

Smoke-free, heated tobacco-free and vape-free places in England.

Making outdoor places smoke-free

RCP Pharm response:

1.1 Do you agree or disagree with our proposal to make public children's playgrounds (those with council involvement) smoke-free places?

- **Agree**
- Neither agree nor disagree
- Disagree
- Don't know

1.2 Do you agree or disagree in principle with our proposal to make outdoor areas of health and care settings smoke-free?

- **Agree**
- Neither agree nor disagree
- Disagree
- Don't know

1.3 Do you agree or disagree with our proposed list of health and care settings where outdoor areas would be smoke-free?

- **Agree**
- Neither agree nor disagree
- Disagree
- Don't know

1.4 Do you agree or disagree in principle with our proposal to make outdoor areas of education settings smoke-free?

- **Agree**
- Neither agree nor disagree
- Disagree

- Don't know

We propose to make outdoor areas of education settings smoke-free. A detailed list of these is above in the 'Proposals for smoke-free, heated tobacco-free and vape-free places' section.

This excludes private outdoor dwellings that are not used as workplaces, such as the garden of an on-site school caretaker's house.

1.5 Do you agree or disagree with our proposed list of education settings where outdoor areas would be smoke-free?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

1.6 Please explain your answers to the questions in this section. This could include, for example, sharing comments on any settings in the above categories that are not listed but you think should be included, settings that are listed that you think should not be included or other types of settings that should be considered for inclusion. (Optional, maximum 600 words)

The public health rationale for restricting smoking in playgrounds, education settings, and health and care settings is strong. The consultation states that smoking remains the leading preventable cause of death, disability and ill health in the UK and attributes around 64,000 deaths per year to smoking. National smoking prevalence has fallen, but the burden remains substantial: in England, adult smoking prevalence was 10.4% in 2024, while across the UK 10.6% of adults were current smokers, equivalent to around 5.3 million people. This means that direct exposure and visibility of smoking remain relevant public health issues in the very settings targeted by the consultation.

The settings-based rationale is also reinforced by NICE quality standards, which state that schools and colleges should not allow smoking anywhere on their grounds and that healthcare settings should operate smokefree grounds without designated smoking areas. This supports the public health logic that places associated with education, care, treatment and recovery should actively minimise involuntary exposure and reinforce healthy norms.

Youth data also support the continued relevance of visible tobacco control. In the 2023 NHS England survey, 11% of pupils had ever smoked, meaning they had smoked either regularly or just once or twice. 3% were current smokers, defined as regular or occasional smokers, and 1% were regular smokers, defined as usually smoking at least one cigarette a week. Although those figures are lower than in previous decades, they

still indicate that smoking and exposure to smoking remain live public health concerns in settings used by children and adolescents.

One further point is that the proposals assume that children's playgrounds are predominantly council-owned or council-managed. This may significantly overestimate the reach of any proposed measures.

A large proportion of new-build housing estates constructed in the last 10–15 years include privately managed communal amenities, including children's playgrounds, which fall outside local authority control. New-build estates represent a growing share of the national housing stock, and although precise figures are unavailable, it is reasonable to assume that the majority of post-2010 playgrounds are privately managed rather than council-adopted.

This gap does not appear to have been accounted for in the impact assessment. As a result, implementation of potentially costly measures may have limited effect if a substantial proportion of playgrounds are not covered by the proposed regulations.

- [DHSC consultation page](#)
- [Consultation-stage impact assessment](#)
- [Smoking profile: statistical commentary, November 2025](#)
- [Smoking, Drinking and Drug Use among Young People in England, 2023](#)
- [NICE QS82 – Schools and colleges: smokefree grounds](#)
- [NICE QS82 – Healthcare settings: smokefree grounds](#)
- [ASH – Secondhand smoke](#)

1. Exemptions to smoke-free outdoor places

The outdoor settings that we propose should be allowed an exemption are:

- care homes with nursing (nursing homes)
- residential care homes
- assisted living homes
- hospice centres
- mental health residential facilities
- residential schools (only for permitted persons in these settings)

This would mean that the manager or person in charge could decide whether to designate an outdoor smoking area based on the needs of people living on the site.

2.1 Do you agree or disagree with allowing an exemption for the above settings? (Optional)

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

2.2 Please explain your answer. This could include, for example, sharing comments on whether you think more or fewer settings should be allowed an exemption or your views on allowing the manager or person in charge to designate a smoking area. (Optional, maximum 600 words)

2. Heated tobacco-free indoor and outdoor places

3.1 Do you agree or disagree with our proposal that all indoor places that are currently smoke-free should also become heated tobacco-free? These places include enclosed and semi-enclosed workplaces and public places, public transport, vehicles used for work and private vehicles with an individual aged 17 years and under present.

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

3.2 Do you agree or disagree with our proposal to make public children's playgrounds (those with council involvement) heated tobacco-free places?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

3.3 Do you agree or disagree in principle with our proposal to make outdoor areas of health and care settings heated tobacco-free places?

- Agree

- Neither agree nor disagree
- Disagree
- Don't know

3.4 Do you agree or disagree with our proposed list of health and care settings where outdoor areas would be heated tobacco-free? This is the same list as proposed for smoke-free health and care settings.

- Agree

- Neither agree nor disagree
- Disagree
- Don't know

3.5 Do you agree or disagree in principle with our proposal to make outdoor areas of education settings heated tobacco-free places?

- Agree

- Neither agree nor disagree
- Disagree
- Don't know

3.6 Do you agree or disagree with our proposed list of education settings where outdoor areas would be heated tobacco-free? This is the same list as proposed for smoke-free education settings.

- Agree

- Neither agree nor disagree
- Disagree
- Don't know

3.7 Please explain your answers to the questions in this section. This could include, for example, sharing comments on any settings in the above categories that are not listed but you think should be included, settings that are listed that you think should not be included or other types of settings that should be considered for inclusion. (Optional, maximum 600 words)

The available evidence supports treating heated tobacco as a harmful tobacco product rather than as a benign or cessation-oriented product. The consultation and impact

assessment state that all tobacco products are harmful and cite laboratory evidence that heated tobacco aerosol contains toxic and carcinogenic compounds. The consultation also notes that current use remains low but awareness is increasing: around 0.3% of people aged 16 years and over were reported as using heated tobacco in late 2025, while adult awareness had risen to 28%, up from 9% in 2017. From a prevention perspective, these figures support the case for avoiding regulatory gaps in visible public settings before use becomes more established.

ASH's current materials are broadly consistent with this approach. ASH describes heated tobacco as a tobacco product that is not risk free and notes that it is not currently recommended for smoking cessation by NICE. From an Royal College of Pharmacy perspective, the strongest evidence line is therefore precautionary: the product is harmful, its use should not be normalised in child-focused or healthcare-associated settings, and the absence of a smoking-like evidence base on second-hand exposure should not be interpreted as evidence of safety.

It is known that aerosol droplets can travel beyond 2m and can also remain suspended for hours especially if small. So, there is also a risk for outdoor areas,

- [DHSC consultation page](#)
- [Consultation-stage impact assessment](#)
- [ASH – Heated tobacco](#)
- [WHO report on the global tobacco epidemic, 2025](#)

3. Exemptions to heated tobacco-free places

With the exception of specialist tobacconists, we propose matching heated tobacco exemptions with the indoor smoke-free and proposed outdoor smoke-free exemptions.

For the outdoor areas this would mean that the manager or person in charge could decide whether to designate an outdoor heated tobacco area based on the needs of people living on the site.

4.1 Do you agree or disagree with our proposed exemptions for heated tobacco-free places?

- Agree
- Neither agree nor disagree
- Disagree

- Don't know

4.2 Please explain your answer. This could include, for example, sharing comments on whether you think more or fewer settings should be allowed an exemption. (Optional, maximum 600 words)

4. Vape-free indoor and outdoor places

5.1 Do you agree or disagree with our proposal that all indoor places that are currently smoke-free should also become vape-free? These places include enclosed and semi-enclosed workplaces and public places, public transport, vehicles used for work and private vehicles with an individual aged 17 years and under present.

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

5.2 Do you agree or disagree with our proposal to make public children's playgrounds (those with council involvement) vape-free places?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

5.3 Do you agree or disagree in principle with our proposal to make outdoor areas of education settings vape-free places?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

5.4 Do you agree or disagree with our proposed list of education settings where outdoor areas would be vape-free? This is the same list as proposed for smoke-free education settings.

- Agree

- Neither agree nor disagree

- Disagree
- Don't know

5.5 Please explain your answers to the questions in this section. This could include, for example, sharing comments on any settings in the above categories that are not listed but you think should be included, settings that are listed that you think should not be included or other types of settings that should be considered for inclusion. (Optional, maximum 600 words)

Youth exposure and uptake remain important concerns. In the 2023 NHS England survey, 25% of pupils aged 11 to 15 reported that they had ever used an e-cigarette. In the same survey, 9% were current e-cigarette users, and 4% were regular e-cigarette users. The survey also found that, among pupils who had ever used an e-cigarette, 89% had never been regular tobacco smokers. These figures are important because they suggest vaping is not confined to young people already established as smokers and support concern about visibility, uptake and normalisation in child-focused settings such as playgrounds and education settings.

The most evidence-based framing for vaping is that it should be approached proportionately and distinctly from smoking. Royal College of Pharmacy, OHID, ASH and the 2025 Cochrane review all support the position that vaping is less harmful than smoking and can play a role in adult smoking cessation but is not risk free. ASH's February 2026 statement on the consultation says explicitly that vaping is not smoking and should be regulated proportionately, and that evidence that second-hand vapour poses a significant risk to health has not yet accumulated.

The second-hand exposure evidence supports a cautious but proportionate approach. OHID's 2022 evidence update highlighted that short exposures to second-hand vaping did not result in detectable changes in nicotine, VOCs or TSNAs, but that longer exposures during heavy sustained vaping were associated with significant increases in nicotine or potential toxicants' metabolites. A 2024 JAMA Network Open study of 1,777 children aged 3 to 11 years found that nicotine absorption in those exposed to second-hand vapour only was 83.6% lower than in those exposed to second-hand smoke only, but not zero. This suggests that second-hand vapour exposure is materially lower risk than second-hand smoke exposure but is not equivalent to no exposure. However, the range of vaping products contain many different chemicals with unknown toxicity when heated.

From a Royal College of Pharmacy perspective, the strongest scientific framing seems to be that restrictions on vaping in child-focused settings are more robustly supported by concerns about youth uptake, visibility and precaution than by a claim that the

second-hand vapour evidence base is already settled in the same way as second-hand smoke.

- [ASH – Expanding smokefree places popular as Government launches consultation](#)
- [RPS e-cigarettes policy](#)
- [RPS e-cigarettes policy statement PDF](#)
- [OHID nicotine vaping in England: 2022 evidence update](#)
- [Smoking, Drinking and Drug Use among Young People in England, 2023](#)
- [ASH – Use of vapes among young people in Great Britain](#)
- [JAMA Network Open – Secondhand Nicotine Absorption From E-Cigarette Vapor vs Tobacco Smoke in Children](#)
- [Cochrane review – Electronic cigarettes for smoking cessation](#)

5. Exemptions to vape-free places

We propose matching the relevant vape-free exemptions with the indoor smoke-free and proposed outdoor smoke-free exemptions.

We also propose indoor vaping exemptions for smoking cessation services and for mental health residential facilities.

For the outdoor areas and mental health residential facilities this would mean that the manager or person in charge could decide whether to designate a vaping area based on the needs of people living on the site. The manager or person in charge of a smoking cessation service could also decide whether to designate a vaping area to support smoking cessation efforts.

6.1 Do you agree or disagree with our proposed exemptions for vape-free places?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

6.2 Please explain your answer. This could include, for example, sharing comments on whether you think more or fewer settings should be allowed an exemption or your views on allowing the manager or person in charge to designate a vaping area for the relevant settings. (Optional, maximum 600 words)

6. Boundaries to where smoking, heated tobacco use and vaping are restricted outdoors

We are considering 3 different approaches for defining the boundaries of smoke-free, heated tobacco-free and vape-free outdoor places. For all 3 approaches, we propose that the same boundaries are used for smoke-free, heated tobacco-free and vape-free outdoor places.

Please see the consultation document for more detail about the proposed approaches.

7.1 Which is your preferred approach to the boundaries of smoke-free, heated-tobacco free and vape-free outdoor places?

- Approach 1 (site boundary and an additional 10 metre perimeter)
- Approach 2 (site boundary and an additional 10 metre perimeter around access points)
- Approach 3 (site boundary only)
- An alternative approach (please specify in the free text question at the end of this section)
- Don't know

Where an outdoor setting does not have a clear site boundary, we propose that the site boundary is the equivalent to 10 metres from play equipment or buildings.

7.2 Do you agree or disagree with our proposed approach to outdoor settings that do not have a clear site boundary?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

7.3 Please explain your answers to the questions in this section. This could include, for example, sharing comments on an alternative approach to boundaries or additional perimeters, the distance of any additional perimeter beyond the site boundary, any evidence that you have taken into account to support your response or your comments on any potential challenges associated with indicated approaches. (Optional, maximum 600 words)

7. Signs to show where a place is smoke-free, heated tobacco-free and vape-free

We propose that all indoor places that have been designated smoke-free, heated tobacco-free and vape-free must have at least one sign saying this.

We propose that there would be flexibility for these indoor signs, including in relation to size, design and location.

8.1 Do you agree or disagree with our proposed approach for indoor signage?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

We propose that outdoor places that will be smoke-free, heated tobacco-free and in some cases vape-free should also have a sign displaying this.

These signs should describe the rules and the distance the rules apply to, if applicable. At least one sign should be placed at an access point or area boundary.

8.2 Do you agree or disagree with our proposed approach for signage for outdoor areas with a clear boundary?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

We propose that a sign should be positioned next to the play equipment or building where a boundary is not clearly defined.

8.3 Do you agree or disagree with our proposed approach for signage for outdoor areas without a clear boundary?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

8.4 Please explain your answers to the questions in this section. (Optional, maximum 600 words)

8. Smoking, heated tobacco use and vaping areas

We propose that managers or the person in charge of sites with exemptions would be able to designate smoking, heated tobacco use and vaping areas.

9.1 If we proceed with these exemptions, what requirements should we set for the outdoor smoking, heated tobacco use and vaping areas that can be designated under this exemption? This could include, for example, who is permitted to use the areas, the size of the areas, the distance from buildings, whether smoking, heated tobacco use and vaping should be allowed in the same area or kept separate, any other practical considerations and any evidence that can help make these decisions. (Optional, maximum 600 words)

9.2 If there are any potential impacts on the rest of the site that might result from people using designated areas for smoking, heated tobacco use, and/or vaping, please outline them here. (Optional, maximum 600 words)

9. Proposed implementation period

10.1 Do you agree or disagree with our proposed implementation period of no less than 6 months?

- Agree
- Neither agree nor disagree
- Disagree
- Don't know

10.2 Please explain your answer. This may include, for example, sharing comments on whether the total period allowed for implementation between regulations being made and new legal requirements fully coming into force should be longer or shorter or on implications the proposal could have for certain groups. Please reference any evidence that you have taken into account to support your response. (Optional, maximum 600 words)

10. Consultation stage impact assessment

We have published a consultation stage impact assessment alongside this consultation.

11.1 If you have any evidence or data to inform the assumptions or estimates of the costs in the impact assessment, please include it here. This could include any information, evidence or data on signage costs and the potential loss in profit. (Optional, maximum 300 words)

The consultation-stage impact assessment identifies familiarisation and signage as the principal direct monetised implementation costs. Under the preferred option, familiarisation costs are estimated at £279 million, signage costs at £251 million, communication campaign costs at £1.5 million, and enforcement costs at £0.3 million. The impact assessment also notes that the estimates may overstate costs where organisations already operate similar voluntary policies or have existing signage in place.

From an evidence perspective, the most useful Royal College of Pharmacy contribution is therefore to highlight where those assumptions may vary materially between sectors. Estate complexity, number of sites, existing policies, and whether signage can be adapted rather than replaced are likely to influence real-world implementation burden.

- [Consultation-stage impact assessment](#)

11.2 If you have any evidence or data to inform the assumptions or estimates of the benefits in the impact assessment, please include it here. This could include any information, evidence or data on the health benefits associated with any reduction in the use of these products, such as secondhand health impacts. (Optional, maximum 300 words)

The strongest quantitative evidence relates to the health and economic harms of smoking and the benefits of reducing smoking prevalence and exposure. The consultation states that smoking is responsible for around 64,000 deaths per year in the UK. ASH has estimated that smoking costs England at least £21.8 billion each year, including £1.9 billion to the NHS, £1.2 billion in social care costs to local authorities, and £18.3 billion in lost productivity. These figures do not directly quantify the incremental effect of the proposed measures, but they do demonstrate the scale of the health and economic burden into which these proposals intervene.

For heated tobacco and vaping, the impact assessment itself notes that benefits are harder to monetise because long-term evidence remains less mature. The benefit case is therefore strongest where it relates to smoking exposure reduction and to broader public health logic around prevention, visibility and denormalisation in child-focused and healthcare-associated settings.

- [Consultation-stage impact assessment](#)

- [ASH – Latest figures show cost of smoking in England up 25% to at least £21.8 billion](#)
- [ASH – Secondhand smoke](#)

11.3 If you are aware of any stakeholders that will be impacted, or costs and benefits that have not been identified in the impact assessment, please outline

Stakeholders plausibly affected include NHS providers, community health services, educational establishments, early years settings, care homes, hospices, stop smoking services, local authorities, estates and facilities teams, pharmacy teams working in relevant settings, and service users, carers, parents and visitors. From an evidence perspective, additional cost categories that may not always be fully visible in high-level modelling include staff familiarisation, local policy revision, communications, estate mapping, signage audit and replacement, and compliance monitoring. Additional benefit categories may include clearer behavioural norms and reduced ambiguity for staff and visitors in places where voluntary restrictions currently vary.

- [Consultation-stage impact assessment](#)

11.4 If you are aware of any potential unintended consequences as a result of the proposed policy that have not been identified in the impact assessment, please outline them here. (Optional, maximum 300 words)

One potential unintended consequence that should be monitored is whether restrictions on vaping, if poorly communicated, could create confusion about the relative risks of different nicotine products. Clear public health messaging is important because the evidence base and risk profiles for smoking, vaping and other nicotine products differ. This matters because ASH, Royal College of Pharmacy, OHID and the Cochrane review all maintain that vaping is less harmful than smoking and can support adult cessation. However, if something is less risky it is not therefore deemed safe.

A second potential unintended consequence is behavioural displacement, where smoking or vaping shifts to areas just outside restricted zones if boundaries are unclear or enforcement is weak. A third potential unintended consequence is that poorly differentiated messaging could reduce the clarity of public health advice by blurring distinctions between products that carry different risk profiles.

- [Consultation-stage impact assessment](#)
- [ASH – Expanding smokefree places popular as Government launches consultation](#)

- [RPS e-cigarettes policy](#)
- [Cochrane review – Electronic cigarettes for smoking cessation](#)

11.5 Please provide any other comments you have to inform the assumptions or analysis in the impact assessment. (Optional, maximum 300 words)

The evidence base supports maintaining a differentiated public health message throughout implementation. Smoking remains uniquely harmful and is supported by a mature evidence base on mortality, morbidity, inequality and economic burden. Heated tobacco is a harmful tobacco product and is not risk free, but the evidence base on second-hand exposure and long-term outcomes remains less mature than for smoking. Vaping appears less harmful than smoking and can support adult cessation, but it is not harmless and the evidence on long-term harms and significant second-hand risk remains less settled. ASH's current position is particularly useful because it supports proportionate regulation and explicitly warns against treating vaping as smoking.

From a Royal College of Pharmacy perspective, implementation and evaluation should therefore focus not only on compliance, but also on whether the public understands the intended distinctions between products. Relevant post-implementation indicators would include complaints or incidents, evidence of behavioural displacement, any effect on smoking cessation support, and whether messaging remains clear in child-focused and healthcare-associated settings.

- [Consultation-stage impact assessment](#)
- [ASH – Expanding smokefree places popular as Government launches consultation](#)
- [ASH – Heated tobacco](#)
- [RPS e-cigarettes policy](#)
- [OHID nicotine vaping in England](#)
- [Cochrane review – Electronic cigarettes for smoking cessation](#)

References

Action on Smoking and Health, 2025. [ASH Ready Reckoner January 2025: costs of smoking to society](#).

Banks and others. [Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence](#). BMC Medicine 2015: volume 13, article number 38.

Colyer-Patel and others. [Age-dependent effects of tobacco smoke and nicotine on cognition and the brain: A systematic review of the human and animal literature comparing adolescents and adults](#). Neuroscience and Biobehavioral Reviews 2023: volume 146, article number 105038.

Committee on Toxicity, 2017. 'Statement on heat not burn tobacco products', available at [COT statements and position papers](#).

Frazer and others. [Legislative smoking bans for reducing harms from secondhand smoke exposure, smoking prevalence and tobacco consumption](#). Cochrane Database of Systematic Reviews 2016: issue 2, article number CD005992.

He and others. [The association between secondhand smoke and childhood asthma: A systematic review and meta-analysis](#). Pediatric Pulmonology 2020: volume 55, article number 10 (registration and subscription required for full article).

Hwang and Lee. [Determination of outdoor tobacco smoke exposure by distance from a smoking source](#). Nicotine and Tobacco Research 2014: volume 16, issue 4.

Kim and Lee. [Concentrations of outdoor tobacco smoke at different distances from the smoking source: is there an optimal distance for a designated smoking area?](#). Nicotine and Tobacco Research 2024: volume 26, issue 6 (registration and subscription required for full article).

Lindson and others. [Electronic cigarettes for smoking cessation](#). Cochrane Database of Systematic Reviews 2025: issue 1, article CD010216.

Livingston and others. [Dementia prevention, intervention, and care: 2020 report of the Lancet Commission](#). The Lancet Commission 2020: volume 396, issue number 10248.

Lv and others. [Risk of all-cause mortality and cardiovascular disease associated with secondhand smoke exposure: a systematic review and meta-analysis](#). International Journal of Cardiology 2015: volume 199, pages 106 to 155 (registration and subscription required for full article).

Marufu and others. [Maternal smoking and the risk of still birth: systematic review and meta-analysis](#). BMC Public Health 2015: volume 15, article number 239.

Nayak and others. [Regretting ever starting to smoke: results from a 2014 national survey](#). International Journal of Environmental Research and Public Health 2017: volume 14, issue 4, article 390.

NHS England, 2023. [Part 2: smoking-related mortality](#), part of 'Statistics on public health, England 2021'.

NHS England, 2024. [Smoking, drinking and drug use among young people in England, 2023](#).

Office for Health Improvement and Disparities, 2022. [Nicotine vaping in England: 2022 evidence update](#).

Possenti and others. [Association between second-hand smoke exposure and lung cancer risk in never-smokers: a systematic review and meta-analysis](#). European Respiratory Review 2024: volume 33, issue 174.

Reed H. [Estimates of poverty in the UK adjusted for expenditure on tobacco - 2021 update \(PDF, 355KB\)](#). Landman Economics, 2021.

Royal College of Physicians, 2018. [Hiding in plain sight: treating tobacco dependency in the NHS](#).

TackSHS Project Investigators and others. [Secondhand smoke presence in outdoor areas in 12 European countries](#). Environmental Research 2021: volume 195, article number 110806.

World Health Organization, 2025. [WHO report on the global tobacco epidemic, 2025: warning about the dangers of tobacco](#).