Strategic Policy, Planning and Performance Report

Public Health Intelligence

Subject:	Smoking Profile 2021
Date of report:	28th April 2022

Introduction

This profile is the latest collection of smoking related statistics for Jersey. Information in the report is derived from various sources including public surveys and health service data. Trends over time are considered, and statistics are compared to the UK and other OECD countries where appropriate.

Included in this report are:

- smoking in adults, including prevalence, and smoking behaviours
- smoking in children and young adults
- smoking quitters and the smoking cessation service
- smoking related mortality
- smoking related ill health, including hospital admissions
- imports and retail price of tobacco

Summary

In 2021:

- one in seven (14%) people aged 16 years and above smoked cigarettes in 2021, a decline of 11 percentage points compared to 2005 when one in four (25%) were smokers
- in 2021, around three in ten Year 10 pupils (28%) reported they had tried smoking at least once, lower than the proportion in 2010 (48%)
- in 2021 fewer than one in twenty adults (5%) said they currently (at least sometimes) use an e-cigarette; in 2021, current and regular e-cigarette prevalence for secondary school aged pupils (Years 8, 10 and 12) was around one in thirteen (8%)
- the prevalence of current smokers (aged 18 years and above) in Jersey in 2021 (13%) was similar when compared with the latest UK figure of 14% (Quarter 1, 2020)[1]
- 300 people successfully quit through the Help2Quit smoking cessation service in 2021 representing a quit rate of 47%
- around one in seven (14%) of all babies born in 2021 were living in a household where they were likely to be exposed to tobacco smoke by an adult
- 140 deaths were estimated to be attributable to smoking in 2020, this represents 19% of all deaths and 39% of deaths for conditions that can be caused by smoking
- 1,120 hospital admissions were estimated to be attributable to smoking in 2020, this represents 4% of all hospital admissions, and 45% of hospital admissions that can be caused by smoking
- the quantity of tobacco imported into Jersey reduced over the period 1996-2019, falling from around 198,000 kgs in 1996 to around 30,000 kilograms; there has been a marked increase in 2020 and 2021 to a level last seen in 2013
- the relative tobacco price index shows that tobacco prices have increased at twice the rate of retail prices more generally (TPI/RPI 205) since 2000

[1] Smoking prevalence in the UK and the impact of data collection changes - Office for National Statistics (ons.gov.uk)

Jersey Smoking Profile 2021

1 in 7 (14%)
of people aged 16 years and above smoked cigarettes

28% of Year 10 pupils reported they had tried smoking at least once

1 in 20 (5%)
of adults said they currently use an e-cigarette

1 in 13 (8%)
- current and regular e-cigarette prevalence for secondary school aged pupils (Years 8, 10 and 12)

1 in 5 (19%) of all deaths were estimated to be attributable to smoking in 2020

In 2021, **300 people** successfully quit through the Help2Quit smoking cessation service

1,120 hospital admissions were attributable to smoking, this was 4% of overall admissions

tobacco prices have increased at **twice** the rate of retail prices (RPI) since 2000

Contents

1. Smoking Prevalence and Behaviours

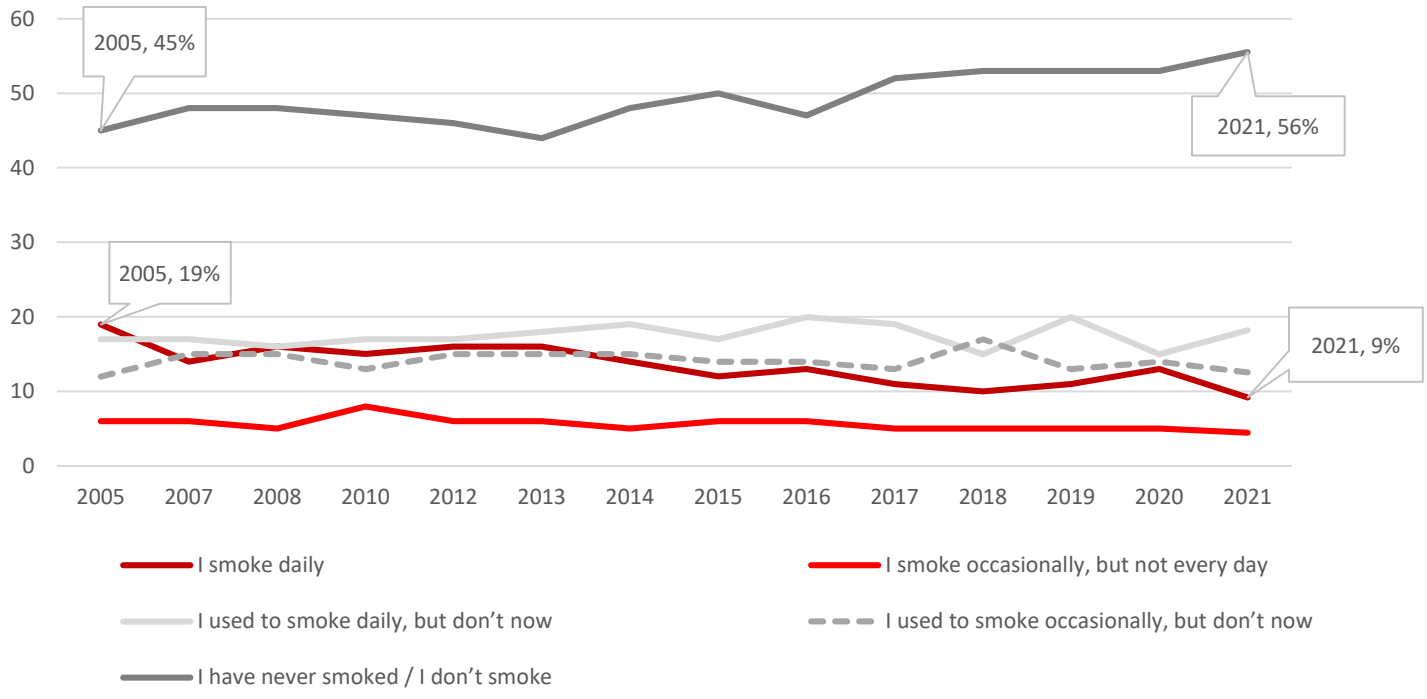
The information presented in this section relates to the smoking patterns of Jersey resident adults (aged 16 years or over). The main source of adult smoking information has come from the 2021 Health, Activity and Wellbeing Survey[2] run by the Public Health Department in conjunction with Jersey Sport, in which households in Jersey were selected at random to take part. Historic data has come from the Jersey Opinions and Lifestyle Survey (JOLS), formerly the Jersey Annual Social Survey (JASS), conducted by Statistics Jersey[3].

1.1 Smoking in Adults (16+)

Figure 1 shows smoking habits in adults over time.

- in 2021, around one in seven (14%) adults in Jersey were smokers (including people who smoked daily or occasionally). This latest figure is a statistically significant decrease of eleven percentage points compared to 2005 when one in four (25%) were smokers (Figure 1)
- for comparison, Jersey's smoking rates were similar to the UK, where rates fell from 24% of over 16's smoking in 2005 to 15% in 2020[4]
- the proportion of Islanders who reported smoking daily has fallen from around one in five (19%) in 2005 to around one in ten (9%) in 2021 (Figure 1)
- There are an estimated 11,900 adult smokers (daily or occasional) in Jersey[5]

Figure 1: Do you smoke? Percentage by year, 2005-2021 (16+)[6]



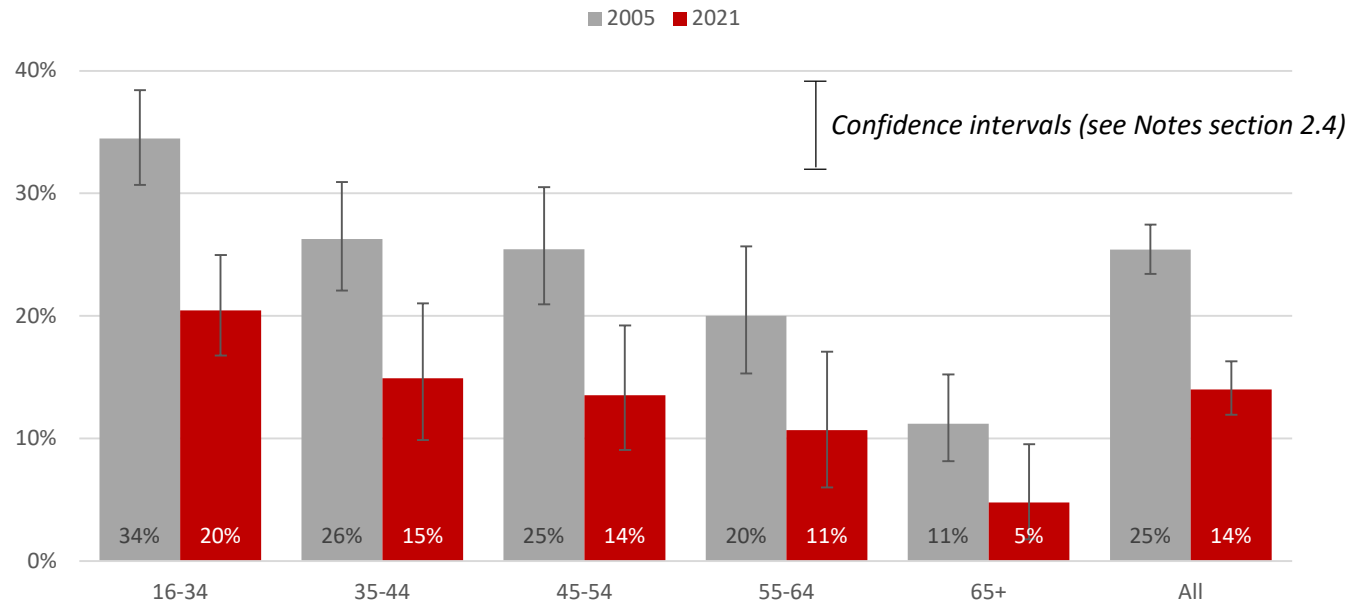
Source: JASS 2005-2015, JOLS 2016-2020, Jersey Health, Activity and Wellbeing Survey 2021

[2] The survey was sent to households selected at random, and was completed by over 16's. Questions covered health, diet, lifestyle, physical activity, wellbeing and volunteering
[3] https://www.gov.je/government/jerseyinfigures/statisticscommunitypeople/pages/socialstatistics.aspx#anchor-1
[4] Smoking prevalence in the UK and the impact of data collection changes - Office for National Statistics (ons.gov.uk)
[5] Calculated by smoking prevalence multiplied by an estimated population of over 16's from Statistics Jersey 2021 CensusBulletin1.pdf
[6] Numbers are rounded independently and as such may not sum to total.

Prevalence of smoking (either daily or occasionally) is down broken down by age group in Figure 2.

- in 2021, smoking prevalence generally declined with age, from one in five adults aged 16-34-years (20%) reporting smoking, compared to one in twenty of those aged 65 years and over (5%)
- the 16-34 age group saw a decrease in the prevalence of smoking from 34% in 2005 to 20% in 2021, a reduction of around 14 percentage points

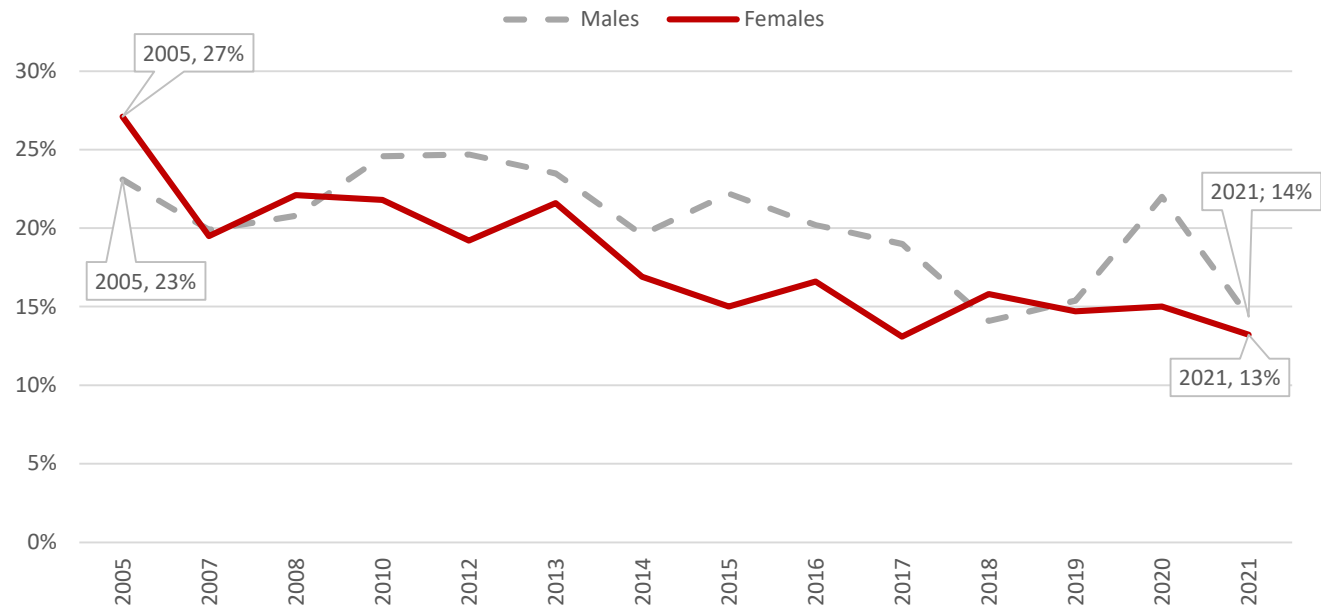
Figure 2: Prevalence of cigarette daily and occasional smoking, by age group, 2005 and 2021



Source: JASS 2005 and Jersey Health, Activity and Wellbeing Survey 2021

- prevalence of smoking (either daily or occasionally) was similar for males (14%) and females (13%) in 2021 (Figure 3)

Figure 3: Prevalence of daily and occasional smoking, by sex, 2005-2021

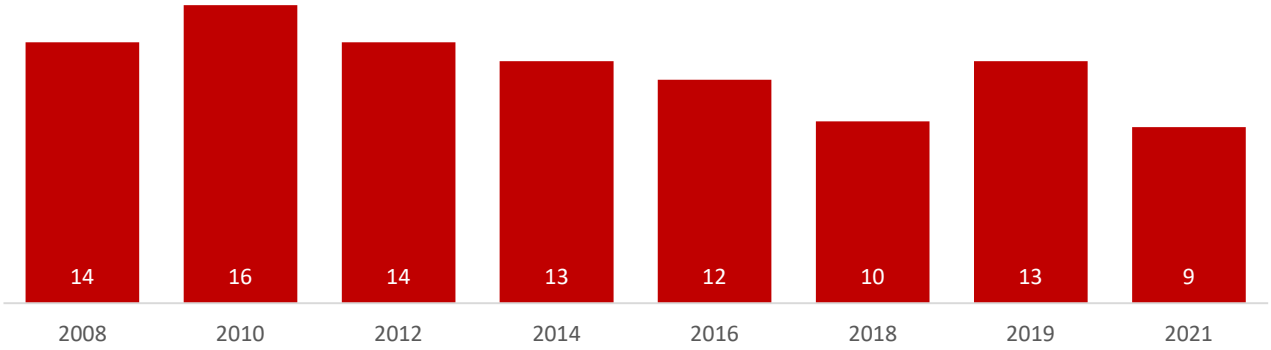


Source: JASS 2005-2015, JOLS 2016-2020, Jersey Health and Wellbeing Survey 2021

1.2 Cigarette Consumption

- the self-declared number of cigarettes (including rollups) smoked each day by smokers has fallen from an average of 16 per day in 2010 to 9 per day in 2021

Figure 4: Number of cigarettes smoked each day by smokers



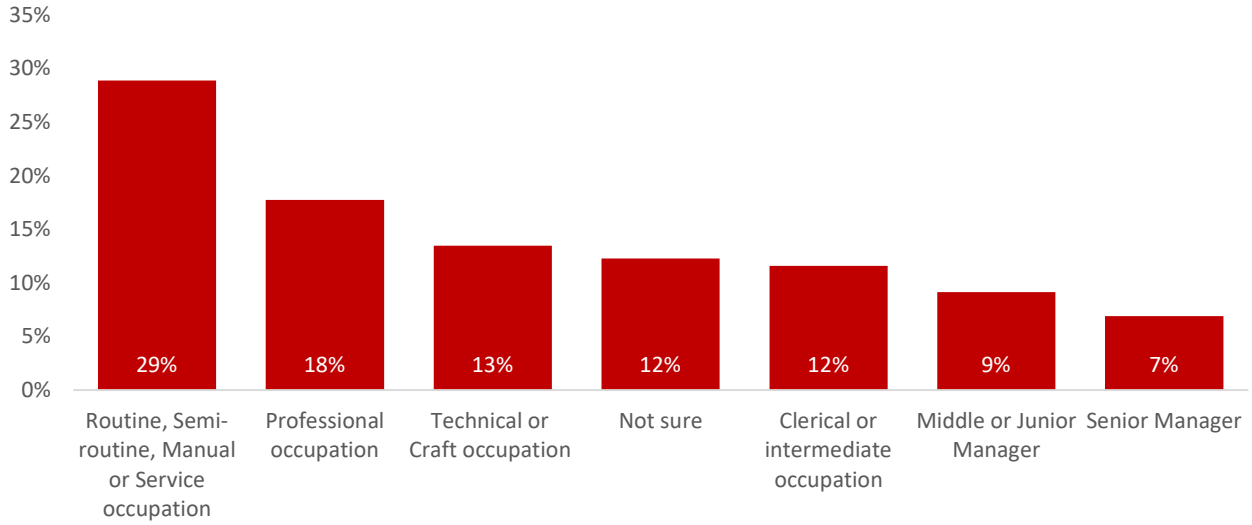
Source: JASS 2005-2015, JOLS 2016-2020, Jersey Health and Wellbeing Survey 2021

1.3 Other characteristics of Smokers

Economic activity and Occupation

- Rates of smoking were similar amongst those of working age, whether they were in employment or not: 15% of those in employment reported being current smokers (daily or occasional) whilst 16% who were not in employment reported being current smokers
- 5% of those above working age were daily or occasional smokers
- in 2021 the highest proportions of daily smoking were among people working in manual and routine professions, where 29% smoked daily. Of those working in managerial and professional occupations 18% smoke daily, while 13% of those working in technical or craft occupations reported daily smoking (Figure 5)

Figure 5: Prevalence of daily smoking by profession



Tenure

- one in five (19%) of those living in social housing, one in six (16%) of those living in non-qualified accommodation and one in seven in qualified rental accommodation (14%) reported smoking daily, this compared to around one in twenty (4%) of those in owner-occupied accommodation
- there was a significantly higher proportion of current smokers (daily or occasional) in social rented accommodation (29%) than owner-occupied accommodation (6%)

Education level

- around one in six (17%) of those educated to secondary level or below were smokers (daily or occasionally), compared to one in ten (9%) of those educated to a higher level[7]

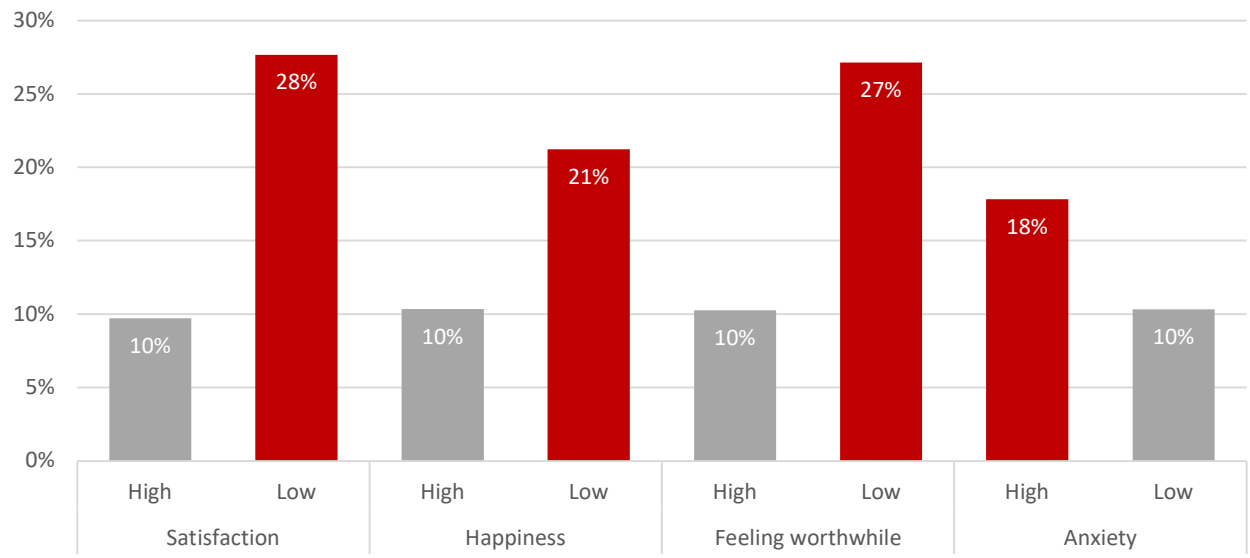
Mental health

A factsheet launched by World Health Organisation (WHO)[8] examines the intricate connections between tobacco use and mental illness. Quitting tobacco is associated with reduction in levels of depression, anxiety, and stress, and with mood enhancement and improvements in the symptoms of ADHD. Using tobacco can also inhibit the effectiveness of certain medications taken for mental health concerns.

Jersey's survey data from 2021 shows that those who had medium or low scores for measure of wellbeing were more likely to be smokers than those who had high scores for wellbeing (Figure 6):

- around one quarter of those who had low scores for life satisfaction, happiness and feeling worthwhile (28%, 21% and 27% respectively) were smokers
- around one in ten of those who had high scores for happiness, life satisfaction and feeling worthwhile (10% for each) were smokers
- around 18% of those with high levels of anxiety were smokers, compared to 10% of those with low levels of anxiety

Figure 6: Prevalence of smoking (daily or occasional) by self-reported wellbeing measures (happiness, satisfaction, feeling worthwhile, and anxiety)



[7] Defined as those with a first or higher degree
[8] WHO/Europe | The vicious cycle of tobacco use and mental illness – a double burden on health

1.5 Comparisons to other jurisdictions

Jersey data from 2020 has been used for this UK comparison, as 2020 is the most recent data available for the other jurisdictions. Smoking prevalence in those aged over 18 years is used to ensure it is comparable to UK data (note that prevalence in those aged over 16 is referenced earlier in section 1.1).

- the prevalence of current smokers aged 18 and over in Jersey (18%) in 2020, compared with the UK (14%) and with the constituent countries, Northern Ireland (13%), England (14%), Wales (15%) and Scotland (16%) respectively as shown in Table 1

Table 1: Smoking by Country, 2012-2021, all persons aged 18 or over (current smokers), 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	15	16	16	17	16
2018	14	16	16	16	15
2019	14	16	15	16	15
2020	14*	15*	16*	13*	18
2021	-	-	-	-	13

Source: JOLS 2012-2020, Jersey Health, Activity and Wellbeing Survey 2021, Office for National Statistics[9]

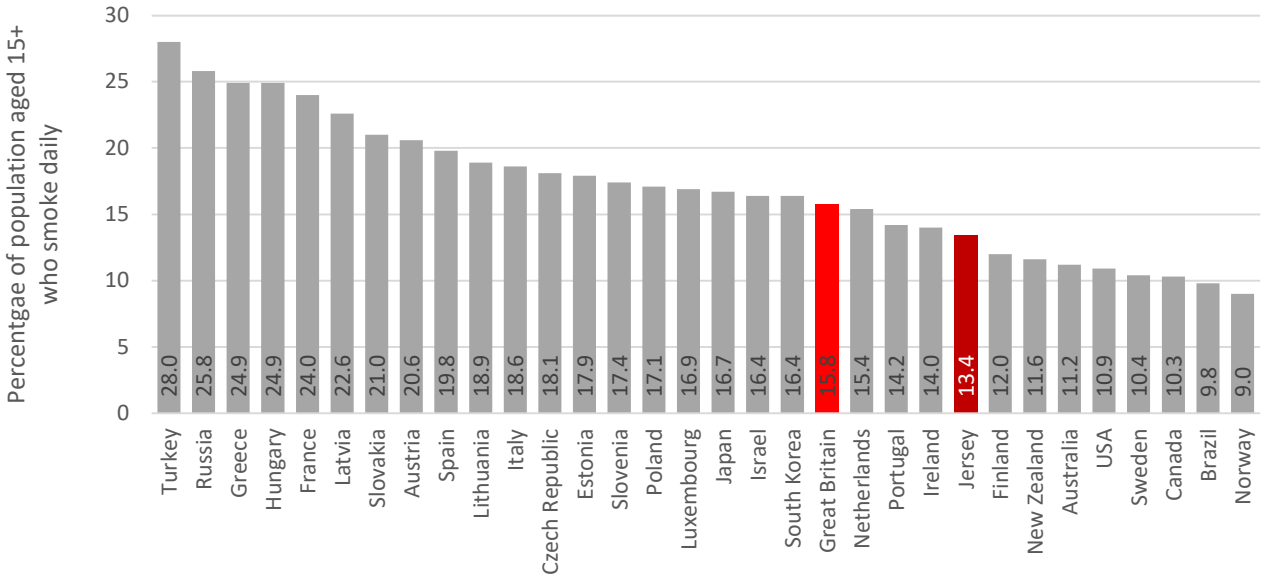
**UK data is from quarter 1 of 2020, mostly were collected before the UK-wide lockdown which began in March 2020 and has been weighted to produce estimates comparable with previous years. Because of mode changes introduced in March 2020, Quarters 2 to 4 are not comparable with earlier periods*

Daily smoking prevalence: Jersey, comparison with Great Britain and other OECD countries

Smoking prevalence (amongst those aged 15 years and over who smoke daily) in Jersey in 2020 has been used for this OECD comparison, as 2020 is the most recent data available for the other jurisdictions. The daily smoking level reported for Jersey in 2020 was 13%; Iceland, Norway, Brazil, Canada, Sweden, USA, Australia, New Zealand and Finland reported daily smoking levels of 12% and less; Great Britain reported 16% in 2019, whilst Turkey reported the highest daily smoking level with 28% (Figure 7). Detailed comparisons of Jersey data on smoking rates to data published by Public Health England are shown in Appendix 1.

[9] Smoking prevalence in the UK and the impact of data collection changes - Office for National Statistics (ons.gov.uk)

Figure 7: Total percentage of population aged 15 years and over who smoke daily, 2020 or latest available



** Note: data from OECD[10]. Data presented in this chart refers to year 2020 or latest available.*

1.6 Use of E-cigarettes

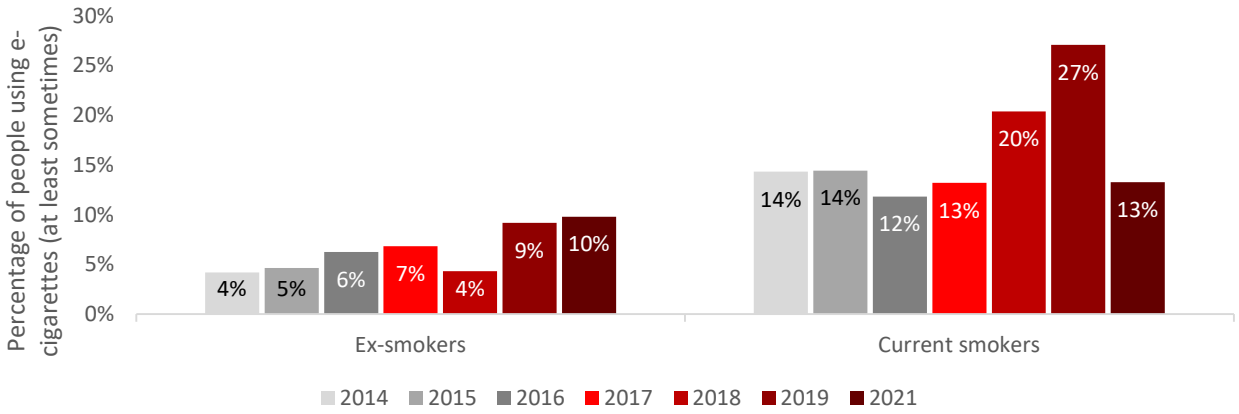
E-cigarettes deliver nicotine that is vaporised and inhaled from a liquid form via a battery-powered device that simulates cigarette smoking; they are classified as nicotine containing products.

Questions about e-cigarettes have been included in the Jersey Opinions and Lifestyle Survey since 2014, A question on electronic cigarette use was also asked in the *Jersey Health Activity and Wellbeing Survey 2021.*

In 2021:

- the majority of Islanders had either never used or heard of e-cigarettes (83%), 12% had used them once or twice, and 5% of adults were using e-cigarette at least sometimes
- 13% of those who currently smoke (either daily or occasionally) used e-cigarettes at least sometimes, and 10% of ex-smokers used them at least sometimes (Figure 8)

Figure 8: Proportion of adults using e-cigarettes at least sometimes, by smoking status, 2014 - 2021



Data source: JASS 2014-2015, JOLS 2016-2019, Jersey Health, Activity and Wellbeing Survey 2021

[10] OECD (2020), Daily smokers (indicator). doi: 10.1787/1ff488c2-en (Accessed on 11 April 2022)

- when looking at the prevalence of vaping by sex, similar proportions of men (6%) reported using e-cigarettes at least sometimes when compared with women (4%)
- by age, those aged 65 years and over had the lowest proportion of users who consume e-cigarettes often or everyday (1%)

In recent years, e-cigarettes have become a very popular stop smoking aid. E-cigarettes are not currently available from Help2Quit, they can instead be bought from specialist vape shops, some pharmacies and other retailers, or on the internet. Clients using them as part of a quit attempt are supported to quit. Clients are encouraged to use the licensed medication, but some will choose to continue to use the e-cigarette to support them in quitting.

- around 30 clients used an e-cigarette in 2021 with a quit rate of 48%

Clients who are not smoking but want support to stop vaping can receive behavioural support from the specialist service only. The numbers are not captured by the database, but are very small, less than five people.

1.7 Smoking in Children and Young People

Smoking behaviour, babies

Public Health advice is that it's best to give up smoking as soon as possible in pregnancy but stopping at any time in pregnancy benefits both mother and baby.

Stopping smoking during pregnancy also reduces the chances that a child will grow up to become a smoker. Children whose parents smoke are three times more likely to become smokers themselves.

Stopping smoking is the single most effective way to reduce the risk of children starting to smoke.

- in 2021, 6% of women were recorded as being a current smoker at their booking appointment[11]

Smoke from other people's cigarettes can be harmful to babies. Smokers are advised to stop smoking or smoke well away from the house as smoke drifting into the house can be harmful. This reduces the risk of sudden infant death syndrome (SIDS) also known as cot death.

Evidence also shows that children exposed to second-hand smoke can be at risk of:

- asthma and other respiratory symptoms including respiratory tract infections
- middle ear disease
- meningitis

As part of the 6-week check of new-borns, the risk of exposure to second-hand smoke is assessed by GPs[12]

- around one in seven (14%) of all babies born in 2021 were living in a household where they were likely to be exposed to tobacco smoke by an adult

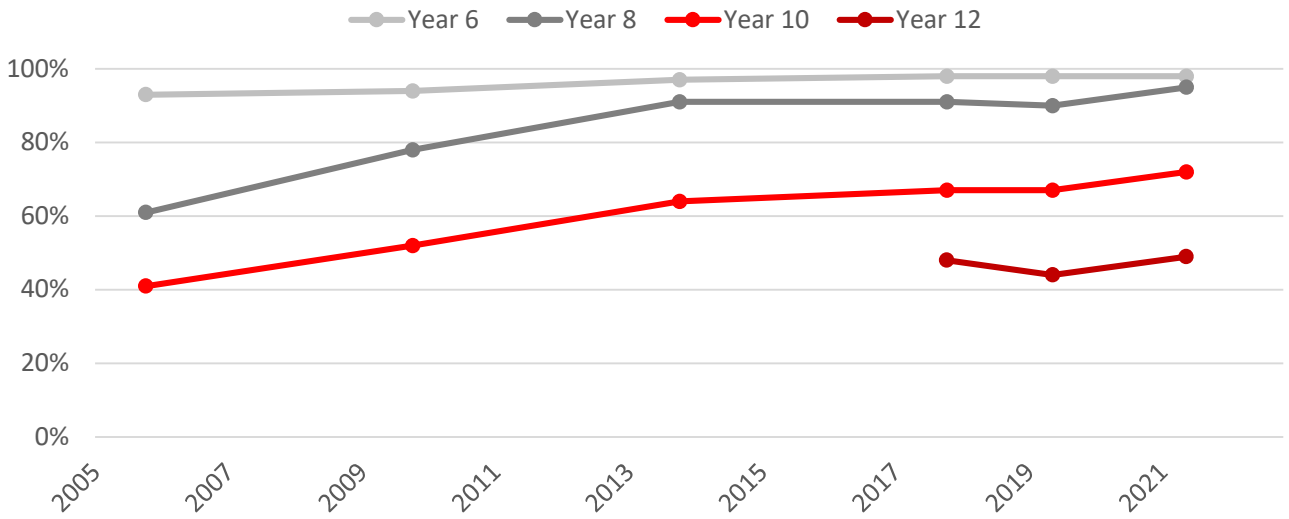
Smoking behaviour children and young people

The Jersey Children and Young People Survey of smoking among secondary school pupils in Jersey defines regular smoking as smoking one or more cigarette per week and occasional smoking as less than one cigarette per week.

[11] The booking appointment is the first official antenatal appointment and will usually happen when the mother is between 8 and 12 weeks pregnant.
[12] Data taken from electronic records on Child Health System - Careplus

- the proportion of children across Year groups 6, 8, 10 and 12 who have '**never smoked'** in 2021 (81%) was similar to 2019 (77%)
- 98% of Year 6; 95% of Year 8; almost three quarters (72%) of Year 10 children have never smoked; around half (49%) of Year 12 young people have never smoked
- in 2021, around one in three Year 10 pupils (28%) reported they had tried smoking at least once, this was a similar proportion to 2019 (33%), but lower than the one in two pupils stated in 2010 (48%)
- 5% of secondary school aged pupils in Year 10, and 12% of Year 12 were regular smokers
- the proportion of Year 10 pupils who smoked regularly fell from 12% in 2010 to 5% in 2021
- 9% of males in year 12 said they were regular smokers compared to 14% of females (this difference was not statistically significant)
- around one in seven children at fee-paying schools had reported they had smoked at least once, compared to one in five in public schools

Figure 9: Percentage of young people who have never smoked, 2006-2021



Factors that may influence children to start smoking

Smoking initiation has been associated with a wide range of risk factors including: parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members, socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media.

- a quarter (27%) of children reported that their parents smoked, this has remained unchanged since 2014
- one in eight (13%) reported being exposed to second-hand smoke, either at home or in the car, at least occasionally
- in 2021, one in ten (10%) of children surveyed reported having some level of exposure to second-hand smoke in the home (theirs or others'); one in twenty (6%) of children experienced second-hand smoke in a car[13]

E-cigarette prevalence - children and young adults

- 91% of Year 8, 62% of Year 10 and 42% of Year 12 students reported they had never used an e-cigarette
- regular e-cigarette use increased with age, from 8% of Year 10 pupils to 19% of Year 12
- current and regular e-cigarette prevalence for secondary school aged pupils (Years 8, 10 and 12) was low at around one in twenty (8%)
- a higher proportion of girls (17%) were more likely than boys (8%) to be current e-cigarette users in 2021

[13] R Jersey Children and Young People's Survey 20220309 SJ.pdf (gov.je)

2. Smoking Cessation

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.

2.1 Smoking Cessation Service

Help2Quit is a free and confidential stop smoking service delivered by local pharmacies on behalf of the Government of Jersey Health and Community 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.

2.2 Use of the stop smoking service

During the Coronavirus pandemic the Stop Smoking Service had to adapt and offered telephone support sessions rather than face to face which might have impacted on use of the service. The specialist service capacity to see clients was also greatly reduced owing to redeployment of staff to support acute areas of the hospital during the pandemic. This has now been addressed with an increase in specialist nurse capacity within the service who are continuing to target those groups who would find it harder to quit.

In 2021:

- 643 people set a quit date through the stop smoking service, a decrease of 12% on 2020 (733) and 27% on 2019 (882)
- 300 people successfully quit through the Help2Quit smoking cessation service in 2021, representing a quit rate of 47%, a similar proportion to that recorded annually since 2014
- around 70 pregnant women were referred to the service in 2021 with about 40 pregnant women using the cessation service, the highest number of women to set a quit date since 2013; the quit rate for pregnant mothers was 35%

Quit rates alone do not provide a measure of use of the service as there were a total of 874 people referred to the service. Some of these people will not engage with the service. However, there are other reasons for not being included in numbers setting quit dates. There were 25 people who had quit shortly before joining the service and these people are not included in quit rates in accordance with guidelines but are supported to remain quit. There are also some people who will be supported with harm reduction to help them to smoke less with a view to support them towards being ready to quit in the future.

2.3 Prison smoke free

From January 2019 the prison at La Moye has been smoke free, with no option for inmates to purchase cigarettes. Prisoners who do not want to stop smoking will be able to buy e-cigarettes.

Prisoners were to be supported by the Help2Quit team, with new prisoners entering La Moye also having access to the Help2Quit service's weekly clinic.

Owing to the COVID pandemic, visits to the prison were halted, though access to nicotine replacement therapy was still available. The aim is for the Help2Quit Team to recommence the behavioural support, which is a key aspect for supporting quit attempts in 2022.

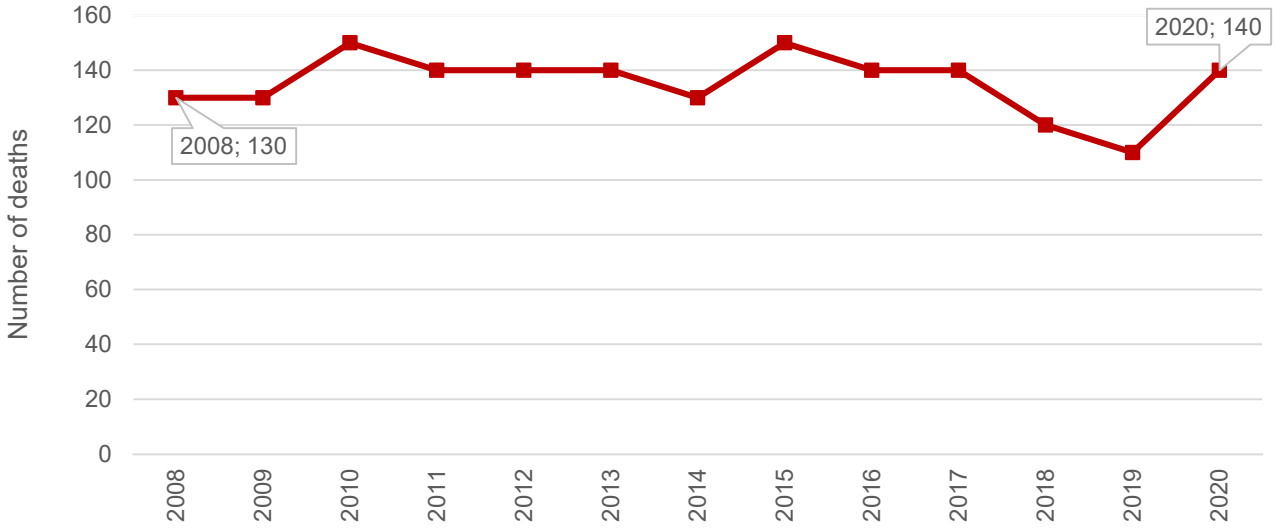
3. Smoking-related Mortality and Ill Health

3.1 Smoking-related Mortality

Monitoring the number of deaths that are attributable to smoking gives a measure of the impact smoking has on Islanders' health. Data is presented for deaths occurring in 2020, the most recent available[14].

- there were 140 deaths of adults aged 35 or over in Jersey in 2020 from conditions attributable to smoking[15], this represents around 19% of all deaths amongst over those aged over 35, a similar proportion to 2019 (15%).
- 39% of deaths of those aged 35 or over were from conditions that can be caused by smoking[15]

Figure 10: Number of deaths among adults aged 35 or over in Jersey which were attributable to smoking, 2008 to 2020



Of those aged 35 and over:

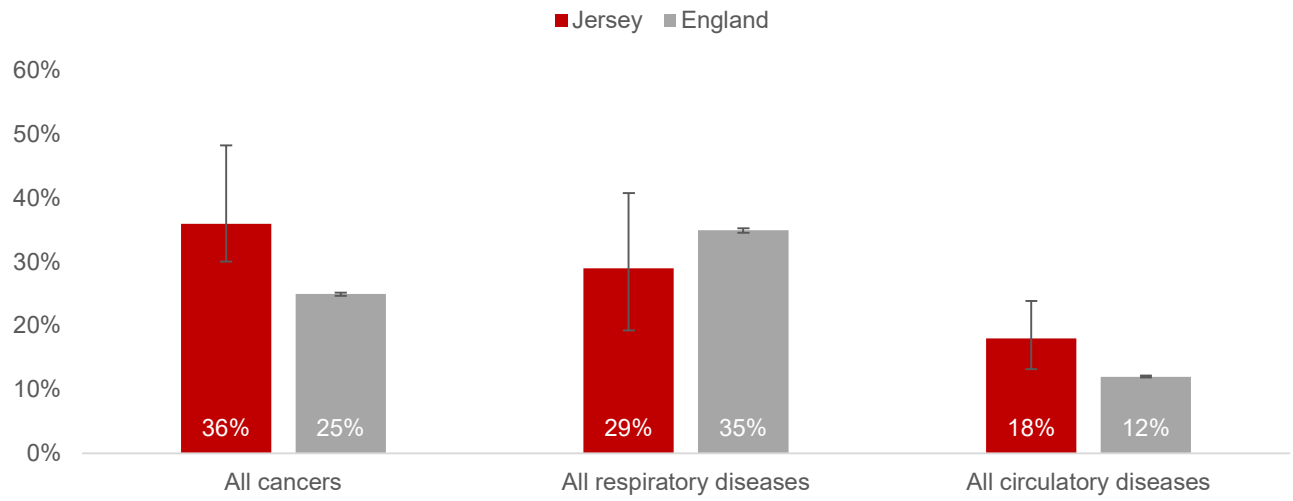
- one in five (21%) of male deaths were estimated to be attributable to smoking in 2020 compared to one in six (17%) female deaths
- the pattern of smoking related deaths in Jersey was similar to that of England, where 19% of male and 12% of female deaths were estimated to be smoking related[16] in 2019
- it is estimated that in Jersey in 2020 (see figure 11);
    - around 20 deaths (29%) of all deaths due to respiratory diseases were attributable to smoking
    - around 80 deaths (36%) of all cancer deaths were attributable to smoking
    - around 40 deaths (18%) of deaths from circulatory diseases were attributable to smoking
    - the proportion of deaths from respiratory disease that were estimated to be attributable to smoking was similar in Jersey (29%) and England (35%)
    - the proportion of deaths from all cancers that were estimated to be attributable to smoking was higher in Jersey (36%) than in England (25%)

[14] 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.

[15] These statistical estimates are based on smoking prevalence and risks of smokers/ex-smokers developing each disease – for more information see Notes section 2.2

[16] NHS Digital, Statistics on Smoking: England 2020, published 8 December 2020, available from www.digital.nhs.uk

Figure 11: Deaths estimated to be attributable to smoking by cause, Jersey (2020) and England (2019)



Source: Public Health Intelligence, Government of Jersey; NHS Digital Statistics on Smoking, England 2020

3.2 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.

COPD

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.

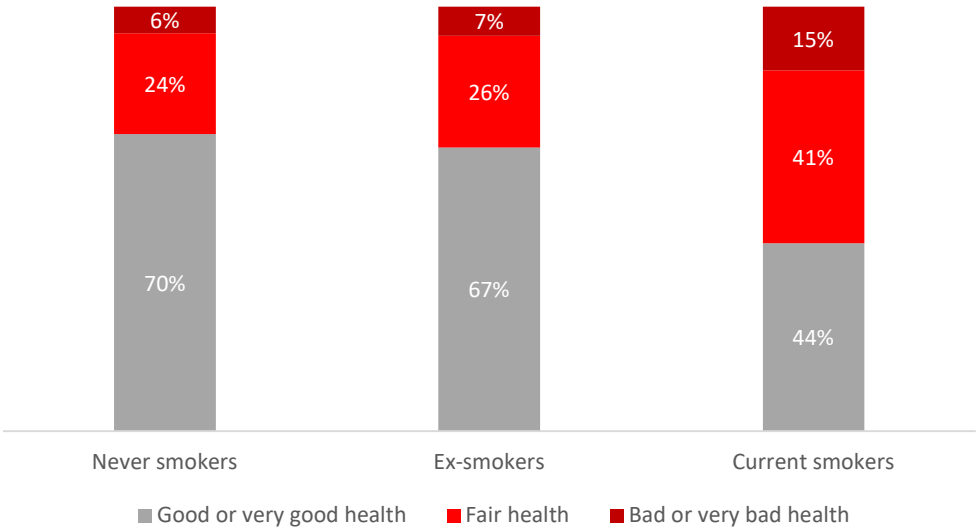
- in 2021, 2,250 people registered with a GP in Jersey were on the COPD disease register[17], this was an increase of 25% on the number registered in 2016 (1,800)

Self-reported Health[18]

- in 2021, adults who have never smoked were more likely to report better health than current or ex-smokers; 70% of those who had never smoked reported being in very good or good health compared to 44% of current smokers (Figure 12)
- current smokers were more than twice as likely to report being in bad or very bad health compared to those who had never smoked (15% compared to 6%) (Figure 12)

[17] Specific disease registers are generated as part of the Jersey Quality Improvement Framework (JQIF) in which GPs accurately record patients that meet a set of disease-specific criteria as being on a particular disease register.
[18] Health, Activity and Wellbeing Survey 2021

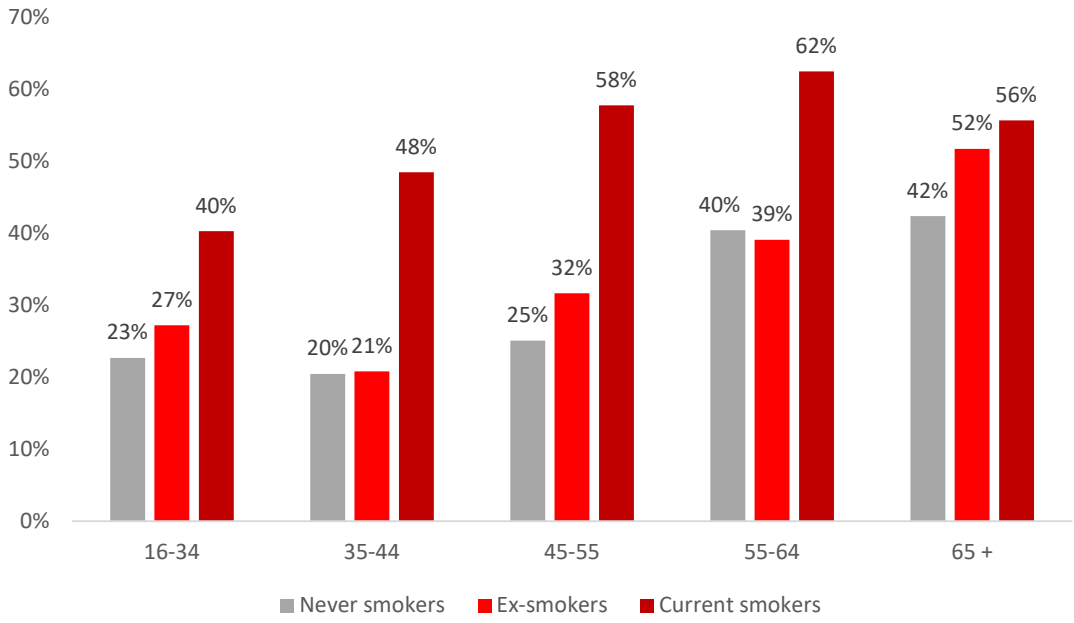
Figure 12. Self-declared health status of never smokers, ex-smokers, and current smokers



Longstanding illness

Across all age groups, a greater proportion of current smokers reported having a long-standing illness[19] than those who had quit smoking (ex-smokers) or those who never smoked (Figure 13)

Figure 13: Proportion who report having a longstanding illness, disability or infirmity, by smoking status and age, 2021



[19] Health, Activity and Wellbeing Survey 2021, Answered "yes" to a question on whether they had an illness, disability or infirmity that had lasted or was expected to last at least twelve months

Premature births and low birth weight

Smoking during pregnancy and exposure to second-hand-smoke can affect the health of babies.[20] 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.

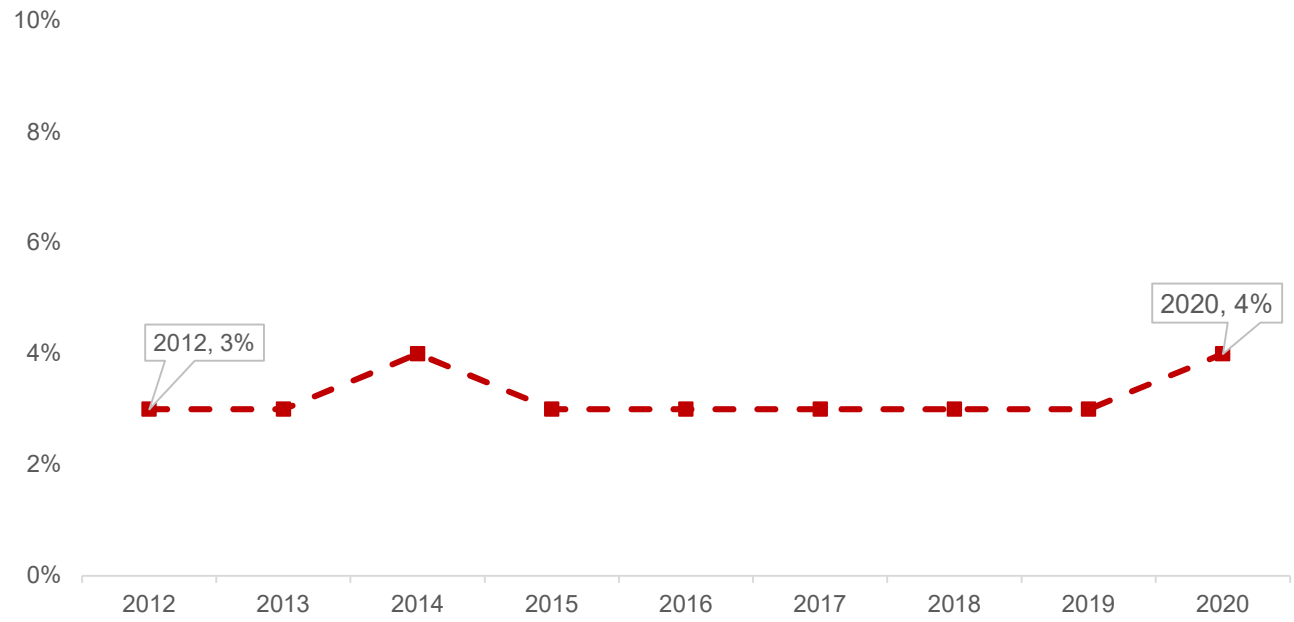
- in 2021, there were around 900 live births to Jersey resident mothers; of these 2% were small for their gestational age (birthweight is below the 5th centile[21] for weight), this proportion has remained stable since 2012
- over nine in ten (93%) babies born in 2021 were delivered at term (after 37 weeks of gestation); a small proportion (2%) of term births were of a low birth weight (less than 2500 grams), this proportion has been similar over recent years, ranging from 1% to 3% of term births
- 7% of babies were born prematurely in 2021; on average, around 6% of births each year in Jersey are premature (born before 37 weeks gestation)

Hospital Admissions

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.

- 1,120 hospital admissions[22] were estimated to be attributable to smoking in 2020, this represents 4% of all hospital admissions and 45% of hospital admissions that can be caused by smoking (Figure 14)
- the proportion of all hospital admissions attributable to smoking has increased since 2018

Figure 14: Proportion of all hospital admissions attributable to smoking, 2012-2020 (adults aged 35 or over)



- males accounted for 60% of smoking attributable hospital admissions in 2020
- around three in ten (29%) of all admissions for respiratory diseases were estimated to be attributable to smoking in 2020 (Figure 15), a higher proportion to than that for England[23] for 2020 (21%)

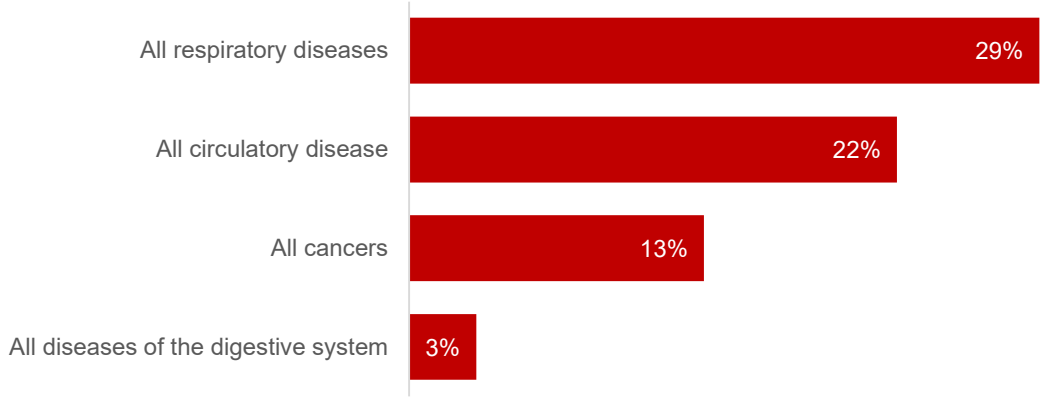
[20] Been, Jasper V et al., 1.Effect of smoke-free legislation on perinatal and child health: a systematic review and meta-analysis, The Lancet, Volume 383, Issue 9928, 1549 - 1560

[21] Births, fertility and breastfeeding 2020 (gov.je)

[22]

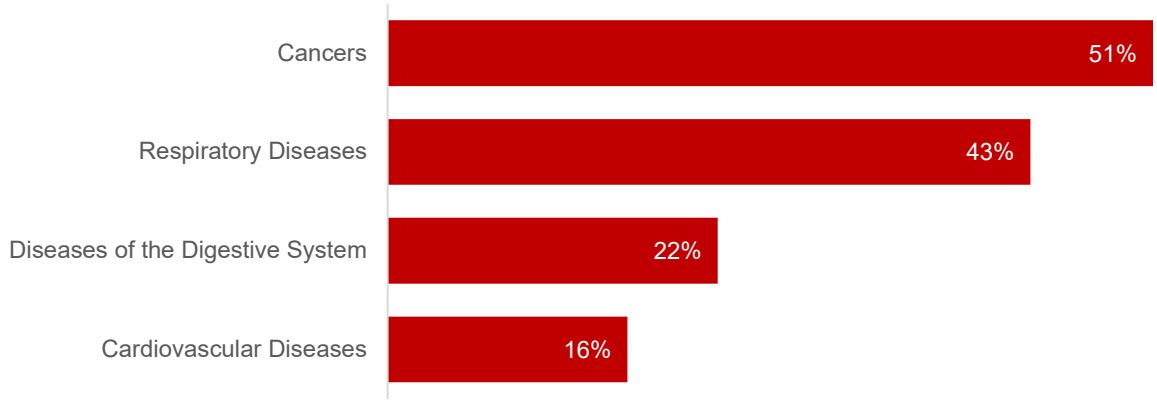
[23] NHS Digital, Statistics on Smoking: England 2020, published 8 December 2020, available from www.digital.nhs.uk

Figure 15: Proportion of smoking attributable admissions for all these conditions



- around half (51%) of admissions for cancers that can be caused by smoking, were estimated to be attributable to smoking (Figure 16)

Figure 16: Proportion of admissions for specific conditions that can be caused by smoking that were attributable to smoking



Source: HCS Health Informatics

- one in two (50%) male admissions for conditions that can be caused by smoking were attributable to smoking in 2020, this compares to around four in ten (39%) of female admissions

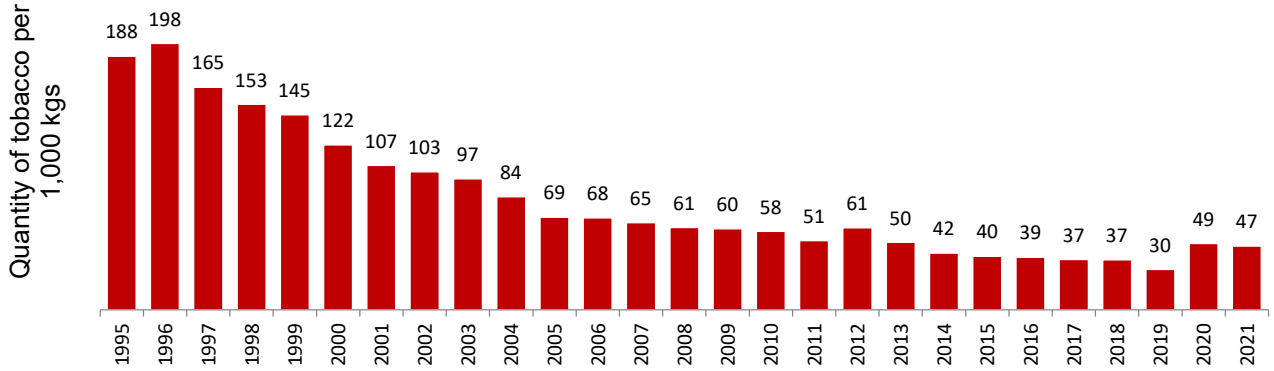
Further comparisons of smoking attributable hospital admissions data for Jersey to data published for England by Public Health England can be found in Appendix 1.

4. Availability of Tobacco

4.1 Tobacco imports

- the quantity of tobacco imported into the Island had fallen from 198,000 kilograms in 1996, to 30,000 kilograms in 2019 (Figure 17)
- there has been an increase in tobacco imports in 2020 and 2021 to a level similar to 2013

Figure 17: Annual Quantity of tobacco imported, thousands of kilograms, 1995-2021



Source: Jersey Customs and Immigration Service[24]

In 2020 the number of passengers arriving in Jersey[25] was 78% fewer than in 2019, with 900,000 fewer passengers arriving than the year before[26]. Decreased passenger numbers may have had an impact on imports of tobacco through Duty Free, although trend data is not held. For information, the decrease in passenger volumes during 2020 was largely a result of the travel disruption caused by the COVID-19 pandemic.

4.2 Retail prices

Retail prices data compiled by Statistics Jersey[27] enables analysis of the price of tobacco over time. Three indices are considered here:

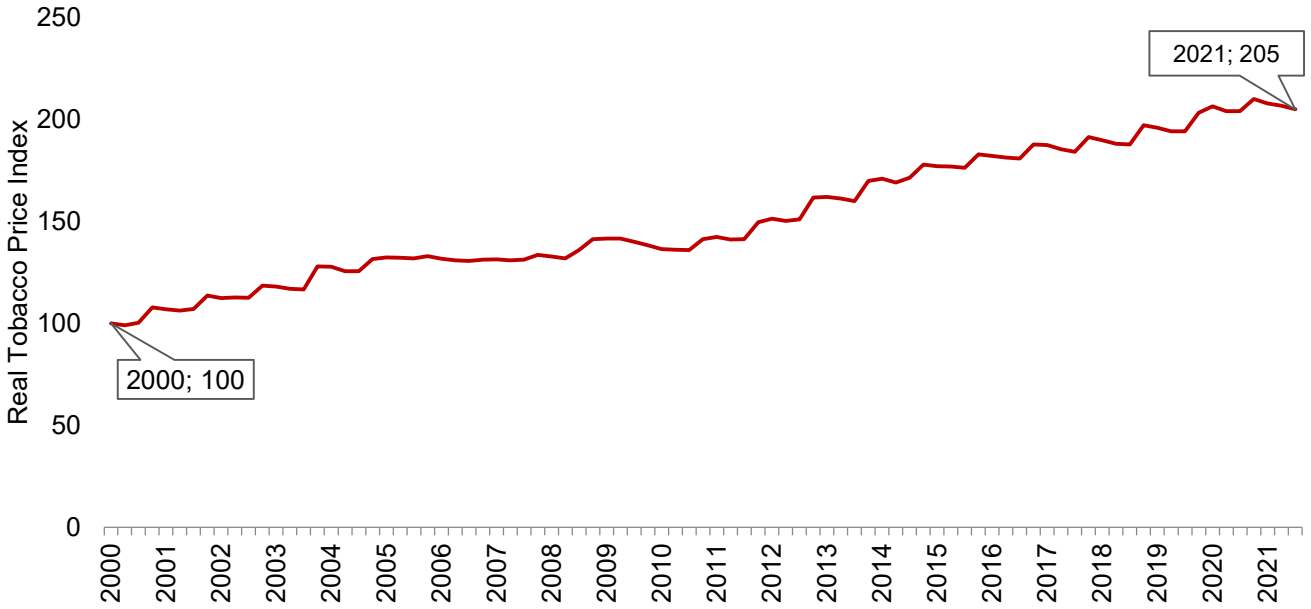
1. the all-items Retail Price Index (RPI) – the main inflation measure in Jersey, compiled using a representative 'basket' of over 500 separate goods and services
2. Tobacco Price Index (TPI) – the group level index of the RPI relating to a 'basket of tobacco products' priced by Statistics Jersey and gives a representative measure of the price of tobacco
3. 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

[24] Customs statistics - Quantities of dutiable goods - Government of Jersey Open Data
[25] Jersey Statistics | Visit Jersey Trade & Media
[26] Due to COVID-19, Jersey has not been able to conduct the ongoing Exit Survey to provide details of visitor numbers and expenditure from April 2020 to the end of 2021. In the absence of data on visitor numbers, Visit Jersey have continued to report on monthly passenger arrivals which include both residents and visitors. Over the whole of 2020, passenger arrivals at 249,750 were 78% lower than in 2019
[27] Inflation (RPI, RPIX, RPI pensioners, RPI low income) - RPI group indices from March 2000 onwards - Government of Jersey Open Data

Between June 2000 and December 2021, retail prices increased by 88 per cent (RPI 188), while the price of tobacco almost quadrupled (TPI 386). The relative tobacco price index shows that tobacco prices have increased at twice the rate of retail prices more generally (TPI/RPI 205) since 2000.

Figure 18 shows the rate of increase in the price of tobacco, relative to retail prices more generally since 2000.

Figure 18: Relative tobacco price index: 2000 to 2021



Source: Statistics Jersey

Details of the annual percentage changes for the Tobacco group are available in the Jersey Retail Prices Index published by Statistics Jersey, and Index numbers for the individual Tobacco RPI group from 2000 onwards are available on open data[28]

[28] https://opendata.gov.je/dataset/4d789cae-cd00-4377-8246-83db3638971a/resource/08447457-f208-4209-aea3-a77cb9713c68/download

Notes

1. Data Sources

The following data sources have been used in this report:

a) **Deaths Register**
All deaths to be registered with the Superintendent Registrar within 5 days of the date of death, unless they have been referred to the Viscount. Cause of death is classified using the International Statistical Classification of Diseases, Injuries and Causes of Death (tenth revision, ICD-10). Latest data available for this profile is from 2020

b) **Passive Smoking at 6-8 Weeks**
Data on births and passive smoking risk at 6-8 weeks of age was taken from the Child Health computer system. The system is administered by the Child Health Team who are part of the Health and Community Services Department Preventive Programmes Team

c) **Public Survey Data**
2021 survey data from the Health Activity and Wellbeing Survey (2021) run by Public Health in conjunction with Jersey Sport is used, alongside historic data from the Jersey Opinions and Lifestyle Survey (JOLS) formerly known as the Jersey Annual Social Survey, run by Statistics Jersey. These surveys are voluntary postal and internet surveys, and should have been completed by whichever person in the household was aged over 16 and has their birthday next. Statistical weighting techniques have been used to compensate for different patterns of non-response from different sub-groups of the population. The survey results can therefore be considered broadly accurate and representative of Jersey's population. All analysis presented in this report uses weighted responses.

d) **Children and Young People Survey Data**
The Jersey Children and Young People Survey , formerly known as the Health-Related Behaviour Questionnaire (HRBQ), is run by Statistics Jersey to record the attitude and behaviour of children and young people in Jersey, regarding their lifestyle, health and wellbeing. The survey now takes place every two years. Every Jersey child in school Years 6, 8, 10 and 12 was given the opportunity to take part. The survey questionnaires were delivered in electronic format. Although broadly similar, there were three different questionnaires – one for Year 6, one for Year 8 and a third for Years 10 and 12.

e) **Hospital Admissions**
Data on hospital admissions is supplied by the Health Informatics Team and is taken from the hospital computer system TRAK. Admissions data are classified using ICD-10 codes; 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.

f) **Disease Register for COPD**
Data on the number of people currently living with chronic obstructive pulmonary disease (COPD) is collected from the GP Central server (EMIS) system, which is used by all general practice (GP) surgeries. The COPD register is part of the Jersey Quality Improvement Framework, in which GPs accurately record patients that meet a set of disease-specific criteria as being on a particular disease register.

g) **Retail Price Index**
The Retail Prices Index (RPI) and the group level data for tobacco products is measured quarterly by Statistics Jersey, and 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

h) **Imports**
Jersey customs and immigration service supply information on volumes of tobacco imported into the Island

2. Methods

2.1 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 OECD.

The Local Tobacco Control profiles have been designed to help the government and health services to assess the effect of tobacco use on their local populations. They will inform commissioning and planning decisions to tackle tobacco use and improve the health of local communities. The tool allows you to compare your local authority against local authorities in the England and benchmark against the England. To show the effect of the COVID-19 pandemic, the mortality indicators are now presented as single years.

2.2 Smoking-related Mortality and Hospital Admissions Attributable to Smoking

Annual mortality rates for Jersey are calculated using the mid-year population estimates supplied by Statistics Jersey based on Census 2011 data. Statistics Jersey will release the first results for Census 2021 data on the population of Jersey in 2022 and rates will subsequently be reviewed and updated based on these new population figures.

Smoking attributable fractions used to calculate smoking related mortality and hospital admissions. 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 TheIndicatorGuideHealthProfiles2012.pdf (Page 248)

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

In ensuing updates Public Health Intelligence will use new estimates, based on an updated methodology, on the deaths and hospital admissions caused by smoking[29].

2.3 Accuracy and reliability

- All figures have been independently rounded to the nearest integer. Percentages may therefore not add up to 100 percent due to rounding.
- The deaths 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 2020; 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.

2.4 Confidence intervals and statistical significance

- Confidence intervals have been used in this report to measure 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.

[29] Local Tobacco Control Profiles - Data - OHID (phe.org.uk)

- 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’.

2.5 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.

Adult smoking indicators

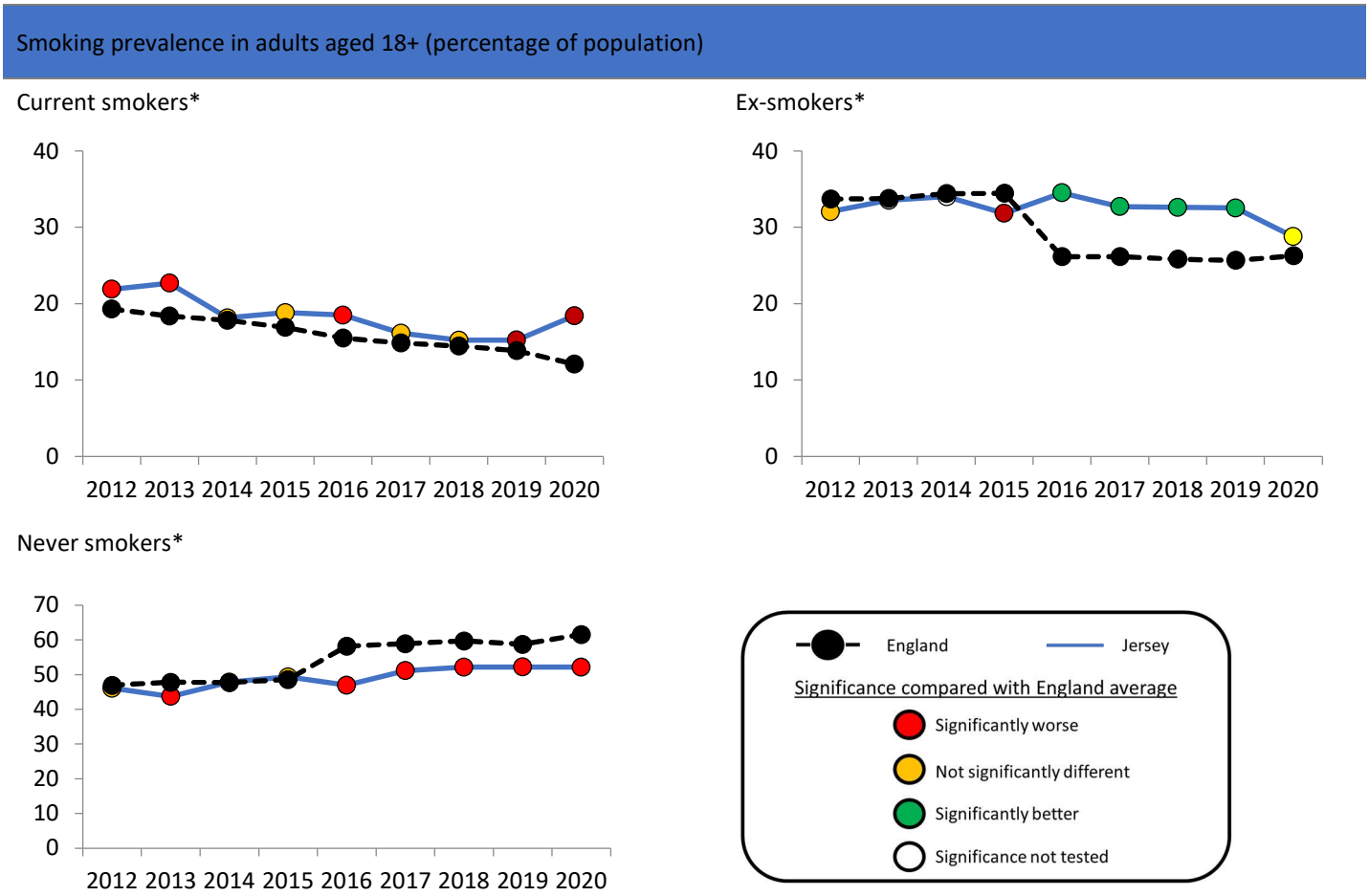
Table A1: Adult smoking indicators (PHE measure)

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*	2020	18	(15, 22)	12	(12, 12)	11	14
Ex-smokers*	2020	29	(26, 32)	26	(26, 27)	20	31
Never smokers*	2020	52	(50, 54)	62	(61, 62)	58	69

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)



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*

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)[30]

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	2016-2018	242	(203, 285)	250	(249, 251)	217	328
Deaths from lung cancer (age-standardised rate per 100,000 population)							
All persons	2017-2019	60	(51, 70)	53	(53, 53)	44	74
Deaths from oral cancer (age-standardised rate per 100,000 population)							
All persons	2017-2019	4	(2, 8)	5	(5, 5)	4	6
Deaths from chronic obstructive pulmonary disease (age-standardised rate per 100,000 population)							
All persons	2017-2019	47	(33, 68)	53	(52, 53)	41	74
Still birth rate (foetal deaths occurring after 24 weeks gestation per 1,000 births)							
All persons	2017-2019	-	-	4	(4, 4)	4	5
Neonatal mortality rate (number of deaths under 28 days per 1,000 live births)							
All persons	2017-2019	-	-	3	(3, 3)	2	4

Source: Public Health Intelligence and Public Health England

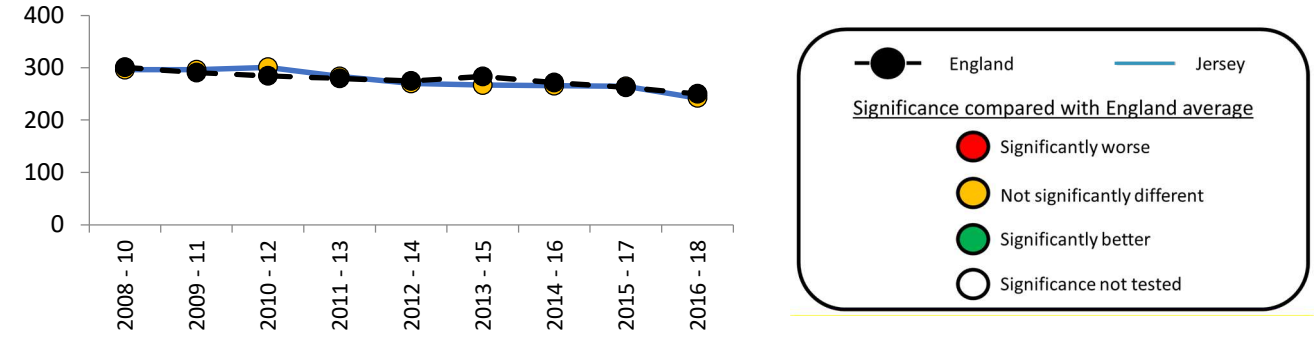
- Where counts of neonatal deaths are less than three, the rate is not calculated for this indicator

[30] comparison to latest available data for England Public health profiles - OHID (phe.org.uk)

Figure A2: Mortality indicators (PHE measure)

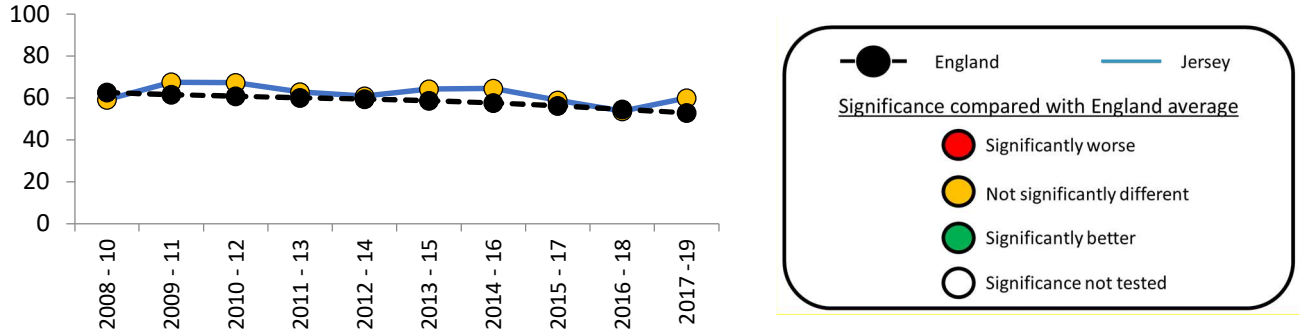
Smoking attributable mortality (age-standardised rate per 100,000 population aged 35+)

All persons



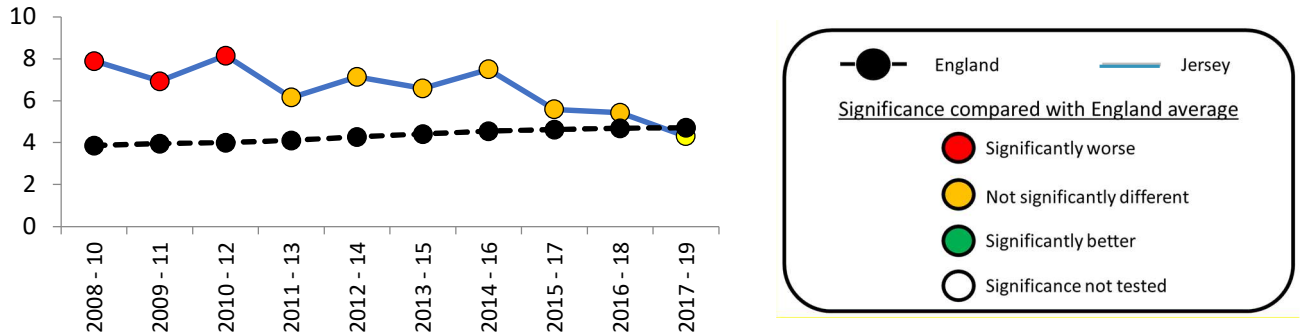
Deaths from lung cancer (age-standardised rate per 100,000 population)

All persons



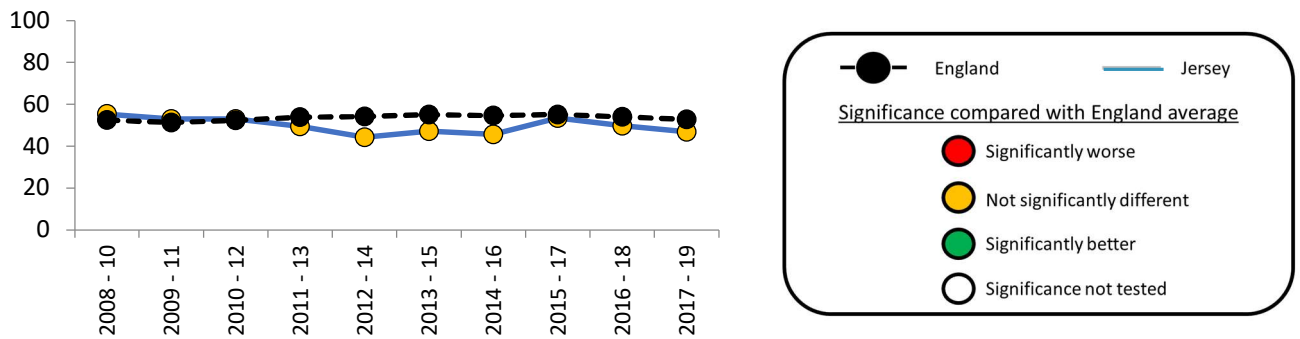
Deaths from oral cancer (age-standardised rate per 100,000 population)

All persons



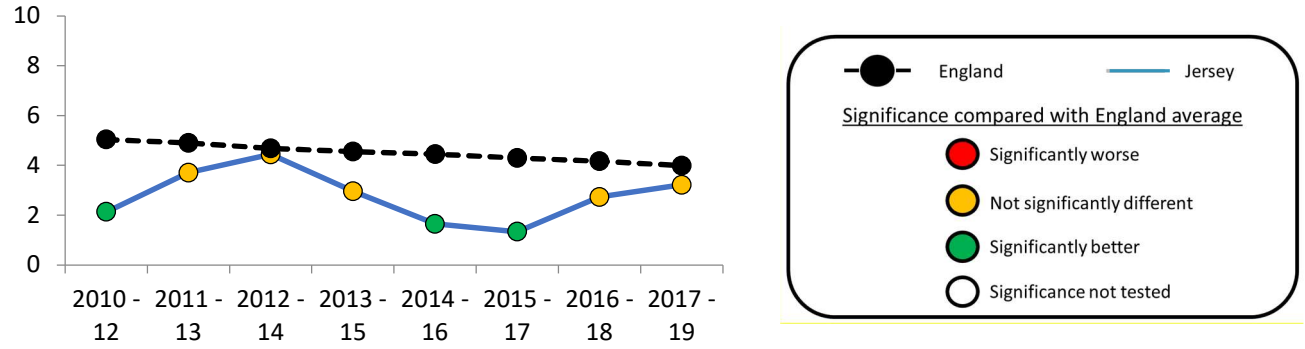
Deaths from chronic obstructive pulmonary disease (age-standardised rate per 100,000 population)

All persons



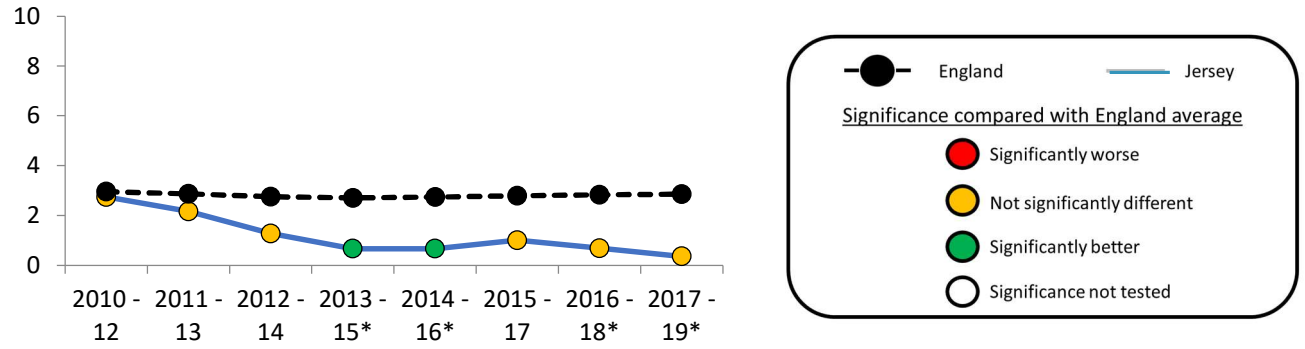
Still birth rate (foetal deaths occurring after 24 weeks gestation per 1,000 births)

All persons



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

All persons



Source: Public Health Intelligence 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	2016-18	58	(50, 68)	81	(81, 82)	75	88
Low birth weight of term babies (percentage of all live births at term with low birth weight)							
All persons	2020	2	(1, 3)	3	(3, 3)	2	3
Hospital admissions for asthma (per 100,000 population under 19 years)							
All persons	2020*	678	(577, 796)	74	(73, 76)	83	512
Smoking attributable hospital admissions (age-standardised rate per 100,000 population aged 35 or over)							
All persons	2019*	1,503	(1,325, 1,692)	1,398	(1,394, 1,402)	721	2990

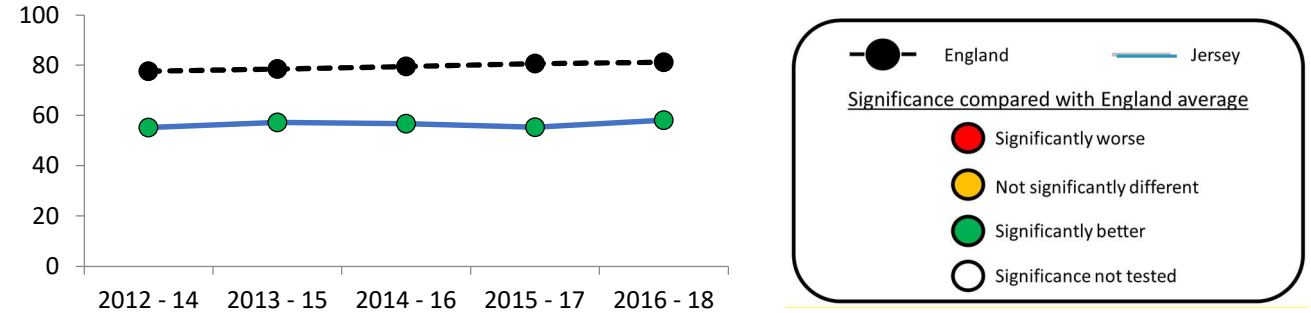
Source: Public Health Intelligence and Public Health England

**Jersey data is for calendar years, whereas Public Health England data is for financial years*

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

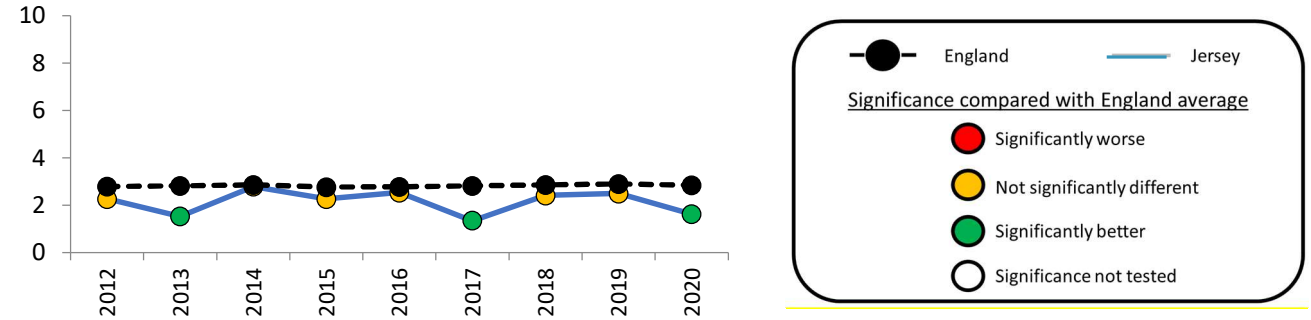
Premature births (less than 37 weeks gestation) and still births per 1,000 live and still births

All persons



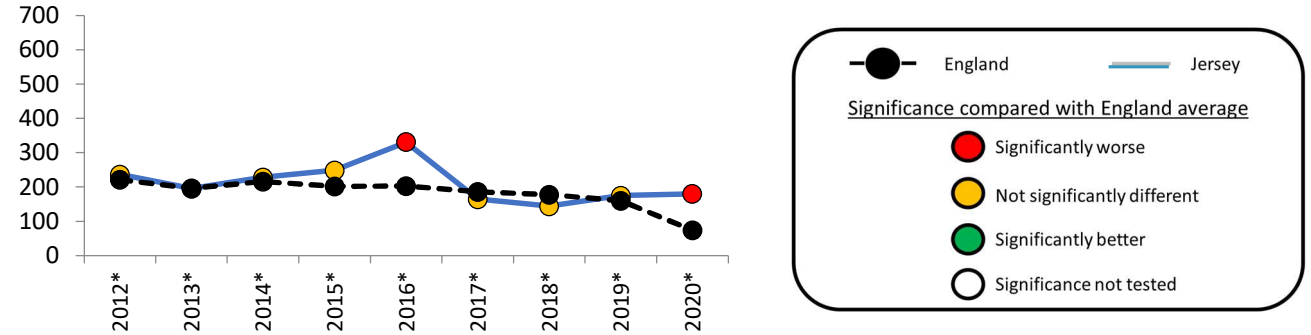
Low birth weight of term babies (percentage of all live births at term with low birth weight)

All persons



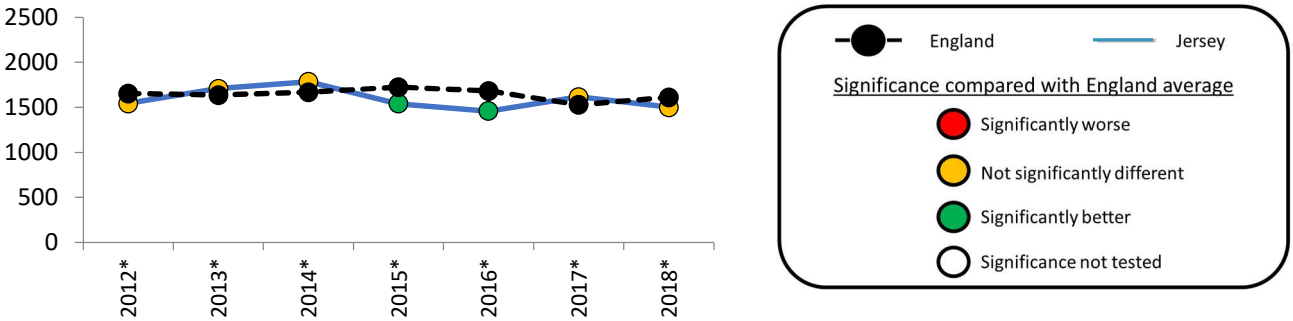
Hospital admissions for asthma (per 100,000 population under 19 years)

All persons



Smoking attributable hospital admissions (age-standardised rate per 100,000 population aged 35 or over)

All persons



Source: Public Health Intelligence 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	2019*	5,540	(5,163, 5,943)	3,512	(3,497, 3,527)	5,419	2,221
Successful quitters at 4 weeks per 100,000 smokers							
All persons	2019*	2,676	(2,414, 2,965)	1,808	(1,798, 1,819)	2,457	1,154
Successful quitters (CO validated) at 4 weeks per 100,000 smokers							
All persons	2019*	2,819	(2,551, 3,118)	1,113	(1,105, 1121)	1,754	727

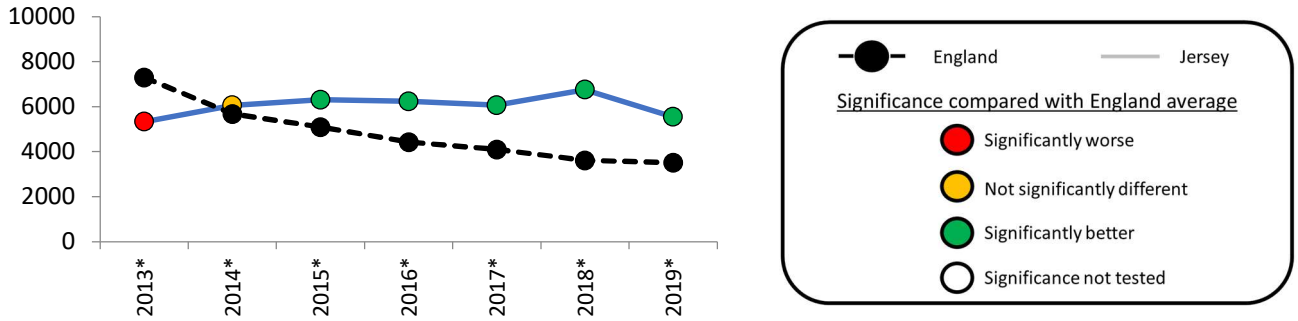
- Confidence intervals not available for this indicator due to PHE concerns about the methodology used

**Jersey data is for calendar years, whereas Public Health England data is for financial years*

Figure A4: Smoking quitters indicators (PHE measures)

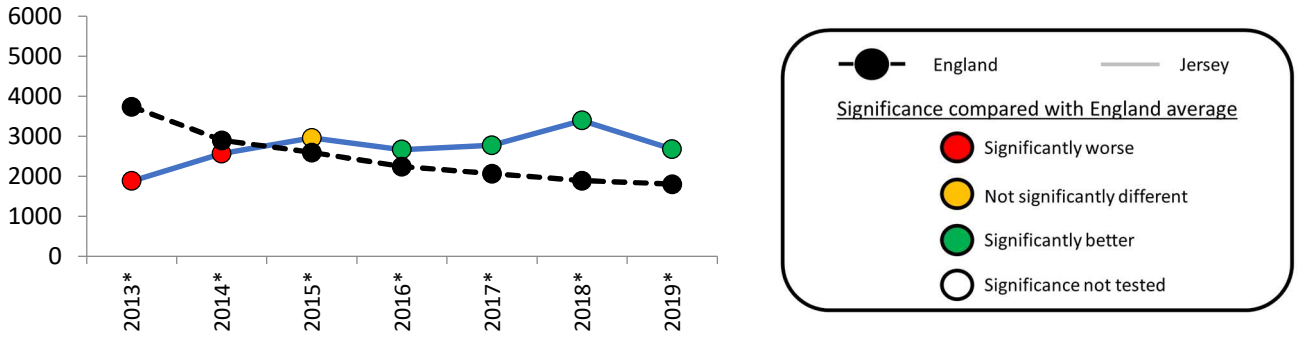
Number setting a quit date per 100,000 smokers

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