Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill

Age Scotland

1. Introduction

Age Scotland welcomes the opportunity to give evidence on the Scottish Government’s Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill. We are content for our response to be published.

2. Age Scotland’s approach

Age Scotland believes that later life is better when it is healthier. Achieving and maintaining good health is important for today’s older people, who are the pre-eminent users of health and social care services. However, healthy living among the whole population – not just today’s older people – will improve later life because the behaviours and lifestyles of today’s younger generations will influence their health outcomes as they age.

Good health involves active ageing – including physical activity, where possible, but also participation and interaction – and the promotion of healthy lifestyle factors, such as good diet, and the avoidance or minimisation of unhealthy ones, including smoking. Cognitive health is also increasingly important. We have been funded by the Life Changes Trust to run an Early Stage Dementia Project, which will – in addition to other outcomes – advance the public understanding of healthy living, not only in reducing the risk of developing dementia but also in delaying its onset. Our sister charity, Age UK, is a leading funder of the Disconnected Mind project, led by the University of Edinburgh’s Centre for Cognitive Ageing and Cognitive Epidemiology (CCACE).

3. Do you support the Bill’s provisions in relation to NVPs?

Yes. Given that smoking is the world’s major avoidable cause of poor health and premature death, exacerbates health inequalities, is highly addictive, and has profoundly adverse effects both on the smoker and also on others (especially babies and children), it is justifiable and responsible to direct public policy towards discouraging smoking and analogous behaviours.

The relatively recent emergence and popularity of NVPs has posed challenges to professionals and organisations interested in public health, who consider and debate whether (and to what extent) they contribute to or inhibit better health. It may be that they are less harmful in some respects than traditional cigarettes. NVPs do (to varying extents, depending upon the product) avoid several of the carcinogenic and toxic aspects of burning tobacco and inhaling its smoke.

Yet – partly because they are such a recent development – the long-term health implications of sustained NVP use are unknown. What we do know is that only a very small proportion (around 2%) of dried tobacco is pure nicotine; in its purer forms it is classed as a poison, with profound pharmacokinetic
effects and toxicological risks. The claim made by some manufacturers that NVPs are harmless seems to us to be premature and unreliable. Given that some tobacco manufacturers have now entered the NVP market, it is relevant to consider that the industry’s track record of publicly admitting the health risks of their products has varied from inconsistent to deceitful.

It also remains unknown the extent to which NPVs are an effective method of either harm reduction or encouraging smokers to quit: they are mostly not marketed that way.

In this environment, adopting a precautionary principle seems to us to be wise, so as to enhance consumer safety and prevent increased pressures on already-stretched health and social care services. If there were consistent conclusions from independent research that NVPs did not represent a long-term public health risk, this might be different, but meantime it seems proportionate to subject these products to similar restrictions to other tobacco and nicotine products.

4. **Do you support the proposal to ban smoking in hospital grounds?**

Yes. It seems to be a reasonable public policy objective to try to reduce the harmful effects of second-hand smoke at or around the entrances to hospital buildings, and also from windows and ventilation systems which pass air into and around those buildings. There are also advantages in having a consistent national policy which reinforces the ideas that smoking is harmful to others, and that hospital buildings should be protected from unnecessary health risks.

As the Bill’s own policy memorandum notes, banning smoking entirely from the whole grounds of hospitals could have had a disproportionate impact on people who smoke but who are or need to be within hospitals for long periods of time (either as patients, parents, staff or contractors) but who have limited mobility, including older people. In some very large hospital sites, this could have entailed making such people travel around a mile or more before exiting the whole grounds.

The reasonable corollaries to such a ban would be that the designated areas where the ban would operate must be clear and properly signed.

5. **Is there anything you would add/remove/change in the Bill with regards to NVPs or smoking in hospital grounds?**

The specified penalty for commission of the proposed offence would be a fine up to level 3 of the standard scale (i.e. £1,000). Age Scotland is concerned that the imposition of a fine as the only specified sentence (subject, for example, to the option of a supervised attendance order for non-payment) would be ineffectual and possibly counter-productive. Smoking is more prevalent among people in lower socio-economic groups, most likely with less disposable income. Imposition of a fine might only exacerbate the financial pressure and stress they experience.
There are a range of other disposals available, such as probation, community service and community payback orders. Use of these disposals to, for example, authorise agreed participation in smoking cessation classes, or engage in other community health promotion activities, might serve better to emphasise the risks of smoking to health. Although there could be pressure on the NHS to deliver such disposals, they would in our view be more likely to have a longer-term benefit. Although the choice of sentence in individual cases properly remains one for the courts, we feel either the legislation or related prosecutorial guidance and judicial training could emphasise and encourage such approaches.

6. **Do you support the proposed duty of candour?**

Age Scotland supports the principle of openness and transparency in the delivery of health and social care services. We would all like to believe that care or treatment of a person which accidentally results in harm being caused to them would be admitted to, for several reasons. It is important to acknowledge failure as a first step towards addressing its causes and making redress for its consequences. However, the person receiving care or treatment should surely have a right to know, and to be offered whatever support is practicable. It also ought to become routine for mistakes with serious consequences to lead directly to an apology, separate from any question of legal liability. We therefore support the intention behind the policy.

However, the nature of a statutory obligation is – unless there are limitations or exceptions – to exclude areas where discretion might be advantageous. Though we are strongly disposed to a rights-based approach, there could be circumstances where an admission of harm could itself cause further harm (especially in clients with psychological or mental health issues), depending upon how and when such an admission is to be made. However, there would also be concerns with any approach which subjected candour to a test – such as the best interests of the patient – which would be extremely difficult to apply objectively. Similarly, we would not wish to see any requirement of public reporting transgressing the privacy of affected individuals, either by naming them or making them easily identifiable: this could aggravate any harm they feel. Essentially we would be keen that any such duty were applied with appropriate sensitivity to the wide range of circumstances it could cover.

Though this does not argue against a duty of candour, we note that mistakes in the health field are commonly caused by an unsatisfactory organisational culture, which legislation is not always the most effective tool to address. The Scottish Patient safety programme, for example, has made significant achievements in reducing adverse events. Legislation would not achieve the ambition of better quality service and fewer errors by itself.

If such a duty were, however, to be introduced, we would favour a high degree of consistency with the approach adopted for the health service in England and Wales. The collection of statistics across the UK would allow for easier analysis about the approaches to safety and adverse events taken in different jurisdictions and also the results. This would allow for greater evidence-based
policy and practice, and encourage the sharing of learning among health professionals.

7. **Do you support the proposal to make wilful neglect or ill-treatment of patients a criminal offence?**

Yes. We strongly support the proposal for a new criminal offence of wilful neglect or ill-treatment in health and social care settings. The absence of such an offence currently is a curable omission among the statutory protections for patients and people with care needs.

Age Scotland submitted a detailed response to the Scottish Government’s original consultation, which we refer to for its terms and incorporate in this evidence.

We note that a failure to provide care or treatment consistent with the implicit duty of care may be inadvertent, and due to a variety of causes or combinations of them. Equally, there may be a range of appropriate responses, depending on the cause(s) (see also comments above in relation to the proposed duty of candour).

However, where ill-treatment or neglect is not inadvertent but deliberate, a new offence would help to build public trust and confidence, empower patients and service users and their representatives to complain, and would be consistent with other approaches to protecting vulnerable people, such as the Adult Support and Protection (Scotland) Act 2007, as well as providing justice in individual cases.

We believe that such an offence should cover all care and treatment settings, though would clearly have to be interpreted and applied differently for care at home services, where neglect may mean something different. To account for this, we also strongly recommend the development of statutory guidance to inform providers, patients/users and police and prosecution authorities. We hope that a requirement to devise such guidance collaboratively among representatives of patients and service users, providers, and lawyers, and to take account of it in the application of the offence, will be inserted as the Bill is considered.

We support the principle that care provider organisations (as well as individual care workers) should be subject to an analogous offence. There is a historic and well-documented difficulty with applying some criminal offences to corporations, where the action and intent are separated, and where proving that the organisation had a “guilty mind” is often prohibitive. Accordingly, we proposed that this offence operate by means of strict liability, subject to a defence of taking all reasonable steps to avoid the neglect or ill-treatment. The provision as drafted defines the offence as requiring that the management or organisation of the care service amounts to a gross breach of a relevant duty of care. We are concerned that this definition is insufficiently robust on two grounds. Firstly, the requirement that the breach be a “gross” one sets a high bar to prove (i.e. conduct falling far below what can reasonably be expected). Secondly, by incorporating this into the definition of
the offence itself, it places the burden on investigators and prosecutors to
discover and then prove to what extent this exacting test is met. To us, this
seems subject to the same sort of awkward dynamic which makes
prosecution of organisations for other offences so problematic.

Under our proposal, the duty would be on the care provider to demonstrate
that their conduct had been reasonable. They would be able to do so to a
court but also in advance of prosecution to the prosecutor, so as to avoid the
prosecution being brought. This in turn would compel care providers to be
more proactive and exacting about compliance.

We also proposed significantly greater financial penalties for organisations
than individuals. We cite the examples of two Canadian provinces, Manitoba
and Alberta, where the maximum fine for corporations is ten to fifteen times as
much as for individuals. Although the provision allows for an unlimited fine in
the case of a conviction on indictment, this is another area where we feel that
statutory guidance would be unhelpful, as legislation only specifies the
maximum punishment of different kinds of disposal, not the minimum or the
typical severity.

8. Is there anything you would add/remove/change in the Bill with
regards to these provisions?

No.

9. About us

Age Scotland aims to help Scotland’s people enjoy a better later life. We
believe that everyone should have the opportunity to make the most of later
life, whatever their circumstances, wants and needs.

That’s why we work to make later life the best it can be. We think Scotland
can and should inspire, engage, enable and support older people to change
their later lives for the better and ensure there is support for those who are
struggling as they live longer to achieve better, happier and healthier lives.

We work in partnership with other charities within the Age Network – Age UK,
Age Cymru and Age NI – to pursue these aims across the UK.

Age Scotland

1 www.scottish.parliament.uk/parliamentarybusiness/Bills/89934.aspx