Science and Technology Committee

Oral evidence: E-cigarettes, HC 505

Tuesday 27 March 2018

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Watch the meeting

Members present: Norman Lamb (Chair); Bill Grant; Stephen Metcalfe; Carol Monaghan; Damien Moore; Neil O'Brien; Graham Stringer.

Questions 217 - 354

Witnesses

I: Michelle Jarman-Howe, Executive Director, Public Sector Prisons South; and Heather Thomson, Smoke-free Lead, Nottinghamshire Healthcare NHS Foundation Trust.

II: Deborah Arnott, Chief Executive, Action on Smoking and Health; and Hazel Cheeseman, Director of Policy, Action on Smoking and Health.

Written evidence from witnesses:

- Nottinghamshire Healthcare NHS Foundation Trust
- Action on Smoking and Health
- Mental Health and Smoking Partnership
- Smoking in Pregnancy Challenge Group

HOUSE OF COMMONS

Examination of witnesses

Witnesses: Michelle Jarman-Howe and Heather Thomson.

Q217 **Chair:** Welcome. I am afraid that you are on your own to start with, due to the train delays for your fellow witness. If we could get started with you, I would be very grateful. Could you introduce yourself to start with?

Michelle Jarman-Howe: Good morning. My name is Michelle Jarman-Howe. I am the executive director of public sector prisons in the south.

Q218 **Chair:** How big an area is the south?

Michelle Jarman-Howe: Currently, it is everything from Lincoln to Dartmoor—the bottom half of the country. It is everything below the midlands.

Q219 **Chair:** Could you summarise the general position across the prison estate with regard to conventional smoking? We hear about the ban on smoking in prisons, but we have also heard about issues with its implementation. Where do we currently stand across the prison estate?

Michelle Jarman-Howe: We have been rolling out a smoking ban, effectively, since early summer 2016. We have done that using a phased approach. Groups of prisons have been introducing non-smoking. Currently, the position in the organisation is that 96 out of 102 closed public sector prisons are operating as non-smoking environments.

Q220 **Chair:** Ninety-six out of 102.

Michelle Jarman-Howe: Yes—of the closed prisons.

Q221 **Chair:** So we are almost there.

Michelle Jarman-Howe: We are almost there. There are some prisons in Greater London that will look to roll out over the coming weeks and months, subject to individual risk assessments. They are part of the final phase, so we are where we expected to be, effectively.

Q222 **Chair:** Is it on track, or has it taken longer than expected to implement?

Michelle Jarman-Howe: It is entirely on track. Although individual sites may have made a decision to defer slightly, by a couple of weeks—

Q223 **Chair:** You have not been alone for too long.

Michelle Jarman-Howe: It is fine. It is no problem at all.

Q224 **Chair:** Welcome. I will interrupt very briefly. I am sorry that you have had difficulties with your travel arrangements.

Heather Thomson: So am I.

Q225 **Chair:** I am sure that it has been rather stressful. Thank you for attending. Would you like to introduce yourself very quickly?

Heather Thomson: I am Heather Thomson. I am the smoke-free lead for Nottinghamshire Healthcare NHS foundation trust.

Q226 **Chair:** At the moment, I am dealing with the prison estate and where the process of implementing a no-smoking policy has got to. I will come to you in a few moments. The process is on track.

Michelle Jarman-Howe: It is on track. Individual establishments take a view, with their operational line managers, on the exact timing of whether a prison is ready to go smoke free. We like to give as much notice as possible to offenders and to staff, to make sure that they can adapt and work with healthcare partners to ensure that individuals in prisons are ready. There is a point prior to an establishment moving to a smoke-free position where a "go/no go" decision is made about whether that feels right and safe for the establishment at that time. Individual prisons may move slightly on the timeline, but, as a service, we are essentially where we expected to be.

Q227 **Chair:** You have described the line between north and south. Are all the remaining prisons in your region?

Michelle Jarman-Howe: Yes. They are all around the Greater London area. I should make a distinction with the open prison estate. Although that part of the estate went smoke free within offender accommodation several years ago, in the open estate offenders can still smoke in designated areas outside.

Q228 **Chair:** Is there a plan to change that?

Michelle Jarman-Howe: That is being considered currently. We hope to move to a position of the open estate being smoke free.

Q229 **Chair:** You have not made a decision as to whether to proceed. There is still a policy decision to be made.

Michelle Jarman-Howe: The policy is that the entire estate will go smoke free. The decision about the timing is happening this week.

Q230 **Chair:** I see. It is only about timing.

Michelle Jarman-Howe: In fact, it is tomorrow. That is just a coincidence.

Q231 **Chair:** The decision on timing will be made tomorrow.

Michelle Jarman-Howe: Absolutely—about the timing.

Q232 **Chair:** Do you have a date for when you anticipate that the programme for the closed prisons will be completed? When you do you expect all those prisons—

Michelle Jarman-Howe: At the end of April. A number of establishments are going in the first week of April. There will then be "go/no go" decisions for the remainder. All of them should be there by the end of April. We are very close.

Q233 **Chair:** Alongside that, what is the policy on e-cigarette use and availability?

Michelle Jarman-Howe: For the purposes of the Committee, I will distinguish between traditional e-cigarettes and vaping. At the point at which the service introduced no smoking, offenders could access disposable e-cigarettes through the offender canteen system on closed sites in the public sector. Later, in October 2017, we also enabled offenders to access rechargeable vaping facilities. That proved to be far more popular.

Q234 **Chair:** To start with, you allowed disposable e-cigs.

Michelle Jarman-Howe: Absolutely. Then we moved to a position to enable access to vaping arrangements at establishments as well. Currently, the position as regards access to that facility is completely consistent at all prisons. It has been enormously helpful to us for offenders and staff to be able to access vaping, which has been more popular than traditional electronic cigarettes.

Q235 **Chair:** All prisons now have facilities for recharging e-cigarettes. Is that right?

Michelle Jarman-Howe: They can buy the chargers, I understand. I do not think that you need separate facilities. I do not vape personally, but I think that they just plug in. All offenders, including those in the private sector, can access that through their canteen.

Q236 **Chair:** Could you say something about the implementation process and what the experience has been like? There have been reports of tension, stress and, in some cases, violence. I take it that you have worked your way through that. Could you describe what the process has been like? How difficult or easy has it been?

Michelle Jarman-Howe: As a large operational organisation, we are very experienced at taking risk-based decisions and introducing operational policy change. A huge amount of work was done in advance of introducing the policy around assessing likely intelligence. That continues to be the case prison by prison as we seek to introduce roll-out. A significant amount of time and attention were given to contingency planning around any potential for disorder when we introduced no smoking.

The reality has been that, while there have been some low-level local issues, as you might expect during any policy change, we have not had any significant issues of disorder that are entirely related to smoking. It is far more likely that, where we have had incidents of any type, if smoking has been a factor, it has been one of a number of contributory factors. We have not lost in prisons as a result of introducing non-smoking, for example.

Q237 **Chair:** Have you noticed any beneficial impacts of the ban, in terms of

improved health, reduced levels of stress and so forth? The evidence suggests that smoking is potentially stress inducing. Have you noticed any improvements?

Michelle Jarman-Howe: Certainly, the prison environments where we have introduced no smoking have felt cleaner. Staff and prisoners have reported that the environment and the air feel cleaner. We have done and will continue to do air tests in those establishments. That provides us with a decent amount of evidence.

In respect of mental health and stress, a study that was completed in 2014 says that going smoke free and giving up smoking have a positive impact on issues such as depression and anxiety. That research was part of our decision making when we were thinking about the mental health impact of going smoke free.

Generally, I would say that it has been a very positive thing for the service. We have been very keen to ensure that the impact of second-hand smoke on the system is reduced as far as possible, both for offenders and for staff, to make it a clean and decent environment for people who have to live and work there. From our perspective, it has been a very positive initiative. It has been extraordinarily well managed by governors and their staff.

Q238 **Chair:** A legal action was brought by a prisoner who wanted the ban to be enforced. Because the Crown Estate is excluded from the legislation, the conclusion was that he did not win his case. Is that now just something that happened in the past? Is the ban now enforced, in effect? Is the reality that the whole estate is smoke free, or is there a problem that you cannot enforce the ban because of the legislation excluding the Crown Estate and, therefore, there are places where smoking persists?

Michelle Jarman-Howe: You are talking about the Black case.

Chair: Yes.

Michelle Jarman-Howe: There has been no impact on us following the Black case. A number of offenders have tried in separate cases to challenge the smoking ban. None of them has been successful. There is currently no inhibition to us continuing to roll out on a smoke-free basis. That remains our absolute intention.

Q239 **Chair:** The ban is effective, in other words.

Michelle Jarman-Howe: Absolutely, apart from on those sites in Greater London that are still progressing towards it. We also have to make the decision about timing for the open prisons.

Q240 **Chair:** That is understood. Heather, the Government's tobacco control plan says, "some professionals mistakenly believe that stopping smoking could negatively affect their patients' mental health." Is that an attitude or view that you have come across in your work? Do professionals still

have the misplaced view that it will be damaging to patients?

Heather Thomson: Definitely. It is a regular challenge when delivering training. Staff are very uncomfortable about removing yet another choice from patients who may have been detained under the Mental Health Act and who see smoking as having been their coping strategy for many years.

Q241 **Chair:** It is part of the culture.

Heather Thomson: It is very ingrained in the culture. For decades, smoking has probably been seen as part of the solution, rather than recognised for the additional harm and problems that it is causing for people's mental wellbeing, as well as their physical wellbeing.

Q242 **Chair:** There have even been suggestions that, in some cases, people take up smoking in in-patient units because that is the culture that persists there. Is that right?

Heather Thomson: Definitely. Prior to our going smoke free in 2016, we still had some patients who were admitted as non-smokers and left our care as smokers. That is one of the things that I quote to our staff to show how wrong it is, given what we now know.

Q243 **Chair:** You do not see any justification for making exceptions for people with severe and enduring mental ill health in in-patient units. You do not think that they should be allowed to smoke because of the traditional view that it may be seen by them as something that eases their stress and trauma.

Heather Thomson: We tried previously to go smoke free in 2008, with the ability to make exceptions. The difficulty is that, when somebody is a smoker, they are not only addicted to the nicotine but are very hooked into the habit. When the triggers of other people smoking are around them, it makes it impossible for them not to smoke. Making an exception just perpetuates the whole vicious circle.

It is much more difficult in some scenarios. We have the ability to make a time-limited exception. Rather than tackle a patient to the ground, we are trying to adopt what we should be doing—the least restrictive practice. However, as soon as we can remove the cigarettes, we should do so.

Q244 **Damien Moore:** Heather, you are from Nottinghamshire Healthcare NHS Foundation Trust, so I appreciate that you cannot speak for all NHS trusts. Do you want to tell us about the pilot that has been happening in your trust? What results and lessons have you learned from that?

Heather Thomson: We started very small, in three units, just prior to going smoke free. The feedback that we had was very positive, with all three unit managers stating that they would like to see this continued and more than 60% of patients who had used the one e-cigarette that we have allowed reporting that it had really helped them. The success of that

was reported to our team of executives, who approved our rolling it out to all 23 in-patient mental health units. We did that in July last year and gathered evidence again after two or three months of its being available to patients, with resoundingly positive feedback. More than 80% of our patients who smoke have used and are using the e-cigarettes that we are providing. Nicotine replacement therapy, which is licensed and research based, is still the first-line offer, but we are also enabling the e-cigarette, which has proven very popular.

Q245 **Chair:** What is your policy on where e-cigarettes can be used?

Heather Thomson: That is trickier. The procedure gives an overarching guide, which is that they should not be used in communal areas because of the concerns about renormalising smoking or normalising vaping. We want to avoid a circumstance where somebody may come into our care not using e-cigarettes and then leave using them. We have said that they may be used in non-communal areas, which include the courtyard areas where people traditionally smoked, and that people can use them in their bedrooms or in discreet areas. We have left it at that, really. We have 23 in-patient units, as I previously said. They are all very different. It is very difficult to adopt a one-size-fits-all approach throughout each of those units. The policy has allowed each unit manager to use their discretion as to whether e-cigarettes can and should be used in their particular unit.

Q246 **Chair:** Have staff changed their attitudes as a result of their experience, or are there still staff who do not really believe in the policy?

Heather Thomson: I would say that there are. We did an awful lot of training with people face to face in order to try to win hearts and minds. We wanted to reach as many people as possible and to challenge those misperceptions. For staff who smoke, it is very uncomfortable to address smoking with a patient, because people feel hypocritical. We are trying through our face-to-face training to raise awareness of the fact that we have to leave lots of our own personal behaviours and beliefs at the door to do our job, because we work for Nottinghamshire Healthcare NHS foundation trust.

There are still some staff where it is a challenge, but, 18 months on, I feel that we are a smoke-free site. That does not mean that we never have people smoking on site, but it means that I can say with confidence that each and every person who smokes and is admitted to our care is now having very different conversations about smoking than they have ever had before. That is not just down to our very small smoke-free team. It is down to the nursing teams on the wards, who are making sure that patients are given nicotine replacement therapy or e-cigarettes within 20 minutes of arrival at units. That is working most of the time.

Q247 **Chair:** That is interesting. Have you done any evaluation of the impact on health and the atmosphere on the ward—the levels of stress, anxiety and so forth—in this early period?

Heather Thomson: The only evaluation that we have done is the feedback from patients. It is not proper research, but we have had feedback from patients. Over 60% of patients felt that they had had benefits in terms of mood and health. They noticed things like being less breathless, having more energy and having a better appetite—which, obviously, we do not want to go the other way. There are lots of health benefits that start.

One of the things we look at closely—I am sorry that I do not have the numbers, because we have not evaluated them—is how frequently somebody's carbon monoxide reading is reduced. That happens very quickly. The evidence is there, but we have not gathered it.

Q248 **Chair:** Has the availability of vaping facilitated this shift of policy?

Heather Thomson: It has definitely helped. Our feedback has said that. Before the 23 units were using e-cigarettes, they were having more difficulties. We have somebody working in our analysis team who has looked at untoward incidents. It is difficult to analyse exactly, because any incident that has smoking written on it is collected, but there was a fall in the number of incidents around the time we introduced e-cigarettes to all 23 units.

Q249 **Stephen Metcalfe:** I have a small technical point. You said that you allow one type of e-cigarette. Can you explain why you have restricted it to one? Is it an e-cigarette or a vaping device?

Heather Thomson: It is an e-cigarette, which is still a vaping device. When I first came into post in 2015, the board was very uncertain and nervous about any e-cigarettes. There were concerns about fire risk and managing the charging. In our settings, there was also a worry about illicit substances being added to liquids. We would not be able to tell what was in the liquid, and there was the possibility of the device being weaponised. The one product we went with has been designed with lots of safety features in mind. It is tamper evident. It is not tamper proof, but it has a lot of safety features.

Q250 **Stephen Metcalfe:** Michelle, did you have the same thought process when thinking about what to allow in prisons?

Michelle Jarman-Howe: The service trialled a number of options. We selected a brand of e-cigarettes in the initial roll-out, following a number of pilots and trials, to make sure that we had something that was of reasonable quality. As I have said, we operated with an e-cigarette—I make the distinction between e-cigarettes and vaping—for the first year of the pilot. We then introduced a broader range, to allow rechargeable vaping devices to be used. In our experience, those have proved to be more popular than the traditional e-cigarette.

The issue for us with e-cigarettes was that they contained the equivalent of 300 to 400 puffs. We found that offenders were getting through one of those as though they were a single cigarette. There was an issue about

learning. In each phase of the roll-out, we have tried to go through a process of lessons learned to inform our decisions going forward.

Q251 **Stephen Metcalfe:** You were not as concerned about things like charging regimes and adding substances to liquids.

Michelle Jarman-Howe: We are concerned, of course. We continue to take a view on intelligence around the security challenges that having any of this equipment can provide for us. For example, it is common knowledge that psychoactive substances are a particular issue in prisons at the moment. The reduction in tobacco has meant that offenders can use those substances in a slightly different way. We are aware that some of these devices can be used for purposes for which they are not intended—as many devices can in prisons. Offenders will find a use for bits of equipment. Generally, however, very significant security concerns have not really played out. The issue for us has been controlling contraband and things like that.

Q252 **Chair:** Heather, you are sticking with the disposable version. You have no plan to widen it, as the Prison Service has done, to allow the recharging option.

Heather Thomson: We do not at the moment. I am looking at reviewing the procedure to make it mainstream, rather than just a trial. As evidence arises, that is something that we will have under constant review. I know that some other mental health trusts are taking a more relaxed approach to e-cigarettes. We are looking at what the evidence says.

Q253 **Neil O'Brien:** My question is mainly for Heather. What advice and resources does the NHS give to trusts such as yours to enable you to make decisions about e-cigarette policy?

Heather Thomson: The Public Health England guide for employers that looks at vaping in workplaces is the closest. I have not been made aware of anything specific that is advising trusts exactly how to do this and what to do about it.

Q254 **Neil O'Brien:** There is no advice from the NHS.

Heather Thomson: There is advice from the NHS. Basically, as we have all heard, Public Health England is saying that vaping is likely to be 95% less harmful.

Q255 **Chair:** There is only that generic advice—nothing more than that.

Heather Thomson: No.

Q256 **Neil O'Brien:** Would it be fair to say that, basically, it is left to the trusts themselves to decide? Is that a fair summary?

Heather Thomson: Yes.

Q257 **Neil O'Brien:** Do you think that it would be beneficial for trusts to have a

central policy, or is it enough to have common guidance that you interpret individually? Would it be helpful to have a central policy?

Heather Thomson: Personally, I think that it would be really useful for us to sit together, to pull together the learning and to have some central guidance. That would be helpful.

Q258 **Neil O'Brien:** Is anyone monitoring what is going on? Is there a point-person you can talk to in the NHS? Is there anyone creating a network of people like you who are doing things in this area?

Heather Thomson: I am not aware of that. There probably is, through the tobacco alliances.

Q259 **Neil O'Brien:** What are the tobacco alliances?

Heather Thomson: The Smokefree Action Coalition. A lot of information is pulled together there. I have not contributed to that, but I would be willing to do so.

Q260 **Neil O'Brien:** Is there any other kind of network? Have any other trusts come to you to ask about your experience? Are you in touch with anyone else?

Heather Thomson: We are sharing best practice between us. I looked very much at what South London and Maudsley, and Cheshire and Wirral had done, because they had gone smoke free prior to us. I took the lead from them for the way in which we started.

Q261 **Chair:** Which trust was that?

Heather Thomson: South London and Maudsley, and Cheshire and Wirral. Since we have been using the e-cigarettes, several organisations have come to me and asked me to share what we have done in Nottinghamshire, which I have done. The report that I wrote for the Committee has been useful, because I forwarded that. That has been very helpful.

Q262 **Chair:** Having gone through it yourself in your trust, do you take the view that national guidance ought to be given some priority, given that smoking is one of the largest causes of premature mortality and that, in your experience, the provision of vaping has facilitated a shift in people's experience?

Heather Thomson: I think that it would be helpful. We are going smoke free at different times, with different approaches. It would be very useful to have some central guidance, because there is an anxiety about bringing in something that, in years to come, may prove to have been harmful. However, we need to balance that against the fact that we absolutely know the harms that are associated with smoking. Anything that allays those fears and lays the foundations will be useful.

Q263 **Chair:** Has every mental health trust now gone smoke free?

Heather Thomson: There is a call from Public Health England for every mental health trust to be smoke free by April 2018, I think.

Q264 **Chair:** The position is similar to that in the prison estate.

Heather Thomson: Yes. Acute trusts should be smoke free by 2020.

Q265 **Bill Grant:** My question relates to e-cigarettes. Does either of you have any data available, from research or anecdotal evidence, on the extent to which staff are concerned about being exposed to second-hand e-cigarette vapour? Do you have any knowledge of whether staff are concerned about that?

Heather Thomson: The only thing that we have is the feedback that we got. We got feedback from 11 of the 23 unit managers and from 64 staff. Within that, one or two concerns were raised about second-hand vape. The device that we allow does not produce plumes of vape. That is one of the advantages. There is not a huge amount of vape from it.

Q266 **Chair:** Can you make it more widely available?

Heather Thomson: It is widely available.

Q267 **Bill Grant:** What about the Prison Service?

Michelle Jarman-Howe: We continue to work with staff associations, which continually remind us of our responsibilities around staff safety, in particular. We have not received any widespread complaints about second-hand smoke from vaping or electronic smoking devices. We take our position from the advice of Public Health England, which says that it is a less harmful substance than that which is produced by traditional cigarettes. As more research comes out in the future, we will continue to review the position. Currently, we have not had significant issues from staff.

Q268 **Bill Grant:** It appears to be emerging that the risks of second-hand vapour are significantly less than those of second-hand smoke. Do you think that there is a perception out there that the risks are equal? Are we advising people that it is not the risk that cigarette smoke is? Do you think that staff fully understand that?

Heather Thomson: No, I do not. Because a vaper can produce so much more vapour, people feel that it is much more harmful. It can still be an irritant. That is one of the misperceptions. In our units, there are still occasions when some people are smoking, which needs to be dealt with as soon as possible, but sometimes there is more concern from staff about sticking to the rule stringently with regard to where somebody can use their e-cigarette. It is about challenging those misperceptions. We have not really got to the bottom of where people's concerns come from.

Q269 **Bill Grant:** Is it similar in the Prison Service?

Michelle Jarman-Howe: To be fair, the service has done a good job in its communication strategy. We take a risk-based approach, as we roll

out in the phases and site by site, to ensure that we have tried to address these concerns. Governors have excellent relationships with health partners operating within their establishments, so there is a big focus in the run-up to a prison going smoke free on communicating effectively with both staff and prisoners. At the moment, we have had very little pushback from staff around e-cigarettes. As part of our strategy, we have encouraged staff to go smoke free and to reduce their smoking.

Q270 **Bill Grant:** As a former smoker, I would say that it is a good thing to give up—it really is.

Leaving aside the risks of liquid tampering and possible fire risk that Heather mentioned with a recharging system, some weeks ago Professor Aveyard from the Cochrane Review advised us, "there are no reasons on health grounds why e-cigarettes should be banned in prisons and mental health institutions." Do you agree with that statement? He was talking about health reasons.

Heather Thomson: I agree that there should be provision for people in mental health units, or any health organisation, to be able to vape, as opposed to smoking.

Q271 **Bill Grant:** So you agree with his suggestion that there is no reason to ban e-cigarettes. Is your view the same, Michelle?

Michelle Jarman-Howe: On the basis of the current research, we take the view that it is less harmful.

Q272 **Bill Grant:** I am getting agreement on that. Are there any circumstances in which e-cigarettes should still be banned in parts, zones or elements of prisons or mental health facilities? Are there no-go areas within facilities where you would put a ban on e-cigarettes?

Heather Thomson: Personally, I still think that there should be some restrictions around communal areas, because it can uncomfortable for other people. The vapour can be an irritant and can be annoying. Our revised procedure will promote consideration for others. With everybody sitting in one area, vaping could be uncomfortable. We need to try to avoid that, but I do not think that there is anywhere where we need them to be specifically banned.

Q273 **Bill Grant:** So the restriction could be applied in recreation facilities, libraries, kitchens and so on.

Heather Thomson: I would not say so, from the research and from our evidence.

Michelle Jarman-Howe: Our policy is room only. We would not allow offenders to smoke in kitchen areas, education areas or work areas, for example.

Q274 **Bill Grant:** It is confined to rooms only.

Michelle Jarman-Howe: It is confined to rooms. In the open estate, it is slightly different. Apart from the fact that we do not want to encourage that behaviour, there is a degree of normalising. When offenders are released, if they are going to a workplace, it is unlikely that they will be able to vape in open work areas. There is something about trying to normalise behaviours.

Q275 **Bill Grant:** You used the term "room only." I am pleased to note that I am not overly familiar with the prison environment. Are there still shared facilities, or are there individual rooms? The reason for the question is that if two people were sharing there might be conflict. Is it single occupancy?

Michelle Jarman-Howe: We have cells that have shared accommodation. Governors will take all the steps that are appropriate to ensure that non-smokers are not sharing with smokers, for example. All prisons have entirely non-smoking wings available to them, where non-smokers can choose to be.

Q276 **Bill Grant:** You have conflict avoidance policies, as you have zones and so on.

Michelle Jarman-Howe: Absolutely. We have a cell-share risk assessment policy, which takes into account all sorts of risks around offenders sharing rooms. Governors are quite well versed in how to manage sharing cells.

Q277 **Neil O'Brien:** In any of your prisons, is it possible to vape in your cell, or is it always done in a particular area, when you are out?

Michelle Jarman-Howe: It is only in rooms—in cells.

Q278 **Chair:** It is only in the cell.

Michelle Jarman-Howe: Yes.

Q279 **Carol Monaghan:** In your opinion, is there anything that NHS England mental health trusts should be learning from the Prison Service's approach to e-cigarettes?

Michelle Jarman-Howe: I am not sure that that is for me to judge.

Q280 **Carol Monaghan:** I am sorry; the question was directed at Heather.

Heather Thomson: We could probably learn from each other. We are having different experiences. Michelle has just answered the question about vaping only in cells. I understand that it is a very different environment. We do not want to make patients become more isolated than they were. If one e-cigarette lasts as long as 30 cigarettes and somebody who is a 40-a-day smoker usually can use it only in their room, we may find that they have even less interaction. We want to encourage them to be a part of activities that are going on. If vaping during an activity enables them to remain focused and within that

activity, that is part of their therapeutic recovery and is a good thing. There are crossovers, but it is very difficult to say that one size fits all.

Q281 **Carol Monaghan:** Within mental health trusts and, perhaps, the Prison Service, can you see that one coherent policy across mental health trusts and one coherent policy across the Prison Service might be useful? Are there still inconsistencies and different approaches?

Heather Thomson: I do not know who is going to answer that. Do you want to go first, Michelle?

Michelle Jarman-Howe: We have a coherent system approach. We have found that very beneficial, because offenders move around our system; they do not stay in one prison. For us, it is very useful that there is a clear expectation about what a prison environment will look and feel like. Of course, as the non-smoking policy has rolled out, we have had parts of the system that have been smoking while other parts have been non-smoking, but it has been a stated intention of the service to move to a non-smoking position.

Q282 **Chair:** With e-cigarettes available in every prison, with the same rules.

Michelle Jarman-Howe: Absolutely. That consistency has been a benefit for us. We have had the experience of introducing roll-out at certain sites where prisoners almost believe that it is not going to happen. However, as we have rolled out more and more across the country, there is increasingly an acceptance, once the non-smoking date has been set for a site, that that will happen. Having that consistent approach has largely been successful, although we give individual establishments the option of making slight adjustments to timing, as we move towards the date, to ensure that we are taking into account operational intelligence risk.

Q283 **Carol Monaghan:** I assume that that makes it easier when staff move from establishment to establishment, as there is already an understanding.

Michelle Jarman-Howe: Absolutely.

Q284 **Carol Monaghan:** Heather, what are your thoughts regarding mental health?

Heather Thomson: It would be very useful. Our patients can move from one area to another, and the lack of consistency can cause real problems. As regards a one-size-fits-all approach, one difficulty that we had because we were allowing only one particular type of e-cigarette was how to get it to our patients. In some trusts, there are retail outlets. We do not have any retail outlets, so the only way in which we could start the ball rolling was to provide the e-cigarettes for our patients on a short-term basis. Therefore, how that would look could be quite complicated.

Q285 **Chair:** How have they got hold of tobacco in the past, if you do not have any retail outlets? Is it all just brought in by visitors?

Heather Thomson: Some patients have leave or escorted leave. If they are going to the shop, they can buy tobacco products. They would be able to go and buy disposable e-cigarettes, but not the type that we say they can use, for all the reasons that we have given. Therefore, it was more difficult.

Q286 **Carol Monaghan:** I believe that you have both indicated that you think that consistency across different establishments is of benefit. To some extent, you have answered my final question, which is about consistency across both types of establishment. Can you confirm that what you are really saying is that prisons and mental health trusts are so very different, with very different people using them, that consistency across both sectors is not particularly helpful?

Michelle Jarman-Howe: I can speak only for the Prison Service and the approach that we have taken. Although we have a number of offenders with mental health conditions, whom we have taken into account as we have rolled out this policy, and although we engaged with secure mental health units as we were considering introducing the policy, to get learning and best practice, the Prison Service operates in a different way. As far as I am concerned, it is probably a different forum.

Heather Thomson: Definitely.

Q287 **Chair:** Heather, from what you have said, it appears that you do not see any case for some mental health trusts banning e-cigarettes, for example. I do not want to put words in your mouth, but I think that your evidence is that, from your experience, the combination of a ban on tobacco and the availability of e-cigarettes is a sensible mix. Is that right?

Heather Thomson: What I probably have not said and need to make clear is that the trial in which we have been using e-cigarettes has been in our adult mental health units, not in our forensic division. Colleagues in the forensic division are just starting to look at how and if we will introduce the e-cigarettes there.

Q288 **Chair:** What is the position in your forensic division?

Heather Thomson: There is no vaping in our forensic division.

Q289 **Chair:** It is smoke free, but there is no vaping.

Heather Thomson: That is right. Actually, it has been smoke free since 2012. It has got that off to a tee, so it did not see a need to change. Nicotine replacement therapy is used very well, but obviously there is more control. Within our mental health units, we have a lot of patients who are less formal and who volunteer to be admitted. The fear before we went smoke free was that the number of people volunteering would go down. We are in a very different environment. The checking and searching of patients is more difficult. We are trying to be less restrictive.

Q290 **Chair:** You want to be less restrictive.

Heather Thomson: Yes. I cannot really speak for all mental health trusts. I work with Nottinghamshire Healthcare NHS foundation trust; I do not know about the complexities of other trusts. Ours is very complex. I would not like to say that I can speak on behalf of all trusts. However, I can speak about mental health patients and the harm reduction they can benefit from by having access to e-cigarettes and being able to vape. I would say that we should be trying to make sure that everybody has access, where we can.

Q291 **Chair:** Thank you very much. We appreciate your coming down.

Examination of witnesses

Witnesses: Deborah Arnott and Hazel Cheeseman.

Q292 **Chair:** Welcome, both of you. Do you want to introduce yourselves quickly?

Deborah Arnott: I am Deborah Arnott, the chief executive of ASH—Action on Smoking and Health.

Hazel Cheeseman: I am Hazel Cheeseman. I am the director of policy at ASH. I am here representing the Mental Health and Smoking Partnership and the Smoking in Pregnancy Challenge Group. I can talk more about those as we go on.

Deborah Arnott: Heather mentioned the Smokefree Action Coalition, which is a group of over 300 organisations interested in tobacco control. They include local authorities, NHS organisations, charities and so on. We co-ordinate that and try to ensure that there is a consistent approach to tobacco control issues through the Smokefree Action Coalition.

Q293 **Chair:** Great. ASH published some statistics on e-cigarettes this morning. Could one of you start by summarising the findings of that work, as well as telling us about your general position on e-cigarettes? Could you include reference to heat-not-burn products as well?

Hazel Cheeseman: We will start by talking you through the new data.

Deborah Arnott: We will then move on to our policy position.

Hazel Cheeseman: The data that we have shared with you this morning are from our annual YouGov data. Every year, in February and March, we do a survey with YouGov. The adult survey is with around 12,000 adults and the youth survey is with around 2,500 children.

The adult survey shows that we have a continued, small and steady increase in the use of electronic cigarettes among smokers and ex-smokers, and an increase in the number of ex-smokers reporting that they used to use electronic cigarettes. In our view, the steady increase in the number of ex-smokers who currently use and used to use e-cigarettes is a good sign. It appears to indicate that these products are being used as a way of quitting smoking.

The reasons why people are using e-cigarettes have not changed a great deal over the period in which we have been running this survey. Primarily, smokers and ex-smokers are using these products to abstain from smoking, to engage in a quit attempt or to cut down the amount that they are smoking. Another thing that appears to be very important for the use of electronic cigarettes is the price difference between using electronic cigarettes and smoking. That is more important for people in lower socioeconomic groups, with, one would expect, lower incomes.

One really important thing that we have done through the survey over a number of years is to track the public's understanding of the relative risks of electronic cigarettes and tobacco smoking. What we have found over time is that the public's perception of e-cigarettes is becoming more inaccurate—that people are more likely to think that electronic cigarettes are as harmful as, or more harmful than, tobacco smoking. There was some good news from this year's survey, in that there is an increase in the proportion of adults both in the general population and among smokers who believe that electronic cigarettes are less harmful than smoking. We do not see the same trend among young people. That may be to do with the size of our sample and some problems with the data, but it may also be that young people simply get their information from different places from adults. That is certainly something to keep an eye on.

I will mention the findings in relation to young people briefly. We are not seeing very big changes in young people's use of electronic cigarettes, particularly among young people who do not smoke. That use has been low throughout the time in which we have been running the survey and continues to be very low. Young people who do not smoke are not regularly—

Q294 **Chair:** So we are not seeing a risk that this is an attractive thing in its own right.

Hazel Cheeseman: From our survey data, the young people who are using electronic cigarettes appear to be the young people who are smoking and trying other things. That seems to be supported by data from elsewhere in the UK. We can talk about that more as we go on. The primary issue still among young people is the prevalence of tobacco smoking, rather than the prevalence of vaping.

We also looked at some issues in relation to regulations in the data. One of the things we asked about was whether people were more reassured by the fact that we have a regulatory framework around e-cigarettes in the TPD. It appears that smokers are more likely to be reassured when they understand that there is a regulatory framework, but there is still a large group of smokers who are not reassured. There is more work to do in relation to reassuring smokers that these products are safe for them to use.

Shall I leave it there? We can then talk about the policy.

Deborah Arnott: That is fine, unless you have more questions about the data.

Q295 **Chair:** That is very helpful. Can we move on to your general position, as it stands now, on e-cigarettes and heat-not-burn products?

Deborah Arnott: First, we believe that public policy should be evidence based, so we are really pleased that the Science and Technology Committee is carrying out this inquiry. As Hazel said, smoking remains the leading cause of preventable premature death in the UK. It is uniquely harmful, killing more people than the next six causes put together. E-cigarette regulation and harms need to be put in that context. As PHE and others have said, the evidence to date is that e-cigarettes are substantially less harmful than smoking, but not risk free.

The other issue is how they are perceived. We have a regulatory framework in the UK, but we also have support for use of e-cigarettes for harm reduction from the Department of Health, Public Health England, organisations such as ourselves, the Royal College of Physicians, the BMA and so on. That is quite important. Although there are still misperceptions, there is a lower level of misperception about the relative risk in this country than in other countries such as the US and Australia.

We are now a global leader in tobacco control. Our policy on e-cigarettes is within the context that we have some of the most stringent regulation of tobacco in the world. We are up there with Australia, which was the first country, before us, to introduce plain packaging. Since e-cigarettes have taken off, our rates of smoking have declined more rapidly than those in Australia. We are now down to levels of smoking that are very similar to Australia's. While you cannot prove causality, I think that that is a sign that the policy that has been put forward by Government, civil society, the MHRA and NICE over recent years has been helpful in reducing smoking prevalence. That is really important.

Q296 **Chair:** What are we down to now? Is it 15.5%?

Deborah Arnott: For the UK, it is 15.8%. For England, it is 15.5%. That is a major improvement when you think that in 2000 it was 27%.

Q297 **Chair:** Bill Grant is one of them.

Deborah Arnott: I am sure that there are many ex-smokers around this room. I am certainly one of them, too.

We support regulation to manage the risk but maximise the opportunities. One of the points that I would like to make—we feel very strongly about this—is that we are pleased that there is a consumer product regulatory system that does not seem to be undermining e-cigarette use. It is required in the regulations that that be reviewed within five years, which we think is appropriate, but at the moment it is not undermining use of e-cigarettes. However, we think that there would be considerable benefits to having licensed medicinal products on the

market. Basically, unless you have a licensed product, it cannot be promoted, advertised and put on prescription for quitting smoking.

Q298 **Chair:** Can I stop you there briefly? If we know that e-cigarettes help people to stop smoking, should e-cigarette manufacturers be able to say that in their marketing material?

Deborah Arnott: It is very difficult, because the medicinal licensing system—which is a UK situation, not just an EU thing—means that, if you are going to promote them for cessation, they have to be medicinally licensed.

Q299 **Chair:** Does that make sense? We have a product here that we know helps people to give up smoking. Why can't people say that?

Deborah Arnott: You can say it, but you have to be careful about how you say it.

On the medicinal licensing point, you need to talk to the MHRA, but my understanding is that it will require a complete overhaul of the medicinal licensing system to enable that to happen. Actually, there is a benefit to having licensed products, because we know that it would reassure doctors. The BMA has said that it would be helpful. We have doctors saying to us all the time, "If we had products that we could prescribe and that were licensed, we would feel much more comfortable." They would be effective on prescription and highly cost-effective. There have been criticisms, with people asking why they should be on prescription. These are cheap products that are highly effective in helping smokers to quit. It would be reassuring to consumers, as well as to the medical profession.

Q300 **Chair:** Do we think that there is evidence that there is a cohort of people who are not being persuaded to give up smoking and simply to choose a commercial product that is available, but who could be persuaded to give up if it was prescribed?

Deborah Arnott: We think that it could work, as part of a comprehensive approach. We know that there are quite a lot of smokers who are not reassured by the consumer regulation and are concerned about the risks. As part of a co-ordinated strategy—not instead of consumer products, but as well as consumer products—I think that it would be very helpful. There are still large numbers of smokers who have not tried these products or who have tried them and not used them to best effect, either because they do not find them attractive or because they lack a sense of security that this is what they should be doing. Smokers who try vaping, do not succeed and carry on dual-using often have very mixed views on the whole thing. I think that it would help.

Hazel Cheeseman: Although for most people using an electronic cigarette is cheaper than continuing to smoke, there is a group of people, particularly people with mental health conditions, for whom there is a barrier to entry—an initial cost that you have to meet. For somebody on a low income, that is quite a risk to take, potentially, if you are not sure

that the product will work for you. Having something on prescription can help to ease that risk for people. It will also lock people into a relationship with medical professionals and quit services, which we know can significantly improve people's chances of quitting successfully. Having something on prescription would be a benefit for both of those reasons. For groups that are vulnerable, have high levels of addiction and face lots of barriers to quitting, a prescription product could be really valuable.

Deborah Arnott: The evidence from the stop smoking service returns is that stop smoking services that are encouraging e-cigarette use are finding higher rates of quitting and that e-cigarettes are a useful addition. However, it is difficult to do that when there is not a prescription product available. The tobacco control plan for England recommended that the MHRA "ensure that the route to medicinal regulation…is fit for purpose so that a range of safe and effective products can potentially be made available for NHS prescription." We would really encourage that.

Q301 **Chair:** Where did that recommendation come from?

Deborah Arnott: It is in the tobacco control plan for England. I imagine that you are going to have the MHRA come before you. I recommend that you urge it to review the system, because, to date, although there have been products that have gone through it, none has come to market. The more the MHRA can do to make the system fit for purpose, the better.

Q302 **Chair:** Do you think that it is a question of the MHRA having too high a hurdle to clear? You are asking the MHRA to review the process. What do you see it changing to?

Deborah Arnott: It is about encouragement, as much as anything else. There was a point in time when the MHRA said that that was the only route that it was going to take, before the TPD was developed, and there was much more interest in companies. When the TPD process came into place, the companies focused on that, naturally, and so did the MHRA—quite rightly, as it had to get the system right. I think that it did a very good job, but now is the time for it to refocus its attention on the medicinal licensing system and on encouraging companies to come forward and make clear to them what the system is.

There are also benefits because it is an authorisation process, not a notification process. The information that we are getting from the notification process is useful, but it is not the same quality of evidence that we will get from products having to go through the authorisation system. Under that system, products have to be made to good manufacturing practice standards, which means that they will be the highest-quality products. However, that has a cost. Over-the-counter nicotine replacement therapy can be sold at 5% VAT, as opposed to 20%. For a number of years, I have been trying to get clarification from the Treasury on whether that would be true for e-cigarettes. It should be, because these products will be very different from the consumer products in their packaging and labelling. Even if they are made by the same

company, the standards they will be made to will be different. Again, that is something on which the Committee could usefully get clarification.

Q303 **Chair:** Given that for many people e-cigarettes appear to be more attractive than traditional nicotine replacement therapy because they are a consumer product, is there a danger that a prescribed, medically licensed product will be less attractive to people than a consumer product that is marketed in the normal way?

Deborah Arnott: People will have the choice. It is about creating greater choice and opportunity, I suppose. Viagra and Temazepam are prescribed. That does not mean that they are not widely used for—

Q304 **Chair:** Do we have any idea whether there is interest from producers in putting forward a product for licensing through the MHRA?

Deborah Arnott: Yes. One product was put forward to the MHRA just before Christmas. A number of manufacturers have talked to me and are interested, but they want more certainty and encouragement. It is a big investment to put a product through the licensing process.

Q305 **Chair:** Can we deal with heat-not-burn? What is your view on that?

Deborah Arnott: Currently, our survey, like others, shows that there are very low levels of use. As you know, the Committee on Toxicity has looked at heat-not-burn products and concluded that they are likely to be less harmful than cigarettes. It has not compared them specifically with e-cigarettes, but, if you look at what these products are delivering, they are likely to be somewhere between combustible tobacco and e-cigarettes. NRT is less risky still.

Q306 **Chair:** Are the levels of use low in part because companies are not permitted to market them?

Deborah Arnott: They are permitted to market them, but they are not permitted to advertise them.

I am slightly cautious about heated tobacco products. They have been very successful in Japan, but in Japan e-cigarettes are not allowed. My view is that the transnational tobacco companies, from which you have heard, have designed heated tobacco products to replicate the smoking experience and their stranglehold on the market. With IQOS, the most widely known product, you buy a device and then packs of 20 heat-sticks, which you use in it. Those are proprietary products that are difficult to copy and quite expensive. E-cigarettes are much cheaper. I can go into the relative prices now, if you are interested, because it is quite salutary. They are also not so proprietary. If you buy a device that is an open system, you can use any e-liquid that you want. That is a benefit to consumers. I think that it is appropriate that these products are legal and on the market, under a notification process, but we need to see how that develops.

Q307 **Chair:** Would you argue for taxation based on the level of risk, on the

evidence?

Deborah Arnott: Yes. It is difficult to know exactly what the level of risk is. E-cigarettes have only VAT. Heated tobacco products have excise tax, in line with other tobacco products. The exact figures are in my submission, but you do not need those at the moment. They are much lower than for combustible tobacco—either manufactured cigarettes or roll your own.

The Treasury has just announced that it will have a new category for heated tobacco products. I do not know exactly what the tax rate should be. However, I think that having them taxed as tobacco products, but less heavily than combustible tobacco products, is appropriate. Where they are at the moment does not seem inappropriate. We can revise that over time.

Q308 **Chair:** I am not sure I am clear on that. Are you saying they are taxed at a lower rate than combustible products?

Deborah Arnott: Yes; they are taxed on the basis of weight. For a start, their weight is quite low. I do not know whether you have seen the packs of heat sticks, but they are smaller. The weight per kilogram for other tobacco products is significantly lower. I can get the figures for you if you would like them now. For roll-your-own, it is £221.18 per kilogram at the moment, whereas for other tobacco products, which is where heat sticks would come in, it is £119.13 per kilogram. You can see that is significantly lower, and manufactured cigarettes are taxed at a higher rate than roll-your-own.

Q309 **Graham Stringer:** I understand that the two of you co-authored a paper on the association between e-cigarettes and smoking. Can you tell the Committee your conclusions and findings in that?

Deborah Arnott: Is that the paper on youth use?

Graham Stringer: Yes.

Deborah Arnott: Yes, and thank you for asking that. This recently published paper has been misinterpreted by an American academic as demonstrating strong evidence of a so-called gateway effect. That is not the case. Causal mediation analysis was used to investigate whether there was a causal relationship, and basically it showed it was equally likely you would move from smoking to vaping, and vice versa. The other point to recognise is that this was over six months, so it was short term and involved small numbers. The total sample size was about 1,100. Only 21 young people had tried an e-cigarette but not smoked, compared with 118 who had tried smoking but not e-cigarettes. In line with our recent survey, we are not seeing a gateway effect transposing to behaviour at population level among young people.

We were the first people to do a survey looking at youth use. We think it is really important to keep monitoring it. That is why we carry out an

annual survey, and we will continue to do so. However, the proportion of young people smoking has continued to decline over the period where e-cigarettes grew most rapidly in popularity. Smoking remains the key problem, not vaping. Many times more young people smoke than vape. We need to continue to monitor. In papers such as the *Daily Mail* in particular, you see headlines that vaping is a gateway into smoking for young people, but currently the evidence is not there. That is also why we support an age of sale of 18 and restrictions on advertising of e-cigarettes. We want to manage those risks; we do not want to see large numbers of young people taking up vaping and moving on to smoking.

Q310 **Graham Stringer:** At the moment young people cannot buy e-cigarettes or cigarettes. Do you think there should be any change in the regulatory regime around e-cigarettes?

Deborah Arnott: We think it needs to be kept under review. There is not really a possibility at the current time.

Q311 **Graham Stringer:** It is political—

Deborah Arnott: The age of sale of 18 is fine. I do not think we need to move to a rapid change in the regulatory system at the moment because there is no evidence that the system we have is causing problems, as opposed to supporting quitting in a context where we are not seeing lots of young people taking up smoking. There is not a massive problem with the current regulatory system. I am sure it can be improved and it needs to be reviewed over time, but in the current political environment there is no possibility of an immediate change in the regulatory system, and I do not think it is necessary.

Graham Stringer: That is very clear.

Q312 **Carol Monaghan:** Do you see any risks in terms of innovation with e-cigarettes that makes them more attractive or addictive to young people or vulnerable adults?

Deborah Arnott: One needs to separate out attractiveness and addictiveness. The advertising regime is quite clear. There are limited opportunities to advertise and they have to be advertised in an appropriate way, so I do not think there is a problem there. As to the products at the moment, there is not a massive amount of research on the speed of uptake, which is closely linked to the level of addictiveness. It is certainly possible that there could be new and innovative products that are more addictive. There are potential benefits as well as risks, because at the moment e-cigarettes are not a magic bullet. Not all smokers find them attractive or useful. Even many of those who try them decide they are not good enough, attractive enough and satisfying enough, so they revert to smoking.

If there were products that delivered nicotine more like smoking, they might well be more effective in helping smokers to quit so there is a

benefit there, but there is a concomitant potential risk that they might be more likely to attract young people. That is something that needs to be monitored and managed.

Q313 **Carol Monaghan:** What about the particular flavours that are marketed? Are you at all concerned about them?

Deborah Arnott: No would be my answer. There are concerns about flavours that appear to be attractive to young people. I do not think we find it is a massive factor in young people trying e-cigarettes; they are trying them more because they are there.

Hazel Cheeseman: They report they are trying them because peers are trying them and just to give them a go. Flavours are not a very big factor in young people's use, but they appear to be important in adult use. In addition, the range of flavours means people can move away from tobacco flavours, which for some smokers or ex-smokers is really important. I guess it is the same with the "addictiveness" point. Flavours have pros and cons and they are part of the reason why e-cigarettes are as attractive as they are to adult smokers.

Deborah Arnott: Nicotine is an aversive substance; it is quite difficult to inhal. Smoke facilitates inhaling it into your lungs. The flavours help smokers find something they can move to, so they play an important role, but they are also potentially part of the risk in the product. We do not know what the impact of all the flavours is. Some flavours have been identified as positively harmful and have been banned. Under the EU regulatory system, if there is evidence about others being harmful, they can be banned too.

Q314 **Carol Monaghan:** How do we make sure we are getting the message out to young people about the risks from e-cigarettes?

Deborah Arnott: I think the best way to get messages to young people is the same as the best way to get messages to adults: mass media campaigns, backed up by social media and digital media, which have been very successful in reducing smoking prevalence. However, my concern is that we have seen spend on anti-tobacco campaigns cut in recent years. At its peak, the Government were spending nearly £25 million a year on those campaigns in 2009-10, which was pretty much in line with best practice. In the most recent year for which we have a figure, 2016-17, it was only £4 million. I do not have a figure for the current year.

Q315 **Carol Monaghan:** It is £25 million to £4 million.

Deborah Arnott: Yes. It has been a massive cut, and we are worried about that. That has been associated with the declining uptake of stop smoking services. There are risks around all of that. One of the things PHE has to be applauded for is that in its most recent Stoptober campaign it used that to promote quitting but also to promote a positive role for e-cigarettes.

It is important that young people understand the risks of smoking and e-cigarettes are put in that context, because believing that nicotine causes cancer, which a significant minority of adults and children seem to believe, is not helpful or positive. The misunderstandings that we see are not helpful to continuing to reduce smoking prevalence. We want to develop a better understanding of nicotine and the role it plays.

Q316 **Carol Monaghan:** The reduction from £25 million to £4 million is unthinkable. You also mentioned quitting services. What about the funding of these? Does that remain steady?

Deborah Arnott: As you know, in the coalition Government there was a move from public health being run by the NHS to local authorities and budgets were transferred. Initially, that was fine, but obviously there have been massive cuts. There have been cuts in public health as well as local authority funding. We are seeing an increasing number of local authorities either cutting back or completely eliminating their stop smoking services. Unfortunately, it is going along with the NHS not doing what it should be doing to help smokers to quit and, in some cases, saying it will not fund prescriptions in places where stop smoking services do not exist.

Q317 **Chair:** Yet there does appear to be an acceleration in the reduction in smoking prevalence alongside cuts in the budget. It is hard to see cause and effect, but it may be related to the plain packaging.

Deborah Arnott: In the broader context, we are one of the global leaders in tobacco control: plain packaging; getting rid of sales of tobacco through vending machines; putting cigarettes out of sight; increased taxation year on year above inflation; and tackling smuggling. All these things have been fine.

Q318 **Chair:** They have been effective.

Deborah Arnott: On stop smoking services, there is a massive issue of health inequalities. Smoking rates have declined much more rapidly in the professional classes than among manual workers and poorer and disadvantaged people. That is where stop smoking services and the NHS doing more have a real role to play. It is not living up to what it should be doing.

Hazel Cheeseman: Although smoking rates are coming down in the adult population, there is at least one group where we have not seen progress over the past 12 months. For pregnant women, rates of smoking throughout pregnancy have not declined where they had previously. It is possible that the lack of coherent service provision across the country is playing a part in why we are not seeing that decline among pregnant women. We do not have good enough data in relation to people with mental health conditions, but, given the higher levels of dependency and the barriers that people face, it is plausible that it will cause problems for supporting that community to quit too.

Q319 **Carol Monaghan:** Is there more we could be doing to support schools and professionals who are working with young people to prevent them taking up e-cigarettes or other cigarettes?

Deborah Arnott: Schools are always being asked to do new things. My son is a teacher. They do not have the capacity to do a lot more unless it can form part of the existing curriculum, and that is really important. The harm caused by smoking needs to be an essential element of health education in schools, but some of the best practice is where it is integrated into other subjects such as maths and biology. Half of all smokers die prematurely from smoking-related diseases. That is a very simple lesson in probability. I have seen examples of schools using that and that is very useful, so it needs to be integrated. Having specialist projects that are funded are, first, very expensive and, secondly, not sustainable.

Q320 **Stephen Metcalfe:** Before I come to questions about smoking and mental health, have we seen a fall generally in the level of experimentation or take-up among young people, not necessarily related to e-cigarettes, to reinforce whether or not these messages in schools and so on are getting through?

Deborah Arnott: When you say "generally," do you mean in other things such as illegal drugs and alcohol?

Q321 **Stephen Metcalfe:** No. I am referring specifically to smoking but not those trying e-cigarettes. Is the number of young people who try a cigarette falling?

Deborah Arnott: Yes.

Q322 **Stephen Metcalfe:** Can you give us any numbers for roughly the past 10 years and perhaps explain why you think that might be?

Deborah Arnott: It is in the smoking, drinking and drug use survey. We can send you more detailed data, but basically smoking rates are going down and experimentation is going down too. I think that in 2006 the rate of child smoking experimentation was 39%, and in 2016, the most recent year, it was 19%.

Q323 **Stephen Metcalfe:** It is slightly higher than the overall level of smoking but much lower than it used to be.

Deborah Arnott: Yes.

Hazel Cheeseman: That is experimentation, so it is about ever having tried it.

Deborah Arnott: The actual smoking rate is much lower.

Q324 **Stephen Metcalfe:** Therefore, the hard-to-reach group you were talking about will diminish because you are saying that the overall number of people taking up smoking is also falling.

Deborah Arnott: Yes, but my concern would be that the smoking, drinking and drug use survey that that comes from does not give you class differences because it is a survey of young people in schools. All the other factors such as advertising, promotion and sponsoring are changing. The environment you grow up in is more important. If your parents or others in the household smoke, or you live in a community where smoking is very common, you are much more likely to take up smoking yourself, and we are seeing growing class differences there.

Q325 **Stephen Metcalfe:** The point I am trying to get to is that, even though the overall budget for smoking cessation has fallen, should we be asking that whatever budget is spent is targeted more specifically at the hard-to-reach group rather than just general messaging if we have already succeeded in some of that?

Hazel Cheeseman: There is a difference between general messaging and the provision of services. You are right that, in a context where there is a diminishing budget, to deliver services directly to people focusing on those who face the most barriers to quitting would be an appropriate allocation of resources, but that does not replace the need for mass media campaigns and those high-impact, population-level measures that we know have an effect in the poorest communities as well.

Deborah Arnott: If you ask PHE about mass media campaigns, they will explain that they do target them. Mass media is good in that way. You can target specific populations; you can put advertisements in programmes that will be seen by the group you are targeting.

Q326 **Stephen Metcalfe:** To go to smoking and mental health issues, we asked English mental health trusts about their approach to e-cigarettes, and it seems there is no collective policy on whether or not they should be allowed or encouraged. Do you think it would be useful to have a single policy—a collective and agreed approach to these issues?

Hazel Cheeseman: Yes. I would say a little bit about the mental health and smoking partnership that I represent. ASH co-ordinates the partnership. It was set up in 2016. It is co-chaired by Professor Ann McNeill, who is an academic at King's and also the lead author on the recent PHE report on e-cigarettes, and the Rt Hon Paul Burstow, former Minister of Health and now chair of an NHS mental health trust, among other things. Its members include the Royal College of Psychiatrists, Rethink Mental Health and so on, so in a way I am speaking on behalf of this coalition.

We agree with the findings of the Committee in its survey of mental health trusts. The inconsistency between policies is inappropriate. One of the things the partnership has been looking at over time has been the issue around e-cigarettes, and we have produced materials aimed at helping to support trusts in thinking about the issue of e-cigarettes. We were deeply concerned about the variation we saw both between trusts

but also within them where individuals could move from ward to ward and not have a clear expectation of what the policy was on e-cigarettes.

Clearly, what you found in your survey work and we have also found in our engagement with trusts is a massive variation from quite liberal policies that allow a variety of different types of electronic cigarettes in a number of different places through to its complete prohibition. Where we see this complete prohibition, our concern is that this is unfair to service users who are perhaps detained under the Mental Health Act and are not allowed to smoke in the context of a smoke-free NHS. It does not support the implementation of these smoke-free policies, nor the efforts to support more people to quit smoking, and there is a missed opportunity in how in-patient environments can help inform a community environment, which, after all, is where the majority of people with mental health conditions are most of the time.

We see mental health trusts such as South London and Maudsley mentioned earlier, which have implemented fairly liberal policies in relation to electronic cigarettes, alongside comprehensive smoke-free policies and appropriate support for good quit services, and they have really positive outcomes from those policies.

I would not want the Committee to think that allowing the use of electronic cigarettes in mental health trusts is a panacea to all the problems in relation to the high levels of smoking in this community; it certainly is not, but it appears to be a useful and important part of the overall policy that is focused on how to support more people to quit smoking. I should have said at the beginning that the rates of smoking among people with a mental health condition are incredibly high compared with the general population, and even higher when you look at the number of people in in-patient environments, which some surveys have found to be up to 80%. So, it is a really deep concern.

Q327 **Chair:** It is the biggest cause of premature mortality.

Deborah Arnott: Absolutely.

Hazel Cheeseman: Indeed. If we are serious about reducing the difference in life expectancy between people with a mental health condition and the rest of the population, we really need to bring down the rates of smoking. What the partnership sees in relation to electronic cigarettes is a big opportunity to do something for a population that faces really big barriers to quitting: higher levels of addiction; a tendency to live in communities where smoking is high and the healthcare staff they are engaging with may have quite low expectations of their ability to quit. Therefore, using electronic cigarettes in that way can be really positive.

Heather mentioned that there is in existence fairly generic national guidance from Public Health England in relation to forming policies within organisations. We think there is an opportunity to do something more

specific for mental health trusts that takes into account the complexities that mental health trusts are experiencing.

There is also guidance from the CQC. It has produced some guidance in relation to going smoke free, which looks at e-cigarette policies and says they should not be routinely treated in the same way as smoking. In our view, if trusts were taking on board the PHE and CQC guidance, it is unlikely that we would be seeing the complete prohibition of e-cigarettes.

There is also a programme of work between NHS England and Public Health England through their "Leading Change, Adding Value" programme, which is looking at the roll-out of smoke-free policies and e-cigarettes within mental health trusts. I do not think it is desperately well resourced. There may be an opportunity there to do more. Clearly, it is not widely known about across the mental health sector.

Q328 **Chair:** Who leads it?

Hazel Cheeseman: NHS England has the lead, and it is a collaboration between NHS England and Public Health England.

Q329 **Chair:** Is there a named person?

Deborah Arnott: We will find out the named person and get back to you.

Hazel Cheeseman: We think that further national guidance would be welcome, and certainly trusts tell us they face a number of problems in developing their own policies.

Q330 **Stephen Metcalfe:** Including trusts that have prohibition at the moment.

Hazel Cheeseman: Yes. Many of them obviously are keen to do the right thing by their staff and patients and are having to make assessments on an individual basis on the complex evidence out there in relation to e-cigarettes. Some of them might have done that a number of years ago and now have a policy that they are less—

Q331 **Stephen Metcalfe:** Is the evidence that complicated? We have heard consistently the same message coming through that this is an aid to cessation for many people, and it works and gets them away from cigarettes.

Hazel Cheeseman: There is certainly a misunderstanding of the best available evidence out there within the population.

Q332 **Chair:** It is a bit worrying if it is within the NHS.

Hazel Cheeseman: People who work in mental health trusts, I guess, are not necessarily that different from the rest of the population, so, given the fact we have such widespread misunderstanding in the population of what the evidence tells us, it is not surprising that trusts are coming to different views about what the evidence says. National

guidance on that and teasing out what the complexities are in mental health settings and how people might be able to move forward in those different environments would be welcome.

ASH has been commissioned by Cancer Research UK to undertake a survey of mental health trusts over this summer in relation to implementing NICE guidance and looking at what has happened around e-cigarettes and smoke-free policies, so, hopefully, the findings of that research can help to inform further national guidance, which we think is really important.

Deborah Arnott: The Committee's survey is very helpful to us in looking at this.

Q333 **Stephen Metcalfe:** The Government's tobacco control plan talks about "some professionals mistakenly believe that stopping smoking could negatively affect their patients' mental health." Presumably, you do not agree with that statement.

Hazel Cheeseman: No.

Q334 **Stephen Metcalfe:** What can we do to ensure that those with mental health conditions get the proper help to stop smoking?

Hazel Cheeseman: Not only do we need some central guidance and policy in relation to e-cigarettes and smoke-free policies, but greater investment in the training of mental health staff, given the sizeable part of the population they are working with who smoke, not only in relation to e-cigarettes, but more generally in tobacco smoking cessation and how to intervene. The partnership is producing materials that aim to tackle some of the myths in mental health services and backing it up with further resources, but as a charitably-funded collection of voluntary sector academia and professional bodies there is a limited amount we can do to intervene in mental health trusts. More training and support of mental health staff to be able to challenge these misunderstandings, which are really prevalent, but also to give them the skills to intervene with that population would be brilliant.

Q335 **Chair:** Do you feel that through your grouping you are getting good engagement from NHS England, or is there a need for them to elevate the priority they are giving to this?

Hazel Cheeseman: Tobacco and the impact of smoking is mentioned in the Five Year Forward View for Mental Health, and that is welcome. There is undeniably a lot of pressures on mental health services at the moment. However, if there is a genuine desire within NHS England and across mental health services to do something about this discrepancy in life expectancy, stronger engagement from NHS England and mental health services on this specific agenda would be welcome.

Deborah Arnott: It is not just on the mental health agenda. The tobacco control plan commits to implementation of NICE guidance. We know from

a survey by the British Thoracic Society that NHS implementation of NICE guidance on smoking cessation is not good.

Q336 **Chair:** In what respect?

Deborah Arnott: Smokers with smoking-related diseases are not being asked whether they smoke. If they are asked whether they smoke, they are not being offered encouragement or advice to quit and prescribed medication. Some hospitals still do not have them on their formularies. We would like to see NHS England having a strategy for tackling smoking. Mental health is a really important part of that, but it needs to be a coherent strategy by NHS England about how it will meet its commitments in the tobacco control plan for England. Public Health England has a strategy but NHS England does not, and I think it has a really important role to play. I know that the NHS has all its challenges, but this is important not just for people with mental health conditions, but smoking-related disease is very costly to the NHS.

Q337 **Chair:** That would reduce cost pressures on the NHS.

Deborah Arnott: It would reduce cost pressures and readmissions. It would have all sorts of benefits, but it is not seen as core to NHS work. Simon Stevens has been very positive about prevention and I know he thinks that smoking is important, but the problem is that prevention is always low down the list of priorities and at the top are all the immediate pressures—the winter crisis and so on.

Q338 **Chair:** Is there any emerging evidence from Australia—I guess it is unlikely to be available yet from the UK—on plain and standardised packaging? Can we associate it with any reduction, or is it just impossible to tell what is cause and effect?

Deborah Arnott: It is fairly early on because, a bit like advertising, there is a cohort effect, in that children growing up now will never see those glitzy packets. There is some initial evidence. I can send you the exact evidence that did seem to show an immediate impact on numbers of smokers trying to quit and on youth use. Cancer Research UK has funded some research on the impact of plain packaging, but it is a bit early to say here. What we can see is that, as part of a comprehensive approach, we are now basically a dark market for tobacco. The pack was the last way in which the industry could really promote its brands, and in the UK we are certainly seeing that the premium brands do not have the cut-through they used to have, so smokers are trading down.

Q339 **Bill Grant:** Hazel, in your introduction you mentioned a responsibility to discourage pregnant women from smoking and you mentioned it elsewhere. In that regard, would it be wise to encourage women who are pregnant and are conventional smokers to migrate to e-cigarettes, or would we be better focusing on discouraging them from smoking altogether? Where would you put your resources? Would it be on encouraging them to migrate to e-cigarettes, or would you still focus on stopping smoking? Deborah might want to come in as well.

Hazel Cheeseman: I will just give a little intro to the Smoking in Pregnancy Challenge Group that was established in 2012 to support the Government's ambition to reduce smoking in pregnancy. It is a coalition of the Royal College of Midwives, Royal College of Obs and Gynae, The Lullaby Trust and other leading baby charities.

Currently, we have not seen a lot of progress in the reduction of smoking among pregnant women over the past 12 months. It is between 10% and 11%. While most women when they are trying to become pregnant, or when they find out they are pregnant, will quit smoking, those who do not have higher levels of addiction and are in communities where smoking is more common. They tend to be younger, more disadvantaged and more economically disadvantaged and so face major barriers to quitting. It is really important that those women are identified quickly and given access to the best support they can have to help them quit smoking. That is the evidence-based support that we provide through stop smoking services. There are problems with that, which we have already talked about, and the performance of local healthcare systems varies.

We do not think that electronic cigarettes are an alternative to providing that high-quality support. However, we have to recognise that for some women using an e-cigarette is how they will be able to abstain from smoking in pregnancy, and it is much better for both mother and baby than continuing to smoke. We have produced guidance for midwives and visual aid to pregnant women, which we can provide to the Committee. That talks about how to make an informed decision about using e-cigarettes. We want health professionals to give women advice about using evidence-based stop smoking services and medications, but if women do not want to access the service, or cannot access it, or the services are not working for them and they want to use an electronic cigarette as a way of abstaining from smoking, they need to be given the advice that all the evidence we have suggests that using an e-cigarette will be safer than continuing to smoke.

Our concern is that, without this advice, there is a risk that women might revert to smoking. Women need to have confidence that these products are a safer alternative if they are going to be sufficiently encouraged to use them. Some of the findings from early research presented in our submission have shown that pregnant women who are using e-cigarettes feel there is a real stigma attached to their use and are worried about using them in public. Our concern about that is that they might not be using them enough and there is a risk that they continue to smoke because they are not getting enough nicotine from alternative sources.

The advice healthcare professionals can provide is really important. From my own experience, one nurse in particular was telling me about a woman who had come into a practice. She had quit smoking and was using an e-cigarette, but she had seen a headline about how awful e-cigarettes were and had gone back to smoking. She was asking the

nurse for advice. She said, "What should I have said?" I asked her what she did say. She said, "I didn't say anything because I didn't know what to say." That is not an okay position for healthcare professionals to be adopting. They need to be communicating to pregnant women and to all smokers that using an electronic cigarette is safer than continuing to smoke.

Q340 **Chair:** Do you think practice varies a lot around the country?

Hazel Cheeseman: Yes, I do. The advice we have provided through the Smoking in Pregnancy Challenge Group has been very widely disseminated, and NHS England and Public Health England have been really good partners in getting that information out there. There is less variability in practice than there might otherwise be, but there continues to be variability in practice even around the prescription of nicotine replacement therapy. That has been licensed for use in pregnancy for over a decade, and there is still uncertainty among midwifery and other maternity staff about whether it is okay to use NRT in pregnancy. The evidence we have is clear that it is safe to use in pregnancy. The studies that have given cause for concern have tended to involve mice. It turns out that the evidence does not translate across into humans.

One of the concerns out there is whether we know enough about e-cigarettes and whether the evidence is specific to pregnancy. We do not have a great deal of evidence that is specific to pregnancy, but we do know a lot about the toxins in tobacco smoke and how they are dangerous to the unborn baby. One of the most dangerous toxins in pregnancy is carbon monoxide, a by-product of combustion, which is obviously not found in e-cigarettes because there is no combustion. When a woman is inhaling carbon monoxide she is oxygen-starving her baby, which results in the illnesses and abnormalities.

Deborah Arnott: They are smaller babies; they are more likely to be in special-care units after birth, or to die.

Hazel Cheeseman: There is a greater incidence of still birth and miscarriage. Cutting out even carbon monoxide is a great step forward. We need women to be informed. We do not know everything about e-cigarettes, but, if they are using them as an alternative to smoking, they will be substantially protecting themselves and their babies from the harms of continuing to smoke.

There may well be some other advantages from encouraging or at least supporting women to use electronic cigarettes during pregnancy. One of the big problems is that women often relapse to smoking once the baby is born, and electronic cigarettes might well be a route to enable parents not to smoke or keep their house smoke-free if they are not able to abstain completely. One of the findings from this year's survey, which looked at parents who vape and have children under the age of five, is that they are twice as likely to say that the main reason they use electronic cigarettes is to protect others from second-hand smoke. We

can see that probably parents are using those products already to keep their homes smoke-free, so there may be a potential to improve that in the future.

Q341 **Bill Grant:** You introduced a further element for pregnant smokers: nicotine replacement therapy. Would you prefer to direct them to nicotine replacement therapy in the first instance, as opposed to the use of e-cigarettes? What would be the order of merit in that regard? I know the first one would be to stop smoking; that must surely be the priority.

Hazel Cheeseman: If you were to have a hierarchy, it would be to quit before conception; quit when they find out they are pregnant; access to stop smoking services and the evidence-based medication that we have absolute confidence in; and e-cigarettes would be the next layer of intervention.

Q342 **Bill Grant:** Followed by nicotine replacement therapy.

Hazel Cheeseman: I think behavioural support and medication come together. I think e-cigarettes as well can be used alongside behavioural support, which has been shown to be more successful.

Q343 **Chair:** Because you could have a process that takes weeks while the damage continues to be done. Presumably, it is better to get a pregnant woman using an e-cigarette rather than smoking as early as possible rather than going through a whole process.

Deborah Arnott: You can have that discussion on booking, if it is clear that she is not interested in it.

Q344 **Chair:** You deal with it all upfront.

Deborah Arnott: You should be able to deal with all of it up front, and obviously there is a need for training.

Q345 **Carol Monaghan:** Can I ask about couples trying to conceive? I believe that nicotine has an effect on sperm. Have there been any studies into the impact of e-cigarette use on couples who are trying to get pregnant?

Hazel Cheeseman: We might need to come back to you on the specifics of the evidence around nicotine. My understanding is that it is not nicotine but tobacco smoke that has an impact on sperm. I am not aware of any current research in relation to vaping and conception.

Deborah Arnott: There is good research on tobacco smoking related to the fertility of both men and women. It damages sperm and also affects fertility.

Q346 **Chair:** But we do not think that applies to vaping.

Hazel Cheeseman: I do not think it applies just to nicotine, but we can double-check and come back to the Committee. I do not think there has been any specific research to connect conception with nicotine.

Deborah Arnott: In terms of relative risk, it is the smoke that does most of the damage.

Q347 **Carol Monaghan:** I found a site a minute ago, but obviously I am not sure where these sites are getting their evidence.

Deborah Arnott: We will go away and look at it.

Q348 **Carol Monaghan:** It would be useful if you could give us that.

Hazel Cheeseman: Much of the research that has been done internationally has been in mice, and the evidence that that applies to humans does not seem to be there. The evidence is really strong around tobacco smoke, and we can clarify the point you raise.

Deborah Arnott: The message is that if you are trying to conceive you should certainly quit smoking. It is probably best not to vape, drink too much or do all these other things, but at the end of the day the key thing is relative risk, so certainly quit smoking.

Q349 **Chair:** To finish on the issue of pregnancy, you are saying that currently more than one in 10 women smoke during pregnancy.

Hazel Cheeseman: They smoke to the end of pregnancy. The data we have is from smoking at time of delivery, so more women than that will smoke during their pregnancy.

Q350 **Chair:** More than one in 10.

Hazel Cheeseman: Yes.

Q351 **Chair:** There is a significant public health issue here that still needs to be addressed more effectively.

Hazel Cheeseman: Absolutely.

Deborah Arnott: It is a core part of the Government wanting to reduce still birth and perinatal mortality. That is absolutely right. It is a leading modifiable risk factor, so we need to do more.

Q352 **Bill Grant:** I read in the note that women, for various reasons, are giving birth later in life, as is their right—that is, in their 30s as opposed to earlier. Does smoking have a greater impact on older mothers, or is it exactly the same for older and younger mothers?

Hazel Cheeseman: Older women are less likely to smoke in pregnancy than younger women.

Bill Grant: That is good.

Hazel Cheeseman: Older women who give birth tend to be from higher socioeconomic groups and are less likely to smoke anyway.

Deborah Arnott: But if they do smoke they will have been smoking for longer, and obviously the number of years you smoke will have an impact too.

Q353 **Stephen Metcalfe:** Someone has just sent me an email about VApril. Are you aware of that, and are you supporting it?

Deborah Arnott: I think VApril is an initiative of the UK Vaping Industry Association, which is a tobacco industry-funded trade body. PHE has been working with the Independent British Vape Trade Association, which is non-tobacco industry-linked. As you know, we are a party to the framework convention on tobacco control. It is fine for them to do what they do, but we certainly would not partner with tobacco industry-funded bodies.

Q354 **Stephen Metcalfe:** I can understand that, but what about the principle?

Deborah Arnott: We think that promoting vaping is a good thing in principle.

Chair: Thank you both very much indeed. It has been a really useful and interesting session.