

**Implementing
the
Wales Tobacco
Control
Action Plan:
new research
& best practice**

**Report by the Bevan Foundation
of a seminar held on July 2012,
All Nations Centre, Cardiff**

Funded by Pfizer

Introduction

The Welsh Government's Tobacco Control Action Plan aims to reduce the prevalence of smoking amongst the Welsh population to 16% of the adult population by 2020. This target is extremely challenging and achieving it requires concerted action by everyone with a role in tobacco control.

The Bevan Foundation is an influential, independent think tank which makes Wales a fairer place through research, conferences and events. The Foundation is concerned that smoking is a major factor in inequality in health between different socio-economic groups, and is anxious that the very high smoking prevalence amongst low-income groups, pregnant women and others are recognised and specifically addressed.

The Bevan Foundation is pleased to have worked with Pfizer Ltd to investigate the question of smoking cessation amongst lower socio-economic groups in Wales. As part of that programme of work the Bevan Foundation worked with Pfizer Ltd to organise a seminar in July 2012 to look at good practice in reaching disadvantaged groups of smokers. The programme included examples from Wales and England, which provided a unique insight into the range of different, effective interventions that can be made.

The response of delegates was extremely positive. In order to reach as wide an audience as possible, we have therefore produced this brief summary of the seminar.

A copy of the seminar programme is in Annex 1 and biographies of the speakers are at Annex 2.

Opening Statement

Peter Bradley, Public Health Wales

Peter Bradley opened the seminar by explaining the current position with the Wales Tobacco Control Action Plan. He highlighted the very considerable challenge of achieving the targets in the Plan and said that meeting it required all aspects of the health service, and wider society, to work together to achieve the reduction in prevalence of smoking. Cessation was important he argued but so too was prevention.



Peter went on to say that it may be time to review current service provision as the scale of the challenge and the impact on people's health was so great that radical action might be needed.

He concluded by saying that the programme for the morning looked to be both informative and thought-provoking – and the main business began.



Evaluation smoking cessation policy and practice in the UK

Henry Burkitt, Pfizer Ltd.



Henry Burkitt summarised recent findings on the different approaches taken by governments in England, Scotland, Wales and Northern Ireland to smoking cessation and tobacco control policy.

Henry began by highlighting different prevalence rates across the UK, with Wales having one of the highest rates at 25% in 2010. He compared estimated costs of smoking to the NHS and the number of deaths that could be attributed to smoking in each area. It was clear that progress towards reducing the prevalence of smoking in the UK has stalled since 2007 across all nations. In Wales the proportion of the population that smokes has increased in recent years, and in 2009 was back to 2004 levels at 23%. Understanding the reasons for this trend and taking action to reverse it is essential he said.

Henry then compared smoking policies and targets in each of the four countries of the UK. He noted the different prevalence targets and dates for their achievement in the four nations of the UK, and pointed out that Wales is the only country not to have targets for specific sub-groups of the population e.g. pregnant women, young people.

Looking at successful quits achieved at 4 weeks via NHS services, Wales has the highest percentage of successful quit attempts in the UK by some margin. However Henry pointed out that evidence from a recent Stop Smoking Wales programme shows that only 10% of smokers were still not smoking at 52 weeks, suggesting that the self-reported 4 week quit measure might not be the most appropriate indicator of success.

The pharmacotherapy most commonly prescribed in Wales is NRT, with nearly three times as many prescriptions as Varenicline. Prescribing of Bupropion is very limited. In England, although NRT is most commonly prescribed, it is only used twice as much as Varenicline.

Henry concluded that there were a number of recommendations about policy in Wales could be drawn, including developing targets for sub-groups of the population and greater clarity in measurement of successful quits and availability of cost per quit data.

Smoking Cessation & Socio-Economic Group

Victoria Winckler

Victoria summarised the emerging findings of a research project recently undertaken for Pfizer on socio-economic differences in attitudes to smoking cessation services.

She began by reminding participants of the scale of the challenge set by the Welsh Government's Tobacco Control Action Plan, and highlighted the significant differences in prevalence of smoking between different socio-economic groups. This made it essential that interventions were based on the differing needs and circumstances of socio-economic groups. Despite the differences in prevalence, however, there was very little evidence on which interventions were most effective for different groups of people.



Victoria then outlined a survey of more than 1,000 people in Wales of which 346 were smokers. Work analysing the results was on-going but there were some important results evident even at this stage.

First, the findings confirmed the difference in prevalence between higher and lower socio-economic groups found in other surveys. In addition, there were marked differences in prevalence by housing tenure, with those in rented housing being more likely to smoke than owner-occupiers, in household composition, with households with children being more likely to include an adult who smoked than households without, and in the health status of smokers.

The survey also confirmed a strong demand across socio-economic groups to quit. Whilst smokers from all socio-economic groups were keen to quit, those from lower income groups were much less likely to have been successful than those from higher groups.

The survey also suggested that smokers from lower socio-economic groups were most likely to use NRT in a quit attempt, whereas higher socio-economic groups were most likely to try to quit without support. Unfortunately the sample was too small to enable analysis of smokers' use of other types of support.

The survey found that smokers in lower socio-economic groups were more likely to attribute a failed quit attempt to lack of willpower than those in higher groups, and that they also more commonly mentioned stress as a reason for failing to quit.

Friends and families emerged as having a key role. While overall the majority of smokers said friends and family were generally supportive of a quit attempt, a significant minority of smokers from lower socio-economic groups said friends and family were very unhelpful – 19% compared with 4%.

Victoria concluded by saying that it was very clear even at this early stage that smokers from lower socio-economic groups faced considerable additional hurdles to quitting, and that they appeared to have different attitudes to and expectations of their quit attempt and the support they would receive.

It is vital that these differences are recognized and factored into services on offer, providing quitters with a range of options, if the Welsh Government's targets and the harmful effects of smoking are to be reduced.

Using Data to Improve Outcomes

William Beer



Will began by highlighting the very considerable challenges that the NHS faces at local level in trying to achieve the Tobacco Control Action Plan targets. He then noted the key role of primary care in smoking cessation, with GPs being seen as the main source of help to quit.

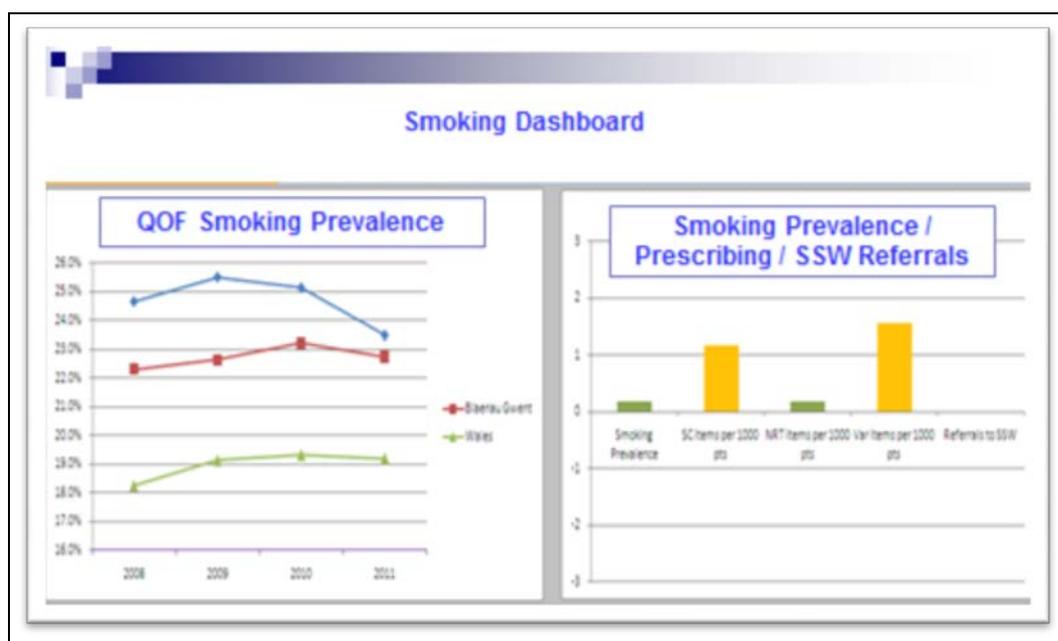
Will reminded delegates of the vital importance of data in improving services. He noted that the NHS collects lots of data but that unless it is turned into intelligence it is rarely useful. Will we achieve a reduction in smoking prevalence without good intelligence, he asked? But turning data into intelligence is not always easy – it requires clinical

engagement, use of relevant, reliable and valid indicators, awareness of reasonable variations in data and presentation of data in ways which encourage ‘indicator-based conversations’.

The GMS Clinical Dashboard being developed in Aneurin Bevan Health Board aims to gather data into one place to support decision making and outcomes in primary care. The dashboard enables multiple indicators to be compared across chronic diseases (initially COPD & smoking), in order to identify variation in general practices (z-scores) to support improvement in quality of service and patient care.

Will then demonstrated how the Dashboard would work, enabling data from individual practices to be compared – an extract from his presentation is shown in Figure 1.

Figure 1 Sample Smoking Dashboard



Will concluded by pointing out that ownership of data rests at a clinical level and must continue to do so if it is to be persuasive. Intelligence needs to be presented in a compelling way to “win hearts and minds”. It should build shared values and help people to understand the barriers to change.

Although the project is still at the early stages it shows how data can be used to help focus on outcomes.

Community Pharmacy Stop Smoking Enhanced Service

Jason Carroll



Pharmacist and community pharmacist lead for Powys Local Health Board, Jason Carroll, outlined his experience setting up a level 3 enhanced pharmacy service for smoking cessation in Powys LHB.

Jason began by outlining the origins of the project. It had taken some time to establish, mainly because of lack of funding, and eventually secured support from the Welsh Government's rural health fund for a 3 month pilot project, along with other support.

The pilot project worked with Stop Smoking Wales to select seven pharmacies in four different areas across Powys, including rural and semi-urban areas and in areas both with and without established Stop Smoking Wales services. There were some concerns about the ability of some pharmacies to deliver effective services and offer service continuity, and so all pharmacies selected had previously engaged with the LHB and raised no issues about the quality of service or contractual performance.

The service was based on the proposed National Enhanced Service, amended to reflect the rurality of Powys and issues about service continuity. It was available to anyone aged over 13 years including pregnant women and those with chronic conditions. All aspects of the service were extended to qualified pharmacy technicians, and paperwork was developed in-house to capture demographic details and client feedback.

Training was facilitated by WCPPE, with Stop Smoking Wales input, and involved a full-day session covering brief interventions, motivational interviewing, NRT products and an overview of the stop smoking enhanced service. All staff then successfully completed online competency assessment.

The evaluation of the 3 month pilot found that 146 clients completed at least 4 weeks of support, ranging from 7 to 44 clients per pharmacy. The overall CO-validated quit rate was 44%, ranging from 0% to 59% per pharmacy – this was a total of 49 quits,

at an average cost per quit of £288 (including NRT costs). Pharmacist views, analysed by the Institute for Rural Health, were broadly very positive although there were some concerns about the time commitment and existing workload. Client feedback was universally positive – clients particularly liked the accessibility and availability of the service, and the support and advice provided by staff.

The service was extended for a further three months - 3 more pharmacies became involved and a further 5 are expected to participate soon. A Champix support service has now been added (although it is not part of a Patient Group Direction). In this second phase, there have been 292 further clients, of which 151 had CO-validated quits at 4 weeks. This is equivalent to a 52% quit rate (varying from 23% to 80% per pharmacy) at a cost per quit of £368 including NRT (£80 without). Client feedback remains universally positive.

Jason highlighted the value of starting small with engaged pharmacies, using technicians to ensure service continuity and ease workload, and the need to engage with local GP practices to ensure local referral routes. Partnership working had been vital, with support from Pfizer, GSK and McNeil helping with equipment, product samples, educational materials, media coverage and support. The considerable variation in pharmacy performance reflected the number of clients, the experience and personality of pharmacy staff, the availability of a technician or second pharmacist and their existing workload.

The service is highly cost effective as only time spent actually delivering the service is paid for. There has been a reduction in NRT prescribing of up to 76% (especially in areas where local referral occurs). While the service was paying for NRT which clients had previously purchased themselves, it was probably achieving a greater quit rate. There was an increased use of dual NRT and there were also costs associated with CO monitor use and administrative time processing claims.

Less positive points were that continuity of service was hampered by pharmacists/technicians moving out of area and by lack of full engagement with GP practices in some areas. The biggest challenge was that future funding was not secure.

Primary Care: Maximising QOF and GP Engagement

Gay Sutherland, Specialist Smokers Clinic, South London & Maudsley NHS Foundation Trust



Gay began by saying that in order to achieve the ambitious targets on quitting smoking set out in the Wales Tobacco Control Plan, two routes need to be taken: first, many more smokers need to make quit attempts and, second, the actual success rates of those attempts needs to be raised.

In tackling the first, GPs have a vital role in motivating smokers to make a quit attempt. Advice from a doctor is one of the most important triggers to a quit attempt. There are ample opportunities for a very brief

intervention to be made during routine GP consultations as smokers see their GP approximately five times a year. More than nine out of ten GPs believe helping a smoker to stop is one of the most important things they can do for their patients' health. Unfortunately, GPs feel they lack the time and skills and are doubtful as to their effectiveness. Some "GP Champions" need to be identified to help address these myths among their colleagues.

Most smokers want to and intend to quit at some time. Recent research on smoking motivation shows it to be very labile, changing hour by hour, and most smokers make the decision to quit suddenly ("like a switch"). Far fewer plan their quit attempt days or weeks in advance and, perhaps surprisingly, unplanned attempts are associated with higher quit rates.

In the past, QOF awarded points for asking and advising smokers to stop but this has been added to recently to reflect the research showing that offering smokers support and treatment straight away spurs quit attempts that would not otherwise have happened. Being offered treatment, even to those smokers not thinking about making an immediate quit attempt, stimulates many to do so.

Fortunately concerns that GPs have about insufficient time could be allayed if they used the effective very brief intervention, as demonstrated on the NCSCT website¹, which can be done in a minute or so.

When the NHS Stop Smoking Services were initially set up in England, the support to smokers trying to quit was offered only by “core” clinics in each region. This support was often in group format. However, it became apparent that (1) not all smokers wanted to be referred to an outside agency, as many wanted support from healthcare staff they knew in primary care; (2) waiting lists built up so smokers failed to attend for treatment having lost their motivation in the meantime; (3) many smokers could not attend appointments during the day and preferred to be seen in a pharmacy with longer opening hours; (4) groups were not popular with smokers.

To address some of these issues and reduce waiting lists, GPs have been encouraged to undertake smoking cessation in their practice with practice nurses or healthcare assistants providing the support. Furthermore, many PCTs in England have set targets for GP practices to refer to the Stop Smoking Services and/or paid surgeries for each successful quitter they produce. Smoking cessation offered by pharmacists is also now very widespread. Though highly effective, group treatment is not used as often now in England.

The second route to achieving more quitters is to increase quit rates. NICE Guidance on the use of pharmacotherapy needs to be adhered to in order to obtain the best quit rates. The NHS stop smoking service’s Monitoring and Guidance document supports NICE and specifies that NRT, bupropion and varenicline are all offered first line so as to ensure smokers have choice and equal access to all effective and highly cost-effective medications. If smokers have to first try to quit with a medication that they do not have faith in, they will not quit smoking and a motivated quit attempt has been wasted. It is essential to allow smokers informed choice of medication, subject of course, to individual medical suitability as this improves adherence and quit rates.

¹ <http://www.ncsct.co.uk/>

Secondary Care smoking cessation service

Helen Poole, secondary care smoking cessation specialist, Cardiff and Vale UHB

Helen explained that Llandough Hospital was the first ever Secondary Care Smoking Cessation Service set up over 20 years ago. Dr Ian Campbell, Respiratory Consultant, realised through various research projects that offering intensive psychological support increased smoking cessation quit rates.

Key points about the service are:

- The service presently has 1½ counsellors.
- Over 750 patients are referred to the service every year.
- 1 month CO-validated results approximately 58%.
- 1 year CO-validated results approximately 33%



Helen set out why smoking cessation support should be made available in secondary care. She told participants that 70% of total NHS expenditure is on secondary care² and that currently 27,700 hospital admissions each year in Wales are due to smoking. Currently 70% of smokers in hospital say they want to stop and 65% of smokers attending chest clinic would prefer support based wholly or partly in secondary care.

Helen also said that research shows that long-term cessation increases amongst people who have been admitted and supported to quit smoking while in hospital, especially if they are admitted with a smoking related disease. Often patients are more open to help at a time of perceived vulnerability during their hospital stay. In addition, in-patients is a place where smoking is restricted and pharmacological and psychological help is readily available.

The Secondary Care Smoking Cessation Programme involves:

² Ashwales.org

- An initial counselling session (approximately 60 minutes)
- Weekly sessions x 4 (approximately 30 minutes each)
- Support literature.
- Cessation validated at one month by expired air CO measurement.
- An open door policy offering tailored support to the patient.

Helen outlined current challenges facing the programme. These include increasing referral rates, ensuring that all smokers (in particular pre-operative patients) who enter the hospital are offered smoking cessation support, and improving the attendance of pre-operative patients (“only in for one day - no need to quit”). As part of this she is undertaking a mini-survey with all the DNAs. She also stressed the need to offer more in-depth counselling at initial contact on the telephone, and the need to improve the smoking cessation pathway to ensure on-going face to face contact continues on discharge. This includes accessing primary care services and working with Public Health Wales.

Helen’s thoughts summing up were that not all smokers are created equal – each one is unique! All services (i.e. in addition to secondary care services) offer their own tailored support programmes – it is important that all smoking cessation providers start working together to support and promote all the options (as long as providers have received adequate training).

Helen noted that there are currently great successes but they are potentially overlooked as no data is collated. Organisations need to work together ensure that all maintain basic information (e.g. numbers referred, total seen once, total who entered programme, plus 1 month and 1 year successes, preferably CO validated).

She concluded by saying that if you increase the options and types of support available there is potentially an increase in the range of smokers reached and therefore a greater need to offer a more tailored support package to the individual. You can also increase the number of quitters and lives saved.

Antenatal Specialist Clinics for Pregnant Smokers

Lisa Fendall, National Trainer in Smoking Cessation



Lisa advised participants on how best to integrate stop-smoking services into routine antenatal care. Lisa drew upon her 12 years of experience in developing and delivering successful stop-smoking programmes to pregnant women, in particular an exciting, new model she devised for Rotherham's Ante Natal Service.

Lisa firstly explained the particular challenges healthcare professionals face in reducing smoking prevalence amongst this key group, which have proved intractable for some.

Midwives are reluctant to bring up the thorny issue of smoking with those they build up close relationships with throughout the pregnancy for fear of damaging it. This was an issue which resonated strongly with a couple of the participants, who agreed that mothers-to-be could become defensive in tone. Lisa added that many mothers in Rotherham suffered from low self-esteem and confidence and feared being judged. Additionally, in Lisa's experience, midwives felt the duty of responsibility fell on GPs who provide traditional smoking cessation services.

Further, conventional approaches to this sub-group whereby referrals are made to clinics proved unworkable, especially for deprived groups. For many, the cost and inconvenience of commuting to clinics, often unaccompanied by partners and in the company of infants, was simply a hurdle too large.

Lisa then went on to describe the Rotherham model, showcased on the BBC documentary *Misbehaving Mums-To-Be*, which sought to take a different view of smoking cessation. Underpinning the success of the model was developing a referral

pathway premised upon treating smoking as a potentially life-threatening medical condition, much in the same way as diabetes.

Lisa emphasised the importance of midwives in diagnosis and referral. She explained that, as a specialist health professional and the main point of contact throughout the pregnancy, it made perfect sense to give midwives master-class training to equip them with the knowledge and skills to sensitively approach mothers-to-be about smoking cessation.

The referral pathway itself is embedded firmly in routine anti-natal work, where all pregnant women are approached as they arrive. Rather than rely on self-reporting, detectors were used to screen all pregnant women. Once 'diagnosed', mothers-to-be were exposed to hard-hitting facts and graphics. One small, but significant, innovation was a 48-hour opt-out referral process, whereby midwives automatically referred every smoking pregnant woman within 48 hours to smoking cessation services unless asked not to. Crucially, homecare visits by midwives followed throughout the course of the pregnancy, engaging the family (a key issue flagged by one participant), and continuing after birth when 70% of mothers are likely to relapse. A dual-therapy approach, with the use of pharmacotherapy, was explained to be the most efficacious.

How successful had the model been? The infant mortality rate dropped from 6.7 to 4.4 and the smoking prevalence rate at time of delivery plunged from 27.3 per cent to 19.7 per cent, both over the course of 18 months.

Asked was this simply the result of one charismatic midwife in Rotherham, Lisa responded that ultimately redesigning a targeted referral pathway that makes it as easy as possible for mothers-to-be to receive assistance was of key importance.

Panel Discussion

Chair: Dr Tony Jewell, Chief Medical Officer

The presentations were followed by a very lively discussion, chaired by Dr Tony Jewell.

Key themes were identified by delegates as follows:

1. Choice

It was clear from the range of presentations that a range of different approaches to quitting smoking were required in order to meet the needs of different groups of people. Whether they were pregnant women, people in rural communities or people in hospital, it was clear that one size does not fit all in terms of either the type of treatment offered or the support provided.

2. Rapid response

A number of delegates commented that the examples of work in ante-natal clinics, GP practices and secondary care had all involved a rapid and pro-active approach to smoking cessation. Help was offered immediately and positively as soon as the smoker expressed an interest in quitting – there was no question of testing the smokers' motivation to quit or joining waiting lists for support groups.

3. Clear pathway

In all the examples that had been discussed, there was a clear pathway for would-be quitters – it was clear where they could ask for help, what help was available, and how they could access pharmacotherapy or NRT. Some delegates felt this compared unfavourably with approaches in Wales where the pathway was unclear and means of accessing therapies could be convoluted.

4. Reaching lower socio-economic groups

Delegates agreed that the Welsh Government's target would not be reached unless the very high smoking prevalence rates amongst disadvantaged groups were reduced. Given that lower socio-economic groups appeared to find group-based behavioural support unappealing, this was a considerable challenge for the NHS in Wales. More needed to be known about the attitudes and behaviours of this group / groups of people so that services could be redesigned accordingly.



Appendix 1 Programme

Time	Session
9am	Registration
9.30am	Taking forward local action plans <i>Dr. Peter Bradley, Public Health Wales</i>
9.45am	An overview of the findings from the IMS report 'Evaluating smoking cessation policy & practice across the U.K.' <i>Henry Burkitt, Pfizer Ltd.</i>
10.00am	Difficult to reach sub groups – new evidence specific to Wales <i>Victoria Winckler, Bevan Foundation</i>
10.30am	Smoking in Wales – Using data to improve outcomes <i>William Beer, Aneurin Bevan LHB & Public Health Wales</i>
11.00am	Break
11.15am	Bite sized good practice sessions:
	1. Pharmacy Smoking Cessation Services <i>Jason Carroll, Powys LHB</i>
	2. Secondary Care Smoking Cessation Services <i>Helen Poole, Cardiff and Vale UHB</i>
	3. Antenatal Specialist Clinics for Pregnant Smokers <i>Lisa Fendall, Rotherham Ante Natal Service</i>
	4. Primary Care: Maximising QOF and GP engagement <i>Gay Sutherland, Maudsley Hospital Smoking Cessation Clinic</i>
12.15pm	Plenary Panel Discussion <i>Chaired by Dr Tony Jewell, Chief Medical Officer</i>
12.45pm	Conclusions <i>Victoria Winckler, Bevan Foundation</i>
1pm	Lunch and close

Appendix 2 Speaker Biographies

William Beer

Will Beer started work in Health Promotion in 1998 and was employed as a Project Officer for Cardiff Community Health Care NHS Trust. He then secured a permanent position in the Local Public Health Team in Rhondda Cynon Taff leading on the Inequalities in Health funded programmes. Will was then seconded to Blaenau Gwent Public Health Team as the Principal Health Promotion Specialist before joining Aneurin Bevan Gwent Public Health Team in his current role. During this time he has completed a Masters Degree in Public Health and Top Up Training which will help him to access the UK Public Health Register as a Public Health Specialist. Will is interested in local politics and is actively involved in his community. He has set up and been involved with a number of environmental projects and is an member of the Abergavenny Civic Society.

Dr Peter Bradley

Peter Bradley has been Director of Public Health Development for Public Health Wales since November 2011. Before this, he was Director of Public Health in Suffolk for many years working for NHS Suffolk and Suffolk County Council.

Peter was one of the founders of the award-winning Healthy Ambitions Suffolk programme which saw health inequalities reduce in the county. Prior to this he has worked in academia internationally.

Peter worked for 5 years in Norway where he led the equivalent of NICE in Norway, worked for the National Prioritisation Council, completed a PhD on medical education and led a project to encourage evidence-based public health. Before this he worked in and led an international project to promote evidence-based practice and critical appraisal (CASP International). Before this he worked for several years as doctor in the NHS – in general practice and child health.

Henry Burkitt

Henry Burkitt is a political consultant and a specialist in healthcare public affairs.

Henry began his career as a Research Assistant to the Conservative MP Alan Duncan. He subsequently became Parliamentary Researcher to David Davis MP during the period he was Conservative Party Chairman and Shadow Deputy Prime Minister.

Henry left the Houses of Parliament to join the public affairs consultancy AS Biss & Co. Over a five year tenure Henry led client service teams for well known public and private sector organisations, including pharmaceutical companies, health charities and NHS bodies. In 2008 Henry was hired by the Swiss pharmaceutical company Novartis to lead government affairs and policy for the UK business.

In 2011 Henry founded Burkitt Communications and became an independent professional political consultant. He currently advises Pfizer on government affairs activity for primary care and oncology.

Jason Carroll

Born in Merthyr Tydfil in 1972, Jason was fortunate enough to escape the mines and complete his comprehensive education. A degree in pharmacy from Bath opened the doors to 12 happy years as a community pharmacist and Jason is currently enjoying his role within the Medicines Management team at Powys Teaching Health Board. He believes that community pharmacy has a vital role to play in improving the health of the population, yet remains under-utilised by the NHS. Surprisingly, Jason is married with two children and now lives near Swansea, where he enjoys eating, drinking and watching TV.

Lisa Fendall

Lisa is a Registered Nurse and Midwife, an experienced practitioner in smoking cessation with 11 years' experience as a Specialist Midwife and 4 years' experience as a National Trainer. As a Clinician she has supported services in South Yorkshire to develop and implement strategies to tackle smoking in pregnancy and address health inequalities.

Lisa has worked closely with the media, TV and Radio, filming in 2011 a BBC Documentary, *Misbehaving Mums to Be* as part of the *Bringing Up Britain* Series. Her idea to develop the Pregnancy Software used on the programme is now being used by many services in the Country. She also supported the NICE Topic Specific Advisory Group to review and advise on the content of the commissioning guide for quitting smoking in pregnancy 2010.

Lisa is involved in various stop smoking strategies, supporting the NHS with her experience and knowledge and delivering training within the UK to help develop services for smokers, pregnant women and their families, tackling health inequalities as a priority. Lisa developed a new model of 'Integrating A Clinical Model of Smoking Cessation Into Routine Antenatal Care' and this was published in the *British Midwifery Journal*, April, 2012. Lisa also works with the National Centre for Smoking Cessation Training (NCSCT) to deliver the training programme to health professionals across the country.

Dr. Tony Jewell

Dr Tony Jewell has been Chief Medical Officer Wales for 5 years. Prior to this he was Clinical Director and Director of Public Health for Norfolk, Suffolk and Cambridgeshire Strategic Health Authority. Dr Jewell trained as a GP and worked in East London for 10 years. He then trained in public health medicine in East Anglia becoming a Director of Public Health in Peterborough and Cambridgeshire before being appointed to the Strategic Health Authority. His professional interests include primary care, preventing accidents and injuries and reducing health inequalities.

Helen Poole

Since October 2001, Helen Poole has been employed as a smoking cessation counsellor at the University Hospital of Wales, Cardiff, having been employed within the NHS for the past 16 years. She offers smoking cessation help and support to in-patients and family members, out-patients and family members, parents of paediatric patients and staff and family members. She has obtained a BA degree in Business Studies and a Masters in Counselling. Prior to this job she worked as a counsellor in the University Of Wales Institute Of Cardiff, alongside her work in the NHS. She is currently a Board Member of ASH Wales.

Gay Sutherland (BA. MPhil. C.Psychol)

Gay is a Research Psychologist at the Institute of Psychiatry, Tobacco Research Unit, King's College London University & Honorary Consultant Clinical Psychologist at the Specialist Smokers' Clinic, South London & Maudsley NHS Foundation Trust. The clinic, has a >45 year history, making it the longest-standing smokers' clinic in the UK. It was highlighted in the Government White Paper "Smoking Kills", receiving a Beacon Award from the Minister of Health in recognition of its evidence-based treatment approach.

She has specialized in treating and researching nicotine addiction for over 28 years. In recent years she has been involved in the implementation of the plans set out in the White Paper, "Smoking Kills", including training several thousand healthcare staff across the UK and internationally, in smoking cessation methods.

Gay has also been involved in a range of research studies on nicotine addiction and treatment including studies on pharmacotherapy, and an invited external advisor to NICE appraisal on smoking cessation medications.

She is Past President of the Society for Research on Nicotine and Tobacco Europe, a Trustee of the national charity – QUIT, and a Training Partner for the UK Department of Health "National Centre for Smoking Cessation & Training".

Victoria Winckler

Victoria is director of the Bevan Foundation, an independent think-tank that seeks solutions to poverty, inequality and injustice through quality research and informed debate.

Victoria joined the Bevan Foundation in 2002 having previously been Head of Economic and Environmental Affairs at the Welsh Local Government Association and Head of Policy, Research and European Affairs at Mid Glamorgan County Council.

Victoria's main interests and expertise are in poverty, inequality and regeneration of disadvantaged areas, on which she writes extensively and frequently comments in the Welsh and UK media. She has given evidence to numerous parliamentary and National Assembly for Wales committees and is currently an adviser to Joseph Rowntree Foundation's UK anti-poverty work. She was previously a non-executive director of Cwm Taf NHS Trust and a board member of the Wales Council for Voluntary Action.