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Public Bill Committee

TOBACCO AND VAPES BILL

Third Sitting

Wednesday 1 May 2024

(Morning)

CONTENTS

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Sunday 5 May 2024

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The Committee consisted of the following Members:

Chairs: Gordon Henderson, Sir George Howarth, Sir Gary Streeter, † Dame Siobhain McDonagh

† Aiken, Nickie *(Cities of London and Westminster)* (Con)
† Baker, Duncan *(North Norfolk)* (Con)
† Bell, Aaron *(Newcastle-under-Lyme)* (Con)
† Blackman, Bob *(Harrow East)* (Con)
Cameron, Dr Lisa *(East Kilbride, Strathaven and Lesmahagow)* (Con)
† Charalambous, Bambos *(Enfield, Southgate)* (Lab)
† Foy, Mary Kelly *(City of Durham)* (Lab)
† Gill, Preet Kaur *(Birmingham, Edgbaston)* (Lab/Co-op)
† Glindon, Mary *(North Tyneside)* (Lab)
† Harrison, Trudy *(Copeland)* (Con)
† Johnson, Dr Caroline *(Sleaford and North Hykeham)* (Con)
† Leadsom, Dame Andrea *(Parliamentary Under-Secretary of State for Health and Social Care)*
† Maskell, Rachael *(York Central)* (Lab/Co-op)
† Oswald, Kirsten *(East Renfrewshire)* (SNP)
† Richardson, Angela *(Guildford)* (Con)
† Tuckwell, Steve *(Uxbridge and South Ruislip)* (Con)
† Wakeford, Christian *(Bury South)* (Lab)

Katya Cassidy, Kevin Maddison, Lucinda Maer, *Committee Clerks*

† **attended the Committee**

Witnesses

Professor Sir Chris Whitty, Chief Medical Officer for England

Sir Francis Atherton, Chief Medical Officer for Wales

Professor Sir Michael McBride, Chief Medical Officer for Northern Ireland

Professor Sir Gregor Ian Smith, Chief Medical Officer for Scotland

Professor Sir Stephen Powis, National Medical Director, NHS England

Kate Brintworth, Chief Midwifery Officer, NHS England

Professor Kamila Hawthorne MBE, Chair of the Council, Royal College of General Practitioners

Professor Steve Turner, President, Royal College of Paediatrics and Child Health

Public Bill Committee

Wednesday 1 May 2024

(Morning)

[Dame Siobhain McDonagh *in the Chair*]

Tobacco and Vapes Bill

9.25 am

The Chair: Good morning everybody. I call the Government Whip to move an amendment to the programme order.

Ordered,

That the Programme Order of the Committee of 30 April be varied by the insertion of the following words at the end of the table in paragraph 2—

"Wednesday 1 May	Until no later than 4.55 pm	Professor Robert West, Professor Emeritus of Health Psychology, University College Long; Professor Ann McNeill, Professor of Tobacco Addiction, King's College London"

—*(Aaron Bell.)*

Examination of Witnesses

Professor Sir Chris Whitty, Sir Francis Atherton, Professor Sir Michael McBride and Professor Sir Gregor Ian Smith gave evidence.

Q103 The Chair: We now move to our first panel this morning, where we will hear from Professor Sir Chris Whitty, chief medical officer for England; Sir Francis Atherton, chief medical officer for Wales; Professor Sir Michael McBride, chief medical officer for Northern Ireland, via Zoom; and Professor Sir Gregor Ian Smith, chief medical officer for Scotland, also via Zoom. We have until 10.25 am for this panel. You can introduce yourselves, if you would like.

Professor Sir Chris Whitty: I think you have introduced us, Dame Siobhain—unless you would like us to make just three comments on previous witness statements, just to help the Committee.

The Chair: That would be great.

Professor Sir Chris Whitty: I think I speak on behalf of all the chief medical officers when I say we enormously welcome the Bill, which I think the overwhelming majority of doctors, nurses and other healthcare workers fully support. It is an extraordinarily important public health measure.

There are three points we thought it would be useful to make, the first of which is about the harms of tobacco overall. You have heard already from witnesses how extraordinarily impactful tobacco is in multiple domains of health, right from stillbirth in children through to dementia in old age, and it is important to stress that that is true of all tobacco products. We have had questions about chewing tobacco, and I know there have been debates about heat-not-burn tobacco. Tobacco is an extraordinarily dangerous product that is highly addictive and causes cancer, heart disease and many other problems in all its forms. It is important to stress that. The cigarette industry is extremely adept at trying to claim that this kind or that kind of tobacco is safer, and therefore safe, and asking why we do not just let it go. The industry did it with filters and many other things. But I think we should be really clear that all tobacco is dangerous.

The second point is to re-stress that the whole basis of the cigarette industry, and indeed the vaping industry, is to addict people and to remove their choice. The tobacco industry has been highly successful at framing the debate as if this legislation is about removing choice, when actually it is selling products whose whole point is to addict people who then regret that choice for the rest of their life, many of whom will die as a result. All of us as doctors have seen so many people in all stages of life—from pregnancy all the way on—who wish they could stop but cannot because their choice has been removed. If you are pro-choice, you should be firmly in favour of this Bill; it is a very pro-choice Bill.

Alongside that are the suggestions that the arguments somehow change at particular ages, such as 21. Tobacco remains equally addictive all the way through the life course, and all the way through the life course, people who start are likely to regret that choice but be unable to come back from it, because they have had their choice removed. We therefore cannot see a logical reason why, if Parliament is going to take this bold public health step, which is extraordinarily widely supported across the country, as well as in the health professions, it would not wish to finish the job and go all the way through. There is not really a logical point to that.

The final point came up in evidence yesterday, and I want to be clear, because I think there is actually a high consensus on this. We are strongly supportive of Ministers in all four nations having the power to regulate flavours as well as colours, packaging and other areas. There is a debate about the best way to do that, which will be dealt with; because it is in secondary legislation, this can be dealt with as we go through. But we would be very supportive of them having those powers. We know that otherwise the vape industry will use this to essentially drive a coach and horses through the aims of the Bill, which is to make products less attractive to children and, to a lesser extent, to non-smoking adults. That would be a big mistake. We also do not know the long-term effects that some of these flavours may have when smoked. We want to clarify that we are strongly in favour of this component of the Bill as well as others.

Q104 The Chair: I think everybody would say that that was a very clear rebuttal. Would any other members of the panel like to introduce themselves before we open the floor to questions?

Sir Francis Atherton: I will briefly say hello. I am Sir Frank Atherton—rather than Francis, if I may, Chair. To echo what Sir Chris has said, it is rare to achieve such a high degree of consensus across the medical community as there is around this Bill. It really matters for people of the UK, and it really matters for the people of Wales.

Professor Sir Gregor Ian Smith: I would reiterate every word that Sir Frank has just said. The consensus across the medical profession, as far as I can see, is absolute. Chris has spoken very clearly and represents the views of all the CMOs and our deputies. From conversations we have had with past CMOs, we know that they are supportive for the same reasons. We have the weight of professional opinion behind us, certainly from the medical profession.

Professor Sir Michael McBride: I am chief medical officer in Northern Ireland. I would echo all that has been said. To add to Sir Gregor's point about the weight of professional opinion, in Northern Ireland we also have the weight of a huge majority of the public. They are hugely supportive of the smoke-free generation and of measures on displays, point of sale and flavours of vapes.

Q105 Preet Kaur Gill (Birmingham, Edgbaston) (Lab/Co-op): We have heard compelling evidence, and we will hear again from the health sector today. Lots of people will say that the Bill could essentially just raise the age of sale from 18 to 21, but we have heard good evidence for why that is not the case. For the record, what would you say to the people who think we will not be able to do the age verification, which we know already exists in Scotland?

Sir Francis Atherton: To echo what Sir Chris said earlier, nicotine is uniquely addictive, and it is addictive across all ages. Simply raising the age to 21 may have a limited effect and may well not have a long-term effect. The tobacco industry is incredibly adept at adapting its tactics to target smokers, whatever their age. It would seem likely to us that people could quite reasonably become addicted beyond the age of 21, but the legislation would prevent that from happening because of the rising age across the course of life.

Q106 Preet Kaur Gill: Do you want to say anything about age verification?

Sir Francis Atherton: Age verification is a relatively simple matter if there is to be a cut-off at 2009. It is much clearer to retailers that that would be the age at which people would not be eligible to buy tobacco products.

Q107 Preet Kaur Gill: One facet of the Khan review recommendations that was touched on a little yesterday is the measures to protect pregnant women and unborn babies. What will be the impact of the Bill on pregnant women and unborn babies, and when do you think the target could be met?

Professor Sir Chris Whitty: Shall I have a first go? One of the first groups to be enormously positively affected by the Bill will be pregnant women and their unborn children. I know you will be hearing from the chief midwife, but briefly, stillbirth, premature birth, "small for dates" babies and birth deformities are all things that happen as a result of smoking. It is extraordinarily dangerous. All mothers want the best for their children; but, to reiterate, smoking is so addictive that people's choices have been removed. They wish to get rid of the smoking in pregnancy, and they cannot because their choice has been removed.

What is clear is that the age band at which the greatest amount of smoking in pregnancy occurs is the youngest women. People who have babies in their late teens or early 20s have by far the highest rate of smoking. Those, therefore, will be the ones who would be positively affected by this Bill the most quickly, because then they would not be going into a pregnancy already addicted to smoking, with all the consequent harms for their baby and subsequent child, which may be lifelong. I do not know whether any of my colleagues want to add to that.

Professor Sir Michael McBride: One of the most concerning aspects of smoking tobacco is the health inequalities that it accentuates. In Northern Ireland, rates of smoking in the most deprived areas are over three times the rate in the least deprived. As a consequence, lung cancer rates are two and a half times higher in the most deprived areas.

If we look at pregnancy, pregnant women in Northern Ireland in the most socioeconomically deprived areas are five times more likely to smoke than those in the less socioeconomically deprived areas. The consequences for their health, and for the health of their children and unborn child, are very significant. They are addicted to a habit that is causing them harm and their unborn child harm.

Professor Sir Gregor Ian Smith: To add to Sir Michael's data, in Scotland in 2023, there were just over 50,000 pregnancies; 11% of those pregnancies—that is 5,500 pregnancies—were booked where the mother was recorded as still being a smoker. A further 6,000 were booked where the mother was a former smoker. These are still really significant numbers. Of course, as Sir Michael has just said, this not only has implications for the mother and the health of the pregnancy; it has longer-term implications for the baby as it develops and grows. We know that anything that we can do to reduce the number of women in these age groups who are coming to pregnancy as smokers will have a beneficial effect not only on them and the health of their pregnancy, but on the health of future generations.

Q108 Preet Kaur Gill: Finally from me, and this question is for Frank and Michael, the latest ONS figures in 2022 show smoking prevalence in Wales and Northern Ireland remaining constant rather than continuing to fall in the way that it did in England and Scotland. Do you think Wales and Northern Ireland have specific challenges related to smoking prevalence?

Sir Francis Atherton: It is certainly true that we are not going as fast in Wales as we would like to see. Smoking prevalence has dropped, from about 22% in 2020 down to 13% at present, but our target is to reach 5% by 2030, and we are not currently predicting that we will meet that target unless we go further and faster. We believe that this Bill will enable us to do that.

You asked for the reasons. One of the reasons is that we have deep-seated sociodemographic problems in Wales, which you have been referring to. Given the inequity that we see, meeting the needs of current smokers from those really deprived socioeconomic groups is really quite a challenge. We are doing everything we can in Wales to try to address that through "Help Me Quit" and smoking cessation support, but we really need to prevent the next generation from coming on board with smoking.

Professor Sir Michael McBride: Just following on from Sir Frank's comments, you are absolutely correct that, while population prevalence of smoking sits at around 14% at the moment—behind the 12% in England and the 13% in Wales—we are doing slightly better than Scotland at the moment, which is sitting at about 15%. The figures for the Republic of Ireland are somewhere in the region of 18%. There is absolutely no doubt that we have the same socioeconomic drivers, in terms of social deprivation and health inequalities, that are fuelling this. Should the Bill succeed and pass into legislation, I see this as a once-in-a-generation opportunity to make a significant change to protect future generations and their children from all the harmful consequences of smoking tobacco and other forms of tobacco use.

Q109 The Parliamentary Under-Secretary of State for Health and Social Care (Dame Andrea Leadsom): I thank all you chief medical officers for being here; we appreciate it. You will understand that your witness evidence is crucial to easing the passage of the Bill. I would like to get you on the record talking, first, about the start of life. The shadow Minister has just asked about pregnancy and, only this week, I was talking to a neonatal nursing lead, who said of the pregnancies of women who smoke that the children had a low birth weight and go on to have severe learning difficulties throughout their lives. That is heartbreaking, but also has significant implications for NHS and educational services, and for whole-life costs to the taxpayer. I would be grateful for your comments on that.

At the other end of the age range, elderly people who have smoked all their lives end up with decades of ill health brought on by a lifetime of smoking. I would be grateful, too, if you talked about some of the health outcomes for those who have smoked all their lives—some of the horrors of that. Sir Chris, you told me an anecdote of when you were a young vascular surgeon. For the record, it is important to talk about some of the heartbreak for those who wish they could stop smoking.

Professor Sir Chris Whitty: I completely agree with all the points you made. Starting off with the beginning of life, there are clear and significant increases in stillbirths, premature births, birth abnormalities and long-term effects from smoking just in the pre-birth period. Then, of course, if parents are smoking around babies and small children, that affects lung development and, if children have asthma, that will trigger asthma effects. Young children are significantly affected by passive smoking from their parents. The parents, of course, want the best for their children, but the problem is that they are now addicted to a product that has taken their choice away. We get those problems right from the very beginning, and we have talked about some of the issues in young pregnancies and where that leads.

Moving to the other end of the age spectrum that you were talking about, the full horrors of smoking for most people start to take effect from middle age onwards. At this point, people get a range of things. Everyone knows about lung cancer, I think, and most people know about heart disease, but there are effects on stroke or increases in dementia, which are significant—one of the best ways to delay dementia is not to smoke or to stop smoking at an early stage. That is a huge problem for all of us. Smoking also exacerbates any problems people have with diabetes—it makes that much worse—and people have multiple cardiac events leading to heart failure. In heavy smokers, we see extraordinary effects, like people having to lose their limbs. As you and I discussed, it is a tragedy to be on a ward with people with chronic obstructive airways disease, or on a vascular ward as a vascular surgeon with someone who has just had an amputation, weeping as they light up another cigarette, because they cannot stop, because their choice has been removed. I cannot hammer that point home firmly enough: this is an industry built on removing choice from people and then killing them in a horrible way.

Sir Francis Atherton: Minister, you also pointed out the cost to the NHS. In Wales, we estimate that we have about 5,500 deaths every year from smoking-related diseases. If we look at admissions to hospital, about 28,000 in the over-35 group is about 5% of overall hospital admissions. That is an enormous burden to the NHS. On a more personal basis, in a former life I was a GP, and I remember sitting with an elderly gentleman who at the end of his life was suffering with chronic obstructive pulmonary disease. There is no worse death than not being able to breathe when just sitting there. I remember sitting with him as he was trying to talk to me and trying to express that same level of regret that Sir Chris talked about. If you talk to any smokers towards the end of their life, who are facing such terrible ends to their life, the sense of regret that you hear as a doctor is quite overpowering.

Professor Sir Michael McBride: It is estimated that in Northern Ireland there are more than 2,000 deaths each year directly attributable to smoking cigarettes; over the past five years, smoking makes up 12% of all deaths in Northern Ireland. Sir Frank and Sir Chris have clearly described the horrors of the impact that it has at an individual level, and as doctors we have all experienced that. We have all had those conversations with individuals who look back on a lifetime of regret.

On a more personal level, I also think at this moment about the impact that premature death, and the morbidity and mortality associated with smoking, has on families and children. My own father died at 46 years of age, when I was 16, from acute myocardial infarction as a consequence of a lifetime addiction to smoking cigarettes. So, we need to bear in mind the very human costs, family costs and wider societal costs as well. It is not just the cost to the health service, but the societal cost, the family cost and the cost to the wider economy.

Professor Sir Gregor Ian Smith: We should never forget the societal cost that Sir Michael just spoke about. I am the child of two smokers who died in their mid-60s from smoking-related disease. We see it all too often in Scotland. In fact, in Scotland we still have 9,000 deaths a year attributed to tobacco addiction and smoking. That is one death every 61 minutes that families suffer across Scotland as a consequence of addiction to smoking.

As a clinician, one of the diseases that I had become quite specialised in treating and led a lot of work on is chronic obstructive pulmonary disease. That is a smoking-related disease that people develop, often at too young an age, and begins to really impair their ability to participate fully in life—not only in employment, but in the pastimes that they love. Gradually, over time, it becomes worse.

Sir Frank touched on the sense of regret that people have that they ever started smoking in the first place and find themselves in this position. Beyond that, there is an even sadder element: many of the people who experience these chronic life-limiting illnesses have not only regret that they ever started, but guilt about the burden that they place on the health service and their family because of the illness and disability that they develop. That guilt sometimes reaches to the extent that they do not seek full care. Many people's attitude is, "I deserve this. I started smoking; I need to pay the consequences." That is a terrible psychological position for any person to find themselves in. Removing the starting point for that addiction, so that people will not experience that through their life, is the aim of the Bill.

Let me make one last point. We talk about the health impacts of all this. The Scottish burden of disease study projects that over the next 20 years, up until 2043, we will see a 21% increase in the general burden of disease across our population in Scotland, despite having a falling population during that time. Much of that projected burden of disease is smoking related; it relates to cancers, cardiovascular disease and neurological conditions such as dementia, which are all influenced by smoking. It is absolutely necessary for us to address this in a preventive way, and I believe that the Bill is a very good way of doing that.

Professor Sir Chris Whitty: I want to reinforce the point that Sir Gregor just made, with which I am sure the Committee fully agrees, that individual smokers should never be blamed for the situation they are in. An incredibly wealthy, very sophisticated marketing industry deliberately addicted them to something, at the earliest age it could get away with it, and they have had their choice removed. It is important that people do not feel guilt and come forward for care, and that no one blames them for a situation that was deliberately put on them by industry marketing.

Q110 Kirsten Oswald (East Renfrewshire) (SNP): I will continue on the theme of marketing. Do you have thoughts about the measures relating to the product restriction of vapes in the Bill? Are they robust enough, in your mind, to prevent the harm that is caused by vapes, particularly to young people? I am thinking of the study that came out yesterday that, concerningly, suggested a risk to teenagers who vape of exposure to toxic metals, potentially harming their organ and brain development.

As a follow-on from that, I am concerned about the advertising of vape companies on sports kits, which is profoundly unhelpful. When we look at sporting figures who young people can admire, that has absolutely no place. I wonder what your views are on that.

Professor Sir Gregor Ian Smith: My views are very clear on vaping in young people and on sales to the youth categories. This is an activity that we are still learning much about but that the evidence, as it emerges, appears to suggest is very harmful to them. In my conversations with my paediatricians and with the Royal College of Paediatrics and Child Health, they are very concerned about the impacts on health of young people from beginning vaping. Any attempt to make products such as single-use vapes or flavoured vapes, or the packaging used or the marketing around vapes, more attractive to that age group is something that we need to counter and resist.

I would say that the aims of the Bill will allow us the means by which we can properly consult on the way that we attempt to reduce overall vaping use in this age group. I am very clear in my views on this: while I understand that vaping may be an assistance to people who are already addicted to tobacco and nicotine products as a consequence of use of many years—I see that there may be an argument that it allows them to reduce the level of harm they are exposed to—I am not convinced or led by any of the arguments that starting vaping in a younger age group is a safe activity at all. I do not believe that that is the case; I believe that it is harmful to those groups. We must try to counter that, and to counter the marketing machine that Sir Chris has spoken about, by reducing the flavours and packaging that are attractive to younger people.

Q111 Kirsten Oswald: Can I press you, Professor Sir Gregor, on the issue of sports marketing? Do you think it is acceptable that big football teams, for instance, are advertising vape companies on their strips?

Professor Sir Gregor Ian Smith: I am very much in favour of the sports industry in general promoting health-promoting behaviours in any way. Where I become very uncomfortable, and I am not supportive, is where the massive attraction of sports companies is used in a way that promotes behaviours that are known to be unsafe or unhealthy. Given the evidence base that we have for this, I would certainly favour breaking the connection between the marketing of these products by any organisation—I do not limit this to sports companies—and anything that is attractive to this demographic and age group.

Professor Sir Chris Whitty: I completely agree with all the points that Professor Sir Gregor has made; I know all the CMOs would agree with that. What all the witnesses that you have heard so far have said, which I think reflects the debate, is that we want to retain vapes as one of the tools to help some smokers to quit. That is a sensible thing to do. We are reasonably confident that they are safer than smoking, but saying that something is safer than smoking is setting an unbelievably low bar, because of all the harms that it does.

So yes, moving from smoking to vaping is a step in the right direction—we want to be clear about that—but we absolutely do not want this to be marketed to anybody who is not a smoker, and above all to children, which is utterly unacceptable. We should be very clear about this. Many people in the vape industry will say, "No, no, no: we don't market to children." You walk into a vape shop and think, "Who are you kidding?" It is very clear what is happening.

We should be really clear that the only thing that is being supported here is to help people who currently smoke to move over to not smoking and eventually to quitting. A step towards that can be vaping; all other uses of vapes we would absolutely not want to do anything to support. The balance in the Bill is to allow enough elements to make it more attractive to vape than to smoke, because we do want to do that, but to make it in no way more attractive than that, because we absolutely do not want anyone else to do it.

Q112 Kirsten Oswald: Does putting it on a football shirt do that?

Professor Sir Chris Whitty: I think we are all very keen for the Bill to get through in the time that remains in this Parliament, so none of us would want to complicate this, but as Sir Gregor says, what we really want is for sports to be very firmly in the area of things that promote health. This is one of the areas that I do not think any of us would suggest is promoting health, so in broad terms we would agree, while not wanting in any way to complicate the Bill that is before Parliament at the moment.

Q113 Rachael Maskell (York Central) (Lab/Co-op): Thank you to all the CMOs. I would like to press that point a little further. Should the advertising of vapes be in alignment with that of tobacco products, for simplicity and understanding? Should the rules on where people can vape be in alignment with those for tobacco products, so not in indoor spaces or in cars transporting children? Are we missing an opportunity, in the light of the opening comments about the addiction to nicotine, to create a nicotine-free generation, as opposed to a tobacco-free generation?

Professor Sir Chris Whitty: I wonder whether Sir Michael might want to go first, and then Sir Frank.

Professor Sir Michael McBride: We have to start somewhere. What we actively want to do, at this point in time, is encourage those individuals who smoke to quit smoking. We recognise that there are nicotine replacement products other than vapes that are very effective and that individuals successfully use, but for some individuals, as has been stated already and as is outlined in the relevant NICE guidance, vapes can be effective and are safer than smoking. It is about finding the sweet spot—hence the powers to consult.

We need to get a balance to ensure that we are absolutely not creating circumstances in which vaping is attractive to young children, starts a lifetime of addiction to nicotine and is potentially a gateway to smoking tobacco, as I think your question is suggesting. But at this point in time, this is an important step to ensure that the next generation are protected from smoking tobacco. We need to support those individuals who currently smoke or are currently addicted to nicotine to gradually move away from that addiction. That includes supporting smokers who currently smoke to quit, but we are increasingly seeing individuals who wish to quit vaping and are finding it difficult.

We are at the start of a journey. As Sir Chris has said, we do not want to delay this Bill and this important step change, in terms of making very significant progress. Sir Frank, do you want to add to that?

Sir Francis Atherton: Very briefly. The principle of alignment is a positive one. Keeping it simple for the public is in the interest of messaging, as a general point. In Wales, we did try—in 2016, I think it was—to align smoke-free and vape-free public places. Personally, I think that there is merit in that, but we have to be careful, because some of the arguments are different. The arguments around smoke-free public places are based on passive smoking, but we do not have a lot of data on passive vaping; many people see it as a nuisance, but that is a very different argument. We need to be a little bit cautious about that, even though I would personally be in favour.

The important thing is to remember that we really need to keep vapes as the quit tool. Your point about moving towards a nicotine-free next generation is absolutely right; that is really what we want to do. If we can make it less acceptable and less prevalent that children take up vaping, we should move towards that. The reality is that over the last three years we have seen a tripling of vaping among our children and young people. That is just unacceptable. The measures in the Bill will help deal with that and lead us, we hope, towards the nicotine-free generation that you talk about.

Q114 Nickie Aiken (Cities of London and Westminster) (Con): I want to go back to the vapes point. As we have all agreed and you have highlighted, vaping was, for all intents and purposes, a product to help people off tobacco, but it has become a product marketed in its own right. What are your personal and professional views on the Bill as it stands? It would stop people selling vapes to under-18s and stop members of the public or family members buying them on behalf of under-18s. Should we ban under-18s from using vapes full stop? Also, should we move vapes on to a prescription basis to ensure that they are aimed at people who want to give up smoking?

Professor Sir Gregor Ian Smith: My view on the Bill as it stands is that it is a starting point for how we take this work forward. It is adequate in that sense because this is a really important area. For me, the absolute priority has to be to remove young people's ability to access vapes and so begin the journey to nicotine addiction.

I am not in favour of criminalising the possession of these products, but I am certainly in favour of banning their sale to younger people. If we can achieve that at this stage, and, as Sir Michael said in his previous answer, if we can begin to shift the culture so that people do not start to use vapes and begin to become addicted—potentially also by using other nicotine and tobacco products—for me that will be a good job done.

If we do things that way, it will allow us to protect the useful use of vapes: where people with a lifelong addiction to tobacco can use them as way to help them stop. That is the only justification that I can see now for the way we have set this up and for continuing to use vapes in society: as a useful tool for those with a pre-existing addiction to tobacco, so that they can reduce the harm and gradually stop using tobacco—through formal cessation services, as well.

Professor Sir Chris Whitty: I agree with Sir Gregor. To reiterate, the Minister wanted to get a balance and most people would agree that criminalising people for individual possession is a step further than anyone would want and is needed. I do not think there is a clamour for that from anybody, and I think it would not help the Bill.

On prescription vapes, I would like to see those available for use at the moment. So far—I will go into the reasons for this on another occasion—no products are available that we can prescribe. We would all very much like those products to be there so that people can prescribe them. That is different from saying that they should be only on prescription; at this point, we do not even have any products to prescribe at all. If we did, that would be a very firm step in the right direction, but it depends on the industry coming forward with products.

Speaking directly to the industry, I should say that I do think there is a very important niche for prescription vapes. They would be very useful for some people, particularly those on low incomes who, for other health reasons, have free prescriptions. I encourage anyone from the industry who is listening to think seriously about bringing forward a prescription vaping product appropriate for aiding people to quit.

Q115 Bob Blackman (Harrow East) (Con): I think the whole panel have said they are 100% behind the Bill. It is great that the whole medical fraternity is going together, but are there any tweaks that you would like to see in the Bill that could make it stronger—for example, making age verification the same in England as it is in Scotland? One of our concerns is that we have a chance to get primary legislation in only once every 10 years or so, and doing it now would be far better than waiting.

Professor Sir Chris Whitty: I have had the privilege of being more heavily involved in this Bill than the other CMOs, so I am going to ask them to answer it. My short answer is that this is a fantastic Bill. What I do not want is for the Bill to be delayed and therefore to not get through in the parliamentary time available. There is always a danger with these things, particularly when we are up against the clock, of the best being the enemy of the good. This is more than good; this is an outstanding Bill, to be clear, in terms of the Prime Minister's bravery in putting it forward and, I think, the huge support from the general public and massive support from those working in healthcare. Really, what we want to do is get this through. I fully accept the points you are making, but that is my real concern about proposing any additions. Maybe you can start with Sir Michael, then Sir Gregor and then Sir Frank.

Professor Sir Michael McBride: I think this is a situation where perfection risks snatching victory from us. The most important thing, having looked at the Bill closely, is that this is an excellent Bill. I think we have all indicated that this is a once-in-a-generation opportunity, as your question suggests. We need to seize this opportunity. I and my colleagues fully support this Bill. I think this is a point that we will look back on five or 10 years from now and we will say that we were on the right side of history in supporting the Bill. This will make a fundamental difference to the next generation and generations to follow. Again, it is entirely consistent with the commitment in the Northern Ireland Executive to gradually phase out tobacco smoking. I fully support the Bill as it stands.

Professor Sir Gregor Ian Smith: I have nothing much more to add. In my view, this is a momentous point in time when we have the ability to really safeguard the future health of generations of people who will not be exposed to the regretful, harmful addiction to tobacco that they might have encountered. I am very satisfied with the content of the Bill as it is just now. The point Sir Michael makes about perfection being the enemy of good is a really important one. This is an opportunity that, to be honest, I really did not anticipate seeing in my career, yet here we are discussing a potential piece of legislation that will allow us to improve the health of people in our country for years and generations to come. This is an opportunity that we cannot afford to miss.

Sir Francis Atherton: There are no changes to the primary legislation that I would recommend at the moment. One thing I would say is that in Wales, we were very impressed with the Khan review, which gave us a really good steer. Many of the Khan review recommendations will be dealt with through the Bill, while a couple will not. I think the Bill as it stands has enough flexibility, particularly around vaping, to allow secondary legislation to keep up with the industry as it adapts and as it tries to find ways around the barriers to getting young people addicted to nicotine.

If I had a wish from the Khan review, it would be around the industry making a contribution to those costs I was talking earlier—the cost to the NHS—so sort of a levy on the industry to correct the damage, or a polluter pays thing, as is being introduced for the gambling industry. However, I do not think that would fit at all with the current Bill.

Q116 Bob Blackman: The other issue is that the medical evidence is very clear on the damage that tobacco smoking does to people's health, but on vaping, medical evidence is emerging. Sir Chris, could you lay out your concerns about vaping, the delivery mechanism and the chemicals in vapes?

Professor Sir Chris Whitty: I reiterate at the beginning that we think it is safer to vape than smoke—I always have to say that first. All of us, including the other CMOs—what I am about to say is a pretty central view in the medical profession—would say that there are many things in vapes that we know cause harm, but we do not know the extent of the harm because they are relatively new products, or we would say we do not know whether they cause harm, but they might well do. We know from work on air pollution that there are large numbers of chemicals that if you breathe them in in reasonable concentrations are highly damaging not just to lungs but to brains, the liver and many other things, but are not damaging if you eat them.

The fact that something is non-toxic—a food additive, say—does not necessarily mean that it is non-toxic if you inhale it. So all of us are very cautious about the long-term effects of vaping and very concerned that we do not see a large expansion of vaping in people who were not smokers. That is particularly true for children. Within that, there are things available in legal vapes—multiple things—and every time a new flavour is brought in, new chemicals are introduced for which we often do not have a good evidence base. In my view, the onus should be on the industry to prove it is safe when inhaled, and not on us to prove 20 years later that it was dangerous. There is a very serious concern about that. Additionally, there is a significant additional risk from illegal vapes, of which there are many, which contain really very dangerous chemicals—heavy metals of various sorts.

None of us would want you to go away with the idea that we think vapes are safe and that we would encourage their use, except in the narrow context of someone who was a smoker, where we definitely think they are safer. But that, as I said earlier, is setting the bar very low.

The Chair: I inform Committee members that we have 14 minutes to go and three people who have not yet spoken and would like to. I want to bring in the

[The Chair]

Minister and the shadow Minister at the end. I notice that there is huge unanimity among our panel members. Could I also ask you to be brief and perhaps get one of your number to answer a question so that we get everybody in? Bambos Charalambous is next.

Q117 Bambos Charalambous (Enfield, Southgate) (Lab): Sir Chris, you mentioned tobacco-related diseases. I want to focus on the impact that that has on the NHS. How would the Bill help the NHS in the short term and then in the long term?

Professor Sir Chris Whitty: In the interests of brevity—the medical director of the NHS is one of your next witnesses—there would be an immediate effect on the NHS because things like asthma attacks in children would be affected almost immediately. Over time there will be a growing positive impact on the NHS as people do not prematurely become unwell with chronic diseases that are extremely difficult to treat and consume enormous resources, in addition to the much more important thing of the extraordinary impact on individuals and their families, their social life, their work life and so on. So there will be a positive and growing impact. If you look forward 30, 40, 50 years, the impact of the Bill on the NHS will be substantial, but we will start to see the effects rapidly, particularly at the paediatric end of the spectrum.

Q118 Trudy Harrison (Copeland) (Con): Bearing in mind what the Chair just said about being brief, can the panel explain the stages of addiction—the physiological, psychological, biological impacts of addiction—and perhaps comment on the frequently heard statement that this is a free country, people should have choice and then use discipline?

Professor Sir Chris Whitty: I will reiterate my point and then hand over to Sir Frank for a longer answer. Cigarettes are a product designed to take choice away. That is the whole basis of the industry. If you are pro-choice you are anti-cigarette—absolutely, straightforwardly, no question.

Sir Francis Atherton: As I have said, nicotine is an incredibly addictive substance and it does not take long to become addicted, so it is not really a stage; it is almost instantaneous. People smoke a few cigarettes and the nicotine addiction kicks in. Obviously, it varies from person to person, but by and large it is highly addictive to young people. The younger you start, the more addictive it is, but it is addictive across the whole of the lifecycle, so nobody is immune to that addiction. Breaking that cycle of addiction and getting out of it gets you into psychological dependencies and repeated attempts to quit—the things that many smokers have been through, which cost them so much time, energy and effort, in terms of money and their personal effort and wellbeing. That is all I can say about the status of addiction. Was there anything more specific that you wanted to know?

Q119 Trudy Harrison: It was more about the biological impact—how nicotine affects your body and makes it so very difficult to give up and be disciplined. It was about the biological impacts that nicotine has on the body, or the psychological impacts.

Sir Francis Atherton: As with any addictive substance, when you are deprived of it you suffer cravings and withdrawal symptoms of a sort, and that leads you to want the next hit—the next cigarette. That cycle of dependency and addiction is well known and well understood, but you would have to talk to a behavioural psychologist or a physiologist to get a more detailed answer.

Professor Sir Chris Whitty: To add to that, most smokers who are determined to quit make multiple attempts—even those who finally succeed, and many people do not succeed. As I was saying, so many people want to succeed and cannot because the addiction has a hold on their brain, essentially.

Q120 Mary Kelly Foy (City of Durham) (Lab): I thank the panellists for being here. I want to go back to clause 62 and the issue of vapes and flavouring. In the interest of brevity, would you say that if we ban all flavours there is a risk that some ex-smokers will be dissuaded from continuing to vape?

Professor Sir Chris Whitty: There is a surprising degree of consensus on this issue, which is sometimes difficult to pick up. We know it is useful to have in the armamentarium the ability to have some flavours to help smokers to quit, but we also know that the cigarette industry is extraordinarily good at adapting its marketing techniques to whatever leeway it is given. If Ministers do not have the power to chase down the industry's ability to market to children using flavours, that is what it will do: it will go for multiple flavours as a way to get to children and non-smokers. That is what it has always done, so that is what it will do. This Bill gives powers to Ministers in the four nations to make sure they can restrict these products to the extent that you can make them not attractive, but attractive enough to smokers to move on. It allows the slider to be moved left or right to balance attractiveness to smokers against not making it attractive to non-smokers.

Q121 Mary Kelly Foy: I have seen a product that is just a plain bottle with "vape" and a number written on it, which is exactly the same flavour as the one that is clearly marketed to children with a teddy bear on it. If we get rid of that packaging and advertising, could we still use some flavours?

Professor Sir Chris Whitty: Possibly, but this Bill gives powers that allow us to vary it depending on what the industry does. That is really the point.

Q122 Angela Richardson (Guildford) (Con): I have just looked online and found the top influencers on social media for vaping. I know the Government sometimes use influencers in order to change behaviour. Has the NHS been involved in paying influencers for vaping? Related to that, a lot of young people and children feel under pressure a certain way, and nicotine is known as an appetite suppressant. What message do you have for young people on that basis?

Professor Sir Chris Whitty: I wonder whether I can turn to Sir Gregor first, and then maybe Sir Michael.

Professor Sir Gregor Ian Smith: I am not aware of the NHS ever engaging any of these influencers, in terms of how we approach the subject of vaping. There is certainly

a real danger that social media is sometimes used by younger people, and they see things that become really attractive to them in terms of lifestyle. The misinformation and disinformation that exists across those platforms can lead them to participate in activities that are potentially harmful.

Directly to your question, my very strong answer to any young person thinking about using one of these products as an appetite suppressant is: please don't. Please safeguard your health. Do not begin the potentially addictive journey of using these products. Do not do it for any reason.

Going back to the point we made earlier on, I would love to see a society where our sports organisations promote much more healthy behaviours, where we have a much better understanding of the huge variation in body image we have across our society, and where we promote the very positive and broad representation of who we are as the general public, because there is no "one size fits all" answer to who we are. We are beautiful in our diversity. Anything we can do to have a more positive representation of society across these platforms would be very beneficial.

Professor Sir Michael McBride: Believe it or not, I was a teenager once too, and I remember what it was like. Teenagers tend to push boundaries and experiment. It is all about finding yourself and your place and space in life. It is not cool to vape. It is not cool to succumb to peer pressure. Be yourself. Make sensible choices about what it is right for you. That is the message I would add to Sir Gregor's point. We have an unfortunate situation where teenagers like to experiment and push boundaries and we have an industry that is only too willing to exploit that and market products at them with, as we heard, cartoon figures on the front, attractive colours and flavours that taste and smell nice. They are extensively marketed by opinion leaders. So don't follow the crowd. Be yourself.

Q123 Preet Kaur Gill: We should all be concerned about the increase in the use of vapes by young children, so it is important that the Bill will ban the sale of vapes to under-18s. It will also close the loopholes for under-16s, because we know that vapes are being marketed and given out for free. That is the issue we must address. My concern with the Office for Health Improvement and Disparities being disbanded is on public health messaging. Parents and families are really concerned that some of their children are going through a number of these vapes per day or per week, and they do not know what is a safe amount.

There is a growing illicit vape market, but how would parents know what is illicit or what the Medicines and Healthcare products Regulatory Agency has notified as being compliant? Where is the public health messaging to support schools? We heard really good evidence yesterday from the union. This is my concern: where can people access support and information? We already have a generation of kids addicted to vapes that are marketed as having 0% nicotine, but we know that there is nicotine contained in them. What would you say to that?

Sir Francis Atherton: There is some messaging going on through the various Governments. In Wales we have a "No Ifs. No Butts." programme, which tries to work at an individual level, to alert people to the dangers that we have been discussing, and with wider society, about the dangers and links between illicit tobacco and illicit vaping and organised crime. Bringing that awareness to the population is really important for those two reasons.

We work with trading standards to try to tackle the issue of illicit tobacco and vapes. It is important that we continue that. My understanding is that wherever we have been successful in reducing demand, which the Bill intends to do, the illicit supply also decreases. We would expect that to be a consequence of the Bill.

Professor Sir Chris Whitty: One of the many talking points of the cigarette industry is, "Well, any kind of downward pressure on cigarettes would lead to an increase in the illicit market." All the evidence shows that the reverse happens. When you bring in reduced demand, the illicit market decreases.

Q124 Dame Andrea Leadsom: I think we might be out of time, but I have one more question. In the passage of the Bill, there is a concern that some may wish to fix flavours on the face of the Bill, rather than allow the powers. Sir Chris, can we have a comment on the record on how damaging that would be?

Professor Sir Chris Whitty: That would be very damaging, because we know that this is one of the most innovative marketing industries in the world. That is how they have managed to sell to people something that will addict them and then kill them. If we give them room for manoeuvre by nailing things down, they will find a way around it, because they always have found a way around regulations. I am absolutely supportive of the comment you have just made.

The Chair: I am afraid this brings us to the end of the time allotted for the Committee to ask questions. I thank all the witnesses, because you answered a huge number of questions and provided great information.

Examination of Witnesses

Professor Sir Stephen Powis and Kate Brintworth gave evidence.

10.25 am

Q125 The Chair: We have until 10.55 am for this session. Would the witnesses like to introduce themselves briefly?

Professor Sir Stephen Powis: My name is Professor Sir Stephen Powis and I am the national medical director of NHS England.

Kate Brintworth: Good morning, everyone. My name is Kate Brintworth and I am the chief midwifery officer for NHS England.

Q126 Preet Kaur Gill: You have raised concerns about the rise in youth vaping. You have said that this needs to be nipped in the bud. Do you think the measures in the Bill will lead to decreased rates of youth vaping?

Professor Sir Stephen Powis: Yes, I do. As you have heard from the chief medical officers, vaping has a role in tobacco cessation and supporting those who want to quit smoking. That is the guidance from the National Institute for Health and Care Excellence, which we

follow and support in the NHS. Evidence is increasing that starting vaping and the use of nicotine-based alternatives to smoking is likely not to be safe. As far as the NHS is concerned, we would support the limited use within smoking cessation, but we have real concerns around the impact that vaping might have over time. At present, we see a relatively small number of admissions into hospital as a result of vaping, but that is growing; it has grown over the last few years. Clearly, as you discussed earlier, the evidence base that these products are not safe is growing.

Q127 Preet Kaur Gill: You have mentioned the smoking cessation services we already have within the NHS, but there is no equivalent for vapes. Do you think there could be a case for these schemes to be made available for young people or pregnant women?

Kate Brintworth: Our position on vapes is that they are a tool for those who are already addicted to smoking. As Chris outlined earlier, this is a way of supporting people to move away from cigarettes. We would then expect that to be part of their journey to becoming a nicotine and smoke-free household.

Q128 Preet Kaur Gill: There is a growing industry in illicit substances, in terms of the vapes available in the market. Is that where you are seeing some of the impact with children in terms of hospital admissions? Have you seen any adverse reactions?

Professor Sir Stephen Powis: Yes, we have. If you look at admissions recorded in our statistics related to vaping, you will see that they are in the hundreds. They are relatively low, and of course much lower than smoking, but as I think you have heard from the chief medical officers' evidence, these are not safe products. We are at the early stages of the evidence-base building around their impact. I think we should be nipping this in the bud. We should not be waiting for those admissions to increase and for those effects to be seen. This is an opportunity to reverse that direction, and I applaud parliamentarians for taking it.

Q129 Preet Kaur Gill: Would you like to say anything about admissions of young people in relation to smoking?

Professor Sir Stephen Powis: I will make a few broad comments on smoking, if I can. Seventy-eight years ago, Parliament passed the National Health Service Act 1946, which led to the formation of the NHS on 5 July 1948. In my view, the legislation that you are considering here today is one of the most important—possibly the most important—pieces of legislation since the passage of that Act. Why? Smoking has an extraordinary impact upon the health of the nation, and of course directly upon the NHS.

To put that into a bit more context—you have heard some of this already, but maybe I will provide some more detail—smoking is associated with, or causes, over 100 individual conditions that are managed and treated within the NHS. It impacts the NHS at all levels: almost every minute of every day there is a hospital admission related to smoking; there are over 100 GP appointments every hour for smoking-related disease; and 400,000 admissions a year are related to or associated with smoking. You have heard the chief medical officers briefly talk about the impact on specific diseases. Lung cancer is the one that everyone knows about, and 80% of lung cancers are caused by smoking. This Bill has the opportunity to transform lung cancer from a common disease into a relatively rare disease, and one that clinicians of the future will not see in any way as commonly as clinicians of my generation.

It is not about just lung cancer; you have heard about the impact on cardiovascular disease, and clearly, chronic obstructive pulmonary disease would again become a rare disease for the clinicians and the patients of the future. This Bill can also have an early impact on diseases that affect young people. Asthma is a disease not caused by smoking but a condition exacerbated by it. We see such admissions particularly over the months when asthma is worse and when there are respiratory infections, which are no doubt exacerbated by smoking.

In mental health, smoking doubles the risk of developing depression. More than one in two people with severe mental health conditions smoke, and the life expectancy of those with mental health conditions is reduced because of smoking. Mental health issues in our young people and children are well-known and well-described, and smoking simply exacerbates them. There is great potential, even in the early years, in the passage of this Bill for an impact on conditions that we see and manage in the NHS. Over the long term, that potential impact is extraordinary on those conditions, which number over 100.

You may know that I am a kidney doctor, but you may not know that smoking can impact on kidney disease. The kidney, like any organ, is supplied by blood vessels. When smoking impacts on the health of blood vessels and causes vascular disease, that can reduce the bloody supply to the kidney, which can cause kidney failure and lead to dialysis and transplantation. There is a large range of conditions that are impacted by smoking, and it will be extraordinary for those clinicians of the future not to have to do what we have done—tell patients and their families that people are going to die prematurely. That is an extraordinarily difficult thing for clinicians to do. Those are preventable diseases, and this Bill will prevent them.

Q130 Dame Andrea Leadsom: Thank you so much for being here today. As I said to the chief medical officers, you will appreciate that your words can be very helpful in smoothing the passage of this very important Bill. I would like to talk to Kate, please, about the impact of smoking on mothers who are pregnant. What is the impact on their babies, on the delivery of the baby, and on the baby's health outcomes? If you could give us an outline, that would be very helpful.

Kate Brintworth: It is important to start with the fact that we know that smoking is the single biggest modifiable risk factor for pregnancy, and we know that every women who gets pregnant wants the best for her baby. As a midwife, I have never sat in front of a woman who does not want the absolute best for her baby. It is important to build on what Chris Whitty said around the removal of choice. Women will go to extraordinary lengths to protect their bodies and babies to ensure that their children have the best start in life, and yet the quit rates that we see in pregnant women are between 30% and 40%, showing how difficult it is for women to extricate themselves from the situation in which they find themselves.

The effects are devastating: stillbirths are increased by 47%; you are twice as likely to have a baby that has not grown properly; and you are 27% more likely to have a baby that is born pre-term. You are more likely to have complications of pregnancy, such as bleeding, the placenta not forming properly or the waters that surround the baby breaking earlier with the risk of infection, so there are immediate effects that we can see. If a baby is small, it goes into labour more vulnerable to the stresses of labour, so we can have more complications there. If a caesarean section is needed, the mother is more vulnerable to recovery and it can be a much harder road to recovery for her, with the risk of infection and blood clots, but also for the baby. If the baby is born early, obviously the risk then is that the baby and mother are separated and you have this unnecessary trauma to a family of a baby having to go into a neonatal unit. The risks that come from prematurity are well-documented for children, for educational attainment and for their lung and health development, but when the children go home, they are more at risk of sudden infant death syndrome—up to three times more—in a smoking household.

There are then the long-term effects. We have already heard about asthma, chest infections and obesity. All those are heightened in children born into smoking households. You have a situation where children are at risk and women are at their most vulnerable when they are pregnant, and it really feels like it is our duty to support this Bill to protect the most vulnerable in our society, because there are the effects of having a child born with possible behavioural problems and malformations, which have been described. Those are really shocking events. I was talking to service users yesterday who have had children in the neonatal unit, and it is incredibly shocking when your pregnancy ends early and you are separated from your baby. There is a mental health impact on the family. There is also the point that this affects those coming from the most socioeconomically deprived backgrounds, for whom having any kind of health challenge makes it a much higher bar to fight.

Q131 Dame Andrea Leadsom: That is very harrowing to hear. Could you further expand on the impact on families of losing a baby due to stillbirth as a result of smoking? How does that impact on their mental health? As you said, parents will do everything they can to protect their baby, but the addiction to cigarettes is so strong that for many it must lead to them blaming themselves for the death of their baby.

Kate Brintworth: The birth of a child is so happily anticipated by every person who gets pregnant. From the moment that you see a thin blue line, you are having a baby. You have hopes and dreams for the expansion of your family, but not just for that individual family: a baby is born, and it is a niece, a nephew, a grandchild, a cousin. It really ripples out across the entire family. When there is then a 35% risk of miscarriage and a higher risk of ectopic pregnancy and, as you said, the absolutely awful, tragic and devastating news that your baby has died when it reaches term, that is something that no parent should ever have to face unnecessarily. It just feels like the worst thing you ever have to do as a clinician to tell someone that their baby has died. Every time I have ever had to do that, it has been the worst point in my career. It is difficult to explain how destroying it can be for families, and we see the long-term sequelae in terms of mental health, to the point where we have put in extra perinatal mental health support for families that have suffered that kind of trauma.

Professor Sir Stephen Powis: Can I pick up on the health inequalities aspect, because I think that is really important and I have the figures in front of me? In 2021-22, 21% of pregnant women in the most deprived areas smoked at the time of delivery, compared with 5.6% in the least deprived areas. That is a really stark difference. Smoking is widely accepted as the most significant driver of health inequalities in the UK. Detailed analysis has concluded that 85% of the observed inequalities between socioeconomic groups could be attributed to smoking. We spend a lot of time in the NHS quite rightly targeting our interventions and support to deprived areas to address health inequalities. At a stroke, this Bill would have the greatest impact that we could possibly see.

Q132 Steve Tuckwell (Uxbridge and South Ruislip) (Con): Thank you for coming to address us this morning. We heard compelling insight from the chief medical officers earlier. Will you update the Committee on how you see this Bill supporting the NHS in the long term and the short term?

Professor Sir Steven Powis: I have already highlighted some of the short-term impacts, and there will undoubtedly be short-term impacts. Some conditions are exacerbated by smoking, with asthma in children being an obvious one. I have talked about mental health conditions and the way that smoking exacerbates conditions such as depression and chronic mental health illness.

We will start to see immediate effects, but those effects will grow over time. I have given you some of the conditions that are impacted on by smoking—there are well over 100 of them—but I can give some more stats. By stopping children from ever starting to smoke, we estimate that we will prevent about 30,000 new cases of smoking-related lung cancer every year. More than 1.4 million people suffer from chronic obstructive pulmonary disease, which is a chronic disease of the lungs caused by smoking—it causes nine out of every 10 cases. As I said, that is a disease that clinicians commonly see. A common cause of admissions to emergency departments, through the winter particularly, is other respiratory infections on top of COPD—these are diseases that future clinicians will see rarely. They will not see them in the way that clinicians of my generation have had to manage them. The impact will begin immediately, but over time that impact will get greater.

Q133 Rachael Maskell: As you have just set out, we understand the harmful impact of tobacco, but I want to look at vaping. Is there any evidence of the impact on individuals who vape, or of a secondary impact, such as on triggering asthma or NHS admissions, or of an impact on admissions from the contents of vapes? We often talk about vapes, which are a delivery mechanism for substances. How should we regulate so that people understand what they are vaping, not least because it is now moving to an illicit market?

Professor Sir Stephen Powis: As I outlined earlier, the impact on the NHS of vaping at the moment is relatively small compared with the impact of smoking. Nevertheless, there is an impact, and we are seeing growing numbers. I have highlighted the number of admissions per year, but they have doubled over the past few years, so that impact is becoming apparent. For example, yellow card reporting to the MHRA is a mechanism for reporting harm, and again the number of incidents related to vaping is increasing, although still in relatively low numbers.

As I said earlier, however, what is important here is that the evidence base, although emerging, is growing. This is an opportunity for us not to get into a position where, in years to come, we regret that we did not take the steps early on to change the trajectory. Instead of seeing rising impact on the NHS—small at the moment, but with the potential to be greater—that trajectory should be changed. This is a golden opportunity for parliamentarians to step in early and to prevent further pressure building over time on the NHS, while recognising that the evidence is still emerging.

I agree with the chief medical officers you heard earlier: I do not believe that vaping is safe. It is undoubtedly safer than smoking, which is why we support its use as a means of smoking cessation, but beyond that the evidence is building that it is not safe. Unquestionably, it will have a building impact on the NHS.

Q134 Angela Richardson: My question is for Kate. I think we all fully accept that vaping is a great smoking cessation tool. About a year ago, the NHS was helping women who smoked to transfer to vaping while they were pregnant. We know that nicotine crosses through the placental barrier, and earlier you outlined the difficulties that mothers and their children have in terms of health outcomes.

How much do we know about the difference between the impacts of smoking and vaping? Thinking of the impact of vaping on babies, is vaping still an okay thing for pregnant women to be doing? Do we need to specifically address the impacts of vaping and smoking on pregnant people in the Bill?

Kate Brintworth: If we start with the evidence, as we have heard this morning there is a limited evidence base around vaping, but that does not mean we should be complacent. We know there is evidence around the transfer of chemicals and the reduction in lung capacity, which we see. As Chris said, while that is an improvement against the very, very low bar of smoking, we would see it as one step on a journey—an interim measure to being nicotine and tobacco free. On that basis, I do not think I would frame it as being okay to vape. We would see it as a tool—a means to an end—to reach the position of being nicotine and smoke free.

We will absolutely support research monitoring the impact of vaping. We cannot be complacent that it is going to be all right. However, at the moment, vaping is absolutely better than smoking, with the very well documented impacts that I have described on not just the mother but the baby and the future health of the family; we know that children born into households where smoking occurs are likely to start smoking themselves.

Q135 Angela Richardson: Can I follow up quickly? Nicotine is having an impact on babies; we heard from teachers about nicotine having an impact on young children when they are in school. Obviously, other substances are involved in tobacco smoking. Do those other substances cross through the placental barrier, or is it just the nicotine?

Kate Brintworth: It is all of it—all the elements. In some babies born to smokers, the children can almost suffer withdrawal symptoms and be jittery and restless in the neonatal period because they themselves are having to go through that withdrawal that is so difficult to enact. We also know of the numerous chemicals—arsenic, carbon monoxide—all of which are toxic to infants, so in no way would you want to distinguish out. It is a whole package of things, all of which we would like pregnant women and babies not to be exposed to.

Q136 Mary Glindon (North Tyneside) (Lab): We hope that this really important Bill will prevent future generations from smoking. In your professional opinion, what impact can the Bill have on that stubborn figure of 6.4 million people who currently smoke? What in the Bill can help those people? It is such a high figure; when you describe the kinds of illnesses and what happens to pregnant women who smoke, it is horrifying.

Professor Sir Stephen Powis: Over time, this Bill will lead to the eradication of an addictive condition that causes the immense harm that we have described. But of course, that will occur over time, so it is also important that we continue with a range of other measures to encourage those not immediately impacted by the raising of the age of sale of tobacco products to cease smoking.

We have a number of smoking cessation programmes within the NHS, which was part of our ambition in the long-term plan for the NHS five years ago. We have been rolling out and supporting those services within hospital settings, and we should continue doing that. Of course, local authorities should also continue their work in supporting smoking cessation. Much of that is also targeted at women who are pregnant.

Part of that work is also supporting staff. Smoking rates across the 1.3 million or 1.4 million people employed within the NHS are lower than across the general public, but we nevertheless continue to see NHS staff who smoke. It tends to be in the lower pay grades within the NHS, but of course for all sorts of reasons we would like that rate to come down. Obviously there is the health benefit, but also, as you all know, smoking causes illness, illness causes absenteeism and absenteeism is a cost to the NHS. Although, as I said, we strongly support the Bill, it is important for us within NHS England and the wider NHS to continue to take other measures and put in place other programmes that will assist the public and our own staff to quit cigarettes.

Q137 Trudy Harrison: Thank you both for powerfully and poignantly outlining the preventable impacts of smoking-related disease and illness on adults. I want to ask about pregnant women. In Cumbria, 12.3% of women at the point of giving birth say that they are smoking. Given the evidence-based proof, why is that still the case? I am left asking why we have we left it so long to have these conversations and bring the Bill forward.

I would like to understand the power of addiction to be able to make the point that this is a pro-choice Bill. It will give women more choice against that addiction that

they are enduring at the most important point of their lives, when they are unable to make that choice for themselves.

Kate Brintworth: I absolutely agree with you. As I have said, pregnant women go to extraordinary lengths to protect themselves and their babies. They change what they eat and drink and how they behave in myriad ways to ensure that they are doing the right thing, yet it has proven very difficult to shift the figures you describe—I think nationally it is a little over 7% of women who are still smoking. That is a poignant demonstrator of just how difficult it is and how addictive nicotine is, when all women want to do is the right thing for their children. That is why all the chief nursing and midwifery officers across the four countries are united in support of the Bill, as our medical colleagues are, because we see the damage wrought across families and generations. We are 100% behind it.

Professor Sir Stephen Powis: It is important to re-emphasise the point made repeatedly by the chief medical officer for England: smoking and nicotine addiction takes away choice. When you are addicted, you do not have the choice to simply stop doing something. It is an addiction. It is a set of products that removes choice, and in removing that choice, people are killed.

Q138 Dr Caroline Johnson (Sleaford and North Hykeham) (Con): I want to ask you about vaping, particularly among children and pregnant women. First, to Kate, are you aware of any research into which chemicals from vaping may be transported from the mother's blood through the placenta and into the baby, and whether that has any effect, or is the research too early to be able to tell us that information? For Professor Stephen Powis, could you tell me what research NHS England is supporting into the effects of vaping on children?

Kate Brintworth: The information that we have so far suggests, as it does across all areas of healthcare, that vaping is safer than smoking. What we do not have is the long-term data that we have on smoking to give us the confidence to describe the harms clearly. That is something that we need to keep observing and understanding so that we can give people the best-quality information.

Professor Sir Stephen Powis: NHS England is not a primary funder of research but we are an evidence-based organisation, as I described earlier, particularly on the use of vaping for smoking cessation. We are very keen that the evidence base, particularly on vaping, is expanded. We would support research in terms of calling for it to be undertaken but also in terms of supporting the NHS as a delivery mechanism for the context in which that research is done.

We very much want to support further research because, as you know as a paediatrician, this is an area where the evidence base is emerging but there is more to do. It is not as complete as the evidence base for smoking. It is really important, even with the passage of this Bill, that that evidence base grows and that we in the NHS support the generation of further evidence where we can.

The Chair: Thank you. That is a good point at which to say that this session has ended and to thank our witnesses for all the information they have provided.

Examination of Witnesses

Professor Kamila Hawthorne and Professor Steve Turner gave evidence.

10.55 am

Q139 The Chair: We now hear from Professor Kamila Hawthorne, chair of the council of the Royal College of General Practitioners, and Professor Steve Turner, president of the Royal College of Paediatrics and Child Health. We have until 11.25 am for this session. Before I call the first questioner, would the panel members like to introduce themselves?

Professor Hawthorne: I am Kamila Hawthorne. I am a GP in south Wales. I work in a post-industrial, very deprived town up in the Welsh valleys. I am chair of council and have been for the past 18 months.

Professor Turner: Good morning, everybody. Thanks for having me. I am Steve Turner, president of the College of Paediatrics and Child Health. My other job is as a paediatrician in Aberdeen. I have 20 years' experience as a consultant looking after children with asthma and other breathing problems, and I have done 20 years' research into the harm of tobacco exposure to children before and after they are born. I am an advocate for our 20,000 members in the UK, including one here, and our 4,000 members overseas. I am also an unapologetic advocate for children and young people. Finally, we believe this Bill is splendid. We would be happy for the version that we have seen to be approved unamended.

The Chair: I call Dr Caroline Johnson.

Dr Johnson: As a declaration of interest, I am an NHS consultant paediatrician and a member of the Royal College of Paediatrics and Child Health.

The Chair: Thank you. I call Preet Kaur Gill.

Q140 Preet Kaur Gill: The point of this Bill is to call time on a system that privatises the profit from nicotine addiction but socialises the social costs. What is the impact that you see on your profession, which we know is already stretched on the frontline in terms of managing long-term chronic illness associated with smoking?

Professor Hawthorne: Smoking-related illnesses cost the NHS about £2.5 billion a year. Everybody knows that lung cancer goes with smoking, but what I am really seeing is awful chronic obstructive airways disease. I work in a deprived area. Many of my patients have smoked ever since they were teenagers and find it very difficult to stop. Every winter, they come to see me repeatedly with severe chest infections that require courses of steroids and antibiotics and sometimes hospital admissions. It is really difficult.

I had a patient who sadly has passed away now with end-stage lung disease caused by smoking. The difficulty we had keeping her as well as we could at home was that she could not have home oxygen because she continued to smoke. It was a massive difficulty for her to stop smoking, even though it was causing her to virtually strangle herself. That just shows what a difficult thing this is.

Professor Turner: To follow on briefly, you might think that children do not demonstrate some of the impacts that Kamila has just described, but that is not the case. Following on from the conversation before, nicotine is not good for you. If you are a foetus inside of your mam, it will cause uterine arteries to spasm and effectively strangle you—reduce the oxygen to you.

We know that vaping contains nicotine. Nicotine makes you small and, if you are born small, you are already on a trajectory for all the non-communicable diseases that Kamila and her colleagues will see in primary care: cancer, heart disease, stroke and hypertension. From the paediatric perspective, there are issues. Children do not concentrate so well when they are addicted to something, so their attention in school is changed. That will affect their learning outcomes and their future economic productivity. The devices sometimes set on fire, so if you have one in your mouth, it can create burns. Fortunately, there are few serious life-threatening complications, but you might have heard of popcorn lung, which is fortunately rare but is very serious. With popcorn lung, when you look at the lungs on a scanner, it looks like they are full of holes.

Q141 Preet Kaur Gill: Do you think that the Bill goes far enough to protect young people from the harmful effects of smoking and vaping?

Professor Turner: Yes, absolutely. The tobacco industry knows that, at the age of 15, we as a species are at the sweet spot for becoming addicted to nicotine for life. The proposed Bill will effectively stop that. Protecting our children from becoming addicted to something that will shorten their lifespan by 10 to 15 years has to be a good thing for us as a responsible society to do.

Q142 Preet Kaur Gill: Finally, what are the harms of vaping to those who have never smoked?

Professor Hawthorne: We know that vaping can cause people to start smoking; it can lead to smoking. We do not have much evidence—I think you have been told this already this morning—as to what the long-term effects of vaping are. We have known about smoking damage since the work of Sir Richard Doll in the 1960s, so this is relatively new. We know there are chemicals in what people are inhaling—that is what causes the popcorn lung—but it is actually only one particular chemical that has been linked, and there are lots. Since 2016, vapes have not been allowed to actually have that chemical any more, but there are other chemicals, and we still do not know what long-term effects they might have.

Q143 Preet Kaur Gill: There seems to be an issue around what is contained in illicit vapes, which we know include things like lead, nickel and high levels of nicotine, versus other vapes that have gone through a notification process. Do you feel that the research on the impacts of illicit vapes is not there, or is it the impact of vapes that have gone through a compliant process?

Professor Hawthorne: There is probably very little research on either.

Professor Turner: If I could just bring a bit of clarity, it is well known that nicotine is bad for us. Sir Walter Raleigh brought it back with some potatoes, and we have known for hundreds of years that nicotine is an addictive drug. As I said previously, it will shorten your life expectancy by between 10 and 15 years. Because we know nicotine is in all nicotine-containing vapes, whether licit or illicit, it is harmful regardless of what the other components might be. It is likely that those other components add to the harm, but there is substantial and well-described harm from nicotine addiction to us as human beings.

Q144 Dame Andrea Leadsom: Thank you both so much for being here. As I said to the other medical professionals, your words today will be incredibly valuable in ensuring the smooth passage of the Bill. Professor Turner, could you explain to us what happens to a baby born addicted to nicotine in terms of the withdrawal symptoms and the impact on its health and development?

Professor Turner: There is not a lot of research on that. Certainly, we know that if you are in utero and your mother is smoking, you will get the harmful effects of nicotine. That is a very good question—I honestly do not know what the effects on the unborn child would be. Certainly, we know that children born to parents who are addicted to morphine or cocaine have learning difficulties. I have to be honest and say that I might have to get back to you on that one, but I can assure you that it is not good to be in utero and exposed to nicotine.

Q145 Dame Andrea Leadsom: Professor Hawthorne, from a GP's perspective, could you talk us through the impact of second-hand smoking on childhood asthma and how that presents in terms of the innocence of the child and the impact of something being done to them?

Professor Hawthorne: We have known for a long time that passive smoking increases the risk of not just asthma, but upper respiratory tract infections and ear infections. It is very much part of a GP's role when they are consulting with such patients coming in with these infections to ask about parental smoking. It is interesting that the responses are nearly always the same. If the parent smokes, they will always say, "But I only ever smoke outside." Of course, one has to take that as it is, but I suspect that they are probably not always smoking outside. It is definitely a well-recognised link, but I am seeing it a bit less than I used to.

Everybody knows about the dangers of smoking. A lot of my patients, when I talk to them about needing to stop smoking, already know what I am saying. Quite often, I will say to them, "Well, you know what I am going to say next, don't you?", and they will say, "Yeah, I know. I need to stop smoking." The conversation then proceeds from there.

We also have evidence that, in general practice consultations, a short intervention can be very effective. We know that people are very pressed for time, and there is only so much we can cover in a 10-minute appointment, especially if the patient is coming with three different problems. But there is good evidence that with even a very short intervention—I think in about 10% of cases—patients will actually stop smoking. It is always worth talking about, and if I get the time, I have a much longer spiel, because you need to think about the behavioural and addictive aspects of smoking. We go through, "When are you most likely to want to smoke? Is it after a meal, when you are on the phone or when you first get up in the morning?" We talk about

what else they can do instead. I had one patient who went and dug the garden whenever she wanted to smoke. It is that kind of conversation.

Q146 Dame Andrea Leadsom: We know that it takes up to 30 quit attempts to actually give up smoking. Can both of you give us a clue as to what is it about the 30th attempt that finally gets people over the line? Specifically to Professor Turner, is it being pregnant or having a partner who is pregnant? Is that the thing that makes people finally achieve their goal?

Professor Hawthorne: For adults, it is having that heart attack that maybe you could have avoided if you had stopped smoking before. Again, that is part of the conversation I have with patients. I say, "You are a heavy smoker, and you are at risk. Wouldn't it be better if you stopped smoking before you have the heart attack, rather than after?" There are things like that, for sure.

We also operate a cycle of change psychological model—the Prochaska and DiClemente model. Essentially, it is a bit like having a clock face. We work out where the patient is on the clock face, and we are trying to get them round the clock to 12. If they are at somewhere like 2 o'clock, that is them saying, "Yeah, I know it is bad for me, but really no way am I going to do anything." By 4 or 6 o'clock, they are saying, "Yeah, I know it is bad for me. I have tried a few times but it is just hopeless." By quarter to, they are saying, "I've really got to do something", and by five to, they are coming in and saying, "Doctor, you have to help me stop now."

Q147 Dame Andrea Leadsom: And is that related to their declining health?

Professor Hawthorne: Not necessarily. It is about pushing people psychologically around that clock face. I try to work out where they are on the clock face and see if I can nudge them a bit further round, until one day they come and say, "I've got to stop now. What can you do to help me?"

Dame Andrea Leadsom: Thank you.

Professor Turner: As Kamila says, there are myriad drivers—teachable moments. Sometimes, when your child is admitted to hospital with an asthma attack, that might be the thing that makes both parents say, "That's it." It might be that the grandmother says to her daughter, "You've got to stop for your child." Legislation might also be one of those teachable moments that make people reflect on their 29 past unsuccessful attempts and think, "I'm going to do it again." There is no one thing, but there are clearly teachable moments, as we all have when we change our behaviour. As I suggested, I think this legislation will be one of those.

Dame Andrea Leadsom: Thank you very much. One last question: do you think the financial incentives for pregnant women and their partners would help?

Professor Turner: I think this is extremely contentious, but the evidence is that it does—sorry, you did ask me about pregnancy before. Pregnancy itself can be one of those opportunities to quit. Those parents who continue smoking—12% in Cumbria—feel terribly guilty. Anything we can do for that person, who has been addicted since she was 15 or 16, can help them to quit. There is no doubt—in Dundee, the trials have shown that, if you give mums incentives, in terms of vouchers rather than money, it helps them to quit, particularly if they are from deprived communities.

Q148 Rachael Maskell: We have already heard how addictive nicotine is, but do we have an understanding of the dosage of nicotine that people inhale through vaping versus through smoking? Secondly, are we missing an opportunity not to introduce a nicotine-free generation?

Professor Hawthorne: I am not a nicotine expert, but my understanding is that there is a risk from vaping, but it is about 5% of the risk from smoking. That is the best I can do in comparing the two. When I talk to patients about stopping smoking, vaping is one of the things we talk about as an alternative, with a view to eventually stopping vaping as well. Of course, there are all the other products: we use patches and chewing gum—all the usual things. It is difficult to quantify exactly how much less dangerous vaping is than smoking.

Professor Turner: Just to supplement that, as a user—if that is the right word—or a customer buying a vape, you can select the dose you want. There are doses that are equivalent to cigarettes and doses that you can wean yourself down on.

You asked whether we would be missing an opportunity if we do not introduce a smoke-free generation. I think we would absolutely be missing an opportunity. If we look back, the legislation on smoke-free public spaces across the UK was landmark. We all remember the days when you went on a plane and there was a smoking bit up front and a non-smoking bit at the back. If we were to go back and say there would be no smoking areas, we would think, "Wow, that would be transformational." We have come on a journey, and the legislation has been part of it. I see a smoke-free generation as the logical next step, and I really think we have to take it.

Q149 Rachael Maskell: Just to come back on that, I said a nicotine-free generation.

Professor Turner: To me, smoking and nicotine are two sides of the same coin. Nicotine addiction is smoking.

The Chair: I just want to advise the panel that we have about 13 or 14 minutes to go, and four Members want to ask questions, so be kind to your colleagues.

Q150 Steve Tuckwell: Thank you for coming along this morning. I am really interested to know whether you think there is a risk that the Bill's restriction on vapes will lead to an increased use of illicit vapes.

Professor Turner: That is a fair question. We recognise that there is a thriving illicit vape market, and the vaping industry is aware of that. As to whether the legislation will exaggerate that should it be passed, that is difficult to tell because, by definition, we do not know how much illegal activity there is. It is a reasonable consideration, and probably a lot of illicit vapes are already being sold. It is one of those things that you might consider when you vote, but I do not think the problem is sufficient to mean that the Bill should not go through.

Q151 Mary Kelly Foy: This question is particularly for Professor Hawthorne. From your experience, can you tell us what impact smoking tobacco has on our most deprived communities?

Professor Hawthorne: It is much more prevalent. There is a theory called future discounting. If you have few choices—if you do not have much money and much choice in what you eat, what you do and where you work—you do not think about your health in 20 years' time; you think about today. Many people feel that smoking helps them get through the day, and that is what they do. It is a really difficult thing to talk to people about because some people will say to me, "I've just got to. I can't get through my day otherwise." I can say, "There are alternatives. There are other ways that we can help you get you through your day," but you have to get them round the clock face that I was talking about, until the point comes when they say, "I've got to do it now."

Q152 Nickie Aiken: Vapes—or e-cigarettes, whatever you want to call them—were introduced to help people to stop smoking. Professor Hawthorne, I would be particularly interested in your view on this, as a GP. We know that vaping has been turned into a massive industry now, but if the whole point of vapes, or e-cigarettes, is to get people to stop smoking tobacco, what is your view about vapes being prescribed?

Professor Hawthorne: Do you mean as part of a smoking cessation programme?

Nickie Aiken: Yes, rather than having them sold as they are at the moment.

Professor Hawthorne: That is an interesting question. I prescribe nicotine patches; why should I not prescribe vapes? That would be my thought.

The Chair: I call Dr Caroline Johnson—you have all been so kind to one another, we are now ahead of time.

Q153 Dr Johnson: Professor Turner, Dr Helen Stewart from the Royal College of Paediatrics and Child Health gave evidence last summer to the Health and Social Care Committee, of which I am a member. She talked about some of the passive effects of vaping on children, such as in the toilets on school premises, where many children had been vaping in an enclosed environment, and children with asthma and other lung conditions were frightened to go into those toilets because their conditions were triggered by being in the presence of second-hand vaping.

Do children breathe in second-hand chemicals when they are proximal to adults vaping, or in an enclosed environment? If they do, what effect does that have on children's lungs? Would you, or the royal college, support a ban on vaping in public places in a similar way that we currently ban smoking?

Professor Turner: I think that vaping in schools and school toilets is a big problem. First, it means that fire engines come out and that disrupts school. As you say, there are some children whose asthma will get set off by exposure to vapes, for example. So I think that it is a big problem, and you have already heard from schools. We are still not sure what components of the exhaled second-hand vape, if you will, are causing symptoms, but, as you described, that happens.

On your third question about banning vaping in public spaces, I would not have an opinion on that. If they are being used by people who are nicotine-addicted to help to come off their nicotine addictions, I would not be unhappy with that. Most of the second-hand vape is water vapour, but if you walk behind somebody who is vaping, you can tell what the taste is, so there are chemicals in there. I think that banning them in public spaces, at this point in time, is something that I would not have a strong opinion on.

Professor Hawthorne: I think we are on a journey, over the years, towards stopping smoking as a nation, so this Bill looks like a great step forward. I think that it is a landmark suggestion, and now that New Zealand has backtracked, I think we will be ahead of the game.

Professor Turner: And we have a proud record of doing this, from a legislative point of view.

Professor Hawthorne: Also, to some extent, sometimes, when you make a big step—which this is—you then might want to stop and wait, consolidate, check and gather more data before you make the next step.

The Chair: If there are no further questions, I thank the witnesses for their evidence. That brings the morning's session to an end. The Committee will meet again at 2 pm this afternoon, here in the Boothroyd Room, to continue taking oral evidence.

Ordered, That further consideration be now adjourned.—*(Aaron Bell.)*

11.19 am

Adjourned till this day at Two o'clock.