HOUSE OF COMMONS

Science and Technology Committee

Oral evidence: E-cigarettes, HC 505

Tuesday 24 April 2018

Ordered by the House of Commons to be published on 24 April 2018.

Watch the meeting

Members present: Norman Lamb (Chair); Bill Grant; Darren Jones; Liz Kendall; Stephen Metcalfe; Carol Monaghan; Damien Moore; Neil O'Brien.

Questions 355 - 495

Witnesses

I: Rob Morrison, Senior Regulatory Policy Executive, Advertising Standards Authority; Professor John Newton, Director of Health Improvement, Public Health England; Professor Gillian Leng, Deputy Chief Executive, National Institute for Health and Care Excellence; and Dr Ian Hudson, Chief Executive, Medicines and Healthcare products Regulatory Agency.

II: Steve Brine MP, Parliamentary Under-Secretary of State for Public Health and Primary Care; and Dr Tim Baxter, Deputy Director of Healthy Behaviours, Department of Health and Social Care.

Written evidence from witnesses:

- Advertising Standards Authority
- Public Health England and the Medicines and Healthcare products Regulatory Agency
- National Institute for Health and Care Excellence
- Department of Health

Examination of witnesses

Witnesses: Rob Morrison, Professor John Newton, Professor Gillian Leng and Dr Ian Hudson.

Q355 **Chair:** Good morning, all of you. Thank you very much for attending. May we start with very brief introductions? I apologise for the late start—some private business took us over our time.

Rob Morrison: I am Rob Morrison, the e-cigarettes policy specialist at the Advertising Standards Authority.

Professor Newton: I am John Newton, director of health improvement at Public Health England and am responsible for tobacco control.

Dr Hudson: I am Ian Hudson, chief executive of the MHRA.

Professor Leng: I am Gillian Leng, deputy chief executive at NICE, the National Institute for Health and Care Excellence.

Q356 **Chair:** Thank you. Will you start by setting out your organisation's view on e-cigarettes? With regard to the ASA and the MHRA, will you briefly describe the regulatory approach you take? Will each of you go in turn? We have quite a lot to get through and there is a panel of four. I urge you to keep your answers succinct. Do not feel that all of you have to answer every question. We will start with you, Rob.

Rob Morrison: Our general policy outlook is that, where products are legal and are available to be sold, they should be capable of being responsibly advertised. Our major strands of work on e-cigarettes involved the implementation of sector-specific rules controlling the content, placement and scheduling of e-cigarette ads in 2014. In 2016, we mirrored the wide-ranging advertising prohibitions that have come from the tobacco products directive, with which you will be familiar. We have been enforcing those since then. Our most recent strand of work was a consultation late last year to revisit the prohibition on health claims that we implemented in 2014. I can come back to that, if the Committee would like.

Chair: We will return to that.

Professor Newton: First, it might be worth pointing out that the UK has an excellent record on tobacco control in general. We are delighted to see in the last five years a reduction in smoking rates of a quarter. We have a very good track record and are internationally judged as excellent at tobacco control.

Q357 **Chair:** We are down to 16% now, aren't we?

Professor Newton: Yes—15.5% or 16%.

Q358 **Chair:** Is that one of the lowest figures in Europe?

Professor Newton: It is one of the lowest in Europe. Sweden is still lower, but they use snus. Of course, Sweden is a much smaller country. We are very pleased with that progress.

The approach across the UK has been to maximise the potential for e-cigarettes to drive down smoking prevalence but at the same time to manage any risks with appropriate regulations. As you will hear—I am sure you already know this—the regulation in the UK is among the strictest in the world, apart from those countries that ban e-cigarettes outright. We are pleased to see that we have minimum standards on safety for the devices. We have strict control of advertising, controls on packaging and the description on the e-cigarettes themselves, and a minimum age of purchasing, which is important.

Public Health England has a number of roles. We continue to review the evidence and publish information for professionals and the public about e-cigarettes. We include messages about e-cigarettes in our public-facing campaigns—particularly Stoptober 2017, which was an important event—and produce guidance for health professionals, in particular, and employers.

At the moment, we are concerned about the misperceptions about relative harm among the public. We are also somewhat concerned that the uptake of e-cigarettes seems to have plateaued among smokers. We are very pleased to see a general consensus around the view that the use of e-cigarettes is likely to be substantially less harmful than smoking.

Q359 **Chair:** You have come up with the figure of 95% less harmful. Is that just a broad-brush expression of their being vastly safer, or is there science behind the 95% figure?

Professor Newton: We quoted the figure. In fact, it originates from a review of the evidence by independent scientists, who were themselves quoting another figure. Our position on the figure is that it is the best available published estimate. It has value. We are trying to convey the extent to which e-cigarettes are likely to be much less harmful than smoking cigarettes. It is a useful figure, but it is not a precise scientific estimate. As the Committee will know very well, it is not the sort of issue you can put a single number on. We are trying to convey the extent to which e-cigarettes are likely to be much less harmful than smoking cigarettes.

Dr Hudson: We regulate e-cigarettes under the tobacco products directive. We run the notification scheme for e-cigarettes. Companies enter their details—on the nature of the product, the ingredients, the toxicology and the emissions—in the European portal. We download and publish the data in the notification scheme. After that, we run a vigilance scheme. Any safety issues that occur with products can be reported to us via the yellow card scheme. We may receive intelligence from elsewhere. Working with trading standards and our partners, we can take action to address any safety issues that emerge in the course of use.

There are limitations under the scheme, which limits tank sizes to 2 ml and refills to 10 ml, and sets a maximum concentration of 20 mg per millilitre. That is the notification scheme that we run.

The alternate route, theoretically at least, for products to get to the market is via the medicines licensing regime, but that has not proven particularly popular. We may get into that a bit more during the discussions.

Q360 **Chair:** You say that it has not proven particularly popular. There is not a single—

Dr Hudson: Nothing is marketed. That is correct.

Chair: We will come back to that.

Professor Leng: NICE's role is to issue guidance, based on the evidence produced by an independent committee. The guidance is aimed at professionals and commissioners. It is not aimed directly at the public, although we know that the public have an interest in what we produce. Indeed, so do the media sometimes, so stories get out in that way. It is primarily evidence-based guidance for professional groups.

Our most recent piece of relevant guidance was published in March this year. It was on smoking cessation interventions and services, so it was in the particular context of stopping people smoking. It was not an overarching statement on e-cigarettes. We were clear about providing advice to people who smoke and are interested in using an e-cigarette. We said a number of things. We explained that they are not licensed medicines, but that they are regulated, and advised that many people have found them helpful to quit smoking. We advised that people stop smoking tobacco completely, that evidence suggests that e-cigarettes are substantially less harmful to health than smoking, but are not risk free, and that the evidence, including the evidence on the long-term health impact, is still developing. We set out all those things for professionals so that they could have that informed conversation with smokers.

We have a suite of guidance on smoking that we are currently beginning to update. A particularly important piece will be around harm reduction, smoking prevention in children and stopping smoking in pregnancy. That is under way. We are currently scoping it, and it will be published in early 2020.

Q361 **Chair:** Professor Newton, you gave evidence to the Australian Health, Aged Care and Sport Committee. You said that the current evidence "points us towards cautious use of e-cigarettes," rather than the more precautionary approach of the Australians, who take a totally different approach. What do you think is the reason for the different approaches of the UK, Australia and, indeed, the United States?

Professor Newton: Why different countries have looked at the same evidence and come to slightly different conclusions about regulation is an

interesting question. The Australian situation was different. They had lower smoking rates to begin with when e-cigarettes first appeared. The feeling there was that they could continue to control and drive down smoking prevalence without using e-cigarettes. Therefore, in the absence of clear evidence of safety, it was wise to ban them.

The situation has changed. In fact, I believe that the outcome of that Australian review was mixed, with some members of the Committee—

Q362 **Chair:** The Chair disagreed with the rest of them.

Professor Newton: Indeed. It would have been interesting to have been a fly on the wall in those discussions.

Chair: I might experience it from time to time.

Professor Newton: Yes. One could ask the question, if the Australians were making the decision de novo now, would they come to the same conclusion? What we know is that in Australia smoking prevalence has plateaued and has not continued to decline, in the way it has in the UK and the US.

Q363 **Chair:** You feel very confident that we are in the right position, based on the evidence.

Professor Newton: I feel confident. The scale of the harm from tobacco is so great, with 79,000 premature deaths a year caused by smoking, that, if there is a good chance that more smokers will quit if they are encouraged to use an e-cigarette than would otherwise quit, the precautionary principle suggests that one should remove barriers to smokers using e-cigarettes to quit. That is likely to save more lives than banning them completely.

Q364 **Chair:** This question is for John and Gillian. It relates to the assertion that getting people on to e-cigarettes maintains an addiction to nicotine. How significant a concern is that to you, if it is a concern at all? What are the potential health risks associated with that?

Professor Leng: That is the distinction between using e-cigarettes as a quitting aid, which you can clearly do—you can downgrade the amount of nicotine that you get through the product, which can help you to stop your nicotine addiction—and where that becomes a long-term lifestyle choice. There might be questions about that, because of the way in which e-cigarettes are being marketed. They are being marketed as an interesting, exciting, edgy product, which might encourage people to use them in the longer term.

Q365 **Chair:** Is there a problem with it being a long-term lifestyle choice? If it does not have any health consequences, that is for the individual, isn't it?

Professor Leng: That is for the individual. We know that they are substantially safer than cigarettes, so that is good.

Q366 **Chair:** What is the risk of continuing to be addicted to nicotine?

Professor Leng: The risk is that we do not know what the long-term impact of using e-cigarettes is, because they are new products. We really need to gather that information. They are 95% safer than cigarettes, but there is 5% we do not know about.

Professor Newton: There are some reassuring data on patterns of use. We know that, of the 2.9 million e-cigarette users, just over half have stopped smoking completely and are now using e-cigarettes. We also know that there are approximately 700,000 people who have been smokers, have used e-cigarettes and have stopped using e-cigarettes as well. The large-scale surveys suggest that there is a progression from being a smoker to using e-cigarettes to stopping. There is some evidence that nicotine delivered in an e-cigarette is less addictive than nicotine delivered through smoking.

Q367 **Chair:** Is any health risk associated with that continuing addiction?

Professor Newton: We do not know, because no one has used e-cigarettes in this form for that long. The scientific evidence suggests that the risk would be low—certainly, much lower than the risk from smoking cigarettes.

Q368 **Liz Kendall:** It is easier to get hold of nicotine gum, but nobody is going around saying, "There is a long-term potential risk of carrying on using nicotine gum." What is the difference you are worried about in e-cigarettes, as opposed to gum, or is there no difference? In that case, why is nicotine gum constantly prescribed? You can buy it in a chemist's whenever you want, but nobody ever warns you about it. Is there any difference between gum and e-cigarettes?

Dr Hudson: Gums have been licensed under the medicines route, with a full package of data. The questions that remain outstanding for me relate to some of the longer-term effects on the lungs from the flavourings, for example, and from the inhalational route.

Q369 **Chair:** In other words, it is nothing to do with the nicotine addiction.

Dr Hudson: It is not about that so much. It is the other elements that may be in it and the route of administration—the inhalational route.

Q370 **Liz Kendall:** It is not about the nicotine per se. It is about the mix of stuff in the e-cigarettes and the breathing in.

Dr Hudson: Yes.

Q371 **Chair:** Gillian, do you want to comment?

Professor Leng: There has been some concern expressed about the long-term use of nicotine gum. There has been no clear evidence that that is safe, either. There is no evidence that it is causing any significant harm, but questions have been raised about it.

Q372 **Chair:** Just to be very clear, it is massively less risky than smoking.

Professor Leng: Yes. It does not have those other components.

Q373 **Chair:** My next question is for Professor Newton and Professor Leng. In one of our earlier sessions, it became clear that there is no coherent policy across mental health trusts on the use of e-cigarettes to help service users to stop smoking, although they all apparently base their policy on the same guidance. Do you think there should be clearer central guidance, perhaps not only from Public Health England but from NHS England, which appears to be very reluctant to come to give evidence to us? It seems extraordinary to me that, according to our survey, a third of mental health trusts ban the use of e-cigarettes, given the evidence that you have both given to us this morning about relative risk.

Professor Newton: We have provided guidance to NHS trusts, including mental health trusts, and to employers on the basis on which they should produce their own policies. We think that there is value in individual organisations developing their own policies, based on a general understanding of the evidence, because they are more likely to know what their particular circumstances are. I agree with you that it seems unlikely that an overall ban is the right approach, given the evidence.

We would like any smoker who finds themselves in an NHS trust to have an opportunity to quit using e-cigarettes, if that is what they are choosing to use. I am pleased to say that, just today, the NCSCT has published this document—

Q374 **Chair:** What is the NCSCT?

Professor Newton: It is the National Centre for Smoking Cessation and Training. Today it has published guidance on good practice for mental health services. This is useful guidance, but it is not—

Q375 **Chair:** Does it encourage the use of e-cigarettes to help people to stop?

Professor Newton: It provides guidance on the use of e-cigarettes.

Professor Leng: Several years ago, NICE published some guidance on stopping smoking in an acute, maternity and mental health setting. That has done a lot to support the reduction in tobacco smoking. I went back to check what we had said about nicotine replacement products. It was far enough back for it to have focused on licensed nicotine-containing products. We advised that licensed nicotine-containing products were available and were on sale to encourage and support people to stop smoking, but clearly that guidance is now a bit out of date. As a support for this from NICE, we need to go back and to reference in that context what we have now said about e-cigarettes.

Q376 **Chair:** Will you do that?

Professor Leng: Yes, we will.

Q377 **Chair:** Over what timescale?

Professor Leng: I would prefer not to be put on the spot around a timescale.

Chair: I want to put you on the spot.

Professor Leng: As soon as we can—even it is just a short-term amendment.

Q378 **Stephen Metcalfe:** What you are all saying is very interesting. I assume that you all think that using e-cigarettes is considerably safer than smoking ordinary tobacco products. You are all professionals who are concerned about our ongoing wellbeing. Although you say that e-cigarettes are potentially 95% safer than smoking tobacco, is there a danger at this stage that the many buts, your reference to a cautionary approach and your statement that you are not sure about the long-term effect of the flavours, the nicotine and so on will drown out the key message, which is, "This product is 95% safer than smoking tobacco. You should move on to it. We will worry about the 5% risk at some later point"? The perception still prevails that e-cigarettes are not much safer than smoking tobacco. I wonder whether that is because, as professionals, you always want to give us the caveats, which are drowning out the key message that it is a safer product. Would you care to comment?

Professor Newton: You are absolutely right. Getting that balance right is crucial. It is right to be cautious and to keep an open mind. As the evidence accrues, the position needs to shift and, perhaps, to be a bit firmer about the relative lack of harm. We avoid using the word "safe," because that is a very difficult word to use, but there is no doubt that using an e-cigarette regularly is much less harmful than smoking cigarettes. It is important to get that message across, particularly to smokers.

Q379 **Chair:** Given that smoking is the biggest single cause of inequality of life expectancy for people with severe and enduring mental ill health, presumably you would want—following Stephen's point—to send out a really clear message to mental health trusts to end these ridiculous bans and to start to enable people to give up smoking through the use of e-cigarettes. Is that right?

Professor Newton: We certainly think that the NHS has an important role to play. A clear message from the NHS about the use of e-cigarettes would be helpful. It is not our position to tell NHS trusts what they should do, but we think—

Q380 **Chair:** It is your position to give clear guidance on public health matters.

Professor Newton: It is.

Q381 **Chair:** I want to hear what that clear guidance is on the use of e-cigarettes by mental health in-patients.

Professor Newton: We think that there is a misconception about safety and that all NHS trusts, including mental health trusts, should not put obstacles in the way of a smoker who wants to use e-cigarettes to quit. Therefore, we would like to see them provide opportunities for patients to use e-cigarettes, if that is what they wish to do.

Q382 **Darren Jones:** How do you get the message out? We are talking about the content of the message, but how do you deliver it? If smokers are not going to their GP about cessation services, or if you are a young person who does not get involved in the health service very much, how do you deliver that message to people, so that they know?

Professor Newton: Public Health England has a significant social marketing group. We undertake a significant mass of campaigning. We use a range of methods, including social media. We consult academics and industry partners on how to get messages across. Getting the message across is meat and drink for our social marketing group.

How you change behaviour is about much more than getting the message across. There are many other organisations and parts of wider society that have a role to play. It is not just about us putting out messages.

Liz Kendall: I say this as an ex-smoker. If you want to give up, you can get your gum on prescription or buy it in the pharmacy. Lots of people who want to quit go into the pharmacy and get something to stop them wanting to smoke. The point is, would e-cigarettes ever be available on prescription? Would they be available to be sold in Superdrug, Boots or LloydsPharmacy? That is how other people get help—either on prescription or by going in and buying it. Is that on the cards?

Q383 **Chair:** This is perhaps a question for you, Ian.

Dr Hudson: We are getting back to the medicines route, potentially.

Q384 **Chair:** For it to be on prescription, it needs to be medically authorised.

Dr Hudson: Yes.

Q385 **Chair:** So far, no product has been medically authorised. Is that right?

Dr Hudson: Products have been authorised. Two products have gone through that route, but they have not been marketed, for one reason or another.

There are pros and cons of the medicines route versus the notification scheme. There are limitations in the notification scheme—tank size, refill size, strength, advertising and the ability to put a product on prescription. The medicines route would get around some of those, but it comes with more requirements on the company, which has to produce a full quality dossier for us for review.

Q386 **Chair:** We will come back to that a little later. I am conscious of time. May I bring in Damien now?

Q387 **Damien Moore:** This is for Mr Morrison. We understand that new guidance on e-cigarettes is soon to be published by the ASA, following public consultation. Are you able to give us any indication of the flow of that?

Rob Morrison: Yes. I can explain a bit of the background. We have a rule that prohibits both health and medicinal claims. Medicinal claims would be those Dr Hudson was talking about, relating to smoking cessation. That reflects the law in this area. There is not really anything that we can do to change it; it is medicines regulation. On the basis of evidence that we saw in our consultation in 2014, we also prohibit health claims—the claims that say that this is less harmful or safer than tobacco—because of very real concerns that there were about the quality and safety of the products that were on the market at that time.

Clearly, we are in a different place now. We conducted a call for evidence in late 2016 and a consultation at the end of last year on a proposal to row that back slightly, to allow marketers to make claims that they can substantiate that concern health. Potentially, this opens the door for marketers to talk about products being less harmful than smoked tobacco, but only in circumstances where they have robust evidence that shows that their product is tested, is TPD compliant and meets those standards, and where they have undertaken a comparative analysis. Now that the TPD is in, we think that the market is probably getting to a point where some manufacturers will want to do that.

You ask about the flow of consultation. We consulted on the proposal. We are still taking that through evaluation. It is fair to say that the majority of voices, in numerical terms, are making the strong, forceful public health arguments that I am sure you have heard at this Committee table.

There are other arguments from a vocal minority of experts who are still there that we have to weigh up as well. It is perhaps worth my summarising what those are. It is worth remembering that the statutory environment is quite cautionary about e-cigarette advertising. We have a tobacco products directive that prohibits advertising in vast swathes of cross-border media. It prohibits these kinds of health claims being made on product packaging or in leaflets.

Q388 **Chair:** It is hard to understand any rational justification for different rules to apply to television and to a cinema.

Rob Morrison: Indeed. That is the effect of the European law. The operative logic is that the jurisdiction of the European law is limited to media that cross borders—broadcast and online media. The media that are purely domestic—posters, leaflets, direct mail and cinema—are outwith the scope of the European law.

Q389 **Chair:** Post Brexit, would you welcome a review of that?

Rob Morrison: I do not think we have a particular view on the law; it is what it is. Obviously, there would be an interesting conversation to be had about whether it is effective and what it is achieving.

The statutory environment is somewhat cautionary about this. It prohibits claims on the pack. We have medicines legislation that prohibits smoking cessation and reduction claims, but there is room for limited claims, potentially, about products being safer than tobacco. The message that comes across in consultation from a vocal minority is that, although e-cigarettes may well be safer than tobacco, they are by no means safe, and that they accrue no positive health benefits whatsoever.

Q390 **Chair:** Other than saving lives.

Rob Morrison: They have no inherently positive effects. That is important when one thinks about how they are communicated. They are not in any sense good for people, beyond that benefit, and there is no benefit from their being used alongside tobacco. Only when one transitions from tobacco entirely to e-cigarettes—

Q391 **Chair:** Even if it reduces the amount of tobacco consumed.

Rob Morrison: My understanding is that that is what the evidence shows. That is certainly what we have heard in consultation.

The collective message from those respondents is that it is very difficult to manage the message that something is desirable or safe only in very specific circumstances and by comparison with something else that is very harmful. That is a difficult message to manage in an ad—in a one-to-many communication. Those are just some of the arguments that we have heard on that side of the debate.

Q392 **Stephen Metcalfe:** The evidence that I think we have heard—I am always willing to be contradicted—is that there is no evidence that e-cigarettes are encouraging people to take up smoking. People may experiment with an e-cigarette, but they do not tend to take it up if they have not previously been a smoker. Therefore, it tends to be targeted at smokers.

Is there not a way of balancing the communication with smokers, rather than the wider public? We have now moved to plain packaging. Smokers play top trumps on who can outdo the other with the pictures on the packets. Surely that is an opportunity to communicate directly with smokers about smoking cessation services and, potentially, to advertise a product that is of reduced relative harm. There are also pack inserts, which were banned under regulation. Again, that would communicate only with someone who has opened a packet of cigarettes. It could, therefore, lead them to a product that is less harmful. Are those areas that could be looked at?

Rob Morrison: We would not regulate a product pack or insert; others on the panel might want to speak to that point.

In terms of the types of messaging, we can set proportionate controls over the kinds of messages that ads include. We would need some sort of statutory backing to mandate messaging to smokers, particularly given that smoking cessation claims would be illegal for these product categories.

Q393 **Damien Moore:** You think changes might be afoot. Obviously, they are not something with health benefits, but they are healthier in comparison to something else that someone might be using. That is the first point. The second point is: was there a consensus in the consultation?

Rob Morrison: In answer to your first question, that was certainly the basis of our proposal: to allow marketers with a good product, for whose effects they have comprehensive evidence, to say things like it is potentially healthier or less harmful than smoking.

There is an attendant question about the nuances of that message—whether "safer" is desirable, or whether something such as "less harmful" is a more desirable message. I suspect that, as and when we go ahead and make that change, the ASA might have to look at those issues in the individual casework that it sees with different ads.

On your second question, we are still going through an evaluation, but our bias is certainly for our proposal to move to that point. At this point, we are looking to see whether there are any show-stoppers in the arguments.

Q394 **Bill Grant:** John Newton partly answered this question, and that goes across the board. To what extent does your organisation take account of the potential for e-cigarettes to be a smoking cessation tool? What efforts do you make to promote and engender that?

Should we, as a nation, recognise more positively the ability of e-cigarettes to reduce conventional smoking and the ensuing harm that, as we are all clear about in our minds, conventional smoking brings? Should we be pushing this? What are you doing in that area?

Professor Newton: E-cigarettes are the most popular quitting aid among smokers. Whatever we think of the evidence on their effectiveness, smokers are choosing to use e-cigarettes much more widely than other available forms, such as nicotine patches and nicotine-containing gums. There is no doubt that they are popular among smokers.

The first step to being an effective aid is that they have to be used by smokers. That is very much in their favour. We have recognised that by introducing references to e-cigarettes in our campaigns. In the Stoptober campaign—a very effective and internationally widely copied campaign—we had some video, for the first time, of a smoker using an e-cigarette. That was quite a prominent feature of the coverage of the campaign. We are introducing messages about e-cigarettes on the basis of smokers choosing to use them.

At the same time, we have to recognise that e-cigarettes are not risk free—we have to be cautious. There is a lack of hard, randomised control-trial evidence of their effectiveness in cessation, but the evidence from observational studies, which are quite convincing, is that many smokers have used e-cigarettes to quit—and to quit completely, not just for dual use.

We need to continue to build the evidence base. At the same time, we need to be clear that this is for smokers, particularly those who have tried to quit before. If they have not tried an e-cigarette, they should try an e-cigarette, because that might be their route out of smoking.

Dr Hudson: Our role is more about the regulation of the individual products to ensure that the e-cigarettes and even the gums and so on comply with the relevant regulations, and then to deal with any safety issues, as they may or may not emerge, as rapidly as possible.

Professor Leng: I often say that developing the guidance is the easy bit and getting it used is the hard bit but, on this occasion, it is quite a challenging piece of guidance to develop.

As for getting it used, we work closely with Public Health England; we have dissemination routes out to GPs; we have a quality standard, which promotes its use; and we communicate with the Local Government Association. We do a lot of work around dissemination and reinforcement. The ongoing challenge is measuring the impact and getting data back on that. It is a collaborative effort.

Rob Morrison: On the smoking cessation part of your question, as I said before, smoking cessation claims cannot be made for these kinds of products. What we can do, however, is change the rules to allow a window for these health claims, which is what we are doing in consultation at the moment. Hopefully, there will be something to say on that in the next couple of months.

Q395 **Chair:** What is the timescale for completing that and getting the guidance changed?

Rob Morrison: We are just finishing the evaluation process with our committees. I would hope that, in the next couple of months, we will be in a position to publish something.

Q396 **Chair:** When you say "publish something," that would change the guidance.

Rob Morrison: That would be the proposed change to the rules.

Q397 **Chair:** "Proposed change" or the actual change?

Rob Morrison: Sorry—that was the change to the rules that we proposed. As I say, that is what we are hoping to do. It has not yet been taken through the full evaluation by our committees yet, so I cannot guarantee the outcome, but that was our proposal.

Q398 **Bill Grant:** The panel members, and Gillian Leng in particular, will recognise that there is a 5% gap in the knowledge of the long-term harm of e-cigarettes. What endeavours have your organisations undertaken to try to bridge that knowledge gap and bring it in holistically, or is there dependency on the tobacco industry and the vaping industry to bridge the gap? Do we need to wait for this long time that was mentioned?

Professor Newton: We are trying our best to get the message across, and we are working with many partners. Of the charities, Cancer Research UK, for example, is very active. We are using every possible route to get the message across to smokers in particular that e-cigarettes are likely to be much less harmful and to encourage them to use them.

Another route that I should perhaps have mentioned is specialist smoking cessation services commissioned by local authorities, which have a very important role to play. We know that smokers have the best chance of quitting if they are supported through such a service.

We would like to see e-cigarettes available through smoking cessation services, alongside other nicotine replacement options.

Professor Leng: It would be good to be clear that we were going to be able have long-term data on both the benefits and the harms of e-cigarettes. That is really important, as are other research questions such as the impact of exposure—if there is any—to second-hand vapour. Is that a problem? There is also the effectiveness of smoking cessation aids. There are relatively small amounts of data at this point on new products. That research is important.

Q399 **Bill Grant:** So, that knowledge gap remains unbridged.

Professor Leng: For the long term it absolutely does, because they are new products.

Professor Newton: Public Health England has a commitment under the tobacco control plan to review the evidence every year. As the evidence is updated, we review it and we publish the results.

Q400 **Bill Grant:** I note that, in discussions, there is a public perception—perhaps it is the conventional smokers' perception—that there is a greater risk from e-cigarettes. Is it possible that that emanates from seeing somebody using an e-cigarette and the emissions that are visible? The person might be buried in a great cloud. Might that be giving out the wrong message such that, because of the sheer volume of smoke, people perceive that to be more harmful, even when evidence suggests that it is not? Where does that negative line come from?

Professor Newton: That is an interesting question. It may be different for different people. One has to be aware that people who are not smokers sometimes find the vapour from e-cigarettes unacceptable.

Q401 **Bill Grant:** It is quite extensive.

Professor Newton: They don't like it. It is worth stressing that there is no evidence of harm in the same way that there is clear evidence that second-hand smoke from tobacco is harmful. There is no evidence that exposure to the vapour of e-cigarettes is harmful. That is not to say that some people do not necessarily like it.

Q402 **Bill Grant:** They may perceive it as the passive risk that has been promoted so much.

Are there any other comments?

Dr Hudson: I cannot comment on where the perception of the cloud comes from. On the safety issues, the manufacturers of course have a clear responsibility for the safety of their products. We have responsibilities for the safety side in monitoring any safety issues that are reported to us. We have also been doing work to promote the reporting of safety issues through social media campaigns, working with the industry, using newsletters and so on—trying to encourage people to report to us any safety issues they experience.

Q403 **Chair:** The assertion was made yesterday at a vaping forum at the King's Fund that I attended that only one or two public health directors around the country had gone out and published clear messages in their locality about the relative safety of e-cigarettes, as opposed to smoking. Have you directly lobbied or communicated with directors of public health around the country to say that they should be doing this? If not, could you?

Professor Newton: We talk regularly to directors of public health. We produce a whole series of outputs for them. We tend to package it up and put it out together.

We have had debates with directors of public health, among whom there is a spectrum of views. I do not recognise those numbers. I would say it is a small minority of directors of public health who have taken the more cautious role.

Q404 **Chair:** But do you encourage them to be proactive?

Professor Newton: We do. We make it very clear in our outputs—for example, in the way we publish the latest evidence update—that we think that e-cigarettes should be part of all local tobacco control policies, and that they should be used appropriately as an option. We make it very clear to our DPH colleagues.

Q405 **Neil O'Brien:** This question is mainly for Dr Hudson. Some people have raised concerns about so-called short fills, because of the concern that people might top them up with unregulated substances, which might be harmful. Do you share those concerns?

Dr Hudson: I think we will have to see the evidence as it emerges. There has been a significant growth in short fills over the course of last year. Short fills do not fall within the notification scheme or the

regulations. Over the longer term, we will have to see where this goes. Some in the industry have been thinking about introducing a voluntary registration scheme for the short fills that do not contain nicotine. We will need to think carefully about that and to watch the direction that it goes in very carefully. At the moment, it is outside the notification scheme.

Q406 **Neil O'Brien:** On that subject, you have told the Committee that the short fill market reduces costs for producers, because the only products requiring notification are the 10 ml nicotine shots. Is that lower cost incentivising e-cigarette producers to keep pushing short fills?

Dr Hudson: I would not like to comment on the cost side of things, but it is a trend that we have seen in the latter part of last year, whereby more people have gone to the short fills not containing nicotine. Whether that will be sustained or not, I do not know.

Q407 **Neil O'Brien:** Do you think that is driven by the fact that they do not have to go through licensing, or is it driven by the consumer desire to have a product that can be topped up?

Dr Hudson: I do not think I am qualified to comment on what is driving it. From our point of view, it is an observation that this is the way the industry has been going.

Q408 **Neil O'Brien:** In your letter to us, you state that the "MHRA is collaborating with the Department of Health and Public Health England" to carry out research into the safety of e-cigarette products. Will you tell us a bit more about this research? What knowledge gap is it specifically trying to fill?

Dr Hudson: We are doing a number of things. One of them is to work with the Chartered Trading Standards Institute in relation to the sampling of products, such that they can be tested, and to confirm that they comply with the regulations and notifications—and also to ensure that there are no banned substances in there. That is an area of work that we are doing with trading standards.

Q409 **Neil O'Brien:** So, you go and buy things on the high street and test them.

Dr Hudson: That is the plan, yes, to do that with trading standards—to do a sampling. We cannot test directly, but we are working with trading standards to do a pilot of testing, to ensure compliance.

Q410 **Neil O'Brien:** Is that the main new thing that the research does—the actual testing of what is out there in the field?

Dr Hudson: There are a number of things. I have mentioned our safety reporting regime, and any signals from that for getting intelligence, in some cases from the industry sector itself about people selling higher strength where it is banned under the regulations. There, we are taking action, again with trading standards and with sellers if it is online, to

ensure that the companies are brought into compliance and that trading standards can follow up and take action.

We are taking action in a number of areas to ensure that people come into compliance. We ensure that, if there are safety issues, they are dealt with rapidly.

Q411 **Neil O'Brien:** Are you finding how prevalent very high-dosage or illegally high-dosage products are? How high a dose are you seeing on the streets?

Dr Hudson: Available online to consumers, we have had something like four cases that we have become aware of that we have reported to trading standards. That has been the experience to date.

Q412 **Chair:** Do you impose packaging requirements, with health warnings?

Dr Hudson: Yes, there are some packaging requirements on the notification scheme in relation to nicotine, with nicotine being—

Q413 **Chair:** What does the warning say on e-cigarette packaging?

Dr Hudson: That it contains nicotine and that nicotine can be addictive. I think that is the wording, although we may have to write to you with the specific wording. Those things are specified in the regulations as things that we have to put on the packaging.

Q414 **Chair:** So, it is just wording.

Dr Hudson: Wording—yes, that is correct.

Q415 **Carol Monaghan:** I wish to ask you about a couple of things that you have just mentioned. Four cases were reported to trading standards. Was that because of particularly high levels of nicotine?

Dr Hudson: Yes.

Q416 **Carol Monaghan:** Is it not the case that, in other countries, nicotine levels can be higher than they are here, and that they have actually been more effective in helping people to stop smoking?

Dr Hudson: The European regulations on the notification scheme apply equally to all countries in Europe. That said, I suspect that different countries in Europe are at different stages of implementation of the regulations. The limits of 20 mg/ml and the refill size of 10 ml and so on are in the regulations, so that is applicable across Europe. I am not sure which countries you are referring to.

If you want to go outside of those, the other route is via the medicines licensing route that we have touched once or twice already.

Q417 **Carol Monaghan:** We heard evidence in a previous session that the US allows much higher levels of nicotine in its products. Is that likely to be considered here, or in Europe?

Dr Hudson: The regulation, or the notification scheme as it affects e-cigarettes, came fully into effect in May 2017, with a year of transition from May 2016. It is relatively early days for the scheme and, as we go forward, we will have to reflect on how well it is working, or not.

It is premature at this point—as it has only come in fairly recently—to be suggesting major changes, and I do not think there are any plans for any significant changes as such, but clearly, as with all regulations, we will have to reflect on the implementation.

I do not think I am competent to talk about the US scheme, but I would say that the e-cigarette notification scheme clearly has some limits. We then come back to the point that, if you want to go outside that, the medicines licensing route is an alternative route, although it is not being used.

Q418 **Carol Monaghan:** You mentioned that short fills are not currently included in the notification scheme.

Dr Hudson: Correct.

Q419 **Carol Monaghan:** You have talked about the possibility of voluntary inclusion or voluntary notification. Is there a case for mandatory notification of short fills in the future?

Dr Hudson: That goes back to a comment I was making earlier. The scheme has come in relatively recently and went fully into force in May 2017. We will have to see how the trend goes—certainly, short fills grew significantly in the latter part of last year. We will have to see how the sector goes and reflect on that, and take a view at some point in the future on whether this is a growing trend that requires some action. At the moment it falls outside the scope of the regulation within which we operate.

Q420 **Carol Monaghan:** Apologies, Dr Hudson, but I have other questions for you. In your letter to the Committee, you stated that your regulatory revenue of £5 million annually is likely to decrease due to "market innovation." What do you mean by "market innovation," and how would that allow producers not to have to notify the MHRA of new products?

Dr Hudson: That partly goes back to the short fill.

On the question of where we are in the whole process of fees, we made some assumptions at the start of the scheme. We were way out in our estimates of the volumes that we would receive. We put a fee regime in place that included an initial notification, an annual fee and a substantial modification fee. Given that we were way out, we have not charged the substantial modification fee, and we have not charged the annual fee. We will be reviewing the fees during the course of this year.

As we have just been discussing, short fills have come on. They grew significantly over the latter part of last year. We will have to see what

their impact will be on the refill containers and whether we will still see the same number of refill containers and so on. That is what we are really talking about here—whether it will have an impact on that.

I am not sure that we are quite at steady state yet, but we will clearly be looking at the trends of the notifications and then taking a view on what our fee levels might be when we feel we are a bit more able to predict what is likely to come, so that we can cover the costs—but just cover the costs.

Q421 **Carol Monaghan:** So, you are not looking to make money.

Dr Hudson: No, no. we are looking to pay for the effort it takes us to do the notification scheme and perform the vigilance function that we have to do, with the systems that support that and so on. That is what we aim to cover the costs of. It is the normal approach to regulation.

Q422 **Darren Jones:** I want to discuss medical licensing. Referring to Liz's earlier question, from a consumer perspective, if you are getting something from a GP or the chemist, you inherently trust that it is safer than cigarettes. However, to get e-cigarettes, you do not go through those avenues. It is interesting from a marketing perspective and a trust perspective that the medical licensing route has not been followed. What are the pros and cons of medical licensing for e-cigarettes as licensed devices?

Dr Hudson: As you say, I think there are pros and cons of the notification versus the medicines licensing. The potential advantages of medicines licensing would include the health claims that can be made. Gum, patches and so on have smoking cessation or harm reduction claims, and those can be promoted as such. The advertising restrictions would be different. They would be able to promote a bit more in relation to the claims for medicines available on prescription—that is the other point—if these were authorised as medicines.

The cons, as it were, are that companies have to provide a full quality dossier, with GMP—good manufacturing product—licences, a tox data full package and a pharmacokinetic study bridging to an existing licensed product of some sort, as well as ongoing obligations in relation to batch release and so on. That is a more onerous dossier to start with. Then, there are some advantages in relation to claims, promotion, advertising and so on as a consequence of doing that.

Those are the pros and cons. We are doing a number of things to re-look at this and to see what we can do to encourage more people to go through the medicines licensing route. We are working with the trade associations to discuss where they see the hurdles and any problems. We have given scientific advice to a number of companies, and we are following up those companies that have come to see us: "Where are you going with your products? Are you interested or not?"

We are doing myth-busting guidance to ensure that people are clear about what we are asking for. We are not looking for long-term randomised control trials, for example—we are looking for a pharmacokinetic study comparing nicotine levels with an established product. We will do that.

We are doing a number of things to re-look at this and to encourage people to use the medicines route again, because of the potential advantages we have been talking about. To date, however, there has been very little interest in going down that route since the e-cigarette notification scheme came in.

Q423 **Darren Jones:** One piece of evidence that we had from some of the companies was about the speed at which the market is developing and technologies are changing, compared with the slow speed of getting medical licensing approvals. Do you agree with that? If so, do you think there will be changes that you might be able to make to allow licensing to keep up with market changes?

Dr Hudson: That is a challenge, and we will see whether the rate of change with e-cigarettes is sustained over time or whether it is because they are relatively new. It takes longer to go through the generation of the evidence for a medicine and through the review process.

Q424 **Darren Jones:** How long would a normal cycle be for that?

Dr Hudson: For?

Darren Jones: For the authorisation.

Dr Hudson: The review period is anything up to 210 days. If it is a good dossier, it could be shorter than that. It depends on the quality of the application that is put in to us, and it depends what it is. It is the time it takes to do the pharmacokinetic study and so on that the company would need to do.

Q425 **Darren Jones:** So, over a year, at least.

Dr Hudson: Oh, yes. It takes a while. If the speed of change is very rapid, that is a challenge.

Q426 **Darren Jones:** Regarding the advice that NICE and Public Health England could give if providers started going down this licensing route, how would that change what you would be able to do in promoting it for smokers?

Professor Newton: We think that both licensing routes have advantages, for some of the reasons that you have discussed. We would not want to see it as only medicinal or only consumer. We would like to see a medicinally licensed product because, for the reasons you have said, it would send a stronger message about relative safety, and it would also provide another avenue and help smoking cessation services to use

e-cigarettes more. We think there would be considerable advantages if there was a medically licensed product.

Professor Leng: Just to echo that, it would be much more straightforward for NICE, because there would be a strong evidence base. We would be reassured on safety. We also know that GPs would find it reassuring, and it would give them the ability to prescribe the product.

There is a need for a number of different options. Not speaking particularly as NICE now, but speaking as someone who has looked at all the websites, e-cigarettes are described as edgy products: they are exciting and different. Inevitably, there is a group of smokers who will be attracted to that, and others who will be attracted to the clarity around a licensed, safe product.

Q427 **Darren Jones:** On the Advertising Standards Authority consultation, Rob, if you relax some of the rules on some of the claims that can be made, have you considered whether that will have a negative impact on going down the licensing route, which could ultimately help with cessation, as we have just heard?

Rob Morrison: I do not think we have tried to look that far ahead. At the moment, the licensing route has not really been used thus far, despite what is going on. It is certainly not our intention to drive people away from that route, but simply to reflect the things that we are hearing from experts, which is that the consumer market is probably in a place where it can substantiate those kinds of general health claims for its products.

Q428 **Darren Jones:** Have you had any evidence—submissions to the consultation—that raise that concern?

Rob Morrison: I would need to look through them in detail, but I do not think that specific concern has been raised, no.

Chair: Liz is next. I am conscious that we have the Minister waiting. We want to make sure that Liz's questions are answered properly, but can you all ensure that you keep it as succinct as possible?

Q429 **Liz Kendall:** The Committee had some evidence of a difference between how younger and older people view the harmfulness of e-cigarettes. Do you think that is a problem? If so, what should we do about it?

Professor Newton: Yes—that is interesting. It is a problem. It is not just older people; there are also different levels of education and social background. Inequalities in smoking are apparently partly driven by this difference in opinion.

That comes back to our previous point, that we need to do everything we can to address misconceptions about relative harm. It is definitely a problem.

Q430 **Liz Kendall:** Do you mean that people who are older and/or on lower incomes, who may be more likely to smoke, are more likely to think

these are harmful?

Professor Newton: Yes. So, people on lower incomes—

Q431 **Liz Kendall:** The people who need it most—

Professor Newton: Exactly.

Q432 **Liz Kendall:** They are most likely to think it is not going to be very good for them.

Professor Newton: Yes. Well—certainly, people who are on lower incomes, where smoking prevalence is higher and there are more barriers to quitting in general, are less likely to think—

Q433 **Liz Kendall:** Why do they think that? They think the action is bound to be bad for them. What is it? Have you done any research into that? Unless we understand why they think it is harmful, and they are the people who most need it, would you do any research on this, so that we can change it?

Professor Newton: The short answer is that I do not think we know. It would be an excellent topic for research. We do not commission such research, but it would be a very good topic for further qualitative research.

Q434 **Liz Kendall:** Who does?

Professor Newton: It would be either Research Councils UK, one of the charities or the National Institute for Health Research, the NIHR.

Q435 **Stephen Metcalfe:** As well as covering e-cigarettes, our inquiry covers heat-not-burn products and other novel products. Will you give us your thinking on heat-not-burn so far, and where that sits on the relative harm scale compared with smoking traditional tobacco?

Rob Morrison: I can talk briefly about the advertising position. Heat-not-burn is a tobacco product, and tobacco products are prohibited from being advertised. We have not yet seen an example of a brand or product being advertised in any of the media we regulate. We have under investigation—as was reported in the press this week—an ad by a tobacco company that talks in general terms. It is a comment piece about the relative harms or safety of heat-not-burn. We are looking at the applicability of the tobacco prohibitions to that.

Some concerns were also reported this week about the Philip Morris product, the IQOS, being advertised in store posters and so forth. Materials advertised in store fall under the remit of trading standards, and they are looking at that. We will be looking to ensure that we understand where that gets to and will follow up with them on that.

Professor Newton: We need to be very cautious about heat-not-burn products. They contain tobacco, and we just don't have very much

evidence. A Committee on Toxicity report suggests that there will be residual harm from heat-not-burn. We need to be cautious about it.

Q436 **Chair:** Can you comment specifically on the relative harm, compared with smoking?

Professor Newton: I do not think we know enough. They are likely to be somewhat less harmful than smoking cigarettes, because they do not contain quite as many toxicants, but the vapour from heat-not-burn products contains more toxicants than e-cigarettes. They are somewhere in between smoking tobacco and e-cigarettes, but where exactly they are is difficult to know.

Dr Hudson: That does not fall within our scope. These are not e-cigarettes.

Professor Leng: I am not sure of the answer. I imagine they would be more harmful than e-cigarettes. They have tobacco in them. We have a guideline on smokeless tobacco, which was all about people who chew tobacco. That has carcinogenic effects, without any heating at all, so it is hard to imagine that a heat-not-burn product is going to be good for you.

Q437 **Stephen Metcalfe:** There is an issue of relativity. We have a huge body of evidence about the harm that smoking cigarettes causes. No one is debating that. It is a matter of how to move people from smoking cigarettes—how we deal with that last 16%: those who are hard to reach. How do we move them, and does heat-not-burn have a part to play in that? Apparently it is more satisfying than an e-cigarette, but potentially more harmful. It is about communicating so as to move smokers stage by stage towards a smoke-free environment. It is how we as a Committee and you as professionals play a part in that so as to play a role in improving public health overall.

Professor Newton: It is early days, but it is likely that heat-not-burn will play a much smaller role in public health campaigns than e-cigarettes, because they contain tobacco. Therefore, it is a much more—

Q438 **Chair:** But it is the burning of tobacco: we have been told that it is particularly carcinogenic. Is that the case?

Professor Newton: Again, I refer you to the Committee on Toxicity, which looked at this. Its finding was pretty clear: there are residual harms from the toxicants contained in heat-not-burn. I am not an expert on the toxicology, however.

Q439 **Chair:** Sure.

Professor Leng, when you update your guidance on e-cigarettes, as you said you would, will you also be providing guidance on your view on heat-not-burn?

Professor Leng: Yes—I will definitely take that back. We also need to update the smokeless tobacco guideline. I cannot give you a timeframe, but I will take all these messages back to the office.

Chair: Thank you all very much indeed. Sorry we have detained you for longer than planned, but we appreciate your evidence.

Examination of witnesses

Witnesses: Steve Brine MP and Dr Tim Baxter.

Q440 **Chair:** Welcome. Will each of you briefly introduce yourselves?

Steve Brine: Hello, Chair. I am Steve Brine, Minister for public health and prevention.

Dr Baxter: I am Tim Baxter, deputy director for healthy behaviours, which covers alcohol, drugs, tobacco, sexual health and one or two other things.

Q441 **Chair:** Thank you. I apologise for keeping you both waiting. I understand that you need to try to get away by 11.30 if possible. We will try to stick to that if we can.

I will start. The tobacco control plan acknowledges a disparity in the prevalence of smoking between local communities and that "addressing the huge variation in harm across the country" disproportionally falls on vulnerable communities. How is the Government working to ensure that local authorities with a higher number of smokers from disadvantaged backgrounds are properly supported to provide specialised smoking cessation services?

Steve Brine: I will kick off, and Tim Baxter, who has more than four and a half years' experience of working in this area—I have a very senior official with me today—may wish to add something.

One of the first things I did was publish the tobacco control plan. Why did I do that? It is still the biggest preventable killer. I am the cancer Minister, and it is the pivot of my role in many ways. Smoking is still the biggest preventable killer in our country and the greatest cause of cancer deaths.

Our view is that the best way for smokers to improve their health and to quit smoking and nicotine use is to stop smoking. We are putting significant resources in through the public health grant: some £16 billion during this spending review period is going to local authorities for their public health spend.

That is not uniform across the country, and it is not meant to be. The Health and Social Care Act, which the coalition Government passed, devolved that to local authorities. It is not uniform across the country.

There have been savings to the public health grant, but we feel, and we felt as a Government under Prime Minister Cameron, that it was better for local authorities, which know their areas best, to have use of that money and to put it together in a combined harm service, for instance. In my county of Hampshire, a new procurement for drug, alcohol and smoking services is being explored.

In other areas, it will be different. In Leicester, for instance, a trailblazing group of people in the public health team are achieving good things. The prevalence of smoking in my county, and perhaps yours, Chair, is very different from some hotspots such as Blackpool.

Sometimes people think that local authority smoking cessation services are not all doing it the same. They shouldn't be, because smoking rates are different in different parts of the country. We have a particular challenge in Blackpool, for instance, with pregnant women smoking. There is a different prescription and application of that money in that area, but we are investing heavily in the public health grant in the course of this spending review period, and rightly so.

Dr Baxter: Public Health England works very closely with local authorities across the country and provides local authorities not only with advice on best practice but with local health profiles, which make it clear to the local populations, the local political leaders and others how they are doing. If a local authority has a high prevalence of smoking and is not investing in that area, it will have to account locally for its investment decisions.

Q442 **Chair:** We have been hearing evidence about the relative harm of smoking compared with e-cigarettes. According to Public Health England, e-cigarettes are 95% less harmful. Would you want directors of public health around the country to be vocal and clear in promoting the value of smokers transferring to e-cigarettes because of that relative harm risk of one compared with the other?

Steve Brine: Yes, and they do that—there is no question that they do.

Q443 **Chair:** There have been some assertions that that is very variable around the country, in that not all directors of public health have been proselytising on the value of e-cigarettes—indeed, the majority of directors have not done that.

Steve Brine: We were talking about this outside. There are a few outriders, but there is Public Health England, for which I am the responsible Minister, which provides advice—and we provide the money through the PH grant. As we have seen in how it has recently put a scorecard up to Northamptonshire County Council, for instance, Public Health England is responsible for ensuring that upper-tier authorities, where we pass public health responsibility and spend, too, are spending the money on what they are meant to be spending it on. When they do not do that, we are more than happy to come down on them.

Do we mandate directors of public health—DPHs—to say one thing? No.

Q444 **Chair:** But you would be encouraging them to get out there and make the case on e-cigarettes.

Steve Brine: Yes, because the evidence is emerging—although it is not final or complete, which is why we have said that Public Health England will do an annual evidence review on the work done during this period through to 2022. The evidence is clear, however, and we do not dispute the 95% figure. The tobacco control plan commits us to the monitoring, safety, uptake, impact and effectiveness of e-cigarettes, and we are doing that where they can be part of the mix, alongside stop-smoking services. That is the key thing. We would not expect directors of public health to say, "Here's the panacea. Here's the golden bullet." I do not think that any of them would be naive enough to say that. We would expect them to bring forward proper harm reduction programmes.

The evidence is emerging, but we are clear that e-cigarettes can and do play a big role in stopping people smoking—but only when that is combined with stop-smoking services.

Dr Baxter: We would expect directors of public health to be engaging with the evidence, essentially.

Q445 **Chair:** You will both be aware that the single biggest cause of the inequality of life expectancy for people with severe and enduring mental ill health is smoking. Therefore, we need a particular focus on reducing smoking levels, which have remained persistently high, among people with mental ill health. Does it surprise you that our survey of mental health trusts shows that a third of NHS mental health trusts around the country ban e-cigarettes within their organisations? Does that strike you as odd, given the evidence you have described?

Steve Brine: It does not surprise me, for the reason that, generally, hospitals do not allow vaping on hospital grounds. However, there is no legislation to enforce that. It is each hospital's decision. Fundamentally, this is a decision for individual organisations.

I know that you are interested in the Prison Service, for instance, but that is a national prison service. As you well know from a previous incarnation, Mr Lamb, the health service is a national health service that is in practice devolved. Since the innovation of foundation trusts, they are individual legal entities.

Is there plenty of guidance from NICE, from which you have heard, from the CQC and from Public Health England? Absolutely there is.

Q446 **Chair:** But are you relaxed about a third of trusts not following the guidance that e-cigarettes should form a central part of efforts to help people give up smoking, particularly given that it is the single biggest cause of early death?

Dr Baxter: It is an issue for each organisation, and—

Q447 **Chair:** That makes it a bit of a postcode lottery for people with mental ill health, does it not?

Dr Baxter: There is a commitment to a smoke-free state of mental health trusts by the end of this year. The trouble is, what works in a mental health trust in one place may not work so well in another. The mental health trusts that I knew well at one time were the highly secure forensic psychiatric hospitals, where it is amazing that they have made such progress in going towards smoke-free.

I was just reflecting on this. I know you are asking about mental health, but for acute trusts, where you might say, "Why don't you have places on a ward where people can vape?", that would depend on the design of the ward and on what other uses you might need to have for that space. It is very difficult, without interrogating an individual trust further and asking it, "Why aren't you allowing e-cigarettes?"

Q448 **Chair:** A representative from the Nottinghamshire mental health trust gave evidence, and talked about how the trial that it ran had won staff over. It had been very effective in using e-cigarettes as a tool to help people give up smoking. There is this golden opportunity, when someone is an in-patient, to make an impact that might extend their life. Yet you are just saying it is up to individual trusts what they do.

Dr Baxter: As the minister said, we cannot mandate—

Q449 **Chair:** You cannot mandate, but it is about the guidance and whether you should be giving a clearer steer.

Steve Brine: I do not think they are short of guidance from us. In my experience, trusts are not desperate for more guidance from the centre.

I am certainly not relaxed about this at all, and I have a very open mind on it. We have discussed this offline, too. The tobacco control plan says that this is a particularly vulnerable group and a group that we are particularly interested in—perhaps low-hanging fruit, to put it crudely.

Becoming smoke-free is about trusts working to end the culture in which smoking is used, I suppose, as a way to build relationships with patients. That is what we mean in the tobacco control plan about mental health trusts, whereby cigarette smoking breaks are used as a reward, where staff and patients may have an interaction that they might not otherwise have.

It is about working with the experts, including the public health experts at PHE, on a full range of evidence-based treatment options to support their quitting or their temporary abstinence while they are in-patients, and then introducing education around e-cigarettes. Very few people are permanent in-patients; most people who are in-patients in a mental health unit soon become an out-patient at a mental health unit. Is the

"making every contact count" agenda an opportunity to talk to them about the benefits of e-cigarette use? Absolutely. I would completely agree.

PHE is commissioning a survey of all mental health trusts, which will ascertain compliance with PH48—which Tim can talk forever about. It would be helpful if the evidence that you as a Committee have gathered joined forces with PHE. We would be grateful if you could do that, because there is an opportunity for us to work together.

Dr Baxter: I suspect that, if you did that survey in a few months or a year's time, the figures would have moved. I think the evidence is there.

Q450 **Chair:** That is why I am encouraging you to be a bit more proactive—not to mandate, but to send messages to mental health trusts to follow the best practice and follow the evidence.

Steve Brine: I could not mandate—

Q451 **Chair:** And I am not expecting you to; I am expecting you to encourage.

Steve Brine: I could not mandate without changing the rules but, for the reasons I have mentioned, I certainly wish to encourage. I think this is low-hanging fruit, and it is an opportunity for every contact being made to count. That is what the NHS surely must be about.

Chair: Stephen is next.

Stephen Metcalfe: Thank you, but—

Chair: I apologise. You appeared shocked.

Stephen Metcalfe: Yes.

Steve Brine: Good effort though, Stephen.

Chair: It is Carol. I do apologise.

Q452 **Carol Monaghan:** I think I was more shocked as I have to leave after this.

Minister, we have looked at research by Cancer Research, which has said that spending on anti-tobacco campaigns and stop-smoking services has decreased dramatically over the past five or six years. Is that because local authorities have other competing needs, or is it because central Government is providing less money for these activities?

Steve Brine: There are two parts to your question. On the central marketing campaigns, I am seeing CRUK tomorrow, and this is one of the things I want to discuss with Harpal Kumar before he retires.

Yes, it is true that there have been savings from the public health grant, due to the state of the public finances that we inherited and still juggle. That is one of the difficult decisions that we had to take when we came

into office in 2010. However, it is not true to say—as some do—that we are not investing in campaigns. We spent about £1.5 million in 2016-17 and an estimated £2 million in 2017-18 on PHE social marketing campaigns. For example, Stoptober featured e-cigarette use for the first time, and I think that made excellent use of the resources available. We estimate that about 1 million made a quit attempt during Stoptober.

Dr Baxter: In 2016.

Steve Brine: In 2016, for which figures are available. On the national side of things, it has been incredibly effective. For fear of repeating myself—Tim can come in in a minute—on the issue of local authorities in England, there is a significant investment. I have mentioned £16 billion in the ring-fenced public health grant. Yes, local authorities have competing priorities, but not where there is a ring-fenced public health grant.

As I have said, Leicester is a very good example. There are some good examples of local authorities that are doing very well. As I am sure you know, the Leicester MPs, one of whom has a very direct interest in matters of health in England, are not known for being cheerleaders for the Government's policy. Leicester does not have buckets more cash than my county or Mr Lamb's county. It is a matter of how you use that cash and how you apply it to local priorities as to whether it is successful. There are very good examples of it being successful.

I appreciate that is not relevant to your constituency, but it is relevant to your inquiry.

Q453 **Carol Monaghan:** Cancer Research UK showed that only 75% of local authorities were promoting e-cigarettes as a method of stopping smoking. What are you doing to get the other 25% on board?

Steve Brine: Building the evidence base, ensuring that we live up to the promises in the tobacco control plan, reviewing the evidence base year on year and ensuring that it gets stronger and stronger, so that it is a no brainer for local authorities to make that decision.

Q454 **Chair:** But if the evidence is clear enough for 75% of local authorities, why is it not clear enough for the 25%?

Steve Brine: It is a devolved local decision. We are not mandating what local authorities should do. That is what Parliament decided when it passed the Health and Social Care Act.

Q455 **Chair:** Do you encourage them?

Steve Brine: We do encourage them. That is why I think it is important to continue to build the evidence base.

Dr Baxter: Public Health England does a lot of work encouraging people around e-cigarettes, as you know. You have heard from John Newton this morning.

Q456 **Carol Monaghan:** You have singled out Leicester. It seems that the work that people are doing there is very good. Is there not a responsibility on Government to try to influence the way in which local authorities are operating if it is considered that they are not doing enough for public health?

Steve Brine: Yes. That is why we continue to resource Public Health England, as you will have heard from John Newton earlier. That is why we resource Public Health England to the extent that we do, so that it builds that expertise and knowledge base. It is not a national organisation that just talks through the national media; it is also a locally devolved organisation, which deep-dives into local authorities.

I was not here for your previous session, but I am sure that John would have said that. Even if he did not, it is true that PHE deep-dives into local authorities and tries to help, encourage and mentor them to do the right thing by their areas—but only in what is applicable for their local population, because what is applicable in Blackpool or Leicester is not necessarily applicable in Hampshire or Kent.

Do you want to add anything on that?

Dr Baxter: No—that puts it very well.

Q457 **Carol Monaghan:** If I could take you back to the figures that you mentioned at the start, I have some figures here, too, showing that, in 2009, the Government were spending £25 million per year on stop-smoking campaigns. The figure we have for 2016 is £4 million per year. Is there a plan to increase that again? You have talked about the economies that you have to work within, but is there a plan to try and move back towards the figure of £25 million per year?

Dr Baxter: On the plans, that is obviously a ministerial, political decision. I think the £4 million applies to the totality of Public Health England's spend. Yes, the money has reduced, for the reasons the Minister has alluded to.

Q458 **Carol Monaghan:** Significantly.

Dr Baxter: We should always look at the outcomes. The proxy outcomes for Stoptober have been incredibly good. That is reaching an enormous number of smokers. We have mentioned the number of smokers who made a quit attempt in 2016.

Yes, in theory, having a lot more money to spend on big TV campaigns would be very nice, but there are decisions about priorities to be made.

Steve Brine: If I could spend significantly more money on national advertising campaigns through national media, which is increasingly diluted by the plurality of the media market in our country and online, I would actually think long and hard before I did that. You have to get a headline message that reaches a certain number of people, but you then

have to combine that with local action. If somebody gave me a choice between spending even more with ITV versus even more with each English county council, I would have to think long and hard about that.

Chair: Your moment has come, Stephen.

Q459 **Stephen Metcalfe:** Thank you, Chair.

I asked the previous panel about whether the message that e-cigarettes reduce harm by 95% was getting lost because of all the caveats that are added to that, because we do not have this evidence base. Will you confirm that the Government support that 95% harm reduction claim? Would it not be better if we moved all smokers on to e-cigarettes and then worried about what we do with that 5% risk and gathered even more evidence? Is there a danger that we are confusing the messages?

Steve Brine: No. I get criticised for not being the cheerleader for e-cigarettes. I do not think it is my job to be a cheerleader for a sector of industry. During the debate in Westminster Hall not that long ago, people were saying that I should be much more of a cheerleader for e-cigarettes.

I met representatives of the Eliminate Cancer Initiative last week, which is working with me, Baroness Jowell and the Department on the new brain cancer work. That is creating the new international cancer databank, which Tessa was the first person to donate to last Thursday. That organisation does not support e-cigarettes, and it would like me to row back.

Q460 **Stephen Metcalfe:** On what basis?

Steve Brine: You would have to ask them. I just saw the headline in their information. I think that keeping our pragmatic evidence base constantly under review puts us in a rather sensible middle way, to be honest. Some people think that is unfair. While also adhering to the European regulations for as long as we are a member state, which we do, we are in a good place, I think.

Q461 **Stephen Metcalfe:** Thank you for that.

Taking the point that, while you may not wish, for reasons you have explained, to be a cheerleader for e-cigarettes, we have heard lots of evidence that they are a significant harm reduction product. We have also heard that doctors would feel more comfortable recommending e-cigarettes if they were medically licensed.

Steve Brine: Yes.

Q462 **Stephen Metcalfe:** The industry may not see enough benefit from going down that route.

Steve Brine: I do not think it does.

Q463 **Stephen Metcalfe:** Is there something more that the Government can do to bring those two parties together?

Steve Brine: I am not sure that there is more that we can do in order to do that. If you were a producer in this industry and you wanted to apply to the MHRA for a licence to have them prescribed, you could do that. There is nothing to stop us doing that. We have the regulations in place, and I do not think they are particularly onerous. I think you can do that, and it has been done. Tim will come in on this in a second. It has been done, and the company that did that then decided not to bring it to market.

We are certainly not standing in the way of that happening. I think we have all the regulations in place. Do you want to expand on that, Tim? The company that did it was—

Dr Baxter: It was BAT, with the EVOKE product. The tobacco control plan had a commitment that we would work with the MHRA to ensure the process is fit for purpose. I met MHRA colleagues, and I think you will have heard from them this morning about the work they are doing.

We can try to ensure that the process is clear and the barriers you have to get over and the hoops you have to jump through are clear. In the final analysis, it is a matter for a commercial decision by a company. Is it worth our while spending the money and the time on this route when I can sell this product as an ordinary commercial product, and we know that around 3 million people in the UK are using e-cigarettes?

Steve Brine: In the TCP, we are committed to ensuring that the system is fit for purpose. I have looked, and I think it is. My officials have met representatives of the MHRA, who engage with the e-cigarette industry to understand any challenges that they highlight in this area.

The fact remains that, as Tim says, it is a commercial decision by the companies as to whether they wish to bring a product to market through the medicinal licence route.

I would not deny that having e-cigarettes available on prescription could be of benefit, but it is still a matter for companies to bring that forward, as it is with any medicine.

Q464 **Stephen Metcalfe:** Do you think that is the only barrier for doctors prescribing it—that they would feel more comfortable if it was a medically licensed product? There is not a cost implication. It is better to get people to pay for their own e-cigarettes than put them on prescription, is it? You have no evidence.

Steve Brine: It is a fact, what you say, yes.

Q465 **Stephen Metcalfe:** But is there any evidence that that is why doctors are not prescribing it?

Dr Baxter: It is not a prescribable product.

Steve Brine: They cannot prescribe it. That is what I mean by, "It is a fact."

Q466 **Stephen Metcalfe:** They cannot prescribe it. Okay.

Steve Brine: You cannot prescribe something that does not have a medicinal licence.

Q467 **Stephen Metcalfe:** Or recommend it.

Steve Brine: They do not have a medicinal licence.

Dr Baxter: What they can do is discuss with a smoker how best they can quit smoking, saying that e-cigarettes are one route.

Steve Brine: And they do. I also look after primary care, and I sometimes spend time sitting in doctors' surgeries—poor patients—watching consultations, with the patients' permission, I hasten to add. I was in one not long ago, where somebody came in with the usual co-morbidities, one of which was a challenge with smoking. The GP had a conversation around e-cigarette use, and the patient went away more informed than when they came in. That is a good place to be. He did not prescribe it, however, because he couldn't.

Q468 **Bill Grant:** Minister, we will all be aware that e-cigarettes are exempt from tobacco excise duty. Have you had any discussions with the Treasury that that will be the case in the future? Would you like to see that retained?

Steve Brine: There are no current plans to change the current rate of 20% VAT on e-cigarettes. We think there is already a large financial incentive for people to choose e-cigarettes over tobacco products. It is a saving of some 50%, which is significant, I would suggest. Tobacco excise duty is paid on the latter, anyway.

HMRC issued guidance 10 years ago, back in 2008, regarding the reduced rate of VAT for smoking cessation products. Where the MHRA approved medicines or e-cigarettes as pharmaceutical smoking cessation products, they could then be subject to a 5% VAT rate, I think I am right in saying, if sold over the counter, or they would be zero rated if dispensed on prescription. That goes back to the point that Mr Metcalfe raised.

Dr Baxter: I should add that that is always looked at on a case-by-case basis. That is the general rule.

Steve Brine: I have to be honest in answering your question: no, there are not those discussions going on.

We would also, of course, be subject to the rules of a member state in changing VAT rates, although that is about to end.

Q469 **Bill Grant:** Stephen has touched on this. If, in the event, one of these products did receive a medical licence, would that just slot into the

existing category?

Dr Baxter: This is a Treasury issue, but, in our understanding, that is the general rule. They would look at any particular case, but the general rule is 5% for over the counter and 0% for a prescribed product.

Q470 **Bill Grant:** As opposed to 20%. Thank you.

Steve Brine: Yes—5% for a consumer product and zero—

Q471 **Bill Grant:** Zero for a medicinal, prescribed product.

Steve Brine: Correct.

Dr Baxter: For a prescribed, medicinal product.

Steve Brine: Which is in line with current practice.

Q472 **Bill Grant:** Thank you for answering Treasury questions.

Steve Brine: I know. God—that is a sure way to end your career.

Bill Grant: It has only just begun—probably peaked at the moment.

Q473 **Chair:** I wish to ask you a question, Steve, on snus. Current evidence would suggest that using snus is significantly less harmful than smoking yet, across the EU, it is banned, with the exception of Sweden. The Health Secretary wrote to us recently in response to a letter from me, explaining that his main objection to the European Court of Justice snus case—you will be aware there has been a case in the ECJ—

Steve Brine: Yes.

Q474 **Chair:** That was based on the proportionality principle. It is rather a complex legal principle.

Steve Brine: It is.

Q475 **Chair:** If we were outside the EU, do you think that the underlying evidence of the relative harmfulness of snus compared with smoking cigarettes, which is lawful in this country, would support a continued ban on it?

Steve Brine: I will be very careful in what I say, because it is an ongoing court case. You are absolutely right in presenting the fact that we attended the hearing to present legal arguments around the proportionality in EU law. That issue goes much wider than snus, I would add.

Chair: Sure.

Steve Brine: As for whether it will continue to be banned across the EU, that is a matter for the ECJ to decide, I understand, and it will make a decision later this year.

On the question of post Brexit and whether Brexit gives us more room for manoeuvre, unquestionably yes. That is a bit of "take back control" that I do not remember seeing on any buses, but it is a fact that we would have more room for manoeuvre.

Q476 **Chair:** Do you have an open mind on that question?

Steve Brine: Definitely, yes. I have a very open mind on most things.

Q477 **Chair:** Would you go further, in saying that you see a case for ending the ban?

Steve Brine: No—but I have an open mind.

Q478 **Chair:** It was worth trying to tempt you.

Steve Brine: Keep trying.

Q479 **Chair:** More broadly, do you see scope for reviewing the regulations more generally on e-cigarettes post Brexit, once we are no longer subject to the GDPR?

Steve Brine: I might ask Tim Baxter to come in on this in a minute.

Q480 **Chair:** I apologise: not the GDPR, but the tobacco control directive.

Steve Brine: At the moment, we are a very good member state and we comply nicely with the directive.

Q481 **Chair:** What about after?

Steve Brine: The Secretary of State wrote about this. I have it here, in fact, and I will leave it with the Committee.

Dr Baxter: Page 27 of the tobacco control plan is headed "Leaving the European Union." It sets out a commitment, and we have to review the tobacco and related products regulations within five years anyway. That is in the regulations. In the context of Brexit, we will be reviewing the legislation to see where changes might be made. There will be that review.

The challenge will be to identify where changes might be made that would continue to protect public health but that might simplify, deregulate and so on. The plan says: "In particular, the government will assess recent legislation such as the Tobacco Products Directive, including as it applies to e-cigarettes, and consider where the UK's exit provides opportunity to alter the legislative provisions to provide for improved health outcomes within the UK context."

It is not glittering prose, but that is a clear commitment that we will look at the legislation.

Steve Brine: I will leave this with the Committee, and it may be worth your citing it in your report. The Secretary of State wrote something for PoliticsHome last week about Britain wanting to continue to be a world

leader in public health. I will quote the relevant section. He said: "We have already committed to looking closely at the legislation on tobacco control, including on e-cigarettes, to make sure we take opportunities to improve outcomes and protect health. We can be more ambitious for health improvement and public health, not less, when we leave the EU."

That is most certainly my view as public health Minister—and I may have had a small hand in the said article.

Q482 **Damien Moore:** Moving on to heat-not-burn products, which we touched on during the last session, both the Committee on Toxicity and Public Health England have pointed to the lack of independent, rigorous research on their harmfulness to the user. Reliable evidence is needed as soon as possible. What more can be done accurately to quantify the risks of these devices and inform how we regulate and monitor them?

Steve Brine: I might ask Tim to come in on PHE's February 2018 review, which I know had a chapter on heat-not-burn.

The evidence to date suggests that heat-not-burn products, or novel tobacco products, still pose harm to users, although they are likely to be less harmful than conventional cigarette smoking. Data on human health in this area is very limited. That is why our recommendation is that smokers quit tobacco completely, rather than moving to heat-not-burn products. I am sure that the industry would disagree with that.

HNB continues to be regulated as tobacco products under European legislation. At this stage, we just do not have sufficient data to consider changing that regulatory approach, even if we were able to. PHE will continue to monitor the evidence base as it develops.

I make that point about them still being regulated tobacco products for this reason: you may have seen some press coverage for me this weekend, Chair, on PMI—Philip Morris International—and its IQOS device. Is it breaching tobacco advertising regulations through poster advertising? I think that it is, and I was not shy in saying that this weekend, which was picked up, not unsurprisingly, through quite a lot of press interest.

Do you want to comment on the PHE review, which mentioned heat-not-burn?

Dr Baxter: Yes. We got advice from the Committee on Toxicity, which published a short report last December. It looked at the evidence. You are quite right. One of the problems in this area is that, as most of the research has been done by PMI scientists, COT was not able to say more than that it appears to have a much lower percentage of harmful compounds. There is not the same issue with sidestream smoke as with conventional cigarettes. It was not able to say, "It is X% safer or less harmful" or anything like that. We need to keep an eye on that.

This is not a problem that we are grappling with on our own. The Food and Drug Administration in the States is looking at an application from Philip Morris on IQOS to see whether it will be marketed in the US and whether it can make any reduced harm claims. That is going through the process as we speak.

One of the advantages of engaging with other countries, as we do, is that we are trying to share our experience. The tobacco industry is a global industry—we need to try to be global, drawing on the evidence where it is.

As the Minister says, at the moment they are regulated under the regulations and the directive. We have to be very careful about making any assumptions about reduced harm. There is some evidence, which is interesting, but we need more.

Q483 **Damien Moore:** We will look at evidence from other countries and potentially make a different assessment on that. Will there be any regulatory divergence after Brexit?

Steve Brine: TBC. Tim was in Cape Town six weeks ago at an international conference, where I know this was discussed.

Dr Baxter: I am part of the Global Tobacco Regulators Forum, which brings together the Americans, the Canadians, the European Union and various others. That is the sort of forum where we discuss these issues. You will not be surprised to hear that heated tobacco products have been the subject of the last couple of face-to-face meetings. We are all grappling with it and we are trying to share intelligence and understanding. We all want to see further good research being done.

Steve Brine: I think I am right in saying that, of the 20 studies that have been conducted in this area, 12 were funded by the manufacturers.

Dr Baxter: In looking at those, we would take advice from PHE on how strong and robust those studies are. Have they been done according to FDA requirements, which are very stringent? Can we put any reliance on them?

Q484 **Damien Moore:** I think it is a case of having more of a rounded approach, and more studies are obviously needed. In previous sessions we have talked about harm being relative to use and use being relative to satisfaction. If people are going from one product to another or using products simultaneously, is that any worse than using one product that is giving the satisfaction? That has been an issue in other sessions.

Steve Brine: Yes. To give you some view of the scope, if you found that the people using these products were exposed to 50% to 90% less of the harmful and potentially harmful compounds, that is a big space to be in, which suggests that we are still very unaware in this area.

Dr Baxter: It also depends what you are measuring. That research has, for good reason, measured the obvious thing: harmful compounds. The concern of many regulators is, "Are we missing something?"

There is a lot of history here. Low-tar was heavily promoted 20 years ago or so, but the consensus then became that people do not smoke like machines. We measure nicotine with standard cigarettes and standard machines. People do not smoke like machines, and smokers adjust to get the nicotine hit that they need or feel they want. In the end, low-tar felt like a bit of a dead end. We do not want to make a similar mis-step in regulation here.

Steve Brine: In Japan, where e-cigarettes are not available, there has been a rapid penetration of heated tobacco products in their population, which suggests great take-up and addiction to them—which, dare I say, may be the point.

Q485 **Stephen Metcalfe:** To achieve our public health aims, we need to get the appropriate information to smokers in particular. That information is about what the alternatives are, whether it is cessation services, e-cigarettes, heat-not-burn, patches, gums and so on. What are the barriers to using the one product that they currently use, which is a packet of cigarettes, to promote those services, with inserts put into the packet promoting alternatives that potentially offer less harm?

Dr Baxter: It is illegal, essentially.

Q486 **Stephen Metcalfe:** Illegal.

Dr Baxter: It is illegal to do so.

Q487 **Stephen Metcalfe:** Under?

Dr Baxter: Under the legislation. The reason for that—

Q488 **Chair:** Which legislation?

Dr Baxter: I am sorry—I will have to come back to you on the precise legislation.

The history here is that, as you will recall, tobacco companies used to put all sorts of things into cigarette packs: pictures of footballers or cricketers, vouchers or coupons. That was all made illegal. That is one of the other things that we can look at with the review that we have talked quite a bit about already.

Steve Brine: Is it your point that we should change that and lift the advertising regulations on e-cigarettes?

Q489 **Stephen Metcalfe:** I am saying that you have the opportunity—

Steve Brine: That is certainly the industry's view.

Q490 **Stephen Metcalfe:** Yes, but you have an opportunity to use the one

product that you know that smokers are using on a regular basis to communicate with them, as opposed to using social media such as Facebook, or posters and so on.

Steve Brine: The old sticks. I see what you are saying.

Q491 **Stephen Metcalfe:** You have the packet to say, "Phone this number. Try this." Everything other than that is a reduced path.

Dr Baxter: I think I am right in saying that there is not a single UK phone number for helping people to stop smoking, so that is an issue. We cannot use inserts. We do effectively use the pack to give various messages, with graphic health warnings.

Q492 **Stephen Metcalfe:** Absolutely. People play top trumps with those.

Steve Brine: I know what you are saying. It is an interesting point. Let me take it away.

Q493 **Stephen Metcalfe:** Okay—I have made the point.

Chair: I would encourage you to look at that. The idea of an inserted public health message encouraging people to think about vaping or other methods of stopping smoking is perfectly rational.

Steve Brine: Yes, and in a time of tight resource, it is a very targeted message to a person who you know will open that packet of sticks. Thank you, Mr Metcalfe—you should work in public health.

Q494 **Stephen Metcalfe:** Was that a job offer?

Steve Brine: No.

Q495 **Chair:** There are no further questions. I thank both of you very much. We really appreciate your evidence. That concludes our evidence session.

Steve Brine: We welcome this inquiry very much. When I heard that you were doing it, we were doing a Westminster Hall debate at the time, and it is very welcome that you are doing it. We see you as a partner in it.

Chair: Good. Thank you very much.