Statistics on NHS Stop Smoking Services: England, April to December 2011 (Q3 – Quarterly report): Appendices
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Author: The NHS Information Centre, Lifestyles Statistics

Responsible Statistician: Paul Eastwood, Lifestyle Statistics Section Head

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Appendix A: Government policy and targets

Introduction

Tobacco use remains one of the government’s most significant public health challenges, and causes over 80,000 premature deaths in England each year.


The Tobacco control Plan sets out how tobacco control will be delivered in the context of the new public health system, over the next five years. The plan sets out three national ambitions to reduce smoking rates in England by the end of 2015:

• From 21.2 per cent to 18.5 per cent or less among adults;
• From 15 per cent to 12 per cent or less among 15 year olds; and
• From 14 per cent to 11 per cent or less among pregnant mothers (measured at the time they give birth).

In the Tobacco Control Plan the Government set out key actions in the following six areas:

• stopping the promotion of tobacco;
• making tobacco less affordable;
• effective regulation of tobacco products;
• helping tobacco users to quit;
• reducing exposure to secondhand smoke; and
• effective communications for tobacco control.

The Medicines and Healthcare products Regulatory Agency (MHRA), published on 9 March 2011 is the Government’s response to the consultation on the regulation of nicotine-containing products. The MHRA will coordinate a period of further scientific and market research to inform decisions about the regulation of nicotine-containing products (NCPS).
A range of tobacco control legislation has been introduced over a period of time, including smokefree legislation; raising the age of sale for tobacco products from 16 to 18; increased retailer sanctions against those that sell to under aged smokers; ending tobacco advertising, promotion and sponsorship; and the introduction of picture warnings on all tobacco products. These interventions have contributed to an improved public health and awareness of the dangers of smoking and exposure to secondhand smoke.

There has been a significant decline in smoking in recent decades as well as a shift in public attitudes towards smoking. Since the early 1970s, there has been a marked decline in smoking prevalence. Today only around one in five adults smoke cigarettes. Seven out of ten smokers say they want to quit. However, whilst smoking uptake in children has been declining, in 2008 an estimated 180,000 young people aged 11-15 regularly smoke, and each year in England an estimated 320,000 young people under the age of 16 try smoking for the first time. Around two thirds of smokers say they started smoking before the age of 18.

Public Commitments

Reduce smoking prevalence among adults in England: To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015 (from 21.2 per cent) meaning around 210,000 fewer smokers a year.

Reduce smoking prevalence among young people in England: To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less (from 15 per cent) by the end of 2015.

Reduce smoking during pregnancy in England: To reduce rates of smoking throughout pregnancy to 11 per cent or less (from 14 per cent) by the end of 2015 (measured at time of giving birth).

NHS Stop Smoking Services

NHS Stop Smoking Services were first set up in 1999/2000 and rolled out across England from 2000/2001. Services provide free, tailored support to all smokers wishing to stop offering a combination of recommended stop smoking pharmacotherapies and behavioural support.

In December 2005, Nicotine Replacement Therapy (NRT) was made available to more people than before, following a change in the guidance for the use of NRT. This change related to adolescents over 12 years, pregnant or breast feeding women and patients with heart, liver and kidney disease who are now able to use NRT in their attempt to stop smoking. In September 2006, the European Commission approved Champix, generic name Varenicline, as a new pharmacotherapy to help adults quit smoking. The National Institute for Health and Clinical Excellence (NICE) issued guidance in August 2007, which recommends the use of Champix in the NHS.
Links to important publications:

Healthy Lives, Healthy People: our strategy for public health in England
Healthy Lives, Healthy People: a Tobacco Control Plan for England
Impact of smokefree legislation: evidence review, March 2011
Stop Smoking Service Delivery and Monitoring Guidance 2011/12
Public consultation (MLX 364): The regulation of nicotine containing products (NCPs): MHRA
Appendix B: Technical Notes

Background

NHS Stop Smoking Services (previously called Smoking Cessation Services) were launched in Health Action Zones (HAZ) in 1999/00, and were set up in all Health Authorities in England in 2000/01.

Monitoring of the NHS Stop Smoking Services is carried out via quarterly monitoring returns. The quarterly reports present provisional results from the monitoring of the NHS Stop Smoking Services, until the release of the annual bulletin when all quarterly figures are finalised.

In March 2011, updated guidance for NHS Stop Smoking Services was published. The new guidance is intended for everyone involved in managing, commissioning or delivering NHS stop smoking services. It was developed by means of collaboration with representatives from Strategic Health Authorities (SHAs), Primary Care Trusts (PCTs), the NHS Information Centre and academics from the field of smoking cessation. The guidance is available from the link below:


Due to the ending of the HAZ initiative in 2003, data are no longer presented by HAZ. Information at HAZ level is published in previous editions of this bulletin. Available from:


Collection of NHS Stop Smoking Data

Prior to 2008/09, detailed monitoring information was collected by PCTs and submitted to the SHAs: the SHAs were responsible for checking the data they received. The NHS Information Centre then carried out further validation checks on the data submitted by the Strategic Health Authorities, in order to check consistency, identify any errors, and resolve queries, so that the data were as accurate as possible.

In 2008/09 a number of key changes were made to the collection. These are described in more detail below.

Monitoring arrangements for 2002/03 and earlier years are available at:

Changes 2008/09

From 2008/09, all data is now collected at a PCT level directly from PCTs using a web-based tool. By collecting PCT level information we will be able to provide much more detailed figures for use by PCTs enabling them to put their own performance in a national context without adding to the burden of current collection, indeed we would hope to reduce that burden for SHAs. The NHS Information Centre will be responsible for the collection of the data from PCTs including chasing any late returns, informing PCTs of developments and key dates and validating the data. SHAs will be able to access information for PCTs in their area using the web-based tool.

The following data items are also collected as part of the current collection. These include:

• Intervention types and settings;
• Socio-economic groups;
• Number who received Nicotine Replacement Therapy (NRT) and Varenicline (Champix) consecutively;
• Free Prescription eligibility.

The reasons for collecting this new data are expanded upon below.

Intervention type and setting data

The report ‘No ifs, no buts’¹ by the then Healthcare Commission (HC) (now known as the Care Quality Commission (CQC)) identified that there are unacceptable levels of variation in data collection and data management practices relating to stop smoking services, thus making it difficult to assess performance and compare services meaningfully. The Department of Health (DH) have identified that this issue needed to be addressed.

Collecting information on the number of people setting a quit date and number of successful quitters by intervention type and setting enables the CQC and DH to monitor performance and identify best practice. It also assists SHAs in monitoring the performance of their PCTs more effectively. Additionally it helps PCTs identify which treatment settings and intervention types are consistently getting the best results and helps inform the person making the stop smoking attempt which settings are available to them in that area and what the relative success rate of these are.

Free Prescription Eligibility and Socio-Economic data

Smoking is the single most preventable cause of death and ill health in England. Half of all smokers will die prematurely as a result of smoking. Smoking disproportionately affects the

¹ No ifs, no buts Improving services for tobacco control, Healthcare Commission, 2007
poorest members of society, owing to differences in culture and lifestyle, and is therefore a primary cause of inequalities in health.

In order to effectively monitor the provision of NHS Stop Smoking Services (SSS) at a national level to the poorest members of society, particularly the routine and manual group, data on the occupational status of clients will be collected using a modified version of the Office for National Statistics (ONS) on National Statistics-Socio Economic Classification. Data on eligibility for free prescriptions will also be collected as an indicator to assess how effectively the NHS SSS is reaching disadvantaged populations.

**Number who received NRT and Champix (Varenicline) consecutively**

This is a new combination of smoking cessation aids being used to assist people in successfully quitting. This data is needed to identify how successful this treatment option is and how popular it is in order to assist in monitoring and performance of best practice amongst the services.

**Experimental Statistics**

Experimental statistics are statistics that are in the testing phase and have not yet been fully developed. The three of the four new data items added to the collection in 2008/09; data for the number of people setting a quit date and the number who successfully quit at the 4 week follow-up categorised by socio economic classification, eligibility to receive free prescriptions and intervention setting are released as experimental statistics, as they are still being evaluated and are subject to further testing. Following improvements in data quality data on intervention type are no longer labelled as experimental statistics and have been published at PCT level.

**Changes 2009/10**

**Socio-Economic data**

A minor addition has also been introduced for collections from 2009/10 onwards. An additional category – ‘Number in prison’ has been added to the socio-economic classification so that clients setting a quit date and those who successfully quit through services run in prisons can be recorded under this category.

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2 Intervention setting refers to the location of the service used by the client, and includes stop smoking service, primary care and pharmacy settings. Intervention type alternatives include closed groups, open groups, one to one support and drop-in clinics.
ONS coding and naming policy

On 1st January 2011 the Office for National Statistics (ONS) implemented a new coding and naming policy for statistical geographies. This nine digit code has been developed to ensure consistencies when comparing geographical areas as the geographical area covered by an NHS organisation is susceptible to change. From this publication onwards this unique marker has been added to the PCT, SHA and National Tables. Further information on the Coding and Naming for Statistical Geographies is available at:

Re-structuring SHAs and PCTs

From 1 April 2002 the NHS was reorganised. The 95 former Health Authorities (HAs) were disestablished on 31 March 2002, and replaced by 28 SHAs. At this time, the 28 SHAs encompassed around 303 PCTs. A table showing the mapping of the ‘old’ HAs to the new SHAs was contained in Annex C of the DH Statistical Bulletin: ‘Statistics on smoking cessation services in England, April 2001 to March 2002’ available at:

In 2006 there was a further restructuring of SHAs and PCTs. The 28 SHAs became 10 new SHAs in July 2006, and 303 PCTs became 152 PCTs in October 2006. Where trends are described, this report discusses the use of NHS Stop Smoking Services since 2006/07 for the SHA and PCT structures which are now in place. Information on pre-2006 SHA and PCT structures can be found in previous editions of this report. Previous NHS Stop Smoking Services bulletins, also published by the NHS Information Centre can be found at:

In April 2010 Blackburn with Darwen PCT (5CC) was renamed to Blackburn with Darwen Teaching Care Trust Plus (TAP). West Hertfordshire PCT (5P4) and East and North Hertfordshire PCT (5P3) merged to become Hertfordshire PCT (5QV). As a result, there are now 151 PCTs post April 2010 compared with 152 pre April 2010.

In April 2011 Solihull Care Trust (TAM) was renamed to as Solihull PCT (5QW).

Suppression

Small numbers in the data are suppressed to ensure confidentiality is maintained. Prior to 2011, cell counts of 2 or less and not in the ‘lost to follow up’ category were suppressed. This method was revised in 2011 to include suppression of small numbers 1-5 in the cell ‘Number
Setting a Quit Date’ (the denominator). Cases where the ‘Number Setting a Quit Date’ (the denominator) equals the number who had, or had not quit smoking (the numerator), were suppressed as this could be disclosive. On occasions this means secondary suppression may be applied to additional PCT(s) in the same SHA to ensure suppressed cells cannot be calculated.

Enhancements to monitoring ethnicity

In light of the 2001 Census, DH policy was amended to collect information on ethnicity based on 16+1 categories rather than 5+1 categories used in previous years. In 2003/04 the monitoring return included the option of either 5+1 or 16+1 categories as a transitional period; from 2004/05 onwards the collection of 16+1 categories has been mandatory.

Up to 2003/04, the following ‘5+1’ categories were used:

- White
- Mixed
- Asian
- Black
- Other
- Not stated

For 2003/04 onwards, the following ‘16+1’ categories were used:

White
- British
- Irish
- Any other white background

Mixed
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

Asian or Asian British
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

Black or Black British
Further information on ethnicity category data is available from:

Metadata

Services monitored

Stop Smoking Co-ordinators are required to monitor all NHS Stop Smoking Services in England. Brief interventions by GPs, health professionals and other relevant practitioners are provided in the normal course of the professional’s duties rather than comprising a ‘new’ service, and monitoring information about clients in receipt of such interventions is not therefore required centrally.

Quit date

It is recognised that in certain cases some time may need to be spent with clients before they are ready to set a quit date. However, only actual quit attempts are counted for national monitoring.

Support

Advisers normally offer weekly support for at least the first four weeks of a quit attempt: this may be by telephone where appropriate.

When has a client successfully quit smoking?

On the basis that the clinical viewpoint tends to be that a client should not be counted as a ‘failure’ if he/she has smoked in the difficult first days after the quit date, a client is counted as having successfully quit smoking if he/she has not smoked at all since two weeks after the quit date.
Follow-up

The four week follow-up (and Carbon Monoxide (CO) validation, if appropriate) must be completed within six weeks of the quit date. Persons not contacted within this time are treated as lost to follow-up for evaluation purposes.

Carbon Monoxide (CO) validation

CO monitoring is normally carried out with all clients of the NHS Stop Smoking Services who self-report as not having smoked since two weeks after the quit date, at the four week follow-up. CO monitoring would not be undertaken where follow-up was carried out by telephone.

Prescriptions dispensed

The prescription data available in this bulletin are not routinely available. This information was obtained from the Prescribing Analysis and Cost tool (PACT) system, which covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Prescriptions written in England but dispensed outside England are included. Prescriptions written in hospitals/clinics that are dispensed in the community, prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in PACT data. It is important to note this as some British National Formulary (BNF) sections have a high proportion of prescriptions written in hospitals that are dispensed in the community. Nicotine Replacement Therapies (NRTs) are not prescription only so the figures for this category may be an underestimate of actual use. ePACT only captures those NRTs that have been written on a prescription form so any NRTs bought over the counter or through other non-prescription routes e.g. smoking cessation clinics, will not have been captured. National prescription data may be available on request. More information is available at:

Prescriptions are written on a prescription form known as a FP10. Each single item written on the form is counted as a prescription item. Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charges income.

Nicotine Replacement Therapy (NRT) and bupropion (Zyban)

Prior to April 2001, Nicotine Replacement Therapy (NRT) was available through NHS Smoking Services on a voucher scheme, and only a few NRT products were available on prescription. All NRT products became available on NHS prescription from April 2001. Bupropion (Zyban) was made available on NHS prescription in June 2000. For more information about NRT products and bupropion generally, see the following website:
gosmokefree.nhs.uk/what-suits-me/patches-gum-and-more/
Nicotine Replacement Therapy (NRT)

- Patches: these work by releasing a steady dose of nicotine into the blood stream, via the skin. Some patches are intended to be worn during the day only and other ‘24-hour’ patches are designed for 24-hour use in order to help stave off early morning cravings.
- Gum: this should be chewed gently and then ‘parked’ in the cheek so that nicotine is absorbed through the lining of the mouth.
- Nasal spray: this is the strongest form of NRT and is a small bottle of nicotine solution, which is sprayed directly into the nose. Absorbed faster than any other kind of NRT, this can help heavier smokers, especially where other forms of NRT have failed.
- Microtab: a small white tablet put underneath the tongue and left. It works by being absorbed into the lining of the mouth.
- Inhaler: this resembles a cigarette. Nicotine cartridges are inserted into it, and inhaled in an action similar to smoking. It is particularly suitable to those people who miss the hand-to-mouth movements of smoking.

Bupropion (Zyban)

This drug works by suppressing the part of the brain that gives the smoker a nicotine buzz when smoking a cigarette. It reduces the cravings as well as the usual withdrawal symptoms of anxiety, sweating and irritability.

Varenicline (Champix)

Champix, generic name varenicline, is a prescription pill designed to help smokers stop smoking. Varenicline works primarily in two ways. Firstly, it reduces the smoker’s craving for nicotine by binding to nicotine receptors in the brain and reduces the symptoms of withdrawal. Secondly, it reduces the satisfaction a smoker receives when smoking a cigarette. It is taken orally.

The European Commission approved varenicline on 29 September 2006 as a pharmacology to help adults quit smoking, based on the results from clinical trials. In trials, 44% of the group treated with varenicline had stopped smoking after being treated for 12 weeks, as opposed to 11% of smokers taking the placebo. Over the same duration, it was also shown to be twice as effective as Bupropion (Zyban), the other main pharmacology to help people quit smoking. The National Institute for Health and Clinical Excellence (NICE) issued guidance in August 2007, which recommended the use of varenicline in the NHS.
Appendix C: Editorial Notes

For the purpose of clarity, figures in the bulletin are shown in accordance with the NHS Information Centre publication conventions.
These are as follows:

- not applicable
* number suppressed (see Appendix B for further information)
Appendix D: Further Information

This annual bulletin draws together statistics on NHS Stop Smoking Services for the year 2011/12. The next annual bulletin is expected to be published in August 2012.

Constructive comments on this report would be welcomed. Questions concerning any data in this publication, or requests for further information, should be addressed to:

The Contact Centre
1 Trevelyan Square
Boar Lane
Leeds
West Yorkshire
LS1 6AE

Telephone: 0845 300 6016
Email: enquiries@ic.nhs.uk

This bulletin is available on the internet. We also welcome feedback through feedback form available at this site:
www.ic.nhs.uk/pubs/sss11q3

Previous NHS Stop Smoking Services bulletins, also published by the NHS Information Centre can be found at: www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services

Editions prior to that were published by the Department of Health. Information about their statistics and surveys is available on the Department of Health’s website at: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_4032542

General Lifestyle Survey

From 2008, the General Household Survey (GHS) became a module of the Integrated Household Survey (IHS). In recognition, the survey was renamed the General Lifestyle Survey (GLF). Please refer to the IHS web page for further information http://www.statistics.gov.uk/CCI/nugget.asp?ID=936&Pos=1&ColRank=1&Rank=224

The General Lifestyle Survey is a continuous survey carried out by the Office for National Statistics (ONS). It collects information on a range of topics from people living in private households in Great Britain. Questions about smoking were included in the survey in
alternate years since 1974. Following a review of the GLF, questions on smoking have been included in the questionnaire every year from 2000 onwards.

The GLF 2009 is the latest report available and presents information about trends in cigarette smoking. It also discusses variations according to personal characteristics such as sex, age, socio-economic classification and economic activity status. The response rate for the 2009 survey was 73%, giving an achieved sample size of 8,206 households and 15,325 adults aged 16 and over. The smoking and drinking questions were answered in person by 13,488 of these adults (interviews obtained by proxy from another member of the household do not include all questions on smoking and drinking).

It is probable that the GLF underestimates both cigarette consumption and prevalence, within all age groups but underreporting of prevalence is most likely to occur among younger people. To protect their privacy, particularly when being interviewed in their parents’ home, young people aged 16 and 17 complete the smoking and drinking sections of the questionnaire themselves.

Weighting to compensate for non-response was introduced into the GLF in 1998. The effect of weighting on the smoking data is slight, increasing overall prevalence of cigarette smoking by one percentage point each year.

Although other surveys collect data on smoking prevalence, the GLF is the preferred source for reporting smoking prevalence due to the large sample size and nature of the survey.

**Move to calendar year**

In 2005, the timeframe for the survey was changed from a financial year basis to calendar year basis. Where questions were the same in 2005 as in 2004/05, the final quarter of the 2004/05 collection has been added to the nine months of the 2005 survey data in order to provide estimates based on a full calendar year, and to ensure any seasonal variation is accounted for.

**Longitudinal data**

Another change in 2005 was that, in line with European requirements, the GHS adopted a longitudinal sample design, in which households remain in the sample for four years (waves) with one quarter of the sample being replaced each year. Thus approximately three quarters of the 2005 sample were re-interviewed in 2006. A major advantage of the longitudinal component of the design is that it is more efficient at detecting statistically significant estimates of change over time than the previous cross-sectional design. This is because an individual’s responses to the same question at different points in time tend to be positively correlated, and this reduces the standard errors of estimates of change.

General Lifestyle Survey 2009: Smoking and Drinking among Adults, 2009. Office for National Statistics. Available at:
ONS have recently undertaken a consultation on the future of the General Lifestyle Survey. This consultation closed on the 6th May 2011, further information can be found at; http://www.ons.gov.uk/about/consultations/closed-consultations/the-future-of-the-glf-survey/index.html

**Infant Feeding Survey**

Statistics on smoking behaviour among women before and during pregnancy are available from the Infant Feeding Survey. The Infant Feeding Survey (IFS) covers the population of new mothers in the United Kingdom and is carried out every 5 years, the first in 1975. In 2010, the survey was conducted by the IFF Research with a sample size of 15,724.

The main aim of the survey is to provide figures on the incidence, prevalence and duration of breastfeeding and other feeding practices. The survey also collects information on the smoking and drinking behaviours of women before, during and after pregnancy. The IFS 2010: Early Results were published in 2011 and the full report is expected to be published by The NHS Information Centre in 2012. The IFS provides information on smoking during pregnancy and presents the information by age, socio-economic classification and region. Some key findings from IFS 2010: Early Results are:

- In 2010, 26% of women in England smoked in the 12 months before or during their pregnancy and 12% smoked throughout pregnancy, a fall from 19% in 2000.

- Younger mothers were more likely to smoke throughout pregnancy; 36% of mothers aged 20 or under reported smoking throughout pregnancy, compared to 6% of mothers aged 35 or over.


**Omnibus Survey**

The Omnibus Survey is a multi-purpose continuous survey carried out by the Office for National Statistics on behalf of a range of government departments and other bodies, last published in 2008/09. In 2008/09, interviews for the smoking module of the survey were conducted with around 1,200 adults aged 16 and over, in private households in Great Britain each month.
In 2008/09, data collected included: views about giving up smoking, attempts to give up smoking and attitudes towards smoking restrictions.


NHS Stop Smoking Services collection 2008/09 onwards

From the 2008/09 collection onwards, all data has been collected at a Primary Care Trust (PCT) level directly from PCTs using a web-based tool. Previously the NHS Information Centre collected quarterly data from local Stop Smoking Services via aggregated Strategic Health Authority (SHA) returns.

By collecting PCT level information we have been able to provide much more detailed figures for use by PCTs enabling them to put their own performance in a national context without adding to the burden of current collection, indeed we hope that burden has been reduced for SHAs. The NHS Information Centre is responsible for the collection of the data from PCTs including chasing any late returns, informing PCTs of developments and key dates and validating the data. To avoid different versions of the data, data relevant to the SHA will be shared prior to publication so they can still meet existing monitoring requirements.

Additional data items were collected for the first time in 2008/09 collection, this will continue to be the case for subsequent collections. These included:

- Intervention type and setting;
- Socio-economic group;
- Exception reporting system.

Research

The Department of Health commissioned an evaluation to complement the routine monitoring of the NHS Stop Smoking Services. The study began in November 2000 and reported in April 2005 in a supplement of the journal Addiction\(^3\). It was conducted by a team of researchers led by Professor Ken Judge of the University of Glasgow and examined issues of service development and impact. There was a particular focus on the extent to which target groups of smokers are being reached and the relationship between different types or models of service and success rates. This study built on an evaluation of services in Health Action Zones in 1999/00 and a study of Stop Smoking Services in Trent region\(^4\). The evaluation included a pilot study examining 52 week success rates.

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\(^3\) Addiction, Volume 100, Supplement 2. McNeill A, Raw M, Bauld L, Coleman T

The evaluation of the NHS Stop Smoking Services programme concluded that equality of access to treatment is very good and that the services have the potential to make a real, if modest, impact on health inequalities. The evaluation also found that around 15% of smokers who set a quit date with the services can be expected to still be non-smokers after a year.

A series of presentations from the 2007, 2008, 2009 and 2010 UK National Smoking Cessation Conference, covering recent and ongoing research into smoking cessation, can be found on the UK National Smoking Cessation Conference website:

http://www.uknscc.org/2008_UKNSSC/intro.html

The presentations cover a wide range of topics, including research into directing resources to help people quit, lapsing and relapsing, the role of pharmacotherapies to help people quit smoking in reducing health inequalities, best practice for smoking cessation in pregnancy and a Stop Smoking Services plan to maximise the effects of smoke free legislation.

Long term quit rates

The NHS Stop Smoking Services data look at quit rates at the four week follow-up. Research on long term quit rates can be found here;


Smoking, drinking and drug use among young people in England

Between 1982 and 2003, surveys of secondary school children in England were carried out for the Department of Health. This was done by the Office of Population Census and Surveys (OPCS) between 1982 and 1994, by the Office for National Statistics (ONS) between 1994 and 1999 and by the National Centre for Social Research (NatCen) and the National Foundation for Educational Research (NFER) between 2000 and 2003. Since 2004, the survey has been run by NatCen and NFER on behalf of the NHS Information Centre.

From 1982 to 1988, the survey was solely concerned with monitoring trends of young people and smoking. In 1988, questions on alcohol consumption were added and have been included in the survey ever since. The 1998 survey was also expanded to include questions on drug use. The core of the questionnaire comprises of questions about the prevalence of drug use, smoking and drinking and, since 2000, the remainder of the questionnaire focuses, in alternate years, on either smoking and drinking or drug taking. The most recent survey in the series is Smoking, Drinking and Drug Use among Young People in England in 2010 (SDD10).
The target population for the survey is secondary school children in England, in years 7 to 11, from almost all types of school (comprehensive, secondary modern, grammar and other secondary schools), both state and public. Only special schools and hospital schools are excluded from the survey.

The design of the sample was changed in 2010. For surveys between 2000 and 2009, the sample of schools was stratified by school type and sex of intake, and selected across regions in proportion to the distribution of the population of 11 to 15 year olds. In 2010, the sample was stratified by Strategic Health Authority (SHA); within each SHA an equal number of schools was sampled.

The survey is conducted using a confidential questionnaire, which the pupils fill in individually. Fieldwork of the most recent survey (SDD10) was carried out during the autumn term of 2010 and 246 schools agreed to take part in the survey, resulting in a sample of 7,296 questionnaires.


Statistics on Smoking in England

The Statistics on Smoking: England report is a compendia report that presents a range of information on smoking which is drawn together from a variety of sources. The report aims to present a broad picture of health issues relating to smoking in England and covers topics such as smoking habits, behaviours and attitudes among adults and school children, smoking-related ill health and mortality and smoking-related costs.

This report combines data from different sources presenting it in a user-friendly format. It contains data and information previously published by the NHS Information Centre, Department of Health, the Office for National Statistics and Her Majesty’s Revenue and Customs. The report also includes new analyses carried out by the NHS Information Centre.

The latest report Statistics on Smoking: England, 2011 is available from the following link: www.ic.nhs.uk/pubs/smoking11