JERSEY SMOKING PROFILE 2017

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Jersey smoking profile 2017

1 in 6 Jersey residents aged 16 or over smoke

25% in 2005

16% in 2017

The proportion of smokers has decreased in the last 12 years

since 2005, the largest decrease in the proportion smoking was in the youngest age group

1 in 6

babies born in 2017 were at risk of passive smoking at 6-8 weeks of age

Help2Quit
Break free from smoking

850 people set a quit date through the stop smoking service in 2017

42% successfully quit at 4 weeks

43%
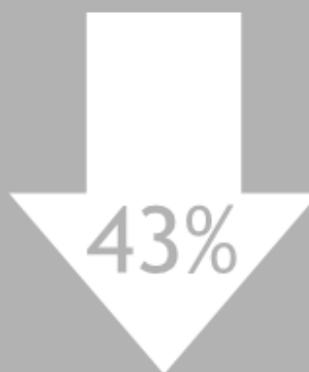
the quantity of tobacco imported into the Island has fallen over the last decade

820

The estimated number of hospital admissions attributable to smoking in 2016

1 in 6

of all deaths in 2016 were from conditions attributable to smoking

Introduction

This report is the latest in a series of reports which examines the effect of tobacco use on Islanders' health. It presents a range of information on smoking among adults,[1] including prevalence, habits, attitudes, attempts to quit and the effect on health in terms of hospital admissions and deaths from smoking related illnesses. Information is also included on tobacco-related prices and expenditure. The report contains both previously published information and new analyses.

A number of States of Jersey Departments have provided data for this report, including the Health and Social Services Department, and the States of Jersey Prison Service.

This report is primarily concerned with cigarette smoking unless otherwise specified. Comparisons are presented with data published by Public Health England (PHE), the UK Office for National Statistics (ONS) and NHS Digital. International comparisons on tobacco consumption are included using data published by Eurostat.

Comparisons made between different jurisdictions or between two time periods are tested for statistical significance. Only statistically significant differences have been described using terms such as 'higher', 'lower', 'increase' or 'decrease'.

For further details about the analysis, statistical testing and comparison sources, see the Background Notes section of this report.

Smoking definitions

Smoking definitions adopted by the main sources used in this report differ in some cases. Key definitions between sources are highlighted below and clarified in the relevant sections of the report.

Definitions of adult smoking behaviours

Current smoker: adults who reported that they do smoke, either daily or occasionally.

Ex-smoker: adults who reported that they used to smoke (either daily or occasionally).

Non-smoker: adults who reported they have never smoked and those that said that they used to smoke

Never smoker: adults who reported that they have never smoked or don't smoke

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[1] Data on the smoking behaviour of children has not been included in this round of the report. This is because the main source of data on smoking in children is the Jersey Schools Survey which currently runs every four years. As such, the previous round of this report included the most recent data on children. The next update on smoking in children will be included in the next iteration of this report using data from the 2018 round of the Jersey Schools Survey.

Key findings

In Jersey, in 2017

- around one in six (16 per cent) of adults aged 16 or over were smokers; a significant decline of nine percentage points compared to 12 years previously, 2005, when 25 per cent were smokers
- since 2005, the largest decrease in the proportion smoking was in the youngest age group (16 to 34 years)
- 1 in 6 of all babies born in 2017 were assessed to be at risk of passive smoking at 6-8 weeks of age
- 850 people set a quit date through the stop smoking service in Jersey. 350 people successfully quit,[2] a quit rate of 42 per cent

In 2016

- daily smokers in Jersey consumed an average of 13 cigarettes a day
- there were more than 800 admissions to Jersey General Hospital for adults aged 35 or over[3] which were estimated to be attributable to smoking. This number represents 3 per cent of all hospital admissions of this age group (35 years or over)
- 18 per cent (140) of all deaths of adults aged 35 or over were estimated to be attributable to smoking. This proportion has remained at a similar level over the past 9 years, since 2008
- the quantity of tobacco imported into Jersey has reduced by 43 per cent over the last decade

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[2] As recorded at 4 weeks
[3] Figures presented relate to people aged 35 or over, as relative risks are only available for this age group

Smoking patterns in adults

The information presented in this section relates to the smoking patterns of Jersey resident adults (aged 16 years or over). The main source of adult smoking information comes from the Jersey Opinions and Lifestyle Survey (JOLS) (formerly the Jersey Annual Social Survey, JASS), conducted by Statistics Jersey. This section of the report also includes information on the smoking patterns of prisoners on the Island provided by the States of Jersey Prison Service.

Smoking patterns in adults 2017

1 in 6 Jersey residents aged 16 or over smoke

25% in 2005

16% in 2017

The proportion of smokers has decreased in the last 12 years

since 2005, the largest decrease in the proportion smoking was in the youngest age group

16-34	35-44	45-54	55-64	65+	All
-16	-11	-6	-4		-9

percentage point

A greater proportion of those who live in St Helier smoke daily compared to those who live in rural parishes

15%   6%

1 in 6 babies born in 2017 were at risk of passive smoking at 6-8 weeks of age

87% of admissions to HMP La Moye in 2017 were smokers

Trends in smoking prevalence

In 2017, around one in six (16 per cent) of adults aged 16 or over in Jersey were smokers. This latest figure is a significant decrease of nine percentage points compared to 2005, when 25 per cent were smokers (Table 1 and Figure 1).

The proportion of Islanders who report smoking daily has fallen from around one in five (19 per cent) in 2005 to around one in ten (11 per cent) in 2017. The figure for 2017 is the lowest proportion of daily smokers recorded.

Table 1: Do you smoke? Percentage by year, 2005-2017

	2005	2007	2008	2010	2012	2013	2014	2015	2016	2017
I have never smoked / I don't smoke	45	48	48	47	46	44	48	50	47	52
I used to smoke occasionally but don't now	12	15	15	13	15	15	15	14	14	13
I used to smoke daily but don't now	17	17	16	17	17	18	19	17	20	19
I smoke occasionally but not everyday	6	6	5	8	6	6	5	6	6	5
I smoke daily	19	14	16	15	16	16	14	12	13	11
Total	100	100	100	100	100	100	100	100	100	100

Source: JASS 2005-2015, JOLS 2016-2017

In the UK, 16 per cent of the adult population (aged 16 or over) were smokers in 2016 compared to 20 per cent in 2010.[4]

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[4] Office for National Statistics, Adult smoking habits in Great Britain, 2016, published 15 June 2017, available from www.ons.gov.uk

Figure 1: Smoking status, 2005 and 2017

	Never smoked	Used to occasionally	Used to daily	Smoke occasionally	Smoke daily
2005	45%	12%	17%	6%	19%
2017	52%	13%	19%	5%	11%
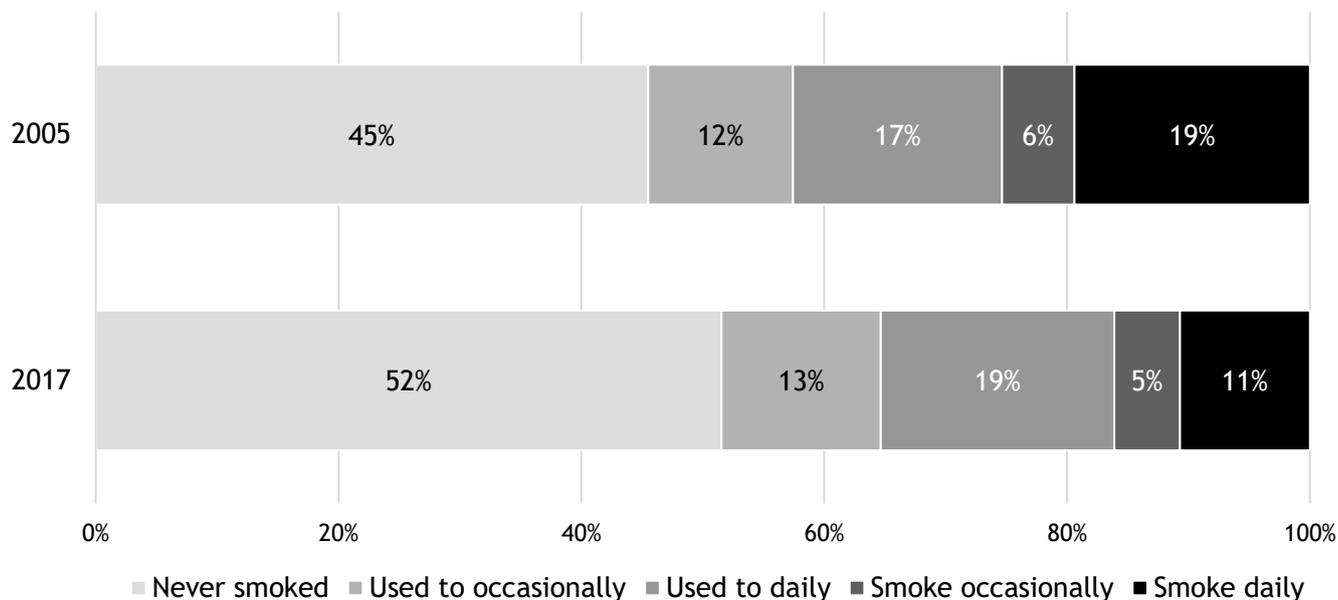
Source: JASS 2005 and JOLS 2017

In 2005, the highest prevalence of cigarette smoking was seen in the 16-34 age group, with around one in three (34 per cent) of 16-34 year olds reporting smoking (Figure 2). Most recently, in 2017, the prevalence in this age group has reduced.

Figure 2: Prevalence of cigarette daily and occasional smoking, by age group, 2005 and 2017
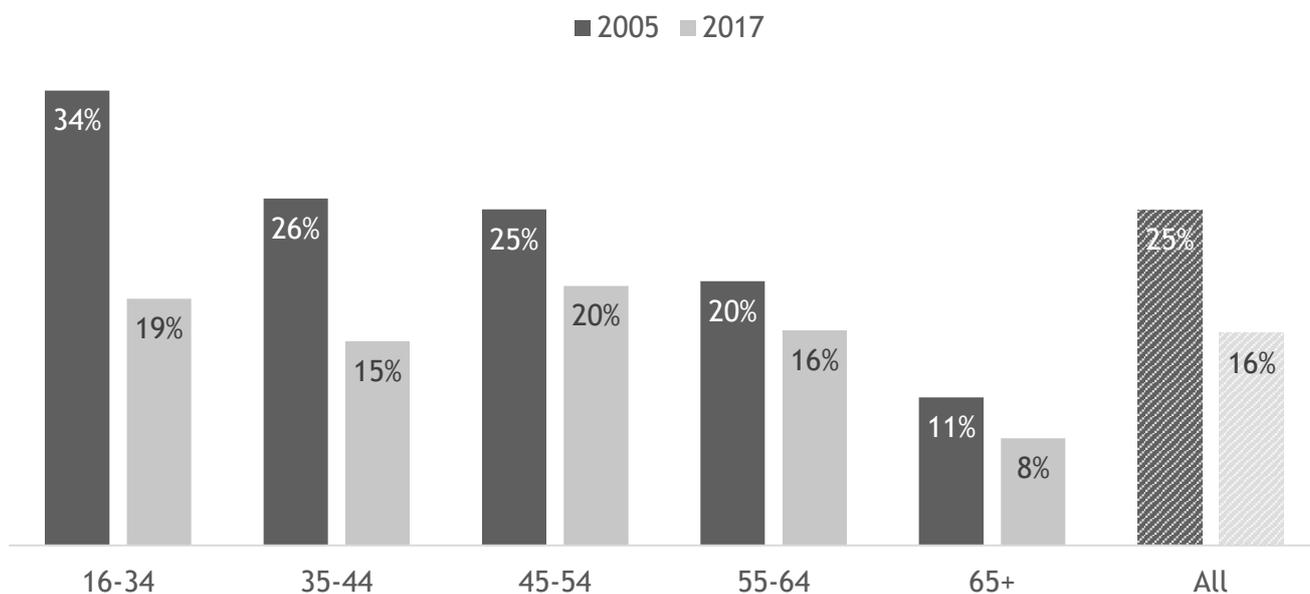
Source: JASS 2005 and JOLS 2017

Prevalence of smoking since 2005 has fallen most in the younger age groups, as shown in Figure 3.

Figure 3: Percentage point change in proportion of daily and occasional smokers, 2005 to 2017
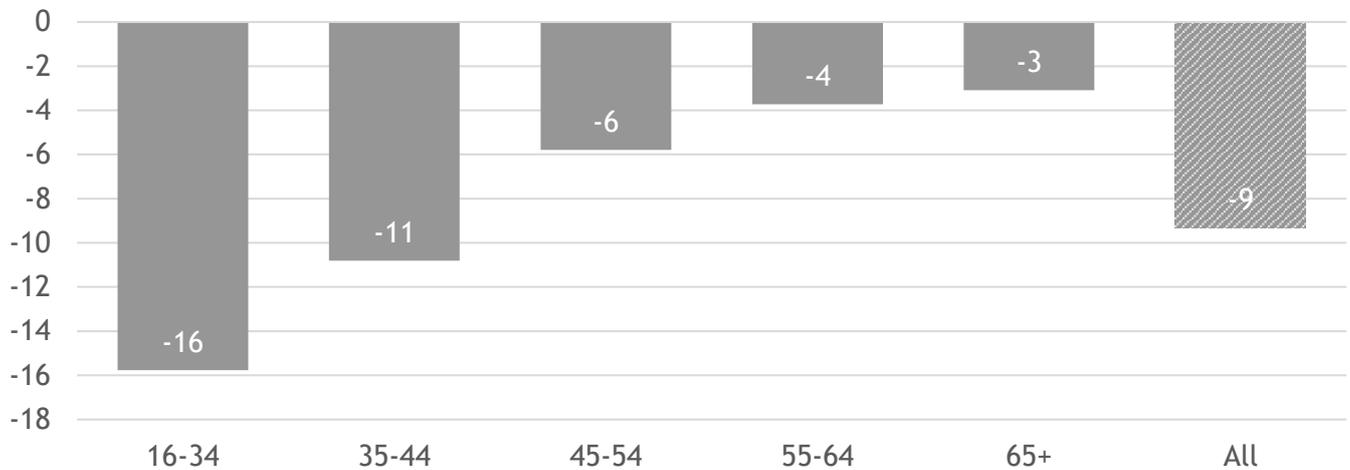
Source: JASS 2005 and JOLS 2017

Prevalence of daily and occasional smoking was higher for males (19 per cent) than females (13 per cent) in 2017. The 2017 prevalence figures compare to 23 per cent of males and 27 per cent of females in 2005. Figure 4 shows the prevalence of male and female daily smoking over the last twelve years.

Figure 4: Prevalence of daily smoking, by gender, 2005-2017
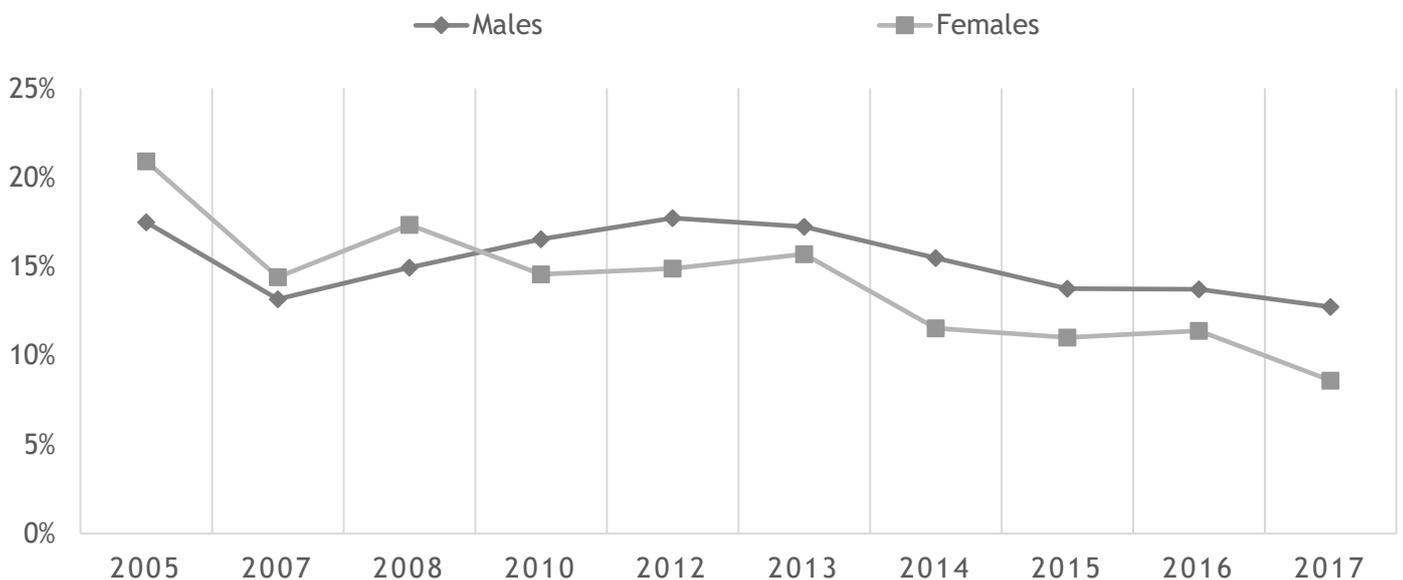
Source: JASS 2005-2015, JOLS 2016-2017

Cigarette consumption

In 2016 (the most recently available data), daily smokers in Jersey consumed an average of 13 cigarettes a day. The number of cigarettes smoked each day by male smokers has reduced slightly since 2008, from an average of 16 per day to 13 per day in 2016 (see Table 2). The average number of cigarettes smoked by females has remained essentially stable over this period. Adults who smoked 'occasionally' smoked 3 cigarettes per day on average.

Table 2: Number of cigarettes smoked per day, average for daily smokers only

	2008	2010	2012	2014	2016
Males	16	17	15	15	13
Females	13	14	13	11	12
All daily smokers	14	16	14	13	13

Source: JOLS 2016

Average daily cigarette consumption in Great Britain[5] was similar to Jersey in 2016. Current male smokers in Great Britain smoked on average 12 cigarettes per day in 2016, whilst female smokers smoked 11 on average.

Other characteristics of smokers

JOLS 2017 data can be used to look at differences in smoking patterns by other characteristics of the population:

- place of birth (for example Jersey, British Isles or elsewhere in the world)
    - there was no significant difference in smoking prevalence by place of birth of respondents

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[5] Office for National Statistics, Adult smoking habits in Great Britain, 2016, published 15 June 2017, available from www.ons.gov.uk

- occupation
    - the highest proportions of daily smoking was among people working in manual and routine professions (23 per cent) while 15 per cent of those in technical and clerical professions reported daily smoking in 2017. For those working in managerial and professional occupations the figure was 5 per cent (Figure 5)

Figure 5: Proportion of daily smoking in Jersey, by occupation, 2017
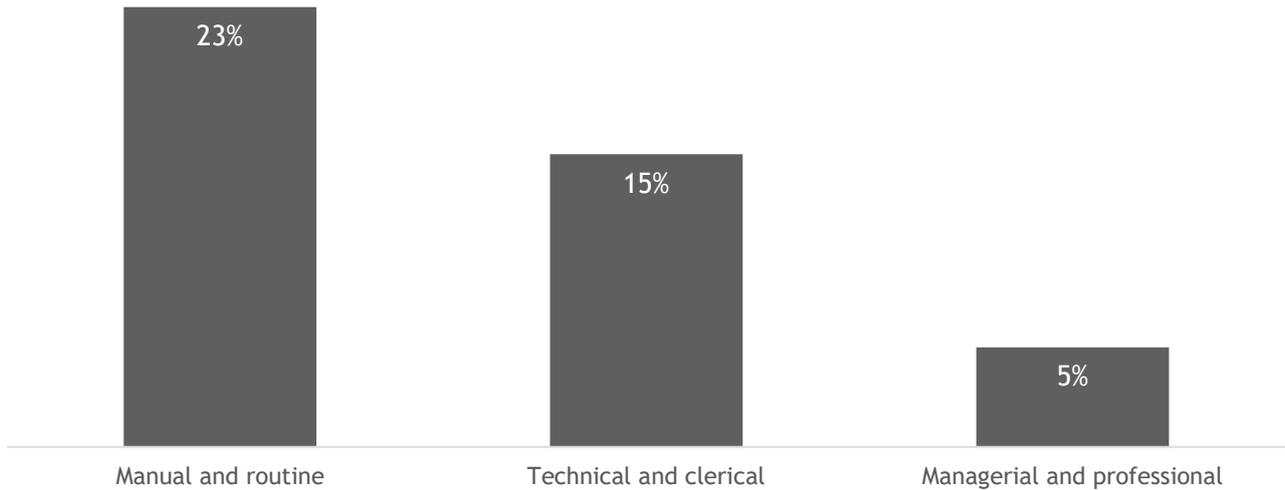
Data source: JOLS 2017

- economic activity
    - more than one in three (38 per cent) of those unable to work due to sickness and around one in four (24 per cent) of those unemployed and looking for work reported smoking daily. For comparison, one in ten (10 per cent) of the working population and 6 per cent of those not economically active[6] report smoking daily
- tenure
    - one in four (25 per cent) of those living in social housing smoke daily, compared to around one in seven in qualified rental accommodation (14 per cent) and in non-qualified accommodation (13 per cent). 6 per cent of those in owner-occupied accommodation report smoking daily

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[6] Defined as retired, in education or homemakers

- education level
  - around one in seven (14 per cent) of those educated to secondary level or who report having no formal qualifications smoke daily, compared to 5 per cent of those educated to a higher level[7]
- household income
  - around one in four (29 per cent) of those in households with the lowest equivalised[8] household income report smoking daily, compared to 2 per cent of those in households with the highest level of income
- area of residence
  - the proportion of daily smokers in urban areas is around twice that of rural areas (15 per cent compared to 6 per cent, respectively)[9]
- material deprivation[10]
  - around half of those living in households experiencing severe material deprivation reported smoking (39 per cent were daily smokers and 9 per cent smoked occasionally). For comparison, 17 per cent of those living in materially deprived (but not severely) households and 13 per cent of those in households that were not experiencing material deprivation report smoking either daily or occasionally
- mental health
  - around one in four of those who had low or medium scores for happiness, life satisfaction and feeling worthwhile were smokers; around one in eight of those with high scores for each wellbeing measure were smokers.
  - there was no difference in smoking prevalence for those with low, medium or high anxiety scores

Smokers' behaviour

One in eight (12 per cent) of Jersey households reported having someone who regularly smoked inside their home.

Looking at whether or not they had children either living in the household, or whether someone in the household regularly looked after children in the home (for example grandchildren or unrelated children) showed that one in ten of such households (10 per cent) *also* had someone who regularly smoked inside

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[7] Defined as those with a first or higher degree
[8] Adjusted to account for household size
[9] Based on parish of residence
[10] This measure refers to the inability (enforced, rather than by choice) to afford some items considered by most people to be desirable or even necessary to lead an adequate life. The measure is defined by the European Union and was included in JOLS 2017 for the first time. The measure used here includes only those who answered yes rather than sometimes in response to items they went without.

the home (Table 3). These figures were essentially unchanged from when the question was previously asked in the social survey in 2014.

Around one in twelve (8 per cent) owner-occupier households had someone who regularly smoked inside their home, compared to 13 per cent of qualified rental households, 15 per cent of non-qualified households and one in four (27 per cent) of social housing households in 2016. A similar pattern was seen in those households where children were either living or were regularly looked after in the home (9 per cent owner-occupier households; 10 per cent non-qualified households; 10 per cent qualified renters and 20 per cent of social housing households).

Table 3: Proportion of households containing a smoker, by households with children living or being looked after in the home

		Are there children in the home, or does someone in the household regularly look after children in the home?		
		Yes	No	All households
Does anyone in the household smoke?	Yes	10	13	12
	No	90	87	88
All households		100	100	100

Source: JOLS 2016

Smoking behaviour around babies

As part of the 6-week check of new-borns, the risk of exposure to second-hand smoke is assessed by GPs. Around one in six (18 per cent) of all babies born in 2017 were living in a household where they were likely to be exposed to tobacco smoke by an adult.

Smoking behaviour of prisoners

In 2017, there was a total of 246 new admissions to HMP La Moye (including repeat offenders); more than four-fifths (87 per cent) of admissions were recorded as being smokers.[11] A 2014 survey of smoking in six prisons across Kent, Surrey and Sussex reported smoking rates of between 62 and 81 per cent.[12]

Comparisons to other jurisdictions

Smoking rates for Jersey were not statistically different to those reported for the countries of the United Kingdom, as shown in Table 4.

Table 4: Smoking by Country, 2012-2017, all persons aged 18 or over, percentages

	England	Wales	Scotland	Northern Ireland	Jersey
2012	19	21	22	19	22
2013	18	20	22	19	23
2014	18	19	20	18	18
2015	17	18	19	19	19
2016	16	17	18	18	19
2017	-	-	-	-	16

*Source: JOLS 2017, Office for National Statistics[13]*

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[11] States of Jersey Prison Service
[12] Public Health England and King's College London, Reducing smoking in prisons: management of tobacco use and nicotine withdrawal, published March 2015, available from www.gov.uk
[13] Office for National Statistics, Adult smoking habits in Great Britain, 2016, published 15 June 2017, available from www.ons.gov.uk

The latest available data for European countries is for 2014.[14] Using contemporary data from JASS 2014 shows that the smoking rate in Jersey is similar to the UK, higher than the Swedish rate but lower than rates seen in most Eastern and Southern European countries (Figures 6).

Figure 6: Daily and occasional smokers, percentage, 2014
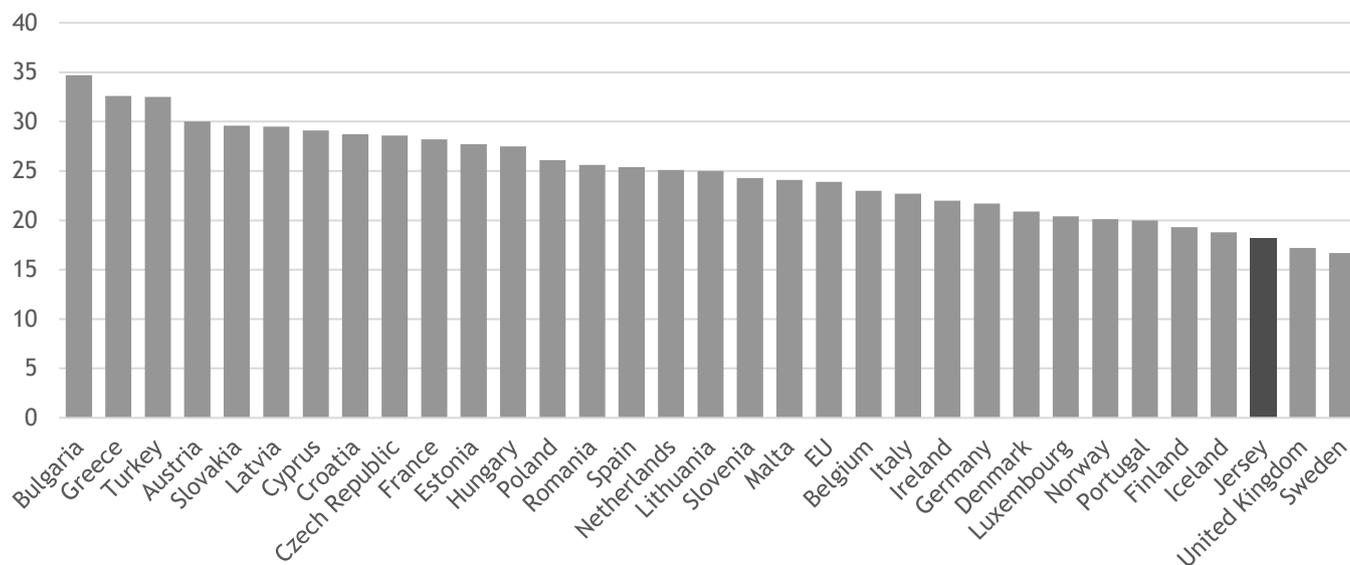
* Note: data from Eurostat is for populations aged 15+ whereas data for Jersey is for population aged 16+
Data source: Eurostat, JASS 2014

Detailed comparisons of Jersey data on smoking rates to data published by Public Health England are shown in Appendix 1.

Use of electronic cigarettes

E-cigarettes deliver nicotine that is vaporised and inhaled from a liquid form via a battery-powered device that simulates cigarette smoking; they are classified as nicotine containing products.

Questions about e-cigarettes have been included in JOLS since 2014, including a question about frequency of use and a more detailed question about why respondents are using these devices asked (every two years).

[14] Eurostat, Daily smokers of cigarettes by sex, age and educational attainment level [hlth_ekis_sk3e], updated 20 March 2017, available from http://ec.europa.eu/eurostat/data

Data for the four years (2014-2017) shows around 4 per cent of the population are using e-cigarettes at least sometimes (defined as sometimes, often or every day). The majority of Islanders (84 per cent in 2017) have never used e-cigarettes. The proportion of users is higher for those who have never smoked cigarettes (97 per cent in 2017) compared to two-fifths (43 per cent in 2017) of those who currently smoke (either daily or occasionally).

There has been essentially no change in use of e-cigarettes by current or ex-smokers since 2014, as shown in Figure 7.

Figure 7: Proportion of adults using e-cigarettes at least sometimes, by smoking status, 2014 - 2017
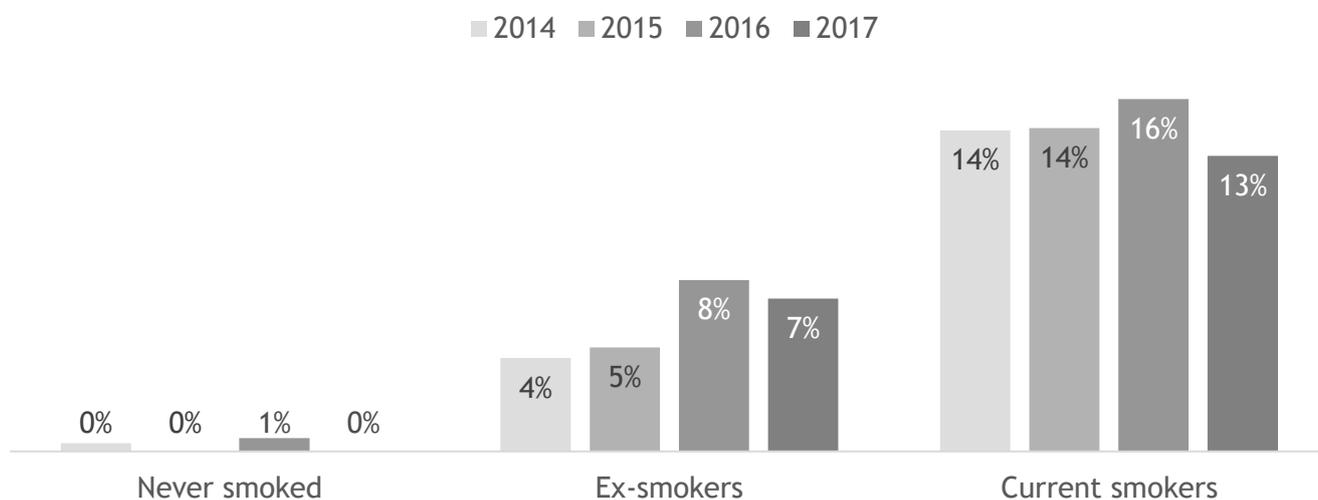
Data source: JASS 2014-2015, JOLS 2016-2017

In Great Britain, 6 per cent of respondents to the Opinions and Lifestyle survey in 2016[15] stated they currently use e-cigarettes. In Jersey, the 2016 JOLS found 4 per cent of the population reported using them often or every day.

In Jersey, one in three (33 per cent) of current smokers used e-cigarettes to help them cut down on the amount they smoke, while one in six (15 per cent) had used them as part of a serious quit attempt.[16]

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[15] Office for National Statistics, Adult smoking habits in Great Britain, 2016, published 15 June 2017, available from www.ons.gov.uk
[16] JOLS 2016 data

Smoking related mortality

Monitoring the number of deaths that are attributable to smoking[17] gives a measure of the impact smoking has on Islanders' health. Data is presented for deaths occurring in 2016, the most recent available.[18]

Smoking related mortality 2016

140 deaths in 2016 were attributable to smoking

1 in 6 18% of all deaths were smoking attributable

2/5 of deaths due to respiratory disease were attributable to smoking (40 deaths)

27% of all cancer deaths were attributable to smoking — 1 in 4
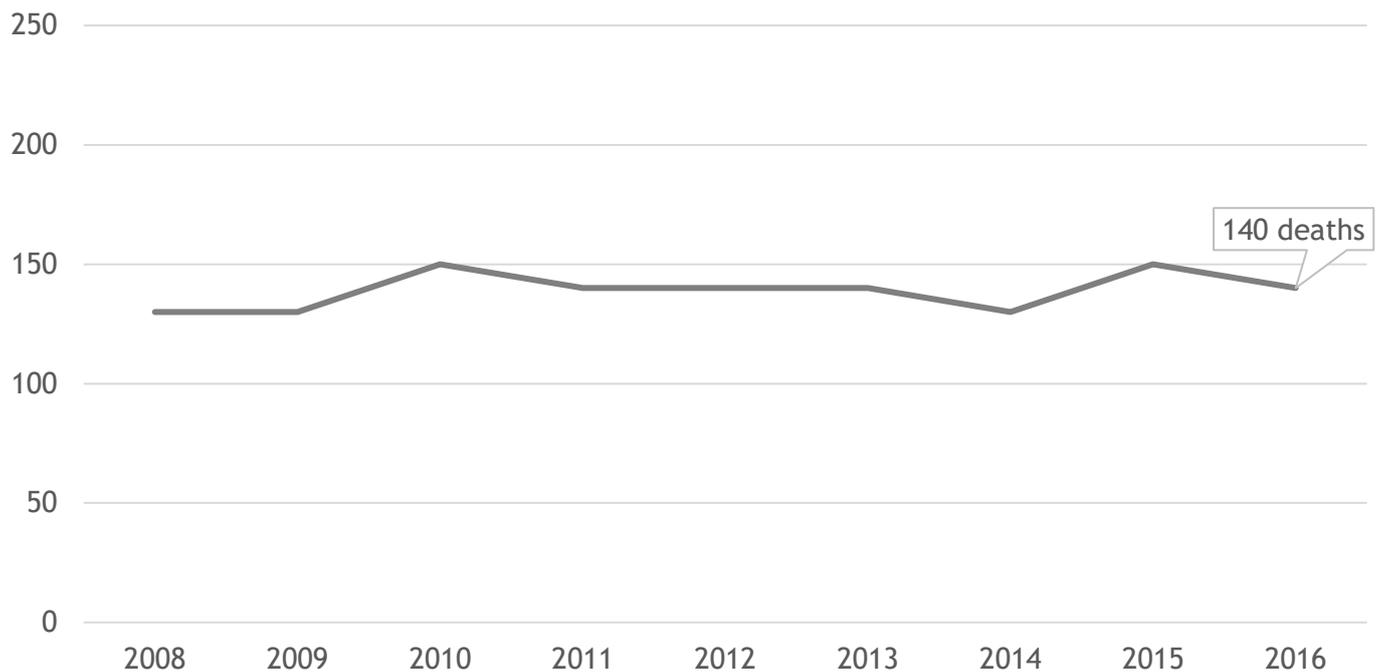
Smoking attributable deaths

In 2016, there were 810 deaths of adults aged 35 or over in Jersey, 140 (18 per cent) of whom are estimated to have died from conditions that are attributable to smoking. The proportion of deaths attributable to smoking has remained at a similar level during the last nine years, since 2008. The latest figure represents 36 per cent of deaths for conditions that can be caused by smoking.[19]

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[17] NHS Digital, Statistics on Smoking, Appendices, published 15 June 2017, available from www.digital.nhs.uk
[18] Deaths data can take up to 18 months to compile due to delays in the registration of deaths that go to inquest and the compilation of data on residents who die abroad.
[19] These statistical estimates are based on smoking prevalence and risks of smokers/ex-smokers developing each disease – for more information see Background Notes

Figure 8: Number of deaths among adults aged 35 or over in Jersey which were attributable to smoking, 2008 to 2016

More than one in five male deaths each year were estimated to be attributed to smoking. In 2016, 22 per cent of all male adult deaths aged 35 or over in Jersey were from conditions that can be caused by smoking, compared to around one in seven female deaths (13 per cent in 2016).

The pattern of smoking related deaths in Jersey is similar to that of England, where 20 per cent of male and 13 per cent of female deaths in 2015 were estimated to be smoking related.[20]

It is estimated that in Jersey in 2016, 41 per cent of all deaths (40 deaths) due to respiratory diseases and 27 per cent of all cancer deaths (70 deaths) were attributable to smoking. In addition, an estimated 14 per cent of deaths (30 deaths) from circulatory diseases and 2 per cent of deaths from diseases of the digestive system were attributable to smoking (Figure 9). These proportions are similar to those reported for England.[21]

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[20] NHS Digital, Statistics on Smoking: England 2017, published 15 June 2017, available from www.digital.nhs.uk
[21] NHS Digital, Statistics on Smoking: England 2017, published 15 June 2017, available from www.digital.nhs.uk

Figure 9: Estimated proportion of deaths attributable to smoking, as a percentage of all deaths from that disease among adults aged 35 or over, 2016
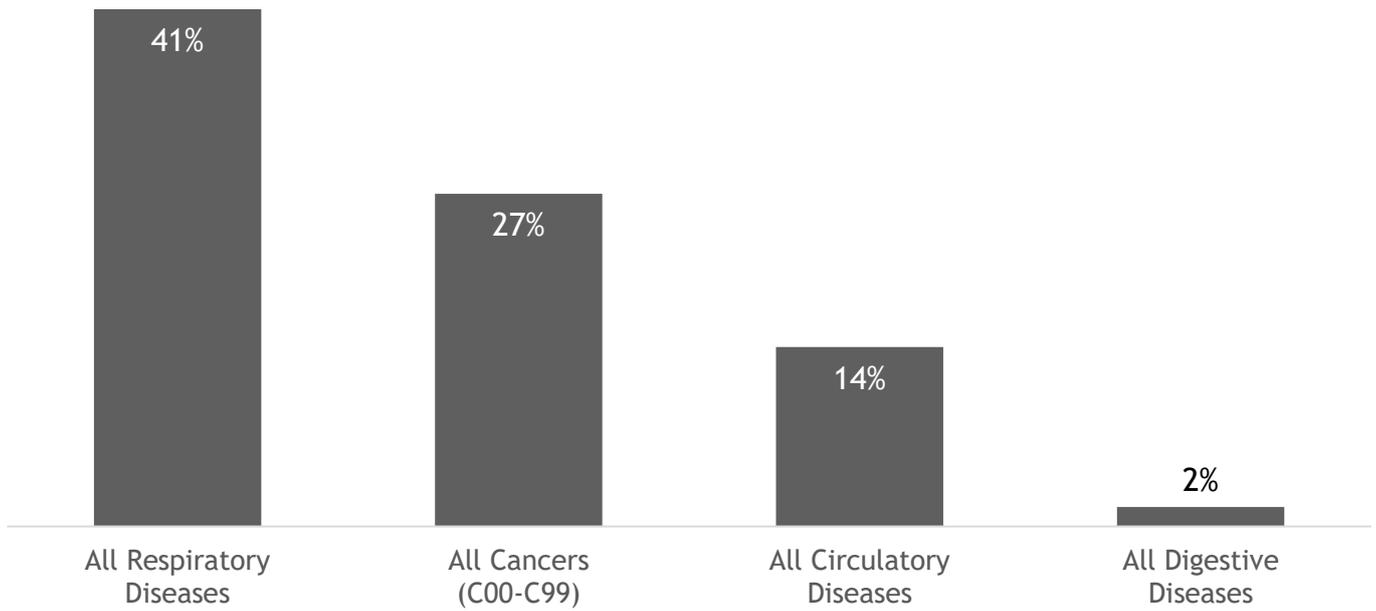
Smoking related ill health

This section presents information on the health impacts of smoking, including hospital admissions and the self-reported health status of smokers.

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases which cause breathing difficulties; this group includes emphysema and chronic bronchitis. COPD mainly affects middle age and older adults who smoke tobacco. In 2016, 1,800 people registered with a GP in Jersey were on the COPD disease register.[22]
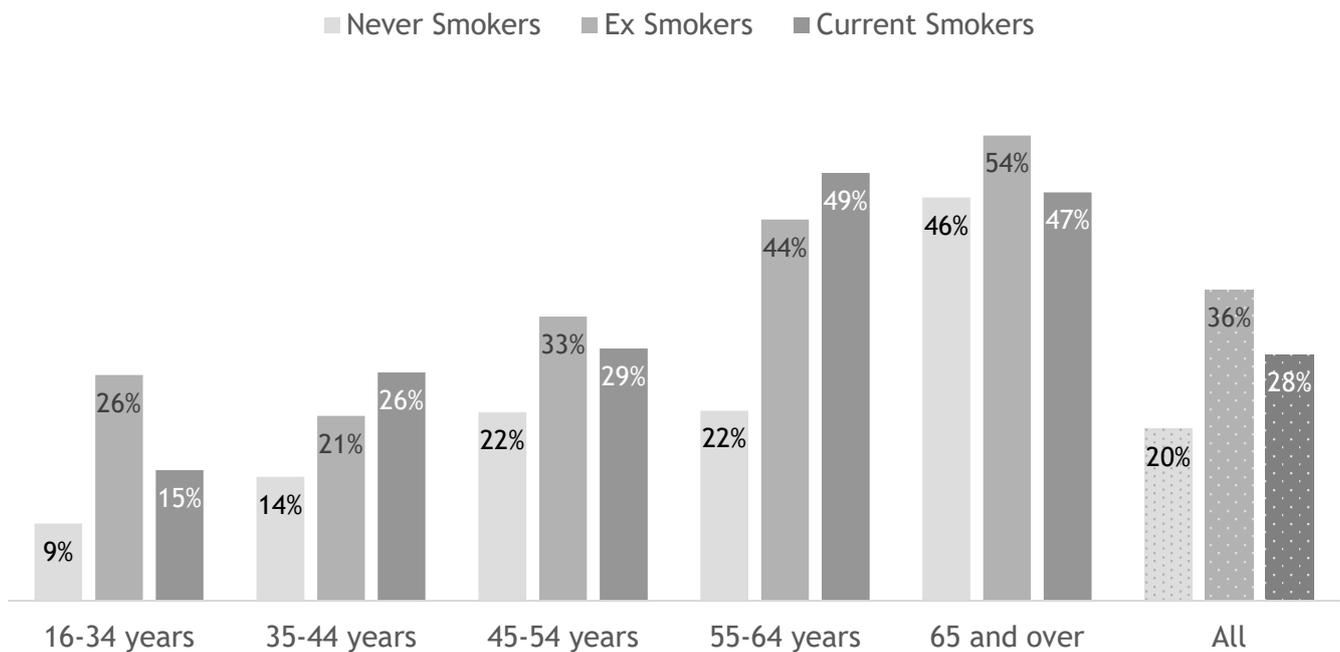
Longstanding illness

When comparing both current and former smokers with those who have never smoked (never smokers), a greater proportion of current and former smokers reported having an illness, disability or infirmity that had lasted or was expected to last at least twelve months (JOLS 2017). Figure 10 shows that before the age of 65, the proportion of long-standing illness was lower in never smokers, but that proportions are similar after 65 years of age.

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[22] Specific disease registers are generated as part of the Jersey Quality Improvement Framework (JQIF) which incentives GPs to accurately record patients that meet a set of disease-specific criteria as being on a particular disease register.

Figure 10: Proportion who report having a longstanding illness, disability or infirmity, by smoking status and age, 2017

Never Smokers   Ex Smokers   Current Smokers

Age group	Never Smokers	Ex Smokers	Current Smokers
16-34 years	9%	26%	15%
35-44 years	14%	21%	26%
45-54 years	22%	33%	29%
55-64 years	22%	44%	49%
65 and over	46%	54%	47%
All	20%	36%	28%

Data source: JOLS 2017

Premature births and low birth weight

Smoking during pregnancy and exposure to second-hand-smoke can affect the health of babies.[23] The inclusion of indicators, such as low birth weight at full term or premature birth, help to monitor if changes in smoking prevalence are having any effect on health related issues.

In 2017, there were 954 live births to Jersey resident mothers. Of these 2 per cent were small for their gestational age (birthweight is below the 5th centile[24] for weight). This proportion has remained stable over the past five years.

Around nine out of ten (94 per cent) of babies born in 2017 were delivered at term (after 37 weeks of gestation). A small proportion, 1 per cent, of these term births were of a low birth weight (less than 2500 grams). This proportion has been similar for the past few years, ranging from 1-3 per cent of term births.

On average, around 5 per cent of births each year in Jersey are premature (born before 37 weeks gestation).

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[23] Been, Jasper V et al., 1.Effect of smoke-free legislation on perinatal and child health: a systematic review and meta-analysis, The Lancet , Volume 383 , Issue 9928 , 1549 - 1560

[24] Jersey gestation and birth weight data is compared to the gender specific World Health Organisation British 1990 birth cohort

Cancer registrations

The latest cancer registration data for Jersey is contained in the *Channel Islands Cancer Report 2017*[25] incorporating data up to 2014.

Around 80 people a year on average are diagnosed with lung cancer in Jersey. Lung cancer accounts for one in eight (12 per cent) of all new cancer diagnosis annually.[26] Smoking is responsible for around 86 per cent of lung cancer incidences.[27]

Figure 11 shows the incidence rate for lung cancer for males and females. Between 2001 and 2009, the male incidence rate was significantly higher than that for females. Since 2010, the incidence rate for males and females have been more similar.

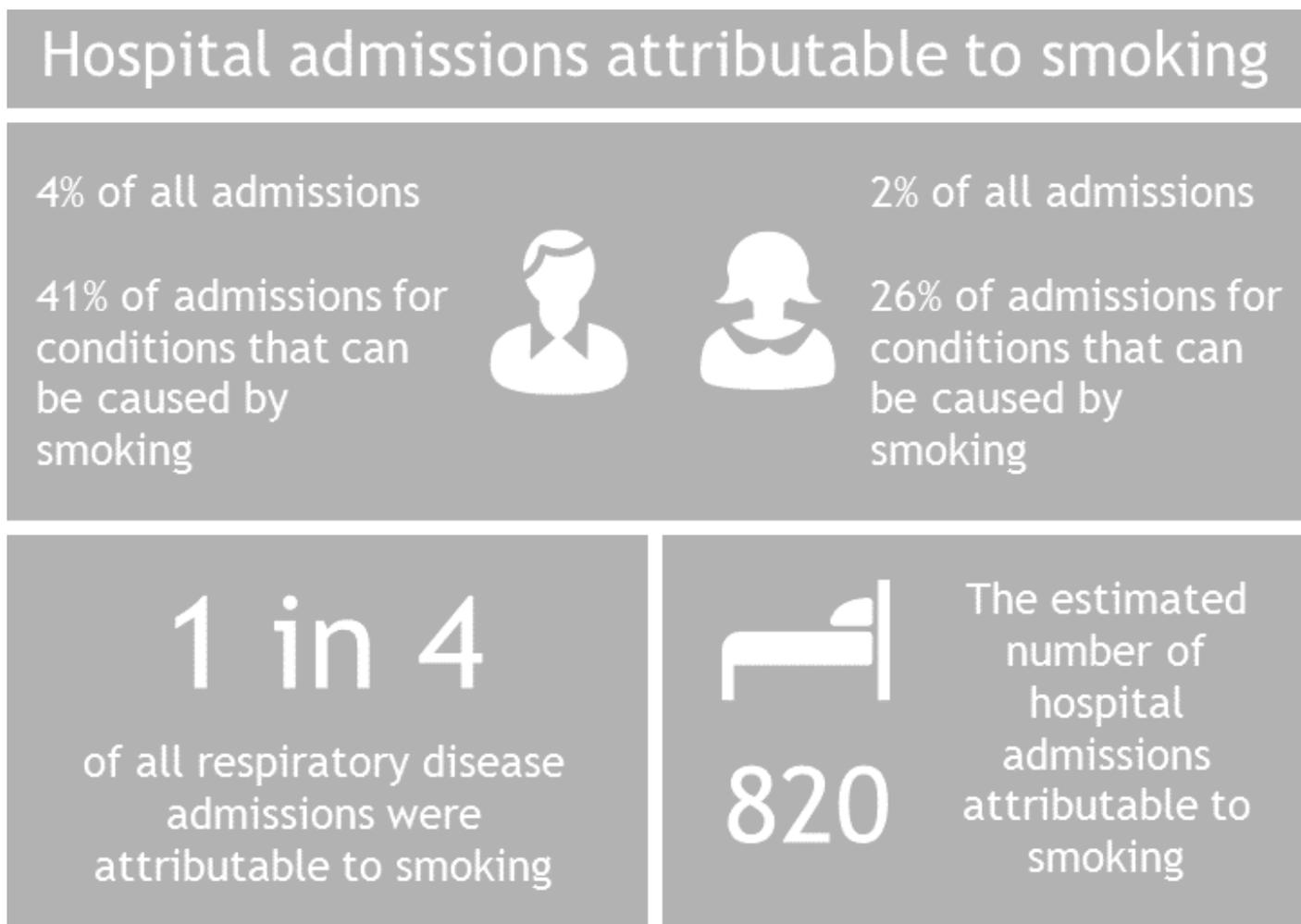Figure 11: Age standardised incidence rates (per 100,000) for lung cancers in Jersey, 2001-2014, by sex
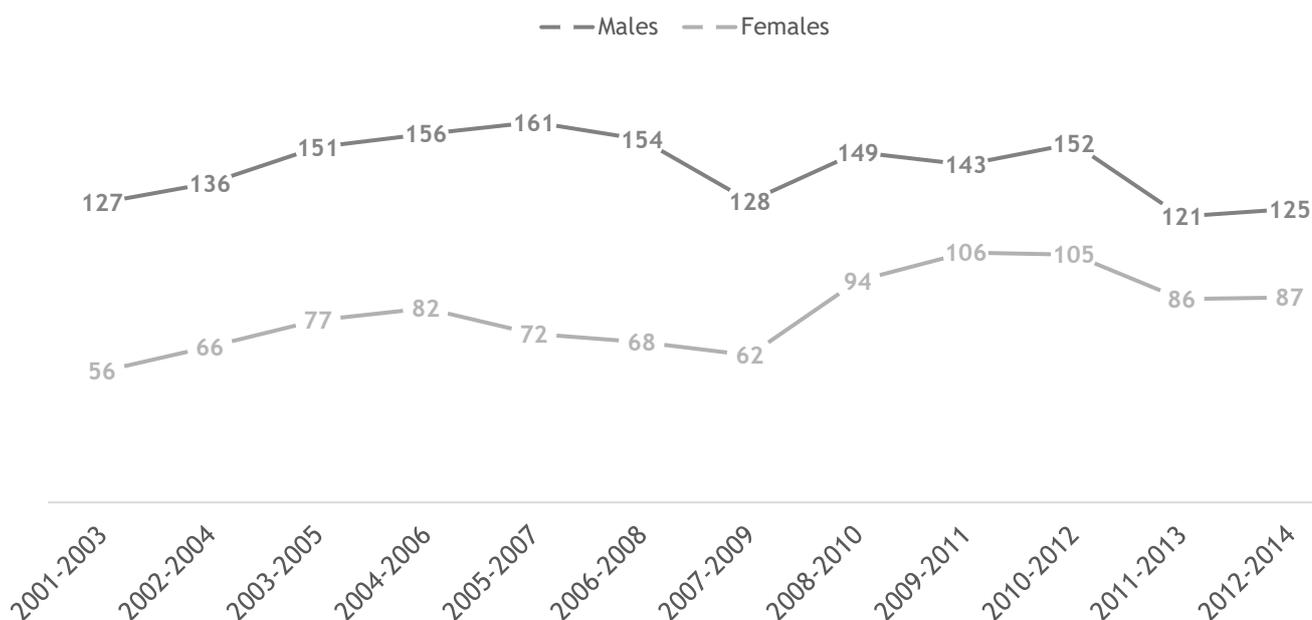
Source: Public Health England

[25] Public Health England Knowledge and Intelligence Team (South West), Channel Islands Cancer Report 2017: incorporating data up to 2014, published 25 July 2017, available from www.gov.je
[26] Based on data for 2012-2014 for all cancers (excluding non-melanoma skin cancer)
[27] Public Health England Knowledge and Intelligence Team (South West), Channel Islands Cancer Report 2017: incorporating data up to 2014, published 25 July 2017, available from www.gov.je

Hospital admissions attributable to smoking

4% of all admissions

41% of admissions for conditions that can be caused by smoking

2% of all admissions

26% of admissions for conditions that can be caused by smoking

1 in 4
of all respiratory disease admissions were attributable to smoking

820
The estimated number of hospital admissions attributable to smoking

This section presents statistical estimates on the number of hospital admissions attributable to smoking; these are based on the prevalence and risks of smokers and ex-smokers developing each disease. For further information, see Background Notes.

In 2016, there were estimated to be around 820 hospital admissions attributable to smoking. A similar number to the previous year (840 in 2015) and around 130 lower than two years previously, in 2014.

In 2016, smoking attributable admissions represented 3 per cent of all hospital admissions, and 35 per cent of all admissions for conditions that can be caused by smoking (Figure 12). These proportions have remained similar over the past five years.

Figure 12: Proportion of hospital admissions[1] attributable to smoking

Percentage of admissions for conditions that can be caused by smoking

| | 2012 | 2013 | 2014 | 2015 | 2016 |

36% ... 35%

Percentage of all admissions

3% ... 3%
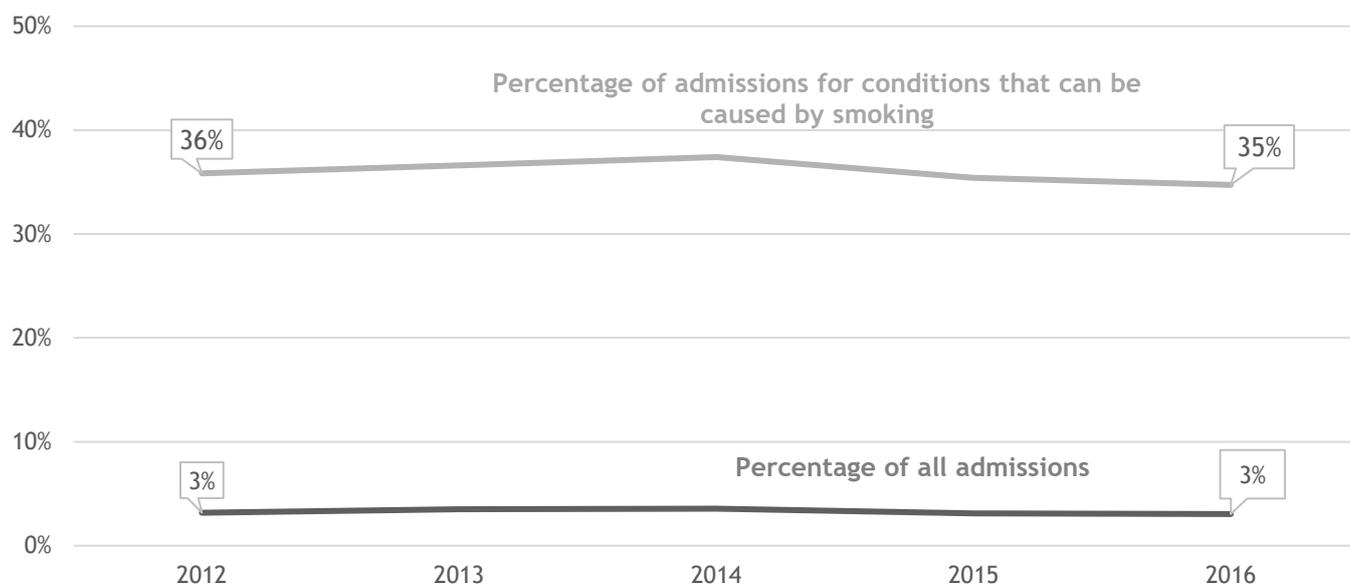
[1]Among adults aged 35 or over

Males accounted for around two-thirds (69 per cent) of smoking attributable hospital admissions in 2016.

Around one in four (26 per cent) of all admissions for respiratory diseases were estimated to be attributable to smoking in 2016 (Figure 13), a similar proportion to that for England[28] for 2015/16 (23 per cent).

Figure 13: Proportion of smoking attributable admissions for <u>all these conditions</u>
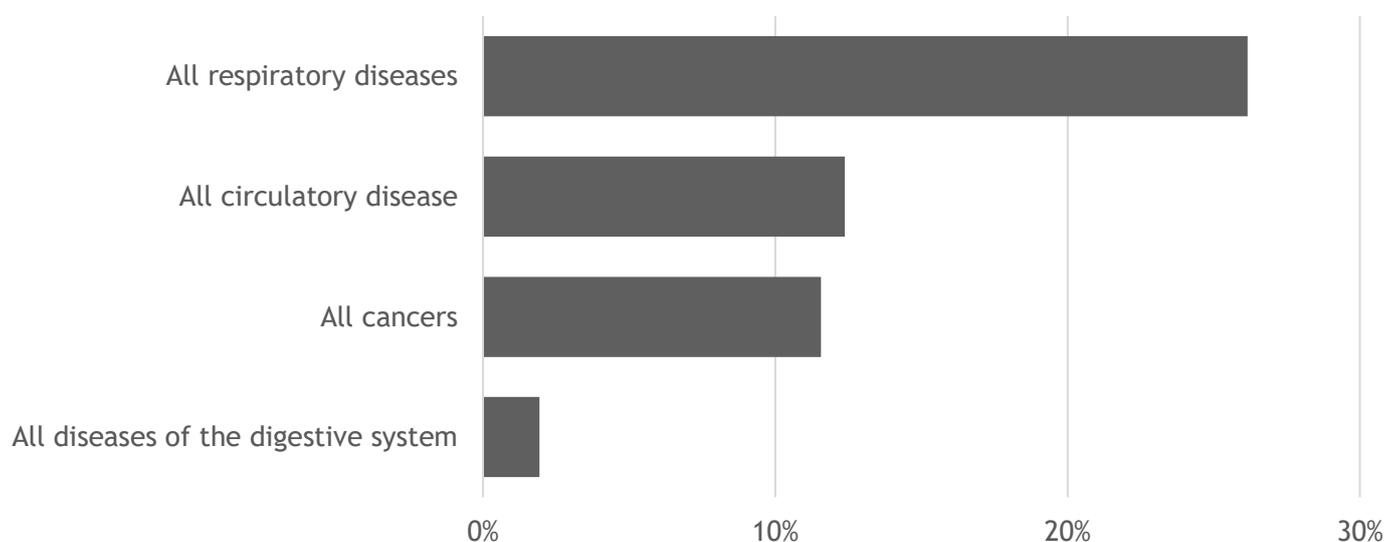
[28] NHS Digital, Statistics on Smoking: England 2017, published 15 June 2017, available from www.digital.nhs.uk

More than half (59 per cent) of admissions for cancers that can be caused by smoking, were estimated to be attributable to smoking (Figure 14).

Figure 14: Proportion of admissions for specific conditions that can be caused by smoking that were attributable to smoking
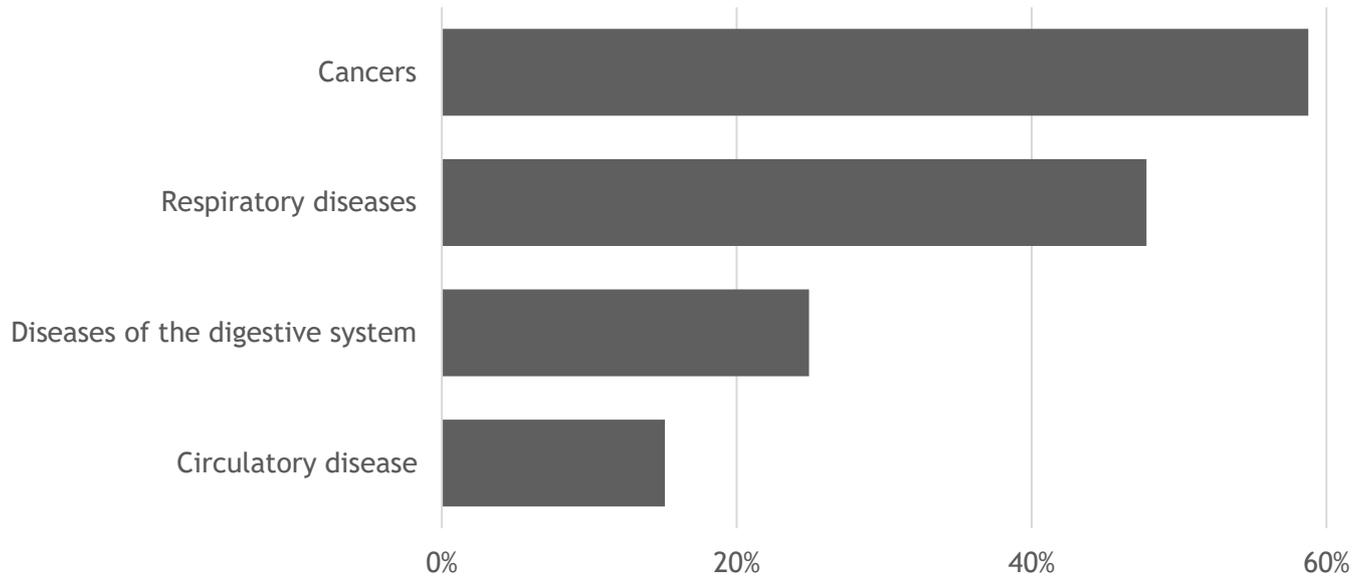
Around two-fifths (41 per cent) of male admissions for conditions that can be caused by smoking were attributable to smoking in 2016. This compares to around one in four (26 per cent) of female admissions.

Further comparisons of smoking attributable hospital admissions data for Jersey to data published for England by Public Health England can be found in Appendix 1.

Smoking quitters

This section contains information on the proportion of smokers who report wanting to quit smoking alongside information about use of the stop smoking service in Jersey.

Help2Quit is a free and confidential stop smoking service delivered by local pharmacies on behalf of the States of Jersey Health and Social Services Department alongside a specialist service which provides support for secondary care, pregnant women, mental health patients and people with long term health conditions. The service offers free information, support and nicotine replacement therapy. The support is designed to be widely accessible within the local community and is provided by trained pharmacy advisors, whilst the specialist service is provided by specialist stop smoking nurses.

Smoking quitters 2017

Help2Quit Break free from smoking

Over 800 people set a quit date through the stop smoking service in 2017

350 people successfully quit, a quit rate of 42% ✓

Wanting to quit smoking

In 2016, the most recently available data, over half of smokers (56 per cent) reported having wanted to quit smoking in the past year. This proportion represented a reduction compared to two years previously, when around two-thirds (67 per cent) had responded to JASS 2014 to say they had wanted to quit in the previous year. There was no difference between the genders in 2016, a change to results for 2014, which showed a higher proportion of females wanting to quit compared to males (75 per cent compared to 60 per cent, respectively).

Use of the stop smoking service

In 2017

- 850 people set a quit date through the stop smoking service in Jersey, a decrease on the previous year of 17 per cent

- 350 people successfully quit,[29] representing a quit rate of 42 per cent, similar to the average for the past five years

- more than 20 pregnant women used the service in 2017; about a third of them quit successfully. The number of pregnant women using the service has been between 20 and 30 each year since 2014; around a third of those pregnant women using the service successfully quit

- around two-thirds (64 per cent) of those reporting having a mental health condition[30] were seen by the specialist service, whilst the remaining 36 per cent were seen in a pharmacy

- one in four (25 per cent) of those using the service were classified as working in routine or manual occupations (around 200 people in 2017), around two-fifths of these (41 per cent) had successfully quit at 4 weeks

- almost half (46 per cent) of those setting a quit date with the service were in private rental accommodation, whilst another quarter (25 per cent) were in social housing and one in six (17 per cent) were in owner-occupied accommodation

Figure 15 shows the number of people using each provider of the Help2Quit service, pharmacies or the specialist service, and the respective number of people successfully quitting.

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[29] Defined by the UK Department of Health as a 'self-reported 4-week quitter' when assessed four weeks after the designated quit data, if they declare that they have not smoked, even a single puff on a cigarette, in the past 2 weeks. This definition of a successful quitter is used throughout this section.
[30] Medical conditions are recorded during the initial assessment with clients; clients are asked whether they have any medical conditions or are taking any medication

Figure 15: Number of people using the Help2Quit service and number successfully quit at 4 weeks, by provider, 2013-2017
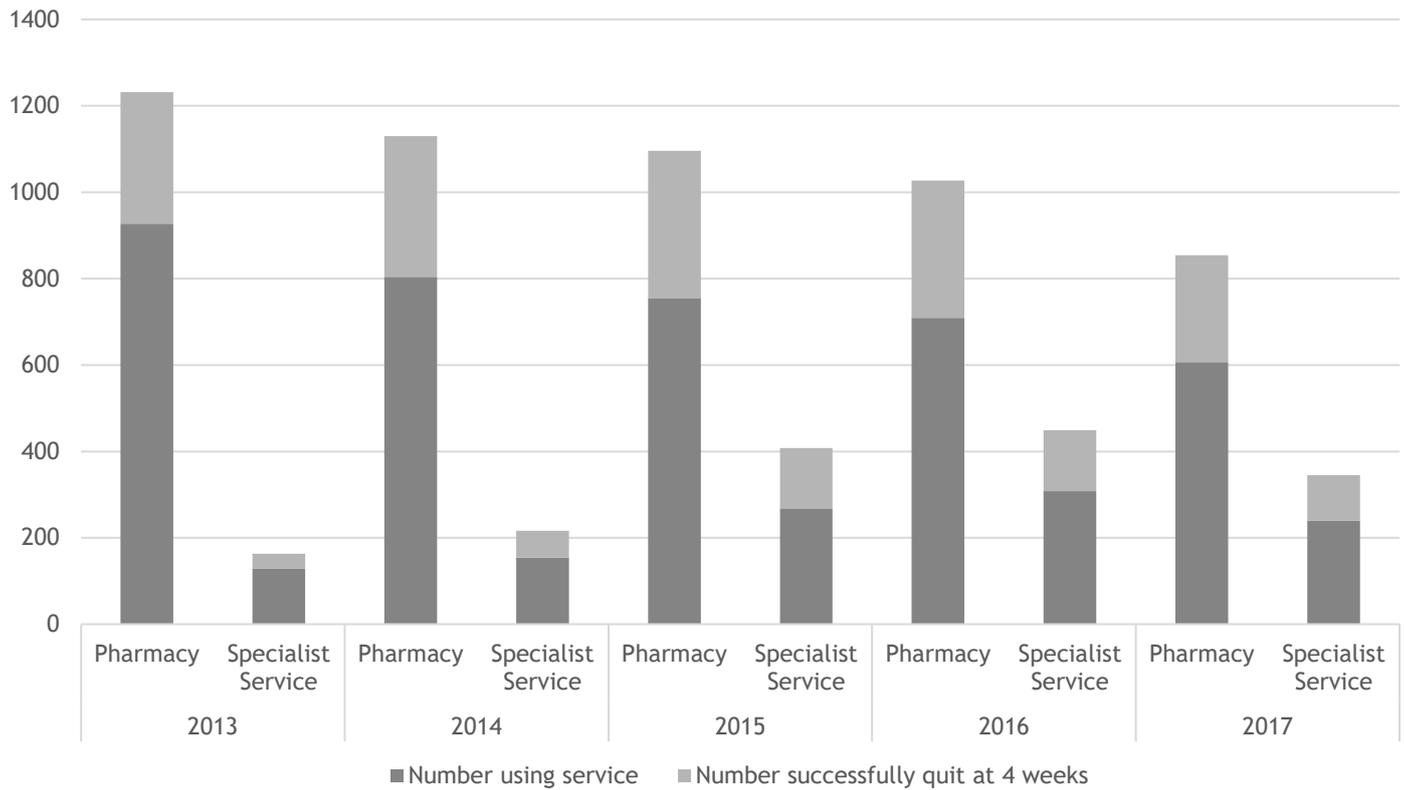
Source: Help2Quit service

Table A4 and Figure A4 in Appendix 1 show the comparison of Jersey data for stop smoking services compared to PHE data for England. NHS Digital[31] report an overall decrease in the number of quit attempts at stop smoking services in England since 2012, which they suggest may be due to an increase in people using e-cigarette to help them stop smoking rather than making use of services. A decline in the number of quit attempts made through the Jersey Help2Quit Service has been seen over the same period.

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[31] NHS Digital, Statistics on Smoking: England 2017, published 15 June 2017, available from www.digital.nhs.uk

Availability and prices of tobacco

Tobacco imports

Since 2006, the quantity of tobacco imported into the Island has fallen from 68,300 kilograms to 38,900 kilograms in 2016, a reduction of more than two-fifths (43 per cent).

Figure 16: Annual Quantity of tobacco imported, thousands of kilograms, 2006-2016
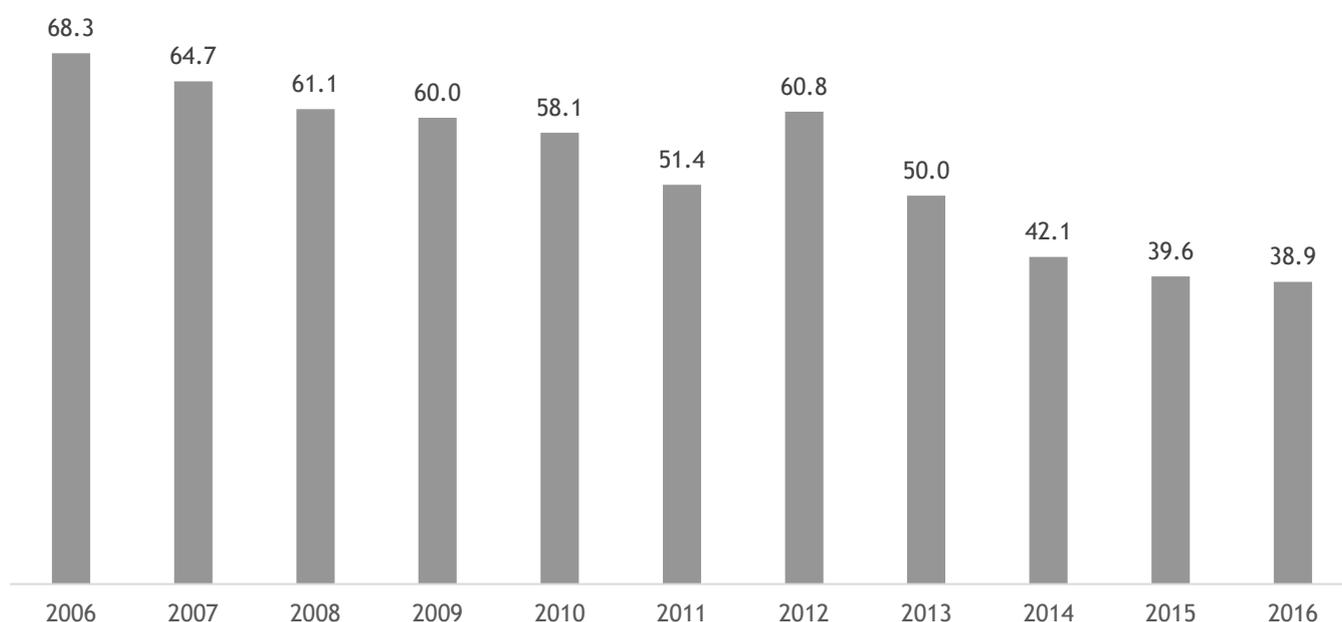
Source: Data provided by States of Jersey Customs and Immigration Service

Retail prices

Data compiled by Statistics Jersey enables analysis of the price of tobacco over time. Three indices are considered here:

- the all-items Retail Price Index (RPI) – the main inflation measure in Jersey, compiled using a representative 'basket' of over 500 separate goods and services
- Tobacco Price Index (TPI) – the group level index of the RPI relating to a 'basket of tobacco products' priced by Statistics Jersey and gives a representative measure of the price of tobacco
- Relative Tobacco Price Index – defined as TPI/RPI and provides an indicator of how the average cost of tobacco has changed in relation to prices overall

Between June 2000 and December 2017, retail prices increased by 69 per cent (RPI 169), while the price of tobacco almost tripled (TPI 311). The relative tobacco price index shows that tobacco prices have increased at almost twice the rate of retail prices more generally (TPI/RPI 184) since 2000.

Figure 17 shows the rate of increase in the price of tobacco, relative to retail prices more generally since 2000.

Figure 17: Relative tobacco price index: 2000 to 2017
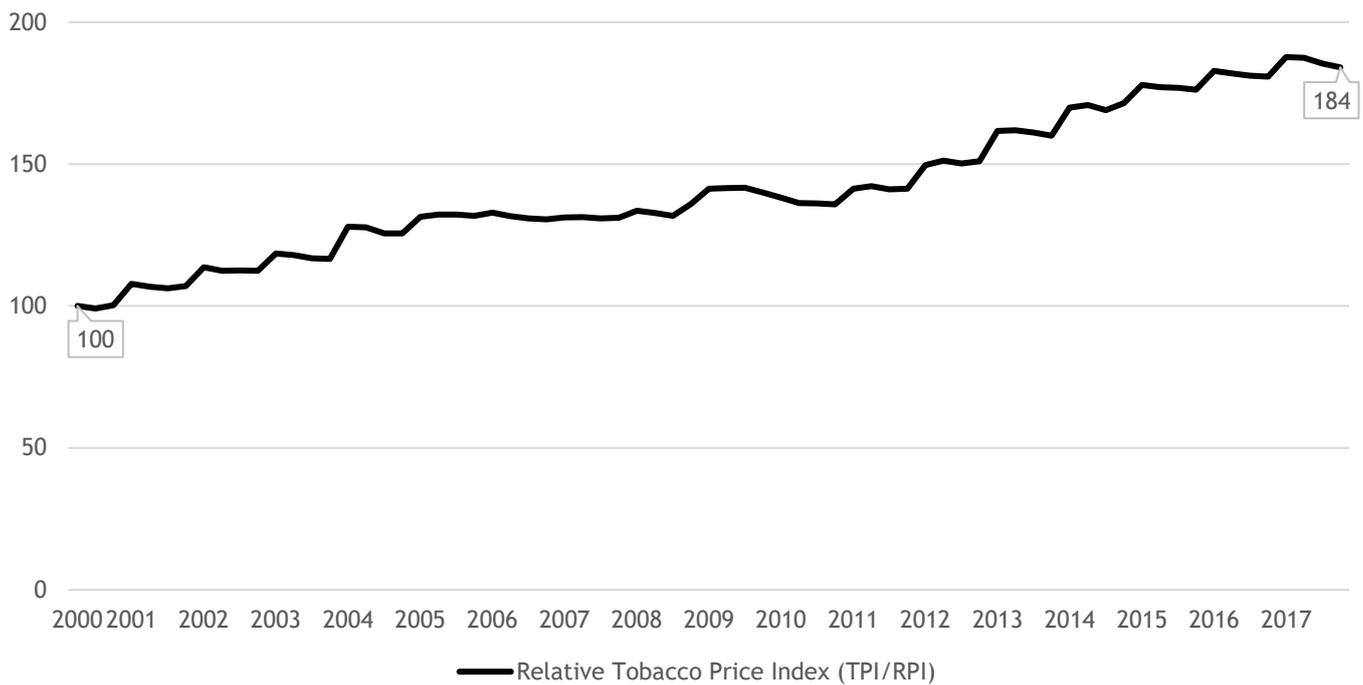
Household Expenditure

Statistics Jersey run a Household Spending and Income Survey (HSIS) approximately every five years. The most recent round of the survey ran for twelve months from April 2014 to April 2015. For more information on household spending, see Statistics Jersey's report *Jersey Household Spending Survey 2014/15*[32] available from www.gov.je

Household expenditure on tobacco

Jersey households spent, on average, almost **£5 a week** on tobacco

Households in the highest income quintile spent the least on tobacco

In 2014/2015, households[33] in Jersey spent an average of £4.80 per week on tobacco, accounting for less than 1 per cent of average total household expenditure.

Household expenditure by income and tenure

Differences in expenditure were seen by household income quintile[34] (equivalised), with households in the lowest two quintiles spending the most on tobacco products (Figure 17).
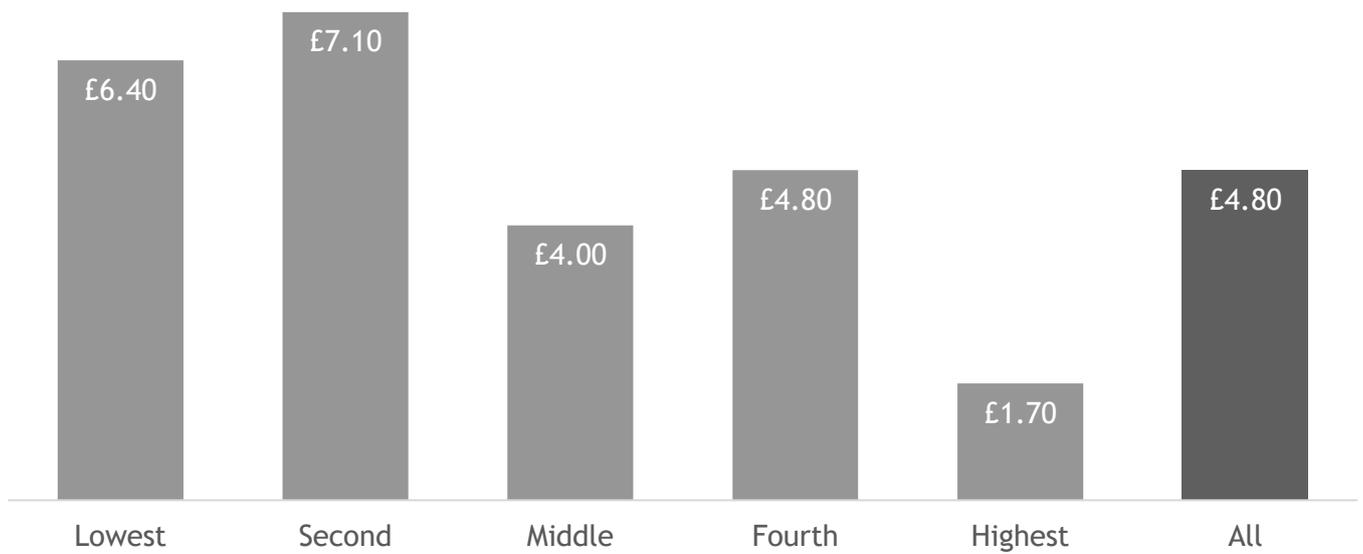
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[32] States of Jersey Statistics Unit, Jersey Household spending 2014/15, published 27 May 2016, available from www.gov.je
[33] Across all households, whether they include smokers or not
[34] If every household were ordered according to its income, from the lowest to highest, the first 20 per cent of households represent the "first income quintile" of households – i.e. those households which have the lowest income. The second income quintile is the next 20 per cent of households, and so on up to the fifth income quintile, which corresponds to the 20 per cent of households with the highest income.
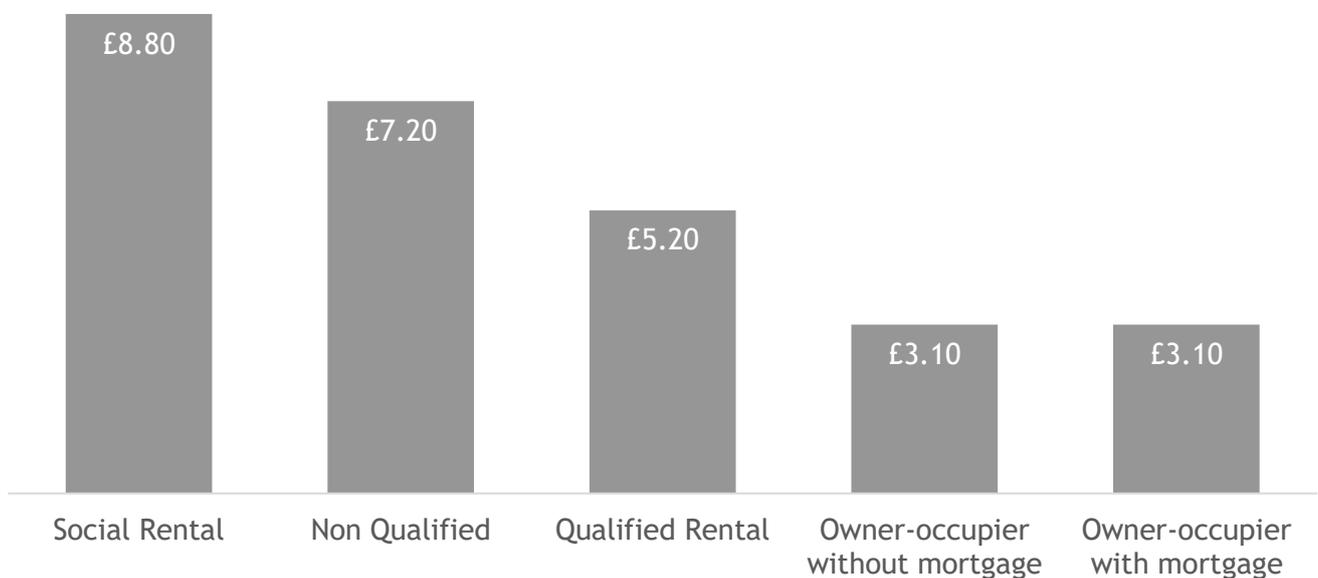
Figure 17: Expenditure per week on tobacco by equivalised income quintile

Bar chart showing expenditure per week on tobacco:
- Lowest: £6.40
- Second: £7.10
- Middle: £4.00
- Fourth: £4.80
- Highest: £1.70
- All: £4.80

Source: Jersey Household Spending Survey 2014/15

Expenditure on tobacco varied by tenure, with those households in non-qualified accommodation and social rental accommodation spending more than twice as much as those living in owner-occupied accommodation (Figure 18).
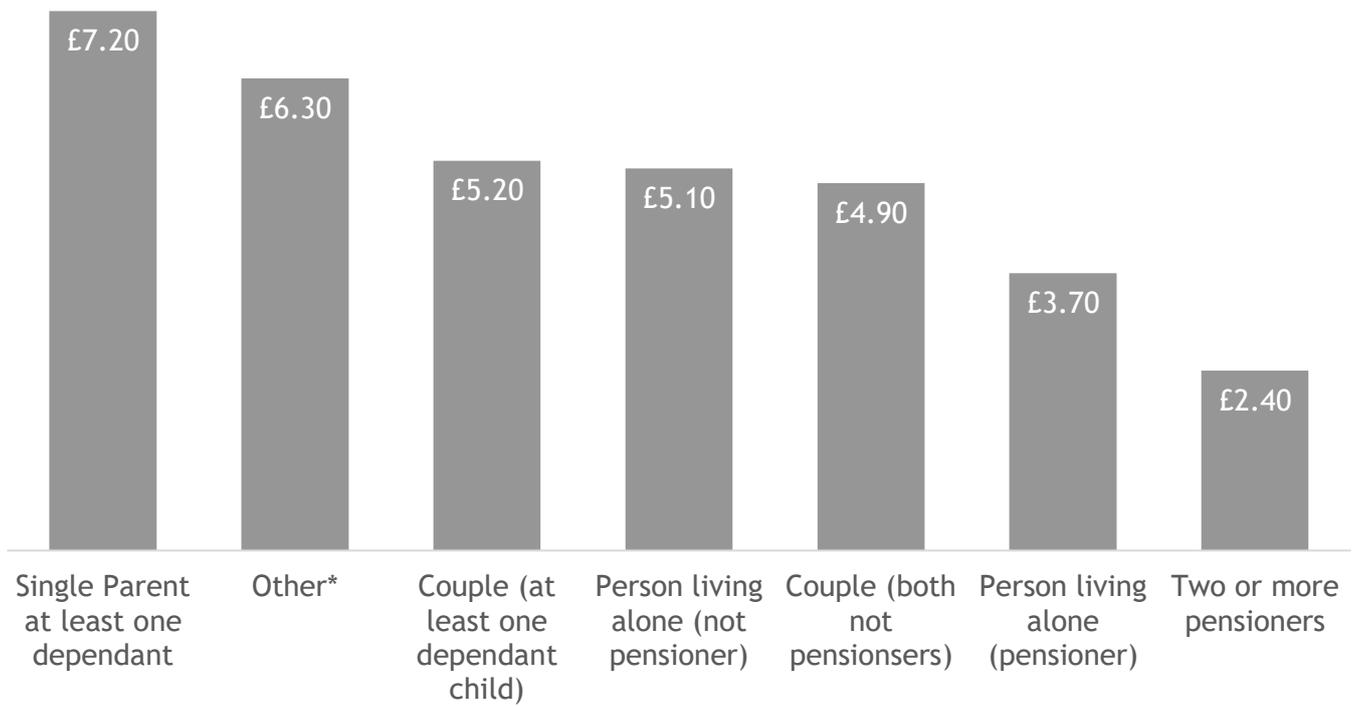
Figure 18: Expenditure per week on tobacco by household tenure

Bar chart showing expenditure per week on tobacco:
- Social Rental: £8.80
- Non Qualified: £7.20
- Qualified Rental: £5.20
- Owner-occupier without mortgage: £3.10
- Owner-occupier with mortgage: £3.10

Source: Jersey Household Spending Survey 2014/15

Figure 19 shows the distribution of expenditure on tobacco by household type. With the exception of households with 'other structures', single parents spent the most on tobacco on average per week.

Figure 19: Expenditure per week on tobacco by household type

Single Parent at least one dependant — £7.20; Other — £6.30; Couple (at least one dependant child) — £5.20; Person living alone (not pensioner) — £5.10; Couple (both not pensionsers) — £4.90; Person living alone (pensioner) — £3.70; Two or more pensioners — £2.40*

* Other household types including professional house-share, family with au pair, two-generation households
Source: Jersey Household Spending Survey 2014/15

Definitions and glossary of terms

Age standardised rates

An age standardised rate is the rate of events that would occur in a population with a standard age structure if that population were to experience the age-specific rates of the subject population (e.g. Jersey). The age groups used are 0 to 4, 5 to 9,…85 to 89, 90+ years. The 2013 European Standard Population has been used to calculate the standardised rates in this report. The same population is used for males, females and all persons and rates are expressed per 100,000 population.

Confidence Intervals

A confidence interval gives an indication of the likely statistical uncertainty around a value that has been calculated. A confidence interval indicates the range within which the true value for the population as a whole could be expected to lie, taking natural random variation into account. Confidence intervals should be considered when interpreting results.

Conditions

Acute – symptoms appear and change or worsen rapidly.

Chronic – develops and worsens over an extended period of time.

Crude Rates

A crude rate refers to the number of events per 1,000 or 100,000 population.

Help2Quit Service

Help2Quit is a free and confidential stop smoking service delivered by local pharmacies on behalf of the States of Jersey Health and Social Services Department alongside a specialist service that provides support for secondary care, pregnant women, mental health patients and people with long-term health conditions. The service offers free information, support and nicotine replacement therapy. The support is designed to be widely accessible within the local community and is provided by trained pharmacy advisors, whilst specialist stop smoking nurses provide the specialist service.

Smoking attributable deaths and diseases

Smoking attributable deaths and diseases are the sums over the smoking attributable fractions for all deaths and diseases. The fraction (between 0 and 1) of a death or disease that is considered to be due to smoking is based on: relative risk (specific for underlying cause of death or primary reason for admission, smoking status, age and sex) and estimated smoking and ex-smoking prevalence (by age and sex) derived from the Jersey Opinions and Lifestyle Survey. This statistical estimate of smoking deaths or ill health can then standardised against the 2013 European Standard Population to allow comparisons over time and place (see Appendix 1). For further information on the methodology, see www.digital.nhs.uk.

Background notes

Data sources

The following data sources have been used in this report:

- deaths data is compiled by Statistics Jersey from notifications and registrations reported by parish registrars to the Superintendent Registrar as required by the Marriage and Civil Status (Jersey) Law 2001. Coding of cause of deaths of Jersey residents is undertaken by the Office for National Statistics on a quarterly basis, classified using the International Statistical Classification of Diseases, Injuries and Causes of Death (tenth revision, ICD-10)

- data on births and passive smoking risk at 6-8 weeks of age was taken from the Child Health computer system. Statistics Jersey has access to the reporting system for statistical purposes. The system is administered by the Child Health Team who are part of the Health and Social Services Department Preventive Programmes Team

- the Jersey Opinions and Lifestyle Survey (JOLS) is a voluntary postal and internet survey run by Statistics Jersey. The survey is sent to more than 3,000 randomly selected households each year, and has a high response rate of around 46 per cent. Weighting techniques are used to compensate for different patterns of non-response from different sub-groups of the population. The result is that the survey results can be considered accurate and representative of Jersey's resident population. As with all sample surveys, there is an element of statistical uncertainty, typically around ±2.5 percentage points for proportions relating to the overall population. For further details, see www.gov.je/JOLS

- household expenditure on tobacco was taken from the Statistics Jersey report on the Jersey Household Spending Survey 2014/15, available from www.gov.je. A total of 1,278 randomly selected households took part in the survey, representing a response rate of 45 per cent. The survey spanned a twelve-month period to capture different spending patterns throughout the year, for example typically higher and different expenditure in the run-up to Christmas. Regular spending (e.g. housing costs, fuel and memberships) and infrequent purchases (e.g. furniture and vehicles) were collected through a face-to-face interview. In addition, each adult household member kept a spending diary for two weeks to capture day-to-day spending. More than 170,000 individual purchases were used to compile the spending report; for further information Jersey Household Spending Survey 2014/15 available from www.gov.je

- data on hospital admissions is taken from the hospital computer system TRAK which was implemented in June 2011. Admissions data are classified using ICD-10; each admission can have up to 20 diagnosis fields which provide the reasons why the patient was admitted to hospital. These diagnosis fields are used in the analysis of smoking attributable hospital admissions in this report

- data on the number of people currently living with chronic obstructive pulmonary disease (COPD) is collected from the General Practice Central Server (GPCS), a computer system introduced into all general practice (GP) surgeries in Jersey in 2013. Data taken from the GPCS are taken from specific disease registers, generated as part of the Jersey Quality Improvement Framework which incentivises GPs to accurately record patients that meet a set of disease-specific criteria as being on a particular disease register. As such, the quality of this data is deemed to be greater than those indicators and disease registers for which GPs are not incentivised to record
- the Retail Prices Index (RPI) and the group level data for tobacco products, as measured quarterly by Statistics Jersey, has been used to analyse changes in the price of tobacco in comparison to retail prices overall. The Tobacco Price Index, used to derive the relative tobacco price index, relates to a 'basket of tobacco products' and is used to measure the average change in price of tobacco bought by an average household in Jersey. For further information see www.gov.je/inflation

Comparisons

Comparisons to other jurisdictions are presented in this report to enable benchmarking and comparison with trends being seen elsewhere. Data is extracted from published reports from the Office for National Statistics, Public Health England, NHS Digital and Eurostat.

Timeliness

The data presented in this report refers to 2017 data or earlier periods if UK comparison data for 2017 is not currently available. Data on deaths in Jersey for 2017 was not available at time of publication therefore 2016 figures have been presented in this report. Hospital admission data for 2017 was not fully coded at time of publication; 2016 data has been used in this report.

Methods

Measures of mortality

Age-standardised rates have been calculated using the number of deaths occurring each year as the numerator and the mid-year population estimate for that year as the denominator. The rates have been standardised using the 2013 European Standard Population. The directly age-standardised rates adjust for differences in age and sex structures between populations to allow comparisons across time and place.

Annual mortality rates for Jersey are calculated using the average of the two corresponding end-year population estimates as published by Statistics Jersey. The resulting estimate of the mid-year population assumes that half of births, deaths and migration occurs in the first half of the calendar year.

Attributable fraction values are the proportion of a health condition or external cause that is attributable to the exposure of a specific risk factor (such as smoking) in a given population. Attributable fractions are used in this report to estimate the number of deaths and hospital admissions that are related to smoking. Fractions comprise relative risk factors, which are based on work by Callum and White in *Tobacco in London: The preventable* burden and Twigg, Moon and Walker in the report *The smoking epidemic: Deaths in 1995*, alongside the local prevalence of current and ex-smokers. The population attributable fraction calculation assumes a causal association between risk factor and outcome, meaning that the attributable fraction can also be viewed as the expected proportional reduction in cases of an outcome arising in the population as a result of removing the exposure, in this case, tobacco. For further information on the methodology, see www.nhsdigital.nhs.uk.

Accuracy and reliability

All figures have been independently rounded to the nearest integer. Percentages may not add up to 100 per cent due to rounding.

The data covers all deaths on- and off-Island of residents living in Jersey. A small number of inquests may still be outstanding for deaths occurring in calendar year 2016; therefore, numbers here should be treated as provisional. All death numbers have been independently rounded to the nearest 10, to reflect the provisional nature of these statistics at time of publication.

When the observed total number of deaths is fewer than 10, mortality rates are not calculated, as there are too few deaths to calculate directly standardised rates reliably.

Data recorded on the GP central server is reliant on GPs and practice staff to accurately record activity occurring in their individual practices. Statistics Jersey has access, through a data sharing agreement, to the central server to allow statistical information to be monitored. This information is anonymised and as a result the data cannot be interrogated to look for errors or duplicates; therefore, figures presented here should be treated with caution. The accuracy and reliability of this data is expected to improve as data is further shared and interrogated and as coding of the data improves.

Confidence intervals and statistical significance

Confidence intervals have been used in this report to compare Jersey mortality rates and hospital admission rates with those of England. Confidence intervals are a measure of the statistical precision of an estimate and show the range of uncertainty around the estimated figure. The confidence interval indicates the range within which the true value for the population as a whole can be expected to lie, taking natural random variation into account.

Comparisons between rates or over time have been tested to determine whether differences are likely to be statistically significant or the result of natural random variation. Only those differences deemed as statistically significant have been described in this report using terms such as 'increase', 'decrease', 'higher' or 'lower'.

Data quality and completeness

A quality assurance process includes checks on data completeness, comparison to previous year data, comparisons to previous data for the same cohorts and investigation of any large changes.

The data quality and completeness of data extracted from the GP central server cannot be assured; however, where variation between GP practices is identified, this is fed back to individual surgeries for further checks. Figures are also compared to previous year's figures and large changes are investigated.

The number of deaths may differ from previously published figures due to the inclusion of data from inquests which can take up to 18 months to complete and register. Data on deaths of Jersey residents that occur outside of the Island may also result in a delay in registering the death with the Superintendent Registrar. This means that total deaths in a given year should be treated as provisional.

Contact details

All enquiries and feedback should be directed to:

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Cyril Le Marquand House

St Helier

JE4 8QT

PublicHealthStatistics@gov.je

Appendix 1: Public Health England comparable indicators

Adult smoking indicators

Table A1: Adult smoking indicators (PHE measure)

Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/ lowest	England worst/ highest
Smoking prevalence in adults aged 18+ (percentage of population)							
Current smokers*	2016	19	(16, 21)	16	(15, 16)	7	24
Ex-smokers*	2016	35	(32, 37)	26	(26, 26)	36	11
Never smokers*	2016	47	(44, 50)	58	(58, 59)	73	48
Smoking prevalence in adults aged 18-64 in routine and manual occupations (percentage of population)							
Current smokers*	2016	21	(14, 27)	27	(26, 27)	8	36
Ex-smokers*	2016	42	(34, 50)	22	(21, 22)	31	6
Never smokers*	2016	37	(29,44)	52	(51, 52)	83	41

Source: Statistics Jersey and Public Health England
* A change to the question asked in the UK Annual Population survey in 2016 meant that those who smoke cigars or pipes are no longer classified as smokers

Figure A1: Adult smoking indicators (PHE measure)

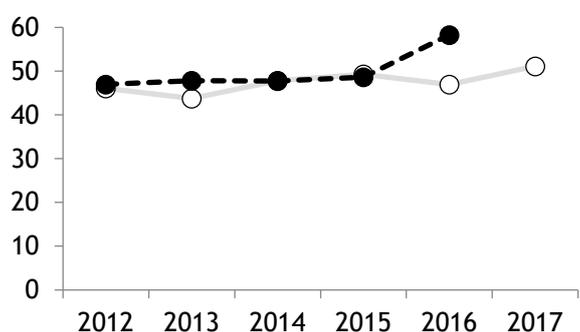### Smoking prevalence in adults aged 18+ (percentage of population)
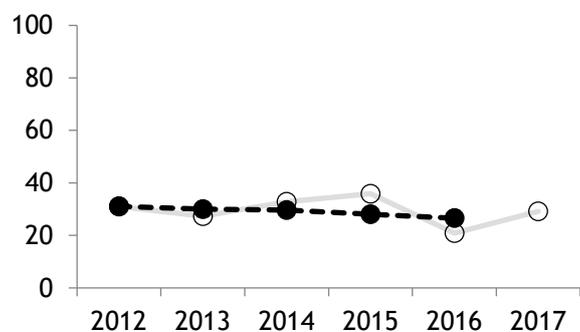
Current smokers*
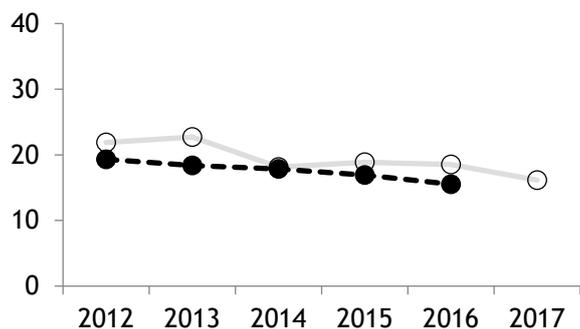
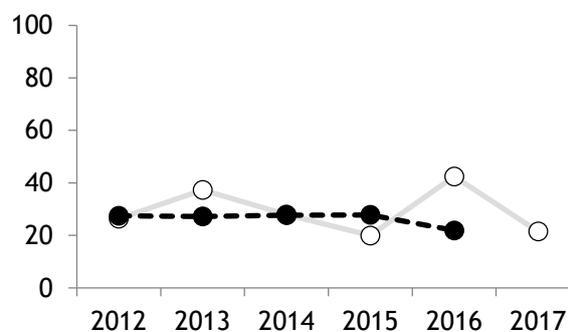**Ex-smokers***
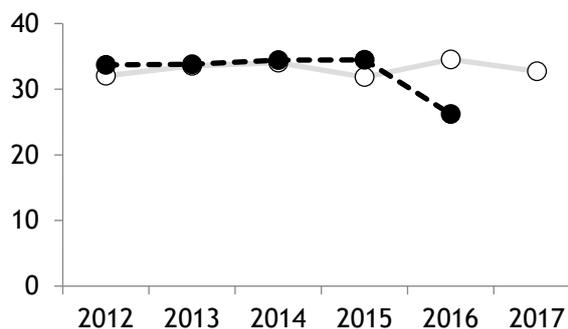
Never smokers*
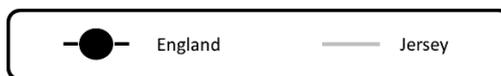
| | England | | Jersey |

Smoking prevalence in adults in routine and manual occupations (percentage of population)

Current smokers*

Ex-smokers*

Never smokers*
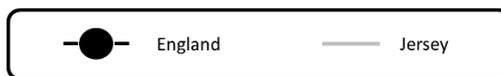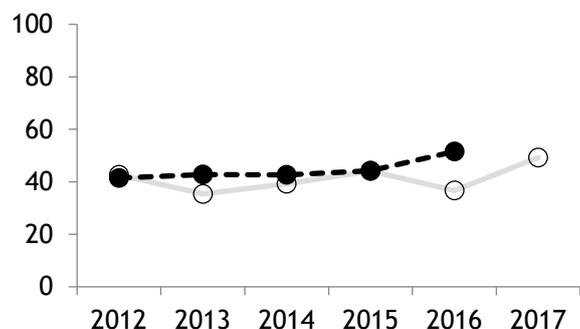
| | England | | Jersey |

Source: Statistics Jersey and Public Health England
* A change to the question asked in the UK Annual Population survey in 2016 meant that those who smoke cigars or pipes are no longer classified as smokers

Smoking related mortality indicators

The following indicators monitor the impact that smoking prevalence has on a population's health. Smoking is a known risk factor for stillbirth and neonatal mortality and the inclusion of these measures, alongside mortality rates from conditions known to be caused by smoking, help to monitor whether changes in smoking prevalence are having an impact on health related issues.

Table A2: Mortality indicators (PHE measure)

| Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/ lowest	England worst/ highest
Smoking attributable mortality (age-standardised rate per 100,000 population aged 35+)							
All persons	2014-16	266	(225, 310)	272	(271, 273)	163	499
Smoking attributable deaths from heart disease (age-standardised rate per 100,000 population aged 35+)							
All persons	2014-16	20	(2, 42)	26.5	(26, 27)	16	59
Smoking attributable deaths from stroke (age-standardised rate per 100,000 population aged 35+)							
All persons	2014-2016	7	(-6, 25)	9	(9, 9)	4	19
Deaths from lung cancer (age-standardised rate per 100,000 population)							
All persons	2014-2016	65	(55, 75)	58	(57, 58)	33	110
Deaths from oral cancer (age-standardised rate per 100,000 population)							
All persons	2014-2016	7	(5, 12)	5	(4, 5)	2	9
Deaths from chronic obstructive pulmonary disease (age-standardised rate per 100,000 population)							
All persons	2014-2016	46	(38, 55)	52	(52, 53)	29	102
Still birth rate (foetal deaths occurring after 24 weeks gestation per 1,000 births)							
All persons	2014-2016	2	(1, 4)	4	(4, 5)	2	8
Neonatal mortality rate (number of deaths under 28 days per 1,000 live births)							
All persons	2014-2016	-	-	3	(3, 3)	1	6

Source: Statistics Jersey and Public Health England
- Where counts of neonatal deaths are less than three, the rate is not calculated for this indicator
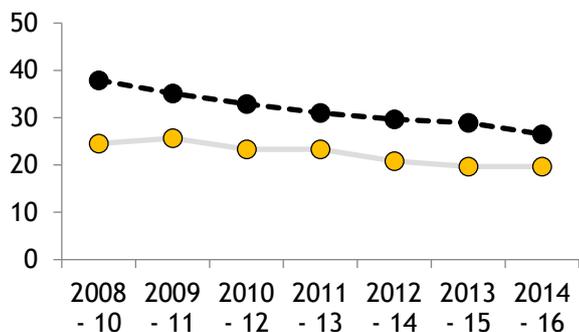
Figure A2: Mortality indicators (PHE measure)

Smoking attributable mortality (age-standardised rate per 100,000 population aged 35+)
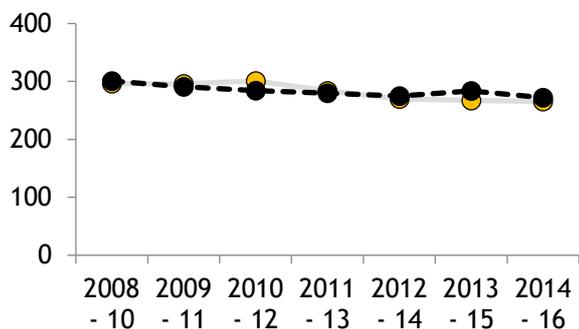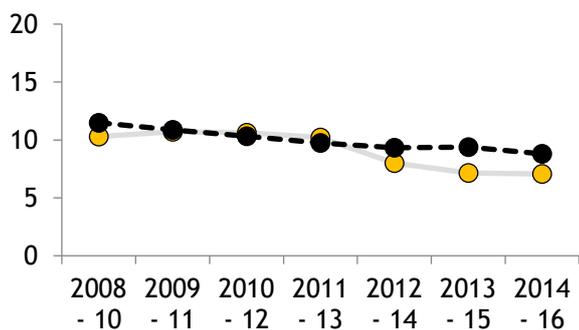
All persons

Smoking attributable deaths from heart disease (age-standardised rate per 100,000 population aged 35+)
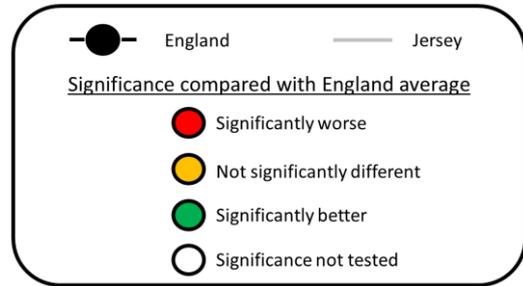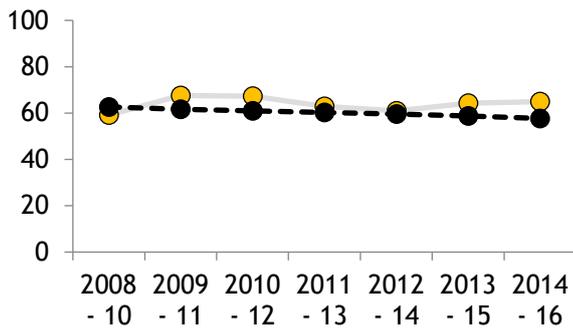
All persons

Smoking attributable deaths from stroke (age-standardised rate per 100,000 population aged 35+)
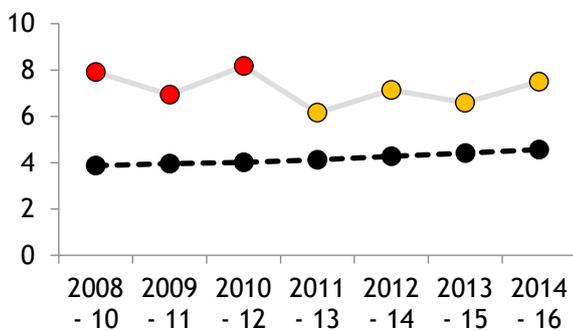
All persons

Deaths from lung cancer (age-standardised rate per 100,000 population)
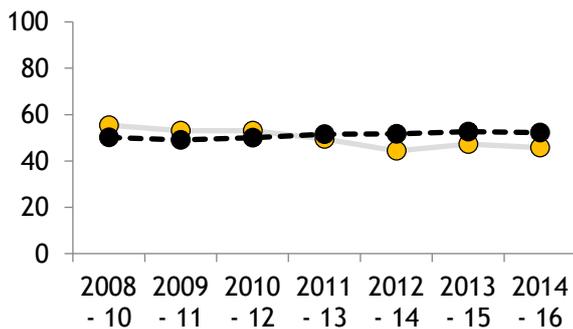
All persons

Deaths from oral cancer (age-standardised rate per 100,000 population)
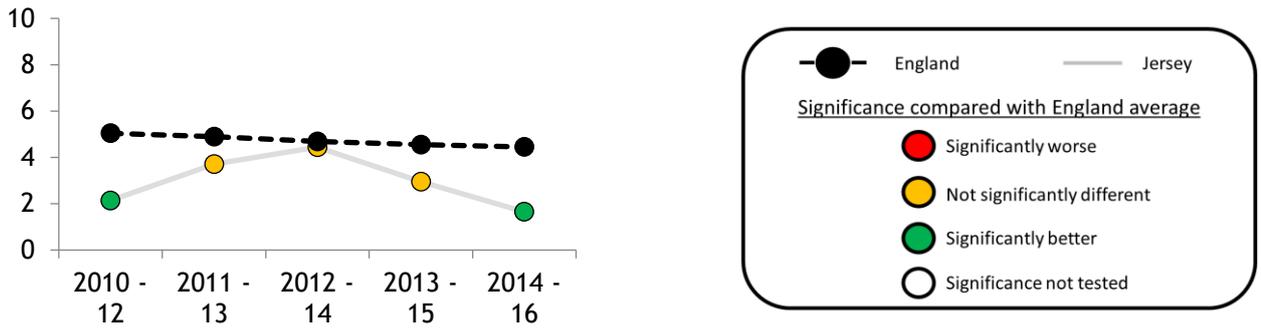
All persons

Deaths from chronic obstructive pulmonary disease (age-standardised rate per 100,000 population)
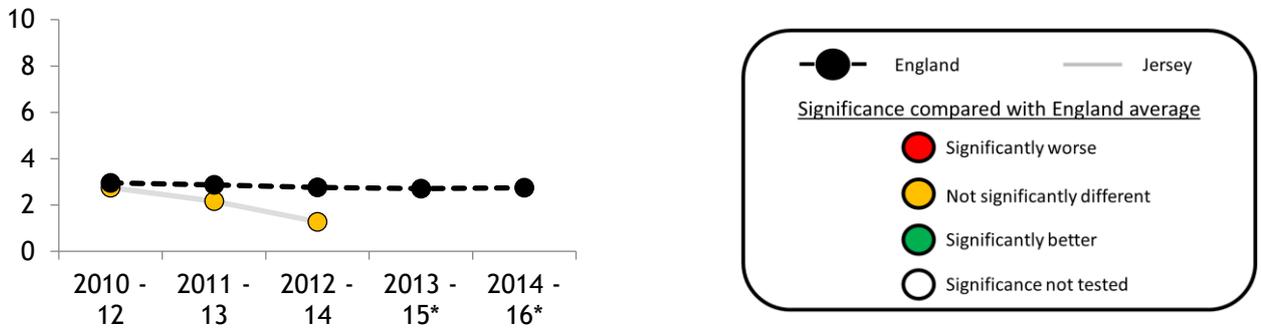
All persons

Still birth rate (foetal deaths occurring after 24 weeks gestation per 1,000 births)

All persons

Neonatal mortality rate (number of deaths under 28 days per 1,000 live births)

All persons

Source: Statistics Jersey and Public Health England
*Where counts of neonatal deaths are less than three, the rate is not calculated for this indicator

Smoking related ill health indicators

The following indicators monitor the impact that smoking prevalence has on a population's health. Smoking is a known risk factor for premature birth and low-birth weight at full term and the inclusion of these measures, alongside hospital admissions attributable to smoking, help to monitor whether changes in smoking prevalence are having an impact on health related issues.

Table A3: Smoking related ill health indicators (PHE measures)

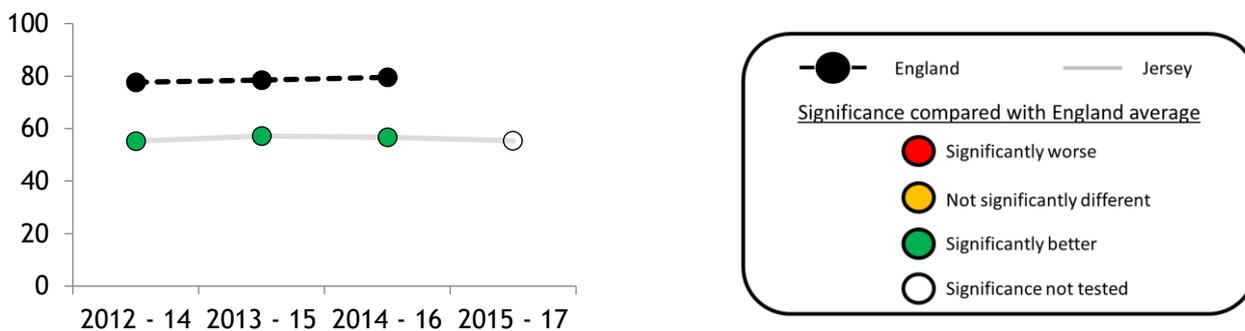| Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/ lowest	England worst/ highest
Premature births (less than 37 weeks gestation) and still births per 1,000 live and still births							
All persons	2014-16	57	(49, 66)	80	(79, 80)	62	110
Low birth weight of term babies (percentage of all live births at term with low birth weight)							
All persons	2016	3	(2, 4)	3	(3, 3)	1	5
Hospital admissions for asthma (under 19 years)							
All persons	2016*	331	(262, 418)	203	(200, 205)	64	498
Smoking attributable hospital admissions (age-standardised rate in people over aged 35 or over)							
All persons	2016*	1460	(1295, 1633)	1685	(1,680, 1,690)	969	3116

Source: Statistics Jersey and Public Health England
*Jersey data is for calendar years, whereas Public Health England data is for financial years

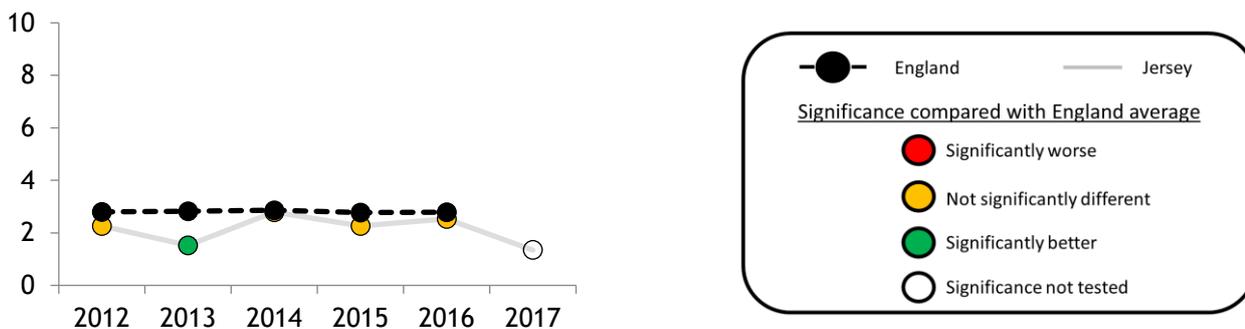# Figure A3: Smoking related ill health indicators (PHE measures)

Premature births (less than 37 weeks gestation) and still births per 1,000 live and still births
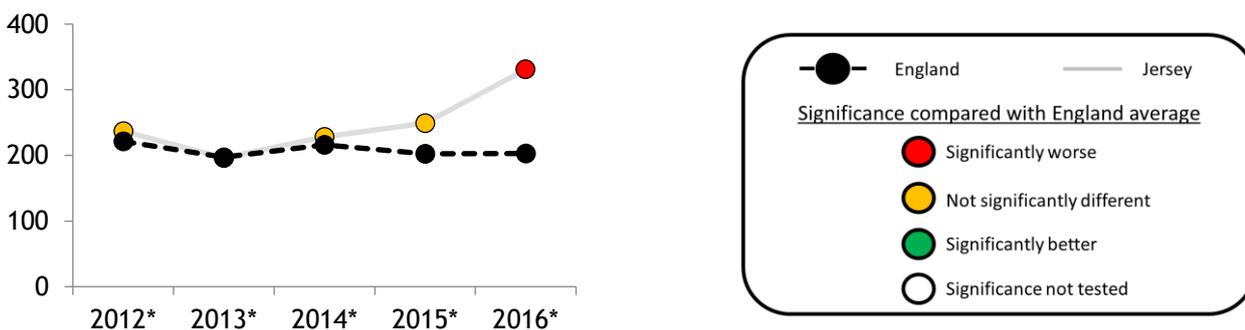
All persons

Legend:
- England
- Jersey
- Significance compared with England average
  - Significantly worse
  - Not significantly different
  - Significantly better
  - Significance not tested

Low birth weight of term babies (percentage of all live births at term with low birth weight)

All persons

Legend:
- England
- Jersey
- Significance compared with England average
  - Significantly worse
  - Not significantly different
  - Significantly better
  - Significance not tested

Hospital admissions for asthma (under 19 years)

All persons

Legend:
- England
- Jersey
- Significance compared with England average
  - Significantly worse
  - Not significantly different
  - Significantly better
  - Significance not tested

Smoking attributable hospital admissions (age-standardised rate in people over aged 35 or over)

All persons

Legend:

England ⚫---   Jersey ———

Significance compared with England average

🔴 Significantly worse

🟡 Not significantly different

🟢 Significantly better

⚪ Significance not tested
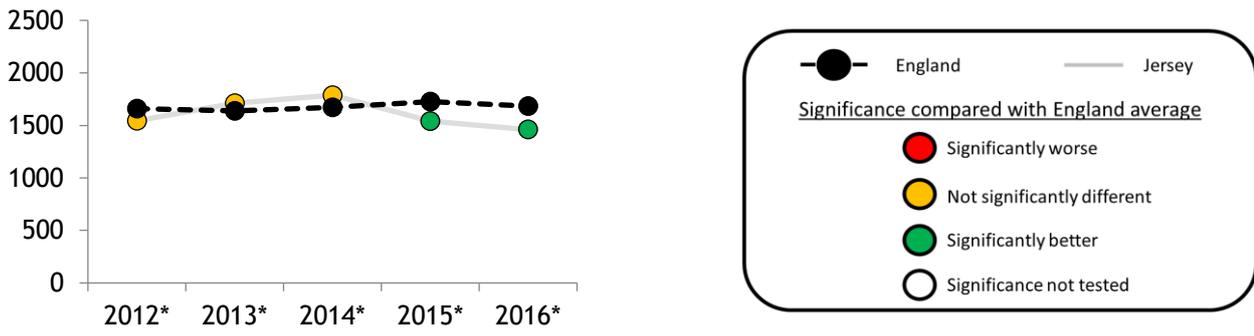
Source: Statistics Jersey and Public Health England
*Jersey data is for calendar years, whereas Public Health England data is for financial years

Table A4: Smoking quitters indicators (PHE measures)

Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best	England worst
Number setting a quit date per 100,000 smokers							
All persons	2016/17	6,235	-	4,434	-	11,248	119
Successful quitters at 4 weeks per 100,000 smokers							
All persons	2016/17	2,664	-	2,248	-	5,529	36
Successful quitters (CO validated) at 4 weeks per 100,000 smokers							
All persons	2016/17	2,207	-	1,627	-	4,246	23
Completeness of NS-SEC recording by stop smoking services (percentage)							
All persons	2016/17	96	-	91	-	100	12

NS-SEC is the National Statistics Socio-economic Classification – the official socio-economic classification used in the UK
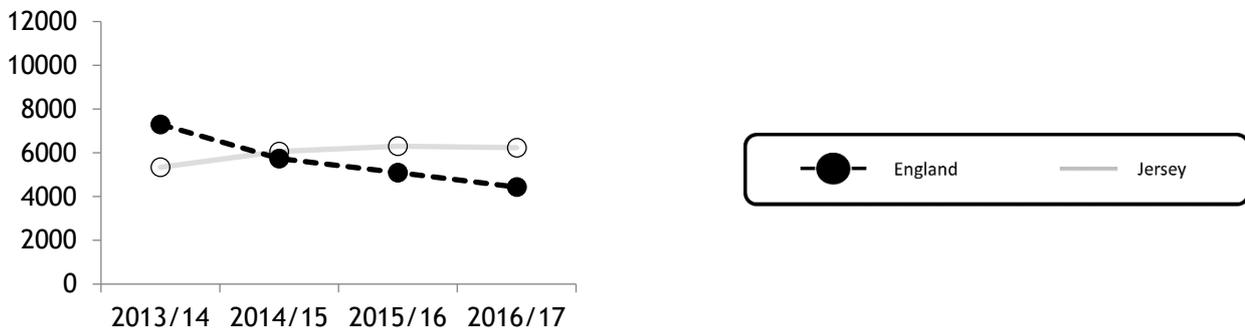*Source: Statistics Jersey and Public Health England*
- Confidence intervals not available for these indicators due to PHE concerns about the methodology used

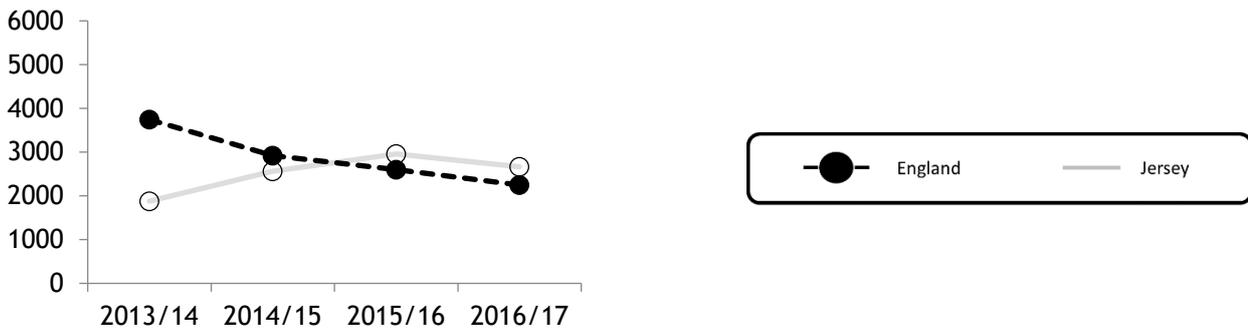# Figure A4: Smoking quitters indicators (PHE measures)

Number setting a quit date per 100,000 smokers
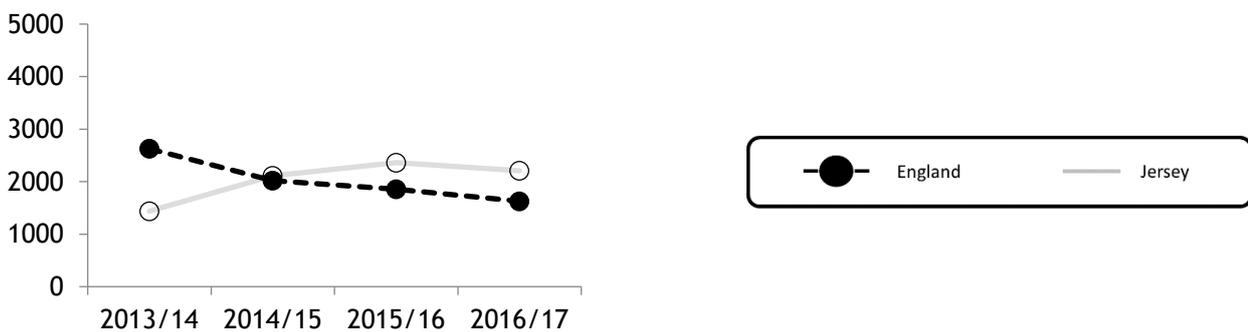
All persons

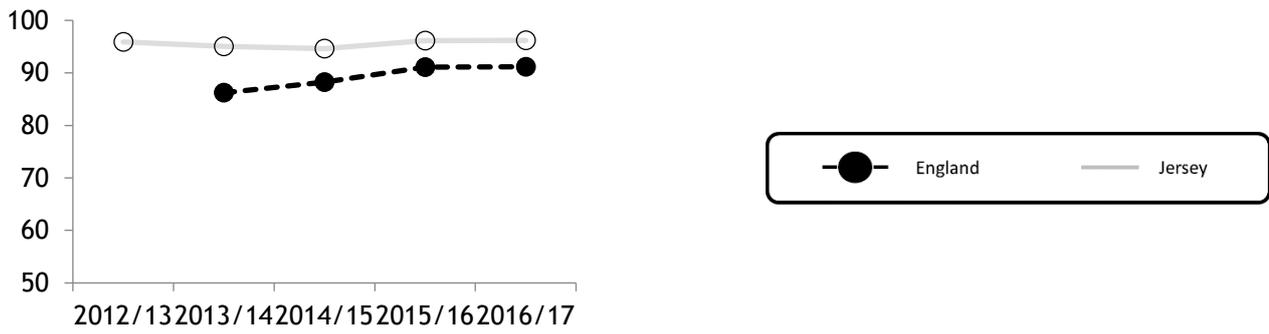## Successful quitters at 4 weeks per 100,000 smokers

All persons

Successful quitters (CO validated) at 4 weeks per 100,000 smokers

All persons

Completeness of NS-SEC recording by stop smoking services (percentage)

All persons

NS-SEC is the National Statistics Socio-economic Classification – the official socio-economic classification used in the UK
Source: Statistics Jersey and Public Health England
Note: confidence intervals not available for these indicators due to PHE concerns about the methodology used