



Investing for Health Team (Tobacco Control)

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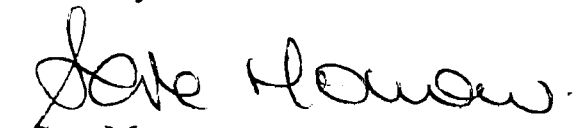
To whom it may concern

Please find attached a response to the Draft Smoking (Northern Ireland)
Order 2006 Consultation from Northern Ireland Chest Heart and Stroke.

This has also been submitted today via the online response form.

I would be grateful if you would acknowledge receipt of this fax by email to
smorrow@nichsa.com or telephone (028 9026 6714).

Thank you


Sara Morrow
Research and Advocacy Co-ordinator

NORTHERN IRELAND CHEST HEART AND STROKE

Response to

*The Draft Smoking (Northern Ireland) Order 2006
Public Consultation*

April 2006

Northern Ireland Chest Heart and Stroke has campaigned for many years on the issue of smoking, especially given the link between smoking and cardiovascular disease. More recently, Northern Ireland Chest Heart and Stroke has been an active member of the Smokefree Northern Ireland Coalition.

To put the importance of The Smoking (Northern Ireland) Order 2006 into context, passive smoking can increase the risk of a stroke by 82%¹. Stroke is the largest cause of long-term disability in our community. The cost of stroke to the health service is crippling. The approximate cost of stroke (direct health care cost only) in 1999 was £43 million in Northern Ireland²

In addition, The Government's Scientific Committee on Tobacco and Health (SCOTH) concluded in 1998 that passive smoking causes lung cancer, heart disease, cot death, middle ear disease and triggers asthma attacks.

This legislation will introduce comprehensive controls to protect employees and the public from exposure to second-hand smoke. Indeed, the Northern Ireland Human Rights Commission agreed that protection for workers [from smoke] was a human rights issue.

Northern Ireland Chest Heart and Stroke welcomes The Draft Smoking (Northern Ireland) Order 2006 and would like to make the following comments in response to the questionnaire.

¹ Passive smoking as well as active smoking increases the risk of acute stroke. Bonita *et al*/ Journal of Tobacco Control 1999; 8: 156 - 160

² British Heart Foundation www.heartstats.org cited by FSA in Consultation on proposed targets for levels of salt in key food categories that contribute most to intakes

QUESTIONNAIRE

Q1. Do you agree with the definition of smoking as set out in the draft Order?

Yes

If you wish to comment, please do so here.

Northern Ireland Chest Heart and Stroke welcomes the inclusion of herbal cigarettes in the definition. While the precise health risks of herbal preparations are uncertain, the presence of smoke causes discomfort and can provoke illness in susceptible individuals, such as those with asthma.

Q2. Do you agree with the definition of smoke-free premises as set out in the draft Order?

Yes

If you wish to comment, please do so here.

N/A

Q3. Do you think that hotel bedrooms, designated rooms, or areas within the following premises should be exempt?

Hotel Bedrooms No. Northern Ireland Chest Heart and Stroke firmly believes that hotel rooms present no convincing argument for exemption

Care Homes

Psychiatric Units

Prisons

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

Northern Ireland Chest Heart and Stroke does not wish to suggest any other exemptions but would like to make the following comments:

There is evidence that a comprehensive smokefree legislation is easier to enforce than smoking restrictions. Restriction means that smoking is allowed in some areas and prevented in other areas, leading to confusion and disputes. Compliance with the legislation in Ireland and Norway improved when total restrictions were introduced in 2004 (source: Lifting the smokescreen. 10 reasons for a smoke free Europe. Published by the Smoke Free Partnership, 2006. Available online at www.ersnet.org)

Northern Ireland Chest Heart and Stroke believes that there is a need to establish fundamental principles under which any premises should be exempt, rather than giving examples of possible exemptions.

We suggest that criteria are established which a premise must meet in order to be exempted.

Recommended criteria include:

- the mobility which people within the premise have to smoke outside (e.g. are they unable to move freely due to either medical limitations to external physical restraints)
- humane issues (such as might apply to palliative care homes) and
- the extent to which staff are placed at risk (i.e. 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 are exempt should be no-smoking premises with exempt status allowing only for a restricted area for smoking. In premises which are exempt, exemption should apply only to those living there and never to staff or visitors.

Regulations should also emphasise and remind that the key issue is eliminating risk for staff and others.

Smoking cessation support should be available to both residents and staff.

Hostels for homeless people may be a premise which needs to be considered.

Northern Ireland Chest Heart and Stroke believes that any provision for exemptions should be kept under constant review.

Psychiatric units - additional comments

Northern Ireland Chest Heart and Stroke noted that the Consultation document makes references to *psychiatric hospitals*, *psychiatric settings* and *psychiatric units*. There is no clear definition of the kind of premise it intends to be exempt.

Current research (Lawn, S and R, Pols. "Smoking bans in psychiatric inpatient settings? A review of the research." Australian and New Zealand Journal of psychiatry 2005; 39:866-885) suggests that there is no evidence to support smokefree legislation treating psychiatric patients differently from medical patients, and 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 to remember the need to protect psychiatric patients, and staff, who do not smoke. Northern Ireland Chest Heart and Stroke believes that general provisions for psychiatric units to be exempt risk failing to protect psychiatric patients who already experience many inequalities in health, and therefore may contradict the Government's public health strategy *Investing for Health* which focuses on tackling inequalities.

Smoking cessation support should be available to both patients and staff.

Prisons – additional comments

In considering whether or not prisons should be exempt, Northern Ireland Chest Heart and Stroke would advise that the DHSSPS consider evidence from prisons elsewhere which have successfully gone smokefree, for example, Ashfield Young Offenders Institute, a prison in South Gloucestershire which accepts remand and sentenced young people between the ages of 15 and 18, introduced a smoke-free policy on 1st February 2005. Smoking is not permitted within the prison by young offenders or staff and all tobacco related products are disallowed.

Furthermore, increasing numbers of jails in the United States have become smoke-free. Most experience so far has shown the feared difficulties arriving when facilities become completely tobacco-free (US experience of smoke-free prisons Lincoln *et al* BMJ 2005; 331:1473).

Smoking cessation support should be available to both residents and staff.

Q4. Do you agree with the offences and level of penalties set out in the draft Order?

No

If you wish to comment, please do so here.

Northern Ireland Chest Heart and Stroke agrees with the differentiation in penalties, and that that the offence of smoking in a smokefree premise and the offence of not displaying appropriate signage should get a lesser penalty than the owner of the premises.

We agree that the largest penalty should be for whoever owns or is responsible for the management of the smokefree premise, but have concerns that the suggested offences shift responsibility to managers not owners. Northern Ireland Chest Heart and Stroke believes that owners should take responsibility.

By making the owner responsible we believe that there is much greater likelihood that the full range of measures necessary to ensure the success of this intervention will be implemented prior to the legislation coming into force, including staff training and smoking policies. This in turn would be likely to increase compliance and reduce the need for significant implementation effort.

It is noted that not all premises will have an individual owner, for example healthcare services. In this instance, the most senior manager or Chief Executive should be responsible.

Northern Ireland Chest Heart and Stroke is concerned at the level of penalties, as the level cited is the maximum level and there is no obligation on a court to impose the maximum level.

In the case of 'a person who controls or is concerned in the management of smoke-free premises... etc', consideration should be given to increasing the fine to level 5 on the standard scale (£5,000) which would keep the offence within the context of other health and safety issues.

Northern Ireland Chest Heart and Stroke believes that peer pressure and public acceptance of the smoke-free workplace legislation will be the most effective method of implementing the regulations. We note that there have been relatively few prosecutions in the Republic of Ireland due to the unanimous acceptance of the smoke-free workplace legislation in the ROI.

Q5. Do you agree with the fixed penalty notice procedures as set out in the draft Order?

No

If you wish to comment, please do so here.

Northern Ireland Chest Heart and Stroke does not agree there should be fixed penalties. We believe that fixed penalties will undermine the legislative message as smokers may prefer to take a chance and break the law if they only have to pay a relatively small fine.

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. Northern Ireland Chest Heart and Stroke strongly recommends a similar policy.

The use of fixed penalty notices in Northern Ireland may also in practice create different regimes in cross-border areas.

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

This will allow links to be made to wider public health issues. District councils already have links with the four Tobacco Control Groups, and will have a community planning role in the future which will enable them to take a strategic view of smoking and related health issues.

Northern Ireland Chest Heart and Stroke believes that there should be a statutory requirement for each council to lay out their strategic plan for compliance every three years, and operational plan on a yearly basis.

If not, please state your reasons below.

N/A

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

If you wish to comment, please do so here.

Northern Ireland Chest Heart and Stroke agrees with this proposal and also recommends that the DHSSPS take the power as soon as possible.

We believe that changing the age to 18 will ensure a consistent message in line with butane gas and alcohol, which emphasises the serious risk which tobacco smoking poses to health. This measure also has the potential to facilitate an integrated approach to compliance. It will align Northern Ireland legislation with Republic of Ireland legislation and therefore reduce the potential for inconsistencies in approaches to tobacco sales amongst border counties.

Northern Ireland Chest Heart and Stroke would also like to make the following comments:

In a paper on the proposal to raise the age to 18 in Scotland, ASH Scotland emphasised that, as a stand alone measure, this proposal may not make a difference on its own. There were 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 smokefree legislation, smoking cessation activities aimed at young people, compliance and education.

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.

Compliance is a real issue which still needs to be considered.

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

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.

The equality section does not refer to the Partial Regulatory Impact Assessment, and we believe that there is a need to acknowledge in the equality section the potential unequal impact on employment of Protestants in the Ballymena area if the existing tobacco factory there were to be relocated due to closure of its Research and Development branch.

Partial Regulatory Impact Assessment (RIA)

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

Northern Ireland Chest Heart and Stroke supports 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 included, for example, the educational benefits of smokefree schools, in terms of the staff-rooms, and the benefits of smokefree workplaces to workers who are pregnant.

The predicted impact of a 2% reduction in smoking prevalence may also have been underestimated; Northern Ireland Chest Heart and Stroke notes that the Wanless Report (Wanless, Derek "Securing Good Health for the Whole Population" Department of Health 2004.) refers to studies estimating that comprehensive legislation preventing smoking in workplaces 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.

Research by Dr Ann McNeill and others indicate that there have been positive advances in the numbers smoking in the ROI. The number of Irish households which are now smoke-free rose by approximately 15% in the year after the implementation of smoke-free work environments in the ROI.

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

Northern Ireland Chest Heart and Stroke recommends including some of the more recent research which hasn't been considered, most notably "How Smoke-free Laws improve air quality: A global study of Irish pubs" (Harvard School of Public Health, March 16 2006.)

Economic

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

We support the RIA.

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?

We support what has been done but believe that, based on the research commissioned by the Scottish Executive (HERU, International review of the health and economic impact of the regulation of smoking in public places, NHS Scotland 2004), the main benefit may be from a reduction in smoking breaks. This is an important point which may be worth highlighting to businesses as part of the DHSSPS smokefree 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 businesses but we feel 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 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. Northern Ireland Chest Heart and Stroke suggests that this is referred to in the integrated impact assessment.