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

07/12/2016

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Others in attendance

Dr Sumina Azam	Ymgynghorydd Iechyd y Cyhoedd, Iechyd Cyhoeddus Cymru Consultant in Public Health, Public Health Wales
Dr Julie Bishop	Cyfarwyddwr Gwella Iechyd ac Ymgynghorydd Iechyd y Cyhoedd, Iechyd Cyhoeddus Cymru Director of Health Improvement and Consultant in Public Health, Public Health Wales
Dr Kelechi Nnoaham	Cyfarwyddwr Iechyd y Cyhoedd, Bwrdd Iechyd Lleol Cwm Taf Director of Public Health, Cwm Taf University Health Board
Dr Gillian Richardson	Cyfarwyddwr Gweithredol Iechyd y Cyhoedd, Bwrdd Iechyd Lleol Aneurin Bevan Executive Director of Public Health, Aneurin Bevan

	Local Health Board
Dr Quentin Sandifer	Cyfarwyddwr Gweithredol Gwasanaethau Iechyd y Cyhoedd a Chyfarwyddwr Meddygol Executive Director Public Health Services and Medical Director

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 09:30.
The meeting began at 09:30.

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

[1] **Dai Lloyd:** Croeso, bawb, i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. O dan eitem 1, croeso arbennig i'm cyd-Aelodau. Mae gyda fi ymddiheuriadau oddi wrth Julie Morgan. Mi fydd hi'n hwyr oherwydd cyfarfod arall ac nid oes yna ddirprwy. A oes unrhyw ddatgan buddiant penodol? Nac oes, nid wyf i'n credu. Felly, a allaf i egluro bod, fel rydych chi wedi darganfod eisoes, y cyfarfod yma'n ddwyieithog a gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar

Dai Lloyd: Welcome, everyone, to the latest meeting of the Health, Social Care and Sport Committee here in the Assembly. Under item 1, a special welcome to my fellow Members. I have apologies from Julie Morgan. She will be late because she is at another meeting, and there is no substitute. Any declarations of interest? No, okay. Can I then please explain that, as you have already found out, this meeting is bilingual and you can use headphones to hear translation on channel 1, or the amplification is available on channel 2? Can I please remind you to switch

sianel 1 neu i glywed 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—gan gynnwys y Cadeirydd—sy'n gallu ymyrryd â'r offer darlledu? A allaf i hefyd hysbysu pobl nad ydym ni'n disgwyl tân y bore yma, felly os oes yna larwm yn swnio, dylid dilyn cyfarwyddiadau'r tywyswyr i adael yr adeilad mewn modd trefnus?

off your mobile phones and any other electronic equipment—including myself—that can interfere with the broadcasting equipment? Can I also let you know that we are not expecting a fire this morning, so if you do hear an alarm, can you please follow the directions of the ushers to leave the building in an orderly fashion?

09:31

Bil Iechyd y Cyhoedd (Cymru): Cyfnod 1, Sesiwn Dystiolaeth 2—Iechyd Cyhoeddus Cymru
Public Health (Wales) Bill—Stage 1, Evidence Session 2—Public Health Wales

[2] **Dai Lloyd:** Felly, gan symud ymlaen i eitem 2, Bil Iechyd y Cyhoedd (Cymru), y cyfnod yma yw Cyfnod 1 a sesiwn dystiolaeth. Rydym ni wedi cael sesiwn dystiolaeth ar y Bil Iechyd y Cyhoedd (Cymru) yma eisoes wythnos diwethaf. Dyma'r ail un ac i'r perwyl yna hoffwn groesawu, fel tystion am yr adran gyntaf y bore yma, Dr Quentin Sandifer, cyfarwyddwr gweithredol gwasanaethau iechyd y cyhoedd a chyfarwyddwr meddygol, yn ogystal â Dr Julie Bishop, cyfarwyddwr gwella iechyd ac ymgynghorydd iechyd y cyhoedd, a hefyd Dr Sumina Azam, ymgynghorydd iechyd y cyhoedd. Croeso i'r tri ohonoch chi. Yn dilyn ein trefn, mae gyda ni gwestiynau ar wahanol adrannau o'r Bil yma, ac felly ein traddodiad ni ydy mynd yn syth i

Dai Lloyd: So, moving on to item 2, the Public Health (Wales) Bill, this is the stage where we are taking evidence, Stage 1. We had one evidence session on the Public Health (Wales) Bill last week. This is the second session we will be holding, and I would like to welcome as witnesses for this first section of this morning's meeting, Dr Quentin Sandifer, executive director of public health services and medical director; as well as Dr Julie Bishop, director of health improvement and consultant in public health, and also Dr Sumina Azam, a consultant in public health. Welcome to the three of you. Following our usual procedure, we do have questions on different sections of the Bill for you, and what we would like to do is to go straight into

mewn i gwestiynu. Nid oes yn rhaid ichi deimlo bod yn rhaid i'r tri ohonoch chi ateb bob cwestiwn neu mi fyddwn ni yma drwy'r dydd, achos, yn benodol, awr sydd gennym nes bydd y tystion eraill yn cyrraedd. Felly, gyda hynny o gyfarwyddyd, a gaf i ofyn i Rhun i ofyn y cwestiwn cyntaf?

questioning, if we may. You don't have to feel that the three of you have to respond to every question, or we'll be here all day, because, specifically, we do have an hour before the other witnesses are due to arrive. So, if we can begin then, can I ask Rhun to ask the first question?

[3] **Rhun ap Iorwerth**: Diolch yn fawr iawn, ac, o bosib, gwnaf i roi cyfle i'r tri ohonoch chi ddweud ychydig o eiriau ar y dechrau yn fan hyn, achos cwestiwn cyffredinol sydd gen i. Mae gwella iechyd y cyhoedd yng Nghymru yn her fawr ac felly mae cael Bil iechyd y cyhoedd yn gyfle mawr inni. Y cwestiwn, felly, ydy: a ydy'r Bil, fel y mae o ar hyn o bryd, yn gwneud yn fawr o'r cyfle yma i fynd i'r afael â blaenoriaethau o ran iechyd y cyhoedd ac a oes yna fwy y gallai o fod yn ei wneud? A oes yna gyfleon yn cael eu colli?

Rhun ap Iorwerth: Thank you very much, and I will give an opportunity to the three of you to say a few words here at the beginning, because I have a general question. Improving public health in Wales is a great challenge and, therefore, having a public health Bill is a great opportunity for us. The question, therefore, is: is the Bill, as it stands at the moment, maximising this opportunity to address public health priorities and could it do more? Are we missing opportunities?

[4] **Dr Sandifer**: Shall I kick off then, Chair? Thank you, bore da, and we're really pleased to be here. Very first off, we think this Bill is important. We hope it'll now pass and we see this as a once-in-a-lifetime opportunity to contribute to the improvement of health in Wales. Across the NHS in Wales, and witnesses following us, I'm sure, will reinforce this point, there's full support for the Bill.

[5] To come to your particular question, with reference to specific sections, then, yes, we think that the Bill could go further. I'd be happy, as I'm sure colleagues will, to expand on that, as and when we get to those parts of the Bill. But my first and overriding priority is to ensure that we now do pass this Bill and build on it over the years ahead to ensure that we maximise the opportunities, as you rightly point out, for the population of Wales.

[6] **Rhun ap Iorwerth:** Tease us a bit, if you would, about those areas that aren't covered. [*Laughter.*]

[7] **Dr Sandifer:** Well, I've been in front of this committee before with regard to this Bill, and I've sort of become the person associated with the special procedures and intimate piercing, not that I would wish that moniker necessarily to attach to me more broadly. [*Laughter.*] However—

[8] **Dai Lloyd:** One Assembly Member has already claimed that title. [*Laughter.*]

[9] **Dr Sandifer:** Oh, well, there we are, we're in good company. I thank you for that.

[10] So, I certainly think that, provided the Bill is crafted in such a way as to allow for additional procedures to be attached, and I'll happily talk about some of those, then I think that the general provisions set out for special procedures are fine, but we do have the Bruce Keogh report from three years ago and I feel there's a lot of unfinished business that the Bill could speak to in that regard. Then, for me personally, as my principal responsibilities are in health protection, I think there may be an opportunity to be a little more creative, for example, around environmental health risks and whether the Bill could speak to some of that. I know air pollution has come up in discussions but, you know, I think we could embrace some of that within the terms of the Bill as well.

[11] Rhun ap Iorwerth: Ac yn olaf gen i, mi awn ni i fwy o fanylion ar feysydd eraill, ond un darn o'r her i iechyd y cyhoedd sydd ddim yma ydy gordewdra ac ati ac ymarfer corff er mwyn iechyd. A ydy hynny'n rhywbeth yr ydych chi'n gresynu ynglŷn â'r ffaith nad yw yn y Bil yma?

Rhun ap Iorwerth: And finally from me, we'll have more detail on other areas, but one part of the public health challenge that isn't here is obesity and so forth and physical activity for health. Is that something that you regret in terms of it not being in the Bill?

[12] **Dr Bishop:** I think one of the things that I was thinking when you were asking your earlier question is that, actually, it's tempting to want to think about trying to put everything that impacts on the population's health into this one piece of legislation. But, actually, when you think about population health, it's the product of pretty much every other piece of legislation that the Assembly passes or, indeed, UK Government—particularly when we look

at obesity, physical activity and nutrition.

[13] In essence, most of the things that are going to make the biggest difference are covered by other aspects of legislation or other policy areas. So, for example, we've got the Active Travel (Wales) Act 2013—actually getting people to take active means to get to work and to school in their local community is one of the single biggest contributions that is going to have an impact on physical activity and, therefore, obesity. We need to make sure that that legislation is delivering the intentions that were there.

[14] Things like land use and planning are amongst the biggest impacts on physical activity in particular. In terms of food regulation, the kinds of measures that we would want to see around promotion of foods—perhaps fiscal measures, such as the sugar tax being extended, and standards around composition and labelling—most of those don't sit within the Assembly's legislative competence. So, actually, I'm not sure there are measures—whilst we would totally agree that obesity is probably the single growing public health challenge that we face, there probably aren't things that it's obvious that you would be able to include in this legislation that would actually tackle that.

[15] **Rhun ap Iorwerth**: That's very useful. Thank you.

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

[17] **Dawn Bowden**: Thank you. It's following on from that, really, because I know, when you gave evidence last time, you were talking about physical activity and the benefit of that, but largely that that sits outside of the NHS, but the NHS actually deals with the consequences of poor physical activity, et cetera, et cetera. But what I wanted to ask you specifically was whether you felt that the Bill provides greater opportunity now for partnership working to address some of these challenges that we've got to face.

[18] **Dr Bishop**: I think generally the Well-being of Future Generations (Wales) Act 2015 provides the framework for partnership working and, certainly, we would see that that mechanism, particularly at a local level through the public services boards, provides a very clear framework for addressing pretty much all of the population health challenges that we would see, and physical activity amongst them. Certainly, from our point of view as an organisation, there is already a great deal of partnership working in this arena. There's always room for improvement, and there's room for co-

ordinated action, but I wouldn't necessarily see that there's a need to put something specific in this Bill that would enable that to happen. I think we have the—

[19] **Dawn Bowden**: You think the framework is already there with the legislation.

[20] **Dr Bishop**: —framework already there. Absolutely.

[21] **Dawn Bowden**: So, following on from that, then, would that also be the same for delivering value for money in terms of achieving the outcomes that the Bill's seeking to achieve? We've got lots of organisations running various campaigns. We don't know how successful those are; we always have to monitor them. But, again, what are the opportunities for producing value-for-money outcomes from some of the provisions in the Bill?

[22] **Dr Bishop**: Certainly, I think one of the pieces of work that we have produced as an organisation this year is a report called 'Making a Difference', which very much focuses on the best buys, in value-for-money terms, for population health. So, we've already set out a range of measures that we feel are either already in place or certainly could be implemented within our current legislative powers, in most instances. So, we think that's quite clearly there. We would certainly agree—and I would certainly, from a personal point of view, agree—that where we are often weak isn't in our policy intentions or our legislation or our strategy. We actually do that really well in Wales. What we are weak on, typically, is actually following through on the implementation, and particularly the monitoring and evaluation.

[23] **Dawn Bowden**: Some of the evidence that we had—. I'm trying to think who it was that came in and gave us evidence and talked about the fact that we're very weak in promoting good practice. I can't remember who spoke to us about that, but, again, is that something you think we should be focusing on as well? I think other campaigns were mentioned, like the Choose Well campaign and other things, but promoting good practice and promoting the benefits is something—presumably, it's the responsibility of your organisation, is it?

[24] **Dr Bishop**: Absolutely, yes.

[25] **Dr Sandifer**: Our organisation and, indeed, all public bodies, I think, ought to, now, with the Well-being of Future Generations (Wales) Act. I think

that's the game changer, since we came and spoke to you about 15 months ago. We've got that umbrella legislation now for public service in Wales that can actually, as it's directly linked to the United Nations' sustainable development goals and goal 3, for health, give us a hugely powerful platform in Wales. It is now about us all stepping up to the challenge—all of us—to deliver against that.

[26] **Dawn Bowden**: Yes. Okay. Thank you, Chair.

[27] **Dai Lloyd**: Okay. Caroline, question 3.

[28] **Caroline Jones**: Diolch, Chair. I'm concerned with health inequalities in Wales. We have lots of socially deprived areas, and one in four children live in poverty in Wales. That brings its own, for example, lack of nutrients in a diet and so on. Therefore, the child is disadvantaged from an early age, really, regarding health. I wonder if you could explain to me how the Bill could contribute to reducing health inequalities in Wales and, indeed, how this could be measured—how this reduction of inequalities in health in Wales could be measured.

[29] **Dr Azam**: One of the first things that I'd like to raise is the health impact assessments. One of the key points of a health impact assessment is to consider the inequalities that our communities face. It's one of the things that is considered when a health impact assessment is carried out. What happens is that the impact on our communities, both positive and negative, and the distribution of those impacts, is considered in detail. So, it's a really good way of looking at how health inequalities can be impacted on at a local level. The recommendations from HIAs—health impact assessments—are also very much attuned to trying to mitigate those effects as well. So, that's one of the things in this Bill that could really help contribute to reducing health inequalities.

[30] I think there are several other things in the Bill that would also contribute, and I'm sure that my colleagues would be able to add, but pharmaceutical needs assessments are looking at population need and making sure that services are actually geared towards meeting needs, which is a key element of addressing health inequalities. I'm sure that my colleagues have other areas that they might want to pick up.

[31] **Dr Sandifer**: In terms of the special procedures, when we come to that discussion, it's often among the very disadvantaged, and in disadvantaged

communities, that some of the poorer practices that cause us concern are often found, and which we want to address with those. So, I think that also speaks very specifically as one intervention.

[32] **Dr Bishop:** Much of the content of the Bill is focused on tobacco. That is still the single underlying cause of health inequality. It's one of the biggest causes of the differences in outcomes we see between our most disadvantaged and our most affluent populations. So, it is very much in there, I think.

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

[34] **Dai Lloyd:** Turning to specific sections, we're talking next about smoke-free premises, and definitions and potential changes. Jayne.

[35] **Jayne Bryant:** Thank you, Chair. Public Health Wales suggests that the grounds of early years education settings and the perimeter areas of school grounds should also be included in the Bill as smoke-free premises. Can you provide any more information about that, or evidence to support that?

[36] **Dr Bishop:** I think we probably need to think about this in the context of where we're trying to go in addressing the impact that smoking has on population health. So, we've got a range of measures that are already in place. The existing smoke-free legislation was predominantly about protecting people from exposure to tobacco smoke. So, we've addressed that particular issue. But it was always recognised that there was a secondary goal, if you like, which was about creating an environment in which non-smoking was the norm. If we think about where we are now—we've made major progress and we've still got a smoking population, and we need to continue to do what we can to encourage those smokers to quit and help them reduce that harm. But we really have to build on the real gains that we've made in terms of turning off the tap, and the number of children and young people that become smokers. And we've seen that come down quite substantially; it's now only about 8 per cent of 15-year-olds who are now smoking weekly.

09:45

[37] One of the ways that we are going to help to do that, we believe, from the evidence that we've seen so far, is by making sure that smoking isn't seen to be a normal adult behaviour. So, that's why our focus is particularly

on places where children are present. We feel that we need to be much more focused on trying to remove smoking as something that's seen. So, early years settings are an obvious one because, obviously, they're a bit like schools. We feel that there's no place for smoking where very young children are and it can be seen by very young children.

[38] I think our feeling about the school grounds is—because the goal is predominantly about the norms, if you like, and presenting that smoke-free environment—that a parent or an adult smoking immediately outside the school gates is going to undermine the goal of not being able to smoke inside the school gates. So, we feel that introducing that perimeter, particularly around schools and early years settings, would actually help to realise the goal of the legislation more completely.

[39] **Jayne Bryant:** Thank you. There's a part about the public playgrounds. Do you have any concerns around the Bill's definition of public playgrounds? Because I think that it states,

[40] 'within five metres of any item of playground equipment.'

[41] So, do you have any concerns about that, or is there a better way to define it?

[42] **Dr Bishop:** I think that's something that's worth looking at because, I think, the conversation that we've just had, if you extend that to think about playgrounds and playing fields—areas that are particularly frequented by children—if we're narrowing that definition to literally to be 'play equipment', so, I presume by that we mean things like slides and swings and those kinds of things, that's actually quite a small area of what most of us would consider to be playgrounds in the broader sense. So, I think certainly we would encourage playing fields and sports grounds to be included, or to consider including those within that definition.

[43] **Dai Lloyd:** Okay. Caroline, question 8.

[44] **Caroline Jones:** Diolch. What benefits do you think will be seen from making the hospital grounds smoke free? With regard to the patients themselves, what sort of support will you be giving patients for smoking cessation?

[45] **Dr Bishop:** Certainly, I think this one is part of the same measures in

terms of creating a smoke-free norm, and we think that the NHS should be setting an example—it should be leading the way. I don't think any of us can disagree with that. We can't, on the one hand, be talking about the consequences of the behaviour for population health and, at the same time, letting it happen. So, I think we all recognise the rationale for that, and, certainly, all of our health boards have taken steps to try and introduce measures to prohibit smoking in their grounds, and they are challenged by the enforcement issue there. So, I think that the view is that the legislation proposed here will help them in that regard.

[46] Obviously, we want to make sure that patients, when they are in hospital, are supported to stop smoking, and most of our health boards have now introduced specific smoking-cessation support in their hospital services. And there are a range of—. We would absolutely say that, as part of pre-admission planning, and once somebody is admitted in an emergency, if they're a smoker, there are a number of nicotine-replacement products that can be available and can be prescribed by the health staff. That should become routine, basically.

[47] **Caroline Jones**: Yes, thank you.

[48] **Dai Lloyd**: Rhun.

[49] **Rhun ap Iorwerth**: One controversial smoking-cessation tool is, of course, vaping or e-cigarettes. You have at least one health board in Wales that has banned the use of e-cigarettes on their grounds. How does that tie in with using somebody's stay in hospital as an opportunity for them to stop smoking, when you're taking away possibly one tool?

[50] **Dr Bishop**: Compared to when we were last here, there has been more research done in terms of the role that e-cigarettes might play in smoking cessation, but the evidence isn't strong, so it's about as effective as some of the other over-the-counter measures that are available. So, I think our view there would be that there is always an alternative and that, when people are actually in hospital or visiting a hospital, there are other ways in which they can think about smoking cessation other than using e-cigarettes.

[51] **Rhun ap Iorwerth**: Is the Bill getting it right, though, in terms of suggesting that powers remain with the health boards themselves about how they deal with this issue? I'm concerned that a stay at hospital isn't always the best time for somebody, due to stress, be it somebody who's a patient

themselves or a family member. You mentioned that enforcement is difficult—yes, it is, because there are times when people are just going to ignore it. Maybe a time in hospital is one of those times when they say, 'I'm just going to go ahead anyway.' How could the Bill deal with that?

[52] **Dr Bishop**: I think the enforcement challenge across the board is a difficult one. I think there are similar issues around the playgrounds. I think that's an interesting one in terms of how that might actually be enforced realistically. But at the same time, I think, by setting it out in legislation, we send a very clear message that it's not something that we would expect to see.

[53] **Rhun ap Iorwerth**: But you're putting something in legislation that you don't expect to be adhered to. That's not a particularly effective way forward.

[54] **Dr Bishop**: I don't think we don't expect it to be adhered to, but we would expect health boards to do everything they can to promote the application of the legislation. But we would have to be sensitive and recognise there are certain circumstances where that might mean that there is infringement and that that would be dealt with in an appropriate way. But I think that's very different to saying there's a free-for-all and anybody can do what they like. I think that sending a very clear message that this is not something that we would normally expect to see is important.

[55] **Rhun ap Iorwerth**: Finally, wouldn't one way forward be to say that smoking visibly anywhere in hospital grounds is totally forbidden but, because of specific circumstances, there may be places that are well hidden away where people can smoke, for example?

[56] **Dr Bishop**: I think that's a conversation that—it would be worth asking the health boards, who I think are coming in next, because they are more familiar with the practicalities of that. All hospital grounds are very different. It's about whether or not, actually in practical terms, that would be beneficial compared to people actually leaving the site and whether that would make a material difference, whether people would actually use it. I'm not aware of any research, particularly, that's looked at that. So, it's a question, but it's probably not the first place that we would think to go.

[57] **Dai Lloyd**: Jayne.

[58] **Jayne Bryant**: Just to follow on from Rhun, really, the Bill states that

hospital managers can designate areas of the hospital where people can smoke. Do you think that should be a local decision or do you suggest that it needs a consistent approach across the board?

[59] **Dr Bishop**: I think each of our hospitals are different. They have different patient groups. You've got the issue of long-stay patients, long stays in mental health units—we recognise that there are particular challenges there. So, I think you have to think differently about the hospital population, the size of the grounds, and the nature of the site and what's reasonably possible. So, in practical terms, I think it probably does have to be a local decision, but we're sending a very clear message here in terms of what we would expect the norm to be.

[60] **Jayne Bryant**: Brilliant, thank you. And do you think there's a case for extending smoke-free requirements across other NHS premises?

[61] **Dr Bishop**: Yes, we would agree with that. We're not sure of the rationale for just including hospitals in this Bill. We think any premises that are predominantly used for healthcare should be included.

[62] **Jayne Bryant**: Okay. And just finally, what evidence is there to support extending this smoke-free legislation to additional outdoor areas, such as cafes and restaurants? And what evidence is there about the health impacts of second-hand smoking on those areas and the normalisation of smoking behaviours? You've mentioned about the school setting—similarly, for hospitals.

[63] **Dr Bishop**: As we said, there are two particular arguments. There's the normalisation conversation and I think we believe that, over time, we should be seeking to increasingly extend the—. As smoking becomes less common, we should be seeking to extend the areas in which smoking isn't permitted. So, places like beaches, national parks—you know, public places, particularly those that are used by children—sporting facilities. I think it's quite reasonable for us to be thinking about that.

[64] I think the issue about outdoor eating spaces is a particular one and it probably covers both of them in the sense that one of the impacts that we have seen of, obviously, the indoor regulations is that smokers now go outside to eat. In some countries, so Australia would be an example, they have extended their smoke-free legislation to include outdoor areas where meals are being served. I think there's probably an argument for thinking

about that, in particular in a Welsh context—although we don't have quite the same opportunities to eat outside as the Australians, I suspect [*Laughter.*]—because actually, if you think about outdoor tables in a pub or a restaurant, they're quite close together, so there probably would be a second-hand-smoke-exposure issue there that would be justified. The same would be said about the perimeter of buildings, which is the other area that we would suggest is looked at, so that the process of going in and out of buildings and smoking around the outside of the immediate perimeter of buildings is also looked at. So, those are things, particularly, that we think could be included, and also particularly places like pubs and cafes that are targeted at families. Now, that might not be this legislation—that could be part of the licensing regulations, for example. But if you think about some of the pubs that have got play areas for children, for example, that are clearly attracting families—if all of the smokers are sitting outside in the same place as the children are playing, then we've got a disconnect in our policies.

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

[66] **Dai Lloyd:** Diolch, Jayne. Symudwn ymlaen rŵan i'r materion ynglŷn â'r gofrestr o'r sawl sy'n gwerthu tybaco ac mae'r cwestiynau yma o dan law Caroline Jones.

Dai Lloyd: Thank you, Jayne. Moving on now to the register of the tobacco retailers and Caroline Jones is responsible for these questions.

[67] **Caroline Jones:** Diolch, Chair. Can you tell me how you think the creation of a retailer's register will help reduce, for example, illegal sales to children under the age of 18? Surely, with the heavy fines that are now imposed upon retailers who break this law, I would suspect that these retailers are very much in the minority, and would we be beating every retailer, with the creation of this register, with a big stick, penalising them for the good practice, which I'm sure would be about 98 per cent of all retailers who adopt good practice? Could you tell me if this is not penalising those instead of dealing with a minority of people who break the law?

[68] **Dr Bishop:** I think there are a couple of things there. One of them is it goes back to the things we've talked about already, about not seeing cigarettes and smoking as a normal activity. So, I think we've got a product that kills half of the people who use it and yet we treat it as almost any other product. We restrict who it can be sold to but we don't have any kind of controls on who can sell it. So, from our point of view, we think part of introducing the register is actually, if you like, formally recognising that this

isn't any other product.

[69] Secondly, I think form our point of view, we don't think there's any evidence to suggest that the infringement of the laws currently is a minority activity. I think that is actually one of our concerns—that enforcement is not perhaps sufficient currently to make sure that that is actually the case. We know form surveys of young people that they find it relatively easy, most of them, to buy tobacco. So, clearly, it's not as infrequent an event as we see. Certainly, trading standards officers do find that there's at least a 15 per cent infringement rate when they do surveys of test purchasing and, unfortunately, those have become less frequent in recent years. So, we think the whole idea of having a register would enable us to understand much more where tobacco is being sold. It would support enforcement colleagues in doing that and would send a very clear message that these are the things that need to be controlled in terms of the way that they're actually sold.

[70] **Caroline Jones**: Do you also take into account the acquisition of cigarettes from when parents buy abroad—so, therefore, you know, you can't really stipulate that it's coming from retailers?

[71] **Dr Bishop**: Well, the surveys ask them where they get them from, so we know that about 30 to 40 per cent of children and young people report that they buy their cigarettes in shops. The remainder do, as you correctly say, get them from family, friends and other sources. So, that is a very significant source, there's no question about that, but there is still a substantial amount through retail.

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

[73] **Dai Lloyd**: Jayne.

[74] **Jayne Bryant**: Just following on from Caroline's question, really, you mentioned that young people still can access tobacco products, but with the growing use of internet shopping that we know is happening, do you think the handling-tobacco-products part of the Bill will reduce the risk of children and young people accessing these products?

[75] **Dr Bishop**: I'm not an expert in how online shopping works in practice and the delivery mechanisms but it seems to us a reasonable measure to be looking at. I suspect is should be extended to other age-restricted products. I think we have a number of regulations about age-restricted products and

most of them are about health and safety grounds and we probably need to make sure that they're all covered by similar kinds of measures in terms of the growth of delivery-based, online and other shopping.

[76] **Jayne Bryant:** Thank you, Chair.

[77] **Dai Lloyd:** Ocê. Diolch, Jayne. Symudwn ymlaen nawr i faterion ynglŷn â thriniaethau arbenigol fel aciwbigo a thatŵio, ac mae Angela yn mynd i serennu.

Dai Lloyd: Okay. Moving on now to special procedures such as acupuncture and tattooing, and Angela is going to shine in this section.

10:00

[78] **Angela Burns:** Thank you very much for your evidence so far. I just wanted to have a talk to you about two particular areas. One is about whether we're covering enough of these additional procedures or special procedures, and, secondly, I wanted to talk about the age that we should be enabling people to go off and do these various things. Could you, first of all, very clearly let us know whether or not in your opinion we are identifying, on the face of the Bill, enough of the special procedures?

[79] **Dr Sandifer:** We think the Bill is a very good start. I think it would be really unhelpful if we didn't have provision such as is set out here and I think the key issue is: can we write the Bill in such a way that it provides for scope for us to extend the list of procedures, or indeed, where appropriate, remove procedures at a future date? I think that is the key issue. And I think that, together with requirements about standards, hygiene, infection control, environmental cleanliness, competence, training and so on, the Bill does provide a very strong foundation.

[80] **Angela Burns:** Thank you, although you didn't entirely answer my question in terms of whether you'd like to see other procedures on the face of the Bill. From a layman's point of view—

[81] **Dr Sandifer:** Yes, I would like to see other procedures. We're indicating here a range of other procedures. I think it goes back to the point that I was making earlier. If you go back to what Sir Bruce Keogh had to say in his report, things like dermal fillers are 'a crisis waiting to happen', and I quote from Sir Bruce himself. So, yes, we would like those. Whether it's necessary to actually identify everything because you have a very long Schedule, or

rather write the legislation in a way that that Schedule can be extended appropriately after the passage of the legislation, I would suggest the latter probably is a practical and more pragmatic way of moving forward.

[82] **Angela Burns:** I totally agree with you and I think that the legislation should be open to being able to add other things on to it as and when they become an issue. I think what we're really trying to ascertain is whether there's anything else that's at that point where it's almost becoming an issue. I understand that there is blood contamination from some of these procedures: tongue splitting, for example. That is surgery; that is somebody taking a knife to somebody else and actually incising them, with all of the inherent risks of that. So, I just wondered if there were one or two other things that you think right now, right this minute, should be added to the list, whilst still leaving the legislation in such a place that other things can be added at a later date. So, that's what we're really trying to have a clear understanding of.

[83] **Dr Sandifer:** Okay. I think there are some things. As I say, dermal fillers might be one of those that one would want to add to that. We indicate a few others. I know that we've discussed around the table previously Botox, for example, and body modification—those sorts of things. I think what it comes down to at the end is: what is it we're trying to accomplish? We want, obviously, to protect the individuals from consequential harms. You've identified some, but not all of them: infection, bleeding, potential disfigurement and scarring—even the psychological impacts. So, all of those need to be taken into account.

[84] **Angela Burns:** And having identified areas that we want to really regulate and monitor and ensure that correct practice is being pursued, do you believe that there are enough resources within both public health and within the local authorities in order to be able to monitor the people who set up this kind of business? Because my understanding from some of the evidence is that we need more public health officers and more people who can actually ensure that somebody who sets up a parlour somewhere to offer one of these procedures actually has that competence. Do you think there are enough standards in place for us to be able to judge that competence? Would you be able to judge that person A is able to carry out a bit of body modification, whereas person B doesn't have those standards? Because I can't quite see where those standards are coming from: who's putting those standards in place? Perhaps you could just give us your view on that.

[85] **Dr Sandifer:** Okay. I think there's quite a lot in your question; it's in multiple parts. So, perhaps not immediately relevant to the business of this committee, I'd have to say that, as a public protection officer, I would fully endorse the view that we need to reinforce and strengthen public protection more generally, and I have a general concern that, historically, over the last 10 or 15 years, that has denuded. So, that's a general point, if you like, peripheral to the key point here.

[86] The view of the Wales Heads of Environmental Health Group is that the proposed licensing system, as set out in this legislation, will enable local authorities not only to carry out their duties, but is deliverable within their current resources. In terms of the standards, there are a number of bodies that can contribute to the drafting of those standards—they wouldn't necessarily just fall to local authorities—such as public health organisations, surgical colleges and other groups, and there's quite a lot of material out there. It's not as if we would be starting from scratch.

[87] Yes, there's a lot of work upfront, because, as I understand it, potentially up to 3,000 practitioners of various types are engaged in these activities that we'd want to bring into scope. So, there would be a lot of initial upfront work. That might need some additional upfront resourcing, but I think if you look at the longer-term economic argument—. I brought along the report—and you're meeting the director of public health from the relevant health board in a moment—of the look-back exercise from Newport, and that cost public bodies £240,000 to sort out, and that was just dealing with the look-back. There's also been a range of legal proceedings that have followed that as well. So, I think you need to look at it in the round, and, in that sense, if we can avoid that sort of expenditure placed on, principally, health and local authorities, and reapply it proportionately to the monitoring and evaluation of a scheme such as proposed here, which I think, as I've already said, is considered deliverable within our resources, then I think that must be a good thing.

[88] **Angela Burns:** That's great. So, my last point on understanding the enforcement element and the standards setting: if a cosmetic surgeon wished to do a dermal filler procedure on somebody, then that person is covered because they have to adhere to the standards set by, I suppose, the college of cosmetic surgeons, or the British Medical Council. But, if a beautician, who was perhaps in one of these multi-places where you go for all sorts of things, wanted to do it, then, at the moment, they don't fall under any standards. So, that's what we're looking to try to establish. Would that be

correct?

[89] **Dr Sandifer:** Putting it very crudely, I'm a medical practitioner. If I were to undertake some of these more extreme measures in a backstreet lock-up and made a complete mess of it, and I had no resuscitation, there's nobody around this table who wouldn't support the fact that I was referred to the General Medical Council. I don't see any reason why we should regard other people—. And, for that matter, if I could also say, on the issue of grandfather clausing, just because you've done it for 30 years doesn't mean to say you get a free pass. I think everyone should be held to the same standards, and judged accordingly and judged competent. I know this makes provision for healthcare professions, broadly, to be considered. I would even, myself, want to test that, because I think just because you might be, I don't know, a medical practitioner—. I've not practised medicine myself for 26 years; I've been in public health medical practice, and many procedures undertaken in primary care and minor surgical procedures I would not think myself competent to undertake those. So, I think we do need to apply consistent standards to everyone, proportionate and appropriate, and not necessarily set by particular bodies. There's an awful lot of material to draw on. It might be some of those you refer to and it might be others.

[90] **Angela Burns:** Thank you. That actually neatly brings me on to my second area of questions, which is about the age at which people might be able to have all these procedures. So, could you just explain to me, if I was 15 and I wanted to have one of these kinds of procedures, and I'd gone to a cosmetic surgeon—so a professional regulated by the British Medical Association—would that person be able to operate on me, and would that person—? Are there already in existence professional standards for surgeons as to whether or not they would undertake that? Because what I'm trying to establish is at what level we can say to the general public, 'You are too young to be considering undertaking this' for a variety of reasons, but particularly protection of that minor and protection of the individual who is performing that procedure?

[91] **Dr Sandifer:** I think the Bill has set out a very sensible proposal. That is, 16 is an appropriate age at which people are presumed competent to make such decisions for themselves. I go back to the situation in the Newport area. Actually, we had a large number of younger children who, because they perhaps were able to present themselves as looking older, or they simply lied, or the practitioner wasn't bothered to make sufficient enquiries about their age—. It would be of considerable concern to me, I

have to say, that a 15-year-old could go to almost any practitioner to have some of these intimate piercings undertaken. I think that what is proposed, based on laws around the age of consent and around rights, is appropriate, as set out here. I think we just ought to simply regard 16 as an appropriate age. There's a debate, perhaps, about 16 versus 18, and I think that's an open debate, and no doubt you might want to pick up on that, so I've given you the segue, if you wish, but I think that is a legitimate discussion. But I think 16 is a reasonable lower cut-off.

[92] **Angela Burns:** Yes. I would accept that. I just want to ensure that, in your view, the Bill covers enough of the additional procedures that people may choose to have, because you might argue that lip piercing is not in an intimate area. So, should we just be saying that it's 16 and that's it and, until you're 16—I guess apart from having your ears pierced—you don't really go down this route at all?

[93] **Dr Sandifer:** Again, at the last attendance, it was drawn to my attention that, in some cultures, ears are pierced at a young age.

[94] **Angela Burns:** They are, yes.

[95] **Dr Sandifer:** We did look into that. We acknowledge that that is an area that if, for example, undertaken by parents who are undertaking it in a responsible way with people who set themselves up with proper standards and everything, is not an unreasonable thing to do. Lip piercing: debatable; I think you could say it is intimate. What would be more of a concern to me is it certainly could have complications—infection, particularly bleeding, and, potentially, depending on what sort of piercing device is used, it could cause some disfigurement in a very prominent part of the face. And I think there are a number of others. So, my general premise is: yes, we could extend this, and although I've mentioned a couple of things, like dermal fillers, Botox, and a whole range of others, they could all be included quite reasonably in an extended Schedule.

[96] **Angela Burns:** Thank you. I think the only other comment I would wish to make is that I do think this is a very difficult line to walk, because I think we need to accept that, particularly for young people today, their body is part of their canvas of life, and young people in particular, but it's not just exclusive obviously to young people, do have a view that it's their body and it's part of their artistic expression of themselves—you know, in whatever way. And, of course, people are getting more mature younger, and you'll

have some very switched-on 14, 15 and 16-year-olds who are going down particular paths who feel that this is part and parcel of their right—their human right—to be able to do with their body what they wish. I think we see it with tattoos, don't we, the prevalence of tattoos now.

10:15

[97] **Dr Sandifer**: But I think the legislation, if written appropriately, should be able to take account over time of changes in societal and cultural norms, fashions, and so on. But at the heart of it has to be a single, consistent set of objectives about ensuring consistent, safe practice that reduces the risks of infection, of bleeding and of other physical and psychological consequences. As long as those are kept as the central premise of the considerations, then I think that over time we can take account of these changes that you rightly describe.

[98] **Angela Burns**: Thank you.

[99] **Dai Lloyd**: Okay. The clock is going to put a bit of a kibosh on further artistic licence amongst Members. So, moving on to health impact assessments, Rhun.

[100] **Rhun ap Iorwerth**: Perhaps we can cover that quite quickly, actually, because you've already mentioned it. Do you think the Bill, as introduced, will ensure a proportionate and consistent approach to the requirement for health impact assessments and how they are to be carried out?

[101] **Dr Azam**: I do. I think that the whole thing about health impact assessments is that they are designed to be very flexible and be proportionate. So, some health impact assessments could be done very quickly, with minimal resources, and some are much larger, and require a lot more resources and a lot more time. What this Bill does is it provides a consistent approach and a clear approach to where health impact assessments can add value. At the moment, Welsh Government mandates health impact assessments in some key areas such as opencast mining and, say, NHS infrastructure business cases. There are also examples of good practice where a HIA is recommended, but our experience is that it is patchy—HIAs, 12 years ago, there were a handful undertaken, and now we're aware of about 20 to 30 a year, so it has increased. We're very supportive of this, and we see our role as very much supporting other organisations in trying to undertake high-quality health impact assessments.

[102] **Rhun ap Iorwerth:** Is there an issue in terms of a need to develop capacity and develop the skills in order to be able to fulfil what the Bill requires?

[103] **Dr Azam:** There is already some capacity out there in that there has been ongoing training over the last 10-odd years by both the health impact assessment support unit as well as the Chartered Institute of Environmental Health, who provide training courses. However, there is still ongoing need for training and capacity building, and I believe that's been factored into the Bill. From what I've seen in the regulatory impact assessment, they mentioned that there would be training in years 1 and 5, I think, although we would think that the requirement would be perhaps more than that.

[104] **Rhun ap Iorwerth:** Okay. I'm happy with that.

[105] **Dai Lloyd:** Reit. Symud ymlaen i wasanaethau fferyllol, ac mae gan Dawn y cwestiynau nesaf.

Dai Lloyd: Right. Moving on then to pharmaceutical services, and Dawn has the next questions.

[106] **Dawn Bowden:** Thank you, Chair. I think, when you gave evidence before, you talked about the cost benefits of community pharmacy services, but I wanted to ask you in particular about the resource impact on health boards of implementing the Bill's requirements in two areas: one, undertaking pharmaceutical needs assessments, which we did touch on very briefly earlier on, and expanding the service provision. So, I just wonder whether you felt that the regulatory impact assessments provide an accurate assessment of the costs of that.

[107] **Dr Azam:** My initial reaction—[*Inaudible.*]—the regulatory impact assessments, and I do think that colleagues from health boards, who are coming up next, would be far better placed to answer that.

[108] **Dawn Bowden:** That's fair enough. I suppose there would be an impact on Public Health Wales in terms of promoting the role of community pharmacists. So, what would you see would be the particular impact on your organisation, then?

[109] **Dr Azam:** Having talked to colleagues in pharmaceutical public health, they very much support this Bill, and they have factored it in, and they see it as part of their business to support this.

[110] **Dawn Bowden**: Okay. So, they're not necessarily concerned. So, are you confident that what we see in the Bill would encourage both the commissioning and delivery of additional pharmacy services or, again, is that something you think is better directed to the health boards rather than yourselves?

[111] **Dr Azam**: I think the health boards would be able to provide a fuller answer, but, in principle, that is the clear aim of this proposal.

[112] **Dawn Bowden**: Going back to Rhun's question about health impact assessments, this really would all be part of the integration of assessments. So, we wouldn't do a community pharmacy needs assessment in isolation; that would be part of the wider—yes?

[113] **Dr Azam**: It should be part of wider planning within the health board.

[114] **Dawn Bowden**: Okay. The other question, I suppose, from your perspective, is one that I did touch on earlier with you, about your role in promoting this and promoting the provision of community pharmacy services.

[115] **Dr Bishop**: I think that, as Sumina said, our team are already actively involved in supporting health boards, undertaking the needs assessment, and working very closely with Government colleagues and the profession in terms of looking at ways of extending and testing new ways of using pharmacies. So, I think we would see us as having a role in supporting that through our primary and community care hub and development areas.

[116] **Dawn Bowden**: That's fine. Thank you, Chair.

[117] **Dai Lloyd**: Diolch yn fawr, Dawn. I'r adran olaf nawr, achos mae'r amser yn brin. Rydym ni'n sôn am doiledau cyhoeddus ac mae Caroline yn arwain.

Dai Lloyd: Thank you, Dawn. On to the final section now, as time is short. We're looking at the provision of public toilets. Caroline.

[118] **Caroline Jones**: Diolch, Chair. The Bill does not make a specific reference to disabled people regarding the use of public facilities, and I would like to know: how will local authorities adopt a robust attitude when considering making facilities available and will the community and public

needs be assessed? Obviously, there are some people in society who totally depend, when running their daily life, as to whether there is a public facility available in the area that they want to go to, perhaps to do their shopping in the community. So, for some people it is a lifeline as to whether these facilities are available within the community that is near them to enable them to carry out their daily duties. How can we measure the needs for the area and how can we assure that there'll be adequate provision, taking into consideration everybody's needs?

[119] **Dr Sandifer:** We acknowledge that this is an important public issue and we, at previous times, have been asked similar questions. We're not actually sure that we are the best placed, in many respects, to answer the points that you make, and we will respectfully suggest that many of the questions that you've put to us might be better directed at other bodies, particularly at local authorities. As a general premise, I think there is very clear legislation and guidance in respect of disability and, indeed, other characteristics of the population, and I would imagine that those will be given due consideration.

[120] **Dr Bishop:** I think the only thing that I would add is that the work that we do to support local authorities and others in things like well-being assessments under the social care and well-being Bill would help provide the data around the needs of the population and would help local authorities to do that.

[121] **Caroline Jones:** So they can make the correct decision then. Thank you very much.

[122] **Dr Azam:** The only other thing I was just thinking is that, in the Bill, it does make provision to consult with communities, and that's a really valuable way of finding out what people are really needing and what their concerns and issues are in terms of identifying need.

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

[124] **Dai Lloyd:** Diolch yn fawr. Gyda hynny o gwestiynu, gallaf ddatgan bod y sesiwn gwestiynu yma ar ben. A allaf i ddiolch yn fawr iawn i'r tystion, Dr Quentin Sandifer, Dr Julie Bishop a Dr Sumina Azam am eu presenoldeb y bore yma a hefyd am **Dai Lloyd:** Thank you very much. This session has now come to an end. Thank you very much to the witnesses, Dr Quentin Sandifer, Dr Julie Bishop and Dr Sumina Azam for being present today and also for the evidence that you've given. There will

eu tystiolaeth? Gallaf gyhoeddi yn bellach y bydd trawsgrifiad o'r cyfarfod yma'n cael ei ddanfon atoch chi er mwyn ichi gadarnhau ei fod o'n ffeithiol gywir. Gyda chymaint â hynny o ddiolchiadau, felly, gallaf ddatgan bod y rhan yma o'r cyfarfod ar ben. Cawn egwyl nawr am 10 munud. Diolch yn fawr.

be a transcript of the meeting available, and it will be sent to you so you can check it for accuracy. Thank you very much. This part of the meeting is now closed. We will now take a break for 10 minutes. Thank you.

Gohiriwyd y cyfarfod rhwng 10:24 a 10:36.
The meeting adjourned between 10:24 and 10:36.

Bil Iechyd y Cyhoedd (Cymru): Cyfnod 1, Sesiwn Dystiolaeth 3—Cyfarwyddwyr Iechyd y Cyhoedd y Byrddau Iechyd Lleol
Public Health (Wales) Bill: Stage 1, Evidence Session 3—Local Health Boards' Directors of Public Health

[125] **Dai Lloyd**: A allaf groesawu pawb yn ôl—ein cyd-Aelodau ac, wrth gwrs, ein tystion newydd ni—i'r sesiwn yma o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad? Rydym yn symud ymlaen i eitem 3, rŵan, craffu ar Fil Iechyd y Cyhoedd (Cymru), Cyfnod 1. Rydym wedi cael sesiynau tystiolaeth eisoes, ac rydym yn cario ymlaen, felly, efo'r tystion diweddaraf.

Dai Lloyd: Can I welcome you all back—my fellow Members and also our new witnesses—to this session of the Health, Social Care and Sport Committee in the Assembly? We are moving on to item 3 and scrutinising the Public Health (Wales) Bill in Stage 1. We have held evidence sessions already, and we are moving on now to our latest set of witnesses.

[126] Felly, a allaf groesawu i'r bwrdd Dr Gillian Richardson, cyfarwyddwr gweithredol iechyd y cyhoedd, bwrdd iechyd prifysgol Aneurin Bevan? Bore da i chi. Hefyd, Dr Kelechi Nnoaham, cyfarwyddwr iechyd y cyhoedd, bwrdd iechyd prifysgol Cwm Taf—croeso a bore da i chi gyd. Mi fyddwch chi wedi gweld sut mae'r dystiolaeth yn cael ei

May I please welcome Dr Gillian Richards, executive director of public health, Aneurin Bevan university health board? Good morning. Also, Dr Kelechi Nnoaham, director of public health, Cwm Taf university health board—welcome and good morning to you both. You will have seen how the evidence works here and how we run the meeting, I'm

harddel fan hyn, a sut rydym yn rhedeg y cyfarfod, rwy'n siŵr, felly, heb ragor o ragymadrodd, awn yn syth i mewn i gwestiynau, ac mae'r cwestiwn cyntaf gan Rhun.

sure, so, with no further ado, can we go straight into questions, please? The first one is from Rhun.

[127] **Rhun ap Iorwerth:** Bore da iawn ichi, a diolch am ddod atom ni y bore yma. Mae iechyd y cyhoedd yn her fawr, ac felly mae cael Bil iechyd y cyhoedd yn gyfle mawr i fynd i'r afael â rhai o'r problemau rydym ni'n eu hwynebu. Cwestiwn cyffredinol, felly, i ddechrau: a ydy'r Bil, fel y mae o, yn gwneud yn fawr o'r cyfle yma? A ydy o'n delio efo'r blaenoriaethau sydd gennym ni o ran yr her iechyd y cyhoedd? A oes yna bethau sy'n cael eu colli yn y Bil yma, er enghraifft gordewdra a gweithgaredd corfforol?

Rhun ap Iorwerth: A very good morning to you, and thank you for coming here this morning. Public health is a great challenge and therefore, having a public health Bill is a great opportunity to address some of the problems that we face. A general question to begin with, therefore: does the Bill, as it stands, make the most of this opportunity? Does it deal with the priorities that we have in terms of the public health challenge? Is there anything that's missed in this Bill, for example obesity and physical activity?

[128] **Dr Richardson:** Bore da, diolch yn fawr. I think that the Bill is an excellent start, and I think that it's difficult to encompass all the areas that could possibly affect the public health of the residents of Wales in one Act. But, I think that, combined with the future generations Act and the social services and well-being Act, actually, the three together will cover pretty much most of the issues that we need. I think there are aspects, perhaps, of the Bill that could be expanded, and we've talked about the special procedures and you've heard from Quentin about that. We've heard about going further on some of the issues in the Bill, but I think there are other aspects that, perhaps, we'd like to highlight—although it may not be in the gift of this Bill to grant—but that we would need to interface on, perhaps. Some of those would be, obviously, the minimum unit pricing for alcohol, and we understand that the Scottish case is going through challenge at the moment in European courts. So, we await that with interest. Also, perhaps the expansion of licensing objectives for granting of licences for alcohol. Public health is an objective, we understand, in the Scottish legislation. It would be good to see that, but I think that needs to be co-ordinated with England as well. The graduated driving licence is something that—although we don't have the powers—I think we should be lobbying for. We're seeing

far too many young people die on our roads; especially young men just immediately following passing their driving test—in the couple of years following—which is a preventable tragedy if we had graduated driving licences.

[129] Then, lastly, I think that there are some issues relating to gambling licensing that we could maybe look at, which would disproportionately benefit those that are living in socioeconomically deprived areas. So, one thing that's of great concern to us is the rise in online gambling; the rise in gambling when people are under the influence of alcohol; and, certainly in areas of deprivation, socioeconomically, having fixed odds betting terminals, which are the crack cocaine, if you like, of the gambling industry where people can, basically, lose the family home in a very short space of time. There are no safeguards with respect to using them, there are no checks that people are not intoxicated, and there are no checks on means before they use them. These are like slot machines in the corner of our gambling shops.

[130] **Rhun ap Iorwerth**: Do you think that a public health Bill, even, could be expanded to include some of those areas?

[131] **Dr Richardson**: Honestly, I'm not sure of all of the licensing objectives and the licensing Act, and how these things would dovetail. I do believe that there are some issues that may not be able to be covered by this particular Act, but we could maybe look at either lobbying or expanding those other Acts to help cover.

[132] **Rhun ap Iorwerth**: And on obesity and physical activity, is a trick being missed?

[133] **Dr Richardson**: I think the food labelling is very important, and that's already being dealt with. I think on some of the other issues, like the sugar tax, decisions have been taken. Physical activity is difficult to legislate for, but perhaps we could ask that local authorities ensure that people with low means can access leisure facilities. Because, we know that if you cannot afford to enter a leisure centre, at certain parts of the year, it's difficult to access green open spaces and our beautiful countryside for a lot of people if the weather is severe. So, particularly for people with chronic conditions, and people on low income, I do think that leisure centre access at a subsidised rate should be, perhaps, looked at.

[134] **Rhun ap Iorwerth**: Thank you. And if I could have your thoughts on

what might be missing from this Bill, in an ideal world.

[135] **Dr Nnoaham**: Bore da. Diolch yn fawr iawn. I think, generally, this is very much a welcome opportunity. I think the Bill itself is a great opportunity and, set alongside the well-being of future generations Act, I think it presents a wonderful opportunity for us to place population health very much at the centre of wider policy, and gives us a wonderful chance, if you like, to continually improve the health and well-being of the Welsh population. So, I personally very much welcome the public health Bill and some of the aspirations that it sets out very clearly.

[136] I'm not going to repeat the areas that Gill has already talked about. I think we're in complete agreement that there are other opportunities that we might be able to explore, not necessarily directly through the agency of this Bill. Some of it would be through the agency of the public health Bill, but clearly, other opportunities like the addition of public health as a fifth licensing objective around alcohol—some of that may be something that is done through lobbying rather than necessarily legislation that is enacted in this Assembly. I think the Bill is a wonderful opportunity, set alongside other legislation like the well-being of future generations Act

10:45

[137] Perhaps, as we go along, we might be able to explore not just the enacting of the legislation but some of the other consequences, like resourcing and implementation, because ultimately that is what gives real meaning to legislation. But generally, we really do welcome this. There are other areas, but those have already been explored, so I won't repeat them.

[138] **Rhun ap Iorwerth**: It's about using the opportunity. Smoking is seen clearly as one of our big public health challenges, and that's addressed in the Bill. Obesity is the other big health challenge. It's not addressed in the Bill. Is that odd?

[139] **Dr Nnoaham**: My feeling would be, first of all, to recognise what is right about the Bill. If we talk about the inequalities in life expectancy and inequalities in health outcomes between one part of our population and another, smoking very easily drives more than 50 per cent of those inequalities. Alcohol misuse is a big driver. Obesity is another big driver. So, I think it is, first of all, right that the public health Bill, as proposed, gets it right, in my view, on smoking. So, that's really positive. Am I terribly worried

that we haven't given, in the Bill, an equivalent focus on obesity and physical activity? Personally, I'm not that worried. The only reason I'm not that worried is that I still think, in terms of maximising the existing opportunities outside of the legislation and outside of the Bill, to get a better handle on opportunities around obesity and physical activity, I'm not sure, as a country, we have necessarily maximised those opportunities. So, outside of the Bill, I still think there are huge opportunities to get greater physical activity in the country, to get diet and nutrition better outside of the agency of the Bill. So, that might be the only reason I'm not as worried, but I do recognise that there may be other views around this.

[140] **Rhun ap Iorwerth**: That's very clear.

[141] **Dai Lloyd**: Ocê. Symudwn ymlaen. Mae'r cwestiwn nesaf gan Dawn. **Dai Lloyd**: Okay. Moving on to the next question from Dawn.

Dawn.

[142] **Dawn Bowden**: Thank you. I think you have answered part of what I was going to ask you in your response to Rhun's question. We did have Public Health Wales and the health boards to give evidence on the Bill last year, actually. In that, on the questions of physical activity, it was recognised that the NHS actually has a very limited role around physical activity, but you have to deal with the consequences of lack of physical activity. I think when the health boards were here last time, they were talking about some of the things you've already touched on—the sugar tax and so on—but things that were really the responsibility of the UK Government. What I think the health boards were focusing on were some of the kind of partnership arrangements. Again, I think you started to talk about this in terms of looking at things you could be doing with local authorities. Could you perhaps just expand a little bit more on what you think some of those partnership arrangements could look like to deal with some of the public health consequences and outcomes that we need to address?

[143] **Dr Richardson**: We work closely with our colleagues in local authority and with contracted-out leisure services, and we work closely with education. I think the public service boards provide a really excellent vehicle for us to prioritise wellbeing objectives together on a regional footprint. We have got some examples of where people have worked very closely together on issues. That might be on a citywide region, on healthy cities such as Cardiff and Swansea. That might be on a regional level. We have a programme in the Heads of the Valleys at the moment, looking at increasing physical activity

levels in women—young women—and that straddles several of the local authorities on the Heads of the Valleys. I think that, together with Sport Wales, which is doing an awful lot in the non-elite sports area, and with Natural Resources Wales, which is doing a lot to try and enhance accessibility to their green spaces, to have strategies for physical activity on a regional footprint would be something that would be welcomed. Certainly, I'm sure it will be prioritised by many PSBs.

[144] **Dawn Bowden**: Okay. You see that as the vehicle, really, to do that.

[145] **Dr Richardson**: I think so, yes.

[146] **Dawn Bowden**: Okay. The other thing, if I can just briefly follow up on, then: if we're looking at, when we're delivering better outcomes and value for money in the outcomes, whether we need to be doing more to promote the best practices where things are working well—. You've seen some of the big public health campaigns around—things like Choose Well—some are well publicised, some seem to have more resonance than others. What do you see as the role of the health boards in that in promoting some of those public health campaigns?

[147] **Dr Nnoaham**: I think the health boards are very much like every other public sector body. I don't just think it is the role of health boards in isolation. I think there is a responsibility for every public sector body to play an active role in promotion of best practice, adoption of best practice, and I'm very conscious that there are perspectives about how well as a country we have performed in terms of embedding and mainstreaming best practice when it's been demonstrated by isolated projects. I do get the sense that we have some way to go on that. I do think, however, that there is a need to understand better what the limitations are around the adoption of best practice. Why is it that we do things that seem to work? We monitor, we evaluate, we produce compelling results and we classify them as best practice, yet we have challenges in terms of upscaling them and mainstreaming them. I do not personally understand all of the factors that are at work there, but I think, perhaps, that's the first thing we need to do. Why is the adoption of best practice not as quick as it ought to be, especially when it's been proven to work? It might, in fact, be that there are some areas where we have not necessarily done very well in terms of gleaning very rigorous monitoring and evaluation from the start of a project, and we tend to do it more retrospectively. I'm not necessarily sure that that would be applicable right across the board and I still think that there is some learning

for us to do as a country in terms of understanding the determinants of the mainstreaming of best practice.

[148] **Dawn Bowden:** Absolutely. Yes.

[149] **Dai Lloyd:** Gill.

[150] **Dr Richardson:** Just to add, I think that we do have some examples of where best practice has been rolled out very successfully. One of those would be the stroke pathway implementation, where we now know, through the metrics, as Kelechi said, and the data, that we can measure who has had their CT scan within a certain number of hours, who has seen the speech and language therapist for a swallowing assessment, and all those things are very important for the patient's recovery. We really are leading the way in the UK on stroke care, I believe. Another example is Wales would be the Living Well, Living Longer and the Cwm Calon projects from my own and Kelechi's health board, which look at cardiovascular assessment for those in deprived areas with high mortality from stroke, heart disease and diabetes. We've been able to look at cascading that learning throughout Wales thanks to funding from the heart disease delivery group, stroke delivery group and diabetes delivery groups together. I think sometimes it's that funding is given for a pilot but then there is no funding for the cascade, and that cascade is not something that can happen with no resource, because, obviously, you have to enable those that have done it to go and teach others whilst maintaining what they're doing. So, for that particular programme, I think it's been £300,000 that's been given by those three—heart disease, stroke and diabetes—delivery groups.

[151] **Dawn Bowden:** Because the objective in terms of delivering best practice outcomes is that, ultimately, that does save money, doesn't it?

[152] **Dr Richardson:** Absolutely.

[153] **Dawn Bowden:** So, what you're saying is investment upfront in developing some of those best practices and rolling that out would deliver value for money in the longer term.

[154] **Dr Richardson:** It would. It needs a little bit of pump-priming at the front end, that's all.

[155] **Dawn Bowden:** Thank you, Chair.

[156] **Dai Lloyd:** Caroline, cwestiwn tri. **Dai Lloyd:** Caroline, question three.

[157] **Caroline Jones:** I'd like to talk about health inequalities in Wales. As you've mentioned previously, there are many socially deprived areas in Wales, and in my region alone, 28 per cent of families are living in poverty. This in itself obviously brings about inequality. Inequality in choosing the right type of food to eat when there's less disposable income available, and, obviously, taking the children out for recreational purposes is extremely limited—so therefore, the social, emotional and mental well-being of the child is obviously not being developed. I'd just like to ask you in what specific ways you think the Bill contributes to reducing health inequalities in Wales and how its impact in this area could be measured.

[158] **Dr Nnoaham:** I'm sure there'll be a number of ways, but if it's okay, I'd just like to start with the opportunity around the health impact assessments? So, if we think about health inequalities as an issue, if we look at the proximal factors that drive health inequalities, it's a host of systemic issues. So, we often talk about access to good-quality healthcare as being, at best, a 20 per cent determinant of the health of your population. So, things like jobs, things like education, employment, access to good-quality housing—. I think that the opportunity for us as, if you like, public sector bodies is to think about the potential impact on health inequalities of our programmes, our projects and our policies. It's a huge, huge step forward because it is possible and perhaps right to suggest—and I'm sure there is evidence to support that—that some of the health inequalities that we're currently dealing with are a product of some of the decisions around policies and problems of projects in other sectors that we may have made in time passed.

[159] So, I think the opportunity to go forward and say we actually want to think about the impact on health inequalities of any projects or programmes that we are about to put in place I think is a huge step forwards. Obviously, there will be questions about methodology, process and resourcing and I think it's important to put all of those factors in the mix of things. But I think that's one huge step forward in terms of tackling health inequalities.

[160] **Caroline Jones:** Whilst I understand the importance of the collation of statistical information, I'd like to know about what action would be taken then on those statistics.

[161] **Dr Nnoaham**: I can give a very specific example of something that is articulated in the Bill, around pharmaceutical needs assessments. To commission community pharmacy on the basis of statistics—in a sense, that's the basis of it. To say we understand the distribution of local needs in this area, on the basis of our understating of local needs, we will determine what community pharmacy needs we have. Now, that is a very practical example of when we're using statistics and numbers to make a decision on the needs of our population, and we already have—. Again, coming back to the well-being of future generations Act, and the public service bodies, the fact that we will be expected, as public sector bodies, to work together to understand the needs of our populations and, on the basis of the needs of our populations, across organisations and across the system, to then think about what services our populations need and how to organise and distribute those services—I think that's a very practical example of how this Bill takes us forward in terms of tackling health inequalities.

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

[163] **Dr Richardson**: And I think that, once a health impact assessment has been done, be it of a policy or be it of a large infrastructure programme, for instance, once the results of that are known, the development can be progressed with cognisance—that there are vulnerable people who perhaps have extra needs who need to be protected. I think at the moment we often don't know those things.

[164] **Caroline Jones**: And I'm concerned about these people, children in particular, slipping through the net.

[165] **Dr Richardson**: And we've had some excellent examples of HIAs. The St Mellons relief road in Cardiff looked at cognisance of the needs of the population and even the perceptions of the population, and they're involved in the design, so that air pollution did not affect residents detrimentally. I think that's probably a good exemplar.

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

[167] **Dai Lloyd**: Fe symudwn i fanylu ar wahanol adrannau o'r Bil rŵan. Fe fyddwn yn sôn yn gyntaf am lefydd—mangreoedd, mae'n debyg—di-fwg ac mae'r cwestiynau hyn o dan law **Dai Lloyd**: Moving to look at different sections of the Bill now. Can we look first at smoke-free zones? Lynne has these questions.

Lynne.

[168] **Lynne Neagle**: Thank you, Chair. My questions are on the smoke-free premises aspects of the Bill. Public Health Wales suggested that the Bill should go further in terms of including early years settings as well as playgrounds, and also the perimeters around schools being designated as smoke-free areas. Have you got a view on that?

[169] **Dr Richardson**: Yes, I do. I'm fully in agreement. We know that smoking during pregnancy, for instance, can contribute to low birth weight and many problems and we know that smoking around children can result in them becoming passive smokers themselves.

11:00

[170] So, it seems that denormalising the behaviour at the school gate is very important, but I think we have to do that in a sensitive way because, particularly in socioeconomically deprived areas, people are often using tobacco as a coping mechanism. So, I think, were we to introduce it, we would be looking for support from stop-smoking pharmacies and stop-smoking services in our own health boards and in the specialist Public Health Wales, just to offer people advice and support. So, I think, as with all these things, there needs to be a long enough lead-in time so that people feel supported and not blamed so that they can understand why they are being asked to change their behaviour and that it is actually in the best interests of their children.

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

[172] **Dr Nnoaham**: I'd add that I fully support that position. I think that if we think about, in some parts of the developed world, in the past 50 years, we have had a 72 per cent reduction in smoking prevalence—that is huge, but we still have a long way to go because, like we said, smoking still accounts for 50 per cent of the inequalities and life expectancy in parts of our population. For me, I think the strongest opportunity that we see articulated in this Bill around the smoke-free environments is the opportunity to denormalise smoking. I think that's what I see with what is being articulated in the Bill and we would fully support that position.

[173] **Lynne Neagle**: And what about the definition of public playgrounds, because Public Health Wales had some concerns about that? Do you share

those concerns?

[174] **Dr Richardson:** Yes. I think it shouldn't be based on the equipment, really, but based on the child. Where are the children playing? With the multi-use games areas, for instance, you probably wouldn't say—I mean, there are no swings or slides, but that's where children are congregating. And then sports fields that are particularly, you know, all-season sports fields where children often go in for organised games, it just behoves—. Most coaches and most people leading teams would not think of smoking, but, where there are parents watching, then I think it's also—. So, it probably needs to be a little bit less restrictive, that sentence about the playground.

[175] **Lynne Neagle:** Okay. Do you feel that the legislation goes far enough in terms of the areas that are going to be designated as smoke free, because other people have suggested that it could go further really than playgrounds and hospital grounds, that we could be looking at wider areas? Have you got a view on that?

[176] **Dr Nnoaham:** Yes. I'm consciously going to caveat my view, but, yes, I think there is an opportunity to go further because, again, I come back to what I said earlier about what I'm assuming that the principle of the Bill around this particular area should be—that of denormalising smoking and making the right choice the easier choice and making the less healthy choice the more difficult choice. Hopefully, that's what this is all about. If that is correct, then I think there's an opportunity to think about extending the premises stipulations in the Bill. As usual, the questions would always need to be balanced with: what is the potential implication of this in terms of enforcing this? I think it's always important, as I'm sure you do, to balance both things. But I do think that there's an opportunity to extend the premises stipulation here.

[177] **Lynne Neagle:** Are there any particular areas you would say should be brought in to the Bill, then, such as outdoor cafes or anything particular where you think we could have a big impact?

[178] **Dr Richardson:** I think it's difficult because, obviously, a lot of smokers have moved, for instance, say, from the restaurant and public house into the beer garden, but actually there are a lot of children in the beer garden or the outdoor dining space and there isn't a choice for families, now, who want to eat outside, but perhaps don't want their children exposed to second-hand smoke. So, we know that many premises haven't got the room to have both,

and I think it's a question of what do our citizens want, where is the public debate on this at the moment, and would that be a step too far. Obviously, as a public health physician, I am seeing the child, and the child's health as paramount, and the non-smoker's health. However, is the public ready to go down that route, and would our restaurants and publicans, and would our citizens actually accept that, and would we able to enforce it? So, I think that's something that, as a public health specialist, yes, I would advise, definitely. I would wish to see zones that are, just as we have alcohol-free zones, smoke-free zones.

[179] **Lynne Neagle:** Okay. Can I just ask one final question? Gill, you came in and gave evidence last time around with this Bill, and, at that time, the e-cigarette provisions were in the Bill. A lot of your comments, both of you this morning, have been around the dangers of normalisation. Do you think it's a mistake that there are now no provisions in this Bill to tackle e-cigarette use in areas where there are children?

[180] **Dr: Richardson** I am disappointed, but I understand that our citizens are on both sides of the debate. I think we do really need to push and lobby for restrictions on the packaging of e-cigarettes, because e-cigarettes are marketed very much to young people. There are glittery, diamond-encrusted vaping devices that have no place really for the adult world, but are very attractive to teenagers, and we are really concerned, and research is ongoing, about e-cigarettes being a gateway to smoking tobacco for teenagers. However, they have huge benefits for those that are smoking tobacco that cannot, or do not wish to, quit, because, obviously the effects on their cardiovascular health will be so much more beneficial. So, we need to make them available to those that need them, but stop the gateway, if you like, for people who would never think of smoking tobacco, because they see it as unclean, but would be quite happy to try a vaping device because it's seen as clean, and seen as licensed, and seen as of no nicotine quantity, which, unfortunately, thus far, it's not, although, obviously, manufacturing is moving in that direction. But, at the moment, we can't say that. So, I think plain packaging, and the same restrictions on advertising, so that young people are not attracted by a glamorisation if you like, are really things that we need to be cognisant of.

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

[182] **Dr Nnoaham:** I would add to that that electronic cigarettes are very interesting in the sense that there was a potential that they'd take us back in

terms of the journey on normalisation, or denormalisation, of smoking, but there is also the potential that they present benefits in terms of reducing the harms associated with tobacco use. And there is a huge amount of evidence, I'm aware, emerging around electronic cigarettes, and I think there is something—I suppose a collective responsibility we have to make sure that our current position reflects the evidence, but I think, as the evidence matures, we'll be in a position as a country to take a more confident position on electronic cigarettes.

[183] **Dai Lloyd**: Okay. Sorry, Caroline had a question on the same issues.

[184] **Caroline Jones**: Yes. I'd just like to ask about the ways in which you think the creation of a retailers register will strengthen the tobacco control agenda in Wales, and how you think it will contribute to the denormalisation of smoking, and, indeed, the underage issuing of tobacco products.

[185] **Dr Richardson**: I think that it will strengthen the efforts to stop the sales to underage children, and I think that trading standards have very much said that they would welcome this, because it will enable them to do their job in a much more efficient way. And, also, it provides safeguards to the retailer, so I think that that's a very positive aspect of the Bill that we would support. I think that perhaps it could be extended. The e-cigarette refills are often in candy flavours: bubble-gum, gummy bear and things like that. I think there are possibly some extensions even to that aspect.

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

[187] **Dai Lloyd**: Ocê. Mae'r cwestiynau nesaf gan Jayne.

Dai Lloyd: Okay. The next questions are from Jayne.

[188] **Jayne Bryant**: Thank you, Chair. With the growing use of online shopping, do you think that the handling tobacco part of the Bill could be strengthened to reduce the risk of children and young people accessing these products?

[189] **Dr Nnoaham**: I would say yes. Again, I think that just staying with that principle—. It feels like we are just saying this until we are blue in the face. But, just staying with that principle of denormalisation, I think the most evidenced contribution that that would make would be to denormalise tobacco use and perhaps limit the age at which children have their debut, if you like, of smoking. So, yes, I would strongly support that.

[190] **Dr Richardson:** Yes. It's difficult to enforce on the ordering, but, on the delivery, there could be a requirement to sign for. Then, obviously, people have to sign. That happens now anyway with some imported clothes and with alcohol and other things. But the online community is difficult. We are not going to be able to police that, and we are not going to be able to police the ordering. But, if people knew that there was a check on collection, for instance, with identification, then that would be a deterrent.

[191] **Jayne Bryant:** The written evidence that we have had suggests a need to look at all age-restricted sales, and I heard what you said, Dr Richardson, in your opening comments about gambling. Do you think there are any other types of products and issues that we could include that would pose a risk to public health?

[192] **Dr Richardson:** Yes. Lynne Neagle has campaigned on legal highs and the ease with which they can be obtained on the internet, and the dubious cocktail of what they represent. There aren't any quality standards. You can say that you are getting it for your house plants, but, actually, that is not what it's for. Unfortunately, we have had some very serious admissions of adolescents. Lynne asked us to look, actually, at the Royal Gwent Hospital and at how many incidents we'd had with legal highs. It was in the 50s for the particular six-month period that we looked at. So, it has consequences for the health board in terms of our resources, but also of course for the people who are trying to maintain good social behaviour and help people such as the police and licensees.

[193] **Dai Lloyd:** Okay. Before we leave tobacco, Rhun has got a question.

[194] **Rhun ap Iorwerth:** Yes, just specifically about restrictions on tobacco use on NHS premises. Being in a hospital either as a visitor or as a patient, it's not the easiest time for some people not to smoke. Are there ways that the Bill, do you think, could address this, in making sure that smoking was in no way visible on hospital grounds, but reflecting the reality that enforcement is very difficult currently in hospital grounds?

[195] **Dr Richardson:** I think that most health boards have a smoke-free policy now. I think that it is difficult to enforce, but many health boards have employed smoke-free wardens or senior managers, or it has become an extended role of some other members of staff—perhaps security. In my own health board we have smoke-free wardens, and they are trained in so much

as, when they approach an individual, their whole ethos has to be one of support. So, their first question will be, 'I'm sorry, did you know that it is not permitted to smoke on the grounds, but did you also know that you can obtain smoking cessation aids and advice through our services?' and then they'll have the conversation with them.

11:15

[196] We realise that it's a stressful time for many, having relatives in hospital, but we do feel that, as ambassadors for health, and with about one in four or one in five of our patients in that hospital being there because of a smoking-related disease, we do have to be really showing the way as an ambassador for that in all of our health premises.

[197] **Dr Nnoaham:** I was just going to add to that that, in Cwm Taf, we do have a very clear smoking policy that, if you could write empathy into a policy, it has it, recognising that there are patients who are in a very difficult position and sometimes smoking is a coping strategy, in some sense. Having recognised the inability or the difficulties that organisations would have around enforcing the smoke-free policy, my view would be that that does not represent a reason or rationale to step back from protecting these patients—recognising that they may be going through a very difficult patch in the process of care seeking, but, ultimately, smoking is going to harm them, but not only harm them—smoking is going to introduce, if I speak in the parlance of economics, other societal externalities that actually makes it a reasonable thing to do to enforce and to have very clear smoking policies even for patients who may be going through very difficult periods in hospital or other care facilities.

[198] **Dr Richardson:** So long as we give that supportive nicotine replacement so that they are not going to be having nicotine withdrawal at a time when they're extremely low and dependent, perhaps, emotionally. So, many of us have hospital pharmacists now who will check that smokers are being prescribed nicotine replacement therapy, and also, patients who know they're going into hospital, their GPs will work with them to say, 'Would you think about just giving up for a short time until after your operation? If you give up six weeks before your operation, you'll have a much speedier recovery, your lungs will recover better, you're not going to lose as much bone density—all sorts of healing benefits because of the oxygenation of your tissues. Will you think about giving up?' so that they can make sure that they're actually on their nicotine replacement as they come in.

[199] **Rhun ap Iorwerth:** Some boards—well, at least one board, has banned e-cigarettes, for example, which could be a very useful smoking cessation tool at that time.

[200] **Dr Richardson:** It has to do with the denormalising, again, I think. We've denormalised smoking in hospital grounds. There still are challenges, but the vast majority of people now respect and agree with that, even if they're smokers, because they don't want children or other vulnerable people, disabled people who are at the level of tobacco smoke, being affected adversely. These are ill people; we are places of healing—we shouldn't be having a cancer-causing substance for use in our grounds. Unfortunately, we don't yet know the full safety profile of vaping for passive recipients. We know that it's an excellent harm-minimisation aid for smokers, and far better for them than tobacco. However, for somebody who is not a smoker, we don't know the full extent of the chemicals within the vapour's effect in semi-enclosed spaces, like hospital entrances, which is where these things tend to happen, and also because of our smoke-free wardens having to police two different types, and knowing from a distance which is which, is extremely difficult. So, I think things, obviously, may change, but, at the moment, the denormalisation has worked and I think we could risk that if we move too quickly with the e-cigarettes.

[201] **Dai Lloyd:** Okay, I'm conscious of time now, and we've got other issues to cover, but, before we leave tobacco, we've been talking about hospital grounds, but is there a case for extending the smoke-free requirements to the grounds of other NHS premises? Just a 'yes' or 'no' will do.

[202] **Dr Nnoaham:** Yes.

[203] **Dai Lloyd:** Yes. Thank you.

[204] Symud ymlaen yn nhermau amser i'r adran dan driniaethau arbenigol fel aciwbigo a thatŵio, ac mae Angela'n mynd i ofyn cwestiynau.

Moving on, then, to the section on special procedures, such as acupuncture and tattooing, Angela is going to ask questions.

[205] **Angela Burns:** Good morning. I've got, essentially, three main questions to ask you. The first is: do you think the proposed Bill

encapsulates on the face of it enough of the special procedures that are available out there and that could be considered a harm to public health? In other words, do you think we ought to have more procedures actually identified on the face of the Bill apart from the four that are there?

[206] My second question is that it's very clear that the current legislation does not adequately protect the public, and that these procedures do have the potential to cause serious harm. So, I wondered if you would perhaps expand on that and perhaps talk about lessons learned as well. The third question I wish to ask is: do you think that the age of 16—to prevent people younger than the age of 16 from accessing any of these procedures—is sufficient?

[207] **Dr Nnoaham:** I'll start by saying that my answer to your first question would be 'yes'. There is an opportunity for us in this Bill to extend the Schedule of procedures. Having said that, this is a good start. But I do think that there are other procedures that could be included here. Whether that's done through adding something around flexibility to add procedures as more and more evidence of the balance of harm and benefit becomes clear, or whether we feel that the evidence is clear enough to add them at this time, I would probably be for the latter. I would think there is sufficient evidence around some of the procedures, around which there is currently no regulation, but which have significant potential public health impacts, for us to add them here.

[208] **Angela Burns:** Thank you. May I just pick you up on that? Because I tried to get an answer out of the previous witnesses, who, despite saying that lip piercing was one of their nominated extra procedures in their evidence, were less clear when they actually gave evidence here. Would you be prepared to actually tell us what those procedures are which you think there is enough evidence today to add on to the Bill—understanding totally that the Bill is built so that we can add more procedures as time goes by?

[209] **Dr Nnoaham:** May I just start by expressing some empathy for the difficulty that my colleagues would have in terms of naming specific procedures? If you look at the evidence, sometimes there is subjective interpretation of evidence. I will give you a very specific example around Botox. So, some people would have the view that Botox should be a procedure that we should add onto this straight away. Some people might think, 'Actually, the evidence is still a bit neither here nor there'. The evidence they would be making reference to is more recent evidence that has

emerged from the United States that we may have thought that Botox was completely danger-free, but we may be wrong, because the botulinum toxin has been demonstrated to have the capacity to move from one neuron to another, and that was something we never thought it had the ability to do. So, you might inject it in a particular site, and it produces effects on another site through migration in the central nervous system. That is new evidence that is emerging. Some people might feel that the potential of that evidence to be replicated in a wider population context should represent sufficient rationale to classify Botox within this. But some others might think, 'That's a bit too early'. So, I can understand the hesitation that colleagues might have and I would probably be exercising that same hesitation.

[210] **Dr Richardson:** I think anything that pierces the skin is basically an invasive procedure, and you would not expect to have anything done in that respect in a health premises without the person having the due competence and being assessed and authorised to do so—so, anything such as scarification, where they make images out of scars, anything such as implants into the skin, anything such as branding, which damages the tissues under the skin, tongue splitting, body modification, ear cartilage removal and the host of things that are available to young people, and also injection of liquids into the body, so, that would include Botox and dermal fillers, but also things that can be obtained online, such as tanning agents. And then chemical peels: although they don't actually puncture the skin, there is very good evidence of quite severe burning if that is not done with great care, and also laser removal of tattoos, which could create a burn.

[211] There are some wacky procedures out there at the moment: putting jewels in your teeth, putting jewels in other places, putting jewels in your eye. I think we have to recognise that anything that would require a medical or a nursing professional in a hospital to have a registration to perform surely must be something that should be regulated enough that people are assured, when they go through the doors of these places, that there are checks and balances and licensing regulations of competency, not on the premises—at the moment, licensing is at a premises level—but on the individual.

[212] In with that, to answer your second question, some of the things that we've learned are that the licensing of the individual needs to encompass safeguarding training for the individual, because, particularly with regard to the tattooing of individuals below 16, and with regard to intimate piercings, what we found in the Newport exercise was that we had children as young as

13 having nipple piercings by men, albeit with the mother present. But what were the implications? Did that child understand that they could have insisted on a female piercer? Did that child understand what the options were? Did that mother understand what options were available to them? Did that piercer, who may be completely ethical, at that moment in time, understand the dangers that they were putting themselves in with regard to safeguarding legislation?

[213] So, the whole area of under-16s piercing is fraught. I certainly think that lip piercing, tongue piercing, are intimate piercings. No dentist in their right mind would pierce a tongue. They know too much about the anatomy of the tongue. If we are being fair to the profession as well, we should put safeguards in place so that no piercer, who has been contracted and given two days training by their boss, perhaps, is faced with a haemorrhaging patient, and has that on their conscience. So, I think it's something that we do feel really strongly about, that this aspect is just vital to progress in the Bill.

[214] **Angela Burns:** And do you think that the Bill is strong enough in this area, or do you think we need to add more to the Bill to strengthen this area?

[215] **Dr Richardson:** We do need to add to it, and I think that we do need to recognise that it deserves policing. We police sandwich shops, perhaps with bigger budgets than we have to police this actually growing industry, as you say, because of people wanting to express their identity through body art because of not wanting to be 'the number', but wanting to be more individual. We have to recognise that that's going to increase. Therefore, we need to make sure that our environmental health departments in local authorities do have the necessary resources to safeguard our public health.

[216] **Angela Burns:** Thank you for giving us a copy of your look-back exercise on Newport. Could you just say, for the record, what you thought was the key failing, then? Did we not have enough people to police, or was it the fact that the individuals were not licensed correctly, or anything else, for that matter?

[217] **Dr Richardson:** The key failure was that the requirements under the law at present, to be licensed, are inadequate. The person thought that they understood infection control. They did not want to infect all these people. They thought they understood infection control, but clearly they didn't. There'd been no competency check because there's no requirement to check

competency, and there's no requirement to license an individual. So, that's the key thing that needs to change.

[218] **Angela Burns:** One more brief question, if I may: given everything that you've said, and let's say that we manage to get a really good licensing programme in place, can you just tell me where the standards should come from, in your view, that we're going to measure somebody who wishes to be licensed against, given the wide variety of everything—the entire sphere of additional things—that you can do to yourself, or have done to yourself?

11:30

[219] **Dr Richardson:** There are already standards and these standards have been worked up in conjunction, actually, with the profession, but these standards are only—. They can be opted at present. It's not mandatory that each local authority accepts these standards—it is a voluntary section of that particular Act, which local government will be able to elucidate far better than I, but it's a voluntary adherence to it at present.

[220] **Angela Burns:** And do these standards come from the medical profession? Are they the people who've—? I want to understand where these standards are being benchmarked and by whom.

[221] **Dr Richardson:** The standards have come from environmental health, who have taken advice from medical professionals and from professionals involved in the trade and they've been very widely consulted on. Our chief environmental health officer would be able to give you full details of that.

[222] **Angela Burns:** Thank you.

[223] **Dai Lloyd:** Diolch. Cwestiynau byr nawr i orffen ar rai adrannau eraill. Asesiadau iechyd—Rhun.

Dai Lloyd: Thank you. Brief questions now to close on some of the other sections. Health impact assessments—Rhun.

[224] **Rhun ap Iorwerth:** Yes, very briefly, do you believe—and you've referred to this already—that the Bill, as introduced, will ensure that health impact assessments—the requirement to have them and the way they are to be carried out—is proportionate and consistent?

[225] **Dr Nnoaham:** I believe it is and, having said that, I believe there is

perhaps a need to be clearer about resource implications. So, how is this going to be done? What is the methodology? What is the process? I am aware that there's a standard methodology around health impact assessments. Are we going to adopt that methodology? Is there a need to look at alternative methodologies that would be more efficient and what is the resource implication? I think those are the accompanying questions that do need to be posed and answered. But I think it is a very good start in the Bill around health impact assessments.

[226] **Rhun ap Iorwerth**: And by 'resource', can I assume that you mean capacity and skills as well as financial—

[227] **Dr Nnoaham**: Absolutely; absolutely.

[228] **Dai Lloyd**: Ocê. Rŷm ni'n symud ymlaen i wasanaethau fferyllol ac mae gan Lynne gwestiwn.

Dai Lloyd: Okay. We are moving on to pharmaceutical services and Lynne has a question.

[229] **Lynne Neagle**: Briefly, then, are you content that the provisions relating to the pharmaceutical aspects of this Bill are going to deliver the kind of changes that we want to see and ensure that communities have the pharmacy provision that we all want?

[230] **Dr Richardson**: Yes, I am.

[231] **Dr Nnoaham**: I am.

[232] **Dai Lloyd**: Thank you, Lynne. The very model of questioning—and answering. [*Laughter.*]

[233] Yr adran olaf ydy toiledau cyhoeddus.

The final section is public toilets.

[234] Caroline, see if you can be inspired by Lynne. [*Laughter.*]

[235] **Angela Burns**: No pressure there then. [*Laughter.*]

[236] **Caroline Jones**: No, no pressure at all. How can the local toilet strategies prepared by the local authorities have an impact on the actual provision? Is there enough emphasis on taking into account the disabled's need for the provision of toilets and the adequate area available for disabled

users? As we know, some people depend on the provision of toilets in order to carry out their daily duties—their shopping and so on—and how can we ensure that all these needs are taken into consideration?

[237] **Dr Richardson:** I think that the Bill could go further in relation to disabled clients.

[238] **Caroline Jones:** It doesn't mention disabled clients. So, that's my concern.

[239] **Dr Richardson:** Exactly, and we know that there are campaigns by carers of disabled people as well. There's been the 'Changing Spaces' campaign, very actively started in the Vale of Glamorgan, which has resulted in, throughout Wales, places where there are changing tables and hoists for carers to use. I think it is essential. Quite often, even if there is a disabled toilet, there are things being stored in there—boxes of spare rolls or whatever—and there is a minimum turning space for wheelchairs and there are requirements. I think that it would be good to have cognisance of the lobbying activities of our disabled citizens and that enables them to lead fully independent lives and we are all, as we age, going to need to have the facility that, if we did need a wheelchair, we could actually still go to the toilet.

[240] I think the use of the radar key is another issue in that not everybody has one. Some people have difficulties with their—if they have Parkinson's, they're not going to be able to find keys. I think it is difficult, obviously, to police, because we don't want them being vandalised either. It's a tricky one to know what the best solution is, but I do think that we need this part of the legislation, actually, not just for the people with health problems and urological problems and prostate problems, but just because we are all ageing, and we do need to have those facilities to live our lives.

[241] **Caroline Jones:** And with an increasing ageing population.

[242] **Dr Richardson:** Absolutely.

[243] **Caroline Jones:** There we are. Thank you.

[244] **Dai Lloyd:** Pawb yn hapus? Diolch yn fawr, Caroline. Gwnaf i gyhoeddi, felly, fod y sesiwn yma ar ben. Diolch yn fawr iawn ichi am eich

Dai Lloyd: Is everyone content? Thank you very much, Caroline. This session, therefore, is now at an end. Thank you very much for your

tystiolaeth ac am eich presenoldeb y bore yma. Byddwch chi'n derbyn trawsgrifiad o'r cyfarfod yma i gadarnhau bod pethau'n ffeithiol gywir. Gyda chymaint â hynny o eiriau, a allaf i ddiolch ichi unwaith eto am eich presenoldeb y bore yma? Diolch yn fawr iawn ichi.

evidence and for being here today. We will send you a transcript of the meeting to check for accuracy. Thanks once again for coming today. Thank you.

[245] **Dr Richardson**: Croeso.

Dr Richardson: You're welcome.

11:36

Papurau i'w Nodi
Papers to Note

[246] **Dai Lloyd**: Symudwn ymlaen i eitem 4. Eitem 4—mae yna bapur i'w nodi yn fanna cyn inni symud ymlaen at eitem 5.

Dai Lloyd: Let's move on to item 4. Item 4—there is a paper to note before we move on to item 5.

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

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

Motion:

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

Cynigiwyd y cynnig.
Motion moved.

[247] **Dai Lloyd**: Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y

Dai Lloyd: Motion under Standing Order 17.42 to resolve to exclude the public from the meeting—are all

cyfarfod—hynny ydy, a ydy fy nghyd-Aelodau yn hapus gyda hynny? Diolch yn fawr.

Members content? Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:36.
The public part of the meeting ended at 11:36.