Tobacco control strategy for Wales and delivery plan

Consultations Questions

Question 1
It is our ambition to become a smoke-free Wales by 2030 (smoke-free means that 5% or less of adults in Wales smoke). All our actions over the next 8 years will work towards and contribute to achieving this.

Do you agree with our ambition of Wales becoming smoke-free by 2030?

Yes

Please explain why our ambition is right or how our ambition would need to change if you think a different approach is needed.

SPECTRUM is a research consortium of academic, policy and advocacy partners working together to generate new evidence to inform the prevention of non-communicable diseases (NCDs). SPECTRUM provides a unique overview of NCD prevention strategies including action on price, availability and marketing of tobacco, alcohol and unhealthy food products and industry influence on health policy. SPECTRUM investigates the conduct and influence Unhealthy Commodity Industries (UCIs) have in driving unhealthy consumption, builds understanding of the systems that perpetuate those drivers, and supports the prioritisation of political, social and other measures to prevent harm to health and reduce the social health gradient. We have no links either directly or indirectly to the tobacco industry. We suggest that in the review of responses to this consultation, the Welsh Government reflects on whether respondents may have a conflict of interest. We recommend the inclusion of a request to declare potential conflicts in order to comply with the obligation to protect the development of public health policy from the vested interests of the tobacco industry as outlined in Article 5.3 of the World Health Organization Framework Convention on Tobacco Control (FCTC)[1].

The ambition for Wales to become smoke-free, that is to reduce the prevalence rate to 5% or less by 2030 (10 years before the European Union aims to achieve the prevalence rate[2]) is a laudable aim, supported by almost two-thirds of the general public who also endorse government action to deliver it[3].

As in other parts of the UK, it is well known and understood that tobacco use continues to be the biggest preventable cause of cancer and death in Wales. Although smoking

[1] WHO Framework Convention on Tobacco Control: Microsoft Word - WHO-FCTC-English-FOR PRINTING_FINAL.doc
[2] European Commission. Communication from the commission to the European Parliament and the council Europe's beating cancer plan. 3 February 2021. eu_cancer-plan_en_0.pdf (europa.eu)
[3] YouGov Survey 2021: yougov-survey-report-2021pdf.pdf (ash.wales)

prevalence is reducing in Wales, 20% of adults aged 16+ smoke[4]. According to the YouGov/ASH Wales[3] survey in 2021, 43% of respondents (including 19% of current smokers) felt that the Government was not taking sufficient action to reduce smoking.

The ambition to be smoke free by 2030 can only be realized if there is recognition of the role inequalities and disparities play in driving tobacco use. Supporting, expanding and/or implementing new evidence-based interventions to reduce prevalence levels within priority groups will increase the likelihood of a smoke-free society becoming the norm. Although smoking rates have declined significantly over the last 50 years, smoking-related inequalities have increased - for example, those in the most deprived areas of Wales are twice as likely to smoke than those in the least deprived areas[4].

Whilst the ambition is right, the Plan as currently outlined includes many explore and review actions for the period 2022-2024 which are potentially unlikely to translate into solid action and increased quitting. It also lacks details and specific targets. The recent All Party Parliamentary Group on Smoking and Health report, Delivering a Smokefree 2030, reported that modelling of smoking prevalence in England indicates that current tobacco control measures will not achieve a target smoking prevalence of less than 5% by 2030 and that people living in the most deprived socio-economic conditions are likely to lag far behind the 2030 target[5]. This indicates that additional measures will be needed to achieve the 5% target overall, and low socio-economic status groups will need to be specifically targeted. Similar modelling for Wales is recommended prior to implementation of the Tobacco Control Plan to ensure the ambition is realistic and achievable.

Remaining connected to the evidence and approaches at both devolved and UK levels, as outlined in Priority Action Area 5, will be beneficial – such as following the evidence and recommendations of the independent review of smoking and the smokefree ambition in England. The review is currently underway and due to be published later this year.

Question 2
The strategy sets out three themes under which we will work as we drive forward the changes in smoking in Wales:

Theme 1: Reducing Inequalities
Theme 2: Future Generations
Theme 3: A Whole-System Approach for a Smoke-Free Wales

Do you agree that these are the right themes to focus the strategy around?

Yes

Please explain why you consider the themes are right or if you think a different approach is needed.

[4] Public Health Wales NHS Trust: Smoking in Wales: /tmp/RtmpLN62xY/20190902_SmokingInWales_Phase3_ML_v0i.utf8.md (shinyapps.io)
[5] Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021: APPGTCP2021.pdf (ash.org.uk)

All three themes are interconnected and appropriate foci for a strategy designed to drive change. They should be clearly underpinned by Article 5.3 of the World Health Organization Framework Convention on Tobacco Control (FCTC) and its implementation guidelines[6]. To achieve a smoking prevalence of 5% or less within the next eight years, a major focus needs to be on helping current adult smokers to stop.

Theme 1: Smoking is an individual health behaviour which has the largest impact on health inequalities[7]. Disadvantages such as poor education, insecure employment and poor housing are known to affect the same people and as such can have adverse, and lifelong accumulating, effects on health. There is clear evidence that the more disadvantaged a person is, the more likely they are to smoke and the less likely they are to quit. Although smoking rates have declined significantly over the last 50 years, smoking-related inequalities have increased: for example, those in the most deprived areas of Wales are twice as likely to smoke than those in the least deprived areas[4]. The ambition to be smoke free by 2030 can only be realized if there is recognition of the role that inequalities and disparities play in driving tobacco use. Supporting, expanding and/or implementing new evidence-based interventions to reduce prevalence levels within priority groups will increase the likelihood of a smoke-free society becoming the norm. The reducing inequalities theme is extremely important, however actions formulated appear vague. It is not clear what smoking cessation support will be provided to smokers - based on the best available evidence, this should include behavioural support, medication and e-cigarettes. Consideration of all types of inequalities is important – often the focus is placed on low socio-economic status groups, however those with a mental health condition for example should also be a priority[8].

Theme 2: Although, across the UK generally, youth smoking prevalence rates have declined in the last 10+ years, youth smoking rates have remained at the same approximate level since 2013/14[8]. The smoking prevalence rate average amongst adolescents in Wales similarly remains steady at around 4%. The prevalence rates increase with age with 9% of year 11 pupils reporting to be a smoker. Analyses also shows that smoking prevalence in adolescents decreases as family affluence rises[9]. In order to facilitate a smoke-free norm for future generations, further reduction of the number of young people who currently smoke is important. Those who are growing up in communities where smoking is an everyday occurrence routinely experience exposure to second-hand smoke, are highly likely to become smokers in the future and therefore continues the cycle of adults modelling smoking as a norm to others[10]. However, it should be acknowledged that preventing uptake among children can only have a limited effect

[6] Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control: https://www.who.int/fctc/guidelines/article_5_3.pdf?ua=1
[7] Marmot M, Wilkinson RG editors. Social determinants of health 2nd edition. Oxford: Oxford University Press
[8] Social determinants of health. The solid facts (who.int) edited by Wilkinson R and Marmot M
[9] Student Health and Wellbeing In Wales: Report of the 2017/18 Health Behaviour in School-aged Children Survey and School Health Research Network Student Health and Wellbeing Survey: SHRN-HBSC-NR_31.05.2019.pdf
[10] Inequalities in smoking and quitting-related outcomes among adults with and without children in the household 2013-2019: A population survey in England. *Nicotine & Tobacco Research*. doi.org/10.1093/ntr/ntab211

due to the much smaller number of people becoming adults in the next few years compared with the number of existing adults. A two-pronged approach of preventing uptake of smoking in younger people whilst providing cessation support to those already smoking (including adult smokers) will, over time, break this cycle.

Theme 3: A whole-system approach to tobacco control to achieve a smoke-free environment is key to progress and in reality could be viewed as the base from which the other themes will be addressed. However the system must be clearly outlined and other social determinants must be considered in addition to the relationships with other commercial determinants and risk behaviours (for example alcohol consumption). It will be important to consider and specifically identify the various stakeholders whilst recognising those that may have a conflict of interest.

Question 3
Whilst we have established that it is our ambition to achieve a smoke-free Wales by 2030, we have not set milestone smoking prevalence targets in our strategy or set a smoking prevalence rate that we will look to achieve by the end of the first delivery plan. However, our aim is for a step-wise reduction in smoking prevalence over the next 8 years. We will use the following data sources to monitoring smoking rates in Wales:

- National Survey for Wales which provides data on smoking in Wales and provides a smoking prevalence rate. Student Health and Wellbeing in Wales survey for smoking and vaping behaviours in young people aged 11-16.
- Maternity and birth statistics for maternal smoking rates.

Do you feel this is the right approach?
Partly

National Survey and Student Health and Wellbeing will both miss people who do not have a fixed address, or who are currently in institutions including mental health hospitals or prisons. We know that smoking prevalence is higher among people with mental health problems and that it increases with severity of the mental health problem. In people hospitalised because of schizophrenia, smoking prevalence reaches over 80%[11]. In people who are experiencing homelessness, smoking prevalence is estimated to be 60% to 80%[12].

While national surveys give an indication of smoking prevalence in people living in households, they omit groups with the highest smoking prevalence and will not allow monitoring of effectiveness in these underserved populations.

[11] Leonard, S., Mexal, S., & Freedman, R. (2007). Smoking, Genetics and Schizophrenia: Evidence for Self Medication. Journal of dual diagnosis, 3(3-4), 43–59. doi.org/10.1300/J374v03n03_05
[12] Soar, K., Dawkins, L., Robson, D., & Cox, S. (2020). Smoking amongst adults experiencing homelessness: A systematic review of prevalence rates, interventions and the barriers and facilitators to quitting and staying quit. Journal of Smoking Cessation, 15(2), 94-108. doi:10.1017/jsc.2020.11

Question 4
Are there any other data sources that should be used to monitor the success of the strategy and delivery plan? If so, what would they be?

Please provide additional comments

The Smoking Toolkit Study is well established representative population survey that has been running for a number of years in England. In 2021, through the SPECTRUM Consortium, the team at UCL expanded its remit to include Wales[13] and Scotland. Data from each nation is refreshed monthly and is available online, allowing researchers, policymakers, and members of the public to closely track headline tobacco trends and monitor the impact of different policies and approaches across devolved nations. As the data is refreshed frequently, it can be used as an indicator of changes to the smoking rates and the annual findings provide an overview of public support for a range of tobacco control policies. Moreover, questions can be added on short notice to interrogate issues that are of interest to policymakers and the public. The STS has recently reported data showing broad support in Wales for a number of existing and potential tobacco control policies (www.smokinginwales.info/graphs/annual-findings).

Tobacco industry monitoring sources such as Tobacco Tactics[14] and the United Kingdom Tobacco Industry Interference Index (UKTI) are good sources of data to monitor tobacco industry influence and commitment to WHO FCTC Article 5.3.

Information on public opinion in Wales relating to tobacco control is collected by ASH Wales Cymru annually in conjunction with YouGov[4]. This survey collects data related to attitudes to smoking in Wales, levels of public support for Welsh and UK Government action in addition to opinions related to policy measures such as raising the age of sale or introducing a tobacco levy.

Primary care data includes information on smoking status and mental health which is not routinely analysed. This would be a valuable source of information if incorporated.

Information on smoking in hospitals, prisons and among people experiencing homelessness is necessary and as there are no existing obvious data sets capturing such information, improved recording of tobacco use amongst these groups should be an action for this plan.

Question 5
To support delivery of the strategy it is our intention to publish a series of two-year delivery plans. Do you agree that we organise our actions into two-year delivery plans?

Partly

Please explain why the structure works well or outline how it could be made better.

[13] The Smoking Toolkit Study: Smoking in Wales
[14] Tobacco Tactics: www.tobaccotactics.org

Regular review and proactive adjustment of plans will ensure the highest likelihood of success. Trends may fluctuate and it will be important to review retrospectively, not only the preceding two years, but trends going back to April 2022 in years 4, 6 and 8. The plans should have very specific goals, and be designed to fit into an overarching framework covering the whole period of the strategy, to ensure that they are not fragmented and to show how they will contribute to the overarching goals of the strategy.

Question 6
In the first two-year delivery plan, which covers April 2022 – March 2024, we have grouped the actions we will take into five priority action areas:

Priority Action Area 1: Smoke-Free environments
Priority Action Area 2: Continuous improvement and supporting innovation
Priority Action Area 3: Priority groups
Priority Action Area 4: Tackle illegal tobacco and the tobacco control legal framework
Priority Action Area 5: Working across the UK

Do you agree that these are the right priority action areas to focus the 2022-2024 delivery plan around?

Partly]

Please explain why you consider the priority action areas are right or if you think a different approach is needed.

In principle these seem appropriate, but are broad areas; given that the delivery plans only cover a two year period, they will need to be very specific from the outset in order to achieve the desired impact. There will be overlap between each of the priority areas and it is important that they are not addressed in isolation e.g. focussing on priority groups will require improvement and innovation in relation to smoking cessation services. Tackling illicit tobacco (PAA34) is a priority for reducing prevalence in low SES groups and in young people (PAA3), and requires multi-agency working (PAA5).

Much progress has been made to date with respect to smoke-free environments. The 2007 ban on smoking in public places[15] drove a marked increase in adoption of smoke free homes. In England, 93% of children reported to live in a smoke free home in 2018 – an increase of 30% since 1998. This increase was significant, with an increase from 17% in 1998 to 76% in 2018[16], where children had at least one parent who smoked at home. In March 2021, Public Health (Wales) Act 2017 and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 came into force and extended the smoke-free regulations to more places and settings within Wales[11]. Therefore, it may be prudent to reduce the priority areas to four and consider approaches that may have a more significant impact on

[15] Smoke-free law: guidance on the changes from March 2021 [HTML] | GOV.WALES
[16] Children's exposure to second-hand smoke 10 years on from smoke-free legislation in England: Cotinine data from the Health Survey for England 1998-2018 - PubMed (nih.gov)

the progress towards the smoke-free goal of 2030.

Whilst priority action area 2 has a focus on innovation, the former part of the action (to focus on continuing improvement) is important. The evidence base in tobacco control, how to motivate people to stop smoking and how to support attempts at smoking cessation is strong, so it is more important to implement the existing evidence rather than spend additional time exploring areas again. As such, better implementation, support and actions using methods and tools that have been previously shown to lead to successful quitting (such as behavioural support, medication and e-cigarettes for cessation support purposes) is vital. A potential gap is the lack of reference to the utilization of mass media campaigns which could drive more people to seek support from cessation services.

All of these priority areas will need to be adequately resourced – e.g. implementation of innovative interventions and tackling illicit tobacco are likely to require significant up-front investment; however, effective interventions are likely to be highly cost-effective. A World Bank report[17] published in 2019 provided a case study on tackling illicit trade in the UK. It found that "*The UK experience demonstrates that the illicit tobacco trade can be addressed effectively even in the presence of high tobacco taxes. The overarching approach of focusing on supply-side measures has proved successful, although demand side measures may also be appropriate where there is cultural acceptance of illicit tobacco and/or a lack of awareness of its implications. The fundamental components of an illicit tobacco strategy are improved detection and enforcement and penalties for those involved. While some technology – such as x-ray scanners and anti-counterfeiting technology – is required, investment in human resources is essential in developing intelligence, detecting illicit products, and undertaking criminal investigations.*"

Question 7
We have developed a number of actions within each priority action area. Do you feel these are the right ones?

Partly

Please explain why the actions are right or how they can be improved.

Health measures and strategies to control tobacco must be developed independently of the tobacco industry and in full compliance of Article 5.3 of the FCTC. Each Priority Action Area should include an action to review compliance with Article 5.3.

Many actions use terms such as 'explore' or 'understand'. The evidence base in tobacco control, how to motivate people to stop smoking and how to support attempts at smoking cessation is strong, so it is more important to implement the existing evidence rather than spend additional time exploring areas again. This is particularly striking in the section on

[17] World Bank. Confronting Illicit Tobacco Trade: A Global Review of Country Experiences. 2019. Available from https://www.worldbank.org/en/topic/tobacco/publication/confronting-illicit-tobacco-trade-a-global-review-ofcountry-experiences

priority groups. There is only really one action which is ensuring referrals of pregnant smokers to smoking cessation services.

It should be clarified which products will be included in which action. The harm of smoking is due to the combustion of tobacco and while it is important to regulate other nicotine products, a differentiation between products is likely more helpful to achieving the ambition.

Much progress has been made to date with respect to smoke-free environments (see previous question) and as such this is not considered to be a high priority for impact and attainment of the smoke-free 2030 goal.

With 5.4% of adolescents[4] from low affluence families identifying as smokers, in order to ensure a smoke-free norm for children we recommend the inclusion of targets for the reduction of smoking rates in young people. The absence of a strategy to tackle smoking in adolescents, who will become adult smokers by 2030, is a gap which must be filled. It is vital that the Welsh Government is aware of attempts by the tobacco industry to recruit younger smokers through front groups or corporate social responsibility activities. The Tobacco Control Research Group at the University of Bath have extensive experience and data which can assist with the identification of such front groups via their Tobacco Tactics website[14].

Actions to consider include supporting a UK-wide move to raise the age-of-sale from 18 to 21. This was reported to be supported by 54% of 18-24 year olds (and 63% of adults) and could reduce the number of smokers aged 18-20 by almost one third with the added bonus of a predicted associated cumulative reduction over time[5].

Provision of financial incentives for pregnant women to quit has proven to be a motivational tool for pregnant women and, as part of a comprehensive quit support package, is the only intervention which has impacted smoking rates in pregnancy in recent times as shown in Glasgow, Manchester and the North East[18]. Further research in Scotland found that those receiving financial incentives were more than twice as likely to succeed in quitting[19].

Investment to reinstate funding of mass media campaigns and stop smoking services to previous levels - which includes campaigns and services tailored to the needs of those with mental health issues – is recommended. A population-level study on motivation to quit by Brose *et al* established that almost one-third of past-year-smokers had experienced mental health problems and 60% had undergone treatment thus indicating an ongoing issue[20]. It is known that individuals with mental health problems are more likely to

[18] Evidence into Practice: Supporting smokefree pregnancies thorugh incentive schemes. Smoking in pregnancy challenge group. https://smokefreeaction.org.uk/wp-content/uploads/2019/10/2019-Challenge-Group-Incentives-Briefing_v4-FINAL.pdf

[19] Financial incentives for smoking cessation in pregnancy: randomised controlled trial | The BMJ

[20] Brose LS, Brown J, Robson D, McNeill A. Mental health, smoking, harm reduction and quit attempts - a population survey in England. BMC Public Health. 2020 Aug 14;20(1):1237. doi: 10.1186/s12889-020-09308-x. PMID: 32795286; PMCID: PMC7427923.

attempt to quit because of health problems and are more likely to use medication and behavioural support than those without mental health issues[21].

Whilst recognising the role of organised crime in the distribution and profiteering related to illegal tobacco, it is important to also recognise an estimated 60-70% of the illicit market[22,23] is comprised of products that have been manufactured legally and subsequently entered the illegal market from a legal supply chain. Such an occurrence does not impact industry significantly since they gain profit from both legal and illegal sales. Cheaper products encourage smokers to continue to smoke and can circumvent tobacco control measures such as age restrictions and labelling/packaging laws. It is essential that action is taken to review measures to ensure that tobacco companies operate supply chains responsibly or face sanctions if they cannot. Action 5 to review tools available in Wales overlaps with Priority Action Area 5 in this regard as, for example, reviewing responses to the UK Government's consultation on "Sanctions to tackle tobacco duty evasion" may provide suggestions on potential enforcement tools such as compliance notices and the issuing of financial penalties.

As the UK is Party to the international treaty: the Protocol to Eliminate Illicit Trade in Tobacco Products, which entered into force in 2018, the Government can apply Article 36.7 of that treaty which provides the option to compel the industry to cover costs related to the implementation of the objectives of the protocol, instead of accepting voluntary corporate social responsibility efforts.

Finally, close communication and sharing of experience, knowledge and data across the devolved nations to develop a four-nation approach to tobacco control is encouraged.

Question 8
Do you think there are any key actions not captured in the priority action areas? If so, what would they be?

Please provide additional comments

The United Kingdom Tobacco Industry Interference Index 2021[24] measures how effective the UK implementation of Article 5.3 has been. Whilst the report findings included that the UK compared favourably with other nations, placing third globally, there is more that can be done. Key findings in this report include examples of industry participation in policy development, industry corporate social responsibility activities (particularly promotion of CSR activities via informal parliamentary groups and direct lobbying), unnecessary

[21] Brose, L.S., Brown, J. & McNeill, A. Mental health and smoking cessation—a population survey in England. *BMC Med* 18, 161 (2020). https://doi.org/10.1186/s12916-020-01617-7
[22] Tobacco industry's elaborate attempts to control a global track and trace system and fundamentally undermine the Illicit Trade Protocol | Tobacco Control (bmj.com)
[23] World Customs Organization, Illicit Trade Report 2016
[24] Alebshehy R., Zatoński M., Dance S., Laurence L., Chamberlain P., Gilmore A.B. 2021 UK Tobacco Industry Interference Index, Policy Brief. Tobacco Control Research Group, University of Bath. November 2021.

interactions, lack of transparency around tobacco industry links of third parties engaging with government and no restrictions on the ability of the tobacco industry to make political donations. Additionally, there were no preventative measures in place to provide guidance related to the disclosure and management of interactions with industry nor has there been a significant effort or strategy to raise awareness of Article 5.3 implementation within government departments or devolved administrations. Article 5.3 of the WHO Framework Convention on Tobacco Control should underpin the strategy, priority action areas and associated key actions in the Tobacco Control Plan. Thus incorporating FCTC obligations within the strategy is encouraged in order to avoid and address the issues identified by UKTI.

There should be a plan in place to evaluate the individual delivery plans and the strategy as a whole. As such, the delivery plans should have clear and specific goals. There should also be plans to evaluate specific activities undertaken and there is an opportunity to contribute to the evidence base for a number of measures.

Actions should include how cessation support will be funded, how practitioners will be trained, how to ensure that all smokers have their smoking status recorded, are regularly offered all available cessation support (medication, e-cigarettes) and supported by trained staff to achieve cessation, and actions to increase the reach of cessation support services. Evidence would also appear to support including consumer products such as e-cigarettes as an additional strategy.

Question 9
Do the strategy and delivery plan align with other relevant areas of policy and practice?

Partly

Please explain why it aligns well or outline how it could be made better.

The objective of the World Health Organization Framework Convention on Tobacco Control (FCTC) is to: "*protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke by providing a framework for tobacco control measures to be implemented by the Parties at the national, regional and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke*[1]."

It includes (but is not limited to) measures to reduce the demand for tobacco which includes protection from exposure to tobacco smoke, regulation of tobacco advertising promotion and sponsorship, reduction measures related to tobacco dependence and cessation.

It further outlines restrictions for illicit tobacco, sales of tobacco to minors and the provision of economically viable alternatives. Aligning the Welsh Tobacco Control Plan with the minimum measures outlined in the FCTC is appropriate and important particularly

as a signatory to the Convention. It is essential that the tobacco industry has no role in shaping public health measures for tobacco control and that their responses to this consultation are considered in isolation.

Question 10
We would like to know your views on the effects that *A Smoke-Free Wales: Our long term tobacco control strategy for Wales and Towards a Smoke-Free Wales: Tobacco Control Delivery Plan 2022-2024* would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.

What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

We do not envision any negative impact on the use of the Welsh language specifically.

Question 11
Please also explain how you believe the proposed strategy and delivery plan could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

We do not envision any negative impact on the use of the Welsh language specifically.

Question 12:
We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

The tobacco industry has an inherent conflict of interest related to tobacco control. They are known to exert pressure to subvert policies related to tobacco control, attempting to sow doubt upon scientific research and operating via front groups who represent industry interests. As such, signatories to the World Health Organization Framework Convention on Tobacco Control are obligated to protect public health policy from the vested interests of the tobacco industry. For example, in Scotland, FCTC Article 5.3 has been applied for a number of years and the Scottish Government now requires those taking part in ministerial advisory groups or responding to consultations on tobacco to declare any links to industry.

WHO's FCTC Article 5.3 implementation guidelines state that: "*Parties should require rules for the disclosure or registration of the tobacco industry entities, affiliated organizations and individuals acting on their behalf, including lobbyists*[6]". It is strongly recommended that these guidelines should be adopted by the Welsh Government with respect to any consultations or working groups around tobacco control. In doing so, it will be easier to protect health policies from the influence of the tobacco industry.

As this consultation did not require a declaration of interest some responses may not

declare any such vested interests. We recommend that a review to identify responses with such conflicts be undertaken and those identified be considered together. One means to identify such respondents would be to cross-check the directory held and maintained by University of Bath's Tobacco Control Research Group in addition to the Tobacco Tactics website. Developing and adopting a requirement by respondents to any future consultations to provide a declaration of interest would be recommended.