HEALTH SELECT COMMISSION

Venue: **Town Hall, Moorgate Street, Rotherham S60 2RB**

Date: **Thursday, 31st May, 2012**

Time: **9.30 a.m.**

A G E N D A

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) to the Local Government Act 1972

2. To determine any item the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of previous meeting (Pages 1 - 11)

8. Health and Wellbeing Board
   - verbal update

9. Work Programme 2012-13 (Pages 12 - 16)

10. Tobacco Plain Packaging Consultation (Pages 17 - 56)

11. Representation on Working Groups/Panels

1) Health, Welfare and Safety Panel
One Member plus a substitute
Meets quarterly on a Friday
(next meeting on 15th July)

(2) Recycling Group
One Member
Meets quarterly on a Tuesday at 10.00 a.m.
(next meeting 19th July)

12. Date and Time of Future Meeting:-
- Thursday, 12th July, 2012 at 9.30 a.m.

HEALTH SELECT COMMISSION
Thursday, 19th April, 2012

Present:- Councillor Jack (in the Chair); Councillors Barron, Beaumont, Beck, Blair, Burton, Dalton, Goulty, Steele and Wootton and Victoria Farnsworth (Speak-Up).

Councillors Doyle, Sharman and Wyatt were also in attendance at the invitation of the Chair.

Apologies for absence were received from Jonathan Evans, Peter Scholey and Russell Wells.

58. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

59. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press present at the meeting.

60. COMMUNICATIONS

There was nothing to report under this item.

61. MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 8th March, 2011, were noted.

It was noted that the Health Inequalities Scrutiny Review BMI>50 (Minute No. 55 refers) was to be considered by Cabinet on 25th April. Disappointment was expressed at the front page head line in the previous week's local press taken from the report which could further isolate this subject group.

62. HEALTH AND WELLBEING BOARD

The minutes of the Health and Wellbeing Board held on 29th February, 2012, were noted.

2 workshops had since been held to develop the Health and Wellbeing Strategy which included the Joint Strategic Needs Assessment.

Councillor Wyatt, Cabinet Member for Health and Wellbeing, then gave the following powerpoint presentation on tackling health inequalities and responding to change:-

Health and Social Care Act

- Received Royal Assent on 27th March, 2012 took forward the areas of Equity and Excellence: Liberating the NHS (July 2010) which required primary legislation
- Covered 5 themes
  Strengthening commissioning of NHS services
  Increasing democratic accountability and public voice

Liberating provision of NHS services
Strengthening public health services
Reforming health and care arms length bodies

- Highly controversial and included significant changes to the way things were done

Health and Wellbeing Board

- Local authorities would lead the co-ordination of health and wellbeing through the creation of high level 'Health and Wellbeing Boards
- Key responsibilities included:-
  Joint Strategic Needs Assessment
  Joint Health and Wellbeing Strategy
  Improving health and reducing health inequalities
  Integrating health, social care and public health
  Productivity and efficiency

Rotherham's Board

- Now established as a Sub-Committee of the Council, Chaired by the Cabinet Member for Health and Wellbeing
- Direct reporting links to the LSP as well as links to other local Boards (including Adults, Children's)
- Terms of Reference agreed and work plan being developed

Vision for Health and Wellbeing

- For everyone in Rotherham to be happy and healthy and have the adequate resources to participate in their community

Core Membership of the Board

- Cabinet Member for Health and Wellbeing (Chair)
- Cabinet Member for Adult Services
- Cabinet Member for Safeguarding Children and Adults
- Director of Public Health
- Chief Executive, RMBC
- Strategic Director of Neighbourhoods and Adult Services
- Strategic Director of Children and Young People's Services
- Strategic Director of Environment and Development Services
- Chair of Clinical Commissioning Group (CCG)
- Chief Operating Officer, CCG
- Chair of PCT Cluster Board (until April, 2013 when position will be reviewed)
- Voluntary Action Rotherham
- Rotherham HealthWatch (once in place 2013)

NHS Commissioning

- Devolved responsibility for the majority of commissioning to local Clinical Commissioning Groups
- Supported and held to account by an independent national NHS Commissioning Board
- Rotherham Clinical Commissioning Group now established
- CCG had a statutory place on the Health and Wellbeing Board

Public Health

- Local authorities would take on statutory duty for Public Health
- Full transfer of responsibilities and resources by April, 2013
- Ringfenced budget allocation provided in 'shadow' form April, 2012
- Directors of Public Health jointly appointed between local authority and Public Health England from April 2013
- Director of Public Health to be added to the list of statutory Chief Officers in the Local Government and Housing Act (subject to Parliament)
- Director of Public Health had a statutory place on the Health and Wellbeing Board

HealthWatch

- HealthWatch England would be the national voice of patients and the public to be established October, 2012
- Local authorities required to procure a local HealthWatch by April, 2013
- Work underway to develop commissioning arrangements for a Rotherham HealthWatch
- Existing LINks being supported to continue to deliver a service in the meantime

Overview of Key Activity

- NHS Commissioning Board Special Health Authority established October, 2011
- NHS Commissioning Board in place by October, 2012
- PCTs abolished 2013
- PCT Clusters now in place until 2013 to support transition
- Clinical Commissioning Groups take on statutory responsibilities from April, 2013
- Public Health England established 2013
- Local authorities take on Public Health responsibilities April, 2013
- Local Health and Wellbeing Boards in shadow form by April, 2012, and take on statutory responsibilities April, 2013
- HealthWatch England established October, 2012
- Local HealthWatch to be in place by April, 2013

63. PUBLIC HEALTH TRANSITION

Dr. Nagpal Hoysal, NHSR, gave a powerpoint presentation on the Health and Social Care Act 2012 and the local authority duties and responsibilities as follows:-

Cause of Disease

- 60% of the causes of the disease burden in Europe was caused by 7 risk factors:-
  High blood pressure (12.8%)
  Tobacco (12.3%)
  Alcohol (10.1%)
  High blood cholesterol (8.7%)
  Overweight (7.8%)
  Low fruit and vegetable intake (4.4%)

And physical inactivity (3.5%)
- Diabetes, which was directly related to obesity and lack of exercise, was also a major risk factor and trigger for cardiovascular disease
- Risk factors frequently cluster and interact – particularly in disadvantaged socio-economic groups

Public Health 2012 Act
- SoS duty as to protection of public health
- Duties as to improvement of public health were functions of local authorities and SoS
- Each local authority must take such steps it considered appropriate for improving the health of people in its area

Duties as to improvement of Public Health Local Authority Functions
- Providing information and advice
- Services or facilities designed to promote healthy living
- Services and facilities for the prevention, diagnosis or treatment of illness
- Providing financial incentives to individuals to adopt healthier lifestyles
- Providing assistance (including financial assistance) to help individuals minimise any risks to health arising from their accommodation or environment
- Making available the services of any person or any facilities

Mandatory Services (Public Health White Paper)
- Ensuring NHS commissioners receive the Public Health advice they need
- National Child Measurement Programme
- NHS Health Check assessment
- Appropriate access to sexual health services

Discretionary
- Tobacco Control and Smoking Cessation Services
- Alcohol and Drug Misuse Services
- Public Health Services for children and young people aged 5-19 (including Healthy Child Programmes 5-19) (and in the longer term all Public Health Services for children and young people)
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population
- Public Mental Health Services
- Dental Public Health Services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long term conditions
- Local initiatives on workplace health
- Comprehensive Sexual Health Services
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Public Health aspects of promotion of community safety, violence prevention and response

- Public Health aspects of local initiatives to tackle social exclusion
- Increasing levels of physical activity in the local population
- Supporting, reviewing and challenging delivery of key Public Health funded and NHS delivered Services such as Immunisation and Screening Programmes
- Local initiatives that reduced Public Health impacts of environmental risk

Commissioning Agencies and Structure

- Local Authority
  Social Care
  Public Health
  Environment
- Clinical Commissioning Group
  Hospital and Community Services Commissioning
  Some GP services
  GP Group + Governing Body
- NHS Commissioning Board
  Establish CCGs
  General Practice contracts
  Commissioning support to CCGs (initially)
  GP Group + Governing Body
- Public Health England
  Health protection
  Screening
  Emergency response
  vaccination
- Health and Wellbeing Board
  Joint Strategic Needs Assessment
  Joint Health and Wellbeing Strategy
- HealthWatch England
  Public involvement in health and social care
  Local HealthWatch
  Independent advocacy

64. ROTHERHAM CLINICAL COMMISSIONING GROUP UPDATE

Sarah Whittle, NHS, gave the following powerpoint presentation on the Clinical Commissioning Group:-

The Health Bill/Act

- Abolished Primary Care Trusts by April, 2013
- Clinical Commissioning Groups (CCGs) formed in shadow form from 1st October, 2011
- Fully authorised by April, 2013
- Public Health responsibilities to transfer from NHS to RMBC (April, 2013)
- GP/Dentist/Pharmacists' contracts and special commissioning to be managed by National Commissioning Board (currently Cluster)
- HealthWatch to be formed to promote the views of patients and service users
- NHS Commissioning staff in Rotherham reduced by 48%

Budget
- NHS Rotherham £460M
- RMB Public Health £20M
- Rotherham CCG £330M
- NHS Commissioning Board – GP/Dentists/Pharmacists £120M

CCG Structure
- CCG Committee/Board
- GP Reference Group
- Strategic Clinical Executive
- Operational Executive
- Strong clinical focus

CCG Authorisation – 6 domains
- Clinical focus and added value
- Engagement with patients and communities
- Clear and credible plans
- Capacity and capability
- Collaborative arrangements
- Great leaders

Finance
- Need to generate £75M of efficiencies over the next 4 years
- Expected make the efficiencies by:-
  Managing long term conditions patients more efficiently and cost effectively
  Making sure only appropriate patients were referred to hospital
  Making GP prescribing more efficient and cost effective
  Reducing commissioning staff by the Government target of 48%

Partnerships with RMBC
- Local Strategic Partnership
- Health and Wellbeing Board
- Adults Board
- Long Term Conditions/Unscheduled Care
- Children and Families Partnership
- Think Family
- Safeguarding
- Public Health

65. IMPLICATIONS OF THE HEALTH AND SOCIAL CARE BILL ON THE FOUNDATION TRUST

Peter Lee, Chairman of the Rotherham Foundation Trust, gave a powerpoint presentation on the implications for the Trust, its Directors, Governors and members of the Health and Social Care Act 2012:-

Where we start from
- Combined hospital and community services
- Income £225M from 1 year contract
- Over 4,000 staff

- Cost improvement programme 2012/13 (£14M)
- FRR – 3 (1-5) and Governance – Green (green/amber/red)
- Lowest waiting times
- Infection control record – excellent

New Commissioning Regime
- Present position – Primary Care Trust until April, 2013
- Future position – Clinical Commissioning Group from 2013
- Transitional arrangements exist
- CCGs – locally managed and directed – all primary care providers had to be members – regulatory supervision – obligations to be transparent
- CCGs – mandated to continuously improve services – reduce inequalities – promote patient involvement and patient choice – innovation – research and the integration of health and social care

New Initiatives
- Promotion of Section 75 NHS Act 2006 arrangements
- Every provider of health services would need to be licensed
- Changing role for Monitor (Foundation Trust regulator)
- Increasing role of Council of Governors
- Duty to promote the NHS Constitution
- Caps and conditions to non-NHS income
- Foundation Trust Board meetings to be held in public

New Roles and Responsibilities – Governors
- To hold the NEDs individually and collectively accountable for the performance of the Board
- To represent the interests of the members (as a whole) and the interest of the public
- To require the Directors to attend Council of Governors to supply information regarding the performance of their duties and functions
- Any amendment to the Constitution of the Trust regarding the powers or duties of the Governors (or their role) was subject to a Members' vote. More than 50% of those voting must be in favour and the motion must be put by a member of Council of Governors
- Any other amendments to the Constitution of the Trust were subject to more than 50% of the Directors voting in favour and more than 50% of those Governors actually voting being in favour
- Constitution could be changed to specify partnering organisations which may appoint one or more members of the council

New Roles and Responsibilities – Directors
- General duty to act with a view to promote the success of the Trust so as to maximise benefits for the members (as a whole) and for the public
- Must supply Governors with meeting agendas prior to their meetings and minutes as soon as practicable after meetings
- Constitution must be amended to provide for meetings to be open to the public and may provide for exclusion of the public for special reasons
- Obligation to promote the NHS Constitution to members of the public in discharging the Trust's functions

- Ensure that the Governors were equipped with the skills and knowledge required in their capacity as such, to discharge their duties
- Accountability to Governors (all Directors) for performance of their functions and duties and the requirement to attend at Council, if requested by Council, to supply information and answer questions regarding their functions and performance of their duties
- Constitutional changes require Governors approvals
- What was a significant transaction may be defined in the Constitution of the Trust (or not) (and not by Monitor) and entry into such a transaction would be subject to approval by more than 50% of the Governors actually voting
- Governors' influence over mergers, acquisitions, separations and dissolutions – any proposal was subject to approval by 50% of the Governors
- Obligations regarding the "complexion" of the membership
- Obligation to hold an annual meeting of its members (open to the public)

Members

- Change to an obligation (not an option) upon the Trust to secure that the actual membership of any public constituency was representative of those eligible for such membership
- In deciding which areas were to be public constituencies (or in deciding whether there was to be a patients constituency) Trusts must have regard to the need for those eligible for such membership to be representative of those to whom the Trust provided services
- Obligation to provide a members' annual meeting

66. ACHIEVING AN EFFECTIVE HEALTH AND WELLBEING STRUCTURE IN ROTHERHAM

A question and answer sessions on the 4 presentations ensued as follows:-

Was the culture of the Health and Wellbeing Board built upon principles of transparency, involvement, accountability, trust and respect between the Health and Wellbeing Board members?
There were a number of requests from a range of organisations wanting to join the Board. However, there was a need for the membership to be focussed and ensure that the representatives were able to represent their organisations and on their behalf as written into the Terms of Reference.

There had to be wider engagement with the community as it would be one of the tests of success or failure as to how effective the engagement with communities was.

There were good examples of work in the Health Inequalities Strategy and the 2 recent workshops had tried to be as inclusive as possible by inviting the wider representative groups rather than just Health and Wellbeing.

With regard to the relationship with Scrutiny, Rotherham had been involved in various projects with the Centre for Public Scrutiny; looking at scrutiny within the context of the health reforms and how to develop successful working relationships.

How would the Board work together as well as with the people who actually used services to tackle difficult issues such as Service reconfiguration? How could Scrutiny best support this?
Any Service changes, in accordance with procedure, had to be submitted to the Select Commission for comment.

With regard to the required wider engagement activities, there was a need to use all the mechanisms in place such as the Foundation Trust network. Rotherham had some very good engagement groups across the Local Authority and Health but there was duplication and a need to know what each partner was consulting on; communication was seen as key to ensuring this happens.

Do you feel Health and Wellbeing partners were able to identify potential conflicts straightaway and were there agreed ways of dealing with them?

Strong partnership working would help ensure that conflicts are easily dealt with, in an open and honest manor.

Having a comprehensive and jointly agreed Joint Strategic Needs Assessment and Health and Wellbeing Strategy would also ensure a common purpose and agreed goals, which should reduce any potential conflicts and issues between agencies.

A key message from the 2nd Health and Wellbeing workshop had been the importance of a joined up approach on communications.

What evidence was there that health and wellbeing partners worked well together outside of formal Board meetings?
The Joint Service Centres were an example where GPs and Council worked alongside but there was a need for further joint work as resources diminished. This was critical to the transition of Public Health and protocols required.

Other good examples of good joint working included: learning disability services, mental health and the Early Help agenda with children and families.

There were concerns that joint working was not always as effective as it should be, issues such as not having co-located teams and IT systems that did not 'talk' to each other presented potential difficulties with joint working.

With respect to IT systems, in June, 2012, the Trust was commencing its roll out of its Electronic Patient System which would completely transform the way patient information was available cross the health community. The Trust was investing a huge amount of money in the system and confident of the results that would be achieved in terms of economy and efficiency.

There would be increased pressure on the different organisations due to competition and possible dilemmas between wanting to work together and having to follow the competitive route

With regard to competition, the issue was about maintaining value for money whilst making sure the system provided quality services. The CCG would have the obligation to achieve that. Health and Wellbeing Board members had to recognise that there may be a conflict of interests in their capacity of providers.

The Section 75 powers enabling money to be moved around the system to deliver services would be good for Rotherham.

Good housing conditions was crucial to the health and wellbeing of the population. To what extent had housing been included in discussions?
The Strategic Director of Neighbourhoods and Adult Services was a member of the Health and Wellbeing Board and also a member of the Adults Board.

How could the Health Select Commission work with the Health and Wellbeing Board and wider health partners to understand the issues in Rotherham and help improve services and experiences for local people in the most effective way?

How could Elected Members most effectively open up a dialogue and build strong working relationships with health and wellbeing partners including GPs and the Clinical Commissioning Group, the Foundation Trust and other NHS providers, Public Health and Social Care?
GPs held a lot of intelligence for their area that had to be used as a community resource. There had to be commissioning for areas rather than just for their practice.

Elected Members needed to think about the new shape to the services and in respect of their lines of communication, the public pound and stretching it as far as it could go. Avoiding duplication and challenging the empires was key to success.

The current CCG was made up of GPs and was a heavy doctor based group. How would the CCG take advice on commissioning other services?
The powerpoint slide had not shown the full Committee. It was currently made up of 4 GPs, 2 from the strategic and commissioning executive and 2 from the GP Reference Group and 4 lay members together with NHS Rotherham Managers, a Consultant GP and a Nurse Consultant. It had still not been agreed what the CCG Board would look like and was been discussed at a national level.

How was the £75M over the next 4 years and the 48% reduction in staff to be made?
The 48% was of 150 staff and the redundancies had been factored into the £75M. However, there would be a low number of compulsory redundancies.

There would be consultation when it was known precisely where the savings would be but the majority of the savings would be coming through working in different ways and transforming services.

The hospital was used as a "refuge" at the moment and not being used as efficiently as it should. Education was required as to what A&E was for and whether it was more appropriate to go to the pharmacy, GP or Walk in Centre. Quite often a patient stayed in hospital for far longer than was required and would have received more appropriate care in the community.

The savings could start at the beginning from a patient attending their GP and was 1 of the reasons why GPs had been given the lead role in commissioning. There were ways of making savings on prescribing branded drugs versus generic drugs that did the same job and were sometimes cheaper. Repeat

prescriptions was also a costly matter with many patients automatically receiving drugs they no longer took/needed.

67. COUNCILLOR JACK

This was Councillor Jack's last meeting as Chair of the Select Commission. She thanked officers for their support.

Members wished Councillor Jack best wishes for the future.

68. DATE AND TIME OF FUTURE MEETING:-

Resolved:- That a further meeting be held during on 31st May, 2012, commencing at 9.30 a.m. in the Town Hall.

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1. Meeting:	**Health Select Commission**
2. Date:	**31st May, 2012**
3. Title:	**Work Programme: 2012/13**
4. Directorate:	**Resources**

5. Summary

The paper outlines current options for a Scrutiny Work Programme for 2012/13.

6. Recommendations

That the Health Select Commission:

- Identifies priority areas to be fed into the draft work programme in line with the Commission's remit
- Identify any areas for review to be undertaken during 2012/13
- Consider how they would like to tackle any nominated themes (as outlined below) and to update verbally at the meeting
- Consider other issues which need to be included, in light of comments made about resource limitations

7. Proposals and details

As outlined in the Council's Constitution, the remit of the Health Select Commission includes:

- To be the council's designated scrutiny body for any issue relating to health and the public health agenda
- Partnerships and commissioning arrangements in relation to health and wellbeing and their governance arrangements
- Health improvements and the promotion of wellbeing for adults and children of Rotherham
- Measures to address health inequalities
- Food law and environmental health
- Issues referred to it by the Local Involvement network (or successor body)

As we are at the start of the new municipal year there is a need to begin the development of a new annual work programme. There are a number of factors which need to be considered in pulling the programme together:

- A retrospective look at what was achieved in 2011/12 and any outstanding issues that need to carry forward

- Health's 2011/12 work programme is attached as Appendix A. Its main focus included development area projects with the Centre for Public Scrutiny and a review of continuing healthcare

- An opportunity for Scrutiny members to feed issues of concern, into the respective Select Commissions, and enter into a wider discussion around the detail of the work programme

- In addition to work identified on priority areas or issues referred from the previous municipal year, members are asked for comments on areas to be addressed by the Commission during 2012/13. These should be in line with the commission's remit (suggestions for areas of work relating to other commissions will be referred to OSMB for consideration).

It is also important to note the changes that have occurred during the last year and the reduction in staffing resources. Any work programme needs to take account of this and look realistically at what can be achieved and where it is best to focus resources and efforts.

Discussions have already been taking place between Cabinet, SLT and Scrutiny Chairs to identify some strategic priorities for the work programme that will involve joint working across both the Executive and Scrutiny's Commissions. These include:

- Fuel Poverty
- 11 most deprived areas
- Troubled Families
- Welfare Reform
- Role of local members in their communities
- Reducing Health Inequalities
- Special Educational Needs and announced legislative changes

These joint priorities of Cabinet, Scrutiny and SLT are to be discussed at the OSMB meeting of 25th May. These priorities would represent overarching themes which can

either be retained by OSMB to explore or allocated to the Select Commissions to lead on. At the time of writing, OSMB have yet to recommend to individual commissions which ones are priorities for the work programme and how these will be allocated. This will be reported verbally to the meeting.

It is suggested that nominated commissions could then work on the theme and develop an appropriate programme to address the issues. An example of this is the recent work done on Fuel Poverty. Following a themed meeting at the Improving Places commission, a working session was set up which looked in depth at a whole range of issues associated with Fuel Poverty, followed by a focused discussion on what issues Scrutiny could add value to by focusing on e.g. a review of the up and coming Green Deal and how it will work in Rotherham.

A range of methods can be used to look at this including task groups, spotlight reviews, information sessions as well as full reviews.

The work programme is flexible and issues may be referred to OSMB and Select Commissions by individual members as well as from other sources, including members of the public. In determining its priorities for the work programme, OSMB Members should make a judgment on what outcomes may be achieved by accepting a referral, bearing in mind resource and capacity implications.

It is suggested that the work programme is reviewed by OSMB members and Select Commissions at regular intervals. This will ensure that issues of greater importance can be given a higher priority, reflecting changing circumstances or events. However if new issues are introduced, to ensure that the work programme is manageable and achievable, Members will need to decide if other items should 'fall off the agenda' to accommodate these discussions.

8. Finance

There are no direct financial implications arising from the report.

9. Risks and Uncertainties

It is important that a robust work plan is put in place to ensure that the work of the Scrutiny is targeted, effective and delivers clear outcomes. The risk of not doing this is that the agenda items will become information items and not add value to the work of the Council.

10. Policy and Performance Agenda Implications

The proposed work programme takes on board key policy agendas the Council is currently considering and performance information as and where necessary.

11. Background Papers and Consultation

Cabinet/SLT/Scrutiny Chairs meetings.

12. Contact

Kate Green
Scrutiny Officer
Kate.green@rotherham.gov.uk

Health Select Commission – work programme 2011/12

Month	Reports	Presentations	Consultations	Reviews
14 July 2011				
August Recess				To note: Health Inequalities review started with sub-group
15 September	Health Inequalities Summit	Local authority and partnership role around health and HW Board – CfPS project	Park Rehab Centre - consultation on service changes To note draft responses for consultations on: allocation options for funding local HealthWatch CQC Regulation	
27 October (joint meeting with LIVES – Adult Social Care themed meeting)		Cabinet Portfolios (Cllrs Lakin/Doyle) JSNA – demographics/ageing population Continuing Healthcare	Caring for our Future Consultation (Dilnot/Law Commission)	
8 December (public health themed meeting)		Health Summit – presentation on findings Public Health in the Local Authority		Breastfeeding Review – update on recommendations and progress made
26 January	Work Programme Update –what has worked well/not so well since restructure	RFT Quality Accounts – to update on 2011/12 and present 2012/13 accounts for comment		Obesity Review - verbal report on draft recommendations of obesity review

				Note: Review of Continuing healthcare to begin late Jan (complete by July)
8 March	**Smoking Cessation – update on projects (social norms) / recommendations for Rotherham to become smoke free**	**RDaSH Quality Accounts - Karen Cvijetic and Helen Dabbs**		**Health Inequalities review – final report and recommendations + discussion around new model for doing reviews**
19 April **Health and Wellbeing Board session**	**Local Health and Wellbeing Board – update on progress and work programme (Cllr Wyatt)**	**Clinical Commissioning Group update** **Rotherham Foundation Trust update**		
31 May	**Work programme 2012/13**		**Standardised Packaging for Tobacco**	

Items to potentially carry forward to 2012/13

- **Excess Medication**
- **Electronic Patient Records – possible spotlight review**
- **E-Market Place**
- **Commissioning for local Healthwatch**
- **Autism Review**

DHSSPS
Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Llywodraeth Cymru
Welsh Government

The Scottish Government

DH Department of Health

Consultation on standardised packaging of tobacco products

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	17194
Title	Consultation on standardised packaging of tobacco products
Author	Department of Health
Publication Date	**16 April 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Directors of PH, Local Authority CEs, Businesses, Public Health Organisations, Academics, Members of the Public
Circulation List	Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Nursing, Directors of Adult SSs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, Communications Leads, Directors of Children's SSs, Voluntary Organisations/NDPBs
Description	A consultation to consider options to reduce the promotional impact of tobacco packaging, including standardised (or "plain") packaging. The consultation is being run on a UK-wide basis by by the Department of Health with the agreement of the Devolved Administrations
Cross Ref	Healthy Lives, Healthy People: A Tobacco Control Plan for England
Superseded Docs	
Action Required	
Timing	**Closing date for consultation responses is 10 July 2012**
Contact Details	Tobacco Packs Consultation Department of Health 7th Floor Wellington House 133-155 Waterloo Road London SE1 8UG http://consultations.dh.gov.uk
For Recipient's Use	

Consultation on standardised packaging of tobacco products

1. Purpose of this consultation

1.1 The purpose of this consultation is to seek the views of interested people, businesses and organisations on a policy initiative that would require the packaging of tobacco products to be standardised, the aim being to improve public health by reducing the use of tobacco. Within the context of tobacco packaging, standardised packaging is sometimes referred to as 'plain packaging'.

1.2 The Department of Health (England), the Chief Medical Officer's Directorate (Scotland), the Health and Social Services Directorate General (Wales) and the Department of Health, Social Services and Public Safety (Northern Ireland)[1] each have responsibility for improving public health, including reducing tobacco use through the implementation of comprehensive tobacco control strategies. Across the United Kingdom, we all wish to explore whether further policy action should be taken on the packaging of tobacco products. The results of this consultation will contribute to the future formulation of tobacco control policies.

1.3 Any decisions to take further policy action on tobacco packaging will be taken only after full consideration is given to consultation responses, evidence and other relevant information. If it is decided to pursue a policy that would require legislation, further consideration will be given to the most appropriate approach.

1.4 We invite your responses to the consultation questions listed at Appendix A, on the consultation-stage impact assessment (published alongside this consultation) and on the impact assessment questions at Appendix B.

2. Introduction

2.1 Tobacco use remains one of the most significant challenges to public health across the United Kingdom. While rates of smoking have declined over past decades, in recent years this decline has lost momentum. Today around 21 per cent of adults in Great Britain smoke. Smoking is harmful not only to smokers but also to the people around them.

2.2 Smoking is the primary cause of preventable morbidity and premature death, accounting each year for over 100,000 deaths in the United Kingdom. The Department of Health and the Devolved Administrations are each considering additional action that could be taken to reduce tobacco use.

2.3 Treating smoking-related illness costs the National Health Service (NHS) billions of pounds each year. However, the wider economic costs of tobacco use are much greater than just costs to the NHS. They include losses in productivity from smoking breaks and ill-health absences, the cost of cleaning up cigarette butts, the cost of smoking-related house fires

[1] Collectively referred to as the Department of Health and Devolved Administrations in this consultation document.

and the loss in economic output from people who die from diseases related to smoking or exposure to secondhand smoke. Reducing tobacco use will benefit not only NHS finances, but also the wider local and national economy.

2.4 Smoking rates are much higher in some communities and in specific social groups, including among those with the lowest incomes and those with mental illnesses. Smoking is the biggest single cause of inequalities in death rates between the richest and poorest people in our communities.

2.5 Reducing the uptake of smoking by young people is a key public health goal. Smoking is an addiction acquired largely in childhood and adolescence, and young people can rapidly develop nicotine dependence. The early age at which people become regular smokers is a cause for concern. Two-thirds of current and ex-smokers in Great Britain say that they started smoking regularly before they were 18 years old, with 39 per cent saying they were smoking regularly before the age of 16.

2.6 Another obstacle to reducing smoking prevalence is the fact that smokers can find quitting extremely challenging. Tobacco addiction is complex, having physical, psychological and social dimensions that manifest differently in different people. By successfully quitting smoking, people can avoid smoking-related diseases and live longer, whatever their age. Evidence shows that people who are successful in quitting smoking are also more able to make other changes in their lives that will benefit their health and wellbeing. The majority of smokers in Great Britain say that they would like to give up smoking altogether. We therefore want to create a supportive environment for smokers who want to quit.

2.7 The Department of Health and Devolved Administrations across the United Kingdom recognise that effective tobacco control forms a crucial component in policies to improve public health. Tobacco control policies in place across the United Kingdom take a comprehensive approach, aiming to reduce the impact of tobacco use by discouraging uptake of tobacco use by young people, supporting tobacco users who want to quit and reducing people's exposure to secondhand tobacco smoke.

2.8 We want to explore whether policy action on tobacco packaging has the potential to bring public health benefits over and above those expected to accrue from existing tobacco control initiatives, including legislation to end the open display of tobacco in shops. While 'plain packaging' is a term commonly used in connection with policies about regulating tobacco packaging, in practice packs would not actually be plain. For example, they would be required to have coloured picture warnings and brand names would still appear in a standardised form. The term 'standardised packaging' is considered to be a more accurate description of the policy concept and, therefore, it is used throughout this consultation document.

3. Policy objectives

3.1 The Department of Health and Devolved Administrations have broad policy objectives to improve public health by:

- discouraging young people from taking up smoking;
- encouraging people to quit smoking;
- helping people who have quit, or who are trying to quit, to avoid relapse back to smoking; and
- reducing people's exposure to secondhand smoke from tobacco products.

3.2 To inform policy development, we wish to explore whether requiring tobacco products to be sold in standardised packaging could contribute to achieving these public health policy objectives by:

- reducing the appeal of tobacco products to consumers;
- increasing the effectiveness of health warnings on the packaging of tobacco products;
- reducing the ability of tobacco packaging to mislead consumers about the harmful effects of smoking; and
- having a positive effect on smoking-related attitudes, beliefs, intentions and behaviours, particularly among children and young people.

3.3 We seek feedback on whether there might be public health benefits from the introduction of standardised tobacco packaging in addition to policies currently in place, including legislation ending the permanent display of tobacco products by retailers.[2]

4. Standardised tobacco packaging

4.1 The United Kingdom is a Party to the World Health Organization's *Framework Convention on Tobacco Control* (FCTC). The FCTC is the world's first public health treaty and places obligations on Parties to meet the treaty objective to 'reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke' and to implement comprehensive tobacco control strategies.[3] Since the United Kingdom became a Party to the treaty in 2004, the Government has taken its FCTC obligations very seriously.

4.2 To help Parties meet their obligations under the FCTC, guidelines have been developed. While these guidelines are not binding, Parties have agreed that they reflect their consolidated view of a desirable means of fulfilling their FCTC obligations.

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[2] Tobacco display legislation comes into force in England on 6 April 2012 in large shops and 6 April 2015 for all other businesses. Similar legislation is also to be introduced in other parts of the UK.

[3] From Article 3 (objective) and Article 5 (general obligations) of the World Health Organization's *Framework Convention on Tobacco Control*, available on the internet at: **http://www.who.int/fctc**

4.3 Guidelines on Article 11 of the FCTC[4] suggest that:

Parties should consider adopting measures to restrict or prohibit the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style (plain packaging). This may increase the noticeability and effectiveness of health warnings and messages, prevent the package from detracting attention from them, and address industry package design techniques that may suggest that some products are less harmful than others.

4.4 Guidelines on Article 13 of the FCTC[5] recommend:

Packaging and product design are important elements of advertising and promotion. Parties should consider adopting plain packaging requirements to eliminate the effects of advertising or promotion on packaging. Packaging, individual cigarettes or other tobacco products should carry no advertising or promotion, including design features that make products attractive.

4.5 The FCTC guidelines explain that:

The effect of advertising or promotion on packaging can be eliminated by requiring plain packaging: black and white or two other contrasting colours, as prescribed by national authorities; nothing other than a brand name, a product name and/or manufacturer's name, contact details and the quantity of product in the packaging, without any logos or other features apart from health warnings, tax stamps and other government-mandated information or markings; prescribed font style and size; and standardized shape, size and materials. There should be no advertising or promotion inside or attached to the package or on individual cigarettes or other tobacco products.[6]

4.6 Reflecting the FCTC guidelines, we have developed the following approach to standardised packaging for the purposes of this consultation:

- All internal and external packaging to be in a prescribed colour/s.
- All text on the pack, including brand names, to be in a standard colour and typeface.
- No branding, advertising or promotion to be permitted on the outside or inside of packs, or attached to the package, or on individual tobacco products themselves. For this purpose 'branding' includes logos, colours or other features associated with a tobacco brand.
- Any foils within a pack to be of a standard format and colour with no text permitted.
- Packs to be of a standard shape and opening, and possibly manufactured with particular materials.

[4] Article 11 of the FCTC relates to packaging and labelling of tobacco products.

[5] Article 13 of the FCTC relates to tobacco advertising, promotion and sponsorship.

[6] FCTC implementation guidelines are available on the internet at: **http://www.who.int/fctc**

- Only the following information or markings to be permitted on packs:
  - a brand name;
  - a product name;
  - the quantity of product in the packaging;
  - the name and contact details of the manufacturer;
  - one barcode to facilitate sale and stock control;
  - health warnings as currently required;[7]
  - tar, nicotine and carbon monoxide yield information as currently required;[7]
  - product identification marking as currently required;[7]
  - fiscal mark requirements as currently required;[8] and
  - markings not visible to the naked eye to assist with the identification of genuine, duty-paid products, or other features to prevent fraud.
- Any wrapper around the pack to be transparent and colourless, without any other markings visible to the naked eye.

4.7 Consistent with the allowances for advertising in section 4 of the Tobacco Advertising and Promotion Act 2002, we do not believe that standardised packaging requirements would be necessary during the course of business solely within the tobacco trade. This means that brand names, colours and logos would still be allowed to be used openly within the tobacco trade. However, tobacco products that are made available for sale to the public, or that could be visible to the public, would need to meet the requirements set out in paragraph 4.6.

4.8 If standardised packaging was to be required in the future, any further details and specifications would be set out by the Government.

5. Other effects associated with standardised tobacco packaging

5.1 There may be other effects associated with introducing standardised tobacco packaging. Through this consultation, we wish to understand in more detail what these could be, together with any evidence.

5.2 In particular, we seek views on whether introducing standardised packaging would have:

- trade or competition implications;
- legal implications;
- costs or benefits for retailers or manufacturers;

[7] Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002, as amended by the Tobacco Products (Manufacture, Presentation and Sale) (Safety) (Amendment) Regulations 2007, implementing the Tobacco Products Directive 2001/37/EC.

[8] Set out in the Tobacco Products Duty Act 1979, the Tobacco Products Regulations 2001 and HMRC Notice 476 dated February 2011.

- implications for the availability of, and demand for, illicit tobacco (both smuggled and counterfeit);
- implications for cross-border shopping;[9] or
- any other unintended consequences.

6. Evidence

6.1 To inform responses to this consultation and any subsequent policy-making, the Department of Health in England commissioned a systematic review of the evidence on plain tobacco packaging. The review was supported through the Public Health Research Consortium (PHRC), a network of researchers funded by the Department of Health's Policy Research Programme. The review was undertaken by academics at the University of Stirling, the University of Nottingham and the Institute of Education, London.

6.2 The resulting report has been peer-reviewed in accordance with the Department of Health's Research Governance Framework[10] and is available on the PHRC's website at: **http://phrc.lshtm.ac.uk/project_2011-2016_006.html**

6.3 The PHRC report represents the work and views of the authors, not necessarily those of the Department of Health.

7. Impact assessment

7.1 A consultation-stage impact assessment has been prepared and is published alongside this consultation document. The impact assessment presents the following options:

- *Option 1:* Do nothing (i.e. maintain the *status quo* for tobacco packaging).
- *Option 2:* Require the plain packaging of cigarettes and hand-rolling tobacco, as described in paragraphs 4.6 and 4.7.
- *Option 3:* A different approach to tobacco packaging to improve public health, if suggested by consultation responses. Options 1 and 2 are considered in the impact assessment. The potential of Option 3 will be explored following consultation, if responses to the consultation suggest an alternative approach to reduce the promotional impact of tobacco packaging.

7.2 Although we have an open mind at this stage about introducing standardised packaging, the impact assessment has been prepared to inform responses to the consultation. We welcome your views on the impact assessment as part of this consultation.

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[9] People travelling from abroad may bring tobacco bought in another country back into the United Kingdom for their own consumption, subject to UK customs regulations. This is known as 'cross-border shopping'.

[10] The Department of Health's *Research Governance Framework for Health and Social Care* is available on the internet at: **http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962**

7.3 An initial assessment of the impact on equality has been prepared and is published alongside this consultation document. We seek your opinions on whether a policy of standardised packaging of tobacco could help us to fulfil our Public Sector duties under the Equality Act 2010.[11]

8. How to get involved in the consultation

8.1 The consultation questions are at Appendix A. The consultation will run for 12 weeks, from **16 April 2012** to **10 July 2012**. We welcome responses from any interested person, business or organisation.

8.2 Respondents are encouraged to provide their views online but responses can be made in any of the following ways, by:

- *Visiting the Department of Health website and completing the online form at:*
  http://consultations.dh.gov.uk
- *Filling in the response form by downloading it at:*
  http://consultations.dh.gov.uk
- *Emailing your response to:*
  tobaccopacks@dh.gsi.gov.uk
- *Posting your response to:*
  Tobacco Packs Consultation
  Department of Health
  7th Floor
  Wellington House
  133–155 Waterloo Road
  London
  SE1 8UG

8.3 We ask that you provide references to research or other evidence with your responses.

8.4 If you wish to get a copy of this consultation document in an alternative format, or need to respond in an alternative format for accessibility reasons, please contact us using the email or postal addresses given in paragraph 8.2.

[11] Bodies subject to the Equality Duty must, when delivering their services and performing their functions, have due regard to the need to:
- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **Advance equality of opportunity** between people who share a particular protected characteristic and people who do not share it; and
- **Foster good relations** between people who share a particular protected characteristic and people who do not share it.

The public sector equality duty covers the 'protected characteristics' of age, disability, gender reassignment, pregnancy and maternity, race (includes ethnic or national origins, colour or nationality), religion or belief (includes lack of belief), sex and sexual orientation. It also applies to marriage and civil partnership status, but only in respect of the requirement to have due regard to the need to eliminate discrimination.

8.5 The Department of Health and Devolved Administrations will not be able to respond specifically to individual consultation responses.

9. Declaration of direct or indirect links to the tobacco industry by respondents

9.1 As a Party to the FCTC, the United Kingdom has an obligation to protect the development of public health policy from the vested interests of the tobacco industry. To meet this obligation, we ask all respondents to disclose whether they have any direct or indirect links to, or receive funding from, the tobacco industry. We will still carefully consider all consultation responses from the tobacco industry and from those with links to the tobacco industry and include them in the published summary of consultation responses.

10. Territorial scope

10.1 This consultation is being run by the Department of Health with the agreement of the Devolved Administrations across the United Kingdom. All consultation responses will be made available by the Department of Health for consideration by the Ministers responsible for public health in all three Devolved Administrations.

11. Next steps

11.1 All responses received by the closing date of **10 July 2012** will be carefully considered. A summary report of consultation responses will be published on the Department of Health website in due course after the completion of the consultation.

11.2 Any decisions to take further policy action on tobacco packaging will be taken only after full consideration is given to the consultation responses, evidence and other relevant information. If it is decided to pursue a policy that would require legislation, further consideration will be given to the most appropriate approach.

12. Consultation process

12.1 This consultation follows the Government's *Code of Practice on Consultation*. In particular, to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks, with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;

- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation; and
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

12.2 The full text of the *Code of Practice on Consultation* is on the Better Regulation website at:
http://www.bis.gov.uk/policies/bre/consultation-guidance

13. Comments on the consultation process itself

13.1 If you have concerns or comments that you would like to make relating specifically to the consultation process itself, please contact:
Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

Email: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

14. Confidentiality of information

14.1 We will manage the information you provide in response to this consultation in accordance with the Department of Health Information Charter. This is available on our website at:
http://www.dh.gov.uk/en/FreedomOfInformation/DH_088010

14.2 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

14.3 If you want the information that you provide to be treated as confidential, please be aware that under the FOIA there is a statutory Code of Practice with which public authorities must comply, dealing with obligations of confidentiality. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

14.4 The Department will process your personal data in accordance with the Data Protection Act and, in most circumstances, this will mean that it will not be disclosed to third parties.

15. Summary of the consultation

15.1 A summary of the response to this consultation will be made available before or alongside any further action and will be placed on the consultations website at:
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

APPENDIX A

Consultation questions

1. Which option do you favour?
   - Do nothing about tobacco packaging (i.e., maintain the *status quo* for tobacco packaging);
   - Require standardised packaging of tobacco products; or
   - A different option for tobacco packaging to improve public health.
2. If standardised tobacco packaging were to be introduced, would you agree with the approach set out in paragraphs 4.6 and 4.7 of the consultation?
3. Do you believe that standardised tobacco packaging would contribute to improving public health over and above existing tobacco control measures, by one or more of the following:
   - Discouraging young people from taking up smoking;
   - Encouraging people to give up smoking;
   - Discouraging people who have quit or are trying to quit smoking from relapsing; and/or
   - Reducing people's exposure to smoke from tobacco products?
4. Do you believe that standardised packaging of tobacco products has the potential to:
   - Reduce the appeal of tobacco products to consumers?
   - Increase the effectiveness of health warnings on the packaging of tobacco products?
   - Reduce the ability of tobacco packaging to mislead consumers about the harmful effects of smoking?
   - Affect the tobacco-related attitudes, beliefs, intentions and behaviours of children and young people?
5. Do you believe that requiring standardised tobacco packaging would have trade or competition implications?
6. Do you believe that requiring standardised tobacco packaging would have legal implications?
7. Do you believe that requiring standardised tobacco packaging would have costs or benefits for manufacturers, including tobacco and packaging manufacturers?

8. Do you believe that requiring standardised tobacco packaging would have costs or benefits for retailers?

9. Do you believe that requiring standardised tobacco packaging would increase the supply of, or demand for, illicit tobacco or non-duty-paid tobacco in the United Kingdom?

10. People travelling from abroad may bring tobacco bought in another country back into the United Kingdom for their own consumption, subject to United Kingdom customs regulations. This is known as 'cross-border shopping'. Do you believe that requiring standardised tobacco packaging would have an impact on cross-border shopping?

11. Do you believe that requiring standardised tobacco packaging would have any other unintended consequences?

12. Do you believe that requiring standardised tobacco packaging should apply to cigarettes only, or to cigarettes and hand-rolling tobacco?

13. Do you believe that requiring standardised packaging would contribute to reducing health inequalities and/or help us fulfil our duties under the Equality Act 2010?

14. Please provide any comments you have on the consultation-stage impact assessment. Also, please see the specific impact assessment questions at Appendix B of this consultation document and provide further information and evidence to answer these questions if you can.

15. Please include any further comments on tobacco packaging that you wish to bring to our attention. We also welcome any further evidence about tobacco packaging that you believe to be helpful.

APPENDIX B

Consultation-stage impact assessment questions

To better understand the likely costs and benefits if standardised packaging were introduced, and to develop the consultation-stage impact assessment, we are seeking further evidence on the following questions:

1. What would be the costs to tobacco and packaging manufacturers of redesigning packs and retooling printing processes if standardised packaging were introduced?

2. Would the cost of manufacturing cigarette packs be lower if standardised packaging were introduced, compared with the current cost of manufacturing packs?

3. How often do cigarette manufacturers amend the design of tobacco packaging for brands on the United Kingdom market, and what are the costs of doing so?

4. How many different types of shape of cigarette pack are currently on the United Kingdom market?

5. Would retailing service times be affected, and if so, why and by how much, if standardised packaging were introduced?

6. How could standardised packs be designed to minimise costs for retailers?

7. Would retailers bear any other costs if standardised tobacco packaging were introduced?

8. What is the average price of a packet of cigarettes in the following cigarette market segments?
   - Premium brands
   - Mid-price brands
   - Economy brands
   - Ultra-low-price brands

9. What percentage of total cigarette sales in the United Kingdom are in each of the following cigarette market segments?
   - Premium brands
   - Mid-price brands
   - Economy brands
   - Ultra-low- price brands

10. How does the total price of a packet of cigarettes break down into manufacturing costs, distribution costs, tax, other costs, profits for retailers and profits for the tobacco manufacturer in the following cigarette market segments?
   - Premium brands
   - Mid-price brands
   - Economy brands
   - Ultra-low-price brands

11. Would consumers trade down from higher-priced to lower-priced tobacco products if standardised tobacco packaging were introduced?

12. Of the total cigarette market in the United Kingdom, what proportion is sold in cartons rather than in individual packs?

2900020 Apr 2012
Produced by Williams Lea for the Department of Health
www.dh.gov.uk/publications

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**31st May, 2012**
3.	**Title:**	**Standardised Packaging of Tobacco Products: Department of Health Consultation**
4.	**Directorate:**	**Public Health**

5. Summary

A UK-wide consultation seeking views on whether tobacco products should be sold in standardised, plain packaging has been launched by the Department of Health. The government is exploring whether action on tobacco packaging has the potential to bring public health benefits over and above those from current initiatives.

The Rotherham Tobacco Control Alliance has put together a draft response which is attached for information, and the Health Select Commission is encouraged to submit a separate response also.

The deadline for responding to the consultation is 10 July 2012.

6. Recommendations

That the Health Select Commission:

- **Discuss and consider the consultation document and questions**
- **Agree a response to be submitted to the consultation by 10 July 2012**

7. Proposals and details

The Department of Health are seeking feedback on whether there might be public health benefits from the introduction of standardised tobacco packaging in addition to policies which are currently in place; including legislation ending the permanent display of tobacco products by retailers. They are also seeking to understand what other effects there may be should standardised tobacco packaging be introduced.

The consultation ends on 10 July 2012 and responses are invited from any interested person, business or organisation.

Why they are consulting

The Government has an open mind at this stage about introducing standardised packaging and is seeking views from interested parties to understand the impact and potential benefits or risks in doing so.

While 'plain packaging' is a term commonly used in connection with policies about regulating tobacco packaging, in practice packs would not actually be plain. For example, they would be required to have coloured picture warnings and brand names would still appear in a standardised form. The term 'standardised packaging' is considered to be a more accurate description of the policy concept and, therefore, it is used throughout this consultation document.

The Department of Health has commissioned a systematic review of the evidence on plain tobacco packaging. The review was supported through the Public Health Research Consortium (PHRC), a network of researchers funded by the Department of Health's Policy Research Programme. The report represents the work and views of the authors, not necessarily those of the Department of Health. The Public Health Research Consortium report is available on the Department of Health Website (see link below).

Standardised packaging could consist of, for example:

- no branding
- a uniform colour
- standard font and text for any writing on the pack

Views are also sought on whether there might be other implications if standardised packaging requirements were introduced, including any potential effect on the illicit tobacco market. The consultation asks for views on whether:

- tobacco packaging should remain unchanged
- plain packaging should be adopted
- a different option should be considered

Responding to the consultation

The Rotherham Tobacco Control Alliance has put together a draft response, which is attached with this report for information. The Health Select Commission is encouraged to submit a separate response also to help strengthen the influence on the government's decisions.

The full consultation document is attached with this report and the full list of questions can be found on page 13.

8. Finance

There are no direct financial implications associated with this consultation.

9 Risks and Uncertainties

Smoking remains one of the most significant challenges to public health. Each year it accounts for over 100,000 deaths in the UK and one in two long-term smokers will die prematurely from a smoking disease.

That is why health ministers across the UK have a responsibility to look closely at initiatives that might encourage smokers to quit and stop young people taking up smoking in the first place.

Responding to this consultation is an opportunity to influence the Government's decision on standardised packaging.

10 Policy and Performance Agenda Implications

Tobacco control remains a key priority in improving health and reducing inequalities. The outcome of this consultation could have a significant impact on reducing smoking prevalence in Rotherham.

11 Background Papers and Consultation

Consultation on Standardised Tobacco Packaging (attached)
http://www.dh.gov.uk/health/2012/04/tobacco-packaging-consultation/

The Public Health Research Consortium report
http://phrc.lshtm.ac.uk/project_2011-2016_006.html

Rotherham Tobacco Control Alliance – draft response (attached)

12 Contacts

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Template response to government consultation on standardised packaging of tobacco products

Introduction

This template has been produced by ASH to support members of the Smokefree Action Coalition (SFAC) in preparing their responses to the Department of Health consultation on plain, standardised packaging of tobacco products. The SFAC supports plain, standardised packaging as part of a comprehensive strategy to make smoking history for our children. Every year 340,000 children in the UK are tempted to try smoking; two thirds of smokers start before they are 18 and the vast majority while they are teenagers.

Wherever possible, responses should be submitted electronically via the Department of Health website in order to facilitate analysis. **The deadline for submission is 10th July 2012.**

The electronic response form and supporting documents are available at:

http://consultations.dh.gov.uk/tobacco/standardised-packaging-of-tobacco-products/consult_view .

Any questions about this template response should be directed in the first instance to Debbie Millward at ASH debbie.millward@ash.org.uk.

The consultation

On 16th April the Department of Health and the Devolved Administrations launched a national consultation on policy proposals to require cigarettes packs and other tobacco packaging to conform to a standardised format. This format will dispense with all brand identifiers other than the name of the brand and the specific brand variant of the product. This is sometimes known as 'plain packaging' but the Department of Health uses the term 'standardised packaging' because packs will still display health warnings.

The purpose of the consultation is to explore whether this policy will help to achieve reductions in smoking prevalence and tobacco-related harm by:

- reducing the appeal of tobacco products to consumers;
- increasing the effectiveness of health warnings on the packaging of tobacco products;
- reducing the ability of tobacco packaging to mislead consumers about the harmful effects of smoking; and
- having a positive effect on smoking-related attitudes, beliefs, intentions and behaviours, particularly among children and young people.

There is already good evidence that this policy will deliver these objectives. An independent systematic review of the evidence, conducted by the Public Health Research Consortium and published alongside the consultation, describes this evidence in some detail. However the government is obliged to consult on the proposals and is bound to face opposition from the tobacco industry and its supporters. It is therefore vital

that all organisations, groups and individuals with an interest in reducing the harms of tobacco respond to the consultation and support the proposals.

How to use this response template

This response template presents answers to all the questions asked in the consultation. If you have limited time, you can simply copy these answers directly into your response. **Where possible, however, make reference to your own or your organisation's activity, experience and interests. Include examples and case studies if you can. This will help to bring the subject to life and make clear the human cost of any form of tobacco promotion.**

The consultation asks that all evidence cited by respondents is referenced. However there is no need to repeat the evidence presented in the Public Health Research Consortium report. Instead, make clear your support for this review and its conclusions. This template response cites some evidence that was not included in the systematic review which should be cited in full if you use it in your response.

The key message to get across in your response is that standardisation of tobacco packaging is an appropriate and *proportional* response to a major population harm. Many government consultations concern policies for which impacts are difficult to assess. This is not the case with standardised tobacco packaging. At the heart of this consultation is the cast iron evidence of the harms of tobacco. This evidence is so strong – and the impact of tobacco so great – that any interventions that will reduce this harm should, where possible, be embraced.

The consultation questions with template responses

Questions a. to g.

Questions a. to g. ask for your details. If you are responding on behalf of an organisation, put the organisation's name in a. If you are responding as an individual, enter your own name, followed by personal email address and contact details.

1. Which option do you favour?

- ☐ Do nothing about tobacco packaging (i.e., maintain the status quo for tobacco packaging);
- ☐ Require standardised packaging of tobacco products; or
- ☐ A different option for tobacco packaging to improve public health.

RESPONSE

Require standardised packaging of tobacco products

2. If standardised tobacco packaging were to be introduced, would you agree with the approach set out in paragraphs 4.6 and 4.7 of the consultation?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

The proposals set out in paragraphs 4.6 and 4.7 of the consultation document will dramatically reduce the opportunities available to tobacco companies to promote and target their products. There is, however, scope for going beyond the approach set out in the consultation document.

1. Firstly, extensive research has been conducted for the government in Australia to identify a standardised design for tobacco packaging that minimises the appeal and attractiveness of the product while also maximising its perceived harm and the noticeability of the graphic health warnings. See:

> Parr V, Tan B, Ell P, Miller K (2011) *Market research to determine effective plain packaging of tobacco products*. GfK Blue Moon, Sydney.

In line with the Australian approach, the specification of standardised packaging in the UK should also include:

- The inclusion of larger health warnings at the top of the pack, occupying 75% of the front and 90% of the back of the pack.
- The inclusion of graphic warnings on the front as well as on the back of the pack.
- The removal of quantitative information on tar, nicotine and carbon monoxide (as this is misleading) and replacement with qualitative information and advice about the risks of smoking.
- The inclusion of a Quitline number and web address on all packs.

Full details of the Australian standard are available at http://www.comlaw.gov.au/Details/F2011L02766

2. The names of brand variants should also be controlled. Brand descriptors with positive connotations such as 'smooth', 'slim' and 'gold' should not be permitted. The length of the variant name should also be restricted in order to prevent the variant name from being used as a new means of promotion.

There is good evidence that brand descriptors, as well as colours, continue to mislead smokers about the risks of smoking. See:

> Mutti S et al (2011) Beyond light and mild: cigarette brand descriptors and perceptions of risk in the International Tobacco Control (ITC) Four Country Survey. *Addiction* doi: 10.1111/j.1360-0443.2011.03402.x.

3. Standardisation needs to encompass cigarette sticks as well as the packs they come in. Research published after the completion of the Public Health Research Consortium review shows that characteristics of the cigarette stick affect smokers' perceptions. Consequently changes in the design of the cigarette can differentiate products in a manner that can be used for promotional purposes. Examples include 'slim' and 'superslim' cigarettes and cigarettes with attractive and colourful filters. See:

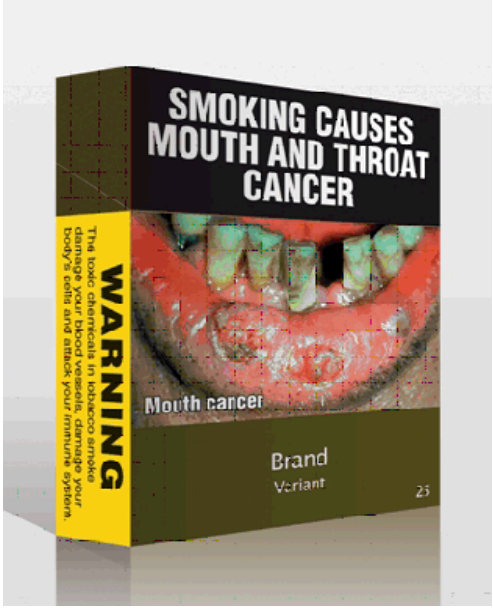
> Borland R, Savvas S (2012) Effects of stick design features on perceptions of characteristics of cigarettes. *Tobacco Control* doi:10.1136/tobaccocontrol-2011-050199

4. Paragraph 4.7 of the consultation document states that 'we do not believe that standardised packaging requirements would be necessary during the course of business solely within the tobacco trade'. This is not logical as, if standardised packaging is the requirement for the market, it is not necessary or helpful to allow current branding to remain for business to business communications.

In the UK some of these changes may need action at EU level. The EU Tobacco Products Directive is currently being reviewed so now is the time for the UK government to press for revisions to the directive which would, for example, allow the UK to mandate larger health warnings, to put picture warnings on the front of packs and to remove quantitative tar, nicotine and carbon monoxide yields on packs and replace them with

qualitative information and advice. Plain, standardised packaging could be introduced initially in line with current EU directive(s) and could then be improved over time as the Tobacco Products Directive is revised.

The approved design for standardised packs in Australia. This design is supported by the Smokefree Action Coalition for the UK.



3. Do you believe that standardised tobacco packaging would contribute to improving public health over and above existing tobacco control measures, by one or more of the following:

- Discouraging young people from taking up smoking;
- Encouraging people to give up smoking;
- Discouraging people who have quit or are trying to quit smoking from relapsing; and/or
- Reducing people's exposure to smoke from tobacco products?

☐ Yes
☐ No
☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

Standardised tobacco packaging will contribute to all four of these outcomes. The branding and design of tobacco packaging is used to make the product more attractive and to target specific audiences, including young people. Branding also distracts attention from the health message on the pack and misleads smokers about the harmfulness of different products. On all these issues the evidence in the Public Health Research Consortium systematic review is conclusive. The report is well-researched and the methodology employed is of a high standard.

The size of the impact of standardised tobacco packaging on the outcomes identified is unknown as no administration has yet introduced this policy (Australia will be the first to do so in December 2012). However, the harm to public health of tobacco is so great that every possible means of reducing this harm

should be considered. Although Britain has an excellent record in tobacco control, smoking still accounts for the majority of preventable deaths nationally. Standardisation of tobacco packaging is an obvious next step within a comprehensive tobacco control strategy as it removes a major communication channel used by the tobacco industry to promote and target its products now that advertising, promotion and sponsorship are banned.

There is growing evidence that standardised tobacco packaging is likely to have most impact on discouraging young people from taking up smoking. One of the key findings of the Public Health Research Consortium report was that non-smokers and younger people responded more negatively to plain, standardised packs than smokers and older people (pages 75-76). Most smokers start young: two thirds of current smokers started smoking before they were 18 years old and 83% started before they were 20 (General Lifestyle Survey 2010). As young people are particularly brand-conscious, removing all brand identifiers from tobacco packaging has great potential to reduce smoking uptake.

Dunstan, S. *The 2010 General Lifestyle Survey.* Office for National Statistics, March 2012.

4. Do you believe that standardised packaging of tobacco products has the potential to:

a. Reduce the appeal of tobacco products to consumers?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

Packaging is the major remaining means by which tobacco companies can make their products more appealing to consumers. Consequently every effort is made by the industry to exploit this opportunity in order both to retain smokers and to attract new smokers.

The Public Health Research Consortium report demonstrates unequivocally that standardised tobacco packaging is less attractive to consumers than branded packaging (page 37). Tobacco products in standardised packs are perceived as being less fashionable, and of poorer taste, than branded products, especially by younger people and non-smokers.

b. Increase the effectiveness of health warnings on the packaging of tobacco products?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

Currently, brand logos and colours distinguish tobacco products and draw attention away from the health warnings. The removal of these brand identifiers will give greater prominence to these warnings.

The Public Health Research Consortium report concludes that the standardisation of tobacco packaging 'tends to increase the recall of health warnings, the attention paid to them and their perceived seriousness and believability' (page 51).

c. Reduce the ability of tobacco packaging to mislead consumers about the harmful effects of smoking?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

Subtle differences in the colour and branding of tobacco products are perceived by smokers as communicating differences in their harm. This is misleading as it falsely reassures smokers that they can choose lower risk products.

The Public Health Research Consortium report demonstrates that when lighter colours are used for tobacco product packaging, the products are perceived (wrongly) as being less harmful than when darker colours are used (page 57). The removal of all colour differentiation between different brands will eliminate this source of confusion.

We recommend that the proposals go further and include the removal of the quantitative information about tar, nicotine and carbon monoxide from tobacco packaging as there is good evidence that this is misleading. See:

> Environics Research Group (2003) *Toxics information on cigarette packaging: Results of a survey of smokers*. Health Canada
>
> Gallopel-Morvan K et al (2010) Consumer understanding of cigarette emission labelling. *European Journal of Public Health* doi: 10.1093/eurpub/ckq087

This information should be replaced by qualitative information and advice about the risks of smoking, following the Australian model.

We also recommend that brand descriptors and variant names such as 'smooth' and 'slim' are also prohibited as these are promotional tools which mislead smokers about the relative harm of different tobacco products. See Mutti (2011), cited in response to Question 2, and:

> Bansal-Travers M et al (2011) The impact of cigarette pack design, descriptors and warning labels on risk perceptions. *American Journal of Preventive Medicine*; 40(6): 674-8.

d. Affect the tobacco-related attitudes, beliefs, intentions and behaviours of children and young people?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

The Public Health Research Consortium report notes that, across the evidence, 'younger respondents were more likely than older respondents to perceive that plain packs would discourage the onset of smoking, encourage cessation or reduce consumption' (page 78).

5. Do you believe that requiring standardised tobacco packaging would have trade or competition implications?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

No

Trade laws allow for measures to protect the public health. The evidence base supports the implementation of standardised packaging as proportionate and necessary to improve public health.

Standardised packaging would apply equally to all tobacco products sold in the UK wherever they are produced. Removing the promotional aspects of packaging will not limit consumer choice as the brand names will still be on the packs. Retailers and consumers will still be able to recognise and choose between different brands and there is no evidence to show that the introduction of standardised tobacco packaging would slow down or impede the sales process. The one peer-reviewed study available on this matter found that the retail sale of standardised tobacco products was quicker than the retail sale of branded tobacco products (Carter et al 2011). See:

> Carter OBJ, Mills BW, Phan T, Bremner JR (2011) Measuring the effect of cigarette plain packaging on transaction times and selection errors in a simulation experiment. *Tobacco Control* doi 10.1136/tobaccocontrol-2011-050087

6. Do you believe that requiring standardised tobacco packaging would have legal implications?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

No

The tobacco industry has challenged the implementation of plain packaging in Australia in a variety of legal fora and may take similar action against any other jurisdiction deciding to go ahead with plain packaging.

The tobacco industry has a track record of losing or withdrawing its legal challenges on other issues of tobacco regulation, such as tobacco advertising bans, vending machines and display legislation. As

with previous regulatory measures introduced by the UK government it is unnecessary for the UK to wait for all legal challenges to be resolved. If every time the tobacco industry threatened or took legal action governments waited until all such challenges were resolved no tobacco regulatory measures would ever be implemented.

Australia is going ahead with plain, standardised packaging in December 2012 before all the legal challenges it faces are likely to be resolved. The evidence is sufficient to support implementation of standardised packaging and the UK should follow the lead of Australia and proceed with legislation as soon as feasible after the consultation is concluded. Delays cost lives.

7. Do you believe that requiring standardised tobacco packaging would have costs or benefits for manufacturers, including tobacco and packaging manufacturers?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

Standardised packaging will reduce manufacturers' costs as the need to refresh and revise brands and branded packaging will be removed.

Manufacturers will lose the opportunity to present their products attractively and to target their products to different audiences including young people. This is, however, the whole point of the policy.

8. Do you believe that requiring standardised tobacco packaging would have costs or benefits for retailers?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Yes

The introduction of standardised tobacco packaging should not inhibit the everyday sales practice of retailers. The one peer-reviewed study available on this matter found that the retail sale of standardised tobacco products was quicker than the retail sale of branded tobacco products. (Carter et al 2011, cited under response to Question 5)

Retailers are likely to see a decline in sales due to the loss of attractiveness of the product, but this will happen gradually allowing retailers to adjust over time.

9. Do you believe that requiring standardised tobacco packaging would increase the supply of, or demand for, illicit tobacco or non-duty-paid tobacco in the United Kingdom?

- ☐ Yes

- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

No

Since 2000, successive UK governments have pursued a highly effective anti-smuggling strategy, including tough measures to force tobacco manufacturers to control their supply chains. This has reduced the size of the illicit trade from 21% in 2000 to 10% by 2009/10 for cigarettes (see table 3 of the impact assessment). This significant drop in the size of the illicit trade has been driven by tough government action to control the supply side.

On the supply side, the tobacco industry argues that standardised tobacco packaging will be easier to counterfeit than branded packaging and therefore will increase the size of the smuggled market. This is nonsense as it ignores the sophistication of current counterfeiting practice. The branded tobacco products available in Britain today have proved to be extremely easy to counterfeit. It is therefore highly unlikely that any change to the design of tobacco packaging will create new opportunities for illicit trade. This trade is responsive to active anti-smuggling measures, not to changes in product design.

In 2008, HMRC and the UK Border Agency launched its updated anti-smuggling strategy, *Tackling Tobacco Smuggling Together*. This included an agreement by the major tobacco producers to include covert markings on their products in order that counterfeit products can be more easily identified by customs and trading standards officers. This was necessary precisely because tobacco products, in all their branded diversity, have proved to be an easy target for counterfeiters.

On the demand side, the tobacco industry argues that the standardisation of tobacco packaging will encourage smokers either to travel abroad to buy more attractive branded packs or to buy imported illicit tobacco products (both counterfeit and authentic brands) which retain current branding. However, despite the fact that the introduction of graphic warnings in the UK in 2008/9 made tobacco products significantly less attractive to smokers, the illicit trade continued to decline in line with the pre-existing trend (see table 3 in the impact assessment). There was no evidence of any change in smokers' purchasing behaviour.

The effects of branding on smokers' choices are significant but they are not so great as to drive smokers to actively seek new sources for products which they can obtain without difficulty at their local shop.

10. People travelling from abroad may bring tobacco bought in another country back into the United Kingdom for their own consumption, subject to United Kingdom customs regulations. This is known as 'cross-border shopping'. Do you believe that requiring standardised tobacco packaging would have an impact on cross-border shopping?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

No

See response to question 9: smokers are unlikely to increase their foreign travel simply because the logos and colours on their tobacco products have disappeared.

There have been significant declines in cross border shopping in recent years for both cigarettes and handrolled tobacco (see table 3 of the impact assessment). This trend is likely to continue given recent changes in the amount consumers are allowed to bring into the UK for personal consumption. In October 2011 the guide level for importing tobacco from the EU for personal use was reduced from 3,200 to 800 cigarettes and from 3 kg to 1 kg for handrolling tobacco. This change aims to deter travellers who seek to purchase large quantities of non-UK duty paid tobacco for illicit resale in the UK.

11. Do you believe that requiring standardised tobacco packaging would have any other unintended consequences?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

No

It is possible that the removal of brand distinctions will push the tobacco companies towards greater price competition leading to lower prices. However, any reductions in the price of tobacco can be compensated for with increases in duty, which would increase government revenues.

12. Do you believe that requiring standardised tobacco packaging should apply to cigarettes only, or to cigarettes and hand-rolling tobacco?

- ☐ Cigarettes only
- ☐ Cigarettes and hand-rolling tobacco
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Cigarettes and hand-rolling tobacco

Standardised packaging should apply to *all* tobacco products including cigarettes, hand-rolling tobacco, cigars, pipe tobacco and shisha. All tobacco products should be treated in the same way.

In Australia, this approach has been mandated and shown to be practicable. For example, when single cigars are sold, they are handed to the customer in a standardised bag with the appropriate health warnings.

13. Do you believe that requiring standardised packaging would contribute to reducing health inequalities and/or help us fulfil our duties under the Equality Act 2010?

- ☐ Yes
- ☐ No
- ☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

RESPONSE

Differences in smoking prevalence across the classes account for fully half of the difference in life expectation between the richest and poorest in society at the current time. Such differences did not exist in the 1970s and have developed in the years since. See:

> Jarvis, M. J and Wardle, J. (2005) Social patterning of health behaviours: the case of cigarette smoking. In: Marmot, M. and Wilkinson, R. (eds) *Social Determinants of Health.* Oxford: Oxford University Press,2nd edition.

Poor non-smokers have longer life expectancy than affluent smokers. See:

> Gruer L, Hart CL, Gordon DS, Watt GCM (2009) Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study. *BMJ* 2009; 338 doi: 10.1136/bmj.b480

Plain, standardised packaging is a population level measure to which all smokers will be equally exposed and therefore, at the very least, will not increase health inequalities.

14. Please provide any comments you have on the consultation-stage impact assessment. Also, please see the specific impact assessment questions at Appendix B of this consultation document and provide further information and evidence to answer these questions if you can.

RESPONSE

Re: costs to manufacturers (questions 1-3)

Long-term costs to manufacturers should decrease as there will be no need to regularly redesign packs to promote specific brands. See:

> Tiessen J et al (2010) *Assessing the Impacts of Revising the Tobacco Products Directive*. Rand Europe (page 151)

Re: retailing times (question 5)

The available independent evidence suggests that retailing times will reduce following the introduction of standardised tobacco packaging (Carter et al 2011, cited under response to Question 5)

Re: trading down to lower-priced products (question 11)

Consumers are already trading down, so it may be hard to identify the specific effect of standardisation of tobacco packaging on this trend. If the trend continues, it would be inappropriate to allocate the decline entirely to plain packaging. However, if any additional effect is seen, this will be more evidence of the importance of packaging in determining consumer choices.

Re: consumer surplus (question 11)

The Impact Assessment states that “in any discussion of consumer surplus it is implicitly assumed that consumers have stable preferences over time and can therefore be regarded as rationally addicted” citing Becker’s theory of rational addiction from 1988. However, two thirds of smokers take up the habit while still under 18 and a similar high proportion of smokers want to quit and regret having started smoking. See:

> Dunstan, S. *The 2010 General Lifestyle Survey.* Office for National Statistics, March 2012.

Decisions over consumption of addictive products are not made rationally, and applying the standard rational choice models is not appropriate. See:

Gruber, Jonathan and Mullainathan, Sendhil (2005). *"Do Cigarette Taxes Make Smokers Happier?,"* Advances in Economic Analysis and Policy Vol. 5: No. 1, Article 4 (2005). Available at
Johnson, P. *Cost Benefit Analysis of the FCTC Protocol on Illicit Trade in Tobacco Products.* A report prepared for ASH. London. 2009.

15. Please include any further comments on tobacco packaging that you wish to bring to our attention. We also welcome any further evidence about tobacco packaging that you believe to be helpful.

If the UK wants to retain its position as a world leader in the implementation of the WHO Framework Convention on Tobacco Control, protecting the health of current citizens and future generations, we need to proceed with plain packaging sooner rather than later. The UK is the standard bearer for tobacco control in Europe and where we lead others will follow.

There is strong public support for the introduction of plain, standardised packaging as specified in Australia, i.e. with larger health warnings and picture warnings on the front of packs. A recent poll by YouGov for ASH found that 62% of adults in England supported plain packaging while just 11% opposed the measure. Even among smokers for every five who oppose plain packaging, there are six who support it. (10,000 adults sampled online between 27th February and 16th March 2012; results weighted for, and representative of, 18+ population in England)

Plain, standardised packaging is needed in addition to, not instead of, display bans

A report by the Cabinet Office Behavioural Insight Team, *Applying Behavioural Insight to Health*, noted that 'If we know anything from behavioural science, it is that behaviour is strongly influenced by what we think others are up to.' The removal of tobacco displays exploits this effect. In Ireland, the prohibition of tobacco displays has been followed by a decline in the number of young people who believe that smoking is widespread among their peers. Before the removal of displays, 62% of young people thought that more than one in five children their own age smoked. This fell to 46% after the displays were removed. See:

McNeill A et al (2010) Evaluation of the removal of point of sale tobacco promotional displays in Ireland. *Tobacco Control* doi:10.1136/tc.2010.038141

If the legislation allowing tobacco displays were repealed, the displays would reinforce the message that smoking is commonplace, even if the packs were plain and standardised.

In Australia, the only country so far to legislate for plain packaging of tobacco products, the measure is being introduced in addition to, not instead of, the removal of point-of-sale displays. It is seen as a natural progression from, not an alternative to, the removal of displays. See:

Australian Government (2010) *Taking Preventative Action, A Response to Australia: The Healthiest Country by 2020, The Report of the National Preventative Health Taskforce*.

The removal of displays is also a recommendation of the guidelines to Article 13 of the WHO Framework Convention on Tobacco Control, to which the UK is a Party. Parties are also urged to consider adopting plain packaging. For details of the guidelines, see: http://www.who.int/fctc/guidelines/article_13.pdf.

Retail registration

Given the legitimate concerns of small retailers about the illicit trade in tobacco, we recommend that the UK government should introduce low cost licensing of retailers. This measure is already in place in Scotland where, since October 2011, it has been an offence to sell tobacco without being registered to do so. All

legitimate tobacco retailers are required to be registered with the Scottish Government, and any unregistered seller now faces a maximum penalty of £20,000 and/or up to six months in prison.

This measure, which helps to inhibit illicit tobacco sales at a local level, is of low cost to retailers and will largely be enforced by council trading standards officers. Similar legislation for England would protect the rights of legitimate tobacco retailers, many of which are small businesses, and make it much easier to force sellers of illicit tobacco out of business. The implementation of such legislation by local councils should be funded by the government in the same way as the implementation of smokefree legislation.

Tobacco industry monitoring

In the US and Canada the tobacco industry is required to report promotional expenditure. Australia is planning to do the same. If such reporting had been in place in the UK, the Department of Health would have been better placed to develop its impact assessments for display legislation and the current consultation on plain, standardised packaging.

The UK should require mandatory reporting of tobacco sales data and all promotional expenditure including payments to public relations companies and any other third parties, such as trade bodies, in line with WHO FCTC Article 5.3 guidelines. This would ensure that government can monitor innovation in marketing activity by the tobacco industry, as well as any lobbying activity, more effectively.

See:

US Bureau of Consumer Protection: Cigarette sales and marketing expenditure reports

Health Canada: Tobacco Industry Reporting: Tobacco Reporting Regulations

1. Which option do you favour?

☐ Do nothing about tobacco packaging (i.e., maintain the status quo for tobacco packaging)

☉ Require standardised packaging of tobacco products

☐ A different option for tobacco packaging to improve public health

If you prefer a different option for tobacco packaging, please describe it.

2. If standardised tobacco packaging were to be introduced, would you agree with the approach set in paragraphs 4.6 and 4.7 of the consultation?

☉ Yes

☐ No

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.
If standardised packaging was introduced we believe the proposals in 4.6 relating to the products sold to the public is appropriate, although we would favour an increase in the size of health warnings. We believe that standardised packaging removes the ability of the tobacco manufacturers to entice new customers through the use of innovative packaging (for example, the perfume packs) or design on the cigarette itself.
It is likely that the companies will develop other smoking accoutrements that will promote their brand (packet covers, for example). If legislation on standardised packaging were introduced we would welcome consideration of similar legislation to prevent this and its potential to undermine the impact of standardised packaging.

3. Do you believe that standardised tobacco packaging would contribute to improving public health over and above existing tobacco control measures, by one or more of the following:

- **Discouraging young people from taking up smoking;**
- **Encouraging people to give up smoking;**
- **Discouraging people who have quit or are trying to quit smoking from relapsing; and/or**
- **Reducing people's exposure to smoke from tobacco products?**

☉ Yes

☐ No

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

4a. Do you believe that standardised packaging of tobacco products has the potential to reduce the appeal of tobacco products to consumers?

☉ Yes

○ No

○ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

We believe that the published studies referenced in the systematic review accompanying this consultation suggest the appeal of plain packs is less than the branded packs. We remain unclear whether this would necessarily translate to fewer consumers in the long term. The studies have not been able to replicate a situation where all tobacco products are in plain packs, and therefore the lack of appeal would be consistent for all products. Whereas a young person may not wish to be seen with an 'ugly' plain pack when friends have normal branded packs, if everybody's cigarettes look the same will this stigma still apply?

4b. Do you believe that standardised packaging of tobacco products has the potential to increase the effectiveness of health warnings on the packaging of tobacco products?

☉ Yes

○ No

○ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

We believe that packs with fewer competing designs would give the health warning greater prominence. Standardised packaging would also mean the small packs used for ultra slim cigarettes would not be in use, and the warnings on these packs are extremely small.

4c. Do you believe that standardised packaging of tobacco products has the potential to reduce the ability of tobacco packaging to mislead consumers about the harmful effects of smoking?

☉ Yes

○ No

○ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

Despite the EU ban on terms such as 'light' or 'low tar' the continued use of colour schemes that were associated with these descriptors mean that people still ask for the 'light' or 'low tar' variants. Standardised packaging should lead to a reduction in the use of these terms as the package design and the terms will no longer by synonymous. Whilst standardised packaging may not mean consumers have greater awareness of the harmful effects, it is likely to reduce misleading information.

4d. Do you believe that standardised packaging of tobacco products has the potential to affect the tobacco-related attitudes, beliefs, intentions and behaviours of children and young people?

☉ Yes

○ No

○ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

The systematic review published alongside this consultation provides study evidence that young people and children find standardised packaging less appealing than branded packs. We remain unclear whether this would necessarily translate to fewer young people smoking in the long term. The studies have not been able to replicate a situation where all tobacco products are in plain packs, and therefore the lack of appeal would be consistent for all products.Whereas a young person may not wish to be seen with an 'ugly' plain pack when friends have normal branded packs, if everybody's cigarettes look the same will this stigma still apply?

If you believe that requiring standardised tobacco packaging could also have other public health benefits, please tell us here. If you believe that requiring standardised tobacco packaging could also have other public health benefits, please tell us here

5. Do you believe that requiring standardised tobacco packaging would have trade or competition implications?

○ Yes

☉ No

○ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

We do not believe that there would be trade or competition implications as the tobacco manufacturers could still sell most of the same products as now, save for some of the ultra slim cigarettes, simply in different packaging. We do believe that any attempt to pass standardised packaging legislation would be challenged on such grounds by the tobacco industry, as has been the case in Australia.

We base this response on reading relevant literature and news sources, not on a knowledge of trade or competition law.

6. Do you believe that requiring standardised tobacco packaging would have legal implications?

○ Yes

☉ No

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

We do not believe that there would be legal implications as the tobacco manufacturers could still sell most of the same products as now, save for some of the ultra slim cigarettes, with the same brand names, simply in different packaging. We do believe that any attempt to pass standardised packaging legislation would be challenged on such grounds by the tobacco industry, as has been the case in Australia.

We base this response on reading relevant literature and news sources, not on a knowledge of trade or competition law.

7. Do you believe that requiring standardised tobacco packaging would have costs or benefits for manufacturers, including tobacco and packaging manufacturers? Multiple choice checkboxes

☉ Yes

☐ No

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

If standardised packaging succeeds in its long term aim of reducing smoking prevalence, then this will inevitably lead to cost to the tobacco manufacturers (ie a reduction in their UK market). However, they may also see a reduction in the cost of packaging and brand development. It is likely that the companies will develop other smoking accoutrements that will promote their brand (packet covers, for example).

Initially packaging manufacturers should not see a significant cost as they will still need to produce packaging, albeit standardised in form. Only if smoking prevalence is reduced may they then see a reduction in turnover/income

8. Do you believe that requiring standardised tobacco packaging would have costs or benefits for retailers?

☉ Yes

☐ No

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

The systematic review that accompanied the consultation refers to studies that suggest retail transaction times were significantly quicker for standardised packs compared with branded packs. This should benefit retailers in that it may lead to reduced queues and the ability to serve more customers in the same time.

9. Do you believe that requiring standardised tobacco packaging would increase the supply of, or demand for, illicit tobacco/non-duty paid tobacco in the United Kingdom?

☐ Yes

☐ No

☒ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

The demand for illicit tobacco is closely associated with the price of the products, so standardised packaging is unlikely to have a significant impact. Providing the standardised packs still require the markings not visible to the naked eye the ability to identify counterfeit products would still exist.

Counterfeit standardised packs will inevitably be produced, and some involved in the illicit trade may consider that standardised packaging will be easier to reproduce and therefore target the UK market more than they have done before. Smuggled/non-duty paid tobacco from outside the UK would be much easier to identify as it is likely to remain in branded packs.

10. Those travelling from abroad may bring tobacco bought in another country back into the United Kingdom for their own consumption, subject to UK customs regulations. This is known as "cross-border shopping". Do you believe that requiring standardised tobacco packaging would have an impact on cross-border shopping?

☐ Yes

☒ No

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

If the same products remain available for purchase in the UK we believe that the main driver for cross-border shopping would remain price.

11. Do you believe that requiring standardised tobacco packaging would have any other unintended consequences?

☐ Yes

☐ No

☒ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

12. Do you believe that requiring standardised tobacco packaging should apply to cigarettes only, or to cigarettes and hand-rolling tobacco?

☐ Cigarettes only

☒ Cigarettes and hand-rolling tobacco

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

The market share for hand-rolling tobacco is increasing. The dangers of tobacco are the same, whether hand-rolled or manufactured cigarettes, so the legislation should be consistently applied across all tobacco products.

13. Do you believe that requiring standardised packaging would contribute to reducing health inequalities and/or help us to fulfil our duties under the Equality Act 2010?

☒ Yes

☐ No

☐ Do not know or have no view

Please provide an explanation for the answer you provided and evidence if available.

Smoking is closely linked with health inequalities and a significant contributor to reduced life expectancy in deprived communities. Any legislative action that will lead to a reduction in smoking prevalence is likely to contribute to a reduction in health inequalities.

14. Please provide any comments you have on the consultation-stage impact assessment. Also, please see the specific impact assessment questions at Appendix B of the consultation document and provide further information and evidence here to answer these questions if you can.

15. Please include any further comments on tobacco packaging that you wish to bring to our attention. We also welcome any further evidence about tobacco packaging that you believe to be helpful.