Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd a Gofal Cymdeithasol

The Health and Social Care Committee

17/09/2015

Trawsgrifiadau'r Pwyllgor
Committee Transcripts

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cynnwys
Contents

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 Rodney Berman	Cymdeithas Feddygol Prydain (Cymru) British Medical Association (Wales)
Paul Burgess	Cymdeithas Nyrsys Cosmetig Prydain British Association of Cosmetic Nurses
Sarah Calcott	Cymdeithas Prydain ar gyfer Tyllu'r Corff British Body Piercing Association
Lee Clements	Ffederasiwn Prydain ar gyfer Artistiaid Tatŵ British Tattoo Artist Federation
Ashton Collins	Save Face
Brett Collins	Save Face
Dr Jane Fenton-May	Coleg Brenhinol yr Ymarferwyr Cyffredinol Cymru Royal College of General Practitioners Wales
Dr Stephen Monaghan	Cymdeithas Feddygol Prydain (Cymru) British Medical Association (Wales)

Dr Fortune Ncube	Epidemiolegydd Ymgynghorol ac Ymgynghorydd mewn Meddygaeth Iechyd Cyhoeddus Consultant Epidemiologist and Consultant in Public Health Medicine
Nick Pahl	Cyngor Aciwbigo Prydeinig British Acupuncture Council
Andrew Rankin	Cymdeithas Nyrsys Cosmetig Prydain British Association of Cosmetic Nurses

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

Amy Clifton	Gwasanaeth Ymchwil Research Service
Sian Giddins	Dirprwy Glerc Deputy Clerk
Gareth Howells	Cynghorydd Cyfreithiol Legal Adviser
Cath Hunt	Clerc Clerk
Philippa Watkins	Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:28.
The meeting began at 09:28.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members to this morning's meeting of the Health and Social Care Committee? Can I remind you that the meeting is bilingual? Headphones can be used for simultaneous translation from Welsh to English on channel 1, or if you need amplification they can be used on channel 2. Can I remind everyone to turn their mobile phones off, please, or to 'silent', and any other electronic equipment on 'silent' that may interfere with the broadcasting equipment? In the event of any fire alarms—there isn't one scheduled for this morning—can you please follow the directions of the ushers? We've received apologies from Darren Millar this morning, but we have not been notified of any substitutions.

[2] Before we commence our business this morning, can I remind

Members that there are now new rules for the declaration of Members' interests in force? The rules now include a requirement to declare relevant interests of Members and their families. It is the responsibility of individual Members to judge whether an interest relates sufficiently to a particular proceeding to require declaration. Advice can be received from the clerks and from the Table Office on the Standing Order requirements, but they can't give advice on specific issues that need further clarification.

09:30

Bil Iechyd y Cyhoedd (Cymru): Sesiwn Dystiolaeth 6
Public Health (Wales) Bill: Evidence Session 6

[3] **David Rees:** Okay, if we now go into our session, Can I welcome our witnesses this morning, representing the British Medical Association and the Royal College of General Practitioners? Dr Rodney Berman, senior policy executive of the BMA, Dr Stephen Monaghan, the chair of the BMA's Welsh council legislation sub-committee, and Dr Jane Fenton-May, representing the RCGP. Good morning. Can I thank you, both groups, for the evidence we've received for the inquiry, and also for the supplementary evidence from Dr Berman this week, which attempted to provide a sort of briefing, a summary, of the evidence we've received? So, thank you for that; it was very helpful for Members.

[4] **Dr Berman:** I was trying to focus on, I think, where we were specifically calling for things to be maybe changed in the Bill. So, hopefully, that did help.

[5] **David Rees:** Well, we'll be discussing those issues this morning. So, if I can go straight into questions, if that's okay with ourselves, Gwyn R. Price has the first question.

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

[7] **Dr Monaghan:** Good morning. We don't feel that it does. We think it's a missed opportunity. We, on the whole, are supportive, in general, of the specific provisions and most of the details within them, and we'll come to that no doubt, but we think this is a massive missed opportunity for a proper, ambitious public health Bill, which would be centred on healthy

public policy in general and particularly focusing, and using as a lever, health impact assessment. So, what I'm drawing on is the fact that, 150 years ago, the UK was a leader in public health law. In fact, before it, really—before medicine was able to make a huge difference to health, law was the main tool to make a difference to health, and, because we urbanised and industrialised first, we were pioneers of making that very successful approach, and most of the world followed us. But now, in an era of chronic disease, we find that our law is not fit for purpose in relation to the huge potential it still could have, and it can now have in a different way, and we are, if anything, in danger of becoming followers rather than leaders. But there's a big opportunity for Wales, within the UK, to be up with the vanguard if it took its opportunity to cast this legislation in a wider focus, as it originally proposed to do in its Green Paper, with large support, and to reinstitute a general approach based on actually setting general objectives for the health of the people on the face of the Bill and a lever of health impact assessment. So, that, we think, is an enormous missed opportunity as it stands, and it's a plea to try and re-join the leaders, which we were shaping to be. The leaders currently are Sweden and Norway, and South Australia has recently legislated in that way. So, in a Westminster-type system, it's perfectly possible.

[8] **David Rees**: RCGP.

[9] **Dr Fenton-May**: I would support that point. I think my public health colleague knows a lot more about the wider public health issues than I do, and I would support it anyway.

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

[11] **David Rees**: Alun.

[12] **Alun Davies**: Thank you very much, and thank you for those opening remarks. It's a very wide and sweeping statement that, essentially, this is a missed opportunity, particularly when you contextualise that with over 100 years of different public health measures, and you emphasise that this is a missed opportunity. I accept that you say that partly because this is what we're discussing this morning. I accept that. However, it would be useful, I think, for committee were you to describe in a bit more detail today why you think this is a missed opportunity and what amendments you would like to see to the legislation that would try to repair those emissions.

[13] **David Rees**: Dr Monaghan.

[14] **Dr Monaghan:** The context is the context of non-communicable chronic disease, and the World Health Forum in Davos, the World Health Organization and Harvard University produced a joint report saying the economic consequences of non-communicable diseases—obviously, I'm interested in the health consequences—are staggering, and, of course, they lie a lot behind our difficulty in funding public services, actually, because of the health-damaging aspects of our society at the moment. This requires—. This is a completely different type of disease than the focus on infectious disease, or on overcrowding, although much of the focus still needs to be on the environment in general. Some of that's the physical, including changing the physical environment, so that people accidentally walk more, for instance. But also it would involve some of the rest of the environment—what you might call the man-made environment—that underpins what we eat, drink, smoke, et cetera.

[15] So, what we need to do is recast our law in that direction. Obviously, that would include, in due course, specific provisions and it might include some of the provisions that are in this Bill—the specific ones—but what we think is missing is an overarching high-level general public health legislation. There hasn't been any general public health legislation in the UK since Chadwick's time 150 years ago. So, all the public health measures are piecemeal all over all the other legislation.

[16] So, we want to reunify, in one sense, or start to have an actual public health Bill that lays down a goal of improving the health of the people and narrowing the inequalities in health. So, it would just say, general duties, much of this puts population health as a goal in primary legislation, emphasises rights to health, mandates the consideration of health impact as the lever—so health impact assessment—and clarifying, in a sense, what's underlying this, that health is the responsibility of everyone. And I don't just mean every individual; I mean everyone in all sectors of society—civil society, the public sector, but also business. It's how it all interacts. You wouldn't start from here. I've got a kind of cartoon.

[17] Obesity probably exemplifies it best of all. You just can't get to grips with obesity by thinking of it only in terms of a medical treatment—and there is an effective medical treatment, bariatric surgery, but if that's purely our frame, are we missing something? We have, partially, that frame. Also, we try and persuade people to eat less via health promotion campaigns, et cetera, and there's nothing wrong with that, but we're going to have to think about

stronger levers than that, which will involve thinking about the health impact of major public decisions like transport networks, and like, as I've mentioned, new developments having pavements. In some parts of the world—I spent a year in Los Angeles—you couldn't walk between a lot of parts even quite close together; there was no pavement.

[18] **Alun Davies:** I share your experience of Los Angeles, but that's not our experience in Wales.

[19] **Dr Monaghan**: There are one or two developments here in Cardiff, actually, where you cannot go between them other than by car.

[20] **Alun Davies:** Okay. Can I challenge you on some of those assumptions that you made in that answer? We were talking about walking and active travel. This Assembly has, of course, passed an active travel Act, which is now delivering significant change in terms of how developments are being planned and how different transport networks are developing today. So, a lot of those issues were addressed in that particular piece of legislation, and the Well-being of Future Generations (Wales) Act 2015 also put on the statute book some of the provisions that you've just described in your answer. So, that has been done. I'm not convinced—take, for example, obesity—that you'd solve obesity in my constituency in Blaenau Gwent by the National Assembly, however well-meaning, passing declaratory Acts here, and it changing the behaviour of somebody shopping in Morrisons in Waun-y-Pound. So, is it not the case that this measure, such as it is, could only go so far, and perhaps the BMA needs to look at individual amendments to this legislation and take into account the existing statutory framework within which this legislation is being pursued?

[21] **Dr Berman:** If I could perhaps come in, I think the key proposal that we're looking at is putting on the face of the Bill a requirement that health impact assessments would be required in certain circumstances. I think, if you look at the evidence we've submitted, we've outlined the initial circumstances that we think could be a good starter for where they could apply. I think, in terms of some of the issues you were referring to, what we're intending is that it would be complementary to the policy direction that Welsh Government and the Assembly have already been following. So, for instance, on the Active Travel (Wales) Act 2013, I think that is taking us in a very good direction in that regard, but—

[22] **Alun Davies:** I'm sorry, can I stop you there? Does it achieve the

objective that your colleague, Dr Monaghan, set out in his previous answer?

[23] **Dr Berman:** Well, what I'm going to say about the active travel Act is that one of the concerns there is that it requires continuous improvement. So, you may get local authorities or Welsh Government bringing forward a certain amount of new transport infrastructure to fulfil those aims every year, but they may also be bringing forward other transport infrastructure at the same time that isn't necessarily fulfilling these aims. So, what we are saying is: why don't we look at significant transport infrastructure and have it all health impact assessed? That way, we can ensure that, whether it's being brought forward specifically to fulfil the aims of the active travel Act, or whether it's been brought forward for another purpose, it still can further that particular aim so, therefore, it's complementary. Similarly, with the Well-being of Future Generations (Wales) Act 2015, it was supposed to be taking us in the direction of health in all policies, but I'm not sure that it goes far enough—and that's certainly the BMA's view—because you're essentially looking at public bodies in Wales having to set maybe a single objective that furthers the goal of a healthier Wales. Why don't we look further in the round at things that they're doing and just check whether these are going to be able to improve health?

[24] One of the advantages of a health impact assessment is that it's not just looking at things you might not have thought about that could have a negative impact on health, it's also looking at how we make decisions. Could we, perhaps, tweak them and make them a bit better where we could then promote health more as we're doing it? So, I think it's about making sure that we take consideration of health into a much wider agenda. I think that's entirely complementary with where Welsh Government has been going. Therefore, I think if you were to put this into this Bill, not only would it lift it up to a higher level and make it more wide-ranging, but it would take that intended objective further into public policy and, I think, as Dr Monaghan has said, that could take us to the situation of being a leader in this area, particularly within the UK.

[25] **Alun Davies:** Can I just ask one final question on those health impact assessments? I don't disagree with you, by the way; I think that would be a very good innovation, but I just wanted to understand the scale of what you have in mind when you make that proposal. Are you talking about small-scale, local authority-type developments, such as the renovation of Brynmawr bus station or Llanhilleth railway station, or are you talking about one of the major transport initiatives, such as the south Wales metro, or are

you speaking about bus networks and the local authority transport grant, for example? At what scale do you see the health impact assessments kicking in? If you take, for example, any one of those examples, how would you see that, then, influencing the final decision?

[26] **Dr Berman:** Well, you've got to have parameters that would apply, and that's why we're saying that that should be specified in regulations, and we've given a list of where we think it should apply initially. So, that could involve the overarching local development plans, for instance, the strategic development plans that are now coming into force, but it would be helpful, I think, to look at certain individual planning applications. Now, you'd have to get a definition of where it would kick in and where it wouldn't kick in, but it may for instance be a housing development over a certain number of units, for instance. Now, we're not going to necessarily give you the exact detail as to exactly how to define that, but that could be dealt with later, and we'd be happy to give you our view on what was proposed. I think it's perhaps taking it not just on the high-level strategic plans, but also on the more individual detail that I think is important, because, certainly, if you're looking at how planning applications are determined, you could just look at the LDP, but that wouldn't necessarily tell you that there may be a problem down the line with an individual application that comes forward within the context of that local development plan. So, I think we do have to go to a smaller level, but we don't want to get to the point where every extension on Mrs Jones's house has to come into that assessment; it's about being proportionate. But, I think there's certainly the capability within Wales to be able to get definitions that are proportionate as to how it should apply.

[27] **Alun Davies:** I guess it would be good if we could return to that later on in our inquiry.

[28] **David Rees:** Yes, okay.

[29] **Alun Davies:** Thank you.

[30] **Dr Fenton-May continues:** Can I just come in there? We've been talking about the legislation, and one of the problems is that there is a big push for GPs to try and improve people's health, but we can't do it by ourselves. So, I would welcome any initiatives that actually put the onus on other people to get people walking more, cycling more, doing more exercise generally, and eating less of all the wrong food. We have too many easy-to-access outlets where you get sugary, fatty fast foods. There needs to be some more control

somehow about where those are sited and how easy they are to access.

[31] 09:45

[32] **Alun Davies:** How do we do that, though? I don't disagree with you, but how do we do it?

[33] **Dr Fenton-May:** I think by having some sort of health assessment on where you site all of these places, and looking at how you develop our society. They shouldn't be too near the schools, or people coming out of gyms, so they go to the gym, do the exercise, and have a McDonald's—sorry, I shouldn't advertise—

[34] **Alun Davies:** I don't think you are, as it happens. Can I say, I don't disagree with you? Intellectually, I don't disagree with you. But that's an extraordinary, intrusive approach. Without being too philosophical this early in the morning, surely an individual has a freedom to choose as well.

[35] **Dr Monaghan:** Can I say something on that? I think, obviously, that's true, but I don't know how free they are to choose in the sense that, I know you can't see this diagram, but that's a pyramid, and on the right-hand side are the different categories of foods, and that's what the World Health Organization says—these are the potatoes and pulses down the bottom, and what you call treats are at the top, in the red. That's the advertising spend. So, all the red is all the advertising spend. So, people are being told, all the time, to eat this, and they're never being told, by the advertising spend, to eat any of the other categories.

[36] **David Rees:** I want to move on, if I can.

[37] **Alun Davies:** I don't disagree with you.

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

[39] **Kirsty Williams:** I'd been very interested, as you've talked about some countries in the world, or part of Australia, that is really at the forefront of this—have those countries taken the route of mandatory health impact assessments? What other steps have those countries taken that you think Wales might be able to emulate, to put us up there alongside world leaders on this agenda?

[40] **Dr Monaghan:** Yes, they have. What they've done is that they've taken the approach I suggested, where you have a central, overarching, modern public health Bill that enshrines the goal. You could say that just enshrining a goal doesn't do anything, but, from that, they're using health impact as one lever, but also, wider than that, a health-in-all-policies approach. They're trying to use the health impact as the lever, think about the health consequences of all decisions in all sectors that have been made by the legislature. But it's enshrined in one central Bill, and then specific measures are increasingly hung under that Bill in the way that historically, over time, since, say, the NHS developed, or any other big part of legislation—well, in fact, there is the NHS Wales 2007 consolidated Bill, and all the NHS provisions fall under that. There isn't actually anything for public health now, although there was 150 years ago. There is no single Bill, so it is about re-instituting that, and that's what they're doing in those countries—Norway, Sweden and south Australia.

[41] **Kirsty Williams:** I wonder if Members' research would be able to get further information on that legislation for Members just to have—

[42] **Dr Monaghan:** I can send a fair bit of it. There's also quite a lot of movement in other parts of Europe, particularly eastern Europe, perhaps surprisingly, but it's less mature. But they're further down the line than we are.

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

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

[45] **John Griffiths:** I think this a very important debate to have, Chair. So much of health spend is reactive rather than preventative, and I think a big majority of people would agree that it makes much more sense to be preventative if you can. So, I think the suggestions that have been made are very strong and valid, and I'm sure that, as a committee, we'll give very careful consideration to them.

[46] In terms of having that sort of general approach, it's a very strong idea that would be entirely in line with the preventative approach. I think it's really important. But, I wonder whether there are any specific measures. You mentioned obesity, for example. If we get health impact assessments as a system it will take some time to feed through, but there may be things that we can do in the shorter term, more specific measures that could be included

in this Bill. I think there are ideas around in terms of obesity, and they recognise the powers that we have in terms of content of food, and marketing, and promotion, and retail, and so on. So, ideas have come forward, I know, and will come forward, but if there's anything in particular that you would like to see in addition to what we've already received, I think we'd be very interested.

[47] Just one thing on the back of that, Chair, in terms of physical activity, obviously, you know, that's really important, as you've mentioned, and there are ideas around, such as perhaps making leisure services a statutory responsibility for local authorities, rather than discretionary as they currently are, although, obviously, there would be big cost implications for that. But, you know, there are ideas around, and some of them do impact on physical activity, which is an important part of the agenda. So, in addition to your more general, overarching approach, as Rodney touched on, it would be interesting to hear a little more, particularly with regard to obesity.

[48] **Dr Monaghan**: Yes, okay. I mentioned the World Economic Forum in Davos, the WHO and Harvard joint report. Actually, as part of that, the staggering impact economically of non-communicable disease, they then looked into the best-buy interventions for chronic disease, including those for unhealthy diet, physical activity, obesity, but also tobacco use, alcohol, and cancer, and they've looked through the evidence base, and, interestingly—I've got something here that's got a number of suggestions; well, they're not just suggestions, they've looked at the evidence, the specifics—most of the interventions that are really cost-effective are actually legislative. So, that's the first thing. And then, in further detail, Johns Hopkins University's school of public health, Georgetown University in Washington DC's law school, and Temple University in Philadelphia's law school are putting a big repository together of all the cost effectiveness of legislative interventions for health in relation to the modern era: non-communicable disease, accidents, et cetera. It's actually staggering that the majority of the interventions that they've been able to unearth, and the evidence base, shows that the majority of them are a cost saving to the public purse. If you think, we operate a cost per QALY—quality-adjusted life year—for drugs, and its £30,000. It's unwritten, but that's what, it appears, NICE uses. If it costs less than £30,000 per quality-adjusted life year, it gets the thumbs up from NICE. But these are interventions that are zero. In fact, they're less than zero; they're negative. They actually save public money. I can give you a long list of them here. I've got a list here—it's on a rather vague slide, because there are so many on it, but I can give you the papers.

[49] **David Rees:** If you could send the papers to the committee, it would be helpful.

[50] **Alun Davies:** Could we see all those papers that you've referred to? You've referred to them in a number of different answers now. It would be useful if we could receive if all those papers for consideration.

[51] **David Rees:** I'm sure they would be happy to pass them on.

[52] **John Griffiths:** Chair, I know we have to move on, but I think some of this gets back to our view on what is necessary in terms of a shift in Government policy to recognise the longer term agenda, rather than be too driven by short-term considerations, and also how expenditure by one Government department can save money for another Government department. It's not always as joined-up as we would like, and it's also a fact that, between Governments, you know, there's expenditure that Welsh Government might make that could save other governments, including the UK Government, expenditure, but those connections are rarely made either, so I think there are some big issues around this.

[53] **David Rees:** I'm sure we'll be able to explore those with the Minister when he comes back to us.

[54] On one final point on the overarching issue, which you've talked about, we've talked about HIAs very much this morning, but you've also questioned the dropping of the nutritional standards issue from the Green Paper. The Government has actually informed us that they would probably be doing more of this through secondary legislation or guidance. In your opinion, would that work? Is that an effective way of doing it, rather than on the face of the Bill?

[55] **Dr Berman:** I think it would be, provided that the measures are brought forward. I think that, perhaps, all our consideration is: that we would like to see what was proposed in the White Paper taken forward. If it's taken forward through secondary legislation, then I think that that would be sufficient. I think, at the moment, though, we haven't necessarily seen that secondary legislation come forward. So, perhaps, we're keen to just flag up that we would still like to see that. We also made some suggestions that could be expanded on in our written evidence.

[56] **David Rees:** Okay. Kirsty?

[57] **Kirsty Williams:** Given the comment that Alun made earlier about our inability, it seems, to date, to be able to influence enough the choices people make when they're in the supermarket, how far do you think Wales can go to not dictate to people what they buy in a supermarket, but actually, if they're choosing the wrong thing, if we changed the formulation of the food that they are buying, we could make it slightly, you know, more healthy than currently? There's a lot of talk internationally in the US, for instance, about the complete banning of trans fats in manufactured food products, and the huge impact that would have; it featured in the British press just yesterday. How far do you think Wales can push the boundaries within the legislative competence that we have in that regard? So, if people don't make positive choices, do we have to make those choices for them in the products that are available to them to purchase in the supermarkets? How far can we push that agenda as a legislative body?

[58] **Dr Monaghan:** I mean, obviously, we can only go so far, but increasingly individuals have little control over their living environment, including stuff that they've voluntarily bought; they've no idea what's in it. And, you know, you might say that the public expects the state—the Welsh Government—to intervene to prevent known threats. There's an assumption that if the state doesn't intervene, it sort of suggests that the threat's illusionary and non-existent, and, actually, frequently it's not. So, the point really is that the lack of parliamentary time given over the last century to public health law is remarkable, and it has actually led to an environment that is actually hazardous for health. So, on trans fatty acids, there is an issue about the limits to the powers of the Welsh Assembly, and that may develop over time. Some levers are not even at the UK level—some of them are at the European Union level and some of them have been ceded to the general agreement on tariffs and trade of the World Trade Organization. The codex alimentarius of foodstuffs, which describes what food stocks are—it's humanity's list—which used to be controlled by the United Nations, is now controlled by the WTO, and largely by the food companies. So, you know, you can see that 'what is a food' is now being defined by the companies, so that's how far we've gone.

[59] So, we know we start from where we are. Wales is small and in economic terms it wouldn't have the power—even if we had the legislative powers—to make the world's food companies kind of jump over, but it is a moving—. You know, there is a trend and trans fatty acids, because they've

got momentum behind them and New York has legislated against them, may be a good one to start with, I think, for instance. And if you recall, we're not as big as—. On car emissions, because they had problems with smog first because of photochemicals and nice weather, California's standards for car emissions are the world's standards. But, Wales is a bit smaller than California. I'm not saying it's easy, but this is about a direction of travel, and some items like trans fatty acids would be a clever one to start with, if we've got the powers and the levers, because others are on the move on that.

[60] **David Rees:** Okay, thank you for that. We've spent half the time on what's not in the Bill. It is important, though, that we recognise how we can improve public health in Wales, and the issues you highlighted are intended towards that. But, can I focus now back on some of the issues that are in the Bill? So, there will be questions on those. Obviously, the Bill is separated into several parts depending on the different areas they've looked at, and I'd like to start perhaps on the latter part, which is the provision of public toilets.

[61] Perhaps a simple question is that we understand the current financial pressures local authorities face and will be facing in years to come. Is the Bill strong enough in ensuring that the strategic approaches to the provision of public toilets can be implemented, particularly with local authorities facing the difficulties that they will be facing, or should we be strengthening the Bill in any way to ensure that those facilities are going to be available to people?

[62] **Dr Fenton-May:** Could I come in on that? I think sometimes the provision of public toilets is very poor, particularly in more rural areas, and very often you go to places and you find that they're locked. And there needs to be a robust mechanism to actually look at where the toilets are sited and how accessible they are, remembering the disabled people's manifesto, which is going on upstairs.

10:00

[63] Are there keys for them that are near, easy to get to? Are they cleaned regularly, because you find them dirty or locked, or the keys some distance away that you have to go to? So, I think the evidence needs to be robust that is provided to make the decisions, and I'm not sure that that is always the case. Somebody says, 'Oh well, tick, there is a lavatory here,' but nobody actually has all of the evidence about how it's functioning and how it's cleaned and all this kind of thing.

[64] **David Rees:** So, are you concerned that this might just be a tick-box exercise?

[65] **Dr Fenton-May:** I think it might be a tick box; you need to ensure it's robust.

[66] **David Rees:** Lindsay.

[67] **Lindsay Whittle:** We're a nation now of pill poppers, which are fairly diuretic and many of our older population happily use their bus pass to go on public transport. Now, if you travel by luxury coach, you can be fortunate enough to use a public convenience on the coach, but not normally on a bus; sometimes trains, but not normally on a bus. If you're travelling from Brecon to Cardiff for the day, it's a long bus ride. Do you think provision should be made for public toilets on buses as well, like coaches?

[68] **Dr Fenton-May:** It possibly should be made a provision for buses going longer distances, but I have had patients who—I've worked in Cardiff—wouldn't go to Cardiff because the provision of public toilets that were easy to access was sometimes limited, even between Butetown and the centre of Cardiff. So, yes, I think it needs to be robust for these people who have particular problems with the medication that us doctors give them that can make that worse.

[69] **David Rees:** Does the BMA have a view on this?

[70] **Dr Monaghan:** We're supportive of the provisions on this subject.

[71] **David Rees:** Thank you very much. And onto pharmaceutical services, the BMA have highlighted concerns that there may have been issues arising following examples in England. Do you want to expand upon that a little?

[72] **Dr Monaghan:** Our understanding is that, on the pharmaceutical needs assessment proposal, while we're not necessary unsupportive of it, and we see no particular reason why in urban areas it should be a problem, we are very worried about its potential effect in rural areas, because taken in isolation, as has been the case when it's been applied in England—it's recently, I understand, come on the statute book or into action in England—it has resulted in the loss of dispensing general practices in rural areas in England. Our particular worry in Wales is that that would be the straw that breaks the camel's back in rural general practices, because, as a business,

each general practice in a rural area, sparse population et cetera, et cetera, is very dependent, to be a viable business, on both providing general practice and providing dispensing services. So, we've already seen in Wales the fragility of rural general practice, and we're just very worried that this change might, as an unintended consequence perhaps, lead to the closure of some rural general practices in Wales.

[73] **David Rees:** Could the Bill be strengthened then to avoid that circumstance arising?

[74] **Dr Monaghan:** Yes. I think we made a suggestion about how that can be— Rodney, do you want to say something?

[75] **Dr Berman:** Yes. We've got two possible suggestions for dealing with this. Our preferred suggestion would be that what are known as 'controlled localities' would be exempt from the pharmaceutical needs assessments, and those are areas where I think other legislation has defined that practices have the right to dispense. So, if you took those out of that, then, obviously, they couldn't be threatened by a pharmaceutical needs assessment. An alternative, which is our less preferred option, which, nonetheless, could also deal with it, would be to make sure that you do take into account the pharmaceutical services that are being provided by dispensing practices when you do the pharmaceutical needs assessment. Coupled with that, we'd also like to see a risk assessment done on whether or not there is any threat to general practice services—GMS services, as they're known—if you were to bring in extra pharmaceutical provision. So, as long as you put those safeguards in—and we've given you two suggestion for how that could be done—I think then we would be happy with the proposals going forward.

[76] **David Rees:** Okay, thank you for that.

[77] **Dr Fenton-May:** Could I just come in and support that? I just want to remind the committee that not all the dispensing doctors are in the very remote areas. You will find that there are some dispensing doctors on the edge of Cardiff who are dispensing into more rural areas on the outskirts of Cardiff. So, you mustn't just talk about rural areas. You need to talk about all the services in the area when you're looking at the GP dispensing practices and the pharmacies, because those practices, although they're larger than the very rural ones in the middle of Powys, may be destabilised and stop serving those very slightly remote villages outside of Cardiff.

[78] **David Rees:** Okay, thank you for that very important note. If we move on now to the special procedures part of the Bill, you have indicated that you support the concept and agree that the regulation being able to include additional procedures is important. Are there any procedures you think should be included? We've had evidence before about certain cosmetic and aesthetic procedures. Are there any sort of procedures you think that should be included on the face of the Bill, as well as the four that have been identified?

[79] **Dr Berman:** We've put forward a list in our evidence of other procedures we thought could be included. I'll just go through them: laser hair removal, chemical peels, dermal fillers, scarification or branding, and subdermal implantation, also known as 3D implantation. I must admit, there are some procedures I wasn't necessarily familiar with, but I can see the rationale for these also being regulated in the same manner, because I think there's the same potential for problems to occur if these procedures are not carried out in a properly controlled way.

[80] **John Griffiths:** In terms of tattooing and piercing, do you think the Bill should be strengthened to make it less likely that people undergo those procedures while intoxicated?

[81] **Dr Monaghan:** I think we do, yes.

[82] **Dr Fenton-May:** I would agree. A lot of people say they're frightened of needles, but they say, 'Oh, well, I go and get drunk, and then I go to the tattooist. Now can I have it removed, please, because it's got the wrong things on it?' So, I think that they are not necessarily making the decisions about their tattoos in the best interest of themselves if they go in when they've had too much to drink.

[83] **Kirsty Williams:** That would tend to suggest that they have every intention of getting a tattoo, they just need to have some alcohol before they go, just to get through the process. At what stage, do you think, as a society, we need to protect people from doing daft things if they've had too much to drink? Surely, if we take that to its logical conclusion, we should stop people getting drunk whatsoever and you would have prohibition on alcohol. Because, it may be a tattoo, but somebody else might say something stupid or do something stupid under the influence of alcohol, and I'm just wondering at what stage do you think, if we are to protect people that much from themselves, you just say, 'Actually, we ban alcohol'.

[84] **Dr Berman:** Can I just say, on behalf of the BMA, that the fairest thing to say is it's not something we've really considered in detail, so we don't have a particular policy on that area? So, it would probably be wrong to extrapolate anything from what we say as being an official BMA policy—

[85] **Kirsty Williams:** Extra-marital affairs—I mean, at what point do we—

[86] **David Rees:** I think that's a bit beyond public health, in a sense.

[87] **Kirsty Williams:** Well, not necessarily.

[88] **David Rees:** I want to ask—. The question I suppose is: I think that they'll introduce a cooling-off period, a concept of discussion before a tattoo takes place. That, therefore, is essential because that cooling-off period does allow the, sort of, immediate getting drunk and then going to the tattooist, rather than perhaps going to the tattooist making a plan, and then going back afterwards, in a sense. But, that is an important element to allow that breathing period between the initial consultation and actually going back for a tattoo.

[89] **Dr Fenton-May:** I would support that because I think sometimes people do go as a group, and it's a group activity that they're going and signing up for, with their tattoos. You know, they've had a couple of drinks, they go on and they all get tattooed.

[90] **David Rees:** Altaf?

[91] **Altaf Hussain:** Yes, it's just on this point, and about whether we should have these procedures under anaesthesia.

[92] **Dr Fenton-May:** I think that is a possibility but, then, that would need a little bit more regulation, and it would have to become, I think, a medical procedure because I don't think your tattooist—. I think the tattooist would need specific training to be able to give even local anaesthesia for these procedures. Some of them are very large, so, you know, they would need quite a lot of anaesthesia and that could be quite toxic.

[93] **Altaf Hussain:** Maybe general—?

[94] **David Rees:** Okay. Lynne.

[95] **Lynne Neagle:** I just wanted to go back to the issue of special procedures. You said in your written evidence that you think that the ones included on the face of the Bill are appropriate, but you've just given us a list now of other ones that you think should be considered. Why do you think it's okay not to have those on the face of the Bill in the first place? Don't you think it's maybe just a bit random—the way some of these have been chosen?

[96] **Dr Berman:** I don't think in our written evidence we specifically said that what was on the face of the Bill—. I can't remember. I need to go back to back to the full one—the right list. I think that what we did say was that those procedures I went through should be also brought under the scope of the proposed licensing system. You know, I think, perhaps, we'd leave that for the Assembly to determine the details of how exactly that was implemented. But we just think those other procedures should also be included.

[97] **David Rees:** So, the concept is the right concept, but it's just which procedures can actually come under that on the face of the Bill is the issue you have identified.

[98] **Dr Berman:** Well, we are saying that those procedures should be included in the licensing system. So, I think I'm not specifically saying whether it's on the face of the Bill or in regulations. I just think that our position is that we would like to see that licensing system applied to those procedures.

[99] **David Rees:** One final point on this topic from me: the Chartered Institute of Environmental Health suggests that 18 should be a more appropriate age restriction for intimate piercing, whereas the Bill identifies 16. Obviously, there is a balance between the ages of 16 and 18 on various other issues. What is your view on this? Is 16 the proper restriction age, or should 18 be the age of restriction?

[100] **Dr Monaghan:** Is this on intimate piercing?

[101] **David Rees:** Yes.

[102] **Dr Monaghan:** We support 'under 16'.

[103] **David Rees**: Okay, thanks. Does the RCGP have the same view?

[104] **Dr Fenton-May**: I think I'd support that but I would have no objection if it was increased to 18.

[105] **David Rees**: Okay. We move on, obviously, to the early part of the Bill, which refers to tobacco, smoking and e-cigarettes. I'll start off. Clearly, we've seen conflicting evidence as to the lesser harm of e-cigarettes compared to tobacco. We've recently seen a Public Health England paper produced. Can I have, basically, your views on: does the Bill actually help or hinder smoking cessation programmes as it stands? Obviously, one of the arguments being used very heavily is that e-cigarettes can help cessation of tobacco products. Does the Bill hinder that?

[106] **Dr Monaghan**: I'm not sure the Bill proposes that, particularly. My understanding is that the Bill is proposing just some narrow measures to bring the regulation of e-cigarettes in line with that of tobacco, particularly in relation to public places and work places. We support that. That's only a minority of time, I guess—particularly the public places, perhaps—that people spend. So, it doesn't interfere with what they do at home, in terms of your question about smoking cessation. This is a rapidly moving area at the moment. Quite controversial evidence is accumulating all the time, although it's still pretty early days. We've confined ourselves to the question of the actual proposal about regulating e-cigarette use in public and workplaces, and we support the proposal, on balance, and we do so because we're worried about undermining the ban in public places by making it more difficult to enforce, on the one hand—the ban of tobacco, which has been so successful. We're worried also about renormalising the habit of smoking, and we're worried also about—well, we're slightly concerned about what is in these e-cigarettes. We realise nicotine's in them in varying concentrations, but there are other things in them, which varies considerably between brands, and we're worried about taking a precautionary approach till we know more about that in terms of being exposed to those, in a sense, pollutants indoors. So, exposing other people to those.

10:15

[107] We've not put it in the evidence, but we've—or, at least, this is me personally—. I've recently become aware that—. I've had advice that, in a different realm, these devices are actually perfect for utilising to fill with other chemicals, such as legal highs, and smoking them. So, I'm a bit worried

about that, about them being opened up and filled with something else. They are actually perfect, apparently, an expert tells me, for utilising to take legal highs. So, that's a little bit of a concern, and nothing to do with this, but it's uncontroversial, I think, and across the board, that they do need to be regulated in terms of their content, whether that's as medicines or whatever, till they're standardised, so that whatever they say they're giving you, you get. But also, there may be need to regulate the actual construction of them, so that you can't take them apart and put something else in, as well.

[108] **David Rees**: Because this Bill obviously doesn't put those regulations in place.

[109] **Dr Monaghan**: No. This is about public places and workplaces, and we support the prohibition.

[110] **Dr Fenton-May**: I find the whole thing about e-cigarettes quite concerning, talking to young people, and you ask them about their smoking habits and they say, 'I don't smoke', and if you specifically ask them about e-cigarettes, they say, 'Oh, well, when I go out, I do have those; we share them around.' Sharing such things actually increases the risk of infectious diseases being spread, particularly things like hepatitis. So, we want to discourage that. And nicotine per se is an addictive product. There is nicotine in these, but people quite often don't realise there's any nicotine in them when you talk to them, and nicotine has got health effects that are not good, like increasing your blood pressure, causing vasoconstriction, and various other things. So, we haven't got enough evidence, because most of the evidence has been on cigarettes. We need pure evidence about the health effects of nicotine and e-cigarettes. Okay, the doses may be low, but they are still addictive, and people want to have more and more of them, very often. If they are used, they should be used as a means to reduce smoking and give up smoking, not as a substitute for smoking.

[111] **David Rees**: Okay. Can I ask a question? You've mentioned already the possible medical use of them, and regulation as a consequence. If the Medicines and Healthcare Products Regulatory Agency actually does decide to approve some, does the Bill cope with that situation—in its present form?

[112] **Dr Fenton-May**: I think that, if they become a medicine per se that is potentially prescribable, then we will need some stronger legislation, which presumably would come in through the medicines Act about prescribing them and the restrictions on the prescriptions, and that would cover the

issue about—. Because, potentially, you might want to prescribe them for somebody who was under 18. There would need to be some specific mechanism whereby you could let an under-18 have them if they were on prescription, and there is other legislation that covers things like controlled drugs that say, if you've got a prescription, you can hold these controlled drugs. So, I don't think that there would be any problem bringing in that sort of legislation, and it could precede this, or supersede, I think is the word, the legislation of the public health Act in Wales.

[113] **David Rees**: Okay. Thanks for that. Do you also think that the extension of the places in which a smoking ban exists, which is part of the Bill, is helpful? We are talking about some open spaces rather than enclosed spaces now, particularly children's playground areas, for example.

[114] **Dr Monaghan**: Obviously, the exposure to the pollutants is lower in an open space. But, partly because of the normalising effect, we support the extension to children's playgrounds.

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

[116] **John Griffiths**: On that, I wonder if you might have any suggestions of other areas that might be included in that extension of public space within which smoking tobacco isn't permitted. We've heard ideas in terms of tourist beaches, for example. I think some people feel strongly that outdoor areas of restaurants and cafes might be included, and shopping centres. There are a number of suggestions. I wonder if you've given any thought as to other extensions that might be included in this legislation.

[117] **Dr Berman**: I don't think we've given specific thought in great detail, but I think that the test you'd have to look at is: is it an enclosed space whereby people are going to be in close proximity to other people, and are therefore liable to be subject to the second-hand effects of smoking? What we have said is that the proposal in the Bill that says that Ministers have to be satisfied that it will enhance the public health of the people of Wales—I think that that is a good test. Therefore, I think the approach we would take is that as long as you apply an assessment and that that assessment is sufficiently robust to tell, then that would satisfy us.

[118] I think it's difficult, isn't it? If you look at, say, tourist beaches, I've been on Porthcawl beach when it's been a very sunny day and it's been very crowded, and I've found myself in close proximity to other people. I'm sure if

you were walking along Porthcawl beach on a cold November afternoon, it wouldn't necessarily be the same scenario if somebody was smoking. So, I think it has to be thought through carefully. I don't think it's necessarily an easy thing to define.

[119] **John Griffiths:** I guess it could be times of the year, as you have restrictions on walking dogs on beaches during the peak months, for example. But, yes, okay.

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

[121] **Elin Jones:** I just wanted to ask whether you believe that e-cigarettes are going to play a significant role in reducing the consumption and use of tobacco for individuals and eliminating it for some. There's obviously a public health benefit to that if it happens. Do you consider that there's any real danger, then, in promoting the concept that e-cigarettes should be placed in the same category as tobacco cigarettes in the public's viewpoint?

[122] **Dr Monaghan:** I mentioned that this is a rapidly developing area. It is possible that e-cigarettes have, you know—. There are a number of conflicting reports out at the moment, and I think it's fair to say that there's a fairly large split. It's too early in terms of evidence within public health and within medicine about it. So, it is possible that they've got something to offer, but there are some worries about it. I've mentioned renormalising. I don't think it's that controversial, actually, about indoor public places, because these are still pollutants. We don't know what the carcinogen is in tobacco; we think there are probably several, but we know there are lots of mutagens. You can cause mutations in a test tube, if you like, using various chemicals, and I think nicotine's one of those, for instance. There's no doubt that it's a lesser evil on the whole than tobacco. I think we are very worried about renormalising smoking in social spaces, and aiding that. We're worried about undermining the ban on public places and workplaces because it's very hard to tell, sometimes, from a distance, whether somebody's vaping or smoking, because some of the devices even light up at the end. So, those are worries. There was something else I was going to say. It'll probably come back to me.

[123] **Elin Jones:** Have you given any consideration to the fact that it may be more appropriate for e-cigarettes to be banned in a restricted number of public places? I'm thinking of social places, as I think you called them—they could be specifically named in legislation as public transport, places that sell

and serve food and drink—so it's not as restricted as tobacco, in order to make that differentiation and in order, possibly, for people to feel that they have more freedom in using e-cigarettes and that it's an incentive to use e-cigarettes over tobacco cigarettes.

[124] **Dr Monaghan:** Well, as I say, at the moment, our policy line is that we support it being congruent with cigarettes for a number of reasons—so, there being no incongruity. But, it's early on. They've taken off, undoubtedly. We're slightly concerned in general that a lot of the companies have been taken over and are now owned by the tobacco industry itself, and we're worried about them being used as a gateway product in certain groups. We're worried that some of the products are coloured and perfumed, and we're worried that they're targeted at—in spite of denials—or attractive to young people. So, we're nervous, but they may have a part to play. We don't want the existing provisions for tobacco to be undermined, though. That's our major point, and we don't want to renormalise the activity of smoking.

[125] **David Rees:** Can I ask the RCGP as well?

[126] **Dr Fenton-May:** I think I would support that. I really don't think that they should be allowed in any public spaces, really. There's also the evidence that children are now kind of picking them up and using them as they used to. When I was a child, you used to go around with your little sweetie cigarette, didn't you? And children are doing the same sort of things with the vapes. So, I think, probably, restricting them is good, however you can.

[127] **David Rees:** Okay. I've got three final questions from Kirsty, then I'll call Alun and then our time is up. Kirsty.

[128] **Kirsty Williams:** Thank you. Dr Monaghan, you've said several times this morning that your concern is about renormalisation of smoking. The report published just last month by Public Health England, in key messages, paragraph 3, says:

[129] 'There is no evidence that EC are undermining the long-term decline in cigarette smoking among adults and youth, and may in fact be contributing to it. Despite some experimentation with EC among never smokers, EC are attracting very few people who have never smoked into regular EC use.'

[130] There is no evidence in England that e-cigarettes are renormalising

smoking at all. I'm just wondering whether, given the several times that you've expressed concerns about renormalisation, you have any specific Welsh evidence that would contradict your colleagues in Public Health England in their report last month, which is quite clear, actually, that there is no evidence of renormalisation or undermining. Maybe, in Wales, there is a different set of data or circumstances.

[131] **Dr Monaghan**: In Wales, the policy line of Public Health Wales is contrary to that. It's not supporting e-cigarettes. What I'm telling you though—

[132] **Kirsty Williams**: There is a difference between a policy line and evidence, isn't there?

[133] **Dr Monaghan**: Oh, yes, and I've mentioned that. That's what I was going to say. It's quite early days in the evidence base in general, and so what I'm telling you is this has been considered by the BMA ARM—annual representative meeting—and what we've told you is our view is what the BMA policy is.

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

[135] **David Rees**: I will highlight that there was a report from the University of Southern California out last month, which also, actually, puts an opposite view to that as well.

[136] **John Griffiths**: Can I say as well, Chair, that I've picked up, just in reading generally, some quite heavy criticism of the report that Kirsty's referred to? I can't quite remember what the criticism was, but it would be quite useful—

[137] **Kirsty Williams**: It was obviously very hard-hitting then. It made a big impression on you—[*Laughter.*]

[138] **John Griffiths**: Well, I was speed reading, Kirsty, but it would be useful for us, I think, as Kirsty's mentioned the report, to also consider what criticism has emerged since its publication.

[139] **David Rees**: Just to clarify the point, there is an article in *The Lancet* that challenges the report. There's also another article recently published by others who have challenged the report. So, it is a question of conflicting

evidence at this point in time, which has already been highlighted by our witnesses today. Two final questions—Altaf and then Alun.

10:30

[140] **Altaf Hussain:** Just a quick point. You know, we talk about the cigarette smoking and e-cigarettes, but how about shisha and hookah? It's so prevalent now in social places lately. Should that be included?

[141] **Dr Monaghan:** Crikey. Help; what's the ARM said on that? Hashish—

[142] **Altaf Hussain:** Shisha and hookah.

[143] **Dr Fenton-May:** They have got nicotine in some of them, haven't they? People don't realise. Again, talking to patients, they don't realise. That's my issue about some of these reports: are people declaring what they are actually inhaling? So, I think that hookahs should be restricted. Are they not mostly now used outside? I don't know; I've not had much experience of their use, or seen their use, I should say.

[144] **Altaf Hussain:** No, I don't know myself, but you're right; they can put anything in them and that's why they are really popular.

[145] **Dr Fenton-May:** Yes, and people, again, use them socially, who may be—. Young people are using these things socially, as the e-cigarettes are used, and they do not necessarily know what is inside. There could be anything, and they're not declaring. So, we need more evidence about how many people are using these different things, because they think it's not smoking; so, they don't say they are using them.

[146] **Altaf Hussain:** So, Chair, the point in that is whether we should include hookah and shisha in this.

[147] **David Rees:** I've noted the point: nicotine products.

[148] **Altaf Hussain:** Yes.

[149] **David Rees:** The final question from Alun.

[150] **Alun Davies:** I agree with that, actually. The language you've used, Dr Monaghan, in answering questions on e-cigarettes, has been very

inconclusive: you're worried; you have concerns. It's very difficult for us to make law on the basis of worries and concerns. We need evidence. Although I don't disagree with your fundamental point—and I actually intuitively think you're probably right that e-cigarettes renormalises the place of tobacco in society in a way that we would not wish to see. Intuitively, I wouldn't necessarily disagree with that at all, but it is a matter of some concern that the BMA is coming here and asking us to legislate without significant, hard evidence upon which to base those points.

[151] **David Rees**: Before you answer, I'd like to clarify that the BMA are returning to the committee on 1 October, when we'll be looking specifically at this topic.

[152] **Aled Davies**: Yes, I understand that, but we're having this conversation this morning. So—

[153] **Dr Berman**: I'm not sure that we're specifically coming here and asking you to legislate. I think the Welsh Government is intending to legislate, and we've been asked to give our view on what's proposed.

[154] **Alun Davies**: But you support it.

[155] **Dr Berman**: Yes. We've said that we support it. Yes, we do.

[156] **Alun Davies**: So, why?

[157] **Dr Berman**: It's just a slight—. I think Dr Monaghan has explained that—

[158] **David Rees**: Dr Monaghan has given us the answer why. He's expressed his concern over the lack of evidence either way, and his precautionary position at this point in time with regard to renormalisation. I think that's being fair.

[159] So, I'll come to an end on this, this morning. Can I thank the witnesses for their evidence? You'll receive a copy of the transcript to check for any factual inaccuracies. Please let us know as soon as possible if there are any. Once again, thank you very much for your time this morning.

[160] **Dr Fenton-May**: Thank you very much.

[161] **Dr Berman:** Thank you.

[162] **David Rees:** Are we going to have a 10-minute break now? Yes? So, we'll have a 10-minute break.

Gohiriwyd y cyfarfod rhwng 10:33 a 10:53.
The meeting adjourned between 10:33 and 10:53.

Bil Iechyd y Cyhoedd (Cymru): Fideo o'r Dystiolaeth a gasglwyd ynghylch Rhan 3 (Gweithdrefnau Arbennig)
Public Health (Wales) Bill: Video of Evidence gathered regarding Part 3 (Special Procedures)

[163] **David Rees:** Can I welcome Members back to this morning's session of the Health and Social Care Committee, where we are taking evidence on the Public Health (Wales) Bill? The first item in this session is a video of evidence that has been collected for us by the outreach team of the Commission. I thank the team for that and let you get on with it—let's watch it.

Dangoswyd DVD. Mae'r trawsgrifiad mewn llythrennau italig isod yn drawsgrifiad o'r cyfraniadau llafar ar y DVD. Mae'r cyflwyniad ar gael drwy ddilyn y linc hon: cyflwyniad DVD.
A DVD was shown. The transcription in italics below is a transcription of the oral contributions on the DVD. The presentation can be accessed by following this link: DVD presentation.

*[164] **Rhonwen Mai Ellis:** Fy marn i ar y system drwyddedu ydy ei fod yn syniad da i helpu pobl fel fi sydd wedi hyfforddi ac wedi arbenigo yn y maes, ac yn sicr yn help i gadw safonau i fyny.*

***Rhonwen Mai Ellis:** My opinion on the licensing system is that it is a good idea to help people like us who have been trained and who are specialists in this area, and it's certainly a help to maintain standards at a high level.*

*[165] **Gwenan Evans:** Ni fuasai neb eisiau i bobl sydd heb gael hyfforddiant penodol i fedru ymarfer, achos mae'n rhaid bod pobl yn gwybod eu bod yn gallu ymarfer yn ddiogel ac yn effeithiol.*

***Gwenan Evans:** Nobody would want someone who hasn't had specific training to be able to practice, because people have to know that they can practice safely and effectively.*

[166] **Teja Entwistle**: *This national licensing system would protect the public from anybody setting themselves up as an acupuncturist without being a member of a professional body.*

[167] **Graham Bowman**: *Despite popular belief, it is a professional business. We do take pride in it—a lot of it. There are people out there who just don't care and will tattoo anyone and everything for money. I think it does need to be regulated more.*

[168] **Brett Collins**: *I think what is apparent is quite often, the theory of licensing or regulations put out there without really truly understanding the landscape that exists in terms of the providers of these treatments. Ultimately, I think what is often missed off, although it's under the guise of providing a better environment and platform for consumers and the public to be safe—quite often, the public are the last people to be considered in terms of how effective a licensing scheme could be.*

[169] **Graham Bowman**: *As in affecting the business, I think it'll just make us all more professional, which we aim to be anyway. It shouldn't do us any harm.*

[170] **Gwenan Evans**: *Mae yna systemau, wrth gwrs, yn barod. Rydym ni fel aciwbigwyr sy'n aelodau o'r British Acupuncture Council yn gorfod dilyn rheolau llym iawn cyn ein bod ni'n cael gosod i fyny mewn practis yn y lle cyntaf. Rydym ni hefyd, ar hyn o bryd, yn gorfod cofrestru efo awdurdodau lleol. So, mae yna systemau mewn lle yn barod ac nid wyf i'n siŵr beth ydy oblygiadau'r system newydd. A fyddai'r system newydd yn gwneud yn lle'r system sirol neu a fuasai fo'n lefel eto o fiwrocratiaeth?*

Gwenan Evans: *There are systems in place, of course, already. We who are members of the British Acupuncture Council have to stick to very strict rules before we're allowed to set up practice in the first place. We also, at the moment, have to register with local authorities. So there are systems in place already, and I'm not sure what the implications of the new system are. Would the new system take the place of the current county system or would it be an additional level of bureaucracy?*

[171] **Dee Yeoman**: *If it's done well, it won't affect it at all, because I'm very good at what I do, but it will increase costs for an already stretched industry if it's done badly. So, the important thing is to streamline the inspection and to do it knowledgeably. That will make it fairly cost-effective. It's got to be*

delivered at a low cost and maybe fining of unlicensed operators might help fund some of it. A system of more regular checks should be put in place for those operating below standards, and less frequent ones, perhaps, for higher studios. Again, this would provide a more cost-effective service. You know, you can do this and do it well.

[172] **Brett Collins***: I think having the compulsory license scheme—. If everybody was on that scheme and everybody was accountable, it'd be effective. I think my concern is that, actually, the people who are currently providing good service will buy a licence and continue to give a good service, and the people where you've got the majority of your issues—guess what?—they won't buy a licence. They'll continue to provide bad service and the consumer will continue to be at risk.*

[173] **Teja Entwhistle***: I don't think that creating a compulsory licensing system would improve the standards of anybody who is already a member of a professional body, but I do think it's important, just to catch anybody who isn't a member of a professional body.*

[174] **Gwenan Evans***: Mae gennym ni system lle mae gennym ni i gyd yswiriant llawn, er enghraifft, indemniad proffesiynol ac atebolrwydd cyhoeddus. Wedyn mae pobl sy'n dod i gael aciwbigo gan bobl sy'n aelodau o'r gymdeithas Brydeinig yn gwybod eu bod nhw'n mynd i fod yn saff.*

Gwenan Evans*: We have a system where we all have full insurance, for example, professional indemnity and public liability. So, people who come to have acupuncture from people who are members of the British council know that they're going to be safe.*

[175] **Andy Millard***: You need a consistent—you need to all be singing from the same hymn sheet straight away like, you know. Then, with that level playing field then, we can only raise standards further, you know. A lot of us, we pay a lot of attention to what we do—to every single part of it. I changed my whole range of inks because of one client—the one who has the intolerance to witch hazel.*

[176] **Dee Yeoman***: We could look at rating systems for tattoo studios; there's been an introduction of that and there's been a look at that across Northern Ireland and Scotland—they're looking at it. But I have talked to artists in this area and they say that it's been done badly and, again, the inspections are done without knowledge, and it's not increased standards*

and it's not stopped illegal tattooing, which is one of the main points here.

[177] ***Catherine Green:*** *Licensing affecting standards of electrologists and electrolysis should always start within, actually, the training within all the colleges in the area. If that can be established, then myself, as an employer, would actually have a very much better level of confidence in having the right kind of, obviously, people coming to me to work actually on the public.*

[178] ***Dee Yeoman:*** *It could gradually increase standards, especially if we put in some sort of apprentice scheme system and an apprentice licensing system. It could gradually increase standards over the years.*

[179] ***Rhonwen Mai Ellis:*** *O ran y mathau o driniaethau, rwy'n teimlo nad ydy pobl yn deall sut mae electrolysis—beth ydy'r camau a sut mae'r driniaeth yn gweithio. Felly, nid ydym ni'n 'pierc-o' ac nid ydy o'n mynd i mewn i'r croen, ond i'r ffoligl, sydd yn ddau beth hollol, hollol wahanol. Efo'r tatŵio a'r aciwbigo, mae hynny'n mynd i mewn i'r croen, ond i'r ffoligl rydym ni'n mynd i mewn iddo fo. O ran triniaethau y buaswn i'n licio iddynt gael eu hadio ato, yn sicr, mae Botox a laser. Ar y funud, mae yna gymaint o glinigau a phobl yn gallu prynu'r peiriannau yma ac efallai sy'n sicr, sicr ddim i fyny i safonau.*

Rhonwen Mai Ellis: *In relation to the different types of treatments, I feel that people don't understand how electrolysis—what steps are involved and how the treatment works. So, it doesn't involve piercing and it doesn't go into the skin, but into the follicle, which is a totally different thing. When it comes to tattooing and acupuncture, they pierce the skin, but we go into the follicle. In relation to treatments that I would like to be added, Botox would be one as would laser treatment. There are so many clinics at the moment and people can buy these machines and perhaps are definitely not up to standard.*

11:00

[180] ***Gwenan Evans:*** *Mae gennyf, fel aciwbigydd, farn sydd efallai yn awgrymu nad wyf yn siŵr pam bod aciwbigo fel yr ydym yn ei ymarfer o yn rhan o'r 'special procedures' o gwbl, achos mae'r pethau eraill yr ydych wedi'u rhestru, sef, tatŵio, tyllu clustiau ac electrolysis, maen*

Gwenan Evans: *As an acupuncturist I have an opinion that perhaps suggests that I'm not sure why acupuncture, as we practise it, is part of these 'special procedures' at all, because the other things you've listed, namely tattooing, ear piercing and electrolysis, are very different*

nhw'n fathau gwahanol iawn o driniaethau, rwy'n credu. Mae'r rhieni'n fwy o driniaethau harddwch, os liciwch chi, yn hytrach na thriniaeth iechyd. Mae aciwbigo, fel mae aciwbigo yn draddodiadol yn cael ei ymarfer, yn broses trin iechyd, mae'n amlwg.

types of treatment, I believe. They are more beauty treatments, if you like, rather than health treatments. Acupuncture, as it's traditionally practised, is a health treatment, clearly.

[181] ***Dee Yeoman:*** *I think laser tattoo removal should be removed from the remit of the HIW as it's proving to be anticompetitive with laser operators in England. It provides a lack of service to Welsh needs, and it's driving Welsh consumers to try dangerous removal practices at home, and it's just not a good thing. Laser removal is expensive and difficult to come by in Wales, and that's due to the expensive licensing system that's been developed by HIW. So, we need to really address that, but also, as far as other procedures are concerned, you need to look at branding, scarification and extreme body modification, which you might not even be aware of. There's a lot going on. It can be done well, if it's done properly, but there are probably only a few operators maybe in the UK that do it well, and everybody else is pretty dangerous. So, you need to look at branding, scarification and extreme body modifications, and by that I mean things like—when I say dermal implants, I don't mean the jewelled dermal implants, I mean things like horns, stars, also modification of body parts like tongue splitting, penis splitting, various other things. Branding, of course, is self-explanatory, and scarification is where they remove a section of the skin and it scars up, and it's becoming more popular now and that really needs to be looked at.*

[182] ***Andy Millard:*** *Special procedures should incorporate scarification in all its forms, whether it's done—. People are doing it with scalpels, people are doing it with tattoo machines with no ink in, you know, and just gouging in scars. As I said, I was an army medic and keloiding the skin is not a nice thing. Branding—you know, they're using blowtorches and bent coat hangers, adapted soldering irons. Inserting foreign objects into your body is not a good thing without some sort of legislative weight behind it to say, 'That's unsafe', or, 'Is the material safe?' or 'Has it been checked?'; 'Is it sterile? Have you autoclaved it before you put it in there? Where did you get it from? Has this come out of a five-penny ball machine round the corner?' None of these things are answered, whereas we have—with our ink, we know where it comes from, the batch where it's from; with my needles, I know where I bought them from, when I bought them and their expiry dates. These*

things, you know—it's part of our pro forma. It should be the same with branding, scarification and inserts.

[183] **Rhonwen Mai Ellis:** *Rwyf wedi bod mewn busnes ers 16 mlynedd ac yn yr 16 mlynedd unwaith yn unig mae yna rywun sydd wedi dod draw i gael gweld os ydwyf yn cael gwared o'r pinnau yn saff, beth rwy'n ei ddefnyddio i lanhau'r croen, os rwy'n cadw record—ac rwy'n cadw record o bawb. Mae pawb gorfod llenwi 'consultation sheet' ac yn arwyddo fo. Rwy'n gorfod mynd yn reit fanwl i mewn i os maent ar ryw fath o feddyginiaeth. Yn sicr, rwy'n gwybod rŵan am rai lefydd nad yw'n gwneud hynny. Wedyn, mae hynny'n anodd i rywun fel fi sy'n cadw i fyny â'r safonau, ac nad yw llefydd eraill. Mae fy mhryder wedyn yw, pe byddai hyn yn mynd yn drwydded, pe byddai rhywun ddod yma i weld y peiriant a gweld beth rwy'n dweud, ar ddiwedd y dydd, nad ydynt efo syniad, dim clem, os ydwyf yn cario'r driniaeth allan yn iawn, ac yn ei wneud o'n iawn.*

Rhonwen Mai Ellis: *I've been in business for 16 years now and in that 16 years only once has somebody has come to see whether I dispose of the needles safely, what I use to clean the skin, whether I keep a record—and I keep a record of everyone. Everyone has to fill in a consultation form and sign it. It's quite detailed, especially if they're on some medications. I certainly know about some places that don't do that. So, that's difficult, then, for someone like me who does adhere to the standards and maybe other places don't. My concern then, of course, is that if this became a licensing issue, if someone came here to see our machine and to see what I do, at the end of the day, maybe they don't have any idea of whether I'm doing carrying out the treatment correctly, and doing it properly.*

[184] **Dee Yeoman:** *The inspections need to be streamlined, they need to be to the point, and accurate and relevant within the industry. This could reduce costs, not increase them, but they do need some training. Most of the inspectors, you know—no fault of their own—have no training in tattooing or piercing, and they don't know what they're looking for. So, that needs to be addressed.*

[185] **Graham Bowman:** *As in difficulties for the local government, I don't think it should make a difference, really. Our council at the moment are quite strict on rules, bye-laws and everything else—licensing, and things like that. They are quite strict, anyway, which is a good thing.*

[186] **Teja Entwistle**: *If somebody is a member of a professional body, then it should be that professional body that has the responsibility, rather than the local council.*

[187] **Andy Millard**: *I think that the local authority has its part, but the best place should be the police. They're breaking the law. If somebody's tattooing under age, it's, you know, grievous bodily harm. It's a permanent mark that is left. That's GBH. That's it; it's assault on a minor, if they're under 18. It's administering a noxious substance. They are more—you know, the law already is there that they can say, 'Bam, we can enforce this', so I don't think it's the council's position to do it.*

[188] **Gwenan Evans**: *Byddwn i'n gobeithio y byddai fo'n diogelu iechyd y cyhoedd; nid wyf yn siŵr am wella iechyd y cyhoedd. Ond y prif nod fan hyn ydy gwneud yn siŵr bod pawb sy'n ymarfer y math yma o driniaeth arbennig neu 'special procedures', fel y maen nhw'n eu galw nhw yn Saesneg, sy'n tyllu'r corff—a hynny ydy'r peth penodol rydym yn sôn amdano fan hyn—. Mae'n bwysig iawn, mae'n amlwg, bod unrhyw fath o broses sydd yn tyllu'r corff yn cael ei gynnal yn ddiogel ac yn effeithiol.*

Gwenan Evans: *I would hope that it would protect public health; I'm not sure about improving public health. But the main aim here is to ensure that everyone who practices this type of treatment or 'special procedures', as they're called, which pierce the body—and that is the specific thing that we are talking about here—. It's very important, obviously, that any type of process that pierces the body is done in a safe manner and effectively.*

[189] **David Rees**: Okay. Members did ask for some views from the industries themselves, and can I thank the outreach team for getting that for us and putting it together? It's very helpful and some very interesting points were being made there. So, thank you very much. Members also have a briefing of most of the speakers on there for your information. That will be made public later in the week as well. Thank you; diolch yn fawr.

[190] Some interesting points were being made, and perhaps some interesting areas that we've already come across and that have been raised with us as to areas and procedures that, perhaps, should be included as well, and ones that we, frankly, hadn't come across before, perhaps. Some of them were very interesting.

11:07

Bil Iechyd y Cyhoedd (Cymru): Sesiwn Dystiolaeth 7
Public Health (Wales) Bill: Evidence Session 7

[191] **David Rees**: We move on now to the next session. Can I welcome the British Association of Cosmetic Nurses and representatives of Save Face? Thank you very much for the evidence you've presented to us and thank you for coming in this morning. It's Paul Burgess and Andrew Rankin from the cosmetic nurses, and then it's Brett Collins and Ashton Collins from Save Face. It it's okay with yourselves, we'll go straight into some questions. Some of the comments that you've just seen might well come back in some of those questions that will be coming to you. Gwyn.

[192] **Gwyn R. Price**: Welcome. How effective is the current system around the regulation of cosmetic procedures in ensuring providers are working in a safe practice in Wales?

[193] **Mr Collins**: In terms of regulation for cosmetic procedures, I guess it depends whether you're talking about, let's say, laser treatments, which could fall into that category, or rather injectables and things like dermal fillers. If we're talking about the latter, dermal fillers and Botox, Botox is a prescription-only drug, but that's the only bit of regulation that exists and, outside of that, there is no regulation and there is no vehicle to ensure public safety in terms of these treatments.

[194] **Gwyn R. Price**: So, really, we do need regulation.

[195] **Mr Collins**: There definitely needs to be some form of regulation. I think the first question that needs to be answered, really, is: who should be providing these treatments to the public? I think that's where the biggest challenge exists at the minute, due to current law. It dictates that everybody can provide these treatments, and it dictates everybody can do it from any type of environment. I think that's where the danger lies, and I think those are some of the challenges that the licensing Act that's been proposed faces as well.

[196] **Gwyn R. Price**: Do you all agree on that?

[197] **Mr Burgess**: Yes. I think for us, it's a horror situation, really, because being the professional association with medical people, nurses, we have all

kinds of procedures and balances in place to ensure that nurses practice accordingly. If something goes wrong, there is redress through the Nursing and Midwifery Council, there are complaints procedures, there's everything; there is nothing whatsoever in place, for example, if a beautician carries out a treatment. There are no standards in place against which to judge competence, so, if you look at this, it means it's basically a free-for-all. What that means is when things go wrong and you hear about the horror stories, the problem is that nine times out of 10 where it goes wrong, it's with people who aren't covered by their basic medical training and all the various other things which go into being a professional medical person. There are still things that go wrong with medical people as well, which we have to accept, and we have the processes, don't we, Andrew?

[198] **Mr Rankin**: Indeed. I would agree in part with that statement. Having said that, I don't think we should underestimate the relevance and the power of the legislation for prescription medicines, and also how that affects us as regulated professionals. I don't entirely agree with Brett insofar as these treatments can be done from any premises. As regulated professionals, we're obliged to set a standard for ourselves to do these treatments from premises that are satisfactory. The problem lies in the fact that there is no standard benchmark to measure that against, and everybody has got different ideas as to what is satisfactory.

[199] **Mr Collins**: Andrew, it's true that anybody in the UK can provide treatments, and in Wales, from anywhere, withstanding what you do through the British Association of Cosmetic Nurses; it's a fact.

[200] **David Rees**: Can I remind you to direct points to me, not to your colleagues? Okay, John first.

[201] **John Griffiths**: In terms of laser removal of tattoos, we heard in that film that there's a view that, within Wales it's unnecessarily expensive and restricted, but we also have evidence I think, Chair, from Cardiff city council that there are gaps in the legislation in terms of regulation and control that's necessary. For example, if you provide laser removal on a mobile basis in terms of premises, or on an ad hoc basis, then you're not necessarily covered by the legislation. What's your view in terms of those issues? Do those gaps exist as Cardiff city council believe? Should they be closed? Is it unnecessarily expensive and perhaps overly regulated in Wales?

[202] **Mr Collins**: All I can give you is feedback from the people who we

interact with. I think one of the biggest indicators was in your own video, in terms of the lady who was asked in that video, 'Should any other treatments be included within the special procedures?' She listed lasers. It's regulated by Healthcare Inspectorate Wales, but somebody who's providing electrolysis right now might not be aware of the fact that lasers are regulated. So, I think the problem with it is—and this is the problem with anything—that there are a number of people, as demonstrated through the members of the BACN and as demonstrated by our members, who are committed to safety, and, with every bit of legislation and regulation that's put in place, they will step up to the mark and ultimately continue to do so. What it doesn't really address is the people who want to operate under the radar. So, we're developing a set of standards around laser-specific treatments because we feel that our accreditation needs improving in that area. We're dealing with a number of laser protection advisers, and they're stating that, actually, one of the biggest problems, especially even within Wales within regulation, is that the inspectors who are going in don't have the necessary knowledge and skill to be able to identify the problem. So, actually, you can buy a cheap machine from China with a CE code that isn't valid and doesn't have a set of protocols, policies and procedures, and it doesn't have anything that supports the provider of the treatments that says, 'If this goes wrong, this is what you do', and that's in the current landscape of regulation for lasers.

[203] I was in Cowbridge just the other week with a clinic that is HIW regulated, and their view is that it's incredibly expensive and it doesn't help them from the point of view that consumers are just not aware of it. In all the consumer research that we've done—and we've researched 1,000 consumers—the problem to a large degree is that there is no awareness, and where people struggle is that there's not one place to go that encompasses every challenge. So, you don't know where to go to find the laser provider in the first place, then who do you go to in terms of laser removal in terms of tattoo removal? It's a challenge, and I see in terms of licensing, regardless of how, even in the best and most ideal world, you've got 22 interpretations, delivering a set of licensing I think is a challenge.

[204] **John Griffiths:** Could I just ask as well, Chair: are you aware, then, of many incidents of harm being caused by laser treatment in Wales, and, if so, what sort of harm is that?

11:15

[205] **Ms Collins:** Not specifically in Wales, but we've been interacting with a

number of patients who have had treatment in other areas that are licensed, such as London, and, one in eight, they have an adverse reaction. So, for example, this one gentleman went for a course of laser treatments and ended up having a hole burnt in his nose because the person, the practitioner, used the incorrect setting. He complained to the local authority, because the premises were licensed and, actually, nothing happened—the person is still operating, licensed, and nothing happened. There was no investigation or any redress at all.

[206] **Mr Collins:** Another real scenario is, we got a case study of a chap who was a builder. He was a builder, and then, during the week, he decided, 'I actually want to provide laser treatments'. So, because it's unregulated, in England, he went and bought a machine, and it wasn't a very good machine, and then, guess what? Three days later, he's providing treatments. And the problem is, I come along, I get some insurance, I show you that I've been on a training course—and that's the other problem: where is the benchmark? What is adequate training? What does it look like? What do you have to go through? So, effectively, I can go on a half-day's training and I can get my training from a manufacturer, which is compromised, because, 'I'm selling you a machine. I'm going to give you a bit of training so you can go out and use the machine'. I give you my certificate that says, 'Look, I've had some training'—half a day. I've ultimately been in a situation where I've got some insurance, because, guess what? Now I've got a certificate, the insurance company will insure me. And then, you come and visit my site, and, ultimately, maybe the person who is coming isn't an expert in the field, therefore doesn't know what to look for, gives the licence, and there's the other challenge—I've got a licence now. Public perception: you must be good at what you do, but there's no benchmark; we don't know that you're good at what you do, we just know you've bought a machine, you've got a licence, you've had half a day's training. Therefore, it doesn't raise standards. What it does, I think, in terms of licensing—without good standards in place, without benchmarks, and without identifying who should be providing the treatments—. I think what you actually provide—.

[207] And another real example: in Nottingham, there's licensing, and there's licensing for IPL laser. There's a salon that provides this treatment. Consumers are seeing that they're licensed, but, under that licence, they also provide Botox treatments and dermal filler treatments, and the members of the public, because they see a licence, think, 'Well, everything must be licensed; this is a licensed premises', and they go along. So, this particular beautician is utilising, allegedly, a nurse—and we can't evidence that,

because we can't find them—and they were actually advertising sharing syringes for members of the public. So, we, the consumer, went to Nottingham council and said, 'You've licensed this particular place, and they're offering sharing of syringes', and Nottingham council said, 'That doesn't sit within our licence; we can't help you'. Not only that, they couldn't direct them anywhere to get help. So, the problem is, unless, in terms of a licence, it encompasses everything, it can be misleading and it can muddy the waters, because it can provide a false impression.

[208] **David Rees**: BACN.

[209] **Mr Burgess**: I'd agree with 95% of that. I think the question for us, when looking at your Bill—and, obviously, that's what you asked us to comment on—is you have a procedure or recommendations in place that, principally, are driven around licensing premises and looking at health and safety matters. The outcome of a lot of what Mr Collins has just said is that there's nothing within that framework that assesses the competence of the individuals concerned, and this is the big issue. So, if you put something with a stamp outside a building, i.e. saying this place is licensed, the general perception of the public is that somebody must have decided that this person is fit to practice. So, you can almost defeat the whole object of what you're trying to do.

[210] So, our position is that you have to take the holistic approach, which is the same position as Save Face, but, in order to do that, you have to step outside the boundaries of premises and health and safety. And you can only do that if you relate it to a set of standards of competence of professionals. Now, the position of the Government in Westminster is anti-regulatory—self-regulation. So, their position is that anybody can do this, okay, if they meet a certain set of standards. Now, the consultation over the last 18 months, after the Keogh review, indicated that the industry was coming forward and has developed a set of standards in England for Botox treatments and all the other treatments. That has to be adopted before you can then start regulating, in our view. So, our position would be that we're sure there are all kinds of public benefits to what you're trying to do in relation to the premises and health and safety, but you have to tackle the overall issue of the competence of the people involved and you have to have routes by which you can assess that and that can be accredited.

[211] **Mr Rankin**: One further point, to answer your question from an English perspective, I do see numerous cases of permanent harm and damage to

patients who have had laser treatments from under-regulated people, with very little comeback. I see the problem not as over-regulation in Wales but under-regulation in England.

[212] **John Griffiths**: Are those problems mainly around scarring?

[213] **Mr Rankin**: Scarring—absolutely, yes.

[214] **Alun Davies**: You draw quite a terrifying picture of this situation. Perhaps you could outline, for our benefit, which treatments you believe provide the greatest threat at the moment because of a lack of regulation or a lack of an understanding of how those services are provided. How would you, from your organisation's point of view, like to see those potential threats managed by any Government action?

[215] **Mr Collins**: In terms of our view, one of the problems is there is no centralised point of data that provides any kind of expert reference around any of the treatments being proposed or any of the treatments that sit outside of the proposals. One question I had, coming here today: we're aware of a breakout of hepatitis C in Newport, but actually, outside of that, I'm not aware of any catastrophic numbers of reported incidents that have led to this Bill being put forward in terms of licensing. In terms of what you have got—and, hopefully, the BACN will agree with us—in terms of the disciplines that you've got, or the treatments that you've got that are specialist, they need a specialist approach. Certainly, non-surgical cosmetic treatments cannot be lumped in with tattoo, nor can they be lumped in with electrolysis. You need a certain calibre and understanding of each treatment set to be able to regulate. I think the biggest challenge is actually being able to establish who should and who shouldn't be providing treatments. From my point of view, I think that's very important, as is having the standards and the frameworks in place to be able to do that.

[216] I've got some comments here in terms of regulation, and, actually, there was a command paper in February 2011 that dictates that Governments should, where there is the opportunity to self-regulate, promote that, because actually it becomes cost-neutral for the taxpayer and can deliver absolute excellence in the delivery model. So, if you're looking at it from our point of view, we would encourage Governments to look more closely at self-regulation. A good example is the acupuncturists; I can't understand for the life of me why acupuncturists are included within the Bill. A good example is that they've recently—

[217] **Alun Davies:** Sorry, can I stop you there? You say self-regulation, but you said in an earlier answer that anybody could set themselves up in business, and you quoted the example of the builder. So, this builder sets himself up in three days; in four days, he is not only self-regulating, but part of a self-regulatory structure. Surely you need something external to provide surety and certainty for the general public?

[218] **Mr Collins:** Where I come back to is, ultimately, the question of who should be providing treatments. So, for example, within Save Face, looking specifically at injectables, we will only accredit doctors, nurses and dentists. Therefore, in terms of our scheme, they have to go through a validation process to be able to demonstrate that. They have to be able to demonstrate the right level of insurance. They do have to be able to demonstrate that they've had training effectively within that discipline. They ultimately have to demonstrate they have a fit-for-purpose set of policies, protocols and procedures. They have to demonstrate they've got a good complaints procedure in place and that it's robust. Then, we do an on-site visit where we send a regulated NMC nurse to complete the site audit to establish that it's safe and hygienic. And then, most importantly, what we provide is the vehicle for the consumers and the public who utilise that service to provide feedback. Ultimately, within that feedback, if a complaint comes in, that can be investigated. Ultimately, the members that we accredit are accountable to their regulatory bodies, like the Nursing and Midwifery Council. So, if there was a breach of conduct that we found through investigation and we could support that with evidence, that could be provided and the regulator then could take necessary steps with that particular individual. So, for example, in this form of self-regulation, the builder can't become accredited and can't be registered because we make a statement that says, 'I wouldn't go to a builder to have a tooth out; I would go to a dentist. Therefore, I wouldn't go to a beautician to have an injection in my face for the same reason.' If you look at some of the serious scenarios in terms of dermal filler treatments et cetera, and you look at the fact that every one of our members has to have anaphylactic training and kit on site—it's for that one time that something goes wrong that the person is medically trained and equipped to deal with that situation. I know for a fact that, if I was a member of the public, I'd rather be sat in Andrew's clinic, where he's medically trained, with an anaphylactic kit—. If I'm that one person, then Andrew saves my life.

[219] **Mr Burgess:** I have to say, Chair, that that is actually is a realistic example that Andrew can relay to you. You had that situation in his clinic,

didn't you?

[220] **Mr Rankin:** Many of us have emergency situations, and it's why the standards that we have set through health education in England have allowed for these scenarios, so that whoever is doing the treatments is capable of dealing with such emergencies—bearing equally in mind that dealing with some of these emergencies requires the use of prescription-only medicines. If the person is not a prescriber, then they are under the supervision of such a person. So, whichever way a situation can be maintained—.

[221] **David Rees:** I understand your points on your self-regulatory approach. Does the Bill harm or damage that approach in any way whatsoever?

[222] **Mr Burgess:** I don't think so, other than the point in relation to what I said earlier about whether giving somebody a licence and the charter mark actually influences them in terms of whether that is a safe place to go. The other thing about self-regulation is that self-regulation will only be effective if there is agreement among all the stakeholders about the standards and the benchmarks and the processes that go with it. So, in other words, you're running that almost parallel with the legislation you're implementing. So, for example, if the processes that will hopefully emerge out of the Government in England soon around self-regulation encompass a lot of those things in terms of competence and standards and that kind of thing, that could run alongside your own proposals in relation to the licensing of premises.

[223] **Mr Collins:** I think as well, just to build on what Paul said there: will this help? Well, I don't think this licensing scheme would have stopped the hepatitis C breakout that was in Newport. I think I'd have still got my licence. Ultimately, what the licence isn't doing—. Take away hepatitis C, and let's break it down. I get a tattoo licence, but what that doesn't do is establish whether I can draw. So, to the public, I've got a licence and I'm a tattooist. Someone comes in and I'm told, 'What I'd like is a picture of a dragon on my back, please.' They're horrified to turn around and find out that they've got an Alsatian, when they come out of the practice—you know, a deformed Alsatian, because they were not very good at Alsatians either. That's the problem. It's not just in terms of: is the environment right? It's actually the competency that Paul referenced earlier, and the capability. It's having that ability to influence and raise standards.

[224] **Alun Davies:** How do you deliver that, then?

11:30

[225] **Mr Collins:** I think you've got to do it treatment by treatment. For example, the British Acupuncture Council is now accredited by the Professional Standards Authority. Since it has become accredited by the PSA, which was set up two years ago by the Government, it has seen a rise in membership from 3,000 to 7,000. Actually, they have to go through a robust process to become accredited through the British Acupuncture Council. Ultimately, in terms of that, if you think about this: if you had a self-regulatory scheme that could establish standards for electrolysis and if you had one for tattoos et cetera—. If you look at the most successful registers and accreditations, they are actually run by businesses independent of the council. So, for example, Gas Safe is run by Capita. It's really, really successful in terms of what it does. There's lots of health and safety regulation out there, but, actually, the accreditation companies are people like Safecontractor, the Contractors Health and Safety Assessment Scheme, CHAS, and Constructionline. Actually, within that, it provides a really, really good landscape. The one thing I come back to, and this is something that we are very, very passionate about, is that there is no point in having any licensing or any register that the public are not aware of. One thing that frightened me when I read the proposal is that, with £6 million between now and 2020, I don't think it can be delivered, realistically. The other thing is that, if you look at the Care Quality Commission in the UK, that costs £250 million a year, currently, and it's underpinned by £110 million of public money. Now, they're about to double the fee on that because the Government have said, 'No more.'

[226] Now, I cannot turn my telly on in the morning without hearing how challenged the NHS is. This morning, I believe they're filming outside because £1 million has been spent on lung research and support because of the issues. I can't read the local paper without hearing about cutbacks in local councils and money saving. I think, in terms of this licensing Bill, you'll find it will cost £6 million. It will cost you an awful lot more, and what's not been accounted for is that, as soon as something like this happens, the one experience that I can give you is that we have our register and you'd be amazed at how many people contact us complaining about people on our register and then how many people complain about the people who are not on our register. And we have to spend time and effort investigating this. Ultimately, in terms of the public, we don't know, actually, how many complaints are going on, so we can't budget for how much we'll need to be

able to address them. And to address these complaints, you need experts in every single field.

[227] **Mr Rankin**: Can I go back to your original question in terms of the risk profile of various treatments? We deal, at the moment, with five interventions, which we consider the primary interventions. I think it's important to understand that the nature of cosmetic medicine is very fluid and very progressive and new treatments will be coming onto the market. So, any legislative way forward would need to be flexible to deal with that. In terms of risk profiles, what stand head and shoulders above everything else are, in fact, dermal fillers. They do have, and have been demonstrated to have, the risk not just in terms of localised scarring but in terms of blindness. I think we welcome the opportunity for voluntary regulation—

[228] **Alun Davies**: Sorry, could you just say what the five are?

[229] **Mr Rankin**: Absolutely. Dermal fillers, botulinum toxins, lasers, chemical peels and medical needling and hair restoration surgery. Those are the five primary interventions, but there are others that we will need to be dealing with as well, like treatment of veins—sclerotherapy—and thread lifting techniques. The list is comprehensive.

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

[231] **Kirsty Williams**: Mr Rankin, you bring up a point that I wanted to raise—how you could create a legislative system that can keep pace with changes in the industry and changes in demand.

[232] **Mr Rankin**: Absolutely.

[233] **Kirsty Williams**: Throughout this, I've always been curious about what made it onto the list and what didn't make it onto the list. One of the things I was concerned about was colonic irrigation, but, apparently, we don't have to worry about that any more because the vogue for colonic irrigation has passed and we've moved on to something else. I'm just wondering how you create a system that keeps pace with the latest trends, fads and treatments. Also, going back to your point, Mr Collins, as a consumer of these products, what is the best way of empowering the consumer? Surely, it's market forces that, in the end, dictate. So, where I live, you know, it's word of mouth. You know where you can go, where you can't go, what's good and what's not good. That kind of drives the success of somebody who is doing the right

thing and leads to the closing of someone who is deemed not to be very good at what they do. I'm just wondering what you feel is the best way to empower consumers so they can make positive choices? Then, hopefully, that creates a lifting of the standards.

[234] **Mr Collins**: I think, for consumers, it's about education. I think there is a misconception among consumers that this is a regulated marketplace. Therefore, in answering your point, I think the only way you do it is by raising awareness in consumer groups. When I was reading the proposal, within the £6 million, between £200,000 and £300,000 is being earmarked for marketing. I've got to tell you that, over the last 12 months, we've spent twice that. I bet there are people in this room who didn't know of Save Face—and you're in Cardiff and we're in Talbot Green—and we've spent double your budget in the last 12 months.

[235] **Mr Rankin**: Can I just answer your question in terms of the flexible approach? The point I was going to make was: whilst we welcome a voluntary approach to regulation, it clearly requires support in terms of legislation, and there's minimum support in terms of Government recognition of what we're doing. We do have that support by virtue of legislation in terms of prescription-only medicines—the Human Medicines Regulations 2012. There is that loophole in terms of dermal fillers—and hopefully, the Department of Health are addressing that—but my feeling is that what the Department of Health are looking at in terms of legislation for dermal fillers is not for dermal fillers; it's going to be flexible to allow for any future non-prescription intervention. So, that gives us something to support the position of any voluntary regulatory position.

[236] **Kirsty Williams**: Thank you very much.

[237] **David Rees**: Lynne.

[238] **Lynne Neagle**: I just wanted to ask Save Face: you described a very rigorous process that people have to go through to get on your register, but then you said later that you still get an awful lot of complaints about people who are on your register. So, how do you marry up the two, then? Because if there is this really robust process, shouldn't that have really brought down the number of complaints?

[239] **Mr Collins**: What I meant by complaints—. Just to clarify that—I wasn't talking about complaints from the public about members of our—. What I

was talking about is: ultimately, because we've got voluntary regulation, everybody's got an opinion. So, actually, what happens is that we're trying to cajole and encourage people who are medical professionals to become Save Face accredited, and actually what you've got are unfounded opinions by other medical professionals as to whether we should be accrediting or not accrediting certain individuals. So, a real example is that we have accredited recently a nurse in Liverpool, who's got the right level of insurance and demonstrates the right level of training. She does a lot of continuous professional development specifically around what she provides, and she operates out of a room within a salon. Ultimately, we've inspected the salon, and the salon passes the requirements—it's got the sharps bin; it's got the complaints procedure; it's got the medicine management; it's got the right lighting; it's got all the sanitary elements you'd need within that environment—and I got an e-mail from a doctor in Liverpool who said, 'How can you accredit this particular nurse because she works out of a salon?' It was subjective. The person had never visited the site. They'd just had this elite view that you shouldn't be doing it from a salon. So, just to clarify, it's more based on opinion and view, as opposed to reality.

[240] **Lynne Neagle:** So, it's not coming from members of the public, then?

[241] **Mr Collins:** It's not from members of the public. I would say—. People say, you know, 'With self-regulation, how can you meet the public requirements and actually meet the requirements of your members if the members are the people paying you?' Well, we have to stay true to that because ultimately we've got to deliver a fit-for-purpose model to the consumers, make sure they're aware of what we're doing and, at the same time, we've got to make sure that the people on our system are accountable and can be held accountable to what happens. We've got a robust process that we can evidence everything from. We do get complaints from the public, and we do get complications, but the one thing I would say is that the people on our register are making a commitment to wanting to raise standards and raise awareness.

[242] **Mr Burgess:** Could I just make a comment, Chair, with regard to the role of professional bodies and commercial organisations, because I think it's relevant? The professional bodies are set up to oversee the activities of their members. We have no commercial interest at all—

[243] **David Rees:** I'm sure that the members of the committee are fully aware of the difference between—

[244] **Mr Burgess**: Yes. So, there is a difference between that and a commercial register where people pay to belong to something, which, I presume, they would deem to be for commercial advantage in the marketplace. Therefore, there is a difference in terms of the criteria that will be attached to the processes involved.

[245] **David Rees**: I think we're aware of those circumstances. It's the views of the industry that have come through to us on this occasion.

[246] Time is catching up on us again and I have one final question. We've talked about the issues, but most of the issues we've talked about, actually, are not on the face of the Bill—most of the practices. In your views, does the Bill address the concerns you've highlighted appropriately? Should the treatments you've identified be included in the Bill or not? Most of those procedures are not included in the Bill at this point in time. Some have said to us that they should be and we'd like to have a view, perhaps, from both your organisations, as to whether you believe the Bill should be expanded to include those procedures. Do you want to start with the BACN?

[247] **Mr Rankin**: To my mind, on the one hand, it would be wholly inappropriate to include these treatments within those specialist treatments. The only way to reasonably include these treatments in the Bill—and bearing in mind we feel that they would need to be in the context not just of premises and inspection, but in terms of the standards that are around that—would be in a whole new section within the Bill.

[248] **David Rees**: Okay. Save Face?

[249] **Mr B. Collins**: Yes, we agree. We don't think they should be within the Bill. We also don't necessarily believe that the Bill will improve standards and raise awareness with consumers of the treatments that are included. I think it will cost the taxpayer a lot of money to deliver something that won't actually provide you with the outcome that you're looking for.

[250] **David Rees**: Okay. Well, thank you for your answers. A very quick one before the end.

[251] **Altaf Hussain**: You say 'special treatments'—of what? Is it a treatment?

[252] **Mr Rankin**: We're talking about the possibility of adding in those

additional what we would call cosmetic medical treatments, for instance—

[253] **Altaf Hussain:** Again, the treatment?

[254] **Mr Rankin:** Yes, I believe so.

[255] **David Rees:** I suppose the difference between the term 'procedure' and 'treatment' is the issue.

[256] **Altaf Hussain:** Absolutely, yes. Rather than a treatment, these are procedures.

[257] **Mr Rankin:** I've not thought about—

[258] **Altaf Hussain:** It doesn't save anything, it doesn't treat you for any illness or complaint or anything, these are—

[259] **David Rees:** I think we'll leave that one.

[260] **Mr Rankin:** Yes, there are some semantics involved with that, but yes, it's important.

[261] **David Rees:** Thank you for your time this morning and thank you for your evidence. You will receive a copy of the transcript and if there are any factual inaccuracies, please let us know as soon as possible. Once again, thank you very much.

[262] **Mr Rankin:** Thank you very much.

[263] **David Rees:** Is it okay if we proceed straight on? We'll go straight into the next one. We've already been delayed a little. We'll go straight in, okay?

11:43

Bil Iechyd y Cyhoedd (Cymru): Sesiwn Dystiolaeth 8
Public Health (Wales) Bill: Evidence Session 8

[264] **David Rees:** The next witness is Dr Ncube who is a consultant epidemiologist and head of the blood-borne virus section of the national infection service in Public Health England. His focus is on tattooing and body piercing, effectively. Good morning and welcome, Dr Ncube. Can I thank you

for your written evidence that you presented to the committee? Clearly, you've been invited to provide some further details and to answer some points. We'll go straight into questions if that's okay with you.

[265] **Dr Ncube:** Indeed.

[266] **David Rees:** If you need amplification for any purpose, the headphones are there; you need channel 2. I don't think there'll be any Welsh questions, but if you do need any translation, the headphones are there for translation on channel 1.

[267] **Dr Ncube:** Thank you.

[268] **David Rees:** So, if we start with a question. Gwyn, do you want to start with the first question?

[269] **Gwyn R. Price:** I see you going for the mic; it's automatic, so you don't have to press it, you're okay. Welcome, anyway. In relation to each of the defined special procedures—acupuncture, body piercing, electrolysis and tattooing—is there sufficient of risk/harm to support their inclusion on the face of the Bill, in your opinion?

11:45

[270] **Dr Ncube:** Yes, there is sufficient evidence, especially for tattooing and body piercing, but also the way that acupuncture is done. The evidence that we have in relation to tattooing and also in relation to body piercing—. Acupuncture, indeed, causes and poses a risk, too. The sort of risks that we're interested in are infections, especially bacterial infections from both tattooing and body piercing, and also viral infections. Here, you're looking at hepatitis B, hepatitis C and, to a lesser extent, HIV, but, indeed, hepatitis B and C. Tattooing—there is evidence of cases, for whatever reason, following tattooing, of hepatitis C. As you know, hepatitis C is a viral infection that causes liver inflammation and, left over a period of time, it will result in scarring of the liver, which will cause cirrhosis, and, left again over a period of time, can lead to the development of cancer of the liver—hepatic carcinoma. So, viral hepatitis causes phenomenal problems.

[271] Hepatitis B is another one that we're concerned about. It's another viral infection and there have been documented cases following tattooing as well as body piercing. Again, the risk there is the development of problems

with the liver, because they are both infections of the liver. Again, the risk of developing cancer of the liver over time is there with hepatitis B—as I say, not so much HIV—but those two are really the key ones that we have seen in the literature following tattooing and body piercing.

[272] Acupuncture, on the other side, because it is also penetrating the skin, and any breach of the skin in an unhygienic environment exposes the individual to infection—so there is a potential for infection following acupuncture, and electrolysis is exactly the same thing. The integrity of the skin is compromised, and when that happens, the risk of infection is always there.

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

[274] **David Rees:** I want to ask two points. There's been opposition to acupuncture and electrolysis being included because the, perhaps, stronger regulation within the profession. Is there still a need for legislation in those areas, or does this stronger regulation through the professional bodies actually do the same as the Bill is intending to do?

[275] **Dr Ncube:** I think the regulation through the professional bodies helps, but for completeness, I would suggest—and this is an opinion from me, not necessarily coming from any particular body—that it would be prudent to include those two as well and then your licensing regime would be complete. Also, we know that inspection is already going on in the premises where these are done, so having the licensing included in that will complete the package and it will, I think, protect the population better.

[276] **David Rees:** Thank you for that. The previous witnesses have just indicated that one of their important issues is the skills and competencies of the individuals practising these procedures. Do you think the Bill addresses that question strongly enough?

[277] **Dr Ncube:** Yes, I think it does, because, enshrined in that is the importance of training—making sure that the practitioners are fully trained and that there is a rule documenting that training. That is very important for making sure that the competencies that they need to be able to do the procedures that they are doing are there. So, I think it is adequately addressed in that respect.

[278] **David Rees:** Obviously, when you have professional bodies, they are

looking at the skills and competencies for anyone wanting to be a member, but there are some practices that don't necessarily have professional bodies and, therefore, there's an importance to make sure that the skills and competencies are there.

[279] **Dr Ncube:** I think the licensing procedures that you've put in place, and also the conditions that you attach to the licensing, will be the bit that is going to help in situations where you don't have professional bodies in place to be able to do that. I think you can achieve the same thing through the licensing regime that you'll introduce.

[280] **David Rees:** Again, you came in and started talking about procedures that pierce the skin and effectively affect the integrity of the skin. There are other practices and procedures that do that which aren't included in the Bill. Should those be included to ensure that therefore there is consistency across the type of approach?

[281] **Dr Ncube:** I think we are standing on slightly shaky ground in relation to these other exotic practices that are in place. The reason I say that we're standing on slightly shaky ground is because we don't have, as yet, the evidence to show the risk of infection in relation to that, and indeed the risk of other complications that can be associated with them, whereas the four that we've mentioned at the beginning, we have got better evidence in relation to that. So, I would suggest, and this is again just a suggestion and an observation, that perhaps at this stage it would be better to concentrate on the four that you have identified already, but allow yourselves room within the Bill for flexibility, to be able to include them when the evidence becomes apparent.

[282] Let me give you an example. We're currently looking at what they call wet cupping; this is a technique of bloodletting, an old technique that was done—if you look at the Chinese medicines, they use that often. Their form of bloodletting is called dry cupping, but in this country they now practice a lot of wet cupping, and if you go especially to some of our Asian communities, especially coming from the Muslim community, you find that they use that as a therapeutic approach. But the difference that we're finding there is that no-one has actually looked at the risk of infection following that. We know that there are some complications surrounding that, but no-one has looked at the risk in great detail. As a result of that, we have put together a small group of experts to review those risks, looking at the literature and bringing in the practitioners and observing them doing their

work. Then, following that, we'll be in a better position to provide guidelines. I think, once detailed work like that has been done, we're in a better position to then decide what sort of licensing is needed, and what sort of regulations are needed. But at the moment I think we're on slightly shaky ground to do that.

[283] **David Rees**: Okay, thank you. Alun.

[284] **Alun Davies**: Your evidence is very useful. In terms of the Bill that we have in front of us, do you believe that the Government has got the balance broadly right in terms of providing the sort of regulation that you've described, but also enabling us to actually implement that, and provide the regulation that provides the protections?

[285] **Dr Ncube**: I can only speak as an expert. I am not a legal man, so I don't have the powers to really comment in greater detail on that. But on discussion with my colleagues who are working in this environment, they broadly feel that the Bill has achieved that, and I think that is really as far as I can comment on that, based on the fact that this is not really my field of expertise.

[286] **Alun Davies**: Sure. From your medical background, as a practitioner, do you believe that the Government is not just delivering the structures of regulation, but is able to provide the reality of that in terms of day-to-day enforcement?

[287] **Dr Ncube**: I think it is providing the reality of that. I think the Bill itself, as it stands, will enable proper licensing conditions to be established, and as I was saying, it is through the licensing conditions, the way those are drafted, and what is included in them, that it is going to give the Bill the power that it needs to be able to protect the population.

[288] **Alun Davies**: And do you think that the Bill needs to be amended in any way?

[289] **Dr Ncube**: I haven't seen anything that I would strongly feel needs to be changed, no.

[290] **Alun Davies**: Okay. Thank you.

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

[292] **Altaf Hussain:** I've just two points. Talking about the wet cupping, you said that Muslims are doing it; I would be interested in having that paper. What I think is that it might be a cultural issue with some countries. That's No. 1. No. 2: who should be giving the licence? Should we have another medical council or should we have a royal college for cosmetic surgeries included in those?

[293] **Dr Ncube:** That's a very interesting question. I don't think that the royal colleges have looked into any of this. I guess there are several reasons for that. One, there is no established education process that has been put in place, and that is one of the things that we'll be looking at. Secondly, the practice has been there for a long time, and it has never been assimilated into medical practice, and that is something that we need to look into as well.

[294] **Altaf Hussain:** Just one point: you know that surgeons started from barbers; that's how we became Misters.

[295] **Dr Ncube:** Sure.

[296] **David Rees:** Can I ask: you highlighted again at the beginning the piercing of the skin, and the infections, and the evidence you've received, and you said that you couldn't progress further than the four in the Bill because of the lack of evidence; is there any evidence coming through in relation to cosmetic procedures that create infections, where there could be a situation where we need to make sure we control the licensing for public health reasons?

[297] **Dr Ncube:** Again, I haven't come across the evidence myself through the work that we have done. We provided the committee with a document that we wrote, 'the tattooing toolkit'. In that, we mention cosmetic work, and the reason that we included it in there is the potential for the transmission of infections. We haven't seen documented evidence of actual transmission of infection, but the potential is there.

[298] **David Rees:** Okay. Can I ask a question on intimate piercing, a very important aspect? The Chartered Institute of Environmental Health believe that 18 should be the age limit at which intimate piercing takes place, and anyone below 18 should not be allowed to have intimate piercing. Do you have any views on the age limit? The current Bill says 16; should it be 16 or

should it be 18? A personal view will be fine.

[299] **Dr Ncube:** My personal view is that the age limit should be 18, and it is based on the following observations: for intimate piercing to be done, you need consent, and that needs to be informed consent. So, you need to be absolutely sure that the person who is giving the consent understands the implications of what they're doing and that they understand the complications—not the immediate complications alone, but the long-term complications as well. So, that's one thing to take into consideration. At the age of 16, people may not be mature enough to be able to give that consent. Secondly, we know that children at the age of 16 will need parental consent, and parents may not want that to be done. If we lowered it down to 16, then they can do that without needing that parental consent, and it could put parents in a difficult position in the relationship that they have with their children.

[300] The other one is the complications that you can get with genital piercing—profound. Let me give you an example: there was a father, who had genital piercing, and he was playing with his daughter, and his daughter accidentally kicked him. The trauma that was caused by the genital piercing resulted in the formation of gangrene in his penis. It's a condition called Fournier's condition. Because of that, the scarring that occurred was profound. So, genital piercing is attended with considerable risks, and it's not just the piercing alone that is important, but it's the long-term implications of it, as I've just given in the example of the trauma that was caused by just a minor kick from a daughter playing with his daddy—with her daddy, rather.

12:00

[301] **David Rees:** Thank you very much for that. Do Members have any questions? Lindsay? Well, you've actually answered most of our questions very quickly, and thank you for that. It's been very interesting to have your view on this, particularly on the longer term implications and the concerns over the potential risks and harms that could arise through some of these procedures. I just have one final question in this sense. We've heard again from previous witnesses to an extent there's a strong argument for self-regulation. Are you finding that self-regulation actually is achieving safe public health, or is there a need to put legislation in place to support any form of self-regulation?

[302] **Dr Ncube**: I don't believe that self-regulation works for several reasons. In this group of practitioners, we're dealing with people that are not necessarily working to predetermined standards. In tattooing, for example, you have people that will carry out tattooing in their own kitchen with their friends, and they won't consider that the individual who is doing the tattooing as a tattooist have no qualifications, they don't actually understand what infection control is and they have not been in an environment where they have been taught how to handle the equipment that they're using or how to sterilise the equipment that they're using. They have no information on how blood-borne viruses—hepatitis B and C—are transmitted and what they need to avoid in order to make sure that they're protecting the individuals that they're looking after. And those individuals, when you talk to them, they will say that they're practising fairly well. Similarly, people on a beach doing the same thing in a kiosk, they will call themselves tattooists and they will feel that they are working within the right environment to protect the people that they are working with, but in actual fact they don't understand the implications of the work that they're doing. I believe that only regulation, properly introduced and properly policed and monitored, will be in a position to identify those individuals and make sure they are removed or they are not given the permission to carry out those procedures until they have gone through the proper channels of training, and they understand the implications of what they're doing in protecting the population as a whole. So, I'm not a believer in self-regulation. I think you need to work within properly defined rules and regulations where there is accountability and you are accountable to somebody else, and not accountable necessarily to yourself. Duty of care is important, of course—we all have a duty of care to the people that we work with—but duty of care is very different from accountability to somebody else.

[303] **David Rees**: Okay, thank you for that. If there are no further questions to the witness, can I say thank you very much for your evidence this morning? It's been very interesting. You will receive a copy of the transcript for any factual inaccuracies. Please let us know as soon as possible if you see anything. Once again, thank you very much for your time and for your evidence; it's been very helpful.

[304] **Dr Ncube**: Thank you.

[305] **David Rees**: And following Dr Ncube, we're going to have the British Acupuncture Council representatives for the last session this morning.

12:04

Bil Iechyd y Cyhoedd (Cymru): Sesiwn Dystiolaeth 9
Public Health (Wales) Bill: Evidence Session 9

[306] **David Rees**: Good afternoon now. Can I welcome Nick Pahl, who is a representative of the British Acupuncture Council? Can I welcome you to this afternoon's session? Can I also thank you for the written evidence you've presented to the committee?

[307] **Mr Pahl**: My pleasure.

[308] **David Rees**: Clearly, we have some questions arising out of that and we'll go straight into those questions, if that's okay with yourself, once you've settled down. The microphones will automatically work so you don't have to worry about those, okay?

[309] **Mr Pahl**: It automatically works—.

[310] **David Rees**: Automatically. So, Gwyn, do you want to start?

[311] **Gwyn R. Price**: Thank you, Chair. Good afternoon. Some organisations have questioned whether acupuncture should be included in the Bill. What is your view on that?

[312] **Dr Pahl**: It's a fair question, because, I think, acupuncture is shown to have an evidence base to help the public in Wales. We've got NICE guidance for lower back pain, for headache and, in Scotland, for chronic pain. So, we have a role to help the public to improve their health, and to sit side-by-side with other professionals in this Bill, you could argue, looks a bit odd. So, it's an anomaly, I think, from the previous legislation. Yes, we see ourselves as health professionals improving health, and whether that sits comfortably with the other professionals dealt with by this legislation is open to question.

[313] **Gwyn R. Price**: Do you generally support the Bill?

[314] **Dr Pahl**: We support the Bill, yes. We think it's good to have a standardised approach. There are anomalies in the way regulation has happened up to now, so, we do support that, but also we support the Bill having recognition of health professionals, such as ourselves, who are regulated with the professional standards authority and those health

professionals who do acupuncture who are already state regulated.

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

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

[317] **John Griffiths**: I note that the British Institute & Association of Electrolysis believes that a previous, what they consider to be similar, licensing arrangement actually lead to a drop in standards, and they cite this previous licensing arrangement, the London special treatment licence, as having had that effect. Are you aware of their concerns in that particular licensing arrangement, and, if so, would you support their view or not?

[318] **Dr Pahl**: I'm not aware of what they've said. I wouldn't necessarily support it. I do think there needs to be a framework by which people are encouraged to be a member of a professional association, and I think the London framework does encourage people who are say they're doing acupuncture to be a member of a professional association like the British Acupuncture Council, because, if they're not, they wouldn't be included in that provision as exempt. So, overall, our view is, being a member of the professional association encourages good practice, safe practice. But I'm not aware of any particular anomalies in London from our data.

[319] **John Griffiths**: Okay, and in terms of existing registration requirements, do you believe this Bill will be a good fit with those? Will the Bill be complementary, or might there be some duplication?

[320] **Dr Pahl**: Well, I think, as it stands now, for our acupuncture practitioners who are a member of our register and are accredited by the professional standards authority, we would be exempt from any extra regulation, and, therefore, we don't think it would have any negative impact. For those people who aren't part of a professional association such as ours, yes, it would have an impact, but the aim of the Bill is to improve public health, and I think being a member of a professional association does support that.

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

[322] **David Rees**: Lindsay.

[323] **Lindsay Whittle**: Thank you, Cadeirydd. I think your view is it's right,

then, that acupuncture is included on the face of this Bill, but I understand that your evidence has told us that you don't wish to see additional procedures added to the face of the Bill—and this Bill has really opened my eyes on many issues, such as branding and scarification. Is that right? Could you tell us why not? That sounds far more invasive than acupuncture, to be honest.

[324] **Dr Pahl**: Well, I think we're saying that, as it stands now, it makes sense in terms of the legislation that's in place and building on that. I think we're saying that there should be an opportunity for the Bill to have flexibility for the Welsh Government and Welsh Ministers to have the power to amend the list of special procedures if there's a change in practice covering this area. So, I'm not aware of what you're saying in terms of those procedures. I'm not sure what you're referring to there, but I do think that the Bill, as it stands, needs to have some kind of flexibility to allow for a change in practice, for example. We referenced in our response wet cupping, which is something that we don't allow for our members. It's something that we would be concerned if other acupuncture professionals, who aren't our members, were doing.

[325] **Lindsay Whittle**: People's habits are changing. When I was a boy, very few people had tattoos. Now, it seems the man, his dog and his granny have got a tattoo, and that's fine. But, who knows, in the next 15 to 20 years, what people will want done to their body? I think that Governments do have a right to allow people to have done, within reason, what they want to their body. But, to protect them, we have to ensure that the people who are doing it are qualified and monitored and licensed.

[326] **Mr Pahl**: I agree. I suppose that's why I started this conversation talking about how acupuncture is very different from the procedures you've talked about. We are health professionals helping people. I've talked about the evidence from NICE. Also, in that conversation that acupuncturists have with their patients, they are looking to improve their diet and their attitude to public health issues like smoking. There's evidence showing that, not just the acupuncture itself, the consultation an acupuncturist has with their patients is an opportunity for that patient to really reflect on looking after their own health. So, we're in a completely different place than some of the people you're talking about.

[327] **Lindsay Whittle**: Thank you very much.

[328] **Alun Davies:** Can I just take you back to the points raised by my colleague, John Griffiths? You welcome the provisions of the Bill with reference to acupuncture and you have been clear this morning that you don't see the requirements in the Bill as duplication in any way. I'm interested to understand how you would see the relationship of the council you represent with practitioners who may be licensed but not members of your council. How do you see that relationship? From my point of view, as very much a lay person, I would have anticipated and expected you to say: 'Actually, we are the council for acupuncture; we are the people with the expertise and the knowledge; who is going to be providing these licenses and what structures and what processes will they follow towards getting a licence?'

[329] **Mr Pahl:** Yes, I suppose we could have gone with that tack, with focusing on those people who aren't members of our council. Our policy position is that acupuncture should be provided by people who are degree-level trained, and the World Health Organization has said that's the standard. We think the Professional Standards Authority accreditation that we belong to should help other acupuncture associations—for example, some Chinese medicine practitioners who aren't necessarily part of our membership—to aim to reach those standards. It's quite difficult, in our statement to you, to offer our opinion on what should happen to other acupuncture professionals who aren't members of the British Acupuncture Council within a climate where we haven't got statutory regulation for acupuncture.

[330] It's worth reminding the committee, if you didn't know, that we were very close to getting statutory regulation for acupuncture in the previous Labour Government, but we were timed out. Our stated intention is still that statutory regulation should occur because then you'd have a protected title and a protected group of professionals meeting that certain standard. So, I suppose there's an opportunity for me to say today that we are concerned about people who don't meet those standards, which is why I suppose we would welcome this Bill. But, just for clarification on your first sentence, we don't welcome duplication for our members, which is why we're pleased there's an exemption. But, we understand—for people who aren't our members or members of Professional Standards Authority accreditation or state regulated—that it does offer benefits in terms of making sure there's a standardised approach by environmental health to acupuncture.

[331] **Alun Davies:** So, why aren't you calling for statutory regulation?

[332] **Mr Pahl:** Well, you know, this is the political climate we're in. Certainly, we've talked to Jeremy Hunt—

[333] **Alun Davies:** In Wales, I mean.

[334] **Mr Pahl:** In Wales—well, maybe there's an opportunity there to have a further conversation with you on that. I suppose I'm here talking about this Bill, but certainly we're interested in Wales, Scotland and other parts of the UK taking on statutory regulation. But, from what I understand, health professional regulation is still a UK-wide position. So, although we would welcome it in Wales, I'm not sure in legal terms whether that would be possible at this stage.

12:15

[335] **David Rees:** Okay, thank you. Altaf.

[336] **Altaf Hussain:** Just a quick point: 20 or 25 years back, it was the anaesthetist who would start giving this acupuncture. They started it. Now, it has come to a situation where anybody can do it. Do you have a regulatory body that looks after your training and licensing, as you call yourselves health professionals?

[337] **Mr Pahl:** For the British Acupuncture Council, I suppose our regulatory body is the Professional Standards Authority, which has this relatively new scheme to assure our register as a voluntary self-regulated body. So, we link in with them. Doctors and physiotherapists: they can provide acupuncture, and obviously they are regulated though the General Medical Council and others. It's worth saying that we have a structure that is ready for state regulation, and we've got our governance for state regulation ready. We have an independent accreditation board that accredits students, and, if they meet those standards, then they join us, and that's independent. So, we have a structure that's fit for purpose.

[338] **Altaf Hussain:** But it's not regulated. It probably should be included in the licensing here.

[339] **Mr Pahl:** Well, no. I think that what is suggested in this scheme is, if you're registered as accredited by the Professional Standards Authority, then you would be exempt. We would be the body that would be exempt under that situation, along with state-regulated professionals.

[340] **David Rees:** Okay. John.

[341] **John Griffiths:** That registration you mentioned that was timed out in the UK Parliament: did that cover some of the areas that this proposed legislation will deal with?

[342] **Mr Pahl:** Well, I think the intended consequence would be that you would not have practitioners who were poorly trained, perhaps having poor safe practice. So, I think the consequence would be similar, in terms of safe practice that you were aiming for in this public health Bill.

[343] **John Griffiths:** So, was there anything in that legislation that you thought was particularly valuable that isn't in this legislation and might well be?

[344] **Mr Pahl:** Well, I suppose the big one is protection of title. As your colleague said, anyone could potentially set themselves up to be an acupuncturist, and that's a concern. I suppose that one of the reasons why the current UK Government isn't regulating acupuncture is that—. There was a policy document in 2011 that talked about the professional regulation of health professionals, and they said that it was only if there was a risk to the public. Acupuncture, I suppose thankfully for the public, isn't a risky procedure. It is extremely low—I think that one in 65,000 cases leads to some kind of adverse event. So, it is a very safe procedure, but there's still a concern when you're an acupuncturist working in the NHS or privately, if you're providing acupuncture and there isn't protection of title, which means that some people who potentially are poorly trained could still set up shop and practice. I think this public health Bill is a really excellent first step across the UK. It's setting a good mark for other nations of the UK to follow in terms of setting a bar and moving up that protection of the public.

[345] **David Rees:** Do you have concerns—clearly, some have been mentioned this morning—in relation to this Bill? You have identified that your members won't have to be approved because they are approved through the PSA. But, those who are not members of your council: who is going to issue the licences, and who will have the expertise to ensure they are meeting the standards you would expect of your own members?

[346] **Mr Pahl:** As we said in our consultation, I think there has been variability in the way local authorities and environmental health teams have

looked at acupuncture. I'm not saying there's a particular issue in Wales. I think that, across the UK, there has been variability, from some people saying, 'You should have a carpet in a practice room,' to other people saying, 'Absolutely not'. As this Bill progresses, I would expect there to be consultation on what environmental health teams would be looking at, and the standardisation. I suppose that what our statement to you has said is that variability is a concern. In terms of focusing attention on a standardised approach, I'm sure that environmental health teams will then follow that rather than, perhaps, deciding, according to whim, what should be allowed and what shouldn't be allowed.

[347] **David Rees**: The skills and competencies of the practitioners have been highlighted. Of course, you are also talking about the skills and competencies of the people issuing licences to understand the practices and to understand the industry.

[348] **Mr Pahl**: That's right. That's why I referred to these World Health Organization standards of 1999, which set standards of education and training in acupuncture. If you're a doctor or health professional, it's lower than if you're someone starting from scratch. If you're starting from scratch to be trained in acupuncture, it's recommending 3,500 hours of training. I would hope that environmental health teams would take that into consideration as to whether they're properly trained.

[349] **David Rees**: Do any other Members have questions?

[350] **Altaf Hussain**: Just a quick question. The number of people wanting acupuncture in Wales—do you have any—

[351] **Mr Pahl**: The overall figure for the UK is 4.5 million consultations a year. The UK ever-use of acupuncture is around 10 per cent to 11 per cent.

[352] **David Rees**: Do you know how many members you have in Wales?

[353] **Mr Pahl**: We've got around 100.

[354] **David Rees**: Okay. Are there any other questions? Well, thank you very much. It's been very interesting, actually—your comments on some aspects. It's been very helpful. Thank you for that.

[355] **Mr Pahl**: Thank you. It's my pleasure.

[356] **David Rees:** Thank you for coming. You'll get a copy of the transcript. If there are any factual inaccuracies, please let us know as soon as possible.

[357] **Mr Pahl:** I will do.

[358] **David Rees:** Thank you very much for your time.

[359] **Mr Pahl:** My pleasure. Thank you.

[360] **David Rees:** I recommend that we now break for lunch. We meet again at 1.15 p.m. Is that okay?

Gohiriwyd y cyfarfod rhwng 12:21 a 13:17.
The meeting adjourned between 12:21 and 13:17.

Bil Iechyd y Cyhoedd (Cymru): Sesiwn Dystiolaeth 10
Public Health (Wales) Bill: Evidence Session 10

[361] **David Rees:** Good afternoon. Could I welcome Members back to today's session of the Health and Social Care Committee? We are continuing our evidence-gathering on the Public Health (Wales) Bill. For the next session we have a representative from the British Body Piercing Association, who is Sarah Calcott. Welcome. We also have a representative from the British Tattoo Artist Federation, Lee Clements. Welcome. Can I thank the British Body Piercing Association for their written paper? We've had various representations from the tattoo side of things as well; so, thank you very much for that. We'll go straight into questions if it's okay with you. Can I start with Gwyn?

[362] **Gwyn R. Price:** Thank you, Chair. Good afternoon, both. Could you tell me whether you believe the proposals in the legislation will adequately protect the public against the risk of harm or whether you think there's any further action that should be put in the Bill to adjust that?

[363] **Ms Calcott:** I believe that there's ample room for more regulation to come up into the piercing industry as, at the moment, there are multiple cases where people have had piercings done and things where there isn't enough in the realm of the registrations that are, at the moment, available. There isn't enough training involved in there. So, I think that there is definitely more room for that.

[364] **Gwyn R. Price:** Are you the same?

[365] **Mr Clements:** Yes, I'd feel the same. I think that most of the issues that arise from tattooing and body piercing could be dealt with with education. For the licensing system, I think there needs to be some sort of minimum sort of standard with, for instance, a blood-borne pathogen training course, which can be done for £20. Basically, all the hygiene could be dealt with with basic education.

[366] **Gwyn R. Price:** Do you believe there's room to make it, on the face of the Bill, the law that you should be registered?

[367] **Ms Calcott:** Yes; most definitely.

[368] **Mr Clements:** Yes.

[369] **Ms Calcott:** There is ample room for that. I think, at the moment, there is very, very little with regard to technical-based training. With the ongoing support of the different associations and federations that are out there, I think it should be more noticeable that any of the registrations that body piercers or tattooists now need—it should go further with that. Training and ongoing support is definitely something that needs to be there for them.

[370] **Gwyn R. Price:** Thank you, both.

[371] **David Rees:** John?

[372] **John Griffiths:** I wonder if you're aware of the recent incidents at a tattoo parlour in Newport.

[373] **Mr Clements:** Yes.

[374] **John Griffiths:** You are. I just wonder, then, whether you think that the provisions that are proposed in this Bill would have prevented those problems from occurring.

[375] **Mr Clements:** I'm not completely familiar with exactly what happened, but I've never known a case that has had as many issues as that. Again, going back to what we were saying earlier, I think education in hygiene and sterilisation, which hopefully would be part of the licence, would have

prevented a lot of the cases.

[376] **John Griffiths:** Right. So, is it your view, then, that in terms of, as you say, the skills and the training that are necessary for practitioners, the premises and their suitability, hygiene and everything else that needs to be in place—is it your view that this Bill will adequately ensure that all of those factors are in place?

[377] **Mr Clements:** Yes. The British Tattoo Artists Federation basically say that we support it completely and we're happy with how it's going forward.

[378] **John Griffiths:** And there's nothing further or additional that you would like to see included that isn't currently proposed.

[379] **Mr Clements:** One of the things that is a little bit unclear is enforcement with regard to environmental health officers being able to actually enforce the issues. Currently, the environmental health officers I have spoken to find it very difficult to actually bring anything to court in the first place. So, I'm hoping that, with the adequate enforcement, they will be able to prosecute people for non-compliance with the licence.

[380] **John Griffiths:** Right, okay. So, the inspection regime and monitoring is going to be absolutely crucial, then.

[381] **Mr Clements:** Absolutely, yes.

[382] **Alun Davies:** It's that point I wanted to follow up with you, Mr Clements. I don't disagree with your position as you outlined in that first question that education and training would eliminate many problems and that would be true in many fields, but of course, that only happens if it's enforced and if there is a structure within which it may be enforced adequately and effectively. So, would you not support a more comprehensive licensing system that would enable the industry itself to, if you like, earn and maintain a reputation for excellence in terms of practitioners and also weed out those people who may be causing problems?

[383] **Mr Clements:** I think, as you've said, we do support the licensing system in its current form, but we would like it to go further, as you said, because it needs to be constantly looked at and updated and enforcement needs to be quite thorough and regular. I would suggest that perhaps we do need to go further with some of the education, for instance. Education for

environmental health officers, I think, is quite important.

[384] **Alun Davies:** I appreciate that. Would you have any suggestions or proposals for amendments to this Bill?

[385] **Mr Clements:** Basically, I haven't had a great deal of time to look into it. I got informed about this on Monday evening, so I'm being thrown into the deep end. But basically, after speaking to our members, enforcement is a massive issue that needs to be looked at and they're a little bit concerned that, perhaps, you're going to charge however much to get your licence and then you'll never see an environmental health officer again. Quite often, even in my studio, we'll go two years without seeing an environmental health officer. So, that needs to be looked at, you need to make sure that there are regular inspections and make sure that the standards are constantly high.

[386] **Alun Davies:** Okay, thank you. Ms Calcott, in terms of the organisation you represent, would you share some of those concerns and some of those points of view?

[387] **Ms Calcott:** Absolutely. I think that, on average, we get between 10 and 20 consumer complaints per week with regard to piercings that they have had that haven't been achieved properly and where they've had to seek medical attention and so on and so forth.

[388] **Alun Davies:** Is that in the UK, or is that Wales?

[389] **Ms Calcott:** No, that's in both. We have members in Wales as well.

[390] **Alun Davies:** But the 10 or 20; is that a UK figure or a Wales figure?

[391] **Ms Calcott:** Sorry. That would be, on average, more UK-based and looking at it in that light. We do have members who are in Wales, as well, who we have never had complaints from. But it all fires back to the fact that training is of the utmost. If the people are, you know, going away from a training course or doing some industry-based training with any type of person or persons, they would need to have the support of and ongoing correspondence with environmental health and also any part of the association they are part of.

[392] There are parts in the Bill that I think need to, sort of, come up a little bit more, so things like the age restraints and, you know, the restrictions that

are on there. So, for the intimate-based piercings, things like female nipples, they need to be considered above the age of 18. You know, this is a very intimate area for a woman. For somebody to come in at the age of 16, I just feel that it's far too young. Things like belly-buttons, tongues and the other parts of the body, I feel are absolutely ample. However, that particular area does need to come up, and, you know, with people understanding what we're doing and what the association is doing. We've got codes of practice and ethics, and within those, we have age restraints and constrictions. We only pierce from the ages of 12 and upwards. So, 12 to 14 is simply earlobes; 14 to 16 is at the discretion of the piercer; 16 and over is everything above the waist minus the female nipples; and 18 and above is female nipples. So, that's kind of where we stand with that one.

[393] **Alun Davies:** Thank you.

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

[395] **John Griffiths:** Could I ask about intoxication? There's concern that people have tattoos or piercings, particularly tattoos, perhaps, when they've had rather more to drink than allows them, perhaps, to be in a fully informed position as to whether they really want a tattoo, you know, going forward from that particular time. Is it your view that this should be addressed in this legislation or the regulations, in one form or another? It's been suggested, for example, that there might be a general cooling-off period that somebody would have to go through before having one of these procedures. Rather than just turning up and having the tattoo or the piercing, they would have to go away and then come back on a subsequent occasion.

[396] Mr Clements: Most reputable studios wouldn't even dream of tattooing someone who is intoxicated. I mean, just in the case of my studio, we have a disclaimer that, basically, they have to sign, saying they're not intoxicated on drugs or alcohol, for instance, and if I thought that they were, then we wouldn't do that anyway. But, I understand that it does happen, and I think that introducing it as part of the Bill would be great. The cooling-off period—I know they've introduced something similar in Boston health authority, and I think that that's something that would be of benefit. I think if someone is going to make the jump to have something for the rest of their lives, then waiting a couple of days is not going to make any difference, is it?

[397] **John Griffiths:** No.

[398] **Mr Clements:** I think that that's great. You'll find most of the studios that will be tattooing people who are drunk will have a low standard of hygiene and training, anyway. Hopefully, the system will be getting rid of that sort of studio.

[399] **John Griffiths:** Sarah, would you have any views on those matters?

[400] **Ms Calcott:** Yes, absolutely. Before anyone that's one of our members pierces a body at all, they will rerun through the consent form and they will ask them a series of questions, you know: are you under the influence of drugs or alcohol? Have you drunk anything, alcohol-wise, in the last 24 hours? It's quite an obvious thing if somebody were to come in, you know, smelling of booze, looking a bit tipsy and so on. So, with anything that comes into that, I think that, for somebody that was to go and do a piercing in relation to somebody that is under the influence, then ultimately they kind of need to go to Specsavers, because they need to understand that you can't do that. The achieved piercing or tattoo, at the end of the day, is not going to come out as appropriated, and then they'll just come back a few days later and start complaining. It's a completely pointless circumstance.

[401] With regard to legislation that's in there, I think it's fairly enforced already, that you wouldn't do that. From a piercer's perspective, you just wouldn't do that. End of story, the piercing will not come out amply, it will not heal properly and you'll have lots of further problems with it.

13:30

[402] So, yes, I feel that something could go in there additionally to back that up and to make sure that people are really asking the appropriate questions. At the end of the day, I feel, as a piercing professional, that if you're going to ask somebody, 'Are you under the influence? Have you had anything in the last 24 hours?', it's just giving it another back-up. You can tell whether somebody has or not.

[403] **David Rees:** Okay. Alun.

[404] **Alun Davies:** Yes, following up on that, in previous answers you have, Mrs Calcott, indicated your feelings about some of the proposals in the Bill. Are there any amendments that you would like to see to this legislation?

[405] **Ms Calcott:** I think that, when it goes forward with the legislation that

is being proposed, it needs to be manageable for the body piercers, because that's what we're looking at in that regard—body piercing, tattooing, and so on and so forth. We can't expect people to go away and be held to new legislation that they can't uphold. It all has to be within the constraints of their job, so if you're sort of saying that you have to be able to have insurance and adequate washing facilities and an autoclave, and so on and so forth, brilliant, fantastic; let's make sure that that's enforced. But, at the same time, any type of monetary value and training thereafter needs to be sufficient on both counts. So, if new licensing and registrations and so on and so forth is brought forward, and those particular constraints aren't going to be able to help those body piercers or tattooists from there onwards, it's not going to enable them to work beneficially for it.

[406] There is definitely movement, and I think as the legislation starts to evolve and starts to go forward, the ability to amend it needs to be there as things are presented in front of us.

[407] **Alun Davies**: So, do you think the legislation needs to be somewhat more flexible?

[408] **Ms Calcott**: I think there definitely needs to be a flexibility in it.

[409] **Alun Davies**: And where do you see that flexibility coming in? Because you need the overarching structures of regulation, and then where would you see the flexibility required?

[410] **Ms Calcott**: The flexibility, I feel, needs to come in in regard to people doing certain piercings. So, say for example somebody came to you for a registration for—similar to what London does; so, nose and ear piercing, you can be registered for that, and then for example, for above the waist body piercings, 'which include…'. So, I feel that it would be able to give people a little bit more manoeuvrability to perform certain piercings, and maybe structure and standardisation. If somebody wants to do the full lot of body piercings, they would then have a slightly different registration to people who would be doing ears and noses, for example.

[411] **David Rees**: Okay. Elin.

[412] **Elin Jones**: To be clear on the age restriction and intimate piercing, would you be in favour, then, of the age restriction changing from what it is currently in the proposed legislation, from a ban on under-16-year-olds to

under-18-year-olds? Because you've intimated that you would be for some forms of intimate piercing, but would you be in favour, with all forms of intimate piercing, of a ban on under-18-year-olds?

[413] **Ms Calcott:** We are only trying to standardise above the waist, so we don't deal with anything that's below. So, anything that is above that waist, based on the intimacy of the piercing—and, as I've already suggested, it's the female area—that would be for that age restriction. There need to be boundaries on what would you do in relation to somebody who's 14 or 15 or 16. It's down to the discretion of the body piercer at the end of the day, at this moment in time. However, if we could bring something in to the 18 mark, very similar to tattooing, you've got that age restraint on there for a reason.

[414] **Elin Jones:** We've had evidence that non-intimate piercing, piercing of the tongue and lip, should also have an age restriction of 18 or 16. Have you got any views on age restrictions in legislation? Obviously, you've got guidance that you offer currently, but would you have a view on including piercing of the tongue and lip within the age restriction in this legislation?

[415] **Ms Calcott:** I think it's difficult, because obviously it's a facial-based piercing, and the tongue is an intimate area really, in theory, because it's quite a procedure to go through to have your tongue pierced. However, I don't feel that the lips—I feel that that is absolutely ample as it stands at the moment. I don't feel that that should be over the age of 18 at all. I think what you'd end up doing, personally, is alienating people and pushing them to back-street places, whereas if we made it possible for the body piercer to see—. If a child's going to go to school with a lip ring at the age of 14, we know that that is not going to last very long, in our industry. So, ultimately, the guys who are having these particular piercings done are above the age of 16 naturally, anyway, because that's when they can actually have the piercing for the length of time that they want it, rather than being told to take it out.

[416] **Elin Jones:** Okay.

[417] **David Rees:** Can I ask you a quick question? You mentioned that you, obviously, have situations for piercing above the waist, but not below the waist. Do your members actually do any piercing on parts of the body below the waist?

[418] **Ms Calcott:** With recent female genital mutilation stuff that's come

about, a lot of the body piercers who were doing anything below the waist have now actually completely stopped. Some of them do do that. We're setting the boundaries for above the waist. We're standardising above the waist; we do not deal with anything below the waist. That is where you would need to go and do some sort of anatomy-based course to be able to push that forward. Those particular intimate areas are not something that we want to get into. We're trying to bring a decent standard to above the waist, and, before you can start venturing any further down below, that needs to be sorted first of all, as far as we're concerned.

[419] **David Rees:** So, standards and medical knowledge for individuals undertaking those procedures could be critical.

[420] **Ms Calcott:** Yes, absolutely. I think, you know, at a later date, they could, yes.

[421] **David Rees:** Lindsay.

[422] **Lindsay Whittle:** I just wanted to ask: because of the very nature of both of your crafts, if that's the right word, you're very close to people's personal space, so do you think that your profession should be vaccinated against hepatitis B, for example? Because one accidental cough or sneeze, if you're a carrier—and you may not know you're a carrier—could infect that person. Do you think that your members should be vaccinated?

[423] **Ms Calcott:** This is something, within our codes of practice and ethics, that we all make sure that people are aware of and they are recommended to go and have it done. Again, with some of the licensing conditions in London, because they are obviously slightly different, they actually want proof that you've had these particular vaccinations. So, with any of the members and anyone—because we do lots of training and things like that—who we speak to or who is a member, we do recommend that they do have this course of vaccinations.

[424] **Lindsay Whittle:** Yes, that's good.

[425] **Mr Clements:** It's the same with us. We recommend that the hepatitis B vaccination is done even before they set foot in a studio. Even with regard to apprentices, I think it's very important that any steps that can be taken should be taken for their, and the public's, safety. I've even had cases where we've had people just coming for work experience, and I won't accept

anyone unless they've had their hepatitis B vaccination. So, yes, I think it's very important.

[426] **Lindsay Whittle**: That's good. Thank you.

[427] **David Rees**: Can I ask a question, Lee? Although you're here on behalf of tattooists, clearly there are implications if something goes wrong and you have the removal of a tattoo, and laser removal seems to be the way forward, do you have any views as to whether, perhaps, that should be included in the Bill as well, because, at the moment, I don't think that treatment is included in the Bill?

[428] **Mr Clements**: Yes, I think, more recently, you're seeing laser clinics popping up. As far as I was aware—I'm not particularly knowledgeable on this—it very much differs between which health authority you're part of. I know, in Cardiff, it's very, very difficult to get permission to operate as a laser clinic, but then, for instance, in the Vale of Glamorgan, where I am, there's nothing whatsoever, and there's recently been a laser clinic pop up, and they have no idea what they're doing. They're basically burning and scarring people. So, currently, I really think that we need to get that under the Bill as well—yes, definitely.

[429] **David Rees**: Can I ask you about something that was new to me—the tashing concept, where, apparently, perhaps, tattooing can be with ashes? Does that fall under the Bill, do you think, or is there a loophole in the Bill that doesn't cover that?

[430] **Mr Clements**: I was discussing this with my colleague earlier, because, again, tashing was something that I had to ask Catherine to explain to me. Basically, if something's been through a furnace, then surely it should be sterile, but obviously there's no guarantee, coming from the furnace to your studio, that it's going to be in a sterile environment. So, I guess that any inks that you use currently need to be pasteurised and gamma sterilised. So, anything else that you're going to use basically to pierce the skin with then surely should be the same. I won't do it anyway just out of principle because you don't know where it's been. So, I guess, yes, you could include it in the Bill; I think that would be great.

[431] **David Rees**: One question I want to ask is: you both represent professional bodies—professional representation, in other words. Could I just ask how many members you've got in Wales, each of you?

[432] **Ms Calcott:** I think we've got 11 over the recent course. We're currently undergoing some sort of revitalisation as such. So, the association has been running for 15 years, however it's not been as active as it is today. So, it's commenced as of March this year. So, we're still in our very early stages, however, the codes of practice and ethics and everything that we, you know, live and breathe by haven't changed. So, we are very few members currently, however, we are encouraging this to increase, and people are contacting us a hell of a lot more now for information and want to be part of an association.

[433] **David Rees:** How many businesses do you think are out there that actually undertake piercing at this point in time?

[434] **Ms Calcott:** We recently did a little bit of market research, and there are about 2,500 studios within the UK and Wales that have piercing going on. And piercing and tattooing kind of run side by side, so, naturally, when you have tattooing you do normally have piercing. So, there are very few that are stand-alone piercing studios, but there are not as many stand-alone piercing studios as there are potentially tattooing studios. So, you know, we kind of take that industry and you cut it down to another piece and you cut it down to another piece, and, you know, we're slightly smaller in the grand scheme of things. But, yes, there are about 2,500 out there. Whether or not they all want to be a member or be part of it is, obviously, entirely up to them.

[435] **David Rees:** Lee.

[436] **Mr Clements:** We have, I would say, upwards of 30 members in Wales at the moment. We've kind of been having a sort of regeneration recently of the British Tattoo Artist Federation; it was founded in the 1970s and it kind of went quiet for a while. And the gentleman that's taken over as secretary has appointed a couple of us guys to the committee. We're really trying to push it forward now because, I mean, everyone's aware of the explosion in tattoo studios recently. Just in Cardiff, you've gone from two or three registered studios to over 75 registered studios within a 10-year period. And you could probably say that 80 per cent of those people are not educated enough to be piercing people's skin. So, yes, it's something that we're trying to push quite heavily at the moment because we have our own minimum standards to be a part of the British Tattoo Artist Federation; I suppose it's getting our name out there and trying to get people to join, because it's such a massive industry at the moment.

[437] **David Rees:** The reason I was asking is, obviously, people who join your organisations have an interest in ensuring things are done in a proper manner. The question is how many others are out there who have less of an interest, perhaps.

[438] **Ms Calcott:** Yes, there are still quite a few out there. And I think the thing is that, once people kind of know a little bit more about the standards and everything, it's very, very easy for anyone to walk into the piercing or tattooing industry, and I think that that's kind of one of the major—I wouldn't say a problem—but it's one of the major parts of it. You know, anyone can go to a local borough council and request a registration, and they have to have sterility and hygiene down to an absolute point, but the actual ability of the body piercer, in our view, we can potentially merit those people. We can give them a list of, you know, 'If you do this and if you do this and if you do this, this is your safest operating procedure'. And that's what we're looking to do—we're looking to bring that safest operating procedure to a standard that is at its best. And I'm sure that that is what you're doing as well, but, you know, I came in and I was sitting in the waiting room and I'd actually never heard of what you guys do. So, with those sorts of things there's a potential that, in time, people can start to work together and we can kind of bring tattooing and piercing needs to a standard, and anyone that comes in underneath that, you know, they're out; there needs to be that.

[439] **David Rees:** I think you mentioned earlier, Lee, that the environmental health staff perhaps do not have an understanding of the procedures and issues that you need them to understand for issuing licenses and for enforcing this?

13:45

[440] **Mr Clements:** Just discussing things with my environmental health officer at the moment, he's quite frustrated, because, under the current registration system they are obliged to register someone. So, if someone applies for a registration, they have to register them, with no experience, with no training whatsoever, and they can set up a business and operate, and only then, when an environmental health officer goes to inspect them—and they can only advise; they can't actually enforce anything, they can only give them advisories. So, you could have someone with absolutely no technical expertise or hygiene training operating and tattooing completely legally and there's nothing that anybody can do about it, currently. And I think you often

find environmental health officers who would like to actually enforce things. I know, particularly with Cardiff, there's a gentleman called Gavin, and he is really interested in the tattoo industry, and he's been fighting and doing his hardest to try and actually enforce some of the things that are in the bye-laws, but it's very difficult for them to do it, because they don't have any tools in place to actually prosecute anyone.

[441] **David Rees:** And this will give them the tools.

[442] **Mr Clements:** Unless you give them the tools, of course, yes.

[443] **Ms Calcott:** I think it's also, from where we are, we're actually in the early stage of becoming a primary authority, which is fantastic, because that helps to make sure that all the members are regulated by us as well as EHO. But if something does come about—say, for example, I had somebody contact me from Eastbourne Borough Council, and it was all to do with a nose piercing, and the consumer had gone to the environmental health officer and said, 'Look, there's a problem here; this hasn't gone correctly. My nose has swollen, I'm in lots of pain, I've had to go to the hospital, and blah, blah, blah'. So, she came to us to ask for the relevant technical advice and as to what had happened, how it had happened, potentially why it had happened, and so on and so forth. So, if an environmental health officer, who is the only person who is currently registering that person, if that is the case, then why do they not have that particular knowledge, and why are they potentially relying on us? And I think that the entirety of it is that there are two parts to this particular story: there is not only the sterility and hygiene, there is the ability of the piercer or the tattooist, and I greatly feel that there needs to be some kind of correlation between the two.

[444] We're doing a lot of training at the moment with EHO officers. We've got a lot of guys from the Sussex counties that we could go and do some training with them so they do have that adequate base knowledge. But, for them, that's something they've had to go forward with and look at. They deal with a huge majority of things on a day-to-day basis, not just tattooing and piercing, but food and safety and hygiene. Health and safety at work is kind of the end premise that they can actively try and seek to gain any type of boundaries of what people are doing, if they have actively not done something that's correct. My business partner, he did some expert witness stuff. There was a gentleman based in Blackpool, and he got prosecuted for piercing out of a studio that should never have been registered. You know, this guy didn't have a supply of gas, he didn't have a supply of electricity,

and so on and so forth, but he had a registration certificate at some point in time—why? Why did he have that? And like you've said, why wasn't it looked upon, and why wasn't he checked regularly? You know, because then that wouldn't happened; there wouldn't have been cross-contamination and problems with people's piercings and tattoos.

[445] **David Rees:** Okay, thank you for that. One further question from me is: the Bill actually has a maximum fine of £1,000. In your sense, as representatives of the industry who clearly want to ensure that the right people operate within those industries under the right standards, is that a sufficient level for a deterrent, or should it be a higher level to ensure there is a clear deterrent not to fail to register, shall we say?

[446] **Ms Calcott:** What do you reckon?

[447] **Mr Clements:** I personally think that a higher deterrent would be needed. I mean, how often does a maximum fine get asked for? Quite often, it isn't the maximum fine that will get used. I guess, as a deterrent, if you can earn £1,000 in a week tattooing, then you're not going to worry about maybe having to pay the occasional £1,000 fine every now and again, are you? I think, personally, that it needs to be a lot higher.

[448] **Ms Calcott:** I'd be looking at the same reference as that. I'd say between £5,000 and £10,000 is definitely a deterrent for something like that. If you don't file your tax returns, you might get a £1,000 fine—that's something that might happen. But, if you don't do what you're supposed to do in this restraint, a £1,000 fine is potentially just another week's work. There are orders that you can put on people—21-day orders and things like that—however, it doesn't seem strict enough. I think that's where the industry really needs to grab hold of it now and make sure that it is strict and people are aware, and sometimes making a point of what somebody's done and giving them a bigger fine or something like that. That needs to happen, I definitely believe that; yes, so, more.

[449] **David Rees:** Do any Members have any questions? No. I thank you very much for your evidence this afternoon. It's been very helpful. Thank you for the short notice as well. You'll get a copy of the transcript to check for any factual inaccuracies. If there are any, please let us know as soon as possible. Thank you very much once again.

13:51

Papurau i'w Nodi
Papers to Note

[450] **David Rees:** The next item on the agenda is our papers to note. We have quite a few because it's been the summer recess. Bear with me, please, Members. Can we note: the minutes of the meetings on 9 and 15 July 2015; the additional information from the Minister for Health and Social Services regarding the Public Health (Wales) Bill, following his evidence session on 1 July 2015; the consultation responses to the Public Health (Wales) Bill, which you should all have copies of now; the Minister for Health and Social Services' response to the Health and Social Care Committee and the Constitutional and Legislative Affairs Committee's Stage 1 report on the Regulation and Inspection of Social Care (Wales) Bill; correspondence from the Minister for Health and Social Services regarding his intention to table amendments to the Safe Nurse Staffing Levels (Wales) Bill—the amendments actually have been tabled; additional information from the Minister for Health and Social Services on the general financial scrutiny session on 17 June; correspondence from the Minister for Health and Social Services regarding the appointment of a national professional lead for primary care in Wales; correspondence from the older people's commissioner regarding the Care and Support (Eligibility) (Wales) Regulations 2015; correspondence from the CNO regarding helping babies born at 22 weeks to survive—a petition that was forwarded to us from the Petitions Committee; correspondence from the Minister for Health and Social Services regarding medium-term plans for health boards and NHS trusts; and, finally, the correspondence from the Minister for Health and Social Services regarding the review of financial ring-fencing arrangements for mental health services in Wales? Hard copies of the report have been distributed to Members' offices I understand. Are we all happy to note those? Thank you for that.

13:52

Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y Cyhoedd
Motion under Standing Orders 17.42(vi) and (ix) to Resolve to Exclude the Public

Cynnig: *Motion:*

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o eitem 1 yn y cyfarfod ar 23 Medi 2015 yn unol â Rheolau Sefydlog 17.42 (vi) a (ix).

that the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 23 September 2015 in accordance with Standing Orders 17.42(vi) and (ix).

Cynigiwyd y cynnig.
Motion moved.

[451] **David Rees:** I propose, in accordance with Standing Orders 17.42 (vi) and (ix), that the committee resolves to meet in private for the remainder of this meeting and for item 1 of the meeting on 23 September 2015. Are you content? Then we move into private session.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 13:53.
The public part of the meeting ended at 13:53.