HOUSE OF LORDS

Library Note

Health Bill [HL]
(HL Bill 18 of 2008–09)

The Health Bill was introduced in the House of Lords on 15th January 2009, and is due for a second reading debate on 4th February 2009.

The Bill provides the legal framework for a number of proposals arising from the National Health Service Next Stage Review: the NHS Constitution; quality accounts; pilot direct payments; and innovation prizes. The Bill also includes provisions to deal with the poor performance and failure of certain NHS bodies; to suspend chairs and members of NHS and other health bodies; to prohibit the display of tobacco products at the point of sale; to prohibit or impose requirements on the sale of tobacco from vending machines; to reform pharmacy services; to extend the complaints procedure for adult social care; and to allow HM Revenue and Customs to continue to share summarised and anonymised information on the pay of GPs and dentists.

This Library Note focuses upon the NHS Constitution, direct payments, the display of tobacco products and tobacco vending machines.

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Table of Contents

1. Introduction 1
2. NHS Constitution.. 4
3. Direct Payments 7
4. Tobacco 8
4.1 Tobacco Displays 9
4.2 Tobacco Vending Machines 10
5. Select Bibliography 12
General... 12
NHS Constitution 12
Regime for Unsustainable NHS Providers 13
Suspension Powers.. 13
Tobacco.. 13
Pharmacy 14

1. Introduction

The Health Bill was announced in May 2008 in the *Government's Draft Legislative Programme 2008/09*[1], and was included in the Queen's Speech on 3rd December 2008. The Bill was introduced in the House of Lords on 15th January 2009, and the second reading debate is scheduled to take place on 4th February 2009.

The Health Bill is divided into four parts, and has 37 clauses and six schedules. Part 1 of the Bill gives effect to those proposals arising from the NHS Next Stage Review that require legislation: the NHS Constitution (chapter 1); quality accounts (chapter 2); direct payments (chapter 3); and innovation prizes (chapter 4). The review dates from an announcement made by the Secretary of State for Health, Alan Johnson, in July 2007. He said that Lord Darzi of Denham would take forward a review of the NHS and engage with patients, staff and the public with a view to developing a plan for the NHS for the next decade (HC *Hansard*, 4th July 2007, cols 961–74). Lord Darzi published his interim report, *Our Future, Our NHS*, in October 2007 to inform the comprehensive spending review. The interim report looked at how the NHS could become fairer, more personal, more effective, safer and more accountable locally, and outlined a number of immediate actions that could be taken.

The second stage of the review built upon these immediate actions, and the final report, *High Quality Care for All*, was published in June 2008. Over a twelve month period, the review was led by 2,000 clinicians and staff across the country, and involved 60,000 patients, staff and members of the public. The report set out how the NHS would:

Give patients more information and choice:

- The NHS Constitution will put privacy, dignity and cleanliness at the heart of care, with tough new enforcement powers coming in to tackle, for example, healthcare infections, and a checklist for all hospitals to reduce catheter-induced infections.
- Measuring quality of care and outcomes of treatment right across the service and publishing that information for the first time.
- Most effective drugs for patients with new right to all NICE-approved drugs, faster approvals process and transparent decision making.
- A patient's legal right to choice of any provider, including choice of GP services.
- 5000 patients with complex long-term conditions will pilot new personal budgets.
- Personal care plans for all 15 million patients with a long-term condition.

Help people to stay healthy, as well as treating them when they are sick:

- Supporting family doctors to help patients stay healthy and investing record amounts in new or improved wellbeing and prevention services that are easy to access.

[1] Further information on the documents cited in this note can be found in the Bibliography.

- Launching a nationwide ‘Reduce Your Risk’ campaign to raise awareness of free vascular checks for 40–74 yr olds and help people to know when they need to get help.

- Piloting new approaches to help family doctors, community nurses, hospitals, local authorities and others work across traditional boundaries to provide more joined-up services and better health outcomes for people with conditions such as diabetes.

Enable frontline staff to initiate and lead change that improves quality of care for patients:

- No additional top-down targets beyond the minimum standards. Targets have been vital in driving up minimum standards of care across the NHS, but new accountability faces increasingly outwards to patients and the public and is based on the quality of care delivered.

- Every provider of NHS services will need to systematically measure, analyse and improve quality, displaying it to staff through ‘clinical dashboards’ to measure their performance and use the information to make continuous improvements.

- A clinical voice at every level—to ensure decisions are based on the best medical evidence.

- Enhancing professionalism. There will be investment in new programmes of clinical leadership, with all clinicians encouraged to be practitioners, partners and leaders in the NHS.

Fully support NHS staff:

- Establishing NHS Medical Education England—an independent, advisory non-departmental body that will scrutinise workforce planning proposals for doctors and dentists, as well as bringing a coherent professional voice on matters relating to education and training. Work will be taken forward with other professions to decide what other national advisory bodies are required.

- Tripling investment in foundation periods for nurses—a new period of preceptorship for nurses at the start of their careers, which will provide newly qualified staff with protected time and support as they move into practice for the first time.

- A new tariff-based system for education funding—for the first time education funding will follow the trainee, which will improve transparency, promote fairness and reward quality.

(Department of Health, ‘Next Stage for NHS: Highest Quality Care for All’, 30th June 2008, press release 2008/0071)

Concurrent with the publication of Lord Darzi’s final report, the government published *A Consultation on the NHS Constitution* (June 2008), and established the NHS Constitutional Advisory Forum to advise on and oversee the consultation process. In

December 2008, the forum published *The National Health Service Constitution—Report of the Constitutional Advisory Forum to the Secretary of State for Health.* The report included the Constitutional Advisory Forum's recommendations and a summary of responses. The Department of Health published *The NHS Constitution—Government Response to Consultation* in January 2009.

Part 2 of the Health Bill is concerned with powers in relation to health bodies. In particular, it deals with trust special administrators (chapter 1), and the suspension of NHS and other health appointments (chapter 2). In relation to the former, the government published the consultation paper *Developing the NHS Performance Regime* in June 2008. This paper set out new measures to identify failing trusts, remove poor managers and to bring in new management, including from other hospitals or the private sector. A further paper, *Consultation on a Regime for Unsustainable NHS Providers*, was launched in September 2008, and the government's response to the consultation was published in January 2009.

In relation to the latter, the report of the Healthcare Commission on the *Clostridium difficile* outbreaks at Maidstone and Tunbridge Wells NHS Trust (2007) emphasised the need for swift action in certain cases to suspend chairs and members of NHS boards. The NHS Appointments Commission carried out a review of the NHS public appointments process, *Adding Value to a 21st Century Health Service—A Review of the NHS Public Appointments Process* (December 2007). The review recommended new powers and procedures for suspensions and removals. In January 2008, the government published the consultation paper *Removing or Suspending Chairs and Non-Executives of Primary Care Trusts and NHS Trusts from Office*, which resulted in amendments to the statutory regulations, and gave the Appointments Commission new powers. In a second phase, the government published the paper *Removing or Suspending Chairs and Non-executives of Health Bodies—Consultation on Introducing New Powers of Suspension* in July 2008, and *Removing or Suspending Chairs and Non-executives of Health Bodies—Feedback on the Consultation to Introduce Powers of Suspension* in January 2009. The resulting proposals are contained in chapter 2 of part 2 of the Health Bill.

Part 3 of the Health Bill is headed "Miscellaneous", and contains provisions on tobacco sales (clauses 18–22 and schedule 4), pharmaceutical services in England (clauses 23–27) and Wales (clauses 28–30), on adult social care (clause 31 and Schedule 5) and on the disclosure of anonymised information by Her Majesty's Revenue and Customs to the Department of Health on the pay of GPs and dentists (clause 32). In relation to tobacco, the government published the paper *Consultation on the Future of Tobacco Control* in May 2008, with a summary report published in December 2008. The report raised a number of issues, and the Health Bill contains provisions on two aspects: tobacco displays at the point of sale and the sale of tobacco from vending machines.

The provisions of the Health Bill on pharmaceutical services are intended to ensure that pharmacies provide high quality services based on local needs. In April 2008, the white paper *Pharmacy in England: Building on Strengths—Delivering the Future* was published. The white paper responded to the *Review of the NHS Pharmaceutical Contractual Arrangements* (2007) by Anne Galbraith, formerly Chair of the Prescriptions Pricing Authority, and took account of the recommendations of the All Party Pharmacy Group's report *The Future of Pharmacy* (June 2007). The white paper was also aligned to the NHS Next Stage Review and the development of a new primary and community care strategy, *Our Vision for Primary and Community Care* (July 2008). The results of a listening event on the white paper held in May 2008 have been published. A further consultation exercise on a number of proposals for structural change was launched in August 2008 in *Pharmacy in England: Building on Strengths—Delivering the Future—*

Proposals for Legislative Change, with a summary of the outcome of the consultation published in January 2009.

During the passage of the Health and Social Care Act 2008 through the House of Lords, the government made a commitment to extend the complaints procedure on adult social services to people who arrange or fund their care privately (HL *Hansard*, 16th June 2008, cols 890–1). This commitment is the basis for the provisions on adult social services contained in the Health Bill.

Part 4 of the Health Bill is concerned with general matters. Most of the provisions contained in the Bill extend to England and Wales only, although a small number of provisions extend more widely (clause 35).

The remainder of this note focuses on three areas of the Health Bill: the NHS Constitution; direct payments; and tobacco displays and sales from vending machines. Supporting literature on all aspects of the Bill is listed in the bibliography.

2. NHS Constitution

In the terms of reference of the NHS Next Stage Review, the government undertook to consider whether to introduce an NHS Constitution. In his interim report, *Our NHS, Our Future* (October 2007), Lord Darzi of Denham said that "I … have come to the view that the NHS could benefit from greater distance from the day to day thrust of the political process, and believe there is merit in exploring the introduction of an NHS Constitution" (page 8). He asked the NHS Chief Executive, David Nicholson, to chair a working group on the form and scope of an NHS Constitution.

In his final report, *High Quality Care for All* (June 2008), Lord Darzi reiterated his support for an NHS Constitution:

> The NHS belongs to the people. It is there to improve our health, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can. It works at the limits of science—bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.
>
> To provide high quality care for all, the NHS must continue to change. But the fundamental purpose, principles and values of the NHS can and must remain constant. Setting this out clearly, along with the rights and responsibilities of patients, the public and staff, will give us all greater confidence to meet the challenges of the future on the basis of a shared understanding and common purpose.
>
> (Department of Health, *High Quality Care for All—NHS Next Stage Review Final Report* (June 2008: Cm 7432), page 77)

In the course of engagement and research on the subject, the review found that:

- To qualify as a Constitution, the document needed to be short and enduring;

- The Constitution should be flexible and not hold the NHS back in terms of its ambitions for improving the quality of care;

- For the Constitution to be meaningful it must have bite, with means for enforcement and redress, not just warm words or aspirations; and

- There was no appetite for a 'lawyers' charter', and concern that we should avoid fuelling litigation.

(*ibid*, page 78)

A draft NHS Constitution and accompanying Handbook were published at the same time as the final report of the NHS Next Stage Review. The government also issued *A Consultation on the NHS Constitution* (June 2008), which sought to elicit responses on the source and status of the Constitution; the purpose and principles of the NHS; the rights, pledges and responsibilities of patients and the public; the mechanisms for redress; staff pledges and responsibilities; accountability; NHS values; the Handbook to the NHS Constitution; and awareness and implementation of the Constitution. The consultation was open for three-and-a-half months, and was managed locally by Primary Care Trusts. The Primary Care Trusts submitted reports at the end of the consultation period to their Strategic Health Authority. These reports were collated by the Strategic Health Authorities and submitted to the Department of Health. In addition, over 1,000 responses were received directly by the Department.

On the publication of the draft NHS Constitution and the consultation document, the government set up a Constitutional Advisory Forum consisting of leading stakeholders, to advise on the consultation and to ensure a transparent and robust process. The forum published the results of their reflections on the consultation and a summary of responses to the consultation questions in December 2008. On the NHS Constitution in general, the forum concluded and recommended:

> The reaction of patients, the public, staff and major stakeholders to the Constitution was overwhelmingly positive. There were a number of issues that the evidence suggests respondents felt strongly about... For the most part, however, even where there were parts of the Constitution that people wished to change, they agreed with the need for it and supported the basic shape and balance of it. ***The Department should keep in mind the broad consensus in favour of the Constitution in addressing the issues raised in the consultation.***
>
> (Constitutional Advisory Forum, *The National Health Service Constitution—Report of the Constitutional Advisory Forum to the Secretary of State for Health* (December 2008), page 4)

In January 2009, *The NHS Constitution—Government Response to Consultation* was published. As a result of the feedback received, the government did not make any fundamental alterations, although they did clarify and strengthen the NHS Constitution and Handbook in a number of ways[2]:

[2] A more detailed account of the changes made to the draft Constitution and of the government's response to the recommendations of the Constitutional Advisory Forum can be found in Annexes 1 and 2 of the government's response.

- We have clarified the distinction between 'rights' (legal entitlements protected by law) and 'pledges' (commitments by the NHS that go beyond what is legally required).

- We have extended the rights for patients and the public set out in the NHS Constitution. There is a new legal right (rather than a pledge) to 'receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme', to complement the right to receive NICE-approved drugs and treatments where these are clinically appropriate.

- We are also extending the new right to choice, to include a right to information to help patients exercise that choice. The new right itself is being created through legally-binding directions, published alongside the final NHS Constitution and due to take effect from 1 April 2009.

- We have substantially revised the Handbook, both to make it more accessible and to provide more information about routes for feedback, complaint and redress. We intend to keep the Handbook regularly updated, in a dedicated NHS Constitution section on the Department of Health's website.

> (Department of Health, *The NHS Constitution—Government Response to Consultation* (January 2009), paragraph 8)

The current version of the NHS Constitution was signed by the Prime Minister, Gordon Brown, the Secretary of State for Health, Alan Johnson, and the NHS Chief Executive, David Nicholson, on 21st January 2009. The preamble to the constitution provides an overview of its purpose:

> **This Constitution** establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities** which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services will be required by law to take account of this Constitution in their decisions and actions.
>
> The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff. It will be accompanied by the Handbook to the NHS Constitution, to be renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal will be made legally binding. They will guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.
>
> (National Health Service, *The NHS Constitution—The NHS Belongs to Us All* (January 2009), page 2)

Furthermore, the government have issued a statement of NHS accountability as a result of the support given to the idea by the Constitutional Advisory Forum. The *Statement of NHS Accountability*, published in January 2009, sets out the roles and responsibilities of the constituent parts of the NHS, explains how the NHS is accountable at local level and describes the mechanisms for redress.

The Health Bill contains the legal provisions necessary to ensure that certain bodies have regard to the NHS Constitution (clause 2), for the NHS Constitution to be reviewed and revised at least every ten years (clause 3), for the Handbook to the NHS Constitution to be reviewed and revised every three years (clause 4) and for the Secretary of State to report on the effect of the NHS Constitution at least every three years (clause 5).

3. Direct Payments

The final report of the NHS Next Stage Review led by Lord Darzi of Denham, *High Quality Care for All* (June 2008), announced the government's intention of piloting personal heath budgets:

> Learning from the experience in both social care and other health systems, and in response to the enthusiasm we have heard from local clinicians, we will explore the potential of personal budgets, to give individual patients greater control over the services they receive and the providers from which they receive services. Personal health budgets are likely to work for patients with fairly stable and predictable conditions, well placed to make informed choices about their treatment; for example, some of those in receipt of continuing care or with long-term conditions. With a view to national roll out, we will launch a national pilot programme in early 2009, supported by rigorous evaluation. This will enable the NHS and their local authority partners to test out a range of different models.
>
> The budget itself may well be held on the patient's behalf, but we will pilot direct payments where this makes most sense for particular patients in certain circumstances. We will legislate to enable these direct payments.
>
> The programme will be designed with NHS, local authority, carer and patient group partners, with clear rules. We will ensure that the programme fully supports the principles of the NHS as a comprehensive service, free at the point of use. It will be voluntary—no one will ever be forced to have a budget, and for those that choose to, there will be tailored support to meet their different needs. The programme will be underpinned by safeguards so that no one will ever be denied treatment as a result of having a personal budget, and NHS resources will be put to good use, with appropriate accountability.
>
> (Department of Health, *High Quality Care for All—The Next Stage Review Final Report* (June 2008: Cm 7432), pages 42–3)

In September 2008, a programme called Staying in Control was launched by In Control, a social enterprise, to explore how the principles of personal budgets in social care could be applied to the NHS (for further information see http://www.in-control.org.uk). The programme represents 36 primary care trusts and their partner local authorities. The Department of Health intends to use the experience gathered by the Staying in Control programme to inform its pilot programme.

The Health Bill enables the Secretary of State to make regulations governing the operation of direct payments and direct payment pilot schemes (part 1, chapter 3). The Bill contains a power, which can be exercised subject to the affirmative resolution procedure, to allow the requirement to make direct payments through a pilot scheme to be removed. This would allow direct payments to be made more widely available.

The *Impact Assessments for the Health Bill* include a description of the experience with individual budgets, including direct payments, in social care in England and in health and social care in other countries. The covering note to the *Impact Assessments* states:

> The benefits derive from improved service user wellbeing through greater self-direction, leading to increased satisfaction and feeling of being in control, and lower costs through more planned care and a greater focus on prevention. Pilots will explore the potential to use personal health budgets to give more autonomy and choice to more deprived patients, thus reducing health inequalities. Personal health budgets incur additional costs as the care planning process becomes more personalised, and oversight is necessary to ensure choices are safe and prudent, from the perspective both of patient and of the funding authority. These costs are expected to be justified by the benefits, but piloting is proposed in view of risks and uncertainties regarding how personal health budgets, including direct payments, can best be developed for different groups of people. The specific costs of piloting are justified by the information that will be gathered as to how the policy should best proceed and how it should be applied to different groups of people, thereby mitigating a large part of the uncertainty. The Impact Assessment presents direct payments within the broader scope of the personal health budgets policy, as one potential model of delivery.
>
> (Department of Health, *Impact Assessments for the Health Bill* (January 2009), paragraph 16)

4. Tobacco

The government signalled their intention to consult on the next steps in tobacco control in *Cancer Reform Strategy* (December 2007). In May 2008, they did so through the paper *Consultation on the Future of Tobacco Control*. The consultation looked at reducing smoking rates and health inequalities caused by smoking; protecting children and young people from smoking; supporting smokers to quit; and helping those who cannot quit. For the purposes of this note and the Health Bill, the second area is of most interest. The consultation paper explains:

> Reducing the impact of smoking on health and well-being in our communities means we need to support smokers to quit, but we need to do as much as we can to protect young people from starting to smoke in the first place. Youth smoking is a serious public health problem, and over eight in ten current smokers say they started smoking regularly before the age of 19. Over the past decade, the government has taken significant action to reduce smoking uptake by young people, and to support young people who want to quit, but more still needs to be done to prevent future generations suffering poor health caused by tobacco.
>
> **Controlling the display of tobacco in retail environments**
>
> Since the implementation of a comprehensive ban on tobacco advertising in the UK, concern has been expressed about how prominently tobacco products are

> now displayed in newsagents, supermarkets and corner shops. The number and size of tobacco displays appears to have grown in many premises.
>
> The main reason for controlling the display of tobacco products at the point of sale is to protect children and young people from the promotion of tobacco. Research shows that young people are highly receptive to tobacco promotion and can be influenced to take up smoking as a result. Tobacco promotion familiarises potential customers with the product and can stimulate impulse purchases among those not intending to buy cigarettes and, importantly, among smokers who are trying to quit.
>
> **Limiting young people's access to tobacco products**
>
> While tobacco vending machines account for only 1% of the overall UK market in tobacco sales, a disproportionate number of young people under the minimum legal age for sale of tobacco obtain cigarettes from this source. Tobacco vending machines are 'self-service', which means that currently there are no routine age checks carried out prior to purchase. There are a number of ways in which access to tobacco from vending machines can be limited to ensure that only people aged 18 or over can purchase from the machines. A number of countries have already prohibited or restricted the sale of tobacco from vending machines.
>
> (Department of Health, *Consultation on the Future of Tobacco Control* (May 2008), page 7)

The Health Bill contains provisions on the display of tobacco products at the point of sale, and on the sale of tobacco from vending machines. These areas will be looked at separately in the following two sections.

4.1 Tobacco Displays

The Tobacco Advertising and Promotion (Point of Sale) Regulations 2004, SI 2004/765, made under the Tobacco Advertising and Promotion Act 2002, limit the size of tobacco advertising at the point of sale to the equivalent of an A5 sized piece of paper. In their paper *Consultation on the Future of Tobacco Control* (May 2008), the government set out research findings on the impact of point of sale displays, and industry and retailer concerns. The consultation paper sought views on whether there should be further controls on the display of tobacco products in retail environments, and proposed three options: do nothing, retain current restrictions, monitoring enforcement of relevant legislation; regulate point of sale display more strictly by further restricting permitted advertising space and/or restricting display space or ways in which tobacco products are displayed; or require retailers to remove tobacco products from display.

According to the summary of responses published in December 2008, *Consultation on the Future of Tobacco Control—Consultation Report*, the Department of Health received 95,488 responses to this question (pages 19–23). Stricter controls were favoured by approximately 84 per cent of respondents, with the vast majority preferring the third option of removing tobacco products from display. However, almost all of the 10,570 responses received from small retailers were against the proposal. The most common reasons cited in the report were: the perceived unfair burden on small retailers; stimulation of illicit market; displays did not encourage purchases and lack of displays did not therefore discourage purchases; health and safety and customer care concerns; and refitting costs.

Other responses opposed to the proposals came from organisations such as the Tobacco Manufacturers Association, who believed the proposed restrictions ran counter to the right of freedom of commercial expression; and FOREST, an organisation concerned with smokers' rights, who believed that display restrictions "denormalised" smoking and that this was an improper basis for regulation, as a code should not be imposed by the government that stigmatised the use of legal products. However, the tobacco manufacturers did support the second option of regulating point of sale displays more strictly provided: communications about products to customers were permitted; effective competition between manufacturers was permitted; financial and other impacts on retailers were mitigated; and adverse and uninvited consequences were minimised. The magazine *Independent Retail News* conducted a survey of 780 retailers, and found that 85 per cent disagreed with the proposed ban on the display of tobacco products in stores. The National Federation of Retail Newsagents responded that there was no connection between tobacco displays and smoking, and called for independent research.

On the other hand, Nottingham City NHS Stop Smoking Services conducted a survey which found that 63 per cent of clients surveyed were tempted to start smoking again by displays, 75 per cent said they would not be tempted if tobacco products were not displayed and 44 per cent responded that they purchased tobacco on impulse. Evidence submitted by Cancer Research UK indicated that displays were a well established retail and marketing tool that influenced would-be quitters. They also argued that since the ban on tobacco advertising under the Tobacco Advertising and Promotion Act 2002, point of sale displays had been used by manufacturers as a marketing tool; gantries and tobacco packets were designed to enhance the appeal of smoking; prominent displays made it appear that smoking was more common than it actually is; point of sale displays influenced young people; and smoking would be reduced if tobacco were out of sight.

A number of groups including Cancer Research UK and ASH, a public health charity campaigning to eliminate the harm caused by tobacco, responded that when tobacco displays were banned in Canadian provinces, manufacturers continued to pay retailers for tobacco storage units. In Canada, manufacturers were obliged to disclose the amount they spent on marketing, and Heart of Mersey, a local health charity, thought that this should occur in England as well.

Specialist tobacconists thought that they should be exempt, as did duty free retailers. The former argued that restrictions would be impractical and that their customer base was mature smokers. The latter argued that if displays were removed, non-English speakers would not know that a retailer sold tobacco, and that their competitors were not domestic, but international.

Following these responses, the Health Bill currently before the House prohibits the display of tobacco products in the course of business, and provides powers to regulate, but not prohibit, the display of prices of tobacco products, and the display of tobacco products and prices in the course of a business on a website (clause 19). An exemption for specialist tobacconists is included (clause 18).

4.2 Tobacco Vending Machines

In relation to vending machines, the government's paper *Consultation on the Future of Tobacco Control* (May 2008) stated that although tobacco sales through vending machines only account for one per cent of the overall UK market, a disproportionate number of young people purchase tobacco from vending machines. The consultation

paper set out the rationale for restricting or prohibiting sales from vending machines and concerns over doing so, and asked for responses to the question of whether there should be further controls on the sale of tobacco products from vending machines to restrict access by young people. The consultation paper presented three options: retain the status quo; require mechanisms on all tobacco vending machines to restrict access by young people; or prohibit the sale of tobacco from vending machines.

The total number of responses to this question was, according to the *Consultation on the Future of Tobacco Control—Consultation Report* (December 2008), 82,722 (pages 23–4). Further controls were favoured by 80,501 respondents, 90 per cent of whom preferred the third option of prohibiting the sale of tobacco products from vending machines altogether. Where respondents were opposed to further controls on the sale of tobacco through vending machines, the most common arguments were that controls restricted free trade, particularly in relation to pubs; that the cost of implementing restrictions would outweigh the benefits; and that the controls would not have an impact on smoking by young people.

The National Association of Cigarette Machine Operators argued that the status quo should be maintained, as further controls could have a detrimental impact upon their members. They also argued that the proportion of young people purchasing tobacco from vending machines was declining, and that siting machines in licensed premises acted as a safeguard. The Association of Licensed Multiple Retailers questioned the research put forward by the government in their consultation paper, and suggested that the existing voluntary code on the placement of vending machines could be converted into a statutory one. The majority of members of the British Institute of Inn-keeping favoured a proof of age card, with the least favoured option being a ban on vending machines.

A number of respondents submitted evidence on test purchases of tobacco from vending machines. For example, the Trading Standards Institute found that test purchases from vending machines had a higher failure rate (ie tobacco was sold to children) than those from retail premises. They also found that the voluntary code on the placement of machines was not being adhered to, and that staff sometimes helped children to purchase tobacco from the vending machines. After an intensive programme of activities aimed at premises whose compliance with underage legislation was poor, London Trading Standards gained a 100 per cent success rate on test purchases. However, as the programme was very resource intensive, they favoured an outright prohibition of the sale of tobacco from vending machines.

The Health Bill amends the Children and Young Persons (Protection from Tobacco) Act 1991 and the Children and Young Persons (Protection from Tobacco) (Northern Ireland) Order 1991, SI 1991/2872 (NI 1991/25), to enable regulations to be made by affirmative resolution to prohibit or impose restrictions on the sale of tobacco from vending machines (clauses 20, 21). The regulations may impose requirements as to the location or design, construction or operation of machines. The regulations must include provisions as to the persons liable in the event of a breach. A breach of the regulations is punishable on summary conviction with a fine not exceeding level 4 on the standard scale (currently £2,500).

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Regime for Unsustainable NHS Providers

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