States of Jersey

The States of Jersey Department for
Health & Social Services

Jersey Smoking Profile 2015

Health Intelligence Unit, February 2016

HIU INFORMATION READER

Document purpose	Report on Smoking indicators for Jersey in 2015

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Author	Health Intelligence Unit
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Target audience	Public
Pre-circulation list	States of Jersey Statistics Unit, States of Jersey Fire and Rescue Service, HSSD, Superintendent Registrar, States of Jersey Prison Service
Description	Biennial report on tobacco use and its consequences for Islanders in Jersey for 2015. Information on consumption and patterns of smoking, hospital admissions and deaths as well as other key smoking-related health indicators are presented.
Data Sources	Jersey General Hospital, States of Jersey Statistics Unit, States of Jersey Fire and Rescue Service, Superintendent registrar and States of Jersey Prison Service and Parish of St Helier Municipal Services.
Date that data are acquired	Data extracted in November for the previous calendar year. Comparison data takes some 18 months to be published, so to ensure like for like comparisons are presented, temporal data is provided for ease.
Frequency	Biennial
Relevance and key uses of the statistics	Making information publically available for planning, epidemiology, provision of services and to provide comparative information. To respond to information requests for a variety of customers e.g. researchers, charities, public companies, Freedom of Information requests. To provide information to support answers to Ministerial Questions and support public health interventions.
Accuracy	Information received by Public Health is clerically checked, with additional validation on data entry. Data is also compared to previous year's figures and data providers are asked to confirm reported figures are correct prior to publication.
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Officer	Amendment date and detail
M Clarke K Jervis	Data analysed and report compiled between November 2015 and January 2016 using data provided by other States of Jersey Departments as well as Public Health data. Report data checked against source data for errors and report proof checked.
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Jersey Smoking Profile 2015

Summary

This report presents statistics on the recent trends and epidemiology of tobacco use and its health costs in Jersey. Tobacco use has health and social consequences borne by individuals, their families and the wider community.

Data presented in this report are based on data provided by States of Jersey departments, survey data and data processed by Public Health. Detailed information on the nature of sources and data handling are given in the Background Notes section of this report.

Key findings:

The findings from the latest smoking profile for Jersey are:

- In 2015, nearly one in five (19 per cent) of adults aged 16 and over in Jersey were smokers, a rate that although slightly less than in 2012 and 2013, has remained largely unchanged in recent years, compared to one in four (25 per cent) a decade earlier in 2005.

- One in six pupils (aged 10-15 years) reported that they had tried smoking at least once. At 15 per cent, this is the lowest level recorded since the Jersey Schools Health survey began in 1998, when 47 per cent of pupils reported that they had tried smoking. The latest figure for Jersey is similar to the figure for England in 2014 (18 per cent).

- Between 2000 and 2014 the price of tobacco increased by 70 per cent more than retail prices generally.

- There were over 2,500 admissions to Jersey General Hospital for adults aged 35 and over with a primary diagnosis of a disease that can be caused by smoking in 2014. Around 1,000 admissions are estimated to be directly attributable to smoking. This is 4 per cent of all hospital admissions in this age group (35 years and over).

- In 2015, there was total of 306 new admissions to HMP La Moye (including repeat offenders), around four-fifths (83%) of admissions were recorded as smokers.

- In 2014, 19 per cent (132) of all deaths of adults aged 35 and over were estimated to be directly caused by smoking. This figure has remained at the same level over the past 7 years.

- Over 900 people set a quit date through the stop smoking service in Jersey in 2014-15. Almost 400 people successfully quit,[1] which gives a quit rate of 42 per cent, which is 7 percentage points higher than the previous year.

[1] As recorded at 4 weeks

Introduction

This report is the first report produced by the Public Health Directorate Health Intelligence Unit which examines the effects of tobacco on Islanders' health. It presents a range of information on smoking among adults and children, including its prevalence, habits, attitudes, prices and the effect on health in terms of hospital admissions and deaths from smoking related illnesses. The report contains both previously published information and new analysis.

A number of States of Jersey departments have provided data for this report, including the States of Jersey Statistics Unit, Health and Social Services Department, States of Jersey Prison Service and the States of Jersey Fire and Rescue Service. Discussions were also had with the St Helier Municipal Services Director about the impact of smoking on the town environment. Background notes provide more detail on the key data sources used for this report.

This report is primarily concerned with cigarette smoking unless otherwise specified. Comparisons in this report are to Public Health England, the Office for National Statistics and the Health and Social Care Information Centre publications. International comparisons on smoking prevalence are included in this report using data published by the Organisation for Economic Co-operation and Development (OECD) and the World Health Organisation.

In recent years, Jersey has introduced a number of laws designed to protect Islanders from the harm caused by smoking. These include the restrictions on smoking in public places in 2007, on displaying tobacco products in shops (introduced in 2014) and most recently, the restriction of smoking in cars carrying young people, introduced in September 2015.

Smoking definitions

Smoking definitions adopted by the main sources used in this report differ in some cases, especially between adults and children. 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 said that they do smoke, either daily or occasionally.

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

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

Never smoker: Adults who said that they have never smoked or don't smoke

Definitions of child smoking behaviours:

Regular smoker: is defined as a child who smokes at least one cigarette a week.

Occasional smoker: those children who said they smoke less than one cigarette per week.

Current smoker: These include those who are regular and occasional smokers.

Smoking patterns in Adults

The information presented in this chapter relates to the smoking patterns of local adults (aged 16 years and over). The main source of adult smoking information comes from the Jersey Annual Social Survey (JASS) which is carried out by the States of Jersey Statistics Unit. This is an annual survey covering adults aged 16 and over living in private households on the Island. For more details about this data source, please see the Background Notes section of this report. This chapter also includes information on the smoking patterns of prisoners on the Island provided by the States of Jersey Prison Service.

Trends in smoking prevalence

In 2015, nearly one in five (19 per cent) of adults aged 16 and over in Jersey were smokers. This rate, although slightly less than in 2012 and 2013, has remained largely unchanged in recent years, compared to one in four (25 per cent) a decade earlier in 2005 (Table 1 and Figure 1). This pattern is similar to that seen in Great Britain, with 19 per cent of the 16 and over population smoking in 2013 compared to 26 per cent in 2003.[2]

Table 1: Do you smoke? Percentage by year, 2005-2015, population 16 years and over

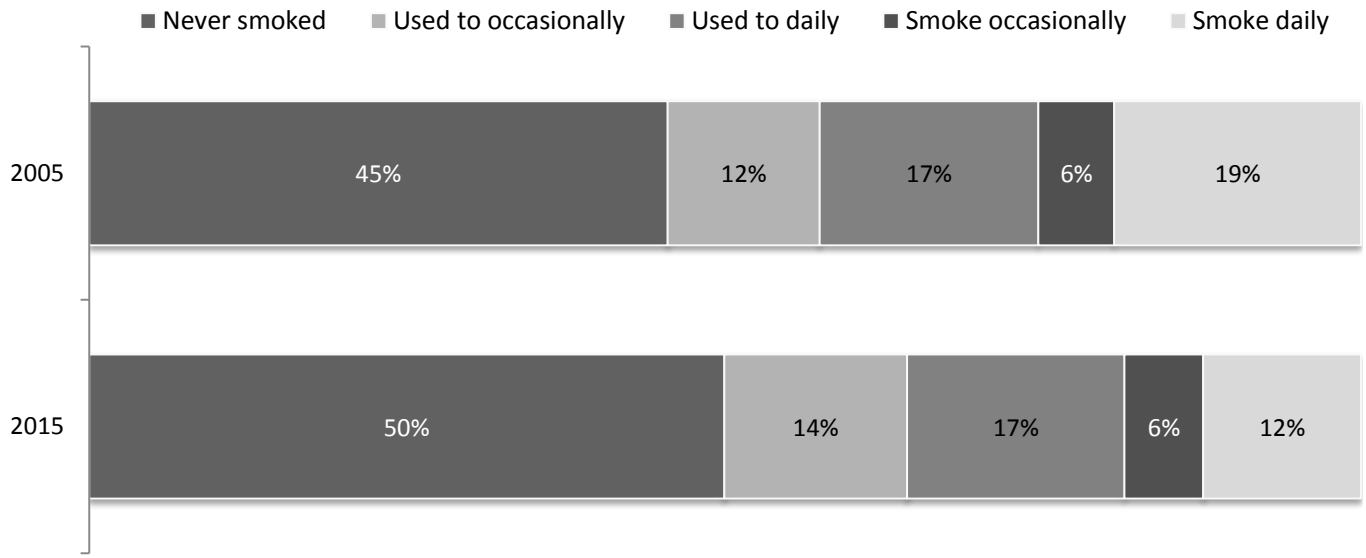
	2005	2007	2008	2010	2012	2013	2014	2015
I have never smoked / I don't smoke	45	48	48	47	46	44	48	50
I used to smoke occasionally but don't now	12	15	15	13	15	15	15	14
I used to smoke daily but don't now	17	17	16	17	17	18	19	17
I smoke occasionally but not everyday	6	6	5	8	6	6	5	6
I smoke daily	19	14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

Note: Numbers independently rounded to nearest integer
Source: JASS 2005-2015

The proportion of Islanders who report smoking daily has fallen from around one in five (19 per cent) in 2005 to around one in eight (12 per cent) in 2015. This is the lowest proportion of daily smokers recorded by the Jersey Annual Social Survey.

[2] Office for National Statistics, Adult smoking habits in Great Britain, 2013, published 25 November 2014, available from www.ons.gov.uk

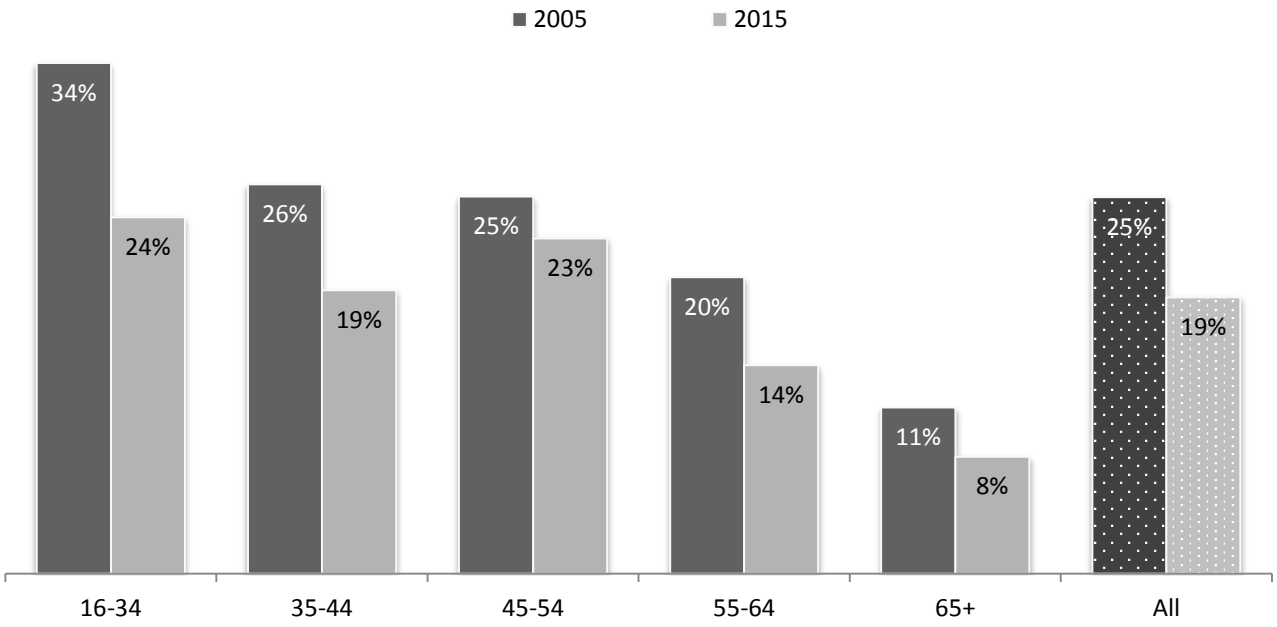
Figure 1: Smoking status, 2005 and 2015



Source: JASS 2005 and 2015

In 2005, the highest prevalence of cigarette smoking was seen in the youngest age group, with around one in three (34 per cent) of 16-34 year olds reporting smoking either daily or occasionally (Figure 2). A decade later, in 2015, the prevalence in this younger age group is lower and now similar to that of 45-54 year olds at around one in four (24 per cent of 16-34 year olds and 23 per cent of 45-54 year olds). The pattern of smoking prevalence by age in 2015 shows a decrease to the position a decade earlier with the youngest age group showing the largest drop. Those aged 65 and over reported the lowest prevalence of smokers at both time periods.

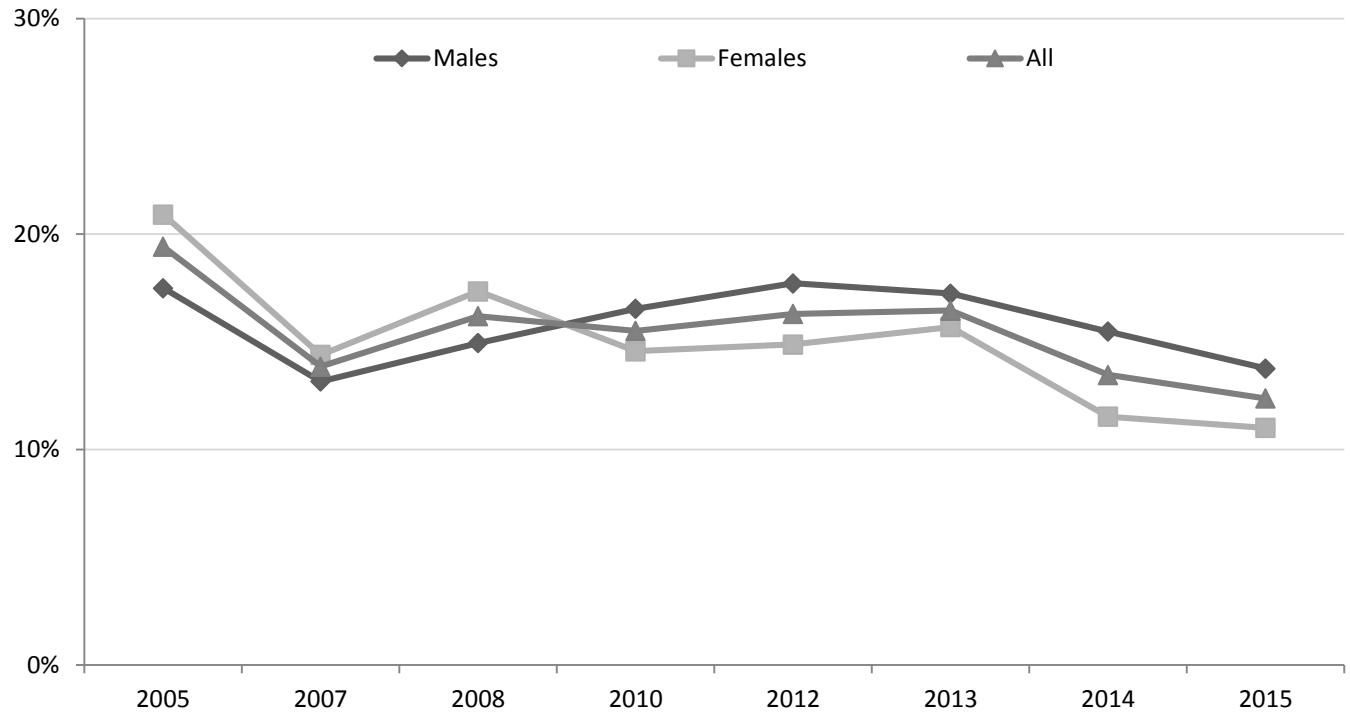
Figure 2: Prevalence of cigarette daily and occasional smoking among adults aged 16 and over in Jersey, by age group, 2005 and 2015



Source: JASS 2005 and 2015

Prevalence of daily and occasional smoking was higher for men (22 per cent) in 2015 than women (15 per cent). This compares to 23 per cent of men and 27 per cent of women in 2005. Figure 2 shows the trend of male and female daily smoking over the last decade.

Figure 3: Prevalence of daily smoking among adults aged 16 and over, by gender, 2005-2015



Source: JASS 2005-2015

Cigarette consumption

In 2014, daily smokers in Jersey consumed an average 13 cigarettes a day. The number of cigarettes smoked each day by female daily smokers has reduced slightly from 13 per day in 2012 to 11 per day on average (mean) in 2014, whilst the number smoked by men each day has remained essentially the same over the same period.

Current smokers in England smoked an average 12 cigarettes per day in 2013,[3] with men smoking 13 and women 11 on average. Men in Jersey smoked more than men in England reported in 2014 whilst Jersey women smoked the same as their English counterparts in 2014.

[3] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk

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

	2008	2010	2012	2014
Men	16	17	15	15
Women	13	14	13	11
All daily smokers	14	16	14	13

Source: JASS 2014

Smoking behaviour around babies

As part of the 6-week check of new-borns, babies are assessed as either being at risk of exposure to second-hand smoke exposure of not. In 2014, around 150 babies (16 per cent) were recorded as being at risk of passive smoking. That means that one in six of all babies born in 2014 were living in a household where they were likely to be exposed to tobacco smoke by an adult.

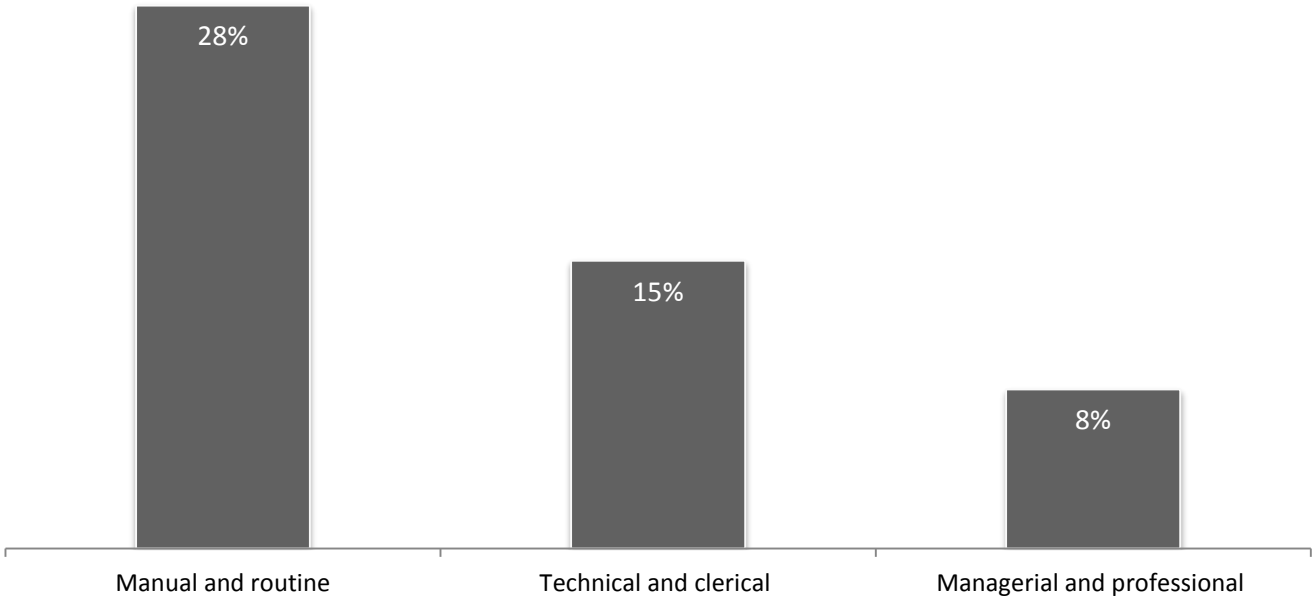
Smoking and socio-economic variables

JASS 2015 data can be used to look at differences in smoking patterns by socio-economic variables:

- The highest prevalence of daily smoking was among people working in manual and routine professions (28 per cent) while 15 per cent of those in technical and clerical professions reported daily smoking in 2015. Less than one in twelve of those working in managerial and professional occupations smoked daily (Figure 4).
- One in four (25 per cent) of those living in social housing smoke daily, while another 8 per cent smoke occasionally. Around one in six (15 per cent) of qualified and non-qualified renters smoke. This compares to 8 per cent of owner occupiers who report smoking daily.
- Over half (56 per cent) of those who are unable to work due to sickness report smoking (42 per cent daily and 13 per cent occasionally). Over a third (35 per cent) of respondents who were unemployed and looking for work smoke daily, while 13 per cent of workers smoke daily and 6 per cent of economically inactive[4] respondents smoke daily.
- Around one in six (15 per cent) of those with no formal qualifications report smoking daily, compared to 13 per cent of those education to secondary level and 8 per cent of those educated to a higher level who report smoking daily.

[4] Defined as retired, in education or homemakers

Figure 4: Proportion of daily smoking in Jersey, by occupation, 2015



Data source: JASS 2015

Smoking behaviours of prisoners

In 2015, there was a total of 306 new admissions to HMP La Moye (including repeat offenders), around four-fifths of admissions were recorded as being smokers. The level of smoking in the prison population at any time is estimated to be between 80-85 per cent.[5] In England, around 80 per cent of prisoners smoke, a 2014 survey of smoking in six prisons across Kent, Surrey and Sussex reported smoking rates of between 62 and 81 per cent.[6]

Locally, prisoners can apply to the in-house smoking cessation course where they are provided with four weeks of nicotine patches and tested weekly for their CO levels, with an option of a reduced program for a further four weeks if they are still not smoking. Prisoners are also able to purchase subsidised nicotine patches from the prison shop. The success rate of the current smoking cessation scheme is low (less than 5 per cent). However, work is ongoing to enhance the current service offered to prisoners through collaboration with the Help2Quit service.

[5] States of Jersey Prison Service
[6] 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

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 3.

Table 3: Smoking by Country, 2012-2015, all persons aged 18 and over, percentages

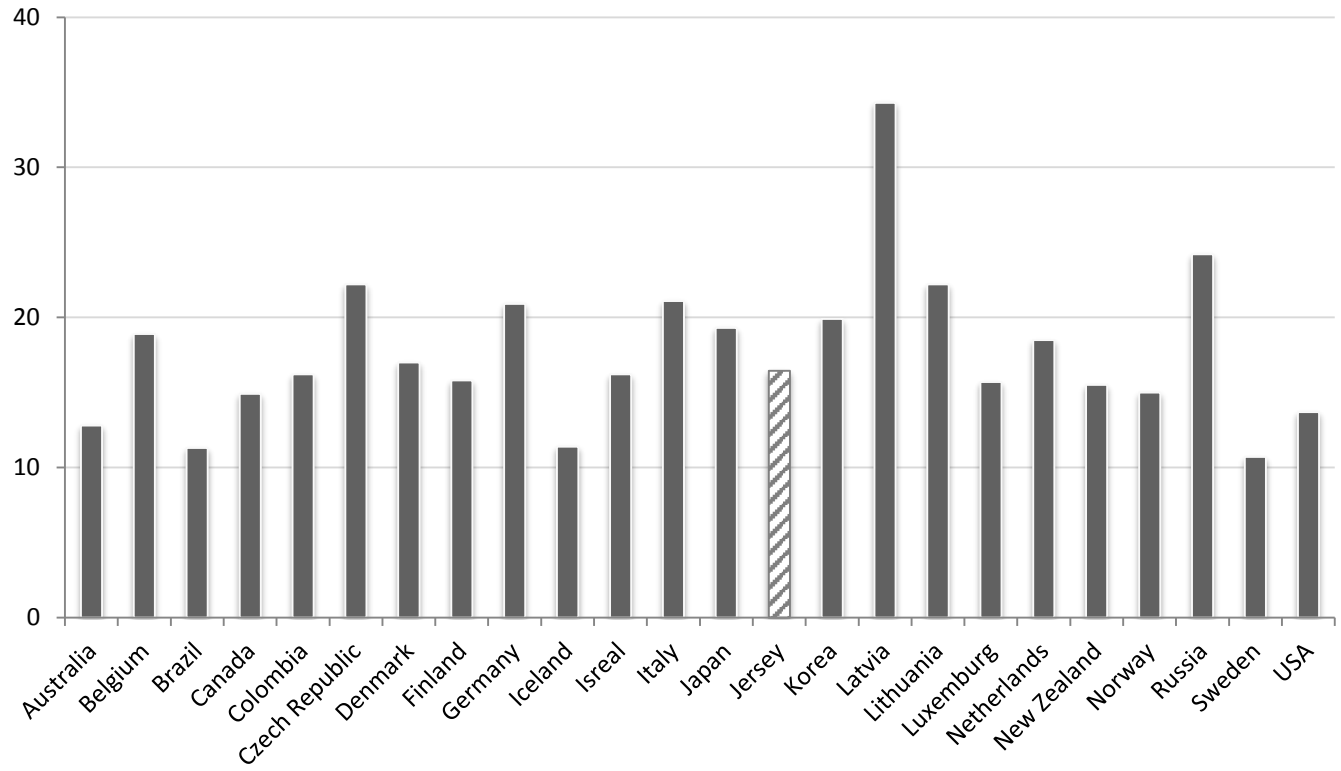
	England	Wales	Scotland	Northern Ireland	Jersey
2012	20	21	22	19	22
2013	18	20	21	19	23
2014	18	19	20	18	18
2015	-	-	-	-	19

Note: the term smoker refers to adults aged 18 and over who stated they currently smoke (daily and occasionally). Data for England, Wales, Scotland and Northern Ireland refers to cigarette smokers.
Source: States of Jersey Statistics Unit, Office for National Statistics[7]

The latest available data for those countries that are part of the Organisation for Economic Co-operation and Development (OECD) is for 2013.[8] Using contemporary Jersey data from JASS 2013 shows that daily smoking rates are similar to the average smoking rates, and well below the highest rate found in Latvia where 34 per cent of adults smoke daily (Figure 5).

[7] Office for National Statistics, Reference table 06: Cigarette smokers by country 2010-2014, published 1 October 2015, available from www.ons.gov.uk
[8] Organisation for Economic Co-operation and Development, Health risks Daily smokers (indicator), 2015, available from https://data.oecd.org/healthrisk/daily-smokers.htm

Figure 5: Daily smokers, percentage, 2013



Note: Data for OECD is for population aged 15+ whereas data for Jersey is for population aged 16+
Data source: OECD, JASS2013

Comparisons to Public Health England Indicators

Public Health England produce Local Tobacco Control Profiles for local authorities in England which provide information for local government, health organisations, commissioners and other agencies to monitor the impact of tobacco on local communities. They also allow for monitoring of services and initiatives that have been put in place to tackle tobacco related problems.

The indicators contained in the Public Health England profiles have been selected following consultations with stakeholders and after a review of the available routine data. Where Jersey has comparable information, the indicators have been produced and compared (Table 4 and Figure 6).

Table 4: Adult Smoking Indicators (PHE measures)

Indicator	Period	Jersey Value	Jersey 95% CI	Eng. Value	Eng. 95% CI	Eng. best	Eng. worst
Smoking prevalence in adults – current smokers	2014	18.1	(15.6, 20.6)	18.0	(17.8, 18.2)	9.8	26.9
Smoking prevalence in adults – ex-smokers	2014	34.0	(31.6, 36.4)	33.9	(33.7, 34.1)	44.2	14.4
Smoking prevalence in adults – never smoked	2014	47.8	(45.1, 50.2)	48.1	(47.9, 48.4)	65.0	38.1
Smoking prevalence in adults in routine and manual occupations – current smokers	2014	32	(25, 39)	28.0	(27.5, 28.4)	14.0	41.1
Smoking prevalence in adults in routine and manual occupations – ex-smokers	2014	28	(21, 35)	30.8	(30.4, 31.3)	40.9	12.7
Smoking prevalence in adults in routine and manual occupations – never smoked	2014	40	(32, 47)	41.2	(40.7, 41.7)	61.9	29.2

Source: Health Intelligence Unit, Public Health England

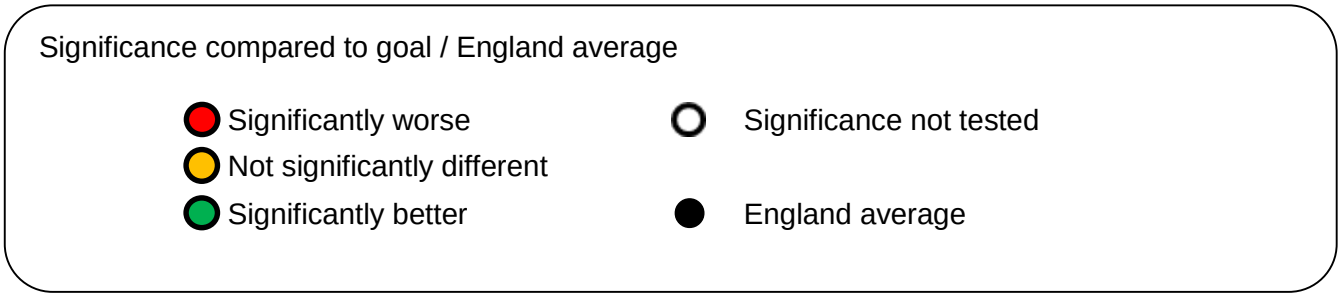
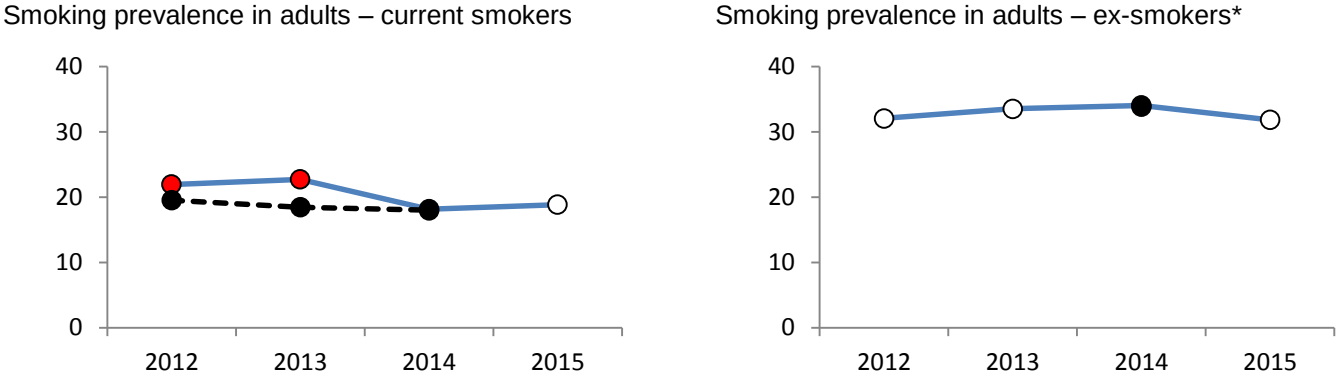
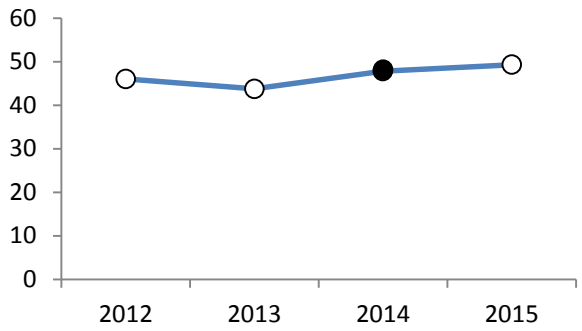


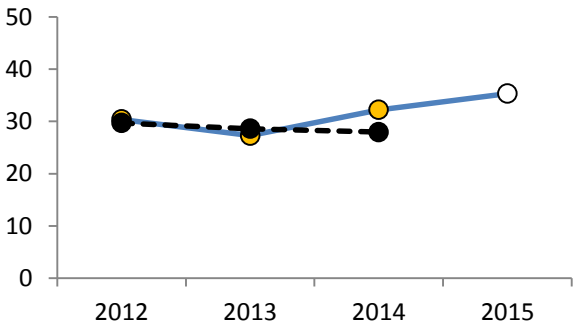
Figure 6: Adult Smoking Indicators (PHE measures)



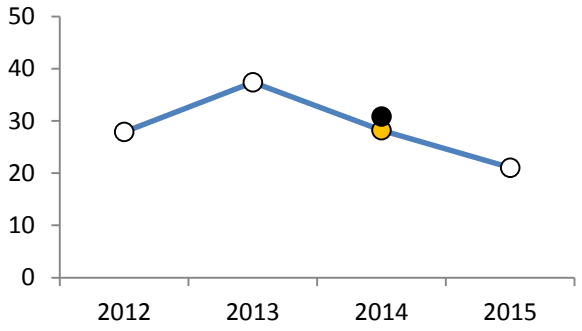
Smoking prevalence in adults – never smokers*



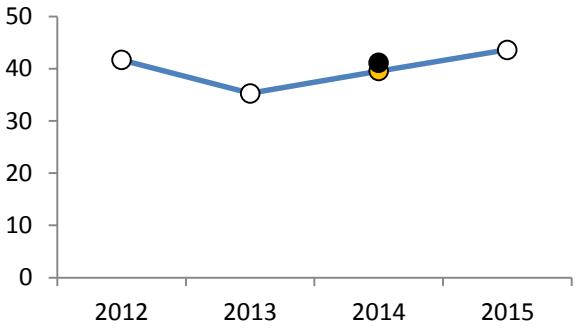
Smoking prevalence in adults in routine and manual occupations – current smokers



Smoking prevalence in adults in routine and manual occupations – ex-smokers*



Smoking prevalence in adults in routine and manual occupations – never smoked*



**Only 2014 data available for England at time of publication*
Source: Health Intelligence Unit, Public Health England

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 classed as nicotine containing products and are currently regulated as general consumer products.

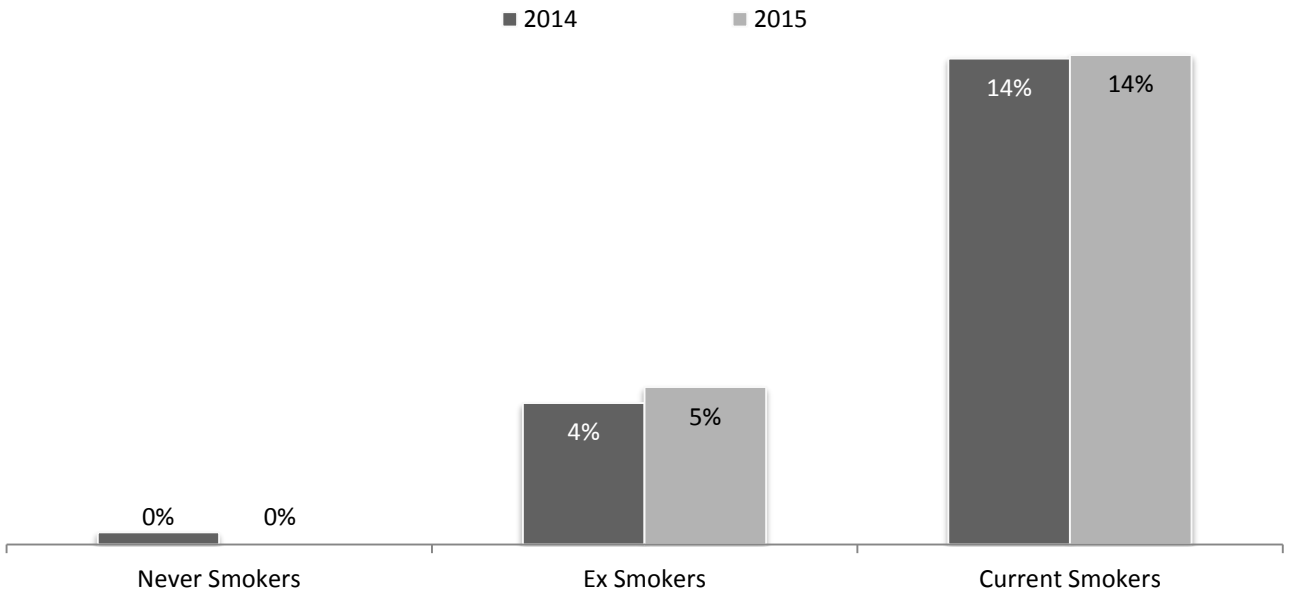
For the first time, JASS 2014 included questions asking participants about their use of electronic cigarettes. A question asking about the use of these devices has now become one of the core health questions asked in each round of JASS.

Data for the two years (2014 and 2015) 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 (85 per cent in 2015) have never used them. This proportion increases for those who have never smoked (97 per cent in 2015) compared to just over half (55 per cent) of those who currently smoke (either daily or occasionally).

There has been no change in use by current or ex-smokers between 2014 and 2015 as shown in Figure 7.

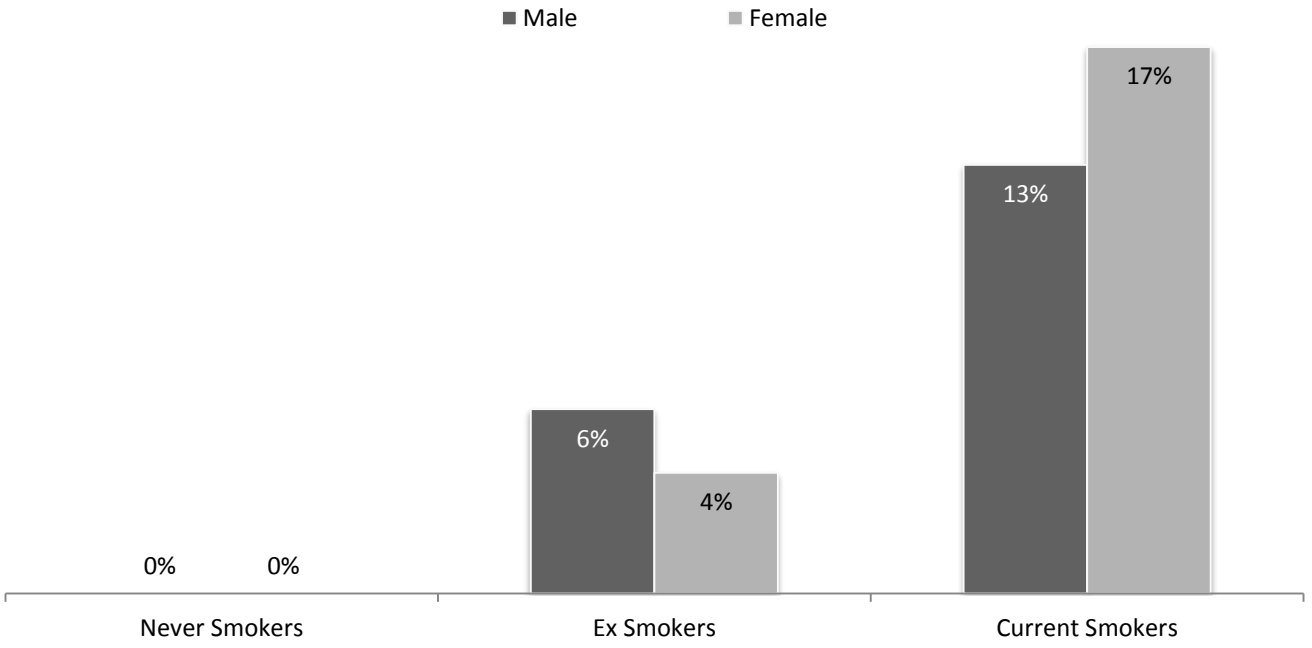
Female smokers were found to have used electronic cigarettes slightly more than male smokers in 2015 (Figure 8).

Figure 7: Proportion of adults using e-cigarettes at least sometimes, by smoking status, 2014 and 2015



Data source: JASS 2014 and 2015

Figure 8: Proportion of adults using e-cigarettes at least sometimes, by gender, 2015



Data source: JASS 2015

The latest figures for e-cigarette use in Great Britain based on a survey carried out for Action of Smoking and Health (ASH) and published in the latest HSCIC Statistics on Smoking, England 2015[9] report show that in 2014 17.6 per cent of smokers reported using e-cigarettes on a regular basis.

[9] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk

Smoking patterns in Children and Young People

Pupils smoking behaviour has been collected in the The Young People's Health and Lifestyle Survey (formally known as the Health Related Behaviours questionnaire) since the series began in 1996 (secondary schools) and 1998 (primary schools). The survey covers children in Years 6 to 11 who will mostly be aged 10 to 15 years. Detailed questions on smoking are included in every round of the survey which is conducted every four years. For more information on the methodology of the survey, please see the background notes section of this report.

Smoking prevalence and consumption

The key findings on smoking prevalence and consumption show that amongst 10 to 15 year olds in 2014 in Jersey:

- One in six of pupils reported that they had tried smoking at least once. At 15 per cent, this is the lowest level recorded since the survey began in 1998, when 47 per cent of pupils reported that they had tried smoking. The latest figure for Jersey is similar to the figure for England in 2014 (18 per cent).[10]
- 3 per cent of pupils said that they smoked at least one cigarette a week, the survey definition of regular smoking. This figure is the same as that found in England (3 per cent).[11]
- The prevalence of regular smoking increased with age. Less than 1 per cent of 10-13 year olds were regular smokers in 2014, and this increased to 7 per cent amongst 14-15 year olds.
- Regular smokers consumed, on average (mean) 34 cigarettes a week. This similar to the amount reported by regular smokers in England (31.1 cigarettes a week)[12] in 2014.

Figure 9 shows the declining trend of the proportion of pupils smoking regularly and occasionally.

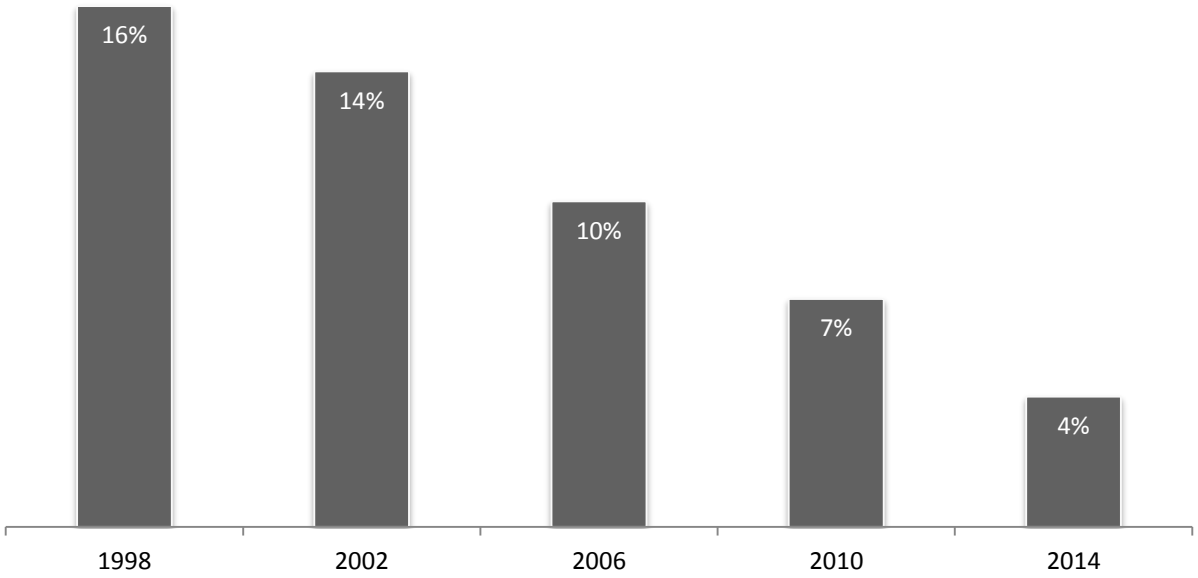
Influences on pupil's smoking

Exposure to second hand smoke can be an influence on pupils' smoking. Results from the Young People's Health and Lifestyle Survey for 2014 show:

- One in ten young people (11 per cent) reported that someone smokes indoors at home, with more 14-15 year olds reporting this than 10-11 year olds.
- Over a quarter of pupils (28 per cent) reported that their parents or carers smoke.
- 42 per cent of smokers reported that a parent or carer smoked (Table 5).
- 9 per cent of pupils were exposed to second-hand smoke in a car regularly (at least once a week); a third of these (3 per cent of all pupils) were exposed on a daily basis.

[10] HSCIC, Smoking, Drinking and Drug Use among Young People in England, 2014, published 23 July 2015, available from www.hscic.gov.uk
[11] HSCIC, Smoking, Drinking and Drug Use among Young People in England, 2014, published 23 July 2015, available from www.hscic.gov.uk
[12] HSCIC, Smoking, Drinking and Drug Use among Young People in England, 2014, published 23 July 2015, available from www.hscic.gov.uk

Figure 9: Percentage of regular and occasional smokers aged 10-15, 1998-2014



Source: HRBQ 2014

Table 5: Percentage of 14-15 year olds by parental smoking status, 2014

	Parent smokes	Parents do not smoke
Smoked	42	58
Never smoked	24	76

Source: HRBQ 2014

Where pupils get cigarettes

Pupils answering the 2014 Young People's Health and Lifestyle Survey were asked where they got cigarettes from.

The key facts show that in 2014:

- 43 per cent of regular smokers aged 14-15 years got their cigarettes from a friend.
- Almost three-quarters (70 per cent) of females got their cigarettes from other people (64 per cent from friends, 6 per cent from parents or carers).
- Corner shops were the most common source of cigarettes for male 14-15 year old smokers (36 per cent) while 18 per cent got theirs from a friend.

- Figures for England in 2014 reveal that the majority (64 per cent) of pupils that smoked were given cigarettes by other people.[13]

Comparisons to other jurisdictions

The latest comparable data for Europe is provided by the World Health Organization (WHO) Health Behaviour in School-aged Children survey.[14] Like the local survey, it is run every four years; however the results of the latest round of the survey (2013-2014) were not available at the time of publication.

The previous round of the survey (2009-2010) found the following proportions of 15 year olds reported smoking daily, as shown in Table 6.

Table 6: Percentage of 15-year old children smoking daily, 2010

Country	Male	Female
England	9.4	14.3
Wales	10.7	15.6
Ireland	11.8	13.7
Scotland	13.5	14.7
France	20.4	20.3
Portugal	11.4	10.1
Poland	15.7	12.1

Source: WHO Health Behaviour in School Aged Children

Directly comparable data for Jersey is not available, as locally pupils are asked if they smoke regularly, not smoke daily. Concurrent data, from the 2010 round of the Jersey Young People's Health and Lifestyle Survey, found that 11 per cent of 14-15 year old males and 14 per cent of 14-15 year old females reported smoking regularly in Jersey.

[13] HSCIC, Smoking, Drinking and Drug Use among Young People in England, 2014, published 23 July 2015, available from www.hscic.gov.uk
[14] WHO, Health Behaviour in School-aged Children survey 2009-2010, published 2012, available from www.euro.who.int

Comparisons to Public Health England Indicators

The Public Health England indicators for child smoking behaviours allow for comparisons to national data where comparable local data is available.

Table 7 and Figures 10 show comparable figures for Jersey and indicate that there are no significant differences to the England average.

Table 7: Child Smoking Indicators (PHE measures)

Indicator	Period	Jersey Value	Jersey 95% CI	Eng. Value	Eng. 95% CI	Eng. best/ highest	Eng. worst/ lowest
*Smoking prevalence age 15 years – regular smokers	2014	7	(5-9)	8	(6.60, 9.40)	-	-
*Smoking prevalence age 15 years – occasional smokers	2014	4	(2-6)	5	(3.88, 6.12)	-	-

** Jersey data is for those aged 14-15 years*
- Data not available for regions of England
Source: Health Intelligence Unit, Public Health England

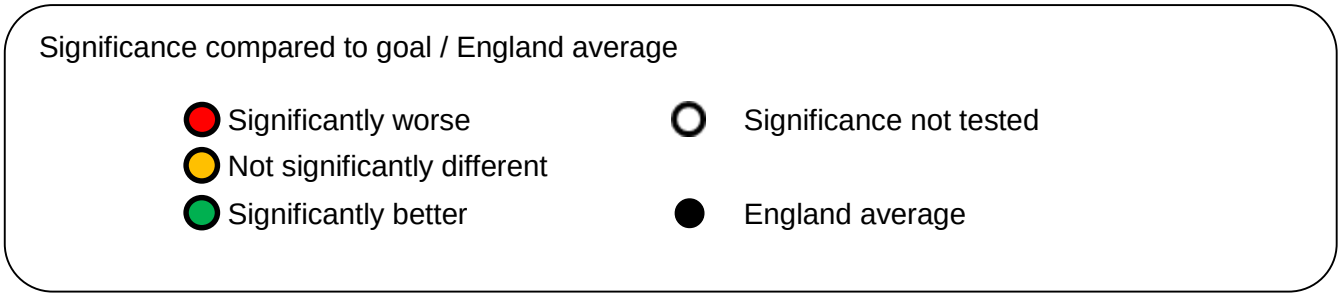
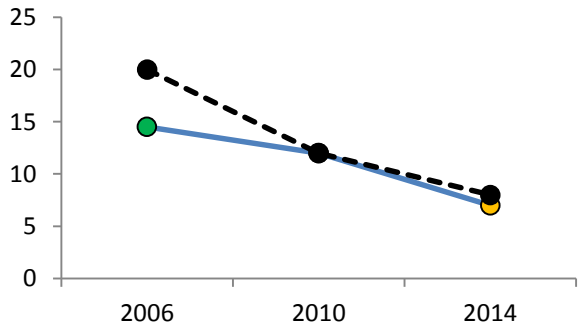
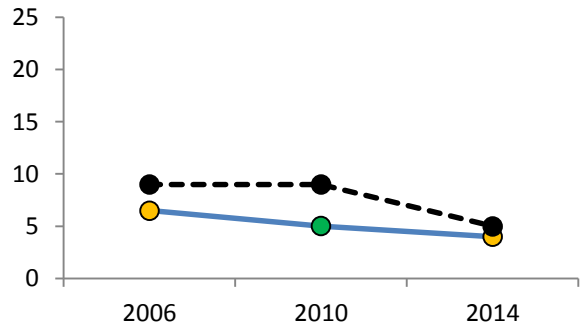


Figure 10: Child Smoking Indicators (PHE measures)

*Smoking prevalence age 15 years – regular smokers



*Smoking prevalence age 15 years – occasional smokers



** Jersey data is for those aged 14-15 years*
Source: Health Intelligence Unit, Public Health England

Smoking Related Mortality

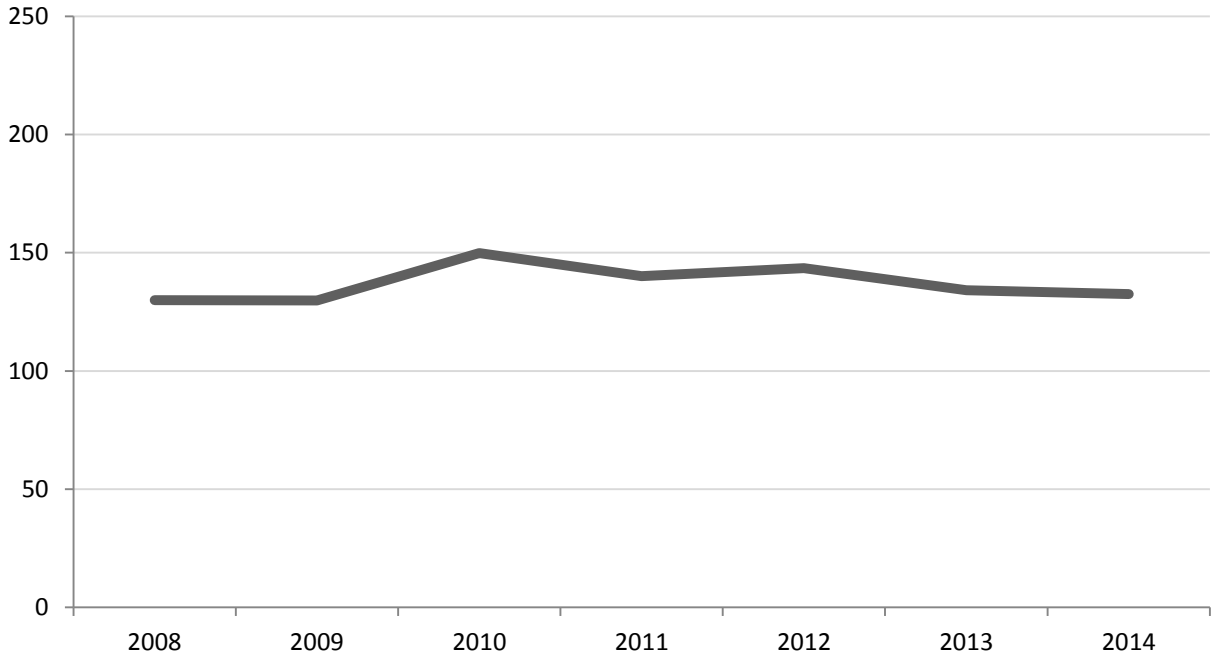
It is estimated that about half of all regular cigarette smokers will eventually be killed by their addiction.[15] Monitoring the amount of deaths that are attributable to smoking gives a measure of the impact smoking has on Islanders health.

Estimated numbers of smoking-attributable deaths in Jersey have been calculated using the methodology employed by the Department of Health in England and Public Health England. This uses both the prevalence of smoking (taken from the Jersey Annual Social Survey) along with details of deaths of Jersey residents. Smoking-attributable deaths from heart disease and stroke have been calculated using Public Health England methodology. Details of all deaths from specific conditions are also included in this chapter; smoking is responsible for the majority of deaths from lung cancer and chronic obstructive pulmonary disease.

Smoking-attributable deaths

In 2014, there were 690 deaths of adults aged 35 and over in Jersey, 132 (19 per cent) of which were from conditions that are caused by smoking. This figure has remained at the same level over the last 7 years.

Figure 11: All deaths among adults aged 35 and over in Jersey which are attributed to smoking, 2008 to 2014



Source: Health Intelligence Unit

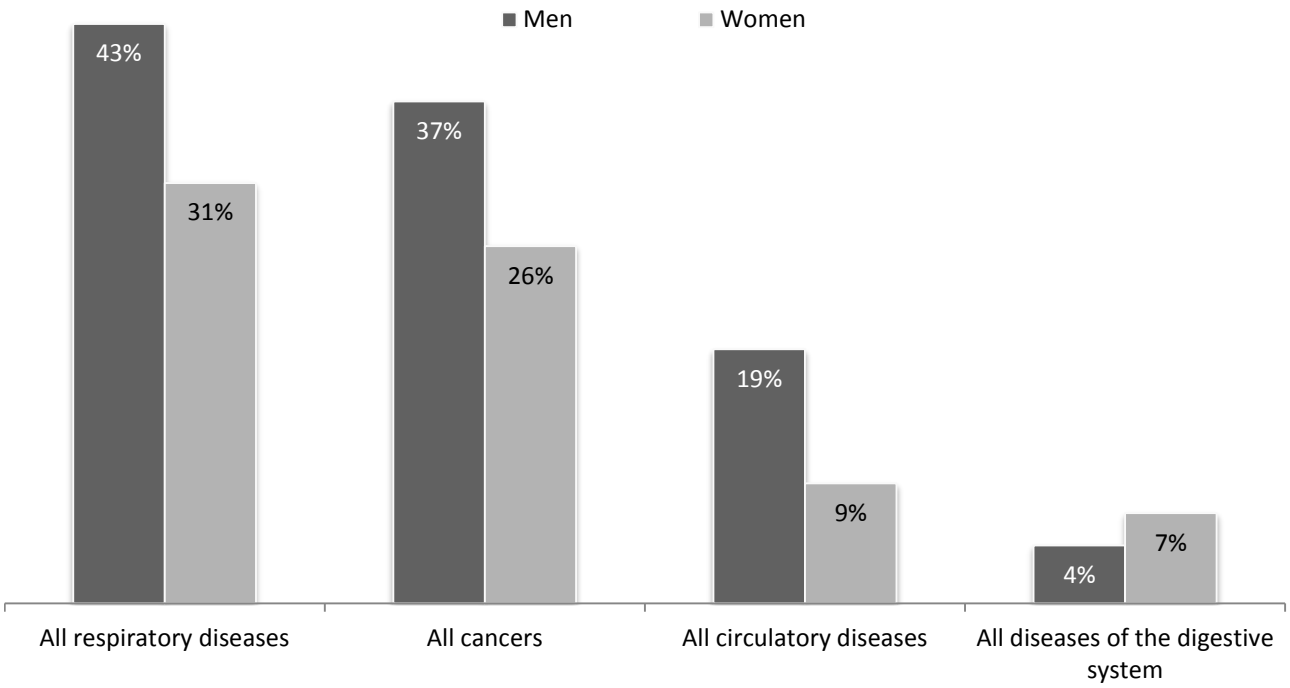
[15] ASH, Facts at a glance: smoking statistics, November 2015, available from www.ash.org.uk

Around one in four male deaths each year are estimated to be attributed to smoking; in 2014, 24 per cent of all male adult deaths aged 35 and over in Jersey were from conditions that can be caused by smoking. This compares to around one in six female deaths (15 per cent in 2014).

The pattern of smoking related deaths in Jersey is similar to that of England, where 21 per cent of male and 13 per cent of female deaths in 2013 were estimated to be smoking related.

It is estimated that in 2014, 37 per cent (23) of all deaths due to respiratory diseases and 31 per cent (83) of all cancer deaths, in Jersey, were attributable to smoking. In addition, an estimated 14 per cent (24) of deaths from circulatory diseases and 6 per cent of deaths from diseases of the digestive system were attributable to smoking. All of these proportions are similar to those reported for England.[16]

Figure 12: Estimated proportion of deaths attributable to smoking, as a percentage of all deaths from that disease among adults aged 35 and over, 2014



Source: Health Intelligence Unit

In terms of the proportion of deaths attributable to smoking in Jersey over the period 2012-2014, the diseases with the greatest proportions were:

- 85 per cent of deaths from chronic obstructive lung disease
- 83 per cent of deaths from trachea, lung and bronchus cancer
- 82 per cent of deaths from cancers of the larynx
- 80 per cent of deaths as a result of chronic airway obstruction

[16] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk

- 71 per cent of head and neck cancers
- 69 per cent of cancers of the oesophagus
- 63 per cent of aortic aneurysms

Proportions of deaths from these diseases are similar to the proportions reported for England.[17]

Comparisons to Public Health England Indicators

Comparable figures for Jersey and indicate that there are no significant differences to the England average (Table 8 and Figure 13).

Table 8 Smoking related mortality Indicators (PHE measures)

Indicator	Period	Jersey Value	Jersey 95% CI	Eng. Value	Eng. 95% CI	Eng. best	Eng. worst
Smoking attributable mortality	2012 - 14	267.4	(224.8, 313.2)	274.8	(273.7, 275.9)	184.9	458.1
Deaths from lung cancer	2012 - 14	60.5	(51.3, 70.9)	59.5	(59.1, 59.9)	107.7	29.8
Deaths from chronic obstructive pulmonary disease	2012 - 14	44.3	(36.4, 53.4)	51.7	(51.3, 52.1)	103.6	28.1
Smoking attributable deaths from heart disease	2012 - 14	20.7	(1.9, 43.8)	29.7	(29.3, 30.1)	18.9	58.1
Smoking attributable deaths from stroke	2012 - 14	7.8	(-6.5, 29.4)	9.3	(9.1, 9.5)	6.3	17.8

Source: Health Intelligence Unit, Public Health England

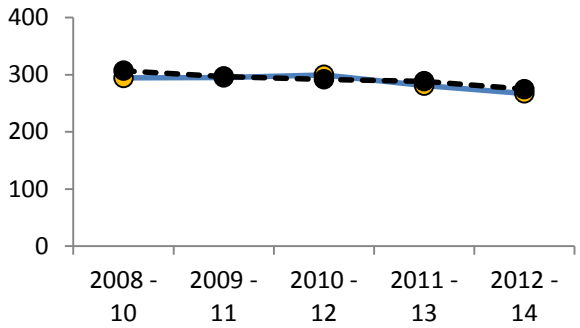
Significance compared to goal / England average

- Significantly worse
- Not significantly different
- Significantly better
- Significance not tested
- England average

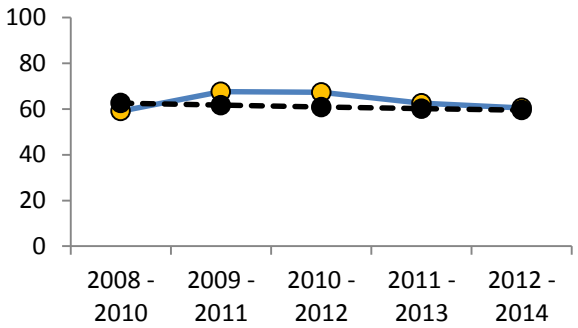
[17] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk

Figure 13: Smoking related mortality Indicators (PHE measures)

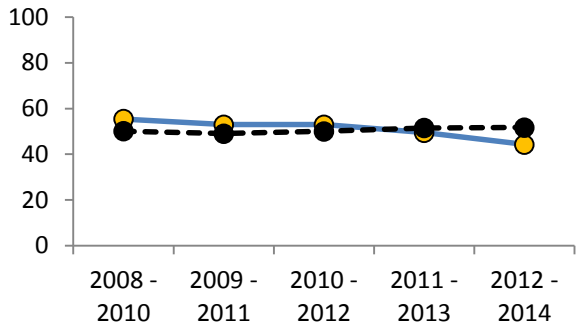
Smoking attributable mortality



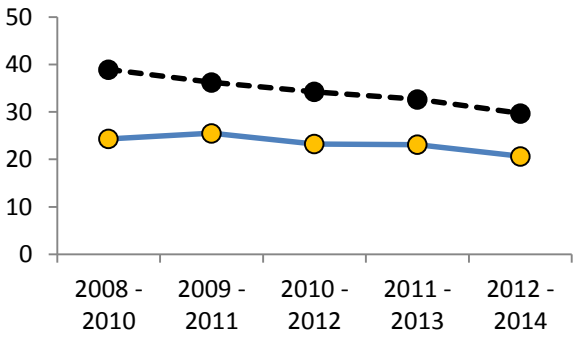
Deaths from lung cancer



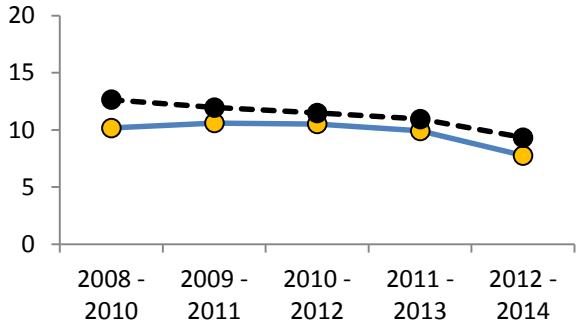
Deaths from chronic obstructive pulmonary disease



Smoking attributable deaths from heart disease



Smoking attributable deaths from stroke



Source: Health Intelligence Unit, Public Health England

Smoking Related Ill Health

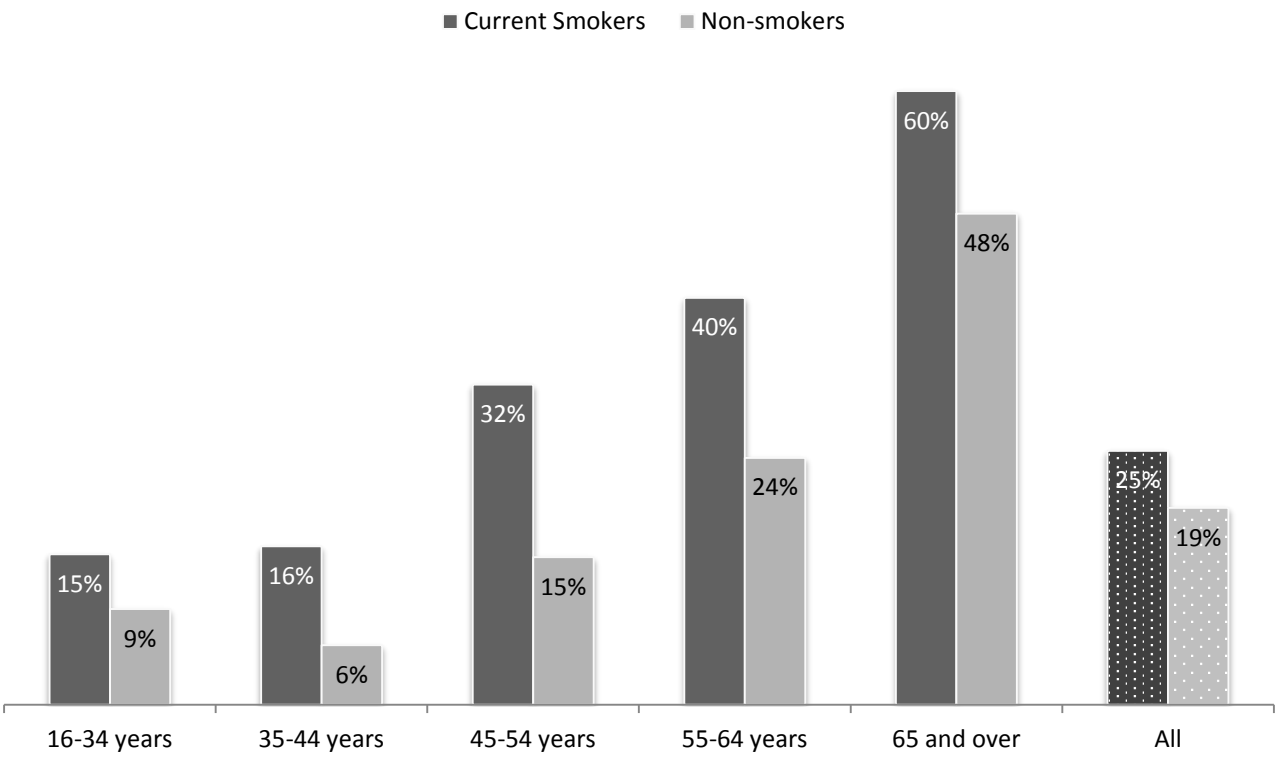
This chapter presents information on the health impacts of smoking, including hospital admissions and self-reported health status of smokers.

Information on hospital smoking-attributable hospital admissions are estimates of numbers of admissions which were caused by smoking. The estimates of the proportion of hospital admissions attributable to smoking in this chapter follow a recognised methodology, which uses the proportions of current and ex-smokers in the population and the relative risks of these people dying from specific diseases or developing certain non-fatal conditions compared with those who have never smoked, see Background Notes section for further details.

Longstanding illness

When comparing current smokers with non-smokers (here defined as those who have never smoked and those who used to), a greater proportion of smokers reported having an illness, disability or infirmity that had lasted or was expected to last at least twelve months (JASS 2015). Figure 14 shows that three out of five (60 per cent) smokers aged 65 years and over reported having a longstanding condition, compared to around half (48 per cent) of non-smokers of the same age. Roughly twice as many smokers in each age group between 35 and 64 years reported having a longstanding condition compared to non-smokers.

Figure 14: Proportion who report having a longstanding illness, disability or infirmity, by smoking status and age, 2015



Data source: JASS 2015

Cancer Registrations

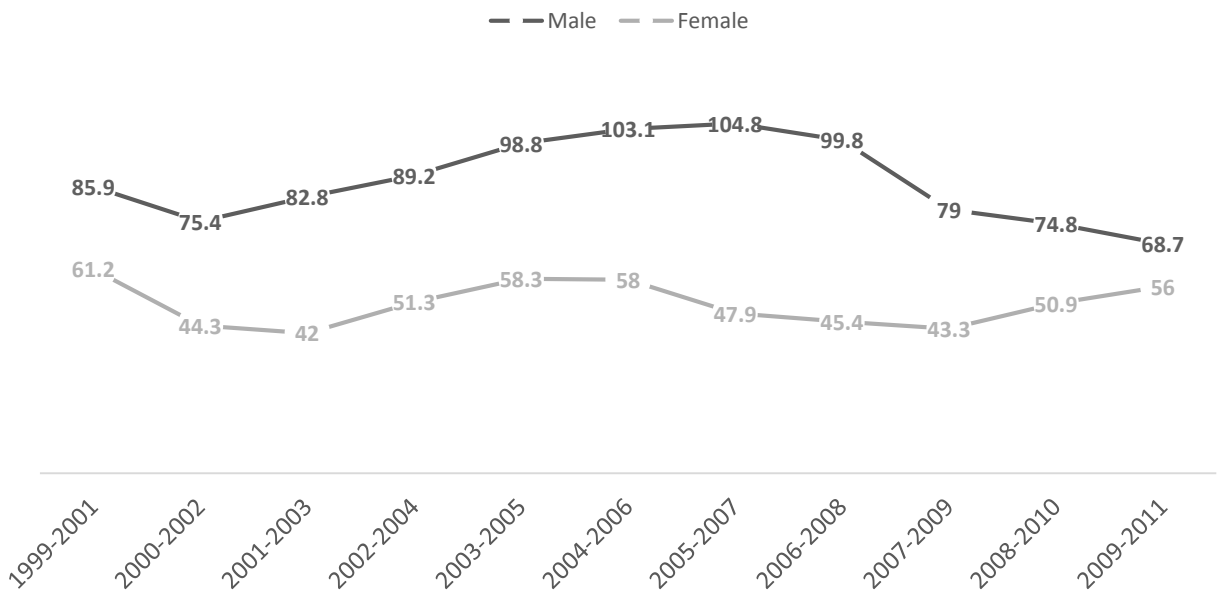
The latest cancer registration data for Jersey is contained in the *Channel Islands Cancer Report 2013*[18] incorporating data up to 2011. The next edition of this report is due to be published in January 2017.

Around 50 people a year on average are diagnosed with lung cancer in Jersey. Lung cancer accounts for one in ten (11 per cent) of all new cancer diagnosis each year for both men and women, making it the second most commonly diagnosed non sex-specific cancer in men (after colorectal cancer) and the top non sex-specific cancer in females. It is anticipated that lung cancer incidence in men will fall whilst incidence in women will continue to increase due to the later onset of female smoking habits.[19] Smoking is responsible for around 85 per cent of lung cancer incidences.[20]

The incidence rate for lung cancer is marginally higher in men than women in Jersey (68.7 and 56.0 per 100,000 respectively for 2009-2011).

One-year relative survival from lung cancer in men has remained at around 31 per cent (2006-2010 cohort) but five-year survival was found to be increased (from 10 per cent for the 1999-2003 cohort to 16 per cent for the 2002-2006 cohort) and unchanged for women (14 per cent).

Figure 15: Age standardised incidence rates (per 100,000) for lung cancers in Jersey, 1999-2011, by gender



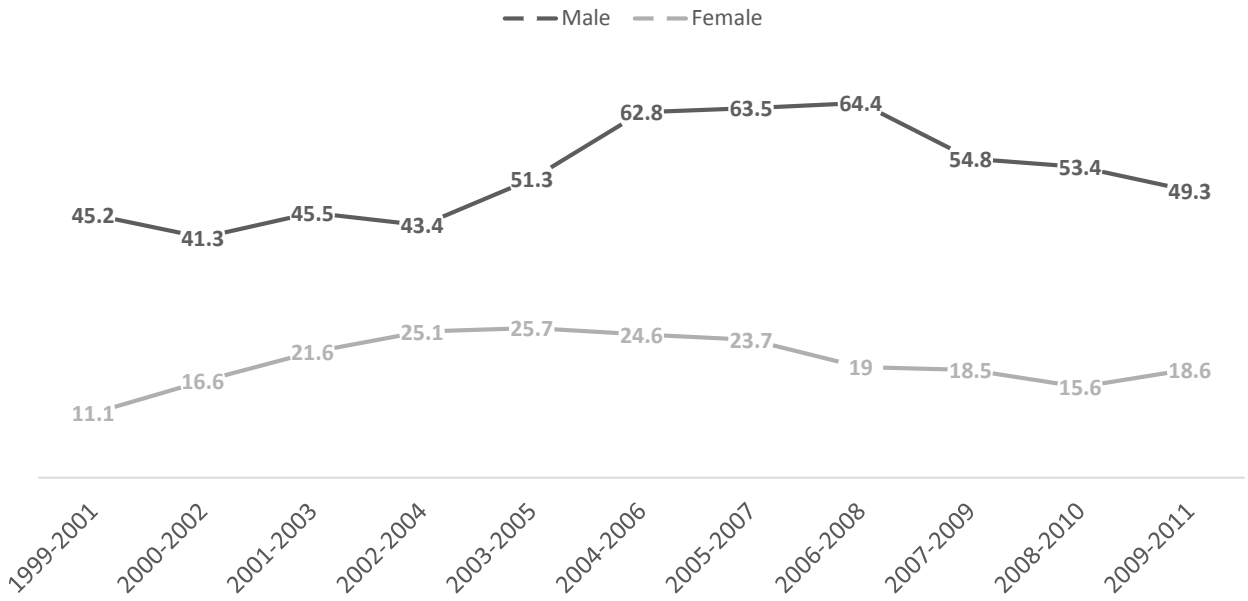
Source: Public Health England

[18] Public Health England Knowledge and Intelligence Team (South West), Channel Islands Cancer Report 2013: incorporating data up to 2011, published 22 January 2014, available from www.gov.je
[19] Parking DM, Boyd L, Walker LC. The fraction of cancer attributable to lifestyle and environmental factors in the UK in 2010. British Journal of Cancer. 2011;105: S77-S81
[20] Public Health England Knowledge and Intelligence Team (South West), Channel Islands Cancer Report 2013: incorporating data up to 2011, published 22 January 2014, available from www.gov.je

Most oral cancers are triggered by tobacco and smoking, which together account for 75 per cent of cases.[21] For Jersey, incidence of oral cancer is calculated as part of head and neck cancers in the *Channel Islands Cancer Report 2013.*

In Jersey, around 30 people are diagnosed with a head and neck cancer ever year. This incidence is significantly higher than that found in England; 36.2 per 100,000 compared to 22.4 per 100,000 for England. The median age of diagnosis in Jersey is 60, whilst one-year survival is around 80 per cent for men and 97 per cent for women. Five-year survival is also better for women at around three-quarters (72 per cent) compared to 65 per cent for men (2002-2006 cohort).

Figure 16: Age standardised incidence rates (per 100,000) for head and neck cancers in Jersey, 1999-2011, by gender



Source: Public Health England

Hospital admissions for diseases that can be caused by smoking

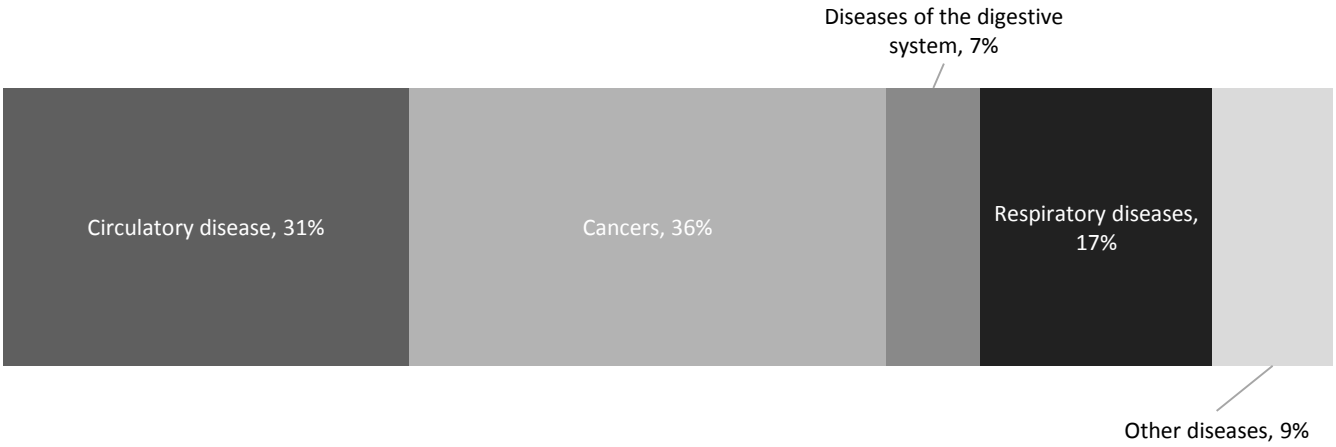
This section details the number of hospital admissions where there is a primary diagnosis of a disease that can potentially be due to smoking. Not all of these admissions will be directly attributable to smoking as there are other contributory factors to these diseases.

In 2014, there were over 2,500 admissions to Jersey General Hospital for adults aged 35 and over with a primary diagnosis of a disease that can potentially be caused by smoking. This is approximately 7 admissions per day on average.

[21] Blot WJ, Mclaughlin JK, Winn DM et al. Smoking and drinking in relation to oral and pharyngeal cancer. Cancer Res 1988; 48: 3282-7

Cancers accounted for the largest number of admissions where there was a primary diagnosis of a disease that can be caused by smoking (around 900). The second most common diagnosis was for circulatory disease which can be caused by smoking (around 800 admissions). There were over 400 admissions in 2014 for diseases of the respiratory system caused by smoking as a primary diagnosis.

Figure 17: Breakdown of admissions[1] in Jersey with a primary diagnosis of diseases which can be caused by smoking, 2014



[1]Among adults aged 35 and over
Source: Health Intelligence Unit

In 2014, men accounted for 55 per cent of admissions for diseases which can be caused by smoking and women accounted for 45 per cent. This pattern is the same as that seen in England.[22]

In both men and women, cancers were the most common reason for admission (37 and 34 per cent, respectively). In England, circulatory diseases were the most common reason for admission to hospital in 2013/14, accounting for 48 per cent of admissions for men and 39 per cent for women.[23]

[22] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk
[23] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk

Smoking attributable hospital admissions

The previous section showed that a large number of hospital admissions of adults aged 35 and over are due to diseases which can potentially be caused by smoking. Not all of these admissions will be attributable to smoking as there are other contributory factors to these diseases.

In order to estimate the number of smoking-attributable admissions (i.e. admissions caused directly by smoking), the relative risks of these diseases for current and ex-smokers have been used. This section contains estimates of the number of smoking-attributable hospital admissions calculated using the methodology used by Public Health England and the Health and Social Care Information Centre in their respective publications. The analysis uses current data on prevalence for current and ex-smokers as reported in the Jersey Annual Social Surveys and details of hospital admissions from the TRAK system at the Jersey General Hospital. Note that the figures in this section for smoking attributable hospital admissions are only estimates as there is no guarantee that in all cases the admissions were directly linked to smoking.

In 2014, there were approximately 27,000 hospital admissions (for all diseases) for adults aged 35 and over in Jersey. Around 1,000 (4 per cent) of these are estimated to have been attributable to smoking.

The number of admissions in 2014 can be broken down further by type of primary diagnosis which shows that:

- One in four (25 per cent) of all admissions (of those aged 35 years and over) with a primary diagnosis of respiratory diseases were attributable to smoking
- One in five (20 per cent) of all admissions with a primary diagnosis of cancer were smoking-attributable
- This compares to 14 per cent of primary diagnoses due to circulatory diseases
- 3 per cent of admissions with a primary diagnosis of diseases of the digestive system.

These proportions are similar to those reported for admissions in England in financial year 2013/14.[24]

A larger proportion of admissions among men than women were attributable to smoking. In 2014, there were an estimated 600 admissions that can be attributed to smoking for men compared with around 400 for women.

- Admissions with a primary diagnosis of chronic obstructive lung disease had the highest percentage of estimated admissions attributable to smoking (88 per cent).
- An estimated 83 per cent of admissions for cancer of the larynx were attributable to smoking.
- An estimated 82 per cent of admissions with a primary diagnosis of cancers of the trachea, lung and bronchus were attributable to smoking.

[24] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk

- Around half (52 per cent) of admissions with a primary diagnosis of stomach ulcers in 2014 were estimated to be attributable to smoking.

Other non-fatal conditions also had smoking attributable admissions, for instance 12 per cent of age-related cataracts (among people aged 45 and over) were attributable to smoking.

Respiratory clinic patients

Over nine out of ten patients (91 per cent) currently being treated by the Respiratory Nurse Specialists have chronic obstructive pulmonary disease (COPD) which is the name for a collection of lung diseases which include emphysema, chronic bronchitis and chronic asthma. The patients seen at the clinic are individuals with moderate to severe COPD, with around 50 patients currently requiring oxygen. In total the clinic sees around 300 patients with lung conditions, a large proportion of which will be attributed to smoking. These patients generated over 1,800 visits for nurses either in hospital or in their homes in 2015.

Premature births and low birth weight

There is substantial evidence that smoking during pregnancy and exposure to second hand smoke can lead to premature birth among many other adverse health effects including complications during labour, low-birth weight at full term and increased risk of miscarriage and stillbirth.

In 2014, there were 985 live births, nine out of ten (91 per cent) were delivered at term (after 37 weeks of gestation). A small proportion, 3 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 2-3 per cent of term births. On average, around 5 per cent of births each year in Jersey are premature (born before 37 weeks gestation).

Comparisons to Public Health England Indicators

Table 9 and Figures 17 show comparable figures for Jersey and indicate where there are significant differences to the England average. Overall, figures for Jersey are broadly similar to England for smoking-related ill health. However, Jersey has significantly worse incidences of head and neck cancers.

Table 9: Smoking-related Ill Health Indicators (PHE measures)

Indicator	Period	Jersey Value	Jersey 95% CI	Eng. Value	Eng. 95% CI	Eng. best/ highest	Eng. worst/ lowest
Smoking attributable hospital admissions	2014*	1872	(1688, 2065)	1671	(1667, 1676)	1030	2835
Hospital admissions for asthma (under 19 years old)	2013+	196.4	(144.2, 267.2)	197.1	(194.6, 199.6)	54.6	509.1
Lung cancer registrations**	2007-2011**	62.7	(55.0, 70.4)	65.9	(65.6, 66.2)	-	-
Head and neck cancer registrations**	2007-2011**	36.2	(30.1, 42.2)	22.4	(22.2, 22.6)	-	-
Low birth weight of term babies	2014	2.8	(1.9, 4.1)	2.9	(2.8, 2.9)	1.6	5.8

**Data for England is for financial year 2014-2015, Jersey data is for calendar year 2014*
+Data for England is for financial year 2013-2014, Jersey data is for calendar year 2013
***Data taken from the Channel Island Cancer Report 2013 for persons aged 20 years and over, English data for 2006-2010*
Source: Health Intelligence Unit, Public Health England

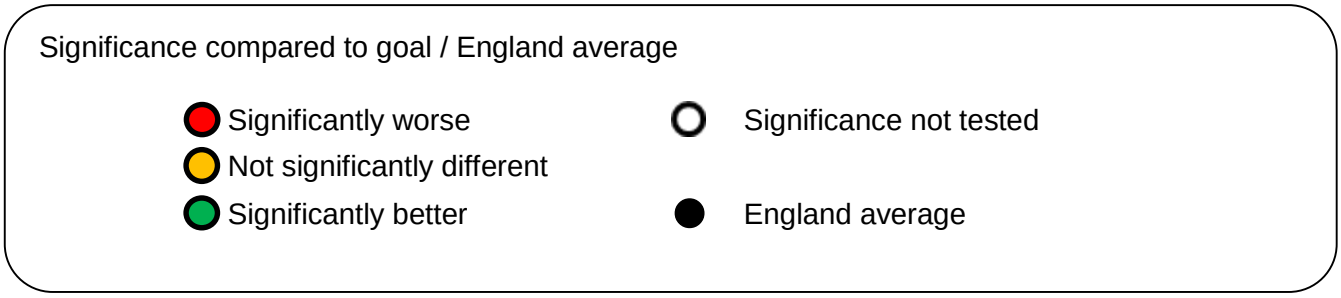
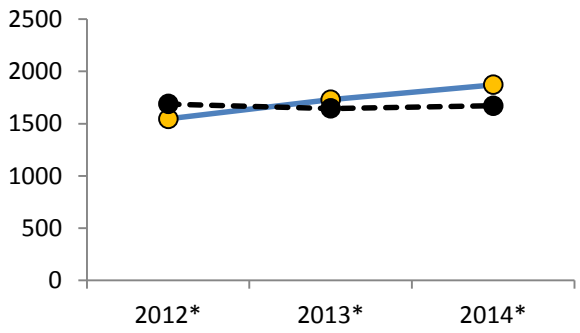
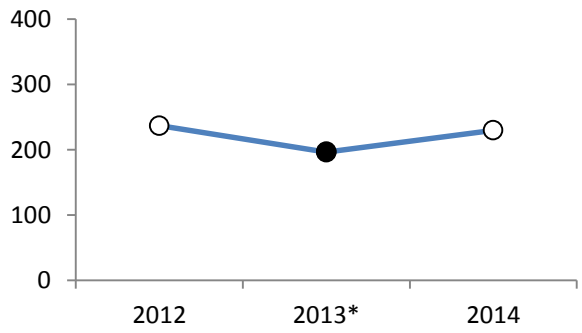


Figure 17: Smoking-related Ill Health Indicators (PHE measures)

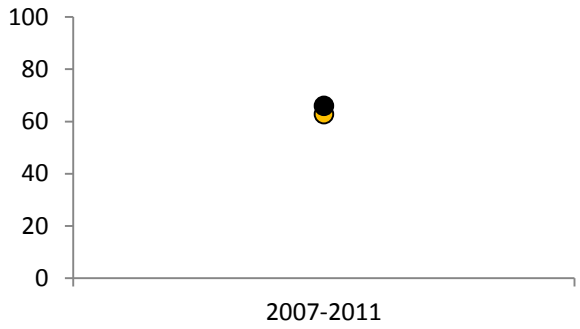
Smoking attributable hospital admissions*



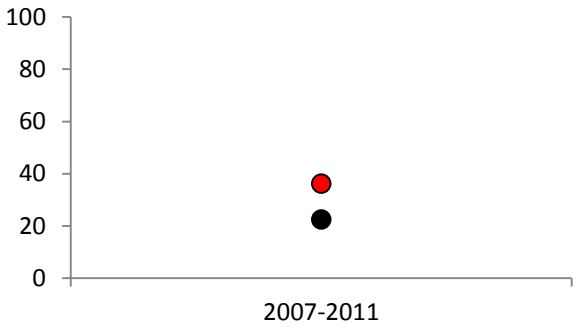
Hospital admissions for asthma (under 19 years old)*



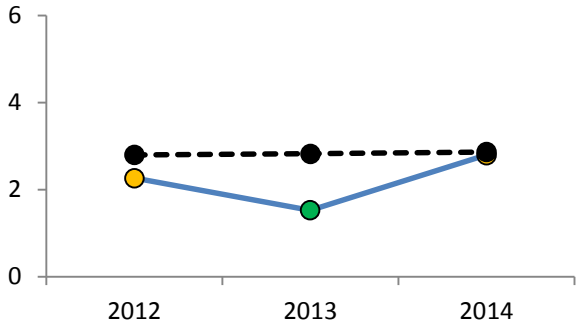
Lung cancer registrations**



Head and neck cancer registrations**



Low birth weight of term babies



**Data for England is for financial years, Jersey data is for calendar years*
***Data taken from the Channel Island Cancer Report 2013 for persons aged 20 years and over, English data for 2006-2010*
Source: Health Intelligence Unit, Public Health England

Impact of Smoking

This chapter presents information from a number of sources about both adults' and children's behaviour and attitudes towards smoking.

Data on adults smoking behaviour and attitudes are taken from the States of Jersey Statistics Unit Annual Social Survey (JASS) which contains a core question every year on smoking and from 2014 a core question each year on electronic cigarette use. Every two years a larger set of smoking related questions are asked to gain a further insight into the attitudes and behaviours of local adults aged 16 and over living in private households. The Jersey Annual Social Survey in 2014 last contained this larger set of questions, with the 2015 round of the survey containing the shorter core set of smoking questions.

Children's attitudes towards smoking are taken from the The Young People's Health and Lifestyle Survey which ran in 2014 and surveyed pupils in all schools at ages 10-11 years, 12-13 years and 14-15 years (school years 6, 8 and 10).

From 1 September 2015 a law was introduced making it illegal to smoke and to allow smoking in a car carrying young people under the age of 18 years. Prior to this, a consultation was run by the Public Health Department in 2013 asking Islanders views on restrictions to smoking.[25] Concurrently, questions were asked in that years round of JASS. Results from JASS only are presented here as results from the social survey are statistically weighted to be representative of Islanders.

Details about Islanders wanting to quit smoking are presented here using data from JASS; information from the local stop smoking service, Help2Quit, is presented in the Smoking Quitters chapter of this report.

Wanting to quit smoking

Two thirds (67 per cent) of adults who smoke at least occasionally said they had wanted to quit in the last year.[26] There was no statistically significant difference between those who smoked occasionally and those who smoked daily. However, a greater proportion of female smokers (75 per cent) reported wanting to quit in the last year compared to male smokers (60 per cent).

Two-thirds (66 per cent) of Jersey born smokers indicated that they had wanted to quit in the last year, compared with three-quarters (75 per cent) of those born elsewhere in the British and less than half (44 per cent) of those born outside the British Isles.

[25] States of Jersey Health and Social Services Department, Results of a public consultation: protecting our children from second-hand smoke, February 2014, available from www.gov.je
[26] States of Jersey Statistics Unit, Jersey Annual Social Survey 2014, published 25 November 2014, available from www.gov.je

Children giving up

Information from the Young People's Health and Lifestyle Survey conducted in 2014,[27] showed that of those regular smokers aged 14-15 years, around three-quarters (74 per cent) had tried to quit smoking. Over a third (38 per cent) said they would like help to quit.

Smokers' behaviour

One in eight (13 per cent) of Jersey households reported having someone who regularly smoked inside their home.[28]

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 the home (Table 10).

Table 10: 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	14	13
	No	90	86	87
All households		100	100	100

Source: JASS 2014

One in ten (10 per cent) owner-occupier households had someone who regularly smoked inside their home, this compares to 14 per cent of non-qualified households; 17 per cent of qualified rental households and one in five (21 per cent) of social housing households. A similar pattern was seen in those households where children were either living or were regularly looked after in the home (7 per cent owner-occupier households; 7 per cent non-qualified households; 17 per cent qualified renters and 22 per cent of social housing households).

[27] States of Jersey Public Health Intelligence Unit, A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years, published 2 March 2015, available from www.gov.je
[28] States of Jersey Statistics Unit, Jersey Annual Social Survey 2014, published 25 November 2014, available from www.gov.je

Views on smoking restrictions

In the 2013 round of the Jersey Annual Social Survey, questions were asked about whether there should be restrictions on smoking in certain outdoor places. Table 11 gives the full set of results as well as the results split by those who currently smoke (either occasionally or daily) and non-smokers (ex-smokers and never smokers).

Table 11: Percentage of respondents who thought smoking should be stopped in the following outside areas, 2013

	Current Smokers	Non-smokers	All
Playgrounds	56	72	69
Outside eating and drinking areas in pubs and restaurants	14	65	54
Pedestrian shopping areas	22	59	51
Bus stops and taxi ranks	24	55	48
Parks	26	47	42
Beaches	10	39	33
None of these	38	13	19

Data Source: JASS 2013

For each location, a larger proportion of non-smokers were in support of restrictions. Two-thirds (69 per cent) of all respondents felt that smoking should be stopped in playgrounds, followed by around half indicating that they would like smoking to be stopped outside pubs and restaurants (54 per cent), in pedestrian shopping areas (51 per cent), and at bus stops and taxi ranks (48 per cent).

Smoking in cars

A law was introduced on 1 September 2015 which made it illegal to smoke and allow smoking in a car carrying people under the age of 18 years. The 2013 Jersey Annual Social Survey found that overall four-fifths (81 per cent) of adults in Jersey would support this ban. A large proportion of current smokers (those who smoke daily or occasionally) were found to be in support of this ban (70 per cent).

Environmental impact of smoking

Figures from Keep Britain Tidy indicate that 244 million cigarette butts are dropped on the streets every year in the UK,[29] which adds up to 104 tonnes of waste. Research found that 99 per cent of British town centres have cigarette litter.[30] Although data for Jersey is not available, the Parish of St Helier have noticed an increase in cigarette litter since the introduction of smokefree legislation locally. Cigarette butts can take up to 12 years to biodegrade, which means they can have a large environmental impact. When discarded in surface water drains, cigarette butts can get into the Islands waters, including streams, reservoirs, ponds and the sea.[31] The improper disposal of cigarette butts can also lead to furze fires, with a number of fires reported locally in 2014.[32]

Smoking related fires

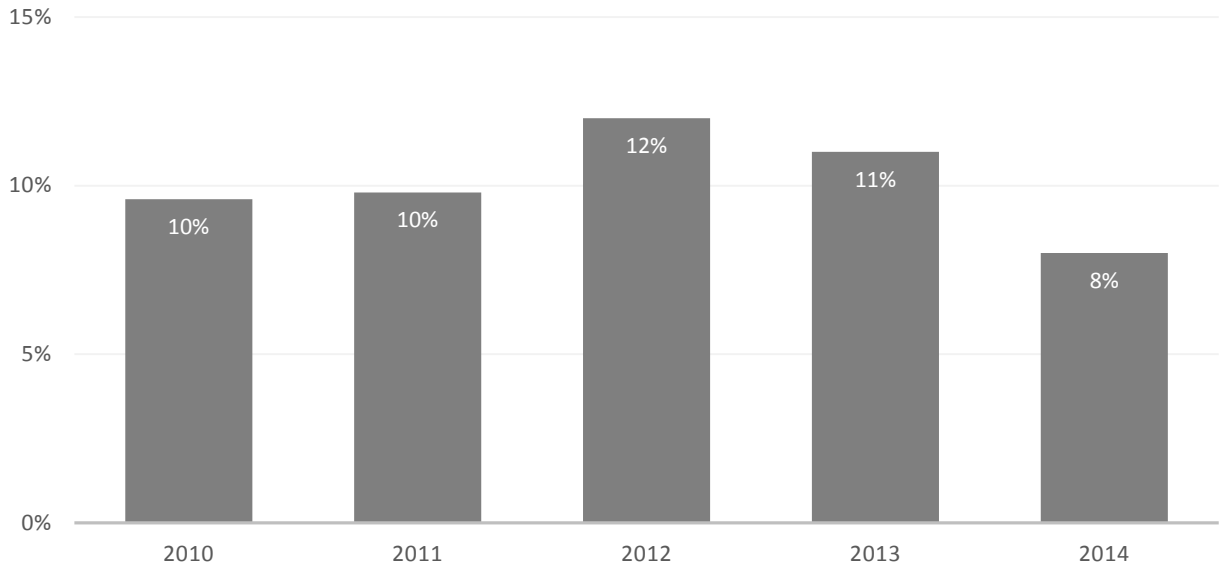
Data from the States of Jersey Fire and Rescue Service shows that there have been no fire fatalities from fires ignited by smoking materials in the last five years. Figure 19 shows the proportion of dwelling fires each year that were started by smoking related materials.

There has been between 5 and 6 accidental dwelling fires caused by smoking materials each year, with smoking materials being, on average, the third most common cause of dwelling fires after electrical and kitchen and cooking related fires. Over the last five years, the estimated cost of accidental dwelling fires caused by smoking materials is around one million pounds (not including costs associated with injury).

When compared to figures for Great Britain, the proportion of smoking related dwelling fires in Jersey is similar (7 per cent for Great Britain 2013/14 and 8 per cent for Jersey in 2014).[33]

[29] Keep Britain Tidy, website www.keeppbritaintidy.org
[30] Keep Britain Tidy, When it comes to litter: which side of the fence are you on?, published 2013, available from www.keepbritaintidy.org
[31] States of Jersey Environment Dept. Eco-Active, Drains for Rain: blue fish campaign, available from http://www.gov.je/environment/savewaterreducepollution/pages/bluefishcampaign.aspx
[32] States of Jersey Fire and Rescue Service, Service annual review 2014, published 25 June 2015, available from www.gov.je.
[33] Department for Communities and Local Government, Fire Statistics: Great Britain April 2013 to march 2014, published 29 January 2015, available from www.gov.uk

Figure 19: Proportion of dwelling fires started by smoking related materials, 2010 to 2014



Data source: States of Jersey Fire and Rescue Service Annual Reports 2010-2014

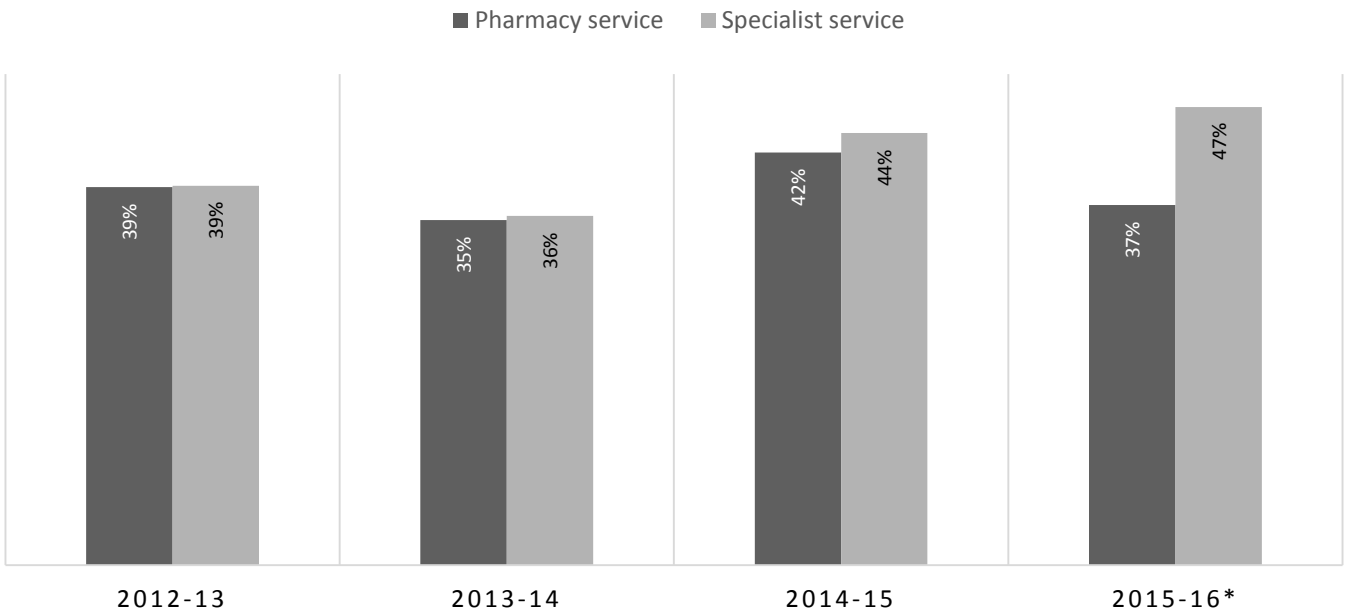
Smoking Quitters

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.

For financial year 2014-2015, information from the Help2Quit database shows:

- Over 900 people set a quit date through the stop smoking service in Jersey, this was a slight decrease on the previous year of 8 per cent.
- Almost 400 people successfully quit (an increase of 40 people on 2013/14) which gives a quit rate of 42 per cent, 7 percentage points higher than the previous year.
- 27 pregnant women used the service in 2014/15 and 27 per cent of them quit successfully. The number of pregnant women was down on the previous year, although the quit rate was similar to previous years.
- Around 250 individuals who were classified as working in a routine or manual profession used the Help2Quit service in 2014/15, half (49 per cent) of those who set a quit date successfully quit.
- The proportion of people who successfully quit having set a quit date with the pharmacy or specialist service has been similar for the last three years, as shown in Figure 20. However, the data for 2015-2016 to date shows an increase in the quit rate achieved by the specialist service.

Figure 20: Proportion of validated successful quitters by service, 2012-2016*



**Data for financial year 2015-2016 is for April 2015-mid January 2016*
Source: Health Intelligence Unit

In 2014-15, Jersey had significantly more smokers setting a quit date than the English average and significantly more who were CO validated quitters as shown in Table 12 and Figure 21.

Table 12: Smoking Quitters Indicators (PHE measures)

Indicator	Period	Jersey Value	Jersey 95% CI	Eng. Value	Eng. 95% CI	Eng. best	Eng. worst
Number setting a quit date	2014/15	6050	(5685, 6439)	5549	(5533, 5565)	12793	1955
Successful quitters at 4 weeks	2014/15	2566	(2328, 2829)	2829	(2817, 2840)	5741	957
Successful quitters (CO validated) at 4 weeks	2014/15	2254	(2031, 2501)	1954	(1945, 1964)	4953	478
Completeness of NS-SEC recording by Stop Smoking Services	2014/15	94.6	(93.0, 95.9)	88.3	(88.2, 88.4)	100	30.8

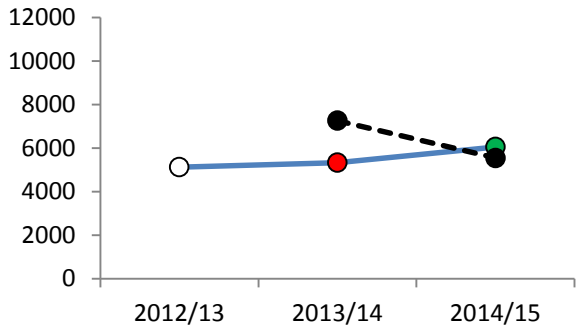
Source: Health Intelligence Unit, Public Health England

Significance compared to goal / England average

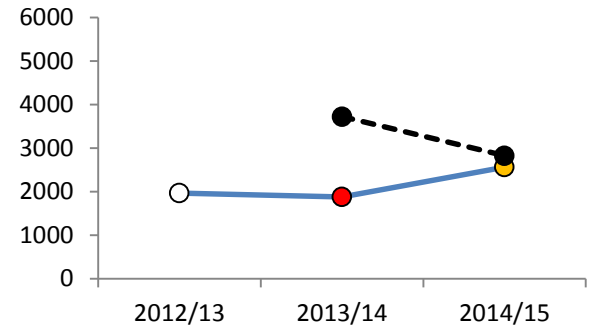
- Significantly worse
- Not significantly different
- Significantly better
- Significance not tested
- England average

Figure 21: Smoking Quitters Indicators (PHE measures)

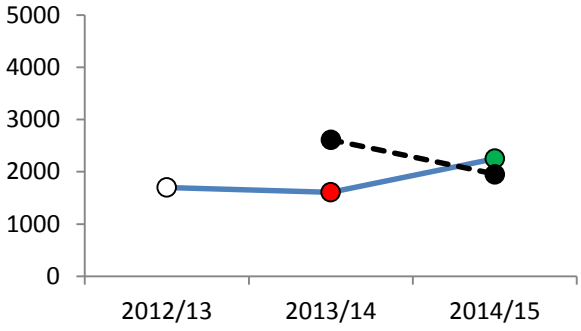
Number setting a quit date



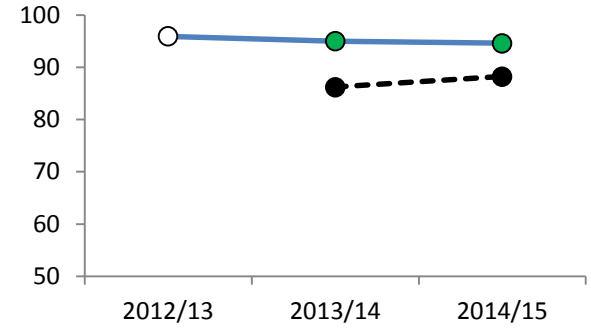
Successful quitters at 4 weeks



Successful quitters (CO validated) at 4 weeks



Completeness of NS-SEC recording by Stop Smoking Services



Source: Health Intelligence Unit, Public Health England

Availability and Prices of Tobacco

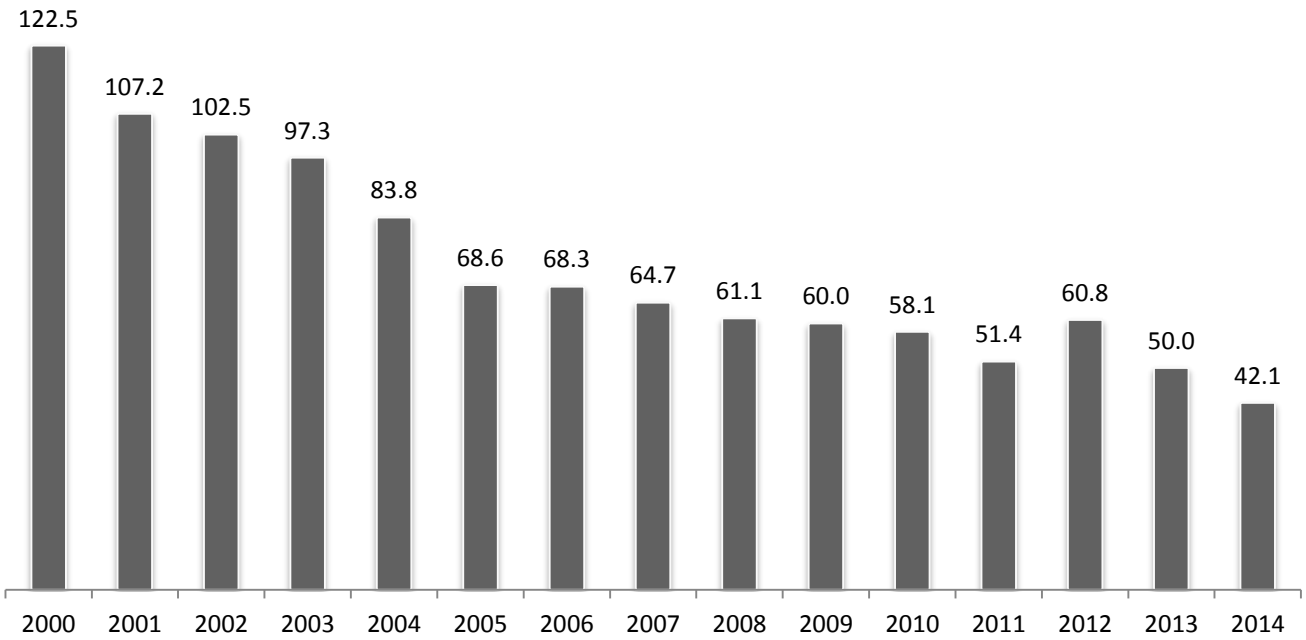
Information on the price of tobacco and the amount spent by households is monitored by the States of Jersey Statistics Unit, while data on the amount of tobacco imported into the Island is collected by the Customs and Immigration service.

Tobacco imports

Information on the quantities of tobacco imported in to the Island is available from the Customs and Immigration Department.

Since 2000, the quantity of tobacco imported into the Island has fallen from 122,500 kgs to 42,000 kgs in 2014, a reduction of approximately two-thirds (66 per cent).

Figure 22: Annual Quantity of tobacco imported, thousands of kilograms, 2000-2014

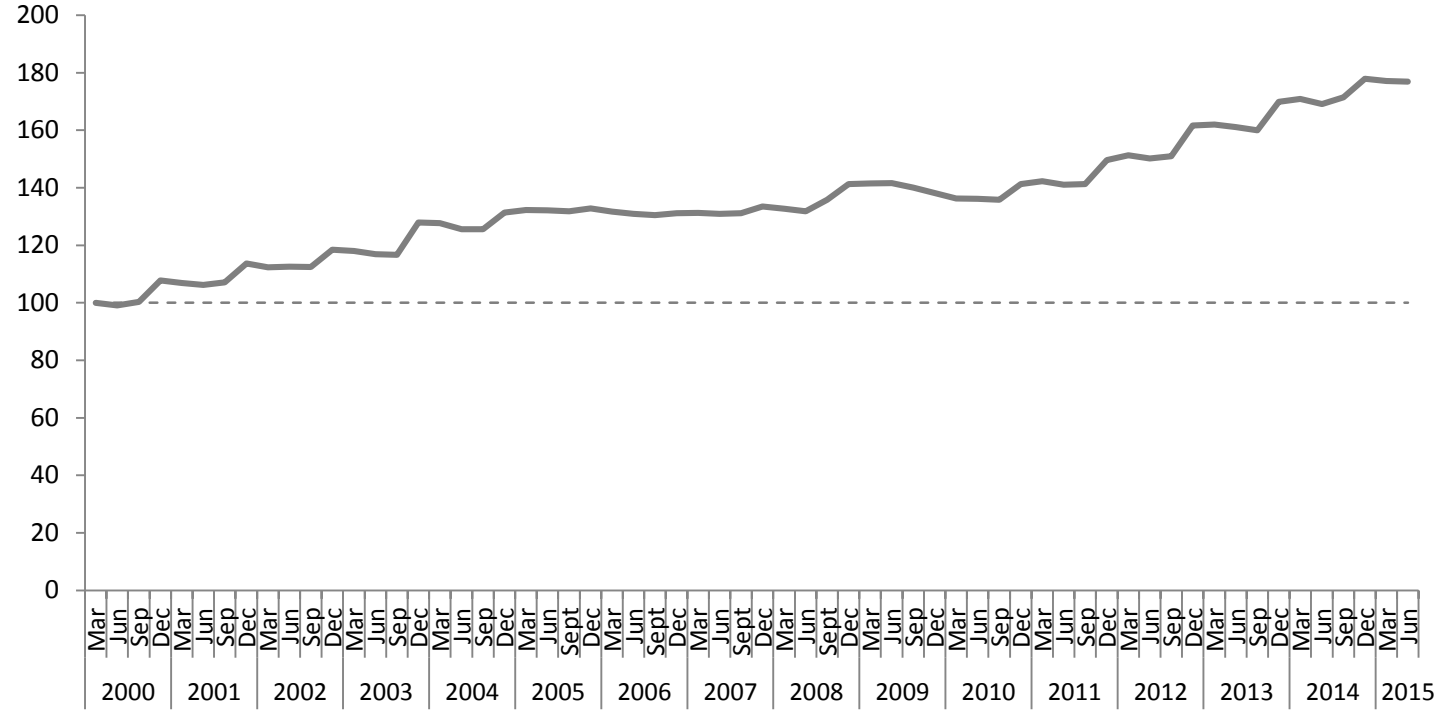


Source: States of Jersey Statistics Unit (based on data provided by States of Jersey Customs and Immigration Service)

Prices

Using data published by the States of Jersey Statistics Unit; analysis of changes to the price of tobacco over time is possible using the tobacco price index (TPI), the retail price index (RPI) and the relative tobacco price index (defined as TPI/RPI).

Figure 23: Relative tobacco price index: 2000 to 2014



Data source: States of Jersey Statistics Unit

Figure 23 shows the change to the relative tobacco price index over time, showing how the average price of tobacco has changed since the base (June 2000) compared with the prices of all other items. A value greater than 100 shows that the price of tobacco has increased by more than inflation, during that period.

In Jersey, prices of tobacco, as measured by the tobacco price index:

- Have increased more than the retail price index since June 2000 (an arbitrarily chosen base period).
- Between 2000 and 2014 the price of tobacco increased by 70 per cent more than retail prices generally.

Comparing the relative tobacco prices in Jersey to those in the United Kingdom over the same period reveals that the price of tobacco rose at a greater rate in Jersey (70 per cent) compared to the United Kingdom (45 per cent) as shown in Figure 24.

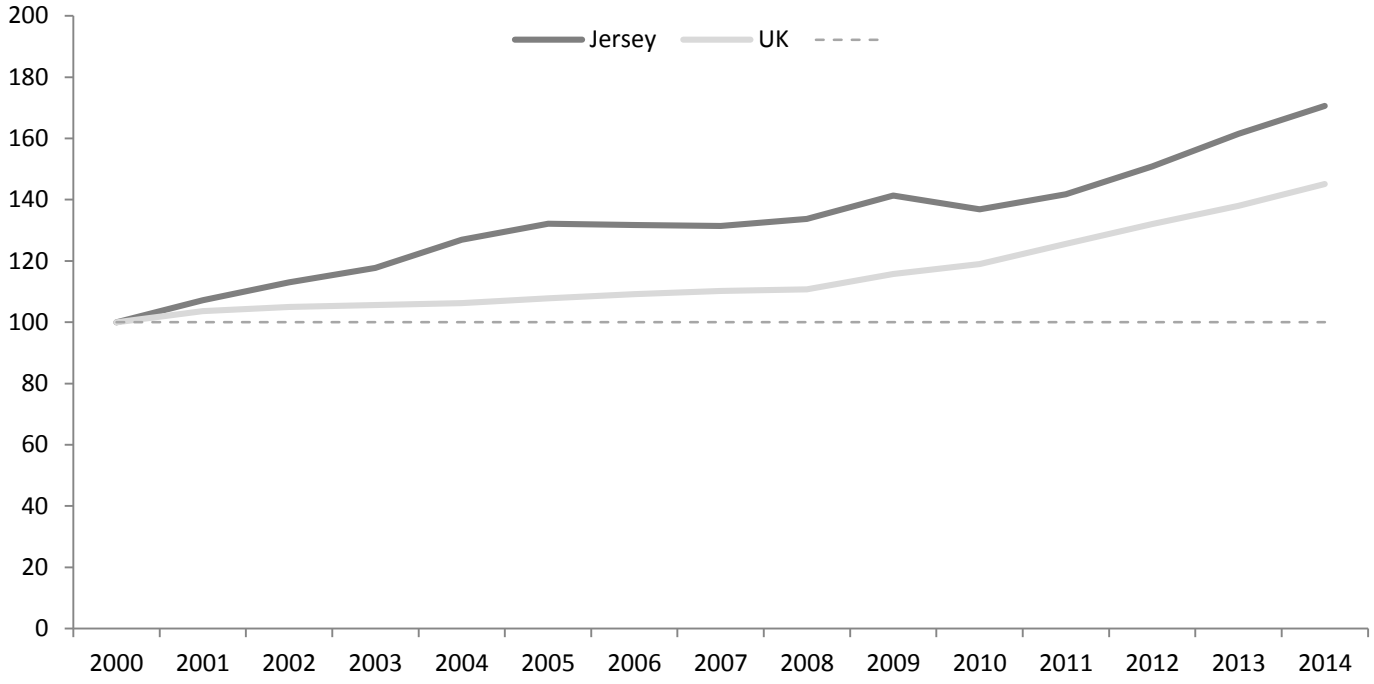
The Health and Social Care Information Centre (HSCIC) have used a measure of real households' disposable income to measure the affordability of tobacco over time. Their findings reveal that tobacco was some 30 per cent less affordable in 2014 than a decade earlier in 2004.[34] Comparable data for Jersey is not currently available.

The tobacco price index used in the relative tobacco price index relates to a 'basket of tobacco products' priced by the States of Jersey Statistics Unit and provides an overall picture of the price of tobacco. It is not

[34] Health and Social Care Information Centre, Statistics on Smoking: England 2015, published 29 May 2015, available from www.hscic.gov.uk

designed to measure the affordability of the cheapest tobacco. It is intended to be used as an indicator – it's relevance at an individual level will depend on the extent to which an individual's choice of tobacco products match the tobacco products included in the measure.

Figure 24: Relative tobacco price index, Jersey and United Kingdom, 2000 to 2014



Data source: States of Jersey Statistics Unit, HSCIC Lifestyle Statistics (based on ONS data)

Comparing the cost of tobacco in Jersey to the cost in Guernsey and the UK since 2005 reveals tobacco prices have seen a greater overall increase in the UK (89 per cent) than in Jersey (74 per cent) and Guernsey (66 per cent).[35]

In June 2015, a pack of 20 cigarettes was, on average, 14 per cent less expensive in Jersey than in the UK, corresponding to being £1.25 per pack cheaper in Jersey (Table 13).

Table 13: Average retail prices of matched tobacco products in Jersey and the UK; June 2015

Item	Mean price (in pence)		Difference in pence	Percentage difference
	Jersey	UK		
20 king size filter	764	889	-125	-14

Source: States of Jersey Statistics Unit

[35] States of Jersey Statistics Unit, Annual price comparison report, June 2015, published 9 September 2015, available from www.gov.je

Spending on tobacco

The States of Jersey Statistics Unit run a Household Spending and Income Survey (HSIS) every five years. The most recent round of the survey ran for 12 months from April 2014, with results to be published in the first quarter of 2016.

At the time of publication, results for this latest round were not available for inclusion in this report. The previous round of the survey ran in 2009-2010.

The results for the 2009/2010 round of HSIS found that:

- On average, households in Jersey spent £5.70 a week on tobacco. This comprised of an average £5.40 on cigarettes and £0.20 on cigars & other tobacco products.
- When households were split by tenure, social rental households were found to spend around five times more than owner-occupier households on tobacco each week (£13.30 compared to £2.70).
- Expenditure was found to vary by age, with the greatest weekly spend seen in the 16-34 age group (£7.90) with the lowest for those aged 65 and over (£2.20) based on the age of the household reference person.
- Households in the highest two income quintiles spent the least on tobacco each week compared to the middle quintile and lower two quintiles.

For more information on household spending, see the States of Jersey Statistics Unit Report *Jersey Household Spending Survey 2009/10* available from www.gov.je.

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. 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

The 95% Confidence Interval is used as a way of quantifying the uncertainty around a point estimate. This uncertainty arises as factors influencing the indicator are subject to chance occurrences that are inherent in the world around us. These occurrences result in random fluctuations in the indicator value between different areas and time periods. Jersey has a comparatively small population so rates or percentage estimates over short periods of time are sensitive to random fluctuations in numbers of events. Confidence intervals quantify the uncertainty in the estimate and, generally speaking, describe how much different the point estimate could have been if the underlying conditions stayed the same, but chance had led to a different set of data. In health profiles, confidence intervals are given with a 95% stated probability level. Where confidence intervals for two estimates are available these can be examined to gauge the statistical significance of the difference in estimates. Non-overlapping confidence intervals signify that estimates are likely to be significantly different. Overlapping confidence intervals, by contrast, suggest that true values of the two estimates may be the same.

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 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-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) as provided by the Statistics Unit from the Jersey Annual Social Survey. This estimate of smoking deaths or ill health is then standardised against the 2013 European Standard Population to allow comparisons over time and place. For further information on the methodology see www.hscic.gov.uk.

Smoking behaviours - Adult:

Current smoker: Adults who said that they do smoke either daily or occasionally.
Ex-smoker: Adults who said that they used to smoke (either daily or occasionally).
Non-smoker: Adults who said they have never smoked and those that said that they used to smoke
Never smoker: Adults who said that they have never smoked or don't smoke

Smoking behaviours - Child:

Regular smoker: is defined as a child who smokes at least one cigarette a week.
Occasional smoker: those children who said they smoke less than one cigarette per week.
Current smoker: These include those who are regular and occasional smokers.

YOLL/YWLL

Years of life lost is a measure of premature mortality which is used to compare the mortality experience of different populations for all causes of death and/or particular causes of death by quantifying the number of years **not** lived by individuals who die under a given cut-off age. The most frequently used cut-off age is 75, this having been set as an age that everyone can be expected to reach. The age of 65 can also be used to calculate years of working life lost (YWLL) which is a useful indicator of the economic impact of premature deaths.

Definitions of Public Health England Indicators

Adults smoking indicators:

Smoking prevalence in adults – current smokers: prevalence of smokers among persons aged 18 and over
Smoking prevalence in adults – ex-smokers: prevalence of ex-smokers among persons aged 18 and over
Smoking prevalence in adults – never smoked: prevalence of never smokers among persons aged 18 and over
Smoking prevalence in adults in routine and manual occupations – current smokers: prevalence of current smoking among persons aged 18 and over in the routine and manual group
Smoking prevalence in adults in routine and manual occupations – ex-smokers: prevalence of ex-smoker among persons aged 18 and over in the routine and manual group
Smoking prevalence in adults in routine and manual occupations – never smoked: prevalence of never smoker among persons aged 18 and over in the routine and manual group

Child smoking indicators:

Smoking prevalence age 15 years – regular smokers: the percentage of 14-15 year olds who reported smoking regularly – comparison to SDD survey results in England

Smoking prevalence age 15 years – occasional smokers: the percentage of 14-15 year olds who reported smoking occasionally (less than 1 cigarette a week) – comparison to SDD survey results in England

Smoking-related mortality indicators:

Smoking attributable mortality: Deaths attributable to smoking, directly age-sex standardised rate for persons aged 35+. Relative risks by ICD10 code as developed by the Health and Social Care Information Centre. Smoking status from the Jersey Annual Social Survey.

Deaths from lung cancer: Age-standardised rate of mortality from lung cancer in persons of all ages per 100,000 population

Deaths from chronic obstructive pulmonary disease: Age-standardised rate of mortality from chronic obstructive pulmonary disease in persons of all ages per 100,000 population

Smoking attributable deaths from heart disease: Directly age-standardised rate of smoking attributable deaths from heart disease per 100,000 population aged 35 years and over

Smoking attributable deaths from stroke: Directly age-standardised rate of smoking attributable deaths from stroke per 100,000 population aged 35 years and over

Smoking-related ill health indicators:

Smoking attributable hospital admissions: total number of hospital admissions for diseases that are wholly or partially attributed to smoking, directly age-standardised rate per 100,000 population aged 35+

Hospital admissions for asthma (under 19 years old): Emergency hospital admissions for asthma, crude rate per 100,000 population aged 0-18 years

Lung cancer registrations: directly age-standardised registration for lung cancer (ICD10 C33-C34), in persons aged 20 and over, per 100,000 2013 European Standard Population

Head and neck cancer registrations: directly age-standardised registration for head and neck cancer (ICD10 C00-C14, C30-C32, C73), in persons aged 20 and over, per 100,000 2013 European Standard Population

Low birth weight of term babies: percentage of full term live births born with low birth weight (<2500 grams)

Smoking quitters indicators:

Number setting a quit date: rate of people setting a quit date per 100,000 smokers

Successful quitters at 4 weeks: rate of successful quitters at 4-week per 100,000 smokers

Successful quitters (CO validated) at 4 weeks: rate of successful quitters (CO validated) at 4-week per 100,000 smokers

Completeness of NS-SEC recording by Stop Smoking Services: percentage of people who set a quit date with a stop smoking service for whom there was a valid NS-SEC recorded

Background Notes

1. The profile provides facts about how Jersey compares with other areas. It does not seek to answer why the figures are as they are or what may need to be done about them, though these will be important questions to consider.

2. Comparisons are performed on a like-for-like basis unless otherwise stated. Where a comparable figure uses a mid-year population, the Jersey rates are calculated using the average of the two applicable end-year population estimates as published by the States of Jersey Statistics Unit. This estimate of the mid-year population assumes that half of births, deaths and migration occurs in the first half of the calendar year.

3. Population figures have been provided by the States of Jersey Statistics Unit and are based on results of the 2011 Census and population projections. For further information see www.gov.je/census.

4. This report uses the 2013 European Standard Population in the calculation of age-standardised rates. Directly age standardised rates use age specific rates for a population and apply these to the standard population to adjust for differences in age and sex structures between populations to allow comparisons across time and place.

5. Percentages may not add up to 100 per cent due to rounding.

6. Deaths
   (1) Death figures are compiled from returns to the Registrars in each parish in Jersey. The Marriage and Civil Status (Jersey) Law 2001 requires all deaths to be notified within 5 days of the date of death.
   (2) 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. This means that total deaths in a given year should be treated as provisional and used with caution.
   (3) The results are based on analysis of all deaths of Jersey residents registered as having occurred in calendar years as stated. Deaths are reported on for the year they occur, this differs to the UK who report on deaths registered each year.
   (4) Cause of death is classified using the tenth revision of the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-10).
   (5) Coding of Jersey deaths is undertaken by the Office for National Statistics on a quarterly basis.
   (6) Potential Years of Life lost estimates the number of years a person would have lived had they not died prematurely. It is based on the assumption that every individual could be expected to live until the age of 75 and premature death before that age may be preventable.

7. The Jersey Annual Social Survey is a voluntary postal and internet survey run independently by the States of Jersey Statistics Unit. The survey is sent to more than 3,000 randomly selected households each year, and has a high response rate of around 52%. In addition to the very good response rates overall, statistical 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 broadly accurate and representative of Jersey's population. As with all sample surveys, there is an element of statistical uncertainty, typically around ±2 percentage points for proportions relating to the overall population. For further details see www.gov.je/JASS.

8. Data on hospital admissions is taken from the hospital computer system TRAK which was implemented in June 2011. Admissions data are classified using the International Classification of Diseases (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-related hospital admissions in this report.

9. Smoking attributable deaths 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) as provided by the Statistics Unit from the Jersey Annual Social Survey. This estimate of smoking deaths or ill health is then standardised against the 2013 European Standard Population to allow comparisons over time and place. For further information on the methodology see www.hscic.gov.uk.

10. Data provided by the States of Jersey Statistics Unit was used to analyse changes in the price of tobacco in comparison to retail prices overall. This data uses information collected for the purpose of calculating the Retail Prices Index. The tobacco price index used in the relative tobacco price index relates to a 'basket of tobacco products' priced by the States of Jersey Statistics Unit and provides an overall picture of the average change in price of tobacco products. It is not designed to measure the affordability of the cheapest tobacco. It is intended to be used as an indicator – it's relevance at an individual level will depend on the extent to which an individual's choice of tobacco products match the products included in the measure.

11. Household expenditure on tobacco was taken from the States of Jersey Statistics Unit Report *Jersey Household Spending Survey 2009/10* available from www.gov.je. The most recent round of the survey ran for 12 months from April 2014, with results to be published by the end of 2015.

12. Data on the smoking behaviours of young people in Jersey is taken from the The Young People's Health and Lifestyle Survey (formally known as the Health Related Behaviours Survey) which is run by the States of Jersey Health Intelligence Unit through Jersey schools. The latest round ran in 2014, and the questionnaire was carried out with students in all primary schools across the Island at ages 10-11

years (school year 6) and in all secondary schools across the Island at 12-13 years (school year 8) and 14-15 years (school year 10). A total of 2,675 students completed the survey, representing an 86 per cent response rate. The survey questions cover a range of health topics including family background and home life through to specific health issues such as diet, physical activity, drugs, alcohol, smoking and wellbeing. With the survey methodology used there is 95% confidence that the sample percentages accurately represent the whole population percentage to ± 2 percentage points. For further information please see the report on www.gov.je

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