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Agenda Supplement – Health and Social Care Committee

Meeting Venue:
Committee Room 3 – Senedd
Meeting date: 17 September 2015
Meeting time: 09.15

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Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

Public Health (Wales) Bill: consultation responses

Public Health (Wales) Bill: consultation responses

(Pages 1 – 945)

Attached Documents:

PHB 01 Chartered Institute of Environmental Health

PHB 02 Local Health Boards in Wales

PHB 03 Public Health Wales

PHB 04 Directors of Public Protection (Wales)

PHB 05 The Welsh NHS Confederation

PHB 06 Welsh Local Government Association

PHB 07 Paul Barnes

PHB 08 British Body Piercing Association

PHB 09 Abigail Cottrill

PHB 10 Carole Coote

PHB 11 Vince Jarvis

PHB 12 Llansteffan and Llanybri Community Council

PHB 13 Under Age Sales Ltd

PHB 14 Dr David Upton

PHB 15 British Acupuncture Council

PHB 16 Graham & Karen Wiseman

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PHB 18 Gordon Beard

PHB 19 Betsi Cadwaladr University Health Board

PHB 20 Dispensing Doctors' Association Limited

PHB 21 Wales Heads of Environmental Health Communicable Disease Expert Panel

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PHB 25 Royal College of Physicians

PHB 26 British Lung Foundation

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PHB 29 British Institute and Association of Electrolysis

PHB 30 Cardiff and Vale University Health Board

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PHB 33 British Association of Cosmetic Nurses

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PHB 37 Robert Heyes

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PHB 40 Royal College of General Practitioners

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PHB 43 Cancer Research UK

PHB 44 Hywel Dda University Health Board

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PHB 54 Jonathan Edwards

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PHB 68 Martin Hensman LLB (Hons)

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PHB 73 British Beer & Pub Association

PHB 74 Association of Convenience Stores

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PHB 80 University South Wales – School of Life Science Education

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PHB 92 Powys County Council

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PHB 94 Royal College of Psychiatrists

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PHB 100 Advertising Standards Authority

PHB 101 British Heart Foundation

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PHB 104 Dee Yeoman

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)

Chartered Institute of Environmental Health
Sefydliad Siartredig Iechyd yr Amgylchedd

Evidence from Chartered Institute of Environmental Health –
PHB 01 / Tystiolaeth gan Sefydliad Siartredig Iechyd yr Amgylchedd – PHB 01

Public Health (Wales) Bill

Response to the Health and Social Care Committee of the National Assembly for Wales

June 2015

Chartered Institute of Environmental Health
Sefydliad Siartredig Iechyd yr Amgylchedd

Sefydliad Siartredig Iechyd yr Amgylchedd

Fel **corff proffesiynol**, rydym yn gosod safonau ac yn achredu cyrsiau a chymwysterau ar gyfer addysg ein haelodau proffesiynol ac ymarferwyr iechyd yr amgylchedd eraill.

Fel **canolfan wybodaeth**, rydym yn darparu gwybodaeth, tystiolaeth a chyngor ar bolisïau i lywodraethau lleol a chenedlaethol, ymarferwyr iechyd yr amgylchedd ac iechyd y cyhoedd, diwydiant a rhanddeiliaid eraill. Rydym yn cyhoeddi llyfrau a chylchgronau, yn cynnal digwyddiadau addysgol ac yn comisiynu ymchwil.

Fel **corff dyfarnu**, rydym yn darparu cymwysterau, digwyddiadau a deunyddiau cefnogol i hyfforddwyr ac ymgeiswyr am bynciau sy'n berthnasol i iechyd, lles a diogelwch er mwyn datblygu arfer gorau a sgiliau yn y gweithle ar gyfer gwirfoddolwyr, gweithwyr, rheolwyr busnesau a pherchnogion busnesau.

Fel **mudiad ymgyrchu**, rydym yn gweithio i wthio iechyd yr amgylchedd yn uwch ar yr agenda cyhoeddus a hyrwyddo gwelliannau mewn polisi iechyd yr amgylchedd ac iechyd y cyhoedd.

Rydym yn **elusen gofrestredig** gyda dros 10,500 o aelodau ledled Cymru, Lloegr a Gogledd Iwerddon.

The Chartered Institute of Environmental Health

As a **professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a **registered charity** with over 10,500 members across England, Wales and Northern Ireland.
The Chartered Institute of Environmental Health (CIEH) welcomes the Public Health (Wales) Bill as a mechanism for regulating and controlling discrete areas of activity that have the potential to have an adverse impact on individuals and on public health in Wales.

Our response addresses the consultation question in the order of raising. Where a question in the Consultation questions is not reproduced we have no comment to make.

Part 2: Tobacco and Nicotine Products

Comment. The CIEH wishes to preface our response to Part 2 of the Consultation with the following comments.

There is clear and incontrovertible evidence that tobacco products damage the health of those who use them and also those who inhale the smoke from them. There have been a number of studies into the risks posed by e-cigarette use, and to date the evidence of health risk is inconclusive. As the products have been on the market less than 10 years there is no evidence of long term health damage, the evidence of health risk from short term use is inconclusive.

With the exception of the study into Attitudes of the Independent Hospitality Industry to use of E-Cigarettes carried out in 2014, the CIEH has conducted no research into the use of or health effect of e-cigarettes.

- **Do you agree that the use of e-cigarettes should be banned in enclosed public places and workplaces, as is currently the case for smoking tobacco?**
  The CIEH strongly supports the ban in smoking tobacco products in enclosed public places, our support being predicated on the recognised detrimental health effects on inhaling tobacco smoke and the harmful effect of passive expose to it.

  E-cigarettes do not generate the same harmful smoke as tobacco products, and although the exhaled aerosol contains nicotine and particulate matter, for which there is no safe level, the levels produced are very low and particularly compared to air borne particulates from road traffic etc. Based on the available evidence, the risk to the health posed by exposure to vapour from e-cigarettes is extremely low. It is therefore the view of the CIEH that a ban on the use of e-cigarettes in enclosed public places and workplaces would not be justified on the grounds of health risk from passive exposure.

  We recognise that the use of e-cigarettes has the potential to undermine enforcement of the ban on smoking in enclosed public places (see answer below regarding enforcement).

  Whilst it is the case that where owners or occupiers of premises feel that use of e-cigarettes by persons in their premises is an issue, whether by undermining their enforcement of the ban on smoking tobacco or for health reasons they can themselves ban their use, as some (BBC, Standard Life and JCB) have already done. The CIEH in partnership with ASH has produced a document providing advice and

guidance for employers titled 'Will you permit or prohibit e-cigarette use in your premises?' (2014) to assist employers making local decisions in this respect.

The CIEH does not support the proposal that e-cigarettes should be banned in enclosed public places and work places, as is currently the case for smoking tobacco.

- **What are your views on extending restrictions on smoking and e-cigarettes to some non-enclosed spaces (examples – hospital grounds and children's playgrounds)?**
  CIEH believes that smoking should be discouraged in all public places, particularly those where children are present, and in hospital grounds where health and the promotion of health should be a primary driver. Wales should move progressively towards a position where smoking is not the norm, and to environments where children and vulnerable individuals are not exposed to tobacco smoke.

  In our view the ban on smoking in enclosed public places should be extended to cover sites such as play grounds and play areas, school grounds (including preschool playgroups) and their immediate vicinity and the grounds of hospitals and medical facilities such as clinics.

  As noted we do not accept that there is a health case to be made for banning to use of e-cigarettes in non-enclosed spaces. Since the health risks of using e-cigarettes are significantly less than those of smoking tobacco we consider that the use of e-cigarettes should be facilitated to make the choice not to smoke tobacco easier.

- **Do you believe the provisions in the Bill will achieve a balance between the positive benefits to smokers wishing to quit with any potential dis-benefits related to use of e-cigarettes?**
  The Bill does not propose to ban the use of e-cigarettes *per se*, but to limit their use in enclosed and some non-enclosed public places. Where e-cigarettes are actively being used a quitting device we believe that the Bill does not achieve a balance, as it acts as a positive disincentive to use e-cigarettes, there being no benefit to the user from doing so.
  We believe that it is extremely important that those who are using e-cigarettes as a quitting device should not be subjected to the same restrictions as smokers and subjected to second hand tobacco smoke, which may undermine their quitting efforts.

  We recognise however that not all users of e-cigarettes use them as a quitting device and that there is no way to readily distinguish between users who use them as a quitting device and those who do not.

- **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?**
  There is no evidence to suggest that use of e-cigarettes re-normalises smoking behaviour in smoke free areas.

  It is the case that second and third generation e-cigarettes do not resemble conventional cigarettes at all, in which case the counter argument, that their use

normalises tobacco avoidance can be made, but it is accepted that there is no evidence to support this point.

Given that CIEH does not accept that use of e-cigarettes re-normalises smoking behaviour in smoke free areas we do not accept that it inadvertently promotes smoking.

- **Do you have any view on whether e-cigarettes are particularly appealing to young people and could lead to greater uptake of their use among this age group, and which may ultimately lead to smoking tobacco products?**
  The available evidence does not suggest that either of the propositions advanced is correct.
  Research published in 2013 shows that experimentation with e-cigarettes by 1-16 years old was low, being 1% and that very few of the experimenting group moved on to sustained use of the products (Use of e-cigarettes in Great Britain amongst adults and young people. Action on Smoking and Health 2013). This data must be balanced against data for young people trying tobacco products which is significantly higher. The ONS survey reporting in on 2013 found that 15% of 16-19 year olds had experimented with cigarettes. (ONS Opinion and Life Style Survey – Smoking habits amongst adults 2012).

- **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?**
  The ban on smoking in enclosed public places in Wales has been extremely successful. There is now an embedded understanding that smoking tobacco in enclosed public places in not permitted which may be undermined by the increasing use of products that replicate closely the appearance of cigarettes in appearance and in the way they respond to being used. We accept that whilst the design of some brands of e-cigarettes do not replicate the appearance of conventional cigarettes there are others that clearly do, being the same size and colour as a conventional cigarette and having a glowing end, the glow from which intensifies when the user 'draws' on the device, and vapour that is exhaled by the user although there is no smell of tobacco smoke from these e-cigarettes when used. They are also packed in a similar way to conventional cigarettes and appear to all intents and purposes to be the same.

  We contend that this is recognised by companies such as Wetherspoons and other national chains, JCB and a number of train companies and airlines where use of e-cigarettes has been banned because their use makes enforcement by staff of the ban on smoking more difficult.

  Research by CIEH looked at attitudes to use of e-cigarettes in the independent hospitality sector in Wales carried out in 2014 showed that the majority of owners of small hotels, B&BS and cafes had banned the use of e-cigarettes, applying to them the same rules as are applied to conventional tobacco products. The reasons for applying the same rules were that (1) it was easier and less confusing for staff trying to enforce the ban on smoking tobacco if e-cigarettes were also banned, and (2) allowing use of e-cigarettes encouraged smokers of conventional tobacco products to believe that they could smoke in enclosed public places.

The evidence suggests that restricting use of e-cigarettes in public places does assist managers in enforcing smoke free legislation.

- **Do you have any views on the levels of fines to be imposed on a person guilty of offences under this section?**
  Yes. We consider that the levels proposed are reasonable and proportionate and are consistent with offences of a similar type.

- **Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?**
  The CIEH supports the proposal to create a tobacco retailers register for Wales. Smoking remains the single greatest avoidable cause of death in Wales. The CIEH supports the introduction of measures that will reduce access to or prevalence of smoking. We are of the view that the creation of the register proposed would allow enforcement agencies to identify those premises from which tobacco and /or nicotine products are sold lawfully, and to target for enforcement purposes those that are not included on the register.

  Access to tobacco and tobacco products remains an issue particular in respect of sales to young people. The CIEH believes that it is important for effective enforcement of the legislation around sales to young persons that enforcement officers be able to identify those premises from which tobacco is lawfully sold. We further believe that the requirement for retailers to be on such a register would ensure that sales of tobacco and tobacco products within the trade, i.e. from wholesalers to retailers will remain visible within the legitimate trade.

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

- **What are your views on creating a new offence for knowingly handing over tobacco and nicotine products to a person under 18, the legal age of sale in Wales?**
  This is a useful additional tool in preventing the uptake of smoking/addiction to nicotine in young people. Internet sales of tobacco have the potential to circumvent the age of sale restrictions currently in place and any steps that assist in controlling them are welcomed.

- **Do you believe the proposals relating to tobacco and nicotine products contained in the Bill will contribute to improving public health in Wales?**
  Yes. Any actions that have the effect of reducing smoking or reducing addiction to nicotine will contribute to improving public health.

Part 3: Special Procedures

- **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?**
  The CIEH strongly supports the proposal to create a compulsory national licensing system for practitioners of specified procedures in Wales. By their natures special procedures are invasive and have the potential to transmit life threatening and life

changing infections between the parties to the procedure. Procedures carried out improperly or unhygenically can have an adverse impact on an individual's physical and mental health in the short and the long term. In addition, in the event that a special procedure carried out improperly causes infection, the implications for those individuals connected to the practitioner and the public health bodies investigating the incident are significant. We cite the recent outbreak associated with a tattooist in Newport by way of example of the number of individuals involved and the cost to the investigation and enforcement teams.

The CIEH considers that a compulsory national licensing system would be beneficial. The proposed licence could contain a number of requirements that would compel the practitioner to demonstrate that they are competent to practice and have the necessary skills to practice safely, without posing a risk to their clients or themselves. It would also give potential clients confidence as they would know that the practitioner they propose to use satisfied the requirements to be a licenced practitioner.

We are further of the view that any premises or vehicle from which a licensed practitioners proposes to practice should be approved prior to use and should be subject to an ongoing inspection regime. It is essential that any premises or vehicle from which special procedure are practised is hygienic and capable of being maintained in a safe and hygienic condition. Even the most capable and competent practitioner cannot practise safely from an unhygienic premises or vehicle and it is the combination of safe and competent practitioners practising from safe and hygienic premises that will protect the health of individuals and wider public health.

- **Do you agree with the types of special procedures defined in the Bill?**
  The special procedures in s47 (a)-(d) of the Bill are those procedures currently registered by local authorities in Wales. We consider it appropriate that they should be controlled as suggested as each has the potential to cause life changing or life limiting infection if carried out in an unsafe or unhygienic manner.

  We however believe that there are procedures that are similarly invasive with the same potential consequences that should be controlled in the same manner. Examples of such procedures are dermarolling, the injection of dermal fillers and plumpers and cosmetic skin peeling.

  We are however satisfied that those procedures outlined in s 47(a)-(d) should property be controlled as proposed, but that consideration should be given to the addition of other procedures, such as those named.

- **What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?**
  Following on from our response to the question above we consider that this provision is essential. The Aesthetic Body Modification industry moves very quickly as new procedures and practises are introduced and become popular. It is critical that Minsters have the power and the ability to respond swiftly to address risks that may be posed to public health by new and emerging practises in this field.

- **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?**
  We consider that the list is appropriate. Practitioners being subject to control by a specified regulatory body are independently assessed as having a suitable and sufficient degree of knowledge and competence.

- **Do you have any views on whether enforcing the licencing system would result in any particular difficulties for local authorities?**

At present local authorities are required to use legislative provision which were not designed to deal with risks posed by special procedure, being the Health and Safety at Work etc. Act 1974 and the Public Health (Control of Disease) Act 1984 as am. By the Health Protection (Part 2A Orders)(Wales) Regulations 2010. Neither piece of legislation was intended to control special procedures, in consequence they are of limited effectiveness, requiring evidential leaps of faith to be made and failing to prevent those individuals against whom action has been taken from continuing to practise should they chose to do so. Neither prevent those who trade other than in the course of a business from doing so, meaning that action to control 'hobby' practitioners is impossible.

The proposed enforcement regime takes precautionary approach, permitting as it does action to be taken where there is evidence of risk of infection, it addresses practitioners who are operating other than in the course of a business and gives local authorities powers to stop activities immediately. We consider that the provisions of s62- 66 inc. allied with the requirement for licensing of practitioners and approval of premises and vehicles are a significant step forward in controlling the way in special procedures are carried out. We note however that the regime proposed, whilst welcome is an additional burden for local authorities and that finance must follow this new function to ensure that local authority environmental health departments have adequate resources to deliver it.

- **Do you believe the proposals relating to special procedures contained in the Bill will contribute to improving public health in Wales?**
  The CIEH believes that the proposals will make a contribution to improving public health in Wales. As noted we believe that there are omissions from the list of special procedures, the inclusion of which would be beneficial, however we believe that the power to amend the list of special procedures to include procedures currently not on the list and new and emerging procedures will address this concern. We further believe that the new enforcement powers given to local authorities will ensure that any risks to public health identified from Aesthetic Body Modification practitioners can be addressed quickly and effectively thereby reducing or eliminating risk to public health.

Delegated powers

- **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?**

The CIEH believes that an appropriate balance has been achieved.

Finance questions

We believe the estimates of costs and benefits identified are accurate, and endorse the selection of option 3A as being the most appropriate at the present time. The potential cost of treating metal health issues arising from special procedures that have been improperly carried out or from illnesses or scaring resulting therefrom have not been quantified. We accept that these costs will not arise in all cases, but that where they do they may be considerable. It is hard to quantify such costs, however they should not be wholly disregarded.

Other comments

The CIEH wishes to make a number of specific comments regarding the proposed provisions, which are raised in the order they arise.

Sec 50(2)(b) – reference appears to '*significant risk of harm to human health'*, this comment is repeated in a number of other section (s60(2)(b), s63(b)). The interpretation section (s77(4)) makes reference only to 'harm to human health' . In the view of the CIEH this means that the question of whether harm is significant or not will be a question for the individual officers in the case to determine, which may lead to inconsistency. We believe further clarification would be helpful both to enforcement officers and to Magistrates.

Sec 55 - Offences are listed that may lead to refusal of a practitioners licence. The listed offences do not include offences under the Offences Against the Person Act 1861 (OATPA 1861). These offences include assault and assault occasioning actual bodily harm. We believe that these offences should be included in the prescribed list, as they directly relate to the manner in which an individual has responded to another when under pressure, s may be the case in the carrying out of a special procedure. The CIEH recommends that unexpired convictions under the OATPA 1861 be included.

Sec 77 (1) definition of '*body piercing'* - defined as the perforation of an individual's skin…. with a view to inserting jewellery. We consider it would be helpful to provide further guidance in this regard, since perforation can, without further guidance be of any size or shape provided it is made to enable jewellery to be attached or inserted.

Sec77 (1) definition of '*tattooing*' – the definition is the insertion of any colouring material into punctures in the skin. We are away of a process known as 'Tashing', in which the ashes of a person or animal are mixed with ink and used in the tattoo process, effectively becoming incorporated into the tattoo. The ashes are not ink or a constituent of it and have no pigmentation effect. It cannot be argued that the ashes are 'jewellery' as defined in 77(2), and even if that argument could be made the reference to jewellery relates to insertion through body piercing not tattooing. We know that 'Tashing' is carried out widely in Wales and whilst we have reservation about the practise from a public health standpoint (ashes may not be sterile, may be contaminated with heavy metals etc.) it is our view that it should either be specifically included and controlled within the legislation or specifically precluded by it. This is not a practice the lawfulness of which should be determined in a magistrate's court.

Part 4: Intimate Piercing

- **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?**
  The CIEH strongly agrees that there should be an age restriction on intimate body piercings. Intimate body piercing is a non-essential invasive procedure with potential health consequences, and should not in our view be available to those who are not capable of making a fully informed choice as to whether or not to accept the risks inherent in the procedure. We consider that an age restriction is the most appropriate way of restricting the decision to engage in the procedure to those most able and capable of making that decision.

  Intimate body piercing is analogous to tattooing, as it is an aesthetic body modification. We are cognisant with the argument that a piercing can be removed whilst a tattoo is intended to be permanent, however we do not accept this as a justification for a lower age restriction for intimate piercings. We do not consider 16 to be the appropriate age because:

- The decision to have an intimate body piercing should be made by a mature individual, we believe that 16 years of age is not sufficiently mature.
- Intimate body piercings require a higher standard of aftercare than tattoos, as they are potentially more susceptible to infection. This level of aftercare requires a mature approach to which a 16 year may not be capable of fully committing.
- Whilst the jewellery inserted into an intimate body piercing may be removed any scarring or damage inflected by the procedure will be permanent. This is particularly important when the skin the subject of the piercing is still growing and its function may be compromised by scarring or thickening. At 16 years an individual is still growing and therefore the risk of damage to skin is greater.

The CIEH also notes that there is considerable potential for confusion to arise if there is a different age restriction for body piercing and for tattooing. We consider that it would be easier for practitioners, enforcement agencies and individuals if the age restriction for both was to be the same. We further consider that an age restriction of 16 years for intimate body piercing is likely to give rise to call for the age restriction for tattooing to be reduced to 16 years.

The CIEH believes that the age restriction for intimate piercing should be 18 years.

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

  Yes.

- **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?**
  The CIEH considers that the enforcement powers proposed are appropriate and proportionate. We note however that enforcement of this provision is an is an additional burden for local authorities and that finance must follow this new function to ensure that local authority environmental health departments have adequate resources to deliver it

- **Do you believe the proposals relating to intimate piercings contained in the Bill will contribute to improving public health in Wales?**
  Yes. We accept that there is little evidence of which we are aware to suggest that large numbers of individuals are being adversely affected by the consequences of intimate piercing we are of the view that all of the vulnerable population should be afforded protection and that these legislative provisions achieve that protection. We are also aware that new techniques and practises in body modification and body art develop quickly and are hot generally subject to any form of testing or control. This is a precautionary and preventative measure in addition to being a protective measure.

Part 5: Pharmaceutical Services

This is not a core area of activity for the CIEH, we therefore make no comment.

Part 6: Provision of Toilets

Toilet provision is a basic public health need. The CIEH believes that the provision of readily accessible public toilets is essential to good public health in Wales. Specific groups of the population such as the elderly, pregnant women, those with young families and people with

specific health conditions require access to toilets, and where provision is limited or absent these groups are disadvantaged and may be deterred from visiting.

It is also the case that lack of adequate toilet provision encourages antisocial behaviour and may potential spread of infectious disease.
The provision of Part 6 are addressed to local authorities. CIEH had not part in the proposed delivery mechanism. We do however wish to record our support for the provisions are being essential to public health in Wales

Other comments

- **Are there other areas of public health which you believe require regulation to help improve the health of the people of Wales?**

The Public Health Wales report 'Alcohol and health in Wales 2014' demonstrates quite clearly the enormous impact that misuse of alcohol has on the health and wellbeing of individuals, on increasing pressure on the NHS and on the economy of Wales. The CIEH a proposed minimum unit price (MUP) for alcohol during the original consultation for this Bill and is disappointed to see that the proposal did not proceed. Whilst we accept that there is an argument for awaiting the outcome of the current challenge to the Scottish Government proposed MUP we wish to put on record our view that Welsh Government must take steps, which may include regulation to address the issue is the use and misuse of alcohol in Wales in order to improve the health of individual and the public health of the nation. This is an imperative and must be given urgent priority.

We would be happy to provide further expansion of or clarification of our comments should this be required.

Julie Barratt
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Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

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

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

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

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

30 June 2015

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

Part 2: Tobacco and nicotine products

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

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

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

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

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

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

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

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

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

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

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

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

Part 3: Special procedures

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

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

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

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

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

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

Part 4: Intimate piercing

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

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

Part 5: Pharmaceutical services

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

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

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

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

Part 6: Provision of toilets

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

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

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

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

Other comments

Food standards

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

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

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

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

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

Further comments

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

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

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

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

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



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

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

1 Overview

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

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

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

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

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

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

1.1 Minimum Unit Pricing Alcohol

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

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

1.2 Nutritional Standards

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

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

2 Part 2: Tobacco and Nicotine Products

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

Public Health Wales strongly supports this action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The most recent published information from Wales, the CHETS 2 study[1], confirms findings of other studies internationally, that e-cigarette experimentation is widespread but that regular use among previous non tobacco users is rare. However, this study does not provide conclusive evidence that there is no risk and raises concerns about the use of e-cigarettes in those vulnerable to tobacco use. The study found that among non-smoking children who reported having used an e-cigarette, 14% reported they might start smoking within the next two years (compared to 2% of those who had not used an e-cigarette) and although intention to smoke within two years was relatively low, children who had used an e-cigarette were substantially less likely to say they definitely will not smoke, and more likely to say that they might.

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

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

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

[1] http://bmjopen.bmj.com/content/5/4/e007072.full
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2.6 Do you have any views on whether restricting the use of e-cigarettes in current smoke-free areas will aid managers of premises to enforce the current non-smoking regime?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Part 3: Special Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

No specific observations at this time.

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

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

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

4 Part 4: Intimate Piercing

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

Public Health Wales supports these proposals.

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

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

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

Public Health Wales agrees with these proposals.

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

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

5 Part 5: Pharmaceutical Services

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

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

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

6 Part 6: Provision of Toilets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 1 – Minimum Unit Pricing Alcohol

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

Minimum Unit Pricing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

quintile. Consequently, tackling alcohol related ill health is an important element in reducing inequalities in health[35].

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

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

See response to question 17.

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

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

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

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

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

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

[35] A Profile of alcohol and health in Wales (2009) http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/85c50756737f79ac80256f2700534ea3/0400558233b1c95c802576ea00407a33/$FILE/Alcohol%20and%20health%20in%20Wales_WebFinal_E.pdf

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

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

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

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

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

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

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

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

below would be inappropriate in this consultation we believe there is sufficient evidence already available to support[7]:

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

Appendix 2 – Part 5 Pharmaceutical Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Type A

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

Type B

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Availability of a private consultation area at the pharmacy

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

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

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

- Identification of pharmaceutical issues raised by health professionals/managers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Evidence from Directors of Public Protection (Wales) – PHB 04 / Tystiolaeth gan Cyfarwyddwyr Diogelu'r Cyhoedd (Cymru) – PHB 04

HEALTH AND SOCIAL CARE COMMITTEE CONSULTATION ON PRINCIPLES OF THE PUBLIC HEALTH (WALES) BILL

Submission of Evidence by Directors of Public Protection Wales (DPPW) in advance of attendance at oral session.

Introduction:

Directors of Public Protection Wales (DPPW) represent a range of local authority services, including Environmental Health, Trading Standards and Licensing which collectively, are often referred to as Public Protection services.

Public Protection services are responsible for applying a wide range of legislation required to protect consumer rights and protect public health. These services directly affect the health, safety and wellbeing of our communities in Wales

The following represents views on Part 2, Part 3 and Part 4, submitted in advance of DPPW attendance at a forthcoming oral session. A more comprehensive consultation response to encompass other aspects of the Bill will be submitted under separate cover in due course.

Part 2: Tobacco and Nicotine Products Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

 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?

YES.

The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason.

DPPW published its views on the availability and use of e-cigarettes in 2013 ***(DPPW, 2013)*** *which included several examples* where the enforcement of the ban on smoking in enclosed public places had been undermined by claims of the use of e-cigarettes. Local authorities have had legal actions fail because offenders claimed they were using e-cigarettes.*

[*examples: Cardiff County Council instigated a prosecution against a taxi driver for smoking in his vehicle. The defendant pleaded not guilty on the basis that he was

smoking an e-cigarette and not a “real” cigarette. The matter proceeded to Court where the defendant was found not guilty despite the alleged offence being witnessed by an Enforcement Officer.

Powys County Council has also experienced difficulties with enforcement, having lost a court case against a taxi driver who as part of his defence in Court suggested he may have been using an e-cigarette. The Court found the defendant not guilty despite the investigating officer’s witness statement.

Similar enforcement difficulties have been experienced by Caerphilly CBC, Wrexham CBC and Swansea CBC where taxi drivers have been witnessed smoking in their vehicles but Enforcement Officers have been unable to prove whether it was a tobacco product or an e-cigarette. These cases demonstrate that where an individual is witnessed contravening the ban on smoking in a wholly or substantially enclosed public place they can simply claim that they were smoking an e-cigarette and it is extremely difficult for enforcing authorities to prove otherwise, thereby compromising the enforcement of the ban.]

Our officers that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people “vaping”. Some vapers argue “it’s not against the law”.

We believe that the use of e-cigarettes in public places can help “normalise” smoking. See later.

There is uncertainty over the potential adverse health implications associated with e-cigarettes and despite recent studies suggesting some benefit to those quitting smoking the efficacy of e-cigarettes as an aid to smoking cessation is not entirely clear. It is therefore appropriate to take a precautionary approach to the risks associated with e-cigarettes. Currently people in Wales can breathe clean air in offices, shops, pubs and other public places and work environments. We don’t want to see a backwards step towards potentially polluted air.

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

We are of the opinion that smoking should be discouraged in all public places, in particular those locations where there are children or vulnerable people. These include:
Playgrounds
School grounds & their immediate vicinity
Hospital & medical facility grounds
Places promoted to children (e.g. “petting farms”, fairgrounds and family centred leisure parks).

There is a need for Fixed Penalty Notice powers which should be consistent powers with existing provisions. In drafting such provisions there is a need to consider that law currently places a responsibility on the person in control of premises to prevent smoking (e.g. hospital grounds) and that local authorities’ usual enforcement approach is against the “person in control of premises” for permitting smoking. (Under the Health Act 2006 “*It is the duty of any person who controls or is concerned in the management of smoke-free premises to cause a person smoking there to stop smoking*.”)

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

Yes.

Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation; intentionally or inadvertently promote or normalise smoking; and the potential impact upon impact upon smoke free environments.

We are concerned that there is a real potential for e-cigarettes to intentionally or inadvertently promote smoking amongst those who currently do not smoke. In particular we feel there is a need to make every effort to deter young people from becoming smokers.

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

Yes. DPPW takes the view that anything that has the appearance of smoking helps "normalise" smoking and therefore promotes smoking behaviour and culture. We also question whether the term ***"inadvertently"*** *is appropriate. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour.*

We are also concerned by the nature of e-cigarette advertising; we note the reappearance of 1950's style marketing of tobacco products.

Workplaces have worked hard to implement the smoke free premises legislation and the use of e-cigarettes undermines this work.

We are concerned that e-cigarettes encourage young people to think that smoking is acceptable and therefore has the potential to act as a gateway to both e-cigarettes and tobacco based products.

Data relating to smoking behaviour in Wales leads us conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach.

 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?*

Yes we feel they are. We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours.

Worryingly, our members have witnessed e-cigarettes being displayed for sale with sweets, at child height, at the checkout in large stores.

Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as "Gummy Bear, Cherry cola and Bubble Gum".

Some products are being packaged and marketed in a way that is closely associated with that of conventional cigarettes. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour. We are also concerned by the nature of e-cigarette advertising; e.g. consistent with the 1950's style marketing of tobacco products.

Many of these factors reinforce the association with conventional tobacco cigarettes and may normalise smoking related behaviour.

 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?

Yes. A number of licensed premises have independently introduced bans on the use of e-cigarettes within their premises in recognition of the difficulty they cause their staff in applying the smoking ban within their premises.

Our colleagues that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people "vaping". Some vapers argue "it's not against the law".

Some employers have had difficulties. e.g. Caerphilly CBC had problems with lorry drivers smoking in their cabs and when tackled claimed they were vaping an e-cig, which made taking action difficult. Caerphilly CBC has also received complaints from their own office based staff that colleagues have been using e-cigarettes at their desks and that they may be also be inhaling the vapours in a similar way to second hand smoke. Hence Caerphilly amended their no smoking policy to include e-cigs.

The proposed legislation in smoke-free places should apply equally to tobacco based products and all forms of e-cigarettes.

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

The power to issue Fixed Penalty Notices and other enforcement provisions need to be consistent with other smoking legislation, and the fines need to be set at such a level as to be a deterrent to (re)offending.

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

Yes. DPPW supports the proposal.

DPPW supports the view that these provisions would best be enforced by Local Government in Wales. Public Protection Services have considerable experience and expertise in the operation of registers and licensing regimes and our Trading Standards and Environmental Health Officers are already enforcing associated legislation at these premises.

Given the significant financial pressures being faced by Local Government in Wales, there will need to be careful consideration of how the implementation of a tobacco retail register

and its enforcement are resourced. Welsh Government may wish to consider the use of on-line or be-spoke registration software, that may be updated by each local authority, rather than to require one host local authority to maintain the register on behalf of Wales.

In addition, DPPW would encourage WG to not be prescriptive in allocating enforcement responsibilities to a particular functional area such as Trading Standards Officers or Environmental Health Officers but allow Local Authorities the discretion to determine how best these provisions may be implemented by their suitably qualified or competent enforcement officers. This will afford Local Government the opportunity and the flexibility to deploy their resources in the most effective manner to suit local circumstances.

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

The introduction of a register will provide an additional control on the availability of tobacco; a register would contain detailed information on those people and premises from which tobacco can be sold legitimately. Furthermore it would restrict access to the trade to those people and premises where tobacco should not be sold. It will be easier for enforcement officers to identify those premises where tobacco is permitted to be sold, which will in turn assist with the enforcement of underage sales and the display ban.

The success of such a measure would be dependent on the legislation including provisions to control access to the register such as a “fit & proper persons” or “suitable persons” test. This is explored further in response to subsequent questions.

If a register is to be established it needs to cover all those that manufacture, distribute and sell tobacco products. We feel that having a register only for the end retailers is not comprehensive and will not cover other parts of the tobacco chain that feed the habit including those under age. An offence should be created where tobacco products can only be sold, distributed, etc to those registered.

We note that section 29(5) provides that ‘A registered person who fails, without reasonable excuse, to comply with section 25 (duty to notify certain changes) commits an offence’. We are concerned by the use of the phrase ‘reasonable excuse’:

a) Firstly, as it is out of step with the more robust due diligence offence common to most current consumer protection legislation, i.e. the two limbed all reasonable precautions and all due diligence defence. There is concern that with section 29(5) as currently worded, individuals failing to notify changes to the register will be able to evade enforcement action. There will be no definition of what is reasonable and so these explanations would need to be tested in court with associated wasting of resources.

   Use of the well established two limbed due diligence system would enable enforcement officers to assess the adequacy of an individual’s defence based on tried and tested case law, well before a case has to enter the court system

b) Secondly, the very use of the word ‘excuse’ in section 29(5) sends out quite the wrong message to the trade, and there is a danger that the current wording will encourage individuals simply to ‘come up with an excuse’ in the expectation that this will be acceptable.

Further, we would suggest that provisions should permit might permit placing limitations on the sale of tobacco products (including e-cigarettes) within a designated distance from schools and colleges for example.

DPPW would also highlight the need to recognise the potential resource implications for Local Authorities enforcing the provisions.

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

Yes. The proposed link to restricted sales orders (RSOs) and restricted premises orders (RPOs) under the Children & Young Persons Act are welcome. However, we see it as essential that the range of offences triggering an RPO is extended to include all tobacco related breaches, for example the supply of illegal (counterfeit and non-duty paid) tobacco, tobacco labelling offences, non-compliance with the tobacco display ban; and not just underage sales. It is hoped that these matters will be addressed through the proposed power for Welsh Ministers to make regulations under section 12D of the Children and Young Persons Act and the range of offences triggering an RPO extended accordingly.

However, our experience of "Registers" introduced under other legal provisions suggest that their efficacy can be limited if they are not also accompanied by robust enforcement powers. Some registers are merely administrative or informative.

Local authority enforcement officers will need effective powers to ensure that the register has the desired effect. These need to include power to restrict access to the register and to remove persons from the register where there has been a relevant infringement of the law, including offences concerning underage sales. We feel that there should be a provision to consider suitability of a retailer - whether the retailer is a "fit & proper" person. For example, whether a retailer been convicted for the sale of alcohol, solvents or other age restricted products to minors. The section 24 provision that an application to register will not be granted if an RPO or RSO is already in place goes some way towards this, but of course does not take account of the selling to minors of other age restricted products.

We welcome the section 23(2)(g) clarification that in addition to sellers of tobacco and nicotine products with a High Street presence, those supplying via online, telephone and mail order channels will be required to indicate this on the register. However, it is unclear from the wording of section 22(1) whether the requirement to register applies only to those based in Wales rather than those outside Wales supplying to customers in Wales, i.e. 'The registration authority must maintain a register of persons carrying on a tobacco or nicotine business at premises in Wales'.

DPPW is disappointed with the section 23(3) definition of a "tobacco or nicotine business" as being a business involving the sale by retail of tobacco or cigarette papers or nicotine products'. Limiting the scope of the register to retail would be a lost opportunity to regulate throughout the supply chain. The illicit supply and sale of tobacco has been identified as a growing concern by Trading Standards in Wales. A register must not inadvertently add to the problem of illicit trade in cigarettes. The penalties of failing to register therefore need to be robust. We emphasise that the definitions of "business" need to be carefully considered to encompass not only legitimate traders but also those persons who are trading illegally in tobacco from domestic premises. We feel it should also include online suppliers. Effectively the provisions must apply to anyone who is *selling* tobacco products in Wales.

We support the need for robust and proportionate penalty for offences and proposed powers of entry (to retail premises) or the ability to seek a warrant (for domestic premises). These are obviously vital. We also support the need for powers to seize tobacco goods in all relevant premises including those that are not registered.

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

We support the proposals which would bring tobacco products into line with alcohol sales.

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

Yes.

Smoking remains the single greatest avoidable cause of death in Wales **(PHW, 2012)**. The introduction of the ban on smoking in enclosed public spaces in 2007 has been hugely successful in reducing exposure to environmental tobacco smoke and in strengthening public awareness and attitudes towards it. However, reducing the prevalence of smoking, remains a key health priority. Protecting young people from the effects of smoking and deterring young people from taking up the habit are particularly important. Therefore DPPW welcomes the proposals and additional powers to help control the availability of tobacco and its potential health impact.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales, these procedures are acupuncture, body piercing, electrolysis and tattooing.

 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?

We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators.

DPPW is of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

DPPW has the following concerns regarding existing provisions:

- There is no requirement for a practitioner to have training or experience to set up a tattoo studio. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk.
- Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the byelaws. This may be viewed as a purely administrative offence when Courts are considering sentencing.
- Current registration requirements rely on being able to prove that a person is carrying on a business and this can be difficult because most unregistered tattooists (‘scratchers’) work from home and deny that they receive payment.

- There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws,
- Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and The Health and Safety at Work etc. Act 1974. Several local authorities in Wales have used Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle “scratchers”.
- When we last gathered information on this, we found that between July 2012 and July 2013, ten applications for Part 2A Orders had been made by local authorities; all of which related to the carrying out of unregistered tattooing from domestic premises.
- New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.
- Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.

DPPW agrees with the concerns of the Chartered Institute of Environmental Health (CIEH) that many procedures are being done by people with little if any knowledge of anatomy, infection control or healing processes **(CIEH, 2014)**.

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future.

We will be pleased to work with WG officials is relation to such matters.

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

We absolutely support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. E.g. a local studio (in Caerphilly) is keen to expand

into scarification and tongue splitting. Other procedures are already becoming more popular e.g. branding, dermal implants, microdermabrasion. All these procedures provide the potential for serious harm and infection.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive activities underground and cause further issues or potentially make it more appealing to some people.

 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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

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

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

 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?

Yes. Local authority officers are aware that such procedures are taking place and it is our view that such intimate procedures should be illegal on under 16s to protect this vulnerable group from potential risks.

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

Yes. However we also feel there is a case to add the tongue. In addition to other risks, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list.

 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?

We support such proposals including the proposal to make it an offence “to enter into arrangements”. This would support enforcement of the provisions including “test purchasing” by local authorities.

We recognise the need for police support in particular in relation to evidence gathering given the intimate nature of such offences and the provisions need to take account of that.

Any duties placed upon local authorities need to be supported by adequate funding.

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

Yes, see above.

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

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

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

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

Introduction

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

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

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

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

Summary

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

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

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

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

Part 2: Tobacco and Nicotine Products

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 3: Special Procedures

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

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

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

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

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

Part 4: Intimate Piercing

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

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

Part 5: Pharmaceutical Services

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

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

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

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

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

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

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

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

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

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

Part 6: Provision of Toilets

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

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

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

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

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

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

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

Finance questions

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

Other comments

Food Standards

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

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

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

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

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

A clear vision for the role public health plays in Wales

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

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

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

To tackle public health issues we need better integration

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

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

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

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

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

People in Wales are empowered to take control of their health

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

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

To improve public health it is essential to tackle poverty

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

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

Conclusion

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

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[i] The Welsh NHS Confederation, June 2014. Response to the 'Listening to you – Your health matters' White Paper.
[ii] USA National Youth Tobacco Survey, April 2015. Tobacco Use Among Middle and High School Students — United States, 2011–2014.
[iii] Health & Social Care Information Centre, 2013. Smoking, drinking and drug use among young people in England in 2012.
[iv] The NHS Confederation, 2013. Health on the high street: rethinking the role of community pharmacy.
[v] Older Peoples Commissioner for Wales, 2014. The Importance and Impact of Community Services within Wales.
[vi] The Welsh NHS Confederation, January 2014. From Rhetoric to Reality – NHS Wales in 10 years' time.
[vii] The NHS Confederation, November 2014. The 2015 Challenge Declaration.
[viii] The Welsh NHS Confederation, June 2015. Socio-economic deprivation and health.
[ix] Public Health Wales Observatory, December 2011. Measuring inequalities. Trends in mortality and life expectancy in Wales.

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 Welsh Local Government Association – PHB 06 / Tystiolaeth gan Cymdeithas Llywodraeth Leol Cymru – PHB 06

Health & Social Care Committee

Public Health Bill

06th July 2015

WLGA • CLILC

INTRODUCTION

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and the three fire and rescue authorities are associate members.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. WLGA welcomes the opportunity to provide evidence on proposed changes to public health. Responses to the specific consultation questions are provided separately (see below); we also draw on a previous paper to Welsh Government, calling for the responsibility for public health to be returned to local government.

Improving Public Health

4. Improving public health is one of the main priorities of the Welsh Government and rightly so, if the quality of life of our residents is to be improved. The WLGA welcomes the proposals in the Public Health bill aimed at **better regulating** matters that impact on our resident's health, but the Welsh Government are missing an opportunity to re-think **how** public health services are delivered.

5. In the forward to the white paper Mark Drakeford AM, the Minister for Health and Social Services recognises that the causes, (and we would argue many of the solutions) lie outside the health service.... *"...We know that the elimination and prevention of health inequalities can only be achieved when linked to the underlying inequalities of income, wealth and power across society. The* fundamental causes of poor health, and its unequal distribution across different parts of Wales, lie outside the health service itself...."

6. What the Bill does not go on to do is learn and apply the lessons from England, where the responsibility for public health was returned to local government in April 2013.

7. We are however deeply concerned to note the £200m budget cut to Public Health funding in England which was recently announced. Prevention measures do not reap instant benefits. They are generational and gradual. If government is truly convinced that the prevention of ill health will save money in the long term, and help alleviate the crisis that looms over treatment costs as the population ages; then short term politics must be put aside by all parties and long term faith in prevention must be funded for the long term.

8. WLGA believe that integrated planning and service provision within local government and our partners, to promote healthy choices, protect health, prevent sickness and intervene early will help to minimise the need for costly hospital treatment. This is supported by the Directors of Public Protection in Wales who are of the view that local government is well placed, if not best placed, to influence the wider determinants of health; tackle the growing inequalities in health experienced by our communities and to provide the leadership for public health required in Wales.

9. This paper outlines what the WLGA sees as the rationale for transferring responsibility and has also started to consider what the lessons from England have been and how they might apply to Wales.

10. The ring fenced budget provided to local authorities in England was based on an average of £51 per head a population. In Wales this may amount to around £157 million / year for local government to administer. The criteria for allocating the budget to areas of Wales most in need, will require careful consideration and not necessarily use the same criteria as England did.

11. The WLGA are calling for new money to support the proposed Public Health bill and local government can use its democratic mandate to reconsider how all available resources can be assembled to make the most impact on public health outcomes.

The rationale for re-integration

12. In 2010, Professor Sir Michael Marmot published his influential report 'Fair Society Healthy Lives'. The conclusions in this report was highly influential in the decision of the UK government to place the responsibility for public health back with local government. They also recognised that re-integration offered the following benefits:

- It was the best way to implement the new Public Health Outcomes Framework for England, 2013-2016
- Local Government provided a strong democratic, accountable and joined up approach to improving public health in local communities
- Local government already had responsibilities for many of the services that could help to improve Public Health; ***'the determinants of health'*** such as leisure, public protection, housing and social care.
- Local government already knew their local communities and their needs well.
- Local government had a track record of reshaping services, doing more with less, and a culture that understood that sometimes you need to invest to save.

Health in all policies

13. The 'health in all policies' approach to be proposed in the Welsh 'Wellbeing of Future Generations bill' will support a council-wide approach to achieving better health outcomes. It will be important that there is alignment between the Public Health Bill and the Future Generations Bill. The latter will set high level national goals with the aim of protecting the well-being of future generations. The goals will be designed to counter/respond to long terms trends such as rising levels of obesity, ageing population, climate change. The sorts of activities in the PH Bill are preventative in nature and therefore in line with such objectives but it will be important that efforts are joined up.

Local Government Capacity

14. Many of the provisions of the White Paper will fall, quite rightly, to local authorities in Wales to implement and enforce. These proposals will strengthen existing tools available to local authorities in Wales to tackle key health issues and should be welcomed.

15. Full consideration should be given to the capacity within local government to deliver these proposals successfully at a time when service cuts and reductions in service standards are all too apparent. Local government, in partnership with other organisations such as Public Health Wales has the expertise and experience to support these new powers and measures. However, many of these provisions will have an impact on resources and therefore the flowing should be considered:

- A full regulatory risk and impact assessment should be undertaken to understand the consequences of the proposed legislation on enforcing authorities and on those subject to regulation,
- Full cost recovery options should be considered or in the absence of a cost recovery mechanism (typically fees & charges) additional resource should be made available to local authorities specifically for the purpose of this legislation,
- In allocating enforcement responsibility Welsh Government should allow local authorities the discretion to allocate the responsibility to suitably qualified or competent enforcement officers.

Response to the consultation questions

16. The WLGA has been in close dialogue with the Directors of Public Protection Wales (DPPW), and has had the benefit of reading their evidence. We

consider the views expressed by them in relation to the specific public health measures proposed in the Bill to be sound.

17. The arguments for strengthening enforcement provisions, legal defences, the clarification of potentially ambiguous terms, and future proofing are particularly relevant if the legislation is to be successful.

18. For that reason, we do not propose to wholly reiterate those views. However we do endorse their comments via the main points below.

Part 2: Tobacco and Nicotine Products Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

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?

Yes.

The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason.

We believe that the use of e-cigarettes in public places can help "normalise" smoking.

There is uncertainty over the potential adverse health implications associated with e-cigarettes and despite recent studies suggesting some benefit to those quitting smoking the efficacy of e-cigarettes as an aid to smoking cessation is not entirely clear.

It is therefore appropriate to take a precautionary approach to the risks associated with e-cigarettes. Currently people in Wales can breathe clean air in offices, shops, pubs and other public places and work environments. We don't want to see a backwards step towards potentially polluted air.

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)?

We are of the opinion that smoking should be discouraged in all public places, in particular those locations where there are children or vulnerable people. These include:

Playgrounds; school grounds & their immediate vicinity; Hospital & medical facility grounds; places promoted to children (e.g. "petting farms", fairgrounds and family centred leisure parks).

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

Yes.

Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation; intentionally or inadvertently promote or normalise smoking; and the potential impact upon impact upon smoke free environments.

We are concerned that there is a real potential for e-cigarettes to intentionally or inadvertently promote smoking amongst those who currently do not smoke. In particular we feel there is a need to make every effort to deter young people from becoming smokers.

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

Yes. We take the view that anything that has the appearance of smoking helps "normalise" smoking and therefore promotes smoking behaviour and culture.

Workplaces have worked hard to implement the smoke free premises legislation and the use of e-cigarettes undermines this work.

We are concerned that e-cigarettes encourage young people to think that smoking is acceptable and therefore has the potential to act as a gateway to both e-cigarettes and tobacco based products.

Data relating to smoking behaviour in Wales leads us to conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach.

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?*

Yes we feel they are. We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours.

Worryingly, our members have witnessed e-cigarettes being displayed for sale with sweets, at child height, at the checkout in large stores.

Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as "Gummy Bear, Cherry Cola and Bubble Gum".

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?

Yes. A number of licensed premises have independently introduced bans on the use of e-cigarettes within their premises in recognition of the difficulty they cause their staff in applying the smoking ban within their premises.

The proposed legislation in smoke-free places should apply equally to tobacco based products and all forms of e-cigarettes.

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

The power to issue Fixed Penalty Notices and other enforcement provisions need to be consistent with other smoking legislation and the fines need to be set at such a level as to be a deterrent to (re)offending

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

Yes. The WLGA supports the proposal.

WLGA and DPPW support the view that these provisions would best be enforced by Local Government in Wales. Public Protection Services have considerable experience and expertise in the operation and enforcement of registers and licensing

Given the significant financial pressures being faced by Local Government in Wales, there will need to be careful consideration of how the implementation of a tobacco retail register and its enforcement are resourced.

In addition, we would encourage WG to not be prescriptive in allocating enforcement responsibilities to a particular functional area such as Trading Standards Officers or Environmental Health Officers but allow Local Authorities the discretion to determine how best these provisions may be implemented by their suitably qualified or competent enforcement officers. This will afford Local Government the opportunity and the flexibility to deploy their resources in the most effective manner to suit local circumstances.

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

The introduction of a register will provide an additional control on the availability of tobacco; a register would contain detailed information on those people and premises from which tobacco can be sold legitimately. Furthermore it would restrict access to the trade to those people and premises where tobacco should not be sold. It will be easier for enforcement officers to identify those premises where tobacco is permitted to be sold, which will in turn assist with the enforcement of underage sales and the display ban.

An offence should be created where tobacco products can only be sold, distributed, etc. to those registered.

Further, we would suggest that provisions could permit placing limitations on the sale of tobacco products (including e-cigarettes) within a designated distance from schools and colleges for example.

We would also highlight the need to recognise the resource implications for Local Authorities enforcing the provisions.

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

Yes. The proposed link to restricted sales orders (RSOs) and restricted premises orders (RPOs) under the Children & Young Persons Act are welcome. However, we see it as essential that the range of offences triggering an RPO is extended to include all tobacco related breaches, for example the supply of illegal (counterfeit and non-duty paid) tobacco, tobacco labelling offences, non-compliance with the tobacco display ban; and not just underage sales.

However, our experience of "Registers" introduced under other legal provisions suggest that their efficacy can be limited if they are not also accompanied by robust enforcement powers. Some registers are merely administrative or informative.

We welcome the clarification that in addition to sellers of tobacco and nicotine products with a High Street presence, those supplying via online, telephone and mail order channels will be required to indicate this on the register.

The illicit supply and sale of tobacco has been identified as a growing concern by Trading Standards in Wales. A register must not inadvertently add to the problem of illicit trade in cigarettes. The penalties of failing to register therefore need to be robust.

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?

We support the proposals which would bring tobacco products into line with alcohol sales.

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

Yes.

Smoking remains the single greatest avoidable cause of death in Wales **(PHW, 2012)**. The introduction of the ban on smoking in enclosed public spaces in 2007 has been hugely successful in reducing exposure to environmental tobacco smoke and in strengthening public awareness and attitudes towards it. However, reducing the prevalence of smoking, remains a key health priority. Protecting young people from the effects of smoking and deterring young people from taking up the habit are particularly important.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales, these procedures are acupuncture, body piercing, electrolysis and tattooing.

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?

We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc. to enable the effective regulation of illegal operators.

We agree with DPPW and is of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

We agree with the concerns of the Chartered Institute of Environmental Health (CIEH) that many procedures are being done by people with little if any knowledge of anatomy, infection control or healing processes **(CIEH, 2014)**.

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body Piercing and Electrolysis. These share a theme of preventing blood borne viruses.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks such as a growing range of procedures including Botox, Dermal Fillers, Sculpting, Microdermabrasion, Dermal Rolling and Dermal Implants. We also recognise that new and novel procedures are continually being developed and Welsh Government should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends.

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

We support that and also welcome the anticipated opportunity to be consulted upon and to work with Welsh Government officials in framing any proposals.

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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

Do you believe the proposals relating to special procedures contained in the Bill will contribute to improving public health in Wale*s?*

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

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?

Yes. Local authority officers are aware that such procedures are taking place and it is our view that such intimate procedures should be illegal on those who are under 16 years of age to protect this susceptible group from potential risks.

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

Yes. However we also feel there is a case to add the tongue. In addition to other risks, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list.

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?

We support such proposals including the proposal to make it an offence "to enter into arrangements". This would support enforcement of the provisions including "test purchasing" by local authorities.

We recognise the need for police support, particularly when gathering evidence, given the intimate nature of such offences and the safeguarding issues needed to be considered in such circumstances.

Any duties placed upon local authorities need to be supported by adequate funding.

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

Yes, see above

Public Health in Wales – Local Government stands ready to deliver

19. For the Committee's consideration, the WLGA has developed a further paper, expanding on the information provided in this document "Public Health in

Wales – Local Government stands ready to deliver". A copy of the paper is available here.

20. The WLGA would encourage and welcome further discussion regarding transferring public health responsibilities to local government in Wales.

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

Evidence from Paul Barnes – PHB 07 / Tystiolaeth gan Paul Barnes – PHB 07

I would like to thank the Health and Social Care Committee for the chance to respond to the proposal as defined in the Public Health (Wales) Bill. The following pages outlines my responses to various paragraphs contained within the Explanatory Memo.

1. It is my opinion that the current proposal to ban the use of e-cigarettes (vapour products) in enclosed public and work spaces does not have sufficient negative health evidence to carry substantial support for enforcement. Current figures provided by ASH UK[1] highlight that the number of current users stands at approximately 2.6 Million, with 1.1 Million confirmed sole-users.

2. Assuming Wales population levels of ~3.1 Million (extrapolated from 64.1M UK residents), approximately 54,200 pro-rata who have quit with the use of e-cigarettes. This figure represents ~85% of the total number of people who have recently quit smoking (assuming that 2% of the population = 64,000).

3. These figures represent successful cessation[2] of combustible tobacco products under the current regulatory and smoke-free regime, enforced by local businesses as an alternative to an enforced blanket ban.

4. With regards to the proposal to extend the smoke-free areas, along with the addition of vapour products in the same legislation can be interpreted by members of the public as a message from the Welsh Government saying that vapour products are no better than traditional tobacco products. The current body of evidence collated to date does not support this subliminal message, in fact the evidence suggests that vapour products are at least 95% safer than traditional tobacco products[3] with no negative health impact on bystanders.[4,5]

5. The provisions as set out in the Explanatory Memorandum[6] do not make the necessary provisions, nor take into account any unintended consequences of imposing a public and work places ban. In imposing such a ban, the Welsh Government will force existing vapour product users; many of whom

[1] http://www.ash.org.uk/files/documents/ASH_891.pdf - ASH UK, Use of electronic cigarettes (vapourisers) among adults in Great Britain
[2] http://www.addictionjournal.org/press-releases/e-cigarette-use-for-quitting-smoking-is-associated-with-improved-success-rates-
[3] http://www.biomedcentral.com/1741-7015/12/225 - Electronic cigarettes have a potential for huge public health benefit; Hajek P.
[4] http://informahealthcare.com/doi/abs/10.3109/08958378.2012.724728 - Comparison of the effects of e-cigarette vapor and cigarette smoke on indoor air quality; T. R. McAuley et al.
[5] http://onlinelibrary.wiley.com/doi/10.1111/j.1600-0668.2012.00792.x/abstract - Does e-cigarette consumption cause passive vaping?; T. Schripp, D. Markewitz, E. Uhde and T. Salthammer
[6] http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf - Public Health (Wales) Bill, Explanatory Memorandum

are recent switchers, into environments that are not conducive to improving their health.[7] Indeed, many recent switchers do find that being in a smoking environment will encourage them back to tobacco smoking.

6. Other unintended consequences of imposing a ban would also include a negative impact on small businesses that retail the vapour products. Many of whom may see a drop in custom should existing users switch back to tobacco products. These small specialist businesses provide much needed employment and trade to Wales and should not be neglected.

7. Furthermore, implementing the Welsh Government's preferred option as detailed in the Explanatory Memorandum[8] adds unnecessarily burdensome regulatory workloads to local authorities in ensuring that the legislation is both effective and implemented sufficiently. The E.M. quotes references to the USA where strict policy has been implemented, however the Health Minister fails to recognise that in such places where vapour product bans are in effect, smoking rates have ceased the rapid decline, and in some cases have in fact increased. There are of course several factors that can potentially account for this increase, including funding limitations to tobacco control programs; however in each instance of prevalence increase there had been a recent legislation passed imposing bans and incorporating vapour products alongside traditional tobacco products.[9]

8. It is clear from the Explanatory Memorandum that the main basis for the preferred option is the "re-normalisation" argument. There is a growing body of evidence that effectively eliminates this argument as the current rate of vapour products by never-smokers remains minimal.[10] [11] [12] [13]

9. Data provided by the US CDC Morbidity and Mortality Weekly Report[14] shows a decrease in combustible tobacco use with an increase in the use of vapour products. This data, in conjunction with data from Cancer Research UK and Action on Smoking and Health clearly demonstrates that the "re-normalisation" argument is invalid. No other cessation product has demonstrated such a clear and rapid decline in smoking prevalence.[15]

10. It is clear that a combination of strategies surrounding smoking cessation should include wide ranging ideas in tobacco harm reduction. The country with the lowest smoking prevalence rate (Sweden) sees the highest use of smokeless tobacco (Snus) that has largely replaced traditional tobacco use with only a ~12% smoking prevalence rate, and substantially lower tobacco mortality rate.[16]

11. Teenagers that use e-cigarettes is a concern, however the data cited in the EM contains serious flaws not least of which and by the authors own admission "This is a cross-sectional study, which

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[7] http://www.clivebates.com/?p=3096 - The Counterfactual, Bates C.
[8] http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf - Public Health (Wales) Bill ; Explanatory Memorandum P102-P130
[9] http://www.wsj.com/articles/new-york-citys-adult-smoking-rate-climbs-1410812653
[10] http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2015-06-12-research-shows-most-children-do-not-regularly-use-e-cigarettes
[11] http://www.ash.org.uk/files/documents/ASH_891.pdf ASH: Use of e-cigarettes among adults in Great Britain (May 2015)
[12] http://www.ash.org.uk/files/documents/ASH_959.pdf
[13] http://ec.europa.eu/public_opinion/archives/ebs/ebs_429_en.pdf
[14] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6414a3.htm?s_cid=mm6414a3_w
[15] HYPERLINK "http://www.addictionjournal.org/press-releases/e-cigarette-use-for-quitting-smoking-is-associated-with-improved-success-rates-"http://www.addictionjournal.org/press-releases/e-cigarette-use-for-quitting-smoking-is-associated-with-improved-success-rates-
[16] http://www.estoc.org/key-topics/the-swedish-experience

allows us to identify associations, not causal relationships.". Data gathered from within the UK does not show significant youth uptake.[17] A fair and proportionate response to address any potential youth uptake would need to address several issues, not least of which the factor that a number of youth already smoke combustible tobacco. Further reductions in smoking prevalence in this age group can be achieved by allowing current smoking youth access to vapour products with professional guidance. It is already clear that professional aid via Stop Smoking Services are beneficial, this can be enhanced by adopting vapour products as an option for cessation.[18]

12. It is clear from the early compliance data[19] that adherence to the existing legislation, with current enforcement by premise staff, is high. There are many factors at work in this instance, not least of which the continued "de-normalisation" of tobacco smoking alongside appropriate public and work place rules. Many premises have already implemented a ban on the use of vapour products to coincide with existing legislation; however an unintended consequence of imposing a vapour product ban on premises that currently allow their use will have a negative economic impact on those premises as many vapour product users will simply stop patronising said premises.

13. The proposal to implement a combined tobacco and nicotine products register does present certain difficulties surrounding the identification of which tobacco retailers are also selling nicotine products. The Government of Scotland identifies that a tobacco register does indeed aid enforcement of age restrictions legislation[20] however care must be taken to significantly identify "dual retailers"; i.e. retailers that sell both tobacco and vapour products, and "sole retailers"; i.e. retailers selling either tobacco OR vapour products, but not both. Additionally, the rules governing the registration must differentiate between the two type of retailer with the appropriate measures and restrictions for the relevant product.

14. The proposals as defined in the Explanatory Memorandum that relate specifically to vapour products will have an overall net negative impact on public health. Imposing the restrictions as defined will effectively send a message to the Welsh public that vapour products are as bad as combustible tobacco when the products have a clear health benefit.[21] [22] [23] However, public perception of these devices caused in large part due to inflammatory media headlines and misrepresented information is causing a significant shift in the view of the public relating to any potential harms.[24]

15. Inclusion of vapour products alongside combustible tobacco which has known harms only serves to reinforce the perception of the public that vapour products are not beneficial for smoking cessation

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[17] http://www.cancerresearchuk.org/about-us/cancer-news/press-release/2015-06-12-research-shows-most-children-do-not-regularly-use-e-cigarettes

[18] http://www.ncsct.co.uk/usr/pub/e-cigarette_briefing.pdf

[19] http://smokefreeengland.co.uk/files/83433-coi-smokefree-legislation-webtagged.pdf

[20] HYPERLINK "http://www.scottish.parliament.uk/S3_Bills/Tobacco%20and%20Primary%20Medical%20Services%20(Scotland)%20Bill/b22s3-intro-pm.pdf"http://www.scottish.parliament.uk/S3_Bills/Tobacco%20and%20Primary%20Medical%20Services%20(Scotland)%20Bill/b22s3-intro-pm.pdf

[21] http://www.biomedcentral.com/1471-2458/14/18

[22] http://www.biomedcentral.com/1741-7015/12/225

[23] http://www.biomedcentral.com/1741-7015/13/54/abstract

[24] http://ash.org.uk/media-room/press-releases/:electronic-cigarette-use-among-smokers-slows-as-perceptions-of-harm-increase

when the body of evidence clearly shows increased cessation rates[25] [26] with minimal, or zero harm to the user[27] or to bystanders.

16. Improvements to public health in relation to tobacco smoking, along with a significant decrease in smoking prevalence can only be achieved by embracing broad scale tobacco harm reduction measures such as Snus and vapour products.

[25] http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010216.pub2/abstract;jsessionid=A53234383572F5DCDBB9CCED547C654E.f04t01

[26] http://www.tobaccoinduceddiseases.com/content/pdf/1617-9625-12-21.pdf

[27] http://www.biomedcentral.com/1741-7015/13/54/abstract

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 British Body Piercing Association – PHB 08 / Tystiolaeth gan Cymdeithas Prydain ar gyfer Tyllu'r Corff – PHB 08

Public Health (Wales) Bill: Consultation questions

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
The British Body Piercing Association has set in place codes of practice and ethics which all members have adopted and use these in their work place. (please find attached) We have the most up to date training and follow the guide lines set by local boroughs. Body piercers need to be more regulated within their premises and have a recognised body in which they can rely on for support and further training.

Question 8

Do you agree with the types of special procedures defined in the Bill?
Yes, all of these areas of work are those of great skill and performed incorrectly can result in emergency medical treatment. Which in turn has consequences? The ability of the body piercer is defined not only by the teachings of the body piercer but confidence and ongoing support.

Question 9

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

By being able to amend current special procedures and aim to put in place newer protocol fits with keeping in with what consumers want. They want to know the best place to have a body piercing, and to know that the studio is certified.

Body piercing is something that has been used for years and does hold a rite of passage to not be regulated, but a huge percentage of body piercers do no withhold a basic understanding of body piercing. By bringing a standard of body piercing there would be far lesser impact on consumers not achieving the desired outcome and incounter problems.

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
By enforcing new licensing systems it brings the industry to a professional standing, Currently there are two candidates that have been working within the body piercing industry outside of EHO, TPIU and The Association of Professional Piercers, (APP) neither of these organisation warrant the merit of the body piercer you can simply fill in a form and make a payment, The memberships are not built to aid the body piercer. By bringing new regulations that are within a workable ability for piercing professionals I believe this will only impact in a positive light. Local authorities should be able to rely on potential training and associations to give help and guidance, but also be able to liaise with local business to keep them up to date with new requirements. By having more understand of the job that a body piercer does I believe will help to encourage people to want to push forward and become the industry recognised people they are.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
The use of age restrictions is something that needs to come in to affect more, especially with in intimate areas of the body. The BBPA do use an age restriction within the codes of practices and ethics, Which is highly regarded with in the studios of our members. Prohibiting intimate piercings for under the age of 16 will give moral standing. Being able to allow a parent or guardian to stand guardian of the person I feel will be adequately sufficient for above the waist piercings. Female's nipples should be considered for piercing over 18 only. However anything below the waist I believe should only be in performed by someone who has adequate knowledge of the anatomy of the genitals and has had further training with in this specific area and should not be performed on anyone under the age of 18. Actively working with the in industry allows me to be in constant communication with piercers and pierce'es on average the majority of under 16's are already aware that they will need a parent or guardian to be present when having their piercing performed.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
Yes, in my opinion the list is correct. I believe that the environment that the intimate piecing is taking place should be performed in a stricter platform. An utilised area which can be designated to the use of genital piercings only. Their also needs to be more information and advise based around these piercing for the general public. The basis of body piercing is training and consultation, the tool book creates a

really good basis to go forward with however it does not promote the ability's of the body piercer.

Weather a body piercer is piercing an ear, an belly button or a nipple the client knows they will have to be contact made in that particular area.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
Yes. There is a huge potential to be able to create an better environment for every one today.

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No. This policy has no merit in scientific fact. The ostensible purpose of the ban on smoking in enclosed public places is the harm to bystanders, but the vapour from e-cigarettes has been demonstrated to have no biological effect on bystanders. http://www.biomedcentral.com/1471-2458/14/18

Question 2

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?
No. Given the lack of any biological effect on bystanders and the huge benefit to smokers that reduce or completely stop their use of tobacco, I consider the Bill to be completely out of balance. The Bill would radically reduce the appeal of e-cigarettes to current smokers. One of the key factors in ensuring an effective switch is trying a multitude of flavours. On my first visit to a vape shop I anticipated walking out with a tobacco flavour liquid. Had I done so I doubt I would have vaped for a week. As I was able to try the flavours on the premises I quickly realised I didn't like any of the tobacco flavours and walked out with Cherry and Honeydew Melon instead. I have now been a non-smoking vaper for 14 months.

Question 3

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?
Yes. The difference between a cigarette and a vapouriser is abundantly obvious to any observers. The use of vaping devices of all shapes and sizes normalises vaping. It provides a key incentive for smokers to switch from the great health harm that is tobacco to the vastly safer alternative.

Question 4

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?
Yes. All the evidence so far from UK sources indicates that uptake of regular vaping amongst non-smoking teens is of very little significance. There is evidence of experimentation, but no evidence that this is leading to regular use. I believe the opposite is happening, the evidence that the youth smoking rates are actually falling indicates that experimentation with e-cigarettes is in fact replacing experimentation with tobacco and given the much lower addictiveness of nicotine without the additional chemicals found in cigarette smoke, this is providing a safety net that is actively preventing the uptake of tobacco use amongst young people.

Question 5

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

I would not support any register that place shops that sold only vaping equipment on the same register as shops selling only tobacco products, though separate registers might be useful.

Question 6

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?

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
Reducing the number of preventable deaths in Wales which are currently due to tobacco use has to be a high priority, I consider the e-cigarette component of this bill to be in direct opposition of that aim.

Question 20

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

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
I stopped smoking on the 21st of May 2015, and that is something I never thought would happen. Not only that I did it by accident. I bought my first vaping device on a whim, I thought it might be a laugh, as I had seen a girl at work using hers. I had no intention of quitting smoking, but 3 weeks later I was completely smoke free. If the proposals in this bill had been in place I would never have bought a vape pen, and I would still be smoking to this day.

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 Carole Coote – PHB 10 / Tystiolaeth gan Carole Coote – PHB 10

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No, I do not. There is no substantive research, or evidence that they pose a threat to the individual or those within their surroundings. There are too many 'could' and 'may' in the evidence put forward by the Minister of Health. Even the BMA is equivocal about their use. Against the evidence backing this claim are highly credible bodies and organisations.

Question 2

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?
No. There is evidence from many bodies such as Tenovus, Cancer Research Uk, and the body responsible for research into Tobacco Addiction that these are a very strong weapon in the armoury to assist people stop smoking cigarettes.

Question 3

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?

No of course it does not normalise the smoking of cigarettes. The early e-cigarettes looked like an actual cigarette. However, the cigarette used by the majority of vapers look more like pens or even torches. It is a massive leap to suggest they inadvertently promote smoking. I am proof of that.

Question 4

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?
Young people will experiment with all kind of illegal substances. Sadly, as I witness daily, cigarette smoking is still attracting some young people. These devices are hardly 'cool' and do not present as cigarettes. The only young person I have discussed this with told me that he was using an e-cigarette to get over his addiction to real cigarettes.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
Yes, I think ensuring that particular products are safe and not potentially dangerous might be a wise development, however, what you would not want is a restriction on choice and a monopoly of businesses that may be backed by persons of dubious motivation – i.e. cigarette manufacturers.

Question 6

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?
I am not sure. If it helped youngster give up cigarettes, it might be helpful to make them available perhaps under some form of supervision.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
No views

Question 8

Do you agree with the types of special procedures defined in the Bill?
No views

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
I am not sure what this would be mean for true democracy.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
Yes

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
Yes

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

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

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
Yes

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?

Yes

Question 16

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

Yes

Question 17

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?

Yes

Question 18

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

Yes

Other comments

Question 19

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

I am totally opposed to the proposals for e-cigarettes. Following the cigarette ban the effect, pub closures followed. ~The consequence was that customers disappeared, did not consume less alcohol but more! I recently spoke to an elderly gentleman who told me that since going on to e-cigaretes he was able to go to his local pub. The affect on his ability to socialise again was marked. Yes he was addicted to nicotine but he felt better mentally and ironically was drinking less.

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
Access to facilities to help people tackle obesity. Slimming clubs are money makers and food like tobacco and alcohol can be considered addictive. Obesity is a real problem in Wales. The NHS are unable to provide for those people not yet in need of acute/chronic disease and to initiative have so far failed.

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
I speak as someone who believes e-cigarettes saved my life. I am evangelical about seeking to divert people from smoking. I attended at least 6 courses of the anti-smoking clinics run by my health board. The drop off rate is high and success is low. Don't believe the statistics produced as I know how the follow up telephone calls were manipulated, that if, for example, you had actually avoided cigarettes for 6 months, that was taken as some indicator of success. I smoked for over 40 years, gave up several times but always lapsed. I have not smoked for over 4 years and will never go back. These products could e used as a force for good – ASH supports their use. Nicotine may be an addiction but you are not the moral police and it should be a matter of do no harm. Your reference from the WHO stance makes very dubious reading and I am afraid that you have drawn on bodies that support your premise rather than looked at the objective data, who have no special interest in the promotion of these product rather have seen clear positive outcomes from their use.

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 Vince Jarvis – PHB 11 / Tystiolaeth gan Vince Jarvis – PHB 11

I moved seamlessly from smoking to a P.V.(Personal Vapouriser) 3 years ago and have not looked back or smoked since! Let us not forget that the smoking ban was introduced to prevent the harmful effects of tobacco smoke to the public.This is as true now as it was then. I do not accept the "We've moved on" argument. Therefore I strongly object to to being treated as a smoker. To me,This proposed legislation is based on a personal dislike without any concrete evidence to back it up. Surely the top priority of the Health Minister is to save the Welsh Health and Ambulance service (Which is hard) rather than trample over our civil liberties (Which is easy) Who's next to face a ban? Junk Food because it normalises Obesity,or limited drinks at the bar in case it encourages Binge drinking ! We'll shortly have no lifestyle choices except the one this Welsh Government graciously allows us. Listen not only to the Pro ban lobby and the voices of the intolerant, also to the eminent anti ban groups I hope this is read without Blinkers and not listened to with deaf ears

LLANSTEFFAN & LLANYBRI COMMUNITY COUNCIL, CARMARTHENSHIRE

Part 6: Provision of Toilets

Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

Part 6 is of significance to the Community Council and therefore the evidence detailed below is confined to Part 6 only. Prior to presenting representations on the individual questions posed by Welsh Government, the Council wishes the following comments (in italics) on the four options reviewed in the Explanatory Memorandum to be given due consideration:

Option 1 - Do nothing:
The harsh realities that many local authorities have (i) made severe cuts to non-statutory public service expenditure and in consequence already closed public toilet blocks in many tourist villages, (ii) placed local councils under ill-conceived pressure to take over public toilets and (iii) inactive Public Facilities Grant Schemes (12 out of 22 authorities) demonstrate the total inadequacy of Option 1.

Option 2 - Re-hypothecate the Public Facilities Grant Scheme:
Once again, a totally inadequate option –illustrated by the indication that a mere 18 business premises would receive a grant of £500 to make privately-owned toilets available for public use within each local authority area.

Option 3 - Require each local authority to develop and publish a local toilets strategy. This is the Welsh Government preferred option:
Once again, an inadequate option focusing on a bureaucratic exercise rather than a comprehensive, feasible and proactive plan of action. A further concern relates to the fact that Welsh Government funding would remain mainstreamed within the Rate Support Grant, which could increase the vulnerability of public toilet survival as funding would be re-directed to other priority services at local authority discretion.

Option 4 - Require local authorities to ensure adequate provision of toilets for public use:
The statutory duty to 'develop and implement a toilet strategy' to ensure adequate provision is without doubt the key to ensuring that a practical, positive and quantifiable improvement would be made to both public health and the tourist economy of Wales. The Council firmly maintains that the Welsh Government argument backing the discarding of Option 4, namely the "prohibitive costs" to local authorities having to finance the construction of directly provided toilets (450 being a 'conservative estimate'), is over-exaggerated. Many coastal and rural villages in tourist destinations across the principality have existing public toilets, whereby the overriding issue is that the ownership and operation of these facilities should be

retained by the local authorities. Where the villages lie adjacent to national or regional tourist attractions such as the Wales Coast Path, the Welsh Government should make ring-fenced financial contributions to local authorities or Natural Resources Wales in order to provide high-class tourism infrastructure, similar to that demanded under the Blue Flag Scheme – the international quality mark for beaches.

* * * * *

The Council requests that the following evidence is taken into full account by the Health and Social Care Committee during the scrutiny of the Public Health (Wales) Bill.

1. <u>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?</u>
    - Whilst this represents a logical step forward in theory, in practice surely most local authorities have already produced such a strategy with the devolution of services agenda into its third year. Furthermore, it is important to raise a note of caution on the basis that the majority of council strategies tend to gather dust on shelves and represent a tick-the-box exercise.
    - A justifiable fear is that the main criteria of preparing and publishing such strategies will be to meet local authority capital and revenue expenditure savings targets.

2. <u>Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?</u>
    - With deep regret, the honest answer is no.
    - Any meaningful toilet strategy must encompass detailed (a) sustainability appraisals – economic, social, environmental and (b) financial and operational feasibility studies in order to secure long-term public access to well-maintained toilets in different parts of the county with different needs.

      <u>Evidence</u>: If County Councils cannot afford to operate their public conveniences (with Technical Services and Human Resources staff support, economies of scale, access to grants), then it is unreasonable and impractical to expect local councils to find the necessary finance and local agreement to take them over, particularly in tourist destinations (most local councils have over-worked part-time clerks, tight precepts, minimal bank reserves, few assets and most importantly, no mandate from the local electorate which generally does not use the local public conveniences).

      <u>Evidence</u>: A group of Carmarthenshire town & community councils from tourist villages collaborated with cross-party MP and AM support from Nov 2012 to Jan 2013 to investigate the financial feasibility of taking over their local conveniences – but – despite all these efforts, results demonstrated that any transfer would bankrupt smaller local councils in a very short period of time. To illustrate in the case of Llansteffan beach car park conveniences (2011/12 figures):-

£8.5k = the minimum annual operating costs
£1.5k = annual income from charging machines if installed

Evidence: In sum, the Cross-Party Statement circulated to Carmarthenshire County Council in February 2013 demonstrated that small local councils did not have the capacity to take on the responsibility for public conveniences along the Wales Coast Path, due to the unfeasible impact of 55% (Llansteffan) and 85% (Pendine) increases in precept required. Moreover, such councils would not secure a local mandate for such asset transfer for reasons stated above.

- The current focus on a 'local' toilet strategy to meet community needs overlooks (a) the 'county' importance of certain toilets to day visitors and holiday makers at tourist destinations such as Llansteffan, Laugharne and Kidwelly, and (b) the 'national' importance of certain toilets to day visitors and holiday makers adjacent to major attractions such as the Wales Coast Path.

  Evidence: National tourist attractions are located in the Carmarthenshire small villages in question including Wales Coast Path, Salmon Falls, Coracle Museum, Castles and Blue Flag beaches, where the public conveniences are chiefly used by tourists and day visitors and not by locals. For example, should the conveniences be closed in Pendine, then the prestigious Blue Flag beach status would be lost and the Wales Coast Path would be shunned. Visitors have high expectations and would not return if Carmarthenshire cannot provide for basic human needs.

  Evidence: The Wales Coast Path stretches for 68 miles along the scenic Carmarthenshire coastline. To its credit, this Welsh Government initiative has prioritised access for the less-abled in key hubs such as Llansteffan. However the fact remains that although many visitors and walkers may be sturdy and self-sufficient, they still have basic human needs and high expectations.

  Evidence: The stark reality presented to local councils in the small tourist villages of Pendine, Llansteffan, Ferryside, Kidwelly and Burry Port was the threatened County Council closure of public conveniences on Easter Sunday 31 March 2013. Thankfully concerted efforts resulted in a stay of execution from the 2013 holiday season to the present day. The closure scenario would have meant that keen walkers attracted from overseas and closer to home would have no access to public conveniences along the Coast Path from Laugharne to Pembrey Country Park, a distance of some 45 miles! A feasible long-term future must be secured at national level for essential infrastructure including toilets along the Wales Coast Path.

  Evidence: It is heartening to learn that Anglesey County Council genuinely listened to local council's concerns in 2011 and the evidence put forward by the tourism sector and amended its political decision accordingly. The

majority of public toilets are located close to the coastline of the Island; this being an important part of service provision to tourists that visit the Island, especially near the busier amenity beaches. Anglesey County Council has clearly acted upon the fact that public toilet provision is important to areas relying on tourism income, or seeking to develop their profile as a visitor destination. Tourism's contribution to the UK economy could grow by more than 60% to £188bn by 2020, as suggested by a report by Deloitte and the forecasting organization Oxford Economics.

Evidence: British Toilet Association 2011: "Tourists include elderly people, disabled people, women, men and children, and amongst them will be those with various medical conditions requiring access to public toilets. They arrive in a variety of transport and their visit may include walking tours and beaches as well as visits to specific places of interest. The growth of festivals requires thought given to temporary toilet provision – and gender equality – to avoid fouling the area, particularly where there are a lot of people crowded together. Short break holidays are rising in popularity and are particularly enjoyed by those over 55 – an age group most likely to need public toilet facilities. Families on beach holidays also require easy to access toilets. Research carried out by ENCAMS [now Keep Britain Tidy] found that the availability of public toilets was an important factor in choosing a beach to visit. To be a visitor or tourist to any area, just getting there will probably involve a visit to a toilet. Tourists always remember their toilet experience – especially if it is a bad one - as illustrated by letters to various local newspapers! Visitors have high expectations but sadly, many local authorities in Wales and throughout the UK make disgracefully poor provision."

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?
    - The provision in the Bill to ensure appropriate engagement with communities will only prove to be effective and consistent in practice where the development and implementation of toilet strategies are introduced in law as "statutory duties" to be undertaken by the local authorities in close partnership with town and community councils and their communities, day visitors and holiday makers.

    - Any engagement process must prioritise genuine participation, rather than a standard consultation tick-the-box exercise that has been too commonly encountered in recent decades.

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?

- Welsh Government guidance on the development of toilet strategies must be issued to local authorities to provide the overarching framework and action planning processes which will meet the public health needs of all members of the public – residents, day visitors and tourists – and secure a sustainable long-term future for public access to toilets which are fit for purpose.

5. What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
    - It will be essential to consider toilet facilities within 'public' settings in receipt of public funding, in particular with respect to county council owned and operated toilet blocks in small coastal and rural villages which represent a county, regional and national tourism infrastructure asset e.g. in Llansteffan and Laugharne situated adjacent to the Wales Coast Path. Priority must be to secure long-term, ring-fenced public capital and revenue funding for such assets.

    - It will also be essential to consider toilet facilities within 'private' settings in receipt of public funding, such as the Welsh Government Public Facilities Grant Scheme with the caveats listed below.

      Evidence: A grave note of realism should be highlighted during consideration of the Bill. The Welsh Government Public Facilities Grant Scheme has made minimal if any contribution to the public health of visitors requiring toilet access in many small coastal and rural villages to-date. To illustrate, the public toilet block in Llansteffan beach car park is frequently closed in the high season due to sewerage blockages. The only local businesses are an ice cream van, a chip van and a tea rooms. The latter has only one outside toilet (not the qualifying criteria of 4 toilet cubicles) which is totally inadequate for the high volume of visitors encountered during spring, summer and autumn. A Council car count undertaken on Bank Holiday Monday 6th May 2013 at 15:30 totalled 286 cars x 3 (average car occupancy) = 858 visitors = concrete proof of a significant demand for public access to toilet provision in a popular tourist destination where private businesses cannot cope with the demand.

      Evidence: British Toilet Association 2011: "However, some people do not want to enter pubs for a variety of reasons and children may not be welcome. Community toilets may not be able to cope with large groups of people and the premises may not be open when needed. Some local authorities are now finding there are fewer companies willing to allow the public into their premises just to use the toilet. With public toilet closures and no other facilities available those who need frequent access to a toilet are restricted in the length of time they can risk being away from home. Community partnership toilets should not be used to replace public toilets, but may be a useful addition to a particular area if properly signposted."

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?
    - Explicit recognition of the public health needs of day visitors and holiday makers must also be included to ensure that the needs of all groups are taken into account. On the grounds that international and national tourist visits to Wales make a significant contribution to the Welsh economy, it is disappointing to note that these groups have been virtually disregarded in the Explanatory Memorandum.

7. Do you believe the proposals relating to toilet provision in the Bill will contribute to improving public health in Wales?
    - The proposed Option 3 may make a minor contribution within those local authorities which have lagged behind in preparing a toilet strategy.
    - However, the Minister is urged to act upon the inescapable fact that the proposed Option 3 – the preparation and publication of a local toilet strategy - is far too limited. Option 4 must become the preferred option on the basis that it represents the only option that could make a long-awaited and ensured improvement to public health in Wales on behalf of both communities, day visitors and tourists.

      Evidence: Reference in the Bill must be made to:

      (a) The importance of partnership-working with Tourism, Economic Development and Property sections of local authorities, due to the cross-cutting theme of toilets for public access.

      (b) The importance of partnership-working with town and community councils on a level playing field i.e. genuine participation, not tokenistic consultation.

      (c) The public health needs of tourists and day visitors in small coastal and rural villages and the significant contribution of tourism to the Welsh economy.

      (d) The practical and financial implications of devolution of services and community asset transfer upon both tiers of local government.

To close the Council trusts that the Health and Social Care Committee will give detailed consideration of the evidence presented in this paper. Thank you.

Llansteffan and Llanybri Community Council

Carmarthenshire

22nd July 2015

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 Under Age Sales Ltd – PHB 13 / Tystiolaeth gan Under Age Sales Ltd – PHB 13

24th July 2015
[redacted]

Health and Social Care Committee
National Assembly for Wales
Pierhead Street
Cardiff
CF99 1NA

Dear Committee,

Thank you for providing the opportunity for interested parties to comment on your call for written evidence relating to the Public Health (Wales) Bill.

We are a social enterprise that specialises in helping retailers to tackle under age sales. We provide support, training, point-of-sale materials and advice to retailers. We also provide the Law of Age Restricted Sales legal text book covering both England and Wales.

We are happy for our response to be published in full and we will also publish our response on our website at www.underagesales.co.uk. In addition, we would ask that any quotes taken from our response are used in the context in which they are intended and we would be happy to advise if the context is not clear.

Public Health (Wales) Bill

Part 2 – Tobacco and Nicotine Offences

We have no comments to make on Chapter One.

In relation to Chapter Two we welcome the proposals in this Bill to establish a national register for Wales of retailers of tobacco and nicotine products.

We have no comments to make on Chapter Three

Chapter Four, Clauses 41 – 44 - Despite reading these proposed clauses several times, we are struggling to understand them. That is rather worrying for how clear they would be to non-expert readers. We think the intention behind the proposal (to prohibit delivery drivers from handing over tobacco to unaccompanied children) is laudable, but we are concerned that it has become lost in overly complex and legalistic language. We recommend a complete redrafting of this Chapter to simplify the language and ensure that it meets the intended purpose.

Part 3 – Special Procedure Licensing

We welcome the creation of a licensing regime in Wales for special procedures.

Clause 46 – we recommend that 'branding and scarification' are included in the list of special procedures (as they are in the list of special treatments in the Greater London licensing regime). Branding and scarification are causing permanent scar tissue to be formed as a cosmetic or ritual procedure. They carry the same hygiene and public health risks as tattooing and piercing.

Clause 51(2) – we recommend that an additional licensing criteria be added here: "(d) the protection of children from harm caused by special procedures" – in our view the protection of children ought to be a core licensing criteria for the issuing of special procedure licences and will allow licensing authorities to take into account such matters as irresponsible marketing, proximity to schools, consideration of premises layouts and prior offences related to under age sales. In addition, we believe that the licensing authority ought to be able to impose conditions about the age at which certain special procedures can be performed where these are not covered elsewhere in legislation.

Clause 52(2) – similarly to clause 51(2) we recommend that an additional category of mandatory criteria be added here: (x) the appropriate age (of the customer) at which special procedures may be performed (where these are not covered elsewhere in legislation).

Clause 55(3) – we recommend the range of relevant offences be extended to include any offence relating to the underage sale or supply of a product or service. In particular we note that many premises of a type that would apply for a special procedure licence may also provide sunbed services and, increasingly, we find they supply nicotine products, such as e-cigarettes or liquids. We would therefore recommend that local authorities have the discretion to take into account, for instance, allowing a person under 18 years of age to use a sunbed, as a relevant offence.

Part 4 – Intimate Piercing

We are concerned about the juxtaposition of this new proposed offence and the existing much more serious offences of sexual assault.

We note the views in the Explanatory Memorandum about the potential limitations of the Sexual Offences Act 2003, but nevertheless consider that genital piercing of children would be covered by those provisions.

In addition, although not mentioned in the Explanatory Memorandum, we would draw the Committee's attention to the Female Genital Mutilation Act 2003. In guidance under that Act, the piercing of a girl's labia majora, labia minora or clitoris would constitute FGM and, therefore, be an offence. We recognise that the definition in proposed **Clause 79(2)(i)** of 'vulva' would cover a

broader intimate area than the narrower definition of FGM, but nevertheless, we feel that it is important that these much more serious offences are reflected on the face of this Bill.

We, therefore recommend that proposed **Clause 78** be qualified as follows:

> (e) this section does not apply to any offences that may be committed under either the Sexual Offences Act 2003 or the Female Genital Mutilation Act 2003.

Clause 88 – we note the provision for test purchasing by local authority officers. We suggest that this is going to present some very serious problems for local authorities to enforce these provisions, not least of which the safeguarding and protection of children used in test purchasing operations. Whilst the 'make arrangements' aspect of the proposed offence in **Clause 78(1)(b)** may provide an opportunity for the local authority officer to step in during a test purchase before the procedure goes ahead, it is conceivable that it could be argued such 'arrangements' had not been concluded and, therefore, the offence had not been established.

We would recommend some specific protection for test purchasers on the face of the Bill, such that it would be difficult to argue that a test purchaser had not 'made arrangements' to have an intimate piercing without exposing themselves to the offender. Perhaps words along the lines of:

> 'for the purposes of test purchasing under this Part, an offender is deemed to have 'made arrangements' for an intimate piercing of a test purchaser at the point when they agree to discuss an intimate piercing without having taken reasonable steps to verify the age of the test purchaser.'

We have no comments to make on the remainder of the Bill.

Declaration

We are happy to declare that our services, in providing training and support to retailers to prevent under age sales, are funded by those retailers (including tobacco retailers) and by trade associations and manufacturers (including the tobacco industry). However, our views are our own and we have not been funded, commissioned or otherwise encouraged to provide this response to you by the tobacco industry or any of their representatives.

We hope that the information that we have provided is useful and we would be happy to discuss any aspects of our response further. I can be contacted [redacted] or [redacted].

Yours sincerely,



Tony Allen
Managing Director

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 Dr David Upton – PHB 14 / Tystiolaeth gan Y Dr David Upton – PHB 14

Consultation questions –Individual Answers from Dr David Upton FRSPH, MCIPD (I have no conflicts of interest in this matter – Only an urge to see evidence based decision making in matters of public health.)

Part 2: Tobacco and Nicotine Products

i. 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?

No. There is no evidence to support such a position. Studies that have been published apparently showing toxicity appear not to have been undertaken by researchers who understand normal usage of these devices. In such studies, the equipment has been run at levels which would be impossible to tolerate in practice and hence are not applicable to the real world.

Those studies conducted using real world conditions show extremely low levels of nicotine and propylene glycol in 'second-hand vapour' and very little else. Neither of these would have any significant impact on bystanders even if a large number of vapers were using them at the same time.

Adopting such a policy would, in effect, be encouraging ex-smokers to take-up combustible cigarette smoking once again. We should be helping smokers to move to e-cigarettes as the research clearly indicates that they are an effective harm reduction method.

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ii. 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)?

This is not supported by the evidence and is likely to have a negative overall effect on public health

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iii. 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?

The provisions of the bill will not achieve a balance since the only ‘dis-benefits’
are in the minds of those who oppose them. I believe that there are two factors here; First, some people do not like the visual similarity with traditional cigarettes. Second, they feel that e-cigarettes might undermine their previous campaigns against smoking.

Visual similarity is not an acceptable basis for legislation – Were we to thus legislate, we would have to sanction water because it looks like vodka and ignore radon gas because it cannot be seen.

On the second point, there is no evidence to support this standpoint. Those adopting this argument frequently cite what they term the ‘gateway effect’ (of leading users onto traditional cigarettes). The research evidence appears to support a gateway away from smoking.
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iv. 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 use of e-cigarettes, if there is any effect at all, is one of normalising NOT smoking. Only the first generation of e-cigarettes resemble traditional cigarettes – the so called ‘cig-alikes’. Most users rapidly progress to devices that look nothing like a cigarette and the pervading smell of tobacco is not present in the novel devices but is obvious where combustible tobacco is in use.
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v. 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?

At this point, the research indicates an extremely low level of use in young people and that those who do use e-cigarettes were invariably already smokers. This is an area that we must carefully monitor in the future but it is not presently an issue.
It is highly unlikely that a user of e-cigarettes who has not previously

been a smoker would ‘progress’ to smoking tobacco products. There are a number of factors here; first, the price differential favours e-cigarettes. Second, the physical experience of cigarette smoking is just as unpleasant (if not more so) to a vaper as it is to a first time user. Those of us who smoked in our early teens, invariably ‘stuck with it’ until it became pleasant. The same path is not there where there is a more pleasurable alternative. Third, the health consequences of tobacco smoking are well known and this creates a further incentive for individuals to use a safer and more pleasurable alternative to combustible tobacco.

Often cited by opponents of e-cigarettes is the view that flavours are appealing to children. Flavours are also appealing to adults. Nicorette gum and other NRT also come in flavoured versions. To understand why the liquid used in e-cigarettes is flavoured, one needs to consider what happens to the sense of taste and smell when an individual gives up smoking. Many initially use either tobacco or menthol flavoured liquids to mimic the experience of smoking. However, as the senses of taste and smell return, many people find that they prefer to move away from tobacco flavours. Thus a wide range of flavours are crucial in facilitating individuals to remain away from tobacco. The result of using flavours (other than tobacco) is that ex-smokers are far less likely to relapse. Variety in liquids enables the user to switch to a different flavour when their taste buds tire of a particular variety.

The view that flavours were produced to lure children is laughable and shows misunderstanding of the product.
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vi. 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?

As was pointed out above, only cig-alikes are potentially a problem here since most devices look nothing like a cigarette. Both the smell and the length of time that cigarette smoke lingers compared to that of vapour makes distinguishing them relatively easy. As I understand it, at the moment there is strong adherence to the smoke-free legislation and permitting the use of e-cigarettes is likely to improve adherence rather than diminish it.
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vii. Do you have any views on the level of fines to be imposed on a person guilty of offences listed under this Part?

This legislation must not be passed and therefore no fine should be imposed.
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viii. Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?

I would question the value of such an initiative, given that internet sales are possible and that such a register could only cover Wales.
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ix. Do you believe the establishment of a register will help protect under 18s from accessing tobacco and nicotine products?

No. See previous answer.
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x. Do you believe a strengthened Restricted Premises Order regime, with a national register, will aid local authorities in enforcing tobacco and nicotine offences?

No
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xi. What are your views on creating a new offence for knowingly handing over tobacco and nicotine products to a person under 18, which the is

legal age of sale in Wales?

This is a problematic area. Whilst I can see the appeal of restricting under age supply, criminalising it is nonsense. For example, if my 17 year olds were to be found smoking, my instinct would be to buy an e-cigarette for them. That would make me a criminal for practicing harm reduction. Legislation must work in the real world. Children will experiment. We can't legislate for that.

As I understand it, suppliers in the UK adopt an 18+ policy voluntarily. This should be mandatory at point of sale BUT it should not be against the law for a responsible adult to purchase e-cigarettes on behalf of an under-18 in their charge.
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xii. Do you believe the proposals relating to tobacco and nicotine products contained in the Bill will contribute to improving public health in Wales?

I believe that if this legislation is passed, history will hold those responsible for failing to take responsible action to improve public health. The minister has been sent the relevant research by others and AM's need to become familiar with it themselves. This proposed legislation is a prime example of (presumably) well-meaning people taking decisions without being in possession of the facts.

The research quoted by the minister to support his position would not stand-up to academic scrutiny and an objective view of the research leads me to conclude that this proposal must be stopped from progressing further.

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 British Acupuncture Council – PHB 15 / Tystiolaeth gan Y Cyngor Aciwbigo Prydeinig – PHB 15

British Acupuncture Council

Response to Consultation on Public Health (Wales) Bill

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?

The British Acupuncture Council (BAcC) believes that the introduction of a new compulsory national licensing scheme for special procedures will remove many of the anomalies which have arisen in the enforcement of Local Government Miscellaneous Provisions Act (1982) as amended by the Local Government Act 2003. The existence of non-mandatory model byelaws has not always led to consistent adoption of similar models by local authorities, and the BAcC's experience is that local enforcement across the UK as a whole has been variable, with many authorities blurring the distinction between legal requirements and best practice advice in enforcement. A standardised system across Wales will both eradicate idiosyncratic interpretations of the law and create a single reference point for discussion and consultation on any variations which might be required in line with developments in health and safety requirements.

It follows that the BAcC supports any provision to approve the premises or vehicles in which or from which special procedures are performed. The provision of clear guidance as outlined in the consultation document would set down a standard which would enable practitioners to ensure their premises were satisfactory, and as above, make very clear what upgrades and updates may be required in future.

In summary, the BAcC supports these proposals, with the caveat that the advantages of a centralised system could be undermined unless suitable consultation procedures are in place for future development of the licensing conditions. The BAcC was heavily involved in the drafting of the model byelaws by the Department of Health in 2005/6 and was able to bring important practitioner concerns to the fore when the national guidelines were created. The special procedures covered by this proposal range from the minimally invasive to the necessarily near-surgical, and it is important to enshrine a level of proportionality into guidelines affecting a range of techniques to avoid an unnecessary and unfair levelling up of requirements. This has to involve input from the professions, and the BAcC hopes that this will be taken into account if these proposals become law.

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

The types of procedure outlined in the Bill are consistent with those in primary legislation elsewhere in the UK, except Greater London where 'special treatments' has a wider definition under the London Local Authorities Act 1991. The BAcC would not wish to see any changes to this list at this stage.

However, the emergence of variations on the standard theme has been considerable over the last forty years, and there are a number of techniques used in Traditional East Asian medicine, for example, which are proscribed by regulatory bodies like the BAcC but may actually be used by practitioners who choose not to register with a voluntary association. The example of 'wet cupping', a procedure widely used in China, demonstrates how there may well be variations to any of the named disciplines in the Bill which could be advertised and used without reference to the provisions of the Bill for want of inclusion within the definitions. The BAcC would welcome further discussion during the implementation of the Bill about the scopes of practice of the various techniques and what a local authority could reasonably claim to hold jurisdiction over.

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

The BAcC believes that such a provision is essential to avoid unnecessary expense or unnecessary delay in extending the range of procedures covered by the legislation. As noted above, however, the BAcC would welcome explicit rules for consultation if secondary powers are invoked in this way.

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 BAcC is pleased to see that registration under the Professional Standards Authority's AVR scheme has been accepted as a basis for exemption. Its experience of submitting itself to this new scheme has been that the requirements for accreditation have been onerous and robustly enforced, and have demonstrated this this is not a 'soft option.'

The only cautionary note which the BAcC would like to sound is in relation to the exemption granted to registrants of professions regulated by statute. Its experience is that while most doctors and physiotherapists who undertake acupuncture belong to the relevant special interest bodies within their professions (the British Medical Acupuncture Society and Acupuncture Association of Chartered Physiotherapists), many other registered professionals like osteopaths and chiropractors go 'off the radar' in the absence of equivalent special interest bodies within their professions. This has meant that neither safety nor training standards of such practitioners are vetted, and the BAcC does not believe that this is entirely adequate. Set against the argument that the threat of loss of title ensures compliance with appropriate rules is the counter argument that you can't know what you don't know, and that it is not satisfactory to find out that something has gone wrong after it has gone wrong.

The BAcC would favour some form of explicit statement that there were powers within the Bill to inspect the premises of exempted practitioners where concerns has been raised about their standards of practice, and would be happy to see this enforced in relation to its own members. The logic applied in Greater London is that the exemption is granted on the assumption of maintaining exemplary standards, and therefore failure to maintain standards

should set aside the veil of exemption. Given that there are several published and readily accessible standards for safe acupuncture practice and recognised training, the BAcC believes that a local authority should have powers within the Bill to inspect and enforce precisely as it does with other licensees.

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

The BAcC is generally satisfied that the system as outlined in the Bill can be enforced effectively by local authorities, and believes that the clarity of the national statements and guidelines will eradicate those problems which it has met elsewhere. These have primarily been the generation of idiosyncratic rules by local Environmental Health Officers based on their personal beliefs, and the turnover of staff which has meant that incoming officers have not been properly inducted into the system, and have applied it somewhat arbitrarily. The new licensing arrangements should ensure that the reference material Is available and consistently applied across the principality.

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

There is no doubt that a clear statement of standards and enforcement will be of benefit to public health in Wales, not least because an increasingly well-informed public used to electronic access to information will be able to find out easily what the relevant standards are and have confidence that anyone licensed within the new system has met and continues to meet them. This will also benefit the practitioners themselves, whose profile will be enhanced by demonstrating that the public can have trust that they are safe and competent.

The BAcC is grateful for having been invited to participate in the consultation, and would welcome any future invitations to be involved in the drawing up of detailed guidelines for acupuncture and acupuncture practitioners.

4th August 2015

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 Graham and Karen Wiseman – PHB 16 / Tystiolaeth gan Graham a Karen Wiseman – PHB 16

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No I do not. Vapour has been shown to be 95-99% safer than tobacco smoke, and the decision should be left with property owners to decide on whether vaping is allowed on their premises.

Question 2

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?
No I do not. There needs to be more encouragement and incentive to help current smokers to switch to vaping, and forcing them outside to smoking areas with lots of tobacco smoke will not achieve this at all, especially in the early days of them trying to switch. I have been tobacco-free for almost 3 years due to vaping and have felt the health and financial benefits for myself – the more people I can encourage to do the same, the better. There are no down-sides to vaping.

Question 3

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 use of personal vapourisers absolutely does not re-normalise smoking in any way – it normalises NOT smoking. As to the comment about their appearance replicating tobacco cigarettes just shows how out of touch with reality the Minister is – hardly any vapers use 1st generation cig-a-likes, they are much more likely to use 2nd and 3rd Generation devices which look NOTHING LIKE tobacco cigarettes, are effective at helping smokers quit tobacco, and do not promote smoking AT ALL.

Question 4

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?
No, e-cigs are not particularly appealing to young people – they are to some, but this is almost exclusively in young people who are already tobacco-smokers. The Gateway theory has been disproved time and time again in studies in Europe and the USA, showing that e-cig use is a gateway AWAY FROM tobacco use, and not the other way round. The latest study of teenage use of e-cigs in the US shows a rise, but that is in conjunction with the lowest-ever recorded rates of tobacco smoking in that age group, more proof that e-cigs are a gateway AWAY FROM tobacco use for young people.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
No, for several reasons. 1. It would treat 2 products at either end of the scale of harm to health in the same way. 2. The administrative burden to compile, maintain and enforce this would be immense and costly. 3. It would serve no useful purpose.

Question 6

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?

For tobacco only. If this was implemented for any nicotine-containing products, then I assume there would have to be an exemption for doctors prescribing and pharmacists dispensing things like nicotine patches, gums and inhalers to children of 12 years old and above to try and stop them smoking where they have been found to be doing so? If so, there should also be exemption for parents to give their children these and vapour products in the same circumstances, i.e. where they have found their child to be smoking and want to help them stop.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
No I do not. This particular Bill seems to be either targeting things that could improve the health of large numbers (in the case of vaping/e-cigs), or trying to disproportionately regulate things which cause minimal quantities of harm (tattoo and piercing parlours) to very small numbers of people. The public toilet issue would require considerable funding to be effective, it is a provision that a lot of Local Authorities have had to cut back on over the last couple of decades as budgets have been cut – will there magically be a pot of money found by the Assembly to pay for this?

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
Alcohol availability, excess consumption, pricing and access by under-18s is a far bigger problem in Wales than all the things in this proposed Bill put together, yet no action put forward to combat any aspect of this. The obvious question is Why not?

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
In these austere times, I cannot understand why the Assembly government is proposing a Bill which will cost a lot to implement for very little if any gain in Public Health. Indeed, it has the potential to do more harm than good if the vaping/e-cig elements are passed. It's about time the Assembly government sorted it's priorities out.

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

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

Evidence from The City of Cardiff Council – PHB 17 / Tystiolaeth gan Gyngor Dinas Caerdydd – PHB 17

HEALTH AND SOCIAL CARE COMMITTEE CONSULTATION ON PRINCIPLES OF THE PUBLIC HEALTH (WALES) BILL

Submission of Evidence by the Health, Safety and Communicable Disease Team, Public Protection Shared Regulatory Services, Cardiff.

Introduction:

The Health, Safety and Communicable Disease Team, Cardiff are responsible for the enforcement of health and safety legislation in the workplace, local byelaws on matters relating to the business of acupuncture, tattooing, semi-permanent skin-colouring, cosmetic piercing and electrolysis and health protection legislation. In addition the team investigates sporadic and outbreak cases of notifiable communicable disease and takes all action required to contain, control and prevent onward transmission. We have therefore responded to sections pertinent to our responsibilities.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales these procedures are acupuncture, body piercing, electrolysis and tattooing.

 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?

We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators.

We are of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

We have the following concerns regarding existing provisions:

- *There is no requirement for a practitioner to have training or experience to set up a tattoo studio. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk.*

- *Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the byelaws. This may be viewed as a purely administrative offence when Courts are considering sentencing.*
- *Current registration requirements rely on being able to prove that a person is carrying on a business and this can be difficult because most unregistered tattooists ('scratchers') work from home and deny that they receive payment.*
- *There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws,*
- *Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and the Health and Safety at Work etc. Act 1974. We have used Request for cooperation letters and Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle "scratchers". In short current legislative provision hinders efficient use of officer resources and time*
- *All are Part 2A order investigations have related to the carrying out of unregistered tattooing from domestic premises. We do not enforce health and safety in domestic premises and where a risk to health cannot be categorically proven with have little effectively legislative options to apply.*
- *New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.*
- *Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.*

We agree with the concerns of the Chartered Institute of Environmental Health (CIEH) that many procedures are being done by people with little if any knowledge of anatomy, infection control or healing processes ***(CIEH, 2014)****.Our experiences concur with this statement*

We would offer the following observations on the proposal regulations:

• *Level 3 fine (£1,000) is too low to act as a meaningful deterrent. The sunbed legislation, which is similar in nature, includes a fine of up to (£20,000); this would be a more appropriate sum.*

• *In determining whether to grant a license a Local Authority should be able to consider whether the applicant is a "fit and proper person" and such a test should be included (akin to our tried and tested procedures for taxi licensing). The test should permit the LA to take into account "any other information" (beyond the "relevant offences" listed in the draft bill) in determining that question. The current proposals do not offer sufficient safeguards.*

• *We would be opposed to grandfather rights for existing traders. In Cardiff we regularly investigate hygiene complaints in well established studio and a recent Myco bacterium chelonae cluster involved investigation of 2 registered studios in Cardiff and one registered tattooist based in Newport.*

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses and skin infections.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future in an efficient and timely manner.

We will be pleased to work with WG officials is relation to such matters.

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

We absolutely support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. In a competitive market studios in Cardiff are always keen to expand into new and emerging body modifications including branding, dermal anchoring, scarification and tongue splitting. These procedures provide the potential for serious harm and infection. We feel it is absolutely essential that the provision to amend the list of special procedures reflects the need for amendments to be made expediently and without unnecessary delay. The list of special procedures will need to be dynamic to be able to incorporate new procedures as trends change. A lengthy amendment process will undoubtedly leave local authorities 'on the back foot', and having to rely on other legislation, for example, Health Protection Legislation 'Part 2A Orders' to tackle new and emerging procedures.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive activities underground and cause further issues or potentially make it more appealing to some people.

 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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

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

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Evidence of public health risk in relation to such procedures is clear. We take the view that any procedure that involves the piercing of the skin poses a very real risk of infection and disease from blood born viruses many of which can be a serious risk to health and that anyone undertaking such procedures should be competent to do so without putting a person at risk.

Current controls are outdated and inadequate. We need to be able to protect the public to better prevent people from undertaking these procedures if they are not competent or are not fit and proper person to be undertaking such practices. We need also to ensure that the conditions in which such practices take place are hygienic and will prevent infection risks.

We are seeing in our day to day work evidence of a growing range of procedures that put the public at risk. These include: dermal implants, beading, ashing, scarring, dermal fillers, tongue splitting, and a range of other procedures that we might loosely describe as "body modification". We feel strongly that regulations should permit all such procedures to be controlled and that the regulations should allow the list of procedures to be extended to cover any form of body modification that may arise in the future.

Some procedures such as "ashing" might not fall within the regulations as proposed. Ashing may fall outside of the current definition of tattooing (which relies on the use of pigmentation) and care is needed that definitions do not inadvertently exclude procedures that are intended to be covered.

In relation to extending the list, we recognise from an enforcement perspective that we are familiar with the necessary controls and safeguards needed in relation to more traditional procedures. There is merit in a considered and stepped approach to extending the list of special procedures so that we are able to develop training, suitable competence

assessments and necessary guidance in relation to the more novel procedures. We are also aware that consideration is needed in distinguishing between a legal service that we might appropriately control and what might be considered an illegal act of assault. We feel some clarity will be required in relation to that question.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

 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?

Yes.

We share the view of the Chartered Institute of Environmental Health (CIEH) that 16 is not an appropriate age for an intimate piercing because:

- *The decision to have an intimate body piercing should be made by a mature individual, we believe that 16 years of age is not sufficiently mature.*

- *Intimate body piercings require a higher standard of aftercare than tattoos, as they are potentially more susceptible to infection. This level of aftercare requires a mature approach to which a 16 year may not be capable of fully committing.*

- *Whilst the jewellery inserted into an intimate body piercing may be removed any scarring or damage inflected by the procedure will be permanent. This is particularly important when the skin the subject of the piercing is still growing and its function may be compromised by scarring or thickening. At 16 years an individual is still growing and therefore the risk of damage to skin is greater.*

Our experience of working with skin piercers and tattooists in Cardiff is that legislative requirements need to be simple and consistent. here is considerable potential for confusion to arise if there is a different age restriction for body piercing and for tattooing. We consider that it would be easier for practitioners, enforcement agencies and individuals if the age restriction for both was to be the same.

We further consider that an age restriction of 16 years for intimate body piercing is likely to give rise to call for the age restriction for tattooing to be reduced to 16 years.

We believe that the age restriction for intimate piercing should be 18 years.

Local authority officers are aware that such procedures are taking place and it is our view that such intimate procedures should be illegal on under 16s to protect this vulnerable group from potential risks.

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

Yes. However we also feel there is a case to add the tongue. In addition to the relatively higher risks of infections associated with tongue piercing, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list of intimate parts.

 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?

We support such proposals including the proposal to make it an offence "to enter into arrangements". This would support enforcement of the provisions including "test purchasing" by local authorities.

We recognise the need for police support in particular in relation to evidence gathering given the intimate nature of such offences and the provisions need to take account of that.

Any duties placed upon local authorities must be supported by adequate funding to enable them to be operated and enforced in an effective manner.

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

Yes, see above.

 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?

Potential costs and benefits have been considered but it is suspected that these are conservative.

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

This appears to be the most cost effective approach to managing this public health risk

 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?

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

Other comments

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

No

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

Yes

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 Gordon Beard – PHB 18 / Tystiolaeth gan Gordon Beard – PHB 18

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
Definitely do NOT agree . Banning should be based on robust medical and scientific evidence,none exists. Theoretical concerns should not form the basis of legislation.

Question 2

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?
I believe the exact opposite will be the case, no balance will be achieved with these proposals. ~55,000 have quit smoking completely with the use of e-cigarettes out of a total of 125,000 users. Of the remaining 70,000 who are in transition the messages that will be inadvertently transmitted to them is 'Why bother',this has to be an unintended consequence and will have a negative impact on the Welsh smoking rates which have moved from 24-20% in a period 2007-present, I would strongly argue that e-cigarettes have contributed significantly to the rate of decline.

Question 3

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?

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The only normalisation is that of ‘non- smoking’, what many people fail to appreciate is that ‘cigalike’ in appearance devices represent a declining fraction of the market - ~40% . Newer more efficient types have zero resemblance and thus do not replicate cigarettes whatsoever.

Question 4

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?
All research would indicate that non-smoking youth have little interest in e-cigarettes, no or little evidence exists of this ‘gateway’ that the question implies. CR-UK,ASH, ONS all have produced data that clearly states little evidence of this theoretical ‘gateway’ Quite the reverse in fact,if a ‘gateway’ exists it is from tobacco cigarette smoking to vaping . 1.1 million sole users in the UK (ASH stats)

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
Partially yes, but the two should be separated . A National Register of retailers of non- tobacco nicotine products would be preferable. Presumably registration would be made compulsory if introduced?, this may eliminate some of the more unscrupulous vendors and allow notifications to be speedily acted upon Registration should be free or at very minimal cost

Question 6

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?
This creates a moral dilema in my opinion, I agree that ‘proxy- purchase’ of tobacco products for U-18’s should be an offence. However, I disagree that the same offence for example to the parents/relatives of a smoking youth wishing to transition to e-cigarettes is appropriate or justifiable. The parents in this circumstance would be reducing the net harm to the U-18 yo thus creating a moral dilema for all concerned.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and

electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
Disagree with this,no extra powers should be given

Ein cyf / Our ref: AJ/MH/KP
☎:
Gofynnwch am / Ask for: Margaret Hanson
Ebost / email [redacted]
Dyddiad / Date: 17th August 2015

Catherine Hunt
Clerk
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Dear Ms Hunt

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

Betsi Cadwaladr University Health Board has considered the draft Public Health (Wales) Bill at the meeting of its Strategy, Planning and Partnership Sub Committee meeting on 27th July 2015.

We are broadly supportive of the Public Health (Wales) draft Bill and wish to endorse the views of the Directors of Public Health (attached), which have previously been sent to you. In particular, we would like to echo their disappointment, along with other bodies, that the regulation of food standards in settings such as pre-school and care homes are not included in the Public Health (Wales) draft Bill.

Poor nutrition is one of the leading causes of avoidable ill health and premature death in Wales currently. The risk of many chronic conditions, in particular coronary heart disease, obesity, diabetes and some cancers, is increased by poor diet. Diet-related disease has been estimated to cost the NHS around £6 billion a year and the cost of obesity alone has been predicted to reach £49.9 billion per year by 2050. Wales faces some of the biggest challenges in the UK, with the Child Measurement Programme reporting prevalence of overweight or obese children to be 26% in reception year.

Good nutrition in very young children is essential for future growth development and health, while poor nutrition in care homes is likely to undermine the residents' health and well-being and increase the need for health services intervention. Therefore, food standards can make an important impact on public health.

The public sector caters for some of the poorest and most vulnerable people in society. Maintaining food standards, particularly in health settings such as hospitals which seek to keep people well, can inform and influence the public's perception of what foods are considered acceptable and healthy. We believe that this aspect could be strengthened so that there is no missed opportunity to place mandatory food standards on all food or drink supplied by or procured for settings directly controlled, commissioned or inspected by public sector organisations. In addition, over 300,000 people are currently employed in the public sector in Wales. Offering healthy choices as the norm to them, and the public they serve, could make a significant contribution to the obesity problem.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

We would recommend that this particular issue is reconsidered as progress of the Bill moves forward.

Yours sincerely



Mrs Margaret Hanson
Vice Chair of BCU Health Board
Chair of Strategy, Planning & Partnership Sub-committee

Enc

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 Dispensing Doctors' Association – PHB 20 / Tystiolaeth gan Cymdeithas y Meddygon Fferyllol – PHB 20

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
Yes

Question 2

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?
Yes

Question 3

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?
We believe that the nature of the advertising and the use of these devices in public places inadvertently promote smoking. We note recent research which shows that the use of these devices is becoming more prevalent amongst young people. The advertising seems to replicate the type used in the 1950s/60s/70s which glamourized smoking. We fear that all of the good work over the last forty years to reduced smoking will be undone by these e-cigarettes.

Question 4

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?
Please see our response to question 3. Recent research seems to suggest that younger people are starting to use these devices more. Given that the advertising, which replicates that used for tabacco cigarettes forty years ago, glamourizes e-cigarettes, this would suggest it is having the same effect.

Question 5

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

Question 6

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?
We support this proposal.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
We support this.

Question 8

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

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
We support his proposal.

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
Given that local authorities already enforce other forms of licenses, this proposal should not pose any particular difficulties, so long as it introduced along the same lines.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
Yes. We support the proposal to ban intimate body piercing on those under the age of 16.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
Yes we are content with the list.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
The proposals **must not** discriminate against the provision of pharmaceutical services by dispensing practices. Practices dispense in remote and rural areas where a community pharmacy is not economically viable. The Cost of Service Inquiry into dispensing practices, published in 2010, demonstrates that dispensing income subsidises the provision of primary medical services in rural practice. It would be most unfortunate for rural communities if the advent of PNA's caused the closure of rural general practices.

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
The community pharmacy contractual framework has been in place for some time now and local contractors ought to have adapted and expanded their services already. The introduction of PNAs must done carefully and sensitively by LHBs and must not lead to a worse service for patients; please see our response to question 13.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
N/A

Question 16

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

Question 17

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?
N/A

Question 18

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

Other comments

Question 19

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

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
No

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
We would reiterate our belief that the introduction of Pharmaceutical Needs Assessments should not destabilise the provision of dispensing doctor practices and GP services in remote and rural areas of Wales.

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 Wales Heads of Environmental Health Communicable Disease Expert Panel – PHB 21 / Tystiolaeth gan Panel Arbenigwyr Clefydau Trosglwyddadwy Penaethiaid Iechyd yr Amgylchedd Cymru – PHB 21

HEALTH AND SOCIAL CARE COMMITTEE CONSULTATION ON PRINCIPLES OF THE PUBLIC HEALTH (WALES) BILL

Submission of Evidence by Wales Heads of Environmental Health Communicable Disease Expert Panel

Introduction:

The Wales Heads of Environmental Health Group Communicable Disease Expert Panel (the Expert Panel) represents the Communicable Disease activities carried out by Environmental Health services in the 22 local authorities in Wales. The Expert Panel acts as a focal point on Communicable Disease matters in Wales and comprises representatives from the 3 regional Communicable Disease task groups, local authority officers, Welsh Government, the Food Standards Agency and Public Health Wales.

Part 2: Tobacco and Nicotine Products Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

 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?

YES.

The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason.

The Directors of Public Protection Wales (DPPW) published its views on the availability and use of e-cigarettes in 2013 **(DPPW, 2013)** which included several examples* where the enforcement of the ban on smoking in enclosed public places had been undermined by claims of the use of e-cigarettes. Local authorities have had legal actions fail because offenders claimed they were using e-cigarettes.

> [*examples: Cardiff County Council instigated a prosecution against a taxi driver for smoking in his vehicle. The defendant pleaded not guilty on the basis that he was smoking an e-cigarette and not a “real” cigarette. The matter proceeded to Court

where the defendant was found not guilty despite the alleged offence being witnessed by an Enforcement Officer.

Powys County Council has also experienced difficulties with enforcement, having lost a court case against a taxi driver who as part of his defence in Court suggested he may have been using an e-cigarette. The Court found the defendant not guilty despite the investigating officer's witness statement.

Similar enforcement difficulties have been experienced by Caerphilly CBC, Wrexham CBC and Swansea CBC where taxi drivers have been witnessed smoking in their vehicles but Enforcement Officers have been unable to prove whether it was a tobacco product or an e-cigarette. These cases demonstrate that where an individual is witnessed contravening the ban on smoking in a wholly or substantially enclosed public place they can simply claim that they were smoking an e-cigarette and it is extremely difficult for enforcing authorities to prove otherwise, thereby compromising the enforcement of the ban.]

A key issue here is that the ban on smoking in public places has been very successful and is almost entirely self-policing by the public. E-cigarettes pose a real threat to that self-policing.

E-cigarettes also undermine the ability of managers of premises to enforce smoke free places, leading to many businesses banning them. Our officers that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people "vaping". Some vapers argue "it's not against the law".

We believe that the use of e-cigarettes in public places can help "normalise" smoking, and can introduce others into the habit of smoking. See later.

There is uncertainty over the potential adverse health implications associated with e-cigarettes and despite recent studies suggesting some benefit to those quitting smoking the efficacy of e-cigarettes as an aid to smoking cessation is not entirely clear. It is therefore appropriate to take a precautionary approach to the risks associated with e-cigarettes. Currently people in Wales can breathe clean air in offices, shops, pubs and other public places and work environments. We don't want to see a backwards step towards potentially polluted air.

Further evidence in support of the above can be found in the 'State Health Officer's Report on E-Cigarettes' (January 2015) (California Department of Public Health).

http://www.cdph.ca.gov/programs/tobacco/Documents/Media/State%20Health-e-cig%20report.pdf

The executive summary says:

While there is still much to be learned about the ingredients and the long-term health impacts of e-cigarettes, this report provides Californians with information on e-cigarette use, public health concerns related to e-cigarettes, and steps that can be taken to address the growing use of these products. The following are key highlights from the report:

E-Cigarette Use

• In 2014, teen use of e-cigarettes surpassed the use of traditional cigarettes for the first time, with more than twice as many 8th and 10th graders reporting using e-cigarettes than traditional cigarettes. Among 12th graders, 17 percent reported currently using e-cigarettes vs. 14 percent using traditional cigarettes.

• In California, adults using e-cigarettes in the past 30 days doubled from 1.8 percent in 2012 to 3.5 percent in 2013. For younger adults (18 to 29 years old), e-cigarette use tripled in only one year from 2.3 percent to 7.6 percent.

• Young adults are three times more likely to use e-cigarettes than those 30 and older.
• Nearly 20 percent of young adult e-cigarette users in California have never smoked traditional cigarettes.

Health Effects of E-Cigarettes
• E-cigarettes contain nicotine, a highly addictive neurotoxin.
• Exposure to nicotine during adolescence can harm brain development and predispose youth to future tobacco use.
• E-cigarettes do not emit water vapor, but a concoction of chemicals toxic to human cells in the form of an aerosol. The chemicals in the aerosol travel through the circulatory system to the brain and all organs.

• Mainstream and second hand e-cigarette aerosol has been found to contain at least ten chemicals that are on California's Proposition 65 list of chemicals known to cause cancer, birth defects, or other reproductive harm.

Heightened Concern for Youth
• The variety of fruit and candy flavoured e-cigarettes entice small children who may accidently ingest them. Even a fraction of e-liquid may be lethal to a small child.

• E-cigarette cartridges often leak and are not equipped with child-resistant caps, creating a potential source of poisoning through ingestion and skin or eye contact.

• Calls to poison control centres in California and the rest of the U.S. have risen significantly for both adults and children accidently exposed to e-liquids.

• In California, the number of calls to the poison control centre involving e-cigarette exposures in children five and under tripled in one year.

Harm Reduction Claims and Myths
• There is no scientific evidence that e-cigarettes help smokers successfully quit traditional cigarettes.

• E-cigarette users are no more likely to quit than regular smokers, with one study finding 89 percent of e-cigarette users still using them one year later. Another study found that e-cigarette users are a third less likely to quit cigarettes.

Unrestricted Marketing
• In three years, the amount of money spent on advertising e-cigarettes increased more than 1,200 percent.

• E-cigarette advertisements (ads) are on television (TV) and radio where tobacco ads were banned more than 40 years ago. Most of the methods being used today by e-cigarette companies were used long ago by tobacco companies to market traditional cigarettes to kids.

• Many ads state that e-cigarettes are a way to get around smoking bans, which undermines smoke free social norms. Various tactics and claims are also used to imply that these products are safe.

• The fact that e-cigarettes contain nicotine, which is highly addictive, is not typically included in e-cigarette advertising.

In Conclusion
California has been a leader in tobacco use prevention and cessation for over 25 years, with one of the lowest youth smoking rates in the nation. The promotion and increasing use of e-cigarettes threaten California's progress. These data suggest that a new generation of young people will become addicted to nicotine, accidental poisonings of children will continue, and involuntary exposure to second-hand aerosol emissions will impact the public's health if e-cigarette marketing, sales and use continue without restriction. Additionally, without action, it is likely that California's more than two decades of progress to prevent and reduce traditional tobacco use will erode as e-cigarettes re-normalize smoking behaviour.

 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)?

We are of the opinion that smoking should be discouraged in all public places, in particular those locations where there are children or vulnerable people. These include:

- Playgrounds
- School grounds & their immediate vicinity
- Hospital & medical facility grounds
- Places promoted to children (e.g. "petting farms", fairgrounds and family centred leisure parks).

There is a need for Fixed Penalty Notice powers which should be consistent with existing provisions. In drafting such provisions there is a need to consider that law currently places a responsibility on the person in control of premises to prevent smoking (e.g. hospital grounds) and that local authorities' usual enforcement approach is against the "person in control of premises" for permitting smoking. (Under the Health Act 2006 "It is the duty of any person who controls or is concerned in the management of smoke-free premises to cause a person smoking there to stop smoking.")

If current restrictions are extended, then it is essential that local authorities receive additional funding to support this work. Receipts from enforcement should be returned to Local Authorities to further support enforcement and education work in this area.

The additional work likely to arise as a result of an extension in the ban to include e-cigarettes and also to prohibit smoking and the use of e-cigarettes in other non-enclosed places is difficult to predict but may be significant.

We appreciate that the 'smoking ban' has, to date, been largely self-policing.

This will have been assisted by the fact that health risks associated with smoking and in turn the inhalation of second hand tobacco smoke are well known and understood. As a result smokers (and the public in general) will appreciate the purpose of the ban and support compliance expectations.

While there are reasoned arguments for extending the ban to include e-cigarettes and to cover certain non-enclosed places, it is foreseeable that smokers will be less understanding of, and compliant with respect to, restrictions on their use of e-cigarettes in the absence of 'proven' health concerns and where they feel that their use of such devices is key to them quitting smoking. Similarly, there is likely to be less public concern for the use of e-

cigarettes, for the same reasons, and accordingly less social pressure on users not to use them in contravention of any ban.

This distinction may create some/significant resistance towards compliance, which would in turn necessitate a significant increase in resources to 'police', compared to the current smoking ban.

This should be taken into consideration in resourcing this work.

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

Yes.

Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation; intentionally or inadvertently promote or normalise smoking; and the potential impact upon smoke free environments.

We are concerned that there is a real potential for e-cigarettes to intentionally or inadvertently promote smoking amongst those who currently do not smoke. In particular we feel there is a need to make every effort to deter young people from becoming smokers.

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

Yes. We take the view that anything that has the appearance of smoking helps "normalise" smoking and therefore promotes smoking behaviour and culture. We also question whether the term **"inadvertently"** is appropriate. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour.

We are also concerned by the nature of e-cigarette advertising; we note the reappearance of 1950's style marketing of tobacco products.

Workplaces have worked hard to implement the smoke free premises legislation and the use of e-cigarettes undermines this work.

We are concerned that e-cigarettes encourage young people to think that smoking is acceptable and therefore has the potential to act as a gateway to both e-cigarettes and tobacco based products.

Data relating to smoking behaviour in Wales leads us conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach.

 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?

Yes we feel they are. We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours.

Worryingly, our members have witnessed e-cigarettes being displayed for sale with sweets, at child height, at the checkout in large stores.

Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as “Gummy Bear, Cherry cola and Bubble Gum”.

Some products are being packaged and marketed in a way that is closely associated with that of conventional cigarettes. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour. We are also concerned by the nature of e-cigarette advertising; e.g. consistent with the 1950’s style marketing of tobacco products.

Many of these factors reinforce the association with conventional tobacco cigarettes and may normalise smoking related behaviour.

 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?

Yes. A number of licensed premises have independently introduced bans on the use of e-cigarettes within their premises in recognition of the difficulty they cause their staff in applying the smoking ban within their premises.

Our colleagues that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people “vaping”. Some vapers argue “it’s not against the law”.

Some employers have had difficulties. e.g. Caerphilly CBC had problems with lorry drivers smoking in their cabs and when tackled claimed they were vaping an e-cig, which made taking action difficult. Caerphilly CBC has also received complaints from their own office based staff that colleagues have been using e-cigarettes at their desks and that they may be also be inhaling the vapours in a similar way to second hand smoke. Hence Caerphilly amended their no smoking policy to include e-cigs.

The proposed legislation in smoke-free places should apply equally to tobacco based products and all forms of e-cigarettes.

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

The power to issue Fixed Penalty Notices and other enforcement provisions need to be consistent with other smoking legislation, and the fines need to be set at such a level as to be a deterrent to (re)offending. Receipts from enforcement/Fixed Penalty Notices should be returned to Local Authorities to further support enforcement and education work in this area.

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

Yes. The Expert Panel supports the proposal.

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

The introduction of a register will provide an additional control on the availability of tobacco; a register would contain detailed information on those people and premises from which tobacco can be sold legitimately. Furthermore it would restrict access to the trade to those people and premises where tobacco should not be sold. It will be easier for enforcement officers to identify those premises where tobacco is permitted to be sold, which will in turn assist with the enforcement of underage sales and the display ban.

The success of such a measure would be dependent on the legislation including provisions to control access to the register such as a "fit & proper persons" or "suitable persons" test. This is explored further in response to subsequent questions.

If a register is to be established it needs to cover all those that manufacture, distribute and sell tobacco products. We feel that having a register only for the end retailers is not comprehensive and will not cover other parts of the tobacco chain that feed the habit including those under age. An offence should be created where tobacco products can only be sold, distributed, etc to those registered. However, the extension of such a register to manufacturers and distributors would need careful consideration to ensure that 'cross-boundary' matters can be effectively dealt with.

We note that section 29(5) provides that 'A registered person who fails, without reasonable excuse, to comply with section 25 (duty to notify certain changes) commits an offence'. We are concerned by the use of the phrase 'reasonable excuse':

a) Firstly, as it is out of step with the more robust due diligence offence common to most current consumer protection legislation, i.e. the two limbed all reasonable precautions and all due diligence defence. There is concern that with section 29(5) as currently worded, individuals failing to notify changes to the register will be able to evade enforcement action. There will be no definition of what is reasonable and so these explanations would need to be tested in court with associated wasting of resources.

   Use of the well established two limbed due diligence system would enable enforcement officers to assess the adequacy of an individual's defence based on tried and tested case law, well before a case has to enter the court system

b) Secondly, the very use of the word 'excuse' in section 29(5) sends out quite the wrong message to the trade, and there is a danger that the current wording will encourage individuals simply to 'come up with an excuse' in the expectation that this will be acceptable.

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

Yes. The proposed link to restricted sales orders (RSOs) and restricted premises orders (RPOs) under the Children & Young Persons Act are welcome. However, we see it as essential that the range of offences triggering an RPO is extended to include all tobacco related breaches, for example the supply of illegal (counterfeit and non-duty paid) tobacco, tobacco labelling offences, non-compliance with the tobacco display ban; and not just

underage sales. It is hoped that these matters will be addressed through the proposed power for Welsh Ministers to make regulations under section 12D of the Children and Young Persons Act and the range of offences triggering an RPO extended accordingly.

However, our experience of “Registers” introduced under other legal provisions suggest that their efficacy can be limited if they are not also accompanied by robust enforcement powers. Some registers are merely administrative or informative.

Local authority enforcement officers will need effective powers to ensure that the register has the desired effect. These need to include power to restrict access to the register and to remove persons from the register where there has been a relevant infringement of the law, including offences concerning underage sales. We feel that there should be a provision to consider suitability of a retailer - whether the retailer is a “fit & proper” person. For example, whether a retailer been convicted for the sale of alcohol, solvents or other age restricted products to minors. The section 24 provision that an application to register will not be granted if an RPO or RSO is already in place goes some way towards this, but of course does not take account of the selling to minors of other age restricted products.

We welcome the section 23(2)(g) clarification that in addition to sellers of tobacco and nicotine products with a High Street presence, those supplying via online, telephone and mail order channels will be required to indicate this on the register. However, it is unclear from the wording of section 22(1) whether the requirement to register applies only to those based in Wales rather than those outside Wales supplying to customers in Wales, i.e. ‘The registration authority must maintain a register of persons carrying on a tobacco or nicotine business at premises in Wales’.

We are disappointed with the section 23(3) definition of a “tobacco or nicotine business” as being a business involving the sale by retail of tobacco or cigarette papers or nicotine products’. Limiting the scope of the register to retail would be a lost opportunity to regulate throughout the supply chain. The illicit supply and sale of tobacco has been identified as a growing concern by Trading Standards in Wales. A register must not inadvertently add to the problem of illicit trade in cigarettes. The penalties of failing to register therefore need to be robust. We emphasise that the definitions of “business” need to be carefully considered to encompass not only legitimate traders but also those persons who are trading illegally in tobacco from domestic premises. We feel it should also include online suppliers. Effectively the provisions must apply to anyone who is *selling* tobacco products in Wales.

We support the need for robust and proportionate penalties for offences and proposed powers of entry (to retail premises) or the ability to seek a warrant (for domestic premises). These are obviously vital. We also support the need for powers to seize tobacco goods in all relevant premises including those that are not registered.

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

We support the proposals which would bring tobacco products into line with alcohol sales.

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

Yes.

Smoking remains the single greatest avoidable cause of death in Wales **(PHW, 2012)**. The introduction of the ban on smoking in enclosed public spaces in 2007 has been hugely successful in reducing exposure to environmental tobacco smoke and in strengthening public awareness and attitudes towards it. However, reducing the prevalence of smoking, remains a key health priority. Protecting young people from the effects of smoking and deterring young people from taking up the habit are particularly important. Therefore the Expert Panel welcomes the proposals and additional powers to help control the availability of tobacco and its potential health impact.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales, these procedures are acupuncture, body piercing, electrolysis and tattooing.

 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?

We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators.

The Expert Panel is of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

The Expert Panel has the following concerns regarding existing provisions:

- There is no requirement for a practitioner to have training or experience to set up a tattoo studio. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk.
- Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the byelaws. This may be viewed as a purely administrative offence when Courts are considering sentencing.
- Current registration requirements rely on being able to prove that a person is carrying on a business and this can be difficult because most unregistered tattooists (‘scratchers’) work from home and deny that they receive payment.
- There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws,
- Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and The Health and Safety at Work etc. Act 1974. Several local authorities in Wales have used Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle “scratchers”.
- When we last gathered information on this, we found that between July 2012 and July 2013, ten applications for Part 2A Orders had been made by local authorities; all of which related to the carrying out of unregistered tattooing from domestic premises.
- New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.

- Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.

We agree with the concerns of the Chartered Institute of Environmental Health (CIEH) that many procedures are being done by people with little if any knowledge of anatomy, infection control or healing processes **(CIEH, 2014)**.

We would offer the following observations on the proposed regulations:

- Level 3 fine (£1,000) is too low to act as a meaningful deterrent. The sunbed legislation, which is similar in nature, includes a fine of up to (£20,000); this would be a more appropriate sum.
- In determining whether to grant a licence a Local Authority should be able to consider whether the applicant is a "fit and proper person" and such a test should be included (akin to our tried and tested procedures for taxi licensing). The test should permit the LA to take into account "any other information" (beyond the "relevant offences" listed in the draft bill) in determining that question. The current proposals do not offer sufficient safeguards.
- We would be opposed to grandfather rights for existing traders. Our officers have only recently dealt with a high profile public health incident in South Wales which related to a long-standing operator.

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future in an efficient and timely manner.

We will be pleased to work with WG officials is relation to such matters.

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

We absolutely support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. E.g. a local studio (in Caerphilly) is keen to expand into scarification and tongue splitting. Other procedures are already becoming more popular e.g. branding, dermal implants, microdermabrasion. All these procedures provide the potential for serious harm and infection. We feel it is absolutely essential that the provision to amend the list of special procedures reflects the need for amendments to be made expediently and without unnecessary delay. The list of special procedures will need to be dynamic to be able to incorporate new procedures as trends change. A lengthy amendment process will undoubtedly leave local authorities 'on the back foot', and having to rely on other legislation, for example, Health Protection Legislation 'Part 2A Orders' to tackle new and emerging procedures.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive activities underground and cause further issues or potentially make it more appealing to some people. However, the Expert Panel is mindful that legislation that could be seen as 'supporting' procedures such as branding and scarification; procedures that could be defined as 'surgical' in nature, may give the public the impression that these procedures are 'safe'. If it is deemed that such procedures should be included then we would suggest that it may be appropriate for additional criteria for such procedures to be specified to meet higher surgical standards. The criteria should cover training, equipment and premises for both the procedure and operator.

In 2011 in Bridgend, a detailed proposal was received to introduce scarification in a local tattoo studio, however on the advice of the Consultant in Communicable Disease Control, the authority agreed to reject the proposal. No further enforcement was required.

 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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register

therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

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

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Evidence of public health risk in relation to such procedures is clear. We take the view that any procedure that involves the piercing of the skin poses a very real risk of infection and disease from blood borne viruses many of which can be a serious risk to health and that anyone undertaking such procedures should be competent to do so without putting a person at risk.

Current controls are outdated and inadequate. We need to be able to protect the public to better prevent people from undertaking these procedures if they are not competent or are not fit and proper person to be undertaking such practices. We need also to ensure that the conditions in which such practices take place are hygienic and will prevent infection risks.

We are seeing in our day to day work evidence of a growing range of procedures that put the public at risk. These include: dermal implants, beading, ashing, scarring, dermal fillers, tongue splitting, and a range of other procedures that we might loosely describe as “body modification”. We feel strongly that regulations should permit all such procedures to be controlled and that the regulations should allow the list of procedures to be extended to cover any form of body modification that may arise in the future.

Some procedures such as “ashing” might not fall within the regulations as proposed. Ashing may fall outside of the current definition of tattooing (which relies on the use of pigmentation) and care is needed that definitions do not inadvertently exclude procedures that are intended to be covered.

In relation to extending the list, we recognise from an enforcement perspective that we are familiar with the necessary controls and safeguards needed in relation to more traditional procedures. There is merit in a considered and stepped approach to extending the list of special procedures so that we are able to develop training, suitable competence assessments and necessary guidance in relation to the more novel procedures. We are also aware that consideration is needed in distinguishing between a legal service that we might appropriately control and what might be considered an illegal act of assault. We feel some clarity will be required in relation to that question.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

 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?

Yes, we believe that an age restriction is required for intimate body piercing.

We share the view of the Chartered Institute of Environmental Health (CIEH) that 16 is **not** an appropriate age for an intimate piercing because:

- The decision to have an intimate body piercing should be made by a mature individual; we believe that 16 years of age is not sufficiently mature.

- Intimate body piercings require a higher standard of aftercare than tattoos, as they are potentially more susceptible to infection. This level of aftercare requires a mature approach to which a 16 year may not be capable of fully committing.

- Whilst the jewellery inserted into an intimate body piercing may be removed any scarring or damage inflected by the procedure will be permanent. This is particularly important when the skin, subject to the piercing is still growing and its function may be compromised by scarring or thickening. At 16 years an individual is still growing and therefore the risk of damage to skin is greater.

The Expert Panel also notes that there is considerable potential for confusion to arise if there is a different age restriction for body piercing and for tattooing. We consider that it would be easier for practitioners, enforcement agencies and individuals if the age restriction for both was to be the same.

We further consider that an age restriction of 16 years for intimate body piercing is likely to give rise to call for the age restriction for tattooing to be reduced to 16 years.

The Expert Panel believes that the age restriction for intimate piercing should be 18 years.

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

Yes. However we also feel there is a case to add the tongue. In addition to the relatively higher risks of infections associated with tongue piercing, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list of intimate parts.

 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?

We support such proposals including the proposal to make it an offence “to enter into arrangements”. This would support enforcement of the provisions including “test purchasing” by local authorities.

We recognise the need for police support in particular in relation to evidence gathering given the intimate nature of such offences and the provisions need to take account of that.

Any duties placed upon local authorities must be supported by adequate funding to enable them to be operated and enforced in an effective manner.

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

Yes, see above**.**

Part 6: Provision of Toilets Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

 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?

The Expert Panel agrees that the provision of, and access to, toilets for public use is important, particularly to older people and those with specific needs. However, this is not an area in which Environmental Health Departments generally have any enforcement responsibility and it seems none are proposed. We are thus not well placed to comment on the proposals

We do however recognise all too clearly the current financial pressures on local authorities. We question whether placing a duty on local authorities to develop a strategy is appropriate, acknowledging firstly the difficult financial climate within which any duty would consume resource and secondly that a strategy will not of itself bring about enhanced provision. Care is needed that WG does not merely impose an administrative and financial burden that delivers no real benefit to the public.

Local Authorities are being forced to make difficult choices around the prioritisation of services to their communities many of which have a significant impact on health & well-being. Any duty regarding the provision of public toilets may result in local authorities being forced to disinvest in other services that are of equal or greater priority.

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

See above

 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?

The consultation requirements set in para 92 are too vague to be meaningful.

 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?

In our experience, such guidance leads to more consistent approaches.

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

 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?

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

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 are generally very supportive of the measures set out in the Bill. However, we are naturally concerned by the capacity within local government to deliver additional responsibilities successfully at a time when service cuts and reductions in service standards are all too apparent. We have a great deal of expertise and experience and local authority Environmental Health Departments across Wales are keen to support these new powers and measures. However we ask WG to ensure that such work can be adequately resourced and in particular to consider:

- Undertaking regulatory risk and impact assessment to understand the consequences of the proposed legislation on enforcing authorities and on those subject to regulation,
- a detailed understanding and quantification of the costs of effective regulation and enforcement so that WG and local authorities can plan properly for implementation,
- Where possible provisions should allow for full cost recovery or in the absence of a cost recovery mechanism (typically fees & charges) additional resource must be made available to local authorities specifically for the purpose of this legislation,
- In drafting the legislation, WG should avoid unnecessary complexity or ambiguity, ensure that provisions are capable of being enforced in a practical and efficient way and that any potential defences are fully and properly understood.

 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?

Local Authority costs summarised in Annex B of the Explanatory Memorandum (see http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf), these look to be underestimated.

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

 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?

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?

Other comments

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

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

Yes

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

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 Decadent Vapours Ltd – PHB 22 / Tystiolaeth gan Decadent Vapours Ltd – PHB 22

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
We do not agree with this proposal. The WG in the Explanatory Memorandum (EM) lays out 4 main underpinning concerns which support the proposal: Concern 1 – Increased difficulty in enforcement of smoke-free policies. In figure 2 of the EM, there is the list of types and the suggested by the Health Minister that e-cigarette use "looks like smoking" is debunked by figure 3. Fig 3 shows that the majority of the user market 'second generation' devices that look nothing like a traditional tobacco cigarette. Furthermore in 2014, a survey of over 10,000 e-cigarette users show the same and an increasing number of respondents preferring larger devices which fall in the 'Mods' option. http://vaping.com/data/big-survey-2014-initial-findings-hardware This survey shows that over 90% of the respondents choose a device that doesn't resemble a traditional tobacco cigarette in any fashion. The 4 members of staff that we employ that have fully switched to e-cigarettes use this sort of product, therefore it makes the enforcement of the smoke-free policy easier. This is due to the increased size of the device and the different manner in which the devices are held. Furthermore, the smell of the e-cigarette vapour is very much different. The odours can be fruity or sweet and even the tobacco flavoured e-liquids used do not replicate the unique characteristic smell

of combustible tobacco. In Paragraph 58 of the EM, concerns about the "hand to mouth" movement makes enforcement more difficult, this could also be applied to the "hand to mouth" action of taking a drink or covering ones mouth when yawning. Again in 58 of the EM concerns about the vapour emitted, the emitted vapour from an e-cigarette is much different. The e-cigarette vapour is more dense, whiter and disappears very quickly in the air compared to tobacco cigarette smoke. What is exceedingly worrying is that in Paragraph 50 of the EM states that new criminal offences for using a "nicotine inhaling device", this not only applies to e-cigarettes but also Nicotine Replacement Therapy products like Nicorette Inhalator, which hold medical licenses, that also do look like cigarettes.
http://www.nicorette.co.uk/sites/nicorette.co.uk/files/inhalator_tab1_left_1.png
Despite Note 15 of explanatory notes in Annex A which suggests an exemption for medical nicotine inhalation devices but not explicitly.
Concern 2 – E-cigarette use renormalizes smoking.
Decadent Vapours Ltd stance will be covered in Q3
Concern 3 – E-cigarette use act as a gateway to smoking.
Nicotine on its own is not addictive.
http://www.jneurosci.org/content/25/38/8593 It is only addictive when combined with the various chemical agents in combustible tobacco. This is well established as far back as the 1970s by William Russell. Today, Prof Peter Hajek, who is cited repeatedly in the EM likens the addictiveness of caffeine. Please see this video which links Tobacco Harm Reduction and nicotine use.
https://www.youtube.com/watch?v=IvDIF9izuMI
In the ASH Survey on "Use of electronic cigarettes (vapourisers) among adults in Great Britain" published in May 2015
http://www.ash.org.uk/files/documents/ASH_891.pdf also proves that there is no gateway to smoking among adults. The figure of 0.2% which has stayed consistent for 3 years proves that the existence of e-cigarettes does not provoke non-smoking adults to take them up continuously. Furthermore, this data shows that it is unlikely that those adults using e-cigarettes will move on to combustible tobacco. This document from ASH on page 5 also supports that e-cigarette users are using "mods" which supports the argument for the previous WG concern as discussed in point 1.
Concern 4 – Indoor air quality
Many studies have found that emitted e-cigarette vapour has very little if any effect on indoor air quality. One study published in January 2015 concluded that " the additional amount of carbonyls contributed into the atmosphere by vaping

under the given conditions can be deemed to be negligible when compared to levels of the same substances typically found indoors."
http://www.sciencedirect.com/science/article/pii/S1438463914000972
There are also beliefs that e-cigarette vapour causes harm to bystanders in the same way that second-hand smoke does. The well established fact that e-cigarettes do not contain the multiple chemical compounds which are in combustible tobacco is one reason why this concern is baseless. In research as recent as July 2015, which concluded "smoke. Under the study conditions cigarette smoke demonstrated a dose-dependent response that resulted in near-complete cell death after a 6 h exposure period. In contrast, e-cigarette aerosol showed no decrease in tissue viability following a 6 h exposure,
despite appropriate positive control responses."
http://www.sciencedirect.com/science/article/pii/S0887233315001228
Despite this research being carried out by a tobacco company, the results support that even at second-hand level exposure there is no risk of harm especially if results through directly exposing cells to e-cigarette vapour shows no cell death. This study also confirms similar research from 2013 where heart cells were exposed to both tobacco smoke and e-cigarette vapour.
http://www.mdpi.com/1660-4601/10/10/5146
From a business point of view, bringing e-cigarettes under smoke-free legislation is very disproportionate. As this is the preferred option according to points 412 and 413 of the EM from a health perspective, the costs laid in Table 7.12 clearly indicate more obvious reasons. These reasons are that the majority of the cost is not footed by the WG but by public/ work places or e-cigarette industry especially over the 5 year period. Not only will it impact our sales, which we believe is grossly underestimated, but it will also have a very negative effect our manufacturing and quality control processes. This involves using an e-cigarette device to test the quality of the flavour raw materials and the final products. Within Annex A, more specifically "Section 10: Exempt premises" paragraph 28 gives current exemptions includes 'research or testing facilities' under smoke-free legislation. We believe that we fall into this category as a manufacturer of nicotine containing liquid (e-liquid) for e-cigarettes. Unfortunately, this paragraph does not extend to cover our business. We specifically request that this section is extended to cover businesses like ours. What is exceedingly worrying from a business perspective is that our customer base in Wales will be hit twice by the proposals as they are both a workplace and a public space due to being retailers. Despite a very vague exemption from

smoke-free legislation in paragraph 27 but then the retailer is covered by the definition within paragraph 21. As a part of the wider e-cigarette business in Wales we would require that this complication to be avoided and the exemption for "the use of nicotine inhaling devices only" to be explained in detail and cover e-liquid manufacturers and e-cigarette retail businesses.
As an employer we have a duty under Section 2.1 of the Health and Safety at Work Act 1974
http://www.legislation.gov.uk/ukpga/1974/37/part/I/crossheading/general-duties
which says that we must minimise the risk of harm to our employees, which includes the risk of second hand smoke exposure. Under the proposals, as a business we would either have to spend further funds to provide a "vapers shelter" which at our current location is unfeasible or send the e-cigarette users among the staff out with the smokers. This clearly undermines our duty under the HASAW Act 1974. The Health and Safety Executive have issued guidance which includes the use of e-cigarettes as part of wider control of risk of smoke exposure. http://www.hse.gov.uk/contact/faqs/smoking.htm

Question 2

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?
No, there is no balance between benefits and dis-benefits relating to e-cigarette use. In paragraph 375 of the EM, it is suggested that e-cigarette users will have to leave the premise to comply with the legislation. (Previously mentioned in the reply to Q1) Through this the WG and local authorities will create an image by the combination of smokers and e-cigarette users in the same area means that there is no difference between the products and hence there are no health benefits in switching. Also, as e-cigarette users will have no immediate enticement to make the switch straightaway which also means that e-cigarette users may not be able to convince smoking family members or friends to switch as the use in social environments will be prohibited. This clear dis-benefit means smoking prevalence will not decrease as sharply as it has in the past year to the 21% from 23%. Our trade association, ECITA, has studied the costs and QALY figures in paragraphs 371 to 373. http://www.ecita.org.uk/ecita-blog/assessing-potential-

impact-unintended-consequences-vaping-ban-wales They suggest that even if 10% of the estimated 33,600 exclusive users were to revert to smoking would equate to a loss £199m in shortened lives. This figure also fails to address the additional costs to health services to treat smoking related illness or disease. The WG fails to see the benefit of the extended lives through using e-cigarettes to the wider economy. If the 15% of e-cigarette users that circumvent the smoke-free requirements, revert to smoking that means that almost 5000 QALYs, using the estimated 33,600 users in paragraph 371, are lost and an equivalent to £300m lost at the lowest estimate. I doubt the WG would like to lose that equivalent in just 1 year as most circumventers will begin smoking again immediately.
The proposals will restrict the opportunities to make the initial switch e-cigarettes as the e-cigarette retailers are those that aid the switch. E-cigarette retailers, our customers, rely on the ability for their customers to try a variety of nicotine concentrations, flavours and devices. The proposals will prohibit this opportunity and hence a drastically reduce the number of switchers which in turn will decrease the rate of smoking prevalence fall. Without this sort of opportunity the benefits of switching which can include Harm Reversal which is being researched by Riccardo Polosa
http://www.biomedcentral.com/content/pdf/s12916-015-0298-3.pdf
http://gfn.net.co/downloads/2015/Plenary%203/Riccardo%20Polosa.pdf

Question 3

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?
Smoking is still “normal” in society with an estimated 10million smokers in the UK as given by ASH http://www.ash.org.uk/files/documents/ASH_93.pdf in January 2015. Implying that smoking is not normal is a ridiculous idea. The fact that smokers now have to smoke outside doesn’t mean there are less smokers, the number of smokers still visible on the streets backs up that the use of tobacco cigarettes is still normal. Decadent Vapours Ltd firmly believe that e-cigarette use normalises stopping smoking. This view is backed up consistent falls in the percentage of the smoking population, which can be seen from page 2 of the ONS publication http://www.ons.gov.uk/ons/dcp171778_386291.pdf . If the use of e-cigarettes promote smoking then tobacco cigarette uptake would increase and this is simply not the case. Furthermore, only 7.5% of e-cigarette users will use their devices wherever they please and with the remainder of the 1000

respondents vaping outside or doing so indoors after being given permission of the premises owner. This supports that the majority of e-cigarette users are attempting to stop smoking or cut down the number of cigarettes smoked. The use of e-cigarettes for most users are not using e-cigarettes as an avenue to bypass the current smoke-free legislation.
http://www.ecigarettedirect.co.uk/ashtray-blog/2015/03/e-cigarette-etiquette.html At a risk of repetition, the current market regarding devices are of second generation or above. First generation e-cigarettes are the imitation of tobacco cigarettes. These devices are proven to be not as effective as higher generation devices, hence the higher prevalence of larger devices. Scientific basis for this opinion can be seen summarised by Dr K Farsalinos here
http://gfn.net.co/downloads/2015/Plenary%203/Konstantinos%20Farsalinos.pdf
Therefore the notion of "replicating cigarettes" has no basis nor do e-cigarettes promote smoking.

Question 4

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?
Currently, all advertising for e-cigarettes falls in line with current rules from the Committees of Advertising Practice which were released in October 2014. There is a specific rule which denotes that advertising should not be deliberately aimed at those under 18. This rule is summarised in points 9 and 11 on this post from our trade industry body ECITA http://ecita.org.uk/ecita-blog/cap-and-bcap-publish-new-uk-advertising-rules-e-cigarettes It is therefore a ridiculous notion that e-cigarettes are directly aimed at young people. We firmly believe that these rules are more than adequate to aid the prevention of e-cigarettes being appealing to young people especially as e-cigarettes are for adult consumers only. Furthermore under the Tobacco Products Directive in Article 20 in Section 5, all advertising of e-cigarettes is prohibited. This is scheduled to be implemented in May 2016 so any further exposure to e-cigarettes will be very limited to none for young people. ASH published results of their "Use of electronic cigarettes among children in Great Britain" survey in August 2015. http://www.ash.org.uk/files/documents/ASH_959.pdf We would like to draw your attention to the bottom of page 2. This graph clearly indicates that the current use of e-cigarettes is low compared to the current use

of combustible tobacco cigarettes. The graph also backs up previous comments that smoking is still normal through the “ever tried smoking” data. If e-cigarettes are particular appealing then the “ever tried e-cigarettes” data would be significantly higher.
Professor Linda Bauld and Cancer Research UK published data also on youth use of e-cigarettes and it ultimately concluded that e-cigarettes do not ultimately lead to tobacco cigarette use.
http://medicalxpress.com/news/2015-06-children-regularly-e-cigarettes.html
Even ASH Wales, published the results of their “Young people and the use of e-cigarettes in Wales” survey in April 2015. Particular attention must be brought to Figures 13 (p23) and 15 (p25) of http://ashwales.org.uk/assets/factsheets-leaflets/ecigyoungpeoplereport_2015.pdf . The first graph Figure 13 shows clear as day that non-smoking youth don’t try e-cigarettes in large numbers therefore the notion of appeal is wrong and only youth that are currently smoke are likely to take up using e-cigarettes. Figure 15 shows that despite a small sample size, those who went on to smoking tobacco after the use of e-cigarettes is 2.4%. This low figure do not warrant any sort of enclosed public space ban on the basis of a gateway effect that simply does not exist. Youth experimentation with tobacco cigarettes will always be present. However, we prefer that if youth were experimenting with e-cigarettes, this would be a far safer option, 95% safer compared to tobacco cigarettes. This figure was released by Public Health England on August 19th in the following release.
https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
On top of this, they said that regular use of e-cigarettes is rare among youth. In addition, experimenting with e-cigarettes among youth is 0.3% or less. This data confirms that there is no particular appeal of e-cigarettes to young people. Without the visible presence of e-cigarettes, those young people experimenting will try tobacco and will stay on tobacco cigarettes which is proven to be a deadly product.
If the WG ignore the surveys from home soil, they clearly have no ambition for the long term health of the smoking public nor the health of the current e-cigarette using population in Wales.

Question 5

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

The proposal is sensible. However, with the current growth of the e-cigarette market, it will become highly costly to maintain.

Question 6

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?
We support this idea. ECITA already operate a sanction system for members that knowingly sell products to under 18s. This offence will enforce the cohesive stance across much of the current e-cigarette business community which Decadent Vapours already enforce and so do our customers.

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 Caroline Evans – PHB 23 / Tystiolaeth gan Caroline Evans – PHB 23

The Public Health [Wales] Bill consultation

I have been asthmatic since I was 18 and for a great deal of that time I would have to try avoid indoor spaces where there were smokers, or try to sit by a window or open door to allieviate breathing in the smoke. The ban on smoking in pubs for example has been marvellous for me and others with breathing problems, however increasingly I now have to look around to check I am not near anyone vaping - second-hand breathing in of the vapour is an unpleasant experience and acts as a trigger for an asthma attack. For example, I regularly attend a meeting where two vapers also attend, and they vape inside the meeting room. I have had to ask that they do not do it when I am in the room which has not gone down very well and has made me feel rather like a leper.

I fully understand how these items can help with smoking cessation plans and the appreciate the importance to people's health to stop inhaling tobacco smoke. I live with a smoker who has tried to give up - so he has to live with not being able to smoke when I am in the room, and me rushing around opening up windows and doors to clear the smoke.

I do fully support the move for a ban in Wales for e-cigarette smoking in enclosed public spaces.

There is not yet enough research on the impact of the second-hand vapour - Asthma UK have told me that if my lungs react to the second-hand vapour then it is definitely acting as a trigger for me and I should avoid it [obvious really!]: as an organisation they are looking at the latest findings to assess their on-line advice knowledge bank on second-hand inhalation of the vapour.

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 Rhydian Mann – PHB 24 / Tystiolaeth gan Rhydian Mann – PHB 24

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
I personally completely disagree with this proposal. The WG in the Explanatory Memorandum (EM) lays out 4 main underpinning concerns which support the proposal: Concern 1 – Increased difficulty in enforcement of smoke-free policies. In figure 2 of the EM, there is the list of types and the suggested by the Health Minister that e-cigarette use "looks like smoking" is debunked by figure 3. Fig 3 shows that the majority of the user market 'second generation' devices that look nothing like a traditional tobacco cigarette. Furthermore in 2014, a survey of over 10,000 e-cigarette users show the same and an increasing number of respondents preferring larger devices which fall in the 'Mods' option. http://vaping.com/data/big-survey-2014-initial-findings-hardware This survey shows that over 90% of those who participated choose a device that doesn't resemble a traditional tobacco cigarette in any fashion. The main issue with enforcement are from devices that look like cigarettes with red LED tips. These are commonly known as "ciggalikes" or 1st generation. However, the current market innovation and better performing products compared to 1st generation will mean that difficulty in enforcing will become obsolete given correct education of enforcers. My employer has encouraged the use of e-cigarettes, myself and 4 colleagues

that have fully switched to e-cigarettes use this sort of product, therefore it makes the enforcement of the smoke-free policy easier for our employer. This is due to the larger size of the device and the different manner that we hold the choice of device. Furthermore, the smell of the e-cigarette vapour is very unlike tobacco smoke. The odours can be fruity or sweet and even the tobacco flavoured e-liquids used do not replicate the characteristic smell of combustible tobacco. In Paragraph 58 of the EM, concerns about the "hand to mouth" movement makes enforcement more difficult, this could also be applied to the "hand to mouth" action of taking a drink or covering ones mouth when yawning. If a perfectly reasonable movement seen from a distance and interpreted as something else, the WG are really desperate for this implementation. Again in 58 of the EM concerns about the vapour emitted, the emitted vapour from an e-cigarette is completely unlike tobacco smoke. The e-cigarette vapour is more dense, whiter and disappears very quickly in the air compared to tobacco cigarette smoke. What is exceedingly worrying is that in Paragraph 50 of the EM states that new criminal offences for using a "nicotine inhaling device", this not only applies to e-cigarettes but also Nicotine Replacement Therapy products like Nicorette Inhalator, which hold medical licenses, that also do look like cigarettes. http://www.nicorette.co.uk/sites/nicorette.co.uk/files/inhalator_tab1_left_1.png However, Note 15 of explanatory notes in Annex A which prompts an exemption for medical nicotine inhalation devices but this is not made clear in any way at all. This will have a negative impact on those using NRT and Stop Smoking Service support avenues.

Concern 2 – E-cigarette use renormalizes smoking.

My reply will be covered by Question 3.

Concern 3 – E-cigarette use act as a gateway to smoking.

Nicotine on its own is not addictive.

http://www.jneurosci.org/content/25/38/8593 It is only addictive when combined with the various chemical agents in combustible tobacco. This is has been concrete scientific fact which has been around since as far back as the 1970s by William Russell. In the modern day, Prof Peter Hajek, who is cited continuously in the EM likens the addictiveness of caffeine. Please see this video which links Tobacco Harm Reduction and nicotine use.

https://www.youtube.com/watch?v=IvDIF9izuMI

In the ASH Survey on "Use of electronic cigarettes (vapourisers) among adults in Great Britain" published in May 2015

http://www.ash.org.uk/files/documents/ASH_891.pdf data proves that there is

no gateway to smoking among adults. The figure of 0.2% that has stayed consistent for 3 years, this proves that the existence of e-cigarettes does not provoke non-smoking adults to take them up continuously on any fashion. In addition, this data shows that it is unlikely that those adults using e-cigarettes will move on to combustible tobacco. This document from ASH on page 5 also supports that e-cigarette users are using “mods” which supports the argument for the previous WG concern as discussed in point 1.

Concern 4 – Indoor air quality

Many studies have found that emitted e-cigarette vapour has very low if any effect on indoor air quality. One study published in January 2015 concluded ” the additional amount of carbonyls contributed into the atmosphere by vaping under the given conditions can be deemed to be negligible when compared to levels of the same substances typically found indoors.”

http://www.sciencedirect.com/science/article/pii/S1438463914000972

There are also beliefs that e-cigarette vapour causes harm to bystanders in the same way that second-hand smoke does. The well established fact that e-cigarettes do not contain the multiple chemical compounds which are in combustible tobacco is one reason why this concern is unjustified. In research as recent as July 2015, which concluded “smoke. Under the study conditions, cigarette smoke demonstrated a dose-dependent response that resulted in near-complete cell death after a 6 h exposure period. In contrast, e-cigarette aerosol showed no decrease in tissue viability following a 6 h exposure,
despite appropriate positive control responses.”

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Despite this research being from a tobacco company, the results support that even at second-hand level exposure there is little to no risk of harm especially if results through direct exposure of cells to e-cigarette vapour shows no cell death. This study confirms similar research from 2013 where heart cells were exposed to both tobacco smoke and e-cigarette vapour.

http://www.mdpi.com/1660-4601/10/10/5146

Bringing e-cigarettes under smoke-free legislation is very disproportionate. As this is the preferred option according to points 412 and 413 of the EM from a health perspective, the costs laid in Table 7.12 clearly indicate more reasons that are obvious. These reasons are that the majority of the cost is not footed by the WG but by tax payers and businesses.

As an e-cigarette user, I visit many retailers of the hardware and e-liquid, the nicotine containing liquids, to obtain new devices or spare accessories. While I

am in the retailers shop, I see many people that are sampling flavours for their next purchase. The proposed ban on enclosed public spaces hits retailers at this most important point in a smokers switch to e-cigarettes. The proposals will stop this and it will have a great negative impact on their sales and most importantly the number of smokers changing to vaping. This move will make the numbers of smokers in Wales increase as the proposed restrictions will not give switchers incentives. There are over 70 retailers that I know of in Wales and this proposal will affect each of those retailers in the worst possible way.
The proposal will also have a harmful impact on the e-liquid manufacturers in Wales. In my local area there are 3 e-liquid manufacturers. In order to create and maintain high quality products they carry out taste tests and this involves using an e-cigarette. The proposal means that as these manufacturers are workplaces therefore the act of using an e-cigarette will be banned. However, I do welcome the suggestion that in section 27 of Annex A which offers manufacturers to be exempt from the smoke-free regulations. Unfortunately, this suggestion does not extend to e-cigarette retailers. It would be best for general smoking prevalence reduction to offer an exemption for these retailer premises.
Finally a grave concern is that the bodies that advise the WG such as Public Health Wales are supportive of the recent report from Public Health England. However, it seems that the WG and PHW do not share the same view as their English counterparts. Please see the official statement from PHW in this link https://twitter.com/PublicHealthW/status/633978563788701696 This not only worries me that my health as a former smoker and e-cigarette user is not worthy of a change of stance by the WG with the most current UK based information.

Question 2

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?
No, there is absolutely no balance between benefits and dis-benefits relating to e-cigarette use. In paragraph 375 of the EM, it is suggested that e-cigarette users will have to leave the premise to comply with the legislation. Through this the WG and local authorities will create an image by the combination of smokers and e-cigarette users in the same area means that there is no difference between

the products and hence there are no health benefits in switching. Also, as e-cigarette users will have no immediate enticement to make the switch straightaway which also means that e-cigarette users may not be able to convince smoking family members or friends to switch as the use in social environments will be prohibited. This clear dis-benefit means smoking numbers will not decrease as sharply as it has in the past year to the 21% from 23%.
ECITA, the Electronic Cigarette Industry Trade Association, has looked at the costs and QALY figures in paragraphs 371 to 373. http://www.ecita.org.uk/ecita-blog/assessing-potential-impact-unintended-consequences-vaping-ban-wales
They suggest that even if 10% of the estimated 33,600 exclusive users were to revert to smoking would equate to a loss £199m in shortened lives. This figure also fails to address the additional costs to health services to treat smoking related illness or disease. The WG fails to see the benefit of the extended lives through using e-cigarettes to the wider economy. If the 15% of e-cigarette users that circumvent the smoke-free requirements, go back to smoking that means that almost 5000 QALYs, using the estimated 33,600 users in paragraph 371, are lost and an equivalent to £300m lost at the lowest estimated QALY. I doubt the WG would like to lose that equivalent in just 1 year as most circumventers will begin smoking again immediately.
The proposals will restrict the opportunities to make the initial switch e-cigarettes as the e-cigarette retailers are those that aid the switch. E-cigarette retailers rely on the ability for their customers to try a variety of nicotine concentrations, flavours and devices. The proposals will prohibit this opportunity and hence a drastically reduce the number of switchers which in turn will decrease the rate of smoking prevalence fall. Without this sort of opportunity the benefits of switching which can include Harm Reversal which is being researched by Riccardo Polosa http://www.biomedcentral.com/content/pdf/s12916-015-0298-3.pdf
http://gfn.net.co/downloads/2015/Plenary%203/Riccardo%20Polosa.pdf

Question 3

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?

Smoking is still “normal” in society, no matter how the WG think otherwise, with an estimated 10million smokers in the UK as given by ASH http://www.ash.org.uk/files/documents/ASH_93.pdf in January 2015. Implying that smoking is not normal is a ridiculous idea. The fact that smokers now have to smoke outside doesn’t mean there are less smokers, the number of smokers still visible on the streets backs up that the use of tobacco cigarettes is still normal. I firmly believe that e-cigarette use normalises stopping smoking. This view is backed up by consistent falls in the percentage of the smoking population, which can be seen from page 2 of the ONS publication http://www.ons.gov.uk/ons/dcp171778_386291.pdf . If the use of e-cigarettes promote smoking then tobacco cigarette uptake would increase and this is simply not the case. Furthermore, only 7.5% of e-cigarette users will use their devices wherever they please and with the remainder of the 1000 respondents vaping outside or doing so indoors after asking permission from the premises owner. This supports that the majority of e-cigarette users are wanting to stop smoking or cut down the number of cigarettes smoked. The use of e-cigarettes for most users are not using e-cigarettes as an avenue to bypass the current smoke-free legislation. http://www.ecigarettedirect.co.uk/ashtray-blog/2015/03/e-cigarette-etiquette.html

At a risk of repetition, the current market regarding devices are of second generation or above. First generation e-cigarettes are the imitation of tobacco cigarettes. These devices are proven to be not as effective as higher generation devices, hence the higher prevalence of larger devices. Scientific basis for this opinion can be seen summarised by Dr K Farsalinos here http://gfn.net.co/downloads/2015/Plenary%203/Konstantinos%20Farsalinos.pdf

Therefore the notion of “replicating cigarettes” has no basis nor do e-cigarettes promote smoking.

Question 4

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?
Currently, all advertising for e-cigarettes falls in line with current rules from the Committees of Advertising Practice which were released in October 2014. There is a specific rule which denotes that advertising should not be deliberately aimed at those under 18. This rule is summarised in points 9 and 11 on this post by ECITA http://ecita.org.uk/ecita-blog/cap-and-bcap-publish-new-uk-

advertising-rules-e-cigarettes It is therefore a preposterous idea that e-cigarettes are directly aimed at young people. I firmly believe that these rules are more than good enough to aid the prevention of e-cigarettes being appealing to young people especially as e-cigarettes are for adult consumers only.
Furthermore, under the Tobacco Products Directive in Article 20 in Section 5, all advertising of e-cigarettes is banned. This is scheduled to be introduced fully in the UK in May 2016 so any further exposure to e-cigarettes will be very limited to none for young people.
ASH published results of their "Use of electronic cigarettes among children in Great Britain" survey in August 2015.
http://www.ash.org.uk/files/documents/ASH_959.pdf
I would like you to look at the bottom of page 2. This graph clearly indicates that the current use of e-cigarettes is low compared to the current use of combustible tobacco cigarettes. The graph also backs up previous comments that smoking is still normal through the "ever tried smoking" data. If e-cigarettes are or were particularly appealing then the "ever tried e-cigarettes" data would be significant ly higher.
Professor Linda Bauld and Cancer Research UK published data also on youth use of e-cigarettes and it ultimately concluded that e-cigarettes do not ultimately lead to tobacco cigarette use.
http://medicalxpress.com/news/2015-06-children-regularly-e-cigarettes.html
Even ASH Wales, published the results of their "Young people and the use of e-cigarettes in Wales" survey in April 2015. Particular attention must be brought to Figures 13 (p23) and 15 (p25) of http://ashwales.org.uk/assets/factsheets-leaflets/ecigyoungpeoplereport_2015.pdf . The first graph, Figure 13, shows very clearly that non-smoking youth don't try e-cigarettes in large numbers therefore the notion of appeal is wrong and only youth that are currently smoke are likely to take up using e-cigarettes. Figure 15 shows that despite a small sample size, those who went on to smoking tobacco after the use of e-cigarettes is 2.4%. This low figure do not warrant any sort of enclosed public space ban on the basis of a gateway effect that simply does not exist. Youth experimentation will always occur with tobacco cigarettes. However, I do prefer that if young people were experimenting with e-cigarettes, this would be a far safer option, 95% safer compared to tobacco cigarettes. This figure was released by Public Health England on August 19th in the following release.
https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
On top of this, they said that regular use of e-cigarettes is rare among youth. In

addition, experimenting with e-cigarettes among youth is 0.3% or less. This data proves that there is no particular appeal of e-cigarettes to young people. Without the visible presence of e-cigarettes, those young people experimenting will try tobacco and will stay on tobacco cigarettes which is proven to be a deadly product. This is not what I want to happen. I would want all young smokers to switch to e-cigarettes and stay on e-cigarettes.
If the WG ignore the surveys from UK sources and continue to use data and research from elsewhere, they are clearly indicating that they do not particularly care for the health of those in their local area.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
The proposal is sensible. However, the e-cigarette industry is growing rapidly. In the past year alone, I know that 2 new e-cigarette retailers have opened in Cardiff alone. This does not reflect the number of new retailers opening in Wales. I believe a register will be a good idea in theory but due to the current number of retailers specific to e-cigarettes growing quickly a register will be hard to maintain especially if it is combined with tobacco cigarette retailers who are already very large if chain supermarkets and corner shops are included.

Question 6

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?
This is a very good idea. This will filter out the retailers that have no basis on good products or harm reduction and want just to make swift money. I would guess that the enforcement of this offence will be handed to Local Councils and Local Trading Standards. These bodies have limited resources to enforce current laws so therefore resources will be further stretched.

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

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 Royal College of Physicians – PHB 25 / Tystiolaeth gan goleg Brenhinol y Meddygon – PHB 25

Public health (Wales) bill

RCP (Wales) consultation response

About us

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in Wales and across the world with education, training and support throughout their careers. As an independent body representing more than 29,000 fellows and members worldwide, including 800 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Amdanom ni

Mae Coleg Brenhinol y Meddygon yn arwain y ffordd o ran darparu gofal o ansawdd uchel i gleifion drwy osod safonau ar gyfer arferion meddygol a hybu rhagoriaeth glinigol. Rydym yn darparu addysg, hyfforddiant a chefnogaeth i feddygon yng Nghymru a ledled y byd drwy gydol eu gyrfa. Fel corff annibynnol sy'n cynrychioli mwy na 29,000 o gymrodorion ac aelodau ym mhedwar ban byd, gan gynnwys 800 yng Nghymru, rydym yn cynghori ac yn gweithio gyda'r llywodraeth, y cyhoedd, cleifion, a gweithwyr proffesiynol eraill i wella iechyd a gofal iechyd.

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From the RCP vice president for Wales
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Dr Alan Rees MD FRCP
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From the RCP registrar
O'r cofrestrydd yr RCP
Dr Andrew Goddard FRCP
[redacted]

25 August 2015

Dear colleague,

WELSH GOVERNMENT PUBLIC HEALTH (WALES) BILL CONSULTATION

Thank you for the opportunity to give written and oral evidence on the Welsh Government's consultation on the Public Health (Wales) Bill.

Our Response

RCP agrees that

- the public health bill should be an *enabling framework* for new and future public health legislation
- legislation should be proportionate , evidence based and is essential in certain circumstances
- there should be a tobacco retail register in Wales
- there should be a ban on the sale of e-cigarettes to people aged under 18
- smoking cigarettes should be banned in hospital grounds and children playgrounds.

RCP does not agree that

- there should be outright ban on e-cigarettes in public places as this is counter -productive and does not reflect the evidence base upon which government should seek to make legislation

RCP urges the government to

- maintain the public health focus and *health for all* in policies
- extend existing regulations for food standards
- reaffirm the necessity for the NHS to implement fully the All Wales Obesity Pathway
- establish a National Forum with cross governmental leadership to tackle Obesity.
- legislate as soon as possible to minimise the harm of excessive alcohol consumption

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Introduction

RCP believes strongly that this public health bill should be substantial and act as the *enabling framework* which will galvanise and support the Welsh Government and other bodies to address emerging public health issues proactively as they arise and also act as the 'coat hanger' for future legislation and regulations.

RCP believes that the Bill should

- set out clearly the direction, ambition and framework for public health policy in Wales including defining the unique role of Welsh Government ,its immediate legislative competencies and those available to Wales for the future
- drive and support targeted, evidence based change to the health and wellbeing of Welsh residents and importantly, as a priority introduce legislation proven to reduce inequalities
- become a crucial and separate component of the legislative armoury available to Welsh Government and by doing so, mitigate the potential for the Well-being of Future Generations (Wales) Act 2015 and the requirement on public bodies to produce local well-being plans to be the only vehicle for tackling public health challenges facing Wales
- enact legislation but its application should be proportionate and always reflect a robust evidence base.

The Health Minister when providing recent evidence to the Health and Social Care Committee in June, 2015 referred to the constraints and the limitations of the powers available in Wales to act immediately. We acknowledge this position but are frustrated that this prevents Wales taking a wider and more immediate proactive approach to mitigate urgent public health challenges such as the obesity epidemic and reducing harm from the increasing numbers of people drinking too much alcohol. We note that the Minister stated that

> *'there are real constraints on us, and those constraints are particular in the field of obesity'*

RCP will continue to lend its support by drawing upon its extensive membership and knowledge, to assist the Welsh Government to influence non devolved policy at the Westminster Government and also to support the Welsh Government secure additional devolved powers for Wales to implement legislation that reflects RCP policy and aspirations.

Our response

Part two: Tobacco and nicotine products

Over the past decade the RCP has powerfully advocated in favour of harm reduction for people addicted to tobacco smoking. The RCP recognises that electronic cigarettes and other novel nicotine devices can provide an effective, affordable, and readily available retail alternative to smoking tobacco. According to the recent independent evidence review of e-cigarettes by Public Health England, published in August 2015, e-cigarettes have the potential to significantly reduce levels of smoking and are 95% less harmful than smoking tobacco. This latest review provides sound evidence to support our view that smoking e-cigarettes is a valuable and effective tool to support people to give up smoking and that is does not provide a pathway for people to start smoking cigarettes.

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The RCP does not support a comprehensive ban on the use of e-cigarettes in enclosed and substantially enclosed public places. The recent report published by Public Health England clearly demonstrates that smoking e-cigarettes has become a popular method to quit smoking tobacco. There is no evidence that smoking e-cigarettes in enclosed spaces poses a significant risk to other people from inhalation of its vapour. We also note the recent announcement that the Scottish Government has withdrawn a similar intention acknowledging that there are health benefits to smokers from using e-cigarettes. We feel that an outright ban on nicotine-containing devices (e-cigarettes) in public places is unwise, counter -productive and does not reflect the evidence base upon which government should seek to introduce new legislation. It will not help to achieve the ambitious Welsh Government target to reduce smoking rates to 16% by 2020, however it is vitally important that the effects of smoking e-cigarettes in public places should continue to be monitored.

We strongly endorse the importance of regulation for e-cigarettes to ensure their safety and to put in place appropriate controls on their sale and marketing. We note the requirement for Wales to comply with the EU Tobacco Products Directive which comes into effect in March 2016. The RCP is not aware of any evidence that shows electronic cigarettes normalise tobacco smoking in indoor public places, although it will be important to safeguard the uptake of e-cigarettes through restrictions on advertising and marketing, and other measures to ensure that e-cigarettes are not promoted as a fashion item, particularly to children .

If a ban on the use of e-cigarettes in enclosed and substantially enclosed public places were to be implemented in Wales, **we would support an exemption for those living in prison**. Smoking prevalence in prisons remains at a level significantly higher than the general population, and this puts prisoners and staff at risk from the harm caused by smoke inhalation. It is crucial that prisoners are given help and support in quitting, which could include the use of e-cigarettes in a controlled way.

The RCP strongly supports a ban on smoking tobacco in the grounds of hospitals and children play areas. The position of voluntary prohibition creates uncertainty, confusion and needs legislation to ensure that people are not subject to the harmful effects of tobacco based products. Starting with public places where children may be present, healthcare facilities, leisure centres, parks is a sensible starting point. However, debate is needed on how far this restriction should extend. RCP notes the intention of some local authorities in England for example, Brighton and Hove Council, to ban smoking on its beaches from 2016.

Creating a national register of retailers and nicotine products

The RCP welcomes the proposal for a retail register which is in line with the Tobacco Control Action Plan. The introduction of a retail register in Scotland has been an effective way of monitoring availability and trends in availability and we would therefore support the introduction of a similar scheme in Wales. We also believe that a retail register would help local authorities to tackle the problem of under-age sales and assist in the enforcement of the display ban. Smoking is also increasingly concentrated in less affluent parts of Wales where many may purchase smuggled or fake tobacco products. A register will mitigate the effects of this practice on legitimate small business. Any measure that helps to reduce the prospect of under-age sales is strongly welcomed.

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The RCP supports the regulation of electronic cigarettes and other novel nicotine products as medicines and it is important to note that in the event of the regulation of e-cigarettes as medicines by the UK Medicines and Healthcare Products Regulatory Agency (MHRA), it would be inappropriate to prevent patients from using prescribed medicines indoors

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

We welcome the proposed ban on the sale of e-cigarettes to people under 18, and on the proxy purchasing of e-cigarettes for those under 18. We would also support measures to prevent marketing to children and non-smokers, and the regulation of these products to guarantee quality standards and protect consumers. The proposal to make it an offence to deliver tobacco products to a person who is under the legal age of sale for tobacco products would be in line with other measures, such as the vending machine ban, point of sale display bans and the introduction of a retail register, to limit as far as possible the access of young people to tobacco products.

The RCP supports the proposal to use restricted premise orders I (RSOs) implemented via enforcement officers of local authorities in Wales as a further deterrent to reduce the under-age sale of tobacco based products.

Other comments

The narrow focus of this particular consultation is under stood and we welcomed the recent announcement by the Welsh Government to consult on a proposal to set a minimum price of 50p per unit of alcohol. However, the RCP wants to take this opportunity to reaffirm its concern regarding the following:

Maintaining the public health focus and health for all in policies

- In a time of austerity and immediate service pressures the level of investment in public health and action to implement public health policies slips down the agenda. The scale and scope of the 'preventable public health challenge' continues to rise at an alarming rate. A continued focus and strong national leadership is needed to stem even greater pressure on resources.

- The Public Health (Wales) Bill should contain a commitment to progressing ***health in all policies*** including a provision in the Bill to specify at a later date, a statutory responsibility to complete a health impact assessment for specific local and national plans. If this became a reality, including government policies, it would raise the profile of public health in society; help to increase awareness and knowledge of important public health issues and concerns across government departments and in all sectors. RCP will follow with interest, the development of the National Well-being Indicators in 2016 and the effectiveness of the proposed local well-being plans of public bodies and hope that these will add impetus to tackling some of our persistent and epidemic challenges clinicians encounter on a regular basis.

Food standards, poor nutrition and obesity

- RCP is disappointed that the regulation of food standards in settings such as pre-school and care homes are not included within the Public Health (Wales) Bill. Food standards make an important impact on people's health.

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- The risk of many chronic conditions, in particular coronary heart disease, obesity, diabetes and some cancers, is increased by poor diet and diet-related disease has been estimated to cost the NHS around £6 billion a year. The cost of obesity alone has been predicted to reach £49.9 billion per year by 2050 by the Foresight report.[26] Wales faces some of the biggest challenges in the UK, with the Child Measurement Programme reporting prevalence of overweight or obese children to be 26% in reception year.[27]
- Maintaining food standards, particularly in health settings such as hospitals which seek to keep people well, can influence the public's perception of foods that are considered acceptable and healthy. The public sector provides food for some of the poorest and most vulnerable people living in Wales. Catering Standards for Food and Fluid Provision for Hospital Inpatients, and the All Wales Hospital Menu Framework standards ensure patients receive adequate nutrition to assist with their recovery whilst in hospital, but a lot more could be achieved if we ensure that healthy and balanced meals and food are offered in staff restaurants (which may also include staff, patients and visitors). Mandated criteria for the provision of only healthier retail items in hospital restaurants and outlets would help hospitals in Wales to fulfil their responsibility for improving the health of the population they serve.
- The extension of the Welsh Government's Health Promoting Hospital Vending Directive into other public sector settings, such as Local Authority premises including leisure centres and community centres, would give added impetus to the cultural change needed regarding healthy and un-healthy food.

- Health and Social Care Committee recommendations of 2014 and the implementation of the governments' **All Wales Obesity Pathway** appear to be ignored, stalled or have secured limited prominence in strategic documents and delivery plans of Local Health Boards.

- The recently announced Strategic Plan for Public Health Wales 2015-2018 referred to action over the next three years to prevent obesity in children (0-7yrs) however it did not identify any action for adults or older children. Welsh Health Survey data from 2009/12 shows that 28 per cent of adults in the most deprived areas of Wales were obese compared to 17 per cent in the least deprived areas. For overweight and obesity combined, these figures were 61 per cent in the most deprived areas and 53 per cent in the least deprived. Obesity significantly increases the risks of diseases, such as diabetes, heart disease, cancer and stroke. A holistic approach to tackling the obesity epidemic is needed that recognises children within a family context and reduces the rising numbers of adults with obesity.

- The potential **for a cross government lead and a national group** to oversee joined up action on obesity is an example of how government can demonstrate leadership, whilst facilitating strategic engagement from a wide range of stakeholders who collectively can marshal significant resources and achieve considerable impact on solving shared problems. RCP would commit fully to, and support such a forum.

Minimising the harm of excessive alcohol consumption

- Opportunities to restrict the advertising of alcohol and the cross marketing of alcohol in retail outlets should be taken so that Wales can adopt where possible similar legislative practices as in Scotland.
- We strongly welcome the consultation on the Draft Public Health (Minimum Price for Alcohol) Bill.

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Finally, RCP is pleased to accept an invitation to give oral evidence and discuss our views in more detail on 17 September 2015. Dr David Price, Regional Advisor for the RCP Wales and Beverlea Frowen will be attending.

With best wishes,





Dr Alan Rees
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
RCP registrar
Cofrestrydd yr RCP

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Consultation on the Public Health (Wales) Bill – response from the British Lung Foundation

About us

The British Lung Foundation campaigns for service improvements for people with lung conditions across all forms of health and social care. We deliver direct support to people living with a lung condition and their carers through our helpline, online forums, health information, and through a network of Breathe Easy groups – whose purpose is to improve the lives of people living with a lung condition by enabling people to better self-manage, reduce isolation, and improve wellbeing.

Chronic lung conditions present a huge challenge for Wales, and one which requires SMART solutions, from prevention and early interventions, to caring for people at the end of their lives. Wales has some of the highest incidence of lung disease in Europe; it affects around one in five people here. Where someone lives, their lifestyle, diet, activity, employment, and education all have a cumulative affect on shaping, for better or worse, overall health and wellbeing. Respiratory disease manifests itself in our most deprived communities and poor lung health is at the epicentre of these economic and social determinants of health.

We are the only UK charity that represents people with any lung condition.

Smoking prevalence in Wales

Based on 2014 Welsh Health Survey data the percentage of the adult (age 16 and over) population in Wales categorised as a smoker is 20%, with this figure greater for males (22%) than females (19%).[1] We are delighted by the reduction in the number of people that smoke in Wales as smoking is the biggest contributor to Chronic Obstructive Pulmonary Disease (COPD). However, weare concerned by the huge variation in the number of people smoking which exists between different local authorities. Smoking prevalence rates are a lot higher in areas such as Blaenau Gwent and Torfaen in comparison with authorities such as Monmouthshire.

Consultation questions

Part 2: Tobacco and Nicotine Products

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

The British Lung Foundation accept that there is a lot we do not know about e-cigarettes at this time, but the national and international evidence does not

[1] Welsh Government (2015). Welsh Health Survey 2014.

appear strong enough to support a ban at this stage. The below points outline our rationale for taking this position.

A. Efficacy as an aid to smoking cessation/use by current smokers

The harm-reduction potential of e-cigarettes as a lower risk alternative to smoking has been widely reported. E-cigarettes have been described by some as "one of the biggest public health innovations of the last three decades that could potentially save millions of lives".[2] A UK-based survey by ASH suggests that the desire to quit, cut down or avoid smoking is the main reason for ongoing e-cigarette use.

Although it has been suggested that e-cigarettes may also satisfy "hand to mouth" behaviour not sufficiently addressed in most Nicotine Replacement Products (NRPs)[3], research has found varying degrees of efficacy for the use of e-cigarettes as an aid to smoking cessation. For instance, a 2014 cross-sectional survey of nearly 6,000 adults, published in the journal Addiction, found that people attempting to quit smoking without professional help are approximately 60% more likely to report succeeding if they use e-cigarettes than if they use willpower alone or over-the-counter NRPs such as patches or gum.[4]

However, other research has delivered more modest results. For instance, a 2013 randomised control trial of 650 people, published in the Lancet, did not find the same degree of efficacy, reporting e-cigarettes to be "modestly effective at helping smokers to quit". Similarly, a 2014 longitudinal study published in the Journal of the American Medical Association (JAMA) found that "when used by a broad sample of smokers under 'real world' conditions, e-cigarette use did not significantly increase the chances of successfully quitting cigarette smoking".[5] There is no indication that e-cigarettes are nearly as effective as methods such as smoking cessation services in helping people quit.

Reviewing all available data on the efficacy of e-cigarettes as an aid to smoking cessation, the Cochrane collaboration published a review in December 2014, concluding that e-cigarettes were more effective that nicotine replacement patches at helping smokers cut down.[6] It also concluded that there was no evidence that dual use of e-cigarettes and cigarettes made smokers any less likely to quit. However, the review also concluded that the quality of evidence in many

[2] Nicotine Science and Policy website http://nicotinepolicy.net/n-s-p/1753-who-needs-to-see-ecigs-as-part-of-a-solution

[3] 'Electronic cigarettes' - Action on Smoking and Health (ASH) briefing, March 2014: http://ash.org.uk/files/documents/ASH_715.pdf

[4] Brown, J. et al. Real-world effectiveness of e-cigarettes when used to aid smoking cessation: a cross-sectional population study. Addiction DOI: 10.1111/add.12623. http://onlinelibrary.wiley.com/doi/10.1111/add.12623/abstract

[5] Grana R et al. A Longitudinal Analysis of Electronic Cigarette Use and Smoking Cessation *AMA Intern Med.* 2014;174(5):812-813. doi:10.1001/jamainternmed.2014.187. http://archinte.jamanetwork.com/article.aspx?articleid=1846627

[6] McRobbie H et al. Can electronic cigarettes help people stop smoking or reduce the amount they smoke, and are they safe to use for this purpose? The Cochrane Collaboration 2014 http://summaries.cochrane.org/CD010216/TOBACCO_can-electronic-cigarettes-help-people-stop-smoking-or-reduce-the-amount-they-smoke-and-are-they-safe-to-use-for-this-purpose#sthash.nWXsbMQj.dpuf

of the areas was low, and that more studies were recommended (many of which have been started).

It has been suggested that e-cigarettes might even prolong smoking habits. For instance, concerns have been raised that e-cigarettes counter-act the "de-normalisation" impact of the ban on smoking in public places by bringing about a "re-normalisation" smoking-related behaviour.[7] Similarly, it has been suggested the use of e-cigarettes in public places where smoking is banned might allow smokers to maintain their nicotine addiction when they might otherwise be encouraged to cut back on their consumption. Although an evidence review by the Cochrane Collaboraion concluded that these fears are currently unfounded, the review authors did recommend further investigation, due to the weakness of current data. The Cochrane review also concluded that nicotine containing e-cigarettes were more effective as cessation aids that those without nicotine.[8]

B. Variation in smoking cessation efficacy between brands

It has been theorised that data in this area has been adversely affected by the difference between brands, particularly with regard to the efficiency of the device in nicotine delivery.[9] There is some evidence indicating that e-cigarettes are gradually becoming more reliable in this regard.[10] Some research has indicated that e-cigarettes are more effective as smoking cessation aids when used by more experienced smoking cessation users.[11] There is little research comparing different brands or efficiencies of nicotine delivery with their efficacy as a smoking cessation aid.

D. Associated health risks

Nicotine in general is associated with a variety of side effects: other NRPs have been shown to increase the users risk of heart palpitations and chest pains, skin irritation, nausea, and mouth and throat soreness.[12] There is anecdotal evidence that people who were not previously heavy smokers have upped their nicotine in-take considerably since they took up e-cigarettes instead of or in addition to smoking, due to the greater ease and lower health risks of consuming nicotine

[7] 'The Renormalization of Smoking? E-Cigarettes and the Tobacco "Endgame"' - Amy L. Fairchild, Ph.D., M.P.H., Ronald Bayer, Ph.D., and James Colgrove, Ph.D., M.P.H. N Engl J Med 2014; 370:293-295, January 2014

[8] Goniewicz ML. and Zielinska-Danch W. (2012): "Electronic cigarette use among teenagers and young adults in Poland", Pediatrics, 130 e879; doi:10.1542/peds.2011-3448.

[9] Vansickel AR, Cobb CO, Weaver MF, Eissenberg TE. A clinical laboratory model for evaluating the acute effects of electronic 'cigarettes': nicotine delivery profile and cardiovascular and subjective effects. Cancer Epidemiol Biomarkers Prev 2010; 19: 1945–53

[10] Robertson OH, Loosli CG, Puck TT et al. Tests for the chronic toxicity of propylene glycol and triethylene glycol on monkeys and rats by vapour inhalation and oral administration. J Pharmacol Exp Ther 1947; 91: 52–76.

[11] Bullen C, McRobie H, Thornley S, et al. Effect of an electronic cigarette on desire to smoke and withdrawal, user preferences and nicotine delivery: randomized cross-over trial. Tobacco Control 2010; 19: 98–103

[12] Mills E et al. Adverse events associated with nicotine replacement therapy for smoking cessation A systematic review and meta-analysis of 120 studies involving 177,390 individuals. Tobacco Induced Diseases 2010; **8**: 8 http://www.ncbi.nlm.nih.gov/pubmed/20626883

through an e-cigarette. However, this has not been supported by any research findings.

Early research into e-cigarette use has indicated a range of short-term health impacts in addition to those associated predominantly with nicotine. For instance, in one study, e-cigarette use for only five minutes by otherwise healthy smokers was found to temporarily increase airway resistance (blocking the air getting into and out of the lungs) and local oxidative stress (a natural response by the lungs for dealing with unwanted inhaled material, which causes inflammation).[13] There is a possibility that the latter might lead to long term obstructive lung damage – this is an area in need of further research.

A recent study also found that e-cigarette use among young people may 'worsen acute respiratory diseases, including asthma and bronchitis'.[14] There is little other research into the health risks of e-cigarettes for people with lung disease, despite smoking cessation being recognised as one of the most effective treatments for respiratory conditions – this is another area in need of research.

Concerns have been raised over the safety of the e-cigarette vapour. The US Food & Drug Administration (FDA) reported detectable levels of known carcinogens and toxic chemicals including diethylene glycol (a toxic constituent of anti-freeze) and nitrosamines (known cancer-causing tobacco constituents) in two different brands of e-cigarettes.[15] A range of studies found various toxins in e-cigarette vapour.[16,17,18,19] Although research has suggested the quantity of toxins are unlikely to represent a significant health risk[20,21,22], with the combination of ingredients having been found to vary so significantly (even between supposedly identical liquids)[23,24], concerns persist over the safety controls around production of vaporising liquids. It has been argued that greater regulatory oversight, as recommended in section 1, would help ease those concerns.

[13] Vardavas C et al. Short-term pulmonary effects of using an electronic cigarette. Chest 2012; **141**: 1400-06
[14] 'Electronic cigarettes may cause, worsen respiratory diseases, among youth, study finds', RTI International, April 2014
[15] US Food & Drug Administration. Summary of results: laboratory analysis of electronic cigarettes conducted by FDA. www.fda.gov/NewsEvents/PublicHealthFocus/ucm173146.htm
[16] Laugesen M. Safety report on the Ruyan® e-cigarette and cartridge. 2008
[17] Williams M, Villarreal A, Bozhilov K, Lin S, Talbot P. Metal and silicate particles including nanoparticles are present in ECcartomizer fluid and aerosol. PloS one 2013;8(3):e57987.
[18] Goniewicz ML, Knysak J, Gawron M, et al. Levels of selected carcinogens and toxicants in vapour from electronic cigarettes. Tob Control 2013;23(2):133–9.
[19] Kim HJ, Shin HS. Determination of tobacco-specific nitrosamines in replacement liquids of electronic cigarettes by liquid chromatography-tandem mass spectrometry. Journal of Chromatography A 2013;1291:48–55
[20] Siegel M. Metals in ECVapor are Below USP Standards for Metals in Inhalation Medications.
[21] Burstyn I. Peering through the mist: systematic review of what the chemistry of contaminants in electronic cigarettes tells us about health risks. BMC Public Health 2014;14(1):18.
[22] Cahn Z, Siegel M. Electronic cigarettes as a harm reduction strategy for tobacco control: a step forward or a repeat of past mistakes? J Public Health Policy 2011;32(1):16–31.
[23] 'Electronic cigarettes' - Action on Smoking and Health (ASH) briefing, March 2014: http://ash.org.uk/files/documents/ASH_715.pdf
[24] 'Electronic cigarettes' - Action on Smoking and Health (ASH) briefing, March 2014: http://ash.org.uk/files/documents/ASH_715.pdf

There have been several reported incidents of e-cigarettes over-heating and exploding or starting fires. Although occurrences remain very rare compared to the breadth of e-cigarette use, they have been a source of considerable concern within the media. Little research has been conducted into the relative safety of various brands when subjected to real life conditions, and their use simultaneous to use of therapies such as oxygen.

Although early research suggests a potential link with the long-term development of obstructive respiratory diseases[26], there is no indication that the risks are anywhere near those of smoking, and have yet to be conclusively substantiated. Overall, there is little research published into the long-term health impact of e-cigarettes, although research in this area is underway and is expected to be published within the next year. E-cigarette use is not advised during pregnancy.

E. Health impact of second-hand exposure to e-cigarette vapour

Research suggests second-hand exposure to e-cigarette vapour may result in involuntary inhalation of nicotine, but not of toxic tobacco-specific combustion products common in second-hand smoke.[25] Testing on animals suggests any health risks associated with second-hand vapour exposure are unlikely to extend beyond irritation of the throat, if at all.[26] The impact of second-hand nicotine exposure is not fully understood.

Conclusion

The harm reduction potential of cigarettes as an alternative to smoking is widely acknowledged as immense, and there is no evidence that e-cigarette use represents anywhere near the same health risk as smoking. Although evidence varies as to the value of e-cigarettes as an aid to smoking cessation – some studies observing considerable improvements over over-the-counter NRP, some observing no noticeable affect - it has been speculated that this may relate to the huge variation between brands, particularly with regard to nicotine delivery. Although the Cochrane review of evidence concluded that e-cigarettes were more effective than patches as a smoking cessation aid, the authors commented that the quality of the evidence currently available to support this is relatively low. This is therefore an area in need of urgent research.

The main reason to still recommend NRPs over e-cigarettes relates to certainty over the safety profile. In the short term, there is some evidence that e-cigarette use can cause adverse side-effects in some people: continued use of the same brand by these people would not be recommended. Greater testing of various products with regard to their propensity for combustion would also be useful, although the relatively low incidence of e-cigarette explosions makes this less

[25] Czogala J et al. econdhand Exposure to Vapors From Electronic Cigarettes. Nicotine Tob Res (2013) doi: 10.1093/ntr/ntt203 http://ntr.oxfordjournals.org/content/early/2013/12/10/ntr.ntt203.short

[26] Bauld L., Angus K. and de Andrade M. (2014). E-cigarette uptake and marketing: A report commissioned by Public Health England.

urgent. More wide-spread concerns arise from uncertainty over the long-term health impact, and the use of e-cigarettes by people with pre-existing lung conditions (for whom smoking cessation represents one of the most cost-effective interventions). In both these applications, more research is urgently required (only in the former is it currently being widely conducted). The establishment of long-term patient cohorts will facilitate research into these areas, though it may take many years to confirm their results.

Overall, current smokers should be advised that while there is uncertainty over the long-term health implications of e-cigarette use, vaping can help with smoking cessation if they have not enjoyed success with NRPs or smoking cessation services alone. They should also be advised that there is considerable variation between brands, and that if one brand doesn't work for them, another might prove successful. As with NRPs, however, they should be advised that e-cigarettes, of any single brand or combination thereof, should not be considered a long-term substitute for smoking.

Due to the uncertainty over the long-term health risks and the more general inadvisability of nicotine consumption, e-cigarette use is not recommended for non-smokers. For this reason, e-cigarettes are not recommended for children. Further research would be useful into the gateway effect of vaping: although this it is expected that such research would currently confirm the risk to be relatively low, this may change over time as e-cigarette use becomes more widespread.

- 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)?

We are in favour of extending the current restrictions on tobacco smoking to include some non-enclosed spaces, such as hospital grounds, mental health units, playgrounds, school gates and beaches. We consider this to be an important development that will serve to further de-normalise smoking as an activity in communities across Wales as well as protect members of the public from the damage to their health caused by inhaling second-hand smoke. The current smoke-free legislation, introduced in the UK in 2007, bans smoking in virtually all enclosed and substantially enclosed public and work places. These regulations have been shown to be effective in terms of initiating health benefits for smokers/non-smokers and changes in smoking related attitudes and behaviour.[27]

As per our answer above, we do not believe sufficient evidence currently exists to warrant blanket banning the use of e-cigarettes in enclosed public and work places, but we would support the right of organisations to introduce local bans and for these to be enforced. This idea is explored further in the consultation document.

[27] Bauld, L. (2011). The impact of smokefree legislation in England: Evidence review.

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

We feel at present that the provisions in the Bill are weighted too heavily in favour of protecting the public from the potential hazards associated with the use of e-cigarettes, to the detriment of the potential benefits accrued by smokers resulting from the use of e-cigarettes as a smoking cessation tool.

The Bill could have gone further and the explanatory memorandum could have gone further in providing support for smoking cessation services and supporting individuals to quit. It could have set statutory targets for numbers of adults smoking and required Welsh Ministers to invest money in smoking cessation services to deliver this target – this was not present and was a missed opportunity.

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

We believe that there is too little evidence to make determine whether smoking behaviours are being re-normalised or not at stage. However in terms of changing the habits of individuals we do have some concerns that life style changes could be undermined by e-cigarettes.

If someone is diagnosed with COPD one of the most important things to do is to stop smoking as soon as possible. This is an incredibly difficult thing to do and typically it would come as part of a lifestyle change. Through pulmonary rehabilitation and/or the exercise referral scheme, the importance of breathing techniques and exercise are introduced, and the hope is that an individual will change their lifestyle, get more active and not fall back into smoking. E-cigarettes do not change life style behaviours and in fact one of the perceived benefits to younger smokers if the ability to 'vape' inside or in a workplace. Studies have shown a significant number of e-cigarette users continue to smoke at a reduced level[28], and we are concerned that they leave the former in the life style they were previously in, reducing the chance that they will quit completely.

[28] Chapman S. (2014). E-cigarettes: the best and the worst case scenarios for public health. British Medical Journal http://www.bmj.com/content/349/bmj.g5512

- 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?

We believe that the existing evidence does not support this position and that it is too soon to tell.

A 2014 US study found that adolescents who used the devices were more likely to smoke tobacco and less likely to abstain from smoking, adding to pre-existing fears that e-cigarettes may provide a route into conventional smoking and nicotine addiction.[29] However, other researchers, assessing the same source data, have commented that the study authors did not give due allowance to experimental use, pointing out that there is no indication that the e-cigarette use came first.

A widely-quoted 2014 study found that between 2010 and 2014, a rise in the rates of e-cigarette use among 15-19 years old Polish students corresponded with an increase in the use of tobacco products.[30] Yet it has been pointed out that the study findings did not methodically trace the same students and (in many) took data from different schools. It was concluded by the study's critics that, as a result, the study as published cannot be considered evidence of a gateway effect (instead merely shows different rates of e-cigarette and tobacco use among different student populations). The study authors are currently analysing the data available to see if more accurate conclusions regarding the gateway effect can be drawn.

UK-based research indicates that general e-cigarette use among children is very low and consists almost entirely of those self-defining as current or former smokers, suggesting no gateway affect.[31] Similar data has arisen from in US jurisdictions and in Europe.[32] More targeted research is being conducted and will shed further light on this issue.

[29] 'Electronic Cigarettes and Conventional Cigarette Use Among US Adolescents: A Cross-sectional Study', UCSF Center for Tobacco Control Research and Education. Lauren M. Dutra, ScD; Stanton A. Glantz, PhD, JAMA Pediatrics (March 2014)
[30] Goniewicz M et al. Rise in Electronic Cigarette Use Among Adolescents in Poland. Journal of Adolescent Health, 2014. DOI: http://dx.doi.org/10.1016/j.jadohealth.2014.07.015
[31] YouGov for ASH Wales. Total sample size was 1,002 adults. Fieldwork was undertaken between 26th February to 12th March 2015. (in press).
[32] CDC. National Youth Tobacco Survey. Atlanta, GA: US Department of Health and Human Services, CDC; 2013.

- 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?

We sympathise with the view that it may be different for managers of premises to enforce the existing Smoke-free premises regulations, but do not believe that this constitutes a justification for a Wales-wide ban on using e-cigarettes in public spaces. We support the right of individual organisations to ban e-cigarettes and have set out proposals in the 'Other comments' section of this document to strengthen the rights of these organisations.

- Do you agree with the proposal to establish a national register of retailors of tobacco and nicotine products.

We agree with the proposal for a national retail register of retailors of tobacco and nicotine products. We welcome the measure as an important step towards reducing the number of young people in Wales who become smokers or start using e-cigarettes, and consider it to be both workable and proportionate. Whilst the evidence on the long term effect of e-cigarettes is limited, nicotine is recognised to be a highly addictive substance, and we are concerned that at present seemingly anyone can sell e-cigarettes or other nicotine products. We believe that the introduction of a registration scheme will help to crack down on underage sales and sales of illegal tobacco/nicotine products.

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

Yes. The establishment of a national register of retailors of tobacco and nicotine products will hold retailors more accountable for their actions if caught partaking in underage sales and will make it easier for them to be monitored and tracked over time.

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

Yes. This will act as a greater deterrent to any retailors tempted to breach the new requirements. It is important however that following any changes the regime is easy to enforce plus there should be clear guidance for enforcement officers and magistrates on how to implement the changed regime.

- 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?

We support the measure and believe that it would serve as a deterrent to prevent tobacco or nicotine products falling into the hands of children.

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

We believe the proposals to establish a national register of retailors of tobacco and nicotine products, strengthening the Restricted Premises Order regime and prohibiting the handing over of tobacco and/or nicotine products to a person under the age of 18 will each contribute to improving public health in Wales.

However, we are concerned that the proposal to place restrictions on the use of nicotine inhaling devices such as e-cigarettes in enclosed public and work places may serve to damage public health in Wales. There is a clear risk that this regulation will reduce uptake of e-cigarettes among current adult smokers who may otherwise have sought to use the device in an attempt to quit tobacco smoking or harm reduce. The British Lung Foundation therefore recommends that any decision to on the wholescale ban the use of e-cigarettes in enclosed public and work places in Wales should be delayed until additional evidence is forthcoming.

Other comments
As stated throughout this document, the British Lung Foundation supports the Welsh Government's efforts to reduce the number of people smoking and sections of the Bill that increase the number of places where people can smoke. We have been shocked by the rapid increase in the popularity of e-cigarettes and remain unclear on the long term effect that they will have on smoking cessation. However there is not enough evidence to prove that second hand vapour from e-cigarettes are harmful or that they are a gateway product.

We would like to see a greater focus on tobacco control from than e-cigarettes in the Bill and would urge the committee to consider the following proposals.

1. Chapter 1 – removal of nicotine inhaling devices from the substantial ban
We would propose that chapter 1 is amended so that the ban is focussed solely on tobacco products an organisation/company wants to introduce a ban in its premises. This would require the following amendments

Chapter 2 title	No change
Section 2	No change
Section 3	No change
Section 4	Remove 'or using a nicotine inhaling device' in title Remove 4(2)
Section 5	Remove 'or using a nicotine inhaling device' in title Remove 5(1)(b) Remove 'or using a nicotine inhaling device' in 5(4)

Section 10	Remove 'or using a nicotine inhaling device' in 10(4) Delete all from 'in relation to' in 10(5)

2. Voluntary bans on the use of e-cigarettes or nicotine inhaler devices

We do not believe that there is sufficient evidence at this time to ban the use of e-cigarettes in every location where smoking tobacco is banned, but we do support organisations having the power to ban the devices if they feel it is appropriate. This might be a community centre due to the high number of children using it. It could be a nightclub where there is concern that staff can't distinguish e-cigarettes and cigarettes in poor lighting. There are countless reasons why an organisation or company might wish to introduce a voluntary ban.

At present there are companies across Wales already that already operate a ban on e-cigarette use,[33] but this relies on the good will of staff or customers, and is not legally enforceable.

We propose inserting a new section into Chapter 2 that gives organisations the ability to apply to a local authority to register that e-cigarettes are banned in their premise. This new provision would allow sections 6,7,9 and 11 to apply to the organisation or company, allowing them to be supported by local authority enforcement officers if needed. This new section would need to be an enabling power so that Welsh Ministers could introduce guidance setting out how the voluntary registration would operate, but we believe that this is more measured response rather than the complete ban across Wales envisaged by the Welsh Government.

3. Statutory target on smoking prevalence

Another additional measure that we would like the committee to consider is a statutory target on the numbers of adults smoking. The Welsh Government has a target within the Tobacco Control Action Plan to reduce the number of adults smoking to 20% by 2016 and 16% by 2020. The 16% is a bold target for Wales, but at present it is simply a health board and civil service target like many other targets. The British Lung Foundation would like to see the 16% target put on the face of the Bill and for Ministers to be required to report on the smoking prevalence rates annually. Statutory targets are not used very often, but do exist on child poverty and climate change. A statutory target would send a powerful message this target matters allowing money to be released to.

[33] 'Is there a stealth ban on e-cigarettes in Cardiff? Here the public places where you already can't use a e-cigarette' http://www.walesonline.co.uk/news/wales-news/stealth-ban-e-cigarettes-cardiff-here-9444814

4. Physical activity and exercise

Finally we note that there is nothing in the Public Health Bill on physical activity and exercise and we wonder whether this is a missed opportunity. The Bill focusses on the huge public health problem caused by smoking and focusses on public bans, but does not focus on smoking cessation, physical activity or exercise. The British Lung Foundation does see a need to legislate for smoking cessation services (money would hopefully be invested based on the statutory target), but we do see an opportunity to legislate on physical activity and exercise.

We would propose an additional section that amends the Well-being of Future Generations Act 2015 to ensure that local plans NHS, local authority and third sector exercise provision from specialised rehabilitation, to the exercise referral scheme through to mainstream leisure.

We believe that access to condition specific exercise is important in improving the health of an ex-smoker, someone with a chronic condition and the general population. We therefore call on Assembly Members to consider this and other proposed amendments.

Appendix to Public Health Bill submission from the British Lung Foundation

Policy Position Statement
E-cigarettes

The BLF believes that:

- More, targeted research is urgently needed into the long-term safety of e-cigarettes and their efficacy as a smoking cessation aid, if we are to unlock their immense harm-reduction potential as an alternative to the much more harmful practice of smoking
- Ongoing research in a number of areas is required, including their safety for use by people affected by lung disease, the relative safety and efficacy of different brands, the appeal of certain flavours to children, and their potential role in the re-normalisation of tobacco
- E-cigarettes should be recommended as an optional smoking cessation aid for people who have not achieved success through other nicotine replacement therapies and local cessation services
- Until there is greater clarity on their long-term safety, e-cigarettes should not be recommended for non-smokers, especially children
- Guidance is needed for healthcare professionals on offering patients e-cigarette advice
- Current regulations on e-cigarette sale and promotion in the UK strike the right balance between maintaining safety without discouraging product development
- The EU Tobacco Products Directive is an important piece of tobacco control legislation that could also help improve e-cigarette safety and labelling accuracy. However, some e-cigarette clauses (such as the nicotine concentration permitted before an product is regulated as medical) lack a sufficiently robust evidence base, and should be considered for updating
- Only products delivering particularly high concentrations of nicotine, or those marketed as medical devices, should be regulated as such
- E-cigarettes should not be banned in enclosed public spaces as smoking is, although bars, restaurants, shops and attractions – particularly those with a high child footfall – should retain their right to ban e-cigarette use on their premises if they see fit

BLF policy position summary

Smoking is the single biggest cause of premature mortality in the UK, killing over 100,000 annually. It is also the single most common cause of respiratory disease in the UK. As such, the harm-reduction potential of e-cigarettes, as an alternative mode of nicotine consumption and smoking cessation aid, is immense.

However, opinion among individuals and organisations with an interest in tobacco control has been divided on e-cigarettes. Many healthcare professionals and tobacco control experts are particularly concerned about tobacco industry involvement in a product that – if successful in the way it is hoped – would result in the collapse of the market for their primary product. That said, while the BLF understands these concerns, we believe that those with an interest in public health should not be deterred from seeking to maximise the potential benefits of e-cigarettes in the fight against tobacco-related illness by the presence of such undesirable parties.

Another reason for the schism of opinion is the lack of conclusive evidence in a number of key areas. The BLF recommends that research into these areas be urgently conducted, in order to unlock any harm reduction potential of e-cigarettes as soon as possible.

Research into the long-term health impact of e-cigarettes should be considered amongst these urgent research needs. Although there is no indication that e-cigarettes pose anywhere near the same risks as smoking, greater certainty over what the health impacts are (if any) would inspire greater confidence in their use among smokers, healthcare professionals and regulators. Long-term user cohorts should be established now to enable this research into the future.

Although there is growing evidence of the efficacy of e-cigarettes as an aid to smoking cessation, the picture here is not yet clear cut, and would also benefit from urgent research. Particular attention should be paid to variation between brands and differing nicotine delivery efficiencies, in both long-term safety and smoking cessation efficacy.
Research is also urgently needed into the health impact of e-cigarette use among people living with respiratory diseases. With up to 60,000 people a year dying of smoking-related respiratory disease, and smoking cessation identified as the most cost-effective intervention for respiratory disease patients, any role e-cigarettes can safely play in minimising smoking rates in respiratory patients will prove invaluable.

Until all of the above research it is carried out, it is advised that e-cigarette use be recommended to smokers with caution. Healthcare professionals should make it clear that while the long-term safety profile is uncertain, e-cigarettes may help with smoking cessation, if an individual has not achieved success through use of other nicotine replacement products (NRPs) and smoking cessation services alone. Additionally, they should be advised that differing brands of e-cigarette may offer differing chances of success, but that as with NRPs, long-term use of e-cigarettes is not advised. Healthcare professionals should be provided with guidelines on how to speak to patients about e-cigarettes, as many have called for.

Given the uncertainties over the long-term health impact of e-cigarette use, the BLF does not recommend their use by non-smokers, particularly children. Current use amongst these groups appears to be low, but this is something that could change as e-cigarette use becomes more commonplace, and should therefore be monitored closely through regular, well-designed surveys. Although there is currently little evidence suggesting any 'gateway' relationship between trying e-cigarettes and smoking uptake among children, this is another area that will need continued, regular monitoring. We also recommend more research in to whether supposedly child-friendly sweet flavours increase the likelihood of children using e-cigarettes.

The BLF welcomes the forthcoming ban on e-cigarette sale to under-18s, and support the 2014 Committee on Advertising Practices restrictions on e-cigarette advertising (particularly that targeted at children or which could be construed as accepting of tobacco use). More research into the effectiveness of advertising regulations is needed, however, given the availability of unregulated content on the internet and through social media.

Although the BLF does not recommend inclusion of e-cigarettes in the ban on smoking in public places, we recommend that their potential role in re-normalising tobacco use be researched. We also support the existing right of individual premises – particularly those with a high child footfall - to prohibit e-cigarette use if they see fit, until more research into long-term safety and renormalisation impact has been conducted.

The BLF generally supports the 2016 EU Tobacco Products Directive as an important piece of tobacco control legislation. If the provisions are more tightly enforced than existing consumer protection regulations, they will help minimise the inclusion of potentially harmful ingredients in e-liquids, and give users greater confidence in the accuracy of labelling relating to ingredients and nicotine content. By making manufacturers and importers responsible for the quality and safety of the product, it will also increase incentives to guard against malfunction, fire hazard and tampering by children. Labelling regulations would help guard against poisoning in children. However, the BLF does have concerns that some of the e-cigarette clauses currently lack an evidence-base. In particular, the clause limiting e-liquid nicotine concentration to 20mg/ml before the product should be regulated as a medicine, seems overly restrictive: a higher limit, that would deliver nicotine at a rate similar to a regular cigarette, should be considered.

On the whole, the BLF believes that regulating e-cigarettes as a medicinal product isn't generally necessary, and could stifle product development and use by smokers in this country. Exceptions to this rule would apply to products that explicitly market themselves as medicinal products, or which contain ingredients or quantities of ingredients that can be considered to have a medicinal (rather than recreational) level impact. However, as e-cigarettes are still an emerging technology, all regulations should be regularly reviewed and updated as new evidence emerges.

In order to remain a fully independent source of information and advice on e-cigarettes, and due to the involvement in the e-cigarette industry of tobacco manufacturers (whose work stands in direct contrast to the desire of the BLF to *reduce* the impact of respiratory disease in the UK), the BLF does not accept any funding from any e-cigarette manufacturers or specialist retailers.

Supporting information

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Section 1: About e-cigarettes

1.1: Definition

E-cigarettes (electronic cigarettes), are hand-held battery-operated products designed to facilitate the absorption of nicotine and replicate smoking behaviour, without the need to inhale harmful combusted tobacco. They are also known as 'e-cigs', 'ENDS' (electronic nicotine delivery systems), or personal vaporisers (PVs).

1.2: Construction and function

An e-cigarette will typically consist of a cartridge or tank/reservoir of nicotine-containing liquid, an 'atomiser' (heating element), a battery, and connecting electronics.[1] They function by heating the nicotine-containing liquid into a vapour, which is then inhaled by the user, delivering the nicotine into the lungs to be absorbed into the blood stream. Some of the vapour is released into the air as a visible gas (not dissimilar to tobacco smoke in appearance) when the user exhales.[2] The process of using an e-cigarette is commonly known as 'vaping' (as distinguishable from 'smoking').

Many devices feature a rechargeable battery, and cartridge that can be replaced or a tank/reservoir that can be refilled once the liquid with has all been vaporised and inhaled. Other devices are designed to be disposed of once the liquid or battery has been used up. Surveys by the charity ASH suggests that reusable devices are around 11 times more commonly used than disposable models.[3]

1.3: Ingredients

The nicotine-containing liquid vaporised by when an e-cigarette is used usually comprises a mixture of propylene glycol, glycerine and water, with flavourings sometimes added[4]. The exact mix of ingredients and the concentration of nicotine within can vary considerably from brand to brand, and even between supposedly identical cartridges.[5,6]

Most brands list the nicotine concentration of their vaporising liquid on the packaging. However, although some research has found this labelling to be broadly accurate, other papers have called the accuracy into question: one study from the US in particular found that nicotine concentration differed from the amounts advertised by more than 20% in one in four products tested.[7] Research has indicated no reliable correlation between the descriptor of a brand and the amount of nicotine it contained.[8]

Further detail on flavour-related additives is covered in section 1.5.

1.4: Appearance

The appearance of e-cigarettes can vary considerably between brands. Many brands of e-cigarette are designed to look like conventional cigarettes, often featuring red LEDs (light emitting diodes) at the end of the device that glow when vapour is inhaled (resembling the glow of burning tobacco at the end of a cigarette when the smoker is inhaling). Some devices resemble cigarettes, but have a blue or other coloured LED light at the end to distinguish them from cigarettes when in use. These e-cigarettes are sometimes referred to as 'cigalikes', and were common amongst older brands of e-cigarette.

'EGos', more common among newer brands and increasingly preferred to cigalikes by consumers[8], are those characterised by refillable tanks and are larger than cigalikes. 'Mods' are larger still versions of eGos, and offer more opportunity for customisation.

EGos and mods frequently only resemble an e-cigarette in its most practical form, but can be customised to resemble pens, make-up containers (such as nail-varnish, lipstick or mascara), or other pocket-size electronic devices such as USB sticks or Dictaphones. Some are brightly coloured, resembling sweets or crayons/colouring pens when displayed next to each other, while others are designed to look unlike any other product of that size.

1.5: Taste

As of January 2014 (the last time a review was conducted) there were over 7,700 flavours of e-cigarette available across over 460 brands[8]. At the time of research, the availability of flavours was increasing by 242 new flavours a month.

Such flavouring vary from those commonly associated with smoking (tobacco, menthol), to fruits, sweets and deserts, drinks and alcohol, spices such as cinnamon, and other food substances. Some flavours are sold as inherent ('normal') or as deliberately indefinable ('mystery'). It has been widely speculated that sweet and fruit flavours, including some relating to specific sweet brands, act as a draw to children. However, insufficient research has been conducted to substantiate or disprove this claim.[9]

Online searches reveal companies producing flavourings that can be added to the e-cigarette liquid to make the vapour taste of cannabis. No major e-cigarette manufacturer themselves have been found to produce such a product. Again, there is little data regarding who such flavours appeal to, and whether they are being used by cannabis smokers as part of quit attempts.

There have been reports of some flavourings leading to lung ill-health. In particular, butterscotch-flavoured refill, manufactured by the VIP brand, contained diacetyl – a flavouring often found in foods (particularly popcorn and dairy-based spreads), but linked to the development of obliterative bronchiolitis when inhaled. Similar concerns have been raised over some coffee-flavoured vapour. Given the range of flavours available, the link between flavouring additives and ill-health is not consistent or widespread.

1.6: Manufacture

E-cigarettes are manufactured throughout the world, with China the biggest producer globally. Concerns have been expressed that differences in manufacturing safety regulations between the EU and other parts of the world may lead to less safe products being manufactured outside of Europe and imported for use. However, there has been no research substantiating this claim.

Some e-cigarette manufacturers have begun making reference to user uncertainty regarding where their e-cigarettes and e-liquids are manufacturers in their marketing. For example, in January 2015, Intellicig issued a press release highlighting that, compared to users of other brands, the majority of consumers of their ECOpure brand knew that their e-liquid was manufactured in the UK, and that the majority of its ingredients were sourced within the EU.[10] The release questioned whether e-cigarette users could be confident of their product's safety if this they did not have such certainty over their device's origins.

All major tobacco manufacturers have e-cigarette divisions, either acquired, developed in-house, or a combination of both. See section 1.8 for further detail on the association with the tobacco industry.

Office staff from one e-cigarette manufacturer (Blu) have held a fundraising event for the BLF, but funds were not accepted due to that company's association with tobacco manufacturer Lorillard.

1.7: Price and sale

In early 2014, the e-cigarette market was valued at £193m a year in the UK. Based on growing rates of use, it was estimated then that it would be worth around £340m by the end of 2015.

The prices of e-cigarettes can vary considerably, from under £5 to in excess of £80. They are sold widely throughout the UK, and are available to order online. Increasingly, this is leading to a tiering of the e-cigarette market according to alleged price and quality: for example, the VIP brand markets its e-liquids as 'premium' grade, while Vype is marketed as 'pharmaceutical-grade'.[11]

There has been little research into whether the health impact of quality of these brands can be genuinely distinguished.

Anecdotal reports suggest that they are not routinely available where smoking tobacco is sold (particular amongst vendors with longer opening hours), but there has been no research conducted to verify this.

Two brands, Puritane and Vype (both made by tobacco companies) are available in pharmacy chains (Boots and Lloyds respectively).[12] Many other brands are available widely, including in supermarkets such as Sainsbury's and Tesco.

Several small, independent specialist e-cigarette vendors have contacted the BLF in order to fundraise or enter into a corporate fundraising arrangement. These advances have been rejected on grounds that the BLF wanted to remain independent in the debate, and on grounds that a variety of products sold by the retailers were made by tobacco manufacturers.

For details on the **marketing** of e-cigarettes, see section 4.3.

1.8: Ownership

All major tobacco manufacturers have e-cigarette divisions, either acquired, developed in-house, or a combination of both. In Britain, British American Tobacco was the first major tobacco group to buy a domestic e-cigarette manufacturer buying CN Creative (makers of Intellicig) in December 2012, merging it with its pre-existing e-cigarette subsidiary, Nicoventures, to launch the new brand Vype.

Amongst other major tobacco companies, Imperial Tobacco owns Fontem Ventures (manufacturers of Puritane), Lorillard owns Blu and the originally-independent Scottish brand Skycig, and Phillip Morris is part of the same company (Altria) that owns MarkTen and Green Smoke.

NJOY are the highest profile e-cigarette brand to maintain no tobacco industry affiliation. The brand has launched major advertising campaigns in the United States commenting on the advantages of e-cigarettes over smoking. Other still-independent e-cigarette manufactures include Ten Motives, and Victory (makers of Vapestick).

1.9: Conclusion and policy recommendations

There is conflicting data regarding whether the list of ingredients most brands display is accurate, particularly with regard to nicotine content. This suggests consumer regulations are not being enforced as tightly as they should be: the BLF recommends that the appropriate government agencies ensure this happens.

In particular, the use of flavourings should be monitored more closely, given the link between some flavouring ingredients and the development of lung disease. Closer monitoring would ensure that ingredients for which an association with lung disease has previously been highlighted, such as diacetyl, are not used.

In addition, the link between supposedly child-friendly flavourings (such as particular sweet varieties) and uptake amongst non-smoking children should be subjected to further research, if only to corroborate the conclusions drawn from research into other areas that there is no correlation between the two.

Although the pricing of various e-cigarette brands has created a tiered market place, there is little evidence looking at whether there is any association between price and safety/quality. This is an area that the BLF recommends be researched so that, as evidence emerges regarding the safety of e-cigarettes and their efficacy as an aid to smoking cessation, price is not a determining factor in the choice of brand by smokers: were higher prices found to be associated with safer or more effective smoking cessation products, this could lead to an exacerbation of tobacco-related health inequalities.

Although all tobacco companies have e-cigarettes subsidiaries, the BLF's evidence-based approach and person/patient-centred focus means that the issue of industry ownership will not impact on the BLF's policy regarding the regulation of e-cigarettes and their role in smoking cessation (discussed in sections 4 and 3 respectively). However, the BLF refute that any involvement of tobacco companies in the manufacture and sale of e-cigarettes should qualify them to be considered public health stakeholders, and as such believe that they should not be consulted and be able to influence policy as such. The BLF will continue to highlight the unethical business practices of the tobacco industry, in line with its tobacco control policy The BLF will also refuse any funding from manufacturers and specialist retailers of e-cigarettes, both tobacco-owner and independent. This is not only to guarantee compliance with the BLF's policy of refusing tobacco industry donations, but to maintain the charity's independence in the ongoing debates around e-cigarette use.

Summary of policy recommendations:

- Regulations on ingredients, particularly flavourings, should be more rigorously enforced
- The link between supposedly child-friendly flavours (sweets, etc) and uptake among non-smoking children should be subjected to further research
- The link between the price of a brand and both its safety and effectiveness as a smoking cessation aid should be subjected to further research
- The presence of the tobacco industry in the e-cigarette market should not impact on the BLF's recommendations on the use of e-cigarettes. However, it should not allow them the opportunity to influence health policy under the guise of being a public health stakeholder
- The BLF will maintain its independence in e-cigarette debates by refusing any money from e-cigarette manufacturers or specialist retailers

Section 2: Awareness and use

2.1: Awareness

Based on ONS population data and a representative survey of over 12,000 adults, the third sector tobacco control lobby group ASH estimate that 95% of smokers and 90% of non-smokers had heard of e-cigarettes, suggesting wide-spread awareness.[12] The correlation between internet searches for e-cigarettes and tobacco control measures, suggests e-cigarette awareness may have been in part driven by tighter tobacco control.[13]

2.2: Extent of use

Based on ONS population data and representative surveys of over 12,000 adults, the charity ASH estimate that there are currently around 2.1 million adult e-cigarette users in Great Britain, of which 700,000 are ex-smokers and 1.3 million are current smokers[13]. This represents a threefold increase in total e-cigarette use since 2011. Research also suggests that fewer than 1% of people who had never smoked had tried an e-cigarette, and continued use in this cohort was negligible (on a par with continuous users of nicotine replacement therapies).[12,14] Continued use amongst people who self-identify as former smokers stands at around 4.7%. Amongst current smokers, rates are 17.6%, suggesting substantial dual use.[12] The prevalence of e-cigarette users in different age groups broadly follows smoking patterns (highest rates among 25-34 year olds, followed closely by 16-24 year olds, and then decreasing use with each age group over 35 years old).[13]

Based on a representative survey of over 2,000 children aged 11-18, ASH have also estimated that around 2% of children within this age bracket have used an e-cigarette within the last month, with around 1% expecting to use an e-cigarette soon. As with adults, ASH estimate that children who smoke are significantly more likely to have tried an e-cigarette and to be a regular user. It should be noted that the method of investigation employed by ASH in this research was to ask children via parent-facilitated online self-reporting, a process with the potential to distort results.

In November 2014, a survey by the Welsh Assembly found a cohort of children in Wales (aged 10-11) were experimenting more with e-cigarettes than smoking (6% vs 4% respectively).[15] This was the

first time such a result had been seen in the UK. Although data was collected that would have allowed for greater analysis of a potental gateway affect, this data was not released. The BLF requested the full dataset to enable this analysis, but this has not yet been provided.

2.3: Reasons for use

UK-based research suggests that the vast majority of current e-cigarette users give smoking-related reasons for the reasons they started using e-cigarettes[12] The main reasons reported in the survey were to help quit, cut down or avoid smoking, although only 40% of users state that they are doing so as part of a current quit attempt.[12,13] E-cigarettes overtook over-the-counter nicotine replacement products (OTC NRPs) as the most popular smoking cessation aid in late 2013.[13] A substantial decline in OTC NRPs, coinciding with the rise of e-cigarettes (and coupled with no change or a minor decline in the use of prescription NRPs) suggests that e-cigarettes are being widely used as a direct alternative to OTC NRPs. The efficacy of e-cigarettes as a smoking cessation aid is looked at in section 3.1.

Amongst those not using e-cigarettes as a smoking cessation aid considered e-cigarettes as a cheaper method of nicotine consumption than smoking, with a few wishing to avoid the impact that their second-hand smoke has on others.[12] The findings published by ASH are the most widely reported estimates, although the nature and methodology of the survey has not been published. Evidence elsewhere has suggested that tighter tobacco control measures may be driving e-cigarette use[16].

2.4: Vaping behaviour

The BLF is aware of anecdotal reports that e-cigarettes use has resulted in a rise in nicotine consumption, although evidence is inconclusive on this.

A number of specialist vaping cafes have been launched across the UK, particularly in London. No data is yet available on whether this has impacted on vaping behaviour, although there are concerns that it might drive increased use.

2.5: Conclusion and recommendations

E-cigarette use is growing rapidly in the UK, mainly former and especially current smokers. The number of people using e-cigarettes who don't smoke is on a par with NRP use by non-smokers. The same applied to use among children. However, although this has been the situation during these early years of e-cigarette use, the situation should continue to be monitored closely and regularly to check that, as e-cigarette use becomes more widespread, it is not widely taken up amongst non-smokers. It is recommended that questions on e-cigarette use be included in the national Survey of Smoking, Drinking and Drug Use among Young People to help verify existing data.

More research is urgently required into the impact dual (with smoking) and single e-cigarette use has on levels of nicotine consumption: a product that escalates an individual's nicotine appetite would not be recommended.

The impact of specialist vaping cafes on vaping behaviour would also be an interesting area of research, although given the relative uncommonness of vaping cafes, this research is not considered urgent.

Summary of policy recommendations:

- Use of e-cigarettes amongst adults and children, especially those who do not smoke, should continue to be monitored closely: policies and regulations may need updating should significant growth in e-cigarette use by children or non-smokers occur
- Questions on e-cigarette use should be included in the Survey of Smoking, Drinking and Drug Use among Young People
- More research is also needed to confirm the impact of e-cigarette use on overall nicotine appetite

Section 3: Health impact

3.1: Efficacy as an aid to smoking cessation/use by current smokers

The harm-reduction potential of e-cigarettes as a lower risk alternative to smoking has been widely reported. E-cigarettes have been described by some as "one of the biggest public health innovations of the last three decades that could potentially save millions of lives".[17] A UK-based survey by ASH suggests that the desire to quit, cut down or avoid smoking is the main reason for ongoing e-cigarette use.

Although it has been suggested that e-cigarettes may also satisfy "hand to mouth" behaviour not sufficiently addressed in most NRPs[18], research has found varying degrees of efficacy for the use of e-cigarettes as an aid to smoking cessation. For instance, a 2014 cross-sectional survey of nearly 6,000 adults, published in the journal Addiction, found that people attempting to quit smoking without professional help are approximately 60% more likely to report succeeding if they use e-cigarettes than if they use willpower alone or over-the-counter NRPs such as patches or gum.[19]

However, other research has delivered more modest results. For instance, a 2013 randomised control trial of 650 people, published in the Lancet, did not find the same degree of efficacy, reporting e-cigarettes to be "modestly effective at helping smokers to quit". Similarly, a 2014 longitudinal study published in the Journal of the American Medical Association (JAMA) found that "when used by a broad sample of smokers under 'real world' conditions, e-cigarette use did not significantly increase the chances of successfully quitting cigarette smoking".[20] There is no indication that e-cigarettes are nearly as effective as methods such as smoking cessation services in helping people quit.

Reviewing all available data on the efficacy of e-cigarettes as an aid to smoking cessation, the Cochrane collaboration published a review in December 2014, concluding that e-cigarettes were more effective that nicotine replacement patches at helping smokers cut down.[21] It also concluded that there was no evidence that dual use of e-cigarettes and cigarettes made smokers any less likely to quit. However, the review also concluded that the quality of evidence in many of the areas was low, and that more studies were recommended (many of which have been started).

It has been suggested that e-cigarettes might even prolong smoking habits. For instance, concerns have been raised that e-cigarettes counter-act the "de-normalisation" impact of the ban on smoking in public places by bringing about a "re-normalisation" smoking-related behaviour.[22] Similarly, it has been suggested the use of e-cigarettes in public places where smoking is banned might allow smokers to maintain their nicotine addiction when they might otherwise be encouraged to cut back on their consumption. Although an evidence review by the Cochrane Collaboraion concluded that these fears are currently unfounded, the review authors did recommend further investigation, due to the weakness of current data.[21]

The cochrane review also concluded that nicotine containing e-cigarettes were more effective as cessation aids that those without nicotine.[21]

3.2. Variation in smoking cessation efficacy between brands

It has been theorised that data in this area has been adversely affected by the difference between brands, particularly with regard to the efficiency of the device in nicotine delivery.[23] There is some evidence indicating that e-cigarettes are gradually becoming more reliable in this regard.[24] Some research has indicated that e-cigarettes are more effective as smoking cessation aids when used by more experienced smoking cessation users.[25] There is little research comparing different brands or efficiencies of nicotine delivery with their efficacy as a smoking cessation aid.

3.2 As potential gateway to smoking

A 2014 US study also found that adolescents who used the devices were more likely to smoke tobacco and less likely to abstain from smoking, adding to pre-existing fears that e-cigarettes may provide a route into conventional smoking and nicotine addiction.[26] However, other researchers,

assessing the same source data, have commented that the study authors did not give due allowance to experimental use, pointing out that there is no indication that the e-cigarette use came first.

A widely-quoted 2014 study found that between 2010 and 2014, a rise in the rates of e-cigarette use among 15-19 years old Polish students corresponded with an increase in the use of tobacco products.[27] It has been pointed out, however, that the study findings reported did not methodically trace the same students and in many took data from different schools. It was concluded by the study's critics that, as a result, the study as published cannot be considered evidence of a gateway effect (instead merely shows different rates of e-cigarette and tobacco use among different student populations). The study authors are currently analysing the data available to see if more accurate conclusions regarding the gateway effect can be drawn.

UK-based research indicates that general e-cigarette use among children is very low and consists almost entirely of those self-defining as current or former smokers, suggesting no gateway affect.[12] Similar data has arisen from in US jurisdictions and in Europe.[28] More targeted research is being conducted and will shed further light on this issue.

3.3: Associated health risks

Nicotine in general is associated with a variety of side effects: other NRPs have been shown to increase the users risk of heart palpitations and chest pains, skin irritation, nausea, and mouth and throat soreness.[29] There is anecdotal evidence that people who were not previously heavy smokers have upped their nicotine in-take considerably since they took up e-cigarettes instead of or in addition to smoking, due to the greater ease and lower health risks of consuming nicotine through an e-cigarette. However, this has not been supported by any research findings.

Early research into e-cigarette use has indicated a range of short-term health impacts in addition to those associated predominantly with nicotine. For instance, in one study, e-cigarette use for only five minutes by otherwise healthy smokers was found to temporarily increase airway resistance (blocking the air getting into and out of the lungs) and local oxidative stress (a natural response by the lungs for dealing with unwanted inhaled material, which causes inflammation).[30] There is a possibility that the latter might lead to long term obstructive lung damage – this is an area in need of further research.

A recent study also found that e-cigarette use among young people may 'worsen acute respiratory diseases, including asthma and bronchitis'.[31] There is little other research into the health risks of e-cigarettes for people with lung disease, despite smoking cessation being recognised as one of the most effective treatments for respiratory conditions – this is another area in need of research.

Concerns have been raised over the safety of the e-cigarette vapour. The US Food & Drug Administration (FDA) reported detectable levels of known carcinogens and toxic chemicals including diethylene glycol (a toxic constituent of anti-freeze) and nitrosamines (known cancer-causing tobacco constituents) in two different brands of e-cigarettes.[32] A range of studies found various toxins in e-cigarette vapour.[33,34,35,36] Although research has suggested the quantity of toxins are unlikely to represent a significant health risk[37,38,39], with the combination of ingredients having been found to vary so significantly (even between supposedly identical liquids)[40,41], concerns persist over the safety controls around production of vaporising liquids. It has been argued that greater regulatory oversight, as recommended in section 1, would help ease those concerns.

There have been several reported incidents of e-cigarettes over-heating and exploding or starting fires. Although occurrences remain very rare compared to the breadth of e-cigarette use, they have been a source of considerable concern within the media. Little research has been conducted into the relative safety of various brands when subjected to real life conditions, and their use simultaneous to use of therapies such as oxygen.

Although early research suggests a potential link with the long-term development of obstructive respiratory diseases[26], there is no indication that the risks are anywhere near those of smoking, and have yet to be conclusively substantiated. Overall, there is little research published into the long-

term health impact of e-cigarettes, although research in this area is underway and is expected to be published within the next year.

E-cigarette use is not advised during pregnancy.

3.4: Health impact of second-hand exposure to e-cigarette vapour

Research suggests second-hand exposure to e-cigarette vapour may result in involuntary inhalation of nicotine, but not of toxic tobacco-specific combustion products common in second-hand smoke.[42] Testing on animals suggests any health risks associated with second-hand vapour exposure are unlikely to extend beyond irritation of the throat, if at all.[19] The impact of second-hand nicotine exposure is not fully understood.

3.5: Conclusion and recommendations

The harm reduction potential of cigarettes as an alternative to smoking is widely acknowledged as immense, and there is no evidence that e-cigarette use represents anywhere near the same health risk as smoking. Although evidence varies as to the value of e-cigarettes as an aid to smoking cessation – some studies observing considerable improvements over over-the-counter NRP, some observing no noticeable affect - it has been speculated that this may relate to the huge variation between brands, particularly with regard to nicotine delivery. Although the Cochrane review of evidence concluded that e-cigarettes were more effective than patches as a smoking cessation aid, the authors commented that the quality of the evidence currently available to support this is relatively low. This is therefore an area in need of urgent research.

The main reason to still recommend NRPs over e-cigarettes relates to certainty over the safety profile. In the short term, there is some evidence that e-cigarette use can cause adverse side-effects in some people: continued use of the same brand by these people would not be recommended. Greater testing of various products with regard to their propensity for combustion would also be useful, although the relatively low incidence of e-cigarette explosions makes this less urgent. More wide-spread concerns arise from uncertainty over the long-term health impact, and the use of e-cigarettes by people with pre-existing lung conditions (for whom smoking cessation represents one of the most cost-effective interventions). In both these applications, more research is urgently required (only in the former is it currently being widely conducted). The establishment of long-term patient cohorts will facilitate research into these areas, though it may take many years to confirm their results.

Overall, current smokers should be advised that while there is uncertainty over the long-term health implications of e-cigarette use, vaping can help with smoking cessation if they have not enjoyed success with NRPs or smoking cessation services alone. They should also be advised that there is considerable variation between brands, and that if one brand doesn't work for them, another might prove successful. As with NRPs, however, they should be advised that e-cigarettes, of any single brand or combination thereof, should not be considered a long-term substitute for smoking. Guidelines should be produce to help healthcare professionals advise patients on the use of e-cigarettes (this may need to be actioned by the Department of Health given restrictions on the products NICE is able to issue guidelines on).

Due to the uncertainty over the long-term health risks and the more general inadvisability of nicotine consumption, e-cigarette use is not recommended for non-smokers. For this reason, e-cigarettes are not recommended for children. Further research would be useful into the gateway effect of vaping: although this it is expected that such research would currently confirm the risk to be relatively low, this may change over time as e-cigarette use becomes more widespread.

Summary of policy recommendations:

- More research is urgently needed into the efficacy of e-cigarettes as an aid to smoking cessation, with particular attention paid to variation between brands and relationship with nicotine delivery efficiency.
- Urgent research is needed (and is being conducted) into the long-term health impact of e-cigarette use, with long-term user cohorts established now

- Urgent research is also needed into the use of e-cigarettes by people with lung disease as a smoking cessation aid
- Smokers should be advised that, although there maybe unidentified long-term health risks, e-cigarettes can be used as a smoking cessation aid if NRPs and smoking cessation services alone have not proven successful. They should be advised that they may find some brands more effective than others.
- Guidelines to help healthcare professionals advise patients on e-cigarette use should be produced, potentially by the Department of Health
- E-cigarette use is not recommended for non-smokers, children or during pregnancy

Section 4: Legal status and regulation

4.1: Legal status, regulation and guidelines within the UK

E-cigarettes are not regulated under smoke-free legislation in the UK. As such, users are free to use them in many public places such as bars and restaurants, although the managers of some premises have prohibited their use.[43]

Legally, e-cigarettes are subject to limited regulation. Manufacturers can choose to license e-cigarettes and other nicotine containing products (NCPs) with the Medicines and Healthcare Products Regulatory Agency (MHRA) as medicines[44], enabling them to make specific health claims if approved. However, to-date, only one brand has licensed as a medicine in the UK.[45] Most e-cigarette brands are instead considered consumer products and thus covered by general product safety legislation.[46] The significant variability in nicotine delivery effectiveness, nicotine content, and e-liquid ingredients - both between and sometimes within product brands – suggests that this legislation is not being enacted as well as is intended.[47]

The Department of Health (DH) has stated that UK regulation of e-cigarettes will be developed in line with European requirements.[48] This will subject e-cigarettes in the UK to the terms of the EU Tobacco Products Directive (TPD), due to come into effect in in mid-2016.

Under the terms of the TPD, e-cigarettes containing more than 20 mg/ml of nicotine will need to be regulated by the MHRA as medical devices. Brands containing less that this quantity of nicotine will come under the terms of the TPD.[49] This has proved controversial, with many researchers suggesting that 20mg/ml threshold (identified as replicating the level of nicotine intake experienced whilst smoking the average cigarette) is too low.[50] The e-cigarette clauses of the TPD are currently being subjected to legal challenge.[51]

Other regulations outlined in the TPD include childproof fastening for e-liquid containers, health warnings on external packaging regarding the nicotine content, full responsibility for manufacturers and importers regarding the quality and safety of the product, prohibition of cross-border advertising, and the ability for EU member states to introduce additional safeguards if desired.[52]

Aside from the e-cigarette clauses, the tobacco control aspects of the TPD have been widely welcomed by tobacco control campaigners and researchers.

NICE has produced guidelines on tobacco harm reduction, which supports the use of licensed nicotine products as an aid to cutting down or quitting smoking.[53] NICE has a policy of not recommending the use of unlicensed nicotine-containing products, which includes the majority of e-cigarette brands.

In 2014, in an amendment to the UK Parliament's Children and Families Bill, a ban on the sale of e-cigarettes to under-18s was approved (initially applying to England only)[54]. The Scottish Government has raised the possibility of introducing an age limit of 18 on purchasing e-cigarettes, following statements by Public Health Minister Michael Matheson MSP (SNP).[55] He has further raised concerns around marketing and the potential use of e-cigarettes as a "trojan horse" by tobacco companies.[56]

During a series of Legislative Content Motions (LCMs) on the Children & Families Bill, Welsh Assembly Members voted to allow provisions of the Bill to apply in Wales. One of these LCMs included banning the sale of e-cigarettes to under-18s. In addition, under proposals outlined in a Public Health White paper (currently out for consultation), a ban on using e-cigarettes in enclosed public spaces has been proposed, effectively placing the devices under smoke-free premises legislation.[57]

It has been widely argued by e-cigarette supporters that the costs involved in tighter regulation, including routine regulation as medicinal products, would stifle e-cigarette development (including of safer and more effective varieties). The relatively gradual development and uptake of NRPs over the last five decades has been given as an example of this. However, even if limited availability and profit margins resultant from greater regulation are likely to act as a disincentive to product improvement, the comparison with the slow development of NRPs does not stand up to scrutiny given this occurred during periods of far lower public awareness regarding the dangers of smoking, meaning demand was always likely to be lower.

Overall, given variation in nicotine delivery systems is a possible factor in the efficacy of e-cigarettes, and the fact that more recent e-cigarette brands are less likely to relate to or resemble cigarettes, e-cigarette development is to be encouraged.

4.2: Legal status abroad

The TPD will apply across the EU. Across the rest of the world, regulation of e-cigarettes varies, with Brazil, Egypt, Australia, New Zealand, Canada and Singapore all banning or regulating the sale, import and marketing of e-cigarettes.[58]

4.3: Use in public places

E-cigarettes are not currently included within the terms of the 2007 smoke-free legislation, although many venues such as bars, restaurants and museums have independently chosen to ban their use. There has been little research into whether there is still significant-enough association between smoking and vaping for e-cigarette use to be considered a risk to the denormalisation of smoking occasioned by the smoking ban. Such research would be useful to determine whether e-cigarette use is advisable in the presence of children. Given that perceptions of e-cigarettes are likely to evolve as their use becomes more widespread, such research will need to be regularly updated.

4.4: Marketing and advertising

In October 2014, the Committee of Advertising Practice (CAP) in the UK advised that e-cigarettes could be advertised on TV and elsewhere in the media, providing they are not targeted at under-18s, do not encourage non-smokers to use e-cigarettes, do not claim e-cigarettes are healthier or safer than smoking tobacco (or make any health claims without MHRA approval), and do not depict tobacco in a positive light. The regulations also restrict marketing targeted at young people through the use of social media and celebrity endorsement.[59] This guidance is due to be reviewed again in October 2015, with particular attention paid to the renormalisation of tobacco.

It has been suggested that domestic regulations on advertising is ineffective in the age of cross-border social media, and that efforts should be sought to achieve international agreement on e-cigarette advertising standards. Some research in this area is currently being undertaken by the University of Stirling, and is due for publication in 2015.

With regard to marketing techniques, research has found that older brands of e-cigarette have traditionally tended to highlight the advantages of their use over conventional cigarettes (these brands are more likely to be 'cigalikes' – brands that resemble the appearance of cigarettes).[8,60] Newer brands tend to emphasise more consumer choice with regards to flavours and product versatility, and less likely to compare themselves to cigarettes in marketing activity.[8] However, the current leading brands have all marketed the relative health benefits if used instead of cigarettes.

Claims made on the use of e-cigarettes as a smoking cessation aid are generally supported by testimonials rather than research evidence; many brands include disclaimers on their efficacy in this regard.

4.5: Labelling and packaging

E-liquids with a nicotine level greater than 5mg per ml must be supplied with appropriate toxic warnings and hazard symbols as required under the Chemical (Hazard Information and Packaging for Supply) Regulations 2009 (CHIP 4).

4.6: Conclusion and recommendations

The BLF recommends the tighter enforcement of consumer protection legislation around e-cigarettes, with regards to nicotine content and other ingredients. This should prove one of several advantages of the EU Tobacco Products Directive (TPD) when it comes into effect in 2016. If it is more tightly enforced than existing consumer protection regulations, it should will help minimise the inclusion of potentially harmful ingredients in e-liquids, and give users greater confidence in the accuracy of labelling relating to ingredients and nicotine content. By making manufacturers and importers responsible for the quality and safety of the product, it will also increase incentives to guard against malfunction, fire hazard and tampering by children. Labelling regulations would help guard against poisoning in children.

That said, the BLF does have concerns that some of the e-cigarette clauses within the TPD currently lack an evidence-base. In particular, the clause limiting e-liquid nicotine concentration to 20mg/ml before the product should be regulated as a medicine, seems overly restrictive: a higher limit, that would deliver nicotine at a rate similar to a regular cigarette, should be considered.

With regards to other regulations, the BLF supports the government's decision to ban the sale of e-cigarettes to under-18s, as part of the Children and Families Bill. The BLF also supports the regulations around advertising recently introduced by the CAP, providing it is rigorously enforced and promises for a review after a year of use are kept. Research should be conducted into whether such advertising restrictions are effective in the age of cross-border social media, particularly among young audiences. This should be used to inform future regulation development and potentially the seeking of international cooperation on advertising regulations.

The smoke-free legislation was introduced with the primary intention of limiting second-hand smoke exposure. With the risks of second-hand vapour exposure relatively minor (see section 3.4), the BLF does not recommend the extension of the smoke-free legislation to incorporate e-cigarettes. However, research is required into any potential renormalisation impact of e-cigarettes on tobacco use, particularly with regard to perceptions among children. The smoke-free legislation may require amending in light of this research. The BLF also supports the right of any individual institution to prohibit e-cigarette use on their premises, and believes that this may even be a wise precaution in child-friendly venues such as museums and school-grounds until such time as research allays any concerns over the renormalisation of tobacco.

Summary of policy recommendations:

- The EU Tobacco Products Directive is an important piece of tobacco control legislation that could also help improve e-cigarette safety and labelling accuracy. However, some of the clauses relating to e-cigarettes (such as the nicotine concentration permitted before an e-cigarette is regulated as a medicinal rather than consumer product) lack a sufficiently robust evidence base, and should be considered for updating
- The BLF also supports the regulation of e-cigarette advertising as outlined by the Committee on Advertising Practice, providing it is rigorously enforced
- Research should be conducted into whether such advertising restrictions are effective among young audiences more likely to come across advertising online and through social media. This should inform future regulations and efforts for international cooperation
- Research should be conducted into the tobacco renormalisation impact (if any) of public – cigarette use, particularly among children

- Although e-cigarettes should not be regulated under the terms of the 2007 smoke-free legislation, the BLF supports the right of individual premises, particularly those with a high child footfall, to prohibit e-cigarette use on their grounds until such time as the research base renders it unnecessary

Section 5: Research

5.1: Current e-cigarette research and the BLF's role within the research sector

Although a number of calls for new research have been made for further e-cigarette research throughout this paper, consultation with leading UK tobacco control experts suggests that much of this research is already planned and receiving appropriate funding.
One notable exception might be the health impacts of e-cigarette use amongst people with lung disease – this should be considered for potential funding as part of the BLF's research strategy, pending more thorough assessment of the current e-cigarette research spectrum.

5.2: Conclusion and recommendations

As detailed throughout this document, there are a number of recommendations for further e-cigarette research, most of which appear to already be receiving funding. It is imperative that this funding continue. More general research into lung disease, by contrast, receives relatively little funding compared to other disease areas, meaning that the BLF is likely to have a great impact on the lung health of the nation by focusing research investment in these areas rather than e-cigarettes. A possible exception may lie where these areas cross: e-cigarette use by individuals with pre-existing lung conditions. The BLF will therefore monitor whether this seemingly underfunded area of research might represent a valuable area for investment.

Summary of policy recommendations:
- The BLF welcomes the level of investment e-cigarette research is currently receiving, and recommends adequate funding for all research areas outlined in this paper
- The BLF will consider the value of research into e-cigarette use by people with lung disease as part of its overall research strategy

Section 6: Overview of policy positions held by selected other organisations

6.1. British Medical Association

The British Medical Association have called for e-cigarettes to be regulated as medicinal products.[61] They also voted in 2014 to call for the inclusion of e-cigarettes in the smoke-free legislation. They have advised doctors to inform patients that e-cigarettes are a lower-risk option than continuing to smoke, whilst also explaining the BMAs view on the lack of certainty over their safety and efficacy.

6.2. World Health Organisation and World Lung Foundation

The World Health Organisation (WHO) has called for stiff regulation of e-cigarettes, including bans on use in enclosed public places, advertising, sale to children.[62] They have also recommended a ban on fruit, candy, and alcoholic drink flavoured varieties This was supported by concerns over the involvement of the tobacco industry in their manufacture and sale, and an in-house review that found a lack of evidence for their efficacy, considerable health risks associated with their use (for both vapers and bystanders), and a potential gateway relationship with smoking.

The WHO's stance has been supported by the World Lung Foundation.[63]

In response to the WHO's statement, and open letter signed by more than 50 researchers and public health specialists (including BLF Honorary Medical Adviser Professor John Britton) was sent to the

organisations Director General, rebuking their recommendations and calling for a full revision.[64] A full critique and proposed revision of the WHO statement was published in the journal Addiction in October 2014.[65]

6.4 European Respiratory Society and European Lung Foundation

The European Respiratory Society (ERS) and European Lung Foundation (ELF) have both called for greater regulation in order ensure greater quality control, greater confidence among smokers, greater certainty over the nicotine content and other ingredients, and to help smokers choose between e-cigarettes and other smoking cessation aids. [66,67] The ERS support their position by stating that "as a Society grounded in scientific principles, ERS believes that the precautionary principle should be applied when scientific evidence is inconclusive and insufficient".

6.5. Royal College of Physicians

The Royal College of Physicians (RCP) have called for the regulation of e-cigarettes as medicines, to ensure effective nicotine delivery, and prevent the promotion of e-cigarettes to children and non-smokers.[68] The RCP also call for close monitoring of e-cigarette use in the UK.

6.6. Royal Pharmaceutical Society

The Royal Pharmaceutical Society (RCP) support the use of e-cigarettes as an option for smokers looking to reduce or quit smoking.[69] The RCP recommend against the regulation of e-cigarettes as medicinal products, and instead call for the implementation of the regulations as outlined in the EU Tobacco Products Directive. They believe that advertising and sales should be restricted in line with tobacco products, and that e-cigarettes should be included in the smoke-free legislation.

6.6. Cancer Research UK

Cancer Research UK (CRUK) call for greater regulaton of e-cigarettes (including restrictions on the ir sale to minors), but not to the extent that development of the market and access of the products by smokers is stifled.[70] CRUK support the EU Tobacco Products Directive as a way of ensuring safer, more effective products.

6.7 Action on Smoking Health

ASH support enhanced regulation to ensure the safety and reliability of electronic cigarettes and to prevent their promotion to non-smokers and children.[71] ASH is against the inclusion of e-cigarettes in the smoke-free legislation, and have welcomed the EU Tobacco Products Directive.

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

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

Evidence from the Welsh Pharmaceutical Committee – PHB 27 / Tystiolaeth gan Bwyllgor Fferyllol Cymru – PHB 27

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 2

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?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 3

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 Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 4

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 Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
The Bill as currently drafted uses the term 'Nicotine Containing Products' but does not define what this means. The Welsh Pharmaceutical Committee are concerned that this definition will also encompass medically licensed Nicotine Replacement Therapy (NRT) products. These products are sold over the counter and/or supplied against a prescription or as part of Stop-Smoking Wales schemes and, as a consequence, this would mean that all 716 community pharmacies in Wales would be required to join the register of retailers. We do not believe that this is the intention of the regulation and we suggest that a definition could be written to specifically exclude licensed medicinal products.

Question 6

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?
There are a limited number of occasions where Nicotine Replacement Therapy is used in patients under the age of 18. The Welsh Pharmaceutical Committee believes that this is an important element in helping young people stop smoking at an early stage. We suggest that this proposed offence for supply to a person under the age of 18 should not apply to sales or supplies of licensed medicinal nicotine products and that the definition used in this chapter of the bill is made more explicit on this matter.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 8

Do you agree with the types of special procedures defined in the Bill?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
The Welsh Pharmaceutical Committee welcomes the focus that the proposed Bill places on the role of community pharmacies in improving and maintaining the health of their local communities. In particular, the committee welcomes the opportunity that the PNA process provides to ensure community pharmacy is better-integrated and aligned with wider health needs assessments and health service planning. We acknowledge that the current regulations in Wales are not perfect. In particular, the current definition of pharmaceutical services, which only really relates to dispensing services, is unhelpful in reflecting the wider role that pharmacies in Wales can and do have. The amount of work involved in writing and reviewing a high quality, stand-alone PNA is significant and is therefore associated with significant cost. A PNA integrated into other Health Board commissioning plans, needs assessments or publications may prove to be a more cost-effective as well as a more integrated option for Health Board primary care services and would prevent the PNA existing in a silo. Community Pharmacy owners are independent contractors and therefore take on investment and financing obligations as part of their business operations. Given that these are major decisions for pharmacy owners the use of PNA in particular could have some unintended negative repercussions which need to be managed. For example; • If a PNA were to suggest that a new pharmacy were needed in an area the current owner may be unwilling to invest in staffing, service provision or premises because expanding their financing in these areas could affect the viability of the business if another pharmacy opened. • Many towns in Wales are quite small and, as a consequence, may only be

able to support a limited number of pharmacies. If a PNA suggests that another pharmacy is needed (to improve choice, for example) this may, perversely, result in no pharmacy being viable which could, in extremis, lead to the absence of a pharmacy or a greater restriction of choice.

- Pharmacy owners take out financing on long-term deals but much NHS spending, particularly for Local Health Board initiatives, is subject to short term financing and pilots. Where PNA are written highlighting that improved service provision is required the funding needs to be in place to support the investment needed for the long term. We recognise that the 3-year funding cycle in Wales is helpful in this regard.
- Where a PNA highlights a need to increase service provision, consideration needs to be given to the reasons why provision may currently be low. For example, some pharmacists choose to exert their conscientious objection and refuse to dispense Emergency Contraception. It would not be correct, therefore, for a PNA to advocate another pharmacy opening when the existing pharmacist is exerting a legal right.

The recommendations made in any PNA therefore need to be carefully nuanced to ensure that, as far as possible, the encouragement to pharmacists and pharmacy owners that is intended is not compromised by the presence or content of the PNA.

The introduction of PNA in Wales will be underpinned by regulations. We suggest that the regulations should be written in such a way that:

- A nationally-determined template is used so that each Health Board's PNA has the same structure and headings.
- Once each Health Board has finalised its PNA there is a national review process to ensure that there is consistency in approach across Wales and that the findings of need in one area could reasonably be replicated if a similar situation existed elsewhere.
- Indicative criteria should be developed so that where it is felt that a new pharmacy is required these criteria must be met before any recommendation is made in the PNA. This is to ensure, as far as possible, consistency in decision making.
- A considerable proportion of English PNAs relate to health statistics for the area. Often these are available in other documents or through on-line resources. For the sake of expediency, it may be appropriate in Wales to link any PNA to these resources rather than to reiterate them in the PNA.

This would be particularly the case if the PNA was developed as a 'chapter' to other Health Board commissioning plans and documents.

- Community pharmacy owners and their representatives (including Community Pharmacy Wales) should be included in drafting the regulations and all stages of the PNA writing and review process.

Pharmaceutical Needs Assessments have been introduced in England and we believe that it is worth reflecting on some of the issues that have been seen there. We suggest that, with regard to the first two bullet points below in particular, there is an opportunity to radically improve the PNA process in Wales over that in England

- Production of the PNA is a very labour-intensive process for the body charged with writing the document. It can take many people (patients, public, pharmacy owners and NHS staff) many months to draft and agree the document. A 60-day formal public consultation is required which is expensive and time consuming to undertake.
- In England there is no national template for the format of the PNA itself. Essentially, each organisation has created its own template and this results in a wide variety of formats, content and detail meaning comparisons between PNA are extremely difficult. This also creates problems on the borders between different organisational areas.
- The majority of PNA have not recommended any increase in the number of pharmacies from which pharmaceutical services are provided. Some PNA have highlighted that when certain conditions are fulfilled (such as when 500 homes in a new housing development are occupied) a new pharmacy may be needed and that a supplementary statement will be issued alongside the PNA when that point is reached.
- Many PNA highlight the services that community pharmacies in the area offer. A proportion of these highlight that an increased volume of enhanced/ locally commissioned services provided from community pharmacy would be welcome in certain circumstances. This often results in a desire to work more closely with existing contractors rather than inviting alternative contracts.

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
We recognise that the proposed Bill has two key elements that, it is hoped, will encourage pharmacists in Wales to adapt and expand/ improve their services: 1. PNA – Under the proposed Bill, existing pharmacies will be incentivised to respond to commissioner requests to deliver additional pharmaceutical services to meet identified needs listed in the PNA. If the pharmacist and pharmacy owner do not provide the services requested, they face the risk of another pharmacy owner making a successful application to join the pharmaceutical list in their area. Where a PNA identifies that new services or increased provision of service is required we believe that most pharmacists would wish to engage with the Health Board to see that gap filled for the benefit of their patients. 2. Breach Notices – We believe that the vast majority of pharmacy owners would, if they received a breach notice, respond positively to it. However, we believe that before issuing a breach notice there must have been reasonable attempts made by the Health Board to work with the pharmacy owner on remedying any issues that may be present. In essence, the breach notice should be the last resort. In addition, there must also be an appeals process so that the owner can challenge the notice if they believe that it has been applied unfairly. However, these are just two aspects which affect service provision. Other examples include (but are not limited to): • Making it more straight-forward for pharmacists to become accredited to provide services. This would increase the number of pharmacists available to deliver the service because accreditation can be particularly problematic for the large locum workforce in pharmacy. Maintaining the governance and quality assurance will be key to any simplification that occurs. • Consistent commissioning of core services from community pharmacy. Services should, ideally, be to a national specification with minimal opportunity for local variation. This is to enable patients, pharmacists &

their teams, out-of-hours service providers and commissioners to fully understand the pharmacy services offered. Having the same service available in Conwy, Carmarthen and Cardiff will help increase provision of the service and will help patients to understand what pharmacies in Wales can offer them as they travel around the country.

- Avoiding 'pilotitis'
  Frequently, a new service is piloted in one area, then piloted in a slightly wider area and never properly rolled-out (or cancelled). If a service delivers the required outcomes, a firm long-term financial commitment to it should be made, preferably to a national specification.
- Ongoing funding
  Pharmacy owners need to believe that funding for services will not ebb and flow so that they can make long-term commitments to delivering services.
- The need for a national conversation/ behaviour change programme.
  This is to encourage the public to make best-use of the services on offer in their pharmacies.

On their own, the proposals in the Bill will encourage some contractors. However, we feel that the Bill's proposals should be included in a more holistic suite of activities undertaken by Welsh Government and Health Boards in conjunction with pharmacy owners and CPW so that they will have a much greater positive impact than they will in isolation.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
A number of classes of medication can increase the frequency with which patients need to use a toilet. The Welsh Pharmaceutical Committee is aware that, in some cases, patients choose not to take their medication if they are going out due to concerns about being able to find a toilet when one is needed. The provision of a local toilet strategy may help to reassure local patients that their needs are being met. This may ultimately lead to better patient compliance with their treatment which should help to better-control the patient's condition.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 17

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?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
The Welsh Pharmaceutical Committee has no comment to make on this issue.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
Provision of additional pharmaceutical services from community pharmacies can increase NHS capacity and improve access (due to location, extended opening hours and availability of many services without an appointment). Completing a PNA process will mean that Health Boards will be better-able to identify which additional pharmaceutical services they wish to commission, where and at what times of the day to meet the needs of their populations. By incorporating the PNA into other Health Board plans and needs assessments this should mean that pharmaceutical services are more likely to be considered as part of wider health service planning. This therefore creates the potential for service redesign for the benefit of patients.

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
A number of community pharmacy services are delivered to national specifications with national accreditations and with a national fee and claims process. However, where the service involves provision of medication using a Patient Group Direction (PGD) these need to be signed locally by each Health Board which has resulted in some local variation. To improve consistency we recommend that the Welsh Government considers whether regulations should be changed to allow the national sign-off of a PGD which can then sit alongside the other nationally-agreed documentation for a particular service.

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
As stated above, the Welsh Pharmaceutical Committee welcomes the focus that the proposed Bill provides on the public health role of pharmacy in Wales. Pharmacy services are often cited as an untapped public health resource and the Welsh Pharmaceutical Committee stands willing and able to help the pharmacy profession reach its full potential.

[redacted]

27th August 2015

Dear Mr Drakeford

Public Health (Wales) Bill

I am writing to you regarding the above Bill.

I note that Section 6 of the Bill extends the definition of "workplace" to include a dwelling that is used as a workplace by one person only, and that smokming would be prohibited in that part of the premises used as a workplace during working hours. I note also that Section 10 provides that Welsh Minister may make exemptions to this provision.

The Government's Explanatory Memorandum provides no further explanation regarding this provision, but I have read also the letter of the Presiding Officer to the Health and Social Care Committee (**http://www.senedd.assembly.wales/documents/s41902/HSC4-20-15%20ptn%202%20correspondence%20from%20the%20Presiding%20Officer.pdf**) in which she expresses the view that there might be human rights implications to the restriction on smoking in a person's home when part of it is being used as a workplace.

In the light of this, I am writing to ask whether you could explain what the situation will be with regards to clergy operating from a vicarage or manse (or, indeed, from their privately owned property) which is, therefore, also a workplace. Would smoking in a manse or vicarage be prohibited, not only for the cleric but also for his/her family and personal visitors, during the cleric's working hours? Given that the working hours of clergy are indefinable, and that the whole of a manse or vicarage is regarded as a workplace for taxation and other purposes, this would constitute a considerable restriction on the freedom of these individuals.

If a provision of this kind is included in the final Act, would it be your intention to introduce an exemption under Section 10 to prevent or restrict these consequences in the case of clergy?

As the Committee's call for evidence closes on 4th September 2015, I have taken the opportunity to copy this letter for the attention of the Committee also.

Yours faithfully,

Gethin Rhys (Parch.)
Policy Officer

To:- The Health & Social Care Committee, National Assembly for Wales

Response from Cytûn and CLAS to the call for evidence regarding the Public Health (Wales) Bill

1. Cytûn: Churches Together in Wales represents 14 Christian denominations in Wales, which between them engage the majority of Christian clergy currently serving in Wales. CLAS (the Churches' Legislation Advisory Service: Reg Charity No. 256303) is an ecumenical body representing all the major denominations in the United Kingdom and many of the smaller ones, together with the United Synagogue, in their dealings with government on issues of secular law and policy.

2. This submission relates to Sections 6 & 7 of the Public Health (Wales) Bill, as introduced, which extend the definition of 'workplaces' for the purposes of the smoke-free designation. We are concerned about the possible impact that this may have on clergy and their families.

3. The clergy of most of the major denominations are required by the nature of their offices to live in the parsonage house or manse. Moreover, for tax purposes in matters such as travel expenses the "place of work" of a minister of religion is normally defined by HMRC as that minister's residence rather than the place of worship that he or she serves – principally because an individual minister may have pastoral charge of more than one church. This applies even if the cleric works from his/her personally owned property rather than from a clergy house owned by the church.

4. The parsonage house is often used for meetings, one-to-one pastoral counselling, bible study groups, marriage preparation and suchlike. It is not clear to us whether or not that means that they are "premises" for the purposes of the definition in Clause 6(2)(b).

5 The vast majority of people have a workplace and a home: clergy are highly unusual in that they have no such separation. Some clergy (and some members of clergy families and others who live with clergy) smoke tobacco or use e-cigarettes; and we are concerned that, perhaps inadvertently, the impact of the legislation as drafted might bear unduly harshly on such people.

6. First, it is not entirely clear to us whether the definition in 6(2)(b) extends to (eg) a parishioner who is invited for a casual coffee in the family living-room as opposed to the minister's study/office. Does the living-room then attract the provisions of the legislation? Or would it attract the saving in 7(3)?

7. Secondly, the legislation applies to e-cigarettes as well as to tobacco. The inability of a cleric or members of the cleric's household to use e-cigarettes in their own home might be a disincentive to moving from tobacco to a less harmful alternative: is that what the Welsh Government intends?

8. Thirdly, Clause 6(5) says that such premises are smoke-free "only when used as a place of work". The ordination promises of clergy make it clear that their "work" is all-consuming, covering all of their lives. They have no set working hours. As worded, it would appear therefore that this clause would require clergy houses to be smoke-free

at all times, as the minister would be “on call” even when enjoying private time with his/her family.

9. We suspect that these potential consequences of the legislation for clergy and their families are unintended, because the situation of clergy was not taken into account when the legislation was at the drafting stage.

10. Finally, we wonder whether a ban on someone (or a member of that person’s family) smoking or using an e-cigarette *in his or her own home* is entirely consonant with Article 8 ECHR (Right to respect for private and family life). Article 8(2) provides a saving for interference by a public authority with the exercise of the right where it is “… necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”. Presumably the Welsh Government would contend that a ban would be “for the protection of health”; we wonder, however, whether this degree of interference in private life is “necessary in a democratic society”.

11. We would be grateful if you could as part of your consideration of the Bill seek clarification regarding this matter and, if necessary, make an appropriate recommendation to the Government.

Contacts:

- Revd Gethin Rhys, Cytûn, 58 Richmond Road, Cardiff CF24 3AT. [redacted]
  Cytûn is a registered company in England and Wales | Number: 05853982 | Registered name: “Cytûn: Eglwysi Ynghyd yng Nghymru/Churches Together in Wales Limited” | Cytûn is a registered charity | Number: 1117071
- Frank Cranmer: Secretary, Churches’ Legislation Advisory Service, Church House, Great Smith Street, London SW1P 3AZ [redacted]

28th August 2015.

This evidence may be published in full.

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

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

Evidence from the British Institute and Association of Electrolysis – PHB 29 / Tystiolaeth gan Sefydliad a Chymdeithas Electrolysis Prydain – PHB 29

THE HEALTH AND SOCIAL CARE COMMITTEE – PUBLIC HEALTH (WALES) BILL

In response to your email of 16th July, the British Institute and Association of Electrolysis (BIAE) are considering your invitation to attend on Thursday 17th September to give oral evidence on the above Bill.

Having evaluated the proposal to 'Create a compulsory, national licensing system in relation to acupuncture, body piercing, electrolysis and tattooing', the BIAE have studied the 'Special Procedures' category, with specific reference to electrolysis, ie safe working practices; good infection control; good pre and aftercare procedures.

It is the BIAE's considered opinion that the standards you are wishing to license are a 'basic' requirement of all our members and are covered in the BIAE Entrance Assessment, which we believe gives us a good case for exemption and point no 120 on p34 of Explanatory Memorandum – FINAL.PDF supports this theory.

For information, the BIAE has been in existence since 1948, initially as the Institute of Electrolysis, then joining forces with the British Association of Electrolysis in 2004. Electrolysis is a broad field, and the purpose of the BIAE is not to regulate everyone, but only members who need to prove their competence is higher than the national minimum standard, e.g. NVQ/VRQ level 3 (hospital work being the most important).

In addition, to further support our exemption entitlement:

1. Is the license going to be per treatment, or will it be a generic license for a group of treatments? If it is per treatment then we would want exemption for all BIAE members. If it is for a group of treatments, like the London license, then we would be liable for any BIAE member performing other treatments (beauty, laser, piercing etc) which is not possible. Also it would create a potential loophole where people would join the BIAE as a cheaper alternative to the license fee, so we could potentially have members who were not actually performing electrolysis.

2. Electrolysis has long been relegated to the status of an orphan treatment by the Dept of Health because the use of the treatment for consumer cosmetic purposes far outweighs the number of medical treatments. It is simply not cost effective to train up Electrolysists within the health system, nor to nationally regulate the profession via a statutory register as we have investigated several times. For this reason any electrolysis for medical reasons is regulated by the commissioning doctor or surgeon (both NHS and private) as this has proven to be the most practical arrangement for

all since the 1960s (with our members acting as service providers for aforementioned doctors and surgeons).

3. There is no other treatment like electrolysis so that is why regulation such as licensing tends to under regulate for medical electrolysis treatments and registers like the Health and Care Professions Council are excessive for beauty electrolysis treatments. We were advised by the HCPC not to pursue a national register because only the title would be regulated, not the treatment. Licensing regulates the treatment but not the practitioner which is what the BIAE does.

4. Our entrance exam is far more in depth than nationally accredited electrolysis qualifications, because of the aforementioned broad field of use for this treatment. As we do not seek nor receive any public funding for our work there is no benefit to becoming Ofqual regulated, as we have investigated thoroughly. When national vocational qualifications were first introduced we were consulted and assured they would not be seeking to replace our qualification. We have had this confirmed recently by the Dept of Business, Innovation and Skill who said that industry recognised qualifications can be of a high standard and it is up to business to decide which is best. Therefore nationally accredited qualifications should only be seen as a minimum standard.

5. London licensing created a similar model to what is being proposed in Wales. We fulfil all the criteria for exemption as medical treatments, but since electrolysis is not a medical treatment per se and because the legislation was not worded correctly we found ourselves penalised heavily. Ironically the license ended up lowering standards. Electrolysists did not want to pay an extra fee to be a BIAE member when they had to pay out hundreds of pounds every year or few years to be licensed, so the number of BIAE members dwindled. Anyone who wanted to train in electrolysis was forced to take the lesser NVQ course as only nationally accredited courses were allowed. We have negotiated with the London councils to have our qualification accepted, and for our members to apply for exemption on an individual basis but it is too late to change the legislation due to cost. For this reason we would like the Welsh Government to exempt our organisation from the start so that the small number of BIAE members providing electrolysis do not go through the same issues. It has been very harmful to those seeking medical electrolysis treatments as they have to either forego treatment or travel to another county.

6. In conclusion, the BIAE would just like to make the point that in December 2014, at a Health Education England workshop entitled ‘Standards and practice and proposed legislative changes, attended by a BIAE member, the principal policy officer of the CIEH, Ian Gray, was surprised to learn that the BIAE had suffered as a profession because of regulations that forced a DROP in standards to the minimum level of an NVQ. This opinion was supported by attending licensing officers had no idea who was performing so-called regulated treatments in their area due to poor legislation.

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 Cardiff and Vale University Health Board – PHB 30 /
Tystiolaeth gan Fwrdd Iechyd Prifysgol Caerdydd a'r Fro – PHB 30

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

Written evidence submitted by Cardiff and Vale University Health Board (August 2015)

1. Cardiff and Vale University Health Board (the UHB) fully supports the introduction of the Public Health (Wales) Bill as an important opportunity to improve and protect the health and well-being of the population of Wales. We welcome this opportunity to submit views on the principles of the Bill.

Part 2: Tobacco and nicotine products

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

2. We support the restriction of nicotine inhaling devices, such as electronic cigarettes (e-cigarettes) in enclosed and substantially enclosed public and work places, bringing the use of these devices into line with existing provisions on smoking.
3. The concentrations of potentially harmful inhalants in e-cigarette vapour may be lower than that of cigarettes, however, they are still present and can still impact on involuntary bystanders, exposing them to greater than normal levels.[1,2] Levels also remain higher than found in nicotine inhalers and, while there is much variation between brands, some have been shown to contain levels of cancer-causing agents, such as formaldehyde and acrolein, as high as that found in cigarette smoke.[2] Evidence of long-term harm from these will take time to accumulate.
4. Many of these devices have not yet been tested by independent scientists and, where testing has taken place, wide variations in toxicity have been found.[2] Current guidance by NICE only supports the use of licensed nicotine containing products to help smokers cut down.[3] It is important that the public are aware of the potential harms from using e-cigarettes when choosing whether to use them as a smoking cessation tool. For example, nicotine has been shown to increase HbA1c levels in established diabetics, and potentially to affect insulin-producing cells in the pancreas of foetuses following exposure in utero.[4,5] Nicotine may also increase cell division rates and exacerbate tumour growth.[6]
5. There may also be indirect risk from such devices and their refills which are not child protection packaged, if the device/refill is left unattended, dropped or discarded. The liquid is extremely toxic to young children if ingested or even if spilled onto skin, and often sold in attractive colours and flavours that appeal to young people/children such as 'gummy bear' or 'bubble gum'. Exposure can cause cardiac effects. Figures from the UK and overseas report

large increases in cases of accidental poisoning from contact with nicotine from these devices, with large proportions of the cases involving very young children.[7-9] The batteries from these devices are also very small and could cause serious damage if ingested by small children.

6. We consider that allowing use of e-cigarettes in places where smoking is banned will undermine and make more difficult enforcement of the smoking ban. The use of these devices is also highly likely to normalise smoking behaviour and undermine the public health progress made so far. While close observers may be able to detect the absence of smell or ash, those further away will not, for example in hospital settings across large concourses. Particularly with electronic nicotine delivery systems that are very similar in shape to cigarettes. This will send mixed messages to the public about smoking acceptance. Legislation would provide clarity and help ensure a consistent message across Wales. Evidence of their effects on normalising smoking will take time to gather and much damage could be done in the meantime. The burden of smoking on the NHS in Wales, means it is imperative that clear messages on the unacceptability of smoking on health site grounds are not compromised and made unenforceable.

7. Use of these devices can both create and maintain nicotine addiction. E-cigarettes may act as a gateway to the use of tobacco by appealing to young people in their design and colours. Currently they are mainly used by those who already smoke, but evidence from studies in the UK and overseas suggests that e-cigarettes are being used by young people who have never previously used tobacco and this may increase as their popularity increases.[10,11] Anecdotal evidence also suggests that people are using the devices interchangeably with tobacco, with easy access to short term but unsustainable relief of nicotine withdrawal symptoms. In existing smokers these devices are likely to result in the reduction of cigarette use rather than in quitting, with dual use of e-cigarettes and cigarettes. The number of years spent smoking is considered to be of greater importance than intensity of smoking in causing negative health effects and therefore the benefits of dual use will be much lower than those of quitting completely due to the sustaining of an interchangeable habit.[2]

8. There is not yet good quality evidence of the benefit of e-cigarettes to continuous long-term abstinence. Published rates suggest that they are less effective than NHS smoking cessation services.[12,13] Research on e-cigarettes as a gateway to cigarettes is still in train as studies take time and the use of nicotine inhaling devices is relatively new to the market. We strongly advocate the precautionary principle where there is a sound theoretical argument to support a risk to public health. It is important not to wait for confirmation of harm before taking action and much public health progress may be undone in the meantime. There is no evidence to suggest that limiting access to e-cigarettes will prevent smokers from using other, more effective, methods to quit or to cause those trying to quit to revert back to cigarettes which are already restricted in these areas.

9. The companies that produce these devices are using many of the advertising, promotion and sponsorship approaches used by the tobacco industry, and there is currently open advertisement of products which closely resemble cigarettes. The same promotions which make the devices appeal to smokers, may also make them attractive to children and non-smokers.[2] Research by the North Wales Public Health Team found that use of e-cigarettes is widespread among 11-12 year-old girls and that the girls were often attracted by the range of flavours available.[14] Studies by ASH also show that awareness and use of e-cigarettes among young people in Wales is increasing.[15,16]

10. The UHB would also support the extension of restrictions to some non-enclosed spaces such as hospital grounds and children's playgrounds. Enforcement of the voluntary ban on NHS premises has proven difficult and time consuming, requiring employment of additional staff specifically to enforce such bans. Legislation would send a clear message around smoking

being prohibited in these areas and make consistent enforcement easier. It is important that the additional support needed to enforce such bans is adequately resourced.

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

11. We support the creation of such a register which is in line with the Tobacco Control Action Plan for Wales. A register would help to enforce legislation on the display of tobacco products and tackle underage sales by helping Trading Standards Officers to easily identify retailers and check compliance with regulations. A recent survey in England showed that nearly half of young smokers (44%) reported being able to purchase tobacco from retail premises despite the ban on the sale of tobacco products to those under the age of 18.[17]
12. Smoking is also increasingly concentrated in less affluent areas, where many may purchase smuggled or fake tobacco products at reduced cost. This has the potential to undermine tobacco control measures, encourage higher consumption, and deprive small businesses in these areas of legitimate trade.

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

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

Part 3: Special procedures

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

14. We support the creation of a mandatory licensing scheme for both practitioners and businesses carrying out 'special procedures'. This Bill also presents an opportunity to regulate the administration of the following procedures: body modification (to include stretching, scarification, sub-dermal implantation/3D implants, branding and tongue splitting), injection of any liquid into the body e.g. botox or dermal fillers, dental jewellery, chemical peels, and laser treatments such as used for tattoo removal or in hair removal.
15. Such a register would be beneficial in recognising legitimate practitioners and businesses and help to regulate these procedures in Wales. It would help to ensure a consistent approach to regulation across Wales. Suitable resources would need to be made available to realise and sustain the benefits of such a register. We also advocate national guidance with a maximum and minimum cost threshold for registration. The ability to amend the list of procedures through secondary legislation would also provide flexibility to incorporate new procedures with the potential to cause harm in the future.
16. The current legislation does not adequately protect the public and these procedures have the potential to cause harm if not carried out safely. In a recent look back exercise in Wales, nine people were identified as needing hospital admission due to severe *Psuedomonas aureaginosa* infection, eight of whom required surgical intervention (including incision, drainage, reconstruction and stitching), following body piercing at a tattoo and body piercing premises. The individuals needed weeks of hospital treatment and follow-up care, and some are permanently disfigured. More minor problems for other clients included swelling and trauma around the site, scarring, local skin infections, and allergic reactions which were more prevalent. A lack of good hygiene and infection control can lead to blood poisoning (sepsis) or

transmission of blood-borne infections through contaminated equipment, such Hepatitis B, Hepatitis C or HIV.

17. There is some older evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare.[18-20] 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.[21] However, in our view, the risk of transmission is the same in professional parlours where sterile conditions and infection control measures are not in place. Scarring from complications following such procedures can also have long-term psychological impacts.[22-24] Anecdotal evidence suggests that localised infections associated with such procedures are often seen in GP practices and Accident and Emergency departments, particularly following tongue piercings. All of the nine cases identified in the look back exercise self-presented to healthcare, often multiple times.

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

Part 4: Intimate piercing

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

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

Part 5: Pharmaceutical services

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

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

21. Pharmacies have been shown to be effective at delivering enhanced services such as smoking cessation, harm minimisation in substance misuse, flu vaccination, and emergency hormonal contraception.[25,26] Currently, the majority of pharmacy time is spent dispensing prescriptions and providing advice on medicines. We believe the legislation proposed in the Public Health (Wales) Bill will encourage existing pharmacies to adapt and expand their services in response to local needs. The risk of another contractor making a successful application to join the pharmaceutical list in their area, if they fail to respond to need will be an effective incentive. This can help to ensure services are available where needed.

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

Part 6: Provision of toilets

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

23. The UHB sees that there is a need for accessible public toilets and feel these are an important community amenity, particularly for older people, those with disabilities, and families with children. In addition an estimated 14 million British people have a bladder control problem, while 7.5 million have a bowel control problem.[27]

24. Without adequate public toilets some people may feel unable or reluctant to leave their home for periods of time, which can lead to a lack of mobility, worsening health, and isolation.[28] Accessible public toilets contribute towards an age-friendly community reflecting the aging population in Wales. Whilst there is a lack of research evidence on the health benefits of accessible public toilets, this is supported by professional opinions and public surveys.

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

Other comments

Food standards

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

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

28. The risk of many chronic conditions, in particular coronary heart disease, obesity, diabetes and some cancers, is increased by poor diet and diet-related disease has been estimated to cost the NHS around £6 billion a year. The cost of obesity alone has been predicted to reach £49.9 billion per year by 2050 by the Foresight report.[29] Wales faces some of the biggest challenges in the UK, with the Child Measurement Programme reporting prevalence of overweight or obese children to be 26% in reception year.[30]

29. Maintaining food standards, particularly in health settings such as hospitals which seek to keep people well, can inform and influence the public's perception of what foods are considered acceptable and healthy. The public sector caters for some of the poorest and most vulnerable people in society. Catering Standards for Food and Fluid Provision for Hospital

Inpatients, and the All Wales Hospital Menu Framework standards ensure patients receive adequate nutrition to assist with their recovery whilst in hospital, but there is much work needed to make sure that healthy and balanced meals and food are offered to all those accessing the restaurants (including staff, patients and visitors). Mandated criteria for the provision of only healthier retail items in hospital restaurants and outlets would help hospitals in Wales to fulfil their responsibility for improving the health of the population they serve.

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

Further comments

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

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

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HEALTH AND SOCIAL CARE COMMITTEE CONSULTATION ON PRINCIPLES OF THE PUBLIC HEALTH (WALES) BILL

Submission of Response by Wales Heads of Environmental Health.

Introduction:

The Wales Heads of Environmental Health Group (WHoEHG) represents the professional heads of environmental health services for the 22 local authorities in Wales. The Group is supported by a number of Expert Groups (generally multi-agency in composition) that focus on key specialisms within environmental health. These include Communicable Disease Control, Health & Safety at Work, Pollution Control, Food Safety, Housing, Health Improvement and Licensing.

Part 2: Tobacco and Nicotine Products Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

 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?

YES.

The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason.

Directors of Public Protection in Wales published its views on the availability and use of e-cigarettes in 2013, which included several examples where the enforcement of the ban on smoking in enclosed public places had been undermined by claims of the use of e-cigarettes. Local authorities have had legal actions fail because offenders claimed they were using e-cigarettes.*

However, whilst the following examples illustrate enforcement challenges, WHoEHG feel it is important to underline that the ban on smoking in public places is almost entirely self-policing by the public... and has been highly successful. The use of E-cigarettes in smoke-free areas poses a threat to that self-policing.

E-cigarettes also undermine the ability of managers of premises to enforce smoke free places, leading to many business banning them.

*[*examples: Cardiff County Council instigated a prosecution against a taxi driver for smoking in his vehicle. The defendant pleaded not guilty on the basis that he was smoking an e-cigarette and not a "real" cigarette. The matter proceeded to Court where the defendant was found not guilty despite the alleged offence being witnessed by an Enforcement Officer.*

Powys County Council has also experienced difficulties with enforcement, having lost a court case against a taxi driver who as part of his defence in Court suggested he may have been using an e-cigarette. The Court found the defendant not guilty despite the investigating officer's witness statement.

Similar enforcement difficulties have been experienced by Caerphilly CBC, Wrexham CBC and Swansea CBC where taxi drivers have been witnessed smoking in their vehicles but Enforcement Officers have been unable to prove whether it was a tobacco product or an e-cigarette. These cases demonstrate that where an individual is witnessed contravening the ban on smoking in a wholly or substantially enclosed public place they can simply claim that they were smoking an e-cigarette and it is extremely difficult for enforcing authorities to prove otherwise, thereby compromising the enforcement of the ban.]

There is uncertainty over the potential adverse health implications associated with e-cigarettes. There have been no published long term studies on the health of e-cigarette users so the impact of vaping on the body over many years or decades is unknown. There are many e-cigarette brands and reportedly thousands of flavours on the market; they work in different ways, delivering varying amounts of nicotine, toxins and carcinogens. A recent report on e-cigarettes, commissioned by Public Health England estimates that these devices are 95% safer than cigarettes. However the report also states that "Despite some manufacturers' claims that electronic cigarettes are harmless there is also evidence that electronic cigarettes contain toxic substances, including small amounts of formaldehyde and acetaldehyde, which are carcinogenic to humans,[34] and that in some cases vapour contains traces of carcinogenic nitrosamines, and some toxic metals such as cadmium, nickel and lead.[34] Although levels of these substances are much lower than those in conventional cigarettes,[34] regular exposure over many years is likely to present some degree of health hazard, though the magnitude of this effect is difficult to estimate". In our view it is appropriate to take a precautionary approach to the risks associated with e-cigarettes in smoke-free places. Currently people in Wales can breathe clean air in offices, shops, pubs and other enclosed public places and work environments. We don't want to see a backwards step towards potentially polluted air.

We are also concerned by reports suggesting that the use of e-cigarettes in public places can help "normalise" smoking. Very recent studies in the USA have highlighted the increasing use of e-cigarettes by schoolchildren.

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

We are of the opinion that smoking should be discouraged in all public places, in particular those locations where there are children or vulnerable people. These may include:

- *Playgrounds*
- *School grounds & their immediate vicinity*
- *Hospital & medical facility grounds*
- *Places promoted to children (e.g. "petting farms", fairgrounds and family centred leisure parks).*

There is a need for Fixed Penalty Notice powers which should be consistent powers with existing provisions. In drafting such provisions there is a need to consider that law currently

places a responsibility on the person in control of premises to prevent smoking (e.g. hospital grounds) and that local authorities' usual enforcement approach is against the "person in control of premises" for permitting smoking. (Under the Health Act 2006 "*It is the duty of any person who controls or is concerned in the management of smoke-free premises to cause a person smoking there to stop smoking*.")

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

Yes.

Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation and their potential impact upon smoke free environments.

We are also concerned by reports that e-cigarettes may intentionally or inadvertently promote or normalise smoking and therefore promote smoking amongst those who currently do not smoke. In particular we feel there is a need to make every effort to deter young people from becoming smokers.

We note the cautionary words of England's Chief Medical Officer that e-cigarettes should only be used to help smokers quit.

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

Data relating to smoking behaviour in Wales leads us conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach. We take the view that anything that has the appearance of smoking may help "normalise" smoking culture and behaviour and undermine this approach.

 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?*

We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours. We are therefore concerned by those reports that suggest that young people who are non-smokers may be attracted to e-cigarettes.

The use, marketing and sale of e-cigarettes should be controlled to reduce the risk of young people becoming addicted to nicotine. We have witnessed e-cigarettes being displayed for sale with sweets, at child height, at the checkout in some stores.

Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as "Gummy Bear", "Cherry Cola" and "Bubble Gum".

Some products are being packaged and marketed in a way that is closely associated with that of conventional cigarettes. For example, some e cigarettes glow and emit a vapour. We

also note the nature of some e-cigarette advertising; e.g. consistent with the 1950's style marketing of tobacco products.

 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?

Yes. There are many organisations and companies now banning the use of e-cigarettes across the UK, for various reasons including ensuring the smoke free legislations is enforced easily. A number of licensed premises have independently introduced bans on the use of e-cigarettes within their premises in recognition of the difficulty they cause their staff in applying the smoking ban within their premises.

Our colleagues that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people "vaping". Some vapers argue "it's not against the law".

Some employers have had difficulties. e.g. Caerphilly CBC had problems with lorry drivers smoking in their cabs and when tackled claimed they were vaping an e-cig, which made taking action difficult. Caerphilly CBC has also received complaints from their own office based staff that colleagues have been using e-cigarettes at their desks and that they may be also be inhaling the vapours in a similar way to second hand smoke. Hence Caerphilly amended their no smoking policy to include e-cigs.

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

The power to issue Fixed Penalty Notices and other enforcement provisions need to be consistent with other smoking legislation, and the fines need to be set at such a level as to be a deterrent to (re)offending.

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

Yes. WHoEHG supports the proposal. Our experience of implementing similar schemes leads us to conclude that such an approach, supported by suitable enforcement powers, can help control regulated activities.

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

We would refer you to the comments of Directors of Public Protection Wales and Wales Heads of Trading Standards.

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

We would refer you to the comments of Directors of Public Protection Wales and Wales Heads of Trading Standards.

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

We would refer you to the comments of Directors of Public Protection Wales and Wales Heads of Trading Standards.

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

Yes.

Smoking remains the single greatest avoidable cause of death in Wales **(Public Health Wales, 2012)**. The introduction of the ban on smoking in enclosed public spaces in 2007 has been hugely successful in reducing exposure to environmental tobacco smoke and in strengthening public awareness and attitudes towards it. However, reducing the prevalence of smoking, remains a key health priority. Protecting young people from the effects of smoking and deterring young people from taking up the habit are particularly important. Therefore WHoEHG welcomes the proposals and additional powers to help control the availability of tobacco and its potential health impact.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales, these procedures are acupuncture, body piercing, electrolysis and tattooing.

 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?

We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators.

WHoEHG is of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

WHoEHG has the following concerns regarding existing provisions:

- There are no specific requirements for a practitioner to have training or experience relating to skin piercing prior to setting up such a business. This would only be covered under general H&S legislation. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk.
- Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the Local Government

(Miscellaneous Provisions) Act 1982. This may be viewed as a purely administrative offence when Courts are considering sentencing.

- Current registration requirements rely on Local Authorities being able to prove that a person is carrying on a business. As the majority of unregistered tattooists ('scratchers') work from domestic premises it is difficult to prove that it is a business and they deny that they receive payment.
- There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws and the magistrate cancelled a previous registration. However, Local Authorities are still reliant on the applicant informing them that they have been prosecuted in another area.
- The current application process does not require any proof of identity, criminal records checks or "fit and proper person test", therefore, even if an applicant had been prosecuted in another LA then there would be no way of knowing.
- Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and The Health and Safety at Work etc. Act 1974. Several local authorities in Wales have used Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle "scratchers".
- When we last gathered information on this, we found that between July 2012 and July 2013, ten applications for Part 2A Orders had been made by local authorities; all of which related to the carrying out of unregistered tattooing from domestic premises.
- A domestic premises can be registered to carry out skin piercing and comply initially with the byelaws. However, unless there is a separate entrance, the Health and Safety Executive are responsible for the enforcement of H&S legislation within that premises. Our experience in Newport is that the HSE have previously been reluctant to transfer enforcement responsibility to local authorities in such a situation. Therefore, if there is a serious risk such as lack of sterilisation, Officers are unable to serve prohibition notices as they would in a commercial setting. The only option would be to simply prosecute for non-compliance with the byelaws or to apply to the courts for a Part 2A order- both being a time consuming process.
- New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.
- Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.

We would offer the following observations on the proposal regulations:

• Level 3 fine (£1,000) is perhaps a little low. This should be worded more strongly – we understand that the experience of Caerphilly and BG is that multiple convictions of an individual resulting in low fines have not deterred the individual from illegal tattooing.

• In determining whether to grant a license a Local Authority should be able to consider whether the applicant is a "fit and proper person" and such a test should be included (akin to

our tried and tested procedures for taxi licensing). The test should permit the LA to take into account “any other information” (beyond the “relevant offences” listed in the draft bill) in determining that question. The current proposals do not offer sufficient safeguards.

- We would be opposed to grandfather rights for existing traders. Our officers have only recently dealt with a high profile public health incident in South Wales which related to a long-standing operator.

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future.

We will be pleased to work with WG officials is relation to such matters.

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

We absolutely support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. E.g. a local studio (in Caerphilly) is keen to expand into scarification and tongue splitting. Other procedures are already becoming more popular e.g. branding, dermal implants, microdermabrasion. All these procedures provide the potential for serious harm and infection.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive activities underground and cause further issues or potentially make it more appealing to some people.

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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed

provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

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

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Evidence of public health risk in relation to such procedures is clear. We take the view that any procedure that involves the piercing of the skin poses a very real risk of infection and disease from blood born viruses many of which can be a serious risk to health and that anyone undertaking such procedures should be competent to do so without putting a person at risk.

Current controls are outdated and inadequate. We need to be able to protect the public to better prevent people from undertaking these procedures if they are not competent or are not fit and proper person to be undertaking such practices. We need also to ensure that the conditions in which such practices take place are hygienic and will prevent infection risks.

We are seeing in our day to day work evidence of a growing range of procedures that put the public at risk. These include: dermal implants, beading, ashing, scarring, dermal fillers, tongue splitting, and a range of other procedures that we might loosely describe as “body modification”. We feel strongly that regulations should permit all such procedures to be controlled and that the regulations should allow the list of procedures to be extended to cover any form of body modification that may arise in the future.

Some procedures such as “ashing” might not fall within the regulations as proposed. Ashing may fall outside of the current definition of tattooing (which relies on the use of pigmentation) and care is needed that definitions do not inadvertently exclude procedures that are intended to be covered.

In relation to extending the list, we recognise from an enforcement perspective that we are familiar with the necessary controls and safeguards needed in relation to more traditional procedures. There is merit in a considered and stepped approach to extending the list of special procedures so that we are able to develop training, suitable competence assessments and necessary guidance in relation to the more novel procedures. We are also aware that consideration is needed in distinguishing between a legal service that we might appropriately control and what might be considered an illegal act of assault. We feel some clarity will be required in relation to that question.

Educational establishments:

Some further consideration may be needed about how best to apply or amend the proposals in relation to students of educational establishments.

Apprentices.

Section 48(3) and (4) need to better address the supervision and training of apprentices

An issue linked to apprentices, is that performing a ‘special procedure’ needs to be defined as an action that breaks the skin in our view. Otherwise there could be confusion about whether apprentices are performing a special procedure, when they have done every other part of the process but break the skin.

Proving a business exists.

There should be no need to prove a premises is operating as a business at a given moment in time. A premises should be deemed to be operating as a business at all times it is licensed, similar to a hackney carriage.

FPNs.

The use of FPNs for ‘minor’ breaches of the legislation may be useful.

Section 52(2)(c): Information to be communicated to clients.

Perhaps this information should be specified in the regulations, as it has been in the Sunbeds legislation – prescribed information to provide to a person each time that person seeks a treatment and prescribed posters to be displayed in a prominent position.

A National Register

We take the view that it would be sensible to have one single national register that is administered by one local authority in Wales. This would be an efficient, collaborative method of delivery. A number of local authority Environmental Health departments have indicated their willingness to take on that responsibility on a cost recovery basis. We would underline the importance of local authority administration because of the potential intelligence / data sharing issues in relation to applicants between enforcement agencies.

We would be happy to facilitate a more detailed discussion of the above points with appropriate Welsh Government officials / policy leads.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

 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?

Yes. Local authority officers are aware that such procedures are taking place and it is our view that such intimate procedures on under 16s should be illegal to protect this vulnerable group from potential risks. It is also agreed that even with parental consent these procedures should not be permitted.

Because of the higher risks associated with intimate piercings, coupled with the relative vulnerability and immaturity of some 16 and 17 year olds, WHoEHG considers there is a strong case for setting the age limit at 18. This would offer further protection to a greater number of young people.

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

Yes. However we also feel there is a case to add the tongue. In addition to the relatively higher risks of infections associated with tongue piercing, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list of intimate parts.

 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?

We support such proposals including the proposal to make it an offence “to enter into arrangements”. This would support enforcement of the provisions including “test purchasing” by local authorities.

We recognise the need for police support in particular in relation to evidence gathering given the intimate nature of such offences and the provisions need to take account of that.

Any duties placed upon local authorities need to be supported by adequate funding.

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

Yes, see above**.**

Part 6: Provision of Toilets Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

 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?

WHoEHG agrees that the provision of, and access to, toilets for public use is important, particularly to older people and those with specific needs. However, this is not an area in which Environmental Health Departments generally have any enforcement responsibility and it seems none are proposed. We are thus not well placed to comment on the proposals

We do however recognise all too clearly the current financial pressures on local authorities. We question whether placing a duty on local authorities to develop a strategy is appropriate, acknowledging firstly the difficult financial climate within which any duty would consume resource and secondly that a strategy will not of itself bring about enhanced provision. Care is needed that WG does not merely impose an administrative and financial burden that delivers no real benefit to the public.

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

See above

 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?

The consultation requirements set in para 92 are too vague to be meaningful.

 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?

In our experience, such guidance leads to more consistent approaches.

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

 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?

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

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 are generally very supportive of the measures set out in the Bill. However, we are naturally concerned by the capacity within local government to deliver additional responsibilities successfully at a time when service cuts and reductions in service standards are all too apparent. We have a great deal of expertise and experience and local authority Environmental Health Departments across Wales are keen to support these new powers and measures. However WHoEHG ask WG to ensure that such work can be adequately resourced and in particular:

- Where possible provisions should allow for full cost recovery or in the absence of a cost recovery mechanism (typically fees & charges) additional resource must be made available to local authorities specifically for the purpose of this legislation;
- In drafting the legislation, WG should avoid unnecessary complexity or ambiguity, ensure that provisions are capable of being enforced in a practical and efficient way and that any potential defences are fully and properly understood.
- Effective collaboration with enforcement agencies to help deliver a suitably supported, appropriately timed and operationally practicable implementation of proposals. We are pleased to assist in this.

 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?

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

 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?

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

Other comments

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

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

Yes

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

Through our licensing teams and through a broad range of officers working closely with local residents in our communities, we are all too familiar with the problems caused by alcohol. However, we understand that Minimum Unit Pricing is a proposal to be taken forward in a future draft bill – something that we would welcome and will be pleased to work with officials working towards that.

We are also aware of public health concerns around obesity, nutrition and exercise – and we have an interest in this area through our vital role in relation to the regulation of food standards and food labelling and our general contribution to the wider public health agenda. We acknowledge the potential contribution of the Future Generations Act and Active Travel Act for example in this area but note also the potential for planning controls and licensing arrangements to play a greater part. We also recognise that some of these issues may need action at the level of UK Government.

In our submission in advance of the White Paper we also raised the possibility of considering an overarching general offence of prejudicing public health …. enabling appropriate bodies to protect public health in situations which fall outside existing legislation.

We are increasingly concerned by the supply of products known as “legal highs”.

Document Control:

WHoEHG Response to Public Health Bill draft ver3 Aug15; dated 28th August 2015.

(Replaces: WHoEHG Response to Public Health Bill draftver2 dated 25th August15.)

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

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

Evidence from the Older People's Commissioner for Wales – PHB 32 /
Tystiolaeth gan Gomisiynydd Pobl Hŷn Cymru – PHB 32



Response from the Older People's Commissioner for Wales

to the

National Assembly for Wales consultation on the Public Health (Wales) Bill

September 2015

For more information regarding this response please contact:

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About the Commissioner

The Older People's Commissioner for Wales is an independent voice and champion for older people across Wales, standing up and speaking out on their behalf. She works to ensure that those who are vulnerable and at risk are kept safe and ensures that all older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services they need. The Commissioner's work is driven by what older people say matters most to them and their voices are at the heart of all that she does. The Commissioner works to make Wales a good place to grow older - not just for some but for everyone.

The Older People's Commissioner:

- Promotes awareness of the rights and interests of older people in Wales.
- Challenges discrimination against older people in Wales.
- Encourages best practice in the treatment of older people in Wales.
- Reviews the law affecting the interests of older people in Wales.

National Assembly for Wales consultation on the Public Health (Wales) Bill

1. As the Older People's Commissioner for Wales I welcome the opportunity to respond to the National Assembly for Wales' Health and Social Care Committee consultation on the Public Health (Wales) Bill[1].

2. There are almost 800,000 people aged 60 and over in Wales, over a quarter of the population, and, in the next twenty years, this is expected to exceed one million people. The fact that Wales is a nation of older people should be seen as something positive.

3. Whilst the Bill does include some proposals that should help maintain the health and wellbeing of older people, I believe that the Bill lacks ambition and does not address the real public health issues that matter to older people across Wales.

4. A more proactive and ambitious Bill is required to promote the benefits of a healthy lifestyle in all age groups. The Bill must drive forward improvements in service provision and address the public health challenges on Wales' high streets that have a detrimental impact on older people's health and wellbeing. These challenges include, as examples, drinking establishments (a fifth of people over 65 years old are drinking unsafe amounts of alcohol at the UK level[2]), bookmakers (gambling participation amongst people 55 years and older remains a concern[3]), payday loan shops (the growth of such providers is contributing to rising debt amongst older people[4]), and fast-food outlets (on the UK level, 32% of women aged 65 years and older are classed as overweight, with 54% of men in the same age group also classed as overweight[5]).

[1] http://www.senedd.assembly.wales/mgConsultationDisplay.aspx?id=181&RPID=662102&cp=yes
[2] http://www.theguardian.com/society/2015/aug/24/over-65s-unsafe-alcohol-consumption-drinking-study
[3] http://www.gamblingcommission.gov.uk/pdf/Trends-in-gambling-participation-2008-2014.pdf
[4] http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Policy/ageuk_ilc_debt_report_summary_040613.pdf?dtrk=true
[5] http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true

5. Older people are vital assets, currently worth over £1bn to the Welsh economy annually[6]. The Public Health Bill has a crucial role to play in establishing a 'virtuous circle'; maintaining the independence of older people, ensuring that they can continue to contribute to society, local and national economies, and reducing dependence on health and social care services already under significant pressures. The Bill should promote a preventative, outcomes-focused model that helps unlock the huge potential of older people to communities and economies across Wales.

6. The Bill should complement and drive forward the Strategy for Older People 2013-2023[7] and also dovetail with the two legislative drivers that should help improve the lives of older people across Wales, namely the Social Services and Wellbeing (Wales) Act 2014[8], and the Wellbeing of Future Generations (WFG) (Wales) Act 2015[9].

7. It should also contribute towards my Framework for Action 2013-17 priorities, particularly ensuring that people's health and wellbeing is considered across all policies and portfolios ('Embedding the wellbeing of older people at the heart of public services'), work towards a preventative approach that integrates health and social care services ('Driving up the quality of, and availability and access to, health and social care'), and recognising that public toilets and other non-statutory services are essential community health assets ('Protecting and improving community services, facilities and infrastructure')[10].

Provision of Toilets

8. The proposal for Local Authorities to prepare and publish a local toilets strategy is welcomed, however it does not go far enough

[6] http://www.olderpeoplewales.com/Libraries/Uploads/The_Importance_and_Impact_of_Community_Services_within_Wales.sflb.ashx
[7] http://gov.wales/docs/dhss/publications/130521olderpeoplestrategyen.pdf
[8] http://gov.wales/topics/health/socialcare/act/?lang=en
[9] http://gov.wales/legislation/programme/assemblybills/future-generations/?lang=en
[10] http://www.olderpeoplewales.com/en/Publications/pub-story/13-05-23/Framework_for_Action.aspx#.VbJYCmctAdU

and falls short of obligating Local Authorities to provide and maintain public toilets. Older people rarely call for strategies and instead require firm commitments and actions to ensure that they can continue with their daily lives and remain connected with their communities through the provision of public toilets and other non-statutory services. Older people in Wales have the right to expect access to open, clean and accessible public toilets.

9. As I have consistently emphasised and highlighted in my report on 'The Importance and Impact of Community Services within Wales'[11], public toilets and other community services are vital assets and are absolutely essential in maintaining the health, independence and wellbeing of older people.

10. Good public toilet provision is a public health necessity. Closing public toilets affects physical health (older people are more likely to suffer from bladder or bowel incontinence), mental health (the fear of being unable to access toilets can lead to isolation and depression), and environmental health (the risk of infection from street fouling increases with the closure of public toilet facilities). Closing down or reducing access to public toilets is damaging to public health and has a detrimental effect on the economy, with older people, including local residents, visitors and tourists, less likely to visit places.

11. As the Explanatory Memorandum acknowledges, poor public toilet provision is known to have particular negative impacts on older people, and often disproportionate impacts. Many older people will not leave their homes without the assurance of being able to access a public toilet in their village, town or city when the need arises[12]. The closure of public toilets across Wales has had a huge impact on the physical and mental health of older people. Almost 20% of public toilets managed by Local Authorities closed between 2004 and 2013, leading to older people becoming more

[11] http://www.olderpeoplewales.com/en/news/news/14-02-25/The_Importance_and_Impact_of_Community_Services_within_Wales.aspx#.VbDAcmctAdU
[12] http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

susceptible to loneliness and social isolation, and requiring costly packages of health and social care[13].

12. The proposal for public toilets to include changing facilities for babies and changing places for disabled persons is welcomed, but could go much further. Public toilets must be clean, safe and accessible places for older people and others, with handrails, wheelchair ramps and visual and hearing aids for those with mobility issues and sensory loss.

13. The proposal for Local Authorities to consult with local stakeholders is welcomed, and, as emphasised in my Best Practice Guidance for Engagement and Consultation[14], I fully expect that older people across Wales are given every opportunity to voice their needs and concerns. As regular users of community services, older people are 'experts by experience' and are well placed to gauge the effectiveness of local public toilet provision.

14. The requirement for Local Authorities to assess local need for public toilets must be supported by adequate resources. I am fully aware of the stark financial challenges facing Local Authorities and support all efforts to provide them with the resources required to provide public toilets. I am not convinced that the former Community Toilet Grant scheme, whereby the public are able to use toilets in local businesses, is a model that can adequately replace public toilet provision.

15. Older people have told me that they often feel uneasy or embarrassed about using Community Toilet Schemes, and instead require dependable and accessible public toilets. Furthermore, the Welsh Senate of Older People's 'P is for People' campaign found that 85% of respondents would be prepared to pay a small amount in order to use a public toilet[15].

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[13] http://www.itv.com/news/wales/2014-06-30/public-toilet-closures-in-wales-shortsighted/

[14] http://www.olderpeoplewales.com/en/Publications/pub-story/14-07-01/Canllawiau_ymarfer_gorau_ar_gyfer_ymgysylltu_ac_ymgynghori_%c3%a2_phobl_h%c5%b7n_ar_newidiadau_i_wasanaethau_cymunedol_yng_Nghymru.aspx

[15] http://www.welshsenateofolderpeople.com/Documents/P%20is%20for%20People%20Questionnaire.pdf

16. As part of the Ageing Well in Wales Programme[16], all Local Authorities have signed the Dublin Declaration, a commitment to establish age-friendly communities in their area. Adequate public toilet provision plays a key role in establishing such communities and the Bill must go further in ensuring that older people and others can access public toilets across Wales.

General remarks

17. Beyond public toilet provision, there is very little reference to older people in the Bill and Explanatory Memorandum. The Bill is a missed opportunity in terms of addressing the range of public health issues that matter to older people. These include the following:

- **Loneliness and Isolation**: A serious public health issue that is affecting an increasing number of older people across Wales, and exacerbated by the closure of 'lifeline' community services such as public buses, public toilets, libraries, day centres, meals on wheels and befriending schemes. Loneliness can have a serious impact on a person's physical and mental health and wellbeing, and has an effect on mortality that is similar in size to smoking 15 cigarettes a day[17].

  It is estimated that more than 75% of women and a third of men over the age of 65 live alone. Without the means to leave their homes, or with fewer visits from community workers and service providers, an increasing number of older people will feel lonely and isolated, resulting in damaging effects to their mental health and increased exposure to alcohol misuse. These 'silent killers' need to be addressed as a matter of urgency, and for this reason Loneliness and Isolation is a priority theme within the Ageing Well in Wales Programme[18]. The Bill should be complementing the Programme's aims and outcomes,

[16] http://www.ageingwellinwales.com/en/home
[17] http://www.campaigntoendloneliness.org/threat-to-health/
[18] http://www.ageingwellinwales.com/en/themes/loneliness-and-isolation

unfortunately the urgent need to tackle loneliness and social isolation is a glaring omission in the Bill.

- **Nutritional value of food in care homes**: As I mentioned in my response to the consultation on proposals for a Public Health Bill[19], it is crucial for older people living in care homes that they are provided with a nutritional, balanced meal and that care home staff are aware of the benefits that good nutrition brings to older people. Malnutrition is estimated to affect between 16-29% of older people living in care homes across Wales and one in three older people are affected by malnutrition upon entry into residential care homes.

  As my Review into the quality of life and care of older people living in care homes in Wales states[20], action to ensure that the dietary needs of individuals are met and that malnutrition is prevented wherever possible is essential to maintain the health, wellbeing and quality of life of older people living in care homes. It is regrettable that the White Paper proposal to introduce nutritional or food based standards in care homes settings is not taken forward in the Bill.

- **Building community assets for health**: I welcomed this approach in the White Paper as it recognises the importance of local health care services in maintaining the health, independence and wellbeing of older people and others. Whilst the Bill does recognise the importance of accessing local pharmaceutical services and public toilets, it does not address improved access to effective integrated care and support and person centred primary care services, as referred to in the White Paper.

  A preventative approach is required to ensure that older people stay safe, independent and healthy, and that healthcare support is timely, accessible and effective when they require it. The Bill

[19] http://gov.wales/docs/phhs/consultation/141104phwhitepaperresponses15en.pdf
[20] http://www.olderpeoplewales.com/Libraries/Uploads/A_Place_to_Call_Home_-_A_Review_into_the_Quality_of_Life_and_Care_of_Older_People_living_in_Care_Homes_in_Wales.sflb.ashx

does not address the barriers that older people often face in accessing support, such as GP appointment booking systems, nor the need to improve integration between GP surgeries, dental practices and pharmacies in order to reduce avoidable hospital admissions and the need for costly packages of health and social care.

- **Obesity and physical inactivity**: As I highlighted in my supplementary response on the benefits of physical activity[21], the maintenance of a healthy lifestyle and keeping active is a significant preventative measure in the onset of a number of health conditions. Evidence suggests that physical activity levels decline rapidly with increasing age; people over 65 years old in Wales attain less than half the physical activity of 16-34 year olds. Despite the worrying levels of physical inactivity amongst older people, the Bill does not address the needs of older people and improve the awareness of older people of physical activity opportunities available to them e.g. free swimming classes, outdoor activities, or tailor-made exercise classes in community settings or residential care homes.

  It is regrettable that the Bill does not promote the benefits of physical activity and the particular needs of older people. Such an approach, complemented by a proactive approach on nutritional standards and educating citizens on healthy eating, would be effective in addressing Wales' obesity crisis, with 58% of people aged 16 years and older classified as overweight or obese[22]. Obesity amongst older people is a growing concern, with one in four older people now considered obese in the UK[23].

- **Tobacco and Alcohol**: Much of the debate around the new Bill has centred on the banning of e-cigarettes in enclosed public spaces. The Bill however could go further in tackling tobacco

[21] http://www.olderpeoplewales.com/Libraries/Consultation_Responses_150107/141111_-_Welsh_Government_Public_Health_Bill_consultation_Physical_Activity_Policy_Development.sflb.ashx
[22] http://gov.wales/statistics-and-research/welsh-health-survey/?lang=en
[23] http://www.telegraph.co.uk/news/health/elder/10473122/Obesity-crisis-more-than-one-third-of-60-70-year-olds-now-dangerously-overweight.html

and alcohol dependence in Wales, and educating people about the dangers of misuse and the benefits of a healthy lifestyle. Such an approach would be helpful in addressing dependence amongst different age groups, including older people.

Around 20% of adults in Wales are smokers, and more needs to be done to address smoking amongst older people. Quitting smoking in later life can lead to significant health benefits and increase longevity[24].

Since the publication of the Public Health Bill, the subsequent Public Health (Minimum Price for Alcohol) (Wales) Bill may be useful in deterring some individuals from alcohol misuse but will do little to address harmful alcohol drinking amongst older people in 'middle classes', with minimum pricing unlikely to deter those with steady incomes and live in relative affluence[25]. Alcohol misuse in this group is a growing concern as demonstrated by a recent study in England[26].

As the White Paper indicated, the Welsh Health Survey between 2008 and 2012 showed an increase in older people drinking above the daily guidelines[27]. With an ageing population, alcohol misuse amongst older people is a growing concern, with an estimated 1.4m older people drinking above guidelines at the UK level[2829].

I am pleased that the National Assembly's Health and Social Care Committee report on 'Alcohol and substance misuse', published after the publication of the aforementioned Bills, does address older people and that more awareness raising and training around the issues facing older people is needed, particularly as alcohol and substance misuse amongst older

[24] http://www.ageuk.org.uk/health-wellbeing/keeping-your-body-healthy/healthy-living/smoking/
[25] http://gov.wales/docs/dhss/consultation/150715consultation-draften.pdf
[26] http://bmjopen.bmj.com/content/5/7/e007684
[27] http://gov.wales/docs/phhs/consultation/140402consultationen.pdf
[28] http://www.alcoholpolicy.net/older-people/
[29] http://www.bbc.co.uk/news/health-19509434

people ‘often goes undetected’ due to ‘trigger events’ such as retirement or bereavement’[30].

The Public Health Bill should go further in issuing guidance to improve identification and access to substance misuse services for older people, as referred to in the White Paper. Clarification on how the Public Health (Minimum Price for Alcohol) (Wales) Bill will complement and link with the broader Public Health Bill is also needed.

Conclusion

18. Although the public toilets proposal is a step in the right direction, and the importance of assessing local need for pharmaceutical services is addressed, I believe that the Bill lacks ambition and is a missed opportunity to tackle the real public health issues that affect older people across Wales; it falls short of what is needed for older people. With such a broad and diverse set of issues ranging from tobacco, intimate piercing and public toilets, I am very concerned that the Bill lacks a coherent vision, and omits many of the positive proposals included in the White Paper; there is no holistic approach.

19. Wales’ health, social care and public services cannot afford not to maintain the independence and wellbeing of older people, and I am concerned the Bill will not add value in enhancing Welsh public health, reducing health inequalities, contributing to the Strategy for Older People and the ‘A healthier Wales’ national wellbeing goal within the WFG Act. In its current form Wales will miss an opportunity to improve the quality of life of older people across Wales.

[30] http://www.assembly.wales/laid%20documents/cr-ld10329/cr-ld10329-e.pdf

British Association of Cosmetic Nurses

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

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

Evidence from the British Association of Cosmetic Nurses – PHB 33 / Tystiolaeth gan Gymdeithas Nyrsys Cosmetig Prydain – PHB 33

Consultation – Public Health (Wales Bill) – Submission by the British Association of Cosmetic Nurses (BACN).

Introduction

1. The BACN is delighted to have been invited to comment on the above Bill as it passes through the Committee stages of the National Assembly for Wales. The format of our response will follow the guidelines that were sent with the invitation to provide evidence. We have also sent confirmation of our willingness to attend a meeting of the Committee on 17th September 2015 if required.

The BACN – An Introduction

2. The BACN was formed in 2009 by a small group of registered Nursing and Midwifery Council nurses who wanted to provide a forum for networking and mentoring in what was and still is the rapidly growing sector of non-surgical aesthetic treatments.
3. The BACN is now the largest Professional Association in the field of non-surgical aesthetic treatments and has over 600 members – a number of which practise in Wales. A detailed breakdown of our constitution, governance and activities can be found on our website at:

www.bacn.org.uk

Regulation in the UK – Non- Surgical/Aesthetic Treatments

4. It is worth reiterating that there is no regulation at all in England, Wales, Scotland or Northern Ireland for non-surgical aesthetic treatments. There is regulation by governing councils and statutory legislation for prescription medication. The problem is interpretation of regulation, the difficulty of enforcing it and the maintenance of best practice standards under the legislation (and of course, fillers are not prescription drugs therefore not regulated).

England

5. There is a lot of activity going on in England with regard to potential models of regulation following the publication of the Keogh Report on 'Non-Surgical Cosmetic Interventions' on 11th September 2014.
6. This report was commissioned by the Secretary of State for Health and looked in particular at the need for regulation in the non-surgical sector. The findings outlined a principle of self-regulation for England and initiated a consultative process amongst stakeholders led by Health Education England (HEE). The BACN was a member of the Expert Reference Group established by the HEE to review the findings of the Keogh Report.
7. The findings of the Expert Reference Group were published in December 2014 and final comments were provided to the Secretary of State for Health by 31st March 2015. The HEE is currently considering the responses prior to making recommendations to the Minister of Health.
8. The Keogh Report identified the absence of any regulation for dermal fillers. The Department of Health have expressed the desire to address this through the introduction of statutory legislation which focuses on dermal fillers and possibly other non-prescription treatments. This would have the effect of bringing these treatments under the jurisdiction of statutory regulated healthcare professionals which, we believe, is to be welcomed.

Scotland

9. The Scottish Executive is about to announce a licensing system for aesthetic businesses. The BACN has contributed to the development process and been invited to sit on the Health Inspection Service (HIS) which will inspect premises. They are now looking at establishing standards and have looked towards the BACN Competency Framework as a guide in this area. At the moment there are no plans to establish an overarching body to oversee standards or to look

at the assessment of competence. This function will be performed by the Chief Medical Officer for Scotland and as yet there are no proposals for review.

BACN Competency Framework

10. The BACN Competency Framework is the only set of standards published for the non-surgical aesthetic sector which is also accredited by the RCN. As part of the HEE process the Competency Framework was adapted to also include hair restoration and various laser treatments. We recommend the standards in the Competency Framework to the National Assembly for Wales as the basis for setting a national set of standards in this area either through primary or secondary legislation and to include non-surgical cosmetic interventions.

Joint Council Model

11. The BACN in its final submission to the HEE also recommended the establishment of an over- arching body, a 'Joint Council' that would own and update standards and take a strategic view on regulation in the sector. It also suggested that there is an Accreditation Body established under the wing of the Joint Council to review training programmes that are outside the usual remit of academic institutions and OFQUAL.
12. Detailed discussions are now taking place on the format, remit and financing of a Joint Council between the HEE and some of the key Professional Associations that oversee activity in the non-surgical sector. However, without legislation this process is subject to the industry and professional bodies agreeing an acceptable way of working which is proving very difficult.
13. One option that has been suggested is the establishment of a 'Voluntary Register' in England. It is the view of the BACN that this is fraught with difficulties in terms of who is required to register, who keeps the register and who polices it. It is also open to misinterpretation by the public if it is not clear what the register has been established to do. An approval to be on a register that is just based on premises inspection, availability of policies and procedures for the activity or hygiene gives no guarantees in relation to the competence of the persons providing treatments.

The Welsh Proposals – Comments

14. The BACN in this section respond to the key areas outlined in the 'Guidance Notes' for responders and the questions that are asked to be covered. The

single most important point to make here is that the proposals published in the Bill refer to licensing 'Special Procedures' and 'Cosmetic Procedures' but no reference is made to 'aesthetic procedures' (see para 107 in Guidance Notes). The BACN would support licensing however do not believe that a 'Public Health Bill' is the most appropriate route or vehicle to achieve the desired aims for the reasons set out below.

15. The risks associated with aesthetic procedures include serious facial scarring and blindness, which require rapid and expert identification and intervention. The importance of and need to identify competence is reflected by the serious complications that can occur in aesthetic procedures. In its current form we would question the extent to which the Bill refers to such competence and the ability of it to be measured and verified by the arrangements suggested.

16. Experience tells us that the public are frequently not judicious in determining the true meaning of any licence, kite mark or title. Any such annotation is usually perceived, without question, as competence in the broadest sense. Any move to license practitioners to all but the fullest measure is likely to cause confusion at best and misplaced trust at worst.

17. By virtue of the prescription status of certain popular treatments, unregulated practitioners cannot work in isolation, but are subject to the overview of regulated healthcare prescribers. Any move to license those who are unregulated would have to entertain the complexities of this impinging upon those who are regulated from another source. e.g. NMC or GMC.

18. The draft proposals do appear to discuss providing exemptions to 'members of specific professions' (see para 120 in Guidance Notes) who are overseen by 'Governing Councils'. Our position on this is with regard to nurses in particular where we would agree that such exemptions are appropriate. The alternative would seem to be a layering of regulation upon regulation. We would question the benefits as set against the complexities of such a measure.

19. The emphasis of the Bill appears be on 'Special Procedures' being carried out in 'an unhygienic fashion' (Para 108 of the Guidance Notes) and the need for practitioners to 'employ safe working practices' (Para 108 of the Guidance Notes). Para 115 of the Guidance Notes refers to the lack of a 'Competency Test' for practitioners and also to there being no requirement 'for consent forms, pre and post-procedure consultation, aftercare advice or record keeping' which are all critical points. However we refer to Para 14 in this submission which states that the suggested framework for licensing is inadequate to support the assessment of professional competence.

20. The principle of licensing individuals as well as premises (Para 117 of the Guidance Notes) is thoroughly endorsed by the BACN from its experience of the non-surgical sector in the UK. This is necessary to avoid large chains of

clinics or bodies providing 'Special Procedures' registering on bloc under the licensing system and then having a number of individuals carrying out 'Special Procedures' without a licence and redress for the patient.

21. Recognition in the Bill of the need to update various 'Special Procedures' via secondary legislation is also welcomed by the BACN from its experience of the rapidly changing 'non-surgical aesthetic sector' in the UK.
22. The BACN notes that it is local authorities in Wales who are being charged with the responsibility for licensing and enforcing the conditions of the licence (Para 122 of the Guidance Notes) and questions if they have the specialist expertise and resources to do this in respect of aesthetic treatments. If the area of 'non-surgical aesthetic treatments' did come under some kind of licensing procedure how would local authorities ensure that they have the relevant expertise to assess competence.
23. The power of local authorities to issue 'Stop Notices' to practitioners (Para 123 of the Guidance Notes) who have contravened the licensing rules is good in theory but may be very difficult to implement in practice. It also places the Licensing Authority in a position where 'loss of business income' could be part of a major counter claim.
24. It is suggested that the legislation will 'institute a system of mandatory licensing for those practitioners who provide special procedures in Wales, to which national standards will be attached and enforced by local authorities' (Para 125 of the Guidance Notes) however this is dependent on agreement being reached on national standards. It is our experience in the field of non-surgical aesthetic treatments that this is a major issue. As referred to earlier the BACN has developed its own 'Framework of Standards and Competencies' to meet this gap and this is now being incorporated into a broader framework by the HEE in England. It has taken over 18 months to agree this framework with numerous stakeholders participating.
25. Reference in Para 127 of the Guidelines to 'Public confidence and client understanding will be further enhanced by the requirement for practitioners to provide pre- and post - procedure consultations' is definitely recognised by the BACN with regard to non-surgical aesthetic procedures but only if the regulations and enforcement procedures deliver an effective process for monitoring.
26. The Bill talks about possible exemptions to the arrangements for persons carrying out 'Special Procedures'. In England this matter has been discussed in great depth with a number of 'Professional Bodies/Governing Councils' making the case that existing arrangements are adequate to cover any negligence by a practitioner or to deal with a complaint from a member of the public.

BACN – Concluding Statement

27. The BACN maintains that there is a need to regulate 'non-surgical cosmetic interventions' in Wales but does not believe it fits well within a 'Public Health Bill' that has not been designed for this purpose and concentrates on premises and hygiene regulation only. The extensive work done by the HEE in England provides an excellent backdrop to the issue of regulation in Wales. However the BACN is concerned about the length of time it has taken and the fact that there is still no clear set of proposals or structures agreed.

28. We consider that there are two options involved with regard to providing a regulatory framework for non-surgical cosmetic interventions in Wales:

Option 1

Adopting the framework currently being developed in England where considerable work has been undertaken to define the area and the standards/competency involved. However this is subject to agreements being reached and final proposals published.

Option 2

Reviewing what emerges from the process in England and then deciding if a more regulated framework via statute is necessary in Wales. This would enable Wales to make its own decision on regulation but could mean considerable delays which would not be in the interest of the general public or regulated medical professionals.

The BACN is happy to work with the Welsh Assembly whichever approach it decides to take with regard to the issue of regulating 'non-surgical cosmetic interventions' separately from this current Bill.

Sharon Bennett – Chair – on behalf of the BACN Board

Andrew Rankin – Vice Chair – on behalf of the BACN Board

Paul Burgess – CEO – BACN

29th August 2015.

Comisiynydd y Gymraeg
Welsh Language Commissioner

Health and Social Care Committee
Welsh National Assembly
Pierhead Street
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28/08/2015

The Welsh Language Commissioner's response to the Health and Social Care Committee consultation: Public Health (Wales) Bill

The Welsh Language Commissioner welcomes this opportunity to respond to the committee's consultation on the Public Health (Wales) Bill.

Background

The principal aim of the Commissioner is to promote and facilitate the use of Welsh. This entails raising awareness of the official status of the Welsh language in Wales and imposing standards on organizations. This, in turn, will lead to the establishment of rights for Welsh speakers.

Two principles underpin the Commissioner's work:

- The Welsh language should be treated no less favourably than the English language in Wales;
- Persons in Wales should be able to live their lives through the medium of the Welsh language if they choose to do so.

In due course, secondary legislation will introduce new powers allowing the setting and imposing of standards on organizations. Until then, the Commissioner will continue to inspect statutory Welsh language schemes through the powers inherited under the Welsh Language Act 1993.

The office of Commissioner was created by the Welsh Language (Wales) Measure 2011. The Welsh Language Commissioner may investigate failure to implement a language

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Welsh Language Commissioner

scheme, interference with the freedom to use Welsh in Wales and, in future, complaints regarding the failure of organizations to comply with standards.

One of the Commissioner's strategic priorities is to influence the consideration given to the Welsh language in policy developments. The Commissioner provides observations in accordance with this remit, acting as an independent advocate on behalf of Welsh speakers in Wales who might be affected by this consultation. This approach is advocated to avoid any potential compromise of the Commissioner's regulatory functions and should the Commissioner wish to conduct a formal review of the performance of individual bodies or the Welsh Government in accordance with the provisions contained in the Measure.

Context

Recognizing the importance of language in this context, the Welsh Language Commissioner conducted her first statutory inquiry, under Section 7 of the Welsh Language Measure (Wales) 2011, into the Welsh language in primary care. Evidence was gathered from over a thousand patients and members of the public and a broad range of practitioners and other parties with interest in this area. In 2014, a report was published on the inquiry, ‘My Language: My Health - the Welsh language in Primary Care’. The evidence gathered supported what is said in *'A Living Language: A Language for Living*', that is, that language is essential to the provision of quality health services and that Welsh language services in the health sector do not fully meet the needs of patients at the present time. This supports the finding of the European Council Committee of Experts on the implementation of the European Charter for Regional or Minority Languages in Wales, which is that there is 'considerable concern about the situation on the ground' with regard to Welsh language service provision in health and care.

In the committee's consultation letter it is noted that one of the committee's functions in scrutinising the general principles of this Bill is to consider to what extent the Bill matches the priorities in relation to the improvement of public health in Wales. One of those priorities is to develop and improve the provision of Welsh language services. The aim is to achieve this by several different means. A specific strategy was drawn up for the Welsh language in health and care, 'More than just Words', together with an action plan to support the strategy. Preparations are in progress to place responsibilities on health and care service suppliers to make provision in Welsh under the Welsh Language Measure (Wales) 2011, thus building on the success of Welsh Language Schemes.

Public Health Bill

In June 2014, in response to the Welsh Government's White Paper on Public Health, the paper that preceded the drafting of this Bill, the Welsh Language Commissioner noted,

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Welsh Language Commissioner

"In order to comply with the general undertakings of Section 78 of the Welsh Government Act 2006, as it was amended, and its Welsh Language Scheme, particular attention should be paid to every opportunity to improve Welsh medium provision. Careful consideration should be given to what opportunities there are to close any gaps in the provision of Welsh language services in health care throughout Wales. There is a responsibility upon local authorities, health boards, other statutory agencies and the Government alike to identify and close these gaps and plan at local and national level in the wake of the Welsh Language Measure (Wales) 2011. ***It is essential that organisations endeavour to correct those areas where the Welsh language is being treated less favourably than the English language."***

The Welsh Government published an assessment of the impact of the Public Health (Wales) Bill on the Welsh language. It is suggested in the report on that assessment that the direct effects of the Bill on the Welsh Language will be minimal. Some indirect positive effects that will emanate from specific sections of the Bill are identified, including the creation of an entirely bilingual statute book on smoking or the use of e-cigarettes and the publication of bilingual guidelines and signs in relation to certain other specific developments. These effects are to be welcomed. We consider, however, that Part 5 of the Bill, which relates to pharmaceutical services, could have a direct and significant impact on the use of the Welsh language. Therefore, in discussing below to what extent this Bill's general principles accord with the need to improve Welsh language services in health and care, specific attention will be paid to Part 5 of the Bill.

Welsh Language Pharmaceutical Services

Part 5 of the Bill will

- place a responsibility on every LHB to complete a regular assessment of the pharmaceutical needs of its population ('pharmaceutical needs assessment');

- change the "controlled access" test, which the LHBs are required to use in considering applications to join their pharmaceutical list, to one that is more clearly based on meeting local pharmaceutical needs;

- in circumstances where people who are included on their pharmaceutical list are unable to provide specific services to meet the needs identified in the Pharmaceutical Needs Assessment, power is given to the LHB to invite other people, apart from those who are on their list, to provide pharmaceutical services; and

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- provide for regulations that will enable the LHB to remove listed pharmacists or premises from the pharmaceutical list where they consistently and/or seriously breach the terms and conditions of service.

All these provisions are related to the planning and provision of pharmaceutical services that meet the needs of the community being served. However, neither the Bill nor the documentation that supports the Bill, including the assessment of its impact on the Welsh language, explains the relationship between the provisions of Part 5 of the Bill and the measures that are in place for the improvement of Welsh language services in health and care. There is no explanation of how Part 5 of the Bill will support the provision of Welsh language pharmaceutical services.

Is there potential, for example, for the assessments of pharmaceutical needs, which the Health Boards will be obliged to conduct in accordance with Part 5 of the Bill, to include an assessment of the adequacy of the Welsh language provision in community pharmacies in Wales? How should Health Boards take the Welsh language into account when they conduct those assessments, and how should the findings of those assessments be considered when planning Welsh language services for the future? Should the ability to make provision in Welsh be one of the criteria for the 'controlled access test' that the LHBs will be required to apply in considering applications to join their pharmaceutical list? Could a community pharmacist jeopardize his eligibility to be included on a 'pharmaceutical list', if he were to fail to provide Welsh language services?

Unfortunately, the documentation that accompanies the Bill, including the assessment of the Bill's impact on the Welsh language, does not discuss or offer answers to such questions. The Welsh Government's Welsh Language Scheme states '*We will take advantage of every opportunity to ensure that new primary and secondary legislation will support the use of Welsh*'. It is not evident what consideration has been given, if any, to the opportunities for Part 5 of the Bill to support the work of planning and providing Welsh language pharmaceutical services.

Conclusions

The Welsh Language Commissioner's statutory inquiry revealed the need for improvements to the Welsh language primary care service provision, including pharmaceutical services. The Welsh Government is committed to the improvement of these services and has put measures in place to achieve that. Part 5 of the Bill deals specifically with the planning and provision of pharmaceutical services and it may therefore be assumed that there should be a clear connection between the measures that are in place for the improvement of Welsh language pharmaceutical services and Part 5 of this Bill.

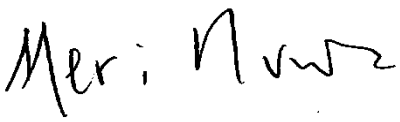
However, the documentation that accompanies the Bill does not identify any direct link and, without detailed consideration of that, there is a risk that any opportunities afforded by

Comisiynydd y Gymraeg
Welsh Language Commissioner

Part 5 of the Bill to support the provision of Welsh language services may be lost. In accordance with the general undertakings of Section 78 of the Government of Wales Act 2006, as amended, and the Welsh Government Welsh Language Scheme, any act that is introduced by the Government is expected to exploit any opportunities available to improve Welsh medium service provision. Therefore, if there is no intention to refer to the Welsh language on the face of the Bill itself, it will be necessary to consider and plan how any secondary legislation that accompanies the Bill, for example, the secondary legislation concerned with conducting an assessment of the pharmaceutical needs of the population, or related advice or statutory guidelines, can contribute to the improvement of Welsh language pharmaceutical service provision. We are of the view that clarity on this matter is necessary in order to allow Assembly Members to reach a judgement concerning the extent to which the Bill accords with national objectives for the Welsh language.

I would be very willing to meet the committee in order to discuss these comments, if that were useful.

Yours faithfully,



Meri Huws
Welsh Language Commissioner

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

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

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

Evidence from the Royal College of Nursing – PHB 35 / Tystiolaeth gan Goleg Nyrsio Brenhinol – PHB 35

Consultation on the Public Health (Wales) Bill
Response of the Royal College of Nursing Wales

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 400,000 nurses, midwives, health visitors and nursing students, including over 24,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

Part 2: Tobacco and Nicotine Products

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

The Royal College of Nursing (RCN) Wales has no public position on this matter.

There is clear evidence that the use of e-cigarettes can, with appropriate guidance and support, assist people to stop smoking.

It is possible that that applying the same restrictions on public use to e-cigarettes will assist people to stop smoking by reinforcing the anti-smoking message, however the evidence at present is mixed.

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

RCN Wales is cautiously in favour of extending the ban on smoking to some non-enclosed spaces. This would assist in de-normalising smoking and would also reduce the risk for some vulnerable groups (e.g. children in a playground).

However thought is needed on the consequences of extending the ban to each specific place. For example residential health facilities need careful consideration as they are in effect people's homes.

The Royal College of Nursing (RCN) Wales has no view on the question of whether the use of e-cigarettes should be banned in the same manner.

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

The Royal College of Nursing (RCN) Wales has no public position on this matter.

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

The Royal College of Nursing (RCN) Wales has no view on this matter.

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 Royal College of Nursing believes this is a concern and supports stronger controls over advertising, packaging, marketing and display of these products to reduce the risk that these products are used to reintroduce brand names and promote smoking as a habit.

The Royal College of Nursing is concerned that e-cigarettes are appealing to young people and this is the result of deliberate marketing. We are especially concerned at the fruit or sweet flavours being advertised or offers that incentivise 'trying' at low cost.

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?

No

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

No

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

Yes

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

Yes

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

Yes

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

The Royal College of Nursing is strongly supportive of this measure which is a sensible approach codifying what undoubtedly members of the public would believe is the current law.

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

Yes, with the exception of the first matter on which we hold no view.

Part 3: Special Procedures

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?

The Royal College of Nursing supports the creation of this system. It is possible the Bill could go further and specify criteria of competency/a suitable level of knowledge and skill required to obtain such a licence.

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

Yes. However the RCN would advocate a standing group of stakeholders that could be regularly convened (e.g. annually) to provide advice to the Welsh Government on amending this list of special procedures. This is a professional area where practices change swiftly as technology and public awareness change. As a professional organisation with members practising in the field of aesthetic procedures we would expect to consulted on this.

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

The RCN would advocate a standing group of stakeholders that could regularly be convened (e.g. annually) to provide advice to the Welsh Government on amending this list of special procedures. This is a professional area where practices change swiftly as technology and public awareness change. As a professional organisation with members practising in the field of aesthetic procedures we would expect to consulted on this.

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 list seems appropriate.

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

No

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

Yes. The public should have assurance that the persons carrying out these procedures are doing so in an appropriate manner.

Part 4: Intimate Piercing

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?

The RCN is supportive of this provision.

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

Yes. Tongue piercing could also be considered as an intimate body part. Certainly there is an increased risk of harm with piercing the tongue.

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?

No

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

Yes. There needs to be strict governance around the prevention of infection for procedures that piece or infiltrate the skin.

Part 5: Pharmaceutical Services

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

Yes

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?

We hope this will be the case.

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

Yes

Part 6: Provision of Toilets

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?

This could be beneficial. Certainly a published map of the local area with toilets clearly identified (with opening times) would be invaluable for the local and tourist community. A strategy could set out how these would be maintained and hopefully expanded. Without a published strategy there is a real danger that the significance of public toilets will not be considered and they will closed down piecemeal without any consideration of the impact.

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

It will certainly help to ensure that the provision is maintained. It would be helpful for the Committee to consider whether a duty on local authorities to maintain the current level of provision or ensure a minimum level of provision could be possible.

RCN Wales is aware that local authorities are currently suffering from financial cutbacks which are likely to increase. However the provision of public toilets is hugely beneficial to public wellbeing as it enables social mobility and helps to prevent isolation for much of the public.

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?

There is a need to ensure that legislation is not overly detailed if the detail can be set out in national guidance.

Paragraph 198 of the explanatory memorandum states that the local authority must consult with those it considers likely to be interested and paragraph 197 suggests that the Welsh Government could include suggested consultees in national guidance. This does seem sufficient as of course particular organisations may change over time. However perhaps

broad groups could be considered for inclusion such as parents, women, disabled people and older people etc.

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?

National guidance underpinning this legislation would be a support to both local authorities and interested stakeholders**.** For example average maintenance costs, details of good schemes that could be adopted locally etc.

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

It seems very sensible to consider this.

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?

It certainly needs to be very explicit, both in the legislation and in any accompanying guidance that changing facilities are including as a provision. For Bill drafting purposes we can understand why 'toilets' as a phrase is attractive a s a shorthand way of expressing 'toilets and changing facilities'.

However changing facilities are vital. Our community nurses report that families of children and young people with disabilities are disadvantaged by the lack of such a basic provision. This is damaging to attempts to build a sense of equality and inclusion. Children and young people in this situation often have to limit trips, return home early or in times of great need, be subjected to the use of a toilet floor which does not provide dignity and respect.

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

Yes

Finance questions

The Royal College of Nursing has no view on the questions contained within this section.

Delegated powers

The Royal College of Nursing has no view on the questions contained within this section.

Other comments

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

We would support the suggestions found in the Equality Impact Assessment on the Welsh language (paragraph 861 p.252). The planning arrangements for assessing the need for pharmaceutical services should include services provided in the Welsh language.

In addition the administrative arrangements for licensing special procedures could if they were to be considered for publication easily contain in addition other factors that might be of interest or importance to the public e.g. facilities that are accessible for the mobility impaired or Welsh language spoken.

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

Improving Public Health in Wales is the single biggest challenge facing the Welsh Government.

Increasing physical activity, reducing drug and alcohol misuse, and improving sexual health services are public health priorities our members in Wales have identified as significant.

However public health is a wide topic. The provision of public toilets and licensing special procedures are also important areas of concern and our members have responded very positively to these proposals.

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

The Royal College of Nursing has welcomed the publication of a green paper outlining a second Public Health Bill focusing on alcohol misuse. We believe legislative action is required to tackle this issue and we are very supportive of these proposals.

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

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

Evidence from the Faculty of Dental Surgery, Royal College of Surgeons – PHB 36 / Tystiolaeth gan Gyfadran Llawfeddygaeth Ddeintyddol, Coleg Brenhinol y Llawfeddygon – PHB 36

National Assembly for Wales Health and Social Care Committee
Scrutiny of the Public Health (Wales) Bill

Evidence from the Faculty of Dental Surgery, Royal College of Surgeons

Introduction

The Faculty of Dental Surgery at the Royal College of Surgeons of England is a professional body committed to enabling dentists and specialists to provide patients with the highest possible standards of practice and care. We represent over 5500 specialist dentists who work in primary care, hospital and public health settings in fields such as orthodontics, restorative dentistry and paediatric dentistry.

Our response relates to the proposals in Parts 3 and of 4 the proposed Public Health (Wales) Bill to introduce compulsory licensing in relation to body piercing, and prohibit the intimate piercing of children under 16 years of age.

As specialist dentists, we are confronted with a significant number of complications which arise from the practice of piercing various sites within the mouth, especially the lips and tongue. These complications not only include the loss, fracture or excessive wear of teeth as well as irreversible gum damage, but also severe bacterial and fungal infections, prolonged bleeding and recurrent ulceration. Therefore our comments are restricted to the proposals in relation to oral piercing.

Part 3: Special Procedures

Part 3 of the Bill provides for the creation of a mandatory licensing scheme for businesses/practitioners offering specified 'Special Procedures', namely acupuncture, body piercing, electrolysis and tattooing.[1]

Reliable and high quality research studies have indicated that around 80 per cent of piercings take place in tattoo establishments[2] but those undertaking the piercings have little, if any, knowledge of the anatomy of the regions involved, whilst only 30 per cent of customers were told of any potential risks or complications of the procedures.[3]

The Faculty therefore support the proposals in the Bill for the licensing and regulation of providers of body piercing to ensure these issues are addressed. Our view is that customers should be required to give informed consent for oral piercings, as for other oral/dental procedures, once all the risks have been explained. As a consequence, under current legislation, this would limit the oral piercing of children under 16 years of age without parental consent.

Part 4: Intimate Piercing

Part 4 of the Bill introduces a prohibition on the intimate piercing of persons under the age of 16 years.[4]

The Faculty is concerned that the mouth is not explicitly included in the list of intimate body parts defined in the Bill under section 79 subsection (2), and urge the Committee to consider its inclusion either in this section, or as an additional clause.

As detailed above, lip and tongue piercings in particular can led to complications so these should be prohibited for children under 16 years of age to protect them from potential health risks.

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[1] Public Health (Wales) Bill, Explanatory Memorandum, June 2015; http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

[2] Garcia-Pola MJ, Garcia-Martin JM, Varela-Centelles P, Bilbao- Alonso A, Cerero-Lapiedra R, Seoane J. Oral and facial piercing: associated complications and clinical repercussion. Quintessence Int 2008;39:51–59

[3] Vozza I, Fusco F, Bove E, Ripari F, Corridore D, Ottolenghi L. Awareness of risks related to oral piercing in Italian piercers. Pilot study in Lazio Region. Ann Stomatol (Roma). 2015 Feb 9;5(4):128-30.

[4] Public Health (Wales) Bill, Explanatory Memorandum, June 2015; http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

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 Robert Heyes – PHB 37 / Tystiolaeth gan Robert Heyes – PHB 37

Public Health (Wales) Bill: Consultation questions

1.1 Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
Not even remotely. For many smokers, part of the motivation to try using e-cigarettes is to avoid the need to stand around in the rain and cold when they need their nicotine, it certainly was in my case. By banning the use of e-cigarettes in enclosed public and work places this nudge will disappear. It also means that current e-cigarette users will now be forced outside with the smokers – for many smokers that have only just started vaping, this may just tempt them to start smoking again. Furthermore, it is important to consider the message that such a ban will convey to existing smokers (as well as non-smokers), ie that in the opinion of the government, e-cigarettes are as dangerous as tobacco cigarettes – which flies in the face of all the current scientific evidence – see the recent report from Public Health England. I would also like to question if any exemptions are envisaged for vape-shops? Many vape-shops allow their customers to try out devices and liquids before purchase, as far as I can tell this legislation will prohibit this. Similarly for e-

liquid manufacturers (of whom there are a number in Wales) – where do they test their products?

There are 3 options set out in the explanatory memorandum – and it appears that the health minister is seeking to pursue the most draconian and the one that will cause the highest cost to the Welsh economy, and all for absolutely no benefit to the health of the public.

Point of information #1– in the explanatory memorandum point 339 about the assumption that e-cigarette breaks would last the same amount of time as cigarette breaks: for a vaper to absorb the same amount of nicotine as a smoker on a 5-10 minute break they would have to vape for around 30 minutes as the uptake rate is substantially lower. Accordingly the costs of vaping breaks would have to be increased, possibly by a factor of 3.

Point of information #2 – premises that provide a smoking shelter would also have to provide a vaping shelter so as not to expose vapers to second-hand smoke – this will impose an additional cost on businesses (companies will be sued if they do not provide vaping shelters – I can guarantee this).

Point of information #3 – explanatory memorandum point 363 claims to have found 26 specialist e-cigarette retailers in Wales in January 2015. Data from 2014 showed 42 specialist retailers in Wales and that number has certainly increased to my knowledge since that map was compiled.

Question 2

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?
Not at all – the **purported** reason behind the Smoke-Free Premises bill was that second-hand smoke poses a health hazard to non-smokers. The same can definitely not be said about second-hand vapour. The Bill as it stands can only dissuade smokers from switching to vaping.

Question 3

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?
Vaping normalises vaping, not smoking. Particularly since the overwhelming majority of vaping products in use today look absolutely nothing like conventional tobacco cigarettes. I cannot recall the last time I saw a first generation e-cigarette (or cigalike) being used here in Cardigan, yet I see second and third generation devices pretty much every day.

Question 4

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 evidence says that they are not – see the Smoking Toolkit Study for example, and the recent Public Health England report. To suggest that a non-smoker would start vaping and then go on to using lit tobacco is, quite frankly clutching at straws. It is certainly possible that some young people may do this, but the likelihood is that they would be the sort of person that would have tried smoking anyway. In theory this point should be moot given that sales to under-18s will be banned soon, although that doesn't seem to work too well with conventional cigarettes.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
It seems like pointless bureaucracy to me, even for tobacco products.

Question 6

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?

I am unclear what the intent of this part of the bill is. If it's for retailers and those people delivering to the home then I am unconcerned about it. However, if it comes to parents of a smoking teenager becoming criminals for providing their child with a vaping product to help them to stop smoking then I'm very much against. The explanatory memorandum is not helpful in regard to this.

1.2 Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
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Question 8

Do you agree with the types of special procedures defined in the Bill?
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Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
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Question 10

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

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
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Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
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1.4 Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
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Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
--

1.5

1.6 Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
More pointless bureaucracy as far as I can see, unless there are minimum standards set in the Bill.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
This seems very unlikely – since it will require funds to prepare the strategy that could be better spent on actually improving toilet provision.

Question 17

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?
Not in the slightest. When Ceredigion closed several public toilets in Cardigan there was no consultation – as a result all the public toilets are on one side of the High street, and there are no public toilets near to the bus station (excepting the one in the Council office that closes at 4:30pm).

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
All very well, but generally such places are only open during the working day.

1.7 Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
By no means – we need improvements in the NHS, particularly in rural Wales. We do not need petty legislation that deals with insignificant trivia.

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
There is a crying need for more dentists – certainly in Ceredigion, and I suspect the same applies to other rural areas. There are two dentists in Cardigan, but neither of them has been taking on NHS patients for at least the last 5 years as far as I am aware. My dentist is in Aberystwyth, which is a 2 hour bus ride in each direction.

Question 21

Are there any other comments you would like to make on any aspect of the Bill?



Consultation on the Public Health (Wales) Bill

The Company Chemists' Association (CCA) provides a forum for the large businesses engaged in community pharmacy to work together to help create an environment where pharmacy can flourish and providers compete in a fair and equitable way. The CCA aims to represent our members, empower our members to understand the changing policy environment, and influence that policy environment.

Our nine member companies – Boots, The Co-operative Pharmacy, Lloydspharmacy, Tesco, Sainsbury's, Wm Morrison Supermarkets, Asda, Rowlands Pharmacy and Superdrug – own over 6,400 pharmacies between them which represents almost 50% of the pharmacies in the United Kingdom. Our members own 381 pharmacies in Wales representing over 53% of the total pharmacies in Wales.

We are pleased to be able to respond to the Welsh Governments call for evidence on the Public Health (Wales) Bill

Part 5: Pharmaceutical Services

Part 5 of the Bill includes provision to require each local health board to publish an assessment of the need for pharmaceutical services in its area with the aim of ensuring that decisions about the location and extent of pharmaceutical services are based the pharmaceutical needs of local communities.

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

Yes. Pharmaceutical needs assessments have proven to be a highly effective method for Health commissioning bodies to identify the needs of its population and what services can be commissioned from community pharmacies to address those needs. However only by periodically reviewing those needs, commissioners can stay up to date with the continued requirements and identify new issues that arise within its population. We also stress that PNAs must be part of a wider assessment of need. PNAs should not be written in isolation but should encourage inter-professional and inter-sector collaboration. By reducing the geographical scope of PNAs would be to the detriment of patient needs. It is important to remember that patients do not always adhere to geographical boundaries when accessing healthcare, therefore neighbouring LHBs PNAs as well as

bordering English CCGs PNAs should be considered. An example of a well worked assessment that meets many of the relevant criteria is from Salford[i]

- What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?

PNAs should provide a clear guide to contractors on what services are required and are expected to be delivered locally. There must be a clear service delivery target, agreed between the Health Board, Community Pharmacy Wales and the contractors. Furthermore, Health Boards must have properly advertised the service to the public. Preparation of promotional material should be done in collaboration with Community pharmacy Wales. If these factors are considered and incorporated accordingly then PNAs should act as both the 'carrot' and 'stick' in driving delivery of services that would benefit local patient populations. We would add that some services, such as emergency contraception, introduce a 'conscientious objection' element into service delivery. It would seem inappropriate to penalise a contractor (by encouraging new pharmacies to open) where the pharmacist is exercising their right of conscientious objection.

We recommend that failure to consistently offer services specified in the PNA which were a condition of granting a pharmacy contract lead to a rapid removal from the Pharmaceutical List for that site since the conditions of grant and the health needs of the population would not be being met.

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

The proposals in the Bill if adopted with enthusiasm by both commissioners and service providers should see the availability of services that improve public Health in Wales expand and become more accessible to patients across the nation and at times that suit them. Community Pharmacy plays a significant role in looking after the health needs of the nation. Our position at the heart of every community gives us an unique vantage point as an accessible and welcoming health care provider. This should be capitalised on by LHBs and Pharmacy should be at the forefront of their thinking when dealing with pressing public health needs.

For any queries please contact:

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[i] https://www.salford.gov.uk/pharmaceuticalneedsassessment.htm

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 Counterfactual – PHB 39 / Tystiolaeth gan Counterfactual – PHB 39

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No. It is common error for public health advocates to believe that their personal preference should become law. But the purpose of law in this case is to override the preferences of owners or managers. Many places will decide to ban vaping without needing the law to tell them. However, the test of the credibility of this law is where it would actually bite: where legal powers are used to stop an owner or manager allowing it. As examples, this could arise in the following situations: 1. A pub wants to have a vape night every Thursday 2. A pub want to dedicate one room to allowing vaping 3. In a town with three pubs, one decides it will cater for vapers 4. A pub manager decides on balance that his vaping customers prefer it and his other clientele are not that bothered – he'd do better allowing it 5. A hotel decides it want to have a few rooms in which it allows vaping 6. An office workplace decides to allow vaping breaks near the coffee machine to save on wasted smoking break time 7. A care home wants to allow an indoor vaping area to encourage its smoking elderly residents to switch during the coming winter 8. A vape shop is trying to help people switch from smoking and wants to

demo products in the shop…

… and so on for cafes, restaurants, hotels, workplaces, institutions, shops, transportation etc.

The purpose of a legal ban would be to use the coercive force of law to override these choices and substitute a uniform and inflexible prohibition. So what justification would be need for such a blunt and coercive intervention? The government can only really justify this intervention if there is evidence that one person's vaping causes material harm to someone else and therefore that bystanders (especially workers) need legal protection whatever the owner or manager wants to do. But there is no evidence whatsoever of harm from "second hand vapour" and all the most credible reviews of vapour chemistry give no grounds for concern:

- Burstyn I. Peering through the mist: systematic review of what the chemistry of contaminants in electronic cigarettes tells us about health risks, *BMC Public Health*2014;**14**:18. doi:10.1186/1471-2458-14-18 [**Link**]
- Farsalinos KE, Polosa R. Safety evaluation and risk assessment of electronic cigarettes as tobacco cigarette substitutes: a systematic review. *Ther Adv Drug Saf* 2014;**5**:67–86. [**Link**]
- Hajek P, Etter J-F, Benowitz N, Eissenberg T, McRobbie H. Electronic cigarettes: review of use, content, safety, effects on smokers and potential for harm and benefit. Addiction. 2014 Aug 31 [**link**]

So if there are no grounds for believing that vaping harms bystanders, then the Assembly should ask what other rationale there is for an imposition of the law to override thousands of decisions made individually by the owners and managers of enclosed spaces, who might reasonably feel they are better placed than ministers to judge their interests and the interest of their clients. A better approach would be for the government either to stand aside or to provide reliable information and issue-framing to help owners and managers make decisions.

Inappropriate policy-making by analogy

The problem with this measure is evident in the way the question is asked: it is policy-by-analogy, and reckless analogy. The question states: *"…as is currently the case for smoking tobacco*" and the Explanatory Memorandum states (para 49): "*The purpose of the Bill provisions is to bring the use of e-cigarettes into*

line with existing provisions on smoking." Why – on what basis? This policy-by-analogy overlooks three important differences between smoking and vaping:

1. Vaping is likely to be at least 95% lower risk to the user than smoking
2. There is no evidence or reason to think that vapour emissions pose a threat to the health of bystanders
3. E-cigarettes are used as alternatives to smoking by people trying to improve their health and wellbeing, while continuing to use nicotine.

It should be obvious that bringing vaping and smoking provisions "into line" does not follow from these difference and it does not even sound like a good idea. In fact, because they are alternatives and substitutable, restrictions on vaping amount to a protection of the cigarette trade and encouragement to smoking. The Bill would have the opposite effect of that intended.

Question 2

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?

No. The benefits of e-cigarettes are real and follow from common sense as well as the available data: that people act in their own interests and use much lower risk products to reduce their health risks and improving their personal and financial wellbeing. Those, like the Health Minister, suggesting that people do not use these products in a way that benefits their health should bear the burden of proof – to show that these much less dangerous products somehow shape people's behaviour so that they do more damage to health.

The Welsh Government's analysis does not even recognise the potentially harmful impact of bans on indoor vaping mandated by law. These include:

- Degrading the attractiveness of e-cigarettes as an alternative to smoking and so protecting the cigarette trade through reduced switching or increased relapse to smoking;
- The harmful effects of forcing vapers to join smokers to use e-cigarettes – discouraging switching and promoting relapse;
- The possibility that vaping bans in public places will discourage people from visiting hospitality venues and so encourage more smoking in the home with

greater direct impacts role-modelling effects on children.

Deprivation – vaping as a strategy for health inequalities

Given the pro-poor character of the Welsh Government, it is particularly disturbing that the Welsh Government has not embraced the potential of vaping to improve health among Wales' most deprived communities, where smoking is most pervasive and intransigent.

From Tobacco and Health in Wales 2012 [link]

"Smoking causes nearly one in five of all deaths and around one third of the inequality in mortality between the most and least deprived areas in Wales,

"Smoking rates are highest in the most deprived areas of Wales. More than 40 per cent of people who have never worked or are unemployed are current smokers, with no recent signs of this figure decreasing. Smoking rates in managerial and professional groups continue to fall. These trends are likely to contribute to widening health inequalities in the future."

Low-income status is associated with stronger nicotine dependence [1] and though the most deprived smokers are just as likely to try to quit smoking, they are about half as likely to succeed as the most affluent smokers [2]. It follows that a strategy to reduce harm to continuing nicotine users is a promising opportunity for poorer smokers. If there is no need to fully break from nicotine to attain significant benefits, then there is likely to be a greater chance of success among the poorest smokers than insisting (i.e. hoping) that they will quit smoking and nicotine completely.

Potential benefits to low-income smokers quitting by switching to vaping:

- Improved health outlook with respect to major diseases
- Better fitness and reduced morbidity, including better fitness to work
- Sense of control, achievement and reduced stigma
- Improved family finances with knock on benefits to children
- Reduced second hand smoke exposure – 39 per cent of Welsh children live in households where at least one adult is a current smoker
- Reduced hospital admissions: there were over 28,000 smoking related admission in Wales in 2011 (latest), with more than twice the rate in the most deprived communities as least deprived (2,037 vs 939 per 100,000).

A better public health and health inequalities strategy would be to maximise the potential opportunities of vaping rather than see only threats.

[1]. Pennanen M, Broms U, Korhonen T, Haukkala A, Partonen T, Tuulio-Henriksson A, et al. Smoking, nicotine dependence and nicotine intake by socio-economic status and marital status. Addict Behav 2014; **39**(7):1145–51.

[2]. Kotz D, West R. Explaining the social gradient in smoking cessation: it's not in the trying, but in the succeeding. Tob Control 2009; **18**: 43–6.

Question 3

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?
Why would vaping normalise smoking, when it is an alternative to smoking? If anything the presence of e-cigarettes in places where people can no longer smoke serves as an advertisement for switching to vaping – and therefore is a form of covert stop-smoking message and pro-health role-modelling. This would be similar to more people visibly drinking water in bars – it does not normalise vodka drinking, but offers the normalisation of an alternative pro-health behaviour. To my knowledge the Welsh Government does not collect the Welsh survey data that it could use to develop evidence-based Welsh policy. The authors of the English Smoking Toolkit survey conclude: *Evidence conflicts with the view that electronic cigarettes are undermining tobacco control or 'renormalizing' smoking, and they may be contributing to a reduction in smoking prevalence through increased success at quitting smoking* West R. Brown J, Beard E. *Trends in electronic cigarette use in England.* Smoking Tool Kit Study. 13 June 2014 [link] I am unaware of any differences between the English and Welsh populations that would incline Welsh citizens to confuse smoking and vaping or to be led into smoking when presented with e-cigarettes. If the Welsh Government believes there is a difference, it has not so far explained what it is. **The importance of listening to real people**

Most of the arguments that suggest a problem with e-cigarettes are in the form of implausible abstract hypotheses advanced by public health campaigners with no direct familiarity with smoking or e-cigarette use. I strongly recommend that both the Welsh Government and Assembly Members take into account the direct experience of those whose lives have been changes by e-cigarettes. Thousands of powerful testimonials are gathered on the Internet [1]. Five examples suffice to make the point:

"Vaping has probably saved my wife's and my own life's, I was a smoker for 50 years, nothing I have ever tried has had the impact of vaping, this alone was the only thing that saved me, how can governments legislate against something that is saving so many peoples life's

"In 5 days (the 25th sept) I will have been tobacco free for 2 years, I smoked for over 40 years & had given up giving up … that is until I tried an ecig. I stopped smoking within 24hrs, I now feel fitter my bank account is noticeably fitter, It's like I turned the clock back 20 years. But then public health people are not really interested in people like me because I don't know what I'm talking about.

"I am 48 now and have been tobacco free for more than two years, with only 3 one day lapses, one of which was last week. Tobacco use has been a way of life and experience has shown I will never be free from the desire having quit for more than 12 months 3 times in the past. Vaping has freed me form the terror of tobacco, with out it I will revert sooner or later.

"I was a smoker for 30-35 years, I tried an e-cig & my tobacco consumption dropped to 1/4 in the first week, I bought a second e-cig & I found no time to smoke.That was 6 months ago & I've not touched a cigarette since. I'm now mixing my own e-liquids and even though I'm not working, I have found the money saved allows me to buy gifts for my family,fuel for my car,pay the bills etc.

"I smoked for 45 years and tried every NRT product available, none of them worked. I continued to smoke even though my health was getting worse, resulting in COPD and using oxygen daily. September 2011 I discovered e-cigarettes and they worked. It was like someone handed me a miracle. In less than a week I stopped using regular cigarettes. I haven't had a tobacco cigarette since.

[1] Examples from Counterfactual. Vaping testimonies. clivebates.com. Updated May 2015. [link] See also AussieVapers forum, Your story. [link] Consumer Advocates for Smoke-free Alternatives Association (CASAA), E-cigarette user testimonials. [link] for thousands of examples.

These testimonies are not a substitute for quantified data (which also tell a very positive story) but a qualitative augmentation of what we know statistically, and a window into how the experience works in practice. Welsh public health policy should be aiming to secure as many personal success stories of this nature as possible – not rejecting the idea because public health activists would rather everyone stopped using nicotine altogether – the so-called "quit or die" philosophy.

Question 4

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?
Observations of e-cigarette use among young people are exactly what would be expected and provide no basis for concern. This is despite many misguided effort to create a moral panic – many of which are cited as evidence in the Explanatory Memorandum. This is what a neutral observer would expect to see: 1. Some adolescents imitating or trying adult behaviours or experimenting with e-cigarettes 2. Growth in use among adolescents increasing in line with growth in adult society 3. Adolescents with independent 'risk factors' for smoking being more likely to try e-cigarettes – either as users or experimenters. These risk factors (poor, smoking in the family, smoking peers, poor educational attainment etc) create a 'shared liability' that explains why most e-cigarette use is by smokers; 4. Very low use among non-smokers, but even where it is found, it may be an alternative to smoking and so a benefit, not a cost. 5. No sign of a causal progression from vaping to smoking – there is no evidence from any study anywhere in the world of a 'gateway effect', despite several quite desperate attempts to suggest it has been found. 6. Most observational data are showing smoking in decline faster where vaping is among adolescents is rising. It is not possible to establish a causal link between

rising vaping and falling youth smoking, but these data are more consistent with the hypothesis that vaping is displacing smoking and diverting young smokers from onset, than with the opposite.

There is nothing in the data or in any of the studies cited in the Explanatory Memorandum that is not explained by the account given above. Some additional discussion of these issues is at these links:
Bates C. Alarmist survey on teenage vaping misses the point – reaction [link]
Bates C. JAMA paper finds some adolescents experiment with stuff [link]
Bates C. We need to talk about the children – the gateway effect explained [link]

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
The government needs a better argument that these administrative burdens will actually lead to an improvement: e.g. a pilot in one local authority. The costs and burdens must kept to the minimum needed to meet the policy objective and its design should not make it more difficult to stock e-cigarettes than cigarettes.

Question 6

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?
Only for tobacco products. If young people are smoking, it is an advantage for them to be able to access e-cigarettes. Consider the following cases: • a youth worker wants to persuade kids she's working with to try e-cigarettes rather than smoking. • a worried father is concerned about his son smoking and has tried and failed to persuade him to quit, but wants to get him over the financial hurdle of buying the initial vaping starter kit. • a 15 year old girl is pregnant and smoking, and showing no sign of quitting – her pregnancy counsellor wants to introduce her to vaping to try something new to reduce risk to the baby. In each case someone trying to do the right thing would guilty of an offence. These examples are to make the point that there is no case for making 'harm reduction' wait until 18, and measures like this do not read over well to the real world where young people do actually smoke below the age of 18 and do harm

themselves as result. The Explanatory Memorandum is written from a highly idealised standpoint in which everyone does as instructed and obeys the law. If Wales wants to have a real-world approach to public health it has to deal with people as they are, not as the government wishes them to be.

Question 7-18 not answered.

Other comments

Question 19

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

No the Bill attempts to apply policy and legislation used to control smoking to controlling vaping. There is confusion at the heart of this. The emergence of products with very low risk to health compared to cigarette smoking presents an enormous opportunity for public and the drive towards ending smoking related disease. Instead of thinking that more restriction and regulation must be the right approach in public health, it would be better for Wales to take a more forward-looking approach that goes with the grain of ordinary people's lives. Two examples of a constructive vision are included below:

The Royal College of Physicians explained in its landmark report, Harm reduction in nicotine addiction:

This report makes the case for harm reduction strategies to protect smokers. It demonstrates that smokers smoke predominantly for nicotine, that nicotine itself is not especially hazardous, and that if nicotine could be provided in a form that is acceptable and effective as a cigarette substitute, millions of lives could be saved. Royal College of Physicians Harm reduction in nicotine addiction: help people who cannot quit, London 2007 [link]

Derek Yach, the former WHO Director for tobacco policy who led development of the global Framework Convention on Tobacco Control, summarises thus:

At the moment, it's estimated that there will be a billion tobacco-related deaths before 2100. That is a dreadful prospect. E-cigs and other nicotine-delivery devices such as vaping pipes offer us the chance to reduce that total. All of us

involved in tobacco control need to keep that prize in mind as we redouble efforts to make up for 50 years of ignoring the simple reality that smoking kills and nicotine does not. Yach D. E-cigarettes save lives. Commentary in The Spectator. February 2015 [link]

Question 20

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

Question 21

Are there any other comments you would like to make on any aspect of the Bill?

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
Yes, we do. As the Bill states this should include all nicotine inhaling devices. It will be easier for organisations to manage a total ban on smoking tobacco and use of nicotine inhaling devices including e cigarettes. The actual vapour being exhaled by those "vaping" can be very annoying to others and it is also a poor example to children, who may follow the example and either vapour or smoke. There will also be some residual nicotine in the vapour which may have harmful effects on others. It has been known for many years that nicotine is addictive and it also has adverse medical effects so should not be encouraged in any manner.

Question 2

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?
Yes. Those wishing to quit smoking need to gradually reduce their use of the e-cigarettes over time and restrictions on use will help enhance this behaviour. We are not aware of any dis-benefits.

Question 3

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?

|Yes, we feel that the use of e-cigarettes normalises the behaviour in smoke free zones and potentially encourages others to take up the habit. Some patients only used e-cigarettes in public areas, where they are accepted due to social pressures to conform. They were actually upset to learn that e-cigarettes contained nicotine as they thought they are was only steam or water. Some of the also shared the -cigarettes and were unaware of potential risk of spreading infections such as viral hepatitis. The same is also true of hocker or bubble pipes which should be made to include these into the Bill.

Question 4

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?
Yes we do have concerns about risks to young people as there is an increasing social trend to their use in these age groups partly due to social pressures.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
Yes This may need to be modified to include pharmacies if the law is changed to allow short term use of e cigarettes to be used for smoking cessation therapy.

Question 6

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?
We support this. This may need to be modified if the law is changed to enable the use of e-cigarettes to be used short term for smoking cessation on prescription as some of the patients may be under 18 years of age.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
We support this. People are very often unaware of the risks related to these procedures due to infection, allergy or potential carcinogens in some inks used for tattoos. They are also unaware of the potential for life long scaring resulting occasionally in disfiguring or disabling deformity from procedures which have complications. They are also unaware that it is difficult to remove evidence of piercing or tattooing, when they no longer want the associated affect.

Question 8

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

Question 9

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

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
No

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
Yes

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
We believe naval, lip, nose and tongue piecing should be added to the list. These have high risk of infection and complication and the implications of these need to be understood fully by the person having the procedure, hence the support to restrict this to over 16 year olds.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

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

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
We believe that if need is shown in an area potentially pharmacies will respond but there may be restrictions due to suitable premises or staff availability.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
We support this. Some people restrict their activity due to lack of available accessible public toilets in the area. The published data should include data on the current toilets including opening times and accessibility especially for disabled toilets.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
We hope that this will be the case but the strategy will need to be open to public comment

Question 17

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?
Yes

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
These should be included but some may need to have restrictions to those using the settings for their prime purpose.

Other comments

Question 19

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

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
Minimum alcohol pricing which is already being considered

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
No

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol
Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)
Evidence from the Police Liaison Unit – PHB 41 / Tystiolaeth gan Uned Gyswllt yr Heddlu – PHB 41

Police Liaison Unit Welsh Government, Cathays Park	
Protective Marking:	**NOT PROTECTIVELY MARKED**
Author:	Collated on behalf of the four Welsh Police forces by Helen Hill, Police Liaison Unit
Title:	Welsh Police response to Public Health (Wales) Bill
Version:	V1
Summary:	The Public Health (Wales) Bill has been circulated to each of the four Welsh forces so they are aware of the new proposals laid out in the Bill. The forces anticipate that the legislation would not significantly increase the burden on the police service in Wales and is unlikely to have a major impact on police resources. Forces welcome the legislation regarding piercing of young people who a potentially vulnerable situation
Authorised by:	Ch Superintendent Alun Thomas [redacted]
Date sent:	1st September 2015
Sent to:	SeneddHealth@Assembly.Wales

Health and Social Care Committee
National Assembly for Wales

Dear Health and Social Care committee,

The Public Health (Wales) Bill has been circulated to each of the four Welsh forces so they are aware of the new proposals laid out in the Bill. It is acknowledged that this Bill is primarily enforced by local authorities and forces envisage normal working relationships with local authority agencies to continue. The local authority(s) will remain the lead agency with police support. When confronted with an offence, police officers will be able to make local authority officers aware, as is the case now regarding current smoking legislation.

Since the original smoking ban there has been an increase in relation to noise complaints late at night from locations such as beer gardens or pavements outside pubs, however this legislation will not change this. The forces anticipate that the legislation would not significantly increase the burden on the police service in Wales and is unlikely to have a major impact on police resources.

Part Four of this Bill, looking at intimate piercing, recognises the requirement for police to work alongside local authority officials in investigations and additional engagement which will be required. During the creation of this Bill Detective Chief Inspector Steve Cockwell of Dyfed Powys Police was invited to speak with the WG Health Team to offer subject matter expertise on how the WG proposals would impact policing and to highlight to them public protection issues and police response/ responsibility which they had not previously considered.
Where there are specific child protection concerns police would revert to offences contained within the Sexual Offences Act 2003 and other related legislation. This would also incorporate powers of arrest, entry and search that would more likely be used than the powers contained within this Bill.

Whilst none of the Sections within this Bill raise particular concerns for the police it has already been brought to the Welsh Governments attention that when adults have physical contact with young people's intimate areas there are greater safeguarding concerns which the police will need to investigate. Det Insp Cockwell has been invited to assist with the writing of the Guidance for this Part of the Bill when it is enacted to ensure local authorities are aware of how and what needs to be reported to the police.

Whilst very few cases across Wales regarding piercing of children and young people (reports appeared to be mainly nipple piercing of older teenagers) have been reported to the police; it is welcomed by forces how the Bill seeks to avoid circumstances where children and young people are placed in a potentially vulnerable situation by prohibiting the piercing of a person under the age of 16.

Respectfully submitted on behalf of the four Chief Constables of Wales.

Police Liaison Unit
[redacted]

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 Age Cymru – PHB 42 / Tystiolaeth gan Age Cymru – PHB 42

Consultation Response

Public Health (Wales) Bill: Stage 1

August 2015

Introduction

Age Cymru is the leading charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.

We are pleased to respond to the Health and Social Care Committee's consultation on Stage 1 of the Public Health (Wales) Bill. In our response, we will focus in particular upon pharmacy services and public toilet provision.

Part 5: Pharmaceutical services

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

We believe there is scope for community pharmacies to make a greater contribution to health services in Wales in a way which will be of benefit to older people by ensuring services are delivered within communities and are easily accessible. Further work is also needed to raise the profile and awareness of services which are available from pharmacies, as people are often simply unaware of the services they can access at their local pharmacy.

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?

It is to be hoped that the use of pharmaceutical needs assessments by the Local Health Boards would encourage existing pharmacies to adapt and expand their services in response to the needs identified. However, the impact of the pharmaceutical needs assessments will need to be kept under review and, specifically, will need to consider whether the provisions of the Public Health (Wales) Bill are in fact encouraging existing pharmacies to respond in the intended manner.

Y grym newydd sy'n cyfuno
The new force combining
AGE Concern Cymru
HELP THE AGED WE WILL
Help the Aged yng Nghymru
Help the Aged in Wales

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

The provisions of the Bill have the potential to improve public health in Wales through the extension of pharmaceutical services. In particular, Age Cymru would welcome the extension of services in the following areas: minor ailments schemes; management of chronic conditions; and hospital discharge.

Age Cymru believes that there is the potential for community pharmacies to deliver minor ailments schemes in a way which beneficially reduces pressure on GPs and improves access and choice for patients. A shift towards providing more identification and treatment of minor ailments in community pharmacies could reduce pressure on GP appointments and therefore improve access for patients with more severe health conditions. This will require greater commissioning of such services by local health boards, increased referral by GP surgeries so that they can better prioritise GP and nurse appointments, and improved public awareness of the services which can be provided by community pharmacies.

Statistics from Community Pharmacy Wales[1] indicate that an estimated 5 million GP consultations every year concern minor ailments. An independent review concluded that almost 40% of these consultations could have been effectively handled in a community pharmacy. Research has also indicated that if patients with minor ailments were seen by their pharmacist instead of their GP potentially £30 million could be saved by the NHS in Wales each year.[2]

Two-thirds of the population of Wales aged 65 or older report having at least one chronic condition while one-third have multiple chronic conditions.[3] The Auditor General's report on the management of chronic conditions[4] concluded that too many patients with chronic conditions were treated in an unplanned way in acute hospitals, accounting for one in six of all emergency medical admissions.

Community pharmacies already play a significant role in supporting people living with chronic conditions through medicines management services combined with regular monitoring and support, but we believe that this could be done in a more consistent and comprehensive way. Community pharmacies could be fully integrated into chronic conditions pathways providing easily accessible facilities for testing a range of morbidities, delivering flu vaccinations, supporting people living with diabetes, heart disease and respiratory conditions.

Over a long period of time Age Cymru has heard many examples of poor practice in relation to the discharge of older people from hospital. A frequent concern relates to older people being discharged without a suitable after-care package in place (including medication reviews), sometimes with an assumption that the family will provide support. A lack of support, including in medication management, can result in side-effects, deterioration of patient's conditions and hospital re-admission.

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[1] Community Pharmacy Wales Manifesto 2011: The best medicine for healthy lives in Wales, Community Pharmacy Wales, 2011
[2] The Bow Group: Delivering Enhanced Pharmacy Services in a Modern NHS, 2010
[3] The management of chronic conditions in Wales – an update, Wales Audit Office, 2014
[4] The management of chronic conditions by NHS Wales, Wales Audit Office, 2008

As a result we would support a much greater role for community pharmacy in hospital discharge and after-care, and greater publicity around the role that a community pharmacist can play in providing regular medication reviews. In Wrexham, a community pharmacy-based pilot scheme involving medicines information exchange on patient discharge from hospital resulted in clinically significant interventions in 19% of patients.[5] There is also greater scope to be explored in the role of community pharmacy in the management of medication in care homes.

Part 6: Toilets for public use
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?

Adequate public toilet provision is vital to enable older people to maintain their dignity and participate in community life. Despite the importance of these facilities, public toilets are disappearing from our communities at an alarming rate and we believe that assertive action is needed to halt this decline. To that end, we welcome the proposal to establish a duty for each local authority to prepare and public a local toilets strategy for its area. However, we remain concerned that creating a duty to develop a strategy will be insufficient to halt the decline in numbers of public toilets.

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

We recognise that the current proposal to place a duty on local authorities to develop a strategy for the provision of and access to toilets for public use in their area is a step in the right direction. We are acutely aware that all local authorities face difficult challenges when managing current and future budgets, and we are very concerned that Wales' public toilets network is at real risk unless action is taken to protect them.

We therefore remain concerned that the duty to develop a toilet strategy will not lead to any improvements in the current level of provision as there is no guarantee that the development of a strategy will ensure that adequate numbers of accessible public toilets are made available.

Do you believe that 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?
We welcome the proposal for these strategies to be based on local community needs, consulted upon and reviewed on a regular basis.

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?

We welcome the prospect of Welsh Ministers being able to issue guidance on the development of strategies aimed at ensuring a more consistent approach to the provision of

[5] Community Pharmacy Wales Manifesto 2011: The best medicine for healthy lives in Wales, Community Pharmacy Wales, 2011

public toilets across the local authorities in Wales. It is not appropriate that the ability of older people to maintain their dignity and participate fully in community life through the provision of public toilet access be restricted as a consequence of living within the boundaries of a particular local authority.

It is also vitally important that the implementation of these strategies is enforced and closely monitored by the Welsh Government to ensure that adequate numbers of accessible toilets for public use are provided across Wales.

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

All appropriate mechanisms should be considered to ensure that older people have access to safe, accessible and well-maintained facilities.

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?

We believe that these local strategies should work alongside standards to ensure that toilets for public use are in convenient locations, open, accessible and clean. Toilets, including changing facilities, must be provided where people need them, to ensure that older people across Wales are able to manage any increased dependency on toilets with dignity. This includes transport terminals, shopping centres and parks. Disabled access toilets should also be provided in all civic areas, to ensure that local authorities meet their statutory duty to ensure disabled people are able to use those areas with the same confidence and freedom as all other users.

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

Age Cymru's preferred position would be for the Welsh Government to impose a statutory duty on local authorities in Wales to provide adequate numbers of accessible public toilets across Wales. Public toilets play a vital role in ensuring that communities are accessible to people of all ages. They can be a lifeline for older people, providing them with freedom, independence and the confidence they need to lead fulfilling and active lives.

We welcome the extension of the Welsh Government funded Community Toilet Grant Scheme, which provides local authorities with grant funding to encourage local businesses to open their facilities to the public. However, we have concerns that sign-up to the Scheme varies considerably across Wales,[6] as demonstrated in the Explanatory Memorandum, and that the future funding for this Scheme will no longer be ring-fenced but will be part of the general Revenue Support Grant. We note from the Explanatory Memorandum that re-hypothecation of the funding was considered but ruled out due to potential impacts on other service areas. It is difficult to see how a duty to develop a strategy can deliver adequate

[6] Welsh Senate of Older People (2014) P is for People. Campaigning for better public toilets in Wales. Report on findings of Campaign Working Group of the Welsh Senate of Older People. Spring 2014.

access to safe, well-maintained and accessible public toilets without funding to underpin improvements in the current level of provision.

We believe that the Community Toilet Grant Scheme, together with the provision of toilet facilities for public use within public buildings, must be better publicised and promoted. There must be clear and visible branding and signage, if they are to form part of a co-ordinated sustainable solution to toilet provision alongside public toilets provided by the local authority.

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

In our response to the Welsh Government's White Paper consultation, Age Cymru welcomed the principle of ensuring the implementation of the principle of nutritional standards in care homes. We note the Welsh Government's intention to proceed on this issue through the use of subordinate legislation. We urge the Health and Social Care Committee (or potentially its successor) to ensure that this commitment is met.

Care home residents should be provided with balanced meals and it is also vital that all residents have ready access to fluids, and support to consume them if required, to prevent malnutrition and dehydration.

In recent years the public health agenda has focused resources on tackling the obesity crisis with much less attention being paid to malnutrition. This is despite the economic burden of malnutrition in the UK being estimated to be around £7.3 billion a year - equivalent to obesity. Over half of these costs are being expended on people over the age of 65.[7]

It is important to stress that whilst work has been done to try to tackle malnutrition and dehydration in hospitals, unfortunately it still remains a problem in some wards, as demonstrated by the 2014 'Trusted to Care' report which identified, among other serious areas of concern, failures in keeping older patients hydrated. Therefore further work is required in hospitals as well as care homes to improve nutrition and hydration.

Hydration standards are particularly welcomed as we often hear anecdotally in care homes (and in hospitals) that people do not have constant access to fluids, often if you miss the 'tea trolley run', you may not be offered a drink for hours.

A balanced diet is also clearly important for good health, but we note standards must be careful to avoid restricting individual preferences and right to choice over foods. People with dementia often experience a change in their taste preferences and flexibility must be incorporated to allow for this. It should also be considered whether such standards should be extended to cover domiciliary care in situations where a paid carer is the sole provider of main meals.
We hope these comments are useful and would be more than happy to provide further information if required.

[7] Tackling malnutrition among older people in the community, Discussion paper from the Welsh Consumer Council, 2008

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

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Evidence from Cancer Research UK – PHB 43 / Tystiolaeth gan Ymchwil Canser y DU – PHB 43

Cancer Research UK response to the Health and Social Care Committee call for evidence on the Public Health (Wales Bill)

About Cancer Research UK[1]

1. Every year around 330,000 people are diagnosed with cancer in the UK and more than 160,000 people die from cancer. Cancer Research UK is the world's leading cancer charity dedicated to saving lives through research. Together with our partners and supporters, our vision is to bring forward the day when all cancers are cured. As the largest fundraising charity in the UK, we support research into all aspects of cancer through the work of over 4,000 scientists, doctors and nurses. In 2014/15, we spent £341 million on research. In Wales we fund the Wales Cancer Trials Unit which is dedicated to improving clinical practice through quality research evidence. We also fund the Cardiff Cancer Research UK Centre which draws together world class research and areas of medical expertise to provide the best possible results for cancer patients nationwide. . The charity's pioneering work has been at the heart of the progress that has already seen survival rates in the UK double in the last forty years. We receive no funding from the Government for our research.

2. Cancer Research UK has an ambition for a tobacco-free UK by 2035, where less than 5% of the adult population smoke. We call on the government to share in this ambition and to help bring this vision to reality, through a continued commitment to tobacco control measures. Public health policy should be designed and implemented, independently of the tobacco industry, consistent with the World Health Organization's Framework Convention on Tobacco Control (WHO FCTC). The WHO FCTC is the first international treaty negotiated under the auspices of the WHO[2].

Overview

3. Tobacco is the single biggest cause of premature mortality in the UK causing over 100,000 premature deaths each year. Over a quarter of cancer cases are caused by tobacco. In our response to this consultation we make the following key points:

- E-cigarettes are almost certainly far less harmful than conventional tobacco cigarettes.
- E-cigarette use in enclosed public and work spaces does not require legislation as there is insufficient evidence to support the claims that they normalise smoking, are harmful to bystanders or undermine the enforcement of smokefree legislation.
- A voluntary approach to smoke free open spaces is sufficient.
- A tobacco retailers' register can reduce illegal tobacco sales to minors.
- A tobacco retailers' register would assist with the display ban.
- There is insufficient evidence to suggest whether or not minors' access to tobacco over the internet is a significant problem in the UK.

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?

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?

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

4. No, we do not believe that these provisions of the Bill represent an appropriate response or a balanced approach.

5. According to a recent independent review, commissioned by Public Health England, electronic cigarettes (e-cigarettes) are almost certainly much safer than tobacco cigarettes and the overall evidence to date points to e-cigarettes actually helping people to give up smoking tobacco[3]. The authors also noted that there is insufficient evidence that e-cigarettes renormalize smoking or act as a gateway to smoking.

6. Cancer Research UK believes e-cigarettes have significant potential to help smokers who are not otherwise ready or able to quit smoking[4,5]. Free Stop Smoking Services remain the most effective way for people to quit but, given the relative popularity and acceptability of e-cigarettes among smokers, we recognise the potential benefits for e-cigarettes in helping large numbers of people move away from tobacco.

7. Cancer Research UK has consistently supported effective legislative measures to tackle the huge burden of tobacco, the only consumer product which kills up to two thirds of its long term users. This includes our support for standardised packaging and smokefree legislation to protect workers from second hand tobacco smoke, both of which were supported by a substantial evidence base. We believe that public health policy should be based on evidence.

8. According to Professor Robert West, Professor of Health Psychology and Director of Tobacco Studies at Cancer Research UK's Health Behaviour Research Centre, smoking cessation makes a greater contribution to changes in smoking prevalence compared to preventing uptake[6]. Policymakers should ensure public health policy aims to increase quit attempt rates as this would lead to the greatest impact on prevalence reduction. According to ASH data, we are seeing rising numbers of smokers who perceive e-cigarettes to be as harmful as tobacco[7]. Between 2013 and 2015 the number of people who wrongly assume they are as harmful has increased from 6% to 20% and a further 22.7% were unsure. Extending smokefree legislation to cover e-cigarettes could potentially increase this confusion and risks dissuading smokers from moving away from tobacco and therefore undermining quit attempts.

9. In response to concerns raised around the potential harm of second hand or third hand e-cigarette vapour to bystanders, to our knowledge there are currently no scientific studies convincingly demonstrating harm to bystanders from second or third hand vapour. In the UK, around 11,000 people die of diseases caused by toxicants in tobacco smoke as a result of passive smoking[8]. Although sidestream tobacco smoke is about 4 times more toxic than mainstream tobacco smoke, it is inhaled by others in a more diluted form so tobacco smoke is not as harmful to bystanders as it is to the smoker. E-cigarettes do not use combustion and there is no sidestream vapour so the only source of second hand vapour is that exhaled by the user. The relatively limited evidence to date suggests toxicants may be present but mostly at much lower levels in second hand e-cigarette vapour than second-hand cigarette smoke [9] [10] [11] [12].The relative harm to both users and bystanders is likely to be much lower than that of tobacco.

10. We do not believe the Bill as currently drafted offers an appropriate balance between the potential benefits of helping large numbers of smokers to quit using e-cigarettes versus the potential risks in terms of renormalization or gateway effect, for which there is limited, if any, evidence.

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)?

11. We believe tobacco products and e-cigarettes require different regulatory approaches which use different regulatory frameworks, to recognise their likely relative harms and the role the latter can play in helping some people to quit smoking. The arguments in favour of smokefree legislation relating to tobacco smoke are not relevant for e-cigarettes based on the evidence available.

12. NICE guidance is clear that non-smoking should be the norm in all NHS premises and grounds.[13] The guidance states that hospitals should ensure that there are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services.

13. We support the principal that patients should not be exposed to carcinogenic tobacco smoke in the very place they have gone to get well. We are aware that Health Boards across Scotland have already implemented completely smokefree policies[1415]. We note the recommendations of the WHO which highlight that compliance with smokefree legislation requires three components: good legislation, a good enforcement strategy and; a good communications and outreach strategy.[16] This supports the case that compliance with Health Boards' smokefree policies would be improved through the granting of a legislative mandate. However, there were a number of issues which we raised in response to the Scottish Government's consultation on the issue with respect to the enforcement of smokefree bans:

- There are issues of enforcement which need to be confronted, one of the most pressing is the size of some NHS facilities, which are not 'contained', but rather are separated by trunk roads and alike. It will be extremely difficult to prevent enforcement across such large areas becoming an arbitrary exercise.
- The responsibility of that enforcement is unclear. The Royal College of Nursing, for example, have been clear in their position that nursing staff should not be expected to enforce complete smokefree bans[17].

14. A number of media reports have noted the practical difficulty of enforcing the smokefree policies in NHS sites across Scotland[181920]. While this does not constitute an 'evaluation' of the measures, it does highlight the high-level scrutiny these measures are subject to.

15. It may be appropriate, as has been the case with a number of local authorities in England and Wales, to introduce voluntary bans on tobacco smoking in areas such as children's playgrounds, parks and school grounds.

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

16. One of the consequences of the smokefree legislation was to 'denormalise' smoking which helped to facilitate quit attempts.[2122] We recognise there are concerns that the introduction of new behaviours that imitate smoking may undermine the denormalisation of smoking and may affect the number of people who quit but there is very limited evidence to support this view. It is equally fair to argue that the converse could be true and e-cigarettes could normalise quitting and moving away from tobacco, though again there is insufficient evidence to say which way this would go.

17. One study has shown that exposure to e-cigarette use does increase the urge to smoke among young adult daily smokers.[23] However, there were some methodological problems with this small, lab-based

study and it is unclear to what extent e-cigarette use will increase urges to smoke in a real world context. Furthermore this study was conducted in 2013 using a cig-a-like e-cigarette so we cannot say whether this finding would still be applicable as public perception of e-cigarettes progresses or for newer devices that do not resemble a cigarette. Further research is needed to understand how exposure to e-cigarettes affects attitudes towards smoking conventional tobacco cigarettes amongst smokers and non-smokers.

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?

18. Uptake of e-cigarettes by children is of concern because nicotine use in adolescence may cause lasting adverse consequences for brain development.[24] We support restrictions on advertising and age of sale to ensure they do not appeal to children.

19. We recognise there are concerns that the use of e-cigarettes may renormalize the use of tobacco among children, but this is currently speculation and there is insufficient evidence to support this view.

20. Currently, there is little evidence that children are using e-cigarettes in great numbers. In particular, among children who have never smoked only 1% of children surveyed have used an e-cigarette once or twice in the UK.[2] However, this is subject to regional variation with some areas showing evidence of higher use.

21. For example, in Wales, the proportion of children aged 11-16 years old who had never smoked but had experimented with e-cigarettes was 5.3% at age 10-11 and 8.0% at age 15-16. Importantly, this does not translate to regular use with only 0.3% of never smokers regularly using e-cigarettes more than once a month.[25]

22. Experimentation with e-cigarettes in 'never smokers' remains low and coincides with the continuing decline in youth smoking – for now arguments about renormalisation and e-cigarettes being a gateway to taking up smoking aren't based on evidence.

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?

23. We recognise that the growth of e-cigarette use may present some challenges for individual businesses and organisations. However, so far there remains very little evidence of systematic problems around the enforcement of the current smoking ban which has high compliance rates. A more effective solution would be the provision of further information and guidance to local authorities and businesses to help them make sure that the enforcement of the current ban on tobacco use continues. Such guidance should be developed with expert organisations.

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

24. As previously stated we do not believe that it would be a proportionate response to ban the use of e-cigarettes in enclosed spaces and work places. We believe that should the Welsh Government wish to pursue a ban, greater consideration should be given to how best it can be done to minimise unintended consequences. Given the differences between e-cigarettes and traditional tobacco cigarettes, they would need to undertake a detailed assessment to determine which enclosed public places and work places any potential ban would apply to.

25. Given the likely reduced harm of second hand vapour compared to second hand smoke, it would **not** be reasonable to apply the same penalties for use of e-cigarette as for use of tobacco cigarettes in smokefree places.

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

26. Cancer Research UK supports the introduction of a tobacco retailer's register is Wales, in consideration of the following points**:**

- A tobacco retailers' register can reduce illegal tobacco sales to minors – through enabling easier detection and enforcement by Trading Standards Officers. The Chartered Institute of Environmental Health recognises that a positive licensing system (as proposed in this consultation) provides an effective deterrent to retailers considering selling tobacco to underage customers.[26,27]
- In enabling easier identification of retailers who sell tobacco, a retail register would also enable analysis of tobacco retailer outlet density – which evidence shows has contributed to the underage purchase in 'high-risk' areas such as near schools, and which may inform further policy.[28,29,30]

27. Legislation introducing a form of a tobacco retail registers' has already been introduced in Scotland[31], Northern Ireland[32] and The Republic of Ireland[33]. In Scotland, the first country to introduce such a measure, the *Tobacco Strategy for Scotland* notes the register has allowed enforcement agencies to target their activity.[34]

28. Evidence also suggests that simply providing information about the law is not effective, but sustained compliance is reliant on regular enforcement (or warning thereof)[35], underlining the importance that the measure is backed by a commitment to support compliance.

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

29. Trading Standards Officers have commented that a tobacco retailers' register would help them to identify retailers who sell tobacco once the display ban[36] is operational in small shops in April 2015. Furthermore, as noted in the response to question one, the *Tobacco Strategy for Scotland* notes their register has allowed enforcement agencies to target their activity.[37]

30. Based on this information, we believe a central register of tobacco sellers, maintained by a nominated local authority, would assist in the enforcement of the display ban – providing the scheme is adequately funded and staffed, and coordinated between the nominated local authority and Trading Standards officers.

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?

31. There is insufficient evidence to demonstrate whether or not there is a significant number of young people accessing tobacco products over the internet.

32. However, the EU Tobacco Products Directive (TPD) (2014/40/EU) recognises the potential for tobacco control legislation to be undermined by cross-border distance sales, and gives a proviso for member states to prohibit cross-border distance sales of tobacco and related products[i].

i See section (33) of Directive 2014/40/EU on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC: *Cross-border distance sales of tobacco products could facilitate access to tobacco products that do not comply with this Directive. There is also an increased risk that young people would get access to tobacco products. Consequently, there is a risk that tobacco control legislation would*

33. We believe that more research is needed to give a clearer picture, but welcome the enabling instrument which the TPD has put in place in enabling member states to act if they choose to do so. Therefore, if research demonstrated there to be a problem, implementation of UK-wide action would be optimal.

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be undermined. Member States should, therefore, be allowed to prohibit cross-border distance sales. Where cross-border distance sales are not prohibited, common rules on the registration of retail outlets engaging in such sales are appropriate to ensure the effectiveness of this Directive. Member States should, in accordance with Article 4(3) of the Treaty on European Union (TEU) cooperate with each other in order to facilitate the implementation of this Directive, in particular with respect to measures taken as regards cross-border distance sales of tobacco products.

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

Evidence from Hywel Dda University Health Board – PHB 44 / Tystiolaeth gan Fwrdd Iechyd Prifysgol Hywel Dda – PHB 44

Hywel Dda University Health Board (HDdUHB) is committed to reduce the harm that smoking causes to individuals and to the population. The University Health Board's three year vision is to "reduce smoking rates across Hywel Dda, so that its population enjoys better health and wellbeing; to ensure people live longer, healthier lives; and to reduce the impact of smoking related illness on quality of life." (Draft HDUHB IMTP, 2015). This can be achieved by:

- Preventing young people taking up tobacco use in the first place (smoking prevention)
- Implementing environmental measures to make non-smoking the norm across Health Board sites and across the population
- Supporting more smokers towards successfully quitting (smoking cessation)

These aspects of Tobacco Control are also addressed through the local implementation of the *Tobacco Control Action Plan for Wales* (Welsh Government, 2012), and are embodied in the HDUHB 3 year Integrated Medium Term Plan (IMTP); County Foundations for Change Plans; Single Integrated Plans; Population health groups (Transforming Health Care Delivery Plans and the HDdUHB 10 pledges.

Part 2: Tobacco and Nicotine Products.

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

Hywel Dda University Health Board recognises many of the concerns relating to the use of e-cigarettes. These concerns relate, primarily, to a lack of consistent evidence that does not, at this stage, provide a clear indication of harm.

In an effort to provide consistent messages relating to the smoking ban legislation to restrict the use of e-cigarettes in enclosed and substantially enclose spaces would be supported. This would also ensure their use does not undermine prevention and smoking cessation interventions by normalising smoking behaviour

Hywel Dda University Health Board supports the position statement issued by Public Health Wales on electronic cigarettes which contains the advice that 'their use should be prohibited in workplaces, educational and public places, to ensure their use does not undermine smoking prevention and cessation by reinforcing and normalising smoking.' This is in line with previous advice from the British Medical Association which calls for 'a strong regulatory framework to prohibit their use in workplaces and public places to limit second-hand exposure to the vapour exhaled by the user, and to ensure their use does not undermine smoking prevention and cessation by reinforcing the normalcy of cigarette use.

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

Hywel Dda University Health Board are in favour of extending current restrictions on tobacco smoking to include some non-enclosed spaces. The current smoke-free legislation introduced in 2007 has been shown to be effective in terms of promoting health benefits for smokers and non-smokers through behaviour change and reduced exposure environmental exposure.

Hywel Dda University Health Board believes there are a number of issues to consider:

E-cigarettes normalise smoking, as their use mimics this behaviour.

- The use of e-cigarettes in enclosed public places risks reversing the progress that has been made on implementing the smoking ban.
- The current best available evidence on e-cigarettes supports the prohibition of e-cigarettes from workplaces, educational and public places. This would ensure that their use does not undermine smoking prevention and cessation activity, by reinforcing and normalising smoking.
- Whilst there is limited evidence that e-cigarettes act as a gateway to conventional tobacco products, this risk remains. The main concern being that e-cigarettes appear to appeal to young people e.g. having pleasant tastes / flavours and being glamorised through advertising. In addition, young people who are non smokers, but who start using e-cigarettes because they believe them to be safe, are likely to become addicted to nicotine and therefore may move on to use tobacco products.
- There is little evidence of effectiveness of e-cigarettes in smoking cessation.

Hywel Dda University Health Board is committed to the health and wellbeing of its staff, patients and visitors. This means that staff, patients and visitors are not able to smoke on any of the hospital sites across Hywel Dda. Hywel Dda University Health Board has a Smoke Free Policy, a copy of which is available at http://www.wales.nhs.uk/sitesplus/862/opendoc/194807

The policy is intended to promote the right of everyone to breathe smoke free air on all Health Board sites, and also recognises the responsibility of the Health Board to promote public health to all its employees, patients and visitors and act as an example of good practice. The smoke-free policy states that the use of electronic cigarettes is not permitted on Health Board sites (this would include vaping devices). This reflects concerns that:

- Use of e-cigarettes re-normalises smoking behaviours
- Use of e-cigarettes impacts on indoor air quality
- Use of e-cigarettes undermines the enforcement of the existing smoking ban.

E-cigarette products are currently unregulated, with unproven efficacy and safety. Therefore, continued use in public places not only risks causing confusion in terms of smoke-free legislation enforcement, but risks endorsing the use of e-cigarettes as a safe activity.

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

Whilst the introduction of the HDdUHB smoke-free policy has seen some reduction in smoking on Health Board premises particularly amongst staff, the policy has proved to be extremely difficult to enforce with patients and visitors to Health Board sites, who continue to smoke on its premises as well as use e-cigarettes within enclosed hospital sites. Evidence from other Health Boards suggest similar issues are being encountered.

Concerns have been raised by staff who have no wish to become involved in a confrontation with someone who is smoking on the hospital site. A series of policy 'policing options' therefore has been explored such as a Community Safety Accreditation Scheme and Local Authority officers policing sites, however it is only the littering aspect of tobacco use that currently is able to be enforced and not the act of smoking on Health Board premises.

It should be made clear therefore with the introduction of legislation that smoking is not permitted on Health Board sites. Hywel Dda university Health Board would therefore welcome the prospect of legislation in this area in order to ensure that this issue is taken seriously by staff, patients and visitors alike.

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products? And do you believe the establishment of a register will help protect under18's from accessing tobacco and nicotine products?

A retail register is an important step towards reducing the number of young people in Wales who become smokers. The introduction of a registration scheme will help prevent underage sales and sales of illegal tobacco. Creating a tobacco retail register will provide Trading Standards with the authority needed to tackle the problem of under-age sales.

Hywel Dda University Health Board agrees that this action would help prevent access to tobacco products by children and would therefore support local and national initiatives outlined in the Welsh Government Tobacco Control Action Plan.

We therefore believe that a register will help bring a more co-ordinated approach to tobacco control and would increase the accountability of retailers. A register should also support the enforcement of current

measures, for example, extend the display ban to small/independent retailers.

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

Smoking places a significant burden of illness on the health of the population of Wales, the effects of which place an unprecedented demand on Health and Social Care services across community, primary care and secondary care; and on the services provided by its partner organisations across statutory and voluntary sectors. The full impact of tobacco use on the health of individuals, communities and the population, and its impact on health services is wide-reaching. While overall death rates from smoking are falling, it still continues to be the largest single preventable cause of ill-health and premature death, therefore, measure proposed in the Bill with continue to support prevention and cessation.

HDdUHB believe that the proposals to establish an national register of tobacco and nicotine retailers, strengthening the Restricted Premises Order and prohibiting access to tobacco/nicotine products to those under the age of 18 years will contribute to improving public health in Wales

Part 3: Special Proceedures

Hywel University Health Board believes that the current information, regulation and enforcement in relation to the procedures listed in the Bill does not protect the public effectively. Much of the legislation and regulation in this area is both inconsistent and fails to reflect a range of recent developments in tattooing and body piercing etc, many of which are invasive and similar to minor medical procedures. These procedures have the potential to cause harm, if they are not carried out safely e.g. risk of blood borne viruses and infection.

If these procedures were carried out in a healthcare setting, there would be a clear expectation that patients would be provided with clear information about risks and benefits and that clinicians would undertake them in a safe way.

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

Hywel Dda University Health Board believes that a National Special Procedures Register should be introduced so that there is a consistent approach across Wales. This would help to ensure that the public are better informed and protected from harm, specifically reducing the risk of blood borne viruses.

Part 4: Intimate Piercing

HDdUHB agree that intimate piercing of anyone under the age of 16 should be prohibited.

Part 5. Pharmaceutical Services:

As the NHS shifts towards upstream interventions and moves away from the current 'illness' model, the wider contribution community pharmacy can make beyond supply of medicines will become increasingly important.

It would be appropriate for Health Boards to consider applications on all the services proposed by the applicant that are included in the Health Board Pharmaceutical Needs Assessment. Proposed services outside of those identified through a needs assessments should not be considered during the application process, unless there is compelling evidence of benefit. Where an application is approved on the basis of addressing specific unmet pharmaceutical need, approval of the contract should be conditional on delivery of these services, consideration should be given to appropriate timescales for conditional offers and sanctions available to the Health Board should the contractor fail to deliver required services.

Local Health Boards should be allowed to invite community pharmacies in their areas to provide specified services to meet identified pharmaceutical needs. Where those pharmacies are unable to do so adequately the Health Board should be allowed to invite additional pharmacies to become established to provide pharmaceutical services provided the Health Board acts reasonably in terms of the service(s) required and the specified timescale for introduction of the service(s).

Part 6: Provision of Toilets

Adequate provision of and access to toilets for public use is an important public health and equality issue as it has a disproportionate impact certain

population groups such as families with young children, older adults and disabled people.

A lack of public toilets results in certain groups feeling anxious about going out. Older people, for example, may be reluctant to leave their home or may reduce fluid intake unless reassured that they will have access to public toilets. Poorly designed, located and inadequately maintained public toilets can also discourage public use.

Hywel Dda University Health Board support placing a duty on Local Authorities to develop a strategy for the provision of toilets for public use. However, whilst recognised as an important public health issue its prioritisation needs to be balanced against the demands of other service provision. Therefore it would seem appropriate to incorporate this as an assessment of need as part of the next round of needs assessment for the single integrated plan/wellbeing plans.

Clara Greed, "Taking Stock: an Overview of Toilet Provision and Standards" (paper presented at the World Toilet Conference, Belfast, September 2005), p 14.

Help the Aged "Nowhere to Go: Public Provision in the UK", March 2007, p5.

Nowhere to go in Wales, Help the Aged in Wales (now Age Cymru), 2009.

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 Margaret Hermon – PHB 45 / Tystiolaeth gan Margaret Hermon – PHB 45

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No. The use of an electronic cigarette, or vaping as it is know, bears no relation to smoking either in harm to the user or to those in their vicinity. Employers, hoteliers, brewery chains etc. are at liberty to prohibit any activity on their premises as they see fit so legislation is unnecessary and pointless.

Question 2

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?
No. The potential benefit to a smoker is the saving of his/her life by switching from a killer habit to a 96% safer one. The dis-benefit to those who have already made the switch is that a ban on use in specific areas could well dis-incentivise them into a return to smoking. The number of vapers in U.K has increased from a few thousands in 2010 (when I switched) to 2.6 million currently and rising; this has happened with virtually no advertising, just word of mouth. To cut the rate of smoking related disease it is essential that e-cigarettes are visible so that vapers can spread expertise.

Question 3

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?
On the contrary, the use of e-cigarettes in pubs and clubs, where they are freely permitted and encouraged has resulted in more smokers kicking the habit in favour of vaping – some brewery chains have already rescinded bans for this reason. The appearance of e-cigs varies from a "look-alike" to a box to a small torch etc. – none could be confused with a tobacco cigarette since there is no odour of tobacco smoke which is unmistakeable. Vaping can only normalise vaping and has the potential to consign smoking to the pages of history.

Question 4

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?
This, the so-called "Gateway" effect, has been dismissed by no less a body than A.S.H as being a non-existent threat, and they have the research to prove this. Children will always experiment – far better they should do so with a relatively harmless product than to "light up" and become addicted to tobacco cigarettes which, it is said, kills 50% of users.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
It seems that if such a register is not already in existence it has not been needed. At a time of stringent cut-backs it would hardly seem to be a priority.

Question 6

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?

This would depend entirely on circumstances. Children as young as twelve (and under) are known to be already smoking addicted; I would feel duty-bound to assist in breaking this addiction by any means possible. If e-cigs had been available when my son was a 16 year old smoker I would certainly have provided him with this efficient alternative.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
No

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
No

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
In the matter of the electronic cigarette; to impose restrictions and limitations on the use of a technology that has the potential to save the health and lives of millions, while failing to deliver on the most basic requirements of health care is, at best, irrelevant – at worst, criminal. Legislation should be based on scientific fact, not on prejudice and false perceptions, and this piece of legislation is totally unnecessary – a conclusion reached by the rest of the U.K.

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 Save Face – PHB 46 / Tystiolaeth gan Save Face – PHB 46

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?

'The principal purpose of regulation of any (healthcare) profession is to protect the public from unqualified or inadequately trained practitioners. The effective regulation of a therapy thus allows the public to understand where to look in order to get safe treatment from well-trained practitioners in an environment where their rights are protected. It also underpins the (healthcare) professions' confidence in a therapy's practitioners and is therefore fundamental in the development of all (healthcare) professions.'

We would question how the identified risks have undergone an appropriate assessment, and analysis of achievable, quantifiable and desirable outcomes which justifies the measures (and investment of public funds and resources) proposed.

In February 2011, the Government published the Command Paper 'Enabling Excellence – Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers'. This document sets out the current Government's policy on regulation, including its approach to extending regulation to new groups. In particular, it sets out the Government's policy that, in the future, statutory regulation will only be considered in 'exceptional circumstances' where there is a 'compelling case' and where voluntary registers, such as those maintained by professional bodies and other organisations, are not considered sufficient to manage the risk involved.
The paper also outlines a system of what is called 'assured voluntary registration'. The Health and Social Care Act 2012 has implemented a number of the policies described in the Command Paper. The Professional Standards Authority for Health and Social Care now has powers to accredit voluntary registers of people working in a variety of health and social care occupations. The idea behind this to provide assurance to the public that these registers are well run and that they require their registrants to meet high standards.

Has The Assembly considered supporting established Professional Associations to explore and develop more robust voluntary self regulatory frameworks (self-funded)? Well organised and appropriately focused professional bodies are better placed to establish;

- Standards of training and accreditation
- Codes of Conduct
- Standards of Practice
- Public and professional education
- Credible influence on both practitioner and consumer behaviour
- Appropriate expertise
- Flexibility to respond to public and professional concerns
- Hold, manage and publish registers of members
- Hold members accountable to Standards
- Manage complaints and report/refer to appropriate statutory regulators (e.g.Public/Environmental Health/MHRA)

The British Institute & Association of Electrolysis should be consulted and may prove to be the best vehicle to protect the public- sign posting consumers to properly trained professionals?

Alliance of Professional Tattooists
The Association of Professional Tattoo Artists
Association of Professional Piercers
Tattoo and Piercing Industry Union
The above (Tattoo) bodies should be brought together to collaborate, sharing experience and expertise to inform developing their own model for self regulation.

The British Acupuncture Council is a recognised body registered with The Professional Standards Authority. This model is one, other Associations should aspire to.

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

We trust that the list has been devised based on evidence of harm caused, high risk behaviour and poor practice related to these procedures. We would question how the measures proposed will impact on public health more effectively than encouraging and supporting more robust self regulation.
Acupuncture already has a model for registration and regulation, The British Acupuncture Council. We would question the need for this procedure to be included in the legislation, but perhaps the authorities should signpost the public to regulated practitioners (Registered members of The BAC).

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

We are very pleased the Assembly has had the foresight to ensure provision for flexibility to respond and adapt in a timely fashion. Statutory regulation should only be imposed if Voluntary self or co-regulation fails to deliver improved standards of safety and practice. With the exception of Acupuncture, this model of self- regulation has not yet been explored. The problem always lies with a lack of recognised standards of practice, training and accreditation and inclusion on a register which is accessible to the public and holds practitioners accountable. In the interests of gathering information and data, we would ask of the assembly whether the licensing process could include a questionnaire on other potentially high risk procedures performed and by whom and facilitate some form of reporting for members of the public who wish to raise concerns or complaints, as a means of gathering data for risk assessment to inform decisions on whether ,and for what procedures the list should be extended. Also, if in the course of inspection, the officer observes anything which he or she sees as a risk to public health, they record and report to appropriate authority/regulator.

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?

We appreciate the exempted professionals are accountable to their own statutory regulators, but the procedures included do not fall within their recognised scope of practice, and we feel it would be appropriate, in the interests of clarity for the public, that ALL those providing these procedures should be subject to the same mandatory licensing and inspection. It is our experience that regulated healthcare professionals are capable of unsafe practice in inappropriate environments. Their regulators do not inspect premises, would not be in a position to manage complaints and the process for appraisal and revalidation would not include any of these procedures.

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

Effective enforcement requires more than the process of licensing; application, verification, inspection and publication on a register. It must be supported with education, motivation and deterrent.

Education

The public must be familiar with the regulation and actively seek licensed providers.

- This can best be achieved by providing license holders with materials to promote their licensed status- badge, poster, logo for website and social media. The website and social media 'badge' should have an embedded link to the register- so that consumers can verify their license, and provide feedback on the service. The logo could say, 'click to verify'. Display should be compulsory.
- Articles about the licensing and regulation should be published in all trade and specialist magazines. It may be possible to require trade/specialist publications to include a statement about licensing wherever services are advertised. Not unlike the 'Drink Aware Campaign'.
- The register itself should also provide a platform for public education and should include advice and information to support the consumer to make safe choices and be aware of risks.
- The licensing process itself affords the opportunity to educate the practitioners, establish standards and provide guidelines. Save Face has provided model templates and guidelines on patient information, consent, complaints management, adverse event reporting, confidentiality/data protection, record keeping, infection control etc. which have been welcomed by our registrants and provide a clear bench mark for our inspectors to measure against.

Motivation

In a competitive market, providers will recognise the 'marketing value' of the logo/license. If the process is supportive, providers will see added value to obtaining a license.

Deterrent

- With the necessity of online presence, it is not difficult, with routine searches (Google, Facebook and Twitter) to identify providers and check they are licensed. This pro active activity, if neglected, allows unscrupulous providers to practice with impunity. They need to know they cannot fly, 'under the radar'.
- Fixed penalties, escalating for persistent offenders must be applied without exception. The penalty should be sufficient to act as a deterrent and should not be preceded with a warning.
- Advertising of unlicensed services (print media) should be prohibited, with fixed penalties applied.
- Reporting process must be accessible and responsive. To identify issues, to monitor and audit success/failure, to inform continuous improvement and to promote public confidence in the regulation.

Clearly, Education and motivation could be provided through self regulatory models, the deterrent aspects would be weak, without legislation to enable enforcement, but perhaps the Assembly could consider a model for co-regulation- when standards are breached, there is enforcement by local authorities?

Problems:

Lack of appropriate knowledge/expertise exploited by practices

Enforcement officers applying standards not applicable to specialism.

Reluctance of public to report/ or lack of understanding- who to report to and for what?

Lack of public/consumer engagement

Lack of engagement with trainers and professional bodies

Lack of targeted resources to prevent harm, rather than act retrospectively to punish when harm is caused.

Poor data collection for audit

Lack of consistency across regions.

Safe practices will be more inclined to register, whilst high risk services go 'underground'. It is our experience that the public who use unsafe services are less likely to raise concerns or make complaints, for a variety of reasons.



- There is none who will take responsibility
- They don't know who to complain to
- They are embarrassed
- They have been intimidated/ threatened

THIS needs to be addressed as a matter of priority. Current licensing models tend to cling to the four corners of the legislation (has the practitioner/premises breached the terms of the licensing?) This fails the consumer.

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

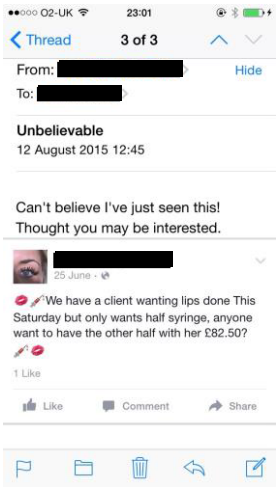
We believe the proposals have the potential to contribute to public health in Wales. Lessons might be learned from similar regulations applied in London Boroughs and Nottingham. This must not be perceived, either by the licensees or the public as 'just another income generator'. The officers must be well trained, well informed, understand the wider regulatory framework and be clear on their public protection responsibilities which may at times, go beyond the four corners of this Act, and require referral to or collaboration with other statutory or executive bodies.
Complaints must be recorded, resolved and audited. 360 degree feedback must be encouraged and published to inform continuous improvement.

It is our opinion that **effective** regulation would be more expensive and complicated than anticipated. It is currently estimated that the cost of fully implementing this licensing bill would cost in excess of £6m of public funding and is the second most expense item on the health bill. This would place an additional burden on already challenged public services at a time when there must be higher priorities. Local Authorities are not best placed to implement the measures proposed and

do not have sufficient resources to do so. However, when practice breaches standards and legislation already in place (Health and Safety Legislation) they should have clear responsibilities and publicly accessible processes to act and prosecute; this is already assumed and expected.

Save Face propose it is not in the public's interest to allocate such a significant amount of public funding to such services. These are elective procedures and there are other forms of introducing more stringent standards across the board that would be cost neutral to the tax-payer but would be income generate for the local authorities who would still have ownership of applying legislation where standards have been breached to apply enforcement action. Save Face propose that it would it would be more appropriate cost effective and efficient to contract the ownership and management to a third party scheme. To Contract the development of standards, assessment model and audit to a third party organization who would submit a competitive tender for the contract. This would facilitate business growth and job creation in Wales whist mitigating risk and cost to each authority. The appointed origination would have the existing infrastructure and training framework to implement the model at a far greater pace and would have access to the areas of specialism required to create a fit for purpose set of standards to assess both the suitability of the practitioner and the environment in which the treatments are performed. It would also have the necessary experience and infrastructure to develop and raise consumer awareness of the register, a vital element of successful licensing which other public facing registers have failed to do.

This model has proven significantly more effective in other cases of accreditation that are managed on an outsourced basis on behalf of the government in other areas requiring the application of a stringent set of standards. For example there are several of government appointed health and safety accreditation schemes including; Safecontractor, Altius, Constructionline and in utilities; Gas Safe which is managed by Capita PLC on behalf of the UK government.



Case History (Not Wales)

I reported to Public Health England.
I was referred to the local Authority
I was contacted and spoke to a nurse who understood and acknowledged my concerns
The Inspectors established the salon was not licensed to provide IPL hair removal or permanent makeup and did an unannounced inspection, but did not find the provision of dermal fillers as within their scope, so declined to take any action or any investigation of my complaint!
The full name of the nurse is not published, the salon will not provide it to me, therefore I cannot complain to The NMC (Nursing and Midwifery Council-) in any case, they would require more 'evidence'. There is no regulator who can take any action without further evidence, and no regulator who will use their authority (and resources) to investigate, based on my complaint….Presumably we will have to wait for a member of the public to contract Hep B or Hep C and be able to trace it to a shared syringe of dermal filler or botulinum toxin, before any action is taken, This is unacceptable,

We are happy to provide further and better particulars, upon request ,on any of the comments we have made.

Save Face

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 Caerphilly Council – PHB 47 / Tystiolaeth gan Cyngor Caerffili – PHB 47

HEALTH AND SOCIAL CARE COMMITTEE CONSULTATION ON PRINCIPLES OF THE PUBLIC HEALTH (WALES) BILL

Submission of Evidence by Head of Public Protection, Caerphilly Council.

Introduction:

Part 2: Tobacco and Nicotine Products Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

 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?

YES.

The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason.

Our Enforcement Officers have experienced difficulties where drivers have been witnessed smoking in their vehicles but have then been unable to prove whether it was a tobacco product or an e-cigarette. These cases demonstrate that where an individual is witnessed contravening the ban on smoking in a wholly or substantially enclosed public place they can simply claim that they were smoking an e-cigarette and it is extremely difficult for enforcing authorities to prove otherwise, thereby compromising the enforcement of the ban.

A key issue here is that the ban on smoking in public places has been very successful and is almost entirely self-policing by the public. E-cigarettes pose a real threat to that self-policing.

E-cigarettes also undermine the ability of managers of premises to enforce smoke free places, leading to many business banning them. Our officers that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people “vaping”. Some vapers argue “it’s not against the law”.

We believe that the use of e-cigarettes in public places can help “normalise” smoking. See later.

There is uncertainty over the potential adverse health implications associated with e-cigarettes and despite recent studies suggesting some benefit to those quitting smoking the efficacy of e-cigarettes as an aid to smoking cessation is not entirely clear. It is therefore appropriate to take a precautionary approach to the risks associated with e-cigarettes. Currently people in Wales can breathe clean air in offices, shops, pubs and other public places and work environments. Having secured clean air in enclosed public spaces we do not want to see a step backwards.

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

We are of the opinion that smoking should be discouraged in all public places, in particular those locations where there are children or vulnerable people. These include:

- *Playgrounds*
- *School grounds & their immediate vicinity*
- *Hospital & medical facility grounds*
- *Places promoted to children (e.g. "petting farms", fairgrounds and family centred leisure parks).*

There is a need for Fixed Penalty Notice powers which should be consistent powers with existing provisions. In drafting such provisions there is a need to consider that law currently places a responsibility on the person in control of premises to prevent smoking (e.g. hospital grounds) and that local authorities' usual enforcement approach is against the "person in control of premises" for permitting smoking. (Under the Health Act 2006 "*It is the duty of any person who controls or is concerned in the management of smoke-free premises to cause a person smoking there to stop smoking*.")

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

Yes.

Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation; intentionally or inadvertently promote or normalise smoking; and the potential impact upon impact upon smoke free environments.

We are concerned that there is a real potential for e-cigarettes to intentionally or inadvertently promote smoking amongst those who currently do not smoke. In particular we feel there is a need to make every effort to deter young people from becoming smokers. We note the cautionary words of England's Chief Medical Officer that e-cigarettes should only be used to help smokers quit.

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

*Yes. We take the view that anything that has the appearance of smoking helps "normalise" smoking and therefore promotes smoking behaviour and culture. We also question whether the term **"inadvertently"** is appropriate. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour.*

We are also concerned by the nature of e-cigarette advertising; we note the reappearance of 1950's style marketing of tobacco products.

Workplaces have worked hard to implement the smoke free premises legislation and the use of e-cigarettes undermines this work.

We are concerned that e-cigarettes encourage young people to think that smoking is acceptable and therefore has the potential to act as a gateway to both e-cigarettes and tobacco based products.

Data relating to smoking behaviour in Wales leads us conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach.

 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?*

Yes we feel they are. We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours.

Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as "Gummy Bear, Cherry cola and Bubble Gum".

Some products are being packaged and marketed in a way that is closely associated with that of conventional cigarettes. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour. We are also concerned by the nature of e-cigarette advertising; e.g. consistent with the 1950's style marketing of tobacco products.

Many of these factors reinforce the association with conventional tobacco cigarettes and may normalise smoking related behaviour.

 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?

Yes. A number of licensed premises have independently introduced bans on the use of e-cigarettes within their premises in recognition of the difficulty they cause their staff in applying the smoking ban within their premises.

Our colleagues that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people "vaping". Some vapers argue "it's not against the law".

Some employers have had difficulties. e.g. we have had problems with lorry drivers smoking in their cabs and when tackled claimed they were vaping an e-cig, which made taking action

difficult. We have also received complaints from their own office based staff that colleagues have been using e-cigarettes at their desks and that they may be also be inhaling the vapours in a similar way to second hand smoke. Hence we have subsequently amended our no smoking policy to include e-cigs.

The proposed legislation in smoke-free places should apply equally to tobacco based products and all forms of e-cigarettes.

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

The power to issue Fixed Penalty Notices and other enforcement provisions need to be consistent with other smoking legislation, and the fines need to be set at such a level as to be a deterrent to (re)offending.

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

Yes. We support the proposal.

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

The introduction of a register will provide an additional control on the availability of tobacco; a register would contain detailed information on those people and premises from which tobacco can be sold legitimately. Furthermore it would restrict access to the trade to those people and premises where tobacco should not be sold. It will be easier for enforcement officers to identify those premises where tobacco is permitted to be sold, which will in turn assist with the enforcement of underage sales and the display ban.

The success of such a measure would be dependent on the legislation including provisions to control access to the register such as a “fit & proper persons” or “suitable persons” test. This is explored further in response to subsequent questions.

If a register is to be established it needs to cover all those that manufacture, distribute and sell tobacco products. We feel that having a register only for the end retailers is not comprehensive and will not cover other parts of the tobacco chain that feed the habit including those under age. An offence should be created where tobacco products can only be sold, distributed, etc to those registered.

We note that section 29(5) provides that ‘A registered person who fails, without reasonable excuse, to comply with section 25 (duty to notify certain changes) commits an offence’. We are concerned by the use of the phrase ‘reasonable excuse’:

a) Firstly, as it is out of step with the more robust due diligence offence common to most current consumer protection legislation, i.e. the two limbed all reasonable precautions and all due diligence defence. There is concern that with section 29(5) as currently worded, individuals failing to notify changes to the register will be able to evade enforcement action. There will

be no definition of what is reasonable and so these explanations would need to be tested in court with associated wasting of resources.

Use of the well established two limbed due diligence system would enable enforcement officers to assess the adequacy of an individual's defence based on tried and tested case law, well before a case has to enter the court system

b) Secondly, the very use of the word 'excuse' in section 29(5) sends out quite the wrong message to the trade, and there is a danger that the current wording will encourage individuals simply to 'come up with an excuse' in the expectation that this will be acceptable.

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

Yes. The proposed link to restricted sales orders (RSOs) and restricted premises orders (RPOs) under the Children & Young Persons Act are welcome. However, we see it as essential that the range of offences triggering an RPO is extended to include all tobacco related breaches, for example the supply of illegal (counterfeit and non-duty paid) tobacco, tobacco labelling offences, non-compliance with the tobacco display ban; and not just underage sales. It is hoped that these matters will be addressed through the proposed power for Welsh Ministers to make regulations under section 12D of the Children and Young Persons Act and the range of offences triggering an RPO extended accordingly.

However, our experience of "Registers" introduced under other legal provisions suggest that their efficacy can be limited if they are not also accompanied by robust enforcement powers. Some registers are merely administrative or informative.

Our enforcement officers will need effective powers to ensure that the register has the desired effect. These need to include power to restrict access to the register and to remove persons from the register where there has been a relevant infringement of the law, including offences concerning underage sales. We feel that there should be a provision to consider suitability of a retailer - whether the retailer is a "fit & proper" person. For example, whether a retailer been convicted for the sale of alcohol, solvents or other age restricted products to minors. The section 24 provision that an application to register will not be granted if an RPO or RSO is already in place goes some way towards this, but of course does not take account of the selling to minors of other age restricted products.

We welcome the section 23(2)(g) clarification that in addition to sellers of tobacco and nicotine products with a High Street presence, those supplying via online, telephone and mail order channels will be required to indicate this on the register. However, it is unclear from the wording of section 22(1) whether the requirement to register applies only to those based in Wales rather than those outside Wales supplying to customers in Wales, i.e. 'The registration authority must maintain a register of persons carrying on a tobacco or nicotine business at premises in Wales'.

We are disappointed with the section 23(3) definition of a "tobacco or nicotine business" as being a business involving the sale by retail of tobacco or cigarette papers or nicotine products'. Limiting the scope of the register to retail would be a lost opportunity to regulate throughout the supply chain. The illicit supply and sale of tobacco has been identified as a growing concern by Trading Standards in Wales. A register must not inadvertently add to the problem of illicit trade in cigarettes. The penalties of failing to register therefore need to be robust. We emphasise that the definitions of "business" need to be carefully considered to encompass not only legitimate traders but also those persons who are trading illegally in tobacco from

domestic premises. We feel it should also include online suppliers. Effectively the provisions must apply to anyone who is *selling* tobacco products in Wales.

We support the need for robust and proportionate penalty for offences and proposed powers of entry (to retail premises) or the ability to seek a warrant (for domestic premises). These are obviously vital. We also support the need for powers to seize tobacco goods in all relevant premises including those that are not registered.

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

We support the proposals which would bring tobacco products into line with alcohol sales.

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

Yes.

Smoking remains the single greatest avoidable cause of death in Wales **(PHW, 2012)**. The introduction of the ban on smoking in enclosed public spaces in 2007 has been hugely successful in reducing exposure to environmental tobacco smoke and in strengthening public awareness and attitudes towards it. However, reducing the prevalence of smoking, remains a key health priority. Protecting young people from the effects of smoking and deterring young people from taking up the habit are particularly important. Therefore we welcomes the proposals and additional powers to help control the availability of tobacco and its potential health impact.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales, these procedures are acupuncture, body piercing, electrolysis and tattooing.

 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?

We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators.

We are of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

We have the following concerns regarding existing provisions:

- There is no requirement for a practitioner to have training or experience to set up a tattoo studio. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to

protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk.

- Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the byelaws. This may be viewed as a purely administrative offence when Courts are considering sentencing.
- Current registration requirements rely on being able to prove that a person is carrying on a business and this can be difficult because most unregistered tattooists ('scratchers') work from home and deny that they receive payment.
- There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws and the magistrate cancelled a previous registration. However, Local Authorities are still reliant on the applicant informing them that they have been prosecuted in another area.
- The current application process does not require any proof of identity, criminal records checks or "fit and proper person test", therefore, even if an applicant had been prosecuted in another LA then there would be no way of knowing.
- Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and The Health and Safety at Work etc. Act 1974. Several local authorities in Wales have used Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle "scratchers".
- A domestic premises can be registered to carry out skin piercing and comply initially with the byelaws. However, unless there is a separate entrance, the Health and Safety Executive are responsible for the enforcement of H&S legislation within that premises. The HSE have previously been reluctant to transfer enforcement responsibility to local authorities in such a situation. Therefore, if there is a serious risk such as lack of sterilisation, Officers are unable to serve prohibition notices as they would in a commercial setting. The only option would be to simply prosecute for non-compliance with the byelaws or to apply to the courts for a Part 2A order- both being a time consuming process.
- New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.
- Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.

We agree with the concerns of the Chartered Institute of Environmental Health (CIEH) that many procedures are being done by people with little if any knowledge of anatomy, infection control or healing processes **(CIEH, 2014)**.

We would offer the following observations on the proposal regulations:

- Level 3 fine (£1,000) is a little low and we have experience of an individual against whom we have secured multiple convictions resulting in low fines that have not deterred the illegal tattooing activity.

- It is recommended that the penalty includes the possibility of a custodial sentence of in excess of 6 months to enable us to apply for RIPA authorisation from the Magistrates

Court when necessary. This would enable us to be able to undertake surveillance on a private dwelling where illegal tattooing may be taking place for example, which we may need in order to provide sufficient evidence for the Magistrates to issue a warrant for Power of Entry when we subsequently apply for this.

- In determining whether to grant a license a Local Authority should be able to consider whether the applicant is a "fit and proper person" and such a test should be included (akin to our tried and tested procedures for taxi licensing). The test should permit the LA to take into account "any other information" (beyond the "relevant offences" listed in the draft bill) in determining that question. The current proposals do not offer sufficient safeguards.
- We would be opposed to grandfather rights for existing traders.

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future.

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

We absolutely support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. A local studio in our county borough is keen to expand into scarification and tongue splitting. Other procedures are already becoming more popular e.g. branding, dermal implants, microdermabrasion. All these procedures provide the potential for serious harm and infection.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive activities underground and cause further issues or potentially make it more appealing to some people.

 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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

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

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Evidence of public health risk in relation to such procedures is clear. We take the view that any procedure that involves the piercing of the skin poses a very real risk of infection and disease from blood born viruses many of which can be a serious risk to health and that anyone undertaking such procedures should be competent to do so without putting a person at risk.

Current controls are outdated and inadequate. We need to be able to protect the public to better prevent people from undertaking these procedures if they are not competent or are not fit and proper person to be undertaking such practices. We need also to ensure that the conditions in which such practices take place are hygienic and will prevent infection risks.

We are seeing in our day to day work evidence of a growing range of procedures that put the public at risk. These include: dermal implants, beading, ashing, scarring, dermal fillers, tongue splitting, and a range of other procedures that we might loosely describe as “body

modification". We feel strongly that regulations should permit all such procedures to be controlled and that the regulations should allow the list of procedures to be extended to cover any form of body modification that may arise in the future.

Some procedures such as "ashing" might not fall within the regulations as proposed. Ashing may fall outside of the current definition of tattooing (which relies on the use of pigmentation) and care is needed that definitions do not inadvertently exclude procedures that are intended to be covered.

In relation to extending the list, we recognise from an enforcement perspective that we are familiar with the necessary controls and safeguards needed in relation to more traditional procedures. There is merit in a considered and stepped approach to extending the list of special procedures so that we are able to develop training, suitable competence assessments and necessary guidance in relation to the more novel procedures. We are also aware that consideration is needed in distinguishing between a legal service that we might appropriately control and what might be considered an illegal act of assault. We feel some clarity will be required in relation to that question.

Educational establishments:

Some further consideration may be needed about how best to apply or amend the proposals in relation to students of educational establishments.

Apprentices.

Section 48(3) and (4) need to better address the supervision and training of apprentices

An issue linked to apprentices, is that performing a 'special procedure' needs to be defined as an action that breaks the skin in our view. Otherwise there could be confusion about whether apprentices are performing a special procedure, when they have done every other part of the process but break the skin.

Proving a business exists.

There should be no need to prove a premises is operating as a business at a given moment in time. A premises should be deemed to be operating as a business at all times it is licensed, similar to a hackney carriage.

FPNs.

The use of FPNs for 'minor' breaches of the legislation may be useful.

Section 52(2)(c): Information to be communicated to clients.

Perhaps this information should be specified in the regulations, as it has been in the Sunbeds legislation – prescribed information to provide to a person each time that person seeks a treatment and prescribed posters to be displayed in a prominent position.

A National Register

We take the view that it would be sensible to have one single national register that is administered by one local authority in Wales. This would be an efficient, collaborative method of delivery. A number of local authority Environmental Health departments have indicated their willingness to take on that responsibility on a cost recovery basis. We would

underline the importance of local authority administration because of the potential intelligence / data sharing issues in relation to applicants between enforcement agencies.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

 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?

We agree that there should be an age restriction for intimate body piercing, but consider that prohibiting the intimate piercing of anyone under the age of 18 would be more appropriate. This is because:

because:

- The decision to have an intimate body piercing should be made by a mature individual, we believe that 16 years of age is not sufficiently mature.

- Intimate body piercings require a higher standard of aftercare than tattoos, as they are potentially more susceptible to infection. This level of aftercare requires a mature approach to which a 16 year may not be capable of fully committing.

- Whilst the jewellery inserted into an intimate body piercing may be removed any scarring or damage inflected by the procedure will be permanent. This is particularly important when the skin the subject of the piercing is still growing and its function may be compromised by scarring or thickening. At 16 years an individual is still growing and therefore the risk of damage to skin is greater.

We also notes that there is potential for confusion to arise if there is a different age restriction for body piercing and for tattooing. We consider that it would be easier for practitioners, enforcement agencies and individuals if the age restriction for both was to be the same.

From a Safeguarding perspective a child is defined as anyone who has not yet reached their eighteenth birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate does not change his or her status or entitlement to services or protection under current legislation. We believe that intimate piercing of a child should be prohibited and that the age restriction for intimate piercing should be 18 years.

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

Yes. However we also feel there is a case to add the tongue. In addition to the relatively higher risks of infections associated with tongue piercing, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list of intimate parts.

 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?

We support such proposals including the proposal to make it an offence “to enter into arrangements”. This would support enforcement of the provisions including “test purchasing” by local authorities.

We recognise the need for police support in particular in relation to evidence gathering given the intimate nature of such offences and the provisions need to take account of that.

Any duties placed upon local authorities need to be supported by adequate funding.

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

Yes, see above**.**

Part 6: Provision of Toilets Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

· 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?

We agree that the provision of, and access to, toilets for public use is important, particularly to older people and those with specific needs.

However, we question whether placing a duty on local authorities to develop a strategy is appropriate, acknowledging firstly the difficult financial climate within which any duty would consume resource and secondly that a strategy will not of itself bring about enhanced provision. Care is needed that WG does not merely impose an administrative and financial burden that delivers no real benefit to the public.

Local Authorities are being forced to make difficult choices around the prioritisation of services to their communities many of which have a significant impact on health & well-being. Any duty regarding the provision of public toilets may result in local authorities being forced to disinvest in other services that are of equal or greater priority.

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

See above

· 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?

The consultation requirements set in Para 92 are too vague to be meaningful.

· 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?

In our experience, such guidance leads to more consistent approaches.

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

There are obvious benefits from opening other public toilet facilities (eg: leisure centres and libraries) to the general public and in the context of the current financial climate this may be the only opportunity to deliver such facilities as local authorities are being forced to prioritise service provision to make financial savings.

· 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?

Generally yes, but in the current financial climate it is unlikely that local authorities will be able to afford to make significant alterations to any buildings to create such provision if it does not already exist.

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

No - as stated above, placing a duty on local authorities to develop a strategy will not of itself bring about enhanced provision or result in improvements in public health.

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 are generally very supportive of the measures set out in the Bill. However, we are naturally concerned by the capacity within local government to deliver additional responsibilities successfully at a time when service cuts and reductions in service standards are all too apparent. We have a great deal of expertise and experience and local authority Environmental Health Departments across Wales are keen to support these new powers and measures. However ask WG to ensure that such work can be adequately resourced and in particular to consider:

- Undertaking regulatory risk and impact assessment to understand the consequences of the proposed legislation on enforcing authorities and on those subject to regulation,
- a detailed understanding and quantification of the costs of effective regulation and enforcement so that WG and local authorities can plan properly for implementation,
- Where possible provisions should allow for full cost recovery or in the absence of a cost recovery mechanism (typically fees & charges) additional resource must be made available to local authorities specifically for the purpose of this legislation,
- In drafting the legislation, WG should avoid unnecessary complexity or ambiguity, ensure that provisions are capable of being enforced in a practical and efficient way and that any potential defences are fully and properly understood.
- There appears to be no money for the initial inspection of the tobacco retailer outlets by each Authority and subsequent follow up visits in the case of non-compliance. The proposal states that inspection of premises for compliance with the new requirement will be undertaken as part of enforcement officers regular schedule of inspections. With Authorities working toward an intelligence led enforcement approach, this could mean that some tobacco retailers who have failed to register could be operating un-registered for up to a year, until they are next inspected. This means that the register is not up-to-date.
- The initial monitoring of compliance of the tobacco register may not take place by Authorities if not funded as this may require inspections/visits to take place outside of the routine inspection programme.

 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?

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

 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?

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

Other comments

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

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

Yes

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

Through our licensing teams and through a broad range of officers working closely with local residents in our communities, we are all too familiar with the problems caused by alcohol. However, we understand that Minimum Unit Pricing is a proposal to be taken forward in a future draft bill – something that we would welcome and will be pleased to work with officials working towards that.

We are also aware of public health concerns around obesity, nutrition and exercise – and we have an interest in this area through our vital role in relation to the regulation of food standards and food labelling and our general contribution to the wider public health agenda. We acknowledge the potential contribution of the Future Generations Act and Active Travel Act for example in this area but note also the potential for planning controls and licensing arrangements to play a greater part. We also recognise that some of these issues may need action at the level of UK Government.

Robert Hartshorn
Head of Public Protection | Pennaeth Diogelwch y Cyhoedd
Caerphilly County Borough Council | Cyngor Bwrdeistref Sirol Caerffili

☎ [redacted]
✉ [redacted]

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 Ash Wales – PHB 48 / Tystiolaeth gan Ash Cymru – PHB 48

Consultation on the Public Health (Wales) Bill – response from ASH Wales

ASH Wales is the only public health charity in Wales whose work is exclusively dedicated to tackling the harm that tobacco causes to communities. Further information about our work can be found at http://www.ashwales.org.uk/

We are engaged in a wide range of activities including:

- Advocating for tobacco control public health policy
- Undertaking tobacco control research projects
- Training young people and those who work with young people to provide factual information about the health, economic and environmental effects of smoking
- Engaging young people and professionals working with young people through the ASH Wales Filter project
- Bringing health information and advice to the heart of the community

We also oversee the Wales Tobacco or Health Network (a network of over 300 individual members) and the Wales Tobacco Control Alliance (an alliance of 35 voluntary and professional bodies in Wales), providing forums for sharing knowledge and best practice.

ASH Wales has no direct or indirect links with, and is not funded by, the tobacco industry.

Smoking prevalence and electronic cigarette (e-cigarette) usage in Wales

Based on 2014 Welsh Health Survey data the percentage of the adult (age 16 and over) population in Wales categorised as a smoker is 20%, with this figure greater for

males (22%) than females (19%).[1] In terms of numbers of smokers, this equates to approximately 518,000 adults in Wales currently smoking. Smoking is the largest single cause of avoidable early death in Wales. In 2010, around 5,450 deaths in people aged 35 and over were caused by smoking[2], and about half of all life-long smokers will die prematurely as a result of their habit.[3]

In terms of e-cigarette usage, ASH UK reports that an estimated 2.6 million adults (aged 18+) in Great Britain currently use e-cigarettes.[4] Based on the most recent population data for Wales this equates to approximately 129,000 e-cigarette users (aged 18+) in Wales[Δ].

Consultation questions

Part 2: Tobacco and Nicotine Products

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

We believe any proposal to ban e-cigarettes in enclosed public and work places in Wales should be evidence based. The law to prohibit smoking in enclosed public places was implemented to protect people from exposure to tobacco smoke and thus reduce the toll of ill-health and premature death caused by second-hand smoke. A comprehensive review of the most up-to-date evidence on e-cigarettes commissioned by Public Health England concludes “EC [e-cigarette] use releases negligible levels of nicotine into ambient air with no identified health risks to bystanders”.[5] In an article published in 2012, McAuley et al[6] analysed pollutant concentrations from e- and tobacco cigarettes, and showed that the e-cigarette vapour was found “to pose a significantly lower risk than cigarette smoke under the same testing conditions”. Other authors have pointed out that the levels of toxins contained within e-cigarettes are comparable to conventional nicotine replacement products, rather than tobacco products.[7]

Before taking steps to regulate we believe policy makers should review all existing evidence and appraise the views of experts in the field. This is vital in order to make sure that any proposed measure would have a positive impact on public health. There is at present no clear evidence to suggest that including e-cigarettes under the Smokefree Premises regulations would benefit the health of the public in a similar way to the smokefree legislation currently in operation. Some people have argued

[Δ] There is no precise figure for e-cigarette use in Wales. The estimate provided is an approximation based on the proportion of the Welsh population relative to the population of Great Britain applied to the number of e-cigarette users in Great Britain.

that because there is still much that is unknown about the health impact of using e-cigarettes that the precautionary principle should be applied, i.e. to warn against their use until we can be sure of their safety. However, there could be a public health risk in doing so, since smokers are clearly using the devices to help them reduce their consumption of tobacco and/or to quit smoking altogether.[5,8] To be precautionary it is necessary to take all effects into account of both over regulating and under regulating. It could be equally argued that under regulation is a precautionary approach for instance.

The National Institute for Health and Care Excellence (NICE) has developed guidance on a harm reduction approach to smoking.[9] NICE's recommendations aim to inform how best to reduce the illness and deaths attributable to smoking through a harm reduction approach. As part of this guidance, NICE supports the use of licensed nicotine containing products (NCPs) to help smokers cut down, for temporary abstinence and as a substitute for smoking, possibly indefinitely. NICE guidance cannot recommend the use of unlicensed nicotine containing products. However the guidance is clear that using an e-cigarette is likely to be less harmful than smoking. ASH Wales supports a harm reduction approach to tackle smoking.

There is no clear evidence to support the hypothesis that the use of e-cigarettes serves to renormalise smoking behaviour or act as a gateway to tobacco products among young people. In terms of renormalisation, the 2015 report commissioned by Public Health England states "there is no clear evidence to date that EC [e-cigarettes] are renormalising smoking, instead it's possible that their presence has contributed to further declines in smoking, or denormalisation of smoking".[5] With regards to e-cigarettes acting as a gateway to smoking among young people the report found no evidence of this during their comprehensive review leading them to conclude "Whilst never smokers are experimenting with EC [e-cigarettes], the vast majority of youth who regularly use EC [e-cigarettes] are smokers. Regular EC [e-cigarettes] use in youth is rare".[5] The existing evidence base suggests the situation is no different in Wales specifically. For instance, studies by ASH Wales[10] and Moore et al[11], which were based on a cohort of young people living in Wales, found regular use of e-cigarettes to largely be confined to tobacco smokers, with use among never smokers rare.

Furthermore, it is worth noting that the uncertainty regarding the impact of e-cigarettes, and in particular the debate around banning the use of e-cigarettes in enclosed public and work places, has the potential to shift public opinion of e-cigarettes. ASH UK runs an annual survey on e-cigarette use among adults and young people in Great Britain. Between 2013 and 2015 the number of adults who wrongly considered e-cigarettes to be as harmful as conventional cigarettes increased from 6% to 20%.[4] Given the potential benefits of e-cigarettes as a smoking cessation tool this represents a worrying trend since it is important for the public not to get the wrong impression of the dangers of e-cigarettes.

ASH Wales therefore recommends that any decision to ban the use of e-cigarettes in enclosed public and work places in Wales should be delayed until additional evidence is forthcoming. In the meantime ASH Wales recommends that premises continue to be allowed to make decisions for themselves on whether or not to permit the use of e-cigarettes, although we recognise that there may be environments where the use of these devices is inappropriate, such as schools for example. ASH UK have provided a briefing on the issues that organisations need to consider in relation to permitting use of e-cigarettes on their premises.[12] ASH Wales recommends that Public Health Wales disseminates responsible guidance such as this to businesses and other organisations.

- 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)?

We are in favour of extending the current restrictions on tobacco smoking to include some non-enclosed spaces, such as hospital grounds and mental health units. We additionally support the introduction of voluntary smoking bans in places like playgrounds, school gates and beaches. We consider this to be an important development that will serve to further denormalise smoking as an activity in communities across Wales as well as protect members of the public from the damage to their health caused by inhaling secondhand smoke. The current smokefree legislation, introduced in the UK in 2007, bans smoking in virtually all enclosed and substantially enclosed public and work places. These regulations have been shown to be effective in terms of initiating health benefits for smokers/non-smokers and changes in smoking related attitudes and behaviour.[13] Furthermore, the extension of smoking bans to include non-enclosed public places has also been shown to be effective. For instance, following the parks and beaches in New York City (NYC) becoming smokefree in 2011 Johns et al found the trend in the frequency of NYC residents noticing people smoking in local parks and beaches decreasing significantly over the six quarters after the law took effect, leading the authors to conclude that their results provide population-level evidence that suggest the law has reduced smoking in parks and on beaches.[14] Furthermore, there is strong public support in Wales for an extension of the smoking ban to include additional non-enclosed spaces. According to a 2015 YouGov survey commissioned by ASH Wales 54% of respondents agree that smoking should be banned in communal recreational spaces such as parks and beaches.[15]

In contrast, we are not in favour of restricting the use of e-cigarettes in some non-enclosed spaces. As per our answer above, we do not believe sufficient evidence currently exists to warrant banning the use of e-cigarettes in enclosed public and

work places, and hence we also feel it is too early to consider banning e-cigarettes in non-enclosed spaces.

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

We feel at present that the provisions in the Bill are weighted too heavily in favour of protecting the public from the potential disbenefits associated with the use of e-cigarettes, to the detriment of the potential benefits accrued by smokers resulting from the use of e-cigarettes as a smoking cessation tool.

We agree that it is important to ensure the health of the public is safeguarded at all times, and that given the fact e-cigarettes are still relatively new it is necessary to be cautious with regards to the potential health risks. However, at present the majority of evidence does not suggest that e-cigarettes are particularly harmful to health. Whilst e-cigarettes do contain some carcinogens and toxicants these are at much lower levels than those observed in tobacco smoke, and as such e-cigarettes are widely regarded as being much safer than tobacco cigarettes. A number of studies have not reported any significant adverse effects on health of e-cigarettes. As part of a Cochrane review McRobbie et al looked at whether it is safe to use e-cigarettes as a smoking cessation aid.[16] None of the studies found that smokers who used e-cigarettes short-term (for 2 years or less) had an increased health risk compared to smokers who did not use e-cigarettes. As part of a systematic review appraising existing laboratory and clinical research on the potential risks from e-cigarette use, Farsalinos and Polosa concluded that the currently available evidence indicates that e-cigarettes are by far a less harmful alternative to smoking.[17] Furthermore, in a study of the levels of selected carcinogens and toxicants in the vapour from e-cigarettes Goniewicz et al found the levels of the toxicants were 9 - 450 times lower than in cigarette smoke[18], whilst according to the 2015 report commissioned by Public Health England e-cigarette use is around 95% safer than smoking.[5]

A related concern surrounding e-cigarettes is that they may become a new form of nicotine addiction. However, there is an emerging body of evidence which suggests that at present e-cigarettes are not currently as addictive as tobacco cigarettes given the other constituents of tobacco smoke enhance the addictiveness of nicotine. According to Guillem et al compounds present in tobacco smoke may combine with nicotine to produce the intense reinforcing properties of cigarette smoking that lead to addiction.[19]

In contrast to the relative lack of evidence in terms of the adverse impact on health of e-cigarettes, there is a growing body of evidence suggesting that e-cigarettes are

increasingly being used for smoking cessation purposes. In England, since the third quarter of 2013 a higher percentage of smokers have tried to stop smoking using e-cigarettes compared to any other popular smoking cessation aid. Indeed, by the last quarter of 2014 approximately 15% more smokers used e-cigarettes as a means to give up smoking relative to over-the-counter NRT.[20] Research is also becoming available signifying the effectiveness of e-cigarettes as a smoking cessation aid. In 2014 Brown et al undertook a cross-sectional population study aimed at assessing the real-world effectiveness of e-cigarettes when used to aid smoking cessation.[8] Among the findings of the study was that e-cigarette users were more likely to report abstinence than either those who used NRT bought over-the-counter or those who used no smoking cessation aid.

Given the above, plus the fact that restrictions on the use of e-cigarettes reinforces the belief that the products are as risky as tobacco cigarettes in the public consciousness, we feel it is necessary to take more time to assess the relative benefits and disbenefits associated with the use of e-cigarettes. We consider this to be the best option as opposed to regulating on the basis of insufficient evidence, as is currently the case in relation to the Public Health (Wales) Bill. If there was a ban on using e-cigarettes in all enclosed public places, users could be less inclined to use them which could result in more of them reverting back to smoking. Prohibition would also increase the likelihood that vapers and smokers would effectively be required to share the same spaces. This not only undermines quit attempts but would also expose users of e-cigarettes to second-hand smoke. Before regulation of this nature proceeds, it needs to be clear that the harms to others outweigh the benefits to those who are using e-cigarettes for harm reduction or cessation purposes, as otherwise there is a risk that the regulation in question could harm public health by making a potential avenue for smoking cessation less attractive to current smokers.

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

To date, there has been very little research based upon the question of perception of e-cigarettes and whether or not they can be argued to normalise, or indeed denormalise, the act of smoking. E-cigarettes are distinct from tobacco products. Whilst the early version of e-cigarettes were designed to look like the tobacco equivalent this tends to be no longer the case with current developments in e-cigarette design meaning that most devises now look more like pens as opposed to conventional cigarettes. Furthermore, e-cigarettes lack the most distinctive characteristic of smoking – its smell (which travels rapidly) – plus they do not

produce ash. It is therefore difficult to see how any confusion between the products could be sustained for long. Indeed, the 2015 report commissioned by Public Health England reviewing the most up-to-date evidence in relation to e-cigarettes states "there is no clear evidence to date that EC [e-cigarettes] are renormalising smoking, instead it's possible that their presence has contributed to further declines in smoking, or denormalisation of smoking".[5]

In fact emerging evidence suggests that the advent of e-cigarettes is playing a role in the observed reduction in smoking prevalence. According to Professor Robert West the number of smokers in England estimated to have quit in 2014 who would not have quit if e-cigarettes had not been available is 20,340.[21] This appears to be borne out by further evidence from the Smokers' Toolkit study which revealed that people attempting to quit smoking without professional help are about 60% more likely to report succeeding if they use e-cigarettes than if they use willpower alone or over-the-counter nicotine replacement therapies.[8]

- 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?

Recent figures suggest that the awareness and usage of e-cigarettes among young people in Wales and Great Britain as a whole is increasing.[10, 22] We consider this finding to be concerning and are keen to see young peoples' use of nicotine minimised as much as possible.

It is important to note however that the evidence collected so far about young people and e-cigarette experimentation and usage from a number of countries has not yet demonstrated any 'gateway' effect, that is non-smokers taking up e-cigarettes, much less progressing to conventional tobacco products. Writing in a report on e-cigarette marketing commissioned by Public Health England, Bauld, Angus and de Andrade note that ever use is concentrated among young people who smoke. They also state that they "could not identify any evidence to suggest that non-smoking children who tried e-cigarettes were more likely then to try tobacco."[23] A recent ASH Wales survey of young people across Wales also suggested that e-cigarettes are not currently acting as a gateway to smoking among non-smokers. Regular use by never smokers was negligible at 0.16%. Of those respondents who reported using both e-cigarettes and tobacco cigarettes at some point (n=84), 98% had first used tobacco cigarettes suggesting the absence of any gateway theory.[10] A survey commissioned by ASH UK found that in 2014 of those who had never smoked a cigarette 99% reported never having tried an e-cigarette and 1.5% reported having tried them "once or twice". They found negligible evidence of regular e-cigarette use among children who

have never smoked or have only tried smoking once. In addition, only 1% of those who had never smoked thought that they would try an e-cigarette soon.[22] Research conducted in the United States aimed at identifying the beliefs that predicted subsequent e-cigarette use also found that a relatively small number of (baseline) never smoking respondents reported ever using an e-cigarette (2.9%) when compared with (baseline) former smokers (11.9%) or (baseline) current smokers (21.6%).[24] Findings in a survey conducted among young people (15-24 year olds) in Poland also returned similar results with regard to non-smokers. Whilst around one-fifth of respondents reported having tried an e-cigarette at some point, this dropped to 3.2% among those who had never smoked a cigarette. This percentage fell even further, to 1.4%, when asked if they had used an e-cigarette in the previous 30 days indicating that for many non-smokers who had tried one, this had not led to long-term use.[25]

On balance therefore, from the evidence currently available on the issue of young people and e-cigarettes, the majority of the data shows that ever cigarette use is concentrated among current and former smokers with negligible evidence of never-smokers trying e-cigarettes, much less progressing to regular use of e-cigarettes, let alone tobacco products. Although ASH Wales recognises the need to continue monitoring the situation and enhancing the evidence base in this area.

- 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?

Whilst recognising the concerns about enforcing the Smoke-free Premises regulations, we are unaware of any evidence to suggest that the regulations are being consistently undermined by the use of e-cigarettes in public places, i.e., causing people to use tobacco products illegally. Consequently, ASH Wales does not feel that an outright ban on the use of nicotine containing devices (e- cigarettes) in enclosed public places under the existing regulations is warranted. As noted above, vaping is not smoking and we believe it is inappropriate to place non-combustible nicotine delivery devices under smokefree legislation.

There may be some uncertainty regarding how businesses appropriately deal with e-cigarettes, and, in particular, whether they are able to adopt and enforce bans themselves. For this reason we feel there is a clear need to provide education and clear guidance for businesses so that they are fully informed about e-cigarettes and what their rights and responsibilities are. ASH UK have provided a briefing on the issues that organisations need to consider in relation to permitting use of e-cigarettes on their premises[12] and we should be adopting similar guidance in Wales.

- Do you agree with the proposal to establish a national register of retailors of tobacco and nicotine products.

We agree with the proposal for a national retail register of retailors of tobacco and nicotine products. We would favour retailors of tobacco to be on a separate register from retailors of nicotine products given these are very different products.

We welcome the measure as an important initial step towards reducing the number of young people in Wales who become smokers or start using e-cigarettes, and consider it to be both workable and proportionate. Evidence from Scotland suggests that the register has been useful as a means of improving proactive communication to retailors in terms of what their responsibilities are. However, from an enforcement point of view the retail register in place in Scotland appears to be less successful. There have been very few prosecutions and the register doesn't improve the ability of enforcement officers to tackle illicit tobacco outside legitimate retailors. For this reason we view the proposal to establish a national retail register in Wales as a first step towards a positive licensing scheme, which is what we would like to see adopted for tobacco in the same way it is applied to alcohol. Such a scheme would mean tobacco retailors have to meet certain conditions to gain a licence to sell tobacco, with the potential to suspend, revoke or vary the conditions of a licence. We believe a positive licensing scheme would initiate more effective enforcement than a retail register, affording enforcement officers more powers to address tobacco being sold outside the legitimate retailors.

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

Yes. The establishment of a national register of retailors of tobacco and nicotine products will hold retailors more accountable for their actions if caught partaking in underage sales and will make it easier for them to be monitored and tracked over time. This is important since evidence from the North East of England in 2013 showed that young smokers (14-15 year olds) are significantly more comfortable than their adult counterparts in purchasing illegal tobacco. 30% of 14-15 year olds were buyers of illegal tobacco, making them twice as likely as adult smokers in having purchased illegal tobacco.[26] We believe under 18s will be afforded additional protection from a positive licensing scheme however and would support the introduction of such a scheme to replace the retail register in the long term.

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

Yes. This will act as a greater deterrent to any retailors tempted to breach the new requirements. It is important however that following any changes the regime is easy to enforce plus there should be clear guidance for enforcement officers and magistrates on how to implement the changed regime.

- 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?

We believe that this measure would be in line with the commitment demonstrated by other legislative steps, such as the vending machine ban, point of sale display bans and the introduction of a retail register, to limit as far as possible the access of young people to tobacco/nicotine products.

We would support the proposal to prevent under-18s receiving delivery of tobacco/nicotine products in principle, as unintentionally or not, allowing under-18s to receive delivery of tobacco/nicotine products blurs the message that is being developed on the issue of proxy purchasing. If an under-18 is the only person present to receive a delivery, even if ordered by an adult, there would be no way of preventing them accessing the goods delivered, whether they were intended for their consumption or not. However, before this offence is created we believe it is important to ensure that there is evidence that this issue is a problem. All decisions of a regulatory nature such as this needs to be evidence based.

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

We believe the proposals to establish a national register of retailors of tobacco and nicotine products, strengthening the Restricted Premises Order regime and prohibiting the handing over of tobacco and/or nicotine products to a person under the age of 18 will each contribute to improving public health in Wales.

However, we are concerned that the proposal to place restrictions on the use of nicotine inhaling devices such as e-cigarettes in enclosed public and work places may serve to damage public health in Wales. There is a clear risk that this regulation will reduce uptake of e-cigarettes among current adult smokers who may otherwise have sought to use the device in an attempt to quit tobacco smoking or harm reduce. ASH Wales therefore recommends that any decision to ban the use of e-cigarettes in enclosed public and work places in Wales should be delayed until additional evidence is forthcoming.

Other comments

As we have stated we believe there are several components of the Public Health (Wales) Bill that will serve to improve public health in Wales. However there is a risk that such positive aspects of the Bill will be overshadowed by the debate surrounding the proposal to ban the use of e-cigarettes in enclosed public and work places. For this reason we recommend that this specific proposal be removed from the Public Health (Wales) Bill, if only temporarily, so that it can be debated separately at a later date. This will allow for a more considered debate to be had and more evidence from experts to be heard. By introducing a longer timeframe to consider the e-cigarette proposal there will be an opportunity for more evidence to be forthcoming to inform the debate and given the current uncertainty regarding the issue of whether e-cigarettes act as a gateway to tobacco products among young people and/or renormalise smoking as an activity such a stoppage for reflection is most welcome.

In terms of other areas of public health that require legislation to help improve the health of people in Wales we support the extension of the current smokefree legislation to include a ban on smoking tobacco in some non-enclosed spaces, such as hospital grounds and mental health units. We are also in favour of the introduction of voluntary smoking bans in places like playgrounds, school gates and beaches. We consider these proposals to be an important development that will serve to further denormalise smoking as an activity in communities across Wales as well as protect members of the public from the damage to their health caused by inhaling second-hand smoke.

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

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

Evidence from Owain Rowley-Conwy – PHB 49 / Tystiolaeth gan Owain Rowley-Conwy – PHB 49

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No

Question 2

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?
No

Question 3

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?
There is no evidence whatsoever to support these suggestions.

Question 4

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?

There is no evidence for either of these contentions.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
No. There is no need for such a register and it would simply add to the bureaucratic burden on the taxpayer

Question 6

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?
How can this possibly be policed? Legislation which is unenforceable simply brings the law into disrepute

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
Where is the demand for this? Are welsh tatooists and acupuncturists particularly dangerous? Once again it simply adds to the bureaucratic burden on the taxpayer.

Question 8

Do you agree with the types of special procedures defined in the Bill?
No. See my answer to Qu7 above

Question 9

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

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
It would add to administration and the cost would inevitably be borne by the council tax payer.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
It would appear reasonable but once again how is it be enforced. Intimate piercings are, of their very nature, concealed throughout most of the day.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
See above Qu11.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
I see no problems with the current system.

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
The market will see to this. If there is a need for a pharmacy then an enterprising pharmacist will soon find it and solve it.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
Absolute waste of time and money.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
No.

Question 17

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?
People within these communities generally have better things to do with their time.

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
Fine. No problem with that.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
No.

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
Sorting out the NHS in Wales so it works as least as well as the one in England would be a good start.

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 Electronic Cigarette Industry Trade Association - PHB 50 / Tystiolaeth gan Cymdeithas Fasnach y Diwydiant Sigarets Electronig - PHB 50

'The Industry Standard of Excellence'

1st September 2015

Dear Sir/Madam,

We are writing in response to your invitation to contribute to the inquiry, and to submit written evidence to assist the Health and Social Care Committee in its scrutiny of the proposed Public Health (Wales) Bill. Our evidence and comments relate exclusively to electronic cigarettes and vaping, and not to tobacco products, or any of the other areas covered by the Bill.

When it comes to vaping products, we believe it is vitally important that legislation and regulations recognise the enormous harm reduction potential of e-cigarettes, as acknowledged by Public Health England in their report, *E-cigarettes: an evidence update*[1], published in August 2015. PHE rightly identified the dangers to public health of e-cigarettes being incorrectly treated as, or widely viewed as being, as harmful as tobacco. For many smokers, e-cigarettes are the surest way they can avoid the harms associated with smoking, so imposing restrictions is contrary to public health.

This is particularly important in light of the evidence that it is almost exclusively current and former smokers who are using e-cigarettes. According to the Action on Smoking and Health fact sheet, '*Use of electronic cigarettes (vapourisers) among adults in Great Britain*'[2], the UK has an estimated 2.6 million e-cigarette users. Of these, approximately 1.1 million are ex-smokers and 1.4 million are current smokers using e-cigarettes to reduce the amount they smoke. Use by never smokers remains negligible.

Welsh Government figures from the explanatory memorandum to the Bill[3] estimate that there are 33,600 Welsh citizens whose only source of nicotine is electronic cigarettes – all of whom are former smokers. While it is impossible to be precise on how many are likely to relapse into tobacco use, the potential is high. If vapers are pushed out into smoking areas – as they would be under the proposals in the Bill – peer pressure is likely to force many back to smoking.

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454516/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England.pdf
2 http://www.ash.org.uk/files/documents/ASH_891.pdf
3 http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

The proposals in the Bill, therefore, seem counterintuitive, particularly when the explanatory memorandum suggests:

> "*14. In bringing forward this Bill, the focus of the Welsh Government is on shaping social conditions that are conducive to good health, and where possible, preventing avoidable health harms. As part of this approach, it is also recognised that individuals have a responsibility to look after their own health, and to act in ways which promote their own physical and mental well-being.*"

Since over 30,000 Welsh citizens have already recognised their own "responsibility to look after their own health" and acted to "promote their own physical and mental well-being" by switching to vaping rather than continuing to smoke, introducing legislation which strongly indicates that this is frowned upon seems contrary to the stated objectives of the Bill. Many people are understandably deferential to what they believe to be medical advice. There are, therefore, great risks of conflating smoking and vaping: it discourages people from opting to vape instead because they come to falsely believe the harm is the same.

In the explanations of the Committee's role in the consultation documents on the Welsh Assembly website, it states the following:

> "*The Committee has agreed the following terms of reference for its work:*
>
> *To consider*

- *The need for legislation in the following areas –*
  - *Placing restrictions on the use of tobacco and nicotine inhaling devices (NIDs) such as electronic cigarettes in enclosed and substantially enclosed public and work places, and giving the Welsh Ministers a regulation-making power to extend the restrictions to certain open spaces;*

[and]

- "*Whether there are any unintended consequences arising from the Bill;*
- *The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum – the Regulatory Impact Assessment, which estimates the costs and benefits of implementation of the Bill);*

[and]

- *The extent to which the Bill reflects priorities for improving public health in Wales.*"

We have significant concerns about the framing of the terms of reference concerning the proposed ban on vaping in public spaces, and the unintended consequences which, as we shall demonstrate, are likely to have a significant detrimental effect on public health in Wales.

For ease of reference, we shall reproduce the consultation questions provided in Annex A, and address each in turn. We shall start by providing some brief information about our organisation.

Founded in March 2010, ECITA (EU) Ltd is the longest-running trade association for the electronic cigarette industry anywhere in the world, with members across England, Scotland and Wales. We are also one of only two e-cigarette trade associations in the world which is not managed/operated by those engaged in the sale of vaping products, directly or indirectly, which makes it easier for us to represent the interests of our members – and their customers – fairly and fully.

We developed the Industry Standard of Excellence, and our members are audited bi-annually to ensure they are fully compliant with all the legal requirements. We also sponsored and provided Technical Authorship for the British Standards Institution PAS 54115, *Vaping products, including electronic cigarettes, e-liquids, e-shisha and directly-related products – Manufacture, importation, testing and labelling – Guide*, which was published in July 2015.

One of our 20 members is a wholly-owned subsidiary of Imperial Tobacco, however, Fontem Ventures (who now own the brand Blu) are not a tobacco company. Our membership fee is a flat rate, and all of our members pay the same fee. Their membership fees are the only funding which might potentially be viewed as coming indirectly from the tobacco industry.

Annex A – Consultation questions

- ***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?***

No. The use of e-cigarettes is fundamentally different from smoking tobacco, and conflating the two is actively bad for public health. As Public Health England identified in their recent report:

> "*EC [electronic cigarettes] should not routinely be treated in the same way as smoking.*"

ECITA opposes the banning of vaping in enclosed public spaces because, unlike the smoking ban, such a restriction is not supported by scientific evidence, the general public, the tobacco control community, or the other nations of the United Kingdom. There is no scientific evidence that vaping in public spaces is harmful to bystanders and a substantial body of evidence to suggest otherwise. The Welsh Assembly Government has not cited harm from second-hand exposure in its rationale for the proposal.

A ban would have negative public health consequences for Wales by discouraging switching to vapour products and encouraging relapse to smoking. As ASH Wales said:

"*Before taking steps to regulate, legislators should be sure that any proposed measure would have a positive impact on public health. There is currently no clear evidence to suggest that including electronic cigarettes under the Smokefree Premises regulations would benefit the health of the public in a similar way to the 'smoking ban'. Indeed, it may even have a negative impact upon current smokers who may otherwise have attempted to quit or harm reduce, potentially damaging rather than enhancing public health.*"

ASH UK agree:

"...there is little evidence of any harmful effects from exposure to the vapour from electronic cigarettes among non-users. Therefore there is currently no justification of a ban on the use of electronic cigarettres in public places on health grounds. Before taking steps to inhibit personal choice, legislators should be sure that any proposed measure would not lead to unintended consequences.

The dramatic rise in sales of electronic cigarettes in recent years has led some people to fear that their use in public places could undermine compliance with the smokefree law. However, to date, we have seen no evidence to support this hypothesis. Electronic cigarettes are very different from tobacco products. Although some are designed to look like tobacco cigarettes, the most distinctive characteristic of smoking is the smell of the smoke which travels rapidly and the presence of ash. As these are absent from electronic cigarettes it is not clear how any such confusion would be sustained.

In fact, electronic cigarettes have more in common with licenced nicotine replacement products such as sprays and inhalers. There is no combustion and therefore no secondhand smoke from using electronic cigarettes. Consequently, it is inappropriate to treat them in the same way as tobacco products by prohibiting their use in public places."

It is interesting to note that PHE identified a key issue with licensed nicotine replacement therapy products:

"*...even with a relaxation of the licensing restrictions which increased their accessibility, NRT products have never become popular as an alternative to smoking.*"

As PHE pointed out:

"*EC should not routinely be treated in the same way as smoking. It is not appropriate to prohibit EC use in health trusts and prisons as part of smokefree policies unless there is a strong rationale to do so.*"

It is completely within the spirit of PHE's findings to suggest that the same is true for enclosed spaces generally, particularly in the context of the potential public health benefits from more smokers switching to vaping.

ASH UK raised this issue, too:

> *"When considering enforcement of the smoke-free public places legislation it is important to take into account the potential impact of extending the regulation to people who are using electronic cigarettes as a means of quitting or reducing their harm from smoking. If there was a ban on using these devices in all enclosed public places, users could be less inclined to use them which could result in more of them reverting back to smoking. Prohibition would also increase the likelihood that vapers and smokers would effectively be required to share the same spaces. This not only potentially undermines quit attempts but would also expose users of electronic cigarettes to secondhand smoke."*

- ***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)?***

We do not have any comment on the tobacco aspect of this question, as it falls outside our area of expertise. However, since there is no evidence that justifies a ban on the use of e-cigarettes in enclosed spaces, there is no justification at all for a ban in non-enclosed spaces. We would, however, consider that there may be places or circumstances in which a business or organisation might want to introduce a ban through their own policy, and this is entirely reasonable.

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

No. In order for e-cigarettes to achieve the maximum possible health gain, as a consumer product, they have to appeal to smokers. The ability to use electronic cigarettes in places where smoking is prohibited adds to the value of e-cigarettes to smokers who are unlikely to seek NRT or other products marketed for smoking cessation. Everything that reduces the appeal of e-cigarettes, compared to continued smoking, is likely to have a negative effect on public health. Where this reduction in appeal relates to improved safety of e-cigarettes, this might be justified, but where it is based on entirely theoretical risks that are unsupported by any current evidence, the disbenefits are likely to cost lives.

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

There is no evidence for the potentially condescending notion that people are unable to distinguish between them. Electronic cigarettes are increasingly dissimilar to tobacco cigarettes, and the absence of smoke continues to make the difference very apparent. Another very observable difference is that, for the

moment, electronic cigarette use remains legal and commonplace in enclosed and partially enclosed public places. It is possible that the use of electronic cigarettes may normalise the use of electronic cigarettes, but the smell of smoke, ash and 'dog ends' will continue to make smoking strikingly different – and by contrast, strikingly unpleasant.

Insofar as there is a risk of people conflating e-cigarettes and tobacco cigarettes, it is in the false belief – identified by Public Health England – that the harm is the same. It is important to ensure the public is properly informed about the difference. The proper response, from a public health point of view, is not to treat them as similarly as possible in spite of important differences; it is to ensure that people who falsely believe the harms are the same become more aware of the harm reduction potential of electronic cigarettes.

- ***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?***

While the use of potentially addictive products by youth is a clear cause for concern, and we have always supported a mandated age limit for sales, there is considerable evidence from within the UK that indicates that youth uptake (despite the current lack of a mandated age limit) is currently very low, and almost exclusively in existing smokers. There is no indication of any effects that would change this, although we agree with the public health experts that this requires continuous monitoring. The evidence so far demonstrates that electronic cigarettes are a gateway for smokers away from tobacco - not a gateway for non-smokers to smoking tobacco products.

- ***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?***

Compliance with the existing smoke-free legislation is extremely good, and has continued to be so while the use of e-cigarettes has increased. It is, therefore, not clear how extending this restriction to the use of e-cigarettes can have a significant beneficial effect. Insofar as the proposed ban gives managers another responsibility on top of many others, it could be expected to limit the time they can devote to enforcement of existing legislation.

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

No.

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

Yes. Enforcement action of all types will be facilitated by having a register of all vendors of tobacco and other nicotine containing products.

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

With the imminent introduction of a minimum age of sale for electronic cigarettes, something ECITA has always called for, having a register will be of considerable benefit to enforcement agents in checking that vendors are meeting their obligations.

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

There appears to be very little information on how the existing regime is working, making it hard to answer this question meaningfully.

- ***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?***

While in principle we would support this, this is an area where there is the potential for this to be problematic. While older youths purchasing vaping products for younger children should be prohibited, it seems counterintuitive that a parent should not be able to purchase, for their smoking child, vaping products as a means of harm reduction. Nicotine replacement therapies are considered suitable for those aged 12 and over. While in the future, it is possible that a medicinal e-cigarette would fill a similar niche, currently this would make non-medicinal (i.e. more appealing) harm reduction products unavailable to smoking teens. On balance, we believe this measure is justified, however, the potential for adverse effects should be considered carefully.

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

No. The potential for the proposals to reduce the appeal of e-cigarettes to existing smokers is likely to do significant harm. If even a few smokers are dissuaded from switching away from smoking, the net effect will be negative, as indicated in our report "*Banning e-cigarettes in public places: the unintended harm to smokers and non-smokers*" which is included with this response.

The report uses data from the Public Health (Wales) Bill's Explanatory Memorandum to calculate the harm in Quality Adjusted Life Years if only small percentages of Welsh non-smoking vapers return to smoking as

a consequence of the ban. If only 5% of non-smoking vapers return to smoking tobacco cigarettes, between 1,646 and 4,334 QALYs would be lost, at a value of between £99 and £260 million.

Relapse rate	Number of new smokers	Quality adjusted life years lost, population level (range) [6]	Cost of shortened lives (range), £ [7]
5%	1,680	1,646 – 4,334	£99 - 260 million
10%	3,360	3,293 – 8,669	£198 - 520 million
15%	5,040	4,939 – 13,003	£296 - 780 million
20%	6,720	6,586 – 17,338	£395 – 1,040 million

There are also major potential opportunity costs if the ban results in fewer of Wales's more than 500,000 existing smokers moving away from tobacco cigarettes to electronic cigarettes:

If as few as an extra 1% of smokers decline to take up e-cigarettes instead of tobacco cigarettes, between 5,042 and 13,274 QALYs would be lost, at a value of between £303 and £796 million.

Smokers who would otherwise have quit (as % of smoking population)	Smokers who would otherwise have quit (number)	Quality Adjusted Life Years lost, population level (range)	Cost of shortened lives (range), £
1%	5,145	5,042 - 13,274	£303 - £796 million
2%	10,290	10,084 - 26,548	£605 - £1,593 million
3%	15,435	15,126 - 39,822	£908 - £2,389 million
4%	20,580	20,168 - 53,096	£1,210 - £3,186 million
5%	25,725	25,210 - 66,370	£1,513 - £3,982 million

As PHE recommended:

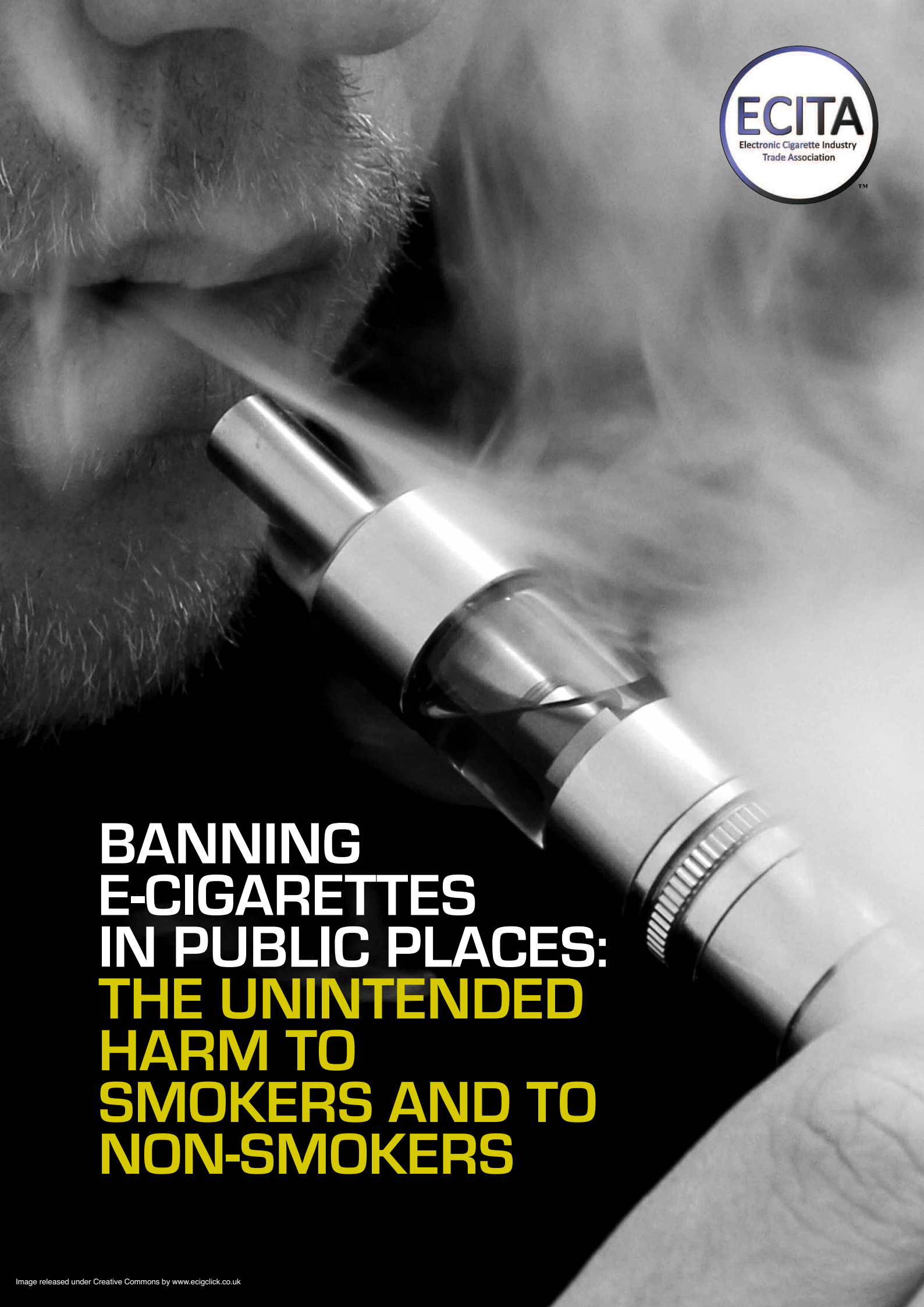
> "*Consideration could be given to a proactive strategy to encourage disadvantaged smokers to quit smoking as quickly as possible including the use of EC, where appropriate, to help reduce health inequalities caused by smoking.*"

We agree with another policy recommendation made by Public Health England in their recent report on e-cigarettes:

> "*Regulatory interventions should ensure optimal product safety but make sure EC are not regulated more strictly than cigarettes and can continue to evolve and improve their competitiveness against cigarettes.*"

Regulatory proposals that reduce the appeal of e-cigarettes to smokers **but without having any effect on safety** seem ill-considered, and fail to consider the possible negative outcomes. As PHE pointed out:

> "*Encouraging smokers who cannot or do not want to stop smoking to switch to EC could be adopted as one of the key strategies to reduce smoking related disease and death.*"



ECITA
Electronic Cigarette Industry Trade Association
™

BANNING E-CIGARETTES IN PUBLIC PLACES: THE UNINTENDED HARM TO SMOKERS AND TO NON-SMOKERS

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Trade Association
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Executive Summary

The Welsh Government's proposed ban on electronic cigarettes in public places could be extremely costly to Welsh citizens, according to the Welsh Government's own data, analysed in this report.

A worst case scenario based on conservative estimates of the numbers of people who will return to cigarettes, and the numbers who will continue smoking rather than begin 'vaping', implies:

- Welsh citizens as a whole losing almost **84,000** (quality adjusted) years of life, and;
- the loss of the equivalent of over **£5 billion**.

The Welsh Government is currently proposing a ban on vaping in all bars, restaurants and workplaces – treating e-cigarettes in the same way as tobacco products. This is despite overwhelming evidence of harm reduction when smokers switch to electronic cigarettes. Tobacco cigarettes are currently responsible for one in six deaths in the UK. Nearly all vapers are former or current smokers; a negligible number of vapers have never smoked.

The ban would force vapers out into smoking areas. This risks many of Wales's 33,600 non-smoking vapers falsely believing that the harm from e-cigarettes is the same as tobacco, and bowing to peer pressure to return to cigarettes.

The risk of relapse

According to the Welsh Government, each person returning to smoking would lose an average of between 0.99 and 2.58 years of life, quality adjusted (i.e. QALYs).

If 20% of Welsh vapers return to smoking, between 6,586 and 17,338 quality adjusted years of life would be lost.

This would cost the Welsh economy up to **£1.04 billion.** (Each QALY is valued at £60,000.)

Opportunity costs

The opportunity costs of a ban are even greater. Every existing smoker who switches to e-cigarettes would also gain the same number of extra life years.

Quality Adjusted Life Years – QALYs – are years of life, adjusted for quality, such that 10 years of life in perfect health equates to 10 QALYs while the same 10 years of life at 50% quality of life would equate to 5 QALYs.

If the ban results in only 1 smoker in 100 continuing to smoke when they would otherwise have switched, that means 5,145 more smokers and a consequent loss of an extra **5,042** to **13,274** quality adjusted life years. The cost cost of these shortened lives would be as much as **£796 million**.

If 5% of existing smokers would otherwise have switched, that means 25,725 more smokers and a consequent loss of an extra **25,210** to **66,370** quality adjusted life years. The cost would be as much as **£3.98 billion**.

Recommendations

1.	The Welsh Government should re-examine the case for banning vaping in enclosed and semi-enclosed public places in light of the above figures, taken from its own data. The ban risks considerable harm to Welsh citizens and to the Welsh economy and NHS.
2.	The Welsh Government should respond in full to the evidence from the August 2015 report from Public Health England 'E-cigarettes: an evidence update' in deciding the future of the Public Health (Wales) Bill. The Public Health England report noted that "the current best estimate [is] that using EC [e-cigarettes] is around 95% safer than smoking" and warned against an inaccurate perception of e-cigarettes as at least as harmful as cigarettes. The Public Health England report also noted that there are no identified health risks to bystanders from e-cigarettes; that there is no evidence e-cigarettes are undermining the decline in tobacco smoking and may be contributing to it; that e-cigarettes are attracting very few people who have never smoked into regular e-cigarette use; that e-cigarettes demonstrably help people quit smoking and reduce cigarette consumption; and recommended that any new regulation of the sector should "maximise the public health opportunities" of e-cigarettes.
3.	The Welsh Government should investigate the potential for exclusive e-cigarette smokers to relapse to smoking if a ban on vaping in public places is introduced, damaging public health in Wales. The same risks are posed to current smokers who may in the future opt for e-cigarettes. Given the evidence above, failure to distinguish between greater harms and much lesser harmscreates significant possible unintended consequences, which have a very real prospect of damaging the health of Welsh citizens.

The risk of relapse

The Welsh Government is currently proposing a ban on vaping in all bars, restaurants and workplaces – treating e-cigarettes in the same way as tobacco products. This is despite overwhelming evidence of harm reduction when smokers switch to electronic cigarettes. Cigarettes are currently responsible for more preventable deaths and ill health than any other cause.[1]

Electronic cigarettes or e-cigarettes are already having considerable success in reducing this harm. Nearly all vapers are former or current smokers: a negligible number of vapers have never smoked. In the Great Britain as a whole, Action on Smoking and Health estimates that there are currently 2.6 million adults in Great Britain using electronic cigarettes. Of these, approximately 1.1 million (42%) are ex-smokers while 1.4 million (54%) continue to use tobacco alongside their electronic cigarette use.[2]

Quality Adjusted Life Years – QALYs – are years of life, adjusted for quality, such that 10 years of life in perfect health equates to 10 QALYs while the same 10 years of life at 50% quality of life would equate to 5 QALYs.

The proposed ban would force vapers to join smokers in smoking areas if they wish to vape. The ban also risks many of Wales's 33,600 non-smoking vapers[3] falsely coming to believe that the harm from e-cigarettes is the same as tobacco. Despite the best efforts of Public Health and Tobacco Control, smoking is still considered normal – more so than the use of e-cigarettes. This means that if vapers are pushed out into smoking areas, peer pressure may well force them back into smoking.

According to the Welsh Government, each person returning to smoking would lose an average of between 0.99 and 2.58 years of life, quality adjusted (ie QALYs).[4]

If 20% of Welsh vapers return to smoking, between 6,586 and 17,338 quality adjusted years of life would be lost.

This would cost £1.04 billion in shortened lives. (Each QALY is valued at £60,000.[5])

1 Public Health (Wales) Bill Explanatory Memorandum, http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=12763, p.10

2 Use of electronic cigarettes (vapourisers) among adults in Great Britain, Action on Smoking and Health, May 2015, http://www.ash.org.uk/files/documents/ASH_891.pdf, p.1

3 Public Health (Wales) Bill Explanatory Memorandum, http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=12763, p.116

4 Ibid

5 Ibid, p.188

Relapse rate	Number of new smokers	Quality adjusted life years lost, population level (range) [6]	Cost of shortened lives (range), £ [7]
5%	1,680	1,646 – 4,334	£99 - 260 million
10%	3,360	3,293 – 8,669	£198 - 520 million
15%	5,040	4,939 – 13,003	£296 - 780 million
20%	6,720	6,586 – 17,338	£395 – 1,040 million

6 Range of QALY lost calculated by multiplying the number of new smokers by both the lower and upper estimate of QALY gained by quitting smoking.

7 Range of costs calculated by multiplying the lower and upper lost QALY numbers by £60,000.



Vaping vs. Smoking I E-Cigarette/Electronic Cigarette/E-Cigs/E-Liquid/Vaping/Cloud Chasing, released under a Creative Commons license by Vaping360.com (Vaping360)

The opportunity cost: smokers who don't quit

The opportunity costs of a ban are even greater. Every existing smoker who switches to e-cigarettes would also gain between 0.99 and 2.58 extra quality adjusted life years.

The Welsh Government estimates there are 514,500 smokers in Wales.[8]

If the ban results in only 1 smoker in 100 continuing to smoke when they would otherwise have switched, that means 5,145 more smokers and a consequent loss of an extra 5,042 to 13,274 quality adjusted life years. The cost in shortened lives would be as much as £796 million.

If 5% of existing smokers would otherwise have quit, that means 25,725 more smokers and a consequent loss of an extra 25,210 to 66,370 quality adjusted life years. The cost would be as much as £3.98 billion.

Smokers who would otherwise have quit (as % of smoking population)	Smokers who would otherwise have quit (number)	Quality Adjusted Life Years lost, population level (range)	Cost of shortened lives (range), £
1%	5,145	5,042 - 13,274	£303 - £796 million
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4%	20,580	20,168 - 53,096	£1,210 - £3,186 million
5%	25,725	25,210 - 66,370	£1,513 - £3,982 million

8 Public Health (Wales) Bill Explanatory Memorandum, http://www.senedd.assembly.wales/mgIssueHistoryHome.aspx?IId=12763, pp.116-117

Combining these tables gives the following best and worst case scenarios.

	Smokers who would have quit + vapers who relapsed (number)	Quality Adjusted Life Years lost, population level (range)	Cost of shortened lives (range), £
Best case scenario (5% relapse and 1% of smokers who would otherwise have quit)	6,825	6,757 – 17,609	£405 - £1,057 million
Worst case scenario (20%	32,445	32,121 – 83,708	£1,927 - £5,022 million



Vaping vs. Smoking I E-Cigarette/Electronic Cigarette/E-Cigs/E-Liquid/Vaping/Cloud Chasing, released under a Creative Commons license by Vaping360.com (Vaping360)

Electronic cigarettes: the evidence and reactions

Public Health England

- "The current best estimate is that e-cigarette use is around 95% less harmful to health than smoking… over the last year, there has been an overall shift among adults and youth towards the inaccurate perception of e-cigarettes as at least as harmful as cigarettes."[9]
- "e-cigarettes release negligible levels of nicotine into ambient air with no identified health risks to bystanders"[10]
- "Encouraging smokers who cannot or do not want to stop smoking to switch to EC could help reduce smoking related disease, death and health inequalities"[11]
- "new regulations currently planned should also maximise the public health opportunities of EC"[12]
- "There is no evidence that EC are undermining the long-term decline in cigarette smoking among adults and youth, and may in fact be contributing to it. Despite some experimentation with EC among never smokers, EC are attracting very few people who have never smoked into regular EC use."[13]
- "Recent studies support the Cochrane Review findings that EC can help people to quit smoking and reduce their cigarette consumption. There is also evidence that EC can encourage quitting or cigarette consumption reduction even among those not intending to quit or rejecting other support."[14]
- "EC should not routinely be treated in the same way as smoking. It is not appropriate to prohibit EC use in health trusts and prisons as part of smokefree policies unless there is a strong rationale to do so."[15]

9 E-cigarettes: a new foundation for evidence-based policy and practice, Public Health England, 19 August 2015, at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454517/Ecigarettes_a_firm_foundation_for_evidence_based_policy_and_practice.pdf, p.4

10 Ibid

11 E-cigarettes: an evidence update, Public Health England, 19 August 2015, at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454516/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England.pdf, p.6

12 Ibid

13 Ibid

14 Ibid

15 Ibid

Action on Smoking and Health

- "ASH estimates that there are currently 2.6 million adults in Great Britain using electronic cigarettes. Of these, approximately 1.1 million are ex-smokers while 1.4 million continue to use tobacco alongside their electronic cigarette use. Regular use of the devices is confined to current and ex-smokers and use amongst never smokers remains negligible."[16]
- "As they do not produce smoke, research suggests that electronic cigarettes are relatively harmless in comparison with smoking."[17]

Cancer Research UK

- "It is important that regulation does not stifle the development of e-cigarettes nor make accessing these products more difficult for smokers… At present, we do not believe there is enough evidence to justify an indoor ban on e-cigarettes."[18]

Professor Robert West, Director of Tobacco Research, University College London

- "On the science, we'd say there are no grounds for banning it in public because there isn't a risk to bystanders."[19]

16 Use of electronic cigarettes (vapourisers) among adults in Great Britain, Action on Smoking and Health, May 2015, http://www.ash.org.uk/files/documents/ASH_891.pdf, p.1

17 Regulating nicotine products, Action on Smoking and Health, at http://www.ash.org.uk/current-policy-issues/harm-reduction-product-regulation/regulating-nicotine-products

18 Cancer Research UK Briefing: Electronic Cigarettes, Cancer Research UK, March 2015, at http://www.cancerresearchuk.org/sites/default/files/policy_march2015_ecigarettes_briefing.pdf, p.1

19 E-cigarettes: is vaping any safer than old-fashioned smoke?, Will Storr, The Guardian, 13 December 2014, at http://www.theguardian.com/society/2014/dec/13/e-cigarettes-vaping-safe-old-fashioned-smoke

20 RCP welcomes evidence review on e-cigarettes, Royal College of Physicians, 19 August 2015, at https://www.rcplondon.ac.uk/press-releases/rcp-welcomes-evidence-review-e-cigarettes

21 RCP statement on e-cigarettes, Royal College of Physicians, 25 June 2014, at https://www.rcplondon.ac.uk/press-releases/rcp-statement-e-cigarettes

Royal College of Physicians

- "[E]-cigarettes are not a significant gateway into smoking for a new generation. Instead they will help existing generations of smokers to give up, reducing smoking related harm and saving lives."[20]
- "On the basis of available evidence, the RCP believes that e-cigarettes could lead to significant falls in the prevalence of smoking in the UK, prevent many deaths and episodes of serious illness, and help to reduce the social inequalities in health that tobacco smoking currently exacerbates."[21]

20 RCP welcomes evidence review on e-cigarettes, Royal College of Physicians, 19 August 2015, at https://www.rcplondon.ac.uk/press-releases/rcp-welcomes-evidence-review-e-cigarettes

21 RCP statement on e-cigarettes, Royal College of Physicians, 25 June 2014, at https://www.rcplondon.ac.uk/press-releases/rcp-statement-e-cigarettes

Recommendations

1.	The Welsh Government should re-examine the case for banning vaping in enclosed and semi-enclosed public places in light of the above figures, taken from its own data. The ban risks considerable harm to Welsh citizens and to the Welsh economy and NHS.
2.	The Welsh Government should respond in full to the evidence from the August 2015 report from Public Health England 'E-cigarettes: an evidence update' in deciding the future of the Public Health (Wales) Bill. The Public Health England report noted that "the current best estimate [is] that using EC [e-cigarettes] is around 95% safer than smoking" and warned against an inaccurate perception of e-cigarettes as at least as harmful as cigarettes. The Public Health England report also noted that there are no identified health risks to bystanders from e-cigarettes; that there is no evidence e-cigarettes are undermining the decline in tobacco smoking and may be contributing to it; that e-cigarettes are attracting very few people who have never smoked into regular e-cigarette use; that e-cigarettes demonstrably help people quit smoking and reduce cigarette consumption; and recommended that any new regulation of the sector should "maximise the public health opportunities" of e-cigarettes.
3.	The Welsh Government should investigate the potential for exclusive e-cigarette smokers to relapse to smoking if a ban on vaping in public places is introduced, damaging public health in Wales. The same risks are posed to current smokers who may in the future opt for e-cigarettes. Given the evidence above, failure to distinguish between greater harms and much lesser harmscreates significant possible unintended consequences, which have a very real prospect of damaging the health of Welsh citizens.

About ECITA

Founded in March 2010, ECITA (EU) Ltd is the longest-running trade association for the electronic cigarette industry anywhere in the world, with members across England, Scotland and Wales. We are also one of only two e-cigarette trade associations in the world which is not managed/operated by those engaged in the sale of vaping products, directly or indirectly, which makes it easier for us to represent the interests of our members – and their customers – fairly and fully.

We developed the Industry Standard of Excellence, and our members are audited bi-annually to ensure they are fully compliant with all the legal requirements. We also sponsored and provided Technical Authorship for the British Standards Institution PAS 54115, Vaping products, including electronic cigarettes, e-liquids, e-shisha and directly-related products – Manufacture, importation, testing and labelling – Guide, which was published in July 2015.

The ECITA name is recognised internationally as synonymous with the Industry Standard of Excellence, so displaying our logo on your site and promotional materials immediately tells consumers that you are a serious vendor who has made a genuine commitment to the Standard of Excellence. ECITA membership provides a comprehensive program of assistance with compliance with the law as it currently stands and as it changes over time. We provide advice and support to all of our members to ensure that the necessary legal measures have been followed, and that they have the correct legal documentation to prove their due diligence.

For information about joining ECITA please contact Katherine Devlin at [redacted] or telephone us on [redacted]

Members

blu -
www.blu.co.uk

Concept Liquids -
www.conceptliquids.com

Cuts Ice E-Liquid Laboratories -
www.cutsice.com

Decadent Vapours -
www.decadentvapours.com

e-cigarette DIRECT -
www.ecigarettedirect.co.uk

Halcyon Haze -
www.halcyonhaze.co.uk

HouseOfLiquid -
www.houseofliquid.com

iBreathe -
www.i-breathe.co.uk

JAC Vapour -
www.jacvapour.com

Liberro -
www.liberro.co.uk

Liberty Flights -
www.liberty-flights.co.uk

Mirage -
www.miragecigarettes.co.uk

No-Match -
www.no-match.co.uk

Socialites -
www.socialiteszero.com

T Juice -
www.t-juice.com

TABlites -
www.tablites.com

Vaper Trails -
www.vapertrail.co.uk

Vapestick -
www.vapestick.co.uk

Vaporized -
www.vaporized.co.uk

Vapourlites -
www.vapourlites.com

VIP Electronic Cigarette -
vipelectroniccigarette.co.uk

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 Merthyr Tydfil County Borough Council – PHB 51 / Tystiolaeth gan Cyngor Bwrdeistref Sirol Merthyr Tudful – PHB 51

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
YES. *The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason. Directors of Public Protection in Wales published its views on the availability and use of e-cigarettes in 2013, which included several examples* where the enforcement of the ban on smoking in enclosed public places had been undermined by claims of the use of e-cigarettes. Local authorities have had legal actions fail because offenders claimed they were using e-cigarettes. However, whilst the following examples illustrate enforcement challenges, MTCBC feel it is important to underline that the ban on smoking in public places is almost entirely self-policing by the public... and has been highly successful. The use of E-cigarettes in smoke-free areas poses a threat to that self-policing. E-cigarettes also undermine the ability of managers of premises to enforce smoke free places, leading to many business banning them.*

Question 2

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?

Yes.
Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation and their potential impact upon smoke free environments.
We are also concerned by reports that e-cigarettes may intentionally or inadvertently promote or normalise smoking and therefore promote smoking amongst those who currently do not smoke.
In particular we feel there is a need to make every effort to deter young people from becoming smokers.
We note the cautionary words of England's Chief Medical Officer that e-cigarettes should only be used to help smokers quit.

Question 3

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?

Data relating to smoking behaviour in Wales leads us conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach. We take the view that anything that has the appearance of smoking may help "normalise" smoking culture and behaviour and undermine this approach.

Question 4

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?

We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours. We are therefore concerned by those reports that suggest that young people who are non-smokers may be attracted to e-cigarettes.
The use, marketing and sale of e-cigarettes should be controlled to reduce the risk of young people becoming addicted to nicotine. We have witnessed e-cigarettes being displayed for sale with sweets, at child height, at the checkout in some stores.
Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as "Gummy Bear", "Cherry Cola" and "Bubble Gum".
Some products are being packaged and marketed in a way that is closely associated with that of conventional cigarettes. For example, some e cigarettes glow and emit a vapour. We also note the nature of some e-cigarette advertising; e.g. consistent with the 1950's style marketing of tobacco products.

Question 5

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

Yes. MTCBC supports the proposal. Our experience of implementing similar schemes leads us to conclude that such an approach, supported by suitable enforcement powers, can help control regulated activities.

Question 6

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?

MTCBC agrees with the proposal. It will align tobacco and alcohol which has already has a proxy supply offence.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators. MTCBC is of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators. MTCBC has the following concerns regarding existing provisions: • There are no specific requirements for a practitioner to have training or experience relating to skin piercing prior to setting up such a business. This would only be covered under general H&S legislation. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk. • Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the Local Government (Miscellaneous Provisions) Act 1982. This may be viewed as a purely administrative offence when Courts are considering sentencing. • Current registration requirements rely on Local Authorities being able to prove that a person is carrying on a business. As the majority of unregistered tattooists ('scratchers') work from domestic premises it is difficult to prove that it is a business and they deny that they receive payment. • There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws and the magistrate cancelled a previous registration. However, Local Authorities are still reliant on the applicant informing them that they have been prosecuted in another area. • The current application process does not require any proof of identity, criminal records checks or "fit and proper person test", therefore, even if an applicant had been prosecuted in another LA then there would be no way of knowing. • Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and The Health and Safety at Work etc. Act 1974. Several local authorities in Wales have used Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle

"scratchers".

- When we last gathered information on this, we found that between July 2012 and July 2013, ten applications for Part 2A Orders had been made by local authorities; all of which related to the carrying out of unregistered tattooing from domestic premises.
- A domestic premises can be registered to carry out skin piercing and comply initially with the byelaws. However, unless there is a separate entrance, the Health and Safety Executive are responsible for the enforcement of H&S legislation within that premises. Our experience in Newport is that the HSE have previously been reluctant to transfer enforcement responsibility to local authorities in such a situation. Therefore, if there is a serious risk such as lack of sterilisation, Officers are unable to serve prohibition notices as they would in a commercial setting. The only option would be to simply prosecute for non-compliance with the byelaws or to apply to the courts for a Part 2A order- both being a time consuming process.
- New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.
- Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.

We would offer the following observations on the proposal regulations:
•Level 3 fine (£1,000) is perhaps a little low. This should be worded more strongly – we understand that the experience of Caerphilly and BG is that multiple convictions of an individual resulting in low fines have not deterred the individual from illegal tattooing.
•In determining whether to grant a license a Local Authority should be able to consider whether the applicant is a "fit and proper person" and such a test should be included (akin to our tried and tested procedures for taxi licensing). The test should permit the LA to take into account "any other information" (beyond the "relevant offences" listed in the draft bill) in determining that question. The current proposals do not offer sufficient safeguards.
•We would be opposed to grandfather rights for existing traders. Our officers have only recently dealt with a high profile public health incident in South Wales which related to a long-standing operator.

Question 8

Do you agree with the types of special procedures defined in the Bill?
Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses. However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure

that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future.

Question 9

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

We support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. Other procedures are already becoming more popular e.g. branding, dermal implants, microdermabrasion. All these procedures provide the potential for serious harm and infection.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive activities underground and cause further issues or potentially make it more appealing to some people.

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver. The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to. There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
Yes. Local authority officers are aware that such procedures are taking place and it is our view that such intimate procedures on under 16s should be illegal to protect this vulnerable group from potential risks. It is also agreed that even with parental consent these procedures should not be permitted. Because of the higher risks associated with intimate piercings, coupled with the relative vulnerability and immaturity of some 16 and 17 year olds, MTCBC considers there is a strong case for setting the age limit at 18. This would offer further protection to a greater number of young people.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
Yes. However we also feel there is a case to add the tongue. In addition to the relatively higher risks of infections associated with tongue piercing, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list of intimate parts.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?

We recognise all too clearly the current financial pressures on local authorities. We question whether placing a duty on local authorities to develop a strategy is appropriate, acknowledging firstly the difficult financial climate within which any duty would consume resource and secondly that a strategy will not of itself bring about enhanced provision. Care is needed that WG does not merely impose an administrative and financial burden that delivers no real benefit to the public.

Question 16

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

See response to q15

Question 17

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?

The consultation requirements set in para 92 are too vague to be meaningful.

Other comments

Question 19

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

Yes

Question 20

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

Through our licensing teams and through a broad range of officers working closely with local residents in our communities, we are all too familiar with the problems caused by alcohol. However, we understand that Minimum Unit Pricing is a proposal to be taken forward in a future draft bill – something that we would welcome and will be pleased to work with officials working towards that.

We are also aware of public health concerns around obesity, nutrition and exercise – and we have an interest in this area through our vital role in relation to the regulation of food standards and food labelling and our general contribution to the wider public health agenda. We acknowledge the potential contribution of the Future Generations Act and Active Travel Act for example in this area but note also the potential for planning controls and licensing arrangements to play a greater part. We also recognise that some of these issues may need action at the level of UK Government.

In our submission in advance of the White Paper we also raised the possibility of considering an overarching general offence of prejudicing public health …. enabling appropriate bodies to protect public health in situations which fall outside existing legislation.

We are increasingly concerned by the supply of products known as "legal highs".

Question 21

Are there any other comments you would like to make on any aspect of the Bill?

Special Procedures

- The consideration of 'fit and proper' should extend the relevant offences to cover assault, sexual offences and possibly drugs. The issue here is that many of the special treatments are intimate and carried out in privacy which could lead to customers being placed in a very vulnerable situation. This is aligned to consideration of 'relevant offences' of licensed vehicle drivers.
- Concerns regarding the 3 year licensing regime particularly with regards to the requirement of the register. Customers will see the register as an assurance. In reality, Local Authorities may not be aware of any convictions or relevant offences in the 3 year period. Therefore, it would be more appropriate to introduce annual licensing to provide a more robust assurance.
- In light of the recent case law Westminster vs Hemmings, LA can charge for enforcement contrary to the wording in para 603. Additionally, it could be argued that the fees could cover the cost for the central register (para 628)

Special Procedures – if the offence deterrent includes the possibility of a custodial sentence in excess of 6 months that will enable local authorities to apply for RIPA authorisation from the Magistrates Court when necessary. This would enable us to be able to undertake surveillance on a private dwelling where illegal tatooing may be taking place for example, which we may need in order to provide sufficient evidence for the Magistrates to issue a warrant for Power of Entry when we subsequently apply for this

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

Evidence from Cardiff third Sector Countil (with input from GVS) – PHB 52 / Tystiolaeth gan Cyngor Trydydd Sector Caerdydd (gyda mewnbwn gan GVS) – PHB 52

Public Health (Wales) Bill: Consultation questions

All unanswered questions have been removed, so only the ones relevant to this response are included below.

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
Yes, a number of national and international bodies, namely US Food and Drug Administration, World Health Organisation, BMA and ASH have identified a number of potential risks to health and propose that a precautionary approach is adopted until further information becomes available. As a result, the current requirement for all Public Health Wales buildings to be e-cigarette free should be applied to all enclosed public and work places. (Ref: http://www2.nphs.wales.nhs.uk:8080/phwpapersdocs.nsf/($all)/5f0bc2a265e30d0380257dd30054d655/$file/36%2014%20smoke%20free%20environment%20policy%20v1.pdf)

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15, 16, 17 & 18

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?
Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
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?
What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
A strategy is useless unless it is enacted upon, therefore is a duty for a local toilet strategy going to distract from the actual provision of toilet facilities? The requirement needs to sit with planning departments and should be considered on every planning application outside of individual house adaptations. The provision and access to public toilets is vital for people living with a disability, long term health condition and older people. This is not just about providing the additional facilities for changing facilities for babies or disabled people, it is providing the facilities to start with. Many health conditions can cause people to become isolated and unable to leave their homes unless they have confidence that venturing out will be a worthwhile and positive experience. Access to public toilet facilities is essential to ensure people are able to continue with their everyday life with peace of mind that, if required, they will have access to use toilet facilities quickly which are easily available and accessible. Without proper toilet facilities older people will be more inclined to stay at home and lose their link to their communities, and experience social isolation with a subsequent impact on mental and physical health. The `Magic Key' giving people access to disabled toilets is seen as a huge asset

to people using this service, but if the facilities are not there in the first place then the key is useless. Disabled toilets also need to be in an appropriately accessible location. For new buildings there should be a requirement for a changing room to be included in the facility itself, with space for a full length / width changing bench plus ceiling hoist or mobile hoist, and room for a wheelchair with circulation space and room for 2 carers.

There was a drive recently to involve establishments in Cardiff to open their toilets for non-customer use. With the financial constraints on local authorities and the cost involved in providing public toilets, it would be useful if this was more of a `provision' by an establishment (possibly as part of obtaining a licence) to ensure that facilities are openly available not based on goodwill. Whilst this may work in a city like Cardiff, a reliance on community toilet scheme facilities may not be sustainable in rural areas where there may be few facilities available in local shops etc. Furthermore, this could move the responsibility to provide toilet facilities from local authorities onto local businesses.

There are examples from across the UK in which community volunteers have taken on the management of existing toilet facilities, often where there are limited other local services. This relies on the goodwill of local residents; it is not the most attractive volunteering opportunity, and may not be sustainable long term and again removes responsibility from local authorities.

The closure of public toilets poses a real public health risk which affects everyone, according to the Older Persons' Commissioner. There is an increase in the risk of heart attacks and strokes, for example, due to a temporary increase in blood pressure caused by not being able to empty one's bladder. (Ref: http://www.olderpeoplewales.com/Libraries/Uploads/The_Importance_and_Impact_of_Community_Services_within_Wales.sflb.ashx)

A map showing the vicinity of public toilets across each Local Authority area would also be a useful tool. It is crucial that the needs of older people, people with a disability and/or long term health condition are considered as part of any strategy to ensure there are plenty of public toilets available, fit for purpose and accessible.

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

Evidence from The British Toilet Association – PHB 53 / Tystiolaeth gan Cymdeithas Toiledau Prydain – PHB 53

The British Toilet Association Ltd
Enterprise House, 2-4 Balloo Avenue
Bangor, Co. Down, Northern Ireland, BT19 7QT
Tel: [redacted] Mob: [redacted]

The British Toilet Association Limited
Is a Not-for-Profit Members Organisation working to promote the highest standards of hygiene and provision in all "away from home" toilet facilities across the UK. The Association, as a whole, has a wealth of knowledge on toilet related issues and practices and every day handles a constant stream of enquiries from everyone who has a real desire to help improve the current provision as well as reduce the number of toilet closures. We support consumers and suppliers alike on the future development and installation of more hygienically clean publicly accessible toilets across the country. Our survey team carries out a number of consultations each year, which can include a wide variety of detailed reporting on: toilet facilities and their fixtures, hygiene, cleaning, design and innovation, specification and maintenance, current & future provision along with change of purpose, use and operation. As an independent body we are frequently invited to give an opinion, statement or judgement regarding legal issues and regulation revolving around publicly accessible toilets. Having access to a wealth of knowledge through our growing membership can allow us to be proactive in many instances. We are currently developing a Toilet Map project that will greatly enhance the public's quest for finding a decent clean – open – facility as the map will contain/identify all recorded sites and then give a detailed profile of what each contains.

Written Evidence on the general principles of the Public Health (Wales) Bill.

Part 6 – Provision of Toilets

Question 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?

The BTA fully supports – Option 3 of the proposal – to place every council in Wales under a duty to prepare a local strategy for the provision of public toilets.

However, very careful consideration must be given to the foundation of these strategies to make sure that authorities continue to control and administer the correct levels of provision. It would not be acceptable for councils to devise a strategy that pushes the total responsibility onto other providers – whether community or private – and thereby relinquishes all responsibility for the strategy. A combination of council and community toilets working in tandem/partnership is probably the most effective overall solution across the country – but especially in the less populated towns and villages. Individual strategies should not allow councils to completely opt-out of providing toilets.

Since the Public facilities Grant was withdrawn in 2014 and the monies transferred to the Revenue Support Grant in a move to increase flexibility of funding to local authorities, it is our understanding that only a very small proportion of this money was in fact used for the provision of toilets. We believe that the impetus has been lost and the department would need to revisit this funding structure and make sure that monies originally intended to improve public provision are ring-fenced for that purpose.

When any of us are travelling and away from home for an extended time, we will on one or more occasions require the use of a decent, clean toilet. There are also an increasing number of specialist user groups, whose lives are adversely affected by the poor state public toilets across the country. These include people with mental or physical disabilities and their carers; older persons and many focus groups; families with babies or young children, schoolchildren and residents and visitors of all ages who are coping with a range of medical conditions. This is a basic human function and we need to have a greater level of adequate provision for everyone and anyone who has a sudden urge to find relief when they are away from their normal residence. It's a problem faced by thousands of people every day, truck/lorry and van

drivers, car drivers and that includes taxi & private hire, coach drivers and passengers, emergency services and transient workers.
The failure to get to or use a toilet, when the need arises to, can very often lead to both embarrassing medical and social problems.

Question 2: Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
Public toilets – owned or operated by local authorities – have historically fallen into a shared responsibility over a number of departments. This has made overall management and ultimate responsibility difficult to assign, and in many cases has led to neglect and the lowering of acceptable standards in many facilities across the country. The preparation of a toilet provision strategy can only have extremely beneficial outcomes in focussing attention onto this vital provision for so many independent users. With improved management and a clearer understanding of the needs of residents and visitors, must come higher standards of health and hygiene.

Question 3: Do you believe the provision in the Bill to ensure appropriate engagement with communities is sufficient to guarantee the views if local people are taken into account in the development of local toilet strategies?
The BTA believes it is absolutely vital to involve not only local communities and community groups but consideration should also be given to engagement with local support groups, shop owners and representatives from organisations who completely understand the needs and daily requirements for people living with medical and social conditions that require them to visit the toilet on a much more frequent basis. A wealth of knowledge can be gained through interaction with local community representatives.

Question 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?
The provision and placement of public toilet facilities has a significant impact on the health and vitality of the local community and the surrounding area. Anyone suffering with any type of medical or social problem relating to toilet usage can find themselves isolated or unable to move around an area

when no provision is easily accessible. The range of health problems is often underestimated and we need to have a clearer understanding of the problems being faced by a growing number of individuals who need to plan their journeys and daily routines around the need to frequently visit a toilet facility. The BTA is delighted that the Health Minister has understood and had the foresight to question the current lack of any strategy to answer the needs of those with disabilities, older persons, families with young children, pregnant women, and all persons who are transient through their work. It is our firm belief that public toilet provision specifically addresses the following issues:
Health & Well-being, Equality, Social inclusion, Privacy & Public Decency

Question 5: What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
It has been our long-term belief that local authorities should be in receipt of direct funding from central government to provide these types of facilities. It has always been extremely difficult for councils to maintain a range of facilities and to attain acceptably high standards of hygiene and provision when government refuses to recognise its responsibilities to public health. The BTA has continuously worked with local authorities and the relevant departments in trying to maintain an acceptable standard of provision as expected by the general public and a considerable number of specialist user groups. The responsibility for these facilities has always been perceived to belong to the local authority. Considerable efforts have been made in recent years to involve shops, stores, and other local providers to enter into controlled community toilet schemes. This has had a significant effect on the amount of provision available, however, unless closely controlled there can still be a considerable number of variants and negative factors that can affect the overall provision. Opening times, bank holidays, closures, management and staff attitudes as well as high volume visitor numbers can lead to businesses withdrawing their support after only a short period. Careful consideration and management must be applied.

Question 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?
In recent years we have seen a considerable positive shift in the provision of

toilets, where we now have child changing beds in both male and female and in a growing number of cases, a completely separate unisex baby-changing room. The growth of these types of units is to be applauded as we invite more families to visit and enjoy our towns and city centres, as well as our parks and beaches. In our work with Mencap, we have been heavily involved in the promotion and installation of Changing Places toilets that are designed for users with profound and multiple difficulties. We believe all toilets should be equally accessible for all persons whether able-bodied or struggling with a temporary or permanent disability; and this must include carers and parents who need to attend to a range of special needs. Normally a block of toilets will contain both male and female facilities along with a separate accessible unit. Many of these disabled units are poorly maintained and this has a detrimental effect on the health and well-being of many visitors.

Question 7: Do you believe the proposals leading to toilet provision in the Bill will contribute to improving public health in Wales?

The BTA believes this is a huge step forward in striving to improve the health and well-being of both residents and visitors to Wales. Without decent, clean public toilets, many citizens affected with bowel and urinary problems will find it almost impossible to move around and enjoy the normal freedoms the rest of us take for granted. A lack of decent, clean public facilities can be correlated directly to isolation, infection, dizziness, disorientation and a general distress at feeling unwell. We know from studies that more and more people are experiencing reluctance to leave their own homes, or in some cases temporarily altering their medication to allow them to stay away from home for longer than usual. Drivers and road users may become disorientated and unwell from the effects of not being able to relieve themselves for extended periods. This could in extreme cases result in a loss of control of a vehicle, or extremely poor judgement at major junctions. It is our belief that operating a vehicle and not being able to find a toilet when necessary could be a major factor in the number of accidents that occur on our roads each year.

Public toilets are a major health issue, which has gone unrecognised for many years. In extreme cases the inability to relieve oneself can lead to raised blood pressure, stroke or even heart attack. When one considers the cumulative effect of all the points and considerations above, it becomes

blatantly apparent that Wales has through this proposed bill taken a massive step in recognising the importance and trying to address the health and equality inadequacies that its people have faced since austerity first began to bite.

Finance Statement

What price can you put on public health? It was recognised in the 11th Century as part of the Magna Carta that the health and well-being of the populace, far outweighs that of the government and the crown. If your people are sick it has a massive effect on all aspects of life. Costs go through the roof for healthcare, welfare and social services. Whilst sick people are not fit to work, shop or go on holiday, the economic imbalance is very easily understood.

The figures as detailed in Part 2 of the Explanatory Memorandum seem perfectly fair and correct. Negated over a five year period, it appears to cost in and around £5000 per council, per year, to implement and administer the strategy around public toilets. The BTA like many other organisations is working with local authorities to reduce overall running costs, whilst maintaining the highest possible level of provision and hygiene. The installation of charging gates and doors, the introduction of franchising and commercial partnerships, along with the inception of the community toilet scheme are all current methods employed to reduce the pressure on capital and revenue budgets.

The BTA is the leading authority on the provision of public, private and commercial toilets, and is ready and willing to work with local authorities and government to formulate ideas and plans covering the implementation of any future strategy.

Assuring you of our best attention at all times.

I remain yours faithfully,

Raymond Martin
Managing Director
British Toilet Association

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 Jonathan Edwards – PHB 54 / Tystiolaeth gan Jonathan Edwards – PHB 54

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

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Question 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?
No. E-cigarettes are not tobacco products and emit no smoke. Emissions from e-cigarettes are primarily glycerine and propylene glycol, which are non toxic in quantities encountered. Nicotine emissions are extremely low and below levels likely to have any effect on bystanders. See study for detailed analysis of e-cigarette vapour during intensive use in a small room – http://www.mdpi.com/1660-4601/12/5/4889 Businesses currently have discretion over whether they allow vaping on their premises. Many already have policies in place. Additionally it would ban "vape shops" which are lawful businesses from demonstrating their products in their own premises. A law is unnecessary in my view. Guidance giving accurate information to employers and premise owners (such as guidance provided by ASH – http://www.ash.org.uk/files/documents/ASH_900.pdf) to enable them to make informed decisions would be preferable to legislation in my view.

Question 2

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?
No. I believe as it incorrectly proposes to treat e-cigarettes the same as smoked tobacco, it will act as a disincentive to those who wish to quit smoking using e-cigarettes. It will mean that those who wish to use e-cigarettes (overwhelmingly former smokers, or those reducing smoking) have to stand in "smoking areas" to use them. This results in them being exposed to harmful second hand smoke and may trigger relapses in those who have quit smoking. It will ban shops from demonstrating e-cigarette products to prospective customers. This has the potential to reduce the number of people wishing to switch from smoking to e-cigarettes. For example, a prospective customer (smoker) may wish to try an e-cigarette in store before investing what may be a significant sum in equipment, and this will not be possible in Wales under these proposals. Therefore, I believe that the proposals will actually be harmful to public health, and will encourage continued smoking.

Question 3

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?
I do not believe they re-normalise smoking. The devices most commonly used now (2nd and 3rd generation) do not resemble cigarettes. Neither do they smell like cigarettes. Only at the most superficial glance from a distance could it be considered to look like smoking. An alternative view is that they "normalise" harm reduction rather than smoking, which in my view should be considered a positive. They have been on the market since 2007, and over that period both youth and adult smoking rates have continuously declined in the UK, while e-cigarette use has increased dramatically. If smoking were being re-normalised, surely it would be expected to go up in prevalence? The Public Health England view is that there is no evidence in the extensive data they have gathered that e-cigarette use "re-normalises" smoking. They concluded "E-cigarettes are 95% less harmful to your health than normal cigarettes. When supported by a smoking cessation service, they help most

smokers to quit tobacco altogether". There is currently no evidence to support the re-normalisation argument.

Question 4

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?
There is some evidence of young people trying e-cigarettes, and there are now numerous UK surveys showing a similar pattern. Levels of youth who have ever tried e-cigarettes (at least one puff ever) is relatively high. What is in my view more important is that the numbers who are regular users are extremely low, and regular use is almost entirely confined to current and former smokers. The numbers to date do not suggest many are going on to regular use, or that this is initiating tobacco use. Cancer Research UK carried out a study which shows this to be the case - http://www.cruk.cam.ac.uk/news/latest-news/research-shows-most-children-do-not-regularly-use-e-cigarettes Statistics from England's Health and Social Care Information Centre also show this - http://www.hscic.gov.uk/catalogue/PUB17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf and also show that smoking rates in pupils are at the lowest levels since their records began. It has not been established by any survey to my knowledge, how many of the youth who try e-cigarettes are using non-nicotine containing products. It is also important to note that although most e-cigarette vendors are responsible, and do not currently sell to minors, there is currently no law enforcing that. A law banning sale of e-cigarettes, refills and e-liquid to under 18's would be a sensible step that I support.

Question 5

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

No specific objections to this as long as requirements reasonable and not excessively costly or onerous for businesses. I understand that the EU Tobacco Products Directive will impose registration requirements on retailers in any event.

Question 6

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?

I disagree with this proposal to criminalise "handing over" nicotine products. E-cigarettes are effective as a method of harm reduction (95%+ less harmful than cigarette smoking). It would therefore criminalise parents who wish to for example provide an e-cigarette to their cigarette smoking child, as a means to encourage quitting smoking. Also such offences are likely to be hard to enforce effectively, and places further demands on an already stretched Police force.

Pharmaceutical NRT products, which contain nicotine, are widely available as general sale items, with few restrictions on sale.

Other comments

Question 21

Are there any other comments you would like to make on any aspect of the Bill?

Regarding the proposals to ban e-cigarette use in public spaces, I firmly believe that legislation should only be considered as a response to evidence of harm. There is no evidence of harm being caused at the population level by e-cigarette use, and they are extremely helpful for smokers who wish to quit. Legislating based on unfounded concerns, fears or on a precautionary basis is fundamentally wrong. Laws once enacted are usually extremely difficult to reverse, even if found with hindsight to be unhelpful. The proposals also fly in the face of recommendations from respected anti tobacco groups including ASH.

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

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

Evidence from the Paediatric Continence Forum – PHB 55 / Tystiolaeth gan Y Fforwm Ymataliaeth Pediatrig – PHB 55

Public Health (Wales) Bill
Written evidence from the Paediatric Continence Forum

Background to the Paediatric Continence Forum

1.1 The Paediatric Continence Forum (PCF) is an expert group of patient representatives and healthcare professionals which campaigns for improved services for children with continence problems (bladder and bowel dysfunction) in all settings across the UK. Established in 2003, it works closely with the national charities ERIC (Education and Resources for Improving Childhood Continence) and PromoCon (Promoting Continence through Product Awareness), with representation from the Royal College of Paediatrics and Child Health, the Royal College of Nursing and the Community Practitioners' and Health Visitors' Association.

1.2 One of the key goals of the PCF is for every area in the UK to have a proper community-based integrated paediatric continence treatment service, led by an expert paediatric continence professional, with a clear system of referral and care pathways across primary and secondary NHS care, education and social services. The PCF has recently published NICE-accredited guidance for the commissioning of paediatric continence services, which can be found at www.paediatriccontinenceforum.org/resources.

1.3 The PCF actively supports The Right to Go – a campaign organised and run by ERIC - which calls on schools and the Government to ensure that all educational settings have appropriate policies and procedures in place to support children with continence problems, and to provide school toilets which are safe, hygienic and well-maintained.

1.4 The PCF is chaired by Dr Penny Dobson MBE.

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?

2.1 The PCF welcomes the proposal by the Welsh Government to require each local authority in Wales to prepare and publish a local toilets strategy. UK-wide data suggests around one in 12 children has an ongoing continence problem, which can be distressing for them and their family/carers. Conditions like chronic constipation, incontinence and urinary infections can be caused or exacerbated by limited access to toilets. Open access to high quality toilet facilities is crucial to the health and welfare of children, enabling more effective self-manage their condition whilst away from their home.

2.2 However, the PCF has identified opportunities to improve the Bill, particularly regarding consultations and national guidance. These are outlined below.

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

3.1 Preparing a local toilet strategy will only lead to improved provision of public toilets if local authorities engage with patient groups interested in continence and toileting when developing their local strategy. These groups have a strong understanding of the needs of people with continence problems and can highlight areas to consider which local authorities may not be aware of, for example related to the specific facilities available or the design and layout of the facilities.

3.2 Local authorities must also be willing to fully fund any of the provisions within their toilet strategy. The strategy needs to contain deliverable outcomes which can be measured to assess the progress of the local authority in implementing their strategy.

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?

4.1 We are pleased that the Bill states that local authorities must consult with any person it considers is likely to be interested in the provision of toilets in its area. However, we would like to know how this will be defined. For example, local authorities should be required to engage with local patient groups, local community care services, elderly homes, schools and educational settings, and local businesses. There is currently no set criteria in the Bill; consideration should be given to naming specific groups.

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?

5.1 The PCF believes that by developing and issuing national guidance, Welsh ministers can help local authorities ensure a consistent approach towards toilet provision. In the summer of 2014, prior to the launch of the Paediatric Continence Commissioning Guide, the PCF conducted research on the provision of paediatric continence services in Wales and the rest of UK and discovered significant variation between service providers.

5.2 Should Welsh Ministers decide to issue guidance on the development of local strategies, this guidance should be developed in consultation with stakeholders with an understanding of what constitutes effective toilet provision. This should include organisations such as the PCF as well as patient groups like PromoCon and ERIC.

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

6.1 The PCF welcomes the fact that the local authority must have regard to the local toilet strategy when determining whether to provide toilets and the types of toilets to be provided.

6.2 Toilets which require payment to access can be problematic from a convenience/cost standpoint. Moreover, people may not be able to access toilets requiring payment as they do not have the appropriate level of change. This can result in people with continence problems being restricted in the management of their condition when out and about in public. Should local authorities mandate payment, we believe that contactless payment by card should be an option as this would help increase accessibility.

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?

7.1 The current definition does not cater for people with a medical condition that requires special toilet facilities, but do not consider themselves disabled. For example, some people with bladder and/or bowel dysfunction may otherwise be able bodied, but may require larger, more hygienic washing rooms (extra space and a basin) to carry out actions like catheterisation. To accommodate these people, we would suggest that the legislation states that 'toilets' also cover those with

specialised continence problems, and that local authorities give consideration to these special toilet facilities.

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

8.1 This Bill will improve public health by enabling better provision of toilets to people who need them, especially children and young people with continence problems. Inadequate provision of public toilets for these children can contribute to stress, isolation, embarrassment, effects on bladder and bowel function, urinary tract infections and spread of infection. Moreover, the declining provision of public toilets is disproportionately affecting groups like children and young people with continence problems or other medical conditions that businesses or the public may not consider. Finally, inadequate provision can impact on the ability of children to leave their house without fear of wetting or soiling themselves due to a lack of appropriate toilets for them to use.

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

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

Evidence from the Welsh Dental Committee – PHB 56 / Tystiolaeth gan Bwyllgor Deintyddol Cymru – PHB 56

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
We agree. Just when smoking has become socially unacceptable it would be a retrograde step to permit use of nicotine inhalational devices to be used where smoking is not allowed. We acted to protect people from second hand smoke, we need to protect them also from second hand nicotine which is produced from these devices and exhaled by users. One aspect of the approach to regulation should be to permit use of these devices only where and when tobacco smoking is currently permitted.

Question 2

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?
Yes. Smoking tobacco is a major cause of adverse health impact including oral health impact. Nicotine is addictive. Burnt tobacco carries additional harm. For the individual who cannot stop smoking e-cigarettes may be a less harmful alternative, but the better outcome would be to avoid individuals becoming nicotine addicts in the first place. The advent of nicotine inhaling devices may assist those who are addicted to nicotine but

are unwilling or unable to address their addiction to avoid the risks of inhaled tobacco, but to date evidence on this is weak.

While the evidence on young people using e-cigarettes is similarly weak at this stage we should also acknowledge that once the e-cigarette market is saturated there may be much more effort put into marketing e-cigarettes to young people which could become more effective.

Although it is beyond the scope of this Act ideally some thought should be given to the concentrations of fluids used and to the taxation of these to encourage a shift from higher to lower concentrations. There are parallels here to how we apply duty to alcohol products.

Section 2 (2) refers to inhalation of nicotine via a mouth piece. It would seem wise to refer to a mouth piece or nose piece to reduce risk of some circumventing the intent of the Act.

Section 4 Offences. Subsections 5 and 6 refer to defences. It would be helpful if that Act made it clear that continuing to smoke/inhale after a person had been made aware that the premises/vehicle are smoke free negates any defence based upon lack of awareness. This would assist those charged under Section 5 to keep smoke-free premises smoke-free.

Question 3

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?

As was stated above, just when smoking has become socially unacceptable it would be a retrograde step to permit use of nicotine inhalational devices to be used where smoking is not allowed. We acted to protect people from second hand smoke, we need to protect them also from second hand nicotine which is produced from these devices and exhaled by users. Although some smokers believe they should be free smoke such freedom should not extend to imposing their smoke or exhaled e-cigarette vapours (including nicotine) on others.

Question 4

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?

With the moves of tobacco companies into the nicotine inhalational device marketplace comes the further risk of product design, device marketing, and development of flavours or other features intended to target the young and vulnerable.

We are still in the early stages on the introduction of these devices. When the market becomes saturated efforts to target non-users will become more creative and aggressive. Thus another aspect of the approach to regulation is to restrict sales to young people, and to restrict advertising, and of features such as flavouring.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
The registration of those selling nicotine products and restrictions on sales to under 18's are supported by Welsh Dental Committee.

Question 6

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 registration of those selling nicotine products and restrictions on sales to under 18's are supported by Welsh Dental Committee.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?

We support the proposal for compulsory national licensing of premises/vehicles and practitioners.

Recent events in Newport have highlighted the cross infection risks associated with some of these areas and the resulting large impact on public resources when incidents need investigation and follow up. Application of appropriate standards including licensing to protect the public during these activities seems entirely appropriate and necessary.

Question 8

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

In general yes.

However the approach taken to define intimate piercing in the draft Bill excludes piercing within the oral cavity which appears to Welsh Dental Committee to be an inappropriate omission. The tongue is a highly vascular and sensitive organ, and the tongue and lips are frequently involved in intimate acts. Worryingly the tongue and floor of the mouth are sites from which a local haemorrhage or a locally spreading infection can rapidly threaten the airway. There are sufficient reports of adverse events both minor and major to suggest that intra-oral piercings should not be performed on anyone aged under 16.

Question 9

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

No views on this matter.

Question 10

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

We believe it is appropriate for the local authority to have the proposed powers and trust that personnel who carry out this role will be appropriately trained and supported to enforce the provisions of the act

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
The WDC believes it is correct to require an age restriction for intimate body piercing, and that intimate body piercing should not be performed on anyone who has not yet reached their 16th birthday. Furthermore the WDC believes it is appropriate to obtain valid consent before carrying out intimate body piercing so that customers are fully aware of the potential risks. Customers should be provided with an opportunity to ask questions about the risks and be required to complete a written consent form.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
The WDC agrees with the list of intimate body parts, but want to see tongue piercing or any other intra-oral piercing added to the list. There are known risks associated with tongue piercing as detailed below and there are reports in the literature that tongue piercing is associated with sexual contact. We recognise that tongue piercing does not require the customer to undress, but we believe the oral cavity can be considered an “intimate area” and that tongue piercings on under 16’s is to some degree sexualisation of them. The WDC believes that tongue piercing is a public health issue since it commonly leads to adverse effect locally in the mouth and more rarely systemically. Many patients attend for dental treatment following damage caused by tongue piercing, and we believe that including tongue piercing in intimate body piercing will contribute to improving public health A brief review of the literature shows there are numerous studies in the UK and globally on the adverse effects of tongue piercing. It is not possible to give accurate figures for the number of people with tongue piercings, but studies show the practice is most common among young people aged 16 to 24 and in some communities up to 50% of these young people will have a body piercing. The data varies, but in 2 UK studies (including one in Cardiff) over 90% of the dentists surveyed had seen patients with tongue piercings, and about half had treated patients for complications arising from tongue piercing. About half of the patients had received advice about risks of piercing,

but the advice was very limited and usually about pain and swelling

Complications of tongue piercing can occur immediately after the piercing, and then after healing. Reports consistently show approximately 90% or piercees will have immediate complications including pain, swelling, bleeding , nerve damage and infection. There are a small number of reports of severe spreading infection which has compromised the airway, putting life at risk.

Later complications commonly include –

- Gingival (gum) recession
- Bone loss around teeth near the piercing
- Enamel chips / cracks and tooth fracture
- Swallowing or inhalation of the barbell
- Calculus formation around the barbell increasing the risk of infection
- Tissue overgrowth causing the barbell to become embedded in the tongue
- Split (bifid) tongue
- Hypersalivation
- Speech impediment
- Metallic taste and allergic reaction to the metal

All of these complications can require treatment by the dental team, and may lead to tooth loss and soft tissue damage

There are reports of severe complications. While they may be very rare, they can be life threatening – in 2003 the UK Government debated the death of a Sheffield teenager following tongue piercing **http://news.bbc.co.uk/1/hi/england/south_yorkshire/4418512.stm** **http://www.bbc.co.uk/news/uk-england-south-yorkshire-12743471** .
This is not the only case of death or of near fatality within Wales
http://www.dailymail.co.uk/news/article-1266456/Woman-tongue-pierced-birthday-treat-dies-blood-poisoning-days-later.html or beyond
http://www.mirror.co.uk/news/uk-news/cheek-piercing-killed-woman-after-3178556
http://news.bbc.co.uk/1/hi/health/8302444.stm .

Severe complications include –

- Spreading infection which can compromise the airway
- Endocarditis
- Cerebellar abscess
- As with all body piercing there is risk of infections such as Hepatitis B if strict cross infection control measures are not followed

There is evidence that people who have tongue piercing or other intra oral piercings are not fully informed of the risks beforehand, or provided with written advice on care of the piercing site. Dental teams are aware of many of the risks, but the evidence suggest they would welcome more information on advising patients about risks and care of the mouth after tongue piercing."

Other comments

Question 19

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

Given the extensive legislation covering many aspects which impact on public health these are appropriate issues.

Question 20

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

There are many issues which potentially impact upon the health of the people of Wales. Rather than legislate for everything a more balanced approach would be the requirement for Health Impact Assessment of policies and of both public and private planning applications.

Question 21

Are there any other comments you would like to make on any aspect of the Bill?

None

UK Health Forum submission National Assembly of Wales, Health and Social Care Committee call for evidence on general principles of the Public Health (Wales) Bill

Date: 4 September 2015

Contact: Hannah Graff
Senior Policy Researcher, UK Health Forum
Phone: [redacted]

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About the UK Health Forum

The UK Health Forum (UKHF), a registered charity, is both a UK forum and an international centre for the prevention of non-communicable diseases (NCDs) including coronary heart disease, stroke, cancer, diabetes, chronic kidney disease and dementia thru a focus on up-stream measures targeted at the four shared modifiable risk factors of poor nutrition, physical inactivity, tobacco use and alcohol misuse. UKHF undertakes policy research and advocacy to support action by government, the public sector and commercial operators. As an alliance, UKHF is uniquely placed to develop and promote consensus-based healthy public policy and to coordinate public health advocacy. UKHF works to encourage integrated policy approaches that link prevention of NCDs with sustainable development, climate stabilisation, human rights and the reduction of health inequalities.

We welcome the opportunity to respond to the Health and Social Care Committee's call for evidence.

Public Health (Wales) Bill – Summary of Interest

The UKHF has been involved with and interested in the future of public health in Wales for some time. In February 2013, we hosted an all-day seminar in Cardiff with the Royal Society for Public Health (RSPH), Institute of Healthcare Management (IHM) and the Institute for Welsh Affairs to discuss the Green Paper *A consultation to collect views about whether a Public Health Bill is needed in Wales* and the value of public health law. In addition to numerous responses to the Green Paper, this meeting served as the impetus for a commissioned paper on public health law and NCDs, which UKHF published in partnership with RSPH and IHM in summer 2013 (please see Appendix 1).

In November 2014, UKHF co-hosted a policy development roundtable with RSPH, Royal College of Physicians Cymru and University of Wales Trinity Saint David. The purpose of the roundtable was to look at the proposed aims, objectives and outcomes from the - at the time - proposed Well-being of Future Generations Bill and its potential impact on public health. A report highlighting the key points and recommendations from the day was produced and shared with key stakeholders (please see Appendix 2).

UKHF along with its partners and members have also responded to all previous consultations on related white papers and proposed legislation.

Globally, NCDs are increasingly responsible for serious health and economic burdens to governments. Because treatment of these diseases is expensive, prevention is highly cost-effective. Unchecked, NCDs will create exponentially unsustainable demands on health and social care services

and be a major risk to sustainable and economic development, leading to a mal-distribution of health and social inequalities. Inequalities account for approximately 18.9 lost years in life expectancy in Wales between the highest and lowest socio economic classes.[1] Wales is one of the highest ranking NCD burdened countries on global comparative league tables. However, with the right legislative powers this could be addressed and place it well ahead of other nations who fail to take such action.

There are many effective ways in which policy and public health law can be utilized to influence NCD determinants including litigation against industry, advertising or marketing restrictions, or financial measures, all of which have proven remarkably effective in reducing risk factors.[2] The key points which we encourage the Government to consider with regards to public health in Wales are:

- Any legislation the Government proposes should begin with a clear and simple preamble which sets out the goals and principles of any law (see box on following page).

- The Government needs to consider all areas and options available under UK and EU law.

- Mandating Health Impact Assessment (HIA). HIAs are important for indicating how new policies will impact – positively or negatively – on population health. Mandating their use will ensure consistent application across government departments and agencies. *UKHF notes HIAs have been removed from all new and currently proposed legislation in Wales*.

- The measures under any new legislation should provide the social conditions and impetus for shifts in culture and environment needed to support health and reduce inequalities.

- Legislation can renew focus on prevention and wellbeing.

- The ability to efficiently introduce necessary health protection – inclusive of environmental, communicable and non-communicable hazards – in secondary legislation or reserved powers.

[1] Lozano R, Naghavi M, Foreman K et al. 2012. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet.380: 2095–128.
[2] Galbraith-Emami, S. Public Health Law and Non-communicable Diseases. UK Health Forum. July 2013.

A Preamble

Any preamble should include the following within a concise and clear statement of the principles, aims and intent of the legislation:

- Current public health legislation for Wales is not capable of dealing with the health challenges of the 21st century.
- The state has the ultimate legal and moral responsibility for the welfare and future prospects of new generations. Health is a public good and defined by the UN as a human right.
- The state has the responsibility to protect the population from new health threats, promote good health and wellbeing and prevent disease.
- The state needs to legally define its duties and responsibilities to secure and protect the health of the people of Wales.
- The state must recognise the need to balance at times, the collective good achieved by public health regulations with resulting infringements of individual or commercial rights and freedom.
- The Bill should ensure that the Welsh Assembly and its executive is obliged to consider the impact on the health of the population in developing and appraising social, economic, fiscal and environmental policy (or policy in all Government areas). Health concerns need to be owned across Government and its executive.

Note: This section is taken from UKHF, RSPH and IHM's joint response to the Green Paper: A consultation to collect views about whether a Public Health Bill is needed in Wales (2013).

Summary of submission

- We strongly support Wales' interest in Health in All Policies and the new Future Generations Act.
- We support the proposal to create a tobacco retailers' register.
- We acknowledge electronic cigarettes as a new and evolving public health issue.
- Current voluntary smoking bans for hospital grounds, school grounds and children's playgrounds are not sufficient.

UKHF is pleased to see the proposal for separate legislation on minimum unit pricing of alcohol – as was originally included in *Listening to you: Your health matters* - and strongly support the introduction of a MUP at the level of at least 50p/unit.

However, **we are concerned that key prevention measures have been left out of the proposed Public Health (Wales) Bill, most notably, provisions to tackle obesity including policies to address nutritional standards and the relative affordability of healthy food**.

Response

Tobacco and Nicotine Products

Wales should strive to implement and support policies that remove tobacco products from the market and move the country closer to achieving an end game for tobacco. Marketing and promotion of tobacco products will have to meet updated health warning requirements and other measures coming into effect under the EU Tobacco Products Directive.[3]

Even before any proposed legislative changes, we encourage the Welsh Government to note the findings of the expert review of evidence on e-cigarettes recently published by Public Health England[4] and to promote and support comprehensive monitoring of e-cigarette use (inclusive of all issues related to these products i.e. as a cessation tool; potential route into tobacco smoking; potential long-term health risks; etc.). **If Wales goes forward with banning e-cigarette use in enclosed public places we strongly encourage Wales to ensure that the impact on smoking and vaping patterns is closely and comprehensively monitored and evaluated as it will serve as important evidence for this evolving topic.**

We support the position that e-cigarettes should be regulated and made subject to robust and comprehensive marketing restrictions that provide the highest level of protection to children and young people, their presentation and marketing should avoid any confusion with smoked tobacco products or tobacco brands and they should always be presented clearly as an alternative to tobacco. Current self-regulatory rules governing the advertising of e-cigarettes introduced by the Advertising Standards Authorities in 2014 will be reviewed in October 2015 when the details of the EU Tobacco Products Directive are made known.

The current voluntary smoking bans for hospital grounds, school grounds and children's playgrounds are not sufficient. Legislation should mandate these bans.

Introducing a registration scheme will enable Trading Standards Officers to more easily identify tobacco retailers for test purchasing purposes and to check compliance with the point of sale display regulations. We believe that this is both a workable and proportionate measure and is an important means to help reduce the number of young people in Wales who become smokers.

According to Action on Smoking and Health (ASH), Trading Standards Officers have already advised that the existence of a register will make it easier for them to identify whether a retailer sells tobacco once the display ban on tobacco products comes into force for small shops in 2015. Data from England shows nearly half (44%) of young smokers reported they were able to acquire tobacco from retail premises despite the ban on the sale of tobacco products to under 18s.[5] It is likely that

[3] European Commission: http://ec.europa.eu/health/tobacco/products/index_en.htm
[4] Public Health England. 2015. *E-cigarettes: An evidence update.* London: Crown Copyright. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454516/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England.pdf
[5] Health and Social Care Information Centre. Smoking, drinking and drug use among young people in England in 2012. 2013.

children in Wales are also getting tobacco from shops. We welcome and encourage any measure that helps to reduce the likelihood of underage tobacco sales.

We do not believe the fee will impose an excessive cost to small retailers. The requirement for annual registration will ensure that records are kept up-to-date for purposes of monitoring and enforcement.

We note that the detail of penalties associated with failure to register to sell tobacco will be subject to additional legislation. Any new penalties introduced should be: easy to enforce; provide clear guidance for enforcement officers and magistrates, and should be set at a level sufficient to deter breaches of the new requirements.

Public Health Law and Non-communicable Diseases

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Acronyms

EU	European Union
HIA	Health Impact Assessment
HiAP	Health in All Policies
NCDs	Non-communicable diseases
WHO	World Health Organization

Executive summary

Non-communicable diseases (NCDs) are increasingly responsible for serious health and economic burdens to governments around the world. Most NCDs in all countries stem from risk factors including tobacco use, harmful use of alcohol, the over-consumption of saturated fat, sugar and salt, and lack of physical activity. Because treatment of these diseases is expensive, prevention is highly cost-effective. One way for governments to respond to the growing burden of NCDs is through the use of public health law in order to reduce exposure of their populations to these risk factors.

There are many effective ways in which public health law can be utilised to influence these risk factors. These may include litigation against industry, advertising or marketing restrictions, or taxation or pricing restrictions, all of which have proven remarkably effective in reducing risk factors. However, it may be politically difficult or unfeasible for individual local governments to pursue these types of legislation on their own, in the absence of more over-arching powers. This paper instead concentrates on four types of potential legislation highlighted in the recent Welsh consultation on public health law. These include: 1) extending the requirement to use Health Impact Assessments; 2) imposing a statutory duty on a range of bodies to reduce health inequalities; 3) legislation to bring about a renewed focus on prevention of ill health; and 4) legislation to strengthen community action around health protection and health improvement.

The paper examines a number of pieces of legislation in each of these four areas, from different jurisdictions in the UK and other countries in Europe, and in the United States, Canada, Australia and New Zealand, in order to provide precedents and, where available, feedback about success or challenges of each given approach. Throughout these approaches, the themes of multi-sectoral approaches and equity appear repeatedly. Faced with the growing burden of NCDs, governments have been finding effective and in some cases novel ways to use public health law to address relevant risk factors over the last decade. The four focuses of legislation listed above may be particularly appealing as ways of enabling local governments to effect changes in NCD rates, for three reasons: they are relatively less politically controversial than other possibilities; they are multi-sectoral approaches; and they focus on health inequalities.

1 Introduction

Non-communicable diseases (NCDs) create a serious health and financial burden for local and national governments. NCDs can be defined as diseases that are not infectious. These diseases may result from genetic or behavioural factors and include coronary heart disease, stroke, hypertension (high blood pressure), type 2 diabetes, kidney disease, certain forms of cancer, respiratory and liver diseases, and overweight and obesity, as well as certain mental health conditions. Most NCDs can be linked to the modifiable determinants of tobacco use, harmful use of alcohol, poor diet and lack of physical activity.

Legislation is one key tool to address these risk factors and determinants. While traditionally public health law has addressed issues of communicable diseases, the changing global burden of disease means that in recent decades it has also been used to address non-communicable disease.

There is a broad spectrum of ways in which public health law can address the determinants of non-communicable diseases. However, this paper will address four specific options in light of the over-arching themes of multi-sectoral engagement and the reduction of health inequalities. The first such option is legislation requiring Health Impact Assessments – tools that help decision-makers identify the public-health consequences of proposals that potentially affect health. The second involves imposing a statutory duty on a range of bodies to address and reduce health inequalities. The third is the use of legislation to bring about a renewed focus on prevention of ill health, both within and outside the health sectors. Fourthly, the use of the legislation to strengthen community action around health protection and health improvement will be reviewed.

2 Background to non-communicable diseases and public health law

2.1 The burden of disease

Non-communicable diseases (NCDs) include coronary heart disease, stroke, hypertension, type 2 diabetes, kidney disease, certain forms of cancer, respiratory and liver diseases, overweight and obesity, and mental health conditions such as vascular dementia. These diseases, which are often treatable but not always curable, are responsible for sizable economic burdens on governments. Most NCDs can be linked to the modifiable determinants of tobacco use, harmful use of alcohol, poor diet and lack of physical activity.

Over the past few decades, global health has witnessed a shift in the burden of disease from communicable to non-communicable diseases. Worldwide, the contribution of different risk factors to disease burden has changed substantially, with a shift away from risks for communicable diseases in children towards those for non-communicable diseases in adults.[i] In 2008, nearly two-thirds of all deaths – 36 million – resulted from NCDs, comprising mainly cardiovascular diseases, cancers, diabetes and chronic lung diseases.[ii] NCDs disproportionately impact young and middle-aged adults, and on a global scale they are quickly becoming dominant causes of death and disability.[iii] Within the WHO European Region, NCDs account for 86% of deaths and 77% of the disease burden.[iv] In the UK, NCDs are the leading cause of death, and in 2008 there were 518,400 deaths from NCDs, of which 23.75% were among the under-70s.[v]

The economic burden of NCDs is sizable. A 2011 projection of costs carried out by the World Economic Forum and Harvard School of Public Health suggests that the cost of NCDs to the global economy will amount to $47 trillion over the next two decades, approximately 75% of the 2010 global GDP.[vi] The cost of diabetes and related complications to the NHS in England and Wales amounts to an estimated £9 billion a year,[vii] and over half of these cases could have been prevented. According to the World Health Organization, “Investing in prevention and better control of this broad group of disorders will reduce premature death and preventable morbidity and disability, improve the quality of life and well-being of people and societies, and help reduce the growing health inequalities they cause”.[viii]

Though too rich and complex to explore comprehensively in this paper, there has been a sizable international response to the problem of NCDs. One of the most notable was the September 2011 UN High-level Meeting on Non-communicable Diseases which generated substantial global attention for the problem of NCDs. Similarly, in a World Health Assembly Resolution of May 2012, governments pledged to adopt a global target of a 25% reduction in premature mortality from NCDs by 2025.[ix] NCDs are related to sustainable development issues including nutrition and energy, and there have also been calls to integrate NCDs carefully into the United Nations’ Sustainable Development Goals as well as the post-2015 Millennium Development Goals.[x]

Clearly, governments have much to gain – and certain targets to meet – through the implementation of effective prevention techniques.

2.2 NCD risk factors and interventions

As stated above, the proximate causes of NCDs across all countries include tobacco use, harmful use of alcohol, the over-consumption of saturated fat, sugar and salt, and lack of physical activity. While many interventions may be cost-effective, WHO has classified some as 'best buys' – meaning "actions that should be undertaken immediately to produce accelerated results in terms of lives saved, diseases prevented and heavy costs avoided." These are listed in Table 1.

Table 1: The World Health Organization's 'best buys' for NCD interventions

- Protecting people from tobacco smoke and banning smoking in public places
- Warning about the dangers of tobacco use
- Enforcing bans on tobacco advertising, promotion and sponsorship
- Raising taxes on tobacco
- Restricting access to retailed alcohol
- Enforcing bans on alcohol advertising
- Raising taxes on alcohol
- Reducing salt intake and salt content of food
- Replacing trans fats in food with polyunsaturated fat
- Promoting public awareness about diet and physical activity, including through mass media.

Source: World Health Organization, 2011[xi]

There is substantial evidence of the success of preventive interventions. Frequently cited is the case of Finland's North Karelia province, where a policy focused on healthy diet, exercise and reduction of smoking was implemented in the early 1970s. Between 1972 and 2006, North Karelia witnessed an 85% decrease in annual mortality rate from coronary heart disease.[xii] More recently, in New York City, a five-year-old Health Department regulation banning trans fats has reduced the consumption of trans fats among fast-food customers from about 3 grams to 0.5 grams per purchase – showing also that local health regulations can significantly influence public consumption.[xiii]

It should be noted that corporate interests have markets to protect, and legislation restricting advertising, marketing or use of alcohol, tobacco and unhealthy foods may face numerous legal and political obstacles. Certain interventions require a cross-border approach. These may include advertising restrictions, labelling requirements, taxation and minimum unit pricing measures. A key example is the WHO's Framework Convention on Tobacco Control – developed in response to the globalisation of the tobacco epidemic and the cross-border effects of many factors – which has made substantial progress in reducing tobacco consumption.[xiv] One advantage of the four approaches outlined in this paper – and which will be appealing to national and local governments – is that the general and multi-

risk-factor NCD prevention strategies may be less likely to incur this kind of industry opposition.

2.3 The importance of public health law in improving population health

A central question in public health law and policy is what degree of intervention is appropriate to improve population health. In response to this, in 2007 the Nuffield Council on Bioethics presented a vision of the stewardship role of the state.[xv] Under this model, it is understood governments have a "duty to look after important needs of people individually and collectively". Goals of public health programmes in this perspective should encompass reduction of risk, environmental protections, protections for vulnerable populations, health promotion, enabling the population to make healthy choices, access to medical services and a reduction of health inequalities.[xvi]

Public health law can be defined as "the study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g. to identify, prevent and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty or other legally protected interests of individuals for protection or promotion of community health".[xvii]

Law can be used to advance public health in a number of different ways. A 2011 report from the WHO Regional Office for Europe sets out four major roles: defining the objectives of public health and influencing its policy agenda; authorising and limiting public health action with respect to protection of individual rights, as appropriate; serving as a tool for prevention; and facilitating the planning and coordination of governmental and non-governmental health activities.[xviii]

While in most European countries public health legislation is contained in separate acts and regulations because of the scope of the issues and stakeholders, another approach is to develop a law specifically addressing public health. In practice, most jurisdictions use a combination of the above approaches, with a specific public health law as well as provisions integrated into other legislation. Table 2 below, adapted from a WHO Regional Office for Europe document on public health law, reflects some of the benefits and disadvantages of each approach.

Table 2: Advantages and disadvantages of public health law structure

	Advantages	Disadvantages
In separate acts and regulations	A wider constituency may be benefited when public health provisions are inserted into legislation outside the health sector.	Difficulty of ensuring coverage of all legislative aspects relevant to public health.
Law specifically addressing public health	Ease of enactment and adoption, without the need for multiple amendments to existing public health legislation. Good opportunity to raise public awareness about public health issues and to educate policy-makers.	Need to amend all impacted legislation.

Source: Chichevalieva, 2011[xix]

The legal system and public health situation will determine which of these options are most appropriate for a given government. Examples of each relevant to NCDs can be found within Europe:

- *In separate acts and regulations:* In 2009, a Portuguese law established standards to reduce the salt content in bread, set a maximum limit of salt content in bread and encouraged information on salt content on the labelling of pre-packaged foods.[xx] Denmark has brought in a tax on trans-fatty acids, Hungary a 'junk food tax' and France a tax on all sweetened drinks.[xxi]

- *Law specifically addressing public health*: The Netherlands Public Health Act (2008) created a single instrument bringing together the previously separate Public Health (Preventive Measures) Act, the Infectious Diseases Act and the Quarantine Act, as well as provisions for the obligatory storage of digital data in the context of health care for young people.[xxii]

The purpose of public health law may vary considerably from country to country. Table 3 compares the stated purposes of a number of recent acts. These vary in specificity as well as in the extent to which they focus on communicable versus non-communicable diseases.

Table 3: Purposes of public health laws

Public health law	Purpose
CANADA British Columbia Public Health Act 2008 [xxiii]	This act replaces the outdated legislation, supports improved health and wellness of British Columbians and helps to address current public health issues including new challenges in infectious disease control like SARS or pandemic influenza, environmental toxin exposures, prevention of chronic disease, injuries, and poisonings and bioterrorism threats.
FRANCE Public Health Act 2004	To improve the health of the population by establishing a more effective administrative system in public health and by reinforcing the implementation of national and regional programmes.
AUSTRALIA New South Wales Public Health Act 2010 [xxiv]	To protect and promote public health. • To control the risk to public health. To promote the control of infectious diseases • To prevent the spread of infectious diseases. • To recognise the role of local governments in protecting public health.
NORWAY Norwegian Public Health Act 2011[xxv]	To contribute to societal development that promotes public health and reduces social inequalities in health. Public health work will promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders or injuries.
AUSTRALIA Queensland Public Health Act 2005[xxvi]	To protect and promote the health of the Queensland public.
SCOTLAND The Public Health etc. (Scotland) Act 2008[xxvii]	To re-state and amend the law on public health; to make provision about mortuaries and the disposal of bodies; to enable the Scottish Ministers to implement their obligations under the International Health Regulations; to make provision relating to the use, sale or hire of sunbeds; to amend the law on statutory nuisances; and for connected purposes.
AUSTRALIA South Australian Public Health Act 2011	To provide a modernised, flexible legislative framework, so South Australia can better respond to new public health challenges as well as traditional hazards.

The number of public health law instruments within Europe is on the rise. A recent literature review found over 400 legally binding instruments in the area of public health at global and European levels, reflecting the expanding and complex nature of such a system in recent years.[xxviii] At the national level, there is increasing interest in legislation that can improve public health and avoid the fiscal and economic burdens associated with costly treatment of NCDs and loss of productivity.

2.4 How public health law is used to address NCDs and their risk factors

As explained in section 2.2, the risk factors for NCDs fall primarily into four categories: tobacco use, harmful use of alcohol, poor diet and lack of physical activity. Although public health law can be an effective mechanism for NCD prevention, two potential political obstacles include: firstly, strong public and political resistance to laws intended to influence choices and behaviours, with a perception of NCD risk factors being a matter of personal choice; and secondly, that effective interventions are difficult politically because it means challenging the rights of profitable businesses to manufacture and sell potentially harmful products.[xxix] One Canadian article points out that – despite the public health crisis around NCDs – jurisdictional disputes, legal challenges, ideological opposition and doubts about effectiveness can all serve to forestall legislation in this area.[xxx]

There are a number of ways in which law can influence behavioural risk factors for NCDs. These fall into the following categories: health infrastructure and governance; shaping the informational environment; creating economic incentives and subsidies; designing or altering the built environment; addressing health inequalities through economic policies; and command and control regulation, i.e. directly regulating persons, professionals, businesses and other organisations.[xxxi]

For example, improved infrastructure might be accomplished through the establishment of structures or institutions that support whole-of-government approaches to NCD risk factors. An improved informational environment could include restrictions on advertising of harmful products, inclusion of health warnings, or nutritional labelling. Fiscal strategies might include increasing excise taxes on tobacco and alcoholic beverages to reduce demand, and grants to encourage other levels of government to fund worthwhile interventions. An improved built environment could mean smoke-free places, zones with restrictions on sales of tobacco, alcohol or certain foods, improved school food, or environments facilitating physical activity.[xxxii]

In recent years in Europe, public health laws have often been introduced in response to specific disease threats, or to strengthen national public health institutes. However, as NCDs become an increasing burden on economies through treatment costs and loss of productivity, more and more governments are exploring how public health law can best manage NCD risk factors. Current laws relating to NCDs have proved to be an effective and central component of comprehensive prevention and control strategies. Magnusson et al, in an Australian paper, wrote:

> *"Although governments are increasingly using law in innovative ways to support chronic disease prevention, law's role remains controversial. The food, tobacco and alcohol industries have lucrative markets to protect and there is a pervasive assumption that the solution to galloping rates of obesity, diabetes and other lifestyle diseases lies in individuals exercising greater self-control. But preaching self-control will not work if healthy choices are constantly undermined by other, more*

powerful influences. While law is not a complete answer, it can help to create supportive environments for changing the average behaviour of populations."[xxxiii]

The next four sections of this paper outline how the approaches identified in this discussion have been and can be used as tools in public health law. These four were selected as they are the focus of a current Welsh consultation on public health law.[xxxiv] They are:

- extending the requirement to use Health Impact Assessments (section 3)
- imposing a statutory duty on a range of bodies to reduce health inequalities (section 4)
- legislation to bring about a renewed focus on prevention of ill health (section 5), and
- legislation to strengthen community action around health protection and health improvement (section 6).

3 Extending the requirement to use Health Impact Assessments

There has been increasing recognition that addressing public health issues effectively is a multi-sectoral undertaking – i.e. that public health agencies and the health care delivery system need support to adequately address the social, economic and cultural environments which impact health. This approach has been endorsed by many national governments, as well as by the WHO and the EU.

3.1 Background to Health Impact Assessments

In keeping with the emphasis on a multi-sectoral approach, Health Impact Assessments (HIAs) provide a means to assess all policy development in terms of its health impact. For example, transport, housing or education policy may all potentially protect or damage people's health. WHO defines HIA as "a combination of procedures, methods and tools by which a policy, programme, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population."[xxxv] The National Research Council (in the United States) defines HIA as "a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population."[xxxvi] The Health in All Policies (HiAP) approach likewise recognises and addresses the fact that many of the determinants of health lie outside the health sector, and encourages governments to take a more inclusive approach through inter-sectoral and 'whole-of-government' policy and governance.[xxxvii]

HIAs are widely used internationally and nationally by public (and private) sectors. WHO notes that the benefits of HIAs include: the promotion of cross-sectoral cooperation; a participatory approach which values community views; provision of the best available evidence to decision-makers; improvement of health and reduction of inequalities; the possibility to strengthen the features of a proposal which will positively impact population health; flexibility; and links with sustainable development and resource management.[xxxviii] HIAs may also be effective in promoting accountability for decision-makers whose policies may have negative impacts on health. This aspect may explain why HIAs are also increasingly used by international organisations such as the World Bank and the International Monetary Fund as a condition for loans, and by international industry, for example mining.

In terms of NCDs, there are clear links between policy decisions in sectors such as agriculture, energy, housing and transportation and the risk factors for disease. These include, for example: agricultural policies which promote healthy food production; energy and housing policies which relieve fuel poverty and reduce the risk of respiratory and heart diseases; and transport policies which facilitate physical activity, helping to combat rates of obesity and diabetes. Some of these links are set out in Table 4.

Table 4: Links between policy decisions in various sectors and the risk factors for NCDs

Sector	Relation to NCDs
Health and social protection systems	NCD-related illness and disability can destabilise these systems. However, measures such as promoting access to preventive health services, screening and early detection, and healthy aging can reduce the costs of treatments and disability.
Food and agriculture	Because of the role of unhealthy diets as a key NCD risk factor, food/agriculture industry measures around production, trade, manufacturing, retail, labelling, pricing, and taxation options can all impact dietary choices, especially through the reduction of salt, sugar and saturated fat in prepared foods.
Urban transport and urban design	With growing populations in urban areas, public transit, cycling and pedestrian routes, green spaces and similar transport/design initiatives can impact physical activity, a key risk factor for NCDs.
Education	Healthier choices among children can be promoted through the creation of healthy environments, education of children about healthy living, provision of safe spaces for physical activity, and access to nutritious foods.
Employers	Workplace health promotion programmes may include wellness checks, healthy food and exercise options, and smoke-free workplaces. These can result in reduced healthcare costs, as well as increased employee productivity and improved corporate image.
Telecommunications and media	These sectors can highlight features on healthy living. Also, telehealth and mobile phones can further health promotion, offer treatment reminders, and connect individuals with NCD-related information and resources.

Source: Pan-American Health Organization[xxxix]

3.2 The legal basis for a statutory duty to promote Health Impact Assessments

One means of ensuring that the public-health impacts of decisions taken in other sectors are considered is to impose a statutory duty on organisations and authorities to promote or to require HIAs.

At the European level, Article 152 of the Amsterdam Treaty states that: "A high level of health protection shall be ensured in connection with the formulation and implementation of all Community policies and all Community measures"; and Health 21 lists as one of its key strategies that "multisectoral strategies … tackle the determinants of health, taking into account physical, economic, social, cultural and gender perspectives, and ensuring the use of health impact assessment".[xl] The adoption by the EU of a White Paper on HiAP (Health in All Policies) requires the European Commission and the Member States to ensure that health concerns are better integrated into all policies at Community, Member State and regional level, including in environment, research and regional policies, regulation of pharmaceuticals and foodstuffs, and governance of tobacco taxation and foreign policy.[xli]

Another precedent can be found within UK legislation, where HIAs form part of the mandatory 'Impact Assessment' required by Government for all relevant policies, with the aim of developing better, evidenced-based policy by careful consideration of the impact on the health of the population.[xlii] Impact Assessments are obligatory for all UK Government interventions of a regulatory nature that affect the private sector, civil society organisations and public services, and apply to primary and secondary legislation, as well as codes of practice or guidance.[xliii]

Section 54 of Québec's 2001 Public Health Act (implemented in 2002) requires government ministries and agencies proposing laws or regulations to first undertake an HIA. This obligation aims to ensure that legislation does not negatively impact population health and, concomitantly, to allow the Minister of Health and Social Services the capacity to share health-related concerns with other government ministries or agencies as necessary. A 2012 assessment found that, while initially there had been resistance to the measure from the affected ministries and agencies, there has been a consistent trend towards acceptance of the HIA process, with 519 requests for consultations between 2002 and 2012.[xliv]

At the federal level in the United States, legislation proposed in January 2013 contains measures on Health in All Policies, which would require the Department of Health and Human Services to carry out HIAs of major non-health legislative proposals and to assign staff to other departments to help them consider the health impacts of their activities.[xlv]

While HIAs are increasingly popular within the United States, they are rarely legislatively mandated at State or local level. A 2012 US study commissioned by the Health Impact Project looked at 36 selected jurisdictions where existing laws offered opportunities for health to be factored into a range of decision-making in which it would typically not otherwise be considered. Sectors included were environment and energy, transportation, agriculture, and waste disposal and recycling.[xlvi] Only 22 of the 36 jurisdictions surveyed had laws requiring or facilitating HIAs. The authors highlighted that the laws that most clearly

facilitate HIAs feature two criteria: either “They refer to a broad range or description of health impacts, such as effects on public health, safety, general welfare, environmental health, health disparities, social or economic well-being, or effects that are borne disproportionately by vulnerable populations,” or “They call for studies or assessments that are used to inform public policy, programs, projects, regulations, or decision making”. Other, less ‘strong’ laws may simply allocate funding for or authorise evaluations of health impacts without making the link to policy decisions. One example cited was an Oregon statute authorising the state’s health authority to survey and investigate how the production, processing or distribution of agricultural products may affect the public’s health.[xlvii]

Summary

Health Impact Assessments are increasingly being required in a number of jurisdictions. In the case of Québec, an examination over ten years has shown that, while government departments were reluctant to work inter-sectorally at first, eventually the HIAs were accepted and collaboration from the health sector sought out. One issue for discussion is the extent to which HIAs are used: should they apply only to government undertakings (and to which ones?), or should they also apply more broadly to private-sector projects which also contribute to the NCD risk factors to which a given community is exposed?

4 Imposing a statutory duty on a range of bodies to reduce health inequalities

According to Marmot et al:

> *"The lower people are on the socioeconomic gradient, the more likely they are to live in areas where the built environment is of poorer quality, less conducive to positive health behaviours and outcomes, and where exposure to environmental factors that are detrimental to health is more likely to occur … People who live in areas of high deprivation are more likely to be affected by tobacco smoke, biological and chemical contamination, hazardous waste sites, air pollution, flooding, sanitation and water scarcity, noise pollution, and road traffic*. *These people are less likely to live in decent housing and places that are sociable and congenial, of high social capital, that feel safe from crime and disorder, and have access to green spaces, adequate transport options, and opportunities for healthy living."* [xlviii]

There is a clear link between social inequalities and ill health, both because disadvantaged groups have poorer access to services, and also fewer resources in education, employment, housing, and transport, and reduced participation in civic society to make healthy choices. NCDs have a strong link to health inequalities, since opportunities to make healthy choices may be affected by social determinants including socioeconomic status, gender, ethnicity or education. Health inequalities are costly: UK estimates suggest that the consequences of inequalities in illness account for productivity losses of £31-£33 billion per year, and lost taxes and higher welfare payments in the range of £20-£32 billion per year.[xlix]

Reducing health inequalities is not a straightforward undertaking, and policies should be clear about what is meant by promoting equity in health. One expert classifies policy responses into three groups: those aimed at improving the health of poor groups (e.g. by promoting smoking cessation or healthy eating among disadvantaged groups); those which work to narrow the gap between the health of disadvantaged groups and health in the population as a whole; and those which attempt to improve the health gradient with the greatest improvement for the poorest groups, and the rate of gain progressively decreasing for higher socioeconomic groups (e.g. a smoking cessation intervention which is available to the whole population but which is actively promoted via additional services for less advantaged groups, with the most intensive support for the most disadvantaged groups).[l]

A focus on health inequalities may serve to better inform public health choices about the types of interventions used. For example, tobacco use and poor diet are major risk factors for cardiovascular disease, and a high-risk approach to cardiovascular disease prevention usually involves population screening, with those individuals above a particular risk threshold being given advice on behaviour change and/or medication to reduce blood cholesterol and blood pressure. However, it has been found that this approach exacerbates socioeconomic inequalities which have been reported in screening, healthy diet advice, smoking cessation, and statin and anti-hypertensive prescribing and adherence, and that a population-wide approach which legislates for smoke-free public spaces or for reducing salt intake could be more effective and reduce health inequalities.[li] A 2012 American study suggested that – after adjustments for demographics, health care access, and physiological

distress – the level of education attained and financial wealth remain strong predictors of mortality risk among adults with diabetes.[lii]

Table 5 shows the guiding principles relating to equity in public health legislation in various countries.

Table 5: Guiding principles relating to equity in selected public health legislation

BULGARIA Bulgarian Health Act 2004[liii]	"The protection of the citizens' health as a condition of full physical, mental and social wellbeing is a national priority and it shall be guaranteed by the government through the application of the following principles: … equality in the use of health services …"
FINLAND Health Care Act 2010[liv]	"The objective of this Act is to … (2) reduce health inequalities between different population groups;" (Section 2)
GREECE Law on Public Health 2005	"Action to support vulnerable groups and to reduce socioeconomic inequalities in health is an essential part of public health." (Article 2)
NORWAY Norwegian Public Health Act 2012 [lv]	The purpose is to "contribute to societal development that promotes public health and reduces social inequalities in health".
AUSTRALIA South Australian Public Health Act 2011[lvi]	"Decisions and actions should not, as far as is reasonably practicable, unduly or unfairly disadvantage individuals or communities and, as relevant, consideration should be given to health disparities between population groups and to strategies that can minimise or alleviate such disparities." (Part 2, section 13)
SWEDEN Health and Medical Services Act 1982	Lists as the overall objective of health and medical care: *"*Good health and care for the whole population on equal terms".

In Finland, the 2010 Health Care Act was designed in response to equity challenges in healthcare services, and contains provisions that give a number of new rights to patients. For example, patients can access health services outside their municipality, and each patient has the freedom to choose his or her own health setting and specialised healthcare unit (from 2014).[lvii] Patients enjoy similar benefits under the Swedish 2011 Patient Care Act, which provides the right to choose care providers, the right to health care within a certain time, and a free choice of health centre.[lviii]

Under the New Zealand Public Health and Disability Amendment Bill 2010 (which amends the New Zealand Public Health and Disability Act 2000), the objectives of the district health boards include: to reduce health disparities by improving health outcomes for Maori and other population groups; and to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and

implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.

One approach suggested in the Welsh consultation on public health law is the imposition of a statutory duty on selected organisations to reduce health inequalities. For example, health boards could be required to address why take-up rates of health services may be lower in deprived groups. Section 1C of the UK Health and Social Care Act 2012 addresses the "Duty as to reducing inequalities" and provides that: "In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service".[lix] The Act imposes explicit duties on the Secretary of State, the NHS Commissioning Board and clinical commissioning groups to have regard to the need to reduce inequalities in the benefits which can be obtained from health services. The duty applies to both NHS and public functions, and incorporates access to and benefits from health care services.[lx]

Summary
Many public health laws explicitly consider the issue of inequities. This could be either as a general principle to be applied in interpretation of the entire act, as well as specific duties such as in the Finnish act which gives new choices to patients, the New Zealand act which sets out responsibilities to district health boards, or the UK act which requires bodies to consider the reduction of inequalities when commissioning health services.

5 Legislation to bring about a renewed focus on prevention of ill health

Legislation may support prevention through reduction of risk factors, through the creation of bodies charged with disease prevention, or through specific activities relating to the financing of prevention.

5.1 Flexible legislation to reduce risk factors

While the category of 'legislation to reduce risk factors' could be construed quite broadly, this paper will focus specifically on public health laws which provide flexibility to address current and future NCD threats. This type of flexibility is another approach to dealing with particular threats as they arise – which we might see, for example, in Scotland's 2008 Public Health Law which contains a provision prohibiting operators from allowing minors to use sunbeds.[lxi] Two relatively novel approaches can be found in the British Columbia Public Health Act and the South Australian Public Health Act.

The British Columbia Public Health Act (2008) not only allows the Minister of Health to require development of public health plans for health promotion and protection to address issues such as chronic disease prevention or inclusion of mental health and substance services in communities. It also enables the development of health impediment regulations, which address matters that adversely affect public health from long-term, cumulative exposures that cause significant chronic disease or disability, interfere with the goals of public health initiatives, or are associated with poor health in the population (e.g. foods high in trans fats).

In Part 8 of the South Australian Public Health Act 2011 (Prevention of non-communicable conditions), the Minister of Health is vested with the power to declare a particular non-communicable condition to be of significance to public health, which then allows the Minister to develop a code of practice in relation to preventing or reducing the incidence of the non-communicable condition. Such a code of practice can relate to: an industry or sector; a section or part of the community; or an activity, undertaking or circumstance. It may relate to: goods, substances and services; advertising and marketing; manufacturing, distribution, supply and sale; building and infrastructure design; or access to certain goods, substances or services. While not mandatory, performance reports can be published and breaches of a code of practice may result in enforceable compliance notices being issued. Additionally, there is a specific regulation-making power for taking measures to manage any non-communicable condition.[lxii]

These two laws grant Ministers of Health the powers to creatively and flexibly regulate those products and activities that impact the public health – a potentially valuable tool for reducing the risk factors for NCDs. This kind of flexibility can make it easier to respond to public health threats as they emerge and as evidence becomes available, without needing to resort to lengthy legislative processes.

5.2 Creating bodies and expanding mandates to tackle NCDs

Finland has merged the National Public Health Institute (KTL) and the National Research and Development Centre for Welfare and Health (STAKES) into one large and comprehensive entity, the National Institute for Health and Welfare (THL), which "provides the government with broad background research and expertise to serve public health and welfare and to support health and social services with expert advice, development, and monitoring and to help protect and promote the welfare of Finnish people by active communication and interaction in Finnish society." This supports a multi-sectoral approach to health and has led to increases in alcohol and tobacco tax, a new soft drink and sweets tax, strengthening of tobacco control legislation and discussions with the Ministries of Agriculture, Education and Communications.[lxiii]

In Article 6 of Greece's Law on Public Health (2005), the Centre for the Control of Special Communicable Diseases was renamed the Hellenic Center for Disease Control and Prevention (KEELPNO) and its mission broadened to include NCDs, accidents, environmental health, a central public health laboratory, and the evaluation of health services.

In Iceland, amendments made in 2011 to the Medical Director of Health and Public Health Act incorporated the Public Health Institute of Iceland into the Directorate of Health, and expanded the mandate of the Directorate of Health to include public health measures and health promotion.[lxiv] Functions include: advising the Minister of Welfare and other government bodies, health professionals and the public on matters concerning health, disease prevention and health promotion; and sponsoring and organising public health initiatives.[lxv]

Similarly, the South Australian Public Health Act establishes a South Australian Public Health Council (SAPHC). This is the successor body to the Public and Environmental Health Council established under the previous Act. The principal difference between these two bodies is that the SAPHC has an expanded membership that reflects the broader scope of contemporary public health. The Act also provides terms of reference for the SAPHC that define a high-level strategic advisory role.[lxvi]

5.3 Increasing budgets for prevention of ill health

Investments in prevention and in protecting and improving the population's overall physical and mental health will have positive consequences in terms of healthcare spending and productivity. 2006 OECD data suggest that spending on prevention currently amounts to an average of 3% of OECD Member States' total annual budgets for health, as opposed to 97% spent on healthcare and treatment.[lxvii] Since prevention is a cost-effective measure, government intervention to shift resources towards prevention will result in long-term benefits.

The US Affordable Care Act establishes a Prevention and Public Health Fund (Section 4002). The Fund "aims to provide an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private

and public sector health care costs, with a dedicated fund for prevention and wellness". The Secretary of Health and Human Services has the authority to transfer amounts from the Fund to increase funding for any programme authorised by the Public Health Service Act for "prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs." The Fund will invest $12.5 billion in prevention activities over the decade 2013-2022. The Fund also supports the Community Transformation Grants that support local initiatives for chronic disease prevention.[lxviii]

This category may also include channelling specified funds into prevention. In Switzerland, the 2009 law on prevention and health promotion *(La Loi Fédérale sur la Prévention et la Promotion de la Santé)* includes provisions requiring that certain proceeds from the LAMal (health insurance) are used for prevention, health promotion and early detection of diseases. Similarly, tax collected from tobacco producers and importers (destined under a 1969 law for health promotion measures) must be used specifically for tobacco control.[lxix]

Summary

Use of legislation to bring about a renewed focus on prevention work can encompass a variety of measures. In looking at the flexible approaches to the reduction of risk factors, the creation of bodies charged with disease prevention, or specific activities relating to the financing of prevention, there are a number of recent developments that may be of interest to governments. These include: British Columbia's and the South Australian Public Health Acts, which allow Ministries of Health to respond flexibly to NCD threats as they arise; the trend towards replacing or expanding the scope of communicable disease institutes to manage NCDs as well; and the recognition by the US Government of the importance of having funds earmarked for prevention through the Prevention and Public Health Fund under the 2010 Affordable Care Act.

6 Legislation to strengthen community action around health protection and health improvement

The fourth and final topic involves giving local communities an opportunity to be more involved in local decision-making on improving public health. Support for this approach can be found in documents such as the *Action Plan for Implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases*, which endorses empowerment and the 'whole-of-society' as key principles.[lxx] 'Empowerment' means that all public health and healthcare activities should support community action, promote health literacy, and respect the patient, while the 'whole-of-society' approach is understood as encouraging cooperation and collaboration between public health and health care and between State and non-State actors, and engaging civil society, businesses and individuals in public health and healthcare decisions.[lxxi] Strategies like this are intended to facilitate patients to manage disease, adopt healthy behaviours and use health services effectively.

This section will focus on three interpretations of this type of legislative action: 1) using Health Impact Assessments as a support for community action; 2) mandates or programmes to share information about NCDs with communities; and 3) increasing the role of local government.

6.1 Using Health Impact Assessments as a support for community action

Clearly, this is closely linked to the discussion on HIAs in section 3, as throughout the HIA process communities will ideally play a critical role in identifying the health consequences of a given proposal. A participatory approach that values the views of the community, treating them as relevant stakeholders, will reinforce this perspective. Furthermore, the HIA process can demonstrate that organisers of a given project are eager to listen to, involve and respond to community members.[lxxii]

6.2 Sharing information about NCDs with communities

The concept of legislation to strengthen community action is also based upon the principle that communities have the right to receive appropriate information on reducing the risk of NCDs, empowering them to make appropriate healthy choices. Legislative precedents – and innovative policy and incentives – can be found in the United States, the UK, Finland and South Australia:

- *United States* – Title IV of the US Affordable Care Act (2010)[lxxiii] addresses prevention of chronic disease. This contains a section addressing the creation of healthier communities through grants for community initiatives that will support more 'walkable' communities, healthier schools and increased access to nutritious foods in safe environments. One component of this strategy is the use of Community Transformation Grants, which may be used for programmes to promote individual and community health and prevent the incidence of chronic disease.

- *UK* – The UK Health and Social Care Act (2012) endorses the principle of "No decision about me, without me". The phrase describes a vision of health care where the patient is an active participant in treatment decisions. To this end, legislative changes include: strengthening the voice of patients; imposing additional duties on Commissioning Groups, Monitor (the health care regulator) and Health and Wellbeing Boards to involve patients, carers and the public; and establishing Healthwatch England, a national body representing the views of service users, the public and local Healthwatch organisations.[lxxiv]

- *Finland* – The Health Care Act (2010), section 11, states: "When planning and making decisions, local authorities and joint municipal authorities for hospital districts shall assess and take into consideration any effects that their decisions may have on the health and social welfare of residents."

- *Australia* – Principle 11 of the South Australian Public Health Act (2012) states: "Individuals and communities should be encouraged to take responsibility for their own health and, to that end, to participate in decisions about how to protect and promote their own health and the health of their communities."[lxxv]

6.3 Increasing the role of local government

A broader interpretation of the objective of strengthening community action would be to involve local government more in making public health decisions and policy. For example:

- *Finland* – The Health Care Act aims to give key responsibility for public health promotion to the municipalities in order to improve prevention and to reduce the demand for services which accompanies later stages of NCDs. The Act requires each municipality to monitor the health and welfare of its residents and to compile relevant statistics during terms of office.[lxxvi]

- *Sweden* – Twenty county councils have the responsibility for the organisation of health care, and are also responsible for health and social care for the elderly. New changes under the 2011 Patient Care Act aim to better protect and involve patients in decisions.[lxxvii]

- *UK* – Similarly, in the UK, the Health and Social Care Act (2012) grants new responsibilities to local authorities for improving the health of local populations. Components of the legislation require the engagement of a director of public health, a ring-fenced budget, and annual progress-charting reports. The rationale for this move is the notion that "wider determinants of health (for example, housing, economic development, transport) can be more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations."[lxxviii]

Summary
Legislation is frequently used to strengthen community action promoting health protection and improvement. This can give local communities an opportunity to be more involved in local decision-making to improve public health. Some legislative examples come from programmes which endorse a multi-sectoral and community-oriented approach through inclusive processes, such as through the HIA process, or sharing information with communities (e.g. through the UK Healthwatch or the US Community Transformation Grants programmes); while others strengthen the role of local governments in health promotion and disease prevention (e.g. in Finland and the UK).

7 Conclusions

There are a number of tools available to national and local governments in order to address non-communicable diseases. Public health legislation, where appropriate, can be an extremely powerful mechanism in this regard. This paper has explored four legislative options: extending the requirement to use Health Impact Assessments; imposing a statutory duty on a range of bodies to reduce health inequalities; legislation to bring about a renewed focus on prevention of ill health; and legislation to strengthen community action around health protection and health improvement. Precedents in each of these areas, and particularly novel precedents in terms of granting flexibility to health authorities to address NCDs, will help governments to craft their own policy options.

The first discussion showed the increasing use of Health Impact Assessments, and cited a Québec study suggesting that mandatory HIAs will lead to better inter-sectoral collaboration.

The second considered the issue of inequities and a statutory duty on bodies to address and reduce health inequalities. Many public health laws list reducing inequities as a key principle (particularly in Scandinavian legislation). Furthermore, there are specific duties in, for example: the Finnish act which gives new choices to patients; the New Zealand act which sets out the responsibilities of district health boards; or the UK act which requires bodies to consider the reduction of inequalities when commissioning health services.

Legislation can bring about a renewed focus on prevention work through measures including flexible approaches to the reduction of risk factors, the creation of bodies charged with disease prevention, or through specific activities relating to the financing of prevention. Of particular interest are: British Columbia's and the South Australian legislation granting health ministries the ability to respond flexibly to NCD concerns as they arise; and refocusing national health institutions to consider NCDs or earmarking funds for prevention, as in the US 2010 Affordable Care Act.

Fourthly, public health law can strengthen community action promoting health protection and improvement. This can be through programmes which endorse a multi-sectoral and community-oriented approach such as HIAs, community-based information-sharing programmes such as UK Healthwatch or the US Community Transformation Grants programmes, or increasing the role of local governments in health promotion and disease prevention as in Finland and the UK.

Throughout the discussion of the four highlighted legislative options we have repeatedly seen the key concepts of multi-sectoral approaches and of reducing inequalities. This paper has set out a few of the many precedents for ways in which public health law can be used to reduce risk factors for NCDs.

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Appendix 2 – Event Report: Policy development roundtable

From the Public Health Perspective

Policy development roundtable event report on the Well-being of Future Generations (Wales) Bill

Background
In November 2014, the UK Health Forum, the Royal College of Physicians in Wales (RCP) and the Royal Society for Public Health (RSPH) partnered with University of Wales Trinity St David to host a policy development roundtable looking at the proposed aims, objectives and outcomes from the Well-being of Future Generations Bill and its potential impact on public health. This report highlights the key points from the day and the recommendations that arose from it.

Key points

- The Bill should provide an enabling framework which will galvanise and support the Welsh Government and other public bodies to proactively address emerging public health issues.

- The Bill must place a duty on Ministers to consider the health impact of all policies coming out of the Welsh Government.

- The title of the Bill should be changed to 'Health and Well-being of Future Generations Bill'.

- The Welsh Government must take an integrated approach and consider the specific outcomes implied by this Bill in more detail. Ministers must provide detailed guidance and practical support to public bodies affected by this Bill.

About us
The **UK Health Forum** is a charitable alliance of professional and public interest organisations working to reduce the risk of avoidable non-communicable diseases (NCDs) by developing evidence-based public health policy and supporting its implementation through advocacy and information provision.

The **Royal College of Physicians** plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in Wales and across the world with education, training and support throughout their careers. As an independent body representing more than 30,000 fellows and members worldwide, including 800 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The **Royal Society for Public Health** is an independent, multi-disciplinary charity dedicated to the improvement of the public's health and wellbeing. Formed in October 2008 with the merger of the Royal Society of Health and the Royal Institute of Public Health, we help inform policy and practice, working to educate, empower and support communities and individuals to live healthily.

The case for change in Wales

The Welsh Government must take this opportunity to reduce health inequalities by addressing why so many people in Wales have poor health outcomes. We know that these outcomes can be linked to poverty, lifestyle, culture and deprivation. Many of these reasons are historical and deep-rooted in some communities in Wales, and will require a raft of measures.

Chronic disease (eg cardiovascular disease, diabetes, cancer, chronic respiratory disease) continues to place a heavy burden on the health service in Wales. Around a half of adults report being treated for an illness such as high blood pressure, respiratory illness, arthritis, mental illness, heart condition or diabetes and a third of adults report a limitation in their daily activities due to a health problem or disability (Welsh Government, 2014a). This high level of ill health also has a negative effect on economic growth due to the loss of income, productivity and capital formation. Indeed, levels of ill-health increase with levels of area deprivation. In general, those in the most deprived areas report the worst health (Welsh Government, 2014a).

Around 3 in 5 (58 per cent) adults are classified as overweight or obese, including just over 1 in 5 (22 per cent) adults classified as obese (Welsh Government, 2014a) and Wales has the second highest rates of adolescent obesity in Europe (WHO, 2012). Smoking continues to be the greatest single cause of avoidable mortality in Wales; around 21% of the population smoke (Welsh Government, 2014a), resulting in around 6000 smoking-related deaths every year (NHS Wales, 2007). Moreover, smoking is estimated to cause around 27,700 hospital admissions each year in Wales (Public Health Wales Observatory, 2012).

Around 2 in 5 (42 per cent) adults report drinking above the recommended guidelines on at least one day a week, including around a quarter (26 per cent) who report binge drinking (Welsh Government, 2014a). There are around 1000 alcohol-related deaths in Wales every year (Wales Centre for Health, 2009). Furthermore, this is already affecting future generations: in a survey of 40 countries, 13 year olds in Wales were the most likely to have been drunk twice (Wales Centre for Health, 2009). The scale of this public health challenge places a huge strain on the NHS in Wales.

The importance of public health law

A key part of the day's discussions highlighted the general importance of public health law and its potential to contribute to improving and protecting the public's health.

New legislation on public health would provide us with a collective response to preventing and reducing public health harms and would pave the way for future behaviour change. Legislation has a role in changing socio-cultural norms: by putting in place penalties for unacceptable behaviour, we make a statement about that behaviour. Two excellent examples of this approach are seat-belt legislation and smoke-free legislation, which are widely understood to be fundamentally-important catalysts in changing attitudes, expectations and behaviour in road safety and smoking respectively.

Law can be an essential tool for creating the conditions that enable people to live healthier lives. The World Health Organisation (WHO) 'best buys' for impacting on public health suggest that most of the really cost-effective interventions are regulatory (World Economic Forum, 2011) eg alcohol

taxes, minimum unit pricing schemes, trans-fatty acid bans, tobacco advertising bans, plain cigarette packaging or a ban on smoking in public places. Many of the 'best buys' are linked to increases in tax and therefore create wealth for the economy. Furthermore, law is more effective and more cost-effective because it allows intervention on a much wider scale than can be directed at an individual. This gives legislation far more potential to alter the environment (Chokshi and Farley, 2012) and consequently, lead to wide scale behaviour change. Even if the effect of an altered environment on each person is small, the cumulative population effect can be large and the cost per capita is relatively small. Yet many public health laws that would produce a cost saving to society have not been put in place (Miller and Hendrie, 2012).

The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice. The state's moral mandate is to protect its citizens from foreseeable threats of harm. This requires justifying where interference with individual rights to protect public health is a public good and where it is proportionate to the public health threat. Law also provides a public expression of cultural values and can change socio-cultural norms. This can create expectations on corporations, who may comply because they wish to be seen as good corporate citizens. Conversely, the absence of law also serves to send messages about acceptable behaviours and can send the message that the threat is minimal, imaginary or unimportant. This creates a legal environment which is harmful to public health through its failure to clarify unacceptable sources of health harms. Without a comprehensive and coherent legal framework, public health endeavours are weakened, hampering efforts to combat both communicable and non-communicable diseases and to protect public well-being.

The focus of public health should therefore lie on preventing, not just managing poor health. Many of the underlying reasons for health inequality in Wales cannot be solved by solely local initiatives and local authorities but will need a more strategic national approach by the Welsh Government.

Key recommendation: The Well-being of Future Generations Bill should provide an enabling framework which will galvanise and support the Welsh Government and other bodies to address emerging public health issues proactively as they arise.

The Welsh Government should be prepared to use a number of public health interventions available (including regulation) and must coordinate action across different government departments and partners. We are supportive of legislation that takes an 'all society' approach to a broader conception of health problems and we would support a requirement on appropriate bodies to consider how to reduce and prevent health inequalities and involve communities in their decision making. However, we urge Welsh Government to consider the specific outcomes implied by this Bill in more detail as soon as possible.

Public health legislation in Wales

The Welsh Government has announced two distinct pieces of public health legislation for the fourth Assembly: the Well-being of Future Generations Bill and the Public Health Bill.

The Well-being of Future Generations Bill seeks to ensure that sustainable development is the central organising principle of the Welsh Government and public bodies in Wales, in line with the 2009 Sustainable Development Scheme 'One Wales, One Planet' (Welsh Assembly Government, 2009). The Welsh Government has an almost unique duty to ensure that sustainable development is included as a priority at all levels of government.

The definition of sustainable development used in the 2012 white paper is '*enhancing the economic, social and environmental wellbeing of people and communities, achieving a better quality of life for our own and future generations in ways which: - promote social justice and equality of opportunity; and enhance the natural and cultural environment and respect its limits – using only our fair share of the earth's resources and sustaining our cultural legacy*' (Welsh Government, 2012). However, despite the Welsh Government's statutory duty to promote sustainable development, a 2011 WWF report suggested that sustainable development is far from embedded (WWF, 2011) because the legal duty is to 'promote' rather than to 'achieve' sustainable development.

The two key aims of the Well-being of Future Generations Bill are to legislate to make sustainable development the central organising principle of the Welsh Government and public bodies in Wales, and to create an independent sustainable development body for Wales. The Bill seeks to address issues including climate change, skills, employment, poverty, health inequalities, biodiversity decline and environmental limits.

While sustainable development is often understood to be environmental issue, this overlooks many of its other important aspects. This Bill aims to encourage wider thinking about the concept and contains six well-being goals: a prosperous Wales; a resilient Wales; a healthier Wales; a more equal Wales; a Wales of cohesive communities; and a Wales of vibrant culture and thriving Welsh language. These goals are linked to the social, economic and environment well-being for the people of Wales. 'A healthier Wales' is defined as *'a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood'* (Welsh Government, 2014b).

The Bill relates only to forty four public sector organisations, including the Welsh Government, local authorities, and NHS local health boards and trusts. It will not apply to private or third sector organisations. The Bill will create an independent Future Generations Commissioner who will monitor outcomes and ensure support for public bodies.
The second major piece of public health legislation will be the Public Health Bill. The recent White Paper proposed the introduction of minimum alcohol unit pricing; a tobacco retailers' register; and a ban on the use of e-cigarettes in public places. A Bill is expected in 2015.

A 'health in all policies' approach
Integration and collaboration on public health must be embedded across the NHS, local authorities and the Welsh Government.

Key recommendation: The Well-being of Future Generations Bill must place a duty on Ministers to consider the health impact of all policies coming out of the Welsh Government and other public bodies.

We strongly urge the Welsh Government to consider how best to ensure that reducing inequality and improving health outcomes underpins everything they do by implementing a 'health in all policies' approach.

Other recommendations

- **The title of the Bill should be the '*Health and* Well-being of Future Generations Bill'**
  The Bill must send a clear message that health outcomes underpin the success of this legislation. The title of the Bill should include the word 'health'. In addition, the definition of

'a healthier Wales' should include the word 'health', that is 'a society in which people's physical and mental *health and* well-being is maximised and in which choices and behaviours that benefit future health are understood' (Part 2, Section 6(1) Wellbeing goals). Assessments of local well-being should be 'a public services board must prepare and publish an assessment of the state of economic, social and environmental *health and* well-being in its area' (Chapter 2, Section 35(1) Assessments of local well-being).

- **The Welsh Government must take an integrated approach and consider the specific outcomes implied by this Bill in more detail. Ministers must provide detailed guidance and practical support to public bodies affected by this Bill**
  We are not convinced that the current Bill will be a truly effective piece of legislation. A great deal of work still needs to be done to ensure that the Bill makes a tangible difference to the lives of future generations in Wales. Ministers should take an integrated approach to implementing this legislation, and provide detailed guidance and practical support to public bodies when the Bill is enacted, especially around the sharing, if appropriate, of budgets.

  The Bill should make provision about the contents of accompanying guidance. In the short term, the Welsh Government should work with public bodies to review existing activity to understand what local service boards are already doing. National and local indicators will need to fit together effectively and should be chosen to measure progress in the best way, not just the easiest way. Furthermore, Ministers should consider the impact on private and voluntary sector organisations and how these bodies can be encouraged to work within the framework of the Bill.

- **The Bill must ensure that accurate, relevant data is collected, reported and monitored**
  We note chronic, longstanding problems of gaining access to data which is already being collected. This is vital to ensure independent and authoritative data. The Bill should place a duty on public bodies to collect and store appropriate data so that it can be independently used to demonstrate that the Bill can make a difference. The 2008 Public Health Act in Netherland included '*provisions for the obligatory storage of digital data in the context of healthcare for young people*' and there is no reason why there could not be specific provision for data storage and collection in Wales. The types of data referred to in the Bill should be defined more clearly, and the Welsh Government should explore whether there is a role for the Commissioner in data collection and sharing. This could improve accountability and give the Commissioner the responsibility for monitoring the health and well-being of the most vulnerable people in Wales.

- **The Bill should place a duty on Ministers to improve health outcomes for children and pregnant women**
  There is no mention of women or children in the Bill. Yet we know that health inequalities begin from early life experiences and cast a long shadow: a healthy pregnancy and healthy early years are vital. To protect the health and well-being of future generations, the Bill should recognise that epigenetic effects in the womb and modifiable risk factors (eg stress, smoking, alcohol) have an impact not just on the individual, but on the next generation. The Bill should acknowledge this through Goal 4: A more equal Wales. Please see further discussion of this point at annex 1 of this paper.

- **The Bill must ensure that public bodies listen to and work with communities**
  Ensuring that this Bill is effective will rely on building communities where green space, physical activity, access to food and a healthy environment are all integrated. While laudable, this will be very difficult to achieve and to monitor. Public bodies, including the

Welsh Government should work closely with communities to ensure that the potential for social change is not wasted.

- **The Bill should be designed along Cynefin principles**
  The Cynefin framework is a decision making tool that deals with the complexity and unpredictability of the world. It '*signifies the multiple factors in our environment and our experience that influence us in ways we can never understand*' (Snowden and Boone, 2007). Cynefin principles should be used to understand and respond to the complexity associated with creating a Wales that lives up to the six goals in the Bill. Research suggests that the appearance of a neighbourhood is positively correlated with the self-reported health and well-being of community members. There is also a positive correlation between social cohesion and mental health in close-knit communities: '*trust in others has been repeatedly found to be a vital support for happier lives*' (OECD, 2014).

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Annex 1 – Improving health outcomes for children and pregnant women

Based on the fact that the NHS is the only statutory body in contact with all mothers and children in their early years, and the leading role that local government plays in education and other services, this Bill should:

- Place a duty on the Welsh Government to prepare an Early Start Plan every four years, setting out how it will aim to ensure every child has the chance to grow up fit and healthy and achieve school ready status, which would:

  - Identify and report by local area on aspects of poor health
  - Identify the responsibilities of different agencies to tackle them
  - Propose actions to target the most deprived communities and reduce the gap in outcomes.

- Place a joint duty on local health boards and local authorities to prepare child health improvement and health equality plans every four years, setting out how with others they will act. This should require them to set out how they would:

  - Identify differences in health status in different communities
  - Design and implement a programme to improve outcomes
  - Target the most deprived communities and reduce the gap in outcomes
  - Report annually on progress.

- Place a duty on Public Health Wales to advise the responsible bodies on effective interventions to discharge their duty

- Place a duty on the Wales Audit Office to monitor progress, especially through reviewing the plans.

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

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

Evidence from Wrexham County Borough Council – PHB 58 / Tystiolaeth gan Cyngor Bwrdeistref Sirol Wrecsam – PHB 58

Response from Wrexham County Borough Council to Public Health Wales Bill

Part 2: Tobacco and Nicotine Products

Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

This section has been responded to by the Smoke Free Wrexham Partnership Group.

 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?

Yes Smoke Free Wrexham agrees.

Comment from Environmental Health *:* The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. In our view it is appropriate to take a precautionary approach to the risks associated with e-cigarettes in smoke-free places.

 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)?

Yes we agree with children's playgrounds, we already have Smoke Free playgrounds and Smoke Free school gates in Wrexham, and are working towards smoke free bus shelters. On the whole we believe the enforcement of this works quite well on a voluntary basis as most people are in agreement of not smoking in these areas. In terms of the hospital sites we also agree, but have some concerns about compliance, as current compliance is not good and there needs to be support from the Health Board to implement this effectively e.g. cleaning up cigarette ends, regular monitoring. Work needs to be done to look at current non-compliance before introducing. Perhaps start with staff, then the public. Pharmacotherapy needs to be offered as part of every admission process for a smoking patient. Will this also apply to prisons in the future?

 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?

Yes at present, until regulated and then this may need to be re-visited. We have concerns about re-normalising particularly with children and young people. We have concerns that the user may claim the device does not contain nicotine and we would have no way of knowing this unless the product was analysed, in these cases the user should be responsible to proving the product does not contain nicotine or a preferable option would be to prohibit all vaping devices regardless of the contents.

 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?

We totally agree that the use of e-cigarettes re-normalises smoking particularly in children and young people.

 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?

We have concerns about this especially when flavours are targeted to be appealing to young people. We also have concerns about these devices being tampered with to vape NPS (New Psychoactive substances) and illegal substances. Anecdotal evidence from group members suggests that young people (in this case ages 14 and 17 and their peers) found e cigarettes appealing and believed them to be not harmful to health in any way.

 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?

In our opinion at this time e-cigarettes should be treated the same as tobacco products and yes we feel this will most definitely aid managers of premises to enforce.

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

We would suggest a fixed penalty fine on a par with littering. There will be issues with enforcement, how will you address these? We would also suggest seizure of the products from under 18’s.

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

Yes we agree, but is there going to be an exemption for NRT products?

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

We believe this will have a limited impact as it won't stop proxy purchases or purchase of illicit tobacco (where price is affordable to young people).

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

This provides an extra incentive, but compliance is already good. Where is the evidence this is the source of supply?

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

We would wholeheartedly support the offence relating to proxy sales to under 18's, this may impact on parental / sibling supply by proxy and retailers. But who will deal with the offence and how will it be enforced?

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

Yes we agree.

Part 3: Special Procedures

Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales; these procedures are acupuncture, body piercing, electrolysis and tattooing.

This section has been completed in consultation with Environmental Health.

 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?

We agree as the existing system in not sufficient to tackle such issues as illegal tattooists. A licensing framework designed to cover a wide range of situations and procedures with more robust and tailored enforcement options is welcomed.

We would be opposed to grandfather rights for existing traders.

Licensing conditions need to cover competence and training in areas such as infection control.

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

We agree, but would like it clarifying whether this includes micropigmentation.

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

This is a good idea, as new procedures are being developed all of the time. Recent procedures causing us concern include branding, scarification, dermal implants, botox, laser tattoo removal, chemical peels, ink eye injections.

 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?

We have no adverse view on this list.

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

If it is to become a licencing function and minor infringements are heard by licencing committees, this is going to mean more work for licencing teams (and EHOs) but the increase is difficult to quantify at this stage.

May have an adverse affect on the 'good' or compliant members of the trade (as they believe we should focus our resource on 'scratchers' / illegal tattooists).

An increased number of offences will require more capacity for enforcing at a time when we have less capacity.

We need the police to have a power of arrest for key offences to strengthen our enforcement role. Consideration should also be given to higher penalties (with significant fines and perhaps the possibility of a custodial sentence for some offences) to give a greater deterrence effect. Difficulties in gathering evidence due to RIPA restrictions or for activities in domestic premises should be addressed.

The statute of limitations needs to be from date of discovery of the offence (for example when a young person conceals an illegal tattoo).

It is unclear what the arrangements and status will before those wishing to train to undertake tattooing or other special procedures. How will the framework allow for and deal with trainees/apprentices who have not yet developed the necessary competence to carry out procedures – will they require the close supervision of a licensed individual?

The licensing framework needs to address current anomalies with such situations as tattoo conventions, 'guest' / visiting tattooists, and mobile/temporary services offering special procedures.

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

Yes we agree as it will give us stronger powers to deal with illegal tattooists / 'scratchers'.

We suggest that a requirement to undertake training in infection control which is commensurate to the procedure(s) undertaken should form part of the licensing conditions.

Part 4: Intimate Piercing

Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

This section has been completed in consultation with Environmental Health.

 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?

We would agree, this is entirely consistent with safeguarding procedures.

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

We agree with the list, but would suggest that tongue piercing is added to this list due to the severe risks if this is done incorrectly and the reasons for tongue piercings may raise safeguarding concerns.

 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?

We agree to make this a duty, but it needs to be sufficiently funded. Our ability to enforce this will be dependent on minors coming forward making a statement and press charges. The local authority regulator relationship with the Police will be important (not least because of the overlap with potential safeguarding issues) and it is requested that the Police also be given power of entry and arrest regarding offences under the Act.

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

Yes we agree.

Further comment – it is suggested that individuals wishing to carry out intimate piercings on young people between the age of 16-18 should be required to have a DBS check. It is also suggested that persons licensed to carry out intimate piercings should be over 18.

Part 5: Pharmaceutical Services

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

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

Community Pharmacy Wales will be responding separately to this section.

Part 6: Provision of Toilets

Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

This section has been responded to by Wrexham County Borough Council's Assets and Economic Development Department.

 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?

The Public Health Act 1936 gives local authorities a power to provide public toilets. However, it imposes no duty to do so. This lack of compulsion, together with a perception of nuisance associated with managing them, has arguably resulted in a steady decline in the provision of public toilets in recent years in some other local authority areas. It is reasonable to assume therefore that without additional funding from central government it will be problematic to provide enhanced facilities.

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

Public toilets matter to everybody, regardless of their age, ethnic origin, gender, ability. They are even more important to certain sections of our society, including older people, disabled people, women, families with young children and tourists. Public access to toilets is important for local shops and businesses too. People respond to locations that demonstrate a sense of civic pride, where it is obvious that they are welcomed. Tourists choose their destinations carefully, drawing on their previous impressions, talking to friends and family, looking up feedback on the internet. The work that is being undertaken by this Council and partners links to this. That said, there is no certainty that consultation with the local community, people, businesses, visitors and other interest groups will lead to improved provision of public toilets, - if additional funding is not forthcoming to improve them.

 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?

It's important to take local opinion into account when considering toilet provision. That said, national views are also important. It would not be appropriate if consultation didn't consider this. For example, Nationally, many organisations are campaigning for better provision of public toilets. That said and mentioned above, it's difficult to see how this desire can be aligned with dwindling public sector finances.

The British Resorts and Destinations Association (BRADA) highlight the importance of good quality public toilets for tourists and other visitors, who make a crucial contribution to many local economies. The National Organisation of Residents' Association (NORA) points out the negative impact on residents where lack of good provision results in street fouling, an increasing problem because of extended licensing laws. Help the Aged and other groups stress the importance of public toilets to give older people the confidence to leave their homes and to avoid problems arising from isolation and dependency. There is a strong lobby fighting for equal rights for disabled people, including the Changing Places Consortium, which has developed and introduced public toilets that are accessible to severely disabled people.

Clearly, local opinion is important. A lack of clean, accessible and safe toilets impacts on some people more than others. Some people may feel unable or reluctant to leave their homes and visit areas where they fear they will not be able to find a public toilet. Older people (a growing section of the population in our ageing society), mothers, fathers, and carers with young children, disabled people and people with chronic health problems – all need easy access to suitably equipped public toilet facilities. Legislation already exists, - The Single Equality Act 2010 that places additional responsibilities on public authorities in relation to accessible facilities for all Protected Characteristics, specifically for this report; Age, Disability, Sexual Orientation, Gender, Religion and Belief and Pregnancy and Maternity.

 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?

There is already a wealth of strategies in place. The UK Government's Strategic Guide on the provision of public toilets, "Improving Public Access to Better Quality Toilets" was published in March 2008. The guide highlights existing powers at the disposal of local authorities that can be used to improve public access to toilets.

There is a wide range of detailed information and guidance on all areas concerned with the provision of public toilets, including location, design and signage: the Government's strategic guide is a general overview about the provision of public toilets; the BTA has a list of recommendations and a comprehensive website; and British Standards BS8300 and BS6465 both provide codes of practice for the design of sanitary facilities and scales of provision

The British Standard Institute memorandum describes the proposed British Standard BS6465 Part 4, which is based on the current Annex C of BS6465-1:2006, and provides a comprehensive standard for providers of public toilets, which takes into account physical (spatial/geographical) distribution issues, user requirements and design considerations (taking into account the Single Equality Duty 2010) and practical, economic and management issues

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

Giving access to the public in settings in receipt of public funding has parallels in the now ended Community Toilet Scheme. The CTS scheme enabled local businesses like pubs, restaurants and shops, to work together with the council to make cleaner, safe and accessible toilets available to the public. All the businesses involved in the scheme had to allow non-customers to use their toilet facilities during their normal opening hours. Participating businesses displayed a sticker in the window, showing that the public are welcome to use the toilet facilities without necessarily having to ask or make a purchase. The scheme in Wrexham had a low rate of take up, principally because of the loss of control and the perception of that the premises being vulnerable and open to all.

There was some anecdotal evidence of anti-social behaviour and inappropriate use of facilities caused increased management and cleaning costs as a result of participating. In some cases security of public buildings and buildings in receipt of public funding would be unworkable unless buildings were adapted and modified to allow access without compromising security considerations.

 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?

The needs of all groups should be taken into account within the current legislation taking into account (the Single Equality Duty 2010) and practical, economic and management issues.

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

A lack of toilet facilities at the right time in the right place contributes to dirty streets that are unsanitary and unpleasant. A lack of available and appropriate facilities at the right time during the day and night encourages street fouling, and cleaning up the mess is a significant and costly task - especially at the weekend.

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.)

The concept of charging for the use of public toilets needs to be approached with a certain amount of care due to the potential negative impact. However, with the alternative option being closure, reducing costs and increasing income could make charging the only sustainable option. Evidence from other local authorities generally suggests that overall usage will reduce by 50% when a charge is introduced. People may also question about having to 'pay twice' for toilets, once through their 'council tax' and secondly paying again at the door.

Successfully generating revenue will depend on a variety of factors, including the price. The British Toilet Association (BTA) recommends a charge of 20p for most parts of the UK outside of major cities. Tourists, with their relatively low price sensitivity have the potential to provide the most income generation. However, as most toilets are mixed use between visitors and locals, it would be prudent to consider the ratio of users and the alternatives in the area. In general the BTA suggest a charge of 50p, while a mixed use would command a charge of 20p. Whilst the toilets in the Town centre are used extensively by tourists and visitors, introducing a charge of 50p may be a step too far and a 20p charge would probably be far more acceptable.

Where we are creating offences, registers and licencing regimes, this needs to be resourced with ring fenced funding provided to the local authorities

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

Other comments

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

Where we are creating offences, registers and licencing regimes, this needs to be resourced with ring fenced funding provided to the local authorities for awareness raising and enforcement.

How are you going to tackle/ensure consistency of enforcement across local authorities?

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

Yes

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

Controls on New Psychoactive Substances

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 Gower Enterprises Limited – PHB 59 / Tystiolaeth gan Gower Enterprises Limited – PHB 59

Dear Sir/Madam,

We write from Gower Enterprises Limited, electronic cigarette vendors with several shops both in Wales and England, in response to your invitation to contribute to the Inquiry regarding electronic cigarette use in Wales.

As recognised by Public Health England in their peer reviewed report released earlier this month, it is essential to recognise the enormous potential for harm reduction of e-cigarettes. The PHE report has identified the danger to public health should electronic cigarettes be treated as being as harmful as tobacco. Many ex-smokers have found e-cigarettes the best way they can avoid the harm associated with tobacco smoking - to impose restrictions is damaging to public health.

This fact has now been widely accepted by Public health bodies, including The Royal College of Physicians, Cancer Research UK, ASH, The British Heart Foundation, Tenovus, British Lung Foundation, the UK Nudge Group - and now Public Health England who have come out strongly in support of e cigarettes - and many others have opposed this ban.

The emotional response of those who are anti-nicotine should not influence the long term health of individual users, who are trying to take responsibility for their own improved health.

According to the Action on Smoking and Health fact sheet, "Use of electronic cigarettes (vapourisers) among adults in Great Britain" the UK now has an estimated 2.6 million e-cigarette vapers. Approximately 1.1 m are ex-smokers, and 1.4m are current smokers using e-cigarettes to reduce their use of tobacco. As has been emphasised in several reports, use by never smokers remains negligible, and there is no evidence whatsoever of electronic cigarettes being used as a gateway to children taking up smoking.

The proposed ban would inevitably lead to a significant number of users of e cigarettes reverting to smoking tobacco, and being subject to peer pressure by association with tobacco smokers forced upon them. The proposed restrictive ban on the use of e-cigarettes in enclosed public and workplaces will force e-cigarette users outside, to be surrounded by harmful tobacco smoke and temptation to revert." We answer the points raised in Annex A below:

- **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?**

No. This is contrary to public health requirements, for the reasons stated above. We know from our long association with e-cigarette users, meeting many daily in our 7 shops in Wales that people benefit hugely from switching to electronic cigarettes both in improved health and finances. We make no claims in our shops or on our website as to these benefits, but are told by our customers on a daily basis of the benefits they have found.

As stated in the PHE England report, “EC should not routinely be treated in the same way as smoking” electronic cigarettes are a benefit to public health. To deny the Welsh public the right to take responsibility for their health is a shocking proposal.

No scientific evidence has been found that vaping in public spaces is harmful to bystanders, rather there is a substantial body of evidence refuting this claim.

This proposed ban would have negative public health impact by preventing those who have made the switch to relapse, and could prevent new e cigarette users from making the switch. The PHE report also stated that e cigs are 95% less harmful than tobacco products.

ASH Wales comment:

“.. There is currently no clear evidence to suggest that including electronic cigarettes under the Smokefree Premises regulations would benefit the health of the public in a similar way to the “smoking ban”. Indeed it may even have a negative impact upon current smokers who may otherwise have attempted to quit or harm reduce, potentially damaging rather than enhancing public health.”

ASH UK agree with these sentiments.

“there is little evidence of any harmful effects from exposure to the vapour from electronic cigarettes among non-users. Therefore there is currently no justification of a ban on the use of electronic cigarettes in public places on health grounds. Before taking steps to inhibit personal choice, legislators should be sure that any proposed measure would not lead to unintended consequences.

The dramatic rise in sales of electronic cigarettes in recent years has led some people to fear that their user in public places could undermine compliance with the smokefree law. However to date we have seen no evidence to support this hypothesis.”

ASH UK again:

“..If there was a ban on using these devices in all enclosed public places, users could be less inclined to use them, which could result in more of them reverting back to smoking. Prohibition would also increase the likelihood that vapers and smokers would effectively be required to share the same spaces. This not only potentially undermines quit attempts, but would also expose users of electronic cigarettes to secondhand smoke”

- **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)?**

We do not take a position on tobacco, as this is not something we can comment on. Since there is no evidence to support a ban on electronic cigarettes in enclosed space we can see no reason for a ban in non-enclosed areas. We believe that it should be at the discretion of the proprietor of any business/shop/bar whether he/she chooses to permit e-cigarette use. Many businesses are pleased to allow this, removing the need for frequent cigarette breaks away from the work station.

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

No, to achieve maximum health advantage and improvement the product should appear to smokers. Being able to use these in places where smoking is banned adds value, and encourages the use of the product, where the alternative might be to go outside and use a tobacco cigarette.

Reducing the appeal of e-cigarettes, reducing the usage of them will have a detrimental effect on public health. The proposed ban is based on unsupported claims, and the disbenefits could clearly cost lives of those deterred from making the change.

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

The presumption that people are too ignorant to distinguish between tobacco and e-cigarettes is rather insulting to common intelligence. More and more the models now do not resemble tobacco cigarettes in any way, and the absence of smoke, ash and smell emphasises the difference.

As Public Health England emphasised, there is a false belief that the harm is the same for tobacco and electronic cigarettes. This belief is now clearly disproven, and it is important that the public is fully informed. The benefit of the tobacco harm reduction potential should be broadcast, and the life-saving potential of the product should be made clearly and widely known. To limit and restrict the use on no scientific basis seems to be totally against the obligation of the Welsh Government to protect and improve the health of its citizens, since the product has now been shown to be beneficial and effective in enabling smokers to make the change. .

- **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?**

In Wales, compliance does not appear to be an issue. Additional vigilance on prohibiting e cigarettes would be time consuming .

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

No. this is not our area of expertise.

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

Yes. will this include NRT products?

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

We have implemented a ban on under 18's since 2008. This will be a benefit.

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

We have no statistics on the performance under the current regime,.

- **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 key word here is "knowingly". We have had instances of teachers and parents requesting purchase of electronic cigarettes for young people in their care, who are presently using tobacco cigarettes. . This is always refused where we are made aware.

We believe that such an offence would be justified, although if in future a medicinal e cigarette is licenced this should be available to already smoking teens.

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

Emphatically NO. We refer you to the Public Health (Wales) Bill's Explanatory Memorandum to calculate the harm in Quality Adjusted Life Years. There is absolutely no evidence to support any deterrent to use of electronic cigarettes as opposed to tobacco. As shown in this report, if only 5% of non-smoking vapers return tio smoking tobacco, between 1646 and 5334 QALY's would be lost, at an estimated value of between £99, and £260m.

If as few as an extra 1% of smokers decline to take up e-cigarettes instead of tobacco, between 5042 and 13272 QALY's would be lost at a value of between £303 and £796m.

Public Health Wales and the Welsh Government cannot, and must not, ignore the peer reviewed report from Public Health England.

PHE again:

“Encouraging smokers who cannot or do not want to stop smoking to switch to EC could be adopted as one of the key strategies to reduce smoking related disease and death”

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 Helen Smith – PHB 60 / Tystiolaeth gan Helen Smith – PHB 60

Annwyl Syr/ Fadam,

Rwy wedi cael gwybodaeth am y bil uchod, yn enwedig yng nghyswllt defnydd baco, o Ash Cymru, ac yn ysgrifennu atoch i fynegi anfodlonrwydd ynglŷn â'r bwriad i wahardd e-sigarennau o fannau cyhoeddus caeedig. Yn fy nhyb i, moddion yw e-sigarennau – cymorth i roi'r gorau i smygu, ac iddynt yr un pwrpas yn union â gymiau cnoi â nicotin, losin â nicotin ayyb, h.y. therapi amnewid, er mwyn helpu smygwyr i roi'r gorau iddi'n raddol trwy ddogni'r dogn o nicotîn a gymerant i mewn, a hynny heb y gwenwynau sy'n cysylltiedig â sigaret arferol, megis seianeid, arsenic, tar ac ati. Yn hyn o beth, mae e-sigarennau'n ddull o leihau niwed. O'r herwydd, dwy ddim yn credu y byddai'n briodol eu gwahardd o fannau dan do, megis swyddfeydd neu dafarnau. Yn hytrach, credaf mai'r ffordd orau i ymdrin ag e-sigarennau fyddai lansio ymgyrch dros eu marchnata a'u gwerthu fel moddion, a moddion yn unig (fel cynhyrchion Nicorette neu Nicotinelle ayyb), er mwyn cyfleu'r neges wrth y cyhoedd nad cyffur adloniannol o gwbl mohonynt, a bod nicotin yn wenwyn caethiwus y mae angen ei waredu o'r system. Yn fy meddwl i, dyma fyddai'r ffordd fwyaf synhwyrol ymlaen, a gobeithio y bydd y Cynulliad yn gweld y ffordd yn glir i hyrwyddo pob dull o leihau'r niwed a ddaw o ysmygu, yn hytrach na gwahaniaethu'n erbyn un dull yn benodol.

Yn gywir,

Helen Kalliope Smith

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No. NNA strongly disagrees with this proposed ban on use in public and work places and in vehicles, and no compelling evidence is forwarded by the Welsh Government to necessitate this. The proposals relating to nicotine products will not contribute to improving public health in Wales – rather, the opposite. The Welsh Government has set an ambitious target to reduce smoking prevalence to 16% by 2020, and this will not be achieved without embracing and supporting a full range of tobacco harm reduction products. Policies should ensure that those who choose to use e-cigarettes to help them quit should be supported rather than prevented in their choice of how to quit smoking. Bans on the use of e-cigarettes in public enclosed spaces have no basis in the evidence of risk of exposure to bystanders, act as a deterrent to those who wish to quit smoking by vaping, and stigmatises e-cigarette users in the same way that smokers are stigmatised. Usage bans have the tendency to stigmatise not only the product but also the user, and this together with the actual restrictions on use will serve to discourage switching to safer products. Usage bans should be a matter not for government, but for individual business and premises managers, who should be supported in order that they can decide for themselves whether to allow the use of e-cigarettes on their property. Smokers who wish to switch to safer products should be both supported and encouraged to do so. **A ban on e-cigarettes use in enclosed public spaces and vehicles (including public transport) is not justified on the grounds of protecting bystanders from second-hand smoke** Smoke free legislation was enacted in order to protect employees and the public from the harmful effects of second hand smoke. In the case of e-cigarettes there is no combustion and therefore no smoke. Any by-product in vaping an e-cigarette is in the exhalate (breath) of the e-cigarette user. There is no evidence of any potential for harm to bystanders from e-cigarette use. A systematic review conducted in 2014 Igor Burstyn concluded that: *"Exposures of bystanders are likely to be orders of magnitude less [compared to the users themselves], and thus pose no apparent concern."* [1]

[1] Igor Burstyn: 'Peering Through the Mist' http://www.biomedcentral.com/1471-2458/14/18

Permitting e-cigarette use in enclosed public spaces and vehicles would not make enforcement of smoke free legislation more difficult

Compliance with existing smoke free legislation is very high, and there is no reason to think that the use of e-cigarettes would have any negative effect. E-cigarettes are easily distinguishable from tobacco cigarettes by appearance and smell. The majority of e-cigarettes in use (66%) are now the tank system variety [2], which cannot be confused with a cigarette The general public is now well acquainted with e-cigarettes and there is little chance of confusion by premise's staff. The ability to use an e-cigarette where smoking is not permitted gives smokers a legal alternative. If anything it should assist in delivering still greater compliance with smoke-free legislation.

A ban on use in enclosed public spaces and vehicles (in particular public transport) will have a negative effect on those using them to quit or reduce their tobacco consumption

Patterns of actual use of e-cigarettes differ from those of smoking tobacco cigarettes. Nicotine delivery is still very much sower from e-cigarettes than tobacco cigarettes and particularly so when using nicotine liquid strengths under the maximum which will be permissible under the EU Tobacco Products Directive, i.e. 20mg/ml[3]. Whilst a smoker will smoke an entire cigarette in a few minutes and then not smoke again until nicotine levels have dropped to a level which triggers the desire to smoke, an e-cigarette user will take one or two puffs every few minutes in order to keep nicotine levels up and prevent cravings. The differing patterns of actual use and the ability to vape in places where smoking is not permitted assist the user to disassociate the use of nicotine from the act of smoking. Forcing e-cigarette users to go outside to vape, often to places where they will be among smokers and also perhaps in time limited situations, may encourage them to smoke instead in order to increase nicotine levels quickly within the time available.

A ban on use in public places would discourage vaping

If it is true that smoking bans discourage people from smoking then the same will be true for vaping. Bans diminish the value proposition of e-cigarettes (compared with traditional cigarettes) and at the same time communicate the message that e-cigarettes are as dangerous as smoking. This will therefore discourage smokers from making the complete switch to the safer alternative. The ability to use e-cigarettes in enclosed public spaces is an important factor in many smokers' decision to try e-cigarettes, and leads many to switch completely.

Subsidiary question: 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)?

The NNA strongly disagrees with this suggestion for similar reasons as outlined above, especially with regards to the inclusion of e-cigarettes in further proposed restrictions to non-enclosed spaces as shown in the examples. The positive aspects of e-cigarettes should not be hidden from the public with inappropriate restriction, e-cigarette use has largely evolved by 'word of mouth' to further restrict would be ill-advised.

[2] Action on Smoking and Health. *Use of electronic cigarettes (vapourisers) among adults in Great Britain*. 2015 23 July 2015]; Available from: http://www.ash.org.uk/files/documents/ASH_891.pdf.

[3] Farsalinos et al :'Nicotine absorption from electronic cigarette use: comparison between first and new-generation devices' http://www.nature.com/srep/2014/140226/srep04133/full/srep04133.html

Question 2

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?
No. The provisions in the Bill have no public benefit, will discourage the use of e-cigarettes, and have negative impact on individual and public health. The Welsh Government target to reduce smoking prevalence to 16% by 2020 will not be achieved without embracing and supporting tobacco harm reduction products. Policies should ensure that those who choose to use e-cigarettes to help them quit should be supported rather than prevented in their choice of how to quit smoking.

Question 3

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 use of e-cigarettes in enclosed spaces does not renormalize smoking behaviour or cause young people and never smokers to initiate use and addiction to nicotine or to take up smoking. Despite the dramatic increase in the use of e-cigarettes there is no evidence in surveys to date that renormalisation of smoking is happening. As the recent Public Health England evidence review concluded: 'There is no evidence that EC are undermining the long-term decline in cigarette smoking among adults and youth, and may in fact be contributing to it. Despite some experimentation with EC among never smokers, EC are attracting very few people who have never smoked into regular EC use.' [4]. Regular e-cigarette use among people is rare and most common among those who already smoke or have smoked [5]. The dramatic rise in use of would suggest that far from renormalizing smoking, use of e-cigarettes is normalising not smoking. E-cigarette users provide a positive anti-smoking role model that normalises the use of a very much safer alternative and encourages smokers to switch, or reduce their tobacco consumption.

Question 4

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?

[4] McNeill A and Hajek P. E-cigarettes: an evidence update. A report commissioned by Public Health England: August 2015. Public Health England

[5] www.**ash**.org.uk/files/documents/**ASH**_891.pdf

E-cigarettes have little appeal to young people, as evidenced in surveys by ASH [6]. Moore et al, in their survey of e-cigarette us by young people aged 11-16 in Wales concluded that:*"the very low prevalence of regular use…suggests that e-cigarettes are unlikely to be making a significant direct contribution to adolescent nicotine addiction".*[7]

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
We are unclear what public health gain can be achieved (and at what cost) by a register of retailers of nicotine products. Should such a register be introduced then there should be separate registers for tobacco and for nicotine products. Electronic cigarettes are not tobacco products, and indeed the distinction between them and tobacco products is an important message to current and potential users. We feel that if e-cigarettes are included on the same register as tobacco they could be viewed by retailers and consumers as being as harmful as tobacco – which they are clearly not. In our view it would be inappropriate for the proposed e-cigarette and current tobacco registers to be combined.

Question 6

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?
We support the restriction of sales to minors as a measure intended to reduce the risk of initiation of nicotine use in young people. However, young people can and do access lit tobacco products which are more dangerous by several orders of magnitude. It seems likely that many young people who would otherwise initiate lit tobacco use will instead choose the safer product if it is available to them. There is currently a voluntary ban by manufacturers and retailers on sales to under-18s and there is currently no evidence that young people are taking up the regular use of e-cigarettes in significant numbers, or that they are progressing from them to smoking lit tobacco. We understand the intent to prevent proxy sales, but are concerned that this would criminalize parents with a teenage smoker. A parent, who purchased a healthier alternative (an e-cigarette) for the teenager to try to get them off smoked tobacco, could be prosecuted for trying to help their daughter or son. NRT is available to people as young as 12 and there is no reason to place greater restrictions on e-cigarettes.

[6] www.**ash**.org.uk/files/documents/**ASH**_891.pdf

[7] Moore, G., et al., *Electronic-cigarette use among young people in Wales: evidence from two cross-sectional surveys.* BMJ Open, 2015. **5**(4): p. e007072.

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Evidence from Centre for Drug Misuse Research – PHB 62 / Tystiolaeth gan Y Ganolfan Ymchwilio i Gamddefnyddio Cyffuriau – PHB 62

Response to the Health and Social Care Committee Call for Evidence on the Public Health (Wales) Bill

Neil McKeganey Ph.D.
Director
Centre for Drug Misuse Research
Glasgow
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1) Introduction
In this response to the consultation comments are confined to those areas related to Part 2 of the Consultation Document (Tobacco and Nicotine Products).

2) Harm Reduction Potential of E-Cigarettes. Regular e-cigarette use is likely to be substantially less harmful to the user compared with smoking combustible tobacco cigarettes, and no more harmful to the user than would be associated with regular use of approved stop smoking medications and nicotine replacement therapies. The toxins found in studies of e-cigarettes are consistently at levels much lower than are found in combustible cigarettes and fall substantially below the levels that would give cause for concern. Smokers who switch completely from cigarettes to an e-cigarette experience improvements in bronchial health, including reduced cough and sputum production, improved breathing, stamina and ability to exercise. There is emerging evidence that switching completely from combustible cigarettes to e-cigarettes may reverse some of the harm caused by tobacco smoking.

3) There is little evidence that any significant harm is caused to bystanders by the inhalation of second-hand nicotine-containing vapour, and growing evidence that emitted vapours are relatively harmless compared to inhalation of tobacco smoke, even in compact enclosed spaces.

4) E-cigarettes are more attractive as a product to support attempts to stop smoking than other nicotine-containing products. There is growing evidence that e-cigarettes have comparable or superior efficacy for helping smokers to reduce the number of cigarettes they smoke daily or stop smoking completely, compared to approved medications and other products indicated for smoking cessation. Using an e-cigarette increases smokers' confidence that they will be able to quit smoking for good, and increases their motivation to persist with smoking abstinence in the face of a distressing withdrawal experience.

5) There is good evidence that e-cigarette use can rapidly and efficiently suppress the symptoms of nicotine withdrawal brought on by smoking abstinence, thereby reducing the likelihood of a relapse to smoking. There is good evidence that e-cigarettes are effective for suppressing symptoms of

negative affect that typically accompany smoking cessation, as well as symptoms of negative affect occasioned by environmental stimuli.

6) E-cigarettes have a significantly lower abuse liability and evoke a withdrawal experience that is significantly milder and more tolerable than the withdrawal experience evoked by smoking abstinence.

7) Banning Electronic Cigarettes in Enclosed Public and Work Spaces

Legislation banning the use of combustible tobacco within enclosed public spaces was supported by the clear evidence of the harm arising from passive smoking. Whilst there is some evidence of the presence of chemicals in expressed vapour following electronic cigarette use, the overwhelming body of evidence indicates that these are present at substantially lower levels than are generated by combusted tobacco and that the risks to those who are close to electronic cigarette users, is extremely low. Banning the use of electronic cigarettes in enclosed public spaces would them be an excessive regulation predicated on the precautionary principle that it is better to ban a substance that has not been shown to pose no health harm than to wait until such health harm is evident before initiating such a ban. Whilst there may be a case in some areas of public health to act in accordance with this principle the decision to do so where the act being banned may be associated with other benefits in reducing harm is much less persuasive. If a ban on the use of electronic cigarettes reduced the use of those cigarettes by smokers then one would in effect have prioritised a theoretical possible risk over a known health benefit (of stopping smoking).

8) Possible Extension of Electronic Cigarettes to Non Enclosed Public Spaces

The possible extension of a ban on the use of electronic cigarettes to non-enclosed spaces would be excessive and deeply problematic. Whilst there are some non-enclosed environments within which it might be appropriate to ban the use of electronic cigarettes (children's play areas for example) it is difficult to see how a generic ban on non-enclosed spaces could be operationalized. For example, would it be an offence to consume an electronic cigarette on a beach with no others nearby? To seek to define which non enclosed spaces it would be appropriate to ban the use of electronic cigarettes within would also be deeply problematic since it is hard to see how such a list could be generated that was sufficiently inclusive to represent a useful and valuable restriction whilst not being so inclusive to represent an unwelcome intrusion into individual's private lives in circumstances where there can be no conceivable risk from environmental exposure to electronic cigarette expressed vapour.

9) The possible banning of electronic cigarettes within some non enclosed environments could also produce a limitless array of disputes as to whether a specific non enclosed environment should be covered by such a ban resulting in a costly process of adjudication with an increasing number of otherwise law-abiding citizens finding themselves involved in conflictual dealings with public officials charged with implementing such a ban.

10) Possible Renormalisation of Smoking Arising from Electronic Cigarette Use

The concern that use of electronic cigarettes might re-normalise smoking though frequently voiced by those advocating greater restrictions on electronic cigarettes is deeply problematic. First, it is not clear what re-normalising actually means in this context. If the process of renormalisation is taken to mean something that encourages an increase in the frequency of smoking combustibles there is no evidence that this is actually occurring. Indeed within many of the areas where electronic cigarettes are available there is evidence of a decreasing prevalence of smoking, as noted in the recent report from Public Health England, such that it is entirely possible that electronic cigarettes are contributing to a decrease in smoker numbers. In effect it seems more plausible that electronic cigarettes are contributing to a further de normalisation of smoking than its re-normalisation.

Second, if the notion of renormalisation is taken to mean that in the light of growing electronic cigarette use there is an increased likelihood that some individuals may come to accept smoking as an increasingly unremarkable feature of their social world again there is no evidence of this occurring. Indeed the proposition that publicly visible electronic cigarette use might result in smoking coming to be seen as increasingly attractive would seem to be premised on the idea that many people viewing electronic cigarette use mistakenly interpret such use as a sign that the individual is smoking a combustible cigarette. With increasingly visible use of electronic cigarettes in public spaces there is a much greater awareness of this technology such that electronic cigarette use is unlikely to be interpreted as evidence of smoking. Indeed many of the electronic cigarettes being used both in their form (design) and their colouring do not in any way resemble a normal cigarette.

11) Third, the re-normalisation thesis could be taken to mean that following some level of electronic cigarette use the individual is more likely to graduate onto use of combustible tobacco. Again there is no evidence of this actually occurring with repeated studies showing that predominantly electronic cigarettes are being used by current and former smokers. The growth in the use of electronic cigarettes whilst in some way normalising vaping cannot persuasively be said to be normalising smoking. What we are seeing here is vaping becoming increasingly visible as a distinctive behaviour in its own right rather than a behaviour that leads on to other behaviours (smoking). There is a parallel here with the recent growth in the carrying and everyday consumption of bottled water- whilst this is more common now than in the past, there is no indication that the frequent consumption of bottled water is leading to an increase in the consumption of other drinks- including alcohol. Rather, the carrying and consumption of bottled water has become a new and noticeable behaviour in its own right.

12) Appeal of Electronic Cigarettes to Young People

The finding of a recent survey commissioned by the UK charity Action on Smoking and Health (ASH) [1] that the proportion of 11-18 year olds in the UK who have tried using an electronic cigarette at least once rose from 5% in 2013 to 13%. However, regular use (once a month or more) of an e-cigarette is rare among young people, and largely confined to young people who already smoke cigarettes. The most recent data suggest only 0.5% of 11-18 year olds use e-cigarettes at least once per week, and only 2.4% use e-cigarettes at least once per month. Moreover, only 4% of young never-smokers have ever tried an e-cigarette, compared to 77% of young regular cigarette smokers. Together, these data suggest that using an e-cigarette is not currently an attractive behaviour to the vast majority of young people in the UK, and even less attractive to young people who have never smoked.

13) Possible New Offence of Handing Over Tobacco to a Person Under 18

In the same way that purchasing combustible tobacco products for someone below the age of 18 is an offence a strong case can be made for extending such legislation to electronic cigarettes thereby providing a means for tackling proxy purchasing of electronic cigarettes.

14) Will Proposals contained Within the Bill Improve Public Health in Wales

In my view there is a real possibility that the proposals contained within the Bill will not improve public health in Wales and may even increase public health harm by restricting use of a category of product that is associated with a significant reduction in tobacco related harm. The Public Health England report has noted that electronic cigarettes may well be as much as 95% less harmful than combusted tobacco. That 95% figure has become the locus of some controversy as various commentators including the authors of a recent Lancet editorial dispute the accuracy of that figure. However whatever the actual precise level of reduced harm there are no commentators suggesting that electronic cigarettes are more harmful than combusted tobacco. On that basis there is a very strong case for believing that the switch from using combustible products to using electronic

cigarettes will reduce the level of tobacco related health harm at both an individual and a societal level.

15) There is a real danger that placing increasing restrictions on the use of electronic cigarettes and effectively regulating this product as if it were largely the same as combustible tobacco will both reduce the prevalence in the use of electronic cigarettes reduce the likelihood of smokers transitioning to using electronic cigarettes and by implication result in more not fewer individuals using combustible tobacco products.

16) There is an analogy here in relation to the current and proposed regulation governing the New Psychoactive Products. These drugs, which mimic the effects of many of the currently illegal drugs (cocaine cannabis heroin LSD), have been shown to be associated with significant harm (both morbidity and mortality). On that basis there is a strong argument for making the trade in these drugs illegal. However had these substances been shown to be less harmful that the currently illegal drugs, and had it been shown that large numbers of users were switching from using heroin, cocaine cannabis to less harmful substances, there would have been no call to have these new drugs made illegal. There is a clear parallel here with electronic cigarettes. If these products are increasingly to be regulated on the same basis as combustible tobacco (even despite the fact that it is universally accepted that they are less harmful than combusted tobacco) there is a real danger than the rate of switching between combustible to vapour products will reduce and more people will continue to smoke combusted tobacco thereby placing themselves at increased health risk.

17) Electronic cigarettes should not be regulated as if they are the same as combustible tobacco products- rather electronic cigarettes require their own bespoke regulation. That regulation should appropriately limit the access of young people to these products, it should ensure that there is no advertising of these products to young people, it should ensure that sales of electronic cigarettes to young people either on a commercial basis or by proxy provision (asking somebody else to purchase on the young persons behalf) is appropriately punished. What regulation of electronic cigarettes should not do, however, is to substantially limit the range of places where these products can be used.

Declaration

The Centre for Drug Misuse Research has received funding from the tobacco industry and the nicotine industry in connection with its research on reducing smoking related health harm. No funding was received from either industry in connection with the preparation of this document or in the decision to submit a response to the consultation.

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

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

Evidence from One Voice Wales – PHB 63 / Tystiolaeth gan Un Llais Cymru – PHB 63

Public Health (Wales) Bill

Part 6: Provision of Toilets:

Questions listed in the consultation document for Part 6:

- 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?

One Voice Wales agrees with the need for local authorities to prepare local toilet strategies. Each authority will have its own particular range of needs and priorities, although there is a question over the continued relevance of such a local strategy once the imminent local government reorganisation exercise results in changed regions and boundaries. But, basically, the principle of requiring a well thought through strategy, towards which members of local communities have been encouraged to contribute, is a sound and positive philosophy.

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

Yes – hopefully, although much will depend upon the overall level of public funding resources that will be available in the future. “Improved provision” will depend upon “quality” as well as “quantity” in terms of toilet provision, and future public sector budgets will have an important part to play in this agenda. One Voice Wales questions the way in which the four basic options have been considered during the early stages of developing this Bill. The “do nothing” option is agreed to be unsatisfactory, but there are some merits to the other three options and One Voice Wales wonders whether the preferred option of requiring local strategies (only) will in itself provide sufficient momentum to generate the improvements desired. There was much merit in the former Public Facilities Grant scheme, and One Voice Wales has called for its reintroduction in order to help tackle the lack of public conveniences in many areas of Wales. Furthermore, the option of imposing a duty on local authorities to carry out a full implementation of their new strategies would surely give members of the public more confidence that the public engagement exercises leading to the formation of these strategies were indeed meaningful.

Therefore, One Voice Wales would ask the Welsh Government to think again about the preferred option (which is in general supported) as to whether there might be room for manoeuvre in terms of more strict guidelines over the availability of funding for partnership initiatives (in line with the former Public Facilities Grant scheme) and, again, in terms of giving local authorities a stronger message with regard to the need to put their strategies into full implementation.

- 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?

One Voice Wales calls on the Welsh Government to ensure that any such consultation exercise introduced in order to facilitate engagement with stakeholders would be robust and wide enough to provide confidence that all appropriate voices will be heard. The current thinking for the Bill is that there should not be a prescribed format for the consultation process, but this aspect could well be strengthened via guidance, as mentioned in the response to the next question. It is considered absolutely essential that local community and town councils should need to be formally engaged as a part of this process, and that their voices should be heard as well as being encouraged to consider potential solutions in areas with critical needs. Many local councils have already taken on public toilet provisions that were traditionally within the domain of unitary authorities. The fact that the latter authorities are struggling financially (hence, leading to these transfers) should signal a cautionary note to the Welsh Government as it faces up to this particular agenda of ensuring adequate public toilet provision across Wales.

- 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?

The issuing of Welsh Ministers' guidance could well prove useful in the drive for consistency across Wales in this matter. The guidance would need to take into account all reasonable aspects of the challenge, including how local authorities should have to liaise with community and town councils within their borders when considering the details of the strategy. Such guidance would also be potentially useful in driving a stronger implementation regime, as mentioned in the answer to the second question above.

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

One Voice Wales would support any sensible arrangements for making public toilets available and these could include housing the facilities

within different types of settings, such as public buildings, private enterprises and so on.

- 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?

Yes – provided that all other equalities aspects are incorporated within the guidelines for the local strategies, such as any specific needs, use of bilingual signage and so on.

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

Yes – along the lines outlined in the explanatory memorandum.

Dr. Del Morgan
Swyddog Datblygu/Development Officer
Un Llais Cymru/One Voice Wales

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 Truckers Toilets UK – PHB 64 / Tystiolaeth gan Truckers Toilets UK – PHB 64

RESPONSE TO THE CONSULTATION QUESTIONS
Relating to the Public Health (Wales) Bill

September 2015

(Mrs) Gillian Kemp, MA
Public Toilets UK www.facebook.com/ptukcampaign
Truckers Toilets UK www.facebook.com/TTUKcampaign
Member, British Toilet Association <www.britloos.co.uk>
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Email: [redacted]

Part 6: Provision of Toilets:

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?

1. Good in theory. However whilst Section 93 (1) allows LAs the option of providing public toilets it does not demand that they do so. Therefore the strategy could result in not establishing public toilet facilities (91,2,a).
2. As 100% of the population needs a toilet several times a day and Wales is a tourist hotspot, it would seem vital that areas such as Gwynedd, where toilets are under threat, should have toilet facilities available. Toilets encourage tourism and enable people with urgency problems and disabilities to leave their homes in the knowledge they can access a loo relatively easily. This is in turn reduces mental health problems, especially in older people who are often scared to go out in case of an 'accident'.

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

3. Not necessarily. It could be read as a 'paper' exercise. Yes, it might give some LAs encouragement to consider toilet provision but for those who are looking for ways to reduce spending, toilet closures will continue to be considered an easy option to save money in the short term. Without the legal requirement to provide public toilets there will

be no pressure to make the necessary adjustments. Communities and tourists will continue to suffer in the meantime.

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?

4. It's a step in the right direction but it is not a 'guarantee' that views will be taken into account. This has been proved in other areas of the UK. That said, there are some very active groups who have succeeded in keeping their public toilets open and others groups who have managed, by keeping up the pressure, to have toilets made available.
5. The term 'appropriate engagement' needs clear definition. There are some LAs who provide a tick box document and call it a 'consultation'. In some instances the questions have been directed to the outcome required with little or no opportunity for respondents to voice an opinion.
6. Consultations, if done properly, are a good way of learning opinions but few LAs have the time or experience to gather groups together to discuss the issues and summarise the results. Consultations should include a wide range of people / organisations / businesses and anyone likely to be affected.

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?

7. There may be a more consistent approach in developing the strategies but it is the outcome for the various communities which is the important issue. Guidance is always useful. Someone with knowledge of the subject of the strategy in question would be most appropriate.

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

8. Not clear what is being asked here. If it means considering toilet facilities in publicly funded areas eg council offices, museums, tourist information etc, then why not? Toilets are a necessity for everyone.
9. Many local authorities are closing public toilets because their funds are being squeezed and they have statutory obligations to provide certain services. Public toilets are not part of that provision so if there are no means to ensure public toilet availability, then having a toilet strategy will be a waste of public money and time for many LAs who don't appreciate the need for public toilet facilities.
10. In order to develop a useful toilet strategy LAs will need to understand the need for having public toilets available.

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?

11. Changing facilities for babies need to be available to men and women and should be in a separate area to general toilet facilities
12. There are many types of disability. Often forgotten are those with 'hidden' disabilities such as IBS, those with a stoma, people taking certain types of medication; those with bladder and/or bowel conditions etc who all require space and clean facilities – often with a shelf - in which to address their needs. Those in wheelchairs need to be offered suitably sized and well designed surroundings whilst those who have severe impairments should have access to Changing Places facilities where hoists and adjustable height equipment is available.
13. Women's needs are often forgotten: they need somewhere hygienic to change sanitary pads / tampons when they have their period and pregnant women need the loo more frequently;
14. British Standards BS6465 1-4 provides information on sanitary installations and BS6465-4 in particular relates to the Code of practice for the provision of public toilets.

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

15. Having a strategy is good but if that strategy is not implemented then it is time consuming in its construction and worthless
16. Access to a toilet is necessary for our health – and safety. Research has shown that 'urgency' and 'holding on' can affect concentration which is especially dangerous when driving. 'Holding on' can also cause serious health problems. Lack of toilets encourages many people, including drivers, to reduce their fluid intake to avoid the need for the toilet. This can result in dehydration.
17. Making toilets a legal requirement would contribute to the sustainability of local communities; support the growing 24 hour economy; encourage tourism; enable people to travel and take up work opportunities; reduce infections; encourage good hygienic practices; reduce incidents of fouling and improve public health in Wales

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Brief Biography

Gillian Kemp has been active in managing charities but began her career in education and law and has also worked in the media. She is the founder of Truckers' Toilets UK www.facebook.com/TTUKcampaign and joint founder of Public Toilets UK www.facebook.com/PTUKcampaign – both are campaigns which aim to improve toilet provision in the UK. She has been involved with the British Toilet Association [BTA] for a number of years and has given evidence on behalf of The IBS Network on the effects of public toilet closures to the Health & Social Care Committee at the Welsh Assembly. On behalf of the BTA Gillian chaired a joint venture with Hertfordshire Constabulary to

revise a booklet on reducing vandalism in publicly accessible toilets. She is currently in the throes of editing another booklet on public toilet facilities. Gillian is a Founder Director of an international medical equipment manufacturing company

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

Evidence from Alcohol Health Alliance – PHB 65 / Tystiolaeth gan Y Gynghrair Iechyd Alcohol – PHB 65

3 September 2015

Welsh Government Public Health (Wales) Bill Consultation

The Alcohol Health Alliance UK (AHA) is a group of more than 40 organisations whose mission is to reduce the damage caused to health by alcohol misuse. The AHA works together to:

- highlight the rising levels of alcohol-related health harm
- propose evidence-based solutions to reduce this harm
- influence decision makers to take positive action to address the damage caused by alcohol misuse.

Thank you for the opportunity to give written evidence on the Welsh Government's consultation on the Public Health (Wales) Bill. The AHA is pleased to endorse the response submitted by the Royal College of Physicians Wales (attached).

The AHA also recommends that action is taken on the following areas:

- **Action on price**
  In the long term it is not the price but the affordability of alcohol that shapes consumer behaviour. Over the last 30 years the affordability of alcohol in the UK has increased despite rises in alcohol taxes[1]. In 2010, alcohol was 48% more affordable than in 1980[2] – the heaviest drinkers currently pay only 33p/unit of alcohol, with some high-strength ciders costing the equivalent of only 6p/unit.[3] The Alcohol Health Alliance Strongly supports a minimum unit price for alcohol. International evidence demonstrates that this is an effective and cost effective intervention. In Canada it has been shown that a 10% increase in average price results in approximate an 8%

[1] Gilmore, I., Anderson, W., Bauld, L., Bellis, M., Brown, K., & Drummond, C. (2013). Health First: an evidence-based alcohol strategy for the UK. *Stirling: University of Stirling*.
[2] University of Stirling. Health First: An evidence based alcohol strategy for the UK. March 2013.
[3] Sheron, N, Eisenstein, K. Minimum unit price — how the evidence stacks up. BMJ 2004;348:g67

reduction in consumption, a 9% reduction in hospital admissions and a 32% reduction in deaths which are wholly attributable to alcohol.[4] Research from the AHA demonstrates that the majority of people in Wales (52%) support minimum unit pricing[5]. However when further information was given about the impact of alcohol misuse on hospital admissions and alcohol-related crime, this figure rose to 59%.

- **Restrictions on alcohol advertising**
  There is significant evidence demonstrating a link between advertising and consumption. Alcohol advertising increases the likelihood that young people will start to use alcohol and will drink more if they are already using alcohol.[6] Current regulation is failing to adequately curb the activities of the alcohol industry both in terms of the volume of young people's exposure to alcohol advertising and the appeal of content. No regulation exists to tackle the volume of advertising to which audiences are exposed; the weak wording of the self-regulated codes and a failure by the Advertising Standards Authority to apply the codes in full, including the spirit behind the codes, means content frequently makes associations with prohibited themes. Evidence from the AHA shows that the people of Wales overwhelmingly support restrictions on alcohol advertising. 83% of people in Wales support a ban on alcohol advertising before the 9pm watershed and 84% of people in Wales support alcohol advertising only being shown in the cinema during films rated 18. 58% of people in Wales support restrictions on alcohol companies sponsoring sporting events. This climbed to 68% after participants were provided with information on the number of alcohol adverts children under the age of 18 watched during the 2014 FIFA World Cup.[7]

- **Restrictions on the availability of alcohol**
  The number of premises licensed to sell alcohol in the UK doubled between the 1950s and the beginning of the 21st century[8]; over the same period, the British population grew by only a fifth. Any increase in the availability of alcohol leads to an increase in alcohol consumption and subsequent increases in alcohol-related harm. Conversely, when the availability of alcohol is restricted, consumption and its associated harms decrease.[9] 72% of people in Wales believe that licensing decisions should take into account the quality of life for residents living locally.[10]

- **Reduction in the drink-drive limit**

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[4] Stockwell, T. Is alcohol too cheap in the UK? The case for setting a Minimum Unit Price for alcohol. British Colombia, 2013.
[5] The AHA commissioned a survey of UK residents to obtain information on alcohol behaviour, attitudes and perceptions. Fieldwork was undertaken between the 23rd October and the 9th November 2014, with a final sample of 3077 respondents. All UK countries were represented and data was weighted by age, gender and socio-economic classification and is representative of the resident population.

[6] Anderson P, de Bruijn A., Angus K., Gordon R., and Hastings G. (2009b) *Impact of alcohol advertising and media exposure on adolescent alcohol use: Systematic review of longitudinal studies, Alcohol and Alcoholism* 44, pp229-43.
[7]AHA public opinion survey (2014)
[8] British Medical Association Board of Science (2008) Alcohol Misuse: tackling the UK epidemic. London: British Medical Association.
[9] Anderson, P., & Baumberg, B. (2006). Alcohol in Europe: a public health persepctive. A report for the European Commission. *Alcohol in Europe: a public health persepctive. A report for the European Commission*.
[10] AHA public opinion survey (2014)

Wales, along with England, has one of the highest blood alcohol limits for driving in the world at 80mg of alcohol per 100ml of blood. Drivers with a blood alcohol level between 50mg and 80mg are 2 to 2½ times more likely to crash than those with no alcohol in their blood, and up to 6 times more likely to be involved in a fatal collision.[11] There is international evidence that a reduction in such limits is accompanied by major falls in road fatalities.[12] The AHA believes that the blood alcohol limit for driving in England and Wales should be reduced from 80mg/100ml to 50mg/100ml as soon as possible to fall in line with most of the European Union and Scotland.

- **Reduce the stigma associated with alcohol related problems**
  Alcohol can affect personal health and wellbeing in numerous ways ranging from anxiety and depression to severe and potentially life-threatening conditions such as liver disease, cardiovascular disease, cancer and neurological disease. It is not unusual for alcohol to cause multiple problems in the same individual, affecting both mental health and physical health.[13] At a population level, most alcohol-related problems are attributable to hazardous and harmful drinking rather than to alcohol dependence1. Yet few people who drink more than the recommended low risk levels of alcohol consumption seek professional help for their drinking. Often people are unaware of the long-term dangers to their health of their drinking and, when they develop alcohol dependence, they may take a long time to seek help. However, many will still encounter doctors or other health and social care professionals either because of acute alcohol-related problems or for reasons unrelated to their alcohol consumption. Such encounters provide an opportunity for professionals to identify risky drinking and respond appropriately.

Further information and evidence for each of these proposals can be found in 'Health First: An evidence-based alcohol strategy for the UK', published by the University of Stirling in 2013 and supported by the Alcohol Health Alliance. The document is accessible at: http://www.stir.ac.uk/media/schools/management/documents/Alcoholstrategy-updated.pdf

Submission made by:-

Paul Jordan
Policy & Communications Officer
Alcohol Health Alliance
[redacted]

[11] Royal Society for the Prevention of Acccidents (2012) *Drinking and driving*, online, available at: http://www.rospa.com/roadsafety/info/drinking_and_driving.pdf [accessed 4 September 2013].
[12] Bailey, J. et al. (2011) *Achieving positive change in the drinking culture of Wales*, London, Alcohol Concern, online, available at: http://www.alcoholconcern.org.uk/assets/files/Publications/Wales%20publications/Achieving-positive-change-final.pdf [accessed 6 August 2013].
[13] Kaner, E.F.S., Newbury-Birch, D., Heather, N. (2009) Brief Intervention. In: Miller, P.M. (Ed.) Evidence-Based Addiction Treatment. Burlington, MA: Academic Press; pp 189-213.

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Evidence from Nicoventures – PHB 66 / Tystiolaeth gan Nicoventures – PHB 66

Submission by Nicoventures to the Health and Social Care Committee on the Public Health (Wales) Bill

1. Introduction

1. This is Nicoventures Holdings Limited's (Nicoventures) submission to the Health and Social Care Committee of the National Assembly for Wales (the "Committee") concerning the consultation on the Public Health (Wales) Bill (the Bill). Nicoventures is engaged in the development and sale of innovative and high-quality nicotine products, including vaping products (also commonly referred to as e-cigarettes)[1]. It is part of the British American Tobacco Group, but managed separately from the tobacco business.

2. Nicoventures appreciates this opportunity to comment on Part 2 of the Bill, concerning Tobacco and Nicotine Products and will use it to reiterate several points put forward in its response in the Consultation concerning the White Paper issued on 2 April 2014.

2. Vaping products: the evidence

3. Vaping products do not contain tobacco, they do not rely on combustion and, as a consequence, no smoke is formed when the e-liquid is "vaped" and no tobacco tar is formed. Instead, nicotine is delivered in an aerosol predominantly of inert glycerol or propylene glycol Moreover, vaping products do not expose users to any significant level of toxicants, and nicotine itself is not related to chronic health effects such as cancer, heart disease or pulmonary disease. Indeed, as reported by the Royal College of Physicians: "[a]lthough nicotine is the addictive component of tobacco products it is the toxins and carcinogens in tobacco smoke that cause most of the harm from using tobacco."[2] The UK National Institute for Health and Care Excellence similarly concludes: "Most health problems are caused by other components in tobacco smoke, not by the nicotine."[3]

4. A panel of experts in nicotine science, medicine, toxicology and public health policy applied a multi-criteria decision analysis approach to tobacco and nicotine products based on harms to users and harms to the wider society. The study attributed a relative harm score of 100% for conventional cigarettes, while giving a score of 4% for vaping products.[4]

5. More recently, an independent expert review commissioned by Public Health England found, among others, that:

   a. The current best estimate is that vaping products are around 95% less harmful than smoking.[5]

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1 In this submission, the term "vaping products" refers to electronic nicotine and non-nicotine delivery systems ("ENDS", also commonly referred to as e-cigarettes), including e-shisha and e-liquids that deliver an aerosol, which may contain nicotine, composed predominantly of inert glycerol or propylene glycol.

2 Tobacco Advisory group of the Royal College of Physicians. 2007. *Harm reduction in nicotine addiction. Helping people who can't quit.* London RCP.

3 UK National Institute for Health and Care Excellence (NICE). 2013. *Tobacco: Harm reduction approaches to smoking*.

4 Nutt et al, Estimating the Harms of Nicotine-Containing Products Using the MCDA Approach. Eur Addict Res 2014;20:218-225, at 224, Fig 3 at 223. See also Fagerström Report, ¶ 20 and fn. 18.

5 Public Health England, *E-cigarettes: an evidence update*, A report commissioned by Public Health England, p. 80. Available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454516/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England.pdf>

b. Vaping products release negligible levels of nicotine into ambient air with no identified health risks to bystanders.[6]

6. In view of this evidence, there is a growing consensus that vaping products are in general significantly less risky than conventional cigarettes and that they have a significant potential for harm reduction. Already in May 2014, 53 leading experts on Nicotine Science and Public Health Policy addressed a letter to Margaret Chan, Director General of the World Health Organization, expressing their concern about the marginalisation of and insufficient emphasis on harm reduction as part of a critical strategy of tobacco policy. These experts concluded:

> *The potential for tobacco harm reduction products to reduce the burden of smoking related disease is very large, and these products could be among the most significant health innovations of the 21st Century – perhaps saving hundreds of millions of lives. The urge to control and suppress them as tobacco products should be resisted and instead regulation that is fit for purpose and designed to realise the potential should be championed by WHO.*[7]

7. Bearing in mind the significant potential for public health benefits and harm reduction, Nicoventures argues in favour of an evidence-based regulatory framework that provides adult consumers with access to high quality and safe vaping products without imposing unwarranted or disproportionate restrictions.

8. Turning to the specific consultation questions and the content of the Bill, Nicoventures wishes to express its concern about the proposed extension of the ban on smoking tobacco in enclosed public and work places in Wales to include the use of vaping products. As will be further explained below, in this respect the Bill appears to be unsupported by, and running counter to scientific evidence.

9. Moreover, from a legal point of view, the Bill gives rise to concerns under the European Convention on Human Rights ("ECHR").

3. Consultation Questions

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?
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)?
3. 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?
4. 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?

10. In the following paragraphs, Nicoventures addresses the above four questions together. The ban on the use of vaping products in enclosed public and work places, as well as the possible extension to non-enclosed spaces is based on the following concerns and considerations:

a. The use of vaping products may re-normalise smoking behaviours in places where the public has become unaccustomed to smoking as a result of the smoke free requirements.[8]

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6 Public Health England, *E-cigarettes: an evidence update*, A report commissioned by Public Health England, p. 65. Available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454516/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England.pdf>

7 Letter to Margaret Chan, Director General WHO. Signed by 53 leading public health leaders from around the world. Available at <http://nicotinepolicy.net/documents/letters/MargaretChan.pdf>

8 Public Health (Wales) Bill, Explanatory Memorandum, paras. 54 and 380-389.

b. The use of vaping products may act as a gateway to nicotine addiction and tobacco smoking (with specific reference to youth).[9]
c. Vaping products contain various chemicals that are vaporised and emitted into the air, and studies have suggested that e-cigarette aerosol can contain some of the toxicants present in tobacco smoke, albeit at levels which are much lower.[10] The possibility of adverse health effects for third parties exposed to e-cigarettes cannot be excluded.[11]
d. E-cigarette use is undermining the enforcement of the smoking ban.[12]

11. As will be further explained below, these concerns and considerations are contradicted by the evidence.

"Re-normalisation"

12. In relation to re-normalisation, the Explanatory Memorandum fails to clearly articulate where the concern stems from because, as the Memorandum itself concedes, "[e]-cigarettes have not been on the market long enough for definitive evidence to be available about whether this effect is occurring."[13]

13. The Memorandum goes on to refer to evidence that greater perceived difficulty of smoking in public places as being associated with a lower likelihood of smoking among youth.[14] It then states that increasing number of youth have seen people vape in public places recently,[15] that e-cigarette products closely replicate smoking[16] and that passive exposure to vaping products use increases the desire to smoke in young adult daily smokers.[17] The conclusion that the use of vaping products may re-normalise smoking because of a perceived similarity is conjecture for which no evidence is adduced. Moreover, even if it were correct that exposure to vaping products may increase the desire to smoke in young daily smokers, this specific category concerns persons who are daily smokers already and to whom re-normalisation concerns would not seem to apply. In any case, it is preferable for daily smokers to use vaping products instead of cigarettes.

14. The Memorandum's reasoning appears to rest on the similarity in appearance, which is true for a limited number of vaping products only, and which has been contradicted in a report commissioned by Public Health England, which concludes that the use of vaping products in smoke free places is unlikely to give rise to normalisation concerns:

> *[A]lthough similar in apprearance, even cigalike products are easily distinguishable, both in appearance and smell, from tobacco cigarettes. Therefore, use of electronic cigarettes in smoke free places is more likely to lead to a normalisation of nicotine devices than to smoking, and hence potential benefit as a support to existing well smoke-free policies.*[18]

15. More fundamentally, however, is the fact that the evidence available to date plainly contradicts re-normalisation concerns and instead shows that vaping products are contributing to lower smoking prevalence rates. The most recent review of the available evidence by Public Health England concluded as follows:

> *Since EC were introduced to the market, smoking prevalence among adults and youth has declined. Hence there is no evidence to date that EC are renormalising smoking, instead*

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9 Public Health (Wales) Bill, Explanatory Memorandum, paras. 55 and 390-401.
10 Public Health (Wales) Bill, Explanatory Memorandum, paras. 56 and 402-403.
11 Public Health (Wales) Bill, Explanatory Memorandum, para. 57.
12 Public Health (Wales) Bill, Explanatory Memorandum, para. 58.
13 Public Health (Wales) Bill, Explanatory Memorandum, para. 380.
14 Public Health (Wales) Bill, Explanatory Memorandum, paras. 381 and 382.
15 Public Health (Wales) Bill, Explanatory Memorandum, paras. 383.
16 Public Health (Wales) Bill, Explanatory Memorandum, para. 386.
17 Public Health (Wales) Bill, Explanatory Memorandum, para. 387.
18 Electronic cigarettes: a report commissioned by Public Health England. Available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/311887/Ecigarettes_report.pdf>

it's possible that their presence has contributed to further declines in smoking, or denormalisation of smoking.[19]

16. In view of the above, Nicoventures submits that the evidence does not support banning the use of vaping products in enclosed public and work places in Wales because of any risk of "re-normalisation."

Gateway concerns and youth uptake

17. Turning to the concerns that the use of vaping products might act as a gateway to nicotine addiction and tobacco smoking,[20] it is worth noting at the outset that even the Explanatory Memorandum concedes that "the evidence remains limited, but there is not sufficient evidence to rule it out."[21] This underlines the fact that there appears to be no clearly identified risk in relation to gateway concerns that would warrant a prohibition on the use of vaping products in public places.

18. There is, in fact, no meaningful data that supports gateway concerns. Instead, the evidence shows that "[r]egular use of the devices is confined to current and ex-smokers and use amongst never smokers remains negligible," and that *"[r]egular use of electronic cigarettes amongst children and young people is rare and is confined almost entirely to those who currently or have previously smoked*." [22]

19. Similarly, a recent review of the available research concluded that "although there have been claims that EC [e-cigarette] is acting as a 'gateway' to smoking in young people, the evidence does not support this assertion. Regular use of e-cigarettes by non-smokers is rare and no migration from e-cigarettes to smoking has been documented (let alone whether this occurred in individuals not predisposed to smoking in the first place). The advent of EC has been accompanied by a decrease rather than increase in smoking uptake by children."[23]

20. Again with specific reference to youth, a report commissioned by Public Health England also found no data to support a claim of gateway effect or increased smoking uptake, especially amongst youth:

> *There have been some suggestions that among non-smokers, electronic cigarettes might be used as a gateway to smoking and promote smoking uptake and nicotine addiction, particularly among children and young people. However, to date there is no data supporting this claim. Experimentation with electronic cigarettes among non-smoking children in the UK is currently rare, and only about 1% of 16 to 18-year-old never smokers have experimented to electronic cigarettes and few if any progress to sustained use. Furthermore, experimentation with electronic cigarettes should be considered in the context of current levels of experimentation with tobacco cigarettes, which in Great Britain currently generates a prevalence of smoking of 15% among 16 to 19-year olds, and 29% in 20 to 24-year olds. It is therefore relatively unlikely that availability and use of electronic cigarettes causes or will cause significant additional numbers of young people to become smokers than do at present."*[24]

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19 E-cigarettes: an evidence update: a report commissioned by Public Health England. Available at <https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update>

20 Public Health (Wales) Bill, Explanatory Memorandum, para. 55.

21 Public Health (Wales) Bill, Explanatory Memorandum, para. 396

22 ASH UK Fact Sheet May 2015, Use of electronic cigarettes (vapourisers) among adults in Great Britain; see also ASH UK Fact Sheet May 2015, Use of electronic cigarettes among children in Great Britain).

23 See Hajek 2014, citing US Center for Disease Control and Prevention. National Youth Tobacco Survey (NYTS). Smoking and Tobacco Use. 2012.

24 Britton J, Bogdanovica I. (2014). Electronic cigarettes: A report commissioned by Public Health England, citing ASH, Use of e-cigarettes in Great Britain among adults and young people, May 2013. Available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/311887/Ecigarettes_report.pdf>

21. In conclusion, Nicoventures submit that the available evidence suggests that "gateway" concerns are unsupported by the available evidence and that, consequently, a ban on the use of vaping products in public places on the account of those concerns is unwarranted. Indeed, the evidence indicates that vaping products may in fact be acting as a gateway *out of* smoking.

Exposure to second-hand vapour

22. The Explanatory Memorandum's concerns about exposure to second hand vapour are equally speculative and rely entirely on untested assumptions. Indeed, the Explanatory Memorandum cites a number of studies that suggest that there are no health concerns about exposure to second-hand vapour.[25] The Memorandum notes only one DKFZ study suggesting that second hand vapour *may* "justify health concerns"[26] even though the available evidence suggests that high quality vaping products emit vapour in which carcinogens are present in insignificant concentrations that do not warrant health concerns.

23. Nicoventures refers to the preceding section of this submission, showing that e-cigarette vapour does not expose users to any significant level of toxicants and nicotine itself is not related to chronic health effects that are associated with the consumption of combustible tobacco products. Given the extremely low level of exposure to users, risks to bystanders is likely entirely insignificant. Indeed, a wide range of authorities have concluded that second hand vapour of e-cigarette use poses negligible risks to the health of others. For instance, the international public health researchers who petitioned the World Health Organization to refrain from banning and/or unduly restricting e-cigarettes, noted that: "*It is inappropriate to apply legislation designed to protect bystanders or workers from tobacco smoke to vapour products. There is no evidence at present of material risk to health from vapour emitted from e-cigarettes*."[27]

24. Similarly, in their recently published survey on public place vaping, Public Health England state**:** "Based on the available evidence, the risk to the health of bystanders from exposure to vapour from nicotine vapourisers is extremely low. A legal ban on the use of nicotine vapourisers in enclosed public places and workplaces would not be justified on the grounds of passive exposure."[28] Nicoventures recalls, in this respect, that the Bill and its proposed restrictions on the use of vaping products in public places was opposed by highly reputed public health bodies:

> *"There isn't enough evidence to justify a ban on using e-cigarettes indoors. The measure could create more barriers for smokers trying to quit tobacco."*[29]
>
> *"To date, we can see no suggestion in the existing evidence base that would support an outright ban on the use of e-cigarettes."*[30]

Impact on the enforcement of the smoking ban

25. The Explanatory Memorandum raises the concern that the use of vaping products might undermine the enforcement of the smoking ban, noting that several prosecutions under the Health

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25 See studies referred in para. 402 of the Explanatory Memorandum.

26 *Id.*

27 Letter to Margaret Chan, Director General WHO. Signed by 53 leading public health leaders from around the world. Available at <http://nicotinepolicy.net/documents/letters/MargaretChan.pdf>.

28 Public Health England. 2015. *Policies and practice on use of e-cigarettes in enclosed public places: towards a consensus.* Public Health England. Available at: <www.ukctas.ac.uk/ukctas/documents/e-cigarettes-in-enclosed-public-places-final-survey.pdf>

29 Cancer Research UK. 2015. *Welsh Government proposes banning e-cigarettes in public places.* [News Report] [Online] Available at: <http://www.cancerresearchuk.org/about-us/cancer-news/news-report/2015-06-09-welsh-government-proposes-banning-e-cigarettes-in-public-places>

30 Action on Smoking and Health Wales. 2015. *Electronic Cigarettes.* [Website] Accessed 23 July 2015. <http://ashwales.org.uk/en/information-resources/topics/electronic-cigarettes>

Act 2006 have failed where the defendant claimed to have been using an e-cigarette.[31] This would not appear to be a serious concern. Indeed, it is a generally accepted principle that individuals must not be prosecuted or sanctioned without sufficient proof. If it cannot be conclusively established that a person actually violated a smoking ban, there simply is no reason for that person to be sanctioned.

26. The fact that some "cigalike" products, which account for a minority proportion of vaping products, may look similar to cigarettes does not undermine the fact that they remain easily distinguishable. Users are increasingly switching to second and third generation "pen" and "tank" devices which are clearly distinguishable from cigarettes, even at a distance.

27. In line with the above, the Chartered Institute of Environmental Health stated that there is a 99.7 per cent compliance rate with the smoking ban, and they have found no evidence to support the idea that the use of e-cigarettes in public is undermining this.[32]

28. In view of the above, Nicoventures submits that there is no evidence that would support the notion that the use of vaping products in public places may undermine the enforcement of smoking bans.

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?

29. Nicoventures fully supports the prohibition on the sale of vaping products to persons under 18. At the same time, it is important that the minimum age requirement should be applied without depriving adult consumers of reasonable access to vaping products.

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

30. Nicoventures has explained in the preceding sections why the available evidence shows that there is little evidence to suggest that e-cigarette vapour is harmful to non-users. The available evidence suggests that vaping products do not re-normalise smoking behaviour, inhibit the enforcement of smoking bans or act as a gateway into smoking. Therefore, the available evidence does not support the introduction of a ban on the use of vaping products in public places. In view of this evidence, Nicoventures does not believe that the proposals relating to vaping products contained in the Bill will contribute to the improvement of public health in Wales.

31. On the contrary, bans on the use of vaping products in public places have the potential to damaging to public health by inhibiting the switching to products with a lower risk profile. Additionally, the legislative assimilation of vaping products to tobacco products (as far as restrictions on their public use are concerned) further undermines public health because it misinforms the public by incorrectly giving the impression that both product categories are equally harmful. It is worth noting in this respect that, in light of its findings concerning the lower risk profile of vaping products and of the shift to the inaccurate perception that vaping products are at least as harmful as cigarettes, Public Health England has recently argued that the public should be provided with balanced information on the risks of vaping products.[33]

4. The Bill engages concerns under human rights law

32. The second paragraph of Article 1 of Protocol No. 1 to the European Convention on Human Rights provides as follows:

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31 Public Health (Wales) Bill, Explanatory Memorandum, para. 58.

32 Meeting of the All Party Groups on Smoking and Health, Pharmacy, and Heart Disease 10 June 2014

33 Public Health England, E-cigarettes: a new foundation for evidence-based policy and practice, p.4. Available at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454517/Ecigarettes_a_firm_foundation_for_evidence_based_policy_and_practice.pdf>

The preceding provisions [concerning the peaceful enjoyment of possessions and the protection against deprivation] shall not, however, in any way impair the right of a state to enforce such laws at it deems necessary to control the use of property in accordance with the general interest or to secure the payment of taxes or other contributions or penalties.

33. In application of this provision, the European Court of Human Rights has held that it protects against interference with the right of property that does not serve a legitimate general interest objective or that is disproportionate.

34. Nicoventures submits that in view of the lack of contribution to public health and the undermining of tobacco harm reduction strategies, as outlined in the preceding sections and in the answers to the first set of questions, the ban on the use of vaping products is manifestly disproportionate. Indeed, there is no balance between the interests of public health, which are not served by a ban on the use of vaping products in public places, and the prohibition imposed on users of vaping products.

5. Conclusions

35. Nicoventures appreciates this opportunity to provide its views on Part 2 of the Public Health (Wales) Bill to the Health and Social Care Committee. Throughout this submission, Nicoventures has expressed the view that the available evidence shows that high quality vaping products have the potential for significant harm reduction and public health. The available evidence shows that the concerns behind the proposal to ban the use of vaping products in public places are unwarranted. Moreover, such a ban engages concerns under human rights law.

36. In view of the above, Nicoventures urges the Committee to reconsider the proposal to ban the use of vaping products in public places and to refrain from imposing unreasonable and disproportionate limitations on their use.

3 September 2015

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 UK Faculty of Public Health – PHB 67 / Tystiolaeth gan Cyfadran Iechyd y Cyhoedd y DU – PHB 67

Health and Social Care Committee
National Assembly for Wales
Pierhead Street
Cardiff CF99 1NA
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3 September 2015

UK Faculty of Public Health response to the National Assembly for Wales consultation of the Public Health (Wales) Bill

About the UK Faculty of Public Health

The UK Faculty of Public Health (FPH) is committed to improving and protecting people's mental and physical health and wellbeing. FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). Our vision is for better health for all, where people are able to achieve their fullest potential for a healthy, fulfilling life through a fair and equitable society. We work to promote understanding and to drive improvements in public health policy and practice.

As the leading professional body for public health specialists in the UK, our members are trained to the highest possible standards of public health competence and practice – as set by FPH. With 3,300 members based in the UK and internationally, we work to develop knowledge and understanding, and to promote excellence in the field of public health. For more than 40 years we have been at the forefront of developing and expanding the public health workforce and profession.

Consultation response

The UK Faculty of Public Health (FPH) welcomes this opportunity to respond to the National Assembly for Wales' consultation of the Public Health (Wales) Bill. At each stage of the development of the proposed Bill, FPH has responded to each relevant consultation, including on both the Green Paper[1] and the White Paper.[2]

FPH strongly supports Wales' commitment to Health in All Policies and the new Future Generations Act and we are pleased to see the proposal for separate legislation on minimum unit pricing of alcohol. However, we are concerned that key prevention measures have been left out of the proposed Public

[1] UK Faculty of Public Health, Response to Welsh Government Green Paper about whether a public health bill is needed for Wales, 2013, http://bit.ly/1O0veAx
[2] UK Faculty of Public Health, http://bit.ly/1nQwVAX, response to the Welsh Government consultation of the Public Health White Paper, "Listening to you – Health Matters"

Health (Wales) Bill, most notably, provisions to tackle obesity including policies to develop nutritional standards and address the relative affordability of healthy food.

The broad ranging proposals set out within the White Paper consultation that preceded this latest consultation were very encouraging, including action to reduce the harms to health caused by smoking, alcohol misuse and obesity. As the Welsh Government indicated, and FPH was confident of, they provided a set of practical actions which, when combined, would have a positive impact on health and wellbeing in Wales.

FPH further reiterates and emphases that a firm commitment to upstream legislative action to ensure health is at the heart of all national and local government policy formulation – thereby reducing health inequalities by taking action across all social and economic determinants of health – is critical. We therefore strongly advocate that a framework for health in all policies should form a central pillar of an eventual public health Bill, ensuring strong cross-sectoral collaborative links may be made and a strategic national approach adopted, supported by local initiatives.

We thus underscore the importance of the introduction of a statutory duty on Ministers to consider the health impact of all policies developed across the Welsh Government, which will be of practical utility in improving health outcomes and reducing health inequalities. This will ensure that public health is at the heart of wide ranging departmental portfolios and central to policy formulation, e.g. in relation to the economy, transport, town planning, housing and the environment, early years, mental health and wellbeing and education (including adult education).

It is regrettable that this consultation does not also build on the positive signal made within the original Green Paper, in which significant weight was given to this pioneering and progressive public policy proposal which would have the potential to make a tremendous impact on the health of the Welsh population. FPH would welcome the opportunity to discuss this issue in greater detail and offers the support of our expert membership to the Welsh Government in addressing these important concerns.

In relation to electronic cigarettes, FPH draws attention to our existing policy statement on this matter.[3] FPH strongly believes that the ideal regulatory framework for electronic cigarettes should prevent initiation among youth and other non-tobacco users and protect bystanders. It should also maximise product safety and enable current smokers who would not or cannot otherwise quit to move to electronic cigarettes.

We recognise that it is difficult for a single regulatory framework to achieve all these aims. We note that regulations already agreed under the 2014 EU Tobacco Products Directive (TPD) will come into force in 2016. These stipulate that electronic cigarettes can either be regulated as medicines (and then subject to the same marketing controls as medicines) or as consumer products (and then subject to the same marketing controls as tobacco).

FPH recognises the advantages of this regulatory approach, and, in particular the marketing controls it puts on electronic cigarettes. The UK Government is permitted to implement the Tobacco Products Directive without delay and we strongly encourage it to do so. FPH is concerned about the high levels of marketing and exposure (e.g. through use in public places) that young people will be exposed to between now and 2016. As such it recommends that:

- comprehensive controls on marketing in line with the TPD should be urgently implemented
- as such, unlicensed products should be subject to the same comprehensive and binding marketing controls as tobacco products so that they cannot be marketed or advertised
- marketing controls should extend to bans on the sponsorship of sports clubs or sporting events, any events targeting young people, product placement, use of flavours designed to

[3] UK Faculty of Public Health, Policy Statement on Electronic Cigarettes, July 2014, http://bit.ly/1Iz8M0i

4 St Andrews Place • London • NW1 4LB • Tel: 020 3696 1479 • Email: *enquiries@fph.org.uk* • Website: *www.fph.org.uk* • Registered Charity No: 263894

appeal to youth and celebrity spokespersons – no advertising or use should ‘re-normalise‘ or ‘re-glamourise‘ smoking and undermine smoking prevention policies
- all products, whether licenced as medicines or consumer products, should be required to carry a health warning clearly indicating the addictive nature of nicotine and detailing ingredients and their safety, and also encourage smoking cessation, with links to the NHS Smokefree website
- outlets selling electronic cigarettes should provide information on the dangers of smoking, the addictive nature of nicotine and encourage cessation
- until further information is available on effectiveness as a quit product, smokers should be informed that the most effective means of quitting is via the NHS stop smoking service
- age of sale legislation on e-cigarettes should be actively enforced
- a ban on use in public places should be introduced in order to protect bystanders
- products must be consistent in quality and deliver nicotine as effectively and safely as possible
- independent data on exclusive and ‘dual use‘ by socioeconomic status should be collected
- studies must be in place to detect any small changes in youth smoking rates in a timely manner

In light of evidence showing how the tobacco industry intends to misuse its claimed interest in harm reduction, FPH stresses that full weight should be accorded to Article 5.3 of the FCTC. Developments should be closely monitored and independent data on use of electronic cigarettes by socioeconomic status should be collected.

FPH, for the reasons outlined within our policy statement on electronic cigarettes, fully supports the restriction of the use of electronic cigarettes in enclosed and substantially enclosed public and work places, bringing the use of these devices into line with existing provisions on smoking. FPH also supports the prohibition of handing over of tobacco or nicotine products to people under the age of 18, and the creation of a national register or retailers of tobacco and nicotine products (as outlined in our previous response to the White Paper.

FPH also supports the submission to this consultation made by the UK Public Health Forum.

For further information, please contact Mark Weiss, Senior Policy Officer UK Faculty of Public Health at: [redacted] or on [redacted].

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

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

Evidence from Martin Hensman LLB (Hons) – PHB 68 / Tystiolaeth gan Martin Hensman LLB (Anrh) – PHB 68

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No. Most definitely not. After more than 45 years as a tobacco smoker I enrolled on a Quit Smoking Course, at my GPs surgery, on 24th July 2015. I had made numerous attempts to stop smoking in the past. None of these were successful despite the use of the following NRT products: – Patches, chewing gum, lozenges and an inhalator. In addition I had also tried to quit using hypnotherapy and acupuncture. Prior to my recent Stop Smoking attempt I researched alternative smoking cessation products on the internet. Of relevance were the following reports: – E-cigarettes: an evidence update – A report commissioned by Public Health England, 2015, and, ASH (Action on Smoking and Health) Briefing (Electronic cigarettes), November 2014. The PHE report stated that '*current expert estimate that **using Electronic Cigarettes is around 95% safer than smoking**'*. The ASH briefing stated that '*Toxins have been found in a number of studies of electronic cigarettes although these are at levels much lower than those found in cigarettes and **not at levels which would generally cause concern***'. Having read those reports I decided to use an e-cigarette and can report that I have not

smoked tobacco in the last 6 weeks. The two reports I have cited above are certainly not in favour of the restrictions on e-cigs currently being proposed in the Public Health (Wales) Bill.

'*In the UK smokefree legislation exists to protect the public from the demonstrable harms of secondhand smoke. ASH does not consider it appropriate for electronic cigarettes to be subject to this legislation, but that it should be for organisations to determine on a voluntary basis how these products should be used on their premises*' – ASH (Action on Smoking and Health) Briefing (Electronic cigarettes), November 2014

'New regulations currently planned should also maximise the public health opportunities of Electronic Cigarettes' – E-cigarettes: an evidence update – A report commissioned by Public Health England, 2015

It is impossible to see how the proposals to ban e-cig use in enclosed public and workplaces in Wales does anything other than detract from the public health benefits offered by them.

Furthermore, had e-cigarettes been banned in enclosed and substantially enclosed public places at the time of my latest 'quit attempt' it is more than likely that I would have again been unsuccessful.

Question 2

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?

No. The provisions will achieve the opposite. In practice the provisions would require e-cig users to occupy the same areas outside workplaces and social venues now occupied by smokers. E-cig users would again be exposed to the same toxic second hand smoke that the Smoke-free Premises etc. (Wales) Regulations 2007 were supposed to protect them from.

The proposed provisions are therefore illogical and work contrary to harm reduction principles.

Question 3

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?

They don't "replicate cigarettes" and don't normalise smoking, they normalise using something completely different. For example, here's a picture of my current e-cig which could not possibly be confused with a traditional cigarette.



A leading UK Charity actively promoting smoke free policy has the following to say on this point in its report ASH (Action on Smoking and Health) Briefing (Electronic cigarettes), November 2014

'*The fact that many electronic cigarettes look similar to conventional cigarettes has been said to risk confusion as to their use in enclosed public places, such as on public transport. However, given that the most distinctive feature of cigarette smoking is the smell of the smoke, which travels rapidly, and that this is absent from electronic cigarette use, it is* ***not clear how any such confusion would be sustained'***.

'*One stated advantage of smokefree legislation is that it de-normalises smoking, effectively distancing the behaviour from what is an accepted social norm…. There are concerns that electronic cigarettes will undermine this process, threatening the now established practice of smokefree public places, such as at work or on public transport. However to date there is* ***little evidence to suggest this is the case'***.

In addition The Smoking Toolkit Study carried out in England found that e-cigarettes were taking over from nicotine gum and patches as an aid to giving up smoking. The leader of that study, Professor Robert West, said: *"Despite claims that use of electronic cigarettes risks renormalising smoking, we found* ***no evidence to support this view.*** *On the contrary, electronic cigarettes may be helping to reduce smoking as more people use them as an aid to quitting*."

Question 4

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?

I certainly do not agree with this inference.

In fact, according to **E-cigarettes: an evidence update - A report commissioned by Public Health England, 2015**

- Despite some experimentation with Electronic Cigarettes among never smokers, Electronic Cigarettes are attracting very few people who have never smoked into regular EC use.

-No evidence that Electronic Cigarettes are undermining the long-term decline in cigarette smoking among adults ***and youth****, and may in fact be contributing to it*.

According to Deborah Arnott, ASH Chef Executive

"*While it is important to control the advertising of electronic cigarettes to make sure children and non-smokers are not being targeted, there is no evidence from our research that e-cigarettes are acting as a gateway into smoking*."

The evidence appears to be demonstrating the exact opposite of what this consultation document is suggesting.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
Whilst I would support the proposal to establish a national register of tobacco retailers I would not support the introduction of a similar register of e-cig retailers.

Question 6

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?
I have no problem with the creation of an offence in relation to the handing over of tobacco to a person under 18. However, I do not believe that a parent should be penalised and criminalised for handing over an e-cig to their 16 year old child who currently smokes tobacco.

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 Bevan Foundation – PHB 69 /
Tystiolaeth gan Sefydliad Bevan – PHB 69

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4th September 2015

Dear Chair,

Evidence on the general principles of the Public Health (Wales) Bill

Introduction

1. The Bevan Foundation develops ideas to make Wales fair, prosperous and sustainable. It is a registered charity and is independent of government, any political party or line of thought. We welcome the opportunity to submit a response to the Committee's inquiry. We have also submitted evidence as part of a group led by Tenovus Cancer Care.

2. Our submission addresses your specific questions on smoking and e-cigarettes and on toilets, and your general questions on the approach taken in the Bill.

Smoking and e-cigarettes

3. Our research on smoking cessation in Wales[1] argued that the end to the downward trend in smoking amongst the population as a whole and the high prevalence and upward trends in smoking amongst the least well-off require a new approach to smoking cessation. This would involve:
    a. Regarding smoking as an addiction not a lifestyle choice.
    b. Active intervention by a wide range of health professionals to support quitting.[2]

[1] Bevan Foundation (2013) Hitting the Quit Target: Smoking and Low Income Groups.
http://www.bevanfoundation.org/publications/hitting-the-quit-target-smoking-and-low-income-groups/

[2] Accessing help to quit can involve several separate steps which lose smokers en route - intervention should occur immediately a smoker indicates they want to quit.

c. Active use of a **range** of quit aids to reflect smokers' circumstances.[3]
d. Creating a no-smoking culture and environment particularly amongst groups at greatest risk of smoking.

4. The use of e-cigarettes in enclosed public places is a minor issue compared with the scale of the smoking problem, and we are not convinced that a ban is the right focus for public health in Wales.

5. The rationale for the 2007 ban on smoking in enclosed public places was to reduce the harm from second-hand smoke, and for this reason it has had high levels of compliance. The Bill's proposals change the rationale of a ban: we are not aware of evidence that second-hand e-cigarette vapour causes harm, and it is hard to see how smoking conventional or e-cigarettes in open public spaces e.g. a hospital car park harms others.

6. Indeed, the evidence suggests that e-cigarettes are less harmful to the user than smoking, and the evidence that their use 'normalises' smoking is weak. As an NRT product (albeit unregulated at present) e-cigarettes can help with quitting especially for those who do want to engage with smoking cessation services.

7. We understand the wish to be cautious about the use of a new nicotine device, but believe that the resources involved in implementing and enforcing a ban would be better used on promoting more effective stop smoking support.

Provision of Toilets

8. We welcome the inclusion of public toilets in the Bill. Access to toilets is a much neglected issue of importance to everyone but especially children, older people and people with certain health conditions.

9. We are concerned that the proposed requirement for each authority to prepare and publish a toilet strategy adds to local authorities' paper mountain without resulting in the provision of more toilets. Instead, we suggest that the Bill is less cautious and places a direct requirement on public and private bodies alike to provide and maintain public toilets in places open to the public, such as shopping centres, bus stations, sports venues and town centres. The requirement could be proportionate to footfall, e.g. one toilet per X visitors.

10. There should be an explicit requirement that toilets are accessible to disabled people and are open for specified hours.

Priorities for public health

11. Wales has one of the least healthy populations in the UK, with high levels of smoking, obesity and alcohol misuse. A Public Health (Wales) Bill is a unique opportunity to tackle the underlying environmental and behavioural causes of poor

[3] The preferred approach of nicotine replacement therapy (NRT) plus group support is not appropriate for all quitters. Other methods (e.g. prescription medicines or multiple NRT) are slightly less effective but are very much better than no support at all or repeated failures with the preferred method.

health in an innovative way which meets Wales' needs.

12. We would like to see the Bill take a coherent and broad approach to promoting public health, bringing together action to address all the key challenges.

13. The Bill should include the general principles that underpin the Welsh approach to public health, and should:

    a. Recognise that poor public health is much more than 'lifestyle choice' – it is caused by ***structural problems*** in the economy and society, including low income, low levels of education, poor housing, and unregulated promotion of unhealthy products and services.

    b. Recognise the deep inequalities in health associated with socio-economic group, gender, age, ethnicity and disability.[4]

    c. Ensure the infrastructure for healthy living is available e.g. adequate housing, access to affordable and nutritious food, access to sport facilities.

    d. Combine positive incentives for good health behaviours with restrictions on others.
    e. Be willing to innovate and test new interventions.

Other areas of public health

14. There are many other areas of public health that are critically important, including:

    a. Nutrition (including obesity)
    b. Alcohol and substance misuse
    c. Damp, cold and over-crowded housing
    d. Physical inactivity
    e. Sexual health

15. These issues are arguably more important than where people use e-cigarettes and we would welcome their inclusion in a comprehensive Public Health (Wales) Bill.

Yours sincerely

Victoria Winckler

Director

CC:

Minister for Health and Social Services

Deputy Minister for Health

Chief Medical Officer

[4] Bevan Foundation (2015) **Social Justice Briefing: Inequalities in Health**.

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 Chartered Society of Physiotherapy – PHB 70 / Tystiolaeth gan Cymdeithas Siartredig Ffisiotherapi – PHB 70

CHARTERED SOCIETY OF PHYSIOTHERAPY
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David Rees AM, Chair
Health & Social Care Committee
Cardiff Bay
Cardiff
CF99 1NA

4th of September 2015

Dear Chair and Committee Members

CONSULTATION ON THE PUBLIC HEALTH (WALES) BILL

In response to the call by the Health and Social Care Committee for written evidence on the general principles of the Public Health (Wales) Bill, the Chartered Society of Physiotherapy (CSP) in Wales is pleased to make a written contribution.

The CSP has one key issue to which we would like to draw the Committee's attention and that relates to 'Part 3 - Special Procedures'. In particular, the issue relates to exemptions from a requirement to be licensed for the specific practice of acupuncture as undertaken by physiotherapists.

Acupuncture is within the scope of physiotherapy practice and physiotherapists are already registered and regulated by the Health Care Professions Council (HCPC) so do not need to be dual registered with the special procedures register.

In Section 49 sub section (3) paragraph (b) the Bill spells out that '*regulations may provide that an individual who is registered, in the capacity of a member of that profession or a worker of that description, in a qualifying register is to be treated as exempt'* and section (4) goes on to identify that paragraph (a) – *'a register maintained by the Health Care*

Professions Council'. This wording on the face of the Bill does provide the opportunity to ensure there is no need for dual registration **just so long as the regulations are definitely brought forward by Welsh Government**.

The CSP would be keen to see this point made strongly by the Health & Social Care Committee in its report at the end of Stage 1.

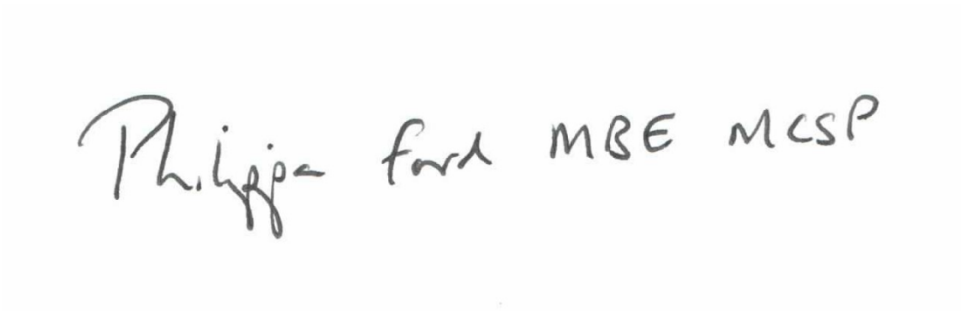
Doctors, dentists and nurses already have exemption by way of the National Health Service Reform and Health Care Professions Act 2002 and their exemption, as can be seen, does not need to be conferred by regulations. Physiotherapists and other HCPC regulated professions are dependent on Welsh Government bringing forward the regulations within Section 49. We are keen to see that they do so and keep pace with the current situation found in Scotland where physiotherapists practising acupuncture are already exempt.

The CSP would also like to take this opportunity to highlight that the profession is a signatory of the submission made by a wide range of professions and third sector organisations and looks forward to continuing to play an active role in this collaborative. We hope the points raised will be useful to committee members.

The CSP looks forward to continued involvement in the scrutiny of the Public Health (Wales) Bill.

If you require any further information from the professional body please do not hesitate to get in touch.

Yours sincerely



Philippa Ford MBE MCSP
CSP Policy & Public Affairs Manager for Wales
[redacted]

In association with:

Chartered Society of Physiotherapy Welsh Board
The Welsh Physiotherapy Leaders Advisory Group

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 53,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,300 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

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 Fontem Ventures – PHB 71 / Tystiolaeth gan Fontem Ventures – PHB 71

Fontem Ventures' response to the Public Health (Wales) Bill, Health and Sports Committee consultation.

About Fontem Ventures:

1 Fontem Ventures is a fully owned subsidiary of Imperial Tobacco Group. Fontem Ventures is committed to developing and growing a portfolio of innovative non-tobacco products including e-cigarettes.

2 Fontem Ventures manufactures the blu™ e-cigarette range which is available online and in store from over 20,000 UK stockists.

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?

3 No. There is no scientific-based justification for the inclusion of e-cigarettes in existing smoke-free regulations in Wales.

4 There are clear and substantial differences between e-cigarettes and tobacco products. E-cigarettes do not contain tobacco, do not burn, and do not smoulder unlike tobacco products. As a result, bystanders may only be exposed to vapour exhaled by the consumer into the air but not to smoke. Numerous reviews of the scientific literature have concluded that exposure to nicotine and other chemicals that may be present in exhaled e-cigarette vapour is negligible with all chemical analyses to date indicating exhaled e-cigarettes vapour does not warrant a health concern to bystanders [1-6].

5 The overwhelming majority of scientific evidence also show e-cigarettes are not renormalising the act of smoking or serving as a "gateway" to tobacco products, particularly amongst youngsters. A recent review of the scientific literature found the use of e-cigarettes in areas where smoking is banned "*may encourage smokers to make the switch to a product that could save their health and their lives, thereby helping to de-normalise smoking by reducing the overall number of smokers*" [4].

6 By banning e-cigarette use in public and work places in Wales, the Welsh Government are forcing e-cigarette consumers to use their products in designated smoking areas where e-cigarette users are exposed to "second-hand smoke". The public health community has previously concluded "second-hand smoke" is a cause of smoking-related disease and there is no safe level of exposure to tobacco smoke [7].

7 Greater uptake of e-cigarettes in Wales could be an effective cessation and smoking reduction aid and help the Welsh Government achieve its target of reducing smoking rates to 16% by 2020. By restricting use of e-cigarettes in public and enclosed places achieving this target will be difficult. The Welsh Government should embrace e-cigarette products which have been found to be a less harmful alternative to smokers and present no apparent risk to bystanders [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)?

8 In principle, Fontem Ventures does not support extending restrictions on use of e-cigarettes to some non-enclosed spaces. As an e-cigarette manufacturer, Fontem Ventures will not comment on legislation related to smoking, since this pertains to an entirely separate product category.

9 E-cigarettes have been found to be 95% less harmful than normal cigarettes and help adult smokers quit smoking and reduce their cigarette consumption with no identified risks to bystanders when used indoors or outdoors [2,3,5,8].

10 Fontem Ventures are of the view that effectively extending an indoor e-cigarette ban to include an outside area only serves to further stigmatise adult e-cigarette users and as such we consider it to be an unjustified restriction on the freedom of individuals to use a product with the greatest potential for those seeking an alternative to tobacco. In principle, Fontem Ventures does not believe there should be any bans in non-enclosed spaces, except on actual school premises or other premises whose purpose is expressly child-oriented.

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

11 No. Fontem Ventures are of the view that the Bill is shaped entirely by precautionary impulse and not scientific evidence. The Bill should embody a regulatory approach aimed at preventing uptake by under 18s while encouraging tobacco smokers to shift to e-cigarettes as a smoking-cessation tool and a means of reducing the number of tobacco-related illnesses in Wales.

12 The Bill fails to recognise the fundamental differences between e-cigarettes and tobacco products and differentiate both product types. E-cigarettes do not contain or burn tobacco, and so do not generate the many thousands of different chemicals that are present in tobacco smoke, but work by heating a simple liquid mixture containing propylene glycol and/or glycerol which may contain nicotine into an inhalable vapour [8]. These ingredients have a long history of use in medicinal products [9]. The current Bill treats smoking and vaping as the same and thereby promotes the false impression that vaping presents the same risks as smoking.

13 It has been reported that e-cigarettes are not undermining and may contributing to the long-term decline in cigarette smoking [2] and could help the Welsh Government achieve its goal of reducing smoking amongst the population to 16% by 2020. There is emerging scientific evidence that e-cigarettes can also encourage reduced cigarette consumption and cessation even among those smokers not intending to quit or reject other support [2,10-12].

14 The Welsh Government's concerns on e-cigarettes should be considered relative to significant health risks from tobacco. Given the consensus among public health experts that switching to e-cigarettes has significant health benefits for smokers and their use is confined to former or current smokers, the Bill should be an opportunity for the Welsh Government to introduce measures to ensure safety and quality is consistently high across all products rather than

restricting access to e-cigarettes, their use in indoor public and work places and stigmatising smokers who shift to using e-cigarettes.

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

15 Based on the overwhelming majority of scientific evidence, it is the view of Fontem Ventures that e-cigarettes are not renormalising the act of smoking or serving as a "gateway" to traditional tobacco products.

16 There is no scientific evidence that show e-cigarettes are undermining the long-term decline in tobacco smoking among adults and youth and they may in fact be contributing to it [2]. It is estimated 2.6 million adults in the UK currently use e-cigarettes with 60% current smokers and 40% ex-smokers [13]. Despite some very limited experimentation among never smokers, regular use among never smokers is extremely rare and estimated around 0.2% [2].

17 A recent scientific study by academics at the University of Cardiff studying e-cigarette use in young people in Wales funded by the Welsh Government's Public Health Division concluded "*the very low prevalence of regular use…suggests that e-cigarettes were unlikely to be making a significant direct contribution to adolescent nicotine addiction*" [14]. This is further scientific evidence that suggests e-cigarettes are not renormalising the act of smoking or serving as a "gateway" to traditional tobacco products, particularly among youngsters in Wales.

18 Most e-cigarette users do not wish to be associated with smoking and choose e-cigarettes that do not resemble conventional tobacco products. The majority of e-cigarettes do not resemble conventional tobacco products and for that reason Fontem Ventures uses the term 'electronic vapour products' (EVPs) to describe such products. The use of EVPs is likely to contribute further to the de-normalisation of smoking by reducing the number of smoking role models, reducing frequency of public smoking and by providing a role model for the rejection of smoking, which can help the Welsh Government achieve its target of reducing smoking rates to 16% by 2020.

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?

19 Fontem Ventures is of the view that e-cigarette products should not be sold or marketed to anyone under the age of 18.

20 Scientific studies have found regular use of e-cigarettes among youth is rare with around 2% using at least monthly and 0.5% weekly and whilst there is very limited experimentation among never smokers, nearly all youth using e-cigarettes are tobacco smokers [2].

21 Fontem Ventures is of the view that no e-cigarette flavour should be marketed or appeal to anyone under the age of 18 e.g. *bubble-gum*, *milkshake*, *cotton candy*. Flavours have been found to play an important role in both perceived pleasure and the effort to reduce cigarette consumption of quit smoking in e-cigarette users [15]. Given the uptake of e-cigarettes by

youth is minimal, any restrictions to flavours used by adult e-cigarette users could have a negative impact on current e-cigarette users while no public health benefits would be observed in the young [2,15]. Fontem Ventures is of the view that flavour variability should be maintained with any potential risk for anyone under the age of 18 being attracted to e-cigarettes sufficiently minimised by strictly prohibiting e-cigarette sales in this population group.

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?

22 There is little evidence that shows the use of e-cigarettes in smoke-free areas undermines smoke-free laws [16]. Most people have no difficulty differentiating exhaled e-cigarette vapour from tobacco smoke. Fontem Ventures is of the view that compliance with smoke-free laws can be supported by emphasising a clear distinction between smoking and vaping and by communicating this clearly to mangers of premises.

23 There is no scientific-based justification for the inclusion of e-cigarettes in existing smoke-free regulations in Wales. All testing of e-cigarette vapour so far has shown no evidence that use of e-cigarettes results in exposure to inhalable chemicals that would warrant health concerns by common safety and regulatory standards [5,16]. Fontem Ventures is of the view that managers should have the choice whether to allow employees and customers to use e-cigarettes on their premises or not.

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

24 Fontem Ventures is of the view that the Welsh Government should determine the level of fines to be imposed and not e-cigarette manufacturers and suppliers.

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

25 Fontem Ventures agrees with the proposal to establish a register of retailers of tobacco and e-cigarette products, however given the clear and substantial differences between tobacco and e-cigarettes products including public health benefits, Fontem Ventures is of the view there should be two separate registers.

26 By establishing separate registers for tobacco and e-cigarette products, smokers wishing to reduce or quit tobacco smoking would have greater access to e-cigarettes and reduced access to conventional tobacco products. Fontem Ventures is of the view that a single register does not convey the message that e-cigarettes are a less harmful alternative to conventional tobacco products nor does a single register for both products help remove less reputable e-cigarette vendors from the market, which would help drive standards up across the industry.

27 Fontem Ventures strongly believes that there should be no fee to register and as limited an administrative burden on retailers as possible.

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

28 Yes. Fontem Ventures is of the view that e-cigarette products should not be sold or marketed to anyone under the age of 18 and an e-cigarette register will help restrict access to youngsters.

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

29Yes, with the reservations expressed above.

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?

30 Fontem Ventures supports legislation which restricts the access and consumption of nicotine products by anyone under the age of 18, and to make it an offence to proxy purchase nicotine-containing products.

31 Fontem Ventures also supports the introduction of a requirement for retailers of e-cigarettes to have an age verification policy in place to prevent anyone under the age of 18 accessing nicotine-containing products.

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

32 No. Fontem Ventures is of the view that the Bill may have diverse unintended consequences on public health and does not clearly differentiate the fundamental differences between e-cigarettes and tobacco products. The Bill also fails to recognise the public health benefits e-cigarettes offer to smokers seeking a less harmful alternative to tobacco. It has been estimated more than 70,000 lives a year could be saved in England and Wales if every smoker switched to e-cigarettes, equivalent to the population size of the Isle of Anglesey, North Wales.

33 Fontem Ventures is of the view that the Bill does not support the Welsh Government's goal of reducing smoking rates to 16% by 2020 as it restricts access and use of e-cigarettes by adult smokers and misses an opportunity to introduce positive measures that would drive up industry standards and build confidence in the e-cigarette category.

34 Fontem Ventures is of the view that despite 27,000 people in Wales being admitted to hospital suffering tobacco-related illnesses at a cost of £380 million to NHS Wales each year [17], the Welsh Government's Bill is shaped entirely by precautionary impulse and fails to acknowledge the overwhelming scientific evidence which recognises the public health benefit e-cigarettes can offer.

35 Fontem Ventures is of the view that e-cigarettes and other electronic vapour products offer the greatest potential to adult smokers seeking an alternative to tobacco use. The Welsh Government's Bill appears to inadequately cover so-called "heated tobacco" or "heat not burn" products, an emerging novel tobacco category in the UK. These products are being positioned as an alternative to conventional cigarettes, and there is evidence in other countries that the manufacturers of such products are seeking favourable excise treatment compared to both conventional cigarettes and non-tobacco products such as e-cigarettes. Fontem Ventures is of the view the Welsh Government's Bill should ensure all heated tobacco products are regulated and taxed accordingly, i.e. as conventional cigarettes.

The annual cost to the Welsh NHS due to admitting people suffering tobacco related illnesses is £380 million. In 2010 this meant that 27,500 people per year were admitted to hospital in Wales with tobacco related illnesses.

Sadly the Welsh Government has taken a negative epistemological stance towards NVP and will not accept the scientific evidence of their positive potential. It is estimated that tobacco related illness costs the Welsh NHS 380 million pounds per year. In human terms this is over 27,000 people admitted to hospital for tobacco related illnesses and sadly, 5,600 premature deaths.[1] Fontem Ventures believes that NVPs can play a significant role in reducing these figures.

The Bill has the opportunity to recognise the positive role NVPs can play in the reduction of the number of people using tobacco products. It is suggested that 70,000 lives can be saved if everyone in England and Wales who used tobacco switched to NVP (See Public Health England report; reference 1).

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17. BMA. **http://bma.org.uk/working-for-change/improving-and-protecting-health/tobacco/smoking-statistics**

Name	Fraser Cropper
Are you responding as an individual or on behalf of an organisation?	Organisation (independently owned electronic cigarette company)
Organisation and role	Managing Director of Totally Wicked Ltd
Telephone number	[redacted]
E-mail address	[redacted]
Would you like to be added to the Committee's contacts database for future inquiries?	Yes, for anything relating to electronic cigarettes.
Would you be content to attend a Committee meeting to give oral evidence?	Yes.

Dear Mr Rees,

Public Health (Wales) Bill Consultation Response

Totally Wicked welcomes the opportunity to respond to the above named consultation.

Totally Wicked is an independent electronic cigarette manufacturing business based in Lancashire. The company, which was formed in 2008 now employs over 120 people locally and has established businesses in both Germany and the United States. Significantly, unlike most companies in this sector, Totally Wicked manufacture in the UK and export globally. This includes the manufacture of our own fluid ranges which use only UK sourced ingredients and our own product development team which includes a dedicated manufacturing and assembly business in Lancashire. Since 2008 Totally Wicked has been responsible for creating over 500 jobs in eight EU Member States.

Totally Wicked has a significant presence throughout Wales in terms of customers and individual retail outlets selling our products.

The guiding principle of our business is to put our customers' needs first. We therefore wish for our sector to be robustly and proportionately regulated. We have always gone above and beyond what has been required under the current regulatory regime. Over the last year we have also been working with Public Health, consumers, Trading Standards, and others from our industry to develop the very first nationally recognised voluntary standard that electronic cigarette and e-liquid manufacturers, importers and distributors can adopt to provide assurance to their end customers that they are doing the right things to ensure quality and safety in the end product – British Standards Institution Publicly Available Specification for vaping products (BSI PAS 54115).

According to figures produced by the Welsh Government around 5,450 people die from a tobacco related illnesses every year in Wales[1] costing the Welsh taxpayer £302 million.[2] Figures produced by ASH Wales/Cymru show that a staggering 21 per cent of the adult population in Wales still smoke.[3] Part two of this bill should therefore be focussed on working to reduce both the number of smokers and the number of people who die from smoking related illnesses. Electronic cigarettes have a significant role to play in this.[4] In Wales at least 130,000 smokers have switched to vaping.[5] This is not surprising as NRT products have a 90 per cent failure rate.[6] Electronic cigarettes by comparison are recognised as being at least 60 per cent more effective in helping smokers to quit.[7] Electronic cigarettes are now recognised as the number one quitting aid used by smokers.[8]

[1] http://www.wales.nhs.uk/sitesplus/922/page/59800
[2] ASH Wales/Cymru and BHF Cymru (2013). The economic cost of smoking to Wales: a review of existing evidence
[3] http://www.ash.org.uk/files/documents/ASH_93.pdf
[4] http://summaries.cochrane.org/CD010216/TOBACCO_can-electronic-cigarettes-help-people-stop-smoking-or-reduce-the-amount-they-smoke-and-are-they-safe-to-use-for-this-purpose
[5] http://ashwales.org.uk/en/information-resources/topics/electronic-cigarettes
[6] Dr Jed Rose, Director of the Duke Center for Smoking Cessation and a Professor in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center, speaking at the Global Forum on Nicotine (Warsaw, Saturday 6th June 2015): http://gfn.net.co/downloads/2015/Plenary%202/Jed%20Rose.pdf
[7] Study carried out on 5,000 smokers, by Professor Robert West looking at the success rate of different methods to stop smoking: nicotine gum, nicotine patches, nothing, or e-cigarettes. Reported on BBC Breakfast 28 April 2014
[8] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes

Regulation whilst being robust needs to be proportionate. Policy makers with an interest in public health should therefore develop regulation that allows adult smokers throughout Wales to have the genuine choice of an alternative and significantly less harmful product. That means electronic cigarettes need to be an attractive products for established smokers.

For clarification, Totally Wicked has no links to the tobacco industry.

In this context please find below Totally Wicked's responses to the aspects of the Public Health Wales Bill that relate to electronic cigarettes and e-liquids.

Part 2: Tobacco and Nicotine Products

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?

Totally Wicked does not think that the use of electronic cigarettes should be banned in enclosed public and work places in Wales.

The Welsh Government states that the purpose of the Bill provisions is to bring the use of electronic cigarettes into line with existing provisions on smoking. Why? Electronic cigarettes are not a tobacco product as the recent negotiations surrounding the revision of the Tobacco Products Directive made clear, electronic cigarettes are a consumer product. The new rules from the Committee of Advertising Practice for the marketing of electronic cigarettes actually state: 'Marketing communications / advertisements must make clear that the product is an e-cigarette and not a tobacco product.'[9]

If electronic cigarettes are not a tobacco product why should they be subjected to the same regulatory regime as tobacco products, particularly when the recent Independent Expert Evidence Review published by Public Health England concluded that electronic cigarettes are at least 95 per cent less harmful than tobacco products? [10]

The rational for introducing the ban on smoking tobacco in enclosed public areas was to protect the health of non-smokers. This same rational does not exist for vaping because as a growing body of independent scientific evidence is showing – electronic cigarette vapour poses no harm to bystanders.[11]

The Welsh Government state three reasons for wanting to ban the use of vaping in enclosed public and work places in Wales:

- It may lead to a renormalisation of smoking,
- It could undermine the current smoking ban, and
- It might be a gateway to smoking.

As Elen de Lacy, Chief Executive of ASH Wales/Cymru has made clear,[12] policy relating to electronic cigarettes should be evidence based. It should not be based on 'mays', 'coulds', and 'mights'.

Does vaping in enclosed public and work places lead to a renormalisation of smoking? No. A wide variety of independent public health experts have looked into the issue of renormalisation of smoking and a link to vaping and all have concluded that there is no link. Vaping normalises vaping, it is a simple as that. Robert West, Professor of health psychology and director of tobacco studies at University College London's department of epidemiology and

[9] https://www.cap.org.uk/News-reports/Media-Centre/2014/~/media/Files/CAP/Consultations/ecig%20consultation/Regulatory%20Statement.ashx
[10] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
[11] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
Safety evaluation and risk assessment of electronic cigarettes as tobacco cigarette substitutes: a systematic review: Konstantinos E. Farsalinos and Riccardo Polosa published online 13 February 2014 *Therapeutic Advances in Drug Safety*
http://tobaccocontrol.bmj.com/content/early/2013/03/05/tobaccocontrol-2012-050859.abstract
http://www.sciencedirect.com/science/article/pii/S0273230014002505
http://informahealthcare.com/doi/abs/10.3109/08958378.2012.724728
http://www.biomedcentral.com/1471-2458/14/18/abstract
[12] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes

public health, following his latest research concluded: “Despite claims that electronic cigarettes risk re-normalising smoking, we found no evidence to support this.”[13]

Does vaping in enclosed public and work places undermine the current smoking ban? No. The Chartered Institute of Environmental Health stated that there is a 99.7 per cent compliance rate with the smoking ban, and they have found no evidence to support the idea that vaping in public is undermining this.[14]

Does vaping in enclosed public and work places result in a gateway to smoking? No. Recent research from ASH has shown that just 0.1 per cent of vapers had never smoked tobacco products previously. Given the fact that 99.9 per cent of people who vape are current or former smokers, it is not surprising that electronic cigarettes are not acting as a gateway to smoking.[15]

The weight of independent evidence so unequivocally demonstrates that a ban on the use of electronic cigarettes in enclosed public and work places would be disproportionate, counterproductive from a public health standpoint, go against the precautionary principle as originally intended, and demonstrate that the Welsh Government and the Welsh Assembly’s Health and Social Care Committee were worrying about problems that do not exist. Importantly, there is no justification for a ban as electronic cigarettes are not a tobacco product nor is the vapour from electronic cigarettes harmful to bystanders.

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)?

Totally Wicked is an independent company with no links to the tobacco industry, furthermore neither electronic cigarettes nor e-liquids are tobacco products or tobacco related products. Totally Wicked therefore will not comment on issues directly relating to the regulation of tobacco products.

Totally Wicked does not support the extension of the proposed restrictions on electronic cigarettes to some non-enclosed spaces such as hospital grounds and children’s playgrounds.

The Welsh Government and the Welsh Assembly’s Health and Social Care Committee must ask themselves what current problem requires a ban on vaping in non-enclosed public spaces such as hospital grounds and children’s playgrounds. In addition to this they must consider the impact on public health such a ban would have.

Is the current use of electronic cigarettes in hospital grounds and children’s playgrounds leading to an increase in smoking rates? No. Recently published figures from the Welsh Health Survey show a two per cent fall in the proportion of people smoking in Wales since 2013.[16] This has coincided with a rise in the number of smokers switching from smoking to vaping. As Professor Robert West has made clear, there is a link between a rise in vaping and a fall in tobacco sales.

Is the current use of electronic cigarettes in hospital grounds and children’s playgrounds leading to non-smokers and children taking up vaping? No. The latest research from ASH continues to show no evidence that electronic cigarettes are encouraging young people to take up smoking.[17] Official figures from the Office of National Statistics show that only 0.14 per cent of vapers have never smoked previously.[18]

Is the current use of electronic cigarettes in hospital grounds and children’s playgrounds resulting in a renormalisation of smoking? No. A wide variety of independent public health experts have looked into the issue of renormalisation of smoking and a link to vaping and all have concluded that there is no link. Vaping normalises vaping, it is a simple as that. Professor Robert West, following his latest research concluded: “Despite claims that electronic cigarettes risk re-normalising smoking, we found no evidence to support this.”[19]

[13] http://metro.co.uk/2014/04/27/e-cigs-cleared-of-being-route-into-smoking-4710734/
[14] Meeting of the All-Party Groups on Smoking and Health, Pharmacy, and Heart Disease 10 June 2014
[15] http://www.theguardian.com/society/2014/apr/28/e-cigarette-users-triple-ash-survey
[16] http://wales.gov.uk/topics/statistics/theme/health/health-survey/results/?lang=en
[17] http://www.ash.org.uk/media-room/press-releases/:latest-data-finds-no-evidence-that-electronic-cigarettes-are-a-gateway-to-smoking-for-young-people
[18] http://www.ons.gov.uk/ons/rel/ghs/opinions-and-lifestyle-survey/adult-smoking-habits-in-great-britain--2013/sty-facts-about-smoking.html
[19] http://metro.co.uk/2014/04/27/e-cigs-cleared-of-being-route-into-smoking-4710734/

Is the current use of electronic cigarettes in hospital grounds and children's playgrounds damaging to the health of non-vapers? No. A growing body of independent scientific evidence demonstrates that electronic cigarette vapour poses no harm to bystanders.[20]

Would the introduction of a ban on the use of electronic cigarettes in hospital grounds and children's playgrounds lead to more or fewer smokers switching to from smoking to vaping? Fewer. Such a ban would send a message to smokers that the Welsh Government equates vaping with smoking and that the Welsh Government considers vaping a negative rather than a positive activity.

Research undertaken by Dr Konstantinos Farsalinos[21] demonstrates that smokers' perceptions of risk are very far from accurately aligned with reality. This affects their smoking/vaping behaviour. It is therefore very easy for a vaper to go back to being a smoker or a smoker to stay a smoker. In Spain a ban on the use of electronic cigarettes in public combined with a series of unsubstantiated negative stories in the media relating to vaping lead to a fall of 70 per cent in the number of vapers in Spain.[22] These people did not just give up vaping, they went back to smoking.

In reality vaping is at least 95 per cent less harmful than smoking.[23] There is never a situation where it is better for someone to smoke than to vape. As Professor John Britton from the Royal College of Physicians has said, "If all the smokers in Britain stopped smoking cigarettes and started using e-cigarettes we would save five million deaths in people who are alive today. It's a massive potential public health prize."[24]

The Royal Society for Public Health has recently called on health chiefs across the UK to take a less negative attitude towards electronic cigarettes[25] and the UK Government's Behavioural Insights Team and Sir Jeremy Heywood, Cabinet Secretary and Head of the Civil Service have publicly declared their support for electronic cigarettes in helping smokers switch to a significantly less harmful alternative.[26] Importantly, far from discouraging vaping in places such as children's playgrounds and hospital grounds, the British Dental Health Foundation called for electronic cigarettes to be used in "prominent public locations" so as to encourage their use.[27] It is interesting to note that based on the latest evidence The Royal Stoke Hospital is now reviewing its previous decision to ban vaping in the hospitals grounds.[28]

Rather than discouraging vaping, the Welsh Government should be encouraging smokers to switch to vaping.

If the current use of electronic cigarettes in hospital grounds and children's playgrounds is not leading to non-smokers and children taking up vaping, is not leading to an increase in smoking rates, is not leading to a renormalisation of smoking, and is not harmful to the health of non-vapers, what possible justification could the Welsh Government have for introducing such a move, particularly when the evidence suggests that such a move would lead to fewer smokers switching to vaping and significant numbers of vapers going back to smoking?

As Elen de Lacy, Chief Executive of ASH Wales/Cymru has made clear,[29] policy relating to electronic cigarettes should be evidence based. There is no evidence demonstrating a need to ban the use of electronic cigarettes in places such as hospital grounds and children's playgrounds. There is also no evidence to suggest that such a ban would have a positive impact on public health across Wales.

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[20] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
Safety evaluation and risk assessment of electronic cigarettes as tobacco cigarette substitutes: a systematic review: Konstantinos E. Farsalinos and Riccardo Polosa published online 13 February 2014 *Therapeutic Advances in Drug Safety*
http://tobaccocontrol.bmj.com/content/early/2013/03/05/tobaccocontrol-2012-050859.abstract
http://www.sciencedirect.com/science/article/pii/S0273230014002505
http://informahealthcare.com/doi/abs/10.3109/08958378.2012.724728
http://www.biomedcentral.com/1471-2458/14/18/abstract

[21] http://www.ecigarette-research.com/research/index.php/component/k2/item/85-the-importance-of-proper-information-risk-perception-about-e-cigarettes-is-the-strongest-predictor-of-dual-use&Itemid=213

[22] http://www.thinkspain.com/news-spain/24345/e-cigarette-sales-in-spain-drop-by-70-per-cent

[23] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

[24] The Independent Newspaper, 29 March 2013

[25] https://www.rsph.org.uk/en/about-us/latest-news/press-releases/press-release1.cfm/pid/542EBBA5-9D34-4791-A1B90FF9F2BA3C00

[26] https://civilservice.blog.gov.uk/2015/08/11/how-the-nudge-unit-threw-light-on-lighting-up/

[27] http://www.dentalhealth.org/news/details/875

[28] http://www.stokesentinel.co.uk/8203-Royal-Stoke-bosses-review-ban-staff-using-e/story-27681321-detail/story.html

[29] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes

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?

Totally Wicked does not believe that 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 electronic cigarettes.

This question states that there are potential dis-benefits related to vaping and that the benefits of switching from smoking are only 'potential'. Totally Wicked is unaware of any such dis-benefits based on currently available evidence, and far from being 'potential', the benefits of switching from smoking to vaping are real and are recognised as being such by a growing number of independent experts and millions of vapers across the world.

Vaping is at least 95 per cent less harmful than smoking.[30] There is never a situation where it is better for someone to smoke than to vape. As Professor John Britton from the Royal College of Physicians has said, "If all the smokers in Britain stopped smoking cigarettes and started using e-cigarettes we would save five million deaths in people who are alive today. It's a massive potential public health prize."[31] With 99.9 per cent of vapers being current or former smokers there is also no issue of electronic cigarettes being used on a regular basis by never-smokers or children.[32] There is also no evidence to show that vaping leads to neither a renormalisation of smoking, nor any evidence that vaping acts as a gateway to smoking. There is no evidence to suggest that vaping in public undermines the smoking ban. The Chartered Institute of Environmental Health stated that there is a 99.7 per cent compliance rate with the smoking ban, and they have found no evidence to support the idea that vaping in public is undermining this.[33] Finally, a growing body of independent research demonstrates that electronic cigarette vapour is not harmful to bystanders.[34]

What this bill does do is equate vaping with smoking and electronic cigarettes with tobacco cigarettes. Vaping is not smoking and electronic cigarettes are not a tobacco product. How is this helpful for a smoker wishing to switch to a less harmful alternative?

Figures produced by ASH Wales/Cymru show that a staggering 21 per cent of the adult population in Wales still smoke.[35] All those with a genuine interest in public health should be working to reduce this number.

Many smokers have tried to quit numerous times using NRT products and have failed. However, with vaping they have cut down or ceased smoking. In Wales at least 130,000 smokers have switched to vaping.[36] This is not surprising as NRT products have a 90 per cent failure rate.[37] Electronic cigarettes by comparison are recognised as being at least 60 per cent more effective in helping smokers to quit.[38] Electronic cigarettes are now recognised as the number one quitting aid used by smokers.[39]

Electronic cigarettes deliver clean nicotine – without the tar, carbon monoxide, and volatile hot gases of cigarettes. For smokers who switch, they hugely reduce risk, while satisfying any need for nicotine and some of the behavioural aspects of smoking. As the UK Government has recognised, it is much easier to substitute a similar (less harmful) behaviour than to eliminate an entrenched one.[40] Fundamentally, unlike NRT products they are customisable to an individual smokers needs. A vaper can choose what device they want, they can choose their nicotine strength, and they can choose their flavour of e-liquid.

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[30] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
[31] The Independent Newspaper, 29 March 2013
[32] http://www.ons.gov.uk/ons/rel/ghs/opinions-and-lifestyle-survey/adult-smoking-habits-in-great-britain--2013/sty-facts-about-smoking.html
[33] Meeting of the All-Party Groups on Smoking and Health, Pharmacy, and Heart Disease 10 June 2014
[34] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
Safety evaluation and risk assessment of electronic cigarettes as tobacco cigarette substitutes: a systematic review: Konstantinos E. Farsalinos and Riccardo Polosa published online 13 February 2014 *Therapeutic Advances in Drug Safety*
http://tobaccocontrol.bmj.com/content/early/2013/03/05/tobaccocontrol-2012-050859.abstract
http://www.sciencedirect.com/science/article/pii/S0273230014002505
http://informahealthcare.com/doi/abs/10.3109/08958378.2012.724728
http://www.biomedcentral.com/1471-2458/14/18/abstract
[35] http://www.ash.org.uk/files/documents/ASH_93.pdf
[36] http://ashwales.org.uk/en/information-resources/topics/electronic-cigarettes
[37] Dr Jed Rose, Director of the Duke Center for Smoking Cessation and a Professor in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center, speaking at the Global Forum on Nicotine (Warsaw, Saturday 6th June 2015):
http://gfn.net.co/downloads/2015/Plenary%202/Jed%20Rose.pdf
[38] Study carried out on 5,000 smokers, by Professor Robert West looking at the success rate of different methods to stop smoking: nicotine gum, nicotine patches, nothing, or e-cigarettes. Reported on BBC Breakfast 28 April 2014
[39] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes
[40] https://civilservice.blog.gov.uk/2015/08/11/how-the-nudge-unit-threw-light-on-lighting-up/

With literally thousands of devices and flavours, and multiple nicotine strengths available how does a smoker wishing to switch to vaping know what device, nicotine strength, and flavour is right for them? Initially they do not and that is why vape shops are so fundamentally important.

By visiting a vape shop a smoker benefits not just from the expertise of the vendor, but critically, they are able to sample the different devices, nicotine strengths, and flavours. This allows them to find a device, nicotine strength, and flavour that are right for them. Virtually no smoker walks into a shop picks up a cig-a-like product and successfully switches to vaping, it is more complicated than that. The expert advice and the product sampling are critically important in virtually all successful switch attempts. This means that they need to vape in an enclosed public place.

If the Welsh Government succeeds in banning vaping in enclosed public places then vapers will be forced to go back to standing with the smokers, re-enforcing their smoking habits and letting them wrongly understand that vaping is the same as smoking, when in reality it is 95 per cent less harmful.[41] This will expose them to the dangers of second-hand smoke and penalises a smoker that has taken decisive action to switch to a less harmful product. It is the equivalent of holding an Alcoholics Anonymous meeting in a pub. Why would any government do this?

The Welsh Government's proposed ban will also prevent vape shops from allowing smokers to sample devices, nicotine strengths, and flavours and their own impact assessment acknowledges this. As a direct consequence of this the importance of vape shops will decline so many will close, resulting in empty premises and unemployment. More importantly, without the ability to sample nicotine strengths, devices, and flavours in advance, a smoker would simply have to guess what flavour they might like, what nicotine strength they might need, and what device is best for them. Virtually all will make the wrong guesses and few will go back to try and get it right for a second time. This will mean that fewer smokers will successfully switch to vaping and will therefore continue to smoke and die prematurely.

This bill will remove fundamentally important aspects of the switching process from smoking to vaping: the ability to sample the different devices, nicotine strengths, and flavours. Take away a smokers ability to vape in a vape shop and you put a barrier in the road to them switching to a significantly less harmful alternative. Take away a smokers ability to witness vaping at work or in the pub and you deprive them of the chance encounter that for many smokers was their first step on the road to vaping. What possible public health benefit does the Welsh Government hope to achieve with this proposed ban?

Far from achieving a balance, this bill in focussing on a small number of unfounded fears related to vaping, will make it harder for smokers to switch to a significantly less harmful alternative. As a result many vapers will go back to smoking and many smokers will never make the switch to vaping.

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?

For Totally Wicked this is not about having views, it is about the evidence. As Elen de Lacy, Chief Executive of ASH Wales/Cymru has made clear,[42] policy relating to electronic cigarettes should be evidence based. Is there any credible evidence linking the use of electronic cigarettes in smoke-free areas with a renormalisation of smoking behaviours? Totally Wicked is aware of no such evidence.

There is a very simple way of demonstrating this. Electronic cigarettes have been used in smoke-free areas throughout Wales since roughly 2008. In that time have smoking rates in Wales increased or decreased? They have continued to decrease. Recently published figures from the Welsh Health Survey show a two per cent fall in the proportion of people smoking in Wales since 2013.[43] This has coincided with a significant year-on-year rise in the number of smokers switching from smoking to vaping. As Professor Robert West has made clear, there is a link between a rise in vaping and a fall in tobacco sales. If vaping was leading to a renormalisation of or promotion of smoking then surely smoking rates would be increasing rather than decreasing.

[41] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
[42] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes
[43] http://wales.gov.uk/topics/statistics/theme/health/health-survey/results/?lang=en

Professor Robert West, following his latest research concluded: "Despite claims that electronic cigarettes risk re-normalising smoking, we found no evidence to support this."[44]

The Chartered Institute of Environmental Health stated that there is a 99.7 per cent compliance rate with the smoking ban, and they have found no evidence to support the idea that vaping in public is undermining this.[45]

Vaping normalises vaping, it is a simple as that. This is a point that is clearly understood by the British Dental Health Foundation who recently called for electronic cigarettes to be used in "prominent public locations" so as to encourage and normalise their use.[46]

There is no credible evidence showing that vaping in smoke-free areas either promotes or leads to a renormalisation of smoking and it must be evidence that guides policy development.

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?

For Totally Wicked this is not about having views, it is about the evidence. As Elen de Lacy, Chief Executive of ASH Wales/Cymru has made clear,[47] policy relating to electronic cigarettes should be evidence based. Is there any credible evidence showing that young people are using electronic cigarettes on a regular basis or that electronic cigarettes act as a gateway to smoking? Totally Wicked is aware of no such evidence.

In recent years a huge amount of highly credible independent work has been carried out looking at electronic cigarette usage amongst young people and the gateway issue.

Research undertaken by Queen Mary University in London[48] found that a child trying a tobacco cigarette for the first time is 50 per cent likely to become a regular smoker. The same research found no evidence that a child trying an electronic cigarette for the first time goes on to become a regular vaper. A recent study by John Moores University found that, 'Overall seven out of eight young people had never accessed e-cigarettes'[49].

Recently Cardiff University came to the same conclusion: 'E-cigarettes are popular with teens, including those who have never smoked, but few of those who try them become regular users, with most of those who do so also being smokers.'[50]

ASH regularly carries out research into the use of electronic cigarettes by children, they concluded: 'Of those who had heard of e-cigarettes and had never smoked a cigarette, 98 per cent reported never having tried an electronic cigarette and two per cent reported having tried them "once or twice". There is almost no evidence of regular electronic cigarette use among children who have never smoked or who have only tried smoking once.'[51]

Cancer Research UK looked in detail at two major studies into electronic cigarette use amongst young people in Wales, they concluded: 'Looking specifically at two studies dedicated the use of e-cigarettes amongst young people in Wales only a minority of teenagers who try e-cigarettes go on to become regular users. And the majority of those who do use the devices regularly were already smokers.'[52]

On the issue of gateway, Deborah Arnott, Chief Executive of ASH, said, "There is no evidence from our research that e-cigarettes are acting as a gateway into smoking."[53]

Official figures from the Office of National Statistics show that only 0.14 per cent of vapers are people who have never previously smoked.[54]

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[44] http://metro.co.uk/2014/04/27/e-cigs-cleared-of-being-route-into-smoking-4710734/
[45] Meeting of the All-Party Groups on Smoking and Health, Pharmacy, and Heart Disease 10 June 2014
[46] http://www.dentalhealth.org/news/details/875
[47] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes
[48] Research undertaken by Professor Peter Hajek, Director of the Tobacco Dependence Research Unit at Queen Mary University of London
[49] John Moores University – 'Young People's Perceptions and Experiences of Electronic Cigarettes'
[50] http://www.cardiff.ac.uk/news/view/93573-e-cigarette-use-among-welsh-teenagers
[51] http://www.ash.org.uk/files/documents/ASH_950.pdf
[52] http://www.cancerresearchuk.org/about-us/cancer-news/news-report/2015-04-16-regular-e-cigarette-use-low-among-teens-analysis-suggests
[53] http://metro.co.uk/2014/04/27/e-cigs-cleared-of-being-route-into-smoking-4710734/

If electronic cigarettes were being used by young people on a regular basis then the evidence would show this and it does not. If electronic cigarettes were acting as a gateway to smoking then the evidence would show this and it does not.

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?

For Totally Wicked this is not about having views, it is about the evidence. As Elen de Lacy, Chief Executive of ASH Wales/Cymru has made clear,[55] policy relating to electronic cigarettes should be evidence based. Is there any credible evidence to show that vaping in current smoke-free areas is undermining the smoking ban or leading confusion amongst staff or venue managers? Totally Wicked is aware of no such credible evidence.

This question is based on the outdated premise that all vapers will be using a product that looks like a tobacco cigarette. The overwhelming majority of vapers use second, third, and even fourth generation products that look nothing like tobacco cigarettes. Therefore arguments about electronic cigarettes making it difficult for venues to enforce the smoking ban do not really hold water particularly when the Chartered Institute of Environmental Health, the body charge with enforcing the smoking ban, stated that there is a 99.7 per cent compliance rate with the smoking ban, and they have found no evidence to support the idea that vaping in public is undermining this.[56]

Commenting on this issue, ASH stated, "The fact that some electronic cigarettes look similar to conventional cigarettes has been said to risk confusion as to their use in enclosed public places, such as public transport. However, given that the most distinctive feature of cigarette smoking is the smell of the smoke, which travels rapidly, and that this is absent from electronic cigarette use, it is not clear how any such confusion would be sustained."[57]

Some companies and places of work have introduced their own bans on the use of electronic cigarettes. The overwhelming majority of these were done prior to the most recent evidence on vaping being available. However, a growing number of such organisations are now reversing these bans as new evidence emerges as to the benefits of vaping. Recently, Cambridgeshire Police, following a review of "health fears", decided to allow their officers to vape at work[58]. Other public bodies such as the Royal Stoke Hospital[59] and Hertfordshire County Council[60] are also reconsidering their previous position on vaping in favour of a more positive stance. In the private sector companies are also reversing previously imposed bans on vaping. Leading Pubco Enterprise Inns have recently reversed their ban on vaping in their licensed premises. Recently, the Chartered Institute of Environmental Health published advice to employers encouraging them to allow their employees to vape at work.[61]

Recently ASH and the Chartered Institute of Environmental Health have been working together to promote vaping policies for businesses and the public sector. Totally Wicked recommends that the Welsh Assembly's Health and Social Care Committee looks at the positive results generated from this work.

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

Totally Wicked is an independent company with no links to the tobacco industry, furthermore neither electronic cigarettes nor e-liquids are tobacco products or tobacco related products. Totally Wicked therefore will not comment on issues directly relating to the regulation of tobacco products.

The offences listed under part two of the Bill are:

a) An individual using an electronic cigarette in an enclosed public or work place in Wales,

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[54] http://www.ons.gov.uk/ons/rel/ghs/opinions-and-lifestyle-survey/adult-smoking-habits-in-great-britain--2013/sty-facts-about-smoking.html
[55] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes
[56] Meeting of the All-Party Groups on Smoking and Health, Pharmacy, and Heart Disease 10 June 2014
[57] http://ash.org.uk/files/documents/ASH_715.pdf
[58] http://www.cambridge-news.co.uk/Cambridge/Police-in-Cambridgeshire-can-smoke-e-cigarettes-after-health-review-but-they-are-banned-on-our-trains-20130821131920.htm
[59] http://www.stokesentinel.co.uk/8203-Royal-Stoke-bosses-review-ban-staff-using-e/story-27681321-detail/story.html
[60] http://www.hertfordshiremercury.co.uk/Council-support-e-cig-report/story-27686172-detail/story.html
[61] http://www.thetimes.co.uk/tto/health/news/article4534760.ece

b) A body, company or employer allowing electronic cigarettes to be used on their premises (enclosed public or work places), and
c) Knowingly handing over an electronic cigarette or e-liquid to someone under the age of 18.

The fines are set out under section 37 of the Criminal Justice Act 1982 and for the purposes of part two of the Bill are level one and level four on the standard scale of fines for summary offences. A level one fine is set at up to and including but not exceeding £200 and a level four fine is set at up to and including but not exceeding £2,500.

Someone found guilty of offence a) would be subject to a level one fine, whilst offences b) and c) carry a level four fine.

Totally Wicked supports the creation of a new offence of knowingly handing over electronic cigarettes and/or e-liquids to a person under the age of 18.

Totally Wicked believes that electronic cigarettes are a product for current/former adult smokers and current users of nicotine containing products. Therefore Totally Wicked fully supports a ban on the sale of electronic cigarettes to those under the age of 18.

Totally Wicked has been voluntarily implementing a ban on the sale of electronic cigarettes and e-liquids to those under the age of 18 for the past seven years, as have other responsible companies.

However, this bill draws equivalence with tobacco in terms of punishment. Someone who knowingly hands over an electronic cigarette or a bottle of e-liquid is fined the same amount as someone who knowingly hands over a packet of tobacco cigarettes.

To be clear, Totally Wicked supports the ban on knowingly handing over electronic cigarettes or e-liquids to someone under the age of 18 and anyone found guilty of such an act should be fined. However by fining such a person the same amount as someone who has been found guilty of handing over a tobacco product implies that the Welsh Government views these two products as the same. They are not the same. Tobacco is a highly dangerous product that currently results in around 5,450 people deaths from tobacco related illnesses every year in Wales,[62] costing the Welsh taxpayer £302 million.[63] In contrast electronic cigarettes are recognised as being at least 95 per cent less harmful than tobacco products, have helped at least 130,000 smokers in Wales to reduce the amount they smoke or quit all together,[64] and they cost the Welsh taxpayer nothing.

Yes offenders should be punished and repeat offenders should be restricted from selling electronic cigarettes and e-liquids for a defined period (see question 10), but the fine should be proportionate to the product in question.

For the reasons set out in answer to questions one, three, four, six, and 12 Totally Wicked does not believe there to be any justification for the Welsh Government's proposed ban on vaping in enclosed public and work places throughout Wales.

Totally Wicked therefore does not believe there to be any justification for the offences listed under this part in relation to either personally using an electronic cigarette in or allowing electronic cigarettes to be used in enclosed public and work places.

With this in mind, if the Welsh Government's ban on vaping in enclosed public and work places is introduced then Totally Wicked believes that it is unacceptable, in terms of fines, to treat electronic cigarettes and tobacco products in the same way. For the reasons set out above they are completely different products.

The rational for introducing the ban on smoking tobacco in enclosed public areas was to protect non-smokers whose health could be damaged through passive smoking. So someone smoking a tobacco product in an enclosed public or work place is not just breaking the law, they are also having a negative impact on the health of those around them. The same would apply to a company, venue manager or employer who allowed someone to

[62] http://www.wales.nhs.uk/sitesplus/922/page/59800
[63] ASH Wales/Cymru and BHF Cymru (2013). The economic cost of smoking to Wales: a review of existing evidence
[64] http://ashwales.org.uk/en/information-resources/topics/electronic-cigarettes

smoke in an enclosed public or work place. However, with electronic cigarettes the vapour produced is of no harm to bystanders.[65]

The law is full of examples where punishments differ depending on the exact nature of the crime. Two people can be found guilty of what on paper looks like similar offences only to see their punishments differ. The law does not simply punish people for breaking the law; it takes into account what they did in breaking the law. Speeding is one such example. There is not a single punishment for breaking the speed limit. When determining the appropriate punishment to give someone who has been found guilty of speeding the law takes into account how many miles above the speed limit they were driving at. Someone found guilty of driving at five miles above the limit will receive a more lenient punishment than someone found guilty of driving at 20 miles above the limit. Illegal drugs are another example. Someone found guilty of possessing/smuggling/selling a class C drug will find themselves far more leniently punished than someone found guilty of possessing/selling a class A drug.

Totally Wicked sees no reason what-so-ever why this same principle should not apply to the offences listed under this part of the Bill.

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

Totally Wicked is an independent company with no links to the tobacco industry, furthermore neither electronic cigarettes nor e-liquids are tobacco products or tobacco related products. Totally Wicked therefore will not comment on issues directly relating to the regulation of tobacco products.

Totally Wicked does not agree with the proposal to establish a national register of retailers of tobacco and nicotine products.

The Welsh Government and the Welsh Assembly's Health and Social Care Committee must ask themselves what current problem necessitates the creation of such a register and what would be the impact on public health in Wales if such a register was introduced.

In its justification for introducing this register the Welsh Government states that, "It has long been established that nicotine is highly addictive." Is it?

All Totally Wicked e-liquids use pharmaceutical grade MHRA approved nicotine. This is exactly the same nicotine that is contained in NRT products; is the Welsh Government proposing that retailers of NRT products also be included on this register? If nicotine is the sole reason for including electronic cigarette retailers on such a register then surely *all* retailers of *all* nicotine containing products should be included, and if not, why not?

The reality is the clean nicotine contained in e-liquids is not harmful. Professor Robert West said, "E-cigarettes are about as safe as you can get. We know about the health risks of nicotine. Nicotine is not what kills you when you smoke tobacco. E-cigarettes are probably about as safe as drinking coffee."[66] Recently ASH[67] and the Royal Society of Public Health[68] have publicly called for more to be done to ensure that medical professionals, the media, and the public understand that nicotine is 'not the deadly component in cigarettes.' Furthermore, both the National Institute for Health and Care Excellence (NICE) and the MHRA have ruled that long term use of nicotine is not detrimental to the health of the user.[69] In 2013, NICE identified a need for better public understanding of the relative safety of nicotine containing products.[70]

[65] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update
Safety evaluation and risk assessment of electronic cigarettes as tobacco cigarette substitutes: a systematic review: Konstantinos E. Farsalinos and Riccardo Polosa published online 13 February 2014 *Therapeutic Advances in Drug Safety*
http://tobaccocontrol.bmj.com/content/early/2013/03/05/tobaccocontrol-2012-050859.abstract
http://www.sciencedirect.com/science/article/pii/S0273230014002505
http://informahealthcare.com/doi/abs/10.3109/08958378.2012.724728
http://www.biomedcentral.com/1471-2458/14/18/abstract
[66] The Guardian newspaper 05 June 2013
[67] http://www.ash.org.uk/:ash-supports-calls-for-more-to-be-done-on-public-understanding-of-nicotine
[68] http://www.theguardian.com/society/2015/aug/13/health-bosses-promote-e-cigarettes-harmful-tobacco-smoking-experts
[69] http://www.nice.org.uk/guidance/ph45
[70] Ibid

Appearing before the Scottish Parliament's Health and Sport Committee, Linda Bauld, Professor of Health Policy at the University of Stirling made it clear that nicotine when consumed in a form other than tobacco is not a harmful or a particularly addictive substance.[71] It is for this reason that some years ago, for example, health officials felt able to approve the use of nicotine patches for pregnant woman.

Nicotine is a normal and natural part of the diet. It is present in many vegetables and fruits including aubergines, tomatoes, cauliflowers, and potatoes.[72] It is present in other foodstuffs, including tea. That it is dependence-forming unless/until it is administered in tobacco cigarette smoke or used by smokers/ex-smokers has been questioned by scientists. Tobacco cigarette smoke contains at least 9,600 other compounds,[73] some of which are likely to be synergens; some are likely to be additives that may boost the effect by freebasing it; some are the multiple other active alkaloids in tobacco; and some pyrolytic compounds may be dependence forming, in addition. Tobacco cigarettes, far from being simple products are very carefully engineered. A recent study found that electronic cigarettes, far from generating dependence equivalent to cigarette smoking, were comparable in addictiveness to nicotine gums.[74]

Based on independent evidence it would appear that nicotine becomes highly addictive after being supplied with a cocktail of 9,600 other compounds. Nicotine is certainly dependence-creating when delivered in tobacco cigarette smoke: many (but not all) smokers become dependent on nicotine. However, there is no evidence that nicotine is highly addictive in the pure form as delivered in the diet, through NRT or electronic cigarettes, indeed, many vapers actually forget to use their electronic cigarettes. Would they do this if they were addicted?

If nicotine in the form consumed in electronic cigarettes is not as addictive or harmful as the Welsh Government makes out what is the justification for wanting to include retailers selling electronic cigarettes on a register alongside tobacco products?

Is there currently a problem with large numbers of under 18s in Wales buying electronic cigarettes on a regular basis? No. Cancer Research UK looked in detail at two major studies into electronic cigarette use amongst young people in Wales, they concluded, "Looking specifically at two studies dedicated the use of e-cigarettes amongst young people in Wales only a minority of teenagers who try e-cigarettes go on to become regular users. And the majority of those who do use the devices regularly were already smokers."[75]

What the creation of this register will do is place a regulatory and financial hurdle in front of a small businessman thinking of selling electronic cigarettes and/or e-liquids. As the Welsh Government has made clear there will be a financial cost to be on this register, there will be paperwork to complete, and there will be an inspection regime linked to the register. All of this will act as a disincentive to anyone thinking of setting up a new business selling electronic cigarettes or starting to sell electronic cigarettes in an established business. Not only will this result in fewer businesses and jobs being created throughout Wales, it will also have a negative impact on public health.

With literally thousands of devices and flavours, and multiple nicotine strengths available how does a smoker wishing to switch to vaping know what device, nicotine strength, and flavour is right for them? Initially they do not and that is why vape shops are so fundamentally important.

By visiting a vape shop a smoker benefits not just from the expertise of the vendor, but critically, they are able to sample the different devices, nicotine strengths, and flavours. This allows them to find a device, nicotine strength, and flavour that are right for them. Virtually no smoker walks into a shop picks up a cig-a-like product and successfully switches to vaping, it is more complicated than that. The expert advice and the product sampling are critically important in virtually all successful switch attempts.

If the Welsh Government introduces a bureaucratic and costly registration system fewer vape shops will open and some established vape shops will close, particularly if the proposed ban on vaping in enclosed public and work places is also introduced. This will place a barrier in the road of someone making the switch from smoking to vaping. Furthermore, by including electronic cigarettes on the same register as tobacco products the Welsh

[71] http://www.scottishparliament.tv/category.aspx?id=19&page=1&sort=date
[72] http://www.vidarholen.net/contents/junk/nicotine.html
[73] http://www.crcpress.com/product/isbn/9781466515482
[74] http://www.drugandalcoholdependence.com/article/S0376-8716(14)01986-3/abstract
[75] http://www.cancerresearchuk.org/about-us/cancer-news/news-report/2015-04-16-regular-e-cigarette-use-low-among-teens-analysis-suggests

Government is creating the impression that it sees the two products as the same and carrying the same risk. This sends out completely the wrong message to existing vapers and smokers.

The key health benefit of electronic cigarettes is determined by how many smokers switch to them or use them as a staging post to quitting completely. This means that they have to be an attractive alternative to tobacco cigarettes for established smokers. It would therefore be perverse and counterproductive from a public health standpoint to subject electronic cigarettes to the same restrictions as tobacco products.

The Welsh Government and the Welsh Assembly's Health and Social Care Committee must ask themselves if the inclusion of retailers of electronic cigarettes and e-liquid on a register alongside tobacco products is likely to increase or decrease the number of smokers switching to vaping.

The very fact that the Welsh Government feel compelled to include retailers of electronic cigarettes and e-liquid on a register alongside tobacco products implies that they consider nicotine to be a dangerous substance. This risks consumers gaining a distorted and confused view on the safety of electronic cigarettes compared with smoking tobacco.

Rather than discouraging their use and placing unnecessary restrictions on their sale, surely the Welsh Government should, as the Royal Society for Public Health[76] and the UK Government's own Behavioural Insights Team[77] have proposed – encourage their use.

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

Totally Wicked is an independent company with no links to the tobacco industry, furthermore neither electronic cigarettes nor e-liquids are tobacco products or tobacco related products. Totally Wicked therefore will not comment on issues directly relating to the regulation of tobacco products.

Totally Wicked does not believe the establishment of a register will help protect under 18s from accessing electronic cigarettes.

Totally Wicked believes that electronic cigarettes are a product for current/former adult smokers and current users of nicotine containing products. Therefore Totally Wicked fully supports a ban on the sale of electronic cigarettes to those under the age of 18.

Totally Wicked has been voluntarily implementing a ban on the sale of electronic cigarettes and e-liquids to those under the age of 18 for the past seven years, as have other responsible companies.

Totally Wicked has done this not because there was a problem with people under the age of 18 routinely coming to buy its products, but because the company believes electronic cigarettes to be an adult product.

Is there currently a problem with large numbers of under 18s in Wales buying electronic cigarettes on a regular basis? No. Cancer Research UK looked in detail at two major studies into electronic cigarette use amongst young people in Wales, they concluded, "Looking specifically at two studies dedicated the use of e-cigarettes amongst young people in Wales only a minority of teenagers who try e-cigarettes go on to become regular users. And the majority of those who do use the devices regularly were already smokers."[78]

The register is therefore not necessary as there is not a significant problem that needs addressing.

[76] http://www.theguardian.com/society/2015/aug/13/health-bosses-promote-e-cigarettes-harmful-tobacco-smoking-experts
[77] https://civilservice.blog.gov.uk/2015/08/11/how-the-nudge-unit-threw-light-on-lighting-up/
[78] http://www.cancerresearchuk.org/about-us/cancer-news/news-report/2015-04-16-regular-e-cigarette-use-low-among-teens-analysis-suggests

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

Totally Wicked is an independent company with no links to the tobacco industry, furthermore neither electronic cigarettes nor e-liquids are tobacco products or tobacco related products. Totally Wicked therefore will not comment on issues directly relating to the regulation of tobacco products.

According to the Welsh Government a magistrates' court can currently impose a Restricted Premises Order (RPO) on an individual who has persistently (at least three separate occasions within a two year period) sold tobacco to those under the age of 18. A RPO prohibits all sales of tobacco products (including cigarette papers) for a period up to, but not exceeding one year.

Totally Wicked supports the extension of the RPO regime to cover individuals who persistently sell electronic cigarettes or e-liquids to those under the age of 18. However, this bill draws equivalence with tobacco in terms of punishment. Someone who persistently sells electronic cigarettes or bottles of e-liquid to under 18s is prohibited from selling electronic cigarettes and e-liquids for the same period as someone who persistently sells tobacco products to under 18s.

To be clear, Totally Wicked supports the ban on selling electronic cigarettes and e-liquids to those under the age of 18, but as Totally Wicked set out in answer to question seven, by punishing persistent sellers of electronic cigarettes/e-liquids and tobacco products to under 18s in the same way implies that the Welsh Government views these two products as the same. They are not the same. Tobacco is a highly dangerous product that currently results in around 5,450 people deaths from tobacco related illnesses every year in Wales,[79] costing the Welsh taxpayer £302 million.[80] In contrast electronic cigarettes are recognised as being at least 95 per cent less harmful than tobacco products, have helped at least 130,000 smokers in Wales to reduce the amount they smoke or quit all together,[81] and they cost the Welsh taxpayer nothing.

Yes persistent offenders should be punished but the period of time an individual is prohibited from selling electronic cigarettes and e-liquids should be lower than that for tobacco products, reflecting the significantly lower risk of electronic cigarettes (see question seven for more detail).

Totally Wicked does not support the creation of a new register for retailers of such products believing it to be unnecessary and disproportionate.

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?

Totally Wicked is an independent company with no links to the tobacco industry, furthermore neither electronic cigarettes nor e-liquids are tobacco products or tobacco related products. Totally Wicked therefore will not comment on issues directly relating to the regulation of tobacco products.

Totally Wicked supports the creation of a new offence of knowingly handing over electronic cigarettes and/or e-liquids to a person under the age of 18.

Totally Wicked believes that electronic cigarettes are a product for current/former adult smokers and current users of nicotine containing products. Therefore Totally Wicked fully supports a ban on the sale of electronic cigarettes to those under the age of 18.

Totally Wicked has been voluntarily implementing a ban on the sale of electronic cigarettes and e-liquids to those under the age of 18 for the past seven years, as have other responsible companies.

In all Totally Wicked's physical shops, the company enforces a "Challenge 21" policy to ensure that no person under the age of 18 purchases electronic cigarettes or e-liquids. Totally Wicked's e-commerce website does not have a box asking users to verify their age as over 18 before entry. Totally Wicked believes it is too easy for a

[79] http://www.wales.nhs.uk/sitesplus/922/page/59800
[80] ASH Wales/Cymru and BHF Cymru (2013). The economic cost of smoking to Wales: a review of existing evidence
[81] http://ashwales.org.uk/en/information-resources/topics/electronic-cigarettes/

potential customer to simply tick the box even though they may be under 18 years of age, a point this consultation acknowledges. However, Totally Wicked uses a Paypal payment portal that disallows account holders that are under 18. Totally Wicked also retains a register of postcodes where parents have informed the company that they believe their children have or may have attempted to buy its products online.

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

Totally Wicked is an independent company with no links to the tobacco industry, furthermore neither electronic cigarettes nor e-liquids are tobacco products or tobacco related products. Totally Wicked therefore will not comment on issues directly relating to the regulation of tobacco products.

Totally Wicked does not believe that the proposals relating to electronic cigarettes contained in this bill will contribute to improving public health in Wales. If the proposals relating to electronic cigarettes contained within this bill are implemented then this bill will contribute towards a worsening of public health in Wales.

Every year in Wales around 5,450 people die from a tobacco related illnesses according to figures produced by the Welsh Government[82] with tobacco related illnesses costing the Welsh taxpayer £302 million per year.[83] Figures produced by ASH Wales/Cymru show that a staggering 21 per cent of the adult population in Wales still smoke.[84] Part two of this bill should therefore be focussed on working to reduce this number.

As further evidence emerges into the effectiveness and efficacy of electronic cigarettes it is clear that any concerns the Welsh Government may previously have had were unfounded. Electronic cigarettes are now the number one quitting aid used by smokers[85] and to date at least 130,000 Welsh smokers have made the switch to vaping,[86] cutting down the amount they smoked or quitting smoking entirely. This should be a cause for celebration rather than concern. Left to develop under the current proportionate regulatory regime electronic cigarettes could make a significant reduction in the disproportionately high smoking rates in Wales. In time electronic cigarettes have the potential to render tobacco obsolete.

However, if the Welsh Government goes ahead and implements the proposals contained within the Public Health (Wales) Bill then all of this tremendous potential for public health good will not just come to an end, much of the good achieved to date will be reversed.

The key health benefit of electronic cigarettes is determined by how many smokers switch to them or use them as a staging post to quitting completely. Vaping in public and in particular enclosed public places has a vital role to play in this.

A smoker walking down the street is unlikely to walk up to a vaper to ask them what they are doing. However, a smoker in an enclosed public environment like a pub or work place will go up to a vaper and have that crucial initial conversation about how to start and where to go for advice and support.

Many smokers have tried to quit numerous times using NRT products and have failed. However, with vaping they have cut down or ceased smoking. This is not surprising as NRT products have a 90 per cent failure rate.[87] Electronic cigarettes by comparison are recognised as being at least 60 per cent more effective in helping smokers to quit.[88]

Electronic cigarettes deliver clean nicotine – without the tar, carbon monoxide, and volatile hot gases of cigarettes. For smokers who switch, they hugely reduce risk, while satisfying any need for nicotine and some of the behavioural aspects of smoking. As the UK Government has recognised, it is much easier to substitute a similar

[82] http://www.wales.nhs.uk/sitesplus/922/page/59800
[83] ASH Wales/Cymru and BHF Cymru (2013). The economic cost of smoking to Wales: a review of existing evidence
[84] http://www.ash.org.uk/files/documents/ASH_93.pdf
[85] http://ashwales.org.uk/en/whats-new/we-welcome-extensive-research-by-public-health-england-on-the-safety-of-electronic-cigarettes
[86] http://ashwales.org.uk/en/information-resources/topics/electronic-cigarettes
[87] Dr Jed Rose, Director of the Duke Center for Smoking Cessation and a Professor in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center, speaking at the Global Forum on Nicotine (Warsaw, Saturday 6th June 2015): http://gfn.net.co/downloads/2015/Plenary%202/Jed%20Rose.pdf
[88] Study carried out on 5,000 smokers, by Professor Robert West looking at the success rate of different methods to stop smoking: nicotine gum, nicotine patches, nothing, or e-cigarettes. Reported on BBC Breakfast 28 April 2014

(less harmful) behaviour than to eliminate an entrenched one.[89] Fundamentally, unlike NRT products they are customisable to an individual smokers needs. A vaper can choose what device they want, they can choose their nicotine strength, and they can choose their flavour of e-liquid.

With literally thousands of devices and flavours, and multiple nicotine strengths available how does a smoker wishing to switch to vaping know what device, nicotine strength, and flavour is right for them? Initially they do not and that is why vape shops are so fundamentally important.

By visiting a vape shop a smoker benefits not just from the expertise of the vendor, but critically, they are able to sample the different devices, nicotine strengths, and flavours. This allows them to find a device, nicotine strength, and flavour that are right for them. Virtually no smoker walks into a shop picks up a cig-a-like product and successfully switches to vaping, it is more complicated than that. The expert advice and the product sampling are critically important in virtually all successful switch attempts. This means that they need to vape in an enclosed public place.

The Welsh Government states that the provisions included in the Bill are not intended to interfere with the use of electronic cigarettes in any smoking quit attempt, but that is exactly what they will do, because they limit the accessibility, attractiveness, and opportunities to use electronic cigarettes.

If the Welsh Government succeeds in banning vaping in enclosed public places then vapers will be forced to go back to standing with the smokers, re-enforcing their smoking habits and letting them wrongly understand that vaping is the same as smoking, when in reality it is at least 95 per cent less harmful.[90] This will expose them to the dangers of second-hand smoke and penalises a smoker that has taken decisive action to switch to a less harmful product. It is the equivalent of holding an Alcoholics Anonymous meeting in a pub. Why would any government do this?

The Welsh Government's proposed ban will also prevent vape shops from allowing smokers to sample devices, nicotine strengths, and flavours and the Welsh Government's own impact assessment acknowledges this. As a direct consequence of this the importance of vape shops will decline so many will close, resulting in empty premises and unemployment. More importantly, without the ability to sample nicotine strengths, devices, and flavours in advance, a smoker would simply have to guess what flavour they might like, what nicotine strength they might need, and what device is best for them. Virtually all will make the wrong guesses and few will go back to try and get it right for a second time. This will mean that fewer smokers will successfully switch to vaping and will therefore continue to smoke and die prematurely.

Far from improving public health in Wales, this bill will remove fundamentally important aspects of the switching process from smoking to vaping: the ability to sample the different devices, nicotine strengths, and flavours. Take away a smokers ability to vape in a vape shop and you put a barrier in the road to them switching to a significantly less harmful alternative. Take away a smokers ability to witness vaping at work or in the pub and you deprive them of the chance encounter that for many smokers was their first step on the road to vaping. What possible public health benefit does the Welsh Government hope to achieve with this proposed ban?

[89] https://civilservice.blog.gov.uk/2015/08/11/how-the-nudge-unit-threw-light-on-lighting-up/
[90] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No. The BBPA is of the view that it is up to individual pub premises to decide whether or not they will permit the use of e-cigarettes, given they are a legal product with no evidence that they cause harm to either the user or others in an enclosed environment. Please see the recent report by Public Health England for further information. On a practical level, we do recognise in some cases it can be difficult for some publicans to identify real, as opposed to e-cigarettes, and they could cause concern for other customers. A number of managed pubs have already banned their use as this is a head office-level decision, but in tenanted estates and freehouses which make up the majority of pubs) it is at the discretion of individual licensees. This freedom to decide on a premises-by-premises basis should be retained as many licensees may wish to allow the use of e-cigarettes in their premises if they so choose. Therefore we do not support the legislation as drafted, as it add a further layer of regulation on business (in the case of the majority of pubs, small businesses), and in some cases could indeed discourage customers from visiting venues and remain at home to use e-cigarettes. A particular proposal in the Bill which will increase bureaucracy is contained in s.11, setting out a requirement for signage to be displayed informing customers that e-cigarettes prohibited in the premises. The legislation stipulates that regulations may be made to proscribe the size, wording, colour and design of such signs. Not only is this requirement overly proscriptive, it also cuts across the

wider de-regulation agenda in respect of licensed premises – with the UK Government recently abolishing the requirement for specific no-smoking signs in premises which this Bill seeks to re-introduce for the purposes of e-cigarettes. The situation would arise where in effect two different signs (one for tobacco smoking indoors, and one for e-cigarettes) would have to be displayed inside pubs in Wales.

Question 2

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?
We would highlight again that the evidence of significant risks related to e-cigarettes is very low (either to users or the general public), as highlighted in a recent report by **Public Health England**. Key findings of the review include: • the current best estimate is that e-cigarettes are around 95% less harmful than smoking; • nearly half the population (44.8%) don't realise e-cigarettes are much less harmful than smoking; • There is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers. The comprehensive review of the evidence finds that almost all of the 2.6 million adults using e-cigarettes in Great Britain are current or ex-smokers, most of whom are using the devices to help them quit smoking or to prevent them going back to cigarettes. It also provides reassurance that very few adults and young people who have never smoked are becoming regular e-cigarette users (less than 1% in each group). We do not believe evidence has been presented as part of this consultation to contradict the above, and therefore bring in legislation which will affect businesses. We strongly support the right for pub licensees to choose whether or not to allow e-cigarettes in their premises.

Question 3

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?
Please see answer to Question 2, regarding recent PHE report.

Question 4

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?
Please see answer to Question 2, regarding recent PHE report.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
No. Public houses can legally sell tobacco products. However many do not, and those that do decide to stock tobacco products tend to provide only limited quantities of items such as cigarettes, cigars, rolling paper etc. and is not usually part of core trade, but provides a convenient service to customers who do wish to purchase tobacco who otherwise may leave the premises. Therefore, it would be costly and burdensome on small businesses to force pubs to pay a registration fee in this situation, especially as the suggested structure of one flat rate per registration (as proposed in the White Paper) would apply to a pub as to a retailer with a high proportion of tobacco sales. If there is to be a register it should be free (as in Scotland) and there is little evidence such a register would even be effective.

Question 6

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?
No comment.

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 Association of Convenience Stores – PHB 74 / Tystiolaeth gan Y Gymdeithas Siopau Cyfleustra – PHB 74

ACS Submission: Public Health (Wales) Bill

ACS (the Association of Convenience Stores) welcomes the opportunity to respond to the National Assembly for Wales Health and Social Care Committee's call for evidence for the general principles of the Public Health (Wales) Bill. ACS represents 33,500 stores across the UK, all of which have an important role to play in supporting public health policy. In Wales, there are 3,219 stores, employing over 24,530 staff[1].

ACS' primary concern regarding the Public Health (Wales) Bill is the proposal to introduce a tobacco retailers' register in Wales. Not only would this impose financial and administrative burdens to convenience retailers; but would also pose a significant risk of enforcement activity being refocused on legitimate retailers, rather than those that participate in the illicit tobacco trade.

Part 2: Tobacco and Nicotine Products

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

The proposed tobacco and e-cigarette retailer register would impose additional costs on retailers. Any proposed register should reflect the current register that is used in Scotland, which operates as a negative licensing system with free registration for retailers. However, we support Option 1 of the impact assessment, 'do nothing', as we are not convinced that the benefits of a tobacco register outweigh the financial and administrative burdens of the scheme and other tobacco legislation. Instead, we would like to see instead a focus on tackling the illicit tobacco market in communities across Wales through greater investment in HMRC and local authority enforcement activity.

Additional Burdens

[1] ACS Local Shop Report 2014

Tobacco is an important product category for convenience retailers, representing an average of 20% of sales in the UK convenience market[2]. Retailers work hard to ensure they retail these products responsibly through enforcing age restrictions using policies, such as Challenge 25. Convenience stores selling tobacco are already burdened by a number of restrictive tobacco legislation, most notably the tobacco display ban, the Tobacco Products Directive and the standardised packaging of tobacco to be introduced next year. A tobacco retailer register will only exacerbate these burdens and add further complexities to tobacco legislation.

Additional Costs

The Bill stipulates that the regulations may make provision to require payment of a fee to accompany an application for a retailer to register. The Explanatory Notes propose that this fee would be set at £30 for the first premise and £10 for each additional premise. Based on the number of convenience stores in Wales, the cost to the convenience sector to register is estimated to be over £90,000.

In light of this significant financial burden that retailers will face when registering, ACS seeks further clarity on exactly what will be disseminated regarding the Impact Assessment's claim that "the register will be an invaluable tool in disseminating information and guidance to retailers around the sale of tobacco and nicotine products." Currently the Welsh Government has sought advice from trade bodies on what information to disseminate to local retailers, including the ACS Tobacco Display Ban guide.

Enforcement agencies already have limited resources for enforcement activity. ACS does not deem the use of funds from the register to disseminate information and guidance to retailers as a justifiable cause to charge for registration. Enforcement activity should be focused on tackling the illicit tobacco trade.

Failure to Address Illicit Trade

The introduction of a tobacco retailers' register risks focusing enforcement activity on legitimate, registered retailers rather than addressing retailers participating in the illicit trade. The tobacco register neglects to consider that illicit tobacco retailers will not sign up and will risk enforcement action because the offence is not as great as evading duty.

The illicit tobacco market costs the Treasury approximately £2billion[3] every year, as such, it represents a significant threat to both public health and legitimate retailers. One of the most common sales avenues for illicit tobacco are 'tab houses', selling

[2] ACS Local Shop Report 2014
[3] HMRC Measuring Tax Gaps 2014

from private houses, which accounts for 34% of illicit tobacco sales[4]. There is an increase in the proportion of 14-15 year old illicit tobacco buyers who have bought from 'fag houses' from 15% in 2009 to 34% in 2011[5]. Illicit tobacco makes tobacco accessible to children and young people. Tackling this must form a central part of any tobacco control or public health policy.

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

Recent data from HSCIC shows that the most frequent source of age restricted products, such as alcohol and tobacco products is not local shops. Young people are more likely to access these products through other people, including parents or older siblings, with 64%[6] of young people accessing tobacco through these means. This is a reflection of the industry's positive work of introducing voluntary age verification schemes, such as challenge 25. The introduction of a tobacco register is unlikely to further the reduction of underage sales.

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

We agree that the use of restricted sales orders and restricted premises orders in cases where retailers repeatedly breach regulations would be proportionate. However, detailed guidelines would be needed to ensure these strict penalties would be used only where appropriate to target repeat offenders.

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?

Retailers need to ensure that they have a robust age verification policy for remote sales, both at point of sale and point of delivery.

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

ACS continues to advocate further action on tackling the illicit market. We believe that retailers have made significant progress in reducing young people's access to tobacco products over the last ten years. We would like to see a greater focus on targeting resources on the most frequent source of tobacco products (parents and older siblings) through education and campaigning. It is incredibly difficult for

[4] APPG on Smoking and Health - Inquiry Into the Illicit Trade in Tobacco Products 2013
[5] APPG on Smoking and Health - Inquiry Into the Illicit Trade in Tobacco Products 2013
[6] HSCIC: Smoking, drinking and drug use among young people in England in 2014

retailers to address proxy purchasing as all proxy purchases start with a legitimate sale.

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.)

If introduced, a tobacco register should not be funded by retailers, but operated on a similar model that is already in place in Scotland where registration is free. As highlighted in the consultation document, the benefits of the registration scheme would fall primarily to trading standards and local authorities, yet retailers would be expected to fund this scheme.

Therefore, we do not believe the potential benefits of a tobacco register for retailers is proportionate to the burdens that would be imposed on them.

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?

All potential costs are accounted for in the Regulatory Impact Assessment.

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?

Any proposed tobacco retailer register should reflect the register already in place in Scotland. Not only would this provide consistency to retailers who operate nationwide, but would not be as burdensome on retailers.

For more information on this submission, please contact Julie Byers, Public Affairs Executive, at [redacted] or by calling [redacted].

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

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

Evidence from the Royal College of Midwives – PHB 75 / Tystiolaeth gan Goleg Brenhinol y Bydwragedd – PHB 75

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
The evidence to date would suggest that at present e-cigarettes does not pose the same risk to health as cigarette smoke does. Nevertheless e-cigarettes are a new product, and further cumulative evidence over time would guide future policy. Given that this is an emerging area for further research into risks associated with the vapour from e-cigarettes and the smell travels quickly, the RCM believes that a precautionary approach should be taken until further evidence becomes available.

Question 2

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?
The RCM believes that the provisions in the bill will achieve a balance between the benefits to smokers wishing to quit and protecting the public from any unknown risks associated with the vapour from e-cigarettes.

Question 3

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?

Only a small number of young non-smokers were identified in Wales as using e-cigarettes. The imagery of "vaping" e-cigarettes appears closely aligned to the act of smoking and could inadvertently promote smoking and normalise smoking in smoke free areas. Time and further research is required to answer this question objectively.

Question 4

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?
Only a small number of young non-smokers were identified in Wales as using e-cigarettes. However, this use is increasing and, by implication, their use of Nicotine is too. This is why it is important to regulate the places where e-cigarettes can be used , as the trend could lead to consumption of tobacco products by young people.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
Yes. The RCM is in favour of establishing a national register of retailers of tobacco and nicotine products as it is likely to make retailers accountable for their actions. We believe that both – retailers of tobacco and nicotine products-should be on the same register in order to monitor their activities and reduce the number of young smokers and those who may take up the use of e-cigarettes

Question 6

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 RCM supports the proposal to create a new offence in order to prevent under-18s accessing and using tobacco and nicotine products. This would be in line with other legislation, such as the vending machine ban and the point of sale display bans. With the introduction of a retail register, together, these could limit the access of young people to tobacco and nicotine products.

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Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
The RCM welcomes this proposal as a public protection measure for a compulsory licensing system for those who carry out tattooing, body piercing, acupuncture and electrolysis. The terms '*practitioner and procedures* 'imply that the individuals carrying out these activities are trained and accredited and that their competence will be regularly validated. Any licensing system must require minimum standards of hygiene for the premises from which they work and a defined set of rules and principles governing this group.

Question 8

Do you agree with the types of special procedures defined in the Bill?
Yes, There is a need to exclude genital piercing from this and future list as a procedure that should be licensed because it is illegal under the Female Genital Mutilation Act as Type 4 FGM and cannot be carried out on a girl under the age of 18 in England and Wales.

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
The RCM sees no reason why the list cannot be varied, depending on the circumstances, as long as the intention is always to protect the public from harm.

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
Local Authorities would initially require initial funding and resources to set up the agreed systems, which defines at the outset what is permitted under the Bill, the category of persons who can have intimate piercings, and the required competence of the individuals who is licensed to carry out these procedures. That way, it would be easier to monitor bad practices and protect the public.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
Yes. The RCM believes that intimate body piercing should be prohibited in anyone under the age of 18. Genital piercing in girls under the age of 18 is illegal throughout the UK (Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland and the Prohibition of Female Genital Mutilation (Scotland) Act 2005 in Scotland) and classified as Type 4 FGM.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
Given the proposal to require a licensing system for intimate piercing, it would be important to consider the fact that under 18s are deemed to be minors and cannot not give informed consent to *'invasive procedures'* involving the use of needles or cutting equipment. The procedures listed for example, naval piercing, tongue piercing, etc should be prohibited on young people under the age of 18.

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

Evidence from BMA Cymru Wales – PHB 76 / Tystiolaeth gan BMA Cymru Wales – PHB 76

PUBLIC HEALTH (WALES) BILL – GENERAL PRINCIPLES

Consultation by the National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

4 September 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by the National Assembly for Wales' Health and Social Care Committee on the general principles of the Public Health (Wales) Bill.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

When the Welsh Government published the Public Health White Paper in 2014, BMA Cymru Wales expressed extreme concern that the proposals contained within it represented a significant step backwards from the more innovative high-level proposals that had been contained within the preceding Public Health Green Paper published in 2012.

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We have therefore been further disappointed that the now-published Public Health (Wales) Bill currently contains a narrower set of proposals than even the White Paper.

Whilst we are nonetheless broadly supportive of many of the proposals that have been brought forward within the Bill as published, we do feel that it represents a missed opportunity to provide more ground-breaking legislation that could have made Wales an international exemplar in the field of public health.

Health Impact Assessment (HIA)

We are particularly disappointed by the absence of proposals within the Bill to place Health Impact Assessment (HIA) on a statutory footing.

As far back as 1999 the then Welsh Assembly Government committed to taking forward HIA, and set out its approach in a document entitled *'Developing Health Impact Assessments in Wales'*.

In the present Assembly term, the idea of introducing HIA in Wales on a statutory basis was also consulted upon by the Welsh Government in the Public Health Green Paper published in 2012. The subsequently published summary of responses to that Green Paper stated that *"there was a high level of support for the concept of using Health Impact Assessment as a method for ensuring health issues are considered as part of policy making."* It also stated that a clear majority of those who responded indicated that Welsh Ministers, Welsh Government departments and local authorities should be required to use HIA.

We also note that the Minister for Health and Social Services, Mark Drakeford, expressed support last year for undertaking HIA in relation to local authority planning and licensing applications. During a plenary debate on an update statement on the Public Health White Paper on 7 October 2014, he said: *"I would be very keen—I always have been—to be able to make the public health impact one of the considerations that local authorities are able to take into account in making planning and licensing determinations."*

The Chief Medical Officer for Wales, Dr Ruth Hussey, has also expressed her support for HIA, telling the Health and Social Care Committee on 8 October 2014: *"…we should be using health impact assessments at the beginning of a process to ask how we can get the most health benefit from whatever proposals, policies or services we are developing, and to ask whether we can get added value."*

Given this recent consideration and expression of support, we were extremely surprised and disappointed to see that the idea of legislating to require HIA in specific circumstances was dropped in the Public Health White Paper and has not been reinstated in the Bill as published.

Appendix 1 to this submission outlines in more detail our case for placing HIA on a statutory footing in Wales through incorporation of such a proposal within the Bill. We suggest a requirement for the use of HIA be placed on the face of the Bill, with regulations subsequently being brought forward to specify in exactly which circumstances a mandatory HIA would be required. In the first instance we would suggest that these regulations could require that HIA is made mandatory in relation to Strategic and Local Development Plans, certain larger scale planning applications, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

Minimum unit pricing for alcohol

In our responses to both the Public Health Green Paper and the Public Health White Paper, we expressed strong support for the proposal to introduce minimum unit pricing for alcohol in Wales. We are disappointed that, owing to the on-going legal challenge to a similar proposal in Scotland, it has not been possible to include this proposal in the current Bill. However, we recognise that the Welsh Government has recently published a draft Bill for consultation aimed at taking the initiative forward in future should the legal challenge in Scotland be appropriately resolved.

We are pleased that the Welsh Government therefore still intends, if possible, to introduce minimum unit pricing for alcohol at a later date, and we look forward to responding positively to the consultation on the Draft Public Health (Minimum Price for Alcohol) Bill in due course.

Obesity and nutritional standards

The Public Health White Paper sought views on introducing nutritional standards in certain public sector settings, as well as asking what other steps could be taken on these issues.

We are especially disappointed that those proposals have now been dropped and that there are no specific proposals within the Bill directed at tackling obesity. We believe this further weakens the impact that this Bill will have.

In our view, the proposals for introducing nutritional standards in both pre-school settings and care homes should be reinstated, as well as being extended to cover hospitals in Wales by way of an update to the implementation of the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2012).

Our members witness first-hand the effects of obesity on the health of their patients. We would therefore also like to see further measures brought forward aimed at assisting people in Wales to make healthier nutritional choices. While doctors have a key role in providing advice on dietary choices and physical activity patterns, we feel this needs to be supported by a comprehensive range of public health interventions to tackle the obesity epidemic. In our view, individual programmes alone are likely to have little effect and legislative measures are also required to help people make healthy choices as part of a comprehensive strategic approach.

We do, however, recognise that some of the legislative changes we would wish to see may be outside the competence of the Welsh Assembly. We have, for instance, repeatedly called for the introduction of a standardised, consistent approach to food labelling, calling for all pre-packaged products to have front of pack labelling based on a ‘traffic light’ colour coding system combined with information on guideline daily amounts (now known as reference intake). We have been disappointed that neither the EU nor the UK Government has backed mandatory ‘traffic light’ labels for food packaging.

We remain concerned that unhealthy food is positively marketed to a young audience and feel there should be a complete ban on the advertising and marketing of unhealthy foodstuffs. This should include product placement and inappropriate sponsorship programmes targeted at school children.

It should also be noted that a significant proportion of the UK population is consuming saturated fat, salt and added sugar at levels above recommended guidelines; and too little fruit, vegetables, oily fish, and fibre. More therefore needs to be done to promote healthy eating. One option that could be considered would be to subsidise the cost of fruit and vegetables.

Maternal obesity is associated with increased maternal and fetal risks in pregnancy, as well as increased intervention rates and an increased risk of major chronic disease for their offspring in adulthood. With rates of obesity in pregnancy rising across the UK, steps need to be taken to ensure that young people understand the importance of health and wellbeing before pregnancy – giving attention to their diet and optimal body weight before planning a pregnancy. This could include offering nutrition education and counselling, which have been shown to improve knowledge and behaviour. We also support the need to provide education and support aimed at promoting and prolonging the duration of breastfeeding.

We recognise that physical activity levels in Wales and the rest of the UK are very low and have been declining for the past 30 years, whilst sedentary activity is increasing. Promoting physical activity is therefore an important aspect to reducing levels of obesity in the UK. Initiatives such as the application of the Active Travel (Wales) Act 2013 can play a contributory role, alongside the promotion of other activities that involve physical exercise.

Other initiatives which could be taken forward would be to require all NHS premises to clearly display the healthcare risks involved with junk food and drinks, especially in catering areas and on vending machines; and for NHS premises to ban the sale of junk food and unhealthy drinks or offer subsidised healthier options.

Tobacco and nicotine products

BMA Cymru Wales is largely supportive of the proposals laid out in Part 2 of the Bill and would consider that on balance the available evidence favours their enactment. In particular, we support:

- creating a national register of retailers of tobacco and nicotine products;
- adding to the offences which contribute to a Restricted Premises Order (RPO);
- prohibiting the handing over of tobacco or nicotine products to people under the age of 18; and
- restricting the use of nicotine inhaling devices such as electronic cigarettes in enclosed and substantially enclosed public and work places, bringing the use of these devices in line with existing provisions on smoking.

E-cigarettes

While e-cigarettes have the potential to reduce tobacco-related harm, by helping smokers of convetional cigarettes to cut down and quit, we believe that a strong regulatory framework is required for their sale and use in order to:

- prohibit their use in workplaces and public places to limit second hand exposure to the vapour exhaled by the user, and to ensure their use does not undermine smoking prevention and cessation by reinforcing the normalcy of cigarette use;
- restrict their marketing, sale and promotion so that it is only targeted at smokers as a way of cutting down and quitting, and does not appeal to non-smokers, in particular children and young people; and
- ensure they are safe, quality assured and effective at helping smokers cut down or quit.

Emerging evidence suggests that e-cigarettes are predominantly used together with conventional cigarettes by current smokers, for the purposes of cutting down or quitting smoking or to circumvent smoke free legislation.[1] It is evident that the risks of using e-cigarettes with tobacco cigarettes (dual use) are likely to be much less beneficial than quitting smoking completely, or switching exclusively to e-cigarette use.

Current evidence suggests that e-cigarettes are primarily effective in helping smokers reduce the intensity of smoking (by cutting down), rather than the duration of smoking (by quitting). We support a regulatory framework that helps to ensure they are effective cessation aids.

Data from the 2011 International Tobacco Control Four Country Survey (Australia, Canada, UK, US) confirms that individuals report using e-cigarettes because they believe they are less harmful than cigarettes (79.8%), to reduce smoking (75.8%), and to help quit smoking (85.1%).[2,3]

E-cigarettes are no doubt less harmful than smoking tobacco and, while we welcome the recent research published by Public Health England,[4] we believe that there needs to be much more research into the safety of their long-term use.

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1 Grana R, Benowitz N & Glantz SA (2014) E-cigarettes: A scientific review. Circulation **129**: 1972 - 87

2 Adkinson SE, O'Connor RJ, Bansal-Travers M et al (2013) Electronic nicotine delivery systems: international tobacco control four country survey. American Journal of Preventative Medicine **3**:201

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4 Public Health England. E-cigarettes: an evidence update (2015) Available at: https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

While BMA Cymru Wales supports the use of licensed nicotine replacement therapies (NRT) as a smoking cessation aid, it should be recognised that the consumption of nicotine is not risk-free. Nicotine is a highly addictive substance and users can become physically dependent.[5] We are also concerned by the lack of regulation to ensure the efficacy, quality and safety of e-cigarettes including the variable concentration of nicotine in these devices.

Nicotine withdrawal is associated with craving, anxiety and stress.[6] Research suggests that nicotine may be an important mechanism by which tobacco promotes tumour development, progression and resistance to cancer treatment; this is a particular issue for dual-use of e-cigarettes and conventional cigarettes.[7] The physiological effects of nicotine include increased blood pressure, increased heart rate, transient tachycardia and vasoconstriction.[8,9,10]

Symptoms of nicotine toxic overdose include tremors, nausea, vomiting, convulsions, neuromuscular blockade, diarrhoea and gastrointestinal irritation.

Chronic exposure to nicotine is associated with an increased risk of stroke, hypertension, reproductive disorders, peptic ulcer disease and high total cholesterol.[11]

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In addition to nicotine, e-cigarettes have been found to contain a range of other substances with negative health implications.[12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29] Studies have also indicated that bystanders can be exposed to vapour emitted from e-cigarette use,[30,31,32,33] and the World Health Organisation (WHO) has warned of the potential adverse health effects of exposure to toxicants and particles contained within e-cigarette vapour.[34]

Despite the evidence of risk associated with using e-cigarettes, it is nonetheless worth emphasising that substituting tobacco with e-cigarettes is likely to substantially reduce exposure to tobacco-specific toxins and the potential health risks associated with exclusive e-cigarette use are therefore likely to be very much lower than the risks of smoking tobacco cigarettes.

On balance, however, whilst we believe that more research is required around the extent to which hand to mouth use of e-cigarettes either breaks or reinforces smoking behaviours – and the actual effectiveness of e-cigarettes in helping smokers to quit – from our overall view of the evidence that is currently available, we would agree that their use should be banned in enclosed public and work places as is currently the case for smoking tobacco.

In our view, it is vital that the use of e-cigarettes does not undermine the success of conventional tobacco control measures by reinforcing the normalcy of smoking behaviour in a way that other products containing nicotine do not. This specifically relates to the way these devices commonly resemble tobacco

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cigarettes, in terms of appearance, nomenclature and the way they are used, as well as features such as flavouring and styling that are potentially highly attractive to children, and may include cigarette brand reinforcement. And because e-cigarettes commonly resemble tobacco cigarettes, and may not be immediately distinguishable from them, we also believe that restricting their use in current smoke-free areas will aid the managers of such premises in their ability to enforce the current smoking ban.

It is our concern that the e-cigarette marketing methods used across a range of advertising media and locations are likely to appeal to children, young people and non-smokers. These include point-of-sale displays; advertising via television, radio, in-print media and online; on billboards near schools; at university freshers' fairs; and the marketing of flavoured e-cigarettes.[35]

BMA Cymru Wales is also concerned that e-cigarette marketing may have an adverse impact, reinforcing conventional cigarette smoking habits, as well as indirectly promoting tobacco smoking, increasing the likelihood of young people starting to smoke.[36,37,38]

The e-cigarette market increased by 340% in 2013, and is estimated to be worth £193 million.[39] There are now more than 450 brands of e-cigarette, and 7,700 unique flavours.[40]

E-cigarette promotion ranges from being advertised as 'a healthier alternative to smoking traditional tobacco products', to evocative advertising with phrases such as 'love your lungs', 'vape with style', 'smoking is so last season' and 'add flavour to your lifestyle'. The advertising and promotion also frequently makes positive associations with recreational activities, sports and youth culture, and can incorporate celebrity endorsements.[41] [42] [43] [44] The UK Advertising Standards Authority (ASA) has previously ruled that certain e-cigarette advertisements were considered misleading and made unsubstantiated claims relating to health.[45]

In terms of accessibility, e-cigarettes can be bought from a variety of high street outlets, ranging from newsagents, superstores, and pharmacies to pubs and specialist shops. E-cigarettes and liquid nicotine can also be purchased online, even in wholesale quantities.[46]

The legal status of e-cigarettes varies around the world. In some countries (eg Denmark, Canada, Israel, Singapore, Australia and Uruguay) the sale, import, or marketing of e-cigarettes is either banned, regulated in various ways, or the subject of health advisories by government health organisations. In others (eg New Zealand), e-cigarettes are regulated as medicines and can only be purchased in pharmacies.

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[35] English PM (2013) Re: EU policy on e-cigarettes is a "dog's dinner" says UK regulator (rapid response) BMJ **347**: f6871.

[36] Andrade M, Hastings G & Angus K (2013) Promotion of electronic cigarettes: tobacco marketing reinvented? BMJ **347**: f7473

[37] National Institute for Health and Care Excellence (2013) Tobacco: harm reduction approaches to smoking. Manchester National Institute for Health and Care Excellence.

[38] Cancer Research UK (2013) The marketing of electronic cigarettes in the UK. London: Cancer Research UK.

[39] Public Health England (2014) E-cigarette uptake and marketing. London: Public Health England.

[40] Zhu S-H, Sun JY, Bonnevie N et al (2014) Four hundred and sixty brands of e-cigarettes and counting: implications for product regulation. Tobacco Control **23**: iii3-9

[41] Andrade M, Hastings G & Angus K (2013) Promotion of electronic cigarettes: tobacco marketing reinvented? BMJ **347**: f7473

[42] Grana R, Benowitz N & Glants SA (2013) Background paper on e-cigarettes (electronic nicotine delivery systems) San Francisco: University of California.

[43] Cancer Research UK (2013) The marketing of electronic cigarettes in the UK. London: Cancer Research UK.

[44] US Senate report (14.4.14) Gateway to addiction? A survey of popular electronic cigarette manufacturers and targeted marketing to youth.

[45] www.asa.org.uk/Rulings/Adjudications/2013/5/Nicocigs-Ltd/SHP_ADJ_219974.aspx (Last accessed October 2014)

[46] Kamerow D (2014) The poisonous "juice" in e-cigarettes. BMJ **348**: g2504

In the UK, e-cigarettes are subject to regulation under the General Product Safety Regulations 2005, the Chemicals (Hazard Information and Packaging for Supply) Regulations 2009, and by trading standards.[47] Worryingly, there is no requirement for manufacturers of e-cigarettes to list the nicotine content of their products, to include childproof safety features, or to take measures to protect against accidental overdose.[48]

Laboratory analysis of e-cigarettes indicates that labelling of nicotine levels in e-cigarette liquid may be inconsistent and misleading.[49] The Trading Standards Institute and others have stated that safety concerns have come to light around some brands of e-cigarettes, including electrical safety, the need for proper labelling, and the provision of child resistant packaging.[50] [51]

BMA Cymru Wales would advocate the introduction of stringent guidelines in terms of appropriate labelling and childproof safety features.

Extending restrictions to non-enclosed spaces

We recognise that a clear case can be made that banning smoking in certain circumstances in open spaces will have a positive health benefit in the same way as it does within enclosed spaces. We note that whilst voluntary smoking bans have been effective in some areas when applied to open spaces, in others they remain largely ignored and extremely hard to enforce locally.

We therefore support the proposals in the Bill that create the provision to extend statutory restrictions on smoking and e-cigarettes to certain non-enclosed spaces which could include such locations as hospital grounds and children's playgrounds.

Careful consideration may, however, need to be given to how this is applied in order to take account of the impact on individuals using e-cigarettes if they are forced to share a defined combined 'smoking area' with users of tobacco cigarettes.

We note the approach that has been advocated in the Bill of enabling additional locations that could come under the scope of these restrictions to be subsequently specified in regulations, and welcome the stipulation that the addition of new locations can only be supported when Welsh Ministers are satisfied that doing so is likely to contribute towards the promotion of the health of the people of Wales.

National register and Restricted Premises Orders (RPOs)

BMA Cymru Wales welcomes the provisions within the Bill to establish a tobacco retailers' register. We believe it is a proportionate and reasoned measure which need not be overly bureaucratic or burdensome on retailers.

We believe that its establishment would be a pragmatic step that will help to prevent underage sales and sales of illegal tobacco. It will also assist in ensuring compliance with the point of sale display and advertising regulation.

The additional information that will be gathered as a consequence of the introduction of the register and the strengthened RPO regime, will assist local authority trading standards officers in identifying where tobacco is, or is not, permitted to be sold and thereby help in enforcing tobacco and nicotine offences.

[47] Trading Standards Institute (2010) Response of the Trading Standards Institute to MHRA consultation on the regulation of nicotine containing products. Basildon, Essex: Trading Standards Institute.
[48] Benowitz NL (2010) Nicotine addiction. New England Journal of Medicine **362**(24): 2295-303
[49] US Food and Drug administration (2009) Evaluation of e-cigarette. St Louis, MO: US Food and Drug Administration.
[50] Trading Standards Institute (2010) Response of the Trading Standards Institute to MHRA consultation on the regulation of nicotine containing products. Basildon, Essex: Trading Standards Institute.
[51] North East Lincolnshire Council press release (05.01.12) Use e-cigarettes with care, warn trading standards officers.

Creating a new offence for knowingly handing over tobacco and nicotine produces to a person under the age of 18 is also something that we support.

Additional suggestions

To ensure successful and expedient implementation of the Public Health (Wales) Bill we would urge the Welsh Government to ensure an appropriate commensurate budget to ensure that the general public is made fully aware of the implications of the Bill coming in to force.

In addition to the Bill, BMA Cymru Wales would advocate regulating e-cigarettes as a licensed medicinal product to best reflect their use for harm reduction, bringing them in line with other existing NRT products, and ensure effectiveness, quality and safety. This form of regulation would also provide the necessary controls on their marketing and promotion.

Special procedures

The proposals in the bill to create a compulsory, national licensing system for practitioners of specified procedures in Wales – such as acupuncture, body piercing, electrolysis and tattooing – seem reasonable in our view.

We also support the proposal to give Ministers the power to amend the list of special procedures to which this licensing system will apply through regulations.

As we previously indicated in our response to the Public Health White Paper, we would suggest that consideration could also be given to including the following additional procedures under the proposed licensing system:

- laser hair removal;
- chemical peels;
- dermal fillers;
- scarification/branding; and
- sub-dermal implantation (or 3D implant).

Intimate piercing

We are supportive of the plan to prohibit the intimate piercing of anyone under the age of 16 in Wales. The proposals in this section of the Bill would therefore seem reasonable.

Pharmaceutical Services

The Bill includes provision to require each local health board to publish an assessment of the need for pharmaceutical services in its area with the aim of ensuring that decisions about the location and extent of pharmaceutical services are based on the pharmaceutical needs of local communities.

Whilst such a proposal seems superficially reasonable, we are concerned about the experience in England where the interpretation of a similar requirement for pharmaceutical need assessments has led to the withdrawal of dispensing rights for some GP practices, with potentially catastrophic impact on some rural communities if this were to be repeated in Wales. The experience in England is that there seems to be no mechanism whereby the pharmaceutical needs assessment considers the wider primary healthcare needs of a locality – particularly a rural one. As such, we would be concerned that the resultant provision of additional pharmaceutical services under section 81 of the National Health Service (Wales) Act 2006 would be unlikely to compensate for the closure of a local GP practice.

The *Cost of Service Inquiry*[52] conducted in 2010 by the Department of Health in England demonstrated the cross-subsidy of services provided under the General Medical Services (GMS) contract by dispensing

[52] http://www.pwc.co.uk/government-public-sector/publications/cost-of-service-inquiry-for-community-pharmacy.jhtml

in rural dispensing practices. Many of these dispensing practices rely on the additional profit from dispensing to remain viable when catering for often small and dispersed registered patient lists.

The additional pharmaceutical services mentioned in the Explanatory Notes which accompany the Bill – flu immunisation, smoking cessation and emergency contraception (and indeed many others) – are ones that are provided under GMS services already. However, there have been instances in England where, because such services have not been provided under a pharmaceutical contract, there has been a determination that there were unmet pharmaceutical needs and thus applications to provide additional pharmaceutical services were agreed. This led to the closure of dispensing services even in areas that have been defined as controlled localities (i.e. areas that have been designated as being 'rural in character' such that, in certain circumstances, doctors can provide pharmaceutical services to certain of their eligible patients.) This, in turn, can have a huge negative impact on the provision of GMS services in such localities. With current GP recruitment problems this could be devastating for rural areas and lead to directly to GP practice closures.

Ideally, we would therefore suggest that controlled localities be excluded from the proposed provisions of the Bill. Failing that, as an absolute minimum, GMS services similar to extended pharmaceutical services should be required to be considered in any pharmaceutical needs assessment, and all pharmaceutical needs assessments should include a risk assessment to existing GMS provision of any new approvals to provide pharmaceutical services.

In the light of these quite serious concerns, the view of BMA Cymru Wales is that we believe the provisions in this section of the Bill might improve the planning and delivery of pharmaceutical services, but only as narrowly defined and in isolation.

We further believe that the proposals will encourage existing pharmacies to adapt and expand services according to local need – an aim we can most certainly support.

However, it must be recognised that the proposals relating to pharmaceutical services in the Bill have the potential to seriously undermine public health in Wales if (as they have in England) they negatively impact on the provision of GMS GP services in rural areas and lead to the closure of existing GP practices.

Provision of toilets

We welcome the proposed provisions in this section of the Bill. These proposals seem both sensible and reasonable, and we are therefore happy to provide our support.

APPENDIX 1 – The case for Health Impact Assessment (HIA)

Introduction

Pre-assessing new policies, plans or programmes in order to avoid any unforeseen negative impacts on the environment or equalities is already well-established within decision-making by public bodies in Wales. However, there is clearly also a strong case to be made that we should be equally seeking to avoid or minimise any negative impacts on the health and well-being of the Welsh population, as well as promoting positive impacts. Indeed, this would appear to be both a logical and desirable development of an already well-established approach.

It also makes sense in light of the accepted recognition that health is, to a large extent, determined by factors outside of healthcare provision. Known as the wider determinants of health, these include social and community factors; access to services; and economic and environmental factors.

It can hopefully be taken as a given that public bodies in Wales would wish to avoid negative impacts on health that could arise from decisions they might be taking, or from the application of new policies they might be adopting. But if we are considering potential deleterious consequences that are neither

intended nor envisaged, it cannot simply be assumed that these will be obvious in the first instance and hence mitigated against automatically.

If such outcomes are therefore to be systematically avoided, it would seem logical that some form of pre-decision assessment needs to be undertaken before decisions are made, plans approved or new policies adopted. This would maximise the likelihood that something that might not otherwise be obvious can brought to the fore and properly considered in a timely manner.

HIA is a well-established tool that can fulfil this role. The World Health Organisation (WHO) defines HIA as '*a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques. HIA helps decision-makers make choices about alternatives and improvements to prevent disease/injury and to actively promote health*.'[53] A definition known as the Gothenburg Consensus describes HIA as a combination of procedures methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.[54]

As practiced in Wales, HIA assesses the implications for health and wellbeing through the broad lens of the wider determinants of health. It is a process which considers to what extent the health and well-being of a population may be affected, whether positively or negatively, by a proposed action – be it a policy, programme, plan or project. As such it can provide an opportunity to identify ways in which health benefits can be maximised as well as how health risks can be minimised. It can not only identify health impacts and health inequalities affecting the general population, but also those affecting vulnerable groups (e.g. children, young people, the elderly etc.). It can be used to identify opportunities for health improvement, as well as to fill identified gaps in service provision or delivery.

For as long as its application in decision-making by Welsh public bodies remains optional, however, its effectiveness in avoiding un-envisaged negative impacts on health – or in identifying ways in which health benefits might be maximised – will in our view be substantially reduced. It might only be through the undertaking of an HIA that an unforeseen negative impact on health might is in fact identified.

Relationship with existing policy and legislation

The use of HIA can also be seen as a logical progression of the current policy direction in Wales, complementing the aims of many recent developments in legislation.

For instance, the Active Travel (Wales) Act 2013 requires Welsh Government and Welsh local authorities to undertake continuous improvement through the development of transport infrastructure that can facilitate travel by active means – thereby helping people to undertake healthier travel options. However, whilst this will lead to a certain amount of new transport infrastructure being developed to further the aims of this Act, it is possible that other new transport infrastructure may also be developed alongside which is not assessed for its impact on health and which might therefore have an un-considered negative impact, or might not be developed in a manner which maximises the opportunities for promoting health benefits. In our view it therefore makes sense for all new transport infrastructure to be assessed for its impact on health so that health concerns can be brought to the fore whether or not the infrastructure in question is being specifically developed to further the aims of the Active Travel (Wales) Act 2013. That way Wales can adopt a more holistic approach to furthering this policy aim.

Another example of where HIA could provide added benefit can be highlighted in relation to planning considerations, where we would also argue that it might not be seen as sufficient to only require HIAs to be undertaken at the level of the over-arching Local Development Plan (LDP). Generalised land use allocations within an LDP will not necessarily reveal the impact on health that individual development

[53] http://www.who.int/hia/en/

[54] European Centre for Health Policy. Health impact assessment: main concepts and suggested approach. Gothenburg consensus paper. Brussels: WHO European Centre for Health Policy. 1999. Available at: http://www.euro.who.int/document/PAE/Gothenburgpaper.pdf

proposals, which are subsequently brought forward during the lifetime of the plan, might have. It may only become apparent once the specific details of individual planning applications are known what impacts they could have on a broad-range of public policy considerations, including health. It might therefore be considered that certain categories of planning applications – e.g. housing developments above a certain size – could be subject to HIA.

Application

HIAs need not be overly burdensome. This is often used as an argument against their use being made a requirement, but the first stage in the process should be a screening exercise which can determine whether an HIA would both be valuable and feasible within a particular decision-making context.

In our view, it would be too simplistic to just dismiss this as a tick box exercise. A methodology could be developed which would ensure those policies, plans and programmes which should be subject to an HIA could then go on to be subject to a suitably more rigorous assessment – but for those for which this would not be necessary, this can also be straightforwardly identified.

Additionally, HIA need not be undertaken as a stand-alone process but could also be undertaken as part of a wider, but integrated, impact assessment. An example of this is the approach which was employed in Tasmania[55] as a result of legislation introduced there in 1996. That legislation required all proposed developments requiring an environmental impact assessment (EIA) to also be subject to an HIA, with these being carried out as part of one integrated assessment.

Indeed it should be recognised that broad HIA can provide added benefits even in circumstances where EIA is already required. Even though there may be a requirement within EIA to consider human health, this may done in a manner which could be much narrower in scope than would be required in an HIA. At present, for instance, EIA undertaken in accordance with current EU regulation only looks at negative risks and implications for health, and only those which may be caused by environmental determinants.

Undertaking HIA alongside other assessments, as part of a wider integrated assessment, could be seen as a worthwhile adjunct to the recently passed Well-being of Future Generations (Wales) Act 2015 which seeks to promote a healthier Wales as one of its seven identified well-being goals. Whilst this Act requires public bodies in Wales to set objectives that will further each of these well-being goals, it does not however establish a specific requirement for Welsh public bodies to consider the impact on health of other decisions they may make, or of new policies they may adopt, when these are outside of those which are specifically being brought forward to further the aims of the Act. A mandatory application of HIA by Welsh public bodies could therefore ensure that the impact on health and wellbeing is considered more widely across the board, thereby more effectively delivering the intention of a health-in-all-policies approach.

HIA is an open and transparent process which promotes the active inclusion and participation of key stakeholders and communities affected. It can therefore ensure greater involvement of these groups in decisions that affect them. As such, it can bring reassurance in relation to certain decisions that potential impacts on health and well-being are properly understood.

Existing requirements for HIA use in Wales

It should be recognised that there are already circumstances in which HIA is referenced in existing guidance in Wales. Examples include the *Vibrant and Viable Places: New Regeneration Framework (2013)*[56] which includes the need for a HIA to be included in all Stage 2 bids for Welsh Government funding; the *Welsh Transport Appraisal Guidance (WelTAG), 2008*[57]; the *Collections, Infrastructure and*

[55] Ewan C, Young A, Bryant E, Calvert E, Calvert D. *National framework for environmental and health impact assessment.* Canberra: National Health and Medical Research Council, Australian Government Publishing Service, 1994. Available at: https://www.nhmrc.gov.au/guidelines-publications/eh10

[56] http://gov.wales/topics/housing-and-regeneration/regeneration/vibrant-and-viable-places/?lang=en

[57] http://gov.wales/topics/transport/planning-strategies/weltag/?lang=en

Markets Sector Plan[58] which covers the management of waste; and the *Minerals Technical Advice Note (MTAN) 2: Coal*[59], which provides planning advice in relation to facilities for coal extraction including open-cast mining. These include circumstances in which HIA has already been made a mandatory requirement in Wales.

Making HIA a statutory requirement

Given that there are already circumstances in which Welsh Government has specified that HIA should be undertaken, it could therefore be a logical progression to include a statutory requirement for HIA in certain defined circumstances. Indeed, such a provision could substantially strengthen the scope and impact of the Public Health (Wales) Bill, as well as being seen as an evolution of the existing approach.

The principle for HIA to be a requirement in specific situations could be incorporated on the face of the Public Health (Wales) Bill, with the intention that regulations would subsequently be produced which could then specify in exactly which particular situations a mandatory HIA would be required. That way the requirement for mandatory HIA could initially be applied in a number of discrete areas where it is most apparent that this would be of benefit, with scope for this to be easily broadened to further areas in the future. This would be a similar approach, for instance, to the manner in which the provisions of the Welsh Language (Wales) Measure 2011 are being applied.

In the first instance, we would suggest that regulations could require that HIA is made mandatory in relation to Strategic and Local Development Plans, certain larger scale planning application, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.

Summary

We feel that a mandatory requirement for HIA in certain defined circumstances would be entirely in line with the wider Welsh Government policy direction and recent legislative developments.

It would ensure greater consideration within decision-making of ways in which negative impacts on health can be mitigated against and positive health benefits maximised, thereby ensuring unforeseen impacts are avoided at the same time as providing greater reassurance for communities in the way such decisions are reached.

Legislating for mandatory HIA could provide a significant contribution to improving the future health and well-being of the Welsh population, at the same time as helping Wales to become a World leader in the application of public health policy.

[58] http://gov.wales/topics/environmentcountryside/epq/waste_recycling/publication/cimsectorplan/?lang=en
[59] http://gov.wales/topics/planning/policy/mineralstans/2877461/?lang=en

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 Forest – PHB 77 / Tystiolaeth gan Forest – PHB 77

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
No. There is no evidence that the use of e-cigarettes is harmful to anyone. At worst the health risks of vaping are significantly less than the health risks associated with smoking. There is also no evidence that bystanders are at any risk from exposure to the vapour exhaled by consumers. We therefore object strongly to nationally imposed restrictions on the use of e-cigarettes in enclosed public places. Vapers are almost exclusively smokers who wish to cut down or quit or are looking for an alternative nicotine delivery system in places where smoking is banned. Given the lack of evidence that the use of electronic cigarettes is harmful to (a) the user and (b) bystanders and the significant uptake in vaping among smokers, many of whom are using the product in an attempt to cut down or quit smoking, it would be hugely counterproductive to the stated aims of tobacco control to discourage the use of e-cigarettes in public places. The exhalation or smell of vapour may, in a small enclosed space, be offensive to some people but that is insufficient reason to ban the use of e-cigarettes in enclosed public places. Landlords, proprietors and other employers must be allowed to decide on a policy that best suits their business, including the interests of staff and customers. In terms of evidence, we draw your attention to the ASH (London) briefing paper on e-cigarettes (November 2014) that declares:

"In the UK smokefree legislation exists to protect the public from the demonstrable harms of secondhand smoke. ASH does not consider it appropriate for electronic cigarettes to be subject to this legislation, but that it should be for organisations to determine on a voluntary basis how these products should be used on their premises." We do not agree with ASH about the alleged dangers of secondhand smoke, which we believe have been greatly exaggerated. We do however agree that banning the use of e-cigarettes in enclosed public places would be highly inappropriate and, in our opinion, counter-productive if the Government's aim is to reduce the number of people who smoke combustible cigarettes.

Question 2

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?
No. If the goal of government is to reduce the number of people who smoke or encourage people to quit it makes no sense to ban the use of electronic cigarettes in enclosed public places, including pubs and clubs, or introduce unnecessary regulations that might restrict their sale or promotion. There is a very real danger that over-regulation could destroy a potentially game-changing product in its infancy.

Question 3

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?
There is no evidence that the use of e-cigarettes re-normalises smoking, nor is there is evidence that e-cigarettes provide a gateway to tobacco. With few exceptions, the overwhelming majority of e-cig users are existing smokers, many of whom are trying to cut down or quit tobacco, or ex-smokers who are seeking an alternative nicotine delivery device. Complaining that the use of e-cigarettes inadvertently promotes smoking is not borne out by evidence. FOREST supports consumer choice and evidence-based policy making and to penalise vapers in the unsubstantiated belief that it 'normalises' smoking is self-defeating. It also ignores the point that the success of e-cigarettes compared to other smoking cessation aids is due largely to the fact that vaping mimics the

physical act of smoking. Without that USP it's highly unlikely that e-cigarettes would have been so successful so quickly. As more and more smokers switch to e-cigarettes the public will soon get used to the fact that consumers are vaping not smoking. Meanwhile the look and feel of second and third generation e-cigarette devices have little in common with the traditional combustible cigarette so it is increasingly hard to confuse smoking with vaping.

Question 4

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?
There is no evidence we are aware of that suggests e-cigarettes are particularly appealing to young people. Likewise there is very little evidence that non-smokers, including children, are using e-cigarettes as a gateway to tobacco.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
No, not if it adds to the cost and burden of red tape on small businesses including village shops and local convenience stores. We certainly see no reason why retailers of e-cigarettes should be included on a national register alongside retailers of tobacco. Electronic cigarettes do not contain tobacco. They are a totally different product so why register them together? While the health risks associated with smoking are well known, there is no evidence of harm to the consumer as a result of using e-cigarettes. It is essential that any new measures take this into account because the policy must be proportionate to the risk.

Question 6

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?

FOREST supports a ban on the proxy-purchasing of cigarettes and other combustible tobacco products to persons under 18. We do NOT support a ban on the proxy-purchasing of e-cigarettes, especially for those aged 16 or 17. If, for example, a parent discovers his or her child is smoking cigarettes why should they be prosecuted for purchasing an e-cigarette for their child in the hope they will switch from smoking to vaping? There is no evidence that by proxy-purchasing an e-cigarette for a 16 or 17-year-old child they are putting that child's health at risk, nor is there evidence that a vaping habit will lead to smoking.

Regarding the sale of e-cigarettes to persons under 18, we are undecided whether the age restriction should be 18 or 16. If however the primary aim is to discourage children from smoking combustible cigarettes it makes little sense to prohibit the sale of e-cigarettes to those aged 16 or 17.

Setting the minimum age of sale for e-cigarette devices at 16 rather than 18 would distinguish between two very different nicotine delivery systems. It might also nudge those teenagers who are tempted to smoke towards electronic cigarettes in preference to the potentially more harmful combustible cigarette.

Other comments

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
Re electronic cigarettes, e-cigarettes are market-led devices that have the potential to revolutionise public health if the product is not strangled in its infancy by hyper-regulation and unnecessary restrictions. Based on existing evidence there is no reason to believe that e-cigarettes are a serious risk to the health of the consumer or that vaping is a gateway to smoking tobacco. Politicians must overcome their unwarranted fear of nicotine (which can be addictive but is no more harmful than caffeine) and embrace the potential that electronic cigarettes have to become a game-changing harm reduction product that could eventually wean millions of smokers off cigarettes.

To achieve that requires a leap of imagination and the ability to reject unnecessarily restrictive legislation. At the same time, attempts to force smokers to quit combustible cigarettes could be counter-productive with many consumers 'reaching for their fags in defiance'.

FOREST supports education not coercion. In a free society adults must have the freedom to make an informed choice and as long as tobacco remains a legal product consumers should neither be vilified for their habit nor forced to quit.

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
As a UK-wide organisation we would always defer in matters relating to devolved administrations to our local members. We therefore refer you to the response from Directors of Public Health in Wales. In December 2014 we issued an **interim position statement** which ADPH is reviewing and currently consulting its members on this. ADPH is currently considering the emerging evidence on the impact of nicotine vapourisers, however we are concerned that marketing of nicotine vapourisers and their widespread use in enclosed public spaces may undermine the successful efforts which have been made to denormalise smoking behaviour. We are cognisant of arguments for the potential impact of nicotine vapourisers as a means of quitting or reducing harm by substituting for conventional tobacco products. However, we believe that more research is needed to establish clear evidence of safety and their long term impact on health. As demonstrated by our 2014 survey of UK Directors of Public Health[1], ADPH believes that the use of nicotine vapourisers in enclosed and substantially enclosed public places (including work places) undermines and makes more difficult the enforcement of the current ban on smoking in such places[2].

[1] **http://www.adph.org.uk/wp-content/uploads/2015/02/ADPH-2014-Policy-survey-report-Final.pdf** [accessed 05th August 2015]
[2] **http://www.adph.org.uk/wp-content/uploads/2014/12/ADPH-Position-Statement-Nicotine-vapourisers-20141.pdf** [accessed 05th August 2015]

In our survey, 78% of Directors of Public Health who responded said that the restrictions and regulations relating to the use of smoked tobacco products in public places should also apply to nicotine vapourisers.

There is also a potential indirect risk from such devices and their refills which are not child protection packaged, if the device/refill is left unattended, dropped or discarded. The liquid can be toxic to young children if ingested or even if spilled onto skin, and often sold in attractive colours and flavours that appeal to young people/children such as 'gummy bear' or 'bubble gum'. Exposure can cause cardiac effects. Figures from the UK and overseas report increases in cases of accidental poisoning from contact with nicotine from these devices, with large proportions of the cases involving very young children.6-8 The batteries from these devices are also very small and could cause serious damage if ingested by small children.[3][4][5]

The concerns of Directors of Public Health include that some e-cigarettes look similar to regular cigarettes, making people wary of challenging smokers where bans exist. The sight of electronic cigarettes - which can't always be easily distinguished from tobacco cigarettes - sends mixed messages to the public about acceptance of smoking. Evidence supports the need for consistency in messages in trying to support behaviour change and culture change.

We are also concerned over the second hand effects of vapour on those with respiratory conditions (such as asthma) particularly when nicotine vapourisers are used in enclosed and substantially enclosed public places.

Question 2

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?

[3] Jame Meikle (2014). E-cigarette poisoning figures soar as vaping habit spreads across UK. Available online at: **http://www.theguardian.com/society/2014/apr/14/e-cigarette-poisoning-figures-soar-adults-children** [accessed 25th June 2015]

[4] Chatham-Stephens K, Law R, Taylor E, et al. (2014). Notes from the field: calls to poison centers for exposures to electronic cigarettes – United States, September 2010-February 2014. MMWR 63(13): 292-293. Available online at: **http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6313a4.htm** [accessed 25th June 2015]

[5] The Local (2013). Nicotine poisoning rockets mid e-cig battle. Available online at: **http://www.thelocal.se/20131230/sweden-child-nicotine-poison-ecigarettes-increase** [accessed 25th June 2015]

As previously stated ADPH is currently considering the emerging evidence on the impact of nicotine vapourisers, so it is difficult to fully answer this question based upon the existing body of evidence.

Question 3

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?
We are cognisant of arguments for the potential impact of nicotine vapourisers as a means of quitting or reducing harm by substituting for conventional tobacco products. However, we believe that more research is needed to establish clear evidence of safety and their long term impact on health – as well as on wider questions relating to re-normalisation of smoking behaviour, and the impact on young people of product development, advertising and marketing. The involvement of the tobacco industry in product development raises concerns, and whilst efforts to de-normalise tobacco use are welcomed, attempts to maintain a population addicted to nicotine (including tobacco) are not. We will continue to canvass the views of our members and to review our policy position – both in the light of further research and evidence, and in response to product development. ADPH is particularly concerned that marketing of nicotine vapourisers and their widespread use in enclosed public spaces will undermine the successful efforts which have been made to de-normalise smoking behaviour. In our 2014 survey of UK Directors of Public Health, 84% of the Directors of Public Health who responded believed that the restrictions and regulations for the advertising and marketing of smoked tobacco products should also apply to nicotine vapourisers. In responding to the Committee of Advertising Practice/Broadcast Committee of Advertising Practice consultation (2014) on the advertising and marketing of

electronic cigarettes and associated products, ADPH advocated for the following principles:
- Advertising and promotion of products containing an addictive drug should always be subject to close supervision by regulatory authorities, since addiction undermines the principle of informed consent by adult consumers.
- Regulation of un-licensed nicotine vapourisers should be consistent with that for licensed products. For example, celebrity endorsement and free samples are not allowed for licensed nicotine containing products and should not be allowed for nicotine vapourisers either.
- Nicotine vapourisers should not be advertised or promoted in ways that could reasonably be expected to promote smoking of tobacco products. As far as possible, nicotine vapourisers should be advertised as an alternative to smoking cigarettes or other tobacco products.
- Nicotine vapourisers should not be advertised in ways or through channels that could reasonably be expected to make them appealing to non-tobacco users.
- Nicotine vapourisers should not be advertised in ways or through channels that could reasonably be expected to make them appealing to children and young people.

We believe that - in addition to the need to establish clear evidence of safety and long term impact on health - more research is also needed in relation to the impact of advertising and marketing of nicotine vapourisers, as well as on their impact on the re-normalisation of smoking behaviour. A particular concern is the impact on young people.

Question 4

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?
If we wish to reduce the chances of e-cigarettes becoming a gateway for non-smokers into nicotine addiction or the use of conventional tobacco products, our efforts need first to concentrate upon restricting the marketing and promotion of these devices as many young people do not recognise how susceptible they actually are to the advertising that continually surrounds them. To date, little research has been conducted in the UK specifically upon this issue of usage by young people, particularly given that the product is still relatively new

to the market and the rapid growth in their use has only been within the last three to four years. This is an important gap in the evidence in a rapidly changing field.

We believe that e-cigarettes may have the potential to act as a gateway to conventional tobacco by appealing to young people and giving the impression that they are a safe alternative, even though they still include addictive and high levels of nicotine.

Nicotine vapourisers should not be advertised in ways or through channels that could reasonably be expected to make them appealing to non-tobacco users.

The involvement of the tobacco industry in product development raises concerns, and whilst efforts to de-normalise tobacco use are welcomed, attempts to maintain a population addicted to nicotine (including tobacco) are not.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
ADPH agrees with the proposal of establishing a national register of retailers of tobacco and nicotine products. Such a register could strengthen the tobacco control agenda in Wales and the proposal is in line with the Tobacco Control Action Plan for Wales. We also welcome. A register would help to enforce legislation on the display of tobacco products and tackle underage sales by helping Trading Standards Officers to easily identify retailers and check compliance with regulations. A recent survey in England showed that nearly half of young smokers (44%) reported being able to purchase tobacco from retail premises despite the ban on the sale of tobacco products to those under the age of 18.[6] This measure will be an important step towards helping to reduce the number of young people in Wales who become smokers. Introducing a registration scheme will enable Trading Standards Officers to more easily identify tobacco retailers for test purchasing purposes and to check compliance with the point of sale display regulations. The additional information, which could be gathered by a registration scheme, will support enforcement of

[6] HSCIC (2013). Smoking, drinking and drug use among young people in England in 2012. Available online at: **http://www.hscic.gov.uk/catalogue/PUB11334** [accessed 25th June 2015]

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

Smoking accounts for approximately 5,450 deaths every year in Wales and it is estimated that 14,500 young people a year take up smoking[7]. It is therefore imperative that measures are taken to reduce this number and thereby reduce the amount of smoking-attributable morbidity and mortality among the Welsh population.

We believe that the proposal to create a tobacco and nicotine products retailer's register is both workable and proportionate.

The rapid rise in internet shopping could offer an easy way for young people to circumvent age restrictions. There is currently a lack of safeguards against children purchasing cigarettes through the internet. There should be consistency in the control of the sale of restricted products across all outlets, physical or virtual.

Question 6

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?
ADPH agrees with the proposal to make it an offence for anyone knowingly handing over tobacco and nicotine products to a person under 18. As stated previously it is vital that measures are taken to reduce the number of young people taking up smoking and thereby reduce the amount of smoking-attributable morbidity and mortality among the Welsh population.

[7] Public Health Wales NHS Trust/Welsh Government: Tobacco and health in Wales (June 2012): p33. Available at **http://www2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf/61c1e930f9121fd080256f2a004937ed/509486bfd300fdef80257a29003c3c67/$FILE/Eng%20Smoking%20Report%20LowRes.pdf** (accessed 29 April 2014)

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
ADPH welcomes and the introduction of a compulsory national licensing system for practitioners of specified 'special procedures' in Wales and that the premises from which the practitioners operate these procedures must be approved. Incompetent practices and procedures can lead to a burden on the NHS which has to pick up short and long term sequelae. Such a register would be beneficial in recognising legitimate practitioners and businesses and help to regulate these procedures in Wales. It would also help to ensure a consistent approach to regulation across Wales. A national licensing system for practitioners and the mandatory licensing conditions which they have to comply with will ensure the provision of consistent standards in respect of infection control, cleanliness and hygiene for all practitioners and businesses operating any of the listed treatments. It will be essential that competency to perform certain procedures is tested. Suitable resources would need to be made available to realise and sustain the benefits of such a register. We also advocate national guidance with a maximum and minimum cost threshold for registration. The ability to amend the list of procedures through secondary legislation would also provide flexibility to incorporate new procedures with the potential to cause harm in the future. The current legislation does not adequately protect the public and these procedures have the potential to cause harm if not carried out safely. In a recent look back exercise in Wales, nine people were identified as needing hospital admission due to severe Psuedomonas aureaginosa infection, eight of whom required surgical intervention (including incision, drainage, reconstruction and stitching), following body piercing at a tattoo and body piercing premises. The

individuals needed weeks of hospital treatment and follow-up care, and some are permanently disfigured. More minor problems for other clients included swelling and trauma around the site, scarring, local skin infections, and allergic reactions which were more prevalent. A lack of good hygiene and infection control can lead to blood poisoning (sepsis) or transmission of blood-borne infections through contaminated equipment, such Hepatitis B, Hepatitis C or HIV.

There is some older evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare [8] [9] [10]. 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[11] However, in our view, the risk of transmission is the same in professional parlours where sterile conditions and infection control measures are not in place. Scarring from complications following such procedures can also have long-term psychological impacts[12] [13] [14]. Anecdotal evidence suggests that localised infections associated with such procedures are often seen in GP practices and Accident and Emergency departments, particularly following tongue piercings. All of the nine cases identified in the look back exercise self-presented to healthcare, often multiple times.

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

[8] Hayes MO and Harkness GA (2001). Body piercing as a risk factor for viral hepatitis: an integrative research review. Am J Infect Control 29: 271–274.
[9] Weir E (2001). Navel gazing: a clinical glimpse at body piercing. CMAJ 164: 864.
[10] Mayers LB, Judelson DA, Moriarty BW, et al. (2002). Prevalence of body art (body piercing and tattooing) in university undergraduates and incidence of medical complications. Mayo Clin. Proc. 77: 29–34.
[11] Tohme RA and Holmberg SD (2012). Transmission of Hepatitis C Virus Infection Through Tattooing and Piercing: A Critical Review. Clin Infect Dis. 54: 1167–1178.
[12] Stirn A (2003). Body piercing: medical consequences and psychological motivations. Lancet 361: 1205–1215.
[13] Stirn A, Hinz A, and Brähler E (2006). Prevalence of tattooing and body piercing in Germany and perception of health, mental disorders, and sensation seeking among tattooed and body-pierced individuals. Journal of Psychosomatic Research 60: 531–534.
[14] Stirn A and Hinz A (2008). Tattoos, body piercings, and self-injury: Is there a connection? Investigations on a core group of participants practicing body modification. Psychotherapy Research 18: 326–333.

practitioner. These measures would ensure that they have the knowledge, skills and experience needed to perform these procedures.

Question 8

Do you agree with the types of special procedures defined in the Bill?
Whilst we agree with the special procedures defined, 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.

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
The ability to amend the list of procedures through secondary legislation will provide flexibility to incorporate new procedures with the potential to cause harm in the future.

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
National guidelines and requirements will help to mitigate against any local variation and discrepancies.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
ADPH recommends that the list of intimate body parts includes tongue piercing because of the risks associated, including infection, chipped teeth, blood poisoning, tongue swelling and blood loss which may cause a risk to someone's airways. Through the Bill children and young people will be protected from the potential health harms which can be caused by intimate piercing. Competency checks will also be required before nipple, genital and tongue piercing, and before body modification such as ear cartilage removal, tongue splitting and branding. Currently there are no checks on the ability of the practitioner to conduct these forms of minor surgery which are much more invasive than most minor surgery performed in primary care for which General Practitioners need additional qualifications.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
Pharmacies have been shown to be effective at delivering enhanced services such as smoking cessation, harm minimisation in substance misuse, flu vaccination, and emergency hormonal contraception.[15] [16] Currently, the majority of pharmacy time is spent dispensing prescriptions and providing advice on medicines. We believe the legislation proposed in the Public Health (Wales) Bill will encourage existing pharmacies to adapt and expand their services in response to local needs. The risk of another contractor making a successful application to join the pharmaceutical list in their area, if they fail to respond to need will be an effective incentive. This can help to ensure services are available where needed. We also believe that undertaking and incorporating such assessments of need will help to improve the planning and delivery of pharmaceutical services in Wales by making them more integrated and aligned with wider health needs assessment and service planning.

[15] Brennan N. (2012). Education programmes for patients. Community pharmacy public health campaign report. Available online at: **http://www2.nphs.wales.nhs.uk:8080/pharmaceuticalphtdocs.nsf/61c1e930f9121fd080256f2a004937ed/6767e0d54074f12680257a48004ee581?OpenDocument** [accessed 25th June 2015]

[16] Fajemsin F (2013). Community pharmacy and public health SPH. Available online at: **http://www.sph.nhs.uk/sph-documents/community-pharmacy-and-public-health-final-report/?searchterm=community%20pharmacy** [accessed 25th June 2015]

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
Pharmaceutical needs assessments should examine the demographics of their local population, across the area and in different localities, and their needs. Pharmaceutical needs assessments should describe the pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. They should describe accessibility to these services, including by public transport. Pharmaceutical needs assessments should look at other services, such as dispensing by GP surgeries, and services available in neighbouring areas that might affect the need for services in its own area. They should examine whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. Over provision of pharmacies in particular areas should be considered and the pharmaceutical needs assessments should also take account of likely future needs. The NHS Confederation's discussion paper 'Health on the high street: rethinking the role of community pharmacy'[17] highlights that evidence is emerging around the potential role community pharmacy can play in improving and maintaining the nation's health. The paper finds that, as trusted and professional partners in supporting individual, family and community health, sitting at the heart of our communities, effective community pharmacy services have a significant and increased role to play in ensuring we have a sustainable healthcare system and that the NHS is able to survive and thrive over the coming decades. However, this will require providers, patients and the public to be more aware of community pharmacy's role alongside other primary and community care service, as highlighted within the Health and Social Care Committee's inquiry into community pharmacies in August 2011. The Committee's report clearly demonstrated the contribution that community pharmacy can have on the health service but better

[17] The NHS Confederation, 2013. Health on the high street: rethinking the role of community pharmacy.

communication mechanisms are needed to inform the general public about the services available at any individual community pharmacy.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
The Local Health Boards of Wales see that there is a need for accessible public toilets and feel these are an important community amenity, particularly for older people, those with disabilities, and families with children. In addition an estimated 14 million British people have a bladder control problem, while 7.5 million have a bowel control problem.[18] Accessible public toilets are a necessity to maintain population health for everyone, but some groups have specific needs. These include disabled people, parents with babies and young children, pregnant women, older people and those with specific conditions including incontinence, inflammatory bowel disease, irritable bowel syndrome, multiple sclerosis and people who have been prescribed diuretics. If toilet provision is inadequate, people can become afraid or reluctant to go away from the home for periods of time, leading to poor mobility, isolation and depression. [19] Accessible public toilets also contribute towards an age-friendly community reflecting the aging population in Wales. Whilst there is a lack of research evidence on the health benefits of accessible public toilets, this is supported by professional opinions and public surveys.

[18] Bladder and Bowel Foundation. Available online at: **www.bladderandbowelfoundation.org** [accessed 25th June 2015]
[19] Older Peoples Commissioner for Wales (2014). The Importance and Impact of Community Services within Wales. Available online at: **www.olderpeoplewales.com** [accessed 25th June 2015]

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
While the preparation of a strategy that considers the need for and plans for the future provision of toilets for public use would provide clarity at the local level (for elected members, officers and the public) the real issue of making resources available to address this remains. The duty on Local Authorities within the Bill is that they "may provide toilets in its area for use by the public" and it is important that the strain already place on local government services is recognised due to the significant financial pressures already experienced by Local Authorities. The statutory duty to write a strategy will have little impact on actual provision, unless resources can be identified to put such a strategy in place. This presents challenges in Local Authorities' ability to safeguard existing provision and to promote new facilities. We believe that any additional duties placed on Local Authorities should be adequately funded, as some previous closures have been due to heavy maintenance and upgrading costs. The preparation of a local strategy may not result in improved provision and accessibility without adequate resources provided to Local Authorities to implement such a strategy. In addition to the duties the Bill places on Local Authorities, consideration and awareness needs to be increased around other schemes. The public access Community Toilet Scheme introduced in 2009 is reportedly underused with large variation between Local Authorities and some people are not comfortable with using this type of facility. This is a scheme through which people can use the toilet facilities in participating local businesses when they are open, without having to make a purchase. However communication of location and access to potential users can be inadequate and access is necessarily limited to business opening hours. The problem of lack of street signage can also be an issue to accessing public toilets. Signage should be standardised, showing opening times and facilities available. Examples of alternative sources of information which exist elsewhere include Australia's National Toilet Map, the UK disabled drivers' mapping portal and Westminster City Council's SatLAV, which allows visitors to text for their nearest toilet and opening times.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
ADPH is disappointed that regulation of food standards in settings such as pre-school and care homes are not included in the Public Health (Wales) Bill. Food standards can make an important impact on public health. Good nutrition in very young children is essential for future growth development and health, while poor nutrition in care homes is likely to undermine their health and well-being and increase the chances of the need for health services intervention. We are strongly persuaded that this aspect could be strengthened so that there is no missed opportunity to place mandatory food standards on all food or drink supplied by or procured for settings directly controlled, commissioned or inspected by public sector organisations. Over 300,000 people are currently employed in the public sector in Wales. Offering healthy choices as the norm to them, and the public they serve, could make a significant contribution to the adult obesity problem. The risk of many chronic conditions, in particular coronary heart disease, obesity, diabetes and some cancers, is increased by poor diet and diet-related disease has been estimated to cost the NHS around £6 billion a year. The cost of obesity alone has been predicted to reach £49.9 billion per year by 2050 by the Foresight report[20]. Wales faces some of the biggest challenges in the UK, with the Child Measurement Programme reporting prevalence of overweight or obese children to be 26% in reception year[21]. Maintaining food standards, particularly in health settings such as hospitals which seek to keep people well, can inform and influence the public's perception of what foods are considered acceptable and healthy. The public sector caters for some of the poorest and most vulnerable people in society. Catering Standards for Food

[20] Foresight (2007). Tackling Obesities: Future Choices, Government Office for Science, London. Available online at: **https://www.gov.uk/government/collections/tackling-obesities-future-choices** [accessed 25th June 2015]

[21] Public Health Wales (2015). Child Measurement Programme for Wales 2013/14, PHW, Cardiff. Available online at: **http://www.wales.nhs.uk/sitesplus/888/page/67767** [accessed 25th June 2015]

and Fluid Provision for Hospital Inpatients, and the All Wales Hospital Menu Framework standards ensure patients receive adequate nutrition to assist with their recovery whilst in hospital, but there is much work needed to make sure that healthy and balanced meals and food are offered to all those accessing the restaurants (including staff, patients and visitors). Mandated criteria for the provision of only healthier retail items in hospital restaurants and outlets would help hospitals in Wales to fulfil their responsibility for improving the health of the population they serve.

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

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
We are disappointed that the vision and the outcomes that the Bill is trying to achieve are not included. As it stands the Bill deals with areas that could predominantly be dealt with through secondary legislation and it does not include a clear vision which sets out the goals and principles of the law. We believe it is important that the Bill includes information to explain clearly to the public that public health is everybody's business, and not solely confined to the NHS and the public sector. Minimum unit pricing for alcohol is also not included in the Public Health (Wales) Bill and we are aware of current testing of Scotland's decision to include this. We feel it is highly important that this is taken forward in the future when the position is clarified. There is a strong evidence base for a link between alcohol affordability and levels of harm and until this prudent initiative is implemented alcohol-related morbidity, mortality and cost will continue to impact on society.

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
We consider that it is important the Public Health (Wales) Bill contains a commitment to progressing health in all policies which may impact on the health and well-being of the people of Wales. ADPH believes that this would raise the profile of public health in society, increasing awareness and knowledge of important public health issues across government departments and in all sectors. The Public Health (Wales) Bill provides a once in a generation opportunity to place public health at the centre of public policy and practice in Wales in order to enable people to live healthy, long lives with a public service that is organised to promote self-care, prevent ill-health and keep people healthier for longer. The future success of the NHS relies on us all taking a proactive approach to public health and ensuring that we create the right conditions to enable people in Wales to live active and healthy lifestyles. Through introducing this Bill we have an opportunity to make Wales a nation that takes the health of its citizens very seriously. There is an over-riding case for the Bill to take advantage of this 'once in a lifetime opportunity' to raise the profile of public health in society. In addition we have the opportunity to increase awareness and knowledge of public health across all Government departments, and among those who develop and implement policy, to support the population to live long, healthy and independent lives. Public health plays a key role in ensuring that demand is reduced and in empowering people to take control of their health. The introduction of this legislation can renew focus on prevention and well-being and contribute to achieving prudent healthcare in NHS Wales. However, to ensure that this is done

people need to be educated and empowered to have the knowledge and understanding, in order to remain in good health and receive appropriate interventions.

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

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

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

Finally, Under the Public Health (Wales) Bill, the Welsh Government should provide greater consideration to the impact poverty has on the health of the population.

The importance of tackling poverty to improve people's health cannot be underestimated. Poverty and deprivation are linked to many of the public health concerns and outcomes in Wales.

There are still significant health inequalities, including by age, ethnicity and socio-economic group[22]. The Welsh NHS Confederation recently published the 'Socio-economic deprivation and health' briefing[23]. This highlights the correlation between socio-economic deprivation and people's health and well-being outcomes, with the gap in life expectancy for people living in the most deprived and the least deprived areas of Wales currently stands at 9.2 years for men and 7.1 years for women for all Wales[24]. In some Health Boards the discrepancy in healthy life expectancy between the most and least deprived is over 20 years. Through analysing trends across socio-economic groups we highlight how deprivation has an impact on child development, people's lifestyle choices, healthy life expectancy, including living with an illness or chronic condition, and life expectancy. It is now the time for all public sector organisations, including the health service, to work together to tackle deprivation and inequality. Through the Public Health (Wales) Bill and the Well-being of Future Generations (Wales) Act it is imperative that collaboration across all public bodies improves to achieve a "healthier Wales" and an "equal Wales". We must deliver a more integrated and preventative approach for our public's health that has maximum impact to reduce inequalities and keep people healthier for longer.

As the Welsh NHS Confederation's 'From Rhetoric to Reality – NHS Wales in 10 years' time' highlighted[25], engagement with all public service colleagues is necessary to take us all from an ill health service that puts unnecessary pressure on hospital services, to one that promotes healthy lives. Engagement is necessary

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

with all our public service colleagues, from social care to housing, education and transport. All public bodies in Wales must build on how we might improve our ability to work together and support our partners and colleagues in other sectors.

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

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 Philip Morris Limited - PHB 79 / Tystiolaeth gan Philip Morris Limited - PHB 79

PHILIP MORRIS LIMITED

Philip Morris Limited's Response to the Health and Social Care Committee Call for Evidence on the Public Health (Wales) Bill.

Introduction

Philip Morris Limited ("PML") welcome the opportunity to respond to the Health and Social Care Committee's call for evidence on the general principles of the Public Health (Wales) Bill. Our response is limited to those measures contained in Part 2 of the Bill which are of direct relevance to our business. Last year, Philip Morris International through an affiliate of PML, entered the UK e-cigarette market by acquiring one of the leading UK e-cigarette manufacturers, Nicocigs Limited.

Tobacco Harm Reduction, E-Cigarettes and Reduced Risk Products[1]

PML agrees with many public health professionals that e-cigarettes, like other non-combustible products, are likely to be reduced risk alternatives to combustible tobacco cigarettes.[2] Many smokers will continue to smoke; by switching to less harmful products, such as e-cigarettes, significant individual and public health benefits can be accrued, as acknowledged in the recent Public Health England Report endorsing tobacco harm reduction approaches[3]. Furthermore, as the US FDA recently stated, there is *"a continuum of nicotine-delivering products that pose differing levels of risk to the individual"* and if certain products are shown to be less harmful, *"they could help reduce the overall death and disease toll from tobacco use at a population level."*[4] Thus, e-cigarettes should be regulated in a different manner from cigarettes and other traditional tobacco products.

The Royal College of Physicians Wales (RCP Wales) noted in their White Paper consultation response that *"electronic cigarettes and other novel nicotine devices can provide an effective, affordable, and readily available retail alternative to tobacco. These innovations could make harm reduction a reality for smokers."*[5] With such important harm reduction considerations in mind, advancing proportionate regulation must be a firm consideration of the Welsh Government, and this particularly applies to their intention to prohibit the use of 'Nicotine Inhaling Devices' in enclosed public spaces.

We have integrated our answers to the questions raised by the Committee into our analysis of the four chapters contained in Part 2 of the Bill. In addition to the written evidence supplied here, we would appreciate the opportunity to provide oral evidence to the Health and Social Care Committee at a future date.

Chapter 1: Smoking and Use of Nicotine Inhaling Devices

[1] Reduced Risk Products is the term used by Philip Morris International to refer to products with the potential to reduce individual risk and population harm in comparison to smoking combustible cigarettes.
[2] P. Hayek et al. 'Electronic cigarettes: review of use, content, safety, effects on smokers and potential for harm and benefit'. *Addiction*, 109, 11 (2014), p1801-1810. See: http://onlinelibrary.wiley.com/doi/10.1111/add.12659/abstract
[3] McNeill A., Brose L. S., Calder R., Hitchman S. C.,Hajek P, and McRobbie H., E-cigarettes: an evidence update, A report commissioned by Public Health England, August 2015, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/454516/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England.pdf
[4] US Food and Drug Administration. *Deeming Tobacco Products To Be Subject to the Federal Food, Drug and Cosmetic Act. 21 CFR Parts 1100, 1140 and 1143*. See: http://www.fda.gov/downloads/TobaccoProducts/GuidanceComplianceRegulatoryInformation/UCM394914.pdf
[5] Royal College of Physicians Wales. *Consultation Response to Public Health White Paper* (2014). See: http://gov.wales/docs/phhs/consultation/141104phwhitepaperresponses18en.pdf

Restrictions on Nicotine Inhaling Devices

PML supports evidence-based regulation of tobacco and its alternatives. However, the Welsh Government's decision to proceed with an excessive restriction on the use of Nicotine Inhaling Devices, such as e-cigarettes, disregards the accumulated evidence, as well as the considerable level of opposition from public health organisations and individuals alike.[6] Restrictions on the use of e-cigarettes in enclosed and public spaces must be evaluated in light of: (a.) the science which shows a clear distinction between cigarette smoke and e-cigarette vapour; (b.) the need to encourage smokers to switch from cigarettes to less risky alternatives; (c.) and the desire not to expose minors to adult products.

We believe the Bill mistakenly treats smoking and the use of e-cigarettes in the same manner. The Welsh Government contend that such an intervention is required to prevent the so-called gateway effect, the re-normalisation of tobacco smoking and to avoid undermining smokefree legislation. However, this rationale does not meet the standard of proportionate evidence-based policy making and is critically undermined by the available data.

Renormalisation and the Gateway Effect

An abundance of recent statistics illustrate that e-cigarettes are used almost exclusively by existing adult smokers who switch from combustible cigarettes, while use among never-smokers is negligible, and there is little evidence that children in Wales are using e-cigarettes regularly.[7] New data from the ASH Smokefree GB Youth Survey found no evidence of a gateway effect, with only 2.4% of young people stating that they had used e-cigarettes at least once a month in 2015 and that almost all who reported regular use were those who had been or were already smokers. Crucially, with regular smoking among 11-15 year olds now at a historic low of 3%, ASH note that *"an increase in awareness and use of electronic cigarettes was not coinciding with any increase in teen smokers."*[8]

In fact, the Welsh Government acknowledge in the Bill's *Explanatory Memorandum* that at present, few teenagers who experiment with e-cigarettes go onto become regular users.[9]

The lack of evidence on renormalisation and the gateway effect was emphasised by a number of leading public health stakeholders during the White Paper consultation process, including:

- UK Centre for Tobacco and Alcohol Studies (UKCTAS): *"…there is no evidence that use of e-cigarettes, and particularly the use of e-cigarettes in public, is resulting in appreciable gateway uptake of tobacco smoking."*[10]
- RCP Wales: *"The RCP is not aware of any evidence that shows electronic cigarettes normalise tobacco smoking in indoor public spaces, or that electronic cigarettes are acting as a gateway to tobacco use in young people."*[11]

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[6] 79% of responses were opposed to the measure in the public consultation on the proposals last year. BBC Wales. 'E-Cigarette ban in enclosed spaces in Wales pushes ahead', BBC News, 09/06/15. See: http://www.bbc.co.uk/news/uk-wales-33025872

[7] ASH UK. *Use of electronic cigarettes among adults in Great Britain* (2015). See: http://www.ash.org.uk/files/documents/ASH_891.pdf; R. West & J. Brown. *Trends in Electronic Cigarette Use in England* (2015). See: http://www.smokinginengland.info/latest-statistics; Office for National Statistics. *Opinions and Lifestyle Survey: Adult Smoking Habits in Great Britain, 2013* (2014). See: http://www.ons.gov.uk/ons/dcp171778_386291.pdf; Health and Social Care Information Centre. *Smoking, Drinking and Drug Use Among Young People in England - 2014* (2015). See: http://www.hscic.gov.uk/catalogue/PUB17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf; G. Moore et al. 'Electronic-cigarette use among young people in Wales: evidence from two cross-sectional surveys', *BMJ Open* (2015). See: http://bmjopen.bmj.com/content/5/4/e007072.full.pdf+html; ASH Wales. *Young people and e-cigarettes in Wales* (2014). See: http://ashwales.org.uk/assets/factsheets-leaflets/young_people_and_e-cigarettes_in_wales_final_march_2014.pdf

[8] ASH UK. 'Latest data finds no evidence that electronic cigarettes are a gateway to smoking for young people', 17/08/15. See: http://www.ash.org.uk/media-room/press-releases/:latest-data-finds-no-evidence-that-electronic-cigarettes-are-a-gateway-to-smoking-for-young-people

[9] Welsh Government., *Public Health (Wales) Bill: Explanatory Memorandum* (2015), p20. See: http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

[10] UKCTAS. *Consultation Response to Public Health White Paper* (2014). See: http://gov.wales/docs/phhs/consultation/141104phwhitepaperresponses21en.pdf

[11] RCP Wales. *Consultation Response.*

- DECIPHer, Cardiff University: *"We are not aware of evidence to suggest that the use of e-cigarettes in public places normalises the act of smoking, or evidence supporting the 'gateway' hypothesis."*[12]
- Cancer Research UK (CRUK): *"We also do not believe that there is sufficient evidence to legislate to prevent e-cigarettes renormalizing smoking."*[13]

Contrary to the view of the Welsh Government that e-cigarettes may re-normalise smoking, the available scientific evidence suggests that e-cigarettes are being used as a means to quit tobacco.[14] Blunt legislative measures to restrict e-cigarette use could have unintended consequences for those seeking to undertake a quit attempt, as e-cigarettes have now become the most popular smoking cessation aid.[15] E-cigarettes have been shown to be as effective as NRT among smokers who have attempted to quit without professional guidance. The recent report of the Behavioural Insights Team of the UK Government concluded its review of the data by stating that "*e-cigarettes are now the most successful product at helping people quit smoking, and the evidence shows that almost all users of e-cigarettes are former smokers.*"[16]

With the growing acceptance of the harm reduction potential of e-cigarettes, the Royal Society for Public Health has called for the greater utilisation of the devices in NHS stop smoking services.[17] In this context, it is telling DECIPHer commented that any ban in Wales *"would penalise those who use electronic cigarettes as a smoking cessation aid."*[18] The Welsh Government should therefore view the increased use of e-cigarettes as a means of facilitating their ambitious target to reduce adult smoking prevalence to 16% by 2020, rather than a hindrance.[19]

The views expressed by a number of various public health experts are also validated among UK adult smokers and e-cigarette users as measured by a recent nationally representative survey conducted by Populus Limited, a leading opinion research firm, on behalf of PML.[20] The initial results send the clear message that smokers and e-cigarette users see the benefit of e-cigarettes and demand the reasonable regulation of these products:

- Three-quarters (76%) agree that "*e-cigarettes represent a positive alternative to today's conventional cigarettes*". Agreement increases among those most familiar with e-cigarettes: current e-cigarette users (89%) and those who switched from conventional cigarettes to e-cigarettes (93%).
- Over eight-in-ten (82%) agree that the Government should enact appropriate regulations to ensure e-cigarettes are not used by minors under 18.

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[12] DECIPHer. *Consultation Response to Public Health White Paper* (2014). See: http://gov.wales/docs/phhs/consultation/141104phwhitepaperresponses08en.pdf

[13] CRUK. *Consultation Response to Public Health White Paper* (2014). See: http://gov.wales/docs/phhs/consultation/141104phwhitepaperresponses05en.pdf

[14] J. Brown et al. 'Real-World effectiveness of e-cigarettes to aid-smoking cessation: a cross sectional population study', *Addiction*, 109, 9 (2014), p1531-1540. See: http://onlinelibrary.wiley.com/doi/10.1111/add.12623/abstract; H. McRobbie et al. 'Electronic cigarettes for smoking cessation and reduction', *Cochrane Database of Systematic Reviews*, 12 (2014). See: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010216.pub2/pdf

[15] Recent data has shown a 31% decrease in quit attempts in Scotland using NHS smoking cessation services. The report from NHS Scotland states that the *"rise in the use of electronic cigarettes is a plausible explanation"* for the fall. NHS Scotland. *NHS Smoking Cessation Services (Scotland): 1 January to 31 December 2014* (2015). See: https://isdscotland.scot.nhs.uk/Health-Topics/Public-Health/Publications/2015-06-30/2015-06-30-SmokingCessation-Report.pdf?7744997740

[16] The Behavioural Insights Team Update Report 2013-2015 at p. 12 (July 2015)

[17] Royal Society for Public Health. *Stopping smoking by using other sources of nicotine* (2015). See: http://www.rsph.org.uk/filemanager/root/site_assets/our_work/position_statements/rsph_smoking_positional_final.pdf

[18] DECIPHer. *Consultation Response.*

[19] Welsh Government. *Tobacco Control Action Plan for Wales* (2012). See: http://www.senedd.assembly.wales/documents/s4255/Tobacco%20Control%20Action%20Plan.pdf

[20] Survey on attitudes to e-cigarette regulation carried out by Populus Limited, on behalf of Philip Morris Limited, using a national quota of 1,083 smokers and e-cigarette users aged 18 and above. The survey was executed via the online methodology from 24-28 July 2015 and the national representative sample was drawn from a combination of the Populus Live research panel and Random Online Sampling.

- Three-quarters (78%) believe "*the Government should do all it can to encourage smokers to switch to less harmful alternatives to cigarettes, including lower taxes and less restrictions compared to normal cigarettes*".

These findings are further reinforced when examining the opinion of those that have fully switched from conventional cigarettes to e-cigarettes:

- Nearly all e-cigarette switchers (92%) agree that "*switching to e-cigarettes has been a positive change*" in their life, with three-quarters (75%) *strongly* agreeing.
- A majority (55%) revealed that they were interested in e-cigarettes as the devices could be used in some indoor public places.
- Significantly, half (53%) agreed that further restricting the use of e-cigarettes in indoor public places would discourage them from switching to these products.

PML encourages the Health and Social Care Committee to carefully consider the views and opinions of smokers and e-cigarette users when discussing the Bill. The full report of the study, as well as all supporting data, will be submitted to the Committee and we would welcome the opportunity to further discuss the research at a future date.

Undermining Smoke-Free Legislation

The Bill will bring the use of e-cigarettes into line with conventional cigarettes in terms of smokefree legislation through a re-statement of Chapter 1, Part 1 of the Health Act in relation to Wales. Equating two fundamentally distinct products in this regard demonstrates a basic misunderstanding of how e-cigarettes operate: e-cigarettes do not generate smoke by burning tobacco and therefore deliver nicotine with far fewer chemicals. Many public experts and organisations have concluded that e-cigarettes are not significantly hazardous either for users or by-standers.[21]

PML concur with CRUK that "*there is no evidence that the use of e-cigarettes in the majority of smokefree premises undermines the enforcement of the smokefree legislation.*"[22] Furthermore, UKCTAS maintain it is not the case that e-cigarettes undermine smokefree policies as *"it is in practice easy to distinguish e-cigarettes from tobacco cigarettes"* and that their use in public spaces *"normalises electronic rather than tobacco use."* [23] Similarly, RCP Wales emphasised there was *"no evidence that smoking e-cigarettes in enclosed public spaces poses a significant risk to other people"* and on the basis of available evidence, *"electronic cigarettes and related products could actually generate significant falls in the prevalence of smoking in the UK, prevent many deaths and episodes of serious illness."*[24]

ASH Wales have stressed the practical implications of any ban on the use of e-cigarettes in enclosed public spaces, noting it would *"increase the likelihood that vapers and smokers would effectively be required to share the same spaces. This not only undermines quit attempts but would also expose users of electronic cigarettes to second-hand smoke."*[25]

Overall, we would respectfully encourage the Welsh Government to value science-based regulation and avoid jeopardising the public health gains of e-cigarettes by introducing any disproportionate measures – such as the restriction on use in enclosed public spaces or any extension of smokefree environments to include e-cigarettes – which may dissuade adult smokers from choosing these devices. PML believe that

[21] R. *West et al. Electronic cigarettes: what we know. A report to UK All Party Parliamentary Groups (2015). Updated July 2015. See:* http://www.smokinginengland.info/downloadfile/?type=report&src=6*; Royal College of Physicians. 'What you need to know about electronic cigarettes', 20/03/14. See:* https://www.rcplondon.ac.uk/commentary/what-you-need-know-about-electronic-cigarettes

[22] CRUK. *Consultation Response.*

[23] UKCTAS. *Consultation Response.*

[24] RCP Wales. *Consultation Response.*

[25] ASH Wales. *Consultation Response to Public Health White Paper* (2014). See: http://gov.wales/docs/phhs/consultation/141104phwhitepaperresponses01en.pdf

banning the use of a product that has been proven to be an effective and recognised less harmful alternative for adult smokers would undermine the Welsh Government's own targets on reducing smoking prevalence and would not contribute to improving public health in Wales.

Restrictions on Smoking

The Bill also grants powers to Welsh Government Ministers to designate additional premises, including non-enclosed spaces, as smokefree in relation to tobacco smoking. PML believe that the conclusions of public health officials on the health effects of second-hand smoke warrant restrictions on public place smoking, including bans in many locations. However, a balance must be struck between the desire to protect non-smokers, especially minors, from exposure to second-hand smoke, and allowing the millions of adults who smoke to do so in some public places.

We believe, smoking should be prohibited inside hospitals and health institutions, as well as in schools and other facilities for youth. In addition, smoking should be prohibited in public places where people must go, such as public transportation vehicles and businesses offering general public services (e.g. supermarkets, banks and post offices). In such places, signs should be posted clearly stating that smoking is not permitted. We believe smoking should be allowed in outdoor public spaces, except areas intended primarily for children or where smoking could be dangerous.

As the Committee scrutinises the Bill, it should acknowledge the fact that reduced risk tobacco products are being developed that also produce vapour[26]. A blanket prohibition on the use of tobacco products, even when no second-hand smoke is emitted by such products, is not consistent with the intent of public smoking restriction legislation and regulation, or the principle of tobacco harm reduction. Please refer to the above section on e-cigarettes.

Chapter 2 Retailers of Tobacco and Nicotine Products & Chapter 3 Prohibition on Sale of Tobacco and Nicotine Products

PML supports comprehensive, evidence-based regulation that helps reduce the harm caused by smoking. Therefore, we endorse the principle of a creation of a tobacco retail register in Wales; however, we oppose the unnecessary and bureaucratic nature of the proposed fee-structure and registration process. We believe the Welsh Government should duplicate the Scottish Government's approach to the Scottish Tobacco Retail Register in making registration free, especially as retailers have had to deal with the impact of the costly tobacco display ban. However, drawing from the Scottish experience, the key issue will be one of enforcement: recent figures show that only five irresponsible retailers have been banned from selling tobacco on a temporary basis since the introduction of the policy in 2011.[27] As UKCTAS academics have observed: *"[There is] little evidence that merely enacting a law without sufficient enforcement [has] any impact on youth tobacco use."* [28]

Chapter 4: Handing Over Tobacco etc. to Persons Under 18

PML believe that minors should not have access to either tobacco or e-cigarettes and as such we welcome any activity that prevents youth access to these products. That is why we advocated for regulation around proxy purchasing and continue to support educational programmes highlighting the adverse health effects of smoking.

[26] https://www.pmiscience.com/

[27] S. Parsons. 'Was the Scottish tobacco register worth it?' *Retail Express*, 10/08/15. See: http://www.betterretailing.com/was-the-scottish-tobacco-register-worth-it/

[28] E. Donaghy et al. 'A qualitative study of how young Scottish smokers living in disadvantaged communities get their cigarettes', *Nicotine & Tobacco Research*, 15, 12 (2013), p2053-2059. See: http://ntr.oxfordjournals.org/content/early/2013/08/02/ntr.ntt095



PHILIP MORRIS INTERNATIONAL

Attitudes to E-Cigarette Regulation Amongst Smokers and E-Cigarette Users

August 2015

Populus
RESEARCH | STRATEGY

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Methodology

Methodology

Populus interviewed 1,083 adults online aged 18+ from across Great Britain between 24th and 28th July 2015.

All those interviewed were current smokers of cigarettes and / or users of e-cigarettes.

A Nationally Representative sample was drawn from a combination of the Populus Live research panel and Random Online Sampling and participants screened to identify those who were smokers or users of e-cigarettes.

Populus is a founding member of the British Polling Council and abides by its rules, and follows the Market Research Society's Code of Conduct. More information about Populus and the methods we use can be found at www.populus.co.uk.

Where results do not sum to 100%, this may be due to rounding, the exclusion of 'Don't Know' responses, or multiple answers given.

Acknowledgements

Populus wishes to thank the 1,083 participants, across Great Britain, who gave generously of their time and thoughts.

Report Author

Laurence Stellings, Associate Director, Populus

Key Findings

- Awareness of proposed regulation of e-cigarettes was extremely low. 18% of smokers and e-cigarette users were aware of the Scottish Government's plans, and just 15% the Welsh Government's plans. Amongst Scottish smokers and e-cigarette users, a little over one-in-five (22%) were aware of the Scottish Government's proposals.
- Amongst this audience of cigarette smokers and e-cigarette users, attitudes towards e-cigarettes were generally positive. Three quarters (76%) regarded e-cigarettes as a positive alternative to conventional cigarettes, a figure that increased to 93% amongst users of e-cigarettes. In Scotland, nearly four-in-five (78%) regarded e-cigarettes as a positive alternative to conventional cigarettes.
- Smokers and e-cigarette users strongly supported the provision of information about e-cigarettes to adult smokers. 90% of smokers and e-cigarette users nationally, including 94% of those in Scotland, wanted information about the potential of e-cigarettes to reduce the risk of smoking as compared to conventional cigarettes to be made available once reliable scientific evidence was compiled. Nearly three quarters, 74%, thought it wrong for there to be restrictions on the advertising of new products like e-cigarettes in places like retail shops, leaflets, posters, and brochures.
- Those who had switched from conventional to e-cigarettes were extremely positive about the change. 75% strongly agreed that the change had been a positive one for them, with a further 17% somewhat agreeing. For those who had made the switch, information about the products and advertising in shops, brochures, and billboards was thought important by more than four-in-five (83%) in helping them become familiar with e-cigarettes.
- For those who exclusively used conventional cigarettes, and never e-cigarettes, Government provided information and clarity on the health effects of e-cigarettes and the role they could play in helping to stop smoking conventional cigarettes was important. 61% of smokers, including 69% of those in Scotland, would be more likely to switch to e-cigarettes if such information was provided.
- Smokers and e-cigarette users were divided on the importance of being able to use e-cigarettes in some public places where the smoking of conventional cigarettes was banned. For 55% of e-cigarette users this has been a factor in their change, for 39% it had not played a part. For smokers of conventional cigarettes, 61% felt any ban on the use of e-cigarettes in public places would make them less likely to switch.
- Although smokers and e-cigarette users viewed e-cigarettes generally positively, and wanted information made available to adult smokers, they were also strong supporters of regulation to prevent minors under 18 using e-cigarettes. 82% of Britons, and 85% of those in Scotland, supported such regulation – with e-cigarette users themselves the strongest supporters of restrictions (88% supporting them).

Attitudes to E-Cigarette Regulation

Awareness of, and Knowledge about, E-Cigarettes

In total, around three-in-five (62%) smokers and e-cigarette users recalled seeing, reading, or hearing about e-cigarettes recently. This figure did not vary significantly by demographic characteristics like geography, age, or gender. It was, however, noticeably higher amongst those who personally used e-cigarettes (68%) and those with a partner, child over 18, or parent who regularly used e-cigarettes (73%).

Of those recalling seeing, reading or hearing something recently about e-cigarettes, half had done so through broadcast media like TV and radio.

Retail displays and shops were another important source of information; 42% had seen, read, or heard about e-cigarettes in shops, and 37% in retail shops that sold cigarettes and other tobacco products. Those in Scotland were more likely to cite retail shops as a source of information than those in England and Wales.

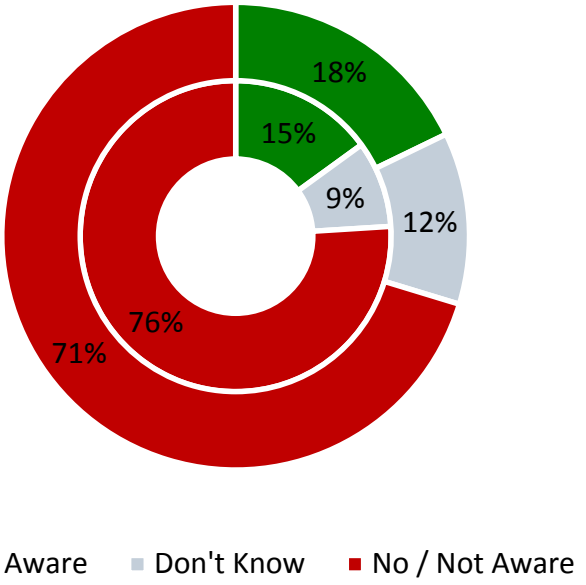
Most – amongst this audience of smokers and e-cigarette users – felt familiar with e-cigarettes. 71% described themselves as being either 'very' or 'somewhat' familiar with e-cigarettes, a view that did not vary significantly by geography or gender.

Younger adult smokers and younger adult e-cigarette users were more likely to be familiar than older people, however, with 76% of those aged 18-34 describing themselves as familiar with e-cigarettes, compared to 65% of those aged 55+. Similarly, those in socio-economic groups AB and C1 were more likely to be familiar with e-cigarettes than those in group DE, with three-quarters (75%) aware in the former groups and only two thirds (66%) in the latter group.

General Attitudes to E-Cigarette Regulation

Q9. Have you specifically heard about the Scottish Government's plans to regulate e-cigarettes? [Sample = All, 1,083 interviews, Outer circle]

Q10. And are you aware of the Welsh Government's plans to regulate e-cigarettes? [Sample = All, 1,083 interviews, Inner circle]



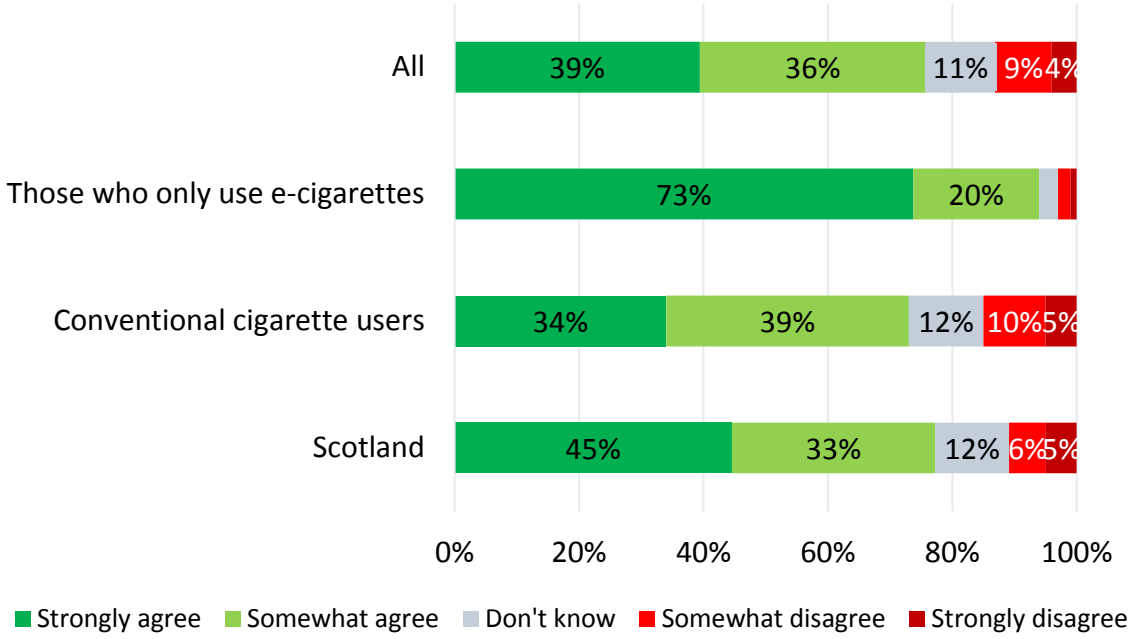
Across both Britain as a whole, and in Scotland and Wales, awareness of proposed regulation of e-cigarettes was extremely low. Overall, 71% were not aware of the Scottish Government's plans to regulate e-cigarettes, and three quarters (76%) were unaware of the Welsh Government's plans.

In Scotland, specifically, just over one-in-five (22%) Scottish smokers and e-cigarette users were aware of proposed regulation by the Scottish Government of e-cigarettes. 63% of Scottish smokers and e-cigarette users were not aware of the Scottish Government's plans.

E-cigarette users were, slightly, more aware of proposed regulation than non-users of e-cigarettes. 22% of e-cigarette users were aware of the Scottish Government's proposals and 20% of the Welsh Government's plans. In contrast, just 13% of non-users of e-cigarettes were aware of plans in Scotland and 9% in Wales.

Q12. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

E-cigarettes represent a positive alternative to today's conventional cigarettes. [Sample = All, 1,083 interviews]



In total, three quarters (76%) of smokers and e-cigarette users believed that e-cigarettes represented a positive alternative to conventional cigarettes. Just 13% disagreed.

Perhaps unsurprisingly, those who used e-cigarettes exclusively agreed very much with the statement: nearly three quarters (73%) strongly agreed that e-cigarettes offered a positive alternative, and a further 20% somewhat supported the statement. Fewer than 1-in-20 (3%) e-cigarette users disagreed with the statement.

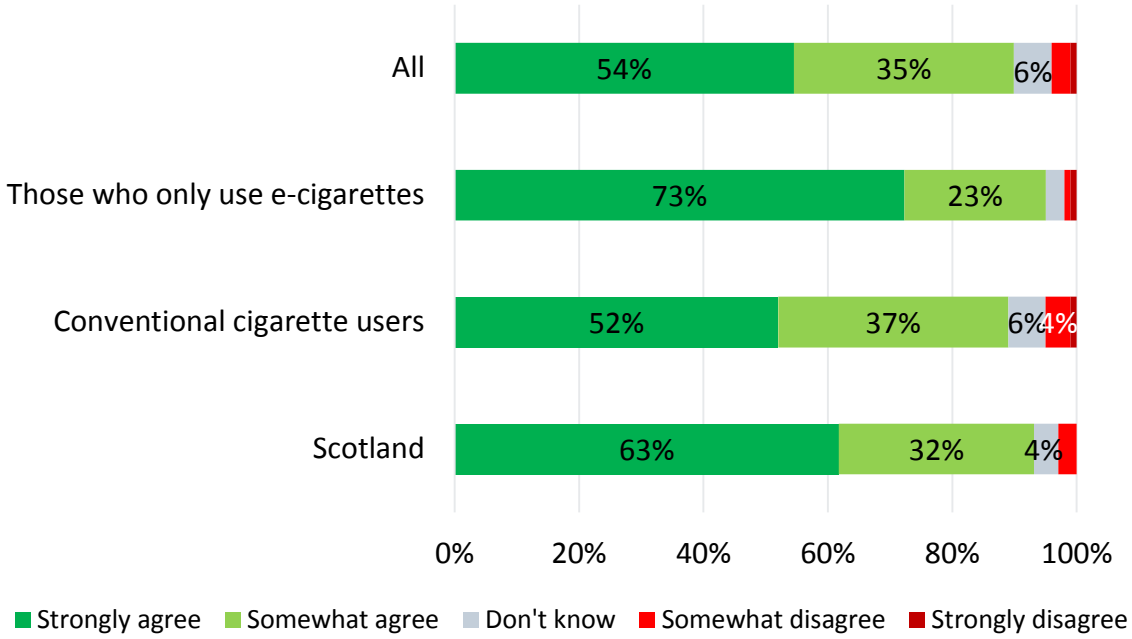
Users of conventional cigarettes tended to agree that e-cigarettes offered a positive alternative too. 34% did so strongly, and 39% somewhat. While the number disagreeing was higher than amongst e-cigarette users, at 14%, it remained a minority.

Attitudes in Scotland very closely matched those in the rest of Britain. In Scotland, nearly four-in-five (78%) agreed that e-cigarettes represented a positive alternative to conventional cigarettes – a figure just two percent higher than that for Great Britain as a whole (at 76%).

Although all age groups agreed that e-cigarettes represented a positive alternative to conventional cigarettes, older smokers and users of e-cigarettes were more likely to view e-cigarettes as a positive alternative than younger adults. 82% of those aged 55+ agreed, compared to 70% amongst those aged 18-34.

Q13. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Information about e-cigarettes and their potential to reduce the risk of smoking as compared to conventional cigarettes should be widely available to adult smokers provided reliable scientific evidence is available. [Sample = All, 1,083 interviews]



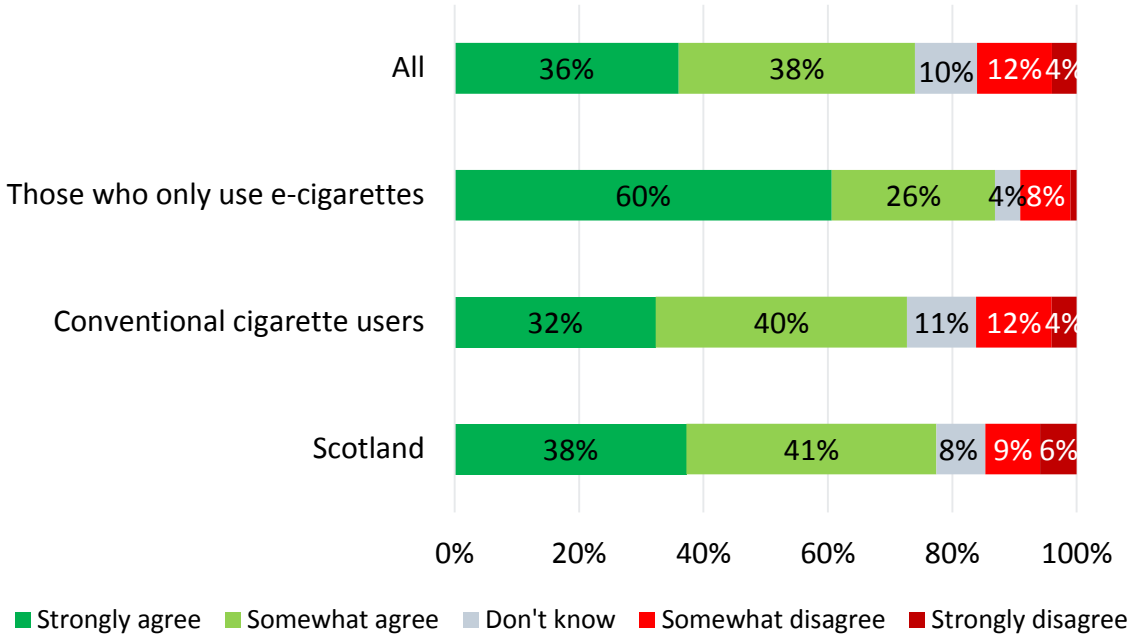
Of all the statements tested in this section, more smokers and e-cigarette users agreed with this proposition than any other.

In total, nine-in-ten (90%) agreed that as soon as reliable scientific evidence was available information should be provided to adult smokers on the potential for e-cigarettes to reduce the risk of smoking as compared to conventional cigarettes. More than half (54%) of all smokers and e-cigarette users strongly agreed.

Support in Scotland for information being provided to adult smokers about e-cigarettes and their potential to reduce the risk of smoking as compared to conventional cigarettes once reliable scientific evidence is available exceeded that in the rest of Britain. 94% of Scottish smokers and e-cigarette users agreed, including more than three-in-five (63%) strongly doing so.

Q14. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

As e-cigarettes are new products, it would be wrong for the Government to restrict the advertisement of these products in places like retail shops, leaflets, posters, and brochures. Adult smokers need to be aware of these products in order to make informed decisions on their use. [Sample = All, 1,083 interviews]



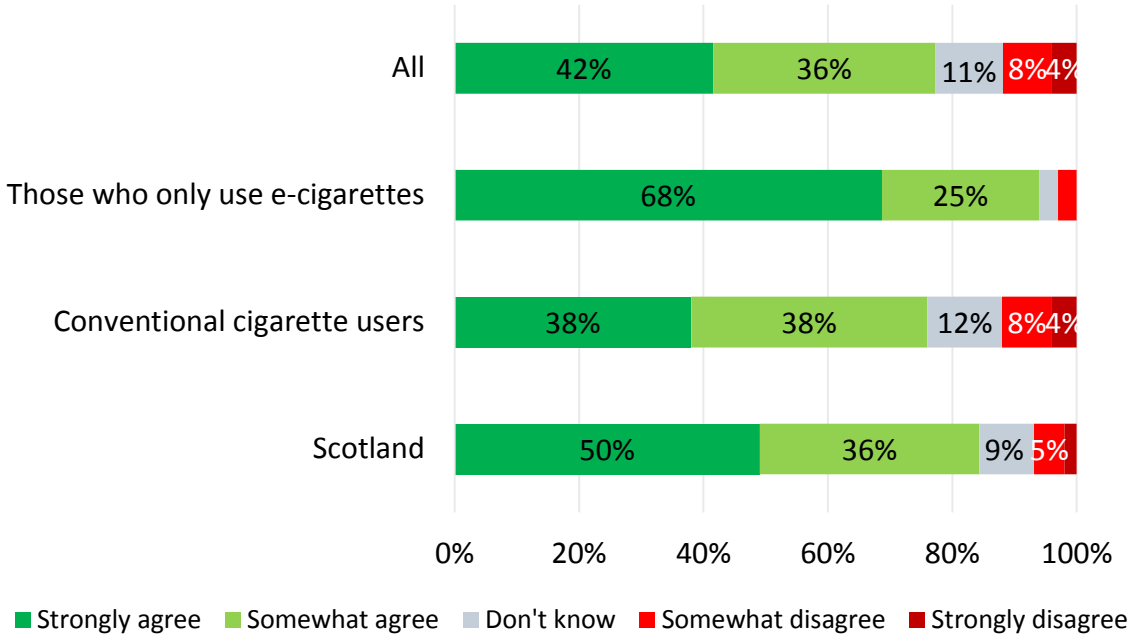
Although of the statements tested in this section this one saw the largest proportion of smokers and e-cigarette users disagreeing with the proposition (at 16%), the majority (74%) still agreed that owing to e-cigarettes' recent introduction it would be wrong to restrict advertisements of the products in places like shops, leaflets, posters, and brochures.

Existing users of e-cigarettes were particularly concerned about the prospect of advertising of e-cigarettes being restricted. 86% of e-cigarette users agreed that it would be wrong for the Government to restrict advertising, including three-in-five (60%) who did so strongly.

While users of conventional cigarettes felt less strongly on the subject, most were against restrictions on advertising e-cigarettes in shops, leaflets, posters, and brochures. 72% agreed that it would be wrong for the Government to restrict advertising of e-cigarettes, with 17% disagreeing and not objecting to Government restrictions on the advertising of e-cigarettes.

Q15. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

The Government should do all it can to encourage adult smokers to switch to less harmful alternatives to cigarettes, including lower taxes and less regulation compared to normal cigarettes. [Sample = All, 1,083 interviews]



More than three quarters (78%) of smokers and e-cigarette users wanted the Government to do all it could to encourage adult smokers to switch to less harmful alternatives to cigarettes, including lowering taxes and regulations for these alternative products as compared to conventional cigarettes.

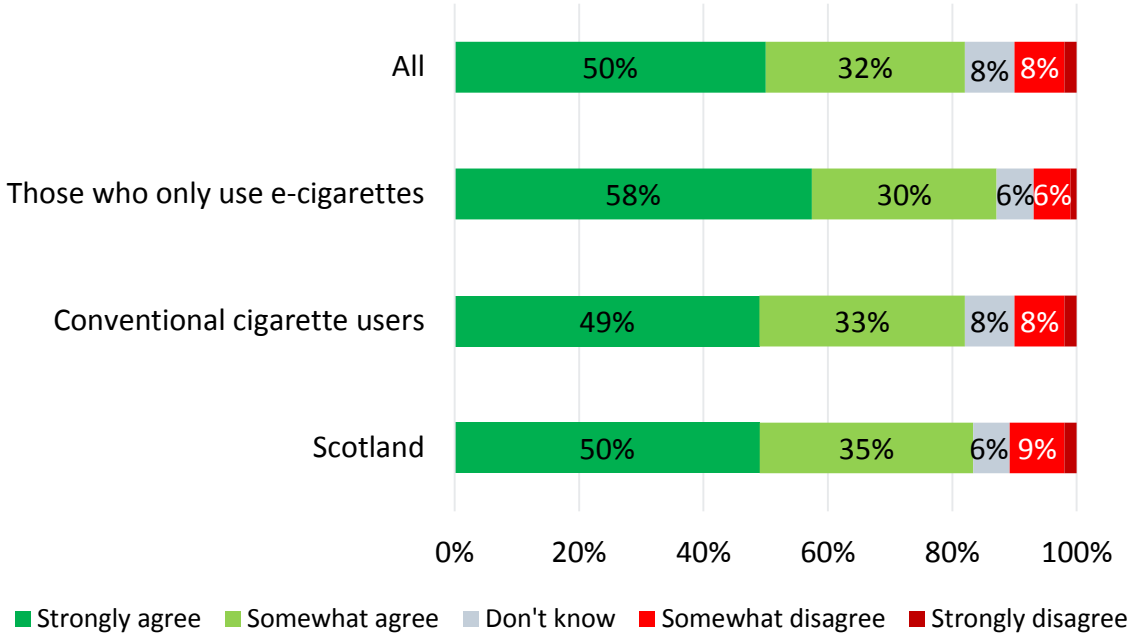
Support was stronger still in Scotland where 85% - around six-in-seven – of smokers and e-cigarette users supported the Government using means like lower taxes and less regulation to encourage adult smokers to switch from conventional cigarettes to less harmful alternatives. Only 6% of Scottish smokers and e-cigarette users disagreed with this approach.

Amongst conventional cigarette users, equal proportions - 38% - strongly and somewhat agreed that Government should encourage adult smokers to switch to less harmful alternatives. Of the remainder, users of conventional cigarettes were split half and half between those who opposed the Government attempting to move adult smokers to less harmful alternatives (12%) and those who did not express an opinion (again, 12%).

E-cigarette users were very strong supporters indeed of the idea – more than two thirds strongly supported the approach (68%), a further quarter somewhat did so (25%), meaning in total 93% of e-cigarette users supported the Government doing all it could to encourage adult smokers to switch to less harmful alternatives to cigarettes, including lower taxes and less regulation compared to normal cigarettes.

Q16. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

The Government should enact appropriate regulations to ensure e-cigarettes are not used by minors under 18. [Sample = All, 1,083 interviews]



Smokers of all types, and in all parts of Britain, supported regulation to ensure e-cigarettes were not used by minors under 18.

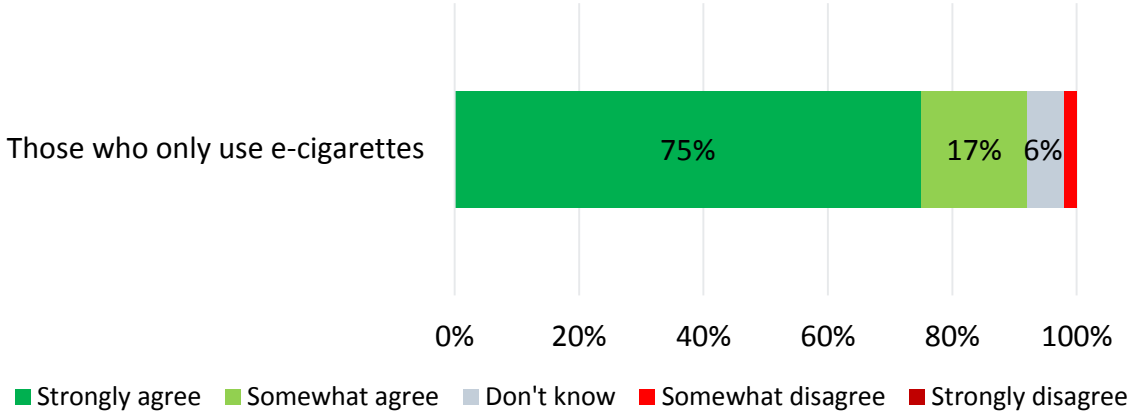
Across Great Britain as a whole, 82% supported appropriate regulation to ensure e-cigarettes were not used by minors – including half of all smokers and e-cigarette users who strongly wanted to see such regulation in place. Just 10% disagreed that regulations should be enacted to protect under 18s.

Views in Scotland were very little different to those across Britain as a whole.

Existing users of e-cigarettes were particularly keen to see regulations in place to prevent use by under 18s, with 88% of e-cigarette users supporting such rules – including 58% doing so strongly.

Q17. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

For me, switching to e-cigarettes has been a positive change. [Sample = Those who only use e-cigarettes having switched from conventional cigarettes, 115 interviews]



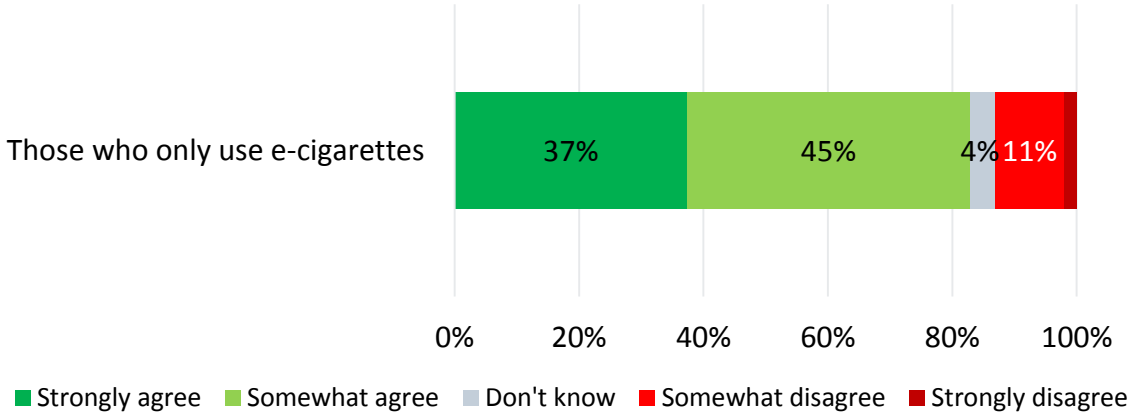
Almost all switchers to e-cigarettes regarded the change from conventional cigarettes as a positive one.

75% of those who only used e-cigarettes strongly agreed that switching from conventional cigarettes to e-cigarettes had been a positive change. A further 17% somewhat agreed – a total of nine-in-ten (92%) e-cigarette users, therefore, described the change as a positive one.

Just one-in-fifty (2%) disagreed, with 6% unsure about whether the change had been a positive one or not.

Q18. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

When making the switch to e-cigarettes, it was important for me to have access to information about these products and to see advertisements in shops, on billboards, and in brochures. I could only make an informed decision regarding the use of e-cigarettes, once I became familiar with the products. [Sample = Those who only use e-cigarettes having switched from conventional cigarettes, 115 interviews]



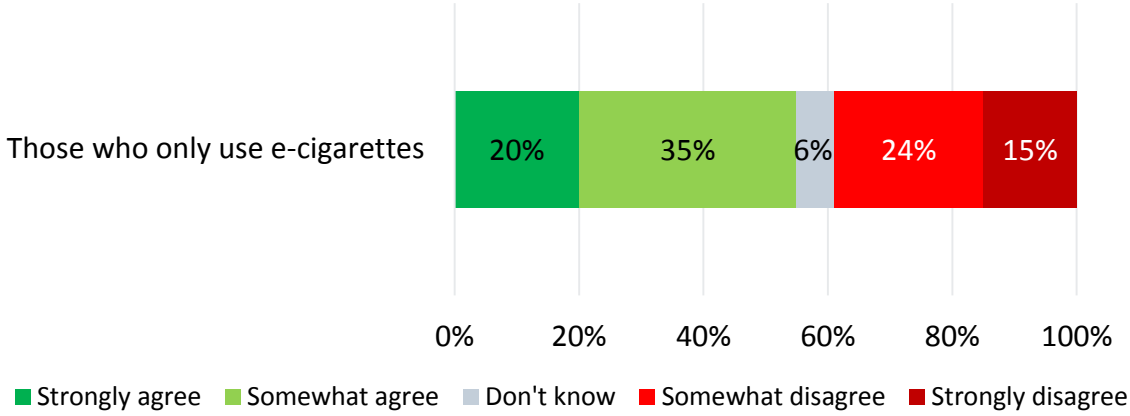
More than four-in-five (83%) switchers from conventional to e-cigarettes regarded the provision of information and advertisements as important in having helped them make a decision to change to e-cigarettes.

37% strongly agreed that when making the switch to e-cigarettes, it was important to them to have access to information about these products and to see advertisements in shops, on billboards, and in brochures in order they could make an informed decision regarding the use of e-cigarettes and become familiar with the products. A further 45% somewhat agreed this had been important.

Around one-in-eight (13%) e-cigarette users did not feel access to information and advertisements had been an important factor in them making the change to e-cigarettes.

Q19. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

One of the reasons I was interested in switching to e-cigarettes was because their use was allowed in some indoor public places. [Sample = Those who only use e-cigarettes having switched from conventional cigarettes, 115 interviews]



For those who have switched to e-cigarettes, the ability to smoke in some indoor public places was not a major consideration. Just one-in-five (20%) strongly agreed that using e-cigarettes indoors was one of the reasons they had been interested in switching.

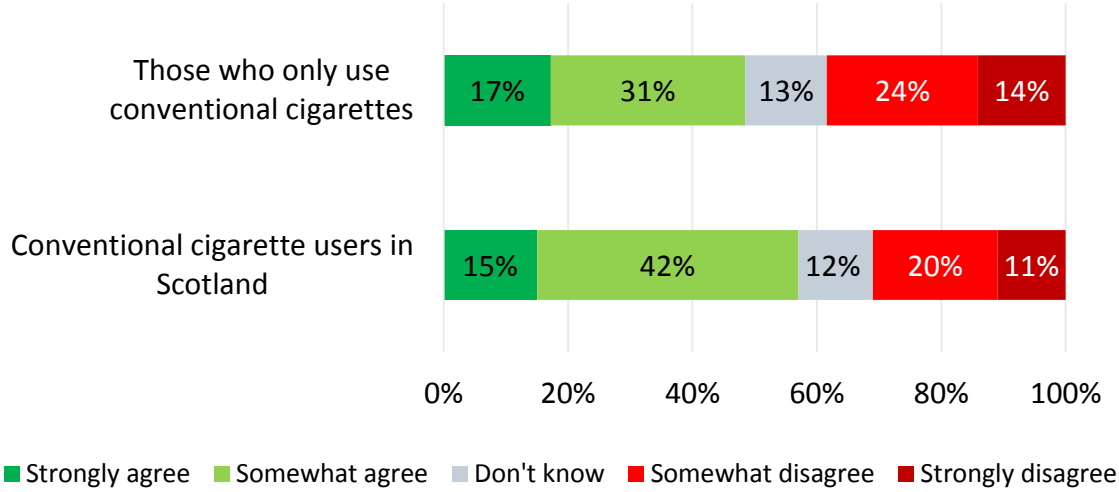
For about twice the number, around two-in-five (39%), the prospect of being able to use e-cigarettes in some public places played no part in making the change to e-cigarettes.

Of the remainder, 35% somewhat agreed that being able to use e-cigarettes indoors had played some part in their change, and 6% did not know.

Attitudes amongst Non E-Cigarette Users

Q20. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

As an adult smoker, it is important for me to see advertisements for e-cigarettes in places like shops, billboards, leaflets and brochures. If I decide to switch to e-cigarettes, this is the best way for me to gather information about which products are available and how they operate. [Sample = Those who only use conventional cigarettes and have never used e-cigarettes, 452 interviews]



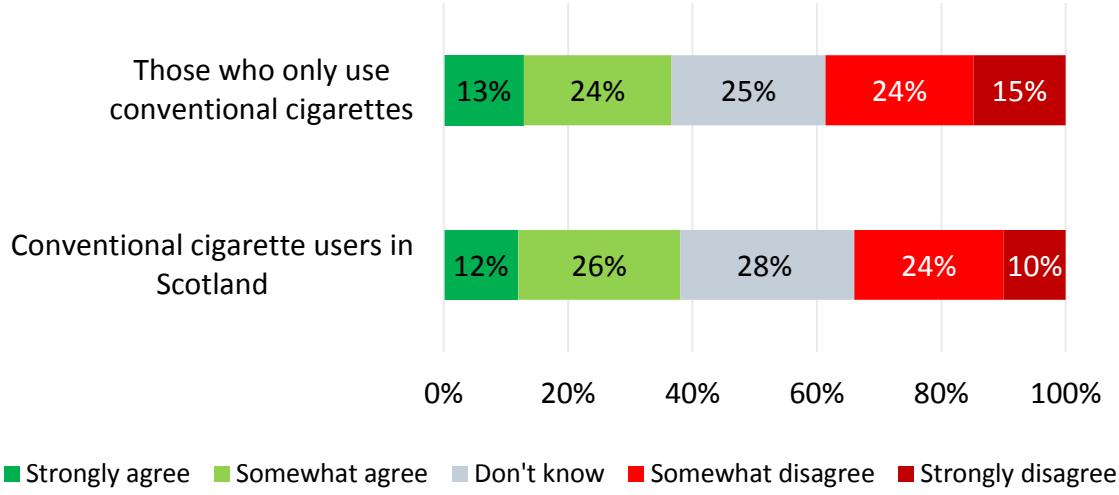
Across Great Britain as a whole, smokers of conventional cigarettes were divided on the importance of advertisements for e-cigarettes. In Scotland, there was a clearer belief in the importance of advertisements for e-cigarettes in places like shops, billboards, leaflets and brochures for informing adult smokers about e-cigarettes and how they operate.

Overall, 48% thought it important that information was available to adult smokers through advertisements in shops, billboards, leaflets and brochures to provide information on e-cigarettes to adult smokers. This figure was 10% higher than those who disagreed, 38% of British smokers. Few felt strongly on either view, however, with only 17% strongly agreeing and 14% strongly disagreeing.

Scottish smokers were, however, stronger believers in the importance of information provision through advertisements for e-cigarettes in places like shops, billboards, leaflets and brochures. More than half, 56%, supported this provision of information, with a little less than a third (31%) disagreeing.

Q21. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

If the government passed regulations that would ban e-cigarette advertising on billboards, posters, leaflets, and in retail shops, I would be <u>less</u> likely to switch to e-cigarettes. [Sample = Those who only use conventional cigarettes and have never used e-cigarettes, 452 interviews]



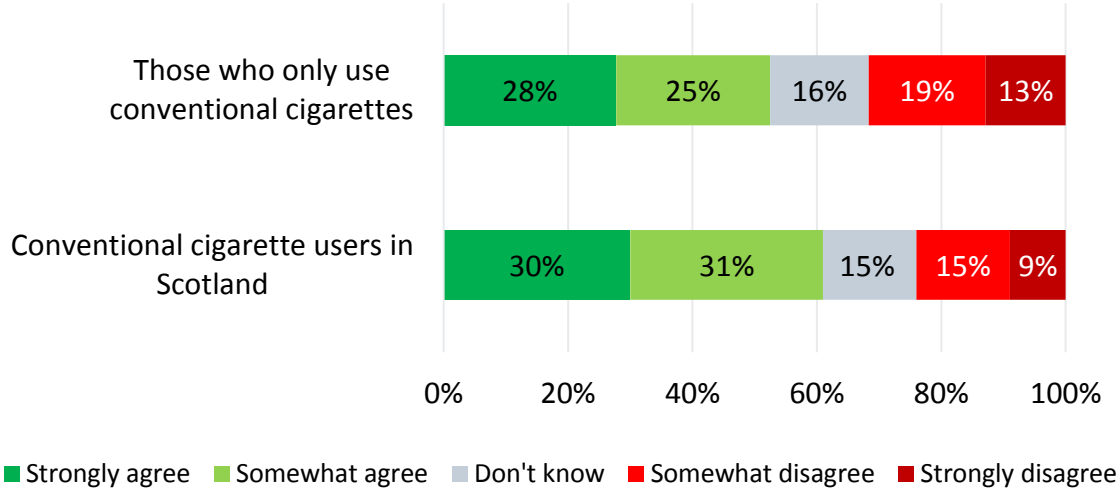
Of all the statements tested, *"If the government passed regulations that would ban e-cigarette advertising on billboards, posters, leaflets, and in retail shops, I would be less likely to switch to e-cigarettes",* resulted in the highest levels of don't know responses. One quarter (25%) overall, and a slightly higher figure of 28% in Scotland, answered that they were uncertain what impact a ban on e-cigarette advertising would have on their likelihood of switching to e-cigarettes.

Across Great Britain, smokers of conventional cigarettes divided roughly evenly between those who felt an advertising ban would make them less likely to switch and those who did not. 39% disagreed with the statement, saying that an advertising ban would not make them less likely to switch. 37% agreed with the proposition, feeling that without advertising on billboards, posters, leaflets, and in shops they would be less likely to ever switch.

In Scotland, while opinion was still divided, the balance shifted towards a belief that an e-cigarette advertising ban would make switching less likely. 38% of conventional cigarette smokers in Scotland agreed that a ban on e-cigarette advertising would make them less likely to switch. This figure was 4% higher than the 34% who disagreed saying that an advertising ban would make no difference to their likelihood to switch to e-cigarettes.

Q22. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Regulations that would ban the use of e-cigarettes in indoor public places and force e-cigarettes to be used only in zones designated to conventional cigarettes would discourage me from switching to these products. [Sample = Those who only use conventional cigarettes and have never used e-cigarettes, 452 interviews]



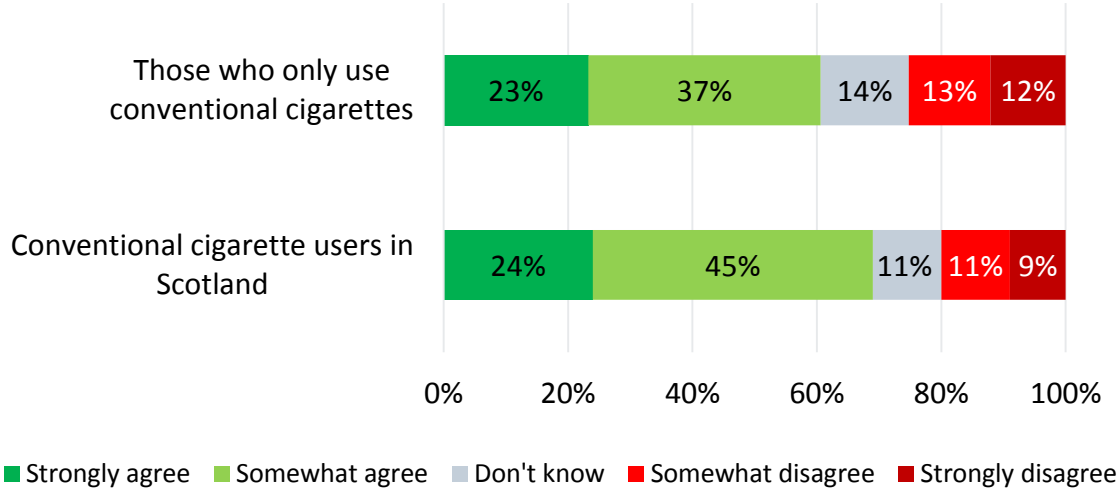
Across Great Britain more than half of users of conventional cigarettes (53%), and more than three-in-five (62%) in Scotland, agreed that restricting the use of e-cigarettes to those areas where the smoking of conventional cigarettes was allowed would discourage them from switching to e-cigarettes.

30% of Scottish smokers strongly agreed, and a further 31% somewhat agreed, that banning the use of e-cigarettes in indoor public places would discourage them from switching from conventional to e-cigarettes. Around a quarter (24%) disagreed that restricting the use of e-cigarettes to those places where conventional cigarettes could be used would have an impact on their likelihood to change product.

Opinion across the rest of Great Britain was a little less certain that an e-cigarette indoor use ban would impact on likelihood to switch to e-cigarettes from conventional cigarettes. Nearly a third (32%) thought a ban on indoor public use of e-cigarettes would not have an impact on the chances of changing from conventional to e-cigarettes. The majority, 53%, however remained of the view that they would be discouraged from switching by place and usage restrictions.

Q23. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

I would be more likely to switch to e-cigarettes if the Government provided clarity on the health effects of e-cigarettes and the role they can play in quitting smoking conventional cigarettes. [Sample = Those who only use conventional cigarettes and have never used e-cigarettes, 452 interviews]



Government-provided information on the health effects of e-cigarettes and the role they can play in quitting conventional cigarettes would make three-in-five (61%) smokers more likely to switch to e-cigarettes. In Scotland, this figure increased to more than two thirds (69%).

Across Great Britain, a quarter (25%) of smokers of conventional cigarettes thought that Government provision of information on health effects and the role of e-cigarettes in quitting conventional cigarettes would make no difference to their likelihood to switch to e-cigarettes. 14% did not know what impact clearer Government advice and guidance would have on their likelihood to switch.

Smokers in Scotland were stronger believers in the importance and role of Government-provided information than those elsewhere in Britain. 69% of Scottish smokers said they would be more likely to switch to e-cigarettes if the Government provided clarity on the health effects of e-cigarettes and the role they can play in quitting smoking conventional cigarettes. Just one-in-five (20%) disagreed.

Appendix: Questionnaire

Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.

1 Regular user
2 Occasional user
3 Former user
4 Complete non-user

(RANDOMISE ORDER)
Q1. E-cigarettes
Q2. Cigarettes
Q3. Soft drinks
Q4. Chocolate
Q5. Tea
Q6. Alcohol

[IF ((Q1=FORMER USER OR NON-USER) AND (Q2=FORMER USER OR NON-USER)): TERMINATE INTERVIEW]

Thinking about e-cigarettes in the UK…

Q7. Have you recently seen, read, or heard anything about e-cigarettes?

1 Yes
2 No
3 Unsure

Q8. And where have you recently seen, read, or heard about e-cigarettes? Please check all that apply.

1 Print media
2 Broadcast media like TV and radio
3 Internet news sites
4 Social media like Facebook and Twitter
5 E-cigarette user groups
6 In retail shops that sell e-cigarettes
7 In retail shops that sell cigarettes and other tobacco products
8 Your personal environment such as family, friends, and colleagues
9 Other (SPECIFY)

10 Unsure

Q9. And have you specifically heard about the Scottish Government's plans to regulate e-cigarettes?

1 Yes
2 No
3 Unsure

Q10. And are you aware of the Welsh Government's plans to regulate e-cigarettes?

1 Yes
2 No
3 Unsure

Q11. And, regardless of whether you have recently seen, read, or heard something about e-cigarettes, how familiar would you say you are with e-cigarettes?

1 Very familiar
2 Somewhat familiar
3 Not very familiar
4 Not at all familiar
5 Unsure

As you may know, e-cigarettes are battery powered devices that vaporize nicotine liquid to create an inhalable aerosol. E-cigarettes do not contain tobacco leaf and come in various shapes and sizes, and can be disposable, rechargeable, or refillable.

You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

1 Strongly agree
2 Somewhat agree
3 Somewhat disagree
4 Strongly disagree
5 Unsure

(RANDOMISE ORDER)

Q12. E-cigarettes represent a positive alternative to today's conventional cigarettes.

Q13. Information about e-cigarettes and their potential to reduce the risk of smoking as compared to conventional cigarettes should be widely available to adult smokers provided reliable scientific evidence is available.

Q14. As e-cigarettes are new products, it would be wrong for the Government to restrict the advertisement of these products in places like retail shops, leaflets, posters, and brochures. Adult smokers need to be aware of these products in order to make informed decisions on their use.

Q15. The Government should do all it can to encourage adult smokers to switch to less harmful alternatives to cigarettes, including lower taxes and less regulation compared to normal cigarettes.

Q16. The Government should enact appropriate regulations to ensure e-cigarettes are not used by minors under 18.

[IF ((Q1 – E-CIGARETTES = "REGULAR USER" OR "OCCASIONAL USER") AND (Q2 – CIGARETTES = "FORMER USER")), ASK:]

Q17. For me, switching to e-cigarettes has been a positive change.

Q18. When making the switch to e-cigarettes, it was important for me to have access to information about these products and to see advertisements in shops, on billboards, and in brochures. I could only make an informed decision regarding the use of e-cigarettes, once I became familiar with the products.

Q19. One of the reasons I was interested in switching to e-cigarettes was because their use was allowed in some indoor public places.

[IF ((Q2 – CIGARETTES = "REGULAR USER" OR "OCCASIONAL USER") AND (Q1 – E-CIGARETTES = "COMPLETE NON-USER")), ASK:]

Q20. As an adult smoker, it is important for me to see advertisements for e-cigarettes in places like shops, billboards, leaflets and brochures. If I decide to switch to e-cigarettes, this is the best way for me to gather information about which products are available and how they operate.

Q21. If the government passed regulations that would ban e-cigarette advertising on billboards, posters, leaflets, and in retail shops, I would be <u>less</u> likely to switch to e-cigarettes.

Q22. Regulations that would ban the use of e-cigarettes in indoor public places and force e-cigarettes to be used only in zones designated to conventional cigarettes would discourage me from switching to these products.

Q23. I would be more likely to switch to e-cigarettes if the Government provided clarity on the health effects of e-cigarettes and the role they can play in quitting smoking conventional cigarettes.

There are just a few final questions for statistical purposes.

[IF Q1 – E-CIGARETTES=”REGULAR USER” OR “OCCASIONAL USER”, ASK:]

D1. On average, how much do you spend **per week** on e-cigarette and e-cigarette supplies?

[RECORD AS AMOUNT]

[IF Q2 – CIGARETTES=”REGULAR USER” OR “OCCASIONAL USER”, ASK:]

D2. On average, how many cigarettes do you smoke **a day**?

[RECORD AS NUMBER]

D3. Do you have a partner, child over 18, or parent who **smokes cigarettes** on a daily or weekly basis?

1 Yes
2 No

D4. Do you have a partner, child over 18, or parent who **uses e-cigarettes** on a daily or weekly basis?

1 Yes
2 No

D5. How interested would you say you are in politics and public policy issues? Would you say you are…

1 Very interested
2 Somewhat interested
3 Not very interested
4 Not at all interested

D6. In the past week or so, how often would you say you have talked about government, politics, or society with your family, friends, or co-workers?

1 Several times
2 Once or twice
3 Not at all

D7. Thinking about national level elections in this country, do you tend to vote in these elections all of the time, most of the time, some of the time, rarely, or never?

1 All of the time
2 Most of the time
3 Some of the time
4 Rarely
5 Never
6 Unsure

D8. At the last general election in May, many people didn't vote. Can you remember, did you vote in that election, or did you not vote?

1 Voted
2 Did not vote
3 Unsure

[IF D8="VOTED", ASK:]

D9. Which party did you vote for at the last general election in May? Was it…

(RANDOMISE)
1 The Conservative Party
2 The Labour Party
3 The Liberal Democrat Party
4 The UK Independence Party or UKIP
5 SNP [SCOTLAND ONLY]
6 Plaid Cymru [WALES ONLY]
7 Another party (SPECIFY)
8 Unsure / Don't remember

Appendix: Data Tables

Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 1
S1. Age
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
18-24	77	7	29	48	77	-	-	13	33	7	24	7	17	9	8	9	27
	7%	4%	5%	10%c	32%fg	-	-	6%	13%hjk	4%	6%	4%	8%	7%	7%	6%	10%
25-34	162	33	88	74	162	-	-	41	42	28	51	33	31	9	14	23	52
	15%	17%	15%	15%	68%fg	-	-	19%k	17%	14%	12%	17%n	14%n	7%	13%	16%n	19%
35-44	214	30	130	84	-	214	-	42	46	50	76	30	52	28	28	28	48
	20%	15%	22%	17%	-	47%eg	-	19%	19%	25%k	18%	15%	24%l	21%	25%l	20%	17%
45-54	245	49	152	93	-	245	-	38	52	54	101	49	51	30	26	35	54
	23%	25%	25%d	19%	-	53%eg	-	18%	21%	27%h	24%	25%	23%	23%	23%	25%	19%
55-64	208	49	117	91	-	-	208	41	36	32	98	49	36	27	17	23	56
	19%	25%	19%	19%	-	-	54%ef	19%	15%	16%	23%ij	25%m	16%	20%	15%	16%	20%
65+	177	32	86	91	-	-	177	41	37	27	72	32	33	29	19	22	42
	16%	16%	14%	19%c	-	-	46%ef	19%	15%	14%	17%	16%	15%	22%	17%	16%	15%
Mean	47.88	49.30	48.07	47.63	27.55	45.07e	63.84ef	47.90	45.22	47.82	49.42i	49.30	47.00	50.36m	48.19	47.45	46.46
Standard deviation	14.70	13.56	13.87	15.69	4.50	5.77	5.91	15.53	15.79	12.96	14.21	13.56	14.73	14.10	14.46	14.89	15.60
Standard error	0.45	0.96	0.57	0.72	0.29	0.27	0.30	1.06	1.01	0.92	0.69	0.96	0.99	1.23	1.37	1.26	0.93

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

Prepared by Populus

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 1
S1. Age
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
18-24	77	44	33	9	68	9	31	46	17	60
	7%	8%	6%	6%	7%	6%	7%	7%	9%	7%
25-34	162	98	64	24	138	24	73	89	43	119
	15%	18%b	12%	17%	15%	17%	16%	14%	24%i	13%
35-44	214	104	110	20	194	20	79	135	35	179
	20%	20%	20%	14%	21%	14%	18%	21%	20%	20%
45-54	245	112	133	33	212	33	108	137	32	213
	23%	21%	24%	23%	23%	23%	24%	21%	18%	24%
55-64	208	106	102	34	174	34	81	127	31	177
	19%	20%	18%	24%	19%	24%	18%	20%	17%	20%
65+	177	66	111	24	153	24	72	105	21	156
	16%	12%	20%a	17%	16%	17%	16%	16%	12%	17%
Mean	47.88	46.20	49.48a	49.09a	47.69	49.09	47.58	48.08	44.45	48.55h
Standard deviation	14.70	14.62	14.61	15.04	14.65	15.04	14.59	14.79	15.17	14.52
Standard error	0.45	0.64	0.62	1.25	0.48	1.25	0.69	0.58	1.13	0.48

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 2
S2. Gender
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Male	602	98	602	-	117	282	203	134	118	119	230	98	140	85	61	73	145
	56%	49%	100%d	-	49%	61%eg	53%	62%i	48%	60%i	55%	49%	64%lp	64%lp	54%	52%	52%
Female	481	102	-	481	122	177	182	82	128	79	192	102	80	47	51	67	134
	44%	51%	-	100%c	51%f	39%	47%f	38%	52%hj	40%	45%	51%mn	36%	36%	46%	48%mn	48%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 2
S2. Gender
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Male	602	298	304	82	520	82	216	386	92	510
	56%	56%	55%	57%	55%	57%	49%	60%f	51%	56%
Female	481	232	249	62	419	62	228	253	87	394
	44%	44%	45%	43%	45%	43%	51%g	40%	49%	44%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 3

Q1-Q6. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Summary table

	Q1. E-cigarettes	Q2. Cigarettes	Q3. Soft drinks	Q4. Chocolate	Q5. Tea	Q6. Alcohol
Base	1083	1083	1083	1083	1083	1083
Regular user	222	725	554	575	696	496
	20%	67%	51%	53%	64%	46%
Occasional user	308	214	437	462	217	437
	28%	20%	40%	43%	20%	40%
Former user	101	115	43	25	52	68
	9%	11%	4%	2%	5%	6%
Complete non-user	452	29	49	21	118	82
	42%	3%	5%	2%	11%	8%

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 4

Q1. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
E-cigarettes

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Regular user	222	44	139	83	50	99	73	49	53	37	83	44	57	40	19	26	36
	20%	22%	23%d	17%	21%	22%	19%	23%	22%	19%	20%	22%	26%	30%op	17%	19%	13%
Occasional user	308	52	159	149	92	117	99	77	71	63	97	52	63	31	30	36	96
	28%	26%	26%	31%	38%fg	25%	26%	36%k	29%	32%k	23%	26%	29%	23%	27%	26%	34%
Former user	101	15	59	42	20	48	33	14	29	17	41	15	15	10	13	20	28
	9%	8%	10%	9%	8%	10%	9%	6%	12%	9%	10%	8%	7%	8%	12%	14%lm	10%
Complete non-user	452	89	245	207	77	195	180	76	93	81	201	89	85	51	50	58	119
	42%	45%	41%	43%	32%	42%e	47%e	35%	38%	41%	48%hi	45%	39%	39%	45%	41%	43%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 4

Q1. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
E-cigarettes

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Regular user	222	222	-	99	123	99	82	140	80	142
	20%	42%b	-	69%ab	13%	69%d	18%	22%	45%i	16%
Occasional user	308	308	-	45	263	45	130	178	70	238
	28%	58%bc	-	31%b	28%	31%	29%	28%	39%i	26%
Former user	101	-	101	-	101	-	39	62	6	95
	9%	-	18%ac	-	11%e	-	9%	10%	3%	11%h
Complete non-user	452	-	452	-	452	-	193	259	23	429
	42%	-	82%ac	-	48%e	-	43%	41%	13%	47%h

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 5

Q2. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Cigarettes

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Regular user	725	140	399	326	125	327	273	130	160	137	297	140	149	84	76	95	181
	67%	70%	66%	68%	52%	71%e	71%e	60%	65%	69%	70%h	70%	68%	64%	68%	68%	65%
Occasional user	214	32	121	93	81	79	54	53	55	35	71	32	42	21	26	29	64
	20%	16%	20%	19%	34%fg	17%	14%	25%k	22%	18%	17%	16%	19%	16%	23%	21%	23%
Former user	115	24	62	53	24	42	49	27	26	20	42	24	22	24	5	14	26
	11%	12%	10%	11%	10%	9%	13%	13%	11%	10%	10%	12%o	10%	18%mo	4%	10%	9%
Complete non-user	29	4	20	9	9	11	9	6	5	6	12	4	7	3	5	2	8
	3%	2%	3%	2%	4%	2%	2%	3%	2%	3%	3%	2%	3%	2%	4%	1%	3%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 5

Q2. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Cigarettes

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Regular user	725	293	432	-	725	-	336	389	100	625
	67%	55%c	78%ac	-	77%e	-	76%g	61%	56%	69%h
Occasional user	214	93	121	-	214	-	71	143	33	181
	20%	18%c	22%c	-	23%e	-	16%	22%f	18%	20%
Former user	115	115	-	115	-	115	27	88	33	82
	11%	22%b	-	80%ab	-	80%d	6%	14%f	18%i	9%
Complete non-user	29	29	-	29	-	29	10	19	13	16
	3%	5%b	-	20%ab	-	20%d	2%	3%	7%i	2%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 6

Q3. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Soft drinks

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Regular user	554	107	313	241	168	263	123	123	130	99	202	107	123	68	59	69	128
	51%	54%	52%	50%	70%fg	57%g	32%	57%k	53%	50%	48%	54%	56%	52%	53%	49%	46%
Occasional user	437	73	240	197	65	167	205	79	100	86	171	73	87	52	38	63	124
	40%	37%	40%	41%	27%	36%e	53%ef	37%	41%	43%	41%	37%	40%	39%	34%	45%	44%
Former user	43	13	26	17	4	12	27	8	8	6	21	13	4	5	8	3	10
	4%	7%	4%	4%	2%	3%	7%ef	4%	3%	3%	5%	7%m	2%	4%	7%m	2%	4%
Complete non-user	49	7	23	26	2	17	30	6	8	7	28	7	6	7	7	5	17
	5%	4%	4%	5%	1%	4%e	8%ef	3%	3%	4%	7%h	4%	3%	5%	6%	4%	6%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 6

Q3. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Soft drinks

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Regular user	554	309	245	73	481	73	227	327	107	447
	51%	58%b	44%	51%	51%	51%	51%	51%	60%i	49%
Occasional user	437	190	247	61	376	61	183	254	63	374
	40%	36%	45%a	42%	40%	42%	41%	40%	35%	41%
Former user	43	16	27	5	38	5	16	27	5	38
	4%	3%	5%	3%	4%	3%	4%	4%	3%	4%
Complete non-user	49	15	34	5	44	5	18	31	4	45
	5%	3%	6%a	3%	5%	3%	4%	5%	2%	5%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 7

Q4. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Chocolate

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Regular user	575	105	298	277	161	253	161	117	135	107	216	105	111	68	56	78	157
	53%	53%	50%	58%c	67%fg	55%g	42%	54%	55%	54%	51%	53%	50%	52%	50%	56%	56%
Occasional user	462	88	278	184	71	192	199	86	100	86	190	88	101	56	52	57	108
	43%	44%	46%d	38%	30%	42%e	52%ef	40%	41%	43%	45%	44%	46%	42%	46%	41%	39%
Former user	25	2	15	10	5	10	10	7	7	3	7	2	5	5	1	2	10
	2%	1%	2%	2%	2%	2%	3%	3%	3%	2%	2%	1%	2%	4%	1%	1%	4%
Complete non-user	21	5	11	10	2	4	15	6	4	2	9	5	3	3	3	3	4
	2%	3%	2%	2%	1%	1%	4%ef	3%	2%	1%	2%	3%	1%	2%	3%	2%	1%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 7

Q4. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Chocolate

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Regular user	575	311	264	65	510	65	235	340	115	460
	53%	59%bc	48%	45%	54%e	45%	53%	53%	64%i	51%
Occasional user	462	198	264	69	393	69	192	270	58	404
	43%	37%	48%a	48%a	42%	48%	43%	42%	32%	45%h
Former user	25	15	10	7	18	7	10	15	2	23
	2%	3%	2%	5%b	2%	5%d	2%	2%	1%	3%
Complete non-user	21	6	15	3	18	3	7	14	4	17
	2%	1%	3%	2%	2%	2%	2%	2%	2%	2%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 8

Q5. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.

Base: All respondents

Tea

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Regular user	696	123	388	308	153	286	257	145	159	132	260	123	148	85	75	82	183
	64%	62%	64%	64%	64%	62%	67%	67%	65%	67%	62%	62%	67%	64%	67%	59%	66%
Occasional user	217	46	114	103	56	102	59	47	54	36	79	46	43	26	12	33	57
	20%	23%	19%	21%	23%g	22%g	15%	22%	22%	18%	19%	23%o	20%o	20%	11%	24%o	20%
Former user	52	11	31	21	11	23	18	7	12	13	20	11	9	5	9	10	8
	5%	6%	5%	4%	5%	5%	5%	3%	5%	7%	5%	6%	4%	4%	8%	7%	3%
Complete non-user	118	20	69	49	19	48	51	17	21	17	63	20	20	16	16	15	31
	11%	10%	11%	10%	8%	10%	13%e	8%	9%	9%	15%hij	10%	9%	12%	14%	11%	11%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 8

Q5. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.

Base: All respondents

Tea

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Regular user	696	369	327	91	605	91	296	400	126	570
	64%	70%b	59%	63%	64%	63%	67%	63%	70%	63%
Occasional user	217	102	115	31	186	31	80	137	31	186
	20%	19%	21%	22%	20%	22%	18%	21%	17%	21%
Former user	52	18	34	5	47	5	22	30	9	43
	5%	3%	6%a	3%	5%	3%	5%	5%	5%	5%
Complete non-user	118	41	77	17	101	17	46	72	13	105
	11%	8%	14%a	12%	11%	12%	10%	11%	7%	12%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 9

Q6. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Alcohol

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Regular user	496	87	319	177	116	222	158	123	119	89	164	87	110	59	46	68	126
	46%	44%	53%d	37%	49%	48%g	41%	57%jk	48%k	45%	39%	44%	50%	45%	41%	49%	45%
Occasional user	437	83	212	225	102	172	163	75	100	86	176	83	85	57	44	52	116
	40%	42%	35%	47%c	43%	37%	42%	35%	41%	43%	42%	42%	39%	43%	39%	37%	42%
Former user	68	13	35	33	10	32	26	9	13	7	39	13	10	6	8	11	20
	6%	7%	6%	7%	4%	7%	7%	4%	5%	4%	9%hj	7%	5%	5%	7%	8%	7%
Complete non-user	82	17	36	46	11	33	38	9	14	16	43	17	15	10	14	9	17
	8%	9%	6%	10%c	5%	7%	10%e	4%	6%	8%	10%hi	9%	7%	8%	13%	6%	6%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 9

Q6. Please indicate whether you are a regular user, occasional user, former user, or non-user for each of the following products.
Base: All respondents
Alcohol

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Regular user	496	265	231	61	435	61	212	284	90	406
	46%	50%b	42%	42%	46%	42%	48%	44%	50%	45%
Occasional user	437	202	235	59	378	59	171	266	68	369
	40%	38%	42%	41%	40%	41%	39%	42%	38%	41%
Former user	68	28	40	9	59	9	26	42	5	63
	6%	5%	7%	6%	6%	6%	6%	7%	3%	7%h
Complete non-user	82	35	47	15	67	15	35	47	16	66
	8%	7%	8%	10%	7%	10%	8%	7%	9%	7%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 10

Q7. Thinking about e-cigarettes in the UK. Have you recently seen, read, or heard anything about e-cigarettes?
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Yes	667	125	368	299	156	283	228	152	155	128	232	125	133	82	67	90	170
	62%	63%	61%	62%	65%	62%	59%	70%k	63%k	65%k	55%	63%	60%	62%	60%	64%	61%
No	293	50	168	125	62	118	113	46	65	48	133	50	58	34	37	34	80
	27%	25%	28%	26%	26%	26%	29%	21%	26%	24%	32%h	25%	26%	26%	33%	24%	29%
Don't know	123	25	66	57	21	58	44	18	26	22	57	25	29	16	8	16	29
	11%	13%	11%	12%	9%	13%	11%	8%	11%	11%	14%	13%	13%	12%	7%	11%	10%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 10

Q7. Thinking about e-cigarettes in the UK. Have you recently seen, read, or heard anything about e-cigarettes?
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Yes	667	359	308	99	568	99	281	386	130	537
	62%	68%b	56%	69%b	60%	69%	63%	60%	73%i	59%
No	293	117	176	30	263	30	116	177	34	259
	27%	22%	32%ac	21%	28%	21%	26%	28%	19%	29%h
Don't know	123	54	69	15	108	15	47	76	15	108
	11%	10%	12%	10%	12%	10%	11%	12%	8%	12%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 11

Q8. And where have you recently seen, read, or heard about e-cigarettes?
Base: All respondents who recall anything about e-cigarettes

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	667	125	368	299	156	283	228	152	155	128	232	125	133	82*	67*	90*	170
Broadcast media like TV and radio	334 50%	59 47%	198 54%d	136 45%	48 31%	151 53%e	135 59%e	70 46%	69 45%	65 51%	130 56%i	59 47%	71 53%	40 49%	34 51%	44 49%	86 51%
In retail shops that sell e-cigarettes	279 42%	63 50%	157 43%	122 41%	68 44%	117 41%	94 41%	56 37%	71 46%	51 40%	101 44%	63 50%mo	48 36%	41 50%m	23 34%	35 39%	69 41%
In retail shops that sell cigarettes and other tobacco products	246 37%	51 41%	127 35%	119 40%	54 35%	111 39%	81 36%	50 33%	57 37%	55 43%	84 36%	51 41%	51 38%	28 34%	24 36%	34 38%	58 34%
Your personal environment such as family, friends, and colleagues	241 36%	53 42%	131 36%	110 37%	62 40%	102 36%	77 34%	58 38%	63 41%k	52 41%k	68 29%	53 42%	48 36%	34 41%	24 36%	33 37%	49 29%
Print media	207 31%	34 27%	134 36%d	73 24%	50 32%	76 27%	81 36%f	61 40%ik	41 26%	44 34%	61 26%	34 27%	43 32%	30 37%	18 27%	33 37%	49 29%
Internet news sites	177 27%	30 24%	110 30%d	67 22%	55 35%g	80 28%g	42 18%	52 34%k	41 26%	37 29%	47 20%	30 24%	35 26%	18 22%	17 25%	25 28%	52 31%
Social media like Facebook and Twitter	140 21%	28 22%	80 22%	60 20%	57 37%fg	63 22%g	20 9%	31 20%	43 28%j	21 16%	45 19%	28 22%	32 24%	12 15%	14 21%	17 19%	37 22%
E-cigarette user groups	56 8%	13 10%	39 11%d	17 6%	19 12%g	27 10%g	10 4%	12 8%	15 10%	15 12%	14 6%	13 10%	14 11%	8 10%	5 7%	6 7%	10 6%
Other (SPECIFY)	22 3%	2 2%	14 4%	8 3%	3 2%	9 3%	10 4%	3 2%	5 3%	7 5%	7 3%	2 2%	1 1%	4 5%	4 6%m	4 4%	7 4%
Don't know	6 1%	- -	2 1%	4 1%	1 1%	4 1%	1 *	1 1%	1 1%	1 1%	3 1%	- -	1 1%	- -	2 3%	2 2%	1 1%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p
*** small base**

Prepared by Populus

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 11

Q8. And where have you recently seen, read, or heard about e-cigarettes?
Base: All respondents who recall anything about e-cigarettes

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	667	359	308	99*	568	99*	281	386	130	537
Broadcast media like TV and radio	334 50%	169 47%	165 54%	42 42%	292 51%	42 42%	136 48%	198 51%	58 45%	276 51%
In retail shops that sell e-cigarettes	279 42%	149 42%	130 42%	39 39%	240 42%	39 39%	123 44%	156 40%	56 43%	223 42%
In retail shops that sell cigarettes and other tobacco products	246 37%	127 35%	119 39%	36 36%	210 37%	36 36%	109 39%	137 35%	47 36%	199 37%
Your personal environment such as family, friends, and colleagues	241 36%	139 39%	102 33%	45 45%b	196 35%	45 45%d	108 38%	133 34%	59 45%i	182 34%
Print media	207 31%	118 33%	89 29%	32 32%	175 31%	32 32%	95 34%	112 29%	40 31%	167 31%
Internet news sites	177 27%	114 32%b	63 20%	34 34%b	143 25%	34 34%	88 31%g	89 23%	44 34%i	133 25%
Social media like Facebook and Twitter	140 21%	84 23%	56 18%	26 26%	114 20%	26 26%	64 23%	76 20%	38 29%i	102 19%
E-cigarette user groups	56 8%	42 12%b	14 5%	14 14%b	42 7%	14 14%d	26 9%	30 8%	22 17%i	34 6%
Other (SPECIFY)	22 3%	15 4%	7 2%	5 5%	17 3%	5 5%	7 2%	15 4%	2 2%	20 4%
Don't know	6 1%	4 1%	2 1%	2 2%	4 1%	2 2%	3 1%	3 1%	1 1%	5 1%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i
*** small base**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 12

Q9. And have you specifically heard about the Scottish Government's plans to regulate e-cigarettes?
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Yes	190	44	128	62	53	85	52	54	45	31	60	44	39	30	17	23	37
	18%	22%	21%d	13%	22%g	19%g	14%	25%jk	18%	16%	14%	22%	18%	23%	15%	16%	13%
No	767	125	406	361	159	324	284	130	172	144	320	125	165	86	78	102	211
	71%b	63%	67%	75%c	67%	71%	74%	60%	70%h	73%h	76%h	63%	75%ln	65%	70%	73%l	76%
Don't know	126	31	68	58	27	50	49	32	29	23	42	31	16	16	17	15	31
	12%	16%	11%	12%	11%	11%	13%	15%	12%	12%	10%	16%m	7%	12%	15%m	11%	11%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 12

Q9. And have you specifically heard about the Scottish Government's plans to regulate e-cigarettes?
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Yes	190	119	71	21	169	21	96	94	40	150
	18%	22%bc	13%	15%	18%	15%	22%g	15%	22%	17%
No	767	346	421	99	668	99	297	470	111	656
	71%	65%	76%a	69%	71%	69%	67%	74%f	62%	73%h
Don't know	126	65	61	24	102	24	51	75	28	98
	12%	12%	11%	17%	11%	17%d	11%	12%	16%	11%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 13

Q10. And are you aware of the Welsh Government's plans to regulate e-cigarettes?

Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Yes	158	23	112	46	44	63	51	41	35	26	56	23	36	18	9	41	31
	15%	12%	19%d	10%	18%	14%	13%	19%	14%	13%	13%	12%	16%o	14%	8%	29%lmno	11%
No	827	157	436	391	175	353	299	152	190	152	332	157	172	97	93	88	220
	76%	79%	72%	81%c	73%	77%	78%	70%	77%	77%	79%h	79%p	78%p	73%	83%p	63%	79%
Don't know	98	20	54	44	20	43	35	23	21	20	34	20	12	17	10	11	28
	9%	10%	9%	9%	8%	9%	9%	11%	9%	10%	8%	10%	5%	13%m	9%	8%	10%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 13

Q10. And are you aware of the Welsh Government's plans to regulate e-cigarettes?
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Yes	158	108	50	29	129	29	76	82	43	115
	15%	20%b	9%	20%b	14%	20%d	17%g	13%	24%i	13%
No	827	370	457	97	730	97	329	498	116	711
	76%	70%	83%ac	67%	78%e	67%	74%	78%	65%	79%h
Don't know	98	52	46	18	80	18	39	59	20	78
	9%	10%	8%	13%	9%	13%	9%	9%	11%	9%

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Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 14

Q11. And, regardless of whether you have recently seen, read, or heard something about e-cigarettes, how familiar would you say you are with e-cigarettes?
Base: All respondents

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
NET: Familiar		764	144	429	335	181	331	252	162	185	137	280	144	158	95	71	96	200
		71%	72%	71%	70%	76%g	72%g	65%	75%k	75%k	69%	66%	72%	72%	72%	63%	69%	72%
Very familiar	(4)	239	50	145	94	50	105	84	50	48	49	92	50	45	43	17	26	58
		22%	25%	24%	20%	21%	23%	22%	23%	20%	25%	22%	25%o	20%	33%mop	15%	19%	21%
Somewhat familiar	(3)	525	94	284	241	131	226	168	112	137	88	188	94	113	52	54	70	142
		48%	47%	47%	50%	55%g	49%	44%	52%	56%jk	44%	45%	47%	51%n	39%	48%	50%	51%
Not very familiar	(2)	223	35	120	103	46	97	80	41	47	46	89	35	42	25	32	33	56
		21%	18%	20%	21%	19%	21%	21%	19%	19%	23%	21%	18%	19%	19%	29%l	24%	20%
Not at all familiar	(1)	83	19	46	37	5	28	50	10	13	15	44	19	18	11	7	10	18
		8%	10%	8%	8%	2%	6%e	13%ef	5%	5%	8%	10%hi	10%	8%	8%	6%	7%	6%
NET: Not familiar		306	54	166	140	51	125	130	51	60	61	133	54	60	36	39	43	74
		28%	27%	28%	29%	21%	27%	34%ef	24%	24%	31%	32%h	27%	27%	27%	35%	31%	27%
Don't know		13	2	7	6	7	3	3	3	1	-	9	2	2	1	2	1	5
		1%	1%	1%	1%	3%fg	1%	1%	1%	*	-	2%j	1%	1%	1%	2%	1%	2%
Mean		2.86	2.88	2.89	2.83	2.97g	2.89g	2.75	2.95k	2.90	2.86	2.79	2.88	2.85	2.97o	2.74	2.81	2.88
Standard deviation		0.85	0.90	0.86	0.84	0.71	0.82	0.94	0.78	0.77	0.88	0.91	0.90	0.84	0.93	0.80	0.82	0.82
Standard error		0.03	0.06	0.04	0.04	0.05	0.04	0.05	0.05	0.05	0.06	0.04	0.06	0.06	0.08	0.08	0.07	0.05

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 14

Q11. And, regardless of whether you have recently seen, read, or heard something about e-cigarettes, how familiar would you say you are with e-cigarettes?
Base: All respondents

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
NET: Familiar		764	474	290	131	633	131	316	448	147	617
		71%	89%b	52%	91%b	67%	91%d	71%	70%	82%i	68%
Very familiar	(4)	239	206	33	82	157	82	95	144	72	167
		22%	39%b	6%	57%ab	17%	57%d	21%	23%	40%i	18%
Somewhat familiar	(3)	525	268	257	49	476	49	221	304	75	450
		48%	51%c	46%c	34%	51%e	34%	50%	48%	42%	50%
Not very familiar	(2)	223	45	178	11	212	11	92	131	24	199
		21%	8%	32%ac	8%	23%e	8%	21%	21%	13%	22%h
Not at all familiar	(1)	83	4	79	1	82	1	33	50	4	79
		8%	1%	14%ac	1%	9%e	1%	7%	8%	2%	9%h
NET: Not familiar		306	49	257	12	294	12	125	181	28	278
		28%	9%	46%ac	8%	31%e	8%	28%	28%	16%	31%h
Don't know		13	7	6	1	12	1	3	10	4	9
		1%	1%	1%	1%	1%	1%	1%	2%	2%	1%
Mean		2.86	3.29b	2.45	3.48ab	2.76	3.48d	2.86	2.86	3.23i	2.79
Standard deviation		0.85	0.65	0.81	0.67	0.83	0.67	0.84	0.86	0.77	0.85
Standard error		0.03	0.03	0.03	0.06	0.03	0.06	0.04	0.03	0.06	0.03

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 15

Q12-Q23. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.
Base: All respondents/ current e-cigarette and former cigarette smokers/ cigarette and not e-cigarette smokers
Summary table

		Q12. E-cigarettes represent a positive alternative to today's conventional cigarettes	Q13. Information about e-cigarettes and their potential to reduce the risk of smoking as compared to conventional cigarettes should be widely...	Q14. As e-cigarettes are new products, it would be wrong for the Government to restrict the advertisement of these products in places like...	Q15. The Government should do all it can to encourage adult smokers to switch to less harmful alternatives to cigarettes, including lower...	Q16. The Government should enact appropriate regulations to ensure e-cigarettes are not used by minors under 18	Q17. For me, switching to e-cigarettes has been a positive change	Q18. When making the switch to e-cigarettes, it was important for me to have access to information about these products and to see advertisements...	Q19. One of the reasons I was interested in switching to e-cigarettes was because their use was allowed in some indoor public places	Q20. As an adult smoker, it is important for me to see advertisements for e-cigarettes in places like shops, billboards, leaflets and brochures...	Q21. If the government passed regulations that would ban e-cigarette advertising on billboards, posters, leaflets, and in retail shops, I would...	Q22. Regulations that would ban the use of e-cigarettes in indoor public places and force e-cigarettes to be used only in zones designated to...	Q23. I would be more likely to switch to e-cigarettes if the Government provided clarity on the health effects of e-cigarettes and the role...
Base		1083	1083	1083	1083	1083	115	115	115	452	452	452	452
NET: Agree		820 76%	971 90%	801 74%	848 78%	891 82%	106 92%	95 83%	63 55%	219 48%	165 37%	238 53%	275 61%
Strongly agree	(4)	426 39%	589 54%	391 36%	457 42%	540 50%	86 75%	43 37%	23 20%	78 17%	58 13%	125 28%	106 23%
Somewhat agree	(3)	394 36%	382 35%	410 38%	391 36%	351 32%	20 17%	52 45%	40 35%	141 31%	107 24%	113 25%	169 37%
Somewhat disagree	(2)	96 9%	35 3%	128 12%	82 8%	85 8%	2 2%	13 11%	28 24%	108 24%	108 24%	84 19%	59 13%
Strongly disagree	(1)	45 4%	14 1%	43 4%	38 4%	22 2%	- -	2 2%	17 15%	65 14%	67 15%	59 13%	54 12%
NET: Disagree		141 13%	49 5%	171 16%	120 11%	107 10%	2 2%	15 13%	45 39%	173 38%	175 39%	143 32%	113 25%
Don't know		122 11%	63 6%	111 10%	115 11%	85 8%	7 6%	5 4%	7 6%	60 13%	112 25%	71 16%	64 14%
Mean		3.25	3.52	3.18	3.31	3.41	3.78	3.24	2.64	2.59	2.46	2.80	2.84
Standard deviation		0.82	0.63	0.82	0.79	0.74	0.46	0.73	0.99	0.99	0.99	1.06	0.98
Standard error		0.03	0.02	0.03	0.03	0.02	0.04	0.07	0.10	0.05	0.05	0.05	0.05

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 16

Q12. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.
Base: All respondents
E-cigarettes represent a positive alternative to today's conventional cigarettes

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
NET: Agree		820	155	461	359	168	335	317	167	194	149	310	155	168	107	77	105	208
		76%	78%	77%	75%	70%	73%	82%ef	77%	79%	75%	73%	78%	76%	81%o	69%	75%	75%
Strongly agree	(4)	426	90	247	179	86	166	174	93	101	76	156	90	83	61	36	49	107
		39%	45%	41%	37%	36%	36%	45%ef	43%	41%	38%	37%	45%o	38%	46%o	32%	35%	38%
Somewhat agree	(3)	394	65	214	180	82	169	143	74	93	73	154	65	85	46	41	56	101
		36%	33%	36%	37%	34%	37%	37%	34%	38%	37%	36%	33%	39%	35%	37%	40%	36%
Somewhat disagree	(2)	96	11	47	49	29	44	23	17	24	22	33	11	23	11	11	15	25
		9%	6%	8%	10%	12%g	10%	6%	8%	10%	11%	8%	6%	10%	8%	10%	11%	9%
Strongly disagree	(1)	45	10	27	18	8	25	12	12	5	8	19	10	7	2	4	7	15
		4%	5%	4%	4%	3%	5%	3%	6%i	2%	4%	5%	5%	3%	2%	4%	5%	5%
NET: Disagree		141	21	74	67	37	69	35	29	29	30	52	21	30	13	15	22	40
		13%	11%	12%	14%	15%g	15%g	9%	13%	12%	15%	12%	11%	14%	10%	13%	16%	14%
Don't know		122	24	67	55	34	55	33	20	23	19	60	24	22	12	20	13	31
		11%	12%	11%	11%	14%g	12%	9%	9%	9%	10%	14%	12%	10%	9%	18%mnp	9%	11%
Mean		3.25	3.34	3.27	3.22	3.20	3.18	3.36ef	3.27	3.30	3.21	3.23	3.34	3.23	3.38p	3.18	3.16	3.21
Standard deviation		0.82	0.83	0.82	0.81	0.82	0.86	0.75	0.86	0.75	0.83	0.82	0.83	0.79	0.72	0.81	0.84	0.86
Standard error		0.03	0.06	0.04	0.04	0.06	0.04	0.04	0.06	0.05	0.06	0.04	0.06	0.06	0.07	0.08	0.07	0.05

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 16

Q12. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

E-cigarettes represent a positive alternative to today's conventional cigarettes

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
NET: Agree		820	471	349	134	686	134	340	480	154	666
		76%	89%b	63%	93%b	73%	93%d	77%	75%	86%i	74%
Strongly agree	(4)	426	311	115	105	321	105	167	259	102	324
		39%	59%b	21%	73%ab	34%	73%d	38%	41%	57%i	36%
Somewhat agree	(3)	394	160	234	29	365	29	173	221	52	342
		36%	30%c	42%ac	20%	39%e	20%	39%	35%	29%	38%h
Somewhat disagree	(2)	96	25	71	3	93	3	47	49	9	87
		9%	5%	13%ac	2%	10%e	2%	11%	8%	5%	10%h
Strongly disagree	(1)	45	10	35	2	43	2	18	27	4	41
		4%	2%	6%ac	1%	5%	1%	4%	4%	2%	5%
NET: Disagree		141	35	106	5	136	5	65	76	13	128
		13%	7%	19%ac	3%	14%e	3%	15%	12%	7%	14%h
Don't know		122	24	98	5	117	5	39	83	12	110
		11%	5%	18%ac	3%	12%e	3%	9%	13%f	7%	12%h
Mean		3.25	3.53b	2.94	3.71ab	3.17	3.71d	3.21	3.28	3.51i	3.20
Standard deviation		0.82	0.68	0.85	0.58	0.83	0.58	0.82	0.82	0.71	0.83
Standard error		0.03	0.03	0.04	0.05	0.03	0.05	0.04	0.03	0.05	0.03

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 17

Q13. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

Information about e-cigarettes and their potential to reduce the risk of smoking as compared to conventional cigarettes should be widely available to adult smokers provided reliable scientific evidence is available

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
NET: Agree		971	188	537	434	202	406	363	195	219	178	379	188	191	122	99	131	240
		90%	94%	89%	90%	85%	88%	94%ef	90%	89%	90%	90%	94%m	87%	92%	88%	94%m	86%
Strongly agree	(4)	589	125	327	262	102	242	245	131	116	112	230	125	108	77	59	79	141
		54%	63%a	54%	54%	43%	53%e	64%ef	61%i	47%	57%i	55%	63%m	49%	58%	53%	56%	51%
Somewhat agree	(3)	382	63	210	172	100	164	118	64	103	66	149	63	83	45	40	52	99
		35%	32%	35%	36%	42%g	36%	31%	30%	42%h	33%	35%	32%	38%	34%	36%	37%	35%
Somewhat disagree	(2)	35	5	17	18	14	16	5	10	12	3	10	5	13	1	5	1	10
		3%	3%	3%	4%	6%g	3%g	1%	5%	5%	2%	2%	3%	6%np	1%	4%	1%	4%
Strongly disagree	(1)	14	-	9	5	3	8	3	1	3	3	6	-	5	2	1	2	4
		1%	-	1%	1%	1%	2%	1%	*	1%	2%	1%	-	2%l	2%	1%	1%	1%
NET: Disagree		49	5	26	23	17	24	8	11	15	6	16	5	18	3	6	3	14
		5%	3%	4%	5%	7%g	5%g	2%	5%	6%	3%	4%	3%	8%lnp	2%	5%	2%	5%
Don't know		63	7	39	24	20	29	14	10	12	14	27	7	11	7	7	6	25
		6%	4%	6%	5%	8%g	6%	4%	5%	5%	7%	6%	4%	5%	5%	6%	4%	9%
Mean		3.52	3.62a	3.52	3.51	3.37	3.49e	3.63ef	3.58i	3.42	3.56i	3.53i	3.62m	3.41	3.58m	3.50	3.55	3.48
Standard deviation		0.63	0.54	0.64	0.63	0.67	0.66	0.56	0.61	0.65	0.62	0.63	0.54	0.72	0.60	0.64	0.60	0.65
Standard error		0.02	0.04	0.03	0.03	0.05	0.03	0.03	0.04	0.04	0.05	0.03	0.04	0.05	0.05	0.06	0.05	0.04

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 17

Q13. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

Information about e-cigarettes and their potential to reduce the risk of smoking as compared to conventional cigarettes should be widely available to adult smokers provided reliable scientific evidence is available

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
NET: Agree		971	495	476	138	833	138	405	566	164	807
		90%	93%b	86%	96%b	89%	96%d	91%	89%	92%	89%
Strongly agree	(4)	589	343	246	105	484	105	253	336	113	476
		54%	65%b	44%	73%b	52%	73%d	57%	53%	63%i	53%
Somewhat agree	(3)	382	152	230	33	349	33	152	230	51	331
		35%	29%	42%ac	23%	37%e	23%	34%	36%	28%	37%h
Somewhat disagree	(2)	35	13	22	1	34	1	16	19	5	30
		3%	2%	4%c	1%	4%	1%	4%	3%	3%	3%
Strongly disagree	(1)	14	6	8	1	13	1	8	6	2	12
		1%	1%	1%	1%	1%	1%	2%	1%	1%	1%
NET: Disagree		49	19	30	2	47	2	24	25	7	42
		5%	4%	5%c	1%	5%	1%	5%	4%	4%	5%
Don't know		63	16	47	4	59	4	15	48	8	55
		6%	3%	8%ac	3%	6%	3%	3%	8%f	4%	6%
Mean		3.52	3.62b	3.41	3.73ab	3.48	3.73d	3.52	3.52	3.61i	3.50
Standard deviation		0.63	0.60	0.65	0.51	0.65	0.51	0.66	0.61	0.61	0.64
Standard error		0.02	0.03	0.03	0.04	0.02	0.04	0.03	0.03	0.05	0.02

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 18

Q14. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

As e-cigarettes are new products, it would be wrong for the Government to restrict the advertisement of these products in places like retail shops, leaflets, posters, and brochures. Adult smokers need to be aware of these products in order to make informed decisions on their use

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
NET: Agree		801	156	444	357	155	333	313	164	183	141	313	156	162	105	81	101	196
		74%	78%	74%	74%	65%	73%e	81%ef	76%	74%	71%	74%	78%	74%	80%	72%	72%	70%
Strongly agree	(4)	391	75	223	168	65	157	169	77	81	76	157	75	80	54	42	46	94
		36%	38%	37%	35%	27%	34%	44%ef	36%	33%	38%	37%	38%	36%	41%	38%	33%	34%
Somewhat agree	(3)	410	81	221	189	90	176	144	87	102	65	156	81	82	51	39	55	102
		38%	41%	37%	39%	38%	38%	37%	40%	41%	33%	37%	41%	37%	39%	35%	39%	37%
Somewhat disagree	(2)	128	17	73	55	29	63	36	30	30	26	42	17	23	18	16	21	33
		12%	9%	12%	11%	12%	14%g	9%	14%	12%	13%	10%	9%	10%	14%	14%	15%	12%
Strongly disagree	(1)	43	12	26	17	15	18	10	8	6	6	22	12	10	2	2	7	10
		4%	6%	4%	4%	6%g	4%	3%	4%	2%	3%	5%	6%n	5%	2%	2%	5%	4%
NET: Disagree		171	29	99	72	44	81	46	38	36	32	64	29	33	20	18	28	43
		16%	15%	16%	15%	18%g	18%g	12%	18%	15%	16%	15%	15%	15%	15%	16%	20%	15%
Don't know		111	15	59	52	40	45	26	14	27	25	45	15	25	7	13	11	40
		10%	8%	10%	11%	17%fg	10%	7%	6%	11%	13%h	11%	8%	11%	5%	12%	8%	14%
Mean		3.18	3.18	3.18	3.18	3.03	3.14	3.31ef	3.15	3.18	3.22	3.19	3.18	3.19	3.26	3.22	3.09	3.17
Standard deviation		0.82	0.85	0.84	0.80	0.88	0.83	0.76	0.82	0.77	0.83	0.85	0.85	0.84	0.76	0.79	0.86	0.82
Standard error		0.03	0.06	0.04	0.04	0.06	0.04	0.04	0.06	0.05	0.06	0.04	0.06	0.06	0.07	0.08	0.08	0.05

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 18

Q14. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

As e-cigarettes are new products, it would be wrong for the Government to restrict the advertisement of these products in places like retail shops, leaflets, posters, and brochures. Adult smokers need to be aware of these products in order to make informed decisions on their use

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
NET: Agree		801	437	364	124	677	124	334	467	144	657
		74%	82%b	66%	86%b	72%	86%d	75%	73%	80%i	73%
Strongly agree	(4)	391	252	139	86	305	86	162	229	89	302
		36%	48%b	25%	60%ab	32%	60%d	36%	36%	50%i	33%
Somewhat agree	(3)	410	185	225	38	372	38	172	238	55	355
		38%	35%	41%c	26%	40%e	26%	39%	37%	31%	39%h
Somewhat disagree	(2)	128	45	83	12	116	12	53	75	13	115
		12%	8%	15%ac	8%	12%	8%	12%	12%	7%	13%h
Strongly disagree	(1)	43	14	29	2	41	2	16	27	7	36
		4%	3%	5%ac	1%	4%	1%	4%	4%	4%	4%
NET: Disagree		171	59	112	14	157	14	69	102	20	151
		16%	11%	20%ac	10%	17%e	10%	16%	16%	11%	17%
Don't know		111	34	77	6	105	6	41	70	15	96
		10%	6%	14%ac	4%	11%e	4%	9%	11%	8%	11%
Mean		3.18	3.36b	3.00	3.51ab	3.13	3.51d	3.19	3.18	3.38i	3.14
Standard deviation		0.82	0.76	0.84	0.72	0.83	0.72	0.81	0.83	0.81	0.82
Standard error		0.03	0.03	0.04	0.06	0.03	0.06	0.04	0.03	0.06	0.03

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 19

Q15. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

The Government should do all it can to encourage adult smokers to switch to less harmful alternatives to cigarettes, including lower taxes and less regulation compared to normal cigarettes

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
NET: Agree		848	170	461	387	178	344	326	176	206	150	316	170	166	105	86	109	212
		78%	85%a	77%	80%	74%	75%	85%ef	81%	84%jk	76%	75%	85%m	75%	80%	77%	78%	76%
Strongly agree	(4)	457	99	248	209	88	186	183	103	100	85	169	99	92	66	41	56	103
		42%	50%	41%	43%	37%	41%	48%ef	48%	41%	43%	40%	50%o	42%	50%o	37%	40%	37%
Somewhat agree	(3)	391	71	213	178	90	158	143	73	106	65	147	71	74	39	45	53	109
		36%	36%	35%	37%	38%	34%	37%	34%	43%hjk	33%	35%	36%	34%	30%	40%	38%	39%
Somewhat disagree	(2)	82	9	49	33	25	40	17	16	19	14	33	9	20	13	5	13	22
		8%	5%	8%	7%	10%g	9%g	4%	7%	8%	7%	8%	5%	9%	10%	4%	9%	8%
Strongly disagree	(1)	38	3	30	8	7	20	11	5	4	9	19	3	8	2	3	9	13
		4%	2%	5%d	2%	3%	4%	3%	2%	2%	5%	5%i	2%	4%	2%	3%	6%ln	5%
NET: Disagree		120	12	79	41	32	60	28	21	23	23	52	12	28	15	8	22	35
		11%b	6%	13%d	9%	13%g	13%g	7%	10%	9%	12%	12%	6%	13%l	11%	7%	16%lo	13%
Don't know		115	18	62	53	29	55	31	19	17	25	54	18	26	12	18	9	32
		11%	9%	10%	11%	12%	12%	8%	9%	7%	13%i	13%i	9%	12%	9%	16%p	6%	11%
Mean		3.31	3.46a	3.26	3.37c	3.23	3.26	3.41ef	3.39	3.32	3.31	3.27	3.46mp	3.29	3.41p	3.32	3.19	3.22
Standard deviation		0.79	0.67	0.84	0.71	0.79	0.83	0.72	0.75	0.70	0.83	0.83	0.67	0.81	0.75	0.72	0.88	0.82
Standard error		0.03	0.05	0.04	0.03	0.05	0.04	0.04	0.05	0.05	0.06	0.04	0.05	0.06	0.07	0.07	0.08	0.05

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 19

Q15. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

The Government should do all it can to encourage adult smokers to switch to less harmful alternatives to cigarettes, including lower taxes and less regulation compared to normal cigarettes

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
NET: Agree		848	475	373	134	714	134	347	501	147	701
		78%	90%b	67%	93%b	76%	93%d	78%	78%	82%	78%
Strongly agree	(4)	457	300	157	98	359	98	186	271	96	361
		42%	57%b	28%	68%ab	38%	68%d	42%	42%	54%i	40%
Somewhat agree	(3)	391	175	216	36	355	36	161	230	51	340
		36%	33%	39%ac	25%	38%e	25%	36%	36%	28%	38%h
Somewhat disagree	(2)	82	20	62	4	78	4	29	53	10	72
		8%	4%	11%ac	3%	8%e	3%	7%	8%	6%	8%
Strongly disagree	(1)	38	7	31	-	38	-	21	17	7	31
		4%	1%	6%ac	-	4%e	-	5%	3%	4%	3%
NET: Disagree		120	27	93	4	116	4	50	70	17	103
		11%	5%	17%ac	3%	12%e	3%	11%	11%	9%	11%
Don't know		115	28	87	6	109	6	47	68	15	100
		11%	5%	16%ac	4%	12%e	4%	11%	11%	8%	11%
Mean		3.31	3.53b	3.07	3.68ab	3.25	3.68d	3.29	3.32	3.44i	3.28
Standard deviation		0.79	0.64	0.86	0.53	0.81	0.53	0.82	0.76	0.79	0.78
Standard error		0.03	0.03	0.04	0.04	0.03	0.04	0.04	0.03	0.06	0.03

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 20

Q16. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

The Government should enact appropriate regulations to ensure e-cigarettes are not used by minors under 18

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
NET: Agree		891	168	492	399	192	383	316	174	201	170	346	168	184	107	94	112	226
		82%	84%	82%	83%	80%	83%	82%	81%	82%	86%	82%	84%	84%	81%	84%	80%	81%
Strongly agree	(4)	540	99	298	242	118	229	193	105	110	109	216	99	114	68	44	68	147
		50%	50%	50%	50%	49%	50%	50%	49%	45%	55%i	51%	50%	52%o	52%	39%	49%	53%
Somewhat agree	(3)	351	69	194	157	74	154	123	69	91	61	130	69	70	39	50	44	79
		32%	35%	32%	33%	31%	34%	32%	32%	37%	31%	31%	35%	32%	30%	45%mnp	31%	28%
Somewhat disagree	(2)	85	17	45	40	19	36	30	25	21	11	28	17	13	16	6	13	20
		8%	9%	7%	8%	8%	8%	8%	12%jk	9%	6%	7%	9%	6%	12%m	5%	9%	7%
Strongly disagree	(1)	22	4	15	7	4	5	13	2	3	6	10	4	5	3	-	2	8
		2%	2%	2%	1%	2%	1%	3%f	1%	1%	3%	2%	2%	2%	2%	-	1%	3%
NET: Disagree		107	21	60	47	23	41	43	27	24	17	38	21	18	19	6	15	28
		10%	11%	10%	10%	10%	9%	11%	13%	10%	9%	9%	11%	8%	14%o	5%	11%	10%
Don't know		85	11	50	35	24	35	26	15	21	11	38	11	18	6	12	13	25
		8%	6%	8%	7%	10%	8%	7%	7%	9%	6%	9%	6%	8%	5%	11%	9%	9%
Mean		3.41	3.39	3.40	3.42	3.42	3.43	3.38	3.38	3.37	3.46	3.44	3.39	3.45	3.37	3.38	3.40	3.44
Standard deviation		0.74	0.74	0.75	0.72	0.73	0.70	0.79	0.74	0.71	0.75	0.74	0.74	0.73	0.80	0.60	0.74	0.77
Standard error		0.02	0.05	0.03	0.03	0.05	0.03	0.04	0.05	0.05	0.05	0.04	0.05	0.05	0.07	0.06	0.07	0.05

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 20

Q16. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All respondents

The Government should enact appropriate regulations to ensure e-cigarettes are not used by minors under 18

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
NET: Agree		891	445	446	126	765	126	367	524	151	740
		82%	84%	81%	88%	81%	88%	83%	82%	84%	82%
Strongly agree	(4)	540	276	264	83	457	83	226	314	96	444
		50%	52%	48%	58%b	49%	58%d	51%	49%	54%	49%
Somewhat agree	(3)	351	169	182	43	308	43	141	210	55	296
		32%	32%	33%	30%	33%	30%	32%	33%	31%	33%
Somewhat disagree	(2)	85	47	38	8	77	8	38	47	15	70
		8%	9%	7%	6%	8%	6%	9%	7%	8%	8%
Strongly disagree	(1)	22	11	11	1	21	1	11	11	4	18
		2%	2%	2%	1%	2%	1%	2%	2%	2%	2%
NET: Disagree		107	58	49	9	98	9	49	58	19	88
		10%	11%	9%	6%	10%	6%	11%	9%	11%	10%
Don't know		85	27	58	9	76	9	28	57	9	76
		8%	5%	10%a	6%	8%	6%	6%	9%	5%	8%
Mean		3.41	3.41	3.41	3.54	3.39	3.54d	3.40	3.42	3.43	3.41
Standard deviation		0.74	0.75	0.73	0.64	0.75	0.64	0.76	0.72	0.75	0.74
Standard error		0.02	0.03	0.03	0.06	0.03	0.06	0.04	0.03	0.06	0.03

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 21

Q17. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.
Base: All current e-cigarette and former cigarette smokers
For me, switching to e-cigarettes has been a positive change

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		115	24**	62*	53*	24**	42*	49*	27**	26**	20**	42*	24**	22**	24**	5**	14**	26*
NET: Agree		106	21	58	48	20	38	48	23	25	19	39	21	22	24	5	12	22
		92%	88%	94%	91%	83%	90%	98%	85%	96%	95%	93%	88%	100%	100%	100%	86%	85%
Strongly agree	(4)	86	19	44	42	11	35	40	16	20	17	33	19	16	21	5	10	15
		75%	79%	71%	79%	46%	83%	82%	59%	77%	85%	79%	79%	73%	88%	100%	71%	58%
Somewhat agree	(3)	20	2	14	6	9	3	8	7	5	2	6	2	6	3	-	2	7
		17%	8%	23%	11%	38%	7%	16%	26%	19%	10%	14%	8%	27%	13%	-	14%	27%
Somewhat disagree	(2)	2	-	-	2	1	1	-	1	1	-	-	-	-	-	-	1	1
		2%	-	-	4%	4%	2%	-	4%	4%	-	-	-	-	-	-	7%	4%
Strongly disagree	(1)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NET: Disagree		2	-	-	2	1	1	-	1	1	-	-	-	-	-	-	1	1
		2%	-	-	4%	4%	2%	-	4%	4%	-	-	-	-	-	-	7%	4%
Don't know		7	3	4	3	3	3	1	3	-	1	3	3	-	-	-	1	3
		6%	13%	6%	6%	13%	7%	2%	11%	-	5%	7%	13%	-	-	-	7%	12%
Mean		3.78	3.90	3.76	3.80	3.48	3.87	3.83	3.63	3.73	3.89	3.85	3.90	3.73	3.88	4.00	3.69	3.61
Standard deviation		0.46	0.30	0.43	0.49	0.60	0.41	0.38	0.58	0.53	0.32	0.37	0.30	0.46	0.34	0.00	0.63	0.58
Standard error		0.04	0.07	0.06	0.07	0.13	0.07	0.05	0.12	0.10	0.07	0.06	0.07	0.10	0.07	0.00	0.17	0.12

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p
*** small base; ** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 21

Q17. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.
Base: All current e-cigarette and former cigarette smokers
For me, switching to e-cigarettes has been a positive change

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		115	115	-**	115	-**	115	27**	88*	33*	82*
NET: Agree		106	106	-	106	-	106	26	80	32	74
		92%	92%	-	92%	-	92%	96%	91%	97%	90%
Strongly agree	(4)	86	86	-	86	-	86	21	65	27	59
		75%	75%	-	75%	-	75%	78%	74%	82%	72%
Somewhat agree	(3)	20	20	-	20	-	20	5	15	5	15
		17%	17%	-	17%	-	17%	19%	17%	15%	18%
Somewhat disagree	(2)	2	2	-	2	-	2	-	2	-	2
		2%	2%	-	2%	-	2%	-	2%	-	2%
Strongly disagree	(1)	-	-	-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-	-	-
NET: Disagree		2	2	-	2	-	2	-	2	-	2
		2%	2%	-	2%	-	2%	-	2%	-	2%
Don't know		7	7	-	7	-	7	1	6	1	6
		6%	6%	-	6%	-	6%	4%	7%	3%	7%
Mean		3.78	3.78	-	3.78	-	3.78	3.81	3.77	3.84	3.75
Standard deviation		0.46	0.46	-	0.46	-	0.46	0.40	0.48	0.37	0.49
Standard error		0.04	0.04	-	0.04	-	0.04	0.08	0.05	0.07	0.06

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i
*** small base; ** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 22

Q18. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All current e-cigarette and former cigarette smokers

When making the switch to e-cigarettes, it was important for me to have access to information about these products and to see advertisements in shops, on billboards, and in brochures. I could only make an informed decision regarding the use of e-cigarettes, once I became familiar with the products

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		115	24**	62*	53*	24**	42*	49*	27**	26**	20**	42*	24**	22**	24**	5**	14**	26*
NET: Agree		95	21	50	45	20	32	43	23	22	17	33	21	17	23	4	9	21
		83%	88%	81%	85%	83%	76%	88%	85%	85%	85%	79%	88%	77%	96%	80%	64%	81%
Strongly agree	(4)	43	11	21	22	6	10	27	8	11	6	18	11	5	16	2	2	7
		37%	46%	34%	42%	25%	24%	55%f	30%	42%	30%	43%	46%	23%	67%	40%	14%	27%
Somewhat agree	(3)	52	10	29	23	14	22	16	15	11	11	15	10	12	7	2	7	14
		45%	42%	47%	43%	58%	52%	33%	56%	42%	55%	36%	42%	55%	29%	40%	50%	54%
Somewhat disagree	(2)	13	1	9	4	1	7	5	3	4	2	4	1	4	1	1	4	2
		11%	4%	15%	8%	4%	17%	10%	11%	15%	10%	10%	4%	18%	4%	20%	29%	8%
Strongly disagree	(1)	2	-	1	1	1	1	-	-	-	-	2	-	1	-	-	-	1
		2%	-	2%	2%	4%	2%	-	-	-	-	5%	-	5%	-	-	-	4%
NET: Disagree		15	1	10	5	2	8	5	3	4	2	6	1	5	1	1	4	3
		13%	4%	16%	9%	8%	19%	10%	11%	15%	10%	14%	4%	23%	4%	20%	29%	12%
Don't know		5	2	2	3	2	2	1	1	-	1	3	2	-	-	-	1	2
		4%	8%	3%	6%	8%	5%	2%	4%	-	5%	7%	8%	-	-	-	7%	8%
Mean		3.24	3.45	3.17	3.32	3.14	3.03	3.46f	3.19	3.27	3.21	3.26	3.45	2.95	3.63	3.20	2.85	3.13
Standard deviation		0.73	0.60	0.74	0.71	0.71	0.73	0.68	0.63	0.72	0.63	0.85	0.60	0.79	0.58	0.84	0.69	0.74
Standard error		0.07	0.13	0.10	0.10	0.15	0.12	0.10	0.12	0.14	0.14	0.14	0.13	0.17	0.12	0.37	0.19	0.15

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

*** small base; ** very small base (under 30) ineligible for sig testing**

Prepared by Populus

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 22

Q18. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All current e-cigarette and former cigarette smokers

When making the switch to e-cigarettes, it was important for me to have access to information about these products and to see advertisements in shops, on billboards, and in brochures. I could only make an informed decision regarding the use of e-cigarettes, once I became familiar with the products

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		115	115	-**	115	-**	115	27**	88*	33*	82*
NET: Agree		95	95	-	95	-	95	24	71	26	69
		83%	83%	-	83%	-	83%	89%	81%	79%	84%
Strongly agree	(4)	43	43	-	43	-	43	9	34	13	30
		37%	37%	-	37%	-	37%	33%	39%	39%	37%
Somewhat agree	(3)	52	52	-	52	-	52	15	37	13	39
		45%	45%	-	45%	-	45%	56%	42%	39%	48%
Somewhat disagree	(2)	13	13	-	13	-	13	1	12	4	9
		11%	11%	-	11%	-	11%	4%	14%	12%	11%
Strongly disagree	(1)	2	2	-	2	-	2	-	2	1	1
		2%	2%	-	2%	-	2%	-	2%	3%	1%
NET: Disagree		15	15	-	15	-	15	1	14	5	10
		13%	13%	-	13%	-	13%	4%	16%	15%	12%
Don't know		5	5	-	5	-	5	2	3	2	3
		4%	4%	-	4%	-	4%	7%	3%	6%	4%
Mean		3.24	3.24	-	3.24	-	3.24	3.32	3.21	3.23	3.24
Standard deviation		0.73	0.73	-	0.73	-	0.73	0.56	0.77	0.80	0.70
Standard error		0.07	0.07	-	0.07	-	0.07	0.11	0.08	0.14	0.08

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

*** small base; ** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 23

Q19. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All current e-cigarette and former cigarette smokers

One of the reasons I was interested in switching to e-cigarettes was because their use was allowed in some indoor public places

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		115	24**	62*	53*	24**	42*	49*	27**	26**	20**	42*	24**	22**	24**	5**	14**	26*
NET: Agree		63	14	28	35	17	20	26	15	13	11	24	14	12	15	3	7	12
		55%	58%	45%	66%c	71%	48%	53%	56%	50%	55%	57%	58%	55%	63%	60%	50%	46%
Strongly agree	(4)	23	8	7	16	4	6	13	2	5	5	11	8	2	6	1	2	4
		20%	33%	11%	30%c	17%	14%	27%	7%	19%	25%	26%	33%	9%	25%	20%	14%	15%
Somewhat agree	(3)	40	6	21	19	13	14	13	13	8	6	13	6	10	9	2	5	8
		35%	25%	34%	36%	54%	33%	27%	48%	31%	30%	31%	25%	45%	38%	40%	36%	31%
Somewhat disagree	(2)	28	5	21	7	-	12	16	8	7	5	8	5	7	6	1	2	7
		24%	21%	34%d	13%	-	29%	33%	30%	27%	25%	19%	21%	32%	25%	20%	14%	27%
Strongly disagree	(1)	17	4	9	8	4	7	6	2	3	4	8	4	3	3	1	3	3
		15%	17%	15%	15%	17%	17%	12%	7%	12%	20%	19%	17%	14%	13%	20%	21%	12%
NET: Disagree		45	9	30	15	4	19	22	10	10	9	16	9	10	9	2	5	10
		39%	38%	48%d	28%	17%	45%	45%	37%	38%	45%	38%	38%	45%	38%	40%	36%	38%
Don't know		7	1	4	3	3	3	1	2	3	-	2	1	-	-	-	2	4
		6%	4%	6%	6%	13%	7%	2%	7%	12%	-	5%	4%	-	-	-	14%	15%
Mean		2.64	2.78	2.45	2.86c	2.81	2.49	2.69	2.60	2.65	2.60	2.67	2.78	2.50	2.75	2.60	2.50	2.59
Standard deviation		0.99	1.13	0.90	1.05	0.98	0.97	1.01	0.76	0.98	1.10	1.10	1.13	0.86	0.99	1.14	1.09	0.96
Standard error		0.10	0.23	0.12	0.15	0.21	0.16	0.15	0.15	0.20	0.24	0.17	0.23	0.18	0.20	0.51	0.31	0.20

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

*** small base; ** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 23

Q19. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All current e-cigarette and former cigarette smokers

One of the reasons I was interested in switching to e-cigarettes was because their use was allowed in some indoor public places

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		115	115	-**	115	-**	115	27**	88*	33*	82*
NET: Agree		63	63	-	63	-	63	19	44	20	43
		55%	55%	-	55%	-	55%	70%	50%	61%	52%
Strongly agree	(4)	23	23	-	23	-	23	5	18	7	16
		20%	20%	-	20%	-	20%	19%	20%	21%	20%
Somewhat agree	(3)	40	40	-	40	-	40	14	26	13	27
		35%	35%	-	35%	-	35%	52%	30%	39%	33%
Somewhat disagree	(2)	28	28	-	28	-	28	4	24	6	22
		24%	24%	-	24%	-	24%	15%	27%	18%	27%
Strongly disagree	(1)	17	17	-	17	-	17	3	14	6	11
		15%	15%	-	15%	-	15%	11%	16%	18%	13%
NET: Disagree		45	45	-	45	-	45	7	38	12	33
		39%	39%	-	39%	-	39%	26%	43%	36%	40%
Don't know		7	7	-	7	-	7	1	6	1	6
		6%	6%	-	6%	-	6%	4%	7%	3%	7%
Mean		2.64	2.64	-	2.64	-	2.64	2.81	2.59	2.66	2.63
Standard deviation		0.99	0.99	-	0.99	-	0.99	0.90	1.02	1.04	0.98
Standard error		0.10	0.10	-	0.10	-	0.10	0.18	0.11	0.18	0.11

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

*** small base; ** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 24

Q20. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All cigarette and not e-cigarette smokers

As an adult smoker, it is important for me to see advertisements for e-cigarettes in places like shops, billboards, leaflets and brochures. If I decide to switch to e-cigarettes, this is the best way for me to gather information about which products are available and how they operate

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		452	89*	245	207	77*	195	180	76*	93*	81*	201	89*	85*	51*	50*	58*	119
NET: Agree		219	50	115	104	31	97	91	41	45	39	94	50	35	26	29	23	56
		48%	56%	47%	50%	40%	50%	51%	54%	48%	48%	47%	56%	41%	51%	58%	40%	47%
Strongly agree	(4)	78	13	44	34	11	29	38	20	11	19	28	13	12	9	10	11	23
		17%	15%	18%	16%	14%	15%	21%	26%ik	12%	23%i	14%	15%	14%	18%	20%	19%	19%
Somewhat agree	(3)	141	37	71	70	20	68	53	21	34	20	66	37	23	17	19	12	33
		31%	42%	29%	34%	26%	35%	29%	28%	37%	25%	33%	42%mp	27%	33%	38%	21%	28%
Somewhat disagree	(2)	108	18	56	52	18	43	47	16	29	21	42	18	24	11	7	17	31
		24%	20%	23%	25%	23%	22%	26%	21%	31%	26%	21%	20%	28%	22%	14%	29%	26%
Strongly disagree	(1)	65	10	39	26	12	29	24	12	10	10	32	10	13	8	5	12	17
		14%	11%	16%	13%	16%	15%	13%	16%	11%	12%	16%	11%	15%	16%	10%	21%	14%
NET: Disagree		173	28	95	78	30	72	71	28	39	31	74	28	37	19	12	29	48
		38%	31%	39%	38%	39%	37%	39%	37%	42%	38%	37%	31%	44%o	37%	24%	50%lo	40%
Don't know		60	11	35	25	16	26	18	7	9	11	33	11	13	6	9	6	15
		13%	12%	14%	12%	21%g	13%	10%	9%	10%	14%	16%	12%	15%	12%	18%	10%	13%
Mean		2.59	2.68	2.57	2.62	2.49	2.57	2.65	2.71	2.55	2.69	2.54	2.68	2.47	2.60	2.83	2.42	2.60
Standard deviation		0.99	0.90	1.02	0.95	1.01	0.97	1.00	1.07	0.87	1.03	0.98	0.90	0.98	1.01	0.95	1.07	1.01
Standard error		0.05	0.10	0.07	0.07	0.13	0.07	0.08	0.13	0.09	0.12	0.08	0.10	0.12	0.15	0.15	0.15	0.10

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

*** small base**

Prepared by Populus

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 24

Q20. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All cigarette and not e-cigarette smokers

As an adult smoker, it is important for me to see advertisements for e-cigarettes in places like shops, billboards, leaflets and brochures. If I decide to switch to e-cigarettes, this is the best way for me to gather information about which products are available and how they operate

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		452	-**	452	-**	452	-**	193	259	23**	429
NET: Agree		219	-	219	-	219	-	96	123	13	206
		48%	-	48%	-	48%	-	50%	47%	57%	48%
Strongly agree	(4)	78	-	78	-	78	-	40	38	3	75
		17%	-	17%	-	17%	-	21%	15%	13%	17%
Somewhat agree	(3)	141	-	141	-	141	-	56	85	10	131
		31%	-	31%	-	31%	-	29%	33%	43%	31%
Somewhat disagree	(2)	108	-	108	-	108	-	46	62	6	102
		24%	-	24%	-	24%	-	24%	24%	26%	24%
Strongly disagree	(1)	65	-	65	-	65	-	26	39	2	63
		14%	-	14%	-	14%	-	13%	15%	9%	15%
NET: Disagree		173	-	173	-	173	-	72	101	8	165
		38%	-	38%	-	38%	-	37%	39%	35%	38%
Don't know		60	-	60	-	60	-	25	35	2	58
		13%	-	13%	-	13%	-	13%	14%	9%	14%
Mean		2.59	-	2.59	-	2.59	-	2.65	2.54	2.67	2.59
Standard deviation		0.99	-	0.99	-	0.99	-	1.01	0.97	0.86	0.99
Standard error		0.05	-	0.05	-	0.05	-	0.08	0.06	0.19	0.05

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

**** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 25

Q21. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.
Base: All cigarette and not e-cigarette smokers
If the government passed regulations that would ban e-cigarette advertising on billboards, posters, leaflets, and in retail shops, I would be less likely to switch to e-cigarettes

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		452	89*	245	207	77*	195	180	76*	93*	81*	201	89*	85*	51*	50*	58*	119
NET: Agree		165	34	96	69	26	69	70	35	37	26	67	34	28	15	23	19	46
		37%	38%	39%	33%	34%	35%	39%	46%	40%	32%	33%	38%	33%	29%	46%	33%	39%
Strongly agree	(4)	58	11	37	21	8	23	27	14	14	7	23	11	9	5	8	8	17
		13%	12%	15%	10%	10%	12%	15%	18%	15%	9%	11%	12%	11%	10%	16%	14%	14%
Somewhat agree	(3)	107	23	59	48	18	46	43	21	23	19	44	23	19	10	15	11	29
		24%	26%	24%	23%	23%	24%	24%	28%	25%	23%	22%	26%	22%	20%	30%	19%	24%
Somewhat disagree	(2)	108	21	52	56	17	48	43	17	26	21	44	21	26	18	9	13	21
		24%	24%	21%	27%	22%	25%	24%	22%	28%	26%	22%	24%	31%	35%	18%	22%	18%
Strongly disagree	(1)	67	9	36	31	15	26	26	9	8	12	37	9	12	7	3	9	27
		15%	10%	15%	15%	19%	13%	14%	12%	9%	15%	18%i	10%	14%	14%	6%	16%	23%
NET: Disagree		175	30	88	87	32	74	69	26	34	33	81	30	38	25	12	22	48
		39%	34%	36%	42%	42%	38%	38%	34%	37%	41%	40%	34%	45%o	49%o	24%	38%	40%
Don't know		112	25	61	51	19	52	41	15	22	22	53	25	19	11	15	17	25
		25%	28%	25%	25%	25%	27%	23%	20%	24%	27%	26%	28%	22%	22%	30%	29%	21%
Mean		2.46	2.56	2.53	2.38	2.33	2.46	2.51	2.66	2.61	2.36	2.36	2.56	2.38	2.33	2.80mn	2.44	2.38
Standard deviation		0.99	0.94	1.02	0.95	1.02	0.97	1.01	1.00	0.93	0.94	1.02	0.94	0.94	0.92	0.90	1.05	1.09
Standard error		0.05	0.12	0.08	0.08	0.13	0.08	0.09	0.13	0.11	0.12	0.08	0.12	0.12	0.14	0.15	0.16	0.11

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p
*** small base**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 25

Q21. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.
Base: All cigarette and not e-cigarette smokers
If the government passed regulations that would ban e-cigarette advertising on billboards, posters, leaflets, and in retail shops, I would be less likely to switch to e-cigarettes

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		452	-**	452	-**	452	-**	193	259	23**	429
NET: Agree		165	-	165	-	165	-	74	91	13	152
		37%	-	37%	-	37%	-	38%	35%	57%	35%
Strongly agree	(4)	58	-	58	-	58	-	29	29	3	55
		13%	-	13%	-	13%	-	15%	11%	13%	13%
Somewhat agree	(3)	107	-	107	-	107	-	45	62	10	97
		24%	-	24%	-	24%	-	23%	24%	43%	23%
Somewhat disagree	(2)	108	-	108	-	108	-	45	63	5	103
		24%	-	24%	-	24%	-	23%	24%	22%	24%
Strongly disagree	(1)	67	-	67	-	67	-	33	34	1	66
		15%	-	15%	-	15%	-	17%	13%	4%	15%
NET: Disagree		175	-	175	-	175	-	78	97	6	169
		39%	-	39%	-	39%	-	40%	37%	26%	39%
Don't know		112	-	112	-	112	-	41	71	4	108
		25%	-	25%	-	25%	-	21%	27%	17%	25%
Mean		2.46	-	2.46	-	2.46	-	2.46	2.46	2.79	2.44
Standard deviation		0.99	-	0.99	-	0.99	-	1.04	0.96	0.79	1.00
Standard error		0.05	-	0.05	-	0.05	-	0.08	0.07	0.18	0.06

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i
**** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 26

Q22. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All cigarette and not e-cigarette smokers

Regulations that would ban the use of e-cigarettes in indoor public places and force e-cigarettes to be used only in zones designated to conventional cigarettes would discourage me from switching to these products

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		452	89*	245	207	77*	195	180	76*	93*	81*	201	89*	85*	51*	50*	58*	119
NET: Agree		238	55	132	106	36	93	109	44	52	43	99	55	37	30	30	25	61
		53%	62%	54%	51%	47%	48%	61%ef	58%	56%	53%	49%	62%mp	44%	59%	60%	43%	51%
Strongly agree	(4)	125	27	69	56	19	49	57	24	20	26	55	27	18	17	17	15	31
		28%	30%	28%	27%	25%	25%	32%	32%	22%	32%	27%	30%	21%	33%	34%	26%	26%
Somewhat agree	(3)	113	28	63	50	17	44	52	20	32	17	44	28	19	13	13	10	30
		25%	31%	26%	24%	22%	23%	29%	26%	34%k	21%	22%	31%	22%	25%	26%	17%	25%
Somewhat disagree	(2)	84	13	35	49	18	37	29	16	16	13	39	13	18	7	10	16	20
		19%	15%	14%	24%c	23%	19%	16%	21%	17%	16%	19%	15%	21%	14%	20%	28%	17%
Strongly disagree	(1)	59	8	38	21	8	33	18	6	11	13	28	8	12	8	2	9	20
		13%	9%	16%	10%	10%	17%	10%	8%	12%	16%	14%	9%	14%	16%	4%	16%	17%
NET: Disagree		143	21	73	70	26	70	47	22	27	26	67	21	30	15	12	25	40
		32%	24%	30%	34%	34%	36%g	26%	29%	29%	32%	33%	24%	35%	29%	24%	43%lo	34%
Don't know		71	13	40	31	15	32	24	10	14	12	35	13	18	6	8	8	18
		16%	15%	16%	15%	19%	16%	13%	13%	15%	15%	17%	15%	21%	12%	16%	14%	15%
Mean		2.80	2.97	2.80	2.80	2.76	2.67	2.95f	2.94	2.77	2.81	2.76	2.97	2.64	2.87	3.07mp	2.62	2.71
Standard deviation		1.06	0.98	1.10	1.02	1.04	1.11	1.01	0.99	0.99	1.14	1.09	0.98	1.07	1.12	0.92	1.10	1.11
Standard error		0.05	0.11	0.08	0.08	0.13	0.09	0.08	0.12	0.11	0.14	0.08	0.11	0.13	0.17	0.14	0.16	0.11

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

*** small base**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 26

Q22. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.
Base: All cigarette and not e-cigarette smokers
Regulations that would ban the use of e-cigarettes in indoor public places and force e-cigarettes to be used only in zones designated to conventional cigarettes would discourage me from switching to these products

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		452	-**	452	-**	452	-**	193	259	23**	429
NET: Agree		238	-	238	-	238	-	108	130	12	226
		53%	-	53%	-	53%	-	56%	50%	52%	53%
Strongly agree	(4)	125	-	125	-	125	-	60	65	4	121
		28%	-	28%	-	28%	-	31%	25%	17%	28%
Somewhat agree	(3)	113	-	113	-	113	-	48	65	8	105
		25%	-	25%	-	25%	-	25%	25%	35%	24%
Somewhat disagree	(2)	84	-	84	-	84	-	38	46	5	79
		19%	-	19%	-	19%	-	20%	18%	22%	18%
Strongly disagree	(1)	59	-	59	-	59	-	27	32	2	57
		13%	-	13%	-	13%	-	14%	12%	9%	13%
NET: Disagree		143	-	143	-	143	-	65	78	7	136
		32%	-	32%	-	32%	-	34%	30%	30%	32%
Don't know		71	-	71	-	71	-	20	51	4	67
		16%	-	16%	-	16%	-	10%	20%f	17%	16%
Mean		2.80	-	2.80	-	2.80	-	2.82	2.78	2.74	2.80
Standard deviation		1.06	-	1.06	-	1.06	-	1.08	1.05	0.93	1.07
Standard error		0.05	-	0.05	-	0.05	-	0.08	0.07	0.21	0.06

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i
**** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 27

Q23. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All cigarette and not e-cigarette smokers

I would be more likely to switch to e-cigarettes if the Government provided clarity on the health effects of e-cigarettes and the role they can play in quitting smoking conventional cigarettes

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		452	89*	245	207	77*	195	180	76*	93*	81*	201	89*	85*	51*	50*	58*	119
NET: Agree		275	61	133	142	51	112	112	51	60	49	115	61	47	35	28	35	69
		61%	69%	54%	69%c	66%	57%	62%	67%	65%	60%	57%	69%	55%	69%	56%	60%	58%
Strongly agree	(4)	106	21	49	57	19	41	46	23	15	26	42	21	22	16	12	8	27
		23%	24%	20%	28%	25%	21%	26%	30%i	16%	32%ik	21%	24%	26%	31%p	24%	14%	23%
Somewhat agree	(3)	169	40	84	85	32	71	66	28	45	23	73	40	25	19	16	27	42
		37%	45%	34%	41%	42%	36%	37%	37%	48%j	28%	36%	45%m	29%	37%	32%	47%m	35%
Somewhat disagree	(2)	59	10	35	24	10	26	23	12	15	9	23	10	14	4	6	8	17
		13%	11%	14%	12%	13%	13%	13%	16%	16%	11%	11%	11%	16%	8%	12%	14%	14%
Strongly disagree	(1)	54	8	40	14	5	25	24	6	5	15	27	8	7	10	5	6	18
		12%	9%	16%d	7%	6%	13%	13%	8%	5%	19%i	13%i	9%	8%	20%	10%	10%	15%
NET: Disagree		113	18	75	38	15	51	47	18	20	24	50	18	21	14	11	14	35
		25%	20%	31%d	18%	19%	26%	26%	24%	22%	30%	25%	20%	25%	27%	22%	24%	29%
Don't know		64	10	37	27	11	32	21	7	13	8	36	10	17	2	11	9	15
		14%	11%	15%	13%	14%	16%	12%	9%	14%	10%	18%	11%	20%n	4%	22%n	16%n	13%
Mean		2.84	2.94	2.68	3.03c	2.98	2.79	2.84	2.99	2.88	2.82	2.79	2.94	2.91	2.84	2.90	2.76	2.75
Standard deviation		0.98	0.90	1.04	0.87	0.87	0.99	1.01	0.93	0.79	1.13	1.00	0.90	0.97	1.11	0.99	0.88	1.03
Standard error		0.05	0.10	0.07	0.07	0.11	0.08	0.08	0.11	0.09	0.13	0.08	0.10	0.12	0.16	0.16	0.13	0.10

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

*** small base**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 27

Q23. You will now be shown a number of statements that have been made about e-cigarettes. For each of the following, please indicate whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree.

Base: All cigarette and not e-cigarette smokers

I would be more likely to switch to e-cigarettes if the Government provided clarity on the health effects of e-cigarettes and the role they can play in quitting smoking conventional cigarettes

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		452	-**	452	-**	452	-**	193	259	23**	429
NET: Agree		275	-	275	-	275	-	130	145	12	263
		61%	-	61%	-	61%	-	67%g	56%	52%	61%
Strongly agree	(4)	106	-	106	-	106	-	54	52	4	102
		23%	-	23%	-	23%	-	28%	20%	17%	24%
Somewhat agree	(3)	169	-	169	-	169	-	76	93	8	161
		37%	-	37%	-	37%	-	39%	36%	35%	38%
Somewhat disagree	(2)	59	-	59	-	59	-	18	41	3	56
		13%	-	13%	-	13%	-	9%	16%f	13%	13%
Strongly disagree	(1)	54	-	54	-	54	-	23	31	5	49
		12%	-	12%	-	12%	-	12%	12%	22%	11%
NET: Disagree		113	-	113	-	113	-	41	72	8	105
		25%	-	25%	-	25%	-	21%	28%	35%	24%
Don't know		64	-	64	-	64	-	22	42	3	61
		14%	-	14%	-	14%	-	11%	16%	13%	14%
Mean		2.84	-	2.84	-	2.84	-	2.94	2.76	2.55	2.86
Standard deviation		0.98	-	0.98	-	0.98	-	0.98	0.97	1.10	0.97
Standard error		0.05	-	0.05	-	0.05	-	0.07	0.07	0.25	0.05

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

**** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 28

D1. On average, how much do you spend per week on e-cigarette and e-cigarette supplies?
Base: All e-cigarette smokers

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	530	96*	298	232	142	216	172	126	124	100	180	96*	120	71*	49*	62*	132
Up to £2.50	71	8	40	31	13	26	32	13	12	16	30	8	20	12	7	10	14
	13%	8%	13%	13%	9%	12%	19%e	10%	10%	16%	17%	8%	17%	17%	14%	16%	11%
£2.51 to £5.00	162	32	92	70	29	69	64	39	31	34	58	32	42	17	9	21	41
	31%	33%	31%	30%	20%	32%e	37%e	31%	25%	34%	32%	33%	35%o	24%	18%	34%	31%
£5.01 to £7.50	38	9	22	16	10	14	14	6	10	6	16	9	7	8	3	2	9
	7%	9%	7%	7%	7%	6%	8%	5%	8%	6%	9%	9%	6%	11%	6%	3%	7%
£7.51 to £10.00	94	20	57	37	36	39	19	25	22	11	36	20	21	9	14	7	23
	18%	21%	19%	16%	25%g	18%	11%	20%	18%	11%	20%	21%	18%	13%	29%np	11%	17%
£10.01 to £12.50	13	3	6	7	4	5	4	5	2	3	3	3	3	1	-	2	4
	2%	3%	2%	3%	3%	2%	2%	4%	2%	3%	2%	3%	3%	1%	-	3%	3%
£12.51 to £15.00	24	3	15	9	5	12	7	6	9	4	5	3	4	6	3	2	6
	5%	3%	5%	4%	4%	6%	4%	5%	7%	4%	3%	3%	3%	8%	6%	3%	5%
£15.01 to £17.50	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
£17.51 to £20.00	27	5	18	9	10	11	6	8	10	2	7	5	8	5	2	2	5
	5%	5%	6%	4%	7%	5%	3%	6%	8%j	2%	4%	5%	7%	7%	4%	3%	4%
£20.01+	48	8	25	23	18	19	11	10	15	14	9	8	9	6	5	8	12
	9%	8%	8%	10%	13%	9%	6%	8%	12%k	14%k	5%	8%	8%	8%	10%	13%	9%
Don't know	53	8	23	30	17	21	15	14	13	10	16	8	6	7	6	8	18
	10%	8%	8%	13%c	12%	10%	9%	11%	10%	10%	9%	8%	5%	10%	12%	13%	14%
Mean	10.53	11.22	10.96	9.96	13.92fg	10.27	8.16	10.27	13.61k	10.56	8.61	11.22	10.00	10.26	10.92	11.35	10.16
Standard deviation	14.34	21.58	16.54	10.65	20.97	11.36	10.10	11.35	21.50	11.66	10.77	21.58	13.20	11.00	10.42	14.87	10.97
Standard error	0.66	2.30	1.00	0.75	1.88	0.81	0.81	1.07	2.04	1.23	0.84	2.30	1.24	1.37	1.59	2.02	1.03

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p
*** small base**

Prepared by Populus

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 28

D1. On average, how much do you spend per week on e-cigarette and e-cigarette supplies?
Base: All e-cigarette smokers

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	530	530	-**	144	386	144	212	318	150	380
Up to £2.50	71	71	-	17	54	17	18	53	16	55
	13%	13%	-	12%	14%	12%	8%	17%f	11%	14%
£2.51 to £5.00	162	162	-	57	105	57	55	107	31	131
	31%	31%	-	40%a	27%	40%d	26%	34%	21%	34%h
£5.01 to £7.50	38	38	-	18	20	18	17	21	13	25
	7%	7%	-	13%a	5%	13%d	8%	7%	9%	7%
£7.51 to £10.00	94	94	-	26	68	26	39	55	34	60
	18%	18%	-	18%	18%	18%	18%	17%	23%	16%
£10.01 to £12.50	13	13	-	5	8	5	6	7	8	5
	2%	2%	-	3%	2%	3%	3%	2%	5%i	1%
£12.51 to £15.00	24	24	-	8	16	8	10	14	7	17
	5%	5%	-	6%	4%	6%	5%	4%	5%	4%
£15.01 to £17.50	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-	-	-	-	-
£17.51 to £20.00	27	27	-	3	24	3	11	16	9	18
	5%	5%	-	2%	6%	2%	5%	5%	6%	5%
£20.01+	48	48	-	3	45	3	30	18	25	23
	9%	9%c	-	2%	12%e	2%	14%g	6%	17%i	6%
Don't know	53	53	-	7	46	7	26	27	7	46
	10%	10%	-	5%	12%e	5%	12%	8%	5%	12%h
Mean	10.53	10.53c	-	7.07	11.93e	7.07	13.91g	8.37	14.98i	8.63
Standard deviation	14.34	14.34	-	5.41	16.43	5.41	20.01	8.36	21.78	8.90
Standard error	0.66	0.66	-	0.46	0.89	0.46	1.47	0.49	1.82	0.49

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i
**** very small base (under 30) ineligible for sig testing**

Prepared by Populus

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 29

D2. On average, how many cigarettes do you smoke a day?

Base: All cigarette smokers

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	939	172	520	419	206	406	327	183	215	172	368	172	191	105	102	124	245
1-5	213	29	113	100	88	78	47	54	62	33	64	29	44	23	22	24	71
	23%	17%	22%	24%	43%fg	19%	14%	30%jk	29%jk	19%	17%	17%	23%	22%	22%	19%	29%
6-10	224	39	126	98	58	100	66	47	59	43	75	39	45	29	22	32	57
	24%	23%	24%	23%	28%g	25%	20%	26%	27%	25%	20%	23%	24%	28%	22%	26%	23%
11-15	204	40	101	103	28	90	86	37	42	42	82	40	42	22	26	27	47
	22%	23%	19%	25%	14%	22%e	26%e	20%	20%	24%	22%	23%	22%	21%	25%	22%	19%
16-20	176	38	105	71	22	81	73	25	33	33	85	38	40	16	18	19	45
	19%	22%	20%	17%	11%	20%e	22%e	14%	15%	19%	23%hi	22%	21%	15%	18%	15%	18%
21-25	56	10	33	23	4	29	23	10	7	12	27	10	7	7	10	11	11
	6%	6%	6%	5%	2%	7%e	7%e	5%	3%	7%	7%i	6%	4%	7%	10%m	9%	4%
26-30	40	8	24	16	5	18	17	5	8	5	22	8	6	6	4	8	8
	4%	5%	5%	4%	2%	4%	5%	3%	4%	3%	6%	5%	3%	6%	4%	6%	3%
31-50	23	8	15	8	1	9	13	5	4	3	11	8	7	1	-	2	5
	2%	5%	3%	2%	*	2%	4%e	3%	2%	2%	3%	5%o	4%	1%	-	2%	2%
51+	3	-	3	-	-	1	2	-	-	1	2	-	-	1	-	1	1
	*	-	1%	-	-	*	1%	-	-	1%	1%	-	-	1%	-	1%	*
Mean	13.62	15.06	14.21d	12.89	9.08	14.24e	15.72ef	11.93	11.81	13.88hi	15.39hi	15.06	13.62	13.64	13.27	14.21	12.45
Standard deviation	8.97	9.02	9.44	8.31	7.42	8.69	9.24	8.35	8.27	8.68	9.47	9.02	8.78	9.19	7.70	9.53	9.12
Standard error	0.29	0.69	0.41	0.41	0.52	0.43	0.51	0.62	0.56	0.66	0.49	0.69	0.64	0.90	0.76	0.86	0.58

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 29

D2. On average, how many cigarettes do you smoke a day?
Base: All cigarette smokers

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	939	386	553	-**	939	-**	407	532	133	806
1-5	213	118	95	-	213	-	70	143	33	180
	23%	31%b	17%	-	23%	-	17%	27%f	25%	22%
6-10	224	96	128	-	224	-	99	125	34	190
	24%	25%	23%	-	24%	-	24%	23%	26%	24%
11-15	204	64	140	-	204	-	94	110	19	185
	22%	17%	25%a	-	22%	-	23%	21%	14%	23%h
16-20	176	63	113	-	176	-	83	93	26	150
	19%	16%	20%	-	19%	-	20%	17%	20%	19%
21-25	56	19	37	-	56	-	28	28	7	49
	6%	5%	7%	-	6%	-	7%	5%	5%	6%
26-30	40	16	24	-	40	-	23	17	9	31
	4%	4%	4%	-	4%	-	6%	3%	7%	4%
31-50	23	9	14	-	23	-	8	15	5	18
	2%	2%	3%	-	2%	-	2%	3%	4%	2%
51+	3	1	2	-	3	-	2	1	-	3
	*	*	*	-	*	-	*	*	-	*
Mean	13.62	12.40	14.47a	-	13.62	-	14.57g	12.89	13.77	13.60
Standard deviation	8.97	8.96	8.89	-	8.97	-	9.00	8.90	9.39	8.91
Standard error	0.29	0.46	0.38	-	0.29	-	0.45	0.39	0.81	0.31

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i
**** very small base (under 30) ineligible for sig testing**

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 30

D3a. Do you have a partner, child over 18, or parent who smokes cigarettes on a daily or weekly basis?
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Yes	444	85	216	228	104	187	153	84	89	97	174	85	95	51	52	61	100
	41%	43%	36%	47%c	44%	41%	40%	39%	36%	49%hi	41%	43%	43%	39%	46%	44%	36%
No	639	115	386	253	135	272	232	132	157	101	248	115	125	81	60	79	179
	59%	58%	64%d	53%	56%	59%	60%	61%j	64%j	51%	59%	58%	57%	61%	54%	56%	64%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 30

D3a. Do you have a partner, child over 18, or parent who smokes cigarettes on a daily or weekly basis?
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Yes	444	212	232	37	407	37	444	-	129	315
	41%	40%c	42%c	26%	43%e	26%	100%g	-	72%i	35%
No	639	318	321	107	532	107	-	639	50	589
	59%	60%	58%	74%ab	57%	74%d	-	100%f	28%	65%h

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 31

D3b. Do you have a partner, child over 18, or parent who uses e-cigarettes on a daily or weekly basis?
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Yes	179	30	92	87	60	67	52	39	29	47	64	30	53	18	21	20	37
	17%	15%	15%	18%	25%fg	15%	14%	18%	12%	24%ik	15%	15%	24%lnp	14%	19%	14%	13%
No	904	170	510	394	179	392	333	177	217	151	358	170	167	114	91	120	242
	83%	85%	85%	82%	75%	85%e	86%e	82%	88%j	76%	85%j	85%m	76%	86%m	81%	86%m	87%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 31

D3b. Do you have a partner, child over 18, or parent who uses e-cigarettes on a daily or weekly basis?
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Yes	179	150	29	46	133	46	129	50	179	-
	17%	28%b	5%	32%b	14%	32%d	29%g	8%	100%i	-
No	904	380	524	98	806	98	315	589	-	904
	83%	72%	95%ac	68%	86%e	68%	71%	92%f	-	100%h

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 32

D4. How interested would you say you are in politics and public policy issues? Would you say you are ...?

Base: All respondents

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
NET: Interested		872	168	514	358	191	370	311	192	211	155	313	168	176	109	82	106	231
		81%	84%	85%d	74%	80%	81%	81%	89%jk	86%jk	78%	74%	84%o	80%	83%	73%	76%	83%
Very interested	(4)	343	66	229	114	69	149	125	105	81	61	96	66	73	44	28	49	83
		32%	33%	38%d	24%	29%	32%	32%	49%ijk	33%k	31%k	23%	33%	33%	33%	25%	35%	30%
Somewhat interested	(3)	529	102	285	244	122	221	186	87	130	94	217	102	103	65	54	57	148
		49%	51%	47%	51%	51%	48%	48%	40%	53%h	47%	51%h	51%	47%	49%	48%	41%	53%
Not very interested	(2)	164	21	70	94	39	66	59	22	29	34	79	21	37	18	20	29	39
		15%	11%	12%	20%c	16%	14%	15%	10%	12%	17%h	19%hi	11%	17%	14%	18%	21%l	14%
Not at all interested	(1)	47	11	18	29	9	23	15	2	6	9	30	11	7	5	10	5	9
		4%	6%	3%	6%c	4%	5%	4%	1%	2%	5%h	7%hi	6%	3%	4%	9%m	4%	3%
NET: Not interested		211	32	88	123	48	89	74	24	35	43	109	32	44	23	30	34	48
		19%	16%	15%	26%c	20%	19%	19%	11%	14%	22%hi	26%hi	16%	20%	17%	27%l	24%	17%
Mean		3.08	3.12	3.20d	2.92	3.05	3.08	3.09	3.37ijk	3.16k	3.05k	2.90	3.12o	3.10o	3.12o	2.89	3.07	3.09
Standard deviation		0.80	0.80	0.76	0.82	0.78	0.81	0.79	0.70	0.72	0.81	0.83	0.80	0.79	0.78	0.88	0.84	0.75
Standard error		0.02	0.06	0.03	0.04	0.05	0.04	0.04	0.05	0.05	0.06	0.04	0.06	0.05	0.07	0.08	0.07	0.04

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 32

D4. How interested would you say you are in politics and public policy issues? Would you say you are ...?
Base: All respondents

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
NET: Interested		872	442	430	116	756	116	348	524	139	733
		81%	83%b	78%	81%	81%	81%	78%	82%	78%	81%
Very interested	(4)	343	194	149	42	301	42	145	198	62	281
		32%	37%b	27%	29%	32%	29%	33%	31%	35%	31%
Somewhat interested	(3)	529	248	281	74	455	74	203	326	77	452
		49%	47%	51%	51%	48%	51%	46%	51%	43%	50%
Not very interested	(2)	164	70	94	21	143	21	72	92	30	134
		15%	13%	17%	15%	15%	15%	16%	14%	17%	15%
Not at all interested	(1)	47	18	29	7	40	7	24	23	10	37
		4%	3%	5%	5%	4%	5%	5%	4%	6%	4%
NET: Not interested		211	88	123	28	183	28	96	115	40	171
		19%	17%	22%a	19%	19%	19%	22%	18%	22%	19%
Mean		3.08	3.17b	2.99	3.05	3.08	3.05	3.06	3.09	3.07	3.08
Standard deviation		0.80	0.78	0.81	0.80	0.80	0.80	0.84	0.77	0.86	0.79
Standard error		0.02	0.03	0.03	0.07	0.03	0.07	0.04	0.03	0.06	0.03

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 33

D5. In the past week or so , how often, if at all, would you say you have talked about government, politics, or society with your family, friends, or co-workers?

Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Several times	297	58	194	103	66	136	95	99	63	51	84	58	60	36	30	44	69
	27%	29%	32%d	21%	28%	30%	25%	46%ijk	26%	26%	20%	29%	27%	27%	27%	31%	25%
Once or twice	498	97	267	231	119	211	168	93	121	92	192	97	107	61	46	62	125
	46%	49%	44%	48%	50%	46%	44%	43%	49%	46%	45%	49%	49%	46%	41%	44%	45%
Not at all	288	45	141	147	54	112	122	24	62	55	146	45	53	35	36	34	85
	27%	23%	23%	31%c	23%	24%	32%ef	11%	25%h	28%h	35%hi	23%	24%	27%	32%	24%	30%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 33

D5. In the past week or so , how often, if at all, would you say you have talked about government, politics, or society with your family, friends, or co-workers?

Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Several times	297	169	128	39	258	39	144	153	65	232
	27%	32%b	23%	27%	27%	27%	32%g	24%	36%i	26%
Once or twice	498	237	261	65	433	65	183	315	74	424
	46%	45%	47%	45%	46%	45%	41%	49%f	41%	47%
Not at all	288	124	164	40	248	40	117	171	40	248
	27%	23%	30%a	28%	26%	28%	26%	27%	22%	27%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 34

D6. Thinking about national level elections in this country, do you tend to vote in these elections all of the time, most of the time, some of the time, rarely, or never?

Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
All of the time	630	133	374	256	97	251	282	145	154	111	220	133	113	85	62	88	149
	58%	67%a	62%d	53%	41%	55%e	73%ef	67%jk	63%k	56%	52%	67%m	51%	64%m	55%	63%m	53%
Most of the time	221	36	117	104	59	98	64	39	47	46	88	36	50	25	24	27	59
	20%	18%	19%	22%	25%g	21%	17%	18%	19%	23%	21%	18%	23%	19%	21%	19%	21%
Some of the time	113	17	60	53	47	46	20	23	20	22	48	17	28	12	10	13	33
	10%	9%	10%	11%	20%fg	10%g	5%	11%	8%	11%	11%	9%	13%	9%	9%	9%	12%
Rarely	46	3	18	28	12	28	6	2	10	11	23	3	14	5	5	5	14
	4%	2%	3%	6%c	5%g	6%g	2%	1%	4%h	6%h	5%h	2%	6%l	4%	4%	4%	5%
Never	49	8	23	26	11	27	11	7	10	4	28	8	7	2	8	6	18
	5%	4%	4%	5%	5%	6%g	3%	3%	4%	2%	7%j	4%	3%	2%	7%n	4%	6%
Don't know	24	3	10	14	13	9	2	-	5	4	15	3	8	3	3	1	6
	2%	2%	2%	3%	5%fg	2%	1%	-	2%h	2%h	4%h	2%	4%	2%	3%	1%	2%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 34

D6. Thinking about national level elections in this country, do you tend to vote in these elections all of the time, most of the time, some of the time, rarely, or never?

Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
All of the time	630	301	329	89	541	89	253	377	91	539
	58%	57%	59%	62%	58%	62%	57%	59%	51%	60%h
Most of the time	221	123	98	25	196	25	98	123	46	175
	20%	23%b	18%	17%	21%	17%	22%	19%	26%	19%
Some of the time	113	54	59	11	102	11	38	75	17	96
	10%	10%	11%	8%	11%	8%	9%	12%	9%	11%
Rarely	46	21	25	11	35	11	24	22	5	41
	4%	4%	5%	8%	4%	8%d	5%	3%	3%	5%
Never	49	19	30	4	45	4	22	27	15	34
	5%	4%	5%	3%	5%	3%	5%	4%	8%i	4%
Don't know	24	12	12	4	20	4	9	15	5	19
	2%	2%	2%	3%	2%	3%	2%	2%	3%	2%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 35

D7. At the last general election in May, many people didn't vote. Can you remember, did you vote in that election, or did you not vote?
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Voted	925	181	536	389	186	390	349	196	211	171	347	181	188	117	93	127	219
	85%	91%	89%d	81%	78%	85%e	91%ef	91%k	86%	86%	82%	91%	85%	89%	83%	91%	78%
Did not vote	147	18	61	86	45	66	36	18	32	25	71	18	32	13	17	12	55
	14%	9%	10%	18%c	19%g	14%g	9%	8%	13%	13%	17%h	9%	15%	10%	15%	9%	20%
Don't know	11	1	5	6	8	3	-	2	3	2	4	1	-	2	2	1	5
	1%	1%	1%	1%	3%fg	1%	-	1%	1%	1%	1%	1%	-	2%	2%m	1%	2%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 35

D7. At the last general election in May, many people didn't vote. Can you remember, did you vote in that election, or did you not vote?
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Voted	925	462	463	119	806	119	375	550	147	778
	85%	87%	84%	83%	86%	83%	84%	86%	82%	86%
Did not vote	147	62	85	23	124	23	65	82	30	117
	14%	12%	15%	16%	13%	16%	15%	13%	17%	13%
Don't know	11	6	5	2	9	2	4	7	2	9
	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 36

D8. Which party did you vote for at the last general election in May? Was it ...?

Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
The Conservative Party	201	17	122	79	43	65	93	48	56	43	54	17	38	26	24	23	73
	19%b	9%	20%	16%	18%	14%	24%f	22%k	23%k	22%k	13%	9%	17%l	20%l	21%l	16%l	26%
The Labour Party	327	47	194	133	63	155	109	68	63	63	133	47	93	44	28	46	69
	30%	24%	32%	28%	26%	34%e	28%	31%	26%	32%	32%	24%	42%lo	33%	25%	33%	25%
The Liberal Democrat Party	52	7	28	24	9	22	21	20	9	3	20	7	7	9	7	12	10
	5%	4%	5%	5%	4%	5%	5%	9%ijk	4%	2%	5%j	4%	3%	7%	6%	9%lm	4%
The UK Independence Party or UKIP	172	3	98	74	28	70	74	17	39	33	83	3	41	26	25	30	47
	16%b	2%	16%	15%	12%	15%	19%e	8%	16%h	17%h	20%h	2%	19%l	20%l	22%l	21%l	17%
SNP	100	100	55	45	23	39	38	30	18	20	32	100	-	-	-	-	-
	9%	50%a	9%	9%	10%	8%	10%	14%ik	7%	10%	8%	50%mnop	-	-	-	-	-
Plaid Cymru	7	-	6	1	2	4	1	1	5	1	-	-	-	-	-	7	-
	1%	-	1%	*	1%	1%	*	*	2%k	1%	-	-	-	-	-	5%lmno	-
Another party (SPECIFY)	60	5	31	29	15	33	12	10	20	6	24	5	8	11	9	8	19
	6%	3%	5%	6%	6%	7%g	3%	5%	8%j	3%	6%	3%	4%	8%l	8%l	6%	7%
Did not vote	147	18	61	86	45	66	36	18	32	25	71	18	32	13	17	12	55
	14%	9%	10%	18%c	19%g	14%g	9%	8%	13%	13%	17%h	9%	15%	10%	15%	9%	20%
Don't know	17	3	7	10	11	5	1	4	4	4	5	3	1	3	2	2	6
	2%	2%	1%	2%	5%fg	1%	*	2%	2%	2%	1%	2%	*	2%	2%	1%	2%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 36

D8. Which party did you vote for at the last general election in May? Was it ...?

Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
The Conservative Party	201	100	101	31	170	31	79	122	32	169
	19%	19%	18%	22%	18%	22%	18%	19%	18%	19%
The Labour Party	327	165	162	38	289	38	127	200	48	279
	30%	31%	29%	26%	31%	26%	29%	31%	27%	31%
The Liberal Democrat Party	52	22	30	3	49	3	18	34	6	46
	5%	4%	5%	2%	5%	2%	4%	5%	3%	5%
The UK Independence Party or UKIP	172	84	88	22	150	22	76	96	31	141
	16%	16%	16%	15%	16%	15%	17%	15%	17%	16%
SNP	100	53	47	14	86	14	46	54	20	80
	9%	10%	8%	10%	9%	10%	10%	8%	11%	9%
Plaid Cymru	7	3	4	-	7	-	1	6	-	7
	1%	1%	1%	-	1%	-	*	1%	-	1%
Another party (SPECIFY)	60	31	29	11	49	11	24	36	7	53
	6%	6%	5%	8%	5%	8%	5%	6%	4%	6%
Did not vote	147	62	85	23	124	23	65	82	30	117
	14%	12%	15%	16%	13%	16%	15%	13%	17%	13%
Don't know	17	10	7	2	15	2	8	9	5	12
	2%	2%	1%	1%	2%	1%	2%	1%	3%	1%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 37

D9. What is the highest educational level that you have achieved to date?

Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
No formal education	16	1	12	4	3	8	5	1	1	1	13	1	6	2	1	1	5
	1%	1%	2%	1%	1%	2%	1%	*	*	1%	3%hij	1%	3%	2%	1%	1%	2%
Primary school	9	1	5	4	4	1	4	-	1	3	5	1	-	-	3	1	4
	1%	1%	1%	1%	2%f	*	1%	-	*	2%	1%	1%	-	-	3%m	1%	1%
Secondary school, high school, NVQ levels 1 to 3, etc.	689	117	362	327	107	308	274	82	145	144	317	117	150	92	79	94	157
	64%	59%	60%	68%c	45%	67%e	71%e	38%	59%h	73%hi	75%hi	59%	68%l	70%l	71%l	67%	56%
University degree or equivalent professional qualification, NVQ level 4, etc.	247	60	144	103	71	99	77	95	66	33	53	60	42	25	18	32	70
	23%	30%a	24%	21%	30%fg	22%	20%	44%ijk	27%jk	17%	13%	30%mno	19%	19%	16%	23%	25%
Higher university degree, doctorate, MBA, NVQ level 5, etc.	88	17	61	27	36	34	18	35	22	12	19	17	14	10	7	7	33
	8%	9%	10%d	6%	15%fg	7%	5%	16%ijk	9%k	6%	5%	9%	6%	8%	6%	5%	12%
Still in full time education	13	1	7	6	13	-	-	2	8	1	2	1	4	2	1	3	2
	1%	1%	1%	1%	5%fg	-	-	1%	3%jk	1%	*	1%	2%	2%	1%	2%	1%
Prefer not to answer	16	3	9	7	4	6	6	1	3	3	9	3	4	-	2	2	5
	1%	2%	1%	1%	2%	1%	2%	*	1%	2%	2%	2%	2%	-	2%	1%	2%
Don't know	5	-	2	3	1	3	1	-	-	1	4	-	-	1	1	-	3
	*	-	*	1%	*	1%	*	-	-	1%	1%	-	-	1%	1%	-	1%

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 37

D9. What is the highest educational level that you have achieved to date?

Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
No formal education	16 1%	7 1%	9 2%	4 3%	12 1%	4 3%	5 1%	11 2%	3 2%	13 1%
Primary school	9 1%	4 1%	5 1%	- -	9 1%	- -	7 2%g	2 *	3 2%	6 1%
Secondary school, high school, NVQ levels 1 to 3, etc.	689 64%	304 57%	385 70%ac	82 57%	607 65%	82 57%	306 69%g	383 60%	99 55%	590 65%h
University degree or equivalent professional qualification, NVQ level 4, etc.	247 23%	135 25%b	112 20%	38 26%	209 22%	38 26%	81 18%	166 26%f	46 26%	201 22%
Higher university degree, doctorate, MBA, NVQ level 5, etc.	88 8%	62 12%b	26 5%	13 9%b	75 8%	13 9%	36 8%	52 8%	21 12%	67 7%
Still in full time education	13 1%	8 2%	5 1%	2 1%	11 1%	2 1%	2 *	11 2%	2 1%	11 1%
Prefer not to answer	16 1%	7 1%	9 2%	3 2%	13 1%	3 2%	6 1%	10 2%	4 2%	12 1%
Don't know	5 *	3 1%	2 *	2 1%	3 *	2 1%	1 *	4 1%	1 1%	4 *

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 38

D10. What is the combined annual income of your household, prior to tax being deducted?

Base: All respondents

				Gender		Age			Social Grade				Region					
		Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base		1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Up to £7,000	(3.5)	87	15	46	41	23	39	25	2	14	5	66	15	15	13	5	12	27
		8%	8%	8%	9%	10%	8%	6%	1%	6%h	3%	16%hij	8%	7%	10%	4%	9%	10%
£7,001 to £14,000	(10.5)	245	30	133	112	45	96	104	17	46	22	160	30	58	32	29	36	60
		23%b	15%	22%	23%	19%	21%	27%ef	8%	19%hj	11%	38%hij	15%	26%l	24%l	26%l	26%l	22%
£14,001 to £21,000	(17.5)	228	40	123	105	33	94	101	36	61	41	90	40	50	26	25	31	56
		21%	20%	20%	22%	14%	20%e	26%ef	17%	25%h	21%	21%	20%	23%	20%	22%	22%	20%
£21,001 to £28,000	(24.5)	215	32	119	96	55	93	67	55	56	55	49	32	45	29	27	30	52
		20%	16%	20%	20%	23%	20%	17%	25%k	23%k	28%k	12%	16%	20%	22%	24%	21%	19%
£28,001 to £34,000	(31)	139	29	86	53	33	68	38	39	35	38	27	29	28	15	12	12	43
		13%	15%	14%	11%	14%	15%g	10%	18%k	14%k	19%k	6%	15%	13%	11%	11%	9%	15%
£34,001 to £41,000	(37.5)	74	22	46	28	23	28	23	30	15	22	6	22	14	9	2	6	21
		7%	11%a	8%	6%	10%	6%	6%	14%ik	6%k	11%k	1%	11%op	6%	7%	2%	4%	8%
£41,001 to £48,000	(44.5)	18	4	12	6	7	8	3	10	2	3	3	4	2	5	1	2	4
		2%	2%	2%	1%	3%g	2%	1%	5%ik	1%	2%	1%	2%	1%	4%	1%	1%	1%
£48,001 to £55,000	(51.5)	21	9	12	9	11	7	3	9	7	3	2	9	3	1	3	2	3
		2%	5%a	2%	2%	5%fg	2%	1%	4%k	3%k	2%	*	5%	1%	1%	3%	1%	1%
£55,001 to £62,000	(58.5)	5	1	4	1	1	4	-	2	1	1	1	1	1	-	1	2	-
		*	1%	1%	*	*	1%	-	1%	*	1%	*	1%	*	-	1%	1%	-
£62,001 to £69,000	(65.5)	5	1	3	2	3	2	-	4	1	-	-	1	1	-	-	-	3
		*	1%	*	*	1%g	*	-	2%k	*	-	-	1%	*	-	-	-	1%
£69,001 to £76,000	(72.5)	3	1	2	1	-	2	1	3	-	-	-	1	-	-	1	-	1
		*	1%	*	*	-	*	*	1%k	-	-	-	1%	-	-	1%	-	*
£76,001 to £83,000	(79.5)	2	-	2	-	1	1	-	2	-	-	-	-	-	-	1	-	1
		*	-	*	-	*	*	-	1%k	-	-	-	-	-	-	1%	-	*
£83,001 or more	(86)	1	1	1	-	-	1	-	1	-	-	-	1	-	-	-	-	-
		*	1%	*	-	-	*	-	*	-	-	-	1%	-	-	-	-	-

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

Prepared by Populus

Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 38

D10. What is the combined annual income of your household, prior to tax being deducted?

Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Prefer not to answer	40 4%	15 8%a	13 2%	27 6%c	4 2%	16 3%	20 5%e	6 3%	8 3%	8 4%	18 4%	15 8%mn	3 1%	2 2%	5 4%	7 5%m	8 3%
Average income (£000's)	21.27	24.32a	22.05d	20.25	23.73g	21.71g	19.15	29.75ij k	21.82k	24.54ik	14.96	24.32mn p	20.27	20.18	21.29	19.58	21.33

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 38

D10. What is the combined annual income of your household, prior to tax being deducted?
Base: All respondents

			E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base		1083	530	553	144	939	144	444	639	179	904
Up to £7,000	(3.5)	87	36	51	10	77	10	24	63	10	77
		8%	7%	9%	7%	8%	7%	5%	10%f	6%	9%
£7,001 to £14,000	(10.5)	245	114	131	24	221	24	104	141	40	205
		23%	22%	24%	17%	24%	17%	23%	22%	22%	23%
£14,001 to £21,000	(17.5)	228	106	122	34	194	34	86	142	42	186
		21%	20%	22%	24%	21%	24%	19%	22%	23%	21%
£21,001 to £28,000	(24.5)	215	104	111	36	179	36	87	128	34	181
		20%	20%	20%	25%	19%	25%	20%	20%	19%	20%
£28,001 to £34,000	(31)	139	74	65	22	117	22	68	71	27	112
		13%	14%	12%	15%	12%	15%	15%g	11%	15%	12%
£34,001 to £41,000	(37.5)	74	42	32	4	70	4	28	46	10	64
		7%	8%c	6%	3%	7%e	3%	6%	7%	6%	7%
£41,001 to £48,000	(44.5)	18	12	6	2	16	2	8	10	4	14
		2%	2%	1%	1%	2%	1%	2%	2%	2%	2%
£48,001 to £55,000	(51.5)	21	12	9	3	18	3	9	12	3	18
		2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
£55,001 to £62,000	(58.5)	5	3	2	-	5	-	3	2	1	4
		*	1%	*	-	1%	-	1%	*	1%	*
£62,001 to £69,000	(65.5)	5	3	2	2	3	2	2	3	2	3
		*	1%	*	1%	*	1%	*	*	1%	*
£69,001 to £76,000	(72.5)	3	2	1	-	3	-	3	-	1	2
		*	*	*	-	*	-	1%g	-	1%	*
£76,001 to £83,000	(79.5)	2	2	-	1	1	1	1	1	1	1
		*	*	-	1%	*	1%	*	*	1%	*
£83,001 or more	(86)	1	1	-	-	1	-	1	-	-	1
		*	*	-	-	*	-	*	-	-	*

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 38

D10. What is the combined annual income of your household, prior to tax being deducted?
Base: All respondents

	Total GB	E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
		Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Prefer not to answer	40 4%	19 4%	21 4%	6 4%	34 4%	6 4%	20 5%	20 3%	4 2%	36 4%
Average income (£000's)	21.27	22.52b	20.06	22.10	21.14	22.10	22.36g	20.52	22.34	21.05

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 39
D11. Social Grade
Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
A	54	12	36	18	10	20	24	54	-	-	-	12	10	7	3	7	15
	5%	6%	6%	4%	4%	4%	6%	25%ijk	-	-	-	6%	5%	5%	3%	5%	5%
B	162	41	98	64	44	60	58	162	-	-	-	41	28	16	14	20	43
	15%	21%a	16%	13%	18%	13%	15%	75%ijk	-	-	-	21%mn	13%	12%	13%	14%	15%
C1	246	37	118	128	75	98	73	-	246	-	-	37	46	33	31	36	63
	23%	19%	20%	27%c	31%fg	21%	19%	-	100%hjk	-	-	19%	21%	25%	28%	26%	23%
C2	198	36	119	79	35	104	59	-	-	198	-	36	48	25	16	20	53
	18%	18%	20%	16%	15%	23%eg	15%	-	-	100%hik	-	18%	22%	19%	14%	14%	19%
D	182	34	103	79	44	84	54	-	-	-	182	34	49	20	17	22	40
	17%	17%	17%	16%	18%	18%	14%	-	-	-	43%hij	17%	22%	15%	15%	16%	14%
E	240	40	127	113	31	93	116	-	-	-	240	40	39	31	31	35	64
	22%	20%	21%	23%	13%	20%e	30%ef	-	-	-	57%hij	20%	18%	23%	28%m	25%	23%
NET: ABC1	462	90	252	210	129	178	155	216	246	-	-	90	84	56	48	63	121
	43%	45%	42%	44%	54%fg	39%	40%	100%jk	100%jk	-	-	45%	38%	42%	43%	45%	43%
NET: C2DE	620	110	349	271	110	281	229	-	-	198	422	110	136	76	64	77	157
	57%	55%	58%	56%	46%	61%e	59%e	-	-	100%hi	100%hi	55%	62%	58%	57%	55%	56%
Refused	1	-	1	-	-	-	1	-	-	-	-	-	-	-	-	-	1
	*	-	*	-	-	-	*	-	-	-	-	-	-	-	-	-	*

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 39
D11. Social Grade
Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
A	54	29	25	9	45	9	21	33	11	43
	5%	5%	5%	6%	5%	6%	5%	5%	6%	5%
B	162	97	65	24	138	24	63	99	28	134
	15%	18%b	12%	17%	15%	17%	14%	15%	16%	15%
C1	246	124	122	31	215	31	89	157	29	217
	23%	23%	22%	22%	23%	22%	20%	25%	16%	24%h
C2	198	100	98	26	172	26	97	101	47	151
	18%	19%	18%	18%	18%	18%	22%g	16%	26%i	17%
D	182	86	96	26	156	26	79	103	34	148
	17%	16%	17%	18%	17%	18%	18%	16%	19%	16%
E	240	94	146	28	212	28	95	145	30	210
	22%	18%	26%a	19%	23%	19%	21%	23%	17%	23%
NET: ABC1	462	250	212	64	398	64	173	289	68	394
	43%	47%b	38%	44%	42%	44%	39%	45%f	38%	44%
NET: C2DE	620	280	340	80	540	80	271	349	111	509
	57%	53%	61%a	56%	58%	56%	61%g	55%	62%	56%
Refused	1	-	1	-	1	-	-	1	-	1
	*	-	*	-	*	-	-	*	-	*

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 40

D12. Which one of these regions do you live in?

Base: All respondents

			Gender		Age			Social Grade				Region					
	Total GB (a)	Total Scot-land (b)	Male (c)	Female (d)	18-34 (e)	35-54 (f)	55+ (g)	AB (h)	C1 (i)	C2 (j)	DE (k)	Scot-land (l)	North England (m)	Mid-lands (n)	East of England (o)	Wales/ SW (p)	London/ SE (q)
Base	1083	200	602	481	239	459	385	216	246	198	422	200	220	132	112	140	279
Scotland	200	200	98	102	40	79	81	53	37	36	74	200	-	-	-	-	-
	18%	100%a	16%	21%c	17%	17%	21%	25%ik	15%	18%	18%	100%mnop	-	-	-	-	-
North East	37	-	24	13	11	13	13	10	7	6	14	-	37	-	-	-	-
	3%b	-	4%	3%	5%	3%	3%	5%	3%	3%	3%	-	17%lnop	-	-	-	-
North West	99	-	72	27	20	52	27	17	25	15	42	-	99	-	-	-	-
	9%b	-	12%d	6%	8%	11%g	7%	8%	10%	8%	10%	-	45%lnop	-	-	-	-
Yorkshire & Humberside	84	-	44	40	17	38	29	11	14	27	32	-	84	-	-	-	-
	8%b	-	7%	8%	7%	8%	8%	5%	6%	14%hik	8%	-	38%lnop	-	-	-	-
West Midlands	68	-	46	22	12	25	31	14	15	15	24	-	-	68	-	-	-
	6%b	-	8%d	5%	5%	5%	8%	6%	6%	8%	6%	-	-	52%lmop	-	-	-
East Midlands	64	-	39	25	6	33	25	9	18	10	27	-	-	64	-	-	-
	6%b	-	6%	5%	3%	7%e	6%e	4%	7%	5%	6%	-	-	48%lmop	-	-	-
Wales	76	-	38	38	22	32	22	14	23	12	27	-	-	-	-	76	-
	7%b	-	6%	8%	9%	7%	6%	6%	9%	6%	6%	-	-	-	-	54%lmno	-
East of England	112	-	61	51	22	54	36	17	31	16	48	-	-	-	112	-	-
	10%b	-	10%	11%	9%	12%	9%	8%	13%	8%	11%	-	-	-	100%lmnp	-	-
London	132	-	60	72	40	46	46	34	34	23	40	-	-	-	-	-	132
	12%b	-	10%	15%c	17%f	10%	12%	16%k	14%	12%	9%	-	-	-	-	-	47%
South East	147	-	85	62	39	56	52	24	29	30	64	-	-	-	-	-	147
	14%b	-	14%	13%	16%	12%	14%	11%	12%	15%	15%	-	-	-	-	-	53%
South West	64	-	35	29	10	31	23	13	13	8	30	-	-	-	-	64	-
	6%b	-	6%	6%	4%	7%	6%	6%	5%	4%	7%	-	-	-	-	46%lmno	-

Proportions/Means: Columns Tested (5% risk level) - a/b - c/d - e/f/g - h/i/j/k - l/m/n/o/p

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Attitudes to E-Cigarettes and Regulation

ONLINE Fieldwork: 24th - 28th July 2015

Absolutes/col percents

Table 40

D12. Which one of these regions do you live in?

Base: All respondents

		E-Cigarette Use			Cigarette Use		Family Smoke		Family E-Cigarette	
	Total GB	Users (a)	Non-Users (b)	E-cig-arette switch-ers (c)	Users (d)	Non-Users (e)	Yes (f)	No (g)	Yes (h)	No (i)
Base	1083	530	553	144	939	144	444	639	179	904
Scotland	200	96	104	28	172	28	85	115	30	170
	18%	18%	19%	19%	18%	19%	19%	18%	17%	19%
North East	37	24	13	8	29	8	18	19	13	24
	3%	5%b	2%	6%b	3%	6%	4%	3%	7%i	3%
North West	99	56	43	10	89	10	43	56	23	76
	9%	11%	8%	7%	9%	7%	10%	9%	13%	8%
Yorkshire & Humberside	84	40	44	11	73	11	34	50	17	67
	8%	8%	8%	8%	8%	8%	8%	8%	9%	7%
West Midlands	68	29	39	10	58	10	27	41	8	60
	6%	5%	7%	7%	6%	7%	6%	6%	4%	7%
East Midlands	64	42	22	17	47	17	24	40	10	54
	6%	8%b	4%	12%b	5%	12%d	5%	6%	6%	6%
Wales	76	37	39	9	67	9	34	42	10	66
	7%	7%	7%	6%	7%	6%	8%	7%	6%	7%
East of England	112	49	63	10	102	10	52	60	21	91
	10%	9%	11%	7%	11%	7%	12%	9%	12%	10%
London	132	72	60	17	115	17	44	88	18	114
	12%	14%	11%	12%	12%	12%	10%	14%	10%	13%
South East	147	60	87	17	130	17	56	91	19	128
	14%	11%	16%a	12%	14%	12%	13%	14%	11%	14%
South West	64	25	39	7	57	7	27	37	10	54
	6%	5%	7%	5%	6%	5%	6%	6%	6%	6%

Proportions/Means: Columns Tested (5% risk level) - a/b/c - d/e - f/g - h/i

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

Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)
Evidence from University South Wales – School of Life Science – PHB 80 / Tystiolaeth gan Brifysgol De Cymru – Yr Ysgol Gwyddorau Bywyd ac Addysg – PHB 80

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
Definitely agree – • Risk of passive inhalation from vaping • Evidence base on potential risks from chemicals in these devices is currently limited – so could pose further health risk of future • Sends confused messages – is it/isn't it a cigarette – can't tell first glance. • Problem enforcing smoking ban in public places/cars if confusion on what is being used • Promotes copying/replicating behaviour by children and adolescents • A child public health issue due to their age and vulnerability – cognition, knowledge and understanding immature to be able to make informed choices. • Smoking/vaping is a leisure activity – should not be allowed in the workplace

Question 2

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?
Yes • Need to control products in case additional chemicals are added • Need to prevent replacing the smoking habit with vaping habit • Need to ensure those wishing to 'quit' smoking are assisted in an organised way • Access to these can assist quitting but nicotine replacement is addictive so same control as tobacco encouraged. • Promoting good choices for future population out ways the need for those who are trying to give up smoking by using other forms of inhalation products/e cigarettes as they could use

other forms to help which are not visible to children – i.e. patches or a placebo cigarette which contains no inhalation.

Question 3

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?

Yes –

- Sends confused messages – is it/isn't it a cigarette – can't tell first glance.
- Problem enforcing smoking ban in public places/cars if confusion on what is being used
- Children and adolescents understanding immature to be able to make informed choices on what is being used and differences
- E-cigs produce a vapour which looks like a smoke so smoke free must mean smoke free

Question 4

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?

Yes–

- Copying behaviour, fashion and media pressure may encourage take up that could lead to 'trying' smoking

Question 5

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

Yes –

- Prevent room for illegal products
- Health& Safety e.g. Fire hazard, exploding devices also needs to be accounted for

Question 6

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?

Yes though difficult to police_

- Until evidence base is robust on long term use safety

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
Excellent to create compulsory licensing system etc – to protect both the practitioner and the public • Known significant risk of blood borne infection if not controlled • Public health risk from unscrupulous practitioners • Invasive procedure • Need to protect the vulnerable be it children or adults • Should adhere to code of practice •

Question 8

Do you agree with the types of special procedures defined in the Bill?
Yes but – • Need to consider fish pedicures also as no age limit stated in previous documents • Need to consider colonic irrigation unless it is captured elsewhere

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
Yes but through expert advice and consultation with key stakeholders

Question 10

Do you have any views on whether enforcing the licensing system would result in any particular difficulties for local authorities?
• May be additional duties but implications for infection and H&S need to be controlled. • Already inspect tattoo parlours. • Recent evidence of hepatitis spread via such establishment in Wales. Need to protect children • Need to apply advertising rules as for smoking

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
Yes- • Think a legal age limit is definitely required however again this does depend also on the competence/capacity of the child regarding this and perhaps consent of a parent should also be sought between age 16 and 18? Or even raised to 18. • Need to consider cultural aspects. • Risk assessment of any consent given required – why would they need at an age below 18yrs • Are all operators DBS checked? •

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
Yes agree • the legal and ethical issues regarding consent and capacity should be considered at this age however for such intimate piercings the issues around vulnerability and safeguarding are also paramount – protecting children from harm should be the first priority and therefore by making the age restriction at 16 would in some way go to enforce this however again as in Question 11 there may still be some young people who would be vulnerable at age 16 – 18 and this needs careful consideration regarding being fully aware and informed of decision to have an intimate piercing – i.e. infection, scarring etc and therefore may be a need to raise the age to 18. • May have implications for future health – psychological/physical • Should prohibit advertising of such procedures

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
• Depends what exactly is being proposed as it is unclear- • Must protect those vulnerable individuals to ensure they can get access to services if they are disabled, elderly, vulnerable, don't drive, have intellectual problems in care etc • Must be equitable not just efficient based on cost • Must be truly needs based

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
Definitely agree- • Reduce GP pressure for non acute care e.g. coughs/colds as they advise now • Encourage existing pharmacies to adapt and extend their services – particularly undertaking training in the assessment of competence for children/young people requesting any medication or advice. • Need to have link to GP for referral if needed • Good examples – flu vaccine, routine vaccination clinics for travel health, BP checks, glucose and weight checks etc - promote as 'well being services' rather than illness support Need to diversify and utilise skills of the pharmacist – perhaps employ nurse practitioners in pharmacies s

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
Publishing it doesn't necessarily mean it will get to the highest risk groups who it may affected. Stating what they will do should be after they have consulted

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
No- • Difficulty accessing in some areas now – rural Wales shutting public toilets because of cost. • Needs to be guided by key elements they must provide for public

Question 17

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?
NO- • Must protect those vulnerable individuals to ensure they can get access to services if they are disabled, elderly, vulnerable, have particular health needs where access required – bowel/ bladder disorders, continence issues, stoma. Also young children. • How will you seeks the views of those most likely to be affected

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
There are positives and negatives to this- • An example of setting - public houses are paid – will they have to be DDA friendly, would a parent of small child feel happy to enter. • Those with religious and cultural needs have to be considered • Thinking of waste issues – who will control • How would public access during bank holidays, out of hours etc

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
Some but not all – obesity and alcohol abuse are key problems in Wales also!

Question 20

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

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
Need more information on each aspect to make further informed responses

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 Gwynedd Council – PHB 81 / Tystiolaeth gan Cyngor Gwynedd – PHB 81

YMGYNGHORIAD Y PWYLLGOR IECHYD A GOFAL CYMDEITHASOL AR EGWYDDORION CYFFREDINOL Y BIL IECHYD Y CYHOEDD(CYMRU)

Cyflwyniad o sylwadau gan adran Rheoleiddio, Cyngor Gwynedd

Cyflwynir y sylwadau isod yn bennaf o bersbectif Gwasanaeth Gwarchod y Cyhoedd fydd yn bennaf gyfrifol am orfodi agweddau sylweddol o'r Bil pan fydd yn cael ei gyflwyno fel Deddf Gwlad. Yn gyffredinol, mae'r Cyngor yn cefnogi mesurau pellach gan Gynulliad Cenedlaethol Cymru i atgyfnerthu pwerau gorfodaeth mewn perthynas â'r meysydd pwysig hyn sydd yn effeithio ar iechyd y cyhoedd.

RHAN 2 : Tybaco a chynhyrchion nicotin

Mae Rhan 2 o'r Bil yn cynnwys darpariaethau sy'n ymwneud â thybaco a chynhyrchion nicotin, ac mae'r rhain yn cynnwys gosod cyfyngiadau er mwyn sicrhau bod y defnydd o ddyfeisiau mewnanadlu nicotin megis sigaréts electronig (e-sigaréts) yn cyd-fynd â'r cyfyngiadau presennol ar ysmygu; creu cofrestr genedlaethol o fanwerthwyr tybaco a chynhyrchion nicotin; a gwahardd trosglwyddo tybaco neu gynhyrchion nicotin i berson o dan 18 oed.

Cwestiwn – A ydych yn cytuno y dylai'r defnydd o e-sigarets gael ei wahardd mewn mannau cyhoeddus a mannau gwaith caeedig yng Nghymru , yn yr un modd ag y mae tybaco sy'n cael ei wahardd ar hyn o bryd?

Rydym yn cefnogi ymestyn gwaharddiad i ddefnydd o e sigaréts mewn mannau cyhoeddus a mannau gwaith caeedig os yw'r dystiolaeth yn dangos fod y cynhyrchion hyn yn beryglus i iechyd. Diben y rheoliadau gwahardd ysmygu mewn mannau cyhoeddus yw gwahardd cynhyrchion tybaco gan fod tystiolaeth benodol fod tybaco yn niweidiol. Nid oes tybaco mewn e sigaréts; ond mae angen ymchwil pellach ynglŷn â diogelwch y cynhyrchion nicotin a'r cynhwysion eraill sydd yn gallu cael eu cynnwys yn yr hylifau a ddefnyddir ar gyfer e sigaréts.

Cytunir yn llwyr yn dylid gwahardd defnydd e sigaréts sydd gydag edrychiad sigarennau confensiynol; gan y gall eu defnydd mewn mannau cyhoeddus normaleiddio ysmygu unwaith eto. Fe all eu defnydd hefyd annog plant a phobl ifanc i ysmygu; ond nid yw'r dystiolaeth yn glir yn hyn o beth.

Mae e sigaréts sydd yn edrych fel sigaréts confensiynol yn gallu tanseilio ymdrechion awdurdodau lleol i orfodi'r ddeddfwriaeth mannau cyhoeddus di - fwg. Mae hefyd yn anodd i berchnogion a rheolwyr busnesau i weithredu'r ddeddfwriaeth os oes unigolion yn defnyddio e sigaréts sydd yn debyg i sigaréts confensiynnol.

Cwestiwn - Beth yw eich barn ar ymestyn y cyfyngiadau ar ysmygu ac e-sigaréts i rai mannau nad ydynt yn gaeedig (gallai enghreifftiau gynnwys tir ysbytai a meysydd chwarae i blant)?

Rydym o'r farn y dylid parhau i annog busnesau a sefydliadau i beidio caniatáu ysmygu mewn unrhyw le agored cyhoeddus. Credir y dylid cyfyngu pwerau gorfodaeth mewn mannau cyhoeddus lle mae Plant neu bobl fregus yn ymgynnull er enghraifft parciau a chaeau chware; ffeiriau, tir o gwmpas ysgolion ac ysbytai.

Cwestiwn - A ydych yn credu y bydd y darpariaethau yn y Bil yn sicrhau cydbwysedd rhwng y manteision posibl i ysmygwyr sydd am roi'r gorau iddi ac unrhyw anfanteision posibl sy'n gysylltiedig â'r defnydd o e-sigaréts?
Ydym. Mae angen monitro'r dystiolaeth yn ofalus i sicrhau nad ydyw defnydd o e sigaréts yn annog pobl i ysmygu, a bod e sigaréts yn cael eu defnyddio fel teclyn i geisio rhoi'r gorau i ysmygu yn unig.

Cwestiwn - A oes gennych farn ynghylch a yw'r defnydd o e-sigaréts yn ail-normaleiddio ysmygu mewn mannau di-fwg, ac o ystyried eu bod yn efelychu sigaréts o ran eu hymddangosiad, a ydynt yn hyrwyddo ysmygu yn anfwriadol?

Mae yna bryder fod defnydd o e sigaréts yn enwedig rhai sydd wedi eu cynllunio i edrych fel sigaréts confensiynol yn 'normaleiddio' ysmygu ac agwedd pobl tuag at ysmygu. Yn dilyn cyflwyno'r gwaharddiad i ysmygu mewn mannau cyhoeddus caeedig; mae newid sylweddol wedi bod mewn diwylliant o ran ysmygu; ac mae yna berygl fod annog a chaniatáu defnydd o e sigaréts yn tanseilio'r gwaith sydd wedi ei wneud yn hyn o beth.

Cwestiwn - A oes gennych unrhyw farn ynghylch a fydd cyfyngu ar y defnydd o e sigaréts mewn mannau di-fwg cyfredol yn cynorthwyo rheolwyr mangreoedd i orfodi'r drefn dim ysmygu bresennol?

Oes. Rydym wedi sylwi fod rhai eiddo trwyddedig wedi cyflwyno polisïau eu hunain i wahardd cwsmeriaid a staff rhag defnyddio e sigarets mewn mannau caeedig o'u heiddo. Mae'r camau hyn wedi eu cymryd mewn ymateb i'r problemau mae defnydd e sigarets yn eu creu i reolwyr safleoedd sydd yn ceisio sicrhau fod y gwaharddiad ysmygu yn cael ei weithredu. Mae defnydd e sigarets yn creu dryswch ymysg y cyhoedd; yn enwedig pan mae'r cyfarpar yn edrych fel sigarets electronig.

Cwestiwn - A oes gennych farn ynglŷn â lefel y dirwyon i'w gosod ar berson sy'n euog o droseddau a restrir o dan y Rhan hon?

Dylid sicrhau fod y ddarpariaeth gorfodaeth mewn perthynas â Rhybuddion Cosb Penodedig ac yn y blaen , yn gyson gyda darpariaeth gorfodaeth a dirwyon mewn perthynas â'r gwaharddiad ysmygu mewn mannau cyhoeddus caeedig.

Cwestiwn - A ydych yn cytuno â'r cynnig i greu cofrestr genedlaethol o fanwerthwyr tybaco a chynhyrchion nicotin?

Nid yw yn glir lle mae'r dystiolaeth o'r buddiant iechyd cyhoeddus o sefydlu cofrestr genedlaethol. Mae data cyfredol yn cael ei gadw gan bob Awdurdod Lleol ynglŷn â manwerthwyr sydd yn gwerthu cynhyrchion sydd gyda chyfyngiadau oedran beth bynnag. Mi fyddai sefydlu trefn o'r fath yn gostus; a ddim yn cynorthwyo Awdurdodau Lleol i dargedu adnoddau ar unigolion sydd yn gwerthu cynhyrchion tybaco yn anghyfreithlon.

A ydych yn credu y bydd sefydlu cofrestr yn helpu i amddiffyn pobl o dan 18 oed rhag cael mynediad i dybaco a chynhyrchion nicotin?

Os mai'r prif nod yw hwyluso gorfodi deddfwriaeth mewn perthynas â gwerthu i rai o dan 18 a gorfodi'r rheoliadau mewn perthynas â arddangos cynnyrch tybaco; nid yw yn glir sut y gall cofrestr o'r fath lwyddo at bwrpas y dibenion hyn.

Bydd y gofrestr yn gynllun costus ac angen ei orfodi ymhellach a bydd masnachwyr cydwybodol yn cael eu cosbi oherwydd masnachwyr diegwyddor. Nid ydym yn meddwl bod cofrestr o'r fath yn mynd i leihau gwerthu dan oed os nad oes darpariaeth ar gyfer cryfhau'r drefn gyfredol o gosbi manwerthwyr sy'n troseddu.

Mae'r wybodaeth am y mwyafrif sy'n gwerthu sigaréts eisoes gennym ar fasdata ac os oes cofrestr yn cael ei greu, nid yw'r gwerthwyr anghyfreithlon am gofrestru sy'n debyg iawn i'r sefyllfa bresennol.

Cwestiwn - Beth yw eich barn ynglŷn â chreu trosedd newydd ar gyfer trosglwyddo tybaco a chynhyrchion nicotin yn fwriadol i berson o dan 18 oed, sef yr oedran gwerthu cyfreithiol yng Nghymru?

Rydym yn cefnogi'r bwriad gan y bydd yn gosod trefn fel y gweithredir mewn perthynas â gwerthiant alcohol.

Cwestiwn - A ydych yn credu y bydd y cynigion yn ymwneud â thybaco a chynhyrchion nicotin a gynhwysir yn y Bil yn cyfrannu at wella iechyd y cyhoedd yng Nghymru?
Ydym. Ein pryder mwyaf yw sicrhau nad ydyw defnydd e sigarets yn tanseilio ymdrechion Awdurdodau Lleol i orfodi deddfwriaeth gwaharddiad ysmygu mewn mannau cyhoeddus caeedig; ac nad ydyw defnydd e sigarets yn annog pobl i gychwyn ysmygu ac yn normaleiddio ysmygu cyhoeddus yn ein cymdeithas unwaith eto.

RHAN 3: Triniaethau Arbennig
Mae Rhan 3 o'r Bil yn cynnwys darpariaeth i greu system drwyddedu orfodol, genedlaethol ar gyfer ymarferwyr sy'n darparu triniaethau arbennig penodol yng Nghymru, sef aciwbigo, tyllu'r corff, electrolysis a thatwio.

Cwestiwn - Beth yw eich barn ynglŷn â chreu system drwyddedu orfodol, genedlaethol ar gyfer ymarferwyr sy'n darparu triniaethau arbennig penodol yng Nghymru, a bod yn rhaid i'r fangre neu'r cerbyd lle mae ymarferwyr yn gweithredu fod wedi ei gymeradwyo?

Credir mai dyma yw'r r argymhelliad yn y Bil sydd fwyaf tebygol o gael effaith bositif ar iechyd cyhoeddus, a diogelu'r cyhoedd oddi wrth ymarferion peryglus.
Mae'r pwerau a argymhellir yn cynnwys creu trosedd uniongyrchol o fethu a chofrestru, ynghyd ag ystod eang a chynhwysfawr o bwerau gorfodaeth effeithiol. Mae'r ddeddfwriaeth bresennol yn annigonol i fynd i'r afael ar broblem o weithredwyr angyfreithlon - ac felly rydym yn methu yn ein hymdrechion i ddiogelu iechyd y cyhoedd. Mae Swyddogion Iechyd yr Amgylchedd ar hyn o bryd yn dibynnu ar ddeddfwriaethau nad ydynt wedi eu creu yn bwrpasol ar gyfer targedu gweithredwyr angyfreithlon.

Cwestiwn - A ydych yn cytuno â'r mathau o driniaethau arbennig a ddiffinnir yn y Bil?
Ydym. Cefnogir y bwriad i gynnwys Aciwbigo, Tatwio, Tyllu Croen ac Electrolysis. Rydym o'r farn y dylid ehangu'r diffiniad i sicrhau fod y ddeddfwriaeth yn ymestyn pwerau gorfodaeth i amryw o driniaethau newydd sydd yn cynyddu'r risg o haint drwy dreiddio'r croen i mewn i'r cnawd . Argymhellir fod y darpariaethau gorfodaeth yn cael eu geirio fel bod posib ychwanegu triniaethau newydd yn y dyfodol - fel mae tystiolaeth o'r angen i reoleiddio triniaethau arbennig yn dod i'r amlwg.

Cwestiwn - Beth yw eich barn ar y ddarpariaeth sy'n rhoi pŵer i Weinidogion Cymru ddiwygio'r rhestr o driniaethau arbennig drwy is-ddeddfwriaeth?
Cytunir y dylid sicrhau pwerau i ddiwygio'r rhestr o driniaethau arbennig am y rhesymau sydd wedi eu nodi uchod.

Cwestiwn - Mae'r Bil yn cynnwys rhestr o broffesiynau penodol sy'n esempt o'r angen i gael trwydded i roi triniaethau arbennig. A oes gennych unrhyw farn ynglŷn â'r rhestr?
Rydym yn cytuno fod angen cynnwys rhestr o broffesiynau penodol sydd angen ei heithrio o'r gofynion. Mae'r proffesiynau hyn yn ymarfer hylendid da a gyda chanllawiau effeithiol mewn lle o ran atal ymledaeniad afiechydon heintus. Mae'r proffesiynau hyn yn cael eu rheoleiddio gan gyrff proffesiynol penodol; ond os penderfynir fod triniaeth arbennig yn disgyn tu allan i ystod eu cymwysterau, cefnogir yr argymhelliad i ystyried hyn yn y ddeddfwriaeth.

Cwestiwn - A oes gennych unrhyw farn ynghylch a fyddai gorfodi'r system drwyddedu yn arwain at unrhyw anawsterau penodol i awdurdodau lleol?

Fe fyddai gorfodi'r system drwyddedu arfaethedig yn caniatáu i awdurdodau lleol i ymgymryd â'u dyletswyddau gwarchod y cyhoedd yn fwy effeithiol. Mae sefydlu cyfundrefn drwyddedu hefyd yn caniatáu i awdurdodau lleol i adennill costau er mwyn sicrhau fod posib ariannu'r elfennau hyn o'r gwasanaeth. Mae'r argymhellion yn cryfhau pwerau gorfodaeth mewn perthynas â gweithredwyr cyfreithlon, ac yn cyflwyno pwerau pwrpasol newydd er mwyn gwarchod y cyhoedd rhag ymarferion peryglus gweithredwyr anghyfreithlon.

Cwestiwn - A ydych yn credu y bydd y cynigion yn ymwneud â thriniaethau arbennig a gynhwysir yn y Bil yn cyfrannu at wella iechyd y cyhoedd yng Nghymru?

Ydym. Credir fod gan yr argymhellion a gynhwysir mewn perthynas â thriniaethau arbennig botensial sylweddol i gyfrannu at wella iechyd cyhoeddus yng Nghymru. Yn ein barn ni; dyma'r argymhelliad mwyaf grymus ac effeithiol sydd yn cael ei gynnwys yn y Bil. Mae'r dystiolaeth o'r risgiau i iechyd y cyhoedd mewn perthynas â unrhyw driniaeth sydd yn tyllu drwy'r croen yn glir. Mae risg gwirioneddol o halogiad oddi wrth firysau a gludir yn y gwaed a all beryglu iechyd gydag ymarferion o'r fath. Mae rheolaeth gyfredol o'r triniaethau hyn yn annigonol; ac mae angen y grymoedd ychwanegol hyn i wahardd pobl nad ydynt yn gymwys i ymarfer y triniaethau hyn. Rydym hefyd angen y grymoedd arfaethedig i sicrhau fod y triniaethau hyn yn cael eu cynnal mewn modd hylan fel y gellir rheoli'r risg o halogiad.

<u>Rhan 4: Rhoi Tyllau Mewn Rhannau Personol o'r Corff</u>
Mae Rhan 4 o'r Bil yn cynnwys darpariaeth i wahardd rhoi tyllau mewn rhan bersonol o'r corff i unrhyw un o dan 16 oed yng Nghymru.

Cwestiwn - A ydych yn credu bod angen cyfyngiad oedran ar roi tyllau mewn rhannau personol o'r corff? Beth yw eich barn ynglŷn â gwahardd rhoi tyllau mewn rhannau personol o'r corff i unrhyw un o dan 16 oed yng Nghymru?

Ydym. Mae'n rhaid sicrhau fod pobl ifanc o dan 16 yn cael eu diogelu - nid yw ymarferion tyllu rhannau personol o'r corff yn briodol o gwbl ar gyfer rhai o dan 16 ac fe ddylai'r ymarferion hyn fod yn anghyfreithlon.

Cwestiwn - A ydych yn cytuno â'r rhestr o rannau personol o'r corff a ddiffinnir yn y Bil?
Ydym

Cwestiwn - A oes gennych unrhyw sylwadau ar y cynigion i roi dyletswydd ar awdurdodau lleol i orfodi'r darpariaethau, ac i roi'r pŵer i awdurdodau lleol fynd i mewn i fangre, fel y nodir yn y Bil?

Cefnogir yr argymhellion. Cydnabyddir y bydd angen cefnogaeth yr Heddlu mewn sefyllfaoedd lle fydd tystiolaeth yn cael ei gasglu yn dilyn honiad o drosedd; oherwydd natur bersonol a sensitif y driniaeth . Dylid sicrhau fod adnoddau digonol ar gael i awdurdodau lleol mewn perthynas â unrhyw ddyletswyddau statudol newydd.

Cwestiwn - A ydych yn credu y bydd y cynigion sy'n ymwneud â thriniaethau arbennig a gynhwysir yn y Bil yn cyfrannu at wella iechyd y cyhoedd yng Nghymru?
Ydym.

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 Joint response from organisations – PHB 82 / Tystiolaeth gan Ymateb ar y cyd gan sefydliadau – PHB 82

11 September 2015

Dear Chair,

Evidence on the general principles of the Public Health (Wales) Bill

1. Introduction

1.1. We welcome the opportunity to respond to the Health and Social Care Committee's call for evidence on the general principles of the Public Health (Wales) Bill. We represent a cross-section of public health interests in Wales and we collectively recognise the potential health improvement gains that can be made from the Public Health (Wales) Bill and the Public Health (Minimum Unit Pricing) Bill.

1.2. Whilst individual organisations may pursue specific issues relating to the Bill, jointly we have agreed to three key improvements that we believe would enhance the health of the Welsh public and we recommend they should be added to develop the Public Health (Wales) Bill.

1.3. The recommendations in this document are direct responses to the committee's specific questions:

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

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

1.1. In our discussions we recognised that many of the levers available to improve public health are already accessible to Welsh Ministers already and do not require legislation. Conversely, issues such as marketing regulations and food labelling fall beyond their competence. In making these recommendations we considered a range of evidence-based interventions, and agreed on the measures below, which meet the criteria of requiring a legislative vehicle to improve public health.

1.2. The proposals for the legislation would make a notable impact on Welsh public health and contribute towards stemming the increases in chronic conditions.

2. General Principles and Health Impact Assessments

1.1. We believe that there should be an additional Chapter which includes

a) A set of principles based on a positive approach to public health, which set a clear and unambiguous vision and tone for improving public health in Wales.

b) Legislation to enable Health Impact Assessments to be required by certain bodies

General Principles

1.1. In developing public health legislation, the principles of health promotion and enhancement should be placed as a primary concern within the legislation. At present the Bill primarily focuses on negative actions - i.e. restricting the use of certain products or practices. While restrictions have their place, we believe that the Bill should have a more positive emphasis on health promotion and encouraging positive action. This should be a guiding principle of the Bill.

1.2. The Bill also appears disjointed, with nothing in the proposed legislation that pulls the different proposals together into a single, coherent narrative about improving public health in Wales. We believe that a coherent narrative is important in order to communicate the importance of the public health agenda in Wales.

1.3. As a result, we suggest that a set of principles should be included in this new Chapter – such as:

a) Decisions made under the Bill should aim to:
    i. create and shape social conditions which enable people to be healthy
    ii. improve health over people's life course, including protecting the future health of our children and young people and protecting health interests in later life.
    iii. build community assets which contribute to healthy communities
    iv. regulate to protect health
b) Health promotion must be the primary consideration when Welsh Ministers or Public Bodies make decisions under this Bill.
c) Restrictions and penalties should only be introduced if doing so is likely to contribute towards the promotion of the health of the people of Wales.
d) Any decision regarding public health and wellbeing must include consideration of both physical and mental health and wellbeing. It should also build on the Rights of Children and Young Persons (Wales) Measure 2011 requirement to due regard to the UN Convention on the Rights of the Child, including Article 24 which confirms a right to 'a clean and safe environment'.
e) The impact on groups of people facing health inequalities, including those with protected characteristics, must be considered in any decisions made by Welsh Ministers or Public Bodies regarding public health promotion.

Health Impact Assessment (HIA)

1.4. Developments to our surrounding environments can often lead to consequences for the physical and mental health and wellbeing of a community. It could be the simple decision to remove or add some green space; new planning or environmental legislation; health board reconfiguration of services or hospital redevelopments; or changes to transport infrastructure and provision.

1.5. The potential impact that Planning policy and developments have, not just on the physical environment but on our health and wellbeing is significant. Health Impact Assessment (HIA) has been defined as 'a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population'[i].

1.6. The use of HIA was a major recommendation in the Acheson report on inequalities in health[ii] and the World Health Organisation (WHO) has continued to champion its use not just in planning, but in all major policy decisions.

We recommend that as part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce such inequalities. (Acheson). [iii]

1.7. The Welsh Government's Public Health Green Paper placed a focus on the potential use of HIA in policy and planning as part of a 'Health in All Policies' approach. Many of our organisations supported the use of HIA at the Green Paper stage; however, it was not included in the White Paper and subsequent Bill.

1.8. We believe that this Bill is a real opportunity for innovative thinking and a different approach to tackling chronic conditions by encouraging healthier lifestyles and addressing some of the wider determinants of health which impacts on these. We would strongly encourage the committee to take note of the work currently undertaken by the Wales Health Impact Assessment Support Unit[iv] throughout their deliberations – particularly the Unit's recent work with several Local Authority Planning Departments across Wales.

Our proposals

1.9. We propose that Health Impact Assessments which consider the wider determinants of health (including, but not restricted to, access to public toilets, exercise, active travel, green space for wellbeing), should be placed on the face of the Public Health (Wales) Bill. Subsequent regulations that specify exactly in what circumstances the assessments would be applied to on a mandatory basis can then develop over time.

1.10. We would anticipate that regulations would extend the use of HIA as a method of considering any potential impacts on health and wellbeing to include:

a) Local Development Plans, Strategic Development Plans and Developments of National Significance
b) Specific larger scale planning applications (such as housing developments over a certain size or proportionate to an existing community)
c) The development of new transport infrastructure
d) Welsh Government legislation and Bills
e) Specific statutory plans required as part of the Future Generations Act such as Local Well-being Plans
f) New NHS developments (e.g. new hospitals) or redevelopments
g) Major LHB proposed service reconfiguration.
h) Any major reorganisation of local government services

3. Obesity and Nutrition

1.1. Poor nutrition and obesity is a leading cause of preventable death and costs the Welsh NHS £73 million every year, increasing to nearly £86 million if people classed as overweight were to be included. The condition significantly increases the risk of heart disease and can contribute to chronic conditions such as diabetes, cancer, obesity, high blood pressure and depression. Severely obese people are estimated to die around a decade earlier than those with a healthy weight, mirroring the loss of life expectancy suffered by smokers.

1.2. Childhood obesity is recognised as a growing and serious problem with strong links to deprivation. Levels of childhood obesity in Wales are the highest in the UK and are storing a future public health burden on the Welsh NHS.

1.3. Obesity must therefore rank as one of the most serious and preventable public health challenges of our time. We urge that the government takes a holistic approach to both prevention and treatment for children and adults. Tackling specific parts of the problem or client group has the potential to lose the focus on other parts of the problem which have equal importance.

1.4. The World Journal of Pediatrics reports that an obese child is 80%[v] more likely to be an obese adult – a vicious cycle that must be broken. The journal Gut recently highlighted that being overweight in adolescence is linked to a greater risk of bowel cancer later in life. It also showed overweight teenagers went on to have twice the risk of bowel cancer and the figures were even higher in obese teen[vi]s.

1.5. The Welsh Governments' approach to tackling obesity is set out in the All Wales Obesity Pathway launched in 2012. However, implementation has been patchy and slow. Both the Welsh Government and the National Assembly for Wales Health and Social Care Committee have made it clear that the All Wales Obesity Pathway should be implemented in full, as soon as possible, and all patients in Wales must be given access to multidisciplinary Level 3 obesity services as a matter of urgency. The lack of progress is leaving many parts of Wales without adequate multi- disciplinary care for rising numbers of obese children and adults.

1.6. The public sector can play a substantial role in adapting catering practices and ensuring food served is of a higher nutritional standard.

What is most distinctive about public sector catering is that it caters for some of the poorest and most vulnerable people in society and this lowly social status helps to explain why the sector has been burdened with a Cinderella status for so many years. But the public sector catering service needs to be viewed and valued anew because the best index of a just (and sustainable) society is the way it treats its poorest and most vulnerable members, be they pupils, patients, pensioners or prisoners. In the UK the public sector spends some £2.5 billion a year on food and catering services, of which schools and hospitals are the largest categories by value. This budget ought to be deployed more strategically to render good food more readily available in public sector settings (Morgan, 2015).[vii]

Our proposals

1.7. Welsh Government included in the original white paper, proposals on nutritional standards within public sector settings. The Public Health (Wales) Bill is certainly weaker for not including these changes and we would welcome their reintroduction in the legislation.

1.8. We recognise that many legislative interventions are currently outside of the powers available to the National Assembly for Wales. However we wish to offer support for lobbying by the Welsh Government at the UK level for the following:

a) Restricting advertising of unhealthy food and drinks for example during, before and after children's TV programmes. Endorsements by children's TV or film characters and celebrities should also be banned.

b) Setting maximum levels on fat, salt and sugar in food marketed substantially to children.

4. Alcohol displays in the off-licensed trade

1.1. It is now common practice in grocery stores (and particularly in the major supermarkets) for alcohol to be displayed not only on a dedicated drinks aisle but also on other aisles within the shop, at front-of-store, and on end-of-aisle displays. Alcoholic drinks are also often placed with specific food types (e.g. lagers with ready-to-eat curries, red wine with red meats), a practice known as cross-marketing, intended to promote associations between everyday dining and alcohol consumption.

1.2. The importance of dispersing alcohol displays as a means to maintain and increase alcohol sales has been made very clear by the drinks industry:

1.3. The Carlsberg brewery have urged retailers to "create stacks of your promotional beers" and "site stacks away from the beer fixture to drive impulse purchase"[viii]

1.4. A unilateral decision by Asda in 2011 to end front-of-store alcohol displays was reversed in 2013 after the other supermarkets declined to join them in ending the practice[ix]

1.5. Marks and Spencer have stated that "separate siting [of alcohol] will mean we will be unable to place alcohol with other food products, making it difficult to promote alcohol as an accompaniment to food".[x]

1.6. In 2010, Alcohol Concern commissioned an independent research company to undertake a snapshot survey of four major supermarkets in Cardiff, recording where alcoholic drinks were located within stores. The findings are summarised below:[xi]

Sainsbury's: Discounted alcohol (wine, spirits, beer) found at front of store entrance Alcohol found on seasonal aisle, main food aisles, end of food aisles, and end of alcohol aisles	**Asda:** Discounted cider found at front of store entrance Alcohol found on seasonal aisle, end of food aisles, end of alcohol aisles, and free standing
Tesco: Alcohol displayed on seasonal aisle, main food aisles, end of food aisles, ends of alcohol aisles, free standing, and in the tills area	**Morrisons:** Alcohol found on main food aisles, end of alcohol aisles and free standing

Our proposals

1.1. Since 2009, there has been a statutory requirement in Scotland that "the display of alcohol for consumption off the premises...be confined to a single area of the premises", i.e. either on a dedicated alcoholic drinks aisle in large shops, or on a specific set of shelves in small shops. The precise nature (size, location etc.) of the display area is agreed between the licensee and the licensing authority. It is also permitted for shops to display alcohol in "an area that is inaccessible to the public", i.e. behind a counter.

1.2. According to the Scottish Government, this measure "effectively eliminates cross-merchandising of alcohol with other products and means that customers will need to make a more conscious decision to go to that area if they intend to browse or buy an alcohol product. They will no longer encounter numerous alcohol displays as they select their everyday groceries".[xii]

1.3. We propose that alcohol sold in the off-trade (i.e. in shops) in Wales should be displayed in an equivalent manner to that in Scotland. The Welsh Government has previously backed the introduction of "separate areas for [alcohol] sale in supermarkets",[xiii] whilst a survey in 2010 of 1,000 people in Wales who had purchased alcohol in the previous three months found that 70% of respondents supported confining alcohol displays to a single part of any shop, with only 20% against.[xiv]

1.4. We suggest that, like the Draft Public Health (Minimum Price for Alcohol) Bill, this change comes within the powers of the Assembly to legislate for the "promotion of health, prevention, treatment and alleviation of disease", as defined in Schedule 7 Part 1 Subject 9 of the Government of Wales Act 2006. However, we are aware that the Committee may wish to seek legal clarification on this point.

Yours sincerely,

Professor Kevin Morgan

























Run Wales

CC:
Minister for Health and Social Services
Deputy Minister for Health
Chief Medical Officer

Requests for further information:
Jon Antoniazzi
Policy Officer/ Swyddog Polisi
[redacted] / [redacted]
[redacted]

[i] European Centre for Health Policy (1999) *Health Impact Assessment: main concepts and suggested approach World Health Organisation Gothenburg consensus paper* http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCEQFjAAahUKEwjfyKzR7cPHAhVsOdsKHWB5AyI&url=http%3A%2F%2Fwww.apho.org.uk%2Fresource%2Fview.aspx%3FRID%3D44163&ei=xSzcVZ_SKOzy7Abg8o2QAg&usg=AFQjCNEG__AyNn_zf2pL--waVG_pp93jow&sig2=YyPiYar4LWEg1EzbZvl6-Q [accessed 25.08.15]

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[xiv] RMG on behalf of Alcohol Concern Cymru (2010) *Out of the Way? Alcohol displays in supermarkets* http://www.alcoholconcern.org.uk/wp-content/uploads/woocommerce_uploads/2015/03/Out-of-the-way.pdf [accessed 25.08.15]

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

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

Evidence from The Urology Trade – PHB 83 / Tystiolaeth gan Gymdeithas y Fasnach Wroleg – PHB 83

Public Health (Wales) Bill: Consultation questions

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
The Urology Trade Association (UTA) welcomes the Bill's proposal to introduce 'pharmaceutical needs assessments (PNAs)' in Wales and believes that the proposals would bring planning and delivery of pharmaceutical services in Wales in line with other primary care services across the UK. The UTA also welcomes the Bill's proposal to require Health Boards to keep PNAs under review, encouraging pharmacies to adapt and expand their services in response to local needs. The UTA would like to highlight the need to ensure that the definition and regulations of PNAs are comprehensive in setting out the needs for the area and assess how they might impact on the community with specific needs, including the 25% of the UK population who suffers from incontinence. The UTA would like to see the in the inclusion of requirements for Health Boards to consult with patients with continence problems and experts in the field as part of the PNA review process, moving towards a more patient-centred approach. We are therefore pleased that the PNAs will move away from applications from pharmacy contractors that is focused on the dispensing of prescription to one of broader pharmaceutical and DAC services. that takes into account the needs of the community. We hope that this approach allows patients to have better access to a wide range of high quality urology products and services which allow them to maintain their independence, quality of life and clinical wellbeing. Patients being unable access products that meet their own specific needs also lead to product wastage, an increased incidence of urinary tract infections due to the products' invasive nature, and an increased reliance of health and social care services – leading to increased costs. We hope that this proposal, particularly the requirement for Health Boards

to review their assessments opens up the necessary opportunity for engagement – both with patients and healthcare professionals in the field.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
The UTA supports the Bill's proposal to require each local authority to prepare and publish a local toilets strategy for its area. In the UK, an estimated 6 million people are affected by continence problems and many rely on urology appliances on a daily basis. High quality urology appliances such as catheters allow users to manage their conditions, maintaining their quality of life and independence and avoiding repeated medical consultations. However, many people who use catheters fear not being able to access public toilets and can often left housebound. Requiring each local authority to prepare and publish a strategy which ensures the provision of sufficient public toilets which is maintained, safe and accessible is a starting point in addressing the issues currently faced by people with continence problems.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
Please refer to the above response.

Question 17

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?

The UTA understands that the current system poses a number of challenges including poor planning around making the best use of toilets already accessible to the public and the lack of uniformity in the provision and maintenance of public toilets. We believe that the provision in the Bill to ensure appropriate engagement with communities must consider the need of patients with continence problems and engage with users of urology products and experts to improve the quality of continence care in Wales.

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

Evidence from Royal Pharmaceutical Society – PHB 84 / Tystiolaeth gan Y Gymdeithas Fferyllol Frenhinol – PHB 84

Health and Social Care Committee
Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

20th August 2015

Dear Sir / Madam

Public Health (Wales) Bill consultation

The Royal Pharmaceutical Society (RPS) welcomes the opportunity to respond to the National Assembly for Wales' Health and Social Care Committee's calling for evidence on the general principles of the Public Health (Wales) Bill.

Part 2 – Tobacco and Nicotine Products

In order not to undermine recent advances in public health policy regarding the use of tobacco products, the RPS advocates that e-cigarettes should be treated in exactly the same way as any other form of smoking, including the same age restrictions as applied to tobacco products and restrictions on their use in public spaces, advertising and displays.

The RPS agrees that the use of e-cigarettes should be banned in enclosed public and work places in Wales in order to avoid the normalisation of any form of smoking and to help prevent recruitment of non-smokers, particularly young people.

We agree that it should be an offence to sell or supply nicotine inhaling products to a person under the age of 18, unless supplied legitimately through a registered healthcare professional, in line with specific service requirements for smoking cessation. In the same respect we are supportive of the intent to make the proxy purchase of nicotine products for children under the age of 18 an offence. We believe that clear guidance will be necessary to support this act and bring it in line with equivalent current offences regarding alcohol and tobacco.

Patron: Her Majesty The Queen Chief Executive: Helen Gordon Member enquiries T [redacted] E [redacted]

While it is currently difficult to ascertain with any certainty whether e-cigarettes are used as a gateway in or out of smoking, we would like to highlight that individuals under the age of 18 can currently be supported to give up smoking through the use of currently licensed nicotine replacement products including inhelation devices. Community pharmacy services are well placed to support young people in this respect.

The RPS recognises that licenced nicotine inhaling products have a benefit to adults and young people under the age of 18 who are seeking medical advice on giving up smoking, and could benefit from being supplied with these items under the guidance of an appropriate healthcare professional, including a pharamcist.

The RPS welcomes stronger regulation of e-cigarettes to ensure quality control and standardisation of products including carrying health warnings. However, we are concerned about the limited evidence and long-term studies into the health impact of e-cigarette use and would urge for further research to be taken to explore the impact on health from e-cigarettes and exposure to secondhand emissions.

The RPS believes that while e-cigarettes could have a potential role in harm reduction and in supporting smoking cessation in the short term, more high-quality peer-reviewed studies on safety and efficacy should be completed in order provide policy makers and health professionals with evidence-based assurance, particularly if they are to be included in the publicly funded smoking cessation programmes, once licensed by the MHRA

We welcome the proposal to establish a national register of retailers of tobacco and nicotine products and believe that a strengthened restricted premises order, with a national register, will aid in enforcing tobacco and nicotine offences as well as helping to protect vulnerable or impressionable young people from accessing and starting smoking. We would recommend that all registered pharmacies supplying nicotine products be automatically included in the register.

Part 3 – Special Procedures

The RPS is supportive of the creation of a compulsory, national licencing system for practitioners of specified special procedures, we believe that this system will help to give people in Wales assurance of standards of care and mimimise any potential health risks. We are supportive of the suggestion that the premises in which the practitioner operates as well as the practitioner themselves should be approved in order to give assurance of cleanliness and appropriateness of the premises.

We believe that the procedures covered by this bill are appropriate as they all involve ‘invasive’ treatments where the skin is penetrated, this could in turn expose the patient to risk of infection if the procedures were not carried out appropriately. We also condone the provision which gives Welsh Ministers the power to amend the list of special procedures, but would advocate that this is done through a consultation process to allow input form interested parties.

Part 4 – Intimate Piercing

The RPS is supportive of the need for age restrictions on intimate body piercing. We believe that it would be irresponsible to allow anyone under the age of 16 to undergo a procedure for an intimate piercing. All procedures for intimate piercing and special procedures should be regulated and auditable.

Part 5 – Pharmaceutical Services

The RPS is supportive of the proposal for assessment of a population's pharmaceutical need. This assessment should lead to better planning and delivery of pharmacy services to address identified local health inequalities and needs.

Pharmaceutical needs assessment (PNA) should reflect a wider definition than pharmaceutical services which relates to supply of prescribed drugs and appliances. A wider definition of pharmaceutical needs should encompass the essential and advanced services of the pharmacy care contract and potential developments for public health services.

We strongly believe the PNA should take a patient centred approach to access of medicines and pharmaceutical care provided and also link in with the wider health needs of a community such as social care and care at home. The development of primary care clusters is a real opportunity to assess the needs of the population at a local level. The RPS believes that the appropriate use of the PNA should result in better managed and planned pharmaceutical services for patients and the public at a cluster level. PNA have the potential to enable primary care clusters and LHBs to reduce health inequalities, through planning for services that will address locally identified needs.

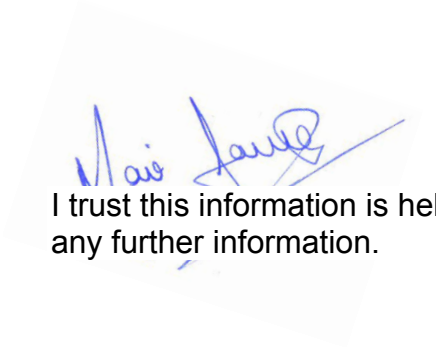
Part 6 – Provision of toilets

The RPS is supportive of the proposal that each local authority in Wales will have a duty to create a strategy for improved provision of public toilets. Many patients have medical conditions that will increase the likelihood of them requiring timely access to public toilets. Medicines can also increase the need for accessing toilets. For example anecdotal evidence for patients who take diuretic tablets has highlighted that many feel housebound in the morning as access to public toilet is limited and if they are required to attend appointments or visit a town centre in the morning they will not take their "water tablet" that night. We therefore believe this is a patient safety issue that could be easily rectified through better access to public toilets.

The RPS would encourage the development of Welsh guidance to support this strategy in order to ensure a consistent approach across local authorities as well as

Patron: Her Majesty The Queen Chief Executive: Helen Gordon Member enquiries T [redacted] E [redacted]

engaging with the local population in each LHB. The provision of disabled toilets and baby changing facilities should be explicit in each LHB's strategy.



I trust this information is helpful. Please do not hesitate to get in touch if you require any further information.

Yours sincerely

Mrs Mair Davies

Chair, Welsh Pharmacy Board

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy. In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
We are aware that e-cigarettes are relatively new to market and their popularity and use has grown rapidly, concurrently research has been ongoing and evidence is now emerging which gives greater clarity with regard to their efficacy and safety. The most recent publication is from Public Health England[1], in which independent experts concluded that e-cigarettes are significantly less harmful to health than tobacco and have the potential to help smokers quit smoking. Key findings of the review include: • the current best estimate is that e-cigarettes are around 95% less harmful than smoking • nearly half the population (44.8%) don't realise e-cigarettes are much less harmful than smoking • there is no evidence so far that e-cigarettes are acting as a route into smoking for children or non-smokers In the absence of a licensed medical product, we do not have a comment to make on whether the use of e-cigarettes should be banned in enclosed public places in Wales; however we do hope that provisions in the Bill are based on current independent

1

E-cigarettes: an evidence update, A report commissioned by Public Health England
Authors: McNeill A, Brose LS, Calder R, Hitchman SC
Institute of Psychiatry, Psychology & Neuroscience, National Addiction Centre, King's College London
UK Centre for Tobacco & Alcohol Studies
Hajek P, McRobbie H (Chapters 9 and 10)
Wolfson Institute of Preventive Medicine, Barts and The London School of Medicine and Dentistry Queen Mary, University of London
UK Centre for Tobacco & Alcohol Studies

evidence that is available, and would make suitable provisions for use should e-cigarettes become licensed medicinal products in future.

Question 2

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?
No comment.

Question 3

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?
No comment.

Question 4

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?
As previously mentioned, over recent years there has been an increase in popularity of e-cigarettes in the UK. Action on Smoking and Health estimates that there are 1.3 million current users of e-cigarettes in the UK. This number is almost entirely made of current and ex-smokers; with perhaps as many as 400,000 people having replaced smoking with e-cigarette use.

There is little evidence to suggest that 'never-smokers' are taking up the use of e-cigarettes, and therefore highly unlikely that e-cigarette use could be a gateway to conventional tobacco products for those people that have no history of prior tobacco use.

There is concern that the younger generation could be affected by aggressive marketing of e-cigarettes especially through the use of sexualised images and a wide range of flavoured products. We therefore support the view that sales to under 18s should be prohibited and any marketing should be aimed exclusively at current tobacco smokers.

In new evidence published in August 2015 by Public Health England[2], the findings state that "*there is no evidence that e-cigarettes are undermining the long-term decline in cigarette smoking among adults and youth, and may in fact be contributing to it. Despite some experimentation with e-cigarettes among never smokers, e-cigarettes are attracting very few people who have never smoked into regular e-cigarette use*".

The report also states that "*e-cigarette use among youth is rare with around 2% using at least monthly and 0.5% weekly. E-cigarette use among young people remains lower than among adults: a minority of British youth report having tried e-cigarettes (~13%). Whilst there was some experimentation with e-cigarettes among never smoking youth, prevalence of use (at least monthly) among never smokers is 0.3% or less*."

Question 5

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

[2] **E-cigarettes: an evidence update,** A report commissioned by Public Health England
Authors: McNeill A, Brose LS, Calder R, Hitchman SC
Institute of Psychiatry, Psychology & Neuroscience, National Addiction Centre, King's College London
UK Centre for Tobacco & Alcohol Studies
Hajek P, McRobbie H (Chapters 9 and 10)
Wolfson Institute of Preventive Medicine, Barts and The London School of Medicine and Dentistry Queen Mary, University of London
UK Centre for Tobacco & Alcohol Studies

Celesio UK seeks clarification on the term 'nicotine containing products' as this clause could unintentionally introduce the requirement of all community pharmacies (over 700 in total) to enter into an additional register due to their part in the sale and supply of licensed nicotine replacement therapy products, including those which are part of NHS stop smoking programmes.

We suggest that the term 'nicotine containing products' is defined more specifically and that licensed medicinal products are exempt.

We would also suggest that in order to guarantee the quality of the product and information about their use, the sale of e-cigarettes should be exclusively made when coupled with advice from a health professional, such as in community pharmacy, where decisions about reducing or quitting smoking can be supported and the most appropriate products and services can be recommended. This would include NHS Stop Smoking Services where available.

Question 6

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?

Celesio UK believes that the offence in the draft legislation for supply to a person under the age of 18 should not apply to sales or supplies of licensed medicinal nicotine products.

There are instances where people under the age of 18 benefit from the use of licensed medicinal nicotine products as part of a stop smoking programme, or supply via WP10 prescription, and we suggest this area of the Bill is amended to reflect the use of such products in public health/pharmacy practice.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
Community pharmacy is ideally placed to meet the health needs of local populations. With convenient locations and opening times, we see a very broad range of people, not just those that are ill and already accessing services from the NHS. By effectively engaging with a broader range of providers, there is a real public health opportunity to add capacity in identifying and targeting those groups that are harder to engage using both systematic and opportunistic approaches. The inclusion of the promotion of healthy lifestyles within the essential services of the pharmacy contract has provided a platform to extend the role of the pharmacist and pharmacy support staff in health promotion activities and the development of numerous enhanced services in response to national public health priorities (e.g. substance misuse, smoking, sexual health) has further enhanced the role of the pharmacist. Any assessment of pharmaceutical need should extend from a wider local health needs evaluation. Whilst LHBs will produce individual reports and assessments, we would expect the framework to be developed on an **all Wales** basis, so that there is a clear comparator between one LHB and another, and that there is a consistent approach, which will also take into account neighbouring LHB provisions • PNAs should include pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. • It should look at other services, such as dispensing by GP surgeries, and services available in neighbouring LHB areas that might affect the need for services in its own area. • It should examine the demographics of its local population, across the area and in different localities, and their needs. • It should look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take

account of likely future needs.

- Any relevant maps relating to the area and its pharmacies. Opening times and services that they offer.
- PNAs must be aligned with other plans for local health and social care.
- There must be a defined consultation period for stakeholders, for example members of the public, community pharmacy representative bodies (Community Pharmacy Wales) and community pharmacy contractors to respond to the findings of the PNA. We suggest that this is 60 days.

The Pharmaceutical Needs Assessment should be consolidated to provide a national picture of pharmacy provision in Wales, which can inform commissioning decisions and ensure that there is a cohesive strategy for community pharmacy.

The data should be robust and support strategic assessments which need to be reviewed in a timely manner. This should ensure that there is not an overly bureaucratic process, but that the assessment is reflective of health needs and takes into account changes in population, demographics, etc.

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?

There are a number of considerations which need to be taken into account and widely agreed upon by providers, Health Boards and Community Pharmacy Wales.

As independent providers, community pharmacy contractors need to have confidence in the quality of the PNA and willingness of the LHB to develop services in identified areas so that they can invest in their premises and teams to deliver them.

In addition to the proposals outlined in the Bill around the strategy assessment of pharmaceutical needs and the consequences of failure to engage through breach procedures, external factors should also be taken into account as to why a contractor may not be engaged in service delivery. These maybe include inconsistent marketing and commissioning by the Local Health Board, engagement of other health professionals in delivering, signposting and advocating services, lack of access to necessary training for pharmacists and pharmacy staff, and appropriate fees for the delivery of services.

These factors will need to be reviewed and resolved prior to the decision being taken to

award any additional pharmacy contracts due to the non-delivery of services by existing contractors.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
No comment.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
No comment.

Question 17

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?
No comment.

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
No comment.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
We believe that the introduction of the PNA process will provide LHBs with better clarity and consistency in the identification of which services are required to improve the health of the populations for which they are responsible and in reducing health inequalities. We hope that as a direct consequence of the assessments, community pharmacy is rightly seen as being at the forefront of public health provision and acts as an enabler to provide opportunities for health improvement in Wales.

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
We believe that there is an opportunity with the Bill to support and improve consistency in some services which are provided under a Patient Group Direction (PGD). By changing the regulations in favour of the national sign off by the NHS, in place of the current process of them needing to be signed off locally on an LHB by LHB basis, this can potentially reduce local variation and support service provision.

Question 21

Are there any other comments you would like to make on any aspect of the Bill?
We would welcome the opportunity to work with Welsh Assembly Government to support the greater integration of community pharmacy into delivering a wider public health role and improving health outcomes for people in Wales.

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 Powys Teaching Health Board – PHB 86 / Tystiolaeth gan Fwrdd Iechyd Addysgu Powys– PHB 86

Public Health (Wales) Bill: Consultation questions

Tobacco and Nicotine Products

The Bill includes proposals to ban the use of nicotine inhaling devices, such as e-cigarettes, in enclosed spaces like restaurants, pubs and at work. Shops will also have to join a register for retailers of tobacco and nicotine products, and it will become an offence to "hand over" tobacco and e-cigarettes to anyone under the age of 18.

Question 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?
Yes, on balance, this position is supported. The restrictions on smoking and e-cigarettes should be equal to ensure consistency in messages and support existing work to de-normalise smoking behaviours. Many organisations are already confused as to whether e-cigarettes fall under the smoking ban, and it is important to minimise this confusion and ensure consistency in messages. The use of e-cigarettes in public places is likely to cause confusion in the minds of the public of whatever age (whether smokers or non-smokers) and so potentially dilute the impact of the current legislation through a number of mechanisms (including by undermining enforcement). E-cigarettes are designed to mimic tobacco containing cigarettes and it is often difficult to distinguish between them. This again could add to confusion of existing policies/laws if someone who is smoking an e-cigarette is mistakenly thought to be smoking a cigarette. Having different restrictions could make it more difficult to enforce the existing smoking ban. Smoking in enclosed public places has been banned for many years and current smokers have become accustomed to smoking in designated smoking areas. Although for many people e-cigarettes are used as an aid to quitting, allowing e-cigarettes to be smoked in enclosed spaces could undermine the existing law. There is some evidence that smoking e-cigarettes can pollute air in enclosed spaces, potentially affecting others.[7,8] There is no longitudinal evidence of this due to the infancy of e-cigarettes, but it is important that the risk to others is minimised.

Currently there is little evidence to suggest that anything more than a negligible number of never-smokers regularly use e-cigarettes.[1,2] In addition, there is also little hard evidence that e-cigarettes are acting as a 'gateway' to smoking tobacco among children.[3,4] However, large scale use of e-cigarettes remains a very new phenomena, and some evidence is beginning to emerge from studies in the UK and overseas which suggests that e-cigarettes are being used by young people who have never previously used tobacco.[5,6] There is a need to take a pragmatic approach to e-cigarette use and it is therefore sensible to restrict its use in enclosed public and work places. Notwithstanding this, there are some concerns about the quality of currently available evidence to make a judgement one way or the other.

Question 2

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?
Yes. The smoking ban has been in place for a significant amount of time, and smokers are used to smoking in designated smoking areas. However, it may be difficult for someone who is making a quit attempt (by using e-cigarettes) to be exposed to cigarette smoke if e-cigarette use was in a designated smoking area. It will be necessary to have designated spaces for use of e-cigarettes as well as designated areas for smokers as part of any smoking ban. There is a theoretical risk that those using e-cigarettes indoors could switch back to cigarettes if they had to go to designated smoking areas to smoke – especially if those areas were also designated for tobacco use.

Question 3

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?
E-cigarettes do have the potential to undermine the existing smoke-free regulations, and on balance, a precautionary approach should be adopted. As mentioned in response to Question 1, some evidence is beginning to emerge from studies which suggests that e-cigarettes are being used by young people who have never previously used tobacco.[5,6] There is potential that children and young people will be more susceptible to emulating behaviour of adults or role models if e-cigarette use becomes normalised. In addition, as well as the appearance of e-cigarettes, there is also marketing around different flavours which may be more likely to attract children and young people into tobacco use. Finally, the widespread use of e-cigarettes in public places could be a constant

temptation/reminder for smokers that are making a quit attempt, thus making it more difficult to make a successful quit attempt and more difficult for ex-smokers to stay quit.

Question 4

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?
Two thirds of current smokers started smoking before 18yrs of age.[9] It is even more concerning that almost 40% started smoking regularly before 16yrs of age.[10] Thus, to date, a large part of the profit model of tobacco companies has been based on attracting young people to take up smoking. It is therefore in the commercial interest of tobacco companies to target advertising at young people. This is happening now, with the variety of flavours of e-cigarettes, and the packaging seen as attractive to young people, in much the same way as 'alcopops' in the drinks industry. Terminology is also important. The terms 'vaping' instead of smoking may suggest to children and young people that this is different and perhaps less harmful than smoking, which could lead those who may have never intended to try smoking to experiment instead with using e-cigs as a 'safe way' to smoke. The most recent research suggests that those young people most likely to access e-cigarettes are those who engage in other substance-related risk behaviours including binge drinking, drinking to get drunk and alcohol-related violence.[11] Thus, current behaviours among the young are more consistent with teenagers viewing e-cigarettes as a recreational substance, or an appealing risky behaviour rather than as a smoking cessation tool.

Question 5

Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?
Yes. The creation of a national register is in line with the Tobacco Control Action Plan for Wales.[12] A register would help to enforce legislation on the display of tobacco products and tackle underage sales by helping trading standards officers to easily identify retailers and check compliance with regulations. A recent survey in England showed that nearly half of young smokers (44%) reported being able to purchase tobacco from retail premises despite the ban on the sale of tobacco products to those under the age of 18yrs.[13] Smoking is also increasingly concentrated in less affluent areas, where many may purchase smuggled or fake tobacco products at reduced cost. This has the potential to undermine tobacco control measures, encourage higher consumption, and deprive small

businesses in these areas of legitimate trade.

A register would also provide an opportunity to disseminate key health information in relation to tobacco and nicotine products to retailers, and could provide an opportunity to deliver training/awareness raising information to prevent proxy sales and sales to those under the age of 18yrs.

Question 6

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?
This is supported on the basis that it would help to reinforce the restriction of sales of either tobacco or e-cigarettes to those over 18yrs of age. It remains important however, that sufficient capacity is in place in local authority trading standards teams to monitor compliance and act on intelligence to catch anyone who flouts this offence.

Special Procedures

The Bill includes a proposal to create a compulsory licensing system for people who carry out special procedures in Wales. These special procedures are tattooing, body piercing, acupuncture and electrolysis. The places where these special procedures are carried out will also need to be approved.

Question 7

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?
Recognising the invasive nature of these procedures, further health protection measures are entirely feasible. For example, understanding of the types and levels of risk associated with the procedures is likely to be variable in the minds of the public and (potential) service users. Whilst Local Authorities may have voluntary powers relating to registering persons/ premises carrying out such procedures and have discretionary powers to create hygiene byelaws, this will tend to generate variation in public protection (e.g. in regulation) across Wales. The lack of record keeping makes surveillance (of impact, including harm) and redress challenging. Therefore, the creation of a mandatory licensing scheme for both practitioners and businesses carrying out 'special procedures' is strongly endorsed. Such a register would be beneficial in recognising legitimate practitioners and businesses and help to regulate these procedures in Wales. It would help to ensure a consistent approach to regulation across Wales. Suitable resources would need to be made available to realise and sustain

the benefits of such a register.

There is some evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare.[14–16] 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.[17] However, the risk of transmission would also extend to professional parlours where sterile conditions and infection control measures are not in place. Scarring from complications following such procedures can also have long-term psychological impacts.[18–20]

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

Question 8

Do you agree with the types of special procedures defined in the Bill?
Yes, although the Bill presents an opportunity to go further and regulate the administration of the following procedures: colonic irrigation, 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. Consideration could also be given to sunbed use to protect users from the risks associated with excessive UV exposure.

Question 9

What are your views on the provision which gives Welsh Ministers the power to amend the list of special procedures through secondary legislation?
Inclusion of the power is supported as this is an area where new procedures can appear rapidly the consumer may need protection to be put in place quickly.

Question 10

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

It is apparent from current joint working on tobacco control that local authority trading standards teams are struggling to maintain capacity due to public service funding constraints. Adding responsibility for a licensing system for special procedures will add to the demands placed on these teams and may further diminish the support available across the breadth current public health activity, especially around alcohol and tobacco sales.

Intimate piercings

The Bill includes a proposal to ban intimate body piercings for anyone under the age of 16 in Wales.

Question 11

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?
Yes, an age restriction is supported. A ban on the intimate piercing of those aged under 16 yrs is supported to ensure consistency in arrangements (and so to improve current arrangements) and to better protect the public (including through informed choice). This will help to protect the public and ensure a clear and consistent message across Wales.

Question 12

Do you agree with the list of intimate body parts defined in the Bill? Whether any other types of piercings (for example naval piercing, tongue piercing) should be prohibited on young people under the age of 16.
All piercings carry the risk of infection. However, in the case of tongue piercing there is the additional risk that the airway could become partially or wholly obstructed due to swelling secondary to infection. For this reason, we would endorse the inclusion of tongue piercing in the list of prohibited procedures for people under the age of 16yrs.

Community pharmacies

The Bill will require local health boards in Wales to review the need for pharmaceutical services in its area, and that any decisions relating to community pharmacies are based on the needs of local communities.

Question 13

Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
Yes, on balance, the proposal is supported in principle. However, some suggestions/reservations are outlined below. Regardless of the overall mode of completion, the phrase "pharmaceutical needs assessment" must be more clearly defined before any implementation/roll-out to ensure a systematic, comparable and equitable approach across Health Boards. In particular, the White Paper strongly implied that "pharmaceutical" activity encompasses (or should encompass) activity which goes beyond the traditional dispensing work of pharmacies; this still needs to be defined. Likewise, the resource implications (e.g. data and intelligence) of pharmaceutical needs assessments must be understood and addressed before implementation. The role of Public Health Wales in supporting Health Boards to meet any future requirements in relation to local pharmaceutical needs assessments should also be defined.

Question 14

What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
Pharmacies have been shown to be effective at delivering enhanced services such as smoking cessation, harm minimisation in substance misuse, flu vaccination, and emergency hormonal contraception.[21,22] Currently, the majority of pharmacy time is spent dispensing prescriptions and providing advice on medicines. We believe the legislation proposed in the Public Health (Wales) Bill will encourage existing pharmacies to adapt and expand their services in response to local needs. The risk of another contractor making a successful application to join the pharmaceutical list in their area, if they fail to respond to need will be an effective incentive. This can help to ensure services are available where needed. We also believe that undertaking and incorporating such assessments of need will help to improve the planning and delivery of pharmaceutical services by making them more integrated and aligned with wider health needs assessment and service planning.

Public toilets

The Bill includes a proposal that will require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing public toilet facilities. However, the Bill does not require local authorities to actually provide toilet facilities.

Question 15

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?
While recognising the obvious importance of access to toilets for public use, PTHB is not offering a position on this Question. Local authorities are much better placed to understand the financial opportunity cost of imposing such a duty on local authorities in times of financial austerity.

Question 16

Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?
Not necessersarily. It is important to recognise the strain already placed on local government services, and that there will be an opportunity cost when prioritising services with limited resources. The preparation of a local toilet strategy may not result in improved provision and accessibility without adequate resources to implement such a strategy. There is a risk that expectations are raised inappropriately in communities when the necessary resources to deliver on a strategy are not going to be made available.

Question 17

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?
Yes. The Bill is clear that a local authority must consult any person it considers is likely to be interested in the provision of toilets in its area that are available for use by the public before it publishes its local toilets strategy. While more could be done to engage with communities, the requirement to consult publicly will provide that facility for engagement.

Question 18

What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?
This would promote a greater recognition of the importance of toilet facilities, and may improve the signage and standard of existing provision in public buildings. However, it must also be recognised that access to toilets cuts across both the public and private sector.

Other comments

Question 19

Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
No. It is disappointing that regulation of food standards in settings such as pre-school and care homes are not included in the Public Health (Wales) Bill. Food standards can make an important impact on public health. Good nutrition in very young children is essential for future growth development and health, while poor nutrition in care homes is likely to undermine their health and well-being and increase the chances of the need for health services intervention. Food standards is an issue that could be strengthened so that there is no missed opportunity to place mandatory food standards on all food or drink supplied by or procured for settings directly controlled, commissioned or inspected by public sector organisations. Over 300,000 people are currently employed in the public sector in Wales. Offering healthy choices as the norm to them, and the public they serve, could make a significant contribution to the adult obesity problem. Minimum unit pricing for alcohol remains a key priority for improving public health. This is not included within this Bill, although it is welcomed that legislation is being considered in the draft Public Health (Minimum Price for Alcohol) Bill.

Question 20

Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?
As above. Minimum unit pricing for alcohol is not included in the Public Health (Wales) Bill and we are aware of current testing of Scotland's decision to include this. It is highly important that this is taken forward in the future when the position is clarified. There is a strong evidence base for a link between alcohol affordability and levels of harm and until this prudent initiative is implemented alcohol-related morbidity, mortality and cost will continue to impact on society.

Question 21

Are there any other comments you would like to make on any aspect of the Bill?

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

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March 2010: 2,297 adult smokers March 2013: 2,178 children aged 11-18

March 2012: 12,436 adults March 2014: 2,068 children aged 11-18

February 2013: 12,171 adults

March 2014: 12,269 adults

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JTI's written evidence to Health & Social Care Committee's consultation on the Public Health (Wales) Bill

4 September 2015

Organisation name

Japan Tobacco International (JTI) is part of the Japan Tobacco group (JT Group) of companies, a leading international tobacco product manufacturer.

JTI has its UK headquarters in Weybridge, Surrey, and has a long-standing and significant presence in the UK. JTI manufactures a range of tobacco products for the UK market in Northern Ireland and other EU Member States (Germany, Romania and Poland). In the UK alone, JTI employs over 1,800 people. Gallaher Limited is the registered trading company of JTI in the UK.

In 2014 the JT Group acquired Zandera Ltd, one of the UK's largest electronic cigarette companies and integrated it into JTI. Zandera Ltd is best known for its E-Lites brand. With electronic cigarettes being an increasingly popular alternative to cigarettes among many adult smokers, E-Lites is a logical and important extension to JTI's portfolio and is its first non-tobacco, nicotine-containing product. The JT Group further expanded its portfolio of electronic cigarettes with the acquisition of Logic Technology Development LLC in 2015, one of the leading U.S. electronic cigarette brands. As part of JTI, the E-Lites and Logic brands have access to:

- JTI's extensive manufacturing expertise (enabling standards of product quality to be further enhanced);
- JTI's wider technological, research and scientific resources (facilitating compliance with future regulatory requirements, driving the development of next generation products to meet evolving consumer expectations, and delivering ever better electronic cigarette products); and
- JTI's global distribution network in over 120 countries.

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Confidentiality

JTI has no objection to this response being made public.

Introduction

Under-18s should not smoke and should not have access to tobacco products or nicotine containing products. This belief is central to the way JTI does business.

JTI supports regulation that is proportionate, carefully defined, necessary and appropriate to achieve a clearly articulated and legitimate public policy objective. Regulation should be made in accordance with internationally-accepted Better Regulation principles, which are supported by the Welsh Government, UK Government and the European Commission. In essence, these principles require regulation to be transparent, accountable, proportionate, consistent and targeted at cases where action is needed.

JTI actively seeks dialogue, either written or oral, with government authorities around the world regarding the regulation of tobacco products and all other nicotine containing products that it makes and sells. JTI has a right – and an obligation – to express its point of view regarding regulation that affects its products and the industry. It is our belief that we have the responsibility, when engaging in a consultation process, to be open and transparent in our dialogue with government authorities, and to propose alternative, less restrictive and more targeted solutions that meet Better Regulation principles where we believe proposed regulations to be excessive.

JTI supports reasonable and proportionate regulation of electronic cigarettes. It believes that:

- Adults should be free to choose whether they wish to use electronic cigarettes, including as an alternative to tobacco products;

- All marketed electronic cigarettes should comply with all relevant regulations concerning general consumer product safety, electrical safety and consumer protection from misleading marketing claims;

- Regulation of electronic cigarettes should aim to keep electronic cigarettes out of the hands of under-18s and to remind users of the risks associated with their use; and

- Governments and regulators should avoid excessive regulation that prevents adult consumers from choosing these products.

JTI strongly supports the objective of preventing under-18s from having access to electronic cigarettes and other nicotine containing products. However, the Public Health (Wales) Bill (the Bill) contains various provisions relating to the use of cigarettes and electronic cigarettes by adult consumers with which we do not agree. We therefore welcome the opportunity to provide this written response.

Part 2: Tobacco and Nicotine Products

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?

1.1. No, vaping (the use of electronic cigarettes) is not smoking and the two should not be conflated. Legal requirements to prohibit or restrict the use of electronic cigarettes in public places, workplaces or vehicles are unnecessary and unjustified.

1.2. There is no credible evidence that exhaled electronic cigarette vapour poses a health risk to bystanders.

- Public Health England's recent report has found that electronic cigarettes release negligible levels of nicotine into ambient air with no identified health risks to bystanders[1].
- A separate systematic review of the available evidence also concluded; "*… there is no evidence that vaping produces inhalable exposures to contaminants of the aerosol that would warrant health concerns by the standards that are used to ensure safety of workplaces. … Exposures of bystanders are likely to be orders of magnitude less, and thus pose no apparent concern[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)?

2.1. There already exists a high level of public awareness regarding the health risks associated with smoking. It is JTI's strong belief that since tobacco smoke is easily dispersed in the atmosphere and highly diluted in outdoor environments, there is no basis on which to regulate smoking outdoors. JTI notes that there is limited scientific literature on outside tobacco smoke. Even well-known anti-tobacco advocates have questioned the scientific basis for restrictions on smoking outdoors[3]. Considering these factors JTI considers that a smoking ban in outdoor spaces is excessive.

2.2. We recognise that cigarettes are a legal but controversial product; as such, we believe adults are entitled to make an informed choice about whether they want to smoke. More generally, it is not legitimate to seek to discriminate against or stigmatise existing adult smokers, or to treat the use of tobacco as abnormal, unacceptable, or tainted. Therefore we believe it is inappropriate for the Welsh Government to dictate how adult smokers behave when going about their everyday lives.

2.3. Users of electronic cigarettes should always consider other people around them before using the device in public places. JTI is opposed to any ban in public spaces for similar reasons to those put forward in response to Question 1. Such restrictions are unnecessary and unjustified.

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?

3.1. No. JTI supports reasonable and proportionate regulation that aims to keep electronic cigarettes out of the hands of under-18s and to remind users of the risks associated with their use. The Welsh Government should avoid excessive regulation that prevents adult consumers from choosing these products.

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

4.1. There is no credible evidence that the use of electronic cigarettes leads to future cigarette smoking. Surveys of the electronic cigarette market indicate that these products are predominantly used by adults who are smokers or ex-smokers[4]. The argument that electronic cigarette use could 'renormalize' smoking is highly speculative.

4.2. Public Health England's recent report was very clear that e-cigarettes are not 're-normalizing' smoking and the report noted that it's possible that e-cigarettes have contributed to further declines in smoking and the 'denormalization' of smoking.

4.3. The argument that there could be confusion between electronic cigarettes and conventional cigarettes does not stand up to scrutiny. While some types of electronic cigarettes may at first sight appear similar to conventional cigarettes, they tend to be made of different materials, such as plastic or metal. Furthermore, during use, such electronic cigarettes have an LED light at the distal end which lights up with each puff taken. This light is often coloured blue or green, making the distinction with lit cigarettes easy. Refillable (tank) electronic cigarettes typically do not have LED lights to indicate when puffs are being taken. Such products, however, typically do not look or smell like conventional cigarettes, making it easy to distinguish the two.

4.4. More broadly, public policy objectives that aim to 'denormalize' or prevent the 'renormalization' of smoking and/or vaping are not, and cannot be, a self-standing objective. It is not legitimate to seek to discriminate against or stigmatise users of electronic cigarettes, or to treat the purchase of electronic cigarettes as abnormal or unacceptable.

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?

5.1. We are not aware of any credible evidence that the use of e-cigarettes leads to future cigarette smoking. Surveys of the electronic cigarette market

indicate that these products are predominantly used by adults who are smokers or ex-smokers.

- A recent worldwide survey of 19,414 e-cigarette users found that only 0.4% were non-smokers before starting e-cigarettes[5].
- In the UK, annual YouGov surveys, conducted between 2010 and 2014, consistently found that e-cigarette use among 'never smokers' was between 0.1 and 0.2% (circa 12,000 participants in each survey year) [6]. The authors of the survey concluded that *"e-cigarettes are used almost exclusively by smokers and ex-smokers. Almost none of those who had never smoked cigarettes were e-cigarette users."*
- The same UK survey found that "*There is almost no evidence of regular electronic cigarette use among children who have never smoked or who have only tried smoking once*."
- This finding was echoed in a 2014 UK Government report which stated *"We could not identify any evidence to suggest that non-smoking children who tried e-cigarettes were more likely to then try tobacco."*[7]
- In a 2014 Ipsos MORI survey for the UK Government of Smoking Prevalence amongst 15 year olds in England[8] it was found that 0% of non-smokers (tobacco) were regular (at least once a week) users of e-cigarettes and 1% of non-smokers reported using e-cigarettes occasionally (less than once a week).
- Public Health England has also recently stated that there is no evidence that electronic cigarettes act as a route into smoking for children or non-smokers[9].

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?

6.1. As stated above in paragraph 4.2 the use of electronic cigarettes and smoking are different. Such products typically do not look or smell like conventional cigarettes, making it easy to distinguish between the two.

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

7.1. We do not support the proposed restrictions in the Bill and so it would be inappropriate to comment on this.

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

8.1. JTI agrees with the rationale underlying this proposal; that under-18s should not smoke or have access to tobacco products or nicotine products. JTI believes that smoking and vaping is, and should be, an adult choice. This is central to our Code of Conduct, and the way that JTI does business.

8.2. JTI does not oppose a national retailer register if this would help improve compliance with the ban on sales to under-18s. However, JTI strongly believes that any regulation in this area should result in the minimum feasible

burden upon retailers – many of whom are small, independent businesses already working hard to deal with large swathes of regulation. To that end, we are especially concerned that the proposal under consideration here allows the Welsh Government to charge retailers a registration fee – we remain strongly opposed to any such additional financial burden upon retailers.

8.3. In Scotland, which operates a similar national register, registration is free and compliance has been high. In Scotland retailers are also permitted to make their application online, which helps to minimise the administrative burden. As such, JTI would like to encourage the Welsh Government to ensure that registration is free and easily accessible, including online, in order to maximise compliance.

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

9.1. As stated above (in answer 8) JTI does not oppose a national retailer register if it helps to improve enforcement of under-age sales legislation, but remains concerned that registration fees and complex bureaucratic applications may undermine compliance.

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

10.1. JTI agrees that including a broader range of tobacco offences in the Restricted Premises Order regime is an effective way of supporting the work of local authorities in enforcing tobacco and nicotine laws. JTI believes strongly that retailers who repeatedly break the law – including by selling tobacco products to under-18s, selling smuggled or illegal tobacco, or committing any other offence – should have their right to sell tobacco products removed.

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?

11.1. JTI has fully supported legislation to make it an offence to sell tobacco and electronic cigarettes to under-18s and to buy these products on behalf of under 18s. We believe that these measures could make a significant contribution to reducing young people's access to tobacco and nicotine containing products from legitimate retailers and therefore would support this measure.

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

12.1. Tobacco products carry risks to health and JTI believes that appropriate and proportionate regulation of the tobacco sector is both necessary and

right. We believe that more can be done to reduce smoking by under-18s, such as voluntary youth access prevention programmes, but have a number of concerns with the legislative proposals contained in the Bill. We question whether the measures relating to public place use are evidence-based, proportionate and/or likely to achieve their stated aims.

12.2. JTI believes that some of the measures included in the Bill relating to nicotine products are unnecessary, particularly the introduction of a ban on vaping in public and work places. There is no credible evidence that exhaled electronic vapour poses a health risk to bystanders, it would be unjustified to introduce such a ban.

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

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

Evidence from Mental Health Foundation – PHB 88 / Tystiolaeth gan Y Sefydliad Iechyd Meddwl – PHB 88

Response of the Mental Health Foundation to Committee's call for evidence on the general principles in the Public Health (Welsh) Bill

The Mental Health Foundation

The Mental Health Foundation (MHF), incorporating the Foundation for People with Learning Disabilities (FPLD), is the leading UK charity working in the field of mental health and learning disability. We combine policy, research, campaigning and service development to promote good mental health and to improve services for anyone affected by mental health problems or with a learning disability.

Our contribution is based on our experience, over 60 years, of advocating for improved mental health for all, applied research on effective interventions on mental health and learning disabilities and influencing reform in policy and practice.

Emily Wooster
Head of Development Wales
[redacted]

We are urging the Welsh Assembly to introduce a clause in the Public Health Bill recognising the importance of mental health. Our response will be limited to the question regarding what other areas the Bill needs to address (Question 21). It is imperative that the Bill includes mental health and wellbeing as key determinants of physical health, beyond smoking. Mental health must be part of any Public Health Bill. Mental health is a universal asset that we all share, it enable us to reach our potential as individuals, as communities and as a society. Conversely poor mental health can lead to a cycle of disadvantage. This can involve higher levels of physical morbidity and mortality, lower levels of educational and work performance, and poor community and societal cohesion.

Placing mental health at the heart of public health policy will lead to healthier lifestyles, reducing health risk behaviour and physical illness. This aligns to the aims of the Welsh government to reduce the risk and occurrence of mental and physical illness, disability and premature death.[1]

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1. Mental health as a public health issue
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1. Mental health is a public health issue:

1.1 Mental health is a public health issue, and therefore it must be at the core of any public health strategy. Ill-health in the UK, carries huge financial costs . It is been estimated that NHS Wales' largest single programme budget category is mental health problems, which amounts to 11.4% of the £5,560.1 million total.[2] Cancer and diabetes cost NHS Wales £380.1 million and £95.2 million respectively.[3] In terms of welfare, mental health problems attributes to 43% of the 2.6 million people on long-term, health-related benefits.[4] In 2013/14, Wales experienced 25,000 lost working days due to work-related stress, depression or anxiety; more than for any other illness.[5]

1.2 No other health condition matches mental ill-health in prevalence, persistence or breadth of impact.[6] In Wales, one in four adults experience mental health problems at some point during their lifetime and one in six will experience symptoms at any one time.[7] Additionally, Wales needs to provide sufficient mental health services, as only one in nine adults requiring treatment in 2011 were in fact being treated.

"There is no public health without mental health…investment is needed to promote public mental health."[8]

2. Mental health equity: giving to every person the best chance to achieve in life

2.1 By addressing mental health in the Public Health Bill, the Welsh Government will be able to address deep social, economic and health inequalities.[9] The relationship between inequalities and poor mental health and wellbeing is a two-way process. Experiencing disadvantage and adversity increases the risk of mental ill health, and experiencing mental ill health increases the risk of experiencing disadvantage. Living with mental health problems can create a cycle of adversity where related factors such as employment, income and relationships suffer.

2.2 Mental ill health is not evenly distributed across society. People from certain groups are more likely to experience mental health problems, and therefore face significant disadvantages in life. Evidence shows there are strong relationships between factors such as poverty, disability, gender, sexual orientation, age and ethnicity, and mental ill health. The Green Paper itself recognises the "social and

economic determinants of health,"[10] including, income and education, lifestyle, physical environment and access to quality care.[11]

2.3 To reduce health inequalities, the Welsh Government needs to take into consideration the different characteristics and circumstances of each individual in the development of any public health regulations. Mental health problems are more than a health issue, they have a broad range of influences and determinants. We know that, for example, people's gender, age, race, sexual orientation, work status, home and neighbourhood –to name a few- have a, positive or negative, effect on people's mental wellbeing. Unsurprisingly, in Wales people who, for example, live in poverty are at higher risk of developing a mental health problem. This evidence strongly suggest that only by closing health inequalities will we be able to live in a society where every person -regardless of their gender, sexual orientation, race, socio-economic background, religion or belief, disability or age- can flourish and achieve the best of their potential in life.

"Without addressing the promotion…of a diverse population's mental health across government, not only are individuals poorly served, but many government goals and commitments on physical health, social cohesion and productivity are simply not achievable. Investment across the board will more than pay for itself…through a reduced need for public services and an increased opportunity for people with mental health conditions to contribute socially and economically."[12]

2.4 To reduce the prevalence and associated social and financial costs of mental health problems, mental health must be embedded across the public policy spectrum, and be recognised in the Public Mental Health Bill. The mediating role of mental health in improving health and socio-economic outcomes needs to be better understood, and entrenched as a central aspect of all health and public service delivery. Parity in public mental health is essential to better understand the determinants and influencing factors of mental health, and to enable early diagnosis and support. Delivering on parity of esteem requires working to achieve equal funding and prioritization for mental health services, for public mental health programmes, and within wider public policy.

3. Addressing mental health will help to tackle non-communicable diseases:[13]

3.1 The Bill needs to recognise that the mind and body are intrinsically linked. Having poor physical health causes stress. Likewise, experiencing a mental health problem places people at greater risk of developing a long term condition, and produces poorer outcomes for those that do. Despite many years of aspiring to person-centred care, there is still much to do before fully integrated and holistic support is standard. Working collaboratively across physical and mental health services will not only achieve better outcomes for individuals, but has the potential to be cost effective. This can be achieved by using the points of service access to improve mental health for those experiencing physical ill health, and by promoting the health of people with mental health problems.

3.2 There is a significant link between non-communicable diseases and mental health. Mental health issues can onset physical ailments and vice versa. Rates of depression are doubled in those with diabetes, hypertension, coronary artery disease and heart failure[14]. In addition, the prevalence of depression among those with two or more chronic physical conditions is almost seven times higher than healthy controls.[15] Depression almost doubles the risk of coronary heart disease[16] and increases death by a cardiovascular disease by 67%.[17] The trend continues: schizophrenia is associated with a three-fold increase in death rate of respiratory diseases and four fold by infectious diseases.[18]

3.3 Failing to recognise the link between the two will perpetuate the unacceptably large mortality gap. People with mental health problems die prematurely compared to the general population. On average, men and women with mental health problems die 20 and 15 years earlier respectively[19] .Those living with schizophrenia and bipolar disorder have a 25-year shorter life expectancy, largely due to the increased risks from smoking. The majority of deaths arise from preventable causes and could have been avoided by timely medical intervention.[20]

"Individuals with mental illness experience increased levels of physical illness and reduced life expectancy."[21]

3.3 **The Welsh Government recognises that "mental health is as important as physical health in a long, happy and active life."[22]** In doing so, the Government will be better equipped to address its primary non-communicable disease concerns of smoking, alcohol consumption, diet and physical activity,[23] and minimise obesity, alcohol misuse, cancer, cardiovascular diseases and diabetes.[24]

Key statistics: inequality, mental health and non-communicable diseases

- **20-25% of the British population that are either obese or smoke experience the highest prevalence of anxiety and depression.[25]**
- **Obesity is more common for those living with depression, bipolar disorder, panic disorder and agoraphobia.[26]**
- **Not only are low-income households disproportionately affected by physical and mental health conditions, but evidence suggests that they are more likely to have their physical health needs unrecognised, unnoticed and poorly managed.[27]**
- **Smoking is the largest single cause of preventable death and health inequality, which disproportionately impacts people with mental ill health. 70% of people in in-patient mental health units, compared to 21% of the general population, smoke,[28] and almost half of total tobacco consumption and smoking-related deaths occur in people with mental health problems.[29]**

Prevention:

4.1 It is understood that it will not be possible to absorb the rising costs of providing care and support for mental health problems in the long term, and the economic case for working to prevent mental health problems has been clearly stated. [30] If we are to rise to this challenge then we will need to act decisively as we have in the past when faced with significant risks to public health.

"The preventable nature of many of the related physical and mental health conditions also reinforces the need for an increased focus on preventative action, particularly to safeguard the future health of our children and young people." [31]

4.2 Our first waves of public health improvements whilst significantly reducing mortality were rightly centred on curing illness and responding in crisis. This has left a legacy of services designed to fix deficits. Although it will be crucial to continue to improve access to good quality service provision, we have to do this alongside working to improve health so that illness is a rarer event.

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

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

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

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

Date: 4 September 2015	**Version:** 1

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*[1]*,* 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.

[1] 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[2], 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

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

this to young people aged 16 – 18 years in 2013[3]. 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[4] 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[5] 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[6] 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

[3] ASH. Electronic Cigarettes. ASH Briefing, March 2014. www.ash.org.uk (last accessed 16/06/14)
[4] E-cigarette access among young people in Cheshire and Merseyside. Centre for Public Health, Liverpool John Moores University. March 2014. www.cph.org.uk (accessed 16/06/14)
[5] ASH. Electronic Cigarettes. ASH Briefing, March 2014. www.ash.org.uk (last accessed 16/06/14)
[6] 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 the is legal age of sale in Wales?

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

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

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

3 Part 3: Special Procedures

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

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

There is some older evidence that procedures such as piercing are a risk factor for hepatitis, though actual occurrences may be rare.[15-17] A recent review suggests there is a significant risk of transmission through piercing and tattooing procedures which are not done under sterile conditions, such as at home or in prison.[18] However, in our view, the risk of transmission is the same in commercial parlours where sterile conditions and infection control measures are not in place. Scarring from complications following such procedures can also have long-term psychological impacts.[19-21] Anecdotal evidence suggests that individuals with localised infections associated with such procedures often present in GP practices and Accident and Emergency departments, particularly following tongue piercings. All of the nine cases identified in the look back exercise 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[7].

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.

[7] 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 undert aking 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[8].

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[9].

[8] 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

[9] 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[10].

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.

[10] 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[11] 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.

[11] 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, Psuedomonas* 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 facia* 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

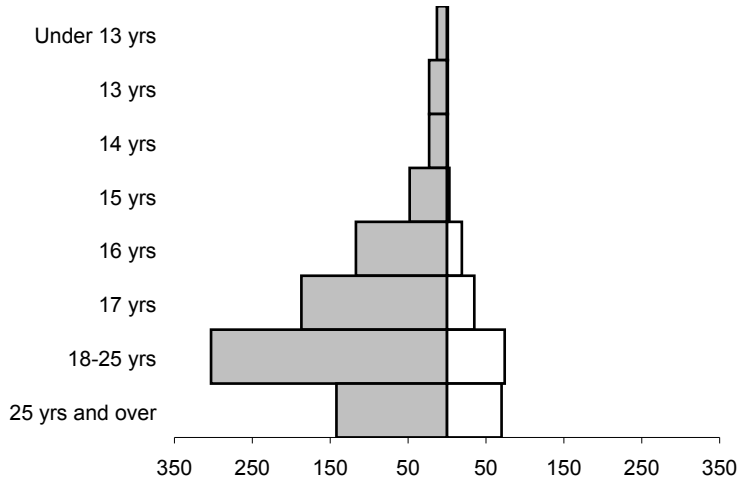
A cohort of people at risk of infection following a body piercing or tattoo at a premises under investigation (termed 'at-risk cohort') was identified. This 'at-risk cohort' was identified from client lists held at the premises and from people who self-presented following media reports of the incident,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

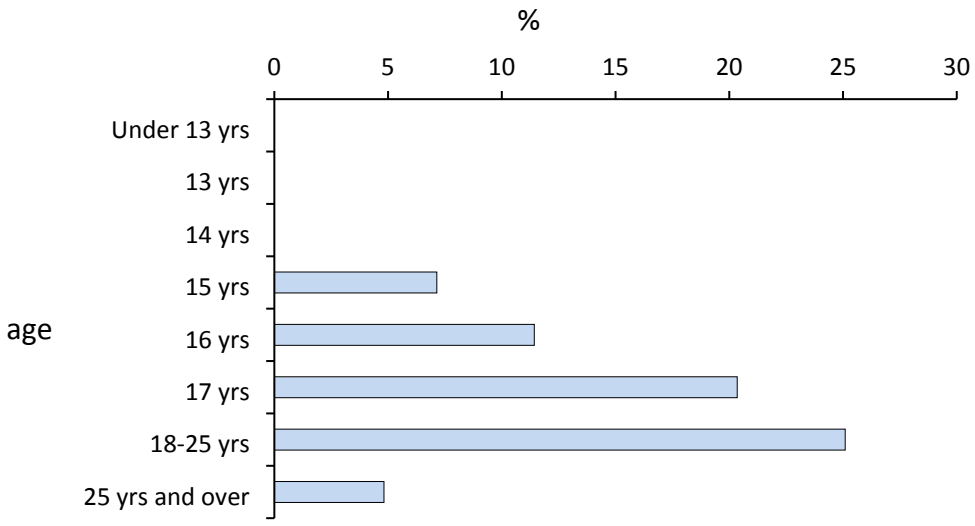
Figure 1. Age[1] and sex distribution of cohort of people considered to be at risk of infection following a piercing or tattoo at the premises under investigation ('at-risk cohort')



[1] 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[1]



[1] 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[1] and true age[2] in 387 clients attending a piercing/tattoo studio under investigation in Exercise Seren by age at time of procedure[3]

	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%

[1] Age calculated by subtracting client date of birth from date of procedure. Both dates obtained from piercing studio client records

[2] Age calculated from dates of birth obtained by checking client's details against Welsh Demographics Service

[3] 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[12], 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

[12] 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:[13,14,15]

- 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[16] 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[17]) 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[18] (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

[13] 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
[14] 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
[15] 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
[16] World Health Organisation (2009) Harmful Use of Alcohol http://www.who.int/nmh/publications/fact_sheet_alcohol_en.pdf
[17] 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
[18] 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[19,20,21,22].

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[23].

A 2005 review by the World Health Organisation (WHO)[24] 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[25].

[19] 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/
[20] Home Office (2012) *A minimum unit price for alcohol: impact assessment 1A*. Home Office, London, UK.
[21] 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.
[22] Gallet, C.A. (2007) The demand for alcohol: a meta-analysis of elasticities. *Austalian Journal of Agriculture and Resource Economics*, *51*, 121-35.
[23] 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/
[24] WHO fact sheet. 2005. www.parpa.pl/download/fs1005e2.pdf.
[25] Holmes, J., Meng, Y., Meier, P.S., Brennan, A., Angus, C., Campbell-Burton, A., Guo, Y., Hill-McManus, D. and Purshouse, R.C. (2014) Eff ects of minimum unit pricing for alcohol on different income and socioeconomic groups: a modelling study. *Lancet, 383,* 1655-1664

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[26,27]. 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,[28,29] 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[30], 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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[26] 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.

[27] 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.

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

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

[30] 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.[31]

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[32] and, as well as youth violence, is strongly associated with domestic violence, child abuse and self-directed violence (e.g. suicide)[33].

In Scotland 50 per cent of people reported one or more harms as a result of someone else's drinking in the last year[34].

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[35].

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[31] 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.

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

[33] World Health Organisation (2006) Interpersonal violence and alcohol. http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/pb_violencealcohol.pdf

[34] 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

[35] 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.[36]

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[37]. 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.[38] 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[39] 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

[36] Zhao, J., Stockwell, T., Martin, G., Macdonald, S., Valance, K., Treno, A., Ponicki, W., Tu, A. and Buxton, J. 2013. The relationship between changes to minimum alcohol price, outlet densities and alcohol-related death in British Columbia, 2002-2009. *Addiction*. URL:http://onlinelibrary.wiley.com/doi/10.1111/add.12139/pdf.
[37] 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.
[38] Welsh Assembly Government (2008) 'Working Together to Reduce Harm, The Substance Misuse Strategy for Wales 2008-2018'.
[39] '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.[40]

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[41].

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:

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

[41] 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

- 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[7]:

- Public health and community safety should be given priority in all public policy-making about alcohol
- At least one third of every alcohol product label is an evidence based health warning from an independent regulatory body
- Sales in shops should be restricted to specific times of the day and designated areas with no promotion outside these areas
- Tax on alcohol products should be proportionate to volume of alcohol to incentivise sales of lower strength products
- Licensing authorities should be empowered to tackle alcohol-related harm by controlling total availability in their area
- Alcohol advertising should be strictly limited to newspapers and other adult press while its content should be limited to factual information
- There should be an independent body to regulate alcohol promotion, including product and packaging design for public health and community safety
- The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.
- Graduated driver licensing should be introduced, restricting the circumstances in which young and novice drivers can drive

- All health and social care professionals should be trained to provide early identification and brief alcohol advice
- People who need support for alcohol problems should be routinely referred to specialist alcohol services for assessment and treatment
- Existing laws to prohibit the sale of alcohol to individuals who are already heavily intoxicated should be enforced in order to reduce acute and long term harms to their health and that of the individuals around them

Appendix 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[42] 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[43] 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

[42] Welsh Government. Active Travel (Wales) Act (2013)
[43] 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[44] 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[45] 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

[44] Welsh Government (2012). National minimum standards for regulated child care. http://wales.gov.uk/topics/childrenyoungpeople/publications/regulated childcare
[45] National Minimum Standards for Care Homes for Older People (2004) 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[46] 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[47]. Dental health in young children is still poor in Wales with 41.4 per cent of five year olds experiencing dental decay in Wales[48] although this is a reduction of 6 per cent from 2007/8 .

[46] 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.
[47] Public Health Wales (2013). Child Measurement Report for Wales 2011/12

[48] 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[49].

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[50] 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[51], 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

[49] http://www.fph.org.uk/public_health_experts_call_on_pm_to_take_action_on_nutrition_and_hunger
[50] Welsh Government (2010). Welsh Childcare and Early Years Survey.
[51] NICE (2014) Implementing Vitamin D Draft Guidance.

needs[52]. 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[53].

Prevalence of under-nutrition is widespread; within the care home setting it is estimated to be between 16-29 per cent[54]. 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[55] 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.

[52] 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)
[53] CSSIW. Regulations and National Minimum Standards: Adult Services http://cssiw.org.uk
[54] BAPEN (2009). Nutrition Screening Survey in the UK in 2008. British Association for Parental and Enteral Nutrition.
[55] 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.

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 National Federation of Retail Newsagents – PHB 90 / Tystiolaeth gan Ffederasiwn Cenedlaethol Manwerthwyr Papurau Newydd – PHB 90

NFRN
The voice of the independent retailer

Submission from the NFRN to the National Assembly for Wales' Health and Social Care Committee's consultation on the Public Health (Wales) Bill

Introduction

The National Federation of Retail Newsagents (NFRN) would like to thank the National Assembly for Wales' Health and Social Care Committee for the opportunity to present the views of its members on the Public Health (Wales) Bill, in particular on the issue of tobacco and nicotine products.

The NFRN is one of Europe's largest employer's associations, representing over 15,000 independent retailers across the British Isles. We are a membership led organisation that assists the independent retailer to compete more effectively in today's highly competitive market, as well as representing members' interests at governmental and parliamentary level.

Summary

The NFRN believes the proposals on tobacco and nicotine products, put forward by the government, are laudable but ill conceived. We urge the government to look more closely at the benefits of e-cigarettes to smokers trying to quit. We also call on the government to tackle the illicit tobacco market, something we feel the retailers' register will not achieve in its current form.

Response

Part 2: Tobacco and Nicotine Products

Question 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?

The NFRN does not support a ban on the use of e-cigarettes in enclosed public spaces and work places. This is because we consider that e-cigarettes offer those who smoke tobacco an alternative which is more preferable for their health.

In support of this, a recent report from Public Health England[1] (PHE) found that e-cigarettes are approximately 95 per cent less harmful to health than smoking. The PHE report states that whilst e-cigarettes are not free from risk for their users, they have the potential to contribute to the end of

[1] https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

tobacco use completely, particularly as the large majority of users are current or former conventional smokers, as opposed to being used by those who have not smoked before. This is in line with the MHRA's findings, with evidence suggesting that much e-cigarette use is to support stop smoking attempts or for partial replacement to reduce harm associated with regular tobacco smoking[2].

The PHE report also found that e-cigarettes release negligible levels of nicotine into ambient air, therefore causing no identifiable health risks to bystanders. The NFRN supports evidence based policy making and feels that, in light of the findings of the PHE report, it would be an error on the government's part to not continue to allow the use of e-cigarettes in enclosed public and work spaces.

The 2013 Welsh Health Survey reported that 72 per cent of smokers would like to give up, and 41 per cent had tried to give up in the last year[3]. By banning the use of e-cigarettes in enclosed public spaces, these products will be denied the opportunity to be used as cessation devices. We encourage the government to reconsider this proposal and recognise the usefulness of these products in efforts to tackle the prevalence of tobacco smokers.

Nonetheless, the NFRN does believe that non-smokers and non-vapers should be respected. As such, we believe the government should encourage a compromise on the use of e-cigarettes in enclosed public and work places, through the use of designated vaping areas within these enclosed areas.

Question 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 disbenefits related to the use of e-cigarettes?

As detailed in our answer to question 1, the NFRN does not feel that these provisions are based on evidence. Until evidence is made available that finds results other than those stated in the PHE report, we feel that the proposed ban is too repressive and will hinder those smokers trying to quit by using e-cigarettes.

Question 4: Do you have any views on whether the use of e-cigarettes renormalizes smoking behaviours in smoke-free areas, and whether, given their appearance in replicating cigarettes, inadvertently promote smoking?

We would urge the government to adopt another term to refer to e-cigarettes. This will help to distinguish them from tobacco products and raise awareness that they are a useful tool for those trying to quit smoking.

Question 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?

Our members have informed us that it is their experience that young people are not attempting to buy these products in large numbers, despite currently being legal to do so.

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[2] http://webarchive.nationalarchives.gov.uk/20141205150130/http://www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/Product-specificinformationandadvice/Product-specificinformationandadvice%E2%80%93M%E2%80%93T/NicotineContainingProducts/index.htm

[3] http://gov.wales/statistics-and-research/welsh-health-survey/?lang=en

As responsible retailers our members act as the barrier between young people and these products, and continue to prevent the sale of e-cigarettes to them to protect them ahead of the introduction of the age restriction later this year.

Question 7: Do you have any views on the level of fines to be imposed on a person guilty of offences listed under this Part?

The NFRN considers it important that any level of fine imposed is reviewed in future, to ensure it continues to act as a deterrent.

Question 8: Do you agree with the proposal to establish a national register of retailers of tobacco and nicotine products?

In principle the NFRN supports the establishment of a national register of tobacco and nicotine retailers. However, we continue to express our concerns about the exact register being proposed by the Welsh Government for the reasons set out below.

Firstly, the register is dependent on the retailer actively registering. Consequently, our members feel that it is targeting them as responsible retailers. We believe that those retailers that are not selling age restricted products responsibly will avoid joining the register.

The NFRN would like to know how the government proposes the register will overcome this problem.

Secondly, as there is a cost to apply to register we feel that it is equating to a tax on responsible retailers who will feel compelled to join the register to prove they are law abiding.

The NFRN believes that responsible retailers should not have to pay to join a register stating they are selling tobacco and related products responsibly. We argue that Trading Standards departments should be aware of those retailers in their area that sell tobacco and a centralised list will do nothing to tackle the problems the government proposes the register will alleviate.

Thirdly, following a conversation with the Welsh Government we are concerned that Trading Standards departments have little intention of using the register for tackling illicit suppliers of these products any more than they currently do. Rather, the register will assist them in focussing on law abiding retailers.

The NFRN would like to see more effort focussed on tackling the illicit tobacco trade which adversely affects our members' businesses. As NFRN members already work with their local authorities to report suspicious activity, they feel that this register will do little to address their concerns.

Question 9: Do you believe the establishment of a register will help protect under 18s from accessing tobacco and nicotine products?

The NFRN does not believe that the establishment of a register of tobacco and nicotine retailers will provide any more protection to under 18s who are trying to access these products.

We strongly believe that those retailers that are irresponsibly selling these products to under 18s will not be signing up to this register and will continue to supply these products to those under the age restriction. The responsible retailers that will join this register are already conducting age verification checks and are striving to ensure that young people under 18 are not able to access these products from their premise.

Question 10: Do you believe a strengthened Restricted Premises Order regime, with a national register, will aid local authorities in enforcing tobacco and nicotine offences?

Whilst a strengthened restricted premise order regime will allow local authorities the opportunity to enforce offences relating to tobacco and nicotine products, and could work in conjunction with a national tobacco retailers' register, we fail to understand why the register is required for this and why a restricted premise order regime could not function on its own to tackle offenders.

Question 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 NFRN supports the creation of a new offence for retailers that knowingly sell tobacco and nicotine products to a person under 18 years old and throughout this response are urging the government to do more to tackle these offenders.

Question 12: Do you believe the proposals relating to tobacco and nicotine products contained in the Bill will contribute to improving public health in Wales?

The NFRN does not feel that the proposals within the Public Health Wales Bill will contribute towards improving public health in Wales.

This is because e-cigarettes are a useful tool for smokers trying to quit. They have been found by PHE to be up to 95 per cent less harmful than smoking, with their use primarily prevalent amongst current and former smokers. Consequently, the NFRN cannot sympathise with the government's efforts to restrict their use in enclosed public spaces, as they would be forcing those who use e-cigarettes for cessation purposes to vape in the same area as traditional smokers, challenging them in their attempts to quit.

We also consider that the tobacco register will not stop irresponsible retailers from selling tobacco and nicotine products to under 18s and call on the government to redirect their efforts towards tackling these retailers and the illicit market, something we feel the register will not achieve.

Finance questions

Question 1: 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.)

The creation of a tobacco retailers' register is estimated to cost responsible retailers throughout Wales nearly £286,000 in the first year alone, yet the NFRN is not convinced that it will have the desired results. In comparison, the illicit tobacco market throughout the UK is estimated to cost the Treasury £1.3 billion a year[4] and needs to be addressed.

Question 3: What financial impact will the Bill's proposals have on you/your organisation?

The cost of registering on the tobacco retailers' register will have a substantial impact on our members' businesses.

Our members have provided the following example to explain this impact.

Cost of 20 packet of cigarettes = £6.99

[4] http://www.theretailbulletin.com/news/summit_calls_for_counterfeit_crackdown_18-02-14/

Flat rate tax paid to government = £3.79
16.5% of sale price in tax paid to government = £1.15
VAT @ 20% paid to government = 1.39
Total paid to government = £6.34
Retailer is left with 34p, of which 7p is paid in VAT to government
Total retailer profit = 27p

To afford the £30 charge to register, a retailer would have to sell 111 packets of cigarettes, or take £775.89 in sales.

It is clear from these figures that whilst £30 may not seem a significant sum, to an independent retailer it involves a great deal of hard work and eats into their already small profit margins. The charge to register could see many independent retailers have to close their shop, particularly when taking into account the upcoming introduction of the National Living Wage and the additional cost and impact this will have.

Question 4: 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?

The NFRN believes that by removing the plans for the register from the Bill entirely and focussing more effort on the illicit tobacco market, including working with responsible retailers, the government and local authorities would have greater success in tackling these issues.

Question 5: 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?

The NFRN does not consider the costs of the Bill's proposals to be reasonable and proportionate. This is because the register will focus on responsible retailers, rather than addressing the issue of the illicit tobacco market. Currently our members feel they will pay to join the register to ensure Trading Standards departments know where they are and what business they are conducting, yet it has not set out how it will address those retailers that do not register and are not selling these products responsibly, or worse still, are selling illicit versions of these products.

Other comments

Question 2: Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?

No, the Bill does not address tackling the illicit tobacco market or plans to improve education on the dangers of using tobacco and nicotine products amongst the public.

Question 3: Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales?

Yes, the government needs to improve education and thus awareness of the dangers of using tobacco and nicotine products amongst the public. However, we argue that the government also needs to raise awareness of the dangers of illicit products. ASH Wales' recent report[5] found that the illicit market share in Wales has reached 15 per cent of the total market, with a quarter of current smokers purchasing illicit products. This is particularly concerning because these products can be much more dangerous to a person's health than legitimate tobacco products, with many

[5] http://ashwales.org.uk/assets/factsheets-leaflets/illegal-tobacco-report-v4.pdf

found to contain asbestos and human excrement, as well as increased levels of toxic ingredients such as tar, nicotine, carbon monoxide, lead, cadminium and arsenic[6].

Contact

For more information on this submission please contact Charlotte Parsons at [redacted] or [redacted].

[6] http://www.local.gov.uk/media-releases/-/journal_content/56/10180/6164176/NEWS

Health and Social Care Committee Consultation: General Principles of the Public Health (Wales) Bill

FSB Wales Response

4 September 2015

General Principles of the Public Health (Wales) Bill
FSB Wales

FSB Wales welcomes the opportunity to present its views to the National Assembly for Wales Health and Social Care Committee consultation on the General Principles of the Public Health (Wales) Bill. FSB Wales is the authoritative voice of businesses in Wales. With 10,000 members, a Welsh Policy Unit, two regional committees and twelve branch committees, FSB Wales is in constant contact with business at grassroots level. It undertakes regular online surveys of its members as well as a biennial membership survey on a wide range of issues and concerns facing small business.

In June 2014, FSB Wales was pleased to present our comments to the Welsh Government on the Public Health White Paper[1], and our comments presented in this response to the Committee are consistent with this previous submission.

Tobacco and Nicotine Products

FSB Wales notes the Welsh Government's intention to extend existing provisions on no smoking to electronic inhaling devices. Although we do not have a formal position in respect of such an extension, we are conscious that there has been significant debate on this issue since the publication of the White Paper last year. We believe it is important that the Welsh Government provide clear guidance to Welsh businesses following the introduction of this legislation, so as to ensure the avoidance of any confusion over responsibilities in relation to workplaces or premises open to the public.

In respect of the creation of a national register of retailers of tobacco and nicotine products, we have previously indicated that we accept the need to examine the effectiveness of the existing legislation. However, we believe any new functions that are required of trading standards departments must not place additional strain on their already limited resources. Additional responsibilities must come with additional funding, so as not to undermine the ability of trading standards officers to perform their existing functions.

Moreover, whilst we see some merits in the introduction of a national register of retailers, this must also not place additional administrative burdens on small businesses. Our survey of FSB members in 2012 showed that the cost of complying with regulation was already more than £1,000 per year for 61% of small businesses, and for 10% the cost was £10,000 or more per year[2]. The Bill also does not specify if a charge is to be levied on businesses for application for inclusion on the national register, and we believe Welsh Government should be clear about the costs likely to be incurred by businesses as a result of the new legislation.

[1] FSB Wales (2014). *Public Health White Paper Consultation Response.*
http://www.fsb.org.uk/policy/rpu/wales/images/final%20public%20health%20white%20paper.pdf

[2] FSB (2012). *Regulatory Reform: Where Next?*
http://www.fsb.org.uk/frontpage/assets/fsb_regulatory_reform_web.pdf

Pharmaceutical Services

FSB Wales notes the provisions in the Bill to change the way that Health Boards make decisions with regard to assessments of pharmaceutical need in communities. Whilst we find it unusual that such changes are being introduced as part of the Public Health (Wales) Bill, we believe there is an opportunity to derive a wider public health benefit from this change, should the Welsh Government include a local economic impact indicator as part of its decision-making.

Pharmacies play an important role in communities across Wales. Evidence has shown that areas of poor economic performance tend to experience poor health, which illustrates the clear correlation between local economies and health inequalities[3]. We believe that the Welsh Government must clearly legislate to ensure that Local Health Boards also undertake economic impact assessments when making decisions on where to locate pharmacies.

Provision of Public Toilets

We welcome the provision within the Bill to require local authorities to prepare local public toilets strategies to ensure the provision of toilets for public use. In our response to the Public Health White Paper in 2014, we argued that the provision of public toilets was a key issue for many small businesses, particularly those located on high streets. The closure of local authority public toilets places additional pressure on the public use of toilets in private businesses.

Furthermore, we believe that public toilets are an important public facility particularly in town and village centres, and their removal has a detrimental impact on local footfall and local economies. As with our comments on the location of pharmacies, we believe that local authorities should be required to undertake local economic impact assessments, as part of the public toilets strategies that the Bill requires them to develop.

[3] See for example: Adamson, D. and Lang, M. (2014). *Toward A New Settlement: A Deep Place Approach to Equitable and Sustainable Places.* https://www.researchgate.net/publication/272358132_Toward_a_New_Settlement_A_Deep_Place_Approach_to_Equitable_and_Sustainable_Places

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The Federation of Small Businesses Wales
The FSB Wales is non-profit making and non-party political. The Federation of Small Businesses is the UK's largest campaigning pressure group promoting and protecting the interests of the self-employed and owners of small firms. Formed in 1974, it now has 200,000 members across 33 regions and 194 branches. FSB Wales currently has around 10,000 members, a Welsh Policy Unit, two regional committees and twelve branch committees meaning FSB Wales is in constant contact with small businesses at a grassroots level in Wales.

Lobbying
From the Press and Parliamentary Affairs Office in Cardiff, FSB Wales campaigns with AMs, MPs and MEPs in Cardiff Bay, Westminster and Brussels in order to promote our members' interests. FSB Wales also works closely with local, regional and national media outlets to highlight our members' concerns. Development Managers work alongside members in our regions to further FSB Wales influence at a regional level. More widely, the FSB has Press and Parliamentary Offices in Westminster, Glasgow, Belfast and Brussels to lobby the respective Governments.

Member Benefits
In addition, Member Services is committed to delivering a wide range of high quality, good value business services to members of the FSB. These services will be subject to continuing review and will represent a positive enhancement to the benefit of membership of the Leading Business organisation in the UK.

Vision
A community that recognises, values and adequately rewards the endeavours of those who are self employed and small business owners within the UK.

The Federation of Small Businesses is the trading name of the National Federation of Self Employed and Small Businesses Limited. Our registered office is Sir Frank Whittle Way, Blackpool Business Park, Blackpool, Lancashire, FY4 2FE. Our company number is 1263540 and our Data Protection Act registration number is Z7356876. We are a non-profit making organisation and we have registered with the Information Commissioner on a voluntary basis.

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 Powys County Council – PHB 92 / Tystiolaeth gan Gyngor Sir Powys – PHB 92

HEALTH AND SOCIAL CARE COMMITTEE CONSULTATION ON PRINCIPLES OF THE PUBLIC HEALTH (WALES) BILL

Submission of Evidence by Powys County Council.

Introduction:

Powys County Council is pleased to submit this response to Welsh Government on the proposals contained within the Bill. In preparing this response we have taken the views of the Trading Standards, Environmental Health and Local Environment colleagues. These include expertise in Communicable Disease Control, Health & Safety at Work, Pollution Control, Public Health Improvement, substance misuse controls, fair trading and public toilet provision.

We have made reference to our professional bodies responses to this consultation ie Wales Heads of Trading Standards and Environmental Health Groups as well as the Directors of Public Protection in Wales (DPPW) and some of the responses are identical in content.

Part 2: Tobacco and Nicotine Products Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

 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?

YES.

The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason.

DPPW published its views on the availability and use of e-cigarettes in 2013 ***(DPPW, 2013)*** *which included several examples* where the enforcement of the ban on smoking in enclosed public places had been undermined by claims of the use of e-cigarettes. Local authorities have had legal actions fail because offenders claimed they were using e-cigarettes.*

> [*examples: Cardiff County Council instigated a prosecution against a taxi driver for smoking in his vehicle. The defendant pleaded not guilty on the basis that he was smoking an e-cigarette and not a “real” cigarette. The matter proceeded to Court

where the defendant was found not guilty despite the alleged offence being witnessed by an Enforcement Officer.

Powys County Council has also experienced difficulties with enforcement, having lost a court case against a taxi driver who as part of his defence in Court suggested he may have been using an e-cigarette. The Court found the defendant not guilty despite the investigating officer's witness statement.

Similar enforcement difficulties have been experienced by Caerphilly CBC, Wrexham CBC and Swansea CBC where taxi drivers have been witnessed smoking in their vehicles but Enforcement Officers have been unable to prove whether it was a tobacco product or an e-cigarette. These cases demonstrate that where an individual is witnessed contravening the ban on smoking in a wholly or substantially enclosed public place they can simply claim that they were smoking an e-cigarette and it is extremely difficult for enforcing authorities to prove otherwise, thereby compromising the enforcement of the ban.]

A key issue here is that the ban on smoking in public places has been very successful and is almost entirely self-policing by the public. E-cigarettes pose a real threat to that self-policing.

E-cigarettes also undermine the ability of managers of premises to enforce smoke free places, leading to many business banning them. Our officers that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people "vaping". Some vapers argue "it's not against the law".

We believe that the use of e-cigarettes in public places can help "normalise" smoking. See later.

There is uncertainty over the potential adverse health implications associated with e-cigarettes and despite recent studies suggesting some benefit to those quitting smoking the efficacy of e-cigarettes as an aid to smoking cessation is not entirely clear. It is therefore appropriate to take a precautionary approach to the risks associated with e-cigarettes. Currently people in Wales can breathe clean air in offices, shops, pubs and other public places and work environments. We don't want to see a backwards step towards potentially polluted air.

Further evidence in support of the above can be found in the 'State Health Officer's Report on E-Cigarettes' (January 2015) (California Department of Public Health).

http://www.cdph.ca.gov/programs/tobacco/Documents/Media/State%20Health-e-cig%20report.pdf

The executive summary says:

While there is still much to be learned about the ingredients and the long-term health impacts of e-cigarettes, this report provides Californians with information on e-cigarette use, public health concerns related to e-cigarettes, and steps that can be taken to address the growing use of these products. The following are key highlights from the report:

E-Cigarette Use

• In 2014, teen use of e-cigarettes surpassed the use of traditional cigarettes for the first time, with more than twice as many 8th and 10th graders reporting using e-cigarettes than

traditional cigarettes. Among 12th graders, 17 percent reported currently using e-cigarettes vs. 14 percent using traditional cigarettes.

• In California, adults using e-cigarettes in the past 30 days doubled from 1.8 percent in 2012 to 3.5 percent in 2013. For younger adults (18 to 29 years old), e-cigarette use tripled in only one year from 2.3 percent to 7.6 percent.

• Young adults are three times more likely to use e-cigarettes than those 30 and older.

• Nearly 20 percent of young adult e-cigarette users in California have never smoked traditional cigarettes.

Health Effects of E-Cigarettes

• E-cigarettes contain nicotine, a highly addictive neurotoxin.

• Exposure to nicotine during adolescence can harm brain development and predispose youth to future tobacco use.

• E-cigarettes do not emit water vapor, but a concoction of chemicals toxic to human cells in the form of an aerosol. The chemicals in the aerosol travel through the circulatory system to the brain and all organs.

• Mainstream and second hand e-cigarette aerosol has been found to contain at least ten chemicals that are on California's Proposition 65 list of chemicals known to cause cancer, birth defects, or other reproductive harm.

Heightened Concern for Youth

• The variety of fruit and candy flavoured e-cigarettes entice small children who may accidently ingest them. Even a fraction of e-liquid may be lethal to a small child.

• E-cigarette cartridges often leak and are not equipped with child-resistant caps, creating a potential source of poisoning through ingestion and skin or eye contact.

• Calls to poison control centres in California and the rest of the U.S. have risen significantly for both adults and children accidently exposed to e-liquids.

• In California, the number of calls to the poison control centre involving e-cigarette exposures in children five and under tripled in one year.

Harm Reduction Claims and Myths

• There is no scientific evidence that e-cigarettes help smokers successfully quit traditional cigarettes.

• E-cigarette users are no more likely to quit than regular smokers, with one study finding 89 percent of e-cigarette users still using them one year later. Another study found that e-cigarette users are a third less likely to quit cigarettes.

Unrestricted Marketing

• In three years, the amount of money spent on advertising e-cigarettes increased more than 1,200 percent.

• E-cigarette advertisements (ads) are on television (TV) and radio where tobacco ads were banned more than 40 years ago. Most of the methods being used today by e-cigarette companies were used long ago by tobacco companies to market traditional cigarettes to kids.

• Many ads state that e-cigarettes are a way to get around smoking bans, which undermines smoke free social norms. Various tactics and claims are also used to imply that these products are safe.

• The fact that e-cigarettes contain nicotine, which is highly addictive, is not typically included in e-cigarette advertising.

In Conclusion

California has been a leader in tobacco use prevention and cessation for over 25 years, with one of the lowest youth smoking rates in the nation. The promotion and increasing use of e-cigarettes threaten California's progress. These data suggest that a new generation of young people will become addicted to nicotine, accidental poisonings of children will continue, and involuntary exposure to second-hand aerosol emissions will impact the public's health if e-cigarette marketing, sales and use continue without restriction. Additionally, without action, it is likely that California's more than two decades of progress to prevent and reduce traditional tobacco use will erode as e-cigarettes re-normalize smoking behaviour.

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

We are of the opinion that smoking should be discouraged in all public places, in particular those locations where there are children or vulnerable people. These include:

- *Playgrounds*
- *School grounds & their immediate vicinity*
- *Hospital & medical facility grounds*
- *Places promoted to children (e.g. "petting farms", fairgrounds and family centred leisure parks).*

There is a need for Fixed Penalty Notice powers which should be consistent powers with existing provisions. In drafting such provisions there is a need to consider that law currently places a responsibility on the person in control of premises to prevent smoking (e.g. hospital grounds) and that local authorities' usual enforcement approach is against the "person in control of premises" for permitting smoking. (Under the Health Act 2006 "*It is the duty of any person who controls or is concerned in the management of smoke-free premises to cause a person smoking there to stop smoking*.")

If current restrictions are extended, then it is essential that local authorities receive additional funding to support this work. Receipts from enforcement should be returned to Local Authorities to further support enforcement and education work in this area.

The additional work likely to arise as a result of an extension in the ban to include e-cigarettes and also to prohibit smoking and the use of e-cigarettes in other non-enclosed places is difficult to predict but may be significant.

We appreciate that the 'smoking ban' has, to date, been largely self-policing.

This will have been assisted by the fact that health risks associated with smoking and in turn the inhalation of second hand tobacco smoke are well known and understood. As a result smokers (and the public in general) will appreciate the purpose of the ban and support compliance expectations.

While there are reasoned arguments for extending the ban to include e-cigarettes and to cover certain non-enclosed places, it is foreseeable that smokers will be less understanding of, and compliant with respect to, restrictions on their use of e-cigarettes in the absence of 'proven' health concerns and where they feel that their use of such devices is key to them quitting smoking. Similarly, there is likely to be less public concern for the use of e-cigarettes, for the same reasons, and accordingly less social pressure on users not to use them in contravention of any ban.

This distinction may create some/significant resistance towards compliance, which would in turn necessitate a significant increase in resources to 'police', compared to the current smoking ban.

This should be taken into consideration in resourcing this work.

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

Yes.

Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation; intentionally or inadvertently promote or normalise smoking; and the potential impact upon impact upon smoke free environments.

We are concerned that there is a real potential for e-cigarettes to intentionally or inadvertently promote smoking amongst those who currently do not smoke. In particular we feel there is a need to make every effort to deter young people from becoming smokers.

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

*Yes. We take the view that anything that has the appearance of smoking helps "normalise" smoking and therefore promotes smoking behaviour and culture. We also question whether the term **"inadvertently"** is appropriate. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour.*

We are also concerned by the nature of e-cigarette advertising; we note the reappearance of 1950's style marketing of tobacco products.

Workplaces have worked hard to implement the smoke free premises legislation and the use of e-cigarettes undermines this work.

We are concerned that e-cigarettes encourage young people to think that smoking is acceptable and therefore has the potential to act as a gateway to both e-cigarettes and tobacco based products.

Data relating to smoking behaviour in Wales leads us conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach.

 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?*

Yes we feel they are. We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours.

E-cigarettes have, for example, been displayed for sale with sweets, at child height, at the checkout in large stores which is unacceptable.

Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as "Gummy Bear, Cherry cola and Bubble Gum".

Some products are being packaged and marketed in a way that is closely associated with that of conventional cigarettes. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour. We are also concerned by the nature of e-cigarette advertising; e.g. consistent with the 1950's style marketing of tobacco products.

Many of these factors reinforce the association with conventional tobacco cigarettes and may normalise smoking related behaviour.

 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?

Yes. A number of licensed premises have independently introduced bans on the use of e-cigarettes within their premises in recognition of the difficulty they cause their staff in applying the smoking ban within their premises.

Our colleagues that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people "vaping". Some vapers argue "it's not against the law".

Some employers have had difficulties. e.g. Caerphilly CBC had problems with lorry drivers smoking in their cabs and when tackled claimed they were vaping an e-cig, which made taking action difficult. Caerphilly CBC has also received complaints from their own office based staff that colleagues have been using e-cigarettes at their desks and that they may be

also be inhaling the vapours in a similar way to second hand smoke. Hence Caerphilly amended their no smoking policy to include e-cigs.

The proposed legislation in smoke-free places should apply equally to tobacco based products and all forms of e-cigarettes.

In a recent Powys CC prosecution case, a landlord (unsuccessfully) argued that the tobacco product seen in CCTV cameras being `used` was an e cigarette. Restricting the use in such premises would remove this argument completely

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

The power to issue Fixed Penalty Notices and other enforcement provisions need to be consistent with other smoking legislation and the fines need to be set at such a level as to be a deterrent to (re)offending. Receipts from enforcement/Fixed Penalty Notices should be returned to Local Authorities to further support enforcement and education work in this area.

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

Yes. Powys CC supports the proposal.

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

The introduction of a register will provide an additional control on the availability of tobacco; a register would contain detailed information on those people and premises from which tobacco can be sold legitimately. Furthermore it would restrict access to the trade to those people and premises where tobacco should not be sold. It will be easier for enforcement officers to identify those premises where tobacco is permitted to be sold, which will in turn assist with the enforcement of underage sales and the display ban.

The success of such a measure would be dependent on the legislation including provisions to control access to the register such as a “fit & proper persons” or “suitable persons” test. This is explored further in response to subsequent questions.

If a register is to be established it needs to cover all those that manufacture, distribute and sell tobacco products. We feel that having a register only for the end retailers is not comprehensive and will not cover other parts of the tobacco chain that feed the habit including those under age. An offence should be created where tobacco products can only be sold, distributed, etc to those registered.

We note that section 29(5) provides that ‘A registered person who fails, without reasonable excuse, to comply with section 25 (duty to notify certain changes) commits an offence’. We are concerned by the use of the phrase ‘reasonable excuse’:

a) Firstly, as it is out of step with the more robust due diligence offence common to most current consumer protection legislation, i.e. the two limbed all reasonable precautions and all due diligence defence. There is concern that with section 29(5) as currently worded, individuals failing to notify changes to the register will be able to evade enforcement action. There will be no definition of what is reasonable and so these explanations would need to be tested in court with associated wasting of resources.

   Use of the well established two limbed due diligence system would enable enforcement officers to assess the adequacy of an individual's defence based on tried and tested case law, well before a case has to enter the court system

b) Secondly, the very use of the word 'excuse' in section 29(5) sends out quite the wrong message to the trade, and there is a danger that the current wording will encourage individuals simply to 'come up with an excuse' in the expectation that this will be acceptable.

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

Yes. The proposed link to restricted sales orders (RSOs) and restricted premises orders (RPOs) under the Children & Young Persons Act are welcome. However, we see it as essential that the range of offences triggering an RPO is extended to include all tobacco related breaches, for example the supply of illegal (counterfeit and non-duty paid) tobacco, tobacco labelling offences, non-compliance with the tobacco display ban; and not just underage sales. It is hoped that these matters will be addressed through the proposed power for Welsh Ministers to make regulations under section 12D of the Children and Young Persons Act and the range of offences triggering an RPO extended accordingly.

However, our experience of "Registers" introduced under other legal provisions suggest that their efficacy can be limited if they are not also accompanied by robust enforcement powers. Some registers are merely administrative or informative.

Local authority enforcement officers will need effective powers to ensure that the register has the desired effect. These need to include power to restrict access to the register and to remove persons from the register where there has been a relevant infringement of the law, including offences concerning underage sales. We feel that there should be a provision to consider suitability of a retailer - whether the retailer is a "fit & proper" person. For example, whether a retailer been convicted for the sale of alcohol, solvents or other age restricted products to minors. The section 24 provision that an application to register will not be granted if an RPO or RSO is already in place goes some way towards this, but of course does not take account of the selling to minors of other age restricted products.

We welcome the section 23(2)(g) clarification that in addition to sellers of tobacco and nicotine products with a High Street presence, those supplying via online, telephone and mail order channels will be required to indicate this on the register. However, it is unclear from the wording of section 22(1) whether the requirement to register applies only to those based in Wales rather than those outside Wales supplying to customers in Wales, i.e. 'The registration authority must maintain a register of persons carrying on a tobacco or nicotine business at premises in Wales'.

We are disappointed with the section 23(3) definition of a "tobacco or nicotine business" as being a business involving the sale by retail of tobacco or cigarette papers or nicotine products'. Limiting the scope of the register to retail would be a lost opportunity to regulate throughout the supply chain. The illicit supply and sale of tobacco has been identified as a growing concern

by Trading Standards in Wales. A register must not inadvertently add to the problem of illicit trade in cigarettes. The penalties of failing to register therefore need to be robust. We emphasise that the definitions of “business” need to be carefully considered to encompass not only legitimate traders but also those persons who are trading illegally in tobacco from domestic premises. We feel it should also include online suppliers. Effectively the provisions must apply to anyone who is *selling* tobacco products in Wales.

We support the need for robust and proportionate penalty for offences and proposed powers of entry (to retail premises) or the ability to seek a warrant (for domestic premises). These are obviously vital. We also support the need for powers to seize tobacco goods in all relevant premises including those that are not registered.

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

We support the proposals which would bring tobacco products into line with alcohol sales.

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

Yes.

Smoking remains the single greatest avoidable cause of death in Wales **(PHW, 2012)**. The introduction of the ban on smoking in enclosed public spaces in 2007 has been hugely successful in reducing exposure to environmental tobacco smoke and in strengthening public awareness and attitudes towards it. However, reducing the prevalence of smoking, remains a key health priority. Protecting young people from the effects of smoking and deterring young people from taking up the habit are particularly important. Therefore Powys CC welcomes the proposals and additional powers to help control the availability of tobacco and its potential health impact.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales, these procedures are acupuncture, body piercing, electrolysis and tattooing.

 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?

We support WG proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators.

Powys CC is of the view that current legislation does not adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

Powys CC has the following concerns regarding existing provisions:

- There is no requirement for a practitioner to have training or experience to set up a tattoo studio. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk.
- Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the byelaws. This may be viewed as a purely administrative offence when Courts are considering sentencing.
- Current registration requirements rely on being able to prove that a person is carrying on a business and this can be difficult because most unregistered tattooists ('scratchers') work from home and deny that they receive payment.
- There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws,
- Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and The Health and Safety at Work etc. Act 1974. Several local authorities in Wales have used Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle "scratchers".
- When we last gathered information on this, we found that between July 2012 and July 2013, ten applications for Part 2A Orders had been made by local authorities; all of which related to the carrying out of unregistered tattooing from domestic premises.
- New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.
- Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.

We agree with the concerns of the Chartered Institute of Environmental Health (CIEH) that many procedures are being done by people with little if any knowledge of anatomy, infection control or healing processes **(CIEH, 2014)**.

We would offer the following observations on the proposal regulations:

- Level 3 fine (£1,000) is too low to act as a meaningful deterrent. The sunbed legislation, which is similar in nature, includes a fine of up to (£20,000); this would be a more appropriate sum.
- In determining whether to grant a license a Local Authority should be able to consider whether the applicant is a "fit and proper person" and such a test should be included (akin to our tried and tested procedures for taxi licensing). The test should permit the LA to take into account "any other information" (beyond the "relevant offences" listed in the draft bill) in determining that question. The current proposals do not offer sufficient safeguards.
- We would be opposed to grandfather rights for existing traders. Officers have only recently dealt with a high profile public health incident in South Wales which related to a long-standing operator.

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future in an efficient and timely manner.

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

We absolutely support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. E.g. a local studio (in Caerphilly) is keen to expand into scarification and tongue splitting. Other procedures are already becoming more popular e.g. branding, dermal implants, microdermabrasion. All these procedures provide the potential for serious harm and infection.

We feel it is absolutely essential that the provision to amend the list of special procedures reflects the need for amendments to be made expediently and without unnecessary delay. The list of special procedures will need to be dynamic to be able to incorporate new procedures as trends change. A lengthy amendment process will undoubtedly leave local authorities ‘on the back foot’, and having to rely on other legislation, for example, Health Protection Legislation ‘Part 2A Orders’ to tackle new and emerging procedures.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive activities underground and cause further issues or potentially make it more appealing to some people. However, we are mindful that legislation that could be seen as ‘supporting’ procedures such as branding and scarification; procedures that could be defined as ‘surgical’ in nature, may give the public the impression that these procedures are ‘safe’. If it is deemed that such procedures should be included then we would suggest that it may be appropriate for additional criteria for such procedures to be specified to meet higher surgical standards. The criteria should cover training, equipment and premises for both the procedure and operator.

In 2011 in Bridgend, a detailed proposal was received to introduce scarification in a local tattoo studio, however on the advice of the Consultant in Communicable Disease Control, the authority agreed to reject the proposal. No further enforcement was required.

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 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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

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

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Evidence of public health risk in relation to such procedures is clear. We take the view that any procedure that involves the piercing of the skin poses a very real risk of infection and disease from blood born viruses many of which can be a serious risk to health and that anyone undertaking such procedures should be competent to do so without putting a person at risk.

Current controls are outdated and inadequate. We need to be able to protect the public to better prevent people from undertaking these procedures if they are not competent or are not fit and proper person to be undertaking such practices. We need also to ensure that the conditions in which such practices take place are hygienic and will prevent infection risks.

We are seeing in our day to day work evidence of a growing range of procedures that put the public at risk. These include: dermal implants, beading, ashing, scarring, dermal fillers, tongue splitting, and a range of other procedures that we might loosely describe as “body modification”. We feel strongly that regulations should permit all such procedures to be controlled and that the regulations should allow the list of procedures to be extended to cover any form of body modification that may arise in the future.

Some procedures such as “ashing” might not fall within the regulations as proposed. Ashing may fall outside of the current definition of tattooing (which relies on the use of pigmentation) and care is needed that definitions do not inadvertently exclude procedures that are intended to be covered.

In relation to extending the list, we recognise from an enforcement perspective that we are familiar with the necessary controls and safeguards needed in relation to more traditional procedures. There is merit in a considered and stepped approach to extending the list of special procedures so that we are able to develop training, suitable competence assessments and necessary guidance in relation to the more novel procedures. We are also aware that consideration is needed in distinguishing between a legal service that we might appropriately control and what might be considered an illegal act of assault. We feel some clarity will be required in relation to that question.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

 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?

Yes. Local authority officers are aware that such procedures are taking place and it is our view that such intimate procedures should be illegal on under 16s to protect this vulnerable group from potential risks.

In fact we share the view of the Chartered Institute of Environmental Health (CIEH) that 16 is **not** an appropriate age for an intimate piercing because:

- The decision to have an intimate body piercing should be made by a mature individual; we believe that 16 years of age is not sufficiently mature.

- Intimate body piercings require a higher standard of aftercare than tattoos, as they are potentially more susceptible to infection. This level of aftercare requires a mature approach to which a 16 year may not be capable of fully committing.

- Whilst the jewellery inserted into an intimate body piercing may be removed any scarring or damage inflected by the procedure will be permanent. This is particularly important when the skin, subject to the piercing is still growing and its function may

be compromised by scarring or thickening. At 16 years an individual is still growing and therefore the risk of damage to skin is greater.

There is considerable potential for confusion to arise if there is a different age restriction for body piercing and for tattooing. We consider that it would be easier for practitioners, enforcement agencies and individuals if the age restriction for both was to be the same.

We further consider that an age restriction of 16 years for intimate body piercing is likely to give rise to call for the age restriction for tattooing to be reduced to 16 years.

We believe that the age restriction for intimate piercing should be 18 years.

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

Yes. However we also feel there is a case to add the tongue. In addition to the relatively higher risks of infections associated with tongue piercing, we are aware that there are sexual connotations with piercing of the tongue and for that reason consider there is a case to include in the list of intimate parts.

 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?

We support such proposals including the proposal to make it an offence “to enter into arrangements”. This would support enforcement of the provisions including “test purchasing” by local authorities.

We recognise the need for police support in particular in relation to evidence gathering given the intimate nature of such offences and the provisions need to take account of that.

Any duties placed upon local authorities must be supported by adequate funding to enable them to be operated and enforced in an effective manner

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

Yes, see above.

Part 6: Provision of Toilets Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

 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?

Powys CC notes that the provision of, and access to, toilets for public use can be important, particularly to older people and those with specific needs. The following response has been prepared by Highways Ground and Streetscene team.

In our view, placing a duty to prepare and publish a local toilets strategy on local authorities will not have much effect on the actual provision of conveniences.

Question 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?

Response: Placing a duty to prepare and publish a local toilets strategy will not have much effect on the actual provision of conveniences and will place an additional burden on local authorities.

•Question 2 : Do you believe that preparing a local toilet strategy will ultimately lead to improved provision of public toilets?

No, without additional funding it is difficult to see how simply having a strategy will improve provision by itself..

Question 3: Do you believe that 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 provision?

Response: in general terms yes it does raise the question as to what is classed as appropriate?

Question 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?

Response: Guidance if provided would assist in the delivery of a more consistent approach across Local authorities. .

Question 5: What are your views on considering toilet facilities within settings in receipt of public funding when developing local strategies?

Response: There are many other “public” bodies, such as Welsh Government and health boards with suitable facilities. Consideration needs to be given as to how these can be included.. Similarly with many councils considering the community service delivery of such services and this will also need to be factored in.

Welsh Government is uniquely placed and could require any government funded/grant aided organisations to make available their toilet facilities where appropriate for use as a public convenience.

Question 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?

Response: Yes this may help in the development of a strategy but may still prove extremely challenging in terms of improving facilities.

Question 7: Do you believe the proposals relating to toilet provision in the Bill will contribute to improving public health in Wales?

Response: Given the importance to public health being placed on the issue of toilet provision it would seem appropriate for Welsh Government to take a lead in the transformation. An approach to overhaul the service so that it is truly fit for purpose, properly funded from government and sustainable would ensure public health issues are addressed on a national basis..

 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?

This seems a reasonable approach but will potentially be of limited as per other attempts at public engagement.. Issues such as these are relevant only to a portion of the population and unless direct contact with young people for example is made then it is unlikely that they will forward a view.

 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?

In our experience, such guidance should lead to a more consistent approach..

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 are generally very supportive of the measures set out in the Bill. However, we are naturally concerned by the capacity within local government to deliver additional responsibilities successfully at a time when service cuts and reductions in service standards are all too apparent. We have a great deal of expertise and experience and local authority Environmental Health Departments and Trading Standards services across Wales are keen to support these new powers and measures. However we ask WG to ensure that such work can be adequately resourced and in particular to consider:

- Undertaking regulatory risk and impact assessment to understand the consequences of the proposed legislation on enforcing authorities and on those subject to regulation,
- a detailed understanding and quantification of the costs of effective regulation and enforcement so that WG and local authorities can plan properly for implementation,
- Where possible provisions should allow for full cost recovery or in the absence of a cost recovery mechanism (typically fees & charges) additional resource must be made available to local authorities specifically for the purpose of this legislation,
- In drafting the legislation, WG should avoid unnecessary complexity or ambiguity, ensure that provisions are capable of being enforced in a practical and efficient way and that any potential defences are fully and properly understood.

 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?

It is best for the professional bodies to comment on this on behalf of all LAs in Wales, rather than individual Councils to comment.

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

Significant impact

 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?

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

Other comments

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

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

Yes

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

Powys County Council supports the following view forwarded by WHOEG : Through our licensing teams and through a broad range of officers working closely with local residents in our communities, we are all too familiar with the problems caused by alcohol. However, we understand that Minimum Unit Pricing is a proposal to be taken forward in a future draft bill – something that we would welcome and will be pleased to work with officials working towards that.

We are also aware of public health concerns around obesity, nutrition and exercise – and we have an interest in this area through our vital role in relation to the regulation of food standards and food labelling and our general contribution to the wider public health agenda. We acknowledge the potential contribution of the Future Generations Act and Active Travel Act for example in this area but note also the potential for planning controls and licensing arrangements to play a greater part. We also recognise that some of these issues may need action at the level of UK Government.

In our submission in advance of the White Paper we also raised the possibility of considering an overarching general offence of prejudicing public health …. enabling appropriate bodies to protect public health in situations which fall outside existing legislation.

We are increasingly concerned by the supply of products known as “legal highs”.

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 Rhondda Cynon Taf County Borough Council – PHB 93 /
Tystiolaeth gan Gyngor Bwrdeistref Sirol Rhondda Cynon Taf – PHB 93

HEALTH AND SOCIAL CARE COMMITTEE CONSULTATION ON PRINCIPLES OF THE PUBLIC HEALTH (WALES) BILL

Submission of Evidence by Rhondda Cynon Taf County Borough Council

Part 2: Tobacco and Nicotine Products Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

 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?

Yes.

The use of e-cigarettes, in particular those that have the appearance of traditional cigarettes, undermines enforcement of smoke-free legislation, not only by local authorities but also those that manage smoke-free places. Many business owners have banned them for that reason.

The Directors of Public Protection Wales (DPPW) published its views on the availability and use of e-cigarettes in 2013 (DPPW, 2013) which included several examples* where the enforcement of the ban on smoking in enclosed public places had been undermined by claims of the use of e-cigarettes. We are aware that local authorities have had legal actions fail because offenders claimed they were using e-cigarettes.

> Examples: Cardiff County Council instigated a prosecution against a taxi driver for smoking in his vehicle. The defendant pleaded not guilty on the basis that he was smoking an e-cigarette and not a “real” cigarette. The matter proceeded to Court where the defendant was found not guilty despite the alleged offence being witnessed by an Enforcement Officer.
>
> Powys County Council has also experienced difficulties with enforcement, having lost a court case against a taxi driver who as part of his defence in Court suggested he may have been using an e-cigarette. The Court found the defendant not guilty despite the investigating officer’s witness statement.
>
> Similar enforcement difficulties have been experienced by Caerphilly CBC, Wrexham CBC and Swansea CBC where taxi drivers have been witnessed smoking in their

vehicles but Enforcement Officers have been unable to prove whether it was a tobacco product or an e-cigarette. These cases demonstrate that where an individual is witnessed contravening the ban on smoking in a wholly or substantially enclosed public place they can simply claim that they were smoking an e-cigarette and it is extremely difficult for enforcing authorities to prove otherwise, thereby compromising the enforcement of the ban.

A key issue here is that the ban on smoking in public places has been very successful and is almost entirely self-policing by the public. E-cigarettes pose a real threat to that self-policing.

E-cigarettes also undermine the ability of managers of premises to enforce smoke free places, leading to many businesses banning them. Our officers that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people "vaping". Some vapers argue "it's not against the law".

We believe that the use of e-cigarettes in public places can help "normalise" smoking, and can introduce others into the habit of smoking. See later.

There is uncertainty over the potential adverse health implications associated with e-cigarettes and despite recent studies suggesting some benefit to those quitting smoking the efficacy of e-cigarettes as an aid to smoking cessation is not entirely clear. It is therefore appropriate to take a precautionary approach to the risks associated with e-cigarettes. Currently people in Wales can breathe clean air in offices, shops, pubs and other public places and work environments. We don't want to see a backwards step towards potentially polluted air.

Further evidence in support of the above can be found in the 'State Health Officer's Report on E-Cigarettes' (January 2015) (California Department of Public Health).

http://www.cdph.ca.gov/programs/tobacco/Documents/Media/State%20Health-e-cig%20report.pdf

The executive summary says:

While there is still much to be learned about the ingredients and the long-term health impacts of e-cigarettes, this report provides Californians with information on e-cigarette use, public health concerns related to e-cigarettes, and steps that can be taken to address the growing use of these products. The following are key highlights from the report:

E-Cigarette Use

• In 2014, teen use of e-cigarettes surpassed the use of traditional cigarettes for the first time, with more than twice as many 8th and 10th graders reporting using e-cigarettes than traditional cigarettes. Among 12th graders, 17 percent reported currently using e-cigarettes vs. 14 percent using traditional cigarettes.
• In California, adults using e-cigarettes in the past 30 days doubled from 1.8 percent in 2012 to 3.5 percent in 2013. For younger adults (18 to 29 years old), e-cigarette use tripled in only one year from 2.3 percent to 7.6 percent.
• Young adults are three times more likely to use e-cigarettes than those 30 and older.
• Nearly 20 percent of young adult e-cigarette users in California have never smoked traditional cigarettes.

Health Effects of E-Cigarettes

• E-cigarettes contain nicotine, a highly addictive neurotoxin.
• Exposure to nicotine during adolescence can harm brain development and predispose youth to future tobacco use.

• E-cigarettes do not emit water vapor, but a concoction of chemicals toxic to human cells in the form of an aerosol. The chemicals in the aerosol travel through the circulatory system to the brain and all organs.
• Mainstream and second hand e-cigarette aerosol has been found to contain at least ten chemicals that are on California's Proposition 65 list of chemicals known to cause cancer, birth defects, or other reproductive harm.

Heightened Concern for Youth
• The variety of fruit and candy flavoured e-cigarettes entice small children who may accidently ingest them. Even a fraction of e-liquid may be lethal to a small child.

• E-cigarette cartridges often leak and are not equipped with child-resistant caps, creating a potential source of poisoning through ingestion and skin or eye contact.
• Calls to poison control centres in California and the rest of the U.S. have risen significantly for both adults and children accidently exposed to e-liquids.
• In California, the number of calls to the poison control centre involving e-cigarette exposures in children five and under tripled in one year.

Harm Reduction Claims and Myths
• There is no scientific evidence that e-cigarettes help smokers successfully quit traditional cigarettes.
• E-cigarette users are no more likely to quit than regular smokers, with one study finding 89 percent of e-cigarette users still using them one year later. Another study found that e-cigarette users are a third less likely to quit cigarettes.

Unrestricted Marketing
• In three years, the amount of money spent on advertising e-cigarettes increased more than 1,200 percent.
• E-cigarette advertisements (ads) are on television (TV) and radio where tobacco ads were banned more than 40 years ago. Most of the methods being used today by e-cigarette companies were used long ago by tobacco companies to market traditional cigarettes to kids.
• Many ads state that e-cigarettes are a way to get around smoking bans, which undermines smoke free social norms. Various tactics and claims are also used to imply that these products are safe.
• The fact that e-cigarettes contain nicotine, which is highly addictive, is not typically included in e-cigarette advertising.

In Conclusion
California has been a leader in tobacco use prevention and cessation for over 25 years, with one of the lowest youth smoking rates in the nation. The promotion and increasing use of e-cigarettes threaten California's progress. These data suggest that a new generation of young people will become addicted to nicotine, accidental poisonings of children will continue, and involuntary exposure to second-hand aerosol emissions will impact the public's health if e-cigarette marketing, sales and use continue without restriction. Additionally, without action, it is likely that California's more than two decades of progress to prevent and reduce traditional tobacco use will erode as e-cigarettes re-normalise smoking behaviour.

 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)?

We are of the opinion that smoking should be discouraged in all public places, in particular those locations where there are children or vulnerable people. These include:

- Playgrounds
- School grounds & their immediate vicinity
- Hospital & medical facility grounds
- Places promoted to children (e.g. “petting farms”, fairgrounds and family centred leisure parks).

There is a need for Fixed Penalty Notice powers which should be consistent with existing provisions. In drafting such provisions there is a need to consider that law currently places a responsibility on the person in control of premises to prevent smoking (e.g. hospital grounds) and that local authorities’ usual enforcement approach is against the “person in control of premises” for permitting smoking. (Under the Health Act 2006 “*It is the duty of any person who controls or is concerned in the management of smoke-free premises to cause a person smoking there to stop smoking*.”)

If current restrictions are extended, then it is essential that local authorities receive additional funding to support this work. Receipts from enforcement should be returned to local authorities to further support enforcement and education work in this area.

The additional work likely to arise as a result of an extension in the ban to include e-cigarettes and also to prohibit smoking and the use of e-cigarettes in other non-enclosed places is difficult to predict but may be significant.

We appreciate that the ‘smoking ban’ has, to date, been largely self-policing.

This will have been assisted by the fact that health risks associated with smoking and in turn the inhalation of second hand tobacco smoke are well known and understood. As a result smokers (and the public in general) will appreciate the purpose of the ban and support compliance expectations.

While there are reasoned arguments for extending the ban to include e-cigarettes and to cover certain non-enclosed places, it is foreseeable that smokers will be less understanding of, and compliant with respect to, restrictions on their use of e-cigarettes in the absence of ‘proven’ health concerns and where they feel that their use of such devices is key to them quitting smoking. Similarly, there is likely to be less public concern for the use of e-cigarettes, for the same reasons, and accordingly less social pressure on users not to use them in contravention of any ban.

This distinction may create some/significant resistance towards compliance, which would in turn necessitate a significant increase in resources to ‘police’, compared to the current smoking ban.

This should be taken into consideration in resourcing this work.

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

Yes.

Our key concerns are the potential for e-cigarettes to undermine the enforcement of smoke free legislation; intentionally or inadvertently promote or normalise smoking; and the potential impact upon smoke free environments.

We are concerned that there is a real potential for e-cigarettes to intentionally or inadvertently promote smoking amongst those who currently do not smoke. In particular we feel there is a need to make every effort to deter young people from becoming smokers.

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

Yes.

We take the view that anything that has the appearance of smoking helps "normalise" smoking and therefore promotes smoking behaviour and culture. We also question whether the term **"inadvertently"** is appropriate. For example, we are not aware that there is any technical reason why e cigarettes need to glow or emit a vapour.

We are also concerned by the nature of e-cigarette advertising; we note the reappearance of 1950's style marketing of tobacco products.

Workplaces have worked hard to implement the smoke free premises legislation and the use of e-cigarettes undermines this work.

We are concerned that e-cigarettes encourage young people to think that smoking is acceptable and therefore has the potential to act as a gateway to both e-cigarettes and tobacco based products.

Data relating to smoking behaviour in Wales leads us to conclude that we cannot afford to step back from promoting smoke free behaviour and the health and societal benefits associated with that approach.

 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?*

Yes we feel they are. We feel every effort must be made to prevent young people developing nicotine addiction or smoking behaviours.

Worryingly, e-cigarettes have been witnessed being displayed for sale with sweets, at child height, at the checkout in large stores.

Some e-cigarettes utilise scented or flavoured refills that may be attractive to younger users, which is a particular concern if combined with the highly addictive properties of nicotine. Some of these are branded in ways that may be particularly attractive to younger users, such as "Gummy Bear, Cherry cola and Bubble Gum".

Some products are being packaged and marketed in a way that is closely associated with that of conventional cigarettes. For example, we are not aware that there is any technical reason why e-cigarettes need to glow or emit a vapour. We are also concerned by the nature of e-cigarette advertising; e.g. consistent with the 1950's style marketing of tobacco products.

Many of these factors reinforce the association with conventional tobacco cigarettes and may normalise smoking related behaviour.

 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?

Yes. A number of licensed premises have independently introduced bans on the use of e-cigarettes within their premises in recognition of the difficulty they cause their staff in applying the smoking ban within their premises.

Our colleagues that visit business premises on a regular basis, often hear concerns from owners and managers about confrontation when dealing with people “vaping”. Some vapers argue “it’s not against the law”.

The proposed legislation in smoke-free places should apply equally to tobacco based products and all forms of e-cigarettes.

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

The power to issue Fixed Penalty Notices and other enforcement provisions need to be consistent with other smoking legislation, and the fines need to be set at such a level as to be a deterrent to (re)offending. Receipts from enforcement/Fixed Penalty Notices should be returned to local authorities to further support enforcement and education work in this area.

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

Yes. We support the proposal.

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

The introduction of a register will provide an additional control on the availability of tobacco; a register would contain detailed information on those people and premises from which tobacco can be sold legitimately. Furthermore it would restrict access to the trade to those people and premises where tobacco should not be sold. It will be easier for enforcement officers to identify those premises where tobacco is permitted to be sold, which will in turn assist with the enforcement of underage sales and the display ban.

The success of such a measure would be dependent on the legislation including provisions to control access to the register such as a “fit & proper persons” or “suitable persons” test. This is explored further in response to subsequent questions.

If a register is to be established it needs to cover all those that manufacture, distribute and sell tobacco products. We feel that having a register only for the end retailers is not comprehensive and will not cover other parts of the tobacco chain that feed the habit including those under age. An offence should be created where tobacco products can only be sold, distributed, etc to those registered.

We note that section 29(5) provides that 'A registered person who fails, without reasonable excuse, to comply with section 25 (duty to notify certain changes) commits an offence'. We are concerned by the use of the phrase 'reasonable excuse':

a) Firstly, as it is out of step with the more robust due diligence offence common to most current consumer protection legislation, i.e. the two limbed all reasonable precautions and all due diligence defence. There is concern that with section 29(5) as currently worded, individuals failing to notify changes to the register will be able to evade enforcement action. There will be no definition of what is reasonable and so these explanations would need to be tested in court with associated wasting of resources.

   Use of the well established two limbed due diligence system would enable enforcement officers to assess the adequacy of an individual's defence based on tried and tested case law, well before a case has to enter the court system

b) Secondly, the very use of the word 'excuse' in section 29(5) sends out quite the wrong message to the trade, and there is a danger that the current wording will encourage individuals simply to 'come up with an excuse' in the expectation that this will be acceptable.

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

Yes. The proposed link to restricted sales orders (RSOs) and restricted premises orders (RPOs) under the Children & Young Persons Act are welcome. However, we see it as essential that the range of offences triggering an RPO is extended to include all tobacco related breaches, for example the supply of illegal (counterfeit and non-duty paid) tobacco, tobacco labelling offences, non-compliance with the tobacco display ban; and not just underage sales. It is hoped that these matters will be addressed through the proposed power for Welsh Ministers to make regulations under section 12D of the Children and Young Persons Act and the range of offences triggering an RPO extended accordingly.

However, our experience of "Registers" introduced under other legal provisions suggest that their efficacy can be limited if they are not also accompanied by robust enforcement powers. Some registers are merely administrative or informative.

Local authority enforcement officers will need effective powers to ensure that the register has the desired effect. These need to include the power to restrict access to the register and to remove persons from the register where there has been a relevant infringement of the law, including offences concerning underage sales. We feel that there should be a provision to consider suitability of a retailer - whether the retailer is a "fit & proper" person. For example, whether a retailer been convicted for the sale of alcohol, solvents or other age restricted products to minors. The section 24 provision that an application to register will not be granted if an RPO or RSO is already in place goes some way towards this, but of course does not take account of the selling to minors of other age restricted products.

We welcome the section 23(2)(g) clarification that in addition to sellers of tobacco and nicotine products with a High Street presence, those supplying via online, telephone and mail order channels will be required to indicate this on the register. However, it is unclear from the wording of section 22(1) whether the requirement to register applies only to those based in Wales rather than those outside Wales supplying to customers in Wales, i.e. 'The registration authority must maintain a register of persons carrying on a tobacco or nicotine business at premises in Wales'.

We are disappointed with the section 23(3) definition of a “tobacco or nicotine business” as being a business involving the sale by retail of tobacco or cigarette papers or nicotine products. Limiting the scope of the register to retail would be a lost opportunity to regulate throughout the supply chain. The illicit supply and sale of tobacco has been identified as a growing concern by Trading Standards in Wales. A register must not inadvertently add to the problem of illicit trade in cigarettes. The penalties of failing to register therefore need to be robust. We emphasise that the definitions of “business” need to be carefully considered to encompass not only legitimate traders but also those persons who are trading illegally in tobacco from domestic premises. We feel it should also include online suppliers. Effectively the provisions must apply to anyone who is *selling* tobacco products in Wales.

We support the need for robust and proportionate penalties for offences and proposed powers of entry (to retail premises) or the ability to seek a warrant (for domestic premises). These are obviously vital. We also support the need for powers to seize tobacco goods in all relevant premises including those that are not registered.

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

We support the proposals which would bring tobacco products into line with alcohol sales.

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

Yes.

Smoking remains the single greatest avoidable cause of death in Wales **(PHW, 2012)**. The introduction of the ban on smoking in enclosed public spaces in 2007 has been hugely successful in reducing exposure to environmental tobacco smoke and in strengthening public awareness and attitudes towards it. However, reducing the prevalence of smoking, remains a key health priority. Protecting young people from the effects of smoking and deterring young people from taking up the habit are particularly important. Therefore we welcome the proposals and additional powers to help control the availability of tobacco and its potential health impact.

Part 3: Special Procedures Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales, these procedures are acupuncture, body piercing, electrolysis and tattooing.

 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?

We agree that there is a need for a licensing regime that requires approval; the current system is outdated, inadequate and fails on many levels e.g. automatic registration, no competency criteria for the operator, no hygiene standards relating to the premises, difficulty in dealing with unregistered operators etc. We believe that the current legislation does not

adequately protect the public. Environmental Health Officers are relying on legislation that is not made specifically for the purpose of tackling illegal operators.

The legislation will cover the whole of Wales and will create continuity throughout Wales that will also be of benefit to the industry.

We support the proposals to regulate for special procedures including the creation of a direct offence of failing to register, a full set of enforcement powers including powers of entry, seizure, prohibition, etc to enable the effective regulation of illegal operators.

We have the following concerns regarding existing provisions:

- There is no requirement for a practitioner to have training or experience to set up a tattoo studio. However the need to understand the importance and practical application of hygienic practices and infection control procedures is essential to protect the public. The public need some assurance that a practitioner is competent to perform what they are doing without putting them at risk.
- Currently, an unregistered tattooist applying unsafe practices in unhygienic premises only commits the offence of being unregistered under the byelaws. This may be viewed as a purely administrative offence when Courts are considering sentencing.
- Current registration requirements rely on being able to prove that a person is carrying on a business and this can be difficult because most unregistered tattooists ('scratchers') work from home and deny that they receive payment.
- There is no facility to refuse registration unless a previous successful prosecution has been taken for breach of bye laws,
- Current regulation relies in part on the use of legislation not specifically intended for such use e.g. The Public Health (Control of Diseases) Act 1984 and The Health and Safety at Work etc. Act 1974. Several local authorities in Wales have used Part 2A Orders to seize equipment from unregistered and unhygienic premises, however these provisions do not always provide the appropriate enforcement tools to safeguard the public and to tackle "scratchers".
- When evidence was last gathered on this by WHOEHG, they found that between July 2012 and July 2013, ten applications for Part 2A Orders had been made by local authorities; all of which related to the carrying out of unregistered tattooing from domestic premises.
- New procedures are being developed and becoming increasingly popular such as body modification, dermal implants, branding, tongue splitting and scarification all of which have potential to spread infection or cause permanent damage.
- Existing legislation does not prevent the sales of relatively cheap tattooing equipment over the internet. Anyone can purchase a kit and start operating, possessing no basic training, no knowledge of infection control and not using an autoclave or equivalent sterilisation procedure.

We agree with the concerns of the Chartered Institute of Environmental Health (CIEH) that many procedures are being done by people with little if any knowledge of anatomy, infection control or healing processes (CIEH, 2014).

We would offer the following observations on the proposed regulations:

- Level 3 fine (£1,000) is too low to act as a meaningful deterrent. The sunbed legislation, which is similar in nature, includes a fine of up to (£20,000); this would be a more appropriate sum. Given the amounts of money that many operators can make, such an amount may not discourage the unlicensed or irresponsible operators.

- In determining whether to grant a licence a local authority should be able to consider whether the applicant is a “fit and proper person” and such a test should be included (akin to the tried and tested procedures for taxi licensing). The test should permit the LA to take into account “any other information” (beyond the “relevant offences” listed in the draft bill) in determining that question. The current proposals do not offer sufficient safeguards.
- We would be opposed to grandfather rights for existing traders. Officers from another local authority have only recently dealt with a high profile public health incident in South Wales which related to a long-standing operator.

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

Yes. We support the proposals to include Acupuncture, Tattooing, Body piercing and Electrolysis. These share a theme of preventing blood borne viruses.

However, we strongly support the view that legislation should enable other body modification procedures to be addressed, some of which present significant risks. The aim must be to ensure that all procedures that involve piercing, body modification / enhancement or any invasive treatment or procedure where there is a risk of infection or injury are covered by some form of control or regulation. We are concerned about a growing range of procedures including Botox, dermal fillers, sculpting, microdermabrasion, dermal rolling and dermal implants. We also recognise that new and novel procedures are continually being developed and WG should ensure that the register and any associated enforcement powers will be applicable to the widest range of circumstances and developing trends.

However, we also acknowledge the need to take a considered and incremental approach to encompassing these matters over time. We therefore support framing the provisions in such a way that additional procedures might be added in the future in an efficient and timely manner.

We will be pleased to work with WG officials is relation to such matters.

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

We absolutely support that (see above) and also welcome the anticipated opportunity to be consulted upon and to work with WG officials in framing any proposals.

We feel that we need to get ahead of the game and be able to address the next body modification development to emerge. Other procedures are already becoming more popular e.g. scarification, tongue splitting, branding, dermal implants, microdermabrasion. All these procedures provide the potential for serious harm and infection. We feel it is absolutely essential that the provision to amend the list of special procedures reflects the need for amendments to be made expediently and without unnecessary delay. The list of special procedures will need to be dynamic to be able to incorporate new procedures as trends change. A lengthy amendment process will undoubtedly leave local authorities ‘on the back foot’, and having to rely on other legislation, for example, Health Protection Legislation ‘Part 2A Orders’ to tackle new and emerging procedures.

Whilst we feel there is a strong case that procedures such as tongue splitting, branding, dermal implants and scarification should be prohibited, we recognise that to do so may drive

activities underground and cause further issues or potentially make it more appealing to some people.

The special treatments industry is dynamic and novel procedures are introduced frequently. Any procedure involving penetration or cutting skin has the potential to release blood and body fluids and therefore there is a risk of blood borne virus transmission; all such procedures should be regulated.

We agree with the provision to add or remove a special procedure, however, we recognise that there is not always a clear line between special procedures and body modification treatments. Many extreme body modifications such as 'ear pointing/pixie ears', dermal implants, tongue splitting, scarification etc are essentially unregulated surgical procedures and we believe that such extreme procedures fall outside the expertise of the local authority.

 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?

We are content with these because these professions should have the necessary understanding of good hygiene and infection control. However, we support the proposed provision that individual professions could be required to have a licence in relation to certain procedures that their regulating body feels do not fall within the scope of their competence.

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

We feel that the proposed licensing system would enable local authorities to undertake public protection duties more effectively and more readily. The establishment of a licensing scheme enabling local authorities to recover their costs will ensure that finance is available to deliver.

The proposals would give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that chose not to.

There is a loophole in current legislation enforced by the Health Inspectorate Wales in respect of the use of lasers. Class 3b and 4 lasers (4 being what is used in a hospital setting) only have to be registered with the HIW if used in certain circumstances. Where this class of laser is used on a mobile or ad hoc basis there is no requirement to register therefore this highly dangerous equipment could be used unregulated. We will be facing an increase in the use of lasers when fashion dictates that tattoos are no longer "trendy" and the increase in poor artwork by illegal tattooists will see a demand in laser removal.

The enforcing of a licensing system will have financial implications for local authorities; firstly in terms of the administrative side that would be necessary to support such a system and secondly, regarding the staffing resources necessary to operate a licensing regime for what is an increasing and popular activity.

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

Yes.

See http://www.wales.nhs.uk/sitesplus/888/news/37472 (The recent Newport case)

Proposals contained in the Bill such as requiring a standard of competency will make a significant contribution to protecting health from risks associated with such procedures.

Evidence of public health risk in relation to such procedures is clear. We take the view that any procedure that involves the piercing of the skin poses a very real risk of infection and disease from blood borne viruses many of which can be a serious risk to health and that anyone undertaking such procedures should be competent to do so without putting a person at risk.

Current controls are outdated and inadequate. We need to be able to protect the public to better prevent people from undertaking these procedures if they are not competent or are not fit and proper person to be undertaking such practices. We need also to ensure that the conditions in which such practices take place are hygienic and will prevent infection risks.

We are seeing in our day to day work evidence of a growing range of procedures that put the public at risk. These include: dermal implants, beading, ashing, scarring, dermal fillers, tongue splitting, and a range of other procedures that we might loosely describe as “body modification”. We feel strongly that regulations should permit all such procedures to be controlled and that the regulations should allow the list of procedures to be extended to cover any form of body modification that may arise in the future.

The industry is a very dynamic one and over the past decade it has grown and diversified rapidly. Most towns and villages now have one or two businesses offering some sort of special treatment from the traditional tattoo studio offering tattooing and body piercing to beauty salons offering semi permanent make up and other invasive procedures. These businesses are capturing a very wide range and diverse clientele. As a result of the significant increase in these practices there has been a rise in complaints and infections from the procedures. Over the past few years there have been a number of media reports on individuals suffering infections after receiving a procedure. The very recent case in Newport, South Wales where 6 people were infected and around 800 people potentially affected after receiving a procedure from a local business demonstrates the extent just one business can have.

With the rise in popularity of special procedures there has also been a rise in the number of individuals that operate without registration (as required by the current scheme). This is not only an issue for enforcing bodies but is also of concern to the legitimate operators. Unregistered operators generally try to avoid contact with the local authority by operating from their domestic premises in secrecy thereby avoiding any form of intervention. This authority has had cause to deal with a number of these individuals and in every case we have dealt with, the operators have demonstrated extremely poor knowledge towards cleaning, disinfection and infection control. Therefore, these operators pose an increased risk of their clients developing serious infections such as including hepatitis A, B, and C and HIV, as well as less serious skin infections, which require medical intervention. Some blood borne viruses, for example hepatitis B, can be transmitted by very small volumes of blood; too small to be visible to the naked eye. Such diseases can be debilitating, have a major impact on the quality of life and, if not medically treated, can lead to death.

The proposal to require ‘standards of competence’ before an individual is eligible for a license is an area that we agree with. As mentioned, the risks associated with special procedures can have a major impact on public health. It is essential that operators have an

understanding of the risks associated with their procedures, the types of infections that can be transmitted and the possible effects. A competence requirement will demonstrate that operators have sufficient experience and knowledge in areas such as infection control.

Some procedures such as “ashing” might not fall within the regulations as proposed. Ashing may fall outside of the current definition of tattooing (which relies on the use of pigmentation) and care is needed that definitions do not inadvertently exclude procedures that are intended to be covered.

In relation to extending the list, we recognise from an enforcement perspective that we are familiar with the necessary controls and safeguards needed in relation to more traditional procedures. There is merit in a considered and stepped approach to extending the list of special procedures so that we are able to develop training, suitable competence assessments and necessary guidance in relation to the more novel procedures. We are also aware that consideration is needed in distinguishing between a legal service that we might appropriately control and what might be considered an illegal act of assault. We feel some clarity will be required in relation to that question.

Part 4: Intimate Piercing Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

 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?

Yes, we believe that an age restriction is required for intimate body piercing.

We share the view of the Chartered Institute of Environmental Health (CIEH) that 16 is not an appropriate age for an intimate piercing because:

- The decision to have an intimate body piercing should be made by a mature individual; we believe that 16 years of age is not sufficiently mature.
- Intimate body piercings require a higher standard of aftercare than tattoos, as they are potentially more susceptible to infection. This level of aftercare requires a mature approach to which a 16 year may not be capable of fully committing.
- Whilst the jewellery inserted into an intimate body piercing may be removed any scarring or damage inflected by the procedure will be permanent. This is particularly important when the skin, subject to the piercing is still growing and its function may be compromised by scarring or thickening. At 16 years an individual is still growing and therefore the risk of damage to skin is greater.

We note that there is considerable potential for confusion to arise if there is a different age restriction for body piercing and for tattooing. We consider that it would be easier for practitioners, enforcement agencies and individuals if the age restriction for both was to be the same.

We further consider that an age restriction of 16 years for intimate body piercing is likely to give rise to call for the age restriction for tattooing to be reduced to 16 years.

We believe that the age restriction for intimate piercing should be 18 years.

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

Yes. However we also feel there is a case to add the tongue. In addition to the relatively higher risks of infections associated with tongue piercing, we are aware that there are sexual

connotations with piercing of the tongue and for that reason consider there is a case to include in the list of intimate parts.

 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?

We support such proposals including the proposal to make it an offence "to enter into arrangements". This would support enforcement of the provisions including "test purchasing" by local authorities.

We recognise the need for police support in particular in relation to evidence gathering given the intimate nature of such offences and the provisions need to take account of that.

Any duties placed upon local authorities must be supported by adequate funding to enable them to be operated and enforced in an effective manner. A licensing system will have financial implications for local authorities; firstly in terms of the administrative side that would be necessary to support such a system and secondly, regarding the staffing resources necessary to operate a licensing regime for what is an increasing and popular activity.

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

Yes, see previous comments relating to special procedures. Additionally, it also contributes to the protection of vulnerable and impressionable children / young people.

Part 6: Provision of Toilets Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

 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?

We agree that the provision of, and access to, toilets for public use is important, particularly to older people and those with specific needs. However, this is not an area in which Environmental Health Departments generally have any enforcement responsibility and it seems none are proposed. We are thus not well placed to comment on the proposals.

We do however recognise all too clearly the current financial pressures on local authorities. We question whether placing a duty on local authorities to develop a strategy is appropriate, acknowledging firstly the difficult financial climate within which any duty would consume resource and secondly that a strategy will not of itself bring about enhanced provision. Care is needed that WG does not merely impose an administrative and financial burden that delivers no real benefit to the public.

Local authorities are being forced to make difficult choices around the prioritisation of services to their communities many of which have a significant impact on health & well-being. Any duty regarding the provision of public toilets may result in local authorities being forced to disinvest in other services that are of equal or greater priority.

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

See above.

 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?

The consultation requirements set in para 92 are too vague to be meaningful.

 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?

In our experience, such guidance leads to more consistent approaches.

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

 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?

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

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 are supportive of the measures set out in the Bill. However, we are naturally concerned by the capacity within local government to deliver additional responsibilities successfully at a time when service cuts and reductions in service standards are all too apparent. We have a great deal of expertise and experience and local authority Environmental Health Departments across Wales are keen to support these new powers and measures. However we ask WG to ensure that such work can be adequately resourced and in particular to consider:

- Undertaking regulatory risk and impact assessment to understand the consequences of the proposed legislation on enforcing authorities and on those subject to regulation,
- a detailed understanding and quantification of the costs of effective regulation and enforcement so that WG and local authorities can plan properly for implementation,

- Where possible provisions should allow for full cost recovery or in the absence of a cost recovery mechanism (typically fees & charges) additional resource must be made available to local authorities specifically for the purpose of this legislation,
- In drafting the legislation, WG should avoid unnecessary complexity or ambiguity, ensure that provisions are capable of being enforced in a practical and efficient way and that any potential defences are fully and properly understood.

 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?

Local authority costs summarised in Annex B of the Explanatory Memorandum (see http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf), appear to be underestimated.

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

 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?

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?

Other comments

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

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

Yes

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

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

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

Evidence from the Royal College of Psychiatrists – PHB 94 / Tystiolaeth gan Goleg Brenhinol y Seiciatryddion – PHB 94

RCPsych in Wales

Baltic House, Mount Stuart Square, Cardiff, CF10 5FH

Tel: [redacted] **Fax:** [redacted]

Email: [redacted]

Health and Social Care Committee
National Assembly for Wales
Pierhead Buildings
Cardiff Bay
4 September 2015

Dear Chair

Response from the Royal College of Psychiatrists in Wales to the Public Health (Wales) Bill: Call for feedback on the general principles of the Bill

Thank you for giving us the opportunity to respond to the Committee's consultation on the Public Health (Wales) Bill.

The Royal College of Psychiatrists in Wales supports the need for a Public Health Bill for Wales. We responded favourably to the Green Paper in 2013 and the White Paper in 2014. We now look forward to the debates during the legislative process and we plan to contribute at all stages.

The general health of the population of Wales is poor compared with other parts of the UK.

- The levels of obesity in adults and in children are comparatively high and continue to rise (58%[1] and 35%[2]).
- Alcohol contributes to 20 deaths per 100,000 per year[3] and can result in over 60 different medical conditions including depression[4].
- Smoking levels have fallen but remain at 20% of the adult population[5].
- The pregnancy rate of teenagers is 25 per 1000, which has decreased but is still amongst the highest in Europe (after Bulgaria, Romania and Slovakia)[6].
- There are many areas of deprivation in Wales. Rates of unhealthy lifestyles are considerably higher in deprived areas than in affluent areas.

The NHS in Wales is struggling to meet the needs of those with physical and mental health problems caused by poverty and unhealthy lifestyles and we feel that the Bill will go someway in tackling this. Although the Bill lacks a public mental health perspective, the provisions in the Bill will impact positively on mental health and well being, for example regulating tobacco may achieve more in improving health and reducing mortality in people with serious mental illness than other sections of the population.

We are concerned that the Bill's principles assume that making healthy lifestyle choices is understood and can be embraced by all. It is well evidenced that poor mental health is associated with poor lifestyle. People with poor mental health have higher rates of obesity, substance and alcohol misuse and are more likely to smoke compared with the general population. They are also more likely to suffer from inequalities in employment, living standards, education and health provision.

This link between poor mental health and lifestyle must be supported and reinforced in the Bill. We suggest that the Bill include the following:

- Principles that promote a positive approach to public health rather than exclusively negative actions and restrictions.

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[1] Welsh Government (2014), Welsh Health Survey, Lifestyles. https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Welsh-Health-Survey/lifestyles-by-gender-year

[2] http://www.assembly.wales/Research%20Documents/Childhood%20Obesity%20-%20Quick%20guide-02072013-229581/qg12-0004-English.pdf

[3] ONS (2015) *Alcohol-related deaths in the United Kingdom, Registered in 2013*. P. 11

[4] https://www.alcoholconcern.org.uk/help-and-advice/statistics-on-alcohol/

[5] http://gov.wales/docs/statistics/2015/150603-welsh-health-survey-2014-health-related-lifestyle-en.pdf p.4

[6] ONS (October 2014) International comparisons of teenage births 2012. http://www.ons.gov.uk/ons/rel/vsob1/births-by-area-of-usual-residence-of-mother--england-and-wales/2012/sty-international-comparisons-of-teenage-pregnancy.html

- The statutory duty of public bodies to carry out Health Impact Assessments when developing policy. This proposal was set out in the Green Paper and was favoured by most stakeholders and respondents. We would urge that this is included in the Bill and that assessments include the impact on mental health and wellbeing as well as the physical health of the population. The focus must be on health inequalities and those in deprived communities who are more likely to suffer poor mental and physical health.
- A provision in the Bill to regulate nutritional standards in public settings such as schools and hospitals. This proposal was featured in the White Paper and was endorsed by respondents. Hospitals and schools are institutions that promote health and wellbeing and nutritional standards relay a clear message of healthy living and good diet.
- Widening the smoking ban to secure units, hospital grounds and public play areas. This promotes health and wellbeing in environments where health and activity are promoted and supported. Smoking in secure units and on hospitals grounds is inappropriate and sends the wrong message that the NHS facilitates this behaviour. We would welcome legislation in this area provided there are effective smoking cessation services available to patients and proper training for staff.

Yours sincerely,



Professor Rob Poole
Chair, Royal College of Psychiatrists in Wales

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol
Public Health (Wales) Bill / Bil Iechyd y Cyhoedd (Cymru)
Evidence from the Professional Standards Authority - PHB 95 / Tystiolaeth gan Yr Awdurdod Safonau Proffesiynol - PHB 95

BY E-MAIL: seneddhealth@assembly.wales

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

4 September 2015

Consultation on the Public Health (Wales) Bill

The Professional Standards Authority for the Health and Social Care welcomes the opportunity to contribute to the consultation on the Public Health (Wales) Bill.

About the Professional Standards Authority

As you may know the Authority promotes the health, safety and wellbeing of patients, service users and the public by raising standards in regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

As part of our work we:

- Oversee nine health and care professional regulators and report annually to Parliament on their performance
- Conducts audits and investigations and can appeal fitness to practise cases to the courts if sanctions are unduly lenient and it is in the public interest
- Conduct research and advise the four UK governments on improvements in regulation
- Promote our concept of right-touch regulation and publish papers on regulatory policy and practice
- Accredit voluntary health and care occupational registers to improve consumer protection and raise standards

More information about our work and the approach we take is available at www.professionalstandards.org.uk

Our response to the consultation

The consultation proposes the creation of a 'mandatory licensing scheme for practitioners carrying out 'special procedures', namely acupuncture, body piercing, electrolysis and tattooing'.

As we have mentioned above, the Authority operates a programme to accredit voluntary health and care occupational registers to improve consumer protection and raise standards. This programme was established by the *Health and Social Care Act (2012)* to provide assurance about those health professions not regulated by statute. An up to date list of currently accredited registers is provided on our website: https://www.professionalstandards.org.uk/accredited-registers/find-a-register

As you will see, a number of registers already include acupuncturists, including those managed by the British Acupuncture Council, the Complementary and Natural Healthcare Council and the Federation of Holistic Therapists. Our concern about the proposal to create a register for the occupation in Wales therefore is that it would duplicate what already exists. Our accreditation programme requires that registers set standards of practice for an occupation and issue guidance, set standards of education and quality assure courses, check practitioners' competence and behaviour before registering them, encourage practitioners to continue to develop their skills, respond to complaints about practitioners and exclude them from the register as necessary to protect the public.

Our recommendation would be that rather than establish a further register in Wales for acupuncturists, instead the profile of our programme could be raised and the assurance we provide in relation to accredited registers taken into account, encouraging the public to use those practitioners who are listed on an accredited register.

Further, general information about the programme is available on our website: http://www.professionalstandards.org.uk/accredited-registers

We would be pleased to discuss this response further with you. Please feel free to contact me at [redacted]

Yours sincerely

Douglas Bilton
Assistant Director of Standards and Policy

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 Tenovus Cancer Care - PHB 96 / Tystiolaeth gan Gofal Canser Tenovus - PHB 96

4 September 2015

Dear Chair,

Tenovus Cancer Care evidence on the general principles of the Public Health (Wales) Bill

1. Introduction

1.1. As Wales' leading cancer charity, Tenovus Cancer Care welcomes the opportunity to respond to the Health and Social Care Committee's consultation on the general principles of the Public Health (Wales) Bill. Tenovus Cancer Care is at the forefront of cancer support; helping those affected by cancer, whether it is through our Mobile Support Units, our Freephone Support Line or through funding the latest cancer research in Wales.

1.2. As a co-signatory of the evidence submitted by a group of public health organisations and experts, we fully support those joint recommendations put forward. In the interest of brevity for the committee, we will not go into the same detail on those issues in this submission.

2. Executive Summary

2.1. Tenovus Cancer Care has closely examined the development of evidence around electronic cigarettes over the past two years. Whilst we understand the concerns highlighted around re-normalisation and the introduction of younger generations to nicotine addiction, in our view the evidence in support of the restrictions in enclosed spaces is so far not enough to justify legislation at this time.

2.2. The introduction of a Tobacco Retailers Register is an important lever against underage sales and illegal tobacco. We fully support the aims of the Bill in this area and believe that this is a substantially positive step in the right direction for tobacco control.

2.3. Pharmacies already play an essential role in our communities. Often the first point of contact for minor ailments and a key advisor in whether a person should visit their GP. The provision within the Bill for Health Boards to prepare and publish 'pharmaceutical needs assessments' for their area will be a major lever for improving the services available in communities across Wales. We are wholly supportive of this next step and believe it has the potential to significantly enhance the consistency of smoking cessation services across Wales.

2.4. The inclusion within the Bill around the provision of public toilets is another very positive move. Tenovus Cancer Care recognises the importance this will have for people affected by cancer, in particular those who may have continence related issues following a colorectal or urological cancer.

2.5. We believe that public health in Wales would be substantially improved by introducing levers in the following areas:

2.5.1. Risk warnings placed on the windows of businesses offering harmful UV tanning.

2.5.2. Health Impact Assessments to be used in major decision making.
2.5.3. The introduction of nutritional standards in public sector settings.
2.5.4. Single aisle sales of alcohol in supermarkets.

3. Tobacco and Nicotine Products

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

3.1. Tenovus Cancer Care recognises the concerns highlighted around the re-normalisation of smoking and introducing new generations of children to nicotine addiction. However, on the evidence available, we have not come to the same conclusion that electronic cigarettes should be brought into line with smoking in public places at present.

3.2. Nearly 1,894[i] people in Wales die from lung cancer annually. 8 in 10[ii] of those deaths will be due to lung cancer caused by smoking. Tobacco related deaths continue to be one of the most easily preventable, despite this 21%[iii] of the Welsh population still continue to smoke.

3.3. The comprehensive evidence review[iv] presented by Public Health England into Electronic Cigarettes shows that use of electronic cigarettes are substantially safer than smoking, and more people are using them as an aid to move away from smoking, rather than for non-smokers to experiment.

3.4. Tenovus Cancer Care's 'Quit with Us' campaign engages with a cross section of smokers from Wales. We are finding that using e-cigarettes as part of a suite of measures such as pharmacy support to aid a quit attempt are often successful. In our latest survey two in three people found using electronic cigarettes and help from pharmacies were the most effective way to make a quit attempt.

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

3.5. We agree with the proposal to create a tobacco retailers' register for Wales and believe that it will play a key role in lowering the number of young people who become smokers. The introduction of a national register will help to hold retailors to account and it will become more straightforward to monitor trends.

3.6. In registering retailers of tobacco local authorities will be able to more easily carry out test purchasing and compliance checks, in turn lowering instances of unscrupulous retailers from selling tobacco products to underage customers and also tackling counterfeit cigarettes from the black market.

3.7. We believe that a register as set out in the proposals would be both a practicable and proportionate response.

4. Pharmaceutical Services

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

4.1. We welcome the proposals contained the Bill which aim to improve the availability of pharmaceutical services across local health boards, and enhance the powers available to local health board to set out which services they need.

4.2. Developing effective smoking cessation services across Wales through community pharmacies will be a critical next step in helping people move away from cigarettes. Level 3 Smoking Cessation services are a critical part in the suite of measures to help a person quit. Intensive one-to-one behavioural support typically involves an initial assessment of the client's needs followed by a six-week behavioural support programme, covering the period immediately prior to the quit attempt and the initial weeks following it.

4.3. Through a combination of one-to-one behavioural support and access to pharmacological therapies, successful quit attempts are often made through this method[v]. It is notable that in Wales this gold standard service is only offered to smokers in around 30%[vi] of community pharmacies (Of around 700 community pharmacies in Wales, around 200 offer Level 3 smoking cessation services).

4.4. The provision within the Bill for Health Boards to undertake a 'pharmaceutical needs assessment' and to request provisions from pharmacies will play a key role in developing community services across Wales. As highlighted, the current inconsistencies across services such as smoking cessation could be tackled effectively with more strategic control from Health Boards.

5. Provision of Toilets

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?

5.1. The work by Welsh Government to make public toilets more readily accessible is an achievable first step that will make a difference to the lives of people affected by cancer who may have a stoma bag; or deal with some form of urinary or bowel incontinence.

5.2. Local authority toilet strategies need to be undertaken with key stakeholders and the public, along with ensuring that there are clear actions for improving access across the authority. As public toilets are not classed as a statutory provision for local authorities, they are at risk of being given restricted hours of opening or even closed. Welsh Government should ensure that local authorities do everything within their power to recognise the importance of easily accessible toilets for people with certain medical conditions.

5.3. The Royal College of Art[vii] published a map of every available public toilet within the United Kingdom. The work mapped over 8,000 toilets and is a simple resource for people to use to plan journeys. It also highlighted the range of availability for public toilets across the United Kingdom, with some local authorities not making any provision.

5.4. The Health and Social Care Committee would be well placed to examine the work undertaken by the office of the Mayor of London and the Open London scheme[viii], where toilet facilities in Marks & Spencer, Tesco, John Lewis, Sainsburys and Asda are available to use without the need to buy anything as part of the scheme.

6. Other comments

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

6.1. Tenovus Cancer Care is particularly concerned with how future Welsh Governments and the NHS in Wales will manage continued increases in demand due to preventable diseases. We recognise that controls on food labelling, marketing and restrictions on the sale of goods are not within the competence of the National Assembly for Wales and also that many of the levers required to improve public health do not require legislation. However, we believe that policymakers in Wales should be taking every reasonable step within their powers to improve public health. We have been openly challenging of the Public Health (Wales) Bill because we strongly believe it should go further in protecting and enhancing the health of our nation.

6.2. We believe that a minimum age of sale set at 18 is appropriate and we further recognise that the approach to marketing of many e-cigarette brands has been overtly aimed at introducing younger people to nicotine addiction. We will vigorously support both the UK and Welsh Governments efforts to control the marketing of e-cigarettes.

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

6.3. As we have highlighted in our joint submission, we believe that the Welsh public would benefit from the introduction of the following health improvement levers:

- *Health Impact Assessments*
- *Alcohol Display Controls*
- *Minimum Nutritional Standards*

Warning Labels on Tanning Beds

6.4. Skin cancer has seen substantial increases in incidence over a short period of time. Malignant melanoma is the fifth most common cancer in Wales with 609[ix] people being diagnosed in 2013 with around 120 people dying from it each year.

6.5. Skin cancer is highly preventable and caused often by poor knowledge of sun safe behaviour and the risks associated with tanning beds. People who use solariums before the age of 35 increase their risk of developing melanoma by 60%[x].

6.6. In Canada[xi] there has now been positive steps taken to publish health warnings clearly on tanning beds. Tenovus Cancer Care would welcome greater information about the risks associated with the use of tanning beds and for this to be published clearly for users. Whilst labelling isn't removing the fundamental problem of tanning beds being easily accessible, this measure to improve public information, would allow for an informed choice to be made about the harms that an individual would be exposed to.

6.7. Australian states and territories have gone even further in a commitment to eradicating skin cancer, making it illegal for any business or individual to offer UV

tanning services for a fee. In Australia total bans of sunbeds have come into in force across New South Wales, South Australia, Victoria, Western Australia, Tasmania, ACT, Queensland and the Northern Territories.

6.8. We would welcome the Health and Social Care Committee to dedicate some time in the course of their deliberations of the Public Health (Wales) Bill to consider the application of health messages either on sunbeds or in the windows of businesses that operate sunbeds.

Should you require any further evidence or information about our contributions to the Stage 1 evidence on the Public Health (Wales) Bill, please do not hesitate to get in touch with our Policy Officer, Jon Antoniazzi.

Yours sincerely,



Dr Ian Lewis
Director of Research & Policy

CC:

Minister for Health and Social Services

Deputy Minister for Health

Chief Medical Officer

Further Queries

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Available to give oral evidence	Yes

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Tobacco Manufacturers' Association

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

04 September 2015

1. Introduction

The Tobacco Manufacturers' Association (TMA) represents the views of its member companies when communicating with the UK Government, regional and local authorities and other stakeholders on tobacco-related issues, such as the illicit trade in tobacco products, youth access prevention and taxation. The TMA's members are British American Tobacco UK Ltd, Imperial Tobacco Ltd and Gallaher Ltd (a member of the Japan Tobacco Group of companies).

2. Scope of Response

In this document the TMA will set out its views on three areas related to the tobacco and nicotine products sub-section of the *Public Health (Wales) Bill*: the proposed national register of retailers of tobacco and nicotine products; the suggested additions to Restricted Premises Orders (RPO); and the planned prohibition of the handing over of tobacco and/or nicotine products to under-18s. The TMA will defer to member companies for comment on nicotine inhaling devices, such as e-cigarettes. The proposals relating to these products will not, therefore, form a part of this response.

3. Background

The intended effect of the tobacco-related provisions in the *Public Health (Wales) Bill* is to protect children and young people under the age of 18. The TMA and its member companies actively support this objective. The tobacco industry continues to support youth access prevention schemes, which operate independently and do not require legislation to enforce.

The TMA's member companies also conduct test purchasing exercises in selected areas across the country that assess shopkeepers' compliance with youth access prevention legislation. Where legislation to limit children's access to tobacco products has been

proposed – proxy purchasing regulation, for example – tobacco manufacturers have supported its implementation.

Moreover, the TMA conducts research into attitudes and behaviour in relation to tobacco. Earlier this year, the TMA commissioned a survey of more than 12,000 UK smokers.[1] This survey was designed in conjunction with HMRC, among other stakeholders, and followed a similar poll that was conducted in 2014. Principally, it focused on the illicit tobacco trade, but respondents were asked a number of questions on a wide range of subjects related to illicit tobacco. One such area was under age sales. The results of these questions are presented below.

- In the TMA's 2014 survey, 16% of smokers were aware of under-18s buying or selling illicit tobacco locally in Wales. This corresponded with the UK average, which was also 16%.

- In the TMA's 2015 survey, 13% of smokers were aware of under-18s buying or selling illicit tobacco locally in Wales. This was slightly higher than the UK average, which was 12%.

Illicit tobacco venders do not respect age restrictions on tobacco products. The TMA and its member companies support efforts to tackle the illicit tobacco trade through intelligence sharing, communications campaigns and dedicated on the ground resources. The TMA will continue to work with all relevant stakeholders in order to reduce the size of the illegal tobacco market in the UK and help to enforce youth access prevention measures.

4. Tobacco Retailers' Register

The TMA is not opposed to the establishment of a tobacco retailers' register in Wales. However, the TMA would like to emphasise that any register must be designed in a way that minimises the burdens on businesses, particularly retailers. This approach is supported by the Federation of Small Businesses (FSB). The FSB argues that in regard to "a registration regime, the cost of any such regime is of vital importance."[2] Its assessment of the Welsh Government's proposed tobacco registration scheme is worth quoting at length.

> *FSB Wales surveys show that regulation can be a significant burden for small firms, with 61 per cent of firms saying regulation costs more than £1,000 per year with a further 10 per cent saying it costs £10,000 per year or more. The proposals in the White Paper suggest that there would be a £30 fee plus £10 per additional premise registered. The consultation document states that the Scottish register of tobacco retailers does not require a fee for registrations…FSB Wales believes it would be more appropriate to follow the Scottish model. This*

[1] TMA Smoker Survey 2015

[2] http://www.fsb.org.uk/policy/rpu/wales/images/final%20public%20health%20white%20paper.pdf

would enable Trading Standards to target their resources in terms of inspection and enforcement without adding costs to the retailers concerned.[3]

FSB Wales also stated that it "believes any information requests required by such a scheme should be kept to a minimum."[4] The Welsh Government's own assessment of the costs retailers are likely to incur as a result of the introduction of a registration scheme found that the overall cost to retailers in Wales in 2017/18 could be as high as £246,000.[5] This is clearly excessive and the TMA encourages the Welsh Government to remove from the legislation provisions for the inclusion of a fee payable by retailers in order to register.

Should the fee paying approach be retained, Welsh retailers will be placed at a significant disadvantage compared to their English, Scottish and Northern Irish counterparts. In the first instance, no registration scheme exists for English retailers; in the second and third instances, the registration schemes established in Scotland and Northern Ireland do not levy fee payments from retailers.

5. Adding Offences to Restricted Premises Orders (RPOs)

The consultation document states that the addition of new offences that would result in a local authority applying a RPO "would be intended to create a more effective negative licensing scheme for Wales, which would reinforce the importance of retailers complying with relevant legislation."[6] The TMA does not oppose a negative licensing approach to the regulation of tobacco retailers.

However, it will be possible to comment on the specific offences the Welsh Government proposes to include under this provision only once further details have been published.

6. Handing Over of Tobacco Products to Under-18s

In principle, the TMA is not opposed to the prohibition of the handing over of tobacco products to under-18s. However, given that the products in question are likely to have been purchased online, the TMA is concerned that this provision will be difficult to enforce and could needlessly criminalise those men and women charged with providing postal services. What is also clear is that there is a lack of evidence surrounding the scale of this activity, any problems associated with it and the likely impact of the measure proposed by the Welsh Government.

Given these significant issues, the TMA encourages the Welsh Government to reconsider this proposal – specifically, whether it will be workable in practice.

7. Conclusion

[3] http://www.fsb.org.uk/policy/rpu/wales/images/final%20public%20health%20white%20paper.pdf
[4] http://www.fsb.org.uk/policy/rpu/wales/images/final%20public%20health%20white%20paper.pdf
[5] http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf
[6] http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

The TMA and its member companies are committed to ensuring that tobacco products are consumed only by those members of the public who are over the age of 18 and that the tobacco products consumed are legal. The TMA does not oppose a registration scheme in principle, but it does oppose one that will significantly increase costs for retailers. Similarly, the TMA does not oppose other measures that will encourage youth access prevention, but it believes such proposals must be proportionate and evidence-based, not to mention workable.

DRAFT

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

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

Evidence from the Tobacco Retailers' Alliance – PHB 98 / Tystiolaeth gan Y Gynghrair Manwerthwyr Tybaco – PHB 98

Tobacco Retailers' Alliance

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

04 September 2015

1. Who Are We?

The Tobacco Retailers' Alliance (TRA) represents legitimate retailers who sell tobacco products in a legal and responsible way. It is an organisation that works to raise awareness about tobacco-related issues that affect smaller shops and convenience stores – of which there are more than 50,000 in the UK. The TRA helps to drive up standards in the retail sector by providing its members with guidance on legal compliance in regard to illicit trade, under age sales and other areas of tobacco legislation.

The TRA is funded by the Tobacco Manufacturers' Association (TMA) through its member companies – British American Tobacco, Imperial Tobacco Limited and Gallaher (a member of the Japan Tobacco Group of Companies). The TMA supports the TRA so that it can offer free membership to any independent retailer who sells tobacco legally and wishes to join the Alliance.

2. Scope of Response

The TRA comments only on legislative proposals which are likely or certain to have an impact on shopkeepers. The tobacco and nicotine products sub-section of the *Public Health (Wales) Bill* encompasses two proposals that will affect retailers: the planned national register of retailers of tobacco and nicotine products and the suggested additions to Restricted Premises Orders (RPOs).

3. Background

The tobacco-related provisions in the *Public Health (Wales) Bill* aim to protect children and young people under the age of 18. The TRA works with the TMA and other interested stakeholders in order to provide its members with information and advice on how to comply

with existing youth access prevention legislation. The TRA also offers training to its members in this area in an effort to spread best practice throughout the network of affiliated stores. These services are offered free of charge. They form an integral part of the TRA's offer to its members. In this sense, the TRA supports the objectives of the Welsh and wider UK Governments.

The TRA also campaigns against the illicit tobacco trade in the UK. In Wales alone, illicit tobacco consumption cost retailers more than £316 million in lost sales in 2014, which amounted to approximately £43,000 per small shop.[1] It is clear that those who sell illegal tobacco do not adhere to youth access prevention legislation and that tackling this issue must form a key plank in any attempt to protect children.

4. Tobacco Retailers' Register

The TRA are not opposed to a tobacco retailers' register in Wales if it helps improve the level of compliance, specifically in relation to preventing sales to children. But, TRA members are concerned that the current proposals will result in significant additional costs for retailers. Retailers have been subjected to a range of anti-tobacco legislation over the past five years, which has increased overheads at a challenging time for high street stores. Moreover, in the Summer Budget, the Government announced that it would introduce a National Living Wage, which will increase employment costs for retailers considerably over the course of the present Parliament.[2] Indeed, the Centre for Retail Research estimates that by 2020:

> *The introduction of the so-called 'living wage' will cost retailers £3.26 bn per year in extra pay, national insurance and pensions. It will increase inflation by 1.1% per year to 2020, cut jobs and hours in the sector by 42,000 FTE and lead to a further 6,274 stores closing in the period 2016-2020.*[3]

In this context, the introduction of a fee paying retailer registration scheme – as the Welsh Government proposes – that will introduce new costs to retailers in Wales in 2017/18 of up to £246,000 is irresponsible and is likely to damage the Welsh retail sector.[4] The TRA urges the Welsh Government to reconsider the charges associated with the proposed register in light of the other pressures on shopkeepers' balance sheets.

5. Adding Offences to Restricted Premises Orders (RPOs)

The TRA is not opposed to the addition of new offences that would result in a local authority applying a RPO, especially as this is perceived as a means of enforcing a "negative licensing

[1] TRA Regional Non-UK Duty Paid Loss Estimates.
[2] Summer Budget 2015
[3] http://www.retailresearch.org/livingwage.php
[4] http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

scheme for Wales".[5] The TRA favours a negative licensing approach to tobacco retailers, rather than a formal alternative. The TRA considers this to be the most cost effective approach to ensuring that retailers comply with legislation.

6. Conclusion

The TRA wants to work with all relevant stakeholders in Wales and beyond to ensure that tobacco products are sold, purchased and consumed only by those legally allowed to do so. It also wants to work with partners to ensure that such tobacco products are legal. The TRA does not oppose a registration scheme, so long as it is designed in a way that will not place greater cost burdens on retailers. Nor does the TRA oppose other measures that are intended to encourage youth access prevention, so long as such proposals are grounded on evidence and, crucially, practicality.

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[5] http://www.assembly.wales/laid%20documents/pri-ld10224-em/pri-ld10224-em-e.pdf

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 Crohn's & Colitis UK – PHB 99 / Tystiolaeth gan Gymdeithas y DU ar gyfer Clefyd Crohn a Cholitis – PHB 99

Crohn's and Colitis UK
Consultation Submission to Health and Social Care Committee

Public Health (Wales) Bill

Inflammatory Bowel Disease

At least 300,000 people or 1 in 210 people in the UK have Crohn's Disease or Ulcerative Colitis, collectively known as Inflammatory Bowel Disease (IBD). It is estimated that over 15,000 people are living with this chronic disease in Wales. IBD is a lifelong condition that most commonly first presents in the teens and early twenties (mean age of diagnosis is 29.5 years).

In IBD the intestines become swollen, ulcerated and inflamed. Symptoms include acute abdominal pain, weight loss, diarrhoea (sometimes with blood and mucus), tenesmus (constant urge to have a bowel movement), and severe fatigue. Symptoms vary in severity from person to person and from time to time and relapses often occur suddenly and unpredictably throughout a person's lifetime. Between 50% and 70% of patients with Crohn's Disease will undergo surgery within five years of diagnosis. In Ulcerative Colitis, lifetime surgery rates are approximately 20-30%.

Crohn's and Colitis UK

Crohn's and Colitis UK is a national charity leading the battle against Crohn's Disease and Ulcerative Colitis. We provide high quality information and services, support life-changing research and campaign to raise awareness and improve care and support for anyone affected by Inflammatory Bowel Disease (IBD).

Established in 1979, the charity's services include four helplines, a wide range of accredited information sheets and booklets and a nationwide network of locally-based volunteer groups. The charity raises awareness of these little known and understood conditions, campaigns for improved services and care for people with IBD, funds vital research and seeks to influence policy to ensure that it reflects and meets the needs of people living with IBD.

IBD and access to toilets

For those with Inflammatory Bowel Disease (IBD), debilitating symptoms like diarrhoea and tenesmus can occur instantly and unpredictably so quick access to suitable toilet facilities is absolutely crucial either to prevent or should an accident occur.

Understandably, these incapacitating symptoms are accompanied by a continuous anxiety about suddenly needing the toilet and having very little time to find one. Experiencing an episode of incontinence in public is profoundly embarrassing. For many individuals, the result is a devastating impact on their ability to engage in regular activities away from home such as going to work, shopping or socialising.

A Crohn's and Colitis UK survey of 974 young people with IBD in 2007, revealed the extent to which isolation can be brought about by the need to be within easy reach of a toilet, combined with the symptoms of pain and tiredness. 43 per cent of those who participated reported feeling seriously isolated at the time of their diagnosis. When asked for general comments about their lives and the impact their condition had on them, 246 young Crohn's and Colitis UK members stated that their disease made socialising almost impossible. 183 of these attributed this to "always needing to know the proximity of a toilet." The provision of public conveniences thus becomes a service upon which many people with IBD rely in order to leave their homes and retain some sort of normal life. Outings have to be meticulously planned to take into account the availability and location of publicly accessible.

Many individuals living with IBD carry a RADAR key as part of a National Key Scheme to allow independent access to disabled people to approximately 7,000 locked public toilets across the country. However concern has been expressed about toilet closures which have undermined confidence in the scheme.

Crohn's and Colitis UK members are issued with a Can't Wait Card which has the message *"Please help - our member has a medical condition which means they need to use your toilet facilities very urgently. Your kindness and cooperation would be much appreciated."* The purpose of the card is to make it easier for members to ask to use toilets in shops and offices without having to give a long explanation about their condition. Nevertheless, the card does not guarantee access and we hear from members who have been very distressed when access to toilet facilities has been refused. Therefore, the provision of toilets available to the public is an absolute necessity for those living with IBD.

Travel can also present a barrier to independent living outside the home due to a lack of adequate public toilet facilities at bus, tube and railway stations and on-board trains. Furthermore, the Blue Badge Scheme has yet to be extended to cover those people with IBD who may need to park in restricted areas for urgent access to a toilet.
The above grievances are exacerbated by diminishing public conveniences, with the number of public toilets halved in a decade from 10,000 to 5,000.

Summary of Crohn's and Colitis UK Position

- *We welcome provisions within the Bill to introduce a toilets strategy.*
- *We believe that the Bill may increase the provision of public toilets and will ensure that local authorities pay more attention to the provision of public toilets in their area.*
  However:
- *The provision of toilets needs to be set on a statutory level - due to budget restrictions across local authorities and the need to tackle current under-provision of local toilets.*
- *More funding needs to be made available to ensure that toilet strategies are implemented and this funding should be ring fenced.*
- *We do not support charging for public toilets and are concerned that introducing charging will decrease access to toilets for those living with IBD who may need frequent and immediate access to toilets.*
- *We would welcome the introduction of a monitoring system to ensure that areas with a low provision of public toilets take significant steps to increase provision of publicly available toilets in their area.*

Crohn's and Colitis UK survey on Health and Social Care Consultation

In order to ensure the consultation response from Crohn's and Colitis UK adequately represented the views of those living with IBD in Wales, Crohn's and Colitis UK undertook an online survey on the consultation questions as set out by the Health and Social Care Committee.

This survey was sent out to all our members living with IBD in Wales which totals over 3,000 people across Wales. The survey was open from 3rd August and Crohn's and Colitis UK received 98 responses. This survey will be referenced throughout this document.

Question 15

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?
Crohn's and Colitis UK are very supportive of the proposals within the Bill which will create a duty for each local authority in Wales to prepare and publish a local toilets strategy for its area and set out a statement about how they propose to meet identified need. Crohn's and Colitis UK welcomes the duty to assess, plan and then review a toilets strategy for ensuring a suitable provision of toilets in an area. When responding to a survey conducted by Crohn's and Colitis UK on the Health and Social Care Committee's consultation on the Public Health (Wales) Bill, 96% of those living with IBD in Wales that

responded to the survey stated that they agreed with proposals in the Bill that each local authority in Wales should have a duty to create and publish a local toilets strategy.

Of those that said yes to implementing a local toilets strategy, 40% said they did so due to their need for urgent and frequent access to toilets, 38% cited the significant health benefits and peace of mind that would come from better access to toilets and 16% responded saying that a toilets strategy was necessary due to the increasing incidence of local public toilets being closed.

Some of the written responses included:

- *"I suffer from Crohn's disease and need access to public toilets in order to carry out my everyday life."*
- *"The availability of public toilets is vital to the wellbeing and quality of life of people with IBD."*
- *"I have Crohn's disease and often need to use the loo at short notice. There are no public toilets in my town."*
- *"I feel it is of utmost importance for each local council to have a toilets strategy and for the results to be published publicly. The community would show a great interest in knowing how abandoned these essential services have now become and would encourage ways in which councils plan on tackling this and improving essential services such as public toilets."*

Crohn's and Colitis UK welcomes the provisions in Article 91(10) of the Bill which adds the inclusion of changing places for disabled people and young children as part of the local assessment criteria. We welcome the four year time limit set for the life of the toilets strategy and believe that the annual review of the toilets strategy seems to be a reasonable period for strategy review.

Through feedback from people with IBD, Crohn's and Colitis UK are aware that the provision of toilet facilities across Wales can be variable and we welcome any provisions which will encourage the greater availability of clean and accessible public toilets.

As part of the toilets strategy, Crohn's and Colitis UK would like to see stipulations around the provision of multiple toilets at any one site. The provision of multiple toilets as the standard must take preference so that people with conditions such as IBD are not at risk of incontinence if they find a toilet is out of order or engaged upon their arrival.

Crohn's and Colitis UK believe that location is an important aspect of public toilet provision and would like to see an increase in provision across all areas, rather than restricted to tourist hotspots, so that the individual is never far from a toilet. Adequate information will be a central requirement to improving access to publicly accessible toilets and Crohn's and Colitis UK would like to see an increase in the amount of information published and made easily available to members of the public.

Question 16

Do you believe that preparing a local toilets strategy will ultimately lead to improved provision of public toilets?
Responding to a survey conducted by Crohn's and Colitis UK on the Health and Social Care Committee's consultation on the Public Health (Wales) Bill, 77% of respondents stated that they thought preparing a local toilet strategy would lead to improved provision of public toilets. Of these respondents almost half stated that this was their view because it creates an obligation on a local authority to become active on the issue of access to toilets, whilst 31% thought that creating a toilet strategy would raise awareness and thereby lead to a higher provision of toilets in their local area. However, 88% of those that did not think a toilet strategy would lead to improved provision of public toilets felt this was the case because of issues with local authority funding and budget cuts. Crohn's and Colitis UK share this view, and whilst we believe that creating a local toilet strategy may lead to a higher provision of public toilets, we are very concerned that with increasing calls on local authority budgets, coupled with future budget cuts, proposals to meet assessed local need will not be prioritised unless there is a statutory duty to meet the assessed need as identified through the toilet strategy. Article 91(6) of the Bill which includes a duty for local authorities to publish a statement of the steps they have taken in accordance with the strategy to meet assessed need, is welcome. However, the Bill does not state that local authorities need to ultimately meet 100% of the assessed need in their area. Should a local area assess that they need to increase toilet provision by 75%, a local authority could only include small steps that they have taken to meet this need in their statement, rather than having more concrete timescales for priority areas or areas with low levels of public toilet provision. Crohn's and Colitis UK would urge the Health and Social Care Committee to consider the implementation of a form of monitoring system to ensure that those local authorities with a low provision of public toilets are taking significant steps to meet the identified need for toilets in their area. 99% of people that responded to our Public Health Bill survey stated that there should be a statutory duty on local authorities to provide access to public toilets. 55% of these respondents thought that access to public toilets should be a statutory requirement due to the significant health benefits that would created for those living with IBD, and a further 32% stated that statutory provision was indispensable to tackling the current under provision of public toilets in their local area. Some of the written responses included: • *"Many cafes, bars, restaurants etc are not happy for you to use the*

establishment simply for the toilet facilities. Public toilets make life easier for everyone, the ill, elderly, and young children and baby changing facilities are also a must."

- *"As an IBD sufferer, I fully rely on public toilets in order to leave my house."*
- *"Too many toilets have closed during cut backs. New facilities should be built and numbers increased."*
- *"~~Yes, using~~Using the toilet is a necessity, just like parking. Everyone needs the toilet, everyone has different needs, some people can't 'hold'. Just one bad experience of not being able to reach a toilet in time can cause a lifetime of anxiety. Anxiety involving not being able to access a toilet when out and about is a serious and common unknown issue."*

Crohn's and Colitis UK fully support this view and believe that only the creation of a statutory duty for local authorities to meet the assessed need through the toilet strategy, will guarantee the increase in provision of toilets accessible to the public. We urge the Health and Social Care Committee to consider this issue carefully when reporting on the Public Health (Wales) Bill.

Crohn's and Colitis UK welcome the commitment by the Welsh Government to continuing the Public Facilities Grant Scheme. However, we are disappointed that the Welsh Government are not proposing to increase the monies available under this grant given that all authorities will need extra funding to adhere to the provisions of the Bill.

Option 3 of the summary of costs on p233 of the Bill's Explanatory Memorandum, estimates that the total extra cost of implementing a four year toilets strategy will cost each of the 22 local authorities in Wales £18,318 over the four year period of the strategy. This figure does not include any investment in the actual provision of extra toilets and meeting the identified need.

Because the Public Facilities Grant Scheme is not a ring-fenced scheme but funding made available through the General Fund, and given the costs associated with creating a local toilets strategy, Crohn's and Colitis UK are concerned that local authorities will use funding previously allocated to businesses through the Public Facilities Grant Scheme to pay for the new toilets strategy. Therefore, Crohn's and Colitis UK does not support the continuation of the Public Facilities Grant scheme being made available through the General Fund and calls upon the funding to once again become a ring-fenced grant.

The Bill does not make any extra capital funds available for the provision of toilets. The Bill's Explanatory Memorandum on p236 suggests that it would cost £107,500 to build a new a block of four toilets. As p237 of the Bill's Explanatory Memorandum states, there are 950 public toilets currently available across Wales and to meet the assessed need of public toilet provision using the ratios set out by the British Toilet Association, a conservative estimate states that the number of public toilets would need to rise by 50%, which would lead to capital costs to local authorities of £25.5million.

With ever increasing cuts to local government budgets and greater calls on their services, local authorities will need more funding if they are to fully implement the assessed local need through the toilets strategy.

Crohn's and Colitis UK believe that it is important to ensure the continued usage of current public toilets if they are not to be closed. Often public toilets are old, dirty and foster anti-social behaviour which results in the lack of usage of the facility. Therefore, in order to safeguard their future, efforts should be made to increase public confidence in these services with the presence of toilet attendants, or the assurance of regular inspections.

Should local authorities be able to charge for the use of public toilets?

57% of people that responded to our survey stated that they would support charging for the use of public toilets. 52% of these supported a small charge if free access was maintained for disabled people or those with long term conditions such as IBD whilst 47% supported charging to ensure that toilets are clean and accessible.

However, 43% of respondents did not think that charging for access to public toilets was appropriate with 53% of these stating that they had concerns over the cost for those living with IBD that may have to use public toilets several times in any one outing. These people also had concerns with access to suitable change and lack of access to toilets. 47% of respondents, who were opposed to charging, stated that they thought that public toilets should be funded through council tax payments.

Whilst Crohn's and Colitis UK understand the arguments around implementing a small charge for the use of public toilets to ensure that they are well maintained, we have grave concerns about the accessibility for those living with IBD as well as the extra costs incurred by those with a lifelong condition. We are aware of incidences where charging has become a significant barrier to accessing toilets in moments of urgency when immediate access to a toilet is essential to prevent an involuntary bowel movement in public.

For example, those living with IBD have said:

- *"I feel that public toilets should be free to all, as an IBD sufferer, I need to get to the toilet ASAP, I don't need to be worrying if I have the right change to get to the toilet."*
- *"Using a toilet should not be a privilege. As someone who has Crohn's Disease, urgency is a huge factor so rummaging around for money could potentially result in an embarrassing accident as well as being out if pocket."*

Therefore, Crohn's and Colitis UK cannot support the provisions under Article 93(5) of the Bill which would allow a local authority to charge for the use of public toilets.

Additionally, to ensure that those living with IBD have access to safe and clean toilets, Crohn's and Colitis UK advocates the view that, where possible, toilet attendants should be employed. Recommendation 6 of the House of Commons Communities and Local Government Committee Report 2008 into Public Toilets encourages local authorities to study the costs and benefits of employing toilet attendants. At the very least, there should be some assurance regarding regular inspections to make certain that toilets are as clean, safe and secure as possible. Doing so should reduce the occurrence of toilets being closed - temporarily or permanently - due to unsuitable conditions. We would encourage the Committee to advise the Welsh Government to consider this issue when creating regulations on this Bill.

Question 17

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?

Crohn's and Colitis UK welcomes Article 92 of the Bill which ensures that interested parties in a local area will be consulted on local toilet strategies.

56% of respondents to Crohn's and Colitis UK's survey of members with IBD in Wales considered the engagement provisions in the Bill would ensure that the views of local people are taken into account when developing the local toilet strategy.

59% of these stated that local knowledge of need and accessibility of toilets was fundamental in creating a suitable toilet strategy, whilst 41% said that the input and knowledge of people living with IBD into the strategy is key. Crohn's and Colitis UK fully support this view and would urge the Health and Social Care Committee to recommend to the Welsh Government that Crohn's and Colitis UK is a key stakeholder for all local areas in the engagement and implementation of local toilet strategies.

However, 44% of respondents to the survey stated that they did not believe that the provisions within the Bill would guarantee suitable public consultation with 52% citing lack of confidence in previous public consultations with 30% stating their view that lack of funding by local authorities would limit the scope and comprehensiveness of local strategies.

Question 18

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

Crohn's and Colitis UK are very supportive of the suggestion to include all facilities that receive public funding such as libraries, museums or council buildings, in the toilets strategy in order to meet assessed local need. A key requirement of this would be to ensure that facilities were suitable and appropriate signage to the general public was put in place.

Furthermore, whilst strengthening provisions for the public to use toilets in facilities that receive public funding is welcome, this must always be in addition to traditional public toilets and must never be as a replacement. This is because such facilities will close after opening hours limiting the availability of toilets into the evening and night time.

39% of respondents to our survey stated that they were supportive of including the provision of facilities that receive public funding into the strategy to increase the availability of toilets available to the public, with a further 26% making the point that toilets in public facilities were often nicer and better maintained than public toilets situated elsewhere.

Some of the written responses from people with IBD in Wales included:

- *"If a building receives public funding they should ensure that adequate toilets are available. These toilets should also be available for those with IBD even if they are not using the building at that time."*
- *"I was once refused entry to use the public toilets in a public library at a particularly urgent time which resulted in one of the most embarrassing days of my life so far while I tried to explain to a member of staff why I should be allowed to use the facilities."*
- *"There are definitely not enough public toilets available, in some places you have to explain your medical condition to them in order for them to decide if they will even let you use the facility."*
- *"If a building receives public funding then its toilets should be easily available for everyone. This should include proper signage and no obstruction from staff on the premises."*
- *"Toilets in public buildings are generally better maintained than public toilets."*
- *"There should be provision in all such buildings, however it would presumably only be available during office hours.*

Crohn's and Colitis UK believes that local toilet strategies should also include the provision of publicly accessible toilets within the local transport system. Access to toilets on the public transport system has been a substantial issue for people with Inflammatory Bowel Disease and this has worsened over the last number of years. Therefore, we would urge the Health and Social Care Committee to consider the need for the adequate provision of suitable toilets at all large transport facilities and interchanges to be included within the needs assessment for a local area.

Crohn's and Colitis UK would also support the inclusion of retail, food outlets and private business that receive public funding for the use of their toilets to be included within a local toilets strategy.

An alternative means to ensuring the quality and accessibility of toilets for public use is to supplement those services provided by the local authority with access to facilities in commercial premises. At present, many establishments providing food and drink offer their services solely to those who make a purchase and few facilities are provided and maintained for general public use. Crohn's and Colitis UK support schemes like the Public Facilities Grant scheme that encourages local authorities to establish schemes which utilise toilets in commercial premises if they are accessible, well maintained and properly sign posted for public use. Utilising an area's current toilet provision, whether from public or private sources will help increase the provision of toilet facilities for local people whilst acknowledging the limitations on available local authority budgets.

However, the use of such schemes must be in addition to the availability of public toilets as the provision of publically accessible toilets is required for all times of the day and night, and it is unlikely any scheme of this sort will have the capacity to offer round-the-clock access due to restrictive business opening hours. As a result, access to facilities in commercial premises is only a partial solution and should be a supplementary measure rather than the basis for provision of toilets in a local area.

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4 September 2015
By email

The Advertising Standards Authority and Committees of Advertising Practice's response to the Health and Social Care Committee's call for evidence on the Public Health (Wales) Bill

1 Introduction

1.1 This evidence is provided by the Advertising Standards Authority (ASA) and Committees of Advertising Practice, CAP and BCAP (the 'ASA system').

1.2 We are committed to upholding high standards in advertising, and recognise the important role that advertising regulation has to play in ensuring that e-cigarette advertising is responsible.

1.3 We welcome the opportunity to respond to the Health and Social Care Committee's call for evidence on the Public Health (Wales) Bill. We would like to submit comments about Part 2: Tobacco and Nicotine Products.

1.4 We recognise the concerns surrounding the use of e-cigarettes and we note that while Part 2 of the Bill does not specifically reference e-cigarette advertising, it does ask for 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.

1.5 Since November 2014 e-cigarettes have been subject to product specific advertising rules, which are comprehensive and robust. They place an emphasis on the protection of young people and ads must avoid containing anything that promotes tobacco. Based on the available evidence, we feel confident the current advertising rules for e-cigarettes provide the appropriate level of protection for consumers across the UK.

1.6 The ASA system acts as the first line of control for ensuring advertising is responsible and we ask that the Welsh Government takes into account the role and

Chairman Rt Hon Lord Smith of Finsbury **Chief Executive** Guy Parker
ASA Council Kate Bee, Alan Bookbinder, Rachel Childs, Roisin Donnelly, Ray Gallagher, Wesley Henderson, David Hepworth, John Mayhead, Suzanne McCarthy, Sir Martin Narey, Shireen Peermohamed, Hamish Pringle and Sam Younger

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The Advertising Standards Authority (Broadcast) Limited, registered in England No 05130991, Mid City Place, 71 High Holborn, London WC1V 6QT.

work of the established advertising self-regulatory system in ensuring ads for these products are responsible. The ASA system has the capacity to help the Welsh Government meet its public health objectives, and the advertising rules provide a strong platform for consumer protection.

1.7 This submission provides an overview of:

- the UK advertising regulatory system
- the e-cigarette advertising rules
- the ASA's enforcement of the e-cigarette advertising rules
- The ASA system's next steps

2 Overview of the ASA system

2.1 Advertising in the UK is regulated by the self-and co-regulatory ASA system. We have been regulating advertising in non-broadcast media since 1962. Our remit was extended to include TV and radio advertising in 2004, and we began regulating companies own websites and social media in 2011.

2.2 The Advertising Codes (the Codes) are written and maintained by CAP. The Codes cover advertising across media, including that which appears on billboards and leaflets. More information on what we cover can be found at http://www.asa.org.uk/Consumers/What-we-cover.aspx.

2.3 The ASA is the independent body responsible for administering the Codes. In 2014 it received 37,073 complaints about 17,002 ads. Its action led to 3,384 ad campaigns being changed or withdrawn.[1]

2.4 The system is entirely funded by industry, through an arms-length levy. This ensures a proper separation between the system's regulatory functions and its industry funders.

2.5 The ASA system takes a 360° approach to regulation. In addition to handling complaints, it pro-actively monitors ads across both national and local media to make sure standards are being maintained.

2.6 CAP, recognising that prevention is better than cure, provides a wealth of training and advice services for advertisers (most of which are free) to help them understand their responsibilities under the Codes, meaning fewer problem ads appear in the first place. CAP gave advice on 194,200 occasions in 2014.[2]

[1] ASA Annual Report 2014 https://www.asa.org.uk/News-resources/Media-Centre/2015/~/media/Files/ASA/Annual%20reports/Annual%20Report%202014_FULL.ashx
[2] ASA Annual Report 2014 https://www.asa.org.uk/News-resources/Media-Centre/2015/~/media/Files/ASA/Annual%20reports/Annual%20Report%202014_FULL.ashx

3 Background: Sector-specific rules

3.1 In 9 October 2014, after a period of public consultation, the Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) put in place specific rules for the advertising of e-cigarettes in the UK. Those came into effect on the 10 November 2014. They apply across all media and are administered by the ASA.

3.2 The rules place an emphasis on the protection of young people and ads must avoid containing anything that promotes tobacco. The rules address concerns about the advertising of e-cigarettes:

- Ads must not be likely to appeal to people under 18, especially by reflecting or being associated with youth culture (including using celebrities popular with young people)
- People shown using e-cigarettes or playing a significant role must neither be nor seem to be under 25
- Ads must not be directed at those under 18 either through the choice of media or the context in which they appear
- Ads must not encourage non-smokers or non-nicotine users to use tobacco products and must do nothing to promote tobacco smoking
- Ads must make clear that the product is an e-cigarette, not a tobacco product, and must not cross-promote tobacco brands
- Ads must not contain health claims or (illegal) medicinal claims

3.3 As well as the above rules, e-cigarette ads must continue to comply with all the other general rules in the Codes which prevent, for example, misleading, offensive, harmful or otherwise irresponsible advertising.

3.4 When drafting rules, CAP and BCAP will always consider whether any new evidence has regulatory implications for the Advertising Codes, where necessary taking into account the public health context. In the e-cigarette sector, that context includes concerns around the safety of e-cigarettes and their potential to 'normalise', and be a gateway in to, smoking. It also includes the arguments and evidence for the potentially significant public health benefit at the population level if smokers or would-be smokers switch some or all of their tobacco consumption to e-cigarettes and the part responsible advertising might play in encouraging that switching.

3.5 When the new rules were introduced, CAP and BCAP were mindful that there had already been at least two years of steadily increasing advertising of e-cigarettes, mostly in non-broadcast media. Despite the increase in advertising, the evidence base showed then, and continues to show now, that the use of e-cigarettes amongst

children and young people remains rare and confined to those who currently or have previously smoked tobacco.[3]

3.6 Similarly e-cigarettes are used almost exclusively by adult current and ex-smokers and that use amongst never smokers remains negligible.[4] The available evidence suggests that e-cigarettes are not acting as a route into smoking for children or non-smokers.[5] The CAP and BCAP rules reflect the gradient of risk and, were this evidential picture different, the rules would be different. We therefore remain of the view that the rules themselves continue to describe the proportionate level of protection for consumers across the UK.

3.7 More detail on the rules can be found in CAP and BCAP's Joint Regulatory Statement (Annex A).[6]

4 ASA Enforcement

4.1 In the eight months[7] since the inception of these rules the ASA received a total of 644 individual complaints about e-cigarette advertisements. Approximately 250 of those complaints objected to e-cigarettes being advertised at all. These complainants often take the view that e-cigarettes are the same as tobacco in some way or present the same health risks, or that they can act as a gateway to tobacco. Given the growth of the e-cigarette sector and the strength and divergence of opinion, we expect to continue to receive such complaints. However, our decision to allow responsible advertising for e-cigarettes, subject to strict rules, is based on a consultation in which the majority of respondents supported responsible advertising and on an evidence base (discussed above) that continues to show that the products are overwhelmingly used by smokers as a tobacco alternative.

4.2 The remaining complaints related to 88 actual cases (cases broadly correspond to ads). In a pattern consistent with our wider work, 71 of those cases did not need to be taken forward, generally because the complaint did not raise issues under the Codes. For example, in one case the complaint was that the ad was making a smoking cessation claim for an unlicensed product and in another the complainant felt that the ad was encouraging illegal drug use. However, after obtaining copies of these ads and assessing them, we did not consider that they were likely to be interpreted by most consumers in the ways suggested by the complainants. In another case the complainant believed that she had seen an e-cigarette advertisement on a children's channel, but enquiries with the broadcaster and our media monitoring databases revealed this not to be the case.

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[3] *Use of electronic cigarettes in children in Great Britain* – May 2015, ASH Fact Sheet. Data taken from YouGov Poll. http://www.ash.org.uk/files/documents/ASH_959.pdf.

[4] Use of electronic cigarettes among adults in Great Britain – May 2015, ASH Face Sheet, Data taken from YouGov Poll. http://www.ash.org.uk/files/documents/ASH_891.pdf

[5] E-cigarettes: an evidence update https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update

[6] CAP and BCAP's Joint Regulatory Statement https://www.cap.org.uk/News-reports/Consultations/Closed-consultations/CAP-BCAP-consultation-on-ecigs.aspx

[7] 10 November 2014 to 30 June 2015 inclusive

4.3 Of the remaining 17 cases, six were judged by the ASA Council not to be in breach of the rules and were closed. A further six presented minor or clear cut breaches of the Codes and were resolved on an informal basis by the advertiser agreeing to make changes to their ads to bring them in line with the Codes. Five cases were formally investigated and ruled on by the ASA Council. Of those, four were found to be in breach of the Code either in whole or in part, and one was found not to be in breach.

4.4 In the same period we received a total of 19,062 complaints and 10,186 cases about all ads[8] meaning that e-cigarette advertisements account for 3.4% of complaints and 0.9% of ASA casework since the inception of the new rules. In that light our view is that the number and nature of e-cigarette complaints and cases does not reveal a systemic problem with the sector's advertising at the moment.

5 Next Steps

5.1 CAP and BCAP recognise the importance of ensuring that the rules for e-cigarettes remain fit-for-purpose. For that reason, in November 2015 the ASA system will conduct a formal review, looking particularly at the detailed data from ASA complaints and investigations during that time and conducting a monitoring exercise to look at media and issues that have not been brought to our attention by complainants.

5.2 The review will evaluate the up-to-date evidence base on e-cigarette use and trends and might also include commissioning our own consumer research on, for example, whether ads for e-cigarettes are likely to particularly appeal to under 18s. If any of these factors give us concerns about either the rules themselves or the way in which we administer them, we are committed to making any changes that are required.

5.3 ASA/CAP and the Tobacco Products Directive

5.3.1 Directive 2014/40/EU (on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC) is now in force but has not yet been given effect in UK law. The UK Governments are required to transpose its provisions by 20 May 2016, with a further transitional period for non-compliant e-cigarette products until 20 November 2016. Those provisions include restrictions on advertising.

5.3.2 The e-cigarette advertising rules do not pre-empt the requirements of the Directive but serve as an interim measure. When more is known about the application of the Directive in the UK, CAP will clarify what role its Code will have after the new law has been given effect.

[8] In the 12 months of 2014 we received 37,073 complaints about 17,002 cases across all sectors.

6 Summary

6.1 The e-cigarette rules, developed by CAP and administered by the ASA, provide a robust vehicle for the protection of young people. We feel confident that the ASA system is well-placed for responding to concerns about advertising in the first instance, with CAP open to receiving and considering evidence-based representations on the rules themselves and how they might evolve as society changes over time.

6.2 We would be happy to meet with the Welsh Government to discuss our role, or to provide further written information on request.

7 Contact Details

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New rules for the marketing of e-cigarettes

CAP and BCAP's Joint Regulatory Statement



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1. Executive summary

The Committee of Advertising Practice (CAP), author of the UK Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing (the CAP Code) and the Broadcast Committee of Advertising Practice (BCAP), author of the UK Code of Broadcast Advertising (the BCAP Code) are implementing new rules for the marketing of electronic cigarettes. The rules add to those already in place, which ensure advertisements for e-cigarettes must not mislead, harm, offend or otherwise be socially irresponsible.

After a rapid rise in popularity of e-cigarettes and a concurrent increase in the advertising of them, CAP and BCAP ("B/CAP" or "the Committees") considered that new rules were required to offer reassurance to the public and clarity to industry over how these products may be advertised. In early 2014 they proposed a draft set of rules and conducted a public consultation to inform their views on the nature and extent of rules to apply.

The final rules are provided and discussed in the following sections. They apply a level of protection that the Committees consider to be fair and proportionate, balancing the need to protect consumers with the need to allow marketers freedom of commercial speech. B/CAP are however mindful of the relative infancy of the e-cigarette market and the emerging evidence base and intend to monitor the effect of the rules, conducting a formal review after 12 months.

The rules will come into effect on **Monday 10 November 2014** at which time the ASA will begin to enforce compliance with them. Until that date the ASA will continue to investigate complaints under the current general rules.

2. Background

2.1 E-cigarettes: rise in popularity

Recent years have seen a well-documented rise in the use and availability of e-cigarettes with an estimate 2.1 million people[1] now using them in the UK. Their rise in popularity has been mirrored by a growing debate amongst the public, policymakers and public health professionals about their potential impact, good and bad, on public health outcomes. There is widespread interest in their potential public health benefits as an alternative to tobacco, however there are concerns about the fact that they contain nicotine; their efficacy and safety; their potential to renormalise smoking, and questions over whether they act as a gateway to nicotine or tobacco for the young or non-smokers.

2.2 The decision to consult

Concurrent with their popularity, advertising for e-cigarettes has been growing steadily in non-broadcast media for some time. The CAP Code provides general protections from misleading, offensive, harmful or otherwise irresponsible advertising under which the ASA has investigated numerous complaints about e-cigarette advertising. Up until now the CAP Code has not had any specific rules concerning the advertising of e-cigarettes.

The BCAP Code, covering broadcast advertising, provides the same general protections but it also includes broadly-written prohibitions in the Tobacco section of the Code that have severely limited advertising for products which share characteristics with tobacco products. These prohibitions have led the ASA to uphold complaints about various e-cigarette advertisements[2]. Aside from those prohibitions, which inadvertently apply to e-cigarette advertisements, the BCAP Code also has had no specific provisions for e-cigarettes.

The Committees consider that e-cigarettes' particular characteristics, their potential for harm, for addiction and their relationship with tobacco, carry a reasonable expectation of specific regulatory protection in relation to how they may be advertised. CAP and BCAP are concerned to ensure that advertising is responsible and consider that new rules are the best way to deliver that protection and to clarify to the industry what they regard as responsible marketing in this sector, taking into account the views of a wide range of stakeholders. BCAP is also keen to address the aforementioned difficulties being presented by the Tobacco rules, which is dealt with in detail in section 5.3.

B/CAP launched a joint consultation in February 2014 in which they proposed new rules drawn in part from their experience setting rules for sectors that have presented similar public policy issues, such as alcohol and gambling. However, the Committees have been mindful that e-cigarettes are a unique product with their own complexities and, unlike with alcohol and gambling, strong arguments are made for e-cigarettes' public health benefits. In addition to their general objectives CAP and BCAP seek to offer particular protection to the young, the vulnerable and to non- and former-users of nicotine. The results of that consultation are set out in the following sections and the accompanying evaluation of responses.

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[1] ASH: Use of electronic cigarettes in Great Britain. http://www.ash.org.uk/files/documents/ASH_891.pdf
[2] More information about the issues presented by the BCAP Tobacco rules can be found in section 4.3 of the original consultation document, which also includes links to relevant ASA adjudications

2.3 The Tobacco Products Directive

The new European Tobacco Products Directive governing the manufacture, presentation and sale of tobacco and related products (including e-cigarettes) was signed on 3 April 2014. The UK Government is required to transpose its provisions by 20 May 2016, with a further transitional period for *non-compliant* e-cigarette products until 20 November 2016. It will allow e-cigarettes to remain as consumer goods subject to various quality controls and limitations on nicotine content, however marketers wishing to apply for a medicines authorisation will be able to do so. Additionally there will be specific prohibitions on categories of advertising.

The new CAP and BCAP rules do not pre-empt the requirements of the Directive but serve, at least, as an interim measure. B/CAP understand that the Department of Health is now working to establish what effect the Directive will have in the UK. When more is known about the effect of the Directive in the UK, CAP and BCAP will clarify what role their Codes will have in relation to e-cigarette advertising in future.

2.4 Policy objectives

CAP and BCAP's general policy objective is to set standards to ensure that all advertisements are legal, decent, honest and truthful and prepared with a due sense of social and professional responsibility.

CAP and BCAP intend their Codes to be based on the enduring principles that advertisements should be responsible, respect the principles of fair competition generally accepted in business and should not mislead, harm or offend. The Committees wish to maintain an environment in which responsible advertising can flourish. They intend their rules to be transparent, accountable, proportionate, consistent, targeted only where regulation is needed and written so that the rules are easily understood, easily implemented and easily enforced.

3. Rules which CAP and BCAP are implementing

This section discusses the rules which CAP and BCAP will implement. The content rules are deliberately harmonised to be the same in both Codes, except for the difference in descriptor used in each Code: the term “marketing communications” is used to describe non-broadcast advertising in the CAP Code, whereas “advertisements” is used to describe broadcast advertising in the BCAP Code.

The CAP and BCAP Codes naturally approach targeting / scheduling restrictions in a different way. Those rules are set out separately in sections 4 and 5. Section 5 also addresses BCAP’s implementation of mandatory central clearance for radio advertising and the necessary changes to the BCAP Tobacco rules. The rules which B/CAP consulted on but, following an evaluation of consultation responses, have chosen not to implement are discussed in section 6. Advertisements for e-cigarettes must also comply with all relevant other rules in both Codes. In section 7 some additional discussion is provided on the main issues raised through the consultation process, and the rationale behind the key decisions made.

Rule 1: *Marketing communications / advertisements for e-cigarettes must be socially responsible.*

It is a general rule in the CAP and BCAP Codes that advertisements must be socially responsible. The Committees see fit to repeat the rule in certain Code sections, typically so that it can provide more detail in recognition of specific concerns or risks for the sector in question. For example the corresponding rule in the Alcohol sections in the Codes discourages excessive use. Although B/CAP received various suggestions from respondents as to types of creative approaches they might consider irresponsible, above and beyond the approaches identified in other rules for e-cigarette advertising, B/CAP did not consider any were so harmful as to require outright prohibition within this rule. Instead, B/CAP are implementing the rule in its briefest form with a view to supplementing it with guidance as ASA casework begins to define the boundaries of responsible advertising for this sector.

Rule 2: *Marketing communications / advertisements must contain nothing which promotes any design, imagery or logo style that might reasonably be associated in the audience’s mind with a tobacco brand.*

Many respondents raised concerns that the rules drafted by B/CAP did not go far enough in preventing advertisements invoking tobacco brand identity. As discussed in section 7.2 B/CAP have added this rule, which is a variation on the text proposed by many respondents to answer those concerns.

Rule 3: *Marketing communications / advertisements must contain nothing which promotes the use of a tobacco product or shows the use of a tobacco product in a positive light. This rule is not intended to prevent cigarette-like products being shown.*

Rule 4: *Marketing communications / advertisements must make clear that the product is an e-cigarette and not a tobacco product.*

Rule 3 remains in the form originally proposed by B/CAP. It recognises the relationship that e-cigarettes have with tobacco and prohibits any positive reference to tobacco use.

B/CAP acknowledge that there is significant concern about the potential indirect promotion of tobacco products via advertising for e-cigarettes but are also mindful that the similarity of e-cigarettes to tobacco products is a chief appeal to those seeking a tobacco alternative.

Neither this rule, nor the broader rule framework within which it sits, prohibits products being shown, or shown in use, either in broadcast or non-broadcast advertising, so long as it is clear that the product is an e-cigarette and not a tobacco product (see section 7.3). The rule should therefore be read in conjunction with Rule 4. Rule 4 has been augmented since consultation with the words "…and not a tobacco product" to clarify its purpose, operating alongside rule 3.

Rule 5: *Marketing communications / advertisements must not contain health or medicinal claims unless the product is authorised for those purposes by the MHRA. E-cigarettes may be presented as an alternative to tobacco but marketers must do nothing to undermine the message that quitting tobacco use is the best option for health.*

Advertisers may obtain a licence for their product from the MHRA. Such a licence would typically allow marketers to make smoking cessation and reduction claims in the same way as other licensed nicotine replacement therapy (NRT). Marketing for such products is subject to the rules in section 12 of the CAP Code and section 11 of the BCAP Code. Claims that e-cigarettes are an "alternative" to tobacco may be made.

Although the rule remains mostly in the form originally proposed, the second sentence has been augmented slightly to include the requirement *"…but marketers must do nothing to undermine the message that quitting tobacco use is the best option for health".* This responds to comments made by various consultation respondents and seeks to make clear that, although unlicensed e-cigarettes may not make smoking cessation / reduction claims and may be described as an alternative to tobacco, advertisers should be cautious not to imply anything other than cessation of tobacco offers the best chance for health improvement.

Rule 6: *Marketers must not use health professionals to endorse electronic cigarettes.*

This rule is a new addition as a result of the consultation and is consistent with the prohibition on health claims.

Rule 7: *Marketing communications / advertisements must state clearly if the product contains nicotine. They may include factual information about other product ingredients.*

B/CAP consider that advertisements for products which contain nicotine, an addictive substance, need to make that fact clear in order to avoid harm to consumers. B/CAP also examined whether they might require marketers to make clear when a product did not contain nicotine, but concluded that a straightforward statement about the presence of nicotine in a product was the most proportionate way to advise people of the risk, given the natural limits of time and space.

Rule 8: *Marketing communications / advertisements must not encourage non-smokers or non-nicotine-users to use e-cigarettes.*

Although e-cigarettes are available as a consumer good, many regard their primary purpose as an alternative to tobacco smoking. CAP and BCAP understand that there is presently little evidence of e-cigarette take-up in never-smokers, but accept that this could change. While it is not the Committees' role to mandate the proper use of e-cigarettes, for example by requiring that advertisements always present them as an alternative to tobacco, they do consider that it is proportionate to provide a rule which prevents, as far as possible, advertisers actively encouraging non-smokers or non-nicotine-users to use e-cigarettes.

The rule does not require every marketing communication to target only tobacco smokers / e-cigarette users explicitly, rather that they must not explicitly encourage those who do not currently use nicotine to start.

Rule 9: *Marketing communications / advertisements must not be likely to appeal particularly to people under 18, especially by reflecting or being associated with youth culture. They should not feature or portray real or fictitious characters who are likely to appeal particularly to people under 18. People shown using e-cigarettes or playing a significant role should not be shown behaving in an adolescent or juvenile manner.*

CAP and BCAP wish to prevent advertising which might, through its content or context, encourage children or young people to use e-cigarettes. Drawing on their experience setting rules for the alcohol and gambling sectors the Committees are therefore introducing this rule and the next, in addition to the Code-specific targeting restrictions, to prevent advertisements being directed at, or appealing to under-18s.

Prompted in particular by a specific recent advertisement, some respondents were concerned that the last sentence of the rule might inadvertently serve to prohibit responsible advertising by preventing, for example, any depiction of juvenile behaviour. The advertisement cited by respondents had grouped tobacco smoking with various juvenile behaviours of which the characters were shown to positively grow out of. While B/CAP does not take a view on the acceptability of specific advertisements the Committees' consider that the ASA may find advertisements to be compliant with the rule if, when taken as a whole and in context, the advertisement is judged to not be of particular appeal to children or young people.

Rule 10: *People shown using e-cigarettes or playing a significant role must neither be, nor seem to be, under 25. People under 25 may be shown in an incidental role but must be obviously not using e-cigarettes.*

This rule provides that children and young people do not identify, by age, with those playing a significant role or featured using e-cigarettes in the advertisement. Some consultation respondents considered that the age might be reduced to 18 in order to more effectively appeal to the significant number of tobacco smokers who become established in their nicotine use below the age of 25. While B/CAP understand the rationale put forward, they are also mindful of the strong need to minimise the appeal of advertisements for these products to under-18s generally and particularly those who do not already consume nicotine.

The age of 25 was proposed because by that age people clearly look and sound more adult than adolescent. It also mirrors the minimum age limit in other Code sections and gives more certainty to the advertising industry when creating advertisements and to the ASA Council when deciding if an advertisement has breached the Codes. In that context B/CAP consider that retaining a minimum age limit of 25 is the most proportionate decision.

4. CAP Code-only rule

CAP Rule 11: *Marketing communications must not be directed at people under 18 through the selection of media or the context in which they appear. No medium should be used to advertise e-cigarettes if more than 25% of its audience is under 18 years of age.*

For other sectors that present societal concerns around the protection of children and young persons, such as alcohol and gambling, CAP applies a rule which requires non-broadcast marketing communications not to appear in media which has an audience of under-18s of more than 25%. CAP is therefore providing this rule for e-cigarette marketing also.

Some respondents suggested that the 25% threshold was not strict enough (it should be lower), or that CAP should consider a means of addressing the actual number of total impacts (the actual number of under-18s who see an ad) as well as thresholds. While it is CAP's intention to minimise as far as possible children and young people's exposure to non-broadcast e-cigarette advertising, CAP is also mindful of the need execute that policy objective without disproportionately limiting advertisers' ability to reach a legitimate audience for their products. Through its experience of setting rules for sectors which present similar societal concerns, and through the ASA's activities in enforcing those rules CAP considers that the 25% threshold continues to describe the appropriate limit at and beyond which it is proportionate to prevent advertising for e-cigarette products, or other products restricted by law for sale to under-18s.

5. BCAP Code-only rules

5.1 Central Clearance for radio advertisements

BCAP Rule 11: *Radio Central Copy Clearance* – *Radio broadcasters must ensure advertisements for e-cigarettes are centrally cleared.*

It is a licence requirement of broadcast services that the advertisements that they air comply with the BCAP Code. The RACC was set up by the commercial radio industry to ensure, before they are broadcast, that radio advertisements comply with the BCAP Code. The RACC is administered by the RadioCentre, whose members consist of the majority of UK Commercial Radio stations who fund the organisation. The RadioCentre aims to maintain and build a strong and successful commercial radio industry.

Although central clearance is provided for some radio advertisements by the RACC, the vast array of small, local advertisers and radio stations has meant that local clearance procedures are commonplace. The BCAP Code therefore requires certain categories of radio advertisements to be centrally cleared by the RACC. Those categories of radio advertisements have in common a particular potential to mislead, offend or harm. BCAP considers that procedure is necessary for e-cigarette advertisements also. This provides that such advertisements receive the necessarily high level of pre-broadcast scrutiny to ensure they are appropriately scheduled and do not cause harm.

Some consultation respondents queried why a similar rule does not exist for television advertising. BCAP understands that most, if not all, television advertisements for e-cigarettes will receive pre-broadcast scrutiny and clearance from Clearcast. On that basis BCAP does not consider it necessary to mandate television pre-clearance for this sector.

5.2 Scheduling

In addition to the new content rules BCAP will add a scheduling restriction to its Code to limit under-18s exposure to e-cigarette advertisements. In practice it will do this by adding e-cigarettes to the list of products and services set out in rule 32.2 of the Scheduling section of the Code, which should be considered alongside the BCAP Advertising Guidance Note on Audience Indexing, found here. The specific rule and proposed amendment are set out below:

> ***32.2*** *These may not be advertised in or adjacent to programmes commissioned for, principally directed at or likely to appeal particularly to audiences below the age of 18:*
>
> ***32.2.7*** *electronic cigarettes*

Some respondents, while agreeing with the principle behind the rule, noted that although some programmes that attract high viewership (e.g. prime time programming or sporting events) may not be 'directed at or likely to appeal' particularly to under 18s, they nevertheless are viewed by large numbers of under 18s. As with the non-broadcast targeting restriction discussed in the previous section, those respondents asked BCAP to consider this 'total impact' in its rules in addition to the existing scheduling restrictions.

BCAP seeks to set rules which are proportionate. This requires policy measures that respond to the need to limit under 18s' exposure to e-cigarette advertising while avoiding a significant intrusion on adult viewing that would disproportionately limit advertisers' ability to reach a legitimate audience for their products. Any policy move seeking to exclude e-cigarette advertising from programmes of broader appeal that are watched by a predominantly adult audience would, in BCAP's view, run counter to this principle.

BCAP considers that adults should be able to view responsible advertising for products of legitimate interest to them, but in cases where the elimination of child impacts does not significantly outweigh the reduction in adult impacts that proportionality will have been lost. There is also the possibility that advertisement spend displaced from a small number of programmes of broader appeal towards a greater number of programmes with a narrower appeal may result in no actual meaningful reduction in the total number of impacts, but only their dispersal. The notion of intrusion into adult viewing also influences BCAP's thinking on the recent findings[3] about changing viewing patterns among older children and the usefulness of the current approach to scheduling. Recent research suggests that viewing by older children to adult commercial channels now peaks after 9pm.

The 120 index, which is explained in the BCAP Advertising Guidance Note on Audience Indexing, gives broadcasters the capacity to determine programmes of particular appeal to a youth audience at any time of day, including beyond 9pm, and exclude e-cigarette advertising from those programmes. BCAP considers that the 120 index continues to describe the appropriate limit at and beyond which it is proportionate to prevent a given audience profile from seeing advertising for e-cigarette products, or other products restricted by law for sale to under-18s..

5.3 Corresponding updates to the Tobacco rules

The existing Tobacco rules in the BCAP Code act, inadvertently, to prohibit any depiction of e-cigarettes in broadcast advertising. Upon implementation of these rules, BCAP will modify the Tobacco rules such that Code rules 10.1.3 and 10.3 – 10.5 inclusive do not apply to advertisements for e-cigarettes which are caught within the remit of the new section. Those modifications can be found in Annex C of this document.

[3] Children and young people's exposure to alcohol advertising. http://stakeholders.ofcom.org.uk/market-data-research/other/tv-research/alcohol-advertising/; accessed on 8 October 2014.

6. Rules upon which CAP and BCAP consulted, but are not implementing

6.1 Background

Additionally B/CAP consulted on several other rules which, after further consideration, they consider are not merited. These are set out below.

6.2 Links with gambling, alcohol or illicit drugs.

B/CAP consulted on a rule which would prohibit linking e-cigarettes with gambling, alcohol or illicit drugs. However, the Committees also made clear in the original consultation document that they had doubts about whether this rule was necessary because any e-cigarette advertisement which features or refers to alcohol or gambling already has to comply with the relevant provisions in the Alcohol and Gambling sections of the Codes. B/CAP have therefore had to consider whether the depiction within an advertisement of co-locating e-cigarettes with the responsible depiction of alcohol or gambling is in every circumstance likely to be regarded as irresponsible.

B/CAP's consideration is that such a restriction is disproportionate. While B/CAP do not and cannot pre-approve specific creative treatments, it is their view that there are likely to be ways in which advertisements may feature an e-cigarette in an environment in which alcohol is being consumed or gambling conducted without being harmful or irresponsible. This is particularly the case given that, as some respondents have noted, e-cigarettes have a particular appeal as an alternative to tobacco in such environments.

In B/CAP's view it is highly unlikely that any advertisement will be able to link e-cigarettes with illicit drugs in a way that is responsible and the ASA will have the capability to deal with any advertisement which does make that link under the general responsibility rule in this section, or by using rules that prevent harm.

6.3 Use in "unwise" situations.

Mirroring a rule in the Alcohol section of the Codes, B/CAP had also proposed, again on a precautionary basis, a rule which stipulated certain situations in which e-cigarettes should not be depicted because it would be unsafe or unwise. At the time of proposal they had considered that driving was one such circumstance, but had not identified any others and welcomed suggestions.

While B/CAP welcome the feedback provided by respondents, having reviewed it they do not consider that any of those specific suggestions (for example certain locations, in public vehicles) are so unambiguously harmful in all instances that they need to be precluded in the wording of the rule. Some of the suggestions would more appropriately be addressed under other Code rules e.g. rules which prevent anything that is "likely to condone or encourage an unsafe practice" (CAP) or "prejudice health and safety" (BCAP)[4]. With those

[4] The relevant rules can be found in Section 4 (Harm and Offence) of the CAP Code and Section 4 (Harm and Offence) of the BCAP Code.

protections already in place B/CAP consider that the rule is unnecessary and have elected not to implement it.

6.4 “18 and over” messages

B/CAP consulted on a rule which would require all advertisements to state that products were only suitable for those aged 18 years and over. B/CAP are aware that e-cigarette advertisements commonly include information making clear that the product is for sale only to consumers aged 18 or over. BCAP and CAP Codes do not typically prescribe specific informational messaging in advertisements. A rare example is the requirement in CAP Code rule 11.7 and BCAP Code rule 9.9 that advertisements for specific energy-related products must include the product’s energy efficiency class. Usually when compulsory messages appear in advertisements, it is because other regulators, such as the Financial Conduct Authority (FCA), require them.

While B/CAP welcome efforts that may further the objective of discouraging under 18s from purchasing e-cigarettes the Committees have previously had cause to question the overall value of warning messages[5]. Many consultation respondents shared B/CAP’s scepticism. In light of that and the available evidence, B/CAP consider that the limited effect of warning messages, when weighed against their potential to create warning fatigue, to have a result that is opposite to the one intended and their potential cost to advertisers, make the implementation of an 18 and over message unnecessary. B/CAP consider that the rules provided serve to offer sufficient protection to under 18s.

[5] Section 7 (proposed rule 11) of the original consultation document sets out in full CAP and BCAP’s view on compulsory warning messages.

7. Key decisions

7.1 Background

When setting rules B/CAP must take into account advertisers' right to impart information and audiences' right to receive information without undue interference. From this starting point, B/CAP may consider what restrictions, beyond the enduring principles that advertisements should not mislead, harm or offend, might be needed to reduce the potential for harm. In making decisions about the final rules in the light of a developing and relatively immature evidence base, B/CAP have had to weigh up the rights to impart and to receive information with the wide-ranging views of respondents. In that context, B/CAP consider the rules are both proportionate and defensible, but are mindful of the need to keep the rules under review; more information on that is provided in section 8.

The consultation responses raised a number of key concerns and themes, often repeatedly, in relation to different questions and proposed rules. B/CAP's evaluation of those and responses to the ancillary questions asked in the consultation are provided in this section.

7.2 Prohibiting references to tobacco branding

A number of respondents were concerned that B/CAP's proposed rules did not go far enough to prevent advertisements for e-cigarettes alluding to tobacco branding. B/CAP agree and have introduced an additional rule (rule 2) to prohibit ***"any design, imagery or logo style that might reasonably be associated in the audience's mind with a tobacco brand"***. This wording is a slight variation on that put forward by some respondents and does not include "colour" in the prohibitions. This recognises that colour is likely to be too broad a criterion and may well catch advertising executions that do not actually invoke a tobacco brand. Additionally the revised rule states tobacco "brand" instead of "product", recognising that e-cigarettes may naturally be associated in the audience's mind with a tobacco product without requiring their advertising to be prohibited.

7.3 Allowing responsible depictions of products, including on television

It is not uncommon for non-broadcast advertisements for e-cigarettes to depict e-cigarette products and e-cigarette paraphernalia e.g. boxes, refills etc. The CAP Code does not explicitly prohibit e-cigarettes being shown, or shown in use, in non-broadcast advertising, provided that such depictions are responsible and compliant with any other relevant rules. That situation will not change with the implementation of the new CAP rules.

Up until now the situation on television has been different. Section 10 of the BCAP Code prohibits advertisements for certain products and services, either because those products may not legally be advertised or because of a clear potential for harm or serious or widespread offence to the audience or to society. Within that section there are specific rules for tobacco products which are intended to prevent the indirect promotion of tobacco products, particularly through brandsharing across products (for example advertising a t-shirt with a tobacco brand logo). Reflecting the high degree of protection that BCAP and predecessor regulatory bodies have sought to offer in broadcast advertising (and particularly on television) those rules are more restrictive than those found in the relevant legislation or the CAP Code and, with the ASA obliged to apply them, their effect up until

now has been that e-cigarette marketers have not been able to show their products on television. This is an inadvertent and unintended function of those rules.

E-cigarettes are not a tobacco product and are not currently subject to the same legislative controls as tobacco; although B/CAP understands that restriction of sale to those aged 18 and over is imminent. E-cigarettes are also a product of legitimate interest for those looking to consume nicotine without tobacco. While B/CAP understands the concern expressed by many respondents about the representation of smoking-like behaviours, the Committees consider that there is not currently a case for prohibiting the responsible depiction of e-cigarettes, either in broadcast or non-broadcast media, including their depiction in use.

For that reason, BCAP will dis-apply the broad tobacco prohibition in section 10 specifically and only to advertisements which fall within the remit of the new e-cigarette rules. BCAP consider that the new rules, which have strong prohibitions about the indirect promotion of tobacco and which require advertisements to make clear that the product is an e-cigarette and not a tobacco product, achieve the right balance between the legitimate right to commercial speech and the need to protect audiences from potentially harmful material.

7.4 E-cigarettes as an alternative to tobacco

A number of respondents argued that e-cigarettes have a particular role as an alternative to tobacco and that B/CAP should therefore set rules to require that they always be described in that way in advertising. B/CAP however do not consider such a restriction to be proportionate.

While the Committees are mindful that e-cigarettes have a primary appeal to those looking for an alternative to smoking it is not B/CAP's role to dictate the proper use of a consumer good, nor are they aware of an evidence base which might require them to implement such a restriction. B/CAP have considered the issue of compulsory messages previously and again during this consultation, but not been persuaded by the evidence that they produce a worthwhile effect, particularly when weighed against the potential for warning fatigue, effects opposite to the ones intended and the issues and costs to advertisers stemming from the natural confines of time and space.[6] That is particularly the case in broadcast advertising. B/CAP have provided a separate rule which prohibits any explicit appeal to non-nicotine users.

7.5 Glamorisation and other specific creative treatments

A number of respondents suggested that B/CAP prohibit glamorisation or other specific types of creative treatment. B/CAP wish to set proportionate rules which allow marketers to use varied and creative approaches so long as those approaches are not particularly likely to be attractive to non-smokers or under-18s, and are not harmful, offensive or otherwise irresponsible. Given that the natural function of advertising is to present products in their best light, B/CAP consider that prohibiting glamorisation is too broad a criterion to be instructive to advertisers seeking to make responsible advertisements, or to the ASA when enforcing the rules.

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[6] For more information on B/CAP view on the role of compulsory messages see section 7.4 of this document and section 7 of the original consultation document.

Some respondents suggested that the rules replicate provisions provided in the Alcohol and Gambling sections of the Codes. For example, by prohibiting links with sexual success, or limiting their depiction in social situations. However, the content restrictions provided for alcohol and gambling reflect specific concerns that exist for those sectors. E-cigarettes present only some of the same concerns as alcohol and gambling and crucially there are strong arguments for the public health benefits of e-cigarettes. B/CAP therefore do not currently consider that the same content restrictions currently need to apply.

7.6 Prohibiting health claims

Many believe that e-cigarettes are less harmful than tobacco, precisely because they do not contain it. However, B/CAP understand that there is presently no evidential basis which demonstrates that conclusively. E-cigarettes do not currently have to meet any particular safety or efficacy standards, other than those which are common for consumer goods. In June 2013 the MHRA published the results of a consultation and further scientific market research into the safety and quality of unlicensed e-cigarettes. That work showed that across the market there was significant variability in the ingredients and nicotine delivered and an absence of evidence to suggest that they are safe and effective for their intended use.

The MHRA commented that *"Although it is reasonable to assume that using electronic cigarettes is a safer alternative than smoking tobacco cigarettes the long term safety of these components to the consumer remains unknown at this stage."*[7] B/CAP's own consultation indicates that situation has not changed and the prohibition received broad support from the public health community. In that light B/CAP consider that they currently need to set and communicate a broad prohibition on any claims that e-cigarettes are able to convey health benefits or that they are 'safer' or 'healthier' than smoking tobacco. This does not prevent marketers presenting their products as alternatives to tobacco, nor does it prevent them making factual statements about what the product does or does not contain: e.g. "no tar", "no tobacco"-type claims. This restriction does not apply to advertisements for e-cigarettes which are authorised by the MHRA, which may make claims consistent with the summary of product characteristics. Consistent with the ban on health claims, B/CAP have also added a separate rule which prohibits endorsement of products by health professionals.

7.7 Mirroring smokefree legislation

A number of respondents suggested that B/CAP implement a rule which would prohibit depictions of e-cigarette use in places where tobacco smoking was currently prohibited by law. However, B/CAP understands that while some workplaces and public venues have prohibited their use, others have not and the ability to use e-cigarettes in some of these settings is a legitimate part of the appeal of e-cigarettes for tobacco users seeking an alternative source of nicotine. B/CAP therefore does not wish to prohibit depictions of legitimate use of the product or, in so doing, take a view on where e-cigarettes may legitimately be used. Any direct or implied claims made in advertising about where

[7] MHRA: The Regulation of Nicotine Containing Products: Public Summary Report, 12 June 2013: http://www.mhra.gov.uk/home/groups/comms-ic/documents/websiteresources/con286834.pdf, p. 5

products may or may not be used will need to be responsible, substantiated and not misleading.

7.8 E-cigarettes which are licensed as medicines

Advertisers may obtain an authorisation for their product from the MHRA. Marketing for such products is subject to the rules in section 12 of the CAP Code and section 11 of the BCAP Code. Although such products will, by their nature, have had to meet particular standards of quality and safety, B/CAP considers that their advertising presents many of the same concerns as that for consumer electronic cigarettes. Specifically, they can look like tobacco products, are used in the same way and contain nicotine. For those reasons the new rules will apply to these products also.

7.9 E-cigarettes which do not contain nicotine and other vapour products

Application of the rules to products which don't contain nicotine received widespread support from consultation respondents and B/CAP considers that, irrespective of the presence or absence of nicotine, the nature of the product and the potential for harm, combined with the value of consistency in how they may be advertised warrants the rules being applied to such products also. Respondents were also keen to ensure that the rules applied to the full range of e-vapour products, such as e-shisha and e-hookah products. B/CAP have therefore provided a broad definition at the beginning of their respective Code section to catch all such products and have also made clear that the ASA may act if it encounters advertisements for novel products which do not meet the strict definition but which are sufficiently similar to present the same potential for harm.

7.10 Applicability to social media

A number of consultation respondents pointed out that the marketing of e-cigarettes on popular social networks is commonplace and queried whether or to what extent the new rules applied to such sites, and to online marketing generally.

The CAP Code applies to all marketing communications on companies' websites, or in other non-paid-for space online under their control, that are directly connected with the supply or transfers of goods or services. Where those criteria are met this would include posts on social media and the like. More information about the scope of the CAP Code can be found here.

8. Implementation and next steps

8.1 Implementation

It is the view of both CAP and BCAP that the new rules set proportionate and responsible standards and are in line with the more general, well established principles in both of their Codes, the legal framework and ASA adjudications. While CAP and BCAP do not consider that the new Code sections are difficult to comply with, they do accept that the e-cigarette industry will need a short period in which to ensure that their advertising is in line with the new rules.

In view of that the new CAP and BCAP Code rules and the modifications to the Tobacco rules in the BCAP Code will take effect on **Monday 10 November 2014** and the ASA will enforce compliance with them from that date. The general provisions in both Codes will continue to apply to e-cigarette advertising until then.

8.2 Review

CAP and BCAP will conduct a review of the rules after 12 months to assess whether they are working as intended and whether the evidence base has developed in a way which requires the Committees to reconsider any of the rules or augment them.

8.3 Announcements concerning the Tobacco Products Directive

As discussed in section 2.3, CAP and BCAP will make further announcements concerning the impact of the Tobacco Products Directive when more is known about its effect in the UK. Interested parties should monitor the CAP website and sign-up for relevant news alerts.

Annex A: CAP Code Section

Background

For the purposes of this section “electronic cigarette” means a product that is intended for inhalation of vapour via a mouth piece, or any component of that product, including but not limited to cartridges, tanks or e-liquids. The rules in this section apply to marketing communications for, and which refer to, electronic cigarettes and related products, including but not limited to e-shisha and e-hookah products, whether or not they contain nicotine.

The e-cigarette market continues to innovate rapidly and new products may emerge which may not be caught precisely by the above definition. The ASA may apply these rules in circumstances where it considers that an advertised product is sufficiently similar to warrant the protection provided by this section.

The majority of e-cigarettes are currently sold as consumer goods, however marketers may seek a medicines licence for their product from the Medicines and Healthcare products Regulatory Agency (MHRA). The rules in this section also apply to marketing communications for electronic cigarettes which are authorised by the MHRA. For products authorised as medicines, the rules in section 12 (Medicines, medical devices, health-related products and beauty products) also apply.

Depending on the formulation of their product and the means by which it is supplied, marketers may have obligations relating to their advertising under chemical classification, labelling and packaging legislation. Marketers are advised to take legal advice to ensure compliance with the relevant law.

The Tobacco Products Directive

Directive 2014/40/EU (on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC) is now in force but has not yet been given effect in UK law. The UK Government is required to transpose its provisions by 20 May 2016, with a further transitional period for non-compliant e-cigarette products until 20 November 2016. Those provisions include restrictions on advertising. The rules in this section do not pre-empt the requirements of the Directive but serve as an interim measure. When more is known about the application of the Directive in the UK, CAP will clarify what role its Code will have after the new law has been given effect.

Rules

1. Marketing communications for e-cigarettes must be socially responsible.

2. Marketing communications must contain nothing which promotes any design, imagery or logo style that might reasonably be associated in the audience’s mind with a tobacco brand.

3. Marketing communications must contain nothing which promotes the use of a tobacco product or shows the use of a tobacco product in a positive light. This rule is not intended to prevent cigarette-like products being shown.

4. Marketing communications must make clear that the product is an e-cigarette and not a tobacco product.

5. Marketing communications must not contain health or medicinal claims unless the product is authorised for those purposes by the MHRA. E-cigarettes may be presented as an alternative to tobacco but marketers must do nothing to undermine the message that quitting tobacco use is the best option for health.

6. Marketers must not use health professionals to endorse electronic cigarettes.

7. Marketing communications must state clearly if the product contains nicotine. They may include factual information about other product ingredients.

8. Marketing communications must not encourage non-smokers or non-nicotine-users to use e-cigarettes.

9. Marketing communications must not be likely to appeal particularly to people under 18, especially by reflecting or being associated with youth culture. They should not feature or portray real or fictitious characters who are likely to appeal particularly to people under 18. People shown using e-cigarettes or playing a significant role should not be shown behaving in an adolescent or juvenile manner.

10. People shown using e-cigarettes or playing a significant role must neither be, nor seem to be, under 25. People under 25 may be shown in an incidental role but must be obviously not using e-cigarettes.

11. Marketing communications must not be directed at people under 18 through the selection of media or the context in which they appear. No medium should be used to advertise e-cigarettes if more than 25% of its audience is under 18 years of age.

Annex B: New BCAP Code Section and Scheduling rule amendments

Background

For the purposes of this section “electronic cigarette” means a product that is intended for inhalation of vapour via a mouth piece, or any component of that product, including but not limited to cartridges, tanks or e-liquids. The rules in this section apply to marketing communications for, and which refer to, electronic cigarettes and related products, including but not limited to e-shisha and e-hookah products, whether or not they contain nicotine.

The e-cigarette market continues to innovate rapidly and new products may emerge which may not be caught precisely by the above definition. The ASA may apply these rules in circumstances where it considers that an advertised product is sufficiently similar to warrant the protection provided by this section.

The majority of e-cigarettes are currently sold as consumer goods, however marketers may seek a medicines licence for their product from the Medicines and Healthcare products Regulatory Agency (MHRA). The rules in this section also apply to marketing communications for electronic cigarettes which are authorised by the MHRA. For products authorised as medicines, the rules in section 11 (Medicines, medical devices, treatments and health) also apply.

Depending on the formulation of their product and the means by which it is supplied, marketers may have obligations relating to their advertising under chemical classification, labelling and packaging legislation. Marketers are advised to take legal advice to ensure compliance with the relevant law.

The Tobacco Products Directive

Directive 2014/40/EU (on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC) is now in force but has not yet been given effect in UK law. The UK Government is required to transpose its provisions by 20 May 2016, with a further transitional period for non-compliant e-cigarette products until 20 November 2016. Those provisions include restrictions on advertising. The rules in this section do not pre-empt the requirements of the Directive but serve as an interim measure. When more is known about the application of the Directive in the UK, BCAP will clarify what role its Code will have after the new law has been given effect.

Rules

1. Advertisements for e-cigarettes must be socially responsible.

2. Advertisements must contain nothing which promotes any design, imagery or logo style that might reasonably be associated in the audience’s mind with a tobacco brand.

3. Advertisements must contain nothing which promotes the use of a tobacco product or shows the use of a tobacco product in a positive light. This rule is not intended to prevent cigarette-like products being shown.

4. Advertisements must make clear that the product is an e-cigarette and not a tobacco product.

5. Advertisements must not contain health or medicinal claims unless the product is authorised for those purposes by the MHRA. E-cigarettes may be presented as an alternative to tobacco but marketers must do nothing to undermine the message that quitting tobacco use is the best option for health.

6. Advertisements must not use health professionals to endorse electronic cigarettes.

7. Advertisements must state clearly if the product contains nicotine. They may include factual information about other product ingredients.

8. Advertisements must not encourage non-smokers or non-nicotine-users to use e-cigarettes.

9. Advertisements must not be likely to appeal particularly to people under 18, especially by reflecting or being associated with youth culture. They should not feature or portray real or fictitious characters who are likely to appeal particularly to people under 18. People shown using e-cigarettes or playing a significant role should not be shown behaving in an adolescent or juvenile manner.

10. People shown using e-cigarettes or playing a significant role must neither be, nor seem to be, under 25. People under 25 may be shown in an incidental role but must be obviously not using e-cigarettes.

11. **Radio Central Copy Clearance** – Radio broadcasters must ensure advertisements for e-cigarettes are centrally cleared.

Amendment to existing rule 32.2(.7)[8]:

> **32.2** These may not be advertised in or adjacent to programmes commissioned for, principally directed at or likely to appeal particularly to audiences below the age of 18:
> **…**
>
> **32.2.7** electronic cigarettes

[8] The full text of BCAP Code Section 32 (Scheduling) can be found here.

Annex C: Amendments to BCAP Code section 10 (Prohibited categories)

[Amendments shown in underlined text]

10.1 Advertisements for products or services coming within the recognised character of or specifically concerned with these are not acceptable:

…

10.1.3 all tobacco products. Also non-tobacco products or services that share a name, emblem or other feature with a tobacco product (as provided for by rule 10.4), rolling papers and filters. This rule does not apply to advertisements for electronic cigarettes which are regulated by section 33.

Tobacco

These rules do not apply to advertisements for electronic cigarettes which are regulated by section 33.

10.3 Advertisements must not promote smoking or the use of tobacco products.

10.4 If it shares a name, emblem or other feature with a tobacco product, a non-tobacco product or service may be advertised only if the advertisement is obviously directly targeted at an adult audience, makes or implies no reference to smoking or to a tobacco product, does not promote tobacco or smoking and does not include a design, colour, imagery, logo style or the like that might be associated in the audience's mind with a tobacco product.

10.5 Advertisements that might be of particular interest to children or teenagers must not refer to tobacco or smoking, unless that reference obviously forms part of an anti-smoking or anti-drugs message.

Contact us

Committee of Advertising Practice
Mid City Place, 71 High Holborn
London WC1V 6QT

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

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

Evidence from the British Heart Foundation – PHB 101 / Tystiolaeth gan Sefydliad Prydeinig y Galon – PHB 101

Consultation on the Public Health (Wales) Bill

Response from the British Heart Foundation (BHF) Cymru, September 2015

British Heart Foundation (BHF) Cymru is the nation's leading heart charity. We are working to achieve our vision of a world in which people do not die prematurely or suffer from cardiovascular disease. In the fight for every heartbeat we fund groundbreaking medical research, provide support and care to people living with cardiovascular disease and advocate for change and improvement in services and care.

We are actively involved in tobacco control issues because of the strong association between smoked tobacco and ill-health including cardiovascular disease (CVD). Smoking is a major risk factor for CVD, and smokers are almost twice as likely to have a heart attack as non-smokers. Each year in Wales, an estimated 5,600 smokers die as a result of smoking and around 28,000 hospital admissions are attributed to smoking.[1]

BHF welcomes the opportunity to respond to this consultation. We are supportive of the Government proposal to establish a register of tobacco retailers. We believe that measures of this kind are useful in countering the illicit trade and underage sales and also provide valuable data which can support tobacco control research.

However, we have significant concerns about the way in which this consultation approaches the issue of e-cigarettes. The Welsh Government explicitly states that its aim is to bring regulation of e-cigarettes in line with existing restrictions on smoking. We believe that this goal is fundamentally flawed as it is based on the assumption that cigarettes and e-cigarettes are essentially equivalent in terms of public health harm. This is not the case.

E-cigarettes have the potential to act as one of a range of options for smokers to use to support their quit efforts. Although research on this is at an early stage, early indications are that e-cigarettes may be effective as a smoking cessation aid.[2]

[1] Chief Medical Officer for Wales Annual Report 2009 & Patient Episode Database for Wales (smoking-attributable fractions published by NHS Information Centre), 2010.
[2] McRobbie, H., et al., Electronic cigarettes for smoking cessation and reduction. Cochrane Database Syst Rev, 2014. 12: p. CD010216.

While we recognise that the safest behaviour for any individual is neither to smoke nor to use e-cigarettes, the scale of risk between the two products is not equivalent. Current best estimates are that e-cigarettes are around 95% safer than cigarettes.[3] To regulate two products with such different levels of risk in the same way is misleading and may act to disincentivise smokers from switching to e-cigarettes.

Smokefree legislation applying to tobacco products is underpinned by the health risks posed by passive smoking. No equivalent risks have been demonstrated for e-cigarettes.[4] Arguments to extend the legislation to include e-cigarettes tend to focus on concerns around renormalisation of smoking, but this was not the underpinning argument for the original legislation. It is not robust policy making to extend legislation to new product using a fundamentally different rationale from the one which underpinned the original arguments.

There have been concerns expressed for some time that e-cigarettes have the potential to act as a gateway product for children into smoking. However, current trends demonstrate that use of e-cigarettes among non-smoking under 18s is negligible.[5] It is crucial that we continue to monitor usage data on these trends so that we can observe any changes in patterns, particularly among young people and non-smokers, and react accordingly.

It is important to recognise that, as a new product, evidence on e-cigarettes continues to emerge and, in this context, we must remain vigilant. It is important that we monitor emerging using trends and continue to research potential side effects and long term health consequences of e-cigarette use. We would welcome the Welsh Government's continued engagement in this process.

Cigarettes kill one in two of their long-term users. A smoker switching from cigarettes to e-cigarettes is moving from a more to a less risky behaviour and it is wrong to seek to discourage this. While there remain considerable uncertainties around these products and caution must be exercised in monitoring and regulating them, it is heavy handed and not evidence based to seek to regulate them as if they were cigarettes. As such, we believe that these proposals will not improve public health in Wales and may, in fact, have the potential to damage it. We would urge the Welsh Government to reconsider its approach.

The BHF is also a signatory to a joint response on the general principles of the Public Health (Wales) Bill, which has been drafted by a number of public health organisations in Wales. We would like to restate our endorsement of this response here, in particular the need for the Welsh Government to consider diet and obesity in its work on public health.

To discuss this consultation response in more detail, please contact Jennifer Boon, Policy Manager, Research and Prevention, on [redacted]

[3] E-cigarettes: an evidence update: A report commissioned by Public Health England p.6
[4] Britton, J. and I. Bogdanovica, Electronic cigarettes: A report commissioned by Public Health England. London: Public Health England, 2014 – p.14
[5] E-cigarettes: an evidence update: A report commissioned by Public Health England – p.31

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

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

Evidence from the Welsh Medical Committee – PHB 102 / Tystiolaeth gan Bwyllgor Meddygol Cymru – PHB 102

Response to Public Health Bill as introduced.

Comments on behalf of the Welsh Medical Committee.

This Bill is welcome, though much diminished from the ambitious but overwhelmingly supported green and white papers.

The individual sections are sensible and reasonable.

It is regrettably noticeable that the legislation makes no suggestion as to how evaluate the effect of the Bill once it is enacted. Since the doctors and all health other professionals are being required to provide evidence of its effectiveness, it is a strange omission that legislation with the associated public cost implications has no such requirement to provide evidence of its effectiveness.

If not contained in the face of the bill it would be a welcome improvement if the regulations contained a mechanism by which the effectiveness or otherwise of the legislation will be assessed (outcomes sought and by when would be the minimum.)

If this were to be done then Wales once more will be leading the UK in this aspect of health legislation.

In relation to special procedures the harm caused by unsafe piercing practices has been ignored for too long. And this Bill should help prevent an avoidable epidemic of liver disease including malignancy linked to infection.

The approach proposed for handing Tobacco products to children is again sensible and reasonable, and merely refines the current situation to correct the inconsistencies that have emerged with changes in technology and social patterns.

The ENDS or e-cigarette aspect is the most controversial. It is curious how a product that has never been tested for therapeutic use, and is currently (and correctly) unlicensed for this use is being promoted by its manufacturers as a recreational product. But promoted in the media as a therapeutic aid! The comments by PHE have received wide publicity and some assembly members have used this as evidence to reject the proposal. This would be a tragedy.

Similar argument about reduced toxicity were used in the past to support the release of Heroin as a substitute for Laundanum, and more recently Bruphenorphene for Heroin.

Careful reading of the PHE report does not advance good quality evidence that ENDS help people stop smoking, even in therapeutic controlled environments.

The history of the development of ENDS suggests this was not the intended use. It was developed in China as a safer product to the growing dependence of large sections of the workforce on cigarettes. By transferring the sales to ENDS the growth in addiction would hopefully be accompanied by reduced increase in harm. Thus the intention was not to reduce smoking or tobacco consumption or Nicotine addiction but to make it less harmful. If the UK was still in a Tobacco Growth stage, then this would have some validity. However, after 400 years, the UK has moved to reduce the harms tobacco causes and has made big strides in reducing tobacco consumption. This has been despite the efforts of Tobacco companies to outmanoeuvre those seeking to protect public health. That companies who have made fortunes over the years from selling products that kill when used in the manner intended should seek to maintain their viability by diverting in to less harmful products is to be expected, but the product is still not safe in unrestricted use. (95% less dangerous than the major cause of premature death in Wales)

That a recent paper[1] from the peer reviewed journal JAMA reported a cohort study in adolescent children confirmed that the concerns that E-cigs are associated with increased uptake of burning tobacco products has debunked the theory that there is no gateway effect. (There was a threefold increase in combustible tobacco use in those who used E-cigs compared to their peers who did not after 12 months follow up.)

That does not mean that in a therapeutic setting they may not have use, when a licensed product has been developed, tested and approved then trials will demonstrate its effectiveness or otherwise in use in the real world.

Such a study is being undertaken and until that has been reported it would be premature to add a recreational product to the list of treatments the NHS has to supply.

I trust the Welsh Assembly will support the Welsh Minister and support this bill in all its parts, perhaps with the addition of an evaluative section, to ensure we continue to reduce the burden of ill health borne by the current and future populations of Wales, and so reduce the drain that ill health places on both social and economic prosperity of those AM's represent. The alternative is to ensure future generations are condemned to life that is both less pleasant and shorter than could be achieved.

Dr Mark Temple

GMC reg number 2488589

Reference List

(1) Leventhal AM, Strong DR, Kirkpatrick MG. Association of electronic cigarette use with initiation of combustible tobacco product smoking in early adolescence. *JAMA* 2015; 314(7):700-707.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

SICRHAU GWELLIANT TRWY AROLYGU ANNIBYNNOL A GWRTHRYCHOL

4 September 2015

Response to the consultation on the Public Health (Wales) Bill

Healthcare Inspectorate Wales (HIW) welcomes the opportunity to contribute evidence to the consideration of the general principles of the Public Health (Wales) Bill.

The role of HIW is set out at Annex 1.

Part 2: Tobacco and Nicotine Products

Part 2 of the Bill includes provisions relating to tobacco and nicotine products, these include placing restrictions to bring the use of nicotine inhaling devices (NIDs) such as electronic cigarettes (e-cigarettes) in line with existing restrictions on smoking; creating a national register of retailers of tobacco and nicotine products; and prohibiting the handing over of tobacco or nicotine products to a person under the age of 18.

HIW does not have a specific view on Part 2.

Part 3: Special Procedures

Part 3 of the Bill includes provision to create a compulsory, national licensing system for practitioners of specified special procedures in Wales. These procedures are acupuncture, body piercing, electrolysis and tattooing.

- 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?

However, it will be important to align the language used in this Bill to the language used in other proposed legislation relating to regulation and inspection. The language used in both the recent Regulation and Inspection of Social Care (Wales) Bill and the 'Our Health, Our Health Service' Green Paper identifies a move towards registration and inspection based on 'services' rather than 'establishments'. In proposing to create a licensing

system for individual practitioners and approving the premises or vehicle from which the practitioner operates, this Bill appears to have taken a different approach to regulation.

HIW is responsible for the registration and inspection of services where a Class 3B or 4 laser or Intense Pulse Light (IPL) machine is used. Such equipment can sometimes be found in establishments who undertake tattooing, as tattoo removal can be conducted using a laser. HIW ensures that these services comply with the requirements of the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the National Minimum Standards for Independent Health Care Services in Wales.

HIW conducts a pre-registration visit to these establishments to ensure the safety of the premises and to ensure that policies and procedures are in place to protect patients. HIW then conducts inspections every three years, when we review the service provided to individuals, including infection *prevention and* control procedures.

Under the Local Government (Miscellaneous Provisions) Act 1982, as amended by the Local Government Act 2003, local authorities are responsible for regulating and monitoring businesses offering body piercing and tattooing. Local authorities have the powers to inspect any premises that carry out piercing or tattooing, to make sure that they are observing local byelaws that relate to the hygiene of their premises, staff and equipment.

There is therefore overlap between the work of the local authority in monitoring businesses offering tattoos, and HIW's work in inspecting premises where there is a laser/IPL in use. HIW has established links with some local authorities who share intelligence about tattoo or body piercing establishments in their area who use lasers.

Consideration will need to be given to ensuring that any new system proposed under this Bill operates efficiently. Providers will need clarity as to where they need to register, and as to which standards they are expected to meet. The public will require clarity as to where the service should be registered, and which public body will be monitoring it. There will also need to be clarity to avoid two public bodies monitoring the same service at the same time.

The focus of this Bill is on managing health related risks so the individuals assessing the practitioner's suitability for a licence, and the premises from where they operate, will need to have expertise in assessing standards of infection control.

HIW believes there are benefits in creating a compulsory licensing system for practitioners of special procedures. A national register would be helpful as all information would be held in one place.

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

HIW acknowledges the potential risks associated with the types of special procedures defined in the Bill. However, there are other procedures not currently subject to regulation which could also be considered. For example, skin treatments such as botox, dermal fillers and chemical peels. Services providing these treatments are not required to register with HIW under the Independent Health Care (Wales) Regulations 2011. HIW notes that the UK Government is considering legislation in respect of cosmetic interventions.

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

It will be important for Ministers to have flexibility to include new procedures to the list of special procedures, so that they can be subject to the same licensing scheme and patients can be assured of the safety of the services they receive. However, we question whether there is a need for the special procedures to be itemised in this primary legislation. It may be more appropriate to define the list in secondary legislation so that it can be amended more easily should changes be required.

- 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?

Although the list of exempted individuals includes professions who should have received sufficient training in, for example, infection *prevention and* control, there is no requirement for training relating to these special procedures. Registration with a professional body such as the General

Chiropractic Council, does not automatically equate to fitness to practise a procedure such as acupuncture.

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

The licensing system should be effective for legitimate individuals and premises. However, there will be challenges for local authorities in identifying those providers of services who are practising 'under the radar'. HIW has links with local authorities who share intelligence about tattoo or body piercing establishments in their area who use lasers. Despite this, HIW has had challenges in identifying establishments using laser equipment which are not registered with HIW. HIW has conducted and continues to conduct visits to potentially unregistered providers identified from intelligence, these have resulted in a number of providers then registering and complying with the regulations.

Consideration will need to be given to aligning enforcement activities where an establishment is subject to the provisions of this Bill and the Independent Health Care (Wales) Regulations 2011.

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

A system of effective regulation and inspection can lead to improved public health in Wales. Where a practitioner is operating in an unsafe manner, particularly in relation to infection prevention and control, this can potentially lead to a significant, albeit local, public health issue. HIW has uncovered such issues when conducting inspections where we have found unsafe decontamination procedures. In such examples the services temporarily stopped practising; health boards implemented immediate training and support for the staff; and our findings were referred to public health colleagues for a determination as to the risk to patients and what action should be taken as a result.

Part 4: Intimate Piercing

Part 4 of the Bill includes provision to prohibit the intimate piercing of anyone under the age of 16 in Wales.

HIW does not have a specific view on Part 4.

Part 5: Pharmaceutical Services

Part 5 of the Bill includes provision to require each local health board to publish an assessment of the need for pharmaceutical services in its area with the aim of ensuring that decisions about the location and extent of pharmaceutical services are based the pharmaceutical needs of local communities.

- Do you believe the proposals in the Bill will achieve the aim of improving the planning and delivery of pharmaceutical services in Wales?
- What are your views on whether the proposals will encourage existing pharmacies to adapt and expand their services in response to local needs?
- Do you believe the proposals relating to pharmaceutical services in the Bill will contribute to improving public health in Wales?

We support the aim to maximise the public health role of pharmacies. This would compliment the Welsh Government's plan for primary care services, to provide more care closer to people's homes.

In order to avoid duplication, the Pharmaceutical Needs Assessment should complement the local wellbeing assessment which the health board must produce according to the provisions of the Wellbeing of Future Generations Act 2015. The success of these plans in improving the planning and delivery of pharmaceutical services in Wales will depend on their quality.

Part 6: Provision of Toilets

Part 6 of the Bill includes provision to require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.

HIW does not have a specific view on Part 6.

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.)
- 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?
- What financial impact will the Bill's proposals have on you/your organisation?
- 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?
- 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?

HIW does not have a specific view on this.

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?

There appears to be a lot of detail on the face of the bill relating to special procedures. Given that regulations are required, for example, to set out licensing criteria, could more of the detail have been left for inclusion in the regulations? It may afford greater flexibility for the future if the particular activities that constitute 'special procedures' are defined in regulations which can be more easily updated to reflect current trends.

Other comments

- Are there any other comments you wish to make about specific sections of the Bill?
- Do you believe that the issues included in this Bill reflect the priorities for improving public health in Wales?
- Are there any other areas of public health which you believe require legislation to help improve the health of people in Wales

There are a number of pieces of legislation currently being considered which impact upon the regulation and inspection of health and care related services and issues. It will be important to ensure that any new legislation is joined up and makes sense to the public and where appropriate to patients. This Bill should therefore be carefully considered and cross-referenced in light of the provisions of the Regulation and Inspection of Social Care (Wales) Bill and the 'Our Health, Our Health Service' Green Paper.

Annex 1

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales.

Purpose

To provide the public with independent and objective assurance of the quality, safety and effectiveness of healthcare services, making recommendations to healthcare organisations to promote improvements.

Values

- **Patient-centred:** we place patients, service users and public experience at the heart of what we do
- **Openness and honesty:** in the way we report and in all our dealings with stakeholders
- **Collaboration**: building effective partnerships internally and externally
- **Professionalism**: maintaining high standards of delivery and constantly seeking to improve
- **Proportionality:** ensuring efficiency, effectiveness and proportionality in our approach.

Outcomes

Provide assurance:

Provide independent assurance on the safety, quality and availability of healthcare by effective regulation and reporting openly and clearly on our inspections and investigations.

Promote improvement:

Encourage and support improvements in care through reporting and sharing good practice and areas where action is required.

Strengthen the voice of patients:

Place patient experience at the heart of our inspection and investigation processes.

Influence policy and standards:

Use our experience of service delivery to influence policy, standards and practice.

Health and Social Care Committee

Public Health (Wales) Bill

Special procedures – video evidence

The Welsh Government feel that because of the reported health risks connected to these procedures, it is important that practitioners employ safe working practices, and particularly that good infection control practices are followed at all times, so that both clients and practitioners are protected.

Answer:- to do this you must standardise procedure requirements with inside knowledge from practitioners

1. What are your views on creating a compulsory, national licensing system for practitioners of specified special procedures in Wales?

See Above : if the system is ill informed it will be pointless

It also does not address the main problem which is unlicensed practitioners

2. In what way do you think creating a compulsory, national licensing system will affect your business?

It will increase costs on an already stretched industry the legal skilled operators are being penalised for the cheap untrained or unlicensed or budget operators

This must be delivered at low cost with the fining of unlicensed operations helping fund the checks!!

A system of more regular checks should be put in place for those operating at below par

Less frequent for higher standard studios

This would prove to be more cost effective

3. In what way do you think creating a compulsory licensing system will affect standards?

It could help increase standards but only if it is well informed and efficient

Special procedures are currently defined as acupuncture, body piercing, electrolysis and tattooing, for the purposes of the Bill.

4. Do you agree with the types of special procedures included in the Bill? Do you think any other procedures should be included?

Laser tattoo removal should be removed from the remit of the HIW as it is proving to be a anti competition issue with English studios and provides a lack of service to Welsh needs and is driving Welsh consumers to try dangerous removal practices at home and with licensed and unlicensed practitioners

This is because laser removal has become expensive in Wales due to unnecessary expensive annual licensing it is totally unreasonable to expect a tattoo studio to register as a small hospital!!! It becomes cost inefficient to offer a much needed service and drives consumers underground!

You must also include branding scarification and extreme body modification in this new bill.... Do you even know this exists?

The Bill includes a provision which gives Welsh Ministers the power to amend this list of special procedures through further laws in the future.

5. What are your views on this?

Again as long as it's done with inside knowledge and expertise all good

The Bill provides that local authorities are to be responsible for enforcing the licensing requirements, and for keeping a register of special procedures licences issued by them and premises/vehicles that they have approved. A local authority must make the information on the register open to the public.

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

You must provide the local authority with industry specific training and an easy to use and understand checklist this would make the system efficient

A rating system that is published as in catering establishments with more frequent visits for low scoring studios would give incentives to improve standards but there must be some lines drawn where out of date inks needles should be removed ect

Tiger waste collections sharps bins and autoclaving practices if breached should be no go Items and licenses must be temporarily suspended until issues rectified!

Do you know that we generate Tiger waste and of course the needles razors must be disposed in a sharps bin and collected by a licensed waste collector.. This does not always happen in studios

If you are not a fully disposable studio you should have a vacuum autoclave I cannot see how unpackaged items and tools are allowed! All tattoo supplies and some piercing tools are now available as fully disposable options with the unknown consequence of CJD it may be only a matter of time until we are forced down the all disposable route

Good safe reprocessing of instruments is a skilled operation and easy to get wrong or misunderstand the consequences of getting it wrong are infecting clients or operators!

Of course one shot disposable needles are an industry standard but it's not clear that all studios still follow this it's only a small minority that transgress but it still happens

All reusable tips, tubes, grips and piercing tools should be carefully cleaned packaged and autoclaved

Hawk grips are not autoclaved as the tip and needle cartridge is a fully sealed unit

Tattoo machines cannot be autoclaved but they can be carefully cleaned with a hard surface wipe (I then put mine in a Uv steriliser in between clients)

Tattoo machines can be bagged as can clip cords but this can lead to more contamination especially on coil machines as contaminates are trapped in the bag as they aerosol up the tube

also bagging can lead to a false sense of security and means machines don't get cleaned properly! It's a grey area and totally impossible to legislate for! But by having a mentor program we would have a chance to pass on some good practices

There should be a cohesive policy to prevent underage tattooing this becoming more difficult as people are going to extraordinary lengths to fraudulently access under age tattooing

We could do with a one standard of to be tattooed you must have a photo ID from an approved list (to prevent fraud) they do this in New York and it works well this has to be compulsory and in law to work

At the moment we only have to believe that the person is telling the truth it's vague and woolly and puts us under unreasonable pressure

And there are STILL some tattooers that believe that they can tattoo minors with their parents consent!!! It has been illegal to knowingly tattoo anyone under 18 since 1969!!!

MOST IMPORTANT

You will never take the industry with you if you don't make some attempt to put a stop to illegal unlicensed tattooing, tattoo parties ect

Final thoughts

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

NO not without a full rethink of tattooing and piercing practices.

If you just do a botched nationwide licence and inspection bill it will put legal tattooing in more financial trouble in fact it could drive more people underground if licensing costs overburdens the already stretched legal practitioner the real issues are with unlicensed practitioners, tattoo parties and home kit tattooing with easily available tattooing and piercing supplies from all supply houses and eBay!!!

Also it does not address untrained tattooist setting up legal studios!

Anyone of you could set up a legal studio tomorrow with no training and cheap supplies as long as you fulfil the requirements of EH licensing!!!

In the states they have an apprenticeship licence where a mentor with at least 5 years preferable 7 years experience mentors an apprentice for two years before they can have a full licence (Most tattooists give up/go out of business before 5 years!!! The tattoo club of Great Britain won't take you as a member before 7years of licensed work)

If you come from another country I.e. England ...you have to present your licence and show 2 years of financial records to prove you have been working as a tattooist if you want to move apprenticeship you have to have a letter from your mentor, they do this in the states and it's starting to work

In the states to keep your licence you have to do an annual online first aid course and blood born pathogen (BBP) course the Red Cross do an online course for $25

None of this would guarantee you a "good" tattoo but it would dissuade some of the idiots !!!!

You would have to give grandfather rights to those already operating but bit by bit it would start to address flyby night set ups and at least make an attempt to stop this rampant problem and hopefully slowly increase standards and limit the proliferation of these untrained studios

Hope this helps if you need to clarify anything or have any part of good tattoo practice demonstrated or explained let me know