Annual Report
of the
Director of Public Health
Newcastle upon Tyne
2015
To: Cllr Nick Forbes
Leader of Newcastle City Council March 2016

I have pleasure in presenting my annual report on the health of the population of Newcastle for the year 2015, brought in conjunction with Cllr Streather’s portfolio report for public health and housing.

The decision to raise public health to cabinet status was extremely welcome and sends a clear message both about its significance in council thinking, and the intent to embed wellbeing and health into all mainstream business.

This is an extraordinarily difficult time for councils, and it is unfortunate that the return of public health to its natural home has been followed so rapidly by severe challenges to our ambitions in improving wellbeing and health.

In spite of this, I think most who have been involved in public health over the last three years would agree that the move to local authority leadership remains not only correct but continues to hold great promise for future progress. This view is borne out by the degree of consensus expressed by my colleagues from across the country with whom I recently gave evidence to the House of Commons Health Select Committee’s Inquiry into Public Health Post-2013.¹,²

As I hope this report illustrates, we need to be watchful of the potential for austerity to reverse the significant gains made in health improvement of recent years. The jury remains out on whether some of the statistical patterns seen recently, and which are described in this report, are an initial manifestation of that.

There is broad consensus that the measures needed to tackle the problems we face in sustaining and enhancing health and social care, prevention and wellbeing require an unprecedented degree of collaboration and innovation. It is encouraging to see this has been recognised across the city’s agencies, but the next steps are difficult and will need resolution of purpose.

At the same time, it is clear that the potential of devolution for public health is substantial. This is not just a question of health and social care – it requires an intention to embed health into all policies to be translated into new powers at the proposed level of devolved authority. This is an exciting prospect which requires shedding of prejudices and prior assumptions. If devolution proceeds, we must seize the opportunity to make our approach the most health improving, preventative of settlements. We have aspired to the goals outlined by the Marmot Review – this is an unprecedented opportunity genuinely to deliver that aspiration.

I look forward to continuing participation in, and contribution to that process.

Eugene Milne
Director of Public Health
March 2016
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1. Background

In last year’s report I described how, historically, Medical Officer of Health or Director of Public Health (DPH) annual reports had three roles:

- To serve as a document of record and source of statistical information,
- To deliver an account of the current health of the population to the members of council,
- To describe a direction of travel for improving health.

I noted that to a large extent, the first and second of these had been overtaken by modern availability of data – there is no longer the same need for a document of record describing the health of the local population as there was in the time of Medical Officers of Health. Instead, last year’s report reflected upon the transfer of responsibilities from the NHS and how they were being addressed within Newcastle City Council.

Public health is a long game. Its timescale for impacts upon health can be decades. We aim to minimise low birthweight in babies not only for their immediate health but also for the sake of their cardiac health in 60-80 years time.

This extended perspective is both a blessing and a curse. The impact of getting it right is enormous, the penalty for failing to persuade others of its worth is obscured in the future.

Last year, I made 28 recommendations across a range of areas – identifying ways of working that were endorsed at the Council’s June meeting. Through this report I will identify where we are with each of them, but would emphasise that most continue to be active issues. Many are not yet fulfilled, and we will come back to them again, some of them, I suspect, repeatedly. But it is worth noting that the decision not to keep adding to that list unnecessarily is a conscious choice. These were not intended to be objectives for a single year.

In 2015, reflecting its importance in the Council’s priorities, public health became the subject of a Cabinet Portfolio, held by Cllr Jane Streather in conjunction with the portfolio for housing. This was a very welcome move and I concur entirely with Cllr Streather’s view of her role in aiming to embed health in all policies, articulated in her first portfolio holder’s report. This is thoroughly in keeping with last year’s recommendation that “In line with the 2013 Wellbeing for Life Strategy, the Council’s approach to the public health role of the Council should be to focus on the broader improvement of health and wellbeing of the population rather than on treatment of individuals”. (Rec 3: 2014)

I am aware, at the same time, of the danger that the portfolio and the DPH report simply echo one another or cover the same ground.

I have tried, as far as possible, to avoid repetition and have kept this report short, focusing upon key issues that I wish to draw to the council’s attention. The law requires that the Director of Public Health “must prepare an annual report on the health of the people in the area of the local authority” and that “The local authority must publish the report”. It does not require it to be verbose.
2. Health in the city

Life expectancy is routinely calculated on the basis of three-year rolling averages, and data only become available for each year some time after its completion. The most recent data for life expectancy are, therefore, the figures for 2012-14 and, in the case of healthy life expectancy, for 2011-13.

Both sets of figures are somewhat troubling. Life expectancy for men fell from 78.2 to 77.9 years, and healthy life expectancy fell from 59.8 to 57.8 years.

For women, life expectancy rose slightly from 81.8 to 81.9 years, but healthy life expectancy fell from 60.9 to 59.9 years.

Moreover, the gap in life expectancy between Newcastle and England, which had been narrowing for some years, grew slightly wider in 2012-14.

It is, perhaps, the figures for healthy life expectancy that should trouble us most. For a particular area and time period, healthy life expectancy is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life. Figures are calculated from deaths from all causes, mid-year population estimates, and self-reported general health status, based on data aggregated over a three year period.

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Healthy Life Expectancy for men and women in Newcastle, the North East and England – 3-year rolling averages

These falls represent worsening of self-reported health status in our local population, and indicate that the last 20 years of life for men, and 22 years for women are lived in poor health. In contrast, the average figures for England are around 4 and 3 fewer years of poor health respectively, and for the healthiest of communities the figures are yet lower.

So why have life expectancy and healthy life expectancy fallen?

The fall in life expectancy is likely to be partly (though only partly) a statistical anomaly – we know that some of the local figures for deaths were distorted.

between 2013 and 2014 (some deaths that occurred in 2013 appeared as registrations in the 2014 figures). It is not clear how much impact this may have had.

Deaths certainly went up at the end of 2014 and into the early months of 2015 – figures for excess mortality during that winter are clearly much higher than in previous years. During the months of December 2014 to February 2015, there were around 25% more deaths registered than in the equivalent period of the previous year.

One reason for this may be the mismatch of the influenza vaccine with circulating types of virus that year. Others have argued strongly that we are seeing the impact of austerity upon vulnerable individuals. It is probably truer to observe that it is too soon to be sure of any explanation, and vigilance is clearly needed.

But the combination of increased death registrations, falling healthy life expectancy, major pressure on health and care services and cuts to provision, compounded by such factors as the failure of the influenza immunisation programme are serious cause for concern.

Either way, there is increasing evidence that the long-term fall in deaths, which was highlighted in last year’s annual report, has flattened out and may even have been reversed.

![Deaths registered per month in Newcastle 2006-2015](image)

The fall in healthy life expectancy is larger and reflects a wide range of influences upon wellbeing and health. These include the effects of health and care services, though it is very hard to be precise in attributing proportional effects. In all probability, the major impacts upon self-reported general health are shaped more by broader conditions of living than by direct consequences of care services.
Our mortality rate for diseases that are considered to be preventable continues to be more than 30% higher than the national average. This is driven more by cancers, for which the excess in people below the age of 75 is around 40%, and less by cardiovascular disease for which the excess is lower at about 25%.

To some extent this reflects a stage in health improvement of the local population that one would expect for diseases driven so strongly by smoking – the delay in health improvement as smoking prevalence falls is much longer for cancers than it is for heart disease and stroke. International experience of the impact of reduced smoking clearly demonstrates this staggered effect.

The most encouraging figure of the year in health statistics is probably the fall of our smoking prevalence figure to 19.6% - for the first time in living memory being below 20% for the city. Smoking at the time of delivery for pregnant women remains high, but fell from 16.6% to 14.3%, while smoking among 15 year olds is now at 10.7% locally reflecting a national trend for smoking among teenagers to fall faster than the general population rate.

Smoking in routine and manual groups also fell, but by a smaller margin than the overall pattern to only 31.4%. This remains an unacceptably high figure and illustrates the danger that inequalities will widen with progress on health improvement. The changes that have been put in place in local Stop Smoking Services during the past year are expressly aimed at countering this trend by providing greater support for individuals in communities that are less likely to have ‘normalised’ non-smoking and so present greater difficulties in successful cessation.

In contrast to mortality figures, which apply mainly, and mercifully, to older ages, it is worth considering how things have progressed at the beginning of life.

In the most recent figures, fewer Newcastle babies than in the previous year were born with low birthweight. More were breast fed from birth, and more even than the English average were being exclusively breast fed at 6-8 weeks. As noted above, smoking by mothers through pregnancy fell by one of the largest margins we have seen. Conceptions and teenage pregnancies fell yet further.

Newcastle, in the most recent figures, was better than the national average for:

- Newborn hearing screening
- Newborn blood spot screening
- Almost all childhood immunisation coverage
- Childhood healthy teeth

Infant mortality, despite the recognised levels of disadvantage in the city, does not differ significantly from the national average and has been lower in 9 of the last 11 years (as measured by 3-year rolling averages).

Child poverty in the city fell for the under 16s and for all dependent children under 20. School readiness at the end of reception improved, both across the board and for those receiving school meals, as did the percentage of year 1 pupils achieving the expected level in phonics screening. Pupil absence fell, there were fewer entrants to the youth justice system, and there were fewer young people not in education, employment or training. The emotional wellbeing of looked after children improved.
Many of our indicators remain worse than the national average, but this is by no means a negligible list of improvements. It reflects an extraordinary level of effort by many people across all sectors to make good the promise of a best start in life, in keeping with the city’s Wellbeing for Life strategy.

This progress will be sorely tested by the reductions in support that are inevitable in the face of funding reductions, and we will need to be very clear in forthcoming recommission of early years (health visiting and school nursing) services that our focus should be on delivering effective evidence-based approaches.

The overall picture that we see of health in the city is one in which progress has not stalled, but is looking somewhat vulnerable.

Given the well-recognised pressures upon the health and social care system, it is paramount in the short to medium term that we reduce the burden of disease that is associated with reduced healthy life expectancy and its concomitant extended period of poor health and dependency. The proportion of life lived in this state of diminished health for the people of Newcastle could, in theory, be 20-40% lower.

From this perspective, it is essential that progress is made in developing the promise of the NHS Five Year Forward View to focus to a much greater extent upon prevention.

It is also essential to recognise that reducing the burden of ill health will not be delivered by simply delivering more of the same health care interventions to people suffering disease and disability. Creating additional healthy life is not the same as treating unhealthy people.

We have the longer term obligation to optimise wellbeing and health of children and young people in the city, in the knowledge that action now can yield benefits for many decades to come, and ensuring this is maintained while addressing those more immediate issues will require unprecedented collaboration across sectors.

**Inequalities**

Although the council has unquestionably continued “to actively support the recommendations of ‘Due North’ for reduction of inequalities” (Rec 1: 2014) there has been disappointingly little regional progress on this initiative by Public Health England. The aspirations of ‘Due North’ remain simply aspirations, and there is clear evidence that areas with more deprivation have been hit harder by public sector cuts.

For the city as a whole, as noted above, life expectancy has recently run in the wrong direction, widening the gap between Newcastle and the English average, particularly for healthy life expectancy. We have a large ‘slope index of inequality’ (SII), though this probably owes much to the wider range of socioeconomic groups in Newcastle than in many other areas – in general, the rich in Newcastle are similar in health to the rich in other cities and regions, but the poor are poorer and less healthy. The SII within the city has been relatively stable over time.

However, there is also some cause for optimism in a variety of statistics, if one looks past the array of red indicators in standard rating systems. We know that on many indicators Newcastle does worse than the national average, and we know also that
many of those are indicators that even success will take years or decades to turn around. In that context it is worth considering not only whether we are better or worse than the average, but also whether we are heading in the right direction, and on that count there is much to admire in the way that impacts have been ameliorated.

3. Funding and the Public Health Ring-Fenced Allocation

Questions of funding dominated the public health agenda to a dispiriting degree during 2015, most notably because of the Chancellor’s decision to make an in-year cut to the national public health allocation of £200m. Newcastle lost around £1.5m as a consequence and this was made recurring in the subsequent spending review, along with a further year on year reduction of 3.9% in real terms. Broadly speaking, this means that we will lose a further £0.5m in each of the next 4 financial years.

The ring-fence will be removed in 2018, and by 2021 public health in local authorities will be funded from business rate retention, although the detail of what that will entail has not yet been resolved.

Removing the ring-fence was certainly anticipated at some point, and it is notable that the Greater Manchester devolution agreement had already approved this.

Nonetheless, the decision to cut public health funding seems at odds with the policy direction that had led to return of public health to local authorities. The government’s 2010 White Paper "Healthy Lives, Healthy People: Our strategy for public health in England" had stated:

"Public health budgets have been squeezed. Prevention has not enjoyed parity with NHS treatment, despite repeated attempts by central government to prioritise it. Public Health funds have too often been raided at times of pressure in acute NHS services and short-term crises." 5

In addition, it conflicts with the stated intent of the NHS Five Year Forward View to ‘get serious about prevention’. 6

In last year’s annual report, I had recommended locally that “In considering removal of provision funded through the ring-fenced allocation in order to fund an alternative provision, this should only proceed if the alternative offers greater benefits to the wellbeing and health of the local population than the activity it displaces.” (Rec 4: 2014)

Given the solid weight of evidence supporting the greater cost-effectiveness of public health over health care interventions, we may assume that the cut did not fit with this proviso though, clearly, for reasons beyond the council’s control.

Notwithstanding this, we will be moving to a non-ring-fenced system in two years’ time and it remains essential that we consider public health expenditures in the context of alternative provision to ensure greatest benefit and best value for money for the local population.

It continues to be “essential that the authority collaborate in studies to assess and generate evidence that will allow rational and cost-effective decisions in determining how best to spend for population health improvement” (Rec 5: 2014) We have made
good progress on such approaches during the past year in our work with the CCG and Universities.

A second major financial issue that ran through 2015 was the question of target allocations.

A revised formula for funding had been proposed by the Advisory Committee on Resource Allocation early in the year. This was intended to address appropriate distribution in the light of transferred 0-5 services (primarily health visiting) and issues relating to other pressures such as those facing sexual health services in cities.

The formula proved contentious, as it split authorities into winners and losers – largely as a consequence of historical patterns of expenditure. In many quarters, this was seen as a North South division, with potential for redistribution from poorer to richer areas. In fact, the pattern is not so simple as that implies, though a gradient certainly would exist under the proposal that formed the basis for consultation.

In the end, no formula change was applied in the spending review, though it is unclear if this will be revisited in future.

From Newcastle’s perspective, the proposed formula would have had a relatively limited impact were it not for the fact that the transferred 0-5 service would have attracted a significantly smaller uplift than the cost of its provision. This remains a potential additional threat to future funding.

Alongside the allocation of the public health grant, the government introduced a ‘Health Premium’. This was intended to be a first step towards incentive payments for progress on health outcomes. The premium is to be paid in respect of achievement measured by a national and a locally chosen indicator. The nationally set indicator is a measure of opiate and non-opiate drug use recovery. Local indicators in the first year had to be selected from a subset of the Public Health Outcomes Framework.

I recommended last year that “For the local health premium indicator from 2016-17 onwards, it is proposed that the Council adopt a local indicator that represents an ward-based assessment of quality of life, to include data currently received the Safe Newcastle Board including indicators of violence and crime.” (Rec 10: 2014) We will be pursuing this in the coming year.

For this year, however, our indicator is improvement in smoking prevalence, which fell by 4.1 percentage points to 19.6% in the most recent figures. We await figures on drug recovery following our restructuring of drug and alcohol services over the last two years.

The pressures that are being imposed upon the public health budget are hardly a surprise to local authorities. Many may see them as a taste of the discipline that all other departments have faced for years.

It is now, more than ever, essential that the NHS engages properly in secondary prevention as flagged in the Five Year Forward View.
4. Creating healthy places

In preparing this report, I considered devoting the greater part of it to developing ideas about our approach to creating and adapting places so that they become ‘salutogenic’ – that is that we develop their characteristics in such a way that they support and generate good health.

On reflection, I have not done this in the context of an annual report as the proper approach to such a subject – one which requires a broad consensus and coordination of action – should be collaborative. A DPH report is too unilateral a view.

Instead, I propose that in the coming months within the council we should develop a plan for health in the city that will give shape to specific aims within the context of:

- Wellbeing for Life
- The Core Strategy and Urban Core Plan
- Sustainability and Transformation Plan
- The Health and Social Care Commission
- Broader impacts of potential devolution

This should:

- Articulate our expectations of parks and green space as promoters of health – as places for general wellbeing, as ‘green gyms’, as venues for events and as foci for collaboration between communities, agencies and businesses.
- Articulate our expectations of urban space as a mechanism for wellbeing, and how the built environment can be used to support the health objectives of the city’s population.
- Articulate the need for a transport infrastructure that appropriately rates health and social utility in choices and design, allowing further development of pedestrianisation and traffic speed control in residential, shopping and school vicinities. (Rec 12: 2014)
- Identify how asset-based approaches can be brought to bear on a sustained basis in achieving healthy change.
- Propose targets for indicators of health and risk, such as air quality that are increasingly recognised to be key drivers of morality and morbidity, but also using measures of social isolation and connectivity in recognition of the broader wellbeing and health needs of the population.

To a large extent, these are expressions of what should be implied by WHO Healthy City status (Rec 9: 2014) They also address the previous recommendation to seek opportunities to innovate in conjunction with parks and leisure investment. (Rec 17: 2014)

I would like to suggest that a central aim of such a plan should be that we establish a routine measure of, or proxy for, the distance walked on average by the citizens of Newcastle every day - the technology for doing this sort of thing is increasingly available. And we should set about designing health into our city so that the average time spent walking is gently increased by, let us say, 15 to 30 minutes.

The reason for this is illustrated below in a graph taken from a study that was undertaken in Hawaii some years ago. The study followed up 707 non-smoking
retired men over a period of 12 years, having observed from the outset who among that group walked less than a mile a day, 1-2 miles a day or more than 2 miles each day. In other respects they were similar to one another.  

The graph illustrates the percentage who died over the 12 years of follow up in each of the walking distance groups.

![Graph](image)

Those who walked more were much less likely to suffer cancer, heart disease or stroke. By the end of the study period, those who walked less than a mile a day were almost twice as likely to have died as those walking over 2 miles a day.

If this were a drug, being promoted to improve the health of older people, it would be the most valuable and profitable drug in the world.

Small increases in walking, brought about by changes in our living environment have the potential to bring about substantial change in the health of the population.

Newcastle is already seeing substantial efforts to change its transport and cycling infrastructure, but we need to be much clearer that these changes are pivotal to the type of population shift approach that is central to local authority impact in public health.

If further evidence were needed, a recent analysis of UK Biobank data for nearly 158,000 people has just been published, demonstrating powerful and significant relationships between mode of travel and excess weight. The graph below shows the degree to which Body Mass Index is lower in various categories of regular transport user when compared to those who use car travel only.
To remove bias, these data were adjusted for age, days per week of moderate leisure physical activity, urban or rural area of residence, ethnic origin, household income quintiles, Townsend area deprivation quintiles, highest educational qualification, alcohol intake, smoking status, non-work active travel, walking for pleasure, job involving standing or walking, manual work, shift work, self-rated health, and limiting long-standing illness or disability. 

Figure 3 Reproduced from Flint E, Cummins S. Does active commuting protect against obesity in mid-life? Cross-sectional, observational evidence from UK Biobank. Lancet. Elsevier Ltd; 2015;386(16):S8.

If we are to properly tackle our rates of obesity and overweight, and the continuing excess of respiratory disease, cardiovascular disease and cancer in our city, shifting transport mode and becoming a walking and cycling culture are among the most potent of potential approaches.

But the aim of a plan for health in the city should be to go further and develop consensus about the ways in which public space can shape good mental health, and empower communities.

In the past, we have been constrained often by rules and regulations that do not incorporate wellbeing and health goals in a way that allows social value to determine choices. A good example has been the way in which transport infrastructure decisions have been biased by monetisation rules that, for example, automatically rate cycling journeys at a lower economic value than the same journeys taken by car. This tips the balance toward car dominance in decisions. 

Devolution offers the opportunity for a fundamental shift in the way that decisions are made and weighted. It holds the enticing prospect of remaking places with a different and better set of priorities that better serve their inhabitants.

5. Broader progress

In this section, I wish to give a brief overview of some key elements of progress as they relate to the recommendations made last year. The structure of these is in keeping with our general thematic approach to public health, being built around
• Mental health, wellbeing and broader determinants
• Substances
• Life course
• NHS interface

A substantial part of the ‘broader determinants’ theme is, however, addressed in section 4 – Creating Healthy Places.

**Mental health**

There is widespread consensus that mental health has been a poor relation to physical health in spending and provision for many years. We have seen some progress in attempting to correct that.

During 2015 a large amount of work was devoted to rethinking mental health services in conjunction with the local clinical commissioning group.

Extensive work with partners has been undertaken to transform emotional wellbeing and mental health provision for children and young people and their families across Newcastle and Gateshead, specifying appropriate configuration of services and governance, with a clear project plan for delivery.

Our guiding principles have been to focus on the early years of life, prevention and early intervention, alongside a focus on targeted interventions for those deemed most vulnerable. We have used public health funding to provide interim support to child and adolescent mental health services for Looked after Children during this process.

We have collaborated in some excellent work using arts and film in expressing the views of children with experience of mental health services as part of our efforts to incorporate the views of parents and staff at the heart of service design, and we have commissioned a VCS organisation to recruit, train and support young people as co-commissioners.

Often when we speak of mental health and mental health services, we focus almost exclusively upon mental ill-health and treatments. Whilst we have adopted a whole systems redesign of child and adolescent mental health services, the focus of our work on adult services during 2015 and to date has been to ensure the right inpatient offer for those who require this type of support, and to consider potential community alternatives.

As we move ahead with a new model of mental ill-health care, we will also be pressing for a much greater focus on positive mental health. This is an issue that deserves much greater attention than can be given here, and is one to which I will return on another occasion.

**Seasonal excess mortality**

Although, in common with the rest of the country, we saw a large surge in excess winter deaths during 2015, fuel poverty in Newcastle actually fell marginally. Some relief may have been afforded by lower oil prices, but we need longer term, sustainable solutions for warmth in the city. Efforts will continue to be necessary in
seeking “opportunities for municipal approaches to winter warmth and abolition of fuel poverty”. (Rec 11: 2014)

Notwithstanding theoretical arguments about the efficacy of influenza immunisation, it would seem prudent to emphasise the continuing need for immunisation in appropriate groups. Most notably this should apply to hospital and care staff who risk infecting vulnerable individuals. Levels of immunisation among staff across sectors, however, have remained unsatisfactorily low, and there is a widespread view that the ‘failed’ immunisation of 2014-15 has led to a subsequent perception that influenza immunisation is generally of low value in contrast to that specific mismatch. This needs to be countered strongly, and should form part of plans in preparation for Sustainability and Transformation in the NHS.

**Food and obesity**

Excess weight in 4-5 year olds fell for the third year running in the city. Having peaked at 29.8% in 2011-12 the proportion has fallen to 22.4% in the figures for 2014-15, almost at the level of the national average. whereas previously it had been much higher. Even allowing for confidence intervals, this is now looking like a genuine downward trend.

The same cannot be said of 10-11 year olds, for whom figures are more or less stable at 37.8% in the most recent data, though they are not rising. We have some years to wait before the younger cohorts for whom overweight has been less prevalent reach the older measuring point. It will be fascinating to see if a cohort effect is then apparent.

We await the publication of the promised national child obesity strategy, and we will be looking to “sustain and extend work in schools on obesity prevention as part of an integrated approach” to 0-19 provision in the review of commissioned services this year. (Rec 15: 2014)

At the time of writing, the press is full of talk about sugar tax – a topic of debate that has grown in huge proportion over the last year. I recommended last year that we “monitor Park Lives and similar projects to determine the balance of benefits and risks” (Rec 18: 2014) and we are seeking data to assess trends in consumption of relevant products in the city over the period of its implementation.

Adult excess weight in Newcastle for 2012-14 was slightly below the national average at 61.3%, which is still a startlingly high figure. The proportion of the population achieving ‘5-a-day’ was 59.6%.

There is, though a growing level of public concern and action to address the causes of obesity. The level of community engagement in opposing proposals for a McDonalds at the site Crofter’s Lodge site is heartening, and it is good to see progress on the development of a strong planning directive to guide future fast food regulation in the city.

Work has progressed through the latter part of 2015 on developing a full city food plan. (Rec 16: 2014) In doing this we have been assisted by colleagues from the Institute for Health and Society at Newcastle University, including a full-time
secondment, for an initial period of 3 months, of a lecturer in nutrition to work with us. We will be sharing outputs of this work in the near future.

**Tobacco**

Shelving of plans for a levy on tobacco companies was a significant disappointment to all involved in tobacco control and smoking cessation, and denied the opportunity to argue that such a levy “should be directed primarily towards prevention, and not to further subsidy of the NHS”. (Rec 2: 2014)

But such ideas have a tendency to come around again in time. It took many years to make serious progress on tobacco legislation at all, but we now have some of the most advanced in the world. The general idea – an extension of the ‘polluter pays’ principle is one worth pursuing and is worthy of consideration in a range of other areas (e.g. litter, chewing gum, air quality).

In the meantime, we are seeing the results of our regional initiative to reduce smoking in pregnancy coming through. These will be released as soon as the scientific paper documenting its impact is published, in keeping with the commitment to “Review approaches to smoking and drinking in pregnancy in the light of current initiatives – notably evaluation of babyClear”. (Rec 14: 2014) Analysis of the latter approach is of even greater significance given the failure of the huge Family Nurse Partnership programme to impact upon smoking in pregnancy. 11

The relevance of e-cigarettes to the national debate on smoking and cessation has been underlined by Public Health England’s report “E-cigarettes: an evidence update”. 12 The debate remains polarised, but at least two products have now been licenced as pharmaceuticals. These are not yet readily available. However, we continue to interested in the potential of vaping to assist in harm reduction – notably for those who are at greatest risk by who have not yet reached a point where they choose to cease smoking. We are exploring “the potential role of e-cigarettes in reducing harm among those at greatest risk with partner agencies” (Rec 19: 2014), and aiming to conduct a trial of e-cigarette harm reduction for people with Chronic Obstructive Pulmonary Disease who do not yet wish to give up smoking. The population continues to suffer a substantial excess burden of lung disease in both sexes, and while the best option is to eliminate smoking, reducing harm must be a key part of our short to medium term approach.

A new national tobacco plan will be published during 2016. It is expected to have a major focus on reducing smoking in pregnancy, mental ill-health and in chronic diseases. This is an entirely welcome focus, and one which fits well with the needs of our local population.

**Drugs and alcohol**

Liver disease continues to be higher than the national rate particularly for men, and alcohol-related admissions to hospital are around 30% above the national average. This will be no surprise. Shifting away from a hard-drinking, party culture is not an easy task. But there has been significant progress in managing the night time economy in the city that is admired and mimicked elsewhere. The good practice seen in local licencing and regulation has been insufficiently documented and
shared, though there is much to learn from – and considerable interest from elsewhere.

I suggested last year that “the council should develop a code of practice for protection of children and young people from alcohol advertising”. (Rec 20: 2014) We have still to do this, having focused initially on progressing the Local Government Declaration on Alcohol. On our behalf, Balance has continued to argue the case for more control and restraint on alcohol, and the council has clearly aimed to tread a line of appropriate restriction.

But we need also to look beyond regulatory functions and consider with communities how alcohol impacts on their everyday lives. A programme of training for general practices in brief interventions and advice has been in progress across the city in support of this. We know that the majority of alcohol consumption now takes place in the home and that alcohol is 45% cheaper than it was in the 1980’s. Alcohol is now far more accessible to young people, and is a contributory factor in at least 50% of domestic abuse cases.

Recent guidance published by the Chief Medical Officer on the long term health risks associated with alcohol, and new research on Foetal Alcohol Spectrum Disorder (FASD) make it clear that more work is needed in this field.

In the meantime, our reconfiguration of drug and alcohol services for adults has proceeded. This has not been without difficulties, but the new structure is correct, and commands the support of expert external opinion. There is substantial goodwill among all agencies involved. We should expect to see improvements in performance of these services during 2016.

In contrast to the national trend, the number of drug-related deaths in the city did not change significantly, although it remains high. Whether this can be maintained and reversed in the face of a flood of new and often dangerous substances remains to be seen.

We have commenced the roll-out of naloxone for rapid response to opiate overdose in the city, but have not yet managed to re-institute drug testing on arrest with our partners in the criminal justice system. This continues to be a missing piece in our collective approach.

In last year’s report I had advocated “support [for] national action to regulate NPS (Novel Psychoactive Substances or so-called ‘Legal Highs’). (Rec 21: 2014) Legislation, on this occasion, arrived a great deal sooner than we might have anticipated. This is very welcome as the problem of NPS has continued to grow in the city. As this is a report for 2015, I will elaborate upon the extensive work on this topic that has taken place since Christmas 2015 but will return to that topic in next year’s report.

**Dental health**

Fluoridation of our water continues to be a substantial advantage in protecting our local population. It was striking to see, in rankings of local authorities for aspects of deprivation and health during 2015, that while most parameters clustered around the general deprivation ranking for the city, dental health stood out as markedly better. Across the country, areas with fluoridated water have significantly lower
rates of decayed, missing and filled teeth among children. The effect is larger in more deprived areas, but is still substantial among the affluent. This is a benefit worth celebrating and defending.

Later this year, my colleagues will be undertaking an oral health needs assessment which will support the intention to “Develop a plan for supporting dental health across the life course”. (Rec 23: 2014)

**Sexual health**

A key indicator for sexual health within the Public Health Outcomes Framework is the rate of Chlamydia detection among 15-24 year olds, and on this Newcastle does markedly better on this than the national average.

However, it is troubling to see that our proportion of late HIV diagnoses remains above 40%. Ideally, this figure should be below 25%. In response to this, we are now rolling out self-testing under a new scheme, and will also be moving to more routine testing for HIV in health care settings. Although treatment and support for HIV sufferers has improved enormously over the years, this remains a threat that we cannot ignore.

Last year’s report identified the need to explore the underlying reasons for changes in teenage conceptions and how social media and technology might further empower individuals and protect sexual health. (Rec 24: 2014)

It has been interesting to see in recent press coverage that the relationship between social media and the fall in conceptions has been highlighted. However, this remains quite speculative, and there is a good relationship between the fall in conceptions and availability of long acting contraception. This still deserves further work to understand how risk taking behaviours among young people are changing.

In the meantime, we are continuing to work with partners across agencies on an app to help inform children, young people and their parents about issues relating to sexual health, and also on an app linked to the C-Card scheme. These are being tested and will soon be available.

In common with other immunisations, Newcastle has very good figures for uptake of the HPV vaccination. However, it is of some concern that cervical screening coverage has fallen to 70.5% and is now ‘red’ rated. Our rate of cervical cancer incidence continues to be lower than the national average, but this requires attention and has been raised with the CCG’s quality group.

**Workplace health**

During 2015, we proceeded with a re-alignment of NHS health checks to focus them upon “case-finding targeted at the areas of the city in most need”. (Rec 27: 2014) This has entailed both locality-based action to recruit those most likely to have undetected diagnoses of target conditions, and efforts to take the checks to the people rather than just expecting people to come to the checks. Through commissioning across sectors, we have developed and are offering a combination of workplace health interventions and, where appropriate, NHS health checks. We have also introduced ward-based targeting of health check mail shots and we are experimenting with factors to increase motivation to attend.
We continue to work with the TUC in providing workplace health support and our Health at Work Awards scheme. There are now 37 organisations across the city who are committed to working to achieve the Awards, and collectively their workforce exceeds 44,000 people. This approach has attracted attention from elsewhere and is being used as a model for a similar approach in Cumbria.

**NHS Interface**

The importance and scale of the agenda we share with the NHS is so great that it is possible to see it swamp all other considerations, and there are extensive processes of strategic collaboration under the auspices of the Wellbeing for Life Board and its Accountable Officers, through development of Sustainability and Transformation Plans and the Health and Social Care Commission. Underlying this are many layers of pragmatic collaboration and support. These are addressed elsewhere and need not be a focus of this report.

It is, however, worth noting that there has been no obvious suggestion that CCG merger with Gateshead has resulted in disadvantage to Newcastle citizens. (Rec 6: 2014) Though it has had some unforeseen consequences for data flows in public health, for which certain indicators, previously available for Newcastle, are now combined with figures for Gateshead and are not being provided at a more local level.

This indifference of some NHS processes to external and local community configurations has been reflected also in the imposition by NHS England of a footprint for Sustainability and Transformation Planning (Northumberland, Tyne and Wear) at odds with its own guidance which specifies concordance with proposed devolution footprints.

Over a year ago we requested that the North East Commissioning Service modify its data systems to allow us to undertake analyses at ward level, receiving assurances that this was not a great problem to achieve, and we offered to place a contract to secure those data. Since then, despite repeated requests we have had no response.

Continuing to press for increased access to NHS data in order to deliver the core offer and to assist in targeting action to reduce inequalities was a recommendation made in last year’s report. (Rec 26: 2014) Subsequently, we have secured access to Hospital Episode Statistics through another route.

We will continue to find ways to work around these problems, which are mostly beyond the control of local partners, but they serve as an illustration of conflict between top down and local determination.

This is clearer still in the approach taken by NHS England in moving to establish its proposed National Diabetes Prevention Project (NDPP). Providers of this service have been required to be large organisations capable of delivering ‘at scale’ anywhere within England. This necessarily excluded bidding by local providers, often in the voluntary and community sector, already working in this field. As a consequence, we run the risk that locally established services to support people in lifestyle modification to avoid diabetes could lose out to national, commercial weight loss organisations.
There is much local enthusiasm for establishing a strong, local diabetes prevention service in line with the national aspiration. But we should be able to build upon local strengths rather than having to work within an imposed, top-down model.

During 2015, major efforts were made by colleagues across sectors – and, I wish to note, particularly by Dr Suzanne Moffatt of Newcastle University – to secure evaluation funding through the National Institute for Health Research in support of ‘Ways to Wellness’ as a model of Social Prescribing. (Rec 8: 2014) These efforts failed, principally because of the enormous difficulty associated with conducting research of this kind in the community. Complex community-based interventions which cannot be ‘blinded’ or, in some cases, randomised, continue to suffer a significant disadvantage in terms of research funding and support. Yet often they promise more benefit than trials that focus upon small clinical increments of change.

This is of particular relevance because the Ways to Wellness model links closely to aspects of local provision, such as exercise on referral in Lemington, that could be usefully be supported as part of the NDPP. And I would very much wish to see future models for reviving parks and facilities (such as Elswick Pool) supported by allowing them to become part of NDPP provision. It is this kind of cross-cutting benefit that is lost through central direction of provision.

We continue to press for a shared approach to secondary prevention with the NHS (Rec 7: 2014) that will embrace these different elements in a way that maximises support to local people and communities, and which acts in synergy with other local initiatives.

Work to reduce falls and resulting injuries is an important part of this. Hip fractures were around 15% higher than national rates in 2014-15, and these are life-threatening injuries that have enormous implications for health and social care costs. Effective prevention in this field requires cross-agency action, and public health funding has been allocated to commission aspects of a community-based approach to falls-prevention. (Rec 13: 2014)

We have also collaborated with partners as a part of an integrated approach to local campaigns tackling inequalities arising from late presentation and lack of awareness of cancer. (Rec25: 2014) Key parts of this are handled through specific risk factor approaches – specifically in relation to tobacco and alcohol. These operate best at a level that matches mainstream media, and should be considered in the context of devolution and STPs.

**Emergency response**

We will bring an audit report on health protection arrangements in public health to the health scrutiny committee later this year (Rec 28: 2014) in conjunction with formal assurance submissions relating to those elements of public health that are dealt through Public Health England and in Section 7a contracts with the NHS.

**6. Lobbying and advocacy**

The final issue that I would address in this report is that of lobbying and advocacy – elements of public health activity that are central to its function. Those with longer
memories may recall that lobbying was clearly identified in the former North East Health and Wellbeing Strategy “Better Health, Fairer Health” as one of the key functions needed in the interface between local and national public health action. 13

The functions of lobbying and advocacy had been central to the development of Fresh: Smoke Free North East, building upon international experience in effective tobacco control. 14 And I would argue that this approach, which was always explicit in the remit of Fresh, has been of central importance in its effectiveness on tobacco control. It was in the clear knowledge of this as part of its function that the then Chief Medical Officer for England, Prof Sir Liam Donaldson, awarded it his first Gold Medal for public health in 2009. And it is this mode of working that has led to its international recognition by the WHO and other bodies such as the Irish Cancer Society.

So it was with some alarm that I learned of the new Government guidance on public sector grants and lobbying. In particular, it was troubling to read that the guidance had been predicated upon a publication by the Institute for Economic Affairs entitled “Sock Puppets – How the government lobbies itself and why”. 15 This paper specifically criticises tobacco control activities by a range of organisations including Fresh.

The government guidance has been widely criticised and continues to be a subject of much debate for charities and universities – since, in theory, it would not only preclude charities in receipt of grants from campaigning other than in cases where they had secured alternative specific funding to do so, but would also prevent researchers from seeking to influence policy through their research findings and status as publicly funded experts.

At present, the guidance has not been extended to contracts or to other areas of public spending. However, it sets a dangerous principle that risks unbalancing the possibility of proper debate on key public health topics.

Public funding is often the only avenue to achieving some balance in public and political discourse. Experience around the world has demonstrated that commercial interests are adept at swamping and distorting debate in order to prevent change if it jeopardises profits. The tobacco industry is the textbook example of this, but the same techniques have been used increasingly in other industries to stifle change. Ironically, much of the research that demonstrates this to be the case has been publicly funded.

In last year’s report, I had recommended that we “work with partner authorities to optimise lobbying and advocacy for public health change on behalf of the region – in particular, consider establishing a shared initiative to parallel Fresh and Balance that can provide these functions in relation to e.g. sugar, NPS and other necessary legislative and campaigning issues”. (Rec 22: 2014) This is to be part of the review of Fresh and Balance functions being undertaken on behalf of the funding authorities by Durham County Council this year.

I am sure that Council is already aware of this issue through close connections with local charities and other affected organisations, but I wish strongly to identify the
risk posed to future public health activity by the new guidance. Restriction of this avenue for debate and change would be a seriously retrograde step.

7. Conclusion

The health of the local population over the last two decades has improved very substantially, and we have grown used to steady progress. Indeed, the North East as a whole has tended to outstrip national trends in many areas – albeit starting from a much worse base of health and disadvantage.

There is still much to celebrate in progress on wellbeing and health, but there are warning bells ringing around some central indicators.

I need hardly emphasise that action to tackle integration of health and social care, and development of strong secondary preventive approaches are now absolutely essential.

But there are still major opportunities for stemming resurgence of ill health, and for positively influencing the wellbeing of this and future generations through the currently available opportunities – we should seize them.

Eugene Milne  
Director of Public Health  
March 2016
References:


Appendices

1. Newcastle upon Tyne Unitary Authority Health Profile 2015
   • *Note that the data in this PHE profile are older than some of those quoted in the DPH report – definitions are included at the foot of the main table*

2. Protecting the population of the North East from communicable diseases and other hazards - Annual Report 2014/15
   • *To minimise unnecessary printing this PHE report is available on request (57 pages)*

No updates to mental health or dental profiles were available at the time of writing.
Additional updates on health protection will be made available as they are published.
Health Profile 2015

Health in summary
The health of people in Newcastle upon Tyne is generally worse than the England average. Deprivation is higher than average and about 27.4% (12,700) children live in poverty. Life expectancy for both men and women is lower than the England average.

Living longer
Life expectancy is 12.1 years lower for men and 10.1 years lower for women in the most deprived areas of Newcastle upon Tyne than in the least deprived areas.

Child health
In Year 6, 23.0% (567) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 41.5*. This represents 23 stays per year. Levels of breastfeeding and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 21.6% of adults are classified as obese. The rate of alcohol related harm hospital stays was 847*, worse than the average for England. This represents 2,133 stays per year. The rate of self-harm hospital stays was 229.7*, worse than the average for England. This represents 696 stays per year. The rate of smoking related deaths was 371*, worse than the average for England. This represents 478 deaths per year. The rate of sexually transmitted infections is worse than average. The rate of people killed and seriously injured on roads is better than average.

Local priorities
Priorities for Newcastle upon Tyne include delivering the best possible start in life for all children, increased emphasis on the health impacts of broader policies to deliver health and wellbeing across the life course, and better integration and effectiveness of services designed to deliver universal improvement that reduces inequalities.

Population: 287,000
Mid-2013 population estimate. Source: Office for National Statistics.

This profile gives a picture of people’s health in Newcastle upon Tyne. It is designed to help local government and health services understand their community’s needs, so that they can work together to improve people’s health and reduce health inequalities.

Visit [www.healthprofiles.info](http://www.healthprofiles.info) for more profiles, more information and interactive maps and tools.

Follow @PHE_uk on Twitter

* rate per 100,000 population
Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2010, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.

Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2011-2013. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 12.1 years

Life expectancy gap for women: 10.1 years
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

Health inequalities: ethnicity

This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Percentage of hospital admissions that were emergencies, by ethnic group, 2013

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Newcastle upon Tyne</th>
<th>England average (all ethnic groups)</th>
<th>95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ethnic groups</td>
<td>29.37%</td>
<td>25.70%</td>
<td>24.30% - 30.80%</td>
</tr>
<tr>
<td>White</td>
<td>34.9%</td>
<td>35.5%</td>
<td>33.1% - 37.7%</td>
</tr>
<tr>
<td>Mixed</td>
<td>28.3%</td>
<td>28.3%</td>
<td>26.2% - 30.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>31.7%</td>
<td>31.7%</td>
<td>29.5% - 34.0%</td>
</tr>
<tr>
<td>Black</td>
<td>34.5%</td>
<td>34.5%</td>
<td>32.4% - 36.6%</td>
</tr>
<tr>
<td>Chinese</td>
<td>30.8%</td>
<td>30.8%</td>
<td>28.6% - 33.0%</td>
</tr>
<tr>
<td>Other</td>
<td>36.8%</td>
<td>36.8%</td>
<td>34.6% - 39.0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>27.1%</td>
<td>27.1%</td>
<td>24.9% - 29.3%</td>
</tr>
</tbody>
</table>

Local number of emergency admissions

Local value %

England value %
Health summary for Newcastle upon Tyne

The chart below shows how the health of people in this area compares with the rest of England. This area’s result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

### Children's and young people's health

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Local No Per Year</th>
<th>Local value</th>
<th>Eng value</th>
<th>Eng worst</th>
<th>25th Percentile</th>
<th>75th Percentile</th>
<th>England Range</th>
<th>England Average</th>
<th>England Best</th>
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<tr>
<td>Deprivation</td>
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<td></td>
<td>2</td>
<td>12,650</td>
<td>27.4</td>
<td>19.2</td>
<td>37.9</td>
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<td></td>
<td>3</td>
<td>165</td>
<td>1.4</td>
<td>2.3</td>
<td>12.5</td>
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<tr>
<td></td>
<td>4</td>
<td>1,341</td>
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<tr>
<td></td>
<td>5</td>
<td>3,075</td>
<td>10.9</td>
<td>11.1</td>
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<td>[ ]</td>
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<tr>
<td></td>
<td>6</td>
<td>1,997</td>
<td>10.1</td>
<td>7.1</td>
<td>23.5</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>Breastfeeding initiation</td>
<td>8</td>
<td>2,135</td>
<td>67.7</td>
<td>73.9</td>
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<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Obese children (Year 6)</td>
<td>9</td>
<td>567</td>
<td>23.0</td>
<td>19.1</td>
<td>27.1</td>
<td>[ ]</td>
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<td></td>
<td>10</td>
<td>23.3</td>
<td>41.5</td>
<td>40.1</td>
<td>105.8</td>
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<td>Under 18 conceptions</td>
<td>11</td>
<td>118</td>
<td>26.8</td>
<td>24.3</td>
<td>44.0</td>
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<tr>
<td>Smoking status at time of delivery</td>
<td>7</td>
<td>535</td>
<td>16.6</td>
<td>12.0</td>
<td>27.5</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Smoking prevalence</td>
<td>12</td>
<td>n/a</td>
<td>23.7</td>
<td>18.4</td>
<td>30.0</td>
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<tr>
<td></td>
<td>13</td>
<td>253</td>
<td>55.2</td>
<td>56.0</td>
<td>43.5</td>
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<tr>
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<td>14</td>
<td>n/a</td>
<td>21.6</td>
<td>23.0</td>
<td>35.2</td>
<td>[ ]</td>
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<td>[ ]</td>
<td>[ ]</td>
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<td></td>
<td>15</td>
<td>452</td>
<td>60.3</td>
<td>63.8</td>
<td>75.9</td>
<td>[ ]</td>
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### Adults' health and lifestyle

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Local No Per Year</th>
<th>Local value</th>
<th>Eng value</th>
<th>Eng worst</th>
<th>25th Percentile</th>
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<th>England Range</th>
<th>England Average</th>
<th>England Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of malignant melanoma</td>
<td>16</td>
<td>33.3</td>
<td>15.7</td>
<td>18.4</td>
<td>38.0</td>
<td>[ ]</td>
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<tr>
<td>Hospital stays for self-harm</td>
<td>17</td>
<td>696</td>
<td>229.7</td>
<td>203.2</td>
<td>682.7</td>
<td>[ ]</td>
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<tr>
<td>Hospital stays for alcohol related harm</td>
<td>18</td>
<td>2,133</td>
<td>847</td>
<td>645</td>
<td>1,231</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Prevalence of opiate and/or crack use</td>
<td>19</td>
<td>2,221</td>
<td>11.4</td>
<td>8.4</td>
<td>25.0</td>
<td>[ ]</td>
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<tr>
<td>Recorded diabetes</td>
<td>20</td>
<td>13,966</td>
<td>5.6</td>
<td>6.2</td>
<td>9.0</td>
<td>[ ]</td>
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</tr>
<tr>
<td>Incidence of TB</td>
<td>21</td>
<td>40.7</td>
<td>14.4</td>
<td>14.8</td>
<td>113.7</td>
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<tr>
<td>New STI (exc Chlamydia aged under 25)</td>
<td>22</td>
<td>1,928</td>
<td>979</td>
<td>832</td>
<td>3,269</td>
<td>[ ]</td>
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<tr>
<td>Hip fractures in people aged 65 and over</td>
<td>23</td>
<td>282</td>
<td>639</td>
<td>580</td>
<td>838</td>
<td>[ ]</td>
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<tr>
<td>Excess winter deaths (three year)</td>
<td>24</td>
<td>120.0</td>
<td>15.9</td>
<td>17.4</td>
<td>34.3</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Life expectancy at birth (Male)</td>
<td>25</td>
<td>n/a</td>
<td>78.2</td>
<td>79.4</td>
<td>74.3</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Life expectancy at birth (Female)</td>
<td>26</td>
<td>n/a</td>
<td>81.8</td>
<td>83.1</td>
<td>80.0</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Infant mortality</td>
<td>27</td>
<td>14</td>
<td>4.1</td>
<td>4.0</td>
<td>7.6</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Smoking related deaths</td>
<td>28</td>
<td>478</td>
<td>371.0</td>
<td>288.7</td>
<td>471.6</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Suicide rate</td>
<td>29</td>
<td>27</td>
<td>10.2</td>
<td>8.8</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Under 75 mortality rate: cardiovascular</td>
<td>30</td>
<td>184</td>
<td>96.9</td>
<td>78.2</td>
<td>137.0</td>
<td>[ ]</td>
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<tr>
<td>Under 75 mortality rate: cancer</td>
<td>31</td>
<td>330</td>
<td>173.6</td>
<td>144.4</td>
<td>202.9</td>
<td>[ ]</td>
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<tr>
<td>Killed and seriously injured on roads</td>
<td>32</td>
<td>83</td>
<td>29.3</td>
<td>39.7</td>
<td>119.6</td>
<td>[ ]</td>
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</tbody>
</table>

### Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>% people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits &amp; low income, 2012</td>
</tr>
<tr>
<td>2</td>
<td>Crime rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14</td>
</tr>
<tr>
<td>3</td>
<td>Crude rate per 1,000 population aged 16-64, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14</td>
</tr>
<tr>
<td>4</td>
<td>Indicator has had methodological changes so is not directly comparable with previously released values.</td>
</tr>
</tbody>
</table>