with clear guidance about the pharmaceutical content required in the pharmaceutical needs assessment/ integrated heath and well being needs assessment. This would encourage consistency between assessments and aid the ability to provide support from All Wales organisations such as Public Health Wales.

28. In respect of question 27, do you think that using the Local Health Board's assessment of pharmaceutical needs will be sufficient for this or are there other factors that need to be considered?

The pharmaceutical needs of individuals cared for by social services, including 'at risk' children and adults, and older people should be included as part of the health boards' assessment of pharmaceutical needs.

In England, legislation required Primary Care Trusts to use pharmaceutical needs assessments as the basis for determining market entry to NHS

pharmaceutical services provision[44]. This has led to some legal challenges in relation to the quality of pharmaceutical needs assessments and the decisions made using the pharmaceutical needs assessment.

Whilst supporting the concept that pharmaceutical needs assessment informs the decision about whether to accept an application to join the pharmaceutical list, other factors including health board prioritisation of the totality of health needs identified by the health and wellbeing needs assessment must be considered.

29. Do you consider that it is appropriate for applications to provide pharmaceutical services to be determined on the basis of the contribution that all the services they propose might make to address local health needs?

Public Health Wales does consider it appropriate as the NHS seeks to move away from being an 'illness' service, as the wider contribution community pharmacy can make beyond supply of medicines will become increasingly important.

In answering this question the definition of 'need' is again important. The services under consideration must deliver health benefit to the patient, rather than addressing wants or demands. The priorities/financial position of the health board must be considered and only those services which the health board is considering commissioning should be included in the determination. Finally, health boards should be able to consider applications based on the hours the service will be available as well as the range of services. This is particularly relevant to the provision of advanced and enhanced services which require an accredited pharmacist to deliver the service and without which service delivery can be patchy.

The extent to which new applications address local health needs should be monitored/verified once the contract is granted.

30. Do you agree with the proposal to allow Local Health Boards to invite community pharmacies in their area to provide specified services to meet identified pharmaceutical needs and, where those pharmacies are unable to do so adequately, invite additional pharmacies to become established in order to provide pharmaceutical services? If you disagree please explain your reasons.

We do agree that health boards should be allowed to invite community pharmacies in their areas to provide specified services to meet identified pharmaceutical needs. Where those pharmacies are unable to do so

[44] The National Health Service (Pharmaceutical Services) Regulations 2012. No 1909 Available at The National Health Service (Pharmaceutical Services) (Wales) Regulations 2013

adequately the health board should be allowed to invite additional pharmacies to become established to provide pharmaceutical services provided the health board acts reasonably in terms of the service(s) required and the specified timescale for introduction of the service(s). The health board should:

- Demonstrate there is a pharmaceutical need for the service in the area
- Offer fair remuneration for the service

In making a decision to invite additional pharmacies to become established in order to provide pharmaceutical services the health board should be mindful of the consequences of such a decision on other local pharmacies, not just the pharmacy declining to offer the service.

The health board must also be careful to avoid discriminating against contractors who choose not to provide a service for acknowledged ethical reasons.

The health board should engage in contract verification activities to ensure that contractors are delivering the full range of services they have agreed to. Anecdotally, it has been reported that contractors may promise to deliver a wide range of additional services and over extended hours as part of their contract application, but fail to fully deliver (for example due to locums not having the necessary qualifications for some enhanced services, ethical and religious considerations with some services, e.g. EHC).

31. Do you agree that where pharmacies are not adequately providing services, a range of measures, which could include sanctions against pharmacies for breaches of terms and conditions of service, should be available to Local Health Boards to support improving quality and consistency? What other measures should be available to Local Health Boards?

It would be useful to define/give examples of 'not adequate' such as; where pharmacies are unable to completely provide such a service e.g. not on all days of the week or; pharmacies provide a below standard service.

Improving service quality in pharmacy requires robust monitoring, surveillance and pharmaceutical intelligence systems to support, track and respond to activity across localities. This would also support service mapping and future planning across defined areas.

Consideration should be given to the sanctions used to address poor performance in other primary care contractor professions. There is also a need to clarify whether the performance breach is a professional

performance issue or a contractual performance issue. This may involve close working with the General Pharmaceutical Council.

Contractual performance issues need to be addressed fairly and in a systematic manner, exhausting other options for remedial action before the ultimate sanction of removing the contractor from the pharmaceutical list.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from the Local Health Boards in Wales – PHB 02 / Tystiolaeth gan y Byrddau Iechyd Lleol yng Nghymru – PHB 02

Health and Social Care Consultation on the Public Health (Wales) Bill

Written evidence submitted by the Directors of Public Health on behalf of the Local Health Boards in Wales

30 June 2015

1. The Local Health Boards in Wales fully support the introduction of the Public Health (Wales) Bill as an important opportunity to improve and protect the health and well-being of the population of Wales. We welcome this opportunity to submit views on the principles of the Bill.

Part 2: Tobacco and nicotine products

Restricting the use of nicotine inhaling devices such as electronic cigarettes in enclosed and substantially enclosed public and work places, bringing the use of these devices into line with existing provisions on smoking.

2. We support the restriction of nicotine inhaling devices, such as electronic cigarettes (e-cigarettes) in enclosed and substantially enclosed public and work places, bringing the use of these devices into line with existing provisions on smoking.
3. The concentrations of potentially harmful inhalants in e-cigarette vapour may be lower than that of cigarettes, however, they are still present and can still impact on involuntary bystanders, exposing them to greater than normal levels.[1,2] Levels also remain higher than found in nicotine inhalers and some brands have been shown to contain levels of cancer-causing agents, such as formaldehyde and acrolein, as high as that found in cigarette smoke.[2]
4. Many of these devices have not yet been tested by independent scientists and, where testing has taken place, wide variations in toxicity have been found.[2] For example, nicotine has been shown to increase HbA1c levels in established diabetics, and potentially to affect insulin-producing cells in the pancreas of foetuses following exposure in utero.[3,4] Nicotine may also increase cell division rates and exacerbate tumour growth.[5]
5. There may also be indirect risk from such devices and their refills which are not child protection packaged, if the device/refill is left unattended, dropped or discarded. The liquid is extremely toxic to young children if ingested or even if spilled onto skin, and often sold in attractive colours and flavours that appeal to young people/children such as 'gummy bear' or 'bubble gum'. Exposure can cause cardiac effects. Figures from the UK and overseas report large increases in cases of accidental poisoning from contact with nicotine from these devices, with large proportions of the cases involving very young children.[6-8] The batteries from these devices are also very small and could cause serious damage if ingested by small children.
6. We consider that allowing use of e-cigarettes in places where smoking is banned will undermine and make more difficult enforcement of the smoking ban. The use of these devices is also highly likely

to normalise smoking behaviour and undermine the public health progress made so far. While close observers may be able to detect the absence of smell or ash, those further away will not, for example in hospital settings across large concourses. Particularly with electronic nicotine delivery systems that are designed to look like cigarettes. This will send mixed messages to the public about smoking acceptance. Legislation would provide clarity and help ensure a consistent message across Wales. The burden of smoking on the NHS in Wales, means it is imperative that clear messages on the unacceptability of smoking on health site grounds are not compromised and made unenforceable.

7. Use of these devices can both create and maintain nicotine addiction. E-cigarettes may act as a gateway to the use of tobacco by appealing to young people in their design and colours. Evidence from studies in the UK and overseas suggests that e-cigarettes are being used by young people who have never previously used tobacco.[9,10] Anecdotal evidence also suggests that people are using the devices interchangeably with tobacco, with easy access to short term but unsustainable relief of nicotine withdrawal symptoms. In existing smokers these devices are likely to result in the reduction of cigarette use rather than in quitting, with dual use of e-cigarettes and cigarettes. The number of years spent smoking is considered to be of greater importance than intensity of smoking in causing negative health effects and therefore the benefits of dual use will be much lower than those of quitting completely due to the sustaining of an interchangeable habit.[2]

8. There is not yet evidence of the benefit of e-cigarettes to continuous long-term abstinence. Published rates suggest that they are less effective than NHS smoking cessation services.[11,12] Research on e-cigarettes as a gateway to cigarettes is still in train as studies take time and the use of nicotine inhaling devices is relatively new to the market. We strongly advocate the precautionary principle where there is a sound theoretical argument to support a risk to public health. It is important not to wait for confirmation of harm before taking action.

9. The companies that produce these devices are using many of the advertising, promotion and sponsorship approaches used by the tobacco industry, and there is currently open advertisement of products which closely resemble cigarettes. The same promotions which make the devices appeal to smokers, may also make them attractive to children and non-smokers.[2] Research by the North Wales Public Health Team found that use of e-cigarettes is widespread among 11-12 year-old girls and that the girls were often attracted by the range of flavours available.[13]

10. The Local Health Boards of Wales would also support the extension of restrictions to some non-enclosed spaces such as hospital grounds and children's playgrounds. Enforcement of the voluntary ban on NHS premises has proven difficult and time consuming, requiring employment of additional staff specifically to enforce such bans. Legislation would send a clear message around smoking being prohibited in these areas and make consistent enforcement easier. It is important that the additional support needed to enforce such bans is adequately resourced.

Creating a national register of retailers of tobacco and nicotine products.

11. We support the creation of such a register which is in line with the Tobacco Control Action Plan for Wales. A register would help to enforce legislation on the display of tobacco products and tackle underage sales by helping Trading Standards Officers to easily identify retailers and check compliance with regulations. A recent survey in England showed that nearly half of young smokers (44%) reported being able to purchase tobacco from retail premises despite the ban on the sale of tobacco products to those under the age of 18.[14]

12. Smoking is also increasingly concentrated in less affluent areas, where many may purchase smuggled or fake tobacco products at reduced cost. This has the potential to undermine tobacco control measures, encourage higher consumption, and deprive small businesses in these areas of legitimate trade.

Prohibiting the handing over of tobacco or nicotine products to people under the age of 18.

13. The Local Health Boards of Wales support prohibition of the handing over of tobacco or nicotine products to those aged under 18 years. The rapid rise in internet shopping could offer an easy way for young people to circumvent age restrictions. There is currently a lack of safeguards against children purchasing cigarettes through the internet. There should be consistency in the control of the sale of restricted products across all outlets, physical or virtual.

Part 3: Special procedures

Creating a mandatory licensing scheme for practitioners and businesses carrying out 'special procedures', namely acupuncture, body piercing, electrolysis and tattooing.

14. We support the creation of a mandatory licensing scheme for both practitioners and businesses carrying out 'special procedures'. This Bill also presents an opportunity to regulate the administration of the following procedures: body modification (to include stretching, scarification, sub-dermal implantation/3D implants, branding and tongue splitting), injection of any liquid into the body e.g. botox or dermal fillers, dental jewellery, chemical peels, and laser treatments such as used for tattoo removal or in hair removal.

15. Such a register would be beneficial in recognising legitimate practitioners and businesses and help to regulate these procedures in Wales. It would help to ensure a consistent approach to regulation across Wales. Suitable resources would need to be made available to realise and sustain the benefits of such a register. We also advocate national guidance with a maximum and minimum cost threshold for registration. The ability to amend the list of procedures through secondary legislation would also provide flexibility to incorporate new procedures with the potential to cause harm in the future.

16. The current legislation does not adequately protect the public and these procedures have the potential to cause harm if not carried out safely. In a recent look back exercise in Wales, nine people were identified as needing hospital admission due to severe *Psuedomonas aureaginosa* infection, eight of whom required surgical intervention (including incision, drainage, reconstruction and stitching), following body piercing at a tattoo and body piercing premises. The individuals needed weeks of hospital treatment and follow-up care, and some are permanently disfigured. More minor problems for other clients included swelling and trauma around the site, scarring, local skin infections, and allergic reactions which were more prevalent. A lack of good hygiene and infection control can lead to blood poisoning (sepsis) or transmission of blood-borne infections through contaminated equipment, such Hepatitis B, Hepatitis C or HIV.

17. There is some older evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare.[15-17] A recent review suggests there is a significant risk of transmission through piercing and tattooing procedures which are not done under sterile conditions, such as at home or in prison.[18] However, in our view, the risk of transmission is the same in professional parlours where sterile conditions and infection control measures are not in place. Scarring from complications following such procedures can also have long-term psychological impacts.[19-21] Anecdotal evidence suggests that localised infections associated with such procedures are often seen in GP practices and Accident and Emergency departments, particularly following tongue piercings. All of the nine cases identified in the look back exercise self-presented to healthcare, often multiple times.

18. We would like this Bill to go further by requiring those registering to undertake such procedures to meet national standardised training where criteria of competency will have been met, hygiene standards, and age requirements and by ensuring that they have no criminal background that would make them unsuitable to undertake special procedures (e.g. Child Protection – CRB checks). We would advise that registration should include mandatory proof of identity of the practitioner. These measures would ensure that they have the knowledge, skills and experience needed to perform these procedures.

Part 4: Intimate piercing

Introducing a ban on the intimate piercing of people under 16 years old.

19. We support the introduction of a ban on the intimate piercing of those aged under 16 years, as relates to those body parts defined in the Bill. This will aid in protecting the public and ensure a clear and consistent message across Wales. The recent look back exercise in Wales demonstrates that intimate piercing is not uncommon in this age group and we welcome the outlawing of intimate piercing irrespective of parental consent. We would encourage mandatory proof of age for any client undergoing a special procedure. It should be noted with concern that girls as young as 13 had undergone nipple piercing in the recent Gwent look-back exercise.

Part 5: Pharmaceutical services

Changing the way Health Boards make decisions about pharmaceutical services by making sure these are based on assessments of pharmaceutical need in their areas.

20. We welcome the opportunity to help support healthier lives by basing our decisions on pharmaceutical services on the needs of the community. Expanding pharmaceutical services in community pharmacies offers a great opportunity to strengthen existing relationships with communities, improve access, and NHS capacity. Provision of a national template would help to ensure these assessments are carried out in a consistent way across Wales.

21. Pharmacies have been shown to be effective at delivering enhanced services such as smoking cessation, harm minimisation in substance misuse, flu vaccination, and emergency hormonal contraception.[22,23] Currently, the majority of pharmacy time is spent dispensing prescriptions and providing advice on medicines. We believe the legislation proposed in the Public Health (Wales) Bill will encourage existing pharmacies to adapt and expand their services in response to local needs. The risk of another contractor making a successful application to join the pharmaceutical list in their area, if they fail to respond to need will be an effective incentive. This can help to ensure services are available where needed.

22. We also believe that undertaking and incorporating such assessments of need will help to improve the planning and delivery of pharmaceutical services in Wales by making them more integrated and aligned with wider health needs assessment and service planning.

Part 6: Provision of toilets

Requiring local authorities to prepare local toilets strategies for the provision of, and access to, toilets for public use, based on the needs of their communities.

23. The Local Health Boards of Wales see that there is a need for accessible public toilets and feel these are an important community amenity, particularly for older people, those with disabilities, and families with children. In addition an estimated 14 million British people have a bladder control problem, while 7.5 million have a bowel control problem.[24]

24. Without adequate public toilets some people may feel unable or reluctant to leave their home for periods of time, which can lead to a lack of mobility, worsening health, and isolation.[25] Accessible public toilets contribute towards an age-friendly community reflecting the aging population in Wales. Whilst there is a lack of research evidence on the health benefits of accessible public toilets, this is supported by professional opinions and public surveys.

25. We consider that it is, however, important to recognise the strain already placed on local government services and that there will be an opportunity cost when prioritising services with limited resources. The preparation of a local strategy may not result in improved provision and accessibility without adequate resources to implement such a strategy.

Other comments

Food standards

26. The Local Health Boards of Wales are disappointed that regulation of food standards in settings such as pre-school and care homes are not included in the Public Health (Wales) Bill. Food standards can make an important impact on public health. Good nutrition in very young children is essential for future growth development and health, while poor nutrition in care homes is likely to undermine their health and well-being and increase the chances of the need for health services intervention.

27. We strongly are persuaded that this aspect could be strengthened so that there is no missed opportunity to place mandatory food standards on all food or drink supplied by or procured for settings directly controlled, commissioned or inspected by public sector organisations. Over 300,000 people are currently employed in the public sector in Wales. Offering healthy choices as the norm to them, and the public they serve, could make a significant contribution to the adult obesity problem.

28. The risk of many chronic conditions, in particular coronary heart disease, obesity, diabetes and some cancers, is increased by poor diet and diet-related disease has been estimated to cost the NHS around £6 billion a year. The cost of obesity alone has been predicted to reach £49.9 billion per year by 2050 by the Foresight report.[26] Wales faces some of the biggest challenges in the UK, with the Child Measurement Programme reporting prevalence of overweight or obese children to be 26% in reception year.[27]

29. Maintaining food standards, particularly in health settings such as hospitals which seek to keep people well, can inform and influence the public's perception of what foods are considered acceptable and healthy. The public sector caters for some of the poorest and most vulnerable people in society. Catering Standards for Food and Fluid Provision for Hospital Inpatients, and the All Wales Hospital Menu Framework standards ensure patients receive adequate nutrition to assist with their recovery whilst in hospital, but there is much work needed to make sure that healthy and balanced meals and food are offered to all those accessing the restaurants (including staff, patients and visitors). Mandated criteria for the provision of only healthier retail items in hospital restaurants and outlets would help hospitals in Wales to fulfil their responsibility for improving the health of the population they serve.

30. We would welcome the extension of the Welsh Government's Health Promoting Hospital Vending Directive into other public sector settings, such as Local Authority premises including leisure centres and community centres, and feel that there is also a need to introduce food standards into the wider private sector.

Further comments

31. We consider that it is important the Public Health (Wales) Bill contains a commitment to progressing health in all policies which may impact on the health and well-being of the people of Wales. We believe that this would raise the profile of public health in society, increasing awareness and knowledge of important public health issues across government departments and in all sectors.

32. Minimum unit pricing for alcohol is not included in the Public Health (Wales) Bill and we are aware of current testing of Scotland's decision to include this. We feel it is highly important that this is taken forward in the future when the position is clarified. There is a strong evidence base for a link between alcohol affordability and levels of harm and until this prudent initiative is implemented alcohol-related morbidity, mortality and cost will continue to impact on society.

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National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)

Evidence from The Welsh NHS Confederation – PHB 05 / Tystiolaeth gan Conffederasiwn GIG Cymru – PHB 05

	The Welsh NHS Confederation response to the Health and Social Care Committee inquiry into the general principles of the Public Health (Wales) Bill.
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Officer, the Welsh NHS Confederation. [redacted] Tel: [redacted]
Date created:	30 June 2015.

Introduction

1. The Welsh NHS Confederation, on behalf of its members, wholeheartedly welcomes the opportunity to respond to the inquiry into the general principles of the Public Health (Wales) Bill.

2. By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern NHS in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

3. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Member's involvement underpins all our various activities and we are pleased to have all Local Health Boards and NHS Trusts in Wales as our members.

4. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

Summary

5. Due to the short time frames for responding to the Public Health (Wales) Bill we are not providing detailed answers to all the questions posed at this stage. We will be providing a more detailed response by the closing date, September 4th, but thought it would be beneficial for the Committee to receive comments before the oral evidence session with the Directors of Public Health from Local Health Boards and Public Health Wales NHS Trust on July 9th. The Welsh NHS Confederation also endorses the written submission that has been provided to the Committee by Public Health Wales NHS Trust and from the Executive Directors of Public Health of the seven Welsh Health Boards.

6. As with our response to earlier consultations relating to this Bill,[i] the Welsh NHS Confederation believes that the Public Health (Wales) Bill provides a golden opportunity to improve the health

of the population. The NHS in Wales supports the Bill and is committed to the protection and improvement of the health of the people of Wales and the reduction of health inequalities. All health systems across the UK should work to reduce premature mortality from preventable disease, but this is particularly the case in Wales, which has historically suffered from high levels of chronic ill health.

7. While the Welsh NHS Confederation wholeheartedly supports the Bill, we are disappointed that it does not include a clear and simple preamble which sets out the goals and principles of the law. It is vital that there is a clear vision of what the Bill intends to achieve and the outcomes on which its success will be measured. Health concerns need to be owned across Government departments and by all sectors across Wales. The Well-being of Future Generations (Wales) Act will go some way in ensuring that public bodies work collaboratively to achieve a "healthier Wales", it is also essential that the Public Health (Wales) Bill places duties on Welsh Ministers and public sector bodies to consider health in all policies and developments which may impact on the health and well-being of the people of Wales.

Part 2: Tobacco and Nicotine Products

Do you agree that the use of e-cigarettes should be banned in enclosed public and work places in Wales, as is currently the case for smoking tobacco?

8. The Welsh NHS Confederation agrees that the use of e-cigarettes should be banned in enclosed public and work places in Wales. While we acknowledge there is limited evidence in relation to the impact of banning e-cigarettes on smoking prevalence, we also acknowledge that legislating against their use in enclosed public places would provide a clear and consistent approach across Wales. This has the potential to positively impact on the enforcement of current smoke-free legislation and will 'de-normalise' smoking.

9. While the current research in relation to the use of e-cigarettes is limited, due to their perceived safety, glamorised use and general appeal, the risk remains that e-cigarette use can act as a potential gateway to tobacco products and could 'normalise' smoking behaviour and nicotine use. This is particularly relevant to young people in Wales. A number of our members believe that the use of e-cigarettes in enclosed public places risks 'normalising' smoking and sends out mixed messages about the impact that nicotine has on people's health.

10. A number of strategies have been adopted or are being considered to achieve this 'de-normalisation' including; prohibition of tobacco advertising, promotion or sponsorship; a ban on smoking in enclosed public spaces, tobacco display ban regulation and standardised packaging. The widespread use of e-cigarettes in public places and their uncontrolled marketing and promotion is likely to undermine the attempts to 'de-normalise' smoking behaviour. E-cigarette companies are adopting many of the advertising, promotion and sponsorship approaches of the tobacco industry. This is resulting in advertising of nicotine vaping products, which in some cases closely resemble cigarettes. Evidence from the tobacco field has demonstrated that children and young people are receptive to these messages.

11. The use of e-cigarettes in enclosed public places has the potential to undermine some of the important health gains that have been achieved through the smoking ban in public places. It is very difficult for individuals to differentiate between those smoking tobacco and those using e-cigarettes, therefore making enforcement difficult. Many e-cigarettes look similar to regular cigarettes, making people wary of challenging smokers where bans exist. The use of e-cigarettes in enclosed public places sends mixed messages to the public about smoking acceptance. This has

the potential to cause public confusion and undermine the enforcement of smoke-free legislation. The ban on smoking in enclosed public places has been successfully applied in Wales and there is no evidence to suggest that similar legislation relating to the use of e-cigarettes would not have similar compliance. Legislation on the use of these products would provide much needed clarity to ensure a consistent message across Wales.

What are your views on extending restrictions on smoking and e-cigarettes to some non-enclosed spaces (examples might include hospital grounds and children's playgrounds)?

12. We would support extending the restrictions on smoking and e-cigarettes to some non-enclosed spaces. While there is evidence of voluntary bans being effective in some areas, at present, without legal backing, voluntary behaviours are difficult to enforce. Legislation would send a clear message around smoking being prohibited in these areas and make consistent enforcement much easier. This is particularly relevant in hospital grounds where vulnerable patients are exposed to second-hand smoke from those who refuse to heed the local policies. Ironically many people require NHS services directly because of smoking induced diseases such as cancers of lung, head and neck and gastrointestinal tract, heart diseases, stroke and vascular (circulatory) diseases. Many of these diseases cluster in areas of high deprivation and high smoking prevalence. 'De-normalising' smoking is essential if this burden on NHS resource is to be tackled.

Do you believe the provisions in the Bill will achieve a balance between the potential benefits to smokers wishing to quit with any potential disbenefits related to the use of e-cigarettes?
Do you have any views on whether the use of e-cigarettes renormalises smoking behaviours in smoke-free areas, and whether, given their appearance in replicating cigarettes, inadvertently promote smoking?

13. It is difficult to fully answer this question based upon the existing body of evidence. However, as previously highlighted, we believe that the use of e-cigarettes, which can mimic the act of smoking, can help 'normalise' tobacco smoking. Their use has the potential to undermine smoking prevention and cessation activity and the important gains that have been achieved in this area to date because e-cigarettes do include nicotine, with some delivering a higher dose of nicotine than cigarettes. Through the Bill there will be a clear and consistent message that smoking (whether of conventional cigarettes or e-cigarettes) is harmful.

14. If we wish to reduce the chances of e-cigarettes becoming a gateway for non-smokers into nicotine addiction or the use of conventional tobacco products, our efforts need first to concentrate upon restricting the marketing and promotion of these devices as many young people do not recognise how susceptible they actually are to the advertising that continually surrounds them. Consideration should be given to potentially banning the use of e-cigarettes that resemble conventional tobacco products in order to eliminate, or at least minimise, confusion over the nature of the product. Hospital smoke free wardens find it very difficult to distinguish between normal cigarettes and some e-cigarettes that mimic appearance of traditional cigarettes. It would be impossible to allow some e-cigarettes and not others.

Do you have any views on whether e-cigarettes are particularly appealing to young people and could lead to a greater uptake of their use among this age group, and which may ultimately lead to smoking tobacco products?

15. We believe that e-cigarettes can act as a gateway to conventional tobacco by appealing to young people and giving the impression that they are a safe alternative, even though they still include addictive and high levels of nicotine. The presentation of e-cigarettes as a safe way to smoke may provide a route to nicotine addiction for children and young people. This is not something to be encouraged and is something that seems to be overlooked in much of the debate and discussion

about e-cigarettes. While they may be preferable to smoking tobacco, their use is not something to be encouraged, regardless of whether this leads to use of other nicotine products or not. In addition, it is possible that once established nicotine addiction through e-cigarettes it could lead to tobacco use, although it will be some time before reliable evidence is available that either supports or refutes these concerns.

16. There is little research evidence available on the use of e-cigarettes among young people in the UK, given that the product is still relatively new to the market and the rapid growth in their use has only been within the last three to four years. However the largest international dataset on use of e-cigarettes by young people comes from the USA National Youth Tobacco Survey (NYTS) which evidences a statistically significant increase of e-cigarettes use by students from 2011–2014. This is a survey[ii] of a representative sample of 22,000 middle school (11 – 14 years) and high school children (14 – 18 years) across all 50 US States. The survey showed that e-cigarettes was the product most commonly used by high school students (13.4%) and middle school students (3.9%), with cigarettes third most common for high school students (9.2%) and middle school students (2.5%). The biggest concern about the survey is that the current e-cigarette use among high school students increased from 4.5% (660,000 students) in 2013 to 13.4% (2 million students) in 2014. Among middle school students, current e-cigarette use more than tripled from 1.1% (120,000 students) in 2013 to 3.9% (450,000 students) in 2014. The conclusions from the survey around the implications for public health practice was that due to the rise in the number of students using e-cigarettes it is critical that comprehensive tobacco control and prevention strategies for youths should address all tobacco products and not just cigarettes. Also worrying from the earlier 2012 USA National Youth Tobacco Survey was that while the data suggests that e-cigarette use is largely among tobacco smokers, 20.3% of 11-14 year olds and 7.2% of 14 – 18 year olds were previously non-smokers.

17. We are also concerned about the extent and nature of tobacco industry involvement in the development of the e-cigarette market, and the role of commercial interests in recruiting new and potentially young customers.

Do you have any views on whether restricting the use of e-cigarettes in current smoke-free areas will aid managers of premises to enforce the current non-smoking regime?

18. In relation to the use of e-cigarettes on hospital grounds, legislation would provide a clear message that smoking is not allowed and would aid managers of premises to enforce the current non-smoking regime. This would help strengthen the existing role that NHS staff members currently play in enforcing the voluntary ban on hospital grounds through providing staff with legal backing. A number of our members have voluntary bans across hospital grounds but it is difficult to enforce and it requires a high level of multi-disciplinary support throughout the NHS in Wales. With legal policies in place much of our members' local implementation of the voluntary ban would be considerably easier.

19. While we support extending restrictions to some non-enclosed spaces, it is vital that those enforcing the Bill are resourced properly because it will require increased support.

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?

Do you believe the establishment of a register will help protect under 18s from accessing tobacco and nicotine products?

20. We agree with the proposal of establishing a national register of retailers of tobacco and nicotine products. Such a register could strengthen the tobacco control agenda in Wales and the proposal

is in line with the Tobacco Control Action Plan for Wales. The role of the register in preventing access to tobacco among children is also recognised.

21. We believe that the proposal to establish a register will help protect under 18s from accessing tobacco and nicotine products. A recent survey in England showed that nearly half of young smokers (44%) reported being able to purchase tobacco from retail premises despite the ban on the sale of tobacco products to those under the age of 18.[iii] The register would be an important step towards reducing the number of young people in Wales who become smokers because they will only be able to access tobacco or nicotine produces from registered retailers. Creating a tobacco retail register will also help colleagues in Trading Standards to tackle the problem of under-age sales.

22. The additional information which could be gathered by a registration scheme will support enforcement of under-age sales and assist in enforcement of the display ban by making it easier to identify locations where tobacco is not permitted to be sold. However, while supportive, we have concerns about the resourcing of this initiative centrally and in Local Authorities. Unless the proposal is properly funded, there may be unintended consequences on other critical public health enforcement activity.

Do you believe the proposals relating to tobacco and nicotine products contained in the Bill will contribute to improving public health in Wales?

23. We do believe that the proposals relating to tobacco and nicotine products contained in the Bill will contribute to improving public health in Wales.

24. Additional proposals that our members have put forward around tobacco and nicotine products include:

- E-cigarettes, like tobacco products, should be subject to plain packaging;
- Shops / cafes should be prevented from opening for the sole purpose of selling e-cigarettes and allowing their use within the premises;
- Primary care contractors, such as community pharmacies, should be prevented from selling e-cigarettes;
- There is a need to establish new definitions of smoking status which take account of the widespread use of e-cigarettes and enable population health surveys such as the Welsh Health Survey and patient information systems to accurately distinguish between non-smokers and ex-smokers who are no longer using nicotine products from those who are adopting longer term harm minimisation approaches;
- Ensuring that, where relevant and appropriate, e-cigarettes are subject to the same regulations regarding advertising and marketing as conventional cigarettes (including minimising the attractiveness of dangerous products to children and young people); and
- Adopting a clear position regarding the future research needed to establish the impact of e-cigarettes at population and individual level.

Part 3: Special Procedures

25. We welcome and the introduction of a compulsory national licensing system for practitioners of specified 'special procedures' in Wales and that the premises from which the practitioners operate these procedures must be approved. Incompetent practices and procedures can lead to a burden on the NHS which has to pick up short and long term sequelae, as evidenced by the recent serious skin infection cluster necessitating a blood-borne virus look-back exercise in Aneurin Bevan

University Health Board. One premise alone created a burden of work for the Health Board that required considerable financial and human resource to address.

26. Such a register would be beneficial in recognising legitimate practitioners and businesses and help to regulate these procedures in Wales. A national licensing system for practitioners and the mandatory licensing conditions which they have to comply with will ensure the provision of consistent standards in respect of infection control, cleanliness and hygiene for all practitioners and businesses operating any of the listed treatments. It will be essential that competency to perform certain procedures is tested. Almost all GPs and Dentists would not attempt any procedure on the human tongue without full resuscitation facilities available due to the risk of haemorrhage and airway obstruction. Dentists are seeing tongue piercings that have gone wrong on a regular basis.

27. We support the definition of the 'special procedures' included within the Bill (acupuncture, body piercing, electrolysis and tattooing), however this Bill also presents an opportunity to regulate the administration of the following procedures: body modification (to include stretching, scarification, sub-dermal implantation/3D implants, branding and tongue splitting), injection of any liquid into the body, for example botox or dermal fillers, dental jewellery, chemical peels, and laser treatments such as used for tattoo removal or in hair removal. It is important that, due to the rapidly changing environment, that the legislation is flexible enough to include other procedures in the future.

28. We would also like this Bill to go further by requiring those registering to undertake such procedures to meet national standardised training where criteria of competency will have been met, including hygiene standards, age requirements and ensuring that they have no criminal background that would make them unsuitable to undertake 'special procedures' (for example Child Protection and CRB checks). We would advise that registration should include mandatory proof of identity of the practitioner. These measures would ensure that they have the knowledge, skills and experience needed to perform these procedures.

Part 4: Intimate Piercing

29. We support the proposals within the Bill that prohibits the intimate piercing of anyone under the age of 16 in Wales. This will aid in protecting the public and ensure a clear and consistent message across Wales. The recent look back exercise in Wales demonstrates that intimate piercing is not uncommon in this age group and we welcome the outlawing of intimate piercing irrespective of parental consent. We would encourage mandatory proof of age for any client undergoing a 'special procedure' or intimate piercing. It should be noted with concern that girls as young as 13 had undergone nipple piercing in the recent Gwent look-back exercise.

30. We would recommend that the list of intimate body parts includes tongue piercing because of the risks associated, including infection, chipped teeth, blood poisoning, tongue swelling and blood loss which may cause a risk to someone's airways. Through the Bill children and young people will be protected from the potential health harms which can be caused by intimate piercing. Competency checks will also be required before nipple, genital and tongue piercing, and before body modification such as ear cartilage removal, tongue splitting and branding. Currently there are no checks on the ability of the practitioner to conduct these forms of minor surgery which are much more invasive than most minor surgery performed in primary care for which General Practitioners need additional qualifications.

Part 5: Pharmaceutical Services

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?

31. The proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales. The Welsh NHS Confederation is pleased to note that the Bill recognises the important role that pharmacists can play in improving the health and well-being of the public. Requiring Health Boards to prepare and publish an assessment of the need for pharmaceutical services in its area is a step towards integrating pharmaceutical care and pharmaceutical services into the planning processes of the Health Board. Community pharmacies should play a stronger role in promoting and protecting the health of individuals, families and local communities as part of a network of local health care services.

32. The pharmaceutical needs assessments need to be tightly integrated into the Health Board Integrated Medium Term Plan (IMTP) cycle, driving planning and delivery of services. The pharmaceutical needs assessment will likely consist of information which is already in the local health and well-being needs assessment (and therefore not need to be duplicated), along with information on services currently being provided through pharmacies and their locations. This latter new information might be best assessed in conjunction with the location and accessibility of other NHS services, for example primary care and hospital services.

33. Pharmaceutical needs assessments should examine the demographics of their local population, across the area and in different localities, and their needs. Pharmaceutical needs assessments should describe the pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. They should describe accessibility to these services, including by public transport. Pharmaceutical needs assessments should look at other services, such as dispensing by GP surgeries, and services available in neighbouring areas that might affect the need for services in its own area. They should examine whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. Over provision of pharmacies in particular areas should be considered and the pharmaceutical needs assessments should also take account of likely future needs.

Do you believe the proposals relating to pharmaceutical services in the Bill will contribute to improving public health in Wales?

34. The Welsh NHS Confederation agrees that there is considerable public health benefit to be gained by ensuring that Local Health Boards have a stronger role in planning pharmaceutical services in their areas. Community services play an important role in delivering public health services, including community pharmacies. The Bill provides an opportunity to ensure that the public are aware of the services that they can receive and access locally to remain in good health.

35. The Bill recognises the important role that community services can play in delivering public health services. The NHS has historically undervalued the role that community pharmacy can play in improving and maintaining the public's health. However, there is increasing recognition that community pharmacists can make a significant contribution to improving the public's health. Community pharmacy and the NHS share a common purpose in a number of areas:

- Public health, pharmacists and their teams already have a track record in delivering public health services, such as promoting and supporting good sexual health, reducing substance misuse within communities, stop smoking services to help people quit and weight management services to promote healthier eating and lifestyles;

- Support for independent living, by helping people to understand the correct use and management of medicines as well as provide healthy lifestyle advice and support for self-care, pharmacists and their teams can help contribute to better health, reduce admissions to hospital and help people remain independent for longer;
- Making every contact count, by using their position at the heart of communities pharmacies can use every interaction as an opportunity for a health-promoting intervention, as signposters, facilitators and providers of a wide range of public health and other health and well-being services.

36. The NHS Confederation's discussion paper 'Health on the high street: rethinking the role of community pharmacy'[iv] highlights that evidence is emerging around the potential role community pharmacy can play in improving and maintaining the nation's health. The paper finds that, as trusted and professional partners in supporting individual, family and community health, sitting at the heart of our communities, effective community pharmacy services have a significant and increased role to play in ensuring we have a sustainable healthcare system and that the NHS is able to survive and thrive over the coming decades. However, this will require providers, patients and the public to be more aware of community pharmacy's role alongside other primary and community care service, as highlighted within the Health and Social Care Committee's inquiry into community pharmacies in August 2011. The Committee's report clearly demonstrated the contribution that community pharmacy can have on the health service but better communication mechanisms are needed to inform the general public about the services available at any individual community pharmacy.

Part 6: Provision of Toilets

37. The Welsh NHS Confederation supports the requirement that each Local Authority will have to prepare and publish a local toilets strategy, which assesses the need for public toilets in its area, and sets out steps that the authority proposes to take to meet that need. The adequate provision of and access to toilets for public use is an important public health issue.

38. Accessible public toilets are a necessity to maintain population health for everyone, but some groups have specific needs. These include disabled people, parents with babies and young children, pregnant women, older people and those with specific conditions including incontinence, inflammatory bowel disease, irritable bowel syndrome, multiple sclerosis and people who have been prescribed diuretics. If toilet provision is inadequate, people can become afraid or reluctant to go away from the home for periods of time, leading to poor mobility, isolation and depression.[v]

39. While the preparation of a strategy that considers the need for and plans for the future provision of toilets for public use would provide clarity at the local level (for elected members, officers and the public) the real issue of making resources available to address this remains. The duty on Local Authorities within the Bill is that they *"may provide toilets in its area for use by the public"* and the writing of a strategy alone will not automatically improve provision because of the significant financial pressures already experienced by Local Authorities.

40. The statutory duty to write a strategy will have little impact on actual provision, unless resources can be identified to put such a strategy in place. This presents challenges in Local Authorities' ability to safeguard existing provision and to promote new facilities. We believe that any additional duties placed on Local Authorities should be adequately funded, as some previous closures have been due to heavy maintenance and upgrading costs. The preparation of a local

strategy may not result in improved provision and accessibility without adequate resources provided to Local Authorities to implement such a strategy.

41. In addition to the duties the Bill places on Local Authorities, consideration and awareness needs to be increased around other schemes. The public access Community Toilet Scheme introduced in 2009 is reportedly underused with large variation between Local Authorities and some people are not comfortable with using this type of facility. This is a scheme through which people can use the toilet facilities in participating local businesses when they are open, without having to make a purchase. However communication of location and access to potential users can be inadequate and access is necessarily limited to business opening hours.

42. The problem of lack of street signage can also be an issue to accessing public toilets. Signage should be standardised, showing opening times and facilities available. Examples of alternative sources of information which exist elsewhere include Australia's National Toilet Map, the UK disabled drivers' mapping portal and Westminster City Council's SatLAV, which allows visitors to text for their nearest toilet and opening times.

Finance questions

43. As highlighted above, some aspects of the Bill will need resourcing and Local Authorities are likely to incur costs due to the increased duties placed on them as a result of the Bill. It is important that any requirement on local government is proportionate to the issue. We recognise that, as with NHS services, severe strain has been placed on local government services during the economic downturn and that difficult choices have had to be made around the prioritisation of services provided in local communities, many of which are direct determinants of health. With any new duty there is an opportunity cost around what can be provided with limited resource.

Other comments

Food Standards

44. The Welsh NHS Confederation is disappointed that regulation of food standards in settings such as pre-school and care homes are not included in the Public Health (Wales) Bill. Food standards can make an important impact on public health. Good nutrition in very young children is essential for future growth development and health, while poor nutrition in care homes is likely to undermine their health and well-being and increase the chances of the need for health services intervention.

45. We strongly are persuaded that this aspect could be strengthened so that there is no missed opportunity to place mandatory food standards on all food or drink supplied by or procured for settings directly controlled, commissioned or inspected by public sector organisations.

46. Maintaining food standards, particularly in health settings such as hospitals which seek to keep people well, can inform and influence the public's perception of what foods are considered acceptable and healthy. The public sector caters for some of the poorest and most vulnerable people in society. Catering Standards for Food and Fluid Provision for Hospital Inpatients, and the All Wales Hospital Menu Framework standards ensure patients receive adequate nutrition to assist with their recovery whilst in hospital, but there is much work needed to make sure that healthy and balanced meals and food are offered to all those accessing the restaurants (including staff, patients and visitors). Mandated criteria for the provision of only healthier retail items in

hospital restaurants and outlets would help hospitals in Wales to fulfil their responsibility for improving the health of the population they serve.

47. We would welcome the extension of the Welsh Government's Health Promoting Hospital Vending Directive into other public sector settings, such as Local Authority premises including leisure centres and community centres, and feel that there is also a need to introduce food standards into the wider private sector.

A clear vision for the role public health plays in Wales

48. While the Welsh NHS Confederation supports the Bill, it is disappointing that the vision and the outcomes that the Bill is trying to achieve are not included. As it stands the Bill deals with areas that could predominantly be dealt with through secondary legislation and it does not include a clear vision which sets out the goals and principles of the law. We believe it is important that the Bill includes information to explain clearly to the public that public health is everybody's business, and not solely confined to the NHS and the public sector.

49. With the Public Health (Wales) Bill there is a once in a generation opportunity to place public health at the centre of our public policy and practice in Wales in order to enable people to live healthy, long lives with a public service that is organised to promote self-care, prevent ill-health and keep people healthier for longer. The future success of the NHS relies on us all taking a proactive approach to public health and ensuring that we create the right conditions to enable people in Wales to live active and healthy lifestyles.

50. Through introducing this Bill we have an opportunity to make Wales a nation that takes the health of its citizens very seriously. There is an over-riding case for the Bill to take advantage of this 'once in a lifetime opportunity' to raise the profile of public health in society. In addition we have the opportunity to increase awareness and knowledge of public health across all Government departments, and among those who develop and implement policy, to support the population to live long, healthy and independent lives.

To tackle public health issues we need better integration

51. It is vital that when considering public health issues, the Bill ensures that all Government departments and public bodies work in an integrated and holistic way. While the Well-being of Future Generations Act 2015 goes some way to achieving this, it is essential that the Public Health (Wales) Bill places a duty on Welsh Ministers and public sector bodies to consider health in all policies and developments which might impact upon the health and well-being of the people of Wales.

52. The Bill should ensure that the Welsh Government is obliged to consider the impact on the health of the population in developing and appraising policies in all Government areas. In addition to Welsh Ministers, it is essential that the Bill places duties on all public sector bodies to consider health in all policies and developments which might impact on the health and well-being of the people of Wales, for example closing or limiting access to leisure centres, public transport and provision of safe green spaces.

53. As the Welsh NHS Confederation's 'From Rhetoric to Reality – NHS Wales in 10 years' time'[vi] highlighted, engagement with all our public service colleagues is necessary to take us all from an ill health service that puts unnecessary pressure on hospital services, to one that promotes healthy lives. Engagement is necessary with all our public service colleagues, from social care to housing,

education and transport. All public bodies in Wales must build on how we might improve our ability to work together and support our partners and colleagues in other sectors.

54. The Public Health (Wales) Bill is a crucial first step in tackling the culture of ill health in Wales recognising that health is much more than health services. Better health is the responsibility of all sectors and while the Welsh Government has already taken steps to infuse health into various sectors through, for example, legislation for children and young people, housing and active travel, the Bill is an opportunity to progress this work further. We believe through having health in all policies it will raise the profile of public health in society, increasing awareness and knowledge of important public health issues across government departments and in all sectors.

People in Wales are empowered to take control of their health

55. Public health plays a key role in ensuring that we reduce demand and empower people to take control of their health. The introduction of this legislation can renew focus on prevention and well-being and contribute to achieving prudent healthcare in NHS Wales. However, to ensure that this is done people need to be educated and empowered to have the knowledge and understanding to remain in good health and receive appropriate interventions.

56. We must continue to drive a mass shift in public thinking. In relation to people in poor health, the NHS needs to communicate with people and ensure that they are aware of the decisions that they are making and how they are impacting on their health. In terms of how services are used, the re-education of the public is vital and we must involve the public fully in deliberating what the NHS will and will not provide in future and we need to look at the ways public bodies co-produce services with the public.

To improve public health it is essential to tackle poverty

57. Under the Public Health (Wales) Bill the Welsh Government should provide greater consideration to the impact poverty has on the health of the population. The importance of tackling poverty to improve people's health cannot be underestimated. Poverty and deprivation are linked to many of the public health concerns and outcomes in Wales.

58. There are still significant health inequalities, including by age, ethnicity and socio-economic group.[vii] The Welsh NHS Confederation recently published the 'Socio-economic deprivation and health'[viii] briefing. This highlights the correlation between socio-economic deprivation and people's health and well-being outcomes, with the gap in life expectancy for people living in the most deprived and the least deprived areas of Wales currently stands at 9.2 years for men and 7.1 years for women for all Wales.[ix] In some Health Boards the discrepancy in healthy life expectancy between the most and least deprived is over 20 years. Through analysing trends across socio-economic groups we highlight how deprivation has an impact on child development, people's lifestyle choices, healthy life expectancy, including living with an illness or chronic condition, and life expectancy. It is now the time for all public sector organisations, including the health service, to work together to tackle deprivation and inequality. Through the Public Health (Wales) Bill and the Well-being of Future Generations (Wales) Act it is imperative that collaboration across all public bodies improves to achieve a "*healthier Wales*" and an "*equal Wales*". We must deliver a more integrated and preventative approach for our public's health that has maximum impact to reduce inequalities and keep people healthier for longer.

Conclusion

59. While the debate around this Bill has predominately focused on e-cigarettes it is vital to recognise the key role that public health plays in reducing health inequalities, ensuring positive outcomes for the Welsh population and reducing demand on the NHS. While the demand for NHS services will never go away, the point at which the NHS intervenes has huge implications on both the cost and quality of care provided. By working with public health initiatives, and allowing the public to take more responsibility for their own health, we can reduce the complexity, and therefore the demand, of some of our highest need cases. Services in Wales need to be integrated, person-centred, co-ordinated, community based and focused on people's well-being. We hope that the Public Health (Wales) Bill goes some considerable way in helping to achieve this.

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[i] The Welsh NHS Confederation, June 2014. Response to the 'Listening to you – Your health matters' White Paper.
[ii] USA National Youth Tobacco Survey, April 2015. Tobacco Use Among Middle and High School Students — United States, 2011–2014.
[iii] Health & Social Care Information Centre, 2013. Smoking, drinking and drug use among young people in England in 2012.
[iv] The NHS Confederation, 2013. Health on the high street: rethinking the role of community pharmacy.
[v] Older Peoples Commissioner for Wales, 2014. The Importance and Impact of Community Services within Wales.

[vi] The Welsh NHS Confederation, January 2014. From Rhetoric to Reality – NHS Wales in 10 years' time.
[vii] The NHS Confederation, November 2014. The 2015 Challenge Declaration.
[viii] The Welsh NHS Confederation, June 2015. Socio-economic deprivation and health.
[ix] Public Health Wales Observatory, December 2011. Measuring inequalities. Trends in mortality and life expectancy in Wales.

Health and Social Care Committee

Meeting Venue:	**Committee Room 4 – Tŷ Hywel**
Meeting date:	**Wednesday, 17 June 2015**
Meeting time:	**09.05 – 11.53**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://senedd.tv/en/3011

Concise Minutes:

Assembly Members:	**David Rees AM (Chair)** **Alun Davies AM** **John Griffiths AM** **Mike Hedges AM (In place of Lynne Neagle AM)** **Altaf Hussain AM** **Elin Jones AM** **Darren Millar AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Kirsty Williams AM**
Witnesses:	**Mark Drakeford AM, the Minister for Health and Social Services** **Vaughan Gething AM, the Deputy Minister for Health** **Dr Andrew Goodall, Welsh Government** **Dr Ruth Hussey, Welsh Government** **Albert Heaney, Welsh Government** **Martin Sollis, Welsh Government**
Committee Staff:	**Llinos Madeley (Clerk)** **Helen Finlayson (Second Clerk)** **Catherine Hunt (Second Clerk)**

Sian Giddins (Deputy Clerk)
Rhys Morgan (Deputy Clerk)
Zoe Kelland (Deputy Clerk)
Gareth Howells (Legal Adviser)
Amy Clifton (Researcher)
Martin Jennings (Researcher)
Philippa Watkins (Researcher)

Transcript
View the meeting transcript.

1 Regulation and Inspection of Social Care (Wales) Bill: consideration of draft report

1.1 The Committee considered the draft report. It agreed to give consider the draft report further at its meeting on 25 June 2015.

2 General and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: discussion of approach

2.1 The Committee discussed its approach to the general and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health.

3 Introductions, apologies and substitutions

3.1 Apologies were received from Lynne Neagle. Mike Hedges substituted for Lynne Neagle.

4 General and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health

4.1 The Minister and Deputy Minister responded to questions from Members.
4.2 The Minister agreed to provide:

- A breakdown of the additional £6.8 million planned care performance and £6.8 million Health Board winter pressures allocations provided during 2014-15 (details of which were outlined in paragraph 8 of your written paper), by individual health board.;
- details of the general make up of primary and secondary care budgets, to include information about:
- the allocations made to primary and secondary care respectively in 2014-15;
- the proportion of the 2014-15 overspend that was attributable to primary and secondary care respectively; and

- the increases/decreases for primary and secondary care budgets respectively for each of the last five years, particularly as a proportion of the overall departmental budget.
- clarification of the date on which health boards in Wales were informed that overspends and brokerage funding provided at the end of 2013-14, before the commencement of the National Health Service Finance (Wales) Act 2014, would not need to be repaid; and
- an update on work that the Welsh Government is undertaking on financial flows across health board boundaries.

5 P-04-625 Support for Safe Nurse Staffing Levels (Wales) Bill: proposal to close the petition

5.1 The Committee considered the petition and agreed to recommend that the petition should be closed.

6 Papers to note

6.1 Minutes of the meetings held on 21 May and 3 June
6.1a The Committee noted the minutes of the meeting on 21 May and 3 June 2015.

6.2 Regulation and Inspection of Social Care (Wales) Bill: additional information
6.2a The Committee noted the additional information.

7 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting and for the meeting on 25 June 2015

7.1 The motion was agreed.

8 General and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: consideration of evidence

8.1 The Committee considered the evidence received.

9 Public Health (Wales) Bill: consideration of approach to Stage 1 scrutiny

9.1 The Committee considered its approach to Stage 1 scrutiny of the Bill and agreed to:

- issue a general call for evidence with a consultation period of 11 weeks, from 19 June to 4 September 2015;
- give further consideration to the schedule of oral evidence sessions at its meeting on 25 June 2015.

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 - Senedd**
Meeting date:	**Thursday, 25 June 2015**
Meeting time:	**09.31 - 11.53**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Concise Minutes:
Private

Assembly Members:	**David Rees AM (Chair)** **Alun Davies AM** **John Griffiths AM** **Mike Hedges AM (In place of Lynne Neagle AM)** **Altaf Hussain AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Kirsty Williams AM**
Committee Staff:	**Helen Finlayson (Second Clerk)** **Catherine Hunt (Second Clerk)** **Sian Giddins (Deputy Clerk)** **Rhys Morgan (Deputy Clerk)** **Gareth Howells (Legal Adviser)** **Gareth Pembridge (Legal Adviser)** **Amy Clifton (Researcher)** **Elfyn Henderson (Researcher)** **Philippa Watkins (Researcher)**

1 Introductions, apologies and substitutions

1.1 Apologies were received from Elin Jones, Darren Millar and Lynne Neagle. Mike Hedges substituted for Lynne Neagle.

2 Regulation and Inspection of Social Care (Wales) Bill: consideration of draft report

2.1 The Committee considered and agreed the draft report subject to minor amendments.

3 Inquiry into alcohol and substance misuse: consideration of key issues

3.1 The Committee discussed and agreed the key issues that have arisen during the Committee's inquiry into alcohol and substance misuse.

4 Public Health (Wales) Bill: update on approach to Stage 1 scrutiny

4.1 The Committee considered and agreed its approach to Stage 1 scrutiny of the Bill.