CONSULTATIVE DOCUMENT

THE DRAFT SMOKING (NORTHERN IRELAND) ORDER 2006

QUESTIONNAIRE

March 2006

INTRODUCTION

Purpose

This Questionnaire seeks views on the **Draft Smoking (Northern Ireland) Order 2006** (the draft Order) which will introduce comprehensive controls to protect employees and the public from exposure to second-hand smoke. Comments would be particularly welcomed on a number of key areas:

- the definition of smoking;
- the definition of smoke-free premises;
- the extent of any proposed exemptions;
- offences and level of penalties;
- requirement for fixed penalties; and
- the power to raise the age limit for sale of tobacco to young people.

The Department of Health, Social Services and Public Safety (the Department) carried out an Integrated Impact Assessment (IIA) screening exercise on the proposed legislation. The results, which include equality considerations and a partial Regulatory Impact Assessment, are set out in the IIA Overview.

Background

On 17 October 2005, Shaun Woodward, Minister for Health, Social Services & Public Safety, announced his intention to introduce legislation by April 2007 to protect employees and the public from exposure to second-hand smoke. He also indicated that he would seek views on specific issues such as exemptions and penalties. This followed a public consultation exercise carried out by the Department between December 2004 and March 2005, on options to strengthen existing controls on tobacco use. The consultation elicited over 70,000 responses with 91% of respondents expressing support for comprehensive controls. In framing the draft Order, account was taken of similar legislation and proposals in Scotland and England.

Responses to this Questionnaire must be received by not later than 5.00pm on Friday 5 May 2006.

***In order to facilitate analysis it is important that respondents use the Questionnaire*.**

Responses to this consultation may be made online at:

http://www.dhsspsni.gov.uk/index/consultations/current_consultations.htm

QUESTIONNAIRE

Q1. *Article 2 (a) and (b)* of the draft Order defines "smoking" as covering all lit tobacco or any other lit substance in a form which could be smoked, for example, herbal cigarettes. This is to avoid enforcement difficulties in cases where smokers claim their cigarettes do not contain tobacco.

Do you agree with the definition of smoking as set out in the draft Order?

Yes ❑4 **No** ❑

If you wish to comment, please do so here.

It is good to see the inclusion of herbal cigarettes in the definition.

Q2. *Article 3* of the draft Order defines "smoke–free premises".

Do you agree with the definition of smoke–free premises as set out in the draft Order?

Yes ❑4 **No** ❑

If you wish to comment, please do so here.

N/A

Q3. *Article 4* of the draft Order provides for the Department to make regulations to specify premises or parts of premises not to be smoke-free. In accordance with the Minister's announcement, the intention is that these exemptions will be limited and *Article 4(3)* specifically precludes exemptions in respect of licensed premises. ***The regulations will be the subject of a separate consultation later in the year.*** However, the Department is taking this opportunity to seek views. There are premises which act as a person's home, either on a permanent or temporary basis, but which are also another person's workplace, for example, residential accommodation, hotel bedrooms, prisons and psychiatric facilities. Different approaches to this issue have been adopted by other jurisdictions. In the Republic of Ireland psychiatric hospitals are exempt. In Scotland designated rooms in psychiatric hospitals are exempt while in New York it is necessary to apply for a waiver.

Set out below are examples of premises that serve as a person's home, either on a temporary or permanent basis.

Do you think that hotel bedrooms, designated rooms, or areas within the following premises should be exempt?

Hotel Bedrooms	**Yes**	❑	**No**	❑4	**Don't know**	❑
Care Homes	**Yes**	❑	**No**	❑	**Don't know**	❑
Psychiatric Units	**Yes**	❑	**No**	❑4	**Don't know**	❑
Prisons	**Yes**	❑	**No**	❑	**Don't Know**	❑

Do you wish to suggest any other exemptions? If yes, please specify below.

Exemptions should be kept to a minimum. 'Sensible' implementation of the order should include 'case by case' decision making, where residents, patients or clients are involved. There should be no blanket exemptions.

No. Hotel rooms present no convincing argument for exemption.

Care Homes

Perhaps in some cases, but prefer to see 'case by case' decision making by nurse in charge or doctor in charge and written into notes/records along with how this will be implemented.

Psychiatric Units

No, they should not be exempt. However, a local protocol would be needed that would allow for 'case by case' decision making by nurse in charge/doctor in charge and provision made accordingly.

Prisons

Possibly**.** Prisons are not exempt in New York.

Do you wish to suggest any other exemptions? If yes, please specify below.

As previously stated exemptions should be kept to a minimum.

Rather than giving examples of possible exemptions, there is a need to establish fundamental principles and criteria under which any premises should be exempt.

For example:

- The length of time someone will be likely to stay in a premises – such as long-stay psychiatric units. However, also need to be mindful of protecting non-smoking patients from the harmful effects of Environmental Tobacco Smoke (ETS).
- Mobility - are people able to move freely due to either existing medical conditions/limitations and potentially external physical restraints.
- Criteria may also include humane issues - such as palliative care, respite homes.
- Hostels for homeless people may be an area that needs to be considered.
- The extent to which staff are placed at risk. A premise could not be exempt if staff would be expected to work for significant periods of time in close proximity to second-hand smoke, such as may be the case in prisons.
- Any premises which may be designated 'exempt' should be 'smoke-free' with exempt status allowing only for a restricted area for smoking and this should apply only to those living there and not to staff or visitors.
- Any provision for exemptions should be kept under constant review.
- Regulations, principles or criteria that may be developed, as a result of the order, should also emphasise that the key issue is eliminating risk for staff and others.
- In addition, the HPSS should be seen to send out a message to the wider public that smoking is harmful to health. Therefore hospitals should not be designated 'exempt' but employ 'sensible' case by case decision making in the local implementation of the Order.

Additional comments:

Psychiatric facilities

The Consultation document makes references to psychiatri*c hospitals*, psychiatric *settings* and psychiatric *units*. It has been suggested that there is no evidence to support smoke free legislation treating psychiatric patients differently from other medical patients. Under the criteria suggested the issue would not be the nature of the illness but the average duration of stay on the premise.

It is important that we are mindful of the need to protect psychiatric patients who do not smoke. If a provision is made for psychiatric units/facilities in general to be exempt - we are at risk of failing to protect psychiatric patients who may already experience many inequalities in health. Therefore this move may contradict the Government's public health strategy *Investing for Health* which focuses on tackling inequalities.

A survey of psychiatric nurses carried out by the Royal College of Nursing (RCN) found that around two-thirds of respondents said that psychiatric hospitals should not be exempt in impending legislation.

Prisons

In considering whether or not prisons should be exempt, we would advise that the DHSSPS consider evidence from prisons elsewhere which have successfully achieved 'smoke free', status.

Ashfield Young Offenders Institute, for example, is a prison in South Gloucestershire that accepts remand and sentenced young people between the ages of 15 and 18. A smoke-free policy was introduced on 1st February 2005. Smoking is not permitted within It is important that we are mindful of the need to protect psychiatric patients who do not smoke. If a provision is made for psychiatric units/facilities in general to be exempt - we are at risk of failing to protect psychiatric patients who may already experience many inequalities in health. Therefore this move may contradict the Government's public health strategy *Investing for Health* which focuses on tackling inequalities.

A survey of psychiatric nurses carried out by the Royal College of Nursing (RCN) found that around two-thirds of respondents said that psychiatric hospitals should not be exempt in impending legislation.

Smoking is not permitted within the prison by staff or the young offenders and all tobacco related products are banned.

Q4. *Articles 7, 8, 9 and 12* of the draft Order sets out the following four offences and penalties:

(i) a person failing to display the prescribed no-smoking signs in smoke-free premises commits an offence and is liable on summary conviction to a fine not exceeding level 3 on the standard scale (£1,000);

(ii) a person who knowingly smokes in smoke-free premises commits an offence and is liable on summary conviction to a fine not exceeding level 3 on the standard scale (£1,000);

(iii) a person who controls or is concerned in the management of smoke-free premises and fails to prevent a person smoking in a smoke-free place commits an offence and is liable on summary conviction to a fine not exceeding level 4 on the standard scale (£2,500); and

(iv) a person who intentionally obstructs an authorised officer of a district council acting in exercise of his duties under the Order commits an offence and is liable on summary conviction to a fine not exceeding level 3 on the standard scale (£1,000).

Do you agree with the offences and level of penalties set out in the draft Order?

Yes ❑ **No** ❑4

If you wish to comment, please do so here.

No.

The offence of smoking in a smoke-free premise and the offence of not displaying appropriate signage should get a lesser penalty than the owner of the premises. The suggested offences shift responsibility to managers not owners. Owners should take overall responsibility. However, not all premises will have an individual owner and this would often be the case in the healthcare sector.

The fines cited are for successful prosecution and we would advise that the burden of proof be on the defendant rather than the prosecution. Also, the level of penalties at the level cited is the maximum level. There is no obligation on a court to impose the maximum level.

Q5. *Article 10* of the draft Order provides for an authorised officer of a district council to issue a fixed penalty notice where he believes an offence has been committed under Articles 7, 8 or 9. Schedule 1 makes further provision about fixed penalties. The levels of fixed penalties will be specified in regulations which will be the subject of consultation this year.

Do you agree with the fixed penalty notice procedures as set out in the draft Order?

Yes ❑ **No** ❑4 **Don't know** ❑

If you wish to comment, please do so here.

No

There should not be fixed penalties. This could potentially undermine the legislative message as people may be happy enough to pay the £50 fine, as it is not excessive.

Fixed penalties have not been used in the Republic of Ireland. Instead offences lead to prosecution and a fixed fine. Compliance rates have been very high in the Republic of Ireland, with very low prosecution rates. A similar policy of zero tolerance would be preferred.

Q6. Tobacco control measures are currently enforced by Environmental Health Officers of district councils.

Do you agree that smoke-free legislation should also be enforced by district councils?

Yes ❑4 **No** ❑ **Don't know** ❑

If not, please state your reasons below.

Yes. This will allow links to be made to wider public health issues. Councils are already represented on the area Tobacco Control Groups. Councils will also have a community planning role in the future which will enable them to take a strategic view of smoking and related health issues.

However, further discussion around enforcement roles of the Health and Safety Executive for Northern Ireland and Environmental Health Departments within local Councils is required to ensure a co-ordinated approach to enforcement.

Q7. At present *Articles 3 and 4* of the Health & Personal Social Services (Northern Ireland) Order 1978 make it an offence to sell tobacco products to young people under 16. In the Republic of Ireland, the Health (Miscellaneous Provisions) Act 2001 increased the age limit from 16 to 18 and in Scotland the Smoking, Health & Social Care (Scotland) Act 2005 provides the power to raise the age limit there. The draft Order provides the power *(Article 14)* for the Department to raise the age limit from 16. Any proposal to raise the age limit would be the subject of further consultation.

Do you agree that the Department should take this power?

Yes ❑4 **No** ❑ **Don't know** ❑

If you wish to comment, please do so here.

Absolutely agree with this proposal and recommend that the DHSSPS take the power as soon as possible.

Increasing the age to 18 will be consistent with alcohol legislation and that for butane gas and knives etc. It will emphasise the serious risk which tobacco smoking poses to health, as well as potentially facilitating an integrated approach to enforcement. It will also align Northern Ireland legislation with Republic of Ireland legislation and therefore reduce the potential for inconsistencies in approaches to tobacco sales amongst border counties.

In a paper on the proposal to raise the age to 18 in Scotland, ASH Scotland emphasised as a stand alone measure this may not make a difference. There are also concerns that it may make smoking appear more adult and therefore more desirable as a mechanism for rebelling. This change in legislation would therefore need to be part of a wider package of measures including, for example, the forthcoming smoke-free legislation, smoking cessation activities aimed at young people, enforcement and education.

Enforcement is a big issue that requires further consideration, including child protection issues, around test purchasing.

Although underage smokers are sometimes able to purchase cigarettes, raising the legal age to 18 should make it harder for those under 16 to pass themselves off as the legal age. Although, it is unlikely that this would have any impact on the illegal sales of tobacco products from other sources.

INTEGRATED IMPACT ASSESSMENT OVERVIEW

General

Q8. Do you have any views on the conclusions reached by the Department to screen out from further assessment the implications of the draft Order in respect of:

- **(a) Social Impact Assessment (New TSN, Homelessness etc);**
- **(b) Rural (see Q21 –Q23);**
- **(c) Environmental;**
- **(d) Human Rights;**
- **(e) Victims;**
- **(f) Community Safety & Other Areas?**

Is there any other evidence which you consider should have been taken into account in these assessments?

Equality

Comments are welcome on any aspect of the draft equality conclusions contained in Annex 2 of the Integrated Impact Assessment Overview (IIA). The Department would particularly welcome comments on the following:

Q9. Do you agree with the decision that the draft Order does not require a full equality assessment? (see Annex 1 and Annex 2 of the IIA Overview). If not, please explain why?

Yes

Q10. Is there any other qualitative or quantitative information which you consider should have been taken into account in performing this exercise?

No

Q11. Are you aware of any evidence – qualitative or quantitative that the draft Order may have an adverse impact on equality of opportunity or on good relations? If so, please provide details. Can you suggest any ways of avoiding or minimising such adverse impact?

No

Q12. Are you aware of any other equality implications likely to arise from the draft Order?

There will be benefits to staff in workplaces which have traditionally employed staff from lower socio-economic groups and where staff may currently be exposed to high levels of second hand smoke, for example, factories, bars and working clubs.

Partial Regulatory Impact Assessment (RIA)

(see Annex 3 of IIA Overview)

Health

Q13. Do you have any views on the assessment of health impacts?

Commend the work done on the health impact assessment of the proposed legislation.

Q14. Are there any other potential health impacts that you consider should have been addressed?

Some other positive impacts might be the benefits of smoke-free workplaces to women who are pregnant.

The predicted impact of a 2% reduction in smoking prevalence may also have been underestimated. The Wanless Report refers to studies estimating a workplaces smoking ban in England might reduce smoking prevalence by around 4%, and acknowledges that although this may be an overestimate, it might also be an underestimate if the legislation triggers a move to wider cessation.

Q15. Is there any other material evidence which you consider should have been taken into account in this assessment of health impacts?

Some of the more recent research from Republic of Ireland, notably "How Smoke-free Laws improve air quality: A global study of Irish pubs".

Economic

Q16. Do you have any general comments on the overall approach that was taken in completing the RIA?

We support the approach taken. The RIA is a very comprehensive and detailed piece of work.

Q17. Do you consider that there are other issues which need to be taken into account in the assessment of the impact on business?

No

Q18. Do you agree with the analysis of the sectors and business/organisations which might be particularly affected by the introduction of this policy?

Yes. But based on the research commissioned by the Scottish Executive, the main benefit may be from a reduction in smoking breaks. This is an important point which may be worth highlighting to especially to SME's as part of the DHSSPS smoke-free legislation communications strategy.

Q19. What are your views on the identification and assessment of the costs and benefits?

DHSSPS has assumed signage costs will be met by individual business'. It may help compliance if there was central production and distribution of all signage.

Public Expenditure and Public Service

Q20. Do you agree with the Department's view that a separate Economic Appraisal is not required?

Yes

Rural Proofing

Q21. Do you agree that the draft Order will not have a disproportionate adverse impact on rural business?

No rural impact

Q22. Are there any rural impacts that you consider should have been addressed?

No

Q23. Is there any other material evidence which you consider should have been taken into account in this assessment of rural impacts?

No

Additional Comments

Q24. Do you have any other comments or suggestions on the draft Order and/or the Integrated Impact Assessment Overview?

The Northern Ireland Human Rights Commission (NIHRC) has stated that it recognises as a human right the right of all bar workers in Northern Ireland to protection from exposure to smoke and that Government is therefore obliged to adopt and implement legislative or other measures providing effective protection. This should be referred to in the integrated impact assessment.

A document, produced by the NIHRC for the Health Promotion Agency, on the existence of a human right to health, and on the possibility that a partial smoking ban in bars; may lead to bar workers who are denied protection from second-hand smoke, taking their case to the European Court of Human Rights.

Could the same issue, and course of action, apply to HPSS staff who are faced with this issue during the course of their day on visits to patients/clients homes etc?

Thank you for taking time to complete this Questionnaire.