



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

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1 Overview

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

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

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

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

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

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

1.1 Minimum Unit Pricing Alcohol

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

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

1.2 Nutritional Standards

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

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

2 Part 2: Tobacco and Nicotine Products

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

Public Health Wales strongly supports this action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The most recent published information from Wales, the CHETS 2 study¹, confirms findings of other studies internationally, that e-cigarette experimentation is widespread but that regular use among previous non tobacco users is rare. However, this study does not provide conclusive evidence that there is no risk and raises concerns about the use of e-cigarettes in those vulnerable to tobacco use. The study found that among non-smoking children who reported having used an e-cigarette, 14% reported they might start smoking within the next two years (compared to 2% of those who had not used an e-cigarette) and although intention to smoke within two years was relatively low, children who had used an e-cigarette were substantially less likely to say they definitely will not smoke, and more likely to say that they might.

Action on Smoking and Health (ASH) has conducted a regular survey of use of e-cigarettes among adults in the UK since 2010 and has extended this to young people aged 16 – 18 years in 2013². This survey found that awareness of e-cigarettes among children and young people was high at 83 per cent but that use in this group was low at 7 per cent, the majority of whom were current smokers.

A survey in the Cheshire and Merseyside area by North West Trading Standards³ in students aged 14 – 17 years asked if they had ever bought or tried e-cigarettes. A total of 5,845 young people responded to the survey and 12.7 per cent stated they had accessed e-cigarettes. The majority were current or ex-smokers but 2.4 per cent had never smoked tobacco. Use was also associated with having a parent or guardian who smoked which would reflect known risk factors for smoking.

While these surveys do not suggest widespread use of e-cigarettes it would be inappropriate to draw too much reassurance from this data at this time. There is evidence of use and there is evidence of the conditions (i.e. promotion and widespread use in public), that would encourage increased use. It would seem inappropriate to wait to act until there is clear evidence of a problem. The awareness of children in the ASH survey⁴ that e-cigarettes are safer than tobacco (79 per cent) is a potential concern as this could lead to adoption of the habit because it is perceived to be safe.

¹ <http://bmjopen.bmj.com/content/5/4/e007072.full>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Part 3: Special Procedures

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

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

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

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

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

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

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

We note that these have not been included within the Bill, it is possible that this will be encompassed within specific requirements for cosmetic procedures in line with those proposed by the UK Government for England following the Keogh Review in 2013⁵.

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

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

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

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

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

No specific observations at this time.

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

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

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

4 Part 4: Intimate Piercing

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

Public Health Wales supports these proposals.

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

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

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

Public Health Wales agrees with these proposals.

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

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

5 Part 5: Pharmaceutical Services

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

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

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

6 Part 6: Provision of Toilets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1 – Minimum Unit Pricing Alcohol

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

Minimum Unit Pricing

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

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

Minimum Unit Price (MUP) sets a floor price for a unit of alcohol⁶, meaning that alcohol could not legally be sold below that price. This would not increase the price of every drink, only those that are sold below the minimum price; for example very cheap spirits, beer and wine. MUP is based on two fundamental principles that are widely supported by scientific evidence:^{7,8,9}

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

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

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

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

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

Drinking alcohol increases the risk of developing over 60 different health problems¹⁰ including a range of cancers, liver disease, high blood pressure, injuries and a variety of mental health conditions. It also increases the risk of causing harms to the health of others.

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

The 2011 General Lifestyle Survey (GLS¹¹) 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 Survey¹² (2012) reported that around two in five (42 per cent) adults reported drinking above the recommended guidelines on at least one day in the past week, including 26 per cent who reported binge drinking (drinking more than twice the daily guidelines). Men were more likely than women to report drinking above the recommended guidelines on at least one day in the past week (48 per cent of men compared with 36 per cent of women) and to report binge drinking (31 per cent of men, 21 per cent of women).

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

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

¹⁰ World Health Organisation (2009) Harmful Use of Alcohol http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf

¹¹ Office for National Statistics, (2011) 'General Lifestyle Survey' [online] Available at: <http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/index.html>

¹² Welsh Government (2012) 'Welsh Health Survey' [online] Available at: <http://wales.gov.uk/statistics-and-research/welsh-health-survey/?lang=en> WHO. Alcohol policy in the WHO European Region: current status and the way forward.

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

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

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

Men and women in the UK can now exceed recommended daily limits for about £1 if they purchase inexpensive alcohol from supermarkets or other off-trade outlets¹⁷.

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

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

This evidence has led several countries to consider MUP policy¹⁹.

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

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

¹³ Institute for Social Marketing: University of Stirling (2013) 'Health First: An evidence-based strategy for the UK' [online] Available at: <http://www.stir.ac.uk/management/about/social-marketing/>

¹⁴ Home Office (2012) *A minimum unit price for alcohol: impact assessment 1A*. Home Office, London, UK.

¹⁵ Anderson, P., Chisholm, D. and Fuhr, D. (2009) Alcohol and Global Health 2: Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet*, 373, 2234–46.

¹⁶ Gallet, C.A. (2007) The demand for alcohol: a meta-analysis of elasticities. *Australian Journal of Agriculture and Resource Economics*, 51, 121-35.

¹⁷ Institute for Social Marketing: University of Stirling (2013) 'Health First: An evidence-based strategy for the UK' [online] Available at: <http://www.stir.ac.uk/management/about/social-marketing/>

¹⁸ WHO fact sheet. 2005. www.parpa.pl/download/fs1005e2.pdf.

¹⁹ Holmes, J., Meng, Y., Meier, P.S., Brennan, A., Angus, C., Campbell-Burton, A., Guo, Y., Hill-McManus, D. and Purshouse, R.C. (2014) Effects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. *Lancet*, 383, 1655-1664

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

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

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

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

While a moderate drinker may see a small increase in costs of alcohol per year with a MUP of 50 pence (around £43.17- £55.57²⁴, however, this figure is based on the average drinker per annum), this should be seen in the context of national costs from alcohol related harms (health, social, economic and criminal justice) being equivalent to around £900 per family. These harm-related costs could be substantially reduced if a MUP was introduced.

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

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

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

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

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

²³ Duffy, J.C. and Snowden, 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).

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

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

The Crime Survey for England and Wales reports that within the year 2011/12 there was 917,000 violent incidents where the victim believed the offender(s) to be under the influence of alcohol, accounting for 47 per cent of violent offences that year. Alcohol routinely accounts for over 40 per cent of all violent crimes committed²⁶ and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide)²⁷.

In Scotland 50 per cent of people reported one or more harms as a result of someone else's drinking in the last year²⁸.

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 night²⁹.

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

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

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

In British Columbia with a population of 4.6million, a 10 per cent increase in the average minimum price of all alcoholic beverages was associated with a 9 per cent decrease in acute alcohol-attributable admissions and a 9 per cent reduction in chronic alcohol-attributable admissions two years later³¹. It was estimated from this that a 10 cent (approximately 6 pence)

²⁶ British Crime Survey, ONS; <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Crime+in+England+and+Wales>

²⁷ World Health Organisation (2006) Interpersonal violence and alcohol.

http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf

²⁸ Alcohol Focus Scotland (2013) Unrecognised and under-reported: the impact of alcohol on people other than the drinker in Scotland.

<http://www.alcohol-focus-scotland.org.uk/alcohol-harm-to-others>

²⁹ Barton, A. and Husk, K. (2012) Controlling pre-loaders: alcohol related violence in an English night time economy, *Drugs and Alcohol Today*, 12, 89-97.

³⁰ Zhao, J., Stockwell, T., Martin, G., Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A. and Buxton, J. 2013. The relationship between changes to minimum alcohol price, outlet densities and alcohol-related death in British Columbia, 2002-2009. *Addiction*. URL:<http://onlinelibrary.wiley.com/doi/10.1111/add.12139/pdf>.

³¹ Stockwell, T., Zhao, J., Martin, G. Macdonald, S., Vallance, K., Treno, A., Ponicki, W., Tu, A. And Buxton, J. (2013) Minimum alcohol prices and outlet densities in British Columbia, Canada: estimated impacts on alcohol-attributable hospital admissions. *American Journal of Public Health*, 103, 2014-20.

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

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

Thus, the number of alcohol-related deaths³³ for males in Wales from alcohol increased from 236 in 2002 to 311 in 2012. The corresponding increase for females was 34 per cent from 127 to 193 deaths. The number over the last five years has declined slightly from 541 in 2008 to 504 in 2012 but actually rose again between 2011 and 2012.³⁴

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

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

Many of the health harms associated with alcohol fall disproportionately on the most deprived communities, with levels of alcohol related deaths across Wales increasing from the most affluent to the most deprived

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

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

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

quintile. Consequently, tackling alcohol related ill health is an important element in reducing inequalities in health³⁵.

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

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

See response to question 17.

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

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

- We are aware the issue of compatibility between European law and MUP has been raised as an issue. We understand that certain articles prohibit quantitative restrictions between Member States on the Union's founding principle that goods must be able to move freely between Member States
- Opponents to MUP argue that if goods are subjected to minimum prices in one Member State this could act as a barrier to the free movement of such goods
- However, European law stipulates that such articles do not preclude consideration of public morality, public policy or the protection of health and the lives of humans. In other words measures such as MUP could be introduced when the public health case is sufficiently strong
- Any measures implemented on the basis of Public Health must be proportionate. In other words it is important to demonstrate that public health benefits sought justify the measures implemented and that the same outcome would not be achievable by a less intrusive measure

³⁵ 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)

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

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

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

below would be inappropriate in this consultation we believe there is sufficient evidence already available to support⁷:

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

Appendix 2 – Part 5 Pharmaceutical Services

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

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

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

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

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

We recognise that pharmacies are found in the heart of communities and are more likely to be located in the most deprived areas of Wales³⁶ and therefore, have a reach into those communities which could benefit most from greater support to promote and protect health.

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

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

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

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

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

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

Community pharmacy has already shown its effectiveness in delivering enhanced services such as smoking cessation, substance misuse harm reduction and emergency hormonal contraception⁴⁰. Other services which have been introduced more recently and been positively evaluated include flu vaccination⁴¹ and the North Wales early years pharmacy scheme⁴².

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

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

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

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

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

⁴⁰ Fajemsin F. (2013) Community pharmacy and public health SPH Available at <http://www.sph.nhs.uk/sph-documents/community-pharmacy-and-public-health-final-report/?searchterm=community%20pharmacy>

⁴¹ Welsh Government (2013) Community pharmacy influenza vaccination 2012-13 Cardiff

⁴² Public Health Wales Observatory North Wales early years pharmacy scheme a success Available at <http://www.wales.nhs.uk/sitesplus/888/news/news/31458>

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

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

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

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

Type A

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

Type B

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

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

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

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

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

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

- Where a joint approach can effectively deliver the requirements for the health and well being needs assessment and the pharmaceutical needs assessment this would seem desirable
- Whether the pharmaceutical needs assessment is reported separately or integrated into the local health and well being assessment report is a matter to be debated
- However, both type A and type B pharmaceutical needs should be clearly identifiable within the report, alongside existing service provision
- Unmet needs should be stated and consideration given to prioritising them
- Strategic plans developed from the health and well being needs assessment should clearly identify planning intent relevant to community pharmacy

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

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

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

The current pharmaceutical services regulations require a health board to approve an application for a pharmacy contract if the applicant can demonstrate the pharmacy is 'necessary and expedient' to meet the dispensing needs in the neighbourhood⁴³. Whilst reference to the pharmaceutical needs assessment will be important in determining whether an application meets the 'necessary and expedient' test, NHS Wales is unlikely to have sufficient resources to meet every health need identified in the health and well being needs assessment, including all type B pharmaceutical needs. Clear guidance will therefore be needed for health boards about the use of pharmaceutical needs assessment when making control of entry and service planning decisions. There should be a measured approach to developing the pharmaceutical needs assessment process in Wales, learning lessons from England and Scotland, as there are specific legal considerations for health boards in ensuring there is a robust process in place as part of control of entry decision making arrangements.

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

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

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

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

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

- Information about the range of pharmacy services available in different localities within the health board, particularly enhanced services
- Availability of a private consultation area at the pharmacy
- Factors/patient groups known to have a significantly increased need for pharmaceutical care
- Pharmacy opening hours, contracted and actual, including those open at lunchtimes, evenings and weekends. Hours of availability for services that are not offered continuously during opening hours
- Identification of pharmaceutical issues raised by patients and citizens following formal and informal engagement with them
- Identification of pharmaceutical issues raised by health professionals/managers
- Reference to evidence of effectiveness of enhanced pharmacy services (either local evidence to support existing services or from further afield to support proposed/ potential services)

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

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

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

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

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

pharmaceutical services provision⁴⁴. This has led to some legal challenges in relation to the quality of pharmaceutical needs assessments and the decisions made using the pharmaceutical needs assessment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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