

# Agenda – Health, Social Care and Sport Committee

---

Meeting Venue:

**Committee Room 1 – Senedd**

Meeting date: Wednesday, 7

December 2016

Meeting time: 09.15

For further information contact:

**Sarah Beasley**

Committee Clerk

0300 200 6565

[SeneddHealth@assembly.wales](mailto:SeneddHealth@assembly.wales)

## Informal pre-meeting (09.15 – 09.30)

### 1 Introductions, apologies, substitutions and declarations of interest

### 2 Public Health (Wales) Bill – Stage 1 evidence session 2 – Public Health Wales

(09.30 – 10.30)

(Pages 1 – 47)

- Dr Quentin Sandifer, Executive Director Public Health Services and Medical Director
- Dr Julie Bishop, Director of Health Improvement and Consultant in Public Health
- Dr Sumina Azam, Consultant in Public Health

### Break (10.30 – 10.40)

### 3 Public Health (Wales) Bill – Stage 1 evidence session 3 – Local Health Boards’ Directors of Public Health

(10.40 – 11.40)

(Pages 48 – 64)

- Dr Gillian Richardson, Executive Director of Public Health, Aneurin Bevan University Health Board
- Dr Kelechi Nnoaham, Director of Public Health, Cwm Taf University Health Board



#### **4 Paper(s) to note**

**Correspondence from the Cabinet Secretary for Health, Wellbeing and Sport and Minister for Social Services and Public Health regarding the Welsh Government's draft budget 2017-18**

(Pages 65 – 71)

#### **5 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting**

#### **6 Public Health (Wales) Bill – Stage 1 evidence sessions 2 and 3 – consideration of evidence**

(11.40 – 11.55)

#### **7 Inquiry into loneliness and isolation – consideration of scope and approach to the inquiry**

(11.55 – 12.10)

(Pages 72 – 76)

#### **8 Legislative Consent Memorandum – Health Service Medical Supplies (Costs) Bill**

(12.10 – 12.20)

(Pages 77 – 87)

Document is Restricted



**Public Health Wales NHS Trust Submission to the  
Health, Social Care and Sport Committee  
Call for Evidence: Public Health (Wales) Bill**

**Date:** 28 November 2016

**Version:** 1

*This information should be read alongside the previous (updated) submission 'Public Health Wales NHS Trust, Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill', dated 4<sup>th</sup> September 2015 (Appendix 1).*

**Re- introduction of the Public Health Bill, November 2016**

1. Public Health Wales welcomes the opportunity to further comment on the Public Health (Wales) Bill, and embraces this Bill alongside other complementary legislation such as the Well-being of Future Generations (Wales) Act, the Social Services and Well-being (Wales) Act, Environment (Wales) Act and the Active Travel (Wales) Act.
2. This Bill will help to ensure that the health and well-being of the population is considered and underpins the shared responsibility that all public bodies in Wales have for the health of the nation. The Public Health (Wales) Bill will add to the legislative framework for improving health and well-being, protecting health and reducing inequalities in Wales.

3. The following gives an update on relevant areas following our previous submission dated 4<sup>th</sup> September 2015 (Appendix 1) which should be read alongside this information.
4. In addition to the areas listed below, Public Health Wales strongly supports the re-introduction of the draft Public Health (Minimum Price for Alcohol) (Wales) Bill. Wales has the opportunity to follow Scotland's lead in taking forward this important agenda, to reduce the substantial harm associated with excess alcohol consumption in Wales. Our views on minimum unit pricing were previously articulated in some detail in our submission to the consultation on the White Paper. This is attached for information as Appendix 2.

## **Part 2: Tobacco and Nicotine Products**

5. Public Health Wales strongly supports the proposed action to protect the Welsh population from harms associated with tobacco and nicotine products. We have updated our previous evidence in Appendix 1, and would further support the strengthening of proposals through:
  - Extending smoke free spaces into outdoor areas frequented by children and the margins of buildings.
  - Having a requirement for tobacco retailers to display information about quit smoking support.
  - Have a requirement for smoke free signs to include information on quit smoking support.

## **Part 3: Special Procedures**

6. Minor amendments have been made to Appendix 1.

## **Part 4: Intimate Piercing**

7. Minor amendments have been made to Appendix 1.

## **Part 5: Health Impact Assessment**

8. We welcome the inclusion of Health Impact Assessment (HIA) within the Public Health (Wales) Bill as a statutory duty for public bodies in Wales in specific circumstances.
9. The inclusion of HIA provides an opportunity to strengthen and reinforce the commitment to Health in All Policies demonstrated in the Well-being of Future Generations (Wales) Act. Public Health Wales recommends that HIA should be a statutory requirement for key policies and in other specified circumstances, with due regard for proportionality, resource implications and cost. Legislating for

HIA would consistently ensure that all public bodies consider the impact of their policies on health and well-being and inequalities and would more effectively deliver the intention of a 'Health in All Policies' approach. This would be a step change to the current approach, where health and well-being is considered in an inconsistent way.

10. HIA provides a systematic, objective, yet flexible and practical way of assessing potential positive and negative, or unintended, health and well-being impacts associated with a particular activity. It also provides an opportunity to suggest ways in which health risks can be minimized and health benefits and opportunities maximized. A major objective or purpose of an HIA is to inform and influence decision-making. HIA can provide a valuable source of evidence to be reviewed as part of any decision making process across a wide range of sectors.
11. As practised in Wales, HIA views 'health and well-being' in a holistic way which encompasses mental, physical and social well-being. Based on a social determinants framework, HIA recognizes that there are many, often interrelated factors that influence people's health, from personal attributes and individual lifestyle factors to socioeconomic, cultural and environmental considerations.
12. HIA includes both quantitative and qualitative data including, importantly, community participation and stakeholder knowledge.
13. HIAs generally take one of three forms in Wales – desktop, rapid participatory or comprehensive. A desktop HIA may take only a few hours or a day to execute, a rapid HIA may take a few days to a few months to complete, and a comprehensive HIA is more in-depth and time / resource intensive and can take many months or years to complete. The most appropriate type to conduct can be decided through a short scoping exercise, where timeframes, resources and levels of stakeholder involvement are reviewed. Comprehensive HIAs, whilst infrequent, can involve significant work but also provide significant value especially in respect of involving communities and private citizens. An illustration of such an approach can be seen with historical HIAs e.g. Margam open cast mining and more recently in the proposed Wylfa Newydd Nuclear Power Station in Anglesey.
14. A number of the governmental strategic levers and drivers currently exist and have been put in place to influence the use of

HIA. In a wide range of areas, including road and rail transport<sup>1</sup>, minerals<sup>2</sup>, waste<sup>3</sup> and land use planning<sup>4</sup> and regeneration<sup>5</sup> plans, HIAs are referred to in Welsh Government guidance. HIA is also a mandatory requirement within the NHS in respect of investment in infrastructure and capital build projects<sup>6</sup>.

15. It would therefore appear a logical next step as part of the Public Health (Wales) Bill to include provision for statutory HIAs in these existing circumstances and build on this body of HIA work and the requirements of the Well-being of Future Generations (Wales) Act. Other areas which would benefit from undertaking HIAs would be Public Services Board Well-being Plans; major Health Board or Local Authority service re-configuration; incorporating HIA into Environmental Impact Assessment requirements in Wales (thus avoiding duplication of resources); permitting new fast food outlets e.g. near schools; and for Welsh Government national policies or plans of significant impact. For example, the Wales Health Impact Assessment Support Unit (WHIASU), Public Health Wales has recently supported a HIA for the new Night Time Economy Framework. There could be a future role for WHIASU to support more of this type of work. WHIASU can best add value by providing expert advice on HIAs undertaken on national policies, large infrastructure projects or projects involving multiple agencies.
16. We believe that consideration needs to be given to capacity requirements of a wide range of organisations (including Public Health Wales) to develop systems, and ensure there is sufficient support and skills to undertake HIAs. Public Health Wales, and specifically WHIASU, has a clear role in supporting capacity development through training and the provision of support such as mentoring practitioners (and indeed much work has been successfully undertaken in this area to date). However, WHIASU currently consists of only 2.5 FTE posts and already provides wide ranging expert support. We believe that additional requirements for HIA would need to take into account current limited capacity within WHIASU and any additional resources needed to deliver the defined requirement(s) effectively and to a high standard.
17. Legislating for HIA will make a significant contribution to improving the future health and well-being of the Welsh population, lead to more effective policy making at the same time

---

<sup>1</sup> Welsh Transport Appraisal Guidance ([WelTAG](#)). Welsh Government 2008

<sup>2</sup> Minerals Technical Advice Note ([MTAN](#)) 2: Coal. Welsh Government, 2009

<sup>3</sup> 'Construction, Infrastructure and Markets' Wales Waste Strategy Sector Plan . Welsh Government, 2012

<sup>4</sup>Chapter 2: Development Plans, Planning Policy Wales (PPW), Edition 8, July 2016

<sup>5</sup> 'Vibrant and Viable Places: A New Regeneration Framework'. Welsh Government, 2013

<sup>6</sup> NHS Wales 'Infrastructure Investment Guidance' Welsh Government, 2015.

as enhancing Wales' reputation as a world leader in the application of Sustainable Development and public health policy.

### **Part 6: Pharmaceutical Services**

18. We have no additional comments on pharmaceutical services.

### **Part 7: Provision of Toilets**

19. We have no additional comments on the provision of toilets.

### **Finance**

20. We have no additional comments on matters of finance.

### **Delegated Powers**

21. We have no additional comments on delegated powers.

### **About Public Health Wales**

22. We exist to protect and improve health and well-being and reduce health inequalities for people in Wales. We work locally, nationally and internationally with our partners and communities. Public Health Wales has four statutory functions. These are to:

- provide and manage a range of public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;
- develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;
- undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and
- provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.



**Appendix 1- this paper has been updated where appropriate**



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

**Date:** Previously submitted 4 September 2015

**Version:** 1

## **1 Overview**

Public Health Wales welcomes the opportunity to comment on the 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, Social Services and Well-being (Wales) Act and the Well-being of Future Generations (Wales) Act. The Public Health (Wales) Bill, although relatively narrow in scope adds to the legislative framework for health improvement and health protection.

Public Health Wales believes that the proposed actions in the Bill will have a positive impact on health and well-being in Wales and we look forward to working with the Welsh Government to progress the actions described.

Public Health Wales recognises that the Well-being 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 well-being and the reduction in health inequalities that are required in Wales.

The Public Health (Wales) Bill provides an opportunity to reinforce Welsh Government's commitment to Health in All Policies through inclusion of health impact assessment (HIA), which is not mandated in the Well-being of Future Generations Act. Public Health Wales recommends that HIA should be a statutory

requirement for key policies and other specified circumstances, with due regard for proportionality, resource implications and cost.

In our response to the White Paper we identified the need to define 'well-being' and that it was not appropriate for the only definition and use of 'well-being' to be in the Social Services and Well-being (Wales) Act. The Public Health Bill must explicitly define well-being within its provisions and include reference to physical, mental and social well-being.

## **2 Part 2: Tobacco and Nicotine Products**

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

### **Extending restrictions on smoking in school grounds; playgrounds and hospital grounds.**

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 – for example, we are aware of concerns from those who work in Public Health at a local level that voluntary smoking bans are problematic to enforce. 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 support proposals to prioritise the extension of current restrictions to playgrounds; the grounds of hospitals and schools. We would suggest that there would need to be a clear definition of 'playground' and that 'schools' should include early years educational settings such as nurseries (private and public). In the case of schools and playgrounds this should include the perimeter of these settings otherwise the intended impact of the restrictions is unlikely to be achieved i.e. if parents or other adults are permitted to smoke at the perimeter of a playground or at the school gates in clear view of children this will not impact on the intended goal of 'denormalisation' (reduce smoking being modelled to children as normal behaviour). We would also propose that the restrictions should not be limited to hospitals but should include the grounds of premises used predominately for the delivery of healthcare to include community health facilities and primary care.

We would also suggest that consideration is given to extending the requirement to include signage indicating that the premises or outdoor area is non-smoking to including information on signs (either a website or telephone number) on access to smoking cessation support.

Any additional legislation will need to be accompanied by enforcement powers such as Fixed Penalty Notice, although there will need to be consideration of the enforcement approach as currently enforcement is against the “person in control of premises” which may be less applicable for playgrounds

### **Establishing 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.

The introduction of a register in Scotland has enabled the availability and trends in availability of tobacco to be monitored effectively.

In addition to a register of retailers, we support the view of the Wales Heads of Environmental Health Group that the register should also cover all those that manufacture, distribute and sell tobacco products. This would ensure that the register covers other parts of the tobacco chain. To support this, an offence should be created where tobacco products can only be sold, distributed, etc to those registered. However there is need to be mindful that the aforementioned would appear to be covered by the recent HMRC consultation ‘Tobacco Illicit Trade Protocol – licensing of equipment and the supply chain’. Although this consultation has closed consideration should be given to including this provision should the proposal to introduce the licensing system not progress.

We are concerned about the use of the phrase “reasonable excuse” in section 35(5) ‘*A registered person who fails, without reasonable excuse, to comply with section 30 (duty to notify certain changes) commits an offence*’. This term is not defined in the legislation and may lead to evasion of enforcement action.

### **Establishment of a register to 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 or 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.

### **Strengthened Restricted Premises Order regime, with a national register, to aid local authorities in enforcing tobacco and nicotine offences**

Public Health Wales would support the proposal to enable Welsh Ministers to extend the tobacco offences that may be counted toward the application for a RPO.

Public Health Wales remains concerned that the current enforcement programme and resources available mean that it is highly unlikely that any premises will be found to have infringed the regulations on three occasions in a three year period and that in practice prohibition is therefore unlikely. Anecdotal evidence from the current enforcement of illegal sales legislation suggests that magistrates are reluctant to impose the maximum fines even when cases are brought to court. We would suggest that in the unlikely event of an application for prohibition being brought the minimum restriction on sales should be 12 months.

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. We remain concerned that this is not the case in Wales at the current time.

### **Creating a new offence for knowingly handing over tobacco and nicotine products to a person under 18, which is the 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 requested and received only by an adult.

### **Any additional tobacco control measures which should be considered for inclusion in the Bill**

Wales is currently well placed according to international comparisons in the implementation of policy and legislation to minimise harm from tobacco use. The main area for future development would relate to hypothecated taxes or a levy on cigarette purchase or profits. Work has been done that has demonstrated that the normal competitive market forces do not operate for tobacco products, with the tobacco market being dominated by a few large multinational tobacco corporations. In addition, most notably in California, a levy on every pack of cigarettes sold has funded public health action; they now have among the lowest smoking rates in the world. We recognise however, that these measures may not be within the current legislative competence of the National Assembly for Wales.

We would support early implementation of the extension of the smoking ban in enclosed public places to outdoor environments with a priority given to hospital grounds; school grounds; playing fields and outdoor leisure facilities; beaches and National Parks.

### 3 Part 3: Special Procedures

These proposals will certainly improve the protection of public health. Recent experience within Wales relating to a 'look back' exercise conducted by Aneurin Bevan University Health Board in relation to potential infection risk in Tattoo and body piercing parlours in the area has highlighted the potential risk to Public Health from these procedures. The proposals will mean that basic conditions must be met prior to any special procedures being undertaken. This, together with the strengthened local authority powers to deal with non-compliance, will contribute to protecting public health in Wales.

#### **Creating a compulsory, national licensing system for practitioners of specified special procedures in Wales, and the approval of premises or vehicle from which the practitioners operate**

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 special procedures.

There is some older evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare. 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. 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. 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 in Newport self-presented to healthcare, often multiple times.

The current legislation does not adequately protect the public and these procedures have the potential to cause harm if not carried out safely. In the recent look back exercise in Wales<sup>7</sup>, nine people were identified as needing hospital admission due to severe *Pseudomonas aureginosa* 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

<sup>7</sup> The report is available at:

<http://www.wales.nhs.uk/sitesplus/documents/866/Exercise%20SerenLookback%20Technical%20ReportFinal%20email%20version%20complete%201%208%2016.pdf>

control can lead to severe skin infections, blood poisoning (sepsis) or transmission of blood-borne infections through contaminated equipment, such as Hepatitis B, Hepatitis C or HIV.

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.

### **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<sup>8</sup>

### **Provision for Welsh Ministers to amend the list of special procedures through secondary legislation**

Public Health Wales is of the opinion that the ability to amend the list of special procedures 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.

### **Professions that are exempt from needing a licence to practice special procedures**

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.

### **Impact of enforcing the licensing system on local authorities**

We support the view of the Wales Heads of Environmental Health Group that the proposed licensing system will enable local authorities to carry out their public protection duties more effectively. The ability to recover costs will provide local authorities with the finance to undertake their enhanced role.

---

<sup>8</sup>

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192028/Review\\_of\\_the\\_Regulation\\_of\\_Cosmetic\\_Interventions.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf)

## **Health risks associated with electrolysis and acupuncture**

The addendum addresses this matter. It is informed by a review of the scientific literature since 2000 and by an analysis of the findings from the look back exercise undertaken recently in Newport, Gwent following concerns about skin infections identified in clients who had used a piercing and tattoo studio.

## **Other comments**

Section 75 (5) of the Bill (Special procedure licence: licence holder remedial action notices) should be clarified so as to ensure that where there is a risk to public health, there is the provision to stop an individual undertaking procedures with immediate effect.

Public Health Wales believes that the Bill should place a duty on practitioners to check the age of those presenting for a special procedure, as we do not believe it is sufficient to solely ask for a client's age. We would also advocate that the level of fine for non compliance should be increased from level 3 to level 5.

We have already highlighted other procedures that we believe need to be regulated (body modification, injection of any liquid into the body, laser treatments). Whilst these may be under review as part of specific requirements for cosmetic procedures, we believe this situation needs to be monitored closely to ensure that these procedures are covered by a legislative framework.

## **4 Part 4: Intimate Piercing**

### **Prohibiting intimate piercing of anyone under the age of 16 in Wales**

Public Health Wales supports these proposals.

### **Intimate body parts defined in the Bill**

We would also propose that the risks posed by piercing of the 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.

### **Placing 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.

### **The role of proposals relating to intimate piercing in contributing to improving public health in Wales**

Public Health Wales agrees that these proposals will strengthen the protection of public health in Wales by protecting some of the most vulnerable in our population.

### **Implementing a minimum age restriction for all body piercings**

Public Health Wales recognises that ear piercing in young children is culturally accepted in some populations in Wales.

Current evidence indicates that if there is parental consent and support for ear piercing and if sterile piercing equipment is used in a sterile and appropriate environment and the correct aftercare is provided, then there is no evidence of increased risk of infection in children.

As such, we do not believe there is sufficient evidence to challenge current practice.

## **5 Part 6: Pharmaceutical Services**

Delivery of additional pharmaceutical services at community pharmacies can increase NHS capacity and improve access (location, extended opening hours and availability of some services without an appointment). The proposed changes mean that Health Boards will be better able to identify which additional pharmaceutical services they wish to commission, where, and at what times to meet the needs of their populations.

Pharmaceutical services are more likely to be considered as part of wider health service planning and will be offered where there are advantages to the population and Health Board. The proposed legislation will also enable Health Boards to undertake service redesign.

Overall, Public Health Wales is fully supportive of the proposals outlined with the Bill in relation to Pharmaceutical Services.

### **Improving the planning and delivery of pharmaceutical services in Wales**

Public Health Wales agrees that the proposals will improve the planning and delivery of pharmaceutical services.

By undertaking a Pharmaceutical Needs Assessment (PNA) and aligning the PNA with other needs assessment and planning processes, Health Board planning of pharmaceutical services is more likely to be integrated and aligned with wider health needs assessment and health service planning, rather than being undertaken in isolation.

### **Encouraging existing pharmacies to adapt and expand their services in response to local needs**

Under the proposals, existing pharmacies will be encouraged to respond to commissioner requests to deliver additional pharmaceutical services to meet identified needs listed in the PNA. If the contractor does not provide the services requested, they face the risk of another contractor making a successful application to join the pharmaceutical list in their area. Not only would the new contractor provide the additional pharmaceutical services, but they would also compete for NHS prescriptions and over-the-counter sales, which are important



sources of income for community pharmacy contractors, thus leading to a potential loss of income for the existing pharmacy.

### **Other comments**

Public Health Wales believes that it is crucial that the development of PNAs is aligned with wider Health Board planning and commissioning.

## **6 Part 7: Provision of Toilets**

### **Local authority 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 leave their home for periods of time, leading to poor mobility, isolation and depression.

### **Impact of a local toilet strategy on improved provision of public toilets**

Public Health Wales is cognisant of the financial pressures experienced by local authorities at this time. Local authorities are best placed to comment on their ability to safeguard existing provision and to promote new facilities. A requirement to undertake health impact assessment of changes to service provision and policy decisions would inform the consideration of the adequacy of public toilet provision in an area.

### **Ensuring appropriate engagement with communities to guarantee the views of local people are taken into account in the development of local toilet strategies**

Section 112 (1) 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.

### **The impact of Welsh Ministers' ability to issue guidance on the development of strategies**

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

### **Toilet facilities within settings in receipt of public funding**

It would be useful if toilet facilities could be made accessible to the public 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.

### **Including changing facilities for babies and for disabled people within the term 'toilets' to ensure that the needs of all groups are taken into account**

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. Publicly accessible toilets are a necessity to maintain population health for everyone, but some groups have specific needs. These groups also include parents with 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.

### **The contribution of toilet provision to improving public health**

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.

## **7 Finance questions**

### **Costs and benefits of implementing the Bill**

We have noted the costs and benefits of implementing the Bill in the Regulatory Impact Assessment. Most of the additional costs of implementing the Bill are

borne by local authorities, Welsh Government, businesses and local health boards.

The economic downturn has resulted in strain being placed on public bodies, including the NHS and local authorities. Any additional duties mean that there is an opportunity cost around what can be provided with limited resource available. As the proposed legislation places significant additional duties on local authorities, we believe that they should be sufficiently funded to enable them to meet these requirements e.g. through cost recovery.

Public Health Wales believes that the Bill will help to improve and protect the health of the population of Wales and that the costs are proportionate.

### **Accuracy and completeness of the estimates of costs and benefits identified in the Regulatory Impact Assessment**

The Regulatory Impact Assessment provides detailed estimates of cost and benefit.

Public Health Wales is unable to comment on the accuracy of the costs to other organisations.

Overall, most costs and benefits appear to have been considered in the Assessment, including costs to the health sector and health benefits.

### **Financial impact of the Bill on Public Health Wales**

The areas that may have a financial impact on Public Health Wales are:

- Special Procedures

We welcome the proposal to include Public Health Wales in the development of guidance in relation to special procedures, to assist practitioners and businesses in their understanding of the legislation and its requirements. This is likely to have opportunity costs for Public Health Wales. We will address this through realigning our priorities in order to meet this need.

- Pharmaceutical services - Pharmaceutical Needs Assessment

Public Health Wales has been identified as a stakeholder in the task and finish group to oversee and develop guidance to support local health boards in undertaking a PNA and overseeing market exit. We note that the anticipated resource implications for Public Health Wales are three people attending up to half day meetings, costed at £2,800. We anticipate that representation at these stakeholder meetings will be from Pharmaceutical Public Health and Public Health Wales Observatory. We agree with the proposed costings for this.

We have also identified that the Pharmaceutical Public Health Team, the Primary Community and Integrated Care Team and the Public Health Wales Observatory and potentially the IM&T Team are likely to need to support local health boards with the content of the PNA, as well as with stakeholder and public engagement. This may require the development of webpages to achieve this.

Public Health Wales, via its Integrated Medium Term Plan 2016-19, has committed to supporting local health boards with the development of PNAs and will be looking to prioritise work to ensure that it is able to deliver this.

**Additional costs of the Bill's proposals to businesses, local authorities, community councils and local health boards**

As mentioned previously, most of the costs will be borne by organisations other than Public Health Wales.

Overall, we consider that the additional costs are reasonable and proportionate.

**8 Delegated powers****Balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance**

We agree that the Bill does contain a reasonable balance between what is included in the Bill itself and what is included in subordinate legislation.

We have already commented on the need for subordinate regulation for modifying the list of special procedures included in the Bill.

## **Addendum – Health risks associated with electrolysis and acupuncture**

### **a) Summary of evidence on Acupuncture, Electrolysis, Tattooing and Piercing**

A review of evidence in scientific literature since 2000 examined the reported impacts of the four special procedures outlined in the draft Public Health Bill. This review identified 206 published articles from across the world and reviewed them to draw out key themes. The key points from this review were:

*1 – Range and severity of potential adverse consequences is consistent across the four procedures.*

Infections were the most commonly reported adverse consequences in case reports for all procedures identified. The causative agents for these infections were a wide range of bacteria, including *Haemophilus parainfluenzae*, *Staphylococcus aureus*, *Listeria monocytogenes*, *Pseudomonas* species, Non-tuberculous *Mycobacterium* and *Enterococcus faecalis*, and viruses (e.g. Hepatitis).

In interpreting these findings it is important to note that the nature of the complications reported are different depending on the nature of the study reporting them. Cohort studies involving practitioner reporting of complications generally show high levels of minor consequences (e.g. minor bleeding, itching). This is a different picture to the case reports published by medical professionals which describe more unusual or severe outcomes and outbreaks. This makes estimation of the prevalence of infections following the procedures difficult.

Outbreaks of infectious disease have been reported in the academic literature for all of the special procedures listed. Similar causative agents (e.g. Non-tuberculous *Mycobacterium species* or hepatitis virus) are seen across these outbreaks.

The numbers of studies or reported cases are not necessarily the same, but this may reflect differences in prevalence of the procedure or management and reporting of cases. This is exemplified by electrolysis where only one study was identified within the time period and one older outbreak was subsequently identified. This may reflect a lower risk or a lower prevalence of the procedure being used – there is not sufficient evidence to say which of these applies.

As all procedures proposed in the legislation involve piercing the skin with a needle and the skin is the body's first line of defence against infection there is a *prima facie* case that the risks of infection posed by the procedures are similar. This is apparent in the evidence identified and for most procedures the organisms reported to be causing infection are similar. It is therefore important to ensure that standards of infection control and awareness of infections are similar across the procedures.

*2 – Risk of severe outcome is dependent on type and location of procedure and patient characteristics*

With many of the infectious adverse events the consequences range from minor localised infection to fatal or life changing outcomes for the case. There is

evidence that there are a number of factors which contribute to the severity of the outcome for patients. These factors include susceptibility of the client to serious infection and the body site where the procedure is carried out.

It is clear that diabetes and congenital heart conditions feature regularly in the case reports of severe and fatal outcomes. It is also clear that in some cases the client was aware of the condition but not that it carried an increased risk for the procedure. The outcomes including invasive group A streptococcus infection and infective endocarditis carry large costs for health services (e.g. heart valve transplant) and risks to the patient. Some evidence suggests that risks can be reduced in these vulnerable cases by good infection control or measures such as antibiotic prophylaxis.

For some special procedures specific locations and practices have been associated with increased risk. In piercing there is evidence that some piercing sites (high ear, tongue) carry substantially higher risks of complications and subsequent infection than others. This evidence of location specific risk does not exist for other special procedures. It is clear that tongue piercing in particular carries an especially high risk of complication for individuals, including bacterial endocarditis, aspiration of jewellery and dental issues, compared to other sites. Additionally, high ear piercing was associated with a larger number of outbreaks (mostly pseudomonas species) compared to other piercing sites. Similarly dilution of black ink to create grey during tattooing has been associated with a number of outbreaks of Non-tuberculous mycobacterium in the UK and worldwide.

It is therefore important that practitioners are equipped with sufficient knowledge of the risks to vulnerable patients and the increased risks associated with certain locations and practices in order to minimise the risk for patients and the population. Studies of practitioner knowledge in the UK suggest that this is not currently the case and minimum standards of training have been advocated.

### *Conclusion*

Measures proposed by the Public Health (Wales) Bill requiring minimum standards for knowledge and practice for all special procedures to be set and enforced are proportionate to reduce the risks faced and necessary to protect public health. All four special procedures share the same risk factor, a needle is used to pierce the skin. Although each has technical differences, which alter the likelihood of infection transmission and the severity of infection if acquired, the similarity between the basic technique means that all should be regulated in the same way. The case in Wales supporting these conclusions has been reinforced by the findings from a recent health protection incident in Newport, Gwent, as described in the next section.

### **b) Newport look back**

A cohort of people at risk of infection following a body piercing or tattoo at a premises under investigation (termed 'at-risk cohort') was identified. This 'at-risk cohort' was identified from client lists held at the premises and from people who self-presented following media reports of the incident, either through a Public Health Wales helpline or by directly attending a clinic session for a blood borne virus screen. The cohort represents only those who were known to the Health

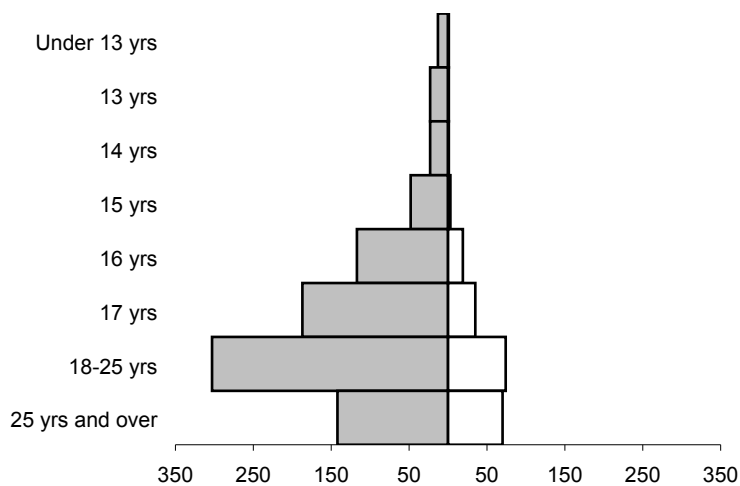
Board, and is unlikely to include all those who attended the premises under investigation.

In total 1069 people were included in this 'at risk cohort'; 680 from client lists, 337 from people contacting the Public Health Wales helpline and considered to be at risk, and 44 who self presented at a clinic session. Source of referral was not recorded for 8 people.

### Age of cohort

Figure 1 illustrates the age profile of those identified in the look back exercise. The largest proportion are aged less than 18 years with many under 16 years.

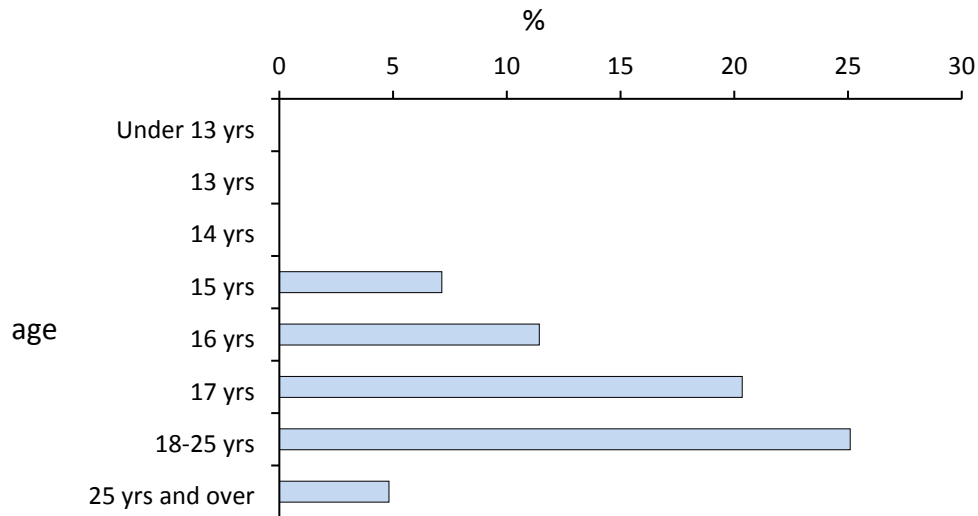
**Figure 1. Age<sup>1</sup> and sex distribution of cohort of people considered to be at risk of infection following a piercing or tattoo at the premises under investigation ('at-risk cohort')**



<sup>1</sup> Age as at May 2015

Figure 2 illustrates those identified who reported having 'intimate' piercings. It is of note that almost 1 in 15 are under 16 years of age. There are many more under the age of 18.

**Figure 2. Proportion of individuals attending for a blood borne virus screen reporting a body piercing at an intimate site (nipples and/or genitals) by age group<sup>1</sup>**



<sup>1</sup> Age as at May 2015

### Evidence of harm

Of the 628 who reported having had a piercing in the previous two years, 215 (34%) reported having had a skin infection following the piercing. Infections were reported across all age groups. Forty-one of the 215 people (19%) reporting a skin infection stated that they had contacted a health service about the infection. Ten reported attending hospital. Twenty-nine percent (28/96 individuals) of those aged less than 16 years reported an infection, compared to 35% of those 16 years or older (187/532).

### Proof of age

From table 1 it can be seen that clients under the age of 18, and under 16 in particular, are adding years to their true age to pass themselves off as older. Requiring the practitioner to check proof of age is necessary to overcome this issue.



**Table 1: Difference in self- reported age<sup>1</sup> and true age<sup>2</sup> in 387 clients attending a piercing/tattoo studio under investigation in Exercise Seren by age at time of procedure<sup>3</sup>**

	Reported age greater than true age			Exact age match	Reported age less than true age		
	>2 years	1-2 years	<1 year		<1 year	1-2 years	> 2 years
<13	0%	6%	38%	56%	0%	0%	0%
13	10%	10%	10%	70%	0%	0%	0%
14	13%	33%	8%	38%	4%	0%	4%
15	6%	15%	48%	29%	2%	0%	0%
16	8%	6%	12%	73%	1%	0%	0%
17	0%	29%	16%	52%	0%	3%	0%
18-25	1%	0%	3%	96%	0%	0%	0%
>25	0%	0%	0%	97%	0%	0%	3%
Total	4%	12%	17%	65%	1%	1%	1%

<sup>1</sup> Age calculated by subtracting client date of birth from date of procedure. Both dates obtained from piercing studio client records

<sup>2</sup> Age calculated from dates of birth obtained by checking client's details against Welsh Demographics Service

<sup>3</sup> First known visit for piercing and/or tattoo. (Clients reported more than one visit and multiple procedures on same visit)

## Appendix 2 – Minimum Unit Pricing Alcohol

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

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**

***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<sup>9</sup>, 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:<sup>10,11,12</sup>

- 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

---

<sup>9</sup> 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;

<sup>10</sup> 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

<sup>11</sup> 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

<sup>12</sup> 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>

Drinking alcohol increases the risk of developing over 60 different health problems<sup>13</sup> 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)<sup>14</sup>.

The 2011 General Lifestyle Survey (GLS<sup>15</sup>) 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<sup>16</sup> (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 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<sup>17,18,19,20</sup>.

<sup>13</sup> World Health Organisation (2009) Harmful Use of Alcohol  
[http://www.who.int/nmh/publications/fact\\_sheet\\_alcohol\\_en.pdf](http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf)

<sup>14</sup> The UK CMOs' Alcohol Guidelines Review (2016) is for both men and women to not drink more than 14 units per week and to spread this over 3 days or more.

<sup>15</sup> 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>

<sup>16</sup> 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.

<sup>17</sup> 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/>

<sup>18</sup> Home Office (2012) *A minimum unit price for alcohol: impact assessment 1A*. Home Office, London, UK.

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<sup>21</sup>.

A 2005 review by the World Health Organisation (WHO)<sup>22</sup> 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<sup>23</sup>.

---

<sup>19</sup> 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.

<sup>20</sup> Gallet, C.A. (2007) The demand for alcohol: a meta-analysis of elasticities. *Australian Journal of Agriculture and Resource Economics*, 51, 121-35.

<sup>21</sup> 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/>

<sup>22</sup> WHO fact sheet. 2005. [www.parpa.pl/download/fs1005e2.pdf](http://www.parpa.pl/download/fs1005e2.pdf).

<sup>23</sup> Holmes, J., Meng, Y., Meier, P.S., Brennan, A., Angus, C., Campbell-Burton, A., Guo, Y., Hill-McManus, D. and Purshouse, R.C. (2014) Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. *Lancet*, 383, 1655-1664

***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.

Both US and UK data show that the heaviest drinkers gravitate towards the cheapest alcohol<sup>24,25</sup>. 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,<sup>26,27</sup> 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<sup>28</sup>, 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

---

<sup>24</sup> 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.

<sup>25</sup> Meier, P., Brennan, A., Purhouse, 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.

<sup>26</sup> Hansard. House of Commons Debate 14 March 2013. *Hansard* 2013; **560**: 451-91.

<sup>27</sup> 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-for-minimum-pricing> (accessed July 2, 2013).

<sup>28</sup> 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>

reduce alcohol related criminal offences by 4,200, with a total value of an estimated saving of £1.3 billion over 10 years.<sup>29</sup>

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 well-being of wider society through reducing alcohol-related crime, including those relating to violent, anti-social and disorderly behaviour, acquisitive crime and criminal damage.

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<sup>30</sup> and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide)<sup>31</sup>.

In Scotland 50 per cent of people reported one or more harms as a result of someone else's drinking in the last year<sup>32</sup>.

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<sup>33</sup>.

***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.<sup>34</sup>

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

<sup>29</sup> 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](http://www.shef.ac.uk/polopoly_fs/1.95608!/file/scottishadaptation.pdf).

<sup>30</sup> British Crime Survey, ONS;

<http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales>

<sup>31</sup> World Health Organisation (2006) Interpersonal violence and alcohol.

[http://www.who.int/violence\\_injury\\_prevention/violence/world\\_report/factsheets/pb\\_violencealcohol.pdf](http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf)

<sup>32</sup> 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>

<sup>33</sup> 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.

<sup>34</sup> 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>.

in chronic alcohol-attributable admissions two years later<sup>35</sup>. It was estimated from this that a 10 cent (approximately 6 pence) 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.<sup>36</sup> 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<sup>37</sup> 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.<sup>38</sup>

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,

<sup>35</sup> 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.

<sup>36</sup> Welsh Assembly Government (2008) 'Working Together to Reduce Harm, The Substance Misuse Strategy for Wales 2008-2018'.

<sup>37</sup> '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.

<sup>38</sup> PEDW; NWIS

<https://www.healthmapswales.wales.nhs.uk/IAS/dataviews/report/multiple?reportId=60&viewId=117&geoTypeId=7,2>

tackling alcohol related ill health is an important element in reducing inequalities in health<sup>39</sup>.

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

***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
- 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

<sup>39</sup> A Profile of alcohol and health in Wales (2009)

[http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/0400558233b1c95c802576ea00407a33/\\$FILE/Alcohol%20and%20health%20in%20Wales\\_WebFinal\\_E.pdf](http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/0400558233b1c95c802576ea00407a33/$FILE/Alcohol%20and%20health%20in%20Wales_WebFinal_E.pdf)



- 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

***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<sup>7</sup>:

- 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.

# Agenda Item 3

## Ymchwilio i'r Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)-14-16 Papur 2/ Paper 2



	The Welsh NHS Confederation response to the Health, Social Care Committee inquiry into the general principles of the Public Health (Wales) Bill.
<b>Contact:</b>	Nesta Lloyd – Jones, Policy and Public Affairs Manager, the Welsh NHS Confederation. <a href="mailto:Nesta.lloyd-jones@welshconfed.org">Nesta.lloyd-jones@welshconfed.org</a> Tel: 02920 349857
<b>Date:</b>	25 November 2016.

### Introduction

1. The Welsh NHS Confederation, which represents the seven Health Boards and three NHS Trusts in Wales, welcomes the opportunity to respond to the inquiry into the general principles of the Public Health (Wales) Bill.
2. 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.
3. 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, person-centred services to the people of Wales.

### Summary

4. As with our response to earlier consultations relating to this Bill,<sup>i</sup> 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.
5. 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 and well-being needs to be owned across Government departments and by all sectors across Wales. The Well-being of Future Generations (Wales) Act 2015 goes 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.

# Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)–14–16 Papur 2/ Paper 2



6. The Welsh NHS Confederation recently published a briefing for Assembly Members,<sup>ii</sup> attached with this submission, which set out the public health challenges in Wales and the steps needed most urgently over the course of the fifth Assembly to aid the sustainable health and well-being for the people of Wales. The next five years represent a critical period of transformation in health and care services in Wales. The NHS will continue to work across Government and public sector partners to invest time and resources in services that promote health and well-being and shift resources towards community based interventions. To achieve a healthier, happier and fairer Wales, it is also key that the public are empowered and informed to take responsibility for their own health and well-being.

## **General principles of the Public Health (Wales) Bill**

### **Tobacco and Nicotine Products**

**Re-state restrictions on smoking in enclosed and substantially enclosed public and work places, and give Welsh Ministers a regulation-making power to extend the restrictions on smoking to additional premises or vehicles.**

7. We would support the restrictions on smoking in enclosed and substantially enclosed public and work places and agree that the Welsh Ministers should have regulation-making powers to extend the restrictions on smoking to additional premises or vehicles.
8. 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. Many people require NHS services directly because of smoking-induced diseases such as cancer, 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.

### **Place restrictions on smoking in school grounds, hospital grounds and public playgrounds**

9. We would support the restrictions on smoking in school grounds, hospital grounds and public playgrounds. At present all Health Boards have individual Smoke Free Environment policies, which includes the prohibiting of e-cigarette use, and having this in legislation would be useful. Legislation would provide a clear message that smoking is not allowed and would aid managers of premises to enforce the current non-smoking regime.
10. In addition in relation to placing restrictions on certain premises we would recommend that prison estates are included. Like hospitals, all prisons in Wales, including the soon to open HMP Berwen, are smoke free. Enshrining it in legislation would be a positive step to reinforce the measure. The inclusion of secure hospitals, and whether the current exemption for psychiatric units should remain, should also be considered. Finally we would recommend extending smoke free spaces into outdoor areas frequented by children and the margins of buildings that have smoking restrictions.

**Provide for the creation of a national register of retailers of tobacco and nicotine products.**

11. 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. We would recommend that the role of the register in preventing access to tobacco among children is also recognised. Having a requirement for tobacco retailers to display information about quit smoking support would also be useful.
12. 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.<sup>iii</sup> 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 products from registered retailers. Creating a tobacco retail register will also help colleagues in Trading Standards to tackle the problem of under-age sales.
13. 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.

**Provide Welsh Ministers with a regulation-making power to add to the offences which contribute to a Restricted Premises Order (RPO) in Wales.**

14. We agree that Welsh Ministers should be provided with a regulation-making power to add to the offences which contribute to a Restricted Premises Order (RPO). We would support the proposal to enable local authority enforcement officers to introduce a RPO. However, as prosecutions for noncompliance 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.

**Prohibit the handing over of tobacco and/or nicotine products to a person under the age of 18.**

15. We would support the prohibition of handing over of tobacco and/ or nicotine products to a person under the age of 18. The growth of online shopping would suggest the need to revisit all age restricted sales in this way.

## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)-14-16 Papur 2/ Paper 2



### **Other comments**

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

### **Special Procedures**

**Provide for the creation of a mandatory licensing scheme for practitioners and businesses carrying out 'special procedures', namely acupuncture, body piercing, electrolysis and tattooing.**

17. We welcome 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 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. We would recommend that the Committee considers the findings of the recent report published by Aneurin Bevan University Health Board "The Technical Report of a Blood-Borne Virus Look-Back Exercise related to a body piercing and tattooing studio in Newport, South Wales"<sup>iv</sup> and the recommendations within the report. The recommendations included:

- Education of young people about risks of tattooing and piercing including blood borne viruses and bacterial infections should be supported nationally.
- There is a need for improved regulatory powers for the enforcement of hygiene measures in body piercing/tattooing premises. There are better safeguards in place with regard to buying a sandwich than having potentially harmful procedures such as tongue piercing currently.
- All premises performing body piercing/tattooing should keep detailed client lists and consent forms with address and contact numbers.
- Intimate piercing should only be performed over the age of 16 where documented proof of age is demonstrated.
- The piercing/tattooing of intimate areas can be considered a safeguarding issue, if the client is not of age or is vulnerable in other ways and it is recommended that these procedures are carried out by a same sex practitioner preferably in the presence of a client advocate.

## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)-14-16 Papur 2/ Paper 2



- All tattooing and body piercing practitioners should have DBS checks completed and undergo safeguarding training.
  - Registration/licensing to perform tattooing/piercing should be on an individual basis of competency based on understanding of infection control, safeguarding legislation, technical aspects and practical skills, similar to other forms of minor surgery e.g. cosmetic. The current situation, whereby anyone with no training can open for trading with no quality assurance, is unacceptable particularly with ever invasive procedures e.g. tongue piercing, body modification.
  - Substantiated complaints against an individual should revoke licence until a period of retraining and reaccreditation fulfilled.
  - Local authorities should have shared databases of licensed practitioners and those whose licence has been revoked.
  - There should be awareness-raising among GPs and ENT doctors so that if anyone presents with infection following piercing/tattooing they alert the local Health Protection team urgently.
18. 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.
19. 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 certain liquids into the body, for example botox, dermal fillers and dermal rolling/micro needling, 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.
20. 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.

### Intimate Piercing



**Introduce a prohibition on the intimate piercing of persons under the age of 16 years.**

21. 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.
22. 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.

**Require Welsh Ministers to make regulations to require public bodies to carry out health impact assessments in specified circumstances**

23. We support the proposal that requires the undertaking and publication of health impact assessments (HIA) by public bodies in specified circumstances and we are pleased that this is included in Part 5 of the Public Health (Wales) Bill 2016. We believe that this inclusion will strengthen the focus on improving population health and well-being and facilitate action-oriented partnership working. This mandatory requirement will support good public health practice across local and national organisations and explicitly reinforce Welsh Government commitment to a 'Health in all Policies' approach which is implicit within the Well-being of the Future Generations (Wales) Act 2015.
24. We have consistently called for HIA to be introduced in Wales. In our response to the previous Public Health (Wales) Bill, and also in our Briefing for the National Assembly election,<sup>v</sup> we called for a 'Health in All Policies' approach being adopted across sectors to ensure the impacts on health, well-being and equity are known and harms are minimised and mitigated.
25. HIA could make Wales an international exemplar in the field of public health. Pre-assessing new policies, plans or programmes in order to avoid any unforeseen negative impacts on the environment or equalities is already well-established within decision-making by public bodies in Wales. However, there is also a strong case to be made that we should be equally seeking to avoid or minimise any negative impacts on the health and well-being of the Welsh population, as well as promoting positive impacts. It also makes sense in light of the accepted recognition that health is, to a large extent, determined by factors outside of healthcare provision. Known as the wider determinants of health, these include social and community factors; access to services; and



## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)–14–16 Papur 2/ Paper 2



economic and environmental factors, as highlighted in our recent “Public Health Challenges in Wales” briefing.<sup>vi</sup>

26. We welcome the development of regulations to inform the implementation of HIAs by public bodies. We request that a broad holistic approach be adopted when considering the circumstances in which a public body carries out a HIA and include the assessment of actions or decisions that are not normally considered to be health related. For example, Public Service Board’s Well-being Plans, major Health Board or local authority service re-configurations, land use plans, policy decisions on classification and location of hot food take-aways, national and local education policies. We also support the requirement that all Welsh Government policies are systematically assessed for their potential positive and negative or unintended consequences on health and well-being; undertaking HIAs on national policies will support delivery at a local level.
27. A number of governmental strategic levers and drivers currently exist and HIAs are explicitly referred to in Welsh Government guidance in a wide range of areas, including road and rail transport, land use planning and regeneration plans, for example. HIA is already a mandatory requirement within the NHS in Wales in respect of investment in infrastructure and capital build projects. We suggest that provision for statutory HIAs commence where already referred to in order to help build and expand the body of HIA work available.
28. HIAs should be required in a way that is manageable and proportionate to the size, scale, scope, significance and nature of any policy, plan or proposal. It should make best use of the resources, knowledge, expertise and evidence available. We recommend that a requirement be included for HIAs to be completed across development stages and that the process be proportionate but still provide helpful and robust information that supports decision making. We also suggest that any method for undertaking HIA needs to be a core component of any organisation’s approach, adding a health dimension to the current impact assessments that are currently used routinely.
29. We would like to stress that HIAs should be viewed as a tool to support public bodies to address inequalities and inequities in health and inform actions that strengthen positive impacts and mitigate negative impacts. We believe that it is essential that HIAs are undertaken in consistent and effective ways and that the process be effectively understood and positively followed both upstream at a governmental level and downstream at a local level.
30. We recommend that consideration needs to be given to capacity and the role of a wide range of organisations to develop systems, and ensure people have the support and skills to undertake HIAs. Public Health Wales NHS Trust, and specifically the Wales Health Impact Assessment Support Unit, has a clear role in supporting capacity development through training and the provision of support such as mentoring practitioners and there needs to be an increased corresponding resource for this.
31. As the Welsh NHS Confederation’s “From Rhetoric to Reality – NHS Wales in 10 years’ time”<sup>vii</sup> 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.

32. 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.

### **Pharmaceutical Services**

#### **Change the arrangements for determining applications for entry onto the pharmaceutical list of health boards (LHBs), to a system based on the pharmaceutical needs of local communities**

33. 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.
34. 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.
35. 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.
36. 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

## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)–14–16 Papur 2/ Paper 2



important role in delivering public health services. 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.

37. 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 sign-posters, facilitators and providers of a wide range of public health and other health and well-being services.
38. The NHS Confederation's discussion paper 'Health on the high street: rethinking the role of community pharmacy'<sup>viii</sup> 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.

### **Provision of Toilets**

#### **Require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use**

39. 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.

## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)–14–16 Papur 2/ Paper 2



40. 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.<sup>ix</sup>
41. 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 writing of a strategy alone will not automatically improve provision because of the significant financial pressures already experienced by Local Authorities.
42. 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. A requirement to undertake HIAs of changes to service provision and policy decisions would permit the consideration of the adequacy of public toilet provision in an area.
43. 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.
44. 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.

### **Food Standards**

**Enable a 'food authority' under the Food Hygiene Rating (Wales) Act 2013 to retain fixed penalty receipts resulting from offences under that Act, for the purpose of enforcing the food hygiene rating scheme.**

45. The Welsh NHS Confederation supports this new offence. Food standards can make an important impact on public health. 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. Catering Standards for Food and Fluid Provision for

## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)-14-16 Papur 2/ Paper 2



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).

46. 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.

### **Any potential barriers to the implementation of these provisions and whether the Bill takes account of them.**

#### **The financial implications of the Bill.**

47. One of the biggest barriers to implementation of these provisions are the financial implications of that some duties will have. 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**

#### **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. By 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

## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)–14–16 Papur 2/ Paper 2



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.

### **People in Wales are empowered to take control of their health**

51. 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.
52. 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**

53. 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.
54. Last year the Welsh NHS Confederation published the 'Socio-economic deprivation and health'<sup>x</sup> 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.<sup>xi</sup> 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 20015 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**

55. While the Public Health (Wales) Bill is debated it is vital to recognise the key role that public health plays in reducing health inequalities, ensuring positive outcomes for the Welsh population and



## Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon Health, Social Care and Sport Committee

HSCS(5)–14–16 Papur 2/ Paper 2



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.

56. With the introduction of the Public Health (Wales) Bill, now is the time for us all to act together. Through a systems approach - sharing our collective assets, following the principles of sustainability and prudent healthcare and complying with our unique legislation, the Well-being of Future Generations (Wales) Act 2015, we have the opportunity and responsibility to work collaboratively across sectors and organisations. It is essential to listen to and empower our people, and to appreciate the assets within our communities, allowing them an equal part in all decisions and plans for their life, health and happiness. Assembly Members have a key role to ensure that together we can achieve a healthier, happier and fairer Wales.

---

<sup>i</sup> The Welsh NHS Confederation response to the 'Listening to you – Your health matters' White Paper in June 2014 and the 'Public Health (Wales) Bill' in July 2015.

<sup>ii</sup> The Welsh NHS Confederation, November 2016. Public Health Challenges in Wales: A briefing for AMs.

<sup>iii</sup> Health & Social Care Information Centre, 2013. Smoking, drinking and drug use among young people in England in 2012.

<sup>iv</sup> Aneurin Bevan University Health Board, July 2016: The Technical Report of a Blood-Borne Virus Look-Back Exercise related to a body piercing and tattooing studio in Newport, South Wales. [www.wales.nhs.uk/sitesplus/866/news/42624](http://www.wales.nhs.uk/sitesplus/866/news/42624)

<sup>v</sup> The Welsh NHS Confederation, October 2015. The 2016 Challenge: A vision for NHS Wales.

<sup>vi</sup> The Welsh NHS Confederation, November 2016. Public Health Challenges in Wales: A briefing for AMs.

<sup>vii</sup> The Welsh NHS Confederation, January 2014. From Rhetoric to Reality – NHS Wales in 10 years' time.

<sup>viii</sup> The NHS Confederation, 2013. Health on the high street: rethinking the role of community pharmacy.

<sup>ix</sup> Older Peoples Commissioner for Wales, 2014. The Importance and Impact of Community Services within Wales.

<sup>x</sup> The Welsh NHS Confederation, June 2015. Socio-economic deprivation and health.

<sup>xi</sup> Public Health Wales Observatory, December 2011. Measuring inequalities. Trends in mortality and life expectancy in Wales.

# Public Health Challenges in Wales: A briefing for AMs

This briefing sets out the public health challenges in Wales and the steps needed most urgently over the course of the fifth Assembly to aid the sustainable health and well-being for the people of Wales.

The Welsh NHS Confederation is the only national membership body which represents all the organisations that make up the NHS in Wales: the seven Local Health Boards and three NHS Trusts. Our role is to support 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.

## Key Points

Wales has made great strides in improving the health and well-being of its population. We are living longer, fewer of us are dying from infections and we have better health and care services. However, we still face a significant number of public health challenges.

While the negative impacts of obesity, drinking above the guidelines, smoking and low levels of physical activity have been well documented, there are other factors that impact on health and well-being, resulting in an ever-increasing demand being placed on the health and care service.

The economic, social and natural environment in which we grow up, live and work is a major determinant of our health and well-being. As the future Public Health (Wales) Bill is discussed

and debated in the National Assembly, we ask Assembly Members to recognise these areas and their impact. We are specifically calling for the implementation of a 'Health in All Policies' approach, with all public sector organisations being required to conduct Health Impact Assessments on future policies.

The next five years represent a critical period of transformation in health and care services in Wales. The NHS will continue to work across Government and public sector partners to invest time and resources in services that promote health and well-being and shift resources towards community based interventions. To achieve a healthier, happier and fairer Wales, it is also key that people are empowered and informed to take responsibility for their own health and well-being.



# Current Public Health Challenges in Wales

## Population changes

- The **population of Wales** is projected to increase by almost 9%, from around 3.1 million in 2011 to over 3.3 million in 2036. The 65 to 84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated 1 in 4 people in Wales will be aged 65 and over. As the population grows older, the number of people living with long term health conditions will continue to increase.

## Wider determinants of health

- **Poor quality housing**, including issues such as mould, poor warmth and energy inefficiency, infestations, overcrowding and noise are linked to physical, mental and respiratory ill health.
- **Active travel**, such as cycling and walking instead of driving shorter journeys, has the double benefit of improving physical fitness and reducing air pollution.
- **Violence** is a major cause of poor physical and mental health. In Wales, domestic abuse costs public services £303.5 million per year.
- **Adverse Childhood Experiences (ACEs)** are associated with over half of cases of violence and drug abuse and nearly a quarter of current adult smokers in Wales.
- **Environmental** risks to health include urban outdoor air pollution, unsafe water, indoor smoke from solid fuels, lead exposure and global climate change. Breathing polluted air increases the risk of heart disease, stroke, respiratory disease and lung cancer.

## Health behaviours

- Approximately 1 in 5 adults in Wales **smoke**, causing 18% of adult deaths and costing £386 million per year to the NHS.
- Each year **physical inactivity** costs the Welsh economy £314 million per year.
- A majority of people (58%) in Wales are either **overweight** or **obese**.
- In Wales alone, **alcohol misuse** directly leads to over 1,500 deaths each year at a total cost of £100 million.
- **Substance misuse** has a significant impact on society. The combined economic and social costs of alcohol and Class A drug misuse in Wales is estimated to be around £2 billion.

## Health and well-being outcomes

- There are significant **health inequalities** in Wales. The Public Health Wales Observatory estimates the average life expectancy of a male living in the least deprived area of Wales is 9 years longer than that of a male living in the most deprived. When we consider healthy life expectancy, this gap is 19 years. For females, the gaps are similarly persistent – 7 years for life expectancy and 18 years for healthy life expectancy.
- In Wales, 13% of adults reported having a **mental health** condition in 2015 compared to 9% in 2003/4. Mental ill health is associated with worse physical health, increased health risk behaviours, poor education and unemployment.
- In Wales, 779 people were admitted to hospital in 2015 due to **influenza**, 125 of whom received treatment in intensive care.

## Protecting health and communicable diseases

- **Screening** is a process of identifying apparently healthy people who may be at an increased risk of disease or condition.
- The NHS provides free **immunisations** and **vaccinations** to every child to protect them from potentially serious diseases, including diphtheria, tetanus, polio, MMR and Meningitis C among others.
- **Resistance to antimicrobials** poses a significant threat to public health, with the emergence of resistance to a wide variety of agents, making them ineffective. The supply of new replacement antimicrobials has slowed and there are fewer options to treat infectious diseases.
- Public Health Wales has found that since 2013 there have been sharp increases in **blood borne viruses** and **sexual health cases**, including the number of cases of hepatitis B, hepatitis C, herpes and chlamydia.
- **Hygiene and food poisoning** can cause ill health. The Food Standards Agency estimate that around one million people in the UK suffer from a foodborne illness of some kind each year.

## Public Health in Wales

The challenges above shows the breadth of public health as both diverse and complex. Public health is generally associated with the health of the entire population, rather than the health of individuals. The three domains of public health practice in the UK are: health improvement; health protection; and improving services. In Wales the role of Public Health Wales NHS Trust is to protect and improve health and well-being and reduce health inequalities for people in Wales and all Health Boards have responsibility for public health.

Wales has led the way in many public health policies and legislation, such as the ban on smoking in public places, and we would urge political parties to keep up this momentum. While legislation and policy-making are only two of many strands in addressing Wales' public health challenges, they can play a vital role in changing behaviour. The development and implementation of policies that help to create the right conditions that will support people to make healthier lifestyle choices are key to securing the health of our nation and we have an opportunity to deliver this through the Well-being of Future Generations (Wales) Act 2015.

The Well-being of Future Generations (Wales) Act 2015 is the first legislation in the world to link with the United Nations' Sustainable Development Goals by putting in place seven well-being goals for Wales to make sure we are all working towards the same long-term vision. Through the Act, and the recently published Welsh Government Public Health Outcomes Framework, we have an opportunity to measure and monitor the health of the Welsh population and understand the impact our individual behaviours, public services, programmes and policies are having on health and well-being in Wales.

**“The new Public Health (Wales) Bill provides a key opportunity for Assembly Members to discuss and highlight...the importance of placing Health Impact Assessments (HIAs) on a statutory footing”.**

## The ways you can support the Public Health (Wales) Bill

As well as the Well-being of Future Generations (Wales) Act 2015, the new Public Health (Wales) Bill provides a key opportunity for Assembly Members to discuss and highlight the range of different public health areas, the key ways to improve the health and well-being of the population and the importance of placing Health Impact Assessments (HIAs) on a statutory footing.

The HIA process is a way to consider the extent to which the health and well-being of a population may be affected, whether positively or negatively, by a proposed policy, plan or programme and can identify any inequalities which may arise from it. Through HIAs, amendments can be suggested and enacted to emphasise health benefits and minimise any risks to health.

At stage 1 of the previous Public Health (Wales) Bill, introduced in June 2015, the Health and Social Care Committee heard from stakeholders that mandatory HIA would provide a mechanism to avoid or minimise negative impacts on the health and well-being of communities, and maximise health benefits where possible. As a result the Bill was amended at stage 3 by Welsh Government amendments introducing a requirement for public bodies to carry out HIAs.

As well as the need to introduce HIAs, the new Public Health (Wales) Bill is a chance to highlight the need for an open and honest conversation with the public about what the NHS can provide in the future. While the NHS is free at the point of contact, it is not free of obligation, and the public will need to be supported in taking more responsibility for their own health. Patients need to become partners in managing and improving their health, rather than passive recipients of healthcare. Patients expect to be asked about their health behaviours, if they are not discussed the perception is that unhealthy behaviours are not as important in addressing illness or disease risks as perhaps pharmacological/ invasive interventions. The NHS also needs to manage expectations and help patients understand exactly which services the NHS can deliver, and what steps patients can take to improve and protect their health and well-being – an approach often badged as ‘making every contact count’.

## A vision for public health in Wales

The Welsh NHS Confederation believes a healthier, fairer and happier Wales is within our reach and can be achieved by:

- Agreeing a **long-term strategy** that involves organisations from across the public sector to encourage collaborative working to reduce inequalities in health outcomes;
- Ensuring impacts on health, well-being and equity are known and harms are minimised and mitigated through adopting a '**Health in All Policies**' approach across sectors;
- **Investing in prevention and early intervention** to support and maintain people's well-being and prevent ill health for as long as possible (as recently highlighted by Public Health Wales NHS Trust in their document "Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales");
- Committing to improve public health through further development and implementation of policies that will create the right conditions to **support people to make healthier choices**;
- **Empowering, encouraging and informing people** to take personal responsibility for their health and shape their own care around their individual needs;
- Keeping people healthier through a greater emphasis on **primary and community care**;
- Engaging the entire **public sector workforce** in public health and prevention;

- Supporting a **culture change** among the public in terms of making healthier choices and reducing reliance on NHS services; and
- **Investing in preventive interventions** which are based on evidence and offer value for money.

## Conclusion

With the introduction of the Public Health (Wales) Bill, now is the time for us all to act together. Through a systems approach - sharing our collective assets, following the principles of sustainability and prudent healthcare and complying with our unique legislation, the Well-being of Future Generations (Wales) Act 2015, we have the opportunity and responsibility to work collaboratively across sectors and organisations. It is essential to listen to and empower our people, and to appreciate the assets within our communities, allowing them an equal part in all decisions and plans for their life, health and happiness. Assembly Members have a key role to ensure that together we can achieve a healthier, happier and fairer Wales.

## How can the Welsh NHS Confederation help you?

Please get in touch if you want further details on any of the issues raised in this briefing. We can also provide information and briefings ahead of Assembly debates on the key issues affecting the NHS.

For more information, please contact Nesta Lloyd-Jones, Policy and Public Affairs Manager: **Nesta.Lloyd-Jones@welshconfed.org**

You can visit our website at **www.welshconfed.org** or follow us on Twitter  **@WelshConfed**

Welsh NHS Confederation  
Tŷ Phoenix, 8 Cathedral Road, Cardiff, CF11 9LJ  
Tel: 02920 349850  
www.welshconfed.org  
Registered Charity No: 1090329

HSCS(5)-14-16 Papur 3/ Paper 3

Vaughan Gething AC/AM  
Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon  
Cabinet Secretary for Health, Well-being and Sport

Rebecca Evans AC/AM  
Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol  
Minister for Social Services and Public Health



Llywodraeth Cymru  
Welsh Government

Ein cyf/Our ref : MA-(P)/VG/7733/16

Dr David Lloyd AM  
Chair of the Health, Social Care and Sport Committee,  
National Assembly for Wales  
Cardiff Bay  
Cardiff  
CF99 1NA

30 November 2016

Dear Dai,

We refer to your letter of 17 November, outlining your main conclusions which have been drawn from your scrutiny of the Welsh Government's 2017-18 draft budget. Please find below our responses in relation to those issues on which you have asked for further information.

### 1. Additional allocation for NHS Services

In terms of our expectations for the use of the additional £240 million for NHS Wales, these are set out in outline in the evidence paper. The first call on this funding will, inevitably, be to enable NHS organisations to meet normal cost growth, including funding the pay award for NHS staff, and increases in contract agreements for general medical and dental practitioners.

As we outlined, we will also set aside some of this funding to support the particular financial issues in Betsi Cadwaladr and Hywel Dda University Health Boards.

In line with our budget agreement with Plaid Cymru, £20 million of the additional funding will be allocated to mental health services, and included in the ring-fenced mental health allocation. This will take this allocation to over £620 million in 2017-18.

Bae Caerdydd • Cardiff Bay  
Caerdydd • Cardiff  
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:  
0300 0604400

[Gohebiaeth.Vaughan.Gething@llyw.cymru](mailto:Gohebiaeth.Vaughan.Gething@llyw.cymru)  
[Correspondence.Vaughan.Gething@gov.wales](mailto:Correspondence.Vaughan.Gething@gov.wales)

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

In addition, we intend to use some of this funding to push further with our aim to provide more care closer to home. We are considering options on how best to incentivise further progress on this, and further details will be provided to the Committee on this in due course. We will write to the Committee in due course with details of the work that is being taken regarding the targeted intervention with the three health boards.

We can confirm that the £30 million 2016-17 allocation for older people and mental health, and the primary care, delivery plan, health technology and mental health funding allocated in 2015-16 has been provided for recurrently in 2017-18.

## **2. Financial Planning and the Financial Position of LHBs**

We will continue to keep the Committee apprised of the financial position of LHBs and the position on the overall Health, Wellbeing and Sport budget as we progress through this financial year. As in 2015-16, a written statement will be issued following the completion and audit of the NHS accounts for 2016-17 before the summer recess.

The position regarding Betsi Cadwaladr and Hywel Dda University Health Boards was set out in the Cabinet Secretary for Finance and Local Government's written statement on 2<sup>nd</sup> November, confirming the allocation of £68.4 million from reserves to manage the deficits in these two organisations. In addition, we have been open about our concerns at the ability of Abertawe Bro Morgannwg and Cardiff and Vale University Health Boards to develop an approvable plan, which is part of the reason why these organisations were placed into targeted intervention in September. We are not confident that these organisations will achieve financial balance in 2016-17, and will continue to work with them through the escalation framework to address these issues.

Leaving aside our concerns regarding these four organisations, we are confident at this stage that the remaining six NHS organisations will achieve financial balance in 2016-17, and that the overall Main Expenditure Group budget will balance.

In terms of the longer term, we are committed to getting these organisations into a sustainable financial position. As outlined in our evidence paper, we will target some of the additional funding to providing support for Betsi Cadwaladr and Hywel Dda University Health Boards. The extent of this support is still to be determined. We will use the NHS Planning Framework to support other organisations develop financially sustainable medium term plans.

## **3. Financial Position of Local Government**

Each local authority is an autonomous and democratically accountable body and is statutorily responsible for managing its own financial affairs. The overall settlement of £4.1 billion is unhypothecated. It is for each authority to determine how it uses this funding in conjunction with the other resources available to it – for example from council tax, grants, and fees and charges – to meet local needs and priorities.

It is vital that every authority ensures it has robust arrangements for informed scrutiny of its spending plans by local elected members and for the ongoing monitoring of performance against these plans. Spending on different services is monitored through the information on the annual revenue account and revenue outturn returns collected by Welsh Government. The expenditure data is published on the Welsh Government's website.

The additional £25 million in the settlement for social care recognises the particular pressures faced by the sector. As you recognise in your letter, it will be for each individual authority to decide how best to spend its share of the additional £25 million taking account

of its own particular circumstances. Consideration of social care outcomes is a matter for the Minister for Social Services and Public Health.

#### ➤ **Social Care Charging**

The Committee enquired about the annual cost of implementing our Taking Wales Forward commitment to increase to £50,000 the capital limit in charging for residential care. Taking our phased approach to implementation of this, the independent research we commissioned estimated this cost as £19.398 million per annum from 2019-20 at that year's prices.

As to the number who would benefit from our other commitment to introduce a full disregard of War Disablement Pensions in financial assessments for charging for social care, the independent research estimated 134 people in receipt of such pensions would benefit. This number is, however, set to reduce over time as the Ministry of Defence has closed this particular pension to newly injured armed forces personnel.

### **4. Prioritisation of Spending**

#### ➤ **Intermediate Care Fund (ICF)**

The Welsh Government is in the process of working with regions to develop robust new guidance in relation to the Intermediate Care Fund. Regional partnership boards will be expected to continue to utilise ICF to deliver effective integrated and preventative care and support services in keeping with the requirements of the Social Services and Well-being (Wales) Act 2014. These Boards are required to respond to the population assessment also required by the Act and prioritise the integration of services in several areas, including in relation to:

- Children and older people with complex needs;
- People with learning disabilities; and
- Carer, including young carers.

The Welsh Government is not prescriptive on the outputs and outcomes expected from ICF. Regions are required to set out their proposals for projects and services based on evidence contained in their population assessment.

We are continuing to engage with regional partnership boards to support their ongoing implementation. This includes in relation to sharing best practice on the utilisation of ICF.

#### ➤ **Primary Care**

We can confirm Welsh Government provided a £42.6m national primary care fund to support health boards' implement primary care improvements as set out in their IMTPs and £10m was allocated for the 64 primary care clusters to invest in their locally determined service improvements. The fund is also supporting a national programme of pathfinders and pacesetters to test new ways of working and new workforce roles.

The intended outcomes of the national primary care fund are sustainable services, better access and more care closer to home. For example, service sustainability is being achieved through the flexibly deployed primary care support teams and appointing

pharmacists, physiotherapists and social workers to free up GPs' time and expertise. Better access to the right care at the right time is supported by new clinically led triage of calls to GPs and directing these to the right response. More care is being provided closer to home, reducing unnecessary demand on hospital services, by extending community resource teams to 7 days a week and delivering care for people with chronic conditions like diabetes in the community avoiding the need to travel to hospital clinics.

### ➤ **Children**

The Improving Outcomes for Children Ministerial Advisory Group, chaired by David Melding, AM, is taking forward a broad programme of work to drive forward improvements across the looked after children, fostering and adoption agendas. Through its work, the group will contribute to reducing the incidences of adverse childhood experiences (ACEs), seek to build resilience within the family, focus on prevention and early intervention and improve outcomes for children in care. This group has a budget of £100k to take forward specific strands of work, although there will be other funding across portfolios which will contribute to achieving the group's activity. The rights of the child are intrinsic to our work programme and new work developed will take account of UNCRC as part of its policy impact assessment process.

### ➤ **Sport & physical activity**

We will be happy to provide you with details of the agreed budget allocations for Sport Wales for 2017-18, together with a statement setting out both the outcomes Welsh Government will seek to have delivered for this investment and the timeframe over which these outcomes should be delivered, in due course.

### ➤ **Mental Health Services**

It is recognised that all parts of the NHS face financial challenges. We recognise the particular interest in Wales for mental health funding. We have provided specific additional funds last year and this year. The additional £20.5m for mental health services (including £0.5m for eating disorders) is in addition to the funding previously made available for 2015-16 and 2016-17. In 2015-16 the additional funding comprised £7.65m for CAMHS, £5.6m for older adults, £1.9 m for psychological therapies (\*£1m of which was made available from the £10m delivery plan funding) and £1.5m for perinatal services. In 2016-17 £6.375m has been made available from the £30m older persons and mental health funding. This included recurring funding of £2.3m for hospital flexible resource teams, £1.5m for local primary care mental health support services, £1.15m for inpatient psychological therapies, £325,000 for transitional support staff and £100,000 for dementia risk reduction awareness. There was also an additional £1m for extra memory clinic capacity and £329,000 for deprivation of liberty safeguards made available on a non-recurring basis. As referred to earlier this will take the allocation to over £620 million in 2017-18 and it is considered appropriate funding has been allocated.

### ➤ **CAMHS**

The almost £8m annual new investment we have made in CAMHS is beginning to show real impact with health boards prioritising funding on improving access whilst new staff and new services are developed.



As a result between August 2015 and September 2016, the total number of children of children and young people reported as waiting for a first outpatient CAMHS appointment has reduced by 27% (3216 to 2355). The new services we are developing for neurodevelopmental conditions, with investment of £2m annually is also ensuring those young people have a route to help and support rather than being referred to CAMHS, where they often did not reach treatment thresholds.

Our investment in Local Primary Mental Health Support Services has also meant that over 5,400 children and young people have been referred for assessment between April 2015 and September 2016

With the establishment of CAMHS Community Treatment Teams across Wales in 2015 fewer young people are being sent out of area or are away for shorter times resulting in a predicted halving of the cost of these expensive placements in 2016-17 compared to 2014-15 [£2.3m from £4.7m]. Young people themselves in the Making Sense report by CAMHS service users [January 2016] stated we cannot emphasise enough that the inappropriate, upward referral of young people towards mental health services is not just inefficient but is also damaging to those young people.... Inappropriate referrals harm both those young people who do not need specialist help and those who do.

Reducing inappropriate referrals is a central principle of the NHS led Together for Children and Young People Programme. It seeks to work with partners across health, education, social services and the third sector to ensure that when a young person does need support they get it from the most appropriate source and in a timely manner.

## **5. Capital Investment**

Investment in NHS infrastructure continues to be a key priority. We will be investing over £1 billion of capital funding over the next four years on NHS buildings, equipment, vehicles and ICT. We described in the last paper to Committee that the forward NHS Capital Programme is based upon NHS organisations' Integrated Medium Term Plans (IMTPs) which described the infrastructure investment requirements to take forward two key delivery strands - service transformation and maintaining, replacing and modernising existing buildings and equipment.

There are a number of key schemes supporting service changes in the coming period including the expansion of obstetrics, paediatrics and neonatal facilities at University Hospital of Wales, Prince Charles Hospital and West Wales General Hospital, and new community hospitals at Cardigan, Tregaron and North Denbighshire. We are keen to accelerate the scale and pace of change in primary and community care settings and how the Welsh NHS can make use of technology and the estate to deliver care closer to home. We are currently considering how this might best be supported. In addition there are significant modernisation programmes that need to progress at the University Hospital of Wales, Prince Charles Hospital, West Wales General and the Wrexham Maelor, as well as continuing investment in the ambulance fleet, imaging and ICT.

Future investments will clearly need to be prioritised and will have to demonstrate real benefits. However, our capital funding will be supplemented by other funding sources. We have already advised that the new £210m Velindre Cancer Centre will be supported through revenue financing using the Welsh Mutual Investment Model and other developments are also being considered, including A Regional Collaboration for Health (ARCH) in West Wales which is examining a number of alternative funding sources and mechanisms.

We would welcome the opportunity to provide further details in a future Committee session.



## 6. Impact of the EU Referendum

You asked for further reassurance on activities considering the impact of the EU referendum. Work is underway across the Welsh Government to ensure we maximise our influence in discussions within the UK, and in turn in formal EU negotiations, to secure the best possible outcome for Wales. We are working closely with the UK Government and other devolved governments to ensure the interests of Wales are heard and protected.

Committee members will be aware from the Plaid Cymru debate on NHS Overseas Workers on 16th November 2016 that, in our view, EU citizens working and living in Wales now should be able to remain here after the UK's exit from the EU. We value the contribution that citizens of other countries living in Wales make to our economy, our public services and our communities. We are committed to exploring all options to facilitate recruitment and retention of NHS workforce from the EU and beyond after the UK leaves the EU. We do not want to see controls introduced that would harm the Welsh economy or Welsh public services, including the NHS.

Clinical research and innovation are key components of NHS activity. EU Research and Innovation programmes enable our researchers to work collaboratively with counterparts across Europe to address the common challenges facing our health systems. This collaboration has helped the NHS to develop new treatments, adopt innovation more quickly, and improve the quality of healthcare delivered. We are working to ensure that, alongside our universities and other research institutions in Wales, health and care organisations can participate in future EU health, research and innovation programmes.

A single EU regulatory framework enables new health technologies to be made available more quickly for the benefit of patients while ensuring a higher level of patient safety and public health protection. We will seek to avoid regulatory divergence between the UK and the EU to ensure that our patients and public services can continue to benefit from early access to innovative health technologies

It is essential that Wales remains an outward looking and engaged player on the European stage and beyond, regardless of the EU exit.

Yours sincerely



**Rebecca Evans AC/AM**

Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol  
Minister for Social Services and Public Health

Vaughan Gething

**Vaughan Gething AC/AM**

Ysgrifennydd y Cabinet dros Iechyd, Llesiant a Chwaraeon  
Cabinet Secretary for Health, Well-being and Sport

# Agenda Item 7

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

Document is Restricted

Document is Restricted