The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Rt Hon Kevin Barron MP (Labour, Rother Valley) (Chairman)
Mr David Amess MP (Conservative, Southend West)
Charlotte Atkins MP (Labour, Staffordshire Moorlands)
Mr Paul Burstow MP (Liberal Democrat, Sutton & Cheam)
Mr Ronnie Campbell MP (Labour, Blyth Valley)
Jim Dowd MP (Labour, Lewisham West)
Anne Milton MP (Conservative, Guildford)
Mike Penning MP (Conservative, Hemel Hempstead)
Dr Howard Stoate MP (Labour, Dartford)
Dr Doug Naysmith MP (Labour, Bristol North West)
Dr Richard Taylor MP (Independent, Wyre Forest)

The following Member was also a member of the Committee in the course of this inquiry:

John Austin MP (Labour, Erith and Thamesmead)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Eliot Wilson (Second Clerk), Laura Hilder (Committee Specialist), Christine Kirkpatrick (Committee Specialist), Duma Langton (Committee Assistant), Darren Hackett, (Committee Assistant), and Amanda Waller (Secretary).

Contacts

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Witnesses

Thursday 20 October 2005

Dr Fiona Adshead, Deputy Chief Medical Officer and Mr Nick Adkin, Project Manager on Tobacco, Department of Health

Professor Dame Carol Black, President, Dr Richard Edwards, Senior Lecturer in Public Health, University of Manchester, Dr Richard Ashcroft, Reader in Biomedical Ethics, Imperial College and Dr Allan Hackshaw, Deputy Director of Cancer Research UK and UCL Cancer Trials Centre, University College London, Royal College of Physicians

Dr Steve Stotesbury, Industry Affairs Manager and Chief Scientist, Imperial Tobacco Ltd (UK), Ms Christine Mohrmann, Head of UK Corporate Affairs, Philip Morris Ltd and Mr Barry Jenner, Director of UK Business, Gallaher Group plc

Thursday 17 November 2005

Mr Phil Wheatley CB, Director General, HM Prison Service, Mr Paul Foweather, Governor, HM Young Offenders’ Institute Wetherby, Mr Paul Thain, Director of Modernisation and Strategic Development, Norfolk & Waveney Mental Health Trust, Mr Ian Hulatt, Mental Health Adviser, The Royal College of Nursing and Mr Paul Corry, Director of Campaigns & Communications, Rethink Severe Mental Illness

Mr Rob Hayward OBE, Chief Executive, British Beer and Pub Association, Mr John Hutson, Chief Executive, J.D. Wetherspoon, Mr Nick Bish, Chief Executive, Association of Licensed Multiple Retailers, Mr Bob Cotton OBE, Chief Executive, British Hospitality Association and Mr Tony Payne CBE, Chief Executive, Federation of Licensed Victuallers Associations

Mr Simon Thomas, Managing Director, Thomas Holdings Ltd , Sir Peter Fry, Chairman and Mr John Carpenter, The Bingo Association

Hugh Robertson, Trades Union Congress, Mr Vincent Borg, UNISON, Mr Michael Ainsley, GMB, Mr Brian Revell and Ms Pauline Robson, TGWU
Thursday 24 November 2005

Mr Bill Callaghan, Chairman, Health and Safety Commission, Ms Deborah Arnott, Director, Action on Smoking and Health (ASH), Councillor David Rogers OBE, Local Government Association (LGA), Mr Derek Allen, Executive Director, Local Authorities Coordinators of Regulatory Services (LACORS), Mr Graham Jukes, Chief Executive and Mr Ian Gray, Policy Officer for Health Development, Chartered Institute of Environmental Health

Professor Sir Liam Donaldson, Chief Medical Officer

Vice Admiral Rory McLean CB, OBE, Deputy Chief of the Defence Staff (Health), and Mr Chris Williams, Finance and Secretariat Branch Leader, Ministry of Defence

Mr Shaun Woodward, a Member of the House, Under-Secretary of State for Northern Ireland, Northern Ireland Office, Ms Pat Osborne, Head of Investing for Health Branch, and Mr Jim Gibson, Deputy Principal, Investing for Health Branch, Department of Health, Social Services and Public Safety Northern Ireland

Caroline Flint, a Member of the House, Under-Secretary of State for Public Health, Fiona Mactaggart, a Member of the House, Under-Secretary of State for the Home Department, and Mr Nick Adkin, Tobacco Programme Manager, Department of Health
# List of Written Evidence in Volume III

1. Department of Health (SP 01)  
2. Supplementary memorandum by Thomas Holdings Ltd (SP 07A)  
3. Supplementary memorandum by Imperial Tobacco Limited (SP11A)  
4. Supplementary memorandum by Gallaher Group Plc (SP 15A)  
5. Supplementary memorandum by Dr Andrew Geens (SP17A)  
6. British American Tobacco (SP 45)  
7. Business In Sport and Leisure (SP 46)  
8. Prison Service (SP 47)  
9. The Bingo Association (SP 48)  
10. Faculty of Occupational Medicine of the Royal College of Physicians (SP 49)  
11. Supplementary memorandum by Dr Allan Hackshaw, Royal College of Physicians (SP 50)  
12. Supplementary memorandum by Dr Richard Edwards, Royal College of Physicians (SP 51)  
13. Action On Smoking and Health (ASH) (SP 52)  
14. Royal College of Physicians (SP 56)  
15. Professor Roger Scruton (SP 57)  
16. BBC Radio 4: You and Yours (SP 58)

# List of Written Evidence in Volume II

17. Thompsons Solicitors (SP 02)  
18. Royal College of Nursing (SP 03)  
19. Royal Pharmaceutical Society of Great Britain (SP 04)  
20. Asthma UK (SP 05)  
21. Thomas Holdings Ltd (SP 07)  
22. CLIC Sargent (SP 09)  
23. Imperial Tobacco Limited (SP 11)  
24. Tobacco Manufacturers’ Association (SP 12)  
25. The Roy Castle Lung Cancer Foundation (SP 13)  
26. Sainsbury Centre for Mental Health (SP 14)  
27. Gallaher Group plc (SP 15)  
28. The Imported Tobacco Products Advisory Council (SP 16)  
29. Dr Andrew Geens (SP 17)  
30. Philip Morris Limited (SP 18)  
31. Smoking Control Network (SP 19)  
32. Lloydspharmacy (SP 20)
List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

K Wass (SP 06)
David Paterson (SP 08)
Adrian Kerton MSc. (SP 53)
Mr Steve Jones (SP 54)
Jo Barrett (SP 55)
Robert Feal-Martinez (SP59)
Oral evidence

Taken before the Health Committee

on Thursday 20 October 2005

Members present:

Rt Hon Kevin Barron, in the Chair

Mr David Amess         Mike Penning
Charlotte Atkins       Dr Howard Stoate
Anne Milton             Dr Richard Taylor
Dr Doug Naysmith

Witnesses: Dr Fiona Adshead, Deputy Chief Medical Officer, and Mr Nick Adkin, Project Manager on Tobacco, examined.

Q1 Chairman: Good morning. Could I welcome you to what is the first public session of the newly formed Health Committee and, for the purposes of this particular inquiry, may I say to anybody in the room who has an interest, we have published a memorandum today of the written evidence that was submitted to this Committee and it is available. I wonder if I could first of all begin by clarifying exactly what the Department of Health’s policy is in relation to smoking in public places and work places. Is it as it appears in the consultation document or has it changed in the last few days or weeks?

Dr Adshead: What we are able to comment on, obviously, is government policy as it stands at the moment and Choosing Health and its subsequent consultations, as you have just reflected, laid out a comprehensive package around progressively promoting smoke-free public places and work places. As you know, the key elements of the package are that by the end of 2006 all government departments in the National Health Service will be smoke-free, with some key limited exemptions which we consulted on, for example, including residence homes and mental hospitals. By the end of 2007 all other work places and public places will be smoke-free except for licensed premises, where we specifically recommended by the end of 2008 arrangements for licensed premises will come into place which made the distinction between all premises going smoke-free where food is prepared and served. Obviously, what we are aiming to do here is complement this with a much broader range of tobacco control, because at the end of the day what we are trying to do is to get people to give up smoking, because ultimately that is what will make England smoke-free.

Q2 Chairman: Are we to assume that the intention is still to exempt pubs where food is not served and membership clubs as well?

Dr Adshead: The consultation obviously asked people what was practicable and also what was going to be effective, and one of the key areas we consulted on was that distinction between food being prepared and served as a way of distinguishing licensed premises, because what we wanted to reflect was public opinion around being in a smoking environment whilst eating food. What we found during the Choosing Health consultation was that there was a very strong preference for there not being smoking environments when people are eating food and therefore we chose to make the distinction around pubs, in particular, on those grounds.

Q3 Chairman: There has been some speculation in the press recently about pubs that have smoking rooms. I understand this is to mean that there is a room in a pub where you can close the door; nobody actually works in it but people can go and sit in it and have a drink and smoke at the same time. Is that something that we should take seriously as being what the Department is looking at at this stage?

Dr Adshead: Current government policy does not include smoking rooms, but we consulted, as you are aware, on a range of different measures, and something that pub industry and its associated partners came back with was that, rather than having the distinction between food and not food, that smoking rooms or rooms where smoking could occur was one possible model that was put forward. We are aware, for example, in Italy there are models on that: so there is an international precedent for that, but it is not current government policy as it stands and was consulted on at present.

Q4 Chairman: Was that a universal view of the industry that that should or could take place?

Dr Adshead: I think a universal view would suggest that everybody who actually put a response in from the industry included that. I am not aware that is the case. Nick, do you have any opinion on that?

Mr Adkin: No. On the responses, I think you have seen a large number of them, the pub industry, lead by the BBPA, have a proposal which is about floor space with an intention to voluntarily go to 90% of floor space being smoke-free by 2009. I believe. That was their voluntary proposal which they say has been signed up to by 50% of the pub industry, but there were a range of different views. The British Hospital Association, for instance, was for a complete ban.
Q5 Chairman: There was not a universal view that smoking rooms are the answer to the problem?

Dr Adshead: No.

Q6 Dr NaySmith: There is no evidence, I think, and I do not think we have seen any evidence, that a policy of banning smoking at the bar has any effect on employee exposure at all. Is that something that you can say sensibly or do you have evidence that we have not seen?

Dr Adshead: The recommendation that there should be a prohibition on smoking within a metre of the bar was not based on evidence of protecting health; it was essentially about trying to reduce the amount of noxious exposure, the irritant effect of smoke, within that distance. Obviously, as you may be aware, again some licensed premises promote this as an example of good practice, but it is not a recommendation that was put forward on heath evidence grounds.

Q7 Dr NaySmith: Why was it put forward? I think David has some questions he wants to ask.

Dr Adshead: It was put forward essentially because it was felt that, if you were a bar worker, having smoke directly blown in your face within that distance was unpleasant, but it was not a recommendation that was based on heath evidence.

Q8 Mr Amess: Chairman, I might have been asleep at the start, but did you begin by introducing yourselves and explaining to everyone what it is you both do and who you are?

Dr Adshead: No, we did not. We would be more than happy to do that. I am sorry, as I was not asked to, I did not.

Q9 Mr Amess: It is no criticism of anyone, but I have not got my bit of paper here.

Dr Adshead: Absolutely. I can explain who I am and I am sure Nick will be able to do the same. I am Dr Fiona Adshead, I am Deputy Chief Medical officer in the Department of Heath and I have a broad range of responsibilities over health improvement in other areas, and one of them includes tobacco policy.

Mr Adkin: I am Nick Adkin, I am the Tobacco Programme Manager in the Department so have responsibility for tobacco policy except for tax, duty and smuggling.

Q10 Mr Amess: Have you been with the department long?

Dr Adshead: I have been with the department for 18 months. In fact I joined in mid February 2004, just as we were beginning to develop the consultation process for Choosing Health, so I have seen Choosing Health through as a policy.

Mr Adkin: I joined the then DHSS about 17 years ago.

Q11 Mr Amess: Goodness. So you really do know where the bodies are buried! Your book would be worth reading. This proposed policy: I have listened to what you have said and I am still a bit puzzled who is driving this. Where is the evidence that it will work?

Dr Adshead: One of key elements of the proposed legislation we put forward is that we have committed in Choosing Health to consult on it. What we know from international experience is that legislation works if is obviously effective in terms of having its desired impact, but also if it is practicable, if it is workable. We know from smoke-free public places legislation from other countries that it is really important that it is well considered and thought through, so that is exactly why we went through the consultation.

Q12 Mr Amess: Can you tell me specifically about the international experience that you are relying on?

Dr Adshead: I think one thing that... There is a whole range, as you are probably aware. There is evidence from New York, from California, more recently from Ireland, obviously the Scottish experience in recent months. I think what many of them demonstrate is that often, certainly in California and New York, a phased approach in the more difficult areas where public opinion is less behind smoke-free public places—and that often tends to be pubs and bars—tends to be more successful certainly in those areas.

Q13 Mr Amess: We always seem to be drawing on America as an example, but, of course, the structures of government are entirely different, so enforceability is quite a big issue, but it is interesting to hear why you are drawing on that proposed policy. The other thing I wanted to ask you is there obviously a different policy in different parts of the United Kingdom. Is this because there is a difference of interpretation of scientific evidence? Can you help the Committee? Tell us why there is this difference in policy?

Dr Adshead: Obviously each of the devolved administrations, as you reflect, have been actually consulting on their own smoke-free public places policy, and I think in England we recognise that the policy that we need to put forward needs to reflect both English needs, circumstances, issues around public opinion, but we need, if you like, to come up with an English solution. Obviously we have been aware of what has been going on in the other devolved administrations, and in Ireland, as I have already said, and are taking that into consideration in terms of not only the way we put forward our own consultation, reflecting, for example, some of the definitions around what would constitute an enclosed public space, but also in terms of keeping an eye on that as policy develops.

Q14 Mr Amess: So the scientific evidence and the forecast of the United Kingdom is exactly the same, we are interpreting it differently. Is that it?

Dr Adshead: Scientific evidence is obviously often international, so the basis for it comes from, for us, the Scientific Committee on the Health Effects of Alcohol (SCOTH), it also comes from some of the WHO work, from their advisory research council.
and cancer, and what those all make clear is that second-class smoking as is a significant public health hazard. Most of us, and I cannot speak for other administrations, but certainly I would imagine that we are all basing it on the same evidence base, but I think what is important is that health evidence is only one part of a decision-making process: so that obviously public opinion in each country, circumstances, workability, practicality and other issues all need to be taken into account, and that is precisely why we put so much emphasis on doing a thorough consultation and listening to as many stakeholders. I think it is worth saying that about 57,000 people responded to our consultation, which I think gives us a firm basis for understanding what would both be practical and effective.

Q15 Mr Amess: Finally, Mr Adkin, with your 17 years of experience, do you agree with everything your colleague has just told the Committee?
Mr Adkin: Yes, I do.

Q16 Mr Amess: We will let you sort it out afterwards.
Mr Adkin: In the international context, I think every government in the world accepts the evidence base, but it is a judgment for each government how they approach it. In California the evidence base was clear and they went for an approach which left out bars until later in the process, New York the same. It is a combination of the medical evidence, which I think is clear, despite what some of the antis say, and then a judgment on how best to implement it in your particular jurisdiction.
Mr Amess: Thank you very much indeed.

Q17 Dr Taylor: Can we try and get behind the aims of the legislation. There are so many aims and I would like you to be absolutely open. Obviously it is to protect employees in the workplace; it is to protect members of the public using those work places; it is to protect kids. Is it also intended to encourage existing smokers to give up?
Dr Adshead: I think the main reason for legislating, as you have reflected, is to protect people from the harmful effects of others' second-hand smoke.

Q18 Dr Taylor: The employees and members of the public in those places?
Dr Adshead: Yes, indeed, but, of course, some of the major benefits, in fact, are in reducing deaths from smoking itself, because providing a smoke-free environment does support and encourage people to give up smoking. We know that in England there are about 86,000 deaths a year from smoking, and so for us the key issue is reduced smoking. I think it is also fair to say from the research evidence that 95% of exposure to second-hand smoke occurs in the home, which is why in the Department we have placed so much emphasis on raising awareness around the harmful effects to children and why we have had things like our children smoking campaign and, more recently, we have extended the scope to point out to adults through the “I smoke you smoke” campaign that, in fact, smoking itself is harmful to individuals but, very importantly, it can harm other people’s health as well.

Q19 Dr Taylor: So a key issue is to encourage existing smokers to reduce or to give up. Is there evidence from the places that have already done this that this works?
Dr Adshead: There is evidence that that is the case, yes. Overall from international experience, if you start against not a comprehensive tobacco control policy, you would find a 4% drop overall in the number of people who smoke, the prevalence of smokers. In this country, as we have reflected in our partial regulatory impact assessment which we also consulted on, we estimate that the impact will be about 1.7%, and, for example, from Ireland, they estimate that an extra 7,000 smokers have given up since the introduction of their ban.

Q20 Dr Taylor: So it does have an effect?
Dr Adshead: Yes.

Q21 Dr Taylor: Is it not illogical when one is thinking of protecting employees to go down the route that the Government appears to be going at the moment, to exempt certain premises so that we are no longer protecting the employees in those places?
Dr Adshead: Obviously the policy we put forward covers more than 99% of work and public places.

Q22 Dr Taylor: Ninety-nine per cent?
Dr Adshead: Yes.

Q23 Dr Taylor: Really?
Dr Adshead: Yes, 99%.

Q24 Dr Taylor: Will not pub owners change what they are doing so they can increase the 1% that is not covered?
Dr Adshead: I think there is already evidence that some pub chains have put forward that they want to go smoke-free anyway, and I think there is quite a lot of evidence, in terms of responsiveness to customer wishes, that businesses have already gone smoke-free.

Q25 Dr Taylor: Would it not be easy for everybody if you went down the big bang approach and introduced the changes immediately—I do not mean immediately—at the end of the consultation all at once rather than the staged approach that you are planning?
Dr Adshead: One of the questions that we included in the consultation were issues around timetabling, and some of the responses that we got, in fact a large proportion, did argue for introducing all the legislative approaches at once and also argued for bringing forward the time scale, for example, for pubs, but some representatives of licensed premises argued the opposite, that the time scale should be increased for them.
Q26 Dr Taylor: You did say there were four things that helped you to decide: health evidence was one part, public opinion was another, and enforceability was another. What was the fourth?

Dr Adshead: It is about how effective and practical it will be, but essentially, as Nick has already reflected, this is based on health advice and evidence, public opinion, really what was will work and be effective obviously in the government in question, which obviously for us is England.

Q27 Chairman: You mentioned that a figure of 99% would be protected. Is that in the leisure industry or a lot wider?

Dr Adshead: That is based on our definition of “enclosed work places”.

Q28 Chairman: All work places, not just the leisure industry?

Mr Adkin: Yes, if you look at the data on where people work, 99% of people who work in enclosed places, over 99, will be protected completely by this proposal.

Q29 Chairman: Because it will cover all work places. What percentage is covered now?

Mr Adkin: If you ask people: “Is your workplace completely smoke-free?” 51% of people currently say their work place is completely smoke-free, so that will increase that response to over 99%.

Q30 Dr Naysmith: Do you have any estimate of what the proportion is or would be in the leisure industry?

Mr Adkin: We have not got a proportion that covers the sort of basket of all the leisure industry. What we produced in the consultation document was an estimate for pubs, where we estimated the proportion that would fall into the category of not preparing and serving food, where we reckoned it was between 10 and 30%, and the responses from the consultation where they have estimated that have both fitted within that range.

Q31 Mike Penning: Can I take you back to the point you made earlier on to do with the declining tobacco sales in Ireland after the ban. I think most of us saw the reports that were shown there. Subsequently there have been reports, which I wonder if you could comment on, where tobacco sales have started to increase again in Ireland. Is this a trend that we have seen around the world where the bans have taken place, there is obviously an initial decline in tobacco sales and then it starts to pick up again, or is Ireland different from the rest of the world?

Dr Adshead: I am not aware of that. Nick, are you?

Mr Adkin: I am not aware of that data, no.

Q32 Charlotte Atkins: Dr Adshead, you said you were there at the beginning of the White Paper “Choosing Health” and therefore you were very much involved in that. Obviously that paper talks about the health policy being “equality proofed”, and obviously that is the objective of the Government, but do you not accept that going down the road of creating drink only pubs where smoking can happen and also membership clubs that that will increase inequalities? For instance, in my part of the world, if you go to Stoke-on-Trent, the more deprived areas are likely to have drink-only pubs, and they are going to become smoking dens, if you like, whereas if you want to go to another pub that sells food there will be no smoking there. The problem is going to be created that more and more people from lower socio-economic groups are going to end up going into the heavily smoke-laden, drinking-only bars and that is bound to increase inequalities, is it not?

Dr Adshead: You are absolutely right. We are committed to tackling inequalities and, in fact, because we want to make sure, as you say, that things are inequality proofed one of the questions that we asked in our recent consultation was exactly that, for people to comment on the potential to increase inequalities. At the time when we formulated the policy the best available evidence to us then from the Food Standards Agency and from others was that ten to 30% of pubs would fall into the category of being exempted. What has been very helpful, I think, as a result of the consultation is that that British Medical Association and others authors in the British Medical Journal and primary care trusts themselves have done more detailed work and looked into some of the issues around the potential for generating more inequalities. The British Medical Association report pointed out that this may well increase inequalities in health and that this pattern, but not exclusively, would show more of a north/south divide. We have looked at evidence from different PCTs who submitted evidence to the inquiry. For example, in Gateshead and Wansbeck, they estimated that 70% of their pubs would fall outside our definition of “prepare and serve food”; so that has been a very important thing for us to consult on to understand through evidence that people have been able to generate for us since the policy was formulated, and that is something that our politicians are reflecting on at the moment as we formulate our policy statement.

Q33 Charlotte Atkins: From what you are saying PCTs have been giving you evidence. Are the PCTs going to be doing work in their own patches to try to encourage pub landlords and owners to go down the route of banning the smoking?

Dr Adshead: There has been a lot of work round the country obviously in trying to tackle inequalities, in particularly in relationship to smoking and, particularly in the north east of England, we have really excellent smoking services—they are some of our highest performing services—and there they have really put a lot of effort into reaching the most deprived groups. In fact, one of the services we highlighted in the white paper is one where people were given access to stopping smoking services in fact in the pub itself. So a lot of PCTs have been taking action inequalities in smoking already to help people to give up in those most deprived groups that you have highlighted.
Q34 Charlotte Atkins: A former secretary of state for health gave as a reason for having some exemptions the fact that he did not want to see smoking being pushed back into the home, but that does not appear to meet with the evidence from the Royal College of Physicians who seem to say that that evidence does not stack up, that that is not likely to happen. Does that not remove one of the reasons for going down the exemptions route?

Dr Adshead: Certainly my understanding of the evidence—Nick may want to add some more detail—is that there is not any evidence that smoke-free public places legislation increases smoking in the home, but I think it is very important, as I have already mentioned, to take into account that 95% of second-hand smoke exposure anyway occurs in the home; so that when we are thinking about how effective we implement policy to reduce smoking we need to be really mindful of targeting smoking in the home by helping smokers to give up and particularly, as I have already mentioned, emphasise the damaging effect that second-hand smoke exposure can have on children.

Q35 Charlotte Atkins: The former secretary of state was just plain wrong, was he, when he gave that view to our Committee?

Dr Adshead: I think that certainly since . . .

Q36 Charlotte Atkins: He is not in the Department any more, and he is unlikely to come back—he tends to move on to other departments—so you should be free to be able to say that he was just totally wrong, and he was a smoker himself at that time himself I think?

Dr Adshead: There is not any current evidence that would support that view, but I am sure that he based his advice to the Committee on the best available evidence to him at that time.

Q37 Charlotte Atkins: Perhaps based on his own personnel experience at that point. Nick would you like to add anything?

Mr Adkin: I think it is a legitimate concern, and I think it should be raised as a concern because it has some intuitive feel about that if you stop people smoking they will buy their drink in the supermarket and take it home. We know there has been a shift in the pattern of buying drink in Ireland, but that has predated what went on in the ban. The evidence is that generally in England more and more people are making their homes completely smoke-free as work places become more smoke-free as well. So there is some evidence that, even without legislation, the general drift towards the smoke-free happens in work places and the home.

Q38 Dr Naysmith: One of the other exemptions that are proposed in the consultation document is to exclude prisons, residential homes and psychiatric institutions. Is there any rationale behind that and, if there is, can you explain to the Committee what it is?

Mr Adkin: As we have said in the consultation document, there are more difficult human rights aspects around where a place is also essentially somebody’s residence or dwelling. You then have to take a different course of action, and this has been pretty universally the case in international experience in legislating in this area, that there is a desire to exempt these places because (1) there is a human rights aspect, and (2) they are often more difficult to enforce and then you take a more guidance-based approach to dealing with smoking in those places, and then there may be some point in the future where you could extend the legislation to those areas. That is broadly how people have attacked it.

Q39 Dr Naysmith: If we are talking about people’s rights and we are talking about second-hand smoke, not the ability to smoke somewhere an in institution, surely that is a conflict of human rights, is it not: the right for someone to occupy a space that does not include someone else’s smoke?

Mr Adkin: Indeed. The general legal view, and it is reflected I think in all international legislation that I am aware of, is that because you allow people to smoke—if they are not in these institutions—in their home there is a human right read across to this being effectively somebody’s home and there should be some degree of allowance for that. For instance in California I know they have moved to make their prisons completely smoke-free on a progressive basis.

Q40 Dr Naysmith: So why are we not doing it?

Mr Adkin: I think what we want to do is say there should be an exemption and then, with the prison service and with prison health, work out a route forward for dealing with smoking in prisons.

Q41 Dr Naysmith: Is there anything to reduce smoking: a program to progressively provide protection for these sometimes quite vulnerable people, not just in prisons, but in residential homes and psychiatric institutions?

Mr Adkin: There is certainly a big initiative for helping people to quit in these places. Which is right?

Q42 Dr Naysmith: That is not same thing?

Mr Adkin: It is not the same as providing protection from second-hand smoke. There is an intention to do that as much as you can, but there is this central core at the heart of it about the human rights question which at the moment is balanced in favour of the rights of a smoker because it is their home essentially.

Q43 Dr Naysmith: I understand that, but it is also a public place as well for other residents?

Mr Adkin: Yes.

Q44 Dr Naysmith: Is there a time limit suggested?

Mr Adkin: No, there is no time limit suggested.

Q45 Dr Naysmith: Would it be a good idea to do that: set a time limit and work towards it?

Mr Adkin: I think that is being considered in the responses to the consultation.
Q46 Dr Naysmith: One more final question related to something that came up earlier. We were talking about the different countries in the UK having possibly different policies. Does that not seem pretty daft, that we could have a different policy in Scotland, in England, marginally different in Wales and Ireland in a relatively small country or group of islands? Would it not be more sensible for us all to work together to have same policy?

Dr Adshead: I think, more generally, one of the strengths of having devolved administrations is that they can look at the needs of their own population and reflect what is right for them, and I think there are other precedents in policy terms of having distinctive policies. I am not an expert on other areas across a broader policy field. I do not think this would be the only time that there is a distinct and different policy. Obviously it is very important, I think, as we have already reflected, that we all work from the same common evidence base and, as far as practical, we learn from each other’s experiences to make things workable and effective.

Q47 Charlotte Atkins: Going back to the issue of prisons, I am concerned about the situation where you have may be two people in the cell and one is a smoker and one a non-smoker. What is the Department’s policy on that? Are you talking to the Home Office about the issue of people being banged up together and one being a heavy smoker and one being perhaps a non-smoker, and are there any policies in place or any protocols in place to try to alleviate that situation?

Dr Adshead: I think you have identified one of the key issues, and, as Nick has already reflected, we need to balance the competing rights of individuals. Certainly as part of the consultation processes some prisons have written to us expressing exactly those kinds of issues about how they could be protected in communal places, and, yes, we are talking to the Home Office and, yes, in the Department we take prison health seriously, so that we are considering all those issues, and that was why we included that in our consultation so that we could get a really broad range of perspectives and balance up the best way forward for now.

Q48 Charlotte Atkins: Are you anywhere near finding a resolution to this given that it is likely to be case that prisons and psychiatric institutions would be exempted?

Dr Adshead: When the bill is introduced into Parliament, obviously that will be the beginning of our more formal policy-making, but at the moment our policy is to discuss and understand what the issues are around prison health and then to formulate next steps, which will be publicly announced when ministers have made their decision.

Q49 Chairman: Could I ask you a supplementary to that. Obviously the concept of non-enforcement in a prison is difficult for most people to grasp, but I saw on regional television a couple of months ago now that one of the young offenders institutes in Yorkshire has just got a national clean air award because it is a non-smoking prison. Has the Department looked at that as opposed to talking to the Home Office about it, or both?

Mr Adkin: The prison health service is jointly the Department of Health and the Home Office. They have the lead in this area. They are looking at it at the moment. They are looking at the experience in places where they have gone completely smoke-free as well as the issues that have been raised about smokers or non-smokers in cells; so that is being looked at at the moment.

Dr Adshead: Choosing Health highlighted the need to think about improving the health of prisoners, because, as you are aware, they often come from some of the most deprived communities and often have quite significant health issues.

Q50 Chairman: It seems that if a young offenders’ institute could do it, then may be we would see legislation that had a time scale on exemptions, or potentially a time scale on exemptions, but we are not that far down the road yet?

Dr Adshead: As we said, obviously all of this is under discussion, but we are aware of some excellent programmes promoting health within prisons.

Q51 Dr Stoate: Can I ask a very quick supplementary to clarify an issue to Nick? You said something about human rights legislation which cuts across this. Is it not therefore your opinion, or the opinion of your legal advisers, that the human rights of a smoker outweigh the human rights of a non-smoker? Yes or no.

Mr Adkin: I do not think it is as clear-cut as that. Because there are issues. For instance, when a worker goes into a person’s home, who has the greater human right there? Is it the person whose home it is to smoke? If they have someone coming in, say, to fit them for a wedding dress, which is an example that has been brought up in the consultation, whose rights predominate? Is it the smoker’s or the non-smoking worker, for instance, who may come in and be exposed?

Q52 Dr Stoate: To pick up Charlotte’s point, say you have two people living in a cell, both of whom have equal residence status, one is a smoker and one is a passionate non-smoker who has asthma which is finding a resolution to this given that it is likely to be exacerbated by smoke. Who has the greatest human right, the smoker or the non smoker, because it cannot be both?

Mr Adkin: I do not have a legal answer to that specific example. I think what we are looking at is exactly how we take forward smoking in prisons.

Q53 Dr Stoate: I am not just talking about prisons. Prisons is a good example, but I am talking about in general terms, assuming all other things are equal, a non-smoker versus a smoker, who has the greatest human right? You are the one who mentioned initially that human rights legislation gives the smoker the right to smoke in their own home. What about the non-smoker’s right not to have smoke in their own home, all other things being equal?
Mr Adkin: I cannot give you a legal answer that will cover all circumstances. I am sorry.

Q54 Anne Milton: Can you ask why second-hand smoke is being dealt with as a priority given the danger to public health posed by other environmental pollutants around, such as exhaust fumes, and also, is it fair or indeed appropriate to pursue what is effectively a punitive policy against the tobacco industry when the effects on public health of other products made by other industries, such as fast food and alcohol, and there has been a lot about that recently, are subject to much less stringent scrutiny and restrictions?

Dr Adshead: To take the first part of your question, which was about comparing tobacco against other pollutants, one thing we do know is that if you are looking particularly at indoor pollutants, tobacco smoke is probably the one that has the biggest impact on health, and it is very important, because it is entirely avoidable, that we focus on that and that is why we put so much emphasis on that. I cannot answer compared to a whole range of other pollutants in its own environment. I am afraid my policy area does not cover that. I think in terms of how we look more broadly across public health, although this particular select committee is focusing on smoking in public places, Choosing Health itself was a very comprehensive policy that looked at all the major health issues that are facing people in England today. It picked up on key issues around sexual health, around alcohol, around diet, exercise and obesity; it looked at how we need to take a much more comprehensive approach not just to focus on individual risk factors but to think about how people live their lives, the realities about how people live their lives, and the influence on how, as the policy name suggests, that healthy choices are the easier choices, and that that means doing exactly what you suggest. It means looking across the broad environmental and cultural influences on people’s health. Some of the work we are taking forward, of which I will not go into the detail as I do not think it is appropriate for this particular committee, is, exactly as you suggest, to work with the food industry, and we have in place a series of processes at the moment to look at issues like food provision to children and other issues around clearer labelling and other policy work; so it would not be fair to say that the Government does not have a balanced programme on public health, it does indeed, and I think tobacco is a very good example of how we have taken a comprehensive policy approach across an area and we are developing and addressing other public health areas in a similar way.

Q55 Anne Milton: It is just that the tobacco is top of the list. So when you want people to smoke less and you bring in legislation to persuade people to smoke less, we could suggest that everybody is weighed before they go into McDonalds or wherever. The obesity issue is equally as big an issue.

Dr Adshead: We have in the Department six priority areas. We have public service agreements... As a department we are also with other Government departments on some of these key health indicators, and obesity is one of them that we share with two other departments and we have a programme of cross government action on this. I think that if a list exists in that format, we have six priorities and we are as a department working equally hard on all of them, but I would want to emphasise that smoking is one of the key avoidable forms of premature mortality and also morbidity and has a major impact on people’s quality of life in this country.

Q56 Anne Milton: I apologise for going on: the effect of this legislation on reducing the number of people who smoke, if you could give that a figure, how effective out of 10?

Dr Adshead: Against what?

Q57 Anne Milton: Reducing the number of people that smoke?

Dr Adshead: As I mentioned, what we know from international evidence is that 4% overall where there are no other tobacco control policies in place will give up smoking. Because we have got a comprehensive tobacco control policy in this country in Choosing Health, if we increase that, we estimate the prevalence, the number of people or the proportion of people in the country who smoke would drop by 1.7% overall. That is our estimate from smoke-free public places legislation.

Q58 Chairman: Can I just ask you, Dr Adshead, the most recent consultation over the summer, we understand, has come back with more of a call for a comprehensive ban than what the Government’s proposals were. Could you tell us what is going to be done as a result of that and what we are likely to find when the Government is going to be maybe responsible?

Dr Adshead: Obviously our commitment as a result of the consultation was to consider all the responses and then address any changes that we needed to make in the policy. Our ministers are currently considering that, and in the Queen’s Speech we made a commitment to introduce a bill within this session of Parliament.

Q59 Chairman: You have got no further timetable than that at this stage.

Dr Adshead: I am afraid not.

Q56 Anne Milton: It is just that the tobacco is top of the list. So when you want people to smoke less and you bring in legislation to persuade people to smoke
Q61 Chairman: Could I welcome you and could I ask you, Professor Black, if you and your colleagues could introduce yourselves to the Committee?

Professor Dame Carol Black: I am Carol Black. I am President of the Royal College of Physicians. I have been its president for the last three years and two months and one day a week I practice as a Professor of Rheumatology at the Royal Free Hospital. Could I perhaps ask my colleagues to introduce themselves?

Dr Ashcroft: Good morning. My name is Richard Ashcroft. I am Reader in Biomedical Ethics at Imperial College, London, where I work in the Department of Primary Care and Social Medicine.

Dr Edwards: I am Richard Edwards. I am a senior lecturer in public health at the University of Manchester. I originally trained in respiratory medicine, hence my interest in tobacco, and I am involved in tobacco policy-related research, particularly around air quality in the hospitality industry.

Dr Hackshaw: My name is Alan Hackshaw. I am Deputy Director of Cancer Research UK and University College London Cancer Trial Centre. I have been there for two and a half years and previously I was a senior lecturer in epidemiology and medical statistics at Bart’s Medical School where I did a significant amount of work in tobacco and health.

Q62 Chairman: Could I open this session up and ask you to summarise for us the main health effects of second-hand smoke and how important they are for individuals and for public health?

Professor Dame Carol Black: Thank you very much. The main health effects of smoking would be (1) lung cancer, (2) heart disease, (3) chronic bronchitis and (4) stroke. They are the main health risks that we perceive to be of great importance, and we believe banning public places from the evidence from active smoking. If you accept that passive smoking causes diseases, then you must accept that passive smoking is associated with some risk: because if you smoke 10 cigarettes a day, your risk of heart disease or lung cancer or any other number of diseases is going to be less than somebody who smokes 40 per day, and if someone smokes five a day it is less than someone smoking 10 a day, so risk changes with increasing exposure. Passive smoking you can think of as a mild form of active smoking, so it must be associated with some risk. There are many studies on active smoking. There have also been many studies in passive smoking in non-smokers. There are over 50 on lung cancer and they consistently show that the increase in risk is of the order of 25%. Similarly for the studies of heart attacks: they consistently show that the risk is of the order of about 25%. Also chronic lung disease and similar evidence for stroke, although there are fewer studies. Estimates of the number of deaths were published in the BMJ recently by Professor Jamrozik. That was a simple analysis based on various estimates of the prevalence of exposure, people who are exposed to passive smoke, the increase in risk associated with four specific disorders and the number of people who get lung cancer, heart disease, stroke and chronic lung disease each year, and if those estimates are put together in a formula you get a rough idea of how many deaths per year you can expect.

Q65 Chairman: How reliable and robust is the evidence of harm caused by second-hand smoke?  

Dr Hackshaw: First of all, the overwhelming evidence for passive smoking disease comes from a wealth of evidence from active smoking. If you accept that active smoking causes diseases, then you must accept that passive smoking is associated with some risk: because if you smoke 10 cigarettes a day, your risk of heart disease or lung cancer or any other number of diseases is going to be less than somebody who smokes 40 per day, and if someone smokes five a day it is less than someone smoking 10 a day, so risk changes with increasing exposure. Passive smoking you can think of as a mild form of active smoking, so it must be associated with some risk. There are many studies on active smoking. There have also been many studies in passive smoking in non-smokers. There are over 50 on lung cancer and they consistently show that the increase in risk is of the order of 25%. Similarly for the studies of heart attacks: they consistently show that the risk is of the order of about 25%. Also chronic lung disease and similar evidence for stroke, although there are fewer studies. Estimates of the number of deaths were published in the BMJ recently by Professor Jamrozik. That was a simple analysis based on various estimates of the prevalence of exposure, people who are exposed to passive smoke, the increase in risk associated with four specific disorders and the number of people who get lung cancer, heart disease, stroke and chronic lung disease each year, and if those estimates are put together in a formula you get a rough idea of how many deaths per year you can expect.

Q66 Chairman: What is that figure?

Dr Hackshaw: The figure quoted in the report is about 12,000.2

Q67 Chairman: When you use the phrase “simple analysis”, how robust is that from a scientific point of view? Has it stood the test that science does in terms of evidence by being overlooked, as it were, and then . . .

Dr Hackshaw: Everyone wants a precise number, but in most things in medicine you cannot get that, so you have a rough idea of what it may be. We know it is going to be something of the order of a few thousand when you put all these four disorders together. Heart disease is quite common—about 120,000 a year get it—so intuitively there is a feel that you might get a few thousand associated with passive smoking. Similarly for lung cancer: the estimate may be a few hundred. It is difficult to get precise estimates, but the important thing that matters is not precise estimates, it is the order of magnitude of several thousand.

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1 Dr Hackshaw later informed the Committee that the estimate of risk due to ETS comes from studies of non-smokers who were or were not exposed to ETS. There have been many studies of lung cancer and heart disease, but fewer on stroke and chronic bronchitis hence why the evidence is sometimes referred to as less strong. This does not mean that there is no excess risk; it simply indicates that there is some uncertainty over the precise estimate of the increase in risk.

2 Dr Hackshaw later informed the Committee that this includes deaths among smokers exposed to ETS and due to ETS. The number of deaths among non-smokers is about 7,500 and using conservative assumptions it would be about 4,000. These numbers do not include deaths from diseases other than lung cancer, heart disease, stroke or chronic bronchitis, nor do they include a multitude of non-fatal diseases or childhood disorders.
Q68 Chairman: How widely accepted is the science that is underpinning this claims?
Dr Hackshaw: The methodology that underpins the claims is established methods in epidemiology.

Q69 Chairman: Is it questioned by other scientists at all?
Dr Hackshaw: Not that I am aware.

Q70 Chairman: How precisely can we attribute the deaths solely to the effects of second-hand smoke rather than to other environmental or lifestyle factors?
Dr Hackshaw: You are speaking of the risk to an individual. If someone, a non-smoker, has lung cancer and they say they have been exposed to passive smoke, the question is: is that lung cancer due to that person’s exposure to passive smoke? The answer is that you cannot say for certain, but that is as with many things in medicine—you cannot say with certainty there is a risk to an individual—but we do know that with a group of people who are exposed to passive smoke the extra number of deaths or non-fatal diseases would be greater than a similar group that is unexposed, so you are talking about groups of people rather than an individual.

Q71 Dr Taylor: I think I ought to draw attention to my declaration of interests to point out that I am a fellow of this organisation. My reason for supporting this inquiry is really to look at the other side: because the side in favour of a total ban appears to be overwhelming and I hope the inquiry is going to get some evidence from the other side as well to get to a balanced decision. We have already heard that 95% of second-hand exposure occurs in the home. I think it was Dr Adshead who said that. The tobacco manufacturers are claiming that second-hand smoke is small and inconsequential compared to other pollutants, and Dr Adshead really answered that, saying it is indoor pollutants of which tobacco is by far the most important and therefore the strongest; but taking all these arguments, when the number of people affected working behind a bar is going to be small, can we justify the sweeping legislation that you are advocating?

Professor Dame Carol Black: Yes, I think we can. A partial ban will really not be of any help to us at all. The fact is that if we could make those places smoke-free, we would be helping people to give up. We know that. We know that there is that evidence, and you only have to look at the figures now coming out of the Irish experience, of the reduction in smoking, as a result of that policy. Therefore, it results not only in the individual giving up but it results in more smoke-free homes. There is good evidence for that. As it results in more smoke-free homes, it helps the next generation, and our great concern is that children should not be exposed to a smoke environment. Really you are building up a benefit, not only to the individual smoker, but actually within the home. I think that even though the numbers may be small, we absolutely know it is a real risk, and I think that there is no excuse for a partial restriction.

Q72 Dr Taylor: The aim, as has been said before, is to affect the smoking of all the people rather than just to attack passive smoking?
Professor Dame Carol Black: Yes, and I think the other thing is that preventing smoking in public places is the most certain way of narrowing the mortality gap that we see in cardio-respiratory disease between those of high and low income. There is nothing that this government could do for health that would be better than to actually bring in this ban, absolutely nothing.

Dr Edwards: Can I add a small comment. You focused on the small numbers involved if you are looking at the exemptions in the bar staff and so on. If you think about bringing in regulation to prevent a proven occupational health hazard, which this is, say you were looking at low dose radiation: if you were looking at introducing a regulation to proven that exposure, you would usually, I think, look at the people who were most exposed, and if the regulation that came in that exempted people who were most exposed—for example, in the example of radiation you exempted radiographers and you exempted people working in the nuclear industry—that would be a pretty strange regulatory intervention. The present proposal is exactly that, because there is no doubt at all, there is overwhelming evidence, that bar staff are the most heavily exposed occupational group and bar staff in deprived areas, which are the pubs which people have commented on already and we have shown evidence of that as well, the ones which are most likely to be exempted are non-food serving and thesmokiest. What you are saying is that you are having a regulatory proposal where the people at most risk with the heaviest exposure are exempted, and that to me does not make any sense whatsoever. The second thing, it was mentioned about the levels of exposure to exhaust fumes and so on. We are doing some measurements at the moment of particulate levels in pubs around the north-west. If you look at levels of particulates, and the one that is particularly used is PM2.5, which is a particle that goes down into the lungs and so it is a big health risk. If you look at the levels in heavily trafficked roads, you may be looking at levels of 20, 50 micrograms per cubic meter (µg/m³), something like that. If you go into a very smoky pub—and I can show you a graph here, if you like—we have found levels of up to 1400 µg/m³. There is a huge difference several orders of magnitude. So when you are talking about exposure from particles which are known to affect health, and there are plenty of studies to show that particulate matter affects health, some of the places where you get the very greatest exposure is in the indoor environment in smoky pubs, much more than you do from traffic pollution at the road side.

Dr Taylor: That is very, very powerful.

Mike Penning: The point I was going to make has been covered by the previous question.

Q73 Charlotte Atkins: Some organisations would argue that the answer to all this is ventilation and within the home. I think that that can deal with second-hand smoke and that this is far too Draconian a way forward. What is your comment on that?
Professor Dame Carol Black: The only thing you do by improving ventilation, however good your ventilation system is, is you make the air smell rather better, you just circulate the air around, you do nothing to take away the carcinogens in that environment from being present. I think, Richard, you might like to give the figures.

Dr Edwards: It is the same thing. The team that I work with in Manchester have done a previous study looking into about 60 pubs in Manchester and they found that there was no significant effective ventilation on nicotine levels and on particulate levels between the different pubs. They have just done a study in a pub in Cannock which has put in some state of the art filtration equipment. The particulate levels with the filtration equipment switched off were about 800 or 900 µg/m^3, so again much higher than a heavily trafficked road, huge levels. When the filtration equipment was put on the levels were about 500 or 600 µg/m^3. You can say, yes, there is a reduction, maybe 30%, 40%, whatever the figure is, but a reduction to still a very high level is meaningless, and there is no evidence that ventilation reduces the level of carcinogens and the level of toxic components in second-hand smoke to levels which would protect health, and even the ventilation industry and the tobacco industry do not claim that. If you look at their statements about ventilation, they talk about improving comfort, improving the appearance of air quality. They make no claims about health effects. None of them has ever done that, and that is because they cannot.

Q74 Charlotte Atkins: What about the work of Dr Andrew Geens? Are you familiar with his work? I think he comes from Glamorgan.

Dr Edwards: I am, yes.

Q75 Charlotte Atkins: What comment would you make about his work, because he seems to imply that it would make a difference?

Dr Edwards: He has done a study in Manchester in one of the airport hotels there, and it is interesting. A lot of what he presents is percentage reductions, which, as I have said, if the levels are very high is meaningless. The other thing is that in some of the studies that I have seen of his, the point when the monitoring stopped was about eight o’clock in the evening, just as the places are starting to fill up with smokers. I am not quite sure what the reason for that is.

Q76 Charlotte Atkins: Perhaps we ought to ask him. Dr Edwards: As I understand it the funding for a lot his studies comes from the tobacco industry, so it may be there is a conflict of interest there. I think there are an awful lot of other studies by independent scientists looking at ventilation and it has never been shown to reduce levels to an appropriate level to protect health. There are other problems with ventilation. It is very expensive. For a pub it may be five, 10, 15 thousand pounds to install. If you are going to have ventilation, then you have to maintain it. You have to switch it on. In a lot of the pubs in Manchester that our team went round it was not switched on. It may not be working if it is not maintained. You have got to have a regulatory enforcement infrastructure to check that it is working and that it is achieving air quality. If you look at, say, the Public Places Charter, all the things about ventilation are talking about air changes or a supply of air. They do not talk about achieved air quality. That is what we are interested in, because that is what causes the health effects.

Q77 Charlotte Atkins: Presumably, if the air smells a bit better, as Professor Black is suggesting.

Dr Ashcroft: Which it probably does.

Q78 Charlotte Atkins: Then of course it could lull people into a false sense of security. Thank you.

Dr Hackshaw: Having separate smoking and non-smoking areas—as many places have at the moment—also has no effect. You can measure nicotine in the air, which is tobacco specific, and you can measure that in smoking and non-smoking areas and find them to be quite similar, so ventilation or non-smoking and smoking areas do not work.

Chairman: Dr Geens did write a letter to the Committee, not with any hard evidence, as it were, but it is our intention to send him the transcript of the last few minutes and invite him to comment on what has been said.

Q79 Dr Naysmith: I would like to pull out a little bit what Dr Edwards said just now, when he said that ventilation was “useless”. You did use that word, did you not?

Dr Edwards: It has not been shown to reduce levels of tobacco smoke pollutants to anything like a level that would protect against the health effects.

Q80 Dr Naysmith: Presumably it would be possible to get extractor fans which were capable of taking the majority of the pollutants out of the atmosphere, would it not?

Dr Edwards: If you could get the technical fix, but which, as I have said, if the levels are very high is meaningless. The other thing is that in some of the studies that I have seen of his, the point when the monitoring stopped was about eight o’clock in the evening, just as the places are starting to fill up with smokers. I am not quite sure what the reason for that is.

Q81 Dr Naysmith: Dr Adshead told us that there was a linear relationship between exposure to tobacco smoke, whether passively or actively, and predicted backwards from that to the suggestion that passive smoking was going to have an effect as well, plus there are a few not particularly terribly well controlled studies which give the same view. If that is the case, then if you take stuff out of the atmosphere it must have some effect. I am not saying that is the answer, I am not saying it should, but from a scientific point of view I think it is overstating the evidence to say it is practically useless.

Dr Edwards: I said it does have an effect but it does not reduce it to a level at which you would expect it to protect against the health effects and there is no evidence that it does that.
Q82 Dr Naysmith: Does it reduce it at all?  
**Dr Edwards:** Yes, I think it reduces—

Q83 Dr Naysmith: You were talking about a particle that is particularly dangerous. Could these particles be reduced by extractor fans?  
**Dr Edwards:** I would imagine they could be reduced, yes, but if you are reducing from a very, very high level to a very high level, that is not necessarily that helpful and it is not an effective solution to the problem which is the health effects of second-hand smoke.  
**Dr Hackshaw:** The relationship between passive smoking and lung cancer is linear but for heart disease it is not. You only need a small amount of exposure and that gives you your big risk of heart disease. That has been shown in lots of studies of active smokers, as in passive smokers as well.3

Q84 Dr Naysmith: It was lung cancer we were talking about when we were doing the projections.  
**Dr Hackshaw:** Together: lung cancer, heart disease and chronic obstructive lung disease.

Q85 Dr Naysmith: It seems that one of the things the Government are considering is having smoking rooms. This question of having some pubs with smoking rooms and others which are completely clean links into the equality agenda, does it not? Some parts of the country know that if this were to apply, then there would be places which had smoking rooms, and the same applies to the other situation where smoking is banned if you provide food. All of these things would impinge, would they not? It would tend to be in the lower income areas where smoking rooms were allowed or where smoking was allowed.

**Professor Dame Carol Black:** To reiterate, on the smoking room idea: if you have a smoking room, you have a door that is being opened and closed. If it is going to be within the building of the pub, the smoke is going to come out every time the door is opened, and presumably you would have to not have any bar worker in there. The idea that within the confines of a pub you could put a smoking room that would still protect the workers in that pub is not reasonable. I would like to emphasise again that this partial ban would simply disadvantage the poor in this country and it would make the gap between good health for the poor and for the rich even larger. That is something we very much do not wish to see happen.

**Dr Edwards:** Someone has to go in and collect the glasses from the smoking room; someone has to clean the smoking room; so staff are still going to be exposed. I think also the licensing authorities might have something to say about partitioned-off rooms which no one is going into most of the time, drinking—

dens, and what might go on in there, let us say, in terms of drug dealing and things like that, where there is no supervision whatsoever. As Carol said, there is the issue of open doors: if you are going to have a smoking room you have to have quite a complex ventilator arrangement, including, ideally, negative pressure within the room to make sure that there is not contamination within the rest of the pub. That is a pretty complex thing to do and maybe it is not that effective.

Q86 Chairman: You probably know that the Committee is going to Ireland in a few weeks time to have a look there. With regard to this concept of non-smoking and smoking areas and the opening of doors, we understand—and we will see for ourselves—that people stand immediately outside the public house to smoke, and yet people will be going in and out all the time presumably. What is your comment on that?

**Professor Dame Carol Black:** I think that once you are outside in the open air, the smoke and the particles within it are dispersed very, very rapidly. I think that would be true.

**Dr Edwards:** I have not seen evidence on that.

Q87 Chairman: We will ask the questions ourselves, but I wondered if you had any thoughts on it.

**Dr Edwards:** We have talked about smoking rooms. The alternative—and we are talking not about whether people can smoke but where—is that all they have to do is go outside. There is an alternative policy, which is the smoke-free policy. It is simple, cheap, and the experience from Ireland and New York and California and so on is that it is highly effective and very popular.

Q88 Dr Taylor: Turning to ethical issues, Dr Ashcroft, people are telling us that this change is going to be quite draconian, that we are attacking people’s liberty, that we are attacking freedom of choice. I think Howard has already referred to this: How do we balance the rights of smokers against those who should be protected from its effects? Would you talk to us generally about the ethical aspects, to make us feel comfortable with the proposals if we support them?

**Dr Ashcroft:** It is a rather simple idea, first set out most clearly by John Stuart Mill in the mid 19th century, the idea that the main way in which you can justify restricting someone’s liberty is where they are causing harm to others. In the case of smoke-free public places, the policy is clearly about controlling harm to specific vulnerable individuals and groups, rather than being directed coercively, to force people to give up smoking. That the policy may have the foreseen but unintended consequence that people may give up smoking is of course useful from the public health point of view, but it is not really the main thrust of the policy, because justifying a policy which would force people to give up smoking is clearly not something that the public consensus would stand, even if it could be justified on paper. In this case, if what you are concerned about is the welfare of workers in public places and the freedom...

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3 Dr Hackshaw later informed the Committee that the estimated risk of heart disease in someone who smokes 1 cigarette per day is about half that of the risk of someone who smokes 20 cigarettes per day (Law & colleagues. BMJ 1997). This provides strong evidence that low tobacco smoke exposure (ie non-smokers exposed to ETS) will also be associated with a significant risk of heart disease.
of non-smokers to move safely through them without exposure to tobacco smoke and the freedom of children not to be encouraged to take up smoking. Then I think it is relatively clear that a policy that is a ban on smoking in public places meets Mill's test very easily.

Dr Taylor: Thank you for pointing to the difference between attempting to ban smoking for everybody across the country, which would be unacceptable. Thank you, that is very clear.

Q91 Dr Naysmith: If there are two pubs in town and a smoker wants to go and smoke sitting down with his pint, and one of the pubs is a non-smoking pub and the other is not, what is the ethical justification for differentiating?

Dr Ashcroft: Then we start talking about the health of workers and occupational health.

Dr Taylor: I am not talking about that at the moment. I am coming back to it; I am talking about what you were talking about a moment ago.

Dr Ashcroft: The hard case would be the private members' club, where there is a clear justification in terms of freedom of association: if you and I and everyone in this room decided to set up a club where we could go and smoke cigars and tell tall stories, then on the face of it there would be no moral justification for stopping us from doing that. The question would then come in: "What if we were to employ somebody who may have less freedom of choice about whether they"—

Q92 Dr Naysmith: I am not moving there yet. We will come to that in a minute.

Dr Ashcroft: I am not going to overstate the case. If that is what we did and it was our private members' club, then I cannot see a ban would be justifiable on that. It is just that there are no private members' clubs which do not employ people.

Q93 Dr Naysmith: But then—and I am not saying anything more about my personal views—can you not apply the same question to someone who chooses to work in that particular establishment? Do they not have a choice of whether they work or do not work in a smoky atmosphere?—especially at a time when employment is now very high and most people can get jobs.

Dr Ashcroft: Relatively speaking, the kinds of people who are choosing to work in bars are the low paid, who may have particularly few other alternatives. Typically my students, for example, will work in bars to pay their way through college. It is not that their health effects are any less severe just because they are young.

Dr Naysmith: It is an interesting area to speculate about.

Q94 Dr Naysmith: Then we start talking about the health of workers and occupational health.

Dr Taylor: I have a specific concern: elderly ladies, whose one outing a week is to the bingo hall, where smoking goes on. How do we address their concerns?

Dr Ashcroft: I am sorry, you might have to expand a little further.

Q95 Dr Taylor: I am concerned about the little old ladies who live alone, who only get out once a week and they go to a bingo hall. They still smoke. They smoke in their own home, there is nobody else there and they are not causing any harm to them. The fact that smoking is banned in their bingo hall means they cannot go to bingo. How can we counter that?

Dr Ashcroft: I am not sure it does mean they cannot go to bingo; it means they can go to bingo and nip out every so often for a cigarette.

Chairman: I have a picture in my mind of somebody standing outside with their bingo card. It is probably not going to work, in that respect! We could pose that question to some witnesses we are having later on in this inquiry.

Dr Naysmith: Good idea. There are many occupational hazards in everyday life. Many jobs have particular hazards attached to them: car mechanics, for example, who might be exposed to diesel fumes whilst working in their car plant;
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Building workers exposed to cement dust. In other words, many jobs do have a particular hazard with them. Obviously health and safety legislation is designed to reduce that hazard as far as possible. As employment, generally speaking, is a free occupation—you either choose to work in a particular sector or not—can it not be argued ethically that bar staff know what they are letting themselves in for when they apply to be a bar worker, and, ethically speaking—and I am not talking about health effects now—does that not act as a defence? The industry might say: They freely chose this job, therefore we do not have a moral duty to be so concerned about their health as we might be if they were forced to do that job.

**Dr Ashcroft:** It is an important argument and one that has been raised throughout the history of workplace health and safety legislation. One important point is empirical: Do people actually know the level of risk to which they are supposedly consenting?

**Q100 Dr Stoate:** The same applies to a car mechanic. Does a car mechanic know the effects of diesel fumes? The answer is that nobody really knows the effect of diesel fumes. The unknowables are unknowable. That does not change the moral argument.

**Dr Ashcroft:** No, you are quite right. Another part of the argument would be the relative risk to which people are choosing to assent: the relative risk of inhaling diesel fumes day and night; the relative risk of inhaling cement dust; the relative risk of inhaling tobacco smoke particles—and I defer to my colleagues on that; perhaps they can help me on this one. In terms of the choice that someone makes about assuming a particular employment, a lot of factors go into it and sometimes people are making decisions which are, all things considered: “Well, it is the least-worst option for me.”

**Q101 Dr Stoate:** That applies to all employment.

**Dr Ashcroft:** Well, it applies to some employment. There will be some forms of employment where people specifically choose them because they like taking a particular risk. They might join the Fire Service because of the danger and also because of the public service aspect. You could say the same about joining the Armed Forces, for example—another context where people do heavily smoke, as it happens. I do want you to distinguish between areas where people are voluntarily assuming a risk for that risk’s own sake and areas where people are assuming a risk as a side-effect of their principal reason for taking up an employment. Where people are taking on employment for reasons of lack of suitable alternatives or a straightforward need to address some short-term need for money as opposed to long-term considerations of their own interest, those are the sorts of cases where we have always considered that workplace health and safety legislation is justifiable.

**Q102 Dr Stoate:** From a purely moral ethical standpoint, you are satisfied that there is no defence; that workers know what they are letting themselves in for and therefore that cannot be used as an argument against this legislation. I am not talking about health at all—that is a separate issue—but specifically about the ethical issue and the ethical duty we have to the workforce. You think that is a non-justifiable argument.

**Dr Ashcroft:** I think, taking all things together with the other arguments in favour of a ban on smoking in work places, it is not a compelling argument. It makes sense to some extent, but it does not at the end of the day trump the other arguments.

**Dr Edwards:** There is also the other argument about how easy it is to deal with an occupational risk. In this case we have a very simple way of dealing with it: you make the workplace smoke-free, and the occupational risk is taken away. There is also the question: Are you excluding people from the workplace? For young women who are pregnant or at risk of becoming pregnant, there is a clear link between passive smoking and effects on pregnancy. For people with angina, which is worsened by passive smoking, or people with asthma, is it an ethical, allowable thing that we exclude certain people from the workplace?

**Q103 Dr Stoate:** Ethically, it is about testing things to destruction. I would argue that we should not have garages: we should have all car mechanics working in the open air because that way you would remove the effects of inhaling diesel smoke and, therefore, we have a duty to take the roof of all garages in the country. If you test ethical arguments to destruction, you do get some very strange situations arising. That is why you have to look at the practical, reasonable argument.

**Dr Ashcroft:** There is a practical reasonable alternative here, which is to make working places smoke-free.

**Dr Stoate:** Thank you.

**Q104 Charlotte Atkins:** Turning now to the economic impact of a comprehensive ban, your reports suggests there will be an overall economic gain of something like £4,000 million per annum. How do you come up with this figure? What evidence do you have for it?

**Professor Dame Carol Black:** I think, if I am right, on the economics and the figures it was Dr Godfrey who put together that evidence. We had hoped she would be here with us today. I am sorry she is not. But I could get that information.

**Q105 Charlotte Atkins:** If you could send us a note.

**Professor Dame Carol Black:** Absolutely. I do apologise.

**Q106 Charlotte Atkins:** We particularly want to know what the impact of a partial ban on those figures overall would be, and also what the impact would be if we continued the exemptions of private members’ clubs, for instance.
**Professor Dame Carol Black:** You would like a breakdown.

**Q107 Charlotte Atkins:** If you could.

**Professor Dame Carol Black:** Most certainly, we will.

**Charlotte Atkins:** Rather than questioning you on something you are not in a position to deal with. Thank you very much.

**Q108 Anne Milton:** There are issues around pubs and community life. The village pub is the mainstay of the community. Particularly in some rural areas, it is the heart of the community. If you ban smoking in licensed premises, people will smoke at home, which will cause the community to break up. There are also issues around young people, that if they want to smoke, they will be outside in parks, as we have already seen this summer. They will be outside, drinking there, and it will increase anti-social behaviour. I would be interested in your comments on that. I am sure you would like people to go to the pub and not smoke, but there will be some effects.

**Dr Edwards:** If you look at the evidence from around the world, and particularly from Ireland, where you have these pubs that are at the heart of the community, the world has not stopped because pubs have been made smoke-free. The pubs are still very popular, the communities are still together. I have been to Dublin and the pubs are vibrant and people are happily smoking outside. There was a survey from Ireland released this week about the popularity of the measures one year on, and this is overwhelmingly popular, even with smokers. With non-smokers, it is 98% or something. What about the people who were previously excluded from those pubs because they were very smoky? Are they not becoming more community orientated, because non-smokers, who previously did not want to be exposed to that, now feel able to go to those pubs? With respect, there is no evidence for that, and it is probably the other way round.

**Q109 Anne Milton:** What about young people drinking and smoking outside? They will not go to the pub any more because they want to have a cigarette and drink. They will drink in public places and smoke in public places and it will increase anti-social behaviour.

**Dr Edwards:** Young people, like other smokers, can smoke outside the pub. I do not know that there is any evidence whatsoever that in Ireland, for example, because of this legislation, young people are more congregated in the parks and drinking.

**Q110 Anne Milton:** You look very puzzled. You should not look so puzzled. I am sorry, you should not look so puzzled, because if you came to my constituency you would see exactly that there is an issue.

**Dr Edwards:** I am sure there is an issue. I do not think this legislation is going to—

**Q111 Anne Milton:** Make it any worse?

**Dr Edwards:** If smoke-free legislation came in, that it would make it any worse.

**Dr Hackshaw:** You have two very different environments which show it works. Rural Ireland, as you have just commented, and the centre of Manhattan. A smoking ban has worked in both those environments quite well, I understand. We are behind here in implementing these bans, We are fortunate to have evidence from these other countries to show that it does work, and effectively so, and that you do not lose customers and also you do not lose revenue.

**Anne Milton:** This is an important question, because we have all had letters, particularly from rural communities, about this.

**Q112 Mike Penning:** The first thing I would like to say is that the questions we are asking, especially from us new people on the Committee, are not necessarily our views, but just the Committee trying to get as much information as possible. Would a complete ban on smoking in licensed premises encourage more people to follow this trend of drinking and smoking at home, thus endangering, as we were talking about earlier, the younger people whom we want to protect? If we have more people smoking at home, then the children will be adversely affected.

**Professor Dame Carol Black:** The evidence of smoking is the opposite, that more people do not smoke at home. If you make public places smoke-free, then there is good evidence that the amount of smoking decreases and that more people wish to make their homes smoke-free. Contrary to what we perhaps thought and was perhaps thought by the previous Secretary of State for Health, that is not what the evidence would show. I am sorry, I do not know about the article, but, certainly from a smoking point of view it will have a beneficial effect rather than a negative effect.

**Q113 Mike Penning:** The Department earlier on were saying that they think there would be a reduction of about 4% in smoking if a ban went ahead. That would still leave an awful lot of people smoking. If they are not going to be smoking at work and they are not going to be smoking in the pub, they are going to be smoking somewhere, and it is not always going to be in the garden shed.

**Professor Dame Carol Black:** I do not think they necessarily will be smoking somewhere. If you combined any policy, any new legislation with very, very good support for giving up smoking, helping people to stop smoking, I do not think they are necessarily going to be smoking somewhere. Most smokers want to give up. That is known to be the fact. If smokers want to give up, you really put a lot of effort and energy into providing them with all the facilities to give up and you add on top this legislation, and then I think we would see a decrease in smoking, not the opposite.

**Dr Edwards:** In the first Royal College of Physicians’ report, which was called _For Smoke-Free Public Places_ it said it may well help in reducing passive
They are asking about the proportion of homes that are smoke-free, and the evidence shows that it is increasing. Therefore, it is not acceptable and that is why we are doing it,” then you are probably less likely to go and smoke in your own home in front of your own children. It is not a great leap in logic, and that seems to be borne out by the evidence.

Q115 Mike Penning: Most smokers are aware of the damage they are doing; they just carry on smoking. Dr Ashcroft: I think most people may be able to rationalise their own smoking but do not particularly want to hurt those closest to them. That would be a more powerful reason for them.

Q116 Anne Milton: From this point of view, when a ban is introduced, more homes become smoke-free because people give up. Dr Edwards: Because people give up and because the people who continue to smoke are more likely to say, “I don’t want to smoke in my home.”

Q117 Anne Milton: Do you know how that splits up? Is it mostly due to people giving up or is it mostly due to the fact that they decide it is inappropriate to smoke?

Dr Edwards: We have evidence from Boston, from Australia and now from Ireland—and there is some evidence from the UK, although obviously there has not been a ban here—about the proportion of homes of smokers that are smoke-free. We have that evidence. We also have evidence of the number of households which have a smoker in them. On both counts, say in the UK, that has been reducing, so the number of households with a smoker is reducing.

Q118 Mike Penning: How much are we talking about?

Dr Edwards: The proportion of homes that are smoke-free which have a smoker in them I think increased from about 22 to 37%.

Q119 Mike Penning: We have not seen any evidence of that.

Dr Edwards: The evidence is in the report.4

Q120 Anne Milton: Presumably that is self-reported. If you introduce a ban, everybody feels guilty to do so, and they then start lying when you ask them what they do.

Dr Edwards: It is self-reported, but if you look at the non-self-reported measure like the cotinine levels in children, which is a metabolite of nicotine and is a good indicator, that has approximately halved over the last 20 years or so in the United Kingdom for that is in this report. The exposure of children, who are very largely exposed in the home—that is the main exposure—has been reducing. That is borne out internationally as well.

Q121 Chairman: Who gathered the evidence in Ireland?

Dr Edwards: One of the main papers was written by Shane Allright, who I think is employed at Trinity College, Dublin. I think it was an independently commissioned research. I would have to check on that.

Q122 Chairman: We will have a look at it.

Dr Edwards: Two papers have been published this week on the Irish experience.

Chairman: Those we have not seen.

Q123 Dr Taylor: I think you said, Carol, that most smokers want to give up and there is evidence of that. Is the evidence in your report? Where is that evidence?

Professor Dame Carol Black: I do not think it is in there. There is literature.

Dr Edwards: It is in Smoking-Related Behaviour and Attitudes survey and maybe, in the Health Service for England, I am not sure. However, there is nationally available data, which has been available year on year, showing that most smokers want to give up.

Q124 Dr Taylor: Presumably that does not apply to the teenagers who are taking it up still pretty heavily.

Dr Edwards: A large proportion of them express the wish to give up as well.

Dr Hackshaw: That estimate is not across the board. It will vary according to age group, I imagine.

Dr Taylor: Yes. It would be nice to see that, because it is the teenagers who many of us are particularly bothered about.

Mike Penning: Especially amongst teenage girls, who seem to smoke for other reasons, not least their weight. I am experiencing this at home at the moment.

Q125 Dr Naysmith: Professor Black, the Government in its consultation paper raises the possibility of exemptions for certain long-stay institutions such as residential homes, prisons and 4 Going smoke-free: The medical case for clean air in the home, at work and in public places. A report on passive smoking by the Tobacco Advisory Group of the Royal College of Physicians, ISBN: 1860162460, July 2005.
psychiatric institutions. I think the ground they argue for is that it is an ingrained part of the culture of these institutions and that a ban on smoking in situations like that could have a very drastic and perhaps adverse effect on the lives of the people in these institutions. That was not quite the argument that was put this morning from the representatives of the Department; nevertheless, you reject the Government’s arguments on this. Why is that?

Q126 Charlotte Atkins: Yes. We would like a comprehensive ban. We would like to be pragmatic perhaps about individual cases, but we think we would be better to have a comprehensive ban. We would take entirely the point that was raised in the earlier discussion, that in a prison you may have a very heavy smoker in a room with a non-smoker. We would prefer most definitely in the situation of a prison—and perhaps it might be difficult to do—that you would have, if necessary, a smoking area—and I can appreciate that the logistics of that are not easy—but that we should have a comprehensive ban and then we should address with the relevant services how we might have to accommodate perhaps individual cases.

Q127 Dr Naysmith: What do your colleagues in the psychiatric profession think? Have you had discussions with them?

Professor Dame Carol Black: We have not had discussions. We do know that in psychiatric institutions we do have a problem with a higher rate of smoking in the staff, both the nursing staff and, I believe, the medical staff. That is obviously something that is of considerable worry to us. We would still say that it should be comprehensive and then we would hope to deal—

Q128 Dr Naysmith: What sort of mechanism could we use in rest homes and psychiatric institutions?

Professor Dame Carol Black: One would have to think somehow of providing a smoking area that is distinct or separate from the home or the institution. I do not think any of these things are easy, but, if you start from the premise that you will have exemptions, it becomes incredibly difficult I think to do it that way.

Q129 Chairman: Obviously there are some psychiatric institutions where people are in there by force of law, as indeed prisoners are in there by force of law as well. What are the practicalities of having a shelter or a place to go to smoke under those circumstances?

Professor Dame Carol Black: I see the difficulties but I think it is up to those institutions. They have to deal with lots of problems, they would have to come to some arrangement for this. I do not think any of these things are easy, but I would have thought we ought to be able to provide some area that is separate from the main buildings. I agree that with staffing and all the problems it is not easy, but I think it would be much better to go for a comprehensive ban.

Q130 Chairman: Is there a case for more smoking-cessation programmes in institutions like prisons and other long-term institutions?

Professor Dame Carol Black: We would like maximum effort put into these types of institutions. I would echo what Fiona said, that in this country we have done very well with the programmes that we have, and for a time you might have to concentrate particular effort in these institutions to try to help them get over what might be a somewhat bumpy period.

Dr Edwards: I think it should be possible to provide secure outside areas, so smoking can still occur outside in the usual way. But, as Carol said, whenever you introduce a policy like this you must do it with providing smoking-cessation support. That is absolutely crucial. As was heard in the Department’s evidence, there are examples of smoke-free prisons in the UK, and certainly in California, and there are examples of smoke-free residential mental health care institutions. One of the institutions in Norfolk has gone smoke-free, and I am sure there are others as well. There are some practical problems, but the principle must be to protect the staff and non-smoking other residents from an unacceptable health hazard.

Q131 Chairman: In the prison I mentioned earlier, the smoking shelter for staff and prisoners is within the boundary walls, as it were, or fences of the institutions. It may be the case that it would be difficult for a complete ban to take place at some institutions. Clearly that is something that would need to be addressed. It might be physically impossible under some circumstances to have that.

Q132 Chairman: If there are no further questions, could I thank you all for coming along to give evidence to the Committee this morning. We will look forward to the further evidence that is going to be submitted.

Professor Dame Carol Black: Could I say, if this were to come in, you would almost complete the report that was first published by the Royal College of Physicians 50 years ago.

Q133 Chairman: Only 50 years!

Professor Dame Carol Black: Our recommendations—and we have moved through them over 50 years—could be complete.

Chairman: There was a dispute about the science a little bit more then than there perhaps is today.
Witnesses: Dr Steve Stotesbury, Industry Affairs Manager and Chief Scientist, Imperial Tobacco Ltd (UK), Ms Christine Mohrmann, Head of UK Corporate Affairs, Philip Morris Ltd, and Mr Barry Jenner, Director of UK Business, Gallaher Group plc, examined.

Q134 Chairman: Good morning. Could I welcome you and thank you for facilitating this earlier start than we originally planned for your evidence session. I do not have to introduce the Committee. Dr Stotesbury, I wonder if you could introduce yourself, and if your colleagues could as well for the record.

Dr Stotesbury: I am Dr Steve Stotesbury and I am Industry Affairs Manager for Imperial Tobacco and I am a qualified analytical chemist.

Mr Jenner: Good morning. My name is Barry Jenner. I am the Managing Director for the UK Business Division for Gallaher Group plc.

Ms Mohrmann: My name is Christine Mohrmann. I am the Corporate Affairs Manager for Philip Morris Ltd. Philip Morris Ltd is the affiliate of Philip Morris International in the UK.

Chairman: Thank you very much. My colleague is going to apply to inhaling second-hand smoke?

Dr Stotesbury: No.

Q135 Dr Naysmith: Dr Stotesbury, you state in your memorandum that you submitted to the Committee that the scientific evidence for the harmful effects of second-hand smoke is “flawed” and that the risk to non-smokers of second-hand smoke is small and impossible to measure. What evidence do you have to support that?

Dr Stotesbury: I would like to say from the outset that I do not feel the evidence is flawed. I do not think I said that in my submission.

Q136 Dr Naysmith: I think that is a quote. It may be that it is somewhere else you said it.

Dr Stotesbury: I believe that the scientific evidence, if you take it as a whole—and that includes the lung cancer, heart disease and chronic bronchitis—is currently insufficient to establish that other people’s tobacco smoke is a cause of any disease.

Q137 Dr Naysmith: You think the Royal College and the Scottish Executive have got the science badly wrong, in that they believe the evidence does—as you just heard from the previous session.

Dr Stotesbury: Yes, I heard what was said in the previous session. I believe to date there have been something like 70 different epidemiological studies on the effects of environmental tobacco smoke and lung cancer and around 30 in relation to heart disease. The vast majority of those failed to come to any statistically significant conclusion as to the relationship between ETS (environmental tobacco smoke) and disease. A few, a small minority, have come to the conclusion that there is an increase in risk and association between ETS and disease, but a few have come to the opposite conclusion. The vast majority have been inconclusive.

Q138 Dr Naysmith: What about the suggestion that was given in evidence in the previous session that, predicting backwards from the known effects of inhaling tobacco smoke directly, gives you almost clear evidence that it is bound to be true that passive smoke causes some harmful effects? I took that to be one of the things that was said previously.

Dr Stotesbury: Yes, that was one of the things that was said.

Q139 Dr Naysmith: What do you think about that?

Dr Stotesbury: I disagree with that.

Q140 Dr Naysmith: You must be aware of the history of direct smoking and inhaling tobacco over the years. People have denied, your industry has denied, that it had any effect, and then there was an accumulation of evidence and an accumulation of evidence until it is now impossible for anyone to maintain that smoking tobacco does not cause a variety of diseases. Do you not think the same thing is going to apply to inhaling second-hand smoke?

Dr Stotesbury: No.

Q141 Dr Naysmith: Is that not the most likely outcome of the current observations? Would it be right that you are trying to hold the tide back?

Dr Stotesbury: No, I do not think so. In fact, I think some of the most recent studies have been the most convincing in terms of throwing some doubt over the relationship between ETS and various diseases. I would point particularly to a study that was published in the British Medical Journal just two years ago by Enstrom and Kabat, which was a major study of over 120,000 Californians over a 40-year period. The authors found that the association between ETS, lung cancer and heart disease was considerably weaker than generally believed.

Q142 Dr Naysmith: They did not find that it did not exist. They may have suggested that it was weaker than had previously been suggested.

Dr Stotesbury: They found absolutely no difference between groups exposed to environmental tobacco smoke and control groups. There was absolutely no difference at all.

Q143 Dr Stoate: You have made some very strong statements. You say there is no statistical link between these diseases and environmental tobacco smoke, but there is extremely strong evidence in children, for example, of cot death, glue ear, respiratory diseases that can be very closely linked to cotinine levels in families, and this is very compelling evidence. For you to say there is no statistical evidence I think is misleading.

Dr Stotesbury: I do not think I said there is no statistical evidence.

Q144 Dr Stoate: You did say that.

Dr Stotesbury: No. I said the statistical evidence, taken as a whole, is inconclusive.

Q145 Dr Stoate: You cannot take it as a whole. I am talking about children’s health. I am talking about cot death, glue ear, respiratory illness. You cannot say there is no statistically compelling evidence that
those are attributable in large measure to environmental tobacco smoke. There is a very, very close relationship.

Dr Stotesbury: If you listened to the previous evidence session, even the people giving evidence were only talking about risk in association with lung cancer and heart disease.

Q146 Dr Stoate: They were looking at the big four killers in adults. I am specifically focusing on the health effects on children. You have said there is no compelling statistical evidence and I am saying that actually there is, and, with children in particular, the evidence is very strong.

Dr Stotesbury: I heard them say there is not much evidence on other diseases.

Q147 Dr Stoate: You are a scientific officer. You are a trained person. Are you saying they got it wrong? Are you saying they misled us? Are you saying the evidence has been interpreted wrongly? I am not clear exactly what you are saying.

Dr Stotesbury: I am saying there is insufficient evidence.

Q148 Dr Stoate: I have to disagree to that. I think particularly with children there is evidence. We will ask our advisers to produce some strong evidence for us.

Dr Stotesbury: Could I refer to a study by IARC which was published in 1998 which specifically looked at that question you raise, disease in relation to children. Whilst they found a statistical association in adults that was non-significant—and I can explain that certainly, if you like—they found no evidence at all of any childhood exposure and disease.

Q149 Dr Stoate: We will certainly ask our advisers to get that paper out for us and we will look at that.

Dr Stotesbury: I can send you that paper, if you wish.

Dr Stoate: That would be helpful.

Q150 Chairman: Dr Stotesbury, have you read recently in the BMJ that Winkel et al found a highly significant risk of heart disease. It is allegedly a good study in that respect. Have you looked at that evidence at all?

Dr Stotesbury: Yes, I have looked at that evidence.

Q151 Chairman: Do you think that is not significant?

Dr Stotesbury: I said earlier on that the vast majority of the scientific evidence is not flawed. I think that paper in particular is. They took blood samples that were 20 years old from the deep freeze, and looked at responses to questionnaires recalling over that time. I think you have to call some of that method into question.

Q152 Chairman: Could I say for the record that in the written evidence that will be published today you did use the phrase, “based on flawed science”. So “flawed” was a word that came out of your memorandum and not out of the office of this Committee. Could I move on now to Ms Mohrmann. You say in your memorandum that you accept the need for some restrictions on smoking in public in order to protect non-smokers from the harmful effects of second-hand smoke. Do you believe that ventilation can provide adequate protection for non-smokers and employees in the smoking environment? If you do, what evidence do you have for that?

Ms Mohrmann: We believe that ventilation is a solution for creating a comfortable environment. We do not believe ventilation should be the basis for regulation. However, it should be an option that a business owner can consider if they are going to allow smoking within their establishment.

Q153 Chairman: Do you have evidence of that?

Ms Mohrmann: We just think it is a solution for creating a comfortable environment. We do not believe ventilation should be the basis for regulation. However, it should be an option that a business owner can consider if they are going to allow smoking within their establishment.

Q154 Chairman: I accept that very well, but the issue around smoking and its harmful effects and everything else—and you are familiar with it because you are a lot closer than certainly most of us in this room—is more scientific than “think”. We have tried, with different witnesses in this session this morning, to get to the science of it. You think that ventilation might be better or do you have any hard study that has been done in relation to ventilation?

Ms Mohrmann: We believe it is up to the business owner to decide what is best to accommodate their customers, smokers and non-smokers. Ventilation may be a solution. We also think that signage, for instance, is very important. It communicates the policy that that establishment has and we also believe that Government should also require on that signage that government and public health officials have concluded that second-hand smoke is harmful to non-smokers. This way, anyone entering an establishment can then make a decision about whether they want to frequent it or not.

Q155 Dr Naysmith: You said it provides a more comfortable environment. Is that not the case? That is what you said, is it not?

Ms Mohrmann: Yes.

Q156 Dr Naysmith: It was not that it had any effect on reducing incidents of any kind of disease or anything, it was that it created a more comfortable environment for patrons.

Ms Mohrmann: Yes.

Q157 Dr Naysmith: That is what you said.

Ms Mohrmann: Yes.

Q158 Chairman: Mr Jenner, do you have any views on ventilation?
Mr Jenner: Yes, Mr Chairman. We welcome the opportunity to participate in your deliberations. Our view is that ventilation does have a role to play. It would seem to us that it is commonsense that ventilation is better than no ventilation. It is a mechanism that is widely employed in other Member States in the European Union. Our company, through the BSRIA (Building Service Research Information Association) and other tobacco companies, is engaged to better understand the benefits of ventilation in a controlled environment. We would quote this as an example where we try to work with the hospitality associations, as we have done through the AIR Campaign (Atmosphere Improves Results). In our fundamental view, it is about getting rid of the smoke and not the smokers. In this way, we can support the notion that we can balance people's responsibilities with their freedoms.

Q159 Dr Stoate: Are you saying that ventilation is about adequate protection both for non-smokers in establishments and employees? The evidence we have heard this morning on BM2.5 from the Royal College of Physicians entirely contradicts that. They would say, and I believe Mrs Rawlins said the same, that it improves comfort and the perception of a clean atmosphere. Does it provide adequate protection for non-smokers and employees? Yes or no.

Mr Jenner: I do not think it can be summed up as easily as that, because I do not think I used the word “adequate”. I was at pains to share with you that I do not think it is fully understood, the benefit. Our view is that it is commonsense that to have ventilation is better than none.

Q160 Dr Stoate: I am not saying it does not work. Mr Jenner: It meets the threshold that passes the needs and preferences of people in other Member States. We are trying, with our investment in the study—and we would look to be able to work with Government, because we think that is important in trying to develop practical, meaningful solutions that do not discriminate against workers—to understand and work with them to establish an air quality standard, perhaps, that could be widely adopted and employed so that those aims could be adequately achieved without discriminating against those 12 million adults in the UK who, after all, do make an informed adult decision to smoke tobacco products.

Q161 Dr Stoate: Surely the only adequate protection for employees is one that reduces their risk pretty much down to the backline level. We have heard that ventilation just does not achieve that. Are you saying that those studies are wrong and that ventilation does achieve the atmosphere to which workers are entitled?

Mr Jenner: I did not say that study was wrong and I am not saying that this study you have in mind is wrong either. Clearly, as far as employees are concerned, it is the case that 88% of the workforce in the United Kingdom are already covered by restrictions and regulations that establish a very clear smoking policy in the workplace. There are only 8% of employees in the United Kingdom who are not covered at all by such a policy. The 4% difference, I understand, being the self-employed and people who work outside.

Q162 Dr Taylor: Ms Mohrmann, you talked about signage. Is there any evidence that signage works? The Government have health warnings on packets of cigarettes. Is there any evidence that those have any effect?

Ms Mohrmann: It is about providing information to a consumer for them to be able to make their own decisions about whether they enter into an establishment. We think it is very important that the Government continues to communicate the public health messages on smoking in public places and in general on tobacco related issues.

Q163 Dr Taylor: Has there been a reduction in smoking generally since the Government put the health warnings on packets?

Ms Mohrmann: I think you have to take into a lot of consideration the many factors that could impact, let us say, smoking rates within the country. Health warning labels may be one of those factors, but there are certainly a lot of factors to take into consideration.

Q164 Anne Milton: Do you support the Government in its aim of reducing both the number of people who smoke and the number of cigarettes that smokers smoke?

Mr Jenner: We support the Government in the aim of providing information for people to be able to make informed choices. As referred to, the advent of health warnings in 1971 certainly illustrates that, and we have worked with Government to safeguard their overall strategy. We are concerned with recognising that 12 million people still choose to smoke tobacco products, whilst we support the Government in its aim to seek a solution that talks about restriction rather than bans, and to work with them. There are many facets of the proposals that our company support. We support the notion that people should not smoke at the bar area in front of bar workers, for example. We support the notion that adult smokers should be courteous, considerate and employ commonsense: they certainly should not smoke around very young children, for example. We agree with the point about signage, both externally to the venue and internally, so that people have the information as to the smoking policy. There is a raft of aspects of the proposals as being deliberated here today that we support, but it is the case that the UK duty paid market has contracted in the UK every year since 1973.

Q165 Anne Milton: But you would be happy if people smoked less.

Mr Jenner: I think it is a situation where we are happy that people can have the right to enjoy, whatever situation they are in, the right to smoke a cigarette should they so choose. That is why, for
example, our view is that the provision of separate areas is a sensible and practical way forward. That seems to us to strike the right balance between responsibilities and freedoms and in our view an outright ban is not really necessary to achieve the Government’s goals.

Q166 Anne Milton: Could I ask you Dr Stotesbury and Ms Mohrmann your views, please?
Dr Stotesbury: We recognise that other people’s tobacco smoke can be annoying. It can lead to concerns of health. We would support the Government in restrictions, but we do not believe that that necessitates an outright ban. We think there are practical solutions which allow choice and that is what we would support.

Q167 Anne Milton: So your issue is bringing choice into it.
Dr Stotesbury: Absolutely.

Q168 Anne Milton: Rather than legislation.
Dr Stotesbury: I think you can achieve it through legislation or through voluntary agreement and I would argue that the voluntary agreement that we have seen in place between the Government and the hospitality sector over the last six or seven years has in fact delivered an amount of choice. There is much more provision of non-smoking pubs and segregation of smokers and non-smokers, and I think that is a good thing.

Q169 Dr Stote: You say that voluntary agreement can work. It certainly did not work with advertising, which is why the Government in the end had to legislate. The voluntary codes which were set up with the tobacco industry over very many years failed to deliver. That is why the only argument was to go down the legislative route, which did produce results. The tobacco industry does not have a good record of voluntary codes being effective.

Dr Stotesbury: As I said, this agreement was with the hospitality sector. I believe that it worked extremely well.

Q170 Charlotte Atkins: What evidence can you give this Committee that that voluntary approach actually worked?
Dr Stotesbury: Under the voluntary approach, it was all about targets of signage, as Christine has said, and provision of non-smoking areas/smoking areas within that. They were all met within the given timeframe.

Q171 Charlotte Atkins: How many outlets were affected by this? If you could give us the detail on that, unless you have it in front of you now.
Dr Stotesbury: I do not have the detail in front of me now.

Q172 Charlotte Atkins: We do need to have that. You are saying the voluntary approach works. We are being told by our advisers that that is certainly not the case. The Public Places Charter scheme was introduced by the Smoking Kills White Paper in 1988 in order to control smoking in public places, but the charter targets were not met according to our evidence and nearly half the licensed premises which were charter compliant allowed smoking throughout the whole public licensed area. If that is the case—do you dispute those figures?—then clearly it did not work.

Mr Jenner: The data the DoH required showed that where effective smoking policies were in place in premises, through the work that we had done, together with the hospitality interest, increased in 1995 from 15% of all establishments to 63% in 2003, concluding that that figure would have been even greater in 2004. That was data collected by the DoH itself. I think we refer to that specific study in the submission to which we are a party through the TMA. I think you will find the detail in there. For smoking areas throughout the target, it is my understanding—although we will certainly check with your permission, Mr Chairman—those set standards were met and were met by some margin actually.

Q173 Charlotte Atkins: You are saying 63%, so over one-third were not compliant.
Mr Jenner: I think it just demonstrates the terrific strides that can be made in a voluntary approach. As I mentioned, it is clear, although the DoH data is not available for 2004, that for sure it would have been exceeded in 2004. All I am saying is that the move from 15 to 63% demonstrates how significant and great strides can be made by working in partnership with all the stakeholders.

Q174 Charlotte Atkins: That may well be the case but you always come back, do you not, to the hard core. In earlier evidence I was disputing that if you have exemptions then you are going to have a situation in inner city areas, for instance, where you have drinking-only pubs that become cancer dens effectively. You may well have got it to 63%, but, usually, when you have a voluntary approach the easy targets are met first. How do you progress that using the voluntary route to hit the hard targets? How are you going to find the over one-third who were not complying? How do you then move it on? How does the voluntary approach do that?

Mr Jenner: I think our view slightly earlier on was that there can be a balance between responsibilities and freedoms and not bans. We are in favour as a company of further restrictions. That is why we do prefer the solution which accommodates not only a minority but a significant tranche of the population, wherever they are domiciled, so that they can enjoy their pleasures, whether it is a drinking den, or whatever the phrase you used was, or a country establishment in rural wherever. I think the provision of separate designated areas where there is information available to all to make a judgment, an informed choice, seemed to us to balance those responsibilities and freedoms that I guess all of us hold dear.
Q175 Charlotte Atkins: How do you move it on from the 63%? That is the easy target. What about the over one-third who are not complying? This is since 1998. Presumably we have now hit a plateau. How do we move from that plateau to get compliance in the other areas? I would like to know from you what aspect of the voluntary approach, what new development within the voluntary approach you can give to us to indicate that there is going to be some movement via the voluntary approach as opposed to via the legislative approach.

Mr Jenner: I think we are very keen to be party to a framework, whether voluntary or not or whether it is a framework that has very clear regulations, that can set out very clearly the options available to those who choose not to smoke and those who choose to do so. That can be a separately designated area, with ventilation. There are low costs in—

Q176 Charlotte Atkins: Do you mean a smoking room within a pub?

Mr Jenner: A separate designated area where it is practical, reasonable and cost-effective so to do. If you take, for example, a situation with a rural area, where there may only be one bar area, then it seems to us that an appropriate way forward would be for the landlord, the proprietor of the establishment, to determine with his clientele what the policy should be. That seems to us to be a very sensible, commonsense, pragmatic approach.

Q177 Charlotte Atkins: Is it an equally pragmatic approach for the smoker to go outside, have a quick cigarette and come back in again?

Mr Jenner: That is what they do in the Republic of Ireland, but you can look across the European Union as a whole and you will find a range of solutions to this topic which extend from exemptions for hospitality areas on the one hand, to regulations in hospitality areas, to ventilation in some instances, for example in Italy. I do not know why necessarily the word “ban” had to come into play, because there are a lot of alternatives to achieve, I am sure, the overall aims of the Government.

Q178 Charlotte Atkins: You have not yet given me an alternative to get into this hard core. What new approach under the voluntary regime can we adopt to get to the over one-third number of premises that are not complying and have not moved on under the voluntary approach?

Mr Jenner: As I think I mentioned, it is to move from a conversation around, in your words, a voluntary approach to a framework, or, if you like, a proposal that the Government has in mind, and our view simply is to accommodate the needs and wishes of all parties and a balance between responsibility and freedom. A regulatory approach that can be derived from a framework, a menu, if you will, seems to go some way to allaying your concerns.

Q179 Charlotte Atkins: A framework does not do very much to meet my concern about going into a 63%? That is the easy target. What about the pub in one of my villages in my constituency and not over one-third who are not complying? This is since having to be a ventilated by second-hand smoke. 1998. Presumably we have now hit a plateau. How do we move from that plateau to get information prior to entering the establishment, and certainly within it, of what the facilities are in there, and clearly, as I have already mentioned, if it is the single bar solution, then we have given a way forward where we think that everyone can be adequately accommodated.

Mr Jenner: I think the opportunity to have clearly delineated areas, to have information prior to entering the establishment, and certainly within it, of what the facilities are in there, and clearly, as I have already mentioned, if it is the single bar solution, then we have given a way forward where we think that everyone can be adequately accommodated.

Q180 Charlotte Atkins: How do you stop smoke coming out of that area? Will it be a worker wearing a gas mask or what?

Mr Jenner: We are of course working with the BSR/IA, as I mentioned, to better understand the air quality and the ventilation opportunities. When that work is completed, Mr Chairman, with your permission, I will happily supply it to this Committee.

Q181 Chairman: Mr Jenner, are you based in Northern Ireland?

Mr Jenner: We have a major factory in Ballymena in Antrim, yes.

Q182 Chairman: You mentioned earlier the issue of what is happening in the Republic of Ireland now, and obviously there was this week’s announcement about Northern Ireland as well. Do you have any strong views on that at this stage?

Mr Jenner: We have balanced views, I hope. Obviously we are disappointed that the wishes of the vast majority of British public opinion, where seven out of ten, as measured by the Office of National Statistics, prefer more restrictions and not a total ban. We have a particular concern specific to our business because we are a major employer in Northern Ireland and we have concerns about a particular detail in the proposals about our ability to test products and even to be able to comply with European Directives and so forth, where we would crave exemption to be able to test those products, both from a quality control point of view and also to meet our obligations under various Directives. That applies to our R&D department, which is also based in Northern Ireland, and also that facility would need to be available for our technical suppliers.

Q183 Chairman: Have you submitted for an exemption for testing in your workplaces, as it were?

Mr Jenner: If that is a requirement for us to be able to continue testing here, then clearly that is something we would have to ensure happens, or re-evaluate where such R&D work is actually carried out.

Q184 Chairman: Have you submitted at this stage to the Department?

Mr Jenner: I am not aware of that. I will be pleased to check and get back to you, if I may.
Q185 Chairman: On this same theme, Dr Stotesbury, you may be aware that there was a leaked internal memo from Imperial Tobacco that I got my hands on in mid-August. It did relate to that. It was in your memorandum that you believed you would need exemption for testing, for the mandatory testing you have to do for the marketing of tar and nicotine yields. What was interesting about the internal memo that was leaked to me, and which the Committee has seen, is that both Gallaher and British American Tobacco will not be asking for exemptions. Why was it that you believed that you had to ask for an exemption of testing of cigarettes, what you believe to be the mandatory testing of cigarettes, and other companies do not have to? I thought that was a rather strange comment.

Dr Stotesbury: I will not answer for other companies. That is for them. But, from our point of view, there are two areas that we are seeking exemptions for. First, the mandatory testing of tar and nicotine yields, which results in us being able to print a number for those on the pack, is done under the European Union legislation, which is currently done in our Nottingham factory and elsewhere as well in the UK. Secondly, we employ smoking panels both for quality control purposes of products and for consumer acceptability of new products. We would like the flexibility to remain able to do so within our R&D and product development departments within the UK.

Q186 Dr Naysmith: There was another statement in the leaked memo, and it said, “If SS”—and I presume that is Dr Stotesbury—“is to be the TMA scientist at these hearings, he must reflect all TMA company views rather than the more robust Imperial views on ETS.” I wonder if you could tell us what the difference is between the robust views that Imperial has and the views that the Manufacturers’ Association are promulgating in public.

Dr Stotesbury: Amongst our TMA member companies, I am not sure there are differences in view, in the main. I would argue that we do not have a more robust view. The memo, I think, means that we are prepared to argue those views more publicly, perhaps, than other companies have chosen to do so. But I do not think the views between us—and you will have to ask others, not myself—

Q187 Dr Naysmith: Somebody within the industry obviously thinks that Imperial has slightly different views from the Manufacturers’ Association.

Dr Stotesbury: In the context of that, it was an internal memo, it was produced for internal consumption and briefing around the events leading up to appearing at the Committee, and it should be seen in that context, basically.

Q188 Chairman: I do not know who the author was, but Kevin Barron would not have an committee he sat on, either as a chair or a member of it, as a show trial in this Place. It was in the internal document of yours, and, whoever was the author, tell them to come and have a chat with me some time. I know about Stalinism and many other show trials as well, and I have been against them most of my life, and you can still do that and be on the left of politics in the UK.

Dr Stotesbury: I have been here this morning and I can testify to them that that is clearly not the case.

Chairman: Perhaps a cup of tea at some stage, maybe with the author.

Q189 Mike Penning: If we can move on to the economic effects of the Government’s proposed legislation. You have mentioned several times this morning, Mr Jenner, that you have 12 million people who purchase your products in this country, who smoke. What effects on your industry would the Government’s proposed ban have? I ought to ask all three of you.

Ms Mohrmann: We do not know what kind of impact the smoking restriction may have on tobacco sales. As I mentioned previously, smoking restrictions may have an impact but there are lots of other factors that may have an impact on the market and I cannot predict what that would for the UK.

Q190 Mike Penning: The Department of Health have already said this morning in evidence that they expect a 4% drop in participation in smoking. Would that be something you would be expecting?

Mr Jenner: I was not able to hear that session, but our view would be that there are 12 million adults in total. They do not all purchase Gallaher brands yet. Clearly there would be some impact. It is very difficult to predict with certainty, because we are talking about, by definition, the future. As Ms Mohrmann has pointed out, there are many factors that impinge upon “participation” (your word). I think the DoH figure almost certainly refers to volume sales rather than participation.

Q191 Mike Penning: Volume sales is what we are talking about.

Mr Jenner: In that case, using the Irish example, it may be to the order of, say, between one and two cigarettes per day. That was the Irish experience in the first 12 months after the implementation of the ban. But I think the most recent data in Ireland, from the Office of Tobacco Control, suggests that the incidence of smoking has increased in the last few months.

Dr Stotesbury: We have been following sales data in Ireland very closely, as you can probably imagine. I would say last year, relative to the year before—that is the first year that the ban was introduced—your figure of about 4% is about right. But this year, in the last six months in particular, I think we have seen sales starting to rise again—probably in the order of 1.5%. So relative to two years ago, that is 2 to 3% down.

Dr Stotesbury: We have been following sales data in Ireland very closely, as you can probably imagine. I would say last year, relative to the year before—that is the first year that the ban was introduced—your figure of about 4% is about right. But this year, in the last six months in particular, I think we have seen sales starting to rise again—probably in the order of 1.5%. So relative to two years ago, that is 2 to 3% down.
then people may choose to smoke fewer per day. But smokers are very adaptable. They may do more smoking, as it were, in other places. The incidence trends, the long-term trends, are affected, as Ms Mohrmann said, by a number of factors: economic, behavioural and the like.

**Q193 Mike Penning:** The evidence given to the Committee indicates that round about 100,000 people a year die in this country from smoking related diseases. How is the industry going to try to fill that gap? Because you have 100,000 people dying who cannot smoke your cigarettes and you have round about 4% no longer smoking, how are you going to promote a market of smoking to fill that gap?

**Mr Jenner:** From a Gallaher perspective, we do not try to fill that gap. We have never and do not try to encourage anybody to start smoking cigarettes. We simply seek, with those who have made an informed decision, to persuade them to choose one of our brands. But it is fair to say that the majority of the competitive tools having effectively been denied us, that is a very difficult task, but it is very much about competing for smokers of other brands—as it has always been the case, in our view.

**Dr Stotesbury:** My view would be very similar. We certainly do not try to fill that gap. We compete between ourselves for smokers, existing adult smokers, to choose our brands in preference to those of our competitors.

**Ms Mohrmann:** I would like to say that if people look towards the view of Government and public health authorities about what they have to say about second-hand smoke and if they have concluded that it harms non-smokers and if they decide to quit, then that is their decision. We have 8% of the market share in the UK. If people decide to quit, there is still a lot of people who have already taken a decision to smoke to whom we could still be able to communicate our brands.

**Q194 Mike Penning:** I am fascinated by you saying that you do not attempt to get anybody to start smoking. If nobody started smoking, you would have a life expectancy of about 20 years. You would have died about 20 years ago as companies.

**Mr Jenner:** The duty-paid cigarette market here in the UK has declined every year since 1973. That demonstrates the history of the last 30 years has been about competition between the respective manufacturers.

**Q195 Mike Penning:** It is all to do with smuggling. It is to do with the black market sales in cigarettes. We can see that in most pubs in my constituency and, I am sure, in everyone else’s constituency.

**Mr Jenner:** I think it is true to say that approximately 30% of all types of white stick cigarette consumed in the UK do not attract any duty or are not subject to the regulations that we ourselves comply with here in the UK.

**Q196 Chairman:** I know you are not directly involved in marketing, but the public houses in particular that I use on occasions have promotions of tobacco products. Do any of your companies use public houses as places to promote their products, as it were?

**Dr Stotesbury:** We do.

**Q197 Chairman:** You do. So obviously there would be a direct effect if smoking were banned.

**Dr Stotesbury:** Yes.

**Q198 Chairman:** Or would you still be able to use public houses without them telling people, “Have this, but don’t light it up here”?

**Mr Jenner:** That particular mechanism you illustrate is illegal. We cannot do this sort of thing that you have mentioned. You can make available brands in public houses, and they are on display; you cannot promote them as such, because to do so would be illegal.

**Q199 Dr Naysmith:** Do you use beer mats and that sort of thing?

**Mr Jenner:** No.

**Q200 Dr Naysmith:** That is banned now, is it?

**Dr Stotesbury:** Yes. It is just by positioning in vending. That is what I was referring to. It is the positioning of your brands in vending machines.

**Q201 Chairman:** There is no other way?

**Mr Jenner:** No.

**Q202 Chairman:** All target promotion has now finished, has it?

**Dr Stotesbury:** Yes.

**Q203 Chairman:** Is that the same with Philip Morris?

**Ms Mohrmann:** Philip Morris sells its tobacco products in public houses.

**Q204 Chairman:** But you do not use the venues beyond that?

**Ms Mohrmann:** We use the venues to be able to sell our tobacco products to the people who choose to smoke and we abide by the current laws that are here today under the TAPA Act of 2002.

**Q205 Dr Taylor:** You have said that the 12 million people who still smoke have made the informed choice to smoke. How do you square that with the evidence we are going to be given that that most smokers want to give up?

**Mr Jenner:** I cannot comment on evidence that you are going to be given. I am not sure what that is to which you refer.

**Q206 Dr Taylor:** This was raised by the College of Physicians to say that there is definite evidence that most smokers want to give up, and that conflicts very much with your statement that these 12 million have made the informed choice still to smoke.
Mr Jenner: The reality is that clearly, as we have discussed this morning, the vast majority of smokers do so in the full knowledge of the risks associated with the products—and those risks have been widely promulgated to them for over 30 years on each and every pack, so they clearly are aware of that. I am not familiar with particular statistic to which you refer.

Dr Taylor: Thank you.

Q207 Chairman: Could I thank all three of you for coming along and completing this morning’s evidence. It has been very informative. Where you can supply us with further information, we would greatly appreciate it. Thank you.
Thursday 17 November 2005

Members present:
Rt Hon Kevin Barron, in the Chair
Charlotte Atkins
Mr Paul Burstow
Jim Dowd
Anne Milton
Dr Doug Naysmith
Mike Penning
Dr Richard Taylor

Witnesses: Mr Phil Wheatley CB, Director General, HM Prison Service; Mr Paul Foweather, Governor, HM Young Offenders’ Institute Wetherby; Mr Paul Thain, Director, Modernisation and Strategic Development, Norfolk and Waveney Mental Health Partnership NHS Trust; Mr Ian Hulatt, Mental Health Adviser, the Royal College of Nursing; and Mr Paul Corry, Director, Campaigns and Communications, Rethink Severe Mental Illness, examined.

Q208 Chairman: Good morning. Can I welcome you to this evidence session looking into the issue of smoking in public places and work places. I wonder if I could ask you to introduce yourselves.

Mr Foweather: My name is Paul Foweather. I am Governor of Wetherby Young Offenders’ Institute.

Mr Wheatley: Phil Wheatley, Director General of the Prison Service, responsible for public sector process.

Mr Thain: Paul Thain. I am the Executive Director of the Norfolk and Waveney Mental Health Trust.

Mr Hulatt: I am Ian Hulatt, the mental health adviser to the Royal College of Nursing.

Mr Corry: I am Paul Corry and I am a Director of the mental health charity, Rethink.

Q209 Chairman: Thanks very much for coming along. Could I just ask you, Mr Wheatley, do you think that prisons should be included among the institutions exempted from the Government’s proposals to ban smoking in public places and work places?

Mr Wheatley: Obviously that is largely a question for Parliament and for the Government as to what they propose to Parliament. I think prisons are special and the circumstances are special and it is important we take account of the fact that they are places in which people not only work, but live and in many cases for years at a time, in some cases for natural life. I think that makes it special.

Q210 Chairman: In the written submission that you gave to us, you had a range of options for creating smoke-free environments in prisons. How likely is it that these will be implemented and do you think there should be any sort of timescale on taking action like that? If you are to get exempted under the proposed legislation, should there be any timescale on it?

Mr Wheatley: Well, I think prison will remain a place where people live for large periods of their life and that, to me, is why prisons are special. We are looking at options, we have not decided on what the best way forward is, and we will pay attention obviously to any legislation, and we are not yet certain what the legislation will say. I would expect them to work towards a situation where prisoners smoke in their cell, they do not share cells with non-smokers, no smokers and non-smokers together, so we keep prisoners segregated by whether they smoke or they do not, and they smoke outside in the open air and in other parts of the prison they do not smoke. That is, I think, replicating largely what the legislation may achieve for the rest of society and I think we can do that. I would expect staff not to smoke, except possibly in the open air and I think there is no real reason why we should stop people smoking in the open air, but that is all to be thought through carefully. We do need to make sure that we do not cause significant problems for disturbed people arriving with us with already a multitude of problems, many of them coming off drugs, many with serious alcohol problems and many of them potentially suicidal. As we try to settle people into prisons, I do not want to heap any more pressure on them than I need in the interests of keeping people alive and safe.

Q211 Chairman: The Department of Health has suggested to us that banning smoking in certain circumstances in prison would be an infringement of human rights. Do you see it like that or is it more control?

Mr Wheatley: I think prisoners would see it as an infringement of their human rights. I do not think staff would see it as an infringement of their human rights and we are not arguing that. It would create control problems in some establishments, there is no doubt about that. You do not know what you are in for in prison; you are deprived of most of the things you might ordinarily enjoy, and probably what you enjoyed last night are things the prisoners do not do, so to take yet another thing away will not be wildly popular with a group who are not always charming and pleasant in their behaviour, so I am not volunteering for a complete ban in every place. We have done things in young offender institutions where we have put in complete bans successfully with a lot of work to support it, but there people are not as well entrenched in their smoking habits and are not normally doing the sentence lengths that we will meet in some of the adult male secure estates.

Q212 Chairman: Why should we give this freedom to smoking when, as you suggest yourself, the people in prison who have alcohol problems would like to feel that they should have access to that as well, although they are not given access to that officially?
Mr Wheatley: We do not give access to anything which we regard as a mind-altering substance. Certainly until my time, we made sure that prisoners, except for remand prisoners at one stage, were allowed to have a pint of beer a day, a rather Victorian custom, but it lasted into my experience of the Prison Service. We have not let prisoners have access to alcohol and we work very hard to make sure they do not get drugs. I do not think that tobacco has quite the same threat to people’s thought processes, but it is just not good for their health and there is no doubt about that.

Q213 Mike Penning: Can I just pick up on one point you made there. Can you assure the Committee that what you said is correct, that no prisoner who does not smoke ever has to share a cell with someone who does?

Mr Wheatley: No, I did not say that. I said that is what I envisaged us doing as we went through the review. That is not true at the moment and, as we pack prisoners in, and we are packing prisoners in, 77,634 today in the whole system including the private sector prisons and with large-scale sharing of cells, I have not got the luxury of being able to differentiate and carefully select. However, we do try to make sure that we do not cause undue problems, and it is not the wisest of things to put smokers and non-smokers together, but we will be doing that in order to get the places for prisoners and make sure we use every available place at the moment.

Q214 Mike Penning: I apologise, I misunderstood what you meant, and I was gobsmacked by that having recently visited The Mount Prison—

Mr Wheatley: No, it is certainly not true and there will be an effect on the amount of prisoners we can put in. It will slightly reduce our ability to use every place.

Q215 Mike Penning: You mentioned earlier on that it was a decision for Parliament as to whether there was a total ban in prisons, so if we assume possibly that Parliament has decided that there will be a total ban, how would that actually affect your capabilities of running your prisons?

Mr Wheatley: It would pose some significant risks.

Q216 Mike Penning: Can you explain those?

Mr Wheatley: Yes, as we announce that smoking is to stop, presumably with some sort of run-in, so we work hard to try and get people off cigarettes and that costs quite a bit of money and we are currently spending about £158 per quitter as we go through the process of using nicotine patches and trying to offer advice and support, or that is roughly what that cost is, as we go through that process, there will be some people who did not come out of that process as quitters and I would expect to find that there was an increased incidence of assaults on staff, that we ended up with prisoners who were more likely to be troublesome and there would be an increased risk of disorder. Those are the things that would be a problem, particularly in the long-term, high-security estates where taking things off prisoners who are doing very, very long sentences always carries a degree of risk.

Q217 Mike Penning: You mentioned earlier on that the Prison Service is doing everything it can to prevent drugs and alcohol getting into prisons, but I think we are all too aware that they do get in. As I say, I recently visited The Mount Prison where there is an issue like there is in most prisons, so would it really be physically possible for the Prison Service to enforce a smoking ban? If they can get alcohol in or even produce it themselves and they can get drugs in of all different types, surely they will be able to get tobacco in and smoke.

Mr Wheatley: Tobacco would end up being more of an illicit currency than it currently is and people would work hard to smuggle it in. It would be very difficult to keep it out of open prisons, as it is very difficult to keep drugs out of open prisons. There would be people who will attempt to bend my staff in order to get them to bring things in, people who will attempt to smuggle stuff in through visits and people who will attempt to throw things over the perimeter, the ways that illicit substances enter prisons. We would not ever, I think, achieve complete success unless I can put lids on prisons, which actually I cannot.

Q218 Mike Penning: So what you are basically saying is that you would drive it under ground?

Mr Wheatley: We would drive it under ground, we would reduce it. Do not get me wrong, I am not saying people would not continue to smoke at the same rate, but there would be another area in which we would be working hard and, as prisoners might see it, battling with them to make sure they did not get what they were trying to get, and we would have to put a lot of effort into that. We would do it if Parliament required us to do it, but it would carry risks, it would carry costs, and I guess it is for Parliament to decide whether that is something we should do because it will involve spending the country’s money.

Q219 Mike Penning: It is for Parliament to decide and for us to try and find out what effect it will have on the different institutions.

Mr Wheatley: It will cost in staff time and produce another significant rubbing point in prisons and we would not have complete success.

Q220 Mike Penning: You were talking earlier on about the significant amount of money that is spent in prisons on trying to get people off smoking and alcohol.

5 The Prison Service later informed the Committee that the current cost per quitter using NHS stop smoking services is around £158 excluding Nicotine Replacement Therapy and Zyban. This compares with £206 in 2001–02. Currently they have only calculated the cost of providing NRT to our prisoners wishing to give up, and that is in the region of £100 per course per prisoner.
Mr Wheatley: Yes, we do.

Q221 Mike Penning: What percentage of your inmates are smokers?
Mr Wheatley: I think about 80% of our prisoners smoke on entering prison, or it is about that.

Q222 Mike Penning: And your success rate of weaning them off it?
Mr Wheatley: I do not know whether Paul would know.

Q223 Mike Penning: Do you not have to tell us exactly.
Mr Wheatley: No, I cannot give you exact figures. I am told that we are getting about the same success on the quitting as we do in the community, so if we go for a quitting programme—

Q224 Mike Penning: So it is quite a high proportion.
Mr Wheatley: We have about the same proportion as you get with ordinary members of the public. In other words, prisoners are not special. With the evaluation, we will be able to give you decent figures of the scheme in the North West that is being done with Health and at that point we will have real figures. The early indications are that we get roughly the same proportion as if you work hard on people in the community.

Q225 Mike Penning: Prisons are starting at a much higher threshold though.
Mr Wheatley: Yes, but prisoners have every incentive to give up because cigarettes are expensive and we do not pay them a lot of money, and there are other things they might spend their money on. Just like the public or in fact more than the public, probably a greater proportion of their money goes on cigarettes and, if they can get more of the other things they might want to buy, like phone cards and so on which give them access to home, they have every incentive of trying to break free as well as the health reasons.

Q226 Chairman: If this legislation is perhaps passed and we have a situation where smokers and non-smokers are sharing cells, you are exempt, so the smoker can actually smoke, would you be concerned that you may have a human rights challenge against you by the non-smoker in that situation?
Mr Wheatley: Well, I am always concerned that there is always that risk of a variety of legal actions being brought against us and this might well be another one, but I would not speculate on that. I would expect to gain support for a policy that says that smokers and non-smokers should not be together. The consequence of that is that we would hold slightly less prisoners because we would be making slightly less efficient use of our accommodation, so there is a real implication for government and, therefore, for Parliament as well as to how many people we can hold. It would make a significant, but not enormous, difference because we would end up with a non-smoker and a smoker arriving, there are two cells and they are put in two separate cells, so we would lose the mixing of people as the wrong sort of prisoners arrive. We cannot order from the courts the required numbers of smokers and non-smokers in advance.

Q227 Chairman: We have seen written evidence sent in by another organisation of prisoners having to share. The one that stuck in my mind was the individual who was in there for a number of years, had never smoked in his life, and yet here he is in a confined space effectively smoking a percentage of the cigarettes that are smoked in that cell. That presumably will become an issue once this legislation is enacted, however it turns out.
Mr Wheatley: It is and, as I say, I would like to move to a situation where we do not have to do that. The effect is that a slightly smaller number of prisoners can be fitted into the number of cells because we make less efficient use of them.

Q228 Chairman: Can I move on to Mr Foweather. I actually saw on my regional television news during the recess that you have been given the National Clean Air Award at Wetherby Young Offenders' Institute and, in part, I was quite surprised. Having visited prisons on occasions, they tend to have a tobacco “thing” about them, as it were, so I was very surprised you got that. Why did you take the decision to go towards getting the National Clean Air Award, was it an easy passage and what difficulties did you find in relation to that?
Mr Foweather: It certainly was not an easy decision to take because it is a major step for any institution, something of that magnitude, but, as a governing Governor, I have got responsibilities both to the trainees in my care, that is 15- to 17-year-olds, bearing in mind for 15-year-olds it is illegal to buy tobacco and smoke, yet we find them in the presence of smokers, so there are unique issues for juveniles, but also I have a legal obligation under the Health & Safety Act 1974 where I need to ensure the safety and decency of my staff and trainees and also the Health & Safety Act 1999 about risk assessing and managing it. When you combine all of that, given the unique needs of the juveniles that I have to take care of, what you see is a high incidence of bullying because tobacco is a currency, you get incidents of fire and other aspects related to tobacco. Because of that, I did an in-depth study and we have researched the issue concerning juveniles, we have weighed the risk and I thought that it was worth taking that risk and we planned a move towards it, so it was not an easy decision, but one I can say I would not have taken if I was managing one of the larger, more secure establishments. The majority of my background is working in the high-security estate, for instance, where taking that decision would have been even harder and much more difficult to impose because the risks would have been significantly greater. Therefore, as we moved to it, there was an eight- to 10-month lead-in period, and that included

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6 The Prison Service later informed the Committee that their latest research indicates that smoking cessation is delivering about 4,000 successful quitters from the prison population over a single year.
consultation with other agencies and particularly the primary care trust and smoking cessation organisations, and there was significant money placed in terms of support, developing staff training, literature and it was not an easy path. The implementation date was 1 January and I coincided with New Year’s resolutions and, as silly as that may look, that had a beneficial effect, so I had 45 staff who were training and I had quite a number of staff that took patches as well as trainees who did. Then you have got to put the systems and processes in place because it is not just about stopping it and having the contingency in place to manage the potential for serious unrest, but also once you have got over that, it is the new trainees coming in and some of them are extremely young and vulnerable and how we manage that process, particularly if they have got mental health needs or other unique needs, so it is the systems and support in place which are all expensive as well. I suppose I am fortunat in that it was a juvenile site and that certainly impacted on my decision-making and I was extremely pleased and proud of the staff who introduced it for Wetherby, the first in the country to introduce it, and Ashfield then followed Wetherby’s template and introduced it later on, so it was very successful, but unique to juveniles, I think.

Q229 Chairman: What has been the effect on the institution from going smoke-free? What is different?

Mr Foweather: I think it is a more decent and healthy environment and the staff and trainee surveys I have done would conclude that. There have been some initial benefits, although it is still early stages, in terms of things like reduced fires because trainees, by their normal sort of impulsive behaviour, tend to play with matches or lighters, if they have them, so we have reduced the number of fires. A third of the bullying was attributed to tobacco and, as a consequence, trainees tell me that there has been a reduction in bullying for tobacco. That does not mean to say that something else, toiletries or other things, has not replaced that currency, but what we have done is reacted to that. There have been instances where we have caught tobacco trying to be smuggled into the establishment. Well, from a governing Governor’s point of view, if the worst of my problems with this is stopping the odd bit of tobacco coming in when it is not drugs, hard drugs or other illicit substances, then I think I can cope with that because it is the lesser of the evils. I have now got a smoke-free environment which is healthier for staff, it is healthier for trainees, and there are some spin-offs for the juvenile agenda inasmuch as 69% of my trainees say that they have tried to stop before and been unable to.

Q230 Chairman: Has there been a move in smoking cessation? Has it been measured? Are you getting more cessation than the norm?

Mr Foweather: Well, the cessation is total, but what we have done is I have put to all the courts and to all the other agencies involved, “If you send a trainee to Wetherby, they will not be smoking”, and all my staff recruitment is, “If you want to work at Wetherby, you will not be smoking inside the establishment”, so the smoking cessation is total and 80 to 85% of my trainees arriving smoke and a growing number of those say they will not smoke on release, although when you look at my survey results, the average cost for a trainee smoking is £110 and most of these are unemployed, so there are some real benefits. The point for me, I would stress, is that if I was managing somewhere like Leeds or Hull or one of the big opens, I do not think, irrespective of all the planning and management, that it would have gone as smoothly and you could be looking at some significant costs and injuries.

Q231 Chairman: You use smoking shelters inside the perimeter fence for staff and for prisoners—is that right?

Mr Foweather: Not at Wetherby because what I said is that it is very difficult to police a no-smoking policy in part. For instance, if staff are still carrying tobacco around in their pockets or if trainees or prisoners have got it on them, would they restrict themselves? You have to police it. If you are going to have a healthy environment and if you are going to take that measured response, which we took, then we saw it as an issue with staff that if they are not smoking on duty, and we do not pay staff to take smoke breaks, then that should be outside of the establishment and in their own time. That in itself is controversial, but nonetheless we have put the system in place where there is covered shelter outside of the establishment. I suppose Wetherby is unique and it is early days, but that has been accepted by the union and it has also been accepted by staff and trainees, although it was not as positive at the outset because there was some resistance to that.

Q232 Chairman: What would be the big risks of attempting to do this at adult jails as opposed to a young offenders’ institute?

Mr Foweather: I think I would mirror what the Director General said inasmuch as you have got a fairly sort of more insatiable population who have probably been smoking for a long time. A lot are doing long sentences, a lot have been deprived of privileges, probably a lot are feeling aggrieved and this will compound any feeling of aggravation. I think you would run the risk of potential unrest, potential serious unrest, and that would accumulate maybe in individual incidents or maybe lead to a larger-scale incident, depending on, establishment to establishment, how it is managed and the severity of the impact of either the legislation or the local policy. However, what you will see across the estate generally is that governing governors are managing as they are required to under current health and safety legislation and managing smoking policies and some are more successful than others, but I would endorse the Director General’s comments that it should be looked at very carefully and the establishments seen as special cases.
Q233 Dr Naysmith: I would like to ask Mr Corry some questions, particularly in the area of mental health and mental health premises because it is one of the proposed areas of exemption in the legislation. What do you think are the main issues that arise from smoking with regard to mental health and particularly in mental health premises?

Mr Corry: I think you have to set the question in some context. Up to 70% of people with severe mental illness who are in institutional care of one kind or another will smoke. People with severe mental health problems are unique amongst health groups in the sense that they can be subject to compulsion, whereas people with other health problems cannot. We are concerned in the legislation that the definition of “premises” is open to local interpretation and we are not quite clear from that quite how that is going to be interpreted. We are also concerned that the smoking cessation work that is being done across the NHS at the moment is very often for the general population rather than targeted at groups with particular needs. People with severe mental illness can very often have problems with their desire to give up smoking first of all, which I think is something where more thought is needed. There are also issues for people with severe mental illness about the effects of giving up smoking in the short term where some of the medications that can be used, the anti-psychotic drugs that are used for the treatment of schizophrenia and other illnesses, can be adversely affected if someone gives up smoking and the dosages have to be changed and so on. Zyban, which is a drug that is used to help people who find it particularly difficult to give up smoking, is unsuitable, for instance, for people who are using anti-psychotic medication. If you take that in the round, then I think you have got a group of people for whom the legislation needs to be particularly tailored.

Q234 Dr Naysmith: Are you suggesting then that smoking is an ineradicable part of the culture of psychiatric hospitals?

Mr Corry: No, I do not think so at all. We have worked very hard and Rethink runs some 370 services across England and Northern Ireland. We have something of a no-smoking policy in our services where it is possible to actually enforce that, but we find it very difficult to get support from the local primary care trust and other health bodies to help us to run smoking cessation policies in our services. To give you one instance, we have a day service in the Amber Valley, called “The Croft”, where the service manager there used a service in the PCT herself and asked the PCT if a similar service could be run inside the day service, and it took over 18 months of negotiation before the PCT would agree to do it inside the service and to tailor it to the particular needs of people with severe mental illness. However, when it was done, we all discovered that the quit rate was actually higher than the PCT was achieving in the community generally, so it certainly can be done.

Q235 Dr Naysmith: So really that is what we should be trying to do rather than applying for an all-out exemption for premises. Perhaps you could also touch on your problem about defining “premises” as far as mental health institutes are concerned?

Mr Corry: We, as an organisation, just need to be clear about what the Government’s intention here is. You have a number of different facilities in mental health where people may reside for short or long periods of time and you need to find a way of balancing the interests of people who are using a psychiatric unit on a voluntary basis and may not wish to be in a smoking environment against those who are there under compulsory detention who may have a long history of smoking and their needs need to be addressed as well.

Q236 Dr Naysmith: Is there any possibility of separating the two in terms of having smoke-free and smoking rooms, for instance?

Mr Corry: It is something that we encourage in our own services and we encourage the NHS to do as well, but I think this Committee will be well aware that, despite seven or eight years of increased investment in mental health, some of the psychiatric units and health facilities that are around are still in need of repair even to the extent of reducing suicide in them. Some of them, I think, would find it difficult to find the money to be able to introduce entirely smoke-free areas for people.

Q237 Dr Naysmith: I am going to bring Mr Thain in in a minute because he has some slightly different experiences from you, but it does sound as if you are not saying, “We need this exemption”, but what you are saying is that you need more resources and you need more will perhaps behind it all to change things within the institutions.

Mr Corry: I think it is difficult to imagine a situation at the moment where you could introduce a complete smoking ban in all psychiatric units given that a significant proportion of the people who are using them will be there under compulsion. However, what I do think we need to do is move from a situation where we are today to a point in the future where we have a complete smoking ban and that will require specific targeted interventions for people with severe mental illness to help them and encourage them, rather than coerce them, to give up smoking.

Q238 Dr Naysmith: Finally for you on this point, how do you feel about the workers, the people who work in these places—do they not deserve protection from second-hand smoke from other people?

Mr Corry: Absolutely. We employ, as an organisation, something like 1,500 staff across our services. A number of our services are delivered directly into people’s homes and there is a whole issue there which is obviously not covered by this legislation. The people who are employed by us who work in institutions do need protecting and it would be fair to say that we, as an organisation, are struggling to find a way to actually deal with their needs.
Q239 Dr Naysmith: Could I move on then to Mr Thain because your experience, as I have said, is different. We understand that you have made your institution smoke-free, so can you tell us how you have managed to do that?
Mr Thain: That is not quite accurate and I need to be accurate. I can only talk about my Trust, not the wider mental health services. Eighteen months ago we introduced a smoking cessation policy and we did that for two reasons fundamentally: one, to reflect our responsibilities and duties under the Health and Safety At Work Act because our view is that mental health staff should be treated no differently from any other staff and, therefore, should be afforded exactly the same protection as other staff; and, secondly, because those who suffer from severe mental illness have added health difficulties if they are also addicted to tobacco, so we felt we should do something in respect of supporting and helping our patients with those difficulties. Those were our motives. We introduced the policy, it has been running and we do allow for some smoking within our Trust. When a patient is brought to our Trust and they are a smoker, it is recorded on their care plan as a clinical issue, and then that clinical issue is addressed at the appropriate time, so there has to be a period of time where people are able to smoke. We do have within our Trust a 66-bed forensic medium-secure unit and it has been our surprise that that has actually taken the lead in smoking cessation rather than, as we expected it to be, towards the end of the journey we are undertaking, and patients within our secure unit who are there for many years do not smoke. The fundamental principle is that they do not smoke within the building itself, but in fact are allowed to smoke one cigarette at a time under supervision, not at night, in small courtyards. Our emphasis has been wholly on trying to support people who do not smoke because it is anecdotally viewed within the service that people have in the past entered the service in some numbers as non-smokers and come out of the service as smokers because of the culture, so we have focused our attention on supporting non-smokers and also on trying to support people who smoke into a position where they do not smoke. We have found that, working with our service users on this issue and with our trade unions, we have made great progress and we are now considering moving in fact to being completely smoke-free. The one issue, I have to say, that has actually made it more difficult for us has been the social context, the fact that there has been no wider legislation which of course does not help if you find yourself as an island trying to move forward in this area.

Q240 Dr Naysmith: So would you be happy with the legislation as it is proposed, giving you an exemption, or would you really prefer something a little bit stronger?
Mr Thain: I think I would be happy as it is because that will allow us to move forward, but I do not want any exemption for mental health services. I am not quite sure what you are asking, but that is my view.

Q241 Dr Naysmith: You do want an exemption, did you say?
Mr Thain: I do not want an exemption.

Q242 Dr Naysmith: So that would mean that you would want the legislation to be a bit stronger, not exempting mental health?
Mr Thain: Yes.

Q243 Dr Naysmith: Do you think there are things that you could say to Mr Corry? I know you said that you could only speak for your own Trust, but could these lessons be transferred more widely?
Mr Thain: Certainly. In fact I invite anybody to come and have a look around our Trust. What I would say though is that we have had now an 18-month/two-year lead-in and we have been working at it and working with our service users and that has given us, I guess, as we sit here at this point in time an advantage over others who may not have started.

Q244 Chairman: Could I just ask you, Mr Thain, on smoking cessation in particular and co-operation with the PCT—do you have it?
Mr Thain: We do, and a totally different position from the one the Committee has heard of already from elsewhere. Yes, our primary care trust has been extremely supportive and, I have to say, as commissioners some 18 months/two years ago were, I suppose, part of the process that brought us to make a decision to move in this direction. In fact we were one of the first, in fact I think we were the first secondary trust in our area to move in that direction with full support from the primary care trust who sat on our steering group and provided us with some financial support.

Q245 Chairman: Mr Corry, you talked about the issue of home visits in particular which is an area which could cover yourselves and many other organisations as well. Do you have any policy where you sort of get messages out prior to one of your people going along that people should not perhaps smoke for an hour or whatever or do you think it is just not feasible to be able to make that type of request?
Mr Corry: We do, and we also encourage staff to be proactive in asking to meet people within the house in a smoke-free area. I think you had some evidence in one of your earlier sessions that it can actually have the effect of appearing to be a smoke-free environment in the sense that it does not smell of smoke, but some of the particles themselves may remain in the air, so it does not offer full health and safety protection for our staff. We are in a situation at the moment on home visits where we leave it very much up to the discretion of staff to negotiate with the service user about how to handle that situation, but I do not think it is a happy situation or one that has actually met its full conclusion yet.

Q246 Chairman: Do you feel that you do get co-operation in the most part?
Mr Corry: From the individuals?

Q247 Chairman: Yes.
Mr Corry: Yes. One of the things we pride ourselves on, and indeed mental health services do generally, is about being a people service and building up strong personal relationships with people. It can actually be quite a useful way to break the ice, a negotiating tactic and a trust-building exercise to negotiate around something like that. On the whole, I think we get co-operation, yes.

Q248 Chairman: Mr Thain, do you have an opinion about it?
Mr Thain: Yes, I do. We, on our letters that go out to people regarding appointments, make it very clear that we do not expect our staff to have to enter a room where people are smoking and we instruct our staff that they have the right not to if somebody should insist that they are going to smoke in their presence. Our staff themselves, just to make it clear, when they are acting on behalf of our Trust and when they are on duty, are asked not to smoke even when they are out visiting people in their homes, so we would not allow our staff to go into a smoke-filled room. The issue about whether in fact there are chemicals left over is one that we have pondered and I believe under the Act we can only do what is reasonable, and we believe we have done as much as we reasonably can. We cannot go in with special equipment and check out a room every time, but we have taken it that far and we are very clear on that, and we have received co-operation from patients and the public.

Q249 Anne Milton: Before I ask Mr Hulatt some questions, I would like to say I am very impressed, Mr Thain, and I did notice you shaking your head as Mr Corry was talking. I should, before I ask you some questions, Mr Hulatt, declare an interest because in fact I am a member of the Royal College of Nursing. Perhaps we could have your perspective on whether nurses in psychiatric institutions are subjected to second-hand smoke more than in other situations?
Mr Hulatt: I think that the RCN position on this, which relates to that question, is that to exclude psychiatric institutions is to perpetuate health inequalities that are not acceptable for people with mental health issues. I think the mental health nursing constituency, if you like, is challenged very much at the moment to promote the wellbeing of individuals with serious mental health issues and to challenge the previously accepted normality that people smoked which was not challenged, yet we know that people with serious mental illness diagnoses, such as schizophrenia, will die ten years younger than someone without that label, we know that twice as many people are obese in that group and up to three times as many people will have diabetes. I think the mental health nurses are currently challenged in our review under the Chief Nursing Officer in that we are very keenly debating the overlooked area of physical health and how we need to address that seriously. I think what we are talking about is almost “denormalising” smoking, not seeing it as an accepted part of the package of being a mental health client. I think that where concerns have been raised and where we do have concerns is how this is “operationalised” in our places of care and that that needs to be done in a sensitive and patient-centred way, by which I mean not a Draconian way such that people would disengage from services because that is an anxiety.

Q250 Anne Milton: So what you are actually advocating, which would be proper, is a holistic approach to people with mental health problems?
Mr Hulatt: Yes.

Q251 Anne Milton: In other words, you do not just treat their mental health problems?
Mr Hulatt: No.

Q252 Anne Milton: Particularly having sat between Mr Thain and Mr Corry, do you feel that stopping smoking in psychiatric institutions would be practicable?
Mr Hulatt: Yes, being in the middle, as nurses often are, I think—

Q253 Anne Milton: Hear, hear! The view would be that it is practicable and I think it is achievable, but I think we have to remember that it is the nurses who will be required to manage and enforce this policy and I think it has to be one where they can do so humanely and reasonably. I think that there are situations in extremis, and Mr Thain has alluded to this, where someone can be admitted under section, extremely distressed, possibly suicidal and very unwell, so is that the most appropriate time to commence smoking cessation? I think these are the questions that have to be carefully considered. I think it is a goal that can be achieved, but it must be done appropriately and humanely.

Q254 Anne Milton: In what way do you feel nurses are exposed to second-hand smoke?
Mr Hulatt: Well, those that do not smoke, I suppose, may well be exposed to smoke in settings such as when one is closely observing the individual who is at risk and who wishes to smoke and currently may be able to, so if one is closely observing an individual within arm’s length, for example, and that person wants to go into the smoking room, then it is safe to be away from that person? Probably not, but your health is at risk while you are with them.

Q255 Anne Milton: So there are special difficulties?
Mr Hulatt: There are difficulties. They are very practical, operational difficulties that need to be thought through very carefully and they are very specific to the environment in mental health institutions.

Q256 Anne Milton: But maybe with the long lead times that Mr Thain was talking about, that is how it is achievable.
Mr Hulatt: Absolutely. When I have been talking to colleagues who are in trusts that are engaged in this, they are talking very much about moving towards, and taking practical steps towards, this ambition and they see it as achievable, but it needs to be carefully managed not only for the vulnerable individuals within those institutions for whom smoking is adding to their social exclusion anyway and who are also impoverished financially, and it is a difficult habit to maintain from that point of view, but also for the staff who are going to police and manage this. It needs to be done sensitively, but it can be achieved.

Q257 Anne Milton: Just moving to home visits of nurses into homes of clients who might well be smokers, do you know if there is any evidence to suggest that that contact that nurses have in people’s homes is doing their health any damage?

Mr Hulatt: I am not able to provide evidence now. That is certainly something that I could look at and supply to the Committee, but I think that we have a situation where it is culturally considered almost inappropriate to challenge the client not to do it and it is things like that need changing.

Q258 Anne Milton: I think that is when it gets even trickier really.

Mr Hulatt: Yes, and what we do not want is people disengaging from services because that adds to the risk and to the negative effects to their health and the relationship with the people providing the care.

Q259 Anne Milton: Do you think that sometimes there are groups of people who are difficult to hang on to?

Mr Hulatt: Yes.

Q260 Anne Milton: For the psychiatric services, you hang on to them like grim death really, knowing that the relationship is very tenuous at any point. Of course visiting people in their own homes, they are entitled not to allow admission if they do not want to. Do you feel that asking people not to smoke when you visit would actually put at risk that relationship, damage, if you like, the therapeutic relationship that the psychiatric nurse might have with their patient?

Mr Hulatt: I think it is a potential risk, but I think that mental health nursing is founded on that collaborative relationship with the client, it is pivotal, and those long-term relationships can be such that difficult and sensitive issues can be discussed, and I think this may well just be another one of those.

Q261 Anne Milton: As you say, there is a holistic approach to people with mental health problems and maybe, and I value your comments, a partial ban is suggesting otherwise, that somehow people with mental health problems do not deserve attention to the rest of their wellbeing.

Mr Hulatt: That is, I think, perpetuating that inequality which, as a college, we are concerned about.

Q262 Charlotte Atkins: I would like to go back to Mr Foweather and ask about the young offenders’ institutions. Very often the health of people in the institution is not the highest priority for governors, so I am interested in how you came to look particularly at health. What was the role of the primary care trust here, or was it the role of maybe the service-level agreement you have with maybe the local GP? Who was your support network in terms of trying to introduce a higher priority for health for the prisoners and indeed for smoking cessation?

Mr Foweather: Firstly, the health and wellbeing of the young people in my care is my priority and I think it is probably the priority of other governors in other juvenile settings. In terms of the close liaison with the primary care trust, we have heard mixed views this morning. I would endorse the view that we had an extremely close working relationship from the outset and that manifested itself in clear, practical support, and it is part of the planning process, it was embodied in the training, the development, getting smoking cessation tutors in the establishment and even smoking awareness days when we had big, red buses coming in and engaging the trainees and staff.

Q263 Charlotte Atkins: And that was the PCT that organised that?

Mr Foweather: That was the PCT and the smoking cessation services. I think it reflects, where there is real partnership working, what you can achieve and I think that was an extremely influential part of the successful implementation at Wetherby.

Q264 Charlotte Atkins: There are a number of institutions around the country, indeed I have one in my own constituency. How many of those have now gone smoke-free?

Mr Foweather: Total institutions?

Q265 Charlotte Atkins: Yes.

Mr Foweather: My understanding is that I think Warrington went some way towards that, Wetherby was the first of its kind to do it fully from 1 January of this year, and since that time we have promoted it to a range of other establishments, including the private sector, who have taken away our information and our template, if you like, our footnote on how to do it, and there are others looking at it as we speak, and Ashfield have taken it on several months later. Therefore, to my knowledge, there are two juvenile sites which are fully no smoking and the rest have all got smoking policies in place, as has the prison estate because it has been left to the discretion of governing governors within their legal remit to implement, but each have different interpretations of that.

Q266 Charlotte Atkins: I am interested that you mentioned Warrington, one, because you say that they are going for a partial ban, two, because it happens to be in my constituency, and also because we are looking at the whole issue of exemptions here.
What have they done which is almost like going down the partial ban route and what is your view of how easy is it to introduce a partial ban?

**Mr Foweather:** My personal view, as a Governor of a juvenile establishment, is that juvenile establishments should not allow smoking on the premises. I think that is detrimental to that particular age group and I also believe there is something along those lines in the prison rules, that juveniles should not smoke, and that is because there are various complications. We have 15-year-olds for whom is illegal to buy tobacco, although not to smoke it, and then you have the bullying issues of those who do get tobacco because they cannot procure it through the canteen route. There are some unique issues surrounding juveniles and we have also got some further complications because some of the sites are in part juvenile and in other parts YOIs, which are up to 21, so there are these added complications.

**Q267 Charlotte Atkins:** What was the worst moment in your bid to ensure that the institution went smoke-free? Was it opposition from staff or was there a particular event during that process? There must have been some difficult times.

**Mr Foweather:** Yes, I think the main resistance that I found was from staff and that is probably in part because my trainee turnover in a place like Wetherby, for instance, is maybe 1,100–1,200 trainees coming through, so when I announced that we were going to be totally no smoking from the 1 January with a ten-month lead, quite a high number of those trainees were not going to be at Wetherby when the policy came in, so it was a case of identifying those boys who were going to be there past that date and then you are actually working on a small number and you are bringing it in through transition. The biggest resistance that I found was that initially there were some union implications and then it was from a hard core of staff. Incidentally, the staff surveys and focus groups which I held showed that quite a high percentage of staff were in favour with a hard core vehemently against, so it meant challenging those staff appropriately, engaging with them, offering support, guidance, occupational health, smoking cessation services, free nicotine patches and other sort of support mechanisms. I think part of the success was the time that it had in which to come in because it was a long process and I think that assisted it. I think we were lucky in terms of juveniles because they are a lot more susceptible to change when it has been managed and well-communicated, whereas for the older adult population, smoking is more entrenched, they have been smoking for years, it is probably seen more as a privilege or entitlement and that would be a harder population to get it across to, I think.

**Q268 Charlotte Atkins:** Did you have any staff leave?

**Mr Foweather:** I have had no staff leave as a direct consequence of that. I have had a few staff who have left the establishment as a consequence of not necessarily wanting to buy into the juvenile agenda, and the smoking cessation may well be part of that process because there is a raft of initiatives and change programmes in order to make establishments, such as Wetherby, more juvenile-appropriate to better meet the individual needs of juveniles.

**Q269 Mr Burstow:** I just have a couple of very quick questions and the first was to Mr Thain. Picking up something you were saying earlier on, you said that one of the drivers for your move to a smoke-free working environment was the protection of the workers and you particularly made reference to the Health and Safety at Work Act. Did you have any advice at the time that you were framing your policy and beginning to implement it which would have suggested that for you not to have this policy in place, you would be legally liable to challenge?

**Mr Thain:** Not specifically, no, but reading all around the subject, thinking about how we could improve the health and safety of our workforce and being part of an NHS initiative called Improving Working Lives, which encompasses trying to make the workplace better, this was the direction that we decided to go in, but it had this health and safety feel about it.

**Q270 Mr Burstow:** Given that you accept that we have got to the point where we know the effects of environmental tobacco smoke in terms of health, have we got to the point where the legislation possibly does mean that people can take action against those who still have workers in smoking environments?

**Mr Thain:** Yes, we are very much aware of that and in fact our trade union supported us on the basis that we needed to take account of health and safety.

**Q271 Mr Burstow:** I have a question for Mr Wheatley and this was something you said in response to Mike Penning’s question about the percentage prevalence of smoking amongst prisoners. You said 80%, but you then went on to say that, in terms of cessation, there was an equivalent success rate amongst smokers in prison to that in the general population, smokers outside prison.

**Mr Wheatley:** Yes. The DoH has put money centrally into our PCTs, so it has been distributed in order to make sure that we have got support to get prisoners off tobacco, and with those who are engaged with that smoking cessation process, we do as well as people who are engaged in the community.

**Q272 Mr Burstow:** Is the level of engagement as good as it is in the community?

**Mr Wheatley:** I cannot give you comparisons on that, so I could not give you an accurate account.

**Q273 Mr Burstow:** The reason I ask that, and it is interesting to tease that out now, is because if the level of engagement had been as good, presumably the level of prevalence would be going down very rapidly and I assume you are saying that the prevalence has not been going down rapidly.
Mr Wheatley: Well, the population is not static.

Q274 Mr Burstow: No, no, but we have also established that quite a lot of people are there for quite long periods of time.

Mr Wheatley: The population is an interesting mix. About 56.7% of the adult male population are serving four years and over and over 6,000 are serving life sentences or indeterminate sentences, but the short-termers move through very quickly and there are a lot more short-termers, so if you look at the population over the course of a year, there have actually been hundreds of thousands of short-termers through the system, but the long-termers are stuck for a very long period of time, so it is quite sharply divided population. Probably the biggest problem, from our point of view, are the people who are coming in, arriving for a week, two weeks, three weeks and then off again and with different people being recruited because it is not always the same people that come back, though far too often it is some of the same people we have seen before.

Q275 Dr Taylor: Mr Wheatley, the whole point of the proposed legislation is obviously to protect the health of staff. Have you any idea of the proportion of prison staff that are smokers and non-smokers?

Mr Wheatley: I have not got any accurate statistics on that. My impression is that amongst younger staff, there are less smokers, people are less inclined to smoke, and amongst the older staff group, there are probably rather more smokers, and smoking was very much what happened in prison. We are aiming to protect staff and our policy already says that staff do not smoke in offices, and that is single offices, not just shared offices, and staff should not be smoking in the public areas of the prison, and my office staff cannot smoke in their offices, so they have to go outside to a sealed smoking room, which is a rather unpleasant place in the bowels of Cleland House. There is of course the question that if prisoners are smoking in their cells, staff will occasionally have to go into cells, mainly to search and to do a security of cells, staff do not spend a lot of time otherwise in prisoner cells, and at that point I would expect them to say to prisoners, “You don’t smoke while I am in here”, so it is possible to have a situation where in effect the prisoners are smoking as if it is their own home without great risk for staff, although I take the point that there may be powerful things that hang around in the air for some time, but we can avoid the straightforward smoking in the face of staff, I think.

Q276 Dr Taylor: I was very impressed with the evidence that you gave us from Wetherby about involving staff as well as customers. Obviously you have had unique cooperation with your PCT. Is there cooperation, Mr Wheatley, with PCTs for smoking cessation services widespread throughout the prison service as a whole?

Mr Wheatley: Yes, because the DH has helpfully centrally put some central money in order to encourage PCTs, working with prisoners, to regard prisons as somewhere where smoking cessation can take place. There is support. I think, as Paul was describing, Wetherby has much more successful cooperation than is being experienced everywhere, but there has been quite a lot of smoking cessation work done. I think Paul has achieved an exceptional level of support and his PCT is to be congratulated on putting that effort in.

Q277 Dr Taylor: Would your smoking cessation services be open to staff as well as prisoners?

Mr Wheatley: No, we have not spent the money on staff. Paul’s experience at Wetherby, where the whole prison has gone completely smoke free, is unique.

Chairman: Could I thank all of you very much indeed for coming along this morning. We are hoping to publish this inquiry before Christmas.

Q278 Jim Dowd: Can I ask one question of Mr Wheatley. Earlier you said 80% of the prison population, in your estimation, were smokers. That is about the reverse of the national picture. Do you have any view as to why that would be?

Mr Wheatley: I think the sort of people who are going for crime are often not thinking a long way ahead—if you did think a long way ahead you would not go in for the sort of casual crimes that people do—and they are living very risky lifestyles. Sixty per cent of them are probably using hard drugs. Again, 60% of the population are not using hard drugs, at least I hope not. This is a group who do risky things.

Q279 Jim Dowd: You are not saying that smokers are more likely to indulge in criminal behaviour?

Mr Wheatley: I am not saying that. I am saying that our criminal population appear to have a larger proportion of smokers amongst them. I think our criminals do engage in risky behaviour without looking at the long-term consequences in many cases. If they looked at the long-term consequences they would not engage in the crimes that they do.

Q280 Chairman: It is almost on the basis of social class well.

Mr Wheatley: That may be part of it.

Q281 Chairman: Again, thank you all very much indeed for coming along this morning and assisting with the inquiry. Hopefully it will be in your stockings for Christmas, but you will have to wait and see what next week brings as well as this week. Thank you.
Witnesses: Mr Rob Hayward OBE, Chief Executive, British Beer and Pub Association, Mr John Hutson, Chief Executive, J.D. Wetherspoon, Mr Nick Bish, Chief Executive, Association of Licensed Multiple Retailers, Mr Bob Cotton OBE, Chief Executive, British Hospitality Association, and Mr Tony Payne, Chief Executive, Federation of Licensed Victuallers Associations, examined.

Q282 Chairman: Good morning. Could I first of all thank you very much for coming along this morning to give evidence to the Committee. I wonder if I could ask you to introduce yourselves for the record?

Mr Hayward: Rob Hayward, Chief Executive, British Beer and Pub Association.

Mr Hutson: John Hutson, Chief Executive of J.D. Wetherspoon.

Mr Bish: Nick Bish, Chief Executive of the Association of Licensed Multiple Retailers.

Mr Cotton: Bob Cotton, Chief Executive of the British Hospitality Association.

Mr Payne: Tony Payne, Chief Executive of the Federation of Licensed Victuallers Associations.

Q283 Chairman: Thank you very much. I suppose it is a question for all of you. Do you believe that second-hand smoke in the workplace is a danger to the health of workers? Who would like to start?

Mr Hutson: The feedback from our staff is that they prefer to be in surroundings that are smoke-free. Whether they perceive it to be a danger or not, they certainly prefer to be in smoke-free premises.

Mr Bish: I think that is the general position, and I think that the operators would like to improve the atmosphere in pubs for staff and for customers.

Mr Cotton: My members employ 600,000 people right across the industry. Over 90% say they would rather have a comprehensive smoke-free environment in all areas.

Mr Payne: Our members do take care to look after the interests of their staff. They have done risk assessments and we make sure that we recommend that people do not smoke at the bar to look after the interests of the staff.

Mr Hayward: I would echo what has been said already. Since we are pressed for time, I am going to keep the answers as short as possible.

Q284 Chairman: I perceive that none of you dispute, or do you dispute, the issue of science in secondary smoke?

Mr Hayward: No.

Chairman: There is no dispute.

Q285 Mr Burston: Given that answer and given what we know about the current state of legislation in terms of the Health and Safety at Work Act, do any of you think that you are liable as a result of that now that you admit that you know the health effects of environmental tobacco smoke?

Mr Cotton: I have a very clear view that our employers have a duty of care to their employees, and we are particularly concerned, if we have current proposals where some employees will have to work in smoke environments, that there may be claims down the track, and our employers feel very nervous about that, where you are exercising a duty of care for some employees but not others.

Q286 Mr Burston: Do any others share that concern?

Mr Hayward: Yes, generally, I think we would probably all echo those concerns. What the industry in different forms has been attempting to do is to introduce progressively smoke-free circumstances in each of the different venues in different ways, and significantly the industry has made more progress over the last few years than government has because we have been introducing those policies.

Q287 Mr Burston: I noted in your submission that you felt there had not been a great deal of support for the roll out of policies around smoke-free environments when you submitted to the consultation earlier on. What is your view about the support you have had from the Government to implement them?

Mr Hayward: Originally, when the original charter was launched, there was government support, but I do not think there has been as much support since then as we might have wished. In fact, the BBPA launched (with a large number signatories) an initiative last year to make more marked progress in terms of no smoking at the bar, no smoking back of house and in smoke-free areas, and we set time deadlines. One of the difficulties in pursuing those deadlines has actually been that there has been so much uncertainty. Given that 70–75% of licensees are small businessmen, trying to induce them to actually take action when there is uncertainty in relation to what government policies are going to be is not an easy set of circumstances, but we have made some progress.

Q288 Mr Burston: So certainty is one of the key things you are looking for out of all of this. Can I come on to a specific question? If the Health Bill does become law, will some pubs stop serving food in order to continue to allow smoking? Secondly, how many pubs are currently drink only and how many additional pubs do you think will stop serving food as a consequence of the legislation and the regulations as currently envisaged by the Government?

Mr Bish: We believe somewhere in the order of 20% of pubs—there are 60,000 pubs for broad comparison—will cease doing food in order to retain their smoking status.

Q289 Mr Burston: That is an additional 20% over and above those who currently do not serve food. Is that what you mean?

Mr Bish: We are in the throws of defining what food is, but there are very few pubs that do no food at all. We are not talking additional, we are talking total. They are about 20%.

Mr Hayward: I am sorry to interrupt, but we have actually provided some data in our submission on page 12 which I think sets out what we expect to be the position.
Q290 Mr Burstow: You suggest something like 34%, I think was the figure I have seen in your paper?  
Mr Hayward: Yes.

Q291 Mr Burstow: The Choosing Health White Paper suggests a range of ten to 30%, so I am interested that you suggest it is 20%. That looks as if you are splitting the difference?  
Mr Bish: That is the report back from my members who are marginally different from the BBPAs.

Q292 Mr Burstow: So 20% of your members are saying that within those multiple premises they will be giving up food in order to retain their smoking status?  
Mr Bish: Yes.

Q293 Mr Burstow: Thirty-eight per cent of your members?  
Mr Payne: Of our membership, yes.

Q294 Mr Burstow: That is based on their statements?  
Mr Payne: On their statements—their statements only—on a total blanket ban.

Q295 Mr Burstow: That would be a higher level of closure than has even been observed in the Republic of Ireland, would it not?  
Mr Payne: Yes, but this is on a total ban: if we had a total ban where you could not have either smoking areas or food areas.

Q296 Mr Burstow: Do you think if a ban of the sort that was implemented in the Republic of Ireland were implemented that figure would go down?  
Mr Payne: The only different position in Ireland is that the family own a lot of the public houses. They do not have rents or mortgages to pay. We still understand that 400–500 public houses have closed in Ireland since the ban came in.

Q297 Mr Burstow: The figure does seem to move about quite a lot, as we discovered when we went to Dublin last week. Even here, in terms of the evidence we have had, we have had the suggestion of very varying levels of speculative figures about job losses. I think 7,500 has been mentioned in another of the submissions we have had.  
Mr Payne: Could I clarify the point about the 38%?

Q298 Mr Burstow: Yes,  
Mr Payne: We are talking about the smaller end of the market. We are not talking about 38% of the country.

Q299 Mr Burstow: That is a helpful qualification. Finally on this issue around partial bans, it has been put to us by a number of those who have submitted evidence that the areas of the country where pubs will opt to remain smoking pubs will be very concentrated in the less well-off areas. Is that a view that you would share, or do you believe that this would be spread across all areas and all social groups as a result? Is there a view here?  
Mr Hayward: Smoking prevalence clearly indicates certain classifications of higher levels of smoking than others, and there is no reason for believing that that would not apply in this set of circumstances.

Q300 Mr Burstow: Would that support the contention that this would exacerbate health inequalities, at least in terms of smoking?  
Mr Hayward: I think the indications are yes.

Q301 Mr Burstow: The other thing which I know is vexing many of you is this question of exemptions for membership clubs. What are your views about the equity of such a proposition that membership clubs should be excluded from the ban?  
Mr Bish: We think it is totally inappropriate. We do not see the consistency or the logic. We fear the sort of political agenda in the original proposals, but it is not equitable, it is not fair on the staff who would work in the club, and it is not fair on the businesses that, as it were, are just down the road competing for the same trade. You would end up with a non-smoking, local community pub and a smoking club just down the road, and there will be a migration of customers, which I think would lead to what Mr Payne was saying about his members’ likely closures.

Q302 Mr Burstow: Does anyone else want to add to that? Is that the general view across the industry?  
Mr Hayward: It is a general view, but I would make the observation: people tend to think of it just as clubs—i.e the RAF Club, or the Conservative Club,
or the working men’s clubs—this is sporting clubs and all sorts of other clubs as well. and, therefore, there would be a substantial impact. Thinking of parts of Bristol, you can think of the rugby clubs and the football clubs which would have the exemption right alongside small pubs which are in Tony’s membership, and there would be a number of problems there.

Q303 Mr Burstow: I think my final question is again going back to the partial ban. Given what you understand currently of the Government’s intentions around this partial ban (and there are obviously issues about the interpretation of what food is for this purpose from what we understand), what are your views about how easy it will be to achieve compliance with this partial ban?

Mr Cotton: Totally impossible.

Q304 Mr Burstow: Do we have any further offers in terms of whether it is possible?

Mr Hutson: Why it is going to be difficult is because there will be no clarity for customers, because they will not know necessarily, before they walk into premises, whether they do or do not serve food and whether it is or is not non-smoking. That is why it will be very difficult to enforce, because it will not be a simple rule.

Mr Bish: I agree up to a point. I think that clarity is an issue. I think the experience from elsewhere has been that the issues of enforcement are the problems. Compliance actually is less of a problem. I think if there is clarity, compliance comes through. The difficulties are of enforcement. Just on that point, I think it is important for the Government to realise that the industry is, as it were, on side in this, that our mission is to serve our customers and to protect our businesses, but in the general smoking cessation debate the remarks that we have previously made are right. Therefore, there is an element of alienation in some of the proposals. I particularly refer to the fines that are being suggested. It seems bizarre that an individual who smokes against the rules is likely to be fined £50 and the proprietor of the premises, the manager of the premises, will be £200. It is like asking a police officer to pay the fines of the speeders on the motorway. It is bizarre.

Mr Cotton: Can I just add, enforcement is best done by the consumer. If there is universal understanding of what the rules are, the consumer will be the enforcer, and you do not need an enforcement officer or the Hos to go round and actually do it, in the same way as when smoking was banned on the underground, for example. If anyone lit up now it would be consumers who would say, “Stop”, and that is the approach that we want.

Q305 Mr Burstow: Certainly that is what we picked up whilst we were in Dublin?

Mr Hayward: Can I disagree with Bob Cotton in relation to his comments. I do not think it is unworkable, but it is complicated. Where there is a will there will be a way, and you can work round it, and certainly I think, in general, pubs and bars would want the process to be achievable.

Q306 Mr Burstow: So the regulatory burden would be higher, the costs would be greater?

Mr Hayward: There is no question. Whichever route you go down, whether you go smoking rooms or food exemptions or any other form of exemption, once you start introducing those exemptions the complexities rise. There is a suggestion, for example, that if the clubs exemption remains you will have pubs switching to clubs in all sorts of fascinating legal manners; so any exemption has a regulatory burden, but you have to work within those and I think those are achievable.

Q307 Chairman: It does not describe a level playing field as far as business is concerned, the sort of exemptions that are being floated around at the moment. Would anybody disagree with that statement?

Mr Bish: I think “level playing field” is a sort of beguiling prospect and to be aspired to, but that the industry is not itself a level playing field and the way that operators operate and the markets that they have and the customer expectations are all different, so we try to reflect that, and to apply this principle in a level playing field way is going to be, as Rob said, complicated.

Mr Cotton: Can I just add, though, that this is primarily a health and safety issue for our employees, not a consumer driven issue per se; so whilst the level playing field issue is key in business terms, we really need to get back to the fact that it is health and safety and protection of employees.

Q308 Chairman: It is the workplace issue.

Mr Cotton: Yes.

Q309 Chairman: The other thing—I think Mr Payne you mentioned it talking about when you went in a pub 30 years ago. Beyond a packet of crisps, none of the pubs I used to drink in as a youth had anything like food at all. What food has done, in a sense, in the area of the country that I know, is changed the culture of what a public house is or is not. Is there a danger that we are going to go back? If people think commercially it is best to get out of food so people can drink, are we going to go back to these men’s drinking pubs that there were in the1960s?

Mr Payne: I think it is important that we just talk in that way, because we have got a situation now where families go into public houses and I think it is important that we encourage that. The public houses do a lot. We have got old age pensioners going in for meals at lunchtimes, and you can see notices all over with offers for old age pensioners, and they have nowhere else to go, a lot of them, no social outlet other than what pubs provide, as far as I am concerned, an excellent service for old age pensioners, people on low incomes, where they can go and relax and have a quiet drink. They do mix with smokers, but I think they are all quite happy that way, and I think that is important.

Mr Cotton: Can I add, though, that the nature of the business has changed over the 30 years in that nowadays for a business to be viable it may serve food and drink at lunchtime, a different type of
business during the afternoon, then certain things in the evening—maybe heavy food in the evening, and then at 10 o’clock it becomes almost predominantly maybe drink only—but in terms of being a viable business you have to reflect customer needs and the nature of your business changes throughout the day, so no longer do you have this sort of clear one thing or the other: What is a pub? What is a restaurant? What is a restaurant hotel bar? They all merge together to reflect the nature of business and the need to have a viable operation.

Q310 Charlotte Atkins: That was a very interesting point, Mr Cotton. The flavour of your evidence seems to be that you think the Government does not realise that you are on side. Can I ask you, therefore, what sort of dialogue you have had with government over these issues?

Mr Cotton: We have had extensive dialogue, not just with government in Westminster but in devolved government as well. I can start off with the extensive discussions we had in Scotland with the Scottish Executive, one-to-one with the chief minister and all the team up there to end up with what I term excellent proposals which the industry is on side with. When we have come to Westminster over the last two and a half, three years, I think, I and my colleagues have had extensive meetings with the Health Department and DCMS, starting off with a voluntary approach, which we felt was the right way forward to start with, but when voluntary, as it were, was not an option, we then discussed in detail possible ways forward, and we have always made two or three clear issues. One is that to run a viable business you have to have a partnership with your consumer (with your customer), so we never wanted to get too far ahead of customers. That is why we have always said we want a progressive change and we want to have sufficient time, whatever change is implemented, to bring your customers with you to mitigate, as it were, the change in business. That is why we have asked for time to do that, and we have suggested 2009, perhaps, would give us sufficient time to do that. We want clarity of understanding for employers, employees and the consumer, and I felt that we had had good dialogue up until a few weeks ago when the proposals were issued, which seemed to be contrary to the nature of the dialogue that we had been having.

Q311 Charlotte Atkins: Would anyone else like to comment on that dialogue thing?

Mr Payne: In 1998 when Rosemary Jenkins was writing a paper for the Department of Health on smoking, I invited her to come to the north and see some of these one-roomed rural pubs. We took Rosemary Jenkins in, left her for half an hour with the licensee, and I took an expert on ventilation with me so that Rosemary could speak to the people, and she was amazed at some of these public houses and the difficulty they would have to compete. The other thing we did put to the government in that paper, you will notice, is that we suggested that public houses could also be health clinics. They could, if they wanted it, issue things like patches. A lot of public houses, in fact, run football sporting teams, which is another thing to keep the nation fit, which is one of the government’s aims.

Q312 Charlotte Atkins: Would anyone else like to comment?

Mr Bish: I think we are actually very proud of what we have achieved. We started engaging with government more or less when labour came into power after the 1997 Election. The result of that was the 1998 White Paper which itself endorsed the charter for smoking, and that was definitely a customer choice issue, but I think the success that we had, and I fear I disagree with Bob Cotton, I do not think that the Government really did engage and support our activity. We have delivered 54... I think the latest figure—public and newspaper will tell us—is that over 54% of all pubs have extensive smoking restrictions, positive smoking restrictions. That was from about 14% back in 1995–96 when we started collecting this information. There is a huge advance, and I think that there was a step-change from customer choice once we had started bringing our customers with us, into the staff issues after we collected that information. I am not really sure the Government has given us credit and seen us as being on side and the people who can deliver the solutions were not in any way in the way.

Mr Hayward: I would just add, in terms of consultation we do not necessarily like some decisions that come out of government, but the Department of Health I would rate on this issue to be above certain other government departments, which I will not identify, in terms of their willingness at least to talk to people. Whether you agree with the decision or not afterwards is a different matter.

Q313 Charlotte Atkins: Mr Hutson, you are going ahead of the later stage in terms of making most of your pubs smoke-free?

Mr Hutson: We are.

Q314 Charlotte Atkins: What exactly are you doing? They are going to be smoke-free from what date?

Mr Hutson: We started to convert our premises to entirely smoke-free from about March this year, and so far we have converted 47, which includes a number of new openings as well. We are doing the whole of Scotland next year. We are going to review it by the end of the calendar year in terms of the pace, but we have been doing about one a week since we decided to convert. Of course, it is quite difficult going it alone, but our view is, and has been for some time, that a ban, whether it is through legislation or consumer choice, is inevitable in any event. Wetherspoon has always tried to appeal to a broad cross-section of the population and we just found that increasingly a large proportion of our customers do not like being around those people that smoke. That was on the basis that at the time we had non-smoking at the bar, and have done for the last 12 years. We used to have a third of our customer area permanently set aside for non-smoking. We increased that to 70% two years ago, and even then we were getting more and more moves...
from our customers to push on and do more, and so that is what we did. In the pubs we have converted so far we have seen sales fall.

Q315 Charlotte Atkins: This is drink sales?
Mr Hutson: This is overall sales, led by drink sales, because food sales have risen sharply, in fairness, and sales overall are down 7% in our pubs, which we think is about what happened in the first year or so of Ireland and which is far better than what happened in New York and about the same as what happened, as far as we can tell, in California. It will be painful for a couple of years, which is why we would advocate, as Bob was saying, a long period of time for the industry to acclimatise to the idea of it, but we just think it is inevitable one way or the other, and above all else we want clarity. You mentioned a level playing field, but that is what we think the suggestions that are proposed do not bring. It will be a mass confusion for consumers, and for operators it will be very difficult to adapt to the legislation as proposed.

Q316 Charlotte Atkins: I believe in Mr Hayward’s evidence that you are talking about having a 20% floor space smoking area. What worries me about that is how can you have 20% smoke-free, and, indeed, you are talking about a meter from the bar, because in my experience air tends to move, and whether it is 20% smoky, it does not mean that 80% is smoke-free. Likewise, with the whole issue of so-called smoking carriages, unless people are going to vault into the top of them, you have to open the door and smoke comes out, and people smelling of smoke has an impact. When we were in Ireland the other day someone told me that it is getting to the stage where if someone goes into a home and smells of smoke there is almost a sort of, “Oh, dear, they smell of smoke.” That is an issue, that if you do have overwhelmingly a smoke-free environment people are going to notice the smell of smoke, and, unless you are going to have a wind-tunnel effect, I do not really see how you can make one area smoky and one area smoke-free when often it is not feasible to have a physical barrier between the two?
Mr Hayward: It is a question, as has already been said, of getting people used to the change. What is interesting is that by introducing progressively smoke-free areas what you actually do is make consumers change themselves. There is a pub very close to here which introduced no smoking at the bar and which I use quite regularly. What is striking about it is that the number of smokers, the proportion of customers who smoke, has gone down throughout the whole of the pub. Scientifically you are absolutely right, but it is a question of changing attitudes over a period of time, and it is quite striking how the introduction of a smoke-free area induces a much more marked level of behaviour than one would actually presume.
Mr Bish: I would not agree. I think that the 1998 White Paper suggested that ventilation was a contributory factor in the solutions. The science definitely exists. The wind-tunnel point is not right. You do not need wind-tunnels to move air around. There is nothing magical about the particulates and carcinogens and things like that that will linger where all other contaminants will be removed. The technology exists for operating theatres with negative or positive pressure to keep them clear. The ventilation industry exists. It is an enormous industry. It must be doing something right somewhere. The Health and Safety Executive offer workers exposure limits and define those, and the ventilation industry provides the kit to deliver those answers. I think, perhaps, there was a time when we believed, in the trade, that ventilation was a solution absolutely in itself. That was then. This is now. Smoking cessation is the issue, but ventilation has a role to play. It can help, but the industry is there to help and advise government.

Q317 Charlotte Atkins: Ventilation does not remove all the harmful effects of second-hand smoke, does it?
Mr Bish: Air replacement replaces air, it replaces everything in it. Nothing clings on, it just moves out.

Q318 Charlotte Atkins: The evidence we have had indicates that the particulates are still there and that they are still damaging. It may make the air feel nicer, and so on, but actually it does not take out the harmful impact. If we are talking about staff, clearly if you have smoking areas or if you have smoking carriages, what about the staff? They have still got to go and clear those areas. Are they given special dispensation? How do they go in there and clear them up, unless, of course, you are going to leave them piled high with cigarette ends, which maybe a solution? Hopefully no-one will go in there anyway, but if we are talking about staff, how do we align our concern about the health of staff and asking them to go in and clean areas piled high with cigarette ends and also with smoke?
Mr Bish: There is a solution there. If we want to do it, there is a way. The ventilation industry can do it. You will get complete air changes, including leaving the room unoccupied for a very good time to allow the air change. That will happen. That is just science. It works. It is whether we want it to work is the point and whether we can afford it to work.

Q319 Charlotte Atkins: That is the issue. The cost issue, of course, is huge. Mr Payne was talking about 38% of the smallest pubs going out of business. They are not going to be able to spend possibly thousand of pounds on ventilation?
Mr Bish: It is very difficult for them.

Q320 Charlotte Atkins: The big chains might able to do that, but it just depends if they have decided to go down the other route.
Mr Hutson: We are fortunate because most of our pubs have been built in the last ten years and have been converted, so they do not have all the grade two listed building aspects which many pubs, particularly in London, would have to face. We spend about £150,000, on average, on air-conditioning, and we change the air 20 times an hour at peak times. Even with all that, on a Friday night it
is very difficult to stop the air from the smoking area drifting into the non-smoking area, but by and large it does work, and Nicky is right, our pubs actually are quite smoke free, but it cannot be guaranteed. I was in premises yesterday and the staff, unfortunately, had turned it off and it was very, very smoky. The only way to guarantee it is to ban smoking. I am afraid.

**Mr Payne:** Even our members who are on low returns themselves have spent a lot of money. As I said before, 30 years ago we got the smog, i.e. full of smoke; today you do get clean air in a lot of public houses and I think it is important to understand that it will improve over a period of time. The only thing is, if we get some assurances from the Government on this people would invest more money to make the pubs even more health conscious.

**Q321 Jim Dowd:** Mr Hutson, when you say you convert Wetherspoon’s pubs to non-smoking, there is no process, is there? You just say it is going non-smoking.

**Mr Hutson:** There has been a process involved, surrounding capital investment and marketing of the pub. Because we are conscious of the fact that we have been going ahead of legislation, so we have had to try and create a bit more impact, and what we have noticed is that food sales do rise. It has cost us, on average, about £50,000 per pub, primarily investment in new kitchen equipment, and we have repainted the pubs and in many cases re-carpeted, but certainly cleaned the carpet, so that when people walk in there is no residue of smoke whatsoever.

**Q322 Jim Dowd:** What kind of notice do you give customers?

**Mr Hutson:** We have been giving customers three months notice in terms of a date, and then, with a month to go, every day we do a count-down.

**Q323 Jim Dowd:** As a commercial organisational do you sell tobacco on the premises?

**Mr Hutson:** At the moment we sell tobacco, yes.

**Q324 Jim Dowd:** Even in the non-smoking pubs?

**Mr Hutson:** In the pubs that we have converted, it is a mixture. If we have an outside area, and we have endeavoured to get an outside area everywhere—and you have been to Ireland yourselves: you will have heard of the importance of trying to get an outside area if you want to retain a lot of the smoking trade—we keep selling tobacco for people who want to go outside. We have not taken a moral issue on smoking. If you want to smoke, fine. It is a legal thing to do. That is why we thought, “Well, if you are going to smoke we will provide facilities outside for you—heaters, canopies, things like that—and we will still sell cigarettes for you.

**Q325 Jim Dowd:** Just a general question to anybody really. My calculation of what you have been saying is that the distinction the Government has chosen, if there is not to be a total ban, is going to be onerous and difficult. Would it be, in your view, better to simply designate certain premises as smoking permitted under restricted circumstances and others just as non-smoking?

**Mr Hayward:** If you are saying certain premises, specifically a venue as against another one further down the street, that will cause the problems that John has just referred to, because people will migrate, so that is not the route that we would prefer. Any exemptions, clearly, as I said earlier on, have a regulatory burden. We personally have indicated that we would prefer some form of segregated smoking rooms, and we will work with whatever clear option is introduced, but it has to be clear and operable across an enormous range of the industry: because, as Bob Cotton has said, we are talking about a mixture in the hospitality sector now which just did not apply 20 or 30 years ago.

**Q326 Chairman:** Is it not the case that any segregation—the smoking carriage is the recent debate—if we are to believe it they cannot get any consensus on that at cabinet level either—just brings the problems about Tony Payne’s smaller pubs and everything else. It seems under those circumstances that . . . Is not your answer to this in a sense, maybe reluctantly in as much as you preferred a voluntary approach, that a comprehensive ban would be more certain for you as a group and as individuals representing organisations? Would that be an unfair assumption to make from what we have heard and from the written evidence that we have taken as well?

**Mr Hayward:** I think it is a conclusion that you can draw, but I think in society, whatever field you are talking about, whether it is smoking or anything else, you either have a complete ban or complete freedom and anywhere between those two imposes a regulatory burden with which one has to work. Yes, the simplistic solution on anything in life, whether it is stopping people from driving over Westminster Bridge, that is a clear decision, or else you allow them to go at 80 miles an hour and anything you impose in between has implications. The simplest solutions are always the extreme ones.

**Q327 Chairman:** You represent a lot of people, and all of you, one way or another, represent some quite small business. Is not the great fear that if it is not a comprehensive ban, it throws this whole question about switching from food to drink, or whatever, into great confusion within the hospitality trade?

**Mr Cotton:** Absolutely. Whatever we have said, all along clarity is absolutely essential in this, fairness, but also recognition that it is about the protection of the employees wherever they work. If you are in a small business or in a chain business, the fact you might be treating employees differently in one place to another—I think in five years’ time it will be very difficult standing in front of the red robed judge saying, “I recognised the problems for that particular employee and we took action, but not for that employee.” I think you will be laughed at, quite frankly.
Chairman: Is that what you heard in Scotland?
Mr Cotton: Yes, indeed, and I also went to Ireland and I have seen the impact in Ireland where I think it has worked extremely well and the whole sector has continued to grow. I am talking about tourism, hospitality, leisure in its totality.
Chairman: We did add it to it for a couple of days last week, I have to say.

Mr Burstow: And we are not the only ones who have been there to add to the expansion in the tourist trade. There seem to be a lot of people going to the Republic to learn about what they are doing. I wanted to pick up on something else we heard whilst we were in Dublin. It was put to us, I think, primarily by the Hospitality Association in the Republic, but they were saying it was something being experienced, anecdotally at least, across all parts of the hospitality industry, and that was the implications for the costs of maintenance of premises. The argument was that in environments which are predominantly smoking environments there are increased costs of maintenance—repainting to remove the obvious tarring effects that cigarette smoke causes and various other things—and that the costs of maintenance went down; and this was something that the Hospitality Association was putting forward as a benefit from this. I wonder whether anyone here would sign up to the proposition we heard from the Republic’s Hospitality Association or whether you say that was an incorrect assumption?
Mr Cotton: It is a clear issue for hotels. Quite frankly, cleaning a hotel bedroom is substantially easier when people have not smoked, and there are particular issues which I think we have given in evidence to you about how you treat hotels. The Irish solution is a very good one, Scotland is almost there, but it is particularly important, and it has reduced the cleaning costs certainly for hotels. I would not comment on pubs.
Mr Hutson: In the ones we have converted we have seen already, costs do come down, but I think for us that is more as a result of change in the customers that come to the pub as opposed to anything else. You get fewer heavy drinkers.

Mr Burstow: Right; so you get less spillage?
Mr Hutson: More food customers, fewer heavy drinkers, and they tend to respect the premises better.
Mr Hayward: One of the reasons why we were arguing for a period of time, because some costs do clearly go down, other costs go up. We were asked by the Department of Health in relation to the question of food the implications since, the Chairman indicated, there has been this huge shift. You have got large numbers of pubs who have invested very heavily in some from of food supplies, food refrigeration, food preparation, et cetera, and those are costs which in the short-term they would clearly face in terms of making the shift from one side to the other. There are clearly some changes which would be beneficial and others which are disadvantageous.

Mr Burstow: Mr Bish, have you any observations?
Mr Bish: Nothing more. Obviously it just weighs in the balance with the declining income. I mean if Wetherspoon’s income has gone down by 7%, they are jolly glad not to have so much cost in refurbishment and cleaning. It is as simple as that. It is a profit and loss issue, but it is weighed in the balance.

Mr Burstow: It is as simple as that in as far as it was presented that way to us in the Republic, but the Republic’s most recent figures show that there is actually an upturn in terms of sales of alcohol both in licensed premises and to take home. Mr Bish, you were talking in response to Charlotte Atkins’ questions about ventilation, saying that this was at least a partial solution to this. I wondered if you had any technical papers or research papers that backed up that position that we might be sent so that we can have a look at that. It might be useful just to see if there are any robust technical assertions that would support your proposition today?
Mr Bish: Yes, the University of Glamorgan, Professor Andrew Geens, has conducted extensive surveys and I believe it is now out for peer review. I am not sure when that response is coming in, but through the contacts that I have I would be very glad to furnish that to the Committee?

Chairman: I do not know, Mr Bish, if you have been to Ireland. We probed this issue in Ireland and could find no evidence of it whatsoever.
Mr Bish: That there was any ventilation.
Chairman: There is ventilation which makes the place more pleasant; it is the issue of protecting the health of the workforce that we were trying to probe, and that was the evidence that was lacking in our visit to the republic of Ireland. Richard.

Dr Taylor: Thank you. It is really just to clarify a point Mr Payne made, and I apologise if I did not quite understand it, but you were talking about about 38% of pubs closing down at the smaller end of the market. Was that with the total ban or the partial ban as proposed?
Mr Payne: A total ban. Thirty per cent of our members, and we are talking about the people that returned it, said that 38% would have to close down with a total ban.

Dr Taylor: So if it was a partial ban, as the Government are proposing, would that therefore be a lesser percentage?
Mr Payne: It would be lesser, but the difficulty is when we talk about non-food elements, say a smoking area, loads of public houses do things, and it has been brought up to my attention that they provide sandwiches for the games team, so that would be stopped. Nothing has been clarified yet, and I think there is a lot of other points that need sorting out. If that type of thing was stopped it would cause more problems.
Q336 Dr Taylor: So, despite the risk to these 38% at the smaller end of the market, you would still be on the side of everybody else, that it is clarity and a total ban that is the only workable option?

Mr Payne: No, we have said all along that as far as we are concerned, like Mr Cotton said earlier—Mr Cotton mentioned earlier the situation why we could not have food, say, 12.00 until 2.00 p.m. and then a smoking pub later on. That type of thing I think would help rather than either talking about just food-led or smoke-led. I think I that would help everybody going down that way or something like that, where licensees could, in fact, make the customers aware what service is being given at certain times of the day.

Q337 Dr Taylor: Can I come back? We have heard “clarity”, we have heard “protection of employees”, we have heard “level playing field”. Is there any way other than a total ban of getting there?

Mr Hayward: We believe there is. In terms of smoking rooms, we believe you can achieve it with food, and I indicated earlier that there is a regulatory implication, but we believe you can achieve an acceptable route.

Mr Hutson: Our view is that it is as simple as it appears to you and that everywhere else in the world it has been a simple solution: a complete ban and anything else is unworkable?

Mr Bish: We believe in self-regulation and responding to the customers. We think that it is likely there will be a ban at some stage. We, above all, want time to prepare for it, time and clarity.

Mr Cotton: Quite clearly a total ban is inevitable, as in Ireland, as in several countries in Europe. All I ask for is time to ensure that the customer adapts to it but that we have complete clarity.

Mr Payne: A total ban, I am afraid, would cause chaos for the rural and community public houses and the customers, and that is the most important thing: the public that we look after.

Q338 Chairman: Do any of you represent people from Northern Ireland?

Mr Hutson: We have some pubs over there.

Q339 Chairman: What do you think of the Government’s announcement in October that we are going to legislate for a complete ban in Northern Ireland?

Mr Cotton: I am staggered that with no devolution to Northern Ireland direct through from Westminster, but we can have a government that puts a total ban in Northern Ireland and does not in England.

Q340 Chairman: And Wales?

Mr Cotton: Wales, I think, is going to ask for permission. I understand very clearly Wales is going to follow the Scottish route.

Q341 Chairman: They will be empowered to do that if they want. I understand they took a principle decision on this.

Mr Cotton: They have already, I understand.

Q342 Chairman: People who are representing Wales will be looking at it differently to England, and Scotland is the same presumably?

Mr Cotton: When we are promoting Britain overseas for tourism that we have different rules in different parts of Britain, I find, is not going to help our tourism business either.

Q343 Jim Dowd: But that is true of the United States.

Mr Cotton: Fine. That was in California. The United States is a very big country.

Q344 Jim Dowd: In Colorado it is different again?

Mr Hayward: I think in Scotland you had a total ban implemented very quickly. In Wales the indications are that they have taken the decision in principle but there is an element of timing, which will be somewhat longer than in Scotland, and I think what we have all argued is that we should have a consistency of time. If I can throw in two quick observations, because they have not come up at any point. I think we are all united: the one thing we do not want is local authorities with different operations, that there should be a consistency across the whole of England; and, secondly, just as a very small point, in the proposed legislation there is the requirement on signage, but as it currently stands you would actually be required, even though it is a no-smoking building, to put up a sign in here saying, “No Smoking”, and the regulatory burden needs to be addressed overall on the subject.

Mr Bish: The reverse in fact: if the presumption is no smoking therefore it is only the smoking places such as remain that should be signed, because this just does not apply to the hospitality industry, and I am sure it has been brought to your attention that it is every single business in every single office-block up and down the land and the VAT man will tell you how many businesses that involves, but it is a lot.

Q345 Chairman: It looks like this is going to be fun. Could I thank you all for coming along and giving evidence in such an open and honest way. If you have anything further on areas we have discussed you sending to us we would be more than happy to receive it.
Witnesses: Mr Simon Thomas, Managing Director, Thomas Holdings Ltd, Sir Peter Fry, Chairman, and Mr John Carpenter, The Bingo Association, examined.

Q346 Chairman: Good morning, gentlemen. Thank you very much indeed for joining us here this morning. I wonder if I could ask you to introduce yourselves for the record.

Mr Thomas: Good morning. My name is Simon Thomas, and I am the Managing Director of Thomas Holdings Ltd and represent gaming operators from across the current leisure market, including bingo halls, adult gaming centres, et cetera.

Sir Peter Fry: My name is Peter Fry. I am the Chairman of the Bingo Association. Unlike Mr Thomas, who only very small number of the people he represents are bingo operators, I think there are two others besides himself, we are the official voice of the Bingo Association. I do not think we are going to disagree, but I think we should put that on record to start with.

Mr Carpenter: John Carpenter, I am an owner/operator of small bingo club in Oxfordshire and I am a member of the Bingo Association.

Q347 Dr Taylor: Can I go first to Mr Thomas, because obviously, as you have said, you only have a small number of bingo halls, so your main interests are really in betting offices, gaming centres, seaside arcades and machine-manufacturing companies. So you have got a wide range of interests?

Mr Thomas: It is not actually entirely true. For example, I have the largest bingo hall in the country, so I am very bingo focused as well. The group I represent has an interest in all of those areas.

Q348 Dr Taylor: In your submission to the Government, I think this was, you proposed that steps taken to improve the health of employees in all types of leisure establishment should apply equally, regardless of the type of establishment. That is your firm belief?

Mr Thomas: Absolutely. The health of the employees is paramount, and our view is unless there is a complete ban it will lead to complete migration of our customers into environments where they can smoke. We find the idea of a partial ban mystifying. A lot of our customers already go to working men’s clubs, et cetera, and, given the choice of coming into a bingo hall or an adult gaming centre and playing the slot-machines, drinking, eating, playing bingo and smoking, or doing more or less the same in one of the 19,000 registered clubs across the country, the customers are going to migrate.

Q349 Dr Taylor: What about betting offices? I have seen people stay in those for quite some length of time?

Mr Thomas: Betting offices are a slightly more specialised product. People will put a bet on, go outside and smoke. It is not really a sessional product, like bingo halls and adult gaming centres, where people spend prolonged periods of time.

Q350 Dr Taylor: Is it true that in some casinos cigarettes are provided free?

Mr Thomas: I am not in the casino business currently, but I believe it is the case, yes.

Q351 Dr Taylor: You also, I think, would be in favour—and you have heard some of the other witnesses in the previous session—of the legislation being brought in rather more slowly?

Mr Thomas: Yes. For example, in bingo halls, 30% of the floor area is non-smoking. Clearly that is an improvement, but it is not a solution, and, regardless of all the ventilation we put in, and like publicans we have put a lot of money into it, the smoke transfers across, the customers go between them. We can hardly have customers wandering around in nuclear biological and chemical suits to protect them or going into these smoking carriages to clean them in yellow suits. It does not work. It has to be complete.

Q352 Dr Taylor: So smoke-free areas do not work. Coming to the Bingo Association, I very much liked the last sentence of your submission to us which was, “The proposals contained in the Choosing Health White Paper are a confused mixture of policies, attempting to keep all sectors on board and reflecting a vague notion of public opinion but in practice discriminating against some premises in favour of others”, and, of course, as you end up, “The proposals will produce a law applying differently in England to the rest of the United Kingdom.” You feel it is all fairly ridiculous?

Sir Peter Fry: We actually take the view that we are more confused with the publication of the Bill, because, under the exemptions, which are not clearly delineated, you could read into the exemption for Government, I think this was, you proposed a partial ban. That rather threw us because we thought entirely in terms of a total or partial ban. We never thought that some bingo halls could be included. We still, I think, would say very strongly that a full ban is necessary, but what we would also say is that any help for the smaller clubs—and I would like Mr Carpenter to talk a little bit about this—any help we can give to the smaller clubs who are the most at risk, who perhaps provide the greatest social content for the customers, if there were exemptions, obviously we would like them to take a chance on using them, but my information from the Department of Health is that it is very unlikely. So, with that caveat, quite clearly we are in favour of a total ban, not just because it is going to affect our industry, our industry’s profits, but because of the effect upon our customer. A partial ban could cause the closure of about 150 clubs all over the country, according to a report we have had from the Henley Centre. A full ban would lead to the closure of something like 90 clubs. If we have to choose between partial disaster and total disaster, quite clearly we believe that the health interests that would require a total ban are also in the best interests of our customers.
**Sir Peter Fry**: A full ban would be less than a partial ban.

**Q354 Dr Taylor**: You have also told us that really nearly 50% of your players are smokers, and a lot of them are elderly ladies as well. Can you see any way of attracting that same sort of clientele to a bingo hall where there is no smoking? Can you see ways of making it attractive to them?

**Sir Peter Fry**: We have done various surveys ourselves, and one that we commissioned independently. We, of course, admit that there will be some people who will go to a bingo club who do not go now because the atmosphere is clearer, but, on balance, there will be a considerable net outflow, and that, as I say, will endanger a lot of clubs. I think it is perhaps a point that is not understood widely. When a bingo club closes we have discovered that about 50% of customers do not transfer to another Bingo club; they just stop going; and that is why we do believe that if many of our customers, such as the category you have mentioned, lose that opportunity, that will be social harm to them and why should they not continue to enjoy what they like to do, to go and have their little flutter and a good night out? I hope that has answered your question.

**Q355 Dr Taylor**: Yes. I think many of us concerned about constituents think of elderly ladies living alone for whom this may be their only outing?

**Sir Peter Fry**: Indeed.

**Q356 Dr Taylor**: Mr Carpenter, did you want to come in from the point of view of the smaller clubs?

**Mr Carpenter**: As Sir Peter was saying about possible exemptions for smaller clubs, I make it clear now that I want to go no smoking. I would like my club to be no smoking and I would do it tomorrow but for the fact it would be financial suicide. I would have 36% displacement of customers who would leave and go and play bingo where they can smoke. Having said that, I think we have got a great opportunity here. I think if there is a total ban our club will survive. It will take a loss of profits for two or three years, yes, obviously, but there is light at the end of the tunnel; we will survive. So I am asking and I am saying that I think we should have a total ban. Let’s do it and get it over and done with. My customers feel the same. Three or four years ago if I had spoken to them and said, “We are thinking about banning smoking,” they would have been up in arms. “The Government can’t do that”, but their mindset has changed. They are now thinking it is going to happen. “I cannot smoke at work, I cannot smoke on the train or bus. Lets do it and hopefully I will give up smoking.” That is what they are saying. They are saying let’s do it.

**Q357 Dr Taylor**: Do you think some of your little old ladies are keener on bingo than on smoking?

**Mr Carpenter**: I think a lot of them are keener on bingo.
Q363 Chairman: Could I welcome you at the final session for this morning and thank you very much indeed for coming along. I think first of all I would just like you to introduce yourselves and your organisations so we have got it on the record exactly where and who you are.

Ms Robson: I am Pauline Robson from the Transport & General Workers Union and I am an area boss representative for the North East.

Mr Revell: My name is Brian Revell and I am National Organiser of the Transport & General Workers Union for the food and agriculture sector.

Mr Ainsley: Michael Ainsley, I am the GMB Organiser for the casino and leisure industry.

Mr Robertson: Hugh Robertson, Senior Policy Officer for prevention, rehabilitation and compensation in the TUC.

Mr Borg: Vincent Borg, from Unison’s Health and Safety Unit, Assistant National Officer.

Q364 Chairman: Thank you. Could I ask you all a question here. What should the Government do to protect employees from passive smoking exposure?

Ms Robson: A complete ban.

Mr Revell: A complete ban.

Mr Ainsley: A complete ban.

Mr Robertson: There should be a complete ban with some small exemptions for places in someone’s residential home, for instance.

Mr Borg: Yes, I agree, with small exemptions.

Q365 Chairman: The next question is what do you think of what we are led to believe is the Government’s partial ban that is doing the airwaves at the moment? Do you have a view on that?

Ms Robson: I would not agree with that at all. Maybe if I could explain, I work in a pub in Newcastle which is licensed for 300. It is quite a busy pub and even if 150 people in the pub are smoking, and we have had new ventilation put in by a new company that just started in the summer, the smoke levels are far too high. I think all workers have a right to a smoke-free environment. Can you imagine this room, and I counted the number when I came in there were about 60 people in here, my pub is about two-thirds the size of this, can you imagine maybe another 100 to 150 people in here with half of them smoking? You might go to a pub say two or three times a week. You might actually spend about eight hours a week in the pub. Our staff spend 40 to 50 hours a week in the pub. We are talking about sessions of eight to ten hours of constant smoke. Apart from the fact it gives you cancer, even if you do not get the cancer, you get sore eyes, you get a sore throat, you stink when you go home, your hair stinks. I think the Government has missed it and there should have been a complete ban in the beginning. I listened to what the gentleman from Ireland said before, and it is very, very true what he says. If you have got no smoking in the pubs you do not have to decorate so much, you do not get so many holes in the furniture, and your insurance is bound to go down. You may lose a few customers but you will probably find you get new ones. You will get the ones who never went to pubs who will start going to pubs. You will get more families going and you will get more children going. It works in America. I have been in America and there is nothing wrong with going outside and having a cigarette. I am sorry, I am ranting, I will let somebody else answer!

Dr Taylor: I think we want her to talk to the Prime Minister!

Q366 Chairman: That is not within my gift but thank you very much for that anyway. Just before I move on to some of my colleagues, we were out in Dublin last week and we took evidence from two trade unions there. Have you been in touch with the trade unions in the Irish Republic about what and why they did what they have done?

Mr Ainsley: Absolutely.

Q367 Chairman: Did it change any minds, to your knowledge, in terms of sections of the British trade union movement?

Mr Ainsley: Certainly what we have done is we have spoken to Mandate who campaign on this issue. They showed us that there has been no drop even in the prevalence of smoking. I think they said there was one cigarette per day which is deemed to be smoked less. What it has done is those people who frequent pubs do not have to worry about other people’s tobacco smoke. That is what our position from the trade union movement is. This is not for us a public health issue, it is a workers’ health issue. If somebody wants to smoke a cigarette that is entirely for them, it is their choice to do so, but they do not have the right or the choice to force somebody else to smoke that cigarette with them. That is our
position and we are bewildered. I have to say, that
the Government have taken this coward’s way out
because they are fully aware of all of the evidence. In
fact, they have published documents themselves.
There are government documents here and I will
pass these round for anybody to have a look at. It
lists the constituent parts of tobacco smoke. Why
anybody should be exposed to that is amazing, why
people want to expose themselves to it is amazing,
but why somebody should expose somebody else to
it is criminal. I do not believe that if that was being
pumped out of a factory chimney that the HSE
would allow it to continue pumping it out. It would
be stopped directly. The Government paper from a
few years ago, which you will all be familiar with,
challenged cutting smoking as the leading cause of
preventable death. That is why we are here, not
because we have got some issues ourselves but
because we represent workers, and workers are
being exposed to other people’s toxins, carcinogens
and tobacco smoke on a daily basis, and it has to
stop. There has been some evidence to show that
there are round about 600 workers per year dying of
second-hand smoke. That would clear the Commons.
Everybody in the Commons would be
gone through somebody else’s tobacco smoke.

Q368 Jim Dowd: We hear this figure and sometimes
it is 600 through passive smoking and sometimes it
is 700,000. How is that figure calculated?

Mr Ainsley: The figure I quote of 600 is workers who
are exposed to second-hand smoke.

Q369 Jim Dowd: Yes, but how is it calculated?

Mr Ainsley: Again I am not a scientist or a doctor.

Q370 Jim Dowd: You are just repeating it?

Mr Ainsley: I am repeating it because that is my job.
I am availed of the facts. I do not need to go out and
find out what those facts are. If somebody tells me it
is dangerous to drive on the pavement I have to
accept that it is dangerous to drive on the pavement.

Jim Dowd: What an astonishingly compliant man
you are! Have you got no curiosity?

Q371 Chairman: We have had evidence from the
Royal College of Physicians on this, both in terms of
secondary smoke and death in this country, and I
think they used a figure overall of secondary smoke
of 12,000, and they said it is certainly thousands. Of
course, it is a lot less in public enclosed places in view
of the fact that most secondary smoking is obtained
at home, as it were, in domestic premises, but
nonetheless I do not think anybody would dispute the
science that there are deaths from that.

Mr Ainsley: If I could just add to that. We can argue
about the statistics forever. I do not think there is
anybody, smoker or non-smoker, that would argue
that tobacco smoke is not harmful. If it is harmful to
the smoker why is it then not harmful to the person
who does not choose to smoke.

Q372 Chairman: Some of my colleagues will want to
come in but trade unions in this country, and I
suppose in many others as well, have a long track
record of both representing people at work and on
odd occasions getting involved in litigation for harm
that is done at work. In the industry in which I used
to work it is a full-time job for many thousands of
people at this current time. What litigation has there
been or threatened within the TUC and its
membership groups against employers who you
believe to be reckless in a sense?

Mr Robertson: There already have been a number of
cases that have been taken against employers. The
problem of course with second-hand tobacco smoke
is that proving cause and effect is very difficult so the
cases that have been taken have mainly been around
asthma and emphysema. It is people, including bar
workers and other workers in a residential home,
who have been unable to work because of second-
hand tobacco. They have given warning to their
employers, nothing has been done and as a result
they have had to leave. They have therefore taken it
under the basic negligence of duty of care. In terms
of taking a case for someone who actually dies as a
result of second-hand tobacco, it is very difficult to
prove that was a result of what happened within the
workplace, so cases like that would be very difficult
to take at present, I am afraid.

Mr Revell: We recently had a case where a woman
suffered from a worsening asthmatic condition, which
caused her to cough so violently that it created a
hernia and also pelvic floor collapse. We pursued
a personal injury claim against the pub owners and
this one was actually settled out of court in favour of
the woman, but I have got a suspicion that, just like
the nuclear industry, a lot of pubcos will be settling
out of court rather than it becoming established on
the record through the courts.

Q373 Chairman: That was a local government
worker I think in the town of Preston a number of
years ago. Perhaps you could tell us about that?

Mr Borg: I am not familiar with the one in Preston.
I am aware that Unison has brought a number of
cases. There were a couple against Stockport
Metropolitan Borough Council where our members
have suffered years of passive smoking at work. One
member, Veronica Bland, eventually developed
chronic bronchitis. She received £15,000 from
In 1995 Beryl Rowe received £25,000 compensation
from Stockport Council. She had to retire on ill-
health grounds after suffering eye, nose, throat and
bronchial hypersensitivity. This returns if she goes
into a smoky atmosphere. The council had increased
her exposure by shutting down the ventilation
system in the office. If I could take the opportunity
to comment on one other issue. It seems we all know
that passive smoking is dangerous and it is
recognised even by the present Government that
passive smoking is dangerous. That is why there is a
proposal for the ban, but it is a partial ban which
seems nonsensical. The distinction seems to be if a
pub does not serve food it will be exempt. There is an
implication there which seems to suggest if you eat in a smoky atmosphere it is worse for you. That is the only sensible interpretation of that and that is clearly not the case. We know passive smoking is dangerous because of inhalation and that happens whether you are in a pub that serves food or a pub that does not serve food.

Q374 Dr Naysmith: Can I just pick up Michael’s point. When we were in Ireland (and you have said something similar) it was very clear that the whole thing had been treated right from the start as a health and safety at work matter. They claim that is why it has been so successful in making it work because once you have established that passive smoke causes problems for the workforce, you then find it very difficult to logically talk about exemptions. They also said that this was discussed pretty well before the ban came in by the Irish government. I have two points to make. Firstly, why do you think our Government has gone along that particular line of mixing up two or three different objectives all in one bill and, secondly, have there been discussions with the trade unions about what shape the bill it should be at all?

Mr Robertson: No, in terms of discussions that have taken place, the unions have made a number of representations as opposed to having discussions with ministers over recent years over a ban. The advantage of the Irish ban is it was clear, simple and understood and therefore it was almost self-enforcing because there are no exemptions all over the place so therefore people know they do not smoke in public places in work places. Also they did the education job as part of the build-up to the bill. There was a very good education campaign. I went over at the time it was going on to ensure that there was an understanding of why it was being brought in. The unions have always said that in actual fact because second-hand tobacco smoke is a carcinogen and it is created from workplace activities, it should be treated in the same way as any other workplace carcinogen, and should be banned as far as reasonably practicable and it is reasonably practicable; you just do not allow people to smoke. The Scottish Executive would have liked to have gone down that path but, of course, health and safety is not a devolved function and that is why they have also had to do it in the public health one. The English Bill is also going to cover it under the public health Bill and we can understand why. The primary role from the trade union point of view is to protect workers. We welcome public health issues, of course, but this should not be seen primarily from our point of view as a public health Bill. We see it as being a very basic, bread and butter, simple, health and safety issue about which there should be no arguments.

Q375 Dr Naysmith: Can you see any way of getting it back onto the rails of being that in this country or is it too late?

Mr Robertson: The Health and Safety Commission have put in a submission to the Government as part of the consultation where they supported a full ban. It is part of a health Bill and I do not think it would help if it was now taken away and looked at separately instead. I think the answer is to remove the exemptions because in effect that would make it a health and safety Bill.

Mr Ainsley: The Government needs to make a case for why there should be any exemptions. It is called a Health Improvement and Protection Bill. Who are they going to protect? Why are they deciding that some workers do not need protection? Why is it that their health is not important? We cannot see any logic in this whatsoever. It is not as though it is a difficult thing to do. Everybody else is doing it, New York, California, New Zealand, Norway, Sweden, you name it. Everybody is accepting that if an individual wants to poison themselves that is entirely up to them but they are not entitled to do it to anybody else. The Government is fully aware of the situation. They are putting warnings on cigarettes warning a smoker that they are poisoning themselves and other people. There is no point in telling somebody who is addicted that they are harming somebody else, you have to tell everybody else. It is everybody else who has the right to know that, not just the smoker.

Q376 Charlotte Atkins: I should declare that I am a Unison member. I want to ask you about the issue of exemption. Mr Robertson said that you would accept certain exceptions. I do not think anyone would argue nowadays that because you know it is going to be smoky in a pub those workers should not be protected. I know that is an argument that has been used in the past. Having said that, there are still certain exemptions and I would like you to go through those exemptions and indicate to us how we can protect those workers in those particular situations because I think it is difficult. You are from the TUC and you are indicating that you have a slightly different view.

Mr Robertson: There are a number of areas where we would support an exemption and it is primarily where someone is in a workplace which is also residential accommodation, for example prisons, secure mental units and ships as well.

Q377 Charlotte Atkins: And oil platforms?

Mr Robertson: That is another example. To tell people who are actually in these places that they have got different rights to smoke, that they cannot smoke as individuals at all because people in secure units in prisons cannot just walk out the door and smoke outside, is not a possibility. We recommend there should be circumstances where there are exemptions. However, in order to protect the staff and to protect the other people in there it should be restricted either to separate rooms or, if they have an individual room, to their own room. There should not be a blanket ban, it should be for the residential part and only where they are not affecting anyone
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else. The rest of the areas where people work or congregate should certainly not be seen as having a blanket exemption.

**Q378 Charlotte Atkins:** Staff will still have to go into prison cells and they will still have to go into the areas that psychiatric patients occupy. What are you suggesting in terms of protecting that workforce? We do not want a workforce that is subjected to unacceptable health impacts whereas others are free of that.

**Mr Robertson:** Absolutely. You will also get that in the case of people who visit people in their homes, for example health visitors and many members of the unions here. It is a very difficult area and is one where we did say in our recommendations there has to be strong guidance to protect the staff. However, I do think there would be problems if you just put a blanket ban on all residential areas. If smoking is to be allowed, it has to be under very controlled conditions, in separate rooms with proper ventilation so that it is not affecting the staff in particular but also other residents who choose not to smoke.

**Q379 Chairman:** Pauline, Charlotte mentioned this issue about people's rights to go to the pub. Nobody would argue that if you go to work in a pub you have certain rights, but some people say if you go to work in a pub you know that people smoke in a pub and you are walking into it, it is your choice. What do you say to that argument?

**Ms Robson:** I have worked in a pub for 35 years and 35 years ago smoking was not an issue. I did not even think about it when I was younger. It is only as you become more educated and when you see the advertisements that are coming on the television now—that is that new one where you see the clot going up the vein, it really freaks you out—that you are encouraged not to smoke. I work in a pub, we take about £40,000 per week, it is a busy pub and we have about 46 staff. I went to them before I came here and I asked them about this. A lot of them are students who are just working in the pub for extra money while they are at university and a lot of them are smokers, but because they have been educated to know how bad smoking is they are quite concerned about it. They do not really want to make a career out of it, it is like a stopgap. It was weird when I got the e-mail from the Health Select Committee. It appeared to me that you were writing off some workers as though they did not matter because they worked in the industries where people go in to smoke. I think a total ban would be the best thing. Everybody would know where they stood and there would not be some playing off against others. We owe the next generation good healthy living and we should show them an example. When this was voted on in Parliament I wonder what percentage of those that voted to keep it were smokers.

**Q380 Chairman:** We are not there yet on that. You have got a lot of students earning some money while they are at Newcastle University.

**Ms Robson:** They supported a total ban.

**Q381 Chairman:** They are not permanent workers, are they?

**Ms Robson:** No.

**Q382 Chairman:** What choice would they have to go and earn some money elsewhere in Newcastle as opposed to working in a pub for a few hours a night or at weekends?

**Ms Robson:** They tend to gravitate to pubs because it is part of their social life as well, that is probably how they view it. They can get a few shifts here and there, especially weekend shifts.

**Q383 Chairman:** Would there be alternative forms of employment for those people working for six or eight hours in a public house on a Friday and Saturday?

**Ms Robson:** There would not be a lot on an evening unless they wanted to work in a restaurant. Then you get the other end of the scale, that is the single mothers or people who are on benefits who can only earn a certain amount of money and they would choose to work in a pub as well because they can get a couple of shifts. It is not really fair on anybody's health. I only came here for the health side of it.

**Q384 Chairman:** I understand that. People do pose the question that if you go to work in a pub you know what you are going to walk into. It is important that we see what alternatives there are on that issue.

**Mr Robertson:** The point is, and one of the reasons we do want to see it as a health and safety issue, is there is no other area where we say you can choose to work in an unsafe environment. It is against all European legislation and against the Health and Safety at Work Act. It is up to employers to protect people. Some people may think, “I can get a job here and I smoke so I do not mind” but the reality is that even smokers are increasing their risk by working in smoky environments, and some pubs are very smoky environments. Not only that, it would mean these people could never give up smoking, for instance, once they have actually started. It is totally contrary to every principle of protection of workers to say that you can either take danger money or that you can decide to take a risk. I certainly think it would be an absolute disaster were that to be countenanced in terms of any legislation on smoking.

**Q385 Dr Taylor:** I think it was Mr Ainsley who said that you have to precede this with a very good education campaign. The T&GW paper in the summary at the end supports a comprehensive implementation date of April 2006. Would that be compatible with education? You probably heard previous witnesses accepting the need for a total ban but wanting to delay it to allow implementation. Is there a compromise? They were thinking of 2009.

**Mr Ainsley:** No. I do not believe that is the case at all. When I was talking about education and getting the public on side, I think that job has already been
done. People are now aware of it. The reason why we sat by passively in the past was because we were not aware that we were being affected by other people’s tobacco smoke. There have been many campaigns now, not least the ones on the tobacco packets that get discarded in the streets where we can see those warnings to smokers. That job has been done, people are aware, and we are not prepared to sit back passively now and allow ourselves to be poisoned by other people. It is entirely up to them what they want to do to themselves. They cannot do it to the rest of us; it is not right. If I could get back to the Government’s position on this, their position is that they will protect everybody, that is where they start from, and they have got a ludicrous suggestion that they will have a metre exclusion zone around a bar to protect the bar staff in pubs. I use an analogy which possibly is not the best analogy to use in mixed company so I will water it down a little bit. There is no such thing as the urine-free end of a swimming pool. Tobacco smoke cannot read, it does not take any notice of signs, and if it is present in the room then the people in that room will be affected by it.

Q386 Chairman: I think we had some transport people here but what about people like ASLEF, regarding the train system, I was going to say public transport but it is publicly accessible transport. GNER, in particular, have gone from two smoking carriages one at either end, as it were, to no smoking. Have you had evidence from the trade unions organised in the transport sector of any problems with that type of move?

Mr Robertson: We have asked the rail unions in particular, but I think also the T&G also have members in transport. The reality is that with the exception of the times when pubs are coming out and when there is a mixture of anti-social behaviour, by and large the bans have been self-enforcing. There are no problems. There have been attempts to have commuter boycotts of smoking bans—and there was one in Brighton when that was introduced—and they totally fizzled out. The reality is passengers themselves have been unwilling to put up with other people’s smoking. If you go on a train nowadays, unless it is late at night or there is other anti-social behaviour going on, you do not see people smoking. The transport unions and the rail unions have been heavy supporters of this. They believe that their members having to go through the one smoking carriage that is left is a bit of nightmare for them and they would rather there was a complete ban.

Mr Ainsley: Can I just say that if the Government are serious about this then you have to change the culture. If you send mixed messages about it is banned, it is not banned, it is banned here, it is not banned there, then you are not going to change the culture. You are not going to do what you set out to do in the first place.

Q388 Chairman: Could I just add that the whole trade union movement would not agree with what people have said here today. We had the Tobacco Workers’ Alliance write to us and they have got trade union members in it. What is the attitude there within the TUC?

Mr Revell: Maybe if I could respond there because I am responsible for tobacco workers within the Transport and General Workers Union and they have made their views very clear. They want things to continue as they are. They do not want a change. Within the T&G we have had quite a lively discussion with those who are involved in the tobacco industry and those who are on the receiving end, bar staff, our NALHM membership, the National Association of Licensed House Managers and Casino Workers. At the end of the day our General Executive Council took the view that the most important issue was that of health and safety for those who were confronted with a smoking environment and accordingly we have submitted our views. To be honest, our members in the tobacco industry do actually understand why we have taken that stance. We do support the Tobacco Workers’ Alliance but, to be honest, we will not engage when it comes to health issues. No way would we say there is anything that is not damaging about smoking, so with regard to the Tobacco Workers’ Alliance, there are areas such as taxation where we are against too much taxation because it leads to a greater degree of smuggling and crime and also it is the poorest decile in society that smokes the most, so it is a regressive tax that hits the poorest people.

Q389 Jim Dowd: The Tobacco Workers Alliance are in Amicus are they not, they are not part of the T&G?

Mr Revell: It is T&G and the GMB, not just Amicus.

Q390 Jim Dowd: But they have the lion’s share?

Mr Revell: They have the lion’s share although there is not very much of a share to go round because there are not many jobs in the tobacco industry now. We have got the largest cigarette factory in Gallagher’s.

Q387 Jim Dowd: The same was true also in the airline business which is overwhelmingly no smoking. There are a few Eastern European airlines that still allow smoking but nearly everyone else has banned smoking completely across the whole network.

Mr Robertson: Yes, that happened after the US would not allow any airline that allowed smoking to pass over US airspace. As a result, every company then introduced a complete ban ten years ago.

Mr Robertson: If I could quote in actual fact at this year’s Congress there was a motion on passive smoking which was supported by every single union (one voted against) and Amicus also have supported it. The TUC and all unions are very concerned about
the loss of jobs within the tobacco industry but that is primarily nothing to do with the public health policy. It is the fact that these factories have been closed because jobs are moving abroad primarily to East Asia. The Southampton factory has just gone, the Midlands one went about two years ago and what is happening is that it is much cheaper to produce them abroad. That is the threat to the tobacco industry and we have always supported tobacco workers in their fight against these closures and we will continue to do so.

Mr Ainsley: I have had some dialogue with workers in the Alliance and put it very clearly to them that what we want for workers everywhere is the same consideration they have in their workplace and that is to have a smoke-free workplace.

Chairman: Could I thank you all very much indeed for this session. I think you may have heard me say earlier we are hoping this report will be out for people’s Christmas stockings, although we have at least another week of evidence taking yet. Thank you for coming along.
Thursday 24 November 2005

Members present:

Rt Hon Kevin Barron, in the Chair

Mr David Amess  Dr Doug Naysmith
Charlotte Atkins  Mike Penning
Mr Paul Burstow  Dr Howard Stoate
Jim Dowd  Dr Richard Taylor

Witnesses: Mr Bill Callaghan, Chairman, Health and Safety Commission, Ms Deborah Arnott, Director, Action on Smoking and Health (ASH), Councillor David Rogers OBE, Local Government Association (LGA), Mr Derek Allen, Executive Director, Local Authorities Coordinators of Regulatory Services (LACORS), Mr Graham Jukes, Chief Executive, Mr Ian Gray, Policy Officer for Health Development, Chartered Institute of Environmental Health, examined.

Q392 Chairman: Good morning. Could I welcome you and ask you to introduce yourselves for the sake of the record.

Mr Gray: I am Ian Gray. I am the Policy Officer for Health Development at the Chartered Institute of Environmental Health.

Mr Jukes: I am Graham Jukes, Chief Executive of the Chartered Institute of Environmental Health.

Ms Arnott: I am Deborah Arnott, Director of ASH, which is a campaigning health charity set up by the Royal College of Physicians to campaign for evidence-based tobacco control policies.

Mr Callaghan: I am Bill Callaghan and I chair the Health and Safety Commission.

Mr Allen: I am Derek Allen. I am the Executive Director of LACORS, Local Authorities Coordinators of Regulatory Services, which is a central body of the Local Government Association.

Cllr Rogers: Councillor David Rogers. I chair the Community Wellbeing Board of the Local Government Association.

Q393 Chairman: Mr Callaghan, should there be a comprehensive ban on smoking in the workplace, including all pubs and clubs?

Mr Callaghan: The answer is yes. I understand the Government has decided that this is an important public health matter and I think you will have seen the letter I sent to Patricia Hewitt which sets out the case for such a ban. We would be concerned about creating through a two-tier system those who are protected and those who are not, and we also think there is a strong better regulation case for having a simple ban. We think that a two-tier system would lead to enforcement difficulties.

Q394 Chairman: What are the problems with the health issues around the Government’s proposals?

Mr Callaghan: We welcome the fact that the Government is treating this seriously. We understand from the SCOTH report the increased risk to workers who are regularly exposed to tobacco smoke. Our job as the Health and Safety Commission is to protect people at work and we think there are benefits from this proposal.

Q395 Chairman: There are many other trades and professions that are quite dangerous in terms of you and ask you to introduce yourselves for the sake of the record. The obvious ones are of the workplace. Why is second-hand smoke such a big issue?

Mr Callaghan: The Department of Health is in the lead on this and is treating this as an important public health measure. Chairman, I agree there are many other risks to workers in the workplace. For example, if one is looking at pubs, there are risks in terms of violence to staff or manual handling, but I think that is one of the reasons why we have pressed for a regulated regime which is going to be simple, because we have a worry that if you create complexity that is going to draw rather scarce environmental health officer resources away from some of the other risks in the workplace. Yes, there are other risks to workers, but we want to make sure that we are allocating, along with our local authority colleagues, resources properly and if you introduce complexity that will get in the way.

Q396 Chairman: Is there any one issue that determines whether workers are allowed to work in a dangerous environment or are there many reasons why people are allowed to work as coal miners or as deep sea divers as it were?

Mr Callaghan: Obviously there are many different hazards in the workplace, hazards to people’s safety and hazards in terms of their health.

Q397 Chairman: What do you say to people who say that people smoke in pubs and so if somebody goes to work in a pub they know they are going into a smoky environment? If somebody goes to work in a coal mine they know it is going to be dusty. What do you say about the pubs?

Mr Callaghan: I think in both cases we would ensure that employers were exercising their duties under the Health and Safety at Work Act to make sure that the risks were minimised as far as is practicable.

Q398 Chairman: There has been no publication of any regulations that are likely to come in if the Bill goes ahead as it is published at the moment. Would
the Health and Safety Commission normally be asked by Government to look at regulations from the health and safety perspective?

**Mr Callaghan:** I am sure both the Commission and colleagues in the Health and Safety Executive would want to be involved with the DOH on any detailed regulations.

**Q399 Chairman:** Have you been asked at this stage to look at any possible regulations that would come along with this Bill?

**Mr Callaghan:** The Commission has not. My understanding is that there has been some contact with officials. Regulations do not exist at the moment. Obviously officials are in close contact with DOH colleagues.

**Q400 Chairman:** I just wondered whether the Health and Safety Commission would be a party to drawing the regulations up as opposed to commenting on them when they have been drawn up. I do not know where within Government the advice would come for what should be in them.

**Mr Callaghan:** I have statutory duties to advise ministers on regulations drawn up under the Health and Safety Act. Obviously this matter is being introduced under public health legislation. I think you know about my letter to Patricia Hewitt. I do think we have a locus. I think the Commission would want to express a view. We have expressed very clear views already and I am sure my Commission will want to maintain a close interest in this not just in terms of the protection of workers but also in terms of what might then be the knock-on effects in terms of HSE inspector resources and environmental health officer resources.

**Q401 Charlotte Atkins:** One of the Government’s arguments appears to be that smoking in pubs and clubs is popular and therefore it should be allowed. What is your response to that in terms of workers’ health in particular?

**Mr Callaghan:** Our view is that workers should not be unnecessarily exposed to harmful substances. We have not taken a policy view on the popularity of smoking or not, but in terms of should workers be exposed unnecessarily, it is clear that they should not be.

**Q402 Charlotte Atkins:** In your previous job you would have recognised that some unions in the past in particular used to take a position that workers in dangerous circumstances and dangerous workplaces should be paid to cope with that danger. Do you think perhaps that is a way forward for people who work in pubs, that they should be paid more to recognise the unfavourable and unhealthy conditions?

**Mr Callaghan:** I am certainly aware of that point of view which some of my former union colleagues put forward. With my present hat on, no, I would not accept that point.

**Q403 Charlotte Atkins:** I assume you did not accept it when you were back at the TUC either.

**Mr Callaghan:** I did not, no. Looking at the construction industry, we would not accept, for example, the view that you are compensated by getting more money just for working in a dangerous environment. We would expect employers to exercise their duties under the Health and Safety at Work Act to reduce those risks.

**Charlotte Atkins:** When I was a former Head of Research at UCATT I did not accept the dangers of asbestos either. Thank you.

**Q404 Dr Taylor:** I want to explore the whole question of enforcement and this really affects most of you except for Deborah. You have already said that the two-tier system will cause problems. Could you start by comparing and contrasting the ease of enforcement of the total ban and the partial ban?

**Mr Callaghan:** An extra complexity, of course, is what is going to happen in the devolved administrations. We know that in Northern Ireland and in Scotland they are moving towards effectively a total ban and I think that is likely to be the case in Wales, so you are already getting some complexity across the United Kingdom.

**Q405 Dr Taylor:** Your organisation covers right across the whole UK, does it?

**Mr Callaghan:** Our organisation covers Great Britain, but obviously we are in very close contact with colleagues in Northern Ireland and also in the Republic of Ireland, and we have talked about this quite a lot amongst the three organisations involved with health and safety.

**Q406 Dr Taylor:** So it puts your organisation in an extraordinarily difficult position.

**Mr Callaghan:** And local authorities as well because I think the expectation is that, particularly as we are now concentrating on pubs and licensed premises, our local authority colleagues will be in the lead. The Commission’s responsibility does not just cover Health and Safety Executive inspectors, we also have an overall responsibility for what our local authority colleagues do. They act as an enforcing body on behalf of the Commission’s policy. If you have a simple regulation, that is much easily enforced and I would say you are going to get good self-regulation. A clear regulation where everyone knows what is going to happen is going to be much simpler to enforce than one which has a degree of complexity.

**Q407 Dr Taylor:** This is exactly what we learnt when we went to Dublin. The people who have to do the enforcing, would you like to add anything?

**Cllr Rogers:** There are a couple of points I would like to make. Firstly, if the system is to be more complex then it will be more costly to enforce. The estimate we have is if there are to be exemptions for pubs not serving food the cost would be something like 50% higher than if those exemptions did not exist.
Q408 Dr Taylor: Is that because you would have to employ more staff?

**Cllr Rogers:** It is largely that. The Government’s New Burdens Doctrine would involve the local authorities concerned being reimbursed for those additional burdens. As to the effect on individual local authorities or environmental health officers, I think Mr Allen from LACORS is better qualified to answer that point.

**Mr Allen:** We have concerns regarding the ability to enforce it if it is a two-tier system. The emphasis for us is really about self-regulation, it is about supporting businesses with compliance, which really underpins the recommendations that came out from the Hampton Review, ie that it is important that legitimate businesses can be supported in complying and making it simple and transparent in terms of the legislation, and that is helpful. Having a two-tier system will make enforcement difficult. I think definitions around food and enclosed spaces, etcetera, will also make it more difficult. There are some calculations that may have to be undertaken to determine what an enclosed space is and what a definition of food is. Our view is there will be a cost anyway and we do not want it to be so prescriptive that it says it must be environmental health officers or it must be trading standards officers. If it is a responsibility for the local authority to undertake this enforcement then we need to field who we think is most appropriate to do that, and there will be opportunities for some joint visits. As you will be aware, today is an important day in terms of the Licensing Act. Local authorities have a key role in enforcing those measures in the licensing regime and it may well be that we can use some of that joined-up working to have a more efficient enforcement regime.

**Mr Jukes:** The Chartered Institute’s membership goes right across the board. We are not just in local government, we are in government and we are in the industry providing advice and support. Frankly, you can enforce anything if you put resources into it. You can take a view that this must be done and here are the resources to achieve it. What we believe fundamentally is that any exemptions and indeed complexities that are being suggested are a complete and utter waste of public funds and resource when we should be spending that resource in trying to deal with some of the fundamental issues of inequalities in health and some of the other issues which the Government wishes us to tackle and for which scarce resources are currently available. Trying to make something more complex when there is a simple issue here about protecting all workers is a very clear message that the Chartered Institute would want to get over to the Health Committee. The Government is trying to make something very complex out of what is quite a simplistic way of approach to protect all workers. The key to compliance is voluntary compliance and management good practice. As Derek has mentioned, we have the mechanisms of the licensing regime that have just been brought in, we have the mechanisms of being very clear about how we enforce food safety and health and safety in pubs and clubs and in other places. It just seems to me that to make additional exemptions in an area which is quite complex anyway is actually going to confuse not only the general public, it will confuse the enforcers, it will confuse the advisers to those pubs and clubs and businesses and it will not create a level playing field. I think it is an absolute waste of public resource.

Q409 Dr Taylor: How do we persuade the Government that they have got it wrong in your view?

**Mr Jukes:** I hope they will listen to the evidence that we have given extensively and indeed the evidence in your initial report and listen to the medical support, which I believe is unassailable, that there is a health issue here. The real question is how one enforces it efficiently, effectively and simply and gets the public to back what is a very sensible measure.

**Mr Gray:** We also think there is an ethical issue here that we would like you to express on our behalf. We provide services and protection for everyone in the workplace. How will we explain to people who work in pubs and clubs that they are not protected when the office worker down the road is? We think there is an ethical issue here that needs to be taken seriously.

Q410 Dr Taylor: How do we persuade ministers from their complacent view that we are protecting 99% of the workforce and we do not need to worry about the 1%?

**Mr Gray:** It is a fundamental principle of health and safety practice that we protect everyone equally; we have never picked and chosen. The whole history of public health legislation is that it protects everyone as best it can; it does not select people for exemption.

**Cllr Rogers:** The Local Government Association and the Department of Health have a shared priority to reduce health inequalities and that has been in existence for a few years now and there is a number of projects that are seeking to work in that direction. We believe that the Bill as currently drafted flies in the face of that because it would tend to increase health inequalities. Some of our member authorities working with health colleagues in different parts of the country have done some research on this and I have a couple of figures I would like to quote to you. This is about the current proportions of pubs serving food and not serving food and in some cases the projected proportions that would or would not. For instance, in the London Borough of Southwark, 47% of pubs in the most deprived area of that borough currently do not serve food, whereas only 18% do not in the least deprived part of that borough. In the North East for instance, the most deprived local authority area is Easington, and 81% of pubs there do not serve food. In the least deprived area in the North East, this figure is 23%. So there is already a health inequalities issue there and we feel that would be worsened if there were to be this exemption about whether food is or is not served. If there were to be an exemption for private members’ clubs, some of those are also located in areas of higher rather than lower deprivation and they often
put on events that involve children attending, that is another way in which we feel that health inequalities would be worsened rather than improved.

**Q411 Dr Taylor:** There are difficulties with defining food as well. This 81% in Easington that do not serve food, do they serve crisps and nuts?

**Cllr Rogers:** Mr Allen is best qualified to comment on the technical detail of that. Yes, in principle the simpler the definition is the easier it will be to enforce. It needs to be in language that the businesses and the public can understand.

**Ms Arnott:** The Government has a target under the Public Service Agreement to reduce health inequalities by 10% by 2010 and that is measured by life expectancy at birth and infant mortality. The research at a local level that Mr Rogers was talking about we have backed up by carrying out a national survey of 1,252 pubs around the whole of Great Britain and it shows the same thing. If you look at the most deprived areas, a far higher proportion of pubs do not serve food, something like 45% on average round the country. If you look at the least deprived areas, it is much lower proportion, it is around 14%. What this means is that the lowest income workers are going to remain the most exposed, the lowest income members of the public are going to remain most exposed and they are also going to be less likely to give up smoking. One of the effects of the smoke-free legislation is going to be encouraging people to give up. This is seriously going to exacerbate the problem of trying to reduce health inequalities and I do not think the Government has taken this on board seriously enough.

**Q412 Dr Taylor:** In Ireland they have a fairly high level of fines. They pick up breaches very quickly and so they have had a relatively small number, but the fines do seem to be working. Their level of fine is €3,000. Do you think there should be this sort of level of fine in this country too?

**Mr Allen:** We have looked at what has been proposed in terms of fines. One of those is related to the non-display of warning notices, that was a £200 fine for failing to prevent working in a non-smoking premises and a £50 fixed penalty for someone caught smoking on those premises and that seems to be quite low. If you compare it with some of the current legislation that relates to tobacco, failing to display a statutory notice in a retail outlet—which is new legislation—is a £1,000 fine, it is level 3. Selling tobacco to an underage person carries a fine of £2,500 and selling alcohol to an underage person carries a fine of £1,000. There are quite significant differences. I think what is currently proposed we would see as being too low.

**Q413 Dr Taylor:** So you would agree that Ireland have it probably about right, would you?

**Mr Allen:** It is certainly higher.

**Q414 Dr Taylor:** They are fining both the person who smokes and the bar owner who allows it to happen, is that right?

**Mr Allen:** That is right. That is what I understand is proposed here. The emphasis has to be on proper and effective control by the management of the establishment, I think that is really important. One of the things that we think would be helpful is to have a clear written policy that needs to be complied with. There is obviously an issue about enforcing this on the ground in a pub where people may have had quite a lot to drink and local authority employers have to go in there and ask someone to stop smoking and also the consideration of issuing the fixed penalty notice. There are some practical issues. I think training is going to be an important element of how we do things. If we can get the management control in the first instance to deal with it at source and deal with that effectively then I think it will reduce the need for that kind of heavy enforcement.

**Mr Jukes:** The real key to good enforcement is voluntary compliance and good management practice. I cannot stress to the Health Committee strongly enough that unless we get that type of approach—and that has to be underpinned by simplicity and understanding—then you are not going to get it. You could throw resource at enforcing this legislation but it would not work effectively. One has to get buy-in right across the board and use all the levers of enforcement that we can use.

**Mr Gray:** Let me give you an example to do with this definition of food. None of the existing definitions of food is helpful here. The definition of pre-packed food, for example, has the presumption that the supply is to a caterer who will in fact be processing that product further before it is used. There are real difficulties in the public understanding of these definitions. Frankly, food includes drink and so any premises that is serving drink is serving food. The more confusion there is in the minds of the public let alone the trade the less reliable complaints will be made. People will not feel confident in complaining or indeed their complaints will be spurious and that will waste enforcement time.

**Q415 Dr Taylor:** What should be done now to try and get the public on the side of a total ban?

**Mr Gray:** I think this example of the spurious link between food and smoking is a good example. The Government is proposing shelf stable pre-packed products, but that does not include a pickled onion or a pickled egg and it is that kind of ludicrous analogy that boggles belief.

**Q416 Dr Taylor:** What do you understand by these other definitions of “enclosed” and “partially enclosed” spaces?

**Mr Allen:** My understanding is that the basis of that is quite a complex definition. It may well be 70% enclosure. You are going to have to do some kind of calculation on the premises to determine how much of that premises is within an enclosed space. We are
saying we need to look at simplicity, eg should it be a single wall with a roof, that may be an enough, so you can see that and it is pretty obvious to everybody that that is considered to be enclosed. Certainly from a management perspective it makes it easier and in terms of the enforcing authority’s responsibility. It is a little bit more difficult for the public and this is where we come back to the issue about having these things dealt with at source and good management practice. What concerns us as well is we could spend a lot of time in the courts arguing over what is an enclosed space, what is food, what is a definition—and it could be a charter for lawyers to make money perhaps—but not good, effective and efficient enforcement.

**Mr Jukes:** The whole point about enclosed spaces is to have protection in inclement weather for those who choose to smoke. It is about how one creates suitable structures in order to protect customers who wish to smoke of their own volition but not affecting other people. There are a lot of suggestions around 70%. We would suggest that all you need to do is to have a shelter, perhaps 30% of the floor space easily understandable by management, enforcers and the general public, that is what it is there to do.

**Mr Gray:** You will have seen examples when you went to Dublin where this allowance has been abused. What the trade have done is extend their premises into some kind of external canvassed area where people are not just resorting to smoke, they are selecting that as their position in that licensed premises for the duration of their visit. That is not our intention. We simply want an overhead canopy to keep the rain off.

**Q417 Mr Burstow:** The issue of guilty knowledge comes under the Health and Safety at Work Act in terms of the point at which you as an employer or an organisation become aware of something becoming scientifically proven as being a matter of risk to a person’s health. We had the hospitality industry represented here last week and I put to them the question as to whether they felt that environmental tobacco smoke and the evidence about its core effects in terms of cancer and health disease were now sufficiently proven that they felt themselves now subject to health and safety prosecution and they effectively said yes to us to that question. Do you feel we have got to the point in terms of the scientific evidence for this that we have crossed that threshold in terms of liability under health and safety legislation?

**Mr Callaghan:** There is existing health and safety legislation as a general duty under section 2 of the Act for employers to safeguard the health, safety and welfare of employees. As you may know, under the Workplace Regulations we have provisions, for example, to make sure that people do not experience discomfort from tobacco smoke in rest rooms. What has happened, particularly with the development of the report from the Scientific Committee on Tobacco and Health, is that the evidence about the increased relative risk in non-smokers exposed to second-hand smoke is quite clear. We see that there is an increased risk to that category.

**Q418 Mr Burstow:** In terms of guilty knowledge, we have got to the point where people would be aware and therefore have to take actions. You were saying yourself that people have to take action to minimise the risk and take all practical steps. What is the practical step that can be taken by an employer to protect their staff from the risk of tobacco smoke?

**Mr Callaghan:** I think our understanding now of what is practicable and effective is not what we had understood ten years ago. Let us take this issue of ventilation, which is obviously one step that employers might take. My understanding of the evidence is that although ventilation can remove the smell, it cannot tackle the issue of removing the carcinogens. When we were looking at this matter ten years ago one would have seen ventilation as a practicable step. I think now we would not see this as an effective step.

**Q419 Mr Burstow:** So is a ban the only practical step?

**Mr Callaghan:** This measure is being introduced to protect not just workers but also members of the public and so there are wider public health issues. I think one of the reasons why we entered the lists is we did not want to see, with such a partial ban, that one group of workers was treated differently from another.

**Ms Arnott:** Can I add to the point of guilty knowledge because ASH has a QC’s opinion on this issue, which I am happy to supply to you, saying that the date of guilty knowledge is definitely passed. We sent this opinion to all the major hospitality trade employers and we explained to them what this meant in terms of their legal responsibilities and that is, because ventilation and other solutions are not sufficient, their only course of action was to prevent smoking in the workplace. They are on notice of that now.

**Q420 Dr Stoate:** You will have heard the question from Charlotte Atkins that one of the Government’s contentions is that smoking in public places is popular and therefore should be allowed to continue. We understand ASH has done a number of surveys gauging public opinion. Can you tell us more about the results of your surveys?

**Ms Arnott:** It does depend a bit how you word it. You get much more support if you ask people if they support the idea that all workers should have a right to a smoke-free workplace and the sort of level of support we got for that was 90% of the public, whereas if you ask people whether they support legislation to make all enclosed workplaces smoke free it drops to around 80%. One of the things we would see interesting—and we have done a lot of public polling over the last couple of years—is the way that public opinion has begun to move on this and move quite considerably, particularly on smoking in pubs and bars. The Government in its
smoking related behaviour and attitudes survey in 2003 started asking the questions, “What sort of restrictions would you support in pubs? Do you think pubs should be allowed to be entirely smoking throughout, mainly smoking throughout but partially smoke free, partially smoke free or entirely smoke free?” In October/November 2003 20% only of the public wanted pubs to be entirely smoke free. A year later, in 2004, that figure rose to 31%. We asked the same question in August this year and 41% of the public supported pubs and bars being entirely smoke free. When you gave people some peer reviewed evidence about the harm caused by second-hand smoke that proportion rose to 52%. The majority of the public wanting pubs and bars to be smoke free. If you look at the difference between 2003 and 2005, not taking into account what happens if you give people more information, you are already seeing a doubling in the amount of support for pubs and bars going entirely smoke free. I think the key point there is not just the results but the speed and direction of change. I do not think the Government has really taken account of the fact that public opinion has moved significantly in support of this measure. 

Ms Arnott: I think you have to look at how the questions are framed and in what context. If you started asking the questions, “What sort of questions would you support in pubs? Do you think pubs should be allowed to be entirely smoking throughout, mainly smoking throughout but partially smoke free, partially smoke free or entirely smoke free?” In October/November 2003 20% only of the public wanted pubs to be entirely smoke free. A year later, in 2004, that figure rose to 31%. We asked the same question in August this year and 41% of the public supported pubs and bars being entirely smoke free. When you gave people some peer reviewed evidence about the harm caused by second-hand smoke that proportion rose to 52%. The majority of the public wanting pubs and bars to be smoke free. If you look at the difference between 2003 and 2005, not taking into account what happens if you give people more information, you are already seeing a doubling in the amount of support for pubs and bars going entirely smoke free. I think the key point there is not just the results but the speed and direction of change. I do not think the Government has really taken account of the fact that public opinion has moved significantly in support of this measure.

Q424 Jim Dowd: They did circulate a correction. 
Ms Arnott: They did circulate a correction, but I am not sure everyone would have seen that correction.

Q425 Mike Penning: If you saw the first one you will see the second.
Ms Arnott: Their misuse of statistics is not effective. They only did that after the Department of Health wrote to them. They were not going to do it on their own account.

Q426 Dr Stoate: The Government has said that smoking is popular and therefore should be continued. Would you say that the general public is in favour of an overall ban or in favour of a partial ban? How would you see the public mood? 
Ms Arnott: When we are talking about workplaces, the majority are in favour. When you talk about pubs and bars, it is moving and I think with the right information the majority of the public will support it. It is not about public opinion, this is about health and safety of workers and that is the key point. However, popularity is important in determining whether or not it is easily enforceable and seatbelt legislation showed that. If you compare seatbelt legislation to mobile phones and the fact you are not supposed to use your mobile phone driving in the car, you can see what happens. What we want is legislation that is easily enforceable. What the levels of public support and the shift in public opinion shows is that this will be easily enforceable.

Q427 Jim Dowd: Mr Gray, you said there had been a universality of public health law previously and that what the Government is proposing would breach that universality. How does that apply to the exemptions for what are regarded as domiciliary premises, ie homes, hotel rooms, etcetera, where people will still have to work?
Mr Gray: The principle that we have espoused in our submission to you is that the protection of the worker should be paramount. So anywhere where there is an exception—and I am using the word exception, not exemption, there are always exceptions to the rules—consideration is then given to how the worker can be protected either by

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8 Ms Arnott later informed the Committee that this enabled them to ensure that the respondents were not able to see the information until after they had been asked the question the first time and that they were able to read the information rather than just have it read out to them.
minimising exposure or affording direct protection to the worker. That is what we do in all other work situations. Wherever we are unable to totally eliminate the risk we protect the worker. There are some practical measures. Some employers are already taking these. They are asking people who are receiving services or treatments in their home not to smoke while the worker is there or to keep a room in which they do not smoke where the worker can go. I am married to a health visitor. She always asks to check the baby in a room where people do not smoke. She has a duty of care to the child never mind a duty of care for her own health, and people are cooperative, that is the other surprising thing. I think. When we tell people this is about protecting the health of a worker who is providing a service for you people are cooperative.

Q428 Jim Dowd: Everybody accepts that self-enforcement is the most effective kind where people are prepared to do it. There will be a different level of protection for workers whose jobs take them into domestic premises, hotels rooms, etcetera, compared to those who ought to be totally protected if there was a total ban.

Mr Gray: There is a difference in order of magnitude here. The bar workers who are working eight or ten hour shifts in a perpetually smoky environment, these are the people most at risk and we are failing to protect the most vulnerable group. There is a difference in order of magnitude between that and the peripatetic worker who will occasionally be exposed to someone else’s smoke and has the right either to refuse the service and leave the building or to request some measure of protection.

Q429 Dr Naysmith: I want to pick up on how questions are framed and what sort of answers you get, Deborah, because really the questions determine quite a lot what result you get. In sociology courses in universities there are often units about how to frame questions and so on, so it is quite difficult. However, we are beginning now in this area to get nearer something that tells you clearly what is happening by looking at changes over time and how views change. If you keep asking almost the same questions then you can pick up changes and opinions. How does the strength of public support in England for a smoking ban compare with other countries such as Ireland before a ban was introduced, and after the ban is introduced what kind of changes do you get in the opinions?

Ms Arnott: I think that is a very interesting question. We asked a question earlier this year in July using BMRB which had been asked in Ireland before their law was brought in, which was, “Do you support legislation to prohibit smoking in public places, including pubs and restaurants?” When they asked it in Ireland prior to the legislation coming in the level of support was 67%. When we asked it here in July the level of support was 73%. I think the interesting point about Ireland as well is that if you look at what happened when they brought the legislation in, the level of support continued to grow.

So three months after the legislation was brought in the Irish Department of Health asked the same question again and 82% of the population supported the legislation.

Q430 Dr Naysmith: What happens amongst smokers if you ask that question in Ireland, do you have any statistics on that?

Ms Arnott: There was some interesting research done in an international tobacco study using a phone poll of respondents in Ireland and I cannot remember the exact figures, I will have to send them to you afterwards, but the level of support amongst smokers for legislation, including pubs and bars, was only about 3% prior to the legislation coming in and it rose to around 50% after it had come in. It is still not the majority of them, but you can hardly expect smokers to support something which stops them smoking in pubs and bars. The level of support has gone up considerably. I have been to Ireland and I have spent quite a lot of time talking to smokers sat outside pubs about what they thought of the legislation. The sorts of things people said to me were, “I’m not very happy me with it but, thinking about it, I am smoking less now and smoking is not very healthy for you. The atmosphere inside the pub is much better than it was.” So there are mixed and conflicting views even among smokers themselves.

Dr Naysmith: We got similar opinions from some smokers when we were in Dublin as well.

Q431 Chairman: Do you think we could expect to see further movement in public opinion in this country if the legislation had gone through Parliament and there was a date set for its implementation, no matter what form it is in?

Ms Arnott: I certainly think we can. I think it is terribly important that the Government takes a lead in saying, “This is a measure being brought in for workers’ protection,” and if they do that the level of support will rise and it will continue to increase because there is no argument against that. The problem is it is very confusing. The message they are giving out is that it is not really a health and safety issue because they are going to leave the workers who are currently most exposed to continue to be exposed in future. There is something very important I know this Committee is concerned about and that is what happens to smoking in the home in front of children. If you give this confused message that it is okay to carry on smoking because, after all, we are allowing pubs to be places where you can smoke, the message you are giving to parents about what they should be doing in front of their children is mixed and confusing. The message we

5 Ms Arnott later informed the Committee the actual figures were 13% before and 46% afterwards from Fong et al, Reductions in tobacco smoke pollution and increases in support for smoke-free public places following the implementation of comprehensive smoke-free workplace legislation in the Republic of Ireland: findings from the ITC Ireland/UK survey Tobacco Control 2005;000:1-8.
want to give to them is that this is harmful and if we do that and we make it a uniform policy outside the home it will lead to a reduced exposure of children inside the home, partly because many of their parents will be giving up smoking but also because those who carry on smoking—and we have seen this in Ireland and in this country as more and more workplaces have gone smoke free—will stand outside to smoke rather than smoking inside the home.

Chairman: Could I thank you all very much indeed for coming along and helping us with this inquiry. Hopefully we will have it published in time to go into one or two people’s Christmas stockings.

Witness: Professor Sir Liam Donaldson, Chief Medical Officer, examined.

Q432 Chairman: Good morning. Could I welcome you to the Committee and ask you to introduce yourself for the sake of the record.

Professor Sir Liam Donaldson: I am Liam Donaldson and I am the Chief Medical Officer in the Department of Health.

Q433 Chairman: Thank you very much for coming to help us with this inquiry. How serious a risk to health is second-hand tobacco smoke? How well established is the science in your view?

Professor Sir Liam Donaldson: All the scientific evidence is clear. I think any doubts or scepticism about the health impact of second-hand smoke are resolved scientifically in my view.

Q434 Mr Amess: Could you give us some precise details of the scientific evidence that you are referring to? When was it conducted? How was it conducted? In what circumstance was it conducted?

Professor Sir Liam Donaldson: There have been a lot of detailed studies carried out over the years of people who live with smokers. There have been syntheses of the research evidence by major international bodies and expert committees that have reviewed the validity of the research and essentially the risks to non-smokers of inhaling a smoker’s smoke through being exposed to 50 carcinogens, which is roughly the number of cancer causing chemicals in cigarette smoke, and to carbon monoxide. There are both short-term risks of an increased risk of clotting of the blood and therefore of a heart attack and longer-term risks such as cancer, coronary heart disease, chronic bronchitis and promoting asthma attacks in children.

Q435 Mr Amess: I accept all of that, but you are our Chief Medical Officer and you are still dealing in generalisations. We are trying to gather evidence. Can you refer the Committee to at least one particular study? Can you tell us when it was carried out, who carried it out and how it was carried out?

Professor Sir Liam Donaldson: It is not that I am not able to. I think to choose one study in isolation—

Q436 Mr Amess: Give us half a dozen studies and we will look at them all.

Professor Sir Liam Donaldson: I think I would point you to the very formidable and rigorous syntheses and analysis of research that has been done by numerous expert bodies.

Q437 Mr Amess: Can you not say that “Mr Brown” carried out a study somewhere? You are our Chief Medical Officer. Surely you could refer us to some precise studies that were carried out instead of just generalisations.

Professor Sir Liam Donaldson: It is not a generalisation. It is pointing to the importance of looking at the entirety of scientific evidence where it is brought together rather than looking at a single study in isolation.

Q438 Mr Amess: I am asking you precisely to refer me to some scientific evidence, who the professors were who carried it out and when they carried it out. Surely you must be able to give us one example. Are you not able to?

Professor Sir Liam Donaldson: It is not that I am not able to. I think to choose one study in isolation—

Q439 Mr Amess: Give us half a dozen.

Professor Sir Liam Donaldson: I think I would point you to the major expert reports that have been done into the risks of second-hand smoke which have summarised the research evidence. Some of them have been done on an international level and some of them have been done nationally.

Q440 Mr Amess: I am a bit disappointed that you have decided that you cannot be precise. I would have thought that at least to shut me up you would have given me two or three. Are you familiar with the study conducted in California by Professors James Enstrom and Geoffrey Kabat, which suggested there is no link at all between second-hand smoke and ill health?

Professor Sir Liam Donaldson: Yes I am.

Q441 Mr Amess: What is your view of their research?

Professor Sir Liam Donaldson: Firstly, the study was carried out by the researchers who were partly sponsored by the tobacco industry, so there was a clear conflict of interest there. Secondly, it was using data from the American Cancer Society. The American Cancer Society subsequently disowned
the study and criticised it on the fact that the methods used were unreliable and misleading. Quite honestly, I do not think that study stands up to any scientific scrutiny whatsoever, leaving aside the conflict of interest in the funding which to me is tantamount or comparable to a research study on organised crime being funded by the Mafia.

Q442 Mr Amess: Why do you think the study reported that there was no adverse effect?
Professor Sir Liam Donaldson: Because they carried out a study with a flawed methodology which led them to the wrong conclusions.

Q443 Mr Amess: I am delighted that you are aware of that study which helps the argument in terms of the ban. It is just a bit surprising and disappointing that you cannot refer me to any studies to reinforce your view.
Professor Sir Liam Donaldson: You have had all the detailed documents. I can refer you in detail to individual reports which have synthesised the research evidence. I did not expect that we would use up all our time going through their research evidence in detail.

Mr Amess: This is a Select Committee. It is up to us to ask the questions. It is not for the Chief Medical Officer to determine which questions he would feel comfortable with or not. I am very disappointed and surprised that you cannot refer me to any scientific evidence base in terms of this inquiry. I would have thought it was an obvious question.

Q444 Chairman: You were presented last November with the Scientific Committee on Tobacco and Health’s (SCOTH) Report.
Professor Sir Liam Donaldson: Yes.

Q445 Chairman: Has that been challenged by anybody?
Professor Sir Liam Donaldson: No, it has not. That is one of the expert reports that I was referring to.

Q446 Mr Burstow: We have read your Annual Report for 2004 with great interest. In the report you say that the proposals for smoke-free public places set out in Choosing Health did not go far enough. I wonder if you could tell us how we could go further to meet your concerns.
Professor Sir Liam Donaldson: I think the case for widening the present proposals to all enclosed public places and workplaces is a very strong case both on health grounds, on grounds of public opinion and I think even on economic grounds, looking at the data from other countries which I analysed in my 2003 report.

Q447 Mr Burstow: So widening would mean a ban more along the lines of the Irish ban or something else, would it not?
Professor Sir Liam Donaldson: Yes it would.

Q448 Mr Burstow: Can you also say a bit more about what you think the effects of a partial compared to a comprehensive ban would be in terms of health inequalities and health outcomes?
Professor Sir Liam Donaldson: The present proposal, which is a partial ban, I think is unsatisfactory for a number of reasons. Firstly, it leaves those most exposed to second-hand smoke unprotected. Secondly, it loses out on the opportunity to reduce the prevalence of smoking and ill health from second-hand smoke as a consequence. Thirdly, in my view it will actively increase health inequalities for two reasons: first of all, pubs and bars in the northern part of England which already have high levels of inequalities are more likely to be pubs that do not serve food; secondly, I think pubs in similar areas which currently serve food may stop serving food in order to allow smoking to take place. It also signals to the public that a drink and a smoke go hand-in-hand when all the efforts on smoking and tobacco control have been aimed at de-normalising smoking and I think it puts Britain amongst the laggards of public policy health making internationally rather than the global leaders. Finally, I think the extension to the licensing laws will increase the period when bar workers will be exposed to second-hand smoke.

Q449 Mr Burstow: It has been put to us from some sources that we should not be so worried because only 1% of the workforce will remain unprotected after the ban as currently envisaged is implemented. Is that a fair way to characterise the policy insofar as that 1% are likely to be the ones at most risk of exposure in the first place?
Professor Sir Liam Donaldson: No, I do not think it is fair and I do not think we can be clear either about the numbers because at this stage we do not know what the policy of the pub and leisure industry will be to continuing to serve food or not serve food.

Q450 Mr Burstow: In the Annual Report you make reference to the—at that point—“upcoming consultation on the proposed consultation to create smoke-free restaurants” and you talk about that providing an opportunity to strengthen the approach originally planned. What did you have in mind when you wrote that?
Professor Sir Liam Donaldson: The point I was making there was that the proposals for this hybrid arrangement of smoking and non-smoking bars and pubs would be subject to consultation. My own feeling, having read already the public opinion surveys and the views of experts, was that the consultation would persuade the Government to widen the proposals in the way that I had recommended.

Q451 Mr Burstow: Would you say that the evidence around this hybrid policy was what you might call sound evidence-based policy?
Professor Sir Liam Donaldson: No, I do not think it is and that is why I strongly recommended a different approach.
Q452 Dr Stoate: Can I first of all compliment you on your wonderful clarity and your directness in the answers because you have put your position extremely clearly and that is very helpful to the Committee. Given that you are the Chief Medical Officer and you advise ministers in exactly the same tone as you have advised us, why do you think ministers are nevertheless deciding to go for a partial rather than a total ban given the strength of your evidence?

Professor Sir Liam Donaldson: I think it is rare for the Government to ignore the advice of its Chief Medical Officer or to fail to act on it. This is the first situation I have encountered in the seven years I have been in post when this has happened. I think I probably have to point to the fact that the policy that is currently being run with was in the Labour Party manifesto before the election and I guess on political grounds there are some difficulties in a party departing from its manifesto commitment, but I could not, and should not, be part of the political process that led to the manifesto being drafted, so I do not know why that proposal was put in so firmly in the way it was.

Q453 Dr Stoate: As far as you are concerned, on purely health grounds and the protection of health force grounds, there is absolutely no argument whatsoever for anything other than a total ban, is there?

Professor Sir Liam Donaldson: No argument whatsoever. Other countries are falling like dominos into that position.

Q454 Dr Taylor: Thank you very much for being so clear. When we were in Dublin the experts said that to introduce a partial ban would be an absolute disaster because it would make it much more difficult to go on to a total ban. Do you agree?

Professor Sir Liam Donaldson: I do not know whether it is more difficult to go on to a total ban. I think it is an unworkable situation. The Norwegians introduced not exactly this form of ban but a hybrid arrangement in the mid-1980s and they found that it was unworkable and it was regularly flouted and as a result they brought in a total ban in 2004. Mr Arculus, the Chairman of the Better Regulation Task Force, also has commented to us that he thinks it would be extremely difficult to regulate.

Dr Taylor: We have just heard from the previous witnesses that enforceability would be very, very difficult.

Q455 Mike Penning: In the seven years you have been in post clear medical advice to our ministers has been ignored completely. Does that not put you in a very difficult position?

Professor Sir Liam Donaldson: It has put me in a difficult position and I have had to think hard about what I want to do about that position. There are some areas where if your advice is ignored and it damages the public health you would have to consider resignation if you were in my position. I have thought very, very carefully about that. My feeling is that I have championed this so far. When I produced my first Annual Report in 2002 nobody was calling for this to happen. I have pushed it so far. I have re-emphasised it in my 2003 and 2004 reports. I have spoken publicly in opposition to the Government’s policies on this one area, which is an unprecedented position for a Chief Medical Officer, and therefore my feeling is that this will eventually come and it is more likely to come if I stay in my post and continue to champion it.

Q456 Mike Penning: If they introduced the legislation as it is at the moment we would have a robust debate in the Commons. If they push forward with the proposal for a partial ban, which would not bring the medical benefits that clearly you passionately believe the public need, would you then have to consider your position again?

Professor Sir Liam Donaldson: I think I would continue to champion the need for a change in whatever law happens to be eventually produced.

Q457 Dr Naysmith: Like everyone else, Sir Liam, I am very impressed with your frankness. This is one of those kinds of electric moments that happen from time to time and I think we are all recovering a little bit from the shock. I was going to ask some rather mundane questions about the National Health Service and I will come to those in a moment. Given everything you have said, why do you think this was treated as a public health policy rather than a Safety at Work Act policy and overseen by the DTI rather than the Department of Health because this is where much of the problem comes from really, is it not?

Professor Sir Liam Donaldson: I think there have always been two principal objections in most countries. One is the economic argument that the leisure industry and the hospitality industry would lose profits, it would harm them. I think that is largely refuted by the experience of other countries and some of the economic analysis. The second one is an ideological one, which is really that you should preserve the freedoms of the minority to smoke. I suppose linked to that is that you do not want to be branded with being part of a “nanny state” and that is then a matter of opinion about whether such an argument should hold sway.

Q458 Dr Naysmith: Some would say that the reason they have gone so smoothly is because it is seen as a health and safety at work issue and once you use that argument there is no argument against it.

Professor Sir Liam Donaldson: Certainly when we talked to the people in New York City who, as you know, were one of the earliest authorities to go into this territory, the campaigners used some very interesting tactics. They sent a questionnaire to all the people who were going to be standing for elected office and they asked them if they would fill out a questionnaire stating trade union by trade union whether they were in favour or against protecting the health of the workers in that trade union. If they refused to answer the questionnaire their name was to be published in a newspaper. When those officials were elected, including Mayor Bloomberg, they called in the questionnaires that they had got
signatures on. They very much pushed the position of the worker as predominant in these arguments. On the question of freedom, as I have said in my Annual Report, for those who have not seen the little paragraph that I wrote, when I went to California on holiday three years ago, where it is completely smoke free, I spoke to a female bar worker on the West Coast and I asked her how she was enjoying the change and the smoke-free atmosphere and I said, “But you’re a great country that puts a great deal on freedom of the individual. Hasn’t this been a problem?” and she said, “Your freedom ends where my nose starts.” I thought that was a very good way of putting it.

Q459 Dr Naysmith: That brings us in a rather round about way to what you think the policy should be in National Health Services’ premises which you have some responsibility for.

Professor Sir Liam Donaldson: The previous Government in 1992 set out a policy that the NHS should be smoke free. That was never implemented. We now have a policy to make NHS premises smoke free by the end of 2006. I think it should have happened a lot earlier, but there we are.

Q460 Dr Naysmith: Does that apply to mental health institutions and hospices?

Professor Sir Liam Donaldson: Certainly mental health institutions are a bit more difficult because the place is somebody’s home and that is an area that is currently being looked at and studied.

Q461 Dr Naysmith: What should the policy be in respect of hospices?

Professor Sir Liam Donaldson: I think those should be the same as in the rest of the hospital premises.

Q462 Dr Naysmith: So we are prepared to have some exemptions in terms of mental health institutions, are we not?

Professor Sir Liam Donaldson: I am not sure whether there should be a full exemption, but it is something that needs to be looked at more carefully before a final decision is taken.

Q463 Dr Naysmith: How should nurses who visit people in their homes be protected?

Professor Sir Liam Donaldson: I do not think they should smoke.

Q464 Dr Naysmith: I mean when they are visiting in other people’s homes.

Professor Sir Liam Donaldson: I do not think a nurse should smoke in somebody’s home.

Q465 Dr Naysmith: I mean when it is people in the home who smoke, and nurses are going in to take care of them.

Professor Sir Liam Donaldson: I am so sorry. I think that is a very difficult area to regulate. I guess the pragmatic solution to that in the short term would be for the healthcare worker to ask, if they objected, to go into a room where somebody was not smoking.

Q466 Dr Naysmith: Should National Health Service staff be role models and not smoke at work? Is there any kind of pressure you can bring to bear on that if you agree that is the case?

Professor Sir Liam Donaldson: I absolutely think so. If you look at the position of football managers, and they are not a breed that you would necessarily point to as role models and some of them are smokers, it would be very rare to see them smoking in a public situation or in a televised football match and I think healthcare staff should adopt the same position.

Q467 Dr Naysmith: My final question, though I think other people may want to come in: do you think public opinion in England would support a comprehensive ban?

Professor Sir Liam Donaldson: I do, from what I have seen of the evidence from surveys and also from the consultation exercise, yes.

Q468 Jim Dowd: In response, if I understood you correctly, to Paul’s question about growing health inequalities as a feature of a partial ban, is that what you said: you feared growing health inequalities if there was a partial ban?

Professor Sir Liam Donaldson: Yes, because more pubs which do not serve food are in the northern parts of England where there are more health inequalities.

Q469 Jim Dowd: The logical conclusion of that then is that a partial ban is worse than no ban?

Professor Sir Liam Donaldson: To my point of view, the complete ban is the . . . .

Q470 Jim Dowd: Sure—nobody disputes that—but one of the features of this issue, and I think in response to Mike’s question you were saying that you regarded this as a step on the way but that what you actually wanted will come to pass parforce one way or another?

Professor Sir Liam Donaldson: Yes.

Q471 Jim Dowd: The Secretary of State herself has said that we are going part of the way, and, I think, reading between the lines, there is probably a similar line of thought, but the issue is between a partial ban and no ban, and a lot of us as part of this inquiry are reaching our own conclusions on the way it has to go, but is a partial ban worse than no ban?

Professor Sir Liam Donaldson: In some respects it is. In respect of health inequalities; obviously in other respects, in creating some completely smoke-free premises, it is more positive; so it is a mixed position really.

Q472 Chairman: Would you measure health inequalities on the basis that if you stopped smoking
in most places their health would improve; in the places you do not stop smoking inequalities grows because you have taken that type of action in some areas but not all? Would that not be a better way of looking at this?

Professor Sir Liam Donaldson: Yes, I think that if you have smoke-free everywhere there would probably be a disproportionate gain in those northern areas, because, after all, nicotine is an addiction, it gives people longer breaks and intervals between smoking and therefore more are likely to give up.

Q473 Chairman: Could I thank you very much indeed for coming along this morning and giving us such an honest appraisal of the situation as you see it, and wish you all the best for the future.

Professor Sir Liam Donaldson: Thank you.

Witnesses: Vice Admiral Rory McLean OBE, Deputy Chief of the Defence Staff (Health), and Mr Chris Williams, Director, Medical Finance and Secretariat Branch Leader, Ministry of Defence, examined.

Q474 Chairman: Good morning. I am sorry we have been a few minutes delayed with our last witnesses. Could I ask you for the sake of the record to introduce yourselves?

Vice-Admiral McLean: I am Admiral Rory McLean. I am here for three reasons. One is I am the single point of contact between the MoD and the Department of Health. I co-chair the Partnership Board with the Department of Health, secondly, I run the Defence Medical Services, which provides healthcare in all its guises across the whole of the Armed Forces in the UK on deployed operations and in garrisons abroad and, finally, I am charged by the Secretary of State with coordinating the implementation of the Choosing Health White Paper as it applies to the Ministry of Defence. Can I introduce Chris Williams, who is my Finance and Secretariat Branch Leader and he deals with the precise detail of the MoD policy. I had a couple of other points I wanted to make, if I may.

Q475 Chairman: By all means. If you would like to do that to start and then we will go to the questions.

Vice-Admiral McLean: Very briefly, I think what we are seeking to do at the moment, however the legislation comes out we will implement the spirit of that within the military circumstances we find ourselves in. We responded to the Department of Health in the consultation phase, where there were one or two areas where we wanted to have some exceptions. Secondly, we have a golden rule that we have been developing, and we have been doing this for some time, and the golden rule is that we will protect the rights of non-smokers not to have to inhale the smoke of others. We have a peculiar circumstance where we have to protect the individual’s private right to smoke in what you would call “the home”. The last thing is that we are seeking to establish an MoD policy that would apply worldwide, because we believe that that will be easier to communicate and easier for our soldiers, sailors and airmen to understand and also to enforce.

Q476 Mike Penning: At this stage I need to declare an interest in that I am a former member of Her Majesty’s Grenadier Guards, the junior service to yourself. I am on the Armed Forces Parliamentary Scheme, which gives me the honorary rank of a major, I believe, which is not bad for someone who only just about made corporal! From my own experience, I know that the prevalence of smoking within the Armed Forces is very high, especially amongst the junior ranks. Can you give us an estimate as to what that is at the present time in the three main forces?

Vice-Admiral McLean: Yes, the information that I think I produced in the parliamentary questioning broadly speaking from memory was about 23% of the Navy smoke, about 19% of the RAF smoke and 33% of the Army smoke. Looked at the other way round, 80% of the Navy and the Air Force do not smoke and 70% of Army do not smoke.

Q477 Mike Penning: But we still, in certain ports of the world, promote reduced price tobacco to our Armed Forces. With the legislation that is proposed, is that going to carry on or are we still going to promote duty-free cigarettes for our Armed Forces?

Vice-Admiral McLean: As part of the work strands I have just been outlining for Choosing Health, we have a whole series of actions to review, not just the smoking but all the other aspects of the Choosing Health policy, of which the duty-free basis for cigarettes and alcohol will be reviewed.

Q478 Mike Penning: Having served when tobacco was rather cheap in the Armed Forces and being discharged and coming back to the UK, I gave up smoking, not because of my health but because I could not afford it at the time. This is not going to go down well with your service men and women who have for generations had massive discounts. I wonder if you can highlight the size of the discounts, if you know.

Vice-Admiral McLean: I would like to answer the question a slightly different way round. I would agree that we are going to be reviewing our policy on duty-free, but we are engaged at the moment in what I would consider to be quite an impressive anti-smoking campaign plan which has at its heart the Executive, who are the people who have to implement it, and so through the encouragement and education we are trying to stop people smoking. For example, every time people go to the medical centre or to the dental they are automatically offered the various different facilities for anti-smoking that we can offer—clinics, patches, all those sorts of things—and so what we are trying to do is to inculcate into the Armed Forces a culture which tries to reduce the instances of smoking.
Q479 Mike Penning: With all due respect, that is not an answer to the question. The question was: are you going to stop the discounts to our Armed Forces of duty-free, and, secondly, have you made any indication with your ranks as to how popular this is going to be? We are trying to reduce smoking throughout the country, and lots of money is being spent from the Department of Heath, but if you continue to give them duty-free, you have having your cake and eating it?

Vice-Admiral McLean: I understand the question completely. My answer is, as I said before, as part of the work strands coming out of Choosing Health, we will be reviewing our policy on duty-free.

Q480 Chairman: You are aware of the fact that both under the last government (under Kenneth Clarke) tax increases were put on cigarettes, effectively on public health grounds, and also under this government they have directly been put on cigarettes and cigarette products on the basis that it reduces consumption?

Vice-Admiral McLean: Yes.

Mr Williams: Of course one can also make the point that there is a duty-free price and there is a price that is available outside in the retail area. If you are in Gibraltar I think you will find there is very little difference between the price that you might get inside the mess and the price outside on the high street.

Q481 Chairman: But Germany is quite different?

Mr Williams: Clearly location by location there will be differences, and that is why we will be reviewing the policy across the board.

Q482 Mike Penning: The point you made before and it just does not equate, because if there is no duty on cigarettes people can afford them, but in most countries where our servicemen and women serve there has been in the past a black market between what you can buy as a serviceman and that is what is available to the general public in that country. Can I move on? You discussed accommodation. For the vast majority of single servicemen and women the barrack room or their barracks is their home. How are you going to adapt a policy of banning smoking if it is their home, and, secondly, in particular to the Navy on a ship where that is their home as well even though it is their workplace?

Vice-Admiral McLean: I will deal with the second point first because it is probably easier. We already have a ban inside surface ships, and so they are only allowed to smoke on what we call the weather deck, i.e. the open air. This is not quite as possible within submarines, for obvious reasons, but what we have done is segregate smoking away from the workplace and the living spaces so they are only allowed to smoke at either end of the submarine. We expect to be able to make submarines completely smoke-free over a period of years, but we will have to wean our submariners off smoking in order to achieve it. In terms of single living accommodation, to the maximum extent possible—and this is true in larger barracks—what we will hope to do is to have areas, smoking blocks, one complete block, where smokers will be able to go, and other blocks which are the completely smoke-free. In areas where that is not possible we will segregate accommodation for use by smokers from the non-smoking area and we will put in procedures to be able to extract smoke, and so on and so forth. That is the only way that we can get round that particular situation of it being a serviceman or woman’s home?

Mr Williams: The key principle we are looking at is that those who are unwilling to be exposed to the smoke of others will not be. That is the spirit of the legislation, we believe, and that is what we are moving towards. Equally, because we provide people with their homes, they live on our premises and in many cases are directed to do so, if they wish to remain a smoker within their own private space, if you like, we will, where it is possible, create such an opportunity, either by physical building construction or modification or by segregation of smoking buildings from non-smoking buildings, but the golden principle is that somebody who is unwilling to be exposed to the smoke of others will not be when we have implemented our policy.

Q483 Mike Penning: I cannot see how this is going to be done. In basic training in most of the Armed Forces you are in a multiple occupancy room, and you are only offered single occupancy later on if you are lucky. Are you telling me we are going to positively discriminate to say that if you join the Armed Forces you should not be a smoker? They pay for this accommodation—they pay rent these days—unlike when I joined the Armed Forces they only paid a contribution. This is their home. Unless you have a massive financial input into accommodation within the Armed Forces, you are not going to be able to do this?

Vice-Admiral McLean: The answer to the question is that we are not going to have people in multi-accommodation subjecting themselves to the smoke of others, and so we are going to segregate them, and if we cannot segregate them we will say there will be no smoking and we will provide smoking areas outside.

Q484 Mike Penning: The implications of this I will follow with some interest?

Mr Williams: Each unit, each command, will make a decision on the amount of provision it is prepared to make for smoking accommodation and the amount of provision it is prepared to make for non-smoking accommodation, and the golden rule is that non-smokers will not be exposed unwillingly to the smoke of others.

Q485 Jim Dowd: Submariners—I think the expression you used was that you are going to “wean” them off it. Does that mean that anybody who smokes cannot now be recruited as a submariner?

Vice Admiral McLean: No, it does not mean that. What it means is that over a period of years we will progressively educate the submariner community down to the non-smoking rule, because they cannot
smoke in submarines at the moment in certain operational circumstances, and we will make it clear in our deputed policy that there will be no smoking in submarines in the future; but that does not mean to say that an individual submariner cannot smoke, and it also does not mean that if the submarine were to surface in benign conditions that the smoker could not go on the upper deck and have a smoke.

Q486 Mike Penning: The MoD has said that it will try and implement as best as possible the legislation but with limited exemptions. Can you highlight the exemptions that the MoD is proposing?

Vice Admiral McLean: We have covered two of them: one is submarines, the second is Royal Fleet Auxiliaries, which, for those who do not understand, are tankers which carry ammunition, and so it is impractical at the moment—a bit like an oil or a gas rig—for people to smoke on the upper deck. Again, the same point though, we are planning over the next few years to gradually reduce the smoking population on board such that they cannot smoke inside the ship, and we will make special arrangements, when the operational circumstances allow, for smokers to be able to smoke on the upper deck within the confines of safety. We have talked about single living accommodation and in messes. In messes there will be, for obvious reasons, our golden rule, you will not be allowed to smoke within the bar area or anything like that. A commanding officer, if he chooses, will be able to designate an area for smoking for those who want to do it for which we will not allow bar staff or cleaners to go in until it has been expunged of the smoke.

Q487 Mike Penning: You were talking there about messes, but for the junior ranks who use the NAAFI—it is one of the most prevalent places they go to—how is that going to be permitted? Is it a club, exemptions, or . . . .

Admiral McLean: No, there will be no smoking in NAAFI bars. It will be again, designated in areas that are away from those who do not wish to smoke.

Vice-Admiral McLean: We recognise this is a challenge, because this is a change in the way that messes and clubs operate at the moment, but what we are advocating is thinking of it not so much as a club but as this is a place where people effectively live—it is their front room where they can watch the television or read the newspaper—so we recognise the challenge, but if the membership wishes to retain a smoking facility within that living space, we would then have to identify whether it is possible to create a separate smoking area so that those who wish to use the club and not be exposed to smoke will be able to do so and, equally, those who wish to smoke in what is effectively their own living room will still be able to do so with the single provision for separation having been made.

Q488 Mike Penning: This is all going to cost money at the end of the day. There is a financial implication for what you have just described. In the budgets—

I used to be a defence adviser myself—where is this money going to come from? Which financial stream is that coming in from?

Vice-Admiral McLean: The way in which the MoD planning process works, it has now moved from an annual to a bi-annual cycle, but what we do is we take all the costs pressures on the department into account when we set and allocate our resources. Some pressures go up and some areas go down. Every two years we rebalance the defence programme between, for example, personnel, logistics, and so on and so forth. In the context of a government policy that has now been enacted through Parliament, we will be obligated to fund whatever is required.

Mr Williams: I think it is also worth making the point that it is already the case in some messes that they have decided to go entirely non-smoking. It is also the case that, of course, there will be financial implications if one wishes to create a separate smoking facility which does not already exist, and that will be judged in the normal process of deciding what are your priorities, where do you want to spend your money? One cannot exclude the possibility that in some cases there will not be the money to set up a segregated smokers area, in which case, our governing advice, it is the right of the non-smoker not to be exposed to other’s smoke that wins.

Q489 Mike Penning: So if the budget is tight the rights of the smoker in tone will be ignored?

Mr Williams: Not ignored, will be put into the balance, and, like all these things, you have to decide: how much do I want it?

Q490 Mike Penning: If the money is not there he or she will not be allowed to smoke, is what you are saying?

Vice-Admiral McLean: It is highly unlikely that we will end up trying to do a policy change on this basis, which is going to be challenging, as Chris has already said. It is highly unlikely that for the sums of money that we are talking about to provide for the rights of the smokers as well as preserve the rights of the non-smoker that we will not find this money in defence across the board; but the specific answer to your question: we have not costed it yet and we have various different systems in place to be able to accommodate not just this policy shift but other policy changes.

Mike Penning: Thank you for being so honest.

Q491 Mr Burstow: Two quick questions. Have you made any assessment of the impact on the health and therefore probably the operational effectiveness of the Armed Services arising from second-hand smoke? Is there any assessment that you have made in terms of the health effects it has?

Vice-Admiral McLean: The answer to that is that there have been some informal and incomplete studies that have been done over a few years, but we have not got any concrete, what I would call, scientific results at this stage. That is why in the case,
for example, of submarines that we are intending to go to a complete ban in submarines over a period of years.

**Q492 Mr Burstow:** Are those incomplete studies possibly documents that could be passed to the Committee?

**Vice-Admiral McLean:** The answer is I do not know the status of those documents at the moment. My understanding is that they are informal because the research was incomplete.

**Mr Williams:** Nothing we have done points to a different conclusion other than that we should be trying to persuade our people to give up smoking or not to start smoking in the first place.

**Q493 Mr Burstow:** There is a benefit to be had from the point of view of your workforce?

**Mr Williams:** We do not challenge that at all, no.

**Q494 Mr Burstow:** The other thing I just wanted to pick up very quickly was the way in which you were intending to roll out your policy in this respect, the desirability of a consistent approach across all countries within Britain, consisting of England, Scotland, Wales and Northern Ireland, and the idea that you are going to implement this. Given that, which of the countries are you taking the lead from in terms of framing your policy? Is it England, is it Scotland, is it Wales, is it Northern Ireland?

**Mr Williams:** What we are trying to achieve is one policy that is a good policy and effective wherever we serve, both in the UK and overseas. It does mean noting that there are various administrations with their own legislative mechanisms and we are in discussions with officials in all of the legislative bodies. It also means that because we know Scotland is going to implement their regulations first, that we will be taking the implementation date for us as effectively the Scottish date.

**Vice-Admiral McLean:** 26 March 2006.

**Mr Williams:** So that is when we will bring the spirit of the regulations instructions into force.

**Q495 Dr Stoate:** I was on the Ark Royal a couple of years ago in the Navy and I had such a good time that I am signed up for next year, so I am going to be a post-graduate.

**Vice-Admiral McLean:** Welcome aboard.

**Q496 Dr Stoate:** I took particular notice of the fact that sailors were not allowed to smoke inside the ship and they went outside on the deck when they wanted a fag, and nobody complained to me at all that that was in any way an issue to them. Have you actually had much evidence of complaints or resistance to this type of policy or do you think it has just been accepted?

**Vice-Admiral McLean:** In the case of the surface Navy, and I have been part of that for many years, we have been engaged in this aggressive anti-smoking policy for quite some time. The difference with submarines is that they do not have the opportunity to go up on deck. A submarine is a highly complex piece of kit and therefore we have many different types of skilled trades, and what we are trying to preserve at the moment is we do not want non-smokers to go and we do not want smokers to go until we have got to the point when we can go completely non-smoking. I have not had brought to my attention any formal representations, although within the submarine community they are a very close band of brothers, they rely on each other heavily, and therefore they are quite tolerant of each other in that environment. Whether there are any formal representations in the system I would need notice of that but, more importantly, we do continuous attitude surveys all the time and it has never been brought up other than in the spirit of cooperation where some messes have decided that they will not smoke anyway.

**Q497 Dr Stoate:** The other thing I noticed was that sailors were extremely unlikely to drink once they had left port. I was quite fascinated by that. The sailors might drink heavily when they are on shore but once the ship sails they almost do not drink at all, even the ratings do not. Do you feel as though you would have any difficulty implementing these things or do you think the Services support broadly what the Government is trying to do and what the Armed Forces are trying to do and accept the policy without much resistance?

**Vice-Admiral McLean:** The answer to that question is that the head of each of the Services is fully behind the spirit of the legislation. It will be perceived in a different way between the Navy which has probably been doing it for longer and the Air Force who have had very strict rules for obvious reasons. I think the most difficult area, or the most challenging area I should say will be to implement it within the Army.

**Mr Williams:** The Admiral gave a snapshot of the figures as they currently are, and sometimes we can detect a trend in the way that we are measuring, and the trend is actually downwards in all three Services. It is a general decline and obviously we would hope that not just the military health education but also the general civilian population health education will be pushing in the same direction on that.

**Dr Stoate:** Thank you very much.

**Chairman:** Could I thank you both very much indeed for coming along and assisting us with this inquiry and also for the written memorandum, which was very informative, Vice-Admiral. Thank very much indeed.
**Witnesses:** Mr Shaun Woodward, a Member of the House, Under-Secretary of State for Northern Ireland, Northern Ireland Office, Ms Pat Osborne, Head of Investing for Health Branch, and Mr Jim Gibson, Deputy Principal, Investing for Health Branch, Department of Health, Social Services and Public Safety Northern Ireland, examined.

**Q498 Chairman:** Good morning, Minister. Could I first of all apologise for us being a few minutes late. We are tending to have quite long sessions on this particular inquiry with sometimes three, four or even five witnesses sat at the table, which tends to take us on a little bit. Could I for the sake of the record ask you to introduce yourselves and the people who have come along with you this morning?  

**Mr Woodward:** Thank you very much indeed for Republic of Ireland where, as you know, they had record ask you to introduce yourselves and the context of Northern Ireland. Very specifically, it was even five witnesses sat at the table, which tends to Ireland as a discrete entity in relation to public health. We are tending to have quite long sessions on this on the merit of devolution. I say that because we did and we were very, very minded to look at Northern Ireland as a discrete entity in relation to public opinion and public support on this issue in the context of Northern Ireland. Very specifically, it was important for us to look at what had happened in the Republic of Ireland where, as you know, they had already introduced comprehensive controls on where people smoke at an earlier stage and, undoubtedly, I think the publicity around the introduction in the Republic had a huge influence on public opinion in Northern Ireland. That I think partly accounts for why there is a considerable disparity between the level of public support in Northern Ireland for a comprehensive set of controls as opposed to that in Northern Ireland. By the time I became Minister for Health in Northern Ireland in May, I think the public there was ready for the decision was taken to implement a comprehensive ban, and I think that needs to be distinguished from the position in England where I am not so sure that the public is ready for a comprehensive ban, but that is a decision for Health Ministers in England and, as I say, that is part of the merit of devolution. In Northern Ireland people there wanted this and we, I think, fulfilled what they wanted.

**Q499 Chairman:** Thank you. Could you explain why the decision was taken to implement a comprehensive ban in Northern Ireland?  

**Mr Woodward:** Yes, we had had a great deal of consultation over the last 12 months in Northern Ireland, concluding with a major exercise between December 2004 and March of this year which produced over 70,000 responses, broken down into three categories. The first category was for no change; the second category was for something of an in-between position between no change and a comprehensive ban; and the third was for a comprehensive ban. Very strikingly, no change had just over half of 1% supporting it in those 70,000 responses; the compromise had the support of around 8%; and the wholesale comprehensive controls on where people smoke attracted the support of just on 92% of those who returned their replies to that. I should stress, Chairman, that I think it is prudent to recognise that there would have been something of a campaign behind that level of response. What is interesting, though, has been that since we announced our intention to introduce controls on where people smoke as a comprehensive set of controls, the response by the public in Northern Ireland would suggest that whilst it may not be 91 or 92%, it is probably of the order of about 80% of the public who absolutely support controls on where people smoke.

**Q500 Chairman:** Is that since the announcement of 17 October? Has that changed public opinion at all, in your view?  

**Mr Woodward:** That is since the announcement of 17 October.  

**Chairman:** David?

**Q501 Mr Amess:** You have sort of answered it already but was a partial ban with the exemptions that is being considered by the Department of Health in England considered, and if it was considered why was it rejected by the Northern Ireland Office?  

**Mr Woodward:** I think the first thing to say really is that what we are doing in Northern Ireland reflects on the merits of devolution. I say that because we did and we were very, very minded to look at Northern Ireland as a discrete entity in relation to public opinion and public support on this issue in the context of Northern Ireland. Very specifically, it was important for us to look at what had happened in the Republic of Ireland where, as you know, they had already introduced comprehensive controls on where people smoke at an earlier stage and, undoubtedly, I think the publicity around the introduction in the Republic had a huge influence on public opinion in Northern Ireland. That I think partly accounts for why there is a considerable disparity between the level of public support in Northern Ireland for a comprehensive set of controls as opposed to that in Northern Ireland. By the time I became Minister for Health in Northern Ireland in May, I think the public there was ready for the decision was taken to implement a comprehensive ban, and I think that needs to be distinguished from the position in England where I am not so sure that the public is ready for a comprehensive ban, but that is a decision for Health Ministers in England and, as I say, that is part of the merit of devolution. In Northern Ireland people there wanted this and we, I think, fulfilled what they wanted.

**Q502 Mr Amess:** So a comprehensive ban is much more popular in Northern Ireland, you would judge, than it would be in England at the moment?  

**Mr Woodward:** I think it is very difficult to make that judgment about England without being close to the health issues as a Health Minister would be in England. What I can say is that in Northern Ireland my officials have done a huge amount of work in the run-up period to the first announcement that we made in July and then the subsequent announcement in October, and their work pointed to the fact that this was going to have a massive level of public support. It was still a risk because of course until you actually announce it you have no idea whether or not that really will come to fruition, but I think what was quite clear was when we announced a partial ban in the summer of this year people felt that we should go much, much further. We then conducted more consultation and we also went to have a look at the effects on hospitality and tourism in Dublin. We also went to New York to look at the effects of the controls there. All that led us to believe that with public opinion so ready for this in Northern Ireland, the right thing to do was to go the whole hog, which is what we announced in October.

**Q503 Mr Amess:** Something that we found interesting when we visited Dublin two weeks ago was it was suggested to us that you personally had changed your mind on this; that you had come to the issue with a particular view supporting your English colleagues and had changed it. We have just had an absolutely electric session this morning when the
Chief Medical Officer at one stage very clearly told us that he felt out of line completely with the Government’s policy and indeed had even thought of resigning. Given that you have changed your view on the matter (this is what we were told), are you behind the scenes, and I know you are deploying the argument of devolution, trying to influence your English colleagues on this issue?

Mr Woodward: Behind the scenes I am not trying to influence my English colleagues. They must make their own decisions about health issues in England because I believe it is right that the Health Minister and officials should make the decision about Northern Ireland separately, and I think to the credit of Health Ministers in England they did not try to influence our decision in Northern Ireland. I understand why the Republic may have reported the influence they had on my decision in the way that they did. It is not entirely accurate. What we announced in the summer of this year was that whatever happened we would have a partial ban. What we said in the summer of this year was that we may need to go further and we may want to conduct further consultation and see what the effects of a comprehensive ban had been, as I said, on hospitality, on employment and indeed on health issues generally, and we were, undoubtedly impressed by the way that the ban had been introduced in Dublin and had not had a negative effect on employment and had not had a negative effect on hospitality, and certainly not in the way that those people who were shroud-waving before the introduction of these controls had suggested would be the effect. They suggested it would be cataclysmic for employment in the hospitality sector, they thought that alcohol sales would plummet, and that it would not have the support of the public. What Dublin showed us was that was not the case and New York in fact showed an increase in employment in the hospitality sector since they introduced controls on where people smoke. Again, we were impressed by the fact that it would not have a dire effect and, indeed, it may even have a positive effect. In both places we were also impressed by the arguments made to us by people who did not smoke but who said they were now going to bars and restaurants for the first time because they were much more pleasant places to be.

Q504 Chairman: Do you think it is very likely that that influence on the public in Northern Ireland by what was going off in the Republic is likely to happen in the rest of the United Kingdom in view of the ban that will be coming into place in Scotland in a few months’ time?

Mr Woodward: I think the important thing to recognise in this, Chairman, is that this is an area where we, first of all, said that this is a policy about protecting workers. We did not feel that we wanted a nanny state in Northern Ireland which said to people you cannot smoke in your own home. If you want to smoke in the privacy of your own home you can go and do that. What we were concerned to do was to protect workers in the workplace and I think what the public, certainly in Northern Ireland, go along with is the idea that you have the right to be protected in the workplace and in public places. Do I think that the long-term effects of this would be to influence the public in England if we go along the route that we are intending to go in Northern Ireland? Yes I do. My personal view is that within a matter of five years or ten years, even if England goes a different route to Northern Ireland, which Health Ministers must decide, and rightly so, I suspect that we will move to more comprehensive controls. It may not be that the time is right yet. When I say that what is terribly important in this is enforcement.

Q507 Mr Burstow: You were talking just now about the issue of enforceability and enforcement and the need to have some degree of consent for that enforcement to be effective. One of the points that has been put to us in an earlier session we have had today around enforcement is the extent to which the complexity of the regime you are trying to enforce makes enforceability more difficult. When you were looking at the options that you canvassed earlier this year, including this intermediate option of a partial
ban, what sort of advice were you receiving about the affordability and complexity of making that method work?

**Mr Woodward:** I think you can make arguments for and against this issue in any way you want. At the end of the day we took a view which was that the public wanted controls on where people smoke in the workplace and public places to be introduced. On the matter of enforceability, you again come back to saying is the public behind this? And again I come back to saying that in Northern Ireland the public were ready for this. Again it comes back to a judgment about exemptions. We will make the first few months of next year a specific set of consultations in relation to this in relation to exemptions. The sorts of places you have got to think about are prisons, psychiatric institutions, and you have got to be very careful about this. Obviously an issue in relation to prisons is law and order. You have got large numbers of people who smoke. It is important, I am told, for people in prisons that they are able to smoke. The interesting thing is that what New York decided to do was to ban smoking in prisons as well but in Dublin they have not done that, and that is an interesting difference between Dublin and New York, and we will be consulting on that because what we have got to do again is proceed on all of this with consensus and when people are ready. Psychiatric institutions are another very, very important area to look at. The route that we may well go down to avoid complexity, although we have not made a decision on this yet and, as I stress, we will consult on this, is to actually ask institutions to apply for an exemption.

**Q508 Mr Burstow:** Can I come back, though, to this point about enforcement and ask you specifically whether or not those who will be charged with enforcing the regulations you are going to be introducing made any representations during the consultation stage that you have been talking about it being more complicated to enforce effectively a partial ban compared to a comprehensive ban?

**Mr Woodward:** We had discussions with people about that. To be honest, the strength of argument around the partial ban that was made to us was one made on economic grounds. That was where the greatest strength of argument came because one of the things that was said to us in both Dublin and New York was the unfair advantage you would give with a partial ban to places that would still continue to permit smoking. One of the reasons in Dublin they got the support of almost the entire hospitality trade behind the comprehensive ban on where people smoked was because they went the whole way...What the trade did not seem to want was a partial ban, because they thought it would create unfair competitive advantages.

**Q509 Mr Burstow:** On your own statements you have said a partial ban would have meant protecting workers in some workplaces but not in bars and pubs, and you go on to pose the question: where is the social justice in that? Where is the social justice in that?

**Mr Woodward:** I think that is why we decided in Northern Ireland we would go the whole way. We were convinced that we could do it in Northern Ireland because we were convinced that we had the support of the public behind us. Yes, there are principled arguments here about social justice, there are very strong arguments about health inequalities, there is no doubt that smoking does create health inequalities and in a place like Northern Ireland, which starts in a very difficult place at the beginning of this, it exacerbates already a very difficult situation.

**Q510 Mr Burstow:** Finally on ventilation, you rejected the idea of using ventilation as the way to solve this problem. What evidence did you look at and what convinced you that ventilation was not the way to go?

**Mr Woodward:** We again consulted in Dublin, we again consulted in New York as well as in the context of Northern Ireland itself, but we were again impressed by the arguments that said if you think that the overall tide of this is moving towards eventually whether you do it now or in five or in ten years’ time, bringing in comprehensive controls on where people smoke, then you have to think about the cost to a small business of introducing very expensive ventilation. If you are a small business with a relatively small turnover, introducing ventilation equipment, which might be cost you anything between £20-100,000, and then in, let us say, five or ten years time you introduce legislation which says you are banning smoking entirely in the premises, it is a pretty unfair burden to put on the businesses, and certainly, again in the context of Northern Ireland, since we felt the public eventually would be behind this in a matter of years, even if not immediately, it would have been a very unfair thing to have done. There is one other issue which I should probably raise on ventilation. We were also very impressed by the arguments given to us when we were in New York by the health officers there that actually ventilation may remove the smoke but it does not remove the carcinogens, and, I say this as an ex-smoker, I do feel very bad about the fact that I do not know what harm I may have done to people who may have been forced to breathe in my smoke; and when we were given the statistic that a bar worker who does not smoke, nonetheless, working in a bar or restaurant where people do smoke, will in the course of an eight hour shift breathe in the carcinogens equivalent to him or her smoking a pack of ten cigarettes a day, it is pretty compelling.

**Q511 Jim Dowd:** First of all, may I congratulate you on giving up. For all of those who have attempted to give up, if you can, I would suggest just about anybody can! What is the attitude of your policy towards private clubs?

**Mr Woodward:** Again, this is an area where we are going to consult, but our inclination is to make the comprehensive control and where people smoke in
the workplace and public places apply across the board, which would mean that if there was an establishment where people were paid to serve drinks, or whatever, even if that was a private club, that is a workplace, and we intend to control where people smoke in the workplace, which would mean that they would not be able to smoke there.

Q512 Jim Dowd: The other point you mentioned—it has been put to us as well by the leisure industry—the dispute about a partial ban giving a competitive advantage, given the fact that that would have existed in broader areas, was there any evidence of that, of people who used to go to pubs in the Republic where they could smoke and when the ban came in migrating to pubs in the north where they could smoke?

Mr Woodward: The evidence that we found came from those organisations which represented bars and restaurants, and they just said to us that they had consulted with their members and their members had told them in the run up to the legislation being introduced in the Republic, that they did not want an unfair competitive advantage to be created, so we have relied on their evidence.

Q513 Jim Dowd: What I am saying is that that unfair advantage, if indeed it was, existed along the border areas where people tended not to go too far?

Mr Woodward: There is no question that right now, for example, that people do nip over the border for a crafty cigarette and, undoubtedly, when we introduce these controls, they will not be able to do so.

Q514 Dr Naysmith: Minister, when you were considering the various policy options—stay as you are, a partial ban, a complete ban—you must have been in receipt of medical advice. Is that right?

Mr Woodward: We were in receipt of medical advice.

Q515 Dr Naysmith: Did that come from Sir Liam Donaldson?

Mr Woodward: No, we had medical advice from our own Chief Medical Officer in Northern Ireland.

Q516 Dr Naysmith: What sort of advice were you receiving from the medical officer in Northern Ireland?

Mr Woodward: Perhaps I will ask Pat to help me out here.

Ms Osborne: The advice of the Chief Medical Officer is she has looked at evidence and that smoking is very harmful. It causes heart disease.

Q517 Dr Naysmith: I think we probably know all the bad things about smoking by now, but was the officer recommending a complete ban or a partial ban.

Ms Osborne: Oh yes.

Mr Woodward: Yes. Absolutely.

Q518 Dr Naysmith: A totally complete ban?

Mr Woodward: A comprehensive ban on where people smoke in the workplace and in all public places.

Q519 Dr Naysmith: So you were prepared to go against that medical advice until you popped over to Ireland and changed your mind. Is that right?

Mr Woodward: Because I do believe that you have to do this with the public support, and if you do not have the public support on the kind of level that I think we have in Northern Ireland the policy will not be effective because people will break it.

Q520 Dr Naysmith: But that is fairly serious, is it not?

Mr Woodward: There are all sorts of things . . .

Q521 Dr Naysmith: Medical advice which tells you the practice is killing people?

Mr Woodward: I think I can see where you are going on this now. There are lots of things that people do to themselves that arguably are harmful, but the state does not stop them from doing it. What we were concerned to do was to stop them from harming people in the workplace and in public places so we would not be a nanny state saying you cannot smoke, but what we would do would be to protect the health of those people who do not smoke and would be forced to breathe in the smoke of those who do, and we thought that in public places and in work places it was right to do that, but we would not have felt we could go that far if the public had not supported us.

Q522 Dr Naysmith: That is your opinion, but we are getting to the stage now where we know that the Chief Medical Officer for England and Wales recommended a total ban, the Medical Officer from Northern Ireland recommended a total ban; I am quite sure it is a total ban from the medical people in Scotland as well. How high does the opinion of medical . . .

Mr Woodward: You have to form a judgment about this. There are plenty of people who think that having more than two units a day of alcohol is really bad for you, but we are not legislating to stop people having more than that two units of alcohol.

Q523 Dr Naysmith: You are not drinking other people’s alcohol. With smoke you are taking in other people’s smoke.

Mr Woodward: Yes, but, as I say, these things are about judgment, and our judgment was that the time was right to do this in Northern Ireland. The evidence undoubtedly for us was compelling, but, as I say, I think you do have to have huge and widespread public support behind this and in Northern Ireland, not least because of the introduction in the Republic a year before, we were ready to do it.

Q524 Mike Penning: You have gone on several times saying that you have to take the public with you; public opinion has to be with you. We have heard a
lot of evidence at this committee that public opinion is there to protect my workers in my constituency and yours, but we are not going to get the protection that you are offering as a minister. Is it not the case that it is nothing to do with public opinion, it is to do with the cabinet’s opinion and whether or not you can get this through the cabinet for a total ban rather than this flat situation?

**Mr Woodward:** No.

**Q525 Mike Penning:** Would you explain then: because the Secretary of State sat there and wanted a total ban. It was clear in everything she said. You said the compelling evidence is that we could save lives if we introduce this. It went to the Cabinet and it was thrown out. Why?

**Mr Woodward:** I am afraid I do not sit in the cabinet and I cannot therefore discuss thing that I genuinely have no knowledge of.

**Q526 Mike Penning:** How can you defend it then if you were not there?

**Mr Woodward:** Sorry.

**Q527 Mike Penning:** How can you defend a decision of the Cabinet if you were not there?

**Mr Woodward:** I can defend the decision that we have made in Northern Ireland because I have responsibility for health in Northern Ireland. I do not have responsibility for health outside of Northern Ireland, and I do believe in devolution and I do . . .

**Q528 Mike Penning:** You have a responsibility to your constituents, like I do. You protected Belfast South and you are not going to protect St Helens South?

**Mr Woodward:** As I have just said, you can only do this if the public are behind you, and in Northern Ireland they are behind this decision. If health ministers here judge that the public is not yet ready for this, that is a judgment that they must make, and I am afraid, as much as you may want to speculate on what did or did not take place in the cabinet, I am unable to assist you because I was not there.

**Mike Penning:** We can read it in the papers. It is quite easy.

**Q529 Chairman:** Can I ask you one last question. When we went to the Irish Republic, and I assume that you saw the same statistics, indeed I think you used them in your statement on 17 October, that smoking prevalence had reduced in Northern Ireland after the ban had taken place—it was one in three; it is now down to one in four—the potential for smoking cessation coming on the back of such a ban, was it an issue in your thinking in terms of Northern Ireland or was it an issue in terms of both the campaigning and the public’s thinking in Northern Ireland about whether or not to have a comprehensive ban?

**Mr Woodward:** I might add a second component to that. Picking up from what Jim said earlier on and his kind comments about congratulating me on a total ban. It was clear in everything she said. You said the compelling evidence is that we could save lives if we introduce this. It went to the Cabinet and it was thrown out. Why?

**Mr Woodward:** I am afraid I do not sit in the cabinet and I cannot therefore discuss thing that I genuinely have no knowledge of.

**Q530 Chairman:** Minister, could I thank you very much for coming along and for giving evidence this morning. I am sure that is going to be very helpful to the Committee in its inquiry.

**Mr Woodward:** Thank you very much.

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**Witnesses:** Caroline Flint, a Member of the House, Under-Secretary of State for Public Health, Fiona Mactaggart, a Member of the House, Under-Secretary of State for the Home Department, and Mr Nick Adkin, Tobacco Programme Manager, Department of Health, examined.

**Q531 Chairman:** Good morning. Could I first of all apologise for the lateness of the hour, as it were. We are still in the morning, but only just really. Could I just ask you for the sake of the record to introduce yourselves and give your positions?

**Fiona Mactaggart:** I am Fiona Mactaggart. I am Parliamentary Under-Secretary at the Home Office with responsibility for offender management and criminal justice.

**Caroline Flint:** I am Caroline Flint, Parliamentary Under-Secretary at the Department of Health responsible for public health.

**Mr Adkin:** I am Nick Adkin. I am the Tobacco Programme Manager at the Department of Health.
Chairman: I understand, Fiona, that you have to leave the committee in about ten minutes or so?

Fiona Mactaggart: Yes, I am sorry. I had hoped to be able to be here for you.

Chairman: I think we will be able to clear the areas that we wanted to discuss with you in that particular time, so we will move straight on to you. What is the Home Office view on smoking in prisons and how should it be controlled or reduced?

Fiona Mactaggart: Our view is that we need to develop a programme together with the prisons to reduce smoking, but, of course, we are dealing with a highly addictive group of people, some 80% of prisoners have addictions of various kinds very often including tobacco; so this is something that needs to be dealt with in, I think, a developing way. Our emphasis to date has been to make the working parts of prisons smoke-free, to make secure training centres and more juvenile establishments, to introduce smoke-free policies there, to try to encourage policies which mean that smokers and non-smokers do not share cells, although we cannot give a guarantee of that, and also, in conjunction with the Department of Heath, to work on the addictions which prisoners have to use the nicotine replacement therapy so that we reduce smoking in prisons.

Chairman: You have seen the likely options listed in the Prison Service memo to the Committee. Do you support them in terms of the areas of exemption?

Fiona Mactaggart: I think it is difficult for us to be legally obliged in every part of a prison to impose smoke-free areas. I am hoping that the arrangements under the legislation, recognising that the cell is a prisoner’s home, as it were, will trust us to drive through making the rest of the prison as a workplace smoke-free.

Chairman: The issue of shared cells. How do you feel about that?

Fiona Mactaggart: I would like us to be able to guarantee that a non-smoker will never have to share with a smoker, but we cannot do that at present with the present size of prison population. We have 77,471 people in our prisons today, which is above our certified normal accommodation. In those circumstances, to give a guarantee that you will not share a cell with a smoker and non-smoker is a pressure that the prisoner state is not capable of guaranteeing. However, in most of our prisons we seek to achieve that, and that ought to be able to be an ambition; and, if we succeed in reducing the overall prison population, it is something we ought to be able to do.

Chairman: What about the protection of prison staff? Should that be looked at differently to prisoners who are there?

Fiona Mactaggart: I think it is important that employees in a prison should be able to work in smoke-free areas. That is why if you visit a prison you will find that the offices are smoke-free; the education wings are smoke-free. In theory, and sometimes in practice, these things are breached and we need to tighten up the way that they are implemented, but generally these policies are conformed to and we ought to do it. Of course, the problem for prison officers is that their working environment includes the cells, and they will need to go into the cells for security duties and other reasons. Therefore we cannot guarantee every part of their working environment will always be smoke-free, even if we have those policies in the common areas and in the offices in prisons.

Chairman: You may have seen the evidence that we took last week from the prison service that went into the issues about non-smokers and smokers sharing cells and the logistics of that at this present time, and it is very unlikely that any legislation will have an exemption and I do not think we would dispute that, but do you think there should be some sort of time-limit on those exemptions? We had firm evidence last week where a young offenders’ institute in Yorkshire—not too far away from where my constituency is—is smoke-free, and we were told another one is smoke-free as well and worked on very hard by staff and by prisoners. Do you envisage that something like that should be written in and some sort of target set, as it were, so that we could exempt for a period of time before people would have to meet the times or standards they meet in these particular institutions?

Fiona Mactaggart: As I am sure that the Governor of Wetherby told you, to introduce a smoke-free policy in a juvenile institute, which is actually the situation that we have where we are focusing to start with—and that is the right place to focus to start with—as I said our secure training centres are all smoke-free; we have two smoke-free juvenile establishments, juvenile wings in adult prisons are sometimes smoke-free; so we are starting there—but he would also have told you, I would have thought, that had he been asked to deliver that policy in, for example, the high security prison that he used to run, that would have been a different kettle of fish in terms of its deliverability and the consequences for order and control in an establishment like that. The other problem, of course, is if we make our prison estate totally smoke-free, if you look at those countries which have been able to have smoke-free prisons, there are consequences in terms of contraband. Tobacco in a prison is, in effect, money. I was visiting Wormwood Scrubs a couple of weeks ago and one of the things that is striking when you talk to prisoners is that a couple of days before their canteen, which is where they get their new supplies of tobacco, they have knocks on the doors from people who have run out saying, “Have you got a smoke?”

That is in the present circumstance. If we were to add tobacco to the substances that we had to prevent being smuggled into prison that would create some further difficulties for prisons, and it seems right to me that we should bear down on these things, that we should try to reduce the consumption of tobacco amongst prisoners. Of course it is one of the least of their health problems, frankly—we are talking...
about people who have multiple appalling health problems very often—but I do not know if it would be sensible to have a legislative deadline. I do, however, think it would be sensible for this Committee to expect my department to make significant progress, and I can assure you we are determined to do that.

Q538 Charlotte Atkins: Could you tell me whether you are satisfied with the smoking cessation policies within prisons? It seems to me that there are quite a lot of disparities between different prisons, some more than others. Is that your view?

Fiona Mactaggart: Smoking cessation, i.e. helping prisoners to give up, we do in partnership with the health provision in prisons, which now is increasingly provided as part of public healthcare by the local primary care trusts, and so on. I was talking about my visit to Wormwood Scrubs. In their quitting programme they have got 15 adult male quitters in their last round. I think they had just over 50 people involved in the programme and 15 of them have stayed quitting. I gather that is a relatively good success rate. I am not an expert on these things. So we are putting NiQuitin and other quitting programmes in place. Am I satisfied that some of the other things, in terms of smoking reduction and ensuring that smoke-free areas are effectively managed and so on? No. I think there is a distance to travel. I think we have to recognise that in the sets of pressures that the prison service is under this has not always come up as high as it should. I believe that as we move towards legislation and as we work more closely with the primary care trusts in terms of improving prisoners’ health, which has substantially improved since the change in arrangements, we can make quite significant progress on this, and we must.

Q539 Charlotte Atkins: Is that because many prison officers smoke themselves and are therefore not committed to a policy of smoking cessation?

Fiona Mactaggart: It is, but the other thing about prison officers is that they are a disciplined service and if there is a policy in the prison they will follow it, and we need to ensure that they recognise that there is and then they will.

Q540 Charlotte Atkins: Where does the responsibility for cessation divide between the prison health service and the primary care trust?

Fiona Mactaggart: The provision of quitting services, like other healthcare provision, is provided within a prison increasingly by primary health care trust provided services, and so, in effect, it is offered through that mechanism; but the prison service can make demands and it can provide other back up to it in terms of some of the work that we do in prison education, and so on, and the carrots work of working with people who are drug-addicted, which is a chronic and very serious problem in prisons and very often the nicotine addiction that prisoners display is one of a series of addictions to drugs, alcohol and other things that they are trying to deal with in prison.

Q541 Charlotte Atkins: It has been said, and this is directed really towards Caroline, that the targets that primary care trusts have discourage them from involvement in prisons or, indeed, young offenders institutions. I believe that my own primary care trust has done some excellent work in Werrington Young Offenders Institution in my constituency, but what is your view about that? Do the targets discourage primary care trusts from taking on the big role of smoking cessation within prisons and young offenders’ institutions?

Caroline Flint: I am not aware of that in particular. I have three establishments in my own constituency, and as far as I am aware the PCTs in Doncaster have done some excellent work with prisons on health and smoking cessation as well. In each of the establishments in Doncaster they have developed their own policies to tackle some of these areas and some of the issues that Fiona has been raising. I am happy to go away and look at that, but I do not think there is any particular barrier to PCTs that have prison establishments in their areas not looking to provide some similar services in the same way as we work on issues around drugs as well.

Fiona Mactaggart: Could I add something to that, and then, I am afraid, Chairman, I have to leave. In our experience, giving a primary care trust targets in terms of general community smoking cessation or giving an education provider targets in terms of the general committee low-level qualifications, basic literacy qualifications—in prisons we actually get better results than elsewhere, and, therefore, having a primary care trust set of targets which they can partly deliver through delivering with prisoners actually, in prisons, if you are talking about a highly addicted adult male population, we tend to get better results than that population does in the community, and so having the targets which they can deliver through prisons is one good way of them being able to make a difference to some of the people who have the worst problems with nicotine and other addictions.

Caroline Flint: I agree with that.

Charlotte Atkins: It is probably a very good and valid reason for having very locally focused primary care trusts as well.

Q542 Dr Naysmith: I have one very quick question, if you do not mind. Does it worry you at all that law suits might be brought under the European Convention of Human Rights, either by prisoners who smoke if you do ban smoking in prisons, or by prisoners who do not smoke if you do not ban it, and have you taken any advice on this?

Fiona Mactaggart: I have not taken advice on that specific point, but in the Home Office, if we spent all our time being concerned about legal action under the European Human Rights Convention, we would not have a chance to think about other things. I think the existence of the Human Rights Convention and the fact it is part of the UK law is a very important reminder to all of us that we need to protect the rights of citizens; and, of course, as your question highlights, one of the tricks in dealing with
that is balancing competing rights; and this is a struggle which we will have to work through in our prisons, as elsewhere.

Q543 Chairman: I will just leave you with this thought. I understand what you talked about, the compounding problems inside prisons, and 80% of prisoners smoke and everything else, but also one in two people who smoke die as well prematurely, so it is an issue in any circumstances that no matter where people are smoking that is the major factor. In terms of smoking in ill-health, one in two people will die prematurely because of it.

Fiona Mactaggart: Very many prisoners die prematurely from other things as well.

Chairman: I accept that entirely. It does seem, and indeed the head of the prison service said this to us last week, the issue about potential litigation and shared cells is probably going to come to the forefront because of this current legislation that the Government is thinking about. We will leave that thought with you. Thank you very much for coming. I think, Minister, we are going to move on to the issue of what we perceive to be government policy at the moment in relation to exemptions in clubs and non-food pubs. Doug is going to ask the first question.

Q544 Mike Penning: Good morning, Caroline. Do you accept that workers in all licensed premises are at risk from second-hand smoke?

Caroline Flint: I think clearly there is a risk from second-hand smoke, that is why we have spent a lot of time over the last few years raising the importance of this issue, and research does show us that workplace deaths caused by second-hand smoke gave an estimate of something like 617 deaths a year in the United Kingdom, so we acknowledge that second-hand smoke is a contributory factor to ill-health and death. But the policy measures that we discussed in Choosing Health, which was widely debated at the time and consulted upon, which led to our proposals, were based on reducing the numbers of places in which people had to be in a smoking atmosphere, and we had to balance both, yes, the health issues, but also what the public was saying about where they felt the priorities were and still recognise that smoking of itself is not an illegal activity.

Q545 Dr Naysmith: You are accepting quite clearly that it is a hazard, so why are you only going to legislate to protect some of them and not all exposed workers?

Caroline Flint: I think there are lots of things that are hazards in life, and that is not to downplay at all the issue around smoking-related hazards. I think we had to look at a way forward which would address public health issues, would give more choice for people to work and enjoy social time in a smoke-free environment, give more choice to workers, and there will be more choice for every worker covered by our proposals, both in the hospitality sector but also with our proposals to protect in the bar area which we are consulting on further as well. So every worker in England will benefit to a certain degree from our proposals, but balanced with that was what we also had in terms of what the public thought. We have had to think very strongly about issues around enforcement, and I know there are lots of different views on that, but part of the reason why the voluntary bans and restrictions have been so successful is that they have gone with the grain of public opinion and therefore they have been pretty much self-enforcing.

Q546 Dr Naysmith: Bar staff are the ones who are most at risk, and they are the ones you are proposing to exempt?

Caroline Flint: No, we are not exempting all bar staff; we are exempting those licensed premises that do not prepare and serve food. The fact is that under our proposals 99% of workplaces would be covered—that is up, I understand, from around 51%—and, therefore, we are moving forward enormously; but even for those bar staff in the drink only establishments, there will be protection for them as well.

Q547 Dr Naysmith: But only for some of them?

Caroline Flint: No, there will be protection for those bar workers as well, because we are consulting on how we can make the area around the bar smoke-free.

Q548 Dr Naysmith: There is no way to make it smoke-free?

Caroline Flint: We are consulting on how we can reduce the impact of smoke, and I would agree with you, that there are issues around a perfect solution to this but there are ways forward in which we can reduce the impact, and that is what we are trying to do.

Q549 Dr Naysmith: All the evidence that we have heard in this Committee—and I am sure you are aware of it—says that there is not any way you can protect bar staff from the effects of second-hand smoke?

Caroline Flint: The purpose of the proposals, which was based on Choosing Health, is people wanted to have more restrictions. It is very interesting when you look at the surveys of individuals' points of view on this. 88% supported restrictions in public places, 91% of restaurants. That went down to 65% in pubs and to 31% for a complete ban in all areas. We have had to try and weigh up that strength of public feeling. Our proposals are going further than the public were suggesting through our bans on those pubs that serve food, but at the same time we are trying to create an environment where people have more choice, and I think more choice is important to this debate.

Q550 Dr Naysmith: What you are saying is: it is because of popularity that this policy is being introduced, because you think it would be unpopular?
Caroline Flint: No, I think there are a number of issues. I think when you are dealing with issues of public health where we are trying to effect change in people’s behaviour, just banning, or telling people to do things for their own good, I think we all know, does not necessarily work. We know 95% of deaths from second-hand smoke are related to second-hand smoke in the home. We know, I am afraid to say, whilst we continue to press the argument about dangers to children and other adults in the home and not smoking in the car with children in the car, we found earlier this year, for example, a third of parents still smoked in the car while their children were present. We are trying to address these issues, but, importantly, and I think it is interesting looking at what has happened in other countries.

Q551 Dr Naysmith: It is very interesting to see if you look at what is happening in other countries.

Caroline Flint: Yes, it is, because if you look across the European Union the only country so far to go for a complete ban is Ireland. Every other country—Sweden, Finland, even Norway that now has a complete ban all started off with exemptions. In Sweden, for example, they allow specific smoking rooms. Finland are planning to bring in legislation which will do the same. Norway exempted bars, as did California and New York, and only after a period of time did they move further. One of the reasons for that is they wanted to bring the public with them, and that was their choice, and we have looked at the situation and that has been our choice on this occasion.

Q552 Dr Naysmith: We have had a very interesting morning here. We have had the Chief Medical Officer of Health telling us that he is in favour of a complete ban, and even in answer to a supplementary question the officer agreed with a member of the Committee that he thought bringing in a partial ban would not necessarily make it more likely that a full ban would come following on behind; it could make it even more difficult. He also said that it is the only time he thinks in seven years, I think he said, when his advice had been completely ignored. We have heard something similar has happened in Northern Ireland, where the medical advice was that a complete ban should go ahead. How can you justify going against what is clearly the evidence of the experts?

Caroline Flint: There clearly is evidence about the health outcomes caused by second-hand smoke, and I think it would be fair to say, and I think the Chief Medical Officer would agree, that in the last eight years of this government we have done more than any other government before. I do not want to be put in too political a situation, but we have done more than any other government before to work within the Department of Health but also other departments as well to tackle issues around smoking. Whether that is in terms of advertising, whether that is in terms of providing on the NHS services for people to give up smoking; and clearly that is one of the reasons why the levels of smoking have gone down in England. They have gone down elsewhere in the United Kingdom, but they are at their lowest level ever in England and they are lower than Scotland, Wales and Northern Ireland. I think that would be acknowledged. We do listen to the advice of the chief medical officers at of other organisations as well, but we also have to make some choices about how we develop the work we are doing, and in our opinion, based on a number of different factors, we felt that it was important to move to a more completely smoke-free environment but recognising that there were very clearly strongly held views—and I think we have all become aware of very strongly held views on this issue in this House and outside of it—about how far we should go at this stage. I think that was a choice that was made based on a number of different factors, but there is no doubt that we are moving further in the direction to get public support for smoke-free public places.

Q553 Dr Naysmith: Despite the figures you quoted earlier on, there probably is support for a complete ban already.

Caroline Flint: I am afraid it would be nice to say there is, but even I think ASH, who produced a survey produced by MORI, I think, earlier this year, found that only 49% of the public were in favour of a complete ban. The ONS survey of 2004 showed it standing at 31%. I would say the previous year it was, I think, 41 points behind that; so there is a movement in terms of public opinion, but I am afraid to say, on a complete ban, when you tell the people a complete ban in all settings, in social settings, pubs, there is not the majority. What you see is it goes extremely higher when we talk about restrictions, which is why 88% support restrictions in public places, 91% in restaurants, and I have to say, even though it is a majority, it goes down to 65% in pubs for restrictions. We are going further in that respect than public opinion, because we recognise public opinion is moving.

Q554 Dr Naysmith: The movement is probably the most important aspect as well, as we discussed earlier on. It does seem, despite your protestations, that popularity is a very important influence in deciding what you can do, whether you think the population will support it or not.

Caroline Flint: I do not think it is about a popularity contest; I think it is about recognising that we are talking something that even of itself is not illegal. Therefore, one of the issues here, one of the issues, I should say, which we have to bear in mind is how we take the public with us in terms of self-enforcement. As I said earlier, I think one of the reasons why in all our lifetimes the voluntary bans have been successful—on the tube, on the bus, in the cinema and so forth—is because there has been a sense that that was the right thing to do. It has meant that there has been limited disorder as a result of that, and part of what we are trying to do here is to have a light touch in terms of enforcement, and I think part of you achieving that is going with some of the grain on challenging, which I think we are challenging, but at the same time recognising that difference. I would
say that I have looked at the consultations in Scotland and Northern Ireland, and, like our own formal consultation this summer, clearly the overwhelming responses to that were in favour of our proposals but would have liked to go further. Interestingly, I have not seen public opinion polls of individual attitudes in Northern Ireland and Scotland; so I cannot comment on that and whether that reflects the same public opinion polls we have done in England.

Q555 Dr Naysmith: You quoted ASH a minute or two ago, and we heard evidence this morning that support in England is now higher than it was in Ireland prior to the introduction of a ban in Ireland. When they introduced it in Ireland, a smaller section of the population were in favour of it than now in England?

Caroline Flint: As I said, the poll that I am aware of in terms of ASH was 49% in favour of a full ban.

Q556 Chairman: Minister, could I just ask you. Is it the Government’s contention that unless it is popular in terms of the public and opinion polls then this would be a hindrance to actual enforcement?

Caroline Flint: No, it is about, I think, weighing up a number of considerations around enforcement and the will of the people to self-enforce in these areas. I think that applies to a lot of issues that we deal with in public life where we actually rely—if you think about things like dropping litter, if you think about a whole host of areas—we rely on public speeding in cars, we rely on the public to support the legislation, support the laws and self-enforce it and then we have safeguards to fall back on. Quite rightly, in those different areas where that is not the case, which is why within our proposals we are making it an offence in certain areas for people to smoke in places that are smoke-free and for businesses not to take action or be seen to encourage smoking when they should not be.

Q557 Chairman: Do you think there is a role for leadership in terms of issues around smoking and health as opposed to waiting for the 51% to tick over?

Caroline Flint: I think there absolutely is a role for leadership, which is why I am very proud that over the last eight years we have both accepted, I think in a way that was not accepted before, the issues around smoking and the dangers, which is why, as I said earlier, both in tobacco control, in terms of the warnings we have on cigarette packets, we will shortly be consulting on a picture warning to see if that will be more effective, or as effective; it is why we have invested a huge amount of money in smoking cessation, and I should say, particularly in our spearhead areas—and I know you are probably going to talk to me about that later—which are the most deprived communities in this country, we have been very much prioritising smoking cessation availability. Of course, I would like to say this as well in terms of other workplaces, because I know people are concerned about the bars, but in terms of the other workplaces, whilst we have seen an increase in either smoking restrictions or smoke-free workplaces, that is still higher amongst those workplaces where it is white-collar workers. Therefore our proposals, willing of themselves, support all those workers in those places that currently are not covered but according to the figures will be particularly important for those who are in the lower paid jobs and more manual working environments.

Q558 Mr Burstow: On that point I wanted to start really. You made reference earlier on to the 99% coverage that you believe the policy will achieve in the workforce. Is it not really the case that that 99% at the moment is just a rhetorical device in terms of presenting the policy and that there is not actually any evidence, and there could not be until the policy is implemented, to actually show that 99% of the workforce is covered? Indeed, when we had the Chief Medical Officer here before us earlier today, he said there is no evidence and, indeed, no figures that support the assertion that 99% of the workforce will be covered. Where is the evidence? What is the evidence that supports that position?

Caroline Flint: That information has been provided by officials at the Department of Health who also advise the Chief Medical Officer. Nick might want to add something to that, but it is based on an uplift from 51% to 99%.

Mr Adkin: I think I explained when I first came to the committee two weeks ago, three weeks ago: if you ask people now, “Is your workplace completely smoke-free?” 51% of people say it is completely smoke-free. On the basis of this policy, looking at where people work, which sectors they work in, the figure will rise to over 99% of people. Based on if you look at the proportion of people who will be working in those exempted sectors, it will be 99%. That is where we came up with the calculation. We are assuming complete enforcement for that assumption.

Q559 Mr Burstow: So it is 100% enforcement of those workplaces where the ban will apply in full. Rather than pursuing this now, I think it would be useful to have those statistics set out in a note, if it is possible?

Caroline Flint: I am happy to provide that to the Committee.

Q560 Mr Burstow: I think otherwise we just end up disputing a number and not making a great deal of progress. I wanted to come on to the issue of the consultation that was held over the summer, because in the documentation you have kindly provided us, in respect of question five in that consultation, which was this issue of the distinction between pubs serving food and those not serving food, you had 41,833 responses, and the majority of those responses to that question—it says in here over 90%—are against an exemption of pubs not serving food. It goes on to say that is because the primary issue here is health and safety at work for the workforce. What I guess I want to get a clear idea of is, given that the Chief Medical Officer in his annual report last year placed
a lot of hope and faith in your consultation exercise providing a basis upon which the policy could be strengthened—and the decision the Cabinet have made is that it is not going to be strengthened, it is not going to change from the manifesto position—what was the point of the consultation?

Caroline Flint: A number of aspects. First of all, the consultation was actually consulting on the details of the proposals in Choosing Health which were then formally part of, if you like, our manifesto in the general election of this year, which was pretty clear about the way forward in terms of policy in this area. The consultation was primarily about: “These are the proposals. We have had the consultation in Choosing Health. Here are the nuts and bolts. What are your thoughts?” That was the main point of the consultation, which is why we had all the questions about food, about exemptions and so forth. I would say actually some things have changed in terms of where we were before. First of all, we brought forward by 18 months to the summer 2007 the enforcement for licensed premises. We have said that we will monitor from day one and review after three years, and in that sense the policy, I think, has been improved and firmed up. Of course, we are also looking at the number of specific issues people have raised in relation to specific questions, and we are still consulting on the issue of the area around bar in terms of how far practically we can reduce the smoke in that environment.

Q561 Mr Burstow: But, if this about having a very clear and explicit policy in the manifesto which the Government has now taken through to legislation, why on earth ask the questions that would pose a potential challenge to that policy? If you have a policy and you are going to implement it regardless of what the public think, why ask the public for their view in the first place?

Caroline Flint: Because we were asking the public their view on specific questions, but, as you can see from the consultation, and I have no problem with that, many of the people who responded wanted to say, “Yes, we know this is your policy. These are our views on this.” And I would hasten to say that whilst I appreciate a number of those who responded want a total ban, there was also an acknowledgement by those people that they felt that the policies that we had were a step forward, and therefore the consultation has had some results and some of those results have ended up, I think, strengthening the policy we had before the consultation.

Q562 Charlotte Atkins: When the Secretary of State came in front of us she made it very clear that she thought it was only a matter of time before we had a complete ban. Given what is happening in Scotland, Northern Ireland, possibly Wales as well, is it not right that we should have introduced the complete ban now? Would it not be wrong to say to pubs, “No, not a partial ban, introduce expensive ventilation”, even though ventilation, in our view, would not take away the health risks? You were talking about the smoke-free area around the bar. To introduce expensive measures, when in fact in three years time, when the monitoring has been done, we go for a complete ban, is that not unfair to everyone concerned?

Caroline Flint: In answer to the first part of your question, I do not think it necessarily follows that because Scotland or Northern Ireland go one way, England should follow, and I think that works the other way round: if England goes one way, Scotland or Northern Ireland should follow. There are some very interesting issues in terms of approaches in attitude to health that are different between ourselves and Scotland, for example. We could have many debates about that and also the way health is carried out in Wales. I do not think it necessarily does follow. On the second point around the issue of is it worth pubs investing, there is the same choice for pubs that was before, to be honest. There are some chains, I understand, that are intending to go smoke-free, and they were intending to do that regardless of whatever policy the government of the day was going to introduce. Really there is a choice here for some of those pubs that are going to be exempted under our proposals as to what they want to do and they have to make some decisions based on where they see change happening, just as in the same way this morning I have been at the Bakers’ Conference talking about issues around food and manufacturers and retailers in that area. They have to make some choices about the way things are changing and that is for them to decide. Having said that, we are concerned to find a way forward about how best we can reduce smoke in the bar area, and that is something we are still considering and taking soundings on.

Q563 Charlotte Atkins: Certainly pub chains like Wetherspoon’s are going down the route of a complete smoking ban recognising that they may take a hit in terms of sales to start off with. What I am concerned about is the health inequalities issue. There will be pubs in places like near my constituency, Stoke-on-Trent, that effectively will be smoky drinking dens, whereas maybe in my part of North Staffordshire we will have pubs that are smoke-free serving food. The problems are—I think the Secretary of State recognised this in her evidence—and I know you have read the evidence—that this would widen health inequalities because smokers will tend to go to the drinking pubs and they would not be able to eat food at those pubs and, in fact, that would contribute towards the binge drinking culture that we are trying to eradicate.

Caroline Flint: There is no point in saying that there is not a difference because there is obviously a difference because there is an exemption. What I would say is that even for those customers in a drink only establishment, they will see a difference because there will be regulations that tackle the issue around the bar area and, therefore, for those people who are currently smoking in those establishments where there may just be, if anything, the metre rule around the bar, which some of the associations have encouraged, they will see a difference. The other aspect to it is this: in terms of health inequalities, I think a major reason why we have some issues not
only in this area but in other areas to face in terms of health inequalities is to do with poverty and affluence. In those areas it is very important to see that the work we do in terms of education, regenerating communities, is also one of the ways in which people start thinking about their futures and aspirations and lifestyles. We know that because we can see very clearly that those who are better off are taking on information quicker in relation to healthy living and acting upon it more than those who are less well off and so forth. Alongside that, I should say, are our spearhead areas which cover 88 PCTs and some 70 or so local authorities. Issues around smoking have been made a priority, along with some other important health issues, in order to look at a different way of providing services that meet the needs of the most disadvantaged in our communities. One thing is for sure, we have found that certainly preaching and just sending information is not of itself enough for people to say, “I am going to give up”. Linked to that, of course, is the fact, as I said before, in terms of workplace coverage, in a greater way my understanding is, looking at those figures, those workplaces that have higher numbers of lower income manual workers in them are going to have a greater effect and impact from this legislation than those in the more white collar well-paid working environments. It is not just about where people drink, it is about where people work as well. If you think of all the people we have working in our health service and public service institutions from within our own communities, that is a substantial number of people who are going to find that their working lives are going to change very dramatically.

Q564 Charlotte Atkins: Can I just take you up on this issue about no smoking within a metre of the bar. Dr Adshead, when she gave evidence to us a couple of weeks ago, said: “The recommendation that there should be a prohibition upon smoking within a metre of the bar is not based on evidence of protecting health”, the health of the workers, “it is essentially trying to reduce the amount of noxious exposure, the irritant effect of smoke within that distance. It is not a recommendation that was put forward on health evidence grounds”. Given that we are primarily trying to protect workers here, how can that recommendation be a sound approach when it is really health we are talking about here and not just about irritation? We know, for instance, that ventilation does not remove the cancer producing you are not arguing, are you, that bar workers, the noxious fumes and their irritant effects of the second-hand smoke that workers are exposed to. Caroline Flint: I agree with Dr Adshead on that. We are not claiming in that respect that is going to eradicate the issues around second-hand smoke. We were looking at issues around reducing, as I think she described it, the noxious fumes and the irritant factor. Having said that, we are further consulting on what other possibilities there might be other than just what is talked about as the metre rule around the bar, which was one of the questions we had in our consultation over the summer, because there are some feelings that perhaps we could improve upon that. We are talking about issues around designated areas or a separate area as well.

Q565 Dr Naysmith: Can you tell us who you are consulting with? Caroline Flint: We have gone back and consulted with industry and others on this issue and their thoughts. I have to say one of the difficulties in all of this is lots of people have different points of view about what should happen, so I am afraid even within industry there is not one solution to this particular issue. Some aspects of industry would rather like us not to do anything at all. We are trying to work our way through this to think about what might be the better way forward; not necessarily the perfect way forward but the better way forward.

Q566 Charlotte Atkins: But, in contrast, we had evidence when we visited Dublin of the real health improvements of bar workers since the complete ban was introduced. Surely that must be the way forward if you are looking at not only the health effects for workers within bars but also the overall health effects for the population at large? Caroline Flint: As I said, we are working to improve the choice of people to both socialise and work in a smoke-free environment. Whilst I accept, because it is there obviously, that there is a small section—a very small section—where smoking will be allowed, and that does have implications for bar staff, for the first time we will be offering to all those people who work in the hospitality industry in one shape or another a far greater choice than they have ever had before about where they should go. That is something that without these proposals would not be available. As I said, the purpose of our legislation is primarily to widen the choice and opportunities for people to work and socialise in a smoke-free environment. To that end, linked to the other issues I have raised about what we took into account, we are making serious progress here. Ireland has made its own decision and that is their choice: as is the case in Scotland and other countries as well. I would say that in terms of the work we have done in this country, in England, on smoking cessation in other areas, we are held up by the World Health Organisation as one of the countries to watch and take advice from.

Q567 Charlotte Atkins: Certainly I accept that but you are not arguing, are you, that bar workers, hospitality workers, make a choice about whether they put their health at risk by working in particular environments? Caroline Flint: I am saying that there is greater choice than there was before. Without our proposals it would be just voluntary still. It does mean that there is greater choice. I accept there are individual choices to be made, but there are greater choices than there would be without this legislation for people both choosing to use pubs and for those working in them. That is something that is achieved as a result of these proposals.
Q568 Charlotte Atkins: But the choice effectively will not be a choice made by the workers, it will be a choice made by the owner of the pub, the pub chain. It is not easy for people to be able to make that choice to go and work in a different establishment, especially if you are a relatively poorly paid worker who perhaps has caring responsibilities at home and cannot readily move from one town to another town.

Caroline Flint: I accept the point that people face different difficulties in terms of their choice of work based on all sorts of factors. I am just saying that through these proposals will be the potential of more choice than ever before for those people working in the hospitality industry. That goes across the piece from, if you like, bars to coffee shops, to restaurants, to hotels, to other leisure environments, where a lot of the same sort of workers we are talking about do work.

Q569 Mr Burstow: To finish this thread off, if I may. We had some figures presented to us earlier on from the Local Government Association on work they have done around the country which showed that in Easington 81% of pubs in the most deprived areas of that council area do not sell food in their pubs. This notion of choice about whether to choose to work in an unhealthy or a healthy environment in a community where the predominant way in which the licensed trade is operating suggests that there really will not be any choice for workers in that sort of area. Is this a policy which says to someone who wants to work in a smoke-free environment they have to get on their bike and find a pub somewhere far, far away from where they live in order to avoid the harmful effects of second-hand smoke?

Caroline Flint: No. As I said before, I am saying that without our proposals there would not be any choice whatsoever because you would have smoking or not down to the publican or the licensee. We are bringing forward legislation that will dramatically change the landscape in which people work and play. Yes, I appreciate the work the Local Government Association and others have done in looking into their own areas. I know a lot of local authorities are engaged with PCTs on strategies that they can carry out to look at their premises, I have to say, as well as others in terms of encouraging a more smoke-free environment. We have done our own work in relation to this and, certainly, in terms of some of the information we have got back we reckon there is a range of between 10% cent up to 30% which will be affected. I appreciate that might be more in some areas but I would also say in terms of places like Easington and elsewhere, if I think of some of the unlicensed places in Doncaster, for example, where people work, local cafes and what have you, they will be smoke-free. Therefore, there are other sectors of the local economy too which are going to be affected by our proposals and make them smoke-free where clearly there are a number of people whose lives will be changed.

Q570 Mr Burstow: If you are bar worker in one of the premises that continues to have smoking because of the exemptions you are not really going to be in a position to benefit from the protection that you are extending and surely, as a result of that, those bar workers will be entitled to avail themselves of the legal protections under the Health and Safety at Work Act, because you have acknowledged that the health consequences of second-hand smoke are clear, proven and harmful.

Caroline Flint: This is not legislation under employment law or health and safety legislation. In fact, I understand the last time this was looked at the proposal was a code of practice, which was clearly just a code of practice, some years ago, that did not move forward and, therefore, in fact, we are moving a way forward from where we were talking about codes a few years ago. In terms of those employees, what I can say is they will still be better off from our proposals. Without going into the discussion again around the bar area, we will be looking to reduce the smoke in that area and we are consulting on that. The Secretary of State has made clear that we will be monitoring from day one and, therefore, will be working with our spearhead communities and others to look at how these proposals work in practice but also how they sit alongside the other activities we are doing within communities to improve health outcomes particularly as a result of health inequalities.

Q571 Mr Burstow: Can I just come on to something else which is about the evidence base that underpins a lot of where we are now. At an evidence session we had last year as a Committee with the former Secretary of State, John Reid, he talked to us about the effects of a comprehensive ban driving more people to go back home and smoke rather than smoke in places that formerly would have allowed smoking. Is that still something the Department supports as a view? Is that still something which the Department thinks will be a likely outcome if there was a comprehensive ban?

Caroline Flint: I read that evidence to have a look at exactly what the former Secretary of State for Health said. From my reading of it, and you have probably got it in front of you, he was referring to off-sales. There is no doubt about it, in terms of a general pattern of drinking behaviour, off-sales have gone up in terms of people’s purchase of alcohol, probably due to the fact of retail outlets and what have you. Not only in Ireland, but in England and elsewhere, the drinking patterns have changed in terms of people buying drink, taking it and drinking at home. You can probably correlate that to when cinema attendance went down because people were watching videos at home. My interpretation of what John Reid said was that he was referring to issues around off-sales. On the second point in terms of is there a displacement, in terms of the evidence we have got, in particular there have been two reports in the last six months, one was the Royal College of Physicians’ report in July of this year and there was a second report, which Nick can remind me of, which had done some work looking at this issue.
about whether there was displacement to the home, which did not show that there was evidence that smoking restrictions did displace into the home. Having said that, we do know that smoking in the home is still a big issue, which is one of the reasons why we ran our campaign in relation to the children inhaling smoke, but also our recent campaign talking about other adults in the family. There are still some serious issues there. The other point to bear in mind, and the RCOP report—I read their evidence as well—was a self-reported report and, I do not know, sometimes people are not always willing to admit what they do when they are being challenged about it, particularly smoking in front of their own children. I think it was a self-reported analysis. I do not dispute it though and I am happy to say, as far as I am aware, there is no current evidence that would suggest there is a move to more smoking in the home as a result of restrictions or bans.

Q572 Mr Burstow: We have certainly seen some evidence from our trip to the Republic which showed very clearly that there was, if anything, a beneficial effect of a comprehensive ban in terms of smoking at home.

Caroline Flint: I should say that there was a slight increase in Ireland last year, as I understand it—I do not know whether it is statistically significant—in terms of smoking prevalence. It went down and there has been a slight increase up.

Q573 Mr Burstow: Our understanding from the research and the evidence so far has been that the prevalence rates in the Republic went down. It went down by 6%, it was quite significant.

Caroline Flint: You are right, the overall prevalence of cigarette smoking in Ireland is 23.6% as at August of this year. That represents a decline of 1.52 percentage points since August 2003, however the most recent figures show a small rise and I am happy to provide the Committee with the evidence.

Q574 Mr Burstow: They must be hot off the press because we were there only about two weeks ago. I just want to make certain we are absolutely clear about what John Reid did and did not say to us. I am interested in the construction you have put on what the former Secretary of State had to say. He also went on to assert that 15% of people in Ireland now did carry out, took stuff home. Is that figure a figure that you still stand by?

Caroline Flint: I have got proportion of beer sales consumed at home. These are based on some figures this summer at the Luxembourg Smoke-Free Europe Conference based on Brewers of Europe data, I understand, so I cannot speak for the wine drinkers here. In terms of Ireland, in 2003 it was 23% of beer sales consumed at home. I do not have any data for post the March 2004 ban in Ireland. It is not just Ireland, but in the UK it is 39% of beer sales that are consumed at home. There has been a steady increase over the years and I think that is about patterns of drinking and socialising that have changed with videos and all that sort of change.

Q575 Mr Burstow: You have not got a figure for the actual change since that ban came in?

Caroline Flint: I do not have data for post-March 2004. To be fair, it has been an issue that has been raised with me amongst people who have been concerned about the bans. It is a legitimate question to ask, whether or not it would have an impact on the home. It does remind us how important it is that whatever proposals we have for public places, there is still a great deal of work to be done in terms of reaching those families for whom smoking is something that they do at home. We know, for example, amongst some of our younger women that they feel smoking may lead to a low weight baby and, therefore, reduce the pain in childbirth. That is something that has been put to me. That is a really important issue we have to address. As I say, in and of itself a ban would not change that young woman’s view on that matter, we have got to find another approach.

Q576 Mr Burstow: That is a very important point. Does it really help, therefore, to get that message across in a very clear way that is readily understood by everyone to have a policy which says one cannot smoke in these environments but it is okay in certain other environments within a pub to smoke? Does that really send a clear, consistent message that people can then act upon? Certainly in our experience in Dublin, the message that was given to us time and time again was that as a result of the comprehensive ban it was changing habits and behaviour in the home as well in a beneficial way.

Q577 Mr Burstow: But we are interested in this policy now and how this moves things forward.

Caroline Flint: This policy now will move things forward by, we believe, reducing prevalence by another 1.7%, I think that is correct. Therefore, there is no doubt that this policy will continue to contribute to the reduction in people who smoke.

Q578 Mr Burstow: What would the prevalence reduction be if it was a comprehensive ban?

Mr Adkin: A comprehensive ban would reduce smoking rates by 1.7 percentage points. Our policy will reduce smoking rates by up to 1.7 percentage points. We are not absolutely clear, because of the policy, how much of that overall reduction—

Q579 Mr Burstow: Are you saying your policy will have exactly the same effect potentially as a comprehensive ban?

Mr Adkin: We think a comprehensive ban is 1.7 percentage points. We think this policy is up to 1.7 percentage points. It is a range.

Q580 Mr Burstow: You are saying it could be as good as if we had a comprehensive ban?
Mr Adkin: It could be as good.

Caroline Flint: Can I just add to that. The reason for that is anybody who is involved in trying to encourage people to give up smoking knows that one part of it is issues around restrictions but another part of it is what services we provide for people to give up, other things we are doing through education in our schools and other factors, as I said through antenatal clinics and so forth, to combine together to provide that package. It has to be acknowledged that we have made huge inroads in this area over the last eight years and I feel, importantly, that is one of the reasons why we have the lowest level of smoking across the United Kingdom.

Mr Burstow: Can we have a note on those figures?

Chairman: I do not think we are disputing that. I have to say one thing. Minister. We had the Minister for the Northern Ireland Office sitting in that chair not a short while ago who told us the reason he stopped smoking was because he had been out to America and he could not smoke except when he stood on the pavement, and it was the incentive that he wanted to get off his particular habit. Could I just finish on this issue of Dr John Reid because I am not exactly sure where this came from. The only thing I have to say about it is that the Deputy CMO was asked about this at an earlier session, that we were told by at least three witnesses when we went to Dublin and took formal evidence that they disputed what Dr John Reid had said about the increase in smoking in homes in Ireland, they said it just was not true. In fact, they used language firmer than I have just used. I thought maybe I ought to get that on the record. We will try and tease that out at some stage. I think we are moving on to David now.

Q581 Mr Amess: As you might have gathered, we had this remarkable evidence session with the Chief Medical Officer this morning. He might have been slightly reticent in answering one of my questions but he certainly was not reticent in telling the Committee that he took this issue so seriously he had actually considered resignation, and that was a big surprise to all of us. I understand entirely the points that you have made about taking public opinion with you, but to many of us it seems as far as the Government is concerned the issue of clubs and how you treat clubs is at the heart of all this. Could you tell the Committee how many clubs are there where smoking will be permitted? From a personal point of view, will that include Conservative Clubs?

Caroline Flint: I will try to get you the exact figures on the clubs, if that is helpful. I think in terms of the licensed area, what percentage of the licensed trade is it, Nick?

Mr Adkin: About 20,000 membership clubs but we do not know within them what their current policies are.

Caroline Flint: Of course, there are lots of very different clubs. There are the Working Men’s Clubs, Conservative Clubs, Labour Clubs, rugby clubs, cricket clubs. The issue that defines them all is do they qualify under very particular legislation that is applied to membership clubs. That is very important because over the summer people have said to me, “Does this mean anybody can set themselves up as a club?” one night’s membership and all of that. As far as I am concerned, that certainly is not the case. We are talking about situations where there are clubs that are in line with the legislation, they have a constitution, it is run by the members. For example, if you take a lot of licensed Conservative Clubs, Labour Clubs, Working Men’s Clubs and so forth, they have to have a committee elected that oversees the licensing aspects of the establishment, including the purchasing of the beer and what have you. In relation to the accusation that lots of pubs will follow this route. I cannot see many licensees in the commercial trade deciding that they will let their clientele take over what would effectively be the management of their establishment. That was one of the reasons why it was felt that because these are clubs that are run by individual members rather than, if you like, a commercial establishment that is much more open access, there should be the provision for them to make the choice themselves. Part of what we are addressing is how do we make sure that in a democratic way the individual members of those establishments do have a say on whether they should be smoke-free or not. I would just like to add, the issue around the area around the bar is something that would apply to those establishments too.

Q582 Mr Amess: If you were able to provide us with the figures before we can complete the report we would be grateful.

Caroline Flint: I will try to do that.

Q583 Mr Amess: Would you also be able to tell us if any of those clubs would be exempt from the ban if they were serving food?

Caroline Flint: No, not if they fall within the definition of the legislation in terms of a licensed membership club. I think that is right.

Mr Adkin: Membership clubs have a general exclusion but it is the bar area which will apply.

Q584 Chairman: Would you ban a staged area if there was a turn on in a Working Men’s Club?

Caroline Flint: That has not been part of our consideration, it has been the bar area, although I know people have voiced their views around issues around musicians in clubs.

Q585 Mr Amess: There has been a point about unfair competition made by the hospitality industry in that it will put pubs that serve food at a significant disadvantage with this exemption. Do you share these views that the exemption could drive many small pubs out of business? We had some interesting evidence in Ireland on that point.

Caroline Flint: Are you talking about in relation to small pubs that serve food?

Q586 Mr Amess: The hospitality industry believes that exempting membership clubs will produce unfair competition.
Caroline Flint: That has been raised but, to be honest, membership clubs already have provisions that apply to them that do not apply to the commercial sector in different ways and I think there has always been that tension in relation to these types of clubs. The other aspect of this is people join membership clubs for certain reasons: they want to be associated with the Conservative Party or the Labour Party or a trade union, or they pay for the rugby club or the cricket club or so forth. There is often a whole host of issues that attracts customers to that establishment in the same way there is a whole host of issues that attracts people to go to Walkabout or another establishment in terms of the commercial sector. I do not think it is that clear—which some people have expressed a fear about—that there would be a mass exodus down to the Conservative Club—I hope not—

Q587 Mr Amess: I hope there will be.
Caroline Flint:—or what have you because there are a number of issues to do with social groups, the aims of the club, what it is there for, and historical issues as much as anything else. As I have said, we are going to be monitoring all aspects of this as and when the legislation comes into being.
Mr Amess: I think time is moving rapidly and we are going to deal with compliance next.

Q588 Chairman: Can I ask you one more question in that area, Minister, and then David can come back in. We had evidence last week from the British Hospitality Association describing a pub that serves lunch and then stops serving at three afternoon and is a drink only pub for a number of hours and then may serve what he described as a “heavy dinner”, and I am not sure that is nutritionally or calorifically balanced, and then by ten at night it becomes drink only because all the meals go off. Presumably the regulations, when we see them, will tell us that would not be a smoking pub, or would it be a smoking pub on some occasions?
Caroline Flint: Our view and direction is that anywhere that serves food at any point in the day—we are discussing issues around definitions and what have you—if they serve food at lunchtime and not in the evening would still be in the total smoke ban.

Q589 Chairman: Throughout the day?
Caroline Flint: Yes.

Q590 Charlotte Atkins: You indicated that membership clubs serving food would be subject to the ban.
Caroline Flint: No, I did not say that. What I said was membership clubs will be subject to our discussion on the area around the bar.

Q591 Charlotte Atkins: Thank you for that clarification.
Caroline Flint: To reduce the smoke in that area.

Q592 Mr Amess: We are now moving on to compliance which is also at the heart of this. I very much agreed with your point of you taking the general public with you because you have only got to look at people driving along in their motorcars on their mobile phones, which just is not working unfortunately. In Ireland we were told the key to compliance is clarity. What does the Government believe the key factor to be?
Caroline Flint: I think clarity is important but also it is about what public opinion feel. In Sweden, for example, they have had their smoking ban in place since 1 June this year, they allow specified smoking rooms, and there have been six breaches of the law so far, although that has obviously been for the summer period and they will be looking at what happens in winter. Obviously we have to look at how we can make sure it is clear and we are going to be talking about how people know when they are going into an establishment whether it is a smoke-free establishment or not. I do think part and parcel of all of this is about people being supportive. I do believe that our proposals will contribute to even greater support, which I think is a good thing.

Q593 Mr Amess: I certainly hope you are right. We have had a lot of evidence telling us that a complete ban would be much easier to enforce than a partial one. Do you accept that evidence?
Caroline Flint: I think there are a lot of areas of legislation which are attractive if you could just have a broad brush approach. We have been upfront about that. In our draft Regulatory Impact Assessment we did demonstrate, in terms of the costs, that the costs would be less if there was a complete ban. There are a number of different factors we take into account when we are making any legislation and what we feel is right. I suppose, yes, in some ways it would be simpler but that does not necessarily mean at this time it is the best way forward.

Q594 Mr Amess: Finally, can you tell us something about what the levels of penalties will be?
Caroline Flint: Yes, in terms of the penalties we are looking at £50 in terms of an individual and I think it is £200 in terms of a business. Obviously we have taken advice from the Home Office on some of those issues and we have tried to look at what are some of the equivalent fines in those areas. I know that is considerably lower than in Ireland but, again, we are not in this sense trying to criminalise people, we are trying to get their support and, in effect, to change their behaviour.

Q595 Dr Stoate: I think the Government does deserve a great degree of praise for what you have done and what has been achieved so far. I think it is very good news that we are going down the road towards a pretty wide-ranging ban. I have to say, however, again, I am not totally happy and personally I would prefer a total ban for all the reasons that have been said: it is more logical; it is easier to enforce; the public would understand the policy very well, although I understand, also, the public would not necessarily be entirely in favour of that. My big issue is around public health. One of the biggest issues of public health is health inequalities.
and one of the biggest issues of health inequalities, of course, is the difference between smokers and non-smokers in terms of public health. Given that a quarter of smokers never collect their pensions because they are dead before they get there it is a really major public health issue. We have talked about the effect on staff, workers and the protection of those people. I am very concerned about the protection of the customers themselves. In Spain, for example, it has always been felt, in fact it was until recently a legal requirement to serve food with alcohol, you could not be offered alcohol in a bar in Spain without food being provided for free as part of your drink. The Spanish people understood that food reduces the harmful effects of alcohol very effectively. What I am concerned about is that if we effectively reduce the numbers of pubs that serve food, because some of them will stop serving food in order to do this, it will make it more likely for people to drink more on an empty stomach and less likely to eat food, in fact damage their own health even more than they do already with the smoking.

Caroline Flint: Yes. I know there are considerable concerns about this and we are going to monitor what the differentials will mean. In pubs that do not serve food—and when I talk about food I am talking in terms of what I consider a meal like food—there will still be the provision for crisps and snacks and we are working our way through that. The other issue there is about how pubs work in terms of responsible drinking too, to be honest. Today, of all days, that is something I think everyone is thinking about in terms of what pubs do in terms of how they sell drink, how people buy drink and, to be honest, how people go out and choose to go out and get drunk. I am afraid, even at the moment with the food establishments that there are, there are some people who will go out with in their head to get drunk even if food is offered on a plate. I do not think necessarily there is a direct correlation there but that is something we will be looking at. Also, for other reasons, there are a lot of establishments, from the big chains to smaller pubs, that will still see food as an important part of what they are and who they are as a family pub. We know there has been a significant trend and change in the pub sector through trying to be more family-orientated and I think you cannot be a family-orientated pub without having food there, to be honest. I think we have to watch that. As I said before, on the health inequalities issue, you will know as well as I do that there are a whole basket of issues in relation to health inequalities. I think issues around poverty, not just in terms of what people have coming in, in terms of money, poverty of their environment, poverty of what they want out of life, is a contributing factor to how people see themselves and their health. One of the reasons why we have to address these different issues is to tackle not only smoking but alcohol and issues around obesity too. That is why our direction and drive—and this is very much part and parcel of choosing health—is to focus not on a one-size-fits-all public health policy but one that really gets into what is happening within families and communities to increase the take-up of the health opportunities which I am afraid more affluent sections of the population are clearly taking up and literally running with.

Q596 Dr Stoate: I entirely agree with that but part of the Government’s responsibility to public health is, of course, to legislate to improve the public health. We heard from the Northern Ireland Minister, Shaun Woodward, that he felt that in Ireland it was very clear that the overall ban on smoking would be a very significant improvement to public health. People would see that you just simply could not go out and smoke, therefore you were less likely to smoke when you were out, therefore smoking became a more difficult thing to do. In his case, in fact, it led him to give up smoking altogether because he found it so difficult to smoke in places like New York, he simply felt it was not worth smoking at all. If we are going to send a public health message out there it needs to be one that is completely impossible to misinterpret. We need to make it absolutely clear you do not smoke in public places or in work places, full stop.

Caroline Flint: I think we are sending out a very strong public message. We are saying to all those people who are currently in workplaces where they have a smoking room or where they just allow smoking, it is not going to happen any more. We are sending a very strong message out about what should be happening in our leisure establishments. We all know that there are leisure establishments, some in the public sector and some in the private sector, that allow smoking on their premises. We are sending out a very, very strong message and I do not think anyone should be in any doubt about that. What we are talking about is a very small area where we feel that is an area which we need to monitor and develop in the future but we are not there yet. All I would say to you is—and I am not saying this is about a popularity contest—I have seen the Northern Ireland evidence, and they had a consultation and, just like our formal consultation, overwhelmingly numbers of people were in favour of a full ban but I have not seen some of the surveys that we have done in relation to public opinion on exactly where restrictions and bans should take place. We have had to look at a whole number of issues in terms of forming our opinion. As I have said before, we are not alone in this, many countries in the world that have already gone as far as we are intending to go went through that same process, including the Californias and the New Yorks which are held up as such shining examples.

Q597 Dr Stoate: One of the biggest issues we have got about smoking now is smoking by young people, and it is teenagers who are the only group in this country where numbers are increasing, particularly teenage girls, even more so than teenage boys. They are the very groups of people who are likely to be going out to pubs and clubs over the next few years, so surely that is the very group we should be targeting. This must send out a message which is not going to encourage them to give up smoking?
Caroline Flint: A lot of the pubs and clubs they go to serve food and, therefore, they are going to be affected by that. Alongside that is the work we do in finding better messages to reach young people. All of us know that sometimes when you talk to young people, particularly teenagers and those in their early 20s, unless they have had an experience in their family, messages about “You will die from this” often do not have as much weight, for example, as “It is not very attractive”. That is one of the reasons why earlier this year we had our smoking campaign aimed at those under 24 which was the one of the guy in the pub seeing an attractive woman but then being put off because basically she smelt of cigarettes. We found through our work with young people some of those messages were very important to them as they are developing their relationships in their teens and early 20s and it was the hook to get them thinking about what smoking is doing to them. Again, I think we have to do more and that is why the blueprint programme that we sponsor with the Home Office and the DfES was trialling out in some schools over the last couple of years a new approach to substance misuse which includes not only illegal drugs but also tackles issues around alcohol, prescription drugs in the home, glue, butane and, of course, cigarettes as well to see if we can have a better approach to these issues with a younger age group. Of course some of our colleagues are also lobbying us on other issues in relation to young people and smoking too.

Q598 Dr Naysmith: Minister, one of the things which has been obvious throughout this inquiry that we have been carrying out is the need for clarity in this legislation, and also some of the difficulties of enforcing it given the way it is set out now. We are talking about things like food versus non-food, pubs that might do something different at lunchtime from the evening, the membership of clubs and all the difficulties that might throw up. One of the reasons for it clearly is the exemptions are being made by by just one of the Section 24 about non-food / food split, although Giles Thorley, the Chief Executive of Punch Taverns, has said: “Although we acknowledge the processed non-food/food split will present some landlords with difficult decisions, nevertheless we feel the distinction is relatively straightforward and workable as well as preserving some degree of choice”. We also know, as I said earlier, that we are consulting on the issue around the area around the bar and I am sure in the Second Reading debate and in Committee there will be plenty of opportunity for parliamentary colleagues to raise these issues and press me and raise a number of different concerns, as we normally do, in Committee processes.

Caroline Flint: We are working in terms of developing the regulations. I think the important aspect of this is all the major regulations will be subject to affirmative resolution. Some people might say “You cannot amend affirmative resolutions” but I think it is important that is a process that is there, to have a debate at each stage as these regulations come forward.

Q599 Dr Naysmith: It could mean the regulations are not amendable by Parliament at all if we do not get them early enough.

Caroline Flint: Again, that puts a responsibility on myself and the Department to make sure that in developing the regulations we do take on board all these issues so that we can present regulations that do have the support of Parliament. I think that is an important part of the process. Obviously we are hoping, as we proceed, to be able to publish regulations so that parliamentarians in both Houses have an opportunity to see the direction we feel we are going in and how we are trying to address. I acknowledge, some of these issues around definition so we can get as much clarity as is possible.

Q600 Dr Naysmith: In a sense we are having a debate next Tuesday about something that is still a bit vague and people are going to have to vote on things which are a bit vague. Why is it being done this way?

Caroline Flint: I do not think it is that vague, is it?

Q601 Dr Naysmith: Some people think it is.

Caroline Flint: We are working through a whole host of issues here as you can imagine. These are tricky areas. We have talked primarily about our exemptions on particular licensed premises today but I know you have had someone in from the MoD to talk to you, obviously. My colleague, Fiona, was here talking about prisons. I am taking soundings at the moment on issues around mental health institutions and so forth. I have to say every single country, including Ireland and Scotland, is having to address exemptions and issues in those areas. In Ireland, for example, they have a complete exemption for adult hospices and those countries are working through these issues as well. I am afraid to say that even in those countries which have gone for a total ban—Ireland and Scotland planning to and now Northern Ireland—the issue of exemptions in all those areas is something they are going to have to deal with and face and discuss. In relation to the particular issue around bars, the issue we have to resolve primarily is the issue around the non-food/food split, although Giles Thorley, the Chief Executive of Punch Taverns, has said: “Although we acknowledge the processed non-food/food split will present some landlords with difficult decisions, nevertheless we feel the distinction is relatively straightforward and workable as well as preserving some degree of choice”. We also know, as I said earlier, that we are consulting on the issue around the area around the bar and I am sure in the Second Reading debate and in Committee there will be plenty of opportunity for parliamentary colleagues to raise these issues and press me and raise a number of different concerns, as we normally do, in Committee processes.
they are in favour of a total ban, a different view from the Beer & Pubs Association. Again, as I said earlier, there is certainly a unity position on the issue of the private members’ clubs. None of this is necessarily in and of itself straightforward. We have to make a decision and I am afraid, sometimes, we can please some of the people some of the time but not all of the people all of the time.

Q603 Dr Naysmith: I am just raising it in terms of the need for clarity.

Caroline Flint: Our endeavour here is to make it as clear as it possibly can be. I think we can work through this. I do not think, based on what other countries have done, who have had differences in approach, particularly to the licensed sector, that that is insurmountable.

Q604 Chairman: Minister, I said last week when we were taking evidence from the hospitality sector about 30 years ago when I started drinking—I was actually ten years out, it was 40 years ago when I started drinking—by and large pubs were where men went to drink and I started my apprenticeship in this area in some pubs in your own constituency which you represent now. The one thing I said to them was the culture of public houses has changed dramatically, not in every public house but in communities like ours that we represent, and the change by and large has been on the issue of food. You see more families in there. The great danger that I see is if there was a situation where they had to get out of food so they could keep smoking, then it may change that culture. I know the Government have said that they want to review this position that they are going to put to the House at some stage in three years’ time, but is there not a great danger that the change of culture, if it did reverse in three years’ time, would be too late to try and save it, in the sense that people will have disinvested out of pubs with meals and family rooms in because they want to stay in business?

Caroline Flint: I think it is really interesting, is it not, that there has been such a shift. I am the granddaughter of a publican so I have spent quite a bit of my time in pubs over the years in one way or another. What I have seen is quite a big shift in terms of food being more and more part of the atmosphere of a pub and also family-orientated to get more women to come into pubs too. Personally I cannot see that in and of itself would change dramatically because there is a customer group there that if you are not providing the food in that sort of atmosphere is not going to come any more. Some pubs are going to make some choices here about what is important: a growing market or going back to a limited market that they had in the past. I think consumer choice here is an important driver for businesses and that is why public opinion amongst smokers and non-smokers was very strongly in terms of restrictions where food was present. We are not just talking about customers who do not smoke here, we are talking about smokers who, when they go out and want to have a drink and something to eat want to do that in a smoke-free environment. I do not think it is clear that there would be that huge shift in terms of the public. The other aspect of all of this, of course, is that as a result of our proposals there will be more smoke-free licensed premises and there could, therefore, be a growing market for people who currently do not like to go out, who are buying their drink from the supermarket and decide to stay at home but who may feel “I feel there is more choice for me to go out and have a drink now in a convivial atmosphere” in a way that they do not at the moment because they have not got the smoke-free choice in Doncaster or elsewhere.

Q605 Chairman: I agree entirely with that but that would be greatly enhanced if there was a comprehensive ban and not one that we think the Government are going to give. In this three-year review that the Secretary of State has talked about, are you planning to put in any evaluation strategy so you can monitor what the implementation of this part-ban is as opposed to any movement that we have in public health because of it?

Caroline Flint: Yes, I think we need to do that. In the same way as we have been able to be informed by changes already which have happened in terms of the evaluation that we do, for example, of smoking cessation courses and all of that, I think we will be looking to not only monitor but look at how we can evaluate how successful the policy has been. I think we have to work through just how we do that though.

Q606 Chairman: You do not have anything on paper in terms of evaluation strategy at this stage?

Caroline Flint: Not at this stage, no, it is something we will be looking at to see how we will address it. Obviously the industry will be able to provide some of its own evaluation because they will look at market trends and issues of pubs and what have you. It is interesting because what we have to try and find is where issues can be linked to the policy and where issues are about a different trend in terms of what is happening in drinking. Clearly we have some issues at the moment in terms of the licensing legislation which in and of itself could potentially lead to some licensed premises being shut down. We have to think about how we can measure this in a real way, bearing in mind all those other factors that are happening at the moment in terms of alcohol licensed establishments.

Q607 Mr Amess: I think this may be the last question. The point made to us very, very firmly in Dublin was that the key to the success of this policy and these changes was very much strong and determined political leadership. Some of us feel that it was not really the best start when it became public knowledge that the previous Secretary of State for Health had a very different view to the present Secretary of State for Health because it was not like two Cabinet Ministers disagreeing, it was on a particular area for which they both had responsibility. Do you think the Government is
giving strong and determined leadership on this matter?

Caroline Flint: I think we are in the sense that, first of all, the Choosing Health White Paper, which is where this discussion stemmed from originally, is the first time in a comprehensive way, not just in terms of smoking but other public health concerns and priorities, has had the public airing that it really deserves. I have to say, in terms of the outcomes of Choosing Health, there is a huge range of activities underway to make sure we deliver. Of course, I think by placing in our manifesto our clear intention, which was discussed through our own policy forums, that again showed leadership. As far as I understand, your own party is in favour of just supporting voluntary measures in this area. In terms of a political choice, I think people had a very clear political choice between voluntary measures or something which was going, in effect, to bring legislation in to create the proposals that we have got. I think that is strong leadership. What I would say is clearly there were some differences about how far we might go and, in many respects, which reflected some of the debates I have heard on radio and people have had outside of Parliament. The important issue here is that there has been collective discussion and decision, and we will bring in radical proposals in England that will, in a very real way, change the debate on smoking from one of just voluntary measures to one which has the force of the law.

Chairman: Minister, and Mr Adkin, thank you very much indeed for coming. I am sorry that the session has gone on but you can imagine when we have multi-witnesses like this we do tend to get slippage in the timetable. Thank you very much indeed for coming along and assisting us with our inquiry.
At Health Select Committee on 24 November I promised to provide further information on three areas.

1. Paul Burstow asked what is the source of the statement that 99% of people will be in entirely smoke-free workplaces?

   From Office for National Statistics data for 2003, of all employees jobs in enclosed places, an estimated 2% were in bars (includes public houses and licensed bars). These are the exempted premises in the proposal we are putting forward. Based on the responses to the consultation we estimate that no more than 30% of these premises do not prepare and serve food so would allow smoking. This means workers in exempted licensed premises make up substantially less than 1% of all employees in enclosed places.

2. Paul Burstow asked what are the most recent figures on smoking rates in Ireland?

   The latest figures, to August 2005, were recently published by the Irish Office of Tobacco Control. The graph is reproduced below from the OTC website which shows the rise in recent months, after an initial fall in prevalence. http://www.otc.ie/fig.asp?image=fig_1.jpg

3. David Amess asked how many membership clubs will still be able to allow smoking after the ban is in place?

   The Clubs we are proposing to exempt are what were known under previous licensing legislation as Registered Clubs, but are known under the Licensing Act 2003 as Qualifying Clubs with a club premises certificate in force. The latest figures were published by the Department for Culture, Media and Sport in October 2004 and are for the year to June 2004. Table 1 is reproduced below and shows that there were 19,913 Registered Clubs in England and Wales in 2004. We do not know how many of these clubs currently voluntarily ban smoking in enclosed parts of the premises.
Table 1
PREMISES LICENSED FOR THE RETAIL SALE OF INTOXICATING LIQUOR, REGISTERED CLUBS AND THEATRES, 1980–2004

<table>
<thead>
<tr>
<th>Date</th>
<th>Public houses etc</th>
<th>On-licensed premises</th>
<th>Residential and Restaurant</th>
<th>Licensed clubs</th>
<th>Total</th>
<th>Off-licensed premises</th>
<th>On- and off-licensed premises</th>
<th>Registered clubs</th>
<th>Theatres</th>
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<td>28,774</td>
<td>3,996</td>
<td>110,646</td>
<td>45,450</td>
<td>156,096</td>
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<td>78,540</td>
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<td>110,256</td>
<td>44,696</td>
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November 2005

Supplementary memorandum by Thomas Holdings Ltd (SP 07A)

I would like to thank you for giving me the opportunity to appear before your Committee. I hope that you found my evidence (as well as the written submission) helpful as part of your inquiry. As a follow-up I thought it might be useful to expand on a couple of the points I referred to in my oral evidence.

Migration

If health is the reason for a smoking ban, it is illogical for it not to be a total ban; otherwise people will migrate to venues where they can continue to smoke, making the situation worse in those venues. A total ban would at least create a level commercial playing field and limit the migration of customers between venues.

— In the consultation paper under competition issues, it is recognised that giving local authorities the power to decide would lead to problems where customers move from a smoke free place in one jurisdiction to a smoking place in another jurisdiction. A partial, national ban would make this situation even worse, as customers can just move to a smoking place across the road. The latest draft of figures prepared by the Henley Centre for the Bingo Association predict that while a total ban will lead to an overall drop in bingo admissions of around 5%, a partial ban would lead to a 12% drop in admissions. This difference is evidence of the likely migration effect of a partial ban. It shows the direct impact of the proposed exemptions (currently on offer for competitor establishments such as membership clubs). With a total ban there is also more likelihood that customers lost initially would return.

— Our customers are, principally, mature women who are happy with the product we offer and enjoy being able to come to a mature, safe environment. They do not want to have to go to places like working men’s clubs, but will do so if they can continue to smoke there.
PRIVATE CLUBS

There are 19,000 registered clubs in the UK—including political, sports, snooker, factory and working men’s clubs. A partial ban will concentrate the smokers in these venues, all of which will still be able to serve hot food and admit children. This will not only undermine any distinction of “food” or “not food”, but will expose these clubs’ customers, their families, children and their employees to even more harm by making their environment worse.

PHASING IN

Whilst a total ban will undoubtedly have a negative economic impact on our businesses, phasing-in will at least allow our customers more time to get used to the idea of a smoking ban, and for bingo halls and other venues to gently persuade them by extending the areas that are smoke free on a gradual basis. This is why we support delaying the introduction of a ban until 2009.

I hope you find this additional information useful. It is, as I explained before the Committee, the view of the companies listed below. Do not hesitate to contact me if you require any additional information.

6 November 2005

Supplementary memorandum by Imperial Tobacco Limited (SP 11A)

At the Health Committee evidence session on Smoking in Public Places on 20 October, I undertook to provide the Committee with evidence from the International Agency for Research into Cancer (IARC) which I raised in my testimony with regard to the health impacts of environmental tobacco smoke on children. The paper by Paolo Boffetta and other authors concludes with the statement that “Our results indicate no association between childhood exposure to ETS and lung cancer risk”. I also enclose another piece of evidence that I referred to in my testimony, published in the British Medical Journal by James E Enstrom and Geoffrey C Kabat, in which the authors concluded that “…the association between exposure to ETS and coronary heart disease and lung cancer may be considerably weaker than generally believed.”

This paper caused controversy when it was published in 2003, leading the editor of the BMJ, Richard Smith, to comment:

— “Of course the study we published has flaws—all papers do—but it also has considerable strengths: long follow-up, large sample size, and more complete follow up than many such studies. . . . I found it disturbing that so many people and organisations referred to flaws in the study without specifying what they were. Indeed, this debate was much more remarkable for its passion than its precision.

— We must be interested in whether passive smoking kills, and the question has not been definitively answered. It's a hard question, and our methods are inadequate.”

Both pieces of information are enclosed for the benefit of the Committee.

I would also like to take this opportunity to remove any confusion that may have arisen between the testimony I gave in relation to the marketing of cigarettes in bars and pubs and that of my colleague Barry Jenner from Gallaher Group. Mr Jenner correctly stated that the law enforces prohibitions on marketing of cigarettes in the UK and, as you would expect, I can obviously confirm that Imperial Tobacco complies with the law in this regard as it does in every other regard.

October 2005

Supplementary memorandum by Gallaher Group Plc (SP 15A)

During the hearing of evidence by the Health Committee on Thursday 20 October, the Committee indicated that it would be interested in being provided with more information on certain points. As a result, I am writing this short note to explain these in more detail, which I hope the Committee will find helpful.

AIR QUALITY STANDARD

As I outlined to the Committee, Gallaher believes that any legislation should allow for separate ventilated smoking rooms in public and work places. This would achieve the aim of separating non-smokers from smokers and also create an environment in which staff, in licensed premises for example, would have a limited exposure to second-hand smoke.

1 Not printed.
In this context, Gallaher, and other principal companies of the TMA are working with the Buildings Services Research and Information Association (BSRIA) to undertake studies in an environmental chamber to demonstrate, under laboratory conditions, the effectiveness of fresh air ventilation at a variety of air flow rates in reducing ETS contaminants (GO, PM2.5 and Volatile Organic Compounds).

We will, of course be happy to share the results with the Committee, when the tests are completed. Furthermore, we are sure BSRIA would be happy to give a demonstration to the Committee. We believe that the findings of this testing could be used as the basis for measuring the efficiency of installed ventilation systems and help establish an agreed Air Quality Standard.

**Exemption for Tobacco Facilities**

Gallaher Group Plc is a major employer in Northern Ireland and Cardiff, where we have manufacturing facilities that produce cigarettes and cigars and other tobacco products, not only for the UK, but for export globally.

Associated with our manufacturing operations is a research and development facility employing circa 150 people in the UK. In order to ensure compliance with UK, European Directives and regulations and the legal requirements of non-member states, we are required to undertake product and quality control testing.

We do this alongside our own internal policies and procedures that are designed to ensure that our products not only comply with mandatory legal requirements, but also are of the quality that our consumers expect.

The work programme also involves panels of smokers who volunteer to smoke products to test their quality and other characteristics. This work is essential in circumstances where mandatory requirements require changes in product specifications. Again, this work and testing is undertaken in a controlled environment.

In response to the Government’s Consultation on the Smokefree Elements of the Health Improvement and Protection Bill, Gallaher, through our trade association, the Tobacco Manufacturers’ Association, requested a particular exemption for the premises of tobacco manufacturers and their technical suppliers, in clearly designated areas where smoking is an essential part of operations, such as testing. Without that exemption, the work will need to be undertaken elsewhere within Europe, with the risk of job losses in Cardiff and Northern Ireland.

As I stated to the Committee, Gallaher welcomes these opportunities to have constructive dialogue, as we are of the firm view that it is only through consultation and co-operation with Governments and public health bodies that issues surrounding smoking can be best addressed and that fair, reasonable and practical solutions can be achieved.

If, during the further consideration of tobacco related matters, any members of your Committee would like to visit our factory in Northern Ireland and receive a detailed presentation on our R&D facility, please let me know. Finally, please do not hesitate to contact me if I can be of further assistance to you or any member of the Committee.

*November 2005*

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**Supplementary memorandum by Dr Andrew Geens (SP 17A)**

Thank you for the opportunity to respond to comments made during the evidence gathering session on Thursday 20 October 2005.

In the first instance I think that it would be useful to clarify my credentials. I am a Senior Lecturer at the University of Glamorgan. I am a Chartered Engineer. I have been a Fellow of the Institute of Healthcare Engineering and Estate Management since 1991 and a Member of the Chartered Institution of Building Services Engineers, (formerly the Institute of Heating and Ventilating Engineers), since 1991.

My primary academic role is as Award Leader for the BEng (Hons) Building Services Engineering. This Award is one of only ten such courses in the UK accredited by the Chartered Institution of Building Services Engineers. Earlier this year the University received a national award (The Happold Brilliant Award) for excellence in teaching Building Services Engineering.

My PhD thesis, (a peer reviewed publication), involved the development of new ventilation techniques with a view to improving indoor air quality. The research was conducted between 1995 and 2000 whilst I was a full time member of staff, so the PhD was funded by the University of Glamorgan.

Given these credentials, I include ventilation and indoor air quality in listings of staff “know-how” provided by the University for knowledge transfer purposes, with a view to providing consultancy services on a commercial basis. As it may be pertinent, I have attached the Conclusions and Further Work Chapter...
of my PhD. It is only six pages long. Please note that this was written and submitted in May 2000, two and a half years before I conducted my first site study into ventilation systems in pubs, (the Manchester Airport pub referred to in the evidence session).

I would like to take the opportunity to respond specifically to comments made in the evidence session referred to above.

Q73.  **Charlotte Atkins to Dr Edwards**

Dr Edwards refers to a study of 60 pubs in Manchester. He is no more specific than that, but he may be referring to the Study conducted by Jo Carrington at Manchester Metropolitan University. I am not aware of any other study. The study carried out by Jo Carrington was carried out in 60 pubs in Manchester, and her findings should be of interest to you, even if it is not the study referred to by Dr Richard Edwards.

A paper was published in the refereed journal Indoor and Built Environment in 2005, entitled “The Contribution of Environmental Tobacco Smoke to Indoor Pollution in Pubs and Bars”. The authors are Ivan Gee, Adrian Watson and Joanna Carrington.

The final paragraph of the paper reads as follows “The effectiveness of ventilation methods in controlling ETS levels in pubs and bars appear from this study to be limited . . . A study involving a larger number of pubs and with a more detailed characterisation of the ventilation systems is required to determine the effectiveness of ventilation strategies for controlling ETS in these environments.

Q75.  **Charlotte Atkins to Dr Edwards**

Dr Edwards is correct that the monitoring at the Airport Hotel was from 10.00 am to 8.00 pm. The study was designed in consultation with the brewery and pub management.

Their advice was that the pub was busier during the day than in the evening. At the end of the four day study period I was not satisfied that we had captured data for the pub at its busiest. The management team had been confident that in the week leading up to Christmas they would be very busy with local firms having Christmas lunch outings. This did not turn out to be the case. Consequently I left my monitoring equipment in the pub for another week to include Christmas Eve. My report included data for a continuous 48 hour period covering 23 and 24 December. If you would like to see the full report I can make it available.

Q76.  **Charlotte Atkins to Dr Edwards**

None of my studies have been funded by a tobacco company. I find the implication that if a study is funded by industry there must be a conflict of interest a bit surprising as according to the University of Manchester website, they receive £7.5 million in research funding from UK industry and commerce.

In response to Dr Edwards remarks on other ventilation studies I would refer to my response to Q73.

Dr Edwards also refers to the cost of ventilation systems. Whether people are smoking or not, all populated buildings require ventilation under current Health and Safety legislation, suggesting to me that ventilation is effective. Dr Edwards mentions a figure of £15,000 as an example of how expensive it can be. He might be interested to know that in a recently refurbished pub in the centre of Cardiff, £140,000 was spent on the ventilation system.

I think that I have addressed the points raised by Dr Edwards. If you would like further information please let me know.

I note from the full proceedings from the evidence session, that you are interested in receiving evidence on ventilation performance and that comments are being made by people who have no apparent expertise in this area. From my credentials above I would hope that you consider that I have the necessary expertise. If you would like to draw on a wider circle of expertise, I would not claim to be unique in my expertise, perhaps you would like to refer to the recently published, (October 2005), REHVA Guidebook—Ventilation and Smoking. This Guidebook is peer reviewed and includes four of my recent studies. REHVA is the Federation of European Heating and Air-conditioning Association, drawing on 29 European countries for its membership.

*November 2005*

**Annex**

The main aim of this thesis has been to investigate the effectiveness of displacement ventilation in providing good indoor air quality when used in conjunction with supplementary cooling devices, and to assess alternative techniques for dealing with higher heat loads by displacement ventilation alone. This chapter presents the conclusions that may be drawn from the results obtained, and recommendations for further research that will strengthen and build on these conclusions.

9.1 Conclusions

1. When a chilled ceiling device is used to provide supplementary cooling in conjunction with a displacement ventilation system, the resulting downward convection plumes will disrupt the buoyancy driven displacement flow, reducing ventilation effectiveness and hence indoor air quality. Further, if the chilled ceiling devices operate following a period of operation of the displacement ventilation alone, the displaced “contaminated” air is “dumped” or re-circulated back into the occupied zone.

2. The “dumping” effect described in 1 above is most pronounced when the chilled ceiling device is of the chilled beam type. The chilled panel does not produce such a strong effect, and with care over the construction of the ceiling this effect can be minimised. It is unlikely in practice that it can be eliminated completely and it is concluded that displacement ventilation cannot be achieved in practice where ceiling mounted supplementary cooling devices are used. Systems currently in use and described as displacement ventilation with ceiling mounted supplementary cooling devices are in fact mixing ventilation systems delivered via displacement ventilation diffusers with ceiling mounted supplementary cooling devices.

3. Textile diffusers show great potential for use as displacement ventilation supply diffusers increasing the number of buildings that can benefit from displacement ventilation. However, care is required in their design to avoid problems of noise generation. The high volume flow rates achievable with the use of textile diffusers introduces the concept of a “high flow” displacement ventilation system, in contrast to the “standard flow” displacement ventilation currently utilised for commercial building applications.

4. When used for displacement ventilation, textile diffusers can be used for cooling loads up to 50 W/m² without the assistance of supplementary cooling devices. At this load, using PPD/PMV as indicators, thermal comfort is comparable with a conventional displacement ventilation system assisted by a supplementary cooling system in a 40:60 ratio.

5. The demonstrated ability of the textile diffuser to create a relatively robust displacement flow regime at high volume flow rates makes it particularly suitable for applications where strong odours or levels of contamination are produced, and where segregation of the occupants from the contaminants is required.

6. The use of a textile diffuser for displacement ventilation significantly reduces the size of the draught zone in front of the diffuser. This increases the effective useful floor area, making the textile diffuser a better diffuser option even when high flow rates are not required, or when supplementary cooling devices are going to be used.

9.2 Further work

The use of textile diffusers for displacement ventilation for cooling loads up to 50 W/m² has been demonstrated to have certain merits over the use of other diffuser types requiring supplementary cooling devices in the ceiling. However these conclusions have been based on physical modelling in one test room facility, using instrumentation to measure temperatures and velocities. These results have been converted to standard comfort indices for comparison with other systems.

The work has clearly demonstrated the technical feasibility of this application. However, the perceived benefits, namely good air quality and low energy consumption whilst maintaining thermal comfort, are deduced rather than measured. This means that there is considerable scope for further work to remove uncertainty in these areas.

The performance of the system in use in an operational building needs to be monitored and assessed. A range of monitoring techniques will be required to address the diverse criteria of thermal comfort, air quality and energy consumption.

The question of thermal comfort of the occupants requires objective and subjective treatment. The objective analysis for comparison with Standards can be provided by the same physical measurement techniques used in the experimental test room, as all the equipment is readily transportable. The subjective analysis to ensure occupant satisfaction can be achieved with the use of questionnaire or interview based surveys of the occupants of a building using this system. The occupants can also assess air quality as part of an occupant survey, particularly where contaminants are readily discernible by the occupants as is the case in buildings where smoking is permitted.

Most office buildings do not have readily detected contaminants, reducing the effectiveness of occupant surveys in assessing air quality. In these buildings, instrumentation to monitor a contaminant level such as carbon dioxide can be used to assess the ventilation effectiveness. Alternatively tracer gas techniques may be used.
The issue of energy consumption can be addressed by analysing the actual energy performance of a building in use over a full 12 month period. Alternatively, computational modelling techniques are available to simulate the operation of a building in terms of the energy performance of the environmental systems.

The only installation currently identified as using this technique is serving a conference facility with a restaurant area as identified in Section 7.8. In the absence of any other opportunity this building could be used as the basis for this proposed monitoring work. The air supply rates for this building are higher by a factor of approximately two than those assessed during the experimental work for this thesis, presenting an opportunity to re-appraise the cooling performance of the technique. As the building operator allows smoking in the building, it also presents a good opportunity for assessing the segregation of smokers and non-smokers. This could lead to applications in leisure and retail buildings where customers smoke and staff need protection from the smoke.

With the possibility of use in leisure and retail buildings there is also scope for incorporating the textile diffusers directly into the decorative finishes of the occupied spaces such as within bar frontages or under bench seating.

However, the main application for displacement ventilation is currently in commercial office buildings. Particularly in respect of thermal comfort, the nature of occupancy is significant and monitoring in other types of building would not be reliably transferable. It is therefore important to have a textile diffuser system installed and monitored in an office building.

Although the use of comfort indices indicated comparable performance for the textile diffusers, the temperature gradient in the room was on the limit of acceptability. By conducting the tests in a test room set up for testing chilled ceilings, the optimum performance of the system was not established, with the test room scenario probably being the worst case. It is likely that the best comfort conditions will be established when the system is used without a suspended ceiling, taking advantage of the thermal mass of the ceiling, with or without the use of night cooling. This needs to be examined, ideally in an operational building rather than a test facility, where the thermal mass may be difficult to model.

The experimental work has addressed cooling loads of the nature and magnitude of typical internal casual gains (machinery, occupants and lighting) for a commercial office application. No account has been taken of the problem of direct or indirect solar gain. The nature and magnitude of these gains and their impact on the occupied space can be significantly varied by the design of the fabric of the building. Further work is required to assess the relative merits of dealing with the issue of solar gains in the design of the building, ie shading and thermal mass or dealing with them through the use of air conditioning systems. There may be scope for dealing with these additional gains with the use of a “high volume” displacement ventilation system, when some care is taken to minimise solar gains, particularly through glazing.

Finally, further physical modelling is required on a fine measurement grid to establish the nature of the discharge profile in close proximity to the diffuser, and hence the size of the draught zone for the diffuser.

Memorandum by British American Tobacco (SP 45)

Please find enclosed a copy of the submission made by British American Tobacco (BAT) to the Department of Health’s consultation on the smokefree elements of the Health Improvement and Protection Bill. I hope that the Health Committee will consider it as a piece of evidence for their own enquiry on this important subject.

In summary, BAT believes that the Government’s balanced approach to this issue provides for choice and is aligned with public opinion. We are, therefore supportive of “Option 4”, but believe that it could be reinforced by ensuring that non-food pubs which choose to have smoking and non-smoking sections use ventilation to an Air Quality Standard defined by Government on the basis of expert advice. This would help separate non-smokers from smokers and also create an environment in which staff in non-food pubs would have a reduction in their exposure to second-hand smoke.

BAT’s international spread of business helps us to follow this issue across much of the world. We believe that we can demonstrate to the Committee that properly ventilated, designated smoking areas or rooms can be effective in addressing the issue. We would welcome the opportunity to do so by inviting the Committee to visit our London office where, from October, we will be showcasing the ventilation and filtration systems available from a number of leading international companies. We hope the Committee might consider it interesting and useful to view these systems and to talk to their manufacturers. We would also extend an invitation to the Committee to visit our research and development facilities to view the work we undertake ourselves, as outlined in our submission.

2 Not printed.
Memorandum by Business In Sport and Leisure Limited (SP 46)

INTRODUCTION

Business In Sport and Leisure is an umbrella organisation that represents over 100 private sector companies in the sport and leisure industry. Its members include most of the major operators of commercial sport and leisure in the UK and many consultants who specialise in this field. The value of members of BISL is in excess of £40 billion. BISL works through five working groups which cover sport, liquor licensing; gambling; employment; and planning and property. The BISL Handbook; “the Active Annual” which gives details of our activities and lists our member companies is available on request.

In summary BISL believes that a total ban on smoking in public places should be a long term aim without exemptions. Additional time should be offered to all licensed premises before a complete ban is enforced. This should be not before 2010.

The following points utilise the terms of the Department of Health Consultation On The Smokefree Elements of the Health Improvement and Protection Bill in detailing the BISL position:

(2) The definition of “enclosed” public place/workplace

BISL supports the definition of an enclosed public place or workplace, but also supports the comments of the British Beer and Pub Association (BBPA) on the greater flexibility offered by the Irish approach. It is important for the leisure and hospitality industry that outdoor space, which is partially covered, will be available for those who need a smoking break.

(3) Other public Places

It would seem sensible and fair for order making powers to allow the legislation to apply to other premises, but the regulations should be as simple as possible and not require any lines to be drawn on the ground around building exits.

(4) Longer lead in for Licensed Premises

The Health White Paper and “Delivering Choosing Health” made it clear that the Department of Health would be investing heavily in a smoking cessation campaign using public advertisements and local initiatives. BISL believes that it is vital that this campaign is evaluated and provides real evidence of success in reducing the number of people who smoke, before smoking is banned in all licensed premises.

Although 25% of the population smoke, this rises to 46% in pubs and 60% in bingo clubs. There is a real danger that businesses, particularly in marginal and rural areas, will fail if a smoking ban is implemented too quickly. BISL believes that the legislation for all licensed premises should not be implemented until April 2010 at the earliest, to allow smoking cessation policies to work.

(5) Food

BISL believes that the hospitality industry should be allowed to gain an exemption by providing separate rooms for smokers and non smokers. This should apply to all premises which have a liquor licence. We would be prepared for this exemption to be time limited to help with phasing.

There are a range of interim measures which could be introduced including separate rooms or separate areas, no smoking at the bar, employees able to choose where they work or allowing smoking in parts of a premises where no staff are required to be present.

BISL does not believe that the exemption offered for premises which do not sell food is either desirable, or workable. If this exemption is to be continued, all premises which do not serve food and have a liquor licence should be included, not just pubs.

(6) Residential Premises

BISL is content with the list shown, but supports the views of the British Hospitality Association (BHA) on hotel bedrooms.

(7) Exemption for Clubs

BISL represents a number of proprietary owned members clubs. These include snooker clubs, casinos, bingo clubs and sport and recreation clubs which are owed by corporate companies. None of these clubs would be included in the definition provided and yet these are the premises which are most likely to be affected the most in terms of viability by a ban on smoking.
BISL notes the principle of an exemption for clubs such as the Royal British Legion, but it seems incompatible with a healthy lifestyle for sports clubs to be offered such an exemption and in fact for any club if the Government is genuinely seeking to help the community to reduce its smoking habit. If one prime purpose of this Bill is also to protect the workforce, these provisions only provide for the protection of employees in commercial premises and not in clubs. This hardly fits in with the objectives of the Bill. Arguments put forward about choice for employees as to which premises they chose to work in are likely to lead to claims for discrimination.

In any event our overriding objection to this exemption is that it would lead to migration. This is particularly true outside London and many other major cities where private clubs are significant players in the night time economy. In such places all the evidence from overseas shows that smokers just migrate from a place where they can no longer smoke to a commercial premises to places where they can smoke.

In summary, BISL does not believe that any exceptions should be provided for clubs. If this exemption is to be continued it must be for all clubs where members can vote on the issue.

(8) Practical Implications

The practical implications for all businesses will be the effect on customers. This effect will be more marked in premises where customers traditionally spend a long time e.g. pub, restaurant, casino, bingo club or betting shop.

(9) Signage

The consultation suggests that “No Smoking” signs should be displayed in all premises (where applicable) and that operators may be prosecuted for not displaying such signs. BISL believes that the requirement to have “No Smoking” signs should at worst be time limited with a “sunset clause” which lasts for perhaps two or three years, but in reality a presumption against smoking in public places should remove any need for these signs apart from “smoking permitted” in exempt areas. You do not put “Don’t rob this bank” on the entrance to all banks. Why should it be necessary for all premises to say “No Smoking”?

Alternatively, BISL would support the view of the BBPA which requires signage only where smoking is permitted. BISL has a concern that if an operator was prosecuted their liquor licence could also become invalid and this would have serious consequences for individual businesses.

On a practical note, there is a need to have a definition of “an entrance”. Is this a notice on the door, or merely close to the door?

(10) Offences and Penalties

BISL believes that these are the right offences and penalties.

(11) Defences

BISL believes it is very necessary to give businesses an opportunity to defend their actions when, either they could not know someone was smoking, or a request to stop smoking is ignored.

BISL does have concerns that fines could be imposed on individual members of staff. £200 may not be much to an operator, but it is a lot for a part time cashier. Particularly where no witnesses are present, it may be difficult to prove whether the individual did give a warning to a customer to stop smoking or not. It may be fairer to require the company to provide training for employees and then impose the fine on the company and not the employee.

(12) Enforcement

BISL notes the role to be played by local authority enforcement officers, but would reiterate the need for clear central direction and consistency across local authorities throughout the country. We support the views of the BBPA and British Hospitality Association (BHA).

(13) Smoking at the Bar

BISL believes that the voluntary work undertaken by the British Beer and Pub Association and other leisure outlets to prevent smoking at the bar should be extended. This is obviously irrelevant if smoking was banned in all hospitality venues.
(14) **Time Table**

The consultation paper asks whether the end of the year is the most suitable time to bring in a smoking ban. **BISL** believes that April would be a better time as this is a month at the beginning of the summer season when days become longer and it is therefore more acceptable for customers to smoke outside.

**BISL** believes that it will be difficult to achieve smoke free premises by the end of 2007. **BISL** believes that all premises should be smoke free by the end of 2008 and that all licensed premises should be smoke free by April 2010.

(15) **Unintended consequences for binge-drinking**

The hospitality industry has spent many years becoming more family friendly, offering facilities more attractive to women and becoming food led. Whilst concerns exist about binge drinking and vertical drinking, it would seem a complete contradiction to offer all operators who only serve alcohol, an exemption. Whilst snacks may be the only food permitted in such premises the vision of hamburger vans outside premises would seem just the beginning of a number of visionary loopholes which are likely to be offered by licensed premises. This would make it difficult to police and possibly unworkable in practice.

As with other exemptions offered, evidence from abroad suggests that where one premises offers smoking and another does not, customers migrate to the smoking premises and the non-smoking premises is left without customers and is likely over time to be forced to close. As already outlined, **BISL** does not believe that separation of smokers and non smokers by serving food is practical or desirable.

(16) **General Points**

**BISL** is in favour of modern legislation which puts fundamental principles in the Act itself and leaves all other details to regulations which can then be changed. It is however, essential that these regulations are available before the Bill enters its Committee stage. Otherwise businesses will accuse Government of passing legislation without its full effect being debated in Parliament or agreed by all parties.

It should be noted that all leisure venues can play a powerful role in educating and taking customers with them on the road to non-smoking. This point has been made by **BISL** verbally in many of the workshops we attended during the consultation on “Choosing Health”. It requires further discussion with the Department of Health.

**In Conclusion**

**BISL** believes that a total ban on smoking in public places should be a long term aim without exemptions. Additional time should be offered to all licensed premises before a complete ban is enforced. This should be not before 2010.

*October 2005*

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**Memorandum by the Prison Service (SP 47)**

**Introduction**

This Memorandum considers how the Prison Service, in the light of Choosing Health and impending legislation, can best contribute to the Government’s commitment to creating a smoke free environment in workplaces and public places.

**Provisions in the Health Bill which the Prison Service Needs to Consider Are**

- The commitments (outlined initially in the Choosing Health White Paper and General Election manifesto) to introduce legislation to ensure that enclosed public places and workplaces are smoke-free. This in the context of the overall government strategy to tackle death and disease caused by tobacco smoke, and to be in place by end of 2007.

- That consultation between DH and the Prison Service is mentioned in Choosing Health, along with a recognition that some establishments such as prisons require special provisions. (Indeed some initial contact has been made, and further consultation will take place soon, probably before the end of the year.)
The Current Situation in Prisons

- Prisons have developed their own “no smoking” policies covering staff and prisoners in line with current health and safety advice, and taking into account the type of establishment it is, its population and the special needs of that population. Up to this point the overall national steer from HMPS/DH has been to encourage local initiatives to reduce/control smoking.

Arrangements for Prisoners

- Currently 80% of prisoners smoke, and many staff also smoke.
- Wetherby and Ashfield prisons for Juveniles have successfully gone totally smoke free this year.
- Wherever possible prisoners should not be required to share accommodation with a smoker if they so request.
- However with the current situation of overcrowding there are inevitable pressures which currently can lead to smokers and non-smokers sharing accommodation.
- Prisoners should only smoke in their cells or where appropriate outside of buildings, and not in another “public areas”, for example on landings or in the visits area or in a class room.
- Prison Rules set out the provisions for smoking by prisoners in prisons:
  - Prison Rule 25(2) says that no prisoner shall be allowed to smoke or have any tobacco except as a privilege (for example, smoking can be forfeited as a disciplinary punishment for up to 42 days.)
  - YOI Rule 21(2) is similar. Sentenced young offenders in YOIs are not to have any tobacco, except in accordance with directions of the Secretary of State. These directions at present allow YOI governors in consultation with their Area Managers to specify at what times and places smoking may be allowed, except in establishments or parts of establishments for juveniles.
  - In juvenile establishments and juvenile units, neither smoking nor possession of tobacco is allowed.
- Health Promotion: Following a successful smoking cessation programme pilot using Nicoten Replacement Therapy in 2001-02, the Department of Health have invested £1.5 million, over three years, so that the Prison Service could contribute towards the Government’s target of 800,000 quitters. Results suggest that quit rates—up to 80% of prisoners smoke—are as good or better than those in the community. Delivery of smoking cessation services involves the local PCT Smoking Cessation Services, working in partnership with prison staff. The “Acquitted” smoking cessation programme is being evaluated further in the North West where all prisons and their PCTs have engaged together to deliver NRT with appropriate support to prisoners (report will be available in December.)
- Fire Safety: The issue of supervising the smoking of prisoners who have mental health problems and whose smoking may present a particular fire risk is a matter under consideration by Prison Health.

Arrangements for Staff

- Local arrangements require staff to be protected from the effects of passive smoking. Staff should not smoke except in designated areas eg outside of buildings or in a smoking room.
- Local smoking policies for staff may range from a complete ban on smoking in the establishment to the provision of a smoking area or a smoking room. Smoking is not permitted in any office accommodation, including single occupancy offices. In Headquarters a smoking room is provided for staff who wish to smoke.
- From a staff perspective most prisons probably already do enough to comply with legislation banning smoking. However staff are still exposed to some of the effects of passive smoke from prisoners who smoke in their cells which staff have, from time to time, to enter to carry out their security duties (this may be considered analogous to someone who works in a bar where smoking is allowed).

The Likely Impact of Impending Legislation in Terms of Compliance Required by Prisons

- Prisons, on the basis that a prison is akin to a residential home, and a cell is “home” to inmates, will be exempt to a certain extent, but only where prisoners are concerned.
- Legislation will not exempt prison staff, for whom prison is a place of work. Similar workplace considerations would apply in prisons as elsewhere. The extent to which this could be inspected under any powers provided for in the Bill is one for crown immunity/ consideration.
COULD A COMPLETE BAN ON SMOKING FOR ALL PRISONERS BE DESIRABLE IN ALL CASES?

— Up to 90% of prisoners may have some form of mental health problem. Up to 60% are addicted to drugs. Many suffer both and may also be nicotine addicted (some 80% of prisoners smoke). To insist that all prisoners on arrival into prison have their cigarettes withdrawn, may increase stress eg. it might well add to the possibility of their self harming or even killing themselves. Prison staff would therefore want to allow prisoners to be able to continue to smoke in such circumstances, providing it did not cause harm to other prisoners or staff harm, and this should continue at least until the prisoner has been stabilised, and may be offered support with this addiction.

— As a direct result of their imprisonment, they are denied access to many of the activities those not in prison would describe as normal and, to remove tobacco could emphasise those deprivations even more and might increase friction within establishments and create problems for control and order.

— As some countries have introduced a total ban successfully, there is scope for more work to see if there are lessons for England.

A WAY FORWARD

— The Prison Service will continue to consult with colleagues in DH about exemptions and the contribution prisons can make to creating smoke-free environments.

— A review should take place in the next three months which considers and makes recommendations on how the Prison Service should proceed concerning the creation of “smoke-free environments within prisons”.

— Without prejudice to such a review, the following are likely options for discussion:

(a) As a workplace all prisons to become “smoke-free work places.” This will mean no smoking anywhere within the prison buildings.

(b) Adult prisoners who smoke to do so in their own cell or while exercising in the open air.

(c) Smokers and non-smokers must not be forced to share a cell where smoking takes place.

(d) All Juvenile establishments might become totally smoke-free as per the Ashfield and Wetherby models.

— After the review and recommendations have been agreed, an implementation plan should be put into place to take agreed action forward locally, as part of the health development plans of the NHS/prison partnerships. “Guidance for smoke-free hospital trusts” (Health Development 2005) could provide a useful role model for the Prison Service in this respect.

November 2005

Memorandum by the Bingo Association (SP 48)

1. Bingo, with its 525 clubs which we represent and its three million regular players, has a unique place in the gambling sector. Licensed bingo clubs form an integral part of the social fabric of communities nationwide. In very many small towns, they provide the only leisure activity where women, who comprise about 75% of bingo players, can go by themselves in total safety.

2. If a ban is to be imposed, our members believe it should be total. A smoke-free policy should be based on the principle of equal treatment across all sectors. If the basis for a ban is health-related, this is the only logical position to adopt, and is consistent with the approach taken in Scotland, Northern Ireland, and likely in Wales. The proposal to exempt specific types of clubs from the general ban defies logic because employees in exempt clubs are equally at risk from secondhand smoke as are employees in other types of clubs. According to the Government’s own document a partial ban is likely to lead to a 40% reduction in benefits compared with a total ban. The partial Regulatory Impact Assessment does not seem to have allowed for the displacement of smokers from non-smoking venues to those where it is still permitted.

3. The proposed exemptions, which would not include licensed bingo clubs, would simply lead to massive displacement as our players moved to clubs and pubs where smoking was still permitted. These premises can legally offer bingo up to a threshold of £2,000 per week, which is not subject to any form of taxation, and would provide a parallel gaming environment. The Government has failed to address the issue of displacement in the Regulatory Impact Assessment. Licensed bingo clubs would suffer significant economic hardship and this is highly likely to lead to the closure of many smaller clubs which will deprive large numbers of our customers of the opportunities and enjoyment provided by commercial bingo.

4. Any form of smoking ban will have a significant economic impact on licensed bingo clubs, particularly since nearly 50% of our players smoke, much higher than the proportion of the population as a whole. The industry recognises the Government’s position on the health benefits of a ban, and accepts that one is inevitable.
5. A widely-applied smokefree policy should have very limited exceptions, which should not include the hospitality and leisure industries. However, if the policy is to include the wider-ranging exemptions contemplated in Option 4 in the White Paper then commercial bingo should be included in those exemptions. To maintain the current range of exemptions would be unfair and anti-competitive.

6. The proposals contained in the Choosing Health White Paper are a confused mixture of policies attempting to keep all sectors on board and reflecting a vague notion of “public opinion” but in practice discriminating against some premises in favour of others. The proposals will produce a law applying differently in England to the rest of the United Kingdom.

November 2005

Memorandum by the Faculty of Occupational Medicine of the Royal College of Physicians (SP 49)

The Inquiry is concerned with smoking in public places. But locations which are public places for most people are also work places for others. The Faculty of Occupational Medicine is primarily concerned with the health of people in their workplaces. We therefore welcome the fact that some workers will be protected from the ill-effects of tobacco smoke under the proposed arrangements. However, we are very concerned that the provisions, as they stand, will exclude some bar staff from that protection. These bar workers, who will continue to be exposed to carcinogens and other noxious agents in some private clubs and non-food pubs, will be amongst the lowest paid in the workforce, and so this measure could exacerbate health inequalities.

We feel that, in the general debate about this issue, the freedom for some to smoke has been given disproportionate prominence at the expense of debate about protecting employees' health. Under the proposed provisions, customers will have the choice to opt for smoke-free environments, but many bar staff will not.

I enclose the Faculty’s response to the consultation on smoke-free places which sets out this argument in more detail.3

I hope that this response will assist the Health Select Committee in its deliberations and might persuade the Committee to consider the benefits of all workplaces, including private clubs and non-food pubs, becoming smoke-free, so that all workers, including those who are amongst the lowest paid in society, can benefit from the protection of this legislation.

November 2005

Supplementary memorandum by Dr Allan Hackshaw Royal College of Physicians (SP 50)

In response to answers given to certain questions by Dr Steve Stotesbury of Imperial Tobacco Ltd (UK) to the Health Committee, I felt it was necessary to provide further comment on these issues to the Committee.

Q137. Dr Naysmith to Dr Stotesbury

Comment: Although many studies did not report statistically significant results, most showed an increased risk (for example, 47 out of 57 studies on lung cancer and ETS). The lack of statistical significance was usually due to insufficient numbers of subjects in a particular study. Combining the results of all studies (using an established approach called “meta-analysis”) overcomes the problem of having small studies and produces unequivocal conclusions, i.e. that ETS exposure is harmful.

Q141. Dr Naysmith to Dr Stotesbury

Comment: Dr Stotesbury referred earlier to “flawed” evidence, yet quotes the Enstrom and Kabat paper as “a major study of over 120,000 Californians over a 40-year period” that reported risks that were “considerably weaker than generally believed”. This study was based on comparing the smoking status of individuals married to non-smokers in 1959 with the death rate from lung cancer and heart disease by 1998. However, the study was conducted in California, which has the highest divorce rate in the US and a high smoking quit rate, so within this 40-year period many non-smokers who were exposed at the start will be considerably less exposed during the study. This would produce a spuriously weak risk. For example, a woman in the study who was married to a smoker in 1959 but divorced him in 1960 would be treated in the 1998 analysis as if she were still married to a smoker. However, her risk of lung cancer and heart disease due to ETS during the 40-year period would be similar to that of a woman who was unexposed, so it would be incorrectly concluded that ETS exposure was not harmful or has a negligible effect.

3 Not printed.
Q147. Dr Stoate to Dr Stotesbury

Comment: The study by IARC 1998 included results associated with exposure to ETS during childhood and the risk of lung cancer in adulthood. The comments made by Dr Stoate referred to childhood exposure and childhood diseases.

November 2005

Supplementary memorandum by Dr Richard Edwards Royal College of Physicians (SP 51)

COMMENTARY ON STUDIES CARRIED OUT BY DR ANDREW GEENS OF THE UNIVERSITY OF GLAMORGAN SCHOOL OF TECHNOLOGY

INTRODUCTION

During my recent appearance to give evidence to the House of Commons Health Select Committee investigating Smoking in Public Places, I was asked about the work of Dr Andrew Geens. I replied that I was aware of his work and gave a brief critique.

Given that I had only looked briefly at his work and that was some time ago, I thought it worth carrying out a more thorough investigation and appraisal of his work for the committee. These are the results of my investigations.

GENERAL COMMENTS

I have come across reports from two studies during previous searches of the internet for publications by Dr Geens in this field 4,5. These reports were published from Dr Geen’s institution. I can no longer find these two reports on the internet. I have also come across an opinion piece in the Building Services Journal co-authored with Max Graham 6, which contains some data. I am uncertain if this is a peer reviewed publication.

I have been unable to locate any other research published on this topic by Dr Geens in the peer-reviewed literature, the usual standard for communicating findings within the scientific community. I have checked with colleagues who have worked in this field for many years and they have also been unable to locate any peer-reviewed publications from this research by Dr Geens. By contrast, almost all the research studies on this subject which were quoted in the Royal College of Physicians report “Going smoke free?” 7, are from the peer reviewed literature.

I said in my evidence that I thought that some of this work was funded by the Tobacco Industry. Having checked the published reports, I do not have direct evidence for this, though the source of funding is somewhat obscure. The first report from the Airport Hotel, Manchester was commissioned by “Corporate Responsibility Consulting Ltd” (CRC Ltd). The website for AIR (“Atmosphere Improves Results”) 8, the organisation which promotes the Public Places Charter, and campaigns against smoke-free legislation and promotes ventilation solution states: “AIR is managed by Corporate Responsibility Consulting Ltd and receives funding from the Tobacco Manufacturers’ Association” 8.

This suggests there is a link between CRC Ltd and the tobacco industry, though the CRC Ltd website does not disclose any details of funders or stakeholders. The source of funding for the Phoenix and Doublet pub study is not declared.

BACKGROUND ABOUT PARTICULATE AIR POLLUTION AND MARKERS OF SECOND-HAND SMOKE POLLUTION

Several markers of second hand smoke (SHS) are available. A commonly used specific marker is vapour phase nicotine (VPN). Other studies have also used a range of particulate markers including tobacco specific markers such as solanesol and less specific markers such as PM2.5. The term “PM2.5” refers to the diameter of the particles—2.5 microns or less. PM2.5 is particularly useful and pertinent as a marker for SHS, as although it is not specific to SHS (PM2.5 is released from the combustion of a variety of fuels for example), it has the following characteristics:

4 Geens, A. Ventilation strategy study at Airport Hotel, Manchester, for Corporate Responsibility Consulting Ltd. UGCS Job: C7043. 2003. School of Technology, University of Glamorgan.
8 [http://www.airinitiative.com/]
— \( \text{PM}_{2.5} \) is released in large amounts in mainstream and sidestream smoke, and hence levels are raised in the presence of cigarette smoking.

— \( \text{PM}_{2.5} \) is known as a “respirable particle” and on theoretical grounds is likely to affect health. This is because due to its size and mass it is easily inhaled deep into the respiratory system where it can be locally adsorbed or absorbed.

— The theoretical effect on health is supported by widespread empirical evidence that exposure to raised levels of \( \text{PM}_{2.5} \) is associated with increased mortality, emergency hospital admissions and adverse events due, for example, to cardio-vascular and respiratory disease \(^{10,11} \)

— Ambient air quality standards such as those used by the US Environmental Protection Agency use \( \text{PM}_{2.5} \) as one of the key indices, and are based on minimising the health risks from poor air quality\(^{12} \). Current UK air quality standards use \( \text{PM}_{10} \) levels, though the use of \( \text{PM}_{2.5} \) is under review.

— \( \text{PM}_{2.5} \) can be measured in real time using relatively cheap and portable monitors such as the TSI SifePak.

Study 1: A ventilation strategy study at Airport Hotel, Manchester

The study consisted of monitoring carbon monoxide (CO), carbon dioxide (CO\(_2\)) and particulate levels on four consecutive days (Monday–Thursday) in December 2002 behind the bar of a hotel close to Manchester Airport. The bar had a dilution ventilation system fitted which was turned off on days 1 and 3, and switched on during days 2 and 4. On days 3 and 4, a policy of no-smoking at the bar was also introduced. Smoking levels were recorded as the numbers of cigarettes smoked per hour. Monitoring was also conducted during a busier period on 23 December and Christmas Eve.

The main findings were that the CO\(_2\) and CO levels were lower (CO maximum levels 2–4 ppm) and rose less through the day on the days when the ventilation was switched on compared with the days without ventilation (CO max levels 10–14 ppm).

This study has numerous limitations, some of which are acknowledged by the author:

1. Little detail on the methods used is given. For example, no details of the monitoring equipment are supplied. The method of monitoring the amount of smoking in the bar is not described. Particulate matter results are presented, but the type of particle being monitored is not revealed. The volume of the bar is not given, so the figures for the number of cigarettes smoked per hour are difficult to interpret in terms of smoking density. The specification of the ventilation system is not described (eg air changes per hour).

2. Carbon monoxide is a relatively insensitive indicator of SHS levels. CO\(_2\) levels are not related to SHS, but is influenced mainly by occupancy levels in indoor environments.

3. The study was carried over a restricted time period with monitoring on week days from 10.10 to 19.45 each day. This is likely to have been a very quiet period. It is not explained why monitoring did not continue during the busier evening period. The author himself notes: “The level of smoking during the test period was very light and so the ventilation system has not been monitored under very testing conditions”.

4. It is apparent from graph 12 that the rate of smoking was lower on one of the “ventilation on” days. The figures are not given, but can be estimated from the graphs as about 22.5 cigs per hour smoked on average on Monday (day 1, vent off), but only 15.5 per hour on Tuesday (day 2, ventilation on). Figures for days 3 and 4 are both about 21 cigarettes smoked per hour. Therefore, SHS levels would be expected to be lower at least on day 2.

5. On the busier days (23/24 December) where monitoring continued after 8 pm, no counts were recorded and only a very crude estimate of occupancy and smoking rates was available based on ratio of daily takings. During the evening on these days, CO levels rose to around 10 ppm, similar to the levels seen on non-ventilated days. No data on particulate levels is given for these busier days. The reason for this is not explained.

In conclusion, due to the lack of information about the methods, inadequacies in the approach, and the particulate data being limited to time periods where smoking and SHS levels were mostly very low, this study provides very little evidence about the effectiveness or otherwise of ventilation in controlling SHS levels in busy pubs and bars where smoking is allowed.

\(^{10}\) Ware JM. Particulate air pollution and mortality—clearing the air. New England Journal of Medicine 2000;343:24.


Study 2: A comparative ventilation effectiveness study at the Doublet and Phoenix Public Houses

In this study monitoring with ventilation switched on and off was conducted over parallel 5/6 day time periods in a smoke-free pub (The Phoenix) and a non-smoke-free pub (The Doublet) in Glasgow. Both pubs had dilution ventilation systems. Real time CO₂, CO and PM$_{2.5}$ levels were measured in the bar serving areas of both pubs, and CO₂ and CO in the customer area in the Doublet. Numerous graphs are used to present the monitoring data. Since for the reasons noted above, particulate levels are the most appropriate SHS markers of those measured, I will focus the commentary on this.

The author quotes in this study and in the Building Services Journal article an Health and Safety Executive EH40 occupational standard for respirable particles (8 hour time weighted average) of 4mg/m$^3$ (or 4,000(µg/m$^3$, as 1 mg = 1,000µg). This is an enormously high level at which the atmosphere would be thick with visible particles. However, this occupational standard is a reference to the following statement in EH40: “The COSHH definition of a substance hazardous to health includes dust of any kind when present at a concentration in air equal to . . . 4 mg/m$^3$ 8-hr TWA [time-weighted average] of respirable dust.”

The authors do not make clear that this is not a standard for SHS nor for PM$_{2.5}$, the particle which is measured in their study. Rather, it is a general level for determining appropriate control of exposure of respirable particles for which no health effects are known to exist, except those associated with the effects on the lung due to presence of a large amount of inert particles. Where dusts have their own limit then exposures will need to comply with the appropriate limit and where dust contain components that have their own assigned workplace exposure limits, all relevant limits should be complied with.

The authors fail to note that the HSE has declined to set an occupational limit for SHS exposure, because the level at which health effects are negligible is not known. Similarly, the Chartered Building Service Engineers (CIBSE) guide A3 states that “… regardless of the ventilation used, the health risks of ventilation cannot be eliminated”. As a complex mixture of 4,000+ substances, with over 50 known carcinogens, and established adverse health effects, SHS can in no way be described as inert particle with limited or no effect on human health. To relate the achievement of the ventilation systems in Geens’ studies to the EH40 4mg/m$^3$ occupational limit for respirable particles is therefore impossible to justify.

As noted above, the UK does not yet use PM$_{2.5}$ indicators for air quality standards, relying on the slightly different PM$_{10}$ particle level instead. In the US, the Environmental Protection Agency (EPA) health-related standards for ambient air are: 15 µg/m$^3$ (ie 0.015 mg/m$^3$) for the annual mean, and 65 µg/m$^3$ (ie 0.065 mg/m$^3$) for a 24 hour period. The US EPA Air Quality index incorporates PM$_{2.5}$ levels as indicators of air quality. Less than 15 µg/m$^3$ is described as “good” air quality, 16–40 µg/m$^3$ “moderate”, 41–65 µg/m$^3”unhealthy”for sensitive groups, 66–150 µg/m$^3”unhealthy,”151–250 µg/m$^3”very unhealthy”and ≥ 251 µg/m$^3”hazardous”. Note that the EPA hazardous level (≥ 0.251 mg/m$^3$) is way below the 4mg/m$^3$ “standard” quoted by Dr Geens. The author does acknowledge in passing that DEFRA may suggest a PM$_{2.5}$ annual exposure limits of 40–50 µg/m$^3$ (0.04–0.05 mg/m$^3$) for the UK.

Data from the Doublet during opening hours (assuming this to be 12 noon to 12 midnight or just after) with ventilation switched on vary from about 100–1,200 µg/m$^3$ on Monday, 100–2,000 µg/m$^3$ on Tuesday, 100–1,300 µg/m$^3$ on Wednesday, 150–1,700 µg/m$^3$ on Thursday, 100–2,300 µg/m$^3$ on Monday, and 100–1,500 µg/m$^3$ on Saturday. When the pub is closed overnight, levels reduce to close to zero (although due to the scale of the graph, this may be up to 50 µg/m$^3$). When the ventilation was switched off on the Friday, levels increased to a peak of 5,500 µg/m$^3$.

Levels in the Phoenix varied between 10–25 µg/m$^3$ on the lowest day to 80–160 µg/m$^3$ on the highest day. Levels differed little between the pub open hours of 12 noon to 12 midnight, and during closure at night.

These results confirm the very high levels of exposure in the Doublet, where smoking is allowed, despite the best efforts of the ventilation system (though levels are even worse when smoking is allowed without ventilation). Every day bar staff and customers were exposed to peak levels of PM$_{2.5}$ of at least 1,200 µg/m$^3$. These levels are enormously in excess of the US EPA annual and 24 hour air quality standards, and five times or more greater than the level used to define “hazardous” air quality in the US. The rapid fall in levels of PM$_{2.5}$ overnight, presumably to close those observed in the external ambient air emphasise the inability of the ventilation system to maintain air quality whilst the pub was open and smoking allowed. The results contrast sharply with the far lower levels seen in the smoke-free pub.

Somewhat incredibly, these results are interpreted by the author as demonstrating: “the ability of the ventilation system in the Doublet to limit and control the concentrations of the parameters under consideration”; and “the performance of the ventilation system in dealing with Environmental Tobacco Smoke”; and that the results “confirm that significant improvements in indoor air quality are achievable with simple inexpensive ventilation systems”. No comment is made about the much better air quality that is achieved in the smoke-free pub, nor about the very high levels of PM$_{2.5}$ observed in the pub with smoking and ventilation relative to the US EPA air quality standards and criteria.

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RESULTS FROM OTHER STUDIES

The RCP report describes several studies in which particulate levels in pubs have been monitored. Two from the US (both published in the peer reviewed literature) demonstrate high levels in a range of ventilated pubs and other venues where smoking was allowed which were much reduced following the introduction of smoke-free policies.

In the first from New York, the mean PM$_{2.5}$ level in 14 bars and restaurants where smoking was allowed was 412 µg/m$^3$. After introduction of the smoke-free legislation, this reduced to 27 µg/m$^3$ two months later, a 90% reduction. Similarly in Delaware, average post-smoke free levels were 9% of pre-legislation levels in eight hospitality establishments.

The sort of levels seen in pubs with smoking in the UK is shown in the two graphs below. These are taken from research underway in the northwest to explore levels of particulates in pubs within deprived and non-deprived areas.

The first graph (figure 1) shows PM$_{2.5}$ data from a pilot study in which we visited a smoke-free pub followed by two pubs where smoking was allowed in Manchester City Centre with a real time portable monitor. This demonstrates firstly, how particulate levels even in a large city centre next to busy roads are relatively low (about 10–20 µg/m$^3$, 0.01 to 0.02 mg/m$^3$). Secondly, levels in the smoke free pub were about the same as in the ambient air (if anything lower). Thirdly, levels increased to 100–350 µg/m$^3$, 0.10 to 0.20 mg/m$^3$ in the pubs where smoking was allowed. Levels were still quite modest as this was early evening and the pubs were relatively quiet with few smokers.

Figure 1

PILOT STUDY DATA FOR PUBS AIR QUALITY STUDY IN THE NORTH WEST

The second graph (figure 2) shows data from one night’s monitoring in four pubs in a north west town. This shows firstly how particulate levels increase immediately on entering a pub where smoking is allowed. Secondly, it shows again how SHS levels can reach levels of 1,200µg/m$^3$—more than five times above the level of PM$_{2.5}$ described as hazardous in the US Air Quality Standards. Finally, it demonstrates the variability between pubs, with in this example PM$_{2.5}$ levels far higher in a pub which serves a deprived community, and which would be exempt under the current Public Health White Paper proposals from being smoke free as it does not serve food. We will be collecting more data in the next few weeks, but preliminary data suggests that the highest levels of SHS are in exactly these pubs, and it will be the most heavily exposed staff working in non-food serving pubs in more deprived areas who will not be protected if the current White Paper proposals are introduced.
CONCLUSION

This appraisal has shown that the studies carried out by Dr Geens have many weaknesses in design and execution, compounded by highly selective presentation and interpretation of the results. These studies do not provide evidence that ventilation can reduce SHS in pubs where smoking is allowed to levels that will protect the health of staff or customers from the adverse health effects of SHS. Detailed review of the studies reveals the opposite. By contrast, studies of the impact of smoke free legislation show that air quality is rapidly improved and that the health of bar staff is improved.

November 2005

Memorandum by Action on Smoking and Health (ASH) (SP 52)

INTRODUCTION

1. Action on Smoking and Health (ASH) welcomes the Select Committee’s investigation into this vitally important public health issue. We would be pleased to provide further written material and to give oral evidence on the issue, at the Committee’s discretion. ASH is a charity working on tobacco control policy. Our funding comes mainly from Cancer Research UK, the British Heart Foundation and the Department of Health.

2. This evidence is divided as follows:
   — Paragraphs 3 to 4 set out current Government proposals.
   — Paragraphs 5 to 13 analyse the current state of public opinion on the issue.
   — Paragraphs 14 to 19 look at the economic impact of smokefree legislation.
   — Paragraphs 20 to 59 look at the proposed exemption for pubs that do not serve prepared food—looking in turn at health and safety, the regulatory burden and market incentives created by such exemptions, the public health implications, the possible consequences for binge drinking and the human rights and other legal implications of exemptions.
   — Paragraphs 60 to 62 look at the proposed exemption for membership clubs.
   — Paragraphs 63 to 69 look at possible exemptions for residential premises that are also workplaces.
— Paragraphs 70 to 72 look at other premises which should be smokefree by legislation but are not currently covered by the definition of “enclosed space”.
— Paragraphs 73 to 75 look at the proposed definition of smoke and smoking.

CURRENT GOVERNMENT PROPOSALS


“We therefore intend to shift the balance significantly in favour of smokefree environments. Subject to parliamentary timetables, we propose to regulate, with legislation where necessary, in order to ensure that:
— all enclosed public places and workplaces (other than licensed premises which are dealt with below) will be smokefree;
— licensed premises will be treated as follows:
  — all restaurants will be smokefree;
  — all pubs and bars preparing and serving food will be smokefree;
  — other pubs and bars will be free to choose whether to allow smoking or to be smokefree;
  — in membership clubs the members will be free to choose whether to allow smoking or to be smokefree; and
— smoking in the bar area will be prohibited everywhere.”

(White Paper, page 99, paragraph 76)

4. On the proposed timetable, the White Paper stated that:

“We intend to introduce smokefree places through a staged approach:
— by the end of 2006, all central government departments and the NHS will be smokefree;
— by the end of 2007, all enclosed public places and workplaces, other than licensed premises (and those specifically exempted), will, subject to legislation, be smokefree;
— by the end of 2008, arrangements for licensed premises will be in place.”

(White Paper, page 99, paragraph 77)

PUBLIC OPINION

— It is clear from extensive polling evidence that the public would give majority support to comprehensive smokefree legislation. The Irish and New York examples suggest that such legislation becomes overwhelmingly popular after it is introduced.

5. It would appear that there is a concern in some parts of Government—carefully fostered by the tobacco industry and its front groups—about whether the majority of (at least) the English public backs comprehensive smokefree provision. This arises because many polls (including the Smoking Related Behaviour and Attitudes module conducted by the Office of National Statistics, and all polls conducted by the tobacco lobby) segment the issue by asking about smokefree legislation in relation to particular categories of public place.

6. Even given this approach, it is clear that public opinion has shifted markedly in recent years towards smokefree legislation. The latest ONS survey report shows a large increase in support for restrictions in pubs, from 48% in 1996 to 56% in 2003 and then to 65% in 2004. When people were asked in more detail what restrictions in pubs they would prefer, 47% thought that pubs should be mainly non-smoking with smoking allowed in designated areas, and 16% thought the premises should be mainly smoking with a designated non-smoking area. Nearly a third (31%) said that smoking should not be allowed anywhere, an increase of more than half since 2003, when only 20% thought smoking should not be allowed anywhere. Only 5% thought there should be no restrictions on smoking at all. Public opinion is continuing to shift on the issue across the UK. Support for smoking restrictions in other locations exceeded 80%—for example, indoor shopping centres (87%), indoor sports and leisure centres (93%) indoor areas at railway and bus stations (82%).

7. However, if the issue is not segmented in this way, it is clear that a majority of the public will assent to the proposition that all workplaces and enclosed public places (including all pubs and restaurants) should be smokefree.

8. The latest poll to show this was conducted by BMRB for ASH (fieldwork between 15 and 17 July 2005, sample size 996).\(^{16}\) Asked “The Government has announced plans to make most enclosed public places smokefree from 2008. Would you support a proposal to make ALL enclosed workplaces, including pubs and restaurants, smokefree?” 73% supported the proposition, with 24% saying no and 3% saying don’t know. The poll also shows that 85% of people would visit bars and pubs as often—or even more often—if they were smokefree by law.

9. Detailed results include:

   — The Government has announced plans to make most public places smokefree from 2008. Would you support a proposal to make ALL workplaces—including all pubs and all restaurants—smokefree?

<table>
<thead>
<tr>
<th>All</th>
<th>Non smokers</th>
<th>Smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73%</td>
<td>82%</td>
</tr>
<tr>
<td>No</td>
<td>24%</td>
<td>14%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

   — If the indoor premises of pubs and bars were smokefree by law, do you think you would use them more often, less often or about the same?

<table>
<thead>
<tr>
<th>All</th>
<th>Non smokers</th>
<th>Smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td>More often</td>
<td>28%</td>
<td>36%</td>
</tr>
<tr>
<td>If would make no difference</td>
<td>57%</td>
<td>59%</td>
</tr>
<tr>
<td>Less often</td>
<td>12%</td>
<td>2%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Smokers made up 25% of the survey sample.

10. This confirms previous poll results. In April 2004, MORI was commissioned by ASH to conduct by far the largest and most representative poll so far conducted on the issue (poll size—4,000 adults across Great Britain). 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;
   — 8% neither support nor oppose;
   — 7% tend to oppose; and
   — 4% strongly oppose.

Support for a smokefree workplace law was strong across all social classes:

   — 86% of social class AB support the proposal;
   — 83% of social class C1 support the proposal;
   — 79% of social class C2 support the proposal; and
   — 72% of social class DE support the proposal.

Even regular smokers support a new law: the MORI poll showed support from 59% of daily smokers and 68% of infrequent smokers.\(^{17}\)

\(^{16}\) Polling firm BMRB and commissioned by Action on Smoking and Health (ASH) and Cancer Research UK to conduct a poll on public support for smokefree legislation. 996 interviews were conducted by telephone with residents in Great Britain aged 16 years and over. Fieldwork was conducted on one wave of the BMRB Access Omnibus (15–17 July 2005). Full results available from ASH on request.

\(^{17}\) www.ash.org.uk/html/press/040611NAT.html
11. The ASH poll cited above also found that 49% of adults specifically supported a complete ban on smoking in pubs. This result was in fact more favourable than polls conducted around smoking in bars in New York before the city ordinance came into effect. In 2002, public opinion surveys in New York showed only 30% of the public specifically supporting legislation requiring fully smokefree bars.18

12. A crucial point about smokefree 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 (in advance of the one-year anniversary of the law) shows extremely high levels of public support:
- 93% think the law was a good idea, including 80% of smokers;
- 96% of people feel the law is successful, including 89% of smokers;
- 98% believe that workplaces are now healthier because of the smokefree law, including 94% of smokers.

Support has grown steadily since the smokefree law was introduced. Before its introduction more than two thirds of the public supported the law (67%) while the vast majority of people wanted it to be complied with (81%). Independent research conducted three months following implementation (June 2004) indicated that 89% of people (smokers and non-smokers alike) felt the law had been a success.

13. We therefore conclude that if the Government opts for a comprehensive smokefree law covering all pubs as well as other workplaces and enclosed public places, then this will receive overwhelming public support, which will rise further after the legislation comes into effect. It is already the case that legislation including pubs and restaurants is more popular here than it was in Ireland prior to its introduction there. Independent research conducted in Ireland after the legislation was published but before it was implemented found that only 67% supported the inclusion of pubs and restaurants compared to 73% in the ASH BMRB poll. Subsequent research for the Irish Department of Health and Children (July 2004) indicated that public support had risen to 82% with 95% of people recognising it as a positive health measure. In addition, in the national New Year’s Poll (“2004—How was it for you?”) carried out for RTE television and broadcast on New Year’s Day—the smokefree law was voted the no 1 “high” of 2004. The poll featured the top sporting, cultural, current affairs and other events throughout the year.19

14. The Government should therefore present this issue as a single yes/no question, either legislation is introduced to end smoking in all workplaces and enclosed public places or it is not. If this is done, public opinion will not represent a significant barrier to action—indeed the legislation is likely to prove, as in Ireland, a major political and popular success.

ECONOMIC IMPACT
- There are large economic benefits to be gained from smokefree legislation and the consequent fall in smoking prevalence rates.
- There is extensive evidence showing that smokefree legislation does not cause economic damage to the hospitality industries.

15. Comprehensive legislation ending all smoking in workplaces and enclosed public places is the cheapest and simplest way to protect the public from the health risks of secondhand smoke. By comparison, the costs of a policy of improved ventilation and more segregation of smokers and nonsmokers would be very considerable. Modern ventilation systems are expensive to install and to maintain. In 1999, the HSE estimated that the initial installation costs of ventilation equipment in all organisations not currently separating smokers and non-smokers would be between £580 million and £2,400 million, with an annual maintenance cost of about 10% of the initial outlay. The HSE estimated that the total cost of a voluntary scheme for all workplaces to have either smoking rooms or mechanical ventilation would consist of “one-off” costs of between £1,259 million and £3,167 million in 1998–99 prices and recurring costs over 10 years of £1,889 million to £5,694 million.20

16. Using previous estimates from the Scottish Executive, Department of Health and HSE, Professor Christine Godfrey of the University of York has estimated that making all workplaces in the UK smokefree would realise substantial economic benefits, of approximately:
- at least £832 million from prevention of death and disease;
- £181 million from prevention of fires and reduced cleaning costs;
- £2,854 million from improved productivity.21

Her detailed estimates are as follows:22

21 Going Smokefree: The medical case for clean air in the home, at work and in public places, a report of the Royal College of Physicians, chapter 11.
22 ibid, table 11.3.
Summary of revised estimates of the annual potential benefit of making UK workplaces smokefree, at 2003–04 prices

<table>
<thead>
<tr>
<th>Source of Benefits</th>
<th>£ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>From reduction in passive smoking:</td>
<td></td>
</tr>
<tr>
<td>Value of reduced deaths from passive smoking</td>
<td>652</td>
</tr>
<tr>
<td>Productivity gains from reduced sickness absences</td>
<td>249</td>
</tr>
<tr>
<td>Reductions in NHS costs from reduced sickness</td>
<td>8</td>
</tr>
<tr>
<td>From reduction in active smoking:</td>
<td></td>
</tr>
<tr>
<td>Reduction in number of smoking related deaths among those aged under 65</td>
<td>133</td>
</tr>
<tr>
<td>Reductions in NHS costs from quitters</td>
<td>39</td>
</tr>
<tr>
<td>Productive gains from reductions in smoking absences among current smokers</td>
<td>9</td>
</tr>
<tr>
<td>From smokefree workplaces:</td>
<td></td>
</tr>
<tr>
<td>Reduced fire damage, deaths and injuries, fire services and administration</td>
<td>53</td>
</tr>
<tr>
<td>Reduced cleaning and refurbishment costs</td>
<td>128</td>
</tr>
<tr>
<td>From productivity gains arising from changes in working patterns</td>
<td>2,596</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,867</strong></td>
</tr>
</tbody>
</table>

17. The tobacco lobby and sections of the hospitality trade often claim that smoking restrictions are bad for business. The objective evidence does not support this claim. 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.”

18. In Ireland, the Vintners Federation of Ireland and other groups have claimed that the smokefree 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 4.0% in the year following the introduction of smokefree 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.

19. A major review of economic evidence from jurisdictions with smoking restrictions was conducted by Luk Joossens et al for the Smoke Free Europe partnership.

20. The review looked at almost 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.

Exemption for Licensed Premises that Do Not Prepare and Serve Food

21. The Government proposes to exempt from full smoking restrictions pubs that do not serve prepared food. ASH considers this proposal highly undesirable for the following reasons:

- It would fail to protect the health and safety of some of the most vulnerable people in the workplace.
- It would create perverse incentives and unfair competition in the pub and hospitality industry.
- It would be more costly and burdensome to enforce and would conflict with regulatory principles set out in the Hampton Review.
- It would undermine the public health benefits of smokefree legislation, particularly in poorer communities.

23 As for footnote 16 above.
— It would undermine the Government’s alcohol policy by encouraging “stand-up” binge drinking rather than alcohol consumption with food.
— It would be open to challenge under the Human Rights Act and under existing health and safety law.

HEALTH AND SAFETY

22. The Scientific Committee on Tobacco and Health (SCOTH), which advises DH, 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”.27

23. Professor Konrad Jamrozik, formerly of Imperial College London, estimated in May 2004 that secondhand 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.28 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 226.29

24. 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 exempted premises) exposed.

25. 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. This is the date by which employers should know of the nature of a specific workplace health and safety risk. Therefore, employees made ill by such exposure in the workplace will have a case for damages against their employer, claiming negligence and citing a breach of the HSWA as evidence. This would remain possible in respect of any premises exempted from a general prohibition on smoking. ASH has been working with the personal injury and trade union law firm, Thompson’s, to identify such cases, and a number have already been settled out of court for substantial sums.30

26. The danger of exemptions to the hospitality trade could be that the Health Bill allows smoking to continue in some premises, only for the employers concerned then to face civil actions under the HSWA. If the legislation proceeds with the proposed exemptions, ASH will make it a priority to find and support such cases in exempted premises.

27. It has been suggested that Ministers may feel bound by the terms of the Labour Party manifesto for the 2005 General Election, which promised smokefree legislation but also offered exemptions for non-food pubs and clubs. However, the manifesto also stated that: “whatever the general status, to protect employees, smoking in the bar area will be prohibited everywhere.”31 We expect the overwhelming expert response to this during the consultation period to be that this proposal will not in fact protect employees—in which case the Government should reconsider the precise terms of the manifesto commitment, and recognise the clear benefits of comprehensive rather than partial legislation.

28. The proposal to prohibit smoking in the “bar area” of exempted pubs would fail to provide adequate protection for employees or members of the public. Smoke drifts. Most pubs currently have any separated smoking and non-smoking areas in the same open space.

29. Ventilation systems are expensive, hard to maintain, and as even Philip Morris has admitted, do not provide good protection from the health effects of secondhand smoke—“While not shown to address the health effects of secondhand smoke, ventilation can help improve the air quality.”32

30. Recent research in venues in Sydney, Australia, showed that designated “no-smoking” areas in the hospitality industry provided at best partial protection and at worst no protection at all against the damaging effects of secondhand smoke.33

31. Research by D Kotzias and others at the European Commission Joint Research Centre’s INDOORTRON facility concluded that “. . . changes in ventilation rates simulating conditions expected in many residential and commercial environments during smoking do not have a significant influence on the air concentration levels of ETS constituents, eg CO, NOx, aromatic compounds, nicotine. This suggests that efforts to reduce ETS originated indoor air pollution through higher ventilation rates in buildings, including . . .”

30 For example, the case of casino worker Mickey Dunn, see: http://www.ash.org.uk/html/workplace/html/employersletter.html
33 Cains, T et al Designated “no smoking” areas provide from partial to no protection from environmental tobacco smoke. Tobacco Control 2004; 13: 17–22. http://tc.bmjournals.com/cgi/content/abstract/13/1/17
residential areas and hospitality venues, would not lead to a meaningful improvement in indoor air quality. Moreover the results show that “wind tunnel”—like rates or other high rates of dilution ventilation would be expected to be required to achieve pollutant levels close to ambient air limit values”.

32. In other words, for ventilation to have any significant effect, it would require tornado-like quantities of ventilation to produce an acceptable risk to those exposed to secondhand smoking. This is patently unrealistic.

**REGULATORY IMPACT AND PERVERSE INCENTIVES**

33. The proposed exemptions for some pubs and clubs would increase the regulatory burden on business, and create perverse incentives and unfair competition. For example, the British Beer and Pubs Association (BBPA) has previously commented that “creating an opt-out for clubs like this is a gross distortion of the market. There must be a level playing field for all”.

34. We agree with the memorandum of evidence submitted to the House of Commons Health Select Committee in February 2005 by the BBPA, which stated that: “if legislation is the preferred Government route, this needs to be implemented nationally and must be applied equally across all sectors of the hospitality industry. The staff and customer issues faced by licensees are no different in public houses, private clubs, restaurants, hotels, or workingmen’s clubs, and preferential treatment or exemptions remain illogical in a public health context.”

35. The proposed exemption for pubs not serving prepared food would also 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”. Paragraph 19 of the consultation document proposes to specify in regulations “a list of permitted foods for smoking licensed premises”. These must be “pre-packaged ambient shelf-stable snacks”.

36. Chapter 4, paragraph 79 of the White Paper suggests that between 10% and 30% of pubs to be exempted. There are about 55,000 pubs across the country, so even if this estimate proves accurate (see response to question 5 above) this exemption may cover anything between 5,500 and 16,500 establishments. However, the RIA states only that while the enforcement costs of comprehensive legislation might be £20 million, the costs of enforcing legislation with exemptions would be £20 million plus.

37. ASH commissioned Jane MacGregor of Jane MacGregor Associates (and the Local Authority Co-ordinating Office for Regulatory Services: LACORS) to survey seven authorities, representing London Borough, Unitary, Metropolitan and District Councils. They also represent different regions of the country and very different social settings. The seven authorities surveyed were:

- Derby City (urban unitary—Labour controlled).
- Gateshead (rural/urban metropolitan borough—Labour controlled).
- Southwark (London Borough—Lib Dem controlled).
- Liverpool (urban, metropolitan borough—Lib Dem controlled).
- Milton Keynes (rural/urban unitary—Lib Dem controlled).
- Reading (urban, unitary—Labour controlled).
- Warwick (rural/urban, district—NOC, Conservative largest party).

38. In order to calculate the cost per authority of enforcing both Option 2 (comprehensive legislation) and 4 (legislation exempting some pubs and clubs) in the Government consultation document, a formula was derived based upon the number of licensed business premises liable to inspection under such new legislation, the number of visits required and cost per officer hour. This formula was applied across all participating authorities, in order to calculate an estimated overall cost of each option. The results were:

- The range for enforcing Option 2: £12,800–£37,440.

The likely annual cost to Local Authorities of enforcing Option 2 is in the range of £4.5 million–£13.3 million; compared to £6.8 million–£19.9 million for enforcing Option 4.

39. Reasons given for differences were:

The greater number of visits required to enforce Option 4—Regulations will be more difficult to understand by both public and business in terms of what is and what is not permissible;

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35 Times: 21 June 2005—http://www.timesonline.co.uk/article/0,,2_1662688,00.html
36 Select Committee on Health, Session 2004/5, Written Evidence: Memorandum by the British Beer and Pubs Association: http://www.parliament.the-stationery-office.co.uk/pa/cm200405/cmselect/cmhealth/358/358we06.htm
— Licensed premises may give up serving food to avail themselves of the exemption afforded by Option 4. This will increase the number of visits required to ensure that the legislation is being complied with and that food is not being served;

— The “level playing field” for businesses created by Option 2 would allow for visits to be carried out in a more routine fashion and as part of other inspections for example food safety or health and safety inspections;

— There are likely to be fewer complaints to deal with from competing businesses and members of the public if Option 2 is adopted—the more straightforward legislation is, the less education and advice is needed before hand;

— If the legislation is less complex, as afforded by Option 2, the work could be undertaken by an officer on a lower salary grade; breaches would be less complex to detect and thus costs of enforcement lower.

40. It should also be noted that there were other costs identified by the respondents, notably the impact that this new legalisation will have upon their other regulatory functions, for example food safety and health and safety inspection work, both of which have performance measures attached to them, set by the Food Standards Agency and the Health and Safety Commission respectively. All the authorities surveyed preferred Option 2 in the Government consultation document. All thought that enforcing the new legislation would be relatively high priority work. Most were intending to bid for additional funding to enable the work to be carried out effectively.

41. The Hampton Review produced a series of regulatory principles which characterise good regulation. Regulations should be easily understood, easily implemented and easily enforced. The current proposals including exemptions and poor definitions conflict with these principles and are therefore at odds with existing Government regulatory policy.

PUBLIC HEALTH IMPLICATIONS

42. 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.

43. It is clear that pubs and clubs that would be exempted under the Government’s proposals would be concentrated in poorer communities. These communities will have higher than average smoking prevalence rates, and will be suffering from the sharp health inequalities that the class distribution of smoking brings.

44. ASH commissioned the survey firm IFF Research Ltd to survey 1,252 public houses and wine bars to establish: how many pubs currently do not serve prepared food; where such pubs are located; and what their likely future business decisions might be in relation to prepared food if the legislation includes the proposed exemptions.

45. Key findings from the survey are as follows:

<table>
<thead>
<tr>
<th>What is your pub/wine bar’s current policy on smoking?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No smoking throughout</td>
<td>1%</td>
</tr>
<tr>
<td>Separate rooms for smoking and non smoking</td>
<td>7%</td>
</tr>
<tr>
<td>Separate areas for smoking and non smoking</td>
<td>36%</td>
</tr>
<tr>
<td>No smoking at bar only</td>
<td>7%</td>
</tr>
<tr>
<td>Smoking throughout</td>
<td>46%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>*%</td>
</tr>
</tbody>
</table>

**Base: All** *(1,252)*

<table>
<thead>
<tr>
<th>Does your pub/wine bar serve any food including hot food and/or cold food like sandwiches, ploughmans etc—or do you only provide packeted food, like crisps and nuts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Packeted food (crisps and nuts) only</td>
</tr>
<tr>
<td>No food at all</td>
</tr>
<tr>
<td>Other food including hot</td>
</tr>
<tr>
<td>Other food not hot</td>
</tr>
</tbody>
</table>

**Base: All** *(1,252)*
As you may be aware, under current Government proposals, all restaurants, pubs and wine bars preparing and serving food will be required to be smoke-free by 2008. If these proposals go ahead which would you opt for—smoke free and serving food, smoke free and not serving food or smoking allowed but no food served?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke free and serve food</td>
<td>44%</td>
</tr>
<tr>
<td>Smoke free but no food served</td>
<td>1%</td>
</tr>
<tr>
<td>Smoking allowed but no food served</td>
<td>41%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Base: All</strong></td>
<td><strong>(1,252)</strong></td>
</tr>
</tbody>
</table>

46. These findings show that the proportion of pubs not currently serving prepared food is at the very top end of the Government’s White Paper estimate (10–30%). ASH also asked IFF to correlate the proportion of pubs serving and not serving prepared food to the deprivation indices for the postcodes in which they were located. Key findings here were:

Proportion of pubs not serving prepared food by deprivation index for postcode (1—richest to 5—poorest postcodes)

<table>
<thead>
<tr>
<th>Deprivation Index</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14%</td>
</tr>
<tr>
<td>2</td>
<td>18%</td>
</tr>
<tr>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>4</td>
<td>37%</td>
</tr>
<tr>
<td>5</td>
<td>45%</td>
</tr>
</tbody>
</table>

Proportion intending not to serve prepared food and to allow smoking throughout if exemptions are included in legislation

<table>
<thead>
<tr>
<th>Deprivation Index</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21%</td>
</tr>
<tr>
<td>2</td>
<td>29%</td>
</tr>
<tr>
<td>3</td>
<td>38%</td>
</tr>
<tr>
<td>4</td>
<td>42%</td>
</tr>
<tr>
<td>5</td>
<td>50%</td>
</tr>
</tbody>
</table>

47. These figures clearly provide powerful supporting evidence for two principal concerns of health and medical organisations:

- the concentration of exempt premises in low income communities means that exposure to secondhand smoke will be far higher amongst low paid bar workers and customers from more deprived areas, exacerbating health inequalities;
- exempted pubs are concentrated in poorer communities, would provide a continuing social focus for smoking and would therefore tend to reduce the impact of the legislation on smoking prevalence rates in these areas and widen health inequalities;
- if exemptions are included in the legislation, the number of pubs not serving food is likely to rise, further undermining public health gains from the legislation as well as undermining a key element of Government strategy in relation to alcohol consumption.

48. Paragraphs 8 and 9 of the RIA estimate that ending smoking in all workplaces and enclosed public places would reduce overall smoking prevalence rates by 1.7%. 0.7% of this effect is estimated to result from the direct effect of ending smoking in employees’ own place of work, and 1% from more places outside smokers’ own place of work going smoke free.

49. The RIA gives no assessment of the reduction in prevalence rates that would be achieved if the Government’s proposed exemptions were adopted. However it does assess the health benefits from averted deaths from secondhand smoke for non-employees (“customers”) of this option as worth £130–£250 million a year, as opposed to £350 million for the full ban. It also gives an estimate of the benefits from non-employees who are now smokers quitting as worth £0–£180 million for legislation with exemptions, and £180 million for a full ban.

50. In total, the RIA assesses the net benefits of a full ban at £1,344 to £1,754 million a year, compared to £998 to £1,586 million for the Government’s preferred option. (For this purpose, one year of additional life expectancy is valued at £30,000). In other words, the Government proposed an option which reduces the net benefits by up to £350 million a year. It is significant that the Government has not yet published an estimate of the net effects on smoking prevalence rates of legislation with exemptions compared with a full ban?

51. The tobacco industry understands very well the benefits from its point of view of partial smoking restrictions in the workplace as opposed to comprehensive legislation. This is why such half-measures are promoted by its front organisations such as FOREST. An internal Philip Morris internal document from 1992 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.”

**Unintended Consequences for Binge Drinking**

52. Chapter 4, paragraph 77 of the White Paper noted the risk that some pubs may cease to serve prepared food in order to qualify as premises that can continue to permit smoking. The fear is dismissed with the words “we believe that the profitability of serving food will be sufficient to outweigh any perverse incentive for pub owners to choose to switch”. But this assertion has been contradicted by senior figures in the pub trade, for example, Tim Clarke, chief executive of restaurant and pubs group Mitchells and Butlers has warned that “the enforced specialisation between food and smoking risks commercially incentivising more pubs than the White Paper currently anticipates to remove food and retaining smoking throughout.”

**Human Rights and Other Legal Implications**

53. ASH has commissioned a legal opinion from Keir Starmer QC on the Human Rights Act implications of the proposed exemptions.

54. The opinion suggests that the current proposals may well breach the European Convention on Human Rights in relation to the proposed exceptions to the smoking ban.

55. In brief, Counsel considers that allowing these exceptions may well breach Articles 2 (right to life) and Article 8 (right to respect for private and family life). He also considers that the proposed exceptions may breach Article 14 (prohibition of discrimination) although it is more difficult to advise on this on account of uncertainties with regard to both the law and the effect of exemptions to the ban on particular groups.

56. Therefore, if the Government does proceed with present proposals by only introducing a partial ban, then this is almost certainly likely to lead to legal challenges by those left unprotected by the exemptions. Employees working in exempt licensed premises or membership clubs or prisoners or patients in psychiatric hospitals in which smoking was allowed would have particularly good grounds for bringing a successful challenge.

57. Apart from bar staff in exempt premises, other classes who might be held to be discriminated against by exemptions for non-food pubs and clubs include pregnant women (and by extension all women of child-bearing age, who may be in the early stages of pregnancy and unaware of the fact) since secondhand smoke is a particular risk to the foetus and therefore these women would not be able safely to use the services and facilities provided by such pubs and clubs.

58. 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. This is the date by which employers should know of the nature of a specific workplace health and safety risk. Therefore, employees made ill by such exposure in the workplace will have a case for damages against their employer, claiming negligence and citing a breach of the HSWA as evidence. This would remain possible in respect of any premises exempted from a general prohibition on smoking. ASH has been working with the personal injury and trade union law firm, Thompson’s, to identify such cases, and a number have already been settled out of court for substantial sums.

59. The danger of exemptions to the hospitality trade could be that the Health Bill allows smoking to continue in some premises, only for the employers concerned then to face civil actions under the HSWA. If the legislation proceeds with the proposed exemptions, ASH will make it a priority to find and support such cases in exempted premises.

**Exemption for Membership Clubs**

— Membership clubs employ staff who would be left at risk under this proposal.

— No special protection is suggested for clubs that admit children. Children are at particular risk from secondhand smoke.

— Even the pub trade agrees—legislation should set a level playing field for all. Clubs should not be allowed to compete unfairly against pubs by continuing to permit smoking.

60. There are 3,751 licensed clubs in England and Wales (clubs in private ownership) and 19,913 registered clubs (owned by the members). (Source: Department for Culture, Media and Sport Statistical Bulletin Liquor Licensing, England and Wales, July 2003–June 2004).

38 http://legacy.library.ucsf.edu/cgi/getdoc?tid=qhs55e00&fmt=pdf&ref=results
40 For example, the case of casino worker Mickey Dunn, see: http://www.ash.org.uk/html/workplace/html/employersletter.html
61. It is clear that since many clubs (e.g. Labour Clubs) compete with local pubs for trade, such pubs would face unfair competition if smoking was ended on their premises but not in neighbouring clubs. We understand that strong representations on this point will be made to the Government by the hospitality trade, and these have our full support.

62. There is no special protection suggested under this legislation for clubs that admit children. Paragraph 4 of the November 2004 SCOTH report states: “A number of new studies have confirmed the range and extent of health damage in infancy and childhood. Children are at greatest risk in their homes and the evidence strongly links secondhand smoke with an increased risk of pneumonia and bronchitis, asthma attacks, middle ear disease, decreased lung function and sudden infant death syndrome. It has also been shown that babies born to mothers who come into contact with secondhand smoke have lower birth weights.” Since children are particularly at risk from the effects of secondhand smoke, this is entirely unacceptable.

RESIDENTIAL PREMISES

Any exemptions for residential premises that are also workplaces must ensure the protection of staff and should not prevent progress towards full smoke freedom as an objective of public policy.

63. We accept the principle of a distinction between public and private (residential) places for the purposes of this legislation. This raises issues of boundaries between the two, particularly where public institutions act—permanently or temporarily—as primary residences, e.g. prisons, hospices, care homes, secure wards for psychiatric patients. It is important to balance the right of residents to behave as they wish in their own “home” with the right of workers and residents to work and live in a safe environment as far as possible free from the hazards of secondhand smoke.

64. We believe that where any exemption is granted, the agreed upon definition of the premises and any associated conditions ensure that in practice, and from the outset, such premises emphasise smokefree, with designated smoking areas, rather than emphasising smoking, with provision of designated smokefree areas.

65. We recommend that a general statement be included in the legislation, similar to that used in the Republic of Ireland’s legislation42 to the effect that: “An exemption does not constitute a right to smoke and employers are still bound by a duty of care to take every possible step to protect their employee”. Workers in any exempted premises should have a legal right to request that they are not exposed to secondhand smoke in their working environment, and they should be accorded this right as part of an employer’s duty of care.

66. We recommend that in any exempted premises, regulations should require all reasonable precautions to be taken to limit the migration of smoke from a smoking room to the rest of the non-smoking environment, in line with best practice. Exempt premises should be strongly encouraged to develop, implement and review a best-practice based smoking policy in order to protect staff and non-smokers from the health hazards associated with secondhand smoke.

67. We recommend that there should be an agreed review process for exempt establishments, with a view wherever possible to increasing smokefree provision in the future.

68. We recommend that all assistance be given to employers where exemptions are granted, in order to assist them prepare staff and service users for change prior to smokefree legislation being introduced. We recommend that specific guidance be tailored for different audiences regarding (a) the health hazards associated with secondhand smoke exposure (b) issues related to smoking cessation, and (c) details of services that are able to assist staff and service users with cessation advice and treatment where applicable. We also recommend that employers receive guidance on effective development and communication of smokefree policies in advance of legislation implementation, and that attention is drawn to existing national guidelines.

69. Psychiatric units raise issues which require a specific strategic approach. ASH supports the approach set out in the Health Development Agency publication “Where Do We Go From Here”,43 which recommends, inter alia:

— Research on any interactions between tobacco use and prescribed medication.
— Research on particular motivations among service users who smoke heavily (e.g. boredom, alleviation of symptoms, etc).
— Smoking cessation programmes designed specifically for mental health service users, which involve advocates, users and staff and can be integrated into overall care plans.

OTHER PUBLIC PLACES AND WORKPLACES OUTSIDE THE DEFINITION OF “ENCLOSED” THAT MIGHT BE SMOKEFREE

The legislation should allow the inclusion of sports stadia etc as relevant public places—wherever secondhand smoke in a public place is a significant danger to health it should not be permitted

70. ASH supports the inclusion of regulation-making powers to allow the legislation to apply to areas which, while not “enclosed” “carry risks of harm from secondhand smoke because of the close grouping together of people”. This would include, for example, sports stadia and major railway stations.

71. 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 with higher levels of exposure must also be accepted. Therefore the exemptions of these venues cannot be justified.

PROPOSED DEFINITION OF SMOKE AND SMOKING

All smoking should be ended in workplaces and enclosed public places: Secondhand smoke is a health and safety risk whether the substance being smoked is tobacco or something else

72. ASH believes that it should be an offence to smoke or permit smoking in enclosed workplaces and public places, regardless of what is smoked. Therefore, the new law should not just cover the smoking of tobacco products, as proposed in the current DH consultation document, but also herbal cigarettes etc. This would make the legislation easier to enforce. It would also be a consistent health and safety approach—inhala- tion of secondhand smoke is a risk to health whatever the substances being burned in the cigarette may be.

73. The main components of smoked tobacco that create health risks from secondhand smoke are carbon monoxide and respirable particulate matter. The second-hand smoke from herbal cigarettes contains both.

74. A study of herbal cigarettes published in the Lancet in 1999 demonstrated a higher level of carbon monoxide produced by burning vegetable based cigarettes compared with emissions from regular cigarettes. Another study to determine the tar, nicotine and carbon monoxide in the mainstream smoke of selected international cigarettes showed that a brand of herbal menthol cigarette which did not contain detectable levels of nicotine, yielded mainstream smoke containing 9.8 mg of tar per cigarette, and substantial amounts of carbon monoxide (16.5 mg/cigarette). This confirms earlier research in Australia, which suggested that tar and particulate matter were present in non-nicotine cigarettes at similar levels to tobacco cigarettes.

75. Exempting non-tobacco cigarettes would also make the legislation harder to enforce. One example comes from Delaware, where a bar owner selling herbal cigarettes claimed he assumed all patrons lighting up were smoking non-tobacco cigarettes.

September 2005

Memorandum by the Royal College of Physicians (SP 56)

BACKGROUND TO RESPONSE

The Royal College of Physicians (RCP) has long recognised that tobacco smoking is a major health hazard, and since publishing its first report on “Smoking and Health” in 1962 has played an important role in raising public and professional awareness of the public health impact of smoking.

The RCP considers smoking to be an addiction typically established during experimentation with and short term use of smoked tobacco in teenage years, typically resulting in a longterm dependence on cigarettes and sustained smoking for many years. Half of all regular smokers die prematurely as a consequence of smoking.

This burden of entirely avoidable mortality, which currently accounts for over 100,000 deaths per year in the UK, falls disproportionately on the poor and disadvantaged in society and contributes more to social inequalities in health than any other known avoidable cause.

Preventing smoking is therefore the most important public health priority in the UK, and the RCP is committed to the promotion of all strategies likely to reduce the prevalence of smoking.

The RCP recognises that passive smoking (exposure to environmental tobacco smoke or secondhand smoke) is a significant public health hazard in its own right, but also that smokefree policies in public and workplaces have a further important health effect through their impact on the incidence and prevalence of smoking. Smokefree policies are therefore an effective means of both health protection and health promotion.

In July 2005 the RCP published a comprehensive report on passive smoking, which recommended the implementation of comprehensive smokefree legislation in all public and workplaces, without exception, throughout the UK. The key conclusions and recommendations of that report were:

1. Passive smoking currently kills about 12,000 people in the UK every year. These deaths are entirely preventable.
2. Most of the deaths are caused by passive smoking at home, but about 500 each year are due to exposure at work. Exposure is particularly high for some workers in the hospitality industry, such as bar workers.
3. There is an unanswerable moral case to protect all people from passive smoking at work. All employees have a right to work in a safe environment, and all employers have a duty to ensure that they do.
4. Comprehensive smoke-free legislation, making all public places and workplaces completely smoke-free, without exception, is the only effective means of achieving this.
5. A clear majority of the public supports smoke-free legislation. Where enacted in other countries, smoke-free policies have proved to be extremely popular and attract high levels of compliance.
6. Comprehensive smoke-free policies also improve public health by helping existing smokers to quit, and discouraging young people from starting to smoke. As a consequence, smoke-free legislation will also generate longterm health improvements and reductions in social inequalities in health.
7. Preventing passive smoking at home, particularly for children, is a public health priority. Home exposure is prevented only by encouraging parents and carers to quit smoking completely, and/or by making homes completely smoke-free.
8. By helping smokers to quit smoking, and by changing usual patterns of smoking behaviour, smoke-free policies in public and workplaces increase the number of smoke-free homes. Strong and sustained health promotion campaigns are required to enhance this process. These and other population and individual-level interventions to encourage smoking cessation are the most effective means of reducing ETS [Environmental Tobacco Smoke] exposure at home.
9. Making the UK smoke-free would benefit the economy by about £4 billion each year.
10. We recommend that the UK Government enact comprehensive legislation to make all workplaces and other enclosed public places smoke-free at the earliest possible opportunity.

The RCP thus takes the view that radical and comprehensive smokefree policy is a crucial public health and health protection priority. The RCP therefore welcomes and fully supports the proposal to introduce smokefree legislation in the Health and Health Protection Bill, but disagrees in particular with some of the proposed exemptions.

The RCP responses to the questions posed in the current consultation are as follow. Where appropriate, to provide a source for a review and summary of the evidence supporting our responses, we cite the relevant chapters in our recent report,7 provided as an appendix to this document in pdf format.

1. **Definition of smoke or smoking**

   Although the evidence on smoking and passive smoking effects relates predominantly to tobacco smoke, many of the major constituents of the tar and vapour produced by burning non-tobacco products are similar to those in tobacco smoke, and are consequently likely to be similarly harmful. The RCP would therefore support the adoption of a definition which includes all products used with intent to inhale smoke.

2. **Definition of “enclosed”**

   In view of the additional value of smokefree policies as a means of “denormalising” smoking and consequently both reducing smoking prevalence and increasing the numbers of smokefree homes [see Chapters 3 and 7], the RCP proposes that the legislation should apply to all public and work places irrespective of whether they are enclosed.
3. **Proposal to include some other non-enclosed public places**

The RCP would support the inclusion of all public places that are part of or in a built environment. Exemptions, if any, should be restricted to outdoor areas in open countryside.

4. **Proposal to delay implementation of smokefree policies in licensed premises**

The RCP sees no justification behind this proposal. Experience in Ireland and New York demonstrates that implementation of comprehensive policies in all premises is effective and achieves high compliance [see Chapter 15]. There is no clear advantage in delaying the implementation in licensed premises, but there is disadvantage arising from the health effects of continued exposure of staff and customers to passive smoke. Licensed premises should become smokefree at the same time as all other work and public places.

5. **Proposed exceptions to permit continued smoking in licensed premises that do not serve food**

The RCP sees no logic or justification for this exemption. All licensed premises are workplaces, and people working there are entitled to the same protection from the health effects of passive smoke as in any other environment. Exposure to passive smoke is especially high in licensed premises [see Chapter 3] so the need for protection of workers in these environments is a particular priority.

6. **Exemptions for residential premises**

The RCP considers that the only exemption should be the private home of the smoker. Residential accommodation (such as hotels, nursing homes, halls of residence) that is also a workplace, and/or includes non-smoking residents, should be smokefree. There are however some special cases, such as prisons or psychiatric institutions, where smokers are detained against their will and are thus deprived of the option of smoking in their own private home [see Chapter 14]. In these cases exemptions should made, but in a context of provision of maximal cessation support for the smoker to quit if he or she chooses, and of preventing exposure of other residents or staff to tobacco smoke. From a moral and ethical perspective, the human rights of the smoker in all of these circumstances are outweighed by the rights of others to a clean and safe environment [see Chapter 10].

7. **Membership clubs**

See comments on licensed premises above.

8. **Practical implications in the workplace**

Experience from the many parts of the world where smokefree policies have been implemented demonstrates clearly that smokefree policies are effective and successful, in almost all circumstances [see Chapters 9 and 15]. It is however crucial in implementing smokefree policies to ensure that as far as possible, smokers are provided with cessation support to encourage and promote quit attempts.

9. **Signage**

Signage is clearly important for public information but only especially so if there is likely to be confusion over where smoking is and is not permitted. The RCP proposes that non-smoking should be the default in any public or workplace, and that signage should be required to reinforce that message.

10–12. **Penalties, Defences and Enforcement**

These are crucially important areas and we would advise the adoption of policies that have proved successful in other countries, and particularly the Irish experience. In Ireland the general approach is similar to that outlined in the consultation but fines are substantially higher. Responding rapidly to episodes of non-compliance in the early days of the smokefree legislation was also crucially important, and appropriate resources need to be made available for this. The experience in Ireland suggests that the need for these resources falls rapidly over time [see Chapter 15].

13. **Proposal to restrict smoking at the bar**

Smoking in an enclosed place is harmful to everyone. Exposure of staff in pubs and bars is especially high [see Chapter 3]. Making the bar area smokefree does not protect staff from exposure, because smoke drifts. Partial policies such as this, or the use of ventilation, can sometimes improve subjective air quality but does not prevent exposure to harm [see Chapter 5]. This proposal is therefore ineffective and also potentially counterproductive, since it implies that non smoking areas within rooms where people smoker are somehow safer. They are not. The RCP opposes this policy.
14. **Timetable**

The RCP considers that the optimum time of year to introduce comprehensive smokefree legislation is the spring (in Ireland the date was late March) and that the sooner the legislation is introduced, the better. To give time to prepare the public (and to allow the further increase in public support for the legislation that follows the announcement of legislation, see Chapter 9) the announcement of intent should be made as soon as possible, and the date no later than March 2007.

15. **Effects on binge drinking**

This concern arises from the proposal to allow exemptions for pubs that do not serve food. The RCP opposes those exemptions. If all pubs are required to become smokefree, this concern is redundant.

16. **Effect on health inequalities**

The prevalence of smoking is highest, and the potential benefits of preventing smoking greatest, in the poorest communities. Exposure to passive smoking is also highest in these communities [see Chapter 3]. It is therefore self-evident and particularly important that comprehensive smokefree policies apply in all communities, so that all can reap the maximum public health benefit. The proposal to exclude pubs that do not serve food will in the long run exacerbate health inequalities, since these pubs tend to be located in poorer areas.

17. **Comments on Partial Regulatory Impact Assessment**

The RCP supports Option 2. We are persuaded by the experience of New York and particularly Ireland that concerns that the policy would not gain public support and may be difficult to enforce are entirely unfounded. We estimate the cost benefits to society of Option 2 at about £4 billion per year [see Chapter 11]. Our analysis is that any adverse effect on the hospitality trade is likely to be extremely small [see Chapter 12].

**Conclusion**

The RCP supports this legislation but believes strongly that it does not, as proposed, go far enough. We urge the government to learn from the experience of other countries and implement comprehensive smokefree policies in all public and workplaces, without exception, as soon as possible.

**References**


September 2005

**Memorandum by Professor Roger Scruton (SP 57)**

Here are some thoughts on the issue of smoking in public places that you might wish to put before your committee.

1. There are two kinds of “public place”—those that we are free to avoid, and those that surround us whether we like it or not. Places where people have to go, in pursuit of their daily business, ought to be smoke free, since most people don’t want to breathe second-hand smoke, and second-hand smoke in any case poses a risk to health. Places where people go partly in order to smoke in company—like the local pub—but which others are free to avoid, raise quite different questions, and it is bound to be controversial for the law to forbid what normally goes on there.

2. There are two general reasons for caution in legislating on matters like this one. First, the scientific base is always shifting, and what is declared to be a major health hazard one week might the next be discovered to be no such thing—having been meanwhile forbidden. There is a school of thought associated with something called the Precautionary Principle which says that, in the absence of conclusive evidence we should nevertheless forbid that which might pose a serious risk—in other words, take no risk. But taking no risks
is itself a risky policy. And the arguments for forbidding tobacco smoke in public places weigh yet more strongly in favour of forbidding car exhaust fumes—something that would have dire effects on the economy, and which no politician contemplates as yet.

3. We need to consider two questions in addition to that of health: the rights of the various parties involved, and the consequences, social and economic, of the legislation. I have no doubt in my mind that people who don’t smoke have the right to be free of smoke exhaled by others. I also have no doubt that smokers have the right to gather together in places where others go, provided the others are free to avoid those places. This is the normal rule in the village pub, which usually has a bar where you can smoke and another where you cannot. The only doubts concern the barman, who is obliged to breathe second-hand smoke if he is to keep his job. On the other hand, a car mechanic is obliged to encounter all the toxic products of his trade, including large doses of carbon monoxide. The assumption is that if he chooses this trade, he also chooses the risks associated with it. Common sense suggests that the same applies to barmen.

4. All the above considerations are familiar and have been regularly discussed in the media. What seems to be less frequently discussed, however, is the social consequences of a ban on smoking in public places, where public places include pubs and bars. As someone who lives in the country, where the pub is a mainstay of community life, I have to say that I regard with considerable apprehension any legislation that either increases the likelihood of excessive drinking or—worse still—leads to people staying at home and doing their drinking there. It seems to me that we need proper statistical research on the extent to which smoking in the pub reduces drinking. I feel sure that it does, since part of the point of both activities, when carried on in company, is to find some other use for the mouth than talking, in order to overcome inhibitions and to slow down the pace of conversation. For many people (especially those brought up after the war) the cigarette and the pint are bound by an indissoluble marriage, and a ban on smoking will therefore drive them from the pub. I believe that the pub, properly managed, frequented by respectable people of the neighbourhood and conducted under a regime of controlled social drinking, is a huge social asset, and that to destroy it would have serious consequences, especially on the socialisation of the young, who would no longer have a place to which they can go and share in an ambience where the older generation dominate. Indeed, the pub, as traditionally conceived, helped to keep binge drinking under control. The binge now usually starts in the off-licence, and proceeds from there to the bus shelter, the park bench or the football stadium. The pub was a place to relax with your neighbours, and since relaxation involved doing things that you were not allowed to do at home but which helped you to be at ease with others, smoking had—and it seems to me (as a non-smoking observer) still has—an important place in the social ambience of the pub. Personally, therefore, I would prefer to see suitable health warnings above the bar, together with the mandatory provision of a non-smoking bar, rather than a legal prohibition of smoking in the pub.

The economic consequences of a ban would also be serious, since it would certainly lead to the closure of many pubs and bars in marginal places—precisely those places where the social function of the pub is most important. This would have a knock-on effect on local economies of a kind that may be serious in rural areas. I assume that you are taking evidence from the Association of Licensed Retailers on this kind of issue.

5. Obviously there are political factors to take into consideration: the present Government is acquiring a negative image on account of its propensity to ban whatever the activists dislike. “When in doubt, ban it” is not a healthy political slogan. It might be thought wise to back off in the present instance, where the ordinary pleasures of ordinary people are at stake. But that is of course a different kind of argument, which may or may not appeal to the committee.

6. As I indicated, my wife and I have a small media consultancy which has a tobacco firm as a client, so that the above may all be discounted as self-serving propaganda. However, the firm in question (JTI) seeks our help in promoting serious debate about the wider issues of marketing and risk. They hope to secure an intellectual climate which recognises their trade as a legitimate and legal part of things. So far as I know they don’t have a line on whether smoking in public places should be banned, and the arguments that I have given above are in any case irrelevant to their interests since they have no business in Britain. If you want to see the kind of work that we do for this firm you should consult www.riskoffreedom.com, which is the briefing that we produce summarising arguments and promoting discussion about the interconnection of risk, freedom and regulation in a modern economy.

7. That said, it should be mentioned that the demonisation of the tobacco industry is one of the factors behind the current legislative proposals. Promoting public health is one thing, punishing an industry (whether or not justly) another. It is very important for legislators to be absolutely clear which of those objectives is guiding them—and this applies to the drinks and fast food industries also, where the health factors are at least as serious as in the case of tobacco, and where some kind of legislation will soon be needed to protect the long term interests of society. Any legislation about smoking in public places is going to create a precedent for legislation governing fast food, alcohol, and the diet of children, and must therefore be founded on clear principles. In general I would say that health is an important consideration but seldom the only one. It is also right and proper to consider people’s desires, their social needs, and the long-term interests of public order and community sentiment.
Memorandum by BBC Radio 4: You and Yours (SP 58)

You and Yours is BBC Radio 4’s flagship consumer and social affairs programme broadcast between 12 noon and 1 pm every weekday lunchtime.

The programme has 3.181 million listeners per week. Their average age is 58. 54.6% of You and Yours listeners are female. 45.4% are male.

The social grading of listeners breaks down as follows:
- A and B: 36%
- C1: 37%
- C2: 13%
- D and E: 12%.

INTRODUCTION

Between 9 November and 23 November, working in conjunction with Health Select Committee members, we gave our listeners the unique opportunity to contribute directly to the committee’s inquiry into smoking in public places.

We specifically asked our listeners to respond to the following question:

“Do you feel the Government was right to stop short of a comprehensive ban on smoking in public places?”

RESPONSE

The response was overwhelming; within two weeks we received 1,055 emails, calls and letters. They break down into 4 categories:
- 60% (626 listeners) called for a total ban.
- 22% (229 listeners) were in favour of no ban.
- 2% (12 listeners) thought the ban would be unworkable in psychiatric hospitals.
- 18% (188 listeners) other.

None of the emails, calls and letters supported the Government’s plan to introduce a partial ban.

SOME EXAMPLES OF THOSE IN FAVOUR OF A TOTAL PROGRAMME

Passive smoking

On the issue of the harmful effects of second hand smoke we received an email from Dr Barbara Hanak:

“I am a GP. This morning I saw someone who works in a restaurant and is suffering from the effects of passive smoking. He gave up smoking due to respiratory problems in 1992, but continues to suffer and needs expensive medication due to exposure to smoke at work. He is not trained in any other work. Any further delay in implementing the ban will cause lives to be damaged or lost.”

We had many emails, calls and letters from asthma suffers. Some of them believed passive smoking was the cause of their asthma. The majority found that passive smoking exacerbated their asthmatic symptoms.

Suzan Spence, a former Registered Nurse:

“I suffer from Asthma and find passive smoking affects my health. As soon as I am near a cigarette my throat tightens and causes me discomfort, followed by coughing and occasional wheezing. As an ex-Registered General Nurse I have looked after people suffering from various health problems, from throat and lung cancer to leg amputations. I find it difficult to defend the rights of people who smoke in public places.”

Brian Frank Holbrook:

“I suffer from asthma and can assure you that secondary inhalation does harm people. I can be ill for days after being in a smoky environment”.

Division between rich and poor

Julia Kilminster-Biggs, an NHS Public Health Manager from Bournemouth, and Deborah McCarthy, a stop smoking nurse specialist from Preston, both summed up many of the responses we had on the issue of the widening health inequalities gap.

Julia Kilminister-Biggs:
“I know six pubs serving a large council estate which already suffers from health inequalities. Two of these pubs serve food—both will probably stop serving food to get round the legislation. I would estimate that 40% of this estate is smokers. However, in more affluent areas of Bournemouth a smoking ban will be in place. Whose health is being protected?”

Deborah McCarthy:
“This policy will add to health inequalities between rich and poor as most pubs that don’t serve food are situated within the poorest communities. Many of my clients inform me that if all public places were smoke free it would help support them quit smoking.”

Knock of effects of a total ban

Many of our emails in this category debated the issue of whether the comprehensive ban on smoking in public places would reduce levels smoking overall. One email on this subject came from Dr. Phil Barber a Consultant Respiratory Physician at the North West Lung Centre in South Manchester, also Director of the Heart and Lung Division in the South Manchester Trust and Chair of the Greater Manchester and Cheshire Lung Network:

“I would invite anyone from your programme, or any interested politician, to visit the clinics and wards here to see for themselves the human misery caused by smoking. I really do think that you should be calling our politicians to account for resisting what the rest of the civilised world cannot wait to implement, bearing in mind that a complete ban on smoking in public places is by far the most effective way to reduce active smoking.”

This argument was also put forward in email from Dr Charles Buckley a GP in Gloucester:

“A comprehensive ban on smoking in all public houses and clubs, not just those serving food, will have a major impact on helping my patients considering quitting and as importantly reduce the relapse rate of those who have quit”.

Other professions affected

The programme has also had responses from people who work in pubs, restaurants and private member’s clubs. Many of those responses ask why their human rights are not considered as important as people who work in other public area.

David Betts, Croupier:
“I work in a Stanley casino in Margate, which as a private member’s club will be exempt from the new protections against passive smoking. I deal roulette and card games and I am therefore in very close contact with a very smoky atmosphere. Why are other staff, such as casino workers, excluded from protection? I imagine customers would be amused if I wore an aqua lung to work but I think my employers would not. If passive smoking is accepted as a risk, what measures are being put in place to assess the risk in my workplace?”

Business

You and Yours received a substantial number of emails from restaurant and bar proprietors calling for a complete ban on smoking in public places to ensure that all businesses could compete on a level playing-field.

Malcolm Schooling, owner of bar and restaurant in Sheffield:
“What a ridiculous idea it is to penalise pubs that serve fresh and healthy food by creating an uneven playing field.”

Marguerite Yeung:
“As restaurant proprietors we trialled a smoking ban a couple of years ago but suffered a decrease in turnover. We found that if one person in a group smoked they would insist the whole group go somewhere else. I was left feeling that a total ban is the only workable solution”.

Edda Locke, owner of bar and restaurant in West Hampstead, London:
“We recently tried to make our restaurant completely smoke free but had to reappraise two months later as we were 20% down on revenue. Unless there is a level playing field with a complete ban we will end up with smokers going to other establishments where they can smoke. Bars like ours which offer a continental style of drinking will be put out of business.”
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Some Examples of Those Who Oppose the Ban

Many of the 157 emails, calls and letters You and Yours received from listeners objected to, what they referred to as the Government’s apparent obsession with a “nanny state”.

Andrew Tarling, a pub landlord of 14 years, raised concerns that the Government has taken away his right to make a commercial decision about the future of his business which is, he says, part of an industry that contributes £20 billion per year to the treasury.

“I'm the landlord of The Half Moon Inn at Horsington and I have built up a successful business. I employ four full-time staff and 12 part timers. All but one of my staff, the chef and about 50% of my customers smoke. The Government has taken away my right to run my business as I wish on the grounds of employee health. I would have thought that unemployment due to business failure would be somewhat more injurious to their well-being, because the loss of smokers will undoubtedly mean lay offs and pub closures through swathes of rural England.”

Andrew Quarrie, proprietor of Exmoor Vending Services:

“I make my sole income from the operation of cigarette machines within licensed premises. This ban will completely undermine my business and probably render me, at best, unemployed or at worst, bankrupt. Why can’t the proponents of this ban accept the installation and maintenance of a smoking room that is ventilated?”

Science:

Other responses questioned the science behind a ban on smoking in public places.

Dr Phil Button:

“I have worked in the health service as a GP and an anaesthetist for 23 years. Bans have been supported by anti-smoking groups. These groups have driven their debate with the invention of ‘passive smoking’. They have used this tool to convince many that smoking is harmful to non-smokers. This is pure fiction as all the available scientific evidence fails to demonstrate any such phenomenon as ‘passive smoking’.”

Dr Ken Denson, Thame Thrombosis and Haemostasis Research Foundation:

“The scientific evidence for any deleterious effect of ETS is wholly false. It is so tenuous and equivocal that similar evidence would not seriously considered. The mean exposure alone of the passive smoker is only 1/500th of that of the active smoker. The decision as to whether ETS is harmful to others should be made in a Court of Law.”

Peta Seel a listener to the programme in France expressed her concerns that one of her husband’s last remaining pleasures was being eradicated:

“My husband has smoked since he was 18. He is now 86 and one of his few enjoyments left to him in life is to go to a restaurant and enjoy a cigarette with his drink before and also with his coffee. When we visit England he will no longer go out.”

Social Implications of the Ban

Finally, in this category of those opposed to the ban, we received an anonymous email from a secondary school teacher in Ipswich.

“My wife and I both work in schools and are both smokers. We work in very stressful situation and rely on the odd cigarette, particularly when things get a touch hairy. Prior to the recent spate of health fascism our schools has smoking rooms, hidden away from sight, well-ventilated, a place to relieve stress without causing anyone any harm. Now we are obliged to go out onto the streets to smoke, in full view of the pupils, which is appalling. The resulting stress on smokers caused by the total bans urgently should be taken into account before sickness levels rise.”

Implementation of the Ban in Psychiatric Hospitals

You and Yours only received 12 responses on this particular section of the inquiry. All of the correspondents said that smoking should be allowed to continue on Psychiatric wards.

Jessica Kate Paterson, former psychiatric patient:

“Two years ago I was a patient in the acute ward of the Royal Edinburgh Hospital where just about everyone smoked. Our lives revolved around smoking. I developed some important friendships in the smoking room. Depriving depressed or otherwise distressed patients of their cigarettes would be problematic in the extreme.”
Nicola Salt, psychiatric nurse with 20 years’ experience:

“I do not relish the idea of telling certain challenging patients that they cannot smoke, nurses will be subject to more verbal and physical abuse. Although I would like to work in a smoke free environment I do not feel that the nursing staff should be implementing the ban on smoking.”

Dr Catherine Jones, psychiatrist:

“If you are physically ill you can always refuse treatment if smoking is so important to you some of our patients can’t make that decision. Many do smoke but should only be given the option to stop when they are mentally stable and back at home. Having what many see as their last freedom taken away leaving them even more anxious and angry will make staff less rather than more safe thus, resulting in a real risk of assault.”

You and Yours Feedback

This particular programme promoted one of the largest responses we have ever had on Call You and Yours. Listeners seemed keen to be involved with a radio programme which could potentially influence Government policy.

September 2005