

National Assembly for Wales
Health and Social Care Committee

**Public Health (Wales) Bill:
Committee Stage 1 Report**

November 2015

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales



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Health and Social Care Committee

The Committee was established on 22 June 2011 with a remit to examine legislation and hold the Welsh Government to account by scrutinising expenditure, administration and policy matters encompassing: the physical, mental and public health of the people of Wales, including the social care system.

Current Committee membership:



David Rees (Chair)
Welsh Labour
Aberavon



Alun Davies
Welsh Labour
Blaenau Gwent



John Griffiths
Welsh Labour
Newport East



Altaf Hussain
Welsh Conservatives
South Wales West



Elin Jones
Plaid Cymru
Ceredigion



Darren Millar
Welsh Conservatives
Clwyd West



Lynne Neagle
Welsh Labour
Torfaen



Gwyn R Price
Welsh Labour
Islwyn



Lindsay Whittle
Plaid Cymru
South Wales East



Kirsty Williams
Welsh Liberal Democrats
Brecon and Radnorshire

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Chair's foreword

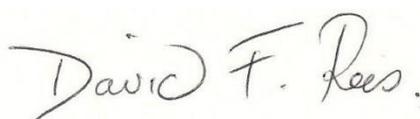
Addressing the public health concerns of the people of Wales is an important element of protecting and enhancing the well-being of our population.

Members of the Committee would like to thank everyone who has assisted us in our consideration of the Public Health (Wales) Bill. We are particularly grateful to those who have given their time to submit their views whether in writing, by attending a committee meeting, through completing our public survey or by giving video evidence. The volume of responses we have received, and the level of public debate surrounding this Bill, demonstrates the public's interest in its provisions and the importance of the Committee's scrutiny of its general principles.

The Bill includes a wide range of subjects, from special procedures to intimate piercings, public toilets to pharmaceutical services, and arrangements in relation to tobacco and nicotine products. Whilst not all of the issues we have deliberated upon have been straightforward, we have been clear from the outset about the need to give detailed consideration to each and every one of them.

The evidence we heard relating to the majority of the Bill was clear: provisions in relation to special procedures, intimate piercings, public toilets and pharmaceutical services were to be broadly welcomed as a positive contribution to improving the public health of the people of Wales. Evidence on the proposals to restrict the use of e-cigarettes in enclosed and substantially enclosed public places was more complex, however, and we were unable to reach a consensus view on these provisions. The evidence we received on these provisions, and the other provisions within the Bill, is summarised in the body of this report, as are our views in relation to each.

We hope that the conclusions we have drawn and the recommendations we have made will be useful to Assembly Members when they consider their views on the general principles of the Bill.



David Rees AM

Chair of the Health and Social Care Committee
November 2015

Recommendations

Recommendation 1. The Committee recommends that the Minister for Health and Social Services work with local authorities to monitor the success of introducing the licensing scheme under Part 3 of the Bill. (Page 89)

Recommendation 2. The Committee recommends that the Minister for Health and Social Services explore the feasibility of amending the Bill to place a duty on Health Boards to:

- maintain a record of anyone who requires treatment as a result of undergoing a special procedure, as defined in the Bill; and
- notify local authorities when such an event occurs. (Page 89)

Recommendation 3. The Committee recommends that, in light of the evidence it has received on the potential harms that can occur as a result of body modification techniques, the Minister for Health and Social Services reconsider adding to the list of special procedures included on the face of the Bill. (Page 94)

Recommendation 4. The Committee recommends that, in light of the apparent delays at the UK level with the implementation of the recommendations of Sir Bruce Keogh's Review of the Regulation of Cosmetic Interventions (published April 2013), the Minister for Health and Social Services work with the appropriate public authorities and industries to identify non-surgical cosmetic procedures to be added, by amendment, to the list of special procedures included on the face of the Bill. (Page 94)

Recommendation 5. The Committee recommends that the Minister for Health and Social Services ensure that the mandatory licensing scheme requires that any licence holder undertakes training on compliance with hygiene procedures, health and safety regulations, providing advice on aftercare, and carrying out basic first aid. (Page 99)

Recommendation 6. The majority of the Committee's members recommend that the Minister for Health and Social Services explore whether it is appropriate to create a criminal offence on the face of the Bill in relation to undertaking a special procedure on an individual who is intoxicated or otherwise unable to give consent to the procedure. (Page 100)

Recommendation 7. The Committee recommends that the Minister for Health and Social Services amend the Bill to increase the level of fine imposed on anyone committing an offence under section 67 of the Bill (in relation to special procedures) to a Level 5 fine. (Page 103)

Recommendation 8. The Committee recommends that the Minister for Health and Social Services amend the Bill to strengthen and expand the provisions around seeking proof of age from individuals wishing to have an intimate piercing undertaken. It recommends that the Minister expand upon the defence available under section 78 of the Bill, so that it mirrors the defence in section 146 of the Licensing Act 2003 (i.e. the defence relating to selling alcohol to under 18s), which sets out the main elements of the defence, such as:

- believing that the individual is over the relevant age, and
- taking all reasonable steps to establish the individual's age (such as asking for evidence of age, and that evidence being convincing to a reasonable person). (Page 107)

Recommendation 9. The Committee recommends that the Minister for Health and Social Services proceed with his stated intention of amending the Bill to add tongue piercing to the list of procedures prohibited to be undertaken on anyone under the age of 16. (Page 109)

Recommendation 10. The Committee recommends that the Minister for Health and Social Services proceed with his stated intention of providing clarity about the differences between the procedures provided for in this Bill and offences covered by the Female Genital Mutilation Act 2003 in a revised Explanatory Memorandum. (Page 110)

Recommendation 11. The Committee recommends that the Minister for Health and Social Services issue a national pharmaceutical needs assessment (PNA) template to avoid the issues of variability reported in England. (Page 116)

Recommendation 12. The Committee recommends that the Minister for Health and Social Services, when making regulations about pharmaceutical needs assessments under section 89 of the Bill, require Health Boards to give consideration to the impact any such assessment may have on GP services in the local area. (Page 121)

Recommendation 13. The Committee recommends that the Minister for Health and Social Services, when making regulations and guidance under Part 5 (Pharmaceutical Services) of the Bill, require a simplified process for relocating a pharmacy within an area. Such regulations or guidance should also specify prescribed timescales for the determining of all applications, including relocations. (Page 121)

Recommendation 14. The Committee recommends that the Minister for Health and Social Services provide clarity about how he intends to address the Welsh Language Commissioner's concerns in relation to Part 5 (Pharmaceutical Services) of the Bill. (Page 122)

Recommendation 15. The Committee recommends that the Minister for Health and Social Services amend the Bill to require local authorities to publish periodically a progress report on public toilet provision detailing how the needs of communities are being met. (Page 128)

Recommendation 16. The Committee recommends that the Minister for Health and Social Services amend the Bill to require local authorities to consider the appropriate distribution of facilities, and their availability throughout the week, when developing their strategies so that people can access public toilets in urban and rural areas, tourist hotspots and within the vicinity of trunk roads when and where they are needed. (Page 129)

Recommendation 17. The Committee recommends that the Minister for Health and Social Services amend the Bill to require the Welsh Government to monitor the extent to which local toilets strategies address national needs, to avoid the risk of poor provision at national sites and on main transport corridors. (Page 130)

Recommendation 18. The Committee recommends that the Minister for Health and Social Services amend the Bill to include a duty on local authorities to increase awareness of toilet facilities by promoting their availability for public use. This should include amending the Bill to require local authorities to ensure that:

- private businesses which receive public funds are encouraged to open their toilet facilities to the public, and
- publicly-funded buildings, such as libraries and leisure centres, make it explicit that their toilet facilities are available for public use.

(Page 135)

Recommendation 19. The Committee recommends that the Minister for Health and Social Services amend the Bill to include a requirement to undertake mandatory health impact assessments when developing certain policies, plans or programmes. For example, BMA Cymru Wales has suggested that these should include Strategic and Local Development Plans, certain larger scale planning applications, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments and health service reconfiguration proposals.

(Page 140)

1. Introduction

1. On 8 June 2015, Mark Drakeford AM, the Minister for Health and Social Services (“the Minister”) introduced the [Public Health \(Wales\) Bill](#) (“the Bill”) and accompanying [Explanatory Memorandum](#) and made a [statement on the Bill](#) in Plenary on 9 June 2015.

2. At its meeting on 9 June 2015, the Assembly’s Business Committee agreed to refer the Bill to the Health and Social Care Committee (“the Committee”) for consideration of the general principles (Stage 1), in accordance with Standing Order 26.9. The Business Committee agreed that the Committee should report by 27 November 2015.¹

Terms of reference

3. The Committee agreed the following framework within which to scrutinise the general principles of the Bill:

To consider—

- The need for legislation in the following areas -
 - Placing restrictions on the use of tobacco and nicotine inhaling devices (NIDs) such as electronic cigarettes in enclosed and substantially enclosed public and work places, and giving the Welsh Ministers a regulation-making power to extend the restrictions to certain open spaces;
 - Creating a national register of retailers of tobacco and nicotine products;
 - Providing the Welsh Ministers with a regulation-making power to add to the offences which contribute to a Restricted Premises Order (RPO) in Wales;
 - Prohibiting the handing over of tobacco and/or nicotine products to a person under the age of 18;
 - Creating a mandatory licensing scheme for practitioners and businesses carrying out “special procedures”, namely acupuncture, body piercing, electrolysis and tattooing;
 - Introducing a prohibition on the intimate piercing of persons under the age of 16 years;

¹ National Assembly for Wales, Business Committee, [Report on the timetable for consideration of the Public Health \(Wales\) Bill](#), June 2015

- Changing the arrangements for determining applications for entry onto the pharmaceutical list of Health Boards, to a system based on the pharmaceutical needs of local communities; and
 - Requiring local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.
- Any potential barriers to the implementation of these provisions and whether the Bill takes account of them;
 - Whether there are any unintended consequences arising from the Bill;
 - The financial implications of the Bill (as set out in Part 2 of the Explanatory Memorandum - the Regulatory Impact Assessment, which estimates the costs and benefits of implementation of the Bill);
 - The appropriateness of the powers in the Bill for Welsh Ministers to make subordinate legislation (as set out in Chapter 5 of Part 1 of the Explanatory Memorandum, which contains a table summarising the powers for Welsh Ministers to make subordinate legislation); and
 - The extent to which the Bill reflects priorities for improving public health in Wales.

The Committee's approach

4. The Committee took oral evidence from a number of witnesses. The schedule of oral evidence sessions is attached at Annex B. The Committee also issued a public consultation which invited anyone with an interest in the Bill's provisions to submit written evidence to inform the Committee's work. A list of the 105 consultation responses is attached at Annex C. The consultation was open for responses between 19 June and 4 September 2015.

5. The Committee undertook a public survey to capture public opinion on the Bill. The survey was conducted by the Assembly's Outreach Team in both online and paper-based formats. Participants were asked a range of questions relating to restricting the use of e-cigarettes in enclosed and substantially enclosed public places, introducing an age restriction on intimate body piercings, provision of public toilets and pharmaceutical services. The survey was open for consultation and responses between 13 July and 4 September 2015.

6. Although the public survey did not represent a scientific sample of the population, it provided an additional means for people in Wales to provide their views and for the Committee to get an indication of those opinions

about the Bill. A [summary note](#) of the responses received to the survey is available on the Committee's website.

7. The Committee also gathered [video evidence](#) from those working as tattooists, piercers, acupuncturists, and practitioners of electrolysis and non-surgical cosmetic procedures about the provisions relating to special procedures in Part 3 of the Bill. Their evidence was filmed and presented to the Committee at its meeting on 17 September.

8. The Committee would like to thank all those who have contributed to its work.

Other Committees' consideration of the Bill

9. The Assembly's Finance Committee took evidence from the Minister on the financial implications of the Bill on 15 July 2015. It [reported](#) on its conclusions in September 2015.²

10. The Assembly's Constitutional and Legislative Affairs Committee took evidence from the Minister on the appropriateness of the provisions in the Bill that grant powers to make subordinate legislation on 21 September 2015. It reported on its conclusions in November 2015.³

² National Assembly for Wales, Finance Committee, [Report on the Public Health \(Wales\) Bill](#), September 2015

³ National Assembly for Wales, Constitutional and Legislative Affairs Committee, [Report on the Public Health \(Wales\) Bill](#), November 2015

2. Background

Legislative competence

11. The Explanatory Memorandum (EM) that accompanies the Bill states:

“Section 107 of the Government of Wales Act 2006 (‘GOWA 2006’) provides legislative competence for the National Assembly for Wales (‘the Assembly’) to make laws for Wales known as Acts of the Assembly.

“Section 108 of GOWA 2006 provides that a provision of an Act of the Assembly is within the Assembly’s legislative competence if it relates to one or more of the subjects listed under any of the headings in Part 1 of Schedule 1 of that Act and does not fall within any of the exceptions specified in that Part of the Schedule (whether or not under that heading or under any of those headings), and it neither applies otherwise than in relation to Wales nor confers, imposes, modifies or removes (or gives power to confer, impose, modify or remove) functions exercisable otherwise than in relation to Wales.

“The provisions of the Bill relate to the following subjects:

Subject 9 ‘Health and Health Services’:

“Promotion of health. Prevention, treatment and alleviation of disease, illness, injury, disability and mental disorder. Control of disease. Family planning. Provision of health services, including medical, dental, ophthalmic, pharmaceutical and ancillary services and facilities. Clinical governance and standards of health care. Organisation and funding of national health service.”

Subject 12 ‘Local Government’:

“...Powers and duties of local authorities and their members and officers...”

Subject 15 ‘Social Welfare’:

“...Protection and well-being of children (including adoption and fostering) and of young adults...”

“The above subjects provide the National Assembly with the competence to make the provisions contained in the Bill. Part 2 of the

Bill contains provisions which remove pre-commencement functions of a Minister of the Crown. Those provisions will be within the Assembly's legislative competence if the Secretary of State consents to the provisions under Part 3 of Schedule 7 to GOWA 2006."

12. The Presiding Officer issued a [statement](#) on 8 June 2015, which stated that, in her opinion:

- Most of the provisions of the Public Health (Wales) Bill would be within the legislative competence of the National Assembly for Wales.
- Sections 4(7), 5(6), and 11(7) and paragraphs 6 and 9 of Schedule 1 would not be within competence. This is because these provisions require the consent of the Secretary of State to bring them within the competence of the National Assembly for Wales and this necessary consent had not been obtained at that time.

13. The Presiding officer [wrote to the Committee on 23 June 2015](#) to provide further detail on the Secretary of State consent and human rights issues she took into consideration in determining whether the Bill was within the legislative competence of the National Assembly for Wales.

14. In relation to Secretary of State consent, she explained that her determination was consistent with previous decisions she had taken as to whether the Bill would be within competence if it were passed as drafted when introduced. [The Minister wrote to the Committee 31 October](#), to confirm that the Secretary of State for Wales had provided the consent required for these sections.

15. In her letter to the Committee, the Presiding Officer explained that under Section 108(6)(c) of the Government of Wales Act 2006, a provision of a Bill is outside the Assembly's competence if it is incompatible with the European Convention on Human Rights (ECHR). As the Bill contains provisions relating to smoking and using nicotine inhaling devices in the context of a workplace which is also a home, careful consideration was given by the Committee during its deliberations in relation to the Article 8 ECHR issues that arise in that context. The Committee's detailed consideration of human rights is outlined in chapter 4.

The Bill's purpose and intended effect

16. The EM states:

“The Public Health (Wales) Bill (‘the Bill’) utilises legislation as a mechanism for improving and protecting the health and well-being of the population of Wales. It comprises a set of provisions in discrete areas of public health policy.

“While a number of the issues addressed in the Bill are already well established, the Bill also responds to new and emerging health challenges. Taken together the provisions are intended to have a cumulative positive benefit for the population of Wales and seek to put in place conditions which are conducive to good health, in which harms to health can be prevented.”⁴

17. The Bill proposes to introduce changes that:

- place restrictions on the use of tobacco and nicotine inhaling devices (NIDs) such as electronic cigarettes in enclosed and substantially enclosed public and work places, and give the Welsh Ministers a regulation-making power to extend the restrictions to certain open spaces;
- provide for the creation of a national register of retailers of tobacco and nicotine products;
- provide the Welsh Ministers with a regulation-making power to add to the offences which contribute to a Restricted Premises Order (RPO) in Wales;
- prohibit the handing over of tobacco and/or nicotine products to a person under the age of 18;
- provide for the creation of a mandatory licensing scheme for practitioners and businesses carrying out ‘special procedures’, namely acupuncture, body piercing, electrolysis and tattooing;
- introduce a prohibition on the intimate piercing of persons under the age of 16 years;
- change the arrangements for determining applications for entry onto the pharmaceutical list of Health Boards, to a system based on the pharmaceutical needs of local communities; and

⁴ Explanatory Memorandum, paras 1 and 2

- require local authorities to prepare a local strategy to plan how they will meet the needs of their communities for accessing toilet facilities for public use.⁵

18. In his oral statement to introduce the Bill, the Minister said:

“The case for public health legislation is ever more clear and pressing, as we face increasingly complex health challenges as a result of lifestyle choices and environmental factors. It is a fundamental responsibility of Government, I believe, to use legislation to its full effect to create an environment that promotes wellbeing, prevents ill health wherever possible, and gives people new opportunities to look after and improve their own health.”⁶

Pre-legislative consultation

19. The Bill was introduced following two periods of consultation by the Welsh Government on legislating to improve the public health of people in Wales.

Green Paper - A consultation to collect views about whether a Public Health Bill is needed in Wales

20. In November 2012, the Welsh Government published a Green Paper seeking views on whether a public health bill was needed in Wales, and the potential role of legislation in driving improvements in population health.⁷ The EM states that 371 responses were received to the Green Paper and that a majority of respondents supported the idea that legislation could make a positive contribution to further improve and protect health. It said that the responses indicated support for two distinct approaches to public health legislation: one for an overarching approach requiring organisations to consider health across their functions, and the other for a targeted approach aimed at addressing specific public health challenges.⁸

Public Health White Paper

21. The Welsh Government’s subsequent White Paper *Listening to you: Your health matters* published in April 2014 contained consultation questions on specific public health measures, including those covered by this Bill.⁹ The EM

⁵ Explanatory Memorandum, para 3

⁶ RoP, Plenary, 9 June 2015

⁷ Welsh Government Green Paper – [A consultation to collect views about whether a Public Health Bill is needed in Wales](#) November 2012

⁸ Explanatory Memorandum, para 217

⁹ Welsh Government White Paper – [Listening to you: Your health matters](#) April 2014

states that 713 responses were received to the consultation on the White Paper and that a summary report was published in November 2014.¹⁰

22. The EM states that, in general, the consultation responses illustrated support for the role of legislation in improving and protecting health.¹¹ It says that the nature of responses to the White Paper varied significantly, with some focused on single issues and others that provided detailed comments of the full range of proposals. It states that the proposals relating to restricting the use of e-cigarettes in enclosed and substantially enclosed public places attracted the most divided response.¹²

¹⁰ Explanatory Memorandum, para 224

¹¹ Explanatory Memorandum, para 225

¹² Explanatory Memorandum, para 226

3. General principles and the need for legislation

Overall view of consultees

23. The Committee received 105 written responses from both individuals and organisations to its consultation on the provisions in the Bill. The views expressed by those respondents as to whether legislation was required varied significantly. This report outlines the detailed consideration given by the Committee to the evidence presented orally, in writing and by those who submitted views through the video and the public survey.

24. There was general support voiced among respondents in respect of the provisions relating to special procedures, intimate piercing, pharmaceutical services and provision of toilets.

25. Those who presented evidence to the Committee were supportive of the proposals to legislate to introduce a mandatory licensing system for the special procedures identified in the Bill. Dr Fortune Ncube, Consultant Epidemiologist and Consultant in Public Health Medicine for Public Health England, told the Committee that there was sufficient risk of diseases such as hepatitis B or hepatitis C as a result of undergoing one of the special procedures to warrant legislating in this area.

26. There was also broad support for introducing a minimum age restriction on intimate piercings. To illustrate why he believed that the Bill was required, Dr Quentin Sandifer, representing Public Health Wales, referred to a recent “look-back” exercise undertaken in the Gwent area, which identified that a number of individuals under the age of 16 had undergone an intimate piercing.

27. Although the evidence gathered on pharmaceutical services was not extensive, the majority of those who did comment on this Part expressed their support for its provisions.

28. Stakeholders generally welcomed the provisions in the Bill to place a duty on local authorities to prepare and publish local toilet strategies, although the Welsh Local Government Association questioned whether such a duty was required.

29. Various views were expressed in relation to the provisions relating to tobacco and nicotine products, particularly those restricting the use of e-cigarettes in enclosed and substantially enclosed workplaces and public places. Several groups, including Public Health Wales and the Directors of

Public Health representing Health Boards, raised concerns that failing to restrict the use of e-cigarettes could create an environment where smoking behaviour is re-normalised and could encourage the use of the products among non-smoking young people or lead to them smoking tobacco cigarettes. Conversely, concerns were raised by others including Cancer Research UK and ASH Wales, that restricting the use of e-cigarettes could prevent existing smokers from using those products as smoking cessation aids, thereby creating a situation which could increase harm to the public health of others.

30. Differing views were also presented in relation to the establishment of a register of retailers who sell tobacco or nicotine products. Some stakeholders, including the Chartered Institute of Environmental Health, Public Health Wales and the Directors of Public Protection Wales, were of the view that the register would assist in identifying those premises where tobacco and nicotine products were being legitimately sold, which would in turn assist with enforcement. Conversely, the Association of Convenience Stores stated that there needed to be more rigorous implementation of the current enforcement regime and sanctions for the illicit sale of tobacco.

The Committee's view

31. In reaching its conclusions on the general principles of the Bill, the Committee has thoroughly considered the evidence presented to it on each of the issues covered by the Bill.

32. Following careful consideration, the Committee concludes that it supports the provisions to legislate in most of the areas specified in the Bill. The exception to this are the provisions in Chapter 1 of Part 2 relating to smoking and the use of nicotine inhaling devices.

33. Owing to the nature of the evidence presented to the Committee on the long-term effects of using e-cigarettes, Members were unable to reach a consensus view on whether to support the provisions to restrict the use of e-cigarettes in enclosed and substantially enclosed workplaces and public places. This was due to differences in Members' views as to whether these provisions were contrary to the aim of the Bill to improve public health. The detailed views of Committee Members in relation to Chapter 1 of Part 2 are outlined in paragraphs 177 to 180 of this report.

34. The Committee has made a series of recommendations which it believes, if implemented, could strengthen the provisions in the Bill.

4. Part 2 – Chapter 1: Smoking and the use of Nicotine Inhaling Devices

35. Chapter 1 of Part 2 of the Bill contains provisions to make enclosed and substantially enclosed public premises and shared workplaces smoke-free (“smoke free premises”). For the purpose of this Chapter of the Bill, “smoke-free” means that smoking and the use of nicotine inhaling devices (commonly known as “e-cigarettes”) is not permitted, unless the premises are exempted by regulations made under section 10 of the Bill.

36. This Chapter of the Bill also contains provision for regulations to be made that provide for additional premises to be smoke-free in certain circumstances. These additional smoke-free premises would not need to be enclosed or substantially enclosed. Vehicles may also be smoke-free.

37. The Welsh Government’s stated intention in bringing forward the provisions in the Bill relating to smoking and the use of nicotine inhaling devices (e-cigarettes) is:

“to bring the use of e-cigarettes into line with existing provisions on smoking. As a result, the use of e-cigarettes will be prohibited in enclosed public and work places in Wales unless an exemption has been provided”.¹³

38. Section 2 of the Bill defines smoking and nicotine inhaling devices as:

- “Smoking”: smoking tobacco or anything which contains tobacco, or to smoking any other substance; and smoking includes being in possession of lit tobacco or of anything lit which contains tobacco, or being in possession of any other lit substance in a form in which it could be smoked;
- “Nicotine inhaling device”: a device enabling the inhalation of nicotine via a mouth piece (whether or not the device also enables any other substance to be inhaled), but do not include
 - (a) a device that is intended to be used for the consumption of lit tobacco;
 - (b) a device, or description of device, specified in regulations;
- “Using a nicotine inhaling device”: using a nicotine inhaling device to create a vapour to be inhaled.

¹³ Explanatory Memorandum, para 49

39. The EM sets out that the intended effect of the provisions is to:

- contribute to the continuing decline in the uptake of smoking by children and young people;
- ensure the de-normalisation of smoking is maintained;
- help to protect children and young people from the risk of nicotine addiction and the impact that nicotine can have on the developing brain;
- protect children and young people from any potential gateway effect into smoking tobacco that may come from the use of e-cigarettes;
- maintain the air quality enjoyed in enclosed and substantially enclosed public and work places in Wales as a result of the current smoke-free environment;
- ensure that the enforcement of the Health Act 2006 is not undermined.¹⁴

40. The provisions set out in the Bill would be achieved by re-stating and extending Chapter 1, Part 1 of the Health Act 2006, in relation to Wales, so that the smoke-free requirements would apply to the use of e-cigarettes in addition to tobacco products. It would therefore be an offence to:

- use an e-cigarette in a smoke-free place; and
- fail to prevent the use of an e-cigarette in a smoke-free place.

41. A person found guilty of smoking tobacco or using an e-cigarette in a smoke-free premises or a smoke-free vehicle would be liable for a fine not exceeding level 1 (currently set at £200) on the standard scale. A person (for example, a person managing premises) found guilty of failing to take reasonable steps to prevent smoking or the use of an e-cigarette in a smoke-free premises would be liable for a fine not exceeding level 4 (currently set at £2,500) on the standard scale.

42. A person occupying or managing premises would need to ensure that 'smoke-free' signs were displayed in those premises. A person found guilty of failing to comply would be liable for a fine not exceeding level 3 (currently set at £1,000) on the standard scale.

43. The Bill would also change the law relating to using tobacco cigarettes and e-cigarettes in a person's private home that is also used as a workplace. The Bill would restrict the use of tobacco cigarettes and e-cigarettes in any

¹⁴ Explanatory Memorandum, paras 30-64

part of a person's private dwelling during the hours that part is being used as a workplace. The Bill would provide that the Welsh Ministers could by regulations designate enforcement authorities to enforce the provisions of this Chapter and authorised officers would be appointed by the enforcement authority. An authorised officer would be given powers of entry to enter premises (or a vehicle) if it was believed that an offence had or was being committed. Authorised officers would not be able to enter premises by force, nor would they be able to enter premises used wholly or mainly as a dwelling, unless they were provided with a signed warrant by a justice of the peace. Section 12 of the Bill would make these regulations subject to the negative procedure.

44. The Committee queried whether the use of non-nicotine e-cigarettes would be restricted by the provisions in the Bill. The response provided by the Minister stated:

“The term ‘nicotine inhaling device’ (NID) is used in the Bill and is defined as: “a device enabling the inhalation of nicotine via a mouth piece (whether or not the device also enables any other substance to be inhaled)”. The definition does not therefore capture non-nicotine e-cigarettes unless they can also be used to inhale nicotine, e.g. by replacing the pre-filled cartridge with a nicotine-containing cartridge, or by filling a cartridge or a tank with a nicotine-containing liquid. As such, devices that may enable nicotine to be inhaled via a mouthpiece would be subject to the restrictions on use in enclosed and substantially enclosed public and work places.

“The Bill gives the Welsh Ministers the power to make regulations that provide for other devices, or descriptions of a device, to be covered by Chapter 1 of the Bill where they are satisfied that this is likely to contribute towards the promotion of the health of the people of Wales. Such additional devices may or may not enable nicotine to be inhaled.

“As set out in the Statement of Policy Intent, there is no current intention to use these powers in relation to a specific known device or description of a device. However, should it be found that non-nicotine inhaling devices not captured by the definition of NID in the Bill as introduced are undermining the smoke-free requirements established by the Bill, this regulation making power would enable the Welsh Ministers to extend the requirements to such devices. Any Regulations made using these powers would be subject to the

affirmative procedure and would be consulted on and debated in plenary.”¹⁵

Precautionary approach

45. In outlining his reasons for introducing the provisions relating to nicotine inhaling devices in Chapter 1 of the Bill, the Minister explained his rationale for following a precautionary approach:

“When I am presented with two sets of evidence, one that says harm may not happen, and one that says harm may happen, then I think it’s my responsibility to act on the precautionary principle and to take seriously the evidence that says that harm may happen and to act in a way that would [...] reduce the risk of that harm. [...] My job is to balance the evidence. E-cigarettes are a very new phenomenon. We won’t have definitive evidence for many years to come. What I don’t think we ought to be prepared to do as a committee or as a National Assembly is to take the risk that, in 10 years’ time, we will look back and say how much we wished we had acted then, before the harm had occurred.”¹⁶

46. A number of witnesses, including BMA Cymru Wales, Directors of Public Protection Wales and the WLGA, supported the view that a precautionary approach would be beneficial. Julie Bishop, representing Public Health Wales, told the Committee:

“We cannot sit around and wait a couple of decades to see whether or not the conclusive evidence that people might like to see is available before making a judgement.”¹⁷

47. Directors of Public Health representing Health Boards stated:

“We strongly advocate the precautionary principle where there is a sound theoretical argument to support a risk to public health. It is important not to wait for confirmation of harm before taking action.”¹⁸

48. Conversely, witnesses such as the Royal College of Physicians, ASH Cymru, and Tenovus Cancer Care called for further evidence on the long-term impacts of e-cigarettes before legislating in the way proposed in the

¹⁵ PHB AI 10 Minister for Health and Social Services - 10 November 2015

¹⁶ RoP [para 109], 1 July 2015

¹⁷ RoP [para 95], 9 July 2015

¹⁸ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales

Bill. Professor Linda Bauld, speaking on behalf of Cancer Research UK, argued:

“The risk is that we will overregulate. [The restriction on e-cigarettes in public places] is not an evidence-based measure; it sends a message that these products are as harmful as smoking and should be treated in the same way as tobacco, and they are not tobacco and they need to be dealt with differently.”¹⁹

49. The Centre for Drug Misuse Research expressed a similar view:

“Banning the use of electronic cigarettes in enclosed public spaces would [...] be an excessive regulation predicated on the precautionary principle that it is better to ban a substance that has not been shown to pose no health harm than to wait until such health harm is evident before initiating such a ban. Whilst there may be a case in some areas of public health to act in accordance with this principle the decision to do so where the act being banned may be associated with other benefits in reducing harm is much less persuasive. If a ban on the use of electronic cigarettes reduced the use of those cigarettes by smokers then one would in effect have prioritised a theoretical possible risk over a known health benefit (of stopping smoking).”²⁰

50. In written evidence, the British Heart Foundation highlighted that, in its view, the Bill’s proposals could actually have a damaging effect on public health:

“Cigarettes kill one in two of their long-term users. A smoker switching from cigarettes to e-cigarettes is moving from a more to a less risky behaviour and it is wrong to seek to discourage this. While there remain considerable uncertainties around these products and caution must be exercised in monitoring and regulating them, it is heavy handed and not evidence based to seek to regulate them as if they were cigarettes. As such, we believe that these proposals will not improve public health in Wales and may, in fact, have the potential to damage it. We would urge the Welsh Government to reconsider its approach.”²¹

51. ASH Wales noted that:

¹⁹ RoP [para 166], 1 October 2015

²⁰ PHB 62 Centre for Drug Misuse Research

²¹ PHB 101 British Heart Foundation

“To be precautionary it is necessary to take all effects into account of both over regulating and under regulating. It could be equally argued that under regulation is a precautionary approach for instance.”

52. The results of the public survey undertaken by the Committee as part of its public engagement work demonstrated that of those who responded, 42.85 per cent agreed or strongly agreed that the use of e-cigarettes should be banned in indoor public places and work places, while 54.24 per cent disagreed or strongly disagreed.²²

53. The varied, complex and conflicting views about restricting the use of e-cigarettes in enclosed and substantially enclosed public and work places, and the lack of definitive evidence on the longer term effects of widespread e-cigarette use, was acknowledged by the Minister in his evidence,²³ and in the EM:

“E-cigarettes are a relatively new product and as such the long term effects of their use are currently not known, with studies into their health impacts continually being published. There are a number of studies that provide contrasting views around the safety and health benefits for both the user and other nearby people.”²⁴

The Committee’s view

54. The Committee did not reach a consensus about whether it believed that the precautionary approach outlined by the Minister was sufficient grounds to legislate to restrict the use of e-cigarettes.

55. Some Members believe that the approach is appropriate given the concerns expressed by some witnesses about the longer term public health impact of e-cigarette use, including whether their use could re-normalise or act as a gateway to tobacco smoking or cause difficulties in enforcing smoke-free legislation. Those Members cite the several decades it has taken to fully understand the health implications of smoking tobacco cigarettes, and believe that adopting a precautionary approach towards e-cigarettes now could reduce the impact of potential harmful effects from their use should they become evident in the future.

²² National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

²³ RoP [para 109], 1 July 2015

²⁴ Explanatory Memorandum, para 43

56. The Committee believes that e-cigarettes have an important role to play in helping smokers to reduce or eliminate their use of tobacco cigarettes, with the potential therefore to deliver significant benefit for public health. Some Members²⁵ believe that this benefit outweighs the concerns about potential future risk of harm, given the lack of scientific evidence to substantiate such concerns. They believe that the proposed restriction could potentially prevent smokers from replacing an activity that is known to cause great harm with one which current evidence demonstrates is significantly less harmful. Those Members believe that, in relation to e-cigarettes, a precautionary approach would be not to restrict their use - they believe that such a restriction could actually cause greater public health harm as it would have the potential to discourage smokers from using e-cigarettes as an alternative to tobacco cigarettes.

57. The Committee understands that the Bill defines a nicotine inhaling device as “a device enabling the inhalation of nicotine via a mouth piece”, and that the Welsh Ministers would have the power to make regulations subject to the negative procedure to exempt a device or a description of a device from that definition. Whilst it acknowledges that the Welsh Government’s Statement of Policy Intent says that this power may be used to exempt a device if its use in public is not undermining the policy rationale behind the provisions, the Committee would be concerned if such an exemption was not granted to medically prescribed devices for use as smoking cessation aids.

Re-normalisation, the gateway effect, and enforcement

58. The Minister explained to the Committee that his reasons for bringing forward the provisions in this Bill were to:

- prevent the re-normalisation of smoking;
- prevent the use of e-cigarettes from acting as a gateway to smoking tobacco cigarettes; and
- assist in the enforcement of smoke free premises requirements.²⁶

Re-normalisation

59. The EM states that a “potential disbenefit” of the increase in the use of e-cigarettes may be that smoking is re-normalised in places now unaccustomed to smoking. It states that e-cigarettes have not been on the

²⁵ Altaf Hussain AM, Darren Millar AM, Lindsay Whittle AM and Kirsty Williams AM

²⁶ RoP [para 128], 1 July 2015

market long enough for definitive evidence to be available about whether re-normalisation is occurring, although it references a study which suggested that, owing to similarities in the appearance and consumption of e-cigarettes compared with tobacco cigarettes, there was “the potential for e-cigarettes to inadvertently promote smoking”.²⁷

60. Those who gave evidence to the Committee differed in their views about whether the use of e-cigarettes re-normalised smoking.

61. Directors of Public Health representing Health Boards, said that the use of e-cigarettes was “highly likely to normalise smoking behaviour and undermine the public health progress made so far”. They believed that allowing the use of e-cigarettes in enclosed and substantially enclosed public places would “send mixed messages to the public about smoking acceptance”.²⁸ The Directors of Public Protection Wales shared this view:

“Anything that has the appearance of smoking helps ‘normalise’ smoking and therefore promotes smoking behaviour and culture.”²⁹

62. In its written evidence, BMA Cymru Wales emphasised the need for a strong regulatory framework to ensure that the use of e-cigarettes did not undermine smoking prevention and cessation through re-normalisation.³⁰

63. In its written evidence, Public Health Wales (PHW) said that use of e-cigarettes in public could influence children to copy adult smoking behaviours. In oral evidence, Dr Julie Bishop representing PHW said that there was no evidence that children and young people would be able to distinguish adequately between an e-cigarette and a tobacco cigarette, particularly if observed from a distance.³¹

64. Julie Barratt representing the Chartered Institute of Environmental Health (CIEH) told the Committee that more evidence was needed to be able to judge whether the use of e-cigarettes would lead to the re-normalisation of smoking. She said that it would be important to trace those young people exposed to e-cigarettes from a young age to see whether it influenced their behaviour towards smoking cigarettes or using e-cigarettes during adolescence and adulthood.³²

²⁷ Explanatory Memorandum, para 54

²⁸ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales

²⁹ PHB 04 Directors of Public Protection Wales

³⁰ PHB 76 BMA Cymru Wales

³¹ RoP [para 97], 9 July 2015

³² RoP [para 59], 15 July 2015

65. In its written evidence, ASH Wales said that very little research had been undertaken on the perception of e-cigarettes to substantiate arguments that their use could lead to the re-normalisation of smoking. It said that developments in the design of e-cigarettes had led to the latest devices resembling pens rather than tobacco cigarettes, and that the lack of ash residue or the distinctive smell of cigarettes made it possible to distinguish between them. In oral evidence, Dr Steven Macey representing ASH Wales referred to a three per cent reduction in smoking prevalence over the last two years; whilst he acknowledged that the reduction would be attributable to a number of factors, he noted that ASH believed e-cigarettes had played a role.³³

66. Cancer Research UK recognised the concern about new behaviours that imitate smoking undermining the de-normalisation of smoking. However, it stated there was very limited evidence to support this view:

“It is equally fair to argue that the converse could be true and e-cigarettes could normalise quitting and moving away from tobacco, though again there is insufficient evidence to say which way this would go.”³⁴

67. The Chartered Institute of Environmental Health agreed that there was no evidence to suggest that use of e-cigarettes re-normalises smoking behaviour in smoke free areas.³⁵

68. Tenovus Cancer Care told the Committee:

“Tenovus Cancer Care has closely examined the development of evidence around electronic cigarettes over the past two years. Whilst we understand the concerns highlighted around re-normalisation and the introduction of younger generations to nicotine addiction, in our view the evidence in support of the restrictions in enclosed spaces is so far not enough to justify legislation at this time.”³⁶

69. Cancer Research UK highlighted that further research was needed to understand how exposure to e-cigarette use affected attitudes towards smoking tobacco cigarettes amongst smokers and non-smokers.³⁷

³³ RoP [para 98], 1 October 2015

³⁴ PHB 43 Cancer Research UK

³⁵ PHB 01 Chartered Institute of Environmental Health

³⁶ PHB 96 Tenovus Cancer Care

³⁷ PHB 43 Cancer Research UK

70. An independent review of evidence in relation to the use of e-cigarettes which was commissioned by Public Health England and published in August 2015, stated that, since the introduction of e-cigarettes to the market, smoking prevalence had declined. It concluded that:

“There is no evidence to date that EC [e-cigarettes] are renormalising smoking, instead it’s possible that their presence has contributed to further declines in smoking, or denormalisation of smoking.”³⁸

71. Many others³⁹ who responded to the written consultation argued against the claim that the use of e-cigarettes was re-normalising smoking, stating that the increase in their use was leading to the normalisation of vaping or not smoking.

72. In response to the question posed in the Committee’s public survey as to whether the use of e-cigarettes in smoke-free areas promotes or normalises the appearance of smoking tobacco, 60.3 per cent believed that it did not while 35 per cent believed that it did.⁴⁰

The Committee’s view

73. The Committee applauds the efforts made to reduce the prevalence of smoking over recent years, and would be concerned by anything that could potentially undermine that progress.

74. A majority of Committee Members share the concerns raised by some stakeholders that allowing the use of e-cigarettes in places where smoking is restricted could potentially lead to the re-normalisation of an activity that is no longer widely socially accepted, particularly as the action of vaping is similar to that of smoking a tobacco cigarette. Those Members acknowledge that the evidence base linking e-cigarettes to the re-normalisation of smoking remains limited and that most new generation e-cigarettes are not similar in appearance to tobacco cigarettes and do not produce the same smell or debris. Nevertheless they are concerned that growing use of e-cigarettes could potentially lead to a situation in which smoking activity is re-normalised.

³⁸ [E-cigarettes: an evidence update A report commissioned by Public Health England](#), August 2015

³⁹ PHB 09 Abigail Cottrill, PHB 18 Gordon Beard, PHB 22 Decadent Vapours Ltd, PHB 24 Rhydian Mann, PHB 37 Robert Heyes, PHB 45 Margaret Hermon, PHB 50 Electronic Cigarette Industry Trade Association, PHB 61 New Nicotine Alliance UK, PHB 62 Centre for Drug Misuse Research, PHB 68 Martin Hensman LLB (Hons) and PHB 72 Totally Wicked Ltd

⁴⁰ National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

75. A minority of Committee Members⁴¹ believe that the lack of evidence presented to the Committee to substantiate the suggestion that e-cigarettes could contribute to re-normalising tobacco smoking is sufficient grounds not to restrict the use of e-cigarettes at this time. Those Members also believe that allowing the use of nicotine inhaling devices which can only be used to vape non-nicotine based liquids in enclosed and substantially enclosed public places could undermine the argument that the Bill's provisions seek to prevent the re-normalisation of smoking.

Gateway effect of e-cigarettes

76. The Minister cited the potential for e-cigarettes to act as a gateway to smoking tobacco cigarettes, particularly among young people, as one of the key reasons for bringing forward proposals to restrict their use in enclosed and substantially enclosed public places.⁴² The EM states that:

“E-cigarettes are used by teenagers, including those who have never smoked, but currently few of those who try them become regular users. Based on data from the USA it is plausible that use among young people will increase, even among non-smokers. The CHETS Wales 2 report found that there is some suggestion that e-cigarette use may be associated with weaker anti-smoking intentions, specifically that:

- Among non-smoking children who reported having used an e-cigarette, 14% reported they might start smoking within the next two years (compared to 2% of those who had not used an e-cigarette); and
- While few children said that they will smoke within two years, children who had used an e-cigarette were substantially less likely to say they definitely will not smoke, and more likely to say that they might.

“Consideration of these data raises concerns that, in addition to re-normalising smoking, e-cigarette use may also act as a gateway to nicotine addiction and tobacco smoking.”⁴³

77. Dr Sara Hayes, Director of Public Health at Abertawe Bro Morgannwg University Health Board, believed that restricting the use of e-cigarettes in the same way as tobacco cigarettes was important to discourage their take

⁴¹ Altaf Hussain AM, Darren Millar AM, Lindsay Whittle AM and Kirsty Williams AM

⁴² RoP [para 128], 1 July 2015 and RoP [para 119], 21 October 2015

⁴³ Explanatory Memorandum, para 55

up among young people. She said that she welcomed the decrease in smoking among young people, but being complacent could lead to that decrease being replaced by an increase in the uptake of e-cigarettes.⁴⁴

78. The Faculty of Public Health said that it supported the proposals to regulate the use of e-cigarettes, particularly owing to concerns around the potential gateway effect. In its letter of additional information dated 1 October it stated:

“Will marketing, role models and peer pressure result in children commencing eCigs who would otherwise not? The answer is yes; it is clearly not zero.”⁴⁵

79. In contrast, ASH Wales told the Committee that, while low numbers of young people were experimenting with e-cigarettes, current evidence did not show that:

- experimentation among young people was leading to long-term use of e-cigarettes;
- use of e-cigarettes among the young was acting as a gateway into smoking tobacco cigarettes.⁴⁶

80. ASH Wales also referred to a survey it had recently conducted among young people in Wales which had shown that:

- regular use of e-cigarettes by “never smokers” was “negligible” at 0.16 per cent;
- of those who had reported using both e-cigarettes and tobacco cigarettes, 98 per cent had first used tobacco cigarettes.⁴⁷

81. ASH Wales concluded that, from the evidence currently available, the majority of data demonstrated that regular use of e-cigarettes by young people was concentrated among current and former smokers. However, it recognised the need to continue to monitor the situation and enhance the evidence base.⁴⁸

82. During evidence sessions some Members of the Committee referred to a study published in the 18 August 2015 issue of Journal of the American

⁴⁴ RoP [para 237], 9 July 2015

⁴⁵ PHB AI 05 UK Faculty of Public Health

⁴⁶ RoP [para 4], 1 October 2015

⁴⁷ PHB 48 ASH Wales and RoP [para 22], 1 October 2015

⁴⁸ PHB 48 ASH Wales

Medical Association Paediatrics which identified a possible link between e-cigarettes and initiation of tobacco use. The study found that:

“Among high school students in Los Angeles, those who had ever used e-cigarettes at baseline compared with nonusers were more likely to report initiation of combustible tobacco use over the next year. Further research is needed to understand whether this association may be causal.”⁴⁹

83. In response to questioning on the study, Professor Linda Bauld, representing Cancer Research UK, said:

“I’ve not only looked carefully at that study, I also know the authors, and I work with them as an editor of the journal *Nicotine and Tobacco Research*, and Adam Leventhal, who is the lead author on that study, himself would say that there is no proof of causality [...] The measure of use in that study is just having tried an e-cigarette at least once, and then 12 months later, just over 200 of them went on to try a cigarette at least once. Those are very weak measures of use [...] I don’t think that the evidence in that study points to a gateway effect. I would say that we do need to keep track of all these studies and look at them in detail, but I’m not persuaded that that single study is a cause for concern that experimenting or trying an e-cigarette means you will become a smoker.”⁵⁰

84. Professor Peter Hajek, representing the UK Centre for Tobacco and Alcohol Studies and co-author of the *E-cigarettes: an evidence update* report commissioned by Public Health England⁵¹, said that, in his view, data used in some studies which explored the use of e-cigarettes were often misinterpreted:

“some studies would label anybody who once tried an e-cigarette as a user, and if they tried an e-cigarette within 30 days, they would label them a current user, which of course makes no sense, because a current smoker is somebody who smokes daily, not somebody who tried a cigarette three weeks ago.”⁵²

⁴⁹ Primack, B.A., Soneji, S., Stoolmiller, M., Fine, M.J. and Sargent, J.D., (2015) [Progression to Traditional Cigarette Smoking After Electronic Cigarette Use Among US Adolescents and Young Adults](#), JAMA, 169(11), pages 1018-1023

⁵⁰ RoP [para 140], 1 October 2015

⁵¹ [E-cigarettes: an evidence update A report commissioned by Public Health England](#), August 2015

⁵² RoP [para 221], 1 October 2015

85. In response to a question in the Committee’s public survey on whether e-cigarettes appeal to young people, and could lead to more young people using them or encourage them to smoke tobacco products, 36.87 per cent agreed or strongly agreed that they could while 54.58 per cent disagreed or strongly disagreed that they could.⁵³

86. Representatives from ASH Wales,⁵⁴ Professor John Britton, a consultant in respiratory medicine at the University of Nottingham and Nottingham City Hospital and Director of the UK Centre for Tobacco and Alcohol Studies,⁵⁵ and Professor Hajek⁵⁶ emphasised the importance of continuing to monitor and conduct research to gather evidence on whether using e-cigarettes was acting as a gateway to smoking tobacco cigarettes.

Marketing and appeal to young people

87. Representatives of Public Health Wales and the Faculty of Public Health raised concerns about the marketing of e-cigarettes appealing to young people. Dr Gill Richardson, Director of Public Health at Aneurin Bevan University Health Board, said that flavours such as “gummy bear” or “bubble gum” would appeal to young people, as would the appearance of some e-cigarettes. She cited an example of one device resembling a pink glitter pen, which she argued would be particularly appealing to young girls.⁵⁷

88. Professor Alan Maryon-Davis, representing the UK Faculty of Public Health, referred to the flavouring and colourful appearance of e-cigarettes as appealing and the prominence of their display in shops as raising awareness among young people.⁵⁸ Julie Barratt representing the CIEH told the Committee she recognised the concern that seeing e-cigarettes being used and sold in places where tobacco was not would increase their exposure to children and young people and could act as a gateway. However, she stated that there was currently no evidence to substantiate that concern.⁵⁹

89. Other witnesses questioned whether the advertising and flavouring of e-cigarettes was specifically targeted at young people alone. Professor Linda Bauld told the Committee:

⁵³ National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

⁵⁴ RoP [paras 6 and 78], 1 October 2015

⁵⁵ RoP [para 222], 1 October 2015

⁵⁶ RoP [para 222], 1 October 2015

⁵⁷ RoP [para 231], 9 July 2015

⁵⁸ RoP [para 424], 1 October 2015

⁵⁹ RoP [para 61], 15 July 2015

“The flavours that are in e-cigarettes are useful for adult smokers who move away from tobacco, because they separate that tobacco product from the e-cigarette product. So, the flavours have a role to play in making e-cigarettes an attractive stop-smoking aid. Whether these flavours are being targeted at children or not is an important question, and that’s why the marketing needs to be addressed, but I’m not seeing any evidence from the studies that never-smoking children are taking up e-cigarettes in any significant number. So, if the marketing is doing that, at the moment it’s not working.”⁶⁰

90. Professor Britton, agreed that the availability of various flavours was important to adult smokers who used e-cigarettes as a smoking cessation aid:

“We do a lot of work with electronic cigarette users, and one of the messages that comes back from them is that the flavours that you or I might perceive as being aimed at children are actually very important to them. So, if you’d asked me this question 18 months ago, I’d have said, ‘No, the bubble gum and so on should go’. I’ve changed my view, because that’s what a lot of adult smokers use and they find it a very helpful adjunct.”⁶¹

The Committee’s view

91. The Committee welcomes the provisions of the *Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations 2015*⁶² which came into force on 1 October 2015, which make it an offence in England and Wales to:

- sell nicotine products (including e-cigarettes) to persons aged under 18 years old;
- proxy purchase nicotine products (including e-cigarettes) for minors.

92. The Committee also welcomes the publication of advertising rules for e-cigarettes by the Committee of Advertising Practice (CAP) and Broadcast Committee of Advertising Practice (BCAP) which came into effect in November 2014. These include the following restrictions around targeting young people:

⁶⁰ RoP [para 134], 1 October 2015

⁶¹ RoP [para 135], 1 October 2015

⁶² [*Nicotine Inhaling Products \(Age of Sale and Proxy Purchasing\) Regulations 2015*](#)

- adverts must not be likely to appeal particularly to people under 18, especially by reflecting or being associated with youth culture;
- people shown using e-cigarettes or playing a significant role must neither be, nor seem to be, under 25;
- adverts must not be directed at people under 18 through the selection of media or the context in which they appear.⁶³

93. The Committee notes that the EU Tobacco Products Directive, which is due to come into force in 2016, will introduce prohibitions on cross-border e-cigarette advertising that will be wide-ranging and could cut across the new UK rules. It notes the joint regulatory statement from CAP and BCAP which states:

“The new CAP and BCAP rules do not pre-empt the requirements of the Directive but serve, at least, as an interim measure. B/CAP understand that the Department of Health is now working to establish what effect the Directive will have in the UK. When more is known about the effect of the Directive in the UK, CAP and BCAP will clarify what role their Codes will have in relation to e-cigarette advertising in future.”

94. The Committee acknowledges the consensus among witnesses that trends in e-cigarette use, and any associated health impacts, must continue to be monitored. It welcomes the fact that such monitoring requirements will be part of the provisions which are due come into effect through the EU Tobacco Products Directive in 2016.

95. The Committee also notes that, under the tobacco display bans now in force across the UK, it is illegal for any business selling tobacco products to display tobacco products to the public. The display of prices of tobacco products is also restricted. The stated aim of the ban is to reduce the uptake of smoking among young people in particular, by reducing the visual temptation of cigarettes on display.⁶⁴

96. The Committee acknowledges that limited evidence is available about whether the use of e-cigarettes is acting as a gateway to smoking tobacco products. Nevertheless, it is concerned to learn of examples of e-cigarette marketing being targeted at children and young people.

⁶³ <https://www.cap.org.uk/Advice-Training-on-the-rules/Advice-Online-Database/Electronic-cigarettes.aspx#.VkBuFdIYSUk>

⁶⁴ <http://gov.wales/newsroom/healthandsocialcare/2012/121203tb/?lang=en>

97. Some Members were concerned to learn of diverging practice in relation to the display of e-cigarettes and tobacco cigarettes at the point of sale, with e-cigarettes not being subject to any display restrictions, and often seen prominently displayed at point of sale in many outlets. They would wish to see work undertaken by the Welsh and UK Governments to explore options to restrict the display and marketing of e-cigarettes.

98. Other Members⁶⁵ believe that, given the limited evidence about whether the use of e-cigarettes acts as a gateway to smoking tobacco products, the concerns around the gateway effect do not provide sufficient grounds on which to:

- legislate to restrict the use of e-cigarettes;
- restrict their display at the point of sale in the same way as the display of tobacco cigarettes is restricted.

They believe that the impact of the legislation introduced to prevent the sale of e-cigarettes to those under 18, along with other measures such as the EU Tobacco Products Directive and UK advertising rules, should be assessed before any further steps are taken to restrict their use in enclosed or substantially enclosed public places.

Enforcement

99. The EM states that it is “a concern that e-cigarette use is undermining enforcement of the smoking ban”. It goes on to say that:

- several prosecutions under the Health Act 2006 have failed where the defendant has claimed to have been using an e-cigarette at the relevant time, rather than smoking;⁶⁶
- respondents to the Welsh Government’s Public Health White Paper consultation suggested that the vapour emitted from e-cigarettes, as well as the hand-to-mouth action associated with the use of e-cigarettes, can make it difficult from a distance for managers of premises required to be smoke-free to differentiate between regular cigarettes and e-cigarettes;⁶⁷
- the proposed restriction would aid enforcement by providing clarity and consistency for businesses and workplaces.⁶⁸

⁶⁵ Altaf Hussain AM, Darren Millar AM and Kirsty Williams AM

⁶⁶ Explanatory Memorandum, para 58

⁶⁷ Explanatory Memorandum, para 58

⁶⁸ Explanatory Memorandum, para 62

100. Representatives from the Chartered Institute of Environmental Health (CIEH) and the Directors of Public Protection Wales (DPPW) told the Committee that restricting the use of e-cigarettes in enclosed or substantially enclosed public places would aid the enforcement of existing restrictions. Julie Barratt representing the CIEH referred to businesses who had voluntarily opted to restrict the use of e-cigarettes on their premises because allowing their use made it difficult for them to enforce the ban on tobacco cigarettes.⁶⁹

101. Paul Mee, representing the DPPW, told the Committee that, for its officers, “the fundamental issue around e-cigarettes is the undermining of the enforcement of the ban on smoking in public places, and we’ve certainly seen evidence to support that view”.⁷⁰ Robert Hartshorn, also representing the DPPW, said that it was particularly difficult to enforce the smoke free restrictions in moving vehicles. He said that if an officer suspected a person was smoking and that person used “it was an e-cigarette” as their defence, it would be almost impossible to prove this either way.⁷¹

102. Simon Wilkinson, representing the WLGA, also cited incidences of individuals using the use of an e-cigarette in their defence against prosecution for smoking in a restricted area:

“Cardiff council instigated a prosecution against a taxi driver for smoking in his vehicle and the defendant pleaded not guilty on the basis he was smoking an e-cigarette and not a real cigarette. That matter did go to court and the defendant was found not guilty, despite the offence being witnessed by an enforcement officer. There have been similar occurrences in Powys County Council, Caerphilly, Wrexham and also Swansea.”⁷²

103. Mr Mee told the Committee that, as the person taking the decision on behalf of his local authority whether to prosecute a person suspected of smoking, he would:

“look at the strength of the evidence and whether there’s anything that’s likely to compromise that case in court. In light of the very clear evidence that cases have failed in those circumstances, if somebody was to use the defence that they were using an e-cigarette

⁶⁹ RoP [para 67], 15 July 2015

⁷⁰ RoP [para 189], 15 July 2015

⁷¹ RoP [para 191], 15 July 2015

⁷² RoP [para 197], 15 July 2015

and we weren't absolutely certain of that, then I'm unlikely to decide to take that case forward".⁷³

104. The Committee has not received any further figures to identify the number of cases that have not been pursued or prosecutions that have failed in such circumstances.

105. In contrast, representatives from the Electronic Cigarette Industry Trade Association (ECITA) questioned the suggestion that the use of e-cigarettes undermined the enforcement of smoke free legislation:

"Even where they do look like cigarettes, it's really difficult to understand how any confusion between the two could be sustained, when you have the complete absence of the unpleasant smell of smoke and all the detritus that's left behind after smoking activity has taken place."⁷⁴

106. Consumer representatives, representatives of the e-cigarette industry, ASH Wales, the British Lung Foundation and Cancer Research UK highlighted the fact that compliance with existing smoke free legislation was already very high, and argued that there was no evidence to suggest that the use of e-cigarettes in public places was having a detrimental effect on enforcement.⁷⁵

107. The New Nicotine Alliance stated:

"The majority of e-cigarettes in use (66%) are now the tank system variety, which cannot be confused with a cigarette. The general public is now well acquainted with e-cigarettes and there is little chance of confusion by premises' staff. The ability to use an e-cigarette where smoking is not permitted gives smokers a legal alternative. If anything it should assist in delivering still greater compliance with smoke-free legislation."⁷⁶

⁷³ RoP [para 201], 15 July 2015

⁷⁴ RoP [para 51], 23 September 2015

⁷⁵ PHB 07 Paul Barnes, PHB 14 Dr David Upton, PHB 22 Decadent Vapours Ltd, PHB 24 Rhydian Mann, PHB 26 British Lung Foundation, PHB 43 Cancer Research UK, PHB 48 ASH Wales, PHB 50 Electronic Cigarette Industry Trade Association, PHB 59 Gower Enterprises Limited, PHB 61 New Nicotine Alliance UK, PHB 66 Nicoventures, PHB 71 Fontem Ventures, PHB 72 Totally Wicked Ltd, PHB 79 Philip Morris Limited and PHB 89 Public Health Wales

⁷⁶ PHB 61 New Nicotine Alliance UK

The Committee's view

108. A majority of Members are unconvinced that the evidence provided is sufficient to substantiate the suggestion that difficulties in distinguishing between e-cigarettes and tobacco cigarettes makes the enforcement of smoke-free legislation difficult to manage. However, other Members accepted the rationale that enforcing smoke-free legislation could be made difficult by allowing the use of e-cigarettes in places where smoking is prohibited.

109. The Committee believes that the Minister's intention not to restrict the use of e-cigarettes which can only be used to vape non-nicotine based liquids will only add to confusion on the basis that distinguishing between e-cigarettes which could or could not contain non-nicotine based liquids would be extremely difficult for enforcement officers and managers of premises.

Use of e-cigarettes as a smoking cessation aid

110. Representatives from ASH Wales told the Committee that the *E-Cigarettes: an evidence update* report commissioned by Public Health England had shown that e-cigarettes were the most popular smoking cessation aid at the moment. ASH Wales argued, that restricting the use of e-cigarettes could convey the message that they were as harmful as tobacco cigarettes thereby potentially preventing people from using them as a smoking cessation method. They argued that this could ultimately cause a greater public health harm should those people continue to smoke.⁷⁷ Dr Steven Macey referred to a study undertaken by ASH UK which demonstrated that, between 2013-15, the number of adults who already considered e-cigarettes to be as harmful as tobacco cigarettes had increased from six per cent to 20 per cent. He said that the contrasting results of various studies on the safety of e-cigarettes could have led to this change,⁷⁸ and he believed that legislating to restrict the use of e-cigarettes in public places would further increase such a perception.⁷⁹

111. In contrast, the Minister referred to a review of evidence carried out by the Cochrane Collaboration in December 2014, which he said showed that evidence for e-cigarettes being an effective means of giving up tobacco smoking was low. He said that the proposals in the Bill would not prevent anyone wishing to use e-cigarettes as an aid to reduce or stop smoking from doing so, and that there was no evidence that restrictions to bring their use

⁷⁷ RoP [paras 17 and 19–20], 1 October 2015

⁷⁸ RoP [para 30], 1 October 2015

⁷⁹ RoP [para 22], 1 October 2015

in line with tobacco cigarettes would prevent people from using them in that way.⁸⁰

112. In written evidence, the British Lung Foundation told the Committee:

“Reviewing all available data on the efficacy of e-cigarettes as an aid to smoking cessation, the Cochrane collaboration published a review in December 2014, concluding that e-cigarettes were more effective than nicotine replacement patches at helping smokers cut down. It also concluded that there was no evidence that dual use of e-cigarettes and cigarettes made smokers any less likely to quit. However, the review also concluded that the quality of evidence in many of the areas was low, and that more studies were recommended (many of which have been started).”⁸¹

113. Furthermore, the report *E-cigarettes: an evidence update* commissioned by Public Health England stated that:

“Recent studies support the Cochrane Review findings that EC [e-cigarettes] can help people to quit smoking and reduce their cigarette consumption. There is also evidence that EC [e-cigarettes] can encourage quitting or cigarette consumption reduction even among those not intending to quit or rejecting other support. More research is needed in this area.”⁸²

114. Dr Julie Bishop, representing Public Health Wales, told the Committee that she was concerned about e-cigarettes being referred to as “being predominately a cessation aid, because actually they are not proven in that context”. She said that stopping smoking required looking at the habit and the social aspects of the addiction, and that replacing a tobacco cigarette with a “pharmacological alternative” would not work on its own. She added that there was evidence of better ways of stopping smoking than by using e-cigarettes, including free help available through the NHS.⁸³

115. Julie Barratt, representing the Chartered Institute of Environmental Health, concurred that it would be preferable for anyone wishing to give up smoking to access a formal support service “that uses a properly regulated product and has other support” as “diminishing amounts of nicotine that are

⁸⁰ RoP [para 113], 1 July 2015

⁸¹ PHB 26, British Lung Foundation

⁸² [E-cigarettes: an evidence update A report commissioned by Public Health England](#), August 2015

⁸³ RoP [para 101], 9 July 2015

taken in a controlled way is the most appropriate way to use a nicotine substitute to give up smoking”. However, she added:

“If someone wants to give up smoking and they can assist themselves to do that using an e-cigarette, that is also to be applauded.”⁸⁴

116. Professor Linda Bauld told the Committee that one of the reasons why it was difficult to get smokers to use the formal smoking cessation services was because nicotine-replacement therapy was not as appealing as e-cigarettes:

“I’ve worked for 17 years doing research on smoking cessation, and we’ve struggled for all these years to get people to use our excellent stop-smoking services, and you’ve got fantastic stop-smoking services in Wales. One of the reasons for that is that they’re not appealing. Nicotine replacement therapy, unfortunately, has never really taken off in the way that it could have done, because it’s not appealing. One of the things about the hand-to-mouth nature of e-cigarettes and the product is that, actually, it is like smoking, and that’s one of the reasons why it’s easier for people to switch and one of the reasons why it has an appeal, because it has those sensory triggers as well as the nicotine delivery. So, I think it is unfortunate, you’re right, that there are the same kind of gestures, and I understand where people’s concerns about that come from. But it’s also a success story, because we’re seeing people using these devices to stop smoking—in many cases gradually—exactly because it’s a similar behaviour. So, we really have to strike the balance there, and I don’t think that treating them exactly like tobacco in public places is the solution.”⁸⁵

117. Professor Bauld went on to explain that as a smoking cessation aid, e-cigarettes were approximately as effective as nicotine-replacement therapy, but not as effective as stop-smoking services. She said using an e-cigarette was around 60 per cent more effective in a stop-smoking attempt than willpower alone.⁸⁶

118. Professor John Britton told the Committee that from his experience as a respiratory physician, he had learnt that while smokers may wish to stop for health or financial reasons, actually doing something about it was a

⁸⁴ RoP [para 82], 15 July 2015

⁸⁵ RoP [paras 157–158], 1 October 2015

⁸⁶ RoP [para 180], 1 October 2015

“frightening prospect”. He said that “there’s always a reason to put it off”, and so was concerned that restrictions on the use of e-cigarettes could potentially send mixed messages about their safety and act as a barrier to anyone considering using them to give up.⁸⁷ Professor Peter Hajek shared these concerns:

“People have to put effort into switching—it’s not easy. You only put effort into things if you think it’s worth it. If there’s a doubt in your mind—‘maybe it’s not any better’—then you won’t.”⁸⁸

119. Written evidence provided to the Committee by numerous individuals described their personal experiences of using e-cigarettes to stop smoking:

“I moved seamlessly from smoking to a personal vapouriser 3 years ago and have not looked back or smoked since.”⁸⁹ (Vince Jarvis)

“I stopped smoking on the 21st of May 2015, and that is something I never thought would happen. Not only that I did it by accident. I bought my first vaping device on a whim, I thought it might be a laugh, as I had seen a girl at work using hers. I had no intention of quitting smoking, but 3 weeks later I was completely smoke free. If the proposals in this bill had been in place I would never have bought a vape pen, and I would still be smoking to this day.”⁹⁰ (Abigail Cottrill)

“I speak as someone who believes e-cigarettes saved my life. [...] I attended at least 6 courses of the anti-smoking clinics run by my health board. [...] I smoked for over 40 years, gave up several times but always lapsed. I have not smoked for over 4 years and will never go back.”⁹¹ (Carole Coote)

120. Martin Hensman said that after more than 45 years as a tobacco smoker and numerous attempts to stop, including enrolling on a ‘Quit Smoking Course’ through his GP:

“I decided to use an e-cigarette and can report that I have not smoked tobacco in the last 6 weeks. [...] Furthermore, had e-cigarettes been banned in enclosed and substantially enclosed public places at the

⁸⁷ RoP [para 201], 1 October 2015

⁸⁸ RoP [para 270], 1 October 2015

⁸⁹ PHB 11 Vince Jarvis

⁹⁰ PHB 09 Abigail Cottrill

⁹¹ PHB 10 Carole Coote

time of my latest ‘quit attempt’ it is more than likely that I would have again been unsuccessful.”⁹²

121. 49.1 per cent of people who responded to the Committee’s public survey said that they had used e-cigarettes. Of those who gave a reason for their use of e-cigarettes, the majority stated that it was as a smoking cessation aid, with 57.27 per cent saying that it was to give up smoking and 13.21 per cent saying that it was to reduce the amount they smoked.⁹³

The Committee’s view

122. The Committee notes and welcomes the contribution made by e-cigarettes as an aid to smoking cessation, and recognises the role they could play in reducing the harms from tobacco smoking. It acknowledges the evidence stating that e-cigarettes are substantially less harmful than tobacco cigarettes and welcomes the positive health impact that switching to e-cigarettes could potentially have on the lives of smokers.

Dual use

123. The Minister told the Committee that evidence suggested that most people who use e-cigarettes use them in an attempt to reduce their consumption of tobacco cigarettes:

“There’s very little evidence for elimination; almost all e-cigarette users turn out to be dual-use users.”⁹⁴

124. The Minister provided further details in his letter of 4 September to the Committee in which he referred to a survey published by ASH UK in May 2015⁹⁵ which found that three out of five e-cigarette users were current smokers,⁹⁶ and the Smoking Toolkit Study which said that approximately 85 per cent of all users were dual users.⁹⁷

125. Representatives from ASH Wales said that they welcomed people using e-cigarettes alongside tobacco cigarettes as a means of reducing their tobacco consumption. Dr Steven Macey told the Committee that, ideally, people would stop smoking altogether. However if that was not possible,

⁹² PHB 68 Martin Hensman LLB (Hons)

⁹³ National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

⁹⁴ RoP [para 140], 1 July 2015

⁹⁵ [ASH factsheet 33: Use of electronic cigarettes in Great Britain](#), May 2015

⁹⁶ PHB AI 01 Minister for Health and Social Services - 4 September 2015

⁹⁷ [Smoking Toolkit Study. Trends in electronic cigarette use in England](#)

then reducing the amount of tobacco they smoked would be beneficial to their health.⁹⁸

126. Professor Linda Bauld told the Committee that many smokers would dual use e-cigarettes and tobacco cigarettes for a while, but that data were showing that the proportion of dual users was gradually declining as more e-cigarette users move away from tobacco completely.⁹⁹

Use of shared shelters

127. Concerns were highlighted in written responses to the Committee's consultation that restricting the use of e-cigarettes in enclosed and substantially enclosed public places could in practice mean that e-cigarette users would be sharing outside space or shelters with smokers.¹⁰⁰ It was suggested by the Chartered Institute of Environmental Health that this could be damaging to those people attempting to stop smoking by using e-cigarettes as it "may undermine their quitting efforts".¹⁰¹

128. This view was shared by the New Nicotine Alliance:

"Forcing e-cigarette users to go outside to vape, often to places where they will be among smokers and also perhaps in time limited situations, may encourage them to smoke instead in order to increase nicotine levels quickly within the time available."¹⁰²

and by ASH Wales:

"E-cigarette users have told us that, obviously, if they are restricted from using them in public places, they are sent to the smoking area, in some cases. Obviously, the Minister has made it clear they're not forced to do that, but, in practical terms, they will be, and that does make it difficult, especially if you're trying to use them to quit; you're out in a smoking area."¹⁰³

129. Professor Peter Hajek also shared this concern:

"Then, of course, you've got the situation where vapers will be forced to go out into the rain to stand next to smokers, which will, of

⁹⁸ RoP [paras 33 and 35], 1 October 2015

⁹⁹ RoP [para 187], 1 October 2015

¹⁰⁰ PHB 07 Paul Barnes, PHB 24 Rhydian Mann, PHB 37 Robert Heyes and PHB 54 Jonathan Edwards

¹⁰¹ PHB 01 Chartered Institute of Environmental Health

¹⁰² PHB 61 New Nicotine Alliance UK

¹⁰³ RoP [para 23], 1 October 2015

course, tempt them back to smoking. I think that the behaviour I want to see is the vaping. I want smokers to stop smoking and start vaping. So, I would be concerned that the regulation will push them in the opposite direction.”¹⁰⁴

130. In response to this concern, the Minister told the Committee:

“people are making choices here, and nobody is forced to use an e-cigarette or a conventional cigarette or to stand next to anybody else who is using either”.¹⁰⁵

The Committee’s view

131. Some Members are concerned that restricting the use of e-cigarettes in enclosed and substantially enclosed public places could lead to a situation where users of e-cigarettes would need to share outside space with smokers, which could:

- undermine their efforts not to use tobacco products;
- cause health harm to vapers from second-hand tobacco smoke.

Harms from e-cigarettes

132. The Minister told the Committee that the potential harms of e-cigarette use and the vapour produced was not the basis on which the Bill was introduced. Nevertheless, he referred to a report produced by the state health officer for California which stated that “e-cigarettes do not emit a harmless water vapor, but a concoction of chemicals toxic to human cells”.¹⁰⁶

133. One of the key findings of the report *E-cigarettes: an evidence update* commissioned by Public Health England was that e-cigarettes were significantly less harmful to health than tobacco. The report stated that the current best estimate was that e-cigarettes were around 95 per cent less harmful than smoking tobacco cigarettes.¹⁰⁷

Harms for users of e-cigarettes

134. Dr Julie Bishop, representing Public Health Wales, told the Committee that e-cigarettes were a relatively new product and, as such, more information about the benefits and risks associated with their use was

¹⁰⁴ RoP [para 271], 1 October 2015

¹⁰⁵ RoP [para 146], 1 July 2015

¹⁰⁶ RoP [para 129], 1 July 2015

¹⁰⁷ [E-cigarettes: an evidence update A report commissioned by Public Health England](#), August 2015

constantly emerging.¹⁰⁸ She went on to say that, as products, e-cigarettes had very little value other than being “better than something that currently causes a great deal of harm”.¹⁰⁹

135. Dr Gill Richardson, Director of Public Health at Aneurin Bevan University Health Board, argued that although the prevalence of lung cancer may decrease owing to the rise in use of e-cigarettes, it was not known whether other cancers may be linked to nicotine. She also noted that some of the cardiovascular problems associated with nicotine would persist if e-cigarettes were used.¹¹⁰

136. While Dr Richardson said that one of the problems that had been associated with e-cigarettes was the fact that their dosage had not historically been monitored strictly, and that some could contain eight times as much nicotine as a traditional cigarette,¹¹¹ the Committee notes that the EU Tobacco Products Directive, which will come into effect in 2016, will regulate the nicotine concentration level of e-cigarettes and will require them to deliver nicotine doses at a consistent level. It will also include requirements for detailed product information to be provided including health warnings, usage instructions, information on addictiveness and toxicity, and the listing of all substances contained including nicotine content.

137. On the basis that more research was needed to understand the public health impact of long-term use of e-cigarettes, representatives of Public Health Wales, the Directors of Public Health representing Health Boards and BMA Cymru Wales supported the proposals to restrict the use of e-cigarettes. They felt that it was appropriate, on balance, to legislate to restrict the use of e-cigarettes in enclosed and substantially enclosed public places in order to mitigate against the potential for such research to demonstrate detrimental health effects in future.

138. Dr Steven Macey representing ASH Wales told the Committee that while e-cigarettes did contain some toxicants and carcinogens, they were at a much lower levels than in tobacco cigarettes. Nevertheless, he added that he was not in a position to say that e-cigarettes were not harmful.¹¹²

¹⁰⁸ RoP [para 95], 9 July 2015

¹⁰⁹ RoP [para 97], 9 July 2015

¹¹⁰ RoP [para 227], 9 July 2015

¹¹¹ RoP [para 226], 9 July 2015

¹¹² RoP [para 118], 1 October 2015

139. Professor John Britton said he believed that the finding in the report *E-cigarettes: an evidence update* commissioned by Public Health England that e-cigarettes were only five per cent as harmful as tobacco cigarettes was a high estimate, but conceded that even at one per cent a risk of harm remained.¹¹³ However, he said that the key point was to compare that risk with the risks from tobacco cigarettes. Professor Britton did not believe that the risk to public health posed by e-cigarettes was proportionate to warrant an “infringement” on their use equal to that applied to the use of tobacco cigarettes.¹¹⁴

140. Representatives from ASH Wales, Professor Bauld and Professor Britton suggested to the Committee that restrictions on the use of e-cigarettes risked conveying the message that they were as harmful as tobacco cigarettes. They believed this could deter some smokers from using them as a smoking cessation aid, which could cause greater harm to public health should those smokers continue to smoke tobacco cigarettes instead. Jamie Matthews, representing ASH Wales, said:

“For this section [Chapter 1 of the Bill], we believe that, in its current form, and if this remains in the Bill, then it potentially could have a damaging effect on public health, if it restricts the use of e-cigarettes for people using them as a cessation aid.”¹¹⁵

141. Professor Britton told the Committee that if all smokers in the UK switched to using e-cigarettes instead of tobacco cigarettes, approximately five million premature deaths could be prevented. He said:

“This is a massive public health opportunity, and any mixed message that says, ‘We should be very cautious about these products,’ is missing the point—missing a golden opportunity to improve public health now.”¹¹⁶

142. Professor Britton noted that whilst he would expect to see some diseases occur more frequently as a consequence of e-cigarette use – possibly a small increase in cancer, damage to the lung, driving emphysema, fibrotic lung disease or cardiovascular risk from absorbed particles – the

¹¹³ RoP [para 173], 1 October 2015

¹¹⁴ RoP [para 165], 1 October 2015

¹¹⁵ RoP [para 44], 1 October 2015

¹¹⁶ RoP [para 182], 1 October 2015

scale would be “trivial” in comparison with diseases caused by smoking tobacco cigarettes.¹¹⁷

143. Professor Peter Hajek concurred that the risks posed by e-cigarette use in comparison with tobacco cigarettes were much less:

“You’ve got chemicals that are in e-cigarette vapour that are not in cigarettes, and none of them is expected to cause any serious damage to health. You don’t want to claim this is 100 per cent safe, although, so far, we don’t really have any evidence of any risk. I can tell you what rates of risk we’ve detected so far, but we don’t want to say this is 100 per cent safe, because, of course, there is long-term use, there are lots of unknowns and something may come up with flavourings, with contaminants. But, soberly, it’s not going to be more than 5 per cent of smoking, because smoking is so terribly risky.”¹¹⁸

144. ASH Wales, Professor Britton, Professor Bauld and Professor Hajek emphasised the need for continued monitoring and further research on the impacts of e-cigarette use to establish a better understanding of the harms they could cause to public health.

145. ASH Wales¹¹⁹, Professor Britton, Professor Bauld¹²⁰ and Professor Hajek¹²¹ also supported a form of regulation of e-cigarettes but, on balance, felt that the provisions in the Bill to restrict the use of e-cigarettes in enclosed and substantially enclosed public places were disproportionate to the evidence currently available on the health impacts, particularly owing to the use of e-cigarettes as a smoking cessation aid and their potential role in reducing the harms from smoking tobacco cigarettes.

Harms for bystanders

146. One of the stated purposes of the provisions in the Bill is to maintain the air quality enjoyed in enclosed and substantially enclosed public and work places in Wales as a result of the current smoke-free environment. The EM states:

“It is known that e-cigarettes contain various chemicals that are vaporised and emitted into the air, and studies have suggested that

¹¹⁷ RoP [para 213], 1 October 2015

¹¹⁸ RoP [para 277], 1 October 2015

¹¹⁹ RoP [para 47], 1 October 2015

¹²⁰ RoP [para 166], 1 October 2015

¹²¹ RoP [para 247], 1 October 2015

e-cigarette aerosol can contain some of the toxicants present in tobacco smoke, albeit at levels which are much lower. [...] The safety of e-cigarettes for bystanders is currently uncertain; but the possibility of adverse health effects for third parties exposed to e-cigarettes cannot be excluded. Allowing the use of e-cigarettes in places where smoking is banned arguably creates an environment that undermines the safer one established by the Health Act 2006.”¹²²

147. In oral evidence to the Committee, the Minister referred to the report *A Smoking Gun: Cancer-causing Chemicals in E-cigarettes* by the Center for Environmental Health in California, which he said:

“looked at 97 different types of e-cigarettes to analyse what they gave off in terms of vapour. It found that, in 50 of the 97, the vapour had higher levels of one or both of the two cancer-causing chemicals that it analysed, above the levels permitted in California. In one case, the level of formaldehyde emitted by the e-cigarette was 470 times higher than the safe limit identified in Californian law”.¹²³

148. Written evidence received from the Directors of Public Health on behalf of Health Boards stated that, while the concentrations of potentially harmful inhalants in e-cigarette vapour may be lower than that of cigarettes, they were still present and could expose bystanders to greater than normal levels.¹²⁴

149. The report *E-cigarettes: an evidence update* commissioned by Public Health England stated that e-cigarette use released “negligible” levels of nicotine into ambient air with no identified health risks to bystanders.¹²⁵ Professor Britton agreed, adding the vapour emitted from e-cigarettes would not present any greater hazard than other everyday products that emitted particles into the atmosphere.¹²⁶

150. In its written evidence, ASH Wales referred to a study which demonstrated that the levels of toxins released by e-cigarettes were significantly lower than released by cigarette smoke.¹²⁷ Dr Steven Macey, representing ASH Wales, told the Committee that currently:

¹²² Explanatory Memorandum, paras 56 and 57

¹²³ RoP [para 120], 21 October 2015

¹²⁴ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales

¹²⁵ [E-cigarettes: an evidence update A report commissioned by Public Health England](#), August 2015

¹²⁶ RoP [para 173], 1 October 2015

¹²⁷ PHB 48 ASH Wales

“There is no evidence that there’s any harm to bystanders from the second-hand vaping.”¹²⁸

151. Professor Peter Hajek said that there was no evidence of harm caused to bystanders through passive vaping to support the rationale for restricting the use of e-cigarettes in enclosed and substantially enclosed public places.¹²⁹ He cited a study by the Spanish Council of Scientific Research which had found that the volume of volatile organic compounds emitted from tobacco cigarettes was significantly higher than that emitted in e-cigarette vapour.¹³⁰

152. Cancer Research UK also stated in written evidence that it was unaware of any scientific studies that convincingly demonstrated harm to bystanders from second or third hand vapour.¹³¹

153. In relation to the impact of e-cigarette vapour on the health of vulnerable groups, the Committee only received evidence in relation to asthmatics. Written evidence from an asthma sufferer stated that being exposed to e-cigarette vapour triggered an asthma attack.¹³² Asthma UK noted that very little research had been done to date looking at the effects of e-cigarette vapour on non-smokers with asthma.¹³³ In response to the specific issue of second-hand vapour, Dr Steven Macey said:

“There’s no evidence at the moment that it causes severe harm to asthma sufferers, to my knowledge.”¹³⁴

154. Another issue raised by the Chartered Institute of Environmental Health in its written evidence was that users of e-cigarettes could be exposed to second hand smoke should they need to share an outside space with smokers:

“We believe that it is extremely important that those who are using e-cigarettes as a quitting device should not be subjected to the same restrictions as smokers and subjected to second hand tobacco smoke.”¹³⁵

¹²⁸ RoP [para 17], 1 October 2015

¹²⁹ RoP [para 261], 1 October 2015

¹³⁰ RoP [para 273], 1 October 2015

¹³¹ PHB 43 Cancer Research UK

¹³² PHB 23 Caroline Evans

¹³³ <http://www.asthma.org.uk/advice-trigger-smoking>

¹³⁴ RoP [para 57], 1 July 2015

¹³⁵ PHB 01 Chartered Institute of Environmental Health

155. This concern was also raised by Martin Hensman in his written evidence:

“In practice the provisions would require e-cig users to occupy the same areas outside workplaces and social venues now occupied by smokers. E-cig users would again be exposed to the same toxic second hand smoke that the Smoke-free Premises etc. (Wales) Regulations 2007 were supposed to protect them from.”¹³⁶

156. The Minister suggested to the Committee that this could be mitigated by employers making alternative arrangements, by providing separate spaces for e-cigarette users and smokers or by staggering the use of their facility:

“They [employers] can, if they so wish, find alternative places for e-cigarette users to congregate, or we know that what they do is stagger the use of the facility they already have. So, they make it available at some parts for an hour for conventional cigarette users, and then another period for e-cigarette users, and that is the way that the employment world is going.”¹³⁷

Voluntary bans

157. The Minister told the Committee that some organisations, including sports and entertainment venues and transport providers, had voluntarily implemented restrictions on the use of e-cigarettes in their premises.

158. Professor John Britton¹³⁸ and Professor Peter Hajek supported voluntary restrictions over a complete ban in public places. Professor Hajek explained:

“If it’s coming from above, that does imply that there is a risk to bystanders, that it’s as bad as smoking and that we need to get rid of it. If it’s coming from the owners of the premises who just don’t like the sight of it or don’t want people to be exposed to, whatever, strawberry flavour from e-cigarettes, I think that puts it in a different category. I still wouldn’t be terribly keen for everybody to ban it, but if they had a good reason, it would just be their own decision; there wouldn’t be the authority of the state and the medical profession and the evidence, which are all implied if you do it as legislation.”¹³⁹

¹³⁶ PHB 68 Martin Hensman LLB (Hons)

¹³⁷ RoP [para 271], 1 July 2015

¹³⁸ RoP [para 205], 1 October 2015

¹³⁹ RoP [para 261], 1 October 2015

Exemptions

159. The Bill also includes provision to exempt premises, or specified areas within premises, from the requirement to be smoke-free. Exemptions may be in respect of both smoking and the use of e-cigarettes, smoking only, or the use of e-cigarettes only.

160. Existing exemptions from current smoke-free restrictions apply to specific rooms within care homes, adult hospices, mental health units, research or testing facilities, hotels, guesthouses, inns, hostels and members' clubs. The Welsh Government's Statement of Policy Intent for Subordinate Legislation which accompanies the Bill states its intention to retain most of these exemptions in respect of smoking, and to include the use of e-cigarettes in these exemptions.¹⁴⁰

161. During the oral evidence session on 1 July, the Minister told the Committee that "there may be some places where exceptions need to be made", and suggested that examples of such places could be premises used by the film and cinema industry and pharmacy consulting rooms.¹⁴¹

162. Professor Britton referred to mental health settings as somewhere that should be exempted from the restrictions. He argued that such settings have a high prevalence of smokers, many of whom may be distressed. Therefore, being able to use an e-cigarette in those circumstances would be beneficial.¹⁴²

163. The Welsh Government's Statement of Policy Intent states that:

- the exemption for mental health units in respect of smoking will be reviewed;
- the Minister intends to exempt mental health units that provide residential accommodation from the restrictions on the use of e-cigarettes in enclosed public places;
- two judicial reviews are currently under consideration regarding smoking in prisons in England and Wales;
- the position in prisons relating to smoking and the use of nicotine inhaling devices will be considered following the outcome of these cases;

¹⁴⁰ Welsh Government [Statement of Policy Intent](#), page 12

¹⁴¹ RoP [para 123], 1 July 2015

¹⁴² RoP [para 161], 1 October 2015

- there is no current intention to restrict entirely the use of nicotine inhaling devices in prisons in Wales.¹⁴³

Ability to use e-cigarettes in vape shops

164. Evidence from e-cigarette users stated that being able to try various e-cigarette devices and flavours before making a purchase was an important element in ensuring that the product they chose met their needs. Concerns were therefore raised that restricting the use of e-cigarettes in enclosed public places would prevent e-cigarette retailers from demonstrating devices and clients being able to test them within vape shops. In his written evidence Rhydian Mann, an e-cigarette user, said that this would “drastically reduce” the number of people switching to e-cigarettes, which would consequently lead to a reduction in the decrease of the smoking of tobacco cigarettes.¹⁴⁴

Additional smoke-free premises

165. Section 8 of the Bill contains regulation-making powers for the Welsh Ministers to designate places to be smoke-free (in relation to tobacco cigarettes and e-cigarettes) in addition to workplaces and public places. Such places would not need to be enclosed or substantially enclosed. The Welsh Government’s Statement of Policy Intent states that the intention is to create:

“additional smoke-free non-enclosed spaces which may include, but are not limited to, hospital grounds, school grounds and children’s playgrounds”.¹⁴⁵

166. The Minister wrote to the Committee on 17 October and provided a copy of illustrative draft regulations to make hospital grounds and school grounds smoke-free.¹⁴⁶

167. Public health and local government witnesses welcomed the provision to extend smoking restrictions (and a restriction on using e-cigarettes) to additional premises, and suggested that areas frequented by children and young people should be a priority.

168. Dr Sara Hayes, Director of Public Health at Abertawe Bro Morgannwg University Health Board, told the Committee:

¹⁴³ Welsh Government [Statement of Policy Intent](#), page 12

¹⁴⁴ PHB 24 Rhydian Mann

¹⁴⁵ Welsh Government [Statement of Policy Intent](#), page 8

¹⁴⁶ PHB AI 11 Minister for Health and Social Services - 17 October 2015

“I would welcome being able to extend the smoke-free areas - areas where children congregate. We have smoke-free playgrounds in my area, in my patch, which is a tremendous step forward. That should apply to e-cigarettes as well. There is an issue about enforcement and about how we enact such policies. That is a challenge, but the more power that we put behind that, the better. I would support smoking bans and e-cigarette bans in open cafe areas where people are sitting down eating food. They are not mobile; they can't move away easily from someone who's using an e-cigarette. I think that concept would be very valuable.”¹⁴⁷

169. The Directors of Public Protection Wales stated:

“We do welcome the proposals for extension to outdoor areas, so to non-enclosed spaces. I think, again, from an enforcement perspective, we would expect the owner or the person responsible for those areas to be our initial point of contact in terms of responsibility for making sure that the legislation was complied with. We do welcome it from the perspective - particularly if we're talking about playgrounds, and children's play areas - of protecting those areas so as not to indicate to our young people that smoking is the norm.”¹⁴⁸

170. They went on to say:

“There's a question, then, about how far you go in terms of what's a proportionate response around whether you include beaches and other areas, I suppose. But, certainly, in terms of things like hospital grounds and playgrounds, we are seeing that sort of policy decision being made by the public sector responsible for those areas, which perhaps indicates that there's a desire to do that.”¹⁴⁹

The Committee's view

171. The Committee notes the illustrative draft regulations provided by the Minister to make hospital grounds and school grounds smoke-free. Whilst the Committee welcomes the proposal to extend smoke-free provisions in terms of smoking tobacco cigarettes, some Members are concerned by the intention to also apply extensions to the use of e-cigarettes, particularly should such restrictions extend beyond the instances cited by the Minister.

¹⁴⁷ RoP [para 212], 9 July 2015

¹⁴⁸ RoP [para 211], 15 July 2015

¹⁴⁹ RoP [para 221], 15 July 2015

Financial implications

172. The financial implications of the Bill were considered in detail by the Assembly's Finance Committee.

173. The Regulatory Impact Assessment highlighted that the additional costs of this part of the Bill to be the largest of all of the Bill's elements, at £8.2 million between 2016-17 and 2020-21, once the potential benefits of the Bill have been considered. Of these costs, an estimated £6.5 million would fall upon public and work places which would be required to update their smoke-free policies and would face a cost associated with working time lost owing to users of e-cigarettes being required to take smoking breaks.¹⁵⁰

174. In addition, e-cigarette businesses would see an estimated loss of sales worth around £1.3 million over this period. The Welsh Government would incur additional costs of £300,000 in 2016-17 for communications to businesses and the public (£200,000) and for smoke-free signage (£100,000). Members of the public and local authorities would incur small additional costs of £22,500 and £12,300 respectively.¹⁵¹

The Committee's view

175. The summary of evidence above illustrates the range of views expressed about the proposals in Part 2, Chapter 1 of the Bill to restrict the use of e-cigarettes in enclosed and substantially enclosed public places.

176. The Committee was unable to reach a consensus about whether the Bill's provisions in relation to e-cigarettes would achieve their aim of improving public health in Wales. The views of Committee Members are outlined below.

177. Alun Davies AM, John Griffiths AM, Lynne Neagle AM, Gwyn Price AM and David Rees AM support the proposals in Chapter 1 of the Bill to regulate the use of e-cigarettes owing to the many uncertainties surrounding the long-term impact of their use. The support is largely based on a restriction on the use of e-cigarettes in enclosed and substantially enclosed public places being necessary and proportionate in order to mitigate against the possibility that the use of e-cigarettes in public places could re-normalise smoking behaviour.

¹⁵⁰ Explanatory Memorandum, page 301

¹⁵¹ Explanatory Memorandum, page 301

178. An alternative approach supported by John Griffiths AM, Elin Jones AM, Lynne Neagle AM, Gwyn Price AM and David Rees AM would be to amend Chapter 1 of the Bill to reflect the need to treat e-cigarettes and tobacco cigarettes differently when restricting their use in enclosed and substantially enclosed public places. This could be achieved by including on the face of the Bill a list of defined areas where the use of e-cigarettes would be prohibited. This is on the basis of accepting the concerns around the risk of the use of e-cigarettes leading to the re-normalisation of smoking behaviour.

179. Altaf Hussain AM, Darren Millar AM, Lindsay Whittle AM and Kirsty Williams AM oppose the provisions in Chapter 1 of the Bill to restrict the use of e-cigarettes in enclosed and substantially enclosed public places on the grounds that:

- there is an insufficient evidence base to support the view that the use of e-cigarettes could re-normalise smoking behaviours, act as a gateway to the use of tobacco cigarettes, and undermine efforts to enforce the existing ban on smoking tobacco cigarettes in enclosed and substantially enclosed public places;
- the evidence presented demonstrates the potential for e-cigarettes to play a significant role in improving public health and reducing harm by providing a safer alternative to smoking;
- restricting the use of e-cigarettes could convey the message that e-cigarettes are as harmful as tobacco cigarettes, which could deter smokers from switching, resulting in the unintended consequence of causing greater public health harm;
- a more appropriate precautionary approach would be to refrain from legislating to ban the use of e-cigarettes in enclosed and substantially enclosed public places until a more robust evidence base about the long-term impact of e-cigarettes is available.

On the basis of the points above, these Members believe that Chapter 1 should be removed from the Bill. Without a commitment from the Minister that he will seek to remove Chapter 1 by amendments at Stage 2, they believe that the Assembly should not agree the general principles of the Bill. They would, however, support the general principles of the Bill should the Minister agree to remove the provisions of Chapter 1 of the Bill, and suggest that the Minister could either introduce those provisions as a separate Bill on e-cigarettes (Annex A to this report provides an outline of the procedures that would enable this to happen), or not pursue them at all.

180. Elin Jones AM's preference is to remove the provisions relating to e-cigarettes from the Bill. She would, nevertheless, support the general principles of the Bill should the Minister agree to amend Chapter 1 of the Bill to reflect the need to treat both e-cigarettes and tobacco cigarettes differently when restricting their use in enclosed and substantially enclosed public places as described in paragraph 178.

Other options considered

181. During its deliberations, the Committee also gave consideration to recommending the removal of the provisions in Chapter 1 of Part 2 of the Bill during Stage 2 proceedings and replacing them with a provision for the Welsh Ministers, through regulations subject to the affirmative or super affirmative procedure, to introduce restrictions on the use of e-cigarettes in the event that sufficient evidence emerged to demonstrate that such an approach was needed to protect the public health of the people of Wales.

182. The Committee also considered the possibility of amending the Bill by inserting a sunrise clause which would set out the criteria that needed to be met before the provisions relating to restricting the use of e-cigarettes could commence.

183. While the Committee did not decide to recommend either approach, the Committee wishes to note for the record that consideration was given to these options.

Human rights

The Assembly's margin of appreciation

184. The Committee is fully aware of its obligation to consider properly any human rights issues that arise under the Bill. The Committee has received a great deal of written and oral evidence which has allowed Members to carry out such proper consideration.¹⁵² In turn, this has allowed the Committee to make informed decisions on the human rights implications of the Bill, in particular the proportionality of section 6(4) of the Bill in the context of a workplace which is also a home.

185. It is important to note that, particularly in areas of social policy such as this, the courts generally recognise that elected representatives are the best

¹⁵² A summary of the evidence is included in this Report, but full details of all evidence (both written and oral) received by the Committee is available on the Bill's web page: <http://senedd.assembly.wales/mglIssueHistoryHome.aspx?lId=12110>

people to determine questions of social policy which involve balancing different rights and freedoms.

186. To reflect this, the Committee is aware that the Assembly is given a margin of appreciation (i.e. an area of discretion) in determining questions involving different rights and freedoms. Therefore, the Committee has approached the issue of proportionality by asking itself whether the approach adopted by the Bill (in particular section 6(4)) is within the Assembly's margin of appreciation. The Committee is also aware that, in areas of social policy such as this, that margin of appreciation is broad, which means that the courts will not generally interfere unless the Assembly comes to a decision that is manifestly without foundation – in other words, extremely unreasonable or arbitrary.

187. The Committee has also been careful to separate human rights questions from policy questions. This means that the Committee's views on human rights have not been influenced by policy views. As part of this, the Committee understands that different policy views can be accommodated with the Assembly's margin of appreciation.

Article 8 of the European Convention on Human Rights

188. The Committee notes that Article 8 sets out the right to respect for private and family life:

- everyone has the right to respect for his private and family life, his home and his correspondence;
- there shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

189. It also notes that Article 8 does not consist of just one right; it embraces four rights:

- right to respect for private life;
- right to respect for family life;
- right to respect for the home;
- right to respect for correspondence.

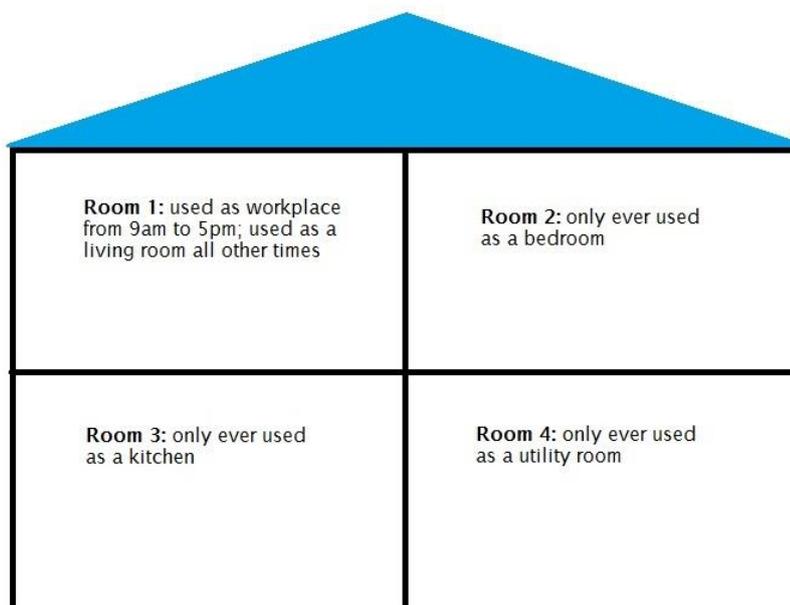
190. Further, the Committee notes these rights are not absolute rights. For example, there is no absolute right to respect for private life. Instead, these rights are qualified rights. This means that the state can interfere with these rights, but only when it is in pursuit of one of the legitimate aims set out in the second part of Article 8 and the interference is proportionate to that aim.

A home which is also a workplace

191. Section 6(4) of the Bill restricts smoking and the use of e-cigarettes in the home: (a) in those parts of the home used as a workplace, and (b) during the hours those parts are being used as a workplace.

192. This can be illustrated using the example of a home which has four rooms, one of which is used as a workplace between the hours of 9am and 5pm. In Figure 1 below, smoking and using an e-cigarette would be restricted in Room 1 between the hours of 9am and 5pm. Smoking and using an e-cigarette would not be restricted in Room 1 between the hours of 5pm and 9am. Smoking and using e-cigarettes would not be restricted at all in Rooms 2, 3, and 4 because they are never used as workplaces.

Figure 1



Workplaces and homes – tobacco smoking

193. In the context of a workplace which is also a home, the Committee notes that the following two Article 8 rights compete with each other:

- a tobacco cigarette smoker whose home is a workplace has the right to smoke in his/her home;
- a non-smoker who goes to work in such a workplace has the right not to be exposed to the harms of tobacco smoke (whether this be second-hand smoke emanating directly from a lit tobacco cigarette or third-hand tobacco smoke which lingers in the air and soft furnishings).

The right to smoke in your own home

194. Under section 6(4) of the Bill, no one living in the home would be able to smoke a tobacco cigarette in his/her home: (a) in those parts of the home used as a workplace, and (b) during the hours those parts are being used as a workplace. If that person wishes to smoke in his/her home during working hours, then he/she would have to use another part of the home. To refer back to Figure 1, the person living in the home would have to go to Room 2, 3 or 4 (or go outside).

195. The Committee recognises that matters become more complicated if, for example, the home is small with limited options for smoking in another room. Matters are also complicated by the fact that many people do not work standard hours. For example, a person who lives in the home may intermittently check work e-mails in Room 4 during the night. If that is enough to make Room 4 a place of work intermittently through the night, then anyone living in the home would not be allowed to smoke in Room 4 while those work e-mails are being checked.

196. The Committee has also considered that people generally choose to use their home as a workplace, and therefore there is an element of choosing to have workplace restrictions imposed in the home environment. However, the Committee is also aware that some people have little or no choice but to work from home (whether this be for health, family or social reasons). On that point, the Committee is aware that if there is only one person working in the home (and the public do not attend the home to receive goods/services), then it is not a “workplace” for the purposes of the Bill and there are no restrictions on smoking in the home.

The right to be protected from harm

197. Under section 6(4) of the Bill, the non-smoker who goes to work in Room 1 is protected from second-hand smoke¹⁵³ because smoking is not allowed in Room 1 during working hours. On that point, the Committee has considered issues such as doors in homes not always being closed and the potential for second-hand smoke to drift from, say, Room 2 to Room 1 during working hours. However, given the current law that smoking is allowed in Room 1 at any time (even when others are working there), the Committee considers the Bill to be a step forward for the rights of such workers (while also being a step backwards for the rights of persons living in the home to do as they wish in the home).

198. The Committee accepts that the non-smoking worker would be exposed to third-hand smoke which lingers in the air and in soft furnishings from the hours when smoking is allowed in Room 1. The Committee has found relatively little evidence of actual harm caused by such third-hand smoke, but the Committee notes that:

- such smoke may have emanated from smoking just minutes before working hours commence, in which case it is effectively second-hand smoke;
- more research into the harms that may be caused by third-hand tobacco smoke should be undertaken.

199. However, as noted above, the Committee considers that the Bill is a step forward for non-smoking workers because the current law provides that smoking is allowed at all time in parts of the home used as both a workplace *and* a home (smoking is currently only prohibited in those parts of the home that are used *solely* as a workplace, save for some exemptions around personal and domestic care etc.).

The Committee's view (workplaces and homes – tobacco smoking)

200. The Committee accepts that the two Article 8 rights compete against each other, and that neither right can be protected entirely – therefore, there must be a compromise.

201. Despite:

¹⁵³ Second-hand smoke is smoke which comes directly from a lit cigarette. Third-hand smoke is the residual smoke which lingers in the air and in soft furnishings after someone has been smoking.

- the Bill expanding the state's interference with the right to respect for the home,
- the possibility of it being difficult to find another room in the home to smoke,
- the fact that some people may have little or no choice but to work from home,
- the possibility of third-hand tobacco smoke causing harm,

the Committee concludes, for the reasons set out below, that the balance struck in the Bill is not manifestly without foundation and is within the Assembly's margin of appreciation.

202. The reasons are:

- the very important benefits of protecting workers from the harms of second-hand smoke;
- the restriction on smoking applies only to those parts of the home being used as a workplace;
- persons living in the home are only prevented from smoking in those parts during the hours the home is being used as a workplace;
- persons living in the home can smoke at any time in any part of the home which is not being used as a workplace (or the person can go outside, as he/she would have to do if working in a traditional workplace); and
- the lack of conclusive evidence of the harms that may be caused by third-hand tobacco smoke.

Workplaces and homes – e-cigarettes

203. The Committee has found the human rights issues in the context of e-cigarettes to be much less straightforward than in the context of tobacco cigarettes.

The right to use an e-cigarette in your own home

204. The Bill treats tobacco cigarettes and e-cigarettes in exactly the same way, therefore paragraphs 194 to 196 (which summarise how the tobacco provisions of the Bill interfere with the right to respect for the home) apply in the same way to e-cigarettes.

Interference with the right to respect for the home – is it within the Assembly’s margin of appreciation?

205. The question for the Committee was whether the interference with the right to use an e-cigarette in the home is within the Assembly’s margin of appreciation. The Committee sees two areas that are relevant to answering that question.

- Does the potential risk of harm caused to others by e-cigarette vapour justify interference and the proposed level of interference with the right to respect for the home?
- The Bill adopts a precautionary approach, to address issues such as the potential for: (1) e-cigarettes re-normalising smoking, (2) e-cigarettes acting as a gateway to tobacco cigarettes for children and young people, and (3) the enforcement difficulties that e-cigarettes cause. Do these factors justify interference and the proposed level of interference with the right to respect for the home?

206. With regard to the potential risk of harm caused by e-cigarette vapour, the Committee considers there is, at present, a lack of evidence of the harm they can cause (although the Committee accepts that the harm from e-cigarette vapour is much lower than the harm from tobacco smoke). However, that does not mean the Committee accepts there is no harm from e-cigarette vapour, and evidence of harm/lack of harm should be reviewed on a regular basis.

207. With regard to the precautionary approach outlined by the Minister, the Committee has received a great deal of evidence on the issues of re-normalisation, the gateway effect and enforcement (discussed earlier in this chapter). This evidence has allowed the Committee to apply these issues to the context of a workplace which is also a home, allowing the Committee to reach informed conclusions on whether the Bill strikes a balance which is within the Assembly’s margin of appreciation.

The Committee’s view (workplaces and homes – e-cigarettes)

208. The Committee is divided on the issue of whether the Bill strikes a balance which is within the Assembly’s margin of appreciation.

209. Five Members¹⁵⁴ conclude that the restriction on using an e-cigarette in the home which is also a workplace is within the Assembly’s margin of

¹⁵⁴ Alun Davies AM, John Griffiths AM, Lynne Neagle AM, Gwyn Price AM and David Rees AM

appreciation. Similar reasoning applies to that set out for tobacco smoking in paragraph 201 and 202 above, save that the benefit of protecting workers from the harm of e-cigarette vapour does not carry the same weight as the benefit of protecting workers from the harm of tobacco smoke. However, these Members consider that that reduction is compensated by the need to protect against the risk of re-normalisation, the gateway effect and enforcement difficulties. Therefore, these Members conclude that the balance struck in the Bill is within the Assembly's margin of appreciation.

210. However, the other five Members¹⁵⁵ conclude that the restriction on using e-cigarettes goes beyond the Assembly's margin of appreciation. These Members believe that the interference with the right to use an e-cigarette in the home goes too far; they emphasise the importance of respect for home life. These Members do not accept that restricting the use of e-cigarettes in the context of a workplace which is also a home would address issues such as re-normalisation, the gateway effect and enforcement difficulties (particularly given the relatively small numbers of people who may see/experience the use of e-cigarettes in the context of a workplace which is also a home). These Members do not believe that there is sufficient evidence of actual harms caused by e-cigarette vapour to justify state interference. They believe that the state should not restrict the use of e-cigarettes in a home that is also a workplace. Therefore, these Members conclude that the balance struck in the Bill is not within the Assembly's margin of appreciation.

¹⁵⁵ Altaf Hussain AM, Elin Jones AM, Darren Millar AM, Lindsay Whittle AM and Kirsty Williams AM

5. Part 2 – Chapters 2 to 4: Other provisions relating to tobacco and nicotine products

Retailers of tobacco and nicotine products

211. Chapter 2 of Part 2 of the Bill includes provisions for the establishment of a national register of tobacco and nicotine products.

212. The Explanatory Memorandum notes that there is currently no method of tracking retailers who sell tobacco or nicotine products, and that local authorities have to rely on local intelligence to enforce tobacco legislation. The EM states that the purpose of the provisions in Chapter 2 is to:

“protect children and young people under the age of 18 from the harms associated with tobacco and nicotine use. This will be achieved by providing local authorities with a definitive list of retailers who sell tobacco and/or nicotine products within their authority area. This will assist trading standards officers within these areas in enforcing existing tobacco legislation, and provide retailers with guidance and information on their responsibilities linked to tobacco and nicotine products legislation”.¹⁵⁶

213. All retailers who sell either tobacco products or nicotine products in Wales would have to register with a national Registration Authority (to be specified in regulations) in order to be permitted to sell these products. The Registration Authority will be required to publish a list of the names of all registered persons, and the address of each premises at which tobacco or nicotine products are sold. This list, and other information in the register relating to premises within their areas, must be made available to the relevant local authority.

214. A person applying for inclusion on the register may submit one application form to cover all of the premises at which they sell tobacco or nicotine products. The registered person would be required to inform the Registration Authority of any changes to their circumstances so that the register may be kept up to date. It would be an offence, subject to a fine not exceeding level 2 on the standard scale (currently set at £500), if a premises in Wales sells tobacco or nicotine products without being registered, or if a registered person fails to notify the Registration Authority of changes to their circumstances.

¹⁵⁶ Explanatory Memorandum, para 88

215. Local authorities will be responsible for enforcing these provisions. The Bill provides local authority officers with powers of entry to premises in Wales where there are reasonable grounds to believe that an offence has been, or may be being, committed. The powers of entry would not extend to premises used wholly or mainly as a dwelling without a warrant from a justice of the peace. The Bill includes provision for powers of inspection for authorised local authority officers, and for offences, subject to a fine not exceeding level 3 on the standard scale (currently set at £1,000), for those who obstruct such officers.

216. Section 38 provides that authorised officers may issue fixed penalty notices in relation to certain offences, other than those relating to operating a tobacco or nicotine business without being registered, or to obstructing an authorised officer.

217. Section 39(2) states that regulations to be made under the affirmative procedure would specify the description of “nicotine product”. The Welsh Government’s Statement of Policy Intent states that the Welsh Ministers intend to use the regulation-making power in this section to define “nicotine products” as any nicotine product that is subject to an age restriction on sale. This would include e-cigarettes. It says that nicotine products that are licensed as medicines would not be included within the definition of “nicotine product”.¹⁵⁷

Enforcement

218. The Minister told the Committee that the register would be “a very important way of strengthening the ability of the system to police the measures that we have put in place”.¹⁵⁸

219. There was broad agreement from stakeholders with this view. The Association of Directors of Public Health stated that the approach was consistent with the Tobacco Control Action Plan for Wales¹⁵⁹, was “workable and proportionate”, and could “strengthen the tobacco control agenda in Wales”.¹⁶⁰

220. Public Health Wales stated in written evidence that the register would support enforcement of relevant tobacco legislation, including underage

¹⁵⁷ Welsh Government [Statement of Policy Intent](#), page 24

¹⁵⁸ RoP [para 104], 1 July 2015

¹⁵⁹ Welsh Government, [Tobacco Control Action Plan for Wales](#), February 2012

¹⁶⁰ PHB 78 Association of Directors of Public Health

sales and display regulations.¹⁶¹ The Electronic Cigarette Industry Trade Association agreed with this, stating that:

“Enforcement action of all types will be facilitated by having a register of all vendors of tobacco and other nicotine containing products”.¹⁶²

221. The Committee heard that the register would enable public health agencies to identify premises selling tobacco illicitly, monitor trends in illegal sales and non-compliance, and enable trading standards officers to identify retailers for test purchasing purposes.¹⁶³

222. The Committee also heard differing views about whether the register would be effective in addressing concerns about the level of illicit tobacco sales in Wales. Some stakeholders were of the view that the register would assist in identifying those premises where tobacco and nicotine products were being legitimately sold, which would in turn assist with enforcement.¹⁶⁴ Dr Sara Hayes, Director of Public Health at Abertawe Bro Morgannwg University Health Board, told the Committee:

“The idea is that if you have a registered outlet, you should know what’s going through that outlet. If cigarettes are coming through non-registered outlets, there’s a reason behind that, isn’t there? It helps.”¹⁶⁵

223. The Committee also heard evidence that the register would help to restrict access to the tobacco and nicotine retail sector for those persons and premises for which it was not appropriate.¹⁶⁶

224. However, the Committee also heard concerns that the register would not be sufficient to address the problems of illicit tobacco, as irresponsible retailers would be likely to avoid registration.¹⁶⁷ The Association of Convenience Stores noted the limited resources available for enforcement activity. It stated that “enforcement activity should be focused on tackling the illicit tobacco trade”, which it identified as costing approximately £2 billion per year.¹⁶⁸ The Association of Convenience Stores stated that there

¹⁶¹ PHB 03 Public Health Wales

¹⁶² PHB 50 Electronic Cigarette Industry Trade Association

¹⁶³ PHB 03 Public Health Wales and PHB 04 Directors of Public Protection Wales

¹⁶⁴ RoP [para 64], 15 July 2015, PHB 01 Chartered Institute of Environmental Health, PHB 03 Public Health Wales and PHB 04 Directors of Public Protection Wales

¹⁶⁵ RoP [para 216], 9 July 2015

¹⁶⁶ PHB 04 Directors of Public Protection Wales

¹⁶⁷ PHB 90 National Federation of Retail Newsagents

¹⁶⁸ PHB 74 Association of Convenience Stores

needed to be more rigorous implementation of the current enforcement regime and sanctions for the illicit sale of tobacco.¹⁶⁹

225. Some concerns were raised by the Directors of Public Protection Wales about the wording of section 29(5), which states that:

“A registered person who fails, without reasonable excuse, to comply with section 25 (duty to notify certain changes) commits an offence.”¹⁷⁰

226. The Directors of Public Protection noted that in their view “reasonable excuse” was inconsistent with the terminology used in other consumer legislation, and might lead to those who failed to notify changes to the register evading appropriate enforcement action.¹⁷¹

227. Speaking on behalf of Public Health Wales, Dr Julie Bishop told the Committee that the establishment of the register was one of the “most important” measures in the Bill, as it would help enforce existing underage sales legislation. Citing recent research, she described a link between the number of retail outlets and the prevalence of smoking in an area, which she told the Committee contributed to the re-normalisation of smoking. She said that over time the register would provide an opportunity for local authorities to begin to look at any concentrations of tobacco retailers, and to make use of their planning and well-being needs assessments to address this.¹⁷²

228. This view was shared by the Directors of Public Protection Wales, who stated in written evidence that the register could enable limitations to be placed on the sale of nicotine or tobacco products within a designated distance from schools or colleges.¹⁷³

The Committee’s view

229. The Committee agrees with stakeholders that the register will support improved enforcement of tobacco and nicotine product legislation. The ability for local authorities and public health agencies to monitor trends should improve the evidence base available to plan and implement enforcement activity. The improved information about the concentration and distribution of tobacco and nicotine product retailers will also be valuable for

¹⁶⁹ RoP [paras 194 and 196], 23 September 2015

¹⁷⁰ Public Health (Wales) Bill Section 29(5)

¹⁷¹ PHB 04 Directors of Public Protection Wales

¹⁷² RoP [para 92], 9 July 2015

¹⁷³ PHB 04 Directors of Public Protection Wales

local authorities in carrying out well-being needs assessments and making planning decisions.

Reducing take-up of smoking among young people

230. The Committee heard evidence from the Minister, and a number of stakeholders, that one of the effects of the register would be to improve the tools available to “prevent the take-up of smoking amongst people who are below the legal age to do so”.¹⁷⁴

231. The Association of Directors of Public Health cited a recent survey undertaken in England by the Health and Social Care Information Centre, which had found that 44 per cent of young smokers had reported being able to purchase tobacco from retail premises despite being under the age of 18. The Association of Directors of Public Health believed therefore that the support the register would provide for enforcement and compliance would help to reduce the take-up of smoking among young people.¹⁷⁵

232. Public Health Wales stated that requiring tobacco retailers to register would contribute to de-normalisation as it would demonstrate that “it is not the same as other consumer products and should not be available for sale in the same way”.¹⁷⁶

233. The Tobacco Retailers’ Association told the Committee that it was not opposed to a tobacco retailers’ register in Wales if it helped to improve the level of compliance with underage sales regulation, specifically in relation to preventing sales to children.¹⁷⁷

234. However, the Association of Convenience Stores was not persuaded that a register would reduce underage sales. It cited recent data from the Health and Social Care Information Centre, which it said showed that 64 per cent of young people who accessed age-restricted products such as alcohol and tobacco, did so via other people, including parents or older siblings, rather than from local shops.¹⁷⁸

¹⁷⁴ RoP [para 103], 1 July 2015, PHB 03 Public Health Wales, PHB 05 Welsh NHS Confederation, and PHB 84 Royal Pharmaceutical Society

¹⁷⁵ PHB 78 Association of Directors of Public Health

¹⁷⁶ PHB 03 Public Health Wales

¹⁷⁷ PHB 98 Tobacco Retailers’ Association

¹⁷⁸ PHB 74 Association of Convenience Stores

The Committee's view

235. The Committee notes the mixed evidence it received about the potential impact of the register on underage sales of tobacco or nicotine products. While it recognises the research cited by the Association of Convenience Stores, the Committee is persuaded that the opportunities to improve enforcement and compliance activity provided by the register could have an impact on underage smoking.

Inclusion in the register

236. The Committee heard a range of views about which retailers should be included on the register. Directors of Public Protection Wales stated that manufacturers and distributors of tobacco products within the supply chain should be included, with a new offence of selling or distributing tobacco products to anyone not included on the register.¹⁷⁹ The Association of Directors of Public Health stated that to provide parity with physical retailers, online retailers should also be required to register.¹⁸⁰

237. Some stakeholders told the Committee that retailers of e-cigarettes should also be included on the register.¹⁸¹ Conversely, the New Nicotine Alliance UK stated that there was a need to draw a clear distinction between e-cigarettes and tobacco products. To make clear this distinction it called for separate registers to be established for retailers of tobacco products, and retailers of nicotine products. However, the Alliance and Totally Wicked Ltd also questioned the necessity of a register of nicotine product retailers, saying that there was a lack of clarity about how it would support the improvement of public health.¹⁸² ASH Wales also stated that it “would favour retailers of tobacco to be on a separate register from retailers of nicotine products given these are very different products”.¹⁸³

238. There were mixed views about whether retailers of nicotine replacement therapy products should be required to register. Totally Wicked Ltd (an e-cigarette manufacturing business) stated that it did not support the proposal to establish a national register and questioned the rationale for including e-cigarettes but not licensed nicotine replacement therapy products. It said that as the nicotine used in liquids for e-cigarettes was the same as that used in nicotine replacement products, retailers of these products should be

¹⁷⁹ PHB 04 Directors of Public Protection Wales

¹⁸⁰ PHB 78 Association of Directors of Public Health

¹⁸¹ RoP [para 167], 23 September 2015 and PHB 03 Public Health Wales

¹⁸² PHB 61 New Nicotine Alliance UK and PHB 72 Totally Wicked Ltd

¹⁸³ PHB 48 ASH Wales

treated equally.¹⁸⁴ The Royal Pharmaceutical Society recommended that “all registered pharmacies supplying nicotine products be automatically included in the register”.¹⁸⁵ Conversely, the Committee heard concerns from Celesio UK and Lloyds Pharmacy that without a more specific definition which exempted products licensed as smoking cessation aids, community pharmacies could be required to register as a result of their role in the sale and supply of licensed nicotine replacement therapy products.¹⁸⁶

239. The Minister told the Committee that the views he had received from the retail industry had indicated a preference for a single register, to avoid two sets of obligations and costs.¹⁸⁷

240. The Directors of Public Protection Wales told the Committee that inclusion in the register should be subject to a fit and proper person test. They believed that the granting of an application for inclusion should take into account any conviction for the sale to minors of restricted products, such as alcohol or solvents. They further stated that local authority enforcement officers should have powers to restrict access to the register, or remove people from the register, if they have committed relevant infringements or offences.¹⁸⁸

The Committee’s view

241. The Committee agrees with witnesses that the register should apply equally to retailers selling e-cigarettes as to those selling other nicotine, or tobacco, products. Section 39 of the Bill defines tobacco products for the purposes of the Chapter, and provides that “nicotine products” will be defined in regulations. The Committee notes from the Welsh Government’s Statement of Policy Intent that the intention is for regulations made under section 39(2), which will be subject to the affirmative procedure, to define “nicotine products” as including “any nicotine product that is subject to an age of sale restriction”.¹⁸⁹ However, it also notes that there is currently nothing on the face of the Bill to require the inclusion of e-cigarettes within the definition of nicotine products.

¹⁸⁴ PHB 72 Totally Wicked Ltd

¹⁸⁵ PHB 84 Royal Pharmaceutical Society

¹⁸⁶ PHB 85 Celesio UK and Lloyds Pharmacy

¹⁸⁷ RoP [para 191], 21 October 2015

¹⁸⁸ PHB 04 Directors of Public Protection Wales

¹⁸⁹ Welsh Government [Statement of Policy Intent](#), page 24

242. The Committee believes that potential confusion could be caused in terms of enforcement as retailers who only sell e-cigarettes for use with non-nicotine based liquids would not be required to register.

243. The Committee agrees with the suggestion made by the Directors of Public Protection Wales that the granting of an application for inclusion on the register should take into account any conviction for the sale of restricted products to minors. It believes that local authority enforcement officers should have powers to restrict access to the register, or remove people from the register, if they have committed relevant infringements or offences.

Administration and resourcing

244. Section 23 provides that the Welsh Ministers may, by regulations, establish registration fees. In its Statement of Policy Intent, the Welsh Government has indicated that:

“It is currently intended that applicants will have to pay a small fee as part of the registration application. The precise detail of the fee structure is yet to be determined, but the current intention is for there to be a £30 fee to cover the application and registration of one premises, with a further £10 for each additional initial premises.”¹⁹⁰

245. The Committee heard concerns about the administrative and financial costs to the retail sector which would accrue from the establishment of the register and the associated inspection and enforcement regime.¹⁹¹ The Tobacco Retailers’ Association described the introduction of registration fees as “irresponsible”, and stated that the anticipated costs of up to £246,000 across the retail sector in Wales were “likely to damage the Welsh retail sector”.¹⁹² The National Federation of Retail Newsagents said that retailers make a profit of 27p on a packet of cigarettes sold for £6.99. It states that “to afford the £30 charge to register, a retailer would have to sell 111 packets of cigarettes, or take £775.89 in sales”.¹⁹³ Noting that these costs could be a disincentive for those considering establishing new businesses, or selling e-cigarettes from an existing business, Totally Wicked Ltd cautioned that if fewer retailers sold e-cigarettes, it could have a consequential impact

¹⁹⁰ Welsh Government [Statement of Policy Intent](#), page 20

¹⁹¹ PHB 72 Totally Wicked Ltd and PHB 74 Association of Convenience Stores

¹⁹² PHB 98 Tobacco Retailers’ Association

¹⁹³ PHB 90 The National Federation of Retail Newsagents

on the number of people using e-cigarettes in place of traditional tobacco products.¹⁹⁴

246. The Association of Convenience Stores outlined the restrictions already in place around the retail of tobacco, including the display ban and the planned introduction of plain packaging. It stated that the register would add an additional layer of complexity, and questioned whether there was sufficient clarity about the benefits of the register and how the fee revenue would be used to justify the estimated £90,000 cost to the convenience store sector.¹⁹⁵

247. The Association of Convenience Stores told the Committee that it did not support the proposals to establish a register as it did not believe that it would be effective in delivering the ambitions to reduce youth smoking rates and increase compliance for retailers. However, it noted that should proposals be put in place, its preference would be to follow the approach taken by the Scottish Government to establish a licensing system which included free registration for retailers.¹⁹⁶ Mr Woodall of the Association of Convenience Stores commended the “light touch” approach, online registration form and lack of registration fee in Scotland, but stated that it still resulted in some burden on retailers.¹⁹⁷

248. The Minister stated that the tobacco retailers register in place in Scotland was providing improved clarity about where tobacco and nicotine products were being sold, which he said would enable local authority enforcement officers to “police” the system.¹⁹⁸ He told the Committee that the Scottish Government intended to review the operation of the register in due course, but that the Minister for Health, Wellbeing and Sport was “very positive about the experience of the register in Scotland”.¹⁹⁹

249. The Minister told the Committee that he intended that the new duties on local authorities in relation to the register would be funded by charging registration fees.²⁰⁰ He believed that the fees set out in the Explanatory Memorandum were proportionate, and would be “commensurate to the

¹⁹⁴ PHB 72 Totally Wicked Ltd

¹⁹⁵ PHB 74 Association of Convenience Stores. Estimate made by the Association of Convenience Stores based on the fee levels set out in the Explanatory Memorandum.

¹⁹⁶ PHB 74 Association of Convenience Stores

¹⁹⁷ RoP [paras 165 and 173], 23 September 2015

¹⁹⁸ RoP [para 104], 1 July 2015

¹⁹⁹ RoP [para 187], 21 October 2015

²⁰⁰ RoP [para 68], 21 October 2015

advantages that the retailer themselves will get from being on the register”.²⁰¹

250. However, the Directors of Public Protection Wales cautioned that the financial pressures currently faced by local government in Wales would mean that further consideration would need to be given to resourcing the implementation and enforcement of the register. They suggested that online software which could be updated by each local authority might be more appropriate than the maintenance of the register by one national Registration Authority.²⁰² Further, they stated that local authorities should be given discretion in terms of which functional areas discharged responsibilities in relation to the register, to ensure that resources could be deployed “in the most effective manner to suit local circumstances”.²⁰³

The Committee’s view

251. The Committee notes the concerns raised by the retail sector about the financial and administrative burden which could result from the establishment of a register. However, on balance it believes that the costs that would be incurred by businesses are reasonable and that the modest fee will enable local authorities to undertake effective enforcement of the register.

Prohibition on sale of tobacco and nicotine products

Restricted Sales Orders and Restricted Premises Orders

252. The Bill provides that the Registration Authority must grant applications for inclusion on the register unless a premises or a person has a Restricted Premises Order (RPO) or a Restricted Sales Order (RSO). In such circumstances the premises would not be included on the register until such time as the relevant Order has expired.

253. In England and Wales, a magistrates’ court is able to impose a RPO or a RSO on those who have persistently sold tobacco or nicotine products to under 18s (at least three separate occasions within a two year period). A RPO prohibits all sales of tobacco products (including cigarette papers) from the premises for a period up to one year. A RSO prohibits a person from selling any tobacco products (including cigarette papers) or having any management functions in respect of any premises in relation to the sale on the premises

²⁰¹ RoP [para 187], 21 October 2015

²⁰² PHB 04 Directors of Public Protection Wales

²⁰³ PHB 04 Directors of Public Protection Wales

of tobacco products (including cigarette papers) to any person. A RSO can be for any period of time up to one year.²⁰⁴

254. The Bill would also enable the enhancement of the RPO scheme by providing the Welsh Ministers with powers to include other tobacco offences that may be counted towards the application for a RPO. The EM states that such an offence must:

“be at least a Level 4 penalty and be an offence that relates to the supply, sale, transport, display, offer for sale, advertising or possession of tobacco or nicotine products”.²⁰⁵

255. The EM states that the intended effect of these provisions is that:

“Combining a strengthened RPO regime with a national register will add benefit by enhancing existing levers available to local authorities for enforcement of tobacco and nicotine offences. These provisions will also support the policy aim of reducing access to tobacco and nicotine products by under 18s.”²⁰⁶

256. There was broad support for the restriction on access to the register for persons subject to RSOs or RPOs, and for the enhanced Orders regime. However the National Federation of Retail Newsagents queried why the strengthened RPO/RSO system could not function on its own without the need for a retailers’ register.²⁰⁷

257. The Directors of Public Protection Wales stated that it was essential for all tobacco-related breaches to be included as offences which could trigger a RPO. They stated that this could be achieved by use of the regulation-making powers to be inserted into section 12D of the Children and Young Persons Act 1933 by section 40 of the Bill.²⁰⁸

258. Under the provisions in the Bill, if a retailer were to commit three relevant tobacco or nicotine offences within a three-year period they could be issued with a RPO, which would prohibit that premises from selling those products for a period up to one year. Public Health Wales was supportive of the enhanced regime, but highlighted the relative infrequency of prosecutions for non-compliance with underage sales regulations. It therefore advocated the use of twelve-month Orders (either issued by local

²⁰⁴ Explanatory Memorandum, para 74

²⁰⁵ Explanatory Memorandum, para 85

²⁰⁶ Explanatory Memorandum, para 89

²⁰⁷ PHB 90 National Federation of Retail Newsagents

²⁰⁸ PHB 04 Directors of Public Protection Wales

authority enforcement officers or by application to a magistrate) for single infringements, with longer Orders to be used in the case of repeated infringements.²⁰⁹

259. Conversely, the Association of Convenience Stores stated that the use of RPOs and RSOs would be proportionate only if targeted at repeated breaches of regulations.²¹⁰

The Committee's view

260. The Committee agrees with stakeholders that the enhanced Restricted Sales Orders and Restricted Premises Orders regime are welcome, and agrees that those persons or premises subject to such Orders should be excluded from the retailers register.

Handing over tobacco etc to persons under 18

261. Chapter 4 of the Bill contains provisions to make it an offence for a person to knowingly hand over tobacco or nicotine products to a person under the age of 18, who is unaccompanied by an adult, during the delivery or collection of tobacco or nicotine products which have already been bought and paid for remotely.

262. The *Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations 2015* which came into force on 1 October 2015, prohibit the proxy purchase of nicotine products (including e-cigarettes) for minors, however the EM states that:

“There is no current legislation which prevents tobacco products or nicotine products which have been purchased remotely from being handed over to a person or persons under the age of 18.”²¹¹

263. The stated intention of the provisions in the Bill is to reduce the risk of young people under the age of 18 accessing tobacco products and/or nicotine products. It aims to achieve this by requiring delivery agents to visually assess if the person they are handing the tobacco products and/or nicotine products is aged 18 or over, and verify age where appropriate.²¹²

264. The EM states that currently every major supermarket chain in Wales that makes home deliveries which include tobacco products has voluntary

²⁰⁹ PHB 03 Public Health Wales

²¹⁰ PHB 74 Association of Convenience Stores

²¹¹ Explanatory Memorandum, para 97

²¹² Explanatory Memorandum, para 105

policies which prohibit their drivers to hand over tobacco products to customers who appear to be under the age of 18 if they cannot provide proof of age. It states that it was likely that some retailers may extend their policies to cover nicotine products following the introduction of a minimum age restriction on sales of those products.²¹³

265. The EM also states that:

“While there are a number of retailers who currently have policies, this voluntary practice is not universal across all retailers who sell tobacco products remotely, and there is currently no legal requirement for retailers to ensure tobacco and/or nicotine products are only being handed over to persons aged 18 or over.”²¹⁴

266. There was broad support for these provisions among those who responded to the Committee’s consultation.²¹⁵ Written evidence received from the Directors of Public Health on behalf of Health Boards stated their support:

“The Local Health Boards of Wales support prohibition of the handing over of tobacco or nicotine products to those aged under 18 years. The rapid rise in internet shopping could offer an easy way for young people to circumvent age restrictions. There is currently a lack of safeguards against children purchasing cigarettes through the internet. There should be consistency in the control of the sale of restricted products across all outlets, physical or virtual”.²¹⁶

267. Written evidence from Under Age Sales Ltd suggested that the wording of these provisions was unclear. It recommended redrafting this Chapter of the Bill to simplify the language to “ensure that it meets the intended

²¹³ Explanatory Memorandum, para 98

²¹⁴ Explanatory Memorandum, para 99

²¹⁵ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales, PHB 03 Public Health Wales, PHB 04 Directors of Public Protection Wales, PHB 20 Dispensing Doctors' Association Limited, PHB 21 Wales Heads of Environmental Health Communicable Disease Expert Panel, PHB 22 Decadent Vapours Ltd, PHB 24 Rhydian Mann, PHB 25 Royal College of Physicians, PHB 26 British Lung Foundation, PHB 35 Royal College of Nursing, PHB 40 Royal College of General Practitioners, PHB 47 Caerphilly Council, PHB 51 Merthyr Tydfil County Borough Council, PHB 56 Welsh Dental Committee, PHB 58 Wrexham County Borough Council, PHB 71 Fontem Ventures, PHB 72 Totally Wicked Ltd, PHB 75 Royal College of Midwives, PHB 76 BMA Cymru Wales, PHB 78 The Association of Directors of Public Health, PHB 79 Philip Morris Limited, PHB 81 Gwynedd Council, PHB 86 Powys Teaching Health Board, PHB 87 Japan Tobacco International, PHB 92 Powys County Council and PHB 93 Rhondda Cynon Taf County Borough Council

²¹⁶ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales

purpose”.²¹⁷ Whilst ASH Wales supported the proposal in principle, it called for further evidence on the extent of the existing problem of products being handed over to under 18s in this way prior to legislating.²¹⁸

268. Written evidence provided by the Welsh Pharmaceutical Committee²¹⁹ and Celesio UK and Lloyds Pharmacy²²⁰ supported an exemption for licenced medicines such as nicotine replacement therapy used to aid smoking cessation.

269. Some respondents expressed concern that the provisions would prevent parents from handing over e-cigarettes to their children for use as smoking cessation aids.²²¹ However, the provisions in this Bill provide that it would be an offence to hand over tobacco/nicotine products etc. to a person aged under 18 only during the delivery or collection of those products in connection with a sale. Therefore, these provisions would not apply to parents who give e-cigarettes to their children. The offence of an adult proxy purchasing nicotine products on behalf of a person under the age of 18 is set out in the *Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations 2015*.

Financial implications

270. Figures provided in the Regulatory Impact Assessment, estimate the additional costs associated with these provisions to be at just under £560,000 between 2016-17 and 2020-21. The majority of these costs would fall on local authorities, which would incur additional costs of just under £415,000, mainly for test purchases by trading standards departments and for staff costs. In addition, retailers would incur costs of around £130,000 to develop terms and conditions and policies on the delivery of tobacco products, and the Welsh Government would incur additional costs of £17,000 for training and guidance.

The Committee’s view

271. The Committee notes the general support for the creation of an offence to knowingly hand over tobacco or nicotine products to a person under the age of 18, who is unaccompanied by an adult. It concurs that this will be an

²¹⁷ PHB 13 Under Age Sales Ltd

²¹⁸ PHB 48 ASH Wales

²¹⁹ PHB 27 Welsh Pharmaceutical Committee

²²⁰ PHB 85 Celesio UK and Lloyds Pharmacy

²²¹ PHB 14 Dr David Upton, PHB 18 Gordon Beard, PHB 37 Robert Heyes, PHB 39 Counterfactual, PHB 45 Margaret Hermon, PHB 50 Electronic Cigarette Industry Trade Association, PHB 54 Jonathan Edwards, PHB 61 New Nicotine Alliance UK and PHB 77 Forest

important step in preventing young people from accessing tobacco or nicotine products online. The Committee notes that whilst supermarket chains in the UK currently operate voluntary policies to govern their deliveries, this provision would extend the practice to all retailers thereby minimising the opportunities for young people under the age of 18 to access products illegally.

6. Part 3 – Special procedures

272. Part 3 of the Bill includes provisions to create a compulsory, national licensing system for practitioners of specified special procedures. Special procedures, as defined in the Bill, are acupuncture, body piercing, electrolysis and tattooing.

273. The system would mean that in order to perform any of the special procedures defined within the Bill, individuals must be licensed and they must operate from approved premises or vehicles. Individual licences and approvals would be valid for three years. Temporary licences and approvals would also be available for exhibitions and events.²²²

274. Practitioners would be required to provide pre and post-procedure consultations to ensure that people are fully aware of the risks associated with the procedure and how to self-administer any required aftercare. Local authorities would be responsible for enforcing the licensing requirements, and for keeping a register of the special procedures licences they issue.²²³

275. The Welsh Government's stated aim for this Part of the Bill is to ensure that where these special procedures are provided, they are carried out in a manner which is not potentially harmful to health.²²⁴ In his oral evidence to the Committee, the Minister explained how he believed that the provisions in the Bill would improve the current arrangements:

“At the moment, it is very difficult indeed, both for members of the public and for any enforcement officer, to see the difference between a legitimate business that meets all the standards that you would expect it to meet and those people who practice scratching and other procedures in an entirely unregulated and not acceptable way. What this Bill will do is to make sure that those people who are at the proper end of the business are recognised for the way that they conduct that business. They will have a licence, they will display the licence and, if you don't have a licence to display, you are operating outside the law. So, the ability to spot backstreet practitioners and other people who don't do it in the right way is really strengthened by this Bill. It is strengthened for enforcement purposes and, most

²²² Explanatory Memorandum, para 116

²²³ Explanatory Memorandum, para 122

²²⁴ Explanatory Memorandum, para 116

importantly of all, it is strengthened for the user of the service as well.”²²⁵

276. The Minister indicated that his rationale for identifying acupuncture, body piercing, electrolysis and tattooing as special procedures on the face of the Bill was the fact they all involve skin piercing.²²⁶ He also noted that they “happen on a scale where we think they’re worth including”.²²⁷ The Minister told the Committee that he remained open-minded about whether there were other procedures that ought to be captured by the Bill’s provisions.²²⁸

277. Section 49 of the Bill includes a provision to allow exemptions to the licensing system. The EM states that exemptions could be granted, for example, to members of specific professions, such as doctors, unless regulations provide otherwise. The Bill also gives the Welsh Ministers the power to exempt members of other specified professions via regulations which would be subject to the affirmative procedure.²²⁹

278. Section 76 of the Bill includes provision for the Welsh Ministers to amend the special procedures covered by the Bill, either by adding or removing procedures. This would also be achieved via regulations subject to the affirmative procedure.²³⁰

279. There was general support for the provisions in the Bill from those who provided evidence to the Committee. Dr Quentin Sandifer representing Public Health Wales (PHW) welcomed the proposals in the Bill. He said:

“I think the current regulatory powers certainly don’t provide sufficient assurance that people would undertake those procedures technically competently, in a safe and hygienic way [...] where people seek to trade by undertaking these activities, then we would want those people to be subject to proper legislative requirements, and that’s what I think this Bill does.”²³¹

280. Dr Fortune Ncube, Consultant Epidemiologist and Consultant in Public Health Medicine for Public Health England, told the Committee that there was sufficient risk of diseases such as hepatitis B, hepatitis C and to a lesser extent HIV following these procedures to warrant legislating in this area. He

²²⁵ RoP [para 69], 21 October 2015

²²⁶ RoP [para 70], 1 July 2015

²²⁷ RoP [para 72], 1 July 2015

²²⁸ RoP [para 72], 1 July 2015

²²⁹ Explanatory Memorandum, para 120

²³⁰ Explanatory Memorandum, para 119

²³¹ RoP [paras 54 and 56], 9 July 2015

explained that the evidence base to suggest that the four procedures listed on the face of the Bill pose a risk, particularly in terms of bacterial and viral infections, was strong.²³²

281. Julie Barratt, representing the Chartered Institute of Environmental Health (CIEH), concurred that a system of mandatory licensing would be an improvement to current arrangements, by requiring practitioners to have the appropriate skills to ensure the safety of those undergoing the specified procedures. She told the Committee:

“I’m confident that the legislation allows for that to happen. I think a great deal of the control will lie in the licence conditions. At the present moment, local government is obliged to register anyone who wants to be registered. So, you can just buy yourself a kit off the internet, set yourself up and have a go. That can’t be stopped unless something actually goes wrong [...] It’s an enormous concern to me at the moment that there is not a fit-and-proper-person test for people who carry out some highly invasive procedures, but we can deal with that through licensing conditions, and I think that’s really important.”²³³

282. In its written evidence, Gwynedd Council said it believed that there was substantial potential for the provisions relating to special procedures to contribute towards improving public health in Wales.²³⁴

283. Additionally, 75 per cent of those who responded to the Committee’s survey believed that a licensing system should be created for people who perform these special procedures. 44 per cent of those who responded agreed that the Bill captured the correct special procedures, 7 per cent felt that more procedures should be covered, 13 per cent felt that there should be fewer procedures listed and 36 per cent did not know.²³⁵

Acupuncture

284. In the Welsh Government’s Statement of Policy Intent, the Welsh Government expresses its intention for regulations to make members of the British Acupuncture Council (BACc) exempt from the requirement to obtain a

²³² RoP [paras 270–272], 17 September 2015

²³³ RoP [para 35], 15 July 2015

²³⁴ PHB 81 Gwynedd Council

²³⁵ National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

licence, subject to the Council maintaining its accreditation with the Professional Standards Authority for Health and Social Care.²³⁶

285. Nick Pahl, Chief Executive of the BAcC told the Committee that he welcomed the proposals in the Bill and the intention to exempt members of the BAcC:

“We support the Bill, yes. We think it’s good to have a standardised approach [...] also we support the Bill having recognition of health professionals, such as ourselves, who are regulated with the professional standards authority and those health professionals who do acupuncture who are already state regulated.”²³⁷

286. Gwenan Evans, an acupuncture practitioner and member of the BAcC, presented her views as part of video evidence gathered by the Committee. Ms Evans noted that membership of the BAcC already offered safeguards to clients, including professional indemnity and public liability insurance. She explained that this meant that people receiving acupuncture from members of the BAcC were assured of their safety.²³⁸

287. Mr Pahl said he believed that the Bill could offer safeguards to people undergoing procedures by a practitioner who was not a member of the BAcC or a member of a Professional Standards Authority accreditation scheme, saying that it could offer “benefits in terms of making sure there’s a standardised approach by environmental health to acupuncture”.²³⁹ He added:

“So, it [acupuncture] is a very safe procedure, but there’s still a concern when you’re an acupuncturist working in the NHS or privately, if you’re providing acupuncture and there isn’t protection of title, which means that some people who potentially are poorly trained could still set up shop and practice. I think this public health Bill is a really excellent first step across the UK.”²⁴⁰

288. Dr Gill Richardson, Director of Public Health at Aneurin Bevan University Health Board, gave the Committee examples of outbreaks of infectious

²³⁶ Welsh Government [Statement of Policy Intent](#), page 31

²³⁷ RoP [para 314], 17 September 2015

²³⁸ RoP [para 174], 17 September 2015

²³⁹ RoP [para 330], 17 September 2015

²⁴⁰ RoP [para 344], 17 September 2015

diseases associated with acupuncture in other countries. These included cases of tuberculosis-type skin infections and hepatitis B.²⁴¹

Body piercing

289. The Bill's provisions in relation to the licensing and regulation of providers of body piercing were welcomed by stakeholders. The Faculty of Dental Surgery at the Royal College of Surgeons quoted research that indicated around 80 per cent of piercings took place in tattoo establishments but those undertaking the piercings had little, if any, knowledge of the anatomy of the regions involved. They also noted that this research indicated only 30 per cent of customers were told of any potential risks or complications of the procedures.²⁴²

290. The British Body Piercing Association (BBPA) argued that body piercers needed better regulation and a recognised, professional body to rely on for support and further training.²⁴³ It supported the inclusion of body piercing in this Part of the Bill, emphasising the high level of skill that is required of piercers if harm and the need for medical treatment are to be avoided.

291. The Committee heard evidence about the potential risks specifically associated with tongue piercing and the need for better regulation in this area. Further details on this are set out in the chapter on intimate piercing in this report.

Electrolysis

292. Stakeholders expressed differing views about the inclusion of electrolysis as a special procedure subject to the licensing controls proposed in the Bill. In its written submission to the Committee the British Institute and Association of Electrolysis (BIAE) argued that its members should be exempt from the requirement on the grounds that the standards the Bill seeks to achieve are "a basic requirement of all our members and are covered in the BIAE entrance assessment, which we believe gives us a good case for exemption".²⁴⁴

293. However, other witnesses told the Committee that the risk of infection following electrolysis was sufficient to warrant its inclusion in the Bill. Dr Gill Richardson told the Committee:

²⁴¹ RoP [para 170], 9 July 2015

²⁴² PHB 36 The Faculty of Dental Surgery, Royal College of Surgeons

²⁴³ PHB 08 British Body Piercing Association

²⁴⁴ PHB 29 British Institute and Association of Electrolysis

“We also know that electrolysis is a risk factor for hepatitis C, so I think it is right to include them. There’s just the potential risk, whenever there’s anything sharp that is reused, that it may not be sterilised properly, and then you’re basically transmitting infection.”²⁴⁵

294. Dr Fortune Ncube told the Committee that while regulation through the professional bodies helped, it would be prudent to include acupuncture and electrolysis within the licensing regime to ensure the regime was comprehensive.²⁴⁶

295. In response to the view submitted by the BIAE, the Minister said that the Bill provides the Welsh Ministers with a regulation making power to grant exemptions to individuals who are (a) members of a profession; and (b) are registered in the capacity of a member of that profession in a qualifying register. He wrote that the process for granting an exemption would apply to electrolysis in the same way as other procedures, subject to meeting the necessary criteria.²⁴⁷

Tattooing

296. The Committee received considerable evidence in support of including tattooing as one of the special procedures covered by the Bill. Julie Barratt representing the CIEH told the Committee that “there’s certainly enough evidence to justify tattooing being in the Bill”.²⁴⁸ Other stakeholders referred to the recent outbreak of skin infections linked to tattoo studios in the Newport area as justification for legislating in this area.²⁴⁹

297. Speaking on behalf of the British Tattoo Artist Federation (BTAF), Lee Clements said that the Federation supported the Bill and were “happy with how it’s going forward”.²⁵⁰ Graham Bowman, a tattoo artist who gave video evidence, believed that the additional regulation was required in order to tackle the issue of irresponsible practitioners:

²⁴⁵ RoP [para 170], 9 July 2015

²⁴⁶ RoP [para 275], 17 September 2015

²⁴⁷ PHB AI 09 Minister for Health and Social Services - 31 October 2015

²⁴⁸ RoP [para 27], 15 July 2015

²⁴⁹ PHB 01 Chartered Institute of Environmental Health, PHB 04 Directors of Public Protection Wales, PHB 06 Welsh Local Government Association, PHB 17 The City of Cardiff Council, PHB 31 Wales Heads of Environmental Health, PHB 51 Merthyr Tydfil County Borough Council, PHB 56 Welsh Dental Committee, PHB 89 Public Health Wales, PHB 92 Powys County Council, PHB 93 Rhondda Cynon Taf County Borough Council, RoP [paras 69–70, 81 –82] 1 July 2015, RoP [paras 169–172], 9 July 2015 and RoP [paras 34 and 166–169], 15 July 2015

²⁵⁰ RoP [para 377], 17 September 2015

“Despite popular belief, it is a professional business. We do take pride in it—a lot of it. There are people out there who just don’t care and will tattoo anyone and everything for money. I think it does need to be regulated more.”²⁵¹

298. The Tattoo and Piercing Industry Union (TPIU) raised concern that legislation would place an increased burden on businesses operating lawfully whilst failing to impact on illegal “underground” operators:

“Every day our members and the local A&E see examples of shoddy and often dangerous work by underground tattooists and piercers. Unfortunately not much is being done about this, instead more legislation, rules, and regulations are laid at the door of established studios instead of these resources being directed at this illegal trade. There seems to be little desire to grasp this nettle, and so to show something is being done, more and more (and regionally different) red tape is being applied to the established licensed studios. This drives up our costs and has no effect on theirs.”²⁵²

299. The ease of obtaining cheap tattooing equipment online was raised as an area of concern by some stakeholders.²⁵³ The TPIU said in its written evidence:

“Historically it was impossible to get supplies of inks, needles, machines etc. unless you were a tattooist known to the other tattooists. The advent of Ebay etc. and Tattoo shows have changed all that, now anyone can obtain their requirements to be able to open an illegal tattoo or piercing studio from these sources”.²⁵⁴

300. The TPIU suggested that controls should be put in place to ensure that supplies are only sold to established licensed studios to prevent the sale of equipment to illegal traders.²⁵⁵

301. Several witnesses highlighted the increasing prevalence of procedures known as “tashing” or “ashing”, where substances such as the ashes of a deceased person or a material that reflects ultraviolet light are implanted under the skin.²⁵⁶ Some stakeholders noted that clarification was needed

²⁵¹ RoP [para 167], 17 September 2015

²⁵² PHB 105 Tattoo and Piercing Industry Union

²⁵³ PHB 104 Dee Yeoman

²⁵⁴ PHB 105 Tattoo and Piercing Industry Union

²⁵⁵ PHB 105 Tattoo and Piercing Industry Union

²⁵⁶ PHB 01 Chartered Institute of Environmental Health, PHB 17 The City of Cardiff Council, PHB 21 Wales Heads of Environmental Health Communicable Disease Expert Panel, PHB 31

about whether these procedures would be covered by the definition of tattooing contained in the Bill, and were concerned that they could be overlooked.²⁵⁷

302. In response to a question on the issue of “tashing”, the Minister confirmed in writing that, in the Welsh Government’s view, the definition of tattooing in the Bill would be broad enough to cover this procedure.²⁵⁸

Exemptions

303. The BACc raised concern about the proposal to exempt those registered with professional bodies. It stated that, in its experience, while most doctors and physiotherapists who undertook acupuncture belonged to the relevant special interest bodies within their professions (the British Medical Acupuncture Society and the Acupuncture Association of Chartered Physiotherapists), many other registered professionals like osteopaths and chiropractors went “off the radar” in the absence of equivalent special interest bodies within their professions. The BACc said this has meant that neither the safety nor training standards of such practitioners were vetted, and it “does not believe that this is entirely adequate”.²⁵⁹

304. Public Health Wales also raised this point, noting that the proposed exemptions include all registered health professions.²⁶⁰

305. The BACc said that it would like to see an explicit statement that the Bill would allow the power to inspect the premises of exempted practitioners where concerns had been raised about their standards of practice.

306. The Welsh Government’s Statement of Policy Intent says that the power in section 49 of the the Bill would enable the Welsh Ministers to require that members of a specified profession hold a special procedures licence in order to perform procedures if the relevant regulatory body for that profession determined that their practice was outside the scope of practice of its members. It said the regulations would be developed in conjunction with the regulatory bodies and the Welsh Government would take account of the practices undertaken by individuals within each profession:

Wales Heads of Environmental Health, PHB 47 Caerphilly Council, PHB 92 Powys County Council, PHB 93 Rhondda Cynon Taf County Borough Council, RoP [para 430] 17 September 2015 and RoP [paras 44–45, 171], 15 July 2015

²⁵⁷ RoP [para 45], 15 July 2015 and RoP [para 430], 17 September 2015

²⁵⁸ PHB AI 09 Minister for Health and Social Services - 31 October 2015

²⁵⁹ PHB 15 British Acupuncture Council

²⁶⁰ PHB AI 02 Public Health Wales

“For example, the regulations may provide that a member of a specified profession, (such as a chiropractor) may be required to obtain a special procedure licence in order to practice body piercing, electrolysis and tattooing, but will not be required to obtain a licence to practice acupuncture as the relevant regulatory body has determined that the practice of acupuncture is within the scope of practice of its members.”²⁶¹

The Committee’s view

307. It is clear from the evidence presented to the Committee that improvements to current arrangements for special procedures are needed. In particular, changes are necessary if members of the public are to be adequately protected from the potential harms of undergoing a special procedure by someone who does not possess the necessary knowledge to be able to advise clients and carry out the procedures safely.

308. The Committee notes the evidence it received from a wide range of witnesses in support of legislating to introduce mandatory licensing for practitioners of special procedures. It also notes the Minister’s rationale for including these four procedures on the face of this Bill and agrees that the potential risk of harm associated with them is sufficient to warrant their inclusion. Further comment about procedures not currently included on the face of Bill is given in the next section of this chapter.

309. The Committee supports the increased regulation provided by the Bill and welcomes the ability for the public, through the licensing system, to identify those practitioners operating safely and within the law. It acknowledges that some irresponsible individuals could continue to operate illegally, but hopes that the powers afforded to local authorities would result in an increase in prosecutions. The Committee believes that continued efforts by local authorities to tackle the irresponsible behaviour of illegal traders in tandem with ensuring that licensed businesses operate within their specified conditions will be key to protecting the public.

310. The Committee notes the provision in the Bill for the exemption of certain professionals from the licensing criteria. While acknowledging that these exemptions are subject to the maintenance of existing professional regulation, the Committee is conscious of the concerns raised by the BACC and Public Health Wales about whether all of those captured within the list of

²⁶¹ Welsh Government [Statement of Policy Intent](#), page 29

exempted professions would have the necessary competence to undertake these procedures by virtue of their professional registration alone.

Recommendation 1: The Committee recommends that the Minister for Health and Social Services work with local authorities to monitor the success of introducing the licensing scheme under Part 3 of the Bill.

Recommendation 2: The Committee recommends that the Minister for Health and Social Services explore the feasibility of amending the Bill to place a duty on Health Boards to:

- maintain a record of anyone who requires treatment as a result of undergoing a special procedure, as defined in the Bill; and
- notify local authorities when such an event occurs.

Procedures not covered by the Bill

311. The Committee heard evidence in support of extending the types of procedures covered by the provisions in the Bill to ensure the same safeguards for those undergoing other procedures. Suggestions for such procedures included:

- non-surgical cosmetic procedures, such as dermal fillers, Botox injections, chemical peels, colonic irrigation, laser treatment for tattoo and hair removal, dermal rolling, dental jewellery and wet cupping;
- body modifications, such as tongue splitting, scarification, branding, stretching and sub-dermal implants.²⁶²

312. Representatives from local government, the Directors of Public Protection Wales (DPPW), and the CIEH told the Committee that they believed the procedures covered by the Bill were the correct ones, and that they supported the inclusion of the four special procedures on the basis that they were:

- the most commonly associated with the risk of infection, particularly blood-borne viruses;²⁶³
- procedures with which local government officers would already be familiar.²⁶⁴

²⁶² PHB 01 Chartered Institute of Environmental Health, PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales, PHB 03 Public Health Wales, PHB 05 The Welsh NHS Confederation, PHB 76 BMA Cymru Wales and PHB 78 The Association of Directors of Public Health

²⁶³ RoP [para 164], 15 July 2015

²⁶⁴ RoP [paras 30 and 175], 15 July 2015

313. Representatives from DPPW welcomed the opportunity to adopt an incremental approach to allowing other procedures to be added over time. They noted that additions should only be made once:

- evidence in support of the need for regulation in relation to emerging body modification techniques has become available;
- officers have been given sufficient time to increase their awareness of - and training in relation to - any new enforcement responsibilities.²⁶⁵

314. Dr Fortune Ncube told the Committee that further evidence on the risk of infection related to other procedures was needed before including them within the Bill's provisions:

"I think we are standing on slightly shaky ground in relation to these other exotic practices that are in place [...] because we don't have, as yet, the evidence to show the risk of infection in relation to that, and indeed the risk of other complications that can be associated with them, whereas the four that we've mentioned at the beginning, we have got better evidence in relation to that. So, I would suggest, and this is again just a suggestion and an observation, that perhaps at this stage it would be better to concentrate on the four that you have identified already, but allow yourselves room within the Bill for flexibility, to be able to include them when the evidence becomes apparent."²⁶⁶

315. However, other witnesses and respondents to the Committee's consultation such as the Association of Directors of Public Health,²⁶⁷ the Welsh NHS Confederation,²⁶⁸ Public Health Wales,²⁶⁹ BMA Cymru Wales²⁷⁰ and Directors of Public Health representing Health Boards²⁷¹ argued that consideration should be given to including other procedures on the face of the Bill. Their views were summarised by the Association of Directors of Public Health, which said:

"Whilst we agree with the special procedures defined, this Bill also presents an opportunity to regulate the administration of the following procedures: body modification (to include stretching, scarification, sub-dermal implantation/3D implants, branding and

²⁶⁵ RoP [paras 164 and 175], 15 July 2015

²⁶⁶ RoP [para 281], 17 September 2015

²⁶⁷ PHB 78 The Association of Directors of Public Health

²⁶⁸ PHB 05 The Welsh NHS Confederation

²⁶⁹ PHB 03 Public Health Wales

²⁷⁰ PHB 76 BMA Cymru Wales and RoP [para 176], 17 September 2015

²⁷¹ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales

tongue splitting), injection of any liquid into the body e.g. botox or dermal fillers, dental jewellery, chemical peels, and laser treatments such as used for tattoo removal or in hair removal.”²⁷²

316. Dr Rodney Berman stated that the BMA Cymru Wales supported calls for consideration to be given to including procedures such as laser hair removal, chemical peels, dermal fillers, scarification or branding, and sub-dermal implantation on the face of the Bill. He noted that the rationale for regulating these in the same manner as acupuncture, body piercing, electrolysis, and tattooing was the fact that they created the same potential for health problems to occur if they are not carried out in a “properly controlled way”.²⁷³

317. Commenting on the procedures not included in the Bill, the Minister told the Committee:

“These are always matters of judgment. These are procedures on a spectrum. At the moment, the Bill draws the line where it does because the four procedures we have identified have something in common [skin piercing] and happen on a scale where we think they’re worth including. I remain open-minded on whether there are other procedures that ought to be added to the Bill at this stage, or whether those are procedures that ought to be considered as part of the regulation-making power that the Bill allows.”²⁷⁴

Non-surgical cosmetic procedures

318. There was agreement among witnesses that the current level of regulation for non-surgical cosmetic procedures was inadequate. Brett Collins, Director of Save Face, noted that the only restriction on the use of injected treatments such as dermal fillers and Botox was the fact that Botox was a prescription only drug. He went on to say:

“outside of that, there is no regulation and there is no vehicle to ensure public safety in terms of these treatments”.²⁷⁵

319. Paul Burgess, Chief Executive of the British Association of Cosmetic Nurses (BACN), said that as professional nurses, BACN members were regulated by the Nursing and Midwifery Council thereby providing redress to their clients should procedures go wrong. However, he emphasised that the

²⁷² PHB 78 The Association of Directors of Public Health

²⁷³ RoP [para 176], 17 September 2015

²⁷⁴ RoP [para 72], 1 July 2015

²⁷⁵ RoP [para 193], 17 September 2015

same safeguard was not available to anyone undergoing a procedure undertaken by another practitioner:

“There is nothing whatsoever in place, for example, if a beautician carries out a treatment. There are no standards in place against which to judge competence.”²⁷⁶

320. Notwithstanding their comments about the inadequacies of current regulation arrangements for non-surgical cosmetic procedures, neither Save Face nor the BACN advocated including non-surgical cosmetic interventions as special procedures within the Bill. The BACN stated that while it would support licensing, it did not believe that the Bill was the most appropriate route or vehicle to achieve the desired aims.²⁷⁷ Its representatives argued that it would be “wholly inappropriate” to include cosmetic procedures within the list of special procedures defined in the Bill, and stated “the only way to reasonably include these treatments in the Bill [...] would be in a whole new section”.²⁷⁸

321. Brett Collins of Save Face told the Committee:

“Certainly, non-surgical cosmetic treatments cannot be lumped in with tattoo, nor can they be lumped in with electrolysis. You need a certain calibre and understanding of each treatment set to be able to regulate.”²⁷⁹

322. In response to questions relating to including non-surgical cosmetic procedures among those listed on the face of the Bill, the Minister told the Committee that he intended to await any UK Government actions arising from the Review of the Regulation of Cosmetic Interventions led by Professor Sir Bruce Keogh, which reported in April 2013.²⁸⁰ The Minister said that, should the UK Government decide not to legislate to cover such procedures at a UK level, or should the Assembly not support those UK provisions, the regulation powers in section 76 of the Bill allowed the Welsh Ministers to add further procedures to the register, subject to the affirmative procedure. He went on to say:

“At the moment, my position has been that, while the Keogh review is still under active consideration and when there could be legislative

²⁷⁶ RoP [para197], 17 September 2015

²⁷⁷ PHB 33 British Association of Cosmetic Nurses

²⁷⁸ RoP [para 247], 17 September 2015

²⁷⁹ RoP [para 215], 17 September 2015

²⁸⁰ UK Government Department of Health, [Review of the Regulation of Cosmetic Interventions](#), 23 April 2013

action elsewhere that would be of wider benefit to Wales, we should be prepared to stand back and allow that process to run its course [...] If it doesn't or if it doesn't do so satisfactorily, then I think the Bill allows us to return to the issue and to add some further procedures to the Bill."²⁸¹

The Committee's view

323. The Committee notes the increased prevalence of people undergoing non-established body modification procedures and non-surgical cosmetic procedures, and the emergence of different types of procedures. It recognises that there is a potential risk of infection to anyone undergoing such procedures if they are not carried out in a professional and hygienic way, and acknowledges the call by witnesses for further procedures to be added to those already covered by this Bill.

324. The Committee accepts that the growing trend for undergoing a range of body modification procedures and non-surgical cosmetic procedures will necessitate the regulation of such procedures in addition to those currently provided for in the Bill. It therefore welcomes the provision in section 76 that enables Welsh Ministers to add special procedures through regulations to the list of procedures in the Bill.

325. The Committee acknowledges that, owing to the pace of these evolving industries, further research on the potential risks faced by people undergoing procedures is necessary to ensure that future licensing conditions are appropriate to those specific procedures. It also recognises the importance of enforcement officers being sufficiently familiar with such procedures to ensure that inspections are carried out effectively.

326. The Committee believes that the four procedures listed on the face of the Bill are appropriate to legislate for at the current time. It recognises that the Minister has identified the procedures to include on the face of the Bill on the basis that they all involve skin piercing and happen on a scale that is significant enough to warrant legislating. Nevertheless, the Committee is aware that significant harm can be caused by the following if poorly administered:

- other body modification procedures, such as tongue splitting, branding, scarification, stretching and sub-dermal implants; and

²⁸¹ RoP [para 70], 1 July 2015

- non-surgical cosmetic procedures, such as dermal fillers, Botox injections, chemical peels, colonic irrigation, laser treatment for tattoo and hair removal, dermal rolling, dental jewellery and wet cupping.

327. While it acknowledges that the scale of such procedures may be smaller than those listed on the face of the Bill, it is concerned about the level of harm that can occur if they are practised poorly. As a consequence it believes that the Minister should consider the evidence provided during the Committee's Stage 1 scrutiny on the harms caused by the body modification procedures and non-surgical cosmetic procedures, and bring forward amendments to list on the face of the Bill any other potentially harmful procedures.

Recommendation 3: The Committee recommends that, in light of the evidence it has received on the potential harms that can occur as a result of body modification techniques, the Minister for Health and Social Services reconsider adding to the list of special procedures included on the face of the Bill.

328. With regard to non-surgical cosmetic procedures, the Committee notes the Minister's explanation for awaiting any actions to be taken by the UK Government in response to the Review of the Regulation of Cosmetic Interventions led by Professor Sir Bruce Keogh. However, it is concerned that over two years after the review reported, details of the precise processes and timescales for implementing the review's recommendations are not available. It welcomes the Minister's commitment to undertake a separate course of action from the UK Government's, if necessary, and urges the Minister to consider the evidence presented to the Committee about the most appropriate way to legislate in relation to non-surgical cosmetic procedures.

Recommendation 4: The Committee recommends that, in light of the apparent delays at the UK level with the implementation of the recommendations of Sir Bruce Keogh's Review of the Regulation of Cosmetic Interventions (published April 2013), the Minister for Health and Social Services work with the appropriate public authorities and industries to identify non-surgical cosmetic procedures to be added, by amendment, to the list of special procedures included on the face of the Bill.

Licensing criteria

329. Section 51(1) of the Bill specifies that the Welsh Ministers must set out, through regulations subject to the affirmative procedure, criteria that must be met in order for a special procedure licence to be granted. Section 52(1)

requires that these regulations set out mandatory conditions that would apply to special procedure licences.

330. The EM states that:

“The licensing criteria will specify, amongst other things, an individual’s eligibility for a licence. The mandatory licensing conditions will set out the requirements a licence holder must meet in order to retain their licence, including conditions relating to the standards of hygiene, the way in which special procedures are to be performed, and the information to be provided during pre and post-procedure consultations.”²⁸²

331. The Minister referred to criteria that a person having a special procedure undertaken at licensed premises could expect to be met. He said that the Bill would:

“give members of the public the confidence of knowing that if a certificate is in the window, then that is an outlet that has been properly inspected, the standards of hygiene are what you would need them to be, the training of staff is what you would want it to be, there will be pre-procedure and post-procedure advice, aftercare, given to people, and both the premises and the staff are fit to carry out the duties that they purport to provide”.²⁸³

332. Dr Quentin Sandifer representing Public Health Wales told the Committee that PHW supported the licensing requirement being placed on “an individual and not just on a business, whether premises or a vehicle”.²⁸⁴ He went on to say:

“I would also want to make the point that the provision should apply to all individuals, whether they are currently providing those services or might provide them in the future. I wouldn’t want a grandfather clause inadvertently to be introduced in the legislative process.”²⁸⁵

Pre-procedure consultations

333. The Committee heard overwhelming evidence in support of practitioners carrying out pre-procedure consultations with clients. This was seen as a solution to overcoming the potential for an individual to undergo a

²⁸² Explanatory Memorandum, para 121

²⁸³ RoP [para 78], 1 July 2015

²⁸⁴ RoP [para 48], 9 July 2015

²⁸⁵ RoP [para 48], 9 July 2015

procedure, especially tattooing or body piercing, whilst under the influence of alcohol or drugs. Julie Barratt representing the Chartered Institute of Environmental Health said:

“I entirely agree with a cooling-off period, whether you’re drunk or not, for tattooing or intimate piercing. I think we can control this through the licence conditions. The licence conditions should make it quite clear that if someone is under the influence of alcohol or drugs, whether they are prescription or non-prescription drugs, the practitioner should refuse to treat them. I think that’s the right thing to do. But, I would prefer to see that as a licensing condition, because licensing conditions can be changed quite quickly”.²⁸⁶

334. Lee Clements representing the British Tattoo Artists Federation concurred that the proposal of a “cooling off” period between the pre-procedure consultation and carrying out the procedure would be beneficial:

“Most reputable studios wouldn’t even dream of tattooing someone who is intoxicated. I mean, just in the case of my studio, we have a disclaimer that, basically, they have to sign, saying they’re not intoxicated on drugs or alcohol, for instance, and if I thought that they were, then we wouldn’t do that anyway. But, I understand that it does happen, and I think that introducing it as part of the Bill would be great. The cooling-off period— I know they’ve introduced something similar in Boston health authority, and I think that that’s something that would be of benefit. I think if someone is going to make the jump to have something for the rest of their lives, then waiting a couple of days is not going to make any difference, is it?”²⁸⁷

335. The Minister said that a mandatory licensing condition could be included to prevent individuals undergoing a procedure whilst intoxicated. He told the Committee that his intention would be to create licensing conditions that provide that a licence holder:

- should not perform a special procedure on a person who is under the influence of alcohol or drugs to such an extent that they are unable to understand the mandatory pre-procedure information;

²⁸⁶ RoP [para 56], 15 July 2015

²⁸⁷ RoP [para 396], 17 September 2015

- must go through a pre-procedure consultation with a user, and that will have to be recorded on the forms that the individual has to complete to show that that has been done.²⁸⁸

336. The Minister said that he was also minded to include, by way of mandatory licence conditions, a direct requirement for the individual themselves to confirm that they were not under the influence of alcohol or drugs before the procedure was undertaken. He noted his intention to use the mandatory premises approval conditions to make it clear that the premises themselves must include notices advertising that body piercing or tattooing will not be carried out on any person under the influence of alcohol or drugs.²⁸⁹

Mandatory vaccination of practitioners

337. The Committee also heard evidence suggesting that the mandatory vaccination of practitioners could be a requirement of being granted a licence. Sarah Calcott, representing the British Body Piercing Association (BBPA), referred to licensing conditions in place in London, under which authorities required proof that practitioners had received particular vaccinations, and said that the BBPA recommended that its members were vaccinated.²⁹⁰ Lee Clements added that the BTAF also recommended that tattoo artists were vaccinated against hepatitis B before being able to work in a studio.²⁹¹

Consulting on the licensing conditions

338. The Committee heard that consulting with the relevant industries would be key to developing effective licensing conditions. Julie Barratt told the Committee that it was important, when drawing up the licensing conditions, to involve both the enforcers and the industries to ensure that the conditions are appropriate. She also said that it would be important for the licensing conditions to be able to be amended in order to “keep up with changes in behaviour”.²⁹²

339. Whilst the BAcC expressed support for the acupuncture proposals in the Bill, it emphasised that the advantages of introducing these arrangements could be undermined unless suitable consultation procedures were put in place for future development of the licensing conditions. Its representatives

²⁸⁸ RoP [para 44], 21 October 2015

²⁸⁹ RoP [para 45], 21 October 2015

²⁹⁰ RoP [para 423], 17 September 2015

²⁹¹ RoP [para 425], 17 September 2015

²⁹² RoP [para 56], 15 July 2015

stressed the need to involve the professions when establishing licence requirements and highlighted the importance of ensuring that environmental health teams adopted a standardised approach across Wales.²⁹³

Inspection of premises/vehicles

340. Lee Clements told the Committee that inspection was an area in which he hoped the Bill would bring improvements, arguing that existing arrangements were insufficient:

“Quite often, even in my studio, we’ll go two years without seeing an environmental health officer. So, that needs to be looked at, you need to make sure that there are regular inspections and make sure that the standards are constantly high.”²⁹⁴

341. The need for inspectors to receive training and have a good knowledge and understanding of the procedure in question was raised in evidence. Dee Yeoman, who participated in the video of evidence, stated:

“Most of the inspectors, you know—no fault of their own—have no training in tattooing or piercing, and they don’t know what they’re looking for. So, that needs to be addressed.”²⁹⁵

The Committee’s view

342. The Committee is concerned about the lack of information currently available to the public regarding the extent to which a practitioner of any of the special procedures is adequately trained in complying with hygiene procedures, health and safety regulations, providing advice on aftercare or carrying out basic first aid. It therefore welcomes the provisions in this Bill to introduce a mandatory licensing scheme to deliver improvements in this area.

343. The Committee believes that undertaking these procedures in a safe and hygienic manner is crucial for ensuring that infection risk is minimised. It therefore welcomes the Minister’s assurance that the provisions in the Bill will result in the public being confident that licensed premises will be properly inspected, that staff will be trained in complying with hygiene procedures and providing advice on the procedures they offer and aftercare, and that both staff and premises will be fit for purpose.

²⁹³ PHB 15 British Acupuncture Council and RoP [para 346], 17 September 2015

²⁹⁴ RoP [para 385], 17 September 2015

²⁹⁵ RoP [para 184], 17 September 2015

Recommendation 5: The Committee recommends that the Minister for Health and Social Services ensure that the mandatory licensing scheme requires that any licence holder undertakes training on compliance with hygiene procedures, health and safety regulations, providing advice on aftercare, and carrying out basic first aid.

344. The Committee notes that, as licences to carry out special procedures expire after three years, inspections of premises or vehicles would need to occur as part of the process of re-applying, therefore ensuring that inspections are undertaken on a regular basis.

345. The Committee particularly welcomes the proposal to introduce the requirement for practitioners to hold a pre-procedure consultation with prospective clients to ensure that they are fully aware of any potential implications prior to undergoing any procedure. It has been concerned to hear about instances of people undergoing procedures whilst under the influence of drugs or alcohol and believes that a “cooling off” period between the consultation and carrying out the procedure will be a big step forward in avoiding people taking hasty decisions about getting a tattoo or a body piercing without being able to give informed consent.

346. The Committee notes the further safeguards suggested by the Minister that could be put in place to ensure that licence holders do not undertake procedures on individuals who may be intoxicated, including:

- creating a licensing condition preventing the licence holder from performing a procedure on a person who may be under the influence of drugs or alcohol;
- creating a licensing condition whereby the individual undergoing the procedure would need to confirm that they were not under the influence.

347. The Committee notes that inserting a needle into someone would normally be a criminal offence such as assault, actual bodily harm or grievous bodily harm, depending on the seriousness of the injuries caused, but that an exception is made for procedures such as tattooing if the practitioner has an honest belief that the customer is consenting to having a tattoo.

348. A majority of the Committee’s members believed that rather than using licensing conditions to address the problem of special procedures being undertaken on individuals who may be intoxicated or otherwise unable to give consent to the procedure, consideration should be given to creating an

offence on the face of the Bill for a practitioner to undertake such procedures in such circumstances. Kirsty Williams AM stated her objection to this proposal, preferring that, as a condition of being granted a licence, the holder would:

- need to undertake all reasonable attempts to confirm that a person undergoing a procedure is not under the influence of drugs or alcohol;
- require an individual undergoing a procedure to provide signed consent to confirm they are not under the influence of drugs or alcohol.

Recommendation 6: The majority of the Committee’s members recommend that the Minister for Health and Social Services explore whether it is appropriate to create a criminal offence on the face of the Bill in relation to undertaking a special procedure on an individual who is intoxicated or otherwise unable to give consent to the procedure.

Enforcement

349. In its written evidence to the Committee, Directors of Public Protection Wales said that the licensing provisions in the Bill would assist local government officers in protecting the public. It believed that the proposed licensing system would:

- enable local authorities to undertake public protection duties more effectively and more readily;
- give enhanced enforcement powers and greater flexibility to deal with public health risks in relation to both those that operate legitimately and those that choose not to.²⁹⁶

350. Lee Clements told the Committee that enforcement was an area in which he hoped the Bill would deliver improvement:

“Currently, the environmental health officers I have spoken to find it very difficult to actually bring anything to court in the first place. So, I’m hoping that, with the adequate enforcement, they will be able to prosecute people for non-compliance with the licence.”²⁹⁷

²⁹⁶ PHB 04 Directors of Public Protection Wales

²⁹⁷ RoP [para 379], 17 September 2015

Funding

351. The Minister told the Committee that the provision in the Bill for local authorities to charge for licences would provide the resources to those authorities to enforce the licensing requirements:

“In the case of special procedures, we are replacing an outdated system, where there was a one-off registration fee that lasted for a lifetime, with a modernised licensing system that will ensure that a cycle of funding is available to local authorities to support them in the discharge of these duties. Local authorities will be able to charge fees to recover the costs of licensing, approval and registration procedures, and to cover the costs of running and enforcing the schemes for successful applications. I know there’s a balance to be struck here again between wanting to make sure that we have an income stream for local authorities to do this important job without making the fees of such a level that they become a burden on legitimate businesses. But we are having to make sure that local authorities get the resources they need to do this very important job, and the Bill allows that to happen.”²⁹⁸

352. In response to a question on whether local authorities would be required to use the money raised by issuing licences for enforcement purposes or other purposes specifically relating to this legislation, the Minister said:

“I’m just taking advice, but I think the answer is that we’ve constructed the Bill in such a way that the fee income is dedicated to the purpose for which the income is being collected.”²⁹⁹

353. In its consideration of the financial implications of this Bill, the Finance Committee questioned the Minister on concerns that the resources required to enforce the special procedures register may divert funding away from other priority services. In response, the Minister said:

“This is one of the places where we will need to update the information provided in the EM because—and this is all very detailed—when we were producing the original explanatory memorandum, the case of *Hemming v. Westminster City Council*, which is the test case in this field [...] had gone to the appeal court,

²⁹⁸ RoP [para 68], 21 October 2015

²⁹⁹ RoP [para 71], 21 October 2015

and the appeal court had concluded that it was not legal for a local authority to recover, in the fee that the registrant was required to pay, the cost of enforcing those people who did not register. So, the costs that we set out here are assumed on that basis: that local authorities would not be able to charge fees that would cover the cost of enforcement. That case has now gone to the Supreme Court, and the Supreme Court has overturned the position set out in the Court of Appeal, and the position, which is now the final position, is that local authorities can include in the cost of registering an element to cover their costs of enforcing the register.”³⁰⁰

The Committee’s view

354. Whilst the Committee welcomes the provisions in this Bill to introduce a mandatory licensing scheme, it believes that improvements will not be made unless proper enforcement follows. The Committee is very aware of the financial constraints faced by local authorities and the pressure on them to deliver services with limited resources. It therefore welcomes local authorities’ ability to charge a fee for issuing licences and the Minister’s assurance that local authorities would be able to use the income from application fees for enforcement purposes or other purposes dedicated to the special procedures aspects of this Bill. The Committee would, however, welcome clarification from the Minister on his statement, which is quoted in paragraph 352 above, as to whether the Bill would require local authorities to use the income generated from application fees for enforcement purposes or other purposes related to this legislation.

355. The Committee welcomes and re-iterates the call made by the Finance Committee in its report³⁰¹ for the Minister to clarify the position in relation to the *Hemming v Westminster City Council* case. It would be helpful if the Minister could provide this clarification during the Plenary debate on the general principles of the Bill.

Level of fine imposed

356. The Bill states that a person who commits an offence relating to the provisions around special procedures would be liable to a fine not exceeding level 3 on the standard scale (currently set at £1,000). A number of stakeholders, including local authorities, tattoo artists and the British Body

³⁰⁰ National Assembly for Wales, Finance Committee, Record of Proceedings [paras 141 and 143], 15 July 2015

³⁰¹ National Assembly for Wales, Finance Committee, [Report on the Public Health \(Wales\) Bill](#), September 2015

Piercing Association, argued that this level of fine was too low and would not act as a meaningful deterrent. The City of Cardiff Council in its response suggested that the £20,000 fine for non-compliance with sunbed legislation would be a more appropriate sum; those representing the tattoo and body piercing industries noted that the level of the fine needed to be higher, between £5,000 to £10,000, as the “occasional £1,000 fine every now and again” would not serve as a sufficient deterrent.³⁰²

357. In response to questions from Members, the Minister committed to bring forward an amendment at Stage 2 which would impose an unlimited fine on anyone breaching the restrictions in this Bill relating to intimate piercing (details on the Committee’s consideration of provisions relating to intimate piercing are set out in a separate chapter). He said that he would be open to reconsidering the level of fine imposed for breaching restrictions relating to special procedures should the evidence received lead the Committee to recommend that a higher fine be appropriate.

The Committee’s view

358. Undertaking special procedures such as those identified by this Bill in an unsafe manner has the potential to cause substantial harm to public health and must not be tolerated. The Committee therefore believes that fines imposed on anyone found acting illegally should be sufficiently high to act as a meaningful deterrent.

359. The evidence from both the tattooing and body piercing industries was clear – if a person can earn £1,000 from undertaking special procedures in one week, then a fine of the same level would not be a sufficient deterrent to prevent them from acting illegally. The Committee believes that the level of fine should reflect the seriousness of non-compliance and that consideration should be given to aligning it more closely with the penalties provided in legislation for other similar offences, such as in the Sunbeds (Regulation) Act 2010.

Recommendation 7: The Committee recommends that the Minister for Health and Social Services amend the Bill to increase the level of fine imposed on anyone committing an offence under section 67 of the Bill (in relation to special procedures) to a Level 5 fine.

³⁰² RoP [paras 447 and 448], 17 September 2015

7. Part 4 – Intimate piercing

360. Part 4 of the Bill contains provisions relating to intimate piercing. The EM states that the purpose of these provisions is to:

“protect children and young people from the potential health harms which can be caused by an intimate piercing, and to avoid circumstances where children and young people are placed in a potentially vulnerable situation”.³⁰³

361. The Bill sets out to achieve this by introducing a prohibition on intimate piercing on anyone under the age of 16. Intimate body parts are defined in section 79 of the Bill as: the anus; breast (including the nipple and areola); buttock; natal cleft; penis (including the foreskin); perineum; pubic mound; scrotum; and vulva.

362. The EM states that provisions in the Bill would not affect the ability of practitioners who currently choose not to perform intimate piercings on people under the age of 18, from maintaining their own policies at a higher age limit.³⁰⁴ The EM also specifies that a practitioner prosecuted for performing the procedure on a person under 16 would not be able to use the defences that:

- the person had given consent;
- the person’s parent or guardian had given consent.³⁰⁵

363. Local authorities would be required to enforce the provisions in the Bill, including bringing forward prosecutions and investigating complaints.

364. In oral evidence, the Minister explained his reasons for including these provisions in the Bill:

“In the evidence that we’ve collected, I think it was 8.5 per cent of all the piercings of people under the age of 16 fell into that category [intimate cosmetic piercings]. I think that does give us some significant evidence of the need to act.”³⁰⁶

365. Dr Quentin Sandifer, representing Public Health Wales, referred to a recent “look-back” exercise undertaken in the Gwent area, which identified

³⁰³ Explanatory Memorandum, para 141

³⁰⁴ Explanatory Memorandum, para 143

³⁰⁵ Explanatory Memorandum, para 145

³⁰⁶ RoP [para 82], 1 July 2015

that a number of individuals under the age of 16 had undergone an intimate piercing:

“In the recent Gwent incident, I was shocked to hear that six individuals below the age of 16 were identified in our look-back exercise. One as young as 13 had a nipple piercing undertaken by an adult male. Now, I do have deep concerns, quite frankly, about a current system that potentially allows for that to happen.”³⁰⁷

366. There was general support for the proposal to introduce a minimum age requirement for anyone undergoing an intimate piercing among those who gave evidence to the Committee. Furthermore, 79.5 per cent of those who responded to the Committee’s public survey believed that an age restriction on intimate body piercing was required.³⁰⁸

Level of age restriction

367. Despite the general consensus that an age restriction was required, witnesses offered differing views as to whether such a restriction should be set at 16 or 18 years of age. Dr Sandifer told the Committee that 16 had been identified in line with the age of consent to sexual intercourse, which he believed to be a “perfectly reasonable position to take”.³⁰⁹

368. In its written evidence, the Chartered Institute of Environmental Health (CIEH) suggested that 18 would be a more appropriate age below which to restrict intimate piercings. It did not believe that 16 was the appropriate age as a person of that age may not be sufficiently mature to make such a decision or to commit to the necessary aftercare required. It added that the risk of damage to skin would be greater at 16 than 18 as the individual would still be growing. It also suggested that having an age restriction consistent with tattooing would avoid any potential confusion that could arise from having different arrangements in place for different procedures.³¹⁰

369. Directors of Public Protection Wales endorsed the proposal to set the minimum age at 16, but accepted the rationale for it to be 18:

“We do agree with the specification of a minimum age, and, in our submission, we have endorsed the age of 16, although, having seen the Chartered Institute for Environmental Health evidence [...] I do

³⁰⁷ RoP [para 75], 9 July 2015

³⁰⁸ National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

³⁰⁹ RoP [para 77], 9 July 2015

³¹⁰ PHB 01 Chartered Institute of Environmental Health

think that that is quite a well-made case, in terms of consistency with tattooing [...] And being consistent with tattooing, it would assist, I think, from a regulatory perspective, if there was the same age limit, and, certainly, for practitioners, that would provide a bit of clarity as well.”³¹¹

370. In its written evidence, the British Body Piercing Association (BBPA) said it believed that 18 was the appropriate age to set restrictions in relation to intimate piercing, but also stated that anyone undertaking such procedures should be properly trained to do so:

“Female nipples should be considered for piercing over 18 only. However anything below the waist I believe should only be performed by someone who has adequate knowledge of the anatomy of the genitals and has had further training within this specific area and should not be performed on anyone under the age of 18.”³¹²

371. In response to the suggestion that the proposed age restriction should be set at the higher age of 18, the Minister explained that, in proposing the age of 16, he had given consideration to balancing the need to provide sufficient protection to children and young people alongside recognising their rights as individuals:

“At what point do you think you strike the balance between protecting a child or young person, without disproportionately trespassing on those rights to make decisions for themselves? Now, at the age of 16, you can leave school, you can get married and you can have sexual intercourse by consent. You are in charge of your life in a whole range of very, very important areas. I understand completely that, you know, there is a debate to be had, but, having thought it through and seen the advice that I’ve seen, I came to the conclusion that, for this purpose, 16 was the right balance to strike between making sure that children are properly protected, but recognising that, by the time you come to the age of 16, there are aspects of your life over which you are entitled to have direct control.”³¹³

³¹¹ RoP [para 179], 15 July 2015

³¹² PHB 08 British Body Piercing Association

³¹³ RoP [paras 47 and 48], 21 October 2015

Proof of age

372. Stakeholders told the Committee that including a requirement for anyone seeking to have an intimate piercing undertaken to provide proof of age would strengthen these provisions.³¹⁴ In their written evidence, the Directors of Public Health representing Health Boards said that they supported mandatory proof of age for any client undergoing an intimate piercing.³¹⁵ This call was echoed by the Welsh NHS Confederation and Public Health Wales.³¹⁶

The Committee's view

373. The Committee is concerned to learn of incidences of intimate piercings being undertaken on young people under the age of 16, and welcomes the proposals in this Bill to help prevent this. It notes the overwhelming support from witnesses for the proposal to legislate in this area.

374. The Committee fully supports the introduction of a minimum age for intimate piercings and acknowledges the arguments for setting the restriction at either 16 or 18. On balance, it accepts the Minister's rationale for choosing 16 as the minimum age, given that it would be consistent with the age of consent for sexual intercourse and the need to consider the rights of young people. Nevertheless, it believes that the ability of practitioners to choose not to undertake procedures on anyone under the age of 18 is important and welcomes the fact that the Bill would not prevent this from continuing.

375. Whilst supporting the introduction of an age restriction for intimate piercings, the Committee acknowledges that the provisions could be strengthened. It therefore believes that a requirement for practitioners to seek proof of age from customers before undertaking an intimate piercing would be a beneficial addition to the Bill and would act as a further safeguard to ensure the protection of young people.

Recommendation 8: The Committee recommends that the Minister for Health and Social Services amend the Bill to strengthen and expand the provisions around seeking proof of age from individuals wishing to have an intimate piercing undertaken. It recommends that the Minister

³¹⁴ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales, PHB 05 The Welsh NHS Confederation, PHB 30 Cardiff and Vale University Health Board, PHB 78 The Association of Directors of Public Health and RoP [paras 79 and 197], 9 July 2015

³¹⁵ PHB 78 The Association of Directors of Public Health

³¹⁶ PHB 03 Public Health Wales and PHB 05 The Welsh NHS Confederation

expand upon the defence available under section 78 of the Bill, so that it mirrors the defence in section 146 of the Licensing Act 2003 (i.e. the defence relating to selling alcohol to under 18s), which sets out the main elements of the defence, such as:

- believing that the individual is over the relevant age, and**
- taking all reasonable steps to establish the individual's age (such as asking for evidence of age, and that evidence being convincing to a reasonable person).**

Tongue piercing

376. The Committee heard considerable evidence about the potential for someone to experience harm as a result of undergoing a tongue-piercing procedure. Many witnesses suggested that, owing to the nature of a tongue piercing and the increased risk of experiencing harm from this, the procedure would warrant an age restriction. Dr Sandifer told the Committee:

“I think tongue piercing in particular would be a valuable additional explicit body part if you like—the tongue itself—to add to this on the grounds, I think, that it is known to present a high risk of infection and other complications, and arguably could be perceived in a young person to be encouraging sexualisation.”³¹⁷

377. Dr Gill Richardson, Director of Public Health at Aneurin Bevan University Health Board, explained the potential impact of a tongue piercing going wrong:

“As a former GP, there's no way that I would do that [pierce a tongue]; there's no way that most dentists would pierce a tongue, and they have four years of specialising in head and neck anatomy. They would not do it without a resuscitation trolley by the side, because of the risk of major haemorrhage, the risk of infection, or anaphylaxis. It doesn't bear thinking about. They pick up a lot of the side effects, in fact, our dentists, because when tongues swell, the piercing becomes embedded and it's very difficult to remove. So, our dentists see them when they need removing.”³¹⁸

378. The Minister told the Committee that having heard the evidence presented, should the Bill proceed to amending stages, he intended to bring forward amendments during Stage 2 to add tongue piercing to those

³¹⁷ RoP [para 75], 9 July 2015

³¹⁸ RoP [para 169], 9 July 2015

procedures defined as intimate piercings, thereby imposing a minimum age restriction for that procedure. The Minister confirmed this to the Committee in his letter of 31 October.³¹⁹

The Committee's view

379. The Committee notes the worrying evidence received on the potential harm that could occur as a result of tongue piercing. It welcomes the Minister's commitment to bringing forward an amendment to introduce a minimum age restriction should this Bill proceed to Stage 2.

Recommendation 9: The Committee recommends that the Minister for Health and Social Services proceed with his stated intention of amending the Bill to add tongue piercing to the list of procedures prohibited to be undertaken on anyone under the age of 16.

Female Genital Mutilation

380. The social enterprise Under Age Sales Ltd noted that the Bill should make reference to the *Female Genital Mutilation Act 2003*. It stated that the piercing of the labia majora, labia minora, or clitoris would constitute Female Genital Mutilation (FGM) and, therefore, be an offence under the 2003 Act. Whilst it recognised that the definition of 'vulva' in section 79 of the Bill would cover a broader intimate area than the narrower definition of FGM, it still argued that these serious offences should be reflected on its face. It therefore recommended an additional line be added to section 78 (on offences related to intimate piercing) to state: "this section does not apply to any offences that may be committed under either the *Sexual Offences Act 2003* or the *Female Genital Mutilation Act 2003*".³²⁰

381. The Royal College of Midwives (RCM) made a similar point:

"There is a need to exclude genital piercing from this and future lists as a procedure that should be licensed because it is illegal under the Female Genital Mutilation Act as Type 4 FGM and cannot be carried out on a girl under the age of 18 in England and Wales."³²¹

382. In response to these concerns, the Minister said:

"I am very sure in my mind, Chair, that these are very different matters and that there is no overlap directly between them, but I've

³¹⁹ PHB AI 09 Minister for Health and Social Services - 31 October 2015

³²⁰ PHB 13 Under Age Sales Ltd

³²¹ PHB 75 Royal College of Midwives

seen that not everybody has been as clear about the distinction as maybe we would have hoped they would be".³²²

383. He confirmed that, should the Bill proceed to the amending stages, the revised EM published after Stage 2 would clarify the distinction between the procedures provided for in this Bill and matters included in the *Female Genital Mutilation Act 2003*.

The Committee's view

384. The Committee acknowledges the difference between the procedures provided for in this Bill and offences covered by the FGM Act. It welcomes the Minister's commitment to provide clarity on this in the revised EM prior to Stage 3. It believes that this will be an important additional safeguard to avoid confusion.

Recommendation 10: The Committee recommends that the Minister for Health and Social Services proceed with his stated intention of providing clarity about the differences between the procedures provided for in this Bill and offences covered by the Female Genital Mutilation Act 2003 in a revised Explanatory Memorandum.

³²² RoP [para 79], 21 October 2015

8. Part 5 – Pharmaceutical services

385. Part 5 of the Bill seeks to change the way Health Boards make decisions about pharmaceutical services by making sure these are based on assessments of pharmaceutical need in their areas. The aim of this Part is to encourage pharmacies to adapt and expand their services beyond their traditional dispensing role, and in response to local needs.

386. Section 89 of the Bill requires each Health Board in Wales to prepare and publish a pharmaceutical needs assessment (“PNA”), and to keep these assessments under review. The Bill requires the Welsh Ministers to make regulations that specify:

- the date by which a Health Board must prepare and publish its first PNA;
- the circumstances in which a Health Board should review or revise its assessment (and may refer to the timescales within which these reviews and revisions should take place);
- the way in which PNAs should be published.

387. This section also states that the regulations may make other provisions about the carrying out of assessments, including:

- their contents;
- the consultation surrounding their development;
- the extent to which they should take account of future needs and other matters.

388. Section 90 of the Bill amends the current “control of entry” test so that decisions on applications to join a Health Board’s pharmaceutical list will be based on whether the application meets the need(s) identified in the local PNA. The current test focuses only on whether there is adequate access to pharmacies for the dispensing of prescriptions. It does not take into account the range of additional services that community pharmacy can provide. The EM states that the current test means:

“pharmacies wishing to offer additional services are unable to enter the market, because the market entry test fails to recognise the

additional services they wish to offer and whether those services would support addressing local health needs”.³²³

389. Section 90 also makes provision for regulations to be made detailing the procedure Health Boards must follow when dealing with applications and the matters they must take into account. Where a PNA identifies that particular services should be provided within a locality, but existing pharmacies do not apply to provide those services, the Health Board will be able to invite other providers to apply to join the pharmaceutical list in order to provide those services. They will also be able to remove pharmacists from their lists following serious and/or persistent breaches of terms and conditions of service.

390. The evidence gathered on pharmaceutical services was not extensive. The majority of those who did comment on this Part expressed their support for its provisions.³²⁴ Stakeholders noted that the Bill would:

- require Health Boards to take a more integrated approach to planning pharmaceutical services;³²⁵
- increase NHS capacity and service accessibility by expanding the provision of additional pharmacy services such as emergency contraception, flu vaccinations and smoking cessation;³²⁶
- drive pharmacies to be more responsive to the needs of their local populations.³²⁷

Pharmaceutical needs assessments

391. The majority of stakeholders who commented on this aspect of the Bill supported the introduction of PNAs. The Company Chemists Association noted that PNAs have proven to be a highly effective method for commissioning bodies in England to identify the needs of their population and to deliver appropriate services to address those needs.³²⁸ Public Health

³²³ Explanatory Memorandum, para 173

³²⁴ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales, PHB 03 Public Health Wales, PHB 05 Welsh NHS Confederation, PHB 27 Welsh Pharmaceutical Committee, PHB 30 Cardiff and Vale University Health Board, PHB 35 Royal College of Nursing, PHB 38 Company Chemists' Association, PHB 40 Royal College of General Practitioners, PHB 42 Age Cymru, PHB 78 The Association of Directors of Public Health and PHB 84 Royal Pharmaceutical Society

³²⁵ PHB 03 Public Health Wales

³²⁶ PHB 03 Public Health Wales and RoP [para 155], 9 July 2015

³²⁷ PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales

³²⁸ PHB 38 Company Chemists Association

Wales welcomed what it described as the potential for Health Boards to use PNAs to improve their planning of integrated services.³²⁹

Avoiding duplication

392. Several stakeholders noted that there was a need to avoid duplication with existing health assessments when developing PNAs.³³⁰ Healthcare Inspectorate Wales emphasised that PNAs should complement the local well-being assessments required under the *Well-being of Future Generations (Wales) Act 2015*.³³¹ Public Health Wales suggested that alignment could be achieved by ensuring that both assessments were conducted at the same time.³³² The Welsh NHS Confederation noted that PNAs should be “tightly integrated into the Health Board Integrated Medium Term Plan (IMPT) cycle”.³³³

393. The Welsh Pharmaceutical Committee warned that the amount of work involved in writing and reviewing a high quality, standalone PNA would be significant and costly. It therefore advocated linking PNAs up with other assessments:

“A PNA integrated into other Health Board commissioning plans, needs assessments or publications may prove to be a more cost-effective as well as a more integrated option for Health Board primary care services and would prevent the PNA existing in a silo.”³³⁴

394. Other stakeholders noted that the term “pharmaceutical needs assessment” should be more clearly defined prior to the commencement of Part 5 of the Bill.³³⁵ They stated that this was essential for the adoption of a systematic, consistent and equitable approach across Health Boards. Given the movement of the population across Health Board and national boundaries, the Company Chemists Association stressed the need for PNAs to take into account the provision of services in neighbouring areas.³³⁶ Powys Teaching Health Board highlighted the importance of defining the role of

³²⁹ PHB 03 Public Health Wales

³³⁰ PHB 03 Public Health Wales, PHB 05 Welsh NHS Confederation, PHB 27 Welsh Pharmaceutical Committee, PHB 85 Celesio UK and Lloyds Pharmacy and PHB 103 Healthcare Inspectorate Wales

³³¹ PHB 103 Healthcare Inspectorate Wales

³³² PHB 03 Public Health Wales

³³³ PHB 05 Welsh NHS Confederation

³³⁴ PHB 27 Welsh Pharmaceutical Committee

³³⁵ PHB 83 The Urology Trade Association and PHB 86 Powys Teaching Health Board

³³⁶ PHB 38 Company Chemists Association

Public Health Wales in supporting Health Boards to meet any future requirements in relation to PNAs.³³⁷

395. The EM states that accompanying regulations would ensure that the timing of PNAs would be arranged to coincide with the frequency of wider need assessments, in particular local well-being assessments.³³⁸

Content and consistency

396. Several stakeholders emphasised the need to provide detailed guidance, or even a national template, for Health Boards to follow when producing their PNAs.³³⁹ A number of respondents to the Committee's consultation warned of the need to learn lessons from the introduction of PNAs in England. They noted that the lack of a national template there had resulted in:

- inconsistency in the approach adopted by Primary Care Trusts to assessments;
- legal challenges against decisions made using PNAs on the grounds of poor-quality assessments.³⁴⁰

397. Public Health Wales and the Royal Pharmaceutical Society mentioned that social care needs should be included alongside health needs in PNAs.³⁴¹ Public Health Wales stated:

“The pharmaceutical needs of individuals cared for by social services, including ‘at risk’ children and adults, and older people should be included as part of the health boards’ assessment of pharmaceutical needs.”³⁴²

398. Furthermore, the Federation of Small Businesses Wales suggested that an economic impact indicator should be used to inform consideration of pharmaceutical needs in an area and decisions on where to locate pharmacies. It argued that this was particularly important given the clear correlation between local economies and health inequalities.³⁴³

³³⁷ PHB 86 Powys Teaching Health Board

³³⁸ Explanatory Memorandum, para 179

³³⁹ PHB 03 Public Health Wales, PHB 27 Welsh Pharmaceutical Committee and PHB 85 Celesio UK and Lloyds Pharmacy

³⁴⁰ PHB 03 Public Health Wales and PHB 27 Welsh Pharmaceutical Committee

³⁴¹ PHB 03 Public Health Wales and PHB 84 Royal Pharmaceutical Society

³⁴² PHB 03 Public Health Wales

³⁴³ PHB 91 Federation of Small Businesses Wales

Review, revision and awareness

399. The Company Chemists Association and Age Cymru emphasised the importance of keeping PNAs under review, particularly the extent to which they succeed in their aim of encouraging existing pharmacies to expand their services to meet local needs.³⁴⁴ Public Health Wales advised that PNAs should be updated every three years as a minimum, in line with local well-being needs assessments.³⁴⁵ Some stakeholders also highlighted the importance of consulting relevant stakeholders in the process of creating and reviewing PNAs.³⁴⁶

400. A number of stakeholders highlighted the need to raise awareness of pharmacy services more generally.³⁴⁷ The results of the Committee's public survey on the Bill suggested that more needed to be done to translate awareness of pharmacy services into use of pharmacy services. While 61 per cent of survey respondents were aware of the range of extra healthcare services that community pharmacies can provide, only 28 per cent had used them.³⁴⁸

The Committee's view

401. The Committee's interest in pharmaceutical services is well documented by its 2011-12 policy inquiry into the contribution of community pharmacy to health services in Wales,³⁴⁹ and its 2014 follow-up work to measure progress on the implementation of its recommendations.³⁵⁰ The Committee welcomes the provisions made in this Bill to introduce PNAs and believes that this will bring the whole community pharmacy network up to the standard of the best.

402. The Committee endorses the calls made to ensure that duplication of effort is avoided when producing PNAs and that they integrate well with other needs assessments, most notably the local well-being assessments required by the *Well-being of Future Generations (Wales) Act 2015*. Furthermore, the Committee agrees that the regulations made under this Bill

³⁴⁴ PHB 38 Company Chemists Association and PHB 42 Age Cymru

³⁴⁵ PHB 03 Public Health Wales

³⁴⁶ PHB 83 The Urology Trade Association and PHB 85 Celesio UK and Lloyds Pharmacy

³⁴⁷ PHB 38 Company Chemists Association, PHB 42 Age Cymru and PHB 78 The Association of Directors of Public Health

³⁴⁸ National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

³⁴⁹ National Assembly for Wales, Health and Social Care Committee, [The contribution of community pharmacy to health services in Wales](#), May 2012

³⁵⁰ National Assembly for Wales, Health and Social Care Committee, [The contribution of community pharmacy to health services in Wales: follow up inquiry](#), November 2014

should seek to ensure that consistency is achieved across all Health Boards' PNAs.

Recommendation 11: The Committee recommends that the Minister for Health and Social Services issue a national pharmaceutical needs assessment (PNA) template to avoid the issues of variability reported in England.

403. While acknowledging the important role PNAs have to play in broadening the services available at local pharmacies, the Committee believes that PNAs alone will not increase the uptake of such services. As the Committee has previously noted, more still needs to be done to increase awareness of the breadth of services available in pharmacies, and to encourage people to use them.

Pharmaceutical lists

404. Under current arrangements anyone wishing to provide NHS pharmaceutical or dispensing services must apply to the relevant Health Board for inclusion on its pharmaceutical list. Applications are decided by applying a control of entry test which focuses only on whether there is adequate access to pharmacies for the dispensing of prescriptions.

405. Section 90 of the Bill seeks to amend this to ensure that a Health Board, in assessing applications, takes into account the range of additional services that community pharmacy can provide – e.g. palliative care support, smoking cessation, and needle exchange services – alongside the local need identified in its PNA. It also makes provision for Health Boards to implement improvement measures where there is a lack of quality or consistent delivery, including:

- taking action against particular pharmacies for persistent breaches of terms and conditions of service;
- inviting additional pharmacies to apply to provide particular services.

Impact on dispensing doctors

406. BMA Cymru Wales and the Dispensing Doctors Association highlighted concerns about the Bill's impact on entry and exit arrangements for dispensing doctors. In its written evidence to the Committee, BMA Cymru Wales noted:

“We are concerned about the experience in England where the interpretation of a similar requirement for pharmaceutical needs

assessments has led to the withdrawal of dispensing rights for some GP practices, with potentially catastrophic impact on some rural communities if this were to be repeated in Wales”.³⁵¹

407. The Dispensing Doctors Association warned that the introduction of PNAs as a basis on which to gain entry to pharmaceutical lists should not destabilise the provision of dispensing doctor practices and GP services in remote and rural areas of Wales:

“The proposals must not discriminate against the provision of pharmaceutical services by dispensing practices. Practices dispense in remote and rural areas where a community pharmacy is not economically viable. The Cost of Service Inquiry into dispensing practices, published in 2010, demonstrates that dispensing income subsidises the provision of primary medical services in rural practice. It would be most unfortunate for rural communities if the advent of PNAs caused the closure of rural general practices”.³⁵²

408. BMA Cymru Wales stated that it would welcome the exclusion of “controlled localities”³⁵³ from the Bill’s provisions so that general practices and general medical services (“GMS”) in rural areas are not affected detrimentally.³⁵⁴ Failing a total exclusion it noted that, as a minimum, GMS that are similar in nature to additional pharmaceutical services should be considered as part of any PNA, and all PNAs should include a risk assessment to existing GMS provision of any new approvals to provide pharmaceutical services:

“It must be recognised that the proposals relating to pharmaceutical services in the Bill have the potential to seriously undermine public health in Wales if (as they have in England) they negatively impact on the provision of GMS GP services in rural areas and lead to the closure of existing GP practices.”³⁵⁵

409. The Minister noted in his evidence to the Committee that he recognised the concerns of dispensing doctors. He also acknowledged that lessons needed to be learned from England’s experiences of PNAs and some of their unintended consequences. He went on to note:

³⁵¹ PHB 76 BMA Cymru Wales

³⁵² PHB 20 Dispensing Doctors Association

³⁵³ A controlled locality is an area that has been designated as being ‘rural in character’ such that, in certain circumstances, doctors can provide pharmaceutical services to certain of their eligible patients (if those doctors are included in a dispensing doctor list)

³⁵⁴ RoP [paras 72–77], 17 September 2015

³⁵⁵ PHB 76 BMA Cymru Wales

“I’ve done two things to try and meet the genuine concerns that you’ve identified. First of all, I’ve made it clear that we wish to invite GPC [General Practitioners Committee] Wales onto the group that will design the detail of how pharmaceutical needs assessments will be conducted in Wales. So, they will have a seat at the table to make sure that those concerns are actively attended to, and I’ve made it clear to GPC Wales—and I’m very happy to put it on the record again this morning—that I expect pharmaceutical needs assessments to reflect consideration of the contribution of all providers in addressing local health needs. In other words, the contribution of dispensing doctors will be explicitly recognised as part of the pharmaceutical needs assessment and not left to the end, where they could be a casualty of the wider strategy.”³⁵⁶

Timescales

410. Hywel Dda University Health Board and the Company Chemists Association emphasised the need to be clear about the timescales within which decisions relating to pharmaceutical services should be made.³⁵⁷

411. Answering a question on how the Bill would address the length of time it can take to determine a new application for a pharmacy, the Minister told the Committee:

“The current system, I think, too often leads to conflicting and contested relationships between potential new entrants and the local health board, with protracted legal disputes between the two. My ambition is that with a new, planned approach of this sort it will be much clearer to everybody what it is that the health board is looking to support, that it will be able to identify the potential suppliers of those services, work positively with them, and that we will see fewer of those disputatious instances, and that there will be a swifter way of making sure that we can maximise the contribution of community pharmacy.”³⁵⁸

412. When asked about reported delays to assessing a request to relocate a pharmacy, the Minister agreed to look at timescales and noted:

“I think the Bill will address that very directly, actually, because the problem with the current arrangement is that the grounds on which

³⁵⁶ RoP [para 31], 21 October 2015

³⁵⁷ PHB 44 Hywel Dda University Health Board and PHB 38 Company Chemists Association

³⁵⁸ RoP [para 60], 1 July 2015

the local health board is able to agree something are so narrow that they end up having to find ways round it [...] This will be a much more straightforward way for the local health board to be able to say, 'That outlet is meeting a pharmaceutical need in that community'. Geography is not the issue."³⁵⁹

Breach notices

413. The Bill makes provision for breach notices to be issued. The Welsh Pharmaceutical Committee emphasised the importance of:

- Health Boards' being required to make reasonable attempts to work with the pharmacy owner to remedy issues before a notice is issued;
- Health Boards' turning to breach notices only as a last resort;
- establishing an appeals process for any owner who believes a notice has been applied unfairly.³⁶⁰

414. Celesio UK and Lloyds Pharmacy highlighted that Health Boards should take into account the influence of external factors that could lead to a breach occurring, including:

- inconsistent marketing and commissioning by the Health Boards themselves;
- poor engagement of other professionals in delivering, signposting and advocating services;
- lack of access to necessary training for pharmacists and pharmacy staff;
- lack of appropriate fees for the delivery of services.³⁶¹

415. The Welsh Pharmaceutical Committee and the Company Chemists Association also argued that pharmacists who chose not to provide certain services, for example emergency hormonal contraception, on the grounds of conscientious objection should not be penalised.³⁶² However the Company Chemists Association supported the ability of a Health Board to remove a provider from its pharmaceutical list if that provider failed consistently to offer services specified in the PNA.³⁶³

³⁵⁹ RoP [para 63], 1 July 2015

³⁶⁰ PHB 27 Welsh Pharmaceutical Committee

³⁶¹ PHB 85 Celesio UK and Lloyds Pharmacy

³⁶² PHB 27 Welsh Pharmaceutical Committee and PHB 38 Company Chemists Association

³⁶³ PHB 38 Company Chemists Association

416. The Minister told the Committee:

“The new rule book will allow them [Health Boards], first of all, to go to the existing provider and see whether they are prepared to add to the range of services that they provide and if they are not in a position to do that, to allow new entrants and even to canvass for new entrants to come in to provide that wider range of pharmaceutical services to meet the needs of the local population.”³⁶⁴

417. The EM states that the exit regime provided for by the Bill would enable graduated actions to be taken to deal with those providers who are failing to meet their terms of service obligations. It notes that the Welsh Ministers would have the power to set out in regulations the grounds or circumstances in which a Health Board may remove a pharmacist or premises from a pharmaceutical list, and that these regulations would set out:

- that a Health Board will be able to remove a pharmacy or premises from the pharmaceutical list in cases where local resolution has failed and where a pharmacist has failed to comply with the notices issued setting out what actions are needed;
- that a Health Board is under a duty to notify a pharmacist about its intention to remove them from its list and the reason for the intended removal, before a decision to remove is made;
- that a pharmacist will be granted the right to make representations to the Health Board before a decision is made;
- a right of appeal to the Welsh Ministers against a decision of a Health Board to remove a pharmacist or a premises from a pharmaceutical list.³⁶⁵

The Committee's view

418. The Committee notes the concerns raised by some witnesses about the impact the provisions in this Part of the Bill could have on dispensing doctors. It also welcomes the Minister's assurances that he has sought to address these concerns by:

- inviting the General Practitioners Committee Wales to participate in the group that will design how PNAs will be conducted in Wales;

³⁶⁴ RoP [para 50], 1 July 2015

³⁶⁵ Explanatory Memorandum, paras 182 and 183

- making it clear that he expects the contribution of dispensing doctors to be explicitly recognised as part of the assessment process.

Recommendation 12: The Committee recommends that the Minister for Health and Social Services, when making regulations about pharmaceutical needs assessments under section 89 of the Bill, require Health Boards to give consideration to the impact any such assessment may have on GP services in the local area.

419. The Committee welcomes the provisions included within the Bill to grant access to new entrants where gaps in service provision are identified. It also welcomes the new arrangements that allow Health Boards to remove from the pharmaceutical list those providers who fail to meet their terms of service obligations. The Committee notes the need highlighted by some stakeholders to take into account factors that may impact on a provider's ability to deliver a service.

420. The Committee welcomes the Minister's assurances that the provisions on the face of the Bill should improve the delays associated with determining applications for entry to the list and granting permission or otherwise for relocating within the same area.

Recommendation 13: The Committee recommends that the Minister for Health and Social Services, when making regulations and guidance under Part 5 (Pharmaceutical Services) of the Bill, require a simplified process for relocating a pharmacy within an area. Such regulations or guidance should also specify prescribed timescales for the determining of all applications, including relocations.

Welsh language services

421. The Royal College of Nursing supported the suggestions found in the Equality Impact Assessment that the planning arrangements for assessing the need for pharmaceutical services should include consideration of Welsh language services.³⁶⁶

422. However, the Welsh Language Commissioner raised her concerns that neither the Bill nor the documentation that supports the Bill explained the relationship between the provisions of Part 5 of the Bill and the measures in place for the improvement of Welsh language services in health and social care. The Commissioner noted that there was no explanation of how Part 5 of the Bill would support the provision of Welsh language pharmaceutical services, and posed the following questions:

³⁶⁶ PHB 35 Royal College of Nursing

- Is there potential for PNAs to include an assessment of the adequacy of the Welsh language provision in community pharmacies in Wales?
- How should Health Boards take the Welsh language into account when they conduct those assessments?
- How should the findings of those assessments be considered when planning Welsh language services for the future?
- Should the ability to make provision in Welsh be one of the criteria for the controlled access test that the LHBs will be required to apply in considering applications to join their pharmaceutical list?
- Could a community pharmacist jeopardise his eligibility to be included on a pharmaceutical list, if he were to fail to provide Welsh language services?³⁶⁷

The Committee's view

423. The Committee notes the Welsh Language Commissioner's concerns about the extent to which consideration has been given to the opportunities for Part 5 of the Bill to support the work of planning, and providing, Welsh language pharmaceutical services.

Recommendation 14: The Committee recommends that the Minister for Health and Social Services provide clarity about how he intends to address the Welsh Language Commissioner's concerns in relation to Part 5 (Pharmaceutical Services) of the Bill.

Financial implications

424. The EM states that the provisions of Part 5 of the Bill create additional costs of £1.3 million between 2016-17 and 2020-21 to Health Boards, and £220,000 to pharmacy contractors.³⁶⁸ These will, according to the EM, be outweighed by the £9.4 million health and travel time benefits to the public. The EM notes that the Welsh Government will also see a small saving of £76,000 as it will face reduced costs in appeals to the Welsh Ministers by pharmacies, which it notes will outweigh the costs of producing guidance.³⁶⁹

425. Few of those who responded to the Committee's consultation commented on the financial implications of the Bill. Powys Teaching Health Board highlighted the need to understand and address the resource implications of PNAs before their implementation. The Welsh Pharmaceutical

³⁶⁷ PHB 34 Welsh Language Commissioner

³⁶⁸ Explanatory Memorandum, page 302

³⁶⁹ Explanatory Memorandum, pages 221-223

Committee highlighted what it called the “significant costs” associated with producing high quality PNAs and reviewing them adequately, recommending that integrating PNAs with other needs assessments would be the most cost-effective way of proceeding.³⁷⁰

426. Giving oral evidence to the Committee, Public Health Wales stated that although it had not calculated the impact it did not foresee that the development and regulation of PNAs would be burdensome for Health Boards as it would form part of a wider programme.³⁷¹

The Committee’s view

427. The Committee notes the Finance Committee’s recommendation that the Minister provide:

- further detail of the work carried out to estimate the financial benefits of the provisions outlined in Part 5 of the Bill;
- an outline of any previous work undertaken in this area to inform these calculations.³⁷²

³⁷⁰ PHB 27 Welsh Pharmaceutical Committee

³⁷¹ RoP [paras 163-164], 9 July 2015

³⁷² National Assembly for Wales, Finance Committee, [Report on the Public Health \(Wales\) Bill](#), September 2015

9. Part 6 – Provision of toilets

428. Part 6 of the Bill seeks to improve the planning and provision of public toilets.

429. The Bill seeks to achieve this by placing a duty on each local authority in Wales to prepare and publish a local toilets strategy for its area based on the needs of its community.³⁷³ This would include the need for changing facilities for babies and for disabled people.

430. The EM acknowledges the health and economic benefits of ensuring adequate provision of public toilets and cites work done elsewhere to develop strategies to address the issue.³⁷⁴

The importance of public toilets

431. The majority of those stakeholders who submitted evidence on this Part highlighted the importance of ensuring adequate provision of public toilets. The Chartered Institute of Environmental Health (CIEH) stated that public toilets are “essential to good public health in Wales”³⁷⁵ and that they “are not a public convenience, they are a public health necessity”.³⁷⁶

432. Evidence presented to the Committee recognised the importance of ensuring adequate public toilet provision for everyone but highlighted the greater effect that insufficient provision may have on certain groups.³⁷⁷ The following groups were mentioned as being at risk of being disproportionately affected:

- people with a disability;

³⁷³ Public Health (Wales) Bill, section 91

³⁷⁴ Explanatory Memorandum, para 198

³⁷⁵ PHB 01 Chartered Institute of Environmental Health

³⁷⁶ RoP [para 15], 15 July 2015

³⁷⁷ PHB 01 Chartered Institute of Environmental Health, PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales, PHB 03 Public Health Wales, PHB 05 The Welsh NHS Confederation, PHB 12 Llansteffan and Llanybri Community Council, PHB 21 Wales Heads of Environmental Health Communicable Disease Expert Panel, PHB 27 Welsh Pharmaceutical Committee, PHB 30 Cardiff and Vale University Health Board, PHB 31 Wales Heads of Environmental Health, PHB 32 Older People’s Commissioner for Wales, PHB 42 Age Cymru, PHB 44 Hywel Dda University Health Board, PHB 47 Caerphilly Council, PHB 52 Cardiff Third Sector Council (with input from GVS), PHB 53 British Toilet Association, PHB 55 Paediatric Continence Forum, PHB 58 Wrexham County Borough Council, PHB 64 Truckers Toilets UK, PHB 69 Bevan Foundation, PHB 78 The Association of Directors of Public Health, PHB 80 University South Wales – School of Life Science Education, PHB 83 The Urology Trade Association, PHB 84 Royal Pharmaceutical Society, PHB 92 Powys County Council, PHB 93 Rhondda Cynon Taf County Borough Council, PHB 96 Tenovus Cancer Care and PHB 99 Crohn’s and Colitis UK

- parents with babies and young children;
- pregnant women;
- older people;
- those with specific conditions including incontinence, inflammatory bowel disease (IBD), irritable bowel syndrome (IBS) and multiple sclerosis (MS); and
- people who have been prescribed diuretics.³⁷⁸

Preparation and publication of local toilets strategies

433. Section 91 of Bill specifies that each strategy must include:

- an assessment of the need for toilets; and
- a statement outlining how the local authority proposes to meet the need.

434. This section also aims to ensure that strategies remain flexible and can be amended to meet the needs of a changing population, by placing a duty on local authorities to review their strategies within a year following a local government election.

435. Many stakeholders, including 36.5 per cent of those who responded to the Committee’s public survey, supported the provisions in the Bill for local authorities to prepare local toilets strategies.³⁷⁹ In its written evidence the British Toilet Association said:

“The preparation of a toilet provision strategy can only have extremely beneficial outcomes in focussing attention onto this vital provision for so many independent users. With improved

³⁷⁸ PHB 32 Older People’s Commissioner for Wales, PHB 84 Royal Pharmaceutical Society and PHB 27 Welsh Pharmaceutical Committee

³⁷⁹ PHB 01 Chartered Institute of Environmental Health, PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales, PHB 03 Public Health Wales, PHB 05 The Welsh NHS Confederation, PHB 12 Llansteffan and Llanybri Community Council, PHB 21 Wales Heads of Environmental Health Communicable Disease Expert Panel, PHB 27 Welsh Pharmaceutical Committee, PHB 30 Cardiff and Vale University Health Board, PHB 31 Wales Heads of Environmental Health, PHB 32 Older People’s Commissioner for Wales, PHB 42 Age Cymru, PHB 44 Hywel Dda University Health Board, PHB 47 Caerphilly Council, PHB 52 Cardiff Third Sector Council (with input from GVS), PHB 53 British Toilet Association, PHB 55 Paediatric Continence Forum, PHB 58 Wrexham County Borough Council, PHB 64 Truckers Toilets UK, PHB 69 Bevan Foundation, PHB 78 The Association of Directors of Public Health, PHB 80 University South Wales – School of Life Science Education, PHB 83 The Urology Trade Association, PHB 84 Royal Pharmaceutical Society, PHB 92 Powys County Council, PHB 93 Rhondda Cynon Taf County Borough Council, PHB 96 Tenovus Cancer Care, PHB 99 Crohn’s and Colitis UK and National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

management and a clearer understanding of the needs of residents and visitors, must come higher standards of health and hygiene.”³⁸⁰

436. The Royal College of Nursing expressed support for the development of local toilets strategies, and emphasised that strategies should highlight the importance of these services and their benefit to the community:

“Without a published strategy there is a real danger that the significance of public toilets will not be considered and they will [be] closed down piecemeal without any consideration of the impact.”³⁸¹

437. Naomi Alleyne, representing the Welsh Local Government Association (WLGA), questioned whether a duty to prepare and publish a strategy was required. However, she acknowledged that existing powers had not delivered adequate public toilet provision.³⁸²

438. Dr Jane Fenton-May, representing the Royal College of General Practitioners, expressed concern that some local authorities would conclude that having a public toilet would meet the needs of a community, and that their strategies would fail to recognise the importance of considering wider issues such as the accessibility and cleanliness of those facilities. She called for local authorities to be required to adopt a robust method for assessing these wider needs when developing their strategies.³⁸³

439. Age Cymru stated that the public toilet network in Wales was at risk owing to financial pressures and that the duty in the Bill would not necessarily lead to an increase in provision.³⁸⁴ Llansteffan and Llanybri Community Council said the approach outlined in the Bill would only make a “minor contribution” to improving provision. It argued that the majority of council strategies “tend to gather dust on shelves and represent a tick-the-box exercise”.³⁸⁵ A number of those who responded to the Committee’s survey believed that the Bill should be strengthened to place a duty on local authorities to provide public toilet facilities.³⁸⁶

440. The Bevan Foundation raised concerns that the duty to prepare and publish a strategy would simply generate more paper work for each local

³⁸⁰ PHB 53 British Toilet Association

³⁸¹ PHB 35 Royal College of Nursing

³⁸² RoP [para 138], 15 July 2015

³⁸³ RoP [paras 62–65], 17 September 2015

³⁸⁴ PHB 42 Age Cymru

³⁸⁵ PHB 12 Llansteffan and Llanybri Community Council

³⁸⁶ National Assembly for Wales, Health and Social Care Committee, [Summary of public survey results](#), September 2015

authority without increasing the number of public toilets. It called for the Bill to place a “direct requirement on public and private bodies alike to provide and maintain public toilets in places open to the public, such as shopping centres, bus stations, sports venues and town centres”.³⁸⁷

Monitoring the scheme

441. The Bill does not provide a formal mechanism for measuring the effectiveness of placing a duty on local authorities to prepare and publish a local toilets strategy.

442. Public Health Wales (PHW), and the Paediatric Continence Forum believed that more could be done to strengthen monitoring arrangements so that strategies would include a specific measureable outcome.³⁸⁸ Dr Julie Bishop, representing PHW told the Committee:

“Writing a strategy doesn’t in and of itself bring about change, and so the critical issue here is that the strategy actually has some requirement, perhaps, to monitor that there is actually genuine improved access, or adequate access, as a result of that. So, we would certainly be supportive of strengthening the proposals in any way that would make that more likely to happen.”³⁸⁹

443. Responding to the calls for progress to be monitored, the Minister told the Committee:

“We align the production of the strategy with the cycle of local authority elections and, if, in the end, a local authority hasn’t done what it ought to do to implement the strategy that it itself will have drawn up in consultation with its local population, then people will have the ability to pass their verdict on that at the ballot box”.³⁹⁰

The Committee’s view

444. The Committee welcomes the proposals to introduce a duty on local authorities to prepare and publish local toilets strategies for their areas but recognises the genuine concerns raised by stakeholders about the lack of a specific duty on local authorities to implement them. Whilst the Committee would have welcomed a provision in the Bill to place a statutory duty on local authorities to provide public toilets, it recognises that the financial pressures

³⁸⁷ PHB 69 Bevan Foundation

³⁸⁸ PHB 55 Paediatric Continence Forum and RoP [para 24], 9 July 2015

³⁸⁹ RoP [para 24], 9 July 2015

³⁹⁰ RoP [para 15], 21 October 2015

facing local government do not make the delivery of any such duty realistic at this time.

445. The Committee believes that adequate monitoring of the strategies will be crucial in assessing whether they have delivered improved access to public toilets across Wales. The Committee believes that the Bill should include a provision requiring a local authority to publish a progress report detailing to what extent it has met the needs identified in its strategy. The Committee does not agree with the Minister that aligning the publication of strategies with electoral cycles is a sufficiently robust mechanism for measuring the implementation and success of the schemes.

Recommendation 15: The Committee recommends that the Minister for Health and Social Services amend the Bill to require local authorities to publish periodically a progress report on public toilet provision detailing how the needs of communities are being met.

Planning

446. Concerns were raised in relation to ensuring that public toilets are:

- situated in convenient locations;
- accessible;
- evenly distributed, taking account of the need for adequate provision for both those living in an area and those passing through.

447. Crohn's and Colitis UK warned against public toilets becoming clustered in "tourist hotspots". They called for a requirement within the Bill to increase the provision of public toilets across all areas, and not limited to one site within a town. They also called for the Bill to require multiple toilets at any one site in order avoid problems when facilities are out of order or in use.³⁹¹

448. Cardiff Third Sector Council noted that consideration of public toilet provision should be a requirement of all planning applications (other than those relating to individual home adaptations). It suggested that this was necessary for the delivery of adequate provision of public toilets and to ensure that people felt confident to leave their homes.³⁹²

449. Public Health Wales told the Committee that it would welcome a requirement to undertake health impact assessments when changes to service provision and policy decisions are made in order to measure the

³⁹¹ PHB 99 Crohn's and Colitis UK

³⁹² PHB 52 Cardiff Third Sector Council

impact of any changes to the provision of public toilets in an area.³⁹³ It also stated that particular consideration should be given to taking account of the needs of visitors to an area:

“It is essential that toilet provision should be adequate at transport hubs and in city centres where local communities will be a minority of potential users.”³⁹⁴

450. In response to questions about the Welsh Government taking strategic responsibility for overseeing the location of public toilets – for example the need to locate facilities close to trunk roads – the Minister referred to funding provided by the Minister for Economy, Science and Transport for public toilets close to the A470 in Rhayader and Builth Wells.³⁹⁵ However, he noted that in the majority of situations, duties relating to public toilets were best discharged at the local level and that a case had not been made for drawing overall responsibility up to national level.³⁹⁶

The Committee's view

451. The Committee acknowledges the concerns raised by stakeholders about the need for public toilets to be conveniently located for both local residents and those passing through the area. It believes that a co-ordinated approach between the Welsh Government and local authorities will be needed to ensure the adequate provision of public toilets to meet the needs of both the people living in an area and those who are visiting. The Committee believes that this is important to enable individuals to leave their homes without fear of being unable to locate a facility.

Recommendation 16: The Committee recommends that the Minister for Health and Social Services amend the Bill to require local authorities to consider the appropriate distribution of facilities, and their availability throughout the week, when developing their strategies so that people can access public toilets in urban and rural areas, tourist hotspots and within the vicinity of trunk roads when and where they are needed.

452. The Committee agrees with the Minister that it is appropriate for local authorities to be responsible for the local strategies. Nevertheless, it also believes that the Welsh Government should provide direction to ensure that national needs, such as locating facilities close to significant trunk roads or

³⁹³ PHB 03 Public Health Wales

³⁹⁴ PHB 03 Public Health Wales

³⁹⁵ RoP [paras 41 and 42], 1 July 2015

³⁹⁶ RoP [para 21], 21 October 2015

visitor sites, are given adequate consideration and are coordinated effectively.

Recommendation 17: The Committee recommends that the Minister for Health and Social Services amend the Bill to require the Welsh Government to monitor the extent to which local toilets strategies address national needs, to avoid the risk of poor provision at national sites and on main transport corridors.

Issuing of guidance

453. Section 91 of the Bill states that the Welsh Ministers may issue guidance which should be taken into consideration when preparing an initial strategy, undertaking a review of the strategy or publishing the strategy.

454. The majority of stakeholders, including the WLGA,³⁹⁷ supported the provisions within the Bill which enable the Welsh Government to issue guidance on how local authorities develop their strategies and welcomed the development of a template.³⁹⁸ It was noted that the principle benefit of this would be a more consistent approach to the development of strategies across local authorities.

455. The Minister confirmed the guidance would include a template which could be adapted to suit the needs of the area:

“In this particular regard, I think we have to recognise that the needs of different parts of Wales will be very different. This is an area where local authorities will need to devise a scheme that meets the particular geographical and other characteristics of their areas. But we will provide a template so that it will be possible to compare the way that local authorities in different parts of Wales have gone about discharging the duty that will be placed on them.”³⁹⁹

Engagement with communities

456. Section 92 of the Bill places a duty on local authorities to:

³⁹⁷ RoP [para 158], 15 July 2015

³⁹⁸ PHB 03 Public Health Wales, PHB 12 Llansteffan and Llanybri Community Council, PHB 21 Wales Heads of Environmental Health Communicable Disease Expert Panel, PHB 31 Wales Heads of Environmental Health, PHB 35 Royal College of Nursing, PHB 42 Age Cymru, PHB 47 Caerphilly Council, PHB 53 British Toilet Association, PHB 55 Paediatric Continence Forum, PHB 63 One Voice Wales, PHB 64 Truckers Toilets UK, PHB 84 Royal Pharmaceutical Society, PHB 89 Public Health Wales, PHB 92 Powys County Council and PHB 93 Rhondda Cynon Taf County Borough Council

³⁹⁹ RoP [para 34], 1 July 2015

- consult with any interested party ahead of the publication of a local toilets strategy; and
- share the draft strategies with interested parties.

457. Some stakeholders thought provisions relating to community engagement proposals should be strengthened. The written evidence submitted by Merthyr Tydfil County Borough Council stated that the provisions were “too vague to be meaningful”⁴⁰⁰ and Truckers Toilets UK noted concern that “there is no guarantee views will be taken into account”.⁴⁰¹

458. Truckers Toilets UK said it would welcome a clear definition of what constitutes “appropriate engagement” to:

- minimise the potential of local authorities providing a “tick box document” with insufficient space for stakeholders to voice their concerns;
- ensure consistency of approach across local authorities.⁴⁰²

459. Stakeholders highlighted the importance of ensuring that, during the consultation process, local authorities engage with a wide range of groups to ensure all specific needs are considered when developing a strategy.⁴⁰³ This, they argued, should include those who may be visiting the area.⁴⁰⁴ Public Health Wales stated:

“This should include not only local communities but also, for example, those representing specific age groups, people with disabilities or impairments or those with medical problems. Consultation should also include the needs of homeless people, mobile workers and visitors to the area.”⁴⁰⁵

⁴⁰⁰ PHB 51 Merthyr Tydfil County Borough Council

⁴⁰¹ PHB 64 Truckers Toilets UK

⁴⁰² PHB 64 Truckers Toilets UK

⁴⁰³ PHB 03 Public Health Wales, PHB 12 Llansteffan and Llanybri Community Council, PHB 32 Older People’s Commissioner for Wales, PHB 35 Royal College of Nursing, PHB 40 Royal College of General Practitioners, PHB 53 British Toilet Association, PHB 55 Paediatric Continence Forum, PHB 58 Wrexham County Borough Council, PHB 63 One Voice Wales, PHB 64 Truckers Toilets UK, PHB 83 The Urology Trade Association, PHB 86 Powys Teaching Health Board, PHB 89 Public Health Wales, PHB 96 Tenovus Cancer Care and PHB 99 Crohn’s and Colitis UK

⁴⁰⁴ PHB 12 Llansteffan and Llanybri Community Council and PHB 58 Wrexham County Borough Council

⁴⁰⁵ PHB 03 Public Health Wales

The Committee's view

460. The Committee welcomes the Minister's intention to provide guidance to local authorities to assist in the development of effective strategies. It believes that this will help achieve a more consistent approach to strategies across Wales.

461. The Committee notes the calls made by some stakeholders for the guidance to provide information about the consultation process which local authorities must undertake, including details of the types of organisations with whom local authorities would be expected to consult and a template for the consultation.

Changing facilities

462. Dr Gill Richardson, Director of Public Health at Aneurin Bevan University Health Board, highlighted the importance of strengthening provisions for changing facilities, despite the additional costs associated with them:

“I think there have been campaigns by parents and carers of disabled people, and disabled people themselves, for the Changing Places type of toilets, whereby there are changing beds in toilets. I know that it is difficult for local authorities to maintain these, but I do believe that there is such a value to the community and to the vulnerable members of the community [...] There are many people who are limited in their independence because of having to take into account those sorts of considerations, especially in rural areas.”⁴⁰⁶

463. Public Health Wales said that consideration needed to be given to how local authorities could maintain the additional equipment needed in order to ensure they remain accessible to all.⁴⁰⁷ The Older People's Commissioner for Wales said that the Bill could go further by placing a duty on local authorities to ensure that public toilets are accessible to all by ensuring they “must be clean, safe and accessible places for older people and others, with handrails, wheelchair ramps and visual and hearing aids for those with mobility issues and sensory loss”.⁴⁰⁸

⁴⁰⁶ RoP [para 141], 9 July 2015

⁴⁰⁷ PHB 03 Public Health Wales

⁴⁰⁸ PHB 32 Older People's Commissioner for Wales

The Committee's view

464. The Committee acknowledges the evidence received about the importance of ensuring that public toilet facilities address the needs of individuals who require changing facilities, additional space, and/or require the aid of specific adaptations. The Committee is nonetheless aware that the financial pressures facing local authorities may restrict their ability to deliver these facilities.

Publicly-funded settings

465. The EM states that the guidance which the Welsh Ministers will be able to issue would include information on additional options for increasing the provision of public toilets such as making available those located in settings that receive public funding.⁴⁰⁹

466. The majority of stakeholders⁴¹⁰ supported such a proposition. However, concerns were raised in relation to the feasibility and practicalities of making toilets in such settings available to the public. Wrexham County Borough Council referred to fear of anti-social behaviour, inappropriate use of facilities, the costs associated with any potential building modification, and additional maintenance as potential deterrents.⁴¹¹

467. The Committee questioned witnesses on the potential benefit of either reinstating the former Public Facilities Grant Scheme or establishing a new scheme to continue this line of work. The WLGA highlighted that the uptake of the previous scheme varied across Wales, but could be addressed by placing a duty on local authorities to promote the co-operative approach.⁴¹²

468. Julie Barratt, representing the CIEH, questioned whether a financial incentive for businesses to allow the public to access their facilities would “be enough”. She suggested that consideration should be given to whether

⁴⁰⁹ Explanatory Memorandum, para 211

⁴¹⁰ PHB 03 Public Health Wales, PHB 05 The Welsh NHS Confederation, PHB 12 Llansteffan and Llanybri Community Council, PHB 40 Royal College of General Practitioners, PHB 42 Age Cymru, PHB 47 Caerphilly Council, PHB 49 Owain Rowley-Conwy, PHB 52 Cardiff Third Sector Council (with input from GVS), PHB 53 British Toilet Association, PHB 55 Paediatric Continence Forum, PHB 58 Wrexham County Borough Council, PHB 63 One Voice Wales, PHB 64 Truckers Toilets UK, PHB 78 The Association of Directors of Public Health, PHB 86 Powys Teaching Health Board, PHB 89 Public Health Wales, PHB 92 Powys County Council and PHB 99 Crohn's and Colitis UK

⁴¹¹ PHB 58 Wrexham County Borough Council

⁴¹² RoP [para 140], 15 July 2015

the Bill could go further in compelling businesses to work with local authorities to ensure adequate provision.⁴¹³

469. The Minister told the Committee that more needed to be done to promote facilities available for public use and to reduce the public's reluctance to use such facilities. He noted that public money had been used to fund toilets in settings such as libraries, art centres, community centres and other council buildings, but that these had been poorly advertised and were often regarded as toilets that were not for public use. He concluded:

“In an era of very severe restraint, when the public purse is already paying for those facilities, I think part of a strategy for any local authority ought to be to make it clear that those facilities are genuinely available for the public.”⁴¹⁴

470. The Welsh NHS Confederation, the RCN and Age Cymru believed that, in order to ensure the success of a co-operative approach to providing public toilet facilities, more needed to be done to publicise their location. They suggested that this could be achieved by:

- producing standardised street signage showing opening times and facilities available;⁴¹⁵
- publishing a map identifying where all public toilets are located, including their opening hours.⁴¹⁶

471. Public Health Wales and Crohn's and Colitis UK raised concerns about the limits created, particularly at night, by the opening hours of participating businesses. They highlighted the need for local authorities to consider opening hours when developing their strategies to ensure that individuals are able to access facilities at all times.

The Committee's view

472. The Committee would welcome further co-operation between local authorities and local businesses to increase the number of toilet facilities available for public use. The Committee believes that guidance issued under this section should encourage local authorities to:

⁴¹³ RoP [para 20], 15 July 2015

⁴¹⁴ RoP [para 31], 1 July 2015

⁴¹⁵ PHB 05 The Welsh NHS Confederation and PHB 42 Age Cymru

⁴¹⁶ PHB 35 Royal College of Nursing

- work with participating businesses to ensure that adequate signage is used and/or a local map detailing all publicly accessible facilities within the area is developed;
- consider the opening times of participating settings to ensure that facilities are available to the community throughout the day.

Recommendation 18: The Committee recommends that the Minister for Health and Social Services amend the Bill to include a duty on local authorities to increase awareness of toilet facilities by promoting their availability for public use. This should include amending the Bill to require local authorities to ensure that:

- private businesses which receive public funds are encouraged to open their toilet facilities to the public, and
- publicly-funded buildings, such as libraries and leisure centres, make it explicit that their toilet facilities are available for public use.

Financial implications

473. Local authorities would continue to receive £200,000 which is mainstreamed within the Revenue Support Grant (RSG) for improving public access to toilets. There would be additional costs of just over £410,000 from this element of the Bill, of which just over £400,000 will fall upon local authorities. Local authorities would incur costs from developing and consulting on their strategy, and some small additional costs from managing the process for grant allocation to businesses allowing free public access to their public toilets.⁴¹⁷

474. The WLGA raised concerns about the cost implications of these provisions:

“The concern is there around the cost, both in terms of the resources to provide toilets, but, obviously, developing the strategy, publicising it, consulting on it and then implementing that and taking forward the steps that the authority would think are necessary to ensure adequate provision.”⁴¹⁸

475. The Directors of Public Protection Wales highlighted that public toilet provision is one of many priorities competing for local authorities’ resources. A number of others raised concerns that without adequate resources, the

⁴¹⁷ National Assembly for Wales, [Research Service Bill Summary](#), July 2015

⁴¹⁸ RoP [para 138], 15 July 2015

provision of public toilets was unlikely to be enhanced by the Bill's provisions. Powys Teaching Health Board suggested that developing strategies may raise expectations where there may be little resource available for their delivery.⁴¹⁹ Truckers Toilets UK said that strategies that cannot be implemented are "worthless".⁴²⁰

476. Under section 93(5), local authorities would have the option to charge fees for the use of public toilets in order to recuperate the additional costs created by the Bill. Crohn's and Colitis UK did not support charges on the basis that they could restrict accessibility and affect disproportionately those living with lifelong conditions.⁴²¹ The Minister stated members of the Welsh Senate of Older People were prepared to pay a modest charge to use facilities on the condition the facilities are clean and maintained to a certain level of standard.⁴²²

477. The Minister noted that he was aware of concerns about the financial implications of the Bill for local authorities. He noted that this was illustrated by his decision to place a duty on local authorities to produce a strategy and not a duty to implement the strategy:

"These are very, very tough times for local government, and we have to think very carefully indeed about placing new obligations on local authorities where our ability to fund those new obligations is equally limited. [...] If we were to place a duty on them to implement that strategy, I think we would be obliged to find the money to support that implementation, and we are not likely to be in that position."⁴²³

The Committee's view

478. The Committee is aware that the resource constraints facing local authorities may require them to consider imposing a small charge for the use of some public toilet facilities. The Committee believes that any charge should be as small as possible, to avoid this acting as a financial barrier.

⁴¹⁹ PHB 86 Powys Teaching Health Board

⁴²⁰ PHB 64 Truckers Toilets UK

⁴²¹ PHB 99 Crohn's and Colitis UK

⁴²² RoP [para 14], 21 October 2015

⁴²³ RoP [para 28], 1 July 2015

10. Issues not covered by the Bill

479. In addition to taking evidence on the provisions contained in the Bill, the Committee sought views about the extent to which the Bill reflects priorities for improving public health, and whether other issues should also have been included in the Bill.

480. The Bill was introduced following two periods of consultation by the Welsh Government on legislating to improve public health. In November 2012, the Welsh Government published a Green Paper seeking views on whether a public health bill was needed, and the potential role of legislation in driving improvements in population health.⁴²⁴

481. The subsequent White Paper published by the Welsh Government in April 2014 contained consultation questions on specific public health measures, including those covered by this Bill.⁴²⁵

Health impact assessments

482. In its written evidence, BMA Cymru Wales (“the BMA”) called for health impact assessments (HIAs) to be placed on a statutory footing, and noted its disappointment that although this had been included in the Green Paper consultation, it had been omitted from the White Paper. It suggested that a requirement for the use of HIAs should be included on the face of the Bill, with the circumstances in which a mandatory HIA was needed to be set out in regulations:

“In the first instance we would suggest that these regulations could require that HIA is made mandatory in relation to Strategic and Local Development Plans, certain larger scale planning applications, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments (e.g. new hospitals) and health service reconfiguration proposals.”⁴²⁶

483. During oral evidence, Dr Steven Monaghan representing the BMA told the Committee that the Bill was a “missed opportunity for a proper, ambitious public health bill, which would be centred on healthy public policy

⁴²⁴ Welsh Government Green Paper – [A consultation to collect views about whether a Public Health Bill is needed in Wales](#), November 2012

⁴²⁵ Welsh Government White Paper – [Listening to you: Your health matters](#), April 2014

⁴²⁶ PHB 76 BMA Cymru Wales

in general and particularly focusing, and using as a lever, health impact assessment”. He added that the BMA would support an approach based on:

“setting general objectives for the health of the people on the face of the Bill and a lever of health impact assessment”.⁴²⁷

484. Dr Jane Fenton-May, representing the Royal College of General Practitioners, told the Committee that more control was needed over the location of fast food outlets. She believed this could be achieved by conducting a health assessment to consider where such outlets should be sited.⁴²⁸

485. A joint response from 22 organisations, including professional bodies and voluntary sector organisations, also argued the case for HIAs to be included in the Bill:

“We believe that this Bill is a real opportunity for innovative thinking and a different approach to tackling chronic conditions by encouraging healthier lifestyles and addressing some of the wider determinants of health which impacts on these. We would strongly encourage the committee to take note of the work currently undertaken by the Wales Health Impact Assessment Support Unit throughout their deliberations – particularly the Unit’s recent work with several Local Authority Planning Departments across Wales”.⁴²⁹

486. The Royal College of Physicians said it believed that the Bill should include a commitment to progressing a “health in all policies” approach, and should include provision to specify at a later date for HIAs to become a statutory requirement.⁴³⁰

Interaction with other legislation

487. The Minister explained to the Committee that the White Paper set out how the Welsh Government intended to pursue achieving the “twin tracks” of a “health in all policies approach” and practical measures to improve public health in Wales. He said that the “health in all policies” approach was pursued through the *Well-being of Future Generations (Wales) Act 2015* (“the Future Generations Act”), “and that’s where health impact assessments

⁴²⁷ RoP [para 7], 17 September 2015

⁴²⁸ RoP [para 33], 17 September 2015

⁴²⁹ PHB 82 Joint response from 22 organisations

⁴³⁰ PHB 25 Royal College of Physicians

discussion went on to take place,” while the practical measures were covered by the provisions of the Public Health (Wales) Bill. He said:

“That’s the way that health impact assessments will be taken forward, as part of the rounded assessments that that Act now requires to be undertaken when there are major developments proposed by local authorities and others.”⁴³¹

488. Dr Julie Bishop representing Public Health Wales told the Committee that it would be impossible for one piece of legislation to cover all aspects of public health improvement. She believed that the provisions in the Public Health (Wales) Bill should be considered alongside the requirements of the *Active Travel (Wales) Act 2013* and the Future Generations Act.⁴³²

489. The Future Generations Act contains “A healthier Wales” as one of its well-being goals. The goal’s stated aim is to achieve “A society in which people’s physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood”.⁴³³

490. Under the *Active Travel (Wales) Act 2013* local authorities are required to make improvements to facilities and routes for pedestrians and cyclists and to prepare maps identifying current and potential future routes for their use. It also requires local authorities and the Welsh Ministers to take reasonable steps to enhance provision for walkers and cyclists in new road schemes (including road improvement schemes).⁴³⁴

491. In its written evidence, Public Health Wales said it recognised that the Future Generations Act included provisions to:

“raise the profile of public health in society and increase awareness and knowledge of public health issues across government departments (national and local) and among those who develop and implement policy”.⁴³⁵

492. Dr Rodney Berman, representing the BMA, told the Committee that introducing mandatory HIAs on developments such as transport infrastructure projects would ensure that all such projects would be

⁴³¹ RoP [para 4], 21 October 2015

⁴³² RoP [para 5], 9 July 2015

⁴³³ [Well-being of Future Generations \(Wales\) Act 2015](#)

⁴³⁴ [Active Travel \(Wales\) Act 2013](#)

⁴³⁵ PHB 03 Public Health Wales

assessed, regardless of whether they were being implemented to fulfil the aims of the Active Travel Act.⁴³⁶

The Committee's view

493. The Committee notes the call made by stakeholders that health impact assessments (HIAs) are an important way of ensuring that practical considerations that could impact upon people's health are taken into account when developing certain policies, plans or programmes. It acknowledges the Minister's comments that health implications are considered as part of the wider considerations required under the Future Generations Act, but notes that this Act does not include explicit reference to HIAs or any requirement for these to be carried out. It sympathises with the suggestion that HIAs can offer an additional safeguard to ensure that when new developments are considered, any health implications are specifically taken into account.

Recommendation 19: The Committee recommends that the Minister for Health and Social Services amend the Bill to include a requirement to undertake mandatory health impact assessments when developing certain policies, plans or programmes. For example, BMA Cymru Wales has suggested that these should include Strategic and Local Development Plans, certain larger scale planning applications, the development of new transport infrastructure, Welsh Government legislation, certain statutory plans such as Local Well-being Plans, new NHS developments and health service reconfiguration proposals.

Nutritional standards in care homes and pre-school settings

494. The proposal consulted upon in the White Paper was to introduce nutritional standards in specified public sector settings, such as pre-school and care homes settings to build on the work previously undertaken in schools and hospitals. It stated that the standards would be set out in secondary legislation and/or guidance.⁴³⁷

495. The Minister told the Committee that the Welsh Government was committed to using legislation, but not this Bill, to set nutritional standards in pre-school and care home settings.⁴³⁸

⁴³⁶ RoP [para 23], 17 September 2015

⁴³⁷ Welsh Government [White Paper – Listening to you: Your health matters](#), April 2014

⁴³⁸ RoP [para 11], 1 July 2015

496. Some stakeholders raised concern that the proposal to introduce nutritional standards in care homes and pre-school settings had not been included in the Bill; however, they noted the Minister's commitment to pursuing this outcome through other legislation.⁴³⁹ In its written evidence, Public Health Wales emphasised the urgency in implementing such standards:

“Poor nutrition is among the leading causes of avoidable ill health and premature death in Wales currently. It is essential that these measures are introduced at the earliest opportunity and that they have the necessary statutory basis to ensure that implementation is comprehensive and can be ‘enforced’.”⁴⁴⁰

The Committee's view

497. The Committee acknowledges the importance of ensuring that people of all ages receive nutritious meals and therefore it welcomes the commitment made by the Minister to introduce nutritional standards for care home and pre-school settings. The Committee would urge him to confirm as a matter of urgency how he intends to implement nutritional standards for care homes and pre-school settings.

Obesity

498. Obesity was cited by the Directors of Public Health, the Chartered Institute of Environmental Health and the Royal College of Physicians as one of the biggest public health problems currently faced by the NHS in Wales.⁴⁴¹

499. Dr Gill Richardson, Director of Public Health at Aneurin Bevan University Health Board, told the Committee that ways of tackling obesity included taxing high-energy, low-nutritional value foods and banning trans fats because of their carcinogenic effects. She recognised that these would largely be outside the competence of the Assembly.⁴⁴² Julie Barratt (representing the Chartered Institute of Environmental Health) suggested that obesity may be too large and complex an issue to be tackled by this Bill.⁴⁴³

⁴³⁹ PHB 03 Public Health Wales, PHB 42 Age Cymru, PHB 57 UK Health Forum, PHB 67 UK Faculty of Public Health, PHB 76 BMA Cymru Wales and PHB 82 Joint response from 22 organisations

⁴⁴⁰ PHB 03 Public Health Wales

⁴⁴¹ PHB 01 Chartered Institute of Environmental Health, PHB 02 Directors of Public Health on behalf of the Local Health Boards in Wales and PHB 25 Royal College of Physicians

⁴⁴² RoP [para 138], 9 July 2015

⁴⁴³ RoP [para 6], 15 July 2015

500. Dr Sara Hayes, Director of Public Health at Abertawe Bro Morgannwg University Health Board, stated that although she would have liked to have seen physical activity included within the Bill, she was “not clear at this point what that would look like”. She said that there may be opportunities to take this forward through local partnership working, for example, rather than legislation.⁴⁴⁴

501. In response to queries about the Assembly’s ability to legislate to tax or ban particular foodstuffs, the Minister’s letter to the Committee dated 4 September indicated that competence issues were not straightforward.⁴⁴⁵ He explained in the letter that it would not be possible to express a definitive view on competence without having the actual provisions of an Act available, but noted that the following factors would need to be considered:

- the extent to which any provisions would relate to the subjects listed in Part 1 of Schedule 7 of the Government of Wales Act 2006 (e.g. promotion of health; prevention, treatment and alleviation of disease, illness, injury, disability and mental disorder; protection and well-being of children; and food and food products);
- the extent to which any provisions would not fall within any of the exceptions in that Part (e.g. consumer protection);
- the extent to which any provisions would be incompatible with Convention Rights or with EU law (the Minister stated “it is highly likely that any provisions which seek to reduce the consumption of high sugar products [...] would constitute an interference with possessions, falling within the scope of Article 1 of the First Protocol, and potentially an interference with the right to freedom of expression provided for by Article 10 of the Convention”).

502. The Minister acknowledged the urgency of putting measures in place to tackle the problem of obesity; however, he did not believe that this Bill was the most appropriate mechanism to achieve the improvements needed. He said that:

- he had sought suggestions from stakeholder organisations on the steps that could be taken to address the issue;
- although many policy initiatives had been suggested to him, they were not measures that were best achieved through legislation.⁴⁴⁶

⁴⁴⁴ RoP [para 131], 9 July 2015

⁴⁴⁵ PHB AI 01 Minister for Health and Social Services – 4 September 2015

⁴⁴⁶ RoP [para 8], 21 October 2015

503. The Minister indicated to the Committee that he intended to pursue some of the suggestions made through policy and practice rather than through legislation.⁴⁴⁷

The Committee's view

504. The Committee acknowledges and shares the concerns raised by stakeholders that action is needed to tackle obesity in Wales. It notes the calls made to introduce a form of taxation or restrictions on food and drink containing high levels of fat and sugar. However, it acknowledges the current legislative competence complexities that would be encountered were the Assembly to seek to pass legislation to this effect. Nevertheless, it believes that tackling obesity is key to improving public health in Wales, and that the Welsh Government should explore all options for tackling it as a matter of priority.

Alcohol

505. The White Paper also consulted on proposals to introduce a minimum unit pricing for alcohol in Wales. Such provisions were not included in this Bill. On 28 April 2015, during a debate on the Welsh Government's legislative programme, the First Minister explained:

“Whilst we believe that minimum unit alcohol pricing is a key public health measure, after careful consideration, we'll not include a provision in the public health Bill whilst there is still some uncertainty about the timing of the European judgment on Scotland's Alcohol (Minimum Pricing) (Scotland) Act 2012, but we do intend to publish a draft Bill relating to the minimum price of alcohol for public consultation in due course.”⁴⁴⁸

506. A consultation on the draft *Public Health (Minimum Price for Alcohol) (Wales) Bill* was announced by Vaughan Gething AM, the Deputy Minister for Health, on 15 July 2015.⁴⁴⁹ The proposals consulted upon include introducing an offence for alcohol to be sold or supplied below a minimum price per unit, which would be set at 50p per unit.

507. Written evidence from the Chartered Institute of Environmental Health (CIEH) highlighted steps to tackle the misuse of alcohol as an issue that should be considered a public health priority for Wales. Julie Barratt

⁴⁴⁷ RoP [para 8], 21 October 2015

⁴⁴⁸ RoP, Plenary, 28 April 2015

⁴⁴⁹ [Draft Public Health \(Minimum Price for Alcohol\) \(Wales\) Bill](#)

representing the CIEH told the Committee that she welcomed the proposals included in the draft Bill as “an enormous step forward”.⁴⁵⁰

The Committee’s view

508. The Committee has recently undertaken an inquiry on alcohol and substance misuse in Wales and is acutely aware of the long-term problems that can be caused by alcohol misuse.⁴⁵¹ In its report on that inquiry, the Committee noted that the majority of stakeholders supported the principle of minimum unit pricing, but acknowledged that some had concerns. The Committee re-iterates the call it made in that report for the Welsh Government to investigate further the impacts of minimum unit pricing proposals on people on low incomes before introducing legislation.

509. The Committee also re-iterates the recommendation it made in that report that the Welsh Government, as part of its discussions with the UK Government on the production of the reserved powers model, ensure that the forthcoming Wales Bill provides the Assembly with an appropriate set of powers to tackle alcohol misuse in a holistic way.

⁴⁵⁰ PHB 01 Chartered Institute of Environmental Health and RoP [para 6], 15 July 2015

⁴⁵¹ Health and Social Care Committee, [Inquiry into alcohol and substance misuse](#), August 2015

Annex A – Procedures relating to the withdrawal, amendment and introduction of Government Bills

During the Committee's discussion on the Public Health (Wales) Bill, Members considered whether it would be possible to recommend that a Chapter of the Bill be removed and introduced as a standalone Bill.

The relevant legislative procedures considered by Members are set out below.

Can a sub-division of a Bill be removed following its introduction?

After a Bill has been introduced, the only way in which the text may be changed is by amendment during a formal amending stage. During amending stages, the Member in charge, or any other Member, may table amendments which seek to remove, add or replace text.

With regard to amending the Public Health Bill, while firm decisions on admissibility may only be taken in the context of specific amendments, should the Bill proceed to Stage 2, it is likely that amendments which sought to leave out sections 2 to 21 would be admissible.

Can the Welsh Government introduce the provisions removed from one Bill as a new, standalone Bill?

Standing Orders provide that the Welsh Government may introduce a Bill provided that it complies with Standing Order requirements, including that it is:

- accompanied by a statement from the Presiding Officer on competence;
- available in English and Welsh;
- accompanied by an Explanatory Memorandum.

Therefore, subject to meeting these requirements, provisions removed from the Public Health (Wales) Bill could be introduced as a new, standalone Bill.

Would a committee of the Assembly be required to undertake Stage 1 scrutiny of provisions re-introduced as a separate Bill?

In accordance with Standing Order 26, an Assembly committee would not necessarily need to undertake Stage 1 scrutiny of a Bill. It would be a matter for the Business Committee to decide at introduction whether or not the

general principles of a Bill should be referred for consideration by a committee.

If the Business Committee were to decide not to refer a Bill to a committee for Stage 1 consideration, the Member in charge would then be able to propose that the Assembly, in Plenary, agree to the general principles of the Bill. If the Assembly were to agree to the general principles, the Bill would then proceed to Stage 2.

Would introducing the specific provisions relating to e-cigarettes in the Public Health (Wales) Bill in a separate Bill effectively mean that they could not be passed prior to the Assembly dissolving ahead of the 2016 election?

While not impossible, the timescales would be extremely tight for any new Bill introduced after November 2015 to be passed prior to the Assembly dissolving ahead of the 2016 election. It could only be achieved if the Business Committee decided not to refer the relevant Bill to a committee for Stage 1 consideration.

Annex B – Witnesses

The following witnesses provided oral evidence to the Committee on the dates noted below. [Transcripts of all oral evidence sessions](#) can be viewed on the Committee’s website.

The Committee also received a private legal briefing from Elisabeth Jones, Director of Legal Services at the National Assembly for Wales, on 23 September 2015.

1 July 2015

Organisation

Mark Drakeford AM	Minister for Health and Social Services
Dr Ruth Hussey	Chief Medical Officer
Chris Tudor-Smith	Welsh Government
Sue Bowker	Welsh Government
Dewi Jones	Welsh Government

9 July 2015

Organisation

Dr Julie Bishop	Public Health Wales
Dr Quentin Sandifer	Public Health Wales
Dr Gill Richardson	Aneurin Bevan University Health Board
Dr Sara Hayes	Abertawe Bro Morgannwg University Health Board

15 July 2015

Organisation

Julie Barratt	Chartered Institute for Environmental Health
Robert Hartshorn	Directors of Public Protection Wales
Paul Mee	Directors of Public Protection Wales
Naomi Alleyne	Welsh Local Government Association
Simon Wilkinson	Welsh Local Government Association

17 September 2015

Organisation

Dr Rodney Berman	BMA Cymru Wales
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Dr Steven Monaghan	BMA Cymru Wales
Dr Jane Fenton-May	Royal College of General Practitioners Wales
Paul Burgess	British Association of Cosmetic Nurses
Andrew Rankin	British Association of Cosmetic Nurses
Ashton Collins	Save Face
Brett Collins	Save Face
Dr Fortune Ncube	Consultant Epidemiologist and Consultant in Public Health Medicine
Nick Pahl	British Acupuncture Council
Sarah Calcott	British Body Piercing Association
Lee Clements	British Tattoo Artist Federation

23 September 2015

Organisation

Katherine Devlin	Electronic Cigarette Industry Trade Association
Tom Pruen	Electronic Cigarette Industry Trade Association
Edward Woodall	Association of Convenience Stores Ltd

1 October 2015

Organisation

Dr Steven Macey	Action on Smoking and Health (ASH) Wales Cymru
Jamie Matthews	Action on Smoking and Health (ASH) Wales Cymru
Professor Linda Bauld	Cancer Research UK
Professor John Britton	UK Centre for Tobacco and Alcohol Studies and Consultant in Respiratory Medicine, University of Nottingham and Nottingham City Hospital
Professor Peter Hajek	UK Centre for Tobacco and Alcohol Studies and co-author of the Public Health England commissioned report <i>E-cigarettes: an evidence update</i>
Dr Phil Banfield	BMA Cymru Wales
Dr Iain Kennedy	BMA Cymru Wales
Dr Alan Rees	Royal College of Physicians
Beverlea Frowen	Royal College of Physicians
Professor Alan Maryon-Davis	UK Faculty of Public Health

21 October 2015

Mark Drakeford AM

Dr Ruth Hussey

Chris Tudor-Smith

Sue Bowker

Dewi Jones

Organisation

Minister for Health and Social Services

Chief Medical Officer

Welsh Government

Welsh Government

Welsh Government

Annex C – Written evidence

The following people and organisations provided written evidence to the Committee. All [consultation responses and additional written information](#) can be viewed in full on the Committee’s website.

Organisation	Reference
Chartered Institute of Environmental Health	PHB 01
Directors of Public Health on behalf of Health Boards in Wales	PHB 02
Public Health Wales	PHB 03
Directors of Public Protection Wales	PHB 04
The Welsh NHS Confederation	PHB 05
Welsh Local Government Association	PHB 06
Paul Barnes	PHB 07
British Body Piercing Association	PHB 08
Abigail Cottrill	PHB 09
Carole Coote	PHB 10
Vince Jarvis	PHB 11
Llansteffan and Llanybri Community Council	PHB 12
Under Age Sales Ltd	PHB 13
Dr David Upton	PHB 14
British Acupuncture Council	PHB 15
Graham and Karen Wiseman	PHB 16
The City of Cardiff Council	PHB 17
Gordon Beard	PHB 18
Betsi Cadwaladr University Health Board	PHB 19
Dispensing Doctors' Association Limited	PHB 20
Wales Heads of Environmental Health Communicable Disease Expert Panel	PHB 21
Decadent Vapours Ltd	PHB 22
Caroline Evans	PHB 23
Rhydian Mann	PHB 24

Royal College of Physicians	PHB 25
British Lung Foundation	PHB 26
Welsh Pharmaceutical Committee	PHB 27
Cytûn	PHB 28
British Institute and Association of Electrolysis	PHB 29
Cardiff and Vale University Health Board	PHB 30
Wales Heads of Environmental Health	PHB 31
Older People's Commissioner for Wales	PHB 32
British Association of Cosmetic Nurses	PHB 33
Welsh Language Commissioner	PHB 34
Royal College of Nursing	PHB 35
The Faculty of Dental Surgery, Royal College of Surgeons	PHB 36
Robert Heyes	PHB 37
Company Chemists Association	PHB 38
Counterfactual	PHB 39
Royal College of General Practitioners	PHB 40
Police Liaison Unit	PHB 41
Age Cymru	PHB 42
Cancer Research UK	PHB 43
Hywel Dda University Health Board	PHB 44
Margaret Hermon	PHB 45
Save Face	PHB 46
Caerphilly County Borough Council	PHB 47
ASH Wales	PHB 48
Owain Rowley-Conwy	PHB 49
Electronic Cigarette Industry Trade Association (ECITA)	PHB 50
Merthyr Tydfil County Borough Council	PHB 51
Cardiff Third Sector Council (with input from GVS)	PHB 52
British Toilet Association	PHB 53
Jonathan Edwards	PHB 54

Paediatric Continence Forum	PHB 55
Welsh Dental Committee	PHB 56
UK Health Forum	PHB 57
Wrexham County Borough Council	PHB 58
Gower Enterprises Limited	PHB 59
Helen Smith	PHB 60
New Nicotine Alliance UK	PHB 61
Centre for Drug Misuse Research	PHB 62
One Voice Wales	PHB 63
Truckers Toilets UK	PHB 64
Alcohol Health Alliance	PHB 65
Nicoventures	PHB 66
UK Faculty of Public Health	PHB 67
Martin Hensman LLB (Hons)	PHB 68
Bevan Foundation	PHB 69
Chartered Society of Physiotherapy	PHB 70
Fontem Ventures	PHB 71
Totally Wicked Ltd	PHB 72
British Beer & Pub Association	PHB 73
Association of Convenience Stores	PHB 74
Royal College of Midwives	PHB 75
BMA Cymru Wales	PHB 76
Forest	PHB 77
The Association of Directors of Public Health	PHB 78
Philip Morris Limited	PHB 79
University South Wales – School of Life Science Education	PHB 80
Gwynedd Council (available in Welsh only)	PHB 81
Joint response from 22 organisations	PHB 82
The Urology Trade Association	PHB 83
Royal Pharmaceutical Society	PHB 84

Celesio UK and Lloyds Pharmacy	PHB 85
Powys Teaching Health Board	PHB 86
Japan Tobacco International	PHB 87
Mental Health Foundation	PHB 88
Public Health Wales	PHB 89
National Federation of Retail Newsagents	PHB 90
Federation of Small Businesses	PHB 91
Powys County Council	PHB 92
Rhondda Cynon Taf County Borough Council	PHB 93
Royal College of Psychiatrists	PHB 94
Professional Standards Authority	PHB 95
Tenovus Cancer Care	PHB 96
Tobacco Manufacturers' Association	PHB 97
Tobacco Retailers' Alliance	PHB 98
Crohn's and Colitis UK	PHB 99
Advertising Standards Authority	PHB 100
British Heart Foundation	PHB 101
Welsh Medical Committee	PHB 102
Healthcare Inspectorate Wales	PHB 103
Dee Yeoman	PHB 104
Tattoo and Piercing Industry Union	PHB 105

Additional written information was received from the following organisations and individuals

Minister for Health and Social Services – 4 September 2015	PHB AI 01
Public Health Wales	PHB AI 02
BMA Cymru Wales	PHB AI 03
Electronic Cigarette Industry Trade Association (ECITA)	PHB AI 04
UK Faculty of Public Health	PHB AI 05
Crohn's and Colitis UK	PHB AI 06
BMA Cymru Wales	PHB AI 07

Minister for Health and Social Services - 23 October 2015	<u>PHB AI 08</u>
Minister for Health and Social Services - 31 October 2015	<u>PHB AI 09</u>
Minister for Health and Social Services - 31 October 2015 (Annex)	<u>PHB AI 09</u> <u>(Annex)</u>
Minister for Health and Social Services - 10 November 2015	<u>PHB AI 10</u>
Minister for Health and Social Services - 17 October 2015	<u>PHB AI 11</u>
Minister for Health and Social Services - 17 October 2015 (Annex)	<u>PHB AI 11</u> <u>(Annex)</u>

Annex D – Engagement activity

To capture people's opinion on all aspects of the Public Health (Wales) Bill, the Committee conducted a public survey during summer 2015. A [summary report](#) of the results is available on the Committee's website.

The Committee also gathered the views of those working in the industry in relation to the provisions in Part 3 (Special procedures) for a [video](#). [Background information about participants](#) is available on the Committee's website.