Minutes
Joint Cross-Party Group on Smoking and Health and Poverty
4 March 2025, 9:30 am – 10:30 am
Hybrid – Tŷ Hywel and Microsoft Teams

Attendees:

In person

- John Griffiths MS (Chair)
- Louise Elliot (Secretariat, Smoking and Health) (ASH Wales Cymru)
- Steffan Evans (Secretariat, Poverty) (Bevan Foundation)
- Suzanne Cass (CEO, ASH Wales Cymru)
- Chris Emmerson (Consultant in Public Health, Public Health Wales)
- Joel Davies (Bevan Foundation)
- Rebecca Miller (Asthma and Lung Cymru)
- Leo Holmes (Early Years Wales)
- Simon Scheeres (Cancer Research UK)

Online

- Dr Alan Curley (Lecturer in Adult Health Studies. University of West of Scotland)
- Darren Daniel
- Adele Pember (ASH Wales Cymru)
- Cath Einon (Hywel Dda University Health Board)
- Cherrie Bija (Faith in Families)
- Deb Parson (Cardiff and Vale University Health Board)
- Eloise Hamon (Public Health Wales)
- Emma Preece
- Greg Pycroft (Tenovus Cancer Care)
- Helen Poole (Cardiff and Vale University Health Board)
- Jacqueline Hotchkiss (Vale of Glamorgan Council)
- Izzabella James (Home-start Cymru)
- Jamie Insole (University and College Union)
- Bronwen Morgan-Jones (British Heart Foundation)
- Catherine Perry (NHS Wales)
- Suzanne Williams (NHS Wales)
- Jane Allwood (Cardiff and Vale University Health Board)
- Jemma Wray (Mental Health Foundation)
- Jonathan Goodfellow (NHS Wales)
- Laura Thomas (Aneurin Bevan University Health Board)
- Lauren Thomas (Cardiff and Vale University Health Board)
- Lisa Purcell (Coleg y Cymoedd)
- Rachel Howell (Public Health Wales)
- Ryland Doyle (Office of Mike Hedges MS)
- Susan Carmichael (Aneurin Bevan University Health Board)
- Susan Evans (Aneurin Bevan University Health Board)
- Susan O'Rourke (Swansea Bay University Health Board)
- Emily Wooster (Royal College of Physicians)
- Lewis Williams (British Medical Association)
- Laura Willis
- Bethan Edwards (British Heart Foundation)

Meeting note

1. The Chair welcomed everyone to the meeting

2. Steffan Evans from the Bevan Foundation gave an overview of poverty in Wales. Points from the presentation included:
    - Poverty is a significant problem in Wales: 670,000 people in Wales live in poverty—this is 1 in 5 people (21%), including 29% of children. These rates have been relatively stagnant over more than a 10-year period and there is no indication that they will improve in the near future.

- Bevan Foundation polling shows how people are managing over time. In terms of being able to afford the basics, things worsened for people between 2021 and 2022 and now appears stuck at that higher level. In May 2021 8% of Welsh adults reported they struggled to afford essentials at least sometimes. As of September 2024 this rate is 15%.
- Rates of debt have also been steadily rising. There was a sharp jump in the proportion of adults who reported they had borrowed money due to financial pressure during the pandemic, from 17% in May 2021 to 25% in November 2021. Since then this has risen steadily to 30% in September 2024.
- People have consistently reported that the cost of living is having a negative effect on their health. Four in ten (44%) adults said in September 2024 that their current financial position has had a negative impact on their mental health while three in ten (29%) said it has had a negative impact on their physical health
- The survey data shows that some groups are affected more significantly than others, in particular people with a long-term health condition or disability, people who rent their home, low-income households (especially Universal Credit claimants), and families with young children.
- The root causes of poverty overlap with each other and include a lack of decent work, the benefits system not being fair or sufficient to support people, the high cost of essentials, and the makeup and changes within households (e.g. added costs of a baby, relationship breakdown). Poverty exists for systemic economic and social reasons.

3. Chris Emmerson gave a presentation on the relationship between smoking and inequalities in Wales. Points made included:
    - Smoking should not be regarded as a lifestyle choice, but a chronic relapsing dependency which will kill half of those who smoke and don't stop.
    - The evidence on smoking reduction shows that policy makers have an important role to play. Previous moves to ban smoking in indoor places and standardising packaging have had significant effects. Since 2014 if the percentage of smokers had not changed there would be more than 170,000 additional smokers.
    - There are over 300k smokers in Wales (13% of the population), but low-income households are affected disproportionately. As smoking rates have fallen, smokers are pooling in areas of deprivation: more than one in five people living in the bottom fifth most deprived areas in Wales smoke.
    - Deaths attributable to smoking are much higher amongst those on low-incomes, and there is a high burden of disease which hits the marginalised the most.
    - Quit services are focused on reaching out to clients in areas of greatest deprivation. Focusing on the financial incentives to quit is an important part of the strategy.
    - The big wins for inequalities are in prevention.
    - One of the dynamics that keeps people smoking is being surrounded by other people who smoke, which contributes to smoking rates in marginalised communities being stubbornly higher.
    - It is estimated that at an area level large amounts of money are being extracted from deprived communities in profits to tobacco companies, as shops only receive a small percentage of proceeds. Tobacco companies act

to keep low-income groups addicted to tobacco in various ways. Evidence shows that prices have been kept low on 'value' products in the face of tax rises by shifting the costs onto higher-value products whose customers are not as sensitive to price increases.
- The Tobacco and Vapes Bill is a huge opportunity to address health inequalities in Wales and there is a need to ensure the public debate is influenced by evidence and not commercial interests

4. Dr Alan Curley spoke about building addiction services to meet the needs of disadvantaged groups. Points made included:
    - More energy and attention is needed to reach smokers in disadvantaged groups.
    - Smoking support needs to be offered through a wide range of health and support services. CO monitors should be rolled out to all clinics for chronic conditions and debt advice/financial support settings. There are diverse practical incentives for this including that smokers may need larger doses of prescribed medications.
    - There is the precedent that CO monitors have been rolled out in midwifery services with positive effects for these reasons.
    - The indicators of success for smoking support services should be widened to include multiple indicators of improving health and wellbeing beyond stopping smoking entirely. At the moment, staff are being demotivated and there is a risk of losing services, because it may look like their services are not providing good value for money though their clients may be moving forward with their health – e.g. on their sleep or caffeine intake.
    - Goals should be set in collaboration with clients instead of them being told e.g. 'next week is quit week'.
    - Given that in communities where a higher proportion of people smoke it is less likely that people will be able to quit, support services should encourage community groups to support each other. Social prescribing is an important part of this as well as the training of staff to support local groups.
    - Cognitive behavioural therapy is an important tool for improving quitting rates. There should be more support for mental health and training for staff to provide CBT interventions.

5. Suzanne Cass from ASH Wales shared a video, 'Gareth', produced by PHW/Help Me Quit, a testimony of a Welsh cancer survivor who quit smoking with support from Help Me Quit, and is now grateful for the benefits it has brought to his life. SC summarised that the evidence the group has heard shows that smoking is a live problem in Wales impacting the most vulnerable in society. It is important to focus on supporting smokers from disadvantaged backgrounds in a way that does not make them feel judged or that they have failed and work to integrate the support that different services have to offer.

6. The Chair thanked the presenters for their contributions and opened the discussion. There was a range of discussion including the following points:
    - There was a question on the indicators that could be used beyond rates of quitting to judge the effectiveness of support services. AC said that various 'Star' outcome metrics can be used – these can evidence that a client may

still be smoking but over time services are supporting improvements in their health. These have been used in other areas of the NHS. The point was made that the same limiting success measures wouldn't be placed on methadone support services for example.

- SC said that while people who use help me quit services are much more likely to quit, 90% of people are not going through these services and trying to quit in other ways. These need to be recognised and supported so people don't feel they are failing.
- The Chair asked how Wales is performing in terms of AC's suggestions. CE said that wide-scale CO monitoring has been present previously and work is being done to bring it back. There is a good rate in Wales of reaching deprived communities. We don't want to put people off attending other services with mandated smoking interventions/screening but this can be balanced where there are opportunities. Wales is still focused on abrupt quitting because reducing an individual's smoking a bit doesn't bring down its health risks that much, but there is flexibility in the approach.
- Cancer Research has found that cancer rates are much higher in deprived communities and 50% of those cancer deaths are from lung cancer. The question of giving financial incentives to people to stop smoking would be a productive strategy, e.g. for pregnant women. CE said that the evidence shows this can work but that it needs to be part of a well-developed support service. Almost all lung cancer cases are in smokers/ex-smokers and little progress has been made on survivability, so prevention is very important.
- AC said that introducing CO monitor tests routinely should be seen in the same way as blood pressure tests—routine health checks rather than something that health workers should not be bothering patients with.
- CE said that smoking cessation is a very cost-effective intervention and while there is a case for being flexible there is still a need to maximise time/efforts of health workers/help me quit workers

There were also contributions using the chat function, including the following comments:

- HP: "A lot of hospital services are using flexible tailored support, known as harm reduction approach. Patients started as 40 cigs a day smokers, now down to 5 cigs. Use CO reading as measure of improved health. CO reading reduced from 54ppm down to 7ppm. Offer longer term support to empower them not make them feel a failure if unable to quit by week 2. Unfortunately none of that work is currently being collected as only requirement is quit dates."
- CE (HD UHB): "Data collection by Welsh Government on smoking success has become increasingly rigid requiring 4 week validated quit rates as only success. This doesn't recognise the successes services have made in engaging and supporting hard to reach smokers. Someone who is able to stop using an inhaler, better quality of life, increased confidence/ finances or massive harm reduction success reducing CO readings just counts as a fail. Too much emphasis on historic evidence e.g. Russell Standard was designed for motivated self-referrals when population smoking rates were 30% not for the clients we see so 4 week quit with face to face validation & and abrupt too limited"

- SC (AB UHB): “Alan's list of top 5 tips makes loads of sense to me, but as Cath has just said currently we are in a position where the outcomes/ successes are measured in a rigid way. The landscape for smokers has changed, but they way we are working with them hasn't. Is there evidence about having smoking cessation services as part of an holistic wellbeing service versus a separate HMQ service ? or as part of a substance misuse service?”
- DP: “When we make contact with a client we offer them all the services available, it is down to them to choose, yet we know they are most likely to succeed in a face to face environment. We have groups in CVHB but they are poorly attended, if they have a 1-1, they now see this as 30 mins with a HCP so we are then signposting clients into many services.”

7. The Chair thanked participants for their contributions and suggested that the group should write a letter to Welsh Government to make sure that quitting services are working effectively

Action Points:

- Write a letter to Welsh Government detailing the concerns and suggestions raised at the meeting around help me quit services.