Annual Report
of the
Director of Public Health
Newcastle upon Tyne

2018-19
To: Cllr Nick Forbes  
Leader of Newcastle City Council

I am pleased to present my annual report on the health of the people of Newcastle upon Tyne for 2018-19. This is my fifth such report as Director of Public Health for the city.

Previous reports have focused on a calendar year, but I have included data here that became available during early 2019 and, in consequence, present this as a report for 2018-19.

In order to avoid overlap of content between reports coming to the council, we will present updates on activity and projects in the Cabinet member’s portfolio report later in 2019, and in more detailed accounts of the extensive public health action taking place through the council, not only via the Public Health Grant, but through the growing impact of the council’s Health in All Policies approach.

Here, I have focused upon indicators of health in the city and some of the evidence base upon which I urge the council to continue to act.

Eugene Milne  
Director of Public Health  
June 2019
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Executive Summary

- This report provides an overview of the state of health in Newcastle using the most recent available data. Council action in response to these challenges will be reported elsewhere.

- Many indicators of health continue to improve for the population of Newcastle – in particular, those that are amenable to health and service intervention. However, life expectancy for women in the city has fallen over recent years by about 7 months while for men it has failed to rise during the same period.

- Official indicators of child poverty show many improvements, but there some worrying underlying issues requiring vigilance, and which may reflect stresses that are not identified in high level statistics.

- Although there is debate about the causes of slowed life expectancy increase, there is clear evidence of reversals arising from death rates in early middle age, particularly for men, with a striking impact of drug misuse.

- For women, there is a lesser effect of substance misuse but a marked shift in data related to dementias – part of this is likely to be a change in reporting practice, but it may reflect vulnerability in older women.

- Both the drug-related effect and the pattern in older women may plausibly be effects of austerity.

- There is also a substantial slowing of progress in reduction of heart disease and stroke deaths that requires further investigation.

- The life expectancy divide between Newcastle / the North East and South East England remains substantial and is unreduced in recent years.

- Major causes of death in the city (e.g. heart disease, stroke and cancers) differ markedly from the major causes of disability and ill-health (e.g. poor mental health, musculoskeletal and sensory conditions), however, tackling the causes of ill-health is crucial to reducing the antecedents of later, fatal conditions.

- Action to address mental health and resilience from birth onwards have the potential to substantially reduce illness, disability and risk of early death. In particular, prevention of adverse childhood events and support for resilience in the face of their consequences is essential.

- Key to council and city opportunities for health improvement is the impact of infrastructure on mental and physical health through, for example, green space, transport policy and planning. In conjunction with more mainstream action on health-supporting opportunities, this offers substantial scope for continued wellbeing and health improvement.
The State of Health in Newcastle

Reporting of health statistics commonly uses the Red / Amber / Green format to show significant differences below and above national averages. This can be a little dispiriting, since so many indicators for Newcastle and the North East invariably lag behind those of more affluent areas. It is generally more heartening and useful to examine where progress is being made and where it is not.

From this perspective, of 20 child and maternal health indicators in the standard data set for which trend data are considered reliable, 12 are trending in the right direction, 6 are keeping pace and only 2 are heading the wrong way.

Of those actions available to us in protecting and improving the health of children, there continues to be encouraging progress. Infant mortality remains low, breastfeeding continues to increase (with better maintenance than the national average), dental health at school entry is impressively better than national rates, childhood immunisation rates remain good.

The pair of measures heading in the wrong direction are childhood obesity and early years A&E attendances, and these hint at an underlying issue. Dig a little deeper and hospital admissions for self-harm are creeping upwards, deaths and serious injuries to children on the roads have worsened, and admissions for unintentional and serious injuries may be starting to rise.

Official statistics for Newcastle show the proportion of children in low income families to have fallen slightly to 24.7%, paralleling the national trend. National parliamentary statistics, however, show relative child poverty to be increasing after allowing for household costs, although the proportion in absolute poverty inclines downward. ¹

End Child Poverty recently suggested that 48% of children in the Central Newcastle constituency live in relative poverty. ²

Newcastle Council for Voluntary Service published a report in late 2018 examining food poverty in Newcastle from an experiential perspective – expressing concerns not only about holiday hunger, but about hunger for children throughout the year, exacerbated by changes to school meals and household income. ³

There is a well-known and powerful relationship between poverty and obesity, its continued rise in children at year 6 is a major concern. But obesity is a consequence of complex factors and cannot be combatted effectively simply by targeting those who are overweight or obese. The response has to be across that complex range of influences.

We need better measures of wellbeing in children to properly understand their experience and the pressures they face. The statistics that are readily available to us tell us too little about mental health, adverse experiences and resilience. It is gratifying to see the increasing attention and focus that these latter issues are receiving by the Council and its partners.
In adults, we continue to see a strong downward trend in smoking – still our single largest alterable cause of death – prevalence in the city has fallen from 24.9% in 2013 to 15.2% in the most recent (2017) figures. The additional emphasis that will be given to smoking cessation by the NHS in implementing its Long Term Plan is very welcome and should help to boost this further. But it should be noted that services to help people quit smoking, although highly cost-effective, contribute only a small part of the overall fall in smoking prevalence. Of the fall in the city since 2013, these services contributed only about 0.5% of the 9.7% change. The rest of the fall occurred through individual choice and, to a degree, the rise of vaping. But the urge to choose to quit can be influenced by campaigns, awareness raising and other measures of the type we commission through Fresh: Smokefree North East.

Collective public health action is shown at its best in this arena. The following graphic is taken from the recent All Party Parliamentary Group Report on smoking and highlights the interestingly greater progress seen by regions with coherent anti-tobacco programmes, of which that in the North East is the longest-standing and most successful:

There is clear evidence more generally that collective action on tobacco is effective in reducing smoking and its consequences. We need to continue being champions of this in the city and our region.

In the meantime, deaths resulting from smoking continue to be well above national rates and will do so for years to come as we see the cumulative impact of damage done over decades. Though this may sound gloomy, it should borne in mind that quitting smoking brings immediate, as well as long-term, reductions in risk, and that it is never too late to benefit from quitting. Even when being treated for cancer, the chances of success are increased by quitting smoking.
During the past year, we saw the broadcast of Hugh Fearnley-Whittingstall’s documentary series “Britain’s Fat Fight”, which featured Newcastle and the “Newcastle Can” campaign to lose a collective 100,000 lbs in bodyweight. Objective evaluation of the impact of a campaign such as this is problematic, though I note in passing that the proportion of overweight and obese adults in Newcastle has crept down over the past 2 years and is below the national average in the most recent data.

More importantly, the documentaries illustrated a journey of understanding from local measures (vegetables to Walker) to lobbying the Secretary of State for regulatory change. And we reached the target, albeit a little late, but with some inspiring personal stories along the way.

Alcohol remains one of our most problematic issues. Admissions for alcohol-related conditions are more than 30% higher than the national average. Collective action in this field remains many years behind that on tobacco, but we await with great interest the results of evaluation of Minimum Unit Pricing (MUP) in Scotland.

High local rates of smoking and drinking are, in no small part, the pathways that result in continued high rates of deaths from cancer and cardiovascular disease for the city.

Our challenge continues to be the necessity of treating people who are suffering those consequences now, while acting upstream to avoid others reaching the same state.

This is clearly not helped by continuing central cuts to the preventive, public health budget. The Marmot Report recommended that spend on prevention should be linked to Gross Domestic Product (GDP) and should rise by 2030 to 0.5%. 6 At the current level of GDP, for England, that would be well over twice the current rate. And though NHS investment in prevention is promised to increase that figure, the choices driving prevention in healthcare are not the most cost-effective or impactful. The encouraging and increasing level of collaboration with our outstanding NHS services in the city is of major importance in maximising local impact.

More detail of specific statistics is included in this report as a statistical appendix, and a very wide range of additional data is available on request or through, for example, PHE’s excellent Public Health Profiles website. 7

However, I would like to explore at greater length a question of crucial importance to Newcastle and the North East – that of the impact on health and life expectancy of austerity.
Is austerity impacting upon health?

In September 2018, BBC News reported that life expectancy progress in the UK had stopped for the first time since 1982. This was based on figures from the Office for National Statistics and reflected observations that have been made over a period of some years by scientists and actuaries.

In truth, figures show the increase to have slowed rather than stopped completely at a national level, but more local figures, including those for men and women in Newcastle show reversals of the previous upward trend. Various commentators, most recently the IPPR, have attributed this to the effects of austerity, though this has mostly been based upon observed correlation rather than clear evidence of causation.

Life expectancy is a peculiar measure. It is an instantaneous reflection of the mortality experience of a population at a single year in time. It does not, as many assume, reflect the likely lifespan of a child born in a particular year, since it allocates to every point in life a risk of dying equivalent to that which exists for that specific age within the index year. This is why we can talk about life expectancy changing from one year to the next and why it can go up and down around its trend.

The most rapid period of increasing life expectancy on record in this country was actually during the period between World Wars, driven primarily by falling child mortality and reductions in infectious disease deaths – the largest part of the fall in TB mortality pre-dated the availability of antibiotics and owed more to sanitation and improved living conditions.
The post-war period of the late 1940s saw a very rapid rise in life expectancy, but it is striking that the establishment of the NHS was followed by a slowing rather than acceleration of the upward trend. Life expectancy in the 1950s rose more slowly than it had during the 1930s for both men and women. Yet it would be foolish to argue that the arrival of the Welfare State and universal health care did not provide immense benefit and comfort to the population.

Considering the noisiness of the data shown above in the earlier half of the 20th century, and differences in major drivers of change during that era, it may be more appropriate to consider the post-war period from a later date. In the graph below, I have broken down the average yearly increases in life expectancy from the 1960s onwards, noting that the 1950s had seen increases of up to 25 weeks per year.

A nadir of life expectancy increase was reached in the the first years of the 1970s but the acceleration from the mid-1970s onwards was sufficiently large that by the end of the decade, the average rise had markedly outstripped that of the ten preceding years. It has been vigorously argued that inequality is bad for health, and income inequality in the UK was at its lowest during this period. Yet the marked growth of inequality during the 1980s was accompanied by an even greater boost to survival. Inequality levelled off, albeit at a high level by European standards, in the 1990s but life expectancy for women accelerated yet further from the late 1990s and through the 2000s. Life expectancy for men slowed in its increase slightly in the 1990s but also accelerated subsequently.

Against this background, the slowing seen since 2010 represents a return to levels of life expectancy rise similar to those of the 1960s.  

![Average yearly increase in life expectancy in weeks for England & Wales](chart.png)
What, if anything, should we conclude from this? I would suggest that life expectancy is not a simple function of a particular political perspective, or a direct consequence of inequality as measured by the Gini coefficient. But something has gone wrong. We are not seeing the advances that we were.

The recent IPPR report suggested 130,000 deaths could have been avoided if the downward trend in preventable mortality between 1990 and 2012 had been maintained. 9 This is an implausibly large figure, at odds both with official statistics and their own report. A more realistic estimate is below 45,000. Putting that in context, allowing for the time period and population size, that is an average difference in deaths in Newcastle of 48 per year, or under 1 per week.

Colleagues at Public Health England have analysed the contributions to life expectancy by age group for the North East between 2002 and 2016, and these are shown here with figures for men are on the left and women on the right: 11

Worth noting are three main features:

- Very early life still contributed a significant amount to the overall increase, even from what are now low levels of infant mortality – this is essentially because changes at this age can contribute many years of life to the calculations, whereas changes in later life contribute fewer;
- Despite this, the largest contributions occurred in later life, and maximally for those in their 70s – consistent with those who were likely to have been
impacted upon by, for example, the National Service Frameworks and advances in healthcare associated with additional investment in the 2000s;

- Negative effects arose from those in their 30s and early 40s.

A further analysis by colleagues at PHE is illustrated on the next page. This looks at positive and negative contributions to change in life expectancy in the North East in a series of four, non-equal, time periods. Several important observations may be made from these figures:

- As could be predicted, improvements in cardiovascular mortality are the biggest positive factor. But there is a very striking fall in impact from this source in the period from 2012 to 2017 both for men and women;
- A boost in life expectancy attributable to falling respiratory disease deaths took place in 2005-2009 – possibly related directly to the impact of smoking legislation;
- Alzheimer’s Disease and Dementia appear, in these analyses, to have contributed to slowing life expectancy particularly for women. A significant part of this is likely to be changes in diagnostic and recording practice, but that may not be the whole story, as we will come back to shortly;
- Falls in cancer mortality are apparent and may be increasing;
- Drug misuse and alcoholic liver disease, particularly for men, have been significant negative factors in recent years;
- There is a substantial negative effect in ‘other causes’ for men after 2012. The level of analysis available at the moment shows only that these deaths were coded with quite general rather than specific terms. This requires further exploration but is beyond the scope of this report.

Taking together, the observation that in Newcastle preventable mortality excess could be around 1 death per week, and comparing that with the specific numbers of deaths arising from drugs and alcohol in the city, which account for around 15-20 additional deaths per year over the rates that would have been expected from prior trends, and in the light of the PHE breakdown in these analyses, it seems that a substantial part of that ‘austerity effect’ arises from substance-related deaths.

That is, around a third of the excess in preventable mortality since 2012 may be attributed to this cause, principally in men.

This is also compatible with figures for life expectancy at age 65 for men in Newcastle, which were, in the in the most recent figures, at a record high of 17.8 years.

For women, however, life expectancy at 65 years has fallen since 2012 by half a year, to the most recent level of 19.6 years. The graph for women on the next page illustrates that disadvantage appearing mainly as deaths attributable to Alzheimer’s disease and dementia. As I noted above, some of this could be influenced by changes in diagnostic practice at death certification. But it may also be that these causes are those that would become more prominent with increasing strain on care provision and support.
Men: contributions to change in life expectancy by cause since 2001

Women: contributions to change in life expectancy by cause since 2001
Women live longer than men, but they also spend more of their later life in a state of poor health, are more likely to be alone through widowhood and are likely to be more vulnerable to loss of social and nursing care. It is salutary in the light of this to compare the experience of Newcastle and North East England with that of Germany before and after reunification. 10,13,14

Although both East and West Germany experienced increasing health and longevity over time, reunification impacted hugely on women in the East. From the time of the fall of the Berlin wall, mortality equilibrated to the West German rate over a period of around 10 years and is now indistinguishable. Superimposing data for women in the North East of England on the same graph shows, in contrast, a continuation of the pre-unification trajectory of East Germany until around 2013, followed by an alarming reversal.

Population level attribution of cause being as problematic as it is, caution is required in identifying why East German women fared as they have, but two factors seem prominent – the equalisation of pension values and improvements in nursing and social care.

In this light, it does not seem unreasonable to propose that the effects of austerity in the North East may be impacting adversely upon life expectancy for local women.

But there is, I suggest, a more profound message here, that determined regional policy could abolish that divide, since the equivalent has already been achieved elsewhere.

Deaths are easy to number, and it is useful to identify areas such as drugs and alcohol, or diminished social care provision as likely candidates for, probably, half or
more of the ‘lost’ preventable deaths of recent years. But the problem we face is not simply that of losing pace on prior progress, it is also the more fundamental issues that generate the divide in wellbeing and health.

A central criticism of health policy in this country and elsewhere is its excessive focus on late responses to problems – how do we stop people from dying, rather than how can we help them to live? The NHS Plan and its predecessors have all, to some extent, fallen into this trap, focusing heavily on causes of death at the cost of causes of disability and impairment of health.

In the main, people don’t die of heart disease or cancer out of the blue. Whether they know it or not, they have usually been harbouring and developing the precursors of fatal events for years beforehand. Some will show warning signs and exhibit early, treatable stages, but others will not. The key to widespread, effective prevention does not necessarily or even commonly lie in better treatment of a specific disease. Instead, it rests upon an ability to live in a way conducive to health rather than ill-health.

The fine details of the next three graphs are, on a printed page, largely unreadable. But the point that I wish to make does not require them to be so. Instead, I have identified the key argument with black and yellow boxes marked with dashed lines. The images are taken from the Global Burden of Disease Study tool. 15

Graph 1 shows causes of death for Newcastle broken down by different category from the International Classification of Diseases. The colours indicate groups of similar types of disease. Within the black box I have identified causes of death from cardiovascular disorders and cancers. These represent the main focus of the NHS plan and tend also to be those that have received and will continue to receive the greatest investment in healthcare.

Graph 2 shows disability adjusted life years. These are a measure both of time spent with a disease and also severity of the disease. In this graph you can see that the causes of death identified in the top graph are reduced in scope, since the size of each box represents the scale of the measure. But you can also see appearing in the yellow boxes various conditions that have very little influence upon rates of death, but which have a substantial bearing upon the degree of disability and its severity in the community.

Graph 3 shows the number of years lived with disability within the community. Here you can see that those things responsible for a majority of deaths have become quite a small minority in terms of years lived with disability. Instead those things that cause disability but not death in the yellow boxes are now dominant. These are largely mental health, musculoskeletal and sensory impairments and skin conditions.

Crucially, the conditions in the yellow boxes are not independent of those in the black. They are, to a large extent, factors in determining the ability of individuals to engage in prevention and avoid entering the black box. It is no coincidence that people with psychotic illnesses are much more likely to die of lung cancer, or that people with mobility problems cannot exercise.
The lesson of this is that those things we need to address in order to improve well-being and health in the community may be very different from those that are addressed through health services in order to reduce mortality.

If we wish people to take a full part in active life and to be able to participate in exercise, social engagement and so on as part of their activities of daily living, we need to address these issues rather than focusing excessively on those that are the final pathways of mortality. This is a crucial issue, since it shapes the choices that we might make in order to try and produce a healthy population rather than simply to respond to an unhealthy one.

And this brings me back, full circle, to understanding and addressing the wellbeing of children. Marmot emphasised action in early life as the most important of his recommendations with good reason, and I would like here to draw particular attention to three areas of action for better health that I think should be central to the council’s thinking.

The first relates to Adverse Childhood Experiences (ACEs) and the degree to which their impact may be ameliorated.

There are standard tools available for assessing the experience of ACEs in childhood, and powerful studies demonstrating the relationship between those experiences and subsequent health and wellbeing. The likelihood of adverse outcomes increases with the number of ACEs experienced, and this has led to much greater emphasis on “ACE awareness”. However, this quantification also presents a risk of scoring children for their degree of disadvantage, when some of the factors that score as ACEs are traumatic but not preventable.

Resilience, on the other hand, can also be quantified to some extent, and I would suggest that this is where we should really place our focus.

**Building Resilience - Helping people cope with ACES**

As a child, there was adult you trusted and could talk to about your problems?

- **Family Resilience Assessment Tool for Health Visitors** (Wallace, University of South Wales)
- **Focus on how being part of ‘Community Wales’ can add resilience**

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Based on Strengthening the Foundations of Resilience, Howard, 2015; Wales ACE Survey, 2015, unpublished data.
The slide above was presented by Prof Mark Bellis of Cardiff University at a conference of the Association of Directors of Public Health last year. It illustrates the degree to which having an ‘always available adult’ impacted upon the likelihood of drinking, drug use and incarceration.

In terms of the problems we face through austerity, whose most stark manifestations are in substance-related deaths and violence, a systematic but non-intrusive approach to ensuring an always available adult for every child makes sense. The Scottish Government fell foul of the law in 2016 for a version of this approach – stressing the need for sensitivity in its application, but the benefits could be immense.

The second area of action to which I wish to draw attention relates to the health impact of green space, and the important meaning of this graph:

![Graph showing the health impact of green space](image)

This is taken from a study of more than 900,000 people in Denmark and shows the degree to which risk of mental health and substance misuse is...
ameliorated by living in proximity to green space during childhood from birth to age 10. The level of risk shown is relative to that of the best decile. The presence of 3 data points for each outcome is to illustrate the partial effect of adjusting for the effect of urbanization, parental socioeconomic status (SES), and the combined effect of urbanization, parental and municipal socioeconomic factors, parental history of mental illness, and parental age at birth on risk estimates. All estimates were adjusted for age, year of birth, and gender and plotted with 95% CIs.

Simply put, better access to green space in early life appears to be markedly protective against psychiatric conditions and substance abuse, regardless of other factors. And this study is important because it looks forward from early exposure to the subsequent / consequent outcomes.

Finally, and with respect to the entire life course – impacting upon behaviours from infancy to potentially isolated old age – I have included a classic illustration of the inverse relationship between traffic volumes and degree of social interaction and sense of ownership of home space on streets. This work was done in San Francisco in the 1970s but has been elsewhere and is well recognised.

Traffic does not just replace exercise but inhibits it for those who are not in vehicles and impacts upon social interaction that might otherwise be protective against the social impacts of austerity.

Policy levers to drive prevention have been proposed to include:

1. Fiscal policies
2. Education
3. Health nudges
4. Regulation and legislation
5. Empowerment
6. Services

But I would suggest that there is a growing evidence base to show that protective and health improving physical and social infrastructure may be at the heart of a truly effective approach to population health improvement.
"The street life doesn't intrude into the home ... only happiness comes in from the street."

"I feel my home extends to the whole block."

"I feel a sense of responsibility, I plant trees, paint all my house and keep property on sidewalk clean."

"I definitely think of it as my real home."

"I feel it's a home. There are warm people on the street. I don't feel alone."

"I'm friendly street. People chatting, washing their cars. People somewhere always stop."

"Definitely a friendly street."

"Not from the street intrudes into my home."

"Just the apartment not even that."

"Not a friendly street - no one offers help."

"It's used by pedestrians on their way somewhere."

"People are afraid to go onto the street because of the traffic."

Source: Appleyard (1981)
Statistical appendix

As in previous years, this snapshot focuses principally on those indicators used by Public Health England in its Local Area Profiles, though with a number of additional items of particular interest.

More extensive data are available through the Know Newcastle website (http://www.knownewcastle.org.uk) and many useful tools for health related data are available through the PHE “Fingertips” site (https://fingertips.phe.org.uk).

Selection of indicators for communities is necessarily quite restricted as there are many areas we could consider that influence the health and well-being of the population.

In the tables that follow, I have stayed with the PHE structure for local profiles, covering:

- Communities
- Children and young people’s health
- Adults’ health and lifestyle
- Disease and poor health
- Life expectancy and causes of death

Each table contains a set of indicators and identifies the period for which the data were derived. I have included the English rates as a reference point and specified the units used in each case. For the values, the colour coding (green, amber, red) implies a good, average or poor position in the national distribution for those instances where such ranking is appropriate, and these are based upon the quartile ranges of the distribution.

Trends are also indicated in accordance with the PHE assessment and the colour coding applies also here to indicate if we are making progress. In some instances, PHE does not supply an assessment of trend, but I have commented in the subsequent text if there are other data that allow us to make assumptions about the direction of travel.

To allow for black and white printing or colour blindness, the colour coding is also signalled with hand symbols as green 🇬, amber 🇦, and red 🇷.

In general, where the PHE profile includes areas addressed through other reports to the council (e.g. for education or social care) I have not made any detailed comment.
### Communities

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>YEAR</th>
<th>ENGLAND</th>
<th>NEWCASTLE</th>
<th>TREND</th>
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<tbody>
<tr>
<td>Deprivation score (IMD 2015)</td>
<td>2015</td>
<td>21.8</td>
<td>28.30</td>
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<tr>
<td>Children in low income families (under 16s)</td>
<td>2016</td>
<td>17.0</td>
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<tr>
<td>Statutory homelessness</td>
<td>2017/18</td>
<td>0.8</td>
<td>2.3</td>
<td>🔘</td>
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<td>Violent crime (violence offences)</td>
<td>2017/18</td>
<td>23.7</td>
<td>36.8 per 1000</td>
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<tr>
<td>Long term job seeker claimants</td>
<td>2017</td>
<td>3.5*</td>
<td>5.6%</td>
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### Children and young people’s health

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<th>NEWCASTLE</th>
<th>TREND</th>
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</thead>
<tbody>
<tr>
<td>Smoking status at time of delivery</td>
<td>2017/18</td>
<td>10.8</td>
<td>15.1%*</td>
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<tr>
<td>Breastfeeding initiation</td>
<td>2016/17</td>
<td>74.5</td>
<td>69.4%</td>
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<td>Breastfeeding prevalence at 6-8 weeks</td>
<td>2017/18</td>
<td>42.7%</td>
<td>46.9%</td>
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<tr>
<td>Infant mortality</td>
<td>2014/16</td>
<td>3.9</td>
<td>2.9 per 1000</td>
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<tr>
<td>Obese children (4-5 years)</td>
<td>2017/18</td>
<td>9.5%</td>
<td>11.8%</td>
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<td>Obese children (Year 6)</td>
<td>2017/18</td>
<td>20.1</td>
<td>24.6%</td>
<td>🔘</td>
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<td>Admission episodes for alcohol-specific conditions – Under 18s</td>
<td>2015/16 - 17/18</td>
<td>32.9</td>
<td>43.3 per 100,000</td>
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<td>Under 18 conceptions</td>
<td>2017</td>
<td>17.8</td>
<td>23.9 per 1000</td>
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<td>Hospital admissions as a result of self-harm</td>
<td>2017/18</td>
<td>421.2</td>
<td>437.8 per 100,000</td>
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<tr>
<td>Decayed, missing filled teeth at age 5</td>
<td>2016/17</td>
<td>23.3%</td>
<td>19.3%</td>
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<tr>
<td>Hospital admissions for dental caries (0-5 years)</td>
<td>2015/16 - 17/18</td>
<td>325.1</td>
<td>796.8 per 100,000</td>
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</table>
Children killed or seriously injured on roads 2015-17 17.4 - 32.0 per 100,000

A&E attendances 0-4 years 2017/18 619.0 841.1 per 1000

Hospital admissions for mental health conditions 2017/18 84.7 71.2 per 100,000

**Adults’ health and lifestyle**

<table>
<thead>
<tr>
<th>INDICATOR</th>
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<th>ENGLAND</th>
<th>NEWCASTLE</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking Prevalence in adults</td>
<td>2017</td>
<td>14.9</td>
<td>-</td>
<td>↓↓</td>
</tr>
<tr>
<td>Percentage of physically active adults</td>
<td>2017/18</td>
<td>66.3</td>
<td>-</td>
<td>•</td>
</tr>
<tr>
<td>Excess weight in adults</td>
<td>2017/18</td>
<td>62.0</td>
<td>-</td>
<td>•</td>
</tr>
</tbody>
</table>

**Disease and poor health**

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>YEAR</th>
<th>ENGLAND</th>
<th>NEWCASTLE</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer diagnosed at early stage</td>
<td>2017</td>
<td>52.2</td>
<td>54.1%</td>
<td>•</td>
</tr>
<tr>
<td>Hospital stays for self-harm</td>
<td>2017/18</td>
<td>185.5</td>
<td>-</td>
<td>•</td>
</tr>
<tr>
<td>Admission episodes for alcohol-related conditions – narrow definition</td>
<td>2017/18</td>
<td>632</td>
<td>-</td>
<td>•</td>
</tr>
<tr>
<td>Recorded diabetes</td>
<td>2017/18</td>
<td>6.8</td>
<td>-</td>
<td>•</td>
</tr>
<tr>
<td>Incidence of TB</td>
<td>2015 – 17</td>
<td>9.9</td>
<td>12.7 per 100,000</td>
<td>•</td>
</tr>
<tr>
<td>New sexually transmitted infections (STI)</td>
<td>2018</td>
<td>851</td>
<td>-</td>
<td>➔ ➔</td>
</tr>
<tr>
<td>Hip fractures in people aged 65 and over</td>
<td>2017/18</td>
<td>578</td>
<td>-</td>
<td>•</td>
</tr>
</tbody>
</table>
### Life expectancy and causes of death

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>YEAR</th>
<th>ENGLAND</th>
<th>NEWCASTLE</th>
<th>TRENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (Male)</td>
<td>2015/17</td>
<td>79.6</td>
<td>- 78.0 years †</td>
<td>-</td>
</tr>
<tr>
<td>Healthy LE at birth (Male)</td>
<td>2015/17</td>
<td>63.4</td>
<td>58.8 years †</td>
<td>-</td>
</tr>
<tr>
<td>Life expectancy at birth (Female)</td>
<td>2015/17</td>
<td>83.1</td>
<td>- 81.2 years †</td>
<td>-</td>
</tr>
<tr>
<td>Healthy LE at birth (Female)</td>
<td>2015/17</td>
<td>63.8</td>
<td>59.7 years †</td>
<td>-</td>
</tr>
<tr>
<td>Killed and seriously injured on roads</td>
<td>2015/17</td>
<td>40.5</td>
<td>- 36.2 per 100,000 †</td>
<td>-</td>
</tr>
<tr>
<td>Suicide rate</td>
<td>2015/17</td>
<td>9.6</td>
<td>- 9.0 per 100,000 †</td>
<td>-</td>
</tr>
<tr>
<td>Smoking related deaths</td>
<td>2015/17</td>
<td>262.0</td>
<td>- 383.4 per 100,000 †</td>
<td>-</td>
</tr>
<tr>
<td>Under 75 mortality rate: cardiovascular</td>
<td>2015/17</td>
<td>72.5</td>
<td>- 88.7 per 100,000 †</td>
<td>-</td>
</tr>
<tr>
<td>Under 75 mortality rate: cancer</td>
<td>2015/17</td>
<td>134.6</td>
<td>- 171.1 per 100,000 †</td>
<td>-</td>
</tr>
<tr>
<td>Excess winter deaths Index</td>
<td>Aug 2016 – Jul 2017</td>
<td>21.6</td>
<td>- 19.8 (ratio) †</td>
<td>-</td>
</tr>
</tbody>
</table>
Public Health budget

Newcastle’s public health grant was subject to a further Treasury cut of £628,000 in 2018-19, to fall by a further £611,000 in 2019-20. In total, we will have lost more than £3.7m to central cuts since the last Spending Review.

As the council’s leisure function is now contained within the Public Health department, both budgets are managed together with a shared focus on improvement of wellbeing and health. However, for clarity, the graph on the following page illustrates only the public health grant component.

Four major service elements comprise over 85% of the entire spend, being:

- **Early years** – health visiting, school nursing, support to community hubs;
- **Sexual health services** – clinical treatments, advice services, support for HIV action;
- **Drug and alcohol services** – prevention, clinical and recovery;
- **Obesity and physical activity.**

Expenditure on obesity and physical activity through the leisure budget is in addition to the last of these, though we are working to more closely integrate those services and develop a sustainable level of provision for the city alongside the NHS.

The figure for physical activity here also includes public health expenditure in support of parks and the establishment of the Newcastle Parks Trust.

Despite the scale of cuts, we do not anticipate reducing public health services during 2019-20 or 2020-21.
Proportional distribution of the PH Grant (2018-19 = £23,501,000)
Assurance / Section 7a

One of the public health functions transferred to local authorities in 2013 is that of supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes.

The function is carried out through various avenues but principally, at local level, through the Health Scrutiny Committee. For an overview of the current position on delivery of these services, which are commissioned by NHS England, please see the report taken to Health Scrutiny in April 2019.

Worth highlighting is the decline in cervical screening performance in the city over recent years. We have continued to raise this as an issue with NHS partners and some remedial action is now taking place. We will monitor this carefully and report on progress.

More generally, NHSE has mooted devolution of commissioning for screening and immunisation services to groups of CCGs. A far better and more appropriate solution would be to devolve commissioning of these services to local authorities as an integral part of the public health system that can be both better delivered and better scrutinised and assured at a local level.

We will be pursuing this further via the Health Scrutiny Committee.
References


5. APPG on Smoking and Health. *Delivering the vision of a ‘Smoketfree Generation’: The APPG on Smoking and Health response to ‘Prevention is better than cure’*. (2019).


