Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

11/01/2017

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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. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Dawn Bowden	Llafur
Bywgraffiad|Biography	Labour
Jayne Bryant	Llafur
Bywgraffiad|Biography	Labour
Angela Burns	Ceidwadwyr Cymreig
Bywgraffiad|Biography	Welsh Conservatives
Caroline Jones	UKIP Cymru
Bywgraffiad|Biography	UKIP Wales
Dai Lloyd	Plaid Cymru (Cadeirydd y Pwyllgor)
Bywgraffiad|Biography	The Party of Wales (Committee Chair)
Julie Morgan	Llafur
Bywgraffiad|Biography	Labour
Lynne Neagle	Llafur
Bywgraffiad|Biography	Labour

Eraill yn bresennol
Others in attendance

Sue Bowker	Cangen Polisi Tybaco, Llywodraeth Cymru Tobacco Policy Branch, Welsh Government
Chris Brereton	Prif Swyddog Iechyd yr Amgylchedd, Llywodraeth Cymru Chief Environmental Health Officer, Welsh Government
Suzanne Cass	Prif Weithredwr, ASH Cymru Chief Executive, ASH Wales
Rebecca Evans	Aelod Cynulliad, Llafur (Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Social Services and Public Health)
Dr Steven Macey	Swyddog Ymchwil a Pholisi, ASH Cymru Research and Policy Officer, ASH Wales
Chris Tudor-Smith	Uwch-swyddog Cyfrifol, Llywodraeth Cymru Senior Responsible Officer, Welsh Government
Rhian Williams	Gwasanaethau Cyfreithiol, Llywodraeth Cymru Legal Services, Welsh Government
Dr Olwen Williams	Coleg Brenhinol y Meddygon Royal College of Physicians

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

Gareth Pembridge	Cynghorydd Cyfreithiol Legal Adviser
Claire Morris	Ail Glerc Second Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:02.
The meeting began at 09:02.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Dai Lloyd:** Bore da i chi i gyd a chroeso i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. Ar y dechrau, felly, a gaf i gyhoeddi croeso i'm cyd-Aelodau? Hefyd, rydym wedi derbyn ymddiheuriadau oddi wrth Rhun ap Iorwerth; nid yw'n gallu bod yn bresennol y bore yma. Gallaf ymhellach egluro fod y cyfarfod yn naturiol ddwyieithog a gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1 a chlywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i atgoffa pawb i ddiffodd eu ffonau symudol ac unrhyw offer electronig arall a allai ymyrryd â'r offer darlledu? Hefyd, rwy'n hysbysu pobl, yn y bôn, nad ydym yn disgwyl larwm tân y bore

Dai Lloyd: Good morning to you all and welcome to the latest meeting of the Health, Social Care and Sport Committee here in the Assembly. At the beginning, here, may I also welcome my fellow Members? We've also received apologies from Rhun ap Iorwerth; he can't be present this morning. I can further explain that the meeting, naturally, is bilingual and that headphones can be used for simultaneous translation from Welsh to English on channel 1 or for amplification in the original language on channel 2. May I remind people to turn off their mobile phones and any other electronic equipment that may interfere with broadcasting equipment? Also, I'll let people know that, essentially, we're not expecting a fire alarm this morning. If there is a

yma. Os bydd yna larwm tân, dylid dilyn cyfarwyddiadau'r tywyswyr ar y ffordd allan.

fire alarm, we should follow directions from the ushers on the way out.

09:03

Bil Iechyd y Cyhoedd (Cymru)—Cyfnod 1, Sesiwn Dystiolaeth 7—Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol
Public Health (Wales) Bill—Stage 1 Evidence Session 7—the Minister for Social Services and Public Health

[2] **Dai Lloyd**: Gyda chymaint â hynny o ragymadrodd, felly, symudwn ni ymlaen i eitem 2, rhagor o graffu ar Fil Iechyd y Cyhoedd (Cymru), Cyfnod 1, sesiwn dystiolaeth 7. Yn bresennol am y sesiwn yma mae Gweinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol—bore da i chi—Rebecca Evans, ynghyd â Chris Tudor-Smith, uwch-swyddog cyfrifol, Rhian Williams, gwasanaethau cyfreithiol, Chris Brereton, prif swyddog iechyd yr amgylchedd, a Sue Bowker, cangen polisi tybaco Llywodraeth Cymru. Croeso i chi i gyd. Fel rydych yn gwybod, y drefn nawr yw: fe awn ni'n syth at gwestiynau. Mae Aelodau, yn naturiol, wedi darllen y papurau angenrheidiol gerbron ac mae cwestiynau yn deillio o hynny ac, wrth gwrs, o rhan o'r dystiolaeth rydym wedi'i derbyn oddi wrth dystion eraill hefyd yn y maes ynglŷn â'r Mesur yma. Felly, rydym yn mynd i ddechrau'r bore yma efo Julie.

Dai Lloyd: With that introduction, we move on to item 2, more scrutiny on the Public Health (Wales) Bill, Stage 1, evidence session 7. Present for this session is the Minister for Social Services and Public Health—good morning to you—Rebecca Evans, as well as Chris Tudor-Smith, senior responsible officer, Rhian Williams, legal services, Chris Brereton, chief environmental health officer, and Sue Bowker, the tobacco policy branch of the Welsh Government. Welcome to you all. You know, the arrangements now: we'll go straight into questions. Members, naturally, have read the necessary papers before them and questions stem from those papers and from part of the evidence that we've received from other witnesses in the area on this Bill. So, we'll start this morning with Julie.

[3] **Julie Morgan**: Diolch. Bore da, Minister. I know you're aware that some stakeholders have suggested additional things to be put into the Bill. I think

we wanted to know what your response was to some of those proposals. The first one was provision for a statutory basis for nutritional standards in early years and care home settings and in hospitals, similar to what exists in school settings under the Healthy Eating in Schools (Wales) Measure 2009. I wondered what your views were about that proposal.

[4] **The Minister for Social Services and Public Health (Rebecca Evans):** Okay. Well, thank you, and good morning, Chair and committee. We've been watching the evidence that's been given to committee very closely, as we did when the Bill went through the first series of scrutiny in the Assembly as well. And I think it's important, I suppose, at the start, to recognise that one piece of legislation can't address all of the public health challenges facing us in Wales. In fact, some things won't actually need to be addressed through legislation; they might be better addressed through policy initiatives or working with the UK Government, with industry, and so on, as well.

[5] But with regard to nutritional standards, I know that was something that was included in the Bill the first time around, but then it was removed because, actually, we thought, 'Well, we can just get on and make some progress with nutritional standards without them necessarily needing to be on the face of the Bill.' So, when I came to committee last time, I said that we were currently looking at the nutritional standards for early years settings and older people in care homes, and I'm pleased to say we're making good progress with that. So, we're finalising those nutritional standards at the moment. Many nurseries, for example, are already covered under this legislation, because they actually sit on the sites of schools, so they'll be covered under the schools legislation, and we're already introducing a wide range of nutritional standards and nutritional work in our hospital settings. For example, all local health boards have received directions in relation to mandatory food and fluid nutrition standards for patients, mandatory food and drink standards for vending machines, and also guidance in terms of food and drink for the people who are visiting the hospitals as well. And we're having ongoing discussions with stakeholders in terms of what we can do to improve nutritional standards in canteen settings and in retail settings in hospitals as well.

[6] So, this work is already going on, and we also have the revised nutritional criteria for the corporate health standard as well, which requires all of our health boards to achieve gold standard in that, and to make the necessary changes that they have to do in order to achieve that through nutritional improvements as well. So, whilst I understand there's a keenness

to explore what more we can possibly add to the Bill, I do think that nutritional standards have been addressed, and are being addressed, outside of the scope of the Bill. However, if the committee does feel strongly about it, I would obviously give it further consideration. I do see legislation as part of a journey, not necessarily the starting point. So, if there are things that can be achieved outside of legislation, then I think it's perfectly appropriate to do that, and I think that we are doing that through nutritional standards. But if committee has had evidence that suggests that a stronger approach is necessary obviously I will consider that.

[7] **Julie Morgan**: Basically, most areas seem to be covered by the policy initiatives you're taking. Are there any areas that aren't covered by the policy initiatives? I was just thinking of nurseries that aren't on school premises, for example. Are you able to address that?

[8] **Rebecca Evans**: We would hope then that that would be covered through the work that we're doing on early years settings more widely.

[9] **Julie Morgan**: Right, right. Thank you for that response. Another proposal was that the future generations legislation should be strengthened to ensure that public services boards' local well-being plans should include actions to address public health issues, such as obesity, physical inactivity, loneliness and isolation. Are there—? I don't know what your views are on that.

[10] **Rebecca Evans**: I do think that the Well-being of Future Generations (Wales) Act 2015 will be an important mechanism for addressing things like obesity, physical inactivity, and loneliness and isolation, as you've outlined. But I'm not sure that putting a specific requirement in the Bill is necessarily the way to do that, because, under the Act, the public services boards have to publish their local well-being strategies, setting out the objectives that they want to see achieved on a local basis, and that will also demonstrate how the public services boards will be working towards meeting the goals of a healthier Wales, and that will include addressing all of the issues that you've just discussed there. The overriding purpose of those public services boards is to improve the economic, social, environmental and cultural well-being of our communities, and I think that that is a—you know, it's a very broad requirement on them. So, perhaps to introduce one aspect of public health or one challenge within it does not necessarily fit with the broad approach of it. However, that doesn't mean that public services boards couldn't take that decision locally to address these issues or others if they

see those as being particularly pertinent to their communities.

[11] **Julie Morgan**: So, you'd see it as their decision on these issues.

[12] **Rebecca Evans**: I think so, yes, but, importantly, Ministers have to also be involved with the public services boards and have a voice on them. So, if it does mean that, in future, the Welsh Government believes that there would need to be a specific focus, that could be addressed either through Ministers, the voice on those public services boards, or potentially through any future changes to the statutory guidance that underpins the future generations Act as well. So, that guidance might be the more appropriate place for this to be addressed within the context of the WFG Act itself.

[13] **Julie Morgan**: Right. The third proposal that I'm raising was raised by Diabetes UK Cymru about mandatory calorie information on food establishment menus.

[14] **Rebecca Evans**: I know this is something that's been addressed on a voluntary basis through the work that the UK Government is doing with the food industry more widely, especially in terms of out-of-home settings for food. So, for example, most major food retailers—I won't name any of them, but we all know who they are—do now include the calorie data, and often much more wide nutritional data is available as well on their websites and so on. In terms of making it mandatory, I think that we would have to balance that against the burden that it might put on small businesses in Wales, particularly in terms of the burden it would take in terms of working it out, publicising the information and so on. I think that the evidence isn't necessarily strong enough to suggest that taking a mandatory approach to this would necessarily have as big an impact as we would require it to have on the basis of the impact it would have on small businesses in Wales. I think that taking a voluntary approach to this in the first instance is the right way to go. Actually, this is part of the journey that we've looked at throughout the Bill, for example, with the work that we're doing on smoking in outdoor spaces. This is part of a journey. So, where a voluntary approach hasn't worked thus far, or where there have been enforcement issues, now we're looking at including those within legislation. So, we could keep this as a watching brief in terms of whether or not it is having an impact. But it is about balancing the impact it would have on public health with the impact it would have on the burden on small businesses.

[15] **Julie Morgan**: So, you'd prefer to go ahead on a voluntary basis on that

issue at the moment—

[16] **Rebecca Evans**: Yes, I think so.

[17] **Julie Morgan**: —with the hope that it will work on a voluntary basis.

[18] **Rebecca Evans**: Yes, I think a voluntary approach would be best unless the evidence does become more strong in terms of the impact it would have, having the calories displayed. I think it also is part of a wider approach in terms of what we're doing in order to try and educate people about the nutritional values of various foods anyway so that people can make good choices, and that the obvious healthy choice becomes more apparent to people when they look at a menu, because they're educated and because they understand what different foods involve both in terms of calories, but their wider nutritional values as well.

[19] **Dai Lloyd**: Ar y pwynt yma, **Dai Lloyd**: On this point, Angela. Angela.

[20] **Angela Burns**: Thank you. Can I just push you on this particular point that Julie has raised, Minister? Because we sit here looking at the public health Bill. We all recognise that obesity is one of the biggest challenges, and I speak as someone who's been big for most of her life. And, once you get big, it's damn hard to get small again. I've got young children, and I spend a lot of my time trying really hard to educate them into how to be a better size and how to be more fit so that, when they get older, they're not going to be facing the challenges that I will face. We say that obesity causes cancer, causes heart diseases, causes all of these other appalling pressures upon our NHS—not to mention the appalling pressure it places on the individual. So, why not be brave and take this? I do hear what you say about making sure it doesn't put an unnecessary burden upon businesses, but we've been talking—you know, on and off, various Governments have flirted with the ideas of a sugar tax, about looking at cutting the sugar levels in drinks and all the rest of it. And there is evidence from New York, that—. Admittedly, it is New York, but they do say that it isn't just the fact that people have that choice, but that one of the side benefits is that it's persuaded restaurants to reformulate their food. So, this is a subtle way of actually getting those amazing chefs and all the rest of it, who actually create the food that we eat and that we like to go out and buy, to actually look at a way of producing it in an incredibly healthy way. I'd really like to push you on this point, because we are having a tsunami of overweight children and overweight adults, with

all the disbenefits to them and to the society. But this is a really small thing that perhaps we could do, so that even if I do go out with my kids to eat a pizza somewhere then I actually might be eating a marginally healthier pizza than I would be today.

09:15

[21] **Rebecca Evans:** Well, we'll certainly look at the evidence. I'm aware of the evidence from New York, but I'm not aware that there's much more evidence beyond that. We'll certainly look again to see if there is further evidence available, but my understanding is that the balance of evidence doesn't suggest that this would have enough of an impact to warrant the extra burden on small businesses across Wales. That doesn't mean that we're not doing a great deal already in terms of the work that we're doing with healthy schools, for example, 10 steps to a healthy weight, the healthy child programme, in terms of ensuring that children get off on a right start that you've just described as well, but then the national exercise referral scheme, all the other work that's going on right across Government departments, the active travel Act and so on—there's a great deal of work going on. I'm sensing that Chris might want to come in at this point.

[22] **Mr Tudor-Smith:** I think, just in terms of the effect in this of the calorie information, the people it affects are those people who are actually interested in the first place in that type of information. It doesn't necessarily impact on those people that we really want to make a difference with. So, I think that's one of the limitations of the approach. And then there's the cost to small retailers, which consists of having to purchase software to convert their menus into calorie amounts, and, secondly, it's the time that it takes to do that, with menus changing. Some bigger chains, who have standard menus, it's quite easy for them to do, but for a small restaurant that changes its menus quite regularly, it does require quite a lot of work to provide that sort of information. So, as the Minister said, it's balancing how effective it is against what is likely to be the impact on small cafes and restaurants.

[23] **Angela Burns:** But it's not just small cafes and restaurants we're talking about either, is it? There are enormous chains out there that produce huge quantities of food eaten by a vast number of the population, and it's getting there. We talk constantly about looking at a sugar tax on drinks, which is a really big thing to try to do and it is fraught with huge corporate issues, and it's Westminster, Cardiff, et cetera, et cetera. We're all trying to push and push and push and say we ought to be doing this, so we say that

on that hand, but, on this hand, where, actually, it's within our competence to perhaps make some changes that could be effective and to be leading the home nations on something, we're kind of shying away from it, so that's just why I wanted to push you on it.

[24] **Rebecca Evans:** You referred to the major retailers and the big chains. Well, I think the vast majority of those provide their nutritional data, beyond calorie content, through part of the UK Government's responsibility deal, which it's brokered with retailers and restaurant chains, and so on. I appreciate it feels like we're pushing back on lots of suggestions that are coming forward to committee, but I think it's important to reflect, really, that the Bill has already been through scrutiny once, and it did have some quite important changes added to it. For example, health impact assessments were introduced, and, hopefully, that will have an impact on not only obesity, but many other aspects of public health in Wales as well. Originally, the Bill only included powers to take action on smoking in outdoor spaces, but the Bill now includes specific places on the face of the Bill, for example. In terms of special procedures, we've included the fact that people can't be tattooed when they're drunk or appear to be on drugs, and so on. So, there have been major changes made to the Bill, which is why I know it's more difficult when it comes to second scrutiny to explore the issues.

[25] **Dai Lloyd:** Ie, rydym ni yn deall hynny i gyd, Weinidog, ond hefyd rydym ni wedi cael toreth eang o dystiolaeth a syniadau newydd, efallai, ar sut i ehangu'r Mesur yma hefyd. Dawn sy'n gofyn y cwestiynau nesaf.

Dai Lloyd: Yes, we understand all of that, Minister, but also we've had a wide range of evidence and new ideas on how to expand on this Bill. Dawn has the next questions.

[26] **Dawn Bowden:** Diolch, Chair. Three areas I think I particularly wanted to follow up—can I start with oral health? The evidence that we had from the British Dental Association was suggesting that we should look at banning all drinks with added sugar in schools as a way of tackling poor health. I wasn't actually aware that there wasn't a ban on some of these very sugary drinks in secondary schools. In fact, there isn't a ban either on some sugary drinks in primary schools—fruit juice with added sugars is not banned in primary schools and so on. So, would you consider looking at that area, as part of the nutritional standards in schools, to see whether we should have these vending machines—you know, however they sell these drinks in schools—and whether they should only be healthy drinks and non-sugary drinks in all

of those areas of secondary and primary schools?

[27] **Rebecca Evans**: I'm interested in the evidence that the committee has received on this particular issue. Obviously, we have the healthy eating in schools regulations, which relate to the food and drinks that can be served in schools, but those regulations don't apply to food that children can bring on to the schools premises, for example, in their packed lunch and so on. Although schools can develop their own policies at a local level in terms of what is allowed to be consumed on the school premises, there isn't that protection underneath the regulations themselves.

[28] We are supporting schools through our healthy schools network to take a whole-school approach to healthy eating and that does include looking at what schools should be promoting as a good packed lunch to bring to school. So, the healthy schools network is about more than just the children; it's about the wider school community, including taking opportunities where they exist, to engage with and educate parents as well. So, any changes would come, really, under the healthy eating regulations rather than necessarily through this Bill, but I am very interested in what the committee would say in terms of changes that might be desirable.

[29] **Dawn Bowden**: Okay, thank you. I think, specifically, it's about what schools sell on their premises as much as anything, I guess.

[30] The other area I wanted to have a look at was alcohol misuse. Again, the Royal College of Physicians has talked about alcohol harm reduction being identified as a significant public health priority, as I'm sure you have, Minister. So, have you considered measures to ensure that local authorities do consider the public health impact of alcohol when they are carrying out their licensing responsibilities? Is that an area that you've given some consideration to or do you think that that could be strengthened within the parameters of this Bill?

[31] **Rebecca Evans**: We very much support the inclusion of considerations of public health when licensing decisions are being undertaken. But unfortunately, despite numerous efforts by me, previous Ministers and officials on a regular basis, we haven't been able to have those powers on the sale and display of alcohol and the licensing of alcohol devolved to us in the Assembly, unfortunately. But we do lobby frequently for those powers to be devolved to us, but I'm not overly optimistic, I think it's fair to say.

[32] **Dawn Bowden**: So, what is it that you feel that you can do within that area at the moment?

[33] **Rebecca Evans**: We don't have the powers devolved—

[34] **Dawn Bowden**: It's not devolved—that aspect.

[35] **Rebecca Evans**: —to take action. All we can do at the moment is press the case with the UK Government and try and seek those powers, which we are actively doing, but without success.

[36] **Dawn Bowden**: Okay. The next area, really, was around air quality and whether you'd given consideration—again, it's part of another Act, so I kind of anticipate what your answer might be, but it's around safe routes to schools and that sort of thing—to improving air quality around schools and around areas, particularly where children are going to be and on active travel routes. I don't know specifically whether that is covered in the active travel regulations or Act—whatever it is—but is it something that could be looked at, again within the parameters of this Bill, or is it something that could be strengthened in the active travel regulations?

[37] **Rebecca Evans**: The Welsh Government has recently consulted widely on air pollution. This is something that has been led by the Cabinet Secretary for Environment and Rural Affairs. The consultation closed, I believe, in December and I actually met the Cabinet Secretary this week to discuss how we can work together from a public health perspective in terms of addressing issues of air quality. The Cabinet Secretary said that she'd be happy to consider evidence that we receive as part of this inquiry, in terms of the wider work that she's doing there, to address air quality. I think it would be, I suppose, inconsistent if we were to take action within the public health Bill on air quality whilst there is an existing consultation, which has only just closed, at the moment. But I see that consultation, and the evidence that you've been receiving, very much as being—

[38] **Dawn Bowden**: As part of it, yes.

[39] **Rebecca Evans**: —close together. So, our officials in health, and in the Cabinet Secretary for environment's department, are working closely on this. And any recommendations the committee would like to make with regard to this I think would be of interest for the Cabinet Secretary as well. And I'll be meeting with her again to discuss the issues that have come out of this

inquiry. I know you have several evidence sessions left to go, in terms of the inquiry as well.

[40] **Dawn Bowden**: Okay, that's great. Thank you very much.

[41] **Dai Lloyd**: Ocê. Diolch yn fawr, Dawn. Rydym yn symud ymlaen nawr at ysmygu a'r mangreoedd di-fwg. Lynne.

Dai Lloyd: Okay. Thank you very much, Dawn. We now move on to smoking and smoke-free premises. Lynne.

[42] **Lynne Neagle**: Thanks, Chair. Can I ask first of all about school grounds? Is it your intention that the smoke-free requirements will apply only to the grounds of primary and secondary schools, or are you considering including other education settings, such as nurseries, early years settings, in those?

[43] **Rebecca Evans**: Well, primary and secondary schools are named on the face of the Bill, and, as I said—and, as you'll remember, this was one of the things that was amended within the process of the Bill, as it came through previously—it does include the grounds where you have maintained school nurseries as well, which sit on the sites of schools as well. These areas, and hospitals as well, were identified in the tobacco control action plan as important settings, both in terms of making sure that children aren't exposed to smoking—so it doesn't become a normal thing for them to see—but also within the hospital setting, because that's a place of health, where people spend extended periods of time, and it's often a place where people make that decision that they want to give up smoking. So, we would want to support that as well. I know that the voluntary restrictions have been pursued in playgrounds, for example, and in hospital settings. And, as we've discussed before, there have been enforcement problems, which is why we're taking this opportunity now to put them on the face of the Bill.

[44] I think in terms of extending it to other settings—and, when I first came to this, I thought it would be simple to stop smoking in areas that just seem like common sense, places where you don't want to see smoking and so on, but actually it is more complicated than I at first envisaged. Because, actually, we're seeking to prohibit a legal activity, in a public space, and there are a lot of sensitivities there, and a lot of arguments and evidence that have to be made. So, whenever we're thinking about places to add to that, we have to think about it within the context of the human rights of the individual to smoke, within existing European Union and other legislation,

and the wider policy context as well. So, were we to extend it at all, it would have to be through consultation.

[45] The Bill, as you know, does give powers to Ministers to extend the areas of outdoor spaces in future—I know you've had lots of suggestions as a committee as to areas you'd like to see it extended to—and I'd be interested in your priority areas for that, so that we consider what areas we want to look at in terms of scoping out those legal issues, and also the policy and the practicality issues as well. Because, again, it's not always as easy to define an open space in practical terms. But, obviously, we're keen to see where else we could extend it to. I was just surprised as to how difficult it is to do that.

[46] **Lynne Neagle**: I hear what you're saying, because, obviously, we had very detailed discussions last time about the human rights elements of this. But there doesn't seem to be much of a jump between a primary school and, say, a private day nursery. I mean, I don't really see that there's much distinction there, really. So, have you given any particular thought to those kinds of settings, where, basically, children are receiving the same service as they would receive in a state-maintained setting?

09:30

[47] **Rebecca Evans**: Well, I agree with you that a childcare setting is particularly important, and would be, in my view, a priority area. So, that's something, depending on other ideas that might come forward through the process and what committee thinks, that would be one of the priority areas that we would consider in terms of scoping out those legal issues—those practical issues for future action.

[48] **Lynne Neagle**: Because one of the suggestions that we've had off a number of witnesses is that the areas around schools et cetera should be smoke free. I can see, based on what you've said, that you might view that as more difficult, but have you got any comments on that particular suggestion?

[49] **Rebecca Evans**: Again, I think that it will be difficult to define the area. I know that there has been some good work done by ASH Wales with schools on a voluntary basis, making school-gate areas smoke free. Again, this is one of these things that start off on a voluntary approach and then you consider how enforceable it is and so on. But, certainly, this could be an area that we would be interested in looking at as well.

[50] **Lynne Neagle**: In a similar vein, the legislation deals with hospital premises but not with primary care settings et cetera. So, I suppose it's a similar argument, really. You know, why do the one without doing the other, really, especially as, obviously, we fund GPs et cetera? Have you got any comments on that?

[51] **Rebecca Evans**: Again, hospital settings, like playgrounds and schools, were priority areas within the tobacco control plan. Also, those three areas had particularly strong support amongst the public as well, because I think we are doing something novel and we are taking quite a big step. Again, as I said before, this is a legal activity. So, there are sensitivities in terms of how people view their own rights and so on. So, I think these three areas are the right ones to start off with, but in future, the Bill does give powers to Ministers to include other areas, but it would have to be done through some quite detailed scrutiny, and it would have to be through public consultation as well and be subject to the affirmative process in the Assembly.

[52] **Lynne Neagle**: Okay. Thank you. Just one final question on the issue of playgrounds. There does seem to be some confusion about what would constitute a playground. So, if there's play equipment, that would be a playground. If it's a sort of park where children congregate or a playing field, that wouldn't be covered. Can you just clarify that and give any thoughts you may have had on extending it to those kinds of settings as well?

[53] **Rebecca Evans**: Well, section 25 indicates what we would consider to be playgrounds. So, things that would be traditionally used by children—sandpits and things like that. It is more difficult to extend it to areas that are of use to people of all ages. I'll ask Chris to say a little bit about the work that went into developing that, or perhaps Sue would be the right person to do that. But, you know, it is something that we would obviously be looking at. I think it's important to recognise as well that we will be issuing detailed guidance to local authorities, because I think good law has to be clear law. Local authorities have to understand it in order to enforce it, but actually, the public has to have it easily understandable as well so that they don't fall foul of the law unintentionally.

[54] **Lynne Neagle**: Thank you.

[55] **Ms Bowker**: The idea was to look at playgrounds, which had already had voluntary bans in place—what the Minister was talking about: the route in which we've moved to legislation. ASH Wales has done a lot of work so

that all local authorities have designated all of their playgrounds as smoke free, and we were wanting to bring those into legislation to support the enforcement. Those are the things that you would normally define as a children's playground, which is mainly for the use of children, whereas some of the other areas, as the Minister said, are not just for the use of children. So, it becomes much more difficult. We would produce guidance, of course, and we have been talking to local authorities about whether they have got any difficulties with the definitions. Of those that have responded to us, none of them have said that they have any difficulty with understanding what would be covered.

[56] **Lynne Neagle**: Okay, thank you.

[57] **Rebecca Evans**: That's some additional work that we've been undertaking over the past few months, as the Bill goes through this second scrutiny.

[58] **Dai Lloyd**: Diolch yn fawr. **Dai Lloyd**: Thank you very much. We Symudwn ymlaen at y cwestiwn move on to the next question, which nesaf. Mae hwnnw gan Caroline is from Caroline Jones.
Jones.

[59] **Caroline Jones**: Good morning. Community Pharmacy Wales and the Company Chemists' Association highlight the important role of nicotine replacement therapy in smoking cessation, and both suggest that nicotine products that are medically licensed be exempt from the retailers register. So, can you clarify please how this part of the Bill will deal with nicotine products licensed as medicines, and will pharmacies that supply nicotine-replacement therapy be required to join the retailers list?

[60] **Rebecca Evans**: Retailers and pharmacists who sell nicotine-replacement therapies that have been given a licence for medical use won't be required to be part of the register. However, many of them sell things that have been licensed for medical purposes alongside other nicotine products. So, those who sell both would have to be registered on the basis that they are selling ones that haven't been registered for medical use.

[61] **Caroline Jones**: Okay, thank you.

[62] **Dai Lloyd**: Mae'r cwestiwn **Dai Lloyd**: The next question, staying nesaf, sydd yn dal ar dybaco, gan on tobacco, is from Jayne Bryant.

Jayne Bryant.

[63] **Jayne Bryant:** Thank you, Chair. Just to follow on from Caroline's question on this, we heard evidence from pharmacy representatives who were concerned that the legislation must not stop young people from being able to access nicotine-replacement therapy. Can you perhaps comment on that part and to perhaps alleviate some concerns that they had over that access for younger people?

[64] **Rebecca Evans:** Our approach is the same as in the regulations that come under the Children and Families Act 2014 regarding the sale and proxy purchase of nicotine-inhaling products. These regulations provide an exemption for medicines to be handed over to under-18s. So, there should be no issue in terms of under-18s receiving those medicines.

[65] **Jayne Bryant:** Thank you.

[66] **Dai Lloyd:** Symudwn ymlaen yn awr at driniaethau arbenigol, fel tatŵio ac aciwbigo ac ati. Dros yr wythnosau diwethaf, mae nifer ohonom ni wedi cael agoriad llygaid i'r nifer o driniaethau arbenigol sydd yn cael eu cario allan yn y byd yma. Mae Angela wedi bod yn arbenigo. Angela.

Dai Lloyd: We'll move on now to specialist treatments such as tattooing and acupuncture and so forth. Over the past few weeks, it's been a real eye-opener for some of us in terms of some of these specialist procedures. Angela has specialised in this. Angela.

[67] **Angela Burns:** Minister, there are a couple of areas in the Bill that I feel require further clarification. So, I'd like to slightly take my questions in a different format and start off with the first one, which is over the age of consent for intimate piercings. I listened very carefully in your first evidence session to your officials and the reason why 16 had been chosen and that that 16 was chosen to protect, if you like, the public rights of a child et cetera, rather than 18, and that 18 for tattooing was an old leftover from a Bill from many, many years ago. However, I have to say that, I think, almost without exception, the evidence that we have taken from a wide variety of specialists is that they would prefer to see 18. They bring forward a number of reasons for it: they think that, in terms of intimate piercings, a young person's body is still changing and that they may undertake procedures that they then come to regret. They talk about the fact that many of the practitioners themselves are very uncomfortable with dealing with people

who are under 18 years of age. There's talk by authorities that the licensing regime would be easier if it was all standardised at 18. So, I'd really like you to clarify why you have chosen to look at 16 as the age for intimate piercings. What evidence would you require to make you review that decision and re-look at 18 as the age? Because, of course, children are still technically children until the age of 18.

[68] **Rebecca Evans:** Thank you for that question. I know that this was one of the areas that attracted quite a lot of interest and discussion through the previous scrutiny session and perhaps Chris might say something about the arguments that were discussed and considered then. But I know that your committee has received evidence from the children's commissioner, agreeing that the age of 16 does ensure a clear and consistent message in terms of the protection of children. It's also in line then with the fact that children or young people, of the age of 16 and 17, can, for example, agree to medical treatment without the permission of their parents and so on.

[69] The age of 16 is, of course, consistent with the fact that children can take other decisions—I should say 'young people'—at that age. For example, it's the age of sexual consent, and so on, and there are various things that you're able to do at the age of 16. When considering the Bill, I know that a lot of consideration was given to the UN Convention on the Rights of the Child, which includes a wide range of protections and rights—for example to assert their identity, having due regard afforded to their views, and to be able to express themselves, and not to be discriminated on the basis of their age as well. So, we felt that 16 was very much consistent, really, with both the UN Convention on the Rights of the Child and the wider list of things that young people can do when they reach the age of 16. It is important as well—there's nothing in the Bill that would suggest that practitioners shouldn't or couldn't increase the age to 18 if they felt uncomfortable undertaking intimate piercings on people under the age of 18, as businesspeople.

[70] **Angela Burns:** Well, actually, that leads me on to my next question to you, Minister, which would have been to flip it on its head slightly and say: will there be any problems for people who say, 'Actually, I have a licence to perform this, but I don't want to treat you, because you are under 18 years old'? Will they be subjected to legal action for discrimination against young people? Because, of course, that does happen in many other areas, where people, individuals, make an individual choice about what they will or will not do, and the law isn't there to support them. Because I would not like to see practitioners—. You know, the Directors of Public Protection Wales said that

[71] ‘our registered practitioners are uncomfortable with 16 generally, and they often put best practice in place—the better registered practitioners—and won’t do intimate piercing until 18 anyway.’

[72] This was Directors of Public Protection Wales. So, I want to ensure that, if you are wedded to the idea that, actually, 16 is the age of consent, those who choose not to practice at 16 and 17 will not be penalised and will not be taken to court for discrimination against young people.

[73] **Rebecca Evans:** Thank you for raising that. I’ll ask Rhian to comment on the legal aspect. But I did want to check whether there was anything that Chris wanted to raise in terms of the arguments we’ve heard.

[74] **Mr Brereton:** Perhaps on that point, Minister, if I could add that I think we’ve got to remember our starting point, which currently is that there is no age of consent for any piercing. You can have what you want, when you want it, subject to your ability to make that decision in a competent way. Many practitioners will automatically turn down young people going for this type of piercing now. They suffer a commercial loss as a result, because presumably that person would go to someone else who would do it. But they aren’t penalised in law, and I don’t think they could be criticised in that way for making that decision on a discretionary or voluntary basis.

[75] In relation to young people having a piercing that they later regret, I think the good thing about piercings—if there is a good thing—is that they can be removed, and, generally, they will heal. They might leave a small scar, but they will generally heal quite effectively. When the Tattooing of Minors Act was introduced in 1969, as you said, it was a different age, but the argument then was, really, all about permanency. And I know that tattoos can be removed—some quite successfully, others not. But that argument still remains—that they’re making a decision early in life, with something that they will carry on in life, whereas that piercing could be removed, and will, effectively, heal. So, I think there’s less likelihood of them taking a decision to have a piercing that they later regret because they could remove it.

[76] **Ms Williams:** And, as I say, you know, a piercer would maintain a discretion not to perform an intimate piercing on someone under the age of 18 if that was their personal preference.

[77] **Angela Burns:** And there’s no legal comeback on them—they won’t

then have some particularly stroppy individual saying, 'Right, you've discriminated against me because of my age, and therefore I intend to take you to court'?

[78] **Ms Williams:** No.

[79] **Angela Burns:** And they'd be absolutely protected?

[80] **Ms Williams:** I believe so, yes.

[81] **Angela Burns:** Okay. I'd be grateful for absolute clarity on that.

[82] **Rebecca Evans:** Shall we write to committee?

[83] **Angela Burns:** That would be absolutely fabulous. Which brings me on to the next little bit that I wanted to really chase down, which is the list of procedures. I understand that there's going to be multiple views on this, and people are adding in procedures all the time—thoughts about, 'Let's add this on to the face of the Bill, that on to the face of the Bill'. When you started off looking at this Bill, and looking at the regulation of these procedures, did you at that time at all consider a blanket clause that actually prohibits piercings full stop until 18, or, as somebody put it very well, 'involving piercing of the skin or mucous membrane', rather than naming specific procedures? And if not, why not? Could you perhaps just restate your thoughts on why you decided just to pick off procedures one at a time? Because, of course, if you were to have that catch-all phrase that covers all of these tricky procedures, you would solve two of the problems that you've mentioned before: one is that you've said you don't want to identify particular procedures because you don't want to make them 'fashionable' by suddenly making them illegal—but of course, they are not going to be named, so they're not going to be raised in public awareness—and the second thing, of course, is you get over the future legislative issues of constantly trying to bring back and go through all of the process of bringing back, actually, a new procedure. And as I'm learning more and more about procedures that none of us ever even knew existed, I suspect that there will be—as we lift the lid on this, there'll be more things that people come up with; frankly, dafter ideas than putting the ashes of your beloved dead pet into a scar that you've decided to create on your arm. More of these things will happen, whereas this will actually protect the 18-year-olds and under full stop. So, I wondered what your view was on that.

09:45

[84] **Rebecca Evans:** I'll ask Chris to say a little bit about how the proposals for the Bill were developed originally and what the thinking was behind that, but the only proviso we have in the Bill is that a procedure is capable of being performed for aesthetic or therapeutic purposes, and the performance for those purposes is capable of causing harm to human health. So, although we're naming four procedures on the face of the Bill, actually, I think the Bill is better futureproofed in terms of allowing us to add further procedures to it in future by not being restricted just to things that pierce the skin. For example, artificial UV tanning, chemical peels, colonic irrigation, for example—all of these things might come under the therapeutic or aesthetic definition and also are capable of causing harm to the individual, but they don't pierce the skin. So I think that the Bill, as drafted, will give us greater scope to respond to changing fashions, changing trends and, as you suggest, procedures perhaps we can't even imagine now that might become popular in just a few years' time as well. So I think that the Bill is well futureproofed in that sense, and also the fact that it would require consultation and the affirmative procedure in the Assembly does give us that safeguard that it would be reasonable to add things to the Bill as well. The four things that are on the face of the Bill at the moment are things that local authorities as enforcement bodies are familiar with, and I think that's important as we start out on this journey as well. But, in terms of the history of why this particular approach was taken at the start, perhaps Chris would say something.

[85] **Mr Brereton:** Certainly, Minister. When we researched the legislation, we had a very old piece of legislation that wasn't fit for purpose and it did encompass those four procedures, as the Minister said. What they do have in common is they all involve the piercing of the skin. I listened carefully to the evidence that was being given to committee by other bodies, and they acknowledged that was the key risk. If you look at the London special treatment regulations, they have grown incrementally over time and there are probably over 110 or 113 procedures that they would license as a special treatment in London. And when you look down that list, probably 40 or so of those would involve piercing of the skin. Many of those are captured by our definition for the four procedures on the face of the Bill. But, if we were to automatically request a licence for any procedure that involved piercing, whether it was aesthetic, therapeutic or not, it would be quite a daunting prospect, to say the least. The preference is to look at those procedures that involve the piercing of the skin, assess their risk, assess their frequency and then add them, on an incremental basis and subject to consultation, using

the regulations under section 90, at a pace that local government could cope with in terms of regulation. I think we've got to remember that we are saying with this Bill that there is no automatic right to a licence, should you already be licensed or registered with a local authority under the Local Government Act 1972.

[86] We've looked at the evidence from the Newport case, and that clearly shows that just being registered doesn't show you are competent to carry out the procedure. So we want local authorities to test the competence of all those individuals currently registered under those four, and that will take some time. There will be some transition and it will require those practitioners to gear up, and then I think we can move on apace to look at what other procedures could be added to these special procedures, using those affirmative regulations, subject to a consultation and subject to the evidence being there, and them passing the test of being aesthetic or therapeutic and capable of causing harm to human health. I think it's not that we're opposed to looking at piercing per se as being an automatic registration issue, because we've demonstrated there is a risk, but we've got to say, 'Does it pass that test; does it happen in Wales; and what is the frequency of it?' and do it at a pace that is proportionate and would allow both local authorities and practitioners to gear up to the competency criteria that we're requiring.

[87] **Angela Burns**: Thank you for that answer, and I hear what you have to say on that. So, again, can I flip it slightly on its head? You used the words 'local authorities to test the competence'. So, in this Bill, you've got exemptions: if you're a nurse, a doctor or a dentist, you're exempted from having to go and get a licence, and yet a physiotherapist, for example, isn't. So, why would a dentist, who, as far as I know, fiddles around mainly with teeth, or a physiotherapist who is going to stretch our muscles—who is to say that the dentist is more competent to take up Botoxing or to take up, I don't know, one of the others on the lists here than a physiotherapist is, because, again, I just see these anomalies? I would say to you: would you not consider actually saying that, if you're going to practise any of these, whether you are a doctor or not, a nurse or not, a dentist or not, you would need to go out and get a licence? We heard some quite interesting evidence from the doctors that said, just because you are a doctor, it doesn't mean to say, actually, that you've got any experience of doing this. So, we're putting an awful lot of trust, and I would be more comfortable, personally, I think, to see a Bill where we're saying that local authorities must test the competence of practitioners and, whether you are a physio, a doctor or actually somebody

who has gone to college and has taken various courses in this, you should all be tested relatively equally. So, I'd be interested in your view on that.

[88] **Rebecca Evans:** Can you start on this, Chris?

[89] **Mr Brereton:** Yes. It's a very important point, and I think the Bill acknowledges it, because exempt individuals will perform special procedures without a licence and it's important that they, as you say, can demonstrate their competence to do so. There is a list of exemptions on the face of the Bill of bodies, such as doctors, dentists, nurses, et cetera, who could potentially be exempt, and I say 'potentially be exempt' because what the Bill allows for is regulations. We'd have to talk to those regulating bodies, the General Dental Council and others, to say, 'Are these special procedures within the scope of competence of that individual within your regulated body?' It could well be that a chiropractor's training includes acupuncture, for example, but it certainly probably doesn't include tattooing, in which case, they will be required to have a licence for tattooing. The regulations would make that the case. So it's only those professions that have it within their scope of competence and can demonstrate that that would be exempt from the licensing requirement, because we don't want to duplicate regulation. If they are not competent within their professional scope—and you gave a good example with acupuncture; many would be competent within that—they could be exempt, but if they were not competent and the regulating body said, 'We're quite happy to exempt for acupuncture, but not necessarily tattooing or piercing—it's not the normal work they would do', then there would be a requirement for them to be licensed.

[90] **Rebecca Evans:** I think it's worth adding as well that the Bill provides Ministers with regulation-making powers to enable individuals who are exempt on the face of the Bill to be brought back within the licensing regime as well. So there's that. And it is intended that we will have some detailed consultation with the regulating bodies to determine whether each of the listed special procedures is within the scope of the professional competence of their members as well.

[91] **Angela Burns:** I've got one last, very quick, question, which is more of a legal issue, if I may, Minister. Evidence has highlighted that the current list of relevant offences does not include, for example, sexual offences, and given the nature of the procedures we're talking about and the ages, I just wondered are you satisfied that there's adequate protection for those, particularly the younger ones, the 18 to 16-year-olds, undergoing special

procedures.

[92] **Ms Williams**: Yes, we're satisfied that section 63 offers adequate protection to those undergoing special procedures, but we are aware that it's an area of concern for the committee. It's important to remember that this is a public health Bill, and the purpose of Part 3 is to minimise the chance of injury or illness caused by the performance of a special procedure in an unhygienic manner. The relevant offences that are listed in section 63(3) are those that could have a material impact upon a person's ability to perform a special procedure in accordance with law and in a hygienic manner. In terms of competence, any provision needs to be compatible with the European convention on human rights and, as such, a balance needs to be struck between the right of a person to practice their profession and earn a living with the need to safeguard clients from potential illness or injury. As you'll be aware, section 63(5) of the Bill contains a regulation-making power that allows the Welsh Ministers to add an offence to the list of relevant offences, but any additions will need to be considered carefully to ensure that this balance is maintained, and detailed assessments of human rights, EU law and policy implications will need to be carried out.

[93] **Angela Burns**: Would you intend to have a look at additional—if I can get the right word for it—relevant offences? Would you intend to look at that, just to expand it? Because there are a couple—again—of small anomalies there.

[94] **Rebecca Evans**: I know that this has been an issue that's been of interest to members of the committee. With regard to sexual offences, I think I'm right in saying that we've had some early discussions in terms of whether it would have to have been a sexual offence carried out in the carrying out of the special procedure in order to bring it within this Bill. Is that—?

[95] **Mr Brereton**: Rhian would be best placed to answer that.

[96] **Ms Williams**: I think it's more a case that the purpose of the Bill is a public health purpose. It's not a safeguarding Bill as such. So, the offences that are currently listed on the face of the Bill are those that we are satisfied are proportionate and can lawfully and legitimately be taken into account when a licensing committee will be determining whether or not to grant a special procedure licence. So, as I say, we are convinced about the—

[97] **Angela Burns**: Although, may I just very quickly add that I thought the

whole purpose of putting intimate piercings to 16 was a safeguarding issue?

[98] **Ms Williams:** Well, we're talking in terms of relevant offences under Part 3. As I say, we are aware of a recent case where an unregistered 18-year-old tattooed three young children. She admitted charges of assault occasioning actual bodily harm and was sentenced to an eight-month prison sentence, which was suspended for two years. I think the Minister has previously indicated that she may welcome the committee's views on the matter of relevant offences listed on the face of the Bill, but any potential changes would need to be considered carefully in terms of human rights, EU law and policy implications because, as I say, we do have to be very careful that we are balancing the rights of individuals to practice a profession with the need to ensure that the procedures are performed in a safe and hygienic manner. If we go too far in taking into account offences that don't provide for procedures to be carried out in a safe manner, we could tip the balance too far and we could be subject to legal challenge, which, I'm sure you'll agree, we wouldn't want to be doing.

[99] **Angela Burns:** I really don't understand the force of your argument, but I am very aware of time. So, if the Chair wants, we can discuss it separately.

[100] **Dai Lloyd:** Dawn has a follow-on.

[101] **Angela Burns:** Okay.

[102] **Dawn Bowden:** It's a short follow-on. I think it's a very important point that Angela is raising. In the example you've just given of somebody tattooing a child and then actually being prosecuted for actual bodily harm, what is the action—the deterrent—to a practitioner, then? What is the offence if they breach the regulation? In that case, it was quite an extreme case, so the person was charged with assault. Taking up Angela's point, if we were to say—and we haven't yet got to that point—that all intimate tattooing—. Not intimate tattooing, but intimate piercing—or intimate tattooing maybe, I don't know. If that was carried out, say, under 18—say we'd got to that point where we decided it was 18—and a practitioner continued and did the intimate work, or even if they did it under the age of 16, what is the offence? Is that not sexual assault? I understand what you're saying, that this is a public health Bill, but I'm interested to know what the offence would be if somebody breaches the regulation and does it anyway to a child who is under-age, basically.

10:00

[103] **Ms Williams:** Intimately piercing someone under the age of 16 isn't automatically a sexual assault. Under the Sexual Offences Act 2003, there needs to be an intention to touch a person in a sexual way in order to commit a sexual assault.

[104] **Rebecca Evans:** Chris.

[105] **Mr Brereton:** I just wanted to comment, Minister, if I may, that the case that Rhian referred to is quite an exceptional case, because what could have happened is that individual could have been prosecuted under the Tattooing of Minors Act 1969, and they could have been prosecuted for failing to have a local authority registration. Both of those offences would have been relevant offences for this Bill. But I think, because of the circumstances and, you know, the affront because they were so young, they chose to go to an assault charge because it carried a higher penalty. That's why it wasn't captured.

[106] We do need flexibility within the Bill to add further relevant offences, and that is provided by way of affirmative regulations. I just wanted to give an indication of that. For example, if, later in the day, we decided to add sunbeds to the list of special procedures, then we would also want to add an offence under the Sunbeds (Regulation) Act 2010 to the list of relevant offences, because that already exists. So, that does provide the flexibility to add in relevant offences as we go along, if circumstances change and if we see a problem arising.

[107] **Rebecca Evans:** Can I suggest that we write to committee on the issue that Angela raised about sexual offences, and the list under the special procedures section of the Bill? Because this isn't something that was scrutinised, I don't believe, previously in the Bill, it will require some research and thinking on our parts. So, if we respond to you in future.

[108] **Dai Lloyd:** Good, because there is a complicated issue of consent there as well, which needs to at least be explored, in terms of, 'Is the young person absolutely content to have this procedure done to them, and free of any duress whatsoever?' and how we go around proving that. But, I'm sure you could incorporate that.

[109] Just to clear up another issue that Angela brought forward. We had some pretty powerful medical evidence that, actually, puncturing the skin is a big deal, even if it's just a needle. There are blood-borne viruses, and all those sorts of stuff. So, I know that there are various procedures that are out with puncturing the skin, but would we take it that any procedure that does puncture the skin is captured by this legislation? Or, if not, why not?

[110] **Mr Brereton:** Provided it's carried out for an aesthetic or therapeutic purpose, and it's capable of causing harm to you in health, then it is capable of being listed as a special procedure for the purposes of the Bill.

[111] **Dai Lloyd:** Okay.

[112] **Rebecca Evans:** But it won't necessarily be in the first instance, in terms of being named within those four procedures on the face of the Bill. However, as Chris outlined, the vast majority of things that are considered aesthetic or therapeutic and that also puncture the skin are covered within the four, one way or another, being piercing or tattooing or so on.

[113] **Dai Lloyd:** Okay, turning to health impact assessments, Jayne Bryant.

[114] **Jayne Bryant:** You mentioned previously the inclusion of the health impact assessments. How confident are you that the Bill will ensure a consistent and robust approach for requiring and carrying out these health impact assessments?

[115] **Rebecca Evans:** Thank you for that. The reason, really, that we brought health impact assessments within the scope of the Bill was to provide that clarity and consistency across the health impact assessments that take place in Wales. It does place a duty on Welsh Ministers to make regulations about both the circumstances in which public bodies must carry out those health impact assessments, and then the detail in terms of what will be involved in those health impact assessments as well. That detail will be determined through a process of public consultation.

[116] **Jayne Bryant:** Okay. You answered that. How will the regulations ensure that proper consideration is given to the issues raised through the evidence that we've heard in committee, such as air quality, health inequalities and mental health?

[117] **Rebecca Evans:** Well, the fact that we deal with this through

regulations will give us the flexibility to consider all of the evidence that you've had, but also to undertake some specific consultation on health impact assessments as well. I think it's really important that, within the Bill, the Bill defines a health impact assessment as:

[118] 'an assessment of the likely effect, both in the short term and in the long term, of a proposed action or decision on the physical and mental health of the people of Wales or of some of the people of Wales.'

[119] I think that's really important because it does give parity between physical and mental health in legislation. I think that sends, really, a strong message in terms of the importance that we put on mental health alongside physical health as well.

[120] **Jayne Bryant:** Thank you.

[121] **Julie Morgan:** Can I just ask about children—how do you see children being brought under this?

[122] **Rebecca Evans:** Well, under the Children and Families (Wales) Measure 2010, obviously, Welsh Government Ministers will have a duty to consider children in doing this. So, we would seek to include the views of children and young people, and the people who represent them, within the consultation work that we do in terms of accessing the advice and ideas and support in terms of developing those health impact assessment details.

[123] **Julie Morgan:** And would you be, sort of, bearing in mind the present inequalities that exist between the different ways or different settings that children live in?

[124] **Rebecca Evans:** In what sort of sense?

[125] **Julie Morgan:** Well, if you're going to have as children part of the impact statement, obviously some children are very disadvantaged already. How are you going to ensure that their voice is heard, really?

[126] **Rebecca Evans:** Well, the health impact assessment should obviously, well, will be undertaken in those situations where the policy plan or programme has an outcome of national or major significance, or which has a significant effect on public health at a local level. Obviously, we'd want to ensure that children, regardless of their backgrounds, are considered within

those health impact assessments.

[127] **Mr Tudor-Smith**: I think the important point here is about the guidance that goes with the health impact assessment, to make sure it sets out very carefully the way in which a health impact assessment has to be conducted, which is appropriate to the issue being looked at. Secondly, it has to identify the sort of topics that should actually be covered by the health impact assessment. So, I think that guidance is going to be critical to the success of how this legislation is carried forward, covering the points that you've raised and other stakeholders have raised.

[128] **Dai Lloyd**: Before I ask Lynne to come in on pharmaceutical services, can I just press you a little bit further on that? Following on from one of Dawn's original questions about air pollution, and tying that into health impact assessments and air quality, I take it that the detail of how you're going to measure air quality—and we're trying to capture our concerns about air pollution and the health impacts of that—the actual minutiae of how you're going to carry out a health impact assessment monitoring local air pollution will become clear in guidance, I take it, then. Is that the case?

[129] **Rebecca Evans**: All of the aspects—I mean, the Bill really places a duty on Welsh Ministers to make those regulations, to make sure that health impact assessments occur in those circumstances. Then we'll provide the guidance and regulations to ensure that those health impact assessments are consistent and robust and so on. In terms of the detail then, as to whether it includes air pollution or any other aspect of issues that affect public health, that would be following consultation. So, we'll be listening to what people have said here in giving evidence to you, but also in a specific consultation piece of work as well.

[130] **Dai Lloyd**: Diolch. Rydym yn symud ymlaen i wasanaethau fferyllol. Lynne.

Dai Lloyd: Thanks. We move on to pharmaceutical services. Lynne.

[131] **Lynne Neagle**: Thank you. When this Bill was going through previously, the then Minister was able to give assurances to the British Medical Association that, on the pharmaceutical needs assessment, they would be involved in the design of those, and also that those assessments would take account of the contribution of dispensing GPs. Are you able to give that same assurance to the BMA this time?

[132] **Rebecca Evans**: Yes. I know the BMA, in their evidence to you, also shared their concern that they were keen to have that reassurance reiterated to them. So, following the evidence that they provided to you, I wrote to the BMA restating our commitment that we would do that. I did that on 21 December, and I'd be more than happy to share the letter that we sent to the BMA with the committee as well, confirming that pharmaceutical needs assessments would reflect the consideration and contribution of all providers addressing the local health needs. So, that clearly includes dispensing doctors as well. I also took the opportunity to confirm the amendments made previously to the Bill to address the BMA's concerns, and their interest, for example, in health impact assessments, so they will all obviously remain in the Bill as well.

[133] **Lynne Neagle**: Okay, thank you. And how will this Bill actually contribute to the development of Welsh-language pharmaceutical services?

[134] **Rebecca Evans**: Well, meeting the pharmaceutical needs of the population is, you know, about all of the population, and meeting them through the Welsh language will be part of that.

[135] **Lynne Neagle**: Okay, thank you.

[136] **Dai Lloyd**: Diolch. Rydym ni wedi dod i'r adran olaf yn y sesiwn yma, sef toiledau mewn mannau cyhoeddus. Rydym ni wedi derbyn cryn dipyn o dystiolaeth achos, yn amlwg, mae hwn yn fater pwysig iawn i filoedd o bobl. Caroline Jones.

Dai Lloyd: Thank you. We now turn to the final section of this session, namely the provision of toilets in public places. We have received a lot of evidence because, clearly, this is a very important matter for thousands of people. Caroline Jones.

[137] **Caroline Jones**: Diolch, Chair. Could you tell me, please, regarding the provision of toilets, how the Bill, and the guidelines issued under it, will ensure that each local authority's strategy will take into account the needs of the whole community and visitors to that community, special needs, such as mobility issues with people, sensory loss, and mobility issues regarding wheelchair access, and also young families, children, and so on? So, the whole community and visitors to that community, particularly people with a disability. Thank you.

[138] **Rebecca Evans**: So, the Bill seeks to improve toilet provision for everybody, and it does place a duty on each local authority to prepare and

publish their local toilet strategy, and that must include an assessment of the whole community's need for toilets, so, including changing facilities for babies and changing places for disabled people, as well as, then, the detail on how the local authority intends to meet those needs as well. Public authorities are already requested by the public sector disability equality duty to consider how they can improve and contribute to a fairer society through their day-to-day activities, including provision of public toilets as well and, if passed, the Bill will extend that to include those strategies within that as well.

[139] The Bill does acknowledge that, you know, to use a toilet in safety and in comfort is different for different people, depending on their needs, and that some people might need more space or different equipment, for example. And that's why, under the definition of toilets in the Bill, we do include disabled changing places—changing places for disabled people—as well. I think the guidance that follows with regard to the provision of toilets and the local toilet strategies will be really important, and I'll take that opportunity to set out Welsh Government's expectations with regard to access for people—you mentioned sensory loss, people who use wheelchairs, families, and so on—within existing legal obligations. So, I'll set that out within the guidance.

[140] **Caroline Jones**: Thank you. And will there be any public consultation regarding the placement of toilets—you know, where they're going to be placed? You know, there may be facilities required that we haven't thought about, or the Bill hasn't considered. So, I think wider public engagement could be beneficial in this area. Also, can we confirm how local authorities will convey where these public toilets will be, the times of opening, and so on, and closing? Because a lot of people depend on all of this information, due to incontinence issues, and so on. So, it is vitally important that the message gets through to every member of the community as to where the location of the toilets will be, times of opening, the provision, and so on and so forth.

[141] **Rebecca Evans**: Okay, thank you. I think it's really important that the Bill actually requires that local authorities must publish their local toilet strategies, so that the information is available to everybody who wants to see it. And it also requires Welsh Ministers to issue guidance to local authorities on the specified matters, including promoting the public awareness of the toilets available for use by the public as well. So, that could include issues such as opening times, as you suggested, locations, accessibility

descriptions, and so on, and local authorities will then have to have regard to that guidance. I think it's important as well that we consider that signposting is going to be really important for people as well. So, all of that will be consideration in the guidance that we give.

[142] And in terms of public consultation—.

10:15

[143] **Mr Brereton**: There is a statutory duty for local authorities to consult under section 112 of the Bill on their local toilet strategies with interested groups and provide them with a copy of that strategy. I think our guidance will help signpost them to what those relevant groups would be, and that would include people representing the disadvantaged and disabled, et cetera.

[144] **Caroline Jones**: And how much consideration will we be giving to the fact that not everyone can access information online?

[145] **Rebecca Evans**: As I've said, it is important that information is accessible to people, which is why signage in windows and so on might be important as well. So, we'll be considering all of the options in terms of ensuring that people are aware of the toilets that are available. I think, as I've said to committee before, there is something to do in terms of creating a culture change where people are comfortable to go into places, such as a library or a coffee shop, for example, to use the toilet there, if the owners are happy for them to do so, and so on. Some people do not feel confident to go into certain settings if they're not buying something, or they're not taking out a book or using the service there. So, there's something for us to do there in terms of changing that culture, with what people are comfortable doing, as well.

[146] You mentioned online, of course, and I did meet recently with the British Toilet Association and they've created a changing places map online. I know officials are having some discussions with them in terms of potential for widening that, and so on.

[147] **Caroline Jones**: Thank you.

[148] **Dai Lloyd**: Julie.

[149] **Julie Morgan**: Yes, thank you, Chair. I support this proposal and I

think it's a step in the right direction, but would you agree that there's no real guarantee that this legislation would actually produce one extra toilet?

[150] **Rebecca Evans:** Well, the legislation—. I understand what you're saying and, in terms of building new toilets, it is expensive. I don't want the legislation to be burdensome on local authorities. It might be that new toilets are built but, actually, it might be that the toilets and facilities that we have available are better used and better promoted—opened up to the public where they're not already at the moment, and so on. So, it's about using what we have already and mapping out what we have, and understanding whether that already meets the needs of the local population, as identified through the work the local authorities will be doing, and, if it doesn't, then taking action to address those gaps.

[151] **Julie Morgan:** Yes, because I think, certainly from my knowledge, it won't meet the needs of the local populations that I know in my constituency, and I wouldn't want there to be a public expectation that this legislation would produce new toilets, because it's a sort of step in the direction isn't it, really?

[152] **Rebecca Evans:** It is difficult in terms of suggesting an extra number of toilets that might result from this. As I say, it's not necessarily about building more; it's about using what we have more effectively.

[153] **Mr Brereton:** I think what it will do is expose public toilet provision, be it directly by a local authority, by other public sector bodies, or through community facility grants to public scrutiny for the first time, really. And it will rely on local authority scrutiny processes and the role of ward members within local authorities to represent their local populations to make sure provision is adequate for the needs of all of the community. I think it will bring a measure of accountability on the issue within local government.

[154] **Julie Morgan:** I think that's very much to be welcomed. Would you see this as being any sort of debate on the type of toilets that are provided, because a lot of people are not happy with the newest types of toilets, where the whole of the door shuts? In fact, in my constituency, those are the ones that have now been taken away, presumably because they're not used enough. I don't know if you have any comments on that.

[155] **Mr Brereton:** Yes, I think the automatic public conveniences—'APCs' as we used to call them—with those types of toilet, you can actually very

accurately measure the usage versus the cost, and you get a cost per use. It could be more economic, as in Cardiff's case when they reviewed theirs, to direct the money elsewhere to provision that would be more frequently used. So, I think, in developing their local toilet strategy, part of the role of guidance will be to help local authorities to ask, 'What decisions do we have to make in terms of best provision?' and the accounting side of public toilets is part of that process, I think.

[156] **Dai Lloyd:** Jest i ddilyn i fyny ar hynny cyn i ni orffen, rydym ni wedi derbyn cryn dipyn o dystiolaeth gref iawn ynglŷn â'r pwyntiau hyn. Yn benodol, roedd pobl eisiau cael hyder yn y defnydd o doiledau cyhoeddus. Yn dilyn y lein roedd Julie yn ei ddweud rŵan, mae nhw eisiau hyder bod y cyfleuster yn mynd i fod yna, ac yn mynd i weithio, ac yn mynd i fod yn lân, ac mae nhw'n gwybod ymlaen llaw lle mae e. Hefyd, rhan gref o'r dystiolaeth oedd yr angen am y bas data yma roedd Caroline wedi cyfeirio ato—hynny yw, ei fod yn eglur i bawb lle mae'r toiledau cyhoeddus, eu bod nhw'n lân, eu bod nhw ar agor, a'u bod nhw yn cael eu defnyddio yn rheolaidd ac ati.

Dai Lloyd: Just to follow up on that before we come to an end, we have received a lot of strong evidence on these points. Specifically, people wanted confidence in the use of public toilets. Following the line that Julie said now, they want confidence that the conveniences are going to be there, and are going to be working, and clean, and they want to know beforehand where they are. Another strong part of the evidence was the need for this database that Caroline referred to—that is, that it's clear for everyone where the public toilets are, that they're clean, that they're open, and that they're used on a regular basis.

[157] Mae eisiau gwneud y peth yn hawdd iawn ac yn wybodus iawn i bobl allu defnyddio hyn, ac yn benodol felly i'r grŵp o bobl hynny sydd angen darganfod toiled mewn brys, mewn argyfwng. Mae yna nifer o gyflyrau meddygol i wneud efo'r coluddion, ond hefyd efo'r system arennau, sydd yn golygu os oes rhaid i chi fynd i'r toiled, mae rhaid gwneud nawr. Ie, mae eisiau i chi wybod lle mae pethau, ond hefyd, mae eisiau rhyw system fel ei bod

It needs to be done in an easy way for people to be able to use this, and specifically for that group of people who need to find toilets in a hurry, in an emergency. There are a number of medical conditions that relate to the bowels, but also relate to the kidney system, that mean that if you use the toilet, you need to go now. Yes, you need to know where things are, but also, there needs to be a system where it's okay to just walk into somewhere. I accept what you say

hi'n iawn i jest gerdded mewn i rywle. Rwy'n derbyn beth rydych yn ei ddweud ynglŷn a weithiau rydym yn swil ynglŷn â cherdded mewn i rywle a jest defnyddio'r toiled heb brynu rywbeth, ond hefyd mae eisiau newid fel mae'r sawl sydd yn darparu siopau coffi ac ati yn trin pobl hefyd, ac i ddisgwyl hynny, yn enwedig i bobl sydd â chyflyrau meddygol, sydd rhaid mynd i'r tŷ bach nawr ar fyrder. Nid wyf yn gwybod os fedrwch chi gadarnhau bod gyda chi unrhyw syniad lle gallwch chi gryfhau hynny yn y Mesur yma.

that sometimes we're shy about walking into somewhere and just using the toilet without buying something, but also, there is a need to change how those who provide coffee shops and so forth treat people, and to expect that, especially for those with medical conditions, who have to go and use the toilet now and quite urgently. I don't know whether you can confirm if you have any ideas on how that could be strengthened in this Bill.

[158] **Rebecca Evans**: Thank you. I know that you're taking evidence shortly from Crohn's and Colitis UK, and I know that they'll have some views on this, and I've also met with them to discuss their views on access to public toilets. They are supportive of what we're trying to achieve through the Bill. I mentioned previously the work that the British Toilet Association have done in terms of their Changing Places toilet map, which is available online, and it allows for geo-centering, which allows the person to use the map in relation to where they are at that moment in time, to find the most accessible toilet, or the nearest toilet that meets their needs, and I think that's something really interesting in terms of potential moves forward beyond this Bill.

[159] I think your issue about shop owners and other people not necessarily understanding how important it is for some people particularly to be able to access the toilet probably goes beyond the scope of the Bill in terms of setting out a requirement to have toilet strategies. However, I think there's a much bigger issue there in terms of disability, discrimination and understanding of unseen disabilities particularly, and creating more awareness amongst the public generally and people in particular professions as to what people's needs might be. I'm not sure that that could necessarily be addressed through this legislation particularly, but it is an important issue.

[160] **Dai Lloyd**: Angela ar hyn. **Dai Lloyd**: Angela on this.

[161] **Angela Burns**: Just a tiny question. We put the onus on shops and

everything and making people aware of how important it is to be able to provide toilets and what a good public service it is. But it does strike me that one of the great architects are our county councils, and they have outposts in all sorts of towns and cities, and yet you try going into a local county council to use their facilities as a member of the public and you are rebuffed. So, should we start by actually saying to the local councils, 'You need to open up your facilities'? Because they're in the middle of town centres. They're easy to access and if somebody gets stuck or gets caught short, and we're saying to the local fish and chip shop, 'You ought to consider being kind and open up your loo', how about saying to the county councils: 'Why don't you practice what you're trying to preach here?'

[162] **Rebecca Evans:** Well, in terms of councils preparing their strategies, I suppose the first place you would imagine that they would look would be to their own estate—

[163] **Angela Burns:** I can tell you for a fact though that they're not imagining that at all.

[164] **Rebecca Evans:** In terms of the guidance, we would obviously be exploring what onus there would be on local authorities themselves to start with the facilities that they have. Did you want to add anything?

[165] **Mr Brereton:** Yes. On both points, I think there's an opportunity in local authorities' dialogue with businesses and offices to try to prompt an attitudinal change in relation to accessibility for their toilets. And perhaps that's something we could prompt with the guidance to say that when they are consulting, and bringing to those businesses the problems that some people face, and some of the methods in relation to cards that are used to prove that you have a problem—to be more accepting. It is an opportunity to communicate on what is a very important issue.

[166] On public buildings, there's always a balance to be struck between security and accessibility and some are better at achieving that because the design allows for the toilet to be in front of the barrier and not behind the barrier. It's something that we have to put in public sector minds—that when they are designing buildings, they have to be both accessible and secure, and it is a difficult balance.

[167] **Dai Lloyd:** Diolch yn fawr. **Dai Lloyd:** Thank you. That's the end Dyna ddiwedd y sesiwn dystiolaeth. A of this evidence session. Can I thank

allaf ddiolch yn fawr iawn i'r Gweinidog, Rebecca Evans, am ei thystiolaeth a hefyd diolch i'r swyddogion am eu tystiolaeth ac am eu presenoldeb? Diolch yn fawr iawn i chi i gyd. Gallaf hefyd rhoi gwybod i chi y bydd trawsgrifiad o'r cyfarfod yma yn cael ei basio ymlaen ichi i'ch galluogi chi i'w wirio i wneud yn siŵr ei fod yn ffeithiol gywir. Gyda chymaint â hynny o eiriau, diolch yn fawr iawn i chi unwaith eto, Weinidog, am eich presenoldeb. Gallaf gyhoeddi i'm cyd-Aelodau y cawn ni egwyl fach am y naw munud nesaf, cyn y sesiwn dystiolaeth nesaf, pan fydd Coleg Brenhinol y Meddygon yma am 10:35. Diolch yn fawr.

the Minister, Rebecca Evans, for her evidence and the officials for their evidence and for their attendance? Thank you very much to you all. I can also inform you that you will receive a transcript of this meeting for you to check that it is factually accurate. So, I'd like to thank you again, Minister, for your attendance. I can also announce to my fellow Members that we'll have a short break for the next nine minutes before the next evidence session when the Royal College of Physicians will join us at 10:35. Thank you.

Gohiriwyd y cyfarfod rhwng 10:26 ac 10:36.
The meeting adjourned between 10:26 and 10:36.

Bil Iechyd y Cyhoedd (Cymru)—Cyfnod 1, Sesiwn Dystiolaeth 8—Coleg Brenhinol y Meddygon
Public Health (Wales) Bill—Stage 1 Evidence Session 8—Royal College of Physicians

[168] **Dai Lloyd**: Croeso nôl i bawb i'r sesiwn ddiweddaraf o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. O dan eitem 3, mae rhagor o graffu ar Fil Iechyd y Cyhoedd (Cymru), Cyfnod 1, a dyma sesiwn dystiolaeth rhif 8. Rwy'n falch i groesawu Coleg Brenhinol y Meddygon yma, ac yn benodol, felly, Dr Olwen Williams, sydd yn swyddog iechyd cyhoeddus Cymru Coleg Brenhinol y Meddygon.

Dai Lloyd: Welcome back, everybody, to the latest session of the Health, Social Care and Sport Committee here in the Assembly. Under item 3, there is more scrutiny of the Public Health (Wales) Bill, Stage 1, and this is evidence session number 8. I'm pleased to welcome the Royal College of Physicians here, and specifically Dr Olwen Williams, who is the Wales officer for public health with the RCP. I think you're aware of the order of

Rwy'n credu eich bod chi'n ymwybodol o'r drefn. Rydym ni wedi derbyn eich tystiolaeth ysgrifenedig gerllaw eisoes, ac felly, fel sy'n draddodiadol, awn ni yn syth i mewn i gwestiynau oddi wrth Aelodau. Felly, i ddechrau, rydym ni'n mynd i gael Dawn Bowden—Dawn.

things. We've received your written evidence beforehand already. So, as is traditional, we'll go straight into questions from Members. So, to start, we'll have questions from Dawn Bowden—Dawn.

[169] **Dawn Bowden**: Diolch, and good morning, Dr Williams.

[170] **Dr Williams**: Good morning.

[171] **Dawn Bowden**: A nice easy one to start with; a nice open question to start with: can you just tell us whether you think, in your opinion, the Bill has maximised all the opportunities available to it to address public health issues?

[172] **Dr Williams**: Obviously, we really do welcome this Bill, but actually feel that it could go further. It might be that parts of the issue are outside the legislative powers of the Welsh Government at the moment, especially our main concerns around the minimum pricing of alcohol, and also on the sugar tax, because we feel that they would have a significant impact on the health of individuals in Wales and the population of Wales.

[173] **Dawn Bowden**: So, those two areas in particular.

[174] **Dr Williams**: Those two areas are major areas of concern for the college. Obviously, the college has got a significant investment in this, as regards the health of the adult population. Most of our membership are consultants and physicians' assistants, who have to deal with the outcomes of some of the ill health related to both of these situations—alcohol abuse and the obesity crisis.

[175] **Dawn Bowden**: Presumably, you've had views back from colleagues in Scotland about the impact of minimum pricing in Scotland, which is leading you to believe that it would be—

[176] **Dr Williams**: Yes, and I think, if we look at the alcohol situation, I think what's changed—there are several ways that we can look at the way people have changed the way they drink. Certainly, with the changes around

smoking in public places, older people are not now going to the pubs in the same way; they're actually drinking at home. They have no regulation of how much they drink, and actually what they're drinking is cheap alcohol at home. So, actually, for the average person, putting, say, 50p per unit is not going to affect the majority of people who drink socially, but actually might affect those who are drinking—and I will use the words in inverted commas—'covertly' at home because they are saving money. There are two sides there. They're smoking at home as well, so the two things tend to go together, So we feel that, actually, that minimum pricing would have a huge impact on those people.

[177] **Dawn Bowden**: Because there's this trend, isn't there, for what they call 'pre-loading'—is that it? When kids go out, generally, they talk about pre-loading.

[178] **Dr Williams**: Yes. When you actually look at young people's drinking—and my background is as a sexual health practitioner, so I regularly ask my young people—what we're finding is that young people under the age of 18 are not drinking as much, or not drinking at all. There has been a significant drop in alcohol consumption among the 18 to 25-year-olds. They can go for weeks without drinking but, when they drink, they do the pre-load and they probably drink their month's—you know, they drink a significant amount. I'm more concerned, actually, with the people I see in the age group of 45 to 55-year-olds who say, 'I have a glass of wine', and when you ask them what size glass of wine, it is half a bottle of wine. So, I think there's a lot of messages out there around how we consume alcohol. But actually putting a 50p per unit price on that will not affect that age group's drinking because they're already paying over 50p or probably £1 a unit.

[179] **Dawn Bowden**: Sorry to interrupt you there. What would you suggest would be the answer to dealing with that? From what you're saying, it seems to be a particularly high-risk group, doesn't it?

[180] **Dr Williams**: Yes, it is because, obviously, we know that women drinking increase their risk of breast cancer, they don't recognise that they have an alcohol issue, they don't understand that they're more prone to having fatty liver and cirrhosis and, actually, there's a message out there. They're certainly drinking much more than their children are, in comparison. So, there needs to be some targeted public health around that. The 50p minimum pricing won't affect them necessarily. What that does is affect the people who run into significant problems around their drinking, the people

who are in that spiral, who drink the cider, who drink the very cheap alcohol, and, you know, that side. So, it might limit them getting into that next stage of ill health.

[181] Also, the alcohol issue around obesity as well. I don't think people understand how many calories there are in alcohol, in that the consumption of a large glass of wine equals a doughnut. Well, we might treat ourselves to a doughnut once a week, but, are we having a glass of wine every night? That's the questioning. So, I think there are a lot of public health messages that need to go out. But, having a regulation and an Act that actually say, 'We are supporting the 50p', might make people wake up a little bit more to the risks of alcohol and their consumption.

[182] **Dawn Bowden**: Okay, thank you for that. Can I just briefly move on now to your evidence? In your evidence, you do talk about:

[183] 'The focus of public health should lie on preventing, not just managing poor health. Many of the underlying reasons for health inequality in Wales cannot be solved by solely local initiatives and local authorities but will need a more strategic national approach by the Welsh Government.'

[184] Can you perhaps enlarge on that a little bit and tell us what you think?

[185] **Dr Williams**: I think what we go into there is that we have a fantastic opportunity in Wales with the well-being of future generations Act, with this public health Bill, and with the engagement with organisations like BMA, like ourselves, to actually have that strategic working together. This links into the health-impact assessment, that we all work together, with our population, in getting that message out so that people are very aware that things like sugar, alcohol and some of the other things, like smoking, are really fundamental things that need to change.

[186] **Dawn Bowden**: So, you're really talking about everybody taking ownership of the issue.

[187] **Dr Williams**: Yes. We should have all our citizens actually making this a citizen-based movement forward. If you look at—I'll bring in the organ donation Act. If you see how that has been embraced by the citizens of Wales, it has been a phenomenal change in what we've managed to do for the health of maybe only a few people as regards getting an organ, but it has been a phenomenal change. That has been driven by legislation but it's also

about buy-in by our population. So, we need that population from the bottom up, driving things. So, creating public health as a social movement, not necessarily as a legislative movement, but legislation does have its place.

[188] **Dawn Bowden**: It's quite evangelical, that is.

[189] **Dr Williams**: Pardon?

[190] **Dawn Bowden**: That's quite evangelical, isn't it? [Laughter.] Okay, thank you, Dr Williams.

[191] **Dai Lloyd**: Julie.

[192] **Julie Morgan**: Yes, thanks very much. The Royal College of Paediatrics and Child Health have suggested a number of other areas that could be included in the Bill as well as the alcohol and obesity issues, including it being used to promote breastfeeding as one issue, and accident prevention. I just wondered if you could comment on that and whether you did see that the Bill should include these sort of issues.

[193] **Dr Williams**: Obviously, the college covers adults, but we also look at transition. We look at adolescents and their movement into adulthood, so we work quite closely with the college.

10:45

[194] I think that's really important—other areas around making breastfeeding the norm and ensuring that facilities are advertising that they're breastfeeding-norm. Again, there's an education point of view.

[195] But I think that there are other issues that we should be thinking about. The public health research on adverse childhood experiences actually highlights nine areas, and if an individual has more than four of those—what they call ACEs, which I'm not sure is the appropriate acronym—then the risk of adult disease, which our members actually have to deal with, so diabetes, heart disease and respiratory disease, is increased threefold. So, I think there are areas that we could actually look at that expand on that, such as breastfeeding, but also looking at—and it probably doesn't go into a public health Bill—other areas around sexual assault, sexual violence, the risks around smoking in the household and those other things around social deprivation and poverty.

[196] **Julie Morgan:** So, you see those as being—

[197] **Dr Williams:** Yes, I think they're—. I think if you invest in your childhood then you will get a healthy adulthood.

[198] **Julie Morgan:** Yes. The other issue I wanted to raise was about accident prevention. There is the issue of accidents in the home and small children, and there's also the issue of driving licences, and I wondered what your view was about having a graduated driving licence.

[199] **Dr Williams:** I don't think we've got any particular views on that. Obviously, we do have a view on alcohol consumption and driving, but also on illegal drugs, and obviously we want people to be driving safely. It's not just substance misuse or alcohol that actually might be the cause there; extreme tiredness has the same effect, as well. So, actually, people's awareness. It might be that the Bill needs to raise awareness of risks to people who drive after a long night's shift, and we know that, in medicine, that's been a significant problem for junior doctors on call, who have then gone and had accidents the next morning.

[200] **Julie Morgan:** Thank you. I think that's all.

[201] **Dai Lloyd:** Symudwn ymlaen i'r adran nesaf rŵan, ac rydym ni'n mynd i sôn am fangreoedd di-fwg a'r holl fusnes tybaco. Mae Lynne yn mynd i arwain ar hyn.

Dai Lloyd: Moving on to the next section, and we're going to talk about smoke-free premises and tobacco and so forth. Lynne is going to lead on this.

[202] **Lynne Neagle:** Thanks, Chair. We have had some evidence that witnesses would like to see the Bill go further in terms of the settings that are set out as being tobacco free. For instance, the Bill currently covers schools, and witnesses have told us they think that places like childcare settings, private nurseries, et cetera, should be included. Have you got a view on that?

[203] **Dr Williams:** I think what we'd like to do is define what you mean by a hospital and healthcare, because I think, when it comes to places where care is being delivered, then it's around GP premises, it's about community hospitals and community clinics. So, yes, as regards the hospital. As regards places where children seek either care or education, or, actually, recreational

facilities, I think the difficulty there is around how you govern and how you police that, bearing in mind that you've got some care facilities that will be in hospital grounds. So, if you omit nurseries, can people smoke around the nursery on a hospital ground? There are all these—.

[204] I really do appreciate that this is a really difficult one, and, again, it's how we police it. I know we are advised to challenge individuals who smoke on hospital premises. It is actually quite difficult, and then, what they ask you is, 'Well, where can I smoke?' and you have to say, 'You have to go out on the main road.' We should be thinking about where these people then go, because they might be going somewhere where it's unsafe to smoke. So I think you've got to actually think about, maybe, facilities for people to go and smoke. But, also, use those facilities to actually engage them in smoking cessation. Don't just move the problem; actually give the people real, clear messages in those sorts of areas as well. Because what we're doing at the moment is we're shifting the problem, so they're not smoking in pubs, but all we're doing is shifting people outside the pub and what happens then is that the people who don't smoke actually move with those people who do smoke. So, inadvertently, they're passively smoking, or they might actually smoke themselves, and that's what people are telling me, 'Oh, I only smoke when I'm out with my friends who smoke.' So, I think we've got to really be careful on that one.

[205] **Lynne Neagle:** Okay. So, the royal college, then, isn't advocating an extension of what's proposed in the Bill to cover more areas where children are.

[206] **Dr Williams:** Yes, we'd like to see that, but we recognise that it's really difficult to enact it. That's the thing.

[207] **Lynne Neagle:** Okay. Can I just ask about the issue of public playgrounds? Playgrounds that have got play equipment in will be covered, but things like playing fields and general parks won't be. How effective do you think that will be?

[208] **Dr Williams:** We welcome the play areas and the restricted areas, but thinking of my own space where I walk my dog and see that sort of thing, one thing is the policing of it. I think, actually, that all people do is stand around that area where the play equipment is. The visual of the smoking will be there still. So, unless you actually make recreational grounds, including play areas, smoke-free, then it's going to be, again, a difficult thing to

police. But we'd obviously support as many places as possible for people not to be seen smoking.

[209] **Lynne Neagle:** Does that include, then, areas like outdoor cafes? Would you go that far?

[210] **Dr Williams:** That then becomes your issue. You've got a cafe with a play area next to it, and parents want to observe their children. Yes, I suppose. I think if you link the two together, that would be an area where you would say that you wouldn't want people to smoke.

[211] **Lynne Neagle:** Okay. Just finally, you referred to people not being seen smoking. A lot of the evidence we've taken has been around the need not to normalise smoking as an activity but, of course, vaping will be allowed in all these places now where we are banning the use of tobacco. What's your view on that as an effective public health measure?

[212] **Dr Williams:** We see vaping as an alternative. We would prefer people to not use cigarettes because we know the harmful effect of them. I think it's too early to actually move to banning vaping. I think our view is that. But yes, I think that walking down a high street, seeing a vaping stall in the middle of Queen Street, gives off the wrong message. I think, when it comes to licensing premises, that will take the vaping into somewhere else. I think that's something that we—

[213] **Lynne Neagle:** So, you don't have any concerns that children are going to see people vaping in their local playground, where the play equipment is, and think—

[214] **Dr Williams:** Yes, I said that we have that concern, but at the moment I'm not sure that we're prepared to ban vaping, to go as far as saying that, as a college.

[215] **Lynne Neagle:** Okay.

[216] **Dai Lloyd:** Julie.

[217] **Julie Morgan:** Yes, just to go back to the issue that Lynne raised about hospitals and hospital grounds, I think that this is a really difficult issue, but from your answer, were you saying that you think there should be a place in the hospital or hospital grounds where people who smoke can go? You think

that's—

[218] **Dr Williams:** Yes. That's a personal view, whether it's my colleagues' view—. But actually what it does is that it gives you an opportunity to work then with those people.

[219] **Julie Morgan:** Right. And in the situation, for example, of a cancer hospital, which feels that they couldn't do that, which I would understand because of their seeing the consequences of it—

[220] **Dr Williams:** Yes, I agree.

[221] **Julie Morgan:** —that is then displaced onto the—

[222] **Dr Williams:** To outside the front door.

[223] **Julie Morgan:** Yes. I've got a particular situation at the moment where people living around a hospital are experiencing lots of people sitting on the front wall and causing a great deal of distress to them and their children, who they're particularly concerned about. So, your answer is to have a place for them.

[224] **Dr Williams:** If you think from a public health point of view, what are we aiming to do? We're aiming to actually engage people in not doing something. So, by supporting them in a transition from doing it to not doing it, if you actually give them a facility where they might actually gain some—. You might want to have an interactive thing that tells them about where they can get smoking cessation advice from. So, it's actually promoting not smoking.

[225] **Julie Morgan:** Right. Does that happen in hospitals? Do you know?

[226] **Dr Williams:** Not that I know. I know that the maternity units have a little stand and have a little sign saying, 'It's best not to smoke in pregnancy.' I think a lot needs to be invested in a lot of the behavioural change around what we're doing.

[227] **Dai Lloyd:** Diolch am hynny. Gan symud ymlaen at yr adran nesaf ynglŷn â thybaco a'r angen i greu cofrestr o'r sawl sy'n gwerthu tybaco,

Dai Lloyd: Thank you for that. Moving on to the next section regarding tobacco and the need to create a register of those who sell tobacco,

mae gan Caroline gwestiwn ar hynny. Caroline has a question on that.

[228] **Caroline Jones**: Diolch, Chair. Could I ask, please, your views on the proposals to create a register of all retailers who sell tobacco and nicotine products, and how do you think the creation of such a register would impact on the reduction of children's access to such products?

[229] **Dr Williams**: We think, as an organisation, that, yes, a register will help. It will mean that these premises will have to be scrutinised, they will actually pay money and therefore it's not just everyone that can sell. I bear in mind that tobacco products, or nicotine products, do include some non-smoking products—so, chewing gum and things like that—that we need to be aware of. I was hearing earlier about the pharmacy and the difference between the nicotine prescribed patches and chewing gum versus the actual nicotine products that are not for therapeutic. I think the ability to not and to actually challenge young people around their age is something that now young people are very much aware of. They carry their ID, they expect to be asked, and that's a normal situation now. Everyone under 21 seems to have ID of some sort with them, and that was not our case when we were young. I think that they wouldn't even attempt now. I think my worry is where they get the tobacco from. It's the covert nicking mum's or having a quick vape of dad's sort of thing that is our biggest challenge. So, the retailers know that they are going to lose their licence, potentially, if they're caught. They don't want to get people hooked either.

[230] **Caroline Jones**: But that does happen now, doesn't it?

[231] **Dr Williams**: Yes.

[232] **Caroline Jones**: You lose your licence if you sell to under-age people anyway, so, when you say they would be under scrutiny, everyone's under scrutiny now who sell tobacco products. So, how do you envisage—

[233] **Dr Williams**: Well, I think there will be a register there, won't there? They'll be able to be visited because they're on the register to ensure that they're complying with the regulations.

[234] **Caroline Jones**: So, how do you envisage the scrutiny progressing? What do you mean by scrutiny, they'll be under scrutiny? In what way?

[235] **Dr Williams**: I haven't read in detail what's in the Bill, so I'm probably

not going to take this any—. What I would expect, if you're on a register, is that you have to relicense that premises so that the local authority will come in and look at what's happened in the last year. They might look at your sales, they might even look at your CCTV to see what you have been doing, have you been selling to under-age—I mean, most premises now do have that—and that you're complying with not displaying your tobacco.

[236] **Caroline Jones**: So, do you see expansion of the public sector in order to carry out these duties?

[237] **Dr Williams**: Of the public sector? I can't answer that question with any degree of authority, I'm afraid.

[238] **Dai Lloyd**: Symud ymlaen yn awr i driniaethau arbenigol, fel aciwbigo a thatŵio a nifer o bethau amgen rydym ni wedi bod yn clywed amdanyn nhw ac wedi bod yn cynyddu ein gwybodaeth yn wir amdanyn nhw ers rhai wythnosau yn awr, mae Angela yn arbenigo yn y maes.

Dai Lloyd: Moving on now to special procedures, such as acupuncture and tattooing and a number of alternative things we've been hearing about and have been increasing our knowledge of for a few weeks now, Angela is a specialist in this area.

[239] **Angela Burns**: Thank you. Good morning.

[240] **Dr Williams**: Good morning, Angela.

[241] **Angela Burns**: It's such a tough subject.

[242] **Dr Williams**: You've walked into my territory professionally, I think.

[243] **Angela Burns**: I have learnt more things that I never knew anything about—. In your evidence that came to the committee, you're very, very clear that you think that the intimidate procedures should be at an age of 18. We are having a bit of a battle with the Minister who, for very good reasons, believes it should be 16. Could you please just go through with some clarity why the royal college believes it should be 18? Because, to be frank, if we are going to shift her mind on this, we need to be able to evidence why it should be 18, rather than 16, very clearly.

11:00

[244] **Dr Williams:** Yes. This comes, probably, from my own professional background in working in sexual health. So, I'm a consultant in sexual health, and I also work in a sexual assault referral centre. My concerns, and our concerns, over the last few years are that we are seeing a lot of vulnerable young women between the ages of 16 up to the ages of 18 who don't really have the maturity to make some of the decisions that they're being put through. They're, maybe not of their own choice, having things done, and therefore we're concerned about that vulnerable group. So, it's not necessarily the age, but it's their vulnerability as well—around child sexual exploitation, around where this fits in with female genital mutilation. Also, I was here earlier, and piercing isn't necessarily reversible, in the sense that it does leave a hole, and I have seen some—and I won't go into detail—significant damage being done as a result of the piercing and the connotations from the anatomy being changed. It's practically irreversible, or—you know, is regarded a very much major reconfiguration of genital anatomy as a result. So, I'm not quite as keen.

[245] So, we feel that, in line with the 18, it would be much better, actually, to have that as the cut off. I do hear the human rights, I do hear the European convention on the rights of the child, and things like that, but also I'm very aware that, as you've probably found out, trends change over time, and individuals change, and what you're like at 15, 16, is not necessarily how you feel at 25 and 26 about things as well. I am concerned that going for a piercing of the genitals specifically at that age suggests other things that are going on in life. It's a very sexualised thing to have done. What has happened to that 16-year-old up until that age? I think, if it was to go to 16, I seriously do believe that, as part of this, there would have to be very rigorous child protection training and monitoring of the practitioners that are registered to do this procedure.

[246] **Angela Burns:** It's very interesting, because we've had evidence from the public protection teams who are saying that, actually, good practitioners won't do this kind of procedure on anyone who is under 18. I'm interested in this whole element of coercive control. I do think that we live in a very sexualised society and there's a lot of abuse that goes on over the internet and pressures and all the rest, on boys as well as girls.

[247] **Dr Williams:** Oh yes.

[248] **Angela Burns:** So, I would be really interested in any evidence or

anything that the royal college might be able to give us or add to about your experience of the types of young people who come to you for—well, you're picking up the pieces, I guess, afterwards of this. And anything about the psychology about it, because I do think this is one area where—I mean, the whole sex business is one area where young people are under immense pressure to either conform or not to conform, and they're either the in-crowd or they're the out-crowd, they're either one of them or not, and so on. It's just absolutely never-ending. So, you've added a dimension that I don't think we've really talked about before.

[249] **Dr Williams**: That's where, immediately I saw that 16, I thought, 'Oh, I'm spending most of my time, actually, now reassessing the 16 to 18-year-olds that come to our clinic around coercive control, CSE, all these things that actually are sort of allowing people to do stuff at 16'. It's also what is the scope of this, as well, that concerns me. Can I be—? Body hair: so, does this mean that a 16-year-old can go and have electrolysis of all body hair in intimate places? It's not a piercing, but it's a body modification and it's permanent. There are lots of things that it brings out that, possibly, you know, you start thinking about. It's not a therapeutic procedure. Would we—? You know, if you then ask a question about, 'Right, if age of consent is 16, how do we feel about breast augmentation in 16-year-old girls?' They can consent for it, but, actually, how many practitioners actually will do it? We're talking about experienced surgeons making decisions who will probably put that person through a psychological—you know, see a psychologist around is it going to do more harm than damage. But what we're talking about here is a 16-year-old can walk into a high-street practitioner and basically get on a bed and have his or her bits have something done to them without anyone asking the question about what's going on in their lives, why they're having it done, how their psychology is at the time. And that is quite worrying.

[250] **Angela Burns**: Gosh, I hadn't even thought about that, because, I guess, body hair removal is actually a very sexual—

[251] **Dr Williams**: It's a big thing at the moment.

[252] **Angela Burns**: It's a thing.

[253] **Dr Williams**: Yes. I don't see it any more.

[254] **Angela Burns**: In that case, then, without going into sort of too many details, probably, but are there obvious—? When we look at the list of the

four procedures that are exempted, would you want to make a comment on the types of procedures, or is there—? Do you feel, have a view, that a more catch-all phrase would be better to protect the sub-18 and sub-16 ages?

[255] **Dr Williams:** I think you probably need an overarching—. I think the thing is you will always be caught out by something that comes up and you haven't thought about. So, an overarching—. But is it piercing of skin and mucous membranes, or permanent alteration to intimate areas? Because, you know, although the thing is particularly about piercing, there are other things that, you know, they—. If you think about tattooing, where does electrolysis come between piercing and tattooing? It's not quite a piercing, but it is a procedure that you might want to think about.

[256] **Angela Burns:** I'm going to show my utter ignorance here, and naivety, probably, but I kind of think that, if a young person goes and gets a jewel in their belly button, that's for fun, I guess, you know, like pierced ears, all these things here and something in your nose. So, I guess I hadn't really thought about what an intimate piercing might actually be like, and, therefore, the question is: of the intimate piercings, would you have a feel for what proportion of them are for fun—you know, they're liked because people just want to express their personality—and what proportion of them are of a very sexual nature? I'm probably saying that so badly, because, of course, sex is fun, but I'm trying to—. Well, it used to be, anyway, when I was younger. [*Laughter.*] I don't remember anything these days. [*Laughter.*] But do you see what I'm trying to say? So, a 26-year-old going to have something put on because it's fun and it adds to their life is fantastic, but I'm talking about the bits that are less fun and perhaps are—.

[257] **Dr Williams:** I mean, it is not a pleasant procedure.

[258] **Angela Burns:** Why do I get this question every time? [*Laughter.*]

[259] **Dr Williams:** I was looking forward to this. [*Laughter.*] I think what we've got to ask is that—. Most genital piercings are to enhance pleasure. That is the purpose. They don't tend to be rebellion or things like that. So, you'd ask the question why would someone at 16 be already in that—where've they got that information from? That's the thing. By 18, they're much more likely to be a bit more worldly, they well might be in a relationship where that is the norm within their cohort of people, but, coming up to 16, where have they been for the last four or five years to learn that that's why they need, you know, their bits piercing?

[260] **Angela Burns:** Thank you. You've encapsulated it very well. I understand that now about rebellion or—.

[261] **Dr Williams:** It's that, you know—. And we do know that there is a piercing movement among people, and a tattooing movement, but it's actually how people get into that. And we're talking, if you say they can do it at 16, they've been thinking about it for a lot longer, and why have they been thinking? So, I think the psychology behind this is as important to understand as actually the public health remit.

[262] **Angela Burns:** And if we had this legislation, if it was, say, at 16 or even 18, there are obviously the younger people. Is there a definition of a vulnerable adult? Because I guess you could argue that a child who's coming forward at 16 to have this done is a 'vulnerable adult' anyway, but there's also the other kind of vulnerable adult.

[263] **Dr Williams:** Yes. I think what we've got to look at is learning disabilities, people with mental health issues, people that have been—the coercion of those individuals and putting in a capacity to consent to a procedure. There is that issue around the capacity to consent, and is this something that is built into the regulation of the operator? I listened earlier to who's got the competency. Well, I would never pierce or tattoo anyone. I wouldn't do that to their genitals even though I've been a practitioner in that field for nearly 30 years now. So, the fact that my title is 'doctor' doesn't mean that I'm competent. I worry that we're saying that individuals who've got that title—. Their colleges need to make sure that there is a mechanism for doing that.

[264] The thing about Botox and the dentist—yes, that's great. Anyone can go to a dentist—well, not anyone—and actually set up Botox because they're licensed to prescribe Botox as a dentist. It's usually not them that does it; they usually get someone else in, who may have the title 'nurse', to do it on their premises, but they're licensed. It's understanding that people will get through these loopholes because 1) it makes money and 2) there's a demand, and that's the thing.

[265] **Angela Burns:** There are a lot of companies out there that offer all sorts of procedures and they fly under the medical banner.

[266] **Dr Williams:** It might be interesting to actually have a discussion with

the British College of Aesthetic Medicine as well, because they control the plastic surgery and body-alteration areas, so they're, sort of, on that fine line as well. They might have an opinion on this.

[267] **Angela Burns**: Thank you. I think, in fact, you've answered—. My other question was going to be about the exemptions, because I can't understand why a dentist can do it but a physiotherapist can't or whatever, because they're all deemed to be professions. So, would you advocate that, whoever you are, whether you're going to train at 20 to do this as a career or whether you are a professional that's decided to take a side step into a new area, actually you should be regulated and licensed as that individual and competent to do that?

[268] **Dr Williams**: Yes. Because I'm a registered doctor, I've got an area of competency, I meet the GMC—. I mean, you probably are covered if you were doing this practice. You'd be covered with your annual appraisal and your revalidation, and you'd need your medical protection to cover you for that sort of work, and it would probably be done outside your NHS remit, but the thing is, what it means at the moment is that anyone who's a qualified doctor can set themselves up. So, there does need to be that regulation as well.

[269] **Angela Burns**: That's the end of my questions to you, except perhaps to say that this is your speciality subject, it is an area in which I'm woefully ignorant, so if there's anything you feel I should have asked you on the subject in this particular area, please feel free to say if you think I've missed a question.

[270] **Dr Williams**: If there's something that comes to mind, can I write to you and give written evidence through the Chair?

[271] **Angela Burns**: Please. Thank you very much.

[272] **Dai Lloyd**: Before we leave this, there's a question from Dawn and then from Lynne.

[273] **Dawn Bowden**: Yes, just for some clarity actually, because obviously the Bill covers all piercings. So, ear piercing, you know, which is—

[274] **Dr Williams**: No, it doesn't cover that. Ear piercing is not covered; it's the intimate piercing. I don't think the belly button is—

[275] **Dawn Bowden**: Intimate piercing, sorry. It covers things—. Sorry, what I should have been saying then is it covers things other than genital piercings. So, are you saying, just so that I'm clear, that your concern is really just the genital piercing and that that would be the area that you would be suggesting shouldn't be done at 16, but that other piercings that are covered are not such a concern?

[276] **Dr Williams**: They're not such a concern, but I think, for ease of legislation, it should all be the same. Everything should be the same with one age for everything.

[277] **Dawn Bowden**: If it's covered by the Bill, that age group—okay, that's fine.

[278] **Dr Williams**: The alternative is, you bring everything down to 16—so tattooing goes to 16, that sort of stuff. I think it should, personally, and I think the college agrees—

[279] **Dawn Bowden**: But your specific concern is about genital piercing.

[280] **Dr Williams**: Although, the breasts are intimate, so it also depends what happens at that point as well.

[281] **Dawn Bowden**: Sure, I understand. That's fine. Thank you, Chair.

[282] **Dai Lloyd**: Lynne.

[283] **Lynne Neagle**: I don't know whether you heard the discussion that we had in the previous session with the Minister about who should be excluded from these kind of things and the discussion that we had about people who had a record of sexual offences.

11:15

[284] One of the officials said that the purpose of this legislation, by the exclusions, is actually to make sure that people can administer the procedures in a safe and hygienic way. She said this wasn't a safeguarding issue, which rang some alarm bells for me really. I just wanted to get your comments on that.

[285] **Dr Williams**: My comments on that are that—I was in the gallery—I was

concerned about that because there have to be some safeguards, even more so with what we've been hearing with people in a position of power and authority in all sorts of areas. I think they need to be realistic. We're very aware that, in Wales, we do have issues around coercion and exploitation and where this leads to. I think, possibly, we could be short-sighted in not taking safeguarding on board here.

[286] **Lynne Neagle**: Thank you.

[287] **Dr Williams**: Can I just address intimate tattooing? There has been some evidence from some of the child sexual exploitation work done with gangs in England around tattooing of intimate places of girls, and that branding then stays with them for life as a sort of mark of being kind of—

[288] **Dai Lloyd**: Property.

[289] **Dr Williams**: Yes. I think we have to think about the wider bit of this, and that's in the last five years.

[290] **Angela Burns**: You've brought in a dimension that we perhaps haven't quite got our heads around. Jayne chairs the cross-party group on child sexual abuse and stuff like that.

[291] **Jayne Bryant**: I'm really pleased that you've been here to make these points today because, as Angela said, and Lynne previously, I was concerned when it was said by the official about it not being a safeguarding issue. For me, it has to be. As Angela said, you've brought an aspect that we definitely should be thinking of and that we haven't heard evidence on before. So, I'm personally very grateful that you've brought that to us today, so, thank you. As Angela says, if there's anything that you think we should be raising, and even the issue—sorry, Chair—

[292] **Dai Lloyd**: No, carry on.

[293] **Jayne Bryant**:—about hair removal. That's something that I hadn't thought of and that is a growing issue and is a trend at the moment, and I think that has to be thought of.

[294] **Dr Williams**: Coming back, obviously, my passion as well is young people, but the smoking, the tattooing, the piercing, the lack of hair—they all seem to me to be a trigger. If I see a young girl who smokes, I am really

worried about what else she's doing. It is one of those things that we need to think about around their risk-taking behaviour. With all young adolescents who do that, you usually find the other things follow and it's actually about supporting them as well. So, there is a protection around a lot of things that you're discussing in this Bill that really needs to be focused on in terms of targeting the early years—the 11 to 13-year-olds.

[295] **Angela Burns**: You recommended perhaps talking to the—

[296] **Dr Williams**: The British College of Aesthetic Medicine.

[297] **Angela Burns**: Do you think it will be beneficial, or is there anybody we might also approach, to talk about the psychology behind all this because that's an element that we might want to investigate, Chair?

[298] **Dai Lloyd**: There are timing issues, but—

[299] **Dr Williams**: Maybe they would come to you personally. I'll have a think about that.

[300] **Dai Lloyd**: Moving on, Jayne, you've got the floor now as regards health impact assessments. You're on a roll. [*Laughter*.]

[301] **Jayne Bryant**: You said to come back in, earlier. You mentioned health impact assessments and the importance of creating a social movement and changing attitudes. On the written evidence that you've provided, you've welcomed the health impact assessment, but you've also warned against the prospect of it becoming a box-ticking exercise. Do you think there needs to be any strengthening in this area at all?

[302] **Dr Williams**: Not particularly. I think the challenge is delivering it and making sure that there are enough resources supporting all the partners in actually doing it, and also making sure that there is co-production happening. I think that, you know, we are now having that co-production movement in Wales, but it's actually making sure that there's that drive, you know, that network that is there, pushing the buttons to say that you've got to do this and you've got to do it properly. You know, I think that we are sometimes short-sighted; we plan for five years, not 10, not 15, and we're certainly not looking towards my eightieth birthday. Well, actually, I'm going to be one of the highest numbers of 80-year-olds ever alive.

[303] **Jayne Bryant:** Wow, that's—

[304] **Dr Williams:** Yes, 1959 has the highest birth rate and the highest surviving number of individuals, so, you know, you put that into context, it makes—.

[305] **Jayne Bryant:** Yes, definitely. Thanks very much for that.

[306] **Dai Lloyd:** Symudwn ni ymlaen i'r adran nesaf, asesiadau fferyllol, ac mae Lynne Neagle yn mynd i ofyn y cwestiynau yna.

Dai Lloyd: Moving on to the next section, pharmaceutical assessments, and Lynne Neagle will ask the questions.

[307] **Lynne Neagle:** Okay. Thank you. You didn't make any specific reference to these provisions, and I just wanted to ask whether there are any things that you want to bring to the committee's attention.

[308] **Dr Williams:** No, not at the moment.

[309] **Lynne Neagle:** You don't see any particular potential for the Bill to actually address some of the concerns that you've raised in other aspects?

[310] **Dr Williams:** Probably strengthening of the availability of the community-based smoking cessation. We would welcome that, you know, to make sure that—. I mean, I know that it's already there, but it's actually promoting it and the facilities that our pharmacies have and our dispensing GP pharmacies have, so that their dispensing pharmacists can actually engage in that sort of activity.

[311] **Lynne Neagle:** And what about the young people side of things, because you obviously feel very strongly about that?

[312] **Dr Williams:** Well, I think that is something that we really do need to address, and that could be multipronged. But, you know, the way to young people is not necessarily through conventional mechanisms; its social media, it's where they hang out, and, actually, do we look to a different way of actually guiding them into going to their chemist or going to—? I mean, they certainly don't go to their GPs very often. But, also, agencies like my own, who actually see young people, have more than one health remit.

[313] **Lynne Neagle:** Thank you.

[314] **Dai Lloyd**: Diolch yn fawr. A'r adran olaf ydy toiledau cyhoeddus. Caroline.

Dai Lloyd: Thank you very much. And the final section is the provision of public toilets. Caroline.

[315] **Caroline Jones**: I was wondering if you'd like to comment generally on the provision.

[316] **Dr Williams**: We fully support the need for toilets. I mean, obviously, it's not just about the disability; it's about the faecal and urine incontinence. I think it's just a no-brainer, and our college supports that they need to do—. You know, you could have the 'toilet app of Wales', couldn't you, so that you actually have the locations, the opening times, that people can download? Because I'm very aware that all groups of individuals will know where their toilets are, but, actually, they might be a bit taken aback when they're closed for whatever reason.

[317] I do believe that they need to be secure environments as well, with proper lighting, proper access, that they're visible, and with the possibility of CCTV available around the areas. We are aware that other activities are carried out in public toilets, and we need to make sure that the people that want/need to use them for the right mechanism get to use them.

[318] **Caroline Jones**: So, do you think that it's not sort of recognised enough how important it is to people's lives to be able to access a toilet?

[319] **Dr Williams**: Yes.

[320] **Caroline Jones**: It makes a difference, doesn't it, to people with, say, incontinence, of going out and doing their daily duties or not, really?

[321] **Dr Williams**: I think it's for everybody. You know, every woman who's been pregnant knows that she knows for nine months where the toilets are in her area. So, it's not an issue just for those other individuals, but it's also being able to take the buggy in, that the toilets are clean—

[322] **Caroline Jones**: Yes, the practicalities that have to be taken. Thank you very much.

[323] **Dr Williams**: You're welcome.

[324] **Dai Lloyd**: Diolch yn fawr. Dyna ddiwedd y sesiwn. Mae wedi bod yn drawiadol, ac mae nifer ohonom ni, yn amlwg, wedi dysgu llawer, ac mae Angela wedi ychwanegu at ei harbenigedd yn y maes, yn amlwg. Felly, dyna'r sesiwn ar ben. Diolch yn fawr i chi am eich cyfraniad ac am eich presenoldeb. Fe allaf i gyhoeddi y cewch chi drawsgrifiad o'r cyfarfod yma i'w wirio fe i wneud yn siŵr ei fod yn ffeithiol gywir. Ond, gyda hynny o eiriau, a gaf i ddiolch yn fawr iawn i chi unwaith eto?

Dai Lloyd: Thank you very much. That's the end of the session. It's been striking, and a number of us, clearly, have learned a lot, and Angela has added to her expertise in this area, clearly. So, that's the end of the session. Thank you for your contribution and for your attendance. You will receive a transcript of this meeting to check the factual accuracy. But, with those few words, I'd like to thank you once more.

[325] **Dr Williams**: Diolch yn fawr iawn i chi.

Dr Williams: Thank you very much.

[326] Thank you very much, Chair.

[327] **Dai Lloyd**: Ac a gaf i gyhoeddi i'r Aelodau y cawn ni egwyl fer rŵan am 10 munud, gan ddod yn ôl wedyn am sesiwn dystiolaeth olaf y bore?

Dai Lloyd: And may I say to the Members that we'll have a short break for 10 minutes and come back for the last evidence session of the morning?

Gohiriwyd y cyfarfod rhwng 11:25 a 11:36.
The meeting adjourned between 11:25 and 11:36.

Bil Iechyd y Cyhoedd (Cymru): Cyfnod 1—Sesiwn Dystiolaeth 9—ASH Cymru
Public Health (Wales) Bill: Stage 1—Evidence Session 9—ASH Wales

[328] **Dai Lloyd**: Croeso yn ôl i sesiwn ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. O dan eitem 4, rydym yn parhau efo'n craffu ar Fil Iechyd y Cyhoedd (Cymru), Cyfnod 1. Byddwch yn

Dai Lloyd: Welcome back to the latest session of the Health, Social Care and Sport Committee here at the National Assembly. Under item 4, we will continue our scrutiny of the Public Health (Wales) Bill, Stage 1. You will be aware that we have had a number

ymwybodol ein bod wedi cael nifer o sesiynau tystiolaeth i fyny at rŵan; hwn, yn wir, yw sesiwn dystiolaeth rhif 9. Mae ein tystion o ASH Cymru gerbron, ac felly hoffwn groesawu Suzanne Cass, prif weithredwr ASH Cymru, a hefyd Dr Steven Macey, swyddog ymchwil a pholisi ASH Cymru. Mae'r Aelodau wedi darllen y dystiolaeth ysgrifenedig, ac yn ôl ein traddodiad rŵan, byddwn yn symud yn syth i mewn i gwestiynau, gyda'ch caniatâd, ac felly dyna beth y gwnawn ni. Yn naturiol, mae yna nifer o agweddau i Fil iechyd y cyhoedd, ond chi sydd yma, ac rydym yn mynd i ddechrau, felly, gyda mangreoedd di-fwg a'r holl agenda ysmygu. Felly, Lynne Neagle.

of evidence sessions up until this point; this, indeed, is evidence session 9. Our witnesses from ASH Wales are before us, and I would therefor like to welcome Suzanne Cass, ASH Wales chief executive, and Dr Steven Macey, ASH Wales research and policy officer. The Members have read the written evidence, and in accordance with our traditions, we will move straight to questions, with your permission, and therefore that is what we will do. Naturally, there are a number of aspects to the public health Bill, but you are here, and so we will start with smoke-free premises and the whole smoking agenda. Therefore, Lynne Neagle.

[329] **Lynne Neagle**: Thanks, Chair. You are strongly in support of the extension of smoking restrictions in Wales. Can I just go into that in a bit more detail? One of the areas covered would be school grounds, which would be primary and secondary schools. How confident are you that that goes far enough to protect children, because it doesn't include things like day nurseries, child-care settings et cetera?

[330] **Dr Macey**: I think, ideally, we would like them to include those additional settings that you mentioned there. Also, school gates are another area where, if smoking is to be banned on the school grounds, being able to distinguish whether the school gate is in the grounds or not can be a bit confusing. It might also diminish the impact of the actual denormalisation that's taking place if children can still see smoking at the school gate, sort of thing. So, with school gates and the other settings that you mentioned there, we'd be in favour of the ban being extended to those areas—yes, definitely.

[331] **Lynne Neagle**: Would you go further then than school gates and, say, include the areas around the perimeter of the school generally, or are you just saying school gates?

[332] **Ms Cass**: Well, we think that, actually, when you look at the rationale

behind the legislation as it stands, the rationale would extend it to the perimeters of the schools as well. Because if you are looking to denormalise smoking as a normal habit and to ensure that children see less smoking in the world around them, that is actually a key area of where children are and where children see this activity.

[333] **Lynne Neagle**: Okay, thank you. What about playgrounds? At the moment, 'playgrounds' would just be ones with play equipment in—you know, the enclosed type. Would about things like areas where children play, like playing fields and what have you? What's your view on whether the Bill is strong enough on that?

[334] **Dr Macey**: I think, again, we'd like to see the Bill include those additional areas where children congregate: you know, around the playground, the playing fields, the sports grounds and areas like that—even beaches, perhaps—where children do attend and go to on a regular basis. You know, in terms of, again, enforcing the ban, if it's just in the playground, what actually counts as a playground? Are they including skate parks and things like that? So, it would be a bit clearer if the Bill specified any areas around the playground, like you say, playing fields, sports grounds and all those types of facilities where children congregate. I think we'd be in favour of that being included in the Bill as well.

[335] **Lynne Neagle**: Okay, thank you. And in terms of hospitals, are you satisfied that the right balance is struck? Obviously, hospitals do have lots of people who are under a lot of stress and might be having a difficult time. Are you satisfied that the right balance is struck there with what's being proposed? Do you think the balance is right with the rights of visitors, patients, et cetera?

[336] **Ms Cass**: We'd like to see a blanket ban of smoking in hospitals. We think that there should be no shelters provided for smokers. Our view on this is that we know that 70 per cent of smokers want to give up smoking. We know that stopping smoking makes the stay in hospital shorter, patient recovery quicker, and that we've introduced—. We know that the smoking ban in prisons, for example, has worked and is working, and that when you compare—. I'm not saying that we compare hospitals to prisons, but there is a similar kind of experience in the fact that they're in an enclosed space and they're unable to get out. So, providing the correct cessation support is really important, making sure that there's nicotine replacement therapy available for those who have that addiction and need that support. But I think, in our

opinion, if you're going to send an unambiguous message that smoking is not accepted behaviour within the NHS premises—. We believe that smoking should be banned in hospital grounds across the board.

[337] **Lynne Neagle**: Okay. And I'm guessing that your answer, then, to the question of whether you think that this should be extended to other NHS premises, such as GPs practices et cetera, is going to be 'yes'.

[338] **Dr Macey**: Yes.

[339] **Ms Cass**: Absolutely.

[340] **Lynne Neagle**: Okay. And what about other outdoor areas then, like cafes et cetera? The Bill doesn't cover those. 'Yes'?

[341] **Dr Macey**: Yes, we'd be in favour of that as well. I think, particularly thinking of cafes and places like that, with outdoor seating areas, they're often located very close to the cafe itself. If windows are open, doors are open, smoke drifts and goes into the actual premise itself. So, in terms of the second-hand smoke issue, and also, the denormalisation of smoking and that agenda, then I think we'd be in favour of outdoor cafe and restaurant areas being smoke free.

[342] **Lynne Neagle**: Okay, thank you. And just one final question: your evidence the last time around with the Bill was very key in changing the committee's view on the whole e-cigarette debate, but you've referred a few times to the dangers of normalising smoking. I'm guessing that your primary concern with e-cigarettes would still be the gateway into smoking, but have you got any concerns at all that tobacco will be banned in all these places, but people will still be able to use e-cigarettes in all these areas where particularly children are present?

[343] **Ms Cass**: When it comes to e-cigarettes, our stance on e-cigarettes is that they are being used now as the No. 1 cessation tool. So, we need to ensure that smokers have access to this product and can use this product and are aware of the health benefits of this product in order to help them to give up smoking. We're very mindful of the fact the way that e-cigarettes are marketed and ensuring that actually they're not seen as a product to be used by children. So, when it comes to the normalisation of e-cigarettes and tobacco products, we think that children—the evidence that we've got so far is that children can distinguish between an e-cigarette and a tobacco

product. So, as far as the normalisation of using e-cigarettes to normalise smoking is concerned, there is a distinction between the two products.

[344] **Lynne Neagle:** So, your position is basically exactly the same as it was last time around, then, on e-cigarettes?

[345] **Ms Cass:** Yes.

[346] **Lynne Neagle:** Okay, thank you.

11:45

[347] **Dai Lloyd:** Could I just probe that a little bit further in terms of—? Nobody's talking about banning e-cigarettes as such, only banning their use—well, making them subject to the same qualifications as normal cigarettes, really. And there's no such consideration about other nicotine-replacement products, like gums and tablets, for instance. The commercial imperative of the large tobacco companies is behind vaping and e-cigarettes. We take the point that, yes, it's a tool, one of many, to help you stop smoking, but nobody's talking about banning e-cigarettes in totality, we're just talking about restricting them, like we would normal cigarettes, because, at the end of the day, 19 per cent of people in Wales smoke at the moment, so if we're saying that e-cigarettes are fine, even though they contain nicotine to varying amounts that we don't know—and nicotine is one of the most addictive substances known to man or woman—you're in favour, then, of potentially the 80 per cent of people who are not smokers being subject to a decision by others to be in touch with nicotine, not the decision they've taken themselves not to be in touch with nicotine. You say the rights of the 19 per cent, then, should override the decision of the 81 per cent to have free fresh air.

[348] **Dr Macey:** We're continually reviewing the evidence on e-cigarettes, so it is something that we're continually reviewing, and from all the evidence that I've seen personally, there is no evidence that there is any harm from a bystander breathing in nicotine vapour. So, it's getting that right balance and supporting smokers to give up that habit of tobacco. I understand you're saying that you're not proposing a complete ban on e-cigarettes, but even just bringing them into line with tobacco cigarettes gives that message that they are the same thing, they are the same product, when they are not. E-cigarettes, from all the evidence out there, have been found to be a lot less harmful than tobacco cigarettes. So, we're very keen to get that message

across: that e-cigarettes should only be used as a cessation tool, not for recreational purposes. Clouding the message, as such, to bring them into line with tobacco cigarettes, is not something that we'd be in favour of as an organisation.

[349] **Dai Lloyd:** Dawn.

[350] **Dawn Bowden:** Thank you, Chair. It is quite clear, isn't it, that vaping and e-cigarettes are not actually just used as smoking cessation tools—they are being marketed now as a recreational pastime in their own right? You see the vape shops and how attractive they are, and all that kind of thing. Have you got any evidence to suggest that people are taking up vaping who have never smoked? Because, as Dai has said, it's a hugely addictive thing, nicotine, and so, even though you haven't got the by-product of the tar and the potential for cancers and that sort of thing, you do nevertheless have the potential for nicotine addiction by starting with them, even if you've never smoked. So, do you have any evidence around that at all?

[351] **Dr Macey:** Yes, and all the evidence that we do have suggests that very, very few non-smokers are regularly using e-cigarettes. So, there might be non-smokers who are trying e-cigarettes once or twice, but regular use among non-smokers is very rare, and they are most frequently used by smokers. So, that's the evidence that we've got at the moment. But, like you said, it is an evolving issue, and it's something that we're monitoring all the time as an organisation; we're continually looking at the evidence on this. So, it's something that we're keeping on top of.

[352] **Dawn Bowden:** Okay, right. Thank you.

[353] **Ms Cass:** I think we need to be mindful and we need to make sure that we don't lose sight of the fact that e-cigarettes are the No. 1 go-to nicotine-replacement therapy for people who are trying to give up smoking. So, they now are the go-to product for people who are trying to stop smoking. We're also very mindful of the fact we've got new regulations coming into play with regard to the content of e-cigarettes and how they're sold. So, we're welcoming that level of regulation around this product. We obviously don't want to see this product being marketed to young people, but we do want to ensure that the public understand that, actually, as a harm-reduction tool and a cessation tool, this could help them to give up smoking. Actually, we feel as an organisation that that message, due to the evidence that is being thrown around about e-cigarettes, is being lost, and the evidence that we've

found is that people are increasingly believing that e-cigarettes are as harmful as cigarettes. So, the understanding amongst the public is somewhat skewed, and we need to ensure that, actually, e-cigarettes are seen as a cessation tool, and a viable cessation tool, for smokers.

[354] **Dai Lloyd**: I think we'd agree with that, and nobody's disputing the fact of their role in smoking cessation. So, treat them like any other smoking cessation drug then, because that's what nicotine is, and register them, medicalise them, if you like, on prescription, just like all the other smoking cessation tools that we have now: the patches, the gums, the tablets, the varenicline, the Champix, all the rest of it. So, there's a job of work to be done there, because with my doctor's hat on, we do view with suspicion something that the large tobacco companies are involved in promoting, and blurring the margins between e-cigarettes and proper tobacco. But that's a debate for another day, I suspect.

[355] Still on tobacco, though, we're moving on to tobacco retailers and Caroline.

[356] **Caroline Jones**: Yes, we are. Thank you, Chair. What would the benefits be of ASH's suggestion that there should be a separate register for tobacco and nicotine products?

[357] **Ms Carr**: We're really keen that the two products are seen as two separate entities, and we want to ensure, when you're sending out messages regarding tobacco products, that they hit the right market, and actually, when you're sending out messages about e-cigarettes, that they hit the right market too. We would look for assurances that, within the retail register as it stands, you would be able to distinguish between those that sell tobacco products and those that, as you say, are vaping shops that are set up separately and are just selling e-cigarettes or vaping materials. So, we'd be keen to ensure that those two are seen as separate entities and have different messages going out to them.

[358] **Caroline Jones**: Okay. Thank you. And what do we know from the experience of operating a register in Scotland? What knowledge have we gained there? Are there ways in which the Bill could be strengthened in the area of compliance and enforcement?

[359] **Dr Macey**: In Scotland they've had the register there since 2011, I think. Since that time they've averaged, I think, one or two retailers being

removed from the register a year. So there have only been five or six since it actually began. So, I think, from an enforcement point of view, we've got a fair bit to learn from Scotland. It's been very successful in terms of communication and in terms of getting the message out to retailers about trading standards and the messages that they've got, and also in terms of knowing where retailers are, which is handy in terms of knowing whether they approach the schools, and things like that. But I think in terms of enforcement and compliance, I certainly think there need to be sufficient teeth to this register to ensure that the deterrent is there for the retailers not to infringe against the law. So, I think at the moment the policy is that if there have been three offences within three years, you get removed from the register. We would like to see just one offence and then you get removed from the register. It's such an important and dangerous product, tobacco, that just one infringement against the law, you'd get removed from the register. So, we'd like to see that potentially added into the register as it stands at the moment.

[360] **Ms Cass**: And actually Scotland are reviewing that retail register at the moment, and one of the things that they're calling for in there is to come up with this one-strike policy.

[361] **Caroline Jones**: Can I just ask one further question? You mentioned that it has been a success in prisons, the smoking ban, and I accept that, but how do you measure success? What sort of tools were given inside the prisons? Because when a prisoner is locked up for 90 per cent of his time, frustration builds. Have you looked at the incident levels? Have the incident levels risen—you know, prisoner on staff, prisoner on prisoner, and so on and so forth, and the incidence of self-harm? Have you looked at the whole picture? Thank you.

[362] **Dr Macey**: We haven't had any reports. We've been working with NOMS on this—the National Offenders Management Service. We haven't had any reports that there has been any major backlash or anything like that in terms of the smoking ban coming into place in prisons, from what we're aware of. In terms of the success, it has been introduced and all prisons are now smoke-free, and it shows that it can be done. So, it's obviously something that we'll continue monitoring.

[363] **Caroline Jones**: Have you looked at the incident levels?

[364] **Ms Cass**: As far as the introduction of the ban was concerned, there

were two important aspects to that. There was the cessation support that was offered within the prison service and for those who were coming in—

[365] **Caroline Jones:** Yes, but with a revolving door, that would be very difficult, wouldn't it?

[366] **Ms Cass:** Yes. And then, also what was important was the fact that they were offered nicotine replacement therapy, and e-cigarettes were being sold within the prisons as well. So, there was a number of options for them. As far as the incidents are concerned, we've had no reports of any further incidents with regard to the ban.

[367] **Caroline Jones:** Okay. Thank you.

[368] **Dai Lloyd:** Mae'r ddau gwestiwn olaf y bore yma, felly, o dan law Jayne Bryant.

Dai Lloyd: The final two questions this morning, then, are from Jayne Bryant.

[369] **Jayne Bryant:** You're supportive of the proposals to prohibit the handing of tobacco products and nicotine products to people under the age of 18. Do you have any further comments you'd like to add to that?

[370] **Dr Macey:** I just think that it follows on, really, with the whole age of sale restrictions and things like that, and the fact that we don't want people under the age of 18 having easy access to tobacco. So, if you have a way of restricting that, I think it's a good thing. We're very much in favour of that measure.

[371] **Jayne Bryant:** Thank you. The British Lung Foundation suggested that the Bill should include statutory targets for reducing smoking prevalence, for example. What's your view on that and, also, do you think there are other tobacco control measures that should be considered within this Bill?

[372] **Dr Macey:** Yes. We'd be very much in favour of statutory targets being put in, and also maybe more specific targets being put into the tobacco control action plan for Wales. There is an overarching target of 16 per cent smoking prevalence by 2020. We would possibly like to see some more specific targets looking at particular sub-groups of the population where smoking is a lot higher. So, maybe, in more deprived communities, people with mental illnesses, perhaps, and smoking among those who are pregnant. Those are all areas where smoking is a lot higher. So, although the overall

smoking prevalence might be falling, in those certain sub-groups of the population, it's either stagnant or reducing a lot less. So, more targeted targets, then, are perhaps what we'd like to see included.

[373] The second part of the question, then, was any other tobacco control policies—

[374] **Jayne Bryant**: Yes.

[375] **Dr Macey**: Illegal tobacco, for instance, that's not mentioned at all in the Bill, but I know that's being tackled with the illegal tobacco task and finish group that the Welsh Government has set up. Illegal tobacco is always an item on our agenda. Is there anything else, Suzanne?

[376] **Ms Cass**: I think we've covered it in the extension of the smoke-free spaces. We'd like to see beaches included, we'd like to see school gates included and parks. We'd like to see that, wherever children gather—family attractions, you know—and wherever they are, we'd like there to be smoking bans in those places to ensure that we de-normalise smoking and that children see less smoking in the world around them, and that we can really hammer home the fact that passive smoking is an issue and still accounts for 9,000 hospital admissions in children in the UK every single year. So, passive smoking is an issue, smoking in the home is still an issue, and we hope that the legislation that is proposed and maybe the additional things that we've asked for will help to address those issues.

[377] **Dr Macey**: The additional things that we're calling for—and we're not sure whether they could be included in this particular Bill—are things like smoking cessation, and to make sure that they are sufficiently funded and that that funding is protected. Other campaigns we're looking at are things like smoking in the home and making sure that people are educated that smoking in the home is not good for the children living in the home and that smoking needs to be taken outside and things like that. So, maybe a public awareness campaign or some mass media around smoking in the home and things like that. But we're not sure whether that is to be included in this Bill.

12:00

[378] **Ms Cass**: And tackling illegal tobacco is a real issue for us in Wales. We commissioned a report back in 2014 that found that the illegal tobacco market in Wales stands at 15 per cent. It's the highest of any UK region.

We've got the highest level of illegal tobacco in the UK, so we're working on that, we're working on a task and finish group to address those issues, but we hope that the measures being put forward in the Bill with regard to the premises restriction orders and the retail register will help us to tackle this issue. So, we're very keen that the premises restriction orders include as many offences as possible, to make sure that those who are selling illegal tobacco or selling to under-age children are prosecuted.

[379] **Dr Macey:** And also maybe for the retail register to include not just those retailers at the street level, but further up the supply chains to the manufacturer, so the whole supply chain is included in that retail register. That is certainly something that we'd be supportive of, to make sure that the whole supply chain is accounted for. Because, obviously, the illegal tobacco is just at the retailers, just at the sharp end, as such, when really it goes back a lot further. So, any attempt to tackle that would be welcome.

[380] **Ms Cass**: The evidence that we've got around that is that 19 per cent of illegal tobacco is being sold in shops and premises. So, illegal tobacco is being sold at that level, so it is an issue and it's something that we can make a difference to, and we're hoping that this legislation will go some way to doing that.

[381] **Dai Lloyd:** Grêt, diolch yn fawr iawn ichi. Dyna ddiwedd y sesiwn cymryd tystiolaeth. A allaf ddiolch i Suzanne Cass a Dr Steven Macey am eu presenoldeb ac am eu tystiolaeth y bore yma? Diolch yn fawr iawn ichi. Fe fyddwn ni yn gyrru trawsgrifiad o'r cyfarfod yma atoch er mwyn ichi ei wirio i fod yn ffeithiol gywir, ac fel ein bod ni ddim yn eich camddyfynnu chi o gwbl. Felly, diolch yn fawr iawn i chi am eich presenoldeb.

Dai Lloyd: Great, thank you very much. That's the end of the evidence-taking session. May I thank Suzanne Cass and Dr Steven Macey for attending today and for their evidence this morning? Thank you very much. We will be sending you a transcript of this meeting so that you can check it for factual accuracy and that we haven't misquoted you at all. So, thank you very much for your attendance.

12:02

Papurau i'w Nodi
Papers to Note

[382] **Dai Lloyd**: Fe wnawn ni droi at

Dai Lloyd: We'll turn to item 5 now

eitem 5 nawr, papurau i'w nodi. Fe fydd Aelodau wedi darllen y pedwar llythyr, a dim ond materion i'w nodi yw'r rhain, cyn i ni fynd i eitem 6.

and papers note. Members will have read the four letters, and these are only matters to note before we go to item 6.

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd
Motion under Standing Order 17.42 to Resolve to Exclude the Public

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o'r cyfarfod ar 23 Tachwedd yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting and from the meeting on 23 November in accordance with Standing Order 17.42(vi).

[383] **Dai Lloyd:** Rydw i'n cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod ac fe fyddwn ni'n symud i fewn i sesiwn breifat i ddygymod efo'r dystiolaeth rydym ni wedi'i dderbyn y bore yma. Diolch yn fawr iawn i chi.

Dai Lloyd: I move a motion under Standing Orders 17.42 to resolve to exclude the public from the remainder of the meeting, and we'll move into private session to consider the evidence we have received this morning. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 12:02.
The public part of the meeting ended at 12:02.