



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Iau, 9 Gorffennaf 2015
Thursday, 9 July 2015

Cynnwys
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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In

addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Alun Davies	Llafur Labour
John Griffiths	Llafur Labour
Altaf Hussain	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales
Kirsty Williams	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Dr Julie Bishop	Iechyd Cyhoeddus Cymru Public Health Wales
Dr Sara Hayes	Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg Abertawe Bro Morgannwg University Health Board
Dr Gill Richardson	Bwrdd Iechyd Prifysgol Aneurin Bevan Aneurin Bevan University Health Board
Dr Quentin Sandifer	Iechyd Cyhoeddus Cymru Public Health Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Siân Giddins	Dirprwy Glerc Deputy Clerk
Gareth Howells	Cynghorydd Cyfreithiol Legal Adviser
Catherine Hunt	Clerc Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Dechreuodd rhan gyhoeddus y cyfarfod am 09:31.
The public part of the meeting began at 09:31.

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members and the public to this morning's meeting of the Health and Social Care Committee, during which we'll be continuing our evidence collection in Stage 1 of the Public Health (Wales) Bill? Can I remind Members that the meeting is bilingual? If you need simultaneous translation from Welsh to English, that is available on channel 1 of the headsets. If you prefer or require amplification, that's available on channel 2. There are no scheduled fire alarms this morning, so can I ask Members that, if one does occur, they follow the directions of the ushers? If you have mobile phones or other electronic equipment that may interfere with broadcasting, can you please either turn them onto 'silent' or turn them off? We have received apologies from Darren Millar this morning and we have been informed that Janet Finch-Saunders may be substituting for him.

09:32

Bil Iechyd y Cyhoedd (Cymru): Sesiwn Dystiolaeth 2 Public Health (Wales) Bill: Evidence Session 2

[2] **David Rees:** Can I therefore go into our next session? Can I welcome Dr Julie Bishop and Dr Quentin Sandifer from Public Health Wales? Good morning. Can I thank you for the written evidence that we've received on the Public Health (Wales) Bill? Clearly, there are some issues that we would like to explore a little bit further. Just to inform you, my intention is to work through the session slightly backwards, so that we can ensure we cover every aspect of the Bill. But we'll start off with a general overview of the Bill. Could I ask Gwyn Price to ask the first question?

[3] **Gwyn R. Price:** Good morning, both. In your opinion, does the Bill adequately reflect the priority areas for public health improvement?

[4] **Dr Sandifer:** I'm going to ask Julie Bishop to speak first in a moment, but could I just, Chair, give apologies on behalf of Professor Mark Bellis? You will have seen three names; I'm afraid he had to give apologies quite late, just in case that message hadn't got through to Members. Julie.

[5] **Dr Bishop:** Thanks. I think it's impossible, when you think about the breadth of the health needs of the people of Wales and the challenges of health improvement, for any one piece of legislation to cover all of the issues that you would need to in one. So, from our point of view, this legislation needs to be looked at alongside other legislation that's already been passed, such as the Active Travel (Wales) Act 2013 and the Well-being of Future Generations (Wales) Act 2015. When you take it in totality, it adds important steps, which are part of that picture. But clearly, there's no one piece of legislation that is going to be a catch-all for all of the health improvement needs in Wales.

[6] **Gwyn R. Price:** So, in your opinion, there are some parts missed along the—

[7] **Dr Bishop:** Well, I think it covers what it sets out to do. We have got the future generations Act, which looks at the wider structural, environmental, economic and social influences on health. So, the commitment to look at health in all policies, if you like, within that legislation, is there. We've got measures within the active travel Act. There are things that this proposed legislation doesn't address, but I think those are probably things that are not within the legislative scope of the Assembly currently.

[8] **Gwyn R. Price:** But we're going in the right direction.

[9] **Dr Bishop:** Yes. Definitely.

[10] **David Rees:** John.

[11] **John Griffiths:** Could I ask, Chair, about mechanisms to get Wales more active, which I think would be a big health benefit and general quality-of-life benefit? The active travel Act, I think, is really good—I would. [*Laughter.*] I think, obviously, there are other things that can be done. Locally, for me, in my area, Aneurin Bevan Local Health Board, I recently met with public health officials there, and I was basically trying—and I will continue to try—to get together some of the key players, really. We've got a new leisure services trust in Newport with, obviously, the city council, the health board, Sport Wales, sports clubs, Newport City Homes and registered social landlords who are doing some environmental improvements—a wide range of players, really—and we need to try and get them around a table and work out how we get the local population more active for health benefits. I think it's always been really difficult to get the health sector engaged with this, because, understandably, they've got so many day-to-day pressures that getting your head above the parapet, as it were, I'm sure, is very difficult. But, we're much more about preventative health now, Chair, and I was just wondering, really, whether you've any views on how we find mechanisms. You know, they could be legislative, obviously, but how do we find mechanisms, whether they're duties or whatever, to try and get all of these players together to get a more active, fitter and healthier population?

[12] **Dr Bishop:** I agree with you completely; greater levels of physical activity in the population would bring tremendous benefits to population health, and it's one of those areas where, actually, most of the action that needs to be taken sits outside the NHS. The NHS picks up the pieces for us not being active, but, actually, it can play a relatively small part in terms of actually helping the population to be more active. I would see that the provisions within the future generations Act and the duties there to look at the wellbeing of the population, and the particular emphasis placed on public bodies coming together to do that work, provides a really strong opportunity for addressing that particular issue. From our point of view, as a public health organisation, we've entered into a partnership with Sport Wales and the Welsh Government to actually drive this agenda forward, because we see it as one of our biggest challenges. So, I think, actually, the levers we need are there; it's for us to actually take the full opportunity and realise the potential of those.

[13] **Dr Sandifer:** Could I just add, briefly, to the opening part of your question about the pressures within the NHS as a potential competing priority? The new integrated medium-term planning process—the new strategic planning process—in Wales now I think has given us a new framework to ensure that public health priorities are expressed clearly in health boards and trusts' priorities. I'm generally encouraged by the commitment that health boards are now beginning to articulate through their strategic planning processes, led by their directors of public health. So, I think we are moving in the right direction.

[14] **John Griffiths:** I know, perhaps, it's a little outwith the parameters of this legislation, Chair, but I wonder if Julie might be able to write to the committee with an account of where that work is with Sport Wales and the Welsh Government; that would be interesting for the committee, I think.

[15] **Dr Bishop:** I'm happy to do so.

[16] **John Griffiths:** Thank you.

[17] **David Rees:** Can I ask a question now? In response to Gwyn Price's question about

prioritisation, you actually didn't reflect on whether you felt the priorities were being delivered; you actually indicated that you felt that these things were part and parcel of the agenda to move forward. We did mention the concept of keeping fit, wellbeing and so on. Now, obviously, in the White Paper, there's the question of nutritional issues, and that is no longer in the Bill. Do you think that's a missed opportunity? Should we have left that in the Bill?

[18] **Dr Bishop:** Our understanding is that the intention is to bring forward those measures via different means. That they need to be there, we would certainly agree. So, if their inclusion in this Bill is the best way of doing that, then, obviously, we would be supportive of that. The principle that we actually need to tackle the nutritional challenges of the population is up there with physical activity and tobacco use, in terms of the things that cause the greatest harm. The specific regulations that were being proposed were related to nutritional standards in care homes and pre-school settings, and there are other ways, through secondary legislation or through guidance, that they can be brought about. They would be important, and we certainly wouldn't want to underplay the importance of that, but whether or not they need to be included in this particular proposed legislation for that to happen—we wouldn't necessarily say it's the only way of doing it, but it's important that they're included somewhere.

[19] **Dr Sandifer:** In the same spirit, you'll have noticed that we put in a paragraph about minimum unit pricing for alcohol. We understand the Assembly's wish to take account of developments elsewhere, but we think that is an important public health measure that we will need in Wales to take a view on at some point.

[20] **David Rees:** Just to highlight, it's not the Assembly's wish, it's the Welsh Government's wish, because it's the Welsh Government that's putting the Bill forward.

[21] **Dr Sandifer:** Of course.

[22] **David Rees:** Okay. If we move on now to perhaps Part 6 of the Bill, which reflects on the issues relating to public toilets. Lindsay?

[23] **Lindsay Whittle:** Thank you, Chair. Good morning. We've had lots of witnesses highlighting the importance of adequate toilet provision, but of course, local authorities are in severe financial restraint at the moment. I'd be interested to know do you think there are any ways this Bill could be strengthened, and how we could ensure local toilet strategies are actually implemented? Maybe you could perhaps highlight issues regarding certain groups, such as people with disabilities or parents with young children, please.

[24] **Dr Bishop:** Okay, shall I start and you carry on? Clearly, I think we've said in our written evidence that we all need access to toilets. There are certain groups of the population, because of their health needs, where that becomes more pressing. I think the challenge that this proposed legislation is looking at is how we can actually make that provision more equitable and more readily available to people. Requiring local authorities to look specifically at the needs of the population and particular parts of the population is important, so it's important that those strategies take that very broad view and are specifically addressing the needs of those who perhaps need more frequent access to toilet provision than others. I think, as we've said in our response, and I suspect others have as well, writing a strategy doesn't in and of itself bring about change, and so the critical issue here is that the strategy actually has some requirement, perhaps, to monitor that there is actually genuine improved access, or adequate access, as a result of that. So, we would certainly be supportive of strengthening the proposals in any way that would make that more likely to happen.

[25] **Dr Sandifer:** I don't think I have anything, really, to add to that, to be honest.

[26] **Lindsay Whittle:** Just one quick supplementary. Strategies are fine, but do you think perhaps some financial incentives should be offered to local authorities, then?

[27] **Dr Sandifer:** I think that there is always scope for a wide range of incentives to improve population health action, and I think perhaps that's a question that we could take away and reflect on, and perhaps give you a view outside this meeting, if we could.

[28] **Lindsay Whittle:** Okay, thank you very much.

[29] **David Rees:** Okay, in that case, I'll move on to Part 5 of the Bill, which relates to pharmaceutical services. Can I ask about the issues relating to pharmaceutical services? You've highlighted the issue of resource within NHS Wales. You've indicated that it's important to assess the needs, to make sure there's no duplication, and that a stronger community pharmacy service should be available. But, of course, on the question of resourcing, what's your view in regard to the resourcing? Do you think that local health boards are going to be able to deliver the requirements of the Bill as it stands?

[30] **Dr Sandifer:** Well, you will be talking to colleagues from the local health boards in a moment. We focused our remarks, essentially, on the opportunity that we think the Bill provides, through needs assessment, to use community pharmacies as a place where we can deliver public health action. I think that's a really important opportunity that we're already, to some extent, developing but I think we could go a lot further, and we've set out some of our thoughts in the paper.

[31] **Dr Bishop:** We recognise from our involvement with, for example, provision of smoking cessation support that pharmacies are actually one of the most cost-effective ways of reaching a very large number of smokers. So, actually, in some respects, they offer savings opportunities for health boards if we actually strengthen some of these provisions. There are other preventative services that health boards might use pharmacies to provide, which might offer similar opportunities. So, it may not all be about additional cost.

[32] **David Rees:** Gwyn.

[33] **Gwyn R. Price:** Thank you, Chair. Will the Bill as drafted ensure the health boards determine applications to provide pharmaceutical services in a timely manner? I'm talking about involving the community and working with the GPs overall to make sure that the pharmacy in that area is what the people require.

09:45

[34] **Dr Bishop:** Well, I think the basic principle of the way that this is set out is really about taking that approach. At the moment, the way in which pharmaceutical services are planned is very much around the very narrow definition of pharmaceutical needs, which is about dispensing of medicines. I think what we're recognising here is that there's a much bigger contribution that pharmaceutical services can make to the health needs of the population. On the work that health boards are currently doing, particularly around looking at primary care clusters, it's about a cluster of GPs, pharmacists, dentists and other community services for a given population looking at their local needs and making sure that they've got services in place that address them, working closely with community partners. Health boards are rolling those mechanisms out quite quickly at the moment, and we've been supporting them in those processes, but it means that we've got a really good, if you like, infrastructure developing that enables that to happen. So, I think it's quite positive.

[35] **Dr Sandifer:** I would just emphasise, as Julie just said a moment ago with regard to

stop smoking services, or particularly in my area of interest, driving up vaccination and immunisation rates, that primary care will need to work closely with community pharmacy. I think this provides an important additional tool to enable us to leverage the additional opportunity from those arrangements.

[36] **Gwyn R. Price:** Thank you very much.

[37] **David Rees:** The Bill obviously highlights the increasing role of community pharmacies and expanding upon those services and their definite needs. Does the Bill actually do enough to ensure that the public are made aware of the changes to the services that this is going to propose, and how these can be beneficial to them?

[38] **Dr Sandifer:** Clearly, all aspects of the Bill will need, I think, when the legislative process has settled on its final provisions, wide publicity. I think the world is looking very closely at what we're doing in Wales, I think there's a lot of excitement about this, and it would be a shame if we didn't make very clear to the population of Wales what it is that is finally presented and offered to them in positive terms of the opportunity to address health inequalities and drive up health improvement across the whole spectrum of public health.

[39] **Dr Bishop:** I think most health boards have already started work to encourage the population to make more use of their local pharmacies as part of their response to some of the pressures that are on other parts of the system—for getting advice on minor illness, for example. Those schemes are in place quite widely. So, I think there are things already in place that this will encourage and enable health boards to build on.

[40] **David Rees:** The question, of course, I suppose I'm asking is: whilst encouraging and enabling is one thing, should there be a duty upon health boards to promote and do that work?

[41] **Dr Sandifer:** Health boards have a responsibility for the population's health, and this is clearly part of that. I think it's for the Welsh Government to determine if it needs to reinforce and remind the health boards, but I think that that is clear for health boards in Wales: they have a statutory responsibility for the population's health, this being, I think, part of the enhanced capability and capacity that will enable them to discharge that.

[42] **David Rees:** We could have a long discussion on that, but I don't intend to open that discussion this morning. Okay. Also the question I'm asking is: clearly, there's a big issue on local wellbeing needs as well. Is the Bill going to allow the integration of the pharmaceutical needs with those general wellbeing needs analyses? I want to make sure that we don't duplicate, but also that we ensure that everything is covered. Does the Bill allow that to happen?

[43] **Dr Bishop:** I certainly don't see any reason why it doesn't. Certainly, as an organisation, we have a contribution to make in both of those arenas. So, we're working closely to support local authorities and other partners, of which health boards clearly are one, in doing the wellbeing needs assessments, so they're clearly part of that process. And, as an organisation, we have a pharmaceutical public health team who will be providing a lot of the support that's necessary for the needs assessments around pharmacy. So, from our point of view, the evidence is that those processes are being very closely joined up, but I think it's a very well-made point. There are also elements relating to the social services and wellbeing needs assessments, as part of that process, so there are a number of things going on locally, and I think all agencies are working quite closely to try and make sure that we make those processes as streamlined as possible.

[44] **David Rees:** Okay, thank you for that. We move on now to Part 4 of the Bill, which is actually the special procedures—. Sorry, Part 3 is the special procedures. Part 4 is intimate

piercing. John, do you want to start on this one?

[45] **John Griffiths:** Yes, thank you, Chair. In terms of the special procedures as defined by the legislation, are you content that there's sufficient evidence for those areas of activity being included in this Bill, and are there any other special procedures that you think might be included that aren't currently?

[46] **Dr Sandifer:** Thank you. Well, we think the public health case is well made for this provision, in both Parts 3 and 4 of the Bill—and we'll take them together, perhaps. Many of you serve the communities of Gwent and will be aware of the recent concerns around tattooing and piercing in that geography. So, we welcome the provisions as set out in Part 3, but we think they could be strengthened.

[47] I think there are just a few points that I would want to make in that context. We talk about special procedures, but I think we should be clear that most of what we are describing as 'special procedures' here are, in fact, minor surgical procedures. If you were a medical practitioner, you would recognise and understand them in that context. If you talk about them, in a sense, as minor surgical procedures and not just simply 'special procedures', I think that's quite relevant to several of the points that we have made in our submission to you.

[48] We welcome the licensing requirement on an individual and not just on a business, whether premises or a vehicle. I would also want to make the point that the provision should apply to all individuals, whether they are currently providing those services or might provide them in the future. I wouldn't want a grandfather clause inadvertently to be introduced in the legislative process. However, coming to your particular point, we are aware that a lot of discussion has taken place in Welsh Government around the list of the procedures, and it is our view that that list of procedures could be extended. Notwithstanding the power of a Minister to extend it through secondary legislation, we could, I think, add a number of additional procedures: those broadly under the heading of 'body modification'—the injection of liquids into the body, sub-dermal fillers, that sort of thing—chemical peels, and laser treatments for tattoo and hair removal. We've set those out in our response to you. We're also aware that there is a discussion about the review that Sir Bruce Keogh conducted, which is giving consideration to all of this at a UK level. But I think the opportunity exists now for us to say clearly at the beginning what we think those procedures are, and I think they could be extended.

[49] **David Rees:** Kirsty.

[50] **Kirsty Williams:** You said that the public health case for this part of the Bill is well proven, but in the paper that you've sent to the committee, you actually refer to older evidence that procedures such as piercing are a risk, although actual occurrences are very rare. You then talk about evidence that piercing and tattooing in prisons and in people's homes is a risk. Is it your understanding that this regulation will apply to people carrying out do-it-yourself tattooing in homes and in prisons?

[51] You then talk about anecdotal evidence—the word 'anecdotal' is used—and you then do actually give the Newport case that has recently happened, and I don't want to diminish the seriousness of what happened to those individuals at all. So, I'm just wondering, on the basis of what you've supplied to the committee, it doesn't seem to me that the evidence is overwhelming for the inclusion of these procedures, especially acupuncture and electrolysis, for which I don't see any evidence at all that lends itself to the fact that we have to regulate those. I just wondered what else you might have that you haven't supplied the committee with.

[52] **Dr Sandifer:** We are obviously concerned about the potential risk, as well as any

actual risks that may or may not have been evidenced. We believe that there is evidence—

[53] **Kirsty Williams:** I, potentially, could get knocked over on my way out of this building.

[54] **Dr Sandifer:** Sorry, I appreciate that. However, for people undertaking these procedures—and I'll deal with your question about the home and prison environment—I think, by licensing individuals, that deals with the settings. As far as I'm concerned, anyone who undertakes these procedures needs to demonstrate that they are competent to undertake these procedures, regardless of the setting. But, the particular point I wanted to come back to is that it would not be acceptable for people to undertake any procedures in an unhygienic way, and I think the current regulatory powers certainly don't provide sufficient assurance that people would undertake those procedures technically competently, in a safe and hygienic way. I think that there is sufficient evidence of the potential risk of infection to justify what's been set out in the Bill and what we're arguing for in addition. I appreciate your comment about not diminishing the situation in Gwent. The situation in Gwent was very serious, as far as I'm concerned, and we simply should not allow a situation like that to occur in Wales. Without this Bill, we do not have that safeguard, because it's clear that the existing regulatory powers available to local government will not give us that assurance.

[55] **Kirsty Williams:** I take your point about the case in Gwent. That was as a result of tattooing. I'm just wondering, because I haven't seen any evidence yet by anybody, actually, about the risks around electrolysis and acupuncture. Can I take you back to what you said about licensing of the individual? I'm not sure—maybe things have moved on since I was a teenager, but the old ice cube and a cork and a needle scenario, which is how we used to do our piercing when we were younger: are you seriously suggesting that those youngsters will be regarded as committing, under these circumstances, a crime if that kind of activity was going on? So, where do we draw the line between teenage girls who get the ice cube and the cork out to pierce each other's ears, or somebody in a prison? I mean, how are we going to regulate that?

[56] **Dr Sandifer:** You're right to draw attention to the wide variety of settings. Clearly, what people do in their own homes, in private, outwith any formal scrutinised arrangements, maybe we can't legislate for those. But, my point is that where people seek to trade by undertaking these activities, then we would want those people to be subject to proper legislative requirements, and that's what I think this Bill does.

[57] **Kirsty Williams:** So, it's the issue of trade that is the—

[58] **Dr Sandifer:** I think it's the fact that somebody puts themselves out to someone else and offers a service for which they may not necessarily be competent, or may not necessarily have knowledge of the risks associated with that activity.

[59] **Kirsty Williams:** And the public health case for acupuncture and electrolysis—are we aware of any problems that have arisen?

[60] **Dr Sandifer:** Well, we're looking at these procedures in the round, and I think, if you're penetrating the skin, potentially, with a needle, then any penetration of the skin with a needle could introduce an infection. Now, I don't think that we could accept that an infection, simply because it was related to acupuncture, was any less acceptable than an infection created by a tattooist undertaking tattooing or some other piercing process.

[61] **Kirsty Williams:** Thank you.

[62] **David Rees:** Altaf.

[63] **Altat Hussain:** Thank you very much. Just to say that, yes, these procedures can be really harmful, and you have to have proper legislation for these. But all such procedures should be included by name. That is no. 1. No. 2, have you had any chance to get in touch with the Royal College of Surgeons to ask what their guidelines are for these small procedures?

[64] **Dr Sandifer:** So, on the first point, that list of procedures clearly will be subject to constant review and can be varied, added to or deleted from. I think that's entirely appropriate. We're just simply proposing that, at the beginning, the legislation might set out an expanded list as described here. My understanding of the list as it's presented here is that it's the list of procedures that are within the regulatory scope of local authorities at the moment and, therefore, potentially, could present the least additional burden to local authorities should the Bill go forward. I mean, that's just an interpretation that I have. You'll be speaking to local government representatives next week and no doubt you'll explore that.

10:00

[65] On the point of the Royal College of Surgeons, we certainly looked at the evidence submitted to the Keogh review, and we're very mindful of the ongoing discussions. We're also very struck by the very strong view of many cosmetic and plastic surgeons about the need for some proper legislative framework around a lot of the procedures that are currently being undertaken.

[66] **Elin Jones:** I wanted to ask whether you think it would be useful to add to this Bill by making it an offence for a licensed individual to undertake a tattoo or any of the minor procedures on individuals who are under the influence of drink or drugs.

[67] **Dr Sandifer:** I think, if we treat these as, if you like, minor surgical procedures, then, as Mr Hussain will be aware, the principle of informed consent should apply and you would reasonably assume that somebody who was intoxicated may not be sufficiently competent to give informed consent. That's why I think this is an important set of new legislative proceedings, because I think it potentially protects people, not just in the context you've described, but in other contexts, for example in festivals and other settings, where they might be tempted to have a tattoo or similar procedure undertaken without having given much prior thought to that; the opportunity simply presents itself. That's why I think it's important that, as the Bill has set out here, the provisions extend quite widely to those settings, as well.

[68] **Elin Jones:** So, it may be useful to make that more explicit on the face of the Bill in terms of formalising what you've just described, really.

[69] **Dr Sandifer:** I think there are a number of opportunities for making some of the provisions in the Bill much clearer than they might be at the moment. That is one. I think another, if I might—and I appreciate you'll want to bring me back to some of the points you wish to focus on—is that we could make much clearer that where there is perceived to be a real risk to public health, we should be able, with immediate effect, to stop an individual undertaking those procedures, and here I'm referring to section 63(6). We talk about the stop and we talk about the remedial action notices, and I think it just would be helpful if section 63(6), which, I think, says, with the word 'prohibit', that immediate stop could apply. So, there are a number of instances in the Bill where I think we could be much clearer than we are now.

[70] **David Rees:** Kirsty, do you want to come back in?

[71] **Kirsty Williams:** Maybe it is, perhaps, slightly too philosophical, but do you believe

it's the role of the state to stop people doing impulsive, stupid or downright foolish things if they've had too much to drink?

[72] **Dr Sandifer:** I think it's the role of the state to protect individuals, through reasonable measures, where that risk is real and evident.

[73] **Kirsty Williams:** Thank you.

[74] **David Rees:** Okay, thank you. Can I ask one question on the intimate piercing aspect? In your paper, you highlight the aspect with regard to tongue piercing and, perhaps, navel piercing. Do you want to expand upon that, because they're not identified in the Bill in that section?

[75] **Dr Sandifer:** No, they're not. To just follow up a point I made a moment ago, I think Part 4 could make much clearer that this is actually about children's safeguarding as much as it is about public health protection, and so I think that's another opportunity for being clearer within the legislative text. But, to your particular point, I think tongue piercing in particular would be a valuable additional explicit body part if you like—the tongue itself—to add to this on the grounds, I think, that it is known to present a high risk of infection and other complications, and arguably could be perceived in a young person to be encouraging sexualisation. In a moment, you'll be hearing from the director of public health in Aneurin Bevan health board. In the recent Gwent incident, I was shocked to hear that six individuals below the age of 16 were identified in our look-back exercise. One as young as 13 had a nipple piercing undertaken by an adult male. Now, I do have deep concerns, quite frankly, about a current system that potentially allows for that to happen.

[76] **David Rees:** Obviously, the Bill talks about under the age of 16, and I think the Chartered Institute of Environmental Health talks about under the age of 18. Is 16 the appropriate age in your view?

[77] **Dr Sandifer:** Well, 16 is identified because it then brings the legislation in line with age of consent. I think that's a perfectly reasonable position to take.

[78] **David Rees:** Should it be strengthened to ensure that there's proof of age on these procedures?

[79] **Dr Sandifer:** As we say in our evidence, we think that would be a helpful additional feature of the Bill.

[80] **David Rees:** I'm going to ask one more question. Last week, a point was raised about babies, for example. We talk about under the age of 16, but should there be an age at which no piercing should be allowed?

[81] **Dr Sandifer:** I think I'd like to take that question away. I mean, there's an answer that I might choose to give, but I think I would want to reflect on that from a professional point of view.

[82] **David Rees:** If you could provide information and a professional point of view, that would be very helpful for us. Thank you for that.

[83] We now move on to Part 2 of the Bill, and there are several chapters in here. If we deal with the chapters relating to the retail of tobacco and nicotine products and the prohibition of sale first, and the handing of tobacco products to under-18s. Gwyn.

[84] **Gwyn R. Price:** Thank you, Chair. In your opinion, are there any additional tobacco

control measures that you think should be considered for inclusion in the Bill?

[85] **Dr Bishop:** I think we already have a very wide range of legislation and measures that protect the public against tobacco. That's right because it is the single leading cause of avoidable ill health and death in the population, and this Bill actually brings forward a couple of the areas that have not previously been addressed. At the moment, I can't think of anything significant that's missing, but I will happily take that away and come back to you and see if there are any other suggestions that we could make. I mean, the measures that are included in here in relation to tobacco products obviously relate to retailing. We know that there is growing evidence internationally—firstly, that you need to enforce legislation as well as pass it. So, it's very important that the measures that are included in here don't just say it's not acceptable, but that retailers have a very real expectation that that legislation will be enforced—and that's important—and that the penalties, obviously, are appropriate to act as a deterrent. I think that's a quite important measure. There are proposals in here that would enable action to be taken in terms of restricting smoking in places where that's not currently permitted, for example in some outdoor areas, and hospital grounds is another one that's been made. We would be strongly supportive of those measures as well.

[86] **Gwyn R. Price:** Thank you.

[87] **David Rees:** John, do you want to come in on that?

[88] **John Griffiths:** Yes, on the latter point, there have been other suggestions as to areas that might be included in the prohibition on smoking, and that's part of denormalisation, I guess, and making it clear that it is socially disapproved of, really, because of public health issues. So, amongst the suggestions are main tourism beaches, and, of course, one of the National Trust beaches in Wales has recently announced that they will not have smoking on their beach. Another suggestion, I think, is outdoor areas of cafes and restaurants, given that, in the nice weather, many people would rather eat and drink outside, but if they're alongside a smoker and maybe asthmatic, or whatever, obviously that's a problem for them. Do you have views on those particular proposals and any other suggestions of areas that might be included?

[89] **Dr Bishop:** There are two basic reasons for introducing restrictions on where you can smoke. The first, obviously, is the very direct public health protection measure, which is about exposure to second-hand smoke. And there are a number of measures even in the outdoor environment where that can be quite significant. Obviously, if it is outdoors, it's a lower risk than in an enclosed space, but if you are in close proximity to somebody who is, or a large number of smokers, then that can present a risk. Also, we are aware of the area immediately around buildings and the potential ingress, if you like, of the smoke into the enclosed space when people are smoking outside. So, that can also be something that's worth consideration. So, that's one very significant part.

[90] The second one is around, as you say, the de-normalisation. We've reached a stage where, thankfully, smoking is becoming a minority activity, but, unfortunately, it's still a significant minority. We know from the best in the world around where these rates of smoking have been brought down—. California is a very good example, where they have actually taken some of these steps, either through legislative or other means. So, beaches in particular have been a focus of the Californian experience and some of the outdoor areas of retail establishments such as those that you mention have also been included within their provision. So, I think we can see that that actually helps with that wider sending of a very clear message that this is something that, ultimately, we want to see become something of the past. If we continue to permit smoking in areas that are widely seen, and particularly where we encourage those to be the focus, because I think that's the challenge currently around the outdoor areas of buildings or cafes—. That's where the smokers currently go because they

can't go inside. So, actually, it could become quite prevalent, which increases the risk. So, I think it is something that it's worth the provisions of this Bill actually thinking about—making it possible for those areas to be extended, when the case can be made to do so.

[91] **David Rees:** Do you think that the Bill will actually assist and strengthen the tobacco control agenda here in Wales as it stands? Will it work towards reducing—. Currently, I think the prevalence is 20 per cent at the moment, and the target is 16 per cent by 2020. Will it actually help achieve that target?

[92] **Dr Bishop:** The measures that are in there certainly will help. For us, one of the most important measures is the tobacco retailers register. One of the significant challenges at the moment is actually the enforcement of the underage sales legislation that currently exists. If we actually have a requirement for retailers of tobacco to register then we know where they are, and that makes that enforcement process that I mentioned earlier much easier. So, we see that as a very significant measure. We also know from international research that has been done that, as you would expect, there is an association between the number of retail outlets and the prevalence of smoking in an area. Some of that is obviously basic supply and demand. But it also feeds that normalisation process. I think that, over time, what we would see is the opportunity for local authorities, through their planning, through their wellbeing needs assessments, to actually start to look at have we got areas where we have got more outlets for tobacco than we would like to see and to start to think about what steps we might be able to take to address that. So, I think this is a really important step along the way from that point of view.

[93] The UK as a whole is rated very highly on an international basis in terms of the action it's taken against tobacco. It's up there as one of the international leaders, and Wales along with that. It's important that we maintain an awareness of all of the steps that are being taken internationally and continue to be at the forefront of those kinds of measures. I'm sure this isn't the end of the process where tobacco is concerned, but what's in here is important for what we understand now.

[94] **David Rees:** Okay. Thank you for that. We move on now to Chapter 1, which is smoking and e-cigarettes. Clearly, this is an issue that has raised a lot of concerns amongst the public and highlighted the need more than anything else, perhaps. Can I ask a question on the evidence base? We've obviously reported here about the evidence base, and we understand there are aspects on both sides of the argument. Do you have sufficient evidence to suggest how it can help or that it does re-normalise smoking through tobacco products?

10:15

[95] **Dr Bishop:** I think, as you say, one of the important things that we are aware of in this particular debate is that that these products are new. We've known about tobacco for a very long time, and the evidence that we've gathered about the risks and harms has been generated over decades. These products are new, and we are learning all of the time about the potential risks and the potential benefits. From our point of view, as a public health organisation, we have to give advice, as specialists in public health, about the potential risks and benefits to population health of any measure, and we cannot sit around and wait a couple of decades to see whether or not the conclusive evidence that people might like to see is available before making a judgment. We have to give advice on the best available evidence that's available at the time, and we have looked quite extensively at this particular issue in order to formulate the views that we have.

[96] I think one of the challenges is that, when you look at the evidence, there are a number of different matters here that you need to consider. So, there's the evidence in relation to the potential benefits of these products to people who are currently smoking. That that we

have currently shows that it is almost without question that, for those who are unable to quit smoking—because that’s the best thing that they can do—e-cigarettes would offer a harm-reduction perspective. That’s growing clear. What that international evidence that’s available does say, though, is that these products are not safe. They are not without risk, and over time we may understand more about the potential risks of these products. So, when we’re looking at people who do not smoke currently, our judgment is slightly different. So, we need to form a balance in terms of those two particular needs, so, from our point of view, it’s the extent to which we look at the risks and benefits to existing smokers, and nobody is proposing here—and we wouldn’t propose—any restriction on the availability of e-cigarettes in the sense that they’re a product that needs to be in the market and they have a place, but we do believe that there is a need to clearly position those products as an alternative to the use of tobacco in a harm-reduction context, and therefore in the environment of tobacco, and harmonise the way in which they are seen alongside other tobacco-related products. So, in our view, the restrictions that are proposed around their use in public places are both a practical and pragmatic approach, in terms of enforcement, and also address the issues in relation to normalisation. We know from work that was done around tobacco, for example, that children and young people are influenced by what they see around them. We know that from alcohol research, we know that from other measures. So, the idea that, for some reason, the same kind of things that influence children and young people in the tobacco arena, when the same tactics are being used, when it’s being publicly seen, wouldn’t have an impact in this case is a very illogical argument to make, we feel.

[97] I think, secondly, we currently have no evidence whatsoever that children and young people at a young age are able to distinguish adequately between these products, particularly the so-called third generation products, which actually generate a lot of vapour. At first glance, when you see them being used, they do look to all intents and purposes like smoking. You actually have to be quite aware of e-cigarettes in order to see the difference at first glance, and we think that would equally be the case for children and young people. It also reinforces the idea that you actually use a product for a particular purpose in terms of—you know, it’s a drug. There’s no two ways about it. Nicotine is a drug, and so there is a very clear message, generally, as a society, that we do not encourage drug use. So, not thinking carefully about how we regulate a product that, in and of itself, has very little value—it only has a value in the context of being better than something that currently causes a great deal of harm—. I think the balance that’s being struck here about recognising those benefits, but in a very particular area, actually using the evidence we already have about what we understand influences people’s behaviour to control any unintended consequences, is the right approach to take.

[98] **David Rees:** John.

[99] **John Griffiths:** I think that was a very comprehensive answer, if I may say so, Chair. If I could just return to this issue of what I think the Minister describes as the precautionary approach, which is pretty well-established in many areas, I think, of Government activity, and perhaps particularly health, and the idea that, as you say, there isn’t that much evidence around at the moment, because e-cigarettes are relatively new, but, if you look at the harm that does potentially and is scientifically shown to come from e-cigarettes, in terms of the nicotine content, for example, that it’s right to have a precautionary approach, notwithstanding that the evidence base is relatively weak—. But some would say set against that is the fact that it’s not a simple equation in terms of not understanding that there might be some potential benefits from the availability and use of e-cigarettes. As you say, obviously people who currently smoke tobacco, or might do so, use e-cigarettes instead, but one of the issues I think that the Minister highlighted in terms of that argument is that people will still be able to use them, as I think you mentioned, Julie, but obviously there will be the same restrictions that currently apply to the smoking of tobacco. But if people go to the same places to use their e-cigarettes that others are using to smoke tobacco products, I think some worry

that there will be a temptation to return, then, perhaps, to tobacco products by those who have made the switch to e-cigarettes, because, you know, they're breathing in the tobacco smoke, and there's temptation, and some of the perceived advantages of making the switch would have gone, because they're now being treated in the same way, largely, as cigarette smokers. Do you see any strength in that argument, that the precautionary approach isn't, perhaps, quite as simple as some are portraying it, and that there are actually issues on either side of that equation?

[100] **Dr Bishop:** I think, as we have said, and we have said in a number of statements that we've made on this issue, this is about a balance. So, we are weighing up risks and benefits. It isn't a straightforward black and white case on either one side or the other. I think there are those who will present it as if it is, and I think that's actually quite unhelpful.

[101] If we look at it from a risk point of view, if you're currently a smoker, then obviously you are putting yourself at significant risk of harm. The best way of reducing that harm is to quit. One of the concerns that we have got is the conversation that is going on around e-cigarettes being predominantly a cessation aid, because actually they are not proven in that context. There is some research out there that says that, at best, they are about as effective in the longer term as somebody going and buying a patch over the counter in the chemist. Actually stopping smoking requires looking at the habit and the social aspects of the addiction, as with any other addiction. It isn't just about a pharmacological alternative; they don't work on their own. What we also know from very good evidence is that there are much, much better ways of stopping smoking, and we have got more help for people who want to stop smoking than has ever been available before—free, and on the national health service. So, one of the things we have to be really careful about not doing in this conversation about e-cigarettes is to give smokers the impression that that's the only way they quit smoking, because, actually, there are very much better ways of them doing that, if that's what they want to do.

[102] For those smokers—and there are smokers out there—who find just the idea of quitting really difficult, and there may be a whole range of reasons for that, that's when we start to have the harm-reduction conversation. So, how do you actually reduce your current risk? You can smoke less, and you can switch to e-cigarettes. So, for a smoker who is currently looking to reduce their risk, if they switch to an e-cigarette, they have immediately reduced their harm. So, that's a positive step to take. If they are currently going outside to smoke—because they will be, because they can't smoke in the places where we're talking about restricting the use of e-cigarettes—they will be already exposed both to their own inhalation of smoke through smoking the cigarette and the second-hand smoke of those around them. So, by not smoking the cigarette themselves, they have automatically reduced their risk, even if they are exposed to those around them. So, I think this is about harm reduction, and, if you look at it in terms of harm reduction, even if we have this in place, they will still be reducing their harm, and I think that's an important position from our point of view, in that sense. So, from that point of view, the precautionary principle, we think, is quite reasonable, because there is still a harm reduction. We know, with tobacco, there is what we call 'a dose-response relationship'. So, the more that you're exposed to, the greater your risk of harm. So, every step that you take to reduce that harm brings about a significant public health benefit and individual benefit.

[103] **David Rees:** Okay, John?

[104] **John Griffiths:** Yes, thank you, Chair.

[105] **David Rees:** Altaf.

[106] **Altaf Hussain:** Just a quick one. Thank you very much; it was fantastic to listen to

you. A paper has just come out in the *British Medical Journal* about electronic cigarette use among young people in Wales, evidence of two cross-sectional surveys, probably might have gone through, and it does say that many young people, including non-smokers, have tried e-cigarettes. However, regular use is less common and—[*Inaudible.*]—cigarette use. They are further saying that there should be future research; it's needed to understand the motivation behind young people's experimentation with e-cigarette use, and to understand the temporal relationships between the use of e-cigarettes and tobacco. What is your opinion about it?

[107] **Dr Bishop:** That's an important piece of research, obviously, from our point of view, because it's a well-conducted piece of research and it's Welsh, so it's very relevant to us and we have talked extensively to the people that undertook the research. I think one of the things that we would want to say as an organisation is that this is an area where much, much more research is required across a whole range of matters. So, we would strongly encourage those issues.

[108] What that work tells us is that, in common with much international work from the United States and elsewhere that says very similar things, young people are trying these things and they're trying them extensively, that the proportion of young people who are becoming regular users is small, but I think one of the things we—you know, those of us that talk about population health—sometimes forget is that even when you're talking about 1 per cent of the population, that's actually quite a lot of people, and we mustn't lose sight of that. And there is this relationship between children and young people who go on to become smokers and the use of e-cigarettes, which the paper points out, as you say. And we don't really understand what's going on there, and obviously we need to understand a little bit more about what comes first and how one reinforces the other.

[109] Certainly, from our point of view, one of the very big gaps in the international literature is understanding really in some detail about how children and young people see these products—how do they perceive them. Because one piece of survey information that we currently have is very much about the fact that they see them as safe, and that concerns us. Because as I've said already, they are safer if you're a current smoker; they are not safe. And so, if, currently, children and young people have a view that this one of these things that they use and it's relatively safe, then that is a matter of concern. So, these kinds of surveys about understanding what is happening to trends over time are very, very important in that we continue to do them and we take account of them. But, I think from our point of view, our, if you like, weighing up of that evidence and those risks and harms and the looking at the precautionary principle is that we feel that we are presenting a scenario where smokers can reduce their harm, and I've talked about that, but we don't believe that—. We think it's a very big risk to take with future generations' health not to consider the very real concerns that, internationally, are out there around these products in that wider context. That is important from our point of view.

[110] **David Rees:** Elin.

[111] **Elin Jones:** I do accept that there is a risk with renormalisation of nicotine use in public places, but I'm still not convinced, even after your evidence, that there isn't a different approach that's required with e-cigarettes in recognising the benefit of harm reduction, in taking a different approach to the legislation, so that it doesn't mirror exactly the banning of use in all enclosed public spaces, but it looks particularly at the naming of particular circumstances where e-cigarettes should not be used. They could be places where food and drink are consumed, public transport, public buildings and places. That may be a more proportionate approach in legislation at this point to the issue around renormalisation. I was wondering whether you have any view or whether you'd thought that through in terms of needing to come to a proportionate response.

[112] **Dr Bishop:** Certainly, it's a matter that we have actually considered, and I agree with you that there are places where we would consider the risks to be greater—those frequented by children and young people, for example, being an obvious one. In talking to our enforcement colleagues, their perspective—I know you're going to talk to them and I'm sure they'll have a view—is that if we distinguish, it becomes more difficult for both the public to understand, 'Where can I use these substances?', and for enforcement agencies who've got different processes in place in different places.

10:30

[113] So, I guess if people feel that it's possible to do that, and people would actually be able to manage those two different regimes, then that could still bring about benefits. I think that's a fair point. But, the case that has been made to us is that's a perhaps more complex picture than the benefits would bring.

[114] **David Rees:** We've come to the end of our time now and I'm going to take the Chair's privilege and ask the two last questions. We have been informed by the Minister that there have been examples of bans in other countries. Do you have any evidence from those countries as to whether those bans demonstrate any effectiveness in stopping normalisation? I know it's an early stage, but is there anything coming through at this point in time to demonstrate that they are effective?

[115] **Dr Bishop:** I think that would be something that you would only see over a significant period of time. So, it's my understanding of those places where they've actually introduced that—obviously, you've got to look at whether or not they are comparable places as well; you look at Wales in the context of societies that have other similar measures in place, where smoking rates are similar, and those kinds of things—is that, at the moment, it's much too soon to draw any clear conclusions about that, from that point of view.

[116] **David Rees:** The final question is: one of the issues is related to smoking in a dwelling where the dwelling is used for a business purpose. It's a very complicated area, particularly on human rights aspects. One of the concerns with smoke, obviously, is the residue smoke within the fabric of a room, the furniture and everything else. Is there any evidence to demonstrate that there's a similar residue from e-cigarettes?

[117] **Dr Bishop:** I'd have to go and look at the evidence and come back to you on that in detail. Certainly, we know that there are some similar particulate matters that come from the use of e-cigarettes in the wider environment—the World Health Organization report makes that very clear—but obviously at much, much lower levels. But whether or not anybody has done any work to look at what the accumulative effect of that would be over time, which will be part of the issue there, I think we'd have to look into.

[118] **David Rees:** If you could let us know if you find anything, that would be very helpful.

[119] **Dr Bishop:** Sure.

[120] **David Rees:** Thank you very much. Time has got us. Once again, thank you very much for your evidence. You will receive a copy of the transcript for any factual inaccuracies. Please let us know as soon as possible if there are any. Once again, thank you very much.

[121] **Dr Bishop:** Okay. Thank you.

[122] **David Rees:** I propose that we have a break until 10:40, and then we'll get the next set of witnesses in.

*Gohiriwyd y cyfarfod rhwng 10:32 a 10:40.
The meeting adjourned between 10:32 and 10:40.*

**Bil Iechyd y Cyhoedd (Cymru): Sesiwn Dystiolaeth 3
Public Health (Wales) Bill: Evidence Session 3**

[123] **David Rees:** I welcome Members back to this morning's session of the Health and Social Care Committee, where we now move to our second evidence session this morning on the Public Health (Wales) Bill. Can I welcome Dr Gill Richardson, who is the executive director of public health at the Aneurin Bevan Local Health Board, and Dr Sara Hayes, who is the director of public health in the Abertawe Bro Morgannwg University Local Health Board? Good morning and welcome. Can I thank you for the written evidence we received from the health boards and the Welsh NHS Confederation? Obviously, there are various issues, and you've obviously been following some of the questions we've had. We'd like you to address similar questions with us today because, clearly, the previous session highlighted that some of these areas would actually be better addressed by the local health boards in particular. So, we'll go straight into questions, if that's okay with you. Can I ask Gwyn Price for his first question?

[124] **Gwyn R. Price:** Thank you, Chair. Good morning, both. In your opinion, does the Bill adequately reflect the priority areas for public health improvement?

[125] **Dr Hayes:** Can I say it is a selection of topics in many ways, but I do see this as part of a developmental journey for Wales? We've got the Active Travel (Wales) Act 2013, which was wonderful. We're looking towards the Well-Being of Future Generations Act 2015—we have wellbeing, which will be a really big step forward. And we're looking beyond there as well for further development. So, I see this as a stepping stone. There are things that I would have liked to see in it, to be absolutely frank, but I do see this as an important journey and an important step forward, and I do understand that some of the big issues are being taken forward elsewhere and you have other ways of doing that. Some things, such as minimum unit pricing for alcohol, are outside. So, I do see this as a very important stepping stone on the journey of improving the public's health in Wales.

[126] **David Rees:** I just remind everyone that minimum alcohol unit pricing is actually going to be a draft Bill being brought forward by the Minister, which will be considered, possibly, before the Assembly finishes.

[127] **Gwyn R. Price:** So, in your opinion, this is a good start and we're going to develop on the Bill.

[128] **Dr Hayes:** Yes.

[129] **Gwyn R. Price:** Thank you, Chair.

[130] **David Rees:** Could you clarify something, perhaps? You identified some areas that you would like to see in the Bill. What are they?

[131] **Dr Hayes:** I would like to see far more about activity, but the active travel Act gives us a big opportunity to do that on a local level. Maybe what we haven't done is taken that far enough forward yet.

[132] **John Griffiths:** Yes, I'd be interested in picking up on that, Chair, unsurprisingly. In terms of activity, getting the population more active has health and wellbeing benefits. It

seems to me that there are opportunities to pull key partners together in terms of their own roles and potential roles in getting a more active population—the health sector, the sport and leisure sector, local authorities and others. I think one question is whether there is some duty or a mechanism that might achieve that, which would go beyond the future generations Bill and other legislation that this particular public health legislation might create. Would you have any particular view on that?

[133] **Dr Hayes:** I see improving activity as being about a cultural change and about identifying opportunities that people can take very easily and very naturally. I'm not sure if regulation is the step forward at this point. Working on the active travel concept and developing local partnerships, there are huge opportunities for us to develop already, and I think all the health boards are taking part in those and trying to establish a much stronger baseline to move forward as a collective group, identifying everybody else's opportunities for working together. So, I'm not clear what role regulation would have at this point. I did say I would have liked to have seen physical activity in there, but I'm not clear at this point what that would look like, and I do think there are opportunities for us to do a huge amount on a local basis through local partnership. It might well be a much stronger partnership issue than a specific regulation issue, if that makes sense.

[134] **John Griffiths:** Yes, okay. Okay, Chair.

[135] **David Rees:** Can I ask a question on this point? You've talked about activity, but, obviously, one of the big issues is obesity.

10:45

[136] **Dr Hayes:** Yes.

[137] **David Rees:** Do you believe that the regulations that currently exist are sufficient to start tackling that aspect without the inclusion of any element of food, nutrition or any aspects in this particular Bill? Perhaps Gill will start.

[138] **Dr Richardson:** Thank you. I think that there are some things that could be done, but it's probably at Westminster that we need some action. For instance, there have been talks about the taxation of high-energy, low-nutritional value foods, and the banning of trans fats because of their carcinogenic effects, but these are probably not within the gift of the Assembly. But I do think that, particularly in our deprived areas, to have subsidised access to leisure facilities for those on benefits or for children is extremely beneficial, and many local authorities are actually offering those services. It becomes more complicated when leisure facilities are contracted out, because, in effect, there are, you know, social enterprises and charities running leisure facilities, so it's hard to legislate. But I do think that there have been notable successes for Wales, such as, you know, the scores on the doors and food labelling, and the UK sort of stance on food labelling could go further. Also, the link between alcohol and obesity is not very clear to people—I think that it's poorly understood—or the link between, you know, the rising liver cancer that we're seeing being due to the dual factors of alcohol and obesity. So, there is much more, perhaps, that we could be doing to warn the public about the choices they make and the implications they have for their lives, but it's probably not within the scope of just Wales to deliver.

[139] **David Rees:** Okay. Thank you. The Bill obviously covers quite a large variety of topics within public health, and we intend to actually go through those topics individually in different parts of the Bill. So, we'll start off with Part 6 on the issues of public toilets. Lindsay.

[140] **Lindsay Whittle:** Thank you, Chair. Good morning. Lots of witnesses have

highlighted the importance of adequate toilet provision and recognise the difficulties that local authorities face, and your evidence to us on Part 6 says exactly the same. So, the messages coming across are consistent. Are there ways in which you think this Bill could be strengthened to ensure that these local toilet strategies are effectively implemented and do you think we take account of the specific needs, for example of disabled people or parents with young children, please?

[141] **Dr Richardson:** I think that we could strengthen the Bill's request in that area. I think there have been campaigns by parents and carers of disabled people, and disabled people themselves, for the Changing Places type of toilets, whereby there are changing beds in toilets. I know that it is difficult for local authorities to maintain these, but I do believe that there is such a value to the community and to the vulnerable members of the community—people with young children and people with, you know, continence issues. Many of us, as we get older, you know—. It will limit our lives and we will have to plot our lives according to where the toilets will be for our day. There are many people who are limited in their independence because of having to take into account those sorts of considerations, especially in rural areas. So, I really think that we would support everything in there; and if there's anything that could be furthered, I would say that it's the provision for the disabled according to the Changing Places standards, which has been campaigned for by many disability rights organisations.

[142] **Lindsay Whittle:** Thank you. Through you, Chair, now I've got my bus pass I totally agree with you about the fact that many of us are getting older. It does isolate older people. Do you think there should be financial incentives offered to local authorities written into this Bill?

[143] **Dr Richardson:** I don't think that's for me to say. I think you know how best to, you know, sort of lever local decisions. But I do think that the elected representatives, if they listened to their populations, would realise this is really a very important issue. Although it seems a smaller issue, compared with some of the things we'll be talking about today, it actually is probably the thing that most affects everybody's life after a certain age.

[144] **Lindsay Whittle:** I agree. Thank you very much.

[145] **David Rees:** Elin.

[146] **Elin Jones:** On placing a duty on local authorities to have a strategy on public toilets, and to look to work with businesses in communities and other public buildings to provide, it strikes me that the NHS itself and local health boards have a lot of properties with toilets in them in all communities, including rural communities. I'm thinking in particular of GP surgeries, which are open from 8 a.m. until 6 p.m., probably, in most places. Do you think that there is a need to include the NHS itself as part of the general toilet provision and to make this a bit more specific in legislation, or certainly in the guidance that follows the legislation?

[147] **Dr Hayes:** Could I answer that one? I think that this does give the potential for those local discussions to take place. I think that there shouldn't be a description of where these toilets should be, but there should be an encouragement to open up opportunities on a local level. It may be easier in some areas than in others, and the local dialogue is the important thing here—the local strategy to be developed. To hark back to my previous comment, having a good strategy for local toilets does allow people to access their environment, and that's the background to this—it helps people to get out and about, and that's the really important thing here.

[148] **Dr Richardson:** It's tricky with general practitioners, because they're independent

practitioners. So, it's difficult, and it would have to become part of their contract, probably, that they opened up their premises because, obviously, they're personal premises.

[149] **Elin Jones:** I understand that, but, during discussions in this place on toilets being available in communities, the use of private sector cafes and hotels has often been talked about, and the same applies to GP surgeries.

[150] **Dr Richardson:** I would welcome it, but I'm not sure that every GP would. I think that many would.

[151] **David Rees:** Thank you. We will move on now to Part 5, which is the pharmaceutical services. Gwyn.

[152] **Gwyn R. Price:** Will the Bill as drafted ensure that health boards determine applications to provide pharmaceutical services in a timely manner, and I'm talking about working with the community and established GP practices, so that communities get the pharmaceutical services that they require?

[153] **Dr Hayes:** I'm not sure what's behind your question as regards 'a timely manner'. Could you elaborate on that?

[154] **Gwyn R. Price:** I represent a rural community that has had many years of a GP practice that dispenses as well. So, when you determine the pharmaceutical requirements of that area, the community should be taken into consideration when we want to establish any new pharmaceutical areas.

[155] **Dr Hayes:** This measure would assist that, because we are required to do a needs assessment for pharmaceutical services, and that will be a broader issue as to what additional measures the pharmacy can support and provide. Up until now, the decision has been made on the prescribing and dispensing question, but now it's a broader question about what other opportunities can be offered through the pharmacy. So, the question is a much broader one, and it would facilitate making more pharmacies available for the population based on the needs assessment, if that population need requires it. So, if pharmacies can provide smoking cessation services, the flu vaccination and a wide range of population-based interventions, that would need to be taken into account in deciding whether to grant entry for new pharmacists. It will help that question and it should make it easier to open up new services.

[156] **Gwyn R. Price:** Thank you.

[157] **David Rees:** Altaf.

[158] **Altaf Hussain:** [*Inaudible.*]—during the weekends and when the GP surgeries are closed. That has also helped us a lot. But, in Wales, prescriptions are free and are not charged for, but many pharmacies are unable to prescribe—they tell them to buy paracetamol or ibuprofen but they don't want to spend the money. As a result, they either go to the GP surgery, if it is open, or, during the weekends, our accident and emergency departments in hospitals remain quite busy with all of these people who want to have a prescription for paracetamol. Is there a way that pharmacists should be able to prescribe and put the prescription through for those medicines?

[159] **Dr Hayes:** Again, I don't think I can answer that question. There are certain circumstances when the pharmacy does give medication out, under certain special requirements, but I can't answer the question about paracetamol and the wide range of medications—

[160] **Altat Hussain:** Should that be included in this Bill?

[161] **Dr Richardson:** I think there is a qualification whereby pharmacists can now train to be dispensing themselves and, in the same way we have nurse-prescribers, we are moving towards being able to have pharmaceutical prescribers. It's very early, but there are pharmacists who would like to have this extended role and extended training. I think it would help a lot, as you say.

[162] **David Rees:** Can I ask, in relation to the Bill's requirement to undertake the pharmaceutical needs analysis, what's the impact upon the resources of the health boards of that aspect of the Bill? I want to try and find out whether you think the Bill will actually meet the needs of the community by ensuring not just that you assess the needs, but also the commissioning and delivery of those needs, effectively? Will the Bill provide that opportunity?

[163] **Dr Hayes:** There's a requirement to do a needs assessment anyway for the health board, and this would add more complexity to that, but it's not a whole new ball game or a whole new activity that would be done. It would influence some of the ways that's done. So, I don't see that the needs assessment itself would be burdensome.

[164] On managing the process, I don't think we've done that preparation. I don't think I can comment on how easily we would manage the regulation of it, but I can't see it being too burdensome, because we have a lot of regulation in place and a lot of performance management arrangements in place. So, I can't see that that would be a problem.

[165] **Dr Richardson:** I think it might help, for areas where there is, perhaps, a high level of substance misuse, that you would be looking for a pharmacy that would wish to participate in directly observed therapy for methadone replacement, for instance, and you would be looking to attract pharmacies that were interested in meeting that need. So, I think it will help.

[166] **David Rees:** Okay. Thank you for that.

[167] We'll move on to Parts 3 and 4 of the Bill, which are special procedures and the intimate piercing aspects. John, do you want to start?

[168] **John Griffiths:** Yes. In relation to each of the defined special procedures, do you believe there's sufficient evidence for their inclusion in the Bill? I think, locally in Newport, we know from the recent experience at the tattoo parlour that there's quite a lot of evidence there, but in general, for each of them, do you think there's enough evidence, and are there any other special procedures that you would like to see included on the face of the Bill?

[169] **Dr Richardson:** I'll start. I think, yes, it's a vital part of safeguarding the population of Wales that, at the moment, is missing. The regulations that are there at the moment are old and they are on a voluntary basis for local authorities. So, the public has absolutely no idea, when they're going to premises, whether they are safe, whether they are clean, whether the person is competent or whether they just walked out of another job the day before. There is no test of competency for any of the procedures. So, somebody could be working in a steelworks today and, on Monday, they could be piercing a tongue. As a former GP, there's no way that I would do that; there's no way that most dentists would pierce a tongue, and they have four years of specialising in head and neck anatomy. They would not do it without a resuscitation trolley by the side, because of the risk of major haemorrhage, the risk of infection, or anaphylaxis. It doesn't bear thinking about. They pick up a lot of the side effects, in fact, our dentists, because when tongues swell, the piercing becomes embedded and it's very difficult to remove. So, our dentists see them when they need removing.

11:00

[170] I think it is including all the procedures within it that are relevant. There have been outbreaks of infectious disease associated with acupuncture. There was an outbreak of 32 cases in Toronto that had mycobacterial—so, tuberculosis-type—skin infections. That was in 2002. Also, in Rhode Island, in the USA, there were 35 cases of hepatitis B from an acupuncture premises. Of the 300 or so people who were on the books, 10 per cent of them were positive for hepatitis B. We also know that electrolysis is a risk factor for hepatitis C, so I think it is right to include them. There's just the potential risk, whenever there's anything sharp that is reused, that it may not be sterilised properly, and then you're basically transmitting infection.

[171] As regards the piercing and the tattoo incident that we've dealt with in Newport, it will have cost our health board, Public Health Wales and the local authority probably about £0.25 million. It will have affected about 1,000 people, most of them young people. Nine people had serious hospitalisations requiring surgery and after-care, some of whom are permanently disfigured. The trader is able to set up and trade again whenever they want, because until there's a prosecution that's successful, there is no way that the local authority—no powers available to them—can prevent this from happening. So, the trader has, in fact, set up again—last week. So, I'm very, very much in favour.

[172] I think the addition of body modification would be an important one. Some of these procedures are irreversible. Taking away part of the cartilage of the ear to make Mr Spock-type ears and other elements of body modification are really things that could be, and should be, included. The intimate piercings are something that should concern us all, really, that young people are having intimate body parts pierced by people whom we would not consider fit and proper to be doing this.

[173] **John Griffiths:** That's great. Were there any particular special procedures that you would like to see included on the face of the Bill, in addition to those that are included?

[174] **Dr Richardson:** I think the Bill gives latitude for the inclusion of more procedures over time, so body modification, sub-dermal implants, basically the 3D tattoos where they actually put fillers under the skin and things like that can all be added, I think, with what is there.

[175] **John Griffiths:** Yes, so you wouldn't particularly want to see any additions on the face of the Bill.

[176] **Dr Richardson:** I think I'd want it to be flexible for any future procedures that are considered, possibly, to be at risk.

[177] **John Griffiths:** Okay.

[178] **David Rees:** In that sense, one of the reasons the Minister identified was that these were skin-piercing procedures, and the ones you've just talked about I would actually see as skin-piercing procedures, so, in a sense, they could be included on the face of the Bill. That's the argument.

[179] **Dr Richardson:** Yes.

[180] **David Rees:** Lynne?

[181] **Lynne Neagle:** I just wanted to ask about enforcement, because obviously the enforcement is going to be down to environmental health. I just wanted to ask both of you

how comfortable you are with that and whether you feel that they are the right agency to be doing that, or whether you think there should be a bigger role for health boards in policing this.

[182] **Dr Richardson:** I think the local authorities have traditionally policed this. I think the sector has grown at such speed that we will need quite a registration fee from the premises to staff the means of inspection, but it is a consideration as to should the body that is inspecting private clinics for minor surgery actually be the body that inspects other areas where minor surgery is taking place. Skin piercing is one thing, but tongue piercing is a very different and much more risky procedure. Should people who are offering tongue piercing actually be inspected by the same bodies that inspect private healthcare providers that offer minor surgery? It's a consideration. I don't know the answer.

[183] **Dr Hayes:** Could I add a comment there? Just to remind Members, there is a proper officer function. Public Health Wales employs communicable disease control consultants, who are proper officers of the local authority, and they have powers bestowed by the local authority to take action on infectious disease issues. That's the way these outbreaks often come to light, through surveillance of infection, investigation of what's happened, and then enacting the public health laws. So, this is an example of where health and local authorities have to work together very closely to identify clusters and then investigate. So, there are different ways to approach this, but through partnership working.

[184] **Lynne Neagle:** But you're confident, then, that environmental health can do it and you haven't got concerns about capacity, given the financial constraints that they're facing. You feel, as long as the fees are right, that that will fund this properly.

[185] **David Rees:** I think they're saying 'yes', for the public record. Okay, thank you, Lynne. Kirsty.

[186] **Kirsty Williams:** Thank you very much. You're the only person so far who's been able to identify issues around acupuncture, so I'm very grateful for that. You say that we need to have flexibility within the legislation, perhaps to take on new trends in body modification or something new that might come forward, but there are other procedures that we know about now that are being undertaken that might not involve skin piercing, and I'm just wondering where you think the line is drawn. So, you talk about body modification, but body modification perhaps could include chemical peels carried out in a beautician's, or colonic irrigation, hair dyeing, semi-permanent eyebrows or eyelashes, and all those kinds of procedures. Where do you think the line should be drawn?

[187] **Dr Richardson:** Well, where there is potential for harm. It's about individuals, I think. If somebody has their hair dyed and it goes wrong, the hair might fall out, it might not look very nice, and it might influence their psychological health, but you wouldn't really say that that was a public protection issue. However, a chemical peel can burn, and we have enough business, thank you, at Morriston Hospital, without that. That is an actual toxic substance that is being applied to somebody's skin, and if the person is not trained and competent, then harm can result. So, I think it has to be: could there be harm? Could there be significant harm to this individual? And is there a competency check needed before the procedure? So, we wouldn't get involved in the hairdressing business, I don't think, but we would definitely want to know that beauty treatments that involve laser treatment or other potential burning aspects would be done safely by people who have been proved to be competent.

[188] **Kirsty Williams:** And I know John thinks I'm obsessed with it, but colonic irrigation?

[189] **Dr Richardson:** It's not without harm, is it? There may be underlying bowel conditions, there may be conditions such as Crohn's disease that the person may have, undiagnosed problems, there may be polyps, and there may be things that could rupture because people haven't actually had check-ups at their GP. However, it is a fashion, it is a trend, and it is a fad. If the person administering it has been truly trained and there is a competency check, then one might consider it, but at the moment, that isn't the case. Are we going to legislate against colonic irrigation? I don't know. I don't know how commonly that is used, outside of health spas and places where it is a trend and a fashion. I don't know how mainstream it is on the high street, but then I may stand corrected. I'm just not aware that it's a mainstream activity, but it certainly has the potential to cause harm, yes.

[190] **Kirsty Williams:** Thank you.

[191] **David Rees:** I think it's fair to say that there are examples where there has been harm caused by the inappropriate use of chemicals through hairdressing as well. Altaf.

[192] **Altaf Hussain:** I'm a retired orthopaedic surgeon, and I know all these small procedures can cause harm. They are risky, and, once they cause harm, they come to the NHS and it is we who take the care. We need to have proper regulation for all of these. That means all these small procedures should be in this legislation by name, which comes to the colonic irrigation as well, because people can die on the table. Everywhere these special procedures are conducted needs to have the evidence that they have first-aid care available and that they are well trained for CPR. I think that's very important, and that is why I say all these procedures should be within the legislation, which we know. We should have the option to include more, if anything else comes within it.

[193] **Dr Richardson:** Exactly.

[194] **David Rees:** Okay, thank you. Can I clarify a point on intimate piercing? You've already identified tongue piercing as an example of a concern you have. Obviously, that's not identified in the Bill for intimate piercing issues for children under the age of 16. Should it be, under those circumstances, included, as with navel piercing as well?

[195] **Dr Richardson:** I think so. I think I would welcome it being included. In fact, you could argue that tongue piercing needs to be a separate category for any age, because it carries so much more risk than piercing anywhere else, but definitely. We saw six people under 16 with intimate piercings. People are getting all kinds of places pierced—you wouldn't believe—but, in particular, nipple piercing is becoming very common.

[196] **David Rees:** Yes, we've heard the evidence of that, I think, from previous witnesses. Should there be a requirement in the Bill? Should it be strengthened to actually ensure that there is proof of age for any piercing being undertaken by whoever does it? Should it be strengthened to ensure that proof of age is included, so that we can put the onus upon an individual to ensure that the person they're acting on is of the appropriate age?

[197] **Dr Richardson:** Yes, and I think the whole of the safeguarding arena and this minor surgery area have really lagged behind, and we need to catch it up to speed with the safeguarding aspects—very much so.

[198] **David Rees:** I'm going to ask one question. There is an age limit of 16. Should there be an age limit below which there should be no piercing at all—for babies or anyone else? Is there any evidence to demonstrate that there's an issue there?

[199] **Dr Richardson:** The youngest child we found with a piercing in our look-back was aged three, but, obviously, that three-year-old has been taken by parents and they have

requested that they have the piercing. It's very difficult because there are cultures where it is normal for that to happen. I'm thinking of Roma cultures and Traveller communities and other communities. Whilst we wouldn't—or, personally, I would never want to take a three-year-old to have their ears pierced, if we try and criminalise it, I think what we may do is drive it underground and have, in those cultures, home piercing. I think that the answer is to regulate the sector and monitor. I think there is a question, under the safeguarding rules, of what should be allowed to be pierced in a minor. An ear seems to be culturally acceptable. In many cultures, other areas, such as the nose, might be acceptable—for Asian cultures—at a younger age, but where would we draw the line? We're always balancing this wish to have things done safely and in a regulated way as opposed to driving them underground, and I know there've been similar discussions with circumcision, and, on balance, I think it's just best to know about it and regulate it properly.

[200] **David Rees:** Thank you for that. If we move on now to Part 2 of the Bill, which relates to tobacco and nicotine products, and if we just, in the first instance, look at chapters 2 and 4, which talk about retailing of tobacco products and handing over tobacco to under-18s. Gwyn.

[201] **Gwyn R. Price:** Thank you, Chair. Are there any additional tobacco control measures that you'd take into consideration for inclusion in the Bill? Do you think anything else could be done in the Bill?

11:15

[202] **Dr Hayes:** I think that the important thing is to treat e-cigarettes the same as tobacco smoking and cigarettes. So, I would simply like to see equivalence. So, where smoking is not allowed in certain areas, e-cigarettes shouldn't be allowed in those areas. The issue about passing e-cigarettes to under-18s, I think, is absolutely right. We need to have equivalence. An e-cigarette should be treated the same as a cigarette. That's my view on it. Keep it really simple. The population can get very mixed messages if we treat one thing differently to another. We just need to treat them all very similarly.

[203] **Gwyn R. Price:** Okay. Thank you very much.

[204] **David Rees:** We will come back to the e-cigarette.

[205] **Gwyn R. Price:** Yes. I think you touched on that. In relation to children being able to get it on the internet today—tobacco online et cetera—on safeguards, do you think we should be looking at the safeguards that we could possibly put in place there?

[206] **Dr Hayes:** So, you meant additional safeguards online.

[207] **Gwyn R. Price:** Yes.

[208] **Dr Hayes:** Sorry, I missed the point. Oh gosh; I think that's outside my level of competence as well. I think we do need to be clear that there need to be precautions in place to stop children accessing things online directly.

[209] **Gwyn R. Price:** Thank you.

[210] **David Rees:** John.

[211] **John Griffiths:** Yes, I wanted to ask, Chair, about the progress that has been made, thankfully, in driving down smoking rates and making smoking less socially acceptable. Obviously, the ban on smoking in enclosed public places has been a very significant part of

that. In terms of this legislation, I wonder whether you might support any additional restrictions. One thing that's suggested, and is happening to some extent, is tourism beaches, for example, not having smoking there. I know that some would like to see outdoor areas of cafes and restaurants included in the restrictions, particularly for people, perhaps, with asthmatic and other conditions that are very worried about the possible effects on their health but would rather sit outside in nice weather rather than be inside. I wonder whether there are any particular examples you would like to identify to this committee in terms of how areas that are restricted at the moment might be added to.

[212] **Dr Hayes:** I would welcome being able to extend the smoke-free areas—areas where children congregate. We have smoke-free playgrounds in my area, in my patch, which is a tremendous step forward. That should apply to e-cigarettes as well. There is an issue about enforcement and about how we enact such policies. That is a challenge, but the more power that we put behind that, the better. I would support smoking bans and e-cigarette bans in open cafe areas where people are sitting down eating food. They are not mobile; they can't move away easily from someone who's using an e-cigarette. I think that concept would be very valuable.

[213] **David Rees:** Okay. We've gone off a little bit from the retail. We've got to come back, in a sense.

[214] **Dr Hayes:** Sorry.

[215] **David Rees:** No, it's okay; it's my colleagues' questioning. They jumped a little bit. Can I just go back to the register process? Is this actually going to enhance the tobacco control actions that have already been set out, by simply keeping a register of those who sell tobacco and nicotine products?

[216] **Dr Hayes:** It should do; yes, it should do. We have a big problem with illegal tobacco across Wales. So, the idea is that if you have a registered outlet, you should know what's going through that outlet. If cigarettes are coming through non-registered outlets, there's a reason behind that, isn't there? It helps. And similarly, for e-cigarettes, we need to know where they're being distributed from. It's about understanding the market and understanding when you find things that don't fit—you know, you get information that's not adding up. This is outside my area of competence—I'm in the health board—but all of this does help in the battle to control the market, as far as is necessary.

[217] **David Rees:** Do you currently have an indication of where the prevalence of retailers are, because of the work you do as public health, in your own areas, and, therefore, is this going to strengthen your understanding, perhaps, of areas that are prevalent in terms of smoking use and areas that you may see as being important to tackle to try and reduce the number of smokers?

[218] **Dr Hayes:** I'm not sure about—. The local authority would have an understanding of where the outlets are and we have an understanding of where the smoking behaviour is, so we know the prevalence of smoking behaviour across our patch to quite a low level of detail, so it's statistically small areas. We don't have that mapped out for e-cigarette use at this point, but that would be something that could be developed in the future through improved monitoring and use of surveys.

[219] **Kirsty Williams:** On this concept of retail registers and trying to regulate the market, do you think that should be extended to other products that may be harmful to health and may be abused, such as butane gas and glue? We know that addicts go into shops and buy these products with the sole intention of abusing them.

[220] **Dr Hayes:** That's a question I would find very difficult to answer, but I can offer that e-cigarettes are sold only for use as e-cigarettes, whereas butane gas and the other things that you talked about have other uses. So, it's a much more complicated question that we'd be trying to address. E-cigarettes are simply for people to use as e-cigarettes.

[221] **Kirsty Williams:** I'm just interested that you said it was an important public health measure with regard to traditional tobacco to regulate the market, but we do know that there are other substances that are sold out of retail that can be hugely harmful to people's health if they're abused—you know, people, as I said, who use gas and glue. I'm just wondering whether you think the principles, if they apply to traditional tobacco, should apply to other products that could be harmful.

[222] **Dr Richardson:** I think I would just echo Sara's comments that it's difficult when there are 10 possible uses and harming yourself with a product is one of them. It's difficult to then penalise the nine other people who would like access to that product. Whereas, when we're talking about tobacco, we're just talking about that product for use as a substance, and it's an addictive substance, so any nicotine over the counter should also be regulated in the same way. So, it's either through pharmacies, or through regulation through the small outlets that supply those. I think it would be quite difficult to enforce, and that's the problem with all these other areas. But, there are dangers and, as you rightly say, in deprived areas, there are very real dangers from these other substances, but I just can't see how that could be enforced.

[223] **Kirsty Williams:** On the principle, then, of addiction, you say that nicotine is addictive, and there are lots of products in our shops that are addictive—and I'm counting the coffee cups that are around here this morning; we all accept that that's an addictive substance as well, but we don't seek to regulate—and again, I'm just testing the boundaries about where you draw lines in legislation where the principle is around regulation of a substance because it's addictive but we don't regulate other substances that are addictive. I'm just wondering where we draw the line.

[224] **Dr Richardson:** We don't believe that coffee causes a huge burden of disease to the NHS, so we don't believe that, in the main, coffee is a cause of much disease. However, we know that—

[225] **Kirsty Williams:** Apart from certain people's palpitations.

[226] **Dr Richardson:** Yes, quite possibly. But, we do know that tobacco products are the cause of people occupying most of our NHS beds, and the problem with e-cigarettes is that, because they're not regulated, the dose isn't so strictly monitored. Some of those might have eight times as much nicotine as a traditional cigarette. So, actually, if you're talking about somebody who is trying to use it as a quit aid, they may, having been a 20-a-day person, end up being a 60-a-day person. So, it actually might have done them a disservice in their addiction and in their route towards trying to quit their addiction.

[227] Many people interchange the two, so we are worried. We know that, obviously, lung cancer will probably go down as a result of these e-cigarettes. We know that the tar and the irritants will probably not cause the inflammation to people's lungs. What we don't know is that some of the other cancers may actually be due to more of a link with nicotine. So we don't know enough yet to know whether e-cigarette users will still get bladder cancers or will still have eye problems related to their habit; we just don't know. The vascular effects of nicotine are very real. We know that the cardiovascular effects—some of those—will persist. So, what we're saying, I suppose, is that it's difficult; at the moment, there seems to be some promise for some people of a reduction in risk, but we have to balance that against the fact that the risk isn't going to go away totally, or the burden to the NHS.

[228] **David Rees:** Is that okay, Kirsty?

[229] **Kirsty Williams:** Thank you; that's fine.

[230] **David Rees:** We'll move on to the smoking of e-cigarettes aspect now, if it's okay. This is chapter 1, effectively. You've highlighted some very interesting points in that last answer as to some of the issues around e-cigarettes. Is there any other evidence that demonstrates these issues? Obviously, we've been hearing evidence on both sides. Is there any evidence to demonstrate the fact that it does create normalisation and it actually can create harm? I suppose we're asking for the evidence base.

[231] **Dr Richardson:** There is some evidence of harm in terms of the toxicity of the nicotine. The nicotine refill products, at the moment, are not the subject of childproof, tamper-proof legislation because they're not classed as a medicine. They have had experience, mainly, I think, in America, where children, or indeed adults, have accidentally spilt some of the liquid and have had to be hospitalised because of cardiovascular effects. So, that's been outlined in the *British Medical Journal*. The toxicity profile of some of these things is very real, and if you think about the marketing of the devices, and the flavours, if you like, unfortunately they're very appealing to children, so there's gummy bear flavour, and bubble gum, and many of the devices young people would find quite attractive. So, young girls would find the pink glitter sticks very inviting. So, unfortunately, children can get hold of these devices, and the toxicity is very serious, actually.

[232] **Dr Hayes:** Can I add to that that there is evidence that it can be hard to police the no-smoking enforcement, because when someone is seen from afar using an e-cigarette, you're not sure whether it's a cigarette or an e-cigarette, and it can be very hard to challenge, and it can give confusing messages? That kind of undermines the smoking bans in certain places, because it's really hard to know what's going on from a distance. Everyone can see someone smoking, but is it a cigarette or an e-cigarette? So, it makes the no-smoking bans harder to manage and enforce. It also creates confusion. A big success of the smoking legislation is actually the public getting on board with it and having constructive conversations and challenging conversations with people who smoke. But, it's a very difficult message to have that conversation with someone using an e-cigarette, and it kind of creates a less supportive background. So, treating e-cigarettes in the same way as we treat cigarettes actually reinforces the public being much more on board with this as well.

[233] **David Rees:** Thank you. I've got questions from John and Elin.

[234] **John Griffiths:** I think some people might say that there's obviously a need for much greater regulation of e-cigarettes; you know, the sort of things you mentioned, Gill, in terms of nicotine content, the way they might be presented and marketed to appeal to young people, with no age limit in terms of purchasing them and that sort of thing. So, I think some people might accept that, yes, we need a lot more regulation, but it should be recognised that they are, for some people, a means of giving up smoking tobacco or reducing their smoking of tobacco and making that switch to e-cigarettes, and if you put them on the same footing as tobacco products in terms of areas where you're allowed to smoke, then there is a danger that people would find it less attractive as a proposition in terms of smoking e-cigarettes and not make that switch from tobacco products.

11:30

[235] Also, if they're in the same smoking shelter or whatever as smokers, then, if they have made the switch, they then may find that the smell of the tobacco smoke is too much of a temptation and they go back to ordinary cigarettes. Do you think there's much strength in those sorts of arguments?

[236] **Dr Hayes:** It is claimed that e-cigarettes are used to help people stop smoking, and that's true, they are used, and some people find them very effective. But, actually, we have a range of ways to stop smoking, and e-cigarettes are just one of them. We've got some much more effective ways that are available through the NHS that involve nicotine-replacement patches and personal support, and ways to cope with the behaviours to get over the need to do the things that are part of the habit of smoking. So, there are more effective ways to give up smoking. I wouldn't want to stop people using e-cigarettes as a way, as it might suit individuals, but there are more effective ways to give up smoking.

[237] I want to be clear: I'm not asking to ban e-cigarettes totally—it is a way to divert people from smoking—but we do need to treat them in the same way as cigarettes, just to keep that really simple message that they are unproven. We don't know what's in the vapour altogether, and we don't know what people around e-cig users are being exposed to, they're unregulated, and we should be treating them very cautiously. I think it is really very sensible to treat them in the same way as cigarettes, because we do not know what we're dealing with. I do think there's a strong argument about prevalence. The less that we see, and the less particularly our children and young people see, people using a cigarette or an e-cigarette, the fewer the people who will be encouraged to take up the behaviour themselves. We are seeing a fall in smoking behaviour in young children, and we really want to push with this. We don't want to be complacent and allow e-cigarettes to replace what's being lost. We want children to actually grow up not taking the course to cigarettes because of whatever reason they take them for. An awful lot of people who are older say that they use cigarettes when they're coping with stress and when they're dealing with difficult issues. A lot of people may give up smoking but return to smoking due to a difficult situation. Well, we want our young children to have other coping mechanisms now, we don't want them to need to use cigarettes as a way of doing that, nor, therefore, e-cigarettes. We want to really welcome the drop in prevalence we've got in smoking, and not see that replaced by e-cigarettes.

[238] **David Rees:** Okay, John?

[239] **John Griffiths:** Yes.

[240] **David Rees:** Elin.

[241] **Elin Jones:** It's slightly beyond the scope of the legislation, but I'm interested to understand how much work you're doing as public health on the dangers or potential harm associated with e-cigarettes. You mentioned something that I hadn't heard before, and that is the intensity of nicotine in e-cigarettes, which is, I think you said, eight times as great as an ordinary cigarette.

[242] **Dr Richardson:** Potentially, yes.

[243] **Elin Jones:** So, there's a harm possible there of increasing the addiction of individuals. How aware do you believe individuals are of that harm within e-cigarettes—those who are users or potential users—and how much effort are you putting in in public health to making people aware of the harms associated, potentially, with e-cigarettes for their own consumption?

[244] **Dr Richardson:** I don't think people are aware of the risks. I think they think the same as of the tattoo parlour on the high street: if it's in mainstream use, it must be safe, and somebody somewhere must have checked it out. They don't realise that nobody has checked out, because they don't need to, because it's not a regulated product, the e-cigarette. So, we don't have a nicotine dosage on the side of them, whereas if you go to a chemist and have a nicotine-replacement product, it clearly states the amount of milligrams per. But that just isn't

the case. I think the public do need to be educated, and I think particularly our young people need to be educated. So, the directors of public health are taking actions in their local areas, but north Wales has particularly done some very good work on this. They have looked at young people's attitudes and they've found that young people do see e-cigarettes as quite glamorous, quite sophisticated, they're quite drawn to them, and they don't understand the entire picture and the possible risks. So, it's something we definitely want to be tackling through our healthy school schemes and our policies and programmes with that programme. Through reinforcing this public health Bill, the Assembly will be sending a very strong message that will help us and strengthen our arm, if you like, in giving those educational messages. The tobacco companies have not, ironically, developed these products through altruism; they've developed these products because they know that the social acceptability of their other product is decreasing, and unfortunately they are seeking to recruit mini consumers who are going to be their long-term profit base for the future, and, actually, I'd rather that they didn't recruit from Wales. So, any help you can give us would be really appreciated.

[245] **David Rees:** Thank you. Do any Members have any other questions? Could I just ask one final question? One of the issues that's been brought to our attention is the aspect of human rights, particularly relating to these—

[246] **Dr Richardson:** Sorry, I couldn't hear.

[247] **David Rees:** One of the issues that's been brought to our attention is the aspect of human rights, particularly relating to a Part of the Bill where a home is used for dual purposes, both as a place of work and a home. And one of the aspects is, obviously, residual smoke and vapours within furnishings in that room or property. Do you have any evidence as to whether e-cigarettes offer the same residue within furnishings as tobacco and cigarettes do, in the sense of where are we in this situation where a building is used for a dual purpose, effectively?

[248] **Dr Hayes:** I don't think we do have any evidence of residue in the furnishings. I'd be more concerned if people were using them while there were visitors in the room—it's being exposed in the room at the time that is the issue from my point of view. But I don't think we do have evidence of off-gassing from furnishings from vapours and e-cigarettes.

[249] **David Rees:** Okay, thank you.

[250] **Dr Richardson:** I don't think we know about the fire risks either, because obviously there's a battery involved. I think that it's just an area where the research will emerge. I know that we had the tube incident, or a bus incident, where there was a fire from an e-cigarette, wasn't there, in somebody's handbag, and the bus had to stop and be evacuated. But I think this evidence will emerge.

[251] **David Rees:** Okay. Thank you very much for your evidence this morning; it's been very interesting and very helpful. You will receive a copy of the transcript for any factual inaccuracies that you may identify. Please let us know if there are any as soon as possible. Once again, thank you very much for coming in; you've been very helpful.

[252] **Dr Richardson:** Thank you.

11:38

Papurau i'w Nodi
Papers to Note

[253] **David Rees:** Are Members happy to note the papers as item 5? That's the minutes of the meetings held on 17 and 25 June. Are you happy to note those?

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting

Cynnig:

Motion:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod, yn unol â Rheolau Sefydlog 17.42(vi) a (ix).

that the committee resolves to exclude the public from the remainder of the meeting, in accordance with Standing Orders 17.42(vi) and (ix).

Cynigiwyd y cynnig.
Motion moved.

[254] **David Rees:** Then under Standing Order 17.42 (vi) and (ix) the committee resolves to meet in private for the remainder of this meeting. Are Members content? Thank you.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:38.
The public part of the meeting ended at 11:38.