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WHAT ABOUT YOUTH?

Health and Wellbeing of 15 year olds in England: Smoking Prevalence – Findings from the What About YOUth? Survey 2014

4 August 2015

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This report may be of interest to members of the public, policy officials and other stakeholders to make local and national comparisons and to monitor the quality and effectiveness of services.

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Version:	**V1.0**
Date of publication:	**4 August 2015**

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Summary of key findings

- 24 per cent of young people had ever smoked.
- 8 per cent of young people were current smokers.
- Girls were more likely than boys to have ever smoked (28% and 21% respectively).
- Over a quarter of young people in the most deprived areas had ever smoked (27%), compared to just over a fifth of young people in the least deprived areas (21%).
- Young people from a BME background were less likely to say they had ever smoked than young people from a white background (17% and 26% respectively).
- The region with the lowest prevalence of ever smoking was London where 21 per cent of young people had ever smoked compared with 28 per cent in the North East.
- 18 per cent of young people had ever used e-cigarettes. There was no significant difference between boys and girls in the percentage who had ever used e-cigarettes (19% and 18% respectively).
- 15 per cent of young people had ever used other tobacco products.

1. Introduction

1.1. Background and policy context

Smoking and tobacco use continues to be one of the most significant public health challenges in England. Although smoking prevalence among adults has declined over recent decades, it has almost plateaued, reducing very little since 2007[1]. Smoking is the main cause of early death and preventable morbidity in England, and smoking rates are much higher in certain social groups, such as those with the lowest incomes. Smoking has continued to decline among young people in recent years[2]. In 2007, the legal age for the purchase of tobacco in England and Wales was raised from 16 to 18 years. Legislation which banned the sale of cigarettes from vending machines in 2011, the display of tobacco products in supermarkets in 2012 and in smaller shops in 2015, was also intended to deter young people from buying cigarettes[3]. The minimum age to smoke in public is 16 years and cigarettes can be confiscated from those under 16 caught smoking in public.

The Department of Health developed and published their policy 'Healthy Lives, Healthy People: a tobacco control plan for England' in March 2011, which set out government plans for reducing tobacco use over 2011 to 2015[4]. This was a wide-ranging approach which identified how healthy behaviour can be promoted. Smoking is an addiction that is largely developed in childhood and adolescence, and young people in particular can quickly develop a dependence on nicotine[5]. The younger the age of uptake of smoking, the greater the harm because of the association of early uptake with heavier smoking and higher levels of addiction[6]. Therefore, the coalition government focused efforts on reducing and preventing smoking among teenagers. By the end of 2015, they were aiming to reduce regular smoking rates to 12 per cent or less for 15 year olds in England, compared to 15 per cent in 2009[7].

The commitment from the coalition government included adding a smoking prevalence indicator (split into three sub-indicators) to the Public Health Outcomes Framework (PHOF)[8,9] in order to monitor performance against this target. These sub-indicators are the percentage of 15 year olds who are regular, occasional and current smokers (current is

regular and occasional combined). The questions on smoking behaviour in the What About YOUth 2014 (WAY 2014) survey provide data for Local Authorities (LAs) to monitor smoking prevalence among young people, and inform local policy making. The data from this survey will become the source for this PHOF indicator. The data will allow comparisons between LAs and against the national position. If the survey is repeated, it will allow trends to be tracked over time.

The WAY 2014 survey also asks about the use of electronic cigarettes (e-cigarettes). These are not subject to the same regulation as tobacco products. There is a lack of information about whether they are safe or effective, and as a result, the Medicines and Healthcare Products Regulatory Agency (MHRA) is carrying out research into e-cigarettes, providing evidence for any regulation that may be needed for these products[10]. The data from WAY 2014 will provide information about the use of e-cigarettes among young people.

The use of other tobacco products[11] is also of concern. These products also carry health risks and tobacco legislation applies to them too. There are a number of initiatives that have been carried out to raise awareness of these health risks and the legislation which also applies to these products[12]. WAY 2014 also collected data on the use of these other tobacco products.

1.2. Definitions and methodological issues

Participants for WAY 2014 were sampled from the Department for Education's National Pupil Database (NPD). The NPD is a near full population database (the exception being that independent schools are not included). The selected sample was split by gender and then proportionately stratified by LA, and then stratified within each LA based on background variables on the sample frame, so that all 15 year olds of each gender within an LA had an equal chance of being selected. Parents or carers of the selected sample were sent a separate pre-notification letter at the same time as the selected respondents, giving them the opportunity to opt-out their child. After this mailout, the questionnaire, a covering letter and a study leaflet were sent to young people who had not opted-out, inviting them to take part.

The original sample for the first mailout was 298,080, of which 3,056 were undeliverable or had opted-out before the questionnaire mailing. Questionnaire packs were subsequently sent to 295,024 young people and 120,115 of these responded with useable data, giving an unadjusted response rate of 40 per cent (based on the issued sample) and an adjusted response rate of 41 per cent (this excludes any undeliverables and opt-outs from the issued sample). Please see Section A.3 of Appendix A for further information. Young people could complete the paper questionnaire or complete online.

All respondents in WAY 2014 were asked the questions about smoking, apart from those who completed the online questionnaire and responded yes to a question which asked whether they were receiving help with completing the questionnaire (approximately 600 participants were helped). These participants were not asked questions about smoking, in order to minimise any under reporting associated with them being observed while completing the questionnaire. Young people who received help when answering the paper questionnaire were asked these questions as it was not feasible to route them out. The question about age when they first smoked was asked of all participants who said they had 'ever smoked'. There was no other routing in this section.

Definitions used within this chapter on smoking frequency are taken from a question which offers six categories to describe their smoking behaviour. This is summarised in Figure 1.1 and more detail is given in Section A.4 of Appendix A.

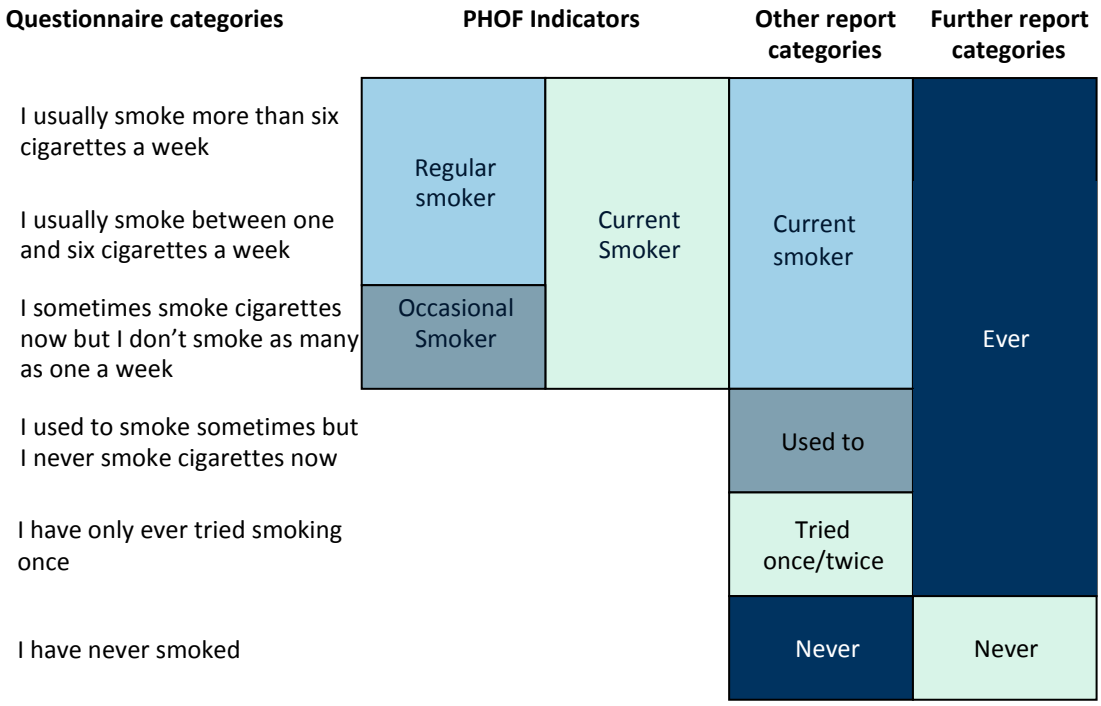
1.3. Further data from the survey

This report covers the key smoking findings from the WAY 2014 survey. The smoking prevalence findings needed for the PHOF have also been published by Public Health England (PHE) on 4 August 2015 via their Fingertips tool on their website: http://www.phoutcomes.info

A main report covering all the key survey findings on all the other health topics (including general health, diet, use of free time, physical activity, drinking, emotional wellbeing, drugs and bullying) is expected to be published in December 2015. Any additional information collected by the survey will be available in the full survey dataset which is to be sent to the UK Data Service for depositing within 3 months of the main publication release.

A set of Excel tables accompany this report which include all the data tables related to this report but not all presented here (therefore, the table numbering does not follow suit in this report document).

Figure 1.1: Questionnaire categories and analysis categories



As well as providing data on smoking prevalence, there are also data on smoking attitudes, the use of e-cigarettes and the use of other tobacco products. E-cigarettes are designed to mimic the sensation of smoking, and are thought to be less harmful, though there is currently a lack of evidence on this. Examples of 'other tobacco products' given in the question were "shisha pipe, hookah, hubble-bubble, water pipe, etc.". These were presented as examples with an "etc." at the end of the question so it is possible that young people included other products when answering this question. The categories for both e-cigarettes and other tobacco products follow a similar breakdown to that used for cigarette smoking (see Section A.4).

1.4. Other sources of data on smoking behaviour among children

Up until the release of WAY 2014 data, the data used to develop the PHOF target[13] and inform policy has come from the Health and Social Care Information Centre's 'Survey of Smoking, Drinking and Drug Use Among Young People' (SDD)[14]. This school-based survey collected data from young people aged 11 to 15, and covers a wide range of topics on smoking behaviour, influences on smoking, attitudes and beliefs about smoking, and other issues that may be associated with cigarette smoking. Other survey data sources include the Health Behaviour in School-aged Children (HBSC)[15], the Health Survey for England (HSE)[16] and the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)[17].

Even though the questions on smoking behaviour in these other surveys are either identical or very similar to those used in WAY 2014, the fact that the surveys are carried out

differently impacts on the comparability of the results. Crucially, the majority of children completing the WAY 2014 survey probably did so at home, since it was sent to their home address. There have been some previously published comparisons of carrying out surveys in home and school settings.

The 2013 Health Survey for England report[18] compared the prevalence of regular smoking among children with those from the 2013 SDD survey. HSE is carried out in a home setting although the smoking module is administered by self-completion questionnaire, whereas the SDD questionnaire is administered in schools under exam conditions, without any involvement from parents, and in circumstances in which teachers cannot see the answers given. Also in HSE, a saliva sample is taken which is examined for evidence of cotinine at a level above 12ng/ml which is considered to be evidence of recent smoking. Combining data across 2011 to 2013 for HSE showed regular smoking prevalence rates of 1 per cent for both boys and girls when using only their answers to the self-reported questions. However, when the evidence from the saliva tests was added, the prevalence rate rose to 4 per cent for both boys and girls, which was comparable to the 3 per cent for boys and 4 per cent for girls from SDD in 2013.

SDD also included saliva tests for around half of the sample up until 1998. The 1999 SDD report summarised the findings from these tests in previous years and reported that in general, the findings from the saliva tests matched those from the self-reported SDD questions on smoking behaviour[19].

Although not directly concerned with smoking, the Home Office published a report in 2006[20] which looked at various methodological issues around measuring drug use. One particular comparison looked at the drug taking prevalence rates from SDD in 2003 with those from the Offending, Crime and Justice Survey (OCJS) which was administered at home. It found much higher prevalence rates from SDD: the prevalence rate for ever tried cannabis was roughly twice as high from SDD when compared to OJCS. There is also evidence in the literature of large by-stander effects in this age group[21].

To summarise, it appears that children feel able to answer questions on smoking more honestly when asked away from the home setting and therefore smoking prevalence results from WAY 2014 are expected to be lower than those from SDD. However, using school based samples was not feasible for WAY 2014 for several reasons. Firstly, a survey of this size would have placed too great a burden on schools. Furthermore, given the importance of providing LA estimates, a school based survey would have been difficult to use for estimates by LA of residence. The results from WAY 2014 are particularly useful for identifying differences between local areas as well as the characteristics of young people who are most likely to engage in smoking, even though young people may be less likely to report risky behaviours at home than they are in a school based survey. Due to its much larger sample size, WAY 2014 is able to provide robust estimates at LA level, which are not available from current school based and interviewer led surveys, which have smaller sample sizes. This will allow resources to be targeted in a more effective way to help those most in need.

Any future waves of WAY will also allow these differences to be monitored more closely over time, than would be possible with data from other surveys, which sometimes need a few years' worth of data to be sure that differences seen over time are real and not statistical quirks due to small sample sizes.

2. What about smoking: Findings

2.1. Prevalence of smoking and smoking behaviour

The majority of young people in England said they did not currently smoke (92%). 8 per cent said they currently smoked, which comprised 5 per cent who were regular smokers and 3 per cent who smoked occasionally. Just over three-quarters of young people said they had never smoked (76%), and a further 12 per cent had only tried smoking once. **(Table 2.1)**

Girls were more likely to report current smoking than boys (10% compared with 7%) and they were more likely than boys to have ever tried smoking (28% compared with 21%).

Table 2.1: Smoking behaviour by gender, 2014

Base: All who were not observed

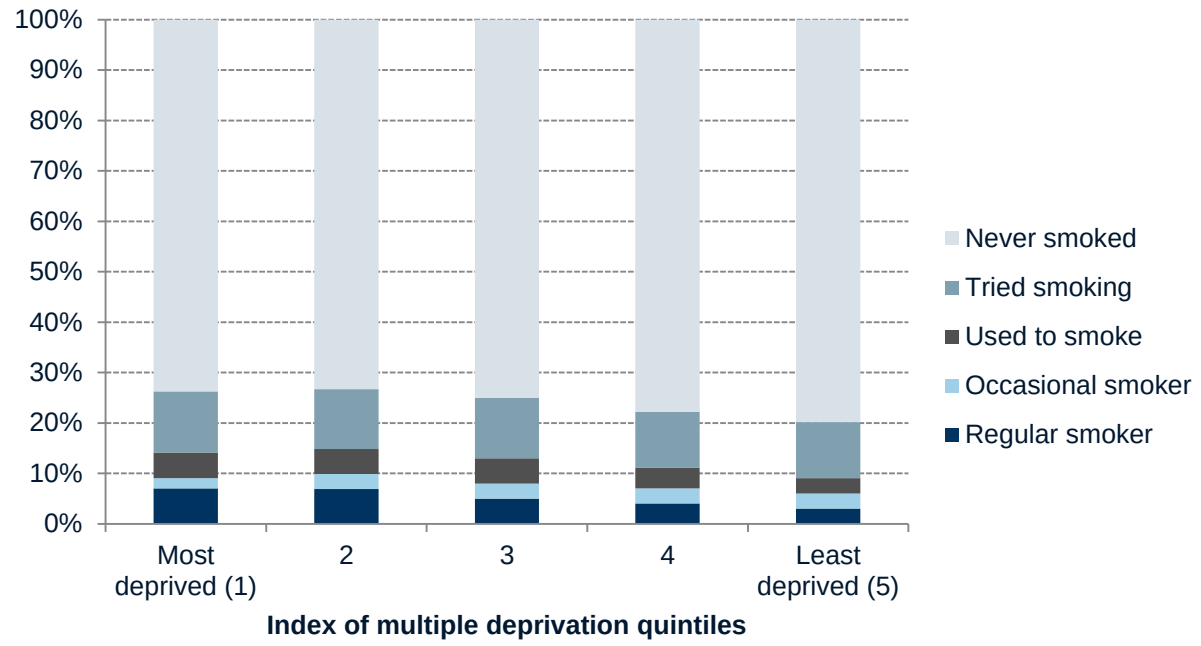
Per cent

	Gender		
Smoking behaviour[a]	**Boys**	**Girls**	**Total**
Regular smoker	*5*	*6*	*5*
Occasional smoker	*2*	*4*	*3*
Current smoker	**7**	**10**	**8**
Used to smoke	*4*	*5*	*4*
Tried smoking	*11*	*13*	*12*
Ever smoked	**21**	**28**	**24**
Never smoked	**79**	**72**	**76**
Base			
Unweighted	*55,711*	*59,801*	*116,646*
Weighted	*276,838*	*265,956*	*548,282*

[a] Regular smokers were those who reported smoking at least one cigarette a week, occasional smokers reported smoking less than one cigarette a week. Current smokers are a combination of regular and occasional smokers. Ever smoked is a combination of currently smoke, used to smoke and tried smoking. Tried smoking includes those who only tried smoking once.

In addition to this, the prevalence of smoking varied considerably among different groups of young people. Young people from the most deprived areas[22] were more likely to be regular smokers than those from the least deprived areas (7% and 3% respectively). Over a quarter of young people in the most deprived areas had 'ever smoked', compared to just over a fifth of young people in the least deprived areas (27% and 21% respectively). Young people who received free school meals were more likely than those who did not to be current smokers (13% and 7% respectively). **(Tables 2.2 and 2.3 and Figure 2.1)**

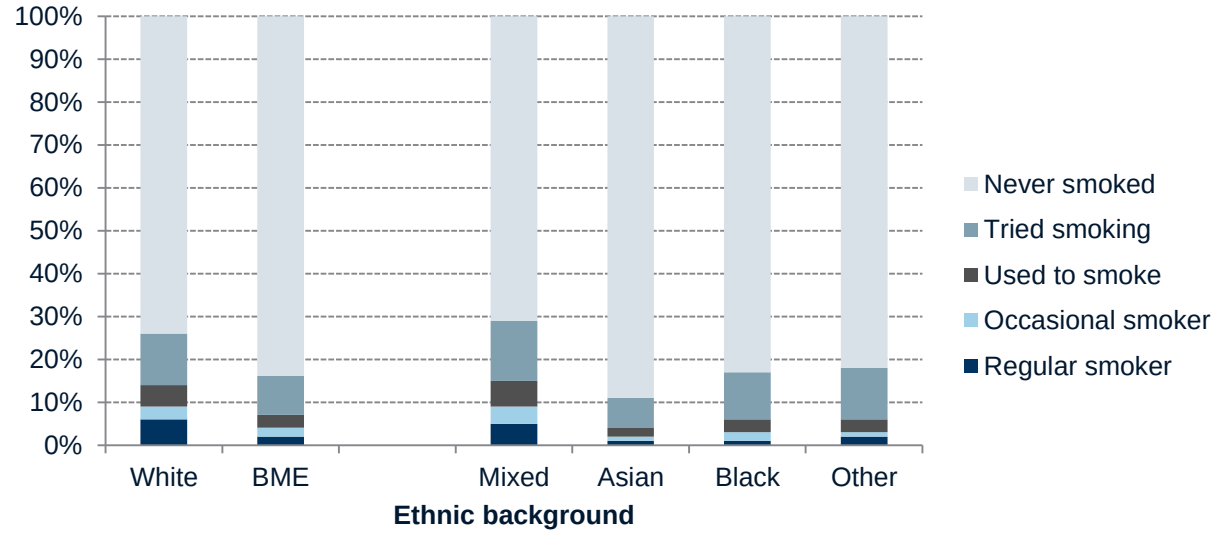
Figure 2.1: Smoking behaviour by Index of Multiple Deprivation Quintiles, 2014



Bases: Unweighted: IMD1 26,911, IMD2 23,526, IMD3 21,723, IMD4 21,431, IMD5 23,055.
Weighted: IMD1 124,739, IMD2 111,903, IMD3 98,285, IMD4 100,412, IMD5 112,943.

Young people from a BME background were less likely to say they had ever tried smoking than young people from a white background (17% compared with 26%). Young people from a white background were more likely than those from a BME background to be regular smokers (6% and 2% respectively) and the same applies to current smoking (9% from a white background and 4% from a BME background). **(Table 2.4 and Figure 2.2)**

Figure 2.2: Smoking behaviour by ethnicity, 2014



Bases: Unweighted: White 89,337, BME 22,128, Mixed 4,462, Asian 11,207, Black 5,399, Other 1,060.
Weighted: White 423,082, BME 100,708, Mixed 21,207, Asian 51,696, Black 23,091, Other 4,715.

Those who reported their general health as poor were most likely to be regular smokers, compared with all young people and those who rated their general health as excellent (14% compared with 5% and 2% respectively). **(Table 2.5)**

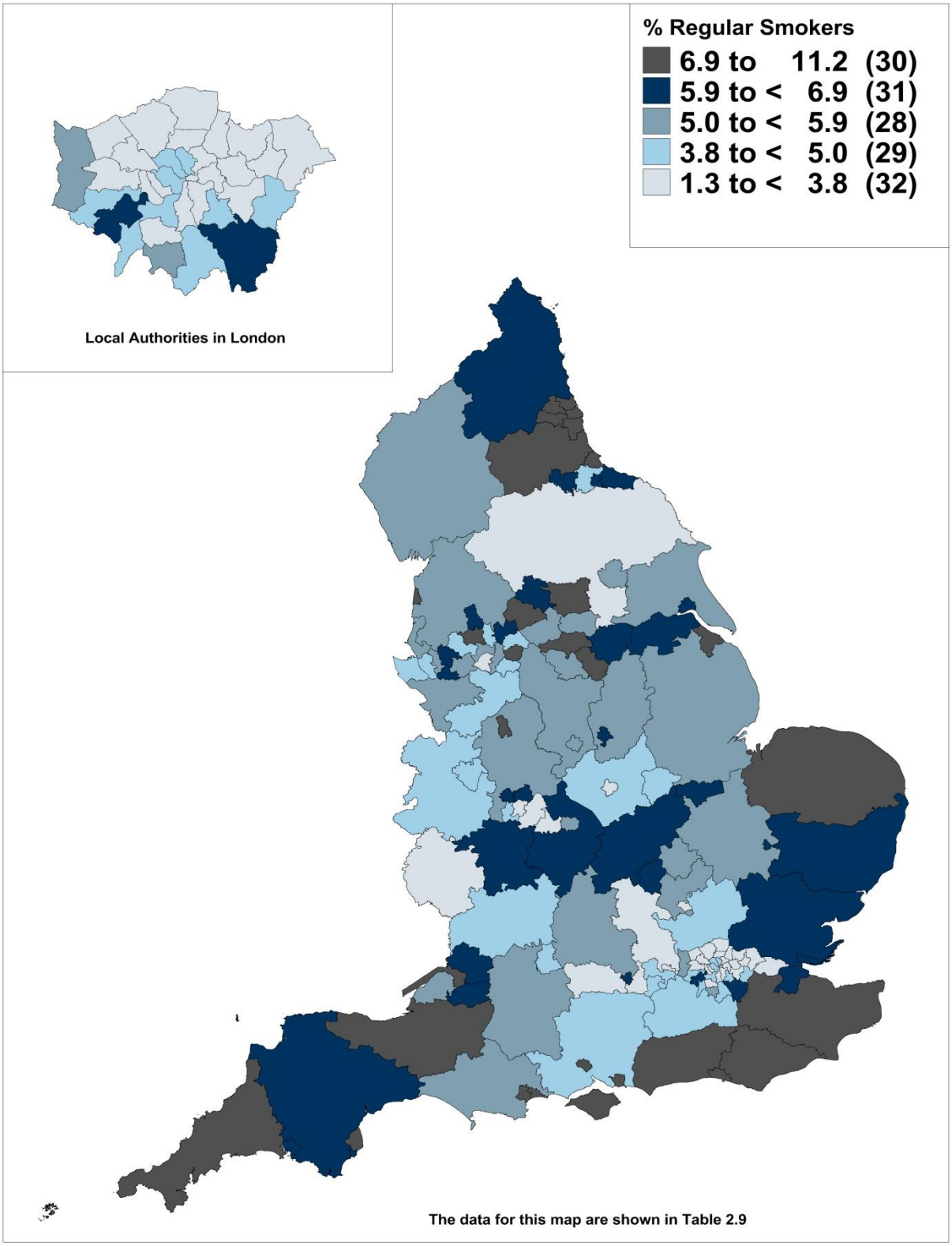
Smoking prevalence was higher among young people who had been bullied as well as those who had bullied others in the last couple of months, compared with those who had not been involved in bullying. Young people who had bullied others were far more likely to be regular smokers (13%) than those who had not bullied others (5%). Those who had been bullied were nearly twice as likely to be a regular smoker (7%), compared with those who had not been bullied (4%). **(Tables 2.6 and 2.7)**

More young people in the North East reported being regular smokers (8%) than in any other region. Young people in this region also reported the highest level of having ever smoked (28%). London had the lowest prevalence of regular smoking, with 3 per cent of young people reporting being regular smokers. **(Table 2.8)**

By LA the highest percentage who had ever smoked were in Richmond upon Thames and Brighton and Hove (36% had ever smoked for both). In Hartlepool, Torbay, Bristol, Blackpool and Sunderland, 32 per cent of young people had ever smoked. The lowest percentage who had ever smoked was found in Redbridge (13%) and Slough (14%)[23].

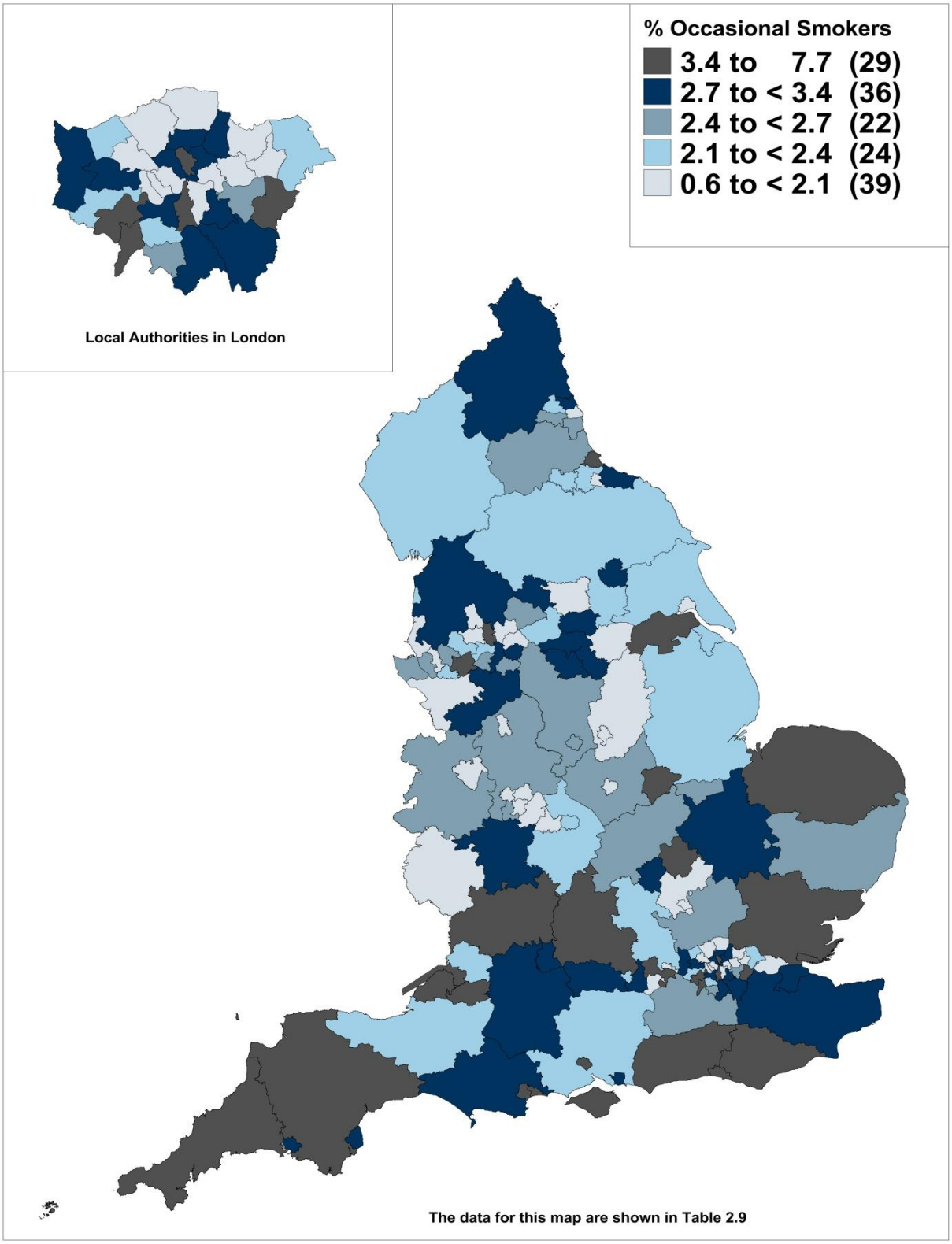
Brighton and Hove, Richmond upon Thames, Torbay, Blackpool and East Sussex were the LAs with the highest percentage who currently smoke (13% or more). Redbridge and Enfield were the LAs with the lowest percentage of current smokers (3%). Data have also been analysed for regular smoking behaviour. Of the eight LAs where 2 per cent or less of young people reported being regular smokers, all but one (Wokingham) were London Boroughs. For the definition of regular/occasional and current smoking please see Figure 1.1.
(Table 2.9 and Figures 2.3-2.5)

Figure 2.3: Percentage of young people who were regular smokers by Local Authority in England, 2014



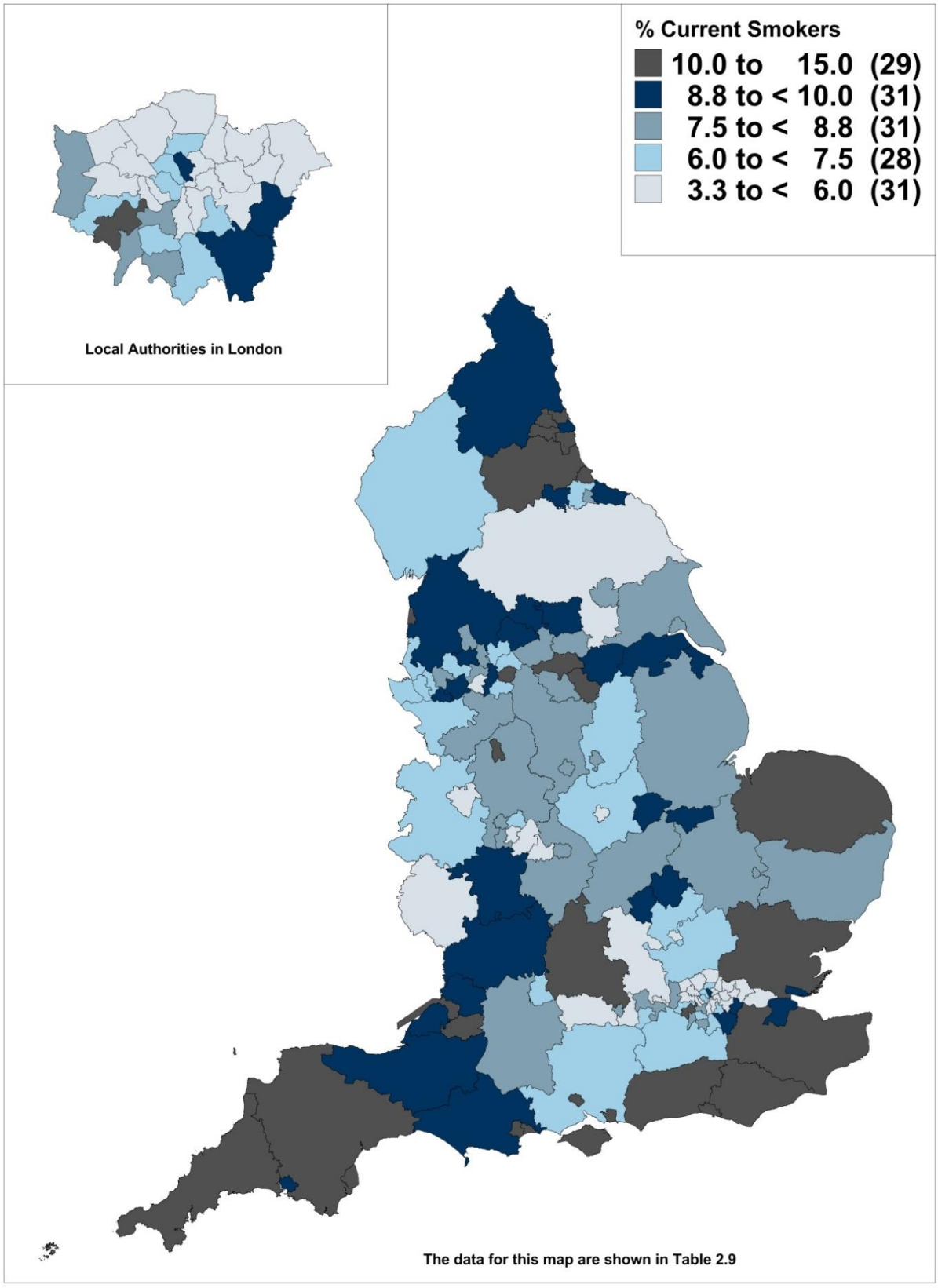
Source: What About Youth Survey 2014

Figure 2.4: Percentage of young people who were occasional smokers by Local Authority in England, 2014



Source: What About Youth Survey 2014

Figure 2.5: Percentage of young people who were current smokers by Local Authority in England, 2014

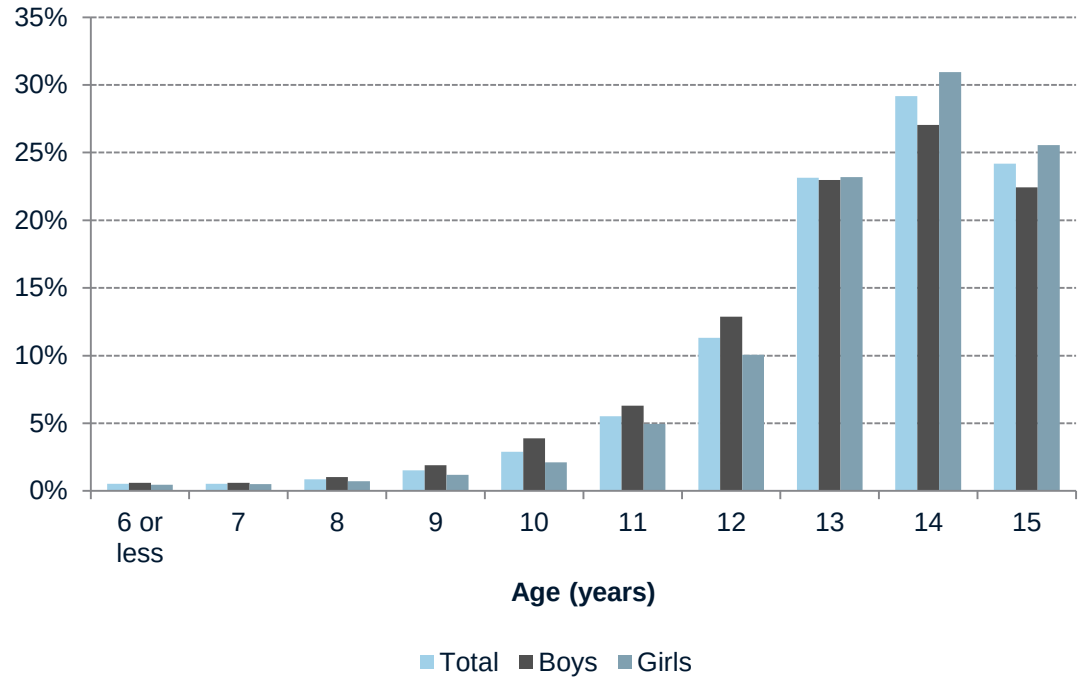


Source: What About Youth Survey 2014

2.1.1. Age of first smoking

The mean age of first trying a cigarette was just over 13 years of age and the modal age was 14 years. Of those who had tried smoking, just over three-quarters had first tried it at age 13 or older (77%[24]). Boys were more likely to have tried smoking before they reached the age of 12 than girls were (14% and 10% respectively). **(Figure 2.6 and Table 2.10)**

Figure 2.6: Age first tried smoking by gender, 2014



Base: includes all those who reported ever smoking at the previous question but excluding those who did not give a valid answer to this question. The base also excludes those who reported first smoking before the age of 4 or at an age older than their current age. The bar for those who reported age of first smoking as 16 years is not shown but they are in the base. All the children surveyed were 15 at the start of the school year in September. Therefore only a few children were 16 by the time they completed the questionnaire which makes the numbers who started smoking at 16 misleading. Data and bases shown in Table 2.10.

2.1.2. Comparisons with other sources

As mentioned before, the WAY 2014 survey follows a number of other surveys which ask questions about smoking, with each survey having a different methodology, sampling strategy or target audience. Although the WAY 2014 data indicates a lower prevalence of smoking compared with many of the other studies, the trends and overall pattern tend to be the same, as discussed below.

The Smoking, Drinking and Drug Use Among Young People in England in 2014[25] (SDD) survey is a key source of data for the development of the Government's strategy. Both surveys found that girls are more likely than boys to have ever tried smoking (37% of girls and 32% of boys aged 15 in the SDD survey had ever smoked compared with 28% of girls and 21% of boys in the WAY 2014 survey). In SDD 2014, 6 per cent of boys and 9 per cent of girls were regular smokers (the corresponding figures from WAY 2014 were 5% and 6% respectively). The higher prevalence reported in the SDD 2014 data reflects the survey methodology as discussed previously. Furthermore, SDD includes a check question for those who reported that they had never smoked. Those who reported that they did once have a puff or two were recorded as ever smoked and there was also a category to report that 'I do sometimes smoke cigarettes'. The responses to this question are used to create a derived smoking status variable in SDD. This check question was not included in WAY 2014

and could contribute to the lower prevalence of ever having smoked in WAY 2014 compared with SDD 2014. However, this impact was investigated and was noted to be very small.

Another survey, although not very recent, also shows a similar pattern. The international study Health Behaviour in School-Aged Children (HBSC) collects information on smoking prevalence. The most recent publically available data is from 2009/10[26]. HBSC data also found a similar pattern in that more girls than boys aged 15 years were regular smokers (14% and 9% respectively)[27].

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) collected data on smoking behaviour among 13 and 15 year olds in Scotland in 2013. This found that 9 per cent of 15 year olds were regular smokers and 87 per cent reported themselves to be non-smokers[28]. However, it also found that there was no significant difference in 'regular' smoking prevalence between boys and girls (8% and 9% respectively), which is different from the other surveys mentioned. SALSUS also found that smoking prevalence increases with age. The trend data shows that regular smoking is at its lowest level since the survey began in 1982 (13% in 2010 down to 9% in 2013).

The SALSUS 2013 survey found that the mean age for young people first smoking was 13 years old, which is the same as the WAY 2014 data. However it should be noted that the SALSUS figure is the mean age for those asked at age 13,14 and 15, whereas WAY 2014 was only asked of 15 year olds.

2.2. Use of e-cigarettes

3 per cent of young people said they currently used e-cigarettes.

18 per cent of young people had ever used e-cigarettes which included 13 per cent who had only tried them once or twice. There was no significant difference between boys and girls in the percentage who had used e-cigarettes (19% and 18% respectively).

(Table 2.11)

Table 2.11: Use of e-cigarettes by gender, 2014

Base: All who were not observed

Per cent

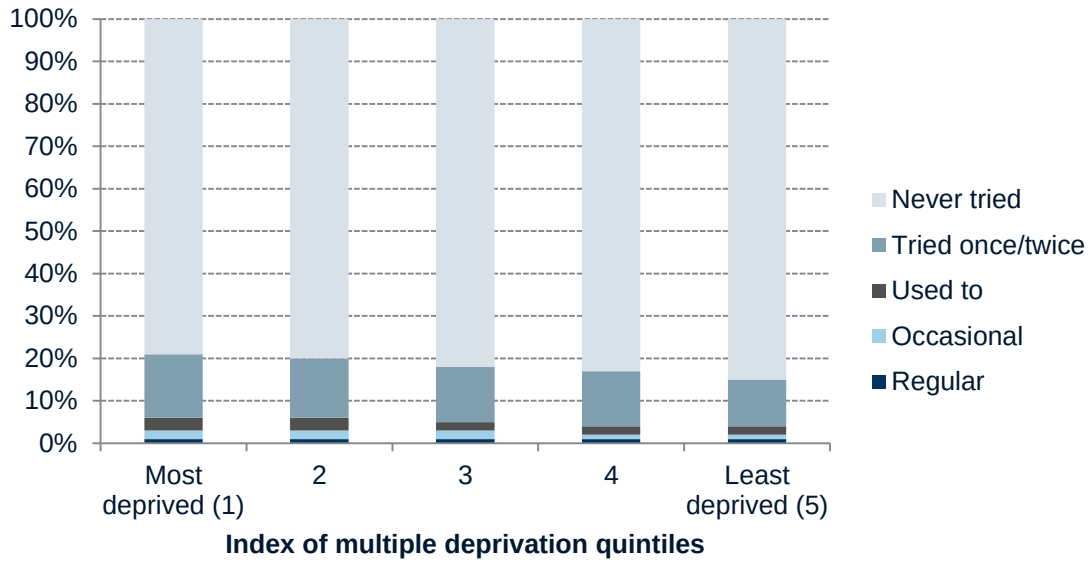
Use of e-cigarettes[a]	Gender Boys	Girls	Total
Regular	*1*	*1*	*1*
Occasional	*2*	*2*	*2*
Currently	**3**	**2**	**3**
Used to	*3*	*2*	*3*
Tried once/twice	*13*	*13*	*13*
Ever	**19**	**18**	**18**
Never tried	**81**	**82**	**82**
Bases			
Unweighted	*56,206*	*60,219*	*117,577*
Weighted	*279,199*	*267,732*	*552,517*

[a] Regular were those who reported using e-cigarettes at least once a week, occasional reported using e-cigarettes less than once a week. Currently is a combination of regular and occasional e-cigarette users. Ever is a combination of currently, used to and tried e-cigarettes. Tried are those who only tried using e-cigarettes once or twice.

Young people living in the most deprived areas[29] were more likely to have ever used e-cigarettes, compared to those in the least deprived areas (21% and 15% respectively). Those who received free school meals were more likely to have ever used e-cigarettes than those who did not receive free school meals (25% and 17% respectively).

(Tables 2.12 and 2.13 and Figure 2.7)

Figure 2.7: Use of e-cigarettes by Index of Multiple Deprivation Quintiles: 2014

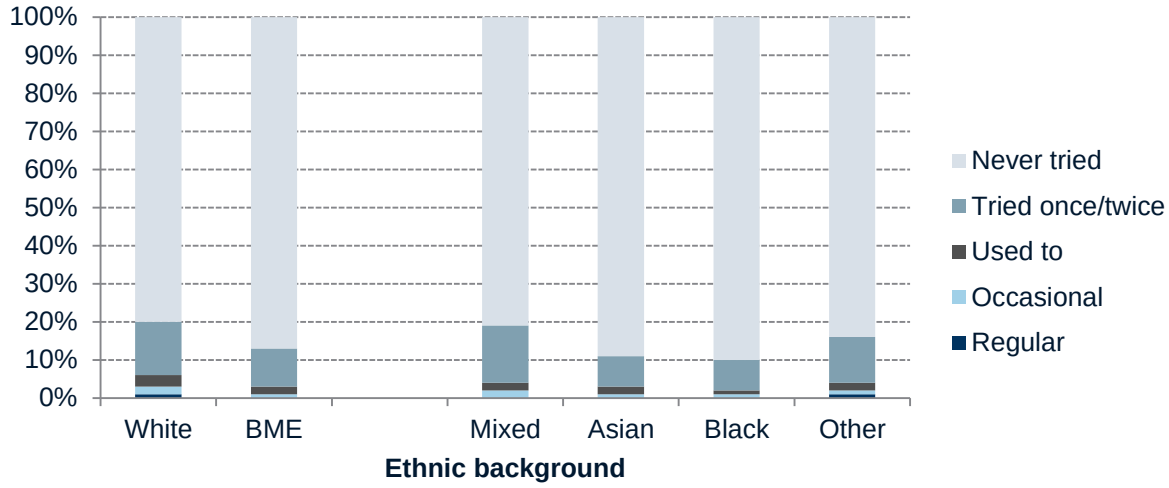


Bases: Unweighted: IMD1 27,188, IMD2 23,753, IMD3 21,866, IMD4 21,564, IMD5 23,206.
Weighted: IMD1 126,026, IMD2 113,065, IMD3 98,825, IMD4 101,031, IMD5 113,571.

Young people from a white background were more likely to say they had ever used e-cigarettes compared with young people from a BME background (20% and 13% respectively). Among those from a BME background, young people from a mixed ethnic background were most likely to have ever used e-cigarettes (19%) and those from Asian and black backgrounds were least like to have ever used them (11% and 10% respectively).

(Table 2.14 and Figure 2.8)

Figure 2.8: Use of e-cigarettes by ethnicity, 2014



Bases: Unweighted: White 90,022, BME 22,328, Mixed 4,501, Asian 11,279, Black 5,474, Other 1,074.
Weighted: White 426,127, BME 101,580, Mixed 21,415, Asian 52,010, Black 23,367, Other 4,788.

Young people who were current smokers or regular smokers were much more likely than non-smokers to have ever used e-cigarettes (76%, 84% and 13% respectively). This pattern was found for both girls and boys: among boys 87 per cent of regular smokers had ever used e-cigarettes compared with 14 per cent among non-smokers. Among girls, 82 per cent of regular smokers and 12 per cent of non-smokers had ever used e-cigarettes. 1 per cent of non-smokers currently used e-cigarettes (among both boys and girls) but among regular smokers, 29 per cent of boys and 21 per cent of girls currently used e-cigarettes.

(Table 2.15)[30]

Table 2.15: Use of e-cigarettes by smoking behaviour, 2014

Base: all who were not observed

Per cent

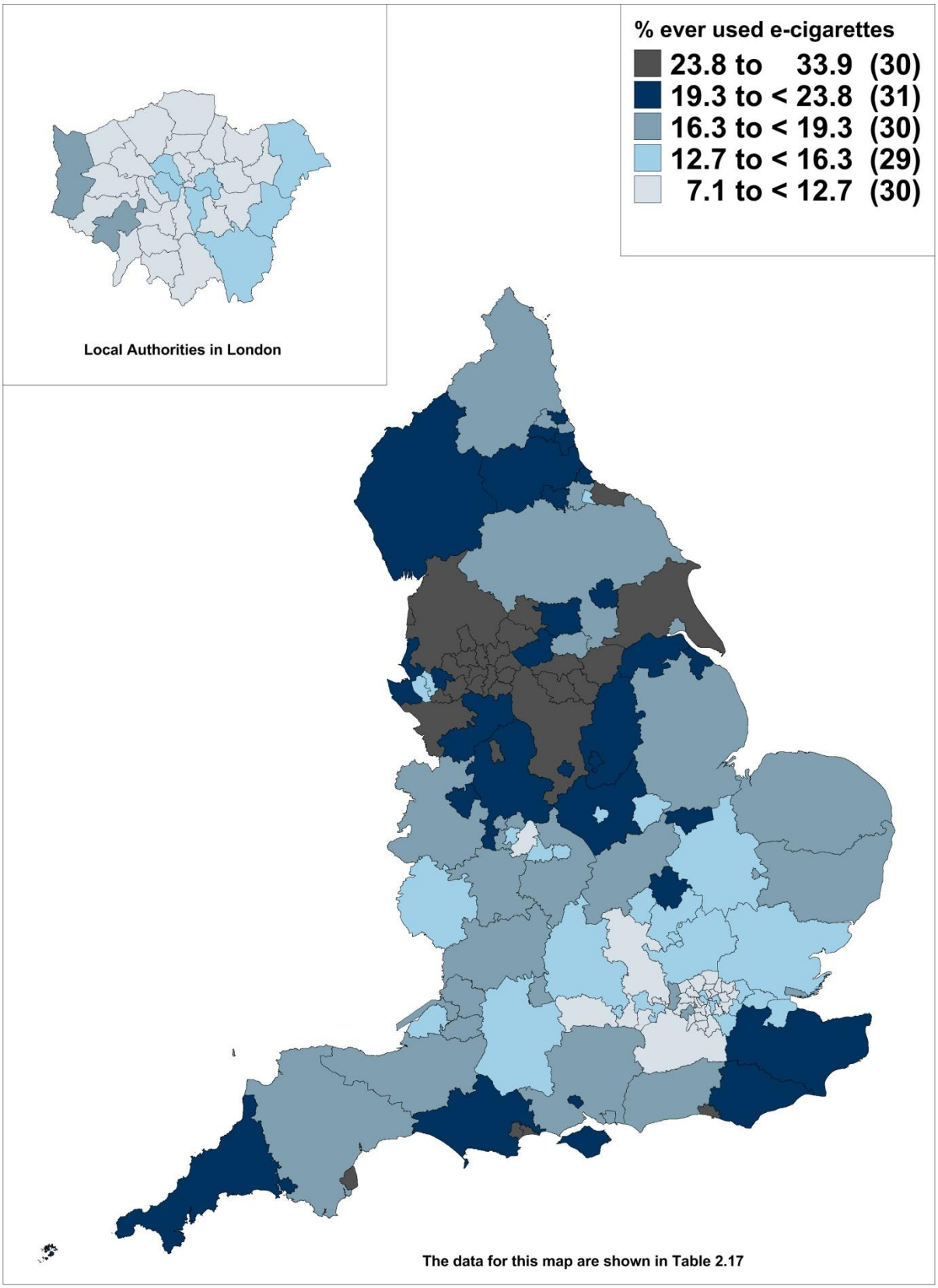
	Smoking behaviour			
Use of e-cigarettes[a]	**Regular smokers**	**Current smokers**	**Non-smokers**	**Total**
Regular	*10*	*8*	*0*	*1*
Occasional	*15*	*13*	*1*	*2*
Currently	**24**	**21**	**1**	**3**
Used to	*20*	*16*	*1*	*3*
Tried once/twice	*39*	*39*	*11*	*13*
Ever	**84**	**76**	**13**	**18**
Never tried	**16**	**24**	**87**	**82**
Base				
Unweighted	*6,018*	*9,237*	*106,401*	*117,577*
Weighted	*29,673*	*44,624*	*498,800*	*552,517*

[a] Regular were those who reported using e-cigarettes at least once a week, occasional reported using e-cigarettes less than once a week. Currently is a combination of regular and occasional e-cigarette users. Ever is a combination of currently, used to and tried e-cigarettes. Tried are those who only tried using e-cigarettes once or twice. For the smoking status cross-break regular smokers are a sub-set of current smokers.

The North West and Yorkshire and Humberside had the highest prevalence of young people who had ever used e-cigarettes (25% and 23% respectively). The lowest prevalence was in London where 12 per cent had ever used e-cigarettes. **(Table 2.16)**

The three local authorities with the highest percentage of young people who had ever used e-cigarettes were Blackpool (34%), Blackburn with Darwen (32%) and Tameside (32%). Blackpool and Tameside were also the local authorities with the highest percentage of current users (7%). Oldham also had 7 per cent who were current users. The four local authorities with the lowest percentage who had ever used e-cigarettes were Redbridge (7%), Wokingham (9%), Kensington and Chelsea (9%) and Barnet (9%). In Lewisham, Haringey, Kensington and Chelsea and Islington, small numbers of young people reported being current users of e-cigarettes (figures are suppressed for these LAs due to the small number of cases). In Rutland, no young people reported being current users of e-cigarettes. For the definition of e-cigarette use, see Section A.4 in the Appendix. **(Table 2.17 and Figure 2.9)**

Figure 2.9: Percentage of young people who had ever used e-cigarettes by Local Authority in England, 2014



Source: What About Youth Survey 2014

2.2.1. Comparisons with other sources

The SDD 2014 report[31] showed that 36 per cent of boys and 33 per cent of girls aged 15 years reported that they had ever used e-cigarettes. This is higher than in WAY 2014. In SDD 2014, 2 per cent of boys and 3 per cent of girls aged 15 years reported being regular users of e-cigarettes which is similar to the findings in WAY 2014. The SDD 2014 report shows that among young people of all ages (11-15 years), 89 per cent of regular smokers had ever used e-cigarettes and 17 per cent of regular smokers were regular users of e-cigarettes. SDD 2014 also shows that among those who had never smoked, 11 per cent had ever used e-cigarettes and less than 0.5 per cent were regular users of e-cigarettes. These findings are broadly in line with those from WAY 2014.

The 2014 SALSUS study covering young people in Scotland found that 17 per cent of 15 year olds had used e-cigarettes[32]. 14 per cent had used e-cigarettes only once or a few times. Unlike WAY 2014, no difference was found between boys and girls in the percentage using e-cigarettes.

2.3. Use of other tobacco products

Participants were asked about use of other tobacco products. The examples given included shisha pipe, hookah, hubble-bubble and water pipe. The majority of young people had never used other tobacco products (85%). However, girls were more likely than boys to report having ever used them (17% and 14% respectively). **(Table 2.18)**

Table 2.18: Use of other tobacco product by gender, 2014

Base: All who were not observed

Per cent

	Gender		
Use of other tobacco products[a]	**Boys**	**Girls**	**Total**
Regular	1	0	0
Occasional	2	2	2
Currently	**2**	**3**	**3**
Used to	2	2	2
Tried once/twice	10	12	11
Ever	**14**	**17**	**15**
Never tried	**86**	**83**	**85**
Bases			
Unweighted	*56,180*	*60,179*	*117,515*
Weighted	*279,049*	*267,539*	*552,176*

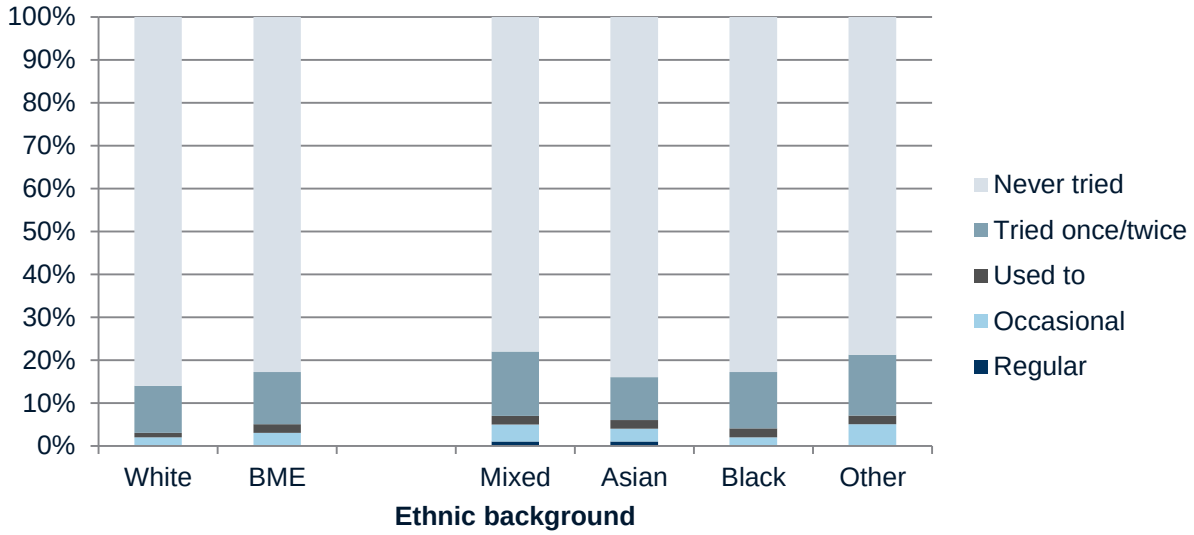
[a] Regular were those who reported using other tobacco products at least once a week, occasional reported using other tobacco products less than once a week. Current are a combination of regular and occasional other tobacco product users. Ever is a combination of currently, used to use and tried other tobacco products. Tried are those who only tried using other tobacco products once or twice.

There were no clear differences in other tobacco use by the deprivation level of the area. Young people who received free school meals were slightly more likely than those who did not, to have ever used other tobacco products (18% and 15% respectively).

(Tables 2.19 and 2.20)

Young people from a BME background were more likely than young people from a white background to have ever used other tobacco products (18% and 14% respectively). Use of these products was highest among those from mixed ethnic backgrounds and other ethnic backgrounds (both 22%). This may reflect the wider use of other tobacco products in these communities, including other types of tobacco which were not given as examples (e.g. chewing tobacco). **(Table 2.21 and Figure 2.10)**

Figure 2.10: Use of other tobacco products by ethnicity, 2014



Bases: Unweighted: White 89,983, BME 22,310, Mixed 4,494, Asian 11,280, Black 5,467, Other 1,069.
Weighted: White 425,941, BME 101,501, Mixed 21,352, Asian 52,038, Black 23,347, Other 4,764.

Almost three in five of those who currently smoked had also ever used other tobacco products (59%), with nearly a third having used them only once or twice (32%), 8 per cent having used them in the past and 19 per cent currently using them. This compares with 11 per cent of non-smokers having ever used other tobacco products and 1 per cent currently using other tobacco products. Three in five of regular smokers had ever used other tobacco products (60%). Around a fifth of regular smokers and current smokers currently used other tobacco products (21% and 19% respectively).

Boys who smoked were more likely to currently use these products than girls, regardless of whether they were a regular smoker (among regular smokers 24% of boys and 18% of girls currently used other tobacco products) or current smoker (among current smokers 22% of boys and 16% of girls currently used other tobacco products). Among non-smokers, boys and girls were equally unlikely to be a current user of other tobacco products (1%) but girls were slightly more likely than boys to have ever used them (12% and 10% respectively).

(Table 2.22)

By region, London had the highest percentage of young people who had ever used other tobacco products (21%), compared to about half that in the North West (11%). **(Table 2.23)**

Richmond upon Thames and Tower Hamlets were the LAs with the highest percentage who had ever used other tobacco products (29% and 25% respectively). The Local Authorities with the lowest percentage who had ever used other tobacco products were Kingston upon Hull (6%) and Cumbria (7%). **(Table 2.24)**

2.3.1. Comparisons with other sources

The SDD 2014 questionnaire asked young people about water pipe tobacco smoking. The findings show that 19 per cent of boys and 16 per cent of girls aged 15 had ever smoked water pipe tobacco and 1 per cent of boys and girls were regular smokers of water pipe tobacco. This contrasts with WAY 2014 where girls were more likely than boys to report ever using other tobacco products. However, it should be noted that the SDD questionnaire asked specifically about water pipe tobacco, whereas the WAY 2014 question asked about other tobacco products which included other examples and so was not restricted to water pipes.

2.4. Attitudes towards smoking

Participants were asked whether they agreed or disagreed with a range of statements covering health and social issues related to smoking. Overall, participants demonstrated a good understanding of the impacts smoking can have.

There was a high level of agreement about the health risks of smoking. 11 per cent agreed that smoking is not really dangerous and that it only harms those who smoke a lot. The statements which attracted the highest levels of agreement were that smoking can cause lung cancer (98%), smoking when pregnant harms the unborn baby (95%), other people's smoking can harm the health of non-smokers (91%) and smoking can cause heart disease (88%).

Statements related to health effects which drew the lowest levels of agreement were smokers get more coughs and colds (71%) and smoking makes people worse at sports (76%).

In terms of the practical or social impacts of smoking there was widespread agreement that smoking makes your clothes smell (95%). Over half of young people said that smoking helps people relax if they feel nervous (53%). The statement with the lowest level of agreement was that smokers are more fun than non-smokers (2%).

Young people who smoked tended to hold different views from those who did not smoke. Those with the largest differences were:

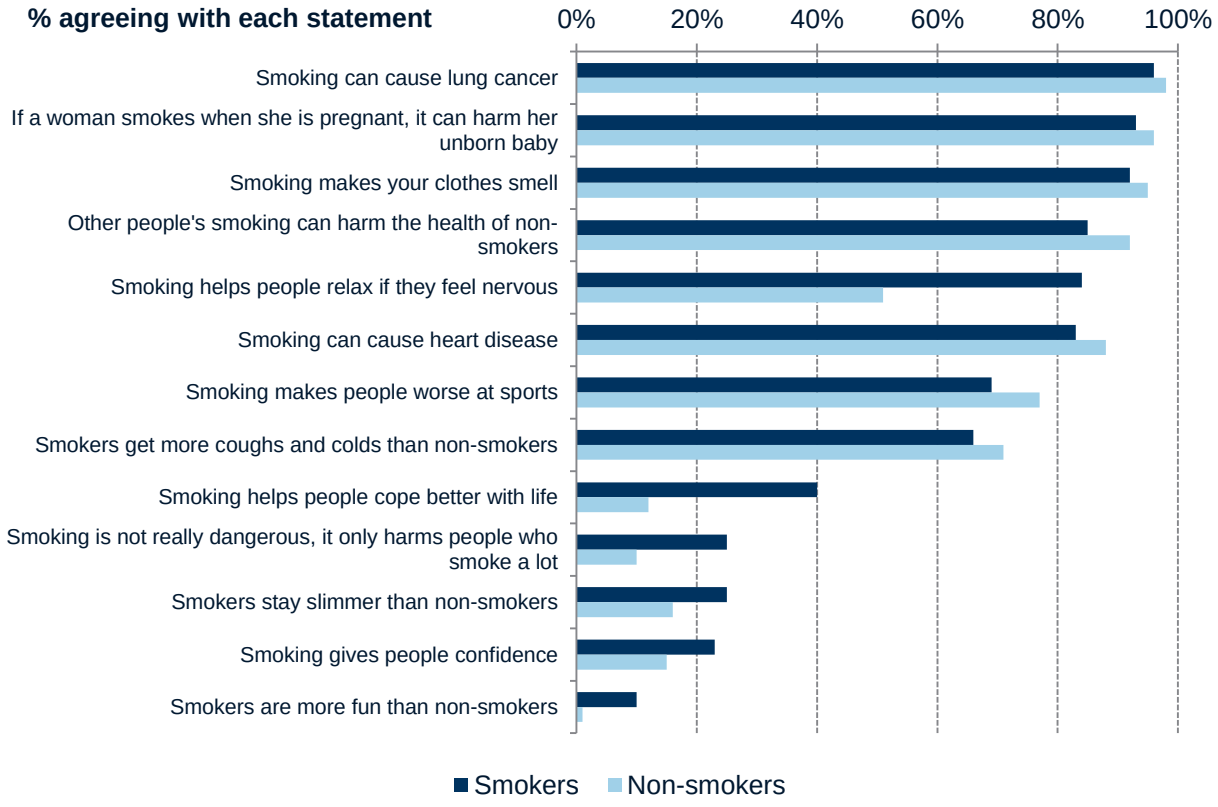
- Smoking helps people relax if they feel nervous (84% of smokers agreed with this compared to 51% of non-smokers);
- Smoking helps people cope better with life (40% of smokers agreed with this compared to 12% of non-smokers);
- Smoking is not really dangerous – it only harms those who smoke a lot (25% of smokers agreed and 10% of non-smokers);
- Smokers are more fun than non-smokers (10% of smokers agreed and 1% of non-smokers)
- Smokers stay slimmer than non-smokers (25% of smokers agreed and 16% of non-smokers). **(Table 2.25 and Figure 2.11)**

There were much smaller differences in levels of agreement to the following statements:

- Smoking can cause lung cancer (96% smokers agreed and 98% of non-smokers);
- If a woman smokes when she is pregnant it can harm her unborn baby (93% of smokers agreed and 96% of non-smokers);
- Smoking makes your clothes smell (92% of smokers and 95% of non-smokers).

(Table 2.25 and Figure 2.11)

Figure 2.11: Attitudes to smoking by smoking behaviour, 2014



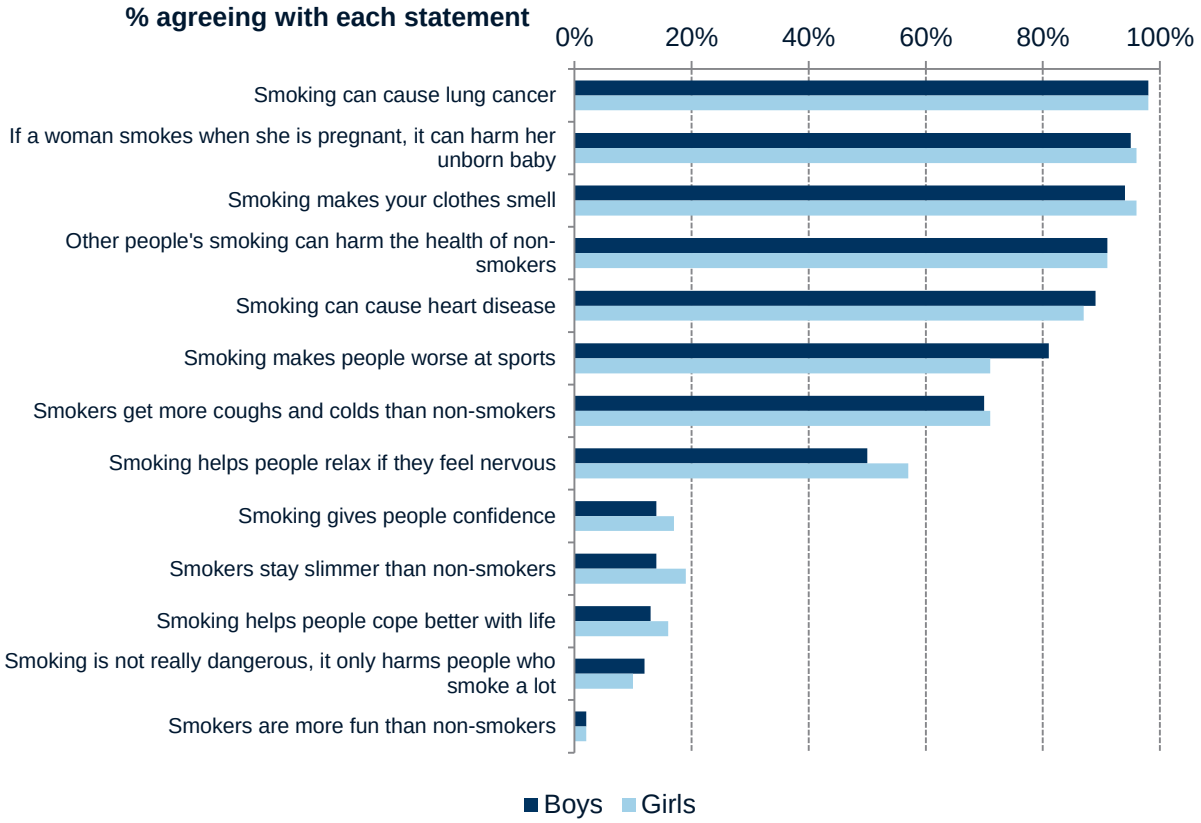
Bases: Smokers unweighted 9,882 and weighted 47,603; non-smokers unweighted 105,899 and weighted 496,355 (first statement).

There were small differences between boys and girls in attitudes to smoking. The main findings were that:

- Boys were more likely than girls to believe that smoking makes people worse at sports (81% and 71% respectively);
- Girls were more likely to think that smoking helps people relax if they feel nervous (57% and 50% respectively);
- Girls were more likely than boys to think that smokers stay slimmer than non-smokers (19% and 14% respectively);
- Girls and boys were consistent in their understanding of the serious health effects of smoking (lung cancer, harm to unborn babies, and heart disease).

(Table 2.26 and Figure 2.12)

Figure 2.12: Attitudes to smoking by gender, 2014



Bases: Boys unweighted 56,122 and weighted 278,906; non-smokers unweighted 60,129 and weighted 267,348 (first statement).

Generally, the differences between smokers and non-smokers were similar for boys and girls. The biggest difference between boys and girls in views by smoking status was for the effects of smoking on sporting ability. Among boys, 81 per cent of non-smokers thought smoking makes people worse at sport compared to 68 per cent of smokers. For girls there was little difference in views between non-smokers and smokers (71% and 69% respectively).

(Tables 2.27 and 2.28)

For attitudes to smoking by region **(Table 2.29)** and by LA **(Table 2.30)**, please refer to the Excel tables that accompany this report.

Endnotes

[1] Statistics on smoking in England, 2015. HSCIC http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf
[2] Smoking, Drinking and Drug Use among young people in England in 2013. HSCIC http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf
[3] Young People and Smoking. ASH Fact Sheet 2014 http://ash.org.uk/files/documents/ASH_108.pdf.
[4] https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england
[5] Gervais, A. et al. (2006). "Milestones in the natural course of onset of cigarette use among adolescents" in *Canadian Medical Association Journal*, 175(3), pp.255–261. Cited in https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england
[6] Young People and Smoking. ASH Fact Sheet 2014 Young People and Smoking. ASH Fact Sheet 2014 http://ash.org.uk/files/documents/ASH_108.pdf.
[7] https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england
[8] Public Health Outcomes Framework information website http://www.phoutcomes.info/
[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/382115/PHOF_Part_2_Technical_Specifications_Autumn_2014_refresh_02.12.2014_FINAL.pdf
[10] https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england
[11] The examples given in the questionnaire were shisha pipe, hookah, hubble-bubble, water pipe but the wording was intended to indicate to participants that these products are not limited to these examples.
[12] https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england
[13] Target linked to PHOF indicator: percentage of 15 year olds who are regular smokers to be <12% by 2015
[14] Smoking, drinking and drug use among young people in England in 2014, HSCIC, 2015 http://www.hscic.gov.uk/pubs/sdd14.
[15] http://www.hbscengland.com/wp-content/uploads/2013/10/HBSC-England-report2011.pdf
[16] Health Survey for England 2013. http://www.hscic.gov.uk/catalogue/PUB16076
[17] The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), NHS National Services Scotland, 2014. http://www.isdscotland.org/Health-Topics/Public-Health/SALSUS/Latest-Report/.
[18] Health Survey for England 2013: Chapter 9 Children's smoking and exposure to others' smoke http://www.hscic.gov.uk/catalogue/PUB16076/HSE2013-Ch9-chi-smok-exp.pdf.
[19] Goddard, E. and Higgins, V. (2000) Drug use, smoking and drinking among young people in 1999.
[20] Measuring different aspects of problem drug use: methodological developments. Home Office Online report 16/06 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116642/hoor1606.pdf
[21] Aquilino,W.S., Wright, D.L., Supple, A.J. (2000) 'Response Effects Due to Bystander Presence in CASI and Paper-and-Pencil Surveys of Drug Use and Alcohol Use' Substance Use and Misuse. 35 (608): 845-867.
[22] Based on Index of Multiple Deprivation (IMD) quintiles
[23] On LA tables, percentages are presented to one decimal place but reported to the nearest whole percentage in the report so the difference in presentation will account for any rounding differences. As an example, a figure for an LA of 14.48 per cent would be rounded to 14.5 per cent in the tables but reported as 14 per cent in the report.
[24] Total for 13 years and over is 77%, though figures in excel add to 76% owing to rounding
[25] Smoking, drinking and drug use among young people in England in 2014, HSCIC, 2015 http://www.hscic.gov.uk/pubs/sdd14.
[26] A more recent HBSC survey was conducted in 2013/14 but the results have not yet been published.
[27] Social determinants of health and well-being among young people, Health Behaviour in School-Aged Children (HBSC) Study: International Report from the 2009/2010 Survey, World Health Organization, 2012. http://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf. This survey was carried out in schools with pupils completing questionnaires (paper self-completion) under exam conditions with responses placed in an envelope so that the teacher or researcher administering the questionnaire could not see what had been written.
[28] The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), NHS National Services Scotland, 2014. http://www.isdscotland.org/Health-Topics/Public-Health/SALSUS/Latest-Report/. This survey was administered by teachers during a lesson but under exam conditions with completed questionnaires placed in un-named sealed envelopes by the pupils.
[29] Index of Multiple Deprivation Quintiles
[30] Note that Table 2.15 in the excel tables includes additional detail by gender as well as smoking behaviour.
[31] Smoking, drinking and drug use among young people in England in 2014, HSCIC, 2015 http://www.hscic.gov.uk/pubs/sdd14.
[32] The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), NHS National Services Scotland, 2014 http://www.isdscotland.org/Health-Topics/Public-Health/Publications/2014-11-25/SALSUS_2013_National_Overview.pdf

Appendix A

A.1 Development of the survey

The trial study involved a significant amount of development work in order to refine all aspects of the survey. A key element of this development work was the involvement of a steering group of stakeholders put together by the Department of Health who developed the questionnaire, pilot study (involving sending out questionnaires to 250 young people to cognitive test the questions) and the trial survey. A small group of young people themselves were asked about their thoughts on development, particularly around the survey branding and materials.

As part of the preparation for this study, the National Research Ethics Service (NRES) was approached to discuss whether or not ethical approval would be required. While NRES confirmed that ethical approval would not be required in order for the trial study to go ahead, it was decided that it was desirable for an ethical review of the approach to be conducted. Doing so would ensure that due consideration was being given to any potential ethical issues. The National Children's Bureau (NCB) was deemed to be best placed to do this, based on their experience of research with the age group in question.

Therefore, during preparations for the trial survey, the NCB Ethics Board worked closely with the Ipsos MORI research team to conduct an ethics review of the trial which was approved. The Ethics Board also carried out a full review, prior to the main survey, whereby ethical approval was granted.

A.2 Sample design

The sampling approach undertaken was informed by the What About YOUth? (WAY) trial survey (conducted in 2013/14). The results of the trial indicated that the response rate achieved varied by gender, ACORN category and region. These variables were used to calculate projected response rates (by gender) for each Local Authority (LA) individually[1]. It was therefore possible to calculate the starting sample needed during the main stage to achieve a given number of responses in a LA. Target sample sizes for each LA were set at the levels necessary to be able to achieve a +/-3 percentage point margin of error at the 95% Confidence Interval (CI).

This resulted in three different scenarios:

- **Scenario 1** – LAs where the total number of 15 year olds for both genders was greater than the target number of achieved interviews required;
- **Scenario 2** – LAs where the total number of 15 year olds for one of the genders was greater than the target number of achieved interviews required, and equal to or less than the target number of achieved interviews for the other gender;
- **Scenario 3** – LAs where the total number of 15 year olds for both genders was equal to or less than the target number of achieved interviews.

[1] This was achieved by calculating a predicted response rate for every ACORN category in the population and then applying these response rates across the ACORN categories present in each of the LAs.

As a result, the process for selecting the sample also varied across LAs (and within LAs by gender) as outlined in the following table.

Scenario	Gender 1	Gender 2
1	1 in n sample selected	1 in n sample selected
2	1 in n sample selected	Census
3	Census	Census

The selected sample was proportionately stratified by LA, and then stratified within each LA based on background variables on the sample frame and postcode. In LAs where it was possible[2], the starting sample was based on the estimated response rate for gender within LA, as the trial showed that response rates were much lower for boys in most LAs.

A random sample of all those pupils who turned 15 in academic year 2013/14, whose dates of birth ranged between 01/09/1998 and 31/08/1999, was selected. At the start of the trial survey, two potential sample frames were available from which to draw a sample of 15 year olds in England. These were MIDAS[3] and the National Pupil Database (NPD)[4]. As permission to use MIDAS for the main stage survey was not granted, the sample was drawn from NPD, specifically the 2014 Spring School and Alternative Provision Censuses. Even though it excluded pupils in independent schools, the NPD was used as a sampling frame as it contains a broader range of matched background variables that could be used in the stratification of the sample. The decision to use NPD, without the inclusion of independent schools, was taken after concluding that the estimates produced by the survey, would not be significantly impacted as a result of these schools not being included in the sample frame.

A.3 Fieldwork procedures, sample size and response rates

Parents/carers of the selected young people were sent a pre-notification letter giving them the opportunity to opt out of the survey on behalf of their child on 1st September 2014. A pre-notification letter and leaflet was also sent to the selected young person on the same date. The total number of opt-outs prior to questionnaire mailout was 3,056 (out of 298,080). Where young people were opted out of the survey, they were removed from the sample and received no further contact about the survey. Young people for whom the initial letter was undeliverable were also removed from the sample as and when the returned mail was received by Ipsos MORI.

The remaining young people were then sent a covering letter and questionnaire inviting them to take part in the survey. Fieldwork for the main survey took place between 22nd September 2014 and 9th January 2015. The timings and mailings for the survey were as follows:

[2] i.e. all LAs where a census was not being drawn.
[3] The Medical Research Information Service Integrated Database and Administration System (MIDAS) based on health records and controlled by HSCIC.
[4] The National Pupil Database based on data for pupils attending schools and colleges in England, and controlled by the Department for Education.

- pre-notification mailing to full sample (sent w/c 1st September 2014 to a total of 298,080 young people) of which 3,056 were undeliverable or opted-out before the questionnaire mailing;
- full questionnaire mailing to eligible sample (mailing 1 – sent w/c 22nd September 2014 to a total of 295,024 young people);
- postcard reminder to eligible sample (sent w/c 29th September 2014 to a total of 294,768 young people – there were a further 256 opt-outs);
- reminder (including questionnaire) to all non-responders (mailing 2 – sent w/c 13th October 2014 to 284,453 young people); and
- second reminder (including questionnaire) to some non-responders (mailing 3) sent w/c 2nd November 2014 – this was targeted to specific genders within specific LAs. In total reminders were sent to 168,945 young people, broken down by:
    - males in 148 LAs
    - females in 74 LAs.
- additional reminder (including questionnaire) to some non-responders (mailing 4) sent on 24th November 2014 – again this was targeted to specific genders within specific LAs. In total reminders were sent to 105,847 young people, broken down by:
    - males in 115 LAs
    - females in 51 LAs.

As noted, target sample sizes for each LA were set at the levels necessary to be able to achieve a +/-3 percentage point margin of error at the 95 per cent CI. Two reminders were targeted to specific genders within specific LAs as detailed above in order to maximise response rates and meet the 3% CI predicted target for all young people in each LA. Reminders were not sent to specific genders within LAs where the targets had been met.

Participants were also given the option to complete the survey online instead of by post. All participants were supplied with a username to access their unique survey link. A website was created for the survey (www.whataboutyouth.com) on which young people could access the online version of the questionnaire; this could also be accessed via a QR code printed on the questionnaire. The website also contained information about the research for young people, parents and teachers.

The questionnaire contained 72 questions, with an estimated completion time of around 15 minutes. Questions in the online and paper versions were identical, although those who had assistance with completing the online version were not asked questions relating to smoking, drinking, drugs and bullying. These questions were felt to be sensitive and that participants completing the survey with assistance – potentially from a parent – may not answer them honestly in such a situation. This was done in an effort to reduce under reporting of activities. These questions were asked in the paper version regardless of whether participants were receiving help, as it would not have been possible to route these questions out for those receiving help with the paper version.

The issued sample was 298,080, of which of which 3,056 were undeliverable or opted-out before the questionnaire mailing. The full questionnaire mailing to eligible sample was sent to a total of 295,024 young people of whom 120,156 responded. The overall unadjusted response rate for the survey was 40 per cent (based on the issued sample) while the adjusted response rate for those sent the questionnaire was 41 per cent (this excludes any undeliverables and opt-outs from the

issued sample). Owing to data cleaning and de-duplication, the final sample for analysis was 120,115. Of these, 19,265 responded online and 100,850 on paper.

Response rates varied by gender with adjusted response rates of 35 per cent for boys and 49 per cent for girls. Response rates also varied across LAs, with the lowest adjusted rates recorded in the London Boroughs of Kensington and Chelsea and Hammersmith and Fulham (both 28%). The highest response rates were recorded in Devon, Poole, Somerset and Wiltshire (all 50%).

(Tables A1, A2 and A3)

A £5 shopping voucher was used as the token of appreciation, which was conditional on completing the questionnaire. Respondents were sent the voucher in monthly batches following receipt of their questionnaire (online or postal). An experiment was conducted as part of the trial study which tested the impact on response rates that using different values had, as well as comparing the impact on response rates. As a result of the experiment in the trial, it was decided that the main study would use a conditional £5 shopping voucher as the most cost-effective means of increasing response rates.

A.4 Survey definitions

Young people: This refers to the young people in the sample, in Year 11 at school, the majority of whom were 15 years old at the time of the survey. A small minority had turned age 16 by the time they completed their questionnaire.

Help received in completing the questionnaire: At the start of the online version of the questionnaire, participants were asked whether they were receiving any help (for example from a friend or parent) in completing the questions. If they selected 'yes', then the questions that covered sensitive material were routed out, as outlined above. This is indicated in the base description using the phrase 'All who were not observed'.

Prevalence of smoking: There are three sub-indicators reported on for the Public Health Outcomes Framework (PHOF) indicator for smoking prevalence of 15 year olds, and another four sub-indicators used to report on young people who do not currently smoke:

Smoking key indicators: The PHOF sub-indicators on smoking prevalence of 15 year olds (regular, occasional and current smokers) have been derived from the question 'Now read the following statements carefully, and tick the box next to the one which best describes you'. The question offered six categories to describe smoking behaviour. The data presented in the chapter have been grouped in a variety of ways based on the six categories in the question as follows:

- 'Regular smoker': this is a combination of young people who said 'I usually smoke more than six cigarettes a week' or 'I usually smoke between one and six cigarettes a week' (two of the questionnaire answer options) (this is a PHOF indicator);
- 'Occasional smoker': young people who said 'I sometimes smoke cigarettes now but I don't smoke as many as one a week' fall into this category (this is a PHOF indicator);
- 'Currently smoke' is a combined (or derived) category which includes regular smoker and occasional smoker and is based on three answer options from the questionnaire (this is a PHOF indicator);
- 'Used to smoke' is from the statement 'I used to smoke sometimes but I never smoke cigarettes now';
- 'Tried smoking' are those who said 'I have only ever tried smoking once';

- 'Ever smoked' is a combination of all the above statements; and
- 'Never smoked' are young people who said 'I have never smoked'.

E-cigarette use: young people were asked how often they used e-cigarettes. The categories follow a similar breakdown to that used for cigarette smoking:

- 'Regularly use e-cigarettes': this is young people who said 'I use electronic cigarettes regularly, once a week or more';
- Occasionally use e-cigarettes': young people who said 'I sometimes use electronic cigarettes, but don't use them every week' fall into this category;
- 'Currently use e-cigarettes' includes regular and occasional users of e-cigarettes (a derived category).
- 'Used to use e-cigarettes' is from the statement 'I used to use electronic cigarettes but I don't now';
- 'Tried using e-cigarettes' are those who said 'I have used electronic cigarettes only once or twice';
- 'Ever used e-cigarettes' is a combination of all the above statements; and
- 'Never used e-cigarettes' are young people who said 'I have never tried electronic cigarettes'.

Other tobacco products: Examples of 'other tobacco products' given in the question were "shisha pipe, hookah, hubble-bubble, water pipe, etc.". The categories follow the same breakdown as that used for electronic cigarettes:

- 'Regularly use other tobacco products': this is young people who said ' I use other tobacco products regularly, once a week or more';
- 'Occasionally use other tobacco products': young people who said 'I sometimes use other tobacco products, but don't use them every week' fall into this category;
- Currently use other tobacco products' includes regular and occasional users of other tobacco products (a derived category).
- 'Used to use other tobacco products' is from the statement 'I used to use other tobacco products but I don't now';
- 'Tried using other tobacco products' are those who said 'I have used other tobacco products only once or twice';
- 'Ever used other tobacco products' is a combination of all the above statements; and
- 'Never used other tobacco products' are young people who said 'I have never tried other tobacco products'.

A.5 Confidence intervals

As mentioned previously, targets were set by LA for the level of response required to the survey, in order to achieve a +/-3 percentage point margin of error at the 95 per cent CI. Progress against the targets was reviewed throughout fieldwork and used as a basis for making decisions about the need for targeting of reminders.

At the end of fieldwork a total of 101 (out of 150) LAs were at or below the 3 per cent target. Of the 49 LAs where the target was not achieved[5] the vast majority of these only missed the target level of response by a small margin. For 44 of these LAs the CIs achieved were less than 4 per cent. Only 5 LAs had a CI in excess of 4 per cent with the highest being 6.7 per cent for Kensington and Chelsea. The CI for the whole of England is 0.3 per cent.

HSCIC will produce CI information for the next report which will cover all the main findings from the rest of the survey topics, expected to be released in December 2015. The data in the PHOF Fingertips tool include the 95% CIs for regular, occasional and current smoking for England, Region and LA level. Please see link for further information: http://www.phoutcomes.info

A.6 Weighting

The data presented in this report have been weighted to be representative of the total population, at LA and England level by gender.

As noted, the sampling approach for the main stage used the differential response rates from the trial for males and females within each LA to select a disproportionate sample for each gender. This has helped to achieve a more representative sample for the main stage.

However, sampling in this way meant that different members of the population had a different chance of being selected in the sample. To correct for this, a design weight was needed. The design weight evens out the selection probabilities so that each selected member of the sample had the correct importance, relative to the size of the sub-group of the population from which they come. The weights applied took account of ethnicity, free school meal eligibility and IMD quintile within gender within LA.

In order to ensure that data can be analysed at an LA level, non-response weights were also applied to correct for any differences in the levels of non-response by different groups of the population. Non-response weights were applied by gender and LA, and weighted to the population totals.

A.7 Comparisons with other sources

Questions from other surveys were used or adapted to develop the WAY 2014 questionnaire. This report also compares the WAY 2014 results to the data from those surveys where relevant:

Survey of Smoking, Drinking and Drug Use Among Young People (SDD): This school-based survey from the Health and Social Care Information Centre, collects data from young people aged 11 to 15, and covers a wide range of topics on smoking behaviour, influences on smoking, smoking attitudes and beliefs, and other issues that may be associated with cigarette smoking.

Health Behaviour in School-aged Children (HBSC): This is a World Health Organisation collaborative cross national study of children aged 11-15. Questionnaires were administered in schools by teachers or members of the research team. The study looks at young people's health and well-being, health behaviours and their social context. In terms of smoking, it asked whether they had ever smoked tobacco, how often, age first smoked, and on how many occasions in the last 30 days they had smoked.

[5] It should be noted that for 30 of these 49 LAs it was known from the outset that there would not be enough 15 year olds in the LA or the response rate would not be high enough to achieve a +/- 3 percentage point margin of error at the 95 per cent CI.

Health Survey for England (HSE): The 2013 Health Survey for England report compared the prevalence of regular smoking among children with those from the 2013 SDD survey. HSE is carried out in a home setting although the smoking module is administered by self-completion questionnaire. A saliva sample is also taken which is examined for evidence of cotinine at a level above 12ng/ml which is considered to be evidence of recent smoking.

Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS): This study looks at substance use among young people aged 13 and 15 in Scotland, with the data used to help monitor progress towards achieving Scottish Government targets. All LA and independently-funded schools were eligible, except for schools for with special educational needs. The survey was conducted in schools, with pupils completing a self-completion questionnaire. Smoking prevalence is measured in a similar way to that used in the WAY 2014 survey.

A.8 Notes on tables and figures

Statistical significance

Unless otherwise stated, changes and differences mentioned in the text are statistically significant at the 5% significance level.

All Tables

A set of Excel tables accompany this report which include all the data tables related to this report but not all presented here (therefore, the table numbering does not follow suit in this report document).

- Figures may not add to 100% owing to rounding.
- Base numbers are shown in italics. Weighted and unweighted bases are shown.
- Weighted bases are scaled to the population and so are higher than the unweighted bases. Unweighted bases should be used as a guide to how many young people actually responded.
- Total column includes those for whom there is no cross-break data. So the base is larger than the total of the bases for each break category.
- The conventions used in the tables are as follows:

  \- No cases

  0 Percentage less than 0.5%

  * Suppression has been applied to cells with prevalence rates where the number of underlying cases are 5 or fewer. On occasion, secondary suppression may be applied to any adjacent cells to avoid any already suppressed cells being calculated by differencing from the totals.

- On LA tables, percentages are presented to one decimal place but reported to the nearest whole percentage in the report so the difference in presentation will account for any rounding differences. As an example, a figure for an LA of 14.48 per cent would be rounded to 14.5 per cent in the tables but reported as 14 per cent in the report.

Tables 2.1 – 2.9:

- Base includes all respondents who answered question on frequency of smoking (excluding those who were observed when completing a web questionnaire and those who did not give a valid answer).
- Regular smokers were those who reported smoking at least one cigarette a week, occasional smokers reported smoking less than one cigarette a week. Current smokers are a combination of regular and occasional smokers. Ever smoked is a combination of currently smoke, used to smoke and tried smoking. Tried smoking is those who only tried smoking once.

Tables 2.11 – 2.17:

- Base includes all respondents who answered question on frequency of using e-cigarettes (excluding those who were observed when completing a web questionnaire and those who did not give a valid answer).
- Regular were those who reported using e-cigarettes at least once a week, occasional reported using e-cigarettes less than once a week. Currently is a combination of regular and occasional e-cigarette users. Ever is a combination of currently, used to and tried e-cigarettes. Tried are those who only tried using e-cigarettes once or twice.

Tables 2.18 – 2.24:

- Regular were those who reported using other tobacco products at least once a week, occasional reported using other tobacco products less than once a week. Current is a combination of regular and occasional other tobacco product users. Ever is a combination of currently, used to use and tried other tobacco products. Tried are those who only tried using other tobacco products once or twice.
- Base includes all respondents who answered question on frequency of using other tobacco products (excluding those who were observed when completing a web questionnaire and those who did not give a valid answer).

Tables 2.25 – 2.30:

- Base includes all respondents who answered questions on attitudes to smoking (excluding those who did not give a valid answer).

Figures 2.2, 2.8 and 2.10 (all bar charts by ethnicity)

These figures have a gap after the BME bar to indicate that the subsequent categories are sub-groups of BME.

Figures 2.3, 2.4, 2.5 and 2.9 (all maps)

The categories for each map are based on quintiles. Owing to rounding the precise number of LAs in each quintile varies slightly. The number of LAs in each category is shown in brackets after the category description. Owing to small sample sizes the data for City of London has been merged with the data for Hackney and the data for the Isle of Scilly has been merged with the data for Cornwall.

Published by the Health and Social Care Information Centre

Part of the Government Statistical Service

Responsible Statistician

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ISBN 978-1-78386-449-2

This publication may be requested in large print or other formats.

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