Welsh Government

White Paper

Listening to you: Your health matters
Consultation on proposals for a Public Health Bill

Date of issue: 2 April 2014
Action required: Responses by 24 June 2014
Overview
This White Paper seeks views on proposals to address a number of public health issues, through a Public Health Bill and related action.

How to respond
The closing date for responses is 24 June 2014.
Responses can be submitted via the online document of consultation questions:
http://wales.gov.uk/consultations/healthsocialcare/?lang=en
Alternatively, responses can be returned to:
E-mail: PHBill@wales.gsi.gov.uk
Post:
Public Health Development Team
Health Improvement Division
Directorate for Public Health
4th Floor, East
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Further information and related documents
Large print, Braille and alternative language versions of this document are available on request.
The consultation document can be accessed from the Welsh Government website at:
http://wales.gov.uk/consultations/healthsocialcare/?lang=en

Contact details
For further information: PHBill@wales.gsi.gov.uk
Address:
Public Health Development Team
Health Improvement Division
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4th Floor, East
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Cathays Park
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Data protection
How the views and information you give us will be used
Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about. It may also be seen by other Welsh Government staff to help them plan future consultations.
The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full.
Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.
Names or addresses we blank out might still get published later, though we do not think this would happen very often.
The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.
White Paper

Listening to you: Your health matters
Consultation on proposals for a Public Health Bill

Contents

Ministerial Foreword

1. Introduction ........................................... 1
2. Improving health across the life course: Tobacco and electronic cigarettes ........................................... 11
3. Improving health across the life course: Alcohol ........................................... 25
4. Improving health across the life course: Obesity ........................................... 35
5. Building community assets for health ........................................... 41
6. Regulation for health ........................................... 53
7. Next steps ........................................... 59

Annex: Summary of consultation questions ........................................... 60
Ministerial Foreword

Taking concerted, collective action to address public health concerns remains amongst the most powerful contributions which any Government can make to the welfare and wellbeing of its local population.

This White Paper signals the intention of the Welsh Government to move forward on more than one front. In the soon-to-be-published Future Generations Bill (working title) we will place good health at the centre of the sort of Wales we want to create in the first half of this century. We know that the elimination and prevention of health inequalities can only be achieved when linked to the underlying inequalities of income, wealth and power across society. The fundamental causes of poor health, and its unequal distribution across different parts of Wales, lie outside the health service itself. The Future Generations Bill will make those connections and demonstrate how a ‘Health in All Policies’ approach forms a central part of our wider agenda.

In this White Paper we concentrate on those actions we can take to control or reduce the immediately visible and avoidable causes of ill health, at the level of the community and the individual. By themselves such actions will not create the sort of societal shift envisaged in the Future Generations Bill, but they do offer a set of practical measures, capable of being put into practice in this Assembly term which, cumulatively, can make a real difference to health and wellbeing. They adopt a preventative approach by seeking to intervene at points which can result in significant long-term benefits, both in terms of the health of individuals and in avoiding the burdens of higher long term costs caused by preventable ill health.

It is nothing short of a tragedy that the lives of so many of our fellow citizens are shortened or blighted by illnesses which were so clearly avoidable. Government has the responsibility to create the conditions in which such harm can be avoided – and that is what this White Paper is all about. Thereafter there is a responsibility which rests with individuals to act in ways which protect and promote their own well-being. That renewed bargain between the citizen and the state lies at the heart of this White Paper. It builds on the process begun through the wide-ranging debate which followed publication of the Public Health Green Paper in late 2012. There is now a further opportunity to test ideas and to make fresh contributions to thinking on the way forward in Wales.

I look forward to receiving responses from as wide a range of people as possible as we look to achieve the greatest possible improvement in health across the whole of the Welsh population.

Mark Drakeford AM
Minister for Health and Social Services
Chapter 1: Introduction

Summary

Every one of us can benefit if Wales has good health. A healthy population is good for economic growth and prosperity. Poor health is bad for individuals, bad for communities and has a negative impact on prosperity.

The responses to the consultation on our Green Paper on Public Health indicated strong support for legislation as a way of driving further improvements in people’s health across Wales. The Welsh Government has taken account of this call for action in two distinct ways, through developing proposals for a Public Health Bill and ensuring health is a key element in the forthcoming Future Generations Bill.

The ‘Listening to you – Your Health Matters’ White Paper presents a series of proposals for primary and secondary legislation which seek to address priority public health issues such as tobacco, alcohol misuse and obesity, and could be taken forward within the scope of our current powers. Together, they can have a real and lasting impact on health and wellbeing. The proposals are presented as part of three strands of activity, reflecting our commitment to action across the life course, to build healthy communities and to regulate certain activities.

In addition to the proposals for a Public Health Bill, the Welsh Government has also responded to suggestions calling for legislation which directs organisations to consider health in all their policy development. The Future Generations Bill will require the whole of the public service in Wales to contribute to healthy thriving communities, a healthy environment and a vibrant culture. This will help ensure health is taken into account with regard to how they operate, set their priorities and allocate resources. Health will therefore be positioned within a broader framework which supports sustainable development rather than be treated as a stand alone issue.

The case for action

1.1 The health of the population of Wales is continuing to improve. In general, people are living longer and enjoy better health than ever before. However, it is also clear that Wales, with other countries, faces a number of specific and significant health challenges.

1.2 The Welsh Government has ambitions to accelerate the pace of improvement and share it more equally. We are fully committed to taking action wherever

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1 The “Future Generations Bill” is the working title for the proposed Bill to give effect to the Welsh Government’s Programme for Government commitment to legislate to make sustainable development the central organising principle of the Welsh Government and public bodies in Wales.
appropriate to help further improve and protect health for everyone. The *Programme for Government* contains a number of commitments intended to help us deliver on this ambition.

1.3 Until fairly recent times, the main focus of government in improving health was protecting the public from major health threats. Those included infectious diseases, occupational disease and injury, unsafe air, water and food, and poor sanitation, housing and transportation. Legislation has played an important part in all these areas, though other factors such as advances in medicine, technology and engineering have also played a significant role.

1.4 Governments over time have needed to keep pace with emerging public health priorities and be in a position to respond appropriately and in a timely manner. We are in a society which is developing quickly and over the last half century a number of new challenges have appeared. These include:-

- a rise in lifestyle-related diseases;
- continued and new challenges associated with communicable diseases, such as the management of antimicrobial resistance and public complacency about the importance of vaccination and immunisation in protecting both individuals and the public at large;
- changing health and social needs related to an ageing population (which is in itself a consequence of successes in increasing life expectancy);
- real and potential health problems associated with climate change; and
- the stress and anxiety resulting from economic/financial conditions, and resulting pressures on living standards and public services.

1.5 Every one of these argues for more preventative action and a closer and more engaged relationship between government and the public. Otherwise we simply cannot afford the human and societal costs that these will produce.

1.6 The Welsh Government, like governments worldwide, needs to respond firmly and effectively to such challenges – and new ones as they emerge. Among the levers available, legislation can be one of the most powerful.

1.7 A prime illustration of how legislation can make a positive contribution to public health can be found in Welsh tobacco legislation, consisting of a ban on smoking in public places, and on selling tobacco through vending machines and point of sale regulations. Such measures have made a real difference to many people, in terms of cigarette smoking, exposure to second hand smoke inhalation, and societal norms about smoking.
1.8 These types of measures are wholly consistent with principles of prudent health care, as they seek to intervene at the point where there is maximum return for investment. The example of the tobacco control measures outlined above provides a clear illustration of how legal intervention can contribute to a long term positive impact in terms of health gain. Such actions are considered to be both proportionate and preventative in terms of protecting public health, as they help avoid far larger damage to the health of individuals in the future, together with the greater costs involved. They also have a powerful impact on health inequality, because we know that many of the dangers which can be addressed through public health legislation fall disproportionately on the most disadvantaged individuals, families and communities. A Public Health Bill gives us an opportunity to continue to intervene at the point where there is maximum return for our investment and pursue further legislation, where appropriate, for improving health.

A shared responsibility

1.9 Health is everyone’s business. Government needs to deliver on creating the social conditions and environments that are conducive to good health, and providing the services necessary for this. There is a corresponding responsibility on all of us to look after our own health, and access services appropriately when we need to.

1.10 This reciprocal responsibility depends on everyone striving for good health and working for it. It underpins the proposals outlined in this White Paper and is consistent with well-established international principles such as those of the Ottawa Charter for Health Promotion and the 2010 Adelaide Statement on Health in All Policies.

1.11 It is a fundamental principle of the Welsh Government that everyone in Wales should have a fair opportunity to lead a healthy life. We should reduce and, if possible, eliminate unfair, avoidable differences in health which harm particular groups or individuals over a lifetime or across generations.

1.12 Whilst people are responsible for their own behaviour, we know behaviours such as smoking are also influenced by family and friends, communities and the wider cultural and economic environment. These factors are of particular consequence to people with lower incomes and low educational achievement, and can contribute to well recognised inequalities in health outcomes and healthy life expectancy.

1.13 We acknowledge that there can be a fundamental tension between a government intervening to address major challenges to public health, and an

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2 https://www.wales.nhs.uk/news/30952
3 http://www.who.int/healthpromotion/conferences/previous/ottawa/en/
4 www.who.int/social_determinants/hiap_statement_who_sa_final.pdf
individual’s freedom to ultimately live their life in the way he or she chooses. There is also a debate to be held, however, about the extent to which people who choose to engage in all kinds of unhealthy behaviours which are known to be risky to their own health and wellbeing should also expect to bear the consequences of such decisions. In an age of austerity, that debate cannot avoid encompassing the fact that treating avoidable illness arising from smoking, misuse of alcohol or obesity draws disproportionately on the pool of resources available to provide health services for all. Compelling Welsh evidence indicates that even modest increases in uptake of healthy behaviours could considerably reduce the population burden of vascular disease, dementia and death from heart disease\(^5\).

1.14 The Welsh Government believes it is duty bound to consider all levers available for improving and protecting health. However, we also accept that any intervention has to be in keeping with prudent health care; justifiable, appropriate and proportionate. Other factors also need to be assessed, such as the associated costs, and whether the intervention needs to be supported by an enforcement regime. Such considerations have been taken into account in the development of the policy proposals outlined in this White Paper and have informed the consultation questions included in each Chapter.

**Taking forward your responses to the Public Health Green Paper**

1.15 The Welsh Government started a discussion about the role of legislation in helping to further improve and protect health in Wales in *Our Healthy Future*\(^6\) and explored this idea in late 2012 / early 2013, through a Green Paper consultation exercise\(^7\). Through this consultation, we were able to collect a wide range of views from organisations across different sectors, as well as many members of the public.

1.16 The aim of the Green Paper was to collect general views rather than consult on detailed ideas for legislation. To aid discussion of the issues, a number of ideas were offered for people to consider. These focused on an approach to legislation involving placing organisations under new duties to require them to act in a way that helps address the many factors across society which affect health and wellbeing, and to help tackle health inequalities.

1.17 The ideas in the Green Paper struck a chord with many organisations and individuals, and a clear majority of respondents supported the idea that legislation could make a positive contribution to improving health and wellbeing. This support provided us with a mandate to further consider legislative opportunities.

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\(^5\) Healthy Lifestyles Reduce the Incidence of Chronic Diseases and Dementia: Evidence From the Caerphilly Cohort Study – PLOS ONE, December 2013 – Volume 8 Issue 12


\(^7\) [http://wales.gov.uk/consultations/healthsocialcare/publichealth/?lang=en](http://wales.gov.uk/consultations/healthsocialcare/publichealth/?lang=en)
1.18 The responses to the Green Paper indicated support for two distinct approaches to public health legislation. The views of those who responded to the consultation have been instrumental in helping us develop our policy in the following two ways:-

i) **Health in All Policies and the role of the Future Generations Bill**

1.19 The conditions in which people are born, grow, live, work and age all affect health. These broader factors are known as the ‘social and economic determinants of health.’ A healthy population is a key requirement for the achievement of society’s goals, as well as a goal in itself. Good health brings a broad range of benefits to society. It enhances quality and length of life, but also improves workforce productivity, increases capacity for learning, strengthens families and communities, supports sustainable habitats and environments, and contributes to security, social inclusion and the reduction of poverty.

1.20 An idea which attracted particular support through the Green Paper was exploring the role of legislation in helping achieve a ‘Health in All Policies’ approach to policy development in Wales. A ‘Health in All Policies’ approach aims to help ensure health interests are addressed across the range of social factors which affect overall health and wellbeing, and which in turn are also affected by health. It aims to help policy makers assess how health may be positively or negatively affected by certain types of activity, helping them to maximise any benefits and reduce any negative effects.

1.21 The Welsh Government’s proposed Future Generations Bill will reflect a number of principles consistent with ‘Health in All Policies.’ This Bill, which is due to be brought forward later in 2014, aims to embed a shared vision for a sustainable Wales at the core of the Welsh public service. Its purpose will be to help future-proof our communities by reinforcing the fundamental role that public services in Wales (such as local authorities and health boards) play by putting the needs of communities, now and in the future, at the heart of the decisions they make. This will help the public service collectively make choices for a better, more sustainable and fairer future in Wales.

1.22 The Future Generations Bill intends to address a number of challenges that are familiar to the public health agenda. These include the need for a renewed focus on prevention and early intervention, the need for working in partnership across a number of sectors, and a need for evidence-based decision making. It therefore provides a mechanism for embedding health within an overall legislative framework, rather than treating it as a separate issue.

1.23 Furthermore, the Bill recognises that while the health sector makes an essential contribution to improving the health of the population, as well as economic
and environmental wellbeing, it cannot on its own deliver sustained high levels of health and wellbeing across all groups in society. It therefore supports the fundamental principle that health is “…not merely the result of clinical care, but the result of the sum of what we do as a society to create the conditions in which people can be healthy.”

1.24 The policy intent of the Future Generations Bill will support our ambitions for health in a number of ways. It is proposed that the Bill will reflect that we as a society should have a number of overarching ‘goals’ which the Welsh Government and the public sector should strive to achieve.

1.25 It is proposed that the Bill will put in place a legislative framework for influencing how key public organisations operate, set their priorities and allocate resources. This will require the engagement and commitment from leaders and policy makers at all levels of government and the wider public sector, which we know is a fundamental part of ‘Health in All Policies.’ There is a significant amount of literature available which indicates that successful ‘Health in All Policies’ can only be achieved if the appropriate governance arrangements, implementation structures and monitoring mechanisms are in place.

1.26 As part of the development of the Future Generations Bill, the Minister for Communities and Tackling Poverty has asked the Commissioner for Sustainable Futures to lead a national conversation with the public about the Wales we want. This co-produced approach to developing policy and legislation is also consistent with another of the themes explored in last year’s Public Health Green Paper, which concerned the importance of involving citizens and communities, patients and consumers in shaping services, policies and programmes. It also reflects a key finding of the World Economic Forum in its report ‘The Future of Government – Lessons Learned From Around the World,’ which refers to the importance of citizen engagement in relation to successful governance, and advocates the need for ‘FAST’ government which is close to its citizens and talks to them effectively.

1.27 In addition, it is also envisaged that the Future Generations Bill will place Single Integrated Plans on a statutory footing. These local ‘well-being’ plans will clearly demonstrate the interplay between different types of decisions made by public service organisations, and reflect how they can make a significant contribution to overall health and wellbeing, and help to reduce health inequalities. Policy areas such as children and families, housing, transport, culture and sport, planning, education, the economy and rural affairs can all make a positive contribution. This

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can be manifested in practical decisions taken locally in as diverse a range of subjects as access to health and social care, tackling poverty, development control and employment opportunities.

1.28 In summary, the proposals being brought forward under the Future Generations Bill make the proposition that health is an agenda for everyone. It is proposed that the Bill will put in place a legal framework which supports improved health and reduced health inequalities as key societal goals for a sustainable society. Health would be considered in the same way and in combination with other goals such as economic resilience and social cohesion, which are themselves determinants of health. Above all, this framework will help to foster the conditions which maximise productivity and wellbeing. By incorporating health as a key component of this legislation, the Welsh Government will help ensure that it is considered as a central part of the overall framework for the public service in Wales.

ii) Legislation to support specific public health priority areas

1.29 The Welsh Government has already shown in the current legislative programme its commitment to legislation on specific matters that support the health agenda. As an example, the Active Travel (Wales) Act 2013\(^\text{10}\) imposes a new duty on Welsh Ministers and local authorities to promote active travel and to create an environment where it is safer and more practical to walk and cycle than it is at present. The Social Services and Wellbeing (Wales) Bill will also make an important contribution by placing an emphasis on mental and emotional wellbeing, and encouraging a renewed emphasis on prevention and early intervention. Welsh Government legislation in other areas, such as the Housing (Wales) Bill, also plays an important role by taking action relating to specific determinants of health.

1.30 Many respondents to the Public Health Green Paper suggested that legislation could also make a positive contribution in a number of discrete public health policy areas, such as tobacco, alcohol misuse and obesity. In response to this we have developed a series of proposals in such areas for consideration as part of a Public Health Bill, as well as plans for complementary secondary legislation. This White Paper sets out these proposals for consultation.

1.31 The proposals comprise a suite of practical legislative steps to help further improve and protect health, and they all seek to uphold Government’s responsibility to create and shape social conditions which enable people to be healthy. As a suite of proposals, they bring together a number of varying measures in one Bill, which together can make a positive impact in some key areas.

\(^{10}\) The Active Travel (Wales) Act 2013 (2013 anaw 7).
1.32 The proposals in this White Paper are intended to form one component part of the Welsh Government’s overall approach to legislation. The resulting Bill will aim to make an important contribution within this broader context, rather than provide a full solution in itself. It will need to be considered alongside other relevant legislation, namely other Assembly Bills/Acts, developments in UK legislation which will apply to Wales, and our plans for secondary legislation. Each type of legislation has an important and complementary role to play. The inter-relationship between these different types of legislation is illustrated in the following diagram:

1.33 This White Paper presents a series of proposals under three overarching themes. In Chapters 2-4 we present a series of proposals under a theme of improving health over the life course. These aim to make a positive contribution in tackling our main lifestyle priorities. The proposals specifically seek to address issues which affect health at a whole population level, with some focusing on particular stages of the life course. They range from measures aimed at protecting the future health of our children and young people, to measures aimed at protecting health interests in later life. Our policy areas and related proposals are outlined below:
• Tobacco and electronic cigarettes: (tobacco retailers’ register and the use of electronic cigarettes in public places; plus seeking initial views in relation to smoke-free open spaces and internet sales of tobacco);
• Alcohol misuse (Minimum Unit Pricing); and
• Obesity (nutritional standards in specific public sector settings).

1.34 A second theme which is integral to our overall aims is that of **building community assets**. We outline two proposals in Chapter 5 aimed at developing local assets which contribute to healthy communities. Specifically, these proposals aim to strengthen the role of Local Health Boards in planning and delivering the number, location and type of pharmaceutical services required to meet the needs of their communities, and to address the provision of and access to toilets for public use.

1.35 A final proposal is presented under a third theme entitled ‘**regulation for health**.’ This seeks to build on past examples of utilising legislation as an effective means for regulating some types of activity in order to protect certain groups of the population. We propose to pursue this through the introduction of a National Special Procedures Register, which would provide a means of regulating standards in relation to the provision of acupuncture, tattooing, semi-permanent skin colouring, cosmetic piercing and electrolysis. This proposal is outlined at Chapter 6.

1.36 In addition to our main proposals, the White Paper also includes some examples of other ideas which the Welsh Government has under consideration in the same policy areas, which are more appropriately pursued through forms of action outside of a Public Health Bill. This reflects the position that primary legislation is only one of the tools available for improving and protecting health and needs to form part of a wider suite of actions.

1.37 Our proposals have been informed by the general principles of prudent health care. They seek to intervene at points where there are significant potential long-term benefits from taking action, both in terms of the health of individuals and in seeking to avoid higher long term costs associated with preventable ill health. Our proposed action in areas such as the pricing of alcohol, developing nutritional standards and regulating standards for specified special procedures all accord with this approach.

1.38 The proposals have also been developed with reference to the case presented by the World Health Organisation and the World Economic Forum in support of certain types of action in their joint report ‘From Burden to Best Buys’\(^\text{11}\). That report recognised and recommended specific preventative measures as highly cost effective, inexpensive and feasible to implement. A number of our proposals, for

example Minimum Unit Pricing for alcohol, are consistent with the types of measures recommended.

1.39 Our proposals for a Public Health Bill must reflect the legislative competence of the National Assembly for Wales. That currently excludes legal powers to introduce certain types of measures, such as those relating to taxation, licensing of the sale and supply of alcohol, advertising, and betting, gaming and lotteries. In such cases we will continue to utilise other methods for achieving our policy objectives, including lobbying the UK government for action, while also seeking new powers where appropriate.

1.40 The Welsh Government has consistently made the case over a number of years for the National Assembly for Wales to have additional legislative competence in areas such as the licensing of the sale and supply of alcohol. This was most recently pursued in our evidence to the Commission on Devolution in Wales (The Silk Commission), which has been reviewing the present constitutional arrangements in Wales.

1.41 In developing the proposals in this White Paper, we are also aware of our obligations in areas such as sustainable development, equality and human rights, and the United Nations Convention on the Rights of the Child (UNCRC). Further work will be undertaken prior to introduction of a Public Health Bill fully to assess the potential impact of all our proposals in these areas, and costs and benefits will be assessed through the preparation of a Regulatory Impact Assessment.

1.42 Alongside pursuing the specific proposals for a Public Health Bill outlined in this White Paper, we recognise that a multi-faceted approach is required to tackle complex challenges to health and wellbeing. We will continue to utilise a full range of approaches such as public health policies, behavioural change programmes and campaigns to progress the public health agenda more generally. We will also seek to maximise potential of existing legislation, such as through the production of secondary legislation and/or guidance where necessary to strengthen its impact.
Improving health across the life course

Chapter 2: Tobacco and electronic cigarettes

Summary

Tobacco smoking is the largest single preventable cause of ill health and death in Wales, and costs the Welsh economy millions of pounds per year in terms of treatment, sickness absence and smoking breaks. Young people who start smoking are more likely to continue into later life and more likely to die from a smoking related disease. We are already pursuing a range of measures as set out in our Tobacco Control Action Plan for Wales\textsuperscript{12}, with the overall target of reducing smoking prevalence levels to 16% by 2020.

In this Chapter, we outline a proposal to create a tobacco retailers' register. This measure aims to support the overall target by further restricting access to tobacco products by young people, and therefore reduce smoking uptake levels. The creation of a tobacco retailers’ register will also assist with the enforcement of the ban on the display of tobacco products which came into force on 3 December 2012 for the purposes of large shops and which will come into force on 6 April 2015 for small shops.

Secondly, we are seeking views and evidence on banning the use of electronic cigarettes in enclosed and substantially enclosed public places and places of work in Wales.

At the end of the Chapter we outline current actions in relation to smoke-free open spaces and seek initial views on these, and also seek views in relation to internet sales of tobacco.

Context

2.1 Tobacco smoking causes serious harm to the health of smokers and to non-smokers who are exposed to second-hand smoke. It continues to be the largest single preventable cause of ill health and death in Wales, causing around 5,450 deaths each year\textsuperscript{13}.

2.2 The significant burden of illness due to smoking has major economic costs for Wales. Research shows that treating smoking related diseases costs NHS Wales an estimated £302 million per year, with the estimated cost to the Welsh economy in


excess sickness absence and smoking breaks amounting to just over £90 million per year\textsuperscript{14}. Smoking is also a main cause of health inequalities, having been identified as a leading cause for the gap in mortality rates between the most and least deprived areas\textsuperscript{15}.

2.3 Smoking experimentation and uptake can begin as early as the primary school years, or occur later in a young person’s life. Two thirds of smokers started before the age of 18, and people who start smoking at an early age are more likely than other smokers to smoke for a long period of time, and more likely to die from a smoking-related disease\textsuperscript{16}. It is clear young people can quickly develop a dependence on nicotine and may be unable to reduce their risks due to addiction\textsuperscript{17}. Interventions to reduce the uptake of smoking amongst young people are therefore crucial to meet the overall aim of reducing smoking prevalence rates. Any action to improve the health of children is also consistent with the United Nations Convention on the Rights of the Child.

2.4 Whilst we have made good progress in reducing smoking among young people, rates of smoking amongst adults have remained steady at 23% since 2010\textsuperscript{18}. We therefore need to do more to increase the number of adults successfully quitting smoking, whilst continuing to prevent young people from starting to smoke. In 2012, we published our Tobacco Control Action Plan for Wales which sets out a comprehensive strategy on tobacco control, with the aim of protecting children and young people from the health harms of tobacco and reducing inequalities in health. The Tobacco Control Action Plan sets out a vision of a smoke-free society for Wales with a challenging target of reducing adult smoking prevalence levels to 16% by 2020.

2.5 We have already implemented a range of legislative measures on tobacco control as part of our programme to reduce the uptake of smoking (particularly amongst young people), reduce exposure to second-hand smoke and encourage existing smokers to quit. In 2007, we introduced a ban on smoking in enclosed public and work places\textsuperscript{19}. In 2011 we went on to introduce bans on the sale of tobacco

\textsuperscript{14} ASH Wales and BHF Cymru (2013). The economic cost of smoking to Wales: a review of existing evidence.
\textsuperscript{18} Welsh Health Survey http://wales.gov.uk/topics/statistics/theme/health/health-survey/results/?lang=en
\textsuperscript{19} The Smoke-free Premises etc. (Wales) Regulations 2007 ( S.I. No. 2007/ 787 (W.68)) came into force on 2 April 2007.
products from vending machines\textsuperscript{20} and in 2012 we made Regulations which banned the display of tobacco products at point of sale\textsuperscript{21}. The enforcement regime for such measures is led through local authority trading standards officers.

2.6 We are now considering primary legislation to address further issues of concern within tobacco control in Wales. The proposal contained in this Chapter aims to support and complement our existing measures through the development and introduction of a national **tobacco retailers’ register**. In addition, we are seeking views and evidence on other areas for potential legislation. In particular, views are sought on whether to introduce a ban on the use of **electronic cigarettes** in enclosed and substantially enclosed public places and places of work in Wales. Views are also sought in relation to smoke-free open spaces and internet sales of tobacco.

2.7 The Welsh Government has also long been a proponent of **standardised packaging of tobacco products**. We recognise the introduction of standardised packaging has the potential to be an important health tool in our bid to reduce the harm from tobacco related illness.

2.8 In November 2013 the Secretary of State for Health in England commissioned an independent review\textsuperscript{22} on the effect on public health if standardised packaging for tobacco products were introduced in the UK. An amendment to the Children and Families Bill\textsuperscript{23} has been approved which gives the Secretary of State enabling powers to make regulations to introduce requirements for the standardised packaging of tobacco products on a UK-wide basis, if he decides to legislate following consideration of the findings of the independent review. The National Assembly for Wales agreed that the Secretary of State could introduce the regulation of retail packaging of tobacco products in Wales, on the basis that there are advantages to legislation to introduce standardised packaging of tobacco products being made on a UK wide basis (not least a common coming into force date, consistency in requirements and ease of enforcement). A condition of this agreement is that the Secretary of State must seek the consent of the Welsh Ministers when making regulations in relation to Wales which would be within the competence of the Assembly.

\textsuperscript{20} The Protection from Tobacco (Sales from Vending Machines) (Wales) Regulations 2011 (S.I. No. 2011/2498 (W.271)) came into force on 1 February 2012.

\textsuperscript{21} The Tobacco Advertising and Promotion (Display of Prices) (Wales) Regulations 2012 (S.I. No.2012/1911 (W.233)) and The Tobacco Advertising and Promotion (Display) (Wales) Regulations 2012 (S.I. No. 2012/1285 (W.163)) came into force for large shops on 3 December 2012 and for all other purposes on 6 April 2015.

\textsuperscript{22} \url{https://www.gov.uk/government/news/independent-review-of-standardised-packaging-for-tobacco}

\textsuperscript{23} \url{http://services.parliament.uk/bills/2012-13/childrenandfamilies.html} – the Bill received Royal Assent in March 2014.
2.9 The purchase of tobacco products by an adult on behalf of a person under the age of 18, i.e. a proxy purchase, is currently not unlawful in Wales. Research\(^{24}\) suggests that the proxy purchase of tobacco products is an issue that needs addressing and, as such, it was originally the intention of the Welsh Government to include a proposal in this White Paper to make the purchase or attempted purchase of tobacco products on behalf of a person under the age of 18 a criminal offence. Progressing a proposal for proxy purchase of tobacco would help ensure that this issue is dealt with in a similar way to an alcohol purchase, which is already an offence under Section 149 of the Licensing Act 2003\(^ {25}\). Proxy purchase of tobacco products is already an offence in Scotland under the Tobacco & Primary Medical Services (Scotland) Act 2010\(^ {26}\) and the Northern Ireland Tobacco Retailers’ Bill\(^ {27}\) was amended, at committee stage, to create an offence of proxy purchasing.

2.10 The UK Government’s amendment to its Children and Families Bill which will make the proxy purchase of tobacco products an offence in England largely mirrored the Welsh Government’s policy intentions on the proxy purchase of tobacco products. Therefore, we took the decision to request that the UK Government extend the provisions being made for England to also cover Wales.

2.11 Our proposal in this Chapter to introduce a tobacco retailers’ register would work in tandem with the proxy purchasing of tobacco offence to help reduce underage consumption of tobacco products.

2.12 The UK Government also tabled an amendment to the Children and Families Bill that would give the Secretary of State power to make regulations prohibiting the sale of nicotine products (NPs)\(^ {28}\) to persons aged under 18, and the power to make regulations that make the proxy purchase of NPs an offence. We have carefully considered our position on this policy area and believe that it makes sense to apply the same age of sale restrictions for tobacco products to NPs, as well as the new offence of proxy purchase. The National Assembly for Wales has agreed that regulations to be made by the Secretary of State to restrict the age of sale for NPs and to make the proxy purchase of NPs an offence should also apply to Wales, provided that he seeks the consent of the Welsh Ministers when making any regulations which would be within the competence of the Assembly.

2.13 On 10 February the House of Commons approved all of the above amendments to the UK Children and Families Bill, plus an additional amendment

\(^{24}\) The report ‘Smoking, drinking and drug use among young people in England in 2012’ suggests that rather than trying to buy cigarettes in shops, pupils were more likely to have asked someone else to buy cigarettes for them (proxy purchasing), and were more likely to obtain cigarettes as a result.  
\(^{28}\) Nicotine products include electronic cigarettes, nicotine patches and gums.
which provides enabling powers for the Secretary of State for Health in England and Welsh Ministers in Wales to introduce regulations to prohibit smoking in private vehicles carrying under 18s. This power could be used to pursue secondary legislation to reduce children’s exposure to second hand smoke in cars. In Wales we have consistently stated that we will consider the possibility of secondary legislation once the results of ongoing research are known, and when the full evaluation of the Fresh Start Wales campaign has been concluded. These enabling powers, once enacted, will provide us with powers parallel to England to implement regulations, should we consider it appropriate following consideration of the results of the campaign evaluation, which we expect to be available in summer 2014.

2.14 As a result of these recent developments, this White Paper does not include proposals to introduce standardised packaging for tobacco products, to introduce an offence of proxy purchase of tobacco products and NPs, to restrict the age of sale of NPs in Wales, or proposals relating to smoking in cars carrying children. We have, however, reserved our position to consider taking forward the standardisation of packaging for tobacco products, should the UK Government decide not to legislate following the outcome of the independent review.

2.15 We also continue to explore other areas of smoke-free environments to complement these proposals. Concurrent to the proposals in this Chapter we are considering possible secondary legislation to extend the smoke-free requirements to mental health units that provide residential accommodation, and, as we are planning to consult separately on this issue in 2014, have not included proposals in this White Paper.

Tobacco retailers’ register

This proposal is for all retailers of tobacco products to be required to register on a tobacco retailers’ register. The principal policy aim behind the creation of such a register is to reduce the sale of tobacco products to under 18s and to make it easier for trading standards officers to enforce the ban on the display of tobacco products.

2.16 Reducing access to tobacco products by young people is a key action within the Tobacco Control Action Plan for Wales. Young people access tobacco products from a wide variety of sources, including being given them by friends and family, having them bought by someone else, and through underage sales.

29 Mental Health Units that provide residential accommodation are currently listed as an exemption in the Smoke-Free Premises etc. (Wales) Regulations 2007.
2.17 The report ‘Smoking, drinking and drug use among young people in England in 2012’ found that despite the law banning sales to under-18s, 44% of pupils who smoked cigarettes said that they bought them from a shop, with 37% buying most commonly from a newsagent, tobacconist or sweetshop. In Wales, underage test purchase sales by local authority enforcement teams in 2012-13 demonstrated a 15% failure rate by retailers to refuse a sale to a person aged under 18.

2.18 Trading standards officers have advised that a tobacco retailers’ register would help them to identify retailers who sell tobacco once the display ban is operational in small shops in April 2015. A register would allow retailers that sell tobacco products to be clearly identified, enabling trading standards and others to offer advice and support to them to avoid illegal sales, as well as help to maintain a consistent schedule of test purchasing.

2.19 All premises that sell tobacco would be required to register their details on the tobacco retailers’ register. This is likely to include contact details for the applicant and the company, plus the name, address and the type of the premises selling tobacco.

2.20 We are currently proposing that registration should be subject to an initial fee of £30, plus £10 for each additional premise registered (i.e. £50 for three premises). We also propose there should be a fee for re-registration of £20 plus £10 for each additional premise registered (i.e. £40 for three premises) which would be payable every three years.

2.21 The register would be established and maintained centrally; possibly by a nominated local authority on behalf of all local authorities in Wales. The fees collected would be used to fund these arrangements. The register would be hosted on-line and local authorities would have access to the register for enforcement purposes. More limited information (e.g. retailer name and address) would be available to the public.

2.22 Local authority trading standards officers would be responsible for enforcing the register. Legislation on the tobacco retailers’ register would take into account the ability of local authority enforcement officers to make applications for restricted sales orders (RSOs) and restricted premises orders (RPOs) as provided for at sections

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31 Will be published on [www.tradingstandardswales.org.uk](http://www.tradingstandardswales.org.uk)
32 The Tobacco Advertising and Promotion (Display) (Wales) Regulations 2012 ban the display of tobacco products. These Regulations came into force in December 2012 for large shops and will come into force for small shops in April 2015.
12A and 12B respectively of the Children and Young Persons Act 1933\(^{33}\). Any premises under an RPO (which can prevent the sale of tobacco products from those premises for up to one year) would be removed from the register or refused entry to the register whilst the RPO is in force. Legislation would also introduce new offences or penalties associated with failure to register to sell tobacco in order to ensure that businesses that sell tobacco products comply with the duty to register.

2.23 A Scottish register of tobacco retailers has been in place since October 2011 and is funded and administered by the Scottish Government\(^{34}\). There is no fee for registration and there is a duty to update the register with any changes, but no requirement to re-register. The Tobacco Retailers Bill, which will create a register of traders in Northern Ireland and introduce steps to deal with persistent offenders, was approved by the Northern Ireland Assembly on 18 February 2014\(^{35}\).

<table>
<thead>
<tr>
<th>Consultation questions:</th>
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<tbody>
<tr>
<td>1. Do you agree with the proposal to create a tobacco retailers’ register for Wales under the terms outlined above?</td>
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<td>2. Do you consider that the creation of such a register will (i) assist in attempts to reduce under age sales of tobacco products, and (ii) assist in the enforcement of the display ban?</td>
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<td>3. Do you consider the proposed fee structure to be reasonable? Please suggest an alternative if not.</td>
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<tr>
<td>4. Do you consider the proposed enforcement and penalty arrangements for the tobacco retailers’ register to be appropriate? If not, could you please provide us with your suggestions?</td>
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<tr>
<td>5. Are there any other features of a tobacco retailers’ register that we should consider?</td>
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\(^{33}\) The Children and Young Persons Act 1933 [http://www.legislation.gov.uk/ukpga/Geo5/23-24/12/introduction](http://www.legislation.gov.uk/ukpga/Geo5/23-24/12/introduction). A restricted premises order or a restricted sales order may be made if a person commits three tobacco related offences in a two year period, a tobacco offence is defined in section 12D of that Act to include sales of tobacco products to minors.


Electronic cigarettes

This proposal is to ban the use of electronic cigarettes in enclosed and substantially enclosed public places (including places of work) in Wales.

2.24 Electronic cigarettes, e-cigarettes or ENDS (electronic nicotine delivery systems) are devices whose function is to vaporise and deliver to the lungs of the user a chemical mixture typically composed of nicotine, propylene glycol and other chemicals, although some products claim to contain no nicotine. A number of ENDS are offered in flavours that can be particularly attractive to adolescents. Electronic cigarettes (e-cigarettes) are the most common prototype of ENDS. Many are shaped to look like their conventional (tobacco) counterparts (e.g. cigarettes, cigars, cigarillos, pipes, hookahs or shishas)\(^{36}\).

2.25 The use of ‘e-cigarettes’ has risen substantially over the last few years. A study in England suggests that electronic cigarette use by tobacco smokers for any purpose has increased from around 2% in 2011 to around 14% in August 2013\(^{37}\). Assuming this trend is reflected across Wales it translates to around 80,000 smokers in Wales who have used e-cigarettes.

2.26 This growing market for e-cigarettes and differing levels of regulation across Europe has prompted the European Union to include e-cigarettes in the scope of the revised Tobacco Products Directive (TPD). The revised TPD introduces mandatory safety and quality requirements on e-cigarettes not covered by the Medicines Directive (2001/83/EC)\(^{38}\). This includes provisions on nicotine content, ingredients and devices, as well as refill mechanisms. It also makes health warnings and information leaflets obligatory and introduces notification requirements for manufacturers and importers of e-cigarettes, stricter rules on advertising and monitoring of market developments. The revised TPD does not, however, introduce restrictions on the age of sale for e-cigarettes, although the text of the Directive states that Member States are free to regulate on such matters in their own domain, and are encouraged to do so.

2.27 The UK Government recently announced its intention to introduce age of sale restrictions for all NPs, including e-cigarettes, in England. This policy is being introduced by way of an amendment to its Children and Families Bill, which will provide the Secretary of State for Health with powers to make regulations that will

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http://www.who.int/tobacco/communications/statements/electric_cigarettes/en/.

\(^{37}\) Smoking Toolkit Study http://www.smokinginengland.info/.

make it an offence to sell NPs to persons aged under 18 years old (thus bringing NPs into line with the age of sale for tobacco products).

2.28 The intention of this policy is to reflect increasing concerns amongst public health practitioners that, as e-cigarettes become more popular, there is a risk that smoking behaviours could be normalised. Although starting from a very low base, evidence suggests⁴⁹ that young people are using e-cigarettes and there are concerns that they could act as a gateway to smoking. E-cigarettes and other NPs contain nicotine which is addictive, and so restricting access to them by young people brings the benefit of reducing the risk of a new generation addicted to nicotine, albeit in a different form to conventional tobacco products.

2.29 It is for these reasons that we have agreed to the Secretary of State for Health having powers to make regulations which will make it an offence to sell NPs to persons aged under 18 years and to proxy purchase NPs in England and Wales (as described earlier in this Chapter). These new offences will bring NPs more into line with tobacco products and work to reduce underage consumption of nicotine products.

2.30 The use of e-cigarettes in public places has also given rise to concern amongst health professionals and enforcement officers. The Smoke-Free Premises etc. (Wales) Regulations 2007 (referred to as “the Smoke-Free Regulations”) prohibit smoking in enclosed and substantially enclosed public places and work places in Wales. The Smoke-Free Regulations do not cover e-cigarettes and so it remains legal to use them in enclosed and substantially enclosed public places and work places in Wales. Despite this, some establishments are taking steps to prohibit the use of e-cigarettes on their premises. This has been to (i) prevent the use of e-cigarettes undermining the smoking ban contained in the Smoke-Free Regulations; and (ii) to avoid difficulties with the enforcement of the Smoke-Free Regulations.

2.31 There have been suggestions that the use of e-cigarettes may undermine the smoking ban on the basis that people seeing them being used may mistakenly believe that they are permitted to smoke in premises where smoking is prohibited. The Directors of Public Protection in Wales have reported difficulties with enforcing the current smoking ban due to the ease of mistaking an e-cigarette for a conventional one. There are also fears that widespread use of e-cigarettes might normalise the act of smoking in public once more, and could act as a gateway to the smoking of conventional tobacco products.

⁴⁹ According to research by the Centers for Disease Control and Prevention, e-cigarette use amongst high-school aged children (aged 11-17 years old) in the US had doubled between 2011 and 2012. [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a6.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6235a6.htm)
2.32 Public Health Wales has issued a position statement on electronic cigarettes which contains the advice that ‘their use should be prohibited in workplaces, educational and public places, to ensure their use does not undermine smoking prevention and cessation by reinforcing and normalising smoking.’ This is in line with previous advice from the British Medical Association which calls for ‘a strong regulatory framework to prohibit their use in workplaces and public places to limit second-hand exposure to the vapour exhaled by the user, and to ensure their use does not undermine smoking prevention and cessation by reinforcing the normalcy of cigarette use.’

2.33 There have been reports that some businesses have introduced prohibitions on e-cigarettes on the basis that it is difficult and time consuming for staff to determine whether customers are smoking conventional cigarettes or are using e-cigarettes. Certain rail companies have also announced that they have banned the use of e-cigarettes in stations and on trains. A spokesperson for First Capital Connect has stated that the company has a no smoking policy regardless of the type of device customers would like to smoke and that ‘Our concern is that e-cigarettes will unsettle other passengers or cause people to think that smoking real cigarettes is allowed. Many airlines also enforce this for similar reasons.’ Glyndwr University has included e-cigarettes in its no-smoking policy which bans smoking in all buildings and vehicles, as well as in the immediate vicinity of the buildings, particularly where there are windows.

2.34 The Welsh Government recognises that e-cigarettes, along with other forms of nicotine replacement therapy, may be helpful to smokers in giving up tobacco. We welcome the new regulatory framework being introduced by the revised TPD and the restrictions on age of sale and proxy purchase proposed by the UK Government. However, we are concerned that the use of e-cigarettes makes it difficult to enforce, and undermines, the Smoke-Free Regulations. With this in mind, we are seeking views and evidence on introducing legislation to ban the use of e-cigarettes in enclosed and substantially enclosed public places (including work places) in Wales, and this will contribute to a definitive assessment of the National Assembly for Wales’ legislative competence to legislate on this subject. It is envisaged that if such legislation was made, it would prohibit the use of e-cigarettes in places where smoking is currently prohibited under the Smoke-Free Regulations with the same penalties for contravention of the prohibition.

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42 Independent – 12 August 2013.
Consultation questions

6. Do you consider that the use of e-cigarettes in enclosed and substantially enclosed public places (including work places) undermines and makes more difficult the enforcement of the current ban on smoking in such places?

7. Do you consider that the widespread use of e-cigarettes in enclosed and substantially enclosed public places (including work places) normalises the act of smoking and acts as a gateway to the use of conventional tobacco products?

8. Do you have any evidence or practical experiences to support your views in relation to questions 6 and 7? If so we would be grateful to receive such evidence or receive details of such experiences.

9. Do you consider legislation would assist in the enforcement of the existing Smoke-Free requirements and reinforce the message that smoking is no longer the norm? Please provide evidence to support your answer, if available.

10. In considering such a proposal, should the ban on the use of e-cigarettes in enclosed and substantially enclosed public and work places be subject to the same exemptions and penalties as conventional tobacco products?

11. What other measures, if any, should the Welsh Government be considering in relation to e-cigarettes?

Smoke-Free Open Spaces

This section considers public places where voluntary smoking bans are currently in operation and seeks views on whether or not the Welsh Ministers should consider making legislation.

2.35 The Smoke-Free Regulations 2007 ban smoking in enclosed and substantially enclosed work and public places with the aim of protecting workers and the public from the harmful effects of second-hand smoke. The Welsh Health Survey suggests that since the ban has been in place the proportion of adult non-smokers reporting being regularly exposed to other people’s tobacco smoke has dropped. A beneficial side-effect has been that the ban has encouraged some smokers to smoke less or to
give up altogether. There is no evidence of any shift in smoking to the home, or of increased exposure to second-hand smoke for children.

2.36 The Welsh Government continues to monitor the impact of the smoking ban and explore how it might be extended to further benefit the health of the Welsh population. Our Tobacco Control Action Plan includes an action for us to consider the possibility of extending the requirements of the Smoke-Free Regulations 2007 to specific designated areas of hospital grounds, for example around entrances where patients, visitors and staff often congregate and where volumes of smoke may be high. Action here would be to supplement the exemplary role all seven Local Health Boards in Wales and Velindre Cancer Centre have taken to implement voluntary smoking bans throughout all of their premises and grounds. Any secondary legislation to ban smoking in such non-enclosed areas would only be taken forward on the basis of evidence that shows significant numbers of people are put at significant risk. We continue to consider the research and possibility of action in this area.

2.37 Local authority bans on smoking in public and school playgrounds is another area of exemplary action by public bodies. ASH Wales has taken forward a smoke-free playgrounds campaign with great success; almost all of the twenty two local authorities have now committed to implementing smoke-free children’s playgrounds, and have received written thanks from the Minister for Health and Social Services.

2.38 Over 99% of maintained schools in Wales are now participating in our Welsh Network of Healthy School Schemes (WNHSS). They can apply to be independently assessed for the WNHSS National Quality Award (NQA) after 9 years’ involvement. It is a minimum standard in the NQA that school grounds are smoke-free.

Consultation questions

12. Do you consider that voluntary smoking bans in hospital grounds, school grounds and children’s playgrounds are sufficient, or are these areas where Welsh Ministers should consider legislating? Can you provide any evidence for your view?

Internet Sales of Tobacco

This section considers the current position regarding internet sales of tobacco products, and asks for views as to whether persons under the age of 18 are sufficiently protected by current arrangements.

2.39 In this Chapter we have discussed the importance of protecting children and young people from the harmful effects of smoking. In doing so, we need to be mindful of new ways in which tobacco products may be accessed, which may require action.

2.40 There is some concern regarding the potential impact changes in people’s shopping habits may have, and the risk of these changes circumventing current legislation. In particular, we are considering the general rise of purchases made over the internet and whether this could undermine our efforts to restrict access to tobacco products by children and young people, for example if there are instances of tobacco products purchased online by an adult which are being physically passed over to a person aged under 18 at the point of delivery.

2.41 It is already an offence to sell tobacco products to persons under the age of 18. This is enforced by local authority trading standards officers and we have had initial discussions with them with regard to the issue of children accessing tobacco via online/remote purchasing. Any enforcement activity in this area will help us to monitor trends. The major supermarket chains also stipulate in their online terms and conditions of sale that a person who receives delivery of a tobacco product must be aged 18 or over.

2.42 We have given detailed consideration to whether the current legislative and administrative arrangements outlined above are sufficient to prevent persons under the age of eighteen from accessing tobacco products via online sales and deliveries. Whilst the current legislative framework clearly provides that it is an offence to sell a tobacco product to a person under the age of 18, it is considered that it would not be possible, in many cases, for trading standards officers to prosecute an online retailer for the offence of selling tobacco products to a person under the age of 18 where an adult purchased the tobacco product online but the retailer made the actual delivery of the product to a person under the age of 18. Currently there is no specific offence of delivering a tobacco product to a person under the age of 18.

2.43 We are seeking views in respect of the extent of the problem of children and young people accessing tobacco products through taking delivery of tobacco products bought online and whether or not the National Assembly for Wales should consider legislating to make it an offence to deliver tobacco products to a person...
under the age of 18. If we were to create such an offence this would operate alongside the new proxy purchase offence in order to protect persons under the age of 18 from accessing tobacco products.

Consultation questions

13. Do you consider there is a problem with persons aged under 18 receiving delivery of tobacco products which have been ordered online by an adult? Please provide evidence to support your response, if available.

14. Is this an area where the National Assembly for Wales should consider strengthening the existing legislative framework to make it an offence to deliver tobacco products to a person who is under the legal age of sale for tobacco products (which is currently 18)?
Improving health across the life course

Chapter 3: Alcohol

Summary

The harmful use of alcohol in Wales is widespread, with a significant number of individuals, families and communities affected. A number of the actions set out in our Substance Misuse Delivery Plan 2013-15 have already been taken forward.

In 2012, there were 504 alcohol-related deaths in Wales, the majority among men. We know that alcohol contributes to more than sixty health conditions and many people with common conditions including stroke, heart disease and hypertension are at substantially increased risks of ill health due to alcohol. Alcohol also accounts for many other premature deaths, including suicide.

Progress is being made to reduce alcohol consumption in some groups but this is not the case across all age groups. It is clear that alcohol consumption in Wales remains too high and that many individuals’ drinking behaviour is changing in ways that adversely affect themselves and their wider communities. We know that alcohol-attributable hospital admissions in Wales are rising and that there are inequalities, particularly for men, in alcohol-attributable mortality rates. We also know that premature death rates from liver disease for those aged under 65 have almost doubled since 1996 and that this rise has been in part attributable to alcohol misuse.

There is indisputable evidence that the price of alcohol matters. The affordability of alcohol has increased substantially in recent decades whilst alcohol-related death and disease has risen. As a result, we are now seeking to further reduce the harms associated with alcohol misuse through a proposal to introduce a Minimum Unit Price of alcohol in Wales.

Context

3.1 Tackling alcohol misuse continues to be a priority for the Welsh Government. Estimated costs to the health service in Wales of alcohol-related chronic disease and alcohol-related acute incidents are between £70 and £85 million each year. There

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is compelling evidence, built up over many decades of research, that alcohol causes harm and the likelihood of harm is proportionate to the amount of alcohol consumed.

3.2 ‘Working Together to Reduce Harm’ is our ten year strategy for tackling the harms associated with the misuse of alcohol, drugs and other substances. The Programme for Government re-emphasised our commitment to reducing the prevalence of problematic alcohol misuse and the number of alcohol related deaths.

3.3 In February 2013, we published the Substance Misuse Delivery Plan 2013-15\(^\text{49}\) which clearly set out our vision for reducing alcohol misuse and outlined the actions that we would be taking to reduce the associated harms. These include a commitment to work with our partners and with the UK Government to do all that we reasonably can to restrict the inappropriate availability of alcohol, and to help and encourage people to drink sensibly and safely.

3.4 There are distinctive issues to be considered in relation to alcohol misuse, particularly a significant minority of people who drink to excess and do not recognise the harm they are doing to themselves. The harmful use of alcohol in Wales is widespread, with a significant number of individuals, families and communities affected.

3.5 In 2012, there were 504 alcohol-related deaths in Wales\(^\text{50}\), the majority among men, although the percentage increase for women during the last ten years has been greater than for men. In Wales these are based on relatively small numbers and fluctuate from year-to-year, so trends must be interpreted with caution. However the general overall picture is of a gradual increase over a number of years up until a peak in 2008. The 2012 figures show that alcohol related deaths are higher in Wales than in England (18.0 per 100,000 population compared with 14.7 per 100,000 population for males, and 10.4 per 100,000 population compared with 7.3 per 100,000 population for females). In addition, alcohol misuse is related to other health harms, such as an increased risk of breast and oral cancers and foetal alcohol syndrome.

3.6 Alcohol-specific hospital admission rates (i.e. those that are wholly related to alcohol such as alcohol-related liver disease or alcohol overdose) generally increased from around 400 per 100,000 population in 2001/02 to around 500 per


100,000 population in 2006/07, and have fluctuated near this level in recent years. There were around 15,500 alcohol specific hospital admissions in 2011/12.

3.7 Analysis by the Public Health Wales Observatory\textsuperscript{51} showed that in Wales between 1999-2009 alcohol-attributable hospital admissions (which include both conditions entirely due to alcohol consumption and those conditions which are partially due to alcohol) rose from approximately 950 to approximately 1400 per 100,000 population for males, and from approximately 560 to over 800 per 100,000 population for females, a rise of nearly 48% and 44% respectively.

3.8 In 2011, the Public Health Wales Observatory also published a report on Measuring Inequalities in Wales.\textsuperscript{52} Inequalities in mortality due to alcohol in Wales were examined using alcohol-attributable and alcohol-related mortality rates. The report presents data up to 2007-09, and shows that in recent years, alcohol attributable mortality rates (a wider definition which includes deaths due to conditions which are in part attributable to alcohol) in the most deprived fifth of areas for males were almost three times higher than rates in the least deprived areas, and were around twice as high in the most deprived areas for females. The inequality gap between the most and least deprived areas was slightly wider in alcohol-related mortality (deaths most directly linked to alcohol use such as alcoholic liver disease) than in alcohol attributable mortality for both males and females.

3.9 The Welsh Health Survey (WHS)\textsuperscript{53} shows that in 2012, 42% of adults reported drinking above the guidelines on at least one day in the past week, including 26% who reported drinking more than twice the daily guidelines (binge drinking). However, people do not necessarily drink at these levels regularly. WHS data between 2008 and 2012 suggests that the percentage of adults reporting drinking above the daily guidelines has decreased slightly, but the pattern by age varies – there has been a decrease for young people, little change for the middle aged, and an increase for older people, although older people are still overall less likely to drink over the guidelines.

3.10 Progress is being made to reduce alcohol consumption in some groups but this is not the case across all age groups. For example, data from the Health Behaviour in School-Aged Children (HBSC)\textsuperscript{54} international report shows that between 1998 and 2009 there was a reduction from 59% to 36% in the number of


15-16 year old boys and a reduction from 46% to 30% in the number of 15-16 year old girls reporting to drink alcohol at least weekly.

3.11 Whilst we are making some progress, there is still a lot of work to do to reduce alcohol misuse in Wales. Alcohol consumption levels are still too high and there is a changing profile in drinking behaviour. This was highlighted by Alcohol Concern Cymru in their report “The Hidden Cost of Drinking at Home”?55 which reported that 46% of drinkers in Wales drink at home because it is cheaper than going to the local pub.

3.12 Many of the tools and powers needed to tackle alcohol harms rest with the UK Government through the provisions of the Licensing Act 2003. The Welsh Ministers do not have the power to legislate in relation to the licensing of the sale and supply of alcohol and as such have written on a number of occasions to the Home Secretary and other UK Government Ministers seeking devolution of alcohol licensing, so that we have the policy levers we believe are necessary to tackle the sale and availability of alcohol. These requests have all been refused. We will continue to pursue the devolution of alcohol licensing to Welsh Ministers, and in February 2013 took the opportunity to make the case again through our evidence to the Silk Commission. The Commission’s report, published on 3 March 2014, did not include a specific recommendation about the devolution of alcohol licensing but suggested that this should be one of the issues to be considered further through the Welsh Intergovernmental Committee proposed in the report.

3.13 We are also aware of specific concerns relating to reported instances of alcohol which has been purchased online being physically passed over to a person aged under 18 when this is delivered to a home address. This issue was specifically discussed in Alcohol Concern Cymru’s 2013 report ‘On your doorstep: Underage access to alcohol via home delivery services’.56 The Licensing Act 2003 applies not only to more traditional sales of alcohol in a pub or nightclub environment, but also to the online sale of alcohol. There is statutory England and Wales-wide guidance in place which specifically covers online sales of alcohol, as well as mandatory Licensing Conditions which provide that companies which sell alcohol remotely should operate an age verification policy. The online purchasing and delivery of age-restricted items is an evolving area as we increasingly turn to new ways of purchasing goods. Through links with local authority trading standards officers, the Welsh Ministers will continue to monitor internet sales and the impact they have on young people and adults in Wales, and if necessary will press the UK Government for further action.

56 Alcohol Concern (2013) ‘On your doorstep: Underage access to alcohol via home delivery services’
3.14 We also believe, and have advocated strongly, that the consideration of public health should be one of the statutory licensing objectives under the Licensing Act 2003. This would mean that representations could be made in response to licensing applications on the grounds that they threatened the protection of public health. This, for example, would allow more scope for the use of health data in licensing decision making and to consider how wider public health implications should influence licensing decisions.

3.15 The planning system provides a similar opportunity for ensuring that the wider public health impact of development is given appropriate consideration. Local development plans should support local strategies to improve health and wellbeing. Undertaking sustainability appraisal of local development plans can ensure draft plans have considered the positive and negative impact on health and wellbeing, in order that unintended health-harming consequences can be avoided or mitigated.

3.16 The Welsh Government is already taking a broad range of action to reduce the harms associated with alcohol misuse. This work includes:

- a range of public health campaigns to raise awareness of the dangers of alcohol misuse and promote responsible alcohol consumption;
- working with Alcohol Concern Cymru to raise awareness of alcohol misuse issues, including through information campaigns, good practice guidance and undertaking research;
- issuing guidance to improve identification and access to substance misuse services for Older People and Veterans;
- working with the Home Office and Public Health Wales to support four Local Alcohol Action Area pilots in Wales to tackle alcohol-related crime and disorder, reduce alcohol-related health harms, and promote growth by establishing diverse and vibrant night-time economies; and
- developing a new systematic process to review alcohol related deaths.

3.17 We are now proposing to utilise legislation to support and complement this range of activity through a proposal to impose a mandatory Minimum Unit Price for alcohol in Wales.

**Minimum Unit Pricing**

The Welsh Government believes that imposing a mandatory Minimum Unit Price for alcohol in Wales will demonstrate prudent health care as this policy will make a strong contribution to our principal aims of promoting health, preventing alcohol misuse and reducing alcohol-related harm and disease.
Introducing a Minimum Unit Price would set a floor price for a unit of alcohol, meaning that alcohol could not be sold below that. This would not increase the price of every drink, only those which are sold at below any minimum price set. A Minimum Unit Price will affect those drinks sold at an unacceptably low price relative to their alcohol content, such as cheap spirits and white cider. For example, a 50p per unit minimum price would mean that a 70cl bottle of whisky could not be sold for less than £14.

3.18 Given the link between consumption and harm, and the evidence that affordability is one of the drivers of increased consumption, the Welsh Government’s view is that Minimum Unit Pricing for alcohol is a key policy proposal for tackling the health harms associated with alcohol misuse. We believe it will have the highest impact and is a recommended action by the World Health Organisation and the World Economic Forum in their joint report ‘From Burden to Best Buys’\(^57\), in the context of reducing premature mortality from non-communicable diseases. In terms of the level at which to set a Minimum Unit Price, the Welsh Government’s view, backed by research from Sheffield University\(^58\), is that a 50p Minimum Unit Price should be set to reduce alcohol consumption.

3.19 Following a consultation on a range of proposals to cut alcohol fuelled crime and anti-social behaviour that ended in February 2013, the UK Government confirmed that it will not be taking forward the proposal to introduce Minimum Unit Pricing throughout England and Wales. The UK Government’s official consultation response\(^59\) stated that the consultation process carried out did not provide conclusive evidence that Minimum Unit Pricing would reduce problem drinking without penalising those who drink responsibly.

3.20 On 4 February 2014, the UK Government announced plans to ban the sale of alcohol below the cost of duty plus VAT. The ban aims to prevent businesses from selling alcohol at heavily discounted prices, and to reduce excessive alcohol consumption and its associated impact on health and alcohol related crime. Whilst this can be considered a step in the right direction, it is considered to have little scope to reduce harmful alcohol consumption to the level required. The Home Office’s impact assessment,\(^60\) also published on 4 February, uses data from a forthcoming update of the University of Sheffield’s School of Health and Related

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Research (ScHARR) model for assessing the impact of alcohol pricing policies on alcohol consumption and health, crime and employment outcomes. The latest update of the ScHARR model\textsuperscript{61} predicts that overall alcohol consumption will fall by 0.04% as a result of a ban on alcohol sold below duty plus VAT. Furthermore, it estimates that consumption of alcohol by harmful drinkers will only fall by 0.08%.

3.21 The Scottish Courts have recently been asked to consider the issue of Minimum Unit Pricing in a judicial review case brought by the Scotch Whisky Association (“SWA”) against the Scottish Government’s Alcohol (Minimum Pricing) (Scotland) Act 2012. The Court held that the reduction of alcohol consumption generally and the reduction of consumption by hazardous and harmful drinkers are both legitimate public health aims with merit. The Scotch Whisky Association has appealed against this decision and five European wine producing countries have referred the matter to the European Commission on the basis that Minimum Unit Pricing legislation would violate EU law.

3.22 Whilst individuals have to take responsibility for their own health, the Welsh Government’s view remains that introducing Minimum Unit Pricing for alcohol would be entirely in accordance with prudent healthcare principles. It involves taking proportionate and preventative action to protect public health in order to avoid longer term health, societal and economic costs, as there is indisputable evidence that the price of alcohol influences consumption. It is no coincidence that as the affordability of alcohol has increased substantially in recent decades, alcohol related death and disease have risen. The World Health Organisation’s report on the evidence for the effectiveness of interventions to reduce alcohol-related harm\textsuperscript{62} found that “when other factors are held constant, such as income and the price of other goods, a rise in alcohol prices leads to less alcohol consumption and vice versa”. If the price of alcohol goes up, alcohol-related harm goes down. The report also found that younger drinkers are affected by price as ‘policies that increase alcohol prices delay the initiation of drinking’ and ‘heavy drinkers are more affected than light drinkers.’ Evidence also indicates that violence-related injury is causally linked to alcohol price\textsuperscript{63}.

3.23 Research carried out by Sheffield University (2008)\textsuperscript{64} indicated that a 50p Minimum Unit Price would be effective in reducing alcohol consumption across

\textsuperscript{61} The ScHARR v.2.5 report will be published on their website: \url{http://www.sheffield.ac.uk/scharr/sections/ph/research/alpol/publications}
\textsuperscript{64} Brennan, A. et al. (2008) Modelling the Potential Impact of Pricing and Promotion Policies for Alcohol in England: Results from the Sheffield Alcohol Policy Model Version 2008 (1-1)’.
England. This showed that, on average, a Minimum Unit Price of 50p would reduce consumption:

- per drinker by 6.9%; this would lead to 97,900 fewer hospital admissions and 10,300 fewer violent crimes per year;
- per 11-18 year old drinker by 7.3%; this would lead to 500 fewer hospital admissions and 2,200 fewer violent crimes per year for that age category; and
- per high-risk drinkers by 10.3%. It also valued the overall cost benefit of harm reduction at £12.9 billion nationally over a 10 year period.

Whilst this research was undertaken for England there is no reason to believe, at this stage, that similar results would not be achieved for Wales.

3.24 The ‘Sheffield model’ was further developed in 2009 \(^{65}\), following additional work commissioned by the National Institute for Health and Clinical Excellence (NICE) \(^{66}\). This further research estimated that a Minimum Unit Price of 50p for England would result in the following outcomes:

- in the first year a moderate drinker would on average pay an extra £13 for alcohol and drink 11 fewer units per year;
- a harmful drinker would on average reduce consumption by 368 units and pay an extra £195 per year;
- there would be annual reductions of 521 deaths, 20,600 hospital admissions and 42,500 crimes attributable to alcohol; and
- the overall value of alcohol sales would increase by £1271m.

3.25 This research provided an evidence base for Minimum Unit Pricing and identified that 50p per unit of alcohol would target irresponsible drinking, impacting on hazardous and harmful drinkers, while imposing a minimal extra financial burden on moderate drinkers and on-trade sales. Overall the Sheffield analysis considered that a Minimum Unit Price for alcohol would have a major impact in reducing alcohol related harm. The model values the national harm reduction cost benefits over 10 years at £12.9 billion. This analysis has subsequently been endorsed by several authoritative national reviews, including:


- Sir Liam Donaldson’s ‘150 years of the Annual Report of the Chief Medical Officer: On the state of public health’ (2008)\(^67\);
- Alcohol Concern ‘The Price is Right’ (May 2009)\(^68\);
- The House of Commons Health Committee Report on Alcohol (December 2009)\(^69\); and
- NICE clinical guidelines (June 2010)\(^70\).

3.26 Minimum Unit Pricing has also been pursued in a number of other countries. In British Columbia (BC)\(^71\) a 10% increase in minimum price of alcohol was significantly associated with a 32% decline in alcohol related deaths. The Centre of Addiction Research of BC looked at the implementation of minimum alcohol prices. It found that a 10% increase in minimum price reduces consumption of spirits by 6.8%, wine by 8.9%, coolers and cider by 13.9%, beer by 1.5% and all alcoholic drinks combined by 3.4%. Similarly, it found that the Canadian province of Saskatchewan’s decision to set minimum prices for alcohol content has been successful in reducing harmful consumption of alcohol. It was calculated that a 10% increase in minimum price across all beverages was associated with an 8.4% reduction in total consumption.

3.27 Given the wealth of evidence across the UK and internationally to support the introduction of Minimum Unit Pricing, the Welsh Government believes that the impact of introducing such a measure in Wales would be equally beneficial. The Welsh Government intends to undertake further work to examine the evidence base for the impact of Minimum Unit Pricing at a Wales level and this will contribute to a definitive assessment on the National Assembly for Wales’ legislative competence to legislate in this area. We will also give detailed consideration to the enforcement action necessary, including penalty arrangements, as well as the costs of introducing and administering Minimum Unit Pricing in Wales.

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\(70\) Jackson R et al (n.d.) Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People [online] Available at: www.nice.org.uk/nicemedia/live/13001/49001/49001.pdf

**Consultation questions**

15. Given the evidence base and public health considerations, do you agree that the Welsh Government should introduce a Minimum Unit Price for alcohol?

16. Do you agree that a level of 50 pence per unit is appropriate? If not, what level do you think would be appropriate?

17. Do you agree that enforcing Minimum Unit Pricing for alcohol would support the reduction in alcohol related harms? Please provide evidence to support your answer, if available.

18. Do you think any level of Minimum Unit Pricing set by the Welsh Government should be reviewed and adjusted over time? Please provide evidence to support your answer, if available.

19. As the Welsh Government cannot legislate on the licensing of the sale and supply of alcohol, what enforcement and/or penalty arrangements do you think should be in place to introduce Minimum Unit Pricing for alcohol in Wales?

20. Do you think there are other measures that should be pursued in order to reduce the harms associated with excessive alcohol consumption?
Improving health across the life course

Chapter 4: Obesity

Summary

As well as impacting on an individual’s health and well being, illnesses associated with obesity place a significant financial burden on services. This is estimated to cost the NHS in Wales nearly £86 million each year.

The Welsh Government recognises that reducing obesity levels is a key national challenge. We are currently taking a cross-departmental approach to reducing the rate of obesity across the entire life-course, with a particular focus on childhood, and support a number of policies and initiatives that aim to improve access and uptake of a healthy diet and increase physical activity levels.

In this Chapter, we outline a proposal to complement our range of existing activity through the introduction of food and drink nutritional standards in certain settings.

Context

4.1 Most cases of obesity are caused by eating too much and doing too little physical activity. If individuals consume high amounts of energy from their diet but do not burn off the energy through exercise and physical activity, the surplus energy is turned into fat.

4.2 Obesity does not happen overnight. It develops gradually from poor diet and lifestyle choices. Childhood obesity can be a strong indicator of weight-related health problems in later life, showing that learned unhealthy lifestyle choices continue into adulthood.

4.3 A balanced diet is one that provides adequate amounts of energy and nutrients for health and wellbeing. Most people in Wales eat and drink too many calories, which can lead to overweight and obesity, and too much saturated fat, sugar and salt. In addition to the excess calories that eating too much fat and sugar may provide, this can have a detrimental long term impact on health.

4.4 Obesity can affect the ability of an individual to participate in everyday activities as well as having both short term and long term impacts on health. In the short term it can impair a person’s wellbeing and quality of life, while longer term health problems include increased risk of coronary heart disease and stroke. People who are obese are also more likely to develop type two diabetes and some types of cancer.
4.5 Illnesses associated with obesity place a significant financial burden on services. This is estimated to cost the NHS in Wales over £73 million, which increases to nearly £86 million if overweight people are included. In 2008/09, between £1.4 million and £1.65 million was spent each week treating diseases resulting from obesity, equivalent to between £25 and £29 per person in Wales and between 1.3% and 1.5% of total healthcare expenditure\(^72\).

4.6 Although there has been a slowing down in the increase of overweight and obesity rates in Wales, the number of people above a healthy weight remains unacceptably high. According to the 2012 Welsh Health Survey over half of all adults are overweight or obese (59%) and nearly a quarter of all adults (23%) are obese. Over a third of all children (34%) are overweight or obese, with nearly a fifth (19%) obese. Rates of overweight and obesity amongst children (aged 2-15) have changed little over recent years.

4.7 Data from the first year (2011/2012) of the Child Measurement Programme\(^73\) indicated that nearly three out of ten (28.2%) reception age children are classed as overweight or obese, and one in eight (12.5%) are obese.

4.8 Levels of obesity, across all ages, are higher in our more deprived areas, with rates of obesity amongst adults ranging from 28% to 18% in the most and least deprived areas of Wales.

4.9 There is not a single answer to this issue. The Welsh Government is committed to reducing the prevalence of obesity through a range of actions. The Welsh Government is committed to a range of actions involving a multi-faceted, coordinated approach to decreasing levels of diet-related ill health and premature death.

4.10 Recent activity in Wales has centred around the All Wales Obesity Pathway. Launched in 2010, this sets out a framework for those in Wales responsible for the prevention and treatment of obesity, from community-based prevention and early intervention to specialist medical and surgical services. Local Health Boards across Wales have examined policies, services and activities for both children and adults, and are taking action to address local needs. This will establish a wide range of programmes and initiatives that will benefit both adults and children.

4.11 One such local response is the Cardiff and Vale University Health Board’s ‘Optimising Outcomes’ policy. This seeks to encourage people to consider the health risks resulting from their behaviour, equip them with the tools for behaviour change and help optimise surgery outcomes and improve recovery rates. From December

\(^{72}\) Assessing the costs to the NHS associated with alcohol and obesity in Wales, Swansea University

\(^{73}\) Child Measurement Programme 2011-12, Public Health Wales.

2013, any patient listed for elective surgery in Cardiff and the Vale University Health Board who has a body mass index (BMI) of 40 or more will be required to complete a weight management support programme before being put on the waiting list. The Minister for Health and Social Services recently wrote to Local Health Boards highlighting this initiative as a good example of prudent health care, and setting out an expectation for them to consider introducing such initiatives.

4.12 A number of national initiatives are in place to encourage and support people to maintain a healthy balanced diet and be more physically active. These include programmes such as Change4life, Appetite for Life, the National Exercise Referral Scheme and a Children’s Weight Management Referral Programme.

4.13 Our Physical Activity Action Plan ‘Creating an Active Wales’ focuses on creating an environment that supports physical activity across all sections of society. The Active Travel (Wales) Act imposes a new duty on Welsh Ministers and local authorities to promote active travel and to create an environment where it is safer and more practical to walk and cycle than it is at present. The aim is to make walking and cycling the most natural and normal ways of getting about. Local authorities will have a duty to make year on year improvements to their active travel routes.

4.14 We know that easy access to high quality public open space improves mental health and levels of physical activity. Alongside better housing, these are just some aspects of the local physical environment which impact on overall health and wellbeing. The planning system has the potential, through the pursuit of good design, to shape local development in a way which complements other measures that address obesity and support wider public health objectives. Creating opportunities for healthy lifestyle choices, such as those that encourage physical activity, should be given early consideration when preparing development plans, including measures such as sufficient provision of homes, open space networks, walking and cycling opportunities and building safe, vibrant places.

4.15 A specific issue which respondents to our previous Public Health Green Paper commonly felt strongly about was that of physical activity in schools. The Schools and Physical Activity Task and Finish Group was established in 2012 to consider how to develop the role of schools in increasing levels of physical activity in children and young people, and to bring forward advice and recommendations to the Welsh Government. Recommendations of the group included that physical activity become a core element of the National Curriculum for Wales, supported by a National Physical Literacy Framework, in a similar way to the national frameworks for

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74 Creating an active Wales [http://wales.gov.uk/topics/health/improvement/index/active/?lang=en](http://wales.gov.uk/topics/health/improvement/index/active/?lang=en)

75 The Active Travel (Wales) Act 2013 (2013 anaw 7).
numeracy and literacy. The Minister for Education and Skills and Minister for Culture and Sport announced on 18 March 2014 that a Physical Literacy Framework will be developed as part of a new Physical Literacy Programme for Schools. The recommendations of the Schools and Physical Activity Task and Finish Group will also be considered as part of the independent review of the National Curriculum and assessment arrangements in Wales, which is being led by Professor Graham Donaldson.

4.16 The food and drink industry has a significant role to play in influencing what we choose to eat. The food industry however does not generally operate on a Welsh level. The major manufacturers and retailers of food in Wales operate on a UK or EU/global basis and for this reason we work alongside the other Health Departments in the UK to influence the industry, whether through voluntary collaboration or regulation.

4.17 The Food Information for Consumers Regulation (FIC) updates and consolidates all general food and nutrition labelling legislation. From December 2016 FIC will require most pre-packed foods to include back of pack nutrition labelling, making it easier for consumers to make informed healthy eating choices when shopping.

4.18 The UK government and devolved administrations have also worked collaboratively with the food industry to introduce voluntary action in this area. The Front of Pack (FoP) nutrition labelling scheme introduced in June 2013 is an example of successful collaborative working. This universal scheme incorporates both colour-coding and reference intakes (guidelines about the approximate amount of particular nutrients and energy required for a healthy diet – formerly known as guideline daily amounts), and will help consumers make a healthy choice at a glance. All the major UK supermarkets have signed up to the scheme and over 60% of pre-packed food and drink on the market will carry FoP labelling.

4.19 Voluntary action around reformulation and portion size reduction is also encouraged through the Department of Health’s Responsibility Deal, and this approach is supported by the Welsh Government. The Minister for Health and Social Services recently wrote to the Secretary of State for Health of the UK Government, urging him to press for more positive action by businesses in this area including in support of reducing sugar intake. He also stated that mandatory action should not be ruled out if voluntary action does not achieve what it sets out to.

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4.20 The promotion of unhealthy food and drink products is now widely recognised as a significant risk factor for childhood obesity, and for the development of diet-related non-communicable diseases. In response to this, in 2007 Ofcom in collaboration with the Food Standards Agency (who were then responsible for nutrition policy for the UK) brought in advertising restrictions for food and drink products high in fat, salt and sugar (HFSS). Advertising of HFSS products is now prohibited in or around programmes specifically made for children and those shown on dedicated children’s channels. The Welsh Government supports this measure and is pressing for these restrictions to be extended to include all programmes shown before the watershed.

4.21 The Welsh Government continues to consider a range of action to tackle obesity in Wales (such as those outlined in this Chapter), the majority of which do not require primary legislation or could be considered using existing legislative powers. We propose that we can make an additional positive impact through the introduction of nutritional standards in specific settings, which would build on positive work which has already been undertaken.

**Nutritional Standards**

This proposal is to introduce nutritional standards in specified public sector settings. This would build on the work previously undertaken in schools and hospitals and would be done through secondary legislation and/or guidance.

4.22 In Wales, the Welsh Government has created and imposed mandatory nutritional standards for all food and drink served in schools, providing a sound nutritional foundation for children under the Healthy Eating in Schools (Nutritional Standards and Requirements) (Wales) Regulations 2013. In hospitals, nutritional standards for hospital patients have been implemented under the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients and the All Wales Hospital Menu Framework, which provides a database of menu items and recipes to be used in hospitals for patients. These standards are in place to ensure that patients receive adequate nutrition to assist with their recovery.

4.23 We are now considering building on this work by developing nutritional standards for additional settings. Two examples which we are considering are pre-school and care homes settings.

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4.24 Introducing standards in pre-school settings would aim to ensure a consistent approach across Wales, and would seek to contribute to improving dietary health, and ingraining good dietary habits from an early age.

4.25 Introducing standards in care homes settings would aim to ensure further protection for vulnerable groups. For example, currently there are no nutritional or food based standards for care homes for older people, and a survey by Trading Standards officers in much of Wales has painted a mixed picture in terms of the adequacy of food and nutrient provision. Older people in care homes are among the most vulnerable in our community and they depend on the care home and its staff to provide balanced meals and ready access to fluids. We would therefore like to build on work undertaken within hospitals and share this best practice with other settings.

Consultation Questions

21. Do you agree that nutritional standards should be introduced in the settings we are proposing, that is, pre school settings and care homes?

22. Do you think there are any other public sector settings that should be considered in relation to mandatory nutritional standards?

23. Do you think there are other practical steps we could take to contribute to this issue?
Chapter 5: Building community assets for health

Summary

We believe that people, their families and the communities in which they live, work and play are all important in the way they protect and promote health and wellbeing. These health ‘assets’ have been categorised as ‘the capacity, skills and knowledge and connections’ in individuals and communities. These need in turn to be supported by the right physical infrastructure and services.

Local health care services have a leading and vital role to play in improving the health of individuals, families and local communities. Local health care which is effective depends on accurate assessment of need, meaningful engagement with local citizens and people working well together; doctors, nurses, community pharmacists, therapists, care workers, dentists, optometrists, social workers and other local government workers. A range of action to strengthen the overall role of local health care services in Wales is being taken forward through our Plan, ‘Delivering Local Health Care – Accelerating the Pace of Change’.

The community pharmacy is one such important community health asset. It plays a crucial role in fulfilling both a social and wellbeing function, often in the most deprived parts of Wales, providing shopping access, local employment and contributing to social capital. There is considerable public health benefit to be gained by fully recognising and extending the role of community pharmacies and the range and reach of the services they provide.

In this Chapter, we outline a proposal to strengthen the role of Local Health Boards in planning and delivering pharmaceutical services to meet the needs of their communities. By doing so, the arrangements for planning pharmacy services will be more closely aligned with those for other primary care services.

Toilet facilities are another important community ‘asset’. Accessible and well maintained toilet facilities have a positive impact on the health, dignity and quality of people’s lives. Poor toilet provision and access affects some groups disproportionately, such as women (who are more likely to be accompanied by children), elderly adults and disabled people. Well located toilet facilities are also essential and will help encourage people who may need regular toilet access to take exercise and stay more physically active.

In this Chapter, we outline a proposal to strengthen the role of local authorities in planning for the provision of and access to toilets for public use, which will meet the needs of their communities.

Context

5.1 In the past, we have often focussed on what is wrong in communities and have spent time and money on finding solutions to ‘fix’ the problem. There is now a greater realisation that the Welsh Government needs to identify and build on the strengths already present in people and the places in which they live. This is referred to as a ‘health assets’ approach and it can be seen as existing at three levels:-

- the individual, for example in his or her resilience, self esteem, sense of purpose, commitment to learning;
- the community, including family, friendship, intergenerational solidarity, community cohesion, religious tolerance and harmony; and
- society; a safe and supportive environment that can promote physical, mental and social health, employment security, religious tolerance and harmony.

5.2 To make this approach succeed, the Welsh Government and other bodies need to ensure that the right physical infrastructure and services are in place.

5.3 The Welsh Government has been working for a number of years to strengthen local health care services and ensure the right care is provided in the right place, at the right time by the right person. This means strong locally led planning and delivering much more care at or close to home to improve the health of individuals, families and communities. This approach aims to provide improved access to effective integrated care and support, with a particular focus on older people and those at risk of, or with, long term conditions.

5.4 Our local health services in Wales have a vital role to play. Over 90% of patient contact with the NHS takes place in primary care, provided by general practitioners, dentists, community pharmacists and optometrists. To be considered prudent health care, our local services must be effective, promote equity of treatment and be responsive to the needs of local people, whatever their circumstances and wherever they live. Whilst we expect the quality of services to be consistent across Wales, the ways in which services are designed and delivered will vary according to need and local circumstances, in order to deliver the best health outcomes.

5.5 Accessible, person centred primary care services sit at the core of local care. GPs and their teams continue to have a crucial role by providing first contact services to the people registered with their practice, considering all their needs – including physical and mental health and wellbeing. The role of the GP will continue to evolve, along with that of the extended primary care team, by responding to shifting patterns of demand due in part to social changes and increasing numbers of older people. As locally led service planning and delivery matures, we will see the
expansion of new and extended roles, such as specialist GPs, community physicians, nurse practitioners and healthcare/physician assistants.

5.6 A range of action to strengthen the delivery of local health care is being taken forward through the Welsh Government’s Plan ‘Delivering Local Health Care – Accelerating the Pace of Change’. Beyond this, we are proposing that legislation could also have a role in helping to develop local health care services in a way which facilitates improved health for the communities they serve. We propose that legislation could make a positive contribution particularly in the context of the public health role of community pharmacies in Wales.

5.7 Community pharmacies have a pivotal and integral role to play in shaping and contributing to public health. There are 712 NHS community pharmacies in Wales, located on high streets, shopping parades, in supermarkets and GP practices in villages, towns and city centres across Wales. Many are open six and occasionally seven days a week. Community pharmacies are more likely to be located in the most deprived areas of Wales where health needs are greatest and are generally patients’ first and often their most frequent point of contact with a healthcare professional.

5.8 In Wales, around 70 million prescriptions (69.2 million in 2012-13) are dispensed in pharmacies every year. Furthermore, pharmacies are high street retailers, routinely visited by people who do not consider themselves to be ill. Each visit is an opportunity to engage with members of the public about their lifestyle and to make a contribution to improving their health.

5.9 Community pharmacies are easily accessible and provide a convenient and less formal environment for those who cannot or do not wish to visit other kinds of health services. They are therefore uniquely well positioned to make a wide range of services easily available to local people. For example, many provide emergency contraception, smoking cessation and sexual health advice, and in 2012 Wales was the first part of the UK to introduce free seasonal influenza vaccination from community pharmacies on a national basis.

5.10 However, the services provided by community pharmacies are not limited to dispensing prescriptions. Increasingly, pharmacies provide a range of services and there has been good progress in expanding the range of public health services provided right across Wales. In 2012-13:

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• 137 pharmacies provided NHS approved Level 3 stop smoking services, and 286 provided Level 2 services;
• 533 pharmacies provided prompt access to free emergency contraception; and
• Over 450 pharmacies provided harm reduction services such as supervised administration of medicines\(^{81}\), with 183 providing syringe and needle exchange; and

In 2013-14:
• Over 25% of pharmacies are providing NHS influenza vaccinations for people at risk of the complications of influenza (based on current management information).

5.11 In addition to the services they provide, community pharmacies have been identified as one of the essential businesses that ensure economic prosperity in communities. Their ongoing presence on Wales’ high streets is important in sustaining local communities, providing shopping access, local employment and building social capital\(^{82}\).

5.12 Whilst there has been good progress in expanding the range of services provided by community pharmacies, there remain significant challenges. In particular, there is significant variation in the extent to which Local Health Boards plan such services and at times delivery by pharmacies has been inconsistent. This is largely because the arrangements for planning pharmaceutical services have not changed in the same way as those for other primary care services. There is considerable public health benefit to be gained by ensuring that Local Health Boards have a stronger role in planning pharmaceutical services, as they do for other services they provide. This would fully recognise and extend the role of pharmacies, and the range and reach of the services they provide.

5.13 As a result, we are now proposing primary legislation to strengthen the role of Local Health Boards in planning and delivering the volume, location and type of pharmaceutical services required to meet the needs of their populations.

Better planning and delivery of public health services through community pharmacy

This proposal is to amend the NHS (Wales) Act 2006 to require Local Health Boards to prepare pharmaceutical needs assessments for their respective communities and determine applications for entry onto the pharmaceutical list in accordance with the needs assessed. This will allow a fundamental change to the way in which decisions about pharmaceutical services in Wales are made, shifting from one driven by applications from pharmacy contractors and focussed heavily on the dispensing of prescriptions, to one which is alert and responsive to the pharmaceutical needs of local communities.

5.14 The NHS Wales Act 2006 (“The Act”) establishes the legislative framework for the provision of pharmaceutical services in Wales. Under the Act (principally sections 80, 83, 84 and 86) the Welsh Ministers can make regulations concerning the provision of pharmaceutical services.

5.15 The NHS Pharmaceutical Services Regulations 2013 (“The Regulations”) set out the arrangements by which pharmacists can apply to provide NHS pharmaceutical services, and set out the terms and conditions under which those services will be provided. This is referred to as “control of entry”.

5.16 A Local Health Board can only approve an application to provide NHS pharmaceutical services where the applicant demonstrates that the existing provision of pharmaceutical services is inadequate, and where it is satisfied that it is either necessary or expedient to grant the application in order to secure adequate service provision. However, the current legislative framework requires only that Local Health Boards consider the adequacy of dispensing services offered by pharmacies when determining the pharmaceutical needs of their communities. This approach has not changed to keep pace with the developing public health role of community pharmacy, and does not support Local Health Boards in maximising their contribution to improving the health of local communities. Furthermore, there are few levers available to Local Health Boards to improve the consistency and quality of pharmaceutical service provision, either in respect of traditional or more innovative services. The result is that there is inconsistent planning and delivery of pharmaceutical services.

5.17 In order for community pharmacies in Wales to make a more telling contribution to improving the public’s health, we believe the planning and performance management of pharmaceutical services must be strengthened.
The Welsh Government considers that legislation governing NHS pharmaceutical services should give Local Health Boards responsibility for securing effective, adequate services which support addressing local public health priorities. It should create an environment in which the existing community pharmacy network is motivated to ‘raise its game’ by providing services which address unmet pharmaceutical needs, and should provide a more objective basis for determining whether or not to develop services or to expand existing provision.

We are therefore proposing to utilise primary legislation to strengthen the arrangements for planning and decision making in relation to pharmaceutical services. This would aim to support the continuing expansion and diversification of community pharmacy services by:

- requiring that each Local Health Board periodically completes an assessment of the pharmaceutical needs of its population;
- requiring that the full range of services that can be provided by community pharmacies, and not just dispensing services, are considered in the determination of applications to provide NHS pharmaceutical services; and
- giving Local Health Boards powers to invite community pharmacies in their area to provide specified services to meet identified pharmaceutical needs and, where those pharmacies are unable to do so adequately, invite additional pharmacies to become established in order to provide pharmaceutical services.

We anticipate that the change would result in community pharmacies providing an increased range of services for the communities they serve. The number and nature of those services will vary between pharmacies but will reflect the specific health needs of their communities. Where there is a lack of quality or consistent delivery Local Health Boards will be able to implement improvement measures, which could include taking action against particular pharmacies for breaches of terms and conditions of service, or inviting additional pharmacies to apply to provide particular services. We anticipate that these measures will provide Local Health Boards with appropriate tools that enable them to improve the quality and consistency of pharmaceutical services in their areas.
## Consultation questions

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<thead>
<tr>
<th>Question</th>
<th>Text</th>
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<tr>
<td>24.</td>
<td>Do you agree community pharmacies can play a stronger role in promoting and protecting the health of individuals, families and local communities as part of a network of local health care services?</td>
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<td>25.</td>
<td>Do you agree with the proposal to require Local Health Boards to complete periodically an assessment of the pharmaceutical needs of its population?</td>
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<td>26.</td>
<td>In respect of question 25 what are your views on such assessments being completed as a discrete part of their assessment of local health and wellbeing needs?</td>
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<td>27.</td>
<td>Please comment on what information you think Local Health Boards should incorporate in its pharmaceutical needs assessment and the frequency with which such assessments should be updated.</td>
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<td>28.</td>
<td>In respect of question 27, do you think that using the Local Health Board’s assessment of pharmaceutical needs will be sufficient for this or are there other factors that need to be considered?</td>
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<td>29.</td>
<td>Do you consider that it is appropriate for applications to provide pharmaceutical services to be determined on the basis of the contribution that all the services they propose might make to address local health needs?</td>
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<td>30.</td>
<td>Do you agree with the proposal to allow Local Health Boards to invite community pharmacies in their area to provide specified services to meet identified pharmaceutical needs and, where those pharmacies are unable to do so adequately, invite additional pharmacies to become established in order to provide pharmaceutical services? If you disagree please explain your reasons.</td>
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<td>31.</td>
<td>Do you agree that where pharmacies are not adequately providing services, a range of measures, which could include sanctions against pharmacies for breaches of terms and conditions of service, should be available to Local Health Boards to support improving quality and consistency? What other measures should be available to Local Health Boards?</td>
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<td>32.</td>
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Toilets for public use

5.21 The provision of and access to toilets for public use is an issue that affects the health, dignity and quality of people’s lives. Public toilets are typically seen as stand-alone facilities provided and maintained by local authorities. Whilst these have an important role to play in ensuring citizens have access to suitable facilities, especially where there are no other possibilities, they are far from the only option. There are now in addition a wide range of toilet facilities available in both public sector (e.g. public libraries, community and town halls, sports centres, theatres and museums etc.) and private sector buildings (e.g. private businesses currently captured by the Community Toilet Grant Scheme). There is a probability that unless a proper local assessment is undertaken, the wide range of facilities potentially available to the public cannot be put to best use.

5.22 There are public health and environmental costs to the wider community of not providing adequate toilet facilities. Poor toilet provision and access disproportionately affects some groups such as women (who are more likely to be accompanied by children), elderly adults and disabled people. Many older people also feel unable to take advantage of local amenities without having confidence that toilet provision is available. Children, young people and their families also need access to suitable facilities, including baby change facilities, in both male and female toilets.

5.23 Accessible, clean toilets that are well located in places like parks, promenades, cycle trails and walking routes will help encourage people who may need regular toilet access to take exercise and stay more physically active. Adequate toilet access can help encourage people out of their cars and back onto more sustainable forms of travel, and therefore supports the intentions of the Active Travel (Wales) Act 2013.

5.24 Conversely, toilets that are poorly designed, inadequately maintained and poorly located can create an atmosphere of neglect that discourages public use. These conditions can attract vandalism, graffiti and criminal damage, and anti-social behaviour.

5.25 In 2006, Help the Aged published a report ‘Nowhere to go – Public Toilet Provision in the UK’ which summarised a survey of older people’s views on public toilet provision in their local area. The survey was sent to older people’s forums and 10% of the respondents lived in Wales. The report showed more than half of older people found that a lack of local public toilets prevented them from going out as often as they would like.

5.26 The over-riding recommendation of the Communities and Local Government Committee [UK] 2008 report, “The Provision of Public Toilets”[^83] was: “…the

[^83]: [http://www.publications.parliament.uk/pa/cm200708/cmselect/cmcomloc/636/63602.htm](http://www.publications.parliament.uk/pa/cm200708/cmselect/cmcomloc/636/63602.htm)
Government imposes a duty on each local authority to develop a strategy on the provision of public toilets in their areas, which should include consultation with the local community and which should be reviewed annually. The duty of compiling and reviewing a public toilet strategy is a simple requirement that will go a long way towards achieving the right of people who live in and visit this country to have accessible and clean public toilets, wherever they live, work or visit. The way in which local authorities plan and utilise their own strategic plan is a decision for them; the fact that they have a plan should be a duty placed on them by the Government.” (p.41). In the same report the Committee explained that: “our public toilet provision should not be allowed to decline at the current rate because of neglect arising from the lack of any clear strategy” (p.4). The UK Government responded to the above report in January 2009 and declined the recommendation to impose a duty on local authorities.

5.27 Following the submission of a petition to the National Assembly for Wales Petitions Committee in June 2010, the National Assembly for Wales’ Health and Social Care Committee held a short inquiry on the ‘Public health implications of inadequate public toilet facilities’ during the winter of 2011/12. The Committee heard evidence from various stakeholders and based on the evidence received concluded:

1) There is a public health case for better public toilet provision; and
2) A set of potential practical solutions exist which could, if implemented, lead to improved local provision of public toilets.

5.28 It was the Committee’s view that these potential solutions merited further investigation by those more expert in local government matters. Possible solutions identified by the Committee included:

1) **Making the most of existing resources** – including scope for the Community Toilets Scheme to make a greater contribution and a requirement to make toilet facilities within public buildings available for public use;
2) **Charging** – to mitigate financial impact on local authorities and allow public toilets to be accessible 24 hours a day;
3) **Planning** – local authorities to use their planning powers to insist on the provision of publically accessible toilets in new developments;
4) **Strategy** – a strategy for Wales to ensure public toilets are accessible to all; and
5) **Community involvement** – local communities keeping public toilets open through donations for cleaning equipment and volunteers to clean the facilities.

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5.29 The Welsh Government’s response to the Health and Social Care Committee Report recognised that inadequate public toilet facilities impacted on the health, dignity and quality of people’s lives.

5.30 In December 2013, a short Assembly debate took place on the importance of public toilets. The Minister for Local Government and Government Business acknowledged the importance of public toilets and stated that the provision of public toilets should remain a priority, and that all possible efforts should be made to sustain the provision of these services.

5.31 The Welsh Government has sought to increase the provision of free public access to toilet facilities in Wales, and to improve the quality and accessibility of these facilities by encouraging local authorities to work in partnership with local businesses to allow public access to their facilities. The Community Toilet Grant scheme was initially established in 2009-10 for three years and all local authorities in Wales were invited to participate. The scheme reimburses local authorities (to a maximum of £17,500 per local authority per year) for payments of up to £500 made to local businesses, for allowing free public access to their toilet facilities (although local authorities may provide a higher level of funding at their discretion from their own resources). The scheme has been extended each year from April 2012 and from 2014-15 onwards the budget allocation for the scheme (£200,000) will be distributed to each local authority via the Revenue Support Grant.

5.32 Businesses in receipt of a grant must allow public access, free of charge, to the toilet facilities for a number of hours agreed with the local authority. The toilet facilities provided must have acceptable standards of safety, hygiene, accessibility for disabled people and provision for both sexes. Businesses must clearly publicise the availability of the facilities and the opening hours, so that the information can be seen clearly by people from outside the premises, and display the bilingual sign designated by the Welsh Government.

5.33 There are a number of challenges with the current system governing public access to toilets, namely:

- the provision and maintenance of public toilets in Wales is at the discretion of local authorities (section 87 of the Public Health Act 1936 establishes a power to provide public toilets in proper and convenient locations, but no duty to do so);
- the provision and maintenance of public toilets in Wales is a considerable cost to local authorities and as a result public toilets are under threat of closure across Wales;
- public toilets which are poorly designed, inadequately maintained and poorly located can create an atmosphere of neglect that discourages public use; these conditions attract vandalism, graffiti, criminal damage
and anti-social behaviour (which increase costs even further for local authorities);

- the current Community Toilet Scheme is limited in that it focusses purely on improving public access to toilets within private establishments; and
- there is poor planning around making the best use of toilets already accessible to the public within public buildings eg. public libraries, community and town halls, sports centres and museums.

A requirement for a local authority strategy on the provision of and access to toilets for public use

This proposal will place a duty on each local authority to develop a strategy on the provision of and access to toilets for public use in their area. The strategy would be based on local community need, consulted upon and reviewed on a regular basis.

5.34 A requirement for a local authority strategy, which could form part of the single integrated planning process, would require local authorities to consider the provision of and access to toilets for public use in all aspects of planning. In particular, this could include the duty to consider the following:

- how local authorities would use the existing planning, licensing and leasing powers to ensure that adequate toilet provision is provided for the public;
- the availability of:
  - public toilets provided by the local authority;
  - toilet facilities which are available for use by the public within public buildings e.g. in public libraries, community and town halls, sports centres, theatres and museums etc.;
  - toilet facilities which are available for use by the public within private businesses e.g. within the existing Communities Toilet Grant Scheme;
- identifying best methods for publicising toilet provision and access in local communities, through a range of media including the use of maps and signage; and
- guidance documentation/tools that could be developed to assist local authorities in developing the strategy.
Consultation questions

33. Should a duty be placed on local authorities to develop a strategy for the provision of and access to toilets for public use in their area?

34. If a duty were to be put in place, should this duty be addressed through the single integrated planning process?

35. Are there any other impacts in relation to this proposal on which you would like to comment?
Chapter 6: Regulation for health

Summary

In recent years the Welsh Government has acted on public concerns to introduce and make changes to legislation aimed at protecting health and supporting communities. Recent examples of such actions include the ban on smoking in enclosed public spaces, legislation to stop the use of sunbeds by young people, banning unsupervised sunbeds on the high-street and a requirement for food businesses to display a food hygiene rating.

Over the last decade, cosmetic procedures such as body piercing and tattooing have become increasingly popular and fashionable, in Wales and more widely. In particular, the range of cosmetic piercing and tattooing procedures has also increased. There are known and well reported health risks connected to these procedures if they are carried out in an unhygienic fashion. It is therefore important that practitioners have safe working practices, and particularly that good infection control practices are followed at all times, so that both clients and practitioners are protected.

We have listened to the concerns expressed about cosmetic piercing and the potential harm poor practice can cause. In this Chapter, we outline proposals to address the wider issues of improved regulation, information and enforcement in relation to cosmetic piercing and other specified procedures such as tattooing, semi-permanent skin colouring, acupuncture and electrolysis. We also want to take this opportunity to gather further evidence in relation to these issues, to inform our future policies.

Context

6.1 The Welsh Government has previously demonstrated its willingness to respond to citizens’ concerns and introduce practical regulations which make a positive contribution to protecting health and strengthening communities.

6.2 This began with the ban on smoking in enclosed public places in Wales, which came into force in April 2007 and was in response to public concerns regarding the harm caused by second-hand smoke. The ban on unsupervised sunbeds in Wales, which came into force in November 2011 and followed on from an England and Wales ban on under 18s using sunbeds in April of the same year, was in response to the public outcry resulting from several young people being burned using unsupervised machines. The introduction of a mandatory food hygiene rating scheme in Wales in November 2013 was in response to calls for the display of food hygiene ratings to be made mandatory by Consumer Focus Wales in 2011 and
supported by Professor Pennington following the tragic E-coliform outbreak in south Wales in 2005.

6.3 We have listened to concerns expressed about the risk from cosmetic piercing in communities and the potential harm poor practice can cause, for example through responses to our earlier consultation on how to make cosmetic piercing safer for young people. We have looked at the current system in Wales and developed proposals to better protect the health of Welsh citizens.

6.4 At present, local authorities are responsible for the regulation and control of businesses carrying out the procedures of cosmetic piercing, tattooing, semi-permanent skin-colouring, acupuncture, and electrolysis in their area. Local authorities’ main powers for doing so are provided in the Local Government (Miscellaneous Provisions) Act 1982.

6.5 This Act provides local authorities in Wales with voluntary powers relating to persons carrying out these procedures. Local authorities which use these powers and adopt these provisions can require businesses:

- to register themselves and their premises; and
- to observe byelaws relating to the cleanliness and hygiene of premises, practitioners and equipment.

6.6 There are some exemptions from the registration requirements set out in the Local Government (Miscellaneous Provisions) Act 1982. They do not apply to practices carried out by or under the supervision of a person who is registered as a medical practitioner (a doctor registered with the General Medical Council or a dentist, or their respective premises).

6.7 The Local Government (Miscellaneous Provisions) Act 1982 provides local authorities with a discretionary power to make byelaws relating to cleanliness of premises, persons, and the cleanliness and sterilisation of equipment, instruments and materials.

6.8 The Welsh Government has produced model byelaws relating to the cleanliness and hygiene of premises, practitioners and equipment that local authorities can adopt in their area. These model byelaws reflect current infection control advice and industry good practice, and are available on the Welsh Government website.

6.9 The Tattooing of Minors Act 1969 imposes a statutory minimum age of 18 years for permanent tattooing (except when carried out for medical reasons by a duly qualified medical practitioner or by a person working under their direction). The

practitioner has a defence if they can show that they had good reason to believe that the person was over 18 years of age; the consent of a client who is under the age of 18 is however not a defence. It is the police and local authorities who currently enforce this legislation.

6.10 The Local Government (Miscellaneous Provisions) Act 1982 creates offences and non-custodial penalties for administering these procedures without local authority registration or for breaching any local authority byelaws. The Court can order a suspension or cancellation of a registration (whether of a person or premises) on conviction.

6.11 An application for registration can currently only be refused by a local authority if a person has previously been convicted of an offence under the Act and the convicting Magistrate cancelled their previous registration. Otherwise, if an application is correctly made then it must be registered by the local authority.

6.12 Following a commitment in the Programme for Government, a consultation seeking views on how to make cosmetic piercing safer for young people commenced on 18 October 2011 and ended on 31 January 2012. The consultation set out the following proposals:

1) the need for a parent or guardian to give their permission (both in writing and through attendance at the piercing appointment) before a young person below 16 years of age can have a cosmetic piercing;

2) a clear age restriction for intimate cosmetic piercings (piercing of the nipples or genitalia); and

3) a standard set of questions which must be asked by the piercer before any cosmetic piercing can be done.

6.13 A total of 228 responses were received, 65 of which were from young people and 37 from piercing/tattoo businesses. The proposals in the consultation received a positive response and a summary of the consultation responses was published on the Welsh Government website.

6.14 The Welsh Government commissioned advice from Public Health Wales in relation to cosmetic piercing, and a literature review was subsequently undertaken. This review found no evidence of an increased risk or incidence of harm to specific age groups (young people for example).

6.15 As a result we remain open minded about regulating the practice of intimate cosmetic piercing. The majority of respondents to the previous consultation were in favour of restricting intimate piercings to those who are 18 years old or older. We are keen to gather evidence in relation to the proposal to introduce an age restriction for

89 http://wales.gov.uk/consultations/healthsocialcare/cosmetic/?lang=en
intimate cosmetic piercings. The purpose of such a proposal would be not only to prevent health complications, but to prevent young people placing themselves in vulnerable situations. Once this evidence has been gathered a detailed analysis of the Human Rights and UNCRC implications of such a proposal will be carried out.

6.16 We still intend to take forward the proposal relating to a standardised consultation for all cosmetic piercings. Nearly all respondents to the previous consultation agreed with this proposal, which would ensure that both the customer and practitioner are fully informed before making the decision.

6.17 Rather than taking forward the standardised consultation proposal in isolation, we recognise that there are wider issues of improved regulation, information and enforcement. We also recognise that these wider issues not only apply to the cosmetic piercing industry but to other high-street procedures which currently have little regulation. We therefore want to continue to gather evidence in relation to intimate cosmetic piercing, whilst integrating the proposal for standardised consultation into a much wider proposal for a National Special Procedures Register, the details of which are set out below.

A National Special Procedures Register

This proposal is for the establishment of a National Special Procedures Register in Wales. The Register would cover cosmetic piercing, tattooing, semi-permanent skin colouring, acupuncture and electrolysis. Practitioners and businesses would need to meet specified standards to obtain registration and then practice to specified standards to maintain this registration. This would include a requirement for practitioners and businesses to undertake a standardised pre and post consultation with customers and to maintain records.

6.18 There are a number of concerns relating to the current system in relation to certain ‘special procedures’. In particular:

- some local authorities in Wales have not voluntarily adopted the provisions within the Local Government (Miscellaneous Provisions) Act 1982 which allow them to create a registration scheme;
- the majority of local authorities in Wales have not adopted the most recent Welsh Government model byelaws relating to the cleanliness and hygiene of premises, practitioners and equipment, although a number are now in the process of doing so despite it not being a mandatory requirement;
- the content of byelaws is restricted to securing the cleanliness of premises, fittings, persons, instruments, materials and equipment;
there is no ‘fit and proper person test’ or any requirement for practitioners to be sufficiently trained and/or qualified; and
there is no requirement for consent forms, pre and post consultation, aftercare advice or record keeping.

6.19 A National Special Procedures Register would cover a specified list of treatments which could be amended over time. We propose this should initially include:

i) cosmetic piercing;
ii) tattooing;
iii) semi-permanent skin colouring;
iv) acupuncture; and
v) electrolysis.

6.20 It is proposed that the National Special Procedures Register would have the following components:

- All practitioners and businesses would be required to register (possibly with a local authority hosting on behalf of others) in order to practice;
- There would be a fee for practitioners and businesses to register;
- There should be a specified ‘fit and proper’ person test for all practitioners and businesses;
- There would be specified cleanliness standards for practitioners and businesses (reflecting current infection control advice and industry best practice);
- There would be a requirement for practitioners and businesses to undertake a standardised pre and post consultation with customers and to maintain records. The pre and post consultation would as a minimum cover the following:

  - Whether the person receiving the treatment has any health problems that may put him or her at greater risk as a result of treatment;
  - How the treatment will be done, including any possible problems; and
  - How to look after any wound to prevent infection.

- Local authorities would be required to grant entry onto the register unless:

  i) the practitioner or business did not meet the requirements set out under a ‘fit and proper’ person test; or
  ii) the practitioner or business failed to meet specified cleanliness standards.
• A practitioner or business convicted of a specified number of procedure related offences, for example practicing without registration, failing to meet cleanliness standards or failing to follow pre and post consultation requirements would be removed from the register for a specified period of time and therefore be unable to practice for that period; and

• Local authority enforcement officers would be responsible for enforcement.

Consultation questions

36. Do you feel that the current information, regulation, and enforcement in relation to cosmetic piercing, tattooing, semi-permanent skin colouring, acupuncture and electrolysis protects the public effectively?

37. Do you have evidence of harm caused by cosmetic piercing procedures (and in particular intimate cosmetic piercing of young people) under the current system? If so, what?

38. Do you think there should be a National Special Procedures Register? If no, why not?

39. Do you think any other procedures should be included on the Register? If yes, what other procedures?

40. Do you think the Welsh Government should be able to amend the Register in the future to include or remove procedures? If not, why not?

41. Should the registration fee be set locally or nationally?

42. How frequently should practitioners and businesses need to re-register?

43. Do you agree that registration should include a ‘fit and proper persons’ test? If yes, what criteria do you feel should be part of this test?

44. Do you agree with the minimum requirements set out for pre and post consultation? If not, please provide details of the suggested content.

45. Do you agree that local authorities should be responsible for administering and enforcing these proposals? If not, who should?
Chapter 7: Next steps

7.1 During the development of this White Paper we have started to gather initial evidence of the impact that might be anticipated for the proposals. Throughout the next stages of development we will be gathering further detailed information on costs and benefits of any proposals to be taken forward, and would welcome any further evidence submitted during the consultation on this White Paper which will assist in this work. This evidence will assist in the assessment of the National Assembly for Wales’ legislative competence to legislate on these subjects. It will also be developed into a full Regulatory Impact Assessment (RIA) as we move towards introduction of a Public Health Bill.

7.2 Developmental work will also take full account of our obligations relating to equalities, sustainable development, the Welsh language and the United Nations Convention on the Rights of the Child (UNCRC), and relevant impact assessments will be completed in due course.

Consultation questions

46. We want to ensure that a Public Health Bill is reflective of the needs of citizens in Wales. We would appreciate any views in relation to any of the proposals in this White Paper that may have an impact on a) human rights; b) Welsh language; or c) the protected characteristics as prescribed within the Equality Act 2010. These characteristics include gender; age; religion; race; sexual orientation; transgender; marriage or Civil Partnership; Pregnancy and Maternity; and disability.

47. Do you have any other comments or useful information in relation to any of the proposals in this White Paper?
ANNEX: Summary of consultation questions

Chapter 2: Tobacco and electronic cigarettes

Tobacco retailers’ register

1. Do you agree with the proposal to create a tobacco retailers’ register for Wales under the terms outlined above?

2. Do you consider that the creation of such a register will (i) assist in attempts to reduce under age sales of tobacco products, and (ii) assist in the enforcement of the display ban?

3. Do you consider the proposed fee structure to be reasonable? Please suggest an alternative if not.

4. Do you consider the proposed enforcement and penalty arrangements for the tobacco retailers’ register to be appropriate? If not, could you please provide us with your suggestions?

5. Are there any other features of a tobacco retailers’ register that we should consider?

Electronic cigarettes

6. Do you consider that the use of e-cigarettes in enclosed and substantially enclosed public places (including work places) undermines and makes more difficult the enforcement of the current ban on smoking in such places?

7. Do you consider that the widespread use of e-cigarettes in enclosed and substantially enclosed public places (including work places) normalises the act of smoking and acts as a gateway to the use of conventional tobacco products?

8. Do you have any evidence or practical experiences to support your views in relation to questions 6 and 7? If so we would be grateful to receive such evidence or receive details of such experiences.

9. Do you consider legislation would assist in the enforcement of the existing Smoke-Free requirements and reinforce the message that smoking is no longer the norm? Please provide evidence to support your answer, if available.
10. In considering such a proposal, should the ban on the use of e-cigarettes in enclosed and substantially enclosed public and work places be subject to the same exemptions and penalties as conventional tobacco products?

11. What other measures, if any, should the Welsh Government be considering in relation to e-cigarettes?

**Smoke-Free Environments**

12. Do you consider that voluntary smoking bans in hospital grounds, school grounds and children’s playgrounds are sufficient, or are these areas where Welsh Ministers should consider legislating? Can you provide any evidence for your view?

**Internet Sales of Tobacco**

13. Do you consider there is a problem with persons aged under 18 receiving delivery of tobacco products which have been ordered online by an adult? Please provide evidence to support your response, if available.

14. Is this an area where the National Assembly for Wales should consider strengthening the existing legislative framework to make it an offence to deliver tobacco products to a person who is under the legal age of sale for tobacco products (which is currently 18)?

**Chapter 3: Alcohol**

**Minimum Unit Pricing**

15. Given the evidence base and public health considerations, do you agree that the Welsh Government should introduce a Minimum Unit Price for alcohol?

16. Do you agree that a level of 50 pence per unit is appropriate? If not, what level do you think would be appropriate?

17. Do you agree that enforcing Minimum Unit Pricing for alcohol would support the reduction in alcohol related harms? Please provide evidence to support your answer, if available.

18. Do you think any level of Minimum Unit Pricing set by the Welsh Government should be reviewed and adjusted over time? Please provide evidence to support your answer, if available.

19. As the Welsh Government cannot legislate on the licensing of the sale and supply of alcohol, what enforcement and/or penalty arrangements do you think should be in place to introduce Minimum Unit Pricing for alcohol in Wales?
20. Do you think there are other measures that should be pursued in order to reduce the harms associated with excessive alcohol consumption?

Chapter 4: Obesity

Nutritional standards

21. Do you agree that nutritional standards should be introduced in the settings we are proposing, that is, pre school settings and care homes?

22. Do you think there are any other public sector settings that should be considered in relation to mandatory nutritional standards?

23. Do you think there are other practical steps we could take to contribute to this issue?

Chapter 5: Building community assets for health

Better planning and delivery of public health services through community pharmacy

24. Do you agree community pharmacies can play a stronger role in promoting and protecting the health of individuals, families and local communities as part of a network of local health care services?

25. Do you agree with the proposal to require Local Health Boards to complete periodically an assessment of the pharmaceutical needs of its population?

26. In respect of question 25 what are your views on such assessments being completed as a discrete part of their assessment of local health and wellbeing needs?

27. Please comment on what information you think Local Health Boards should incorporate in its pharmaceutical needs assessment and the frequency with which such assessments should be updated.

28. In respect of question 27, do you think that using the Local Health Board’s assessment of pharmaceutical needs will be sufficient for this or are there other factors that need to be considered?

29. Do you consider that it is appropriate for applications to provide pharmaceutical services to be determined on the basis of the contribution that all the services they propose might make to address local health needs?
30. Do you agree with the proposal to allow Local Health Boards to invite community pharmacies in their area to provide specified services to meet identified pharmaceutical needs and, where those pharmacies are unable to do so adequately, invite additional pharmacies to become established in order to provide pharmaceutical services? If you disagree please explain your reasons.

31. Do you agree that where pharmacies are not adequately providing services, a range of measures, which could include sanctions against pharmacies for breaches of terms and conditions of service, should be available to Local Health Boards to support improving quality and consistency? What other measures should be available to Local Health Boards?

32. Are there any other specific areas where this approach could be adopted in order to improve public health at a community level?

Toilets for public use

33. Should a duty be placed on local authorities to develop a strategy for the provision of and access to toilets for public use in their area?

34. If a duty were to be put in place, should this duty be addressed through the single integrated planning process?

35. Are there any other impacts in relation to this proposal on which you would like to comment?

Chapter 6: Regulation for health

National Special Procedures Register

36. Do you feel that the current information, regulation, and enforcement in relation to cosmetic piercing, tattooing, semi-permanent skin colouring, acupuncture and electrolysis protects the public effectively?

37. Do you have evidence of harm caused by cosmetic piercing procedures (and in particular intimate cosmetic piercing of young people) under the current system? If so, what?

38. Do you think there should be a National Special Procedures Register? If no, why not?

39. Do you think any other procedures should be included on the Register? If yes, what other procedures?

40. Do you think the Welsh Government should be able to amend the Register in the future to include or remove procedures? If not, why not?
41. Should the registration fee be set locally or nationally?

42. How frequently should practitioners and businesses need to re-register?

43. Do you agree that registration should include a ‘fit and proper persons’ test? If yes, what criteria do you feel should be part of this test?

44. Do you agree with the minimum requirements set out for pre and post consultation? If not, please provide details of the suggested content.

45. Do you agree that local authorities should be responsible for administering and enforcing these proposals? If not, who should?

**Chapter 7: Next steps**

46. We want to ensure that a Public Health Bill is reflective of the needs of citizens in Wales. We would appreciate any views in relation to any of the proposals in this White Paper that may have an impact on a) human rights; b) Welsh language; or c) the protected characteristics as prescribed within the Equality Act 2010. These characteristics include gender; age; religion; race; sexual orientation; transgender; marriage or Civil Partnership; Pregnancy and Maternity; and disability.

47. Do you have any other comments or useful information in relation to any of the proposals in this White Paper?