No smoke without fire: is tougher regulation of shisha premises on the cards?

The Government is looking into the possibility of a licensing regime for shisha premises. About time too, suggest **Richard Brown** and **Charles Holland**

Comprehensive tobacco control is the best thing a local authority can do for public health – Local Government Association, July 2019.[1]

The time has come to enhance the legislative framework surrounding shisha premises and, I believe, institute a licensing regime specifically for shisha premises. – Shabana Mahmood MP, 5 December 2019.

In its July 2019 green paper *Advancing our health: prevention in the 2020s* the government announced its ambition for England to be "smoke-free" by 2030 (meaning only 5% of the population would smoke by then).[2] The government was then able to make the point that good progress had already been made in moving towards a smoke-free society. Smoking rates had halved over the previous decades, with the country having one of the lowest rates in Europe. Fewer than one in six adults smoked cigarettes.

In her recently published independent review of the government's progress towards that goal, *Making smoking obsolete*, Dr Javed Khan observed:

> *Most people don't see smoking as a problem anymore. As a nation we've moved on. Smoking in restaurants, pubs and clubs is long gone. It's no longer common for living room ceilings to be stained yellow from chain-smoking in front of the TV. You have to be my age to have any memory of tobacco adverts on TV and billboards. The problem is less visible.*

However, what was "less visible" was still concerning to the review. Smoking remains the single biggest cause of preventable illness and death. Approximately 64,000 people are killed by smoking each year. Smoking costs society about £17bn per year, with the cost to the NHS alone being £2.4bn. This dwarfs the annual £10 billion tax revenue from tobacco products. Dr Kahn's conclusion was that without further immediate action, England would miss the smoke-free target by at least seven years, with the poorest areas not meeting it until 2044. His fifteen recommendations included radical steps such as raising the age of sale of tobacco from 18, by one year, every year, and licensing the sale of all tobacco.

The growth in shisha over recent years stands in contrast to the visible decline in cigarette consumption in the hospitality sector, and indeed the two may be connected.[3] It was thought that the introduction of the smoking ban in 2007 had encouraged a business model based on outdoor smoking.

This has not gone unnoticed by local authorities, which have multi-faceted concerns in relation to shisha. There are reports of nuisance, anti-social behaviour and crime and disorder arising from badly managed premises. The public health role of local authorities is engaged, as their responsibilities include the enforcement of legalisation relating to smoke-free premises, tobacco sales, payment of duties, planning and fire safety.

In 2019, the Local Government Association (LGA) called for a new licensing system for shisha premises. Simon Blackburn, Chairman of the LGA's Safer and Stronger Communities Board said that "the growing popularity of shisha bars and the lawless way some of them are being run exposes the loopholes that exist in our out-dated and inflexible licensing system."[4]

A campaign headed by the MP for Birmingham Ladywood, Shabana Mahmood, has long lobbied for a "more effective regulatory regime", prompted by a more than tenfold increase

1 https://www.local.gov.uk/publications/must-know-tobacco-control.

2 https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s.

3 British Heart Foundation media release, 14 March 2012, '*Rise in shisha bars prompts warning on dangers of waterpipe smoking*'.

4 https://localgovernmentlawyer.co.uk/community-safety/393-community-safety-news/39942-councils-should-be-allowed-to-opt-in-to-license-shisha-bars-says-lga.

in the number of shisha bars in Birmingham between 2007 and 2016.[5]

The Government is now looking into the possibility of a licensing regime for shisha premises. In August 2021, Luke Hall, Minister for Regional Growth and Local Government, announced that the Government is in the process of drafting a consultation document in relation to possible amendments to the Local Government (Miscellaneous Provisions) Act 1982 (LG(MP)A 1982) to allow for an adoptive regime for licensing of premises offering shisha.[6]

This article will summarise current regulatory requirements, examine the context of the calls for tougher regulation, and evaluate the possibilities going forward.

What is shisha?

Shisha is known by a variety of different terms, such as waterpipe, hookah, hubble-bubble or narghile smoking. It is a method of smoking tobacco (or sometimes a herbal mixture) through a bowl and a pipe / tube. Shisha smoking has existed for several hundred years as a traditional practice in the Middle East and parts of Africa and Asia, and has become increasingly popular in western countries, including the UK, in recent years. Specially prepared tobacco (often mixed with other flavours such as mint, coconut or pineapple) is heated to produce smoke which bubbles through a bowl of water and into a long hose-like pipe to be breathed in. Shisha pipes have a mouthpiece fitted to inhale the smoke. It is usually heated by burning wood, coal or charcoal.

Is shisha harmful?

A joint report from the Association of Directors of Public Health (ADPH) and Public Health England (PHE) in 2017, *Waterpipe smoking (shisha) in England - the public health challenge*,[7] observed that the health effects of waterpipe smoking have received less research attention than cigarette smoking.

However, it reported that the available evidence indicates that waterpipe smoking is associated with cancer, heart disease and lung disease. There have also been reports of increased risk of infectious disease, and the large amount of carbon monoxide created by the constant heating of tobacco by burning charcoal introduces the risk of carbon monoxide poisoning. Regular waterpipe tobacco smokers may report or display signs of addiction, and misperceptions about the potential health risks appear to be widespread. Overall, the report concluded, the existing evidence base underlines the need to minimise waterpipe use, particularly regular use.

There is evidence that smoking herbal shisha is similarly harmful to health as smoking tobacco shisha, yielding similar levels of toxicants such as carbon monoxide, nitric acid and tar.[8]

How prevalent is shisha use?

The main source of data on adult waterpipe use in Britain is the annual ASH Smokefree GB survey. At the time of the ADPH and PHE report in 2017, this survey was showing a slight increase in the proportion of adults who had “ever” used a waterpipe, from 11% in 2012 to 12.9% in 2106. “Current” waterpipe use (up to once or twice a month) remained around 1%.

While waterpipe use in the general population is low, there is substantial variation in prevalence between ethnic groups. On average, ethnic minority groups in England have lower rates of smoking than among the general population – except for those of mixed / multiple ethnicity, who have the highest smoking rates. However, waterpipe use in Great Britain is concentrated among ethnic minorities, in particular South Asian groups and those of other / mixed ethnicity. The ASH Smokefree GB survey for 2019 showed the following responses:

Shisha use	White	South Asian	Black	Other/ mixed
Ever tried	10%	21%	16%	29%
>Once a year	2%	11%	6%	7%
<Once a year	9%	11%	10%	22%
Never tried	77%	58%	64%	57%

The Khan review has called for the Government to commission further research on health disparities, particularly ethnic disparities, where not enough is known about the different impact of tobacco use on particular communities. The review said this should include commissioning research on the effects of shisha, paan and kaat, where it was already well known that these substances were linked to increased risk of cavities and oral cancer.

Local authorities and health

In 2019 the Local Government Association (LGA) and Cancer Research UK jointly published *Tobacco Control: how do you*

5 https://www.shabanamahmood.org/category/shisha/.

6 https://www.birminghammail.co.uk/news/midlands-news/tougher-rules-shisha-lounges-mooted-21306891.

7 https://www.adph.org.uk/2017/03/adph-and-phe-report-waterpipe-smoking-shisha-in-england-the-public-health-challenge/.

8 Shihadeh, A *et al*, ‘Does switching to a tobacco-free waterpipe product reduce toxicant intake? A crossover study comparing CO, NO, PAH, volatile aldehydes, tar and nicotine yields’. (2012) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3407543/.

know that your council is doing all it can to reduce smoking-related harm?[9] It recommended that local authorities "should have a local tobacco control strategy that is monitored and tracked against the Public Health Outcomes Framework."

This echoed messaging from central Government. In July 2017 the Government had published *Towards a Smokefree Generation: A Tobacco Control Plan for England (2017-22),* which included as a national ambition "the first smokefree generation". That plan emphasised the importance of "focused, local action, supporting smokers, particularly in disadvantaged groups, to quit."

The need for local action was repeated in the 2019 green paper, which made the point that prevention policies were not experienced in the abstract, but in the neighbourhoods and communities in which people live, with local authorities having a key role to play given that they:

- Have specific responsibilities around prevention (for example sexual health, children's health. adult social care and support, and drug and alcohol abuse).
- Control many of the assets for good health (for example parks and green spaces, leisure facilities, and cycling and walking infrastructure).
- Have decision-making power for areas like housing policy, planning and social care and support; and
- Shape other policies relevant to health including economic development, education and growing the voluntary and community sector.

According to the LGA, central government messaging placed significant responsibility on local government to contribute towards a reduction in smoking rates. This reflects the increased role for local authorities in the last decade to address public health issues, following changes brought about by the Health and Social Care Act 2012 (HSCA 2012).

The LGA recommended that "councils should implement a robust tobacco control strategy that embeds a health-in-all-policies approach. Lead members for health are well placed to drive political and financial support for tobacco control within the Health and Wellbeing Board, Sustainability and Transformation Partnerships and the wider council."

This reflected the changes in public health policy and delivery brought about by HSCA 2012, which transferred responsibility for various areas of health provision to local authorities, on the basis that they were best placed to take a holistic approach to the health and wellbeing of its residents and assess the public health needs of their residents.

Section 2B(1) of the National Health Service Act 2006 (as amended by HSCA 2012) confers on each local authority a duty to "take such steps as it considers appropriate for improving the health of the people in its area."

These steps include (s 2B(3)):

- Providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way).
- Providing services or facilities for the prevention, diagnosis or treatment of illness.
- Providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment.

Given the well-known health risks associated with consuming tobacco products, it is hardly surprising that local authorities should seek to target this activity in the context of this duty under NHSA 2006. This is particularly the case when (as the LGA report pointed out) the National Institute for Health and Care Excellence estimates that every £1 invested in smoking cessation saves £10 in future health care costs. A statement of local authority intent can be found in what is now known as *The Local Government Declaration on Tobacco Control*, first passed by Newcastle City Council in May 2013 and now signed by over 120 councils, and recently re-launched to be brought in line with the Government's ambition to be smoke-free by 2030.[10]

Smoke-free legislation

The Health Act 2006 (HA 2006) introduced a ban on smoking in many of the country's indoor places. Section 2(1) provides that premises in England are smoke-free if they are open to the public. This is subject to the important qualification in s 2(4) that premises are smoke-free "only in those areas which are enclosed or substantially enclosed".

The Secretary of State specified in regulations what "enclosed" and "substantially enclosed" means, specifically in regulation 2 of the Smoke-free (Premises and Enforcement) Regulations 2006. These provide premises are "substantially

9 https://www.local.gov.uk/publications/must-know-tobacco-control.

10 https://smokefreeaction.org.uk/declarationsindex-html/.

enclosed" if they have a ceiling or roof but there is an opening in the walls, or an aggregate area of openings in the walls, which is less than half of the area of the walls (including other structures that service the purpose of walls and constitute the area of the walls). In determining the area of an opening or aggregate area of openings, no account is to be taken of openings in which there are doors, windows or other fittings that can be opened or shut. A "roof" includes any fixed or moveable structure or device which is capable of covering all or part of a premises as a roof, including, for example, a canvas awning.

In the hospitality sector, this has had the effect of confining smoking to premises that are "outdoor" to the extent that they are not "substantially enclosed" within the meaning of HA 2006. Such is human ingenuity that in certain types of premises such as cigar lounges and shisha bars, what is technically an "outdoor area" can be a close approximation of, and nearly as comfortable as, an indoor area.

A person who smokes in a smoke-free place commits an offence (s 7 HA 2006). "Smokes" in this context refers to "smoking tobacco or anything which contains tobacco, or smoking any other substance" (s 1(2)). It thus includes the tobacco-free herbal offerings of some shisha lounges.

Any person who controls or is concerned with the management of smoke-free premises is under a duty to cause a person smoking there to stop smoking (s 8(1) HA 2006). It is an offence to fail to comply with this duty (s 8(4)). The maximum penalty is a fine not exceeding level 4 on the standard scale, which is currently £2,500. In some areas, this has not been considered to be a sufficient deterrent to rogue premises providing shisha indoors or in non-compliant "outdoor" areas. One option for repeat offenders is to seek compensation orders under the Proceeds of Crime Act 2002.[11]

Shisha on the pavements: anti-social behaviour and the Westminster experience

Shisha smoking is a social activity, and a core part of the business model of shisha bars and lounges is offering places to smoke shisha pipes in comfort and in company. The coming into force of the HA 2006 moved these places outdoors, often onto pavements.

The ADPH/PHE report of 2017 summarised experiences in the City of Westminster. Here, the movement of shisha smoking outdoors had an impact on quality of life for many residents, with breaches across a wide range of legislation, including noise nuisance, smoke and odour complaints, unauthorised use of premises, unauthorised structures and alterations, unauthorised use of tables and chairs outside premises, highway obstruction and health and safety concerns. Despite concerted enforcement efforts, the council found that employing the range of powers available has been an insufficient deterrent to persistent offenders.

In 2011 the council began to take action under the anti-social behaviour legislation (see now the Anti-social Behaviour, Crime and Policing Act 2014). Closure orders gave immediate respite to people affected by the anti-social activity, and provided a period of time in which other enforcement and regulatory powers could be pursued. However, this is a resource-intensive use of powers which provides only temporary closure of premises. Large-scale targeted enforcement operations, including one conducted in May 2016 in collaboration with local police and HMRC, was only able to achieve brief respite from the problems, with shisha services back up and running at those premises very shortly afterwards.

Following the council's commission, in July 2013 Dr Mohammed Jaward produced *The Public Health Implications of Shisha Smoking in London.*[12] The report highlighted the desirability of raising awareness of the risks of waterpipe smoking in local communities, and identified a need for multi-agency work in tackling problems such as antisocial behaviour, illicit tobacco, inadequate health warning labelling and non-compliance with smoke-free legislation.

Westminster Council established a shisha working group, which brought together councillors and officers from licensing, planning enforcement, trading standards, health and safety, communications and public health to consider how the issue could be effectively addressed. Having conducted public consultation, in February 2017 the group published *Reducing the Harm of Shisha: Towards a Strategy for Westminster*.[13] The council's approach took three strands:

- Educate and engage.
- Regulate the activity.
- Lobbying and partnership.

Education and engagement was seen as a priority, given that many of those who smoke shisha were unaware of its health impact. The council wished to look at how it could encourage changes in behaviour and challenge misconceptions about

11 See 'POCA shocker: the unforeseen effects of the Proceeds of Crime Act 2002', Charles Holland, (2017) 17 JoL .

12 http://westminster.moderngov.co.uk/Data/Adults,%20Health%20and%20Public%20Protection%20Policy%20&%20Scrutiny%20Committee/20130718/Agenda/Item%207%20-%20Shisha%20Smoking.pdf.

13 https://www.westminster.gov.uk/health-and-social-care/shisha-westminster.

the safety of shisha smoking.

In terms of existing regulatory intervention, the council's strategy identified a wide range of regulations that shisha premises need to comply with, which serves as a useful checklist. It is not the case that shisha smoking is not regulated at all. On the contrary, it is subject to a panoply of regulatory requirements but, crucially, in the view of Westminster and other campaigners, none effectively deal with the problems caused by shisha smoking specifically.

The council expressed particular interest in lobbying for shisha smoking and sales to be a licensed activity, "to address the anomaly that while selling a cup of tea after midnight requires a licence, none is required for shisha".

Health and safety legislation

The Health and Safety at Work etc. Act 1974 ss 2 and 3 impose duties on employers to ensure, so far as is reasonably practicable, the safety and welfare at work of all their employees, and not to expose persons - not in their employment who may be affected by their undertakings - to risks to their health and safety. The Management of Health and Safety at Work Regulations 1999 requires the conduct of risk assessments and the implementation of health and safety arrangements to comply with these duties. In the context of shisha this will concern matters such as ensuring adequate ventilation so persons are not exposed to the risk of carbon monoxide poisoning and other ill-effects,[14] the cleaning of shisha pipes, the safe storage and use of charcoal, and the safety of structures erected and equipment used.

Pavement activities

The recent pandemic and the desirability of activities being conducted outdoors rather than indoors brought an urgent legislative focus on the regulation of pavement areas, with the Business and Planning Act 2020 introducing the concept of a pavement licence as a fast-track alternative to the requirements of a permit under the Highways Act 1980, the Town and Country Planning Act 1990, and (in London) street-trading legislation.

Such was the success of this initially temporary regime that it is proposed to be made permanent in provisions in the Levelling-up and Regeneration Bill.

Pavement licences are focused at food and drink-led premises, and it will be a question of fact in each case whether the premises to which the pavement licence applies, and whether shisha activities under the licence, are sufficiently ancillary to the usage of the area to the consumption of food or drink. Some authorities have standard "no shisha" conditions on pavement licences.

The pavement licensing regime is an alternative to the suite of consents required under highways, planning and (in some circumstances) street-trading legislation, and in cases where a shisha lounge cannot bring itself within the pavement licensing regime, that suite of alternatives will have to be pursued.

Planning

Westminster's approach is that shisha smoking is an identifiable land use which should be treated as *sui generis* and thus outside any defined use classes. Its strategy provides:

> *A key issue with regard to shisha smoking is the impact on residential amenity arising from noise, odour and fumes often late into the evening. In addition, the material change of use of premises to use for shisha smoking may lead to the loss of a retail unit or part of a retail unit's use thereby potentially reducing the vitality and viability of local shopping areas. Other issues might include alterations to shopfronts to make them fully openable to make the premises more conducive to shisha smoking and/or businesses operating outside of their permitted conditioned hours.*

Trading standards

By virtue of s 7(1) of the Children and Young Persons Act 1933 it is an offence to sell tobacco to a person under the age of 18, tobacco here encompassing "any product containing tobacco and intended for oral or nasal use and smoking mixtures intended as a substitute for tobacco". Section 91(1) of the Children and Families Act 2014 criminalises the proxy purchasing of tobacco for children (tobacco having the same meaning as in s 7 of the 1933 Act).

Section 12A-12D of the 1933 Act gives the magistrates' courts jurisdiction to make restricted premises and restrict sales orders against premises and persons in the event of persistent sales of tobacco to children.

Section 4 of the Children and Young Persons (Protection from Tobacco) Act 1991 requires a notice displaying the statement "It is illegal to sell tobacco products to anyone under the age of 18" at every premises at which tobacco is sold by retail to be exhibited in a prominent position.

14 One study of machine-smoked waterpipes found that compared with cigarette smoking, shisha smoke contained five times the number of ultrafine particles, four times the carcinogenic polyaromatic hydrocarbons and volatile aldehydes and 35 times the CO. These are all toxic or carcinogenic substances. Daher N, et al, *Comparison of carcinogen, carbon monoxide, and ultrafine particle emissions from narghile, waterpipe and cigarette smoking: Sidestream smoke measurements and assessment of second-hand smoke emission factors*. PMC. 2010; 44 (1): 8 - 14.

Regulations make provision for the dimensions of the notice and the size of the statement.[15]

There are detailed labelling requirements for tobacco products found in Part 2 of the Tobacco and Related Products Regulations 2016. Some authorities have indicated that in view of the difficulties in labelling waterpipes, they will accept other, similar labels on menus or cards given with the pipes themselves.

Section 2 of the Tobacco Advertising and Promotion Act 2002 provides that it is an offence to publish a tobacco advertisement in the UK, a "tobacco advertisement" meaning an advertisement whose purpose is to promote a tobacco product, or whose effect is to do so (s 1). A tobacco product here means "a product consisting wholly or partly of tobacco and intended to be smoked, sniffed, sucked or chewed" (s 1). This is a prohibition which appears to be honoured more in the breach than the observance by many operators.

Since January 2014, all herbal smoking products including those used for shisha smoking were made liable for excise duty, with the effect that all substances smoked in shisha bars will have to have duty paid. Tariffs are in excess of £100 per kilogram and product available for sale at less than this amount is indicative of duty evasion.

One of the Kahn review's recommendations was enhanced enforcement in relation to alternative tobacco products such as shisha "because they are routinely sold with no regard to regulations on packaging, display or notification".

Fire safety

Premises need to have regard to potential fire risk and comply with the Regulatory (Fire Safety) Order 2005. Issues and hazards include lit coals and lack of appropriate ventilation within premises, inadequate fire risk assessment to identify the hazards and risk and implement general fire safety precautions, locked rooms and locked fire exits, and lack of emergency lighting and appropriate firefighting equipment. South Wales Fire and Rescue Service has produced detailed guidance on shisha bars.[16]

Licensing Act 2003

The Licensing Act 2003 only impacts tangentially, if at all, on shisha operations. Premises selling alcohol, providing regulated entertainment or late-night refreshment require licences under the Act; premises that do none of these things do not. Where a 2003 Act licence is required, conditions can arguably extend to the shisha activities if to do so promotes the licensing objectives.[17]

Anti-social behaviour and nuisance

Closure orders under the Anti-social Behaviour, Crime and Policing Act 2014 are one option for problem premises, and this avenue was pursed by some authorities to deal with operations that remained open in breach of the business closure regulations passed to deal with the Coronavirus pandemic (which contained the first specific mention of shisha in statute-book).

Noisy and / or malodorous premises may constitute a statutory nuisance under the Environmental Protection Act 1990.

Should shisha be licensed and if so, how?

While the question of whether or not shisha should be licensed is ultimately a matter of politics, the Westminster strategy's point that a licence is required to serve a cup of tea after 11pm but not to provide the significantly more dangerous service of tobacco smoked through a waterpipe would seem to underline the need for specific regulation of shisha, not least given the disproportionate effect it has on minority groups in society.

It would be fairly straightforward to extend the ambit of the LG(MP)A 1982) to allow for an adoptive regime for licensing of premises offering shisha, in much the same way as an amendment to the Act was made to bring sexual entertainment venues within licensing.

However, a further option would be to add the provision of shisha as licensable activity under the Licensing Act 2003.

This would afford the provision of shisha the same level of scrutiny and public consultation that is already given to other activities, such as the consumption of alcohol. It would also allow the responsible authorities and local residents to make representations on new applications and full variations, if they had concerns about the applicant's ability to uphold the licensing objectives.

It would also provide the ability to review the whole premises licence if it was suggested that one or more of the licensing objectives were not being upheld. This means that there would be a higher level of accountability on the premise licence holder to carry out the activities in line with this legislation.

15 The Protection from Tobacco (Display of Warning Statements) Regulations 1992.

16 https://www.southwales-fire.gov.uk/app/uploads/2019/09/2925-Shisha-Bar-booklet_en_v2.pdf.

17 By analogy to the approach to licensing areas not used for licensinable activities in *R (Developing Retail)* v. *East Hampshire Magistrates' Court* [2011] EWHC 618 (Admin).

Including the provision of shisha within the 2003 Act would facilitate a joined up approach within the hospitality sector. It may also constitute an opportunity to consider the long-debated possibility of expanding the "public safety" licensing objective to include "public health".

Shisha has long been the Cinderella of public health smoking intervention, with its effects under-researched and regulatory control not being targeted to anything like the degree of specificity found with cigarettes, which in turns hampers enforcement. What evidence there is points to disproportionate harm to sectors of the community that already suffer from health inequality. It is appears to be hard to see how the status quo does anything other than exacerbate those existing health inequalities, and it might be said that it is high time that a targeted scheme of licensing is brought into effect.

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