OXFORDSHIRE COUNTY COUNCIL

SPH Solutions for Public Health

NHS Arden and Greater East Midlands Commissioning Support Unit

Oxfordshire County Council

Smoking and Tobacco Control Health Needs Assessment

February 2025

This HNA was commissioned by Oxfordshire County Council from Solutions for Public Health (SPH), an NHS public health team based in Arden and Greater East Midlands Commissioning Support Unit. SPH are a multidisciplinary, senior team of clinical, public health, research and analytical experts. We work with decision makers across the public and third sectors to improve health and reduce health inequalities. Our work is centred on evidence, health intelligence, assessment of need and evaluation, which we use to understand and promote better health and better value health care. For more information please look at our website www.sph.nhs.uk or contact: agem.sphsolutions@nhs.net

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Executive summary

Tobacco use is the leading cause of death and disability in England, it is also a key driver of health inequalities and results in significant health spending. It is estimated that two in three people who smoke will die as a result of their tobacco use. Smoking remains the leading cause of preventable heart disease, stroke and respiratory illness. In 2019, in England, 74,600 people died from smoking related conditions; 15% of all deaths that year.

Some sections of the population are more likely to smoke than others in England including: people with a mental health condition; those working in routine and manual employment, or those who have never worked and the long-term unemployed; people experiencing homelessness; those in contact with the justice system; people living in social housing; those without educational qualifications; and people who are part of the LGBTQ+ community. In addition, those who smoke during pregnancy are at risk of a range of adverse pregnancy and birth outcomes. The most recent data for England showed that although on average 9% of women smoked at the time of delivery, this varied depending on where people lived.

In 2022/23, in England, smoking rates were estimated at 12% which equals around 5.8 million people. The annual cost to society is estimated at £21.8 billion (B), whereas income from taxes on tobacco products totalled £8.84B.

Reducing smoking rates is a national priority. The previous government published a plan in 2023 that aims to create a SmokeFree generation by 2030 through a comprehensive range of funded interventions supporting people to quit smoking and providing funds to enforcement agencies targeting underage sales and seizure of illegal tobacco. The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) have pledged to help local people who smoke to quit in line with the government's plans. Working with a range of partners, Oxfordshire County Council's Public Health Team have overseen a Tobacco Control Strategy to reduce smoking prevalence and the County Council, all five Oxfordshire district councils and other key partners have signed the smokefree pledge.

What is the current situation with regards to smoking and tobacco control in Oxfordshire?

In Oxfordshire, one in ten adults are estimated to smoke, which is around 61,000 people. It's estimated that 28,500 Oxfordshire children live in smoking households and each year around 880 children start smoking.

The smoking rates in Oxfordshire have been declining over the past ten years, similar to the rates across England and the South East region. Overall Oxfordshire's smoking rate is similar to those of its statistical peers, with variations by District.

Whilst Oxfordshire is a relatively affluent area of England, there are pockets of deprivation. Living in a deprived area is a known risk factor for smoking, with areas of higher deprivation often having higher rates of people who smoke. Oxfordshire residents

in the most deprived quintile were twice as likely to currently smoke than residents from any other area. Higher smoking rates were also reported for certain population groups in Oxfordshire, including people working in skilled manual and semi-skilled/unskilled manual roles, those with long-term health conditions and people admitted to opiate use treatment. Stop smoking services are particularly important for pregnant women; Oxfordshire has consistently had a lower rate of smoking at the time of baby delivery than both the South East region and England.

The impact of smoking on health is measured by smoking related mortality and hospital admissions for conditions largely attributable to smoking. Most lung cancers are directly caused by smoking or occupational exposures. The lung cancer rate in Oxfordshire has been consistently lower than both England and the South East region over the past decade and has declined steadily since 2011-2013, roughly in line with the England trend. Oxfordshire had a lower mortality rate for lung cancer than several of its local authority peers.

Chronic obstructive pulmonary disease (COPD) is primarily a disease related to smoking; nine in ten cases of COPD are associated with cigarette smoking. Oxfordshire has consistently had a lower rate from COPD than both the South East region and England.

The Office for Health Improvement and Disparities (OHID) reported, in their most recent dataset, that over a three year period 2017 to 2019, more than 3,500 hospital admissions were attributable to smoking in Oxfordshire. The health care costs from these hospital admissions plus primary care services were estimated to be £17.5m.

Between 2017 and 2019, there were approximately 1,700 deaths attributed to smoking in Oxfordshire. This means that around 570 people are dying due to smoking in Oxfordshire every year.

What is working well in Oxfordshire?

There have been significant strides in helping people to stop smoking in Oxfordshire. Stop For Life Oxon is the provider, at the time of writing this needs assessment, of the local stop smoking services (LSSS) for anyone living or working in Oxfordshire. The focus of the service is on behaviour change, social marketing, culture

change, social change, design thinking, community engagement, social movements, and applied behavioural insights. Overall, in Oxfordshire, the stop smoking services are continuing to support people to quit, helping to further reduce the numbers of people who smoke in the county where rates are already relatively low.

Using this service, Oxfordshire has a higher proportion of successful quitters[1] when compared to England and the South East region and the second highest proportion of successful male and female quitters when compared to its statistical neighbours. Compared to England and the South East region, Oxfordshire had the highest proportion of individuals reported as successful quitters across all age groups.

[1] NHS Digital have defined a successful quitter as a client who, at the four week follow-up, "*states that they have not smoked at all since two weeks after the quit date.*"

It is clear from the evidence that smoking is less likely to be an adult choice but is an addiction more likely to start in childhood. Some children may be exposed to nicotine before birth and the development of a maternity service is key to preventing ill health and mortality from tobacco later in life. The stop smoking maternity service in Oxfordshire has been in place since January 2024 and is felt to be robust, offering service equity in terms of culture and language, including for populations who use less common second languages. There is the flexibility to meet people in their homes, workplaces, or other settings to reduce geographical and transport barriers to access.

This health needs assessment also identifies the need to target children and young people to prevent them from taking up smoking and vaping. Oxfordshire has recently commissioned an evidence-based behaviour change smoking and vaping prevention programme (INTENT) to target this vulnerable population.

In 2022, the independent Khan review 'Making Smoking Obsolete' assessed the previous government's current tobacco control policies to gauge whether England's ambition of becoming smokefree by 2030 is likely to be achieved. In that report, the current Smoking and Tobacco Control Strategy in Oxfordshire was highlighted as being an example of best practice for a holistic approach to tobacco control.

In the recommissioning of stop smoking services, it will be important to build upon the significant gains made over the previous decades across Oxfordshire, whilst also continuing to recognise the need for more targeted support for those more at risk of smoking tobacco and at higher risk of health inequalities.

What opportunities are there to reduce residents' risks with regards to smoking and tobacco control in Oxfordshire?

This health needs assessment highlights areas where the existing Smoking and Tobacco Control Strategy has been difficult to implement and the barriers that need to be addressed to ensure the strategic vision is achieved. There are five main areas where there are barriers progressing the strategy.

A flexible LSSS that can respond to different needs

The LSSS service specification is tightly prescribed giving little flexibility for the provider to support people in different ways. It is largely a digital service concerned solely with smoking. A key challenge has been raised by school nurses; the LSSS does not offer support to help prevent or stop children vaping. The LSSS is also unable to offer support to stop people's dependency on nicotine (nicotine cessation pathway).

Some groups who are seldom heard are not being targeted in a way that is likely to impact on their smoking rates. These include people experiencing homelessness, people with mental ill health and people with drug and alcohol use problems. Many people have complex needs including a dual diagnosis or long term health conditions in addition to smoking tobacco. Other groups, who have higher rates of smoking, may be less likely to engage with the current service due to language or cultural barriers or being unable to relate to the service or service providers (e.g. residents identifying as LGBTQ+, residents in ethnic minority communities and younger people).

Tailoring of the service to priority groups in terms of the type of support they need.

There are a range of different teams involved to support people to stop smoking, but they do not currently work closely together. For example, the drug and alcohol team have a great deal of experience in working with people with addiction and other complex needs, and their expertise could inform how to better meet the needs of some of the priority groups in supporting them to stop smoking.

The full range of nicotine replacement therapy (NRT) and other stop smoking aids, such as vapes, may not be available to all priority groups, which may make it harder to quit. People on acute mental health wards or acute medical wards may also struggle to get the full range of NRT and may not experience a seamless pathway to community services (LSSS) when they are discharged from acute services.

Relationships between different services who can offer stop smoking support range from very good to disengaged.

Budgets for providers of stop smoking services within Oxfordshire are separate and linked to different funding streams and targets, some being provided via NHS England through ICBs to the NHS and some via Public Health Grant to Local Authorities. Each team including those in acute hospital, maternity and community settings therefore focus exclusively on their specific area rather than the wider service.

Relationships are felt to be improving due to the work across the system involving partners including Public Health, the ICB, primary care and Stop for Life Oxon

Underutilisation of services that could support people to stop smoking.

Currently, there is one stop smoking service within Oxfordshire, which is primarily an online service; however, there are other health services in the community which are well placed to help people stop smoking which are currently underutilised. These include drug and alcohol treatment walk-in clinics, community pharmacies and GP surgeries. These services may be well placed to reach individuals unwilling or unable to contact the Stop for Life Oxon service. These services may also be able to offer carbon monoxide (CO) validation which can be a motivator to stop smoking.

Visibility of the service across the county – the understanding of stop smoking services in both health and social care is variable.

Professionals, including social workers, housing officers, health visitors and others, do not always know how to signpost people to stop smoking services. Without this knowledge, they cannot promote the service or help people to quit smoking.

Health and care professionals may not understand the latest evidence based guidance about, for example, vaping as an aid to quitting.

The information gathered for this health needs assessment has highlighted certain areas where further progress could be made in regard to implementing best practice. One important element not included in this HNA is the feedback from service users and insight into what would best support residents to stop smoking. This work has been commissioned and the results will inform the future decisions of services alongside this HNA. It is important that the views of residents, with a focus on priority groups, are continually sought in order to understand what works best for them so they can engage with services and reduce harm to themselves from smoking.

Summary list of recommendations

Recommendations are aligned with the Oxfordshire Tobacco Control Alliance "Four Pillars" for a reduction in tobacco use in the county.

Full details of the recommendations and how they are linked to the Smoking and Tobacco Control Health Needs Assessment (HNA) findings can be found in Section 9 Conclusions and Recommendations, Table 44.

PILLAR 1 – PREVENTION

> *"Smoking is not an adult choice but an addiction of childhood."*

Strategic objective: Reduce the prevalence of smoking during pregnancy ensuring a robust and effective pathway for both women and their partners for identification, referral and support to stop smoking.

1. Teams involved in antenatal and postnatal care across organisations need to understand the stop smoking pathway for women and their partners through training in Making Every Contact Count (MECC) and Very Brief Advice (VBA).
2. Explore the issues around the limited options of NRT available to pregnant women and possible solutions.

Strategic objective: Ensure the most vulnerable children and young people are supported not to start smoking.

3. Support schools to update their approach and content concerning smoking prevention.
4. Access to sign-posted, support to stop vaping services for young people.
5. Plan and implement an evaluation of the newly commissioned INTENT[2] programme.

PILLAR 2 – LOCAL REGULATION AND ENFORCEMENT

> *"Cheap illicit tobacco fuels smoking inequalities and is linked to crime at many levels."*

Strategic objective: Adopt a joined up approach to tackling supply and demand of illicit tobacco.

6. Consider how a common approach between all district councils and trading standards could be developed to manage the closure of establishments selling illicit tobacco.

PILLAR 3 – CREATING SMOKEFREE ENVIRONMENTS

> *"Promoting smokefree communities protects our residents from tobacco related harm and the harms of second-hand smoking."*

[2] INTENT is an evidence based behaviour change smoking and vaping prevention programme delivered to school years 7 to 10 with 2-3 one hour sessions delivered per year.

Strategic objective: Ensure that local NHS Trusts are smokefree with comprehensive smokefree policies; including encouraging smokers using, visiting, or working in the NHS to quit.

7. Consider if the barriers offering patients in acute, maternity and mental health settings a full range of NRT and other stop smoking aids can be addressed.
8. Review how the Tobacco Dependency Service (TDS) is addressing the process issues around capturing and recording smoking status.
9. In the maternity setting consider how to ensure midwives and Family Nurse Partnership (FNP) staff are clear about their own and the TDS's role in assessing and supporting pregnant women in the community.
10. Explore funding options for maternity services to ensure retention of qualified staff.

Strategic objective: Encourage workplaces to promote smokefree environments and support staff to quit smoking.

11. Consider the development of signage with QR (quick response) codes to refer current council employees to current local stop smoking services (LSSS).
12. The Smokefree policy at all council sites needs to be underpinned by communication about LSSS for staff.

Strategic objective: Support organisations working across the community to promote smokefree environments in homes, cars, play parks and school gates.

13. Encourage the County Council and District Council Education teams to link with schools to develop a smokefree school gates action plan.
14. Consider a voluntary smokefree play park scheme, supported by local schools and parish councils.

PILLAR 4 – SUPPORTING SMOKERS TO QUIT

> *"The prevalence of smokers in Oxfordshire is lower than the national average, but there are stark inequalities in the population who smoke. Focussing on the groups with higher smoking rates with targeted approach to quit support is essential to address the local inequalities."*

Strategic objective: Reduce health inequalities through targeting populations where smoking rates remain high, including routine and manual workers, the unemployed and those living in the most deprived communities.

15. Consider commissioning a service that can codesign and deliver tailored stop smoking offers to those who are seldom heard in the community
16. Consider the use of community pharmacies.
17. Consider developing local peer facilitators.
18. Explore how to increase CO (carbon monoxide) validation across settings.

Strategic objective: Ensure all care providers and health practitioners can refer direct to LSSS and tobacco dependency services.

19. Increase the visibility of the LSSS across the health and social care sector through a range of channels including offering continuing professional development (CPD) sessions or including a CPD online module for all new starters and training in MECC and VBA.

20. Ensure systems are in place to ensure and enable direct referrals from general practices (GPs) to LSSS.

21. Work with TDS to embed a pathway to stop smoking services from outpatient settings.

22. Consider how support to stop smoking could be offered in the emergency department.

23. Ensure robust pathways are embedded to identify people with smoking related health conditions (e.g. lung cancer, asthma, chronic obstructive pulmonary disease (COPD), cardiovascular disease) so that they have swift access to stop smoking support.

24. Work with adult social care to put in place a pathway to stop smoking services.

Strategic objective: Reduce prevalence of smoking in people with mental health conditions and learning disabilities, offering targeted interventions and ensuring that learning disability services are able to support people who smoke in their care.

25. Plan designated pathways for people with significant mental illness (SMI).

26. Plan to offer NRT and other stop smoking aids in these populations for an extended period of time prior to quitting and afterwards to prevent relapse.

27. Provide person centred support that is tailored to the individual including a flexible appointment venue, more frequent contacts and tailored duration of support.

28. Offer support to family and carers, as well as the patient.

29. Consider working with the Public Health drug and alcohol team and support provider, () the dual diagnosis team, the learning disability service, Response and Mind, along with service users to design a service that works better for people with SMI and learning disabilities.

Strategic objective: Ensure an evidence-based approach is taken to the promotion and use of vapes that is disseminated to all partners.

30. Consider how to ensure there is local evidence-based information about vapes reaching professionals through different channels along with information about signposting people to the LSSS.

1 Introduction

1.1 Aims of the health needs assessment

Reducing smoking rates is a national priority. The national tobacco control plan 'Stopping the start: our new plan to create a smokefree generation' outlines ambitions for the country to reduce adult smoking prevalence and prevent young people from taking up the habit (Department of Health and Social Care (DHSCa), 2023).

This Smoking and Tobacco Control HNA (HNA) aims to map the needs, examine the demand for smoking cessation services, map the supply of smoking cessation services, assess the gaps, and make recommendations for the population of Oxfordshire, taking account national best practice. Although not the focus of this HNA there is also an overview of tobacco control policy, best practice and activities across the county. A previous smoking health needs assessment (HNA) for Oxfordshire was completed in 2020. Since then, further national and local commitments have been made to support smoking cessation and a refreshed HNA is required. A key objective of the HNA is to inform future commissioning decisions around models of care and allocation of resources.

1.1.1 Scope of the Smoking and Tobacco Control HNA

The key areas included within the HNA are:

- A review of national and local strategy, policy, guidance, and best practice concerning interventions that:
    - prevent people starting smoking
    - support people to stop smoking
    - enhance tobacco enforcement and regulation
    - create smokefree environments
- A description of the needs of the Oxfordshire population in relation to smoking
- A description of the demand for stop smoking services
- Engagement with stakeholders to identify the barriers and enablers to delivering stop smoking services to different priority populations and their view on development and improvements required
- A description of key gaps in current provision
- A series of recommendations for consideration about provision of stop smoking services across different priority populations

Excluded areas are:

- Feedback gathered from service users of existing services as this work has been commissioned separately
- A detailed review of regulation and enforcement in Oxfordshire.

1.2 Methods

This HNA aimed to incorporate information from a wide range of sources to understand health needs of the population in relation to tobacco smoking and how these are currently being met.

Global and national policy, guidance and best practice relevant to tobacco smoking from bodies such as the World Health Organisation, Department of Health and Social Care, National Institute for Health and Care Excellence, Royal Colleges, independent bodies and recent research literature was accessed through hand searching, collated and summarised. Local policies and strategies were accessed and reviewed.

Quantitative data using national and local sources were used to provide a demographic overview of the characteristics of the Oxfordshire population and epidemiological perspective of smoking prevalence and harm (e.g. smoking profiles produced by the Office for Health Improvement and Disparities – OHID). Key risk factors/indices of smoking inequality such as age, gender, deprivation, ethnicity, socioeconomic classification, employment and housing status were presented by district and comparisons made between Oxfordshire, the South East region and other similar local authorities (nearest statistical neighbours).

Qualitative information was gathered from conversations with stakeholders structured around specific questions and through a survey of stakeholders (Appendix 1). Questions focused on how services operate, how they link with other services across sectors and geography, including perceived strengths and weaknesses of services, inequalities in who accesses services, perceived gaps, trends, effects of the pandemic, and suggestions for improvement.

The production of the HNA was carried out in conjunction with key members of the OCC public health team and overseen by the HNA project group.

2 National and local context

2.1 National context

Following the announcement of the new government policy to achieve a smokefree generation and funding associated with this ambition, Oxfordshire County Council (OCC) commissioned this smoking and tobacco control health needs assessment. This health needs assessment provides greater understanding of the local picture within the national context and highlights where improvements might be made to support the local population to avoid starting smoking and to stop smoking if they want to.

Tobacco use is the leading cause of death and disability in England, it is also a key driver of health inequalities and results in significant health spending (NHS Digital, 2023, Action on Smoking and Health (ASH), 2019). In 2022/23, in England, smoking rates were estimated at 11.6% equating to around 5.8 million people in England (ONS 2024). The annual cost to society is estimated at £21.8 billion (B) whereas income from taxes on tobacco products totalled £8.84B (Office for National Statistics (ONS), 2022, ASH, 2024, Her Majesties Revenue and Customs, 2024)

It is estimated that two in three people who smoke will die as a result of their tobacco use and smoking remains the leading cause of preventable heart disease, stroke and respiratory illness (OHID, 2022). In 2019, in England, 74,600 people died from smoking related conditions, which equated to 15% of all deaths that year (NHS Digital, 2023).

Some sections of the population are more likely to smoke than others in the UK. These are:

- People with a mental health condition including;
    - 40.5% with severe mental illness in 2014/15 (OHID Smoking Profiles)
    - 25.1% with a long term mental health condition in 2022/23 (OHID Smoking Profiles)
    - 25.8% with anxiety or depression in 2016/17 (OHID Smoking Profiles)
- 19.5% of people working in routine and manual employment in 2023 (OHID Smoking Profiles)
- 18.5% of people who never worked or were long term unemployed in 2023, (OHID Smoking Profiles)
- 76% of people who experienced homelessness in 2021, (Homeless Link 2022)
- 80% of people in contact with the criminal justice system in 2013, (Public Health England 2015)
- 24.9% of people who lived in social housing in 2023, (OHID Smoking Profiles)
- 27.4% of people without qualifications in 2023, (ONS 2024)
- Over 20% of people who were part of the LGBT community in 2018, (OHID Smoking Profiles)

In addition, those who smoke during pregnancy are at risk of a range of adverse pregnancy and birth outcomes. The latest data, 2023 for England, showed that although on average only 8.8% of women smoked at the time of delivery this varied from 3.4% to 19.4% depending on where people lived (OHID Smoking Profiles).

Local authorities have been responsible for stop smoking services and tobacco control since 2013 and each year ASH and Cancer Research UK (CRUK) have conducted a survey to track tobacco control work led by public health teams (ASH and CRUK, 2023). The latest survey was completed in September 2023, prior to the announcement by the government of the proposal for a 'smokefree generation'. Of the 150 upper tier local authorities (LAs), 124 responded to the survey with 43 LAs (37%) citing tobacco as a strategic priority over and above alcohol, obesity, sexual health and gambling. Only substance use was considered a higher priority than tobacco and only nine (8%) local authorities felt tobacco had a low priority.

A total of 84 (68%) local authorities had a specific tobacco control strategy or had developed their tobacco control strategy within a broader strategy on prevention, population health, or inequalities. The most common goals identified in the survey in relation to strategic tobacco control included:

- Reducing smoking prevalence and achieving a smokefree future by helping people who smoke to quit and preventing young people from starting smoking
- Reducing smoking-related inequalities, focused on pregnant women, people with routine and manual occupations and people with mental health conditions
- Promoting smokefree environments (home, workplace and public) and reducing exposure of young people to second-hand smoke
- Reducing the trade in illicit tobacco and vaping products.

Examples of other goals included increasing awareness of the harms of smoking through engagement, communication campaigns, peer education, and a focus on preventing young people from starting vaping.

2.2 Oxfordshire context

The most recent adult smoking rates in Oxfordshire are published by the Office for Health Improvement and Disparities (OHID Smoking Profiles) and are based on the Annual Population Survey in 2023. A rate of 10.3% of Oxfordshire adults are estimated to smoke compared to 11.6% in England as a whole (OHID Smoking Profiles). In Oxfordshire this equates to around 61,000 adults. It's estimated that 28,500 Oxfordshire children live in smoking households and each year approximately 880 children start smoking (ASH 2023).

Higher smoking rates are reported for some groups in Oxfordshire with latest figures from 2022/23 showing 15.3% of routine and manual workers, and 21.5% of people with a long term mental health condition smoke (APS 2023, GPPS 2023). Data from 2019/20 showed between 21.2% and 50.3% of people with substance use problems

smoked (NDTMS 2020). In contrast, 6.4% or 420 women smoked at the time of delivery in Oxfordshire in 2022/23 (OHID Smoking Profiles).

In terms of mortality, between 2017 and 2019, there were 1,698 deaths attributed to smoking or 142.3 people per 100,000 of the population (OHID Smoking Profiles). This equates to around 570 people dying of smoking in Oxfordshire per year. Nearly half the 1,698 deaths over the 2017 to 2019 three-year period were from cancer (764 or 65.4 per 100,000 of the population), predominantly lung cancer (724 people died or 35 per 100,000 people) (OHID Smoking Profiles). Smoking was estimated to cause the deaths of a further 671 people who died from Chronic Obstructive Pulmonary Disease (32 per 100,000 population), 210 who died of heart disease (17.5 people per 100,000 population) and 84 who died from stroke (6.9 per 100,000) (OHID Smoking Profiles).

The OHID Smoking Profiles also report that 3,720 hospital admissions were attributable to smoking in Oxfordshire. The health care costs from these hospital admissions plus primary care services were estimated to be £17.5m (ASH 2024). Further costs of residential and domiciliary care are estimated at £10.9m per year whilst the cost of informal care is £74.3m and unmet need is 46.7m. (ASH 2024).

Wider societal costs of lost earnings and unemployment are estimated to cost £176.6m in Oxfordshire with a further £4m associated with the 24 smoking related fires per year (ASH 2024).

3 Strategies and policies for addressing smoking and tobacco control

This chapter summarises global and national guidance and best practice that underpins current policy in England.

3.1 Global goals addressing smoking cessation and tobacco control

The World Health Organisation (WHO 2005) developed a Framework Convention on Tobacco Control (FCTC) which sets out the blueprint for governments to adopt effective tobacco control. It includes both price and tax measures as well as non-price measures, with the aim of reducing demand for tobacco and giving priority to public health. The UK government was an early signatory of the FCTC and UK policy continues to reflect WHO guidelines in order to meet the FCTC obligations.

The key policy areas of the FCTC are summarised by MPOWER (WHO 2023) which stands for:

- M – Monitor tobacco use and prevention policies
- P – Protect people from tobacco smoke
- O – Offer to help quit tobacco use
- W – Warn about the dangers of tobacco
- E – Enforce bans of tobacco advertising, promotion and sponsorship
- R – Raise taxes on tobacco

The latest survey of 37 countries used the Tobacco Control Scale which quantifies the implementation of tobacco control policies at country level based on the six WHO policy areas (Joossens et al 2022). Scores for each country are out of 100 points with Ireland and the UK scoring highest with 82 points and ranked one and two respectively. In comparison, Germany and Switzerland are ranked 34th and 36th with 43 and 35 points, respectively.

3.2 National goals addressing smoking cessation and tobacco control

In England, in 2017 and 2018, a national tobacco control plan and delivery model were published (DHSC 2017, 2018). These outlined the government's ambition for England to be smokefree by 2030, defined as a reduction in smoking prevalence to below 5%. The national plan expired in 2022 with the objectives set out in the plan having been partially, but not wholly, met. In 2022, the independent Khan review 'Making Smoking Obsolete' assessed the government's current tobacco control policies to gauge whether England's ambition of becoming smokefree by 2030 is likely to be achieved and made 15 recommendations for government action in order to achieve that

ambition (Table 1). The recommendations, which are framed as interventions, are a mix of those that can only be implemented at national level and those that can be wholly or partially delivered at a local level. Of the 15 interventions, four are considered critical to implement in order to achieve the smokefree 2030 ambition.

Table 1: Summary of 15 recommendations to inform tobacco control policies in England

Recommendation	Actions
Invest in reaching smokefree 2030	**National critical intervention: Urgently invest £125 million per year in interventions to reach smokefree 2030.** Make smoking obsolete, addressing the health disparities smoking creates
Stopping the start – reduce the number of people taking up smoking, particularly young people	**National critical intervention*:* Raise the age of sale of tobacco from 18, by one year, every year**, until no one can buy a tobacco product in England
	National intervention: Substantially raise the cost of tobacco duties (more than 30%) across all tobacco products, immediately. This includes, increasing duty rates for cheaper tobacco products, and banning tobacco products at duty-free entry points.
	National intervention: Introduce a tobacco licence for retailers to limit where tobacco is available. The government should also ban online sales for all tobacco products, ban supermarkets from selling tobacco and freeze the tobacco market to stimulate innovation in tobacco-free alternatives.
	National and local intervention*:* Enhance local illicit tobacco enforcement by investing additional funding of £15 million per year to local trading standards. Give trading standards the power to close down retailers known to be selling illicit tobacco. Alternative tobacco products such as shisha need enhanced enforcement.
	National intervention: Reduce the appeal of smoking. Radically rethink how cigarette sticks and packets look, closing regulatory gaps and tackling portrayals of smoking in the media
	National and local intervention: Increase smokefree places to de-normalise smoking and protect young people from second-hand smoke. Strengthen smokefree legislation in hospitality, hospital grounds and outdoor public spaces. Local authorities should make a significant proportion (70% or more) of new social housing tenancies and new developments smokefree
Quit for good – encouraging people who smoke to quit for good	**Local critical intervention: Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals**. The government should accelerate the path to prescribed vapes and provide free Swap to Stop packs in deprived communities, while preventing young people's uptake of vapes by banning child friendly cartoon packaging and descriptions.
	National and local intervention*:* Invest an additional £70 million per year into stop smoking services, ringfenced for this purpose.
	National intervention: Invest £15 million per year in a well-designed national mass media campaign, supported by targeted regional media. This should be nationwide, direct people who smoke to support and dismantle myths about smoking and vaping

Recommendation	Actions
System change – the critical role of the NHS, the importance of collaborative working and improving data and evidence	**Local critical intervention: The NHS needs to prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care.** Healthcare professionals should use every 'teachable moment' to deliver very brief advice on quitting, and this should form part of revised core training curriculums. All hospitals must integrate 'opt-out' smoking cessation interventions into routine care.
	National and Local intervention: Invest £15 million per year to support pregnant women to quit smoking in all parts of the country. The NHS should provide treatment at every stage. There should be a stop-smoking midwife in every maternity department to provide expert support and advice at the front line.
	Local intervention: Tackle the issue of smoking and mental health. Disseminate accurate information that smoking does not reduce stress and anxiety, through public health campaigns and staff training. Make stopping smoking a key part of mental health treatment in acute and community mental health services and in primary care.
	National and local intervention*:* Invest £8 million to ensure regional and local prioritisation of stop smoking interventions through ICS leadership.
	National intervention: Invest £2 million per year in new research and data. The government should invest in an innovation fund to support the commissioning of new research, data and monitoring of impact at all levels. The government must also commission further research on smoking related health disparities, particularly on ethnic disparities and young people.

Source: UK Government, The Khan Review making smoking obsolete, 2022 (Khan 2022)

In April 2023, the government partially responded to the Khan review recommendations outlining the following plans (DHSCa 2023):

- A national 'Swap to Stop' scheme to support adults to quit smoking by switching to vaping, initially targeting at-risk and high smoking prevalence groups
- Financial incentives for pregnant women to stop smoking by the end of 2024
- Investment of £3m for enforcement to tackle underage vape sales and illicit tobacco
- As a minimum, all mental health practitioners will be able to signpost to specially developed digital resources to quit smoking
- Joined up working between the NHS and local authorities to support people who smoke to quit, facilitated by integrated care boards
- A government consultation on the introduction of mandatory pack inserts with messages and information to help people who smoke, quit.

In October 2023, the government updated the policy announcing further measures to significantly ramp up action to create a smokefree generation through a comprehensive range of funded interventions. These announcements respond to more of the recommendations of the independent Khan review including proposals to:

- Legislate to raise the age of sale one year every year from 2027 onwards
- Double the funding of local authorities for smoking cessation
- Increase funding for enforcement of tobacco and vapes by £30 million
- Launch a consultation in October 2023 that closed in December 2023 on specific measures to tackle the increase in youth vaping.

The Khan recommendations relevant to local action reflect many of the ’10 high impact areas’ set out by ASH in 2022. These recommendations were published in the absence of a refreshed national tobacco control plan and provide an evidence based framework for local partnership action to continue to drive down smoking prevalence and reduce the health, social and economic costs of smoking. These actions are to:

1. Prioritise health inequalities
2. Work in partnership
3. Support every smoker to quit
4. Communicate the harms and the hope
5. Promote harm reduction
6. Tackle illicit tobacco
7. Promote smokefree environments
8. Enable young people to live smokefree
9. Set targets to drive progress
10. Protect and promote progressive tobacco control policy.

For each of the 10 high impact areas, ASH have outlined actions local authorities can consider and suggested key points that can be included in local plans.

Other guidance relevant to tobacco smoking in England includes:

- NHS Inclusion health policy outlines the principles to use when designing services focused on inclusion health groups to tackle inequalities (NHS 2023).
- DHSC guidance for government officials and those in arm’s length bodies about engaging with the tobacco industry (DHSCb 2023).
- The Major Conditions Strategy which is in development and will be published by the DHSC. It will focus on best evidence to manage people with six major health conditions. Chapter two will include a section on supporting these groups with a personalised approach to prevention through the management of risk factors, including smoking (DHSCc 2023)
- National combating drugs outcomes framework which recommends that assessment of people for illicit drug use includes tobacco smoking related risk and an offer to support them to quit smoking (DHSCd 2023).

Table 2 outlines the key guidance documents relevant to tobacco control summarised in this section.

Table 2: Summary of national policies and guidance

Strategy	Strategic objectives guidance and national policy relating to smoking and tobacco control
ASH (2022) Smokefree by 2030?: 10 high impact actions for local authorities and their partners	1. Prioritise health inequalities in the conception, design and implementation of all tobacco control policies and interventions 2. Work in partnership including the maintenance of a strong multi-agency tobacco control alliance and senior leadership bringing all partners together with a shared purpose to implement an effective, coordinated and accountable strategy 3. Support every smoker to quit by ensuring all local people who smoke, have access to high quality, evidence based quitting support including behavioural support, pharmacotherapies for smoking cessation and vapes 4. Communicate the harms and hopes with local and regional communications campaigns combining effective messaging about the harms of smoking, quitting and leading a healthier smokefree life 5. Promote harm reduction by communicating that using regulated vapes are less harmful than smoking and are an effective quitting aid 6. Tackle illicit tobacco with partnership working across regional boundaries and in conjunction with the HMRC, police, the NHS, local business and the public ensuring that data is collected and there is awareness raising of illicit tobacco issues 7. Promote smokefree environments with a focus of messaging and support for those in social housing to explore the options of stopping smoking 8. Enable young people to live smokefree through effective engagement about the harms of smoking, promoting smokefree environments to reduce visibility and acceptability of smoking and ensure retailers comply with age of sale legislation. 9. Set targets to drive progress locally such as reducing the proportion of people in particular population groups who smoke by a particular date and track an agreed set of indicators and intelligence to monitor these 10. Protect and promote progressive tobacco control policy by, for example, supporting local elected members to be advocates for tobacco control locally, regionally and nationally, and committing to joining the Smokefree Action coalition of 300 organisations across the UK committed to ending smoking
DHSCa (2023) Stopping the Start: our new plan to create a smokefree generation*	The government aims to: • Introduce new legislation (Tobacco and Vapes Bill) so that children born on or after January 1st, 2009, will not be able to buy tobacco products legally in England and it will be an offence for anyone over the legal age to purchase tobacco products on behalf of someone born on or after January 1st, 2009 To support people to quit the government will: • Invest an additional £70M per year (to a total of £138M) aiming to support around 360,000 people to quit annually

Strategy	Strategic objectives guidance and national policy relating to smoking and tobacco control
	• Fund for new national campaigns to explain legal changes, benefits of quitting and support available Provide further funding to: • Roll out the new 'Swap to Stop scheme' offering 1 million people who smoke that commit to quit smoking with expert support from the local stop smoking services a free vaping starter kit. This will be funded with £45 million over 2 years • Provide financial incentives for pregnant women to quit For children and young people who smoke the government are also assessing proposals to: • Restrict vape flavours • Regulate vape packaging and product presentation • Regulate point of sale displays • Restrict the sale of disposable vapes • Introduce an age restriction for non-nicotine vapes • Explore further restrictions for other nicotine consumer products such as nicotine pouches • Prevent industry giving out free samples of vapes to children The approach to enforcement includes: • Investment of an additional £30M a year for enforcement agencies • Introduction of on the spot fines for underage sales of tobacco products and vapes
DHSC (2017) Tobacco control delivery plan 2017- 2022 Please note this plan has expired	The delivery plan to implement the smokefree generation tobacco control plan for England. Prevention: • Improve effectiveness of legislation such as proxy purchasing and standardised packaging to reduce the appeal of smoking to young people • Support pregnant people who smoke to quit using NICE guidance based on evidence to underpin initiatives Supporting people who smoke to quit: • Provide training for all health professionals on how to help patients stop smoking and NHS Trusts will encourage people who smoke using, visiting and working on site to quit • Promote stop smoking services across the health and care system and implement all relevant NICE guidelines by 2022

Strategy	Strategic objectives guidance and national policy relating to smoking and tobacco control
	• Local areas will develop their own tobacco control strategies based on NICE evidence based guidance • Develop and disseminate guidance to support NHS staff to implement NICE guidance particularly in maternity mental health and acute services respectively • Ensure the most up to date evidence is identified and disseminated about stopping smoking interventions Eliminating variation in smoking rates targeting populations where smoking rates remain high: • Local areas to identify groups and areas with highest smoking prevalence and target these to reduce smoking – ensure data and insight is gathered that supports greater understanding of the local picture • Undertake CLeaR peer review for self-assessment to identify areas for the focus of improvement. • Raise public awareness with mass media campaigns to promote stopping smoking • Support local areas looking to implement local smokefree places • Review young people's smoking prevalence and attitudes to smoking Effective enforcement: • Maintain a robust regime for tobacco control and reduce discrepancies in product prices • Implement the illicit tobacco strategy and reduce the market share of these products • Improve use and effectiveness of sanctions and monitor the development of novel products • Limit direct contact with the tobacco industry and maximise transparency when contact is needed
Khan J (2022) Independent evaluation of the government's smoking policies and recommendations for future policy	The Khan review aimed to evaluate the current progress to meet the governments ambition to make England smokefree by 2030 and to recommend policy and regulatory recommendations relating to: • Increased investment in smokefree policies • Increasing the age of sale of tobacco by one year every year • Promoting vaping as a smoking cessation tool • Improving the prevention of ill health by offering people who smoke advice and support to quit at every interaction within the NHS The report concludes that without further action England will miss the smokefree 2030 target by at least seven years and the poorest areas in society will not meet it until at least 2044. A set of 15 recommendations were outlined to support the 2030 ambition which included four 'critical must do's' centred on:

Strategy	Strategic objectives guidance and national policy relating to smoking and tobacco control
	• Make smoking obsolete, addressing the health disparities smoking creates • Raise the age of sale of tobacco from 18, by one year, every year, until no one can buy a tobacco product in England • Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals. • The NHS should prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care
NHS England (2023) A national framework for the NHS – action on inclusion health.	The principles for action on inclusion health are: • Commit to action on inclusion health by ensuring a named ICB lead and ICP strategies and ICB plans tackle inequalities of access, experience and outcomes for people in inclusion health groups • Understand the characteristics and needs of people in inclusion health groups by proactively improving data and insights of the needs of people in inclusion health groups in the population which will underpin the drive for improvement • Develop the workforce for inclusion health, so all staff understand inclusion health and trauma informed practice • Develop specialists in inclusion. Support employment of people in inclusion groups in NHS anchor organisations • Deliver integrated and accessible services for inclusion health by using best practice to commission sufficient services for inclusion health groups. Raise quality of all services to ensure equitable access, experience and outcomes for all • Demonstrate impact and improvement through action on inclusion health by evaluating the impact of changes made and ensure people with lived experience inform improvement and evaluation
DHSCb (2023) Guidance for government engagement with the tobacco industry	The guidance sets out how the DHSC limits interactions with the tobacco industry in line with the WHO Framework Convention on Tobacco Control (2003) WHO Framework Convention on Tobacco Control. It is aimed at government departments, arm's length bodies, agencies, local authorities and any person or organisation acting on behalf of the other bodies named. Guidance recommends three potential approaches: • Do not engage with tobacco industry representatives • Contact the DHSC tobacco control team before engaging • Engage following the guidance in the document i.e.: • Limit contact with the tobacco industry unless strictly necessary, such as in matters of regulatory significance. This includes any person or organisation that is likely to be working to further the interests of the tobacco industry

Strategy	Strategic objectives guidance and national policy relating to smoking and tobacco control
	• All contact with the tobacco industry should be transparent, for example in public or in writing • There should be no involvement or support in activities that promote the sale, export or import of tobacco or tobacco products • Organisations should not invest in the tobacco industry or provide help to tobacco companies to secure incentives • Organisations should not accept either direct or indirect funding from the tobacco industry, such as for community projects or capital investments. Payments, gifts and services, monetary or in-kind, offered by the tobacco industry can create conflicts of interest. They should also not accept invitations to attend or support a reception or high-profile event sponsored by the tobacco industry
DHSC (2023) Major conditions strategy: the case for change and our strategic framework.	A Major Conditions Strategy will be published by the DHSC and will be based on best evidence to address six major conditions which contribute over 60% of mortality and morbidity in England, including • Cancers • Cardiovascular disease including stroke and diabetes • Chronic respiratory diseases • Dementia • Mental ill health • Musculoskeletal disorders Primary and secondary prevention will be the focus of chapter two and smoking will be identified as the biggest single cause of preventable illness and death, highlighting the government's proposals and support to stop smoking and consult on further tobacco controls.

3.3 Local strategies addressing smoking cessation and tobacco control

In 2019, Oxfordshire County Council undertook both a self-assessment and peer review exercise using the CLeaR model developed by ASH.[3] The process assessed the tobacco control delivery plans in the context of the resources invested and the supporting evidence about what works to maximise effective tobacco control measures and initiatives. OCC have incorporated the CLeaR recommendations (CLeaR 2019) in their most recent strategies and policies in order to:

- Build a strong multi-agency alliance which includes members that can influence policy and practice within their organisations
- Develop a joint vision and action plan with SMART targets enabling the alliance to systematically review progress, inform future activity and all adjustments to the plan
- Maintain and build on excellent practice within trading standards, fire and rescue service and the stop smoking service
- Support the delivery of a smokefree NHS and pathways to support people who smoke

The key strategies and policies which explicitly mention smoking are summarised in Table 3 and includes the high level OCC strategic plan to make Oxfordshire smokefree by 2025, and the Oxfordshire Joint Health and Wellbeing Strategy from 2024 to 2030 which outlines the approach to achieve this, taking into account the most recent government policy. The Oxfordshire Tobacco Control Alliance has a more detailed tobacco control strategy that describes four pillars that support a whole system approach to tobacco use and form the basis for an annual action plan. The four pillars are:

- Prevention
- Creating smokefree environments
- Local regulation and enforcement
- Supporting people who smoke to quit

There are actions in place for 2023/4, including:

- Working with people who smoke who are in hospital as inpatients of acute or mental health wards or who are using maternity services
- Preventing children and young people from taking up smoking or vaping
- Supporting workplaces including council premises to become smokefree and supporting people to quit
- Primary care and any opportunities to support people who smoke to quit
- Developing mass media campaigns

[3] CLeaR stands for **the 3 areas** of focus: **Challenge** of existing services based on latest evidence, **Leadership** for comprehensive action on tobacco control and **Results** demonstrated by outcomes achieved measured against national and local priorities

- Increase staff training across resident facing services in providing advice to quit and making every contact count
- Work with social housing tenants to support smokefree initiatives
- Explore opportunities to connect with people who smoke to offer support through debt management services and food banks
- Work towards local regulation and enforcement actions

To add support to the whole system approach, OCC have made a declaration that they will ensure tobacco control is part of mainstream public health work and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) have pledged to help local people who smoke quit in line with the government's plans to make the country smokefree by 2030. All five Oxfordshire district councils have signed the smokefree pledge.

Other relevant policies include the vision for children and young people (The Childrens Trust 2018) and the Oxfordshire Combating Drug and Alcohol Partnership (2021), which although neither are explicit about prevention and harm reduction from smoking and vaping, do include elements about health and wellbeing and lifestyle change. There are activities both in schools and in drug and alcohol services targeted at preventing people from starting smoking and supporting them to quit if they want to.

Table 3: Summary of local strategies and policies

Strategy	Strategic objectives and local policy about smoking and tobacco control
OCC (2022) A Strategic Plan for 2023-2025	Sets out the vision to lead positive change to make Oxfordshire a greener, fairer and healthier county. Of the nine priorities to achieve this, two are relevant to tobacco smoking: • Prioritise the health and wellbeing of residents – Make Oxfordshire smokefree by 2025, promoting better mental wellbeing and preventing self-harm and suicide • Tackling inequalities in Oxfordshire – work with those communities at risk of poor health, gathering insight to understand the causes of poor health and developing funded action plans to improve residents' health
OCC (2023) Oxfordshire Joint Health and Wellbeing Strategy 2024 to 2030	The strategy sets out its vision to improve health and wellbeing for local people between 2024 and 2030. There are ten priorities developed around a life course approach of which priority three 'Healthy people and healthy places' focuses on the length and quality of people's lives and how they should not be impacted by exposure to tobacco, alcohol or unhealthy weight. The ambitions between 2024 and 2030 are: • Oxfordshire to become smokefree (i.e. fewer than 1 in 20 people smoking tobacco) • For people who have been smoking for a long time, use of vapes as a safer alternative to tobacco use The actions to achieve this include: • Ensure smokefree pathways are in place through all NHS services • Expand the use of vapes as an alternative to ongoing tobacco use whilst reducing their use in children • Continue to raise awareness of the support available to quit smoking with a focus on the highest prevalence groups • Undertake local actions required as part of the national Smokefree Generation policy announced in November 2023
Oxfordshire Tobacco Control Alliance (2020): A tobacco control strategy for a smokefree society in Oxfordshire 2020-2025	The strategy outlines five aims to reduce prevalence in smoking: • In the adult population to below 5% • In routine and manual workers to below 10% • In those with serious mental illness to below 20% • At time of delivery to below 4% • At age 15 to below 3%

Strategy	Strategic objectives and local policy about smoking and tobacco control
	There are 4 pillars for a whole system approach to tobacco use. 1. Prevention: a. Ensure the most vulnerable children and young people are supported not to start smoking b. Provide access to training for all health professionals on smoking cessation c. Promote NICE guidance including 'Smoking: stopping in pregnancy and after childbirth' d. Identify local smokefree pregnancy champions e. Reduce the prevalence of smoking during pregnancy ensuring a robust and effective pathway for both women and their partners for identification, referral and support to stop smoking 2. Local regulation and enforcement: a. Adopt a joined up approach to tackling supply and demand of illicit tobacco b. Raise public awareness through mass media campaigns of the effect of illicit tobacco on society and increase the number of people who volunteer intelligence c. Support regional programmes to reduce illegal tobacco d. Ensure effective prosecutions continue to be pursued in appropriate cases based on intelligence received e. Take actions to reduce the sale of tobacco related products and vapes to people under age f. Take action to ensure compliance to regulations relating to vapes g. Raise awareness of the issue of cigarette littering and increase enforcement for littering 3. Creating smokefree environments: a. Encourage workplaces to promote smokefree environments and support staff to quit smoking b. Ensure that local NHS Trusts are smokefree with comprehensive smokefree policies including encouraging people who smoke using, visiting or working in NHS sites to quit c. Explore further opportunities to protect both adults and children from the harm of second hand smoke d. Support organisations working across the community to promote smokefree environments including homes, cars, play parks and school gates e. Promote smokefree environments through mass media campaigns f. Train and support staff working with families to promote smokefree homes and cars g. Continued enforcement of smokefree legislation in the community

Strategy	Strategic objectives and local policy about smoking and tobacco control
	4. Supporting people who smoke to quit: a. Reduce health inequalities through targeting populations where smoking rates remain high, including routine and manual workers, the unemployed and those living in the most deprived communities b. Commission targeted community based, client friendly, LSSS which prioritise high risk and vulnerable groups c. Train all front-line health care workers in brief intervention/making every contact count, to raise the issue of smoking, provide advice on the benefits of stopping, facilitate access to medications and encourage annual quit attempts d. Ensure all care providers and health practitioners can refer direct to LSSS and tobacco dependency services e. Through local mass-media campaigns integrating with national campaigns, raise awareness of LSSS and encourage all people who smoke to have annual quit attempt f. Promote NICE guidance PH48 'Smoking: acute, maternity and mental health services' to hospital trusts g. Reduce prevalence of smoking in people with mental health conditions and learning disabilities, offering targeted interventions and ensuring that learning disability services are able to support people who smoke in their care h. Ensure an evidence based approach is taken to the promotion and use of vapes that is disseminated to all partners.
Tobacco Control Network South East England Position Statement on Vaping (2024)	The position statement reports the South East Public Health consensus on vaping. It is intended to help organisations develop their policies and practice and encourage a consistent and evidence based approach that helps people who want to use vapes to quit smoking. • Vapes are an effective aid for adults to quit smoking • If you smoke, vaping is safer than smoking. Vaping has minimal serious side-effects when used for a short time to stop smoking • People who want to quit smoking using vapes should be encouraged to quit smoking and switch to vaping • People who do not smoke should not vape • Children should be prevented from using vapes, due to the unknown longer-term harms of vaping and the risk of nicotine addiction

Strategy	Strategic objectives and local policy about smoking and tobacco control
Bucks, Oxon & Berks Integrated Care Board Joint Forward Plan –2022	The joint forward plan of the NHS Buckinghamshire, Oxfordshire and Berkshire West ICB focusses on actions to be delivered by the NHS locally. Those relating to tobacco smoking include: • An increase in primary and secondary prevention to reduce smoking prevalence • An increase in access to tobacco advisory services in acute inpatient, maternity and mental health inpatient wards • An increase NHS Health checks, lifestyle interventions and smoking cessation activities
NHS Smokefree Pledge BOB ICB (February 2024)	BOB ICB has pledged to help local people who smoke to quit in line with the government's plans to make the country smokefree by 2030.The commitment to stop smoking initiatives includes: • Local tobacco dependency treatment services for mental health, acute inpatients and maternity services. • Promoting stop smoking initiatives via tobacco control alliances • Funding of two primary care networks in Buckinghamshire to employ health coaches to work with patients ahead of surgical operations to support them to stop smoking • Support local NHS trusts to demonstrate their commitment to the pledge
The Oxfordshire Tobacco Control Strategy and Local Government Declaration on Tobacco Control (2020)	The Local Government Declaration on Tobacco Control is a statement of a council's commitment to ensure tobacco control is part of mainstream public health work and commits councils to taking comprehensive action to address harms from smoking. The Declaration commits councils to: • Reduce smoking prevalence and health inequalities • Develop plans with partners and local communities • Participate in local and regional networks • Support government action at national level • Protect tobacco control work from the commercial and vested interests of the tobacco industry • Monitor the progress of our plans • Join the Smokefree Action Coalition

4 Population of Oxfordshire

This chapter describes the population of Oxfordshire and differences between districts. It also focuses on the change in population predicted in different areas of Oxfordshire including the priority areas targeted by the stop smoking providers. It describes the prevalence of people with conditions associated with smoking in Oxfordshire.

4.1 Current population estimates

Table 4 shows the total (all ages) population of Oxfordshire and of each of the Oxfordshire district councils for the years from 2019 to 2023, as estimated by the Office for National Statistics (ONS).

Table 4: Population (all ages) of Oxfordshire and Oxfordshire district councils, 2019 to 2023

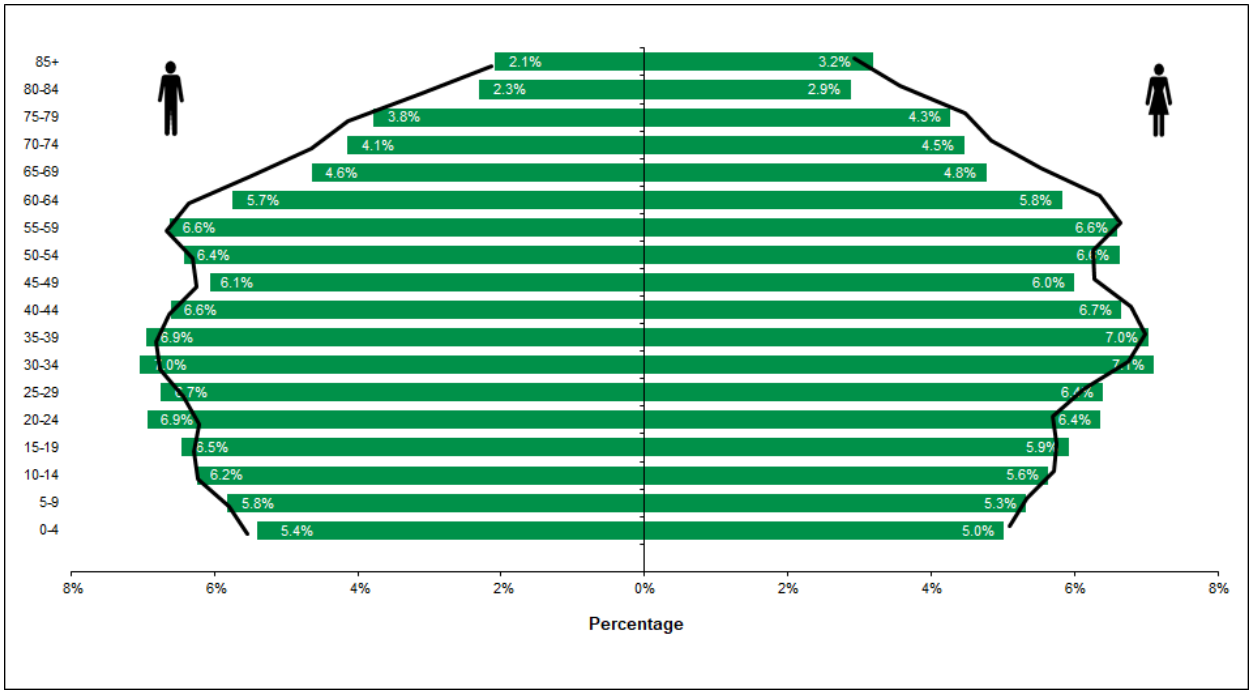
District Council	2019	2020	2021	2022	2023	Percentage Change 2019 - 2023
Cherwell	156,447	158,435	161,830	164,189	166,321	+ 6.3%
Oxford	160,789	160,064	160,379	162,448	165,184	+ 2.7%
South Oxfordshire	144,875	146,844	150,002	151,845	153,424	+ 5.9%
Vale of White Horse	135,040	136,889	139,400	142,335	145,970	+ 8.1%
West Oxfordshire	111,362	112,534	115,116	116,978	119,331	+ 7.2%
Oxfordshire	**708,513**	**714,766**	**726,727**	**737,795**	**750,230**	**+ 5.9%**

Source: ONS mid-year population estimates for lower tier local authorities 2019 – 2023

Table 4 shows that the estimated population of Oxfordshire increased by 5.9% between 2019 and 2023. This increase is not consistent across the Oxfordshire districts, with the population of Vale of White Horse estimated to have increased by 8.1% over the five year period whilst Oxford increased by 2.7%.

Figure 1 shows the estimated mid-2023 population for Oxfordshire by sex and age group compared to England. It shows the percentage of the male and female Oxfordshire population in each age group in the green horizontal bars and the equivalent percentage for England as a thick black line.

Figure 1: Percentage of the Oxfordshire male and female population by age group, compared to England, 2023

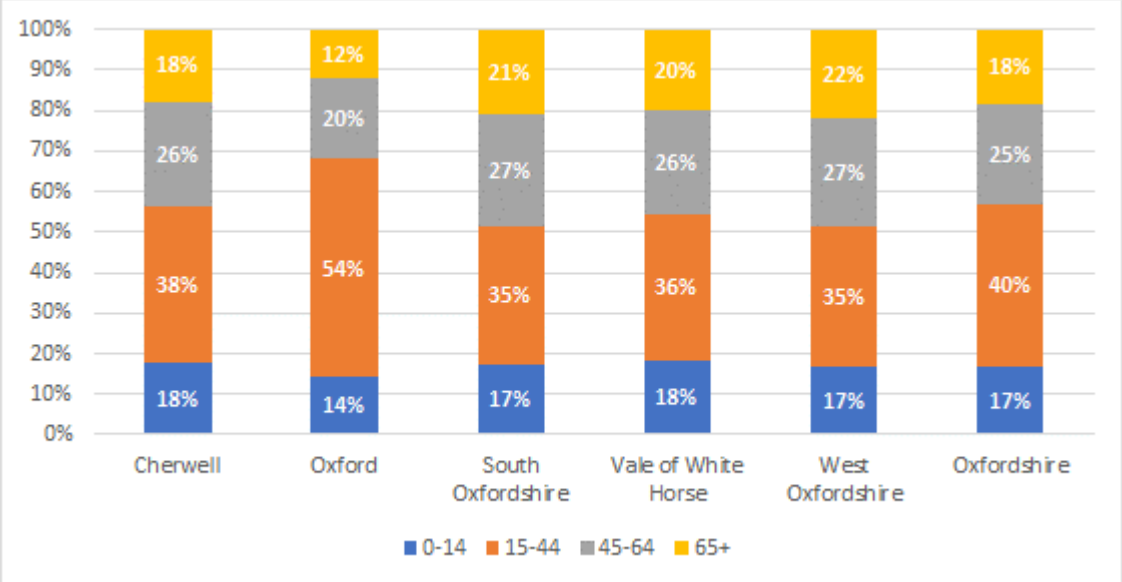


Source: ONS mid-year population estimates 2023

Figure 1 shows that Oxfordshire has a slightly higher proportion of both males and females in the 15 – 19 to 30 – 34 year old age groups than England, but a lower proportion of both males and female in older age groups apart from the very oldest age group (85+) which is higher in Oxfordshire than England for both males and females.

Figure 2 shows the percentage of the population in each age group for each Oxfordshire districts and Oxfordshire as a whole.

Figure 2: Proportion of population of Oxfordshire districts by age group, 2023



Source: ONS mid-year population estimates 2023

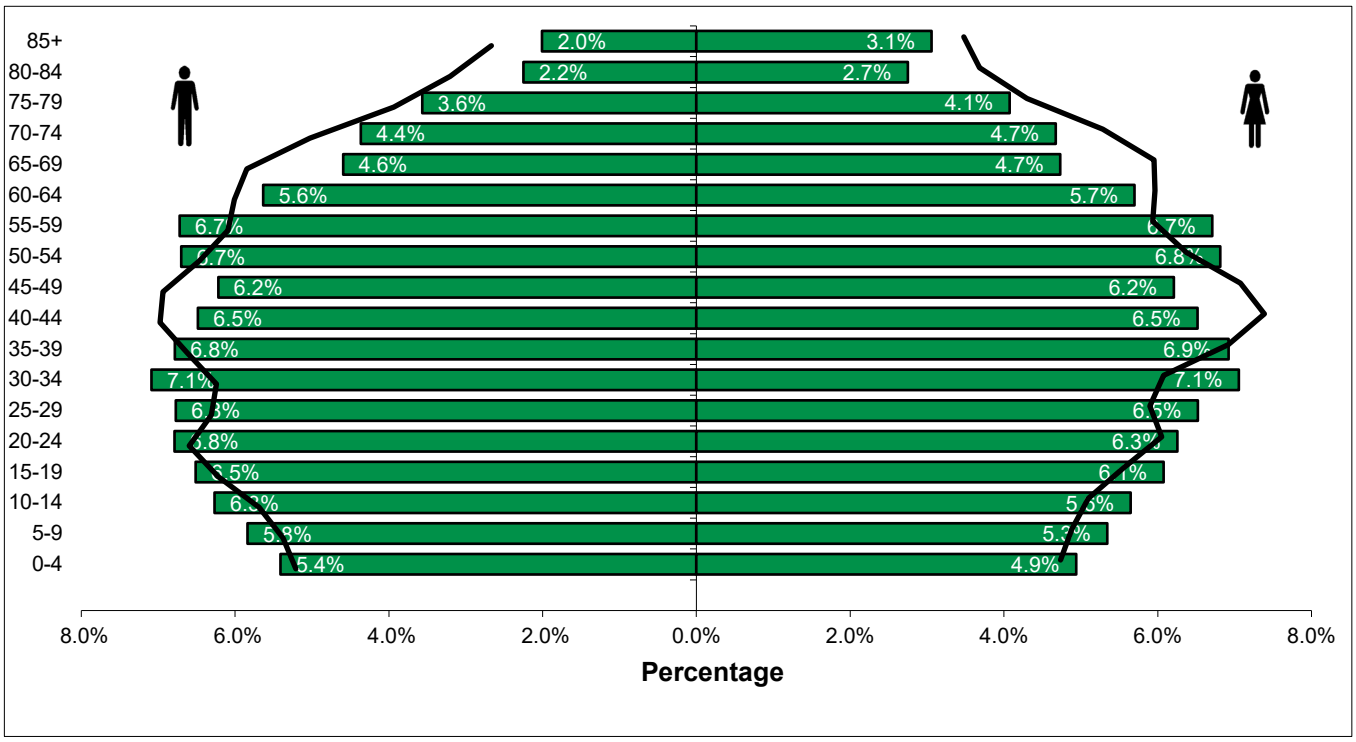
Figure 2 shows that Vale of White Horse had the highest proportion of the population aged 0 – 14 years. Oxford had the highest proportion of residents aged 15 – 44 years.

South Oxfordshire had the highest proportion of residents aged 44 – 64 years, slightly higher than West Oxfordshire. West Oxfordshire had the highest proportion of residents aged 65 and over.

4.2 Future population projections (2022 - 2031)

Figure 3 shows the expected change in the Oxfordshire population between 2022 and 2031 by sex and age group. The green horizontal bars represent the estimated 2022 population and the thick black line represents the forecasted Oxfordshire population for 2031. The population projection data relates to local population forecasts produced by Oxfordshire County Council which include the impact of planned housing developments.

Figure 3: Forecasted change in the Oxfordshire population by age group and sex, 2022 to 2031



Source: Oxfordshire County Council, Oxfordshire Insights, August 2024

Figure 3 indicates that changes in the population will result in a higher proportion of people in older age groups than is currently the case. The greatest proportion of women (>7.0%) will be aged 40 to 44 in 2031 whereas in 2022 they were 30 to 34. A similar shift is seen for men with the greatest proportion aged between 20 to 24 (6.9%) in 2022 whilst in 2031 the highest proportion of men will be aged 35 to 39 years old.

Table 5 shows the change in the total population (all ages) for Oxfordshire and each of the district councils, by year, from 2022 to 2031.

Table 5: Forecasted change in Oxfordshire population (all ages) by district council, 2022 - 2031

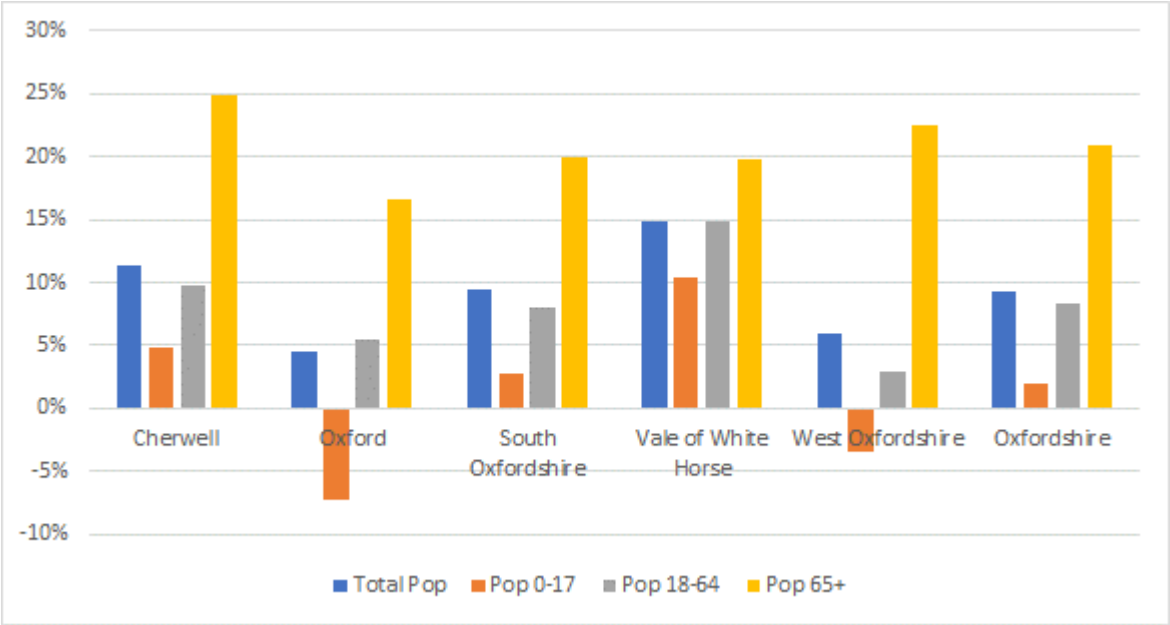
Year	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire	Oxfordshire
2022	164,155	163,257	151,820	142,116	116,928	**738,276**
2023	165,771	163,935	153,306	144,714	117,772	**745,498**
2024	167,646	164,475	154,989	147,412	118,551	**753,074**
2025	169,203	164,851	156,516	150,057	119,253	**759,881**
2026	170,635	165,860	157,879	152,396	120,246	**767,016**
2027	172,314	166,355	159,366	155,078	121,107	**774,220**
2028	174,101	166,860	160,863	157,355	121,541	**780,720**
2029	176,574	168,504	162,203	159,287	121,883	**788,451**
2030	179,515	169,605	163,981	161,318	122,599	**797,018**
2031	182,783	170,763	166,125	163,299	123,905	**806,876**
Change	18,628	7,506	14,305	21,183	6,977	**68,600**
% Change	11.3%	4.6%	9.4%	14.9%	6.0%	**9.3%**

Source: Oxfordshire County Council, Oxfordshire Insights, August 2024

Table 5 suggests that the total population of Oxfordshire is expected to increase from 738,276 in 2022 to 806,876 by 2031, an increase of 9.3% over the 10 year period. The Vale of White Horse is expected to have the highest absolute (21,183) and percentage (14.9%) increase over this period. West Oxfordshire is expected to have the smallest absolute change in population (6,977) and Oxford is expected to have the smallest percentage change in population (4.6%).

Figure 4 below shows the expected percentage population change in each age group for Oxfordshire as a whole and each of the district councils between 2022 and 2031.

Figure 4: Percentage change in Oxfordshire population by district council and age group, 2022 - 2031



Source: Oxfordshire County Council, Oxfordshire Insights, August 2024

Figure 4 shows that the population aged 65 years and over is expected to increase by more than 20% across Oxfordshire as a whole, with the highest increases in Cherwell (24.9%) and West Oxfordshire (22.5%). The population aged 18 – 64 years is expected to increase in all Oxfordshire districts, with Vale of White Horse experiencing the highest increase (14.9%) and West Oxfordshire the lowest (2.9%). The population aged 0 – 17 years is expected to increase only slightly across Oxfordshire as a whole, with reductions expected in the number of 0 – 17 year olds in both Oxford and West Oxfordshire but increases are expected in the other three districts, particularly in Vale of White Horse (10.4%).

Table 6 below shows the ten middle layer super output areas (MSOAs) with the greatest and least expected percentage change in total population from 2022 to 2031. MSOAs are groups of between 2,000 and 6,000 households and have a usually resident population between 5,000 and 15,000 persons. There are 87 MSOAs in Oxfordshire.

Table 6: Ten MSOAs with the largest forecasted percentage increase in population (all ages) from 2022 to 2031 and Ten MSOAs with the lowest forecasted percentage increase in population from 2022 to 2031

MSOA Name	Change	% Change
Yarnton	2,951	42.5%
Harwell	5,133	36.0%
Grove	3,073	31.9%
Berinsfield	2,608	31.5%
East Cherwell	3,489	29.6%
Heyford	2,813	29.6%
Horspath	1,448	24.5%

MSOA Name	Change	% Change
North Cherwell	1,574	21.6%
Didcot North East	1,734	21.2%
Wantage	2,008	19.3%
St Margaret's	-47	-0.7%
Bampton	-68	-0.9%
Sonning Common	-65	-1.1%
Kidlington North	-181	-2.7%
Enstone	-168	-2.8%
Lye Valley & Cowley East	-248	-2.8%
West Cherwell	-211	-2.8%
Wychwoods	-255	-4.0%
Woodcote	-587	-7.0%
Summertown	-522	-7.3%

Source: Oxfordshire County Council, Oxfordshire Insights, August 2024

Table 6 indicates that there are nine MSOAs where the total population is expected to increase by over 20% between 2022 and 2031, with Yarnton MSOA having the greatest percentage increase in population (42.5%). However, some MSOAs are expected to experience a decrease in overall population between 2022 and 2031, with the populations of Woodcote and Summertown MSOAs expected to reduce by around 7%.

Table 7 below shows the expected change in the total population between 2022 and 2031 for the MSOAs that contain the 17 most deprived lower layer super output areas (LSOAs) in Oxfordshire. These 17 LSOAs are the only LSOAs in Oxfordshire that fall into the most deprived 20% of LSOAs nationally. These 17 LSOAs fall within ten separate wards and residents from these LSOAs are one of the priority groups targeted by local smoking cessation services in Oxfordshire.

Table 7: Forecasted change in MSOA populations for the ten LSOAs that are a priority group for Oxfordshire's stop smoking service from 2022 to 2031

MSOA Name	Number of LSOAs in 20% most deprived	Population 2022	Population 2031	Change	% Change
Abingdon South	1	7,836	8,507	671	8.6%
Banbury Grimsbury	2	13,191	15,222	2,031	15.4%
Banbury Neithrop	1	5,992	6,265	273	4.6%
Banbury Ruscote	3	8,967	9,257	290	3.2%
Barton	1	8,586	9,377	791	9.2%
Blackbird Leys	3	6,603	6,759	156	2.4%

MSOA Name	Number of LSOAs in 20% most deprived	Population 2022	Population 2031	Change	% Change
Greater Leys	3	6,831	7,075	244	3.6%
Littlemore & Rose Hill	2	11,393	11,617	224	2.0%
Oxford Central	1	18,337	20,731	2,394	13.1%
Total	**17**	**87,736**	**94,811**	**7,075**	**8.1%**

Source: Oxfordshire County Council, Oxfordshire Insights, August 2024

Table 7 shows that Banbury Grimsbury MSOA (15.4%) and Central Oxford MSOA (13.1%) are expected to have the largest increases in population size by 2031 and Littlemore & Rose Hill MSOA (2.0%) and Blackbird Leys MSOA (2.4%) the lowest. The average population growth across the nine MSOAs of 8.1% is slightly lower than the expected population growth of 9.3% for Oxfordshire over this period.

4.3 Ethnicity

Table 8 below shows the Oxfordshire population by broad ethnic group and age group according to the 2021 Census.

Table 8: Population of Oxfordshire by broad ethnic group and age group, 2021

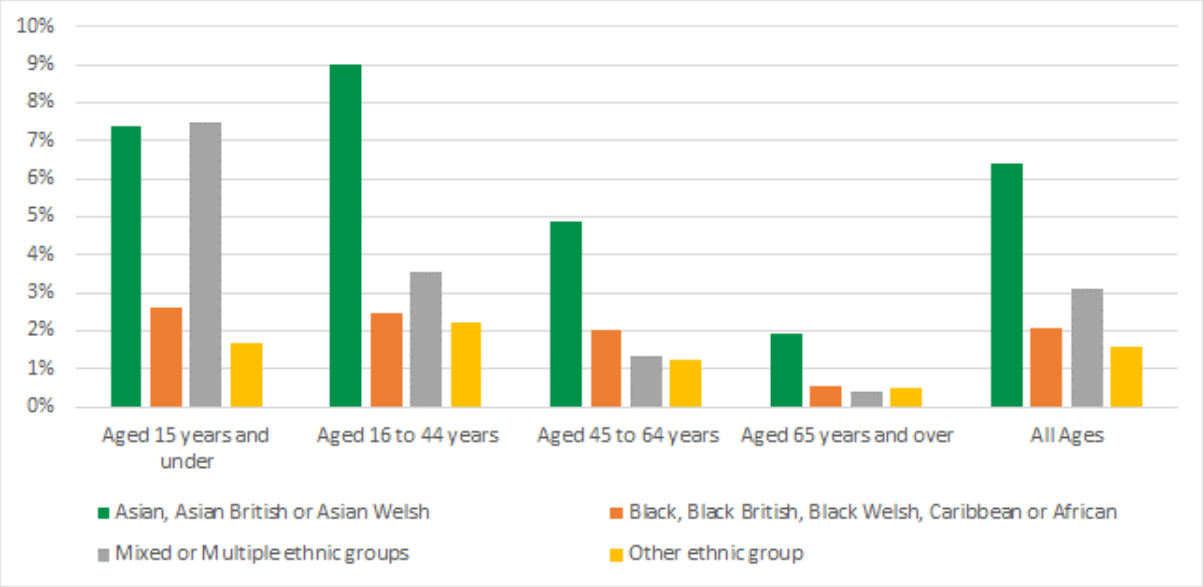
Ethnic Group	Aged 15 years and under	Aged 16 to 44 years	Aged 45 to 64 years	Aged 65 years and over	Total
Asian, Asian British or Asian Welsh	9,627	25,302	8,971	2,487	46,387
Black, Black British, Black Welsh, Caribbean or African	3,420	6,974	3,762	729	14,885
Mixed or Multiple ethnic groups	9,754	9,893	2,430	533	22,610
Other ethnic group	2,198	6,213	2,315	633	11,359
White: English, Welsh, Scottish, Northern Irish or British	105,260	232,519	166,863	125,414	630,056
Total	**130,259**	**280,901**	**184,341**	**129,796**	**725,297**

Source: ONS Census 2021

Table 8 shows that the Oxfordshire population is predominately 'White: English, Welsh, Scottish, Northern Irish or British ethnicity' which accounts for 86.9% of people.

Figure 5 shows the percentage of the population in each age group from non-white ethnic groups. People with 'Asian, Asian British or Asian Welsh' ethnicities accounted for 6.4% of the population, Mixed or Multiple ethnic groups' 3.1%, 'Black, Black British, Black Welsh, Caribbean or African' ethnic backgrounds 2.1% and the remaining ethnic groups 1.6%.

Figure 5: Percentage of Oxfordshire population belonging to ethnic groups other than 'White: English, Welsh, Scottish, Northern Irish or British', 2021



Source: ONS Census 2021

People of 'Asian, Asian British or Asian Welsh' ethnicity aged 16 – 44 years accounted for 9% of the Oxfordshire population in this age group decreasing to 1.9% for those aged 65 years and over. In 2021 'Mixed or Multiple ethnic groups', accounted 7.5% in the population aged under 15 years.

4.4 Deprivation

Whilst Oxfordshire is a relatively affluent area of England, there are pockets of deprivation. Living in a deprived area is a known risk factor for smoking, with areas of higher deprivation often having higher rates of current smoking (ONS (A), 2023). The IMD 2019 is the official measure of relative deprivation in England and has been published by the Ministry of Housing, Communities and Local Government and its predecessor government departments. The IMD 2019 comprises of 39 indicators spanning seven domains of deprivation with are combined and weighted to calculate an overall deprivation score. Scores are published for England, English regions, local authorities and for lower level super output areas (LSOAs). Table 9 below shows the Index of Multiple Deprivation 2019 (IMD 2019) scores and ranks for Oxfordshire and for the district councils.

Table 9: Index of Multiple Deprivation (IMD) 2019 scores and ranks for Oxfordshire and Oxfordshire district councils

Local Authority District name	IMD - Average score	IMD - Rank of average score
Cherwell	14.410	217
Oxford	16.707	182
South Oxfordshire	8.459	302
Vale of White Horse	8.358	305

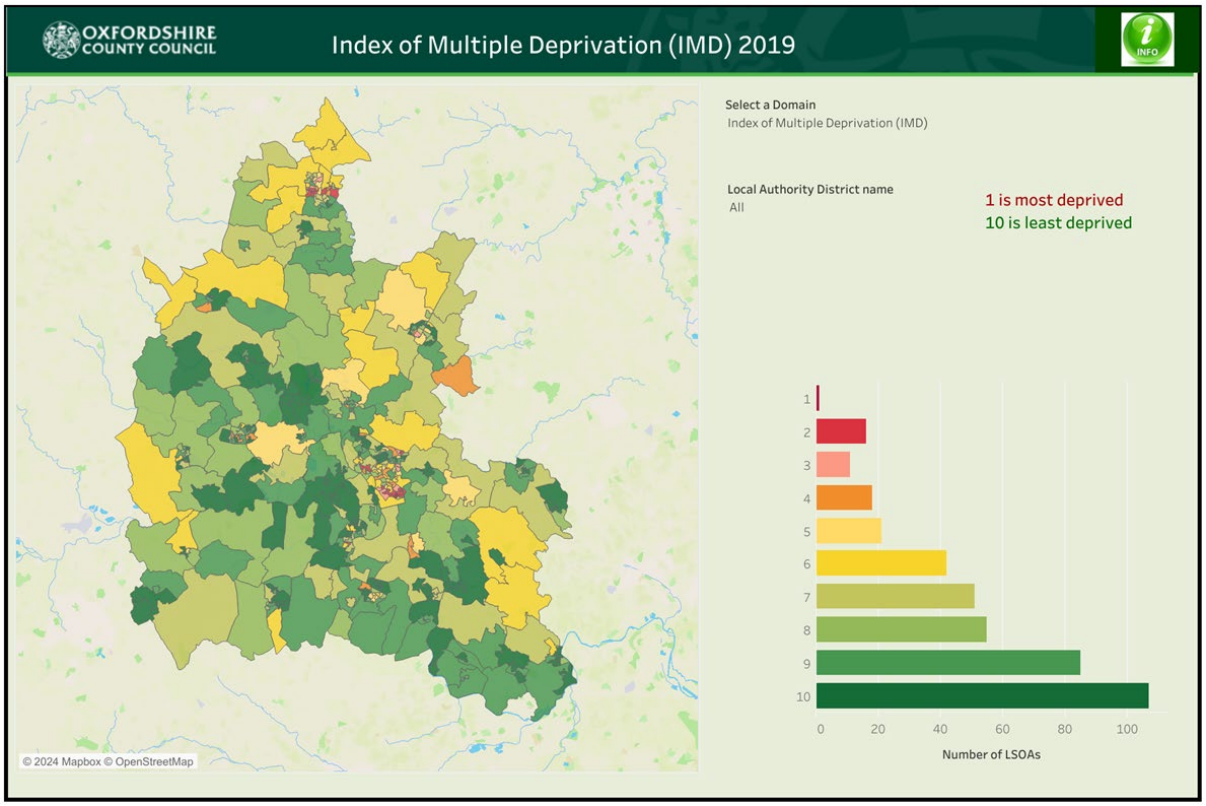
Local Authority District name	IMD - Average score	IMD - Rank of average score
West Oxfordshire	8.684	300
Oxfordshire	**11.656**	**142**

Source: Ministry of Housing, Communities & Local Government (2018 to 2021)

Table 9 indicates that Oxfordshire ranks 142nd of the 151 upper tier local authorities in England, making it one of the least deprived counties in England. At district level, Oxford was the most deprived of the Oxfordshire local authorities, ranked 182nd of the 317 lower tier local authorities in England whilst Vale of White Horse was the least deprived ranked 305th of 317.

Figure 6 below shows a map of Oxfordshire LSOAs along with the number of LSOAs in each deprivation decile in England. Each decile represents the 10% of the population of England arranged from most deprived (Decile 1) to least deprived (Decile 10).

Figure 6: Index of Multiple Deprivation (IMD) 2019 scores Oxfordshire lower super output areas (LSOAs) and number of LSOAs in each deprivation decile



Source: Ministry of Housing, Communities & Local Government (2018 to 2021)

Figure 6 shows that the more deprived parts of Oxfordshire (coloured in red, pink or orange) on the map are generally concentrated in the largest conurbations of Oxford and Banbury. Overall there are fewer than 20 LSOAs in each of the four most deprived deciles and over 100 in the least deprived decile.

Another measure of deprivation was included in the 2021 Census. This is household deprivation (ONS (B), 2023). This classifies households based on four different dimensions:

- Education – a household is counted as deprived if no one has at least level 2 education (five or more GCSE passes at grade A* to C or grade 4 and above or equivalent qualifications) and no one aged 16 to 18 years is a full-time student
- Employment – a household is counted as deprived if any member, not a full-time student, is either unemployed or economically inactive due to long-term sickness or disability
- Health – a household is counted as deprived if any person in the household has general health that is bad or very bad or is identified as disabled
- Housing – a household is counted as deprived if the household's accommodation is either overcrowded, in a shared dwelling, or has no central heating.

Households are then grouped depending on the number of dimensions for which they can be counted as deprived. Table 10 shows the number of Oxfordshire households with one, two, three, or four dimensions of deprivation, along with the number of households with no dimensions of deprivation, by district council according to the 2021 Census.

Table 10: Number of households by dimensions of deprivation by district council, 2021

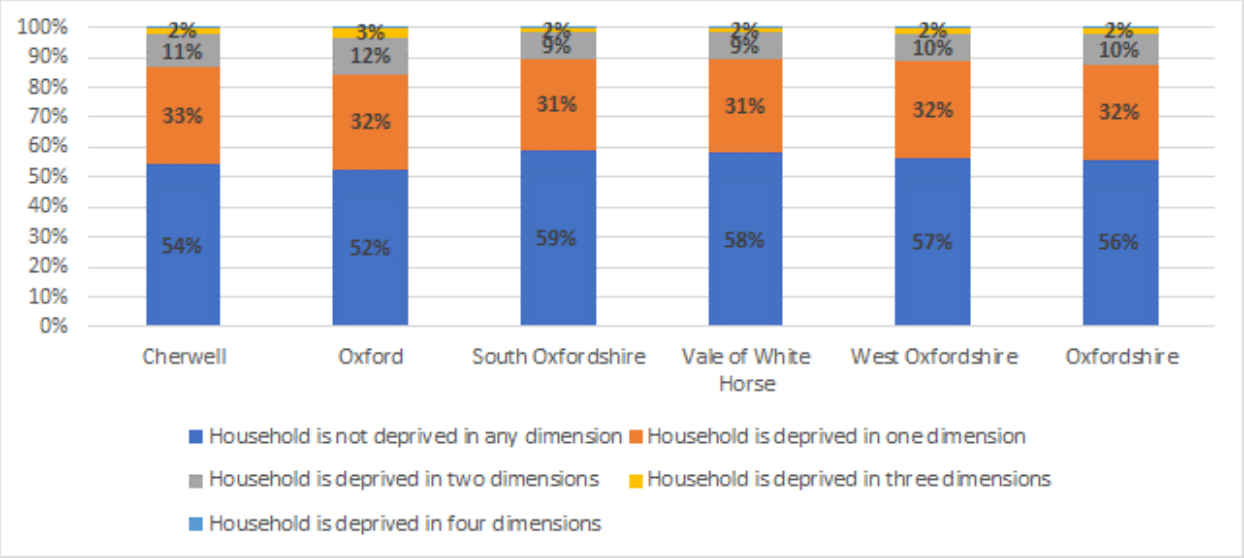
District Council	Household is deprived in one dimension	Household is deprived in two dimensions	Household is deprived in three dimensions	Household is deprived in four dimensions	Household is not deprived in any dimension	Total
Cherwell	21,456	7,160	1,530	95	35,653	65,894
Oxford	17,781	6,713	1,767	146	28,832	55,239
South Oxfordshire	19,008	5,413	956	45	36,075	61,497
Vale of White Horse	17,813	5,252	950	49	33,434	57,498
West Oxfordshire	15,276	4,656	844	40	27,166	47,982
Oxfordshire	**91,334**	**29,194**	**6,047**	**375**	**161,160**	**288,110**

Source: ONS Census

Table 10 shows that Oxford had the highest number of households that were deprived in both three and four dimensions and West Oxfordshire had the least. Cherwell had the highest number of households deprived in one or two dimensions, and West Oxfordshire had the least.

Figure 7 below shows the percentage of households in Oxfordshire and each district council that were counted as deprived in one, two, three, four or no dimensions of household deprivation.

Figure 7: Percentage of households with one, two or three dimensions of deprivation, Oxfordshire district councils, 2021



Source: ONS Census

Figure 7 shows that the percentages of households classified as deprived across the different number of dimensions of deprivation is very similar across the five Oxfordshire districts. Oxford has a slightly higher percentage of households (15%) counted as deprived across two or three dimensions compared with the other districts where this percentage ranges from 11% in South Oxfordshire and Vale of White Horse to 13% in Cherwell.

4.5 Prevalence of health conditions associated with smoking

A planned strategy to be published in 2024 based on best evidence will address six major conditions which contribute to over 60% of mortality and morbidity in England including:

- Cardiovascular disease including stroke and diabetes
- Chronic respiratory diseases
- Cancers
- Dementia
- Mental ill health
- Musculoskeletal disorders

Primary and secondary prevention will be the focus of chapter 2 and smoking will be identified as the biggest single cause of preventable illness and death, highlighting the government's proposals and support to stop smoking and consult on further tobacco controls.

This section describes the prevalence of these six health conditions in Oxfordshire compared to England and the South East.

4.5.1 Cardiovascular disease

Smoking is associated with increased cardiovascular risk and is one of the three principle, non-hereditary risk factors for coronary heart disease (Capwell, 2009).

Table 11 shows the prevalence of coronary heart disease (CHD) for England, the South East and Oxfordshire residents (all ages), by Oxfordshire district. Prevalence of CHD in Oxfordshire is lower than England and the South East and similar across the 2 years for each district. Oxford has the lowest prevalence of coronary heart disease (1.45% and 1.46%, respectively) whilst West Oxfordshire has the highest prevalence (2.82% and 2.86%) which is likely to be attributed for the most part to the lower age profile in Oxford (Figure 2).

Table 11: Prevalence of coronary heart disease in England, the South East, Oxfordshire, and by Oxfordshire district, all ages, 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	3.0%	3.0%
South East	2.8%	3.8%
Oxfordshire	**2.28%**	**2.30%**
Cherwell	2.52%	2.52%
Oxford	1.45%	1.46%
South Oxfordshire	2.52%	2.54%
Vale of White Horse	2.66%	2.70%
West Oxfordshire	2.82%	2.86%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

Smoking causes temporary increases in heart rate and blood pressure via vasoconstriction; however, longer term hypertension is also a risk due to damage to the arterial lining and narrowing of the arteries leading to an increased risk of cardiovascular disease and cerebrovascular disease (ASH, 2021).

Table 12 shows the prevalence of hypertension, for England, the South East and Oxfordshire residents, by Oxfordshire district for 2022/23 compared to 2021/22, Prevalence for Oxfordshire is lower than England and the South East and similar across the 2 years for each district. Oxford district has the lowest prevalence of hypertension (8.44% and 8.58%) whilst West Oxfordshire has the highest prevalence (16.02% and 16.58%) which is above the England and the South East rates.

Table 12: Prevalence of hypertension in Oxfordshire, all ages, for England, the South East and Oxfordshire district, 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	14.0%	14.4%
South East	14.2%	14.7%
Oxfordshire	**12.55%**	**12.89%**
Cherwell	13.03%	13.36%
Oxford	8.44%	8.58%
South Oxfordshire	13.95%	14.41%
Vale of White Horse	14.19%	14.56%
West Oxfordshire	16.02%	16.58%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

4.5.2 Chronic respiratory diseases

Smoking can adversely affect asthma, with smoking being associated with more severe asthma symptoms, a reduced response to treatment as well as an accelerated decline in pulmonary function (Tiotiu et al., 2021). Additionally, exposure to second hand smoke can also trigger asthma symptoms as well as increase the risk of developing asthma in children from passive smoking (Kid Health, 2023; NHS, 2022).

Table 13 shows the prevalence of asthma in England, the South East and Oxfordshire, for each district. For 2021/22 and 2022/23, Oxford had the lowest prevalence (4.78% and 4.72%, respectively) with South Oxfordshire (6.84% and 6.82%) and West Oxfordshire (6.88% and 7.03%) having the highest prevalence, above England and South East rates.

Table 13: Prevalence of asthma in Oxfordshire, for people aged 6 years and above, in England, the South East and Oxfordshire districts, 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	6.47%	6.52%
South East	6.38%	6.45%
Oxfordshire	**6.11%**	**6.12%**
Cherwell	6.41%	6.40%
Oxford	4.78%	4.72%
South Oxfordshire	6.84%	6.82%
Vale of White Horse	6.50%	6.55%
West Oxfordshire	6.88%	7.03%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

Smoking is one of the leading causes of Chronic Obstructive Pulmonary Disease (COPD), accounting for 70% of cases in high-income countries (World Health

Organization, 2023). In addition, patients with COPD who reported more frequent symptom exacerbations were more likely to smoke (Williams et al., 2022).

Table 14 below shows the prevalence of COPD in England, the South East and Oxfordshire, for each Oxfordshire district. Oxford has the lowest prevalence of COPD (0.99% and 0.96%, respectively) with Vale of White Horse (1.54% and 1.50%) and West Oxfordshire (1.56% and 1.49%) having the highest prevalence, although this is still lower than England and the South East rates.

Table 14: Prevalence of Chronic Obstructive Pulmonary Disease in England, the South East and Oxfordshire, all ages, by Oxfordshire district, 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	1.87%	1.85%
South East	1.67%	1.66%
Oxfordshire	**1.34%**	**1.30%**
Cherwell	1.45%	1.42%
Oxford	0.99%	0.96%
South Oxfordshire	1.39%	1.36%
Vale of White Horse	1.54%	1.50%
West Oxfordshire	1.56%	1.49%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

4.5.3 Cancer

Smoking has been linked as a cause for at least 16 types of cancer including lung, breast and bowel cancer (Cancer Research UK, 2023). Inhalation of tobacco smoke can expose the body to multiple carcinogens which, in turn, can induce the development of cancerous cells (ASH, 2023).

Table 15 below show the prevalence of cancer for England, the South East, and Oxfordshire residents, by Oxfordshire district. Cancer prevalence in 2022/23 is higher for all districts compared to 2021/22. Oxford has the lowest cancer prevalence (2.34% and 2.47%) and West Oxfordshire has the highest (4.93% and 5.15%). All districts apart from Oxford have higher rates than England and the South East.

Table 15: Prevalence of cancer in England the South East and Oxfordshire by Oxfordshire district, all ages 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	3.34%	3.49%
South East	3.83%	4.01%
Oxfordshire	**3.80%**	**3.98%**
Cherwell	4.00%	4.18%
Oxford	2.34%	2.47%
South Oxfordshire	4.38%	4.56%
Vale of White Horse	4.37%	4.56%
West Oxfordshire	4.93%	5.15%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

4.5.4 Dementia

There are a range of risk factors associated with dementia of which age, a non-modifiable risk factor is the most significant. Smoking is a modifiable risk factor for dementia as the substances within tobacco smoke containing multiple toxic compounds cause oxidative and inflammatory stress which can both increase the risk and exacerbate Alzheimer's disease (the most common cause of dementia) (Alzheimer's Disease International, 2014). Overall, estimates suggest that smoking can increase the risk of developing dementia by 30-50% (Livingston et al., 2020).

Table 16 below details the prevalence of dementia for England, the South East and Oxfordshire by district. Oxford has the lowest prevalence of dementia (0.45% and 0.46%) and West Oxfordshire has the highest prevalence (1.03% and 1.02%). Notably, the prevalence percentage of dementia in West Oxfordshire is over double the rate for Oxford and higher than England and the South East.

Table 16: Prevalence of dementia for England, the South East and Oxfordshire, by Oxfordshire district, all ages 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	0.72%	0.74%
South East	0.79%	0.80%
Oxfordshire	**0.70%**	**0.72%**
Cherwell	0.68%	0.70%
Oxford	0.45%	0.46%
South Oxfordshire	0.79%	0.79%

District	Prevalence %	
	2021/22	2022/23
Vale of White Horse	0.77%	0.81%
West Oxfordshire	1.03%	1.02%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

4.5.5 Mental ill health

Smoking rates among adults with depression are twice as high compared to adults without depression (ASH 2019). It's estimated that among the six million people who smoke in England, 1.6 million also had depression and anxiety (ASH, 2022). Smoking may be associated with an increased risk of major depressive disorder (Hämäläinen, et al., 2001).

Table 17 below shows the prevalence of depression in England, the South East and Oxfordshire, by Oxfordshire district. Oxford has the lowest prevalence of depression (10.32% and 10.69%) and Vale of White Horse has the highest prevalence (14.11% and 14.79%) which is higher than both England and the South East.

Table 17: Prevalence of depression in England, South East and Oxfordshire by Oxfordshire district, for people aged 18 years and above, 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	12.66%	13.25%
South East	13.21%	13.87%
Oxfordshire	**12.54%**	**13.17%**
Cherwell	13.43%	14.19%
Oxford	10.32%	10.69%
South Oxfordshire	13.35%	14.14%
Vale of White Horse	14.11%	14.79%
West Oxfordshire	13.00%	13.75%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

People with serious mental ill health such as schizophrenia, bipolar affective disorder and other psychoses have higher rates of smoking than the general population. In 2022, it was estimated that among the six million people who smoke in England, 230,000 people who smoke had SMIs and around 40% of people with an SMI smoke (ASH, 2022).

Table 18 shows the prevalence of SMI in England, the South East and Oxfordshire, for each Oxfordshire district. Cherwell, South Oxfordshire and Vale of White Horse have similar rates which are lower than the national and South East rates. Oxford had

the highest rate of SMI (1.06% and 1.09%, respectively) higher than both England and the South East.

Table 18: Prevalence of Serious Mental Illness in Oxfordshire, all ages, by Oxfordshire district, 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	0.95%	1.00%
South East	0.87%	0.91%
Oxfordshire	**0.85%**	**0.89%**
Cherwell	0.75%	0.80%
Oxford	1.06%	1.09%
South Oxfordshire	0.76%	0.79%
Vale of White Horse	0.78%	0.80%
West Oxfordshire	0.82%	0.85%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

4.5.6 Musculoskeletal conditions

Chronic inflammatory stress experienced by people who regularly smoke is found to contribute to the development of Rheumatoid Arthritis (RA). Additionally, tobacco smoking is associated with an increased severity in the symptoms of RA as well as well as dampening the efficacy of RA medication (National Rheumatoid Arthritis Society, 2019).

Table 19 below details the prevalence of RA for England, the South East and Oxfordshire by district. Oxford had the lowest prevalence of RA (0.42% for both years) and West Oxfordshire had the highest prevalence (0.85% and 0.84%, respectively) higher than England and the South East.

Table 19: Prevalence of rheumatoid arthritis in England, the South East and Oxfordshire, by Oxfordshire district for people aged 16 years and above, , 2021/22 and 2022/23

District	Prevalence %	
	2021/22	2022/23
England	0.77%	0.76%
South East	0.77%	0.77%
Oxfordshire	**0.67%**	**0.67%**
Cherwell	0.78%	0.80%
Oxford	0.42%	0.42%
South Oxfordshire	0.74%	0.74%
Vale of White Horse	0.73%	0.73%

District	Prevalence %	
	2021/22	2022/23
West Oxfordshire	0.85%	0.84%

Source: NHS Digital Quality and Outcomes Framework, 2022-23

5 Epidemiology of smoking in Oxfordshire

This chapter describes who and how many people smoke in Oxfordshire and how that translates to smoking related hospital admissions and deaths.

5.1 Historical smoking prevalence

This section explores historical trends in the prevalence of smoking in Oxfordshire and compares the levels of smoking in Oxfordshire to regional and national averages. This section draws on a number of data sources that describe the prevalence of smoking in different population groups, life stages, geographical areas and time periods.

5.1.1 Childhood smoking

Table 20 below shows the estimated number of children in Oxfordshire aged 11 – 15 years according to whether they are people who smoke regularly, occasionally, previously or who never smoked. These data have been taken from a national survey of children aged 11 – 15 published by NHS Digital (2022) and the percentages for each smoking status category for England have been applied to the estimated population of Oxfordshire aged 11 – 15 years based on ONS population estimates to provide estimates of the number of children in each smoking status group for Oxfordshire. The numbers have been rounded to the nearest ten, so sub totals may not add up to totals due to rounding.

Table 20: Estimated number of children aged 11 – 15 years by smoking status, 2021 (England data applied to Oxfordshire population)

Category	11 years	12 years	13 years	14 years	15 years	Total
Boys						
Regular smoker	0	0	10	20	190	220
Occasional smoker	0	0	60	80	150	290
Used to smoke	0	0	40	60	160	270
Tried smoking	30	180	220	340	560	1,330
Never smoked	4,600	4,660	4,300	4,030	3,710	21,300
Currently smoke	***0***	***0***	***60***	***100***	***340***	***510***
Ever smoked	30	190	330	510	1,060	2,110
Girls						
Regular smoker	0	10	0	50	120	180
Occasional smoker	0	0	30	100	350	480
Used to smoke	20	10	30	150	160	370
Tried smoking	90	100	300	520	590	1,610

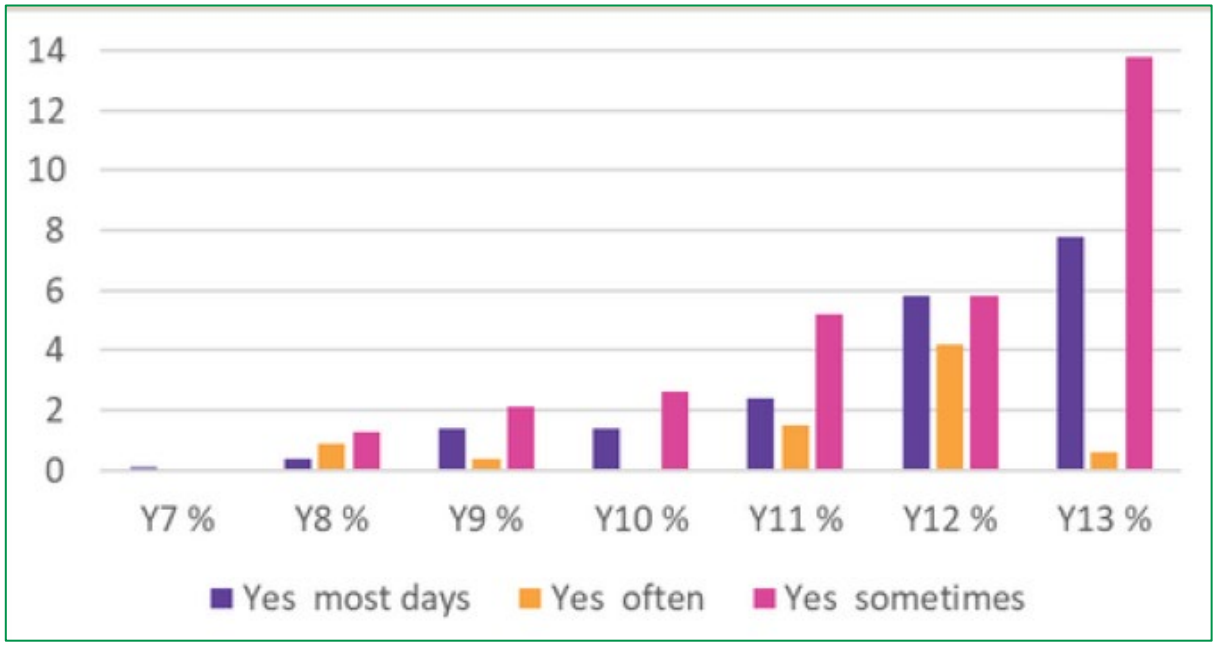
Category	11 years	12 years	13 years	14 years	15 years	Total
Never smoked	4,200	4,310	3,860	3,420	3,240	19,030
Currently smoke	***0***	***10***	***30***	***150***	***470***	***660***
Ever smoked	110	120	360	810	1,230	2,630
Total						
Regular smoker	0	10	10	70	310	400
Occasional smoker	0	10	80	180	500	770
Used to smoke	20	20	70	210	320	630
Tried smoking	120	280	510	870	1,150	2,930
Never smoked	8,800	8,970	8,160	7,460	6,950	40,330
Currently smoke	***0***	***10***	***100***	***250***	***810***	***1,170***
Ever smoked	140	310	680	1,320	2,280	4,740

Source: NHS Digital, Smoking, drinking and drug use in young people in England, 2021

Table 20 indicates that the estimated number of children in Oxfordshire that currently smoked aged 11 – 15 increased with age, with only 2 children aged 11 estimated to be currently smoke compared to 809 children aged 15. More boys than girls are estimated to currently smoke in the 11 – 13 years age group, but the reverse is true in the 14 – 15 years age group where more girls are estimated to be currently smoke than boys.

Figure 8 below shows the results of a different survey, the OxWell survey, which was carried out in Oxfordshire in early 2023. A total of 7,133 students took part in the survey from 12 out of 245 primary schools, 15 out of 43 secondary schools, and all 3 Further Education colleges. The survey asked questions about wellbeing, mental health and the school/college experience. As not all Oxfordshire schools participated in the survey and in participating schools not all pupils responded, the survey results should be taken as indicative and not as representative of Oxfordshire as a whole.

Figure 8: Percentage of respondents saying 'Yes' to question 'Do you smoke cigarettes' by age, 2023



Source: Oxfordshire County Council OxWell Survey 2023

Figure 8 shows the percentage of pupils responding that they smoke cigarettes most days/often/sometimes by academic year. Year 7 refers to pupils aged 11 – 12 years and Year 13 refers to pupils aged 17 – 18 years. As with the results of the NHS Digital national survey, the OxWell survey data suggest that the percentage of pupils that smoke most days increases with age, from less than 2% for those aged 11 – 15 years to nearly 8% for those aged 17 – 18 years.

The county council also carried out a survey of children and young people aged 11 – 17/18 specifically on smoking and vaping[4], which obtained 5,425 useable responses. This survey suggested that 87.3% of young people had never tried cigarettes, with this percentage being slightly higher for males (89.0%) than for females (87.2%) and for those of other genders (67.2%). Overall, 1.0% of children and young people said that they were smoking cigarettes everyday, with the percentage for those of other genders (15.8%) and males (0.7%) being higher than the percentage for females (0.3%). In terms of vaping, the survey suggested, the majority of children and young people had never tried vaping (76.2%), with 9.7% who had tried vaping once or twice and 3.5% vaping every day. These percentages were higher for older age groups than younger children with 10.1% of 17/18 year olds vaping every day.

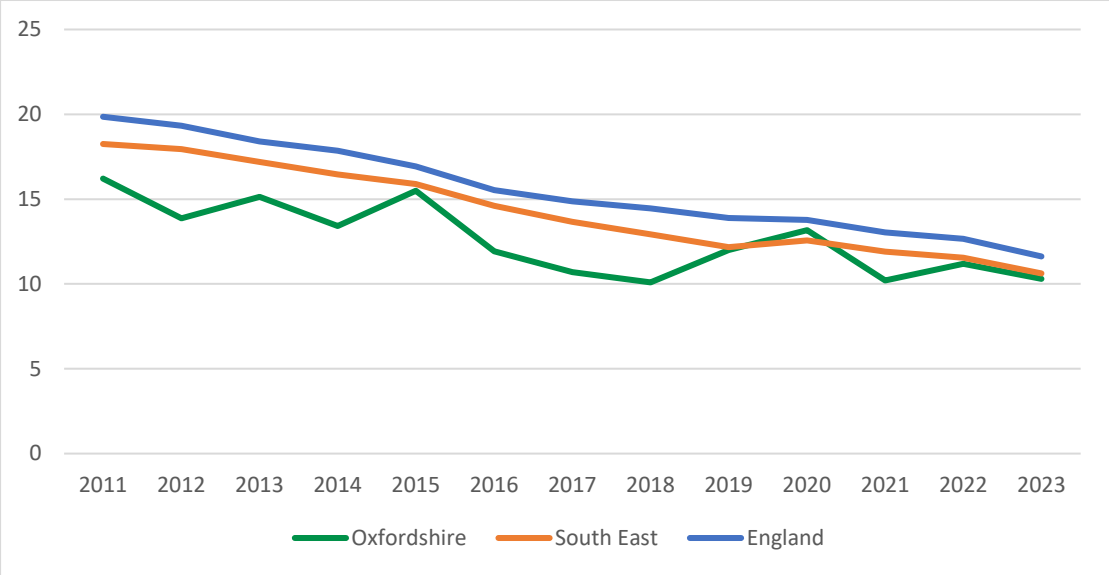
[4] Oxfordshire County Council. Oxfordshire Youth Vaping Survey 2024

5.1.2 Adult smoking in Oxfordshire

This section compares trends in the prevalence of smoking by adults in Oxfordshire from a number of data sources. Where data are available, smoking prevalence in Oxfordshire is compared to the South East region and England and district councils are compared to each other and to Oxfordshire as a whole.

Figure 9 shows the proportion of adults aged 18 years and over that currently smoke in Oxfordshire compared with the South East region and England for the years from 2011 to 2023. These data come from the Annual Population Survey (APS) (Office for National Statistics, 2012). The APS is a UK-wide national household survey commissioned by the Office for National Statistics. It has been carried out annually since 2004 and has around 320,000 respondents each year. The survey includes questions on employment/unemployment, housing, ethnicity, religion, health and education.

Figure 9: Proportion of adults aged 18 years and over that currently smoke (APS survey) in Oxfordshire, the South East region and England, 2011 to 2023

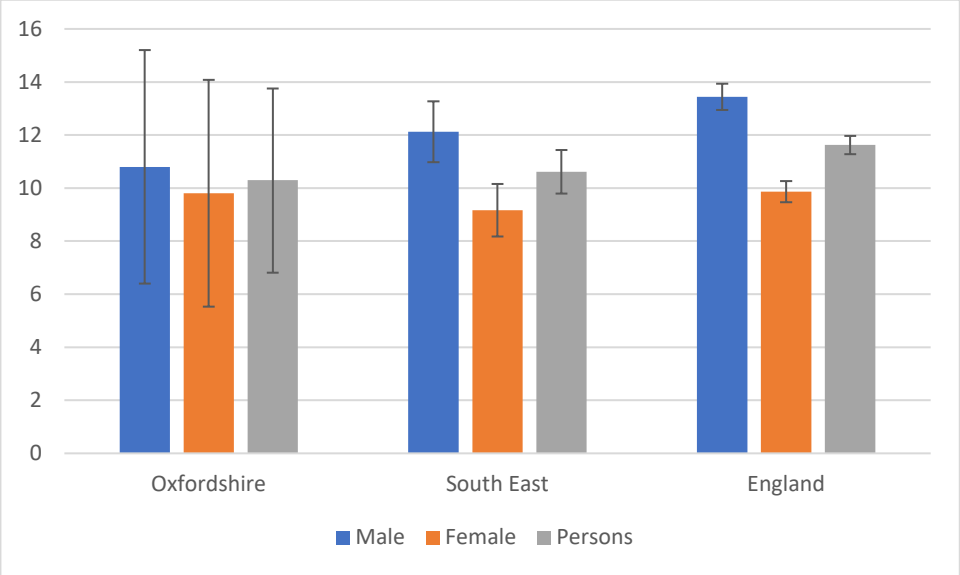


Source: OHID Smoking Profiles

Figure 9 shows that the percentage of adults that currently smoke in Oxfordshire reduced from 16.2% in 2011 to 10.3% in 2023. In comparison, the percentage of adults that currently smoke in England fell from 19.8% to 11.6% over the same period and the percentage of adults that currently smoke in the South East region reduced from 18.2% to 10.6%. This suggests that Oxfordshire has generally had lower adult smoking rates then England and the South East region, but these rates have converged over time.

Figure 10 below shows the percentage of adults that currently smoke for Oxfordshire, the South East region and England in 2023, broken down by males, females and both sexes.

Figure 10: Percentage of adults aged 18 years and over that currently smoke (APS survey), by males, females and both sexes, Oxfordshire, the South East region and England, 2023



Source: OHID Smoking Profiles

Figure 10 indicates that Oxfordshire had similar rates of current smoking to both England and the South East region for both males and females. These differences were not statistically significant, because of the overlapping confidence intervals.

Table 21 shows the percentage of adults that currently smoke in Oxfordshire compared to each of the Oxfordshire district councils for the years from 2011 to 2023.

Table 21: Percentage of adults aged 18 years and over that currently smoke (APS survey), Oxfordshire and district councils, 2011 to 2023

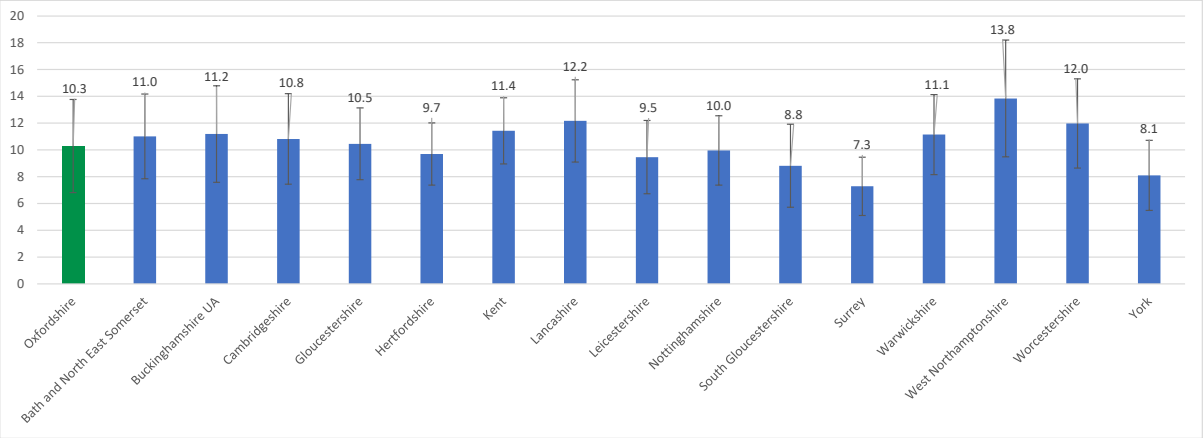
Year	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2011	**16.2**	21.4	21.1	14.5	8.9	13.8
2012	**13.9**	16.9	16.3	11.9	10.1	13.4
2013	**15.1**	15.5	17.1	12.6	14.5	15.7
2014	**13.4**	13.2	13.4	13.5	14.8	12.2
2015	**15.5**	20.5	13.7	9.5	18.1	16.5
2016	**11.9**	9.5	10.7	10.7	15.0	14.8
2017	**10.7**	11.6	9.0	10.4	9.7	13.7
2018	**10.1**	11.4	8.3	13.4	6.8	10.7
2019	**12.0**	11.8	13.5	12.4	11.6	10.3
2020	**13.2**	12.1	12.8	17.9	10.3	12.1
2021	**10.2**	12.5	12.1	9.2	12.8	3.7
2022	**11.2**	13.5	7.4	13.1	8.5	14.3
2023	**10.3**	17.6	7.8	6.8	2.0	18.9

Source: OHID Smoking Profiles

Table 21 indicates that the percentage of adults that currently smoke was lower in 2023 than in 2011 in all the Oxfordshire district councils, with the exception of West Oxfordshire, where it was 5.1% higher. In 2011, Cherwell had the highest percentage of adults that currently smoked (21.4%) which reduced to 17.6% in 2023. The reduction in Oxford was greater, with 21.1% of adults smoking in 2011 dropping by about two thirds to 7.8% in 2023. The size of the sample of respondents to the APS survey from each district council is not published in the available data, but may be relatively small and vary from year to year. This explain the variability in the percentage of adults that currently smoke in each of the Oxfordshire districts.

Figure 11 shows the percentage of adults aged 18 and over that currently smoke in Oxfordshire, compared with the NHS England statistical neighbour peer group, for the year 2023. This is a group of 16 local authorities including Oxfordshire selected as being similar to each other across a range of population characteristics.

Figure 11: Proportion of adults aged 18 years and over that currently smoke (APS survey), Oxfordshire compared with NHS England statistical neighbour peer group, 2023

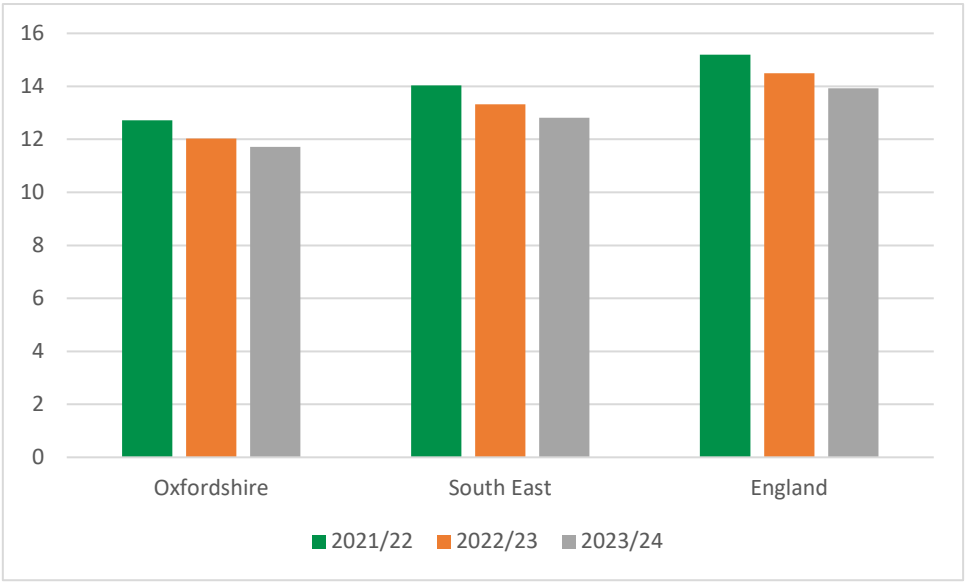


Source: OHID Smoking Profiles

Figure 11 shows that West Northamptonshire had the highest percentage of adults that currently smoked and Surrey had the lowest percentage in 2023. However, as all of the confidence intervals overlap in Figure 11, none of the differences in the smoking rates were statistically significant. Therefore, Oxfordshire's rate is similar to those of its statistical peers.

Figure 12 shows the percentage of people aged 15 and over recorded as people who smoke in GP practice registers for Oxfordshire compared with the South East region and England in 2021/22 and 2022/23.

Figure 12: Percentage of people aged 15 and over recorded as people who currently smoke by GP practices in Oxfordshire, the South East region and England, 2021/22, 2022/23 and 2023/24



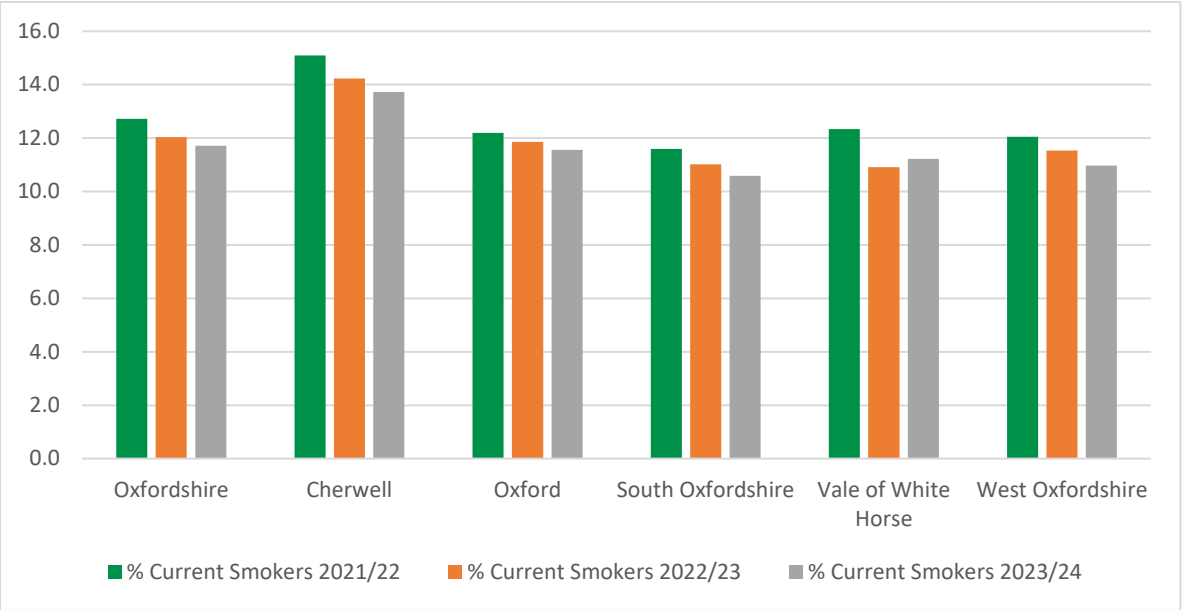
Source: NHS Digital Quality Outcomes Framework (QOF) 2021/22, 2022/23 and 2023/24

Figure 12 indicates that the percentage of people aged 15 and over that currently smoked was lower in Oxfordshire than in both the South East region and England in

both years. The recorded smoking prevalence was lower in 2023/24 than in 2021/22 and 2022/23 in Oxfordshire, as it was for both the South East region and England.

Figure 13 shows the recorded smoking prevalence for persons aged 15 and over for Oxfordshire and each of the district councils in 2021/22, 2022/23 and 2023/24.

Figure 13: Percentage of people aged 15 and over recorded as people who currently smoke by GP practices in Oxfordshire and district councils, 2021/22, 2022/23 and 2023/24

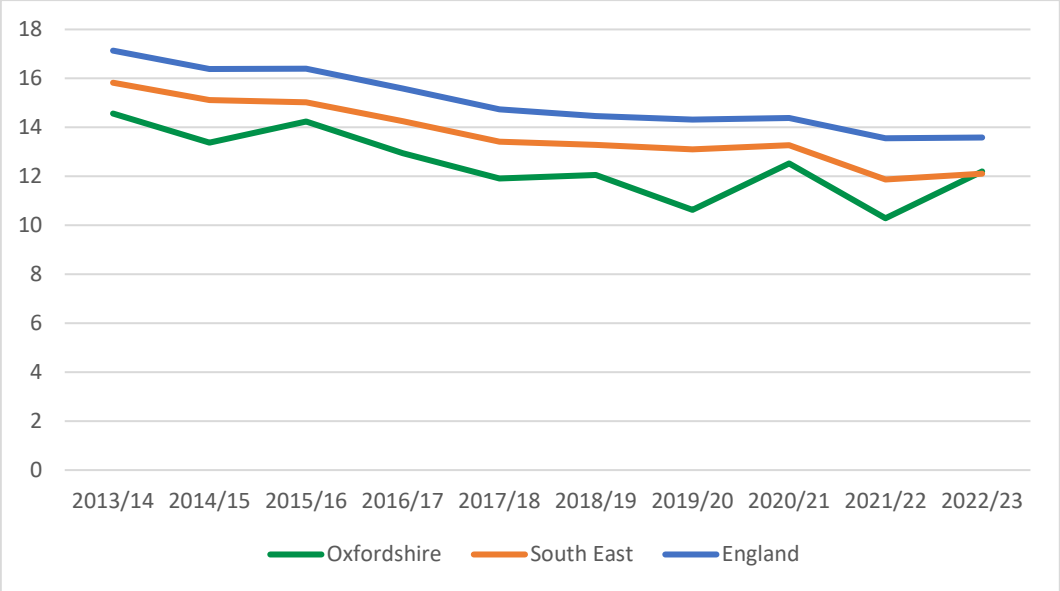


Source: NHS Digital Quality Outcomes Framework (QOF) 2021/22, 2022/23 and 2023/24

Figure 13 shows that Cherwell District Council had the highest recorded prevalence of current smoking in all three years. Rates of current smoking were very similar in each of the other district councils and were lower in 2023/24 than in both preceding years.

Figure 14 shows the adult prevalence of smoking in Oxfordshire compared to the South East region and England based on data from the annual GP Patient Survey (GPPS). This survey asks patients registered with a GP and aged 18 and over how often they smoke and reports the percentage that say that they smoke “regularly” or “occasionally”.

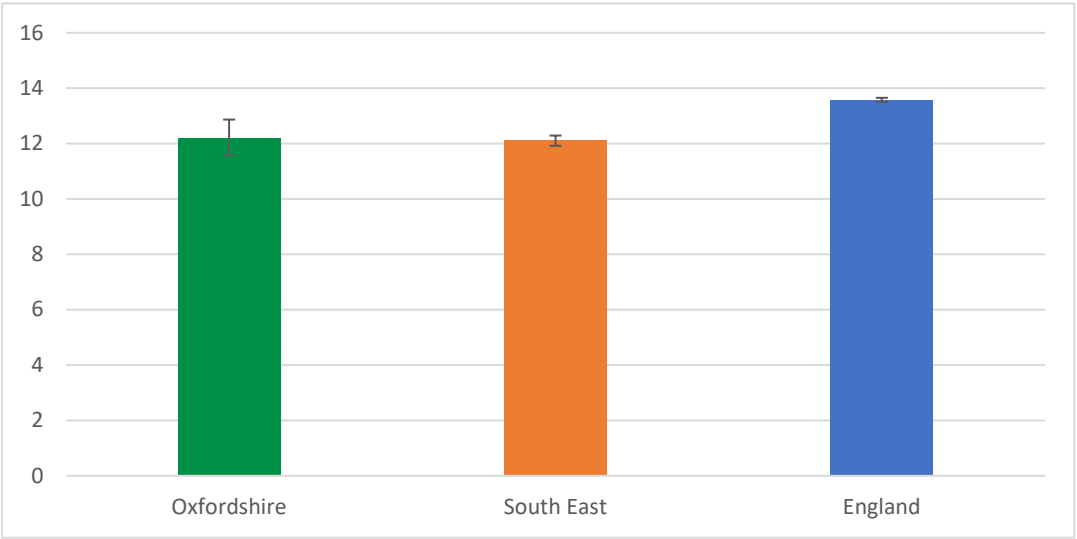
Figure 14: Proportion of adults aged 18 years and over that regularly or occasionally smoke (GPPS survey) in Oxfordshire, the South East region and England, 2013/14 to 2022/23



Source: OHID Smoking Profiles

Figure 14 indicates that adult smoking rates in Oxfordshire have declined since 2013/14, but less consistently than for both England and the South East region. In Oxfordshire rates of people who smoke appear to increase considerably in 2020/21 and in 2022/23 but this is likely a reflection of estimates based on the small numbers of adults who smoke in this population. Figure 15 shows the same data for 2022/23 with confidence intervals. Oxfordshire (12.2%) confidence intervals overlap with those of the South East (12.1%) indicating that the rates between these two areas are unlikely to be statistically significantly different. Rates of both the South East and Oxfordshire are significantly lower than England (13.6%).

Figure 15: Proportion of adults aged 18 years and over that regularly or occasionally smoke (GPPS survey) in Oxfordshire, the South East region and England, 2022/23



Source: OHID Smoking Profiles

Table 22 shows the percentage of adults that regularly or occasionally smoke in Oxfordshire compared to each of the Oxfordshire district councils for the years from 2013/14 to 2022/23.

Table 22: Percentage of adults aged 18 years and over that regularly or occasionally smoke (GPPS survey), Oxfordshire and district councils, 2013/14 to 2022/23

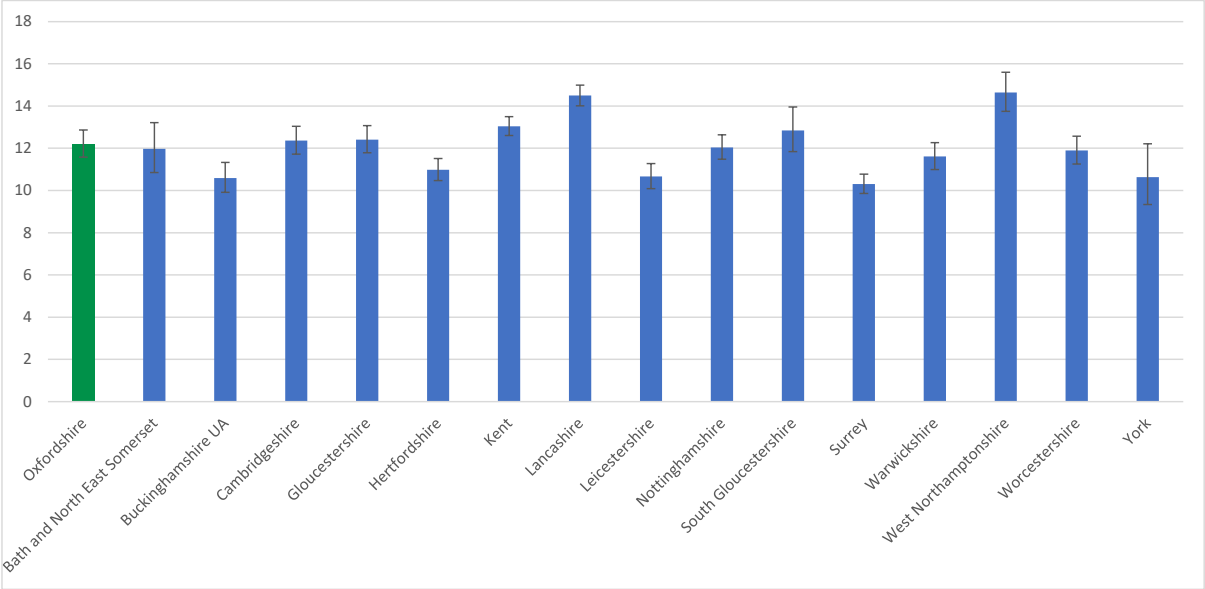
Year	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2013/14	**14.6**	16.9	17.1	12.7	11.9	12.7
2014/15	**13.4**	13.8	13.8	13.2	11.4	14.7
2015/16	**14.2**	15.1	15.5	11.0	14.5	15.0
2016/17	**12.9**	15.5	13.6	11.9	10.1	13.2
2017/18	**11.9**	14.2	12.8	12.0	8.9	10.8
2018/19	**12.1**	13.3	15.1	10.8	10.1	8.8
2019/20	**10.6**	12.0	12.8	9.4	9.1	8.5
2020/21	**12.5**	14.3	14.9	11.0	10.3	10.4
2021/22	**10.3**	11.4	11.0	9.1	9.5	10.1
2022/23	**12.2**	12.2	16.4	9.9	9.5	11.6

Source: OHID Smoking Profiles

Table 22 indicates that although Oxford and Cherwell district councils have generally had higher rates of adult smoking than Oxfordshire small numbers means these differences are only sometimes significant (indicated by the dark pink shading). Amber shading indicates rates were similar to Oxfordshire estimates. South Oxfordshire and West Oxfordshire have generally had lower rates of adult smoking than Oxfordshire. Green shading indicates where rates for these districts are significantly lower than Oxfordshire. As with the APS survey, year on year variation in smoking rates is likely to be impacted by the sample size achieved by the survey each year.

Figure 16 shows the percentage of adults aged 18 and over that smoke regularly or occasionally for Oxfordshire, compared with the NHS England statistical neighbour peer group, for the year 2022/23.

Figure 16: Proportion of adults aged 18 years and over that regularly or occasionally smoke (GPPS survey) compared with NHS England statistical neighbour peer group, 2022/23



Source: OHID Smoking Profiles

Figure 16 suggests that West Northamptonshire (14.6%) and Lancashire (14.5%) had the highest rates of smoking in 2022/23 and Surrey (10.3%) the lowest. Oxfordshire's rate (12.2%) was similar to that of several peer authorities.

Table 23 shows the different estimates of adult smoking prevalence for Oxfordshire and the district councils from the APS, GPPS and QOF data sources for the most recent year of prevalence data available.

Table 23: Comparison of percentage adult smoking prevalence for Oxfordshire and district councils between the Annual Population Survey (APS), GP Practice Survey (GPPS) and Quality Outcomes Framework (QOF)

Area	APS (2023)	GPPS (2022/23)	QOF (2023/24)
Oxfordshire	**10.3 (6.8 – 13.8)**	**12.2 (11.6 – 12.9)**	**11.7**
Cherwell	17.6 (7.8 – 27.3)	12.2 (10.9 – 13.6)	13.7
Oxford	7.8 (2.3 – 13.3)	16.4 (14.9 – 18.1)	11.6
South Oxfordshire	6.8 (0.6 – 12.9)	9.9 (8.7 – 11.2)	10.6
Vale of White Horse	2.0 (0.0 – 5.0)	9.5 (8.2 – 11.0)	11.2
West Oxfordshire	18.9 (6.9 – 30.9)	11.6 (10.2 – 13.2)	11.0

Source: OHID Smoking Profiles and NHS Digital Quality Outcomes Framework (QOF) 2023/24

Variation in the percentage prevalence figures is likely to be influenced by a number of factors including the sample size for each survey (particularly at district council level), the demographic composition of each sample and the different time periods in which each survey was conducted.

5.2 Latest data on smoking and vaping prevalence in Oxfordshire

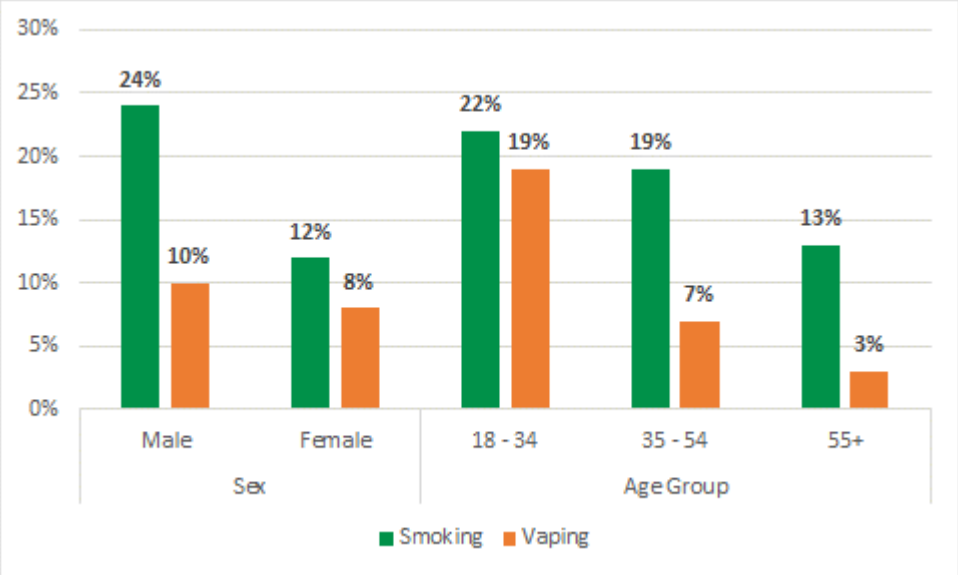
In early 2024, Oxfordshire County Council commissioned a specialist research company to undertake a Communication Channels Survey. This survey included some public health questions relating to smoking/vaping, eating habits, use of green spaces, childhood vaccinations and the mental health and wellbeing of children.

A total of 1,044 interviews were conducted, between April and June 2024, made up of 376 respondents from an online panel and 668 face-to-face interviews. Quotas were set, by age, gender, district, and working status, whilst also monitoring disability, ethnicity and the rural/urban split, to ensure a representative sample was achieved.

Below is a summary of the survey results relating to smoking and vaping.

Figure 17 shows the percentage of respondents that indicated that they currently smoke or vape by sex and broad age group.

Figure 17: Percentage of respondents that currently smoke or currently vape by sex and broad age group, 2024



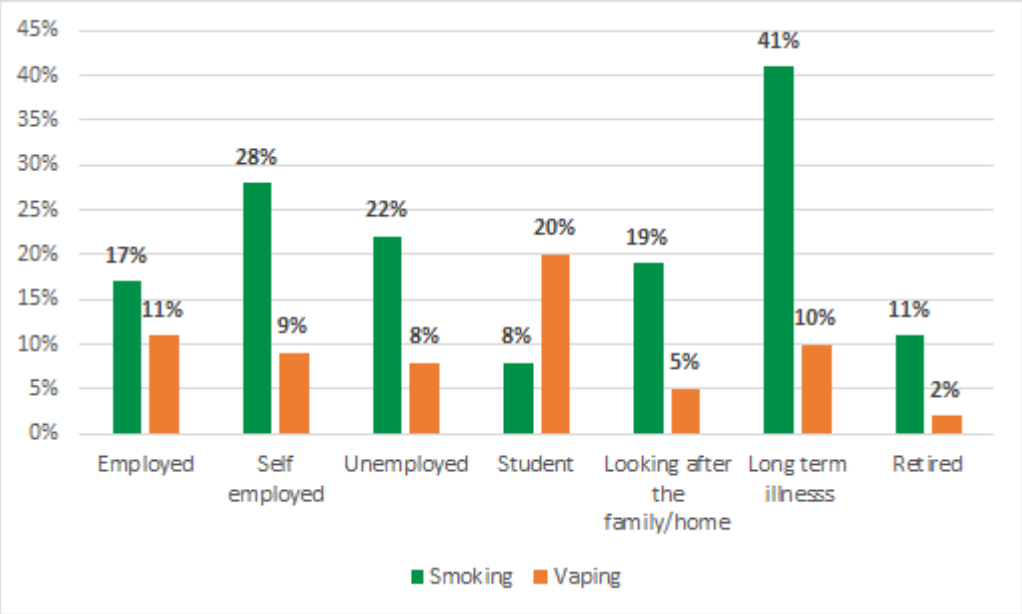
Source: Oxfordshire County Council Public Health Survey 2024. Base sizes: Male=444; Female=589; 18-34=346, 35-54=346; 55+=352

Figure 17 suggests that twice the percentage of males compared to females in Oxfordshire smoke but similar proportions of males and females vape. Vaping was less common than smoking for both males and females, though the difference was less marked in females. Both smoking and vaping were more common in the 18 to 34 year age group and least common in the those aged over 55 years. Only 3% of

respondents aged 55 and over stated that they currently vaped, compared to 19% in the 18 to 24 age group.

The public health survey also asked respondents about their current employment status. Figure 18 shows the percentage of respondents that were currently smoking or vaping by their employment status.

Figure 18: Percentage of respondents that currently smoke or vape by employment status, 2024

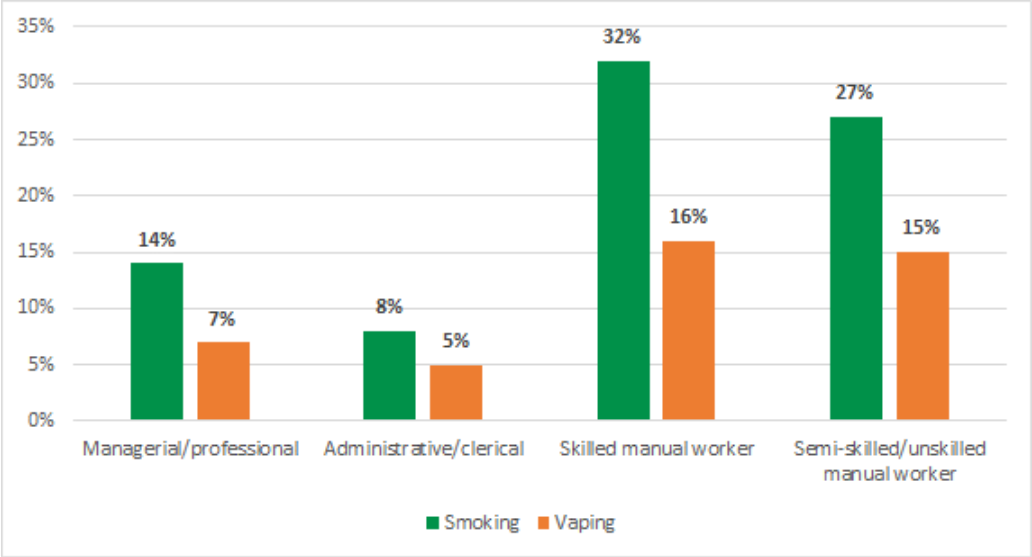


Source: Oxfordshire County Council Public Health Survey 2024. Base sizes: Employed=506; Self employed=87; Unemployed=30; Student=94; Looking after the family/home=58; Long term illness=51; Retired=213

Figure 18 shows that a higher proportion of respondents with a long term illness (41%) were currently smoking compared to other groups. More than one in five respondents who were currently smoking were either self-employed or unemployed. However, the number of survey respondents in the unemployed group was 50 or below, so the data for this group should be interpreted with some caution. Vaping was most common amongst students (20%) and employed people (11%) and least common amongst retired people (2%).

Figure 19 below shows the percentage of respondents currently smoking or vaping according to whether they were working in managerial/professional, administrative/clerical or skilled/semi-skilled/unskilled manual roles.

Figure 19: Percentage of respondents that currently smoke or vape by occupational group, 2024

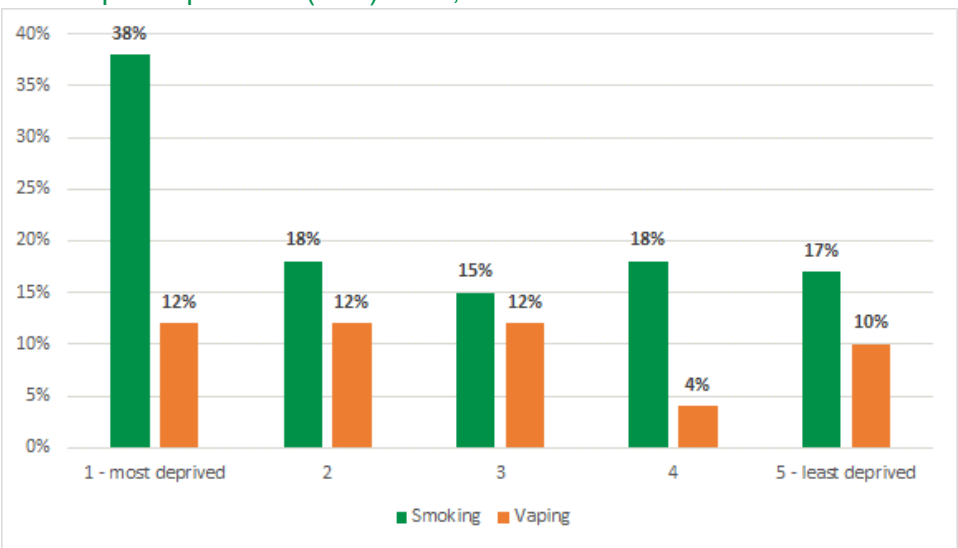


Source: Oxfordshire County Council Public Health Survey 2024. Base sizes: Managerial/professional=212; Administrative/clerical=173; Skilled manual worker=108; Semi-skilled/unskilled manual worker=87

Figure 19 shows that both current smoking and current vaping were more common in people working in skilled manual and semi-skilled/unskilled manual roles. Those working in administrative and clerical roles were least likely to currently smoke or vape.

Figure 20 below shows the percentage of respondents that currently smoke or vape by deprivation quintile of the Index of Multiple Deprivation (IMD) 2019 (Ministry of Housing, Communities & Local Government, 2019).

Figure 20: Percentage of respondents that currently smoke or vape by deprivation quintile of the Index of Multiple Deprivation (IMD) 2019, 2024



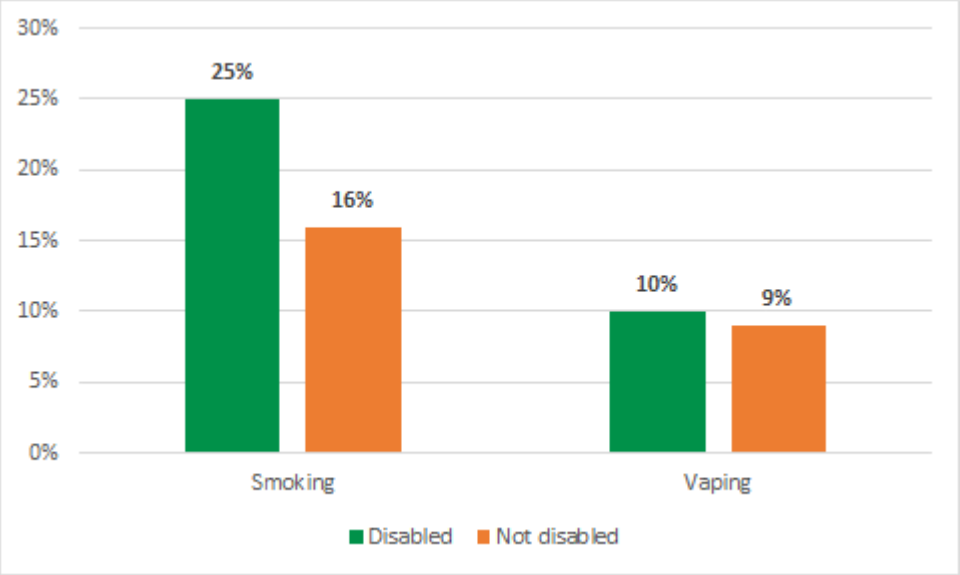
Source: Oxfordshire County Council Public Health Survey 2024. Base sizes: Quintile 1=43; Quintile 2=88; Quintile 3=209; Quintile 4=240; Quintile 5=405

Figure 20 indicates that respondents in deprivation quintile 1 (most deprived) were twice as likely to currently smoke than respondents from any other deprivation quintile.

However, the number of survey respondents from the most deprived deprivation quintile was small (50 or below), so this finding needs to be taken with some caution. A slightly higher proportion of respondents in deprivation quintiles 1 to 3 (the more deprived quintiles) indicated that they currently vaped compared with respondents in deprivation quintiles 4 and 5 (the least deprived quintiles).

Figure 21 below shows the percentage of survey respondents that currently smoke or vape according to whether the respondent considered that they had a disability or not.

Figure 21: Percentage of respondents that currently smoke or vape by disability status, 2024



Source: Oxfordshire County Council Public Health Survey 2024. Base sizes: Disabled=240; Not disabled=804

Figure 21 shows that a higher proportion of respondents that considered themselves to be disabled currently smoked compared to respondents that did not consider themselves to be disabled. The proportion of respondents that currently vaped was similar for those that considered themselves to be disabled and those that did not.

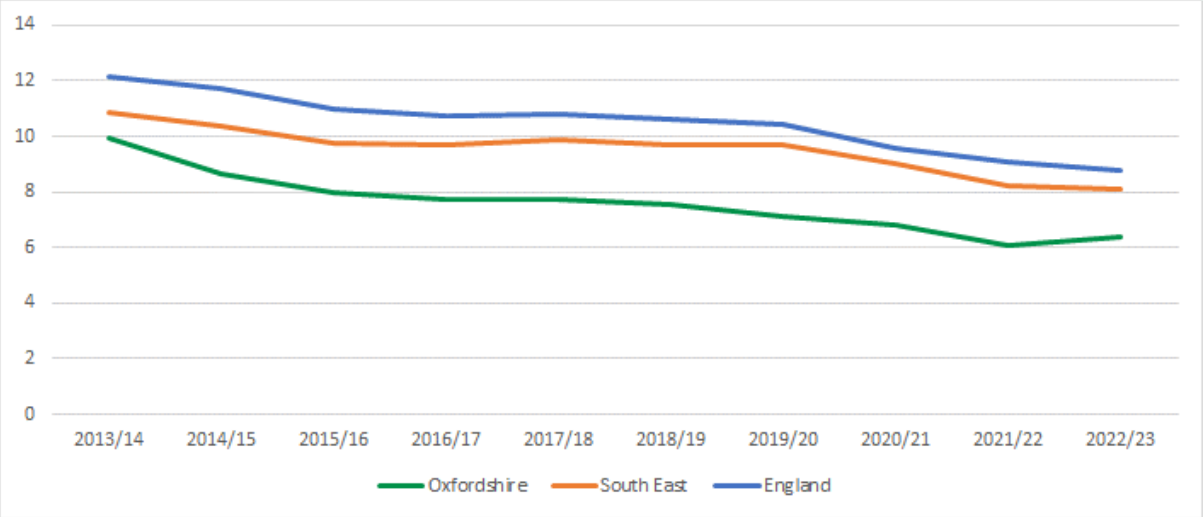
5.2.1 Smoking in priority populations

This section explores the prevalence of smoking in populations that are at an increased risk of smoking and therefore priority populations for local stop smoking services.

Maternal Smoking

Figure 22 shows the percentage of mothers who were recorded as smoking at the time of delivery by local maternity services in Oxfordshire, the South East region and England each year from 2013/14 to 2022/23.

Figure 22: Percentage of mothers recorded as smoking at time of delivery for Oxfordshire, the South East region and England, 2013/14 to 2022/23



Source: OHID Smoking Profiles

Figure 22 indicates that Oxfordshire has consistently had a lower rate of smoking at the time of delivery than both the South East region and England. The rate for Oxfordshire has reduced from 10.0% in 2013/14 to 6.4% in 2022/23.

Table 24 shows the percentage of mothers recorded as smoking at the time of delivery for Oxfordshire and the district councils from 2013/14 to 2022/23.

Table 24: Percentage of mothers recorded as smoking at time of delivery for Oxfordshire, and district councils, 2013/14 to 2022/23

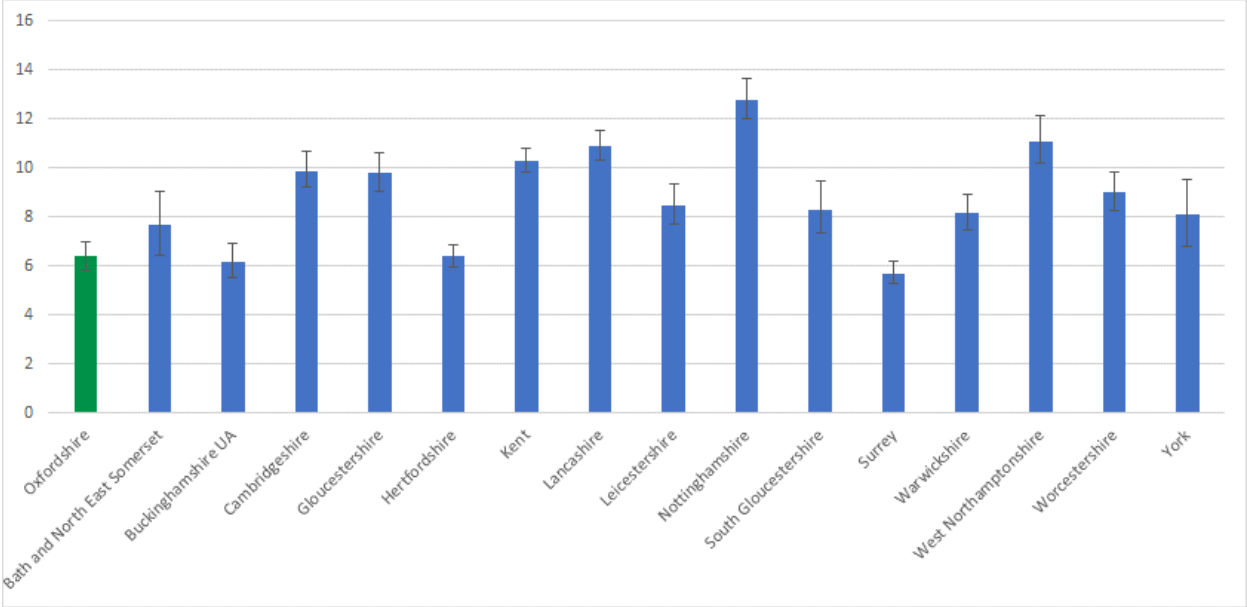
Year	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2013/14	**9.96**	9.92	9.92	9.85	10.20	9.92
2014/15	**8.63**	8.58	8.58	8.58	8.85	8.58
2015/16	**7.96**	7.91	7.91	7.91	8.16	7.91
2016/17	**7.73**	7.67	7.67	7.68	8.00	7.67
2017/18	**7.76**	7.71	7.71	7.73	7.94	7.71
2018/19	**7.53**	7.48	7.48	7.48	7.69	7.48
2019/20	**7.14**	7.09	7.09	7.10	7.33	7.09
2020/21	**6.80**	6.80	6.80	6.70	6.90	6.70
2021/22	**6.10**	6.10	6.10	6.10	6.20	6.10
2022/23	**6.40**	6.40	6.40	6.30	6.40	6.30

Source: OHID Smoking Profiles

Smoking rates at the time of delivery have reduced in the ten years shown in all of the Oxfordshire districts and by similar amounts from around 10% in 2013/14 to a little over 6% in 2022/23.

Figure 23 shows how the percentage of Oxfordshire mothers recorded as smoking at the time of delivery compared with the NHS England statistical neighbour peer group in 2022/23.

Figure 23: Percentage of mothers recorded as smoking at time of delivery for Oxfordshire, compared with the NHS England statistical neighbour peer group, 2022/23



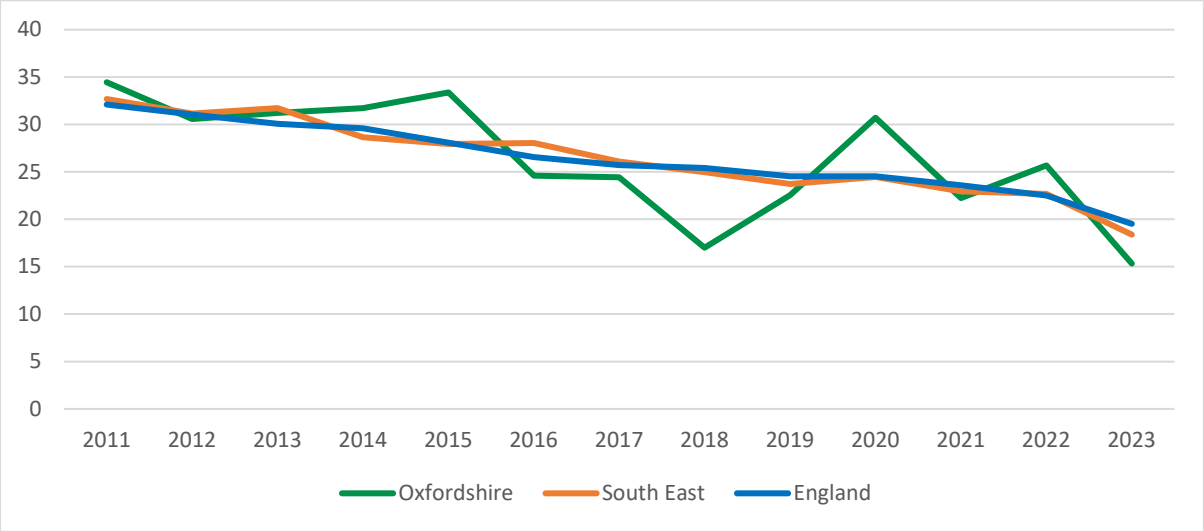
Source: OHID Smoking Profiles

Figure 23 shows that Surrey (5.7%) had the lowest rates of maternal smoking at the time of delivery and Nottinghamshire (12.8%) had the highest rates in 2022/23. The Oxfordshire rate of 6.3% is the fourth lowest of the 16 authorities in the peer group and statistically significantly different to the Nottinghamshire rate.

Smoking in routine and manual workers

Figure 24 below shows the percentage of adults aged 18 – 64 years employed in routine or manual occupations in Oxfordshire, the South East region and England that currently smoked according to data from the APS survey for the years from 2011 to 2023.

Figure 24: Percentage of adults in routine and manual occupations aged 18-64 years that currently smoked for Oxfordshire, the South East region and England, APS survey, 2011 to 2023

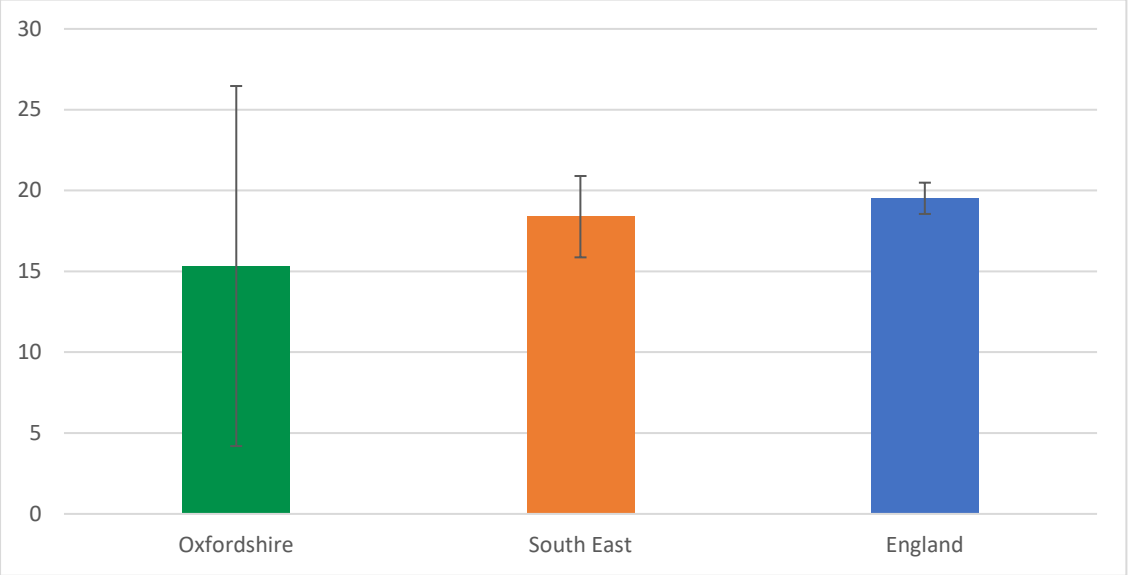


Source: OHID Smoking Profiles

Smoking rates in routine and manual occupations in Oxfordshire declined from 34.5% in 2011 to 15.3% in 2023. These percentages are higher than those for the Oxfordshire general adult population (11.2%), highlighting the increased rate of smoking in this group. A similar trend of decreasing rates between 2011 and 2023 is noted for both the South East Region and England. In the most recent year shown, 2023, the Oxfordshire smoking prevalence of 15.3% was lower than both the England rate (19.5%) and the South East region rate (18.4%).

In Oxfordshire, rates of people who smoke appear to fluctuate considerably from year to year but this is a reflection of the estimates being based on the small numbers of adults who smoke in this population. Figure 25 shows the same data but for 2023 only demonstrating that very wide confidence intervals of the estimate of rates in Oxfordshire overlap with those of England and the South East. This indicates that the rates between all three areas are unlikely to be statistically significantly different.

Figure 25: Percentage of adults in routine and manual occupations aged 18-64 years that currently smoke for Oxfordshire, the South East region and England, APS survey, 2023



Source: OHID Smoking Profiles

Table 25 shows the trend, between 2013 and 2022, in the percentage of adults aged 18 – 64 years employed in routine and manual occupations that currently smoke for each of the Oxfordshire district councils compared with Oxfordshire. No district level data was available for 2023.

Table 25: Percentage of adults in routine and manual occupations aged 18-64 years that currently smoke for Oxfordshire and district councils, APS survey, 2013 to 2022

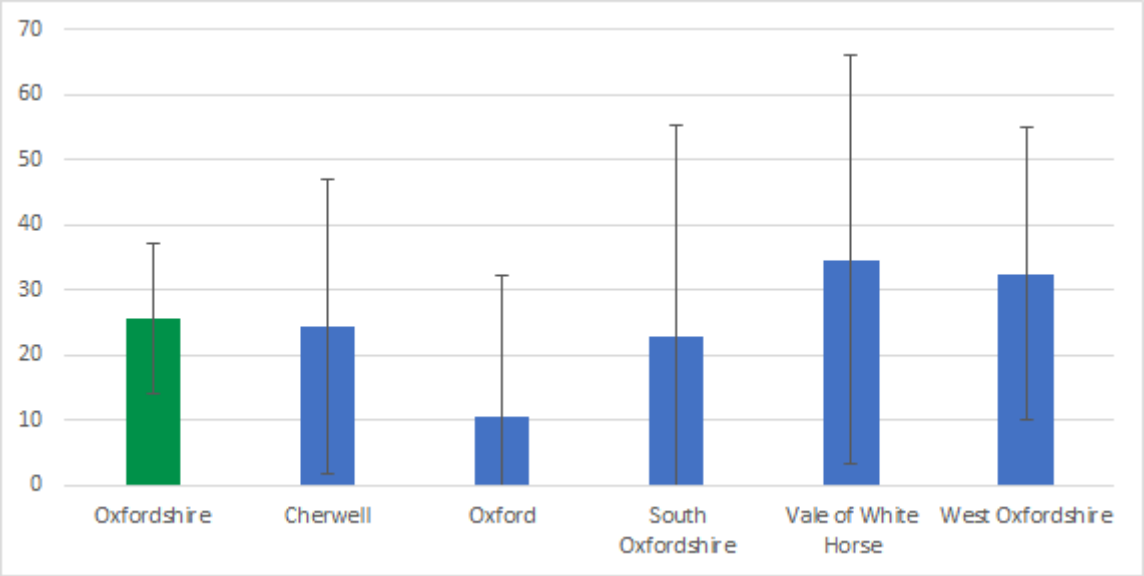
Year	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2013	**31.2**	33.1	32.3	39.3	28.8	24.7
2014	**31.7**	31.2	28.9	35.2	30.9	31.9
2015	**33.4**	37.9	35.2	22.9	32.0	34.9
2016	**24.6**	17.7	25.2	25.6	20.2	34.0
2017	**24.4**	29.6	19.7	21.5	27.6	22.8
2018	**17.0**	22.6	11.9	12.2	12.5	19.3
2019	**22.5**	19.2	26.0	25.5	14.3	25.9
2020	**30.7**	23.4	22.9	53.5	39.4	23.2
2021	**22.2**	15.8	27.9	20.8	38.3	No data
2022	**25.7**	24.3	10.5	22.8	34.7	32.5

Source: OHID Smoking Profiles

The overall trend for Oxfordshire shows a general downward trend, but with some year on year increases. The Vale of White Horse had the highest percentage of adults

employed in routine and manual occupations that currently smoked in both 2021 and 2022 and appears to have had a substantial increase in the percentage of people who currently smoke from 2020 onwards. However, when the rates for 2022 are plotted with confidence intervals shown in Figure 26, they all overlap meaning it is unlikely that the rates between districts is statistically different.

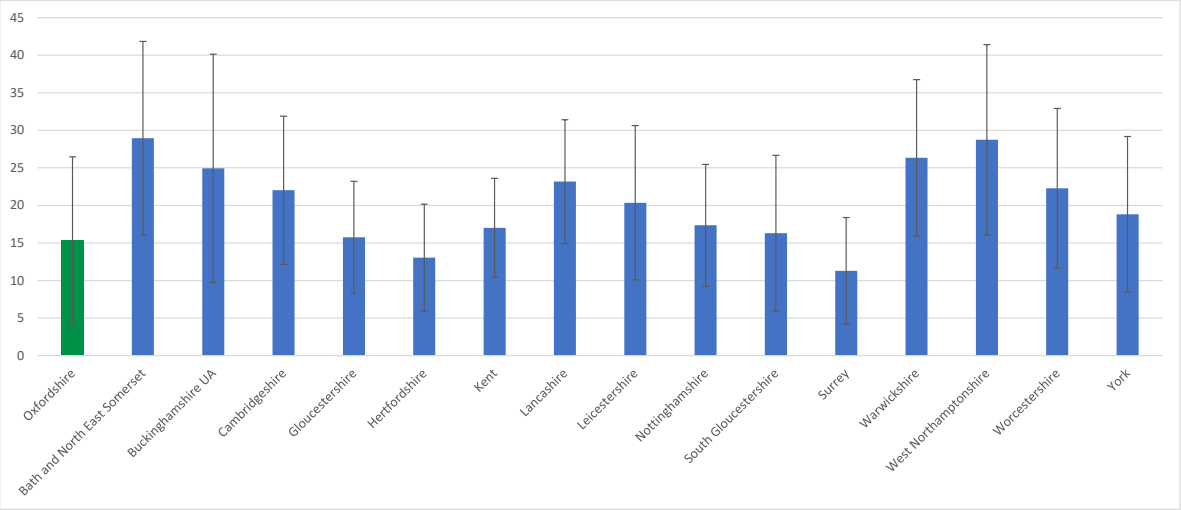
Figure 26: Percentage of adults in routine and manual occupations aged 18-64 years that currently smoke for Oxfordshire and district councils, APS survey, 2022



Source: OHID Smoking Profiles

Figure 27 shows how the percentage of adults employed in routine and manual occupations that were currently smoking in Oxfordshire compared to the percentages of other authorities in the NHS England statistical neighbour peer group in 2023.

Figure 27: Smoking prevalence in adults in routine and manual occupations aged 18-64 years for Oxfordshire compared with NHS England statistical neighbour peer group, APS, 2023



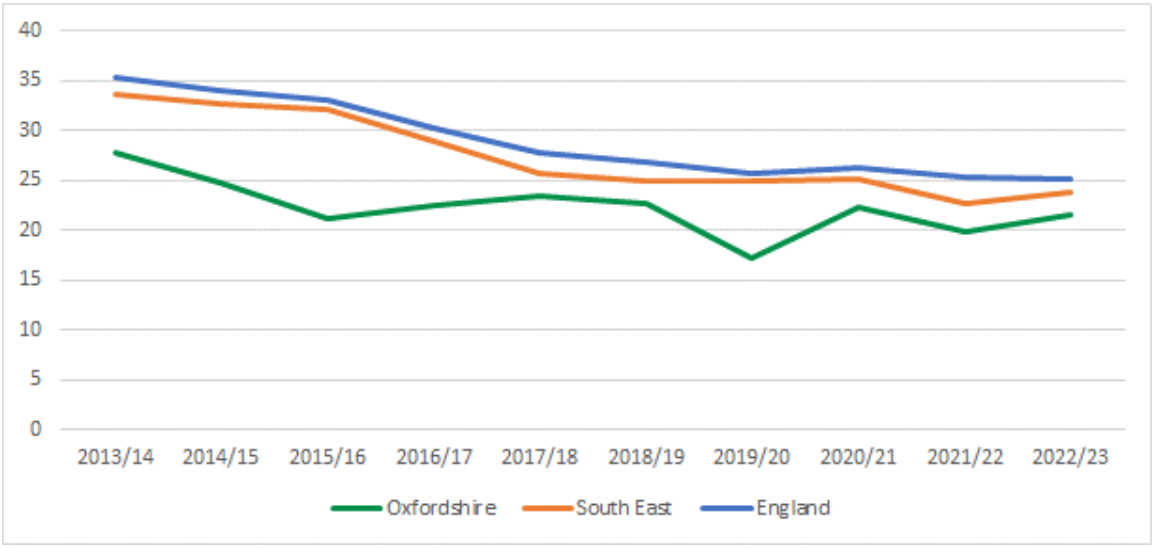
Source: OHID Smoking Profiles

Figure 27 shows that Surrey (11.3%) had the lowest proportion of people who currently smoke employed in routine and manual occupations and Bath and North East Somerset (28.9%) had the highest in 2023. Oxfordshire's rate of 15.3% was the third lowest in the peer group; however, the overlapping confidence intervals suggest that none of the differences were statistically significant.

Smoking in those with a long term mental health condition

Figure 28 shows the percentage of people who currently smoke diagnosed with a long term mental health condition for Oxfordshire, the South East and England for the years 2013/14 to 2022/23. These data are taken from the annual General Practice Population Survey (GPPS) survey commissioned by NHS England (2023).

Figure 28: Percentage of adults who currently smoke with a diagnosed long term mental health condition, Oxfordshire, the South East region and England, GPPS survey, 2013/14 to 2022/23



]S ource: OHID Smoking Profiles

Figure 28 shows that the percentage of adults with a long term mental health condition, who also smoked, in Oxfordshire reduced from 27.7% in 2013/14 to 21.5% in 2022/23. However, in 2019/20, the Oxfordshire rate (17.3%) was lower than in 2022/23. Rates of current smoking in England and the South East region for adults with a diagnosed long term mental health condition have also reduced since 2013/14. The percentage of people who currently smoke in England reduced from 35.3% in 2013/14 to 25.1% in 2022/23 and the percentage of people who smoke in the South East region reduced from 33.6% to 23.8% over the same time period. Although the Oxfordshire rate remained below those of England and the South East throughout the 10 years shown, the gap between the current smoking rates has narrowed over this period.

Table 26 shows the percentage of people who smoke diagnosed with a long term mental health condition for the Oxfordshire district councils compared with Oxfordshire as a whole for the years 2013/14 to 2022/23.

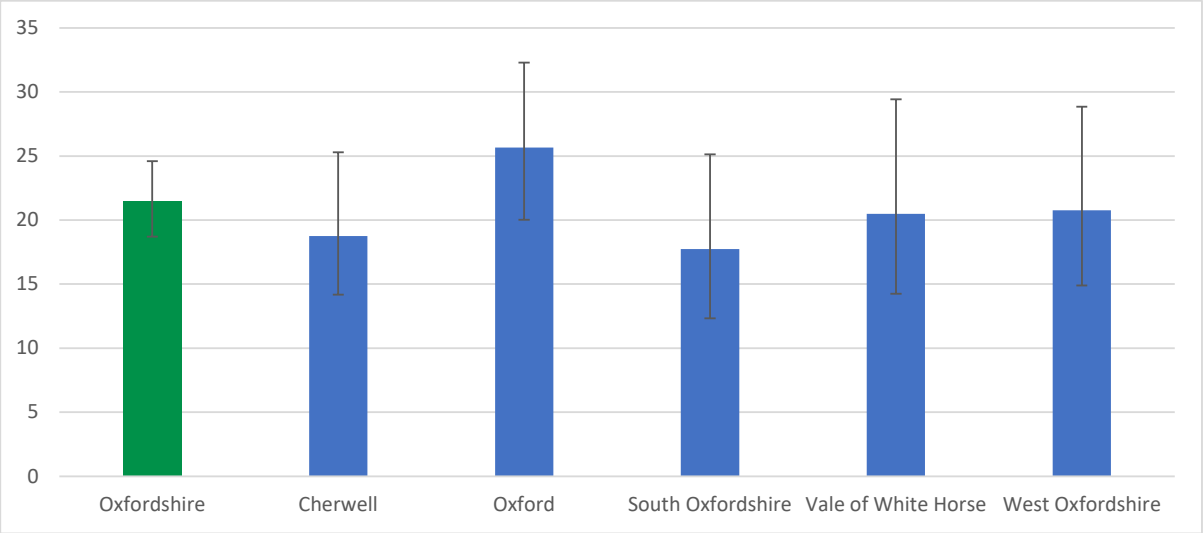
Table 26: Percentage of adults who smoke with a diagnosed long term mental health condition, Oxfordshire and district councils, GPPS survey, 2013/14 to 2022/23

Year	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2013/14	**27.7**	31.4	30.9	20.4	17.4	36.9
2014/15	**24.7**	27.6	29.5	25.2	7.6	28.1
2015/16	**21.2**	27.2	22.2	20.1	24.3	8.8
2016/17	**22.6**	26.5	24.2	14.8	15.3	27.0
2017/18	**23.4**	29.5	24.2	21.8	21.3	17.1
2018/19	**22.7**	19.7	22.0	31.3	22.0	18.8
2019/20	**17.3**	16.7	18.8	17.9	15.2	16.6
2020/21	**22.3**	26.0	23.2	21.9	23.2	14.8
2021/22	**19.8**	19.4	21.6	21.1	14.4	21.5
2022/23	**21.5**	18.7	25.7	17.7	20.5	20.8

Source: OHID Smoking Profiles

Table 26 shows that current smoking rates fluctuated from year to year and between districts over the ten year period. In 2021/22 and 2022/23, Oxford had the highest percentage of adults with a diagnosed long term mental health condition who also smoked; however, when the latest figures are shown (Figure 29) with confidence intervals rates it indicates that they are unlikely to be statistically significantly different.

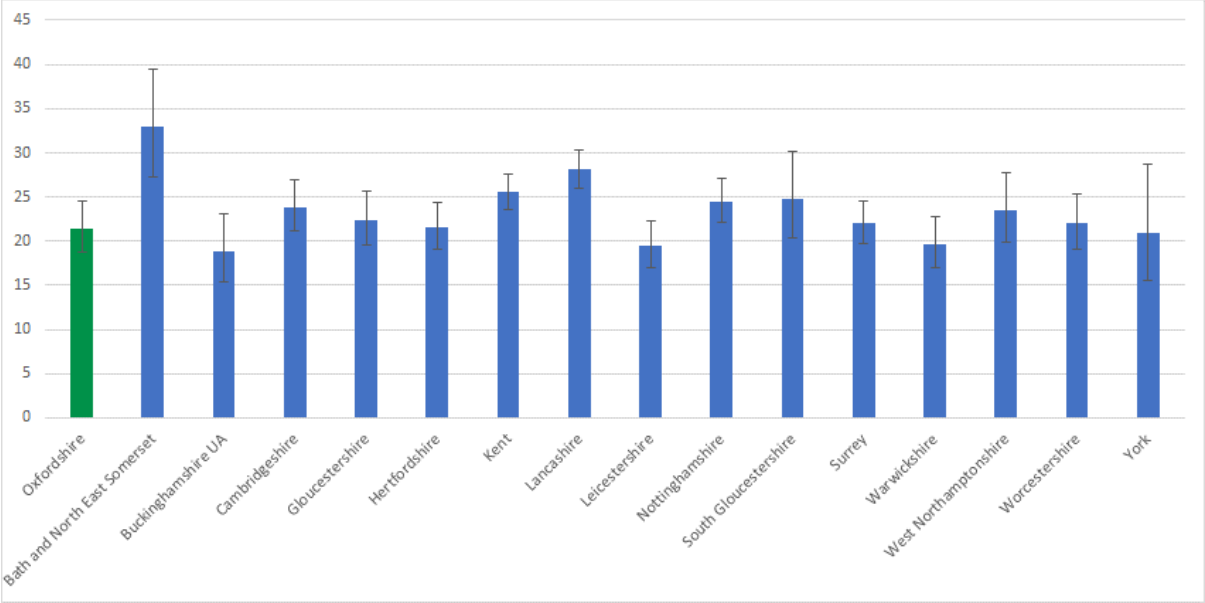
Figure 29: Percentage of adults who smoke with a diagnosed long term mental health condition, Oxfordshire and district councils, GPPS survey, 2022/23



Source: OHID Smoking Profiles

Figure 30 shows how the percentage of people with a diagnosed long term mental health condition that currently smoked in Oxfordshire in 2022/23 compared with the NHS England statistical neighbour peer group.

Figure 30: Percentage of adults who smoke with a diagnosed long term mental health condition, Oxfordshire and NHS England statistical neighbour peer group, GPPS survey, 2022/23



Source: OHID Smoking Profiles

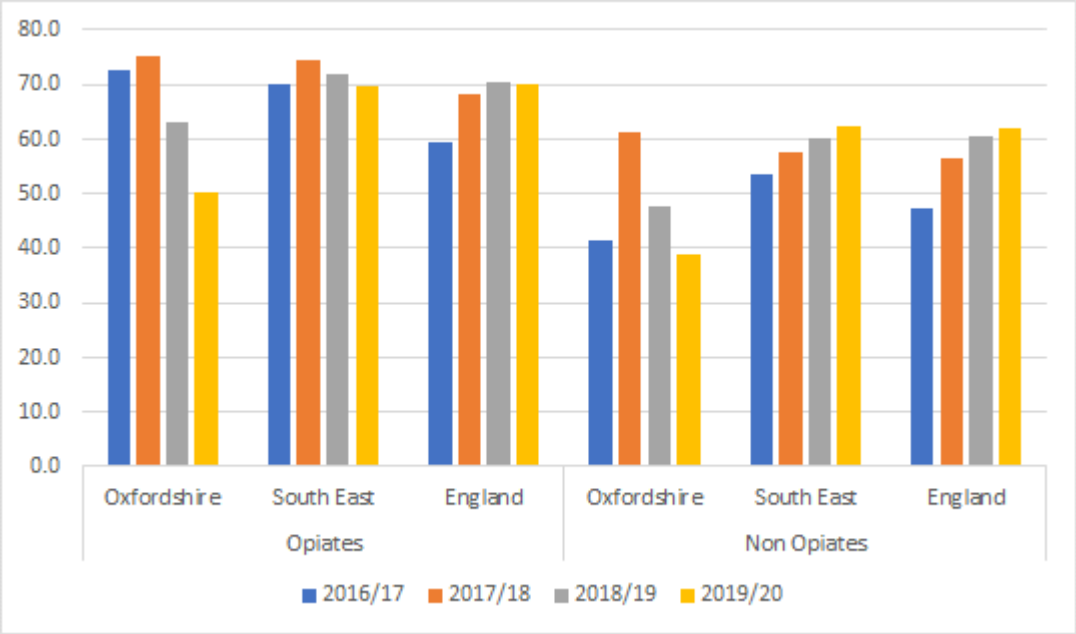
Figure 30 shows that Leicestershire (19.4%) had the lowest proportion of people who currently smoke amongst adults with a diagnosed long term mental health condition and Bath and North East Somerset (33.0%) had the highest. Bath and North East Somerset and Lancashire were the only authorities to have a statistically significantly higher percentage of people who currently smoke than Oxfordshire. Oxfordshire's

percentage of adults that currently smoked (21.5%) placed it just below the middle of the peer group.

Smoking in those receiving treatment for substance use

Figure 31 shows the percentage of adults (aged 18 years and over) admitted for substance use (opiate or non-opiate, excluding alcohol) treatment that were recorded as people who currently smoke at admission, in Oxfordshire, the South East region and England for the years from 2016/17 to 2019/20. These data come from the National Drug Treatment Monitoring System (NDTMS).

Figure 31: Percentage of adults (aged 18 years and over) admitted for substance misuse treatment for all opiates or non-opiates (excluding alcohol) that also smoke, Oxfordshire, the South East region, and England, 2016/17 to 2019/20



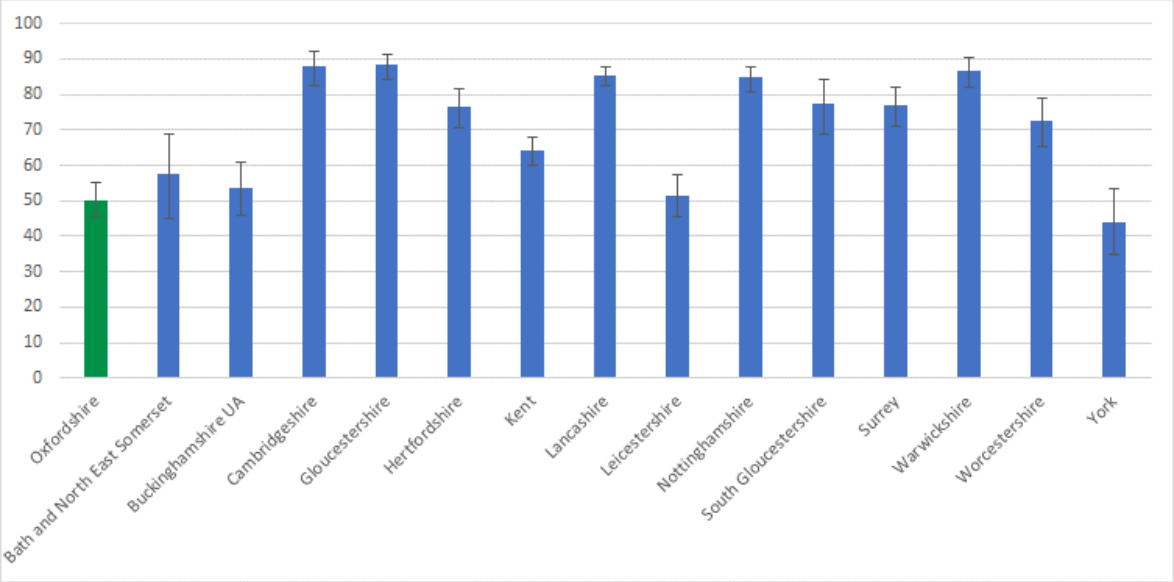
Source: OHID Smoking Profiles

In 2016/17, the percentage of adults admitted for opiate use treatment recorded as people who also smoke in Oxfordshire (72.6%) was higher than the equivalent percentages for England (59.4%) and the South East region (70.1%). However, the Oxfordshire rate declined sharply in 2018/19 and 2019/20 to 50.3% falling significantly below both the South East region (69.9%) and England averages (70.2%).

For adults in treatment for non-opiate use in England and the South East region, the percentage recorded as current smoking increased each year from 2016/17 to 2019/20 whilst in Oxfordshire the smoking rate increased and decreased in this time period, though the 2019/20 rate was slightly lower than the 2016/17 rate. For the latest year recorded (2019/20), Oxfordshire's smoking rates for adults admitted for non-opiate use treatment was 38.8%, notably below England (62.0%) and the South East region (62.2%).

Figure 32 and Figure 33 shows how the Oxfordshire percentage of people who currently smoke amongst adults admitted for opiate use and non-opiate use treatment in 2019/20 compared to those of the NHS England statistical neighbour peer group.

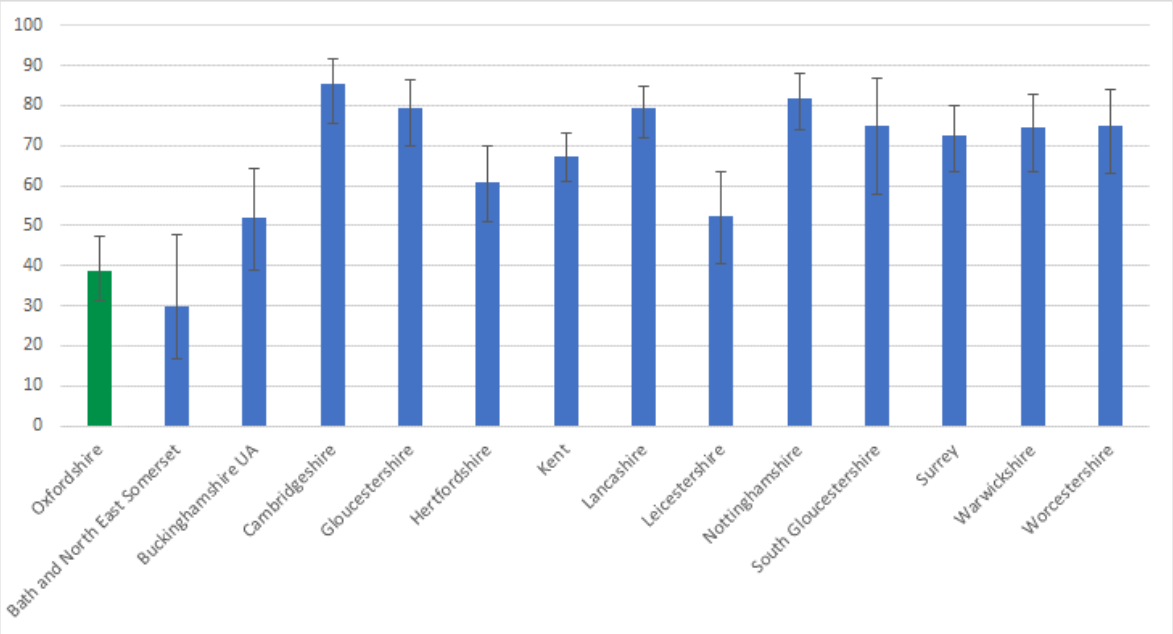
Figure 32: Percentage of adults (aged 18 years and over) admitted for substance misuse treatment for all opiates that also smoke, Oxfordshire and NHS England statistical neighbour peer group, 2019/20



Source: OHID Smoking Profiles

Figure 32 shows that in 2019/20, Gloucestershire (88.3%) had the highest percentage of adults admitted for opiate use treatment that also smoked and York (43.8%) had the lowest proportion. The rate in Oxfordshire (50.3%) was the third lowest in the peer group; this rate was statistically significantly lower than the proportion of people who smoke admitted for opiate use treatment in ten NHS England statistical neighbour peer group

Figure 33: Percentage of adults (aged 18 years and over) admitted for substance misuse treatment for non-opiates that also smoke, Oxfordshire and NHS England statistical neighbour peer group, 2019/20

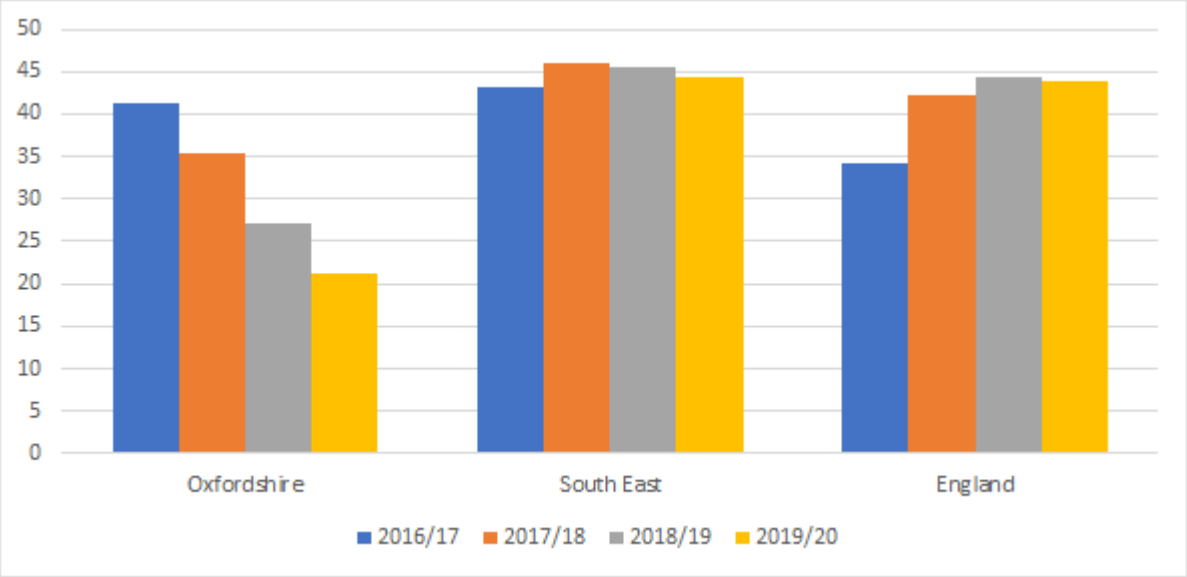


Source: OHID Smoking Profiles

Figure 33 shows that in 2019/20, Bath and North East Somerset (30.0%) had the lowest percentage of adults admitted for non-opiate substance use treatment recorded as currently smoking and Cambridgeshire (85.3%) had the highest rate. Oxfordshire had the second lowest rate (38.8%) across the peer group; this rate was statistically significantly lower than the proportion of people who smoke admitted for non-opiate use treatment in ten OHID statistical neighbours.

Figure 34 shows the percentage of adults aged 18 years and over admitted for treatment for alcohol use that also smoked on admission for Oxfordshire, the South East region and England for the years 2016/17 to 2019/20.

Figure 34: Percentage of adults (aged 18 years and over) admitted treatment for alcohol misuse that also smoke, Oxfordshire, the South East region, and England, 2016/17 to 2019/20

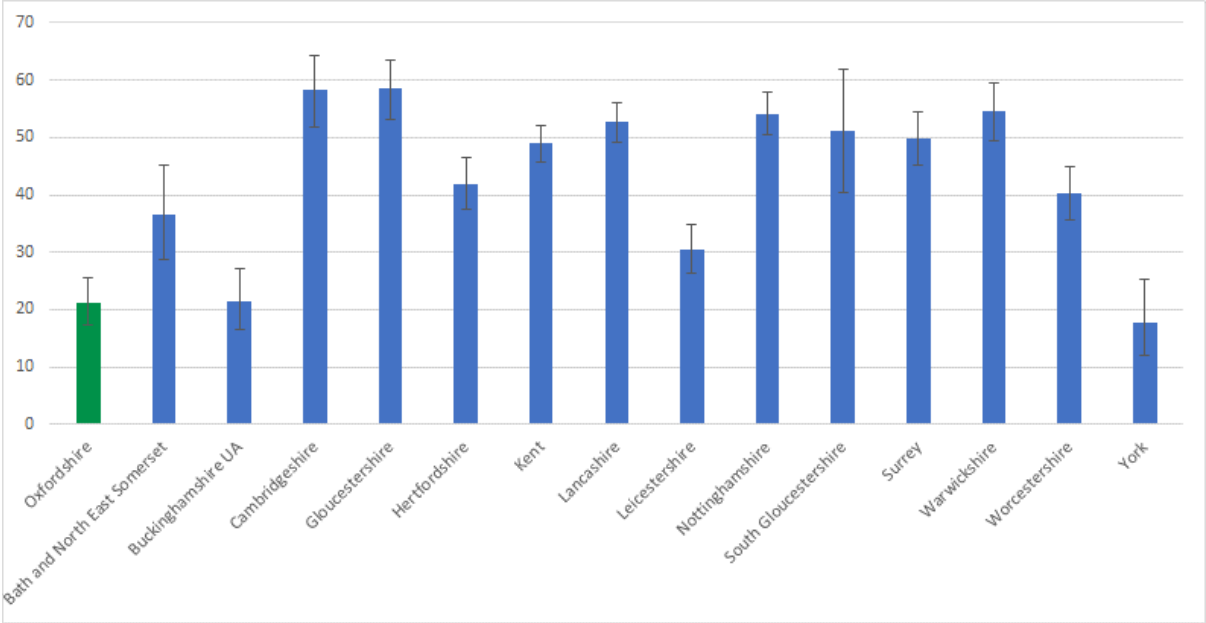


Source: OHID Smoking Profiles

Rates in Oxfordshire have shown a year on year decreasing trend whilst the trend in England and the South East region have increased year on year or have remained largely static. The percentage of people who currently smoke in England increased from 34.2% in 2016/17 to 43.9% in 2019/20 whilst in the South East region the average increased, from 43.1% to 44.2% over the same period. In 2019/20 Oxfordshire's rate of 21.2% was significantly lower than both the South East region and England.

Figure 35 below shows how the Oxfordshire percentage of adults admitted for alcohol use treatment that also smoked compared to the NHS England statistical neighbour peer group in 2019/20.

Figure 35: Percentage of adults (aged 18+) admitted for substance misuse treatment for alcohol that also smoked, Oxfordshire and NHS England statistical neighbour peer group, 2019/20



Source: OHID Smoking Profiles

Gloucestershire (58.5%) had the highest percentage of adults admitted for alcohol use treatment that also smoked in 2019/20 and York (17.6%) had the lowest percentage. Oxfordshire's percentage of 21.2% was the second lowest in the peer group; this was statistically significantly lower than 12 peers.

5.2.2 Vape usage – national data

Table 27 below shows the estimated number of Oxfordshire residents, using vapes by sex. The estimated number of people using vapes has been calculated by taking the national rate and multiplying it by the Oxfordshire population. The national rates of vape use have been taken from a national survey commissioned by NHS Digital (2024) but they may not reflect local rates and the recent local data gathered by the OCC Public Health Survey between April to June 2024 may reflect a more accurate picture (see Figures 14 to 18). The national figures suggest slightly more men (9.5%) than women (8.0%) were estimated to use vapes; however, nearly 80% of people in Oxfordshire are estimated to have never tried a vape.

Table 27: Estimated number of people in Oxfordshire using vapes, by sex, 2020

Sex	Vape use	England Rate	Oxfordshire Population	Estimated number
Men	Currently uses vapes	9.5%	300,982	28,668
	Not a current user but has tried using vapes	13.7%		41,091
	Has never used vapes	76.8%		231,223
Women	Currently uses vapes	8.0%	314,705	25,174
	Not a current user but has tried using vapes	10.9%		34,251
	Has never used vapes	81.1%		255,280
Persons	Currently uses vapes	8.7%	615,687	53,827
	Not a current user but has tried using vapes	12.2%		75,313
	Has never used vapes	79.0%		486,547

Source: NHS Digital - Health Survey for England, 2022 Part 1

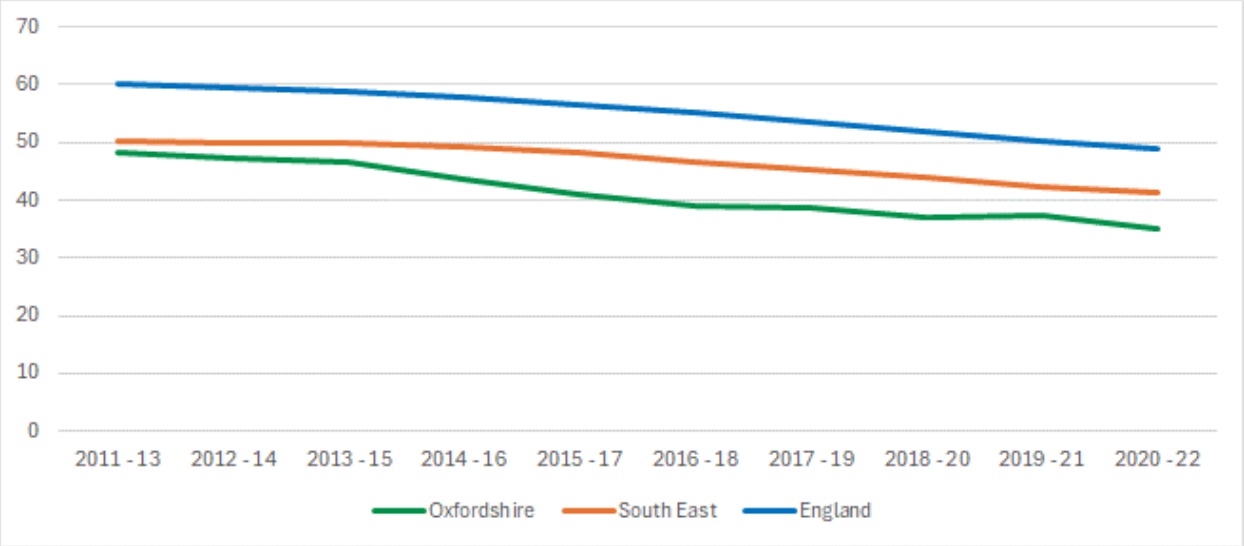
5.3 Smoking impact

The impact of smoking on health is measured by smoking related mortality and hospital admissions for conditions largely attributable to smoking. The analysis below describes Oxfordshire rates compared with the South East region, England and the statistical peer group of NHS England statistical nearest neighbours. Where data are available, this section also explores variation between the district councils in Oxfordshire. Due to small numbers, data are presented as aggregated three year periods from 2011-13 to 2020-22.

5.3.1 Lung cancer mortality

Figure 36 shows the age standardised mortality rate for lung cancer per 100,000 population for Oxfordshire, the South East region and England for the period from 2011-2013 to 2020-2022.

Figure 36: Mortality from lung cancer per 100,000 directly age standardised population (persons, all ages) for Oxfordshire, the South East region and England, 2011-2013 to 2020-2022

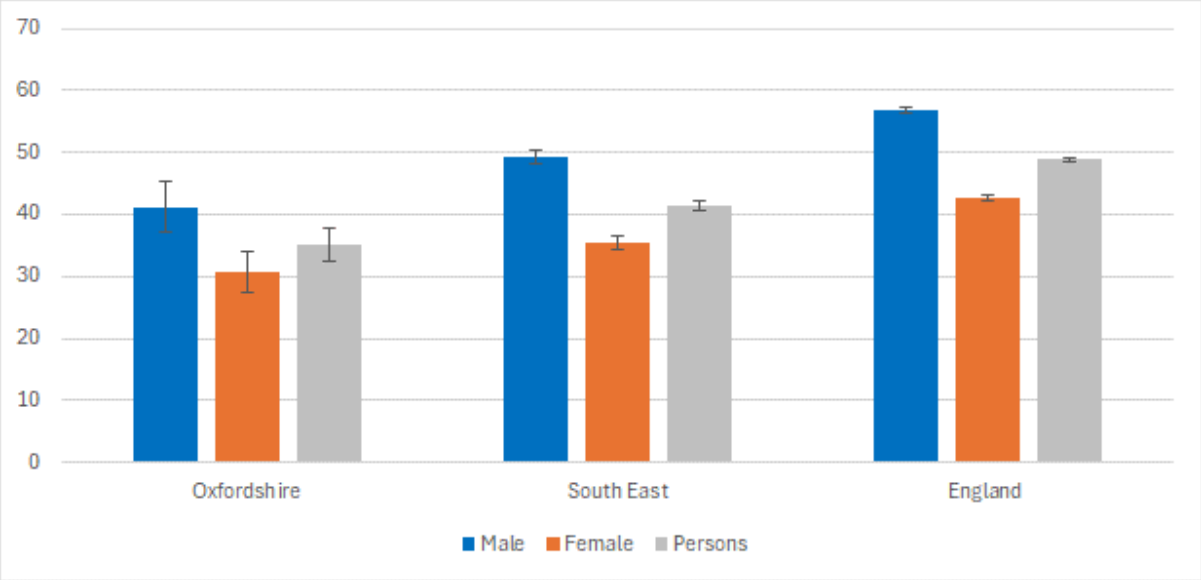


Source: OHID Smoking Profiles

The lung cancer rate in Oxfordshire has been consistently lower than both England and the South East region from 2011-2013 to 2020-2022 and has declined steadily since 2011-2013, roughly in line with the England trend. The gap between the Oxfordshire and South East region mortality rate has widened since 2011-2013, as the South East region rate has reduced to a lesser extent than the Oxfordshire rate.

Figure 37 shows the age standardised mortality rates per 100,000 population from lung cancer for Oxfordshire, the South East region and England for 2020-2022 for males, females and both sexes.

Figure 37: Mortality from lung cancer per 100,000 directly age standardised population (all ages) for males, females and both sexes for Oxfordshire, the South East region and England, 2020-2022



Source: OHID Smoking Profiles

Lung cancer rates for both males and females in Oxfordshire was lower than those of the South East region and England, with the male mortality rate for Oxfordshire statistically significantly lower than those of England and the South East region.

Table 28 shows the directly age standardised mortality rates per 100,000 population for the Oxfordshire district councils compared with Oxfordshire as a whole for the period 2011-2013 to 2020-2022.

Table 28: Mortality from lung cancer per 100,000 directly age standardised population (persons, all ages) for Oxfordshire and district councils, 2011-2013 to 2020-2022

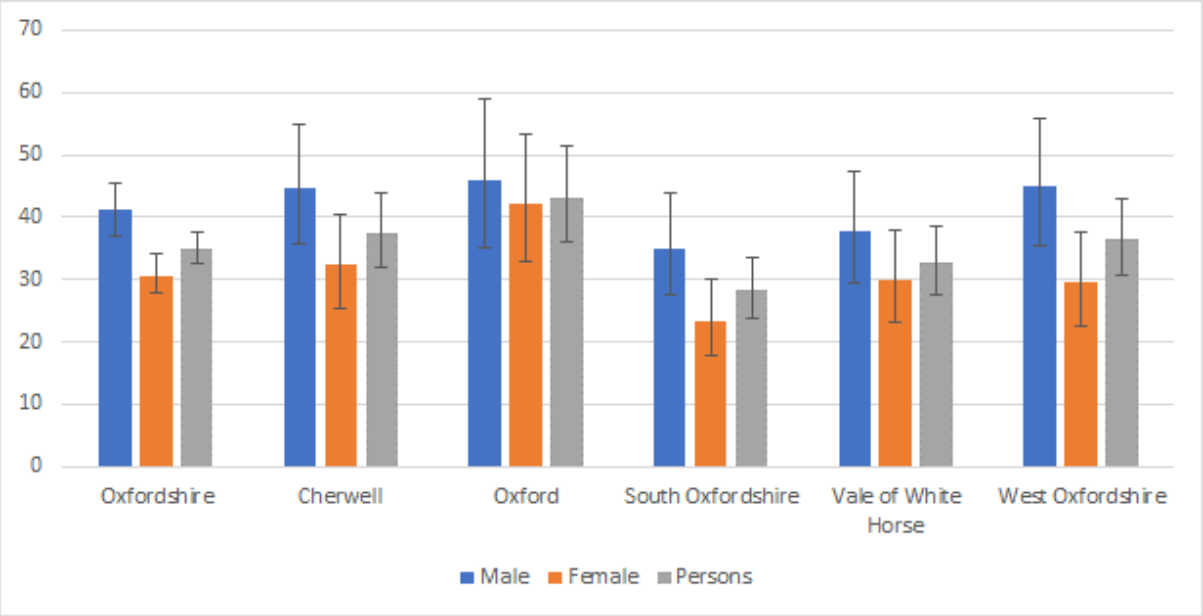
Time Period	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2011 - 2013	**48.4**	56.3	53.2	47.4	41.5	43.2
2012 - 2014	**47.3**	53.8	49.3	48.4	43.4	40.5
2013 - 2015	**46.6**	54.9	53.0	44.7	43.3	37.0
2014 - 2016	**43.5**	52.4	49.2	39.2	41.2	36.0
2015 - 2017	**41.0**	48.6	53.6	33.2	33.5	39.7
2016 - 2018	**38.9**	47.3	47.8	29.6	33.3	39.5
2017 - 2019	**38.5**	45.1	48.5	30.4	32.9	39.6
2018 - 2020	**37.0**	41.5	44.5	30.9	35.9	34.7
2019 - 2021	**37.3**	39.9	44.9	31.9	35.6	36.6
2020 - 2022	**35.0**	37.6	43.3	28.3	32.7	36.6

Source: OHID Smoking Profiles

Table 28 suggests that the Cherwell and Oxford districts have had consistently higher lung cancer mortality rates than Oxfordshire as a whole, with a steeper decrease in mortality rates over time in Cherwell than Oxford.

Figure 38 shows the age standardised mortality rates per 100,000 population for lung cancer for Oxfordshire and the Oxfordshire district councils for the period 2020-2022 for males, females and persons.

Figure 38: Mortality from lung cancer per 100,000 directly age standardised population (all ages) by sex for district councils, 2011-2013 to 2020-2022

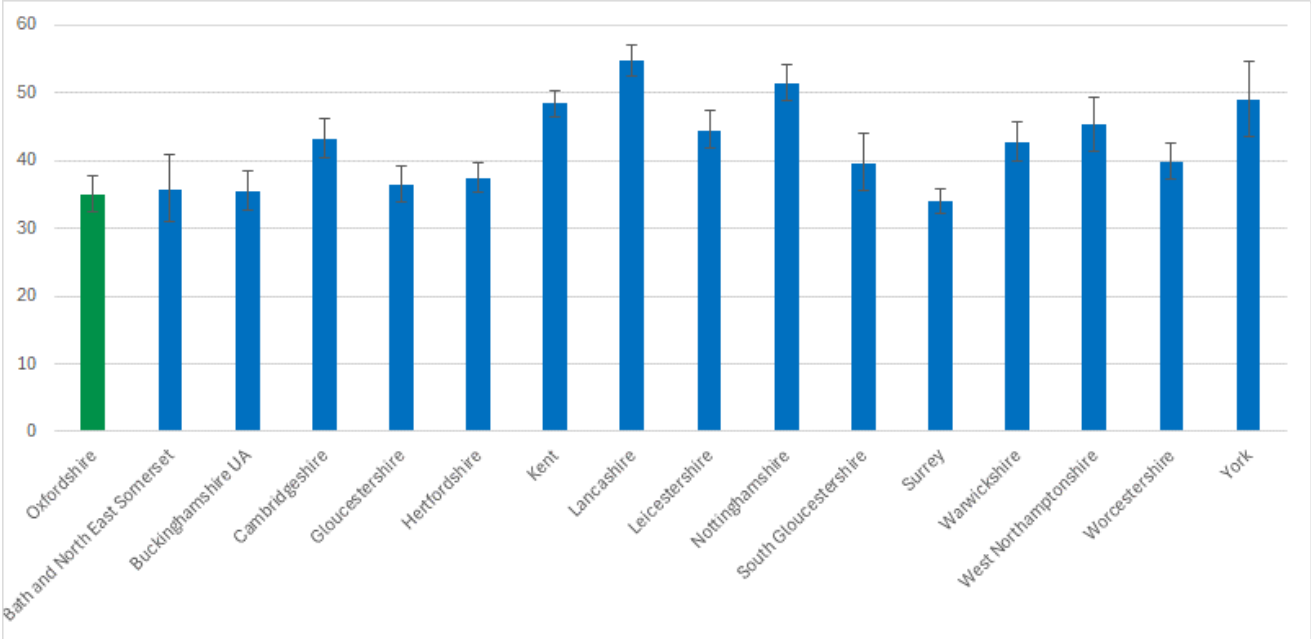


Source: OHID Smoking Profiles

Figure 38 shows that South Oxfordshire had the lowest mortality rate for lung cancer per 100,000 population in 2020-22 for both males and females. The mortality rate for females was statistically significantly lower than for Oxford, but not for any of the other district councils.

Figure 39 shows how the lung cancer mortality rate per 100,000 population for Oxfordshire compared with the NHS England statistical neighbour peer group for the period 2020-2022.

Figure 39: Mortality from lung cancer per 100,000 directly age standardised population (persons, all ages) for Oxfordshire and NHS England statistical neighbour peer group, 2011-2013 to 2020-2022



Source: OHID Smoking Profiles

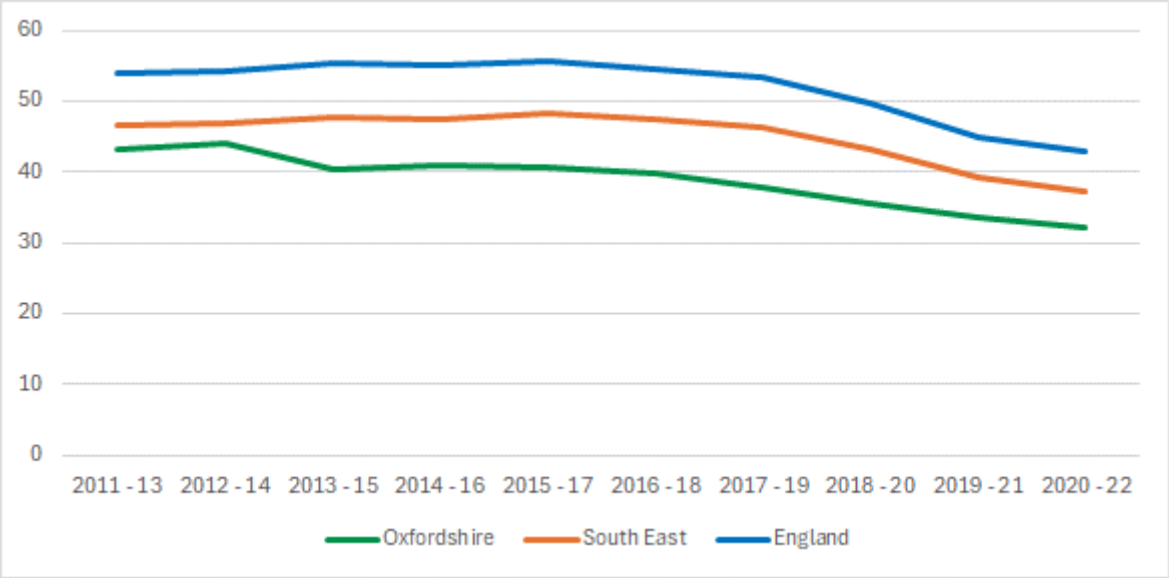
Oxfordshire had a lower mortality rate per 100,000 population for lung cancer than several peer authorities, with a similar rate to Buckinghamshire UA and Bath and North East Somerset. Oxfordshire's mortality rate was statistically significantly lower than Cambridgeshire, Kent, Lancashire, Leicestershire, Nottinghamshire, Warwickshire, West Northamptonshire and York.

5.3.2 Chronic obstructive pulmonary disease (COPD)

COPD mortality

Figure 40 below shows the age-standardised mortality rate per 100,000 population from chronic obstructive pulmonary disease (COPD) for Oxfordshire compared with England and the South East region for the pooled three year periods from 2011-2013 to 2020-2022.

Figure 40: Mortality from chronic obstructive pulmonary disease per 100,000 directly age standardised population (persons, all ages) for Oxfordshire, the South East region and England, 2011-2013 to 2020-2022

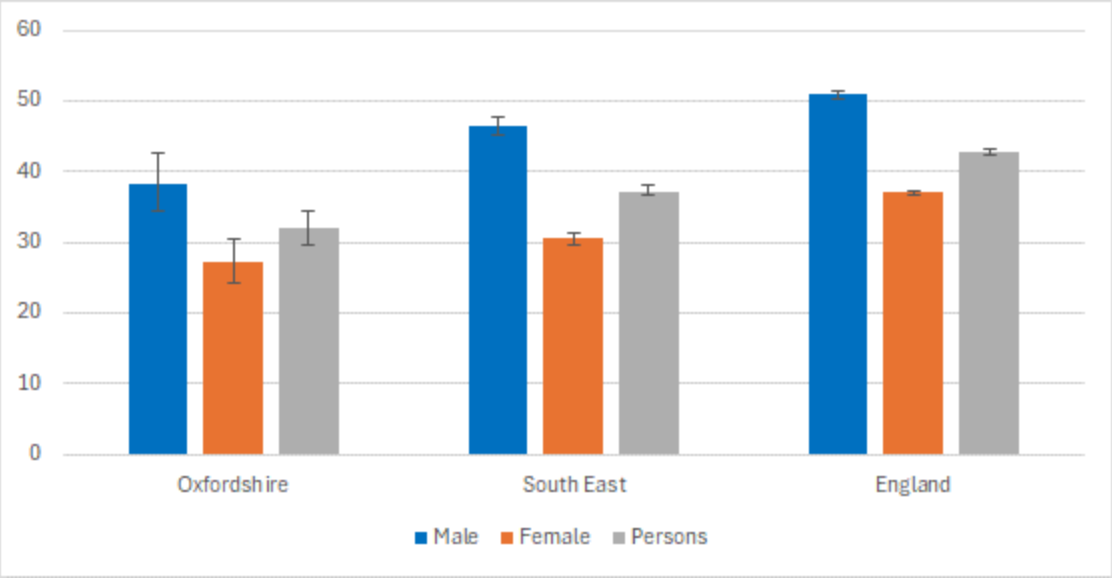


Source: OHID Smoking Profiles

Oxfordshire has consistently had a lower age-standardised mortality rate per 100,000 population from COPD than both the South East region and England. The Oxfordshire mortality rate declined from 43.3 per 100,000 population in 2011-2013 to 32.0 per 100,000 population in 2020–2022. There have been similar reductions in both the England and South East region COPD mortality rates (which have declined from 53.0% to 43.8% and from 46.5% to 37.2%, respectively, over the same period). This reflects the prevalence of COPD in Oxfordshire which is lower in all districts in Oxfordshire compared to England and the South East (see Table 14).

Figure 41 below shows the COPD mortality rates per 100,000 population for Oxfordshire, the South East region and England, for the period 2020–2022 for males, females and persons.

Figure 41: Mortality from chronic obstructive pulmonary disease per 100,000 directly age standardised population (all ages) by sex for Oxfordshire, the South East region and England, 2020-*2022*



Source: OHID Smoking Profiles

Figure 41 shows that COPD age standardised mortality rates for males are statistically significantly higher than for females in Oxfordshire, the South East region and England. The Oxfordshire male COPD age standardised mortality rate per 100,000 population is also statistically significantly lower than those for the South East region and England, but the rate for females is only statistically significantly lower than that for England.

Table 29 below shows the age standardised mortality rate per 100,000 population from COPD for the Oxfordshire district councils compared with Oxfordshire for the periods from 2011-2013 to 2020-2022.

Table 29: Mortality from chronic obstructive pulmonary disease per 100,000 directly age-standardised population (persons, all ages) for Oxfordshire and district councils, 2011-*2013* to 2020-*2022*

Time Period	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2011 - 2013	**43.2**	42.1	61.7	38.6	41.1	36.6
2012 - 2014	**43.9**	48.8	60.4	37.1	38.5	38.7
2013 - 2015	**40.3**	46.6	52.5	35.7	34.3	35.1
2014 - 2016	**40.8**	49.5	49.3	37.3	31.2	38.7
2015 - 2017	**40.7**	49.4	49.4	36.9	33.3	36.7
2016 - 2018	**39.7**	50.0	46.4	34.9	33.8	35.5
2017 - 2019	**37.9**	47.3	44.5	34.8	35.7	28.4

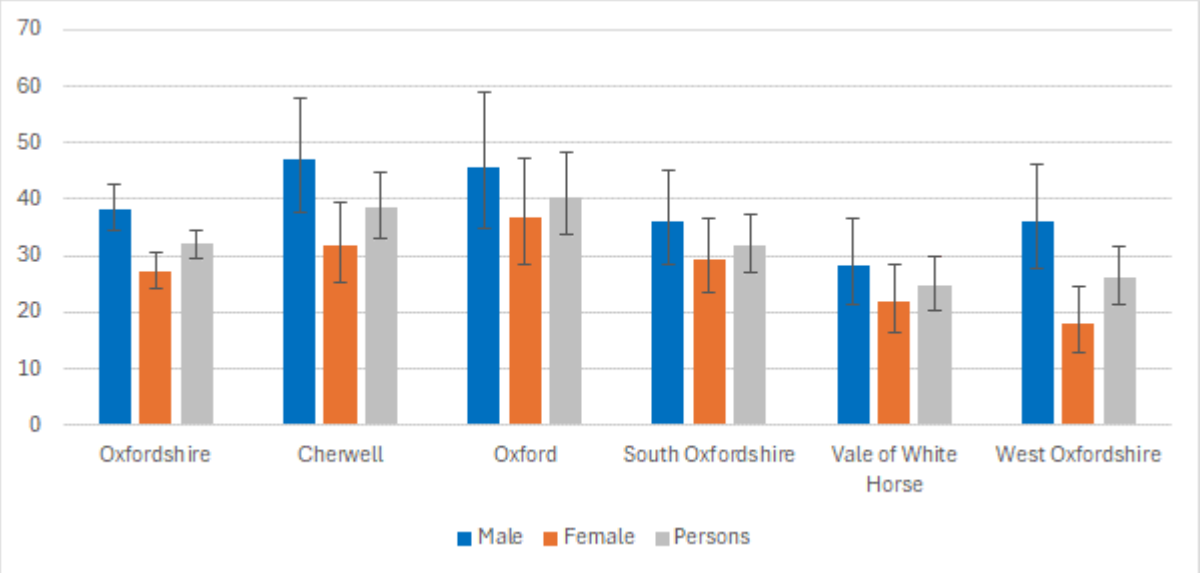
Time Period	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2018 - 2020	**35.6**	43.9	43.8	34.6	30.5	26.4
2019 - 2021	**33.4**	40.9	42.9	34.1	27.6	23.1
2020 - 2022	**32.0**	38.6	40.4	31.9	24.6	26.3

Source: OHID Smoking Profiles

Table 29 shows that Oxford and Cherwell consistently had the highest COPD mortality rate amongst the district councils. The Oxford rate declined sharply from 61.7 per 100,000 population in 2011-2013 to 40.4 per 100,000 population in 2020-2022. COPD mortality rates have declined since 2011-2013 in all the Oxfordshire districts, but Cherwell had the smallest reduction, from 42.1 in 2011-2013 to 38.6 in 2020-2022. Despite the large drop in the mortality rate in the Oxford district, the mortality rate remains the highest; however, the prevalence of COPD in the Oxford district is the lowest of the five districts (Table 14). This could indicate that people with COPD in the Oxford district experience the condition with greater severity with a higher likelihood that this will be the cause of death.

Figure 42 shows the age-standardised mortality rates per 100,000 population from COPD for the districts councils compared to Oxfordshire for males, females and persons for the period 2020-2022.

Figure 42: Mortality from chronic obstructive pulmonary disease per 100,000 directly age-standardised population (all ages) by sex for Oxfordshire and district councils, 2020-*2022*



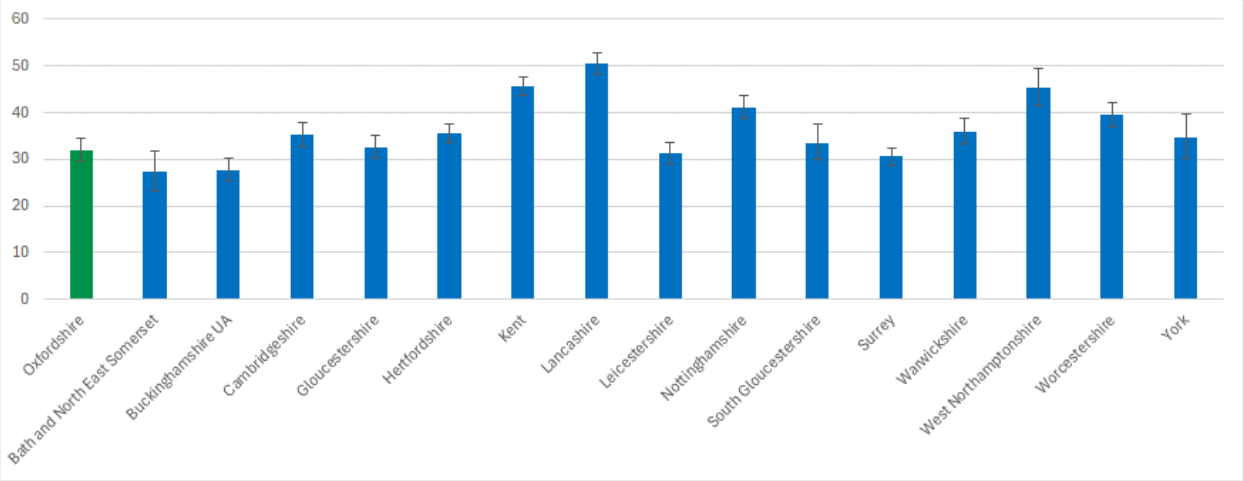
Source: OHID Smoking Profiles

Figure 42 shows that both male and female mortality rates were higher in Cherwell and Oxford than for Oxfordshire as a whole, though these differences were not statistically significant. The female COPD mortality rate for Oxford in 2020-2022 was statistically significantly higher than that for West Oxfordshire, but not for any of the

other Oxfordshire districts. Interestingly in 2022/23 the prevalence rate of COPD in West Oxfordshire is the highest of all the districts (1.49%) compared to Oxford which had the lowest prevalence (0.99%) (Table 14).

Figure 43 shows the Oxfordshire age-standardised mortality rate for COPD in 2020-2022 compared to the NHS England statistical neighbour peer group.

Figure 43: Mortality from chronic obstructive pulmonary disease per 100,000 directly age-standardised population (all ages) for Oxfordshire and NHS England statistical neighbour peer group, 2020-22



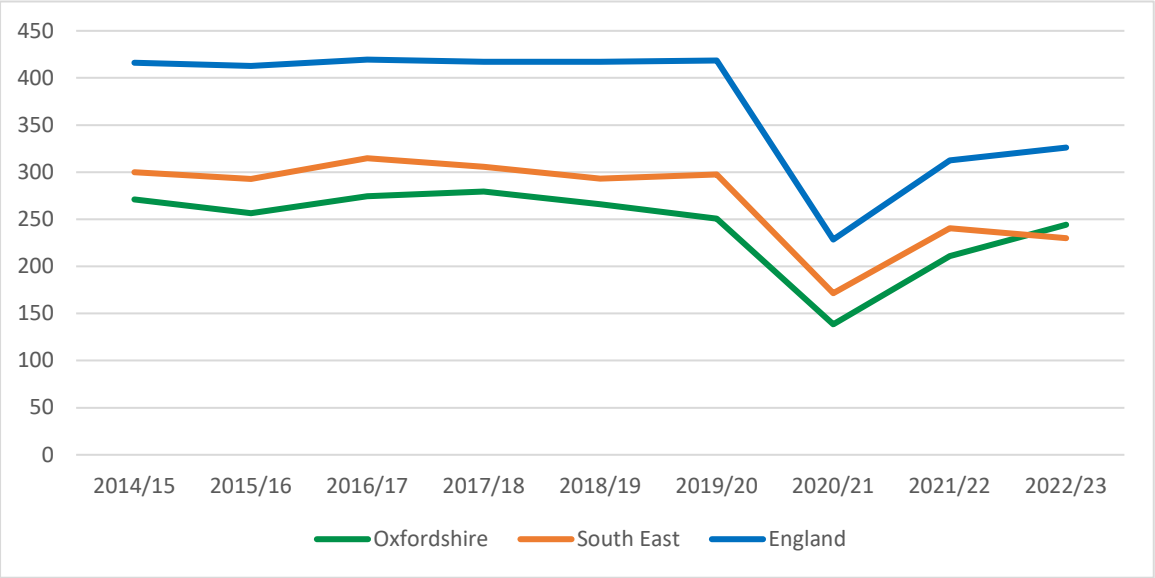
Source: OHID Smoking Profiles

Figure 43 shows that of the Oxfordshire NHS England statistical neighbour peer group, Lancashire (50.5 per 100,000 population) had the highest age standardised mortality rate per 100,000 population and Buckinghamshire UA (27.8 per 100,000 population) had the lowest. The Oxfordshire mortality rate of 32.0 per 100,000 population was the fifth lowest in the peer group of 16 local authorities.

COPD hospital admissions

Emergency hospital admission rates for COPD per 100,000 population aged 35 years and over are shown in Figure 44 for Oxfordshire, the South East region and England from 2014/15 to 2022/23.

Figure 44: Emergency hospital admissions for COPD per 100,000 directly age-standardised population (persons aged 35 *years* and over) for Oxfordshire, the South East region and England, 2014/15 to 2022/23

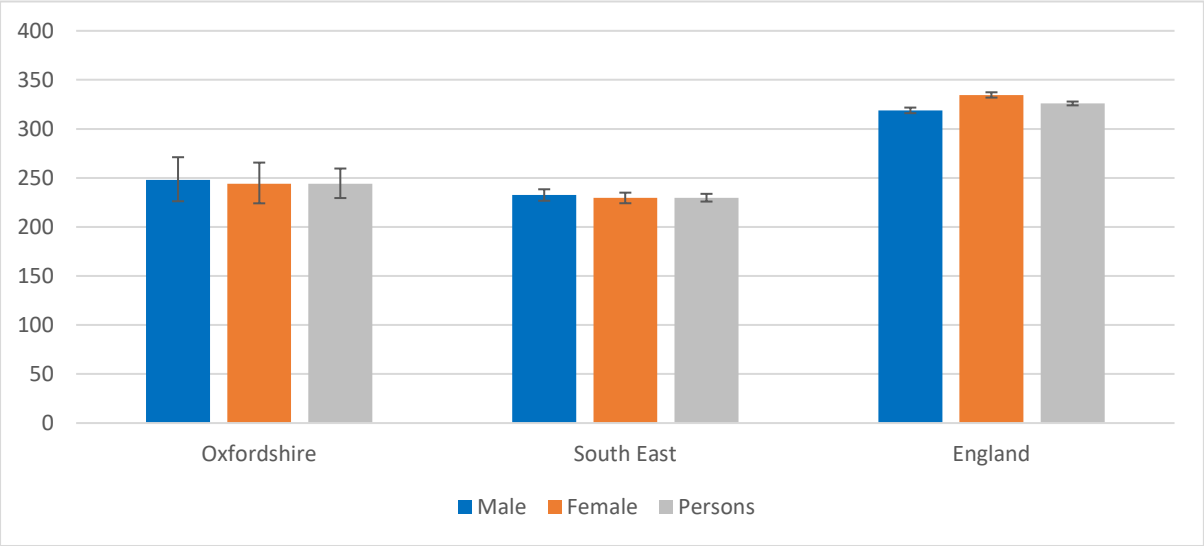


Source: OHID Smoking Profiles

Up until 2022/23 the rate of emergency hospital admissions for COPD in Oxfordshire has followed the similar pattern to the South East region rate. Both the Oxfordshire and South East region rates have been consistently lower than the England rate in the period shown. The emergency hospital admission rate for COPD in Oxfordshire has remained below 300 per 100,000 population since 2014/15 whereas the emergency admission rate for England was in excess of 400 per 100,000 prior to the COVID 19 pandemic.

Figure 45 shows the emergency hospital admission rate for COPD per 100,000 population aged 35 years and over for males, females and persons for the year 2022/23 in Oxfordshire, the South East region and England. The admission rate for Oxfordshire was statistically significantly lower than the equivalent rate for England, for both males and females but not statistically significantly lower than the rate for the South East.

Figure 45: Emergency hospital admissions for COPD per 100,000 directly age-standardised population (aged 35 *years* and over) for males, females and persons for Oxfordshire, the South East region and England, 2022/23



Source: OHID Smoking Profiles

Table 30 shows the trend in emergency hospital admission rates per 100,000 population for Oxfordshire compared with the district councils from 2014/15 to 2022/23.

Table 30: Emergency hospital admissions for COPD per 100,000 directly age standardised population (persons, aged 35 *years* and over) for Oxfordshire and district councils, *2014/15 to* 2022/23

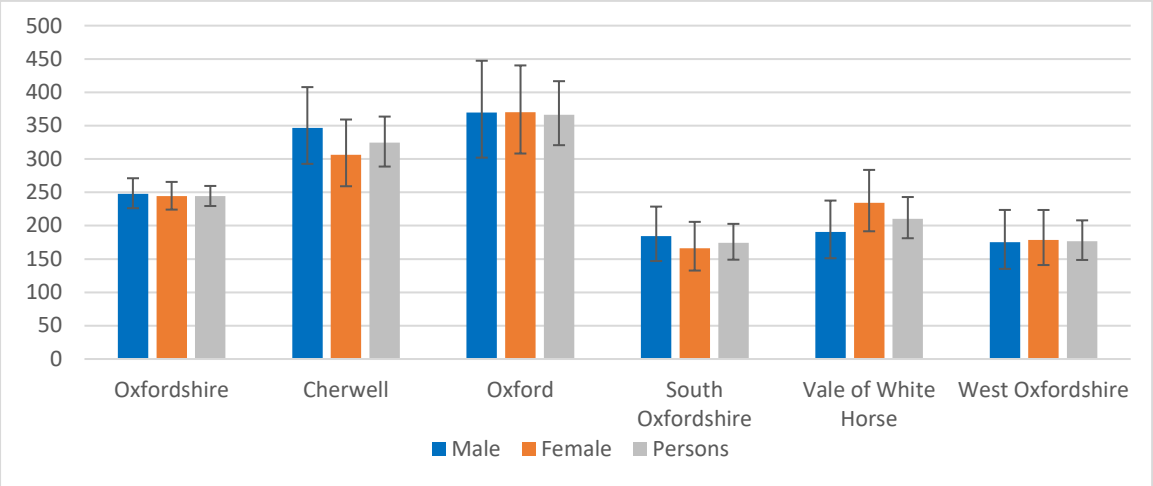
Year	Oxfordshire	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire
2014/15	**271.0**	356.4	434.3	240.4	168.1	183.0
2015/16	**256.3**	341.6	417.3	209.2	177.1	166.2
2016/17	**274.3**	335.2	435.6	257.7	195.9	176.7
2017/18	**279.4**	398.1	435.4	226.1	186.2	185.1
2018/19	**265.9**	359.1	434.8	197.8	177.2	202.7
2019/20	**250.6**	314.3	437.5	180.8	167.2	194.9
2020/21	**138.5**	183.9	249.8	87.4	100.4	99.6
2021/22	**211.0**	250.0	369.6	172.9	143.1	158.2
2022/23	**244.2**	324.5	366.4	174.3	210.4	176.4

Source: OHID Smoking Profiles

Oxford has consistently had higher rates of emergency hospital admissions for COPD compared to other districts and the Oxford rate in 2022/23 was more than double the rates for South Oxfordshire and West Oxfordshire. This reflects the higher mortality rates seen from COPD in Oxford and lends weight to the suggestion that the severity of COPD is greater for those in Oxford despite prevalence rates being the lowest in Oxfordshire (Table 14).

Figure 46 shows the emergency hospital admission rate per 100,000 population for Oxfordshire in 2022/23 for males, females and both sexes.

Figure 46: Emergency hospital admissions for COPD per 100,000 directly age-standardised population (persons, aged 35 *years* and over) for males, females and both sexes for Oxfordshire and district councils, 2022/23

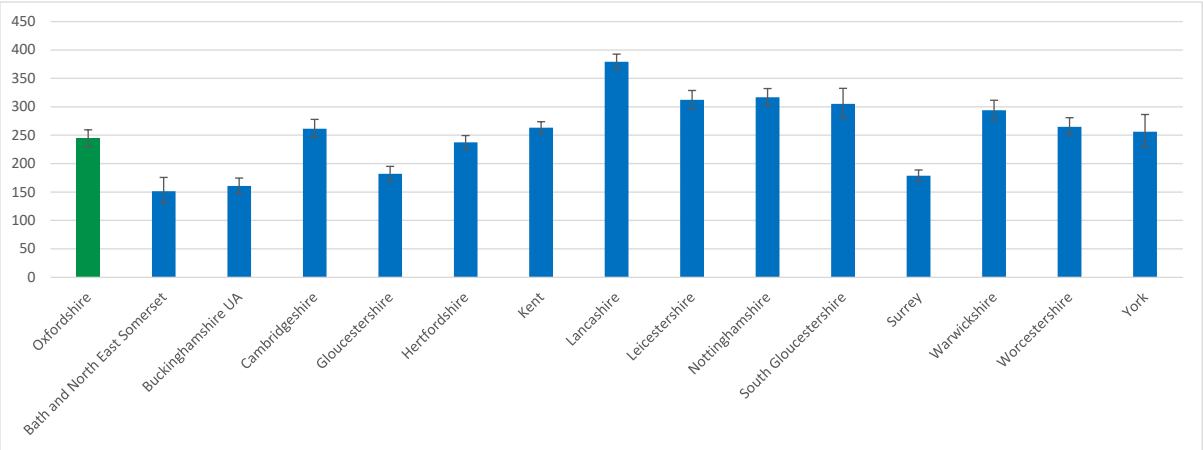


Source: OHID Smoking Profiles

The Oxford emergency hospital admission rates were statistically significantly higher than those of the other districts, except for Cherwell.

Figure 47 shows how the Oxfordshire emergency admission rate for COPD per 100,000 population compared to the NHS England statistical neighbour peer group in 2022/23.

Figure 47: Emergency hospital admissions for COPD per 100,000 directly age-standardised population (persons, aged 35 *years* and over) for Oxfordshire and NHS England statistical neighbour peer group, 2022/23



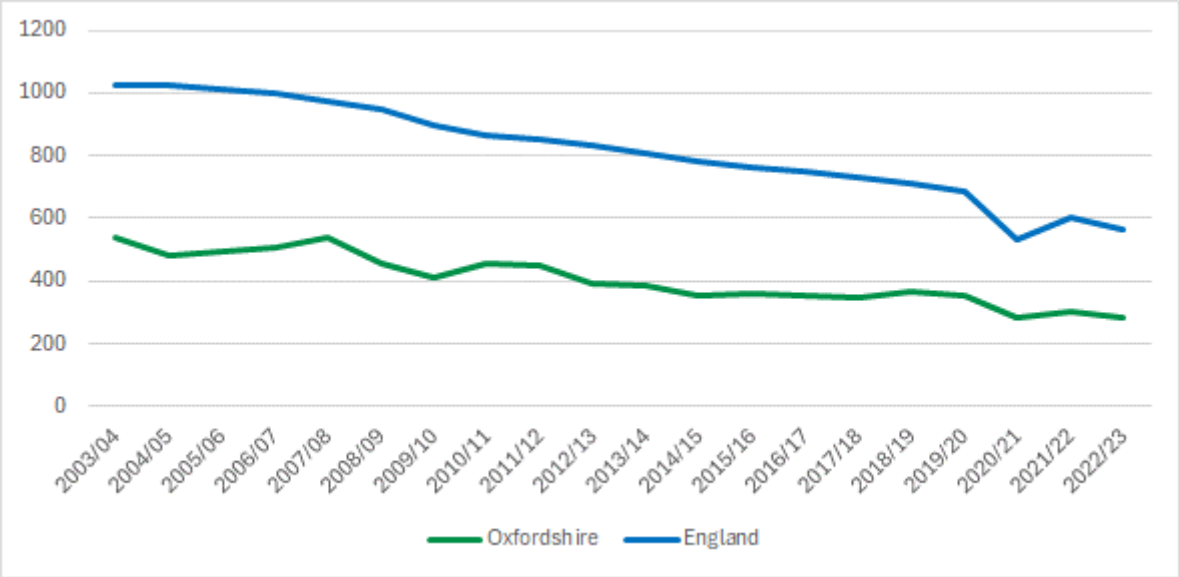
Source: OHID Smoking Profiles

Figure 47 shows that Lancashire had the highest emergency hospital admission rate for COPD in 2022/23. Oxfordshire's rate was close to the average for the peer group.

5.3.3 Hospital admissions for coronary heart disease (CHD)

The coronary heart disease (CHD) age-standardised hospital admission rate per 100,000 population (all ages) is shown in Figure 48 for Oxfordshire and England from 2003/04 to 2022/23. Note that data are not reported at regional level for this indicator.

Figure 48: Hospital admissions due to coronary heart disease per 100,000 directly age-standardised population (persons, all ages) for Oxfordshire and England, 2003/04 to 2022/23

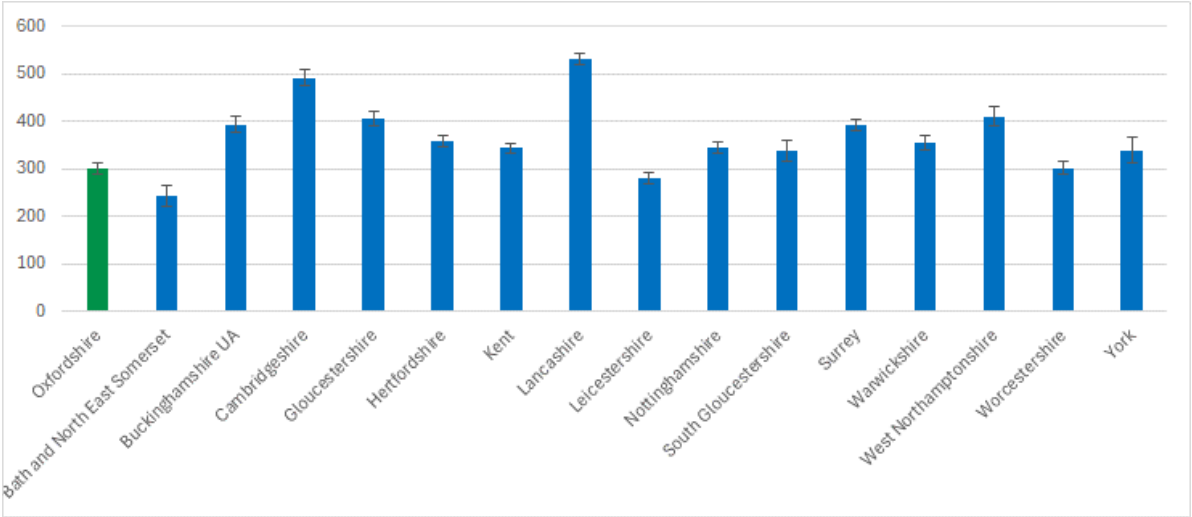


Source: OHID Cardiovascular Disease Profile

Both the England and Oxfordshire hospital admission rates for CHD per 100,000 population have nearly halved since 2003/04; however, the figures for England have been almost double those of Oxfordshire during the last decade. The Oxfordshire rate reduced from 541.5 per 100,000 in 2003/04 to 282.5 in 2022/23,whilst for England rates dropped from 1,027.4 per 100,000 population to 566.6 per 100,000 population over the same period. These hospital admission rate differences between England and Oxfordshire are statistically significant. The impact of the Covid-19 pandemic in 2020/21 on hospital admission rates can also be seen in the graph, with a visible dip during that year.

Figure 49 shows the age-standardised hospital admission rate for CHD per 100,000 population for Oxfordshire compared with the NHS England statistical neighbour peer group in 2021/22. Note that 2021/22 data has been used rather than data for 2022/23 because data for two of the NHS England nearest neighbours (Buckinghamshire UA and Surrey) were not reported in 2022/23.

Figure 49: Hospital admissions due to coronary heart disease per 100,000 directly age-standardised population (persons, all ages) for Oxfordshire and NHS England statistical neighbour peer group, 2021/22



NB. 2021/22 data because no data available for Buckinghamshire UA or Surrey in 2022/23

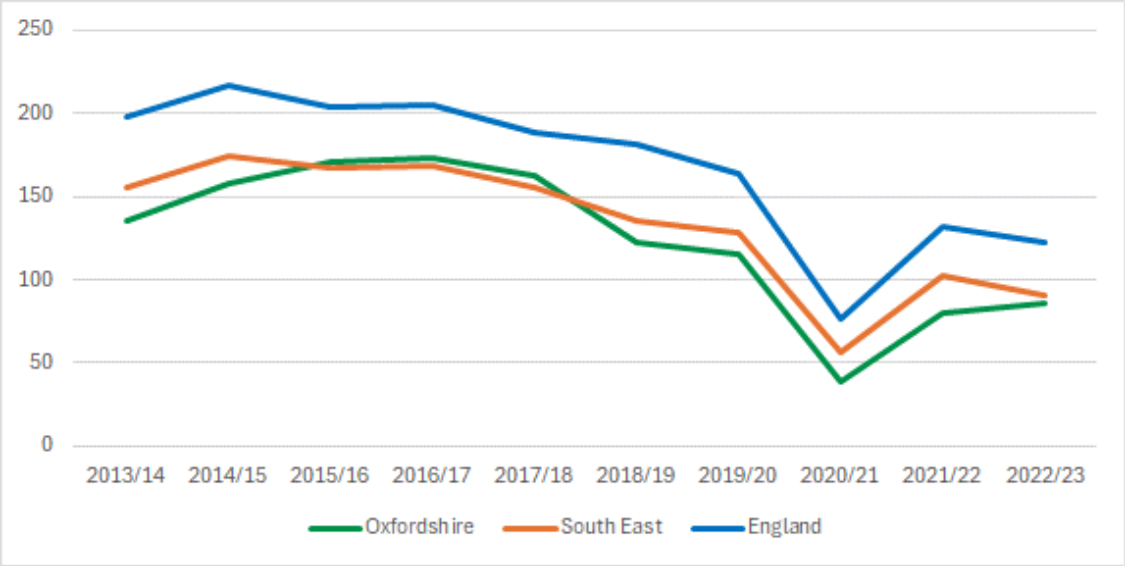
Source: OHID Cardiovascular Disease Profile

Figure 49 shows that Lancashire (530.5 per 100,000 population) and Cambridgeshire (491.1 per 100,000 population) had the highest age-standardised rates for hospital admissions per 100,000 population for CHD in 2021/22, with Bath and North East Somerset (242.6 per 100,000 population) and Leicestershire (280.1 per 100,000 population) having the lowest. Oxfordshire (300.7 per 100,000 population) had the fourth lowest hospital admission rate for CHD of the authorities in the peer group in 2021/22.

5.3.4 Hospital admissions for asthma

Asthma hospital admission rates per 100,000 population for people aged under 19 years in Oxfordshire is compared with the South East region and England from 2013/14 to 2022/23 in Figure 50.

Figure 50: Crude hospital admissions for asthma per 100,000 population aged under 19 years, crude rate, for Oxfordshire, the South East region and England, 2013/14 to 2022/23

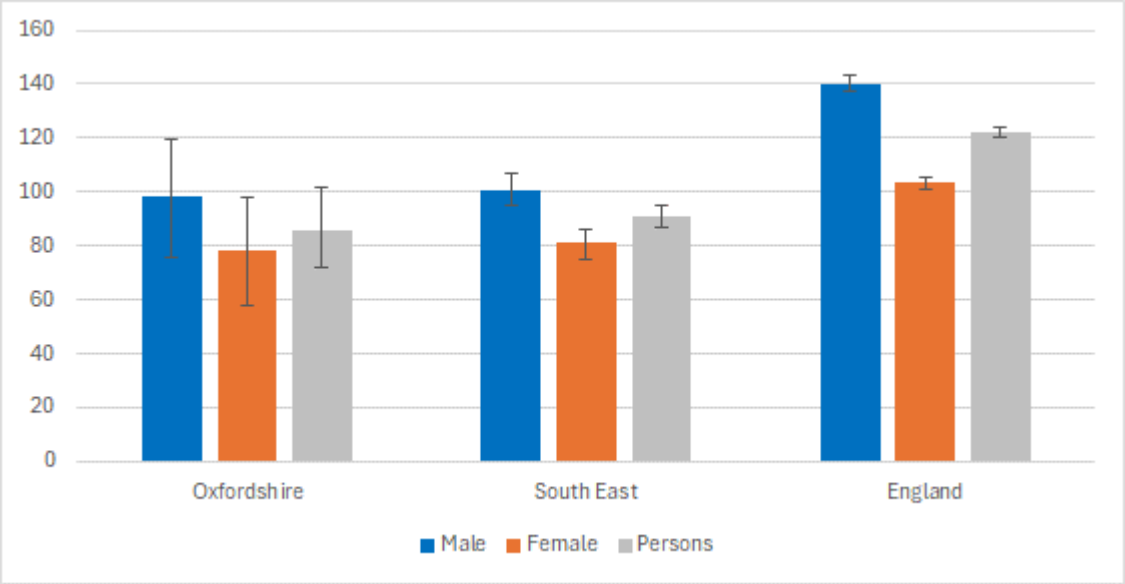


Source: OHID Smoking Profiles

Overall hospital admission rates have been decreasing in Oxfordshire, the South East region and England since 2014/15. Hospital admission rates for asthma in all reduced sharply in 2020/21, due to the Covid-19 pandemic, and although they subsequently increased, they still remain lower than the 2019/20 pre-pandemic rates for all three geographies.

Figure 51 shows the crude hospital admission rates for asthma per 100,000 population for people aged under 19 years in Oxfordshire compared to the South East region and England categorised by males, females and persons.

Figure 51: Crude hospital admissions for asthma per 100,000 population aged under 19 years, crude rate, by sex for Oxfordshire, the South East region and England, 2022/23

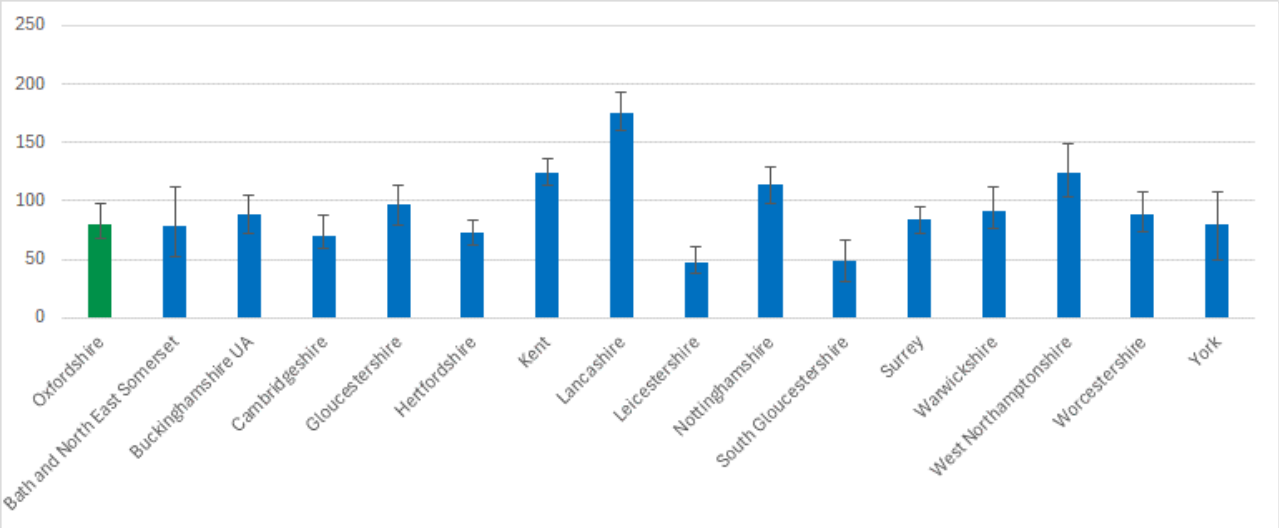


Source: OHID Smoking Profiles

Oxfordshire and the South East region had very similar hospital admission rates for asthma in both males and females in the year 2022/23; both statistically significantly lower than the hospital admission rates for asthma in England.

Figure 52 shows the hospital admission rate per 100,000 population aged under 19 years for asthma in Oxfordshire compared with the NHS England statistical neighbour peer group in 2021/22. Data for 2021/22 has been used for this indicator, rather than data for 2022/23 because of missing data for Buckinghamshire UA and Surrey in 2022/23. There was considerable variation in asthma hospital admission rates between NHS England statistical neighbours in 2021/22, with Leicestershire (47.0 per 100,000 population) and South Gloucestershire (48.1 per 100,000 population) having rates below 50 per 100,000 population, whilst Lancashire (175.6 per 100,000) had a rate that was more than three times higher. Oxfordshire's rate of 80.6 per 100,000 population was similar to many of the other peer group authorities (not statistically significantly different).

Figure 52: Hospital admissions for asthma per 100,000 population aged under 19 years, crude rate, for Oxfordshire and NHS England statistical neighbour peer group, 2021/22



NB. 2021/22 data because no data available for Buckinghamshire UA or Surrey in 2022/23

Source: OHID Smoking Profiles

6 Evidence underpinning current policy

Evidence underpinning national and local policy includes both the most methodologically rigorous studies, such as randomised controlled trials, systematic reviews and meta analyses in areas such as treatment for tobacco dependency along with less robust evidence about the best interventions to engage people to stop smoking in some priority groups such as those who are unhoused or who have current substance use or mental health problems. This section briefly outlines:

- The most recent NICE guidance with links to detailed recommendations
- Recent systematic reviews about treatment and the safety of vapes
- Recent publications aimed at local authorities about best practice and case studies of interventions considered to be effective for primary prevention, stopping smoking, tobacco control and how services can be tailored for the needs of particular groups

6.1 NICE Guidance (2023)

This guideline covers prevention, support for stop smoking and harm reduction should individuals wish to reduce the amount they smoke rather than quit in one go. It is based on a series of systematic reviews on different related topics concerning smoking, with each element updated when new evidence is published. Hence, although the latest update was in 2023, only a small proportion of recommendations were updated at this point and some recommendations have been in place since 2008. Included in the guideline is information on behavioural support and updated recommendations on stop smoking medications and vapes. The guidance also includes recommendations on training for health and social care professionals and highlights the national training standard and National Centre for Smoking Cessation and Training (NCSCT) courses as the go to resource for staff. Additionally, the guideline also addresses wider tobacco control interventions such as ways to prevent the uptake of smoking among children and young adults as well as mass media campaigns.

Specifically, this guideline includes new and updated recommendations on:

- adult-led interventions in schools
- stop-smoking interventions
- support to stop smoking in secondary care services
- adherence and relapse prevention
- identifying pregnant women who smoke and referring them for stop-smoking support
- providing support for women to stop smoking during and after pregnancy
- commissioning and designing services
- organising and planning national, regional or local mass-media campaigns

- campaign strategies to prevent uptake and denormalise tobacco use
- helping retailers avoid illegal tobacco sales
- coordinated approach to school-based interventions
- whole-school or organisation-wide smokefree policies
- peer-led interventions in schools
- using medicinally licensed nicotine-containing products
- promoting stop-smoking support
- promoting support for people to stop using smokeless tobacco
- identifying and quantifying people's smoking
- support to stop smoking in primary care and community settings
- supporting people who do not want, or are not ready, to stop smoking in one go to reduce their harm from smoking
- stopping use of smokeless tobacco
- following up pregnant women who have been referred for stop smoking support
- policy
- training

Recent evidence about treatment includes a Cochrane systematic review protocol (Hartmann-Boyce et al 2022), two Cochrane systematic reviews (Lindson et al 2024, Livingstone-Banks et al 2023) and an evidence review by Office for Health Improvement and Disparities (OHID) (McNeill et al 2022).

The Cochrane systematic review protocol (Hartmann-Boyce et al 2022) aims to assess how the use and availability of vapes might influence cigarette smoking in young people aged 29 years or less (i.e. whether vapes might function as a 'gateway' into smoking, whereby a young person initially uses a vape and then transitions to using tobacco) and the review will be published in due course.

Evidence on the safety and effectiveness of medication to aid cessation of the use of tobacco was provided by a Cochrane systematic review (Livingstone-Banks et al 2023) which included 75 trials (45,049 people) on nicotine receptor partial agonists. This review showed that people are more likely to stop smoking for at least six months when taking varenicline (41 studies; 17,395 people), bupropion (9 studies; 7,560 people), or one type of nicotine replacement therapy, e.g. patches (11 studies; 7,572 people) compared to placebo. Varenicline is more effective in helping people to quit smoking that bupropion and a single form of NRT. The review reported that cytisine may be as effective as varenicline in helping people to stop smoking (2 studies; 2,131 people). The review also indicated that the number of people quitting smoking by using varenicline may be similar to that using two or more types of nicotine replacement therapy, e.g. patches and gum together (5 studies; 2,344 people). A small proportion of people had serious adverse side effects with each of the medications.

Table 31: Proportions of people who successfully quit using different interventions

Intervention	Percentage quits per intervention
Varenicline	21 to 25
Bupropion	18
Cystisine	18 to 23
Single form of NRT	18
Two or more kinds of NRT	20

Source: Livingstone-Banks et al (2023)

Evidence on the safety and effectiveness of vapes to help people who smoke tobacco achieve long-term smoking abstinence was provided by a Cochrane systematic review (Lindson et al 2024) that included 88 studies (27,235 adults). The review found that people are more likely to stop smoking for at least six months if they use nicotine vapes compared to nicotine replacement therapy (7 studies; 2,544 people), or vapes without nicotine (6 studies; 1,613 people). In addition, nicotine vapes may help more people stop smoking compared to no support or behavioural only support (9 studies; 5,024 people). It was unclear from the evidence whether there was a difference in side effects associated with nicotine vapes compared with nicotine replacement therapy, no support or behavioural only support. However, there was some evidence that non-serious side effects were more common in people using nicotine vapes compared to no support or behavioural only support.

The aim of the OHID independent report (McNeill 2024) was to summarise the evidence on vaping products and to inform policies and regulations. The evidence on potential health risks of vaping covered testing for biomarkers of exposure to nicotine and potential toxicants; general biomarkers of potential harm to health across various diseases; biomarkers specifically associated with particular diseases; poisonings, fires and explosions; and the role of nicotine and flavours in vaping products. The report indicated that for some biomarkers (with the exception of nicotine) toxicant levels are at least 95% lower in people who vape compared to people who smoke, at least over short- and medium-term periods. However, the report emphasises that this does not mean vaping is risk free, particularly for people who have never smoked, and there is a need to discourage people who have never smoked from starting using vaping products or smoking.

6.2 Best practice: Prevention

The Khan Review (2022) includes a section on reducing the uptake of smoking, particularly amongst young people, and highlights the benefits of people never starting to smoke. Creating smokefree homes, by encouraging pregnant women and their partners to quit smoking, not only reduces harm from second hand smoke to the foetus and baby but also reduces the likelihood that the child will take up smoking; children whose family members smoke tobacco are three times more likely to smoke

themselves than children that come from non-smoking households (NCSCT 2015). The recommendations on how to achieve this include:

- Raising the age of sale of tobacco: statistics have shown that when the age of sale was increased from 16 to 18 years in England in 2007, it led to a 30% reduction in smoking prevalence for 16 and 17 year olds (Fidler and West 2010). Evidence from the US showed that when the age of sale was increased from 18 to 21 years, there was a 39% decrease in the number of people in that age group smoking (Friedman and Wu 2019)
- Increasing the cost of tobacco through duties: evidence on the impact of price increases on tobacco consumption in Australia, the US and South Africa has shown that substantial price increases result in larger than usual reductions in apparent and reported tobacco use (Greenhalgh et al 2022).
- Preventing tobacco dependence by stopping smoking in pregnancy: The Greater Manchester Smokefree Pregnancy Programme was implemented in 2018 and involved collaborative working between healthcare providers across ten local authorities to provide support to pregnant women who smoke and their partners. The integrated approach involved rapid referral of women to specialist maternity-led stop smoking services, and the provision of a financial incentives scheme which provided the women with access to shopping vouchers during their pregnancy, based on them remaining smokefree. The impact of this approach included an increase in the number of women who successfully stopped smoking, a higher average birth weight in newborns, and reductions in the number of babies requiring neonatal care. Up to January 2022, the programme showed a 75% four-week quit rate among pregnant women, with over 90% of those remaining smokefree until birth. There was also reported to have been more engagement from partners and an increase in smokefree homes (Khan 2022).

In addition to increasing the barriers to smoking through legislation, health promotion interventions for smoking prevention are also vital. Evidence suggests that the best method for smoking prevention involves a three-tiered approach:

1. mass media and social marketing
2. community mobilisation and setting based interventions and
3. individual education.

These methods incorporate change at the individual level, as well as influencing social norms and working at the socio-political level to enhance population health (Golechha 2016).

Meta-analyses of school based interventions have found them to be effective in preventing smoking uptake in adolescents (12% reduction after one year). Interventions led by adults and focusing specifically on teaching younger teens skills in social influence have been found to be particularly effective (Thomas 2015).

- Stop Smoking in Schools (ASSIST), peer led intervention, developed in Bristol. ASSIST combines a 'gold standard' RCT with an innovative approach to reduce adolescent smoking prevalence. The most influential 12 and 13 year old students are identified and trained to work as peer supporters who then have informal conversations with their friends about the risks of smoking and the benefits of remaining smoke-free. The study has shown that the ASSIST training program was effective in the achievement of a sustained reduction in uptake of regular smoking in adolescents for 2 years after its delivery. Internationally and in the UK no other school-based smoking prevention programme has been found to be as effective. Recommended in NICE guidance, and with a QALY of around £12,700 (Golechha 2016; Evidence to Impact).
- INTENT[5], school programme, developed by the University of Leeds. The programme involves delivering two lessons per year to pupils from Y7 to Y10, in which information about smoking is delivered. The programme covers everything from health impacts to financial costs; the course also includes information on vaping. Students are given evidence-based information on the impacts and effects of smoking/vaping and then asked to make a 'battle plan' to prepare what they will do if they are offered a cigarette or vape. This approach has been used for other risky behaviours as a way of planning a response to specific situations reducing the likelihood of impulse on the spot reactions. Teachers are trained to deliver the programme. In North East Lincolnshire, 26% of students that received the INTENT education programme are less likely to report having ever smoked compared to those that did not participate in the programme (LGA 2024 – North East Lincolnshire). This programme has been commissioned locally by Oxfordshire.

6.3 Best practice: Support

As part of the recommendation to encourage people who smoke to quit for good, the Khan Review (2022) provided evidence on the impact of different interventions from two case studies in England:

- Salford City Council conducted a 'Swap to Stop' vape pilot to help people to stop smoking by using vapes. The pilot was primarily aimed at social housing tenants and engaged with over 1,000 people who smoke in Salford by providing advice and guidance on stopping smoking and using vapes. An evaluation of the pilot showed that the cost per quit of using vapes was significantly lower than the standard stop smoking service on offer and the number of people quitting smoking increased by nearly three-fold. The evaluation concluded that

[5] *INTENT | smoking prevention programme | Evidence to Impact*

offering and promoting free vapes significantly increased demand for stop smoking services, particularly in the most deprived areas of Salford.

- The Fresh programme in the North East includes quit campaigns that target areas of highest deprivation to highlight the risks of smoking and benefits of quitting, including campaigns such as 'Every Breath', 'Don't Be the 1', '16 Cancers', and the 'Don't Wait' campaign. The Fresh programme is based on international evidence that suggests mass media campaigns, particularly TV broadcasts, can trigger and maintain attempts to stop smoking. An independent evaluation of the programme found that 51% of people who smoke recalled the campaign, and around one in six (17%) North East people who smoked successfully cut down or quit (approximately 55,250 people) because of seeing the 'Don't Wait' TV campaign.

The review also highlighted 'The Final Push' the Oxfordshire Tobacco Control Alliance strategy for 2020 to 2025 as an example of best practice for a holistic approach to tobacco control (Oxfordshire Tobacco Control Alliance 2020).

The Khan review (2022) commissioned ASH to seek the views of people from more disadvantaged communities to provide insights on attitude and behaviours to smoking. This included reactions to policy ideas, which were reported to be "*muted and negative*", and included the belief that no notice would be taken of cigarette pack inserts and on-cigarette messaging, but positive messaging would be more interesting, as would the provision of free vapes to encourage quitting. Increased restrictions of places where smoking is allowed provoked the strongest negative reaction from those interviewed.

The NCSCT and DHSC guidance (2024) for local authorities provides evidence-based, best practice guidance for commissioners and providers of stop smoking services. The guidance suggests three primary roles for commissioners and providers:

1. To increase the number of people who make aided quit attempts, with a focus on local priority groups
2. To work collaboratively to support people who smoke who want to stop by providing access to person-centred, evidence-based stop smoking support and aids
3. Work in partnership and collaborate with other organisations across systems

It is recognised that although behavioural support, stop smoking medications and nicotine vapes are effective when used alone for treating tobacco dependence, a combination of these interventions is more effective.

6.3.1 Behavioural support

There was strong evidence that the use of behavioural support interventions results in boosting motivation to quit, enhances self-regulation and increases the use of stop smoking aids. It also improves the ability to cope with withdrawal symptoms, the urges to smoke, and high-risk situations. The evidence showed that providing behavioural

support (in-person or via telephone) for people using medication increased quit rates and that individual, group, and telephone counselling were all effective, with their effectiveness increasing with treatment intensity (i.e. contact time). However, the optimal amount of support (for both frequency and duration) was dependent on client need, and there was evidence to suggest that some client groups require more intensive support for a longer duration, such as pregnant women and people with severe mental illness (SMI).

6.3.2 Stop smoking aids

Evidence on smoking aids included nicotine replacement therapy (NRT), stop smoking medications (bupropion, cytisine and varenicline) and nicotine vapes. The most effective stop smoking aids were reported to be:

- Combination NRT (use of a nicotine patch plus a faster-acting NRT product)
- Nicotine vapes
- Nicotine analogue medications (varenicline and cytisine)

The second most effective stop smoking aids included:

- Single-form NRT
- Bupropion

The NCSCT and DHSC (2024) highlighted evidence from nine studies that NRT preloading between one to a few weeks before clients planned to stop smoking increased rates of stopping smoking. The guidance document also reported that there is some evidence that extended use of stop smoking aids can be helpful in reducing rates of relapse, particularly in people with SMI.

The NCSCT and DHSC (2024) guidance document provides advice on best practice for delivering stop smoking services (see Table 32).

Table 32: Summary of best practice for delivering stop smoking services

Referral pathway	Best practices
Self-referral	• A single point of access to all support services with a dedicated helpline, as well as digital access, with information shared across social media • The provision of information in the most prevalent non-English languages locally and in British Sign Language (BSL). Engaging with the local community to understand their needs and co-produce appropriate resources is vital • Co-designing services with people who smoke and with service users to actively identify and remove barriers to access • Regularly updated supply of posters, leaflets and cards for healthcare professionals to hand out and display to promote and maintain the profile of local stop smoking services (LSSS) • Website content, and any information from helpline staff, should include advice and motivation to all people who smoke to quit to help them make an informed decision and encourage them into the most effective and appropriate support available

Referral pathway	Best practices
	• All communications and referral processes should be person-centred and tailored to the local community. This includes using language that will resonate and engage members of priority groups
Primary care	• GP surgery pathways should be developed, with named responsibility for delivering each element of the Very Brief Advice Plus(VBA+) • Have a smoking cessation champion within each primary care setting as this can significantly improve rates of VBA+ delivery and rates of referral to LSSS • Automated medical record prompts and simple electronic referral tools can increase delivery of VBA+ • Offering carbon monoxide (CO) monitoring alongside VBA+ and facilitating access to free or low-cost stop smoking aids can increase patient motivation to quit • Co-location of services: There has been success with co-location of stop smoking support in GP surgeries. General practices may also be commissioned to deliver stop smoking support to patients by a trained member of the primary care team • There is some limited evidence that proactive outreach to patients identified as people who smoke in clinic medical records can serve to increase uptake. As smoking status and referral are Quality and Outcomes Framework (QOF) indicators, people who smoke can also be identified through practice data searches for bulk messaging

Source: NCSCT and DHSC (2024)

Two best practice examples on how to reach people who smoke and promote quitting include the Fresh programme (also mentioned in the Khan Review 2022 and described above) which developed campaigns and year-round communications by working with people who smoke and quitters, doctors, local government and national government departments. Evidence suggests that campaigns can increase success in quit attempts and can also prevent young people from starting. The Stop Smoking London programme provides online tailored support to help people find the right method to stop smoking; guidance on how to manage nicotine withdrawal symptoms; guidance on how to help someone stop smoking; help on finding free support in London to help stop smoking; and top tips for stop smoking success. The online resource also presents case examples of people's experiences on how they successfully quit smoking, how much money they saved, and the impact this had on their lives. An example of cost saving based on an average pack of 20 cigarettes costing £15.20 for someone smoking 12 cigarettes per day would be £63.84 per week; £277.40 per month; £3,328.80 per year.

6.3.3 Best Practice: Stopping vaping

There is very little evidence about how to stop vaping or stopping dependency on nicotine. A recent NCSCT(2022) publication provides the Ask, Advice, and Act model (see Table 33) to help stop smoking services to provide support to clients on how best to stop vaping. This involves providing information and advice, rather than more involved interventions such as behavioural support programmes. The guidance states

that the priority for services should always be to ensure that clients do not go back to smoking cigarettes.

Table 33: Ask, Advice, and Act model

ASK	Ask clients about their reasons for wanting to stop vaping as this can help in tailoring advice and support.
ADVISE	Provide accurate information and advice on available options for stopping vaping gradually or in one step, and advice on whether vaping is the best device for the client. Clarify any misinformation and concerns about vaping.
ACT	Assess risk of relapse to smoking and offer tailored support to clients who want to stop vaping, either gradually (e.g. by reducing the nicotine strength of the product at intervals) or in one step.

Source: NCSCT (2022)

6.4 Best practice: Regulation and enforcement

The Khan Review (2022) recommended increasing illicit tobacco monitoring and enforcement. A case study in Medway, England highlighted a growing concern about illicit 'pop up shops' and the low prices that encourage people who smoke to continue smoking. The case study reported on a successful prosecution which resulted in an offender receiving a 90-day custodial sentence. However, the process took 15 months and during this period, the defendant continued to trade in illicit cigarettes. In a two-and-a-half-day operation in Medway, one shop suffered a seizure of 82,000 cigarettes, but was back in operation selling illegal tobacco within hours.

The ASH Smokefree GB Youth Survey (2024) reported that although a minimum age of sale for vapes of 18 was introduced in England and Wales in 2015 (making it illegal to sell vapes containing nicotine to under 18s or to purchase them on behalf of under 18s), a loophole in the law does not make it illegal to give free samples of vapes to under 18s. Scotland implemented their own age of sale and proxy purchasing regulations in April 2017, and Northern Ireland in February 2022. In 2016, a regulatory framework for vapes was introduced in the UK under the EU Tobacco Products Directive (TPD), which stated that the advertising or promotion, directly or indirectly, of electronic cigarettes and re-fill containers on a number of media platforms, including on television, radio, newspapers and magazines, was prohibited. However, the ASH survey provides evidence on the impact of the current regulations and how the market for vapes is evolving (see Target populations; Children and young people).

6.5 Best practice: The wider environment

The WHO Framework Convention on Tobacco Control (FCTC), Article 8, specifically addresses second hand tobacco smoke and advises that legislation is necessary to protect people from exposure to tobacco smoke (2013). Key to the framework is the

acknowledgment that there is no safe amount of second hand smoke exposure, opening windows or using mechanical ventilation does not reduce exposure, children and babies are at particular risk of second hand smoke and second hand smoke can travel between rooms and even dwellings in large blocks of flats. The Smokefree legislation of 2007, promoted and enforced by local authorities, has meant many fewer people are now forced to breathe second hand tobacco smoke and people who want to smoke need to make additional effort to do so (ASH 2022). A 2016 Cochrane review identified clear evidence of a population level benefit to these legislative measures across several national populations, specifically cardiovascular disease and reduced mortality for smoking-related illnesses.

It is still common for children and young people to encounter tobacco smoke on a daily basis in their own home. For young people, smoking within the home exposes them to second hand smoke, normalises smoking as an acceptable everyday behaviour and is thought to be responsible for one-fifth of all sudden infant deaths in the UK (RCP 2010). These issues are most prevalent in social housing: across all socio-economic measures, housing tenure is the strongest independent predictor of smoking in England after educational qualifications (ASH 2022).

- Fresh North East, the British Lung Foundation and a paediatric respiratory medicine consultant from Newcastle University led a campaign 'Secondhand smoke is Poison' in the North East. It was an eight-strand, local strategic framework focused on raising awareness of the dangers of second-hand smoke, particularly for children and those living in social housing. A primary focus was a mass media campaign raising awareness of the dangers of second-hand smoke (Newcastle University 2017).

Wherever children, young people and young adults congregate, there is a case for going smokefree. Many public playgrounds are already smokefree and smokefree pavement licences have proved to be a popular innovation. Student campuses, parks and sports facilities are all opportunities for creating smokefree environments (ASH 2022).

- Buckinghamshire Council launched Smokefree Sidelines in 2022. The programme encourages local football clubs to prevent smoking and vaping at all youth football matches. The programme is voluntary, but the council provided training to the football association and has provided posters, car stickers and banners with the tagline "We copy what we see, let's make our sport smokefree" to participating clubs. The programme has also worked with local schools to run poster design competitions; posters are then displayed in parks and playgrounds, in the most deprived areas of Buckinghamshire, encouraging parents not to vape or smoke. All programmes are voluntary but are leading to a 'new social norm in the county.' (LGA 2024 – Buckinghamshire)
- Smokefree Sidelines was launched across Oxfordshire in August 2020. A partnership was set up between Oxfordshire Football Association, Bucks & Berks Football Association, Active Oxfordshire, OCC and the counties' four local youth football league . The aim was to help to create healthy, safe places

that provide everyone the opportunity to perform in their chosen sport or activity by encouraging a smoke-free lifestyle. Clubs who agreed to adopt the Oxfordshire Smokefree Sidelines policy and participate, received a range of support and benefits including a briefing session about the scheme, a pre-written policy to adopt, promotional materials and free resources for games and training sessions. The project was re-promoted in July 2024 with further resources, social media promotion and support for welfare officers. Since its launch in 2020 there have been over 70 clubs who have signed up.

Training in brief advice enables professionals who encounter people who smoke to guide them towards quitting or switching to vapes. Professionals working in housing, social care, the fire service and those who offer financial and debt advice will all have opportunities to deliver brief advice opportunistically to residents where appropriate (ASH 2022). In addition, hospital paediatric services can promote smokefree homes to parents of children with unstable and severe asthma, respiratory infections and recurrent ear infections (ASH 2022). All landlords have a duty to ensure that public spaces within housing developments are maintained smokefree. As a minimum this should involve clear signage and appropriate messaging to tenants.

- The Local Government Association (LGA) highlighted the best practice of OCC in working across the community and with a range of partners to de-normalise smoking and 'nudge' people towards quitting, through £1000 grants in the community fund. Creative initiatives have included signage, designed by school-children to create smoke-free parks, supplying vapes for the drugs and alcohol service and proving 'fun' ballot bins for cigarette butts in sheltered housing when making the accommodation smoke-free (LGA 2024 – Oxfordshire).
- Southampton City Council has taken a targeted approach to their tobacco dependency treatment, focussing on training specialist stop-smoking support workers within hostels for people who are homeless, drug and alcohol support services, maternity services and mental health services. Local primary care staff are also trained. The service has created a network of practitioners to share best practice and provide support; the service is both specialist (meeting patients 'where they are') but also fully connected and networked to the city's healthcare system. The service has demonstrated success with 6,000 smokers per 100,000 in Southampton City setting a quit date. The self-reported quit rate is 50% higher than the England average (LGA 2024 – Southampton).

6.6 Best practice: Target populations

The Cancer Research UK and ASH (2023) survey identified the populations targeted by 120 local authorities in England for stop smoking services. Of the local authorities that responded to the survey 64% targeted people with mental health conditions, 62% pregnant women, 61% people in routine or manual occupations, and 48% people living in areas of high deprivation. Only 22% of local authorities targeted young people and only 3% focussed on refugees/asylum seekers.

The NCSCT and DHSC (2024) identifies certain priority groups and the need to modify services for each group and best practices for tailoring these services. Understanding how to tailor these services for specific groups requires a combination of identification of evidence based interventions and codesign or coproduction with groups to understand what would work best in a particular context. Insights identifying barriers to access should be fed back to groups and service providers so these can be addressed and inform development of locally meaningful services (NCSCT and DHSC 2024, Farmer and Samuels 2022).

6.6.1 Low income households and people experiencing socio-economic disadvantage

Based on the available evidence NCSCT and DHSC (2024) suggested it was important to prioritise the following elements for low income households and those experiencing socio-economic disadvantage:

- Ensure an equity-oriented approach to Local Stop Smoking Service (LSSS) delivery that targets people in lower socioeconomic groups
- Provide barrier-free, cost-free access to stop smoking aids and support
- Flexible support programmes that offer more intensive and longer support
- Consider outreach into settings such as workplaces, housing associations and debt advice services
- Work with police and other local partners to reduce access to illegal tobacco
- Ensure LSSS communication and promotional activities, including the design and dissemination of targeted communication campaigns, feature people from lower socio-economic groups
- Use peer facilitators and buddies to encourage engagement with services
- Address language and communication barriers
- Offer a Cut Down to Stop (CDTS) option
- Add text messaging and digital support to the behavioural support programme

6.6.2 People with severe mental illness (SMI)

For people with severe mental illness NCSCT and DHSC (2024) outlined the following best practice:

- Offer quitting in one step (abrupt quit) as the first choice option, with flexibility to offer CDTS for those not interested, or able, to stop in one step
- Facilitate access to NRT, nicotine vapes or other stop smoking aids prior to quitting and for extended periods after quitting to prevent relapse
- Provide person-centred support that is tailored to the individual, including flexible appointment venue, more frequent contacts and tailored duration of support
- Address common barriers to quitting and facilitate alternative activities

- Offer support with quitting to family/caregivers. Be ready for setbacks and build these into the treatment plan
- Ensure good communication with the care team and those performing the mental health medication review

6.6.3 Pregnant women

Based on the evidence the following key elements are recommended by NCSCT and DHSC (2024) when working with pregnant women:

- Delivery of support by stop smoking should be from practitioners trained in working with pregnant women who smoke
- Rapid, flexible behaviour support programme (including home visits and outreach) that continues for as long as it is needed
- Access to, and support with use of, a free combination NRT or nicotine vapes
- Use of CO monitoring as a motivational tool
- Offer support, and access to stop smoking aids, to partners and significant family members to create a social norm and motivate the pregnant client to attempt and maintain a quit attempt

6.6.4 NHS Tobacco Dependence Service (TDS) Transfer of Care

For people who have been admitted to hospital and received support from the hospital based Tobacco Dependency Service, it is important that on discharge they can quickly access community services. Best practices for well-coordinated, efficient pathways to provide a seamless stop smoking support include:

- Simple digital referral processes (e.g. one-click electronic referral method)
- Referral criteria agreed, so that patients are seen by the most appropriate community-based service and that specialist qualified providers see patient groups at greatest risk of relapse or with specific needs (e.g. pregnant women and partners, people who are heavily dependent and people with SMI)
- Provide sufficient detail to allow for seamless Transfer of Care. LSSS and trusts should agree to the minimum information that accompanies referrals to ensure LSSS practitioners can meet individual care needs
- NHS commissioners and local authorities need to ensure that provider organisations give rapid access to follow-up support from LSSS. This includes contact with patients within 48 hours of discharge, multiple attempts to contact patients (at least three to five attempts at different times of day) and reporting back to trusts about patients who have not been reached
- Provision of ongoing supply of stop smoking aids. Mechanisms should be in place to ensure patients are provided with ongoing supply of medication for 10–12 weeks (from the initiation of treatment in hospital). This may require innovative distribution methods for patients that are not initially seen in person

- Adaption of service delivery model to support post-discharge follow-up. The standard treatment plan should be adapted to support patients who have already initiated a quit attempt
- Flexible service delivery options. Not all patients discharged from hospital will be mobile or in good health and this is particularly true in the early post-discharge period. LSSS should be prepared to modify service delivery options to ensure ongoing support, including offering remote support and hybrid service delivery models
- Follow-up support for at least four weeks post-discharge for patients discharged from acute trusts and 12 weeks for patients discharged from acute mental health trusts
- Development of strong working relationships between NHS Tobacco Dependency Service and LSSS commissioners, managers and providers
- Engaging post-partum women. NHS trusts operate a maternity tobacco treatment pathway led by the trust inpatient maternity team. Where possible, continue engagement with postpartum women, as well as partners and other household members, to avoid relapse

6.6.5 Populations with multiple or complex needs

The key elements from NCSCT and DHSC (2024) about tailoring services to people with complex needs includes:

- Ensure support is visible and available where the people are
- Prioritise stop smoking support alongside other addiction and support services
- Train key workers in Very Brief Advice plus
- Partner with local organisations who work with populations with multiple or complex needs to promote and support outreach
- Embed LSSS into settings which have good working relationships with, and/or deliver services to, people with multiple or complex needs
- Train staff in working with local populations with multiple or complex needs, including on how to adapt treatment
- Ensure services can be provided in languages spoken by residents in local areas and translation services are available, where required

6.6.6 People with substance use disorders and co-addictions

The NCSCT and DHSC (2024) reports that there is limited research around best practices for treating tobacco dependence in people who also have alcohol or substance use disorders. However, this cohort often have co-occurring difficulties such as mental health problems, have multiple or complex needs, or experience deprivation. Tailoring the approach to this cohort may include offering support to stop

smoking in drug and alcohol treatment settings, whilst taking into account other difficulties and needs.

6.6.7 People experiencing homelessness

The NCSCT and DHSC (2024) report states that good practice includes having regular offers of stop smoking support embedded in routine health reviews, outreach visits from LSSS and regular offers of harm reduction support.

6.6.8 People from the LGBTQ+ community

The NCSCT and DHSC (2024) reports that evidence on best practice for tailoring treatment to people from the LGBTQ+ community includes holding group sessions in LGBTQ+ spaces, discussing social justice, discussing LGBTQ+ specific triggers, boosting motivation/self-efficacy and addressing social support. Partnering with LGBTQ+ organisations and co-designing and co-locating services in health and community services that work with the LGBTQ+ community were stated to be good practice.

6.6.9 Children and young people

The ASH Smokefree GB Youth Survey analysis is a yearly survey of young people aged 11 to 18 collected by YouGov for ASH. The fact sheet presents patterns of vaping use, reasons for vaping, the main source and type of product used, and awareness of vaping promotion among young people. The results of the 2024 survey showed that the rates of vaping among 11 to 17 years olds increased between 2013 and 2023 but have stabilised in 2024 (since 2015 it has been illegal to sell vapes to anyone under the age of 18). However, 18% of 11 to 17 year olds in 2024 have tried vaping which equates to around 980,000 children. The prevalence of regular use and experimentation was reported to increase with age, and the current use of vapes was considerably higher among people who smoke (54%) compared to people who formerly smoked (26%) or never smoked (1.8%). Regular vapers (i.e. those who used vapes weekly or more) were most likely to have tried smoking first (53%), and less likely to have tried vaping first (23%) or never tried smoking at all (17%). The most common reasons for vaping included: *'Just to give it a try'* (35%), followed by *'Other people use them so I join in'* (14%) and *'I like the flavours'* (12%).

Although the sale of tobacco and vapes to people under the age of 18 is an offence, 48% of 11 to 17 year olds who vaped and 54% of people who smoke tobacco purchased from shops. A further 27% of young people who vape and 30% who smoke tobacco purchased from an informal source. Online purchases were much less frequent, with 13% of current vapers citing this as a source and 9.7% of people who smoke tobacco. The awareness of vaping promotion was reported to have grown among 11 to 17 year olds between 2022 and 2024, with a significant increase in awareness of promotion in shops and online over these years and a decline in those saying they do not see vapes being advertised. In 2024, 72% of 11 to 17 year olds

report they were exposed to some form of vape promotion, the most common type being in shops (55%) and online (29%). An experiment to assess the impact of standardising vape packaging showed that removing brand imagery could have an impact in reducing the appeal of vapes to young people without compromising their appeal to adults who smoke, attempting to quit tobacco.

The Khan Review (2022) proposes the use of vapes to encourage people to quit smoking, it also states that young people and those who have never smoked should not vape. Recommendations on preventing young people taking up vaping included:

- Ban characters or images appealing to young people on vaping products
- Review the way flavours are described – or even the flavours themselves – to ensure vapes do not appeal to young people
- Prohibit vaping companies from giving away vapes for free
- Make the use (or even the possession) of any age restricted products illegal on school and college premises
- Update the school health education curriculum to talk about the risks of vaping and its age restrictions.

Limiting flavours of vapes and reducing the packaging and displays designed to appeal to children are incorporated into the Tobacco and Vapes Bill[6]. In addition the Bill will prohibit the sale of tobacco to people born on or after 2009.

The NCSCT and DHSC (2024) found that there is limited evidence about effective stop smoking interventions, delivered in school or in community settings, for adolescents. Recommendations were made concerning training staff who work in youth services, with whom young people already have a relationship and whose organisations are credible to them, in helping to stop smoking and encouraging signposting to, and raising awareness of services.

The priority groups outlined by NCSCT and DHSC (2024) will overlap with a proportion of individuals being part of several priority groups. For example, an individual may be from a low-income household, be pregnant, have a severe mental illness and cope by misusing alcohol. For these individuals it will be important to work with them to prioritise what they need, identify what works for them and have a single point of contact supporting them with stopping smoking.

The dearth of evidence about helping prevent children and young people begin vaping and smoking may be addressed with a new 10 year research study of 100,000 11 to 15 year olds to investigate the long term health effects of vaping on young peoples health and wellbeing. This aims to provide evidence to protect the next generation from potential health risks of vaping[7].

[6] Tobacco and Vapes Bill - Parliamentary Bills - UK Parliament

[7] 10-year study to shed light on youth vaping - GOV.UK

7 Smoking and tobacco control in Oxfordshire

The scope of this HNA was primarily to identify and support needs related to a planned re-commission of Stop Smoking Services. Consequently, there is greater detail in this section of the report; however, for completeness there is a rapid gap analysis related to prevention and the wider environment in the other sections including national and local policy, best practice and services working together.

There is a range of national data available about the numbers of people who attempt to quit smoking in each local authority, by age, sex, ethnicity and employment status. The metrics used include proportions of people setting a quit date and the outcomes at four weeks after the "quit date". NHS Digital have defined a successful quitter as a client who, at the four week follow-up, "*states that they have not smoked at all since two weeks after the quit date"* (NHS Digital, 2023). If possible, all self-reported quitters should be confirmed by carbon monoxide (CO) validation at the four week follow-up (except for those followed up by telephone); CO validation measures the level of carbon monoxide in the bloodstream and provides an indication of the level of use of tobacco (NHS Digital, 2023).

Table 34 below shows the number of people setting a quit date and the subsequent proportion of people achieving a specific outcome, for Oxfordshire, the South East region and England.

Table 34: Number of persons setting a quit date and the proportion of people achieving a specific outcome, for England, the South East Region and Oxfordshire, all ages, 2023/24

Region	Setting a quit date	Successful quitters (self-reported)	Successful quitters (self-reported), confirmed by CO validation	Not quit	Not known/lost to follow up
England	193,505	53.8%	20.2%	27.3%	18.9%
South East Region	30,590	55.5%	31.3%	26.9%	17.6%
Oxfordshire	**1,390**	**67.6%**	**1.8%**	**21.4%**	**11.1%**

Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

In comparison with England and the South East Region, Oxfordshire has a higher proportion of successful quitters (67.6%). Conversely, Oxfordshire has the lowest proportion of successful quitters confirmed by CO validation (1.8%) as well as the lowest proportion of people not quitting (21.4%).

Table 35 below shows the rate (per 100,000 people who smoke) of people setting a quit date and the subsequent outcomes for Oxfordshire and its NHS England statistical neighbour peer group. Cambridgeshire had the highest rate of persons setting a quite date (4,179 per 100,000 people who smoke) whilst Worcestershire had the lowest rate (802 per 100,000). Oxfordshire (2,200 per 100,000) has the 9th highest rate compared to its NHS England statistical neighbour peer group and is just below the median value.

Gloucestershire has the highest rate of successful quitters confirmed by CO validation (515 per 100,000 people who smoke), whereas Buckinghamshire has the lowest rate (0 per 100,000). Oxfordshire (27 per 100,000) has the 3rd lowest rate and is below the median value.

Table 35: Persons setting a quit date and outcome per 100,000 people who smoke, for Oxfordshire and its Office for Health Improvement and Disparities nearest statistical neighbours, all ages, 2023/24

Local Authority Area	Setting a quit date	Successful quitters (self-reported)	Successful quitters (self-reported), confirmed by CO validation	Not quit	Not known/lost to follow up
Bath and North East Somerset	2,139	1,291	162	286	562
Buckinghamshire UA	1,319	729	0	245	346
Cambridgeshire	4,179	1,291	175	1,583	1,305
Gloucestershire	2,704	1,617	515	375	713
Hertfordshire	3,835	1,818	248	1,091	926
Kent	3,532	1,938	417	1,112	481
Lancashire	2,000	1,071	350	739	190
Leicestershire	3,982	2,235	16	866	881
Nottinghamshire	3,637	2,145	119	1,105	387
Oxfordshire	**2,200**	**1,486**	**27**	**470**	**244**
South Gloucestershire	1,572	565	70	361	646
Surrey	2,008	1,305	36	471	231
Warwickshire	2,351	1,119	209	791	441
West Northamptonshire	4,023	2,338	56	463	1,222
Worcestershire	802	393	312	262	147
York	2,058	1,502	127	134	422

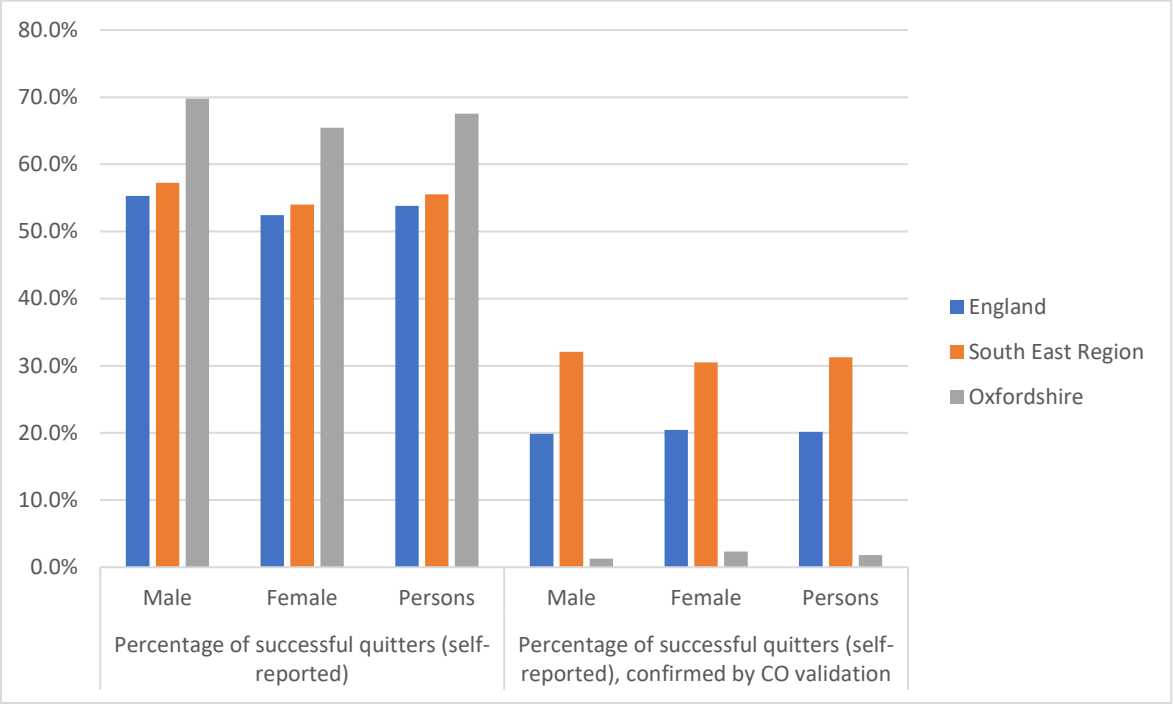
Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

Figure 53 below shows the proportion of people successfully quitting (both with and without CO validation) and sex. The proportions are based on the number of people setting a quit date.

Oxfordshire has the highest proportion of males and females successfully quitting (69.8% and 65.5%, respectively) compared to England (55.3% and 52.4%) and the South East Region (57.3% and 54.0%); however, these successful quitters are generally not

confirmed with CO validation in Oxfordshire (1.8% vs 20% in England and 32% in the South East).

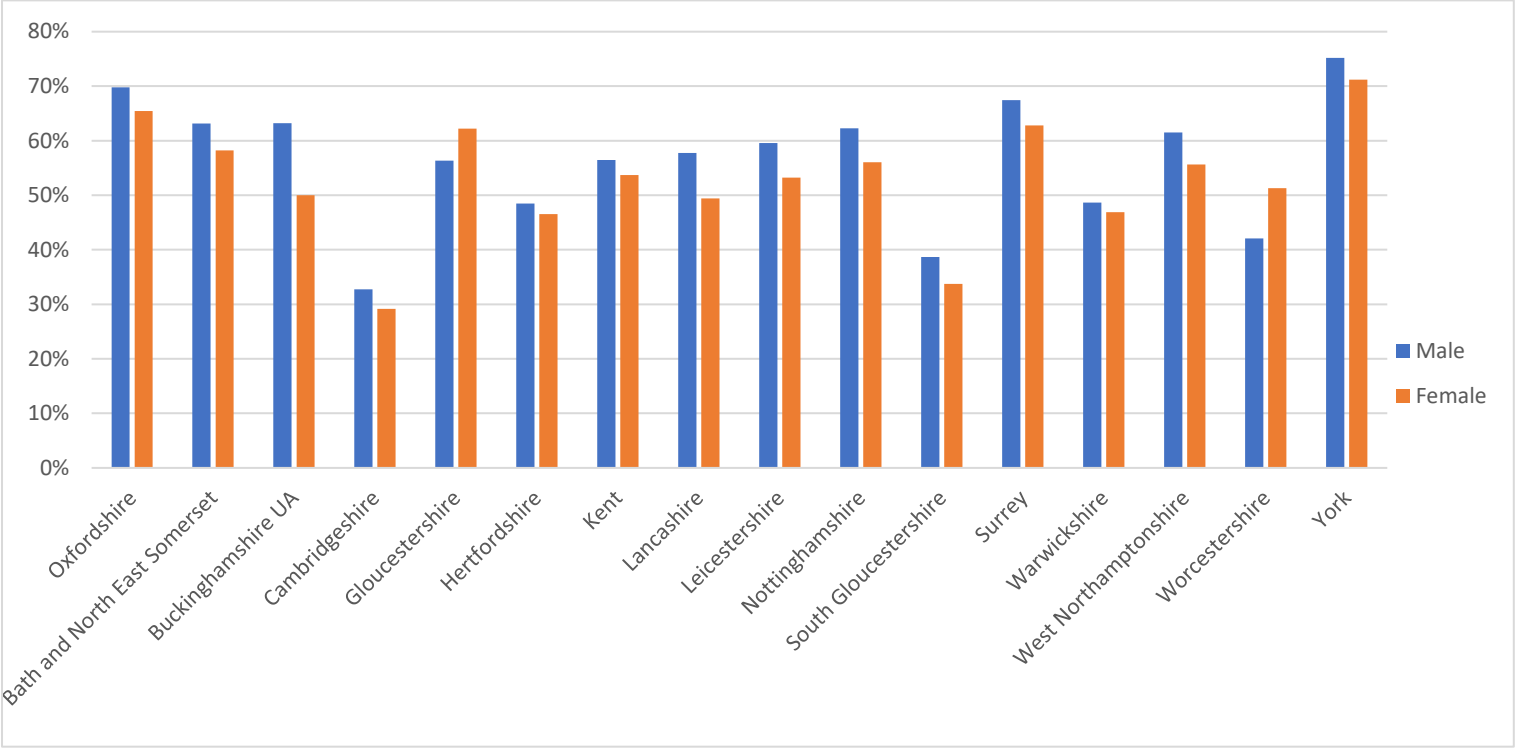
Figure 53: Proportion of people setting quit date who successfully quit smoking and successfully quit smoking confirmed by CO validation, for England, the South East Region and Oxfordshire, by sex, 2023/24



Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

Figure 54 below shows the proportion of people setting quit date who successfully quit smoking, for Oxfordshire and its NHS England statistical neighbour peer group.

Figure 54: Proportion of people setting quit date who successfully quit smoking, for Oxfordshire and its Office for Health Improvement and Disparities nearest statistical neighbours, by sex, all ages, 2023/24



Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

York has the highest proportion of males (75.2%) and females (71.2%) who successfully quit whereas Cambridgeshire has the lowest proportions (32.7% for males; 29.2% for females). Oxfordshire has the 2nd highest proportion of successful male and female quitters (69.8% and 65.5%, respectively) and is well above the median value.

Table 36 below shows the number of people setting a quit date as well as the proportion of people successfully quitting with a confirmation by CO validation, for Oxfordshire and its nearest statistical neighbours peer group. Worcestershire has the highest proportions for males and females (28.9% and 42.2% respectively). Oxfordshire has the 3rd lowest proportion for males (0.9%) and the 4th lowest proportion for females (1.5%). However, these values are likely lower due to Oxfordshire's lower levels of CO validation as opposed to a lower proportion of people successfully quitting smoking.

Table 36: Proportion of people successfully quitting, for Oxfordshire and its Office for Health Improvement and Disparities nearest statistical neighbours, by sex, 2023/24

Local Authority Area	Proportion of successful quitters (self-reported), confirmed by CO validation		
	Male	Female	Persons
Bath and North East Somerset	2.9%	11.1%	7.6%
Buckinghamshire UA	0.0%	0.0%	0.0%
Cambridgeshire	4.2%	4.2%	4.2%
Gloucestershire	15.0%	21.9%	19.0%
Hertfordshire	5.3%	7.4%	6.5%
Kent	11.8%	11.8%	11.8%
Lancashire	19.4%	15.7%	17.5%
Leicestershire	0.0%	0.8%	0.4%
Nottinghamshire	3.9%	2.7%	3.3%
Oxfordshire	**0.9%**	**1.5%**	**1.2%**
South Gloucestershire	6.5%	2.8%	4.5%
Surrey	1.5%	2.1%	1.8%
Warwickshire	3.0%	12.5%	8.9%
West Northamptonshire	1.9%	1.1%	1.4%
Worcestershire	28.9%	42.2%	38.9%
York	6.6%	5.9%	6.2%

Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

Table 37 shows the number of people setting a quit date and the proportion that were successful in England, the South East region and Oxfordshire, by age band.

Compared to England and the South East region, Oxfordshire had the highest proportion of individuals reported as successful quitters across all age groups (under 18 years: 54.8%; 18 to 34 years: 64.9%; 35 to 44 years: 69.5%; 45 to 59 years: 70.8%; 60 years and over: 64.8%).

Table 37: Number of people setting a quit date and the proportion of people successfully quitting, for England, the South East Region and Oxfordshire, by age band, 2023/24

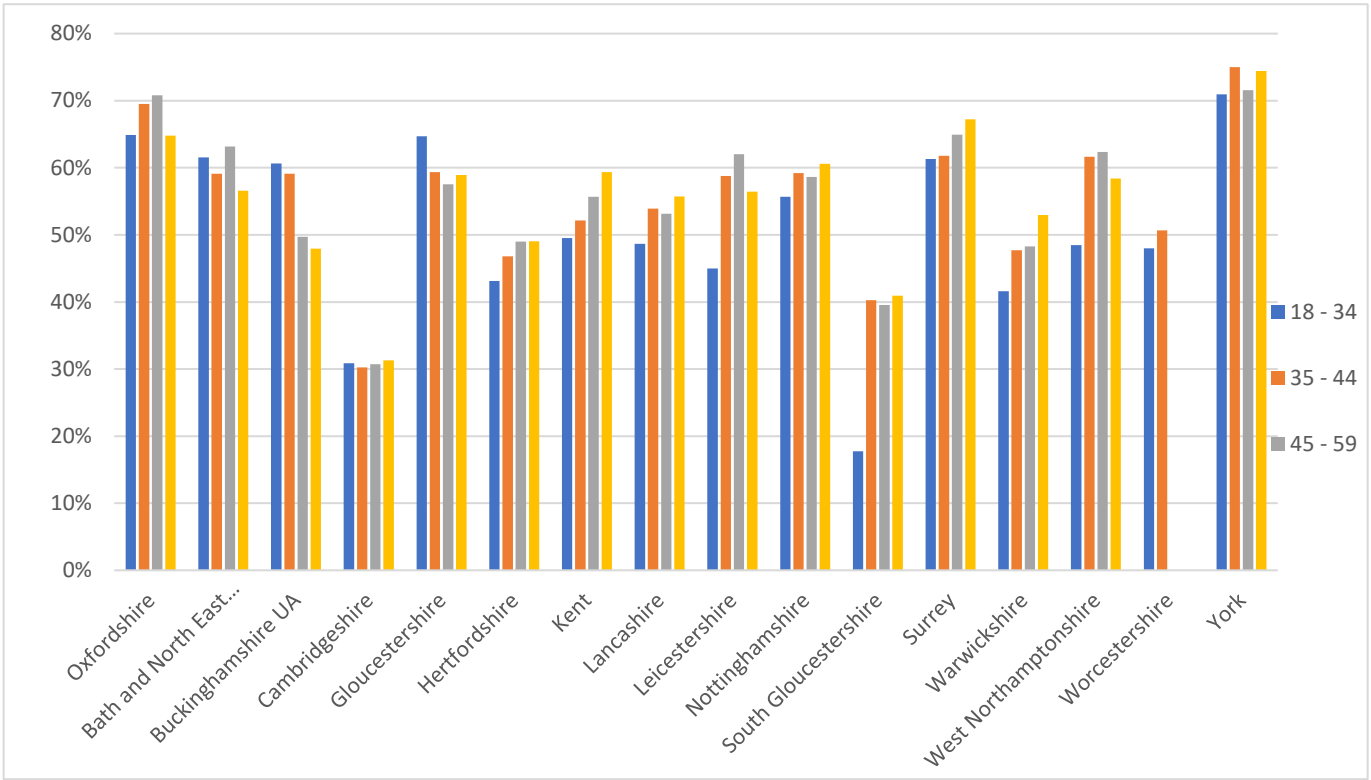
Region	Number setting a quit date					Proportion of successful quitters (self-reported)				
	Under 18	18 - 34	35 - 44	45 - 59	60 and over	Under 18	18 - 34	35 - 44	45 - 59	60 and over
England	31	35,563	36,899	64,970	55,096	49.4%	50.9%	51.5%	54.6%	56.4%
South East Region	193	5,605	5,558	10,107	9,127	54.4%	53.6%	55.2%	55.5%	57.0%
Oxfordshire	66	205	269	476	409	54.8%	64.9%	69.5%	70.8%	64.8%

Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

The percentage of people who smoke that successfully quit following the setting of a quit date is displayed in Figure 55 below for Oxfordshire and its closest statistical neighbours peer group. Due to the suppression of proportions for a number of local authorities, the proportions for those aged under 18 years is not shown in Figure 55.

Over 60% of those that set a quit date in York, Oxfordshire and Surrey, across all age groups, were successful, whereas Cambridgeshire and South Gloucestershire had the lowest rates of successful quit attempts between 17% to 40% across the age bands.

Figure 55: Proportion of people setting quit date who successfully quit smoking, for Oxfordshire and its Office for Health Improvement and Disparities nearest statistical neighbours, by age band, 2023/24



Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

Table 38 shows the number of persons who set a quit date by ethnicity for Oxfordshire, the South East region and England. Most people (91.2%) that set a quit date in 2023/24 identified as White ethnicity.

Table 38: Number of people setting a quit date, for England, the South East Region and Oxfordshire, by ethnicity, 2023/24

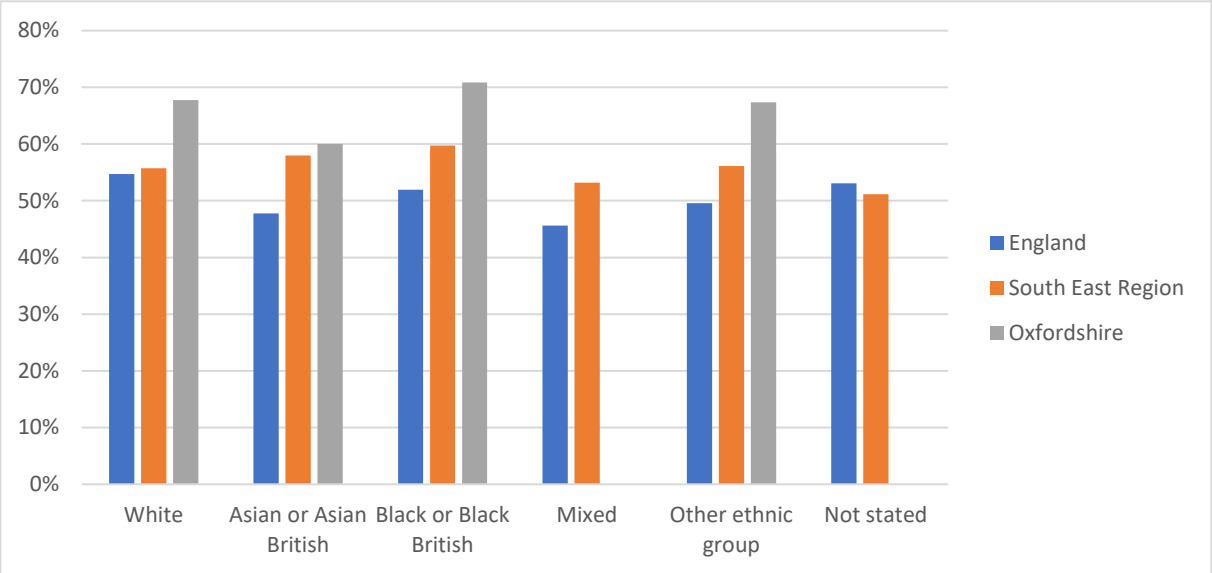
Number setting a quit date							
Region	All ethnic groups	White	Asian or Asian British	Black or Black British	Mixed ethnicity/ heritage	Other ethnic group	Not stated
England	193,505	157,660	10,666	4,471	4,908	3,636	12,164
South East Region	30,590	26,727	919	370	487	310	1,777
Oxfordshire	1,390	1,268	30	24	19	49	0

The original data set used ethnic categories based on those used for the 2001 census.

Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

Figure 56 shows the proportions of people from different ethnic groups who successfully quit in Oxfordshire, the South East and England. Rates in Oxfordshire for all ethnic groups are between 60% to 70%. Rates for England (45% to 55%) and the South East (50% to 60%) are all lower than Oxfordshire.

Figure 56: Proportion of people setting quit date who successfully quit smoking, in England, the South East Region and Oxfordshire, by ethnicity, 2023/24



Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

The percentage of people who successfully quit, by ethnicity, are displayed in Table 39 for Oxfordshire and its NHS England statistical neighbour peer group. Due to the small number of people setting a quit date for certain ethnicities (where the denominator for the proportion is greater than 0 but less than 20) across many local authorities, a number of the proportions have been supressed as the resulting percentage output is not robust enough for comparative purposes.

The proportions of people successfully quitting across ethnic groups has a similar range for each local authority area; if the total proportion of successful quit attempts in a local

authority is high (e.g. 70%) or low (e.g. 20%) it's likely all ethnic groups will have similarly high or low quit rate. In Leicestershire rates across ethnicities vary from 56.0% to 57.1% whilst in Oxfordshire they range from 60.0% to 70.8%, and Cambridgeshire from 15% to 32.7%.

Table 39: Proportion of people successfully quitting, for Oxfordshire nearest statistical neighbours, by ethnicity, 2023/24

Percentage of successful quitters (self-reported)							
Local Authority Area	**All ethnic groups**	**White**	**Asian or Asian British**	**Black or Black British**	**Mixed**	**Other ethnic group**	**Not stated**
Bath and North East Somerset	60.4%	61.3%	*	*	*	*	51.3%
Buckinghamshire UA	55.2%	58.0%	42.9%	*	31.0%	*	*
Cambridgeshire	30.9%	32.7%	31.0%	*	15.0%	35.0%	6.9%
Gloucestershire	59.8%	60.1%	*	*	*	*	61.9%
Hertfordshire	47.4%	46.2%	44.8%	33.3%	47.8%	55.3%	60.1%
Kent	54.9%	55.3%	50.0%	66.7%	49.1%	46.2%	51.3%
Lancashire	53.6%	54.1%	49.6%	*	*	43.5%	47.8%
Leicestershire	56.1%	56.3%	56.0%	*	57.1%	*	45.9%
Nottinghamshire	59.0%	59.2%	39.4%	*	65.0%	*	*
Oxfordshire	**67.6%**	**67.7%**	**60.0%**	**70.8%**	*	**67.3%**	*
South Gloucestershire	35.9%	36.1%	*	*	*	*	38.2%
Surrey	65.0%	65.1%	78.2%	*	64.4%	67.6%	61.4%
Warwickshire	47.6%	48.2%	40.0%	*	*	*	35.4%
West Northamptonshire	58.1%	58.3%	63.8%	52.0%	64.1%	*	36.4%
Worcestershire	49.0%	48.9%	*	*	*	N/A	39.4%
York	73.0%	72.9%	*	*	*	N/A	*

* = suppressed where the denominator is greater than 0 and less than 20, as it is deemed the resulting percentage output is not robust enough for comparative purposes.

The original data set used ethnic categories based on those used for the 2001 census.

Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

Table 40 shows the number of people setting a quit date and the proportion subsequently quitting by socioeconomic classification in Oxfordshire, the South East region and England. The socioeconomic classifications were devised by smoking cessation advisors and are similar to the Office for National Statistics (ONS) National Statistics Socio-Economic Classification (NS-SEC) categories (NHS Digital, 2023).

Where figures are available, Oxfordshire generally had a higher quit rate than England and the South East. However, the largest number of people setting a quit date belonged

to the 'unable to code' classification (n=630 for Oxfordshire) and no people in Oxfordshire, were coded as setting a quit date who belonged to the 'managerial and professional occupations' and the 'intermediate occupations' classifications (n=0 and n=0, respectively). There may be difficulty applying codes to people's occupation or people might not have been asked the question. Alternatively, as the groups with zero quit dates recorded were not in the priority groups being offered a tier 3 service, they would not be targeted by the local service.

Table 40: Number of people setting a quit date and the proportion of people successfully quitting, for England, the South East Region and Oxfordshire, by socioeconomic classification, 2023/24

Socioeconomic Classification	Number setting a quit date			Percentage of successful quitters (self-reported)		
	Region			Region		
	England	South East Region	Oxfordshire	England	South East Region	Oxfordshire
Managerial and professional occupations	17,991	3,819	**0**	57.6%	61.3%	**N/A**
Intermediate occupations	14,456	2,121	**0**	57.8%	57.9%	**N/A**
Routine and manual occupations	44,442	7,186	**112**	55.8%	58.0%	**67.9%**
Full time students	2,056	300	**9**	50.7%	51.3%	*
Home carers (unpaid)	6,730	1,143	**14**	50.5%	52.5%	*
Never worked or unemployed for over 1 year	31,273	3,912	**250**	49.5%	49.0%	**63.2%**
Prisoners	787	6	**<5**	94.7%	*	*
Retired	29,031	4,580	**171**	56.7%	57.1%	**63.7%**
Sick/disabled and unable to return to work	26,057	4,122	**202**	51.8%	51.3%	**64.9%**
Unable to code	20,682	3,401	**630**	48.3%	54.4%	**70.6%**

* = suppressed where the denominator is greater than 0 and less than 20, as it is deemed the resulting percentage output is not robust enough for comparative purposes.

Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

Table 41 shows the total expenditure on stop smoking services as well as the cost per quitter, for Oxfordshire and its NHS England statistical neighbour peer group, for 2023/24. Total expenditure and cost per quitter are both presented including and excluding

pharmacotherapies (e.g. NRT, bupropion and varenicline[8]). The figures excluding pharmacotherapies include behavioural support and advice about over the counter NRT only (NHS Digital, 2023).

There is a considerable difference between local authorities' expenditure per quitter ranging from £6 to £1,111 per head excluding pharmacotherapies and £274 to £1,261 per head including pharmacotherapies. For both measures, Oxfordshire had the fourth lowest cost per quitter at £290 with and £436 without pharmacotherapies.

Table 41: Number of people successfully quitting smoking, the expenditure and cost per quitter, for Oxfordshire and its nearest statistical neighbours, 2023/24

Local Authority Area	Number of successful quitters (self-reported)	Expenditure (excluding pharmacotherapies)	Expenditure (including pharmacotherapies)	Cost per quitter (excluding pharmacotherapies)	Cost per quitter (including pharmacotherapies)
Bath and North East Somerset	239	£265,449	£301,297	£1,111	£1,261
Buckinghamshire UA	339	£221,648	£251,692	£654	£742
Cambridgeshire	780	£515,561	£851,220	£661	£1,091
Gloucestershire	980	£5,580	£268,106	£6	£274
Hertfordshire	1,999	£638,064	£1,033,140	£319	£517
Kent	2,871	£1,947,283	£2,347,352	£678	£818
Lancashire	1,435	£810,237	£1,170,335	£565	£816
Leicestershire	1,225	£453,061	£584,240	£370	£477
Nottinghamshire	1,850	£0	£340,903	£0	£184
Oxfordshire	**939**	**£272,544**	**£409,380**	**£290**	**£436**
South Gloucestershire	161	£140,650	£169,650	£874	£1,054
Surrey	1,495	£452,374	£620,772	£303	£415
Warwickshire	740	£281,996	£521,609	£381	£705
West Northamptonshire	955	£275,165	£449,165	£288	£470
Worcestershire	222	£172,790	£206,393	£778	£930
York	224	Not known	Not known	Not known	Not known

Source: NHS Digital Statistics on NHS Stop Smoking Services in England, April 2023 to March 2024

[8] Some supplies of varenicline have been subject to a 'Supply Disruption Alert' from October 2021. This is likely to have impacted the numbers of prescribed items.

8 Services working together

The information for this section of the HNA was gathered from interviews with key stakeholders, selected key performance indicators from the main community provider and the response to an online survey sent to wider stakeholders in Oxfordshire. The interview and survey questions are in Appendix 1.

8.1 Pillar 1: Prevention

8.1.1 Prevention: Education settings

OCC has recently commissioned the INTENT programme[9] which is an evidence based behaviour change smoking and vaping prevention programme delivered to years 7 to 10 with 2-3 one hour sessions delivered per year. Students are given evidence-based information on the impacts and effects of smoking/vaping and then asked to make a 'battle plan' to prepare what they will do if they are offered a cigarette or vape. The programme meets Personal, Social, Health and Economic Education (PHSE) objectives and evidence suggests that the programme reduces the likelihood of students taking up smoking or vaping by 25% (Conner et al 2019). It will be helpful to plan now how to evaluate the INTENT programme after it has been implemented for the first school year and again following the second school year when it is more established.

School nurses

Two School Health Nurses were interviewed; they were NHS employees and the model used in Oxfordshire means that they were based in schools full-time. This made them much more visible and allowed students to drop-in during breaks and lunch times as well as having booked appointments.

They described the school referral process which included all children found smoking or vaping on school premises:

> *"The school would refer in through a referral process and asked me to see students that they had found vaping on school premises. Then, what I was tasked to do – it was a voluntary service, they didn't have to do it, they could decline. But when we put together a presentation for groups, but we did find that there is very little information and resource about the impact of vaping on young people so we used what we had and information from the public health unit.*
>
> *The difficulties we had was that it's been promoted as a way to step down from smoking and obviously it's really important that message is heard. When we were getting training, the research hadn't caught up and it's still unfolding.*
>
> *I get the Respiratory Magazine and they've recently done some work particularly geared towards young people but actually there is very little guidance to my peers in our public health unit. We've contacted the relevant charities and made sure*

[9] *INTENT | smoking prevention programme | Evidence to Impact*

that the information we shared and what we developed was evidence based, but our hands were somewhat tied, and we were honest with young people, and we had to tie it in with smoking. 'Well, this is smoking, this is vaping, this is how it's designed. But it's not designed for young people to start vaping. We don't know the impact.'"

The nurses described challenges around vaping in schools, particularly safeguarding and inappropriate referrals. Safeguarding concerns included not knowing where children were getting vapes from and whether they were illegal or contaminated, where the money to buy them was coming from, and how vaping could lead to drug exploitation or cannabis use. Additionally, all students found vaping were referred to the nurses described even if students did not want to quit. They found this particularly challenging as there are no resources for quitting vaping, their job is only to promote health where the children are ready for change and, for many, vaping is appealing (easily accessible, cheap to buy, smells and tastes nice and is addictive as they contain nicotine).

The school nurses were clear that fewer younger people are starting with smoking, rather vaping is the entry point and they may move onto other substances. There was concern that the messaging around vaping, in an effort to encourage adult smokers to quit, has sent the wrong message to kids:

"What we constantly hear is that you've got to be careful around vapes because we don't want adults to think they can't vape – so the adults are being protected, but as a consequence, our children aren't."

There is also limited to no support for people to stop vaping after they have stepped down from smoking. For children that have only vaped, there is no support to stop vaping.

Education setting priorities

For this service, it is important to have resources to help children stop vaping. There is no support for children in Stop for Life Oxon and limited support for vaping cessation for any age. A visible service, designed for young people and vaping cessation, is important to prevent subsequent tobacco smoking and transition to cannabis use. There is a children and young people's substance use service available in Oxfordshire (Oxfordshire Here4Youth – Cranstoun) but it is important that students experience early prevention activities embedded in the school setting before young people need to be referred to the service.

8.1.2 Prevention: survey responses relating to education settings

School nurses

Four School Health Nurses responded to the survey, describing their role as giving advice and support to help young people stop smoking, and sometimes working with families.

Three School Health Nurses expressed concern about vaping, one said: *"I think there should be more appropriate support for young people to stop smoking. Support is available but not young people friendly"* and another said *"A lot of people would like support to give up vaping. There are not many services available for young people"*. They

also mentioned that there should be *"more support to help teens who have never smoked stop vaping"*.

Going forward there were suggestions that there should more information available to young people about how pharmacy can support them, and more support tailored to the needs of young people, possibly app based. The need for good training across professions was also mentioned.

Early Years

An Early Years Lead Officer, working with Vulnerable Learners and School Readiness described working with early years settings including childminders, early years staff who work in schools, out of school clubs and holiday provision, multi-agency professionals and local authority colleagues. Part of their role was to signpost or refer people to services to help them stop smoking. They listed several resources they had found helpful including MECC training materials, and had utilised these, in addition to asking public health colleagues for advice. Additional resources they found helpful included the NHS Better Health/ Quit Smoking website, the National Centre for Smoking Cessation and Training, Smoking in Pregnancy Challenge Group materials and ASH Factsheets.

In terms of effective engagement, they suggested *"…maybe friendlier posters with more encouragement and not so DO NOT DO THIS. People have to want to do it. MECC is a nice way to approach the topic"*.

An Early Years Advisory Teacher was working with early years settings and schools with a focus on safeguarding and welfare signposted people to services, often at the request of Health Improvement Team. They felt that it was important to ensure that Oxfordshire County Council staff were not smoking outside OCC buildings.

8.1.3 Prevention: Maternity setting

The lead for the healthy lifestyles team in the maternity service was interviewed. They also had the role of a TDA and linked in with substance use services. They described how support to stop smoking within the maternity services in Oxfordshire has been in place since January 2024. It is part of the healthy lifestyle service, with two midwives and two TDAs delivering a county wide smoking dependency service to pregnant and post-partum women.

At the point of booking the pregnancy with a midwife, women are asked about smoking. If they are a current smoker, a recent ex-smoker and have results of a carbon monoxide (CO) test showing a result of greater than 4.0 parts per million, then an automatic referral is made to the maternity smoking dependency service. A home visit (if possible) is scheduled within 48 hours for an assessment with the aim of setting a quit date. Support provided includes behavioural support plus access to some forms of NRT and continues until 28 days post-partum. If the woman still smokes after this time, a referral is made to Stop for Life Oxon. If someone attempts to quit, but returns to smoking, then the programme can be restarted at any point. If the partner smokes, they can be referred to Stop for Life Oxon or they can be offered vapes through the Swap to Stop initiative (as can the pregnant woman). In 2023/24 the maternity service had an allocation of 200

codes for the swap to stop initiative of which nine were issued. In 2024/25 of the allocation of 400 codes, seven have been issued in the first quarter of the year.

TDAs have a full caseload, however, numbers referred are relatively low. This is attributed to support only being in place for a few months and limited visibility of the service. There is work to partner with Stop for Life Oxon to deliver a mass media campaign to raise the profile of the service. In addition, there is work with Turning Point, the drug and alcohol team in Oxfordshire as the number of pregnant women who smoke cannabis (which may be mixed with tobacco) is increasing. In terms of linking with networks the maternity team are represented at Oxfordshire Tobacco Control Alliance annual meeting.

The service was felt to be robust, offering equity in terms of culture and language including populations who use less common languages such as Tetun (language of those with East Timorese heritage) and can be tailored to the needs of the women being supported. There are some cultural groups, however, that still find accessing the service difficult, namely the travelling community. There is the flexibility to meet people in homes, workplaces or other settings to reduce geographical and transport barriers to access.

Several key challenges to the service were described. Funding for the service, provided by NHS England, is year on year, which can make it difficult to plan ahead, especially with staff who may want longer term security.

There are restrictions about the NRT that can be offered. For example, for women who have hyperemesis and cannot tolerate NRT in the form of gum or lozenges, the mouth spray could be an option, but is considered too expensive. Vaping in pregnancy is contentious and although there is the view that there is no evidence to show it is harmful and better than smoking, there is constant review regarding its appropriateness of use. Setting up the process to prescribe NRT on the Trust pharmacy formulary was a challenge initially when the service was new. Uptake and financial implications of this service were unknown, but this has since been resolved.

The service relies on community midwives referring people for support. Although all midwives have been trained in CO monitoring, this has not always been a priority. Now that the maternity led stop smoking service is available, it is important that community midwives have the time to systematically assess women and refer those that meet the criteria.

In some cases, it has been difficult to find somewhere to meet women who do not want to meet at home or at work. Community midwives are moving out of GP surgeries, as GPs are not funded to provide the space for clinics and community midwifery budgets are funding clinic sessions separately elsewhere.

Maternity setting priorities

For this service, it is important that there is confirmation of funding by NHS England and that funding is released in a timely way and a move away from fixed term contracts for TDAs. This would put the service on a secure footing, enabling the service to invest in staff and for them to have better job security.

8.1.4 Prevention: survey responses relating to maternity services

Health Visiting

In response to the survey for stakeholders, a Professional Lead for Health Visiting in Oxford Health NHS Foundation Trust said that their service provided advice and signposting for clients to Stop Smoking services and described these services as good. When asked whether there were any challenges, they said that *"Midwifery is a different trust, therefore it has been difficult to create a pathway that is seamless from beginning of Midwifery through to 0-19".*

Asked what they considered to be a priority going forward, they said that they would welcome potential expansion of the Stop Smoking incentive scheme, recognising that additional funding would be required for training, resources and possibly staff.

Family Nurse Partnership (FNP)

An operations manager within the FNP service responded to the survey and described their service and role. They worked countywide with pregnant young women (aged 19 years and under for general population, aged 21 years and under if they were care experienced) and their families, from pregnancy until the baby's second birthday. They delivered a preventative, licensed home visiting programme supporting women to have a healthy pregnancy, focus on future goals and aspirations, and the health and development of their baby.

The FNP incentive scheme trained staff to start supporting young pregnant women to quit smoking. Prior to the implementation of the TDS team in the maternity setting FNP staff would refer women to Stop for Life Oxon for ongoing support. One of the initial intended outcomes for FNP globally was the reduction in smoking prevalence. In order to help achieve this, they carried out a number of activities including:

- Discussing risks of smoking on unborn and on babies/children
- Eliciting behaviour change talk and behaviours through advanced motivational interviewing skills
- CO monitoring to support behavioural change (where the client chooses)
- Referring to Stop for Life Oxon

With TDS teams now in place, the new process involves midwives assessing all pregnant women at the booking appointment and support to quit offered from that point onwards. TDS share the quit data and CO readings with FNP who offer generic supermarket or clothes/shoes vouchers to eligible pregnant women after 20 weeks. This is a relatively recent change in the pathway and new FNP staff are taking longer to identify and support young eligible pregnant women.

When asked to consider the strengths of the stop smoking services in Oxfordshire, the FNP manager felt that Stop for Life Oxon had a good reputation amongst young people, based on experience and feedback they had received from the FNP cohort. They said that the setting of 'ambitious goals' was also a strength.

There were challenges in the changing *"trends in how people consume tobacco/ nicotine related products and being able to be responsive and proportionate to this".* They felt that there was ambivalence about offering minors NRT and free vapes to pregnant women to

support them to quit smoking. They also felt it would be beneficial to have more smokefree zones around town centres and leisure facilities.

A strategic priority would be to tackle intergenerational smoking trends and also:

> *"Ensuring people within all public sector person facing roles have an understanding on harms of smoking and have VBA (Very Brief Advice) to ensure consistency of messaging and easy access of support to those who may be considering quitting i.e. making 'contacts' count."*

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8.1.5 Prevention: survey responses

Social Care

A children's practitioner working with families on statutory involvement in Oxford responded to the survey. Their role involved supporting families with parenting, domestic abuse, sexual abuse and neglect. However, they did not currently signpost or refer the people they worked with to services which could help them stop smoking. They said that they would like to do so but did not know how and felt that more could be done to ensure better understanding and knowledge amongst all relevant professionals.

Healthwatch

A survey response from Healthwatch Oxfordshire described their work across Oxfordshire across all populations, and the information and advice service element of this. They promote health awareness and services as part of their communications, outreach and signposting and all Healthwatch staff are trained to 'Make every contact count'. The Healthwatch website includes an information and advice section, which links to Live Well Oxfordshire.

Where people request help to stop smoking, Healthwatch will signpost them to Live Well Oxfordshire on the website and Stop for Life Oxon as the most appropriate place, which also includes other useful health information. They felt that the priority should be to help people to stop smoking through appropriate public health messaging and easy access to services.

Oral Health

An Oral Health Improvement Manager working in Community Dental Services supported people in Oxfordshire to look after their oral health with a focus on those in deprivation wards and of high need. The service discussed stopping smoking during training delivered to health professionals, non-health professionals and care staff. They also gave advice to people during face to face events and engagements

They had collaborated frequently with Stop for Life Oxon, *"therefore know how they work and that they are a great team to offer support"*. However, there was no follow up to check if people had contacted Stop for Life Oxon.

Asked to suggest priorities going forward the response was that *"there needs to be clear communication with the current services and those supporting the people of Oxon,*

collaborative working across services and regular sign posting advice and resources that can be shared".

8.2 Pillar 2: Local regulation and enforcement

8.2.1 Tobacco control: Trading Standards

Conversation with two officers from the Oxfordshire County Council Trading Standards team provided some insight into the extensive work taking place to reduce access to illicit tobacco and vapes. In relation to tobacco control, the small team work in areas such as under-age sales and checking the legality of electronic cigarettes/ vapes (size, strength, packaging, health warnings, etc) at a retail level within Oxfordshire. One of the officers has a designated role as a part-time tobacco control officer, dealing with illegal tobacco (counterfeits and smuggling and the enforcement, engagement and education elements around this) as well as regulatory issues related to advertising and display.

The team deal with criminal activities and more low-key regulation. Two national operations are in place in Oxfordshire including Operation CeCe, which is a joint HMRC and National Trading Standards operation which has been working to seize illicit tobacco and issue financial penalties since January 2021. Operation Joseph, funded by the Department for Health and Social Care, aims to help Trading Standards enforce the regulations that affect vaping and tackle illicit vapes and underage sales. Where this was previously centred on shops and gangs, trade is now often conducted via social media. The pace at which products change always outstrips legislation. The frontline work conducted by Trading Standards teams in each local authority is collated and analysed on a regional and national basis.

The Trading Standards team described some important aspects of Tobacco Control related work in Oxfordshire:

> *"Oxfordshire is very forward thinking in funding, collaboration, it's joined up nature. That is not replicated in lots of other places. Public Health and Trading Standards work very closely together and it's possible to get things done"*

The Tobacco Control partnership met regularly to discuss local issues and included the Council's public health team, hospital representatives, pharmacy, GPs, district councils, environmental health and fire service. Set up several years ago, it was described as a 'mature partnership' funding some of the work of the Trading Standards team as Trading Standards budgets had been reduced in recent decades.

Trading Standards collaborate on regional and national levels. Within this there are specialist groups, for example focused on age restricted sales. The district council Licencing Team panel is also helpful, although it was noted that relationships with and between the district councils were variable.

Although the Police are not represented in the Tobacco Control Alliance, the South East regional organised crime unit has been very supportive and have powers and skills around surveillance and vehicle stops which support Trading Standards locally and are an important resource.

The criminal activities, in particular, are fast-changing and innovative. For example, nicotine pouches or 'snus' are becoming more widely available, with both legitimate and smuggled versions available. There is no age restriction on their sale and there is a particular concern that the high nicotine content poses a significant risk of nicotine addiction, especially for children. Local Trading Standards experiences and insight are being cascaded to regional and national level. There is growing concern that if single use vapes are banned, people may switch to nicotine pouches. Vapes and pouches, which are ostensibly stop smoking aids for adults are, in some cases, effective *"gateways into nicotine"* for teenagers, with social media advertising perpetuating the appeal of products. Trading Standards are continually trying to *"get ahead"* of these developments and noted that as they are the only two officers dealing with tobacco control, it would be beneficial to have *"more boots on the ground"*.

The experience of the Trading Standards team was that there was a range of crime linked with and around illegal tobacco and there was a prevalence in rural areas, drawing similarities with county lines and drugs as well as aspects of modern slavery where staff were forced to sell tobacco. With regard to vapes, the criminal activity was less clear cut as they were more easily accessible in a range of settings.

Several issues related to the national legislative landscape were discussed. There were several anomalies with regard to fines and sentencing around sales of tobacco and vapes. The maximum fine for the under-age sale of vapes was £2,500 which was insignificant when compared with the penalties and custodial sentences that could be imposed for illegal sales of alcohol, knives or lottery tickets. Shops do not need a license to sell tobacco or vapes. Vapes are not taxed in the same way as tobacco or alcohol. There was clear frustration at the lack of deterrent for shops selling tobacco, and in particular vapes, legitimately or illegitimately and at the lengthy and time-consuming process for imposing a successful £2,500 fine.

There was also concern about the 'Closure Order', which Trading Standards in Oxfordshire do not have powers to implement. A Closure Order means that Trading Standards have the power to go to court and can shut the premise for three months. *"A boarded-up shop affects public perception of the business, and impacts landlord's income, encouraging them to carry out better checks in future"*. Closure Orders can be issued by the police, district councils, and unitary County Councils but not a two-tier County Council such as Oxfordshire. This means that currently Trading Standards must persuade the Police or district council to take the necessary action. Whilst this issue might not be a priority for other organisations in Oxfordshire, it would greatly assist the Trading Standards team in their work and the Officers considered that it would be of benefit and streamline processes if the existing legislation was amended giving two-tier County Councils similar powers to close premises across their area.

The Trading Standards Team mentioned a survey about consumer insights on public health themes which included a report on the areas of Banbury and Cowley, where smoking rates were high and disposable income low. Cheap, smuggled tobacco/ cigarettes were more likely to be sold in these areas.

Priority for trading standards in relation to tobacco control

The Trading standards role includes engagement, education and enforcement, however, due to decreasing budgets this was now much more weighted towards enforcement.

The Trading Standards team felt that the messaging about vaping was muddled:

> *"The messaging should be 'this is a smoking cessation tool, nicotine is addictive, these are the side effects, if you are not a current smoker, these products are not for you'. People buying these have never smoked in their lives. We need the messaging to be joined up otherwise it gets watered down."*

Vaping was widely promoted as the best quitting tool which meant that when, for example, the team wanted to put out a press release about illegal vapes, the negative connotations of possible contamination were discouraged or removed.

8.3 Pillar 3. Creating smokefree environments

8.3.1 Creating smokefree environments: District Council Initiatives

An interview with a Community Health Development officer and a Wellbeing Manager at Oxfordshire County Council and Oxford City Council provided insights into the range of community work being undertaken by partners in the Smoking and Tobacco Alliance across the county. They described large projects, such as the Financial Incentive Project, working with the Citizens Advice (formally Citizen's Advice Bureau) to offer a financial incentive to stop smoking and a partnership with Stop for Life Oxon and the local leisure centre to offer free / discounted leisure for residents on the smoking cessation programme.

They described the strengths of their work, including successful relationships with their communities, working closely with Stop for Life Oxon to have visibility at community events and offer bespoke advice to priority groups. They are linked in with Oxfordshire groups including the Smoking and Tobacco Alliance, Integrated Neighbourhood Teams and the Preventing Health Inequalities Forum.

Community work faces challenges in lack of resources to create a smokefree Oxfordshire. Several key roles in the community team have vacancies (Schools officer, Community Outreach posts, etc) and other 'front door' services, customer services, housing and benefits, are under resourced to offer Very Brief Advice on smoking cessation. This can mean that residents have to make multiple contacts before they are signposted to the correct service.

Gaps in the current provision have been identified, particularly around *"smokefree school gates"* and attempts to make parks and green spaces smokefree. There is some concern about how best to engage with parks and green spaces as some are owned by the County Council, some by town / district councils and some by Oxford University. One interviewee felt that the majority of parks outside of Oxford city were owned by town and district councils that were felt to be less *"engaged with this kind of work"*.

Priorities for District Councils in creating smokefree environments

When asked about priorities moving forward, the community workers spoke about trying to *"upskill staff across all departments"* in order to give residents a *"single point of contact"*. This will help residents to engage with services more easily and also make providers more aware of all the programmes available across the city.

8.3.2 Creating smokefree environments: survey respondents

District Council

A Wellbeing Projects Officer at Cherwell District Council worked with local partners to reduce smoking rates and tackle health inequalities associated with smoking. They represented the district council at the County's Smoking and Tobacco Alliance partnership and implemented the relevant areas of the partnership's action plan at District level, for example to implement or enforce tobacco control measures to help reduce tobacco usage and exposure to second hand smoke.

They considered the strengths of the services to support people to stop smoking in Oxfordshire are:

> *"the tailored support that is offered. Many of the services offered provide personalised advice and support to help our residents to quit. I think the main challenges are the engagement from priority groups, lack of engagement can hinder the effectiveness of the services offered and makes delivering the services time consuming with few results"*.

They thought people with mental health conditions, routine and manual workers and people living in deprivation areas could be supported better and suggested that *"increased knowledge and upskilling of staff in settings such as pharmacies, or mental health organisations"* might help noting *"that goes further than the VBA training many community organisations may have received"*.

The Officer said that:

> *"attending and having support from the Smoking and Tobacco Alliance Partnership is hugely beneficial from a resources and good practice sharing aspect. Committing to the alliance and the smokefree pledge has ensured we [as a district council] fulfil certain aspects of the alliance aims etc".*

Going forward it would be helpful to *"increase funding to schemes that we know has successful uptake/quit numbers (the 'swap to stop' scheme). Funding to increase the reach of stop smoking interventions through upskilling staff from community organisations, GP surgeries, mental health services"*.

Housing Association

Peabody Housing Association cover Reading and Oxford and were involved in a Health and Housing partnership across a number of local authorities and stopping smoking was a key part of this. The survey respondent had a role in delivery of operational housing, estate management and allocation services and said that they signpost or refer people to help them stop smoking, usually to GPs or to specialist support in the areas covered by the Housing Association. Supporting people to stop smoking was one of the success

measures of the partnership. They felt that public health teams and stop smoking services would benefit from working more closely with housing providers and described effective joint working as key to success.

Facilities Management

A Soft Facilities Operations Manager at Oxfordshire County Council described their role as supporting the management and business contracts for all the Council's operational sites across Oxfordshire. This included managing a team of approximately 30 staff in supporting those sites to enforce the no smoking policy within the site and grounds. They felt that it would be helpful if there was better information available and more understanding about what the stop smoking service does and what it can offer to employees of the council. This would include *"better communications and signage that is standardised on all of our operational buildings with QR codes on that can direct staff to support services"*.

8.4 Pillar 4: Supporting people who smoke to quit

8.4.1 Supporting people who smoke to quit: Local Stop Smoking Service

Stop For Life Oxon is the current provider of community stop smoking services for anyone living or working in Oxfordshire. The current service has been in place since 2021 and is part of a company called 'ICE Creates' based in the Wirral providing a range of services to the NHS and local authorities. The focus of ICE Creates is on behaviour change, social marketing, culture change, social change, design thinking, community engagement, social movements, and applied behavioural insights.

In Oxfordshire, the stop smoking service comprises 3 tiers:

- Tier 1 is fully remote with signposting to an app which informs people about how to stop smoking and the types of over the counter NRT that can be purchased
- Tier 2 involves an initial assessment with brief behavioural support, signposting to the app and advice on purchasing over the counter NRT. Interventions can be delivered by phone, digital, or face to face methods
- Tier 3 involves offering a range of evidence based interventions through a combination of specialist behavioural support and pharmacotherapy for multiple weekly sessions up to 12 weeks for priority service users who include:
    - Those living in the one of the ten most deprived areas lower super output areas in Oxfordshire;
    - Adults in routine and manual occupations, have never worked or are unemployed, sick/disabled and unable return to work or are carers;
    - Pregnant women;
    - Adults with mental ill health (including those with a dual diagnosis of mental health and substance use)
    - Adults admitted to secondary care settings or living with a long term condition such as CHD, cancer, COPD and asthma.

In July 2024, the service began offering Tier 3 services to any smoker living or working in Oxfordshire; however, there is a target that at least 70% of people offered the Tier 3 service should still come from one of the priority groups.

Over the past two years Stop for Life Oxon has used the 'Swap to Stop' initiative. This involves the service receiving an allocation of codes (400 in 2023/24 and 1755 in 2024/25) which can be given to people eligible for Tier 2 and 3 support. In 2023/24 each code could be 'swapped' for a free vape kit and behavioural support for four weeks. In 2024/25 this support was extended for 12 weeks. There has been low take up of 'swap to stop' vapes with only seven allocated in 2023/24 and 75 in quarter 2 2024/25. It is unclear whether people eligible for vapes in Tier 2 and 3 are being offered them or whether they prefer other forms of NRT. Around 350 vapes from 2023/24 have been reallocated to the Targeted Lung Health Check service (now the NHS Lung Cancer Screening Programme) for people who are eligible for screening because they currently smoke. People are invited to be screened based on their smoking history if during screening they decide to quit they can be referred to Stop for Life Oxon.

Working with other services

Views of how well the Stop for Life Oxon service was working was gathered from the Service Manager and responses to the survey.

The service manager described the current service as 'reactive' with efficient Tier 1 and Tier 2 offers which included a shift towards remote working that was effective for people in need of less intense support to quit smoking, or who had limited time or capacity to attend in-person appointments.

Tier 3 support for priority groups is a key requirement of the Stop for Life Oxon contract. There are also stop smoking services located within inpatient, maternity services and mental health inpatient settings with their own Here for Health, Tobacco Dependency Advisors (TDAs) who are well-placed to offer tailored support to individuals who are part of these priority groups. Relationships between stop smoking teams were seen as positive, with Stop for Life Oxon having trained some of these TDAs and maintaining professional links. However, there was potential for some 'competition' amongst services for people who smoke, as they were targeting similar priority groups.

Discussing links with secondary, primary and community services, the service manager described the relationship with secondary care as strengthened by a 'clear referral stream;' however, the 'pipeline' of referrals from secondary care into community services when patients were discharged from hospital was considered to be relatively small. Stop for Life Oxon had minimal links with the maternity team at Oxford University Hospitals NHS Foundation Trust (OUH), largely because they had their own robust stop smoking support for pregnant women. Referrals were sometimes made to Stop for Life Oxon, for partners of pregnant women who required help to quit smoking. There had been a 4% increase year-on-year in referrals from Here for Health, but this was seen as low compared to services elsewhere.

The first destination for people who smoke seeking help to quit would usually be in a primary care setting, such as at a GP practice or a pharmacy that would, in most cases, signpost individuals to Stop for Life Oxon. GPs themselves are unable to prescribe stop

smoking aids as locally they are not available on the formulary in Oxfordshire. Relationships with primary care were felt to be gradually improving, partly because of work by the ICB with commissioners, primary care and Stop for Life Oxon. One example reported was the development of a fast-referral form that had been developed by partners for the ICB to add to Egton Medical Information Systems (EMIS). GPs were increasingly signposting people to Stop for Life Oxon, and the Service Manager said that last year they received hundreds of people through this signposting and around 40 specific referrals from GPs. While this is positive, the preference of Stop for Life Oxon would be to see more direct referrals, thus removing a step for the smoker.

ICE Creates has a service in Coventry that works closely with GPs, but the service manager reported that these links have not been as well established in Oxfordshire. The service manager described that when Stop For Life Oxon ask for advice of GPs such as checking if an NRT product is compatible with a patient's current medication, they do not usually receive a response.

Pharmacies are supporting Stop for Life Oxon TDAs with provision of NRT (such as varenicline and cytisine) and the relationship is good, but business focussed. Around 10-12 pharmacies have signed up to allow TDAs to refer patients on to the pharmacies, but this is not yet operational. To date, Stop for Life Oxon is working with two pharmacy clinics but is hopeful that relationships will continue to develop.

Another ongoing challenge was to ensure that Stop for Life was well-known and visible in the community as this had an impact on relationship building across the county. The service manager said they had developed some successful and creative marketing strategies but, whilst the quit target for Stop for Life Oxon had increased, the marketing budget remained the same. However, it should be noted that the marketing budget within OCC for promoting smoking cessation had increased with a focus on campaigns such as Stoptober (to encourage residents to give up smoking for a month in October) and Stop Smoking Day (a national annual event on March 10th to raise awareness of the impact of smoking and sign posting to resources to help stop).

Gaps in provision

Stop for Life Oxon were aware that there was not enough support available for people with mental health issues. They had worked with OUH Mental Health services and were also developing stronger links with 'Response'[10] to better support this group and those with dual diagnosis. There was recognition that people with mental health issues living in the community often require a harm-reduction approach, which Stop for Life Oxon is unable to offer, partly because it would likely require a weekly intervention from skilled coaches which does not form part of the Stop for Life Oxon contract. A designated pathway/ pipeline for those with severe mental health issues would be helpful.

Stop for Life Oxon said for a short period of time they had worked with Turning Point, the local provider for people with substance use problems in Oxfordshire. Uptake was limited

[10] Response is a mental health charity offering comprehensive support, from providing mental health services and accommodation to fostering emotional resilience in young people. https://www.response.org.uk/

and people required a different type of support. The service did receive some referrals, but more often from people who did not require face-to-face support.

There were very few referrals from adult social care, and the service manager of Stop for Life Oxon suggested this was because people involved with social services had other more pressing needs and it was not a priority for social work teams. Similarly, there were few referrals from the fire service, although they provided the 'Safe and Well' fire safety visits to people in their homes.

The Service Manager identified the need to find champions in some key groups that were not yet being reached effectively, for example, LGBTQ+, the Polish, Romanian, Black and other ethnic minority communities, non-English speaking people, and younger people (aged <30 years old). There are website landing pages in other languages which had been successful, and interpreting services such as Language Line were available and utilised, but inevitably a barrier was created by having to converse through someone else. Stop for Life Oxon were working with community health groups and the Health and Wellbeing Boards to build networks and bring champions on board, but this was proving difficult.

The Stop for Life Oxon contract stipulates annual quit targets. Nationally the scope, direction and funding is adjusting and there is an appreciation that a 50% quit target might not be achievable with some groups, such as people experiencing homelessness and those with mental health problems. It was suggested a more flexible approach to targets would be helpful in Oxfordshire based on different priority groups.

Several stakeholders mentioned the need to support people to quit vaping and potentially to develop a 'nicotine cessation pathway'. An example given by Stop for Life Oxon was in relation to schools who were typically more affected by vaping than tobacco smoking. Schools were requesting support with educating students about vaping and with vaping cessation, which is currently not a service that Stop for Life Oxon or any other provider is able to offer. Similarly, if people want to quit using other forms of NRT, then there is no mechanism of support for the withdrawal from nicotine.

Key priority for Stop for Life Oxon

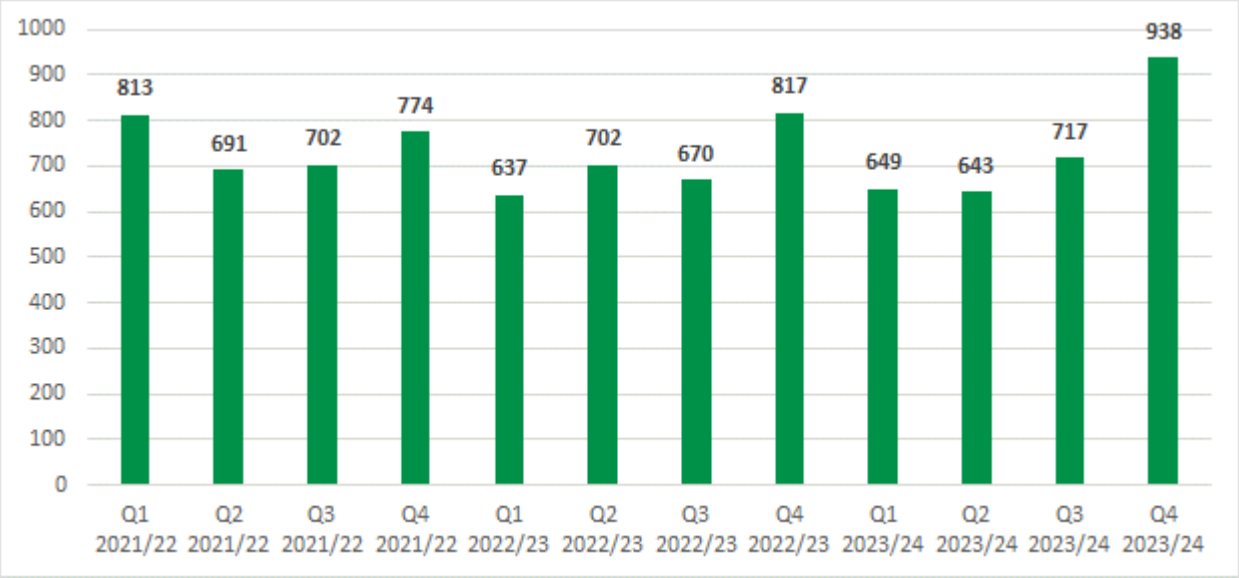
When asked, the Stop for Life Oxon Service Manager said that the key priority was to achieve an *'integrated outlook'* across services to make sure there were no gaps and to ensure work took place in a 'linked up' fashion with other groups, avoiding silo working.

Key Performance Indicators (KPIs) for Stop for Life Oxon

The Oxfordshire County Council public health team have agreed a set of 33 discrete performance indicators with Stop for Life Oxon, which are reported on either quarterly or annually. These KPIs span a wide range of aspects of the service, including activity, staffing, user engagement, innovation and safeguarding. Below are recent trends for a limited selection of the KPIs, chosen to reflect the main activities undertaken by the service and to show the trends in numbers and percentages for the agreed priority groups. The data are taken from the quarterly performance reports produced by Stop for Life Oxon and cover the financial years 2021/22, 2022/23 and 2023/24.

Figure 54 below shows the total number of people who smoke referred to Stop for Life Oxon, by quarter and financial year.

Figure 54: Number of all people who smoke referred into the stop smoking service, by quarter and financial year, 2021/22 to 2023/24 (KPI 1.1)



Source: Quarterly performance reports, 2021/22 to 2023/24

Referrals fluctuated between the quarters of the financial years, with the most recent quarter (Q4 2023/24) having the highest number of referrals (938) and Q1 2022/23 having the lowest number of referrals (637). In the two most recent years, 2022/23 and 2023/24 quarter 4 had the highest number of referrals, and showed a large increase from quarter 3, perhaps due to some people who smoke seeking support to stop smoking following New Year.

Table 42 shows the percentage of people who smoke referred to Stop for Life Oxon by priority group for each financial year and quarter.

Table 42: Percentage of all people who smoke referred to the stop smoking service from each service priority group, by quarter and financial year, 2021/22 to 2023/24 (KPI 1.1)

Year	Quarter	Pregnancy	Mental Health issues	LTCs	LSOAs	RMW/Not employed/carers /sick/disabled	Non Priority Group
2021/22	Q1	27.9%	9.6%	31.4%	6.9%	18.2%	6.1%
	Q2	20.5%	11.4%	33.6%	6.8%	22.7%	4.9%
	Q3	25.1%	8.7%	33.3%	6.0%	24.1%	2.8%
	Q4	22.0%	8.3%	33.3%	9.3%	23.8%	3.4%
2022/23	Q1	25.3%	8.3%	32.8%	7.8%	22.4%	3.3%

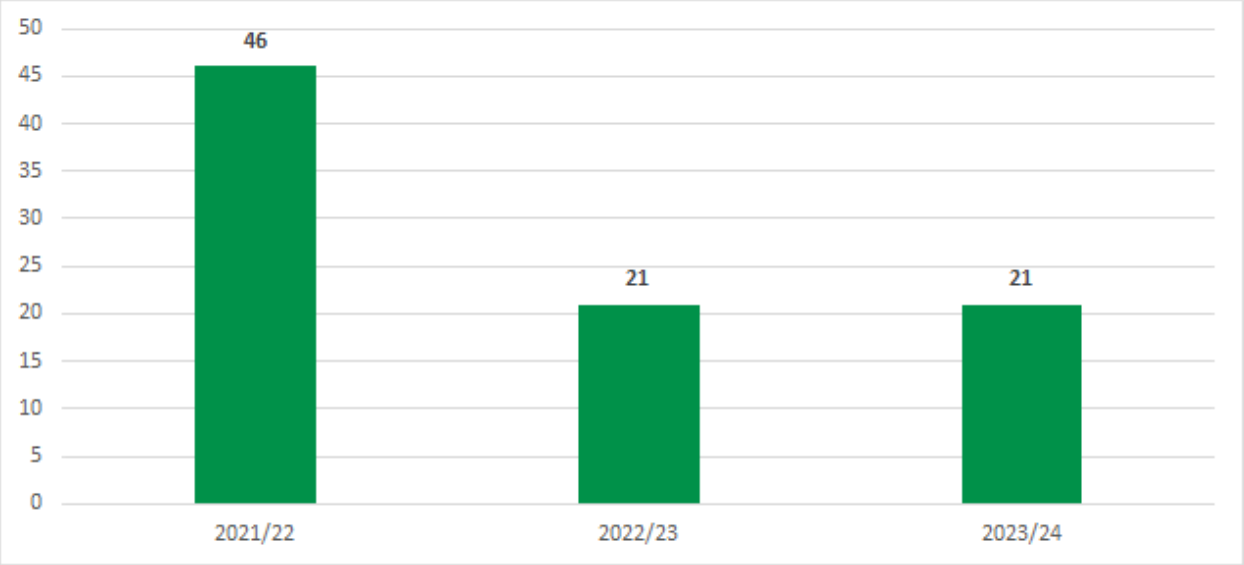
Year	Quarter	Pregnancy	Mental Health issues	LTCs	LSOAs	RMW/Not employed/carers /sick/disabled	Non Priority Group
	Q2	25.6%	9.0%	31.9%	8.4%	21.4%	3.7%
	Q3	19.9%	8.1%	41.6%	6.4%	21.2%	2.8%
	Q4	16.2%	8.5%	40.7%	10.8%	21.4%	2.5%
2023/24	Q1	12.3%	12.6%	47.0%	5.5%	19.7%	2.8%
	Q2	12.1%	16.6%	42.8%	5.3%	21.8%	1.4%
	Q3	18.7%	12.0%	43.5%	5.2%	20.2%	0.4%
	Q4	3.1%	16.5%	42.2%	8.1%	28.1%	1.9%

Source: Quarterly performance reports, 2021/22 to 2023/24

Table 42 shows that of six the priority groups, people who smoke with long term conditions have consistently accounted for the largest proportion of referrals. The proportion of referrals accounted for by the pregnancy priority group has reduced from 27.9% in Q1 2021/22 to 3.1% in Q4 2023/24. This reduction is likely to be the result of the implementation of the Here for Health stop smoking pathway in maternity services at the Oxford University NHS Foundation Trust in January 2024. The proportion of referrals for people with routine and manual occupations has remained relatively stable at around 20% of referrals each quarter. The proportion of referrals for people with mental health problems appears to have increased in 2023/24 (to between 12.0% and 16.6%), having been below 10% for much of the two preceding years.

Figure 55 shows the number of service users referred and then triaged to receive a one-off brief behavioural support session at Tier 2 for the last three financial years. Typically, this is for people not in a priority group or people in a priority group who for some reason are not able to engage with Tier 3 support.

Figure 55: Number of service users referred and then triaged to receive a one-off brief behavioural support session at Tier 2, by financial year, 2021/22 to 2023/24 (KPI 1.2)

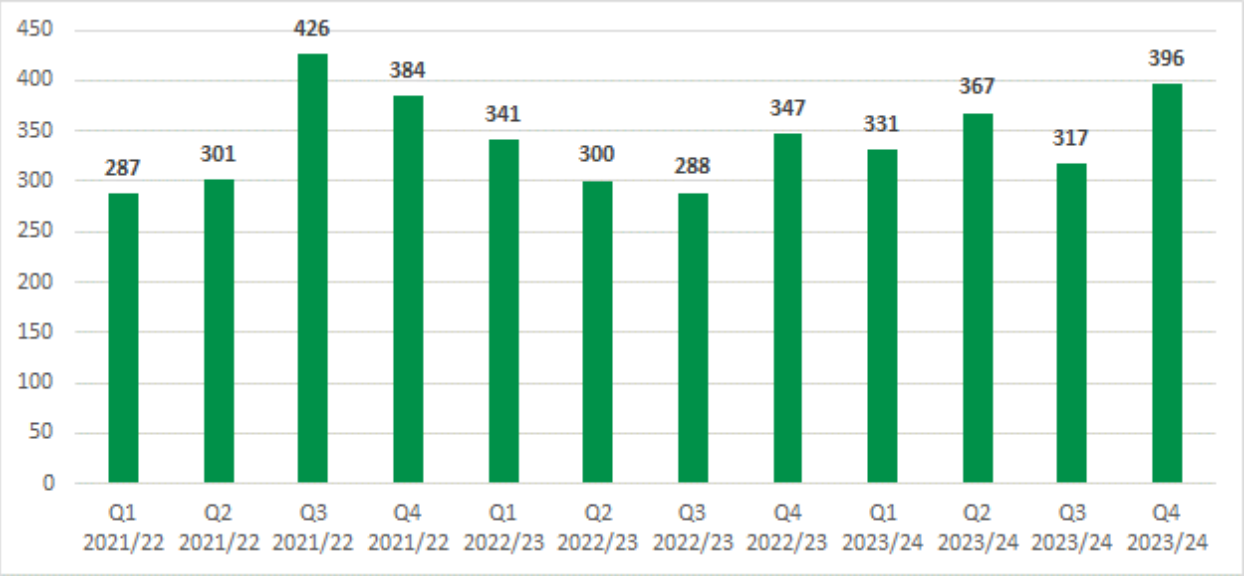


Source: Quarterly performance reports, 2021/22 to 2023/24

Service users triaged to receive Tier 2 support has reduced by more than half since 2021/22. Of the 21 service users triaged to receive Tier 2 support in 2023/24, 19 of them were in Quarter 4, with only two service users triaged to receive Tier 2 support in the previous three financial year quarters. Of those who were triaged for support in 2023/24, 11 set a quit date and completed a one off brief behavioural support session and, of those, three quit. The possible reasons for such low numbers accessing Tier 2 support could be because people do not know it's available and the local service is not incentivised to engage with people eligible for Tier 2 support.

Figure 56 below shows the number of people triaged to received Tier 3 support and who set a quit date with the service, by quarter and financial year.

Figure 56: Number of priority service users referred, triaged to receive Tier 3 support and that set a quit date with the service, by quarter and financial year, 2021/22 to 2023/24 (KPI 1.4)



Source: Quarterly performance reports, 2021/22 to 2023/24

People triaged for Tier 3 support and setting a quit date has fluctuated between 287 in Q1 2021/22 to 426 in Q3 2021/22.

Table 43 shows the percentage of people triaged to receive Tier 3 support and setting a quit date from each priority group, by quarter and financial year.

Table 43: Percentage of people, referred, triaged to receive Tier 3 support and who set a quit date with the service, by priority group, quarter and financial year, 2021/22 to 2023/24 (KPI 1.4)

Year	Quarter	Pregnancy	Mental Health issues	LTCs	LSOAs	RMW/Not employed/carers /sick/disabled	Non Priority Group
2021/22	Q1	16.0%	23.3%	43.6%	5.2%	10.5%	1.4%
	Q2	7.6%	25.6%	49.2%	3.3%	13.0%	1.3%
	Q3	9.6%	18.5%	48.8%	4.5%	16.4%	2.1%
	Q4	8.3%	17.2%	54.7%	5.5%	13.5%	0.8%
2022/23	Q1	7.3%	23.8%	47.5%	3.8%	16.7%	0.9%

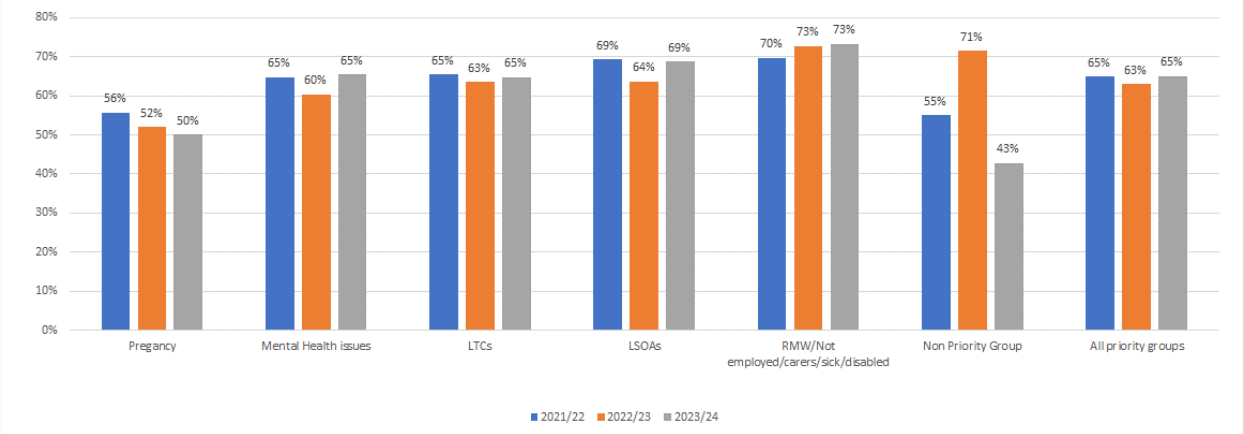
Year	Quarter	Pregnancy	Mental Health issues	LTCs	LSOAs	RMW/Not employed/carers /sick/disabled	Non Priority Group
	Q2	11.3%	24.0%	53.0%	2.0%	9.0%	0.7%
	Q3	6.9%	22.2%	58.0%	3.8%	8.7%	0.3%
	Q4	6.6%	21.9%	56.5%	4.0%	10.7%	0.3%
2023/24	Q1	5.1%	21.8%	61.6%	2.7%	8.2%	0.6%
	Q2	5.2%	25.1%	58.0%	2.7%	8.2%	0.8%
	Q3	5.0%	22.1%	60.6%	1.6%	10.7%	0.0%
	Q4	2.0%	28.6%	54.9%	2.0%	11.9%	0.5%

Source: Quarterly performance reports, 2021/22 to 2023/24

People with long term conditions accounted for over half of those setting a quit date since Q2 of 2022/23 whilst those with mental ill health accounted for a further 20% to 25%.

Figure 57 below shows the proportion of service users in Tier 3 that set a quit date and were successful four-week quitters in line with the Russell Standard[11] by financial year (West, 2005). The currently agreed performance indicator for this measure is that there should be ≥50% successful four-week quitters per financial year which was met for each year.

Figure 57: Proportion of priority service users who received Tier 3 support, set a quit date and were successful four-week quits in line with the Russell Standard by financial year, 2021/22 to 2023/24 (KPIs 1.4 and 1.5)



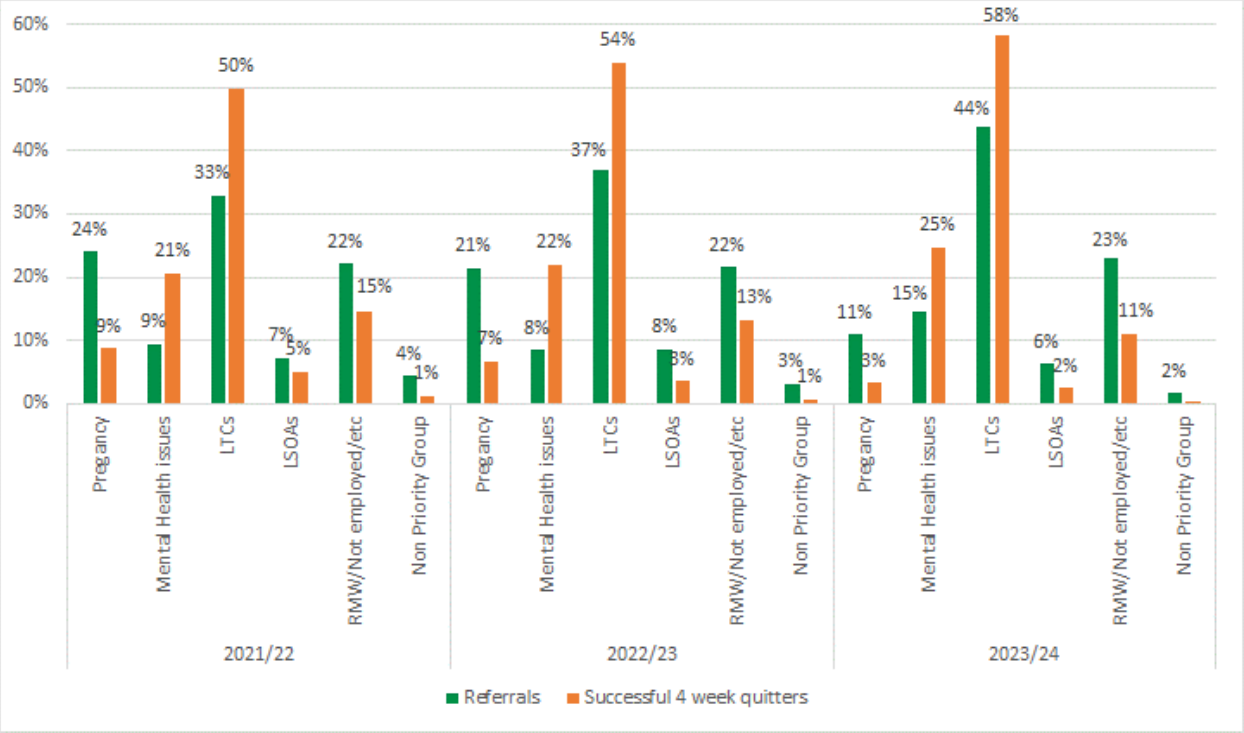
Source: Quarterly performance reports, 2021/22 to 2023/24

The pattern of the number of successful four-week quitters fluctuated in a similar way to the numbers who were triaged for support indicating that, overall, a similar proportion of those triaged are likely to be successful at quitting for each year. There was a median of 65% of those triaged to Tier 3 being successful four-week quitters.

[11] The Russell Standard is an English national standard that provides a consistent definition of the terms ‘smoker’, ‘treated smoker’, ‘self-reported four week quitter’ and ‘CO-verified four week quitter’, 'lost to follow up at 4-weeks', ‘52-week quitter’ and ‘lost to follow up at 52-weeks' for use in reporting by local smoking cessation services

However, this pattern changes when comparing the proportion of referrals into the Stop for Life Oxon service for each priority group with the proportion of successful four-week quitters (Figure 58).

Figure 58: Comparison between percentage of referrals for each priority group and percentage of successful four-week quitters in line with the Russell Standard, by priority group and financial year, 2021/22 to 2023/24



Source: Quarterly performance reports, 2021/22 to 2023/24

People who smoke with a long term condition consistently account for a higher proportion of successful four-week quitters (50% to 58% in each year) compared to the proportion of referrals (33% to 44% in each year). People with mental ill health similarly account for a lower proportion of referrals (8% to 15%) compared to the proportion of successful four-week quitters (21% to 25%).

There is an overall annual target of 30% of successful four-week quitters remaining non-smokers at 12 weeks. In 2021/22, the percentage was 37% and 36% in 2022/23.

There is one access point for the Stop for Life Oxon that receives referrals from all sources including clinicians, other providers and self-referrals. The target is that Stop for Life Oxon respond within two working days to 95% of requests for support. Figure 59 shows the data for all referrals by clinical and non-clinical staff by quarter and financial year.

Figure 59: Number and percentage of requests through the Access Point from and/or referral sources/clinical/non-clinical personnel responded to within two working days, by quarter and financial year, 2021/22 to 2023/24 (KPI 4.4)

Source: Quarterly performance reports, 2021/22 to 2023/24

Figure 59 shows that the number of requests received through the Access point has fluctuated between 267 and 460 per quarter. The target of a response rate within two days has fluctuated between 79.5% and 99.4% and has mostly been over 90% each quarter.

Figure 60 shows the number of people self-referring to Stop for Life Oxon via Access Point, by quarter and financial year.

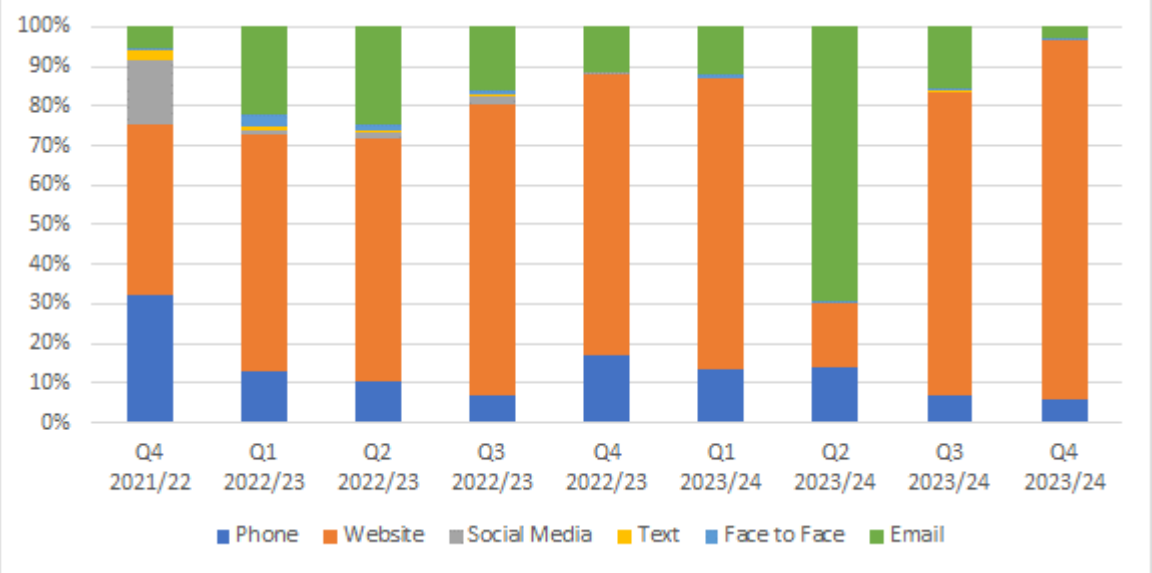
Figure 60: Number of service users contacting the Access Point as a self-referral, by quarter and financial year, 2021/22 to 2023/24 (KPI 4.6)

Source: Quarterly performance reports, 2021/22 to 2023/24

The number of self-referrals has increased from 356 in Q1 2021/22 to 938 in Q4 2023/24 or by 164%. This increase may have made it more challenging for Stop for Life Oxon to respond to requests via the Access Point in two working days.

Figure 61 below shows the quarterly trend in the type of communication used by those contacting the Access Point as a self-referral.

Figure 61: Percentage of service users contacting the Access Point as a self-referral broken down by type of communication used, by quarter and financial year, 2021/22 to 2023/24 (KPI 4.6)



Source: Quarterly performance reports, 2021/22 to 2023/24

The website has been the most commonly used method of communication for those self-referring to the service apart from Q2 2023/24 when e-mail was more commonly used. These may have been an issue with accessing the service through this route during that quarter. The number and proportion of referrals received via social media, text message

and face-to-face methods has reduced from around 55% in total in Q4 2021/22 to around 5% in Q4 2023/24. There have been no recorded social media self-referrals since Q4 2022/23.

8.4.2 Supporting people who smoke to quit: Hospital Tobacco Dependence Programme

The NHS funded tobacco dependence treatment services aim to offer inpatients admitted to acute and mental health services access to effective tobacco treatment services. In addition, there is an adapted stop smoking offer for people who are pregnant and their partners, with a pregnancy pathway consisting of focussed sessions and treatments. The offer of support also extends to long term users of specialist community mental health services. All three teams are funded nationally through NHS England as part of the national scheme.

In Oxfordshire, there are three teams, two based at the Oxford University Hospitals NHS Foundation Trust in the acute and maternity settings and a team based in Oxford Health NHS Foundation Trust, focussed on people admitted for mental health problems.

Acute inpatient setting

At admission, information about patients is gathered and there is a smoking assessment that staff can use to ask about current and previous smoking habits. This information is entered on to the Electronic Patient Record (EPR) and for those who smoke, an automatic referral is made to the Tobacco Dependency Team. A Tobacco Dependency Advisor (TDA) contacts the patient as soon as possible within the same or next day to offer behavioural support and/or NRT. On discharge, patients can be referred to Stop for Life Oxon or pharmacies in Oxfordshire registered with the scheme. However, in practice, all referrals have so far been to Stop for Life Oxon.

One of the key service strengths is that TDAs can meet with patients very quickly following referral. There are key drivers for people to stop smoking whilst in hospital, including a ban on smoking in the hospital and hospital grounds, the speedy support by TDAs, replacing smoking with NRT and the absence of the usual home life triggers that can lead to someone reaching for a cigarette.

There are, however, challenges for the service. Data on EPR is only entered for 25% of admissions. It is not clear if this is because this is not a mandatory question to ask or if clerks are not entering the information on the system if people do not smoke. There are also some reported instances when TDAs have been contacted to see patients who turned out to not smoke.

The NRT available to patients is more limited than in the community stop smoking service and only include lozenges, patches, nicotine gum and vapes. NRT in the form of, mouth and nasal sprays and prescription medications such as Champix, are not available to inpatients. In the hospital setting, all NRT has to be prescribed by a doctor and then dispensed which can delay patients receiving supplies. The view of vapes held and communicated to patients by clinicians varies and, in some cases, consultants have told patients they are more harmful than smoking. Vapes offered to patients at the hospital can only be used away from hospital buildings.

It is difficult to assess the types of people using the service as comprehensive information about ethnicity, contact with the criminal justice system or inclusion group characteristics is not recorded in the EPR. Information recorded once the TDA is in contact with the patient shows that most are of white British ethnicity and living in the least deprived areas of Oxfordshire. Information about referral by hospital ward has not been analysed; however, there is a consensus that there is considerable variation in the proportion of patients referred from different wards but the greatest number coming from cardiology.

Other settings where it would be helpful to have a Stop Smoking service presence is in the emergency department and outpatient departments. Some trusts are offering patches to people attending emergency departments and the previous LSSS provider in Oxfordshire would spend one day a week talking to patients in outpatient departments.

Key priorities for acute inpatient team

The manager of the service listed key priorities they would like to progress:

- Increase the number of smoking assessments carried out at admission
- Improve recording of smoking assessments on EPR by clinical and clerical staff
- Increase the range of NRT available to patients
- Improve access to NRT without it needing to be prescribed and dispensed
- Explore the options of expanding the service into other settings, such as outpatients

8.4.3 Supporting people who smoke to quit: survey responses relevant to the acute inpatient setting

Health Promotion Practitioner, Oxford University Hospitals NHS Foundation Trust

The Health Promotion Practitioner, who was part of Here for Health, described the service they provided to support people and provide information to help in making lifestyle changes (healthy eating, physical activity, stopping smoking, alcohol reduction, general wellbeing, sleep, fatigue management). This support was provided as a one to one consultation focused on the individual and their needs with onward referrals to community services as appropriate. They referred people to specific community services offering specialist support, usually Stop for Life Oxon which they described as a straightforward and very efficient process. They identified a strength as the *"flexibility of services, offering telephone, NRT delivered to home address makes it more accessible for people".* A priority would be to have services that *"support people, with flexibility so that they are accessible to all".*

8.4.4 Supporting people who smoke to quit: Mental health setting

Within Oxford Health NHS Foundation Trust there are four directorates, including Oxfordshire & West Mental Health (Oxfordshire, Swindon, Wiltshire & BaNES), Buckinghamshire Mental Health, Community Health and Specialised Services. Three directorates provide tobacco dependency support, with TDAs present in mental health inpatient settings, and online conversation and behavioural support provided in the Community Directorate.

On admission the patient is asked whether they are a smoker and this is recorded on the patient record system. Inpatients are seen by TDAs, often on the same day or within two days depending on locality. Behavioural support is provided and NRT is offered immediately. Upon discharge, the patient is provided with a two week supply of NRT and is referred to local community services (Stop for Life Oxon), with a follow-up call from the hospital TDA at 28 days.

The team manager and project worker interviewed felt that the starting point of the patient journey, from a stopping smoking perspective, including the referral from wards and the walk-in interface between ward inpatients, is clear and effective. The initial screening was considered good with a recognition that within units there is, of necessity, a 'mandatory' culture and that physical health screening is part of this.

The initial assessment was also viewed as effective, with NRT being quickly provided to people who smoke as the hospital environment is a designated smokefree area. Behavioural support was generally put in place promptly. Whilst behavioural techniques were described as good, there were challenges, because patients were often disturbed or unsettled for the first one to two weeks of their admission and conversations about lifestyle were unlikely to be effective during this period. Most patients were likely to stay in hospital for 30 to 50 days and, sometimes, behavioural support was more effective after the first couple of weeks of this stay.

Community support was felt to be lacking for this priority group. TDAs from Mental Health services would not see the patient face-to-face after discharge but would make a telephone call to them at 28 days, often with no response. At the time of discharge, it was rare that an effective stop smoking link in the community would have been developed for the patient. It was felt that this was partly because of the volume of patients. The tobacco cessation elements of discharge pathway may be unclear to ward staff and it was considered difficult for a single TDA to facilitate the process. In addition, links with community pharmacies were not seen as sufficiently strong that patients could be signposted to specific branches for support.

Once people are discharged from SMI inpatient settings they may be referred to Stop for Life Oxon, but the current offer of support (tier 3) is not tailored sufficiently to ensure this group engage with the service. The majority of SMI/ MH patients are not resilient and will see only one clinician/ worker through most of their journey who contact them and work with them in their preferred setting (at home for example). For people with SMI to proactively reach out and engage with an additional service was described as "*something of a non-starter".* While there is a data sharing agreement with Buckinghamshire, this is not in place in Oxfordshire, so the Mental Health team and the TDAs do not know whether the patient in the community has quit smoking unless they speak with the patient directly.

Standardisation around NRT for inpatients would be helpful, as service users are giving feedback that they want vapes, rather than patches. However, vapes are not licensed and cannot be issued to patients in an inpatient setting. Generally, the range of NRT available for inpatients is limited and many cannot be purchased from the NRT budget. All types of NRT have to be prescribed in the inpatient setting.

There are eight units in Oxfordshire with a geographical spread which can be challenging for staff. Some staff are moving to new roles and there is concern about the lower levels of staffing and their ability to cover the area. Funding constraints mean the team will have a new configuration which it was hoped might not be too detrimental to the level of service provided; however, more staff and a dedicated presence in the community will be helpful.

Priorities for mental health inpatient services

Strengthening of community support for discharged patients was described as a priority so that interactions with the TDAs on the ward could be built upon. One suggestion from the Service Lead would be to have ten individuals working across both pathways from hospital admission through to community, developing and maintaining a relationship with patients. The service would go out to patients in the community rather than requiring them to attend a service or venue. While the focus of Mental Health services was on promoting recovery and independence, there are negative symptoms that mean that harder to reach groups, including people with SMI, might require a 'hybrid' model including both centre-based and outreach support.

8.4.5 Supporting people who smoke to quit: survey responses relevant to mental health services

Oxfordshire Mind

Oxfordshire Mind provide stop smoking support and a Service Manager responded to the stakeholder survey. They managed a team of physical wellbeing workers in Oxfordshire and Berkshire West who carried out physical health checks and also had workers embedded in secondary care settings. *"Fast response and quality staff"* were described as key strengths of the service they provided, and when asked to describe a key challenge they responded, *"we are dealing with highly ingrained habits and will never reach total cessation so we need to take our victories where we can".*

They stated that people with mental health issues were a group who were not adequately supported to quit smoking and that a good variety of NRT (especially if it could be provided free) was important alongside *"other tools and support available at the point where someone is ready to stop."*

Oxfordshire Mind were represented on the Oxfordshire County Council Health Improvement Group.

Response

The Dual Diagnosis Lead of Response completed the stakeholder survey. Response provide supported housing for adults aged 18 – 65 years with mental health needs across Oxfordshire and into Buckinghamshire and West Berkshire.

They offer a vape initiative consisting of free vapes for six weeks alongside one-to-one weekly support to encourage residents to stop or reduce their tobacco use. The Dual Diagnosis lead works across all services supporting staff and working one-to-one with some residents. Their area of focus is drug, alcohol and tobacco use and how residents can be supported to quit or reduce their usage. The housing services are non-smoking, which has brought the topic of smoking to the forefront as they develop, implement or

enforce tobacco control measures to help reduce tobacco usage and exposure to second hand smoke. Response is represented on the Oxfordshire Tobacco Control Alliance and ASH.

They described the strengths of stop smoking services in Oxfordshire as being easily accessible and simple to use. They said that the work around tobacco control strategies they have been involved in *"has been creative and clearly involves people who are passionate about their work and reducing the impact smoking has upon people. The support I have received to set up our initiative has been superb."*

When asked to describe challenges, they (a former smoker) said *"I understand the logistics, but I found that phone support for the stop smoking services depersonalised the experience and meant it was easier to ignore if I wanted. From my experience having to meet someone face to face has more of an impact on people's commitment."*

In terms of gaps, the Dual Diagnosis Lead said that they worked with staff within the homeless pathway and did not know of any stop smoking projects within that area. They also said they were "*aware of the work completed on the inpatient wards with mentally unwell people, but not aware of any projects that follow this up after discharge".*

8.4.6 Supporting people who smoke to quit: Drug and alcohol team

There is a large drug and alcohol team (DAT) in Oxfordshire with 110 staff, and four main hubs in Banbury, Didcot, Witney, Oxford with in-reach and outreach services with 30 sessions a week focussed on homeless settings, mental health secure wards, criminal justice settings, 26 GP practices, RAF Brize Norton and community hubs (Faringdon, Wantage, Henley, Abingdon, Bicester, Chipping Norton). The service sees around 2,500 people per year. Each week the service has around 1,000 face to face contacts and although the service is not strictly commissioned to deliver stop smoking services, it does work with people to quit as part of the drug and alcohol service wider wellbeing offer. The service is very aware of the research that shows people who use heroin are eight times more likely to die of smoking related disease rather than a drugs overdose. As part of their DAT training staff can deliver motivational interviewing and are also trained to hand out vapes which helps some people reduce smoking or quit using this method.

Previous stop smoking providers (prior to 2021) arranged for staff to attend the larger walk-in drug and alcohol support sessions held around the county each week that saw around 100 people per day. There has been a focus and funding to support the wellbeing of rough sleepers and hostels are visited each week to offer a range of interventions, such as drug testing, Covid-19 and flu vaccinations, and motivational interviewing and access to free vapes to reduce/stop smoking. Staff can signpost people to stop smoking services, but it is thought unlikely that many are motivated to act and it is more effective to see people and work with them on the spot. For this particular population, many will not visit services in a planned way, so having a very accessible walk in space where people can quickly access support and are met with a very engaging positive approach from staff who they believe they can quit is important.

Priorities for substance use team relevant to stopping smoking

It is also important that creating the conditions for change underpins service delivery which in the experience of the drug and alcohol team includes face to face appointments, highly motivated positive staff who can build relationships and rapport with people, ensuring the service is based close to where people spend time and that it can be accessed without any notice (i.e. it is a walk in service). Using incentives to help people to quit is also an approach that can work if the right incentive is offered.

8.4.7 Supporting people who smoke to quit: Community pharmacy

Speaking with a senior figure in Community Pharmacy Thames Valley (CPTV) it was clear they felt community pharmacies were an underutilised resource when it came to stopping smoking. OCC confirmed there had been an initiative to offer free NRT via pharmacies for people who set a quit date between January 1st 2021 and 31st March 2021 repeated between January and March 2022. One six week course of free NRT was available per person until mid May each year. It is unclear which pharmacies took part in the initiative and the outcomes in terms of number of people taking up the offer and number of people quitting.

However aside from this initiative community pharmacies have not been locally commissioned to deliver a stop smoking service, other than as part of the Healthy Living Pharmacies offer, where pharmacists give brief advice and signpost to third party provider websites. Community pharmacies are nationally commissioned to support patients who smoke and who are discharged from hospitals. Discharged patients, under the Patient Group Direction (PGD), would be eligible for one week of NRT and would then be invited back to the pharmacy two to three times for help to stop smoking including motivational interviewing. However, the CPTV representative said that two years into the contract, no patient referrals were reported as having been made in Oxfordshire. Vapes are sold over the counter by pharmacies; however, in a pharmacy environment, with strict governance, there was a heightened awareness that vapes are not a medically licensed product approved by the MHRA. The preference would be for a medically approved NRT solution. Whilst there are regulations about to whom vapes can be sold, there is no central guidance about the brand or type of vapes that a pharmacy owner can or should sell.

In a survey response from a senior officer with a role on the Local Pharmaceutical Committee (a statutory body that represents Community Pharmacy at all levels of conversation with ICS, NHS, local authorities, trusts and other stakeholders), the potential for community pharmacy to be better utilised as a resource was stressed:

> *"Ninety-nine pharmacies cover the whole of Oxfordshire - open for a minimum of 40 hours - a few open for over 70 hours a week with access to car parking etc. ALL have clinically trained professionals who are able to advise patients around their desire to stop smoking - mainly through over-the-counter NRT. Two-thirds are signed up to the National Hospital Discharge Smoking service.*
>
> *I firmly believe that community pharmacy is underutilised."*

Asked about stopping smoking service provision in Oxfordshire, the CPTV representative was aware that, while fewer people were smoking overall, there was still a high

prevalence in areas of higher deprivation. Whilst community pharmacies could not provide all the solutions, many were based in less affluent localities and were likely to be able to offer a more personalised service than the current online provision. This would potentially be of benefit to those within priority groups, that struggle with communication, cannot access digital solutions, and in areas where there is less understanding about what is available locally.

The CPTV representative described a good relationship with GPs locally – but not in regard to stopping smoking. There was no referral pathway and NRT could not be prescribed but *"some GPs may signpost a patient to a pharmacy if they feel they can afford an over-the-counter solution".*

The accessibility of pharmacies could be beneficial as many are open for very long hours. There was also a skill set within pharmacies for safeguarding, and motivated staff who are familiar with the community in which they are based and equipped to try and 'make every contact count'.

Provision of stop smoking support would need to be a financially viable opportunity for pharmacy, perhaps with payment made at an initial quit period and at a longer term quit period. The CPTV representative felt that the basic elements were all in place and that it would be sensible to "*use the power of footfall to drive our stop smoking message".* Better use of primary care could be made in general, including optometrists, dental professionals and GPs.

As raised by a number of stakeholders, the CPTV representative commented that in his view vaping is still a nicotine addiction, which he felt can lead to smoking and there is no service currently available to support people who wish to quit vaping. Work between substance use and stop smoking services could also be strengthened. It should be noted that although there is a current perception that vaping leads to smoking there is as yet no evidence to support this view and is not a view held by OCC at the current time.

Priority of community pharmacy in relation to stopping smoking

Asked what a priority might be, from the community pharmacy perspective, the suggestion was to focus on areas of inequality and deprivation and identify particular pharmacies that could deliver exemplar advice based largely on NRT alongside very good behavioural advice. In addition, many people who smoke have other health issues and the current drive for hypertension case-finding was given as a relevant example where there is often overlap that can be built on to improve the health of an individual.

8.4.8 Supporting people who smoke to quit: survey responses

Integrated Care Board

A Long Term Conditions Implementation Manager covered Oxfordshire and worked co-operatively within BOB ICB, across all service areas in a commissioning capacity. Their aim was to support the council in ensuring there was a robust active referral process was in place across primary and secondary care to align with joint strategic priorities.

With regard to both Stop for Life Oxon service and Tobacco Control Measures they felt that the contacts and pathways were clear, with good resources available.

In relation to stop smoking services in general, they commented on the need for responsible promotion of vaping:

> *"When promoting vaping to people the positive, negative and unknown aspects of vaping need to be explained and links to the relevant supporting information supplied, so that the individual can make an informed decision, and the advice (organisation) and the adviser has performed their role in supporting informed decision making".*

A Prevention and Health Inequalities Network Manager at the ICB had the role of Commissioning NHS tobacco dependency treatment services for maternity and inpatients across BOB ICB. In their experience the Stop for Life Oxon service, and the Tobacco Control Network, appeared to have established relationships and good partnerships.

General Practitioner

One GP responded to the survey and said that they signposted or referred patients to services to help them stop smoking. They would refer to Stop for Life Oxon but *"have little faith it will actually help"*. They said *"Previously patients were able to access help via our practice nurses - in the building they were used to, from staff they already knew. Now services are much less accessible, and I think my patients are very much less likely to take advantage of them".*

They suggested that stop smoking services should be moved back into GP practices, and that making them *"more restricted and geographically less accessible means they are less used/ less useful".*

National Centre for Smoking Cessation and Training

A Clinical Consultant from the National Centre for Smoking Cessation and Training completed a survey. The National Centre covers England, and works with other countries to a lesser extent, working on stop smoking training, education and policy and advising commissioners and practitioners. Although they had not had direct contact with the service, they said that they were *"glad to see that Oxfordshire takes a positive approach to tobacco harm reduction".*

8.5 Language and terminology

Throughout both the qualitative and quantitative elements of this health needs assessment there has been a wide range of language and terminology used to describe services and the work that they do. Interview participants and survey respondents were asked:

> *"Currently in Oxfordshire and nationally there is a range of language to describe services that support people to stop smoking. Do you have any views on language related to these services that you prefer to use or tend to avoid?".*

Although the term 'smoking cessation' was sometimes used, the preference particularly when speaking with the public, seemed to be for 'support to stop smoking' or 'help to stop smoking'.

9 Conclusions and Recommendations

Overall, in Oxfordshire the stop smoking services are continuing to support people to quit, helping to reduce the numbers of people who smoke further in the county where rates are already relatively low.

The current strategy in Oxfordshire has been highlighted nationally in the Khan report as being as an example of best practice for a holistic approach to tobacco control.

The challenge in Oxfordshire is that as smoking rates are already relatively low, the likelihood is that those that continue to smoke are mostly within communities that are seldom heard and groups where engagement is less likely to lead to quitting successfully. Meeting this challenge will require tailored solutions for each group, coordinated across settings, with a strong focus on face to face intensive support. From the interviews and surveys of professionals involved with supporting people to stop smoking, there were a range of barriers described which likely result in fewer people stopping smoking and preventing them from starting.

This health needs assessment highlights areas where the existing strategy has been difficult to implement and the barriers that need to be addressed to ensure the strategic vision is achieved. There are five main areas where there are barriers progressing the strategy:

- **A flexible LSSS that can respond to different needs** The LSSS service specification is tightly prescribed giving little flexibility for the provider to support people in different ways and it is largely a digital service concerned solely with smoking. The LSSS is unable to offer schools support to stop children and young people vaping, or support people to stop their dependency on nicotine. They are unable to provide routine frequent face to face support where that might best meet the needs of people.
- **Tailoring of the service to priority groups in terms of the type of support they need**. There are a range of different teams involved with supporting people to stop smoking but they do not currently work closely together. For example, the DAT and Response have a great deal of experience in working with people with addiction and other complex needs, and could OCC consider that expertise to inform how to better meet the needs of some of the priority groups to support them to stop smoking.
- **Relationships between different services who can offer stop smoking support range from very good to disengaged.** Budgets for providers are separate and are linked to KPI targets which leads them to focus exclusively in those areas rather than the wider service.
- **Underuse of services that could support people to stop smoking.** There are other services which are well placed to help people stop smoking which are not currently being fully utilised, including the drug and alcohol support walk in clinics, community pharmacies and GP surgeries.

- **Visibility of the service across the county – the understanding of stop smoking services in both health and social care is variable**. This means professionals do not always know how to signpost people to stop smoking services and they do not promote the service and quitting. Health and care professionals may not understand the latest evidence based guidance about, for example, vaping as an aid to quitting.

OCC has established a range of task and finish groups to look at how to improve visibility of the service and access to support for people with mental health problems, people in social housing and routine and manual workers. There is also a task and finish group about improving the role and support that can be offered by primary care and the relationship between primary care and stop smoking services. It is important that the task and finish groups continue to create the way forward inputting into the action plan with current tasks and those emerging from this HNA.

The information gathered for this HNA has highlighted certain areas where further progress could be made in regard to implementing best practice. One important element not included in this HNA is the feedback from service users and insight into what would best support residents to stop smoking. This work has been commissioned by OCC and the output will inform the future decisions of services alongside the HNA. It is important that there is a continual routine process to engage with different priority groups to understand what works best for them so they can engage with services and reduce harm to themselves from smoking.

Table 44 outlines the strategic objectives from the Oxford Tobacco Control Strategy, the relevant findings from the HNA and the recommendation(s) that could be considered.

Table 44: Strategic objectives from the Oxford Tobacco Control Strategy, findings from the HNA and the recommendation(s) that could be considered.

Strategic Objective	HNA Finding	Recommendations
Strategy Pillar 1: Prevention		
Ensure the most vulnerable children and young people are supported not to start smoking	It is unclear what support is available for the most vulnerable children and young people and/ or the wider population of school aged children who may be tempted to vape and then smoke. The LSSS is not contracted to provide advice about vaping. OCC has recently commissioned the INTENT programme which is an evidence based behaviour change smoking and vaping prevention programme delivered to years 7 to 10 with 2-3 one hour sessions delivered per year; evidence suggest it reduces the likelihood of students taking up smoking or vaping.	Access to sign-posted support to stop vaping services for young people. This may be through the school nursing service, a specialist youth service or an extension of the LSSS. Best practice is limited for this group especially about stop smoking interventions. It is recommended that the school health curriculum is updated to talk about the risks of starting vaping and its age restrictions and includes policies associated with cannabis vaping. The INTENT programme, which has been recently commissioned by OCC, should be evaluated to determine its effectiveness amongst young people in Oxfordshire.
Reduce the prevalence of smoking during pregnancy ensuring a robust and effective pathway for both women and their partners for identification, referral and support to stop smoking	The stop smoking support within the maternity service has been in place since January 2024 and is based at OUH. Not all community midwives understand or have capacity to prioritise stopping smoking at the booking appointment. It is unclear whether other community teams that come into contact with women during and after pregnancy, such as health visitors and the FNP team, understand the new pathways. A full range of NRT is not available through the maternal stop smoking service, which may make it harder to quit.	Consider how to ensure members of community teams are all trained in MECC and Very Brief Advice and understand the maternal stop smoking pathway in Oxfordshire and what is available to women and their families. Explore the issues about the limited options of NRT available to women and possible solutions.
Strategy Pillar 2: Local regulation and enforcement		
Adopt a joined up approach to tackling supply and demand of illicit tobacco.	The trading standards team at OCC may place a different priority on dealing with the supply and demand of illicit tobacco than the district councils who are the ones with the power to close down establishments selling illicit tobacco and vapes.	Until a legal solution enabling County Councils to close down illicit establishments is enacted, consider how trading standards and all the district councils could develop a common approach to dealing with potential closures .

Strategic Objective	HNA Finding	Recommendations
Strategy Pillar 3: Creating smokefree environments		
Ensure that local NHS Trusts are smokefree with comprehensive smokefree policies; including encouraging smokers using, visiting or working in the NHS to quit.	A tobacco dependency service is available in acute, maternity and mental health settings; however, there are some issues with targeting the right groups and the process by which smoking status is recorded in acute settings. The perception is mostly people who are white and who do not reside in the most deprived areas are using the TDS in the acute setting. The need for all NRT to be prescribed and the limited range of evidence-based NRT and other stop smoking aids (e.g. vapes and nasal sprays) means patients have much less choice. Funding is year on year which makes it more difficult to retain staff.	Consider if the barriers to offering patients a full range of NRT and other stop smoking aids can be addressed. Review how the TDS is addressing the process issues around capturing and recording smoking status. In the maternity setting consider how to ensure midwives and FNP staff are clear about their own and the TDS's role in assessing and supporting pregnant women in the community. Is there a way of guaranteeing funding for longer than a year?
Encourage workplaces to promote smokefree environments and support staff to quit smoking.	The council have a smokefree policy at all their sites however there is a lack of information and communication about LSSS to support staff.	Consider developing signage with QR codes to refer people to current LSSS.
Support organisations working across the community to promote smokefree environments in homes, cares, play parks and school gates.	All Oxfordshire hospitals have become smokefree sites; however, schools are struggling to enact smokefree school gates.	Encourage County Council / District Councils to link with hospitals to help develop a smokefree school gates action plan. Work with academies and trusts to develop action plans for their sites. Review sixth form college policies and encourage all schools and colleges in Oxfordshire to become smokefree.
Explore further opportunities to protect both adults and children from the harm of second hand smoke.	There are a number of parks and green spaces in Oxfordshire, but they are owned by a variety of partners including the Town/District councils, County Council and the University. This can lead to confusion as to 'whose responsibility' it is to promote smokefree environments.	Promote the the smokefree play park scheme, supported by local schools and parish councils. Ask local schools to hold contests amongst their primary school children to design posters to 'Keep Play Parks Smokefree.' These are judged by the headteacher or by a parish councillor, and winning posters are displayed in local play parks. The scheme is voluntary and local schools or parishes take ownership of the project.

Strategic Objective	HNA Finding	Recommendations
Strategy Pillar 4: Supporting people who smoke to quit		
Reduce health inequalities through targeting populations where smoking rates remain high, including routine and manual workers, the unemployed and those living in the most deprived communities.	The services involved in stopping smoking target the priority groups. However, there are limitations as to what can be achieved within the current service specification. There is a prescribed approach in how the system is implemented with little flexibility to tailor the service to different priority groups. The service is largely digital, requiring people to have digital access, which for those with low incomes, may be intermittent. As the service is largely digital very few people have CO validation which can be a motivator to stop smoking.	Best practice suggests that barrier free, cost free access and stop smoking support that could include outreach to a range of organisations is important. This might require intensive, longer support. Consider whether community pharmacies could be part of the solution with selected pharmacies in each of the priority areas commissioned to provide services to their local population. This may require a review of the current NHSE pharmacy scheme to understand capacity to deliver and barriers to uptake and referral. Consider developing a group of local peer facilitators to encourage engagement with services. Explore how to increase CO validation in different settings.
Ensure all care providers and health practitioners can refer direct to LSSS and tobacco dependency services.	Not all staff working in health and social care settings who work with people who smoke understand the pathway and how to signpost them to the right place if they want to stop smoking.	Increase the visibility of the LSSS across the health and social care sector through a range of channels including offering CPD sessions or including a CPD online module for all new starters and training in MECC and VBA. Ensure systems are in place to ensure and enable direct referrals from GP practices to LSSS Continue to work with TDS to maintain a pathway to stop smoking services from outpatient settings. Consider how support to stop smoking could be offered in the accident and emergency department.

Strategic Objective	HNA Finding	Recommendations
		Ensure robust pathways are embedded to identify people with smoking related health conditions (e.g. lung cancer, asthma, COPD, CVD) they have swift access to stop smoking support. Work with adult social care to put in place a pathway to stop smoking services.
Reduce prevalence of smoking in people with mental health conditions and learning disabilities, offering targeted interventions and ensuring that learning disability services are able to support people who smoke in their care.	People with mental ill health who are admitted to hospital are supported with NRT and support from a TDA. On discharge to the community they can be referred to the LSSS, but the type of support they can access in terms of 12 week Tier 3 largely digital support may not meet the need of the service user who may need something more intensive, face to face with someone they already know or with whom they can build a rapport. In addition, for those who have SMI and have not been admitted but who smoke, the same difficulties will arise. There was no mention by any interviewees or survey respondents about targeting people with learning disabilities to stop smoking and it is unclear how this group are supported.	Ensure there is a designated pathway/ pipeline for those with severe mental health issues. Best practice for this population is to offer NRT and other stop smoking aids for an extended period of time prior to quitting and afterwards to prevent relapse. Offer support to families and carers with quitting and include the likelihood of setbacks in the treatment plan. Provide person centred support that is tailored to the individual including a flexible appointment venue, more frequent contacts and tailored duration of support. Consider working with the drug and alcohol services, the learning disability service, Response and Mind, along with people who use services to design a service that works better for people with SMI and learning disabilities.
Ensure an evidence-based approach is taken to the promotion and use of vapes that is disseminated to all partners.	Not all professionals support vapes as a step to stop smoking.	Consider how to ensure there is local evidence-based information about the current consensus about vapes reaching professionals through different channels along with information about signposting people to the LSSS.
Additional recommendations to consider		
Co-production of how support could be delivered with different user groups	Currently LSSS ask for feedback from service users and report positive responses in the form of quotes of how the services helped them.	There is a need for a systematic ongoing process to gather priority group views as to the type of services that would best fit the needs of each group. Consider using a combination of best practice and focus groups or a similar method to obtain feedback on what would be the best approach for people who are keen to stop smoking.

Strategic Objective	HNA Finding	Recommendations
CLeaR	The last CLeaR self-assessment was prior to the Covid-19 pandemic.	Undertake a CLeaR self-assessment to check what has been put in place since the last report and what the next steps are.
Stopping vaping and smoking in children and adolescents	The LSSS is not contracted to provide advice about stopping vaping or stopping nicotine addiction. LSSS is contracted to support people to stop smoking, but this is not tailored to young people.	Best practice is concerned with training staff who work in youth services, with whom young people already have a relationship and whose organisations are credible to them, in helping to stop smoking and encouraging signposting to, and raising awareness of services. Consider how that can be achieved, perhaps linking in with the young people's drug and alcohol teams.
Working with seldom heard groups	Some groups who are likely to have higher rates of smoking are less likely to engage due to language, cultural or being unable to relate to the LSSS.	Find champions/peer facilitators in LGBTQ+, the Polish, Romanian, Black and other ethnic minority communities, non-English speaking people, and younger people (aged <30 years old) who can encourage engagement with the LSSS. Work with other LA teams who are engaging with the traveller community and those experiencing homelessness to identify ways to offer stop smoking support to these groups. Consider reducing the 50% quit target for the current service in recognition that this may be disincentivising when considering how to target key groups.
Services working together	The hardest to engage groups such as people who are homeless, people with mental ill health and people with drug and alcohol use problems are not being targeted in a way that is likely to impact on their smoking rates. Many people have complex needs including a dual diagnosis or long term health conditions in addition to experiencing deprivation, housing problems or homelessness.	The LSSS, the mental health TDS, Response, Mind and the DAT all work with the hardest to engage groups. Explore whether a specialist approach could be co-designed with these teams and the potential service users, taking into account best practice. Consider a data sharing agreement to support services working together. In the long term it may be good to consider whether a joint strategy with the drug and alcohol service would be beneficial. This approach been developed in other areas such as Southampton.

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List of abbreviations

Abbreviation	Stands For
ASH	Action on Smoking and Health
B	Billion
BaNES	Bath and North East Somerset
BOB ICB	Berkshire Oxfordshire and Buckinghamshire Integrated Care Board
CDTS	Cut down to stop
CHD	Coronary Heart Disease
CLeaR	**C**hallenge **Lea**dership **R**esults
CO	Carbon monoxide
COPD	Chronic Obstructive Pulmonary Disease
CPTV	Community Pharmacy Thames Valley
CRUK	Cancer Research UK
DAT	Drug and Alcohol Team
DHSC	Department of Health and Social Care
EMIS	Egton Medical Information Systems
EPR	Electronic Patient Record
FCTC	Framework Convention on Tobacco Control
FNP	Family Nurse Partnership
GP	General Practice
HMRC	His Majesties Revenue and Customs
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
KPI	Key Performance Indicator
LA	Local Authority
LGBTQ+	Lesbian, gay, bisexual, transgender and queer/questioning plus other identity terms
LSOA	Lower Super Output Area
LSSS	Local Stop Smoking Services
LTCs	Long term conditions
M	Million
MECC	Make Every Contact Count
MHRA	Medicines and Health Care Products Regulatory Agency
MSOA	Middle Super Output Area
NCSCT	National Centre for Smoking Cessation and Training
NICE	National Institute for Health and Care Excellence

Abbreviation	Stands For
NRT	Nicotine Replacement Therapy
NS-SEC	National Statistics Socio-Economic Classification
OCC	Oxfordshire County Council
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
OUH	Oxford University Hospitals NHS Foundation Trust
PGD	Patient Group Directive
RMW	Routine and Manual Workers
SMI	Severe Mental Illness
TDA	Tobacco Dependency Advisor
TDS	Tobacco Dependency Service
UA	Unitary Authority
VBA	Very Brief Advice
WHO	World Health Organisation

Appendices

Appendix 1: Questionnaire for professional stakeholders

Oxfordshire County Council Health Needs Assessment

Questions for Stakeholder semi structured interviews and survey

INTERVIEW DETAILS

Date:

Name(s):

Organisation:

Role(s):

Questions

1 Can you briefly describe your role(s) in relation to smoking and tobacco control services in Oxfordshire?

2 Could you briefly describe the service(s) your organisation provides and the catchment population served by your service?

3 What do you think are the strengths of the smoking and tobacco control services in Oxfordshire?

4 What do you think are the main challenges in respect of smoking and tobacco control services in Oxfordshire?

5 Are there any significant risks/gaps in smoking and tobacco control services in Oxfordshire?

6. What are your views on current service accessibility of smoking and tobacco control services to?

7. Covid-19 will have had an impact on many services. Is there any important learning, good and/or bad, that can be built on from this experience for smoking and tobacco control services?

8. What do you consider to be the single most important strategic priority for action currently in respect of smoking and tobacco control services in Oxfordshire?

Any further comments?

Appendix 2: Roles of people participating in the semi-structured interviews

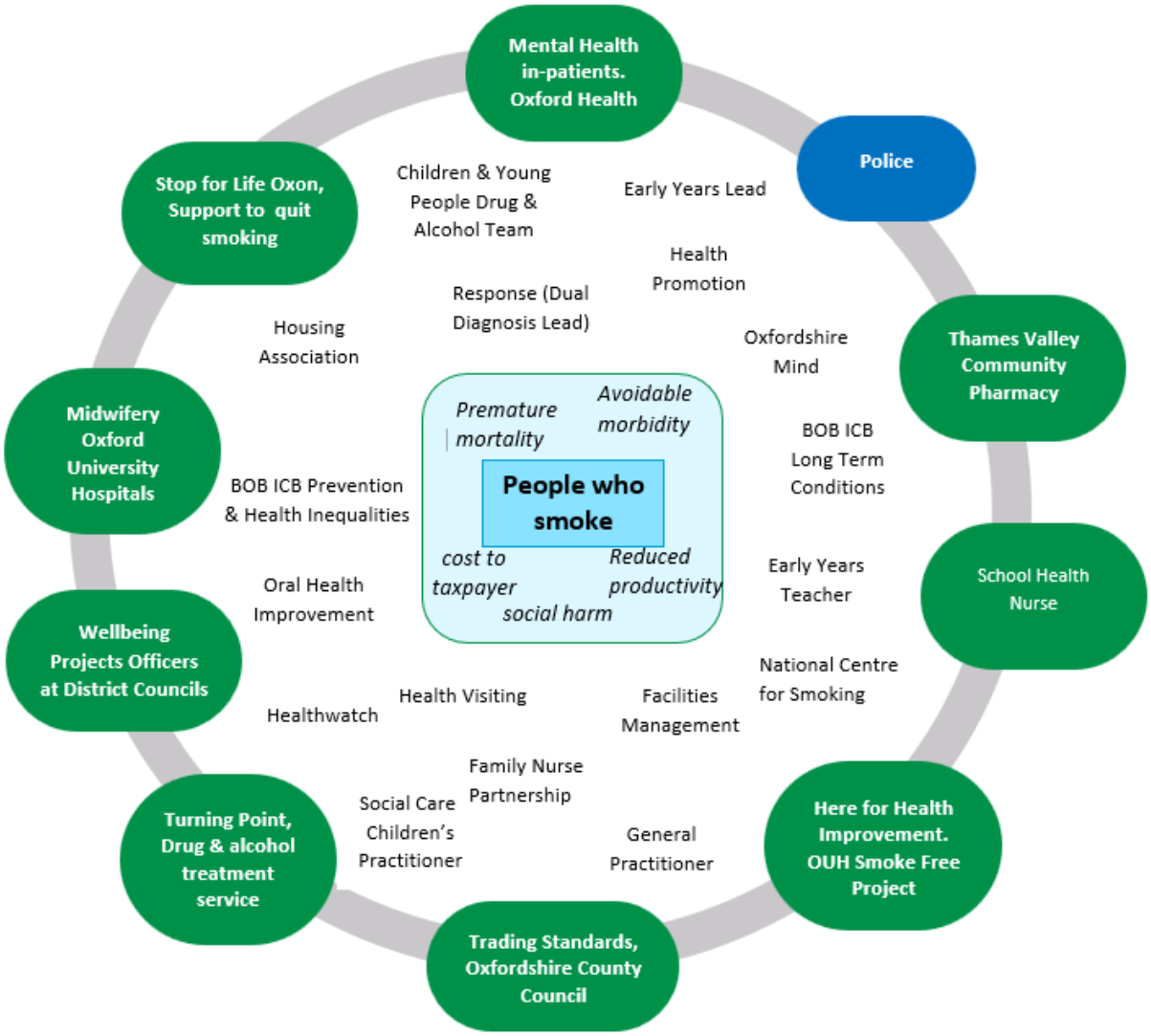
Role	Organisation
Smokefree Project Lead	OUHNHS FT
Healthy Lifestyle Team Lead - maternity	OUHNHS FT
Deputy Director of Quality & Clinical Standards	Oxford Health NHS Foundation Trust
Project Support Lead	Oxford Health NHS Foundation Trust
Service Lead	Stop for Life Oxon
Senior Operations Manager	Turning Point
Chief Executive Officer	Community Pharmacy Thames Valley
Trading Standards Officer	Oxford County Council Trading Standards
Tobacco Control Officer	Oxford County Council Trading Standards

Appendix 3: Stakeholder responses to online survey

An online survey was developed, asking questions very similar to those used in stakeholder interviews (see appendix 1). The Oxfordshire County Council Public Health team utilised a range of channels to distribute the online survey to stakeholders across Oxfordshire. These were individuals working in or with smoking cessation or tobacco control services or who signposted or referred people to them. Twenty two survey responses were received from a wide range of stakeholders, but not from all organisations that were contacted (see below). There may have been an impact from the timing of the survey, which was distributed just before the school summer holidays began.

Organisation	Departments/Teams
Tobacco Control Alliance	Cross cutting across OUH, Mental Health, Trading standings, public health and wider
Prevention and Inequalities Forum	Cross cutting – voluntary and community social enterprises • Job Centres • Health Champions
Oxfordshire County Council departments	• Public Health and Community Safety (including Trading Standards/fire safety) • Elected members. • Adult Social Care • Children's services including youth offending services. • Property and Assets (smokefree policies at council owned buildings) • Economy and Place (including OxLEP) • Libraries
District council /Partnership board	• Housing • Recycling and waste collection, street cleaning • Leisure centres • Building control • Parks • Community centres
Public Health Commissioned services	• Health visiting, • Adult and children's drug and alcohol teams • School nursing • Health checks • Weight management
NHS	• BOB Integrated Care Board • Acute Trust (OUH) TCA • Maternity Teams - TCA • Mental Health Trust (Oxford Health)- TCA • Community hospitals • Ambulance Service • Cancer Alliance • Primary care
Emergency services other than NHS	• Fire & Rescue • Police (and prisons and probation services)
Education	• Primary and secondary schools

Stakeholders from nine services were interviewed and are shown in the green boxes. Although Police representatives were not spoken with, they were recognised as key stakeholders. In addition, an online survey was distributed and 22 responses were received from a range of stakeholders, also featured in the diagram below.



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