

## Summary

- one in seven (15%) adults (aged 16 and over) in Jersey reported being smokers of tobacco products in 2019, a decline of 10 percentage points since 2005, when one in four (25%) adults were smokers
- the prevalence of current (daily or occasional) smokers (aged 18 and over) in Jersey (15%) was similar to that in the UK (15%)
- around one in six (17%) of all babies born in Jersey in 2019 were living in a household where they may have been exposed to tobacco smoke by an adult
- in 2019, 7% of adults said they currently (at least sometimes) use an e-cigarette
- in 2018, one in three Year 10 pupils (33%) reported that they had tried smoking at least once
- e-cigarettes were used by around one in twenty (6%) of secondary school pupils (Years 8, 10 and 12)
- in 2018, more than half (57%) of smokers aged 16 and above reported having wanted to quit smoking in the past year
- around 440 people successfully quit through the Help2Quit smoking cessation service in 2019, representing a quit rate of 50%, and a similar rate to that recorded in each of the previous five years
- 120 deaths were estimated to be attributable to smoking in 2018, representing 15% of all deaths in Jersey in that year and for a third (34%) of deaths by conditions that can be caused by smoking
- 890 hospital admissions were estimated to be attributable to smoking in 2018, representing 3% of all hospital admissions in Jersey and for 30% of hospital admissions due to conditions that can be caused by smoking
- the quantity of tobacco imported into Jersey has reduced by more than half (56%) over the period 2006-2019

## Introduction

This report constitutes the latest collection of smoking related statistics for Jersey<sup>1</sup>. The information presented is derived primarily from the Jersey Opinions and Lifestyle Survey (JOLS) and the Jersey Children and Young People's Survey, as well as data compiled from other sources (see Background Notes).

Included in this report are:

- smoking by adults, including prevalence (page 2)
- comparison of smoking in Jersey and the UK (page 5)
- e-cigarettes (page 6)
- smoking by children and young adults (page 7)
- quitting smoking and the smoking cessation service (page 8)
- smoking related mortality (page 9)
- smoking related ill health, including hospital admissions (page 10)
- importation of tobacco (page 12)
- smoking indicators compared with England (page 17, [Appendix](#))

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<sup>1</sup> Smoking of tobacco products.

## Smoking by adults

The information presented in this section relates to the smoking behaviour of Jersey resident adults (aged 16 and over). The main source of data on adult smoking comes from the Jersey Opinions and Lifestyle Survey (JOLS), formerly the Jersey Annual Social Survey (JASS), conducted by Statistics Jersey.

### Smoking prevalence (16+)

- in 2019, around one in seven (15%) adults in Jersey were smokers, representing a decrease of 10 percentage points (pp) since 2005 when one in four (25%) adults were smokers - see Table 1
- the proportion of adults in Jersey who reported smoking daily has decreased from around one in five (19%) in 2005 to around one in ten (11%) in 2019 – see Figure 1
- in the UK, in 2018, a sixth (17%) of adults (aged 16 and over) were smokers compared to almost a quarter (24%) in 2005<sup>2</sup>

Table 1: Do you smoke? Percentage by year, 2005-2019 (adults aged 16 and over)<sup>3</sup>

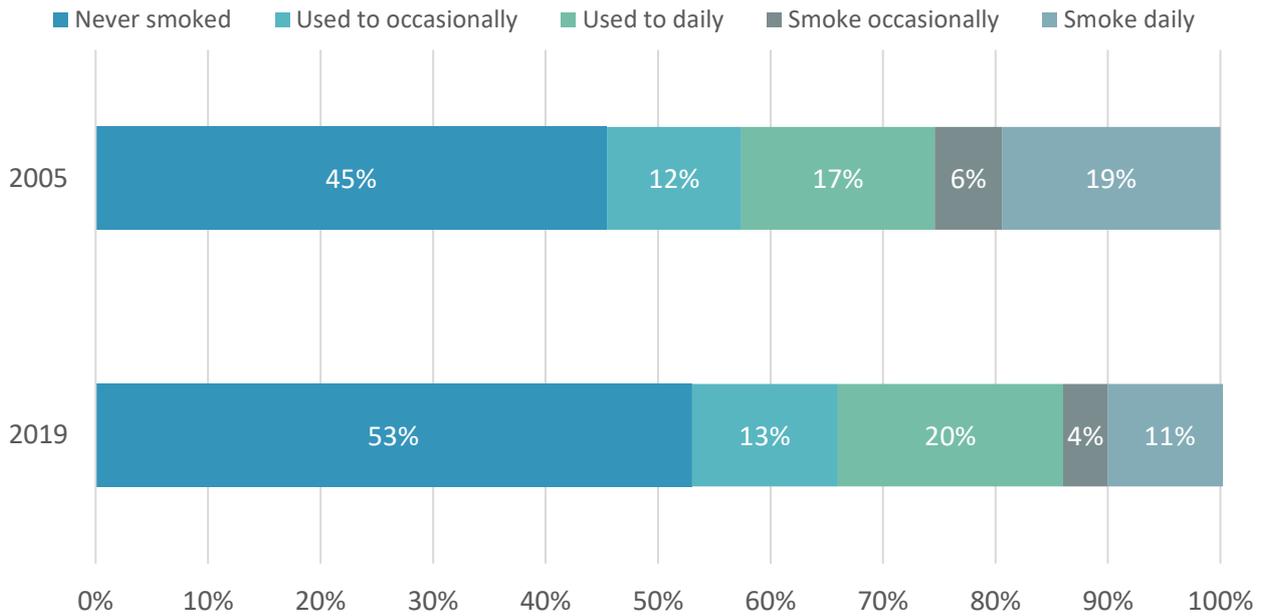
	2005	2007	2008	2010	2012	2013	2014	2015	2016	2017	2018	2019
I have never smoked / I don't smoke	45	48	48	47	46	44	48	50	47	52	53	53
I used to smoke occasionally but don't now	12	15	15	13	15	15	15	14	14	13	17	13
I used to smoke daily but don't now	17	17	16	17	17	18	19	17	20	19	15	20
I smoke occasionally but not everyday	6	6	5	8	6	6	5	6	6	5	5	4
I smoke daily	19	14	16	15	16	16	14	12	13	11	10	11
<b>Total</b>	100	100	100	100	100	100	100	100	100	100	100	100

Source: JASS 2005-2015, JOLS 2016-2019

<sup>2</sup> Office for National Statistics, Adult smoking habits in Great Britain, 2018, published 1 July 2019, available from [www.ons.gov.uk](http://www.ons.gov.uk)

<sup>3</sup> Percentages are rounded independently and as such may not sum to total.

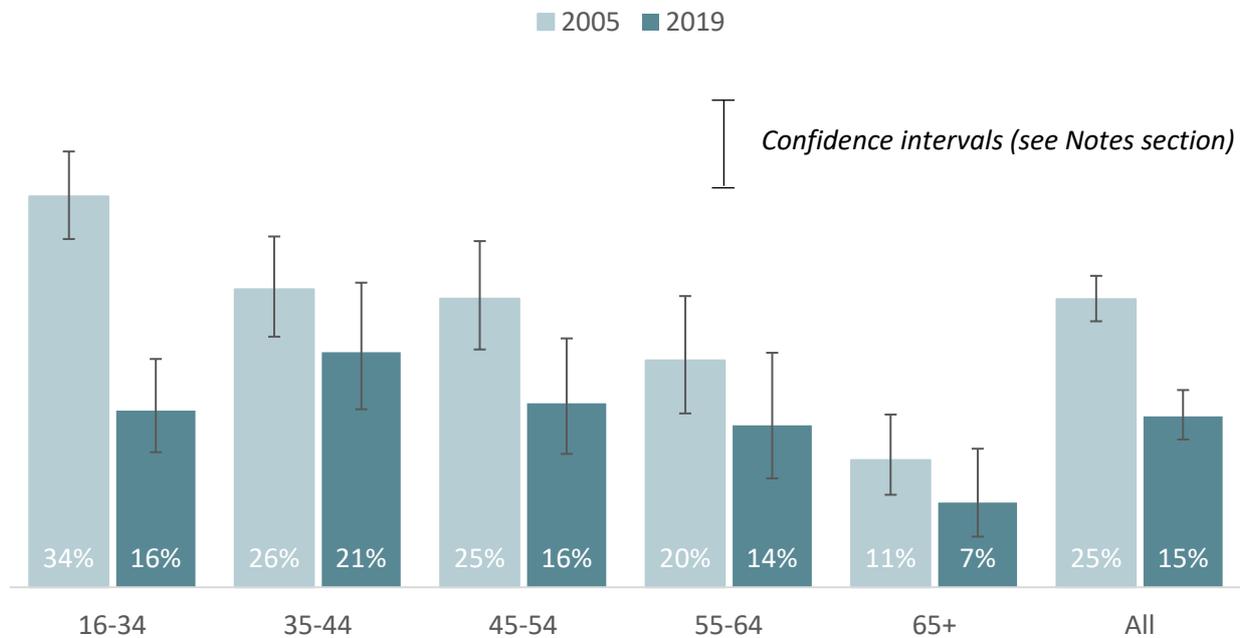
Figure 1: Smoking status, 2005 and 2019



Source: JASS 2005 and JOLS 2019

- in 2019, one in five adults aged 35-44-years (21%) were smokers (occasionally or daily) compared to around one in fifteen (7%) of those aged 65 years and over - see Figure 2
- in 2005, the highest prevalence of smoking was seen in the 16-34 age group, with around one in three (34%) of this age group reporting that they smoked
- over the period from 2005 to 2019, the 16-34 age group saw a decrease in smoking prevalence from 34% in 2005 to 16% in 2019

Figure 2: Prevalence of daily and occasional smoking, by age group, 2005 and 2019

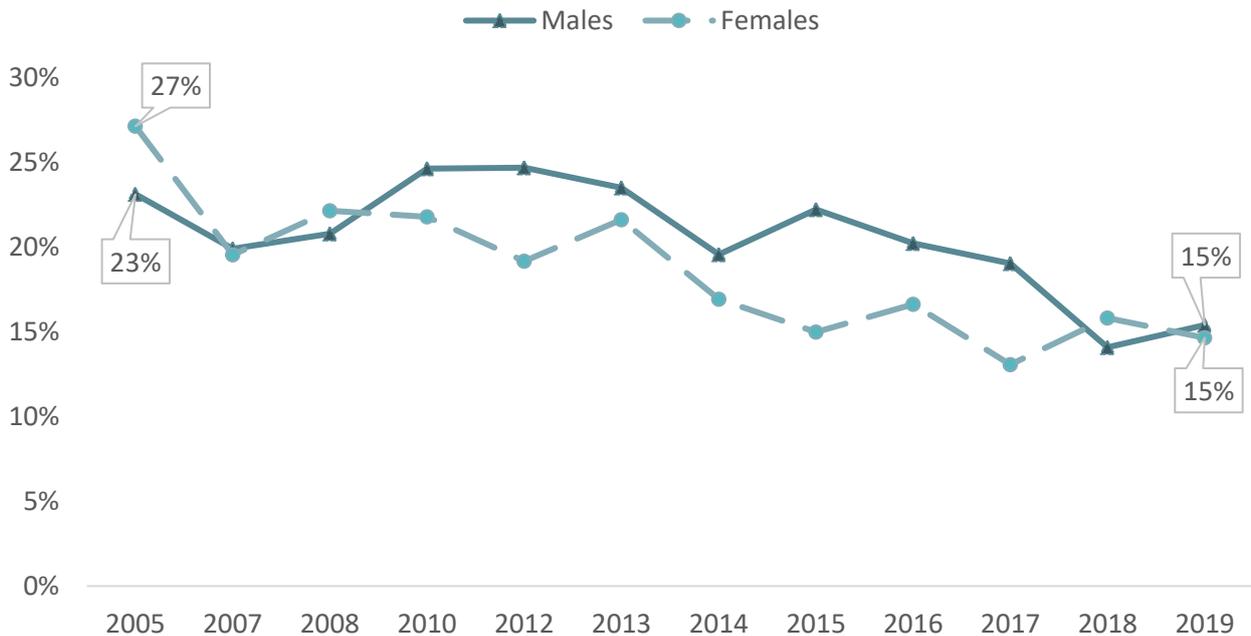


Source: JASS 2005 and JOLS 2019

- in 2019 the prevalence of daily and occasional smoking was similar for males and females (15%)
- in 2005 smoking prevalence was 23% for males and 27% for females

Figure 3 shows that the smoking prevalence of adults in Jersey has decreased for both sexes since 2005.

Figure 3: Prevalence of daily and occasional smoking, by sex, 2005-2019



Source: JASS 2005-2015, JOLS 2016-2019

## Cigarette consumption

- the number of cigarettes smoked each day by adult smokers in Jersey has remained relatively similar over the past decade, with an average of 14 per day in 2008 and 13 per day in 2018

## Characteristics of smokers

### Economic activity and occupation

- around one in eight (12%) of the working population reported being daily smokers in 2019
- the highest proportion of daily smoking was for people working in manual and routine professions (28%); for workers in technical and clerical professions the proportion was 11%; while 10% of people working in managerial and professional occupations reported smoking daily
- since 2014 there has been a decline in the proportion of current (daily or occasional) smokers among all professional groups

### Tenure

- one in five (20%) of adults living in social housing, more than one in six (18%) living in non-qualified accommodation, one in seven living in qualified rental accommodation (15%) and around one in twenty (6%) living in owner-occupied accommodation reported smoking daily
- there was a higher proportion of current (daily or occasional) smokers living in social rented accommodation (25%) than in owner-occupied accommodation (10%)

### Education level

- 13% of adults educated to secondary level or below reported smoking daily, compared to 7% of those educated to a higher level<sup>4</sup>

<sup>4</sup> Defined as having a first or higher degree.

## Mental health

- around one in five adults who had low or medium scores for happiness (21%), life satisfaction (22%) and feeling worthwhile (20%) were smokers (daily and occasional)
- around one in ten adults who had high scores for happiness (12%), life satisfaction (11%) and feeling worthwhile (12%) were smokers
- around one in four (24%) adults with high levels of anxiety were more likely to be smokers than those with medium (16%) or low (12%) levels of anxiety

## Smoking inside the home

- in 2018, one in seven (14%) Jersey households reported having someone who regularly smoked inside their home
- one in ten (10%) owner-occupier households had someone who regularly smoked inside their home, compared to one in six of qualified rental households (17%), one in six non-qualified households (18%) and one in four (25%) of social housing households
- in households where children were either living or were regularly looked after in the home, 7% of owner-occupier households, 15% of qualified rental households, 34% of non-qualified households and 35% of social housing households reported having someone who smoked inside the home

## Smoking around babies

As part of the 6-week check of new-born babies, the risk of exposure to second-hand smoke is assessed by GPs. This assessment indicated that:

- around one in six (17%) of all babies born in Jersey in 2019 were living in a household where they may be exposed to tobacco smoke by an adult

## Comparison with the UK (aged 18 years and over)

- in 2018, the prevalence of current (daily or occasional) smokers aged 18 and over in Jersey (15%) was similar to the UK (15%) and to each of its constituent countries, England (14%), Northern Ireland, Scotland and Wales (all 16%), as shown in Table 2

Table 2: Smoking rates in Jersey and the UK, 2012-2019, all persons aged 18 and over, percentages

	England	Wales	Scotland	Northern Ireland	Jersey
<b>2012</b>	19	21	22	19	22
<b>2013</b>	18	20	22	19	23
<b>2014</b>	18	19	20	18	18
<b>2015</b>	17	18	19	19	19
<b>2016</b>	16	17	18	18	19
<b>2017</b>	15	16	16	17	16
<b>2018</b>	14	16	16	16	15
<b>2019</b>	-	-	-	-	15

Source: JASS 2012-2015, JOLS 2016-2019 and Office for National Statistics<sup>5</sup>

<sup>5</sup> Office for National Statistics, Adult smoking habits in Great Britain, 2018, published 1 July 2019, available from [www.ons.gov.uk](http://www.ons.gov.uk)

## Use of electronic cigarettes

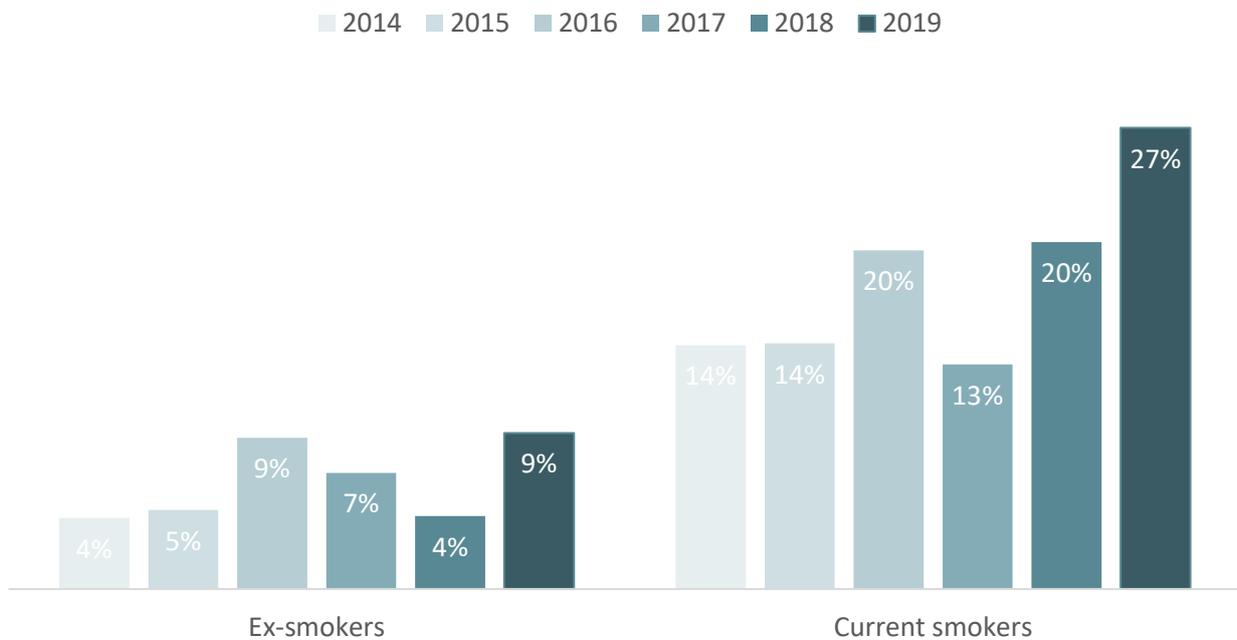
E-cigarettes deliver nicotine that is vaporised and inhaled from a liquid form via a battery-powered device that simulates cigarette smoking; these devices are classified as nicotine containing products.

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

In 2019:

- 7% of adults in Jersey reported using e-cigarettes at least sometimes, a slightly higher proportion than in 2014 (4%)
- more than a quarter (27%) of current (daily or occasional) smokers in Jersey reported using e-cigarettes at least sometimes (see Figure 5)
- four-fifths (81%) of adults reported having either never used or not having heard of e-cigarettes
- similar proportions of men (9%) and women (6%) reported using e-cigarettes at least sometimes
- the 35 to 44 years age-group had the highest proportion of people using e-cigarettes (17%)

Figure 5: Proportion of adults using e-cigarettes at least sometimes, by smoking status, 2014 - 2019



Source: JASS 2014-2015; JOLS 2016-2019

### Main reason given for using e-cigarettes

- almost a third (30%) of current smokers in Jersey reported using e-cigarettes to help them cut down on the amount they smoke, while (22%) had used e-cigarettes as part of a serious attempt to quit<sup>6</sup>

### E-cigarettes - children and young adults

- 85% of Year 8, 63% of Year 10 and 58% of Year 12 students reported they had never used an e-cigarette
- current and regular e-cigarette prevalence of secondary school pupils (Years 8, 10 and 12) was 6%
- boys (8%) were more likely than girls (3%) to be current e-cigarette users
- current e-cigarette use increased with age, from 2% of Year 8 pupils to 8% of both Years 10 and 12

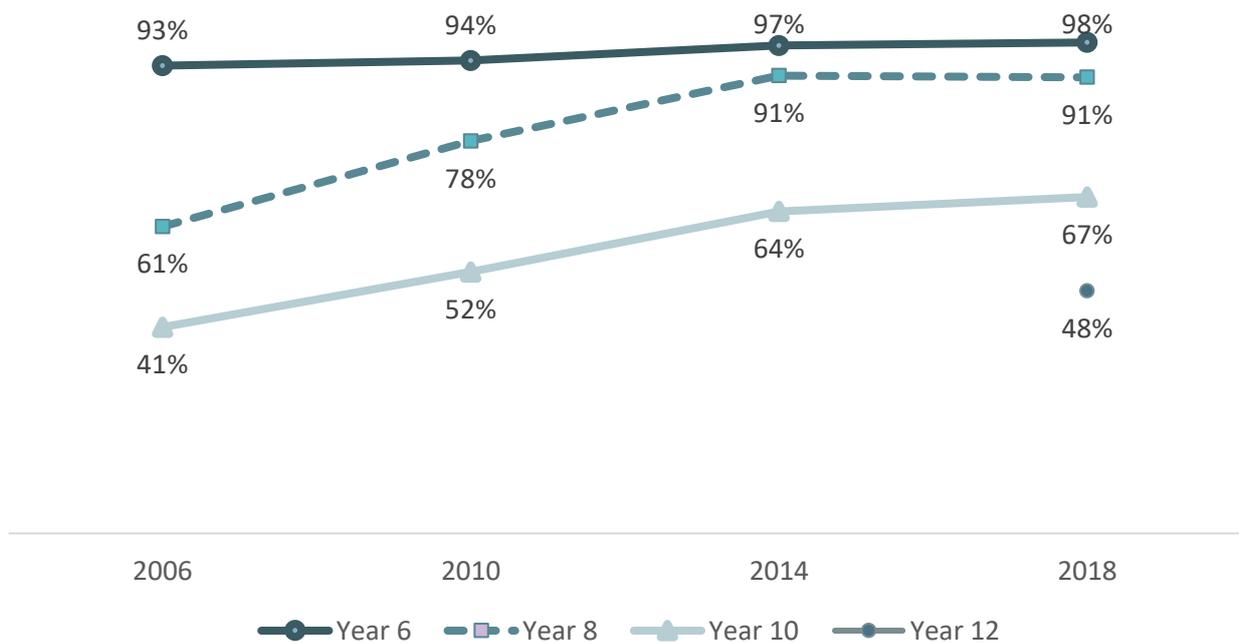
<sup>6</sup> JOLS 2018 data

## Smoking by children and young adults

The Jersey Children and Young People’s Survey defines regular smoking as smoking one or more cigarette per week and occasional smoking as less than one cigarette per week.

- the proportion of children who reported having ‘never smoked’ in 2018 was similar to that in 2014, and greater than in 2010 (Figure 6)
- in 2018, one in three Year 10 pupils (33%) reported they had tried smoking at least once, a similar proportion to 2014 (36%) but lower than in 2010 (48%)
- 8% of secondary school aged pupils (Years 8, 10 and 12) reported being current smokers (regular or occasional); 4% reported being regular smokers
- the proportion of regular smokers increased with age, from fewer than 1% of Year 6 pupils to 6% of both Year 10 and Year 12 pupils
- the proportion of Year 10 pupils who smoked regularly decreased from 12% in 2010 to 6% in 2018
- similar proportions of boys (6%) and girls (4%) in Year 10 said they were regular smokers in 2018
- almost three-quarters (73%) of young smokers in Year 12 reported having started smoking regularly before the age of 16
- in 2018, pupils categorised as regular smokers smoked a mean (average) of 15 pre-made (tobacco) cigarettes a week; pupils smoking roll-up cigarettes smoked a mean (average) of 14 roll-up (tobacco) cigarettes a week

Figure 6: Percentage of young people who have never smoked, 2006-2018



Source: Jersey School Survey Report 2006-2018

### Factors that may influence children to start smoking

Starting smoking 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 (26%) of children reported that their parents smoked
- 4% of households in which children were regularly present contained someone who smoked at home
- around one in ten children (11%) reported having some level of exposure to second-hand smoke in the home (theirs or others’)
- one in twenty (5%) of children experienced second-hand smoke in a car

## Quitting smoking

### Wanting to quit smoking

- in 2018, over half (57%) of adult smokers reported having wanted to quit smoking in the past year; this proportion represents a reduction compared to 2014 when over two-thirds (67%) reported that they had wanted to quit in the previous year
- 53% of men and 62% of women reported wanting to quit in 2018
- in 2018, 43% of children and young adults who were regular smokers wanted to give up smoking

### Smoking cessation service

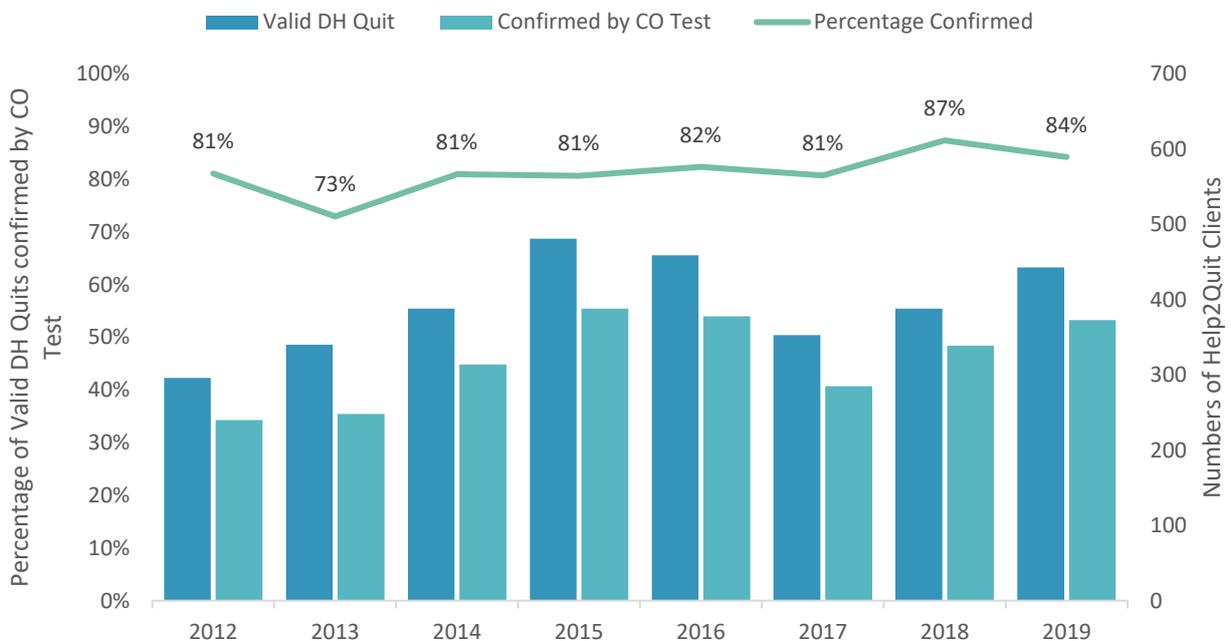
Help2Quit is a free and confidential stop smoking service delivered by local pharmacies on behalf of the Government of Jersey, alongside a specialist service which provides support for secondary care, pregnant women, mental health patients and people with long term health conditions. The service offers 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.

### Use of the stop smoking service

In 2019:

- 882 people set a quit date through the stop smoking service
- 443 people successfully quit through the Help2Quit smoking cessation service (and designated as “Valid DH Quit”), a quit rate of 50% and a similar proportion to that in each of the previous five years
- 373 (84%) of those with a designated quit status were confirmed by CO test (Figure 7)
- around 10 pregnant women used the cessation service, the lowest annual number recorded number since 2012 (60); the quit rate for pregnant mothers was 36%, a similar proportion to the average quit rate for the previous five years

Figure 7: Numbers registered with help2Quit, and percentage that successfully quit



Source: Help2Quit

### 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 can be supported by the Help 2 Quit team and new prisoners entering La Moye will also have access to the Help 2 Quit service’s weekly clinic.

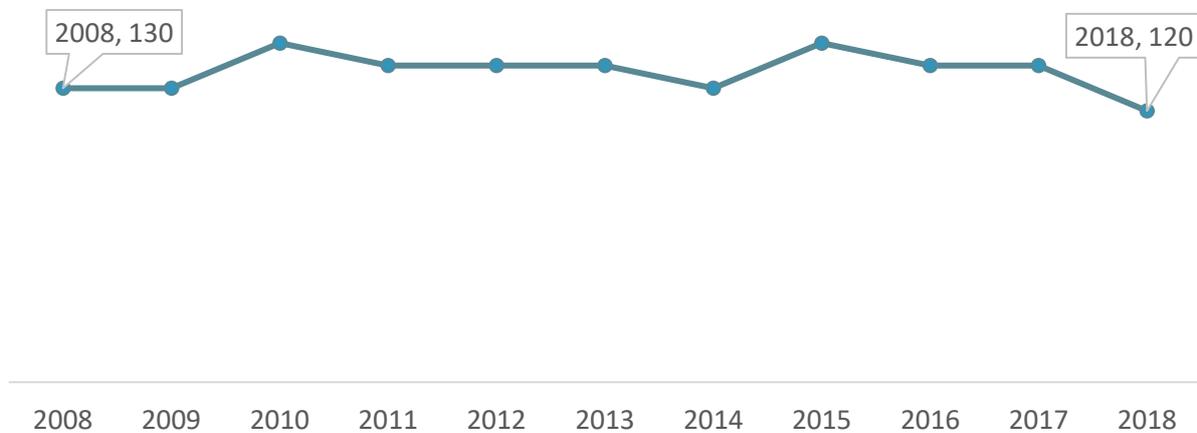
## Smoking related mortality

Monitoring the number of deaths that are attributable to smoking<sup>7</sup> gives a measure of the impact smoking has on Islanders' health. Data is presented for deaths occurring in 2018, the most recent available<sup>8</sup>.

### Smoking-attributable deaths

- there were 800 deaths of adults aged 35 and over in Jersey in 2018, 120 (15%) of which were estimated to have died from conditions attributable to smoking, a similar proportion to 2017 (17%)
- a third (34%) of deaths of people aged 35 and over from conditions that can be caused by smoking were estimated to be attributable to smoking<sup>9</sup>

Figure 8: Number of deaths among adults aged 35 and over in Jersey which were attributable to smoking, 2008 to 2018



Source: Statistics Jersey

Of those deaths of people aged 35 and over:

- 19% of male deaths and 12% of female deaths were estimated to be attributable to smoking in 2018
- these proportions in Jersey were similar to those in England in 2018, where 20% of male deaths and 12% of female deaths of people aged 35 and over were estimated to be attributable to smoking<sup>10</sup>
- in Jersey in 2018 it is estimated that:
  - 30 deaths (40%) of all deaths due to respiratory diseases were attributable to smoking
  - 60 deaths (27%) of all cancer deaths were attributable to smoking
  - 30 deaths (12%) of deaths from circulatory diseases were attributable to smoking
  - these proportions are similar to those reported for England<sup>11</sup>

<sup>7</sup> NHS Digital, Statistics on Smoking, Appendices, published 2 July 2019, available from www.digital.nhs.uk

<sup>8</sup> 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.

<sup>9</sup> These statistical estimates are based on smoking prevalence and risks of smokers/ex-smokers developing each disease – for more information see Background Notes

<sup>10</sup> NHS Digital, Statistics on Smoking: England 2019, published 2 July 2019, available from www.digital.nhs.uk

<sup>11</sup> NHS Digital, Statistics on Smoking: England 2019, published 2 July 2019, available from www.digital.nhs.uk

## Smoking related ill health

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

### Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) refers to a group of lung diseases which cause breathing difficulties; this group includes emphysema and chronic bronchitis.

- in 2018, 2,100 people registered with a GP in Jersey were on the COPD disease register<sup>12</sup>, representing an increase of a sixth (17%) on the number registered in 2016 (1,800)

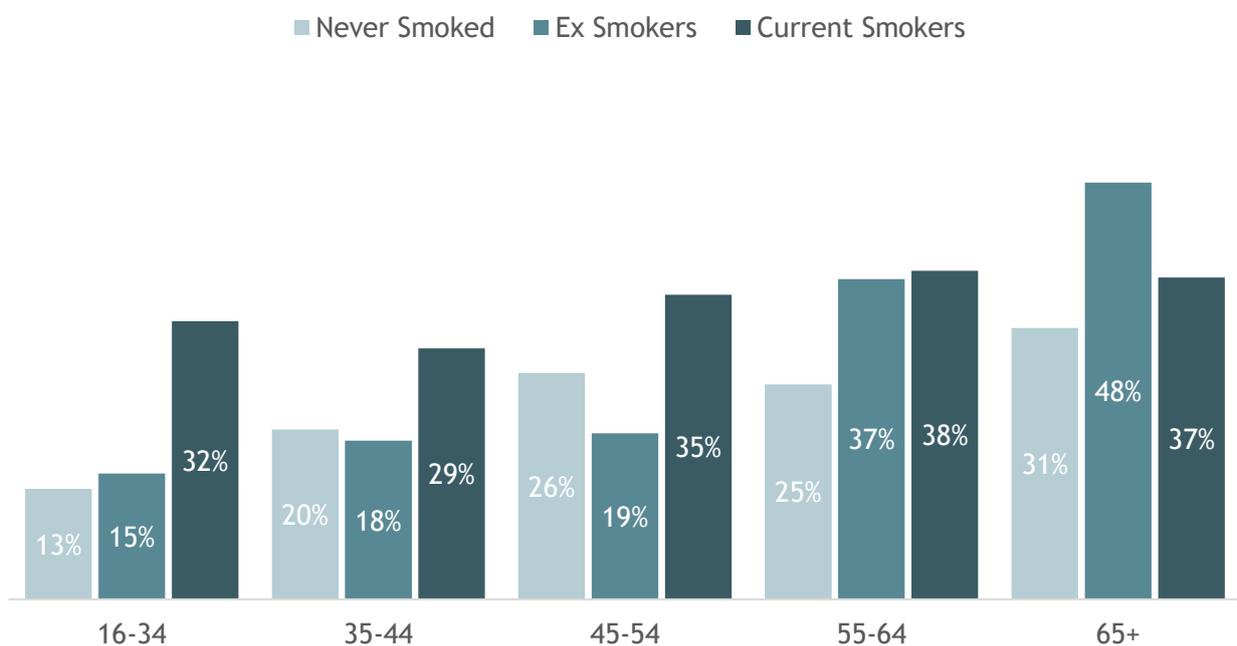
### Self-reported health

- 77% of adults who had never smoked reported being in very good or good health compared to 60% of current (daily or occasional) smokers in 2019
- 5% of adults who had never smoked reported being in bad or very bad health, compared to 12% of current smokers

### Longstanding illness

When comparing both current and former smokers with those who have never smoked (never smokers), except for those aged 65 and over, a greater proportion of current and former smokers reported having an illness, disability or infirmity that had lasted or was expected to last at least twelve months (JOLS 2019) – see Figure 9

Figure 9: Proportion who report having a longstanding illness, disability or infirmity, by smoking status and age, 2019



Source: JOLS 2019

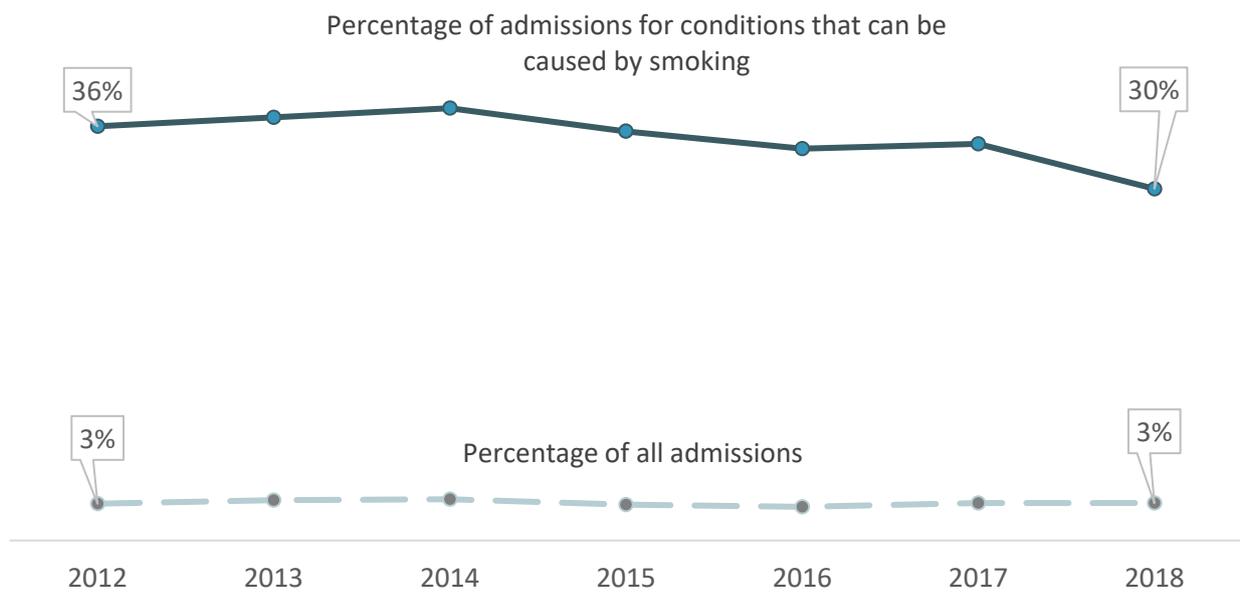
<sup>12</sup> Specific disease registers are generated as part of the Jersey Quality Improvement Framework (JQIF) which incentivises GPs to accurately record patients that meet a set of disease-specific criteria as being on a particular disease register.

### Hospital admissions

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

- 890 hospital admissions were estimated to be attributable to smoking in 2018; this number represents 3% of all hospital admissions in Jersey in that year and 30% of hospital admissions due to conditions that can be caused by smoking (Figure 10)
- the proportion of all hospital admissions attributable to smoking, and of hospital admissions due to conditions that can be caused by smoking, have been relatively similar since 2012

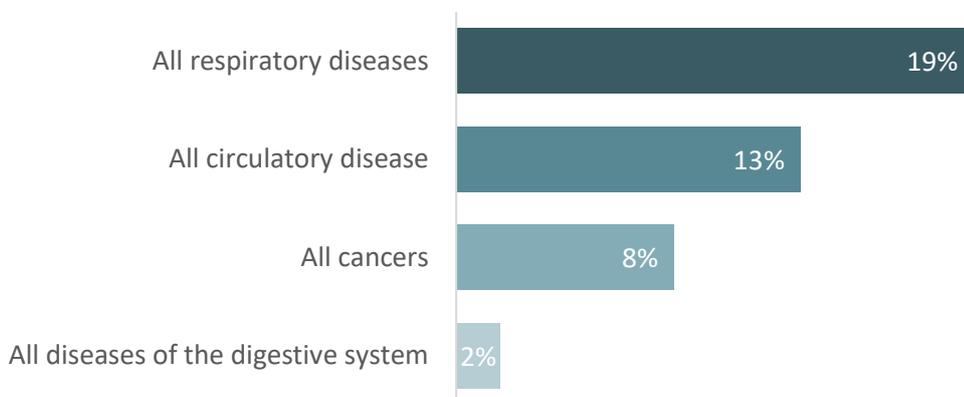
Figure 10: Proportion of hospital admissions attributable to smoking (adults aged 35 and over)



Source: Trak 2018<sup>13</sup>

- males accounted for 57% of smoking attributable hospital admissions in 2018
- around one in five (19%) of all admissions for respiratory diseases were estimated to be attributable to smoking in 2018 (Figure 11), a similar proportion to that for England<sup>14</sup> for 2017/18 (22%)

Figure 11: Proportion of smoking attributable admissions for all these conditions

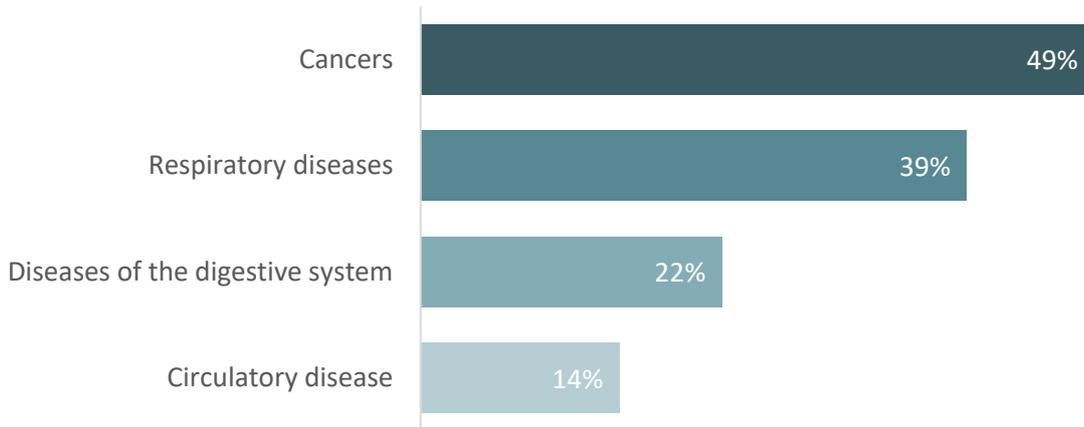


Source: Trak 2018

<sup>13</sup> data on hospital admissions is taken from the hospital computer system TRAK which was implemented in June 2011

<sup>14</sup> NHS Digital, Statistics on Smoking: England 2019, published 1 July 2019, available from www.digital.nhs.uk

Figure 12: Proportion of admissions for specific conditions that can be caused by smoking that were attributable to smoking



Source: Trak 2018

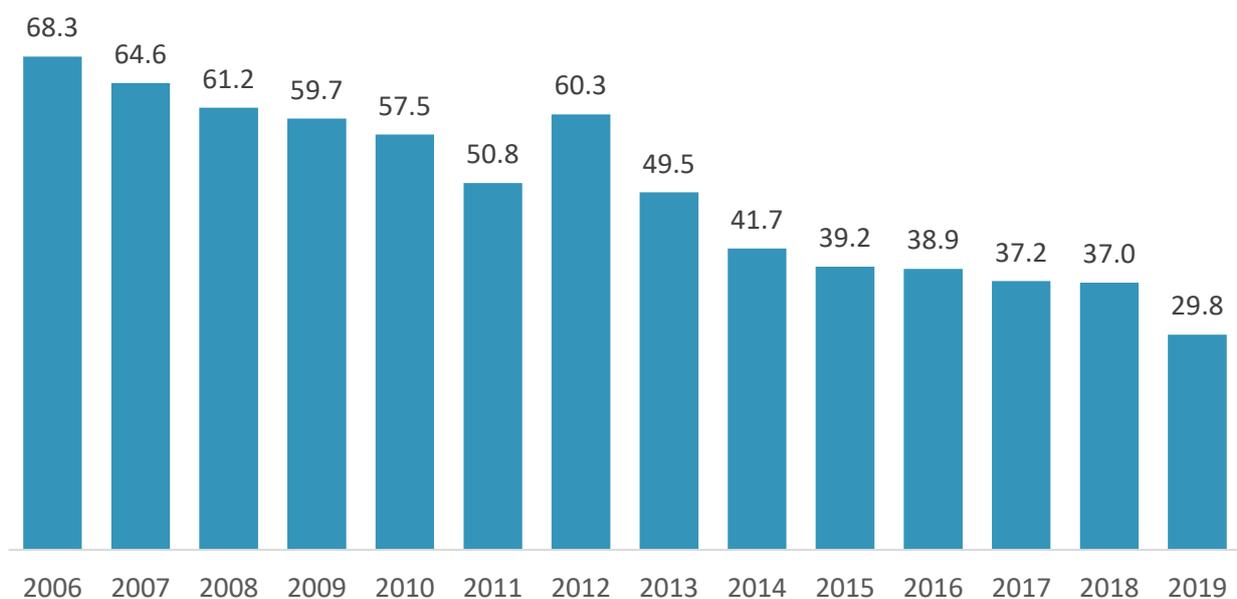
- around half (49%) of admissions for cancers that can be caused by smoking were estimated to be attributable to smoking
- 34% of male admissions and 27% of female admissions for conditions that can be caused by smoking were attributable to smoking in 2018

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.

### Tobacco imports

- the quantity of tobacco imported into the Island has decreased from 68,300 kilograms in 2006 to 29,800 kilograms in 2019, a reduction of more than half (56%) – see Figure 13.

Figure 13: Annual Quantity of tobacco imported, thousands of kilograms, 2006-2019



Source: States of Jersey Customs and Immigration Service

## Definitions and glossary of terms

### Age standardised rates

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

### Confidence Intervals

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

### Crude Rates

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

### Help2Quit Service

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

### Smoking attributable deaths and diseases

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

## Background notes

### Data sources

The following data sources have been used in this report:

- The Marriage and Civil Status (Jersey) Law 2001 requires 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. Data on deaths is compiled by Statistics Jersey and checked against other administrative sources to ensure that all deaths have been accurately detailed.

Cause of death is classified using the International Statistical Classification of Diseases, Injuries and Causes of Death (tenth revision, ICD-10). Coding of cause of death of Jersey registered deaths is undertaken by the Office for National Statistics on a quarterly basis.

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

- The Jersey Opinions and Lifestyle Survey (JOLS), formerly known as the Jersey Annual Social Survey, is a voluntary postal and internet survey run by Statistics Jersey. The Jersey Annual Social Survey was launched in 2005 and was renamed as the Jersey Opinions and Lifestyle Survey in 2016. In 2019 the survey was sent to more than 3,400 randomly selected households. Almost 1,100 people completed the survey questionnaire, a response rate of 33%.

Statistical weighting is 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.

However, as with all sample surveys there is an element of statistical uncertainty in looking at very small changes or differences. With the survey methodology used, we can be 95% confident that the percentages presented in this report accurately represent the whole population percentage to  $\pm 3.0$  percentage points. Therefore, the report focuses on significant findings, for example where differences between groups of the population are at least 10 percentage points. See Annex in the JOLS report for more information on sampling, weighting and definitions used in this survey see [www.gov.je/JOLS](http://www.gov.je/JOLS)

- The Jersey School Survey, formerly known as the Health-Related Behaviour Questionnaire (HRBQ): the survey and subsequent report was first run in 1996 to record the attitude and behaviour of children and young people in Jersey, regarding their lifestyle, health and wellbeing. The HRBQ was first run by the Schools Health Education Unit (SHEU), Exeter, in 1996 (secondary schools) and 1998 (primary schools). The survey has been run every four years since 1998. Although SHEU no longer run the survey (it was subsequently carried out by the Jersey Public Health Intelligence Team), SHEU gave permission for the continued use of a number of their questions in order to measure changes over time. Some of the questions in the questionnaire are taken from, or based on, the work of John Balding/Schools Health Education Unit, Exeter ([www.sheu.org.uk](http://www.sheu.org.uk)). Since 2018 the survey was run, analysed and published by Statistics Jersey.

Every Jersey child in school Years 6, 8, 10 and 12 was given the opportunity to take part. Over 80% for Years 6, 8 and 10, and 58% for Year 12 participated, a total of 3,058 children. 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. Some sections (e.g. drugs and sex) were not included, or were amended, for the younger children's versions of the questionnaire. Parents were given the option to preview the questionnaires and to withdraw their children from participating in the survey. Similarly, the children were given the option to withdraw themselves from the survey or to skip any questions that they weren't comfortable answering. Questionnaires were available in Polish and Portuguese, and staff at Mont a l'Abbe school also developed a set of resources to enable special needs children to participate in the survey. Analysis and statistical testing by sub-group was carried out to assess whether the response pattern for certain questions was significantly related to factors such as gender, ethnicity, school type, self-esteem, lacking material items, and parish type.

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

- Data on the number of people currently living with chronic obstructive pulmonary disease (COPD) is collected from the General Practice Central Server (GPCS), a computer system introduced into all general practice (GP) surgeries in Jersey in 2013. Data taken from the GPCS are taken from specific disease registers, generated as part of the Jersey Quality Improvement Framework which incentivises GPs to accurately record patients who meet a set of disease-specific criteria for each disease register. The quality of this data is deemed to be greater than those indicators and disease registers for which GPs are not incentivised to record.
- Jersey customs and immigration service supply information on volumes of tobacco imported into the Island.

### 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 and NHS Digital.

### Timeliness

The data presented in this report refers to 2018 data or earlier periods if UK comparison data for 2019 is not currently available. Data on deaths in Jersey for 2019 was not available at time of publication; therefore, 2018 figures are presented in this report. Hospital admission data for 2019 was not fully coded at time of publication; 2018 data has been used in this report.

### Measures of mortality rates

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

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

### 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. For further information on the methodology, see [www.nhsdigital.nhs.uk](http://www.nhsdigital.nhs.uk).

### 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 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 2018; therefore, numbers here should be treated as provisional. All death numbers have been independently rounded to the nearest 10, to reflect the provisional nature of these statistics at time of publication.

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

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

### Confidence intervals and statistical significance

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

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

#### Data quality and completeness

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

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

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

## Appendix: Public Health England (PHE) comparable indicators

### Adult smoking indicators

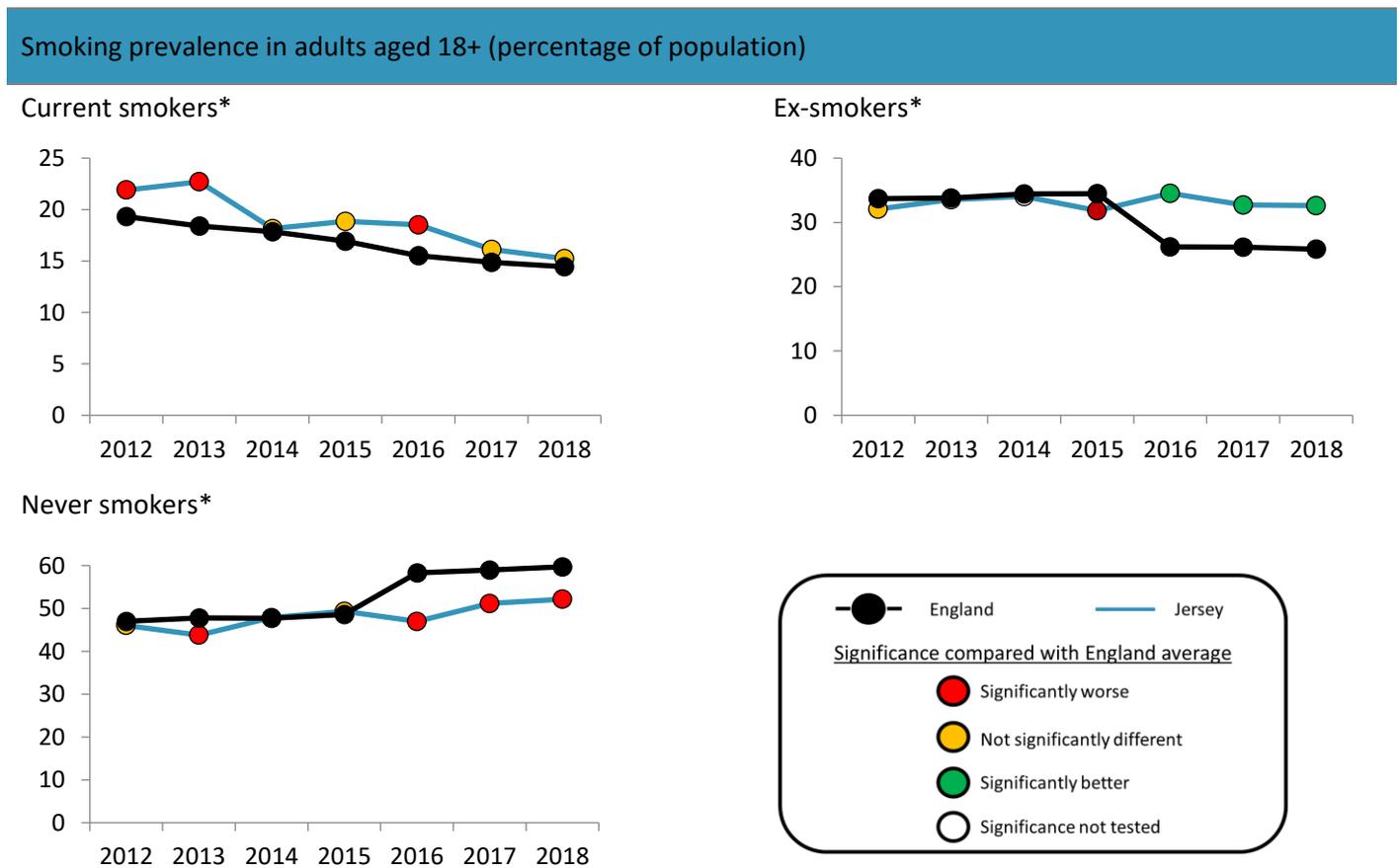
Table A1: Adult smoking indicators (PHE measure)

Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/lowest <sup>15</sup>	England worst/highest
<b>Smoking prevalence in adults aged 18+ (percentage of population)</b>							
Current smokers*	2018	15	(13, 17)	14	(14, 15)	4	26
Ex-smokers*	2018	33	(30, 36)	26	(26, 26)	41	11
Never smokers*	2018	52	(49, 55)	60	(59, 60)	72	41

Source: Statistics Jersey and Public Health England. Public Health Profiles [Date accessed 25/02/2020]

\* 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. Public Health Profiles [Date accessed 25/02/2020]

\* 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

<sup>15</sup> England best/ lowest by Local Authority. Local Authority (LA) is a generic term for any level of local government in the United Kingdom. In geographic terms, LAs include English counties, county districts, metropolitan districts, unitary authorities and London boroughs

## Smoking-related mortality indicators

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

**Table A2: Mortality indicators (PHE measure)**

Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best/lowest	England worst/highest
<b>Smoking attributable mortality (age-standardised rate per 100,000 population aged 35+)</b>							
All persons	2016-18	242	(203, 285)	250	(249, 251)	134	479
<b>Smoking attributable deaths from heart disease (age-standardised rate per 100,000 population aged 35+)</b>							
All persons	2016-18	21	(3, 43)	23	(23, 23)	12	51
<b>Smoking attributable deaths from stroke (age-standardised rate per 100,000 population aged 35+)</b>							
All persons	2016-2018	8	(0, 27)	8	(7, 8)	4	17
<b>Deaths from lung cancer (age-standardised rate per 100,000 population)</b>							
All persons	2016-2018	54	(45, 63)	55	(54, 55)	33	101
<b>Deaths from oral cancer (age-standardised rate per 100,000 population)</b>							
All persons	2016-2018	5	(3, 9)	5	(5, 5)	3	10
<b>Deaths from chronic obstructive pulmonary disease (age-standardised rate per 100,000 population)</b>							
All persons	2016-2018	50	(41, 58)	52	(51, 52)	26	112
<b>Still birth rate (foetal deaths occurring after 24 weeks gestation per 1,000 births)</b>							
All persons	2016-2018	3	(1, 5)	4	(4, 4)	2	7
<b>Neonatal mortality rate (number of deaths under 28 days per 1,000 live births)</b>							
All persons	2016-2018	-	-	3	(3, 3)	1	6

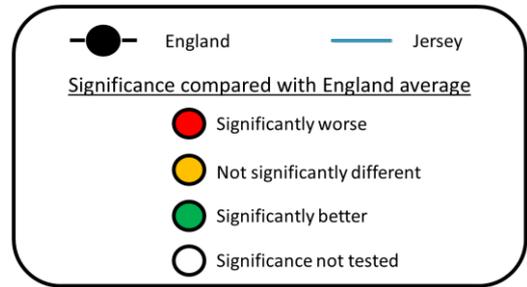
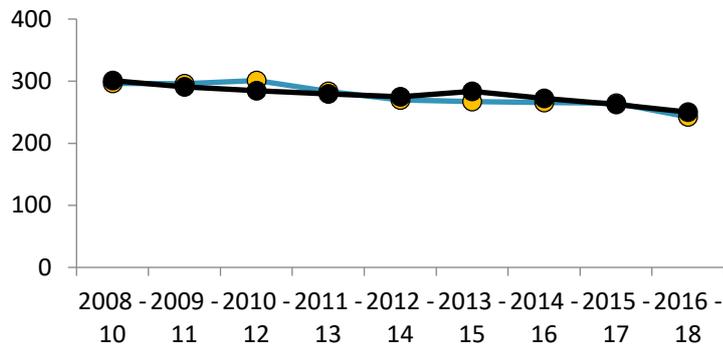
Source: Statistics Jersey and Public Health England. Public Health Profiles [Date accessed 25/02/2020]

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

Figure A2: Mortality indicators (PHE measure)

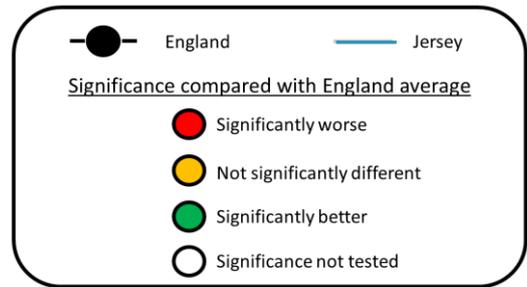
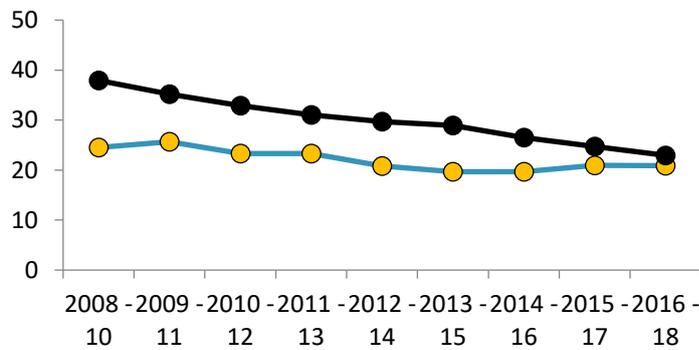
Smoking attributable mortality (age-standardised rate per 100,000 population aged 35+)

All persons



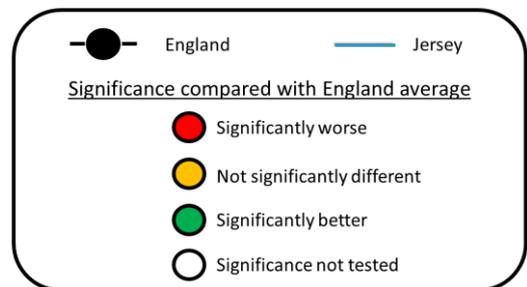
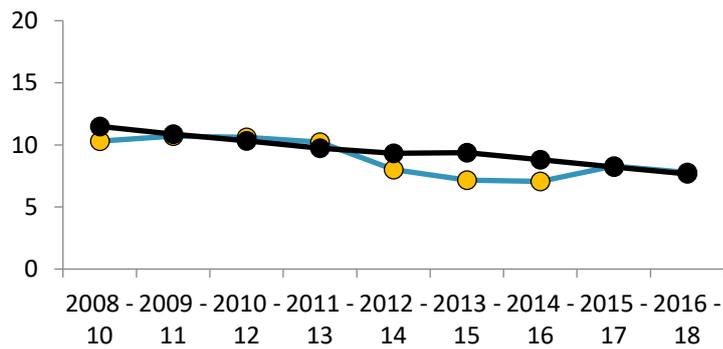
Smoking attributable deaths from heart disease (age-standardised rate per 100,000 population aged 35+)

All persons



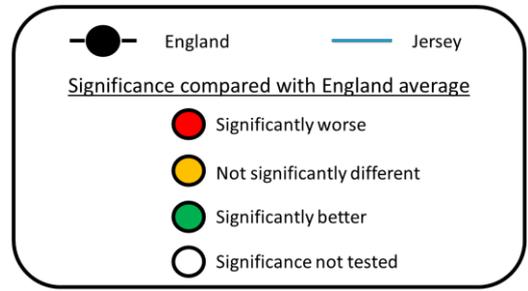
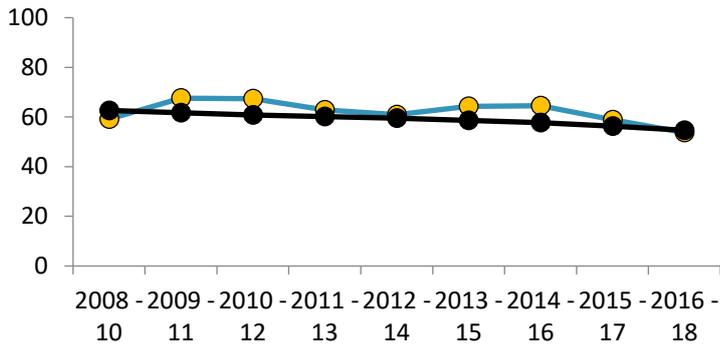
Smoking attributable deaths from stroke (age-standardised rate per 100,000 population aged 35+)

All persons



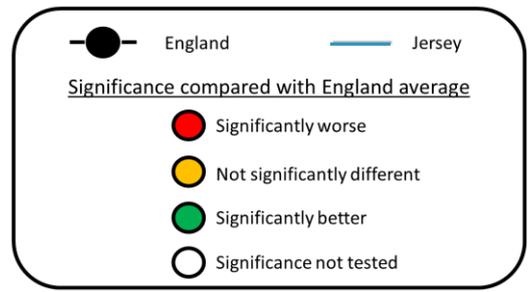
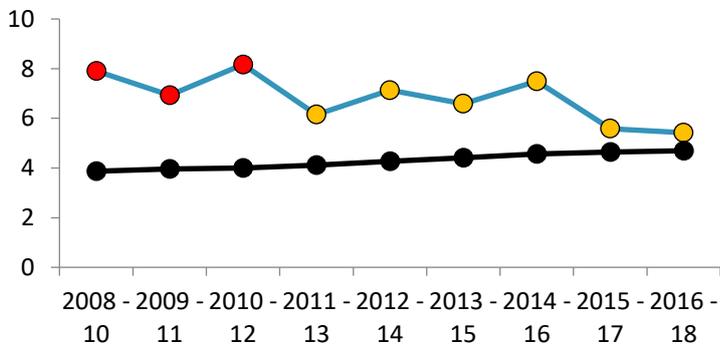
Deaths from lung cancer (age-standardised rate per 100,000 population)

All persons



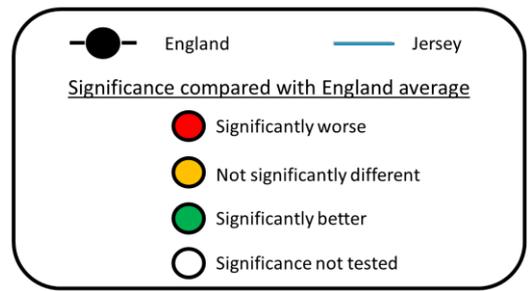
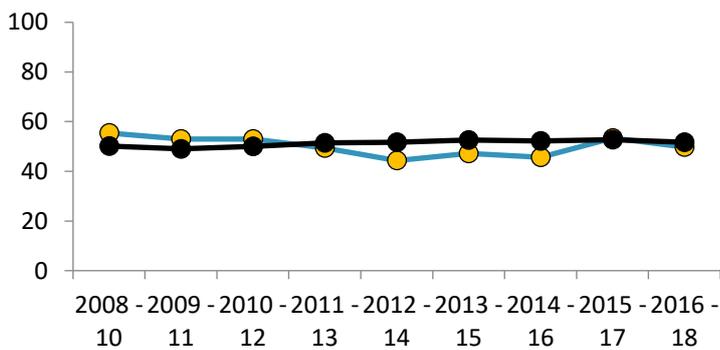
Deaths from oral cancer (age-standardised rate per 100,000 population)

All persons



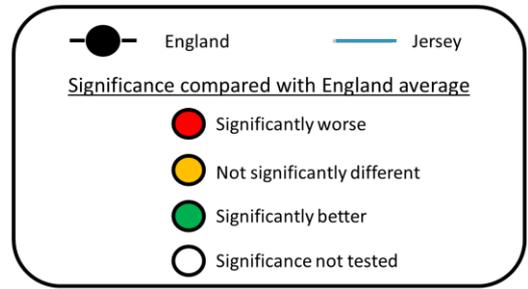
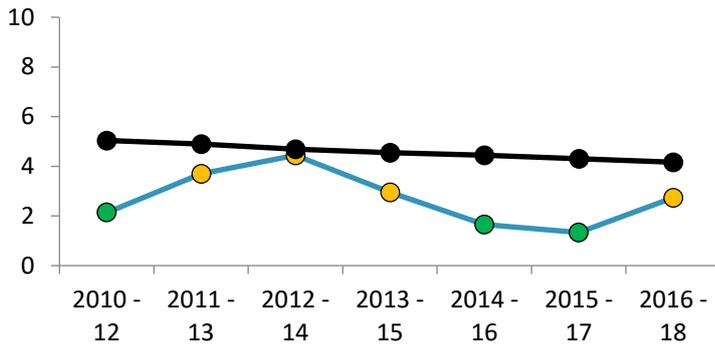
Deaths from chronic obstructive pulmonary disease (age-standardised rate per 100,000 population)

All persons



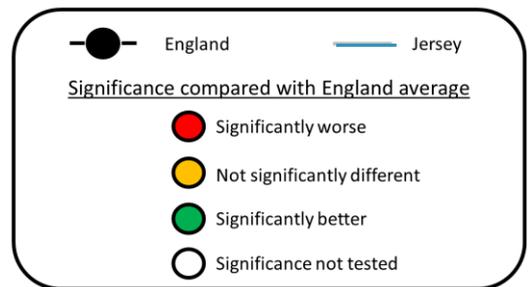
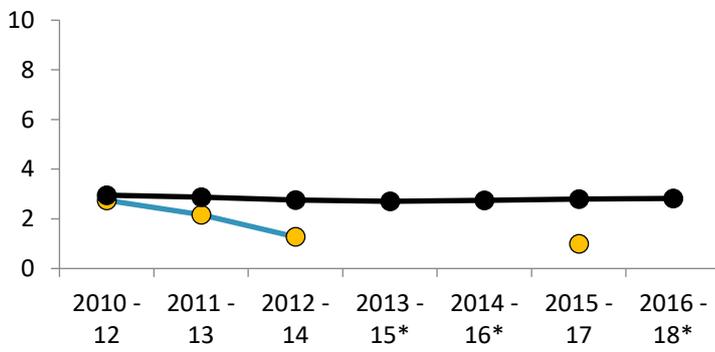
Still birth rate (foetal deaths occurring after 24 weeks gestation per 1,000 births)

All persons



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

All persons



Source: Statistics Jersey and Public Health England. Public Health Profiles [Date accessed 25/02/2020]

\*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
<b>Premature births (less than 37 weeks gestation) and still births per 1,000 live and still births</b>							
All persons	2015-17	55	(47, 64)	81	(80, 81)	65	113
<b>Low birth weight of term babies (percentage of all live births at term with low birth weight)</b>							
All persons	2017	1	(1, 2)	3	(3, 3)	2	5
<b>Hospital admissions for asthma (per 100,000 population under 19 years)</b>							
All persons	2017*	145	(102, 205)	186	(184, 189)	83	512
<b>Smoking attributable hospital admissions (age-standardised rate per 100,000 population aged 35 or over)</b>							
All persons	2017*	1617	(1440, 1802)	1530	(1,526, 1,535)	721	2990

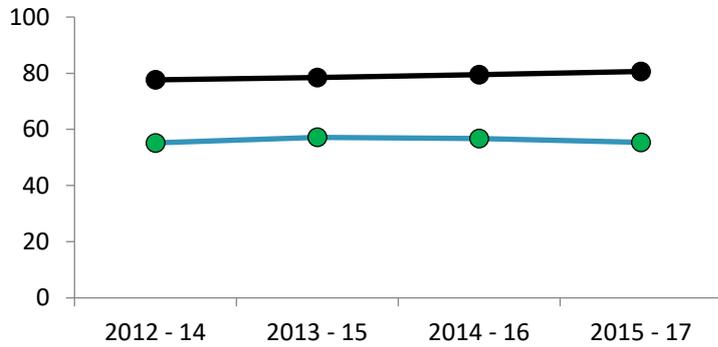
Source: Statistics Jersey and Public Health England. Public Health Profiles [Date accessed 25/02/2020]

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

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

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

All persons



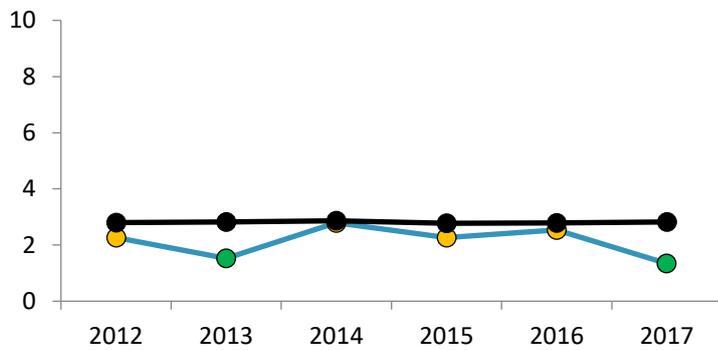
Legend: England (black line), Jersey (blue line)

Significance compared with England average

- Red circle: Significantly worse
- Yellow circle: Not significantly different
- Green circle: Significantly better
- White circle: Significance not tested

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

All persons



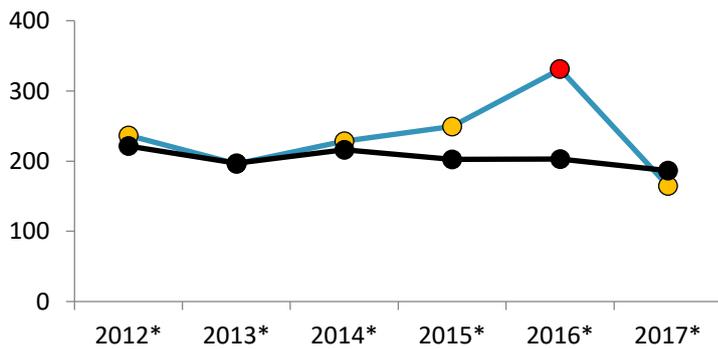
Legend: England (black line), Jersey (blue line)

Significance compared with England average

- Red circle: Significantly worse
- Yellow circle: Not significantly different
- Green circle: Significantly better
- White circle: Significance not tested

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

All persons

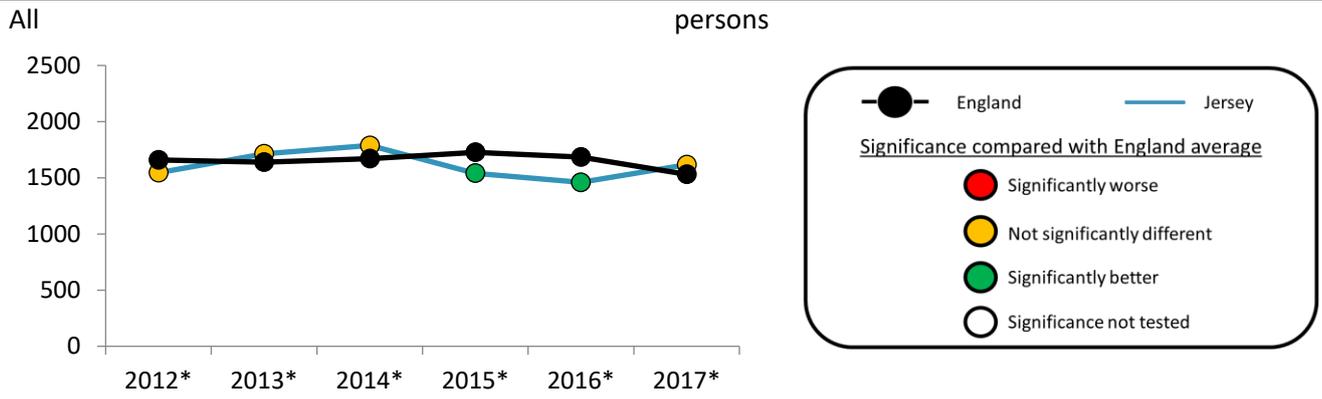


Legend: England (black line), Jersey (blue line)

Significance compared with England average

- Red circle: Significantly worse
- Yellow circle: Not significantly different
- Green circle: Significantly better
- White circle: Significance not tested

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



Source: Statistics Jersey and Public Health England. Public Health Profiles [Date accessed 25/02/2020]

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

# Smoking quitters indicators

Table A4: Smoking quitters indicators (PHE measures)

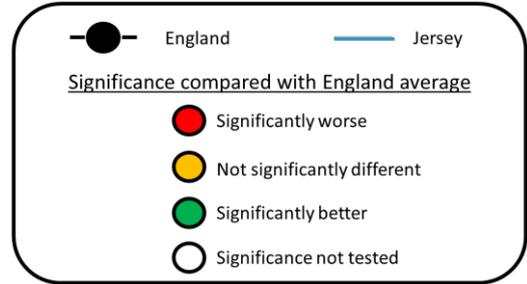
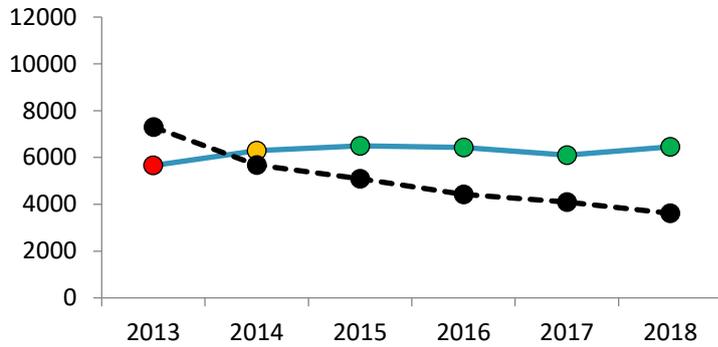
Indicator	Period	Jersey rate	Jersey 95% CI	England rate	England 95% CI	England best	England worst
<b>Number setting a quit date per 100,000 smokers</b>							
All persons	2018*	6,546	(6049, 6889)	3,614	(3569,3661)	12,836	380
<b>Successful quitters at 4 weeks per 100,000 smokers</b>							
All persons	2018*	3,247	(2958, 3564)	1,894	(1869,1920)	7,540	261
<b>Successful quitters (CO validated) at 4 weeks per 100,000 smokers</b>							
All persons	2018*	2,852	(2581, 3150)	1,326	(1308,1345)	5,842	209

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

Figure A4: Smoking quitters indicators (PHE measures)

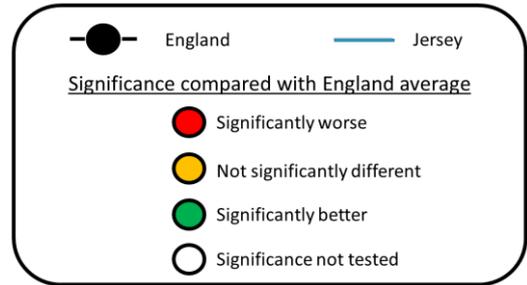
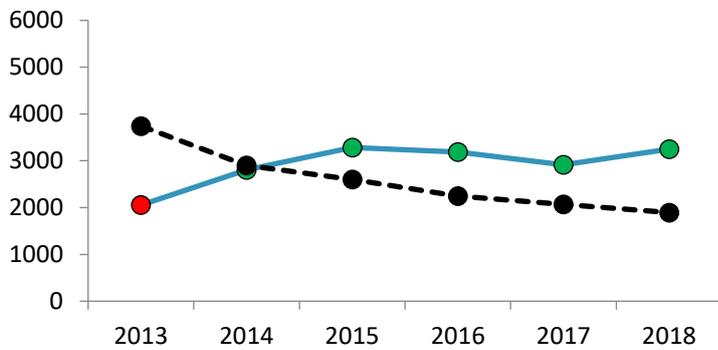
Number setting a quit date per 100,000 smokers

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

