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*Recd
31/5/05*

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Date 24th May 2005
Your Ref
Our Ref DG/SI/Glen

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Dear Mr. Glen

Many thanks for inviting our comments to the consultation on The Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005: Draft.

Please find attached the response from NHS Lothian.

Should you have any queries please contact Fiona Moore (0131 536 3526) in the first instance.

Yours sincerely

Dr. Alison McCallum
Director of Public Health & Health Policy

Enc.



**DRAFT: THE SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) ACT
2005 (PROHIBITION OF SMOKING IN CERTAIN PREMISES)
REGULATIONS 2005
COMMENTS FROM NHS Lothian**

Q1. REGULATION 1: CITATION, INTERPRETATION AND COMMENCEMENT. *Do the definitions of words and phrases ensure clarity of what premises are covered or exempted from the regulations? If not, how might they be improved?*

The term "adult hospice" is listed as well as "hospice". In the list of No-Smoking Premises in Schedule 1 and Exemptions in Schedule 2, there is lack of clarity over this – 'hospices' are in the list of premises to be included in the ban, yet 'adult hospices' appear under the list of exemptions. Clarification on the above would be helpful.

If premises which are subsequently listed under Schedule 1 as "No-Smoking Premises" also include land, this should be made explicit.

If 'premises' does not include land, we would very strongly recommend that "Hospitals, health centres and hospices, *including their car-parks and grounds whether enclosed, partially-enclosed or not enclosed*" are included in the list of No-Smoking premises. Local policies around this issue are extremely difficult to enforce in the absence of legislation. Legislation on this issue of health service grounds would enable the health service to be viewed as health promoting rather than enabling an activity hazardous to health to take place on its premises, and for the issue of secondhand smoke and its effects to be taken seriously.

The draft definition of the term 'bar' provides a loophole for hospitality establishments to circumvent the legislation. We recommend the definition used in New York "Bar means any area (including outdoor seating areas) devoted to the sale and service of alcoholic beverages for on-premises consumption and where the service of food is only incidental to the consumption of such beverages."

The draft definition of the term 'designated hotel bedroom' leaves the management open to designating all hotel bedrooms as smoking areas. We would strongly recommend the practice of 'tendency towards smokefree premises with some smokefree provision' rather than 'tendency towards smoking premises with some smokefree provision'. We would recommend more precise wording and specifics regarding the proportion of hotel bedrooms in any premises designated as smoking areas eg a maximum of 30% of hotel bedrooms as being designated smoking areas to reflect the proportion of smokers in the population. This would create a level playing field for all hotels. This could be reviewed to reflect changes in the population's smoking habits or suggested that this proportion of designated smoking areas is reduced to 25% in 2008.

As for the definition of 'designated police rooms', this should also include "any communal areas within a police station".

'Public transportation facilities' should be extended to include bus shelters, train platforms and train stations, most of which are partially enclosed. In the Republic of Ireland, premises which are more than 50% enclosed are covered by legislation, and we would recommend that the Scottish Executive follow this.

'Restaurants' provides a potential loophole if coffee shop chains choose to define themselves separately from cafes, bistros and snack bars, thus we recommend a clearer definition of the wording. The definition of restaurant, vis-à-vis its distinction from 'bar', could be expanded to include "Restaurant means any establishment devoted to the sale, service and consumption of food or liquid refreshment, and where the service of alcoholic beverages is only incidental to the consumption of such food."

We would recommend that "sports centre", similar to health service premises as health promoting premises, include their grounds.

Additionally, in respect to all premises, we would recommend that Air Quality standards in No Smoking areas should be specified.

Q2. REGULATION 2: DISPLAY OF NO SMOKING NOTICES. *Views are invited on this approach.*

We would recommend signs being proportionate to the size of the wall ie where walls are larger, there would need to be larger signs or multiple signs. It may also be worth specifying that the sign should be "clearly displayed at all times" or in the centre of a room with a specified amount of space surrounding it in order to minimise the risk of it not being seen.

We would also recommend making it easier to report complaints/ contraventions of the legislation eg by providing local contact details such as job-title, phone number and e-mail address. Such information should be displayed in a format which can easily be changed as details change. A compliance telephone line should be displayed if the Scottish Executive intends to follow this route. As in the Republic of Ireland, the Regulations should state who is responsibility and guilty of an offence if signage is not adhered to.

In order to encourage compliance, we recommend that the international no smoking symbol is accompanied by the positive phrase "Thank you for not smoking".

In line with the New Zealand legislation, it would be worthwhile stating that smoke-free signage must be displayed at all principal entrances to the premises.

In line with New York legislation, hotels should have signage drawing attention to the availability of non-smoking rooms within their establishments.

Q3. REGULATION 3: “NO SMOKING PREMISES”. *Your comments are invited on the existing formula and how it might be improved.*

As specified above, we would strongly recommend the specific inclusion of term “premises” or “grounds”, particularly in connection with hospitals, hospices and health centres, in order that this includes the grounds and entrances. At present, there are concerns with passive smoking in hospital grounds as this is unsightly and conveys a very negative image for health promoting services perceived to be condoning smoking. Whilst a Smoking Policy can be written to include hospital grounds, only legislation will make it truly enforceable.

We suggest the inclusion of the term “partially enclosed” in order to incorporate areas such as courtyards and other areas where there is no roof in order to protect those people occupying offices or hotel bedrooms with windows adjacent to where these areas exist. We would recommend the wording used in the Republic of Ireland, whereby premises that are more than 50% enclosed are covered by legislation.

Residential premises being used for business purposes, private vehicles being used for business purposes, company vehicles and lorries used by long-distance lorry-drivers (particularly as they may have an assistant/ passenger occasionally), laundrettes, dry cleaning and clothing alteration premises which offer a service to the public should also be included; whilst these may have one employee, members of the public or employees from other companies may frequent such premises.

Community centres and coffee-shop chains should also be listed, the former under 8 and the latter under 1.

In terms of ‘offices and factories’, we would recommend that this should additionally specify “company vehicles” (which may involve others having to use the vehicle afterwards rather than being interpreted as more than one employee using it at the same time as another), “warehouses, corridors, lifts, stairwells, corridors, toilets, washrooms and other shared internal areas”.

‘Educational institutions’ should, like health service and sports premises, include carparks and grounds in their legislation for similar reasons to those outlined for these respective institutions.

‘Secure accommodation services’ should include “hostels and youth detention centres”.

‘Airport passenger terminals and any other public transportation facilities’ should include catering areas, ticketing, boarding and waiting areas which are 50% or more enclosed.

Q4. REGULATION 4: FIXED PENALTY TIME LIMITS, AMOUNTS AND PAYMENTS. *Views are invited on the level of fixed penalties and time limits for payment.*

Our view is that the level of fixed penalties is not high enough. The potential harm caused to others by passive smoking is much higher than that caused by illegal parking and therefore fixed penalty rates should reflect this

Q5. REGULATION 5: APPLICATION BY COUNCILS OF FIXED PENALTIES AND ACCOUNT KEEPING. *Views are invited on the general approach outlined here.*

We would recommend that the process is similar to that for parking violations ie "on the spot" fines.

The funds raised could be transferred into smoking cessation services to support people stop smoking and also into paying for enforcement of the legislation.

Q6. SCHEDULES TO THE REGULATIONS. *Your views are sought on whether there are any premises which fall into the definition of no-smoking premises at section 4(4) of the bill, but which have been omitted from the list in schedule 1.*

As mentioned above, the grounds of health service, sports and education institutions should be included.

The current list of exemptions could be considered discriminatory and reproducing inequalities. In order to provide a level playing field for everyone, we believe that all those listed in Schedule 2 as Exemptions should also be listed under Schedule 1 of No-Smoking Premises. This would enable the rights of all staff and residents of these premises to a smoke-free and healthy environment and to minimise their risk of acquiring a smoking-related disease as a result of exposure to passive smoking or as a result of being enabled to continue smoking. Once exemptions are made, it opens a gateway for further exemptions. We would recommend that case-by-case exemptions could be made if extreme circumstances exist.

We recognise the need for phased implementation of the ban in some areas but believe this, and a case-by-base approach to initial enforcement, should be separated from blanket exemptions.

Q7. EXEMPTIONS: ADULT CARE HOMES. *Your views are invited on the general merits of this approach, the development of smoking policies for residential care homes, and the targeting of cessation services on these groups.*

As specified in Q6, staff and other patients within these premises should at the very least be entitled to a smoke-free and healthy environment, to minimise their risk of acquiring a smoking-related disease as a result of exposure to passive smoking or as a result of being enabled to continue smoking. We would therefore recommend that this is removed from the list of exemptions and included in the list of No-Smoking Premises. Exemptions run the risk of opening a gateway for further exemptions. An alternative approach might be to make case-by-case exemptions for patients (rather than for all using the premises ie staff, patients and visitors) if extreme circumstances exist and if such exemptions are documented by relevant staff.

If Adult Care Homes remain under the Exemptions list, then Smoking Policies should be devised. These should stipulate the size of non-smoking areas for non-smoking staff and residents and the air quality standards, and the nature of enforcement.

Smoking cessation support should be offered to staff and residents who wish to stop smoking, including access to nicotine replacement therapy and, where appropriate, medication such as bupropion (Zyban). Such support should be available on an ongoing basis to allow for changes in residents and employees. Appropriate funding should be made available for this purpose.

Q8. EXEMPTIONS: PSYCHIATRIC HOSPITALS AND PSYCHIATRIC UNITS. *Your views are invited on the general merits of this approach, and the targeting of cessation services on these groups.*

Again as specified in Q6, staff and other patients within these premises should at the very least be entitled to a smoke-free and healthy environment and to minimise their risk of acquiring a smoking-related disease as a result of exposure to passive smoking or as a result of being enabled to continue smoking. We would therefore recommend that this is removed from the list of exemptions and included in the list of No-Smoking Premises. Exemptions run the risk of opening a gateway for further exemptions eg if a psychiatric patient is in a non-psychiatric ward, an exemption may ensue in that case, followed by an exemption for other distressed patients in that ward, and so on. An alternative approach might be to make case-by-case exemptions for patients (rather than for all using the premises ie staff, patients and visitors) if extreme circumstances exist and if such exemptions are documented by relevant staff.

If Psychiatric Hospitals and Units remain under the Exemptions list, then Smoking Policies should be devised. These should stipulate the size of non-smoking areas for non-smoking staff and patients and the air quality standards, and the nature of enforcement.

Smoking cessation support should be offered to staff and residents who wish to stop smoking, including access to nicotine replacement therapy and, where appropriate, medication such as bupropion (Zyban). There is evidence that patients in psychiatric hospitals/units wish to stop smoking and would be grateful for support to do so, including nicotine replacement therapy and bupropion, where appropriate. Further ringfenced funding should be made available to target these groups from 06-07, by which time some interim findings may be available as a result of the national Tobacco & Inequalities pilot project scheme of which "mental health" is one of the target groups.

Q9. EXEMPTIONS: HOTEL, GUEST HOUSE AND B&B BEDROOMS.

Views are invited on the merits of this approach.

To minimise the effects of passive smoking on the part of staff and avoid situations where non-smoking residents can only be offered a room where smoking has taken place, or of the situation which often arises whereby demand for non-smoking premises or non-smoking sections outstrips supply and non-smokers are subject to a smoky environment against their volition, it would be preferable if all rooms were smoke-free.

It would seem fair that people could be expected to smoke outdoors rather than in hotel/guest house/bed & breakfasts bedrooms as it would be unlikely to cause a significant inconvenience to do so. This has operated successfully for many years whereby guests of such premises have been accustomed to smoking outside on a voluntary basis, and people expect it as a matter of course. In fact by enabling it to take place within bedrooms could create confusion with other similar policies where 'no smoking' is the norm. There would also be the potential problems of litigation if those who were expecting smoke-free rooms are allocated smoking bedrooms.

Should some hotel bedrooms be designated smoking areas, then we recommend appropriate signage to this effect as specified in Q2.

Additionally, in respect to all premises, we would recommend that Air Quality standards in No Smoking areas should be specified.

Q10. OMISSIONS FROM SCHEDULE 2. *Are there any premises which, taking into account humanitarian, practical or other considerations, are omitted from the exemptions list in schedule 2?*

No, we do not see any other premises which should be included in the list of exemptions.

*** We would strongly recommend that the Regulations specify that in all premises classified as Exemptions, that a similar statement to that in the Republic of Ireland legislation be adopted - “an exemption does not constitute the right to smoke and employers are still bound by a duty of care to take every possible step to protect their employees” and that the emphasis should tend towards smoke-free (with designated smoking areas available) rather than smoking (with designated smokefree areas available). ***

**Fiona Moore, NHS Lothian Smoking Cessation Co-ordinator
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