

Agenda – Health and Social Care Committee

Meeting Venue:

Committee Room 4 – Tŷ Hywel

Meeting date: 1 October 2015

Meeting time: 09.10

For further information contact:

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At its meeting on 23 September 2015 the Committee resolved under Standing Orders 17.42(ix) to exclude the public for item 1 of the meeting on 1 October

1 The Committee's forward work programme

(09.10 – 09.30)

(Pages 1 – 9)

2 Introductions, apologies and substitutions

(09.30)

3 Public Health (Wales) Bill: evidence session 13

(09.30 – 10.15)

(Pages 10 – 36)

Dr Steven Macey, Action on Smoking and Health (ASH) Wales Cymru

Jamie Matthews, Action on Smoking and Health (ASH) Wales Cymru

4 Public Health (Wales) Bill: evidence session 14

(10.15 – 11.05)

(Pages 37 – 43)

Professor Linda Bauld, Cancer Research UK

Professor John Britton, UK Centre for Tobacco and Alcohol Studies and Consultant in Respiratory Medicine, University of Nottingham and Nottingham City Hospital

Break (11.05 – 11.20)



5 Public Health (Wales) Bill: evidence session 15

(11.20 – 12.10)

Evidence session with Professor Peter Hajek, UK Centre for Tobacco and Alcohol Studies, and co-author of the Public Health England commissioned report 'E-cigarettes: an evidence update'

Lunch (12.10 – 13.00)

6 Public Health (Wales) Bill: evidence session 16

(13.00 – 13.50)

(Pages 44 – 50)

Dr Phil Banfield, British Medical Association (Wales)

Dr Iain Kennedy, British Medical Association (Wales)

Royal College of Physicians (representative to be confirmed)

7 Public Health (Wales) Bill: evidence session 17

(13.50 – 14.20)

(Pages 51 – 53)

Professor Alan Maryon-Davis, UK Faculty of Public Health

8 Papers to note

(14.20)

Minutes of the meetings on 17 and 23 September 2015

(Pages 54 – 61)

Public Health (Wales) Bill: additional information

(Pages 62 – 72)

9 Motion under Standing Order 17.42(vi) and (ix) to resolve to exclude the public from the remainder of this meeting and item 1 of the meeting on 7 October 2015

(14.20)

10 Public Health (Wales) Bill: consideration of evidence

(14.20 – 14.50)

Document is Restricted

Agenda Item 3

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

Document is Restricted



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 smoking², 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 al⁶ 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 Wales¹⁰ and Moore et al¹¹, 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 smoke¹⁸, 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 devices 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 premises¹² and we should be adopting similar guidance in Wales.

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

We agree with the proposal for a national retail register of retailers of tobacco and nicotine products. We would favour retailers of tobacco to be on a separate register from retailers 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 retailers 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 retailers. 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 retailers 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 retailers.

- 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 retailers of tobacco and nicotine products will hold retailers 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 retailers 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 retailers 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 Cancer Research UK – PHB 43 / Tystiolaeth gan Ymchwil Cancer
 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 UK¹

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 WHO².

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 tobacco³. 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 uptake⁶. 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 tobacco⁷. 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 smoking⁸. 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 policies¹⁴¹⁵. 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 bans¹⁷.
14. A number of media reports have noted the practical difficulty of enforcing the smokefree policies in NHS sites across Scotland¹⁸¹⁹²⁰. 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 in 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 Scotland³¹, Northern Ireland³² and The Republic of Ireland³³. 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 ban³⁶ 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 products¹.

¹ 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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[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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O'r is-lywydd yr RCP dros Gymru
Dr Alan Rees MD FRCP

From the RCP registrar
O'r cofrestrydd yr RCP
Dr Andrew Goddard FRCP

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



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 it does not provide a pathway for people to start smoking cigarettes.



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.



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 (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 understood 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.

- 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.



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



Faculty of Public Health

Agenda Item 7

Of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's 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 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
SeneddHealth@Assembly.Wales

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 Paper¹ 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 emphasises 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/1lz8M0i>

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].

Agenda Item 8.1

Concise Minutes – Health and Social Care Committee

Meeting Venue:

Committee Room 3 – Senedd

Meeting date: 17 September 2015

Meeting time: 09.29 – 14.07

This meeting can be viewed

on [Senedd TV](#) at:

<http://senedd.tv/en/3223>

Attendance

Category	Names
Assembly Members:	David Rees AM (Chair) Alun Davies AM John Griffiths AM Altaf Hussain AM Elin Jones AM Lynne Neagle AM Gwyn R Price AM Lindsay Whittle AM Kirsty Williams AM
Witnesses:	Dr Rodney Berman, British Medical Association Dr Stephen Monaghan, British Medical Association Dr Jane Fenton–May, Royal College of General Practitioners Wales Paul Burgess, British Association of Cosmetic Nurses Andrew Rankin, British Association of Cosmetic Nurses Ashton Collins, Save Face



	<p>Brett Collins, Save Face</p> <p>Dr Fortune Ncube, Consultant Epidemiologist and Consultant in Public Health Medicine</p> <p>Nick Pahl, British Acupuncture Council</p> <p>Sarah Calcott, British Body Piercing Association</p> <p>Lee Clements, British Tattoo Artist Federation</p>
Committee Staff:	<p>Llinos Madeley (Clerk)</p> <p>Catherine Hunt (Second Clerk)</p> <p>Sian Giddins (Deputy Clerk)</p> <p>Gareth Howells (Legal Adviser)</p> <p>Amy Clifton (Researcher)</p> <p>Philippa Watkins (Researcher)</p>

Transcript

View the [meeting transcript](#).

1 Introductions, apologies and substitutions

1.1 Apologies were received from Darren Millar.

2 Public Health (Wales) Bill: evidence session 6

2.1 Apologies were received from Dr Dyfed Huws. Dr Rodney Berman attended in his place.

2.2 The witnesses responded to questions from Members.

2.3 The British Medical Association agreed to provide the Committee with:

- the papers which were referenced during the evidence session; and
- information on how countries such as Norway, Sweden and South Australia have implemented health impact assessments through legislation.

- 3 Public Health (Wales) Bill: video of evidence gathered regarding Part 3 (Special Procedures)**
- 3.1 The Committee noted the [evidence gathered](#).
- 4 Public Health (Wales) Bill: evidence session 7**
- 4.1 The witnesses responded to questions from Members.
- 5 Public Health (Wales) Bill: evidence session 8**
- 5.1 The witness responded to questions from Members.
- 6 Public Health (Wales) Bill: evidence session 9**
- 6.1 The witness responded to questions from Members.
- 7 Public Health (Wales) Bill: evidence session 10**
- 7.1 The witnesses responded to questions from Members.
- 8 Papers to note**
- 8.1 Minutes of the meetings on 9 and 15 July 2015**
- 8.1a The Committee noted the minutes of the meetings on 9 and 15 July 2015.
- 8.2 Public Health (Wales) Bill: additional information from the Minister for Health and Social Services**
- 8.2a The Committee noted the additional information.
- 8.3 Public Health (Wales) Bill: consultation responses**
- 8.3a The Committee noted the consultation responses.
- 8.4 Regulation and Inspection of Social Care (Wales) Bill: the Minister for Health and Social Services response to the Committee's Stage 1 report**
- 8.4a The Committee noted the response.
- 8.5 Safe Nurse Staffing Levels (Wales) Bill: correspondence from the Minister for Health and Social Services**
- 8.5a The Committee noted the correspondence.

8.6 General and financial scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: additional information from the Minister for Health and Social Services

8.6a The Committee noted the additional information.

8.7 National Professional Lead for Primary Care in Wales: correspondence from the Minister for Health and Social Services

8.7a The Committee noted the correspondence.

8.8 The Care and Support (Eligibility) (Wales) Regulations 2015: correspondence from the Older Peoples Commissioner

8.8a The Committee noted the correspondence.

8.9 P-04-603 Helping Babies Born at 22 Weeks to Survive: correspondence from the Chief Medical Officer

8.9a The Committee noted the correspondence.

8.10 Medium term plans for health boards and NHS trusts: correspondence from the Minister for Health and Social Services

8.10a The Committee noted the correspondence.

8.11 Review of the Financial Ring Fencing Arrangements for Mental Health Services in Wales: correspondence from the Minister for Health and Social Services

8.11a The Committee noted the correspondence.

9 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from the remainder of this meeting and for item 1 of the meeting on 23 September 2015

9.1 The motion was agreed.

10 Public Health (Wales) Bill: consideration of evidence

10.1 The Committee considered the evidenced received.

Concise Minutes – Health and Social Care Committee

Meeting Venue:

Committee Room 3 – Senedd

Meeting date: 23 September 2015

Meeting time: 09.20 – 11.31

This meeting can be viewed

on [Senedd TV](#) at:

<http://senedd.tv/en/3230>

Attendance

Category	Names
Assembly Members:	David Rees AM (Chair) Alun Davies AM Altaf Hussain AM Elin Jones AM Darren Millar AM Gwyn R Price AM Lindsay Whittle AM
Witnesses:	Katherine Devlin, Electronic Cigarette Industry Trade Association Tom Pruen, Electronic Cigarette Industry Trade Association Edward Woodall, Association of Convenience Stores
Committee Staff:	Llinos Madeley (Clerk) Catherine Hunt (Second Clerk) Sian Giddins (Deputy Clerk) Gareth Howells (Legal Adviser) Philippa Watkins (Researcher)



Transcript

View the [meeting transcript](#).

1 Public Health (Wales) Bill: briefing from Legal Services

1.1 Members received a briefing from Legal Services on the Public Health (Wales) Bill.

2 Introductions, apologies and substitutions

2.1 Apologies were received from John Griffiths, Kirsty Williams and Lynne Neagle.

3 Public Health (Wales) Bill: evidence session 11

3.1 The witnesses responded to questions from Members.

3.2 The witnesses agreed to provide the Committee with evidence from a smoking cessation service in England regarding the use of vaping products alongside prescribed products as a means of reducing nicotine consumption.

4 Public Health (Wales) Bill: evidence session 12

4.1 The witnesses responded to questions from Members.

5 Paper to note

5.1 Draft Wales Bill: correspondence from the Presiding Officer

5.1a The Committee noted the correspondence.

5.2 Public Health (Wales) Bill: results of the Committee's survey

5.2a The Committee noted the survey results.

6 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from the remainder of this meeting and item 1 of the meeting on 1 October 2015

6.1 The motion was agreed.

7 Public Health (Wales) Bill: consideration of evidence

7.1 The Committee considered the evidence received.

Agenda Item 8.2



To: Sian Giddins
Deputy Clerk
Health and Social Care Committee
National Assembly for Wales

From: Quentin Sandifer
Executive Director of Public Health Services
Public Health Wales NHS Trust

28 August 2015

Submitted by email

Dear Sian,

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-cigarettes¹.

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 increases².

¹ 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

² 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 cigarettes³.

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. An appendix to this response is included that 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.

³ 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

APPENDIX

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

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

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

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

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

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

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

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

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

With many of the infectious adverse events the consequences range from minor localised infection to fatal or life changing outcomes for the case. There is evidence that there are a number of factors

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

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

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

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

Conclusion

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

b) Newport look back

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

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

Age of cohort

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

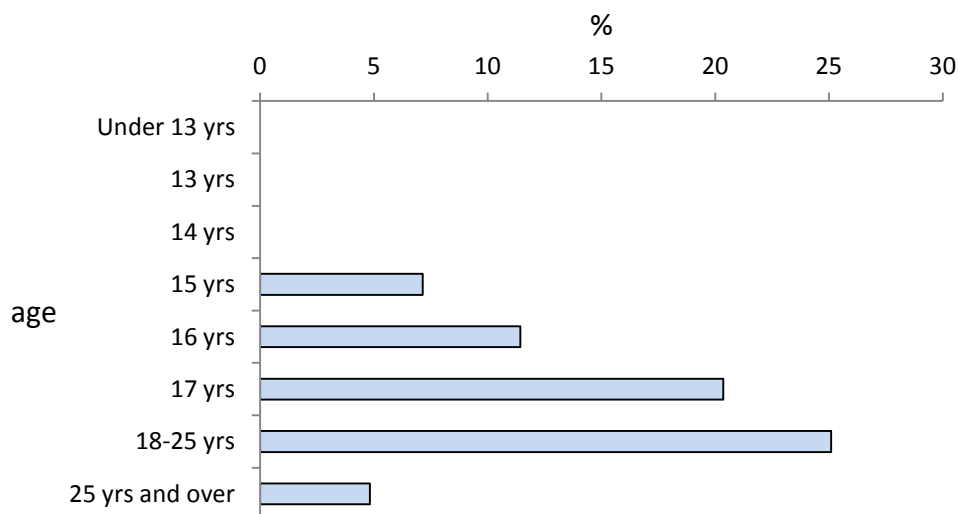
Figure 1. Age¹ and sex distribution of cohort of people considered to be at risk of infection following a piercing or tattoo at the premises under investigation (‘at-risk cohort’)



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 group¹



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 age¹ and true age² in 387 clients attending a piercing/tattoo studio under investigation in Exercise Seren by age at time of procedure³

	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)

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 BMA Cymru Wales – PHB AI 03 / Tystiolaeth gan BMA Cymru – PHB AI 03

Public Health (Wales) Bill – Summary of written evidence from BMA Cymru Wales

Dear Assembly Member,

Ahead of the oral evidence session which BMA Cymru Wales' representatives will be attending on Thursday 17 September, we thought it might be helpful to members of the committee if we provided the following summary of the written evidence which we have already submitted for the committee's consideration.

Overall view and our proposal for Health Impact Assessment (HIA)

Whilst we are broadly supportive of the proposals the Bill contains as published, BMA Cymru Wales is disappointed it is not as visionary in its approach as that of the initial Green Paper published in 2012.

We feel the Bill could become more ground-breaking, and more of an international exemplar in the field of public health, through the addition of proposals to place Health Impact Assessment (HIA) on a statutory footing in defined circumstances.

We therefore 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.

Obesity and nutritional standards

We are disappointed that the Bill does not include proposals included in the earlier White Paper to introduce nutritional standards in both pre-school settings and care homes. We believe these proposals 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).

We also propose a number of other measures which could be considered, although we recognise these may not all be within the legislative competence of the National Assembly. These include:

- *The introduction of a standardised, consistent approach to food labelling, with all pre-packaged products having front of pack labelling based on a 'traffic light' colour coding system combined with information on guideline daily amounts (now known as reference intake).*
- *A complete ban on the advertising and marketing of unhealthy foodstuffs, to include product placement and inappropriate sponsorship programmes targeted at school children.*
- *Subsidising the cost of fruit and vegetables.*
- *Offering nutrition education and counselling to women who are pregnant or contemplating pregnancy.*
- *Providing education and support aimed at promoting and prolonging the duration of breastfeeding.*
- *Promoting activities that involve physical exercise.*
- *Requiring all NHS premises to clearly display the healthcare risks involved with junk food and drinks.*
- *A ban on the sale of junk food and unhealthy drinks on NHS premises, or the offering of subsidised healthier options.*

Tobacco and nicotine products

BMA Cymru Wales supports the proposals put forward in Part 2 of the Bill.

From our overall assessment of the evidence that is available, we support the proposal to ban the use of e-cigarettes in enclosed and substantially enclosed public and work places because:

- *We believe the use of e-cigarettes in such circumstances can undermine the success of tobacco control measures by reinforcing the normalcy of smoking behaviour.*
- *Although less harmful than tobacco, nicotine (which is contained in e-cigarettes) is nonetheless a highly-addictive substance with many document harmful effects.*
- *E-cigarettes have also been found to contain a range of other substances with negative health implications.*
- *The World Health Organisation (WHO) has warned of the potential adverse effects of exposure to toxicants and particles contained within e-cigarette vapour.*
- *Studies have shown that bystanders can be exposed to vapour emitted from e-cigarette use.*

We also advocate e-cigarettes being licensed as medicinal products which could provide necessary controls on quality and safety, as well as on marketing and promotion.

We support the proposals to extend statutory restrictions on smoking and e-cigarettes to certain non-enclosed public spaces such as hospital grounds and children's playgrounds – recognising that whilst voluntary bans have been effective in some areas, they remain largely ignored and hard to enforce locally. We also support the proposals for additional locations to be brought under the scope of these restrictions through regulations, but only when Welsh Ministers are satisfied that doing so is likely to contribute towards the promotion of the health of the people of Wales.

We support the proposals for a national register of retailers of tobacco and nicotine enforcement and for creating a new offence for knowingly handing over tobacco and nicotine products to a person under the age of 18.

We would urge the Welsh Government to put in place an appropriate budget to ensure that the general public is made fully aware of the implications of the Bill coming in to force.

Special procedures

We support the proposals in the Bill on special procedures and suggest that consideration is also given to including the following additional procedures under the scope of the proposed licensing system:

- *Laser hair removal.*
- *Chemical peels.*
- *Dermal fillers.*
- *Scarification/branding.*
- *Sub-dermal implantation (or 3D implant).*

Intimate piercing

We support the plan to prohibit the intimate piercing of anyone under the age of 16 in Wales and feel the proposals in this section of the Bill are reasonable.

Pharmaceutical services

Whilst we would not oppose the general intention of the proposals in this section of the Bill, we would be deeply concerned if they were implemented in the same way as pharmaceutical needs assessments in England. These have led to the withdrawal of dispensing rights from some English GP practices because the pharmaceutical services those practices provided were not taken into account in assessments of unmet pharmaceutical need.

Many rural practices rely on the additional profit from dispensing to remain viable when catering for small and dispersed registered patient lists. With current GP recruitment problems, we would therefore be concerned that the adoption of a similar approach in Wales could be devastating for rural areas and lead directly to GP practice closures.

We therefore propose that 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) ideally be excluded from the proposed provisions of the Bill.

If this is not agreed, we would alternatively propose that those services provided under the General Medical Services (GMS) contract which are similar to extended pharmaceutical services should be required to be considered in any pharmaceutical needs assessments, and that all pharmaceutical needs assessments should include a risk assessment to existing GMS provision of any new approvals to provide pharmaceutical services.

Provision of toilets

We welcome the proposed provisions in this section of the Bill which seem sensible and reasonable.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Rodney Berman', with a long horizontal flourish extending to the right.

Rodney Berman
Senior Policy Executive
BMA Cymru Wales