

October 2006

**Cancer Research UK response to the Department of Health consultation on proposed regulations to be made under powers in the Health Bill- Smokefree premises and vehicles**

**Introduction**

Cancer Research UK<sup>1</sup> is the world's largest independent organisation dedicated to cancer research, with an annual research spend of over £257 million. Our vision is to beat cancer. We carry out world-class research to improve our understanding of cancer and to find out how to prevent, diagnose and treat different types of the disease.

One of our absolute priorities is to reduce the number of people getting cancer. We know that around half of all cancers diagnosed in the UK could be prevented by changes to lifestyle and that by far the most important change an individual can make to reduce their cancer risk is to stop smoking. Smoking causes one in four cancer deaths<sup>2</sup>, and nine out of ten cases of lung cancer, which alone kills one person every 15 minutes in the UK. One in four UK adults smoke<sup>3</sup>, yet 75% of people who smoke say they would like to give up.<sup>4</sup>

We welcome the opportunity to respond to this consultation.

We would be happy to provide any further information or detail as required. Please contact the Cancer Research UK Public Affairs Department at [publicaffairs@cancer.org.uk](mailto:publicaffairs@cancer.org.uk), or on 020 7061 8360.

**Cancer Research UK position**

**Cancer Research UK strongly supports the Government's commitment to implement smokefree legislation in enclosed public places and workplaces in England. We are generally supportive of the draft regulations.**

**We fully support the Government's objectives to regulate to:**

- **reduce the risks to health from exposure to secondhand smoke,**
- **recognise a individual's right to be protected from harm and to enjoy smokefree environments,**
- **increase the benefits of smokefree enclosed public places and workplaces for people trying to give up smoking so that they can succeed in an environment where social pressures to smoke are reduced; and**

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<sup>1</sup> Registered charity no. 1089464.

<sup>2</sup> Doll R, Peto R. The Causes of Cancer. J Natl Cancer Inst 1981; 66:1191-308.

<sup>3</sup> Living in Britain: Results from the General Household Survey 2002. Office for National Statistics, 2004.

<sup>4</sup> Smoking Related Behaviours and Attitudes 2004. Office for National Statistics, 2005.

- **save thousands of lives over the next decade by reducing both exposure to hazardous secondhand smoke and overall smoking rates.**

### **Implementation date**

**We believe that the Health Act should be implemented at the earliest opportunity, as there is no case for delay. We would favour the introduction of the smokefree measures on 31<sup>st</sup> May 2007, World No Tobacco Day.**

### **Communicating the legislation**

**A high profile Government communications campaign is essential to aid implementation. Adequate advice and support must be available for employers, those responsible for smokefree premises and the general public.**

### **Smoking cessation services**

**Extra funding is needed for additional cessation services to accommodate the increased numbers that will want to quit, and to cater for groups in newly smokefree premises.**

### **Monitoring and evaluation**

**It is crucial that the legislation is adequately resourced in terms of financing and human resources in order to a) ensure compliance; b) maintain public support; c) ensure the rebuttal of potential misinformation from vested interests; and d) monitor the health and social impact of the measures (intended and unintended). An evaluation programme should be put into place as soon as possible. A critical component of this should be a pre and post implementation research and evaluation programme, as developed in Ireland and Scotland.**

### **Evaluation and review**

**We welcome the commitment to undertake a formal evaluation of the implementation of the legislation, three years after its introduction, to ensure compliance in the widest sense. We hope the Government will use this opportunity to fully consider the impact of the smokefree measures and to take any necessary steps to amend the legislation to ensure continued effectiveness. Monitoring and evaluation of the health and social impact of the measures will also be key to this.**

### **Waterpipes**

**We welcome the proposal to include premises where waterpipes are smoked, within the scope of the smokefree regulations. Specific communications informing people of this inclusion should be undertaken, to ensure the proposal is well understood.**

### **Exceptions**

**We believe there is no justification for an 'artistic exemption'; performers can and do often use fake products.**

**Any exceptions to the measures should be kept to a minimum, and should be regularly monitored with a view to increasing smokefree provision in the near future.**

**Where very limited exceptions to the legislation are granted, for example in designated hotel rooms, we believe that there should be consistency in the designation of rooms, and smoking rooms should be placed together. This should also be the case in university halls of residence.**

**It is possible for care homes, psychiatric units, hospices, prisons and other similar premises to go smokefree. Whilst we accept that some limited exceptions to the legislation will be made, we urge the Government to be clear that these premises can go further if they wish, and they should be encouraged to go smokefree where possible.**

### **Additional smokefree places**

**Though we are generally supportive of the draft regulations, we are disappointed that the Government does not currently intend to utilise the powers made under Clause 4 of the Act, which would allow for 'other places', not captured in the definition of an 'enclosed' public place or a 'substantially enclosed' public place, to be designated smokefree. This would allow the Government to classify certain types of public places, where large numbers of people congregate closely together, as smokefree, for example sports stadia bus shelters and railway stations.**

**Not doing this, as is the case in Scotland, has caused inconsistency and confusion, so that for example, not all railway stations are smokefree. We believe that by using this power, the legislation will be simpler to understand and easier to enforce.**

**Detailed comments on consultation questions:**

### **Smoke-free (General Provisions) Regulations 200X**

**Question 1: Views are invited on proposals in these regulations for no-smoking signs in smoke-free premises and vehicles.**

We are not expert in this area, and believe that others are best placed to offer comments. However, it is important that there is sufficient signage to indicate places that are to be considered smokefree. In addition, every effort should be made to ensure the signs are clear, consistent and displayed in prominent places at all times to aid understanding of the requirements of the legislation and compliance.

Furthermore:

- We support proposals to clearly identify who is responsible and guilty of an offence if the signage is not adhered to.
- The regulations should specify the person to whom complaints should be addressed.
- The compliance line telephone number should be clearly displayed in all smokefree premises.
- We recommend that signs be made of a durable material.

- The regulations should specify that signage must be displayed so that it is protected from tampering, damage, removal or concealment.
- We support the proposal to ensure that smokefree signage is displayed at all principal entrances to premises, although we believe that the definition of “public entrance” should be broadened to include any entrance reserved for staff use only.
- If there are any open areas on the premises where smoking is permitted, such areas should be identified on the signs.
- Signs in vehicles designated as smokefree after the regulations come into effect and therefore not displaying existing signage (including new public transport vehicles) should have to carry the analogous words to those in smokefree premises (e.g. “it is against the law to smoke in this vehicle”).

**Question 2: Views are invited on proposals in these regulations for the enforcement of smoke-free legislation.**

We are generally supportive of the proposed approach to enforcement; legislation that is well communicated and understood should be largely self-enforcing. It is crucial that a supportive environment is created, where compliance is encouraged and education, advice and support are offered to those charged with enforcing the measures.

Others are better placed to comment on the proposals relating to the designated enforcement authorities for the legislation. However, we note that a number of workplaces, including prisons and Ministry of Defence estates, are normally the preserve of the Health and Safety Executive (HSE) for enforcement purposes. We do not believe it would be in the spirit of the legislation to exclude people working in, or visiting, such premises from protection from secondhand smoke, and would therefore like to see the role of the HSE detailed more clearly in the regulations and supporting guidance. Empowering the HSE may also be helpful should any local authority officer encounter difficulties in enforcing the law within their own premises and vehicles.

The wording of the consultation document on the matter of responsible bodies for enforcement initially gave rise to some confusion, and the subsequent clarification issued by the Department of Health, to include district councils in two tier authorities as enforcement authorities, was helpful.

**Smoke-free (Exemptions and Vehicles) Regulations 200X**

**Question 3: Views are invited on proposals in these regulations for private accommodation, especially on proposals where private dwellings are also a workplace.**

We are generally supportive of the proposals in the regulations relating to private accommodation, and in particular the proposals relating to private dwellings which are also considered a workplace. We are pleased, for example, that dormitories and other communal areas that members of the public and workers have access to in residential premises, are to be considered smokefree.

However, we believe it is essential that relevant employers (including local Councils and the NHS) develop policies on how smoking during residential visits will be addressed and implement them before smokefree legislation comes into force. Care workers, cleaners and others working in private homes have as much right as

anyone else not to have their health affected by exposure to secondhand smoke. Employers who do not adopt effective policies in this area risk legal action under health and safety legislation, and possibly human rights legislation, if their employees' health suffers as a result. Useful guidance on these issues has been issued by the Royal College of Nursing.

**Question 4: Do these proposed regulations cover the types of residential accommodation that should be exempted under smoke-free legislation?**

The overriding view of Cancer Research UK and the Chartered Institute of Environmental Health (CIEH) is that if limited exceptions to the smokefree legislation are granted, measures to minimise exposure of others to secondhand smoke and to protect the worker should be taken. In addition, there is still a duty of care on the employer to protect workers from workplace hazards and growing acceptance that the Health and Safety at Work etc. Act 1974 will apply.

**We strongly believe that wherever possible, all enclosed premises should be smokefree. 'Residential exemptions' and more general exceptions should therefore be kept to a minimum. In addition, staff should not be allowed to smoke while on duty in their workplace.**

Cancer Research UK believes that where limited exceptions to the legislation are granted, **premises should be obliged to review their arrangements in the future, to strengthen their policies with a view to going smokefree.** The Government should also consider whether staff have the right to opt out of working in places where they might be exposed to secondhand smoke.

We believe that individual premises should also take appropriate measures to minimise secondhand smoke exposure and minimum standards must be clearly outlined and we are supportive of the draft regulations in this respect. For example:

- We support the stipulation that where exceptions are agreed, they should not be granted for communal areas;
- If care is being provided, patients should not be able to smoke when particular treatment or care is being administered by a member of staff;
- We believe that all precautions must be taken to limit the migration of smoke from a smoking room to the rest of the non-smoking environment;
- The status of rooms as smoking or non-smoking should not change, except to add more non-smoking rooms, or enhance overall non-smoking provision;
- Members of the public, when visiting such places, should be given adequate protection; and
- There should be readily accessible and appropriate smoking cessation services that are part of individuals'/patients' care plans. Senior members of staff should regularly review these.

### Prisons

We believe that prison officers, other prison staff, and inmates have as much right to protection from secondhand smoke as individuals in any other setting. We recommend that the Government works in partnership with the prison service to develop a comprehensive strategy for increasing smokefree provision in prisons in England.

**It is possible to go further.** Smokefree policies have been successfully introduced in a number of long stay institutional establishments and have been supported by readily accessible smoking cessation services.<sup>5</sup> Willingness to abide by a smokefree policy has also been suggested as a condition of acceptance into other long-term but voluntary places e.g. nursing homes and hospices.<sup>6</sup>

Best practice examples:

**(1) HM Young Offenders' Institution in Wetherby went completely smokefree in January 2004.**

The Governor, Paul Foweather, gave evidence to the Health Select Committee as part of the Committee's 2005 Inquiry into Smoking in Public Places. Mr Foweather reported that he has successfully achieved a smokefree environment at the institution, thereby creating a healthier environment for staff and trainees; 69% of trainees reported that they had previously tried to quit without success.

Mr Foweather was spurred to act after consideration of the implications of the Health and Safety at Work Act (1974), to ensure the safety of his employees and due to the young age of some of the trainees (a proportion are fifteen years old and therefore cannot legally purchase tobacco outside the institution).

We believe it would be possible to role out this example of good practice across other similar institutions.

**(2) Norfolk and Waveney Mental Health Partnership NHS Trust introduced a smokefree policy in enclosed places on its premises in April 2004.**

The decision to go smokefree was taken for two reasons: firstly, to meet the Trust's obligations under the Health and Safety at Work Act (1974) to protect employees and secondly, to support service users with severe mental health illness who would have additional health difficulties if addicted to tobacco.

The Director of Modernisation and Strategic Development at the Trust, Mr Paul Thain, reported on the success of the policy to the Health Select Committee in late 2005. The Trust is considering going completely smokefree throughout its premises in light of the success to date and Mr Thain does not support blanket exemptions for psychiatric units in the Health Act.

In addition, a recent review of smoking bans in mental health and addiction institutions in the US highlighted that partial or total smoking bans resulted in 'no major long-standing untoward effects in terms of behavioural indicators of unrest or compliance.'<sup>7</sup>

**(3) South Essex Partnership NHS Foundation Trust introduced a smokefree policy in August 2006.**

The Trust, comprising of 5 forensic medium secure units, 2 low secure units, 4 adult acute units, 2 ICU, 4 older people's wards, 3 community-based homes and 7

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<sup>5</sup> el\_Guebaly N, Cathcart, J, Currie S et al. Public health and therapeutic aspects of smoking bans in mental health and addiction settings. *Psychiatric Service[s]* Dec 2002; 53: 1617- 22.

<sup>6</sup> *Ibid.*

<sup>7</sup> Hempel AG, Kownacki R, Malin DH et al. Effect of a total smoking ban in a maximum security psychiatric hospital. *Behav Sci Law* 20:507-22 (2002).

community rehabilitation units recently (28<sup>th</sup> August 2006) introduced a smokefree policy. Smoking facilities are no longer provided within the confines of the Trust's wards or homes.

The Director of Inpatients and Emergency Planning, Eunan MacIntyre, indicated at the Smokefree Mental Health Conference organised by the Tobacco Control Collaborating Centre in October 2006 that compliance has been high and the measure has been welcomed and also embraced by service users. Staff and service users alike have been fully supported and assisted in accessing smoking cessation services. He also reported that anecdotally it was staff who displayed greater levels of dissatisfaction with the policy, although even this was at relatively low levels.

**(4) Priscilla Bacon Lodge, an NHS palliative care unit, introduced a smokefree policy in 2003.**

A small conservatory area was designated for patients that wanted to smoke, and all staff and patients were informed of this in advance of the policy coming into force. The rest of the premise was designated as smokefree.

The policy has been successfully implemented, with high compliance rates by both staff and patients.

We hope that the exemption of some residential premises will not lead to greater health inequalities among certain groups. For example, there is very high smoking prevalence among mental health service users. We would not wish to see the gap between average prevalence and prevalence among mental health facility residents widen. **It is imperative that efforts to create smokefree environments and encourage cessation are not neglected in more challenging settings.**

**Question 5: Views are invited on proposals in these regulations for exempting performers from smoke-free legislation. Are the arrangements adequate enough to prevent the development of loopholes, while providing adequate flexibility to uphold the artistic integrity of performance?**

Cancer Research UK does not support the proposed exemption for performers. We do not see the justification for the exception as performers can and do use fake products, and we believe use of such products would ensure that the artistic integrity of performances is upheld.

We believe that the proposed exception could lead to the spirit of the legislation being compromised. There are clearly difficulties in defining circumstances where smoking on stage or on film is 'essential to the artistic integrity' of a production. An exemption of this nature will make the legislation more difficult to enforce and has the potential of compromising compliance.

It is important that efforts are taken to undermine the perception of smoking as a glamorous activity. We believe the proposal as currently drafted could enable smoking to be portrayed in this way.

**Question 6: Views are invited on proposals in these regulations for exempting research and treatment facilities.**

We accept that an exception to the smokefree legislation should be made for research and treatment facilities. However, we urge that the regulations are

sufficiently tight to ensure that the spirit of the legislation is upheld, that only designated areas in research and treatment facilities are exempted, where absolutely necessary, and that staff in such premises are not generally permitted to smoke.

**Question 7: Views are invited on the specific conditions for exempted premises proposed in these regulations to ensure that protection from secondhand smoke is provided.**

In communicating the detail of the legislation to the public, the Government should make clear that there is no obligation for persons in control of premises where limited exemptions are granted, to allow smoking.

We welcome the flexible nature of the regulations, the recognition within them that all premises are unique and that owners and managers should be allowed to make decisions about whether to implement exceptions granted to them.

We support the conditions for premises with designated rooms for smoking. It is crucial that these conditions are communicated to all, ahead of implementation of the legislation.

**Question 8: Views are invited on proposals in these regulations to make certain vehicles smoke-free.**

We are generally supportive of the proposals to make certain vehicles smokefree. However, we would wish to see rented vehicles treated in the same way as hotel rooms, i.e. the owner or manager would designate and sign vehicles as either smokefree or not. This designation should be communicated in all advertising material.

**Additional smokefree places**

We urge the Government to utilise the powers under Clause 4 of the Act, to designate certain other places as smokefree.

We are concerned that the current proposals will create confusion. For example, many railway stations will be entirely smokefree because they will be captured in the definition of a 'substantially enclosed' public place. But many small stations will not be smokefree on the platforms and in some other parts. This scenario will make enforcement more difficult and will potentially cause problems for train operators. It will also involve some risk to health for waiting passengers exposed to secondhand smoke. Similar situations will occur at bus shelters and in sports stadia.

We believe it would be sensible for the Government to develop a list of 'additional' places, not captured in the definition of an 'enclosed' or 'substantially enclosed' public place, but where large numbers of people congregate closely together, and designate them as smokefree.

**Smokefree (Penalties and Discounted Amounts) Regulations 200X**

We urge that the communications preceding implementation will ensure that messages about the three types of offence are clearly conveyed, as well as the levels of penalties and information about how penalties will be collected. Different types of communications will be needed to inform different audiences.

To aid compliance, we support clear guidelines relating to the treatment of repeat offenders. For pub, bar and membership club managers who fail to prevent smoking on their premises on a regular basis there should be an ascending scale of fines together with the ultimate deterrent of withdrawal of a license to sell alcohol. This could prove important in discouraging a small minority of publicans, for example, from attempting to defy the legislation and hence undermine it more widely.

It is crucial that flexibility is built into the legislation in order that there can be regular review of the level of penalties, to ensure continued appropriateness. Similarly, we believe it is important that the level of penalties is considered appropriate in relation to comparable enforcement measures (for example, food safety regulations).

It is also important that those responsible for implementing the legislation are offered support to collect penalties and enact effective disciplinary policies.

Guidance should be issued to assist businesses in the development of written policies. The Scottish Executive developed guidance of this nature.