

National Assembly for Wales / Cynulliad Cenedlaethol Cymru  
[Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol](#)

[Public Health \(Wales\) Bill / Bil Iechyd y Cyhoedd \(Cymru\)](#)

Evidence from Public Health Wales - PHB 89 / Tystiolaeth gan Iechyd  
Cyhoeddus Cymru - PHB 89



<p style="text-align: center;"><b>Public Health Wales NHS Trust Response to the Health and Social Care Committee Consultation on the Public Health (Wales) Bill</b></p>
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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, 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.

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 Bill are important public health issues in their own right. 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. 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 well-being are recognised within policy and legislation and Public Health Wales will continue to support and monitor the implementation of the Well-being 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 Well-being of Future Generations Act or through other legislation how this can be strengthened.

The Public Health 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 all policies, 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**

### **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.

Public Health Wales welcomes the findings of the recent report *E-cigarettes: an evidence update*<sup>1</sup>, which provides further evidence on the prevalence of e-cigarette use, their role in smoking cessation and their safety.

As noted in the report, it is unclear how much of the decrease in smoking prevalence is due to e-cigarettes.

The report highlights that the evidence base on the overall and relative risks of e-cigarettes compared with smoking is still developing. Whilst evidence to date indicates that e-cigarettes are less harmful than cigarettes, we are concerned that there is a lack of evidence on the harms of long-term use of e-cigarettes.

We agree that all smokers should be supported to stop smoking completely – including dual users. Whilst e-cigarettes may be an effective aid for smoking cessation and reduction, it is unclear whether e-cigarettes are more or less effective than licensed smoking cessation medications.

The finding that most of those who try e-cigarettes do not go on to “current use” is positive. However, we believe that it is important to closely monitor these trends in e-cigarette use.

We agree further research is needed in relation to e-cigarettes including:

- Effectiveness as a smoking cessation tool
- Long term harms related to e-cigarette use
- Impact on cigarette smoking in dual users

There are a few areas where we have interpreted the evidence differently. For example, we do not believe that there is sufficient evidence to dispel our concerns that e-cigarettes may re-normalise smoking behaviour.

Overall, we feel it is important to re-iterate that this legislation does not prohibit the use of e-cigarettes – smokers will still be able to use e-cigarettes as an alternative to tobacco.

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<sup>1</sup> McNeill A et al and Hajek P et al. E-cigarettes: an evidence update. A report commissioned by Public Health England. 2015.

## **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 – 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 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.

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 (currently enforcement is against the "person in control of premises").

## **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, which 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 without 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 Well-being 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 to children and young people as a safe way to smoke 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 should not be promoted – 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.

We are also concerned that some e-cigarettes use scented or flavoured refills or are branded in such a way that may be attractive to children e.g. brands include Gummy Bear, Bubble Gum, Cherry Cola.

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

The most recent published information from Wales, the CHETS 2 study<sup>2</sup>, 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

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<sup>2</sup> <http://bmjopen.bmj.com/content/5/4/e007072.full>

this to young people aged 16 – 18 years in 2013<sup>3</sup>. This survey found that awareness of e-cigarettes among children and young people was high at 83 per cent but that use in this group was low at 7 per cent, the majority of whom were current smokers.

A survey in the Cheshire and Merseyside area by North West Trading Standards<sup>4</sup> in students aged 14 – 17 years asked if they had ever bought or tried e-cigarettes. A total of 5,845 young people responded to the survey and 12.7 per cent stated they had accessed e-cigarettes. The majority were current or ex-smokers but 2.4 per cent had never smoked tobacco. Use was also associated with having a parent or guardian who smoked, which would reflect known risk factors for smoking.

While these surveys do not suggest widespread use of e-cigarettes it would be inappropriate to draw too much reassurance from this data at this time. There is evidence of use and there is evidence of the conditions (i.e. promotion and widespread use in public), that would encourage increased use. It would seem inappropriate to wait to act until there is clear evidence of a problem. The awareness of children in the ASH survey<sup>5</sup> 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.

A recent large longitudinal study in California<sup>6</sup> evaluated whether e-cigarette use among 14 year olds who had never tried tobacco was associated with a risk of initiating use of combustible tobacco (cigarette, cigars and hookah). 2,530 students at ten high schools were followed over a 12 month period. At 12 months, 25.2 per cent of students who had used e-cigarette and 9.3 per cent who had never used e-cigarettes were using combustible tobacco. The authors concluded that “those who had ever used e-cigarettes at baseline compared with nonusers were more likely to report initiation of combustible tobacco use over the next year”. This report highlights that the evidence base for e-cigarette use leading to tobacco use continues to develop and remains a matter of concern.

## **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

<sup>3</sup> ASH. Electronic Cigarettes. ASH Briefing, March 2014. [www.ash.org.uk](http://www.ash.org.uk) (last accessed 16/06/14)

<sup>4</sup> E-cigarette access among young people in Cheshire and Merseyside. Centre for Public Health, Liverpool John Moores University. March 2014. [www.cph.org.uk](http://www.cph.org.uk) (accessed 16/06/14)

<sup>5</sup> ASH. Electronic Cigarettes. ASH Briefing, March 2014. [www.ash.org.uk](http://www.ash.org.uk) (last accessed 16/06/14)

<sup>6</sup> Leventhal AM et al. Initiation of electronic cigarette use with initiation of combustible tobacco product smoking in early adolescence. JAMA. 2015; 314(7):700-707

would be difficult. We are aware that some licensed premises have voluntarily introduced bans on the use of e-cigarettes to help their staff to enforce the smoking ban in the premises. 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 note that under the proposed legislation, fixed penalty notices (FPNs) will be issued for a failure to display appropriate smoke free signage and that fines will be relating to the offence of failing to prevent e-cigarette use in smoke free places. We support the proposal to align FPNs and fines with those for smoke free offences.

We support the proposal for FPNs and fines to the public to be aligned to existing smoke free offences and that these payments are made to the relevant local authority.

Similarly, we believe that any FPNs and fines linked to the retailers register and handing over tobacco and nicotine products to a person under 18 years should act as a sufficient deterrent to ensure retailers comply with legislation.

Any payments should be used to offset the costs to local authorities for enforcement of legislation.

## **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.

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.

We are concerned about the use of the phrase “reasonable excuse” in section 29(5) ‘*A registered person who fails, without reasonable excuse, to comply with section 25 (duty to notify certain changes) commits an offence*’. This term is not defined in the legislation and may lead to evasion of enforcement action.

## **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 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.

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.

An RPO should also be used for other tobacco related breaches such as sale of illegal tobacco, non compliance with the tobacco display ban.

**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 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 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.<sup>15-17</sup> 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.<sup>18</sup> 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.<sup>19-21</sup> 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 Register should also consider requiring practitioners of special procedures to have received a course of Hepatitis B vaccinations and routine testing for blood borne viruses.

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

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

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

We note that these have not been included within the Bill, it is possible that this will be encompassed within specific requirements for cosmetic procedures in line with those proposed by the UK Government for England following the Keogh Review in 2013<sup>7</sup>.

### **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.

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[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)

**3.5 Do you have any views on whether enforcing the licensing system would result in any particular difficulties for 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.

**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 University 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 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**

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

Yes, 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.

### **5.2 What are your views on whether the proposals will encourage 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.

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

Yes. 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.

## **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 leave their 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. 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.

**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.

## **7 Finance questions**

### **What are your views on the costs and benefits of implementing the Bill? (You may want to look at the overall costs and benefits of the Bill or those of individual sections.)**

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.

### **How accurate are the estimates of costs and benefits identified in the Regulatory Impact Assessment, and have any potential costs or benefits been missed out?**

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.

### **What financial impact will the Bill's proposals have on you/your organisation?**

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 2015-18, 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.

**Are there any other ways that the aims of the Bill could be met in a more cost-effective way than the approaches taken in the Bill's proposals?**

Overall, we do not think that the aims of the Bill could be met in a more cost effective way.

**Do you consider that the additional costs of the Bill's proposals to businesses, local authorities, community councils and local health boards are reasonable and proportionate?**

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

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

## **8 Delegated powers**

**The Bill contains powers for Welsh Ministers to make regulations and issue guidance.**

**In your view does the Bill contain a reasonable balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?**

Yes, 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.

### **Other comments**

**Are there any other comments you wish to make about specific sections of the Bill?**

- Special Procedures

Section 63(6) of the Bill (Special procedure licence: licence holder remedial action notice) 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.

- Pharmaceutical Needs Assessment

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

**In its oral evidence session at the Health and Social Care Committee meeting held on 9 July 2015, Public Health Wales was asked to provide the Committee with a note on the following matters:**

*The collaboration work being undertaken by Public Health Wales, Sport Wales and the Welsh Government to encourage physical activity in improving the health of local people*

Public Health Wales, Welsh Government and Sport Wales have jointly appointed a new programme director for health and physical activity who will lead efforts to improve population health and reduce health inequalities by increasing physical activity levels.

Evidence shows that successful approaches to achieving this involve collaboration between many sectors and agencies. The programme director for health and physical activity will oversee the introduction of a coordinated approach to a range of policies – transport, education, social justice, health, housing and economic regeneration – to change the social, cultural, economic and environmental roots of inactivity in Wales.

An action plan is being finalised around the themes of Active Places, Active People and Activity for All.

*Our views on whether financial incentives should be offered to assist local authorities in providing public toilets*

Local authorities are best placed to comment on their ability to safeguard existing provision and to promote new facilities and the financial requirements to meet these objectives.

*Our views on 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 the procedure 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.

*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 there is an artificial marketplace for tobacco products and that the normal competitive market forces do not operate, enabling high profits for manufacturers. 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.

*Any evidence which demonstrates the effect of residual and third hand vapours from e-cigarettes*

The context for this question was an enquiry by a member of the Committee about any evidence of residue from e-cigarettes within the fabric of the room.

Evidence regarding indoor environmental residues from e-cigarettes is limited due to their recent commercial introduction. Awareness of 'third hand' contamination of surfaces and textiles from cigarette smoke and the potential for exposure via the skin, by breathing and by ingestion is, however, well established.

Research indicates that products of e-cigarette vaping results in the deposit of nicotine on surfaces including walls, wood and metal but primarily on floor and windows, resulting in a risk of third hand exposure to nicotine from e-cigarettes<sup>8</sup>.

It has been reported that vaping in an eight cubic metre test chamber for half an hour or more does not measurably increase the trace quantities of a variety of organic chemicals above background levels, whereas cigarette smoking causes dramatic and rapid increases<sup>9</sup>.

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<sup>8</sup> Goniewicz ML, Lee L. Electronic cigarettes are a source of third hand exposure to nicotine. *Nicotine and tobacco Research*, 2014; doi: 10.1093/ntr/ntu152

<sup>9</sup> Nitzkin JL. The case in favor of e-cigarettes for tobacco harm reduction. *Int J Environ Res*.

A small study comparing residues from tobacco smoke and from e-cigarettes found that half of the homes of e-cigarette users had detectable surface nicotine deposits, whereas deposits were detected in the homes of all smokers. Nicotine levels in the homes of e-cigarette users was significantly lower than that found in the homes of cigarette smokers but not significantly different compared with the homes of non-users of nicotine containing products. The researchers concluded that nicotine is a common contaminant found on indoor surfaces and that using e-cigarettes indoors leads to significantly less third hand exposure to nicotine compared to smoking tobacco cigarettes<sup>10</sup>.

The limited evidence indicates indoor environmental risks produced by e-cigarette vaping may be present to some degree, but is likely to be appreciably less hazardous than cigarette smoking.

The Executive Director of Public Health Services at Public Health Wales also noted the Committee's interest in the health risks associated with electrolysis and acupuncture. Appendix 1 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.

### **Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?**

Please see section 1 (Overview).

### **Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?**

- Minimum Unit Pricing for 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. We welcome the introduction of the Draft Public Health (Minimum Price for Alcohol) Bill and will be responding to the consultation.

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<sup>10</sup> Bush D, Goniewicz ML. A pilot study on nicotine residues in houses of electronic cigarette users, tobacco smokers, and non-users of nicotine containing products. *Int J Drug Policy* 2015; 26:8: 609-611

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.

- Tackling Obesity

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'.

Public Health Wales believes that there is potential to streamline and consolidate the guidance for the provision of food, drink and vending to hospital visitors and staff, and mandate for an all encompassing approach. This should incorporate current mandatory vending standards and Guidance on Food provision for staff and visitors in hospitals<sup>11</sup> and would enable a more holistic and consistent approach to the food provision across staff restaurants, vending, and retail in hospitals.

Public Health Wales believes that there is an opportunity to further support obesity prevention through legislation through measures such as:

- Fiscal and regulatory policies such as a sugary drinks tax
- Planning permission decisions to take the impact on health into consideration, including through the use of Health Impact Assessments
- Reformulation to substantially reduce the added sugars hidden in junk food and sugary drinks

However, we recognise that not all of these measures can be legislated for by Welsh Assembly at present. Public Health Wales would welcome the opportunity to work closely with the Welsh Government to address the obesity problem in Wales.

Our full response on Nutritional Standards is included in Appendix 3.

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<sup>11</sup> Welsh Government (2011). Supporting Food and Health Choices for Staff and Visitors in Hospital.

## **Appendix 1 – 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**

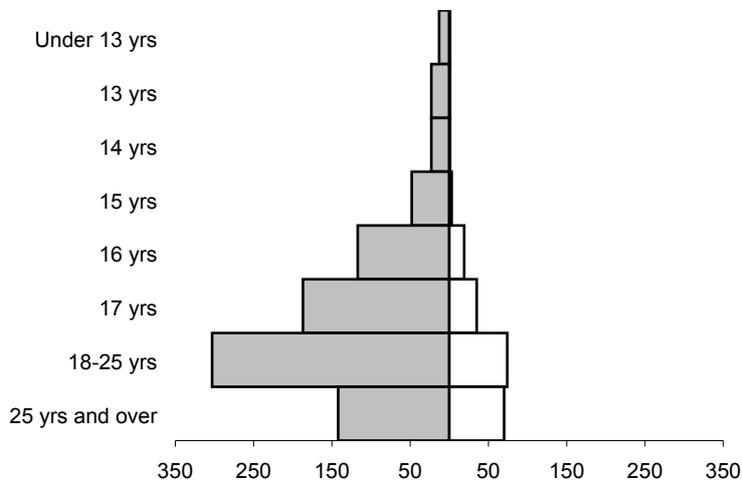
A cohort of people at risk of infection following a body piercing or tattoo at a premises under investigation (termed 'at-risk cohort') was identified. This 'at-risk cohort' was identified from client lists held at the premises and from people who self-presented following media reports of the incident, 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.

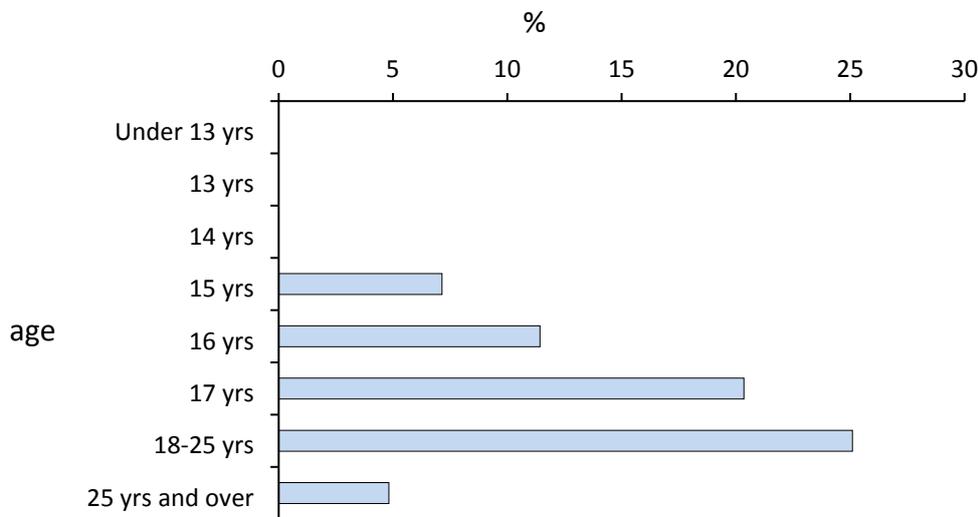
**Figure 1. Age<sup>1</sup> and sex distribution of cohort of people considered to be at risk of infection following a piercing or tattoo at the premises under investigation ('at-risk cohort')**



<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>12</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

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<sup>12</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;

based on two fundamental principles that are widely supported by scientific evidence:<sup>13,14,15</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

Drinking alcohol increases the risk of developing over 60 different health problems<sup>16</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).

The 2011 General Lifestyle Survey (GLS<sup>17</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>18</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

<sup>13</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>14</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>15</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>

<sup>16</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>17</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>18</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.

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>19,20,21,22</sup>.

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>23</sup>.

A 2005 review by the World Health Organisation (WHO)<sup>24</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>25</sup>.

<sup>19</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>20</sup> Home Office (2012) *A minimum unit price for alcohol: impact assessment 1A*. Home Office, London, UK.

<sup>21</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>22</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>23</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>24</sup> WHO fact sheet. 2005. [www.parpa.pl/download/fs1005e2.pdf](http://www.parpa.pl/download/fs1005e2.pdf).

<sup>25</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>26,27</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>28,29</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>30</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,

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<sup>26</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>27</sup> 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.

<sup>28</sup> Hansard. House of Commons Debate 14 March 2013. *Hansard* 2013; **560**: 451-91.

<sup>29</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>30</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>

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.<sup>31</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>32</sup> and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide)<sup>33</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>34</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>35</sup>.

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<sup>31</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>32</sup> British Crime Survey, ONS;

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

<sup>33</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>34</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>35</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.

***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>36</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 in chronic alcohol-attributable admissions two years later<sup>37</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>38</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>39</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

<sup>36</sup> 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>.

<sup>37</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>38</sup> Welsh Assembly Government (2008) 'Working Together to Reduce Harm, The Substance Misuse Strategy for Wales 2008-2018'.

<sup>39</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.

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>40</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, tackling alcohol related ill health is an important element in reducing inequalities in health<sup>41</sup>.

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

***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.

***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:

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<sup>40</sup> PEDW; NWIS

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

<sup>41</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)

- 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
- 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

## Appendix 3 – Obesity

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

Nutritional standards, in themselves are unlikely to contribute significantly to reducing obesity. The Public Health White Paper clearly articulates that addressing the growing impact of obesity and overweight on the health and well being of the people of Wales will require cross-cutting action in all sectors. Initiatives such as the Active Travel (Wales) Act 2013<sup>42</sup> are an excellent example of this approach. The Act imposes a new duty on Welsh Ministers and local authorities to promote active travel and to create an environment where it is safer and more practical to walk and cycle than it is at present. The All Wales Obesity Pathway<sup>43</sup> provides a framework for action to address the challenge of obesity, particularly in relation to the response by the NHS and its partners across Wales. Public Health Wales, through its *Transforming Health Improvement Programme* is currently undertaking work to consider the evidence based interventions that could be implemented on an all Wales basis to prevent obesity in children and young people. This work should be available at the end of July 2014. In terms of the new, complementary proposals set out in this section, for consideration in a Public Health Bill, it is important that there is recognition that the introduction of nutritional standards is not solely about preventing obesity, but also about addressing poor nutrition in general and in particular, under-nutrition in respect of older people.

### **Nutritional Standards**

***Do you agree that nutritional standards should be introduced in the settings we are proposing, that is, pre-school settings and care homes?***

As one component of a multi-faceted programme of work, nutritional standards can make a contribution. Nutritional standards provide a clear framework to support the planning and provision of meals in key settings. We would however, note that the two settings mentioned are very different and that the goals and objectives of nutritional standards in each of these settings would be different.

In pre-school settings, the emphasis is on balanced nutrition to establish good eating habits, providing the range of nutrients required for the rapid

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<sup>42</sup> Welsh Government. Active Travel (Wales) Act (2013)

<sup>43</sup> Welsh Government. All Wales Obesity Pathway (2010)

period of growth and development, and in the longer term preventing obesity.

In care homes for older people, the emphasis is upon the prevention of under nutrition (referred to as malnutrition). This needs to be acknowledged in the proposals as the reason for developing nutritional standards for care homes should not be focussed on obesity prevention.

Regulatory frameworks for these settings already exist. In the pre-school setting the National Minimum Standard for Regulated Child Care<sup>44</sup> states that 'children should receive meals and/or snacks, that are safely prepared, nutritionally balanced, of good quality and appropriate in quantity following recommendations in Welsh Government Food and Health Guidelines for Early Years and Childcare Settings'

The National Minimum Standards for Care Homes for Older People<sup>45</sup> Standard 16 requires that "meals and mealtimes, which includes 'a varied appealing wholesome and nutritious diet which is suited to the individual assessed and recorded requirements , in a congenial setting and at flexible times'".

The challenges in implementing the respective mandatory care standards are:

- the language used is difficult to interpret into evidence based provision
- there are difficulties in assessing compliance
- they are required to apply across a broad spectrum of providers

Public Health Wales supports the development of food standards within a nutrient framework, supported by portion size information, as part of the current regulated minimum care standards for pre school settings (Public Health recommends that the current food and health guidance for pre-school settings) is updated and expanded to provide a practical approach for implementation of the standards, accompanied by appropriate support for providers and the inspectorate.

Experience across Wales shows that in respect of pre-school settings, steady progress is being made, working with providers to improve their provision, through training provision by Public Health Dietitians and use of the Guidance on Food and Health. This can be improved by the introduction of more robust and measurable standards, within the current regulatory framework.

The creation of mandatory nutrition standards is not a panacea for improved food and drink provision in these settings. Experience in Wales is that in settings where mandatory nutrition standards exist, there remain

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<sup>44</sup> Welsh Government (2012). National minimum standards for regulated child care.  
[http://wales.gov.uk/topics/childrenyoungpeople/publications/regulated\\_childcare](http://wales.gov.uk/topics/childrenyoungpeople/publications/regulated_childcare)

<sup>45</sup> National Minimum Standards for Care Homes for Older People (2004)  
[http://www.csiw.wales.gov.uk/docs/nmscarehomes\\_oldpeople\\_revised\\_e.pdf](http://www.csiw.wales.gov.uk/docs/nmscarehomes_oldpeople_revised_e.pdf)

challenges in securing compliance. Such standards can only be effective if they are supported by appropriate resources to allow providers to understand and comply, and if enforced by an adequately resourced and informed inspectorate to interpret, assess and support compliance, underpinned by appropriate sanctions.

Experience across Wales provides a picture that the progression of nutritional standards in older people care home settings is less advanced, and there is much variation in the adequacy of food provision for this client group. However, there are promising signs through the work being undertaken in Torfaen, where providers are coming together with professionals to develop a central planning system that meets nutrition standards for their clients. This has the potential to develop in a similar manner to the support as that provided in health boards, through the All Wales Menu Framework to implement the hospital nutrition standards.

Public Health Wales supports the development of food based standards, within a nutrient framework, with portion size information developed as part of the current regulatory framework for care settings, Care Standard 16.

Public Health Wales recommends that current guidance within the Community Nutrition Pathway<sup>46</sup> is expanded to provide a practical approach to catering and menu planning, accompanied by appropriate support for providers and the inspectorate. Further consideration should be given to pilot work in Torfaen as to whether this approach can be rolled out across Wales to aid implementation of such standards.

## Background Evidence

### **Pre-school Settings**

There is clear evidence of diet related health problems in children at age 5 in Wales. In Wales 1 in 8 children, aged between 4-5 years of age are obese and nearly 3 in 10 identified as being overweight or obese. The prevalence of obesity increases substantially with increasing deprivation, with 9.4 per cent obese in the least deprived fifth of Wales to 14.3 per cent in the most deprived fifth<sup>47</sup>. Dental health in young children is still poor in Wales with 41.4 per cent of five year olds experiencing dental decay in Wales<sup>48</sup> although this is a reduction of 6 per cent from 2007/8 .

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<sup>46</sup> Welsh Government (2011). Nutrition in Community Settings, A Pathway and Resource Pack for Health and Social Care Professionals, the Third Sector, Care Home Staff and Relatives.

<sup>47</sup> Public Health Wales (2013). Child Measurement Report for Wales 2011/12

<sup>48</sup> Welsh Government (2012). Picture of oral health. Dental epidemiological survey of five year olds 2011-2012.

Finally, the UK Faculty of Public Health has recently expressed its concern, through a letter to the Lancet, on the growing number of families which experience food poverty in the UK<sup>49</sup>.

There are approximately 100,000 children under three years of age in Wales of which the majority will take up a pre-school place of some sort. A survey of 600 families<sup>50</sup> showed that 80 per cent of families used child care in some form and 95 per cent of eligible three and four years olds were in early years education. The use of both formal and informal childcare has increased between 2004 and 2009. Since then the number of places has increased through Flying Start provision, which offers free, high quality part time child care for two to three year olds in the most deprived communities of Wales. In some cases, children will spend a considerable portion of their time in an early years setting and this provides an opportunity to support the establishment of a varied diet and the introduction of a wide range of foods.

The potential therefore for nutritional standards in the early years sector to impact positively on the nutritional status of children and young people is significant.

Nutritional regulations or standards in this setting must include the whole range of nutrient requirements in this age group and not just focus on obesity prevention e.g. taking into consideration iron, zinc and Vitamin D requirements, which have been shown to be low intake in this age group<sup>51</sup>, and also higher than recommended intakes of salt.

### Care Home Settings for Older People

Public Health Wales recommends the revitalisation of food based standards for nutrition in care homes but emphasises that this is just one element within the context of a wider programme of work that supports assisted eating and recognises the social role that food plays in society. Public Health Wales recommends that equivalent attention should be applied to the provision of food and drink in the person's own home as part of care provided in the community.

The main focus for food and nutritional standards for older people should be on malnutrition rather than obesity. Ensuring provision of good quality, nutritious food that meets minimum standards within care settings and enabling clients to be able to eat with or without support, and enjoy their meals, is a crucial component within a holistic approach to meeting their

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<sup>49</sup> [http://www.fph.org.uk/public\\_health\\_experts\\_call\\_on\\_pm\\_to\\_take\\_action\\_on\\_nutrition\\_and\\_hunger](http://www.fph.org.uk/public_health_experts_call_on_pm_to_take_action_on_nutrition_and_hunger)

<sup>50</sup> Welsh Government (2010). Welsh Childcare and Early Years Survey.

<sup>51</sup> NICE (2014) Implementing Vitamin D Draft Guidance.

needs<sup>52</sup>. With the number of people aged 65 and over projected to rise by nearly 50 per cent in the next 20 years, it is imperative that prevention of malnutrition is a key focus. Older people residing in care homes will, on the whole, receive their total food intake through this setting and therefore the food provided must adequately meet nutritional needs. The diversity of potential needs among this group will also require consideration.

Public Health Wales believes that creating the right care environment for older people is crucial to supporting maintenance of health and dignity of care with respect to meeting nutritional needs. Any nutritional regulations or standards in this setting must address the risk of malnutrition and the needs of older people with dementia and those requiring texture modification as well as providing healthier choices for those that have normal requirements.

There are approximately 700 older people care settings in Wales, providing around 23,500 places<sup>53</sup>.

Prevalence of under-nutrition is widespread; within the care home setting it is estimated to be between 16-29 per cent<sup>54</sup>. There is a need to increase awareness of at risk people, and to support relevant stakeholders to identify and tackle malnutrition in the community.

***Do you think there are any other public sector settings that should be considered in relation to mandatory nutritional standards?***

Public Health Wales believes that there is potential to streamline and consolidate the guidance for the provision of food, drink and vending to hospital visitors and staff, and mandate for an all encompassing approach. This should incorporate current mandatory vending standards and Guidance on Food provision for staff and visitors in hospitals<sup>55</sup> and would enable a more holistic and consistent approach to the food provision across staff restaurants, vending, and retail in hospitals.

Public Health Wales, through the Consultant Dietitian and local public health obesity leads, is currently involved in discussions with the Shared Services, Lead Dietitian for Procurement and Health Board Caterers to discuss the options for specifications for the types of retail products in hospital settings, which could form part of an overall approach.

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<sup>52</sup> Wilson L. (2013) A review and summary of the impact of malnutrition in older people and the reported costs and benefits of interventions, Malnutrition task force ( [www.malnutritiontaskforce.org.uk](http://www.malnutritiontaskforce.org.uk) )

<sup>53</sup> CSSIW. Regulations and National Minimum Standards: Adult Services <http://cssiw.org.uk>

<sup>54</sup> BAPEN (2009). Nutrition Screening Survey in the UK in 2008. British Association for Parental and Enteral Nutrition.

<sup>55</sup> Welsh Government (2011). Supporting Food and Health Choices for Staff and Visitors in Hospital.

There is existing guidance for youth settings and for leisure centres. The degree to which this guidance is followed should be investigated to determine if the opportunities to encourage healthy and nutritious food provision are being maximised.

***Do you think there are other practical steps we could take to contribute to this issue?***

Public Health Wales believes that there is potential to strengthen the policy and strategy relating to food and health in Wales. Currently, there is no equivalent to the Tobacco Action Plan or Physical Activity action plan. The impact of poor diet on the health of the people of Wales is as significant as both these issues. It is also one of the more complex health related behaviours for individuals and professionals to address. These nutritional standards can only be seen as one part of a complex issue. Public Health Wales would welcome the opportunity to work closely with the Welsh Government to address the growing obesity problem in Wales. In July 2014, Public Health Wales will publish the work to consider the evidence based interventions that could be implemented on an all Wales basis to prevent obesity in children and young people being undertaken through the *Transforming Health Improvement Programme*. We look forward to using this as a firm basis for joint working on this important issue with Welsh Government and our other stakeholders. A Food and Health Strategy would also be able to address issues relating to access to healthy food choices and the growing concern relating to issues of food poverty.