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Health Committee

Smoking in Public Places

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Volume II

Written evidence

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The Health Committee

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Memorandum by Thomsons Solicitors (SP02)

INTRODUCTION

Thomsons Solicitors is the UK’s largest trade union and personal injury law firm. It has a network of 22 offices across the UK, including the separate legal jurisdictions of Scotland and Northern Ireland.

Thomsons only acts for the victims of injury, never for employers or insurance companies. Thomsons brought the first successful passive smoking case and is currently acting for a number of clients with illnesses caused by second-hand smoke.

Thomsons has provided expert evidence to a number of enquiries and reports on the effects of passive smoking, including the Royal College of Physicians’ newly published Going Smoke Free publication.

THE HEALTH COMMITTEE INQUIRY

The evidence that there is some health risk to non smokers from inhaling environmental tobacco smoke (ETS) is now unarguable. At present approximately 2.2 million employees are working in premises where smoking is allowed throughout.

The Labour Force Survey figures for 2002 show that 320,000 people work in pubs, bars and nightclubs. The vast majority of these workers would remain exposed to ETS under the Governments proposal to allow smoking in licensed premises not serving food.

Currently there are no specific legal controls applying to workplace exposure to ETS. Employers must deal with this hazard in the context of their general health and safety duties to safeguard their workforce. The injured non smoking employee exposed to ETS is currently forced to pursue damages in the courts, a time consuming and expensive procedure for all concerned necessitating an adversarial approach.

The law requires a claimant to prove:

— The employers knew or should reasonably have known that second hand smoke presented a risk of injury to their non smoking employees.

— The employers had this knowledge at the time the relevant exposure took place. Many claims involve historical exposure going back over many years, so recent developments and reports are of limited assistance.

— The employer knew not only of the general risk from second hand smoke, but also that they knew that the individual employee was being exposed to dangerous levels of smoke in her day to day work. This needs evidence from work colleagues and would require the Court to make the best assessment it can on the basis of that evidence as to what the levels of exposure were.

Only if it is decided that the exposure levels were high enough to mean that the employer should at the time have done something about it, would the exposure potentially found a claim.

— The employee would need to prove that the medical condition she had developed had been caused by the exposure at work, rather than by any exposure she may have had outside work. A claimant who lives with a smoker is, therefore, likely to encounter significant difficulties. So is someone who regularly socialises with smokers or who is an ex smoker herself. All these things would be matters of evidence requiring not merely a detailed analysis of the claimant’s lifestyle, but also the consideration of this evidence by medical experts. It may be sufficient to prove that the occupational exposure made a material contribution to the development of the condition, rather than being its sole cause, but the hurdles will be high.

None of the above means that claims for occupational exposure to cigarette smoke are impossible. They are challenging and the odds are stacked against them. A few cases have already succeeded and Thomsons is running an increasing number of viable cases for clients working outside the hospitality industry, including a young solicitor (age 28) suffering from asthma, with the lung capacity of the average 56 year old exposed to ETS in an office where smoking was allowed throughout. We are also acting for a computer technician who suffered bronchial shock and an exacerbation of his dormant asthma condition within minutes of working on equipment in a hospital doctors rooms.

Good employers already treat the issue proactively as one of industrial relations, which requires the active involvement of the workforce and their trade unions in finding a solution.

But more needs to be done. Good practice needs to be rewarded. Poor health and safety needs to be exposed and condemned. For many, perhaps most, enclosed workplaces, the banning of smoking is likely to be the outcome. This requires firm and simple legislation banning ETS from all public spaces without exception. We cannot see, with the health risks so well known, what justifiable exceptions there could be. An extension of that would logically include workplaces. Only in this way would it be possible to protect those employees forced to work with less enlightened employers.
We should not look back in years to come and regret the wasted opportunity for clarity and leadership in a key area of health and safety. We must not allow another asbestos horror to develop, where government dithering will have cost thousands of avoidable deaths.

Many workplaces are also public places. Employers should not be allowed to use the excuse of the public’s desire to smoke as a means of failing in their primary duty to protect the health and safety of their workers. The employer who does nothing at all to deal with the health hazards of ETS among their workforce is storing up significant problems for the future.

Compensation claims may always remain difficult but there will be those which can succeed. And it is the employer who does nothing to address the problem who is most likely to be at risk from such claims. The Government faced with an obvious issue of Public Health should not be afraid of passing firm and simple legislation banning ETS from all workplaces.

September 2005

Memorandum by the Royal College of Nursing (SP03)

1. INTRODUCTION

1.1 With a membership of over 380,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets the RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 The RCN welcomes and supports the proposal to introduce smokefree legislation in the Health Improvement and Protection Bill, but disagrees with some of the proposed exemptions. In particular the proposed exemptions which would allow licensed premises that do not serve food to be excluded from the ban or for allowing an extra year for licensed premises to comply with the legislation.

1.3 The Government is sending out mixed messages. On the final day of the Government consultation on the Smokefree Elements of the Health Improvement and Protection Bill a high profile “Second-hand Smoke Kills” campaign was launched. However, the Bill as currently drafted continues to permit smoking in certain enclosed public places. It is proven that second-hand smoke does kill. Therefore, the Government should be sending out a clear message that it is unacceptable to smoke in all enclosed public places without exception.

1.4 There are currently around 500,000 nurses working in a variety of settings, including prisons, mental health settings and hospices. These nurses are in key positions to influence the development of healthy working environments. Nurses equipped with smoking cessation skills working in communities throughout the UK are well placed to work with their patients to help them to quit smoking and improve their health as a result.

2. SUMMARY

2.1 The RCN supports legislation which aims to reduce the number of deaths from smoking. However, only a complete ban on smoking in all enclosed public places will protect people from second-hand smoke, act to tackle the health inequality gap, encourage people to give up and ultimately act as a deterrent. This position was supported overwhelmingly by 86% of members at the 2004 RCN Congress.

2.2 Smoking is the biggest cause of preventable ill health and premature death in the UK, killing more than 114,000 people every year. The NHS spends approximately £1.5 billion a year treating diseases caused by smoking rather than on preventing ill health.

2.3 Closing the health inequality gap between the richest and poorest communities is a key Government priority. Far from decreasing inequalities this Bill could help to widen existing inequalities. Evidence shows that licensed premises in deprived areas are less likely to serve food and, therefore, more likely to be excluded from a ban.

2.4 Second-hand smoke is a serious danger to health. Exposure to second-hand smoke in the workplace causes 617 deaths each year, more than two and a half times those killed in all industrial accidents every year in the UK.

2.5 The RCN believes that it is imperative to the success of the Bill that all smokers are provided with support to encourage and promote smoking cessation. Cessation support is proven to double the success of quit attempts.
3. **Definition of “Enclosed”**

3.1 The RCN is convinced that the legislation should apply to all enclosed public places. The RCN recognises that exposure to environmental tobacco smoke or second-hand smoke is a significant public health hazard in its own right. As such the legislation should be comprehensive to ensure that all workers are protected from the harmful effects of second-hand smoke in their workplace—whether this is in a restaurant, bar, beer garden or football stadium.

3.2 The RCN believes that introducing national smoke-free policies is the only effective means of health prevention and promotion and the only effective way of ensuring that the health benefits of a ban on smoking is felt across the social spectrum. Secondhand smoke in a public place is a proven danger to health with 30 people a day dying as a result of exposure to second-hand smoke. Exemptions, if any, should be restricted to outdoor areas in open countryside.

4. **Longer Lead in Time for Licensed Premises**

4.1 The RCN sees no justification behind the proposal for a longer lead-in time for licensed premises. In Ireland where the law applies to most workplaces, with very few exceptions, compliance within the first month of legislation being introduced was extremely high with over 97% of workplaces complying.

4.2 Estimates suggest that at least one hospitality worker per week dies as a result of exposure to second-hand smoke. By allowing a longer lead in time for a ban on smoking in licensed premises hospitality workers lives would still be at risk from the harmful effects of second-hand smoke and it would, therefore, be unfair to discriminate against these workers. The RCN believes that protection should be extended to all workers at the same time and believes that a ban on smoking in licensed premises should be introduced as part of the legislation in 2007. The RCN can see no logical reason why licensed premises should not become smokefree at the same time as all other workplaces and enclosed public places.

5. **Exclusion of Licensed Premises that do not Prepare and Serve Food**

5.1 The RCN sees no logic or justification for this exemption. All licensed premises are workplaces and should be regulated as such. People working in licensed premises should, without question, be entitled to the same protection from the health effects of second-hand smoke as those working in any other environment. The proposed exemptions for pubs and clubs would leave many of the employees who are currently at greatest risk from second-hand smoke, still exposed to this danger and this cannot be justified. The proposals to delay a ban on smoking until 2008 and exempt licence premises that do not serve food is nonsensical. Whether a pub serves food or not is irrelevant, when considering the damage caused by inhaling second-hand smoke.

6. **Implementation Date**

6.1 The RCN considers that the optimum time of year to introduce comprehensive smokefree legislation is in spring 2007. The impact on public health from an entire ban on smoking in all enclosed public places will be such that this legislation should be introduced as quickly as possible. However, it is necessary to allow a long-enough lead in time to ensure that the public and smoke-free premises are adequately prepared to enforce the legislation. March 2007 would give over a year to ensure co-operation for the ban and to gain maximum public co-operation.

7. **Impact on Health Inequalities**

7.1 The RCN welcomes the work that the Government is doing to introduce health trainers and improve people’s health choices, however we believe that a full ban on smoking in all enclosed public places should be viewed as a vital step in improving the health of those living in Britain’s poorest communities. Without a full ban on smoking in all enclosed public places the inequalities in health between the richest and poorest communities will continue to exist and could even widen.

7.2 Smoking prevalence among manual groups is consistently higher than in non-manual groups in the adult population as a whole. In real terms in 2003 smoking prevalence in manual groups was 48% higher than in non-manual groups.

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1 The Scientific Committee on Tobacco and Health (SCOTH) report—www.advisorybodies.doh.gov.uk/scoth
4 Professor Konrad Jamrozik, University of Queensland, Australia writing in the BMJ, 2 March 2005
7.3 Evidence from a recent British Medical Journal Survey found that rather than reducing health inequalities the Health Improvement and Protection Bill, with the current exemptions for licensed premises not serving food, could in fact lead to widening health inequalities between the richest and poorest communities. By looking at the most deprived areas in the Borough of Telford and Wrekin the survey estimated that two thirds of pubs in the most deprived areas would be excluded from a ban whilst only a quarter of pubs in affluent areas would be excluded.  

Dr Alan Woodall, Telford & Wrekin Primary Care Trust, Published in the British Medical Journal, 18 August 2005.

8. CONCLUSION

8.1 The RCN supports the Smokefree elements of the Health Improvement and Protection Bill but believes strongly that it does not, as proposed, go far enough. We are urging the government to learn from the experience of other countries and implement comprehensive smokefree policies in all enclosed public places and workplaces, without exception, by March 2007.

SEPTEMBER 2005

MEMORANDUM BY THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (SP04)

1. THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales. It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation.

The primary objectives of the RPSGB are to lead, regulate, develop and represent the profession of pharmacy.

The RPSGB leads and supports the development of the profession within the context of the public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession’s policies and views to a range of external stakeholders in a number of different forums.

The RPSGB has responsibility for a wide range of functions that combine to assure competence and fitness to practise. These include controlled entry into the profession, education, registration, setting and enforcing professional standards, promoting good practice, providing support for improvement, dealing with poor performance, dealing with misconduct and removal from the register.

The RPSGB is a member of the Smoking Control Network, a collaboration of leading British health charities and commercial and professional organisations that work together to reduce the deaths and disability caused by smoking-related diseases.

2. THE RPSGB POLICY POSITION

The RPSGB is fully supportive of banning smoking in public places and has been keen to see this measure brought forward by the Government for a number of years. In December 2002, this matter was discussed by the RPSGB Council following a motion put forward by Mr Hemant Patel (now President of the RPSGB). The motion asked the Council to call for a ban on tobacco smoking in public places, including pharmacies, and a new tax on tobacco companies to cut passive smoking deaths.

The Council agreed that the terminology “public buildings” be used instead of “public places.” It was agreed that the RPSGB would call for a ban on smoking in public buildings, with a view to this becoming part of a wider policy on public health in the future.

3. RESPONSE TO THE SELECT COMMITTEE

1. The RPGB welcomes the Government’s broad aim of reducing smoking in enclosed public places and workplaces. We do not see the justification, however, for exempting private members’ clubs or pubs which do not serve prepared food, or for allowing an extra year for licensed premises to comply with the legislation. The RPSGB urges the Government to put forward comprehensive smoke-free legislation to protect workers in all workplaces and to bring this into effect across the country as soon as possible and certainly by the end of 2007.
2. The evidence about risk to workers’ health of second-hand smoke is clear and well documented, not least by the British Medical Association and the Chief Medical Officer. Bar workers’ health is continuously put at risk from second-hand smoke. These groups of workers were specifically identified in a report of the Scientific Committee on Tobacco and Health issued with the White Paper. Research by international expert, Professor Konrad Jamrozik, estimated the number of UK deaths from second-hand smoke in the workplace at 617 per year, including hospitality workers, the equivalent of one death a week.

The Department of Health, in response to the White Paper, Choosing Health, commissioned four professional bodies to develop a public health strategy for pharmacy. The RPSGB was part of this group. This further developed the RPSGB’s strategy to make more use of pharmacists’ skills in providing support for smoking cessation.

For every two smokers who quit, one premature death will be prevented. NHS Stop Smoking Services are used by increasing numbers of people. There is a strong evidence base for the effectiveness of pharmacy-led stop-smoking programmes. NHS smoking cessation services in community pharmacy are a major public success story, in some cases enabling Primary Care Organisations (PCOs) to achieve their stop smoking targets. They have also been shown to be cost effective. Over 50% of PCOs are already commissioning NHS stop-smoking services through pharmacy: there is the potential for community pharmacy to become one of the major providers of NHS stop-smoking services. It is important that pharmacists are aware of local PCO smoking cessation programmes and standards, including local training and/or guidance. Pharmacists should also follow the practice guidance produced by the RPSGB, NICE and Pharmacy Healthlink (currently being revised).

About 70% of smokers want to give up. The wide variety of accredited services available to help smokers to stop, further reinforces the argument that smoking should be banned in all public places.

4. SUPPORTING PROCESSES TO HELP PEOPLE STOP SMOKING—THE ROLE OF THE COMMUNITY PHARMACIST

(i) The role of the community pharmacist

The role of community pharmacists in helping the general public to stop smoking developed in the 1990s when community pharmacists became part of a Department of Health scheme to provide a week’s supply of nicotine replacement patches free of charge. NHS Stop Smoking Services are used by an increasing number of people. There is a strong evidence base for the effectiveness of pharmacy-led stop-smoking programmes, in some cases enabling PCOs to achieve their stop smoking targets.

(ii) Quality Standards for NHS stop-smoking services

The Health Development Agency has produced a national training standard for the NHS smoking cessation services. All pharmacists and providers of pharmacy training services have to meet these standards. The HDA, now part of the National Institute for Health and Clinical Excellence (NICE), will be exploring the accreditation of NHS stop-smoking services.

(iii) Guidance for pharmacists

NICE, Pharmacy Health Link and the RPSGB have recently produced a new guidance—Helping smokers to stop: advice for pharmacists in England.

(iv) Public health strategies

The Department of Health public health White Paper was issued last year and in response the RPSGB welcomed the Government’s broad aim to reduce smoking in enclosed public places and workplaces. This was later followed by, Choosing health through pharmacy—A programme for pharmaceutical public health 2005–15, which describes the role for community pharmacists in providing support for stopping smoking.

Rosie Winterton MP, the Minister of State for Health Services, commented in June 2004: “To date pharmacists have been a major untapped resource for health improvement. The track record of community pharmacists in areas such as stopping smoking, sexual health advice and substance misuse is evidence of how integral they are in tackling public health issues. But we would like pharmacists to do even more.”

8 Estimate by Professor Konrad Jamrozik of Imperial College London for a conference of Physicians in May 2004 (See www.ash.org.uk/html/factsheets/html/fact14.html
13 Helping smokers to stop: advice to pharmacists in England—www.nice.org
(v) A new community pharmacy contract

A new community pharmacy contractual framework for England and Wales was implemented April 2005. This regularised the role of community pharmacists in providing public health advice as part of their “essential services” role. Six key public health campaigns have to be delivered every year.

Ten contractual frameworks have been agreed by the Pharmaceutical Services Negotiating Committee, the Department of Health and the NHS Confederation to enable community pharmacists to provide the enhanced service elements of the new contract. A toolkit for pricing these services that will identify the elements to be considered at a local level will be published at a later date. Stop Smoking is one of the services that PCO’s can commission from their community pharmacists.

(vi) Conclusion

The RPSGB is fully supportive of the Government’s broad aims to reduce smoking in enclosed public places and workplaces and is committed to supporting the development of new services.

The RPSGB recommends that the Government pursues a comprehensive ban on smoking in public places. The current proposals for a partial ban run the risk of increasing undesirable health inequalities. A complete ban would be of greater benefit to the public and would be far easier to implement and enforce.

September 2005

Memorandum by Asthma UK (SP05)

INTRODUCTION

1. The following submission is made by Asthma UK. Asthma UK is dedicated to improving the lives of the 5.2 million people currently receiving treatment for asthma in the UK, 4.6 million of whom live in England and Wales. We work with people with asthma, healthcare professionals and researchers to develop and share expertise to help people increase their understanding and reduce the effect of asthma on their lives. We monitor the needs and priorities of people with asthma, and they consistently tell us that other people’s smoke has a major impact on their everyday lives. We are part of the Smokefree Action coalition and the Smoking Control Network and we would like to be considered for oral evidence to the Committee.

2. Our submission explains why we need comprehensive smoke-free legislation in legislation that restricts smoking in all the places where people go to work or socialise.

THE NEED FOR COMPREHENSIVE SMOKE-FREE LEGISLATION

3. Comprehensive legislation is important for England and Wales because it will save hundreds if not thousands of people’s lives every year. The number of negative effects of second-hand smoke is staggering. As little as 30 minutes exposure to second hand smoke is enough to measurably reduce coronary blood flow in non-smokers. The Department of Health’s Special Committee on Tobacco and Health (SCOTH) states in unambiguous terms that second-hand smoke causes lung cancer, ischaemic heart disease and a variety of respiratory diseases. The Royal College of Physicians recently announced that second-hand smoke is responsible for 12,000 fatalities in the UK every year, 600 of which are due to exposure at work. Respiratory diseases are becoming increasingly serious. They are now responsible for the majority of emergency admissions to hospital, and are responsible for more fatalities than Coronary Heart Disease.

4. Why is comprehensive smoke-free legislation important for people with asthma? An individual’s right to smoke does not trump the right of those around them to breathe clean air. For people with asthma, smoke is a potent lung irritant, and even a small amount is capable of triggering asthma attacks. For those that suffer from severe asthma symptoms a smoker’s decision to light up in public places can have very serious, potentially lethal, consequences. Legislation that makes public places smoke-free is important for people with asthma because of the big improvements it will bring to their lives.

— The vast majority of people with asthma—82%—say that other people’s smoke makes their asthma worse. Many of these people cannot go to the public places where other people smoke.

— 40% of adults with asthma say they avoid smoky pubs and restaurants.

— In the lead up to the last general election, Asthma UK conducted a web poll that found that restricting smoking in workplaces and enclosed public places was the most important election issue for people with asthma.

14 Woodall AA et al (2005). The partial smoking ban in licensed establishments and health inequalities in England: modelling study. BMJ 331: 488-499. [Estimates that 43% of pubs would be exempt from the partial smoking ban, and shows that “people in deprived areas are more likely to live near licensed establishments exempt from legislation to protect them against smoking”.]
Comprehensive legislation is important because it will help to reduce the number of people who develop asthma in the future. Exposure to second-hand smoke at work doubles the risk of acquiring adult-onset asthma, and living with a smoker increases the risk of developing asthma by five times (7). Children whose parents smoke are 1.5 times more likely to develop asthma (8).

5. Exemptions create significant enforcement issues. Exemptions complicate matters because they create the need to differentiate between smoking and non-smoking premises, and increases the need for enforcement officials to ensure compliance. By comparison, comprehensive policy makes things much simpler. People come to expect clean air in public places, and social pressure largely replaces the need for formal enforcement authorities.

Definitions

6. In our recent response to the Department of Health consultation on the smoke-free elements of the Health Improvement and Protection Bill, we raised two objections to the proposed definitions of "smoke" and "smoking". The rationale provided in the consultation document for limiting the definitions to refer to tobacco and tobacco-containing substances is straightforward: the accumulated medical evidence examines the effect of tobacco smoke on the general population, and there is a lack of evidence on the health effects of other kinds of smoke. From our perspective, the legislation needs to recognise that any kind of smoke is capable of triggering sudden asthma attacks and needs to restrict smoking altogether, regardless of whether that smoke comes from tobacco or something else. Limiting the definitions also leads to practical difficulties. For example, those responsible for ensuring compliance need to be able to immediately and unambiguously distinguish between tobacco and non-tobacco smoke. Limiting the definitions will inevitably lead to confrontation and disputes, which will undermine the ability of proprietors and staff to enforce rules. This in turn heightens the demand for appropriately empowered enforcement officials to settle disputes. A definition of smoking that covers smoke from all substances would be much more straightforward.

7. In the same consultation response we also expressed reservations about the strong emphasis on restricting smoking in "enclosed" spaces. The legislation should focus on protecting people from exposure from other peoples’ smoke, whether it be outdoors or indoors. We have no major objections to the proposed definition, provided that it is accompanied by regulations to clearly identify "open" public places where smoking should not be allowed. Regarding public places that fall outside the definition, we support the proposal to include regulatory powers to cover gaps left by the definition of "enclosed public place". We also agree with the suggestion that sports stadia are an example of kind of a public place that should be included. The principle that should guide the selection of other places should be simple: it should to restrict smoking in places where non-smokers (both workers and other members of the public) will be exposed to other peoples’ smoke. Examples of such places would include bus shelters, outdoor garden areas of pubs or clubs, and outdoor theatres or music venues.

Exemptions

8. On the issue of exemptions of pubs that do not “prepare and serve food” — We strongly object to the proposal of providing exemptions to pubs that do not prepare and serve food. There are at least five reasons why these exemptions are unacceptable.

— They are not based on, nor are they supported by, health evidence. There is no health evidence underlying the decision to permit smoking in pubs that do not serve and prepare food.

— With exemptions, the legislation fails to protect many of those most at risk. Every person has a right to work in a safe environment, and every employer has a duty to ensure that right. The SCOTH report identifies that hospitality workers are most at risk from the harmful effects of smoke (2), and with exemptions, the legislation fails to protect many of these workers. We are particularly concerned about hospitality workers with asthma. For people with asthma that work in smokey environments, a shift of several hours leaves their lungs continually agitated for a long while afterwards. Doing simple things like climbing a flight of stairs, or running to catch a bus can bring on debilitating attacks of coughing or wheezing. They come to lead progressively constrained lives, and live with a much higher risk of having a serious, perhaps fatal asthma attack. Worst of all, living continuously with symptoms causes irreparable damage to their lungs, and over time, these people will experience dramatic decreases in their lung function (9).

— Exemptions make the policy complicated to the point of being unworkable. They will require the introduction of licensing systems, which themselves need significant investment of time and resources. The operation of these systems will hinge on definitions for intrinsically ambiguous concepts such as “serve and prepare food”. The creation of loopholes and confusion are virtually guaranteed, and will ultimately undermine effective enforcement.

— Exemptions undermine government targets. Reducing the number of places where people can smoke helps people to change their smoking patterns, and helps them quit (3). In the Choosing Health White Paper, smoke-free legislation is clearly presented as part of a larger strategy to help people quit smoking (10), but providing exemptions in the legislation will seriously undermine Government’s ability to meet its targets for reducing smoking prevalence. It is absolutely critical
that smokers who have asthma are encouraged to quit. 25% of people with asthma smoke, with dramatic repercussions on their health. They experience accelerated decrease in lung function after the age of 30, and to make matters worse, smoking reduces the effectiveness of corticosteroid asthma medications. Without this cornerstone treatment for preventing asthma attacks, their ability to control their condition is severely undermined. Another health target that exemptions undermine concerns the government’s efforts to combat binge drinking. Exemptions will create pubs that specialise as smoking and drinking venues. Food slows the penetration of alcohol, mitigating against its more extreme effects. Because food will not be available, exempt pubs will be much more likely to become places where problem behaviour is more likely to occur. They are also likely to become enclaves that reinforce dysfunctional behaviour. Dependency on alcohol and tobacco are mutually reinforcing, and the emergence of specialist smoking and drinking venues are more likely to encourage rather than discourage unhealthy habits and problematic behaviours.

Finally, exemptions deepen existing health inequalities by discriminating against lower socio-economic groups. Prevalence of smoking is higher amongst these groups. Incentives for pubs to switch to serving only alcohol will be stronger in lower income areas. Lower socio-economic groups will tend to experience fewer incentives to stop smoking, and as a result will tend to be exposed more to second hand smoke and suffer more serious health consequences. Studies from the UK and elsewhere illustrate a strong association between high asthma morbidity and mortality among lower socio-economic groups, and we expect that the proposed exemptions will exacerbate existing health inequities for people with asthma.

9. Exemptions—Residential premises. People have the right to a home life. Places such as prisons and residential psychiatric institutions are a challenge for the legislation because they are private residences in some ways, and public places in others. There are additional complications because they are often home to people with behavioural problems, and complete bans run the risk of creating additional difficulties. For instance, experience in America illustrates that banning smoking in prisons can lead to cigarette smuggling and other disciplinary problems. Complete bans also raise human rights concerns. For example, it is not right to deny cigarettes to people with mental illnesses who have been institutionalised against their will. In circumstances such as these, the legislation needs to find the right balance between individuals’ right to smoke in their home, and the duty to protect others from the effects of that smoke. The legislation should also provide an environment that encourages people to quit, but does not coerce them to do so. In order to meet this balance, we recommend that group residences be required to create designated smoking areas where residents and staff can go to smoke, and where that smoke will not affect other residents or employees.

10. Exemptions—Membership clubs. We strongly object to proposal of making private clubs exempt. This is because the staff of membership clubs would not be granted their basic right to a safe work environment.

ENFORCEMENT ISSUES AND PENALTIES

11. Offences, penalties and defences—The offences and defences are suitable, but the proposed penalties for establishments failing to enforce smoking restrictions need to be revisited. In particular, a £200 fine for failing to discourage patrons from smoking does not provide a strong enough incentive for enforcing no-smoking rules. At £200, establishments opposed to the legislation could decide to flout restrictions and expect that the revenue gained from smoking patrons would easily offset the fine. The fine should be higher, and it should increase with repeat offences, possibly to the point where liquor license is revoked after multiple offences.

12. Enforcement—Exemptions make enforcement complicated. By comparison, a comprehensive policy will be much clearer and easier to enforce. One of the biggest benefits of comprehensive legislation from the point of view of enforcement is that the public comes to expect clean air. In public places, social pressure becomes a powerful curb on smoking and drastically reduces the need for enforcement by formal authorities.

13. Smoking at the bar—The consultation document recognises that the proposal of restricting smoking around the bar will not result in any health improvement. This proposal cannot be considered a serious alternative to restricting smoking, and we consider it to be unacceptable.

TIMETABLE

14. Timetable—The time for the policy to be introduced is far too long. Clearer, simpler legislation without exemptions would be easier to implement and require less time. Given the severity of the health effects of second-hand smoke, the policy should come into force as soon as possible, certainly much earlier than the end of 2008. Evidence suggests that advancing the schedule by one year could save 600 lives.
DEALING WITH OBJECTIONS TO COMPREHENSIVE LEGISLATION

15. Given the weight of evidence gathered and presented in the SCOTH report\(^{(2)}\), and given that the Regulatory Impact Assessment\(^{(17)}\) found that a comprehensive smoke-free policy offers the greatest net benefit, the proposal for exemptions seems puzzling. However, since exemptions have been tabled, we think it is worthwhile to briefly address the strongest objections to comprehensive smoke-free legislation.

16. Fear of negative economic effects—Objections to comprehensive legislation are often based on the fear that there will be losses in employment and revenue in the hospitality sector. The tobacco industry has been particularly active in promoting these fears. They have commissioned numerous studies to distort scientific evidence\(^{(18)}\), and by playing on fears, they have encouraged hospitality industry associations to carry the debate into the public sphere\(^{(19)}\). It needs to be emphasised that fears about negative economic impact are groundless. A recent review of the evidence illustrates how partisan the tobacco industry-supported research really is. It illustrates that the only studies that predict negative economic impacts are those supported by the tobacco industry. It also demonstrates that the findings of these studies are highly suspect, as they tend to be based on the expectations of worried club and bar owners before smoke-free policies are introduced. More robust studies—those not affiliated with the tobacco industry, and based on much more objective data such as bar receipts after policies have been introduced—overwhelmingly show that smoke free legislation does not bring economic harm\(^{(20)}\). The sheer number of positive experiences with comprehensive smoke-free legislation in other countries ought to be reassuring. Ireland and Norway have implemented smoke-free policies with no attributable negative effect on employment or revenue\(^{(21)}\)(\(^{(22)}\). In New York City, businesses actually appear to have had a substantial increase in revenue after comprehensive legislation came in\(^{(23)}\).

17. Prioritisation of individual choice—The second objection made against comprehensive smoke-free policies is that they infringe on smokers’ rights to choose whether they smoke or not. Once again, this is a position that has been largely promoted by the tobacco industry. The tobacco industry has pro-actively lobbied for tobacco control legislation that enshrines individuals’ right to choose to smoke. It does this for a variety of reasons. One is that the medical evidence has accumulated to the point that the industry is no longer able to dispute the proof about the extreme negative health consequences of its products. Another is to repair declining morale amongst its employees\(^{(24)}\). Most of all, the tobacco industry knows that comprehensive smoke-free policies help people quit, and as a result, they have much more drastic effects on their sales than do partial restrictions\(^{(25)}\). It is important for policy makers to remember that the argument for individual choice is a diversion. An individual’s right to smoke does not trump the right of those around them to breathe clean air, and the vast majority of the public understand this. A smoker’s right to light a cigarette in a pub should not outweigh the right of people with asthma to be there. Nor should it outweigh the rights of the pub’s workers to a safe working environment. Policy makers do not have to worry that comprehensive legislation will go against public opinion. Experience in other countries has been that comprehensive legislation becomes increasingly popular once it comes in. Surveys with nationally representative samples in Ireland show that support for the smoke-free law was strong at the outset (67% supported the law) and grew steadily afterwards. That support grew to 82% after the law was introduced, with 95% recognising that it was a positive health measure\(^{(25)}\). There is every indication that comprehensive legislation will be just as popular in England and Wales. The National Assembly for Wales has already voted in favour of comprehensive policy. Studies carried out by the Office of National Statistics for the Department of Health indicate that in England, support for smoking restrictions has been steadily increasing since 1996, and is currently higher than it was in Ireland before the legislation was introduced\(^{(13)}\). And for the 4.6 million people with asthma people with asthma in England and Wales, comprehensive legislation will certainly come as a welcome breath of fresh air.

SUMMARY

18. Reasons why people with asthma need comprehensive smoke-free legislation:

It will dramatically improve the quality of their lives:

— People with asthma will no longer be excluded from going to public places where other people smoke.

— People with asthma working in smoky environments will no longer have to put up with continual asthma symptoms, and they will not suffer the degree of long-term respiratory damage they otherwise would.

— It will encourage smokers with asthma to quit, and as a result, they will reallocate dramatic improvements in their quality of life.

— Smokers that live with people with asthma will be encouraged to quit, which will also improve living conditions of people with asthma.
It will reduce the number of people that develop asthma in the future:

- Exposure to second-hand smoke at work doubles the risk of acquiring adult onset asthma.
- By helping reducing the number of parents that smoke, the legislation will contribute to reducing the number of children who will develop asthma. Children with parents that smoke are 1.5 times more likely to develop asthma than those whose parents do not.

September 2005

NOTES AND REFERENCES

Memorandum by Thomas Holdings Ltd (SP07)

We represent British gaming industry operators involved in many sectors of the current leisure market—including bingo halls, betting offices, adult gaming centres (AGCs), seaside arcades and piers, pubs, restaurants and machine manufacturing companies. Our businesses, comprising outlets across the UK, directly support up to 15,000 jobs.

I write in connection with your committee’s investigation into the Government’s plan to ban smoking in confined public spaces. I have set out below a summary of the arguments we have submitted to the Department of Health (DoH)’s consultation process.

Our key recommendations are that:

— A level playing field should exist across all types of leisure operators as the anti-smoking provisions of the Health Protection and Improvement Bill are introduced.

— Steps taken to improve the health of employees in all types of leisure establishments should apply equally regardless of the type of establishment.

We make a number of representations specific to the DoH consultation document, using their numeration:

QUESTION 4

Exceptions—all licensed premises (receive a longer lead-in time)

There is no basis for giving special treatment to bars and pubs when the effect would be that staff in these venues would continue to suffer the effects of smoking, whereas in venues where smoking was banned, they would not. We can see no reason why bar and pub employees should be exposed to risk compared to those working in venues to which the smoking ban would apply.

QUESTION 5

Exceptions—All Licensed Premises that do not prepare and serve food—definition of “prepare and serve food”

The preparation and service of food should not be a determining factor. The objective of the Government’s policy is set out at paragraph 2 of Annex B to the Consultation Document. There is nothing within that objective which justifies the exclusion, from the effect of a ban, of premises where food is prepared and served.

QUESTION 7

Exceptions—Membership Clubs

There is no reason to assume that those working in members’ clubs should be any less entitled to the benefits of a reduction in the risk to health from exposure to second-hand smoke. Cumulatively, members clubs of the sort referred to in paragraph 24 of the Consultation Document employ vastly more people than do, for instance, the country’s bingo halls, AGCs, seaside amusement arcades or even licensed betting offices. Why should those employed in prospectively exempted clubs be viewed differently to their fellow workers in other sectors of the leisure industry?

QUESTION 10

Offences and Penalties

If there are going to be complex regulations and procedural requirements affecting the implementation of restrictions, it seems iniquitous that the penalties should be higher for the company, manager or operator of premises than for the individual who, in the face of clear signs explaining any ban, deliberately “lights-up” in breach of it.

CONCLUSION

In summary, if there is to be a ban on smoking, it should apply to all leisure outlets and there should be no exemptions. On this basis, we favour Option 2 from the DoH consultation document. However, because such a ban would have wider-reaching consequences than a ban with exemptions, we believe it would be best for its introduction to be delayed until 2009, to give those likely to be affected time to adapt to its effect.

A full copy of our submission to the Department of Health consultation is attached for your reference.15

September 2005

15 Not printed.
INTRODUCTION

CLIC Sargent was formed in January 2005 through the merger of two existing cancer charities, CLIC (Cancer and Leukaemia in Children) and Sargent Cancer Care for Children.

Supporting more than 2,000 families and children with cancer each month, CLIC Sargent provides the clinical, psychosocial, emotional and financial help needed by those affected by childhood cancer.

The result, in part, of our combined 65 years of experience in cancer care and treatment, some seven out of 10 children and young people diagnosed with cancer will survive. CLIC Sargent is committed to improving this figure still further through its specialist care and funding both of clinical and social research projects.

Stronger together, CLIC Sargent is now the UK’s fourth largest cancer charity by turnover and a single authoritative campaigning voice on cancer care in children and young people. Our remit extends to comment on all aspects of policy relevant to the well-being of children with cancer and their families. Priorities in our first year include lobbying on such issues as the cost of cancer, and the bureaucracy surrounding benefit claims and entitlement for the under 16s.

We welcome the opportunity to contribute to the Health Select Committee Inquiry into smoking in public places.

SPECIFIC REMARKS

CLIC Sargent’s primary concern is with childhood cancers and leukaemias rather than those induced by lifestyle or the social environment, but we recognise that significant exposure to second-hand smoke could contribute to the emergence of cancers in later life. Similarly, exposure to smoke during pregnancy can have an impact on a child’s development in the womb. Considering how best to mitigate the risks of second hand smoke—particularly to children and young people—should be a priority for government, and we support the scrutiny of smoking in public places now being undertaken by the Committee.

However, a greater source of a child’s exposure to second hand smoke is likely to occur in the family home. Taking effective action against this point of contact will prove far more complex than introducing a ban on smoking in public places. Unless the problem of home exposure is tackled, the impact on a child’s health of any proposed ban on smoking in public places is likely to be comparatively minor. We urge the Committee not to neglect the wider social context of second-hand smoking, and to consider what actions realistically can be taken to combat involuntary exposure to smoke to which children may be subject in the home.

Although recognising that the public health debate will necessarily emphasise the lifestyle and social environment factors contributing to cancer, CLIC Sargent considers it critical that the Committee not lose sight of the broader context of cancer care and treatment during its Inquiry.

Indeed, the overwhelming evidence demonstrating a link between smoking, ill-health and some types of cancer notwithstanding, targeting exposure to second-hand smoke remains only one aspect of a far wider effort needed to tackle effectively the causes of cancers. Discussion should focus as much on developing the specific treatments needed for unique and discrete types of cancer—and the groups these effect—as on banning smoking in public places.

In this regard CLIC Sargent would highlight the recent National Institute for Health and Clinical Excellence (NICE) Guidance, detailing for the first time appropriate treatment standards in cancer care for children and young people. Advances in cancer treatments, and the effective tailoring of these to patient needs, are the key to combating actual cancers. Action to ban smoking in public places, although important, appears more about addressing hypothetical cancers.

But as cancer treatments improve, so too do rates of survival. Survivors of childhood cancer face major challenges from on-going side-effects in later life as a legacy of past aggressive treatment. Significant exposure to second-hand smoke during their adult years could have an adverse impact upon a childhood cancer survivor’s health and perhaps result in the emergence of additional cancers.

Action that limits the future contact of survivors to second-hand smoke is to be welcomed. CLIC Sargent would therefore highlight to the Committee the role restrictions on smoking in public places can play in protecting the health of childhood cancer survivors in addition to the likely impact of a ban on the first appearance of cancers.

9 September 2005
Memorandum by Imperial Tobacco Limited (SP11)

In response to the Health Select Committee’s call for submissions to its Inquiry into Smoking in Public Places, please find enclosed the following brief memorandum from Imperial Tobacco Limited United Kingdom (“ITL”).

As the Committee has indicated that it will consider the relevant responses already made to the Government’s consultation on the Health Improvement & Protection Bill, we trust that our submission to that consultation will be accepted in that context. Further, as a principal member of the UK Tobacco Manufacturers’ Association (“TMA”) ITL has contributed to and fully supports all documents already submitted by the TMA to various government and parliamentary consultations throughout the UK.

ITL is a long-established UK business and a subsidiary of the Imperial Tobacco Group PLC (“ITG”). ITL is the UK division of ITG and is responsible for the manufacture, sales and distribution of Imperial’s tobacco products in the UK to approximately 100,000 trade customers. ITL employs in excess of 2,600 people in the UK.

This memorandum focuses on ITL’s views with regard to the science of environmental tobacco smoke (“ETS”) in order to explain that the level of risk associated with ETS and various diseases has been exaggerated. It will also address the issue of our ability to properly conduct our business if such a ban, as proposed by the Government, is instituted.

ITL has given our submission thoughtful consideration and we trust it will be of benefit to the Committee’s deliberations.

It is my view that:

— Effective health policy must be based on sound science. In our view, many of the so-called health messages on smoking in public places as presented by a range of interest groups and represented in the media are not based on the most accurate and reliable science.

— The risks associated with Environmental Tobacco Smoke (ETS) have not been proved to be greater than other potentially detrimental risks to human health such as diesel emissions and RF radiation from mobile phones and mobile phone base stations which, although subject to precautionary and advisory measures, are not subject to blanket prohibitions.

— If there is any risk to health from ETS smoke to persons that do not themselves smoke, then that risk is small and impossible to measure.

— Messages to the general public about the levels of risk between ETS and various diseases have been exaggerated. Not only are the majority of the published scientific studies inconclusive, but in the minority of studies that do report a small increase in relative risk, this increase is weak and well below the criteria that the UK Government would normally accept as indicative of a risk factor for disease.

— Chemicals are ubiquitous—there is no such thing as “clean” air, especially inside buildings. There are very few substances that are specific to ETS, and the presence of ETS itself has a minimal effect on the overall level of chemicals present in enclosed spaces.

— Ventilation can greatly improve the quality and feel of indoor environments, and ITL advocates the use of ventilation as part of an overall strategy towards reducing ETS in public places.

— Although some groups claim that ventilation is ineffective at removing the carcinogens present in ETS, it is a scientific impossibility to remove some substances and to leave others. This is because all components of ETS mix with air and are diluted to the same extent by ventilation. This is a fundamental property of gases, and a tenet of basic physics.

Uncertainty is unsatisfactory for both sides of the debate, but with regard to the science of indoor air quality, it will remain. It is not helpful for either side to present the health argument as clear-cut, and some recognition of this will surely allow decision makers the scope to make choices that, whilst minimising involuntary exposure to ETS, give adult smokers reasonable opportunities to continue to enjoy tobacco products in a social setting.

ITL has some specific concerns about our ability to properly conduct our business in the UK within the regulatory framework required, especially if the proposed definition that defines smoking as “…holding or otherwise in possession of lit tobacco” remains. ITL tests products and uses smoke testing machines as part of our regulated product testing requirements in our premises including Bristol, Liverpool and Nottingham. This testing is mandatory to comply with the legislation regarding the marking of tar and nicotine yields which must be displayed on every pack of cigarettes sold in the UK.

In terms of ETS, the output from the smoking machines that we use in this testing process are little different from the effect of a person physically smoking a cigarette. Similar quantities of the particulates and gases in ETS are the by-product of both actions.

ITL requests that our Company, as a tobacco manufacturer, be added to the list of those premises to be exempt from the Regulations. This is a necessary derogation in order for us to be able to test our products for the purpose of regulatory compliance and quality control.
Furthermore, ITL believes it is very regrettable that the adult activity of smoking in public places should be criminalised. 12 million UK adults choose to smoke and it is our view that they should not be targeted and discriminated against in such a fashion, particularly when the justification for such discrimination is based on flawed science.

Our submission has been developed with regard for the public health objectives of the UK Government, and taking into account our own expertise in the science of environmental tobacco smoke and indoor air quality. We ask that the Committee gives it due consideration.

*August 2005*

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**Memorandum by Tobacco Manufacturers' Association (TMA) (SP12)**

Further to the announcement of the Health Committee’s inquiry, this short memorandum is submitted on behalf of the TMA’s principal member companies: British American Tobacco, Gallaher and Imperial Tobacco.

In June 2004, the TMA responded to the consultation on the White Paper Choosing Health. In the TMA’s paper, Choosing Health—Tobacco Issues, we covered the full range of relevant issues in detail and the facts and opinions expressed still apply and are relevant today. Later in July 2005 the TMA responded to the Consultation on the Smokefree Elements of the Health Improvement and Protection Bill. A copy of this most recent contribution on the bill is attached to this letter and the TMA would be happy to provide a copy of its June 2004 response to the White Paper if necessary.

Additionally, the TMA has also responded to the consultations undertaken in Scotland and Wales by the Scottish Executive and the Committee on Smoking in Public Places of the Welsh Assembly, and in Northern Ireland by the Department of Health, Social Services and Public Safety. The TMA also provided written and oral evidence to the Health Committee of the Scottish Parliament that requested further comprehensive information on the scientific evidence relied upon and cited by the TMA. Again, the TMA would be happy to provide further copies of those supplementary submissions if necessary.

In summary, the TMA’s position on the Government’s proposed legislation concerning public and workplace smoking is as follows:

— We do not believe that the proposed legislation to restrict smoking in enclosed public places and workplaces is necessary or justified. We believe that the Government’s objectives can be achieved through voluntarily adopted self-regulation. Such self-regulation has already delivered, and continues to deliver, considerable results within the workplace and in other public places.

— Given, however, that the Government appears intent on introducing legislation, we support the Government’s attempts to achieve “the right balance between responsibilities and freedoms” in particular by maintaining the freedom to smoke in certain pubs and in clubs.

— That said, we believe that a practical and proportionate approach would be to additionally permit smoking in separate designated smoking rooms in all workplaces, including offices, restaurants, pubs etc. where this is reasonable practicable. Such an approach would also reflect the weight of public opinion.

It is the TMA’s view that any legislation on smoking in work and public places should be fair, reasonable and practical by allowing choice for both smokers and non-smokers and be consistent across the United Kingdom. If the Health Committee would like any further information on the TMA views, in writing or in person, please do not hesitate to ask.

*September 2005*

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**Memorandum by The Roy Castle Lung Cancer Foundation (SP13)**

1. **Introduction**

The Roy Castle Lung Cancer Foundation is the only charity in the world wholly dedicated to defeating lung cancer. It does this through research, campaigning and education.

16 Not printed
17 Choosing Health: Making healthy choices easier, Department of Health, November 2004.
2. **Summary**

All smoking should be ended in work-places and enclosed public places whether the substance being smoked is tobacco or something else. Second-hand smoke is a health and safety risk. Wherever second-hand smoke in a public place is a significant danger to health it should not be permitted. Sports stadia, outdoor concerts, railway stations, bus shelters etc should be seen as relevant public places. Furthermore as it is accepted that these areas carry risks of harm, then the much greater risks of harm to those working in pubs, bars and clubs must also be accepted. The exemptions for these venues cannot be justified—as the government accepts through the current second-hand smoking advertising campaign.

The exemptions for pubs and clubs leave many of the employees at greatest risk still exposed to second-hand smoke. There can be no justification for protecting the great majority of employees from this serious health risk while continuing to neglect hospitality employees who are at a greater risk.

Exemptions are going to be far more difficult to enforce and costly for the hospitality trade who will have to apply the exemptions. Evidence from 100 studies around the world shows that smoke-free legislation is good for business and can cause a significant increase in company profits. It is not possible to protect both employees and members of the public by segregating smoking and non-smoking areas. Smoke drifts—and more than one metre—and ventilation systems are ineffective, expensive and difficult to maintain. This legislation should be brought in as quickly as possible and on a single date and as soon after the Scottish legislation comes into force as is practicable.

3. **References**

4. Chartered Institute of Environmental Health.
6. New York City Department of Finance.
7. Retail sales index for bars volume in Ireland.
9. Detailed evidence about smoking in workplaces and public places from the Roy Castle Lung Cancer Foundation is contained in their response to the consultation on the smoke-free elements of the Health Improvement and Protection Bill.

*September 2005*

**Memorandum by the Sainsbury Centre for Mental Health (SP14)**

**Introduction**

This memorandum covers the specific issue of mental health services. It is based on our response to the consultation document.

In the Department of Health consultation document, paragraph 23 includes psychiatric wards in the list of exceptions to the proposed rules for residential premises.

The Sainsbury Centre for Mental Health believes that, while the majority of psychiatric hospitals and units are not usually residential (the average length of stay in an acute ward is less than one month), they are however an appropriate case for a temporary exemption from the proposed legislation.

But the issue of how to make psychiatric wards smoke-free raises some important issues that need to be considered at this point so that people with mental health problems are not left out of the benefits of this legislation.

**Smoking and Mental Health**

Smoking prevalence amongst mental health service users in general is high. Of those who sometimes need to use in-patient services, it is extremely high. Both groups are much more susceptible than average to smoking-related illnesses and deaths: a person with schizophrenia, for example, can expect to live 10 years fewer than a person with no mental health problems.

Mental health practitioners have little training in physical health care and higher smoking rates among these practitioners may militate against their advising patients who are smokers to stop.
SMOKING AND PSYCHIATRIC WARDS

Imposing a complete ban on smoking in psychiatric wards would, at this point in time, be unrealistic and unethical. Both service users and staff have high rates of smoking: for the former in particular smoking may be:

— a form of self-medication;
— a social activity (in wards where therapeutic, social and practical activities are seriously lacking); and
— a part of the “culture” of the ward.

Yet to fail to work towards making acute psychiatric wards and other mental health facilities smoke-free would be to perpetuate the discrimination service users experience in many other aspects of their lives. The costs of not taking action in acute wards would include:

— the health and safety risks of smoking and of passive smoking (for staff, users and visitors);
— the costs to the NHS of treating smoking-related illness among mental health service users; and
— the premature mortality and morbidity also associated with such illnesses.

A WAY FORWARD

Tackling this issue will require thorough and sustained action, led by government and implemented across the NHS. Unlike most other forms of health care, mental health services work with people over long periods of time. Service users are also more likely than most to see their GPs frequently. Yet the opportunities this provides to help them to stop smoking are overlooked in many instances. For example:

— many professionals are reluctant to “upset” service users by raising the issue of smoking with them;
— many service users do not get regular physical health checks, despite their increased risk of many kinds of illness; and
— smoking cessation services are rarely tailored to the specific needs and circumstances of people with mental health problems.

Making psychiatric wards smoke-free cannot be achieved in isolation. Smokers with mental health problems need support to quit throughout their time in contact with the NHS: in primary and specialist services. Staff in mental health services need similar support: inpatient services in particular are stressful, smoky places in which to work.

However, there are opportunities available, too:

— the new GP contract (nGMS) includes incentives to set up registers of people with severe mental health problems and offer them annual health checks;
— the Choosing Health initiative includes a range of smoking reduction and cessation measures for the general population which could be tailored for people with mental health problems;
— the Chief Nursing Officer’s review of mental health nursing consultation document states that promoting physical health among service users should be a core part of practitioners’ roles; and
— NICE is currently producing guidance on smoking cessation in primary care, with a focus on “hard to reach” groups that might include those with mental health problems.

The following steps are necessary to ensure mental health service users and staff get equal treatment to others within the NHS:

1. Research should be commissioned to determine what makes smoking reduction or cessation effective for mental health service users and also for the staff that work in services.
2. A medium-term deadline for making psychiatric wards smoke-free should be set out in the forthcoming Bill, along with an immediate requirement to provide designated smoking and non-smoking areas in all facilities.
3. Mental health services staff should be offered intensive support to quit smoking.
4. All mental health professionals should receive training (pre- and post-registration) to help service users to reduce or give up tobacco use.
5. Evidence-based interventions to help mental health service users to quit smoking should be made available across the country for all those who need them.
6. Once such measures have proven successful, smoke-free measures should be implemented.

This stepped approach offers a realistic way of tackling a major public health issue. It would need to be managed in such a way that measures to ban smoking in mental health facilities progressed at the same speed as measures to reduce smoking among service users take effect. Unless the two processes are in step, neither will be effective and a major health inequality will be allowed to persist.

September 2005
Memorandum by Gallaher Group plc (SP15)

Following the Health Committee’s announcement regarding its inquiry into Smoking in Public Places, Gallaher would like to take this opportunity to respond briefly to your notice.

As I am sure you are aware, smoking in public places has been the subject of a number of consultations across the UK over the last year or so and, recognising that Government bodies normally deal with trade associations on specific sector issues, Gallaher’s views on this matter have been presented during these consultations by our trade association, the Tobacco Manufacturers’ Association (TMA).

As the TMA is responding on behalf of its members to this inquiry we urge you to consider the recommendations expressed in the TMA’s submission to the Department of Health, which Gallaher fully supports. In summary, we believe that, in addition to the Government’s proposals, a practical and proportionate approach, that ensures smokers and those who do not like tobacco smoke are accommodated, would be to permit smoking in separate designated smoking rooms in all workplaces, including offices, restaurants, pubs etc, where this is practicable. Furthermore, we believe that such an approach would also reflect the weight of public opinion.

September 2005

Memorandum by The Imported Tobacco Products Advisory Council (ITPAC) (SP16)

This Association has received notice of the Health Committee Inquiry into Smoking in Public Places, and is submitting this brief memorandum on behalf of its Members.

We responded to the Department of Health’s “Choosing Health” consultation in May 2004; more recently (on 26 August 2005) we also responded to their Consultation on the Smokefree Elements of the Health Improvement and Protection Bill.

With regard to the Government’s proposed legislation on Smoking in Public Places a detailed submission is attached, from which we would emphasise the following points:

— In the five year period up to 2003, the Public Places Charter made substantial progress towards achieving the goals set by Government on a voluntary basis. The current level of self-regulation in public places, workplaces and the hospitality sector is already high and it continues to increase at a significant rate. There is ample evidence that the Government’s targets can be met through voluntary measures; it is our view therefore that a better option would be to pursue the process with a wider and more extensive set of targets, with the threat of legislation if these targets are not achieved.

— This Association believes that people who choose to do so should have the right to smoke, or to permit others to do so if they are in a position to make that choice, but that they must act in a responsible manner that respects the right of those who do not wish to be exposed to tobacco smoke.

— In order to achieve the correct balance between ensuring that people can be in a smokefree environment if they wish, yet observing people’s freedom to smoke providing it doesn’t cause annoyance, this Association believes that designated rooms should be permitted for the exclusive use of smokers in all workplaces and in the hospitality trade; in the specific case of smaller hospitality outlets with restricted space, smoking areas which are part of a larger open space should be permitted, but should be sufficiently ventilated to ensure that to ensure that the (sensor determined) level of air quality in the adjacent non smoking part of the establishment falls consistently within an acceptable pre-determined limit.

This Association urges that any legislation which does result from this exercise should be balanced, and kept as simple and clear as possible, in the interests of effective compliance by the owners/operators of affected premises as well as consistent implementation by the enforcement authorities.

1. INTRODUCTION

ITPAC represents the interests of 13 companies involved in the importation of tobacco products for distribution in the UK. The majority of these are small, private companies many of which are principally engaged in the distribution of specialist tobacco products such as cigars, pipe tobaccos and snuff.

ITPAC welcomes the opportunity to contribute to the Health Committee’s Inquiry into Smoking in Public Places. Having considered the issues carefully, and in the context of this Association’s response dated 26 August to the Department of Health’s (DoH) Consultation, we would like to put forward comments under 2 main headings:
KEY PRINCIPLES

— Environmental tobacco smoke
— Regulation v voluntary codes of practice
— Reasonable freedom of Choice
— Commercial impact on ITPAC Members

RESPONSES TO THE SPECIFIC QUESTIONS IN THE DOH CONSULTATION DOCUMENT

2. Key Principles

2.1 Environmental tobacco smoke

There have been many studies into the effects of ETS. We consider that these studies are inconclusive. The findings have been inconsistent and, even where a positive association has been indicated, it has been of a very low order of relative risk and well below that normally regarded as being significant and indicating a causal link.

Given that the dangers of the effects of ETS have been widely distorted and overstated, it is ITPAC’s opinion that the introduction of draconian legislation based on this hypothesis is disproportionate and unnecessary.

2.2 Regulation v voluntary codes of practice

As is stated in the Partial Regulatory Impact Assessment document accompanying The DoH’s Consultation document, a total of 88% of the working population is employed in “workplaces” which are either smokefree or where smoking is restricted. Additionally, 14% of workers work alone or out of doors and many are already covered by these policies. Furthermore, a significantly high percentage of places to which the general public has access, such as public buildings, transport facilities, retail and leisure centres, are either totally smokefree or have specially designated smoking areas. Inevitably the majority of these venues are also “workplaces” and therefore covered within the significant majority where formal restrictions are in place. In the hospitality sector, apart from pubs, and bars, there is a high level of self-regulation where smoking is either banned or restricted to specially defined areas.

Recent research conducted by the Office for National Statistics (ONS) found that 63% of respondents considered that there should be smoking and non smoking areas in pubs and bars, and that only 31% of respondents felt that smoking should be banned in these outlets. This is an important finding given the significant but distorted debate over ETS, which has been so widely reported in the public domain, and which will have played an important part in influencing respondents’ views.

In the 5 year period up to 2003, the Public Places Charter made substantial progress towards achieving the goals set by Government on a voluntary basis. Given the degree of self-regulation which already exists, and which continues to be introduced at a significant rate, it is the opinion of this Association that the introduction of legislation leading to criminal proceedings is at this stage unnecessary and unwarranted. There is ample evidence that the Government’s targets can be met through voluntary means. A better option would therefore be to pursue the process with a wider and more extensive set of targets, with the ultimate threat of legislation if those targets were not achieved.

2.3 Reasonable freedom of choice

In the foreword to the “Choosing Health” White Paper the Prime Minister says: “Small changes in the choices people make can make a big difference. Taken together, these choices can lead to huge improvements in health across society. But changes need to be based on choices, not direction. We are clear that Government cannot—and should not—pretend it can “make” the population healthy. But it can—and should—support people in making better choices for their health and the health of their families. It is for people to make the healthy choice if they wish to . . .”

ITPAC considers that restricting individuals’ freedom of choice to smoke by prohibition or severe regulation not only exceeds the Prime Minister’s approach, but is also socially divisive and an infringement of individuals’ rights. We believe that people, who choose to do so, should have the right to smoke themselves, or to permit others to do so if they are in a position to make that choice. To achieve this they must act in a responsible manner that respects the rights of those who do not wish to be exposed to the annoyance of tobacco smoke.
The extent to which an establishment permits, prohibits or otherwise regulates smoking should rightly be a matter for employers/owners/operators to decide in consultation with their employees. In the case of hospitality outlets owners/operators are constrained by customer demand and subject to commercial market forces. Where there is a requirement for a smoking ban, or for separate smoking areas, they will and do respond since, if customers have concerns about an outlet’s smoking policy, they will express their own freedom of choice with their feet and their wallets.

Self-regulation has proved itself to be effective and is being progressively adopted, to the extent that there are very few places where smoking is not either prohibited or strictly regulated. We do not therefore believe that there is reasonable justification for legislation which could lead to criminal offences and a costly regulatory burden.

2.4 Commercial impact on ITPAC members

The implementation of a total ban on smoking in public places including hospitality outlets would have a severe commercial impact on our Members. Some smaller companies, particularly those that distribute cigars, depend on the hospitality sector for up to 20% of their sales’ revenues. Furthermore they report that their activity in this sector is typically made up of a high number of small customers, and that servicing these customers is labour intensive. They foresee an immediate need to reduce their numbers of employees if a total ban on smoking were to be introduced in pubs, bars, restaurants and hotels.

3. Conclusion

This Association believes that where there is no choice available, it is entirely reasonable for people not to be exposed to ETS if they do not wish to be. Where there is an element of choice people, who wish to smoke, should be able to do so provided they are in a smoking area and act in a responsible manner.

We believe that self regulation under the Public Places Charter proved itself to be effective, and is now progressively being adopted to the extent that there are very few places where smoking is not either prohibited or strictly regulated. One option would have been to pursue it with a wider and more extensive set of Government targets with the ultimate threat of legislation if those targets were not achieved.

Given however that it is the Government’s intention to introduce legislation, we believe that the specific proposals contained in this submission, and in particular those relating to air quality in “enclosed places” (referred to in Question 2) and also in all licensed premises that do not prepare and serve food (referred to in Question 5), should be given careful consideration.

September 2005

Memorandum by Dr Andrew Geens (SP17)

I am an academic member of staff at the University of Glamorgan.

I have been involved in research testing the efficacy of ventilation systems in buildings.

Recently this research has focused on the problems associated with dealing with tobacco smoke. I am also involved with testing ventilation systems designed to deal with exhaust emissions in vehicle maintenance facilities.

I have given evidence in writing and orally to the National Assembly for Wales—Committee on Smoking in Public Places in November 2004.

I have published articles on this subject in the Town and Country Planning Journal, November 2004, Vol 73 No 11, pp 328–330, and the CIBSE Journal, March 2005, pp 55–57, and I am a member of the REHVA Taskforce on ventilation and smoking. I have other work with referees for publication in a peer reviewed journal.

My work has demonstrated the effectiveness of some existing ventilation systems in reducing exposure to environmental tobacco smoke constituents, and I am now working in collaboration with equipment manufactures to optimise ventilation and energy performance. I think that my work will be useful in drawing up a regulatory framework similar to that recently introduced in Italy, where businesses can only accommodate smokers if they operate a ventilation system that meets a prescribed performance standard.

September 2005
Memorandum by Philip Morris Limited (SP18)

Philip Morris Limited (PML)\(^\text{18}\) welcomes this opportunity to provide comments to the Department of Health on the consultation on the smokefree elements of the Health Improvement and Protection Bill.

In its *Choosing Health?* White Paper (November 2004), the Government announced its intention to introduce smoking restrictions in the UK over the next few years, possibly including:

— a smoking ban in all enclosed public places and workplaces except for licensed premises not serving food and in membership clubs; and

— a smoking ban in the bar area everywhere.

Governments and public health officials have concluded that second-hand smoke causes disease in nonsmokers. The public should be guided by these conclusions in deciding whether to be in places where secondhand smoke is present, or if they are smokers, when and where to smoke around others. Particular care should be exercised where children are concerned, and adults should avoid smoking around them.

**Public Place Smoking Restrictions**

PML believes that public health conclusions on secondhand smoke justify restrictions on smoking in public places. In many places, such as schools, health care facilities, and places providing services to children, bans are entirely appropriate. In general, people should be able to avoid being around secondhand smoke in places where they must go, such as public buildings, many areas in the workplace and public transportation. The Government addresses these areas in its proposal.

In other places, such as in bars and restaurants, we believe that there must be the “right balance between responsibilities and freedom” as the government states.

**Smoking Restrictions in the Hospitality Sector**

In our view, it is important for business owners, particularly in the hospitality sector, to have the flexibility to decide whether and how to accommodate both smokers and non-smokers in their establishments. In having the flexibility to make this decision, business owners should be able to take approaches to address the preferences of their customers that work best for them.

Specifically, in regard to the *Choosing Health?* proposals, we do not believe that a total prohibition on smoking in all premises serving food is necessary or justified. We believe the issue can be addressed more pragmatically by requiring a combination of separation between smoking and non-smoking areas coupled with warning signs stating the public health community’s conclusion that second-hand smoke causes diseases in non-smokers. This allows people to make an informed decision. We also think that employers in the hospitality industry should have the flexibility to continue to implement measures which work for their clientele and their employees, such as smoking bans in bar areas, if they are determined to be the best policy for their establishment.

**Workplace Smoking Restrictions**

In relation to workplaces, we believe employers should be permitted to provide non-smoking and smoking areas for employees. Tobacco companies will also require separate areas for testing their products.

**Implementation Time**

PML supports a lead-in and implementation time that enables business owners to make appropriate adjustments to their business and operations with the minimum adverse affect to their business, and providing adequate time for consumer education. We urge the Government to consider the recommendations of members of the hospitality industry and other business owners on the implementation of the proposals.

In summary, PML supports restrictions on public smoking regulation in workplaces and licensed premises that gives business owners the flexibility to accommodate smokers and non-smokers and protect its employees in a way that is appropriate for their business.

We hope these comments will prove a useful starting point in an on-going dialogue.

*September 2005*

\(^{18}\) Philip Morris Limited is the United Kingdom affiliate of Philip Morris International Management S.A., (www.philipmorrisinternational.com).
Memorandum by the Smoking Control Network (SP19)

The Smoking Control Network has welcomed the Government’s recent consultation on the Smokefree Elements of the Health Improvement and Protection Bill, and is pleased to submit this brief memorandum to the Health Select Committee, to assist its Inquiry into the Government’s proposals.

INTRODUCTION TO THE SMOKING CONTROL NETWORK

The Smoking Control Network is a collaboration of leading British health charities and commercial and professional organisations, which work together to reduce the deaths and disability caused by smoking related diseases. It aims to promote smoking cessation policies and to campaign for strong government action to help smokers give up.

The Smoking Control Network’s voluntary and professional members comprise: Asthma UK, British Heart Foundation, British Lung Foundation, British Vascular Foundation, Cancer Research UK, Diabetes UK, Macmillan Cancer Relief, QUIT, the Roy Castle Lung Cancer Foundation, The Stroke Association, the British Dental Association, Royal College of Midwives, Royal College of Nursing and No Smoking Day. ASH is an observer. The administration of the Network is supported by an educational grant from GlaxoSmithKline Consumer Healthcare.

SUMMARY

Smoking Control Network Members warmly welcome the Government’s broad aims to reduce smoking in enclosed public places and workplaces. We do not see the justification, however, for exempting private members’ clubs or pubs, which do not serve prepared food, or for allowing an extra year for licensed premises to comply with the legislation.

The Smoking Control Network urges the Government to put forward comprehensive smokefree legislation to protect workers in all workplaces and to bring this into effect across the country as soon as possible and certainly by the end of 2007.

RESPONSE

— The evidence about the risks to workers’ health of secondhand smoke is clear, and well documented. The report of the Scientific Committee on Tobacco & Health specifically identified bar workers as one of the groups at greatest risk. Research by international expert, Professor Konrad Jamrozik, has estimated the number of UK deaths from secondhand smoke in the workplace at 617 per year, including 54 hospitality workers per year. We question the idea of legislating to allow barworkers’ health to be put at greater risk from secondhand smoke than that of other workers.

— Pubs and clubs are covered by the comprehensive smokefree legislation successfully introduced in Ireland in March 2004. In the nine months following the introduction of smoke-free workplace legislation, 94% of Irish licensed premises inspected were compliant with the law. The Smoking, Health & Social Care (Scotland) Act, now approved by the Scottish Parliament for implementation in Spring 2006, also applies to pubs and clubs. The Welsh Assembly’s Committee on Smoking in Public Places did not recommend exemptions for pubs and clubs.

— Evidence from the BMA suggests that the former Health Secretary’s (10-30%) estimate of pubs, which do not prepare food on the premises, which would be exempted from the smokefree requirement, would appear to understate the real situation around the country.

— Without an obligation on all sections of the hospitality industry to go smokefree at the same time, there is a real risk that the exemption proposed for non-food pubs could have the unintended and perverse consequence of increasing the number of “wet” pubs. These are likely to be located in some of the poorest parts of England, and serving the more deprived communities. As a result, this measure could lead to a widening of existing health inequalities. This exemption could also serve to exacerbate the problems of binge drinking in these areas.

— Comprehensive smokefree legislation would be much easier and less expensive to enforce than proposals with exemptions. The policing of the definitions of “non-prepared food” could prove tortuous and expensive.

— There is increasing public support for comprehensive smokefree provision. The latest survey conducted in July by the BMRB for ASH and Cancer Research UK concluded that 73% supported the proposal to make ALL enclosed workplaces, including pubs and restaurants smokefree, with 24% saying no and 3% saying don’t know.
— Smoking Control Network members asks the Health Select Committee to urge the Government to review all the evidence on the effective implementation of smokefree provision in many other countries, and to have the confidence to put forward comprehensive smokefree legislation this Autumn—to protect the health of all workers in this country from the known risks of secondhand smoke.

September 2005

Memorandum by Lloydspharmacy (SP20)

1. INTRODUCTION TO LLOYDSPHARMACY

1.1 Lloydspharmacy is the UK’s largest community pharmacy chain with over 12,500 trained health staff in 1,400 pharmacies, offering widespread access to healthcare services and advice. Over two million people visit Lloydspharmacy each week and 90% of our business is directly related to healthcare.

1.2 Our pharmacists and healthcare assistants have daily contact with a large number of individuals seeking help and advice on a wide range of health topics. This includes information on general health issues, minor ailments, chronic conditions and advice on the medicines used to treat such conditions. We see individuals who are ill, those who are well and those who are “apparently well”. This daily access offers community pharmacy a key opportunity to provide services that promote healthy lifestyle and potentially identify individuals who are at high risk of developing certain conditions.

1.3 Lloydspharmacy specialises in providing expert pharmacy services to communities across the UK, supporting and furthering NHS priorities not just in relation to minor ailments, but as part of an integrated strategy to combat major diseases. These services currently include Smoking Cessation support, Diabetes Testing services, Blood Pressure monitoring, Medicines Management advice and we are currently piloting our new Coronary Health Check service. This year we were very proud to be awarded the 2005 Diabetes UK “Raising Awareness” award for our free Type II Diabetes Testing service.

1.4 We have invested in providing private consultation areas in nearly 1,200 of our pharmacies, allowing these services to be conducted in a confidential environment.

1.5 By providing services that have been classified as “Enhanced Services” and which Primary Care Trusts are able to commission to meet local healthcare needs under the pharmacy contractual framework, we believe we are already delivering on our commitment to NHS reform.

1.6 In this way the most accessible healthcare professional—the pharmacist—can help to raise awareness through effective health promotion, counsel on healthy lifestyle and encourage positive adjustment, help prevent the onset of certain conditions and identify people with undiagnosed conditions.

2. COMMUNITY PHARMACY AND THE GOVERNMENT’S PROPOSALS TO RESTRICT SMOKING IN PUBLIC PLACES

2.1 Lloydspharmacy supports the Government’s public health objectives including the move to reduce the incidence of smoking in the United Kingdom.

2.2 Community pharmacy has provided help and information to those wanting to stop smoking for many years. Along with offering advice the pharmacist can talk through the range of products available to help make the quit attempt easier.

2.3 Lloydspharmacy has also developed a smoking cessation service, which we provide in partnership with local Primary Care Organisations. This offers a comprehensive programme involving both ongoing behavioural and pharmacological support. We offer Nicotine Replacement Therapy (NRT) under a locally defined protocol, which can incorporate the use of a Patient Group Direction or the use of vouchers, as well as motivational support.

2.4 Lloydspharmacy is involved in many schemes across the UK. We would encourage Primary Care Organisations to increase the use of community pharmacy in the delivery of these services as access to services is key when an individual has decided to stop smoking.

3. CONCLUSION

3.1 Lloydspharmacy welcomes the opportunity to become involved in the discussions surrounding the Government’s proposals to restrict smoking in public places.

3.2 Lloydspharmacy have demonstrated that community pharmacy can provide a range of healthcare information and services to patients that taken together can impact on public health in the UK.
3.3 We would encourage Primary Care Organisations to increase the use of community pharmacy in the delivery of these services as ready access to services is absolutely key when an individual has decided to stop smoking.

*September 2005*

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**Memorandum by Cancer Research UK (SP21)**

1.1 This memorandum represents the view of Cancer Research UK. All correspondence regarding this submission should be directed to Mr Richard Davidson, Director of Policy and Public Affairs at Cancer Research UK, at the address above.

1.2 Cancer Research UK is the world’s largest independent cancer research organisation, with an annual research spend of over £217 million. Our vision is to conquer cancer through world-class research, aiming to control the disease within two generations.

1.3 We know that around half of all cancers diagnosed in the UK could be prevented by changes to lifestyle and that by far the most important change an individual can make to reduce their cancer risk is to stop smoking. There is also unequivocal evidence that secondhand smoke causes cancer. The 2004 Scientific Committee on Tobacco and Health (SCOTH) Report re-affirmed its 1998 findings that non-smokers exposed to long-term secondhand smoke face a 24% increased risk of lung cancer. We therefore welcome the opportunity to submit evidence to this important inquiry.

1.4 Our Chief Executive, Professor Alex Markham, would welcome the opportunity to provide oral evidence to the Committee.

2. **Summary and Recommendations for Action**

2.1 Cancer Research UK supports the Government’s commitment to legislate to ban smoking in enclosed public places and workplaces and welcomed the opportunity to respond to the consultation on the Smokefree Elements of the Health Improvement and Protection Bill.

2.2 However, we believe that a comprehensive ban on smoking in all enclosed public places and workplaces, including all licensed premises irrespective of whether they serve food, is the only way to ensure that all workers are protected from the harmful effects of secondhand smoke.

2.3 We urge the Committee to recommend that the Government remove the proposed exceptions to a ban detailed in the consultation and follow in the footsteps of the Republic of Ireland and Scotland by enacting comprehensive measures.

2.4 We believe that all workers have the right to be protected. The Government has accepted the fact that secondhand smoke causes cancer, and that it is right for the Government to take action to regulate people’s exposure to secondhand smoke in public places. It would therefore seem completely illogical for the Government to protect only some workers, leaving many in the most at-risk group, those working in the hospitality sector, exposed.

2.5 The Government’s current proposal to exclude certain licensed premises from a ban is likely to increase health inequalities, because exempted pubs are more likely to be concentrated in deprived areas. We urge that legislation is comprehensive, so as to ensure that everyone is afforded equal protection from secondhand smoke.

2.6 We support the implementation of comprehensive smokefree legislation at the earliest opportunity, on a single day. Adequate resources must also be made available to effectively implement, promote and evaluate the legislation.

2.7 We believe that a comprehensive smokefree law would be simple, easy to enforce, popular and would lead over the long term to a dramatic improvement in public health.

**Specific Comments**

3. **Health Evidence**

3.1 Secondhand smoke is a very serious workplace health and safety hazard. For example in the short term, exposure to tobacco smoke has a measurable effect on the heart in non-smokers. Just 30 minutes exposure is enough to reduce coronary blood flow. But secondhand smoke also has longer-term health effects. Two major reviews by the Scientific Committee on Tobacco and Health concluded that secondhand smoke is a cause of lung cancer and heart disease in adult non-smokers, and a cause of respiratory disease, cot death, middle ear disease and asthma attacks in children. Epidemiological reviews, a World Health Organization (WHO) consultation report and a review by the International Agency for Research on Cancer (IARC) all support these findings.
3.2 The Trades Union Congress (TUC) believes that the available health evidence clearly shows that failure to treat tobacco smoke in a similar way to other dangerous chemicals leads to the deaths or incapacity of many thousands of workers across the EU from lung cancer, emphysema, bronchitis and asthma.\(^{(xii)}\) Legislation to protect employees from secondhand smoke is supported by the TUC and most of Britain’s largest unions, including the GMB, TGWU and UNISON.\(^{(xiv)}\)

3.3 It has been estimated that exposure to secondhand smoke at work may cause more than 600 deaths each year across the UK, including over 50 people employed in the hospitality industry (pubs, bars, nightclubs, hotels and restaurants).\(^{(xv)}\) This is the equivalent of one hospitality worker dying per week. In fact, secondhand smoke in the workplace kills over twice as many people every year as are killed in accidents at work in the UK.\(^{(xvi)}\)

4. Health Inequalities

4.1 The current proposal to exclude licensed premises that do not serve prepared food from the legislation is likely to increase health inequalities.

4.2 A recent survey of publicans commissioned by Cancer Research UK and Action on Smoking and Health (ASH)\(^{(xvii)}\) highlighted that 29% of pubs do not currently serve prepared food. This is at the very top end of the estimate in the Government’s Choosing Health White Paper (10–30%). In the poorest areas, 41% of pubs do not currently serve prepared food.

4.3 The survey also found that many pubs would stop serving food to circumvent the Government’s current proposals. Results showed that the proportion of exempt pubs in England and Wales could rise by a third, from 29% at present to 40%, if the Government proceeds with a smokefree law that excludes pubs that do not serve prepared food. In the poorest areas, the proportion could be as high as 50%. Pub workers in deprived areas are already more likely to be exposed to secondhand smoke. 62% of surveyed pubs in the most deprived areas currently allow smoking throughout the premises, compared with 26% in the most affluent areas.

4.4 Poorer communities have higher than average smoking rates. It is well recognised that smoking is the biggest single cause of inequalities in health and the main reason why those who live on the lowest incomes die earlier than those who are the most affluent.\(^{(xviii)}\) But most smokers want to quit.\(^{(xix)}\) When workplaces go smokefree, smoking rates amongst workers can drop by up to 4%.\(^{(xx)}\) The more comprehensive the smokefree law, the greater the protection from secondhand smoke, and the more that smokers are helped in stopping smoking.

4.5 It would be a missed opportunity if this law did not help those in poorer communities to stop smoking as much as is possible and it would contradict the Government’s Public Health White Paper, which has a principal objective to reduce health inequalities.

4.6 Moreover, comprehensive smokefree legislation will make it more likely that the Government will meet its 2010 smoking prevalence target.

5. Public Opinion

5.1 In the UK, public support for smokefree legislation has been consistently high. The most recent and robust poll in England and Wales\(^{(xxi)}\) showed that 73% of people would support a law to make all enclosed workplaces smokefree, including 82% of non-smokers, and 85% would visit pubs and bars that were smokefree by law as often or even more often than they go to pubs and bars at present.

5.2 Public support for smokefree legislation has been increasing steadily to a point where it can no longer be argued that public opposition is a reason to delay or compromise legislation to protect the health of workers across England and Wales. The level of public support in England and Wales is already higher than that in Ireland before their smoking ban.\(^{(xxi)}\)

5.3 Furthermore, the experience of countries including Ireland that have successfully introduced smokefree legislation has shown that levels of support and compliance continue to rise after the introduction of a smokefree law.\(^{(xxii)}\)

5.4 Over 17,500 individuals have signed a Cancer Research UK petition to make all workplaces smokefree. Professor Alex Markham and others presented this petition to 10 Downing Street on 5 September 2005.
5.5 In addition, over 7,000 emails have been sent to the Department of Health in response to the Government’s smokefree consultation, through Cancer Research UK’s Cancer Campaigns website. Of these responses, over 150 were submitted by Cancer Research UK-funded scientists.

6. MPs’ Opinion

6.1 Recent Cancer Research UK/ASH polling of MPs has revealed that more than two thirds of MPs now support comprehensive national smokefree legislation. Support for legislation without the currently proposed exemptions has risen sharply among MPs since the last Parliament, up 18 percentage points to 69%. (xxv)

7. Enforcement

7.1 Cancer Research UK believes that enforcement of smokefree measures will be simpler and less resource-intensive if legislation is more comprehensive and if the presently proposed definition of “smoke or smoking” is broadened to include non-tobacco lit substances.

7.2 Current Government proposals suggest that enforcement officers will have the power to enter premises for the purpose of enforcing the Act, and when on premises for that purpose, to take samples for analysis. It is suggested that samples may be needed to establish that a substance is or includes tobacco, or to determine whether snacks are of a kind which are permitted in a smoking area.

7.3 If the legislation is more comprehensive and the proposed exceptions for licensed premises that do not serve prepared food are removed, the issue of sampling snack foods for compliance purposes would become redundant.

7.4 Likewise, if the definition of “smoke or smoking” is widened to encompass non-tobacco lit substances, as in the Scottish legislation, there would be no need to sample smoked substances to ascertain content.

7.5 The high compliance in Ireland demonstrates that comprehensive smokefree legislation is almost entirely self-enforcing if it is simple, publicised widely and understood by all parties. Legislation with partial exceptions in licensed premises risks undermining compliance levels.

7.6 It is crucial that any smokefree legislation is adequately resourced in terms of financing and human resources in order to (a) ensure compliance; (b) maintain public support; and (c) ensure the rebuttal of potential misinformation from vested interests. A critical component of this should be a pre- and post-implementation research and evaluation programme, as developed in Ireland and Scotland.

8. Economic Impact

8.1 International evidence demonstrates that going smokefree does not harm business. In fact a non-comprehensive law is likely to be far more difficult and costly to enforce and would not provide a level-trading environment.

8.2 Smokefree air laws have been passed in every conceivable type of community - from small towns and suburbs in rural and urban areas to a number of states/provinces and, increasingly, countries. Following a review of 97 evaluation studies in 2003, it was concluded that no objective, peer-reviewed study of smokefree air laws has ever found a significant negative economic impact. All of the 35 studies that found a negative economic impact had been funded by the tobacco industry or a linked source, or had an unknown funding source, and were not peer-reviewed. (xxviii)

8.3 More recent reviews carried out for the Scottish Executive by researchers at the Health Economics Research Unit and Department of Public Health at the University of Aberdeen have also come to this conclusion, as did a recent European-wide study. It is particularly important to take into consideration secular trends when assessing any patterns. For example, there was a decline in the value of bar sales in Ireland by 3.3% in the year following the introduction of smokefree legislation (April 2004 to May 2005) — but this was part of a trend in decreasing bar sales which had been seen in Ireland since 2002, and is likely to be due to changing lifestyles. Off-license sales have increased during the same period and it is likely that people are increasingly choosing to stay home to drink alcohol.

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(xiv) Before the introduction of the Irish legislation, only 67% of the public supported a law.


(xvi) See http://www.canercampaigns.org.uk

(xvii) Action on Smoking and Health (ASH) commissioned poll, 2004. 51% of MP respondents stated support for comprehensive smokefree legislation.


(xxii) Before the introduction of the Irish legislation, only 67% of the public supported a law.


(xxiv) See http://www.canercampaigns.org.uk

(xxv) Action on Smoking and Health (ASH) commissioned poll, 2004. 51% of MP respondents stated support for comprehensive smokefree legislation.


Memorandum by Southwark NHS Primary Care Trust (SP22)

Southwark Tobacco Alliance is a multiagency partnership whose main purpose is to ensure a coordinated approach to the different strands of work relating to tobacco control and smoking prevention and to take forward the tobacco control implications in the Choosing Health Public Health White Paper. The group has representatives from Southwark PCT (Public Health and stop smoking services), the London Borough of Southwark (Trading Standards and Environmental Health), Southwark Healthy Schools, and Southwark DAAT.

Southwark Environmental Health undertook a Survey of Licensed Pubs and Bars in the London Borough of Southwark—to establish proprietors’ views on food and smoking policies. Please find enclosed a copy of the report on this survey. The conclusions of the survey were:

— The proportion of pubs and bars that do not serve food was higher than the 10–30% suggested by the UK government. This proportion is likely to increase significantly given the indicated intentions of the business proprietors, if exemptions are permitted for non-food venues.

— The proportion of pubs allowing unrestricted smoking and the proportion of non-food venues was higher in more disadvantaged areas, suggesting that the proposed UK government policy of exempting pubs that do not serve food from smokefree legislation, will exacerbate inequalities in smoking and health.

Southwark Tobacco Alliance requests that the Health Select Committee considers the findings of this report and recommends that Option 2 as described in Annex B of the consultation document “Consultation on the Smokefree Elements of the Health Improvement and Protection Bill” is implemented. We do not support Option 4 with its proposal to exempt licensed premises that do not serve food, as we believe that this will exacerbate health inequalities in Southwark.

September 2005

Memorandum by SmokeFree Liverpool (SP23)

1. Introduction

The SmokeFree Liverpool Group brings together partners from the statutory and voluntary sector and includes the Roy Castle Lung Cancer Foundation, Liverpool Central, North and South Primary Care Trusts, Liverpool City Council, Liverpool Chamber of Commerce, North West TUC, Health@Work, Scarman Trust, North West AS, Liverpool Health Promotion Service and Heart of Mersey. We are working closely with employers, staff and organisations to create a smokefree environment for all employees in Liverpool.

2. Summary

SmokeFree Liverpool believes that the smoking of any substance should be prohibited in all work and public places. There should be no exemption for any pub or membership club on health and safety grounds, as it is wholly unacceptable to exempt any category of worker from an identified and controllable risk. Exempting a category of workplaces from smokefree legislation could be subject to legal challenge. The date of “guilty knowledge” under the Health and Safety at Work Act 1974 (HSWA) has now clearly passed in relation to secondhand smoke.

Exemptions would be likely to increase existing health inequality in deprived communities. This cannot be an acceptable outcome for a Government that has made a clear commitment to reducing such inequality.

Exemptions do not allow the “level playing field” that the licensed trade in Liverpool tells us it desires.

There is an abundance of evidence, not least the official evidence from Ireland, that comprehensive legislation is not bad for licensed trade business. Evidence from New York shows that smokefree laws have actually increased business prosperity.

All major Unions are supportive of comprehensive legislation to protect the workforce. The TUC, Unison, CWU, GMB and TGWU all support 100% smokefree workplaces as policy. Recently, the TUC General Secretary said, The time for action on this issue is long overdue. Smoking has an enormous social and economic cost. More importantly, it has a devastating human cost.

It is unethical and potentially unlawful under human rights legislation to discriminate against any group of employees or member of the public by exposing them to an identified and controllable public health hazard. Careful consideration should be given to the exemption of classes of premises such as Prisons.

19 Not printed.

Mental Health Care Premises and long stay Residential Care Homes. These “residential” premises are also workplaces and legal opinion obtained by SmokeFree Liverpool indicates that not providing exemptions for such premises is compatible with the Convention.\textsuperscript{21}

Exemptions for pubs that do not prepare and serve food will encourage the consumption of alcohol without food, contrary to the Government’s Alcohol Strategy.

The proposed smoking restrictions in exempted licensed premises are not satisfactory because Smoke drifts and therefore such a policy would be partially or wholly ineffective in protecting the health and safety of staff working at the bar.

The proposed partial legislation will create problems of implementation and enforcement and leave exempted employers open to civil litigation claims. Partial legislation will be more onerous and therefore much more costly to enforce. It will also be confusing to members of the public resulting in lower levels of self/public enforcement.

There is no reason to delay the introduction of this legislation. Ireland has had legislation in place since March 2004 and Scotland will have their legislation in place in 2006. Too much time has been lost already; delaying the implementation will cost lives. The legislation should be brought in urgently on a single date.

Detailed evidence about smoking in workplaces and public places from SmokeFree Liverpool is contained in their response to the consultation on the smokefree elements of the Health Improvement and Protection Bill. 

\textit{September 2005}

\textbf{Memorandum by The Association of Licensed Multiple Retailers (SP24)}

The Association of Licensed Multiple Retailers (\textit{ALMR}) thanks the Committee for the opportunity to present its considered position on the matter of smoking in public places, and especially in the context of the forthcoming Health Improvement and Protection Bill. The \textit{ALMR} represents the interest of 92 companies that own and/or operate nearly 28,000 pubs, bars, restaurants and hotels in England and Wales. Some companies may directly manage their pubs and bars but others may be only their landlords with less immediate control through the provisions of the lease. All these companies’ business will nevertheless be affected, to a lesser or greater extent, by the forthcoming legislation and are well placed to influence its progress and success.

There are in the region of 53,000 pubs and bars in England and Wales. There are about 10,000 fully independent “freehouses”, a further 10,000 managed pubs and the remainder (33,000) are leases and tenancies where the business is conducted by an individual businessman. The high proportion of small businesses in this sector is matched elsewhere in the hospitality industry and should be a significant influence on proposed legislation and the economic effects of its application.

The \textit{ALMR}, with others, led the Charter Group that transformed the awareness levels of smoking issues among hospitality premises and introduced smoking restrictions well ahead of the public’s perceived appetite for a ban. The Association now supports those companies who are setting their own staged progress to further and tighter restrictions ahead of any proposed legislation. We have urged the government to support publicly any and all voluntary initiatives as being not only worthwhile in their own right but also having the merit of preparing the industry and the public for eventual legislation.

We support the intentions of the Health Improvement and Protection Bill in seeking to improve public health by reducing opportunities for consumers to smoke; to improve the welfare of staff in our premises by reducing their exposure to pollutants, and we welcome that the consultation process sought to take account of public opinion and the opinion of those most directly affected by the proposed regulations.

In essence the Association accepts that no-smoking should indeed be the norm and that the legislation will deliver this. Against the background of the near universality of smoking restrictions we believe that there should be the provision of smoking rooms under regulated conditions, and that the smallest and most economically marginal businesses be exempted from a ban.

We are very concerned about the potential impact of this measure on employment in our industry and estimate that this could be in the region of 6% of sector employment of nearly 32,000 jobs. (source BDO Stoy Hayward) We believe that government should acknowledge and support such businesses that can demonstrate severe losses attributable to the new regime.

We acknowledge the exemption proposed for premises not preparing or serving food. We believe that the exemption, as it has been proposed in the White Paper and however imaginative, may lead to unintended consequences.

If the objective is to protect customers and staff from ETS then the government should follow the example of at least three European countries and consider how smoking rooms may be defined and operate in otherwise non-smoking premises.

\textsuperscript{21} James Goudie, QC, Legal Opinion.
The hospitality industry has met and exceeded public expectations in the provision of non-smoking food areas, non-smoking bar areas, genuinely effective ventilation and the opportunity for customers to make their own choices. Nevertheless we are now contemplating legislation and we have urged the government to allow the maximum possible timescale for businesses to prepare themselves and their customers for the new regime. This would be a genuine part of the lead-in to the new regime and much as transition has been part of licensing reform and in which the industry would expect government support to minimise the worst aspects of the downside that the industry fears. We therefore submit that the spring of 2010 would be an appropriate implementation date in order to prepare the businesses and their customers for the new regime.

We consider that the proposed exemptions for members clubs are illogical in terms of staff protection and unfair in competition law. We recommend that all categories of clubs be treated as other licensed premises with the same restrictions, exemptions and regulations as will apply universally.

Our members own and operate premises in England, Wales and in Scotland. We recognise that the Scottish Parliament has powers in this matter and has legislated for a ban in Scotland; we regret this. We strongly recommend that Parliament does not devolve powers to Wales and that the legislation and regulations are applied universally and evenly across England and Wales.

The ALMR opposes any derogation for smoking policy to local authorities. We believe that local smoking policies would cause confusion to customers and businesses, and increase administrative and enforcement costs. Local authorities’ discretion is currently being considered in the House of Lords where we have petitioned against the two Private Bills there. Notwithstanding our preference for national policies, this should not be taken as any sort of support for a national, total ban.

We suggest that compulsory signage should relate only to premises and places where smoking is permitted. This is in the spirit of the new, tight restrictions and indeed could be enhanced by using the “Smoking Allowed” signage to include appropriate public health messages. We believe that the costs of new, universal signage have been not only underestimated but absolutely ignored; these costs include development, installation and maintenance.

We are conscious that planning rules vary markedly throughout the country and would welcome specific planning policy guidance (PPG) from central Government to local authorities to ensure consistency in the treatment of planning permissions for the construction of external facilities, in line with the provisions of the Bill.

We believe that all this can best be achieved by an industry-government agreement to promote the current voluntary change ahead of the legislation. This will help to ensure both that the damage to small businesses and community facilities is reduced, and that some of the benefits eventually accruing from the changes can actually be achieved earlier than the legislative date.

September 2005

Memorandum by Society of London Theatre and Theatrical Management Association (SP25)

1. This is a joint submission from the Society of London Theatre (SOLT) and the Theatrical Management Association (TMA) to the Committee’s inquiry into the Government’s proposals to restrict smoking in public places (as set out in the Department of Health’s recent consultation on the Smokefree Elements of the Health Improvement and Protection Bill).

SUMMARY

2. SOLT and TMA are trade associations representing the interests of those engaged in the production and presentation of medium to large-scale dramatic and lyric theatre in the UK.

3. Although, in principle, we support the Government’s aim to reduce exposure to second-hand smoke, we have a number of concerns about the Government’s proposals.

4. Our main concerns relate to the impact of any measure to restrict smoking on the presentation of theatrical productions, particularly in terms of how it might compromise the artistic integrity of a production and constitute a form of censorship.

5. In order to address these concerns we recommend that the Government provide an exemption for smoking as part of a theatrical production (and related rehearsals).

6. We also have concerns about the definition of “smoke” or “smoking”, the introduction of measures on a piecemeal basis throughout the UK, the display of no-smoking signs and the definition of “enclosed”.

7. We make a number of recommendations to address these concerns.

8. We raise two points on which we recommend that the Government provide clarification.
BACKGROUND

9. SOLT and TMA are trade associations representing the interests of those engaged in the production and presentation of medium to large-scale dramatic and lyric theatre in the UK.

10. SOLT represents members based in London as defined by the London postal districts. TMA represents members throughout the UK. The two organisations are run from a joint office with a largely shared staff.

11. SOLT provides services, such as advice on legal matters and industrial relations, campaign management and audience-development programmes to its London-based membership (numbering around 140 members and covering producers, theatre owners and managers), drawn from both commercial and subsidised theatre. More specifically, those members include the five main theatre owners in the West End: the Ambassador Theatre Group, Clear Channel Entertainment, Delfont Mackintosh Theatres, Nimax Theatres and Really Useful Theatres. Its members also include all the major subsidised theatrical organisations in London (including the four great lyric and dramatic national companies: English National Opera, the Royal National Theatre, the Royal Opera House and the Royal Shakespeare Company), producing theatre companies such as the Wimbledon Theatre and the Theatre Royal Stratford East, and venues such as Sadler’s Wells and the Barbican Centre.

12. The TMA provides services, such as advice on legal matters and industrial relations, training courses, representation and a professional support network for the performing arts industry. Its membership is drawn from the subsidised and commercial theatre and includes repertory and producing theatres, arts centres and touring venues, major national companies and independent producers, opera and dance companies and associated individuals and businesses. Its members number around 360. Members range from the Royal National Theatre and the Royal Opera House to individual performing companies such as English National Ballet and Ballet Rambert, and the great majority of middle to large-scale producing theatres throughout the United Kingdom.

THE SUBMISSION

13. The remainder of this submission sets out our concerns about the Government’s proposals and our recommendations for action by the Government. We are aware that the Government’s proposals apply to England. To the extent relevant to the scope of the Committee’s inquiry, our recommendations apply equally to other areas of the UK.

Potential impact of measures to restrict smoking on the presentation of theatrical productions

14. Whilst, in general terms, we support the Government’s aim to reduce exposure to second-hand smoke, we have concerns about the impact of any measure to restrict smoking on the presentation of theatrical productions.

15. Our main concern is that any measure should not have the effect of prohibiting smoking on stage during performances and in rehearsals (which may or may not take place on stage). Such an outcome is something to which we would object strongly, on the basis that it would unnecessarily and unjustifiably affect the freedom of producers, directors and performers to perform fully and interpret accurately the artistic intentions of writers. Writers often cite smoking as a stage direction, as a detail of character, or smoking may in fact be part of the very subject matter or broader social theme of the work such as addiction to nicotine and/or other substances.

16. Smoking, as for example in the plays of Oscar Wilde, Anton Chekhov and Noel Coward, may also form a significant part of the social milieu or period detail of the work being performed. Or, as in the case of a historical figure such as Sir Winston Churchill or a fictional character such as Sherlock Holmes, it may also be a definitive and inseparable part of the individual’s persona. Performers frequently use smoking as part of their own realisation and characterisation of a role.

17. To prohibit smoking on stage would amount to a restriction on the creative process for all professionals working in the theatre. Such a prohibition would compromise both the work of the writer and the creativity of the performer. This would compromise the artistic integrity of the work in question and could constitute a form of censorship. In certain cases it would prevent the production of some plays.
18. We submit that the majority of the stages of our members’ theatres are large open spaces with high ceilings such that any smoke is dissipated and the risks associated with passive smoking do not apply.

19. As the Committee will be aware, when smoking takes place on stage all appropriate agreements and safety precautions with local councils and fire authorities are put in place to minimise and avoid the risk of fire.

Recommendation

20. In order to meet our concern that any measure to reduce exposure to second-hand smoke should not have the effect of prohibiting smoking on stage during performances and in rehearsals, we recommend that a specific exemption be granted for smoking as part of a theatrical or other artistic production and in related rehearsals. (We have written to the Department of Health seeking such an exemption.)

Recommendation

21. We further recommend that such an exemption be included in the Health Improvement and Protection Bill itself rather than secondary legislation. We would mention that in response to our petition against parallel legislation in London (the London Local Authorities (Prohibition of Smoking in Places of Work) Bill), the promoters of that Bill have seen it appropriate, in principle, to provide for an exemption on the face of the Bill and have drafted an amendment seeking to achieve this. We would recommend that the Government take a similar approach when drafting its Bill.

Definition of “smoke” or “smoking”

22. We would stress that, although we are aware that the legislation in both the Republic of Ireland and New York State confines its prohibition to the smoking of tobacco products—thereby permitting the use of non-tobacco products such as herbal cigarettes, we would not consider this to be an acceptable solution for theatrical productions as these products do not provide an alternative to cigars.

Recommendation

23. As stated above, we seek an exemption for theatrical productions. If, however, an exemption is not provided, we would strongly recommend that the definition of “smoke” or “smoking” in the Bill be limited only to products which contain burning tobacco as proposed in the Government’s consultation document. If the definition were extended to the smoking of any lit substance—as is the position in the recently enacted Scottish legislation—the artistic integrity of theatrical productions would be severely compromised: we are not aware of any products which would enable a performer to simulate the smoking of a cigarette, cigar, pipe, etc, in a realistic and credible way.

The introduction of measures on a piecemeal basis

24. As mentioned above, we are aware of the prohibition of smoking measures in the Scottish Executive’s Smoking, Health And Social Care (Scotland) Act 2005 (in relation to which we sought an exemption for theatrical productions). We are also aware of the proposals set out in the paper, “A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005–25”; and similar proposals relating to London and Liverpool. We are monitoring those proposals and have made our concerns known to the relevant parties. We are also monitoring developments in Wales and have written to the Welsh Assembly.

25. We are concerned that these different proposals relating to different parts of the UK could result in the introduction of legislation or measures on a local, piecemeal, basis. Such a situation would prove confusing and would present practical difficulties for productions being toured from one area of the UK to another.

Recommendation

26. Given its lack of an exemption for theatrical productions and the wide definition of “smoke” we would not want other areas of the UK to follow the Scottish legislation. However, with regard to the rest of the UK, we recommend that the Government ensure that the anti-smoking measures introduced for England are consistent with those for Wales and Northern Ireland.

27. We would add that we regard the London and Liverpool Private Bills as being premature in light of the Government’s proposed Bill.
Display of “no-smoking” signs.

28. We note that it is proposed that smokefree areas should be designated by no-smoking signs. We understand from our meeting with members of the Tobacco Policy Unit that there is no intention for signs to be displayed on theatre stages.

Recommendation

29. For certainty, however, we recommend that the Government provide an exemption (again, on the face of the Bill) from any requirement to display such signs for theatres or other performance venues where this would detract from the artistic integrity of the set or the audience’s theatrical experience.

Recommendation

30. We are strongly in favour of special provision being made in respect of the display of no-smoking signs for listed buildings, given that many theatres are listed buildings, and recommend that the Government make such provision (as suggested in the consultation document).

Definition of “enclosed”

31. We are concerned that the definition of “enclosed” (as in “enclosed public place or workplace”) should not extend to the external doorways, entrance steps or canopied areas outside theatres as these are where audience members tend to smoke during the interval and it is particularly important that those individuals have a covered area to go to if it is raining.

Recommendation

32. We recommend that the Government ensure that the definition of “enclosed” is drafted so that the types of area mentioned do not fall within it.

Exception for licensed premises

33. Under the Licensing Act 2003, theatre buildings will be licensed premises and will have a premises licence permitting them both to present plays and to sell alcohol. We are unclear as to the position if no non-exempted food is served in the building. We assume that it is not intended that the whole building be exempt, but query whether the exception will apply to part of the building.

Recommendation

34. We recommend that the Government clarify the operation of this exception.

Timetable

35. We note that the Government proposes that premises licensed for the sale and consumption of alcohol will receive a longer lead-in time. We are unclear whether this will be the case for all such licensed premises, including those (such as theatres) which are also licensed for public entertainment.

Recommendation

36. We recommend that the Government clarify the application of the longer lead-in time in relation to premises which are licensed for public entertainment as well as for the sale and consumption of alcohol.

Conclusion

37. We recognise the need to reduce exposure to second-hand smoke as part of the overall aim to improve the health of people in England. However, we are extremely concerned about the potential impact of measures to reduce such exposure, particularly in respect of the presentation of theatrical productions (and related rehearsals) and therefore recommend that the Government provide an appropriate exemption.

38. We hope that the above submission may serve to underline the significance of the Committee’s present inquiry for the theatre industry and represent a helpful contribution to its conclusions in due course.

39. We would be most willing to give oral evidence to the Committee.

September 2005
Memorandum by the Chartered Society of Physiotherapy (SP26)

INTRODUCTION

1. The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body representing the UK’s 45,000 physiotherapists, physiotherapy students and assistants. More than 98% of all physiotherapists in the UK are members of the CSP and physiotherapy is the third largest health care profession. Approximately 60% of chartered physiotherapists work in the NHS. The remainder are in education (including students), independent practice, the voluntary sector and with other employers, such as sports clubs or large businesses.

2. Physiotherapy involves the skilled use of physical interventions to promote, maintain and restore physical, psychological and social well being. Using problem solving and clinical reasoning, physiotherapists work to restore functional movement or reduce impairment utilising movement, exercise and the application of electro-physical modalities.

3. The Chartered Society of Physiotherapy welcomes the Health Select Committee’s inquiry into the smokefree elements of the Health Improvement and Protection Bill. Health promotion is a crucial aspect of the work of physiotherapists. They have a primary interest in the cessation of smoking and reduction in exposure to cigarette smoke, as so many come in to direct contact with the harmful effects of smoking on patients. This is particularly true for physiotherapists working in oncology and in respiratory care. Physiotherapy also plays an important role in cardiac rehabilitation and amputee rehabilitation, conditions that often result from smoking.

THE CSP POSITION AND SUPPORTING CLINICAL EVIDENCE

4. The CSP advocates a total ban on smoking in enclosed public spaces. It would be both a progressive step for the health of the nation and a necessary step to protect non-smokers from the harmful effects of tobacco smoke. We have drawn on three major elements to support this policy.

5. The physiotherapy profession is heavily involved in the treatment of patients suffering diseases caused by tobacco inhalation, and has a primary interest in supporting moves to ban smoking in public places. While the main and obvious effects of smoking are in respiratory conditions and oncology, cardiovascular conditions are also exacerbated by smoking. Physiotherapists often see the impact of smoking when undertaking cardiac rehabilitation and amputee rehabilitation.

6. Chronic Obstructive Pulmonary Disease (COPD) also deserves particular mention by the Society with reference to the harmful effects of tobacco smoke inhalation. COPD is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. It is directly caused by smoking and results in around 300,000 deaths a year in the UK. Physiotherapists are able to help people with COPD to manage their condition, but it is not reversible.

7. Chartered physiotherapists in respiratory care report that over 50% of their workload is devoted to this patient group. Physiotherapists are involved in the care of COPD from acute hospital admissions through to maintaining patients in the community, employing evidence based initiatives such as early supported discharge, non invasive ventilation and pulmonary rehabilitation. This patient group often has complex management problems and physiotherapists often assist in helping to manage chest clearance, coping strategies, breathlessness and anxiety management in conjunction with other multidisciplinary team members. Physiotherapists report that people who have been smoking for as little as five years could start to suffer symptoms of COPD.

September 2005

Memorandum by the British Heart Foundation (SP27)

1. INTRODUCTION

The British Heart Foundation (BHF) welcomes the opportunity to provide evidence to the committee on this important public health issue. The aim of the BHF is play a leading role in the fight against disease of the heart and circulation so that it is no longer a major cause of disability and premature death.

The BHF is also a member of the Smokefree Action coalition, alongside the British Medical Association, Cancer Research UK, the Royal College of Physicians, Asthma UK and ASH, which is campaigning to protect non-smokers from the effects of passive smoking in all workplaces.

This response replicates many of the points made to the recent Department of Health Consultation on the Smokefree Elements of the Health Improvement and Protection Bill. We would be delighted to help the Health Select Committee further where appropriate.
2. Evidence in Support of Smokefree Legislation

The BHF believes the scientific evidence in support of a comprehensive ban on smoking in all enclosed public places is overwhelming. The link between smoking and CHD is well-established, and a number of studies show an elevated risk of heart disease in people regularly exposed to secondhand smoke. In particular, we would draw attention to the research carried out by BHF-funded Professor Peter Whincup and his team at St George’s Hospital in London, which has shown that the full effects of passive smoking on the heart have been historically underestimated. This study, part-funded by the BHF as part of the British Regional Heart Study, provides an estimate of non-smokers’ overall exposure to tobacco smoke (at home, work and in public) and shows that the increased risk of heart disease for passive smokers is around 50%—double the earlier estimate of 25%22.

Furthermore, exposure to cigarette smoke does not have to be particularly prolonged for it to damage your heart. One study has shown that just 30 minutes exposure is enough to reduce coronary blood flow to the heart23. This study came to the conclusion that all non-smokers at risk of CHD should avoid indoor environments that allow smoking where possible. The BHF believes it is the Government’s duty to protect workers by making all workplaces smokefree.

Policies restricting smoking in public places help decrease the prevalence of smoking, which is estimated to cause over 30,000 deaths a year from cardiovascular disease in the UK. The Government’s own Regulatory Impact Assessment, published with the White Paper, estimates that ending smoking in all workplaces and enclosed public places would reduce overall smoking prevalence rates by 1.7%. We can therefore expect that a ban on smoking in enclosed public places would prove an extremely cost effective way to reduce the prevalence of smoking—and thereby dramatically reduce rates of heart disease in the UK.

3. Views on Government Proposals

We are pleased that the Department of Health has recently consulted on smokefree workplaces in England and Wales. However, we believe that the proposals to continue to allow smoking in pubs and bars that do not serve food is a policy that would leave thousands of bar workers—and countless customers—exposed to the dangerous effects of secondhand smoke.

The BHF does not support the exemption of any pub or bar which does not serve food from the proposed smokefree legislation. We base this on health and safety grounds, and also believe that concerns over public opinion and economic impact of smokefree legislation have been over-exaggerated.

Health and Safety

Using risk factors virtually identical to those in the Government’s own SCOTH report, Professor Konrad Jamrozik, formerly of Imperial College London, estimated in May 2004 that secondhand smoke in the workplace causes about 600 deaths each year in the UK and one death among employees of the hospitality trades each week24.

Given the strength of this evidence, the BHF is of the view that there can be no justification whatever for protecting the great majority of employees from this serious workplace health and safety risk while continuing to leave some of the employees at greatest risk (bar staff in exempt premises) exposed.

Public Opinion

There is every reason to think that the majority of the public would back a comprehensive smokefree law without piecemeal exemptions for certain pubs and bars. In April 2004, MORI was commissioned by Action on Smoking and Health to conduct by far the largest and most representative poll so far conducted on the issue (poll size—4,000 adults across Great Britain)25. The question asked was:

“Ireland, Canada, Norway and New Zealand have each passed laws to ensure all enclosed workplaces are smoke free. How strongly, if at all, would you support or oppose a proposal to bring in a similar law in this country?”

The results were as follows:
— 54% strongly support.
— 25% tend to support.

24 Academic paper on “Environmental Tobacco Smoke and the Hospitality Industry” presented by Professor Jamrozik 17/05/04, Royal College of Physicians Annual Conference.
— 8% neither support nor oppose.
— 7% tend to oppose.
— 4% strongly oppose.

In addition, it is apparent that smokefree legislation becomes more popular after its successful introduction. In Ireland, a survey conducted for the Office of Tobacco Control in March 2005 demonstrated that 93% of respondents, including 80% of smokers, thought the law had been a good idea.

Economic Impact

We are aware that the hospitality and licensed trade industry has concerns about the impact of any legislation on levels of trade, and on the viability of some establishments—concerns that were also voiced in Ireland and New York when proposals to restrict smoking in public places were tabled.

However, indications suggest that experiences in Ireland and New York did not reflect the fears of the industry and that, in some cases, trade actually improved. For example, in March 2004, a report on the impact of the legislation was issued by the New York City Department of Finance, the Department of Health and Mental Hygiene, the Department of Small Business Services, and the Economic Development Corporation. It concluded that:

“One year later, the data are clear... Since the law went into effect, business receipts for restaurants and bars have increased, employment has risen, virtually all establishments are complying with the law, and the number of new liquor licenses issued has increased—all signs that New York City bars and restaurants are prospering.”

In Ireland, the Vintners Federation of Ireland has claimed that the smokefree law has reduced pub takings by “20–30%”. However, the retail sales index for bars volume in Ireland (2000 = 100) shows that the value of bar sales in Ireland decreased by 3.3% in the year following the introduction of smokefree legislation (April 2004 to May 2005), but this was continuing a behavioural trend that began at least two years before the legislation came into force.

What we do know for certain is that banning smoking in public places will save lives. Any potential fall in revenue in the industry, for which there is little evidence and which has certainly not been proved, is in our view of far less importance than saving the lives of those who are currently being killed as a result of the industry’s failure to protect its own workforce.

4. Effect on Health Inequalities

It is clear that the pubs and clubs that would be exempt under the Government’s proposals are concentrated in poorer communities. There is a strong association between smoking and socio-economic position, meaning that these communities already have higher than average smoking rates. There is a direct link between poverty and heart disease, with a broad range of environmental factors—including smoking—to blame. The BHF believes that exempting pubs and clubs in the most deprived areas will undermine the progress that is being made towards meeting the Government’s targets of reducing health inequalities by 10% by 2010, and tackling underlying determinants of ill health (including reducing smoking prevalence among routine and manual groups to 26% or less). We believe these public health objectives cannot be met without comprehensive smokefree legislation, including all pubs and bars, in England and Wales.

A recent study conducted by Telford and Wrekin Primary Care Trust estimated that two-thirds of English pubs in deprived areas would be exempt from the proposed legislation—compared to only a quarter exempt in affluent areas. This evidence again suggests that many of those pubs in the poorest, most disadvantaged parts of the country would be exempt from the ban, and that health inequalities would widen as a result of the proposed policy to exempt pubs and bars not serving food.

5. Conclusion

Secondhand smoke in workplaces and enclosed public places is a serious health risk to employees and members of the public. Everyone has a right to a smokefree workplace and no-one should be forced to breathe in someone else’s tobacco smoke.

The BHF believes that the Government must introduce legislation to end smoking in all workplaces and enclosed public places, and that exemptions for some pubs, clubs or other workplaces are unacceptable because they would fail to protect many workers and others at most risk. Additionally, a comprehensive law would give many smokers the encouragement they need to give up.

A comprehensive smokefree law would be popular, simple, easy to enforce and would lead to a dramatic improvement in public health across all sections of society including the most disadvantaged. The BHF is urging the Government not to delay in implementing this legislation and calls on the Health Select Committee to use its influence to support this objective.

September 2005

Memorandum by Smoke Free North East (SP28)

INTRODUCTION

Smoke Free North East is a new body funded by each of the sixteen Primary Care Trusts in the North-East and Public Health Group North East. The North-East is the only region in England to have adopted this regional approach to delivering tobacco control and is overseen by an Advisory Panel with a multi agency membership representing both voluntary and statutory organisations.

We welcome the proposed legislation to end smoking in the majority of workplaces and enclosed public places and also welcome the Committee’s inquiry into Smoking in Public Places. We have serious concerns about both the timescale for the proposed legislation and the proposed exemptions and are therefore keen to make a submission based on several elements of the Bill.

KEY POINTS

— The proposed exemptions will leave North East populations disproportionately exposed to second hand smoke and will, we believe, both exacerbate the disadvantage in health suffered by the people of this region and widen inequalities in health.
— Legislation to cover all enclosed public places, without staggered implementation, has been shown to be practical, fair and popular elsewhere.
— Public opinion in the North East shows strong support for such action, and this has grown in recent years.
— We strongly oppose exemptions for licensed premises serving food and for private members clubs.

SECOND HAND SMOKE (SHS)

Second Hand Smoke (SHS) is acknowledged world wide as a major health hazard—a class A carcinogen and the third leading cause of preventable death. It has an immediate impact on health, reducing coronary flow velocity reserve and thus placing a strain on the heart within 30 minutes of exposure, (Otsuka et al 2001; SCOTH 2004). The Scientific Committee on Tobacco and Health (SCOTH), reported in November 2004 that: “overall exposure to secondhand tobacco smoke in the population has declined somewhat as cigarette smoking prevalence has continued to come down. However, some groups, for example bar staff, are heavily exposed at their place of work.” The report concluded that: “it is evident that no infant, child or adult should be exposed to secondhand smoke . . . Secondhand smoke represents a substantial public health hazard”. We are aware of no independently funded research which suggests that SHS is not harmful. All workers deserve protection from second hand smoke and there is no justification for protecting the great majority of employees from this serious workplace health and safety risk while continuing to leave some of the employees at greatest risk exposed.

COMMENTS

1. The Bill suggests that premises licensed for the sale and consumption of alcohol should be given longer to either become smokefree or to become smoking premises. We oppose this proposal. While evidence from abroad has shown that a lead-in period of up to a year is important, there is no evidence that licensed premises need a longer time to implement a smokefree ban than other businesses. Both Ireland and New York introduced their Smoke Free Legislation on a set date. One year evaluations show “New Yorkers overwhelming support the law”, while Ireland reports “overwhelming support for the smoke free law amongst smokers and non smokers”, (Office of Tobacco Control, 2005; New York City, 2004). This proposal would simply continue to expose people to the hazards of second hand smoke and cause further confusion and uncertainty for the hospitality industry, of whom many have expressed their desire for a “level playing field” as soon as possible. The legislation should be brought in as quickly as possible on a single date.

2. However, some organisations, such as the BBPA, suggest that a phased approach aiming for 20% smoking floor space in pubs by 2010, with separate smoking rooms, is best. We strongly oppose this approach as it would simply continue to expose people to SHS. Separate ventilated smoking rooms leak
smoke into the rest of the building, harming everyone in the building. A recent research study showed that up to 10% of smoking room air enters non-smoking areas just by opening and closing of a swing type entry door (ASHRAE, 2003).

3. Some organisations also claim that good work has been done by the industry through voluntary agreements. These include measures such as stopping smoking at the bar. In fact, the proposed legislation suggests that exempted premises should do just this. However, there is no scientific evidence to support the health benefits of banning smoking specifically at the bar in the absence of a ban in other parts of the same room. A recent study found that “no smoking” areas provided virtually no protection from second hand smoke, and suggest that the term “smoke-free area” is misleading and deceptive. Within minutes of someone lighting up a cigarette, the respirable particles, which carry cancer-causing agents into the lungs, contaminate the entire room (Cains 2004). We also do not support the use of ventilation systems which may remove the smell of smoke, but have been shown to be wholly inadequate in removing the toxins in second hand smoke and are expensive and cumbersome to maintain.

4. These sorts of measures simply result in a partial ban of the type advocated by organisations such as FORREST. The tobacco industry understands very well the benefits of partial smoking restrictions as opposed to comprehensive legislation. A Philip Morris internal document states that “total prohibition of smoking in the workplace strongly affects industry volume. Smokers facing these restrictions consume 11% to 15% less than average and quit at a rate that is 84% higher than average . . . these restrictions are rapidly becoming more common. Milder workplace restrictions, such as smoking only in designated areas, have much less impact on quitting rates and very little effect on consumption” (Heironimus, 1992)

5. The Bill proposes that all licensed premises that do not prepare and serve food should be exempted from the proposed legislation. It is also proposed to exempt membership clubs, where the members will be free to choose whether to allow smoking or not. However, the Bill is a health & safety measure and so this proposal would fail to protect staff in many pubs and membership clubs. Evidence from other countries, which have introduced smokefree legislation without exceptions for licensed premises, has shown that their popularity increases following implementation, establishing the norm of protecting all workers from a known health hazard. We oppose this proposal for reasons of health and safety, increasing health inequalities, regulatory impact, public opinion and economic impact.

6. Health and Safety—All workers deserve protection from second hand smoke. There is no justification for protecting the great majority of employees from a serious workplace health and safety risk while continuing to leave some of the employees at greatest risk (bar staff in exempted premises) exposed. Using risk factors virtually identical to those in the SCOTHR report, Professor Konrad Jamrozik, estimated that second hand smoke in the workplace generally causes about 600 deaths each year in the UK and one death among employees of the hospitality trades each week (Jamrozik 2004). This equates to 35 North-East workers dying annually from breathing other people’s smoke and this is unacceptable. For comparison, the total number of fatal accidents at work from all causes in the UK in 2002–03 was reported by the Health and Safety Executive as 226 (HSE 2003).

7. Widening of inequalities—The North-East has one of the highest smoking rates in England (GHS 2003) and also the highest cancer and heart disease incidence. Smoking is the leading cause of health inequalities. (Ogilvie et al 2004). Smokefree environments encourage people to quit smoking, and so will help reduce inequalities currently seen between the poorest and the well off in our society (Chapman et al 1999). At least 70% of people in the lower socio-economic groups who smoke want to quit but they find it much more difficult to do so and have higher relapse rates because of living in an environment in which smoking is the norm (Jarvis et al 2001).

Choosing Health estimated that 10–30% of pubs would be exempt from legislation. This was based on a survey of existing risk assessments for food safety carried out by Local Authorities. We have undertaken our own mapping in the North-East of the premises that would be exempt under the Government’s preferred legislation and it is apparent that exempt premises are much higher than the predicted figures. An average 52% of premises would be exempt. The mapping exercise showed that these premises are also concentrated in our poorer communities, with the highest smoking rates, worst deprivation and highest Lung Cancer Standardised Mortality Rates. Headline results in the North-East are Easington with 81% premises exempt/IMD rank of 6/Lung Cancer SMR of 141; Gateshead with 72% exempt/IMD rank of 30/Lung Cancer SMR of 165; and Wansbeck with 71% exempt/IMD rank of 43/Lung Cancer SMR 170. The consequence of this is that the health benefits, in reduced exposure to second hand smoke and in reduced smoking prevalence, will be less in these communities than in better-off communities, thereby increasing health inequalities. There is also evidence to show that up to a third of pubs might stop serving food to avoid the smokefree legislation, (ASH 2005).

In the absence of comprehensive legislation to restrict smoking in all public places, it is unlikely that targets for reduction in smoking prevalence by 2010 will be achieved, particularly in manual groups.

8. Regulatory impact—In Ireland legislation was enforced by Environmental Health Professionals. It was found that the legislation is almost entirely self enforcing if it is simple, widely enough publicised and understood by all parties. In Ireland compliance rates were well above 90% from day one. This required a comprehensive education programme, particularly for the hospitality trade, and a media campaign for the public. It also showed the advantages of implementing legislation in all workplaces simultaneously. To split
workplaces and hospitality venues risks undermining compliance rates. It is also important that a pre and post legislation surveillance and research programme is put in place so that it is possible to properly assess the effectiveness of the legislation. Ireland and Scotland both have programmes in place that could be used as a model. The proposed exemption for pubs not serving prepared food would require more frequent and more intrusive inspections by enforcing bodies, particularly Environmental Health Officers. The Chartered Institute for Environmental Health has warned that the exemptions would “add to red tape and lead to a more complex licensing regime”, (CIEH, 2004).

A partial ban will be difficult to interpret, compared to a comprehensive ban, which would be straightforward and easily understood. We know that even undertaking our wet/dry pub survey was difficult for the local authorities in the North-East given the confusion over definitions of food. Enforcement will clearly be more time-consuming, difficult and thus more expensive at a local level if the exemptions proposed at present apply. The view of the environmental health officers who are members of local tobacco control alliances and networks in our region is unambiguous.

The Health and Safety Commission Board on 25 July 2005 itself stated that the arguments for a wider ban in all licensed premises include better regulation—for regulation to be effective it must be capable of ready application by those to whom it is addressed. Differing restrictions in the UK will lead to confusion and lessen benefits. A uniform approach to smoking will be easier for employers, employees and the public to understand and comply with. A simpler regime, with fewer and less complex exemptions, will aid enforcement by the Local Authorities.

9. Public opinion. The majority of the public would back a comprehensive smoke free law. In the North-East a telephone survey of adults in May 2005 of 1202 randomly sampled residents throughout the region* showed that:

— 73% supported all enclosed workplaces and public places to be smoke-free.
— 70% would support a law to achieve this.
— 55% supported all bars and pubs being smokefree.

*Other data are available and is broken down into six sub-regions of the northeast.

These figures demonstrate a marked increase in public support for comprehensive restrictions when compared with survey data from earlier years. There has been substantial editorial support from major newspapers in the region with the clear backing of their readership.

We believe that public acceptance can and will grow as a result of planned communications activity if the Government chooses to act—indeed, smoke-free measures internationally have tended to become more popular once implemented. Support for the smoking ban in Ireland was at 67% before the legislation was announced but has since risen to 93% (including 80% of smokers) according to a poll conducted by the Office of Tobacco Control.

It is clear that everyone has the right to work in a safe environment. We frequently receive queries from workers being exposed to second hand smoke in their workplace and asking what they can do. Since our website was launched on 31 May 2005 we have had over 100,000 hits. We have had a huge response to our North-East consultation on the legislation and in total 145,000 postcards have been distributed. During the Tall Ships Races in Newcastle/Gateshead in July 2005 we had a prominent FRESH—Smoke Free North East stand on the Quayside. Over 2,400 members of the general public have approached the stand and individually signed postcards.

10. Economic impact. It has been suggested that smokefree legislation would affect business. However, evidence from around the world shows that smokefree legislation is not bad for business. A comprehensive review (Scollo et al 2002) of 97 studies published before September 2002 on the economic effects of the smoke free policies on the hospitality industry found:

— Of the 35 studies on this topic published that found a negative impact, none were funded by a source clearly independent of the tobacco industry, and none used objective measures and were peer reviewed.
— The 21 best designed studies found that smoke-free restaurant and bar laws had no negative impact on revenue or jobs.

In Ireland, the Vintners Federation of Ireland and other groups have claimed that the smoke free law has reduced pub takings by “20–30%”. This claim is false. The retail sales index for bars volume in Ireland (2000=100) shows that the value of bar sales in Ireland decreased by 3.3% in the year following the introduction of smoke free legislation (April 2004 to May 2005), continuing a trend that began at least two years before the legislation came into force. The decline in volume at drinking places in Ireland is a function of changing social habits—not smoking laws. This decrease in revenues (not the much higher figure claimed by the Irish LVA and lobbyists in the UK) simply continues a trend which started back in 2001, well before smokefree legislation was introduced. The volume of sales in bars in Ireland increased until 2000, but decreased by 3% in 2002, 4% in 2003 and 5% in 2004.
In his Annual Report for 2003, the Government’s own Chief Medical Officer, Professor Sir Liam Donaldson, said that a comprehensive smokefree law could benefit the British economy by up to £2.7 billion. This could include up to £680 million saved by having a healthier and consequently more productive workforce, £140 million saved through fewer sick days, £430 million saved because less production would be lost to cigarette breaks and £100 million saved by not having to clean up behind smokers.

**SUMMARY**

The proposal to exempt some pubs and membership clubs clearly threatens to undermine key Government public health objectives to reduce smoking prevalence rates and tackle health inequalities. Voluntary measures and staged approaches simply continue to expose workers to a recognised workplace health and safety risk. Some organisations suggest this is an issue of human rights and that people should have the choice to smoke. We suggest that the issue is not about whether people smoke, but where. The great majority of people do not smoke and their right to be protected from the harmful effects of SHS must take priority.

*September 2005*

**REFERENCES**


Cains T. Designated “no smoking” areas provide from partial to no protection from environmental tobacco smoke Tobacco Control 2004; 13:17–22.


Memorandum by the British Lung Foundation (SP29)

The following evidence is submitted to the Health Select Committee, from the British Lung Foundation (BLF), for the inquiry into the Government’s proposals to restrict smoking in public places.

The BLF welcomes this inquiry by the Health Select Committee and the recognition of the serious public health issues it addresses. We would be delighted to supply additional information, or clarification on any of the points raised in our response at a later stage.

1. BACKGROUND

1.1 The British Lung Foundation (BLF) is the only UK charity working for everyone affected by lung disease.

1.2 One person in seven in the UK is affected by lung disease.

1.3 We support people affected by lung disease through the individual challenges they will face. Support is the focus of many of our activities, including Breathe Easy, our nationwide support network and Baby Breathe Easy, our parent support groups.

1.4 We help people to understand their condition. We do this by providing comprehensive and clear information on paper, on the web (www.lunguk.org) and on the telephone (via our helpline 08458 50 50 20).

1.5 We work for positive change in lung health. We do this by campaigning, raising awareness and funding world class medical research.

2. GOVERNMENT’S PROPOSALS TO RESTRICT SMOKING IN PUBLIC PLACES

2.1 The BLF broadly welcomed the announcements on smoking made in the Choosing Health? Public Health White Paper.

2.2 The proposals in the White Paper demonstrate significant progress on the issue of smoking and we are particularly pleased with the measures announced on smoking cessation and public health advertising campaigns. However, we do not feel that the proposals on smoking in enclosed public places and workplaces go far enough to adequately protect the health of workers and members of the public.

2.3 The BLF is concerned that non-tobacco cigarettes have not been included in the Government’s proposals. By not including herbal cigarettes, the Government could potentially create difficulties for the enforcement of the legislation. Herbal cigarettes, for example, are very similar in appearance to tobacco cigarettes and this could cause confusion.

2.3.1 In addition, despite the lack of research into the effect of smoke from herbal cigarettes, the BLF believes that any type of smoky particles will cause irritation to the lungs, which will certainly cause discomfort to any of the eight million plus people living with a lung disease in the UK and potentially make people with healthy lungs more susceptible to problems.

2.3.2 We assert that all secondhand smoke is a health and safety risk regardless of whether the substance being smoked is or contains tobacco.

2.4 The BLF believes that all enclosed public places and work places, including pubs which do not serve food and membership clubs, should be included in any legislation to restrict smoking.

2.4.1 The proposed exemptions, for pubs which do not serve food and membership clubs, if permitted, will leave many of the employees at greatest risk still exposed to secondhand smoke and this cannot be justified.

2.4.2 The BLF does not support the proposal to implement a “no smoking at the bar” policy in licensed premises which could continue to allow smoking under the current proposals. It is not possible to protect employees and members of the public adequately by segregating smoking and non-smoking areas. Smoke particles move around an open space, therefore this will not be an effective way of reducing the health risk faced by bar workers in pubs where smoking continues. In addition, workers will be required to collect glasses and clean areas where smoking is permitted having an equally detrimental effect on their lung health.

2.5 The BLF believes that smoking should be banned wherever secondhand smoke in a public place or workplace is a significant danger to health and support proposals to allow the legislation to apply in public places such as sports stadia or bus shelters, where there is a close grouping together of people.

2.6 Whilst we would encourage the provision of smoking cessation support in hospices, long-stay residential care homes, psychiatric hospitals and units and prisons or other places of detention, the BLF acknowledges that arrangements should be made for people living in these organisations who either do not wish to stop smoking or are having difficulty in doing so, to be allowed to continue.

2.6.1 In these instances, the area designated for smoking should, where possible, be a covered area outside, away from areas the public or members of staff have access to or are required to spend any substantial amount of time.
2.7 By introducing comprehensive legislation covering all enclosed public places and workplaces potential confusion will be avoided, increasing compliance and making enforcement less complicated and less resource intensive.

2.8 The BLF does not believe that licensed premises need an additional 12 months to prepare for the legislation to take effect. Introducing the legislation at one time will make it easier to implement, easier for the public to understand and easier to enforce.

2.9 With a comprehensive ban in force in Ireland, and similar legislation planned in Scotland and promised for Wales, it would be incongruous for England to have different restrictions in place.

September 2005

Memorandum by Ken Livingstone, Mayor of London (SP30)

INTRODUCTION

1. This memorandum addresses the Government’s proposals to restrict smoking in public places. I have submitted a formal response to the Department of Health’s consultation on the Smokefree Elements of the Health Improvement and Protection Bill. My memorandum to the Health Committee’s previous inquiry into the Government’s Public Health White Paper also addressed the issue of smoking in public places.

2. I have a duty to consider the health of people in London in planning and delivering strategies and programmes. The GLA Act requires me to seek to “promote improvement in health” and to minimise any negative impacts on health.

SUMMARY

3. I am of the view that a complete national ban on smoking in enclosed public spaces and workplaces, without exemption (Option 2), is clearly the most favourable of the four options set out in the Government’s recent consultation on the Smokefree Elements of the Health Improvement and Protection Bill. A partial ban makes little sense given what we now know about smoking, because:

— a partial ban is likely to be less effective than a total ban in reducing smoking and protecting people from second hand smoke;
— health inequalities are likely to increase if a partial ban is imposed;
— evidence suggests that banning smoking in enclosed public spaces is likely to reduce the amount of smoking in the home;
— public opinion is increasingly in favour of a total ban;
— the economic case for a complete ban compared to a partial ban is overwhelming; and
— recent research has revealed that no country or state has experienced negative economic impact following a smoking ban in bars and restaurants.

BACKGROUND

4. The Government’s admission in its consultation paper that a partial ban is likely to be less effective than a total ban in reducing smoking and protecting individuals from second hand smoke lends support to the argument for adopting Option 2. We know that around 70% of smokers want to give up. Evidence suggests that programmes to create smokefree environments protect people from serious health problems, while providing strong motivation for smokers who are trying to quit. Such programmes have been shown to cause a 30% drop in consumption of cigarettes amongst people who work in smokefree venues. In the long-term, making enclosed public places smokefree will help prevent young people from taking up smoking.

5. A partial ban is likely to increase health inequalities, since it is likely to be in the most deprived areas, where the highest rates of smoking prevail, that customers will put pressure on the pub to allow smoking to continue. This view is borne out by recent research carried out in Shropshire on smoking in deprived areas.

Two recent studies in London come to very much the same conclusion:

28 Smoke ban “will widen health gap”—http://news.bbc.co.uk/1/hi/health/4162352.stm
29 The first of these is a telephone survey of London public houses undertaken by ORC International at the request of Jennette Arnold, the London Assembly rapporteur on smoke-free public policies. The second is a survey of all public houses in Southwark, undertaken by their environmental health service. The final report of the study is available from www.southwarkpct.nhs.uk/menshealth.
6. From an equalities perspective there can be no justification for a ban that exempts certain workplaces. All workers must be afforded the same level of protection from second hand smoke. Ventilation systems are not the answer, since there is no system that is able to remove all particulate material from tobacco smoke in smoking areas.

7. Contrary to concerns about whether banning smoke in pubs would simply shift smoking to the home, the latest research form the Royal College of Physicians has revealed that a ban on smoking in enclosed public spaces is likely to reduce the amount of smoking in the home.\(^{30}\)

8. Public opinion in favour of a complete ban has been increasing over the past several years. The most recent research on smoking behaviour and attitudes among the general population\(^ {31}\) reveals the largest increase in support for smoking restrictions has been for increasing restrictions in pubs—from just under a half in 1996 to nearly two-thirds in 2004. In addition, 30% of non-smokers said they would visit a pub more often if there were smoking restrictions in place, while even among smokers, the vast majority (85%) said they would continue to visit about as often as nowadays.

9. The net annual benefits derived from a total ban (£3,374 million–£3,784 million, compared to £2,842 million–£3,616 million for a partial ban) would appear to make the case for Option 2 overwhelming.

10. There is evidence that similar bans in other places have not met with the kind of hostility that was originally feared. Indeed, all the evidence suggests that both smokers and non-smokers welcome smoking bans and that they benefit the local economy. Recent research presented at the Smoke Free Europe Conference 2005 revealed that no country or state has experienced negative economic impact following a smoking ban in bars and restaurants.\(^ {32}\)

**Recommendations**

11. The Government should introduce legislation as soon as possible to provide for a complete national ban on smoking in all enclosed public spaces and workplaces without exemptions.

12. If only a partial ban is introduced nationally, the Government should give me the power to ban smoking in all enclosed public spaces and workplaces in London.

September 2005

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**Memorandum by the Tobacco Workers’ Alliance (SP31)**

**Introduction**

The Tobacco Workers’ Alliance (TWA) is a coalition of Amicus, Transport and General Workers Union (T&G) and GMB trade union members who work in the UK tobacco manufacturing industry and its major suppliers, currently representing some 7,000 workers across the UK, supported by the Tobacco Manufacturers’ Association. The TWA campaigns on a variety of issues that it believes could cause short and long-term damage to the employment prospects of those employed in the industry.

The TWA recognises that there are health risks associated with tobacco products. The TWA fully supports reasonable and responsible regulation of tobacco products.

This memorandum will summarise the key arguments regarding the TWA’s position on smoking in public places. A detailed version of the TWA’s views is in its submission to the Department of Health’s Consultation on the Smokefree Elements of the Health Improvement and Protection Bill.

1. The TWA recognises that the Government is pursuing a health-oriented agenda in regard to smoking and agrees with this approach. However tobacco products are legally manufactured, sold and consumed in the UK and while this remains the position, adults should not be marginalised or vilified because they smoke. Smoking bans are divisive and a source of aggravation and friction.

2. The TWA is broadly supportive of a degree of Government action on smoking in the workplace and in public places. We agree with the current proposal not to pursue a total ban on smoking and to allow some exemptions in line with public opinion. We believe that a total ban on smoking would lead to job losses in the hospitality, tobacco and related industries. We firmly believe that more should be done to improve the welfare of hospitality industry employees, particularly, who work in smoky environments.

\(^{30}\) See http://www.rcplondon.ac.uk

\(^{31}\) Department of Health. Smoking—Related Behaviour and Attitudes, 2004

\(^{32}\) Ross & Joossens. Smokefree Europe makes economic sense: a report on the economic aspects of smokefree policies, Smoke Free Europe Partnership, 2005
3. The TWA acknowledges the changes the hospitality industry has made in recent years to improve conditions and the welfare of both staff and customers through the introduction of ventilation and no-smoking areas. However, the TWA believes more can be done to enhance the welfare of our colleagues in the hospitality industry by:

- Having adequate ventilation in all licensed premises and using a standard for indoor air quality in all workplaces.
- Not permitting smoking at the bar coupled with effective ventilation such as the use of positive air pressure behind the bar to carry the secondhand smoke (SHS) away from the working area.
- Allowing separate ventilated smoking rooms in hospitality premises, where there is no bar area.

4. The TWA would prefer to see a stronger reinforcement of these kinds of measures and would be supportive if the Government wished to introduce regulations along these lines—this would remove the potential for two tiers of protection for hospitality workers in food-serving premises and “smoking” pubs and bars. We believe that a bar ban alone is insufficient.

5. The TWA is frustrated that the use of ventilation appears to have been dismissed out of hand. In the Smoking Kills white paper in 1999, which outlined the initial steps towards tackling smoking in public places, it was proposed to investigate and set acceptable ventilation standards for hospitality venues that the Government could endorse. To the TWA’s knowledge, this process was not carried out and under the current proposals there is no reference to how ventilation could be used effectively. If the requirement was for an indoor air quality standard it would be easier for environmental health officers to test and enforce and the responsibility would lie clearly with the managers or proprietors of the premises to meet the standard. It would mean that businesses would be subject to the legislation rather than individuals, which would in all likelihood result in greater public support for the measures from both smokers and non-smokers.

6. The current proposals have not taken full account of the fact that voluntarily 88% of workplaces already have either restrictions such as smoking rooms or a total ban.

7. The TWA calls for a full economic impact assessment before the introduction of the regulations looking at all industries that could be affected, including the tobacco industry. Studies of the economic effects of smoking bans in other countries have produced differing results. An independent analysis would be useful to determine the exact effects that smoking bans have had on the hospitality sector. It is the TWA’s view that a total smoking ban in public places would lead to job losses in the hospitality industry.

8. The wider effect that a smoking ban will have on the tobacco industry itself—particularly in a commercial sense is hard to predict. TWA members are acutely aware of the effects that legislation has had on the industry and on their livelihoods. The continuing hostility to the industry in the UK adds to the weight of evidence for the tobacco companies to take their manufacturing base elsewhere. Many members have lost their jobs as a result of the “Export Ban”, which prevents manufacturing cigarettes for export that don’t conform to EU levels. Members perceive smoking ban legislation as just such another threat to their livelihoods with the knock-on effects that factory closures will have on the supply and distribution chains and the local economy. This adds to the existing pressure of knowing that they have to continually compete with lower-wage economies.

9. The TWA is disappointed that the Government intends to effectively criminalise the consumption of a legal product, manufactured by its members and believes that whilst tobacco remains legal smokers should not be marginalised or villified because they smoke.

10. As trade unionists representing many members in poorer communities we are fully aware that health inequalities cannot be addressed by a smoking ban alone and the best way to remove health inequalities is to provide a good economic standard of living.

September 2005

Memorandum by the Royal College of Physicians of Edinburgh (SP32)

Summary

The Royal College of Physicians of Edinburgh welcomes the proposals to ban smoking in most public places but, given the strength of scientific evidence on the dangers of second-hand smoke, the College cannot support the wider exemptions and slower timetable proposed for licensed premises. The College is particularly concerned about the exclusion of some licensed premises serving restricted food items, proposals to permit smoking at the bar and the longer lead time for licensed premises. In addition, it should be clear that any exempted premises should have designated smoking areas only, looking forward to a future when no-one will be exposed to the dangers of passive smoke in a public building or at their place of work. The scientific evidence is now irrefutable that second-hand smoke damages health, and a total ban in public places will support the denormalising of this life threatening habit.
BACKGROUND

This evidence is offered by the Royal College of Physicians of Edinburgh. The College has over 10,000 Fellows and Members across the world and, indeed, has more Fellows and Members in England than in any other country. Our main objectives are to improve the standards of medical practice and health, largely through standard-setting and education of doctors through out their careers. A previous President of the College, Sir John Crofton, was instrumental in the foundation of ASH Scotland and the College continues to be a partner in the Scottish Coalition on Tobacco (SCOT), which has been actively involved in the successful legislation in Scotland which will ban smoking in public places from March 2006. The College is also a strong supporter of colleagues in the Royal College of Physicians of London and their work on the dangers of smoking and passive smoking.

DEFINITION OF SMOKING

The definition used within the Scottish Bill has been amended to smoking rather than smoking tobacco, given the enforcement problems that could arise from distinguishing claims of smoking herbal cigarettes from tobacco-based products. The College recommends that the definition is changed in the proposed Bill for England to focus on smoking any substance.

DEFINITION OF ENCLOSED PUBLIC PLACE

The definition of “enclosed” as used in the Scottish Bill is more rigorous at 50% enclosure rather than the 70% proposed for England. This provides for semi-enclosed structures eg station platforms in large urban stations, and would capture most open fronted bars, entrances and restaurants where walls can be removed onto adjacent pavement terraces. The 70% level could result in a higher number of disputes over semi-enclosed premises and would obstruct enforcement.

SPECIFIC INCLUSIONS THROUGH REGULATION

The College considers it helpful to provide for future amendments by regulation, including the power to include other premises within the definition of an enclosed space. The example cited within the proposed Bill of sports stadia is particularly relevant, given the combined risk to health from second-hand smoke and fire where large numbers of people gather. The opportunity to encourage a smoke-free environment should not be missed, given the number of families and young people who use such stadia, and the College would encourage the inclusion of stadia within the scope of the Bill or regulations.

The issue about smoking in doorways will be critical to enforcement with employers and retailers seeking to maintain a smoke-free environment at their entrances and avoid a “smoking ghetto” on the pavements and car parks. This will also be of particular help to hospitals and other health premises and assist managers to enforce a total ban on all NHS property (including car parks). The College encourages the inclusion of doorways within the definition or regulations to support enforcement.

LICENSED PREMISES

The College cannot agree to the restricted exclusion of licensed premises where food is being served or for private clubs. There is no logic within such proposals if other retailers are bound by the ban, and it is discriminatory to continue to expose workers in the pub and club trades to second-hand smoke, particularly as workers in the hospitality trade have the highest exposure to second-hand smoke of any occupation(1). They are thus at the highest risk to the hazards with a 50% increased risk of lung cancer(2). The exposure of hospitality workers to dangerous components of second-hand smoke falls dramatically following banning smoking(3). In San Francisco, the respiratory health of bar workers improved significantly following banning smoking in bars, whether or not the workers stop smoking themselves(4).

The proposed ban on smoking at the bar is insufficient to protect staff, will complicate enforcement and do much to damage the denormalising of smoking which the majority now support, including the over 70% of smokers who have indicated a wish to stop smoking(5). Ventilation systems do not effectively remove the pollutants in second-hand smoke(6), thus, smoking anywhere in the premises will result in hazard permeating to those in the bar, including staff. Furthermore, staff will need to enter the smoking rooms to serve and/or clear and will thus be exposed to risk. Enforcement will be particularly difficult even for responsible bar owners.

The College accepts that any premises serving non-exempted food at any time will be covered by the ban at all times, and that this will limit those premises that fall outside the Bill. However, this is unsatisfactory and will be difficult to enforce. Taking the power to amend the definition of exempted foods will add to the
confusion as lists change. Exempting any premises that serve food adds to the complication of enforcement by giving responsibilities to Food Standards Officers in addition to Environmental Health and Trading Standards Officers.

There is no justification for a longer lead time for the restrictions proposed for licensed premises, which are themselves inadequate with exemptions of some bars where food is not being served.

**Residential Premises**

The College understands the need for exemptions where the premises are in effect the individual’s home, and that this will include private houses and certain residential homes. However, those working in these environments need to be protected against the hazards of tobacco smoke. Thus, it is critical that communal residential premises are not wholly exempted from the Bill, and that there are designated smoking areas only within these premises as appropriate to the level of need among residents.

There was considerable debate in Scotland over the issue for psychiatric hospitals and units, particularly with the reduction in residential care and the integration of psychiatric units within general hospital buildings and community health centres. Other supportive measures to encourage smoking cessation among psychiatric patients should be provided and promoted to ensure that all non-residential facilities can also be made smoke-free. The College is not in favour of exempting all psychiatric patients from a ban that will capture all other groups of in-patients.

However, it may be necessary on humanitarian grounds to provide, for a limited time, very restricted smoking facilities within in-patient environments. Examples include facilities for elderly patients whose discharge may be significantly delayed.

**Membership Clubs**

The College is strongly opposed to the inclusion of private clubs within the exemption list because of the risk to staff employed in such premises, the lost opportunity to contribute to denormalising smoking, and the potential to avoid the ban by licensed premises not currently offering admission by membership.

The College believes that the risk of increasing the numbers of private clubs that permit smoking will also increase health inequalities if the proposed Bill is not amended. It is critical that all public buildings become non-smoking to support smoking cessation activities by community health workers and those individuals who have expressed a wish to stop but struggle to achieve it. The Department of Health must support the implementation of this important public health measure with training for all healthcare workers in smoking cessation and easier access to smoking cessation services for all current smokers.

**Other Exemptions**

The definition of a place where a self-employed person is working should not include a taxi or private hire coach. The College also has concerns about permitting smoking in a vehicle if, although only occupied by one person at a time, that vehicle may be shared between staff.

**Timetable**

The College believes that the main aims of this legislation are to protect staff from second-hand smoke and to encourage smoking cessation for improved public health. The timetable should reflect the earliest possible introduction date, and the College sees no justification for allowing licensed premises an additional 12 months. Setting a “go live” date that encourages early adoption seems reasonable.

*September 2005*

Memorandum by Help the Hospices (SP33)

1. Help the Hospices Background

Help the Hospices, the national charity for the hospice movement, welcomes the Health Committee’s inquiry into smoking in public places. The dangers of exposure to second hand smoke affect all staff, volunteers and users of hospices and we are encouraged that the Government is addressing this issue.

Help the Hospices acts as the national voice for 189 local charitable hospices in the UK. Help the Hospices also provides support for hospices through grant-aid; education; training; information and advice. Hospices work across traditional boundaries, operating across the health and social services in their work. They provide holistic care for people with life-threatening illnesses, often in the end stages of life. They also provide support for families and carers both pre and post bereavement. In financial terms, hospices provide a £500 million contribution to the UK health economy. In 2004–05, Help the Hospices provided £1,579,000, raised through direct fundraising, and a further £1,018,000 in grants to local hospices in the UK.

2. Scope of Evidence

Help the Hospices’ evidence will be focused only on the issue of the inclusion of hospices in the list of exemptions discussed in question 6 of the DH consultation.

3. Evidence

In order to represent local charitable hospices as fully as possible in replying to this consultation Help the Hospices conducted a survey of adult hospices in England. Our results were used to formulate our evidence which is outlined below. Full details of this survey are appended.

3.1 The Importance of Choice at End of Life

Help the Hospices is keen to highlight the ramifications of denying a lifetime smoker the right to smoke in the last days of their life. Any ban on this would be contrary to the purpose of hospice care—to improve quality of life at the end of life. For some terminally ill people, smoking is one of the few pleasures remaining to them and it can be a coping strategy for patients at what can be a very stressful time.

The responses we received from hospices formed a clear view on this issue. The aim of a hospice is to create as home like an environment as possible for terminally ill people. This often includes the right to smoke, as long as it is respectful of other users. Hospices seek to create a balance between freedom of choice and a smoke free environment.

Some patients who wish to smoke are unable to leave their beds so do not have the choice to leave the building. For this reason the majority of smoking areas are inside the hospice building.

In addition the specific patient group concerned, those receiving palliative care, are unlikely to suffer any disadvantages to their health by smoking and behaviour modification will have no affect on the prognosis of their disease.

We would also like to stress the importance of maximising access to hospices. Hospice CEOs expressed concern to us that some people would not access the service if they were unable to smoke.

3.2 Hospices constitute a place of residence

Help the Hospices agree with DH that all adult hospices should be exempt from smoke free legislation on the grounds that they can act as an individual’s dwelling/home on a day-to-day basis. We understand the department’s concerns that exempted groups should be clearly defined by law, and would be happy to work with them to draw up a definition of “hospice” for this purpose.

3.3 Hospice opinion

The main risk cited with a ban without exemption in the consultation is that a total national ban may not reflect public opinion, and may therefore be controversial and difficult to enforce. Help the Hospices can confirm that a total ban in hospices does not reflect opinion amongst hospice CEOs.

Help the Hospice’s research amongst English adult hospices has shown that 83% of hospice CEOs in England are in favour of smoking facilities being available in adult hospices. This is broken down to 69% of CEOs being in favour of hospices being exempted from any smoke free legislation and 14% in favour of no smoke free legislation at all. Reasons given for this opinion are as those listed above and also the danger of unregulated smoking taking place.
3.4 Promoting best practice

Hospices already actively pursue a reduction in passive smoking and are keen to strike a balance between smokefree environments and those service users who wish to smoke. All hospices that responded to our survey and that allow smoking provide designated areas of the hospice for this.

Help the Hospices are keen to support the Government’s smokefree agenda and would be interested in exploring how passive smoking can be minimised in the hospice environment with DH or any partner organisations.

3.5 Conclusion

Help the Hospices recommend that the Department of Health pursue national legislation to make all indoor public places and workplaces completely smokefree with exemptions and that adult hospices be included in the list of exemptions.

September 2005

Annex 1

Survey details
Conducted: 29 July 2005 - 22 August 2005
Distributed online to 142 independent adult hospices in England
Response Rate: 61% (n = 86)
1. Where are patients allowed to smoke in your hospice?
2. When are patients allowed to smoke in your hospice?
3. Where are staff allowed to smoke in your hospice?
4. When are staff allowed to smoke in your hospice?
5. Where are visitors allowed to smoke in your hospice?
6. When are visitors allowed to smoke in your hospice?
7. If your hospice also operates home visits please choose the option that most closely fits your home visit smoking policy.
8. If your hospice also operates a day unit where are patients allowed to smoke in the day unit?
9. If your hospice also operates a day unit when are patients allowed to smoke in the day unit?
10. If you have chosen “Smoking is allowed in certain situations” in the preceding questions please specify examples of these situations below.
11. How often would you say exceptions were made to these rules?
12. The Government consultation lists four possible options for smokefree legislation. Please read the options below and select which you believe is the most suitable government response. (From the perspective of your organisation/hospice)
13. Why have you chosen this option?
14. Who has previously discussed this issue within your hospice?
15. Who else, if anyone, has discussed this issue within your hospice?
16. Please use the space below to let us know anything regarding smoking in hospices that you do not feel has been addressed fully in your responses so far. Please feel free to write as much as you like.
17. Finally, please enter contact details: your name, your job title and your organisation below. Thank you for your time.

Annex 2

Survey Results
Patient smoking
— 81% of hospices allow patients to smoke somewhere in the hospice buildings
— Smoking is allowed only in specific designated smoking rooms within the hospice—69%
— Smoking is allowed only in specific patient rooms within the hospice—12%
— 18% of hospices do not allow patients to smoke anywhere in the hospice buildings
Staff Smoking
— 15% of hospices provide staff with an indoor smoking room
— 83% of hospices do not allow staff to smoke anywhere in the hospice buildings
Visitor Smoking
— 19% of hospices allow visitors to smoke somewhere in the hospice buildings
— 74% of hospices do not allow visitors to smoke anywhere in the hospice buildings

Home visit policy (n = 67)
— Patients may smoke freely during visits—55%
— Smoking is allowed at the discretion of the home visitor—31%
— Patients have been informed that NO smoking take place during home visits—6%

Day unit smoking policy
— 78% of day units allow smoking throughout the day in a designated area
— 8% of day units do not allow patients to smoke indoors

Flexibility
— 44% say exceptions are NEVER made to these rules
— 45% say exceptions are RARELY made to these rules

Favoured legislation
— Option One: Continue with a voluntary approach to reducing smoke—14%
— Option Two: National legislation to make all indoor public places and workplaces completely smokefree without exception—14%
— Option Three: Legislation giving local authorities new powers to control second hand smoke in indoor places—3%
— Option Four: National legislation to make all indoor public places and workplaces completely smokefree with exceptions—hospices are included in the proposed list of exempted premises—69%

Level of internal consultation
— 61 Management Committees, 60 multi-disciplinary teams, 53 informal discussions, 41 Boards of trustees, 19 service user groups and 9 Carer’s groups in 86 hospices developed these views.

Memorandum by Hunters & Frankau Limited (SP34)

1. Hunters & Frankau Ltd is the main importer and distributor in the UK of hand made cigars from Cuba and other Caribbean and Central American countries. Founded in 1790, we are a successful small company based in South West London employing 54 people. We also import and distribute machine made cigars principally from Holland and Germany. We do not distribute any tobacco products other than cigars.

We are a member of the Imported Tobacco Products Advisory Council (ITPAC) and an associate member of the Association of Independent Tobacco Specialists (AITS).

We supply cigars to a wide range of licensed businesses in England including restaurants, hotels, pubs, wine bars, casinos and golf clubs, and this business accounts for nearly a quarter of our total annual turnover.

We believe that the Smokefree Elements of the Health Improvement and Protection Bill, if enacted, will have a damaging effect on our business. As a result we welcome the opportunity offered by the House of Commons Health Committee present this memorandum. We would be willing to attend the Committee and give oral evidence.

2. Hunters & Frankau considers that the Government’s proposals to restrict smoking in public places are inconsistent with the principles stated by Prime Minister and the then Secretary of State for Health in the Foreword and Preface respectively to the Choosing Health White Paper. (See the statement in Hunters & Frankau’s submission (H&F’s Submission) to the Consultation Document on the Smokefree Elements of the Health Improvement and Protection Bill under the heading “The General Principles of the Bill—attached.)

3. Hunters & Frankau believes there is ample evidence available that the Government can make rapid progress towards its goal to reduce smoking without resorting to legislation that would create new criminal offences and a costly regulatory burden. (See H&F’s Submission under the heading “B. Unnecessary”). Furthermore we would welcome the opportunity to report to the Committee at its hearing the latest figures on the sales of our cigars to hotels and restaurants, which we predict will continue to show a decline.

Not printed.
4. Hunters & Frankau believes that the danger of passive smoking/secondhand smoke has been greatly exaggerated and that the results of current research indicate that the risks are low. (See H&F’s Submission under the heading “C. Unjustified”). We would commend to the Committee two documents on this topic published by FOREST: “The Smoking Issue—an essay by Joe Jackson”; and “Smoking out the truth—a challenge to the Chief Medical Officer by Lord Harris of Highcross”.

5. Hunters & Frankau believes that the Government’s proposals for smokefree exemptions on certain licensed premises are illogical and impractical. (See H&F’s Submission under the heading “C. Impractical”).

6. Hunters & Frankau believes that the Government’s proposals do not reflect public opinion and represent a threat to the rights of individuals. (See H&F’s Submission under the heading “D. and go too far”).

7. Hunters & Frankau respectfully asks the Committee to recommend in its report to the Government either to use voluntary means to reach its goals to reduce smoking, or, if legislation is considered unavoidable, to bring forward new proposals that would confine smoking to separate designated rooms in all workplaces whether licensed or not.

8. Hunters & Frankau would also ask the Committee to recommend to Government to add (i) the premises of tobacco companies, and (ii) the premises of specialist tobacconists to the list of exempted premises to be contained within the Bill. (See “Hunters & Frankau’s response to the questions in the Consultation Document”, which is appended to H&F’s Submission, at Question 6 and Question 8).

September 2005

Memorandum by Rank Group Gaming Division (SP35)

Thank you for providing the opportunity to comment on the Consultation Paper.

Rank Group Gaming Division is a wholly owned subsidiary of Rank Group plc and is a major operator of casinos and bingo clubs in the UK currently owning and operating 37 casinos and 1,017 commercial bingo clubs and employing some 9,000 staff.

Rank Group has already fully participated in the consultation process in relation to “Smoking in Public Places” undertaken by the Scottish Executive together with separately submitting a response to the Department of Health’s consultation process for England and the Welsh Assembly Government’s consultation process.

Rank’s Conclusions

It is Rank’s view and preferred option that the Government’s objective could be achieved by an extension of the voluntary approach as outlined in Option 1 of the Consultative Document but, if smokefree legislation is to be introduced Option 2 is the way forward—national legislation with no exceptions.

The following points summarise the view that Rank has adopted and would seek Government to consider:

1. A simple, consistent UK wide National Policy must be the preferred option.

2. The Policy should not contain exemptions, and apply irrespective of whether food is served or not, and irrespective of whether a club is a members’ club or not.

3. A total ban in all UK public places should be Governments long-term aim, allowing licensed operators three years (from enactment) to prepare their businesses, their staff and their customers if Option 1 is not adopted.

4. If however Government is determined to create exceptions, than responsible Licensed Operators in the Bingo and Casino sectors should also be allowed to create smoking and non-smoking areas within their clubs.

In responding to the consultation document I have endeavoured for purposes of clarity to comment on the questions specifically raised in the document and as if the smokefree legislation is adopted:

1. Proposed Definition of Smoke or Smoking—Question 1

Rank is of the view that in order to avoid any confusion, particularly bearing in mind the the penalties proposed for both individual management and premises owner in the case of non compliance, that all forms of smoking should be banned.

2. Definition of Enclosed—Question 2

Rank’s view is that the definition is clear, but for clarity sake believes that “partially enclosed areas” should reflect the Scottish Executives definition of partially enclosed, 50%—there is then joined up governance across the UK.
3. **Other Public Places and Workplaces That Might Fall Outside the Definition of “Enclosed” Which Might be Smokefree—Question 3**

Rank has no particular view on sports stadia, but in regard to other outdoor areas the inclusion of bus shelters, entrances, exit to public buildings or workplaces does seem overly draconian. Individuals fearful of inhalation of SHS would simply be able to avoid any individual or group of people who choose to smoke in a non-enclosed areas.

4. **Exceptions—All Licensed Premises (Receive a Longer Lead-in Time)—Question 4**

Rank has no comment on this proposal.

5. **Exception—All Licensed Premises That do not Prepare and Serve Food—Definitions of “Prepare and Serve Food”—Question 5**

Rank’s view on this proposal is that—there is no need for a definition on food served as all premises should be included in the legislation irrespective.

6. **Exception—Residential Premises—Question 6**

Rank has no comment on this proposal.

7. **Exception—Membership Clubs—Question 7**

Rank is of the view that no premises should be excluded no matter whether it is a members club or not. The effect of SHS on members and equally importantly on employees is not diminished due to the status of ownership of the premises.

8. **Exception—Practical Implications—Question 8**

The practical implications as far as Rank is concerned will initially revolve around employees and club members acceptance of the legislation and the enforcement by site management. It is felt that there should be a lead in time for implementation and consultation with the enforcement body prior to any penalties being issued at least for an initial period of time—1 year.

9. **Signage—Question 9**

Rank has no particular view on this aspect of the legislation other than that the signage may be displayed free standing rather than a requirement that it is affixed to front doors/windows etc.

10. **Offences and Penalties—Question 10**

The levels of penalties are inequitable—£50 for committing the offence and £200 for not enforcing.

Rank’s view is that the penalties should be

(i) flexible and dependent on circumstance ie if the individual who is smoking has been approached and refused the penalty should only be against the individual and,

(ii) penalties should have the same maximum limit (£200).

11. **Defences—Question 11**

Should be read in conjunction with the response in paras 8 and 10 above.
12. **Enforcement—Question 12**
   See paras 8 and 10 above.

13. **Smoking at the Bar—Question 13**
   No comment on this paragraph.

14. **Timetable—Question 14**
   Rank’s preference would be to move the start date to the end of January 2008 and 2009 respectively thus moving away from any conflict with holiday periods.

15. **Unintended Consequences for Binge Drinking—Question 15**
   Implementing Rank’s view—all premises to be smokefree, would ensure that there would be no risk of an increase in binge drinking.

16. **General Points—Question 16**
   Rank’s view on selected smoking clubs and pubs have been detailed in previous responses.

*September 2005*

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**Memorandum by British Medical Association (BMA) (SP36)**

**Summary**

1. The BMA has long campaigned for smoke-free public places, and welcomes this opportunity to comment on the Government’s proposals for legislation. There can be no doubt that the UK’s doctors want comprehensive action on smoke free places, with only extremely limited exceptions. About 2,000 BMA members took the time to respond to the Government’s consultation on its proposals, and thousands more have written to the Prime Minister to ask for action.

2. The health evidence that second-hand smoke kills is beyond dispute, but doctors’ knowledge does not just come from scientific papers—they also see the effects of second-hand smoke on the lives of their patients and their families. Doctors can see that their least affluent patients bear the heaviest burden of disease from smoking and second-hand smoke, and know that this suffering is preventable. They can see that second-hand smoke kills whether or not there are pies with the pints.

3. The Government’s proposals simply do not go far enough to protect health. The evidence is very clear—partial measures will not protect people, and the proposals for exemptions will penalise the poor. There is robust evidence to show that the proposals will widen the health inequality gap still further. They will condemn low paid bar workers to the health risks of second-hand smoke at work, and smoke-filled pubs and membership clubs will leave customers at greatest risk in the poorest parts of the country. The proposals will consolidate the “smoking culture” in low income communities, perpetuating high smoking rates, and catastrophic levels of smoking related disease amongst the poor.

4. Independent, peer reviewed studies show that comprehensive legislation benefits health. Smoke-free laws prevent ill health from second-hand smoke, and encourage smokers to quit. They motivate smokers to protect their families from second-hand smoke in the home. Countries which have already gone smoke-free have shown that the only business that suffers in the face of legislation is the tobacco industry, and that bars, restaurants and tourism can thrive. Their experiences have also shown that laws are popular, effective and easy to enforce.

5. As Scotland prepares to go smoke-free in Spring 2006, the BMA welcomes the government’s proposals to allow the Welsh Assembly to legislate for Wales, and looks forward to the announcement of plans for Northern Ireland. People throughout the UK deserve the same level of protection from second-hand smoke. There is no need for half measures and compromises, and no justification for further delays. The time has come for a comprehensive law.

6. The BMA welcomes the opportunity to submit evidence to the Committee Inquiry, and would be delighted to assist the inquiry by providing oral evidence or further written submissions to the committee.
INTRODUCTION

7. The BMA is a voluntary, professional association representing doctors from all branches of medicine across the UK. About 80% of practising doctors are members.

8. Our response is based upon a long-term interest in public health issues, and a particular commitment to evidence-based tobacco policies. Our recent reports include: Behind the smokescreen: the Myths and the Facts (2005), The human cost of tobacco (2004), Smoking and reproductive life (2004), and Towards smoke free public places (2002).

THE HEALTH EFFECTS OF SECOND-HAND SMOKE

9. The evidence that exposure to second-hand smoke causes fatal illnesses including lung cancer and heart disease is now conclusive. Major reviews of the evidence by bodies including the WHO International Agency for Research on Cancer, the UK Scientific Committee on Tobacco and Health, the US Surgeon General and the US Environmental Protection Agency have concluded that second-hand smoke is a major health hazard. The major effects are summarised in the table below.

<table>
<thead>
<tr>
<th>Adults</th>
<th>There is conclusive evidence that exposure to second-hand smoke causes:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Lung cancer</td>
</tr>
<tr>
<td></td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td></td>
<td>Asthma attacks in those already affected</td>
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<tr>
<td></td>
<td>Onset of symptoms of heart disease</td>
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<tr>
<td></td>
<td>Worsening of symptoms of bronchitis</td>
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<tr>
<td></td>
<td>Stroke</td>
</tr>
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<td></td>
<td>Reduced foetal growth (low birth-weight baby)</td>
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<tr>
<td></td>
<td>Premature birth</td>
</tr>
<tr>
<td></td>
<td>Chronic Obstructive Pulmonary Disease(2)</td>
</tr>
<tr>
<td></td>
<td>Reduced Lung function(3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th>There is substantial evidence that exposure to second-hand smoke causes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cot death</td>
</tr>
<tr>
<td></td>
<td>Middle-ear disease (ear infections)</td>
</tr>
<tr>
<td></td>
<td>Respiratory infections</td>
</tr>
<tr>
<td></td>
<td>Development of asthma in those previously unaffected</td>
</tr>
<tr>
<td></td>
<td>Asthma attacks in those already affected</td>
</tr>
</tbody>
</table>

10. The BMA welcomes the Government’s position that it accepts the evidence that second-hand smoke causes fatal illnesses. In the light of this, the BMA wonders how the Government can justify a policy which will leave some people—predominantly the poor—exposed to the lethal effects of second-hand smoke in workplaces and public places.

COMPLETELY SMOKE-FREE POLICIES ARE THE ONLY WAY TO PROTECT PEOPLE FROM SECOND-HAND SMOKE

11. Completely smoke-free policies are the only way to protect people from second-hand smoke. No safe level of exposure to second-hand smoke has been identified, and the harmful gases and particles in smoke will diffuse into the available space, whether smoking is permitted there or not. One US study found no differences either in the ambient levels of tobacco smoke or in the amount of nicotine absorbed by workers in smoking and non-smoking areas. An Australian study showed that designated “no smoking” areas, including smoke-free rooms, provided partial protection from tobacco smoke at best. At worst, the data suggested that they provide no protection whatsoever.

12. Ventilation cannot protect people from the hazards of second-hand smoke. Filtered smoke is as carcinogenic as unfiltered smoke, while research from the US and EU has shown that displacement ventilation technology cannot remove the gases and particles from the air. Separate smoking rooms leak smoke into the rest of the building, contaminating the rest of the space with second-hand smoke. Where ventilation systems are used, they are often incorrectly installed or switched off altogether. In one Canadian municipality, 78% of designated smoking rooms failed to meet the standards set by the law.

13. Smoking rooms pose health risks for staff. Even where staff are not required to work in these areas, it may be hard for low paid workers to refuse. In addition, staff would have to clean smoking rooms.

14. Not only are designated smoking rooms and ventilation an ineffective health measure, they also create an uneven playing field. Large scale operations can afford to designate space in this way, and to install ventilation systems, while smaller operators cannot. In Ottawa, small bar owners successfully won a court case to disallow designated smoking rooms because they created unfair competition.

15. Internal tobacco company documents show that worldwide the tobacco industry has consistently proposed voluntary regulation and “accommodation” strategies, such as ventilation and non-smoking areas as a strategy to prevent comprehensive legislation. In the UK, leading proponents of this approach, including AIR (Atmosphere Improves Results) and FOREST receive funding from the tobacco industry.
BENEFITS OF COMPREHENSIVE SMOKE-FREE LAWS

Health

16. Smoke-free laws have significant short and long term health benefits. In Ireland\(^{(12)}\) and California\(^{(13)}\), research studies have shown significant improvements in bartenders’ respiratory health. In one Montana city, the rate of acute myocardial infarction (heart attack) declined over six months while a smoke-free law was in place, only to increase again once the law was revoked after pressure from the tobacco industry\(^{(14)}\).

17. Smoke-free laws also have a major public health impact, because they encourage smokers to quit\(^{(15)}\). It has been estimated that reducing smoking rates by one percentage point per year over 10 years will save nearly 70,000 lives in UK smokers aged 35 to 74\(^{(16)}\). The biggest single factor in reducing deaths from heart disease in the last 20 years has been smokers giving up. Quitting prevented nearly 30,000 heart disease deaths from 1981–2000 in England and Wales\(^{(17)}\). California’s lung cancer rates have declined six times faster than in states without smoke-free laws\(^{(18)}\).

Smoking in the home

18. It has been asserted that smoke-free legislation in all pubs will increase smoking in the home and increase families’ exposure to second-hand smoke. There is no evidence to support this. All the available evidence suggests that smoke-free laws actually reduce smoking in the home—and especially smoking around children. This is because when fewer adults smoke, children’s exposure to second-hand smoke is reduced\(^{(19)}\), and because parents, including smokers, are more likely to adopt smoke-free homes after a policy is introduced\(^{(20)}\).

19. In Australia, the proportion of family homes with smoking restrictions more than doubled after smoke-free workplaces were introduced. The most dramatic increases were seen in households where all the adults smoked—smoking restrictions increased from 2% to 32% of homes\(^{(21)}\). In California, the proportion of children and adolescents living in smoke free homes increased from 38% in 1992, to 82.2% in 1999\(^{(22)}\); the year after the law was applied to all indoor workplaces. Survey data from Ireland shows that the number of smokers who have smoke-free homes has increased since the law came into force\(^{(23)}\).

IMPlications OF THE GOVERNMENT’S PROPOSALS

Exemptions

20. The BMA believes that the most problematic element of the Government’s proposals are the planned exemptions. The evidence is clear—second-hand smoke kills, whether or not there are pies with the pints. Nobody should be exposed to it in the course of their work.

21. Any exemptions to the legislation must be kept to an absolute minimum, as has been the case in Ireland, Norway and Scotland. Exemptions should only be considered for places defined as people’s homes, and a very limited number of other premises. The BMA accepts that there may be compassionate grounds to allow smoking in certain premises in specific circumstances. Nonetheless, the human right to live and work without being exposed to poisonous and life-threatening substances must take precedence over any perceived right to smoke.

22. The Government’s proposals to exempt certain licensed premises from the legislation are arbitrary and inequitable. There can be no justification for legislation that will leave low paid workers at risk, with their health decided by a members’ ballot or their employer’s decisions on menu items.

23. There is now evidence that the proposed exemptions will increase health inequalities. It is also apparent that the government has underestimated the number of wet-led pubs, the variations in geographical distribution of exempt premises, and the impact of the proposals on pubs’ decisions to serve food.

EFFECT OF THE PROPOSALS ON INEQUALITIES IN HEALTH

24. In the UK, smoking rates follow a distinct socio-economic gradient. Smoking rates range between 15% among professional groups, and 37% among those who are employed in routine jobs. Up to 52% of working age men who are economically inactive are smokers\(^{(24)}\).

25. Health inequalities have increased since 1997, despite the Government’s avowed intention to reduce these\(^{(25)}\).\(^{(26)}\). These exemptions will widen the gap between rich and poor still further.
26. The BMA’s Booze Fags and Food report\(^{(27)}\) found that the proportions of non-food pubs reflected a North/South divide, ranging from 88% in Leeds, to 5% in Bromley. A survey of the North East of England found that 52% of all licensed premises would be exempt, with figures ranging from 81% in Easington, which is the 6th most deprived area in England, to 23% in Tynedale, which is ranked 221st\(^{(28)}\).

27. In a recent BMJ study\(^{(29)}\), non-food pubs accounted for more than half of all the pubs located in the most deprived postcodes, and less than one third in the most affluent areas. The proportions were higher once membership clubs were included. If these results were modelled for the whole of England, four out of every five licensed premises will be exempt in low income areas, compared with two in five in more affluent areas.

28. These proposals will increase health inequalities, both in terms of exposure to second-hand smoke, and because of the effect on active smoking.

**Health Inequalities and second-hand smoke**

29. Bar workers are low paid, and the majority of employees in the hospitality sector\(^{(30)}\) are women with few educational qualifications. More than two thirds of hospitality workers are of childbearing age. Exposure to second-hand smoke in pregnancy poses long term risks to child health, such as low birth weight\(^{(31)}\) and premature birth\(^{(32)}\), and women exposed to second-hand smoke stop breastfeeding sooner than non-exposed women\(^{(33)}\).

30. Some other groups are also particularly vulnerable to the health effects of second-hand smoke. In the UK, 8 million people have lung disease, 2.1 million have angina, 1.3 million have survived a heart attack, and 300,000 have suffered a stroke\(^{(34)}\). These conditions are significantly more prevalent in lower income groups\(^{(35)}\). The proposed exemptions will have the effect of preventing people who suffer from these conditions from working or socialising in these venues, or forcing them to experience more severe symptoms in return for employment or social contact.

31. The occupational base of some members’ clubs is also relevant. Members of miners’ clubs and boilermakers’ clubs, for example, are more likely to have developed occupational disease, such as pneumoconiosis, chronic obstructive airways disease, and asbestosis. Exposure to second-hand smoke worsens the symptoms of these diseases.

32. Employees in the hospitality sector are paid less than in any other industry sector\(^{(36)}\), and often have little choice about where they work. Nobody should have to sacrifice their health to stay in a job. The reality is that customers may not be able to exercise choice either—many of our deprived communities are low amenity areas where customers have little choice of social venues. For some, the only choice is between the risk of ill health or isolation.

**Health Inequalities and Smoking**

33. Smoking is the biggest single cause of income-based health inequalities\(^{(37)}\). Smoke-free policies encourage smokers to give up, and comprehensive policies have the biggest effect on behaviour\(^{(38)}\). Although the motivation to quit smoking is similar across all social groups\(^{(39)}\), low income smokers are likely to find it more difficult to quit\(^{(40)}\). High levels of smoking and normalisation of tobacco use in low income communities are important factors\(^{(41)}\).

34. If the partial ban goes ahead, the gap will widen, reflecting the differences in quit rates resulting from comprehensive bans for the rich and partial bans for the poor. This undermines the Government’s existing targets to reduce smoking rates in manual groups, and will further concentrate smoking related disease amongst the poor.

**Likely reduction in food-serving pubs**

35. There is growing evidence that pubs which currently serve food might decide to stop, increasing the numbers of exempted premises. Survey evidence in North West England shows that 13% of pubs that currently serve food would stop doing so as a result of the law\(^{(42)}\). A separate survey also showed a significant number of pubs would cease to serve food, especially in low income areas\(^{(43)}\). The BMA is concerned that this will encourage patterns of heavy and binge drinking, with long term impacts on health and social behaviour.

36. The difficulties involved in defining “prepared food” threaten to provide a range of loopholes, and increase the burden on enforcement authorities. Comprehensive legislation is simpler to enforce than partial bans.
Time 

37. There is no justification for the licensed trade to have a longer lead-in time than other businesses. Each year of delay condemns an additional 54 hospitality workers to die as a result of exposure to second-hand smoke on the job. 

38. Although some legislatures (e.g., California and New York) have phased in legislation over a period of time, this is often because smoke-free bar laws have followed legislation covering other enclosed places. The UK is practically alone in having no legislation at all on smoking in public places. Long lead-in times could lead to momentum being lost before legislation enters into force. It is important that the public, businesses and enforcement authorities are given sufficient information and time to prepare, but there is no reason for this to exceed one year.

Effect of the Proposals on Business

39. Despite the scare stories perpetuated by the hospitality trade and tobacco industry, via funded initiatives such as AIR (Atmosphere Improves Results), independent economic analyses find no evidence that smoke-free laws harm business.

Compliance and Enforcement

40. Evidence from other countries consistently shows that when smoke-free legislation is effectively and sensitively enforced, compliance rates are high. In places as diverse as New York, Ireland, Massachusetts and New Zealand, compliance rates have exceeded 90%.

41. Countries with a phased or partial approach to smoking restrictions have found that such policies are impossible to enforce. In Norway, regulations stipulated that a third of premises should be non-smoking by 1993, rising to half of the area by 1998. There was, however, inadequate monitoring and enforcement of these regulations. In other countries, including Ireland, New York and New Zealand, comprehensive smoke-free legislation was preceded by partial bans which were less well observed and enforced.

42. Although the evidence shows that most smokers and licensees respect smoke-free laws, there is also a need to make sure that the sanctions are meaningful. The BMA believes that the Government must make it a priority to enforce the legislation, and to resource local authorities appropriately so that they have the capacity to carry out their duties.

Public Opinion about Smoke-free Places

43. The government has consistently identified a lack of public support as a barrier to implementing a comprehensive ban. Yet the evidence from other countries shows that public support for comprehensive legislation increases during the run-up to implementation, and once the law is in place.

44. In Ireland, the smoke-free law now has the support of 93% of the population, compared with 59% before the law was introduced, while in Norway, more than three quarters of the public supported the law by the end of the first year, an increase of 25 points in less than two years. In New Zealand, support for the smoke-free bars rose by 13 points, to 69% in the first six months after the law came into force.

45. In the UK, public support for a comprehensive law has markedly increased over the last year. Support for smoke-free pubs rose by 11 points between 2003 and 2004, and polls consistently show that the majority of people support smoke-free policies. In a recent BMA poll, 7 out of 10 people agreed that protecting the health of staff working in pubs and bars by having them completely smoke-free was more important than allowing smoking in such places.

September 2005
REFERENCES

1. British Medical Association (2002) Towards Smoke-free Public Places. London: BMA. Please note that this table has been updated to reflect recent additions to the evidence base.


41. Stead M, MacAskill S et al. (2001) It’s as if you’re locked in: Qualitative explanations for area effects on smoking in disadvantaged communities Health & Place 7: 333-343.


Memorandum by the British Beer and Pub Association (SP37)

The British Beer and Pub Association (BBPA) represents brewing companies and their pub interests, and pub owning companies, accounting for 98% of beer production and just over half of the 60,000 pubs in the UK.

This is a very important issue for our sector and the wider hospitality industry, and we are keen to work towards finding the right solutions that can be implemented over an appropriate period of time.

EXECUTIVE SUMMARY

General

— We would support Government action which takes a staged approach to smoking in public places, for example along the following lines:
— By end of 2007: No smoking at the bar in all licensed premises.
— By end of 2007: No smoking in back of house areas (eg staff rooms, offices etc) in all licensed premises.
— By end of 2009/Spring Summer 2010: Our preferred options would be for the trading floor space in pubs to become predominantly no smoking, with either areas of the premises specifically designated for customers who smoke or smoking rooms where practicable.
— We believe that this proposed Industry Approach is preferable to the proposed exemption for pubs which do not serve food, since it will reduce the exposure of employees and customers to environmental tobacco smoke in all pubs.

Timetable

— It is essential that the timetable is sufficient to enable the pub sector to manage change effectively. This will also ensure the full support of licensees and staff, and the re-education and co-operation of customers. We therefore suggest that the timetable runs to 2009–2010, rather than 2008. We believe that Spring/Summer would be the most appropriate time for the law to come into effect.

Membership Clubs

— In the interests of fair competition and a level playing field for business and employees, it is also crucial that the same rules are applied to all licensed premises, including membership clubs.

Definition of Smoking

— In order to avoid any confusion for both customers and business, and in the interests of clear enforcement, we believe it would be appropriate not to allow any form of smoking to take place in those premises where it would be prohibited by law.
Definition of “Enclosed”

— It is very important that the definition of “enclosed areas” does not affect what are essentially outdoor areas, such as patios, pavement areas etc, which do not form part of the fabric of the main premises structure. We believe that the acceptance by customers of the ban on smoking in Ireland has been due in part to the continued availability of choice made possible by flexible, outdoor structures.

Definition of “Prepare and Serve Food”

— The Association does not believe that food is the best basis for an exemption for licensed premises. It is highly likely that a significant number of pubs could sacrifice food, in order to retain the majority of their customers. According to the BBPA/ALMR Smoking Survey, we estimate that in the region of 34% of pubs in our sample alone may be smoking throughout under the Government proposals.

— We do not see how the protection of staff can be best achieved by the creation of “smoking pubs” under proposed exemption, despite ongoing industry action to ban smoking at the bar.

— The industry is extremely concerned about any potential adverse impact on binge drinking (as highlighted in paragraph 41 of the consultation document), and believes that allowing customers to drink without being able to provide an appropriate choice of food would be irresponsible.

— Any definition of food will create arbitrary distinctions which could be confusing for the general public, who will be uncertain as to whether they can smoke in a pub or not. This in turn will have implications for enforcement. We have nevertheless responded to the Government’s request for views on such a definition in our enclosed response.

Signage

— Rather than imposing signage on the overwhelming majority of premises which will be smoke-free, we suggest that a more sensible approach would be to require smoking areas to be clearly signed.

— We do not see the need for the size and content of signs to be prescribed by regulation.

Offences and Penalties

— We suggest that all three fines for the breaches outlined should be the same. As an alternative to discretionary fines, consideration could also be given to fixed penalty notices.

Enforcement

— Enforcement of the law with respect to individuals who break it will be key to the success of the new legislation. The actual practicalities of this aspect of enforcement need some further thought. Further discussion on enforcement issues between the parties concerned, including employers across both the public and private sectors, would be helpful.

No Smoking at the Bar

— The Association supports no smoking at the bar and believes there is an argument for appropriate regulation in this area, in the form of a general principle in law supported by guidance.

Potential Adverse Effect on Binge Drinking

— The industry takes its social responsibilities very seriously and does not wish to see its work in this area undermined. Any potential adverse impact on binge drinking as a result of these proposals on smoking must be avoided. Clearly, the risk of exacerbating binge drinking exists where Government’s no food exemption is adopted.

Health Inequalities

— While we cannot say for sure whether health inequalities will be exacerbated as a result of the proposed Government exemption for premises not serving food, they are unlikely to be improved or addressed by this approach.
Part One

THE PREFERRED INDUSTRY APPROACH

**INTRODUCTION**

The British Beer and Pub Association (BBPA) represents brewing companies and their pub interests, and pub owning companies, accounting for 98% of beer production and just over half of the 60,000 pubs in the UK. The pub sector contributes over £22 billion to the economy, (representing over 2% GDP) and employs in the region of 600,000 people. The pub food market is currently estimated to be worth in the region of £6 billion, and continues to grow. In the managed pub sector, this growth is 10% year on year. According to Mintel, the pub is now Britain’s second favourite place to eat out.

**Structure of the UK Pub Industry**

It is important that the scale and structure of the pub sector is fully understood, as this is the context for our comments on the proposals. The responsibility for implementing the new legislation will, in the main, fall to individual licensees running their own businesses, and not large companies. In simple terms, pubs will fall into one of the following categories:

(a) Managed Houses
   These are owned by a pub company or a brewery, and employ salaried managers and staff;

(b) Tenanted/Leased Pubs
   These are owned by a pub company or a brewery who receive rent from the licensee who runs the premises as their own business;

(c) Freehouses
   These are owned and managed by the licensee.

There are approximately 60,000 pubs in the UK, of which 49,000 are leased, tenanted or freehold. Of the 60,000 total, 82% of pubs are in England and Wales.

**INDUSTRY APPROACH**

The BBPA and its members have been trying to tackle smoking issues in pubs on a voluntary basis over the last eight years. The publication of the Public Places Charter in the White Paper “Smoking Kills” at the end of 1999 helped to raise the level of awareness of smoking issues across the hospitality industry, providing a number of specific venue policy options and recognisable signage. We acknowledge that progress was not as rapid as either the industry or the Government would have hoped. The Charter would undoubtedly have benefited from more active Government support in raising its public profile, which would have helped to raise the expectations of customers and stimulated even more demand at that time for no smoking choices in hospitality outlets.

The most recent industry initiative was launched last year, and is acknowledged in the consultation document. Since September 2004, 23 BBPA member companies (plus three non-member companies), covering in the region of 30,000 pubs (50% of all pubs in the UK), have committed themselves to achieving the following:

<table>
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<tr>
<th>Deadline</th>
<th>Action</th>
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<tbody>
<tr>
<td>December 2005</td>
<td>No smoking at the bar</td>
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<td>No smoking in back of house areas</td>
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<tr>
<td>December 2009</td>
<td>Pubs and bars to become predominantly no-smoking, with trading floor space being reduced for customers who smoke from a maximum of 65% currently to a maximum of 20% by 2009</td>
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These companies are also committed in general terms to:

(a) Providing a minimum of 50% of restaurant/dining area floor space for no smoking customers, with rapid movement to a much higher proportion.

(b) Continuing to develop exclusively smoke free pubs and bars where appropriate and practical.

The BBPA has surveyed members to assess the progress of this initiative. The latest survey, carried out in July 2005, indicates that:

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34 BBPA Managed House Survey—June 2005.
35 BBPA/ALMR Smoking Survey—July 2005 (sample size 28,000 pubs).
No smoking at the bar: has already been implemented by 42% of the pubs in our sample.

No smoking in back of house areas: has already been implemented by 55% of the pubs in our sample.

Floorspace: 66% of the pubs in our sample have no smoking areas. Of these:
— 34% had allocated over one third of their trading floor space as no smoking;
— 11% had allocated over half of their trading floor space as no smoking; and
— 1% of premises were smoke free.

The Association is committed to continuing to work in partnership with the Department of Health on smoking issues as it has done over the past year. The pub industry is now making much more rapid progress towards the presumption of smoke-free areas in pubs. The pub sector in particular has recognised the gradual public shift in demand for smoking restrictions in leisure venues, and is leading the way in providing customer choice.

The Association recognises and supports the Government’s commitment to choice, which it agrees is important for both individuals and businesses as progress is made towards a presumption of no smoking provisions in public places such as pubs, where people go to relax and socialise.

We firmly believe that achieving the appropriate balance between customer choice and employer responsibility to reduce employee exposure to Environmental Tobacco Smoke (ETS) is fundamental when considering the best approach to managing smoking issues in public places.

For this reason, we have a number of reservations about the proposals contained in the consultation document and would take this opportunity to suggest an alternative route which does not rely on artificial distinctions. We believe that our proposed approach is preferable to the proposed exemption for pubs which do not serve food, since it will reduce the exposure of employees and customers to environmental tobacco smoke in all pubs. Given the wider public health goals of the Government it is surely preferable to reduce exposure of all employees and customers and not just those pubs where food is the differentiating factor.

BBPA members are well placed to set the standards for the industry and participate in delivering the broader promotion of public health messages. We would support Government action which takes a staged approach to the issue, for example along the following lines:

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<th>Timetable Action</th>
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<td>By end of 2007</td>
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<th>Timetable Action</th>
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<tr>
<td>By end of 2009/Spring-Summer 2010</td>
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Our industry initiative will of course continue unabated over the next four to five years, as companies continue to reduce the exposure of staff and customers to ETS while still preserving choice. The initiative has an important part to play in achieving public health goals and changing public expectations on smoking in pubs.

The sudden prohibition at the end of the timetable of smoking in licensed premises that prepare and serve food does not achieve these aims. It is essential that the timetable is sufficient to enable the pub sector to manage change effectively. This will also ensure the full support of licensees and staff, and the re-education and co-operation of customers. We therefore suggest that the timetable runs to 2009–10, rather than 2008.

In the interests of fair competition and a level playing field for business and employees, it is also crucial that the same rules are applied to all licensed premises, including membership clubs. We comment further on this point under Question 7 below.
Part Two

BBPA COMMENTS ON THE DOH CONSULTATION ON THE SMOKE FREE ELEMENTS OF THE HEALTH IMPROVEMENT AND PROTECTION BILL

With regard to the background as outlined in the consultation document, we feel that it is essential that this consultation be looked at in the wider context of the Department of Health consultation “Choosing Health; Making healthy choices easier”. This current consultation is part of the wider white paper on general health and is also part of a Government commitment to cut adult smokers from 25% in 2003 to 21% in 2010. By looking at the issue of smoking in public places in isolation, the consultation proposals are in danger of migrating smoking to the home.

Our views on the specific points raised in the consultation document are set out below.

GENERAL OBSERVATIONS

We note the proposal in paragraph 9 of the consultation document that the Welsh Assembly Government be enabled “to make provision for smoke free public places in accordance with the policy that they may determine in relation to this issue”. The Association will be pleased to engage in separate consultation with the Welsh Assembly on this issue.

PROPOSED DEFINITION OF SMOKE OR SMOKING

Question 1: Does this definition raise any concerns, in particular that non-tobacco cigarettes are not covered?

The proposed definition of smoking does not include herbal cigarettes, on the grounds that they do not contain tobacco. We are concerned about this on two counts:

Firstly, we are concerned that this may lead to difficulties of enforcement. For example, members of the public and staff may not easily be able to distinguish the difference. Members of the public may report a premises in the belief that an offence has taken place on the premises when it has not. After the event, it is difficult to see how the venue manager or owner could prove what type of cigarette had been smoked by a customer.

Secondly, we are concerned that some customers might abuse the definition by smoking cannabis roll-up cigarettes. All drugs are of course illegal on licensed premises, and we would not wish cannabis use to be somehow encouraged in our premises on the grounds that it is a “herbal” substance.

In order to avoid such confusion and in the interests of clear enforcement, we believe it would be appropriate not to allow any form of smoking to take place in those premises where it would be prohibited by law.

SMOKE FREE ENCLOSED PUBLIC PLACES AND WORKPLACES

We believe that in order to ensure certainty for businesses and enforcers, any exemptions should be included on the face of the Bill rather than contained in secondary legislation.

DEFINITION OF ENCLOSED

Question 2: Views are invited on this approach to defining “enclosed”. Does it give the owners of likely premises and enforcement authorities a sufficiently clear definition? If not, how might it be improved? Are there concerns that loopholes are being created?

The concept of “substantially enclosed” in the proposed definition, so that the total area of the roof and wall surfaces exceeds 70% is very prescriptive and is likely to lead to difficulties of evaluation and confusion for both operators and enforcers. We are also concerned that it could inhibit the possibility of using moveable or flexible walls to create open areas as an adjunct to the premises. We suggest, therefore, that 50% would be a more sensible threshold.

It is very important that the definition of “enclosed areas” does not affect what are essentially outdoor areas, such as patios, pavement areas etc, which do not form part of the fabric of the main premises structure. The definition should apply to those areas that are contained within a premises, rather than a sheltered area set aside exclusively for the use of smokers where no staff service or facilities are provided. The Irish
approach to defining outdoor areas is therefore much more workable, and we would prefer to see something along these lines, which would ensure flexibility for the industry with regard to external structures and shelters. We believe that the acceptance by customers of the ban on smoking in Ireland has been due in part to the continued availability of choice made possible by flexible, outdoor structures.

Question 3: Views are invited on other public places and workplaces that might fall outside the definition of “enclosed” which might be smoke free, eg sports stadia, bus shelters, entrances/exits to public buildings or workplaces

It is difficult to see how a ban on smoking in such outdoor areas other than those with very restricted access could be enforced. However, the Association would wish to be involved in any consultation in this area, in case there were any possible implications for facilities for smokers outside pubs. We refer you to our previous comments under Question 2 above.

Exceptions—All Licensed Premises (Receive a Long Lead-in Time)

Question 4: Views are invited on this proposal. Are there any potential difficulties with using the Licensing Act 2003 that consultees would want to raise? Comments on the principles of a longer lead-in time for all licensed premises are also welcome.

The Association very much welcomes the principle of a longer lead-in time for licensed premises. We believe that this is essential for four key reasons.

(a) It will enable companies to educate licensees and staff on smoking issues and gain their support for moving forward with smoking restrictions and their potential enforcement.
(b) It will enable the industry to change the expectations of customers.
(c) It will allow us to work with the Department of Health on the wider issue of Smoking and the desire to reduce down to 21% of the population by 2010. The ability to target smokers with key information on its dangers and how to give up by the Department of Health would be much enhanced by using licensed premises over a period of time due to the high level of customers who do smoke.
(d) It will allow the costs of smoking restrictions in terms of implementation and potential lost revenue for the pub sector to be minimised. The vast majority of pubs are small businesses, and it is therefore crucial that they have sufficient time to implement restriction policies effectively in their premises.

We note that the deadline by which premises would need to comply with Government regulations is the end of 2008. As highlighted above, the Association believes a slightly longer timetable would be helpful. We comment further on this below in response to Question 8.

The BBPAs supports the proposal that the extended implementation period is applied to those premises which are licensed for the sale and consumption of alcohol under the Licensing Act 2003. For commercial premises, this is further defined by the requirement of a Designated Premises Supervisor where alcohol is to be sold.

Exceptions—All Licensed Premises that do not Prepare and Serve Food—Definition of “Prepare and Serve Food”

Question 5: Views are invited on the merits and practicability of this proposal. If a specific list is preferred, are there any things you would and would not want on such a list, recognising the current wish to, in essence, allow smoking only in “drinking pubs”? Are there any major concerns about the impact on licensed businesses that will have to choose between food and smoking? Is the Choosing Health estimate of 10–30% of pubs choosing smoking likely to be borne out?

Preferred Industry Approach

The Association remains unconvinced that food is the best basis for an exemption for licensed premises. Defining what constitutes “prepare and serve food” could create additional and unnecessary layers of bureaucracy for both industry and enforcement agencies. We are also concerned that to legislate along these lines would be a backwards step to the detriment of the pub sector, and would divide the industry in a way that we do not think customers would welcome.

According to the BBPA Managed House Turnover survey36, 90% of managed houses sell food, and this accounts for approximately 36% of their turnover. Universal industry wisdom is that an 80:20 wet/dry split in pubs is the norm. The Association has surveyed its members to obtain an estimate of those pubs, both managed and tenanted, that would remove their food offering in order to allow smoking.

36 BBPA Managed House Survey—June 2005.
The results of the BBPA/ALMR Smoking Survey—July 2005 indicate that:

- 81% of pubs (16,000 pubs) owned by respondents sell food.
- 20% of these (3,200 pubs) have indicated that they would expect to discontinue food sales in order to allow smoking.
- This means that under the Government proposals, only 65% of those pubs owned by respondents would continue to serve food, a decrease of 15%.
- Taking into account the 19% of respondents that do not currently serve food anyway, then a total of 34% of pubs in our sample could potentially continue to allow smoking throughout. This equates to just over 9,500 pubs.

It therefore follows that in some circumstances, it is highly likely that a significant number of pubs could sacrifice food, in order to retain the majority of their customers. In recent years, the industry has become increasingly family friendly, with a varied food offering. Lighter, more open premises have also meant that women feel more comfortable in pubs, which in the main are no longer the male preserve they once were. The withdrawal of food on a large scale would therefore be a truly negative step for our sector, which would not be beneficial to staff or customers.

Customers want choice first and foremost, and should be free to visit any pub or other licensed premises in the knowledge that there is provision for them as either a smoker or a non-smoker, rather than being forced to visit predominantly “food” pubs or “smoking” pubs. Similarly, since the basis of the Government proposals is the protection of staff, we do not see how this could be best achieved by the proposed exemption, despite ongoing industry action to ban smoking at the bar.

Under the proposed Industry Approach outlined above, the presumption would be no smoking throughout except for “defined areas”, which will gradually diminish in terms of trading space, to a target of just 20% over the next four years.

This is similar to the approach that was taken in Norway over a much longer period of time, and would significantly reduce the exposure of both customers and staff to environmental tobacco smoke in all pubs and hospitality venues. We therefore urge the Government to consider the Industry Approach an alternative exemption based on the phased restriction of trading space available to smokers, or the provision of designated smoking areas or smoking rooms.

The industry is extremely concerned about any potential adverse impact on binge drinking as highlighted in paragraph 41 of the consultation document, and believes that allowing customers to drink without being able to provide an appropriate choice of food would be quite simply irresponsible. We comment further on this point in response to Question 15 below.

We are also conscious of the need for sufficient choice on menus, in line with other Government policies on healthy eating, and would not wish to see pubs confined to serving a limited range of what is essentially “convenience food” where smoking is permitted. Ultimately, any definition of food will create arbitrary distinctions which could be confusing for the general public who will be uncertain as to whether they can smoke in a pub or not. This in turn will have implications for enforcement.

**Government Proposal**

In the event that an exemption for those licensed premises that do not prepare and serve food remains the Government’s preferred option, the list of permitted foods should include basic snack items/classic “side order” dishes with no distinction between hot and cold food, for example sandwiches, salads, soup, baked potatoes, chips, onion rings, bread/garlic bread, crisps, nuts, chocolate etc.

Premises where smoking should not be allowed could include those venues which:

- provide table service meals; and
- where three course meals are available, in the form of starters, main meals (of meat and vegetables, ranging from burgers, chips and peas to steak/fish/lamb/beef/pork, potatoes and vegetables) and puddings.

**Exemptions—Residential Premises**

**Question 6: Views are invited on the above list of exceptions, especially in respect of human rights aspects**

We accept that the list contained in the consultation document could be exempted on the basis that they are living accommodation and not commercial enterprises. Again, this list should be included on the face of the Bill, with further detail to be contained in Regulations if necessary.

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37 Sample size for this specific question on food was 20,000 pubs.
Health Committee: Evidence  Ev 65

Exemptions—Membership Clubs

Question 7: Views are invited on the proposal (ie to exempt membership clubs where the members will be free to choose whether to allow smoking or not)

One of the main purposes of Government action on smoking is surely to limit the exposure of employees in particular to ETS in the workplace. We do not see, therefore, why employees in clubs should receive a lesser level of protection. There are 20,000 membership clubs in England/Wales. This is a significant number of premises. Such clubs that employ staff should be subject to the same provisions as other licensed premises, either an exemption based on the preparation and service of food or the alternative exemptions we have proposed above.

To treat clubs differently would also create an uneven playing field with other licensed premises, as there will undoubtedly be a migration of customers from no smoking venues to those where smoking will be permitted. For marginal community or rural pub businesses, a loss in custom of this nature could result in closure. Some may become membership clubs in order to take advantage of the exemption.

The Association therefore strongly opposes the proposal that membership clubs should be exempted from the provisions on the basis of a membership ballot. Irrespective of the nature of their clientele, it is simply not appropriate for club members to vote on the health of staff.

Only in cases where staff are not employed, and clubs rely on members to volunteer to run the bar etc, is it arguable that they should be able to utilise the exemption as proposed.

Exemptions—Practical Difficulties

Question 8: Will the introduction of this legislation present any practical difficulties in your workplace?

There is no doubt that the pub sector will face a number of practical difficulties as a result of the implementation of the Government proposals. The sector is predominately made up of small, independent businesses, many of which will struggle in the face of such a huge change to their operations. As per our earlier comments:

— The Association recognises and supports the Government’s commitment to choice, and believes that achieving the appropriate balance between customer choice and employer responsibility to reduce employee exposure to Environmental Tobacco Smoke (ETS) is fundamental when considering the best approach to managing smoking issues in public places such as pubs.

— We do not believe that food is the best basis for an exemption for licensed premises because:
  — Defining “food” will create an unnecessary layer of bureaucracy.
  — It would be a backwards step to the detriment of the pub sector, making pubs less attractive to key groups such as women, families etc.
  — It does not address the need to reduce employee exposure to ETS.
  — We remain concerned about the potential adverse impact on binge drinking.

It is also very important that the timetable is sufficient to enable the pub sector to manage change effectively, and ensure the full support of licensees and customers. For this reason we believe that the timetable should be slightly longer than that proposed by the Government, and run to 2009–10, rather than 2008. Interim measures would assist businesses during the four/five year transition period. We comment further on the timing of the introduction of the new laws below in response to Question 14.

Signage

Question 9: Views are invited on the proposal (ie that smokefree areas should be designated by no-smoking signs, and the size and content of the signs be prescribed)

Since another purpose of the Government proposals is to introduce a presumption of no smoking across the vast majority of public places, we question the need for smoke free areas to be designated by no smoking signs. Office buildings which currently operate an accepted no smoking policy would have to re-sign. Rather than imposing signage on the overwhelming majority in this way, we suggest that a more sensible approach would be to require smoking areas to be clearly signed. There will obviously need to be an education and information campaign for the general public with regard to the new laws. Another alternative would be for any legal requirement to provide signage in smokefree areas to be subject to a sunset clause in the primary legislation, to the effect that signage would be no longer necessary to denote smokefree after two years for example.

38 Department for Culture Media and Sport.
We do not see the need for the size and content of signs to be prescribed by regulation. This is unnecessary, prescriptive bureaucracy which will add to the regulatory cost burden for our sector which is already high. The focus should be on those breaking the law by smoking where it is prohibited. In the event that signage was required by regulation, there would need to be more flexibility with regard to size and design. A range of signage already exists across the hospitality sector, much of which has been designed specifically to fit in with brands or particular types of premises. Companies have invested a great deal in developing signage. A recent example of a signage and information pack aimed at tenanted pubs is enclosed for information. Removing and replacing existing signage represents a significant cost to the sector, for no real gain. Based on the cost of recent work carried out in the sector to produce updated signage and supporting materials, we estimate that the cost to the industry would be in excess of £1 million. We would be pleased to participate in further discussions about signage, and provide further examples of existing practice in the industry in this area.

OFFENCES AND PENALTIES/DEFENCES

Question 10: Views are invited on the level of penalties and the general approach on the three types of offence, and whether there should be higher penalties for repeat offences

The Association is concerned that a fine of £50 may not be a sufficient deterrent to individuals risking committing an offence by smoking on a no-smoking premises. By contrast, the fines to those responsible for premises with regard to the display of warning notices or failing to prevent smoking on the premises without any defence, are much higher. While we believe that the levels of fine proposed for business are appropriate, we see no reason not to impose a similar penalty on those individuals who flout the law, and suggest that all three fines for the breaches outlined should be the same. In the interests of minimising bureaucracy, perhaps fixed penalties for all might be considered rather than discretionary fines.

Question 11: Views are invited on defences set out in the consultation document

With regard to paragraph 33 on defences, and subject to our comments in response to Question 9 above, it is our view that there should be a presumption that no smoking in public places is the norm unless otherwise stated. Therefore, the onus should be on individuals to obey the law, and on premises to provide signage where smoking is allowed. Given the emphasis on signage in the consultation document we believe that if the display of clear signage to denote smoke-free venues is required, it should be an automatic defence for those in charge of no smoking premises. Individuals should be required to demonstrate that they had acted on the basis of a visible sign clearly stating that smoking was permitted.

ENFORCEMENT

Question 12: Views are invited on the approach outlined

Enforcement officers will obviously ensure compliance with specific aspects of the Act and the Regulations, for example signage, snack menu etc. Otherwise, it is our view that the legislation should be enforced on the basis of complaint against individuals or premises. We believe that compliance on the part of business premises is unlikely to be a major issue. Given the Government’s view that this will be a popular measure, apart from the initial costs associated with the introduction of the law we think that the cost of enforcement will be negligible. Ensuring that customers comply will be the greatest challenge, and therefore enforcement of the law with respect to individuals who break it will be key to the success of the new legislation.

The actual practicalities of this aspect of enforcement need some further thought. For example, the Association would welcome further details on how fixed penalty notices will be served on individuals found to have committed an offence by smoking on a no-smoking premises:

— Would the notice have to be served immediately—in other words would the offender need to be caught in the act?
— Would licensees be expected to report the incident to enforcers if they have tried unsuccessfully to deal with a customer who insists on smoking on their premises?
— Would doing so put them at risk of prosecution because the law had been broken on their premises?
— How would sanctions be brought to bear on such customers?

The enforcement procedures are not immediately clear and need further discussion between the parties concerned, including employers across both the public and private sectors.
SMOKING AT THE BAR

Question 13: Views are invited on how best to regulate a no-smoking at the bar policy in exempted licensed premises

The Association supports no smoking at the bar and believes there is an argument for regulation in this area. However, this should be a general principle in law supported by guidance. No two pubs are the same, and so prescriptive stipulations, for example a one metre rule or similar, would be unworkable for some, and therefore difficult to police and enforce. All licensed premises with a bar, including members clubs should be covered by the final Government proposal on this issue.

TIMETABLE

Question 14: Views are invited on the best time for the law to come into effect. Does the end of December provide any particular challenges or opportunities?

The seasonal timing for the introduction of the new law is important. In our view, warmer weather does have a bearing, not least because it will allow customers a little more time to adjust to the changes, as smoking outside will not be as much of an issue as it might be in colder weather. Restrictions coming into force at Midnight on New Year’s Eve are unlikely to be popular with the general public and could also lead to adverse publicity. We believe that Spring/Summer would be the most appropriate time for the law to come into effect.

UNINTENDED CONSEQUENCES OF BINGE DRINKING

Question 15: Views are invited on the level of risk this policy may present to the drive to tackle binge-drinking and on how any such risk can be mitigated

The Association has produced a wide range of guidance and good practice for pubs, for example on point of sale promotions, security in design and noise management, and has recently been working closely with the Home Office and other alcohol industry bodies on an industry standards document. The industry takes its social responsibilities very seriously and does not wish to see this work undermined. Any potential adverse impact on binge drinking as a result of these proposals on smoking must be avoided. Clearly, the risk of exacerbating binge drinking exists where Government’s no food exemption is adopted. However, if the Government were to decide on an exemption for non-food premises, enabling “smoking pubs” to continue the provision of sufficient food (as highlighted in our response to Question 5 above) is very important to ensure that customers visiting such premises have access to appropriate snacks during the course of their evening out. To deny food to those enjoying an alcoholic drink would be a retrograde step, not least since smoking pubs and nightclubs are also likely to be concentrated in high streets and town centres.

GENERAL POINTS

Question 16: It has been suggested that the proposal in the White Paper detailed here will result in smoking pubs and clubs being concentrated in poorer communities. The consequence of this is that the health benefits, in reduced exposure to second-hand smoke and in reduced smoking prevalence, will be less in these communities than in better-off communities, thereby exacerbating health inequalities. Views and evidence on this issue are invited

It is true that “community locals”, in both rural and urban locations will face more challenges from customers if, under the current Government proposals, their food offering is such that they are required to ban smoking. Such pubs are certainly likely to be less reliant on food for their business and may decide not to serve it in favour of continuing to allow smoking and retaining their customer base. Whilst we cannot point to hard evidence, we do believe that the non-food option is likely to be taken in pubs located in poorer communities, as they are much less likely to be dependant on the food income.

We also believe that the non-food option would lead to some disparity between the North/South of England due to the variation in levels of affluence and the different nature of pubs and communities. For example, some small community or rural pubs are less likely to have a food offering as they have less space for kitchens or no room to accommodate diners. Less affluent customers are also less likely to spend money on eating out. While we are unable to say for sure if health inequalities will be exacerbated, they are unlikely to be improved or addressed by the Government proposal.

As highlighted in our response to Question 15 above, smoking pubs and nightclubs are also likely to be concentrated in high streets and town centres, hence our concerns with regard to the potential impact of the food exemption on binge drinking.
PARTIAL REGULATORY IMPACT ASSESSMENT

Our comments on the Partial Regulatory Impact Assessment are as follows.

CURRENT SITUATION/VOLUNTARY ROUTE

We acknowledge that while the Public Places Charter did not reach the agreed target with regard to formal written smoking policies, it did achieve a great deal in terms of awareness and positive action on smoking issues across the industry. It would have benefited further, in our view, from stronger support from the Department of Health and the Health and Safety Executive in terms of raising general customer awareness of the Charter. Public demand for smoking restrictions has now increased since the launch of the Charter at the end of 1999, and the BBPA welcomes the RIA recognition of the pub industry’s voluntary action plan launched in September 2004 (Paragraph 20). Our industry is now leading the way towards a presumption of smoke free areas, and the provision of customer choice.

COSTS OF ACTION ON SECOND-HAND SMOKE

Implementation costs

The RIA ignores the impact that the smoking ban has had on the licensed trade in Ireland. Retail alcohol sales have not been affected mainly because of the growth in the off-trade sales as people choose to drink and smoke at home. According to the Vintners’ Federation of Ireland (VFI), rural pubs have been worst affected by the ban. The VFI is aware of just over 200 licensed premises that have closed since the introduction of the smoking ban in March 2004. According to the CSO in Ireland, 7,600 jobs were lost in the hospitality sector in 2004. This equates to 150 jobs per week. There is no reason to believe that the impact in England and Wales would be any less.

The same impact would result in the closure of approximately 1,000 pubs. Taking into account the ban on smoking in public places in Scotland, an estimated 33,600 jobs in pubs and bars in the UK would be lost as a result of closures and decreased trade. Furthermore, 5.9% fewer jobs would be created in our sector, which has always been a major source of employment opportunities for a wide range of people of different ages and skill levels.

In Ireland, volume sales in pubs have declined between 10% and 15% and in some cases, the decline is as much as 25%. The trend is increasingly away from pubs to drinking at home. In 2004, draught sales fell by 6% and sales for packaged beer went up by 9%. For the first seven months of 2005, draught sales are down by 8% while packaged have gone up by 15%.

There is no evidence that non-smokers are visiting pubs in increasing numbers or that increasing numbers of pubs are diversifying into food or other areas, so there has been no replacement of lost trade.

Unintended consequences

The RIA suggests possible costs to business and local authorities of cleaning up/providing disposal facilities for cigarette butts outside premises. With the exception of cigarette bins which could be provided by premises, any other form of disposal facilities and street cleaning are surely a matter for local authorities.

THE OPTIONS

Option 1—The Voluntary Approach

Voluntary approaches have been successful in many areas, notably offices and cinemas. It is not surprising that the hospitality sector has taken longer to address smoking issues than other sectors, due to the social nature of our industry. However, substantial progress is now being made on a voluntary basis. With Government support, this progress could still be greatly accelerated.

Option 2—National Legislation Banning Smoking (without exemptions)

The Government recognises the difficulty that without whole-hearted support, such an approach will not be popular with a large section of the general public. The Association agrees that at this stage, the opportunity for choice in the hospitality sector is desirable and necessary.
Option 3—Local Authority Discretion

The industry remains vigorously opposed to this approach. There needs to be consistency of approach to smoking issues at a national level. Although, initially devolving powers to local level would seem a way of enabling flexibility and supporting choice, previous experience shows that this is not always the case and the resulting inconsistencies can cause more problems than solutions.

In reality, local bans would not actually provide for flexibility or customer choice in those areas where local authorities opted for a complete ban. They would also cause confusion for businesses, customers and tourists alike.

Option 4—National Legislation Banning Smoking (with exemptions)

As Option 4 is the basis of the consultation document, we have commented in detail on the approach, including the timetable, above.

The RIA states there would be an overall reduction in second-hand smoke through the creation of separate smoke free premises and smoking premises. We believe it would be better to reduce the overall risks across all pubs rather than only some of them.

The RIA highlights that some pubs may choose not to serve food in favour of allowing smoking and estimates that 10–30% of pubs might be smoking. According to the BBPA/ALMR Smoking Survey, we estimate that in the region of 34% of pubs in our sample alone may be smoking throughout under the Government proposals.

Net sum of all costs and benefits

(i) Implementation

With regard to signage, we believe that if this is to be prescribed for all premises, there is likely to be a cost to the industry of removing and replacing existing signage in excess of £1 million. Costs could be minimised if signage was only required in those premises where smoking was permitted, which should be a significantly lower number of premises.

(l) Revenue losses to Exchequer

We believe that the Exchequer may also experience losses from falling alcohol sales in no smoking pubs. Approximately £2.5 billion could be lost in duty, and a further £3.8 billion in VAT, a total of £6.3 billion in revenue.

(n) Unintended consequences

As per our previous comments above, we do not believe there should be any additional costs on our sector for cleaning costs etc.

In commenting on implementation costs above, we have outlined the impact of the smoking ban in Ireland 16 months on in terms of the job losses, volume sales lost and pub closures. We are therefore concerned that the table contains no estimate of loss of income to the hospitality industry in England, yet some losses will of course be inevitable. The effect on small businesses in the community, particularly in marginal rural pubs, will inevitably be dramatic, as small losses in income will lead to their closure and consequent loss of employment for the local community.

Competition assessment

We do not disagree with the assessment of competition issues for Options 1 to 3. However, with regard to Option 4, the impact of allowing members in membership clubs to choose whether to allow smoking or to be smoke-free is potentially very damaging to pubs, particularly in the club heartland of the north of England where pubs and membership clubs in particular are in direct competition for local custom. In the interests of a level playing field for licensed premises, it is essential that the same rules apply to clubs as to pubs. We refer you to our comments in response to Question 7 of the consultation on this issue.

Rural proofing

According to the Rating Database, 44 18,692 pubs in England and Wales have a rateable value of £10,000 or less, and would be at risk of becoming marginal businesses where any loss of income as a result of the impact of the proposals could result in their closure. There is no reference in the RIA to a “small business litmus test” being carried out. We would strongly suggest that further consideration is given to the impact of the proposals on small businesses in general, and small hospitality businesses such as rural pubs in particular.

Enforcement and sanctions

We agree that further consultation is required on the enforcement arrangements and would wish to be fully involved in this. We do not understand the reference to “licensing” in paragraph 43. Since smoking in public places will obviously be covered by specific, separate, legislation, it surely cannot be the intention to make any link with the licensing of hospitality venues for alcohol and entertainment. Any conditions relating to smoking attached to such licences would be ultra vires, since conditions should not duplicate the requirements of other legislation.

September 2005

Memorandum by The Royal Society for the Promotion of Health (SP38)

1. INTRODUCTION

1.1 The Royal Society for the Promotion of Health (RSPH) is the UK’s largest and longest-established public health body. Since our foundation, our aim has been to promote continuous improvement in human health world-wide through education, communication and the encouragement of scientific research. We do this through events and publications, as well as through our qualifications.

1.2 The Royal Society for the Promotion of Health is an independent and self-financing organisation. We receive no government money. Our charitable activities are mostly funded by the subscriptions we receive from our members.

2. SMOKING IN PUBLIC PLACES—AN OPPORTUNITY TO IMPROVE PUBLIC HEALTH

2.1 The RSPH welcomes the opportunity to contribute to this enquiry and also to the Department of Health’s consultation on the smokefree elements of the Health Improvement and Protection Bill. On this occasion, the Society is opposed to partial prohibition of smoking and is in this instance advocating for legislation that will impose a full ban on smoking in all enclosed workplaces due to the detrimental effects of environmental tobacco smoke (ETS) on human health and particularly due to its causal relationship to respiratory diseases, stroke, heart disease and cancer. Close observation of similar legislation in the Republic of Ireland leads the Society to the conclusion that if the prohibition of smoking is given a legislative basis as an aspect of public health then the necessary steps can be taken to meet objections and obstacles to the successful passage of such legislation, considering the health of people as the primary aim of any such legislation.45

2.2 It is the view of the RSPH that any government action to restrict exposure to harmful ETS should be fully inclusive of all those potentially affected. Exempting specific premises would be considered by the Society to be based not on a concern for public health but on vested economic or commercial interests. There is no evidence that there would be any health gain from exempting certain premises or properties and allowing them to permit smoking. On the contrary, there is significant evidence to indicate that those premises or properties that are exempted under the current proposals would be concentrated in areas where health inequalities are already marked and would therefore further exacerbate these inequalities given the evidence of the experience of improved health in jurisdictions where smoking is already prohibited. Therefore, allowing for such exemptions also contradicts the government’s own aims to improve the public health through Choosing Health and would potentially be detrimental to achievement of proposed targets, particularly in the most disadvantaged communities.

2.3 In this instance, the RSPH asserts the following position regarding smoking in public places and exposure to ETS. The RSPH is fully supportive of measures to reduce the incidence of smoking and the harmful effects of smoking to both smokers and non-smokers alike. Given the undeniable links between smoking and ill health, it is in the public health interest that England and Wales introduce legislation to prohibit smoking in all enclosed workplaces without exemption or delay.

2.4 All workers should have the right to work in an environment which protects their health or at worst does not detrimentally affect it. Given the dangers to health of ETS, the health of a significant number of workers, particularly in the service industry is at risk.

2.5 Exempting certain premises or industries from a prohibition would exacerbate health inequalities and provide for inequalities among the health of workers in certain employment sectors. There is a growing body of evidence which suggests that this particular proposal could exacerbate health inequalities due to the

regional disparities in the provision of food in licensed premises and the concentration of premises which do not provide food in areas with the highest levels of disadvantage. Evidence exists to suggest that rates of smoking are already higher in disadvantaged areas as are smoking related death rates. Research indicates that 44% of bars in the North-West of England do not currently serve food. This same research also shows that the proportion of premises not serving food increased with the level of deprivation, with 21% of premises and 63% of premises serving food in richer and the poorest areas in the region respectively. Arguably therefore, not only will staff in these premises be more exposed to smoke but this policy would undermine government policy which has sought to target disadvantaged areas in health promotion strategies including the new Health Trainers initiative and smoking cessation programmes.

2.6 A prohibition on smoking in all enclosed workplaces is essential to meet the government’s chosen objectives to reduce the harmful effects of smoking and to reduce the incidents of smoking and smoking-related disease and deaths. The RSPH would welcome an opportunity to provide oral evidence to this enquiry.

September 2005

Memorandum by Rethink (SP39)

We are pleased to have the opportunity of contributing to this inquiry. Rethink is the charity for people who experience severe mental illness and for those who care for them. We are both a campaigning membership charity, with a network of mutual support groups around the country, and a large voluntary sector provider in mental health, helping 7,500 people each day. Through all its work, Rethink aims to help people who experience severe mental illness to recover a meaningful and fulfilling life and to press for their families and friends to obtain the support they need.

Rethink believes, after consulting with people who experience severe mental illness and their carers, some of whom smoke tobacco, that people with a severe mental illness should be helped but not coerced into giving up smoking. We see smoking as damaging to the health of tobacco smokers and to others around them, but it needs to be accepted that giving up smoking is difficult for most people and particularly difficult for a person who experiences a severe mental illness. It’s also the case that people with a severe mental illness are more vulnerable to stress; an adverse event may cause them to resume smoking.

You may be interested in the following, which is taken from a literature search undertaken by Dr Ann McNeill for a conference in 2001 organised by “Smoke Free London”, “Mentality” and “Action on Smoking and Health” identified the following key issues:

— nicotine dependence is the most prevalent, deadly and yet most treatable of all psychiatric disorders but is often overlooked by the psychiatric profession;
— smoking prevalence is significantly higher among people with mental health problems than among the general population, highest amongst those with a diagnosis of a psychotic disorder;
— people with psychotic disorders who live in institutions are particularly vulnerable: over 70% of this group smoke including 52% who are heavy smokers; more than half wanted to give up smoking;
— daily cigarette consumption is considerably higher among smokers with mental health problems who may also inhale smoke more deeply;
— smoking related fatal diseases have been shown to be commoner among people with a diagnosis of schizophrenia than among the general population; some of the higher rate of mortality of people with mental health problems is potentially preventable if they are given support to stop smoking;
— nicotine may help alleviate some of the positive and negative symptoms associated with psychiatric illnesses and may also help to alleviate the side effects associated with their medications;
— a significant proportion of people with a diagnosis of schizophrenia recognise that smoking is a problem, want to quit and will attend smoking cessation therapy;
— effective treatments exist to help people stop smoking and are not yet being routinely offered to people with mental health problems;
— all health professionals working with smokers with mental health problems should encourage smokers to quit and refer those needing further support to specialist smoking cessation services;
— there is evidence from other countries that smokers with mental health problems feel excluded from mainstream stop smoking programmes;
— attempts to stop smoking do not appear to exacerbate psychotic symptoms;
— many mental health institutions at best condone and at worst encourage smoking; smoke-free policies encourage smokers to quit, make non-smoking the norm and reduce the harmfulness of environmental tobacco smoke; and
— in the UK, people with schizophrenia who smoke contribute an estimated £1 39m each year to the Treasury.
The Government is consulting on the Health Improvement and Protection Bill from which we note that regulations may exempt a range of premises, including those where we have a particular interest, ie

- residential and nursing care homes;
- psychiatric hospitals and units;
- prisons or other places of detention; and
- detention rooms in police premises.

Given the problems associated with mental illness and smoking cessation, we believe that regulations will be needed to exempt people with a severe mental illness living in these types of accommodation for as long as people smoke. One possible approach that may be acceptable is for people with a mental illness to smoke outside, eg in a designated area like an inner courtyard, but particular attention needs to be paid to compulsorily detained patients who may be unable to leave the ward, who should still retain the ability to smoke. We should like to take the opportunity of advocating smoking cessation programmes for people with a severe mental illness. In psychiatric hospitals, both staff and patients live in a smoking environment, which is not helped by patients being very bored during their stay in hospitals. Indeed, it’s not so long ago that cigarettes were offered to patients as an incentive to behave well.

In April 2002, the National Institute for Clinical Excellence (NICE) recommended the use of the drug, Bupropion and Nicotine Replacement Therapy for smokers who wish to quit and are motivated to do so.

Generally Rethink wishes for people with a severe mental illness to be treated in the same way as other people, free from the stigma and discrimination associated with mental illness. It follows that we believe that they should be treated in the same way as other people as regards smoking in public places. However, we seek recognition of the problem of severe mental illness and smoking that needs to be addressed by providing help to such people to enable them to quit.

*September 2005*

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**Memorandum by Ms Nicola Mills (SP40)**

I write to voice my concern over the proposed ban on smoking in pubs.

I have over 10 years of experience in the licensed trade, having managed many pubs of varying tastes and styles.

I have been the leaseholder and licensee of The Woolpack for over three years and I am very anxious of the affect the bill will have on my trade.

The Woolpack is a small traditional family run free house just outside the city centre.

We have a blossoming food trade lunch times and evenings and we would certainly be forced to close if we were to stop serving food.

We are very popular with the surrounding offices, and their staff enjoy spending their lunch hour relaxing in the bar with a coffee or glass of cola. Many meet in groups or read a newspaper or magazine over a sandwich or bowl of chips. Nearly all enjoy a cigarette away from their no smoking offices—as it is often raining they do not enjoy standing huddled on the pavement!

As a non-smoker myself I am well aware of the danger of passive smoking; but my experience is that, with adequate ventilation, the problem can be contained.

As for protecting the health of staff. All of my bar staff smoke; and most staff are fully aware that they would be working in a smoking environment.

To save a troubled section of the trade—as small independent pubs are—I believe you should be considering demanding that all pubs ban smoking in the bar area, confining smoking to a small, well ventilated, area towards the side or rear of the building (an old Smoke Room if you will).

To insist on a complete blanket ban or, worse, to split pubs with regard to size or the serving of food will not only destroy the most traditional type of English recreation. As science will tell us, the beneficial effects that eating has while drinking alcohol can be seen in bars in France, Italy and Germany amongst others. The proposals to divorce smoking from eating will undermine the creation of a European cafe culture that the new licensing reforms have tried to encourage.

*September 2005*
Memorandum by National Institute for Health and Clinical Excellence (NICE) (SP41)

1. SUMMARY

1.1 In this evidence we set out NICE’s views on the government’s proposals for legislating for smoke-free environments in enclosed public places and workplaces, which are contained in the consultation document, Consultation on the Smokefree Elements of the Health Improvement and Protection Bill. We discuss the evidence underpinning the proposals and make comments on some of the more detailed points raised in the consultation document.

2. ABOUT NICE

2.1 NICE assumed a new responsibility for developing public health guidance on 1 April 2005, when the Institute took on the functions of the Health Development Agency (HDA) to create a single, excellence-in-practice organisation, the National Institute for Health and Clinical Excellence (also to be known as NICE). The new organisation is responsible for providing national guidance on both the promotion of good health and the prevention and treatment of ill health.

2.2 NICE will produce guidance in three areas:

— Public health—the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector.
— Health technologies—the use of new and existing medicines, treatments and procedures within the NHS.
— Clinical practice—the appropriate treatment and care of people with specific diseases and conditions within the NHS.

2.3 NICE’s public health guidance will be produced by its new Centre for Public Health Excellence and will cover both public health interventions and public health programmes.

3. THE EVIDENCE UNDERPINNING THE PROPOSALS

3.1 NICE strongly supports the proposed legislation’s objective of “protecting persons from the health risks attributable to the exposure to second-hand tobacco smoke”. As noted in the consultation document, the Scientific Committee on Tobacco and Health’s (SCOTH) update on evidence about the impact of second-hand smoke concludes that it is evident that “no infant, child or adult” should be exposed to second-hand smoke, and confirms that second-hand smoke “represents a substantial public health hazard”.

3.2 The unequivocal nature of these conclusions raises questions about whether there may now be a case for shifting the balance further in favour of smoke-free environments than proposed in the consultation, and adopting the approach to achieving smoke-free environments that produces the maximum health benefits. According to the analysis in the partial regulatory impact assessment in Annex B of the consultation document, the most effective of the four options considered in terms of public health impact is option 2—ie national legislation to make all indoor public places and workplaces completely smoke-free, without exemptions. The Chief Medical Officer has recently stated that he would like the government to introduce completely smoke-free enclosed public places and workplaces, as several other countries have done.47

3.3 Adopting this option would also avoid potential problems of equity and fairness. For example, it would offer complete protection from second-hand smoke to people who work in pubs and bars, compared to the more limited protection offered by the other options. Under any of the latter, protection would inevitably be patchy, raising questions about the fairness to workers in pubs and bars of arrangements under which the level of their exposure to second-hand smoke would depend on either their employers’ interpretation of health and safety responsibilities or whether the local authority in which their workplace was situated had used powers to control second-hand smoke.

3.4 Furthermore, it would eliminate the risk that the government’s favoured option might aggravate health inequalities. The consultation document acknowledged potential problems of equity by asking for evidence that the health benefits of the legislation may be less in poorer communities than in better-off communities. Recent evidence indicates that there may be such a risk. The findings of a recent BMA survey of a “snapshot” of local authorities suggest that many more pubs in the north, particularly in deprived areas, do not serve food and so would be exempt from the smoking ban.48 Another study concluded that more pubs in the deprived areas of an English borough than in affluent areas would be exempt.49 As tackling health

inequalities is at the heart of the government’s public health policy, it is essential that comprehensive data on the distribution of food- and non-food-serving pubs be gathered so that the potential impact on health inequalities can be assessed.

3.5 There are other advantages to option 2. In particular, it makes enforcement simpler and creates a level playing field for the hospitality industry. The British Beer and Pub Association (BBPA) has called for legislation to be applied equally across all sectors of the industry, if legislation is to be the government’s preferred route.\(^\text{50}\)

3.6 On the question of the extent to which public opinion should inform the proposals, the 2004 ONS survey of attitudes to smoking found that the largest increase in support for smoking restrictions was in relation to smoking in pubs, a rising trend from 48% in 1996 to 56% in 2003 and 65% in 2004.\(^\text{51}\) There is also encouraging evidence from Ireland where support for smoking restrictions has grown since implementation of legislation there in 2004. Ireland’s Office of Tobacco Control reports that 93% of the public, including 80% of smokers, now think that the law was a “good idea”, and 96%, including 89% of smokers, think that the law is successful. Before introduction, 67% of the public supported the law.\(^\text{52}\)

4. **More Detailed Consultation Points**

4.1 NICE agrees with the proposal to create regulation-making powers to allow the legislation to apply in places which may not fall strictly within the definition of “enclosed” in the legislation but where there is risk of harm from second-hand smoke due to the inevitable close grouping of people. However, there may be difficulties in defining “close grouping” and “places” for the purpose of these powers, given that bus shelters, stadiums and entrances to workplaces are very different kinds of public place. We suggest that one defining factor might be whether there are people working in such places who might be exposed to second-hand smoke, as would be the case in sports stadiums.

4.2 NICE agrees that regulations should exempt individuals’ private space in premises that act as an individual’s dwelling. However,

— This should not be seen as discouraging commercial providers of accommodation, such as hoteliers, from reflecting population smoking trends in the proportion of rooms they designate as non-smoking.

— Public sector institutions which provide longer-term accommodation, should enable access to smoking cessation services and encourage residents to use them, as should private providers of services that include accommodation commissioned by public bodies.

4.3 We strongly support the objective of extending the concept of the smoke-free NHS to all aspects of NHS provision, including psychiatric hospitals and units. The HDA guidance mentioned in the consultation document points out that there should be no blanket exceptions for particular categories of patient and no exceptions for staff or visitors, although exceptions can be made for individual patients on a case-by-case basis. Case studies have demonstrated that mental health care trusts can go smoke-free.\(^\text{53}\)

4.4 Employees in membership clubs should be entitled to the same protection from second-hand smoke as employees in other enclosed public places and workplaces.

4.5 As with the geographical distribution of pubs that serve food, there may be implications for the government’s priority of tackling health inequalities in the distribution of membership clubs. This requires further investigation.

4.6 As noted above, the hospitality industry has argued against preferential treatment for any sector.\(^\text{54}\)

4.7 Fines for proprietors of public spaces and workplaces who allow someone to smoke on the premises are 3,000 euros (around £2,000) in Ireland. Ireland’s Office of Tobacco Control reports consistently high levels of compliance with the smoke-free legislation.\(^\text{55}\) It does not comment on the role of fines in supporting the enforcement effort, but it is reasonable to infer that the level of the fine may have had an influence on proprietors’ behaviour, alongside perceptions of the likelihood of inspection by enforcement officers. The Irish experience may be useful in determining what level of fine for failing to prevent smoking is likely to be most effective in the context of the expected enforcement effort.

14 September 2005

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\(^{50}\) Health Select Committee (2005). Memorandum by the British Beer and Pub Association (WP68). Smoking in Public Places. www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/358/358we76.htm


\(^{54}\) See 39 above.

\(^{55}\) See 41 above.
Memorandum by Birmingham Smoke Free Coalition (SP42)

The Birmingham Smoke Free Coalition, that includes members from the Birmingham Strategic Health Partnership, advocates the need for comprehensive national legislation to protect the health of the public and all workers from the dangers of secondhand tobacco smoke.

The city of Birmingham is proud of its record of introducing tobacco control policies in its schools and council buildings, smoke free shopping malls, schools, colleges and workplaces over the past three decades, and of actively campaigning to encourage and help smokers to quit.

Despite these efforts, there are still many indoor areas such as the National Indoor Arena, the National Convention Centre and other places of mass entertainment where smoking is allowed. These venues regularly expose thousands of children, pregnant women and other vulnerable adults to the hazards of second hand smoke.

We need national legislation to protect and promote the health of our citizens and to enable us to make more rapid progress at a local level. Without comprehensive legislation, progress will continue to be slow and depend largely on market forces, the media and local leadership.

We therefore urge you to give serious consideration to our attached evidence that supports the need for new legislation in England to be drafted in such a way that it protects—not harms—the health of our most disadvantaged communities, those staff who work in the hospitality industry, and which enables core cities in England to remain attractive to visitors from abroad.

INTRODUCTION

Birmingham’s Smoke Free Coalition includes members of the Birmingham Strategic Health Partnership, and welcomes the opportunity to respond to the Health Select Committee’s investigation into Smoking in Public Places. We are pleased to provide further written evidence on the issue that may be used at the Committee’s discretion and can confirm that we would also be willing to provide oral evidence if required.

We are aware that smoking and exposure to tobacco smoke kills or shortens the lives of many citizens. Smoking is the single most important preventable cause of ill health in this city and partly explains the health gap in both life expectancy and infant health that exists between Birmingham and elsewhere.

For that reason, the city of Birmingham is proud of its record of introducing tobacco control policies in its schools and council buildings, smoke free shopping malls, schools, colleges and workplaces over the past three decades, and of actively campaigning to encourage and help smokers to quit.

However, we need national legislation to protect and promote the health of all our citizens to enable us to make more rapid progress at a local level. Without legislation progress will continue to be slow and depend largely on market forces, the media and local leadership.

CURRENT GOVERNMENT PROPOSALS

The public health White Paper, Choosing Healthy, Making Healthier choices Easier, published in November 2004 stated that:

“We therefore intend to shift the balance significantly in favour of smoke free environments. Subject to parliamentary timetables, the Government propose to regulate, with legislation where necessary, to ensure:

— All enclosed public places and workplaces are smoke-free (other than licensed premises which are dealt with below).

Licensed premises will be treated as follows:

— All restaurants will be smoke-free.
— All pubs and bars preparing food will be smoke-free.
— Other pubs and bars preparing food will be smoke-free.
— Other pubs are free to choose.
— Membership clubs with members shall be free to choose.
— Smoking in the bar area is prohibited everywhere.”

On the proposed timetable, the White Paper stated that:

“We intend to introduce smoke free places through a staged approach:

— By the end of 2006, all central government and NHS departments will be smoke-free.
— By the end of 2007, all enclosed public places and workplaces, other than licensed premises (and those specifically exempted) will be smoke free.
— By the end of 2008, arrangements for licensed premises will be in place to be smoke free.”
PUBLIC OPINION

The Big Smoke Debate in the West Midlands asked to what extent are you the public bothered by tobacco smoke inside enclosed public places. Over 13,500 people responded; 89% said they were bothered, with a majority (58%) saying they were bothered a great deal. Also 84% of the people who took part in the survey said they would prefer public places to be smoke free.

A recent survey conducted (August 2005) in Birmingham Stop Smoking services shows that smokers who are trying to quit smoking said they would prefer: smoke free restaurants, bars and workplaces and that going smoke free would help them in their attempts to quit.

146 Respondents 46% Male—48% Female
— 96% thought that breathing in other people’s tobacco smoke harms your health and that of others.
— 92% thought that a complete smoking ban in their place of work would help them to quit.
— 85% thought that if places where they usually socialise (drink & eat) were completely smoke free this would help them in their attempt to quit.
— 64% thought that a ban on smoking in bus shelters, sports stadia and exits to public buildings would make it easier for them to quit.
— 79% would support a complete smoking ban in cafes.
— 80% would support a complete smoking ban in restaurants with 50% stating they would support a complete ban in pubs and clubs.
— 92% would support a complete smoking ban in offices.
— 78% would support a complete smoking ban in railway stations.
— 78% would support a complete smoking ban in shopping centres.
— 85% was aware of the government proposing to introduce a new law.
— 53% thought the most important message for the public when it comes to introducing the new law should be “Breathing in Smoke harms your health”. With 26% thinking that the most important message is “smoke makes your hair and clothes smell” with a further 21% opting for “smoke free places will help people to quit smoking”.

It is clear that public opinion has shifted more and more in favour of smoke free workplaces and public places. The latest ONS survey (Smoking Related Behaviour and Attitudes 2004) shows that public opinion is getting stronger in this respect:
— 65% support smoking restrictions in pubs—up 9% from 2003.
— 31% say pubs should be completely smoke free—up 20% from 2003.
— Support for smoking restrictions in other locations shows is greater than 80%–87% for indoor shopping centres, 93% for indoor sports and leisure centres and 82% for indoor areas at railway and bus stations.

A crucial point about smoke free legislation is that it becomes more popular after its successful introduction. In Ireland, the most recent survey, conducted by TNS mrbi for the Office of Tobacco Control in March 2005 shows extremely high levels of public support:
— 96% of people feel that the law is successful, including 89% of smokers.
— 98% believe that workplaces are now healthier because of the smoke-free law, including 94% of smokers.
— 93% think the law was a good idea, including 80% of smokers.

Support has grown steadily during this first year and compares to only 67% of the public supporting the law before its introduction.

We are impressed with the evidence from Ireland, which suggests that smoke free legislation has been popular and easy to enforce. However, we are concerned that by contrast, in England, market forces—not health and safety considerations—could determine how many pubs, bars and clubs stay or become “wet” under the proposed legislation and this may well also aggravate the pattern of binge drinking in certain areas.

ECONOMIC IMPACT

Birmingham is a large, diverse, international city. It has a thriving city centre which attracts many thousands of visitors each year. We believe there are good economic as well as health reasons for having comprehensive smoke free legislation.
We want our city centre, high streets, shopping malls and places of entertainment in Birmingham to have the reputation of being clean, pleasant and attractive places to visit and to compare favourably with those of other cities.

Over the past two years Birmingham’s Strategic Health Partnership has consulted with the business sector, including members of the Broad Street Partnership, and the City Centre partnership, about the introduction of smoke free measures in licensed and other premises.

One key message is that businesses want a “level playing field” and would overwhelmingly prefer national legislation to an incremental piecemeal approach in which they have to worry about which market—smokers or non-smokers—to serve.

Allowing clubs to be exempt potentially gives them unfair advantages over pubs and bars for certain types of trade. Also its implementation would be unwieldy and unlikely to provide a fair route for businesses and staff requiring protection, as they may not have a vote through the ballot process.

Birmingham has approximately 1,093 licensed premises, which potentially could apply to become private members premises, thereby making them exempt under this Bill.

Similar to Ireland, overseas experience of comprehensive tobacco bans become ever more popular following implementation, once the normality of smoke-free workplaces and public places has become established. A review by Luk Joossens et al for the Smoke Free Europe partnership56 looked at approximately 100 studies from Canada, UK, USA, Australia, New Zealand, South Africa, Spain and Hong Kong. It failed to find a negative impact or a positive effect in studies based on objective and reliable measures, such as taxable sales receipts, data several years before and after the introduction of smoke free policies, where controls for changes in economic conditions were employed, and where statistical tests were used to control for underlying trends and data fluctuations.

Businesses in Birmingham, which have gone smoke free, such as the Bull Ring and the Pavilions shopping centres, also indicate that once non-smoking is established as the norm, they experience very few problems with compliance.

Figures released in February 2005 by the Central Statistics Office of Ireland show that the value of bar sales in Ireland fell by 3.5% between April and December 2004 compared to the same period in 2003. The decrease of the value of sales is in line with the decrease of the volume of sales in the bars in Ireland, which began in 2001 well before the smoke-free law was introduced.

**Exceptions for Licensed Premises that Do Not Prepare and Serve Food**

In Birmingham, a survey (August 2005) in which a sample of 238 pubs, which were visited or telephoned by Environmental Health Officers, suggests that around 30% of the pubs in the city would be exempt under the current proposals. The final survey analysis (of c. 1,000 pubs) by Environmental Health Officers will enable us to map in more detail the distribution of pubs and clubs serving foods by smoking rates and social deprivation.

Those staff working in exempt establishments would be continually exposed to second hand smoke. We feel that it is unfair and unacceptable to compromise the health and safety of these men and women, particularly when other employees will be entitled to work in smoke free workplaces.

Evidence from our survey also indicates that there could be a shift to create more “wet pubs” in certain areas within the city, where the main source of income comes from regular drinkers rather than food sales. In our survey 50 of the pubs currently serving food said they would stop serving food in order to allow smoking to continue.

Consequently, we are concerned that certain premises will continue to be exempt from smoking restrictions under the proposed legislation. This will lead to many staff, especially those who work in the hospitality sector, including young women of childbearing age, continuing to be exposed to the harm caused by second hand smoke.

We would prefer to have comprehensive smoke free legislation which:

- requires all indoor public premises to be completely smoke free, including pubs and clubs,
- provides a “level playing field” for the business and hospitality sector.

56 “Smoke Free Europe Makes Economic Sense” [http://www.smokefreeeurope.com/assets/downloads/smoke%e2%80%93free%e2%80%93europe%e2%80%93economic%e2%80%93report.pdf](http://www.smokefreeeurope.com/assets/downloads/smoke%e2%80%93free%e2%80%93europe%e2%80%93economic%e2%80%93report.pdf)
Enables all non-smokers and smokers (including those who wish to give up) to drink in smoke free pubs and bars whatever neighbourhood they live in,

is simple and straightforward to enforce with little scope for doubt or confusion amongst the public, the trade and local authority enforcement staff.

Health and Safety

Evidence from the Department of Health’s Scientific Committee on Tobacco and Health (SCOTH) report has made a strong case for second-hand smoke being a significant health hazard, concluding that “it is evident that no infant, child or adult should be exposed to second-hand smoke... Second-hand smoke represents a substantial public health hazard”. This substantial public health hazard applies to all populations; second-hand smoke does not discriminate between people and is a hazard to everyone of all ages, sexes, ethnicities, socio-economic or employment status—and all places of work.

Exposure to second-hand smoke can cause many of the same illnesses associated with active smoking. The IARC reviewed all available evidence on second-hand smoke and concluded that second-hand smoke increases the risk of lung cancer by 20–30% and CHD by 25–35%.57

As a result of exposure to other people’s tobacco smoke 600 people die each year in the UK and bar workers are particularly vulnerable. The Scientific Committee on Tobacco and Health (SCOTH), reported in November 2004 that “some groups, for example bar staff are heavily exposed [to second-hand smoke] at their place of work”58, this results in one death each week among employees of the hospitality trade59.

We estimate in Birmingham each year, smoking tobacco and breathing in other peoples smoke, leads to around:

— 2,000 premature deaths from smoking related illnesses such as heart disease, cancers and respiratory conditions;
— 400 hospital admissions for respiratory illness in children under the age of five;
— 6,500 middle ear infections in children;
— 62 infants being admitted to hospital with bronchitis or pneumonia;
— over 100 new cases of asthma in children;
— 54 deaths from occupational exposure to second hand smoke.

Public Health Implications

Rates of smoking are much higher in Birmingham wards, which are socially and economically disadvantaged.

In certain ethnic groups eg Bangladeshis and amongst single parents, rates of smoking may be as high as 40%. (See Annex 1.)

Estimates prepared by the West Midlands Public Health Observatory, using a commercial database of licensed premises suggest that Birmingham wards with smoking rates above 30% are most likely to have pubs and clubs, which would be exempt under the current proposals. In contrast wards where smoking rates are below 25% have a greater proportion of pubs, which serve food. (See Annex 2.)

The Regulatory Impact Assessment (RIA) commissioned by Government estimated that ending smoking in workplaces and enclosed public places would reduce smoking rates by 1.7%.

It gave no estimate of the decline in smoking prevalence, which would be achieved if the exemption option were adopted.

We are concerned that smoking rates will remain persistently high in the lowest income groups (bottom income decile) and that these social groups will be much less likely to experience the health benefits of smoke free legislation where they live.

We believe that in certain deprived neighbourhoods where smoking rates are high, most if not all pubs will be “wet” and therefore be exempt from the smoke free legislation. The health benefits which result from ending smoking in all enclosed public places, both in terms of reducing smoking prevalence and harm caused by second hand smoke, would not apply to these areas.

This legislation is therefore likely to widen health inequalities which are smoking related.

REGULATORY IMPACT AND PERVERSE INCENTIVES

The current proposal to exempt membership clubs and pubs that prepare and serve food would be detrimental to efforts to reduce inequalities in health. The proposed exemptions for some pubs and clubs would also increase the regulatory burden on business, and create perverse incentives and unfair competition.

The Regulatory Impact Assessment recognises several points:

- Exposure to second-hand smoke is a significant risk to health.
- National legislation to make all indoor public places and workplaces completely smoke-free would provide protection from the health risks of second-hand smoke.
- Completely smoke-free policies in indoor workplaces will also have a major effect on reducing smoking prevalence.
- The voluntary approach is ineffective.
- Evidence shows the pub sector would not suffer from reduced profits.
- Option 2 offers the highest levels of benefits.

Second-hand smoke is a serious health and safety issue; a comprehensive ban is therefore the only way forward.

The fact the majority of the public also support action, and the popularity of such bans grows with time should encourage the Government to introduce this measure at the earliest opportunity and be responsible for one of the most important pieces of public health action in our time.

UNINTENDED CONSEQUENCES FOR BINGE DRINKING

Birmingham City Council has supported, as part of its community safety strategy, the creation of a Broad Street Partnership to tackle and control binge drinking in the city centre. We are aware, as a result of talking to young people, that “binge or stand up drinking—and not eating” are part of the drinking culture.

Young women in particular will say for example that “eating is cheating” or “moment on the lips, lifetime on the hips”. They deliberately avoid eating before or while they are out in order to get drunk more quickly and “have a good time”. In their desire to stay slim, young women also consciously manage their calorie intake by substituting alcohol for food during a binge drinking session.

The exemption of pubs and clubs which do not serve prepared foods will in our view further reinforce and encourage binge drinking amongst the young and work against any attempts to change the culture and social patterns of drinking in this country.

HUMAN RIGHTS AND OTHER LEGAL IMPLICATIONS

We consider the proposals to exclude certain staff from legislation which protects their health is discriminatory and may be unlawful under the Human Rights Act.

In the light of the proven adverse effects of second hand smoke, we believe that continuing to allow smoking in any place of work discriminates against workers. Second hand smoke is a workplace health and safety issue and workers often do not always have a choice about the environment where they work. The proposed exemptions will leave the most exposed workers the least protected.

We therefore feel the Government should seek legal advice on what claims might be made by individuals if they are obliged to work in areas polluted by tobacco smoke, a known carcinogen.

EXEMPTIONS FOR MEMBERSHIP CLUBS

Staff working in private members clubs would continue to have their health unnecessarily put at risk from exposure to second hand smoke whilst those working in offices and licensed premises serving food would be protected.

Exempted pubs, clubs and private members clubs would contribute to the normalisation of smoking among disadvantaged groups and the two out of three smokers who want to quit would be hindered by the environment in which they socialise.
Many private members clubs admit children who are particularly at risk from second-hand smoke. An annual ballot may not always truly reflect member opinions. Members may feel intimidated into voting in a particular direction.

There is a risk of damage to the customer base of other licensed premises and the need for a level-trading environment has been clearly expressed by trade representatives.

PROPOSED DEFINITION OF SMOKE AND SMOKING

We believe that smoking of all forms should be included in the proposed legislation and that it should be an offence to smoke or permit smoking in enclosed workplaces and public places regardless of what is smoked.

We recommend a broader definition to end all smoking in workplaces and enclosed public places in order to ensure a consistent health and safety approach and to make the legislation easier to understand and enforce.

CONCLUSION

We are concerned that, in England, market forces—not health and safety considerations—could determine how many pubs, bars and clubs stay or become “wet” under the Government’s proposed legislation and that this may well aggravate the problem of binge drinking in certain areas.

The introduction of comprehensive smoke free legislation would demonstrate that the Government is serious about public health, talking inequalities and providing a regulatory environment in which Spearhead Authorities and PCTs can act effectively to reduce the great harm to their populations caused by tobacco.

We believe that if exemptions are permitted under the new law for England, progress in creating smoke free public places in this country will be slower than elsewhere.

September 2005

Annex 1

Cigarette Smoking by Ethnic Group

Source: Current cigarette smoking: by ethnic group and sex, 1999, England, Percentages ONS 2005
**Annex 2**

### Joint memorandum by the Local Government Association (LGA) and Local Authorities Co-ordinators of Regulatory Services (LACORS) (SP43)

**Introduction**

1. The Local Authorities Coordinators of Regulatory Services (LACORS) is a local government central body with the aim of making a major contribution to the development of high quality, consistent and coordinated local authority regulatory and related services across the UK. Our remit is to support, coordinate and promote local authority regulatory services.

2. The Local Government Association (LGA) represents authorities across England and Wales and exists to promote better local government. We work with and for our member authorities to realise a shared vision of local government that enables local people to shape a distinctive and better future for their locality and its communities.

3. This document is a coordinated submission from LACORS and the LGA. The evidence is drawn from the LGA/LACORS joint response to the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill (a full copy of which we are happy to provide on request). In compiling the response, the LGA and LACORS consulted member authorities, receiving written responses endorsed by local councils and detailed information from environmental health and trading standards services. A focus-group debate involving a range of senior local authority officers was also held.

**Evidence**

4. Summary: A key priority for the LGA and LACORS in examining the proposals has been an enforceable regime that does not place unnecessary additional burdens on local authorities. The evidence from member authorities is that the government’s preferred option (Option 4 in the consultation), which proposes smokefree enclosed public places and workplaces with exemptions for licensed premises not serving food, would be unenforceable. Local authorities have also argued, using local evidence, that the proposal would be likely to increase health inequalities by leading to the concentration of smoking pubs in poorer areas. This leads us to support smokefree enclosed public places and workplaces (Option 2), without exemptions for licensed premises not serving food, but with exemptions for certain residential premises such as prisons and residential care units. This option is the most straightforward and cost effective to enforce, and would enable the highest level of compliance as it is the most comprehensive and most easily understood. It also affords the greatest protection to employees.
5. Definitions: The definition of “smoking” and of “enclosed” need to be simplified in order to aid enforcement.

5.1 Using the definition of “smoking” in the consultation, enforcement officers would only be able to establish whether a product contained tobacco through testing the product being smoked. The officer may be faced with a hostile environment in which they must obtain a representative portion of a smoked product for analysis. We estimate the cost to the local authority would be around £120 per item tested. We therefore suggest an extended definition of smoking to include “any smoked lit product” or “smoking of any product”, in order to provide clarity for local authority enforcement staff and for businesses aiming to ensure compliance.

5.2 The definition of “enclosed” should be clear, precise and easily understood by enforcers, businesses and the public. Ideally it should not require the use of a measuring instrument and complicated calculations to decide if a structure or premise is covered by the legislation. We therefore support a simplified definition, for example, “any structure with a roof and at least a single wall shall be defined as being enclosed”. This would then include sports stadiums and entrances to public buildings and thus avoid the need for additional regulations to deal with such premises in the future.

6. Timetable: For enforcement purposes, a sufficiently long lead-in period is required to allow for advice and information to be circulated to all those businesses likely to be affected by the change in legislation, but we cannot see a justification for licensed premises needing a longer lead-in period, as proposed in the consultation. A lead-in period of a minimum of 12 months would be required to run a national, regional and locally coordinated publicity and education campaign to ensure that businesses and the public, as well as enforcers, are well prepared. This would assist in creating a clear national message, which would help to make enforcement consistent and simple from the outset. We therefore recommend that the timescale for implementation of the legislation be brought forward to spring/summer 2007—provided there is at least a year lead-in time for local authority services.

7. Exceptions: Given the clear direction given to us by local authorities in preparing the LGA/LACORS response to the DH consultation, we cannot support the proposal that licensed premises that do not prepare and serve food should be exempt from the legislation.

7.1 An exemption for licensed premises that do not serve food would present potential difficulties for enforcing authorities. The proposed definition of food given in the consultation as “pre-packaged ambient shelf-stable snacks” is unclear and lends itself to different interpretations. It presents an alternative definition of food where a reasonable one already exists within food safety legislation. The underlying principle for any definitions in the legislation is that they should enable businesses to comply easily and self-regulate, with enforcement by local authorities as a secondary means of ensuring compliance. The approach suggested in the consultation document would not lend itself to this approach.

7.2 Data from a number of local authority surveys suggests that the estimate of 10–30% of pubs choosing to allow smoking rather than serve food disguises wide variations in different parts of the country and may be an underestimate. In addition, we note the concern expressed by colleagues in local authorities around the potential increase in number of “wet” pubs as businesses seek to avoid any smoking restriction.

7.3 We acknowledge that there is a need for some exceptions to restrictions on smoking in enclosed premises, notably in residential care, mental health care, accommodation (halls of residence) and prisons, but with clear guidelines restricting smoking to the room of the individual (where it is not shared) or a designated smoking room. Government will, however, need to carefully consider the position of staff working in such environments, for example, prison officers and care workers.

8. Offences, penalties and defences: We recommend that penalties for non-compliance, and defences to charges, reflect the hazard to health that second-hand smoke poses and that these are brought into line with other similar offences. Drawing on responses from local authorities, we consider that the level of fines proposed is too low and unlikely to act as a deterrent. A more serious and effective deterrent would be afforded if these fines were higher in the first instance and set on an increasing scale for repeat offences up to Level 5 (£5,000). By way of comparison:

- Sale of tobacco to underage person: Level 4; £2,500.
- Failure to display statutory (tobacco) notice in retail outlet: Level 3; £1,000.
- Sale of alcohol to underage person: Level 3; £1,000.

8.1 In addition, the use of fixed penalty notices is not a matter that, typically, local authority enforcement staff are familiar with. This presents a training need that, in turn, presents an additional cost to the authority. The practicalities of issuing a fixed penalty notice need to be considered—particularly if the proposed definition of smoke/smoking is allowed to stand. Issuing fixed penalty notices to people under the influence of alcohol will increase risks to enforcement officers, which should also be taken into consideration.
8.2 Local authorities have indicated that the defences could be improved upon. Based upon the comments received, we advocate the inclusion of what is a standard defence in consumer protection legislation—that of “taking all reasonable precautions and exercising all “due diligence” to avoid committing an offence. This defence is well understood by local authority enforcement staff.

9. Enforcement: We support the proposal that this new legislation should be a matter for local authorities to enforce. Each authority should be able to determine who, within their authority, enforces the legislation.

9.1 We would, however, seek further clarification of whether this legislation will become a duty for local authorities to enforce or alternatively a power to act. Similarly, further explanation is sought in respect of premises where currently health and safety enforcement activity is undertaken by Health and Safety Executive (HSE) inspectors and not local authority staff. With Hampton and Better Regulation in mind, this could result in such premises being subject to a greater number of inspections, from more sources.

9.2 Enforcement of the new legislation will undoubtedly give rise to cost implications for each local authority. Every authority who responded to the LGA/LACORS on this issue supports the implementation of Option 2 (completely smokefree enclosed places) as the costs associated with the enforcement of Option 4 (with exceptions) will be significantly greater for each authority. Respondents also indicated that Option 2 was likely to become self-regulating, whereas Option 4 would require more proactive enforcement.

9.3 Whichever option is finally selected, prior to the commencement of the new legislation, local authorities will require adequate funding to allow for the effective training of existing officers and/or for the recruitment of additional enforcement staff. We welcome the commitment to applying the New Burdens Doctrine to cover such costs and would be happy to work with the government in identifying costs.

10. Health inequalities: We believe that the proposal for smokefree enclosed public places and workplaces, with exceptions for pubs serving food, is likely to exacerbate health inequalities linked to smoking and exposure to second-hand smoke. Evidence from local authority surveys suggests that the government’s estimate of 10-30% of pubs choosing to allow smoking rather than serve food certainly disguises wide variations across England and may be an underestimate. Newcastle City Council’s research shows that currently 47% of pubs and clubs in the city would be exempted from the legislation. In Northamptonshire, 54% of pubs would be exempt, with the figure as high as 85% in Corby Borough Council (from research by a partnership between the eight local authorities and three Primary Care Trusts in the county). The Association of North East Councils puts the figure of exempted pubs at 52% for the whole region, with Easington having the highest proportion of pubs that would be exempt (81%), and South Tyneside the lowest (20%). Moreover, the local surveys tend to show that the pubs that do not serve food or would stop serving food in order to continue smoking are concentrated in deprived areas. For example, according to research conducted by Manchester’s Health Inequalities Partnership (part of Manchester City Council’s Local Strategic Partnership), the proportion of premises currently not serving food or intending to stop serving food, if Option 4 in the consultation is pursued, is twice as high in the relatively more deprived North Manchester Primary Care Trust area than in South Manchester Primary Care Trust.

September 2005

Memorandum by Chartered Institute of Environmental Health (CIEH) (SP44)

Founded in 1883, the Chartered Institute of Environmental Health (CIEH) is a professional and educational body, dedicated to the promotion of environmental health and to encouraging the highest possible standards in the training and the work of environmental health professionals.

CIEH has over 10,500 members working in government, non-governmental agencies, companies and the armed forces. As well as providing services and information to its members, CIEH provides information to government departments and evidence to them on proposed legislation relevant to environmental health.

In 1993 the Chartered Institute became the World Health Organisation Collaborating Centre for Environmental Health Management in Europe.

The Chartered Institute of Environmental Health (CIEH) welcomes this opportunity to provide evidence, for consideration and publication by the Health Committee, on the Government’s proposals to restrict smoking in public places as detailed in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill.
1. **OUR POLICY ON SMOKING IN PUBLIC PLACES**

1.1 We observe that the scientific evidence that environmental tobacco smoke damages the health of third parties is incontrovertible. In recent years this has been confirmed by the Government’s Chief Medical Officer for England, Sir Liam Donaldson, (July 2003) as well as by the heads of all Britain’s 13 Royal Colleges of Medicine (November 2003).

1.2 For more than 20 years we have been reflecting our members’ concerns about the issue of “passive smoking”. We acknowledge the rights of employees not to have to work in smokey environments and we support the adoption of smokefree workplaces and public places.

1.3 To that end the General Council of CIEH adopted the following policy in 1999:

The Chartered Institute of Environmental Health believes that:
- there is a significant risk to health from exposure to secondhand tobacco pollution;
- unless by their own choice, no-one should be exposed to secondhand tobacco pollution;
- all places where people work should be free from secondhand tobacco pollution; and
- ventilation is not a suitable alternative to a no-smoking policy.

1.4 Whist recognising that action based on co-operation and consensus is always preferable, on the issue of smoking in enclosed public places and workplaces CIEH believes that only a complete prohibition will result in the level of health protection required. CIEH is therefore supporting its members working to ensure high levels of workplace health and safety using existing risk reduction strategies, but we are also pressing for a national ban on smoking in enclosed public places and workplaces.

1.5 CIEH has therefore agreed the following joint statement with Action on Smoking and Health (ASH):

CIEH and ASH believe that the current “voluntary approach” to smoking restrictions in workplaces and enclosed public spaces is wholly ineffective in tackling the significant public health impacts of involuntary exposure of employees and members of the public to secondhand tobacco pollution. We want to see government leadership in the form of national legislation to end smoking in workplaces and enclosed public places. CIEH and ASH call for the introduction of simple, enforceable legal requirements nationally, as now exist in the Republic of Ireland, operated and enforced at a local level by Councils and their partners.

2. **OUR EVIDENCE TO THE HEALTH COMMITTEE**

2.1 This consultation response will begin by making some introductory comments on our understanding of the intentions of the Government on the issue of prohibiting smoking in workplaces and public places as stated in both *Choosing Health* and the Department of Health consultation on the smokefree elements of the proposed Health Improvement and Protection Bill. We will also state our overall position. Whilst supporting the broad legislative proposals for prohibiting smoking in workplaces and public places (as set out in Option 2 of the Regulatory Impact Assessment), we wish to offer our recommended approach to the proposals for exemptions and relaxations to ensure that the protection of the worker is placed foremost in such considerations. Finally we provide our responses to the specific questions raised in the consultation Department of Health consultation on the smokefree elements of the proposed Health Improvement and Protection Bill.

3. **INTRODUCTORY COMMENTS**

3.1 The Government’s stated objective in proposing this legislation is to:
- reduce the risk to health from exposure to secondhand smoke;
- recognise a person’s right to be protected from harm and to enjoy smokefree air;
- increase the benefits of smokefree enclosed public places and workplaces for people trying to give up smoking, so that they can succeed in an environment where social pressures to smoke are reduced;
- save thousands of lives over the next decade by reducing overall smoking rates.

3.2 One of the specific areas of questioning in the original government consultation *Choosing Health? A consultation on action to improve people’s health* was the issue that: “One person’s choice may spoil the chances of good health for others.” This is a basic principle of the public health legislation that environment health practitioners address. The Government has accepted that the case has been made that secondhand tobacco smoke damages the health of workers. It therefore follows that the proposed protective measures should be extended to all workers. To expect environmental health practitioners to do anything less would be against the principles of environmental health professional practice and could be said to be unethical.

3.3 The need to address inequalities in health has been a prominent feature of many of the important government measures to improve public health. To that end, health improvement initiatives usually include the need to identify vulnerable groups and those who are in the greatest need and, if necessary, to implement special measures in order to meet those needs. In relation to these proposals, we are concerned that the needs
of vulnerable groups and individuals are not being properly addressed. The proposed exemptions for pubs and clubs will leave whole categories of workers at risk, many of whom will be in employment situations where their ability to take steps to safeguard their own health will be severely limited. Bar workers who have asthma and respiratory illness and women workers who are pregnant, or are planning pregnancy, will rightly expect protection under the law equal to that of the office and factory worker.

3.4 “Amicus humani generis” is the motto of CIEH which translates as “Friend of the Human Race” and our members support the entitlement of all people to equality of health protection. However, in relation to this proposed legislation, there is a serious ethical issue being raised by our members as to whether it is professionally acceptable to participate in the enforcement of a law which unjustifiably fails to protect whole categories of vulnerable people and could be open to subsequent challenges under Human Rights Legislation.

4. THE APPROACH RECOMMENDED BY CIEH

4.1 The current proposals contained in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill rely extensively on the use of regulations to determine where and under what circumstances smoking will be prohibited or permitted (there are proposals for such regulations in paragraphs 10, 11, 14, 15, 19, 23 and 24).

4.2 The approach recommended by CIEH is that the architecture of the legislation should be based around a simple straightforward prohibition of smoking in all indoor workplaces and public places.

4.3 For areas where a case can be made for the exercise of discretion or relaxation of the general prohibition, ie where the workplace or public place is not enclosed by four walls and a roof, then the starting point should be a consideration of the need for protection of the worker.

4.4 The discretion or relaxation would then only be granted where either:
   — there are practical means, of effecting protection of the worker; or
   — there are other measures to safeguard the employee by minimising exposure

   and the standard to be applied in both cases would be that of employing the best practical means, which is a concept already in existing law.

4.5 We believe that this model offers a legislative structure that will have long life and is entirely in accordance with the Government’s strategies for better regulation and reducing the burdens on business and we commend it to you.

5. PROPOSED DEFINITION OF SMOKE OR SMOKING

5.1 CIEH has serious concerns that the definition in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill is open to interpretation, creating scope for doubt and increasing the need for and difficulties of enforcement and the resultant costs to both regulatory bodies and businesses. We wish to propose alternative definitions.

5.2 The proposed definition is understood to be inclusive of all “smoking” activities including the use of cigarettes, cigars, pipes and hookahs etc. However, the question of whether smoking materials contain tobacco will be a question of fact and could be a matter of dispute and possibly costly investigation and litigation.

5.3 Conversely, it is anticipated by CIEH that if the legal requirements are comprehensive and clearly understood then the legislation will be largely self-enforcing with managers of premises, responsible persons and members of the public individually and collectively willing to challenge and confront persons smoking in contravention of the law. To expect people to be able to differentiate between tobacco and non-tobacco products, with sufficient certainty to be able to challenge others, is unreasonable.

5.4 In enforcement situations if the smoking materials cannot be readily identified (as with hand-rolled cigarettes) this may necessitate the use of sampling procedures and laboratory analysis which are complex and costly. It will also make it difficult for enforcement officers to follow up on complaints from the public if alleged offenders can claim that they were using non-tobacco products.

5.5 Herbal mixtures may not have been demonstrated to cause damage to the health of smokers, but they certainly cause discomfort to others and can, according to Asthma UK, trigger illness for susceptible individuals and could be included on these grounds alone.

5.6 CIEH supports a definition that includes: “any lit substance or mixture of substances that reasonably appears to be smoking tobacco or is being used for a similar purpose”. In accordance with such a definition, smoking occurs if the person: “is holding or otherwise in possession of control of any lit substance or mixture of substances that reasonably appears to include smoking tobacco or is being used for a similar purpose”
6. Proposed Definition of Enclosed

6.1 CIEH has serious concerns about the proposed definitions in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill which do not in our view adequately address the practical situations that will be encountered and are open to interpretation, creating scope for doubt and increasing the need for and difficulties of enforcement and the resultant costs to both regulatory bodies and businesses. We wish to propose alternative definitions.

6.2 There are two categories of structures that will not be fully enclosed.

6.3 The first category are workplaces which are constructed in a manner so as not to be fully enclosed, eg a stall in an open-air market or an open-sided warehouse, and where it can be anticipated that the level of natural ventilation will reduce the hazards arising from secondhand smoke to that of smoking in the open-air.

6.4 The second category are shelters erected at the discretion of the building owner or occupier for the specific purpose of providing a refuge for people to smoke, whether staff or customers, at workplaces, public places, licensed premises and hospitality establishments.

6.5 For the first category the proposed allowance of not exceeding 70% of the total notional roof and wall area as described is acceptable. However, for the second category it is not.

6.6 The initial point to make is that the purpose of the shelter is solely to provide protection against inclement weather whilst smokers smoke, and not to create outdoor "rooms" which effectively extend the business premises. Therefore, the allowance of not exceeding 70% of the total notional roof and wall area is more than is necessary for the purpose of providing shelter for short periods of use by individuals. CIEH would prefer an allowance of no more than 30% on the basis that this will provide an adequate overhead shelter from the elements. It will also better facilitate natural ventilation, thereby minimising the risks from secondhand smoke to the users and those employees who need to carry out work activities necessary for the continuation of the main business eg the delivery of food and drink purchases and collection of drinking and eating receptacles.

6.7 If the 70% allowance is also to be applied to “smoking shelters” (ie if the CIEH recommendation for a reduction to 30% is not accepted) then further restrictions will need to be applied. The inclusion in this dispensation of movable and temporary structures will mean that owners can frequently reconfigure and relocate their smoking shelters. This may mean that an arrangement which originally met the requirement for “not substantially enclosed”, subsequently is constructed or located in breach of the requirements, whether intentionally or unintentionally. There should therefore be a requirement for the submission of plans, which specify the location, and calculations which specify the configuration of the wall and roofing elements so as to avoid the need for complicated on-site measurements by enforcement officers at both initial approval and subsequent inspection. The local authority should be permitted to levy a fee for this work.

6.8 To assist building owners and managers in meeting these requirements we recommend that a Code of Practice is drawn up, in consultation with trade representatives and key stakeholders, to provide model constructions and acceptable construction materials (eg non-flammable and readily cleanable). Following the pattern of the Building Regulations compliance with the Code of Practice would be deemed to secure compliance with the legislative requirement and any arrangement not prescribed in the Code of Practice would require individual consideration and approval and this would necessitate the payment of a fee.

6.9 The CIEH Policy Officer has visited the Republic of Ireland and has seen at first hand the difficulties that have arisen with the erection of structures, external to the main building, for the specific purpose of providing a shelter for smokers. Particular problems occur where an “outdoor” shelter is sited in close proximity to the main building, or where the location of an “outdoor” shelter is such that effective natural ventilation is restricted eg enclosed by high walls of courtyards and lighting wells. In such circumstances the enforcement officer should have discretion to require the provision of self-closing mechanisms to adjacent doors; the provision of intervening ventilated lobby access to the main building; permanent securing of adjacent windows and their substitution with a system of artificial ventilation.

7. Other Public Places and Workplaces that Might Fall Outside the Definition of “Enclosed” Which Might be Smokefree

7.1 CIEH is of the view that the proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill are unnecessarily complicated and open to interpretation, creating scope for doubt and increasing the need for and difficulties of enforcement and the resultant costs to both regulatory bodies and businesses. We wish to recommend the adoption of the straightforward risk-based approach.

7.2 The main concern of CIEH is the protection of workers within enclosed workplaces and public places and we accept that smoking in the open-air is substantially less hazardous than in enclosed areas. However, there is an inconsistency in the Government’s approach in that if the case is accepted for the need to afford protection from secondhand smoke in open areas then this surely begs the question why protection for indoor areas does not include all pubs and clubs where workers are known to be at a greater risk.
7.3 Whilst we support the proposals for affording protection where there is close grouping of people in outdoor situations, it needs to be recognised that enforcement will be difficult in locations where there is neither on-site supervision nor managerial responsibility—an isolated bus shelter is therefore a different proposition to a bus terminus or a railway station.

7.4 CIEH supports the proposals for prohibiting smoking at entrances and exits to public buildings, health and educational establishments and believes that the operators of such premises should set an example, and that their staff should accept their responsibility to act as role models. We have seen demonstrations of a range of equipment that will both detect smoke and also the use of ignition materials at entrances to buildings and in remote open-air situations.

8. Exceptions—All Licensed Premises (Receive a Longer Lead-in Time)

8.1 CIEH makes the strongest possible objections to the proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill for phasing in the implementation of the legislative requirements for different categories of businesses to become smokefree. The position of CIEH is that requiring all workplaces and public places to become smokefree at the same time will maximise the levels of voluntary compliance, reduce the need for enforcement activities and minimise costs to regulators and businesses.

8.2 The fundamental position of CIEH is that all workers should be afforded an equal level of protection and there can be no justification for licensed premises to be given a longer period, especially as their workers are exposed to the greatest risk.

8.3 Apart from the equality of treatment issue, there are positive advantages for the Government in requiring all workplaces to become smokefree at the same time. This will allow national media campaigns to provide simple straightforward messages that have universal application in all indoor premises will become smokefree at the same date and time. This will positively encourage voluntary compliance because people will know that they cannot smoke in any indoor workplace and public place and it will encourage members of the public to have confidence in challenging smoking indoors whenever they observe it taking place. This in turn will reduce the burden on the enforcement agencies both to give specific advice about which premises are affected and in dealing with complaints of alleged and suspected breaches.

9. Exceptions—All Licensed Premises That Do Not Prepare and Serve Food—Definition of "Prepare and Serve Food"

9.1 CIEH makes the strongest possible objections to the proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill to exempt premises where food is not prepared or served. It is in our opinion, not a “novel approach”, but an entirely illogical and unjustifiable approach and contrary to the essential principles of public health legislation that protection measures against hazards to health are extended to all members of the population likely to be affected. Furthermore, rejecting these exemptions and instead requiring all workplaces and public places to become smokefree at the same time will maximise the levels of voluntary compliance, reduce the need for enforcement activities and minimise costs to regulators and businesses.

9.2 The basis of our objection is that the linking of smoking to food consumption is illogical and spurious in public health terms. There can be no justification for such an exemption on health grounds, indeed the counter argument is true in that bar workers are at the greatest risk from occupational exposure to secondhand smoke and it would be perverse to leave those workers unprotected.

9.3 Our robust position is now being supported by that recently taken by the Health and Safety Executive (HSE) and the Health and Safety Commission (HSC). We wish to direct your attention to the HSC report (HSC/05/100) dated 26th July 2005: HSC’s Response to Department of Health’s (DH) Consultation Document (CD) on the Smokefree Elements of the Health Improvement and Protection Bill. The HSE and HSC are advocating for the prohibition on smoking to extend to all licensed premises and private clubs on the basis that both the science and existing health and safety legislation support the case.

9.4 At a practical level, the Government’s identification of the need for regulations to define “snacks” reinforces the argument that the descriptor of “pre-packaged ambient shelf stable snacks” will not be easily understood and this will substantially increase the need for regulatory advice. The intention to revise the list of snacks from time to time will mean that members of the public will be unlikely to be able to report non-compliance and this will add to the need for investigations by the enforcement agencies and the regulatory bodies.

9.5 It can also be maintained that these provisions will not stop food being eaten on licensed premises. In some premises the food sales have been franchised out so that the “pub” business and the “food” business are operated entirely separately. There are pubs already in existence that encourage patrons to “bring your own food” (emulating some elements of the restaurant trade that allow patrons to “bring your own bottle”). In other premises patrons are allowed to provide their own food for particular social events such as darts matches etc. Take-away menus from nearby restaurants are displayed in other licensed premises where the
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staff place telephone orders on behalf of customers and also facilitate the delivery of these meals and their consumption on the licensed premises. We can also expect to see a proliferation of burger and other hot food vans and an increase in off-street consumption of fast food.

9.6 It has been widely reported in both New York and the Republic of Ireland that a key ingredient of their success has been the universal application of the prohibition on smoking in indoor workplaces and public places and the resultant level trading environment for the hospitality trade.

10. EXCEPTIONS—RESIDENTIAL PREMISES

10.1 CIEH is of the view that the proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill for exempting residential and other premises are unnecessarily complicated and open to interpretation, creating scope for doubt and increasing the need for and difficulties of enforcement and the resultant costs to both regulatory bodies and businesses. We wish to recommend the adoption of the straightforward risk-based approach.

10.2 The legislation should be framed around two key principles: firstly that no-one should be required to work where other people are allowed to smoke; and secondly that the only place a person has a right to smoke is in their private abode and when they are not receiving services or treatments.

10.3 Exemptions, where they are to be agreed, should be specifically for the room used as the private residence and should not include any communal areas.

10.4 Where services and treatments are to be provided in a room used as a private residence it should be the duty of the employer to safeguard the health of the employee as far as is reasonably practicable by preventing or minimising their exposure to secondhand smoke eg by prohibiting smoking whilst the employee is in attendance, ventilating the room and if appropriate issuing and requiring the wearing of personal protective equipment.

11. EXCEPTIONS—MEMBERSHIP CLUBS

11.1 CIEH makes the strongest possible objections to the proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill to exempt private members clubs and view this proposal as an attempt to placate vested interests. There is no justification for such an exemption on health grounds, and again the counter argument is true in that bar and other workers in such premises are at the greatest risk from occupational exposure to secondhand smoke and it would be perverse to leave those workers unprotected. Furthermore, rejecting these exemptions and instead requiring all workplaces and public places to become smokefree at the same time will maximise the levels of voluntary compliance, reduce the need for enforcement activities and minimise costs to regulators and businesses.

11.2 The proposal for annual ballots is an unacceptable method of determining requirements for the protection of workers’ health. Furthermore, what would be the position of workers who took up their employment at a time when the premises were smokefree and there was subsequently a vote to allow smoking.

11.3 Such premises are also attractive to families with young children and their exposure to secondhand smoke should be of concern to the Government.

11.4 Finally there is the very real risk of damage to the customer base of other licensed premises and the need for a level trading environment has been clearly expressed by the trade representatives.

12. EXCEPTIONS—PRACTICAL IMPLICATIONS

12.1 CIEH believes that the greater the number of businesses that can be encouraged and supported to adopt and implement smokefree policies, the less practical difficulties that will arise when the proposed legislation is introduced. CIEH is therefore providing leadership and guidance for both its members and their employers in taking action in advance of the anticipated legislation. CIEH does not accept that lengthy lead-in periods of more than a year, or several years, are necessary or desirable. Furthermore, requiring all workplaces and public places to become completely smokefree at the same time will maximise the levels of voluntary compliance, reduce the need for enforcement activities and minimise costs to regulators and businesses.

12.2 With the reasonable lead-in periods, of up to say 12 months, there is plenty of opportunity for employers to determine how they will adjust, reduce or cease their smoking activities in order to meet their employers’ requirements. To that end there are extensive support services available both locally (smoking cessation support) and nationally (Quit lines etc).

12.3 As a support to business, CIEH is providing training for environmental health practitioners in encouraging and supporting local employers to adopt and implement smokefree policies in advance of the anticipated legislation. This training is based on its “toolkit” (see below) and has been developed in consultation with the National Collaborating Centre for Tobacco Control and has been delivered in partnership with the DH Regional Directors for Tobacco Control Policy.
12.4 CIEH believes that the introduction of prohibitions on smoking should always be accompanied by information and support for staff. CIEH has produced, in association with ASH, a toolkit for use by local authorities and their partners—the Achieving Smoke Freedom Toolkit—A guide for local decision makers. The toolkit outlines ways in which local authorities can act, either alone or in partnership, to bring about local environmental smoke reduction or removal schemes, using the power to promote wellbeing and to promote health and reduce health inequalities. It advocates that support is provided for staff in coming to terms with the employers’ prohibition on smoking in the workplace. CIEH has also endorsed the National Clean Air Award, administered by the Roy Castle Lung Cancer Foundation, as this also requires that such support is available to staff.

13. SIGNAGE

13.1 CIEH recognises the importance of clear and conspicuous signage and makes practical proposals for its use so as to maximise voluntary compliance and assist businesses in complying with the legal requirements for smokefree premises.

13.2 Standardised signage is supported and should refer to the legal requirement so as to reinforce compliance. In the Republic of Ireland the complaint phone line is a national number and has made a significant contribution in securing compliance. It is not stated in the consultation document whether the phone number is intended to be national or local. The phone number to be used should be free of charge.

13.3 Signs should be of a durable material and there should be a requirement for them to be appropriately and conspicuously positioned so that they can be clearly seen by staff and customers, including at all entrances and in positions where staff can indicate them to customers and visitors. In relation to licensed premises and the hospitality sector, signs should be required to be displayed adjacent to bar and other service areas, so that staff can readily point to them.

14. OFFENCES AND PENALTIES

14.1 CIEH objects to the low level of fines proposed in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill and also has major concerns regarding the proposed enforcement arrangements which it views as contrary to existing government policy and, in some respects, as unworkable.

14.2 The level of fines is considered too low given the nature of the hazard to health. There should also be consistency in levels of fines across the UK.

14.3 Local authority staff in general, and environmental health practitioners in particular, are not familiar with imposing fixed penalties and such an activity will pose real risks to their safety and our members have expressed their unwillingness to undertake such a duty without the appropriate safeguards for their personal safety. Our members are also concerned that the inclusion of a power to spot-fine will raise unreasonable expectations about their ability to deal with offences, which will not be met.

14.4 In any case, we believe that the power to impose spot fines will be ineffective unless it is linked to police powers to require the production of identification, detain and if necessary arrest offenders. The risks to enforcement staff will be particularly great in open-air situations where such powers might be better exercised by the police service personnel themselves.

14.5 In our view the emphasis needs to be on management of premises to ensure that the smokefree policy is properly implemented; that contraventions are detected and dealt with; and that controls are maintained and improved to prevent further contraventions. Where managers fail to prevent smoking on their premises there should be an ascending scale of fines, together with the ultimate deterrent of withdrawal of the licence to sell alcohol.

15. DEFENCES

15.1 CIEH broadly agrees with the proposed defences in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill and commends the arrangements in the Republic of Ireland which have been seen to work well, are appropriate for England and should therefore be adopted.

15.2 The arrangements in the Republic of Ireland require the owner of a business to have a written policy that identifies the responsibilities of managers and staff and the procedures to be followed in securing compliance. If this were the case then where repeat offences are reported to the enforcement officers the written policy and its application can be reviewed and improved to ensure that contraventions are detected eg by the deployment of additional staff and the installation of detectors and alarms.

15.3 The manager should be required to keep records of all incidents of non-compliance in order to demonstrate diligence. Due diligence should include taking steps to have persons wilfully contravening the prohibition on smoking removed from the premises.
16. Enforcement

16.1 CIEH wishes to register major concerns regarding the enforcement arrangements proposed in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill which it views as contrary to existing government policies in respect of “better regulation” and reducing the regulatory burdens on business.

16.2 It is intended that the “appropriate enforcement officer” will be officers of the local authority, including their environmental health officers, and this will considerably add to the numbers of premises that the local authority staff will be responsible for.

16.3 CIEH is concerned that this proposal is against the principles of better regulation and that a wider range of enforcement officers should be identified. In particular, officers of the HSE are not included and this will lead to duplication of inspections, in those premises where the HSE is the responsible body, and possible confusion by complainants and business owners.

16.4 CIEH supports the case that has been made for the establishment of a National Office of Tobacco Control that could oversee the implementation of the law. Such a body would ensure consistency of application of requirements and set competence standards for enforcement staff. However, in accordance with the principles of the Hampton Review, the establishment of such a body should incorporate a “sunset clause” to limit its life so that, when arrangements are working well, the role and function could be handed over to an existing agency.

16.5 CIEH is aware that discussions have already commenced with the Local Government Association on questions around enforcement and likely costs and that work is being undertaken by LACORS to obtain estimates of the likely additional resources required by local authorities for the necessary enforcement activities. The point has been strongly made elsewhere in this submission that enforcement will be greatly simplified by a universal ban implemented in all workplaces and public places at the same time as this will positively encourage voluntary compliance and public challenging and reporting of non-compliance.

17. Smoking at the Bar

17.1 CIEH makes the strongest possible objections to the proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill in respect of no-smoking at the bar in exempted licensed premises. The consultation document states that this measure will not furnish any proven health benefit and the proposal is, in our opinion, therefore completely unacceptable and could be said to make a mockery of the Government’s stated intention to reduce the risk to health from exposure to secondhand smoke. Furthermore, disallowing all exemptions and instead requiring all workplaces and public places to become entirely smokefree at the same time will maximise the levels of voluntary compliance, reduce the need for enforcement activities and minimise costs to regulators and businesses.

17.2 The bar area is where bar staff work, including serving drinks, collecting glasses and clearing tables and empties. Smoke drifts—everyone recognises this as a distinguishing feature of secondhand smoke, which is why separate smoking and non-smoking areas are seen to be ineffective and are not being permitted under the proposed legislation. Therefore the proposal for identifying an area, and marking it in some manner that customers can be expected to observe, a measured distance away from the bar counter, is spurious.

17.3 The promotion of ventilation as an alternative to ending smoking in workplaces and enclosed public places is also an expensive, ineffective and unnecessarily complicated option. It is important to note that the Government’s own scientific evidence identifies that there is no safe level of exposure to secondhand tobacco smoke. Ventilation and similar equipment cannot eliminate all smoke and therefore it can only reduce but not eliminate the risk. It would be difficult, if not impossible, to prescribe ventilation standards appropriate for all premises as particular situations vary enormously and therefore bespoke systems will be required. Even basic systems are not cheap and costs even for small establishments will be 6-figure sums; added to which maintenance costs are not inconsiderable and failure to maintain quickly reduces their effectiveness.

17.4 The generally available ventilation systems are designed for comfort, not safety. Air filtration or air ionising equipment can only remove visible particles; it is not intended to remove the invisible and toxic gases contained in secondhand tobacco smoke. It would require much higher ventilation rates than most commercial systems offer to reduce health risks measurably and even these would not be fully effective. Such systems would be very expensive and noisy and would cause discomfort, and are therefore unlikely to be installed in commercial premises.

17.5 CIEH also understands that there may be requests from trade representatives for “smoking rooms” which would be reserved for the specific purpose of patrons to smoke and that neither eating nor drinking would be allowed. The smoky atmosphere that would develop in such rooms would mean that there would need to be a prohibition on workers entering them for any purpose, including cleaning, until they had been effectively ventilated. Clearly, only the larger establishments would be able to set aside a room for such purpose, thereby disadvantaging the smaller establishments. If such a proposal is to receive consideration by the Government, then there would need to be a very careful assessment of the necessary
standards for such rooms including provision of ventilation, limiting capacity and separation from work areas by the creation of an intervening ventilated lobby access. Such arrangements would also add considerably to the inspection and enforcement requirements.

18. **Timetable**

18.1 CIEH makes the strongest possible objections to these proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill for phasing in the implementation of the legislative requirements for different categories of businesses to become smokefree. The position of CIEH is that requiring all workplaces and public places to become smokefree at the same time will maximise the levels of voluntary compliance, reduce the need for enforcement activities and minimise costs to regulators and businesses.

18.2 The fundamental position of CIEH is that all workers should be afforded an equal level of protection and there can be no justification for licensed premises to be given a longer period, especially as their workers are exposed to the greatest risk.

18.3 We have previously stated that, apart from the equality of treatment issue, there are positive advantages for the Government in requiring all workplaces to become smokefree at the same time. This will allow national media campaigns to provide simple straight-forward messages that have universal application ie all indoor workplaces and public places will become smokefree at the same date and time.

18.4 This will positively encourage voluntary compliance because people will know that they cannot smoke in any workplace or public place at any time after the operative date and it will encourage members of the public to have confidence in challenging others wherever they observe smoking taking place contrary to the law. This in turn will reduce the burden on the enforcement agencies both to give specific advice about which premises are affected and in dealing with complaints of suspected and alleged breaches.

18.5 It would be sensible to time the introduction of the prohibition on smoking in indoor workplaces outside of the winter months.

19. **Unintended Consequences for Binge-drinking**

CIEH does not wish to make representations to the Health Committee on this issue.

20. **General Points**

20.1 CIEH has participated in the gathering of evidence that indicates that the proposed exemptions from the smokefree requirements for certain pubs and clubs would be concentrated in poorer communities and we are therefore of the opinion that the proposals in the Department of Health consultation on the smokefree elements of the Health Improvement and Protection Bill would exacerbate health inequalities.

20.2 CIEH has supported the British Medical Association (BMA) in their survey and published report Booze, Fags and Food, that showed that in some areas over 80% of pubs are non-food pubs and that these are concentrated in the north of the country. It is being accepted by Department of Health staff that an effect of this exemption will be to increase inequalities in health and this should be a major concern for the Government as it could undermine the fundamental principles of the Choosing Health initiative.