



# Jersey Health Profile 2016

Data for 2013-2015

*Public Health Statistics Unit,  
Public Health Strategy Unit,*

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States   
of Jersey

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## Introduction

This Health Profile for Jersey provides a set of key indicators for the health status of children and adults in Jersey in 2013 to 2015. The report now includes local information on the wider determinants of health, produced by other States of Jersey Departments, and is equivalent to the data set which would be the major component of a Joint Strategic Needs Assessment used in English local authorities. The Health Profile will support and inform a wide range of strategic initiatives including the Sustainable Primary Care project and wider cross-governmental Public Health work.

The report covers data for the period 2013-2015 (or the most recent year available). The indicators have been selected from health indicators used nationally and internationally, focussing on population health status or modifiable lifestyles and behaviours. Together they provide a snapshot of the overall health of our population and how we compare with other areas. The indicators presented in this publication have been selected on the basis of their policy relevance, data availability and comparability with other areas. This report is an update to the 2014 Health Profile which covered data for years 2010 to 2012 and provides the latest update on many of the indicators contained in the previous version as well as new indicators considering the wider determinants of health.

Statistics on deaths are one of the most widely available, robust and comparable sources of information on health. This latest Health Profile uses the new European Standard Population (2013) in the calculation of mortality rates and as such is not comparable to figures published in the 2014 Health Profile for Jersey which used the previous standard population.

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

The comparative data come from official national statistics, sources include:

- The Office for National Statistics
- Public Health England
- UK Department of Health
- NHS Digital (formerly the Health and Social Care Information Centre)
- Organisation for Economic Co-operation and Development (OECD) Health database
- World Health Organisation

## Overall Findings

The 2016 Health Profile brings together key population health indicators and provides comparisons with other areas, including Guernsey and England. The health we experience is influenced by many 'wider determinants', so this report contains data (all of which is already published and readily accessible) about a whole range of factors that influence health: such as education, employment, income, air and water quality, safety and social isolation.

Overall, Jersey's statistics are positive in many of the comparisons: our population rates their overall health higher than the UK; stillbirth and infant mortality rates remain low; life expectancy is still high; we have very low teenage conception rates; childhood immunisation coverage is high; there are decreasing numbers of deaths from heart disease; unemployment rates are low. Both Channel Islands show similar health outcomes and lifestyle choices.

However, we should not be complacent as within these positive population level statistics will be sub-populations who may experience poorer health outcomes. In addition, Jersey has: comparatively low breast feeding rates; 1 in 6 babies living in homes where they are at risk from passive smoking; deaths from suicide and accidents resulting in many valuable years of working life lost; a high level of premature deaths from liver disease; 1 in 3 children and 1 in 3 pensioners living in relative low income.

Cancers and heart disease remain the major causes of death locally as well as world-wide. The report shows that there are still premature deaths that are preventable, for example much liver and heart disease, many cancers, accidents and suicides.

The impact of alcohol and smoking related ill-health on our economy is still evident in the data. Smoking causes 1 in 5 of all deaths amongst those aged 35 or over, and lung cancer still accounts for a high proportion of working life lost.

Many of the factors known to cause ill health are decreasing but 51 per cent of our population are now overweight or obese. Although we compare favourably in terms of physical exercise and eating '5-a-day' we still have a proportion of the population who do nothing active and eat very few fruit & vegetables.

As in many countries world-wide, our gains in longevity at older ages combined with the reduction in fertility rates are contributing to a steady rise in the proportion of older persons in our population. Whether longer life expectancy is accompanied by good health and functional status among the ageing population has important implications for health & social care systems.

The aim of this report is to provide local population indicators that give a balance of useful information across a range of important areas that can be compared with other regions. Together these provide a snapshot of the overall health of the population of the island and highlight areas of success as well as emerging areas of concern. The Jersey Health Profile thus provides a public, professional and political information resource, which also signposts all the more detailed published reports, profiles and data which it summarises.

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## Key findings by chapter

### Demography (Page 11-17)

- The projected rise in the proportion of older people in our population contributes to the predicted increase in the dependency ratio in Jersey by 2035 when there are likely to be 63 dependent people for every 100 of working age (63 per cent). The current dependency ratio for Jersey is 50 per cent.

### Fertility (Page 18-27)

- There are on average 1.5 children born to women of childbearing age in Jersey (Total Fertility Rate). That is below the figure of 2.1 required to maintain long term population levels assuming no migration.
- Infant mortality and stillbirth rates are low.

### Child Health (Page 28-40)

- Breastfeeding rates are low but a higher proportion of Jersey babies (53 per cent) are partially or totally breast fed at 6-8 weeks than in England (43 per cent).
- A&E attendances for young children are significantly lower than the England average and significantly higher than the average for the South West.
- During the period 2012-14 the rate of children 'killed or seriously injured' on Jersey roads has been similar to the UK.
- There continues to be a decrease in the proportion of young people who smoke or drink alcohol.
- Three-quarters of young people have medium to high self-esteem but there has been a slight increase in the proportion of young people with low self-esteem, particularly among 14-15 year olds.

### Self-perceived health & life expectancy (Page 41-49)

- 80 per cent of our population rank their own health as 'good' or 'very good', which is higher than the UK and EU averages
- Life expectancy at birth continues to increase and ranks Jersey amongst the highest life expectancies of countries around the world.
- Life expectancy at age 65 has also increased to around 20 years for men and 23 years for women.

### Mortality (Page 50-75)

- The top 3 main causes of death in Jersey remain ischaemic heart disease, lung cancer and stroke.
- Cancers are the main cause of death locally. Cancers and circulatory disease account for more than 60 per cent of all deaths.
- Suicide rates in 2015 were lower than in previous years and similar for both men and women.
- Over time there has been an increase in cancer deaths and a decrease in deaths from circulatory disease
- The most common causes of cancer deaths are: lung, breast and colorectal for women; lung, prostate, colorectal, oesophageal and pancreatic for men.
- Most years of working life lost (16-64) are due to accidents, suicide, lung cancer, ischaemic heart disease and chronic liver disease.
- Premature deaths from cancer and liver disease rank us among the worst compared to regions in England. Premature deaths from heart disease and stroke are better than the English average.

### Morbidity (Page 76-83)

- The most frequently diagnosed new cancers locally were: breast, prostate, colorectal and lung. An updated report on the 2012-14 incidence data is due shortly.
- Hypertension, obesity, depression and asthma are the most commonly recorded diseases in GP practices and have similar prevalence rates to England.

- It is estimated that around 24 per cent of GP patients have one or more chronic disease and 8 per cent have two or more chronic diseases.
- A fifth of Islanders reported having a longstanding illness, disability or infirmity that has lasted, or is expected to last, at least 12 months; of these, half (49 per cent) said it limited their activities 'a little', a further 19 per cent said it affected their day to day activities 'a lot'.

### **Mental Health (Page 84-91)**

- Average life satisfaction scores are higher in Jersey than most OECD countries, including the UK.
- There has been no change in average mental wellbeing score in recent years.
- 6 per cent of the population report a low life satisfaction score; 9 per cent report a low worthwhile score.
- Jersey residents report higher anxiety scores than those in England (35 per cent compared to 19 per cent, respectively).

### **Sexual Health (Page 92-99)**

- Teenage pregnancy rates remain very low compared to other areas.
- Under 16 conception rates are 2.1 per 1,000 and less than half the rate for England.
- Under 18 conception rates are significantly lower than rates for all the English regions (6.8 per 1,000)
- Termination rates are significantly lower than in England.
- Termination rates to mothers under 18 is very low.

### **Disease Prevention and early Detection (Page 100-104)**

- Jersey continues to have a high coverage for all childhood immunisations.
- HPV vaccine uptake is similar locally to that of England overall.
- The latest local data on population screening programmes will be published shortly.

### Lifestyle (Page 105-125)

- Smoking rates have decreased and currently 12 per cent of adults smoke daily.
- 1 in 6 babies born in 2015 are living in households where they are at risk from second hand smoke exposure (passive smoking).
- Per capita alcohol consumption has decreased but is still amongst the highest in Europe.
- 1 in 4 of Islanders, who drink alcohol, are doing so at levels that are likely to be increasing their risk of harm, or will cause them health problems.
- Obesity levels in adults have not changed since 2008.
- Over 50 per cent of our local adult population are now overweight or obese.
- Based on waist measurements, 4 per cent of men and 8 per cent of women are at very high risk of cardiovascular disease.
- 33 per cent of men and 40 per cent of women report eating 5 or more portions of fruit and vegetables a day, higher than the English average for men & women.
- 55 per cent of our population are active at the recommended level of activity (five sessions of moderate activity of at least 30 minutes per week)
- 9 per cent of our population do no physical activity. This is highest in the 65+ age group where 1 in 5 do not exercise in a typical week.

### Wider Determinants of Health (Page 126-152)

- 1 in 4 Jersey households were in relative low income in 2014/15.
- Around 1 in 3 children are living in relative low income, a similar figure to the UK.
- Around 1 in 3 pensioners are living in relative low income, double the UK proportion.
- Income inequality in Jersey ranks slightly worse than the UK.
- Local unemployment rates are low (4-6 per cent).
- 1 in 6 over working age are still economically active.
- 22 per cent of school children are eligible for the 'pupil premium'.
- Housing affordability marginally worsened in 2013.
- Over half of lower income houses are considered to be in housing stress (pay more than 30 per cent of their gross income on housing costs).
- 20 per cent of the population have no formal qualifications.

- Air and water quality are monitored regularly and generally fall within accepted limits.
- Recorded crime has decreased since 2011.
- 13 per cent of people in Jersey are living on their own. Around 7,600 adults and 4,900 pensioners.

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# DEMOGRAPHY

## Population

The population of Jersey at the end of 2015 was estimated to be 102,700,<sup>1</sup> comprising 51,900 females and 50,800 males.<sup>2</sup> The last census in Jersey took place in March 2011 and provided the age and gender breakdown for the population. The details of this are provided in Table 1.1.

The resident population estimate for Guernsey in 2015 is 62,600, whilst that of Alderney is 2,000.

**Table 1.1: 2011 census numbers by age and gender and 2015 population numbers**

Source	Age group	Males	Females	Total
2011 Census	<1	509	522	1,031
	1-4	1,957	2,027	3,984
	5-9	2,470	2,382	4,852
	10-14	2,729	2,573	5,302
	15-19	2,863	2,632	5,495
	20-24	3,006	2,938	5,944
	25-29	3,351	3,354	6,705
	30-34	3,670	3,566	7,236
	35-39	3,615	3,610	7,225
	40-44	4,183	4,180	8,363
	45-49	4,187	4,170	8,357
	50-54	3,536	3,662	7,198
	55-59	2,955	3,087	6,042
	60-64	2,832	2,818	5,650
	65-69	1,938	2,110	4,048
	70-74	1,732	1,900	3,632
	75-79	1,343	1,550	2,893
	80-84	822	1,183	2,005
85+	598	1,297	1,895	
	<b>Total</b>	<b>48,296</b>	<b>49,561</b>	<b>97,857</b>
<b>2015 year-end population</b>		<b>50,800</b>	<b>51,900</b>	<b>102,700</b>

Source: States of Jersey Statistics Unit

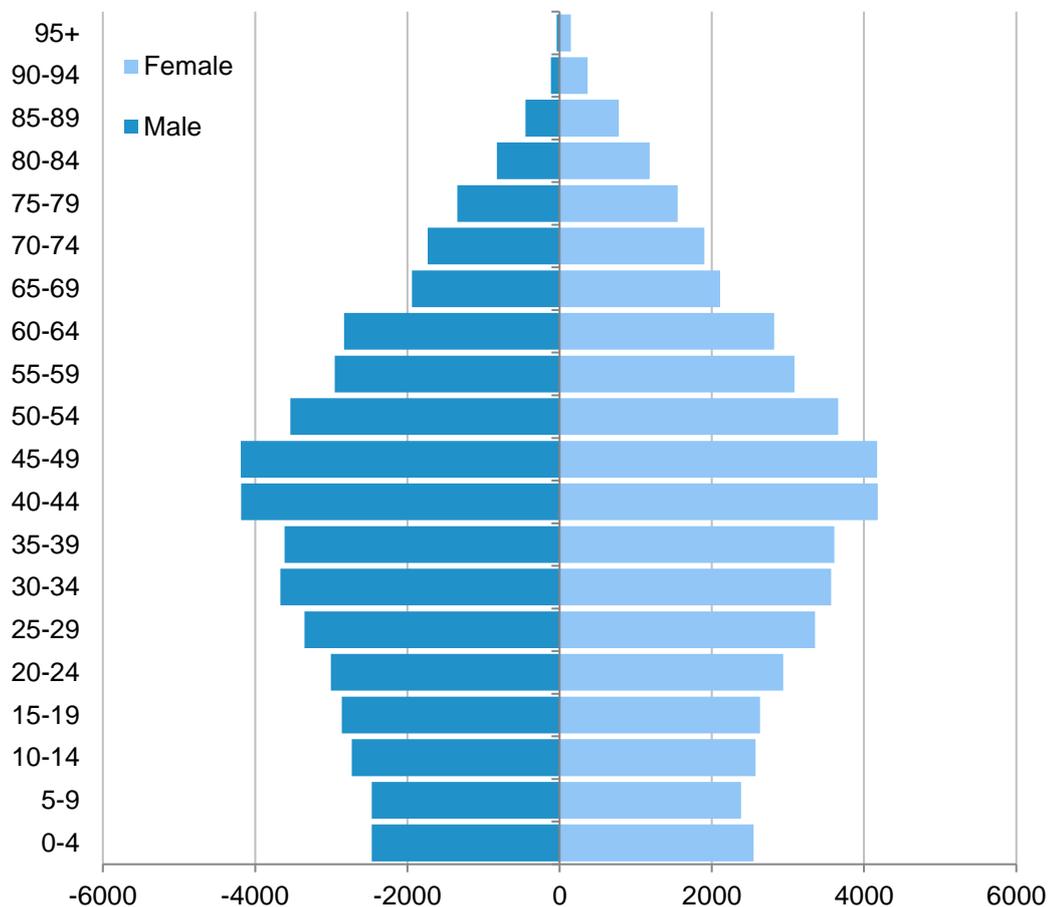
<sup>1</sup> States of Jersey Statistics Unit, Jersey Resident Population Estimate 2015 report, published 22 June 2016, available from [www.gov.je](http://www.gov.je)

<sup>2</sup> Based on States of Jersey Statistics Unit population projections.

The structure of the Jersey population is shown in Figure 1.1. Population pyramids provide a visual representation of how a population is distributed across different age groups. As at 2011, the greatest proportion of people by age are those in their forties. There are a greater proportion of females in the older age groups (65+), which reflects the increased survivorship of women over men at these ages. The Guernsey population shows a similar pattern.

Around 27 per cent of the population are under 25 and 16 per cent of the population are aged 65 and over.<sup>3</sup>

**Figure 1.1: Population Structure of Jersey, 2011**



Data source: States of Jersey Statistics Unit Census 2011

<sup>3</sup> Based on population projections and year-end population estimate for 2015, as per the States of Jersey Statistics Unit reports.

## Population Change

Between 2000 and 2015, the Jersey population has increased by 14,300 people (an increase of 16 per cent) as shown in Figure 1.2. The most recent population estimate,<sup>4</sup> to year-end 2015, showed net migration of 1,500 people in the previous year.

**Figure 1.2: Population change, 2000-2015**



Source: Public Health Statistics Unit

Over the last three years, net migration has averaged +1,000 people per year into the Island. If recent migration trends were to continue, it is estimated that Jersey's population would reach 128,800 by 2035.

The States of Jersey Statistics Unit estimate that the proportion aged 65 and over in our population will increase over the coming years, such an increase will put further demand on our health services (see Table 1.2).

<sup>4</sup> States of Jersey Statistics Unit, Jersey Resident Population Estimate 2015 report, published 22 June 2016, available from [www.gov.je](http://www.gov.je)

**Table 1.2: Short, medium and long term summary demographics based on net inward migration of +1,000 persons per year**

	2025	2035	2065
<b>65+ year olds at year end</b>	21,800	28,400	38,500
<b>16-64 year olds at year end</b>	74,400	79,200	100,600
<b>0-15 year olds at year end</b>	19,600	21,200	27,000
Total population at year end	115,700	128,800	166,000

Data source: States of Jersey Statistics Unit, Population Projections 2016

## Dependency Ratio

The Jersey dependency ratio for year-end 2015 was 50 per cent meaning there are 50 children and dependent adults for every 100 of working age. Essentially for every 1 child or person of pensionable age, there are 2 people of working age.

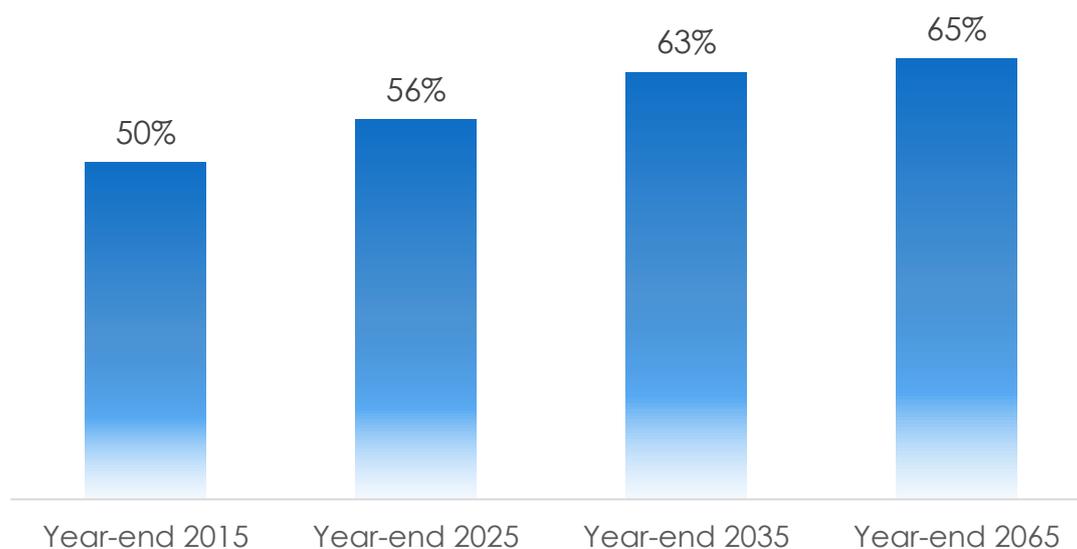
If recent trends in migration were to continue, the dependency ratio will increase to 63 per cent in the medium term (2035). So, in future, Jersey is likely to have a higher proportion of children and dependent adults in our population (63 for every 100 of working age by 2035).

Figure 1.3 shows the short-term (2025), medium-term (2035) and long-term (2065) estimates of the population dependency ratio under the population projection scenario of +1,000 net inward migration per year.

### Dependency Ratio

A measure of the number of people in a population who are dependent (children and people of pensionable age) compared with the number of people of working age. A lower ratio is considered desirable.

**Figure 1.3: Dependency Ratio and Projected Dependency Ratio**



Notes: Assuming +1,000 people net inward migration each year.

For other projection scenarios please see 2016 Population Projection Report.

Data source: States of Jersey Statistics Unit, Population Projections 2016

## Population Density

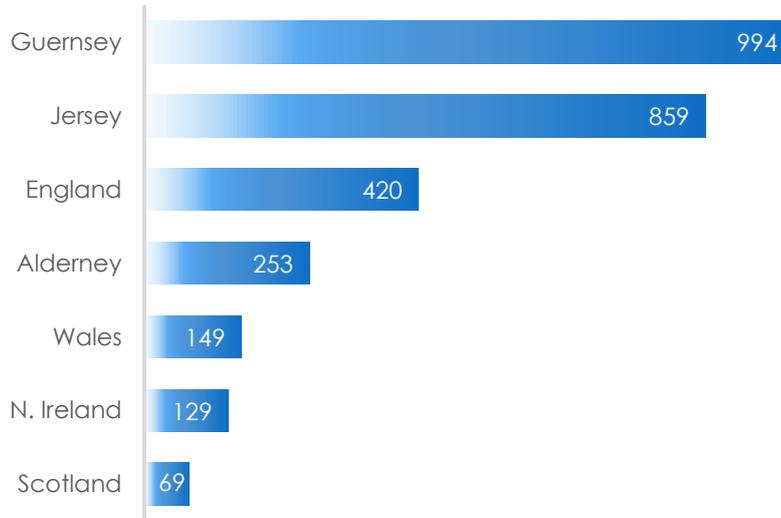
Jersey has an area of 119.5 km<sup>2</sup> at high tide. This translates to a population density of 859 people per square kilometre in 2015 in Jersey. This density is lower than that of Guernsey, and over double that of England (Figure 1.3), which was around 420 people per km<sup>2</sup> in 2015<sup>5</sup>, but lower than Islands such as Malta (1,336 per km<sup>2</sup>) and Bermuda (1,304 per km<sup>2</sup>).<sup>6</sup>

The population density of Guernsey in 2015 was 994 people per km<sup>2</sup> whilst that for Alderney was around 253 per km<sup>2</sup>.

<sup>5</sup> Office for National Statistics, Population estimates for the UK, England and Wales, Scotland and Northern Ireland, June 2016, available from [www.ons.gov.uk](http://www.ons.gov.uk)

<sup>6</sup> The World Bank (2014 data), [data.worldbank.org/indicator/EN.POP.DNST](http://data.worldbank.org/indicator/EN.POP.DNST)

Figure 1.4: Population Density (per square km)



Source: ONS, States of Jersey Statistics Unit, Guernsey Public Health and Strategy Directorate



- States of Jersey Statistics Unit, Report on the 2011 Census, published August 2012, available from [www.gov.je](http://www.gov.je)
- States of Jersey Statistics Unit, Jersey population projections 2016 release, published October 2016, available from [www.gov.je](http://www.gov.je)
- States of Jersey Statistics Unit, Jersey Resident Population Estimate 2015 report, published 22 June 2016, available from [www.gov.je](http://www.gov.je)



# FERTILITY

## Birth Rate

In 2015, there were 1,021 births to resident mothers, giving a crude birth rate of 10.0 live births per 1,000 population. This rate is similar to the three-year average rate of 9.6 per 1,000 in Guernsey & Alderney, where there were around 585 to 660 births a year between 2013 to 2015, and slightly lower than the birth rate of 12.1 per 1,000 in England and Wales<sup>7</sup> in 2015.

### Crude Birth Rate

The number of resident live births per 1,000 total population in a calendar year.

**Table 2.1: Jersey birth rates, 2013-2015**

	Live births	Population estimate*	Birth rate per 1,000
<b>2013</b>	1,029	100,200	10.3
<b>2014</b>	985	101,000	9.8
<b>2015</b>	1,021	102,700	9.9
<b>2013-15</b>	<b>3,035</b>	<b>303,900</b>	<b>10.0</b>

\*Year-end population estimates

Source: Jersey Public Health Statistics Unit, States of Jersey Statistics Unit

The birth rate in Jersey has declined slightly in recent years, from 11.1 over the period 2010-2012, to 10.0 in the most recent period (2013-2015) as shown in Figure 2.1.

The average age of resident mothers (at the time of birth) was 32 years in 2014 and 2015. The highest number of births over the last twenty years have been to mothers aged 30 to 34, with the lowest number of births to the under 20's and over 40's as shown in Figure 2.2.

While the number of births to mothers aged 25 to 29 has decreased since 1997 there has been an increase in births to older mothers aged 35 to 39 over the same period.

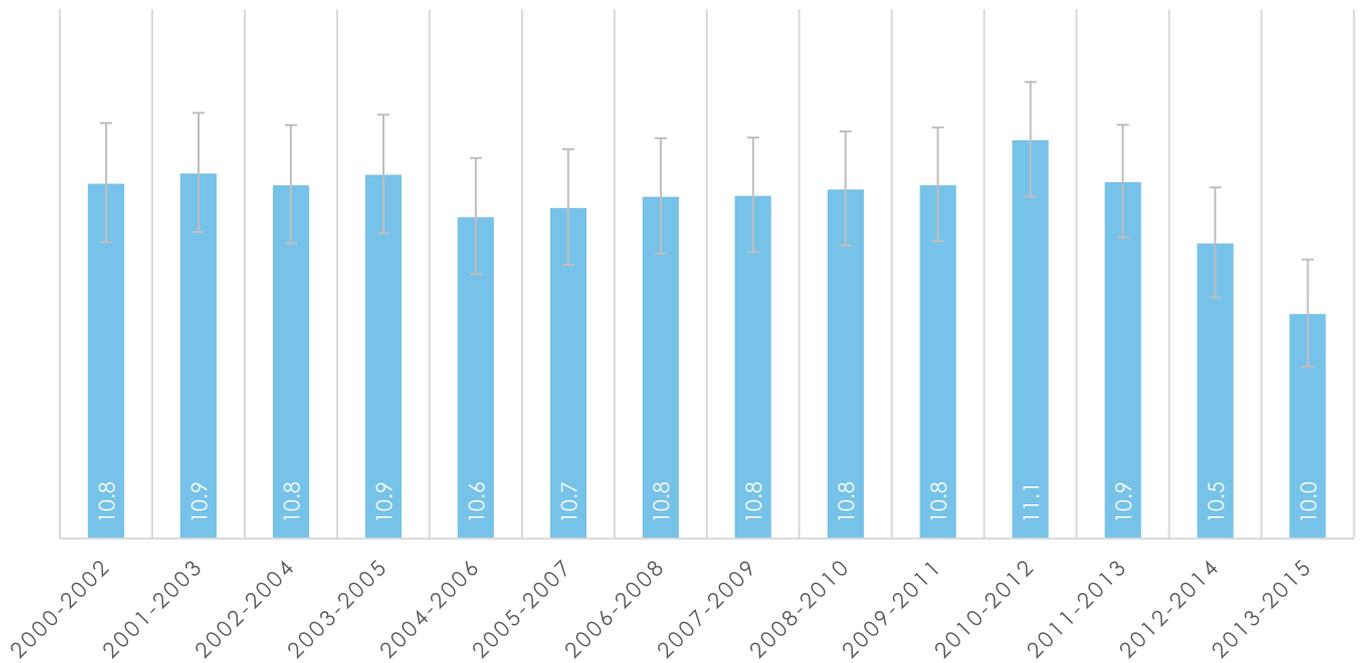


<sup>7</sup> ONS Birth Summary Tables England & Wales 2015, published July 2016, [www.ons.gov.uk](http://www.ons.gov.uk)

## 2. Fertility

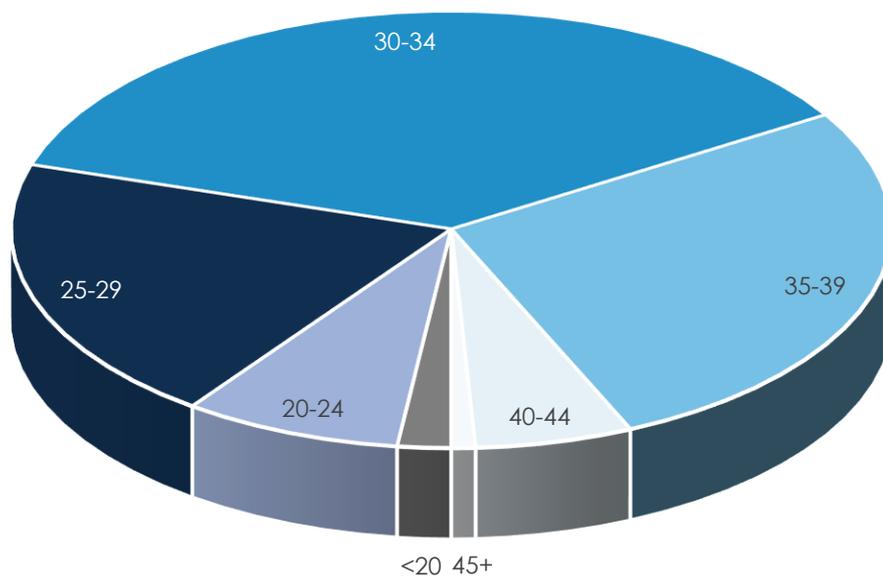
Since 2000 in Jersey, there have been more births to women aged over 40 years than to women under 20 years of age.

**Figure 2.1: Crude Birth Rate, 2000-2015, 3-year averages**



Source: Public Health Statistics Unit

**Figure 2.2: Proportion of births by age of mother, 2015, years**



Source: Public Health Statistics Unit

## General Fertility Rate

Over the period 2013 to 2015, the average general fertility rate (GFR) for Jersey was 51.5 per 1,000 female population. The rate for Jersey was similar to the general fertility rate in Guernsey and both were significantly lower than the latest figure for England overall, as well as the rate for all English regions (Table 2.2).

### General fertility rate (GFR)

The number of live births for every 1,000 females of childbearing age (15-44) in the local population.

**Table 2.2: General Fertility Rates, Channel Islands 2013-15, England, London and South West 2014**

	GFR	95% Confidence Interval (LL)	95% Confidence Interval (UL)
<b>Guernsey &amp; Alderney 2013-2015</b>	51.6	49.3	54.0
<b>Jersey 2013-2015</b>	51.5	49.8	53.3
<b>South West</b>	60.5	60.1	61.0
<b>England</b>	62.2	62.1	62.4
<b>London</b>	63.3	63.0	63.6

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00427

## Total Fertility Rate

The average total fertility rate (TFR) between 2013 and 2015 for Jersey was 1.5; this TFR is similar to Guernsey but significantly lower than for England overall and the English regions (Table 2.3).

The Channel Island rates remain below the level of replacement fertility (see definition box).

### Total fertility rate (TFR)

The average number of children that would be born to a woman who experienced the current age-specific fertility rates throughout her childbearing years (15-49 years). In Western countries a TFR of about 2.1 is required to maintain long term population levels assuming no migration (replacement fertility).

**Table 2.3: Total Fertility Rates, Channel Islands 2013-15 and England, London and South West 2014**

	TFR	95% Confidence Interval (LL)	95% Confidence Interval (UL)
<b>Guernsey &amp; Alderney 2013-2015</b>	1.6	1.4	1.7
<b>Jersey 2013-2015</b>	1.5	1.4	1.6
<b>South West</b>	1.9	1.8	1.9
<b>England</b>	1.8	1.8	1.8
<b>London</b>	1.7	1.7	1.7

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00428

Both Channel Island TFRs are lower than the average rate of 1.8 recorded among high and upper middle income countries<sup>8</sup> globally (Table 2.4).

<sup>8</sup> WHO member states are grouped into four income groups (low, lower-middle, upper-middle and high) based on the World Bank list of analytical income classification of economies, which is based on the Atlas gross national income per capita estimates. A high income country is a country with a gross national income per capita above US\$12,475.

**Table 2.4: WHO Global Average Total Fertility Rate, 2013**

Income bracket	Mean TFR
Low income	4.0
Lower middle income	2.9
Upper middle income	1.9
High income	1.7

Source: World Health Statistics 2015

**Figure 2.3: Comparison of TFR in Jersey and in high income countries**

The average number of children women in Jersey have over their lifetimes based on current fertility rates



The Jersey number is lower than that for women in other high income countries

Source: Public Health Statistics Unit

## Stillbirth Rate

The stillbirth rate for Jersey was 3.0 per 1,000 (2013-15), a rate statistically consistent with that of the previous three-year period (2010-2012) of 2.1 per 1,000. The latest rate is similar to Guernsey's rate for the same period. Both Channel Island's rates are lower than the most recent comparative data for England, but the wide confidence intervals around the local estimates (because of low numbers) mean the differences are not statistically significant (Table 2.5).

### **Stillbirth rate**

The number of stillbirths per 1,000 live and stillbirths. A stillbirth is the birth after the 24th week of gestation of a baby that has died in utero (in the womb, or uterus, before delivery).

## 2. Fertility

The low number of stillbirths in Jersey & Guernsey means that these figures are sensitive to year on year fluctuations.

**Table 2.5: Channel Islands Stillbirth Rates, 2013-2015 and England, London and South West 2012-2014**

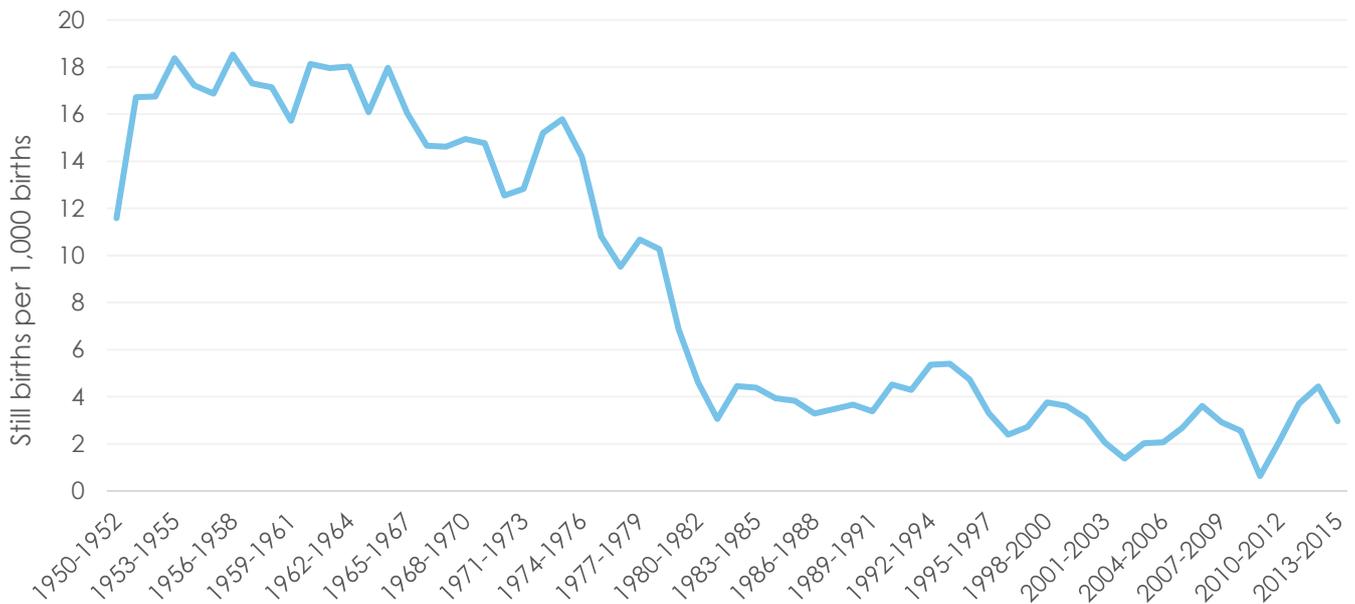
	Stillbirth rate	95% Confidence Interval (LL)	95% Confidence Interval (UL)
<b>Guernsey &amp; Alderney</b>	2.1	0.6	5.5
<b>Jersey</b>	3.0	1.5	5.7
<b>South West</b>	4.0	3.7	4.3
<b>England</b>	4.7	4.6	4.8
<b>London</b>	5.2	5.0	5.5

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00468

The stillbirth rate in Jersey has decreased over time (Figure 2.4). A similar decrease has been reported for Guernsey and England and Wales.<sup>9</sup> Locally, rates have decreased from around 15 per 1,000 births in the 1960's to less than 5 per 1,000 in recent years.

<sup>9</sup> Office for National Statistics, Stillbirth rates 1965-2010, published April 2013, available from [www.ons.gov.uk](http://www.ons.gov.uk)

**Figure 2.4: Stillbirth Rates, 3-year averages, 1950-2015**

Source: Public Health Statistics Unit

## Infant Mortality Rate

The infant mortality rate is considered to be an indicator reflecting the relationship between economic, social and environmental conditions on the health of mothers and newborns, as well as the effectiveness of health services.<sup>10</sup>

The number of children under 1 year of age that die on the Island is low, between 1 and 6 in any given year (since 2000). In the latest three-year period (2013-2015), the Infant mortality rate in Jersey was 1.3 per 1,000. This rate compares with 2.7 per 1,000 in Guernsey (Table 2.6) but is not statistically significantly different. Both Channel Island rates are lower than the average rate for England (4.0 per 1,000) and the EU (28 countries) average (3.7 per 1,000<sup>11</sup>). The Jersey rate is not significantly different from these averages, because of the large confidence intervals due to our population size and relatively low numbers of infant deaths.

### **Infant mortality rate**

The number of deaths under the age of one per 1,000 live births. This calculation excludes still births.

<sup>10</sup> Public Health England, Public Health Outcomes Framework, updated November 2016, available from [www.phoutcomes.info](http://www.phoutcomes.info)

<sup>11</sup> EuroStat, Infant Mortality Rate, Updated 14 April 2016, available from [www.ec.europa.eu/eurostat](http://www.ec.europa.eu/eurostat)

## 2. Fertility

The infant mortality rate in Jersey has decreased significantly (by a factor of more than 20) in the last 60 years (Figure 2.5) from 28 per 1,000 in 1950-1952 to 1.3 per 1,000 in 2013-2015. The Organisation for Economic Co-operation and Development (OECD) reports a fall in infant mortality across all OECD countries<sup>12</sup> since the 1970's.

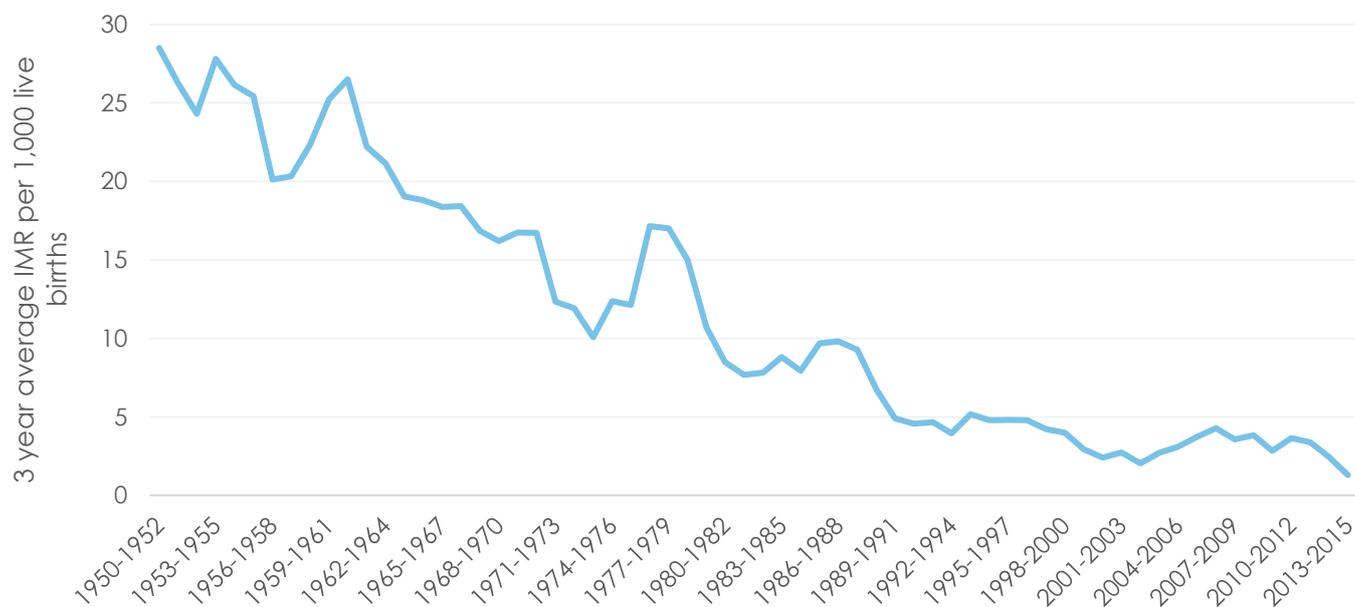
**Table 2.6: Infant Mortality rates, 2013-2015 and England, London and South West 2012-2014**

	Stillbirth rate	95% Confidence Interval (LL)	95% Confidence Interval (UL)
<b>Guernsey &amp; Alderney</b>	2.7	0.9	6.3
<b>Jersey</b>	1.3	0.5	3.5
<b>South West</b>	3.7	3.4	4.0
<b>England</b>	4.0	3.9	4.1
<b>London</b>	3.6	3.4	3.8

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00723

**Figure 2.5: Infant Mortality Rates, 3-year averages, 1950-2015**



Source: Public Health Statistics Unit

<sup>12</sup> OECD (2015), 'Infant mortality' in *Health at a Glance 2015*, OECD indicators, OECD Publishing

Infant mortality rates vary greatly between countries; as seen in the latest OECD<sup>13</sup> data which shows a range from 1.3 in Iceland (a similar rate to Jersey) to 41.4 in India.

## Low Birth Weight

Around one in fifty (2 per cent) live births at term in Jersey over the period 2013-2015 were low birth weight babies. Comparing this to the latest available data for England (2014) of 2.9 per cent<sup>14</sup> shows that Jersey has a similar rate of low birth weight at term babies.

In England the proportion of low birth weight babies ranges from 1.6 per cent in Bath and North East Somerset to 5.8 per cent in Walsall.<sup>15</sup>

### Low Birth Weight

Babies born weighing less than 2,500g. Low birth weight is used as a general health indicator for new-borns because it is a key determinant of infant survival.

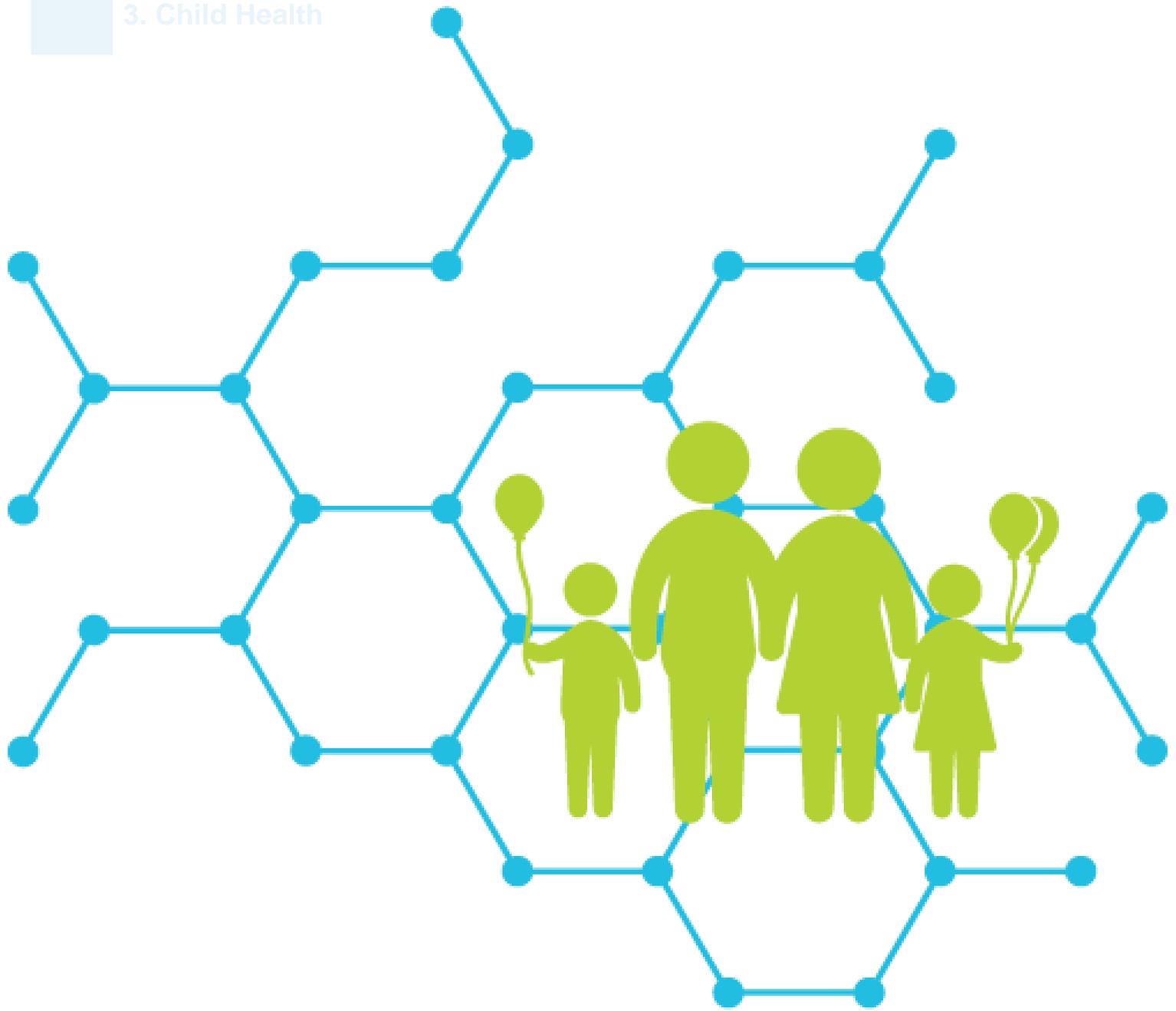


- States of Jersey Health Intelligence Unit, Jersey Births and Breastfeeding Profile 2016, published June 2016, available from [www.gov.je](http://www.gov.je)

<sup>13</sup> OECD (2015), 'Infant mortality' in *Health at a Glance 2015*, OECD indicators, OECD Publishing

<sup>14</sup> Public Health England, Public Health Outcomes Framework, updated July 2016, available from [www.phoutcomes.info](http://www.phoutcomes.info)

<sup>15</sup> Public Health England, Public Health Outcomes Framework, updated July 2016, available from [www.phoutcomes.info](http://www.phoutcomes.info)



# CHILD HEALTH

## Breastfeeding Rates

The global public health recommendation is that infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health, before starting mixed feeding alongside ongoing breastfeeding, where possible.<sup>16</sup> A comprehensive body of evidence exists which supports the benefits of breastfeeding to both mother and baby.

A detailed report looking at births and breastfeeding patterns in Jersey was published by the Health Intelligence Unit in June 2016.<sup>17</sup> Key findings related to breastfeeding were:

- Three-quarters (74 per cent) of mothers breastfed their babies at birth in 2015;
- Over half (54 per cent) of babies were being breastfed at 6-8 weeks of age;
- At 9 months old only one in six babies (17 per cent) who attended a 9 month check with a health visitor were receiving any breastmilk;
- Rates of breastfeeding were higher in rural parishes than urban and sub-urban parishes;

## Breastfeeding Initiation

In Jersey, three-quarters (74 per cent) of mothers breastfed their babies at birth in 2015; this figure has remained essentially constant over the last five years. Jersey is similar to the overall average for England (Table 3.1). As the UK has one of the lowest rates of breastfeeding worldwide, rates for Jersey are also considered low.

### **Breastfeeding initiation**

The proportion of babies born in Jersey recorded as being breastfed within the first 48 hours after birth or at discharge from hospital.

<sup>16</sup> WHO (2001), *The Optimal duration of exclusive breastfeeding. Report of the expert consultation*, [www.who.int](http://www.who.int)

<sup>17</sup> States of Jersey Health Intelligence Unit, *Jersey Births and Breastfeeding Profile 2016*, published June 2016, available from [www.gov.je](http://www.gov.je)

**Table 3.1: Breastfeeding initiation comparisons, Jersey 2015 and Guernsey Q2 2016, English data 2014/15**

Area	Percentage
London	86
South West	79
Jersey	74
England	74
Guernsey & Alderney	63

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, Public Health England



## Prevalence of Breastfeeding at 6 to 8 weeks

Breastfeeding prevalence in Jersey is calculated on all births with a known breastfeeding status (90 per cent of all births in 2015).

Around one in three (35 per cent) mothers were exclusively breastfeeding at 6-8 weeks in 2015 in Jersey.<sup>18</sup> More than half (53 per cent) were either partially or totally breastfeeding, higher than the England proportion of 43 per cent partially or totally breastfed (Table 3.2).

### **Breastfeeding prevalence**

The proportion of babies born in Jersey recorded as being breastfed at the 6 to 8 week check.

<sup>18</sup> Jersey data is for cohort born in calendar year 2015. England data is those babies due a 6 week check in 2015.

**Table 3.2: Infants partially or totally breastfed at 6-8 weeks, 2015 (percentage of known status), English data 2015/16**

Area	Percentage
Jersey	53
England	43

\* Jersey data is for cohort born in calendar year 2015. England data is those babies due a 6 week check in 2015/16. Data for English regions was not reported by Public Health England due to validation issues<sup>19</sup>

Source: Jersey Health Intelligence Unit, Public Health England, breastfeeding statistics [www.gov.uk](http://www.gov.uk)

No comparable data is available for Guernsey as breastfeeding data is collected retrospectively at the eight-month check.

## Child Mortality Rate

Death in childhood represents not only a tragedy for that child's family but also a loss to wider society in terms of lost years of potentially productive life. After the age of one year, the commonest cause of death in young people in the UK is injuries. Many of these injury related deaths are potentially avoidable.

Over the period 2013-2015, there were around 10 deaths of residents aged 1-17 years. Following Public Health England guidelines, it is not recommended that age-standardised rates on events of less than 25 not be calculated.

### Child Mortality Rate

Directly age-standardised rate of death due to all causes, persons aged 1-17 years

<sup>19</sup> Public Health England, Breastfeeding prevalence at 6-8 weeks after birth (experimental statistics), 2015/16 statistical commentary, published 26 October 2016, available from [www.gov.uk](http://www.gov.uk)

## A&E attendances (0-4 years)

Accident and emergency (A&E) attendances in children aged under five years are often preventable, and commonly caused by accidental injury or by minor illnesses which could have been treated in primary care.<sup>20</sup>

In Jersey, an average of around 4,000 children under five attend A&E each year. Over the period 2013-2015, a total of 11,700 attendances were recorded for this age group.

Table 3.3 shows the crude rate of A&E attendances for those aged under five in comparison to the average for England and the English regions.

**Table 3.3: A&E attendances (0-4 years), Jersey 2013-2015 and English data 2014/15**

Area	Crude rate per 1,000 population	95% Confidence Interval (LL)	95% Confidence Interval (UL)
England	540.5	539.7	541.3
Jersey (2013-2015)	508.2	497.2	519.3
London	681.9	679.9	684.0
South West	446.2	443.8	448.6

LL = confidence interval, lower limit; UL = confidence interval, upper limit  
Source: Jersey Public Health Statistics Unit, Public Health England

In England, the crude rate ranged from 263.6 per 1,000 population aged 0-4 years in Norfolk, to 1,761.8 per 1,000 population in Knowsley for financial year 2014/15.

The latest figure for Jersey is significantly lower than the average for England; however, this may reflect the differences in primary care systems between the two jurisdictions.

<sup>20</sup> Public Health England, Child Health Profiles, updated August 2016, available from [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

## Children killed or seriously injured in road traffic accidents

Road traffic collisions are a major cause of deaths in children in the UK, and comprise higher proportions of accidental deaths as children get older. Parents cite vehicle speed and volume as reasons why they do not allow their children to walk or cycle, thereby reducing opportunities for physical activity.<sup>21</sup>

In Jersey, there were no fatalities of children (aged under 16 years) over the five-year period 2011-2015. However, during this period a total of 16 children were seriously injured and a further 129 were slightly injured.

Comparing Jersey figures with the latest rates published by Public Health England shows that the crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population is similar in the two jurisdictions (see Table 3.4).

**Figure 3.4: Crude rate of Children killed or seriously injured in road traffic accidents, 2012-2014**

	Crude rate	95% Confidence Interval (LL)	95% Confidence Interval (UL)
Isle of Wight	38.9	25.4	56.9
Jersey	19.8	9.5	36.4
England	17.9	17.5	18.4
South West	13.7	12.3	15.1
London	12.2	11.3	13.2

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Health Intelligence Unit, Guernsey Public Health and Strategy Directorate, Public Health England

<sup>21</sup> Public Health England, Child Health Profiles, updated August 2016, available from [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

## Child Alcohol Consumption

The 2014 Young People's Health and Lifestyle survey report<sup>22</sup> contains information on drinking behaviours by children aged 12-15 in Jersey.

The key findings for 2014 were:

- Around half (52 per cent) of 12-13 year olds have never drunk alcohol, decreasing to one in five (20 per cent) of 14-15 year olds. The proportion of children who have never drunk alcohol has increased since 2010, when only 30 per cent of 12-13 year olds and 9 per cent of 14-15 year olds had never drunk.
- Boys were more likely to have drunk alcohol in the 12-13 age group, while equal proportions of girls and boys had drunk alcohol in the older age group (14-15 years).
- 1 in 6 (16 per cent) of 14-15 year olds had drunk alcohol in the seven days prior to the survey. This proportion has continued to decline since 1998 when 54 per cent of pupils in this age group reported drinking in the last week. The proportion of young people in Jersey who reported they drank in the previous seven days continues to be lower than in both the UK and Guernsey.
- Around three-fifths (62 per cent) of 12-15 year olds who drank alcohol in the last week did so on one day only.
- 12-15 year olds who drank in the previous week drank a mean of 7.1 units of alcohol. In England this figure was 8.2 units of alcohol.
- Cider was drunk by the greatest percentage of young people in the seven days prior to the survey, followed closely by spirits and beer. The top three drinks consumed by girls (in descending order) were: spirits, wine and cider; and by boys: cider, beer and spirits.
- Two-fifths (40 per cent) of 14-15 year olds reported having been 'really drunk' at least once in their life.

For more information on the drinking habits of young people in Jersey, see the Health Intelligence Unit report '*A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years*'<sup>23</sup>

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<sup>22</sup> States of Jersey Public Health Intelligence Unit, *A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years*, published 2 March 2015, available from [www.gov.je](http://www.gov.je)

<sup>23</sup> States of Jersey Public Health Intelligence Unit, *A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years*, published 2 March 2015, available from [www.gov.je](http://www.gov.je)

## Hospital admissions due to alcohol specific conditions

Over the period 2013-2015, there were fewer than 10 children under 18 admitted to hospital each year with a primary or secondary diagnosis for an alcohol-specific condition. The rate for Jersey is 20 per 100,000 population aged under 18 annually. This is significantly lower than the England average for the latest period available (36 per 100,000 in 2012-2014).<sup>24</sup>

## Hospital admissions due to substance misuse (15-24 years)

There is evidence to suggest that young people who use recreational drugs run the risk of damage to mental health, including suicide, depression and disruptive behaviour disorders. Regular use of cannabis or other drugs may also lead to dependence.<sup>25</sup>

Since 2013, there have been fewer than 10 hospital admissions of 15-24 year olds with a primary diagnosis of substance misuse.

Between 2013 and 2015, there were around 400 admissions of 15-24 year olds where substance misuse was recorded as either a primary or secondary diagnosis, the majority of which were for use of tobacco (ICD-10<sup>26</sup> code F17.1 - Mental and behavioural disorders due to use of tobacco: harmful use).

## Child smoking rates

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

- One in six children reported that they had tried smoking at least once. At 15 per cent, this is the lowest level recorded since the survey began in 1998, when 47 per cent of children

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<sup>24</sup> Public Health England, Local Alcohol Profiles for England, updated May 2016, available from [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

<sup>25</sup> Public Health England, Child Health Profiles, updated August 2016, available from [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

<sup>26</sup> International Statistical Classification of Diseases and Related Health Problems, a publication now in its 10th revision and commonly known as ICD-10.

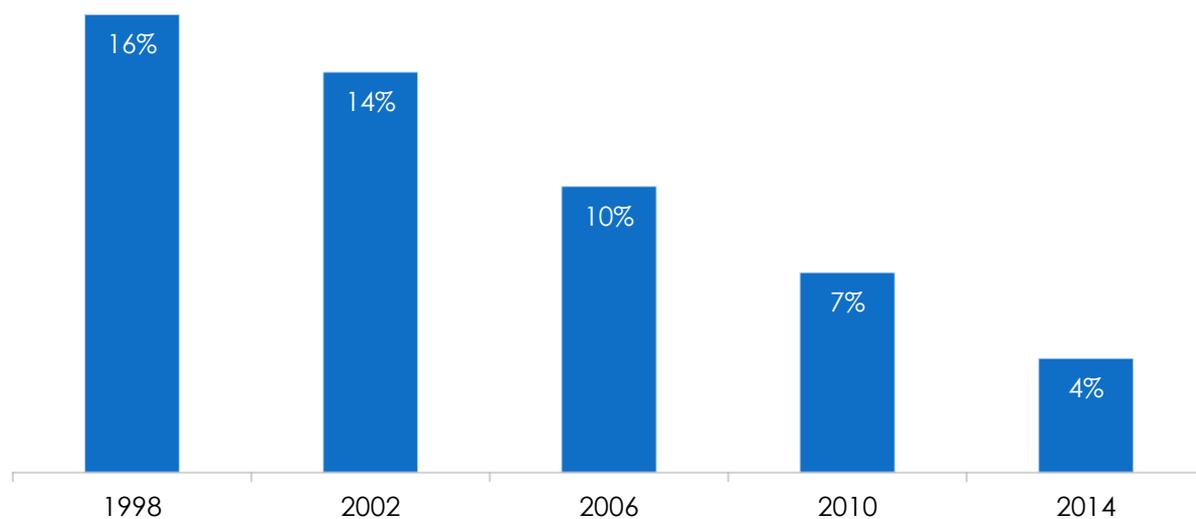
### 3. Child Health

reported that they had tried smoking. The latest figure for Jersey is similar to the figure for England in 2014 (18 per cent).<sup>27</sup>

- 3 per cent of children said that they smoked at least one cigarette a week, the survey definition of regular smoking. This figure is the same as that found in England (3 per cent).<sup>28</sup>
- The prevalence of regular smoking increased with age. Fewer than 1 per cent of 10-13 year olds were regular smokers in 2014, increasing to 7 per cent amongst 14-15 year olds.
- Regular smokers consumed, on average (mean) 34 cigarettes a week, a similar number reported by regular smokers in England (31.1 cigarettes a week)<sup>29</sup> in 2014.

Figure 3.1 shows that proportion of children smoking occasionally and regularly in Jersey has seen an ongoing decline since 1998.

**Figure 3.1: Percentage of regular and occasional smokers aged 10-15, 1998-2014**



Source: States of Jersey Public Health Intelligence Unit, A picture of Health Jersey 2014

<sup>27</sup> HSCIC, Smoking, Drinking and Drug Use among Young People in England, 2014, published 23 July 2015, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

<sup>28</sup> HSCIC, Smoking, Drinking and Drug Use among Young People in England, 2014, published 23 July 2015, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

<sup>29</sup> HSCIC, Smoking, Drinking and Drug Use among Young People in England, 2014, published 23 July 2015, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

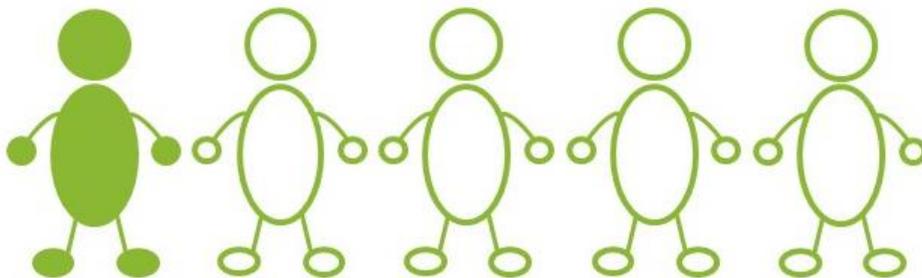
## Excess weight in children

The Jersey Child Measurement Programme (JCMP) measures the height and weight of children aged 4 to 5 years and children aged 10 to 11 years to assess overweight and obesity levels in children. The height and weight measurements are used to calculate a Body Mass Index (BMI) centile for each child.

Figure 3.2 shows the combined results for three-years of the child measurement programme, 2013-2015.

**Figure 3.2: Proportion of overweight and obese children aged 4-5 years and aged 10-11 years, 2013-2015**

**1 in 5** children aged 4 to 5 years were overweight or obese (22 per cent)



**1 in 3** children aged 10 to 11 years were overweight or obese (32 per cent)



Child overweight (including obesity) / excess weight: BMI  $\geq$  85<sup>th</sup> centile of UK90 growth reference

Source: Public Health Statistics Unit

## Physical Activity of Children

The 2014 Young People's Health and Lifestyle survey report<sup>30</sup> asked children about the amount of physical activity they do.



**1 in 5** children are active  
for at least an hour  
everyday

- Around 1 in 5 (22 per cent) reported being physically active for at least an hour every day. This proportion had doubled from 11 per cent in 2010.
- A greater proportion of males reported being active everyday (27 per cent) than females (16 per cent).
- The majority (91 per cent) of children reported having a bicycle, although bicycle ownership was found to decrease with age, from 91 per cent of 10-11 year olds to 74 per cent of 14-15 year olds.

In terms of sedentary behaviours, similar proportions of males and females reported spending more than two hours a day watching TV or movies (19 per cent and 16 per cent, respectively). A greater proportion of males, around one in four (28 per cent), reported spending more than two hours a day playing computer games, compared to one in ten (10 per cent) of females.

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<sup>30</sup> States of Jersey Public Health Intelligence Unit, A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years, published 2 March 2015, available from [www.gov.je](http://www.gov.je)

## Emotional Wellbeing of Children

A set of nine questions were included in the Health and Lifestyle survey which measures self-esteem using a scale based on social confidence and relationships with friends.<sup>31</sup> Three-quarters of young people had medium-high self-esteem, with a greater proportion of males being in the medium-high category than females.



There has been a slight decrease in the proportion of young people having medium-high self-esteem since 2010, particularly among 14-15 year olds (down from 82 per cent in 2010 to 75 per cent in 2014). This decrease was mainly due to a decrease in females with medium-high self-esteem and a corresponding increase in the percentage of females with low self-esteem in this age group.

The survey also included a set of 14 questions to assess the mental wellbeing<sup>32</sup> of secondary school children. Females were found to have a lower mental wellbeing score than males in both the 12-13 age group and the 14-15 age group (Table 3.5).

<sup>31</sup> Lawrence, D, 1981, The Development of a Self-Esteem Questionnaire, British Journal of Educational Psychology, 51 (2): 245-251, Blackwell Publishing

<sup>32</sup> WEMWBS – Warwick Edinburgh Mental Well-being scale

**Table 3.5: Mean WEMWBS score out of 70, 2014**

	Males	Females	All
12-13 year olds	51.3	47.7	49.5
14-15 year olds	49.6	44.5	47.2

Source: Public Health Statistics Unit, A picture of health Jersey 2014 report

Nearly a quarter (24 per cent) of young people reported being bullied in the last twelve months. A similar proportion reported being afraid to go to school (at least sometimes) because of bullying. These figures are similar to those reported in 2010 when the survey was last run.

One in ten young people reported being bullied in the last month. Of these, the majority were bullied face-to-face. However, in the secondary age group, a greater percentage of young people were bullied over the internet or through their mobile phone.<sup>33</sup>



- States of Jersey Public Health Intelligence Unit, A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years, published 2 March 2015, available from [www.gov.je](http://www.gov.je)
- States of Jersey Health Intelligence Unit, Jersey Births and Breastfeeding Profile 2016, published June 2016, available from [www.gov.je](http://www.gov.je)
- Jersey Health Intelligence Unit, Jersey Smoking Profile 2015, published February 2016, available from [www.gov.je](http://www.gov.je)
- States of Jersey Public Health Intelligence Unit, Jersey Alcohol Profile 2015, published November 2016, available from [www.gov.je](http://www.gov.je)
- States of Jersey Public Health Statistics Unit, Report on the Jersey Child Measurement Programme 2015/16 Academic year, published 2016, available from [www.gov.je](http://www.gov.je)

<sup>33</sup> States of Jersey Public Health Intelligence Unit, A picture of Health Jersey 2014: Reflections on the health and lifestyle of young people ages 10-15 years, published 2 March 2015, available from [www.gov.je](http://www.gov.je)



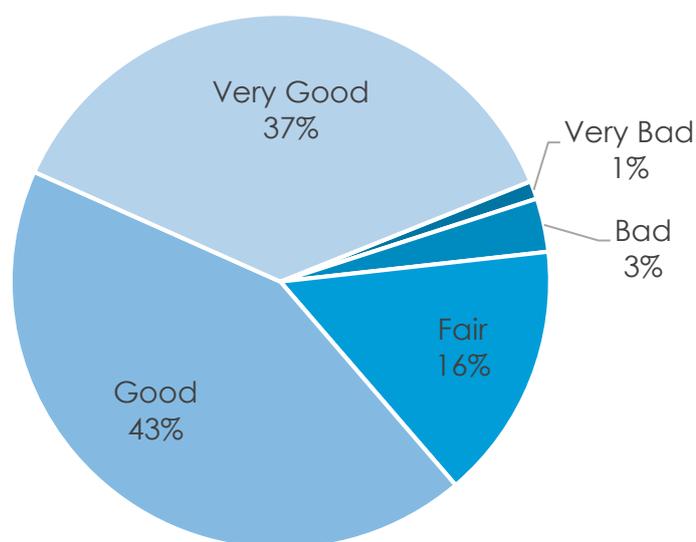
# SELF-PERCEIVED HEALTH AND LIFE EXPECTANCY

### Self-perceived health

Asking individuals to rate their health is considered a good indication of current and future morbidity in a population.

In 2015, four-fifths (80 per cent) of respondents to the Jersey Health and Life Opportunities survey rated their health to be 'Good' or 'Very good'. Fewer than one in twenty adults (4 per cent) reported their general health was "Bad" or "Very bad", while one in six (16 per cent) reported having 'fair' health.

**Figure 4.1: Self-perceived health rating, 2015**



Source: States of Jersey Social Policy Unit, Jersey Health and Life Opportunities Survey, 2015

**Figure 4.2: Self-perceived health rating, 2015**



4 out of 5 Jersey residents report having **Good** or **Very Good** general health

Source: Public Health Statistics Unit

The latest Eurostat<sup>34</sup> data on self-reported health status indicates that two-thirds (67.4 per cent) of Europeans rate their health as good or very good (Table 4.1).

**Table 4.1: Proportion of population rating their health as good or very good, Europe 2014 and Jersey 2015**

Area	Proportion (%)
Ireland	82.5
Jersey (2015 data)	80
UK	70.0
France	68.1
EU 28 countries	67.4
Poland	58.1
Portugal	45.9

Source: Eurostat indicator hlth\_silc\_01 2014 data

Jersey Annual Social Surveys in 2012 and 2013 included a question which asked respondents to rate their health on a scale of one to ten (ten being the best imaginable health and one being the worst). On average, adults in Jersey rated their health (on a scale of one to ten) at 7.6 in 2012<sup>35</sup> and 7.4 in 2013.<sup>36</sup>

The question was most recently asked in Guernsey in 2013, finding four out of five residents (83 per cent) respondents rated their health as 'good' or 'very good'.

<sup>34</sup> Eurostat indicator hlth\_silc\_01 available from [epp.eurostat.europa.ec](http://epp.eurostat.europa.ec)

<sup>35</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2012, published December 2012, available from [www.gov.je](http://www.gov.je)

<sup>36</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2013, published November 2013, available from [www.gov.je](http://www.gov.je)

### Life Expectancy<sup>37</sup> at birth

Life expectancy at birth has continued to increase in European<sup>38</sup> countries, reflecting sharp reductions in mortality rates at all ages. These gains in longevity have been attributed to a number of factors including rising living standards, improved lifestyle and better education, and greater access to quality health services.

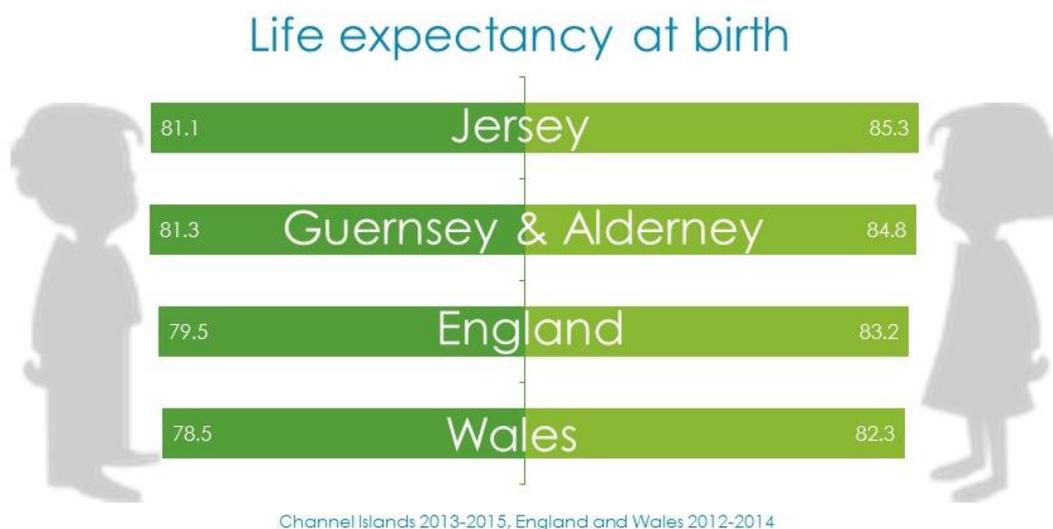
In Jersey, the life expectancy at birth for females is around 4 years greater than for males.

Life expectancy and gender differences are similar in Jersey and Guernsey and similar to the highest English regions.

#### Life Expectancy at Birth

The average length of time a baby born today would expect to live, if current death rates did not change. Similarly, life expectancy at 65 is a measure of how much longer a person of that age today could expect to live if they were to experience the current local age-specific mortality rates.

**Figure 4.3: Life expectancy at birth, Channel Islands 2013-2015, England and Wales 2012-2014**



Source: Public Health Statistics Unit, ONS Life Expectancy at Birth and at age 65 for local areas in England and Wales, 2012-2014, Guernsey Public Health and Strategy Directorate.

Three-year rolling averages, based on deaths in calendar years and proxy mid-year population estimates

<sup>37</sup> Life expectancy is calculated using life tables, which generate the life expectancy of a hypothetical cohort experiencing the current age-specific mortality rates for each year of their life.

<sup>38</sup> Eurostat, Mortality and life expectancy statistics, updated June 2016, available from [ec.europa.eu](http://ec.europa.eu)

The average gender gap in life expectancy across EU countries was 5.5 years in 2014.<sup>39</sup>

In England and Wales, and globally, there is a well-documented socio-economic divide in life expectancy, with individuals living in poorer neighbourhoods or having manual/routine occupations having, on average, a shorter life expectancy than individuals living in more affluent neighbourhoods or with managerial/professional occupations.<sup>40-41</sup> Comparative data for Jersey is currently unavailable as our deaths data are not linked to any employment data.

Globally,<sup>42</sup> male life expectancy in 2015 varied from 49 to 81 years (average/mean = 69) and female life expectancy varied between 51 and 87 years depending on the country (average/mean = 74). Both Channel Islands have life expectancies well above the average for the European region of 75 years for men and similar to the European average of 81 years for women in 2010-2012.

### Life Expectancy at age 65

Life expectancy at 65 has increased among both men and women over the past decades in the Channel Islands. These gains in longevity at older age combined with the reduction in fertility rates are contributing to a steady rise in the proportion of older persons in our population, as across Europe.

Currently, women in Jersey can expect to live, on average, an additional 23 years if they have reached 65, while men who have reached 65 can expect to live for an additional 20 years (Table 4.2). This is similar to Guernsey and England.

The latest available data for the EU, for 2014, shows that on average a 65 year old women had a further life expectancy of 21.6 years, while for men it was 18.2 years.<sup>43</sup>

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<sup>39</sup> Eurostat, Mortality and life expectancy statistics, updated June 2016, available from [ec.europa.eu](http://ec.europa.eu)

<sup>40</sup> For more information, please see *Life expectancy at birth and at age 65 for local areas in England and Wales, 2012-2014, Statistical Bulletin*, Office for National Statistics, November 2015.

<sup>41</sup> World Health Organisation, World Health Statistics 2016, published 19 May 2016, available from [www.who.int](http://www.who.int)

<sup>42</sup> World Health Organisation, World Health Statistics 2016, published 19 May 2016, available from [www.who.int](http://www.who.int)

<sup>43</sup> Eurostat, Mortality and life expectancy statistics, updated June 2016, available from [ec.europa.eu](http://ec.europa.eu)

## 4. Self-Perceived Health and Life Expectancy

**Table 4.2: Life expectancy at 65, Channel Islands 2013-2015, England and Wales 2012-2014 years**

Life expectancy at 65			
	 Males	Females 	Gender gap
Jersey	19.9	22.8	2.9 years
Guernsey & Alderney	19.7	22.1	2.4 years
England	18.8	21.2	2.4 years
Wales	18.2	20.6	2.4 years

Channel Islands 2013-2015, England and Wales 2012-2014

Source: Public Health Statistics Unit; ONS Life Expectancy at Birth and at age 65 for local areas in England and Wales, 2012-2014, Guernsey Public Health and Strategy Directorate.

Three-year rolling averages, based on deaths in calendar years and proxy mid-year population estimates

The gender gap in life expectancy at 65 for both Jersey and Guernsey (Table 4.2) are lower than that reported for the EU at 3.4 years in 2014 (latest available data).<sup>44</sup>

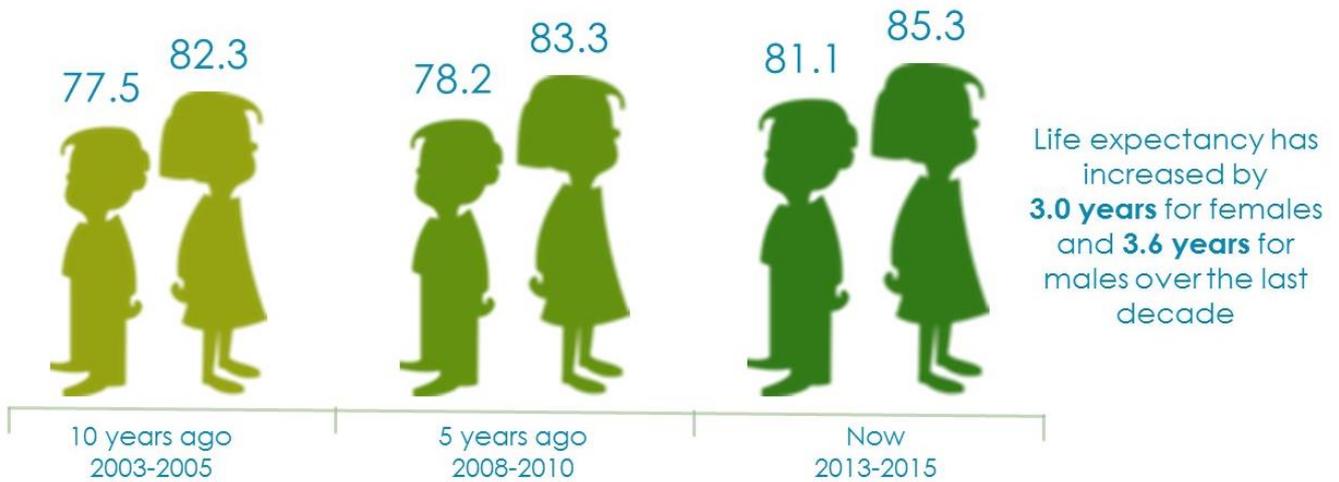
### Changes in life Expectancy

Over the last decade there has been a small incremental increase in life expectancy for both men and women over time (Figure 4.4). This trend is in line with many other European countries.

The increase for males was larger than that seen for females, causing the gender difference in life expectancy to narrow over time. The narrowing of the gender gap has also been seen in Guernsey and England and Wales, as well as in EU countries.

<sup>44</sup> Eurostat, Mortality and life expectancy statistics, updated June 2016, available from [ec.europa.eu](http://ec.europa.eu)

Figure 4.4: Change in Life Expectancy over time



Source: Public Health Statistics Unit

Three-year rolling averages, based on deaths in calendar years and proxy mid-year population estimates

## Life Expectancy comparisons

The World Health Organization<sup>45</sup> reported that in 2013, the average life expectancy at birth for the global population is 71, ranging from 62 in low income countries to 79 in high income countries.<sup>46</sup>

The overall life expectancies of 83.2 and 83.1 in Jersey and Guernsey, in 2015, respectively, are in line with those in high income countries, as reported by the World Health Organisation.<sup>47</sup>

Table 4.3 shows the life expectancy for Jersey and Guernsey along with selected European countries and those countries with the best and worst life expectancies in the world.

<sup>45</sup> World Health Organisation, World Health Statistics 2015, [www.who.int](http://www.who.int)

<sup>46</sup> WHO member states are grouped into four income groups (low, lower-middle, upper-middle and high) based on the World Bank list of analytical income classification of economies, which is based on the Atlas gross national income per capita estimates. A high income country is a country with a gross national income per capita above US\$12,475.

<sup>47</sup> World Health Organisation, World Health Statistics 2015, [www.who.int](http://www.who.int)

## 4. Self-Perceived Health and Life Expectancy

**Table 4.3: World Health Organisation Life Expectancies, 2015**

Country	Life Expectancy
Japan	83.7
Switzerland	83.4
Jersey	83.2
Singapore	83.1
Guernsey	83.1
France	82.4
United Kingdom	81.2
Portugal	81.1
Poland	77.5
Central African Republic	52.5
Angola	52.4
Sierra Leone	50.1

Source: Public Health Statistics Unit; Guernsey Public Health and Strategy Directorate, WHO.



Jersey ranks in the top 10 per cent worldwide for overall life expectancy

### Healthy Life Expectancy

In 2016, the Public Health Statistics Unit calculated measures of healthy life expectancy (HLE) and disability-free life expectancy (DFLE) for Jersey for the first time. These calculations used the data from the Health and Life Opportunities Survey<sup>48</sup> which was conducted in 2015 by the Chief Minister's Department. As these measures only include one year of survey data, the measures are currently considered to be experimental and await further survey data which is being collected within the 2016 Jersey Life and Opinions Survey, results for which were not available at time of publication. A report containing finalised figures will be published by the Public Health Statistics Unit in early 2017.



- States of Jersey Health Intelligence Unit, Premature deaths of Jersey Residents 2012-2014, published April 2016, available from [www.gov.je](http://www.gov.je)
- States of Jersey Public Health Statistics Unit, Annual Report on the deaths of Jersey residents 2015, published August 2016, available from [www.gov.je](http://www.gov.je)

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<sup>48</sup> States of Jersey Social Policy Unit, Jersey Health and Life Opportunities Survey 2015, published 19 January 2016, available from [www.gov.je](http://www.gov.je)



# MORTALITY

## Population Mortality

In Jersey, there were 396 male and 360 female deaths recorded for Jersey residents in 2015, giving a total of 756 deaths. This equates to a crude death rate of 742 per 100,000 population and an age standardised rate<sup>49</sup> (ASR) of 852 per 100,000 in calendar year 2015.

For the period 2013-15 the age standardised mortality rate of 843 per 100,000 was similar to the mortality rate in Guernsey (844 per 100,000) for the same period (Table 5.1).

**Table 5.1: Population Mortality 2013-2015**

	Jersey			Guernsey & Alderney
	Male	Female	Persons	Persons
Deaths	1,110	1,086	2,196	1,643
Average Age at Death	74	80	77	-
Crude death rate (per 100,000)*	744	711	727	846
Age-standardised mortality rate (per 100,000)*	1,004	712	843	844

\* Mid-year population for Jersey, End of March population Guernsey  
Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate

Jersey mortality rates are lower than the England average and English regions (Table 5.2).

The average EU age-standardised mortality rate was reported as 1,020 per 100,000 in 2013, ranging from 848 per 100,000 in Spain to over 1,500 per 100,000 in the Baltic and central European countries.<sup>50</sup>



<sup>49</sup> Calculated using the 2013 European standard population.

<sup>50</sup> Eurostat (2016) database, Causes of death by sex, accessed September 2016, available from ec.europa.eu

**Table 5.2: Ranked comparison of England, Wales and English Regions Mortality 2012-2014, and Channel Islands 2013-2015**

	ASR per 100,000	95% CI LL <sup>51</sup>	95% CI UL <sup>52</sup>
<b>North East</b>	1,096.6	1,089.0	1,104.3
<b>North West</b>	1,077.5	1,072.8	1,082.2
<b>Yorkshire &amp; the Humber</b>	1,040.1	1,034.8	1,045.4
<b>West Midlands</b>	997.5	992.5	1,002.5
<b>East Midlands</b>	985.3	979.9	990.8
<b>England &amp; Wales</b>	973.1	971.5	974.6
<b>England</b>	968.7	967.1	970.3
<b>East of England</b>	915.2	910.7	919.8
<b>South West</b>	911.3	906.8	915.8
<b>South East</b>	901.8	898.1	905.5
<b>London</b>	899.1	894.4	903.8
<b>Guernsey &amp; Alderney</b>	843.7	803.2	885.7
<b>Jersey</b>	842.8	808.5	878.2

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00339

The ASR for Jersey has reduced slightly in recent years, from 1,017 per 100,000 in 2008-2010, to 904 per 100,000 in 2011-2013 to 843 in 2013-2015.

<sup>51</sup> CI LL = confidence interval, lower limit

<sup>52</sup> CI UL = confidence interval, upper limit

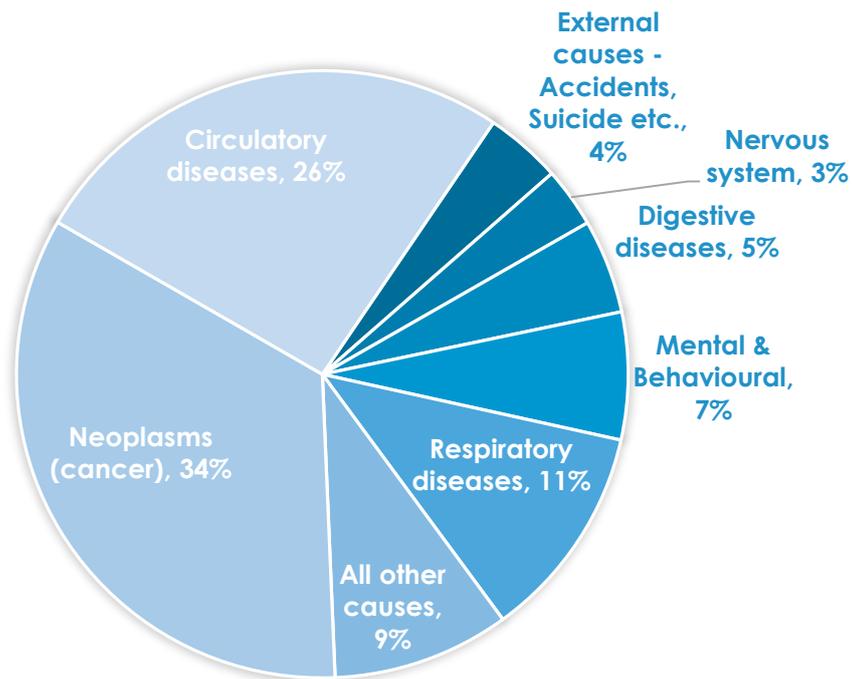
## Main Causes of Death

The three most frequent causes of death in Jersey in 2013-2015 were cancers (neoplasms), accounting for 34 per cent of all deaths, circulatory diseases (26 per cent) and respiratory diseases (11 per cent). Mental and behavioural disorders (mostly accounted for by dementia) accounted for 7 per cent of all deaths, while diseases of the digestive system resulted in 5 per cent of all deaths (see Figure 5.1).

### Causes of Death Analysis

Causes of death are categorised and coded according to the International Statistical Classification of Diseases and Related Health Problems, a publication now in its 10<sup>th</sup> revision and commonly known as ICD-10. Comparing the number of deaths across subcategories of the ICD-10 allows the leading causes to be analysed.

**Figure 5.1: Main causes of death 2013-2015**

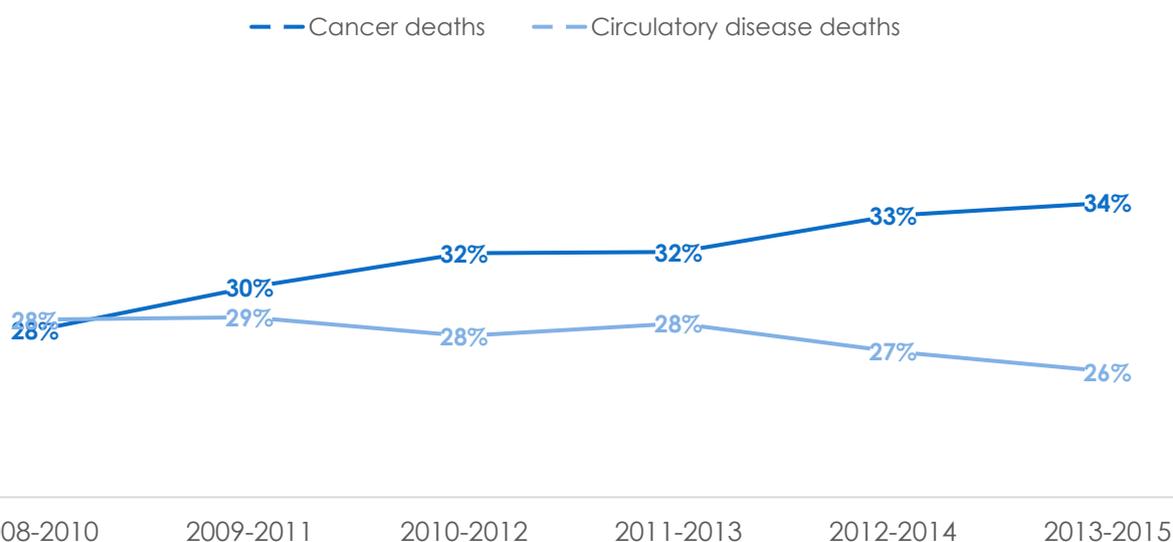


Source: Jersey Public Health Statistics Unit

In recent years, cancers have overtaken circulatory diseases as the main cause of death locally, as shown in Figure 5.2. In the EU countries mortality from circulatory diseases are still the main cause of death, accounting for 40 per cent of all deaths, followed by cancers (26 per cent).

## 5. Mortality

**Figure 5.2: Main cause of death of Jersey residents during the period 2008-2015**



Source: Jersey Public Health Statistics Unit

The pattern in Guernsey is similar to that of EU countries, with the greatest proportion of deaths being from circulatory diseases (31 per cent), followed by cancer (accounting for 29 per cent of Guernsey deaths) and respiratory diseases (13 per cent).

**Table 5.3: Top causes of death 2013-2015**

	Jersey 2013-2015				
	Number	ASR	95% CI LL <sup>53</sup>	95% CI UL <sup>54</sup>	% of all deaths
Neoplasms	747	285.3	266.2	305.5	34
Diseases of the Circulatory System	573	221.9	204.2	240.8	26
Diseases of the Respiratory System	252	98.9	87.2	111.7	11
Mental and Behavioural Disorders	149	58.8	49.6	69.1	7
Diseases of the Digestive System	110	41.5	34.3	49.7	5

Sources: Jersey Public Health Statistics Unit

<sup>53</sup> CI LL = confidence interval, lower limit

<sup>54</sup> CI UL = confidence interval, upper limit

Deaths from cancers (neoplasms) and circulatory disease account for around 60 per cent of all annual deaths in both Channel Islands (Table 5.3) and for 66 per cent of deaths in the EU<sup>55</sup> (2011).

**Table 5.4: Specific causes of death 2013-2015, all ages**

	Jersey 2013-2015				Guernsey 2013-2015			
	Number	ASR	LL	UL	Number	ASR	LL	UL
Cancers								
Lung Cancer	168	64.2	54.8	74.8	92	50.6	40.7	62.2
Breast Cancer*	49	33.8	24.9	44.8	28	26.0	17.1	37.8
Colorectal Cancer	52	20.3	15.1	26.6	47	24.6	18.0	32.7
Prostate Cancer*	45	43.8	31.6	59.1	40	52.4	37.3	71.6
Bladder Cancer	24	-	-	-	17	-	-	-
Malignant melanoma	11	-	-	-	9	-	-	-
Cervical Cancer	5	-	-	-	4	-	-	-
Circulatory Diseases								
Ischaemic Heart Disease	239	92.2	80.8	104.8	197	100.9	87.3	116.1
Stroke	140	54.1	45.5	63.9	155	78.9	66.9	92.4
Respiratory Diseases								
Bronchitis, Emphysema, COPD	125	49.1	40.8	58.5	96	49.8	40.3	60.9
Pneumonia	68	26.4	20.5	33.5	58	29.3	22.3	37.9
Other selected Causes								
Accidents	57	20.4	15.4	26.48	45	22.8	16.6	30.5
Infectious and parasitic diseases	18	-	-	-	19	-	-	-
Chronic Liver Disease incl Cirrhosis	35	12.2	8.5	17.0	14	-	-	-

\*Rates for specific gender only. LL = 95% Confidence Interval lower level, UL = 95% Confidence Interval upper level  
 - Where the observed total number of deaths is less than 25, the rates have been suppressed as there are too few deaths to calculate directly standardised rates reliably, as per Public Health England recommendations  
 Sources: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate

<sup>55</sup> OECD (2014), 'Mortality from all causes' in Health at a Glance: Europe 2014, OECD publications.

## 5. Mortality

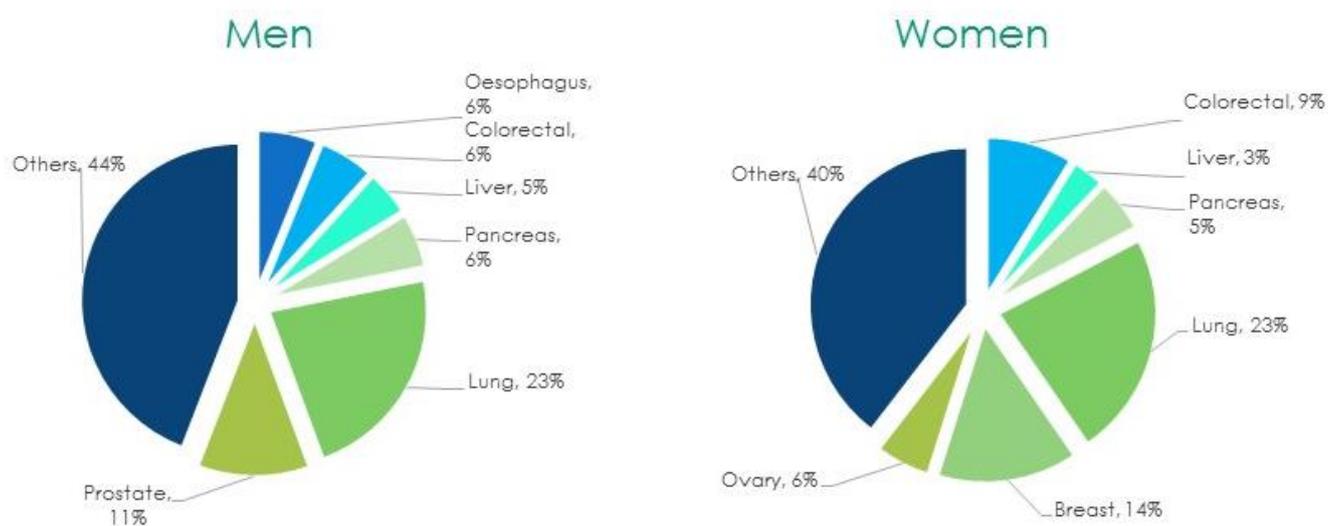
At a more specific level, the greatest numbers of deaths in Jersey are caused by **ischaemic heart disease**, followed by **lung cancer, stroke, bronchitis, emphysema & COPD** and **pneumonia** (Table 5.4). These five more frequent causes of deaths also cause the most deaths in Guernsey.

### Cancers

Cancers are the main cause of death in Jersey accounting for a third of all deaths in 2015 (258 deaths). Cancer is not one disease; there are more than 100 different types of cancer, each with different risk factors and treatment outcomes.

Figure 5.3 shows the main causes of cancer deaths for men and women in Jersey over the period 2013-2015. Lung cancers account for almost a quarter (23 per cent) of both male and female cancer deaths each year, whilst cancers of the digestive organs (which include colorectal, stomach and liver cancers) account for over a quarter of cancer deaths (26 per cent of female and 28 per cent of male).

**Figure 5.3: Main causes of cancer deaths among men and women, 2013-2015**



Percentages of all malignant neoplasms (ICD-10 code C00-C97)

Source: Jersey Public Health Statistics Unit

Across OECD countries, cancer is the second leading cause of mortality after cardiovascular disease. However, in Jersey it is cancer which has become the most frequent cause of death. The rising share of deaths in Jersey due to cancer reflects the fact that mortality from other causes, particularly cardiovascular disease, has been declining more rapidly than mortality from cancer.<sup>56</sup>

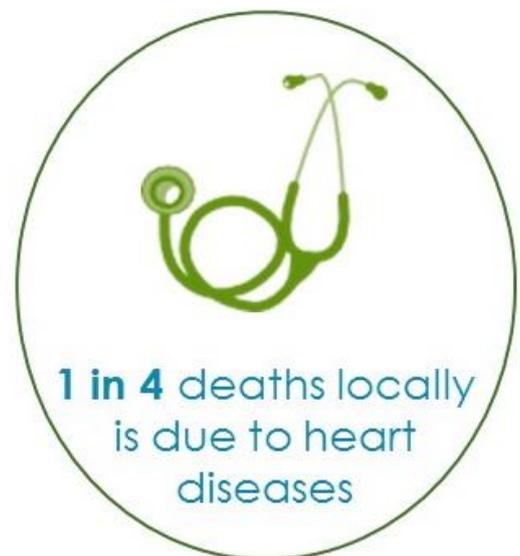
Death rates were higher for men than women in 2013-2015 (ASR for men was 280 per 100,000 compared to 210 per 100,000 for women). This gender difference is reflected in EU data<sup>57</sup> (for 2013).

## Circulatory Disease (also referred to as Cardiovascular Disease)

Circulatory diseases accounted for a quarter (25 per cent) of all local deaths in 2015 (187 deaths), and are the second leading cause of mortality of Jersey residents. This proportion is less than the latest reported OECD average of 32 per cent of all deaths caused by Circulatory Disease in 2013.<sup>58</sup>

Deaths due to diseases of the circulatory system are mostly accounted for by ischaemic heart disease (also referred to as coronary heart disease) and cerebrovascular diseases such as stroke.

Over the period 2013-2015, ischaemic heart disease (IHD) accounted for 42 per cent of all deaths from circulatory disease, 11 per cent of all deaths of Jersey residents. Stroke accounted for 24 per cent of all circulatory deaths, 6 per cent of all deaths over the period. These proportions reflect the latest OECD findings: IHD is responsible for 20 per cent of all deaths in the OECD countries; stroke is responsible for 7 per cent of all OECD country deaths.<sup>59</sup>



<sup>56</sup> OECD (2015), 'Mortality from cancer' in *Health at a Glance: OCED Indicators*, OECD publications.

<sup>57</sup> OECD (2015), 'Mortality from cancer' in *Health at a Glance: OCED Indicators*, OECD publications.

<sup>58</sup> OECD (2015), 'Mortality from cardiovascular diseases' in *Health at a Glance: OCED Indicators*, OECD publications.

<sup>59</sup> OECD (2015), 'Mortality from cardiovascular diseases' in *Health at a Glance: OCED Indicators*, OECD publications.

The number of male deaths from ischaemic heart disease exceeds the number of female deaths, while a greater numbers of females than males died from a stroke.

### Suicide

In 2013 to 2015, deaths from suicide in Jersey returned to previously seen levels after a peak was recorded in 2009 (Table 5.5).

The suicide rate in Jersey was **10 per 100,000** in 2012-14 for persons aged 10 and over. This is lower than in previous years, due to the influence of the particularly high suicide rate observed in 2009. The latest suicide rate has been calculated using the updated definition of suicide used by the Office for National Statistics, and the new 2013 European Standard Population and is therefore is not comparable to figures published in previous editions of the Jersey Health Profile.

#### ONS definition of Suicide

In 2016, the National Statistics definition of suicide was modified to include deaths from intentional self-harm in 10- to 14 year old children, in addition to deaths from intentional self-harm and events of undetermined intent in people aged 15 or over.

**Table 5.5: Annual number of resident deaths from suicide and events of undetermined intent<sup>60</sup>**

Year	2007	2008	2009	2010	2011	2012	2013	2014	2015*
<b>Number of Suicide deaths</b>	15	16	26	10	<10	12	<10	<10	10

Source: Jersey Health Intelligence Unit, ICD-10 codes X60-X84 and Y10-Y34

\*Data for 2015 provisional at time of publication due to potential ongoing inquests

Suicides rates in Jersey were not significantly different to England or the South West region of England (Table 5.6) in 2012-2014, the latest period for which comparable data was available.

<sup>60</sup> Those deaths coded as Intentional self-harm and events of undetermined intent are jointly reported as suicides, this is in line with suicide reporting by the Office for National Statistics for England.

Methodology for reporting suicide rates across Europe varies, with the OECD using only those deaths defined as intentional self-harm (ICD-10 codes X60-X84) which differs from the methodology used by the ONS, Public Health England and Jersey and Guernsey. For information, the latest suicide rate for the EU (28 countries) using their different methodology was 13.7 per 100,000 population for 2011.<sup>61</sup>

**Table 5.6: Suicide ASR compared with England, London and the South West, 2012-2014, persons 10 years or over**

	Number	ASR	95% Confidence Interval (LL)	95% Confidence Interval (UL)
Jersey	27	9.6	6.3	13.9
England	14,122	10.0	9.8	10.2
London	1,645	7.8	7.4	8.2
South West	1,615	11.3	10.7	11.9

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Public Health Statistics Unit, Public Health England

Historically suicide rates in men have been two or three times higher than those recorded for women locally. Suicide rates for the latest period are not statistically different for men and women, but a greater number of male deaths have been recorded each year.<sup>62</sup> Reported suicide death rates across the EU are four to five times greater for men than women.<sup>63</sup>

<sup>61</sup> OECD (2014), 'Mortality from suicide' in *Health at a Glance: Europe 2014*, OECD publications.

<sup>62</sup> Where the observed total number of deaths is less than 25, the rates have been suppressed as there are too few deaths to calculate directly standardised rates reliably, as per Public Health England recommendations.

<sup>63</sup> OECD (2014), 'Mortality from suicide' in *Health at a Glance: Europe 2014*, OECD publications.

### Smoking-related deaths

It is estimated that about half of all regular cigarette smokers will eventually be killed by their addiction.<sup>64</sup> Monitoring the amount of deaths that are attributable to smoking gives a measure of the impact smoking has on Islanders' health.

Estimated numbers of smoking-attributable deaths in Jersey have been calculated using the methodology employed by the Department of Health in England and Public Health England. This uses both the prevalence of smoking (taken from the Jersey Annual Social Survey) along with details of deaths of Jersey residents. Smoking-attributable deaths from heart disease and stroke have been calculated using Public Health England methodology. Locally, smoking is responsible for the majority of deaths from lung cancer and chronic obstructive pulmonary disease (Figure 5.4).

Over the period 2013-2015, one in five (19 per cent) of all deaths were from conditions that are caused by smoking. This figure has remained at a similar level during the last 7 years in Jersey. Around 140 individuals each year die from smoking attributable causes in Jersey. Similar proportions of smoking related deaths are estimated for Guernsey (16 per cent) and England (17 per cent).<sup>65</sup>



**1 in 5** deaths of those aged 35 or over is attributable to smoking

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<sup>64</sup> ASH, Facts at a glance: smoking statistics, published June 2016, available from [www.ash.org.uk](http://www.ash.org.uk)

<sup>65</sup> Health and Social Care Information Centre, Statistics on Smoking: England 2016, published 27 May 2016, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

Around one in four male deaths each year are estimated to be attributed to smoking; in 2013-2015, 24 per cent of all male adult deaths aged 35 or over in Jersey were from conditions that can be caused by smoking. This compares to around one in seven female deaths (14 per cent in 2013-2015).

It is estimated that over the period 2013-2015, 43 per cent of all deaths due to respiratory diseases and 30 per cent of all cancer deaths, in Jersey, were attributable to smoking. In addition, an estimated 14 per cent of deaths from circulatory diseases and 5 per cent of deaths from diseases of the digestive system were attributable to smoking, as shown in Table 5.7. All of these proportions are similar to those reported for Guernsey and England.<sup>66</sup>



**Table 5.7: Estimated proportion of Smoking Related Deaths (aged 35 or over) in each cause of death category, percent**

Cause (ICD-10 codes)	JERSEY 2013-2015	GUERNSEY 2013-2015	ENGLAND 2014
All causes	19	16	17
Respiratory diseases (J00-J99)	43	44	37
Cancers	30	26	27
Circulatory disease (I00-I99)	14	10	13

Sources: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, HSCIC 2016, Statistics on Smoking 2016

<sup>66</sup> Health and Social Care Information Centre, Statistics on Smoking: England 2016, published 27 May 2016, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

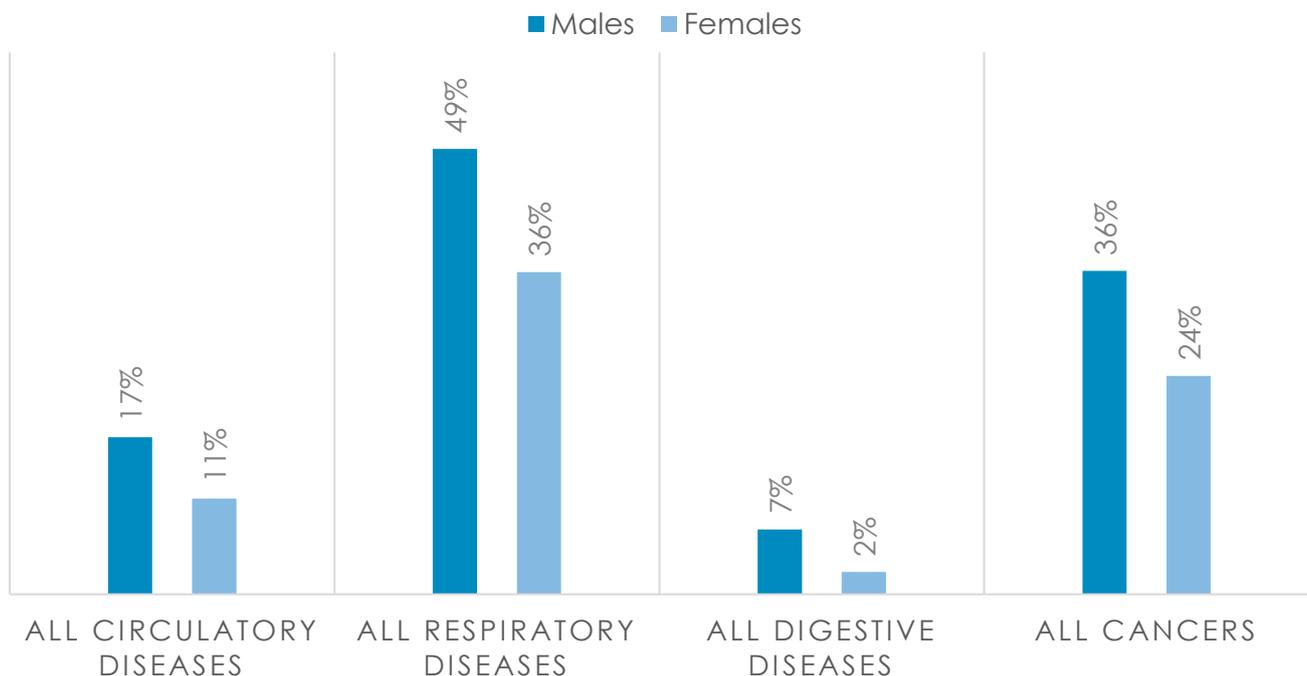
## 5. Mortality

In terms of the proportion of deaths attributable to smoking in Jersey over the period 2013-2015 (along with numbers of deaths during the three-year period), the diseases with the greatest proportions were:

- 85 per cent of deaths from chronic obstructive lung disease (less than 10 deaths)
- 82 per cent of deaths from trachea, lung and bronchus cancer (140 deaths)
- 81 per cent of deaths from cancers of the larynx (less than 10 deaths)
- 80 per cent of deaths as a result of chronic airway obstruction (90 deaths)
- 68 per cent of cancers of the oesophagus (20 deaths)
- 67 per cent of head and neck cancers (10 deaths)
- 62 per cent of aortic aneurysms (20 deaths)

Proportions of deaths from these diseases are similar to the proportions reported for England.<sup>67</sup>

**Figure 5.4: Estimated deaths attributable to smoking, as a percentage of all deaths from that disease\*, by gender, 2013-2015**



\*Among adults aged 35 or over

Source: Jersey Public Health Statistics Unit

<sup>67</sup> Health and Social Care Information Centre, Statistics on Smoking: England 2016, published 27 May 2016, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

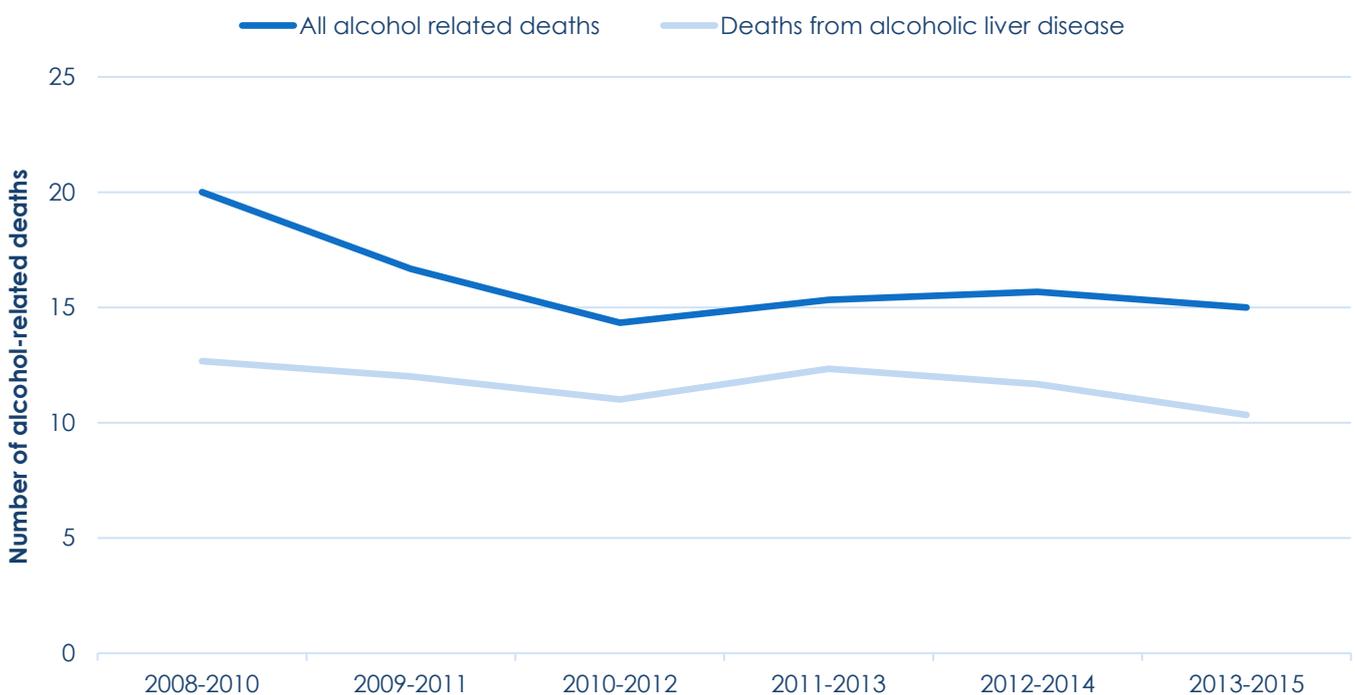
## Alcohol-related deaths

Alcohol misuse can be directly related to deaths from certain types of disease, such as cirrhosis of the liver (including alcoholic liver disease), and in some cases may be associated with other causes of death, such as strokes.

Around 2 per cent of all deaths (around 15 per year) in Jersey are from alcohol-related causes.<sup>68</sup> These deaths account for around 200 years of life lost each year (total years of life lost under the age of 75 - see page 59 for further explanation). In Guernsey there are around 6 deaths per year related to alcohol, accounting for 128 years of life lost.



**Figure 5.5: Alcohol-related deaths in Jersey, 3-year rolling average 2008-2015**



Source: Jersey Public Health Statistics Unit

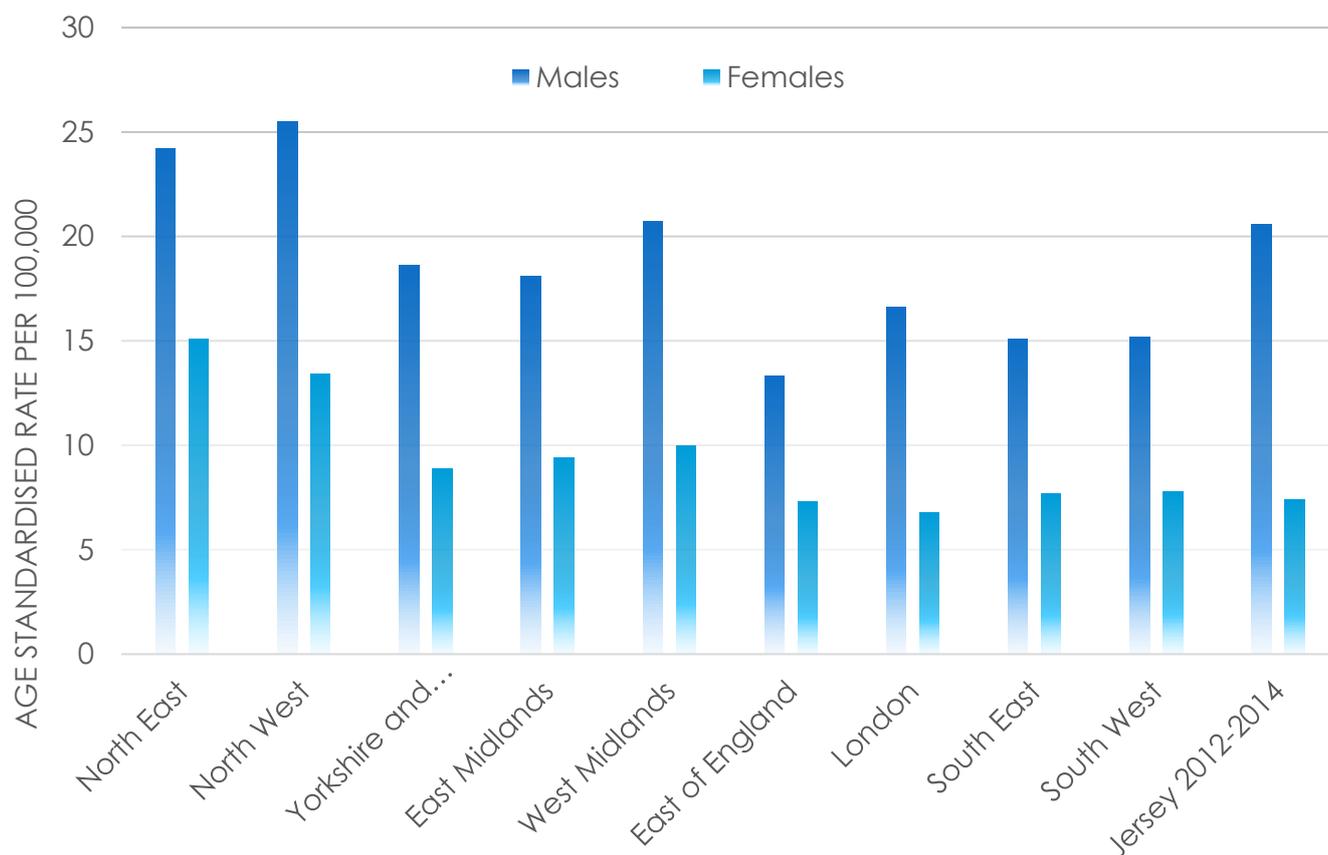
<sup>68</sup> Alcohol-related disease definition used by the Office for National Statistics; see *Alcohol-related deaths in the United Kingdom, registered 2014*, ONS published February 2016, available from [www.ons.gov.uk](http://www.ons.gov.uk)

## 5. Mortality

Deaths caused specifically by alcohol have remained stable over the past 8 years (2008 to 2015) as shown in Figure 5.5. Over the period 2013-2015, the age-standardised death rate in Jersey was 15 per 100,000 population. The majority of these deaths were due to alcoholic liver disease, accounting for around two-thirds (69 per cent) of all alcohol-related deaths over the period 2013-2015. Males accounted for 64 per cent of all alcohol-related deaths.

The latest available figures for England and the English regions is for calendar year 2014.<sup>69</sup> Comparing this to the Jersey data for 2012-2014 (Figure 5.6) shows that alcohol-related deaths locally follow a similar gender pattern to the English regions, with a higher rate of male alcohol-related deaths than for females.

**Figure 5.6: Alcohol-related death rates, by English region, 2014 and Jersey 2012-2014**



Source: Jersey Public Health Statistics Unit, ONS

<sup>69</sup> ONS (2014), *Alcohol-related Deaths in the United Kingdom Report*, deaths registered in 2014, published February 2016, [www.ons.gov.uk](http://www.ons.gov.uk)

## Drug-related deaths

Drug misuse and drug dependence are known causes of premature mortality. Drug-related deaths occur in a variety of circumstances, each with different social and policy implications. Consequently, there is considerable political, media and public interest in these figures.<sup>70</sup>

The Office for National Statistics (ONS) methodology<sup>71</sup> for analysing drug-related deaths has been applied to Jersey data for the years 2010-2014. 2015 data is not available currently, as drugs deaths go to inquest before being registered with the Parish registrars. This results in a delay, of up to 18 months, before such a death is recorded in the Public Health Deaths Database.

This indicator covers accidents and suicides involving drug poisonings, as well as deaths from drug abuse and drug dependence. It does not include other adverse effects of drugs (for instance, anaphylactic shock). Drug poisoning deaths involve a broad spectrum of substances, including legal and illegal drugs, prescription-type drugs (either prescribed to the individual or obtained by other means) and over-the-counter medications. Some of these deaths may also be from complications of drug abuse, such as deep vein thrombosis or septicaemia which can be caused by intravenous drug use, rather than an acute overdose.

The definition of a drug misuse death is: (a) deaths where the underlying cause is drug abuse or drug dependence; and (b) deaths where the underlying cause is drug poisoning and where the substances controlled under the UK Misuse of Drugs Act 1971 are involved. This definition has been used across the UK.

The total number of deaths in Jersey related to drug misuse (23) accounted for less than 1 per cent of all deaths during the period 2010-2014. This proportion is similar to that recorded for England and Wales for the data available (for 2014), where 0.5 per cent of all deaths were related to drug misuse.<sup>72</sup>

The findings of drug-related deaths for Jersey for the five-year period 2010-2014 show:

- There was a total of 23 drugs poisoning deaths (involving both legal and illegal drugs) occurring in Jersey during the period, an average of 5 deaths per year;

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<sup>70</sup> Health and Social Care Information Centre, Statistics on Drug Misuse: England 2016, Publishes July 2016, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

<sup>71</sup> Office for National Statistics, Statistical Bulletin: Deaths related to drug poisoning in England and Wales: 2014 registrations, published 3 September 2015, available from [www.ons.gov.uk](http://www.ons.gov.uk)

<sup>72</sup> Health and Social Care Information Centre, Statistics on Drug Misuse: England 2016, Publishes July 2016, available from [www.hscic.gov.uk](http://www.hscic.gov.uk)

## 5. Mortality

- Of these, 15 (65 per cent) were drug misuse deaths involving illegal drugs, a proportion similar to that recorded for England in 2014 (67 per cent);
- Almost three-quarters (70 per cent) of drugs poisoning deaths were due to accidental poisonings, whilst the remaining 30 per cent were due to intentional self-poisonings;
- Opiates were involved in just over half (52 per cent) of drugs-poisoning deaths over the period, again similar to the proportion seen in England in 2014, 53 per cent;
- Around a fifth (22 per cent) of all drugs poisoning deaths in Jersey involved antidepressants.

### Premature Deaths – Years of Life Lost under 75

Years of life lost (YOLL) data can help health planners to identify areas of concern and prioritise resources to try to avert preventable early deaths. The age of 75 is most commonly used as the cut-off point in premature death statistics.

In Jersey more than 250 people per year die before they reach 75, accounting for over 3,600 YOLL annually from all causes of death. The Jersey rate of 395 YOLL per 10,000 is lower than the average England, similar to the rate in the South West but higher than Guernsey and Alderney (Table 5.8).

#### Years of Life Lost (YOLL)

An estimate of the potential length of time a person would have lived had they not died prematurely. It is based on the assumption that every individual could be expected to live until the age of 75 and premature death before that age may be preventable.

**Table 5.8: Years of Life Lost (all causes), Channel Islands 2013-2015 and England and South West 2012-2014**

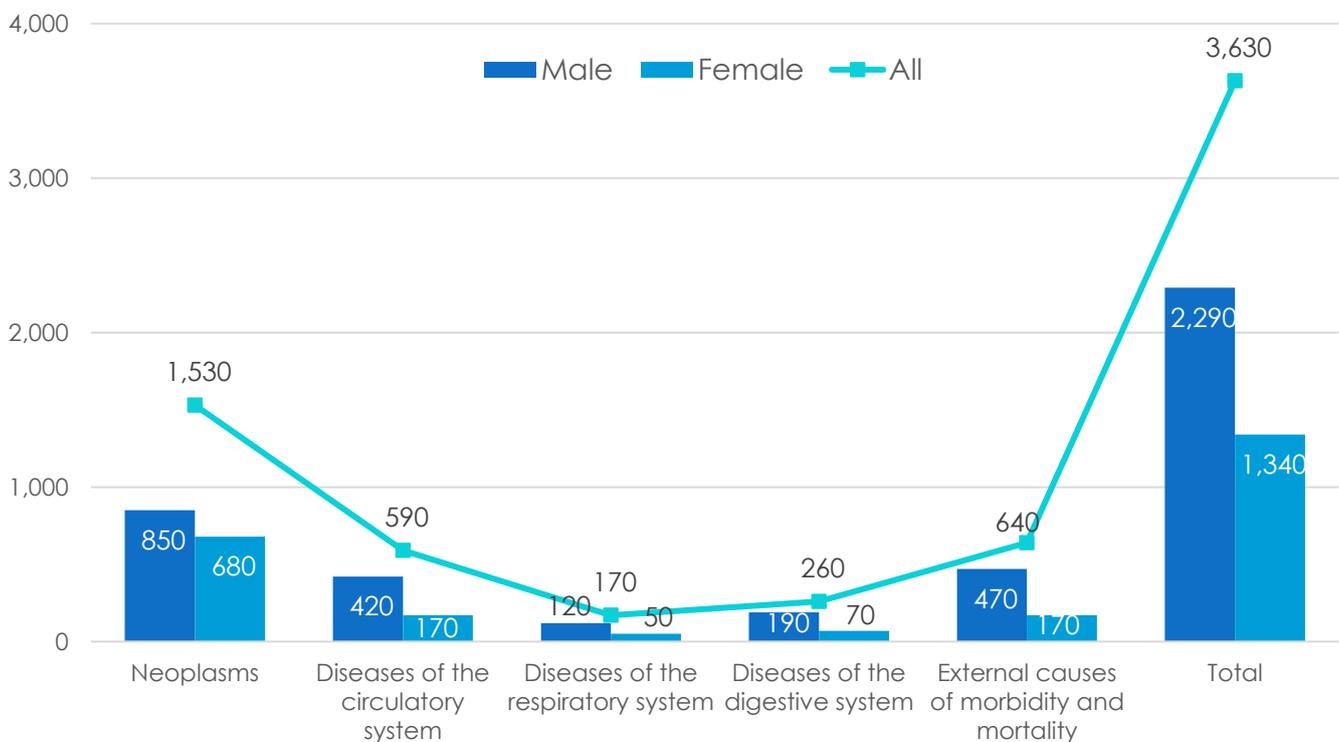
Jersey		Guernsey & Alderney		England 2012-2014	South West 2012-2014
Total YOLL (2013-15)	Rate per 10,000 population (95% CI)	Total YOLL (2013-15)	Rate per 10,000 population (95% CI)		
11,080	394.5 (387.1 to 402.1)	5,618	313.8 (305.6, 322.2)	424.8	396.0

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, HSCIC Indicator P00332

Cancers accounted for the majority of years of life lost due to deaths under 75 in Jersey, followed by external causes (such as suicide and accidents) and diseases of the circulatory system (Figure 5.7). Guernsey has a slightly different picture with coronary heart disease and external causes (suicide & accidents) responsible for slightly more YOLL than cancer.

Deaths from lung, colorectal and breast were responsible for the majority of premature deaths due to cancers in both Islands.

**Figure 5.7: Years of Life Lost due to premature deaths (under 75 years), annual average 2013-2015**



Source: Jersey Public Health Statistics Unit

As Figure 5.7 shows, there is a notable gender difference in years of life lost, with an extra 950 years, on average, lost by men each year.

### Premature Deaths – Years of Working Life Lost

In Jersey, 46 per cent of all Years of Life Lost were due to deaths among people of working age (16-64 years) or younger; this is similar to the proportion in Guernsey (42 per cent).

As for total YOLL, deaths from accidents, suicides & injuries of undetermined intent and lung cancer continue to contribute the most to potential years of working life (YWLL) lost between 2013 and 2015 (Table 5.9).

Conditions with the highest average YWLL are those where death occurs, on average, at younger ages.

Thus accidents, suicide and injuries of undetermined intent account for more years of life lost per individual death than lung cancer, although it causes a greater number of deaths, because these deaths happen in a younger age group.

A similar picture is seen in Guernsey, with accidents, suicides & undetermined injury and coronary heart disease accounting for the greatest potential years of working life lost per death.

#### **Years of Working Life Lost (YWLL)**

An estimate of the potential length of time a person would have worked had they not died prematurely. It is based on the assumption that every individual could be expected to live and therefore work until the pension age (65). YWLL provides a measure of the impact of avoidable mortality in a population and the potential effect premature death has on the economy.

**Table 5.9: Potential Years of Working Life Lost 2013-2015**

CAUSE OF DEATH	Total YWLL 2013-2015	Average YWLL per death	Total deaths 2013-2015
Accidents	650	24	30
Suicide and undetermined injury	590	26	20
Lung cancer	390	8	50
Ischaemic heart disease	320	10	30
Chronic liver disease incl. cirrhosis	230	9	30
Breast cancer	190	12	20
Stroke	160	12	10
Colorectal cancer	150	11	<10
Infectious and parasitic diseases	80	20	10
Pneumonia	60	13	10
Diabetes	60	13	<10
Malignant melanoma	60	28	10
Head and neck cancers	60	6	10
Bladder cancer	50	10	10
Bronchitis, Emphysema, COPD	50	4	10
Prostate cancer	40	7	10

Number of deaths independently rounded to nearest 10

Source: Jersey Public Health Statistics Unit

## Premature Mortality (Longer Lives)

More than 250 people die each year in Jersey before their 75<sup>th</sup> birthday, accounting for more than a third (34-36 per cent) of all deaths each year. Public Health England publish rankings for English local authorities designed to be an enabler for change, making mortality data accessible to everyone and providing evidence to facilitate debate on improving health and living longer lives. Figures for Jersey are published by the Public Health Statistics Unit to provide a benchmark for Jersey; the latest Jersey Premature Mortality Report containing data for 2012-2014 was published in April 2016 and is available from [www.gov.je](http://www.gov.je).

Table 5.10 shows the age standardised mortality rates (ASMR) for Jersey for overall premature mortality and for premature mortality from cancer, heart disease and stroke, lung disease and

## 5. Mortality

liver disease. The table also shows comparison with the Healthier Lives website ([healthierlives.phe.org.uk](http://healthierlives.phe.org.uk)) rankings for England and English regions.

**Table 5.10: Premature ASMR – information from Healthier Lives Website (May 2016)**

	Best (significant at 95% confidence level)		Worse than average (not significant)
	Better than average (not significant)		Worst (significant at 95% confidence level)

Premature Mortality Indicator	Jersey ASMR*	England ASMR*	English Local Authorities Min	English Local Authorities Max	Jersey Ranking**
Overall mortality	311	337	Kensington & Chelsea 244	Manchester 534	47 / 151
Cancer	146	142	Harrow 106	Manchester 196	82 / 151
Breast cancer (females)***	24	22	Hammersmith & Fulham 14	Slough 34	108 / 147**
Heart disease and stroke	55	76	Kensington & Chelsea 48	Manchester 135	5 / 151
Ischaemic Heart Disease	27	41	Kensington & Chelsea 23	Manchester 79	6 / 151
Lung disease	26	32	Bath & North East Somerset 18	Manchester 72	34 / 150
Liver disease	22	18	Buckinghamshire 10	Blackpool 40	99 / 150
Injury	13	12	Merton 5	Blackpool 28	103 / 150

\* ASMR – Age Standardised Mortality Rate per 100,000 population under 75 per annum. Standardised using the 2013 European Standard Population for those aged under 75 years. For further information see the Background Notes section of this report.

\*\* Rankings assume Jersey is added to the total number of regions ranked. For some indicators Public Health England has excluded Rutland from the analysis due to small numbers (fewer than 25 events in the period); for breast cancer other regions with fewer than 25 deaths over the time period have been excluded from the rankings.

\*\*\* For Breast Cancer, female only data is used (deaths for females under 75 and female population under 75).

Source: Jersey Public Health Statistics Unit, Public Health England Longer Lives Tool

Key findings from the Premature Deaths of Jersey Residents 2012-2014 report show:

- In Jersey, overall premature mortality was 311 per 100,000 population per year between 2012 and 2014, a rate lower than the average for England;<sup>73</sup>
- For premature deaths due to heart disease and stroke, Jersey would be categorised as among the best when compared with the English average, equivalent to ranking 5<sup>th</sup> out of 151 English Local Authorities;
- Premature mortality due to cancer in Jersey is higher (worse) than the English average<sup>1</sup>, ranking Jersey equivalent to 82 out of 151 English Local Authorities. Around half of all cancer deaths occur in the under 75 age group;
- For Lung disease, Jersey ranks lower (better) than the overall average<sup>1</sup> for England; equivalent to 37 out of 150 English Local Authorities;<sup>74</sup>
- Jersey's premature mortality rate for diseases of the liver is higher (worse) than the average<sup>1</sup> for England, ranking equivalent to 99 out of 150<sup>2</sup>.

## Place of Death

Around two-fifths (39 per cent) of all Jersey deaths occur in hospital; this is a similar proportion to Guernsey (41 per cent). A further one in five deaths occur in nursing homes, whilst one in six occurs in private homes or at the Jersey Hospice.

The average proportion of local deaths in hospital for 2013 to 2015 in both Islands is slightly lower to that observed in England (46.7 per cent) for the latest year of available data (2015).<sup>75</sup>

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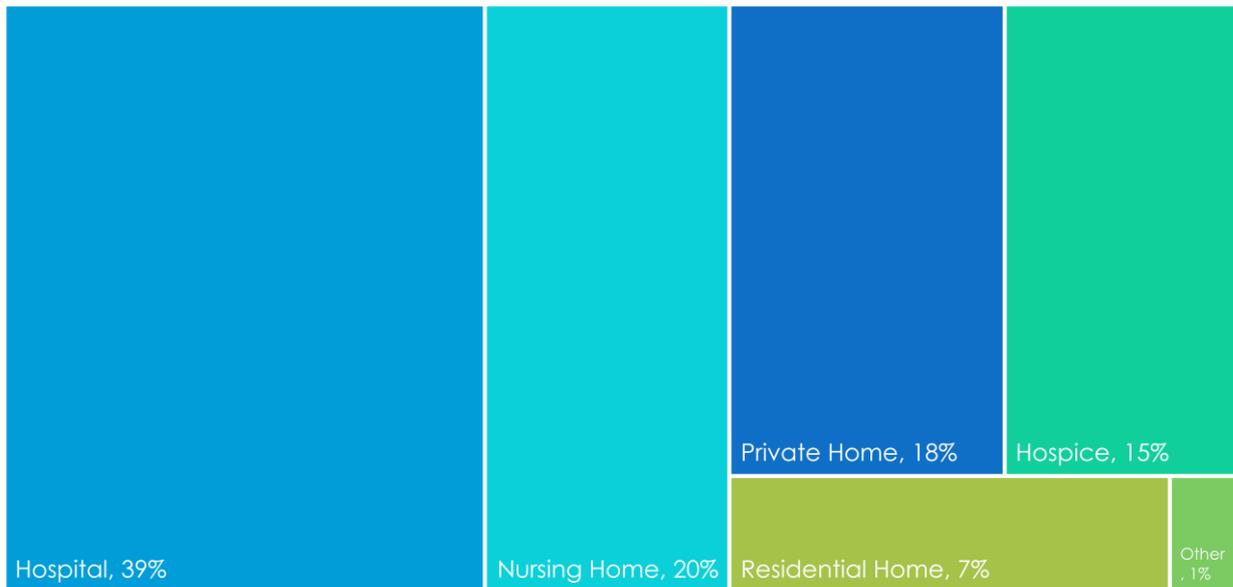
<sup>73</sup> Not a statistically significant difference – this is due to the confidence intervals for Jersey overlapping with the confidence intervals for the English average.

<sup>74</sup> Healthier Lives analysis have 149 regions for Lung and Liver diseases due to small numbers of deaths for Rutland, resulting in Rutland being excluded from the analysis for these two disease categories.

<sup>75</sup> Public Health England, End of Life Care Profiles, updated August 2016, available from [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

## 5. Mortality

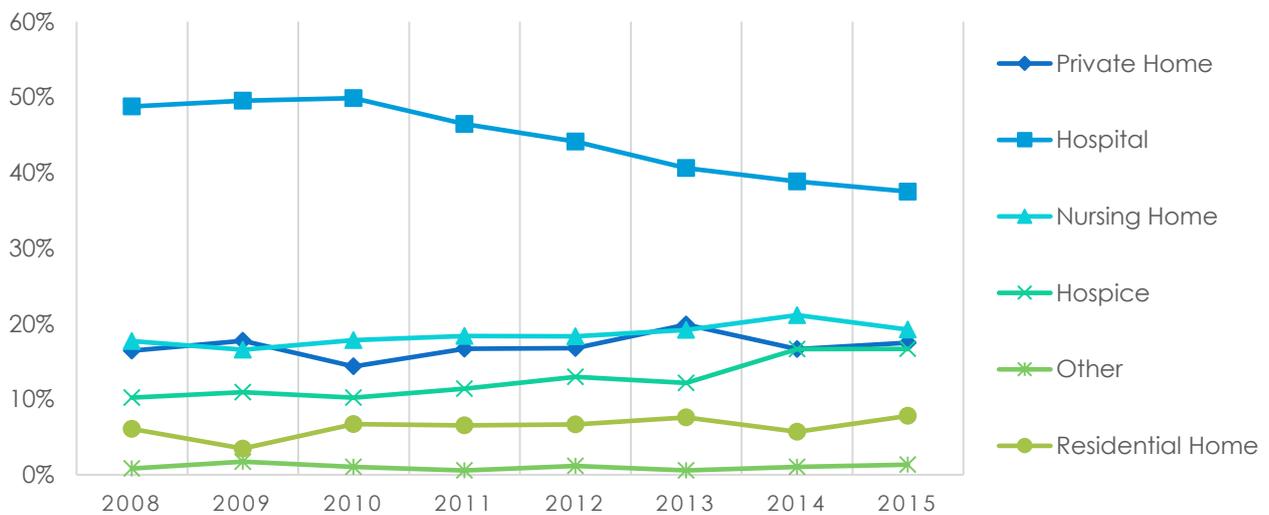
**Figure 5.8: Place of on-Island deaths 2013-2015**



Source: Jersey Public Health Statistics Unit

Over the past few years in Jersey, there has been a decrease in the proportion of death occurring in hospital and a slight increase in deaths in nursing homes and the Jersey Hospice. This is similar to the pattern seen in Guernsey.

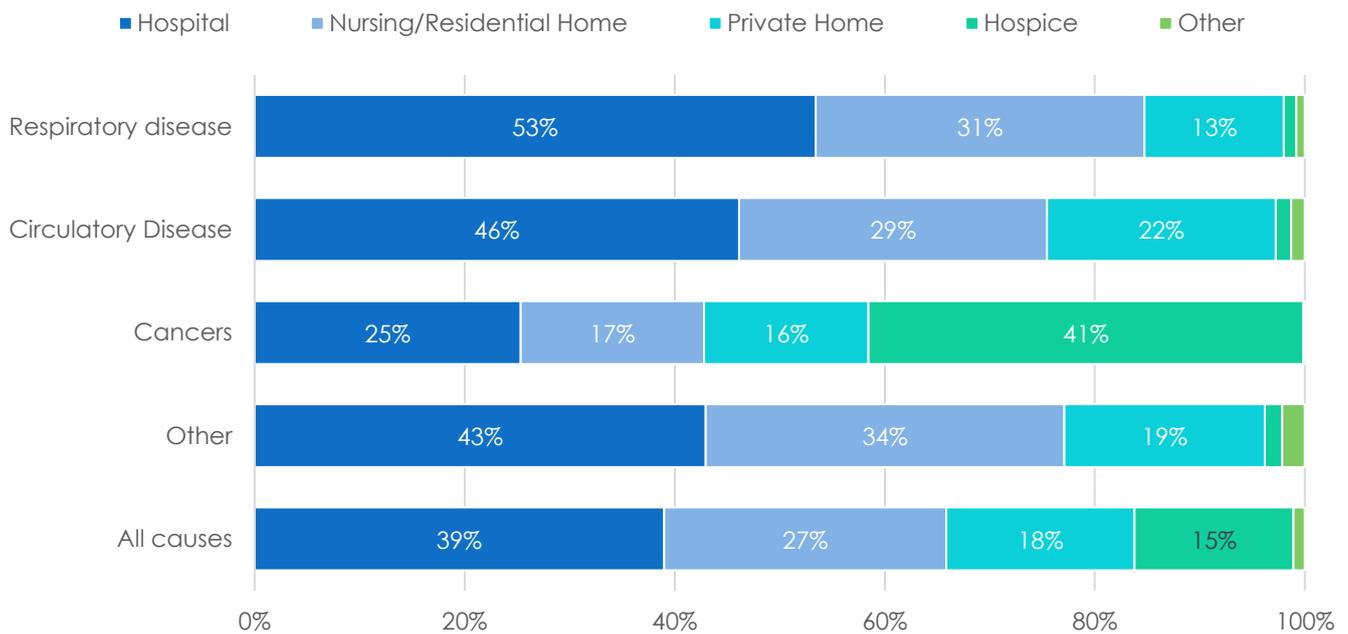
**Figure 5.9: Distribution of on-Island deaths by place 2008-2015**



Source: Jersey Public Health Statistics Unit

Over half (53 per cent) of deaths from respiratory diseases occur in hospital (Figure 5.10) while just under half of deaths from circulatory diseases (46 per cent) and other causes (43 per cent) occur in a hospital. The pattern for cancer deaths is very different, with the highest proportion occurring in the Jersey Hospice (41 per cent). In Guernsey, similar proportions of cancer deaths occur in Hospital (31 per cent) and hospice (30 per cent).

**Figure 5.10: Distribution of on-Island deaths by place and underlying cause 2013-2015**



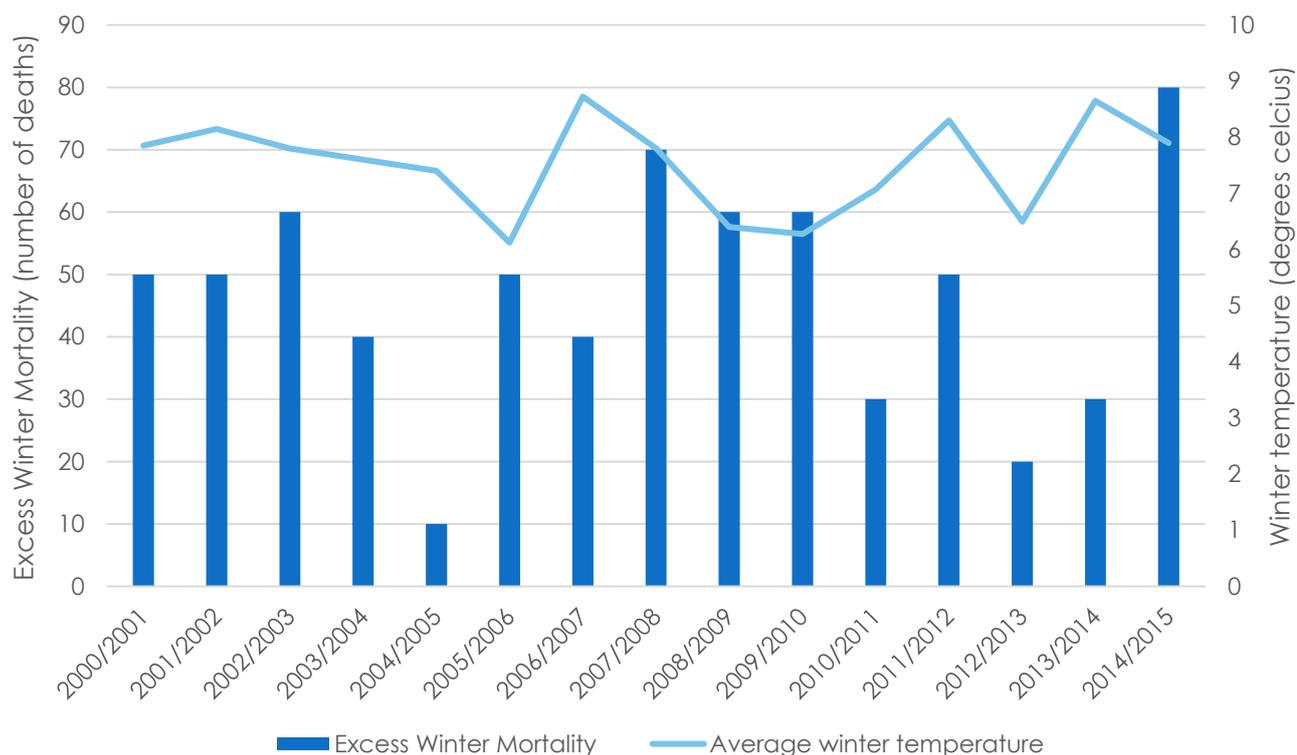
Source: Jersey Public Health Statistics Unit

## Excess Winter Mortality

As seen in other countries, both Channel Islands have more deaths during the winter months than at other times of the year (Figure 5.11). Over the winter period 2014-2015, almost 80 excess deaths were recorded in Jersey when compared to summer months. In Guernsey there were 50 excess winter deaths over the same period.

### Excess Winter Mortality (EWM)

This compares the average number of deaths in the winter period (Dec-Mar) with the average number of deaths in the preceding period (Aug-Nov) and the following period (Apr-Jul).

**Figure 5.11: Excess Winter Mortality and Average Winter Temperature in Jersey, 2000-2015**

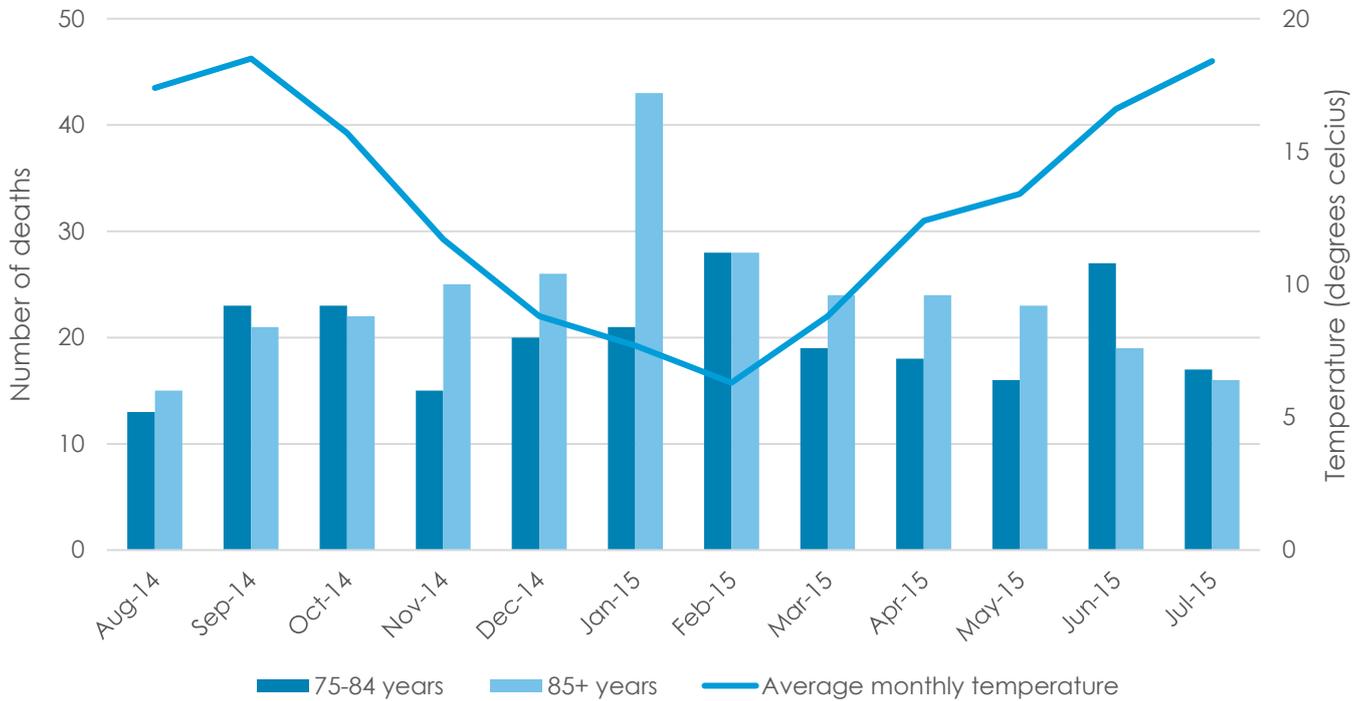
Source: Jersey Public Health Statistics Unit and Jersey Met Office

Colder temperatures are considered to play a part in this observed seasonal variation in mortality, but when the average annual winter temperatures are plotted against excess annual winter mortality, there is no significant correlation (Figure 5.11). A similar lack of correlation is apparent for Guernsey. It is known that levels of Influenza in 2014/15 were higher than recent years, whilst the influenza vaccine was reported as only 34 per cent effective for that year.<sup>76</sup> This was due to a mismatch between the vaccine strains of influenza virus and the actual strains of virus which circulated in that winter flu season.

However, lower monthly temperatures do seem to correlate with more deaths in the older age groups, aged 75 or over (Figure 5.12) and have much less effect on those under 75 years of age. Guernsey data also reflects this effect. Half of the excess winter deaths in Jersey in 2014-2015 were of people aged 85 or over at the time of death.

<sup>76</sup> Office for National Statistics, Excess Winter Mortality in England and Wales: 2014/15 (Provisional) and 2013/14 (Final), published 25 November 2015, available from [www.ons.gov.uk](http://www.ons.gov.uk)

**Figure 5.12: Monthly deaths and Average Monthly Temperatures in Jersey 2014 to 2015, over 75's**



Source: Jersey Public Health Statistics Unit and Jersey Met Office



- States of Jersey Health Intelligence Unit, Premature deaths of Jersey Residents 2012-2014, published April 2016, available from [www.gov.je](http://www.gov.je)
- States of Jersey Public Health Statistics Unit, Annual Report on the deaths of Jersey residents 2015, published August 2016, available from [www.gov.je](http://www.gov.je)



# MORBIDITY

## Cancer Incidence

Cancer incidence in Jersey is monitored by Public Health England's Cancer Registry. A new report with data for Jersey up to 2014 is expected to be published before the end of 2016. This latest data was not available for inclusion in this report.

The previous cancer incidence report<sup>77</sup> (based on 1999-2011 data) showed that around 800 new cancer tumours were diagnosed each year, around 60 per cent being malignant tumours. If the non-melanoma skin cancers (NMSC) are excluded, then there were around 500 new cases of malignant cancer diagnosed annually. Incidence rates in Jersey were found to be similar to the rate for the South West region and Guernsey & Alderney but higher than the England average for data from 2007-2011.

The most commonly diagnosed cancers (excluding NMSC) in Jersey were **breast, prostate, colorectal, lung** and **malignant melanoma** for 2007 to 2011. This is no different to other similar populations. These same cancers account for the highest number of new diagnosed cases in Guernsey, England and the South West region.

While breast cancer and prostate cancer account for the largest number of new cases diagnosed each year, deaths from these cancers (on average 20 and 14 annual deaths, respectively, 2010-2012) are much lower than for lung (55 deaths annually 2010-2012) or colorectal cancers (17 deaths annually 2010-2012).

### Incidence

The rate at which new cases occur in a population during a specified period. For example, the number of new cases of cancer diagnosed each year or the number of cases of measles per 1,000 people in a given year.

### High incidence

This is not necessarily a bad thing. It can indicate that more cancers are being diagnosed or that data collection is better. If high incidence rates are linked with low death rates for a particular cancer it may mean that early detection has allowed for successful treatment of the disease.

<sup>77</sup> Channel Islands Cancer Report 2013, Public Health England Knowledge and Intelligence Team, published January 2014, available from [www.gov.je](http://www.gov.je)

The 2013 Channel Island Cancer Report<sup>78</sup> and The Cancer in Jersey Report<sup>79</sup> give a more in depth summary of cancer in Jersey and the main risk factors associated with the cancers where we have higher incidence rates. The main conclusion was that the cancers for which Jersey has significantly higher incidence rates are readily explained by exposure to the risk factors that cause most of them: smoking; hazardous alcohol consumption; UV exposure. In other words, most of the cancers Jersey has a higher incidence of are preventable.

### Disease Prevalence

Table 6.1 shows the provisional disease prevalence of selected medical conditions which are recorded on disease registers collated from general practice as part of the Jersey Quality Improvement Framework.

A new computer system for primary care was implemented in 2014, providing a new secure central data store for use by all Jersey GP surgeries.<sup>80</sup> Table 6.1 presents information which GPs are incentivised to provide through the Jersey Quality Improvement Framework (JQIF).<sup>81</sup>

#### **Prevalence**

the total number of cases (new and ongoing) of a disease in a given population at a specific time, or the proportion of a population that is affected by the disease.

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<sup>78</sup> Channel Islands Cancer Report 2013, Public Health England Knowledge and Intelligence Team, Published January 2014, available from [www.gov.je](http://www.gov.je)

<sup>79</sup> The Cancer in Jersey Report 2013, Public Health England Knowledge and Intelligence Team, Published July 2013, available from [www.gov.je](http://www.gov.je)

<sup>80</sup> The Health and Social Services Department has access to the system to allow statistical information about conditions 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 should be treated as provisional. Data quality is expected to improve as further interrogation of the data and coding is conducted.

<sup>81</sup> Figures have been rounded to show the uncertainty surrounding them and caution is advised in their interpretation. The number of registered patients is around 10,000 higher than the population estimates suggest the population of Jersey is therefore caution is advised in the interpretation of these figures.

**Table 6.1: Provisional prevalence of various diseases and conditions, as per GP Central Server<sup>82</sup>**

Disease	Population Prevalence (%)	Number of people with condition	Prevalence in England (%)	Range across English regions (%)
<b>Atrial Fibrillation</b>	2	1,700	1.6	0.0 – 14.1
<b>Asthma</b>	5	5,400	6.0	0.7 – 12.5
<b>Coronary Heart Disease</b>	2	2,400	3.2	0.0 – 20.9
<b>Chronic Kidney Disease</b>	2	2,700	4.1	0.0 – 23.8
<b>Chronic Obstructive Pulmonary Disease (COPD)</b>	2	1,800	1.8	0.0 – 9.0
<b>Dementia</b>	<1	400	0.7	0.0 – 59.2
<b>Depression (18+)</b>	6	6,300	7.3	0.0 – 33.0
<b>Diabetes (17+)</b>	3	3,500	6.4	0.3 – 20.4
<b>Heart Failure</b>	1	700	0.7	0.0 – 6.0
<b>Hypertension</b>	13	14,800	13.8	0.1 – 47.6
<b>Learning Disabilities</b>	<1	100	0.4	0.0 – 4.3
<b>Obesity</b>	8	9,300	9.0	0.0 – 29.4
<b>Rheumatoid Arthritis (16+)</b>	1	600	0.7	0.0 – 4.6
<b>Stroke/Transient Ischemic Attack</b>	1	1,400	1.7	0.0 – 20.3

Data for Jersey is for calendar year 2015. PHE data is for 2014-15 financial year, latest year available.

Numbers independently rounded to nearest 100

Source: Jersey GP Central Server, Public Health England

The provisional Jersey figures show that for diseases such as hypertension, obesity, asthma and depression prevalence is similar to that in England overall.

<sup>82</sup> The GP Central Server is provided by EMIS web

## Multimorbidity

Multimorbidity has significant implications for patient care in a small Island jurisdiction and without early intervention can lead to increased resources needed to care for individuals with multiple conditions.

There is no standard definition for measuring multimorbidities in a population. The provisional disease registers mentioned previously, along with patients with cancer in the last five years, can be analysed to show the number of people with one or more, and two or more conditions.

In total, around 27,000 registered patients had at least one chronic condition at year-end 2015, equivalent to 24 per cent of the patient population, or one in four patients.

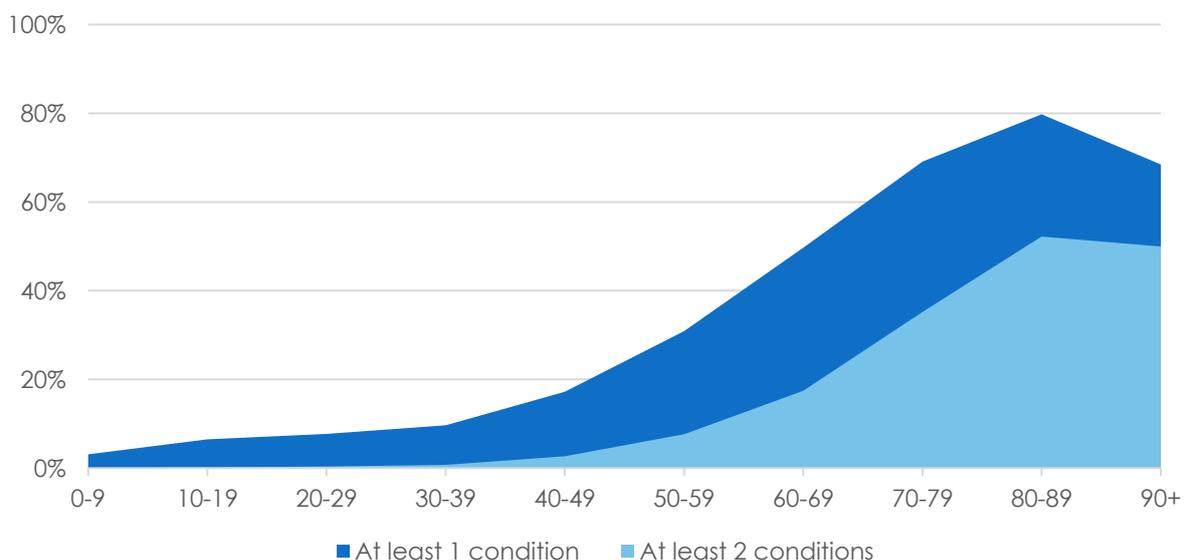
Looking at those who had two or more conditions, around 9,000 patients (8 per cent) were found to be on two or more disease registers, meaning around one in twelve patients have multimorbidities.

Figure 6.1 shows the proportion of each age group with one or more, and two or more conditions. The proportion of those with multimorbidities increases with age. For those aged 60 or over, more than half the population had at least one condition recorded.

**Multimorbidity**

Often defined as two or more long-term conditions that coexist independently in the same individual.

**Figure 6.1: Proportion of each age group with one or more, or two or more conditions**



Based on 14 different chronic conditions. For calendar year 2015.  
Source: Jersey GP Central Server

## Disability Prevalence

In 2015, the States of Jersey Social Policy Unit commissioned a survey of households to establish the prevalence of disability in Jersey. The survey found 14 per cent of all residents living in private households (or around a quarter, 26 per cent, of all Jersey private households) had a disability as defined by the UK Equality Act 2010 (this is that they have a physical or mental condition or illness lasting or expected to last 12 months or more which impacts on their ability to carry out day to day activities a little or a lot). These percentages correspond to around 13,900 Jersey residents living in private households having a disability and 10,800 households that have someone with a disability.<sup>83</sup>

Table 6.2 gives the approximate prevalence of a range of functional impairments experienced by Islanders.

**Table 6.2: Proportion of Jersey residents in private households having functional impairments (percent)**

	<b>% of respondents with functional impairment</b>
<b>Memory/concentration</b>	31
<b>Sight</b>	24
<b>Mobility</b>	21
<b>Social</b>	18
<b>Hearing</b>	16
<b>Learning</b>	13
<b>Problem solving</b>	11
<b>Dexterity</b>	9
<b>Communication</b>	6
<b>Self-care</b>	5
<b>At least one impairment</b>	<b>58</b>

Source: States of Jersey Social Policy Unit: Jersey Health and Life Opportunities Survey 2015

<sup>83</sup> States of Jersey Policy Unit, Jersey Health and Life Opportunities survey, published December 2015, available from [www.gov.je](http://www.gov.je)

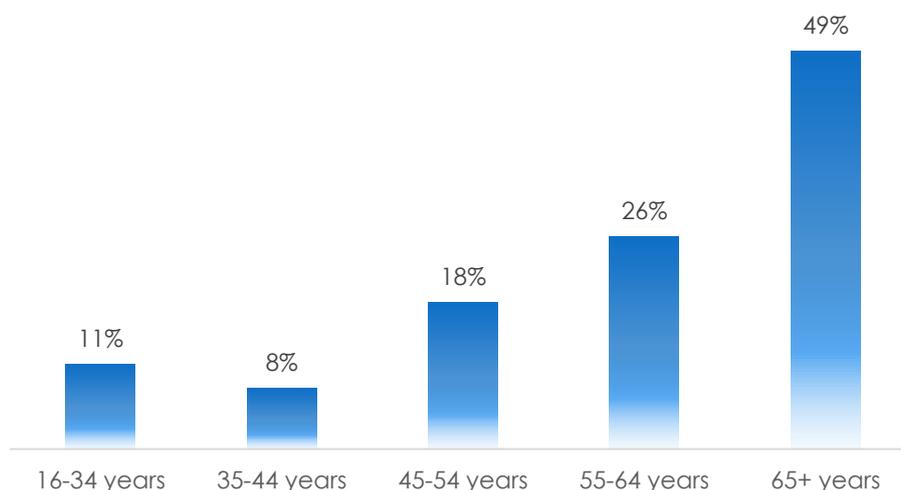
## Longstanding illness, disability or infirmity

A fifth (20 per cent) of Islanders reported having a longstanding illness, disability or infirmity that had lasted, or was expected to last, at least 12 months.<sup>84</sup>

The reported levels of long standing illness or health problems in Jersey are lower than the reported levels in 2012<sup>85</sup> for the EU as a whole (31 per cent), UK (33 per cent), Poland (35 per cent), Portugal (37 per cent) and France (37 per cent). Lower rates were reported for Spain (26 per cent), Luxembourg (20 per cent) and the lowest reported for Bulgaria (19 per cent).

The proportion of people reporting having a longstanding illness, disability or infirmity ranged from one in ten of those aged 16-44 years up to half (49 per cent) of those aged 65 or over (as shown in Figure 6.2). The proportion reporting they had a longstanding illness, disability or infirmity was not significantly different for men and women.

**Figure 6.2: Proportion of each age group who reported having a longstanding illness, disability or infirmity**



Source: Jersey Annual Social Survey 2015

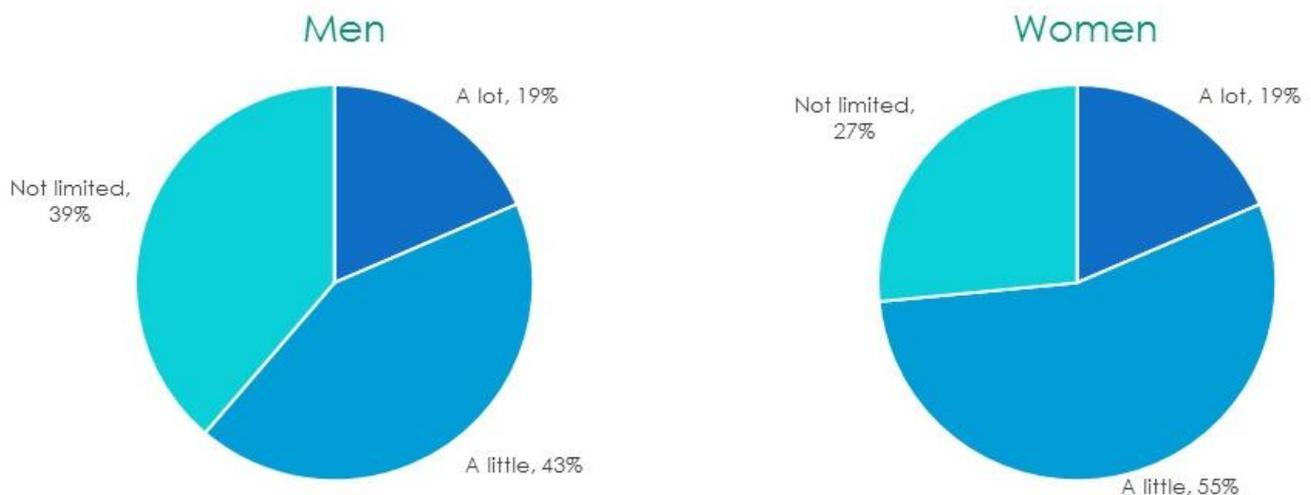
<sup>84</sup> Data from Jersey Annual Social Survey (JASS) 2015. It should be noted that as JASS is a postal self-completion questionnaire it is likely to under-estimate disabilities and infirmities that might affect a person's ability to complete the form, particularly in single person households where there may not be other household members to assist.

<sup>85</sup> OECD (2014), 'Self-Reported Health & Disability' in *Health at a Glance: Europe 2014*, OECD publications.

The proportion reporting they had a longstanding illness, disability or infirmity was not significantly different for men and women.

Of those with a longstanding illness, a fifth (19 per cent) reported that it limited their day to day activities 'a lot', and half (49 per cent) said it affected their day to day activities 'a little'. Whilst similar proportions of men and women reported their longstanding illness limiting their day to day activities 'a lot', a lower proportion of men (43 per cent) identified it as limiting their day to day activities 'a little', compared to women (55 per cent) as shown in Figure 6.3.

**Figure 6.3: “Are your day to day activities limited because of your health problem or disability?” By gender (those who reported having a longstanding illness, disability or infirmity)**



Source: JASS 2015



- States of Jersey Social Policy Unit, Health and Life Opportunities Survey. Published December 2015, available from [www.gov.je](http://www.gov.je)
- States of Jersey Statistic Unit, Jersey Annual Social Survey (JASS) 2015, published November 2015, available from [www.gov.je](http://www.gov.je)



# MENTAL HEALTH

## Population mental wellbeing

A set of questions known as the Short Warwick Edinburgh Mental Wellbeing scale (WEMWBS) were included in the Jersey Annual Social Survey<sup>86</sup> in 2012 and 2013. A person's score on the scale can range between 7 and 35, where a score of 7 represents poor mental health and a score of 35 represents the most mentally healthy a person can feel.

There has been no update since the previous Health Profile was published in 2014. However, a set of questions to calculate WEMWBS were included in the Jersey Opinions and Lifestyle Survey 2016, the results of which were not published in time for inclusion in this report.

The average (mean) score for adults in Jersey in 2012 was 26 out of 35, with no significant difference between males and females. The same average (mean) score of 26 was found for the population in 2013, indicating no change in overall population mental health between these two years.



Average mental  
well-being score  
(WEMWBS)  
2012 & 2013

The Office for National Statistics report on WEMWBS as part of the measures of national wellbeing. For financial year 2012/13, the figure for the UK was 24.6.<sup>87</sup>

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<sup>86</sup> For further information, see Jersey Annual Social Survey 2012 and 2013, States of Jersey Statistics Unit, published December 2012 and November 2013, available from [www.gov.je/statistics](http://www.gov.je/statistics)

<sup>87</sup> Office for National Statistics, Measures of National Well-being, released March 2016, available from [www.neighbourhood.statistics.gov.uk](http://www.neighbourhood.statistics.gov.uk)

## Self-reported Well-being

Respondents to the 2015 Health and Life Opportunities Survey, commissioned by the States of Jersey Social Policy Unit, were asked questions about their satisfaction towards different aspects of their life using a scale of zero (not at all) to ten (completely).

Figure 7.1 shows the proportions reporting high and low scores for each indicator, and comparisons with English data.

**Figure 7.1: Self-reported wellbeing results for Jersey 2015 and comparison to England 2014/15**

Overall, how satisfied are you with your life nowadays?



Overall, to what extent do you feel the things you do in your life are worthwhile?



## Overall, how happy did you feel yesterday?



## Overall, how anxious did you feel yesterday?



For satisfaction, worthwhile and happiness indicators, the categories are banded as those respondents 0-4 out of ten as 'Low', 5-6 out of ten as 'medium', 7-8 out of ten as 'high' and 9-10 out of ten as 'very high'. For anxiety, those responding 0-1 out of ten were categorised as 'very low', 2-3 out of ten as 'low', 4-5 out of ten as 'medium' and 6-10 out of ten as 'high'. These are categorised as per the Office for National Statistics report on Personal Well-being in the UK: 2015-16.

Source: States of Jersey Social Policy Unit: Jersey Health and Life Opportunities Survey 2015 and Public Health England

Around four-fifths of respondents had high or very high life satisfaction or felt things they did in their lives were worthwhile, as shown in Figure 7.1. Three-quarters (76 per cent) of people were also found to report being happy yesterday.

Results from the Health and Life Opportunities Survey 2015 show that fewer than one in ten people would be categorised as having low satisfaction (6 per cent), low feelings of worthwhile (9 per cent) and low happiness (8 per cent). In contrast, around one in three (35 per cent) of Island residents would be categorised as having a high anxiety score, compared to one in five in England. Jersey residents were similar to England for low satisfaction and happiness, but a greater proportion of Islanders reports low worthwhile feelings compared to England.

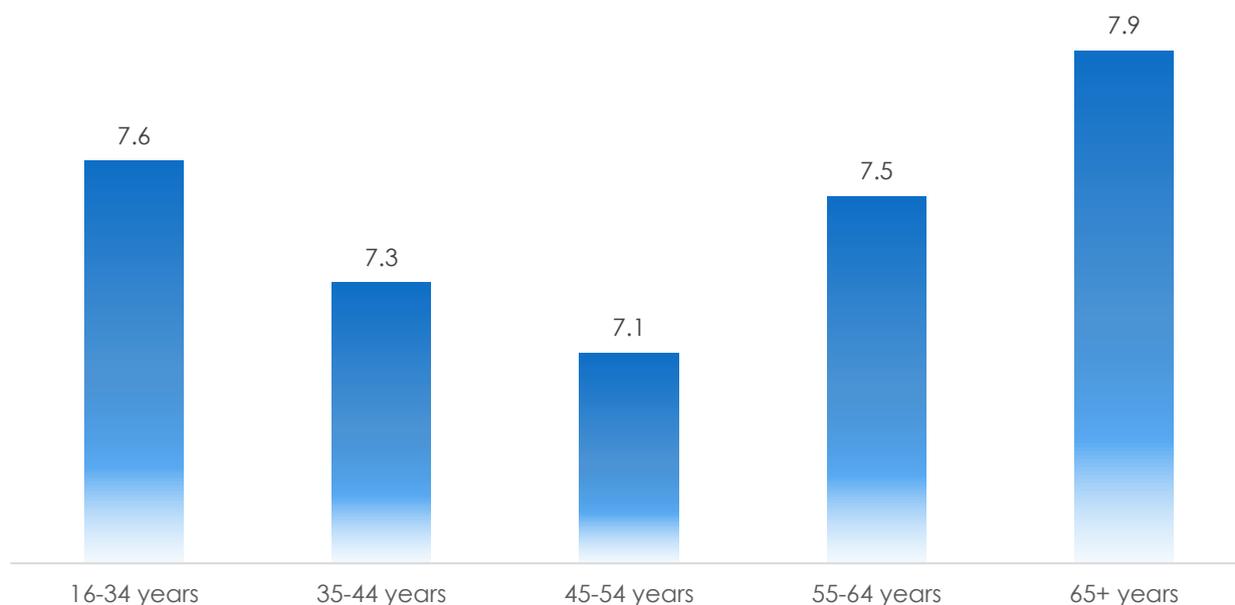
## Life Satisfaction

Over three-quarters (77 per cent) of Jersey residents in 2015 rated their life at 7 or above on a scale from zero (worst) to ten (best).<sup>88</sup> The mean average rating given was 7.5 – not a significant change from when the question was previously asked in 2012 and 2013.

The average rating given by men and women were not significantly different; however, there were significant differences seen between age groups; those in the youngest and oldest category rated their life satisfaction the highest, on average (see Figure 7.2).



**Figure 7.2: Average life satisfaction rating, by age group**



Source: Jersey Annual Social Survey 2015

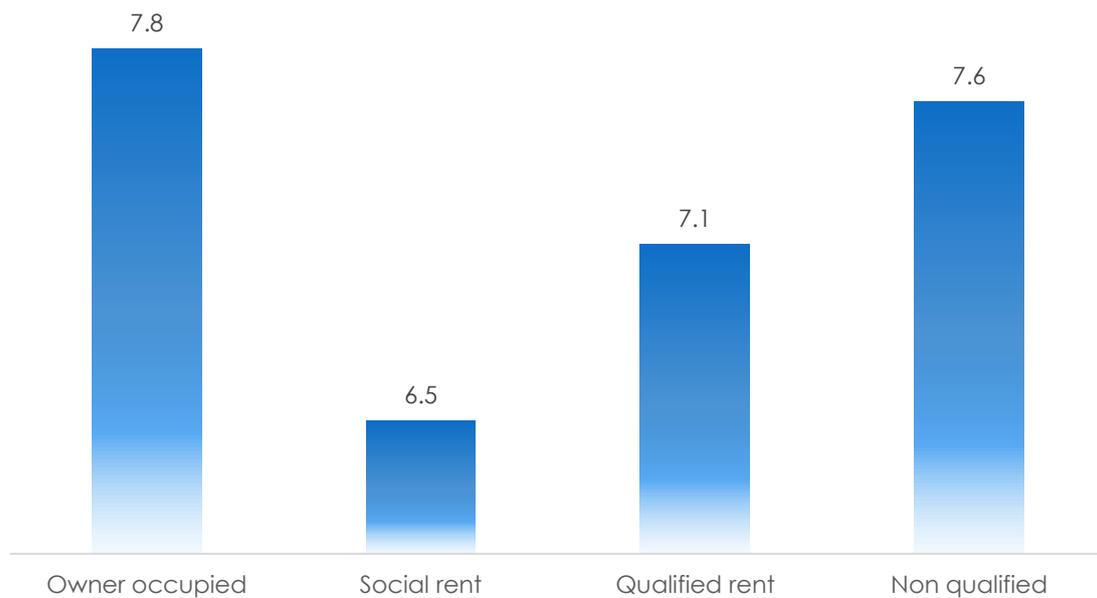
<sup>88</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2015, published November 2015, available from [www.gov.je/statistics](http://www.gov.je/statistics)

Overall life satisfaction, on average, was found to be higher in Jersey (7.5) than in most OECD countries, including the UK (6.5), and was similar to that in Switzerland, Norway, Iceland, Denmark and Finland.<sup>89</sup>

Adults who were unable to work due to sickness or long term disability, or who were unemployed but looking for work, had a significantly lower average score than the average across the rest of the population (5.5 and 5.0 respectively, compared to 7.5).

Differences by tenure were also observed, with owner-occupiers reporting their life satisfaction the highest (7.8), whilst respondents living in social rental accommodation reported the lowest life satisfaction (6.5) on average, as shown in Figure 7.3.

**Figure 7.3: Average life satisfaction rating, by tenure**



Source: Jersey Annual Social Survey 2015

<sup>89</sup> OECD, Better Life Index – Edition 2016, updated June 2016, available from [stats.oecd.org](http://stats.oecd.org)

## Suicide and intentional self-harm

Local data shows that although suicide rates in Jersey have decreased in recent years, a greater number of males die from suicide than females – see the Mortality chapter for more details.

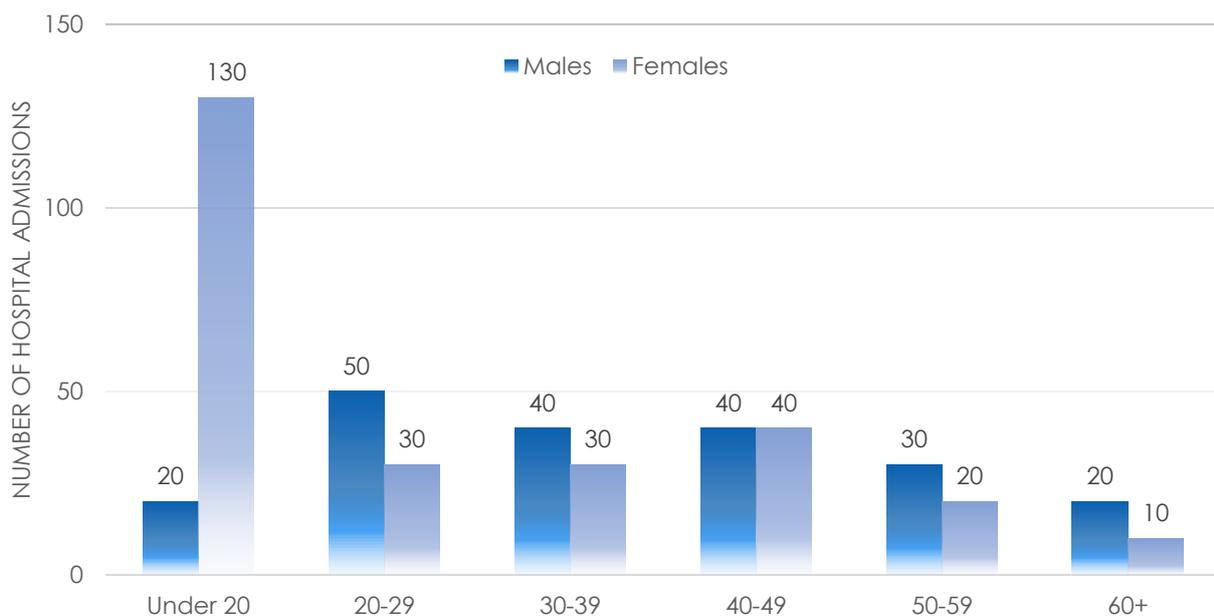
Measuring self-harm hospital admissions can be used as a proxy of the prevalence of severe self-harm in the population, these are only the tip of the iceberg in relation to the health and well-being burden of self-harm. Following an episode of self-harm, there is a significant and persistent risk of suicide which varies markedly between genders and age groups.<sup>90</sup>

Over the period 2013-2015, there were around 450 discharges from hospital coded as self-harm, comprising around 380 individuals.<sup>91</sup> A greater proportion of admissions overall were for females (57 per cent), whilst a third (33 per cent) of self-harm admissions were for those under 20 years of age.

### Self-harm

An intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent

**Figure 7.4: Self-harm episodes 2013-2015**



Source: TRAK care system

<sup>90</sup> Public Health England, Health Profiles, Updated September 2016, available from [fingertips.phe.org.uk](http://fingertips.phe.org.uk)

<sup>91</sup> Data for 2015 is provisional, pending completion of coding for the year

There were around 130 admissions of females under 20 years of age over the period 2013-2015 for self-harm, the largest proportion for any age group, as shown in Figure 7.4. Male admissions for self-harm peaked in the 20-29 age group.



- States of Jersey Social Policy Unit, Health and Life Opportunities Survey. Published December 2015, available from [www.gov.je](http://www.gov.je)
- States of Jersey Statistic Unit, Jersey Annual Social Survey (JASS) 2015, published November 2015, available from [www.gov.je](http://www.gov.je)



# SEXUAL HEALTH

## Teenage conceptions (under 16)

There were ten under 16 conceptions in Jersey during the three-year period 2013-2015; an average of around 3 per year. This gives a rate of 2.1 per 1,000 for 2013-2015, which is similar to that seen in Guernsey and Alderney for the same period (2.0 per 1,000) and less than half the rate for England for the latest reported period (Table 8.1). In Jersey, 40 per cent of these conceptions ended in a termination.

### **Under 16 Teenage Conception Rate**

the total number of conceptions (live births, stillbirths and terminations) to under 16 year olds per 1,000 females aged 13-15

**Table 8.1: Under 16 Teenage Conceptions Channel Islands 2013-2015, English data 2012-2014**

	Conception rate per 1,000	% leading to termination
<b>England</b>	4.9	62
<b>London</b>	4.2	70
<b>South West</b>	4.0	64
<b>Jersey</b>	2.1	40
<b>Guernsey &amp; Alderney</b>	2.0	50

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, ONS Conceptions in England and Wales 2014 Report

There are substantial variations in teenage conceptions and terminations by area in the UK. In populations, such as the UK, with equal access to free contraceptive services, these variations have been shown to be very closely associated with the level of deprivation of an area – the teenage conception rate is higher in deprived areas and the proportion that ends in termination is lower in deprived areas.

## Teenage conceptions (under 18)

The rate of under 18 (teenage) conceptions in Jersey over the period 2013-2015 was 6.8 per 1,000 population of 15 to 17 years olds (based on 34 conceptions) a rate significantly lower than the England average<sup>92</sup> for the latest period (Table 8.2) and also significantly lower than the equivalent rate for Guernsey (16.9 per 1,000). The highest rate in England was observed in the North East (30.2 per 1,000) whilst the lowest was seen in the South East and South West (18.8 per 1,000).

More than half (54 per cent) of under 18 conceptions between 2013 and 2015 ended in a termination. Less than half (45 per cent) of teenage conceptions in Guernsey lead to a termination over the same period.

### **Under 18 Teenage Conception Rate**

the total number of conceptions (live births, stillbirths and terminations) to under 18 year olds per 1,000 females aged 15-17

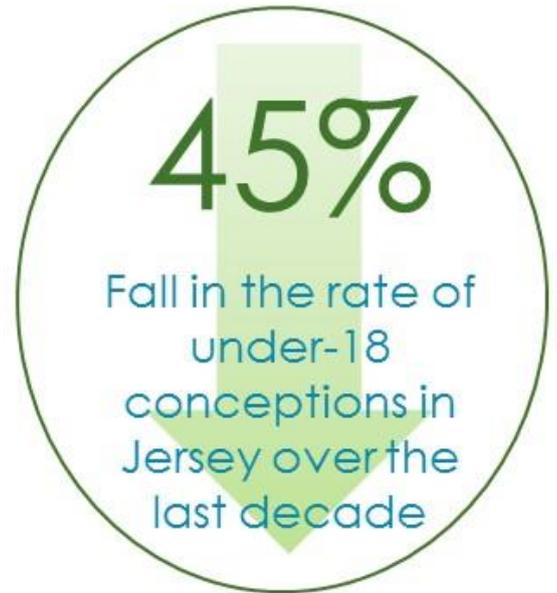
**Table 8.2: Under 18 Teenage Conceptions Channel Islands 2013-2015, English data 2014**

	Conception rate per 1,000	% leading to termination
<b>England</b>	22.8	51
<b>London</b>	21.5	64
<b>South West</b>	18.8	51
<b>Guernsey &amp; Alderney</b>	16.9	45
<b>Jersey</b>	6.8	54

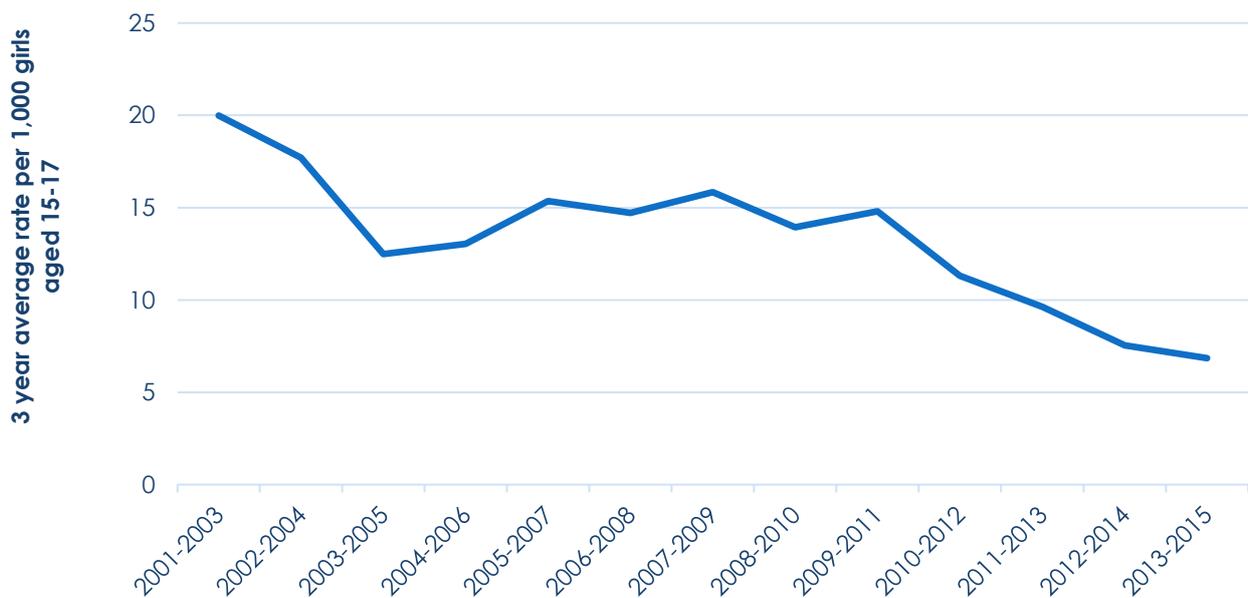
Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, ONS Conceptions in England and Wales 2014 Report

<sup>92</sup> Office for National Statistics, Conception Statistics, England and Wales, 2014, published 9 March 2016, available from [www.ons.gov.uk](http://www.ons.gov.uk)

There has been a considerable drop in the rate of teenage conceptions since the start of the century, from a high of 25 per 1,000 in 2000-2002 to 7 per 1,000 in the latest period (Figure 8.1). Since 2003-2005, the rate has decreased by 45 per cent. A decrease in the rate has also been witnessed in England and Wales, with the latest figure being the lowest since 1969.<sup>93</sup> Guernsey, have also reported a decrease in the rate over the last 8 years (2008 to 2015).



**Figure 8.1: Under 18 Teenage Conceptions in Jersey, three year averages**



Source: Jersey Public Health Statistics Unit

<sup>93</sup> Office for National Statistics, Conception Statistics, England and Wales, 2014, published 9 March 2016, available from [www.ons.gov.uk](http://www.ons.gov.uk)

## Terminations of Pregnancy

Between 2013 and 2015 there were 540 terminations in Jersey, an average of 180 per year. The crude rate of termination was 9.2 per 1,000 in Jersey, similar to the Guernsey rate of 9.9 per 1,000. Both Islands have rates that are significantly lower than the England rate for 2015 (16.7 per 1,000)<sup>94</sup> as shown in Table 8.3.

### Termination Rate

This is calculated as the number of all terminations per 1,000 females aged 15-44 years of age.

**Table 8.3: Termination rate (all terminations per 1,000 females aged 15-44) Jersey and Guernsey 2013-2015, England and regions 2015**

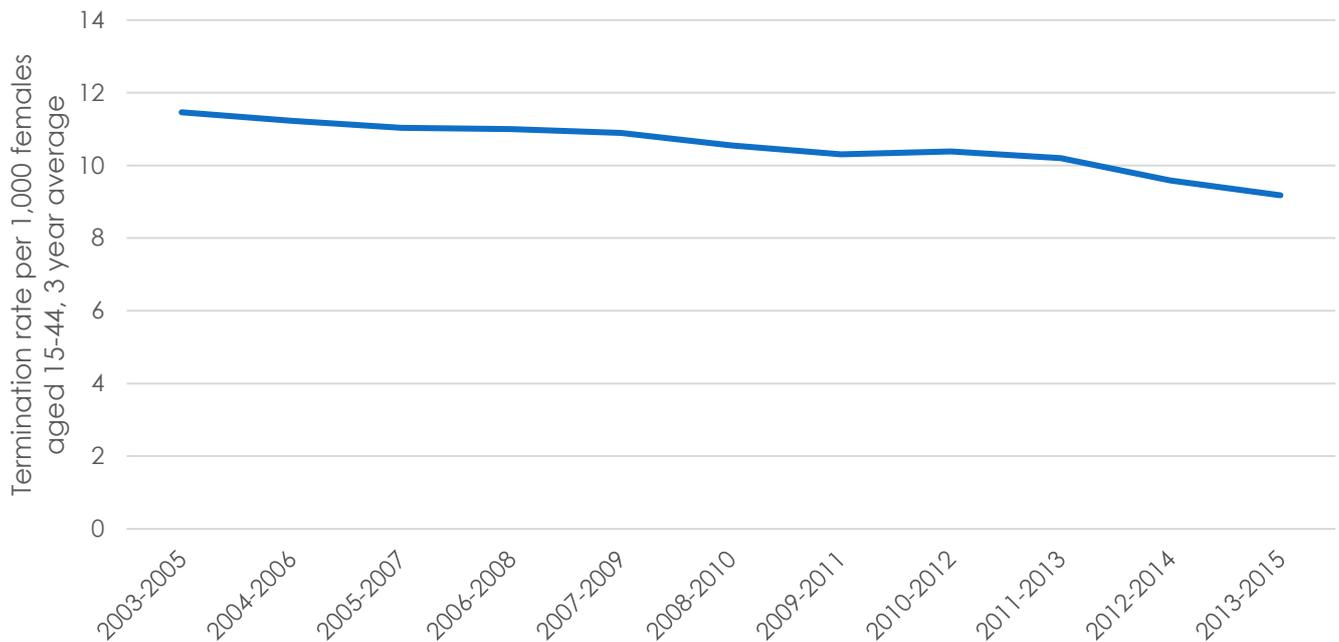
	Crude termination rate per 1,000	95% Confidence Interval LL	95% Confidence Interval UL
London	21.6	21.4	21.8
England	16.7	16.6	16.8
South West	13.6	13.4	13.8
Jersey	9.2	8.4	10.0
Guernsey & Alderney	9.9	8.9	11.0

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate, Public Health England Sexual and Reproductive Health profiles

Over the last decade, the rate in Jersey has reduced from 11.5 per 1,000 females aged 15 to 44 in 2003-2005 to 9.2 per 1,000 in 2013-2015 (Figure 8.2). This picture is similar to that seen in Guernsey.

<sup>94</sup> Public Health England, Sexual and Reproductive Health Profiles, updated October 2016, available from [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk)

**Figure 8.2: Termination rate in Jersey, three year averages**

Source: Jersey Public Health Statistics Unit

The number of terminations to mothers under 18 years of age in Jersey is very low. Jersey has a rate of 4 per 1,000 which is significantly lower than the England average of around 10 per 1,000 and lower than all the English regions. The rate for Jersey has fallen in recent years from 28 per 1,000 in 2009-2011 to 4 per 1,000 in the most recent period.

**Table 8.4: Under-18 Termination rate (all terminations per 1,000 females aged 15-17)  
Jersey 2013-2015, England and regions 2015**

	Termination rate per 1,000	95% Confidence Interval LL	95% Confidence Interval UL
London	11.5	11.0	12.1
England	9.9	9.7	10.1
South West	8.5	7.9	9.1
Jersey	3.8	2.5	6.0

LL = confidence interval, lower limit; UL = confidence interval, upper limit

Source: Jersey Public Health Statistics Unit, Public Health England Sexual and Reproductive Health profiles

## Sexually transmitted infections (STIs)

Over the period 2013-2015, 980 sexually transmitted infections (STI) were diagnosed in Jersey, an average of around 330 a year. The most commonly diagnosed STI was Chlamydia.

Table 8.5 shows the diagnostic rate per 100,000 for the three-year period 2013-2015, with comparison to data for Guernsey and Alderney.

**Table 8.5: Sexual health indicators for Jersey and Guernsey & Alderney, 2013-2015**

	Jersey		Guernsey & Alderney	
<b>Syphilis diagnostic rate per 100,000</b>	1.7	(0.5, 3.9)	4.1	-
<b>Gonorrhoea diagnostic rate per 100,000</b>	14.2	(10.3, 19.2)	8.8	-
<b>Chlamydia diagnostic rate per 100,000</b>	169.8	(155.4, 185.2)	226.1	-
<b>Genital warts diagnostic rate per 100,000 (first episode)</b>	96.7	(85.9, 108.4)	10.8	-
<b>Genital herpes diagnostic rate per 100,000 (first episode)</b>	28.5	(22.8, 35.2)	12.4	-
<b>Prevalence of diagnosed HIV per 1,000 aged 15-59 years</b>	1.3	(1.1, 1.5)	0.7	-

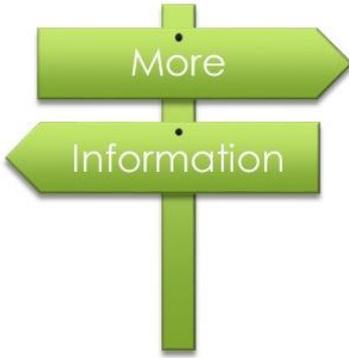
95% confidence intervals shown in brackets

Source: Jersey Public Health Statistics Unit, Guernsey Public Health and Strategy Directorate,

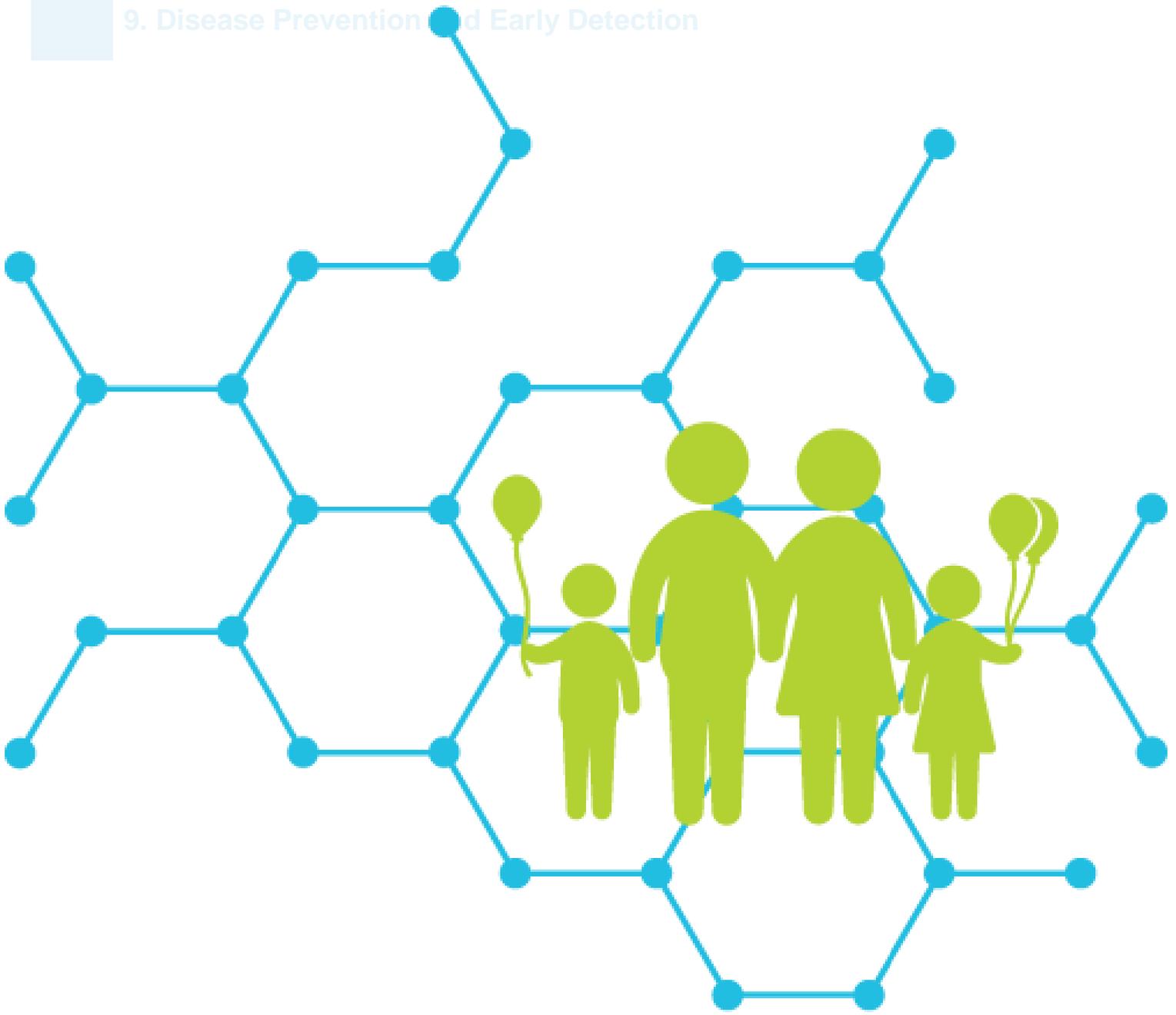
Jersey rates for 2013-2015 were all significantly lower than the latest available data for England.<sup>95</sup>

Around 4,500 HIV tests are performed at the Jersey General Hospital each year. On average, fewer than 10 people per year are diagnosed with HIV in Jersey.

<sup>95</sup> Public Health England, Sexual and Reproductive Health Profiles, updated October 2016, available from [www.fingertips.phe.org.uk](http://www.fingertips.phe.org.uk),



- States of Jersey Health Intelligence Unit, Jersey Abortion Statistics 2015, published 8 July 2016, available from [www.gov.je](http://www.gov.je)
- States of Jersey Health Intelligence Unit, Jersey Births and Breastfeeding Profile 2016, published June 2016, available from [www.gov.je](http://www.gov.je)



# DISEASE PREVENTION AND EARLY DETECTION

## Childhood Immunisation Coverage

Jersey has a high coverage of childhood immunisations (Table 9.1). Our coverage is consistently higher than the average reported for England and, for immunisation given at 2, 3, 4 and 12 months of age, coverage is above the World Health Organization's target of 95 per cent.

### Childhood Immunisations

The UK schedule of routine childhood immunisations is followed in Jersey. This includes the DTaP/IPV/Hib or "5-in-1" vaccine (protecting against diphtheria, tetanus, whooping cough, polio and Haemophilus influenza type b), Rotavirus, PCV (pneumococcal conjugate vaccine), MenC (meningitis C), MMR (measles, mumps and rubella) and for girls, HPV (Human Papilloma Virus).

**Table 9.1: Coverage of Childhood Vaccination in Jersey, Guernsey and England, percent**

	Jersey		Guernsey	England
	2014	2015	2014	2014/15
<b>DTaP / IPV / Hib (by 12 months of age)</b>	97.3	97.3	96.0	94.2
<b>MenC (by 12 months of age)</b>	96.9	96.7	97.4	93.9
<b>Pneumococcal (by 12 months of age)</b>	97.4	97.0	96.2	93.9
<b>Rotavirus 2 dose (by 12 months of age)</b>	95.5	95.0	-	-
<b>MMR (by 2 years of age)</b>	96.2	93.0	96.1	92.3
<b>Hib/MenC booster (by 2 years of age)</b>	96.1	93.3	-	92.1
<b>Pneumococcal booster (by 2 years)</b>	96.4	93.6	-	92.2
<b>DTaP / IPV booster (by 5 years of age)</b>	93.3	89.3	-	89.4
<b>2<sup>nd</sup> dose MMR (by 5 years of age)</b>	91.9	91.7	-	88.6

Source: Jersey Public Health Statistics Unit; Public Health England, Guernsey Public Health and Strategy Directorate

## HPV vaccination

Since September 2008, 12-13 year old girls have been offered immunisation against Human Papilloma Virus (HPV). Girls who have the HPV vaccine reduce their risk of getting cervical cancer in the future by over 70 per cent. Uptake of the complete course of HPV immunisations was similar in Jersey to that achieved in England overall in 2014/15 academic year, as shown in Table 9.2.

**Table 9.2: HPV uptake for 12-13 year old females, percent**

	2014/15	2015/16
<b>Jersey</b>	90.0	86.6
<b>England</b>	89.4	-
<b>South West</b>	88.9	-
<b>London</b>	83.8	-

- Data not currently available

Source: Jersey Public Health Statistics Unit, Public Health England

## Seasonal Influenza Immunisation

Immunisation against seasonal influenza is recommended for people aged 65 or over, those under 65 years in at risk groups, pregnant women and pre-school children (aged 2 to 4 years).

The World Health Organization target for seasonal flu vaccinations in the over 65 age group is 75 per cent. Public Health England set a minimum target of between 40 and 60 per cent uptake amongst children.<sup>96</sup>

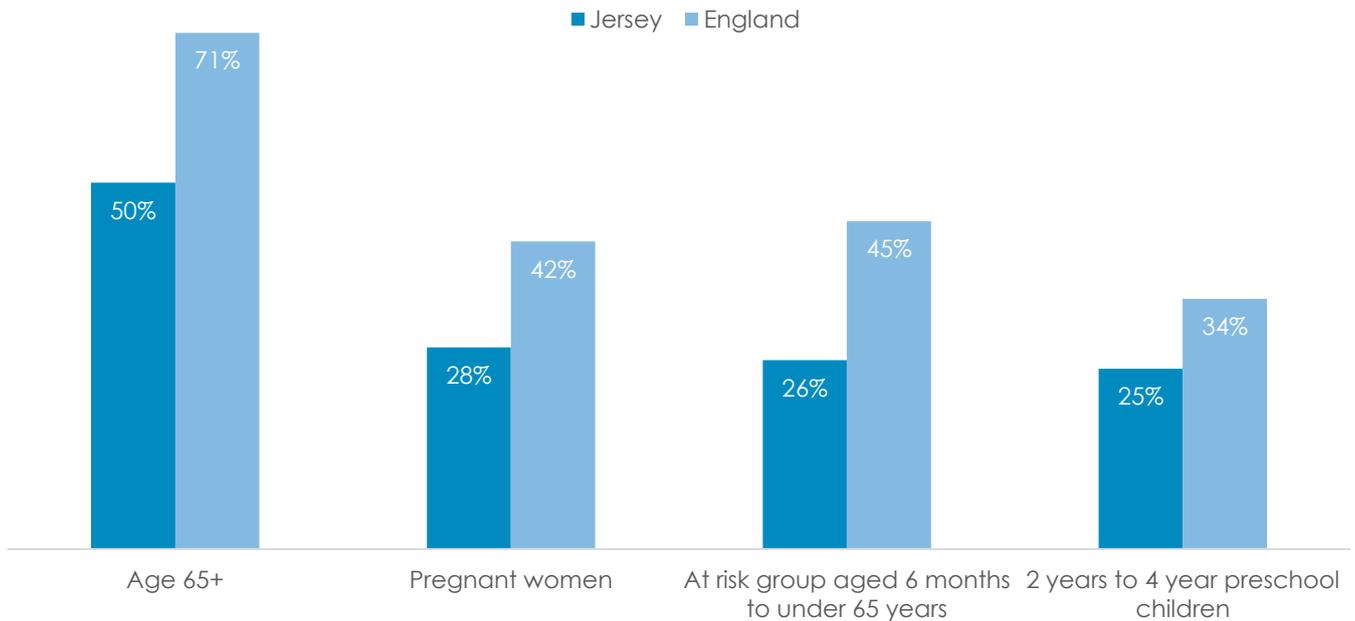
### Seasonal Influenza Vaccinations

Jersey GP practices vaccinate those aged 2-4 years, patients deemed to be 'clinically at risk' due to an underlying health condition, pregnant women and those aged 65 or over aged. Primary school children are vaccinated in school.

<sup>96</sup> Public Health England, The National Flu Immunisation Programme 2016/2017, Published May 2016, available from [www.gov.uk](http://www.gov.uk)

Figures taken from the GP Central Server for winter season 2015/16 compared to data for England are shown in Figure 9.1.

**Figure 9.1: Seasonal influenza vaccine uptake, Jersey and England, winter 2015/2016**



Source: Public Health Statistics Unit, Public Health England Influenza immunisation programme for England: GP patient groups, Data collection survey Season 2015 to 2016

Half (50 per cent) of those aged 65 or over in Jersey had a seasonal influenza vaccine during the 2015/2016 winter period. This compares to around one in four pregnant women (28 per cent), those in at risk clinical groups between 6 months and 64 years (26 per cent) and pre-school children (25 per cent). Figures were lower than those for England and well below the 75 per cent target recommended by the World Health Organisation.

In 2014/15, 70 per cent of children aged 4-5 years (reception year) were vaccinated. The following year, 2015/2016, reception, year 1 and year 2 children were offered the vaccine; coverage was 57 per cent.

### Screening

Jersey offers three population cancer screening programmes to residents:

- colorectal (bowel) cancer screening
- cervical cancer screening
- breast cancer screening.

In addition, a new-born blood spot screening programme screen all babies for nine rare but serious conditions.

An annual report looking in detail at these screening programmes will be published before the end of 2016 by the Public Health Statistics Unit.



# LIFESTYLE

## Smoking

In 2015, nearly one in five (19 per cent) of adults aged 16 or over in Jersey were smokers (daily and occasional), a rate that although slightly less than in 2012 and 2013, has remained largely unchanged in recent years, compared to one in four (25 per cent) a decade earlier in 2005 (Table 10.1). Half of the population of Jersey have never smoked. An Island-wide smoking ban in enclosed public places and work places was introduced in Jersey in January 2007.

### Smoking prevalence

This is estimated in the social survey each year,

It is calculated as the percentage of all adults ages 16 or over who report smoking

The proportion of Islanders who report smoking daily has fallen from around one in five (19 per cent) in 2005 to around one in eight (12 per cent) in 2015.

Similar proportions were found in Guernsey in their 2013 Guernsey Healthy Lifestyle Survey.

**Table 10.1: Smoking habits in Jersey. Percentage by year, 2005-2015, population 16 years or over**

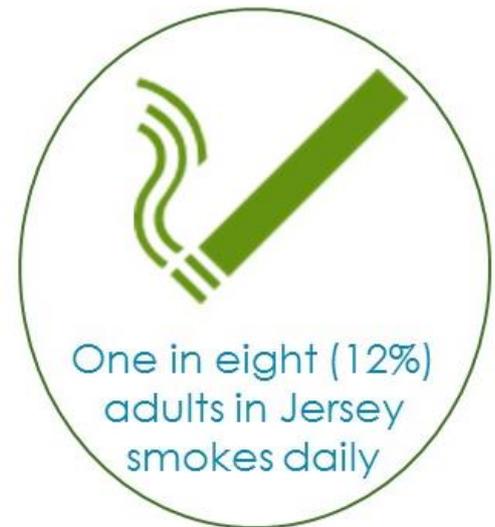
	2005	2007	2008	2010	2012	2013	2014	2015
I have never smoked / I don't smoke	45	48	48	47	46	44	48	50
I used to smoke occasionally but don't now	12	15	15	13	15	15	15	14
I used to smoke daily but don't now	17	17	16	17	17	18	19	17
I smoke occasionally but not everyday	6	6	5	8	6	6	5	6
I smoke daily	19	14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

Note: Numbers independently rounded to nearest integer

Source: Jersey Annual Social Survey 2005-2015

The proportion of the adult population smoking daily varies greatly across countries, ranging from 9 per cent in Brazil to over 36 per cent in Latvia.<sup>97</sup> The OECD average is 20 per cent.<sup>98</sup>

In Jersey, a greater proportion of males than females smoke daily (14 per cent and 11 per cent, respectively), as shown in Figure 10.1. Smoking prevalence is higher among men than women in all OECD countries except Sweden and Iceland.<sup>99</sup>



**Figure 10.1: Proportion of males and females smoking daily and occasionally, 2015**



Source: Jersey Annual Social Survey 2015

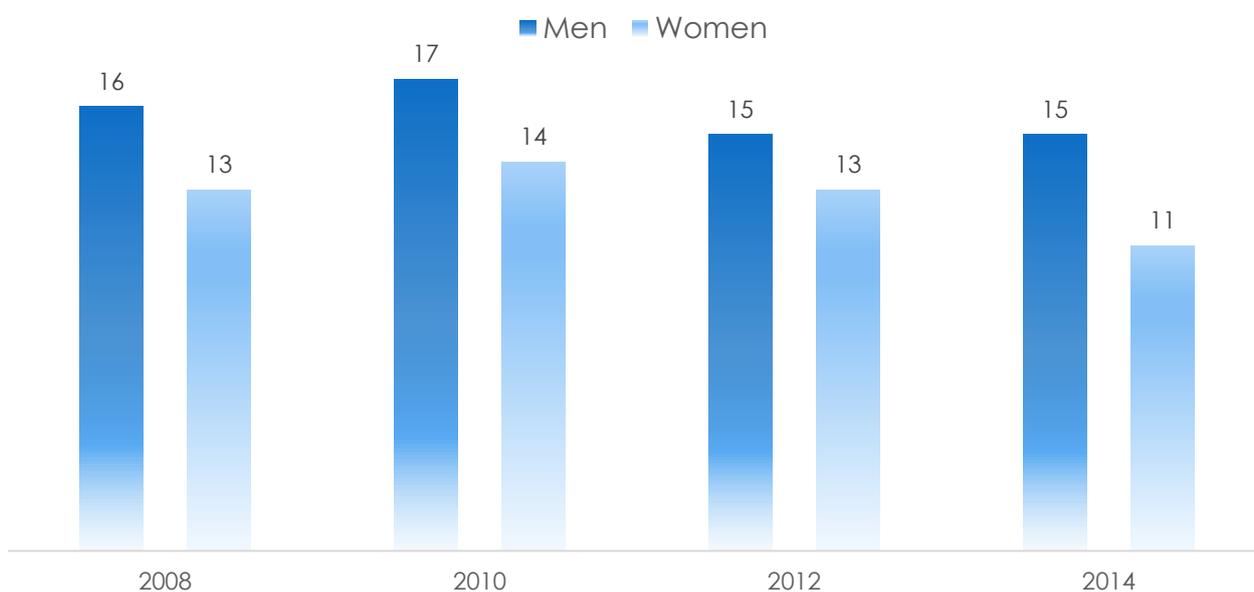
The number of cigarettes smoked each day by daily smokers has decreased since 2008. JASS 2014 found the self-reported average number of cigarettes smoked a day by daily smokers has decreased slightly for males and females (Figure 10.2).

<sup>97</sup> OCED (2016), Daily smokers (indicator), accessed August 2016, available from data.oecd.org

<sup>98</sup> OECD, (2015) 'Tobacco consumption among adults' in Health at a Glance OECD, OECD publications.

<sup>99</sup> OECD, (2016) 'Tobacco consumption among adults' in Health at a Glance 2015: OECD indicators, OECD publications.

**Figure 10.2: Number of cigarettes smoked per day, average for daily smokers only, percentages**



Source: Jersey Annual Social Survey 2014

The findings of the Jersey Smoking Profile 2015<sup>100</sup> also found:

- One in six pupils (aged 10-15 years) reported that they had tried smoking at least once. The proportion of pupils (15 per cent) is the lowest level recorded since the Jersey Schools Health survey began in 1998, when 47 per cent of children at that age reported that they had tried smoking. The latest figure for Jersey is similar to that for England in 2014 (18 per cent).
- Between 2000 and 2014 the price of tobacco increased by 70 per cent more than retail prices generally.
- In 2014, there were over 2,500 admissions to Jersey General Hospital for adults aged 35 or over with a primary diagnosis of a disease that can be caused by smoking. Around 1,000 of these admissions are estimated to have been directly attributable to smoking, corresponding to 4 per cent of all hospital admissions in this age group (35 years or over).
- In 2014, around one in five, 19 per cent (132), of all deaths of adults aged 35 or over were estimated to be directly caused by smoking, a similar proportion to that seen during the past seven years.

<sup>100</sup> Jersey Health Intelligence Unit, Jersey Smoking Profile 2015, published February 2016, available from [www.gov.je](http://www.gov.je)

- Over 900 people set a 'quit date' through the stop smoking service in Jersey in 2014-15. Almost 400 people successfully quit,<sup>101</sup> implying a quit rate of 42 per cent, a rate which is 7 percentage points greater than in the previous year.
- More than four-fifths (83 per cent) of new admissions to HMP La Moye in 2015 were recorded as smokers (a total of 306).

## Smoking behaviour around babies

As part of the 6-week check of new-borns, babies are assessed as to whether they were at risk of exposure to second-hand smoke. In 2015, around a sixth (17 per cent, corresponding to 180 babies) were assessed as being at risk of being exposed to tobacco smoke by an adult (passive smoking).

## Use of Electronic Cigarettes

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

Data recorded in 2014 and 2015, shows that around 4 per cent of the population were using e-cigarettes at least sometimes (defined as sometimes, often or every day). The majority of Islanders (85 per cent in 2015) have never used them. This proportion increases for those who have never smoked (97 per

### **Electronic Cigarettes**

E-cigarettes deliver nicotine that is vaporised and then inhaled from a liquid form via a battery-powered device that simulates cigarette smoking. E-cigarettes are classed as nicotine containing products and are currently regulated as general consumer products.

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<sup>101</sup> As recorded at 4 weeks

cent in 2015) compared to just over half (55 per cent) of those who currently smoke (either daily or occasionally).

### Alcohol

Alcohol use is associated with numerous harmful health and social consequences, including increased risk of liver cirrhosis as well as a range of cancers and of stroke. Alcohol also contributes to death and disability through accidents and injuries, assault, violence, homicide and suicide.<sup>102</sup> Alcohol is considered to be the third leading risk factor for disease and mortality, after tobacco and high blood pressure.<sup>103</sup>

In 2015, the Public Health Statistics Unit (formerly the Health Intelligence Unit) published an updated Alcohol Profile for Jersey with data up to 2014. Where possible indicators presented here have been updated with 2015 data; however, for more detail of alcohol use and its consequences in Jersey please see the report.<sup>104</sup> An updated alcohol profile for Jersey will be published in 2017.

The EU has the highest alcohol consumption in the world. Measured through monitoring annual sales data, per capita consumption in the EU was slightly over 10 litres of pure alcohol per adult in 2012. Lithuania, Estonia and Austria reported the highest consumption of alcohol, with 12 litres or more per adult.<sup>105</sup> In comparison, Jersey's per capita consumption, of 11.5 litres of pure alcohol per adult in 2015,<sup>106</sup> is also relatively high.

#### **Alcohol consumption**

The Jersey Annual Social Survey is used to estimate the drinking behaviour of Islanders and to estimate the impact alcohol has on their lives. As JASS is self-reported, it is likely that local data is an underestimate of the true picture.

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<sup>102</sup> OECD, (2014) 'Alcohol consumption among adults' in Health at a Glance: Europe 2014, OECD publications.

<sup>103</sup> OECD, (2014) 'Alcohol consumption among adults' in Health at a Glance: Europe 2014, OECD publications.

<sup>104</sup> Health Intelligence Unit, Jersey Alcohol Profile 2015, published November 2016, available from [www.gov.je](http://www.gov.je)

<sup>105</sup> OECD, (2014) 'Alcohol consumption among adults' in Health at a Glance: Europe 2014, OECD publications.

<sup>106</sup> States of Jersey Public Health Statistics Unit

The latest consumption figure for Jersey is around 3.5 litres less per capita than a decade earlier, in 2005.

Figure 10.3 converts the per capita consumption for Jersey in 2015 into volumes of different types of drinks.

**Figure 10.3: Conversion of pure alcohol into volumes of different drinks, 2015**



Source: Public Health Statistics Unit

The findings of the 2015 Jersey Alcohol Profile 2015<sup>107</sup> also found:

- One in ten (10 per cent) of respondents to the Jersey Annual Social Survey in 2014 said they never drink alcohol;
- Over the period 2012 to 2014, there were 45 alcohol-related deaths in Jersey (ONS definition) compared to 2 per cent of all deaths in Jersey in those years.
- The most common alcohol-related death was alcoholic liver disease, accounting for three-quarters (76 per cent) of the alcohol-related deaths over this period;

<sup>107</sup> Health Intelligence Unit, Jersey Alcohol Profile 2015, published November 2016, available from [www.gov.je](http://www.gov.je)

## 10. Lifestyle

- In 2014, there were around 500 individuals admitted to the Jersey General Hospital for a condition that was wholly attributable to alcohol.<sup>108</sup> This number has remained at a similar level in each of the past three years;
- One in five of all crimes recorded in 2013 and 2014 had alcohol involvement whilst almost 500 incidents of domestic violence involving alcohol have been reported to the States of Jersey Police since 2012;
- Between 2000 and 2014 the price of alcohol increased by 14 per cent more than retail prices generally.

As one in ten (10 per cent) of Islanders report drinking no alcohol, it follows that some will be drinking at higher levels than those shown in Figure 10.3.

### Self-Reported Drinking Patterns

The Department of Health in England has recently updated the advice for alcohol consumption to prevent health and social consequences.<sup>109</sup> The department now advises that to keep health risks to a low level:

- men and women should not regularly drink more than 14 units a week
- drinking should be spread over three or more days if regularly drinking as much as 14 units a week.
- Pregnant women are advised to avoid alcohol altogether.<sup>110</sup>

This recent advice updates previous health advice where drinking more than 2 to 3 units for women and 3 to 4 units for men a day was classified as drinking at increasing risk to health. Drinking twice this amount per day was classified as being at higher risk of alcohol-related harm.

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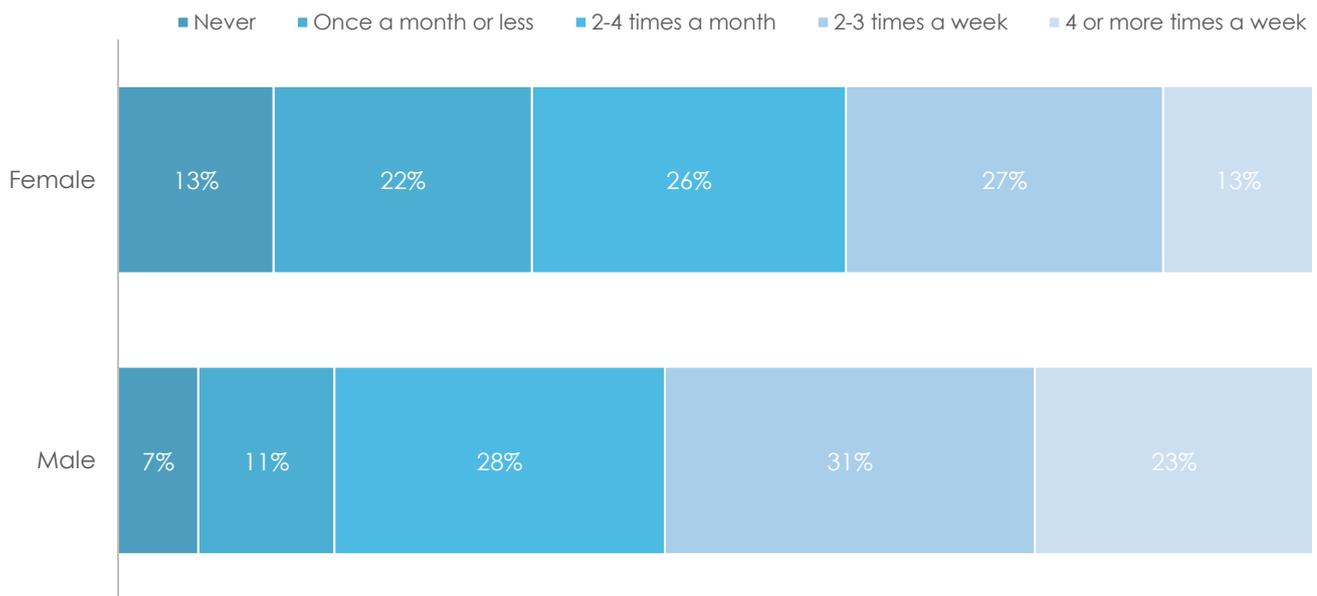
<sup>108</sup> Alcohol-attributable hospital admissions are admissions due to conditions where alcohol is causally implicated in all cases of the condition: for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. This method has been developed by Public Health England.

<sup>109</sup> Department of Health (2016), UK Chief Medical Officers' Alcohol Guidelines Review: Summary of the proposed new guidelines, published January 2016, [www.gov.uk](http://www.gov.uk)

<sup>110</sup> Department of Health (2016), UK Chief Medical Officers' Alcohol Guidelines Review: Summary of the proposed new guidelines, published January 2016, [www.gov.uk](http://www.gov.uk)

Self-reported data shows that in Jersey in 2014 almost half of adults (persons aged 16 and above) drink two or more times a week.<sup>111</sup> This proportion has remained unchanged since 2010. Figure 10.4 shows the pattern of drinking by gender.

**Figure 10.4: How often respondents drink alcohol, by gender**



Source: Jersey Annual Social Survey 2014

Almost half (45 per cent) of 16 to 34 year old drinkers reported drinking five or more units when they usually drank, exceeding the previously recommended daily limits for both males and females. This proportion decreased with age, with one in ten (10 per cent) of those aged 65 or over reporting drinking five or more units when they usually drank.

Differences in drinking patterns by socio-economic variables can be derived for the JASS 2014 data:

- Around one in three (34 per cent) of those born outside of the British Isles reported drinking at least twice a week. This compares to around two-fifths (42 per cent) of Jersey born respondents and over half (56 per cent) of those born elsewhere in the British Isles.
- Drinking behaviours did not differ by achieved education level.

<sup>111</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2014, published 25 November 2014, available from [www.gov.je/statistics](http://www.gov.je/statistics)

## 10. Lifestyle

- Around half of those working in managerial and professional occupations (52 per cent) and those working in technical and clerical occupations (49 per cent) report drinking at least twice a week. This compares to around two-fifths (39 per cent) of people working in manual and routine professions.
- One in five (21 per cent) of those living in States, Parish and Housing Trust rented accommodation reported never drinking. This compares to 7 per cent of owner occupiers, 8 per cent of non-qualified renters and 13 per cent of qualified renters.

### Hazardous or Harmful Drinking

Around one in four (27 per cent) of local drinkers were found to be drinking at potentially hazardous or harmful levels as defined by the FAST score.<sup>112</sup> Table 10.2 shows the proportion of each age and gender group were indicated their drinking behaviour was potentially hazardous or harmful to their health.

#### **Fast Alcohol Screening Test (FAST)**

A 4-item screening tool designed to highlight potential hazardous or harmful drinking behaviours. Hazardous drinking is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual. Harmful drinking denotes the most hazardous use of alcohol, at which damage is likely.

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<sup>112</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2014, published 25 November 2014, available from [www.gov.je/statistics](http://www.gov.je/statistics)

**Table 10.2: Percentage of hazardous and harmful drinkers (FAST score of 3 or more, excluding non-drinkers), by age and gender**

Age	Males (%)	Females (%)	All Persons (%)
16-34 years	34	29	31
35-44 years	43	19	31
45-54 years	38	20	29
55-65 years	25	26	25
65 years and older	20	5	13
<b>16+ population</b>	<b>33</b>	<b>21</b>	<b>27</b>

Source: Jersey Annual Social Survey 2014

An estimate of the number of Islanders who drink at hazardous and harmful levels, indicate that around 20,000 Islanders have drinking behaviours that are potentially hazardous or harmful.

It should be noted that a survey of the local household population is likely to under-represent alcohol dependent adults, who are more likely to be homeless or in an institutional setting.

Moreover, problem drinkers who do live in private households may, like problem drug users, be less able or willing to participate in surveys.

## Drinking and Pregnancy

Details about alcohol consumption during pregnancy are collected by the Maternity Department during pre-natal checks.

Of those woman who were pregnant in 2015:

- 96 per cent reported not drinking during pregnancy
- around two-fifths (41 per cent) said they didn't drink prior to getting pregnant.
- Those woman (4 per cent) who said they drank during pregnancy reported drinking only occasionally.

Information about drinking habits of pregnant woman in Great Britain is collected using survey data, so results are not directly comparable to those of Jersey.

## Healthy weight and obesity

The increasing prevalence of obesity amongst adults and children in the developed world is recognised as a significant public health challenge.

Obesity is a known risk factor for numerous health problems, including hypertension, high cholesterol, diabetes, cardiovascular diseases, and some forms of cancer. Since obesity is associated with higher risks of chronic illness, the condition is linked to significant additional health care costs.<sup>113</sup>

Being overweight or obese can also have adverse social consequences through discrimination, social exclusion and loss of earnings, and adverse consequences on the wider economy through, for example, working days lost.<sup>114</sup>

The latest available data<sup>115</sup> shows that the overall distribution of Islander's BMI has not changed significantly since 2008. Currently around 14 per cent of the adult population are classified as obese and an additional 37 per cent are classified as overweight, see Table 10.3.

### Body Mass Index (BMI)

The weight status of Islanders is currently estimated in the annual social survey from self-reported height and weight.

BMI is a person's weight (Kg) divided by their height (m<sup>2</sup>):

<18.5 = underweight  
18.5-24.9 = healthy weight  
25-29.9 = overweight  
≥ 30 = obese

Obesity scores can be further divided into obese, very obese and morbidly obese. Jersey data is self-reported and is likely to underestimate the true population level.

<sup>113</sup> OECD (2014) 'Overweight & obesity among adults' in Health at a Glance: Europe 2014, OECD publications.

<sup>114</sup> Public Health England, National Obesity Observatory [www.noo.org.uk](http://www.noo.org.uk)

<sup>115</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2015, published November 2015, available from [www.gov.je/statistics](http://www.gov.je/statistics)

**Table 10.3: Distribution of BMI category by year**

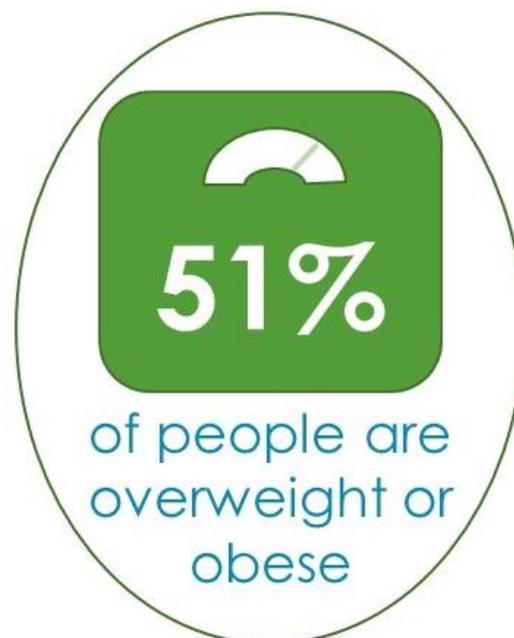
	2008	2010	2013	2015	Guernsey 2013
<b>Underweight</b>	3	2	2	1	2
<b>Normal weight</b>	53	48	51	47	46
<b>Overweight</b>	32	34	32	37	33
<b>Obese</b>	9	11	11	10	
<b>Very obese</b>	2	4	4	2	18
<b>Morbidly obese</b>	1	1	1	2	

Source: Jersey Annual Social Survey 2015, Guernsey Public Health and Strategy Directorate

Guernsey data shows a similar proportion of adults were overweight and obese to Jersey in 2013.

These data show that the proportion of our population that are obese or overweight is lower than the latest figures for England and similar to the EU average. Public Health England reported that almost two-thirds of adults in England (65 per cent) were defined as having excess weight over the period 2012-2014.<sup>116</sup> In the EU, data indicates that more than half (53 per cent) of the adult population of the EU are overweight or obese with around 17 per cent being obese in 2012.<sup>117</sup>

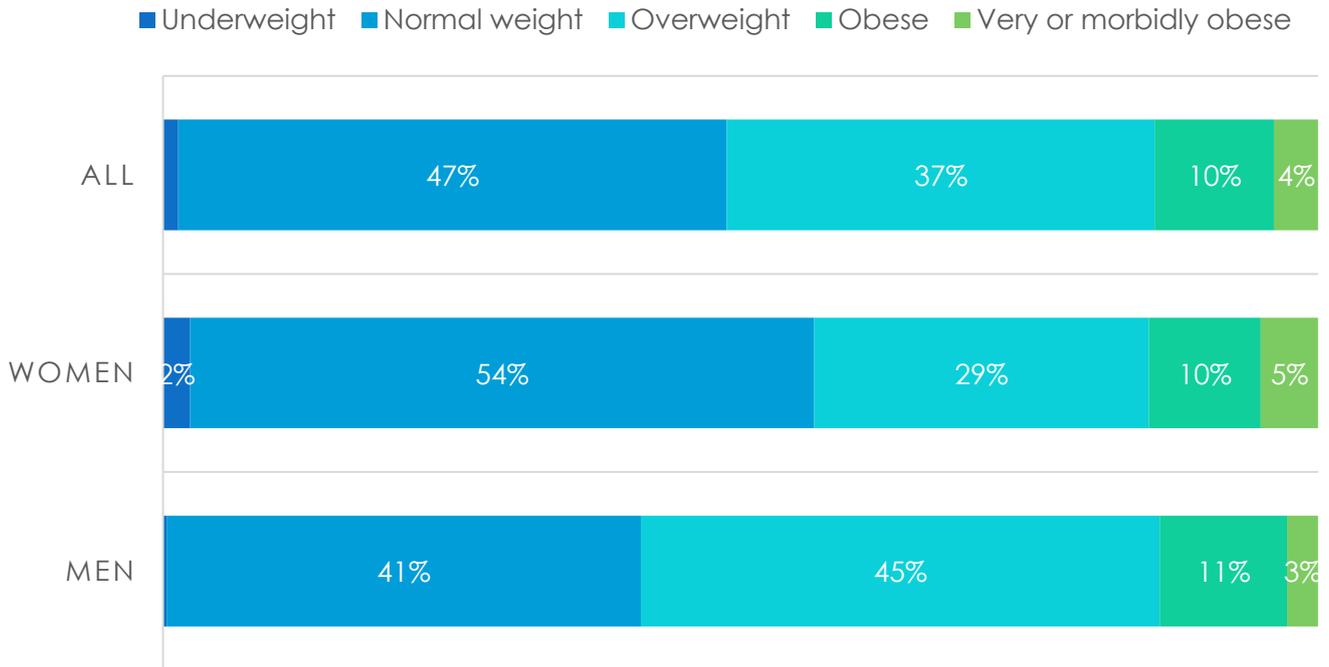
In Jersey, over half (54 per cent) of adult women in Jersey and around two-fifths (41 per cent) of adult men had a normal BMI (Figure 10.4). Similar proportions of men and women were obese, very obese or morbidly obese. A greater proportion of men were reported to be overweight than women.



<sup>116</sup> Public Health England, Public Health Outcomes Framework: Health improvement, updated October 2016, available from [www.phoutcomes.info](http://www.phoutcomes.info)

<sup>117</sup> OECD (2014) 'Overweight & obesity among adults' in Health at a Glance: Europe 2014, OECD publications.

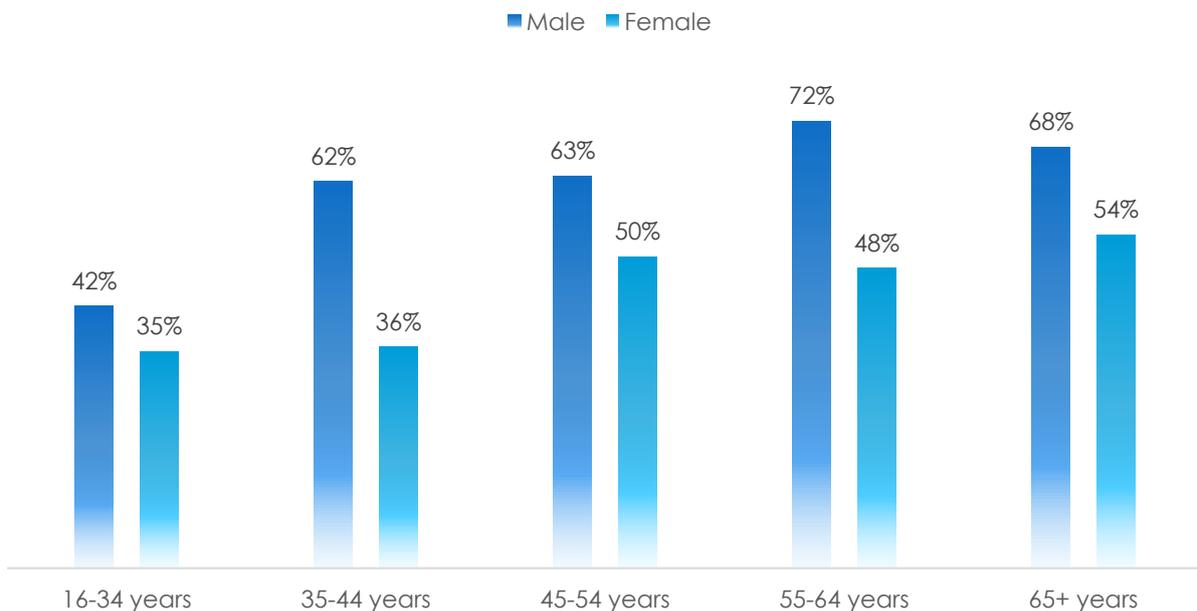
Figure 10.4: Percentage weight status by sex of respondents



Source: Jersey Annual Social Survey 2015

For men, the highest proportion of those with a BMI greater than 25 (overweight, obese, very obese or morbidly obese) was found in those aged 55-64 years. For women, the highest proportions were in those aged 45 or over (Figure 10.5).

Figure 10.5: Overweight and obese persons by age and gender



Source: Jersey Annual Social Survey 2015

In Guernsey, the distribution of the BMI was found to be similar to that of Jersey, with more men in the overweight and obese category than women.

The BMI calculation can classify individuals with a proportionately large muscle mass as being overweight or obese.<sup>118</sup> Using waist measurements together with BMI can identify the proportion of the population at risk of visceral fat (fat stored intra-abdominally), which can lead to the metabolic syndrome.<sup>119</sup>

Table 10.4 and 10.5 show the distribution for the adult population of Jersey in 2015 for males and females, respectively for being at risk of cardiovascular diseases and diabetes, applying the colour code:

	Very high risk
	High risk
	Increased risk

**Table 10.4: Cardiovascular disease risk as indicated by waist circumference and BMI, males**

BMI classification	Waist circumference		
	<94 cm	94-102 cm	102+ cm
Underweight	0	0	0
Normal weight	38	2	0
Overweight	37	7	1
Obese	4	6	4

Source: Jersey Annual Social Survey 2015

<sup>118</sup> UK Faculty of Public Health (2008), Health weight, healthy lives: a toolkit for developing local strategies: Tool E3 Measurement and Assessment of overweight and obesity – Adults, Available from [www.fph.org.uk](http://www.fph.org.uk)  
<sup>119</sup> The metabolic syndrome is a cluster of metabolic disorders, including high blood pressure, high blood glucose levels, high cholesterol and abdominal obesity among others. When an individual presents with these conditions together, the chances for future cardiovascular disease is greater than any one factor presenting alone.

## 10. Lifestyle

Of those men classified by BMI as overweight, the majority reported a waist circumference which classified them as low risk.<sup>120</sup> Around one in ten (11 per cent) are at high risk or worse as classified through the combined measurement of BMI and waist circumference.

The distribution of waist measurements for women reflects the difference in storage of fat between the genders. Almost a fifth (19 per cent) were found to be at high risk or worse.

**Table 10.5: Cardiovascular disease risk as indicated by waist circumference and BMI, females**

BMI classification	Waist circumference		
	<80 cm	80-88 cm	88+ cm
Underweight	3	0	0
Normal weight	46	11	3
Overweight	9	8	10
Obese	1	1	8

Source: Jersey Annual Social Survey 2015

## Healthy Eating

Poor diet and nutrition are recognised as major contributory risk factors for ill health and premature death.<sup>121</sup> In the UK, public health experts have recommended that adults and children eat five or more portions of fruit and vegetables each day ([www.5aday.nhs.uk](http://www.5aday.nhs.uk)).

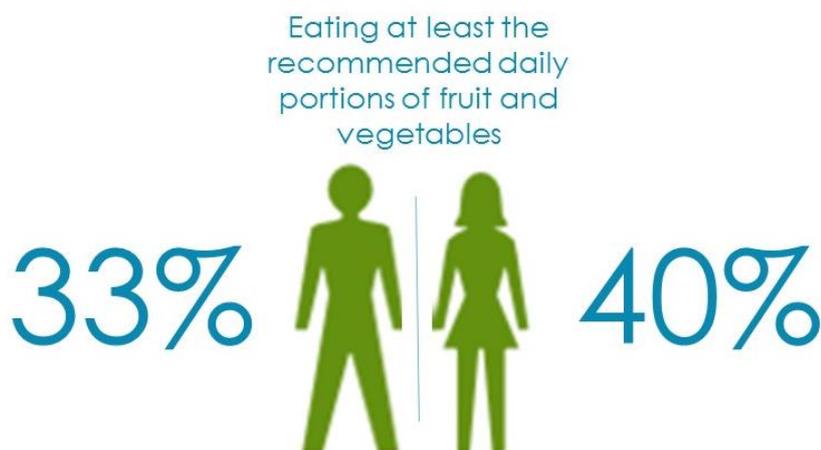
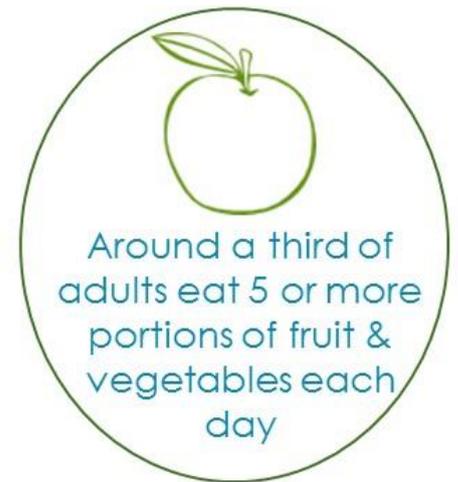
The latest data shows that almost two-thirds (63 per cent) of adults in Jersey eat less than this recommended daily amount of fruit and vegetables, a proportion unchanged since 2008. Almost one in twenty (4 per cent) had not eaten any fruit or vegetables during the previous day.<sup>122</sup>

<sup>120</sup> It is possible that men may underestimate their own waist measurement, based on their trouser waist sizing rather than a direct measure around the most prominent part of their abdomen.

<sup>121</sup> HSCIC (2016), *Statistics on obesity, Physical Activity and Diet England 2016*, published April 2016 [www.hscic.gov.uk](http://www.hscic.gov.uk)

<sup>122</sup> States of Jersey Statistics Unit, *Jersey Annual Social Survey 2015*, published November 2015, available from [www.gov.je/statistics](http://www.gov.je/statistics)

Overall, 37 per cent of all adults (16+) in Jersey reported eating the recommended 'five-a-day' (33 per cent of men and 40 per cent of women). This is higher than reported figures for Guernsey where 22 per cent of women and 19 per cent of men reported eating the recommended number of portions of fruit and vegetables.



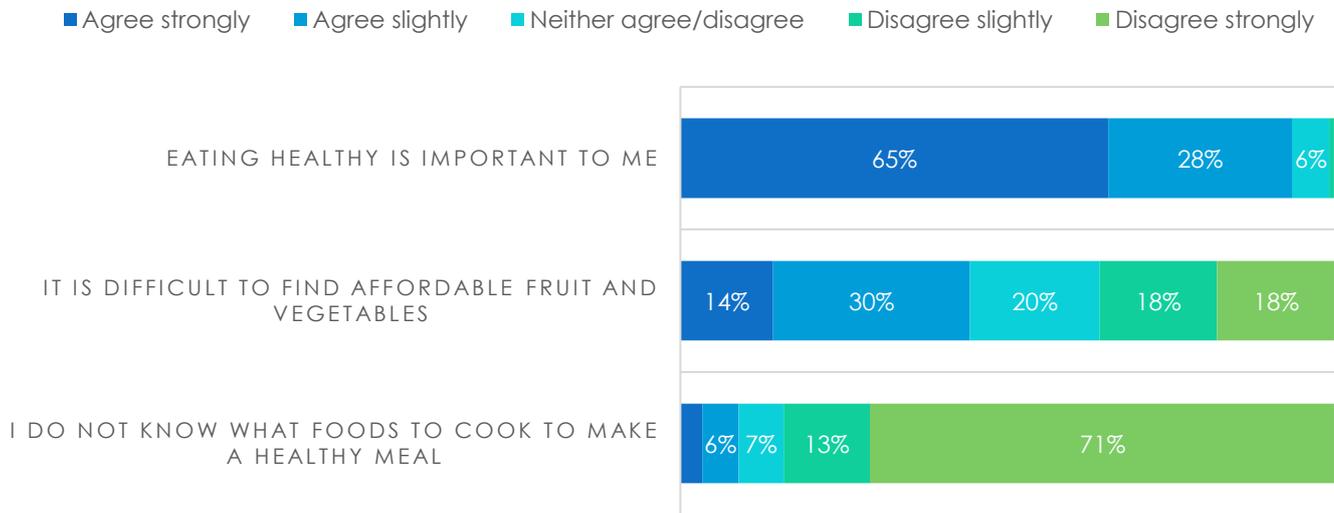
The Jersey figures are higher than the latest available figures for England, where 25 per cent of men and 28 per cent of women were consuming at least 5 portions of fruit and vegetables a day.<sup>123</sup>

A series of questions were included in JASS 2015 to explore various potential barriers to eating healthily. Although the majority of residents (93 per cent) agreed with the statement that 'eating healthily is important' to them at some level, almost half thought that 'it is difficult to find affordable fruit and vegetables' in Jersey. Figure 10.6 shows the results for these questions.

<sup>123</sup> HSCIC (2016), *Statistics on obesity, Physical Activity and Diet England 2016*, published April 2016  
www.hscic.gov.uk

## 10. Lifestyle

**Figure 10.6: “How much do you agree or disagree with the following statements about healthy eating?”**



Source: Jersey Annual Social Survey 2015

There was little difference when these questions were examined by gender. However, there were differences in knowledge about what to cook to make a healthy meal when considered by tenure. One in five (19 per cent) of those living in social housing didn't know what to cook, compared to less than one in ten of those in other tenures (7 per cent of owner occupiers and 9 per cent of qualified and non-qualified renters).



of people living in social housing indicated they did not know what foods to cook to make a healthy meal

## Physical activity

An unhealthy diet and a sedentary lifestyle are known risk factors for the three leading causes of death in adults: cancer, stroke and cardiovascular disease.

The recommended level of physical activity for adults is to engage in at least five sessions of moderate intensity activity each of a least 30 minutes per week.<sup>124</sup> Over half (55 per cent) of respondents to JASS 2015 reported an activity level which met or exceeded this recommendation. A slightly higher proportion of men (59 per cent) met or exceeded this recommended level of physical activity than women (51 per cent). There has been no significant change in the levels of physical activity of residents since the questions were last asked in 2013.

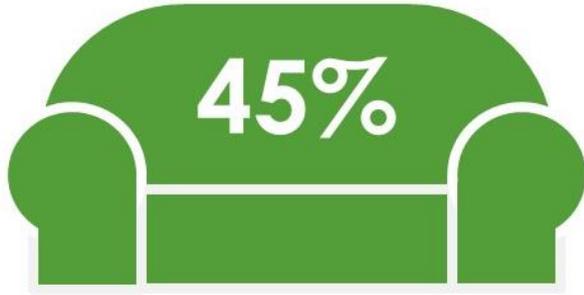
This compares to over a quarter (30 per cent) of adults in Guernsey in 2013.

**Table 10.6: Frequency of weekly moderate intensity sport or physical activity for 30 minutes or longer**

Frequency per week	Whilst at a sports club or using public facilities	Elsewhere (e.g. cycling to work, heavy gardening)	Any episode of physical activity
None	48	10	9
Once	12	11	4
Twice	14	16	9
Three times	14	16	12
Four times	6	10	12
Five or more times	6	36	55
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source: Jersey Annual Social Survey 2015

<sup>124</sup> UK department of Health, [www.dh.gov.uk](http://www.dh.gov.uk)

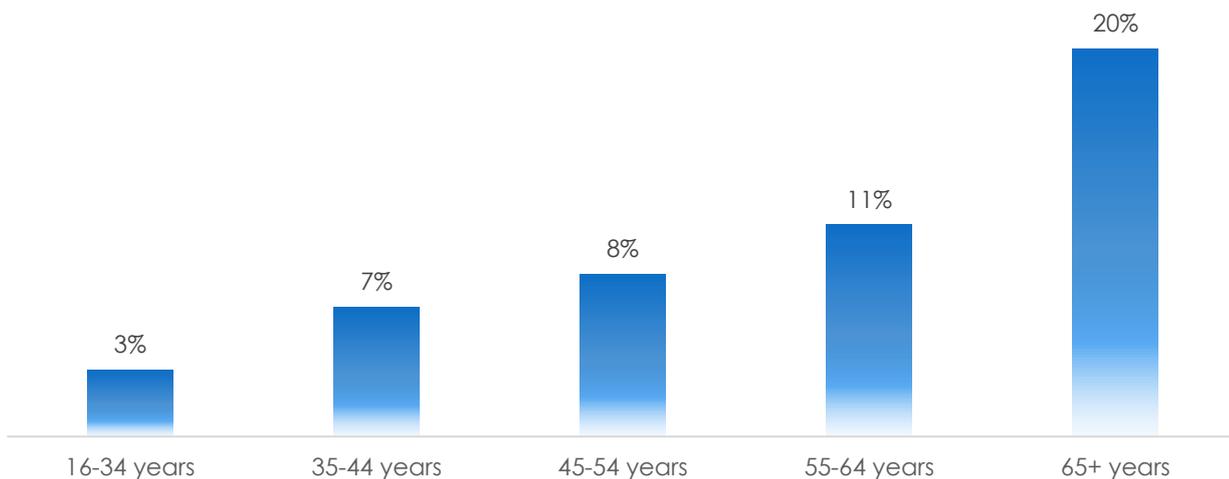


of people do not do enough physical activity each week

Fewer than one in ten (9 per cent) of adults in Jersey aged 16 or over reported undertaking no physical activity at all. Due to differences in questions, the Jersey figures cannot be compared with those for England.

The proportion of those doing no physical activity increases with age, with one in five (20 per cent) of people aged 65 years or over reporting that they did not do any in a typical week (Figure 10.7).

**Figure 10.7: Proportion of each age group who report doing no moderate intensity physical activity during a typical week**



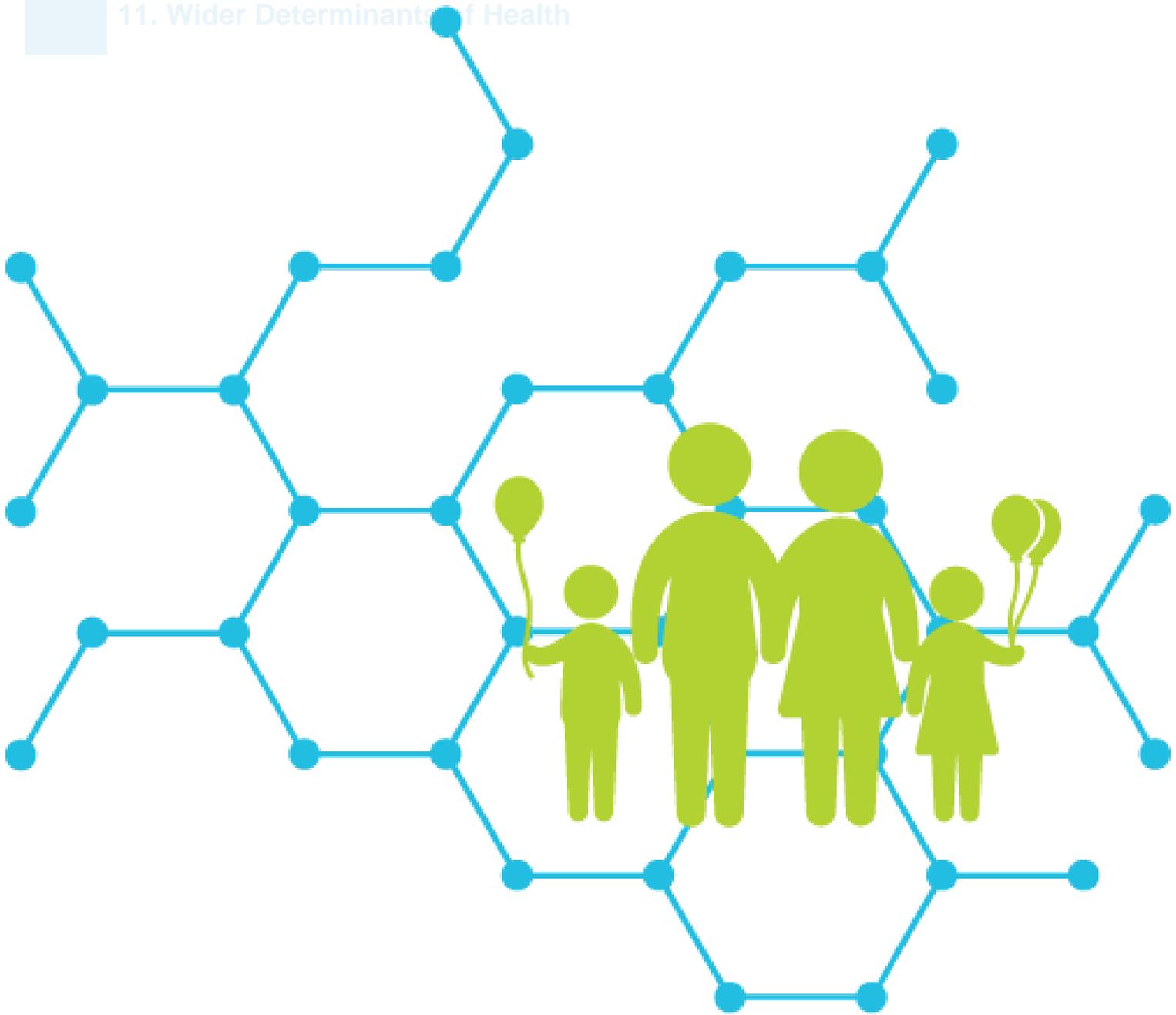
Source: Jersey Annual Social Survey 2015

When asked to rate their level of physical activity, a fifth (20 per cent) reporting being 'very' physically active, and 59 per cent were 'fairly' physically active. The remainder were either 'not very' (18 per cent) or 'not at all' (3 per cent) physically active. A slightly higher proportion of men

reported being at least 'fairly' active compared to women (82 per cent of men compared to 76 per cent of women), although the difference was not significant.



- Jersey Health Intelligence Unit, Jersey Smoking Profile 2015, published February 2016, available from [www.gov.je](http://www.gov.je)
- Health Intelligence Unit, Jersey Alcohol Profile 2015, published November 2016, available from [www.gov.je](http://www.gov.je)
- States of Jersey Public Health Statistics Unit, Annual Report on the deaths of Jersey residents 2015, published August 2016, available from [www.gov.je](http://www.gov.je)



# WIDER DETERMINANTS OF HEALTH

## Social determinants of health

The social determinants of health have been described as 'the causes of the causes'.

- They are the social, economic and environmental conditions that influence the health of individuals and populations.
- They include the conditions of daily life and the structural influences upon them, themselves shaped by the distribution of money, power and resources at global, national and local levels.
- They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances and feel able to make healthier lifestyle choices.

There is a clear link between the social determinants of health and health inequalities, defined by the World Health Organisation as "the unfair and avoidable differences in health status seen within and between countries".<sup>125</sup>

These factors concern the environment, the economy, society and health as a whole and are generally interconnected with one another as shown in the Dahlgren and Whitehead model<sup>126</sup> (see Figure 11.1).

Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are some of the factors that affect the health of individuals and communities. Similarly, good education, inspired public planning and support for healthy living can all contribute to healthier communities.

Much of the information to monitor these determinants are produced and published in Jersey by Government Departments and Organisations. This section details many of these indicators, in comparison to other jurisdictions where appropriate.

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<sup>125</sup> Local Government Association, Understanding and tackling the wider social determinants of health, published 3 November 2010, available from [www.local.gov.uk](http://www.local.gov.uk)

<sup>126</sup> Dahlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Stockholm Institute for Further Studies; 1991.

Figure 11.1: The determinants of Health



Source: Dahlgren and Whitehead, 1991

### Household Income

The latest local Income Distribution Survey<sup>127</sup> (2014-2015) found that mean and median household incomes had increased **by less than inflation** (as measured by the Retail Prices Index) since 2009-2010.

Average (mean) household weekly income was £860 per week before housing costs and £720 after. Median average equivalised income (£680 per week before housing costs, and £560 per week after) was around 50 per cent higher in Jersey than the UK in 2014/15.

#### Socioeconomic status

This is commonly understood as the social standing or class of an individual or group. Based on income, education and occupation in relation to others.

Lower socioeconomic position has been shown to be associated with poorer health.

<sup>127</sup> States of Jersey Statistics Unit, Jersey Household Income Distribution 2014/15, published 13 November 2015, available from [www.gov.je](http://www.gov.je)



Of household  
income was from  
employment  
earnings in 2014/15

Three-quarters (75 per cent) of household income in Jersey came from employment earnings, whilst 4 per cent was from Income Support, benefits and

grants and 12 per cent was from pensions.

The relative low income threshold (60 per cent of median) was £410 per week before, and £340 after housing costs. After housing costs 26 per cent of households and 23 per cent of individuals were living in relative low income.



**1 in 4** households were in relative  
low income in 2014/15

More than a quarter (28 per cent) of pensioners<sup>128</sup> in Jersey were in relative low income, twice the proportion of that in the UK (14 per cent).

More than a quarter (29 per cent) of children were in relative low income, a similar proportion to the UK (28 per cent).

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<sup>128</sup> Pensioner households: includes one adult living alone at or above pensionable age (65 years for men, 60 years for women), or a couple, both of whom were at or above pensionable age.

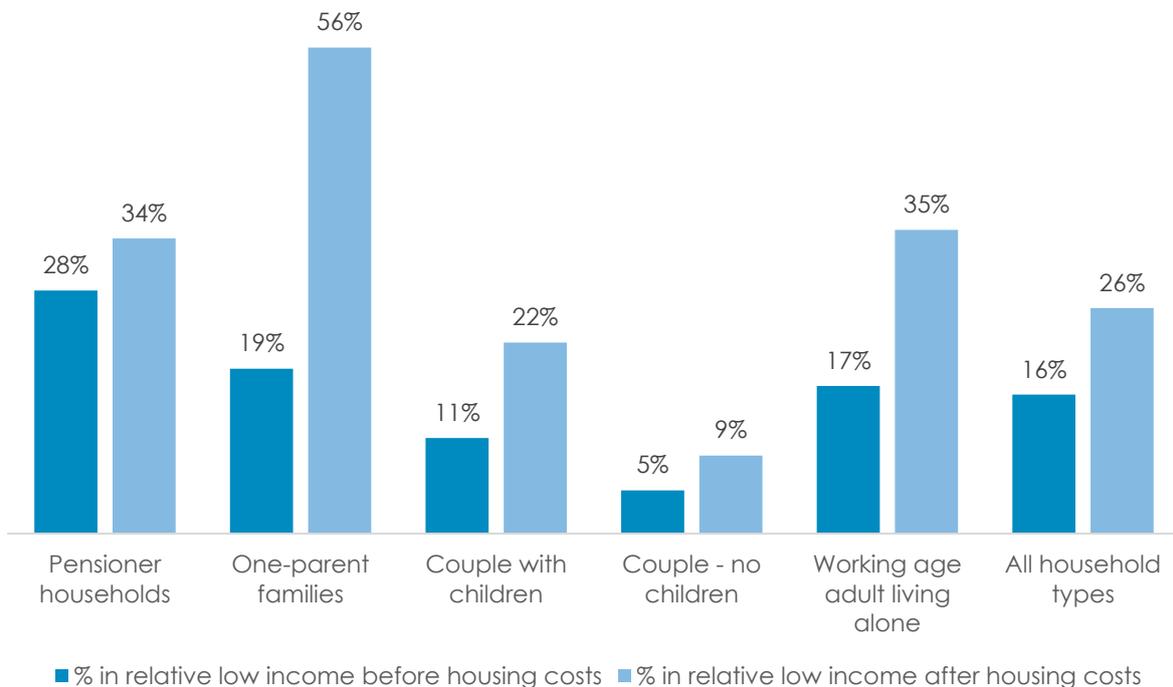


**More than a quarter of children were in relative low income in 2014/15**

Over half (56 per cent) of one parent families were in relative low income after housing costs.

Figure 11.2 shows the proportion of each household type in relative low income before and after housing costs.

**Figure 11.2: Proportion of each household type in relative low income before and after housing costs**



Source: States of Jersey Statistics Unit

## Income inequality

The income distribution survey<sup>129</sup> also provides measures of income inequality. The 90-10 shares ratio divides the mean average income of those households in the top 10 per cent by the mean average income of those households in the bottom 10 per cent. The top 10 per cent of households had an average income 9 times that of the bottom 10 per cent before housing costs, rising to 19 times that of the bottom 10 per cent after housing costs, showing housing costs increase income inequality.

The Gini coefficient is an indicator taking values between 0 and 1, where 0 represents complete equality (all households have equal income) and 1 represents complete inequality (one household accounts for all the income). A reduction in the Gini coefficient represents a more equal distribution of incomes across households.

In 2014/15, the Gini coefficient after housing costs was 0.41 in Jersey.

Since 2009/10, income inequality has increased, that is the distribution of household income has become more unequal, particularly after housing costs are included. In 2014/15, income inequality was worse in Jersey than in the UK (Gini coefficient of 0.39 in UK 2013/14 compared to 0.41 in Jersey 2014/15).

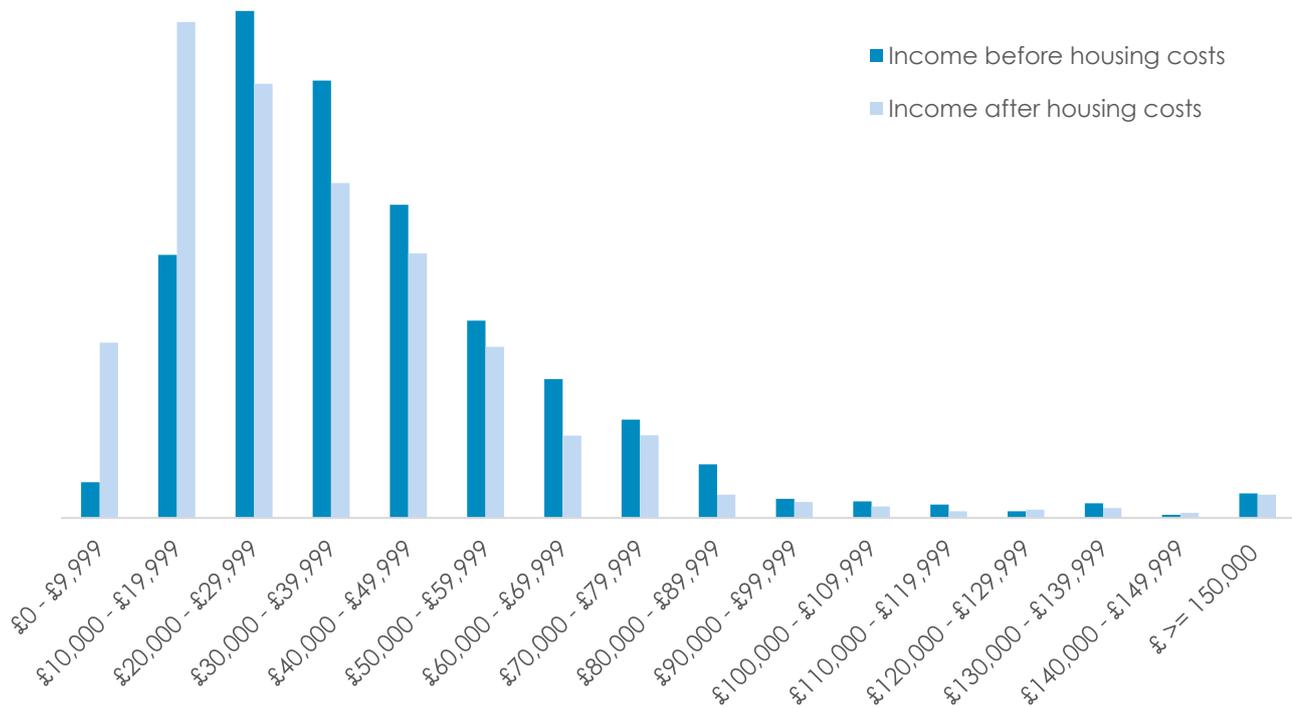
The equivalised household income<sup>130</sup> for Jersey households before and after housing costs shows that more households fall into the lower income bands, once housing costs are taken into account. Figure 11.3

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<sup>129</sup> States of Jersey Statistics Unit, Jersey Household Income Distribution 2014/15, published 13 November 2015, available from [www.gov.je](http://www.gov.je)

<sup>130</sup> To remove the variation caused by differences in household size, and also in make-up (e.g. numbers of children versus adults), a process of equivalisation is used to standardise every household to the same household size and type.

**Figure 11.3: Equivalised household income before and after housing costs, 2014/15**



Source: States of Jersey Statistics Unit

### Employment status

The economic activity rate is the proportion of those in employment, or actively seeking employment, as a percentage of all those of working age (between 16 and 64 for men, and 16 and 59 for women, inclusive).

In relative terms, employment levels in Jersey are high (see Table 11.1). In 2011, the lowest rate was for Jersey-born residents (75 per cent) and the highest rate was for people born in Poland (94 per cent). The economic activity rate for Jersey-born residents of working age was lower than the rates of those born in other jurisdictions. This is as a result of the higher proportion of Jersey-born people who are in full-time education.

**Table 11.1: Economic activity rates (working age adults, percent)**

	JASS 2015	Census 2011
Men (16-64 years)	90	86
Women (16-59 years)	82	77
<b>All</b>	<b>86</b>	<b>82</b>

Source: Jersey Annual Social Survey 2015

The Jersey Annual Social Survey includes questions to gain an indication of the economic activity rate each year. However, due to a higher tendency for working adults to respond to the questionnaire, the economic activity rate continues to be slightly higher in the JASS survey compared to the full population census figure seen in 2011.

Almost one in six (15 per cent) adults over working age (i.e. over 59 years for women and over 64 years for men) were economically active.

## Unemployment rate

The internationally comparable unemployment rate is defined by the International Labour Organisation (ILO). This includes both the registered unemployed and those not registered unemployed but still seeking work.

In recent years, the ILO unemployment rate for Jersey<sup>131</sup> has been between 4 and 6 per cent:

- 4.7 per cent in March 2011, measured by the 2011 Jersey census, corresponding to 2,570 people being unemployed and looking for work in March 2011
- 5.7 per cent in June 2013, measured by the 2013 Jersey Annual Social Survey, corresponding to 3,200 people being unemployed and looking for work in June 2013

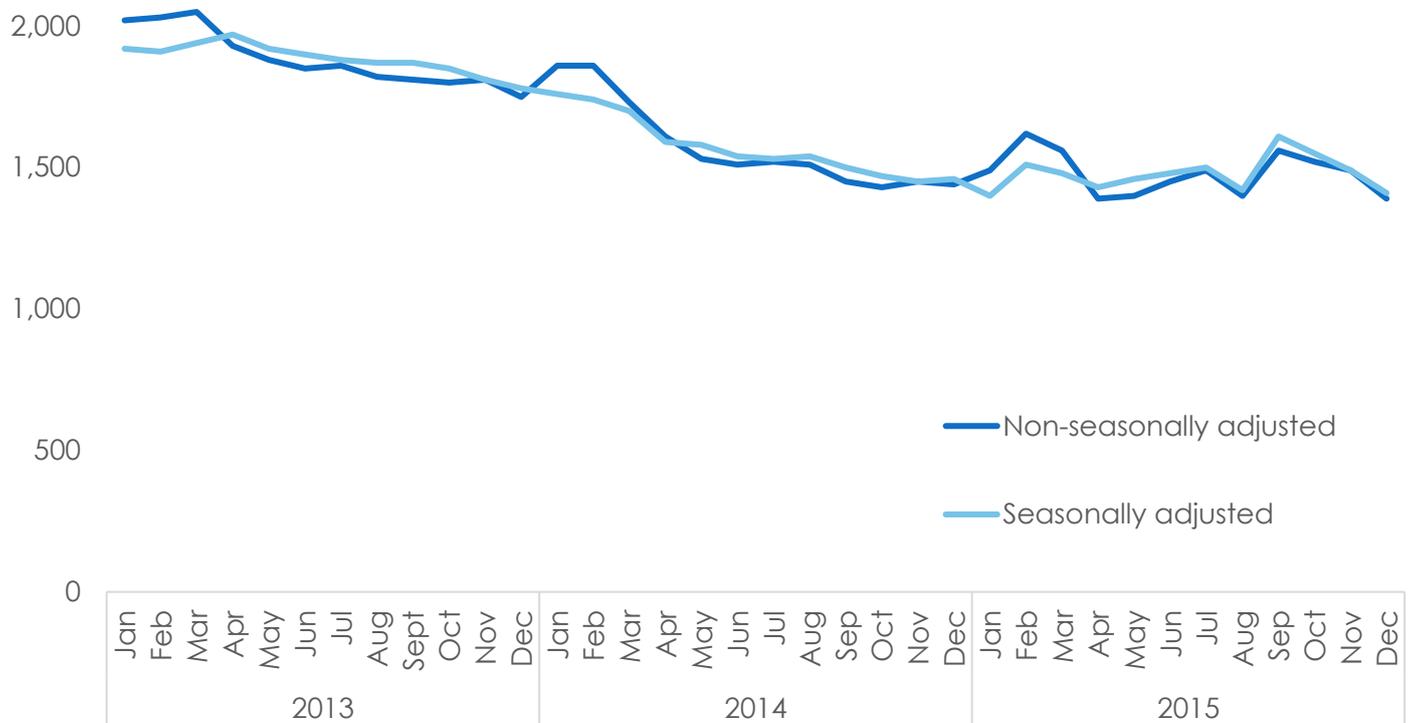
<sup>131</sup> The ILO unemployment rate for Jersey is measured by the Annual Social Survey, the Household Spending and Income Survey and the Census.

## 11. Wider Determinants of Health

- 4 per cent in the period of April 2014 to May 2015, measured by the 2014/2015 Household Spending and Income Survey, corresponding to 2,500 people being unemployed and looking for work

Figure 11.4 shows the registered numbers of people actively seeking work over the three-year period 2013 to 2015. March 2013 saw the largest number of people (2,050 people) registered, the figure had decreased to 1,390 by December 2015.

**Figure 11.4: Total number of individuals registered as Actively Seeking Work, 2013-2015<sup>132</sup>**



Source: States of Jersey Statistics Unit

<sup>132</sup> States of Jersey Statistics Unit, Registered Actively Seeking Work, September 2016, published 11 October 2016, available from [www.gov.je](http://www.gov.je)

## Benefit Claimants

At the end of 2015, over 6,000 households were being supported by the Social Security Department through income support payments totalling £74.9 million in 2015.<sup>133</sup> This benefit supported 8,000 adults and around 3,400 children.

Around 18,000 pensioners in Jersey received a pension from Jersey at the end of 2015, whilst another 12,000 (living outside the Island) received a pension from Jersey.

## Jersey Pupil Premium

A new scheme called Jersey Premium,<sup>134</sup> designed to help children get the best from their education, was launched as a pilot in 2016. Under this scheme, schools in Jersey can receive extra funding for pupils who qualify, which is used to directly support their learning. The money can be used in different ways, depending on what would help the individual pupil most. For example, pupils may receive extra help with English and Mathematics, support for reading, extra equipment or the use of clubs before/after school.

### Who is eligible?

- Children who live in a household receiving Income Support
- Children who live in a household that *could* receive Income Support (i.e. it meets the requirements of the Social Security Department) but have not yet lived in Jersey for five years or more (from 2017 onwards)
- Looked After Children (i.e. who are under the care of Social Services)

Overall 22 per cent of pupils of compulsory school age in States schools in Jersey were known to be eligible to receive Jersey Premium funding in January 2016, corresponding to 2,165 pupils.

States schools have an average rate of eligibility of 23 per cent (Primary) compared to 20 per cent (Secondary).

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<sup>133</sup> States of Jersey Social Security Department, Social Security Annual Report 2015, published 7 October 2016, available from [www.gov.je](http://www.gov.je)

<sup>134</sup> States of Jersey Education Department, Schools Pupils and Characteristics 2016, published 16 September 2016, available from [www.gov.je](http://www.gov.je)

### Local economy

The States of Jersey Statistics Unit produces measures of the performance of the Jersey economy, these include:

- The main economic indicator which measures the value or size of the whole Jersey economy is GVA (Gross Value Added). Jersey's total GVA was £4.11 billion (at current year values) and was the second consecutive year that the Island's economy grew in real terms.<sup>135</sup>
- The overall price level for consumer goods and services in Jersey (when housing costs, health and education are included) was a fifth (20 per cent) greater than the UK average.<sup>136</sup>
- The mean average weekly earnings for full-time equivalent employees in Jersey in June 2016 was £700 per week.

A comparison between the Jersey Retail Prices Index, the Index of Average Earnings and the House Price Index is shown in Figure 11.5. Since 1997, house prices in Jersey have seen a greater overall increase than earnings and retail prices.<sup>137</sup>

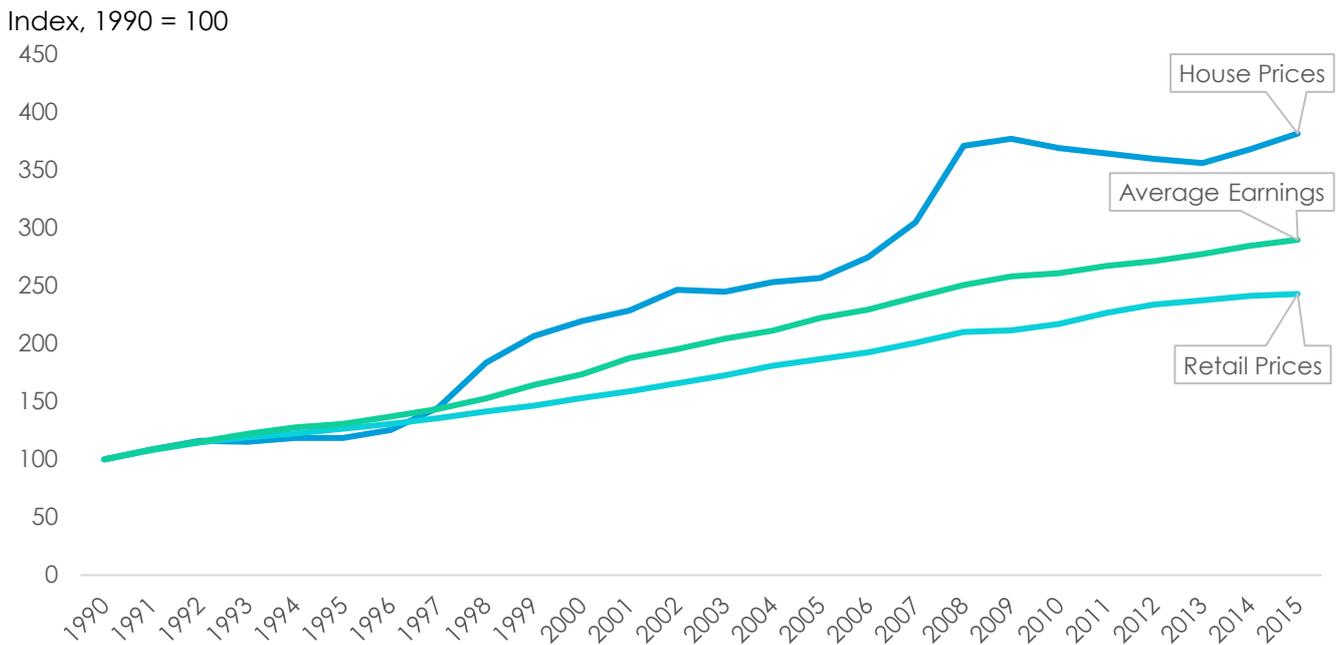
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<sup>135</sup> States of Jersey Statistics Unit, Measuring Jersey's Economy: GVA and GDP 2015 Report, published 28 September 2016, available from [www.gov.je](http://www.gov.je)

<sup>136</sup> States of Jersey Statistics Unit, Jersey-UK Relative Consumer Price Levels for Goods and Services 2013, published 7 March 2014, available from [www.gov.je](http://www.gov.je)

<sup>137</sup> States of Jersey Statistics Unit, Jersey in Figures: House Price Statistics, updated 18 August 2016, available from [www.gov.je](http://www.gov.je)

**Figure 11.5: Retail Prices, Average Earnings and House Prices Indices (1990=100)**



Source: States of Jersey Statistics Unit

## Educational attainment and results

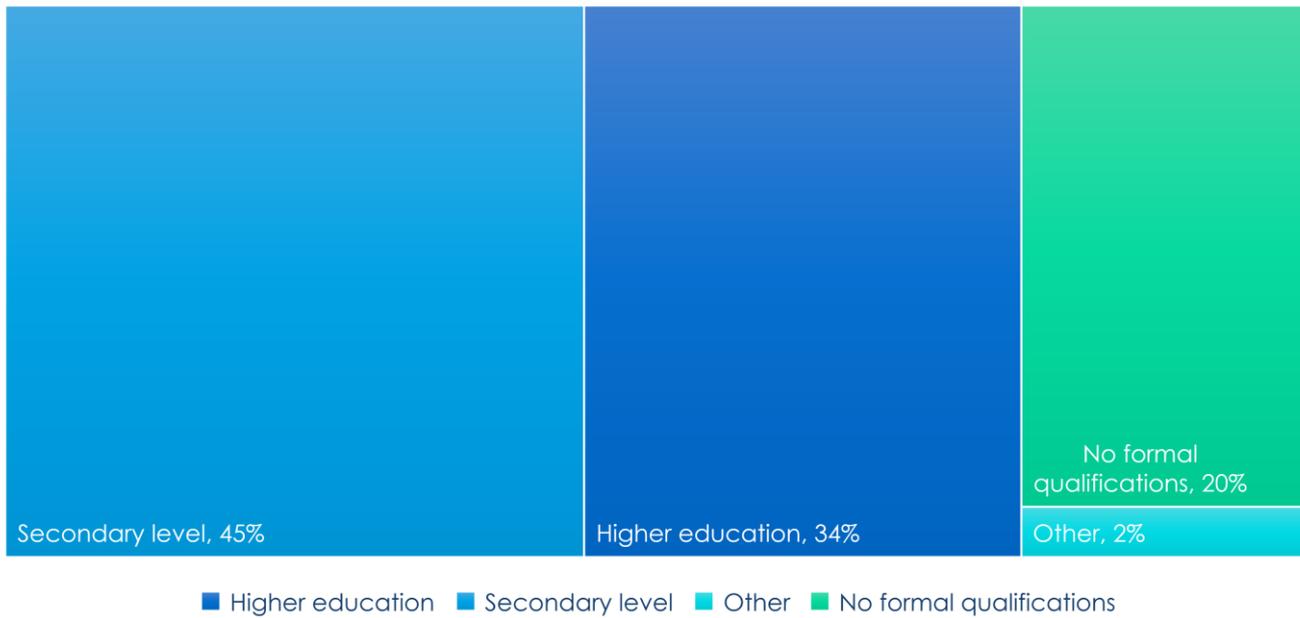
One in three (34 per cent) Jersey adults of working age were educated to a higher level, whilst one in five (20 per cent) had no formal qualifications (Figure 11.6).<sup>138</sup>

### Education

The availability of high quality education is key in enabling residents to maximise opportunities. Educational attainment can determine future employment and income, and is linked to lower risks of alcohol and drug misuse, and teenage pregnancies.

<sup>138</sup> States of Jersey Statistics Unit, Report on the 2011 Census, published August 2012, available from [www.gov.je](http://www.gov.je)

**Figure 11.6: Highest level of educational qualification (working age)**



Source: States of Jersey Statistics Unit

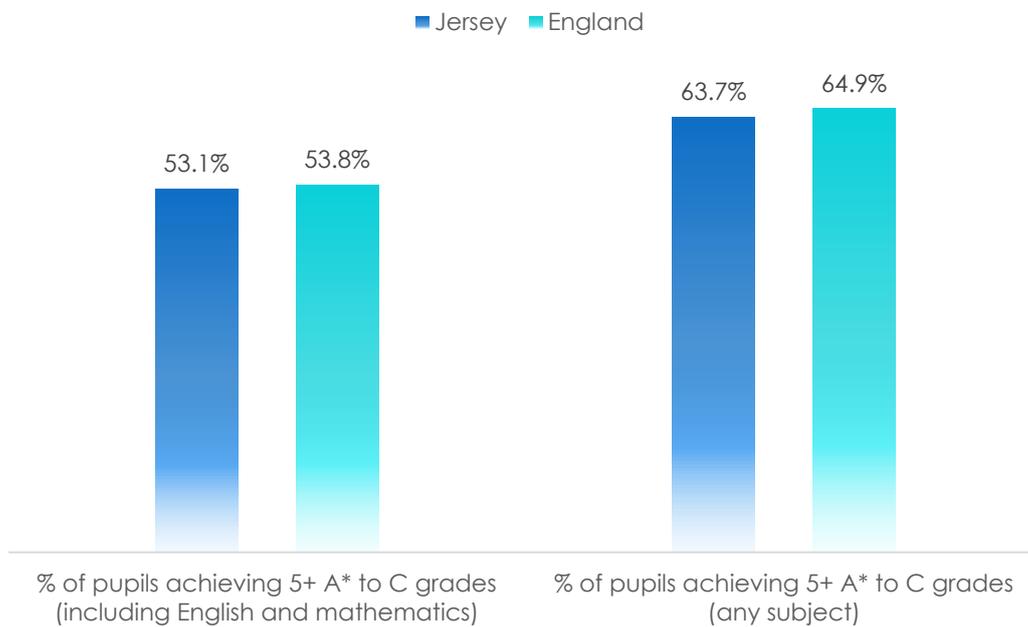
In 2015, more than four-fifths (83 per cent) of A-levels taken achieved grades A\* to C, this rate compares to 78 per cent in England. The average point score per A level entry (229.4) was equivalent to a B-grade and reflects an increase of 5.1 points compared to the previous year.

More than half (58 per cent) of 'the potential end of Key Stage 5 cohort'<sup>139</sup> in Jersey entered at least one level 3 qualification (vocational or academic) in 2014/2015.

Figure 11.7 shows the results for GCSE qualifications in 2014/2015 in comparison to England.

<sup>139</sup> Key Stage 5 is a label used to describe the two years of education of pupils aged 16 to 18, or in sixth form, aligning with Key Stages as labelled for the National Curriculum and Jersey Curriculum

**Figure 11.7: Percentage of pupils attaining 5 or more GCSE and equivalent qualifications at grade A\* to C in Jersey and England in academic year 2014/2015**



Source: States of Jersey Education Department

## Pupil absence

Parents of children of compulsory school age (aged 5 to 15 at the start of the school year) are required to ensure that they receive a suitable education by regular attendance at school or otherwise. Education attainment is influenced by both the quality of education they receive and their family socio-economic circumstances. Educational qualifications are a determinant of an individual's labour market position, which in turn influences income, housing and other material resources.

In both primary and secondary schools, 'illness' was the most common reason for being absent from school in school year 2014/2015, with almost three-fifths of all pupil absences occurring for this reason.

**Table 11.2: Pupil absence in Jersey and England, academic year 2014/2015**

	Jersey		England	
	Primary	Secondary	Primary	Secondary
<b>Authorised absence rate</b>	3.6	5.8	3.1	4.0
<b>Unauthorised absence rate</b>	0.2	1.0	0.9	1.3
<b>Overall absence rate</b>	3.8	6.8	4.0	5.3

Source: States of Jersey Department of Education

The overall absence rate is higher in secondary schools in Jersey (6.8 per cent) than in secondary schools in England. The unauthorised absence rate for secondary school pupils in Jersey (1.0 per cent) is lower than in England (1.3 per cent), whilst the authorised rate in Jersey is around 2 percentage points higher than in England.<sup>140</sup>

### Air and water quality

In 2015, there were 85 water pollution incidents reported, a figure 10 per cent lower than the average for the preceding decade (2004-2014).<sup>141</sup>

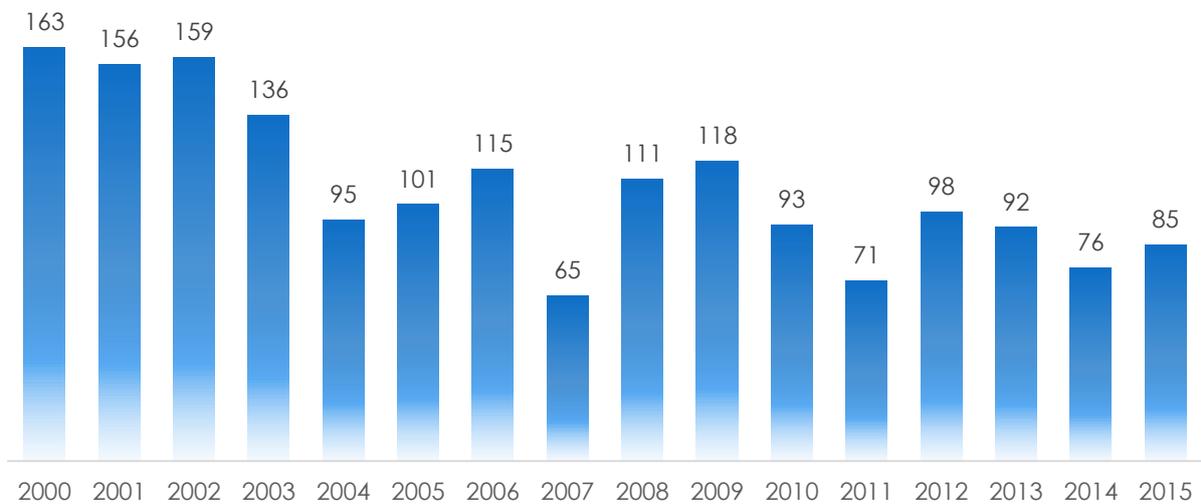
Figure 11.8 shows the number of incidents each year since 2000.

#### Physical Environment

Environmental themes can play a significant role in affecting our quality of life and health. People living in areas with safe water supplies, clean air, a healthy working environment and comfortable, affordable housing are more likely to be in good health than those lacking such conditions.

<sup>140</sup> States of Jersey Education Department, Pupil Attendance and Absence in Schools in Jersey: Academic year 2014/2015, published 21 April 2016, available from [www.gov.je](http://www.gov.je)

<sup>141</sup> States of Jersey Statistics Unit, Jersey in Figures: Environment, accessed November 2016, available from [www.gov.je](http://www.gov.je)

**Figure 11.8: Total number of water pollution incidents 2000-2015**

Source: States of Jersey Department of the Environment

During the 2015 summer season, ten tests of Jersey's sea water at different beaches were of 'Excellent' quality, five were of 'Good' quality and one was 'Sufficient' quality.

Poor air quality can have a detrimental effect on health. Atmospheric pollutants can cause a range of health effects which range from the minor, such as eye irritation, to the more serious, such as impairment of breathing.

Air quality monitoring is carried out daily at sites around the Island.<sup>142</sup> The latest available results showed that in 2014 the annual mean concentration of nitrogen dioxide (NO<sub>2</sub>) measured by the automatic analyser at Halkett Place was well within the EC Directive limit value. Annual mean NO<sub>2</sub> concentrations at two of the diffusion tube monitoring sites exceeded the EC limit value: these were at the Weighbridge and in Georgetown. 2014 represented the first occasion for several years the annual mean limit value has been exceeded.

The diurnal variation in concentrations of oxides of nitrogen at Halkett Place was generally typical of an urban site, but with a particularly early (and sharp) morning rush hour peak, and barely any afternoon rush hour peak. This is thought to be due to traffic patterns around the site: there is early

<sup>142</sup> Ricardo-AEA, Air quality monitoring in Jersey: Report for the States of Jersey, published 12 August 2015, available from [www.gov.je](http://www.gov.je)

morning traffic associated with The Central Market and with waste collection from the previous day.

Annual mean NO<sub>2</sub> concentrations at Jersey's urban sites appear to have generally decreased over the last 10 years, though most sites do not show a consistent downward trend. Pollutant concentrations are expected to fluctuate from year to year, due to meteorological and other factors.

Annual mean benzene concentrations at all five monitoring sites were well within the EC Directive limit value.

### Radon Gas

Radon is a naturally occurring radioactive gas formed from uranium, found in small quantities in soils and rocks. It is colourless, odourless, and can move through the subsoil and into buildings. In Jersey, there are likely to be elevated levels of radon in the rock which can result in higher levels in buildings. Potentially, exposure to high levels of radon gas, for long periods, increases risk of developing lung cancer. The Health Protection Agency (HPA) recommends that radon levels should be reduced in homes where the average is more than 200 becquerels per cubic metre (200 bq/m<sup>3</sup>). The Health Protection Agency in the UK can provide a service to assess a Jersey property for the presence and concentration of radon.<sup>143</sup>

Radon gas is a potential issue for those homes with a ground floor. A small proportion (6 per cent) of Jersey households whose home included a ground floor level reported having had their home tested for radon in the last five years (although an additional 30 per cent, were unsure if their home had been tested). Of the small proportion of households that had been tested, the results indicated that action was required for around one in eight households (14 per cent).<sup>144</sup>

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<sup>143</sup> Public Health England, UK radon website, available from [www.ukradon.org](http://www.ukradon.org)

<sup>144</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2015, published November 2015, available from [www.gov.je/statistics](http://www.gov.je/statistics)

## Housing

There is a recognised link between housing conditions and physical and mental health. Housing-related factors that can affect health include: indoor pollutants, cold and damp, housing design and layout, infestations, hazardous internal structures or fixtures, noise and the environment.<sup>145</sup>

At least nine out of ten people in Jersey rate their home as 'very' or 'fairly' suitable in terms of four factors: location, size, standard of repair and layout inside, in 2015.<sup>146</sup>



**9 out of 10** people were 'very' or 'fairly' satisfied with their current housing

Ratings of the different aspects of home suitability were generally similar across different tenure categories, except for 'standard of repair', which had a lower proportion of social rental residents rating 'very' or 'fairly' suitable (73 per cent), compared to the proportion of residents of other tenures (96 per cent for owner-occupiers, 90 per cent of those in qualified rental, and 85 per cent for those living in non-qualified accommodation).

A higher proportion of people living in rural parishes (68 per cent) were 'very' satisfied with their accommodation compared to those living in St Helier (43 per cent), as shown in Figure 11.9. Levels of dissatisfaction were fairly low across all parish groups.

<sup>145</sup> Department for Communities and Local Government, A Decent Home: Definition and guidance for implementation, published June 2006, available from [www.gov.je](http://www.gov.je)

<sup>146</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2015, published November 2015, available from [www.gov.je/statistics](http://www.gov.je/statistics)

**Figure 11.9: 'Overall, how satisfied are you with your current housing?' By parish of residence, 2015**



Source: Jersey Annual Social Survey 2015

Since 1997, house prices in Jersey have seen a greater overall increase than earnings and retail prices (see Figure 11.5).

In 2013, more than half of lower income households living in private rental or non-qualified rental accommodation could be considered as being in 'housing stress'.<sup>147</sup> Around a third of lower income households in the owner-occupier (with mortgages) and social rental sectors could be considered as being in 'housing stress'.

Jersey housing affordability<sup>148</sup> worsened marginally in 2013 compared to 2011 and 2012, due to increases in the overall median dwelling price and mean mortgage interest rate. Between 2002 and 2012, a working household with mean net income was not able to service a mortgage affordably on the purchase price of a median priced house of any size. In 2013, a working

<sup>147</sup> The 30/40 method of identifying mortgage or rental stress calculates the proportion of lower income households (in the lowest 40 per cent of the income distribution) which are paying more than 30 per cent of their gross income on housing costs.

<sup>148</sup> The Jersey Housing Affordability Index (JHAI) indicates whether a working household with average (mean) income is able to afford to purchase a median-priced property

household with average income was able to service a mortgage affordably on the purchase price of a median price 2-bedroom house for the first time since at least 2002.

Almost half (49 per cent) of all working households could not service a mortgage affordably on the purchase price of a property at the lower quartile price, a greater proportion than in 2011 and 2012. A third (33 per cent) of young working households in Jersey could not afford to service a mortgage on a lower priced starter home in 2013; this proportion was lower in 2011 and 2012.



**1 in 2** working households could not service a mortgage affordably on the purchase price of a property at the lower quartile price

## Accidents

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups. The vast majority of road traffic collisions are preventable and can be avoided through improved education, awareness, road infrastructure and vehicle safety.

An average of 300 people are slightly injured on Jersey roads each year, whilst another 50 to 60 people are seriously injured. In 2015, there were no fatalities from road traffic accidents, the first year since 2002.<sup>149</sup>



In England, the crude rate figure for England of people killed and seriously injured casualties on roads per 100,000 ranged from 15.5 in Bexley to 76.3 in North Yorkshire over the period 2012-2014. Table 11.3 shows the rate for Jersey roads in comparison to the rate for the Isle of Wight as a comparison to another Island population.

<sup>149</sup> Jersey Road Safety website, Facts & Stats, Updated 2016, available from [jerseysaferoads.com/facts-stats](http://jerseysaferoads.com/facts-stats)

**Table 11.3: Rate of killed and seriously injured on roads per 100,000 resident population, 2012-2014**

	Crude rate per 100,000 population	95% Lower confidence level	95% Upper Confidence Level
<b>Isle of Wight</b>	58.8	51.6	66.6
<b>Jersey</b>	57.2	49.9	66.5

Source: Jersey road safety website, Public Health England

The latest rate for Jersey, for the period 2013-2015, is 60.2 per 100,000.

Reported figures show that over the past three years, 155 people have been knocked down crossing the road in Jersey, around a quarter (26 per cent) of these when using a pedestrian facility such as a zebra crossing.

Around 140 cyclists have been injured over the three-year period 2013-2015 on Jersey roads.

### Recorded crime

Living in areas with high rates of crime can affect an individual's health, whether through fear and stress associated with victimisation, or by limiting access to outdoor physical activities such as walking in the neighbourhood.<sup>150</sup>

In Jersey, overall levels of recorded crime have reduced by 23 per cent from 2011 to 2015.<sup>151</sup>

A total of 3,080 crimes were reported in 2015, giving a rate of 30.5 crimes per 1,000 resident population.



<sup>150</sup> Lovasi, G.S., Goh C.E., Pearson A.L., et al, The independent associations of recorded crime and perceived safety with physical health in a nationally representative cross-sectional survey of men and women in New Zealand, 2014, *BMJ Open*, 4(3) e004058 doi:10.1136/bmjopen-2013-004058

<sup>151</sup> States of Jersey Police, Annual Performance Report 2015, published March 2016, available from [jersey.police.uk](http://jersey.police.uk)

In 2015, States of Jersey Police Officers dealt with, amongst other crimes, 697 thefts, 149 dwelling break and entries, 580 offences against property, 744 common assaults, 204 grave and criminal assaults, 63 cruelty/neglect of a child, 174 sexual assaults and 310 domestic assaults.<sup>152</sup>

The States of Jersey Police attended over 1,000 domestic violence incidents in 2015, of these 269 incidents involved 'high risk' parties. Almost 2,000 child protection notifications and 931 adult protection notifications were submitted.

### Satisfaction with neighbourhood

The majority (95 per cent) of Jersey residents reported being 'very' or 'fairly' satisfied with their local neighbourhood in 2014.<sup>153</sup>

Fear of crime and vulnerability can limit how residents interact in their community, whilst also limiting access to physical activity, such as walking and running. More than nine-tenths (93 per cent) of residents reported feeling safe or very safe in their neighbourhood in 2014.<sup>154</sup> This proportion had not changed significantly since 2012.

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<sup>152</sup> States of Jersey Police, Annual Performance Report 2015, published March 2016, available from [jersey.police.uk](http://jersey.police.uk)

<sup>153</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2014, published 25 November 2014, available from [www.gov.je/statistics](http://www.gov.je/statistics)

<sup>154</sup> States of Jersey Statistics Unit, Jersey Annual Social Survey 2014, published 25 November 2014, available from [www.gov.je/statistics](http://www.gov.je/statistics)

### Social isolation

Social isolation has been identified as a factor associated with suicides and poorer mental health.<sup>155</sup>

In Jersey, around 7,600 adults and around 4,900 pensioners were found to be living alone at the time of the 2011 census.

Jersey has a similar proportion of single person households to the English average (Table 11.4).

#### Social Environment

Having support from family, friends and the local community is important for preventing isolation and loneliness, contributing to good mental health.

**Table 11.4: Percentage of people living alone, 2011**

	Jersey	England
<b>Percentage of all households that are recorded as one person households</b>	12.7	12.8
<b>Percentage of all households recorded as occupied by one pensioner</b>	5.0	5.2

Source: States of Jersey Statistics Unit, Public Health England

### Social capital

Overall, nearly one in ten Islanders (9 per cent) 'rarely' or 'never' socialised face to face with people outside their household. No significant trends were found by age or gender, but this proportion was particularly high for those who are unable to work due to sickness or disability – nearly a third (32 per cent) of whom 'rarely' or 'never' socialised outside of their household.

A relationship was found between frequency of socialising and life satisfaction, as Figure 11.10 illustrates. A third of those who 'never' or 'rarely' socialised outside their household reported being 'not very' or 'not at all' satisfied with their life on the whole. This compares with fewer than one in ten of those socialising daily or weekly with people outside their household.

<sup>155</sup> Public Health England, Public Health Outcomes Framework: Health improvement, updated October 2016, available from [www.phoutcomes.info](http://www.phoutcomes.info)

**Figure 11.10: How often do you socialise (face to face) with people outside of your household? By 'On the whole, how satisfied are you with the life you lead?'**



Source: Jersey Annual Social Survey 2012

Over four-fifths (86 per cent) of Jersey residents had someone in Jersey they could count on to help, whilst another one in ten (11 per cent) had friends or relatives outside of Jersey. A small proportion (3 per cent) had no friends or relatives in Jersey or elsewhere to count on to help in times of trouble.

People born outside the Island were less likely to have friends or relatives in Jersey to count on if they were in trouble. Nearly one in ten (9 per cent) Jersey residents born in Portugal reported not having a relative or friend in Jersey or elsewhere whom they could count on. One in twenty (4 per cent) of those born in other European countries or world countries also reported having no friends or relatives they could count on to help.

## Ethnicity and cultural backgrounds

In 2011, half (50 per cent) of Jersey residents were born in Jersey. Nearly a third (31 per cent) were born in the British Isles (including England, Scotland, Wales, Northern Ireland and other Channel Islands). About one in fourteen (7 per cent) of the resident population were born in Portugal / Madeira and 3 per cent were born in Poland (Table 11.5).

**Table 11.5: Jersey's population by place of birth, 2011**

	Persons	Percent
<b>Jersey</b>	48,653	50
<b>British Isles</b>	30,223	31
<b>Portugal / Madeira</b>	7,031	7
<b>Poland</b>	3,133	3
<b>Ireland (Republic)</b>	1,880	2
<b>Other European country</b>	3,146	3
<b>Elsewhere in the world</b>	3,791	4
<b>Total</b>	<b>97,587</b>	<b>100</b>

Source: States of Jersey Statistics Unit Census 2011

While place of birth is informative, a person's self-reported ethnicity can give a different perspective. For example, someone born outside of Jersey who has lived in the Island for many years might consider themselves of 'Jersey' ethnicity. On the other hand, someone else born in Jersey but with parents from outside of the Island may consider their parental or cultural heritage to be the key influence in defining their ethnicity.

Table 11.6 shows the ethnicity of Jersey residents in 2011.

**Table 11.6: Self-reported ethnicity of Jersey residents, 2011**

		2011	Percent
<b>White</b>	Jersey	45,379	46.4
	British	31,974	32.7
	Irish	2,324	2.4
	French	841	0.9
	Portuguese/Madeiran	8,049	8.2
	Polish	3,273	3.3
	Other	3,731	3.8
<b>Asian</b>	Indian	377	0.4
	Pakistani	53	0.1
	Bangladeshi	74	0.1
	Chinese	182	0.2
	Thai	200	0.2
	Other	329	0.3
<b>Black</b>	Caribbean	85	0.1
	African	256	0.3
	Other	38	0.0
<b>Mixed</b>	Asian	274	0.3
	Caribbean	102	0.1
	African	105	0.1
	Other	211	0.2

Source: States of Jersey Statistics Unit Census 2011

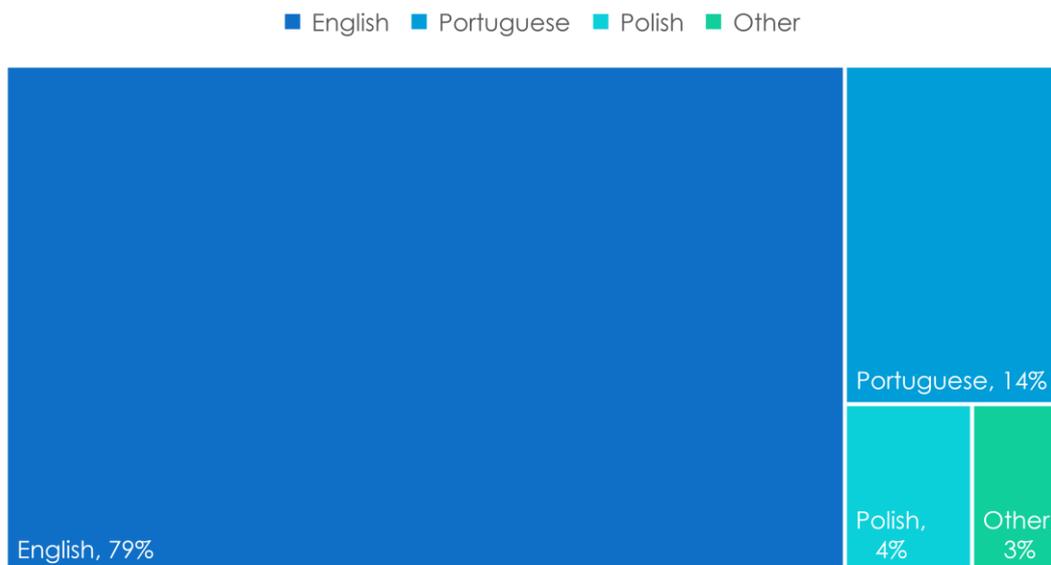
About one in twelve (8 per cent) Jersey residents considered themselves to be Portuguese or Madeiran, representing about a thousand more people than those who were actually born in Portugal or Madeira.

Using language spoken as an indicator of cultural background, the characteristics of school pupils shows that Portuguese is the second most prevalent language spoken in the Jersey schools after English. The overall percentage of pupils of compulsory school age in States schools in Jersey that

## 11. Wider Determinants of Health

have English as an additional language is 21 per cent. Figure 11.11 shows the distribution of first languages of pupils in States schools in Jersey in 2016.<sup>156</sup>

**Figure 11.11: First languages of pupils in States schools in Jersey, 2016**



Source: States of Jersey Education Department



- States of Jersey Statistics Unit, Jersey Household Income Distribution 2014/15, published 13 November 2015, available from [www.gov.je](http://www.gov.je)
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<sup>156</sup> States of Jersey Education Department, Schools Pupils and Characteristics 2016, published 16 September 2016, available from [www.gov.je](http://www.gov.je)

# Glossary & Abbreviations

95% CI LL	95% Confidence Interval Lower Level (see also Statistical Methods)
95% CI UL	95% Confidence Interval Upper Level (see also Statistical Methods)
ASR	Age-standardised rate (see also Statistical Methods)
BMI	Body Mass Index
COPD	Chronic Obstructive Pulmonary Disease
DH	Department of Health
'Flu	Influenza
GUM	Genitourinary Medicine
HSCIC	Health and Social Care Information Centre
HSSD	Health and Social Services Department
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10 <sup>th</sup> revision
MoH	Medical Officer of Health
IHD	Ischaemic Heart Disease (coronary heart disease)
NHS	National Health Service
NMSC	Non-Melanoma Skin Cancer
ONS	Office for National Statistics
PCT	Primary Care Trust (former National Health Service administrative bodies, responsible for commissioning primary, community and secondary health services from providers. PCTs ceased to exist in 2013 since when their work has been taken over by Clinical Commissioning Groups)
PHE	Public Health England
PHOF	Public Health Outcomes Framework (a Public Health England data tool which sets out a vision for public health, desired outcomes and indicators that enable an understanding of how well public health is being improved and protected)
UK	United Kingdom
WEMWBS	Warwick-Edinburgh Mental Wellbeing Scale
YOLL/YWLL	Years of Life Lost/ Years of Working Life Lost (see also Statistical Methods)

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# Statistical Methods

Confidence Intervals	<p>The 95% Confidence Interval is used as a way of quantifying the uncertainty around a point estimate. This uncertainty arises as factors influencing the indicator are subject to chance occurrences that are inherent in the world around us. These occurrences result in random fluctuations in the indicator value between different areas and time periods. Jersey has a comparatively small population so rates or percentage estimates over short periods of time are sensitive to random fluctuations in numbers of events. Confidence intervals quantify the uncertainty in the estimate and, generally speaking, describe how much different the point estimate could have been if the underlying conditions stayed the same, but chance had led to a different set of data. In health profiles, confidence intervals are given with a 95% stated probability level. Where confidence intervals for two estimates are available these can be examined to gauge the statistical significance of the difference in estimates. Non-overlapping confidence intervals signify that estimates are likely to be significantly different. Overlapping confidence intervals, by contrast, suggest that true values of the two estimates may be the same.</p>
Age standardised rates	<p>Age-standardised rates is the rate of events that would occur in a population with a standard age structure is that population were to experience the age-specific rates of the subject population. The 2013 European Standard Population has been used to calculate the standardised rates in this report. The same population is used for males, females and all persons and rates are expressed per 100,000 population.</p>
Crude Rates	<p>A crude rate refers to the number of events per 1,000 or 100,000 population</p>
Life expectancy calculations	<p>Life expectancy at birth is a summary measure of the all-cause mortality rates in an area in a given period. It is the average number of years a new-born baby or 65 year old would survive, were he or she to experience the particular age-specific mortality rates for that time period throughout his or her life.</p>
YOLL/YWLL	<p>Years of life lost is a measure of premature mortality which is used to compare the mortality experience of different populations for all causes of death and/or particular causes of death by quantifying the number of years <b>not</b> lived by individuals who die under a given cut-off age. The most frequently used cut-off age is 75, this having been set as an age that everyone can be expected to reach. The age of 65 can also be used to calculate years of working life lost (YWLL) which is a useful indicator of the economic impact of premature deaths.</p>

# Background Notes

1. The profile provides facts about how Jersey compares with other areas. It does not seek to answer why the figures are as they are or what may need to be done about them, though these will be important questions to consider.
2. Comparisons are performed on a like-for-like basis unless otherwise stated. Where a comparable figure uses a mid-year population, the Jersey rates are calculated using the average of the two applicable end-year population estimates as published by the States of Jersey Statistics Unit. This estimate of the mid-year population assumes that half of births, deaths and migration occurs in the first half of the calendar year.
3. Percentages may not add up to 100 per cent due to rounding.
4. This report uses the 2013 European Standard Population in the calculation of age-standardised rates. The previous health profile, released in 2014, used the 1976 European Standard Population. It is therefore not possible to compare age-standardised rates in the previous health profile to rates contained in this edition.
5. Fertility
  - (1) Information on births in Jersey comes from the Child Health System which uses data provided by the Maternity Department.
  - (2) Stillbirth's data comes from the Maternity Department
  - (3) Information on Infant Mortality is collected via the deaths registrations and details from the Hospital
  - (4) Low birth weight statistics for Jersey are not directly comparable with Guernsey as a different measure has been used, that of birth weight of term babies.
  - (5) Breastfeeding information is collected by the Maternity Department at discharge and by GP's at the 6 to 8 week checks.
6. Deaths
  - (1) Death figures are compiled from returns to the Registrars in each parish in Jersey. The Marriage and Civil Status (Jersey) Law 2001 requires all deaths to be notified within 5 days of the date of death.

- (2) The number of deaths may differ from previously published figures due to the inclusion of data from inquests which can take up to 18 months to complete and register. This means that total deaths in a given year should be treated as provisional and used with caution.
  - (3) The results are based on analysis of all deaths of Jersey residents registered as having occurred in calendar years 2013 to 2015.
  - (4) Cause of death is classified using the tenth revision of the International Statistical Classification of Diseases, Injuries and Causes of Death (ICD-10). As is convention, deaths classified under ICD-10 as 'events of undetermined intent' along with 'intentional self-harm' are jointly reported as 'suicide'.
  - (5) Coding of Jersey deaths is undertaken by the Office for National Statistics on a quarterly basis.
  - (6) Potential Years of Life lost estimates the number of years a person would have lived had they not died prematurely. It is based on the assumption that every individual could be expected to live until the age of 75 and premature death before that age may be preventable.
7. Cancer registry information in Jersey is collated and analysed by Public Health England Knowledge and Intelligence Team (South West) with data supplied by the Public Health Department, for more information see the Channel Islands Cancer Report 2013, published January 2014. The next report is due to be released before the end of 2016.
  8. The GP Central Server, provided by EMIS Web, contains information on disease registers kept by general practitioners in Jersey as part of the Jersey Quality Improvement Framework. The Health and Social Services Department has access to the system to allow statistical information about conditions 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 should be treated as provisional. Data quality is expected to improve as further interrogation of the data and coding is conducted. Figures have been rounded to show the uncertainty surrounding them and caution is advised in their interpretation. The number of registered patients is around 10,000 higher than the population estimates suggest the population of Jersey is therefore caution is advised in the interpretation of these figures.
  9. The Jersey Annual Social Survey is a voluntary postal and internet survey run independently by the States of Jersey Statistics Unit. The survey is sent to more than 3,000

## 14. Background Notes

randomly selected households each year, and has a high response rate of around 52 per cent. In addition to the very good response rates overall, statistical weighting techniques are used to compensate for different patterns of non-response from different sub-groups of the population. The result is that the survey results can be considered broadly accurate and representative of Jersey's population. As with all sample surveys, there is an element of statistical uncertainty, typically around  $\pm 2$  per cent for results for the overall population. For further details see [www.gov.je/JASS](http://www.gov.je/JASS)

10. Passive Smoking Risk data is collected by GP's at the 6 to 8 week check and reported back to the Child Health Team.

11. Graphics are created in-house by Public Health Statistics Unit staff using royalty-free public-domain clip art downloads from [www.clker.com](http://www.clker.com) or created in Microsoft PowerPoint.

10. All enquiries and feedback should be directed to:

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