OVERVIEW:

The British Medical Association (BMA) is a voluntary professional association and an independent trade union which represents doctors and medical students from all branches of medicine throughout the UK. With a membership of over 153,000 we promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality health care.

BMA Cymru Wales welcomes the opportunity to respond to the ‘Listening to you: your health matters’ consultation on the Public Health White Paper.

We are extremely concerned that the White Paper presents is a significant step backwards from the more innovative high-level proposals contained in the preceding Green Paper.

Of notable disappointment is the absence of a proposal to place Health Impact Assessment (HIA) on a statutory footing. This formed a centrepiece of the Green Paper and would have placed Wales as an international exemplar in the field of public health.

Health Impact Assessment have been researched, reviewed and promoted by the BMA across the United Kingdom in a variety of ways since 1994. The Association therefore has a long history and substantial literature on the effectiveness and feasibility of HIA.

BMA Cymru Wales responded very supportively to the Green Paper consultation; and we note that the majority of responses received from other organisations were likewise very supportive of the concept of Health Impact Assessments.

It was therefore with surprise and regret that this subsequent White Paper does not contain this proposal and that Health Impact Assessments, despite their wide support, have been dropped from the White Paper in its current form. The consultation on the Public Health Green Paper consisted of twelve questions, five of which were on Health Impact Assessments yet. The White Paper does not mention HIAs once. The Welsh Government has given no justification or reason for the change of heart on this policy.

The effect of dropping the proposal to place HIA on a mandatory legal footing in the White Paper is that the Bill is now far from innovative or groundbreaking.
The suggestion that HIA may appear as part of the anticipated Future Generations Bill (working title) is not an adequate response to BMA Cymru members' concerns given that we have no indication as to whether or not this will be the case.

As we have outlined in answer to the consultation questions which follow, we support many of the specific proposals, such as a minimum unit price for alcohol, further tobacco control measures and nutritional standards in specific public sector settings. However, many of these fall short in their ability to address the major public health challenges of our time.

The ‘once in a lifetime’ opportunity for Wales to take an international lead in adopting a truly preventative and enabling approach to public health has been lost with the removal of the proposal to place HIAs on a statutory footing.

In addition, we are further disappointed that the White Paper does not adopt the concept of an overarching framework based on a ‘Health of the People of Wales Bill’ nor does it take a true ‘health in all policies’ approach. For instance, it does not include a proposal to place a statutory duty on planning and other public bodies to consider (human health) when developing new policies. These were all central features of the Green Paper; these omissions must be rectified by amendments to the Bill.

BMA Cymru Wales will be working hard to press for this positive policy change.

**RESPONSE TO QUESTIONS:**

**Tobacco Retailers’ Register**

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

Yes.

BMA Cymru Wales widely welcomes the proposal for a tobacco retailers’ register. We believe it is a proportional and reasoned measure and need not be overly bureaucratic or burdensome on retailers.

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

i) Yes

ii) Yes

We believe that such a registration scheme is a pragmatic step in helping to prevent underage sales, sales of illegal tobacco and to check compliance with the point of sale display and advertising regulations.

We further welcome the fact that the additional information gathered by a registration scheme will support Trading Standards in making it easier to identify locations where tobacco is, or is not, permitted to be sold, especially when the ban on display of tobacco products comes into force for smaller shops in 2015.

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

Yes, although we are not best placed to suggest fee structures for retailers.

However, in the current climate it is important that it does not place an excessive financial burden upon small retailers. The proposed initial fee of £30, and £10 for every additional premise, seems reasonable.

The requirement for annual re-registration is an important prerequisite in ensuring that records are kept up-to-date for enforcement purposes.

**Question 4**

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

Yes.

Further information is required about the suggested ‘additional legislation’ regarding penalty arrangements to fully answer this question.

However, it is vital that penalties are enforceable and are clear to enforcers; penalties should also be strong enough to act as a deterrent to would-be breachers.

**Question 5**

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

Yes.

Clarity is required on how the register will apply in different ‘retail’ settings in practice – for example for promotional staff employed at festivals and sporting events.

A duty could be placed on those who register to sell cigarettes to display information on smoking cessation services at point of sale.

Limits could be placed on the number of vendors able to sell cigarettes in a particular location. This could be also be made to apply geographically – for instance limits could be placed on vendors not to sell cigarettes within a certain distance of a secondary school.

**Electronic Cigarettes**

**Question 6**

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

Yes.

At the BMA’s annual UK policy making meeting (ARM) our members overwhelmingly agreed that e-cigarettes should be included in the ban on smoking in public places.

BMA Cymru Wales therefore calls on the Welsh Government to include the devices under the products banned for use in enclosed public places. We also believe that they should only be displayed for sale alongside other nicotine-replacement therapies.
While e-cigarettes have the potential to reduce tobacco-related harm (by helping smokers to cut down and quit), we believe that a strong regulatory framework is required for the sale and use of e-cigarettes to:

- ensure they are safe, quality assured and effective at helping smokers to cut down or quit;
- restrict their marketing, sale and promotion so that it is only targeted at smokers as a way of cutting down and quitting, and does not appeal to non-smokers, in particular children and young people;
- prohibit their use in workplaces and public places to limit second-hand exposure to the vapour exhaled by the user, and to ensure their use does not undermine smoking prevention and cessation by reinforcing the normalcy of cigarette use.

We welcomed the decision by the Medicines and Healthcare products Regulatory Agency (MHRA) to regulate all nicotine-containing products, including e-cigarettes, and understand that the MHRA is looking to licence them as medicines from 2016. Part of the reasoning for this move was concern that the e-cigarettes currently on the market do not meet appropriate standards of safety and quality. The regulator said “levels of contamination” have been found in some products and others have been poorly manufactured.

This MHRA decision best reflects the products actual and intended use, and would bring the regulation of e-cigarettes in line with other available nicotine replacement therapy (NRT) products, ensuring their effectiveness, quality, and safety. The Association also recognises that e-cigarettes will be regulated under the European Union Tobacco Products Directive (TPD).

E-cigarettes are no doubt less harmful than smoking tobacco, however we believe that there needs to be more research into the safety of their long-term use.

The legal status of e-cigarettes varies around the world. In some countries (eg Denmark, Canada, Israel, Singapore, Australia and Uruguay) the sale, import, or marketing of e-cigarettes is either banned, regulated in various ways, or the subject of health advisories by government health organisations. In others (eg New Zealand), e-cigarettes are regulated as medicines and can only be purchased in pharmacies.

The UK has few and variable restrictions on the sale and use of e-cigarettes – ranging from being prohibited in some restaurants and workplaces, to restrictions in controlled environments.

Stronger controls are needed on where e-cigarettes can be used in order to protect others from being exposed to e-cigarette vapours. While the concentrations of the constituents of these vapours (propylene glycol, glycerine, flavouring substances, and nicotine) are lower than with smoked cigarettes, ‘passive vaping’ has been found to occur with the use of e-cigarettes.

Therefore, robust controls are required to ensure the use of e-cigarettes does not undermine existing restrictions on smokefree public places and workplaces, by leading people to believe it is acceptable to smoke.

Of particular concern to BMA members is their use by patients, visitors and staff in hospitals and other healthcare settings. Exposure to nicotine from e-cigarettes (either directly through their use by an individual or indirectly from the vapours they produce) may adversely impact on patients, such as those with heart or circulatory conditions, and their use may also become a source of conflict between staff and patients.

It is worth noting that smoking rates amongst adults in Wales have remained relatively static over the last three years, it is clear that further measures and legislation is now needed to increase the number of people quitting - whilst continuing to prevent others from taking up the habit.

In light of these concerns, the BMA believes the existing smoke-free legislation in place in Wales (and across the UK) should be extended to include vapour from e-cigarettes. As an interim measure, we also encourage employers to implement organisation-wide policies prohibiting the use of e-cigarettes in their workplaces (some companies have already taken this step - including train firms, airlines and the pub chain JD Wetherspoon).

**Question 7**

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

Yes.

It is vital that the use of e-cigarettes does not undermine the success of conventional tobacco control measures by reinforcing the normalcy of smoking behaviour in a way that other nicotine containing products do not. This specifically relates to the way these devices commonly resemble tobacco cigarettes, in terms of appearance, nomenclature and the way they are used, as well as features such as flavouring and styling that are potentially highly attractive to children, and may include cigarette brand reinforcement.

More research is needed to find out if the hand to mouth use of e-cigarettes either breaks or reinforces smoking behaviours, and whether e-cigarettes actually help smokers to quit.

**Question 8**

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

As we have said above more research into e-cigarette usage and long-term impact on health is required.

A 2011 review of the evidence regarding the safety of e-cigarettes concluded that they are a safer alternative to tobacco cigarettes. Their use has therefore been suggested as a way of reducing the harm associated with smoking tobacco. Despite this, there has been little research into the efficacy of e-cigarettes as aids to stop smoking or cutting down, and they are subject to limited regulation in the UK.

In the UK, e-cigarettes are subject to regulation under the General Product Safety Regulations 2005, the Chemicals (Hazard Information & Packaging for Supply) Regulations 2009, and by trading standards. There are no regulations on the sale of e-cigarettes as age restricted products, including their sale to children.

A 2008 review by the World Health Organization (WHO) does not exclude the possibility that the e-cigarette could be useful as a smoking cessation aid, but concluded that no rigorous, peer-reviewed studies have been conducted showing that the e-cigarette is a safe and effective nicotine replacement therapy.

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6 World Health Organization press release (19.9.08) *Marketers of electronic cigarettes should halt unproved therapy claims.*
There is evidence that e-cigarette products are highly variable in the efficacy of their vaporisation of nicotine. A 2013 study analysed sixteen e-cigarette brands (based on their popularity in the Polish, UK and US markets) – the total level of nicotine in vapor generated by 20 series of 15 puffs varied from 0.5 to 15.4 mg.⁷

In 2009, the United States Food and Drug Administration (FDA) released results of an analysis of some e-cigarette products⁸. The analysis found that the e-cigarette cartridges contained carcinogens and toxic chemicals. Analysis of two leading brands revealed:

- diethylene glycol (a toxic chemical) in one cartridge at approximately 1 per cent
- tobacco-specific nitrosamines (which are human carcinogens) in half of the samples
- tobacco-specific impurities suspected of being harmful to humans (anabasine, myosmine, and ßnicotyrine) in a majority of the samples.

The tests also suggested that quality control was inconsistent or non-existent:

- cartridges with the same label emitted a markedly different amount of nicotine with each puff
- one high-nicotine cartridge delivered twice the amount of nicotine compared to a nicotine inhalation product approved by the FDA.

The Trading Standards Institute and others have stated that safety concerns have come to light around some brands of e-cigarettes, including electrical safety, the need for proper labelling, and the provision of child resistant packaging.⁹

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

Yes.

Robust controls are required to ensure the use of e-cigarettes does not undermine existing restrictions on smokefree public places and workplaces by leading people to believe it is acceptable to smoke and particularly to make it clear cut for enforcement purposes.

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

This is something we could support in principle but would like to consider more specific proposals once they are brought forward.

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

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It is clear that the existing regulatory framework is inadequate in ensuring that e-cigarettes are safe and effective as a nicotine replacement therapy. This may also undermine cessation attempts. To be used as part of a harm reduction approach, there is a need to strengthen the regulation of e-cigarettes to ensure they are safe, quality assured and effective at helping smokers to cut down or quit. This includes the requirement for clear unambiguous labelling and packaging that details the contents of the cartridges and the conditions for its safe use.

BMA Cymru Wales is concerned that the marketing and advertising of e-cigarettes is misleading. E-cigarettes are being promoted on TV, internet and social media and at point of sale, often using by provocative and ‘racy’ images and language, urging potential customers to “take our freedom back.”

Therefore there is also a need to restrict the marketing, sale and promotion of e-cigarettes so that it is only targeted at smokers as a way of cutting down and quitting, and does not appeal to non-smokers, in particular children and young people. Sporting sponsorship deals involving electronic cigarettes could encourage some children to take up the habit e.g. Merthyr Town’s The Cigg-e Stadium.

The fact that the world’s leading tobacco companies are top players in the e-cigarette market speaks volumes. RJ Reynolds, Philip Morris, Japan Tobacco International, Imperial Tobacco and British American Tobacco (BAT) have all either already launched e-cigarette lines, or have them in development – and are marketing them in almost exactly the same way as cigarettes used to be in the days when tobacco advertising was still allowed; their adverts show pictures of people, basically, smoking.10

We therefore believe that advertising and availability should be subject to robustly enforced restrictions.

An opinion piece in the BMJ11 stated “Many of the ways smokers use e-cigarettes are worrisome. Some people use them as a substitute for tobacco cigarettes when they need nicotine but can’t smoke because they are at work, at a bar, or at home with objecting family members. E-cigarettes thus help maintain the smoking habit and reduce incentives to quit. Others use them as a way to cut down but revert to tobacco cigarettes on finding them unsatisfactory. Younger vapers start smoking with e-cigarettes, lured by the movie star adverts, implied safety, flavored choices, and permissibility of use anytime and anywhere.”

With the exception of statements about the product needing to be substantiated, the promotion of ecigarettes – which includes point-of-sale displays, and advertising via television, radio, in print media and online – is not specifically controlled. Their promotion ranges from being advertised as ‘cigarette substitutes’ and ‘a healthier alternative to smoking traditional tobacco products’, to evocative advertising with phrases such as ‘an exceptional alternative smoking experience’, ‘vape with style’, and ‘add flavour to your lifestyle’.

The advertising also frequently makes positive associations with recreational activities and can incorporate celebrity endorsements. It is worth noting that the provisions of the 2002 Tobacco Advertising and Promotion Act (TAPA) prohibit any brandsharing or connections with tobacco products.

We support calls for the potential banning of those e-cigarettes that resemble conventional tobacco products in order to reduce confusion over the nature and purpose of the product.

Further research about the effects of long-term use of e-cigarettes is also required, in addition to research about usage in Wales.

Smoke-free Open Spaces

Question 12

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10 See Guardian May 2014 E-cigarettes: miracle or health risk?
11 BMJ 2013;346:f3418
Do you consider that voluntary smoking bans in hospital grounds, school grounds and children’s playgrounds are sufficient, or are these areas where Welsh Ministers should consider legislating? Can you provide any evidence for your view?

Welsh ministers should consider legislating.

We believe that voluntary smoking bans have been effective in some areas but that in others they remain largely ignored and extremely hard to enforce locally.

We fully support a ban on smoking on hospital grounds, and on NHS premises (including contractor premises).

It is important to accompany these measures with smoking cessation support. The BMA has long supported a requirement for all NHS organisations to employ a specialist in smoking cessation for the purpose of helping staff and patients, and believe these services should be widely promoted.

This position is supported by NICE guidance that recommends:

- strong leadership and management to ensure premises remain smokefree
- all hospitals have an on-site stop smoking service
- identifying people who smoke, offering advice and support to stop
- providing intensive behavioural support and pharmacotherapy as an integral component of secondary care
- integrating stop smoking support in secondary care with support provided by community-based services
- ensuring staff are trained to support people to stop smoking while using secondary care services
- supporting staff to stop smoking or to abstain while at work
- ensuring there are no designated smoking areas or staff-facilitated smoking breaks for anyone using secondary care services.

Internet sales of tobacco

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

Banning the proxy purchase of tobacco is something we would support, it seems logical to take steps to deal with this issue on the same basis as an alcohol purchase on behalf of an under 18 year old would be – which is already an offence.

However, we do not have sufficient information on the extent of internet deliveries to under 18 year olds to be able to comment fully. We would therefore welcome further details and information on this.

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

Yes.

As above more information is required. However we agree with the position of ASH Wales on this - that the measure would be in line with the commitment demonstrated by other legislative steps, such as the vending
machine ban, point of sale display bans and the introduction of a retail register, to limit as far as possible the access of young people to tobacco products.

**Alcohol**

**Minimum Unit Pricing**

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

Yes.

We strongly agree with this proposal.

The BMA, which is a member of Alcohol Health Alliance UK, is a staunch supporter of a minimum unit price for alcohol across the UK.

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

Yes.

The BMA policy holds that the minimum price should be no less than 50p per unit. Modelling by Sheffield University researchers has found that a 50p minimum could reduce consumption by 6.3%, alcohol-related admissions by almost 100,000 cases a year and crime by 42,500 offences a year. A 40p minimum would bring some benefits, but much smaller.

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

Yes.

The beauty of minimum pricing, and the reason some brewers support it as well as a vast array of health professionals, is that it does not penalise moderate drinkers. Virtually all pub drinks, as well as the majority of shop-bought beers, wines and spirits would not be affected by a 50p threshold.

Instead, it would help combat the cheap end of the market – for example two-litre bottles of supermarket-brand cider or cut-price vodkas and whiskies. It is these which appeal the most to those they harm the most - younger drinkers, as well as those drinking hazardous.

It would provide a fair price for alcohol that respects its millions of safe drinkers, but also respects the potential harm alcohol can cause.

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

Yes.
To ensure it continues to be proportionate and effective the policy will need to be continuously monitored and routinely reviewed.

**Question 19**

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

We were extremely disappointed that the UK Government decided to renege on its pledge to introduce a minimum price for alcohol which it committed to in its 2012 Alcohol Strategy for England and Wales.

The policy was passed in the Scottish Parliament almost exactly two years ago but implementation has been held up because of legal challenge from the Scotch Whisky Association.

We would support a ‘definitive assessment of the National Assembly for Wales’ legislative competence to legislate’ in the area of minimum pricing – including assessment of possible penalties and enforcement mechanisms.

We would also support the devolution of alcohol licensing to Welsh Ministers.

**Question 20**

**Do you think there are other measures that should be pursued in order to reduce the harms associated with excessive alcohol consumption?**

Yes.

In addition to a minimum unit price (MUP) for alcohol the BMA is pressing the UK governments to also:

- Increase and rationalise tax to ensure it is proportional to alcoholic content
- Reduce licensing hours
- Ensure licensing legislation is strictly enforced
- Ban on all alcohol marketing communications
- Improve labelling, to include alcohol content, advice on recommended daily guidelines, and a health warning
- Introduce a compulsory levy on the alcohol industry to fund an independent public health body to oversee alcohol-related research
- Reduce the legal limit for the level of alcohol permitted while driving from 80mg/100ml to 50mg/100ml
- Ensure the detection and management of alcohol misuse is an adequately funded and resourced component of primary and secondary care
- Increase and ring-fence funding for specialist alcohol treatment services
- Lobby for and support the WHO in developing and implementing a legally binding international treaty on alcohol control.

In London, Transport for London has a policy in place that bans passengers from drinking alcohol or carrying open containers of alcohol on public transport e.g. on buses and railways. This policy could be introduced by the Welsh Government to all public transport in Wales; it would go a long way to help curb alcohol related disorder.

There is a great deal of confusion amongst the public around what constitutes a unit of alcohol. Introducing a requirement in pubs and clubs that alcoholic drinks need to be ordered and served in units rather than other measures (pints etc) would help to educate people about responsible drinking.
Obesity

Nutritional Standards

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

Yes.

The BMA has published a number of reports on obesity and nutrition, which can be accessed on our website at www.bma.org.uk:

- Preventing Childhood Obesity in 2005
- Adolescent health (2003)
- Early Life Nutrition (2009)

The BMA Board of Science is developing a policy report on ways to promote healthier diets among children and young people (to be published later in 2014). One aspect it is looking at is food standards in schools and in healthcare environments.

To date we do not have substantive publications or information on nutritional standards in care homes. However, we do support this proposal, as we know that individuals who are overweight have an increased risk of a wide range of serious life-threatening and chronic diseases. These include diabetes, cardiovascular disease, certain cancers (including colon, ovarian and endometrial cancers), osteoarthritis and gout. Children are also not immune from these risks.

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

Yes – hospitals. We would welcome an update on implementation of the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients (2012).

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

Yes.

Our members witness first hand the effects of obesity on the health of their patients. While doctors have a key role in providing advice on dietary choices and physical activity patterns, this needs to be supported by a comprehensive range of public health interventions to tackle the obesity epidemic. The proposals in this White Paper do not go nearly far enough in this regard.

Legislation is required to help people make healthy choices, individual programmes alone are likely to have little effect – a comprehensive strategic approach is needed.

BMA Cymru Wales is disappointed that neither the EU nor the UK government has backed mandatory ‘traffic light’ labels for food packaging; We have repeatedly called for the introduction of a standardised, consistent approach to food labelling based upon the traffic light front of pack labelling. In order to increase the nutritional information available to consumers we believe that the labelling should also include Guideline Daily Amount (GDA) information.
We remain concerned that unhealthy food is positively marketed to a young audience. The BMA believes that there should be a complete ban on the advertising and marketing of unhealthy foodstuffs. This should include product placement and inappropriate sponsorship programmes targeted at school children.

A significant proportion of the UK population are consuming saturated fat, salt and added sugar above recommended guidelines; and too little fruit, vegetables, oily fish, and fibre. More needs to be done to promote healthy eating – subsidising the cost of fruit and vegetables for instance.

Maternal obesity is associated with an increased risk of major chronic disease for their offspring in adulthood. Rates of obesity in pregnancy are rising across the UK, steps need to be taken to ensure that young people understand the importance of health and wellbeing before pregnancy, giving attention to their diet and optimal body weight before planning a pregnancy. This includes offering nutrition education and counselling, which have been shown to improve knowledge and behaviour. The BMA believes that the Government should continue to provide education and support that promotes and prolongs the duration of breastfeeding.

Physical activity levels in the UK are very low and have been declining for the past 30 years. At the same time, sedentary activity is increasing. Promoting physical activity is therefore an important aspect in reducing the levels of obesity in the UK. This can be achieved by the implementation of policies that promote active travel and other activities that involve physical exercise – e.g prioritise active forms of travel as a means of incorporating physical activity into the daily routine and make them a cheaper alternative to car use for example.

BMA policy also calls for all NHS premises to display clearly the healthcare risks involved with junk food and drinks, especially in kitchen areas and on vending machines; and for NHS premises ban the sale of junk food and unhealthy drinks.

It also calls on UK departments of education to ensure that all schools deliver an appropriate physical education curriculum that ensures our children have achieved basic movement skills on which to build regular exercise.

Pre-surgical weight loss also needs revising to be more effective and focused.

**Building community assets for health**

**Better planning and delivery of public health services through community pharmacy**

**Question 24**

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

Yes.

We consider that the overall growth in community pharmacies has led to the increased availability of routine pharmacy services, which is a very welcome development.

Many GPs across Wales already have close working relationships with their pharmacist colleagues, and that is happening very effectively to the benefit of local patients. There are further ways in which joint working could be considered and we are open to the development of that agenda.

For instance, GP Practices and pharmacies could co-operate in specifically targeting harder to reach populations or patient groups, with chronic diseases such as hypertension. Once patients have been
identified and stabilised in general practice, there is clearly a role of community pharmacy in monitoring patients along an agreed care pathway. Many dispensing practices already employ pharmacists and do undertake this type of work.

Community pharmacy services should be considered holistically, alongside the role and relationship to all other components in the patient pathway and local health services.

**Question 25**

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

Yes.

It is essential to be aware that where community pharmacies are set up in localities which are already served by established dispensing practices, these areas are so-called controlled localities and are rural in nature, that the long-term future of the services provided by the GP Practice will be compromised.

Owing to the very tight financial situation, dispensing income has become a vital stream of funding for the provision of primary care services in many rural areas. The revenue that practices receive from providing dispensing services may not have been designed to subsidise the provision of general medical services in rural areas but in reality this is very much the case. This is clearly demonstrated in the Cost of Service Inquiry commissioned by the Department of Health in 2010.

The recruitment and retention of doctors in these hard-to-staff areas is a serious and longstanding issue, and must also form an essential part of national and local policy deliberations and such needs assessment.

**Question 26**

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

There is certainly more that community pharmacy can do to contribute to health services in Wales.

As we have said, pharmacy provision should be considered holistically, alongside its role and relationship to all other components in the patient pathway.

**Question 27**

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

As above

**Question 28**

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

Yes. With consideration to the impact on other health services locally.
Question 29
Do you consider that it is appropriate for applications to provide pharmaceutical services to be determined on the basis of the contribution that all the services they propose might make to address local health needs?

Yes. With consideration to the impact on other health services locally.

Question 30
Do you agree with the proposal to allow Local Health Boards to invite community pharmacies in their area to provide specified services to meet identified pharmaceutical needs and, where those pharmacies are unable to do so adequately, invite additional pharmacies to become established in order to provide pharmaceutical services? If you disagree please explain your reasons.

Yes. With consideration to the impact on other health services locally.

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

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

The provision of pharmacy services, alongside tobacco and alcohol sales (e.g. in supermarkets) has been highlighted by members as undermining public health messages and interventions.

Toilets for public use

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

Yes, we would welcome further details such as minimum standards for such a strategy and how it will be monitored.

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

We are not best placed to answer this question.

Question 35
Are there any other impacts in relation to this proposal on which you would like to comment?
We support calls for a statutory duty to be placed on local authorities to provide a minimum number of public toilets in particular locations, this duty should include the provision of information on the whereabouts, facilities available and accessibility etc.

**Regulation for health - A National Special Procedures Register**

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

No, we do not believe that current arrangements protect the public effectively.

The current voluntary arrangements mean that there is significant variation in regulation across Wales. Many of these procedures are invasive and have the potential to cause harm - the general public may not understand the associated risks and assume that there are regulations already in place.

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

We do not hold such evidence although harms related to skin infections, allergic or toxic reactions and the risk of transmission of blood borne viruses following skin piercing procedures are clear.

In relation to cosmetic piercing, we support calls to restrict intimate piercings to those who are 18 years or older.

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

Yes.

This would provide a consistent approach across Wales, and improve the information available to the public.

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

Consideration should be given to including procedures that have the potential to cause harm, including:
- Laser hair removal
- Chemical peels
- Dermal fillers
- Scarification/Branding
- Sub-dermal implantation (or 3D implant)

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

Yes, to ensure it is workable and relevant – responding to new procedures for example.
Question 41
Should the registration fee be set locally or nationally?

We are not best placed to answer this question and would welcome further information.

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

Re-registration should be undertaken regularly but not so that it is unmanageable or overly bureaucratic. We would suggest every three years may be reasonable.

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

Yes.

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

Yes – as a minimum.

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

Yes, with adequate resourcing.

Next steps

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

Yes. Please see our comments at the beginning of this paper in relation to Health Impact Assessments.

For further information please contact Lucy Merredy, Head of Policy and Committee Secretariat
029 2047 4646
lmerredy@bma.org.uk