Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Committee Room 3 – Senedd
Meeting date: Wednesday, 11 January 2017
Meeting time: 08.55

For further information contact:
Sian Thomas
Committee Clerk
0300 200 6291
SeneddHealth@assembly.wales

Informal pre-meeting (08.55 – 09.00)

1 Introductions, apologies, substitutions and declarations of interest

2 Public Health (Wales) Bill – Stage 1 evidence session 7 – Minister for Social Services and Public Health

(09.00 – 10.30) (Pages 1 – 25)

Rebecca Evans AM, Minister for Social Services and Public Health
Chris Tudor-Smith, Senior Responsible Officer
Rhian Williams, Legal Services
Chris Brereton, Chief Environmental Health Officer
Sue Bowker, Tobacco Policy Branch

Break (10.30 – 10.35)

3 Public Health (Wales) Bill – Stage 1 evidence session 8 – Royal College of Physicians

(10.35 – 11.35) (Pages 26 – 30)

Dr Olwen Williams FRCP, Royal College of Physicians (RCP)
Lowri Jackson, Royal College of Physicians (RCP)

Break (11.35 - 11.40)

4 Public Health (Wales) Bill - Stage 1 evidence session 9 - ASH Wales Cymru

(11.40 - 12.10) (Pages 31 - 39)

Suzanne Cass, Chief Executive, ASH Wales Cymru
Dr Steven Macey, Research and Policy Officer, ASH Wales Cymru

5 Paper(s) to note

Correspondence from the Chair of the Equality, Local Government and Communities Committee regarding the Public Service Ombudsman for Wales's Annual Report 2015-16

(Pages 40 - 42)

Correspondence from the Children and Young People Wales Diabetes Network regarding routine screening for Type 1 Diabetes in children

(Pages 43 - 45)

Correspondence from the Cabinet Secretary for Health, Well-being and Sport regarding improving Specialised Neuromuscular Services in Wales

(Pages 46 - 47)

Correspondence from the Cabinet Secretary for Health, Well-being and Sport regarding the establishment of Health Education Wales

(Pages 48 - 49)

6 Motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting

7 Public Health (Wales) Bill - Stage 1 evidence sessions 7, 8 and 9 - consideration of evidence

(12.10 - 12.20)

8 Inquiry into loneliness and isolation - consideration of scope and approach to the inquiry

(12.20 - 12.30) (Pages 50 - 55)

Agenda Item 2

Document is Restricted

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

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref: MA-L/RE/5425/16

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

4 January 2017

Dear Dai Lloyd,

Public Health (Wales) Bill

I would like to thank you and the Committee for the opportunity to discuss the Public Health (Wales) Bill on 1 December 2016.

During the discussion about health inequalities, I indicated that I would write to the Committee with further information about how legislation may address the need to ensure the Integrated Medium-Term Plans (IMTPs) of health boards and NHS Trusts identify and address the different needs of their communities. This issue was discussed in the Chief Medical Officer's recent annual report.

Under the National Health Service (Wales) Act 2006, Welsh Ministers must give directions to a health board requiring it to prepare a plan which sets out its plans across a three year period for ensuring it complies with its duties in terms of finances, whilst improving the health of the people for whom it is responsible and the provision of healthcare. The IMTPs produced by health boards are the mechanism by which this is given effect. There is a robust system of direction and approval in place for the IMTPs, and Welsh Ministers most recently gave directions to health boards and NHS Trusts in October 2016 via the 2017-20 NHS Wales Planning Framework.

I am therefore satisfied that the existing legislative framework provides the most appropriate mechanism for addressing the issues discussed in the Chief Medical Officer's annual report.

Bae Caerdydd • Cardiff Bay
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During the discussion I also referred to the provisions in the Public Health (Wales) Bill about health impact assessments. These provisions will make a further positive contribution to reducing health inequalities in Wales. Requiring health impact assessments to be carried out in certain circumstances will help ensure that key decisions taken by public bodies, including health boards, are informed by an assessment of their likely effect on physical and mental health. This will also help strengthen partnership working between health boards and other public bodies to address those factors which contribute to health inequalities but lie outside of the health sector.

I hope that this information will be helpful to the Committee and I look forward to providing further evidence about the Bill shortly.

Kind regards,

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

Agenda Item 3

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

PHB 16
Bil Iechyd y Cyhoedd (Cymru)
Public Health (Wales) Bill
Ymateb gan: Coleg Brenhinol y Meddygon (Cymru)
Response from: Royal College of Physicians

Consultation on the Public Health (Wales) Bill

RCP Wales response

About us

The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Amdanom ni

Mae Coleg Brenhinol y Meddygon yn amcanu at wella gofal cleifion a lleihau salwch, yn y DU ac yn fyd-eang. Rydym yn sefydliad sy'n canolbwyntio ar y claf ac sy'n cael ei arwain yn glinigol. Mae ein 33,000 o aelodau o gwmpas y byd, gan gynnwys 1,200 yng Nghymru, yn gweithio mewn ysbytai a chymunedau mewn 30 o wahanol feysydd meddygol arbenigol, gan ddiagnosio a thrin miliynau o gleifion sydd ag amrywiaeth enfawr o gyflyrau meddygol.

For more information, please contact:

Lowri Jackson
RCP senior policy and public affairs adviser for Wales
[redacted]

Royal College of Physicians (Wales)
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Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff CF99 1NA

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16 December 2016

From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
Dr Alan Rees MD FRCP
[redacted]

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

Consultation on the Public Health (Wales) Bill

1. Thank you for the opportunity to respond to the Health, Social Care and Sport Committee's consultation on the new Public Health Bill. We would be very happy to organise further written or oral evidence from consultants, trainee doctors or members of our patient carer network.

2. The RCP responded to the consultation on the previous Public Health (Wales) Bill (2015). It may be helpful for the committee to consider this earlier response as part of its scrutiny of this Bill.

Our response

Health impact assessments

3. The Welsh Government must take this opportunity to reduce health inequalities by addressing why so many people in Wales have poor health outcomes. We know that these outcomes can be linked to poverty, lifestyle, culture and deprivation. Many of these reasons are historical and deep-rooted in some communities in Wales, and will require a raft of measures.

4. This is why the RCP believes that legislation is only one part of the toolkit for improving public health. **This new legislation should provide an enabling framework for new and future action to improve public health**, and all levers must be used to improve and protect health. We recognise that RCP fellows and members have a key leadership and advocacy role to play in tackling the social determinants of health. Clinicians and public health teams must work together more closely in shaping services and developing programmes to promote and protect people's health, prevent ill health and tackle health inequalities.

5. We recommend that integration and collaboration on public health must be embedded across the NHS, local authorities and the Welsh Government. We strongly believe that a greater emphasis on joint working across bodies will be vital to the success of this legislation. **This is why we support a duty on Welsh Ministers to make regulations to require public bodies to carry out health impact assessments in specified circumstances**. However, these health impact assessments must not become a box-ticking exercise. The Welsh Government must consider how best to ensure that reducing inequality and improving health outcomes underpins everything they do.

6. **The focus of public health should lie on preventing, not just managing poor health**. Many of the underlying reasons for health inequality in Wales cannot be solved by solely local initiatives and local authorities but will need a more strategic national approach by the Welsh Government. The Bill should provide an enabling framework which will galvanise and support the Welsh Government and other bodies to address emerging public health issues as they arise.

7. A new public health law should provide us with a collective response to preventing and reducing public health harms and would pave the way for future behaviour change. Legislation has a role in changing socio-cultural norms: by putting in place penalties for unacceptable behaviour, we make a statement about that behaviour. Two excellent examples of this approach are seat-belt legislation and smoke-free legislation, which are widely understood to be fundamentally-important catalysts in changing attitudes, expectations and behaviour in road safety and smoking respectively. Law can be an essential tool for creating the conditions that enable people to live healthier lives.

8. **The Bill should allow for aspirational action across a variety of areas**, including health literacy and nutrition, tobacco, education, exercise and active travel. It should be overarching and allow for secondary legislation and policy around specific programmes on education, diet and substance abuse. It can be argued that the Welsh Government already has the powers to implement action in some of these areas (for example, in school sports, or healthy eating campaigns) but we believe that a more strategic approach would provide a 'coat hanger' for future emerging health issues.

9. However, **we recognise the limited powers currently available to Welsh Government, especially on alcohol abuse and obesity**, and it is frustrating that this could be preventing a wider and more immediate proactive approach to these urgent public health challenges. The RCP has joined with other organisations to support powers over alcohol being devolved to the National Assembly, based on the argument that alcohol harm reduction must be considered a health issue. We strongly support the introduction of a minimum unit price for alcohol, and we welcome the UK government's proposed tax on sugar-sweetened drinks.

Tobacco and nicotine products

10. **We support restrictions on smoking in enclosed and substantially enclosed public and work places and agree that the Welsh Ministers should have regulation-making powers to extend the restrictions on smoking to additional premises or vehicles.** Smoking accounts for approximately 5,450 deaths every year in Wales where it is estimated that 14,500 young people a year take up smoking. There is some evidence to suggest that the smoking prevalence rate is higher in the most deprived parts of the country and therefore, measures aimed at reducing smoking prevalence and uptake could contribute directly to improving the health and wellbeing of the population in the most deprived areas of Wales.

11. **The RCP welcomes the proposal for a tobacco retail register.** 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. Any measure that helps to reduce the prospect of under-age sales is to be welcomed.

12. **We support the ban on the handing over of tobacco and/or nicotine products to a person under the age of 18**, and we would urge the Welsh Government to ensure that this ban is enforced. 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.

13. **The RCP strongly supports restrictions on smoking in hospital grounds, school grounds and public playgrounds.** Smoke-free grounds in hospitals, for example, help to support non-smoking as the norm for patients who are trying to quit smoking. Enforcing a voluntary ban can be difficult and we believe that legislation would help. We are concerned that voluntary bans in hospital grounds in Wales have been widely ignored by patients, visitors and staff. Smoking is the single largest avoidable cause for many serious illnesses and we would therefore welcome the prospect of legislation in this area in order to ensure that this issue is taken seriously by staff, patients and visitors alike. We would support the inclusion of prison estates in these restrictions. Like hospitals, all prisons in Wales are smoke free. Enshrining it in legislation would be a positive step to reinforce the measure.

Special procedures and intimate piercing

14. **We support the proposal to introduce mandatory national licensing system for practitioners of specified 'special procedures' in Wales** and that the premises from which the practitioners operate these procedures must be approved.

15. When considering a prohibition on the intimate piercing of persons under the age of 16 years, there are several points that we would like to highlight to the committee. This Bill proposes legislation which affects persons under the age of 16. A child in law is defined as someone under 18 years old, so this definition sits uneasily with child protection law. As the law currently stands, children under 16 cannot consent to special procedures as they are not deemed to have capacity, and they must have parental consent. (It is worth noting that the Bill would override parental consent in certain circumstances, and this should be made clear.) Given that there are several pieces of legislation which already cover these issues, **the committee should consider recommending that the age of consent contained within this Bill be raised to 18** in line with the Tattooing of Minors Act 1969.

Other comments

A minimum unit price for alcohol

16. **The RCP strongly supports the introduction of a minimum unit price for alcohol.** We were instrumental in establishing the Alcohol Health Alliance, which, together with the University of Stirling, produced an independent, evidence-based alcohol strategy for the UK, **Health First**, in 2013. This strategy set out a series of recommendations to reduce alcohol consumption and harm from alcohol and was endorsed by over 70 organisations, including Alcohol Concern Cymru. At the heart of this strategy was the introduction of a minimum unit price of 50p together with a mechanism to regularly review the price. Canada has already introduced minimum unit pricing, **where it has been shown that** a 10% increase in average price results in approximate an 8% reduction in consumption, a 9% reduction in hospital admissions and a 32% reduction in deaths which are wholly attributable to alcohol.

17. Moreover, evidence suggests that **minimum unit pricing would play a pivotal role in tackling health inequalities** without penalising moderate drinkers on low incomes: as lower income

households disproportionately suffer the harms of alcohol, they would see the most benefits as a result. **University of Sheffield data** suggests that routine and manual worker households would account for over 80% of the reduction in deaths and hospital admissions brought about by a minimum unit price and yet the consumption of moderate drinkers in low income groups would only drop by the equivalent of 2 pints of beer a year.

18. Public health and community safety should be given priority in all policy-making about alcohol. **This is why we support the introduction of a public health licensing objective.** This would empower local authorities to make alcohol licensing decisions which fully take into account the public health impact of licensed premises in their area. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction.

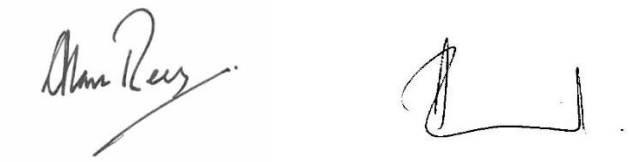
Obesity and ill-health

19. The causes and effects of obesity are complex and multi-faceted, encompassing factors as diverse as advertising regulation, town planning, schools curricula, public transport, and taxation. Obesity has an impact across a number of government departments which is why we have consistently advocated a coherent and coordinated cross-government approach across the four levels of the all-Wales Obesity Pathway, from prevention (level 1) through to bariatric surgery (level 4). **We urge the Welsh Government to explore the use of taxes on unhealthy foods**, starting with sugary soft drinks, as both a lever to support behaviour change and as a means for raising revenue for health promotion. We welcome the UK government's commitment to a tax on sugar-sweetened drinks, and we urge the Welsh Government to follow suit when appropriate.

More information

20. More information about our policy and research work in Wales can be found on our website. Alternatively, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted] with any questions.

With best wishes,



Dr Alan Rees
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Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon
Health, Social Care and Sport Committee
HSCS(5)-01-17 Papur 3 / Paper 3

PHB 29

Bil Iechyd y Cyhoedd (Cymru)

Public Health (Wales) Bill

Ymateb gan: ASH Cymru

Response from: ASH Wales

Consultation on the Public Health (Wales) Bill – ASH Wales response

1. 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/

2. 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

3. 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. Our newsletters for those interested in tobacco control directly reaches 1,190 subscribers every month, whilst our combined social media channels have a following of over 6,400 individuals and organisations, with the content of our three websites being viewed around 6,000

times every month combined. ASH Wales has no direct or indirect links with, and is not funded by, the tobacco industry.

Smoking prevalence in Wales

4. The percentage of the adult (age 16 and over) population in Wales categorised as a smoker is 19%, with this figure greater for males (21%) compared to females (18%)[1]. In terms of numbers of smokers, this equates to approximately 492,000 adults in Wales currently smoking. Smoking is the largest single cause of avoidable early death in Wales. In 2010, around 5,450 deaths in people aged 35 and over were caused by smoking[2], and about half of all life-long smokers will die prematurely as a result of their habit[3]. Smoking prevalence in Wales varies considerably by deprivation level, with current figures showing an 18% difference in smoking rates between the most and least deprived areas of the country (least deprived: 11%; most deprived: 29%)[1]. Indeed, smoking represents the most significant factor underlying the variation in health outcome and life expectancy between the wealthiest and poorest in Welsh communities.

ASH Wales comments on the terms of reference of the Public Health (Wales) Bill

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

5. ASH Wales supports giving Welsh Ministers a regulation-making power to extend the restrictions on smoking in enclosed and substantially enclosed public and work places to include additional premises or vehicles. We believe this will add greater flexibility to the regulation making process and make it easier for new premises and/or vehicles to be added to the list of places where smoking is banned without having to contend with the often time consuming process of manoeuvring through the multiple stages involved in the passage of a

Bill within the National Assembly for Wales. ASH Wales holds the opinion that when extending the restrictions on smoking to additional premises or vehicles are in the interests of the health of the people of Wales it is highly important the necessary changes to the legislation are made without delay. Affording Welsh Ministers with a regulation-making power to extend these restrictions will serve to ensure this is the case.

- *place restrictions on smoking in school grounds, hospital grounds and public playgrounds*

6. ASH Wales is strongly in favour of extending the current restrictions on tobacco smoking to include some non-enclosed spaces, such as school grounds, hospital grounds and public playgrounds. We consider this to be an important development that will serve to further denormalise smoking in communities across Wales given the reduced opportunities for the activity to be seen. By increasing the number of places where smoking is banned the fact that tobacco use is not a mainstream or normal undertaking in our society will be reinforced. Furthermore, in our view restricting smoking in these areas will serve to protect members of the public from the damage to their health caused by inhaling second-hand smoke.

7. In the case of school grounds and public playgrounds specifically, these are places frequented by children and young people on a regular basis. Children, in particular, are especially vulnerable to exposure from second-hand smoke as they breathe more rapidly, inhaling more pollutants per pound of body weight (a higher relative ventilation rate) than adults[4]. Children also ingest higher quantities of tobacco smoke pollutants due to more hand-to-mouth behaviours[5]. In addition, children have little control over their environment and are often unable to remove themselves from the risk of exposure to tobacco smoke. Research has found that after exposure to similar levels of tobacco smoke, cotinine levels (a metabolite of nicotine used to measure second-hand smoke exposure) in children are about 70% higher than in adults[6]. In Wales around 570 hospital admissions in children aged

0-14 were attributable to second-hand smoke exposure in 2010[2], with the majority due to lower respiratory infections.

8. With regards to hospital grounds, in making these smokefree the opportunity to initiate and support cessation among the many smokers, and their visitors, who use hospital services will be created. In addition, secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. For these reasons NICE guidance recommends hospital premises are smokefree[7]. In the case of hospital grounds specifically, legislation banning smoking is necessary given the problems that have been encountered enforcing voluntary smoking bans in these areas. All seven health boards and Velindre NHS Trust currently have comprehensive smokefree policies but evidence suggests many are struggling to enforce the voluntary smoking bans on their grounds. The message that people (patients, visitors and staff) should not expect their smoking behaviour to be facilitated by the National Health Service therefore needs to be reinforced in an unambiguous way. It should be made clear that you cannot come to NHS premises and expect to smoke, given that smoking is the single largest avoidable cause for many serious illnesses. We would therefore welcome the prospect of legislation in this area in order to ensure that this issue is taken seriously by staff, patients and visitors alike.

9. 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[8]. 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[9]. Furthermore,

there is strong public support in Wales for an extension of the smoking ban to include additional non-enclosed spaces. In a 2016 YouGov survey commissioned by ASH Wales 82% of respondents agreed that smoking should be banned in outdoor children's play areas, whilst the 2014 survey found 71% of respondents supported banning smoking in hospital grounds[10].

10. As well as being strongly supportive of extending smokefree legislation to include school grounds, hospital grounds and public playgrounds, ASH Wales believes the Welsh Government should go further and additionally include bans on smoking in the outdoor, non-enclosed, public places of school gates, playing fields, sports grounds and beaches. As with school grounds and public playgrounds these are all places frequented on a regular basis by children and young people meaning the rationale behind banning smoking in school grounds and public playgrounds equally apply to banning smoking at school gates, playing fields, sports grounds and beaches. That is, legislated bans on smoking in these areas will also serve to denormalise smoking as an activity and reduce exposure to second-hand smoke. Furthermore, in the case of school gates, playing fields and sports grounds in particular, banning smoking in these areas through legislation will make it easier to enforce the proposed smoking bans in school grounds and public playgrounds. A potential issue that may arise when enforcing bans in these areas involves confusion around where the restricted smoking area begins and ends. For instance, it is likely some members of the public will be unaware of whether the school gates are included in the grounds of the school or not and, hence, adding school gates to the list of areas where smoking is banned through legislation will serve to ensure this confusion is avoided. Likewise, it is possible some members of the public will not be able to distinguish between the perimeters of a playground and the adjoining playing fields, thereby leading to potential confusion and possible problems with enforcement of, and compliance with, the law.

11. An additional reason why it is necessary for this Public Health (Wales) Bill to extend the smokefree legislation to additionally include the outdoor, non-enclosed, public places of school gates, playing

fields, sports grounds and beaches concerns the fact that should smoking continue to be allowed in these areas it will serve to diminish the impact of the new smoking bans set to be introduced in school grounds and public playgrounds. For example, it will prove difficult for smokefree school grounds to successfully denormalise smoking and reduce exposure to second-hand smoke should smoking at the adjoining school gate be allowed. In the same way not banning smoking in playing fields and sports grounds will potentially reduce the positive impact of denormalisation and exposure to second-hand smoke that banning smoking in public playgrounds will bring.

12. Legislated smoking bans are also further required in places such as school gates and beaches given the difficulty in getting voluntary smoking bans introduced in these areas. For instance, we have been in discussions with all Local Authorities in Wales with regards to the introduction of smokefree school gates and smokefree beaches in their jurisdictions. Whilst some authorities have implemented voluntary restrictions others have not yet done so, often citing a lack of resources or confusion as to whether they have sufficient power to introduce such changes.

- *provide for the creation of a national register of retailers of tobacco and nicotine products*

13. ASH Wales agrees with the proposal to create a national 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 that require different messages to be relayed to the retailer in question. 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. In our view the establishment of a national register of retailers of tobacco and nicotine products will allow regulators to monitor where tobacco is sold in Wales, thereby providing an accurate picture of the number, size and type of legitimate tobacco sellers, and thus facilitating the

identification, and ultimately reduction, of rogue tobacco traders. Illegal tobacco accounts for 15% of the tobacco market in Wales[11], which is by far the highest in the UK. Moreover, 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[12]. The proposed retailers register would also assist enforcement agencies and regulators to communicate tobacco law changes directly to retailers.

14. Evidence from Scotland, where a tobacco retailers register was introduced in 2011, 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. Ultimately an effective tobacco retailers register must provide a deterrent among retailers for breaches of tobacco legislation in order to ensure compliance with age of sale restrictions and to tackle illicit tobacco sellers. In order for this to be the case there must be sufficient sanctions in place to accompany the register. At present, very few retailers have been removed from the retailers' register in Scotland for selling to minors or selling illicit tobacco. Effective enforcement of these restrictions is essential in order to protect young people from tobacco addiction and to keep smuggled tobacco off the streets. Hence, we would like to see a one-strike policy introduced, where one infraction against the law results in expulsion from the retailers' register. We believe this would serve to reinforce the message that selling a product as dangerous as tobacco is a privilege that comes with responsibilities.

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

15. ASH Wales fully supports this measure as we believe it will act as a greater deterrent to any retailors tempted to breach the new requirements associated with a national retailers register. As mentioned in our answer above it is important retailers face the prospect of a severe sanction for failing to comply with the law in order to properly enforce a tobacco or nicotine offence. In our view a strengthened Restricted Premises Order regime will assist in ensuring this is the case. The current system in Scotland has resulted in very few banning orders, at least one of which was side-stepped by transferring registration to another person. With evidence showing that a large proportion of young people who smoke get their tobacco directly from shops, we believe that a dual banning order that can apply to both the registered person and to the premises is necessary.

16. 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.

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

17. ASH Wales supports this proposal as we believe it 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. 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.

References

[1] Welsh Government (2015). Welsh Health Survey 2014.

[2] Public Health Wales NHS Trust / Welsh Government (2012). Tobacco and health in Wales.

[3] ASH (2014). Smoking statistics: illness and health.

[4] Canadian Institute of Child Health (1997). Environmental hazards: Protecting children. Canada.

[5] Matt GE, Quintana PJE, Hovell MF, Bernert JT, Song S, Novianti N, et al. (2004). Households contaminated by environmental tobacco smoke: sources of infant exposures. Tobacco Control. 13(1):29–37.

[6] Willers S, Skarping G, Dalene M, Skerfving S. Urinary cotinine in children and adults during and after semiexperimental exposure to environmental tobacco smoke. Archives of Environmental Health. 1995. 50(2): 130–138.

[7] NICE (2013). Smoking: acute, maternity and mental health services. Public health guideline.

[8] Bauld, L. (2011). The impact of smokefree legislation in England: Evidence review.

[9] Johns M., Farley SM., Rajulu DT., Kansagra SM., Juster HR. (2014). Smoke-free parks and beaches: an interrupted time-series study of behavioural impact in New York City. Tobacco Control.

[10] YouGov for ASH Wales. Total sample size was 1,002 adults. Fieldwork was undertaken between 26th February to 12th March 2015.

[11] ASH Wales (2015). Illegal Tobacco: Undermining Tobacco Control Measures in Wales.

[12] NEMS Market Research (2013). North East Illicit Tobacco Survey. NEMS Market Research.

Agenda Item 5.1

Dai Lloyd AM
Chair, Health, Social Care and Sport Committee

5 December 2016

Dear Dai

At our meeting on 23 November, the Equality, Local Government and Communities Committee (the Committee) took evidence from the Public Services Ombudsman for Wales (the Ombudsman) in connection with his Annual Report 2015-16.

During the session, a number of matters were raised relating to NHS bodies and the provision of health services. Given that these matters fall within the remit of the Health, Social Care and Sport Committee, Members agreed that I should write to you to draw them to your attention. I have written in similar terms to the Cabinet Secretary for Health, Well-being and Sport.

Increase in health complaints

Following correspondence from Simon Thomas AM, Chair of Finance Committee raising concerns about the increase in complaints against NHS bodies and the subsequent burden on the NHS of dealing with complaints, we questioned the Ombudsman on this matter. The Ombudsman reported that there had been a notable increase in complaints against two health boards, namely Abertawe Bro

Morgannwg University Health Board (UHB) and Betsi Cadwaladr UHB, which he believed could explain the overall increase in complaints against NHS bodies. He also reported that complaints against NHS bodies in other parts of Wales were reducing.

The Ombudsman suggested that recent high profile complaints against these UHBs meant that individuals were more prepared to complain than would otherwise be the case. He told us that both Abertawe Bro Morgannwg UHB and Betsi Cadwaladr UHB had been assigned an improvement officer to improve complaint handling and to help ensure that improvements occur in those areas of service delivery where failings have been identified. He also told us that five out of seven health boards have been assigned an improvement officer.

Governance and accountability

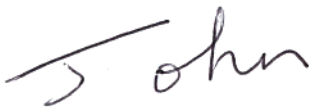
A key theme emerging from the Ombudsman's evidence was the need to ensure good leadership and governance across health boards and to develop a culture in which complaints are viewed as an opportunity for continuous improvement in services. Linked to this, the Ombudsman highlighted the importance of effective scrutiny of health boards and suggested that further clarity was needed on scrutiny arrangements.

Out-of-hours care

The Ombudsman told us that, during the reporting year, he had published his first thematic report, *Out-of-hours: Time to care*, which highlighted a number of cases investigated that showed inadequate standards of care given to patients in hospitals outside of normal working hours. He also told us that he was awaiting a response from the Welsh Government to the report and would be meeting with the Deputy Chief Medical Officer shortly to discuss potential actions arising from it.

I should be grateful if you would consider following up the above matters with the Cabinet Secretary at an appropriate time.

Kind regards



John Griffiths AC / AM
Cadeirydd / Chair

Agenda Item 5.2

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

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DEPARTMENT OF CHILD HEALTH
Morriston Hospital
Morriston
Swansea, SA6 6NL

Our ref: CB/hjw
Your ref:

Date: 16/11/16

Dr Dai Lloyd
AM & Chair of Health & Social Care & Support Committee
National Assembly for Wales
Health & Social Care & Support committee
Cardiff
CF99 1NA

Dear Dr Lloyd

Thank you for your letter dated 10th November 2016. The Children and Young People's Wales Diabetes Network (& Brecon Group) welcomes the aim of the petitioners to see an earlier diagnosis of type 1 diabetes and a reduction in the number of children and young people where a delay leads to potential life-threatening Diabetic Ketoacidosis (DKA).

The Children and Young People's Wales Diabetes Network (& Brecon Group) is comprised of multi-disciplinary team members working in all 14 paediatric diabetes units in Wales. Our membership includes paediatricians, specialist nurses, dietitians and child psychologists. We also have representation from the third sector and parent representatives on our steering group.

Engaging primary care colleagues to reduce the incidence of DKA at diagnosis is one of the priority areas for our network. We continue to pursue a number of different themes to attempt to reduce the frequency of DKA at the time of diagnosis for children and young people with Type 1 diabetes in Wales by making an earlier diagnosis where possible. This includes:-

Research

The Early Detection of Type 1 Diabetes in Youth (EDDY) study carried out in Cardiff University recently reported the results of their feasibility study. The study aimed to assess the feasibility of developing / delivering a community educational intervention for parents of children under 18 years of age and GP / practice nurses in Cardiff, the Vale of Glamorgan and Bridgend, to increase the awareness of early symptoms of type 1 diabetes. The intervention included 120,000 reusable shopping bags and bilingual leaflets for delivery via 329 schools and nurseries (covering 105,000 children) and for GP's and practice nurses the delivery of glucose / ketone meters and single use lancets with posters, stickers and education sessions delivered to 102 practices.

The conclusion of the study was that delivery of the intervention was feasible and although the study was not designed to show a clinical effect, (such as a reduction in rates of DKA at diagnosis), anecdotal reports suggest the impact from the process evaluation is encouraging. The study authors are now looking for funding to conduct a much larger study that would be powered to show a reduction in DKA at diagnosis.

Collaboration with third sector organizations

The network continues to work closely with Diabetes UK Cymru regarding their planned 2017 public health campaign. We have met regularly with Diabetes UK Cymru to provide advice and support for their activities and will continue to do so.

As part of this collaboration we are working on conveying key clinical messages to primary care colleagues through NHS communication channels. These messages will urge primary care colleagues to proactively ask

about the '4 Ts' used to diagnose Type 1 (Toilet, Thirsty, Thinner, Tired) and encourage the use of a fifth and sixth 'T' – to TEST TODAY. Immediate near patient blood glucose testing of suspected diabetes in children and young people is the NICE standard.

Collaboration with primary care colleagues

The network coordinator has met with Dr Alistair Roeves and Dr David Miller-Jones, who both have leadership roles with regard to diabetes in primary care in Wales. We will continue to work with them to develop interventions and education to support learning in primary care. Dr Roeves has suggested making every new diagnosis of a child with diabetes a learning event within GP Clusters, led by primary care colleagues and we will explore this further with him. Dr Roeves has also suggested including a commitment to following the correct procedure at diagnosis within GP Cluster plans as part of this learning programme. This would be in addition to the communications campaigns listed above.

We have recently heard of a scheme in the West Midlands introducing a prompt on the electronic request system that the GP's use, such that should they ever request a formal laboratory blood glucose test for a child under the age of 18, then a message will appear on screen reminding them that this should be done as an immediate finger prick glucose. We will raise this with our colleagues and see if a similar electronic prompt is feasible in Wales.

Dr David Millar-Jones has also suggested that all GPs in Wales complete the e-learning module on diagnosis of diabetes produced by the Primary Care Diabetes Society. As a network, we support this proposal and would like to see all primary care clinical colleagues complete this learning.

Research and screening

There are a number of research pathways being explored around the world to consider the potentially attractive possibility of screening for Type 1 diabetes in children. One suggested pathway would be to identify children at increased risk, either because of their family history, through genetic screening of all children done at the time of birth or through screening of all children via blood testing for auto-antibodies around the age of 2 years. I believe the petitioners refer to the FR1DA study in their correspondence currently taking place in Bavaria. It is suggested that if 2 auto-antibodies are present in the blood stream, then children should be repeatedly screened at 1-6 monthly intervals with oral glucose tolerance tests looking for the emergence of abnormal blood glucose levels. Once abnormal blood glucose levels are present, some authors suggest that it may be possible to intervene with as yet unproven immune therapy to either prevent or defer the onset of Type 1 diabetes. In addition to repeated blood glucose testing, the FR1DA study is evaluating education for families to attempt to reduce the incidence of DKA at diagnosis. The FR1DA authors acknowledge that a limitation of their study is that it does not attempt to address the socio-economic cost of screening. Given the highly intensive nature of the screening process described, it is unclear whether it will be possible to prove that it will be of overall health benefit, or deliver a health economics model that makes it applicable to clinical practice. Indeed, in a journal article in 2015, the conclusion drawn from a health economics evaluation of population screening was that current screening costs far outweigh the economic benefits.

The Wales network continues to work closely with the 10 English networks to evaluate research and introduce best practice into our clinics.

Difficulties with the petitioner's proposal to screen unwell children

As a clinical network, we are unable to support the specific proposal raised by the petitioners calling for, "a **mandatory** duty for all GPs and healthcare professionals in a primary care setting to carry out the finger prick blood test for all children who present to them with an illness that could be masking Type 1." There are several reasons why such an approach would not meet the essential criteria of a good screening test:

1) There is a lack of evidence from research studies that testing whole populations of unwell children is of benefit to prevent DKA at diagnosis. Tragic cases, such as that of Peter Baldwin, appear to be exceptionally rare.
2) Transient stress hyperglycaemia is very common in unwell children. Studies report that between 3.8 and 4.7% of children presenting to emergency departments for any reason have elevated glucose levels and for febrile children this rate rises as high as 11.9% in one study. Transient stress hyperglycaemia does not appear to be associated with an increased risk of later developing diabetes.
3) Due to the lack of specificity of glucose testing in unwell children, there is a significant risk of harm from this approach; i.e. that in order to identify a very small number of cases such as Peter's, very

large numbers of normal children with transient stress hyperglycaemia then undergo follow up including unnecessary painful investigations and anxiety for their families.

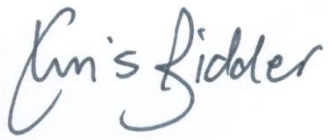
As a Network we strongly recommend all NHS staff adhere to NICE guidelines, which state that the characteristics of type 1 diabetes in children and young people include polyuria, polydipsia, weight loss and tiredness and that children and young people with suspected type 1 diabetes should be referred immediately (on the same day) to the Paediatric Diabetes team.

Many of the recommendations the petitioners make in their correspondence to the committee are of excellent value and many are being pursued by ourselves, primary care colleagues and Diabetes UK Cymru. These include additional training for primary care staff, the provision of glucose meters to GP's / practice nurses and a need for health boards to be aware of and report on pathways of care and DKA rates at diagnosis.

I am happy to be contacted to answer further queries if this would be beneficial to the committee

Best wishes,

Yours sincerely



Dr Christopher Bidder

On Behalf of Children & Young People Wales Diabetes Network (& Brecon Group)

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

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref: Petition P-04-532
Ein cyf/Our ref: MA-P/VG/7843/16

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

8 December 2016

Dear Dai,

Thank you for your letter of 10 November regarding the petition (Petition P-04-532) about improving Specialised Neuromuscular Services in Wales.

As you note in your letter, the Neurological Conditions Implementation Group (NCIG) is refreshing the Neurological Conditions Delivery Plan, due to be published in summer 2017. Further work to develop and improve the contents of the refreshed Delivery Plan is underway. This will shape the policy of care and services across the health boards. The Welsh Neuromuscular Network (WNMN) and third sector organisations via the Wales Neurological Alliance are represented on the Neurological Conditions Implementation Group and as such will have an opportunity to inform the content.

This year, the Neurological Implementation Group has invested £120,000 from the £1 million funding it received from Welsh Government to provide additional physiotherapy and family care advisor time. Whilst there have been some recruitment delays, I understand that the WNMN, in conjunction with health boards, are now pressing ahead with the appointments of a neuromuscular specialist physiotherapist in South Wales and additional Band 6 Family Care Advisor time in all three regions. Together with the Stroke Implementation Group, it has also invested £1.2million in the development of neurorehabilitation services across Wales which should benefit people with neuromuscular conditions.

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The WNMN has used the improving specialised neuromuscular services in Wales Vision Document to engage with health boards and other partners with regard to key objectives and planning requirements. The WNMN has presented a case to the health boards for further investment to sustain the services and is seeking for this to be included the health boards Integrated Medium Term Plans for 2017-18.

I am aware the WNMN has highlighted in the longer-term there is the need for both additional neuromuscular specialist staff and improved access to generic rehabilitation services and the work they are doing to address these concerns by cross working with exemplar networks in Scotland and South West England. I understand WNMN is also developing a service map for access to specialist and generic services for each health board, including cross-boundary working.

I hope my response demonstrates the Welsh Government recognises the importance of providing safe and sustainable services for people with neuromuscular conditions in Wales.

Yours sincerely,

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

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA-P/VG/8085/16

Dr Dai Lloyd AM
Chair
Health, Social Care and Sport Committee

19 December 2016

Dear Dai,

Thank you for your letter of 22 November about my decision to establish Health Education Wales, with the aim for it to be operational from 1 April 2018.

The committee will be aware this announcement builds upon the work previously undertaken by Mel Evans which examined the arrangements currently in place to support the investment made in health professional education in Wales.

Following an extensive engagement process, the review concluded the arrangements were fragmented, lacked real collaboration across the medical and non medical elements of the workforce and did not represent value for money.

That review recommended a new body be established for Wales which would bring together key functions aimed at supporting a sustainable NHS Wales workforce. The subsequent work undertaken by Professor Robin Williams focused on the options for a new body and was considered appropriate for implementation in Wales.

I am content that the model proposed by Professor Williams presents Wales with real opportunity to approach workforce issues on the basis of a more integrated and collaborative approach across professions. The Chair and Chief Executive will sit alongside their counterparts in NHS organisations, ensuring that the workforce aspects of developments are an integral point of discussions from an early stage. This level of access will also enable Health Education Wales to put forward and promote innovation from a perspective which is not driven by the interest of specific profession groups.

I consider this to be an opportunity to maximise the investment we make in our workforce.

A project implementation team is in the process of being appointed and will take forward the more detailed work to support the establishment and implementation of Health Education Wales. I expect this work to be taken forward during the first half of 2017 to inform the legislation required.

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As I said in my statement, I intend to hold a short consultation early in 2017, which will focus on a number of areas upon which we would appreciate stakeholder's views and opinions about transition to the new organisation.

Finally, you have asked about the arrangements for working with affected organisations throughout this period of change. I can confirm that officials are already in contact with these organisations. Currently, activity is focused on identifying the most appropriate method of engagement and ensuring that it is inclusive at all levels of this work.

We are at the early stage of this programme of work and the governance arrangements are currently being finalised. I would be happy to provide the committee with updates as this work progresses.

Yours sincerely,

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

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