Newcastle upon Tyne City Profile

April 2021

A profile of Newcastle’s people
Introduction

The Newcastle upon Tyne City Profile draws together quantitative data and research to help meet our statutory requirement to have a Joint Strategic Needs Assessment (JSNA) and to inform our understanding of the people of Newcastle, the factors that shape their wellbeing and health, and the main illnesses and diseases that affect our residents. We first created this profile of our city – ‘Know Your City’ – in 2016. This is an updated version, produced using the most recent data available as of 2021.

Whilst the city profile brings together this quantitative data, for best results it needs to be used alongside other information, such as your own knowledge and experience and that of your colleagues, and qualitative information about the city. For example, feedback from consultations and discussions with residents and service users helps us understand how they experience the issues presented in this profile. If you have queries about the city profile, please contact the Policy Team at:

research@newcastle.gov.uk

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1. Population

This part of the City Profile considers the overall population of Newcastle upon Tyne. It reviews the overall population of the city, projected population change, population by life stage, and then looks at different population groups within Newcastle, such as disabled people, ethnic groups within the city, and other characteristics.

1.1. Overall population data and projections

This section provides an overview of the number and diversity of people living in Newcastle and how it is projected to change over time. The latest ONS population estimates (2019) suggest there are approximately 300,820 people currently living in Newcastle, compared to 289,800 five years ago in 2014.

We expect the population of Newcastle to increase over the foreseeable future. ONS population projections suggest this might increase to 310,906 by 2030, rising to 315,038 by 2040. Figure 1.1-1 shows Newcastle’s projected population growth over the years 2020-2040 by 5-year age bands, compared to that projected for England.

Figure 1.1-1: The structure of the current and projected population, by 5-year age bands for Newcastle and national data

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Table 1.1-2 shows the components or drivers that ONS reports will contribute to this population change.

**Table 1.1-2: The impact of different drivers of population change on Newcastle’s population (from 2020 to 2040)**

<table>
<thead>
<tr>
<th>Driver of population change</th>
<th>Explanation</th>
<th>Impact by 2040</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural change</td>
<td>Birth and death rates</td>
<td>Net gain of 13,970 people</td>
</tr>
<tr>
<td>Internal migration</td>
<td>Moves within England</td>
<td>Net loss of 33,679 people</td>
</tr>
<tr>
<td>International migration</td>
<td>Moves between England and the Republic of Ireland, moves between England and the rest of the world, migrants, visitor switchers (see below) and asylum seekers</td>
<td>Net gain of 33,094 people</td>
</tr>
<tr>
<td>Cross-border migration</td>
<td>Moves between England and Scotland, Wales and Northern Ireland</td>
<td>No significant gain or loss</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td><strong>Net gain of around 14,155</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Notes:

a) Overall net gain figures do not match exactly the sum of the components of change, due to rounding.

b) ‘Visitor switchers’ are people who enter or leave the UK for a short visit (that is, less than 12 months) but end up migrating for more than a year. These people are visitors who subsequently become migrants.

c) Subnational population projections do not attempt to predict the impact of political circumstances such as the UK’s withdrawal from the European Union.

Table 1.1-3 on the next page provides further information on recent internal migration, illustrating the inflow and outflow within England and Wales during the year ending June 2018 (the latest data we have available). The latest estimates show 23,581 people moving into the city and 23,607 moving out. This results in an overall net loss of around -26 people, slightly lower than that of previous years (in 2015 this was -260 people). ONS analysis of internal migration data reports that:

“People tend to move to nearby areas and to more rural locations. Our internal migration estimates show that the most rural parts of England have net inward internal migration, while the most urban parts have net outward internal migration. In the year to mid-2018, the most rural local authorities gained an average of 9.5 people per 1,000 population and the most urban local authorities lost an average of 6.0 per 1,000.”

Comparison with neighbouring local authorities shows that this general trend is apparent in the North East, with more urban areas such as Newcastle, Gateshead and Sunderland having a net outflow, whereas more rural areas such as Northumberland and County Durham have a net inflow. ONS also state that “internal migration generally occurs between neighbouring areas”, and analysis of data using their online tools shows that of

---


3 Ibid.
the 23,607 people estimated to have migrated out of Newcastle upon Tyne, 2,050 moved to Northumberland (compared to 1,870 moving from Northumberland), and 3,200 moved to North Tyneside (compared to 2,050 moving from North Tyneside) 4.

### Table 1.1-3: Number of people (all ages) moving into and out of Newcastle during the year ending June 2018

<table>
<thead>
<tr>
<th>Area</th>
<th>Inflow</th>
<th>Outflow</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle upon Tyne</td>
<td>23,581</td>
<td>23,607</td>
<td>-26</td>
</tr>
<tr>
<td>Northumberland</td>
<td>11,570</td>
<td>9,763</td>
<td>+1,987</td>
</tr>
<tr>
<td>County Durham</td>
<td>21,282</td>
<td>19,413</td>
<td>+1,869</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>8,864</td>
<td>7,637</td>
<td>+1,227</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>4,584</td>
<td>3,852</td>
<td>+732</td>
</tr>
<tr>
<td>Gateshead</td>
<td>8,738</td>
<td>9,072</td>
<td>-334</td>
</tr>
<tr>
<td>Sunderland</td>
<td>7,421</td>
<td>8,143</td>
<td>-722</td>
</tr>
</tbody>
</table>

### 1.2 Population by life stage

#### 1.2.1 Overview of population by life stage

Here we give an overview of the population by a series of ‘life stages’. Figure 1.2.1-1 shows the 2019 population estimates by 5-year age bands, with life stages highlighted: early years (0-4), school years (5-14), transition years (15-24), working age (25-64), and later life (65 and over). These are approximate ages for these life stages for the population as a whole, as individuals vary – for example, many people start work aged 18, and work later than age 64.

Figure 1.2.1-1: Age structure of people in Newcastle by 5-year age bands

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4 Ibid.


Table 1.2.1-2 below shows a comparison of Newcastle to the North East and England. It highlights that Newcastle has:

- A similar proportion of early-years and school-age children to both the regional and national figures.
- A higher proportion of people in the transition years, influenced by students living in the city.
- A slightly lower proportion of people of working age living in the city.
- A lower proportion of people in later life.

Table 1.2.1-2: The number and proportion of Newcastle’s population by the different life stages compared to the North East and England as a whole

<table>
<thead>
<tr>
<th>Life stage</th>
<th>Newcastle Number</th>
<th>Newcastle %</th>
<th>North East %</th>
<th>England %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early years (0–4 years)</td>
<td>16,629</td>
<td>5.5</td>
<td>5.4</td>
<td>6.0</td>
</tr>
<tr>
<td>School years (5–14 years)</td>
<td>33,717</td>
<td>11.1</td>
<td>11.4</td>
<td>12.1</td>
</tr>
<tr>
<td>Transition years (15–24 years)</td>
<td>60,098</td>
<td>19.9</td>
<td>12.2</td>
<td>11.8</td>
</tr>
<tr>
<td>Working age (25–64 years)</td>
<td>147,976</td>
<td>48.9</td>
<td>51.3</td>
<td>51.9</td>
</tr>
<tr>
<td>(aged 25-44)</td>
<td>(84,576)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(aged 45-64)</td>
<td>(63,400)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Later-life (65+)</td>
<td>44,260</td>
<td>14.6</td>
<td>19.7</td>
<td>18.2</td>
</tr>
<tr>
<td>Total</td>
<td>302,680</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

1.2.2 Forecast of population change by life stage

Here we give an overview of forecast changes in population by a series of ‘life stages’ derived from the ONS sub-national population projections. Table 1.2.2-1 on the next page shows the Census 2011 population data and the latest ONS population estimates. Figure 1.2.2-1 beneath it presents the Newcastle ONS population projections by life-stage.

The ONS population projections for Newcastle indicate that:

- The largest increase is in the later-life group, by 28.7% (12,369 people) from 43,227 in 2018 to 55,623 in 2043.
- The second largest change is a 5.1% increase in the transition years (15-24) stage (3,075 young people) from 60,487 in 2018 to 63,562 in 2043.
- Those in the early years’ stage (0-4 years) will increase by 4.8% to 17,424 by 2043; and those in school years (5-14 years) are expected to decrease by 3.3% to 32,602 by 2043.
- Whilst the working age group is expected to decrease slightly overall, by 0.4%; those aged 25-44 years are expected to increase by 2.1% and those aged 45-64 to decrease by 3.7%.

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8 Ibid.
Table 1.2.2-1: Number and projected changes in population by life stage\(^9\)

<table>
<thead>
<tr>
<th>Life stage</th>
<th>Census 2011</th>
<th>ONS 2018 population estimate</th>
<th>ONS population projections for Newcastle</th>
<th>Change 2018-2043 Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early years (0-4 years)</td>
<td>16,500</td>
<td>16,630</td>
<td>16,629</td>
<td>17,424</td>
<td>794</td>
</tr>
<tr>
<td>School years (5-14 years)</td>
<td>28,500</td>
<td>32,687</td>
<td>33,717</td>
<td>32,602</td>
<td>-85</td>
</tr>
<tr>
<td>Transition years (15-24 years)</td>
<td>57,200</td>
<td>60,487</td>
<td>60,098</td>
<td>63,562</td>
<td>3,075</td>
</tr>
<tr>
<td>Working age (25-64 years)</td>
<td>138,000</td>
<td>147,165</td>
<td>147,976</td>
<td>146,544</td>
<td>-61</td>
</tr>
<tr>
<td>Aged 25-44</td>
<td>-</td>
<td>83,294</td>
<td>84,576</td>
<td>84,993</td>
<td>1,744</td>
</tr>
<tr>
<td>Aged 45-64</td>
<td>-</td>
<td>63,916</td>
<td>63,400</td>
<td>61,551</td>
<td>-2,365</td>
</tr>
<tr>
<td>Later-life (65+)</td>
<td>38,900</td>
<td>43,227</td>
<td>44,260</td>
<td>55,623</td>
<td>12,396</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>279,100</strong></td>
<td><strong>300,196</strong></td>
<td><strong>302,680</strong></td>
<td><strong>315,755</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

Figure 1.2.2-1: Forecast population change based around life stages\(^10\)

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\(^9\) Ibid.
\(^10\) Ibid.
1.3 Early years

As shown in table 1.3-1 below, there are currently around 16,629 early-years children (aged between 0-4 years) living in Newcastle. The numbers are expected to remain similar over the period to 2043, increasing to 17,424 by 2043 (a +4.8% increase).

Table 1.3-1: Forecast number of children in the early years group in Newcastle\(^ {11}\)

<table>
<thead>
<tr>
<th>Early years</th>
<th>Census 2011</th>
<th>ONS 2018 population estimate</th>
<th>ONS population projections for Newcastle 2020</th>
<th>2043</th>
<th>Change Number</th>
<th>Change %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged 0-4 years</td>
<td>16,500</td>
<td>16,630</td>
<td>16,629</td>
<td>17,424</td>
<td>795</td>
<td>+4.8</td>
</tr>
</tbody>
</table>

1.4 School years

The latest ONS population estimates suggest there are around 32,687 children and young people aged between 5 and 14 in Newcastle as of 2018, and overall, the number of children in this life stage is expected to stay almost the same, decreasing slightly by around -0.3% by 2043. Table 1.4-1 below shows this in more detail:

Table 1.4-1: Forecast number of children in the school years group in Newcastle\(^ {12}\)

<table>
<thead>
<tr>
<th>School years</th>
<th>Census 2011</th>
<th>ONS 2018 population estimate</th>
<th>ONS population projections for Newcastle 2020</th>
<th>2043</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9 years</td>
<td>14,000</td>
<td>17,441</td>
<td>17,307</td>
<td>16,623</td>
<td>-4.7%</td>
</tr>
<tr>
<td>10-14 years</td>
<td>14,500</td>
<td>15,246</td>
<td>16,410</td>
<td>15,979</td>
<td>4.8%</td>
</tr>
<tr>
<td>Total</td>
<td>28,500</td>
<td>32,687</td>
<td>33,717</td>
<td>32,602</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>

\(^ {11}\) Ibid.
\(^ {12}\) Ibid.
1.5 Transition years

This section discusses young people in the years of transition to adulthood, aged between 15 to 24. ONS projections suggest this population group is expected to increase by 3,075 people (5.1%) between 2018 and 2043. Table 1.5-1 shows the two age bands within the transition years group. Those aged 15-19 years are expected to increase by 9.6% and those aged 20-24 years by 2.8% over the period.

Table 1.5-1: The transition years Newcastle growth forecast

<table>
<thead>
<tr>
<th>Transition years</th>
<th>Census 2011</th>
<th>ONS 2018 population estimate</th>
<th>ONS population projections for Newcastle</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19 years</td>
<td>22,400</td>
<td>20,588</td>
<td>20,754</td>
<td>+9.6%</td>
</tr>
<tr>
<td>20-24 years</td>
<td>36,000</td>
<td>39,899</td>
<td>39,344</td>
<td>2.8%</td>
</tr>
<tr>
<td>Total</td>
<td>58,400</td>
<td>60,487</td>
<td>60,098</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

1.6 People coming to Newcastle for higher education

People from across the UK and internationally, particularly young people, come to Newcastle upon Tyne to attend university. Due to the disruption caused by the Covid-19 pandemic, we are unable at present to obtain an accurate picture of the numbers of people moving to the Newcastle area to do this. Over the next year we will look at ways of working with Newcastle and Northumbria Universities to review available data and identify trends.

1.7 People of working age

We have selected those aged between 25 and 64 years to describe people in the working age group, although we recognise that people from age 16 onwards may work, and increasingly more people work beyond the age of 65 years. However, these years are important for family building, work, and preparation for later life.

ONS projections suggest this age group is expected to remain effectively the same between 2018-2043. Those aged 25-44 are expected to increase by 2.1% to 84,993 by 2043 whilst those aged 45-64 are expected to decrease by 3.7% (-2,365 people) over the same period. Table 1.7-1 provides further information.

Table 1.7-1: The working age projection for Newcastle

<table>
<thead>
<tr>
<th>Working years</th>
<th>Census 2011</th>
<th>ONS 2018 population estimate</th>
<th>ONS population projections for Newcastle</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-44 years</td>
<td>-</td>
<td>83,249</td>
<td>83,249</td>
<td>2.1%</td>
</tr>
<tr>
<td>45-64 years</td>
<td>-</td>
<td>63,916</td>
<td>63,916</td>
<td>-3.7%</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>147,165</td>
<td>147,165</td>
<td>-0.4%</td>
</tr>
</tbody>
</table>

13 Ibid.
14 Ibid.
1.8 Later life

ONS projections suggest the later life population (aged 65 and over) in Newcastle will increase by 28.7% to 55,623 between 2018 and 2043. Within the later-life age group, we might also expect to see more relative growth over the period in the older age groups; by 2.1% for those aged 65-74, by 53.9% for those aged 75-74 and by 72.5% for those aged 85+. Table 1.8-1 provides further detail.

Table 1.8-1: The later-life projection for Newcastle\(^{15}\)

<table>
<thead>
<tr>
<th>Transition years</th>
<th>Census 2011</th>
<th>ONS 2018 population estimate</th>
<th>ONS population projections for Newcastle</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74 years</td>
<td>19,400</td>
<td>23,272</td>
<td>23,799</td>
</tr>
<tr>
<td>75-84 years</td>
<td>13,900</td>
<td>13,803</td>
<td>14,055</td>
</tr>
<tr>
<td>85+ years</td>
<td>5,500</td>
<td>6,152</td>
<td>6,290</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38,800</strong></td>
<td><strong>43,227</strong></td>
<td><strong>44,144</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>55,623</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>28.7%</strong></td>
</tr>
</tbody>
</table>

1.9 Disability

We know that disabled people are more likely to experience poorer outcomes in employment, income and education. They are more likely to face discrimination and negative attitudes, be a victim of crime and experience problems with housing and transport. From Census 2011 data (the latest available for the population as a whole) and data from the Schools Census 2020, we know that:

- In 2011, 18.7% of people in Newcastle had a long-term health problem or disability that limited their day-to-day activity to some degree. This compares to 17.9% of the England and Wales average for 2011. Of these, just over half were limited a lot (26,661 people) and the rest a little (25,916)\(^{16}\).
- In 2020, of the 41,165 total pupils in Newcastle schools, 6,384 have some form of special educational need, with 1,368 having an education, health and care plan\(^{17}\).

The disadvantage faced by disabled people imposes significant economic, social and human costs, on themselves, their families, carers and friends. The nature of disability can also cause higher living costs to cover such things as high utility bills, taxis and specialist food. Disabled people can be disproportionately impacted by a combination of reduction in benefits, including support for disabled children and support available to disabled people in work.

\(^{15}\) Ibid.
1.9.1 Age and disability

Table shows the number and proportion of people with a long-term health problem or disability. As we might expect, the proportion of people with limited health or disability issues increases with age. In terms of numbers, half of all those with a long-term health problem or disability are of working age (between 16 and 64 years). Please note that this data is based upon the Census 2011 outputs and is included for illustrative purposes; we will analyse the Census 2021 data to achieve a more up-to-date picture of this population as soon as they are available.

Table 1.9.1-1: Number of people with long-term health problem or disability by broad age group in Newcastle18

<table>
<thead>
<tr>
<th>Disability</th>
<th>0 to 15</th>
<th>16 to 49</th>
<th>Age 50 to 64</th>
<th>65 and over</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day-to-day activities limited a lot</td>
<td>942</td>
<td>5,952</td>
<td>7,014</td>
<td>12,753</td>
<td>26,661</td>
</tr>
<tr>
<td>Day-to-day activities limited a little</td>
<td>1,128</td>
<td>7,224</td>
<td>6,788</td>
<td>10,776</td>
<td>25,916</td>
</tr>
<tr>
<td>Day-to-day activities not limited</td>
<td>45,904</td>
<td>135,179</td>
<td>31,327</td>
<td>15,190</td>
<td>227,600</td>
</tr>
<tr>
<td>Total</td>
<td>47,974</td>
<td>148,355</td>
<td>45,129</td>
<td>38,719</td>
<td>280,177</td>
</tr>
</tbody>
</table>

1.10 Transgender and gender non-binary people

Broadly speaking, transgender (trans) people are individuals whose gender expression and / or gender identity does not correspond to the one they were given at birth19. The word ‘transgender’ is an umbrella term that is often used to describe a wide range of identities and experiences, including: transsexual, trans man, trans women, assigned female at birth (AFAB) and assigned male at birth (AMAB). Some people do not define their gender as either male or female. They may describe themselves as gender non-binary, agender, or genderqueer (among other terms)20.

There are no official data available on the number of transgender or gender-non-binary people living in Newcastle. However, ONS estimate that there may be between 200,000 to 500,000 transgender people living in the UK. The 2021 Census includes a question about people’s gender identity, and we will update this analysis once accurate data is available.

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20 LGBT Foundation, ‘Non-binary inclusion’, online at (accessed 20 March 2021): http://ow.ly/4exX50EtXvi. This is not an exhaustive list, but attempts to list some of the more commonly-used terms for transgender and non-binary people, with an awareness that language about gender continually changes and develops.
1.11 Ethnicity

As of 2019-2020, the latest ethnicity statistics for the UK suggest that the BAME population living in the Newcastle area is 26,100, which is 10.7% of the total population\(^{21}\). Further analysis shows that:

- 5.9% of households do not have English as their main language. Younger age groups tend to be more diverse, with larger proportions of people being from a BAME background\(^{22}\).

- Based on the Census 2011 data, the unemployment rate in the BAME economically active population\(^{23}\) was higher in the North East (14.5%) and Newcastle (16.1%) compared to the England average (6.8%). Additionally, a greater proportion of the city’s BAME residents aged 16-64 were economically inactive (46.6%), exceeding both the North East (41.0%) and England (28.0%) averages\(^{24}\).

- Around one in every four school children in the most recent intake in Newcastle comes from a BAME background. Around one in four had English known or believed to be their first language\(^{25}\).

1.11.1 Ethnicity and disability

Table 1.11-1 below shows the percentages of people in Newcastle with a disability, broken down by ethnicity, based on Census 2011 data. We will update this data when the Census 2021 data becomes available in 2022. BAME groups have a slightly lower of disability than the White population.

Table 1.11.11-1: Number of people with a long-term health problem or disability by ethnicity in Newcastle\(^{26}\)

<table>
<thead>
<tr>
<th>Ethnic groups</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British</td>
<td>49,178</td>
<td>20.5%</td>
</tr>
<tr>
<td>White – Irish</td>
<td>313</td>
<td>17.1%</td>
</tr>
<tr>
<td>White – Other</td>
<td>683</td>
<td>8.3%</td>
</tr>
<tr>
<td>Mixed ethnicity</td>
<td>472</td>
<td>11.0%</td>
</tr>
<tr>
<td>Asian / Asian British</td>
<td>2,333</td>
<td>8.6%</td>
</tr>
<tr>
<td>All other ethnic groups</td>
<td>301</td>
<td>7.3%</td>
</tr>
<tr>
<td>Black / Black African / Black British</td>
<td>293</td>
<td>5.7%</td>
</tr>
<tr>
<td>All people</td>
<td>52,577</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: The percentage shown is the percentage of individuals of this ethnicity with a condition that limits their day-to-day life ‘a little’ or ‘a lot’.


\(^{23}\) In other words, people working or looking for work, but not including those studying, retired, looking after home or family, or with long-term sickness or disability.

\(^{24}\) Ibid.


1.11.2 Ethnicity and age

Table 1.11.2-2 shows the proportions and numbers of people within different ethnic groups within different broad age bands. Younger age groups tend to be more diverse with larger proportions of people being from a black and minority ethnic background. We will update this when the Census 2021 data is available.

Table 1.11.2-2: Newcastle population by ethnic group and broad age group

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>0 to 15</th>
<th>16 to 49</th>
<th>50 to 64</th>
<th>65 and over</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: Total*</td>
<td>37,496</td>
<td>121,910</td>
<td>42,581</td>
<td>37,546</td>
<td>239,533</td>
</tr>
<tr>
<td>Mixed / multiple ethnic group</td>
<td>1,590</td>
<td>2,355</td>
<td>237</td>
<td>97</td>
<td>4,279</td>
</tr>
<tr>
<td>Asian / Asian British</td>
<td>6,203</td>
<td>18,007</td>
<td>1,942</td>
<td>955</td>
<td>27,107</td>
</tr>
<tr>
<td>Black African / Black Caribbean</td>
<td>1,404</td>
<td>3,498</td>
<td>189</td>
<td>69</td>
<td>5,160</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>1,281</td>
<td>2,585</td>
<td>180</td>
<td>52</td>
<td>4,098</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>47,974</td>
<td>148,355</td>
<td>45,129</td>
<td>38,719</td>
<td>280,177</td>
</tr>
</tbody>
</table>

* Includes White English / Welsh / Scottish / Northern Irish / British; White Irish / White Other

The School Census data provides additional insights on the Newcastle state school population. The proportion of black and minority ethnic (BME) children is much higher than for adults and the proportion continues to rise. In 2011, BME children accounted for 24% of the school population, which continues to be the case in 2020 (24.3%)\(^{28}\).

1.12 Religion and belief

The reported religion or belief of people question in the Census 2011 data for Newcastle tells us that in 2011, 56% of the population gave their religion or belief as ‘Christian’, and 35% either stated they have no religion, or did not give their religion. The next largest religion is Muslim; 6% of Newcastle’s population, which has almost doubled over the last 10 years\(^{29}\).

As shown in table 1.12-1 on the next page, comparing this with the 2016 mid-year estimates of religion and belief (based upon the Census 2011 data) suggests that we may be seeing the following trends, and we will check this against the Census 2021 data when it becomes available: the percentage of the population who describe themselves as Christian is declining, and the percentages of those describing themselves as Muslim, as having no religion or belief, or who do not state their religion or belief, are increasing.

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27 Ibid.
Table 1.12-1: Religion and belief in Newcastle30

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>70.7</td>
<td>56.4</td>
<td>47.6</td>
<td>67.5</td>
<td>59.3</td>
</tr>
<tr>
<td>No religion, or none stated</td>
<td>23.8</td>
<td>34.6</td>
<td>41.7</td>
<td>29.5</td>
<td>32.3</td>
</tr>
<tr>
<td>Muslim</td>
<td>3.6</td>
<td>6.3</td>
<td>7.6</td>
<td>1.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Hindu</td>
<td>0.6</td>
<td>1.1</td>
<td>1.7</td>
<td>0.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>0.2</td>
<td>0.3</td>
<td>0.7</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Buddhist</td>
<td>0.3</td>
<td>0.6</td>
<td>0.3</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Sikh</td>
<td>0.5</td>
<td>0.4</td>
<td>0.3</td>
<td>0.2</td>
<td>0.8</td>
</tr>
<tr>
<td>Jewish</td>
<td>0.3</td>
<td>0.2</td>
<td>-*</td>
<td>0.2</td>
<td>0.5</td>
</tr>
</tbody>
</table>

1.13 Gender / Sex

We know that: “Gender has a significant impact on risk and protective factors for mental health and the way it which the experience of mental distress is expressed. Depression, anxiety, para-suicide and self-harm are more prevalent in women, while completed suicide, drug and alcohol abuse, crime and violence are more prevalent among men. Women are much more vulnerable to poverty, unemployment, domestic violence, sexual violence, rape and child sexual abuse”31.

Table 1.13-1 below presents data from the latest ONS population projections. Newcastle’s population is split approximately 50/50 between males and females. The ONS 2019 population mid-year estimates (MYEs) suggest there are 153,112 males and 149,708 females. We do not currently have data about people in Newcastle who do not describe their gender as male or female, but will review the Census 2021 data outputs for further information about this.

Between 2018 and 2043, the Newcastle population is projected to increase for males (by 6.5%) and females (4.0%)32.

Table 1.13-1: The ONS 2019-based subnational population projections for Newcastle

<table>
<thead>
<tr>
<th>Gender</th>
<th>Census 2011</th>
<th>ONS MYE 2019</th>
<th>Newcastle population projection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2018</td>
</tr>
<tr>
<td>Males</td>
<td>140,200</td>
<td>153,112</td>
<td>151,740</td>
</tr>
<tr>
<td>Females</td>
<td>139,900</td>
<td>149,708</td>
<td>148,456</td>
</tr>
</tbody>
</table>

1.14 Sexual orientation

We know that: “Evidence from the available literature shows that LGBT people experience significant problems related to both their mental and physical health. Discrimination and social exclusion are seen to be major causes of ill health for people in these communities. [...] Of additional concern is the discrimination some LGBT people face when accessing NHS services.”

Additionally: “some studies suggest that gay, lesbian, bisexual and transgender peoples are at increased risk for some mental health problems – notably anxiety, depression, self-harm and substance misuse – and are more likely to report psychological distress than their heterosexual counterparts, while being more vulnerable to certain factors that increase risk, e.g. bullying, discrimination and verbal assault.”

In 2014, our local analysis estimated that between 13,500 and 18,900 people in Newcastle would feel comfortable disclosing their sexual orientation as lesbian, gay or bisexual (LGB). These figures were based on Government estimates that between 5 and 7 percent of the UK population would describe themselves as LGB. We are not currently able to provide a more accurate estimate, but we note that Census 2021 contains a question about people’s sexual orientation, and we will analyse this data once it is available.

Looking at trends within the UK as a whole, more recent statistics produced by ONS indicate that the proportion of the UK population aged 16 years and over identifying as heterosexual or straight decreased slightly from 95.3% in 2014 to 94.6% in 2018. The proportion identifying as lesbian, gay or bisexual (LGB) increased from 1.6% in 2014 to 2.2% in 2018.

In 2018, there were an estimated 1.2 million people aged 16 years and over identifying as LGB in the UK, and younger people (aged 16 to 24 years) were most likely to identify as LGB in 2018; 4.4% of people in this age group described themselves in this way.

We believe that Newcastle has a higher number of LGB people living in and around the city than other North East areas, partially because of its wide-ranging social scene and regional capital status. We will analyse the Census 2021 data to determine if this is accurate, and if the trends seen in the UK can be found in Newcastle.

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36 Ibid.
2. Deprivation and poverty

This part of the City Profile considers deprivation and poverty within Newcastle upon Tyne, and how this affects people’s life chances, in particular, young people. We consider data from the Index of Multiple Deprivation, child poverty statistics including free school meals and the ‘children in low-income families’ measure, and fuel poverty.

2.1 Deprivation

We know that: “Poor social and economic circumstances affect health throughout life. People further down the social ladder usually run at least twice the risk of serious illness and premature death as those near the top. Nor are the effects confined to the poor: the social gradient in health runs right across society, so that even among middle-class office workers, lower-ranking staff suffer much more disease and earlier death than higher-ranking staff.”\(^{37}\)

2.1.1 Indices of Deprivation 2019 – an introduction

The Indices of Deprivation 2019 provide a set of relative measures of deprivation for small areas across England, based on seven different domains of deprivation and with two supplementary indices existing for children and older people. Whilst designed primarily to be small-area measures, they are commonly used to describe relative deprivation for higher-level geographies such as Local Authorities.

Each of the domains are based on a set of indicators, with each indicator taken from the most recent time point available consistently across neighbourhoods in England. The Index of Multiple Deprivation (IMD) 2019 combines and weights information from all seven domains to produce an overall relative measure of deprivation.

The methodology of approach has remained the same since 2004, so whilst rankings and deciles are relative, they do allow comparisons with other areas to be made over time. It is important to note that whilst we can see that one area is more deprived than another, we are unable to see by how much.

The latest Index of Multiple Deprivation (IMD) was published in 2019 with the last set of comparable data being published four years earlier, in 2015.

2.1.2 Key Highlights

Newcastle has become relatively more deprived between 2015 and 2019 – moving from an overall position of 42, in the second most deprived quartile, into the most deprived quartile (rank 32), i.e. dropping by 10 places\(^{38}\). Figure 2.1.2-1 illustrates these changes.

The main drivers of this relative change are the falls in the Income domain (due to its higher weighting) and the Crime domain, because of the magnitude of the change (falling 57 places). It should be noted, however, that due to changes in crime recording practices


by Northumbria Police, the volume of crime recorded between 2015 and 2019 is likely to have increased in the period, which may have affected the crime domain for Newcastle. It is also expected that other police forces will make similar crime recording changes in the coming years, so the effects should reverse in the future.

**Figure 2.1.2-1 Measures of Deprivation, comparing 2015 and 2019 for Newcastle**

<table>
<thead>
<tr>
<th>Newcastle</th>
<th>IMD 2015</th>
<th>IMD 2019</th>
<th>Change from 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IMD - Rank of average score</td>
<td>IMD - Rank of average score</td>
<td>Change from 2015</td>
</tr>
<tr>
<td>IMD</td>
<td>42</td>
<td>32</td>
<td>-10</td>
</tr>
<tr>
<td>IDACI</td>
<td>30</td>
<td>20</td>
<td>-10</td>
</tr>
<tr>
<td>Health, Deprivation and Disability</td>
<td>20</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Income</td>
<td>35</td>
<td>31</td>
<td>-4</td>
</tr>
<tr>
<td>Education, Skills and Training</td>
<td>29</td>
<td>31</td>
<td>2</td>
</tr>
<tr>
<td>IDAOPi</td>
<td>30</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>Crime</td>
<td>93</td>
<td>36</td>
<td>-57</td>
</tr>
<tr>
<td>Employment</td>
<td>41</td>
<td>40</td>
<td>-1</td>
</tr>
<tr>
<td>Barriers to Housing &amp; Services</td>
<td>105</td>
<td>107</td>
<td>2</td>
</tr>
<tr>
<td>Living Environment</td>
<td>125</td>
<td>133</td>
<td>8</td>
</tr>
</tbody>
</table>

Notes: IMD = Index of Multiple Deprivation; IDACI = Income Deprivation Affecting Children Index; IDAOPi = Income Deprivation Affecting Older People Index.

The Income Deprivation Affecting Children Index (IDACI) ranks Newcastle as 24th out of 317 local authorities in England (where 1 is the highest level of deprivation), as shown in Table 2.1.2-1 below.

**Table 2.1.2-1 IDACI 2019: Comparing North East local authorities**

<table>
<thead>
<tr>
<th>North East local authorities</th>
<th>IDACI rank 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Tyneside</td>
<td>13th</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>24th</td>
</tr>
<tr>
<td>Sunderland</td>
<td>25th</td>
</tr>
<tr>
<td>Gateshead</td>
<td>64th</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>105th</td>
</tr>
<tr>
<td>Northumberland</td>
<td>113th</td>
</tr>
</tbody>
</table>

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39 Ibid.
2.2 Child poverty, including children in low income families

2.2.1 Official Statistics – Introduction and notes

The most recent official statistics relating to child poverty are experimental and contain the number and percentage of children living in relative and absolute low income families across Great Britain. These statistics replace earlier official releases previously published separately by the Department of Work and Pensions (DWP) and HMRC in an attempt to provide a more coherent picture of children living in low income families by local area.

This is the first release of these statistics, replacing DWP’s ‘Children in out-of-work benefit’ and the HMRC ‘Personal Tax Credits: Children in low income families’ local measure. The limitations of the former releases have been addressed and the new statistics provide a more coherent picture of children in low income families for both Relative and Absolute measures Before Housing Costs (BHC).

Notes

Although ‘children’ are defined as dependent individuals aged under 16; or aged 16 to 19 in full-time non-advanced education, the figures provided in these experimental statistics only include children aged under 16 years old, due to the difficulty in identifying 16-19 year olds as child dependents in the population estimates (in other words, distinguishing between 16-19 year-olds who are working, and 16-19 year olds who are in full-time non-advanced education).

A family is defined as a single adult; or a married or cohabitating couple; or a Civil Partnership; and any dependent children.

Relative low income is defined as a family in low income Before Housing Costs (BHC) in the reference year. A family must have claimed one or more of the following: Universal Credit, Tax Credits, or Housing Benefit at any point in the year to be classed as low income in these statistics.

Absolute low income is defined as a family in low income Before Housing Costs (BHC) in the reference year, in comparison with incomes in 2010/11. A family must have claimed one or more of the following: Universal Credit, Tax Credits, or Housing Benefit at any point in the year to be classed as low income in these statistics.

These statistics are experimental Official Statistics, badged as provisional (for the latest year) and are subject to revision in future releases. Experimental statistics are official statistics which are published in order to involve users and stakeholders in the assessment of their suitability and quality at an early stage, in compliance with the UK Statistics Authority’s Code of Practice for Statistics.

2.2.2 Official Statistics - Newcastle

In Newcastle, 14,646 children were living in relative low income families in 2018-19, the equivalent of 28% of children. In terms of absolute low income, the number of children was slightly less at 12,072 (23%). Figure 2.2.2-1 shows that over the past five years there has been a consistent and marked rise in the relative low income measure, with the absolute

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measure also experiencing an increase, but to a lesser extent. Across Great Britain, the proportion of families where child poverty exists ranges from 6%- 38% for relative low income families, and 4%-33% for absolute low income families.\footnote{43}

**Figure 2.2.2-1 – Percentage of children in relative low income families in Newcastle (aged under 16)**\footnote{44}

Newcastle features in the top 20 highest-proportioned local authorities under both categories. The relative rate for Newcastle is also higher than that of the North East (24%) and England (18%), with a similar picture seen in terms of absolute rates, where the North East is at 19% and England is 15%. Figure 2.2.2-2 shows that Newcastle mirrors the North East for relative low income families in its worsening picture over the past five years, with England also showing a deterioration, but to a lesser extent.\footnote{45}

**Figure 2.2.2-2 Percentage of children in relative low-income families (aged under 16) in Newcastle**

Figure 2.2.2-3 shows a slightly different picture of children in absolute low income. Whilst the proportion of children has risen in Newcastle, the picture is more stable in the North East, and has actually decreased for England slightly.\footnote{46}

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\footnote{44} Ibid.

\footnote{45} Ibid.

\footnote{46} Ibid.
2.2.2-3 – Percentage of children in absolute low-income families (aged under 16) in Newcastle

2.2.3 Ward-Level Statistics

Wards that have a high proportion of children in poverty (under both relative and absolute measures) are clustered around the central area of Newcastle and include Byker, Wingrove, Benwell and Scotswood, Walker, Elswick, and Arthur’s Hill. Table 2.2.3-1 shows that significant child poverty is evident in the latter two wards, where more than half of children may live in families below the poverty line, depending on the measure used.

Table 2.2.3-1 Worst wards in Newcastle – Relative poverty

<table>
<thead>
<tr>
<th>Ward</th>
<th>Children living in households experiencing relative poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elswick</td>
<td>56%</td>
</tr>
<tr>
<td>Arthur’s Hill</td>
<td>51%</td>
</tr>
<tr>
<td>Byker</td>
<td>42%</td>
</tr>
<tr>
<td>Wingrove</td>
<td>42%</td>
</tr>
<tr>
<td>Benwell and Scotswood</td>
<td>35%</td>
</tr>
<tr>
<td>Walker</td>
<td>35%</td>
</tr>
</tbody>
</table>

Table 2.2.3-2 shows the proportions of children in these wards living in families below the poverty line when the absolute poverty measure is used.

Table 2.2.3-2 Worst wards in Newcastle – Absolute poverty

<table>
<thead>
<tr>
<th>Ward</th>
<th>Children living in households experiencing absolute poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elswick</td>
<td>48%</td>
</tr>
<tr>
<td>Arthur’s Hill</td>
<td>43%</td>
</tr>
<tr>
<td>Wingrove</td>
<td>35%</td>
</tr>
<tr>
<td>Byker</td>
<td>33%</td>
</tr>
<tr>
<td>Benwell and Scotswood</td>
<td>29%</td>
</tr>
<tr>
<td>Walker</td>
<td>27%</td>
</tr>
</tbody>
</table>
2.3 Free school meals

2.3.1 Free School Meals – Eligibility and Uptake

The level of free school meal eligibility in 2020 was 28.2% across the entire school population in England. The percentage of pupils who were both eligible and claiming a free school meal nationally was 17.3%, whereas in Newcastle this was 31.8%.

- Focusing on Newcastle-maintained primary schools only, claimants of free school meals increased from 2019 by 2.1 percentage points to 33.5% in 2020. This was above the national percentage of 17.7%, and the North East average of 24.4%.
- Focusing on Newcastle-maintained secondary schools only, similarly, uptake increased from 2019 by 2.2 percentage points to 28.7% in 2020, which is above the national percentage of 15.9%, and the North East average of 21.2%.

2.3.2 Free School Meals – SEND population

The Department for Education (DfE) do not publish free school meal uptake with Special Educational Needs and Disability (SEND) population data. To calculate this, we use the DfE Census database tool. Please note that this does not contain census data from non-maintained and independent schools.

The data shown below relates to statutory school-age children attending maintained / academy, primary, secondary, and special schools.

- For Primary school age children (Reception class to Year 6; aged 4 to 10), 8.4% of all pupils in Newcastle were SEND with an Education, Health and Care (EHC) plan or Special Educational Needs (SEN) Support and claiming free school meals in 2020. The percentage of primary school age SEND pupils in Newcastle claiming free school meals is 50.3%.
- For Secondary school age children (Years 7 -11; aged 11-16), 7.8% of pupils in Newcastle were SEND with an EHC plan or SEN Support and claiming free school meals in 2020. The percentage of secondary school age SEND pupils in Newcastle claiming free school meals is 49.1%.

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48 These data are compiled from raw census data held in the internal Department of Education January 2020 Census database tool, online at (accessed 19 April 2021): [http://ow.ly/B5i850Eu701](http://ow.ly/B5i850Eu701)
2.4 Households in fuel poverty

Households living in fuel poverty are likely to find it difficult to afford the cost of staying warm, especially in winter. Living in fuel poverty impacts upon physical and mental health and wellbeing and can lead to debt and financial difficulties.

The way fuel poverty in England is measured has recently changed to using a Low Income Low Energy Efficiency (LILEE) indicator rather than the previous Low Income High Costs (LIHC) indicator. This new methodology considers a household to be fuel poor if:

- It is living in a property with an energy efficiency rating of band D, E, F or G as determined by the most up-to-date Fuel Poverty Energy Efficiency Rating (FPEER) Methodology; and
- its disposable income (income after housing costs (AHC) and energy needs) would be below the poverty line49.

This shift from a LIHC to LILEE methodology significantly changes the percentage of households regarded as being fuel poor. The chart below depicts both methodologies side by side, and the difference is noticeable. It must be borne in mind, however, that the change in methodology does not necessarily mean that performance has dropped – in fact under the new methodology the latest reported year (2019) shows increased performance against the previous year for both England as a whole, and the North East specifically.

Figure 2.4-1 Proportion of fuel poor households in the North East50

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50 Ibid.
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Figure 2.4-1 Proportion of fuel poor households in England\textsuperscript{51}

These national and regional pictures have been provided as context because at present, LILEE has only been published down to a regional level. Until local authority level LILEE data is available, the performance of Newcastle will be measured using LIHC. Whilst this may become obsolete in the coming months and the reported performance may appear to decrease, at present we see a generally improving picture, particularly in 2018 (this being the latest data available), as shown in the chart below\textsuperscript{52}.

Figure 2.4-3 Proportion of fuel poor households: comparing Newcastle with Core Cities, North East region, and England

The chart above shows that Newcastle has improved substantially over the past five years and now sits comfortably alongside the wider North East and England levels. It can also be seen that it has fared considerably better in comparison to the Core City group of local authorities, of which Newcastle is part\textsuperscript{53}.

\textsuperscript{51} Ibid.
3. Best start in life

In this part of the City Profile we review how children and young people in Newcastle can get the best start in life, and factors that affect this. This includes breastfeeding prevalence, children in need and child protection, education, qualifications & skills, excess weight, injuries, immunisations, general child health, looked-after children, oral health, sexual health and teenage conception, and special education needs & disability.

3.1 Breastfeeding

Breastfeeding is a mother’s choice to feed her baby with breastmilk. This may be exclusively with breastmilk, or it may be a combination of a baby being breast-fed and bottle-fed, depending on choice and circumstances. Not all mothers are able to breastfeed and some mothers may find it a difficult skill, which may reduce the time a baby is breastfed if support and advice is not easily accessible.

Some long-term and short-term benefits to babies and mothers from breastfeeding include:

- Breast milk being available for the baby when needed.
- Breast milk can provide a baby with protection from infections, diseases and gastrointestinal issues.
- Breastfeeding is an activity that can help create a strong emotional bond between mother and baby.
- Breastfeeding is thought to lower the risk of certain cancers, osteoporosis, and obesity in mothers.

More information on breastfeeding can be accessed from the NHS online here: ‘Breastfeeding and bottle feeding advice’\(^{54}\).

The Infant Feeding Survey (2010) found that new mothers were more likely to breastfeed if they are:

- Aged 30 or over at time of birth.
- From a Black and Minority Ethnic (BAME) group.
- Had finished their education aged over 18.
- Employed in professional and managerial occupations.
- Lived in a less deprived area\(^{55}\).

An indicator used to monitor breastfeeding uptake in the population is the proportion of infants documented as totally or partially breastfed at six to eight weeks old. In Newcastle, the recent trend of this indicator shows that breastfeeding has been increasing. In 2019/20, just over half (50.9%) of infants were totally or partially breastfed at six to eight weeks old. This is statistically significantly better than the national proportion (48.0%). Admissions to hospital in infants (aged under 1 year) for gastroenteritis and lower respiratory tract

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infections are statistically significantly lower in Newcastle than the national rates. The risk of both these illnesses can be reduced through breastfeeding, alongside good hygiene and diet\textsuperscript{56}.

### 3.2 Children in Need and Child Protection

A child in need is defined under the Children Act 1989 as: ‘a child (aged under 18) who is unlikely to reach or maintain a satisfactory level of health or development, or their health or development will be significantly impaired, without the provision of services, or they are disabled’. Newcastle’s rate of children in need (per 10,000) was 547.9 in March 2019. This is higher than the regional rate for the North East (445.1) and also higher than the England rate (334.2)\textsuperscript{57}, as shown in figure 3.2-1.

#### Figure 3.2-1 Children in Newcastle subject to a child protection plan in 31 March

![Graph showing children subject to a child protection plan at 31 March, rates per 10k children]

Note: Categories given as the reason for the child protection plan are an ‘on the day’ count, and thus the data provide a snapshot picture at 31\textsuperscript{st} March each year since 2010 (Regional-level North East data was not available in 2010, due to missing data from Durham.)

A child protection plan should ensure that children who are likely to suffer significant harm are protected and that they and their families are receiving the services necessary to bring about the required changes in the family situation. At 31 March 2019, the rate of children subject to a child protection plan stood at 101.1 per 10,000 (587 children). This is higher than the North East rate (63.1) and the England rate (43.7). Rates were relatively stable between 2010 and 2017 ranging from 57.7 (2013) to 76.2 (2015). However, rates have


\textsuperscript{57} Department of Education, ‘Children in need and child protection’, table B1, online here (accessed 31 March 2021): [http://ow.ly/rUcm50Eu7mT](http://ow.ly/rUcm50Eu7mT)
increased each year since 2017 in Newcastle, although they decreased in both England and the North East between 2018 and 2019. Due to the low numbers involved, we cannot provide ward breakdowns of these figures. However, in general there is a relationship between higher levels of deprivation and higher rates of children in need of help and protection.

### 3.3 Education, qualifications and skills

#### 3.3.1 Attainment - Early Years Foundation Stage

The Early Years Foundation Stage Profile (EYFSP) is a teacher assessment of children’s development at the end of the EYFS, the end of the academic year in which the child turns five years old. This is typically at the end of the Reception year.

The percentage of children reaching a good level of development in Newcastle has fallen to 70.4% in 2019, compared to the 2018 figure of 70.9% This remains below the national average of 71.8%.

The proportion of disadvantaged children (eligible for free school meals) achieving a good level of development in Newcastle is 61.3%, which is higher than the North East average of 57.7% and the national average of 56.5%.

The inequality gap, defined as the gap in achievement between all pupils and the lowest attaining 20% of pupils measured across all the Early Learning Goals. Newcastle gap is 31.4% and has widened slightly, however Newcastle's gap remains narrower than national, North East and Statistical neighbour comparators.

#### 3.3.2 Attainment – Key Stage 2

Pupils take a national curriculum assessment in year 6, at the end of Key Stage 2 (KS2) when most pupils will reach age 11 by the end of the academic year. Pupils take tests, commonly referred to as SATs, in reading, mathematics, grammar, punctuation and spelling and receive a teacher assessment in writing.

The proportion of pupils in Newcastle who achieved the expected standard in reading, writing and mathematics was 66.0% in 2019. This is higher than the national figure by 1 percentage point, and higher than our statistical neighbours by 2 percentage points.

12% of pupils in Newcastle achieved a higher standard than expected in reading, writing and mathematics. This is 1 percentage point above the national figure, and 2 percentage points above the figure for our statistical neighbours.

54.5% of Newcastle pupils who were disadvantaged achieved the expected standard in reading, writing and mathematics, compared to 51.5% of disadvantaged pupils nationally. Similarly, 6.7% of disadvantaged pupils in Newcastle achieved a higher than expected standard in reading, writing and mathematics, compared to the national figure of 4.7%.

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58 Ibid., table D1.
Pupil progress between Key Stage 1 (typically age 7) and Key Stage 2 (typically age 11), remains strong for pupils in Newcastle. Newcastle is performing higher than national, North East and statistical neighbours in all three subjects of reading, writing and mathematics60.

3.3.3 Attainment – Key Stage 4: Attainment 8 and Progress 8

Pupils take GCSE and equivalent qualifications in year 11, at the end of Key Stage 4 (KS4) when most pupils will reach age 16 by the end of the academic year. GCSEs in England now have a 1 to 9 grading scale, with grade 9 being the highest grade a pupil can achieve.

The ‘Attainment 8’ measure measures the achievement of pupils in up to 8 qualifications. In 2019 Newcastle’s Attainment 8 score was 43.6, which is below the national score of 46.7, also the North East score of 44.7, and statistical neighbours at 43.9. This is also lower than Newcastle’s score of 45.1 in 2018.

The ‘Progress 8’ measure aims to capture the progress pupils make from the end of KS2 to the end of KS4. Newcastle’s Progress 8 score of -0.27 is below the national score of -0.03, and also the North East and statistical neighbours’ average scores. It is also lower than the 2018 score for Newcastle of -0.14.

Newcastle’s results for pupils achieving the threshold of a ‘strong pass’ with a grade of 5 and above in English and mathematics GCSEs is 38.7%. This is 4.5 percentage points below the national score, 0.9 percentage points below the North East score, and 0.7 percentage points above our statistical neighbours’ average score. It is also lower than the score Newcastle’s pupils achieved in 2018, of 40.3%.

The performance of disadvantaged pupils in Newcastle is lower than that of disadvantaged pupils nationally for Attainment 8, Progress 8 and pupils achieving a strong pass in English and mathematics61.

3.3.4 Attainment – age 16 to 19 attainment

Students aged 16 to 19 are reported across four different ‘level 3’ cohorts, determined by the qualifications taken by students: A levels, academic, Applied General and Tech Levels. The headlines below are for the A level cohort in Newcastle state-funded schools.

The proportion of students in Newcastle state-funded schools achieving high grades (three grades of between A*-A grade at A level) is above the comparator national figure for state-funded schools in 2019, and remains well above that of our statistical neighbours and the North East region.

The proportion of students achieving grades AAB or better at A Level, of which at least two are in facilitating subjects62, in Newcastle improved by 1.2 percentage points in 2019. This is above the comparator national figure for state-funded schools of 15.6% and the North East at 15.3%.

62 Please note that A level facilitating subjects are Biology, Chemistry, Physics, Mathematics, further Mathematics, Geography, History, English literature, Modern and Classical languages.
The average point score per entry for the A Level cohort in Newcastle is 34.37, an improvement of 1.7 points when compared to the Newcastle score in 2018. Newcastle is above both the national and North East average point score for state-funded schools\textsuperscript{63}.

3.3.5 Attainment – Widening participation in higher education

This is the latest information on measures of Widening Participation in Higher Education. This data includes estimates of progression to Higher Education (HE) by age 19 for state-funded pupils.

The estimated percentage of pupils in state-funded schools in Newcastle who progressed to Higher Education by age 19 in 2018 was 41%. This is in line with the England average of 42%, and slightly above the North East average of 39%. The percentage in Newcastle has increased over the last decade, and is up 7 percentage points from 34% in 2016.

The gap between pupils eligible for free school meals at age 15 and their peers entering HE continues to increase, and is a 30 percentage point gap in 2018. This is wider than both the national gap of 19 percentage points, and the North East gap of 25 percentage points\textsuperscript{64}.

3.3.6 Attainment – Participation in education, training and employment

These measures are used to monitor progress against the Department for Education objectives of raising participation and reducing the number of young people who are NEET (Not in Education, Employment or Training).

The proportion of 16 to 17 year olds that are NEET in Newcastle continues to increase, and is 4.9% in the latest published figures from 2019. This is higher than both the national and the North East average, and is the highest proportion among the North East Local Authorities.

This is linked to the second measure, of the proportion of 16 to 17 year olds whose activity is not known, where the proportion for Newcastle has reduced to 1.3% and is lower than the comparator averages above.

Any decrease in the proportion of ‘not-knowns’ generally increases the NEET figure, but this is a benefit, as it means we can identify young people who require our support and can ensure that services are targeting their resources effectively where they are most needed\textsuperscript{65}.


3.3.7 Pupil Overall Absence

These data relate to the full academic year 2018/19, and are calculated as the number of sessions missed due to absence, expressed as a percentage of the total number of possible sessions.

The overall absence in state-funded primary, secondary and special schools in Newcastle in 2018/19 was 5.3%. This is higher than the comparator figures for both national (4.7%) and North East (5.0%).

- For primary schools only, overall absence has reduced from 4.4% in 2018 to 4.1%, which is slightly higher than the national figure of 4.0%, and is level with the North East figure.
- For secondary schools, overall absence has increased by 0.5 percentage points to 6.5%, higher than both the national figure of 5.5%, and the North East figure of 5.9%.
- For special schools, overall absence is 14.2%, which is up from 11.9% in 2018, and higher than both the national figure of 10.1% and North East figure of 9.9%.

3.3.8 Percentage of persistent absentees

This data relates to the full academic year 2018/19. Note that enrolled pupils who miss 10 percent or more of their own possible sessions (due to authorised or unauthorised absence) are classified as ‘persistent absentees’.

The overall percentage of persistent absentees in state-funded primary, secondary and special schools in Newcastle in 2018/19 was 13.5%. This is higher than both the national comparator figure (10.9%) and the North East (12.1%).

- For primary schools only, the percentage of persistent absentees has reduced from 10.7% in 2018 to 9.5%, higher than the national figure of 8.2% and the North East figure of 8.5%.
- For secondary schools, the percentage of persistent absentees has increased by 1.5 percentage points to 17.5%, higher than both the national figure of 13.7% and North East of 15.6%.
- For special schools, the percentage of persistent absentees is 36.7%, up from 30.9% in 2018 and higher than both the national figure of 28.8% and North East of 27.7%.

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67 Ibid.
3.4 Excess weight in children

Excess weight in children has been linked to various health issues in childhood and later life. Children who are overweight or obese are more likely to continue carrying excess weight into adulthood.

3.4.1 Excess weight in Reception children

Nationally, just under one quarter (23.0%) of children of Reception age (aged 4-5 years old) are overweight or obese. The North East region has consistently had a higher prevalence of overweight children than the country, the latest data indicating 24.8% Reception age children in the region being overweight or obese. The proportion of Reception age children carrying excess weight in Newcastle is higher than both the national and regional figures, with 26.0% children overweight or obese in 2019/20. While this has fluctuated in the past, data from the last five years has indicated no significant change, remaining consistently higher than national levels.

Looking exclusively at obesity in Reception age children, Newcastle has consistently had a higher proportion than England. An estimated 11.6% Reception children are obese, including severely obese children, compared to 9.9% across the country. At a national level, inequality in obesity levels has increased, from 5.8% in 2006/07, to 7.9% as of 2019/2068. This refers to the Slope Index of Inequality (SII) and indicates the variation of child obesity between levels of deprivation, where the higher the figure, the greater the inequality of obesity levels across levels of deprivation69.

3.4.2 Excess weight in Year 6 children

There is a greater prevalence of carrying excess weight among Year 6 children (aged 10-11). In England the proportion of children overweight or obese increases to over one-third (35.2%) in Year 6 pupils, an increase of 12.2% from Reception. The North East is among the highest regions for the prevalence of excess weight in this age group at 37.5%, this trend remaining stable over the last decade.

Data from 2019/20 indicates that two-fifths (39.6%) of Year 6 children are overweight or obese in Newcastle. Similarly to Reception age children, this is higher than both the North East and England figures, and it has been consistently higher for the last ten years. Newcastle has the third highest prevalence of overweight and obese Year 6 children in the region, closely following South Tyneside and Middlesbrough70.

3.4.3 Sociodemographic characteristics

National data indicates that in reception the prevalence of overweight and obese children in both boys and girls is similar. This gap widens as children age, with Year 6 boys more likely than girls to carry excess weight, at 37.7% and 32.5% respectively.

Children in Year 6 who live in areas of higher deprivation, according to the Index of Multiple Deprivation 2019, have a significantly higher prevalence of obesity than those living in the least deprived areas in England. There is a relationship between deprivation and the prevalence of children carrying excess weight. The rate is lower by 117 children per 10,000 in the most affluent areas compared to the most deprived areas.

Children in Year 6 living in the most deprived areas are more likely to present to hospital from accidental injury, with an admission rate for all injuries of 175.5 per 10,000 children per year, compared to a rate of 111.3 per 10,000 children in the least deprived areas. The difference in admission rates is largely due to children under five presenting to hospital with accidental injuries.

The prevalence of obesity and the admission rate for children is greater in children from lower socioeconomic groups, but this variation is less pronounced in Reception age children.\(^71\)

| 3.5 Injuries in children and young people (unintentional and deliberate) |

Injuries in children and young people that cause them to present to hospital and thus be admitted for their injuries can be split into two categories: unintentional and deliberate. Unintentional injuries are those that are caused by outside external factors, such as a fall, sports injury, road traffic accident, and so on. A deliberate injury includes those coded which indicate assault or self-harm.

As Public Health England uses admissions episodes for these indicators, this means that a child or young person suffering repeated unintentional or deliberate injuries may be counted more than once in the data. Therefore, it is important to note the following figures are numbers of admissions, not numbers of individual children and young people. Also, children and young people may present to accident and emergency services or primary care whose injuries are not deemed serious enough to warrant an admission; these will not be represented in the data below. This is important when considering issues such as self-harm, as admissions data does not give a true full picture of this issue within the population.

3.5.1 Unintentional injuries in children aged under five

Unintentional injuries in children aged under five are a leading cause of preventable ill-health and disability, sometimes resulting in death. Most unintentional injuries in this population occur in and around the home as a result of falls, burns and scalds, and choking. There were 290 admissions for unintentional and deliberate injuries in children aged 0 to 4 in Newcastle in 2019/20. As a crude rate, this is 175.5 per 10,000 head of population, compared to a national rate of 117 per 10,000.

Emergency admissions for exposure to heat and hot substances in 0 to 4 year olds in Newcastle are at a higher rate than the national rate. Similarly, the rate for burns from hot foods and fluids in this age group in Newcastle is higher than the national rate, as is the rate for exposure to ‘animate mechanical forces’, such as accidentally being pushed or trodden on by another person, or injured by an animal. Conversely, emergency admission rates in this age group in Newcastle for falls from furniture is below the national rate.\(^72\)

\(^71\) Ibid.

3.5.2 Unintentional and deliberate injuries in children aged between 0 and 14 years

In the wider population, there were 710 admissions in 2019/20 for unintentional and deliberate injuries in children aged 0 to 14 years in Newcastle. This is a crude rate of 142.6 per 10,000 population in comparison to 91.2 per 10,000 nationally\(^3\).

3.5.3 Unintentional and deliberate injuries in young people aged between 15 and 24 years

Unintentional and deliberate injuries can also occur in the young adult population. The recent trend in unintentional and deliberate injuries in those aged 15 to 24 in Newcastle is increasing, and getting worse. However, the most recent crude rate of 141.5 per 10,000 is statistically similar to the England rate (132.1).

Whilst it is not possible to separate out these admissions in ICD10 codes\(^4\) to look further into the nature of these injuries using publicly available data, it is possible to look at other data indicators available to understand the level of self-harm within the population. As noted above, however, there is the need to be aware that this indicator only shows self-harm prevalence where the injury warranted admission to hospital, and is unlikely to represent the prevalence of self-harm in this population completely.

Hospital admissions as a result of self-harm in the population aged 10 to 24 in Newcastle show a recent trend that admissions are increasing, and the trend is getting worse. The most recent rate for 2018/19 was 497 per 100,000 which is significantly worse than the national rate (444 per 100,000). When breaking this age group down further into smaller age groups, the highest count and rate is within the 15 to 19 age group.

When comparing to the equivalent national rate, the 15 to 19 age group and the 20 to 24 age group rates are both statistically similar to the national rate. In the 10 to 14 age group, the rate is statistically worse than the national rate, with this age group seeing a small increase in admissions, with the count of admissions doubling between 2016/17 and 2017/18 (21 admissions in 2016/17, compared to 43 admissions in 2017/18)\(^5\).

\(^3\) Ibid.
3.6 Childhood Immunisation

3.6.1 Introduction

Immunisations are one of the most useful tools in public health for preserving the health of a population. Through a continuous immunisation programme a herd immunity can be created, which protects not only those who have had the vaccination from a disease, but also affords some protection to those who are unable to be immunised for health or ethical reasons. A successful immunisation programme can lead to the reduction of a disease across a population (examples would be smallpox and polio, which were previously common, but which are no longer a threat in the UK), and can reduce childhood mortality. Diseases that vaccines protect against do still exist, but the vaccine user has the best possible protection against the disease.

The current national immunisation programme requires children to receive a range of immunisations by their first, second and fifth birthday. The range of immunisations include:

- Diphtheria, tetanus, pertussis, polio and Haemophilus Influenza type B (DtaP/IPV/Hib)
- Measles, Mumps and Rubella (MMR)
- Pneumococcal Conjugate Vaccine (PCV)
- Haemophilus Influenza type B and Meningococcal group C vaccination (Hib/Men C Booster)

There has been a recent change to the immunisation schedule, the pentavalent vaccine\textsuperscript{76} DTaP/IPV/Hib has been replaced with a hexavalent vaccine\textsuperscript{77} which contains Hepatitis B (DTaP/IPV/Hib/HepB), for all babies born on or after 1 August 2017.

NHS Digital and Public Health England report childhood vaccination coverage statistics of routine vaccinations offered to all children up to the age of five years in an annual publication, which can be accessed online\textsuperscript{78}.

The key facts reported by NHS Digital and Public Health England nationally for 2019/20 (latest data) are:

- Coverage increased in most routine vaccinations.
- 5-in-1 coverage at 5 years old has remained above the 95% target (95.2%).
- MMR1 coverage at 2 years old increased for the first time since a peak in 2013/14\textsuperscript{79}.

In Newcastle the 2019/20 data (the latest available) shows that:

- MMR first and second dose at five years has remained static (89%) for a third year.
- Hib/Men C booster at five years has decreased, from 92.3% in 2018/19 to 90.3% in 2019/20.

\textsuperscript{76} The pentavalent vaccine is "a combination vaccine which protects against five killer diseases: diphtheria, pertussis, tetanus, hepatitis B and Hib [Haemophilus influenza type B]" (source: http://ow.ly/NeOe50Eu8QG/).

\textsuperscript{77} The hexavalent vaccine is a: “6-in-1 vaccine used in the UK [which] gives protection against these six serious diseases: diphtheria, tetanus, whooping cough (pertussis), polio, Hib disease”.

Source (accessed 31 March 2021): https://vk.ovg.ox.ac.uk/vk/6-in-1-vaccine

\textsuperscript{78} NHS Digital and PHE, ‘Vaccine uptake guidance and the latest coverage data’, online here (accessed 31 March 2021): http://ow.ly/534B50Eu8Si

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- Dip/Tet/Polio/Pert booster (5 years), MMR first dose (two years), PCV (1st birthday), PCV booster (two years), Hib/MenC booster (two years) all saw small percentage increases in vaccination coverage in 2019/20 compared to 2018/19\textsuperscript{80}.

### 3.6.2 DTaP/IPV/Hib

Coverage at first birthday in Newcastle is 93.2%. This is higher than the England figure of 92.6%, but below the regional figure (96.0%). The Newcastle figure was last above the 95.0% target in 2013/14. Coverage at second birthday is better, with 94.7% children in Newcastle vaccinated by their second birthday, in comparison to 93.8% in England and 96.6% in the North East, although there has been a decline in 2019/20.

After a decline in percentage coverage at fifth birthday between 2013/14 to 2015/16, coverage from 2015 onwards has remained relatively static, with small fluctuations between 95.9% and 95.6%; the current percentage uptake is 94.7%. (Please note that values for the years up to and including 2012/13 are for Dip/Tet/Polio vaccination only.)\textsuperscript{81}

### 3.6.3 Dip/Tet/Polio/Pert booster

The Dip/Tet/Polio/Pert booster vaccination (fifth birthday) coverage declined until 2015/16, a decline mirrored regionally and nationally. However, for 2019/20 the Newcastle figure is 86.3% in comparison to 85.4% for England and 90.8% for the region, each seeing a small increase in percentage from 2018/19\textsuperscript{82}.

### 3.6.4 MMR

The percentage of children having the first MMR dose by their second birthday is 93.8% in Newcastle, which is a small increase from the previous year. This coverage has seen small declines since a peak of 94.7% in 2014/15. The regional figure is 95.1%, and nationally this is 90.6%. The percentage of children receiving the first and second dose of the MMR vaccine by their fifth birthday has remained the same since 2018/19, at 89.0%\textsuperscript{83}.

### 3.6.5 PCV

The percentage of children receiving the PCV vaccination by their first birthday was 94.2% in Newcastle in 2019/20 in comparison to 93.7% in 2018/19. In 2019/20 93.2% of children in Newcastle had their PCV booster by their second birthday, showing a small increase from last year\textsuperscript{84}.

### 3.6.6 Hib/Men C booster

The percentage of children receiving the Hib/Men C booster by second birthday for Newcastle is 93.1% (90.5% nationally, 95.1% regionally). Newcastle has seen an increase into 2019/20. Coverage of the Hib/Men C booster by a child’s fifth birthday has decreased from 92.3% in 2018/19, to 90.3% in 2019/20. This percentage decrease was not seen nationally or regionally.

\textsuperscript{80} Ibid.
\textsuperscript{81} Ibid.
\textsuperscript{82} Ibid.
\textsuperscript{83} Ibid.
\textsuperscript{84} Ibid.
3.6.7 HPV Vaccine

The national HPV (Human papillomavirus) programme was introduced in September 2008. The aim of the programme is to reduce the incidence of cervical cancer. The vaccine is offered to all girls in year 8 aged 12-13 years. When first introduced, it consisted of a course of three separate vaccinations. It now consists of two separate vaccinations which protect against 2 HPV types that cause over 70% of cervical cancers. The first dose is offered when girls are in year 8, and nationally the second dose is offered when girls are in year 9 (aged 13-14). However, in some areas girls are offered the second dose in year 8 and Newcastle offers this.

The latest data for 2018/19 shows that in this time period, 87.0% of 12-13 year old girls in Newcastle had received their first dose of the HPV vaccine and 81.9% had received two doses. This is very similar to the national uptake.

3.6.8 PHE Surveillance of type-specific HPV in sexually active young females in England, to end 2018

Public Health England have recently conducted a surveillance of type-specific HPV infections in sexually active young women who were undergoing chlamydia screening. The results of the surveillance found that the prevalence of the specific type of HPV 16/18 in females who were offered the HPV vaccination aged 12-13 years has been less than 2%.

This is in comparison to over 15% prior to the vaccination programme starting in 2008. In 2018, the surveillance detected no HPV 16/18 infections in all 16-18-year olds screened suggesting in both direct and indirect protection from the programme (herd protection). There has been no evidence of an increase in any other of the high-risk types of HPV, showing concerns about other HPV types becoming more common as so far unsubstantiated. The surveillance report findings show the importance of the HPV programme.

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85 More about HPV and its impact on health can be found here: NHS, ‘Human papillomavirus (HPV)’, online at (accessed 14 April 2021): http://ow.ly/8KDV50Eu8Wa
3.7 Looked-After Children

Children in Care (CIC), or ‘looked-after children’ rates were relatively steady between 2010 and 2014 in Newcastle. After a reduction in 2015 and 2016, the rate increased year-on-year to 2018 when the number of CIC in Newcastle was 570. This number climbed again in 2019 to 683; a rate of 118 per 10,000 children aged under 18 years, as shown in figure 3.8-1 below.

Figure 3.7-1 Children in Newcastle in care at 31 March 2019

3.8 Oral health

Good oral hygiene, such as brushing teeth twice daily and regular visits to the dentist, has many benefits. Brushing regularly using a correct method reduces the likelihood of tooth decay and gum disease, both of which can be painful, expensive to treat, cause low self-esteem and disfigurement. Poor hygiene habits leading to poor oral health in childhood can have lifelong impacts on an individual.

The Global Burden of Disease (2017) estimates that untreated dental carries (tooth decay) in permanent teeth is the most common health condition globally, with the World Health Organization estimating that oral disease affects nearly 3.5 billion people globally\(^89\). In England, Public Health England conducts oral health surveys among the child population as part of the National Dental Epidemiology Programme (NDEP).

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3.8.1 Oral health in three-year-olds

The latest survey of the three-year-old population was conducted in 2019 to 2020. However, the survey had limitations due to the coronavirus pandemic which led to an incomplete collection of results, and the survey was terminated early. Additionally, the minimum sample sizes required were rarely met across the local authorities. Therefore, data from this survey should be treated with caution.

Just under 20,000 three-year-olds nationally (19,479) were surveyed, with 10.7% of those already experiencing dental decay (this includes decayed teeth, and missing or filled teeth due to decay). Within that 10.7%, on average each child had three affected teeth. For comparison, children aged three by this age normally have all 20 baby teeth. The highest levels of decay were estimated in northern regions compared to southern regions. For Newcastle, only 1% of the three-year-old population was examined in this survey, and therefore results cannot be meaningfully compared to the national findings90.

3.8.3 Oral health in five-year-olds

The most recent survey of the five-year-old population was conducted in 2018 to 2019. Nationally, 23.4% of the children surveyed had experienced dental decay, with the average number of teeth with decay being 3.4. The prevalence of dental decay in five-year-olds was higher in more deprived areas than less deprived areas. In Newcastle, 24.2% of those surveyed had experience of tooth decay, with an average of 3.2 teeth with decay, which is similar to the national figures.

3.8.4 Oral health in school-age children

Locally, school-age pupils are asked about their oral hygiene habits via the Healthy Behaviours Survey which is conducted among participating schools every two years. The latest survey, conducted in 2019, found:

- The vast majority of pupils have a toothbrush to clean their teeth at home.
- Whilst most clean their teeth twice a day, almost 20% clean them once a day or less.
- Small numbers of pupils did not clean their teeth at all on the day before the 2019 survey. 3% of primary and 2% of secondary pupils did not clean their teeth at all.
- Secondary students are more likely to clean their teeth at least twice a day; 83% of secondary students, compared to 76% primary pupils.
- Nearly a quarter of primary pupils had had fillings when last at the dentist.
- Secondary students were more likely to have visited the dentist in the last year.
- Since 2013, the numbers of pupils visiting the dentist have increased.
- Just over one in ten primary pupils had not visited the dentist in the last year91.

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3.9 Sexual health and teenage conceptions

Young people having a good understanding of good sexual and reproductive health practices, including consent, contraception, self-esteem, and puberty, is important to ensure healthy behaviours in this age group. This section explores data about sexual and reproductive health in younger people, though please note that information specifically about Chlamydia screening among people aged 15 to 24 is discussed in section 4.19.2, ‘Chlamydia’.

3.9.1 Relationships and Sexual Education (RSE)

A new compulsory curriculum of Relationships and Sexual Education (RSE) was announced in Summer 2019, with the aim being that it would start to be delivered in schools in September 2020. However, with the disruption in schools due to the Covid-19 pandemic, it is currently unclear how much of the new curriculum has been delivered to pupils. We will continue to monitor this situation and will report on it when reliable data is available.

3.9.2 Teenage conceptions

Access to sexual health services, contraception and thorough Relationship and Sex Education (RSE) can all be factors affecting a populations rates of teenage pregnancy. Although the rate of conceptions in young people has been declining, they still remain an at-risk group for unplanned pregnancies.

Over the last two decades, the rate of conceptions in under-18s has been declining nationally. This trend is also seen in Newcastle, with a crude rate of 24.2 per 1,000 conceptions in under-18s in 2018, compared to 52.8 per 1,000 in 1998. Despite this decline, Newcastle’s latest rate (2018) is statistically worse than the national rate – but similar to the regional rate. The rate of abortions in under-18s in 2019 was 7.1 per 1,000. This rate has seen a small decline since 2012, which mirrors the national trend.

The crude rate of conceptions in under-16s has declined nationally in the last decade. For Newcastle, this decline has fluctuated more with a plateau between 2013-2015 and a decline in recent years. The crude rate of under-16 conceptions in 2018 in Newcastle was 4.1 per 1,000, compared to 4.6 nationally, and 2.5 nationally.

Overall, the proportion of teenage mothers in Newcastle in the last decade has reduced, although the trend in more recent years has shown no statistically significant change. The proportion of teenage mothers in Newcastle in 2018 was 0.8%, compared to 0.6% nationally and 1.2% regionally.

3.9.3 Chlamydia

Chlamydia is a Sexually Transmitted Infection (STI), with the burden of the infection mostly falling on the younger population. As such, Public Health England runs a National Chlamydia Screening Programme with a focus on those aged 15 to 24. In 2019, 23.7% of the Newcastle population aged 15 to 24 were screened for Chlamydia, which is statistically better than the England percentage.

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When looking at the long-term trend, the percentage of Newcastle’s young population screened has been declining over the decade. The detection rate of Chlamydia was 2,058 per 100,000 population in 2019. This is similar to the England detection rate\(^{93}\).

### 3.9.4 Healthy Behaviours Survey 2019 results

Newcastle City Council conducts a survey every two years of school pupils in Newcastle on a range of health and wellbeing topics including relationships, puberty and sexual health. Primary-age pupils are asked about their knowledge of growing up and puberty, whereas older secondary-age pupils are asked about their knowledge of safe sexual health and relationships.

From the latest survey results (2019) we found that 15% of primary-age boys and 20% of primary-age girls (Years 4 and 6, or ages 8-9 and 10-11) worry quite a lot or a lot about how they look. 17% worry about changes to their body as they get older. 7 in 10 pupils in Year 6 felt they knew enough about how their body will change as they grow, but nearly a quarter of Year 6 pupils (24%) were not sure. In Year 4 pupils just under half (49%) felt they knew about what body changes to expect, and nearly 4 in 10 (39%) were not sure.

Looking at the results for secondary-age young people, we found that 83% of Year 10 pupils (aged 14 to 15) self-reported that they have never had a sexual relationship, showing that the majority of young pupils in Newcastle are not sexually active. Only 62% of Year 10 pupils stated they knew how to access sexual health advice and contraceptive services. 38% got their main information about sexual health and relationships from school sex education lessons, with friends (22%) and family (17%) the next most common sources.

The above results show the need for comprehensive and open discussions, starting with primary-age pupils, on puberty and sexual health and relationships to avoid misinformation from other sources as they grow and start to experience these changes. The majority of 14 and 15 year olds in the survey stated they were not sexually active, but there is still a need for young people to understand how to access advice and contraception to ensure safe, informed and healthy choices around healthy relationships, sex and contraception\(^{94}\).

\(^{93}\) Ibid.

\(^{94}\) Newcastle City Council Services to Schools, ‘Healthy Behaviour Surveys’, online here (accessed 13 March 2021): http://ow.ly/VOX250Eu95o
3.10 Special educational needs and disability

3.10.1 Special Educational Needs and Disabilities (SEND) – An overview

In January 2019, there were 7,180 pupils in Newcastle schools with special education needs. Of these, 13.2% of pupils have Special Educational Needs (SEN) Support (5,934 pupils) compared with a national average of 11.9%. A further 2.8% have an Education, Health and Care (EHC) plan (1,246 pupils), compared with 3.1% nationally\(^96\).

85% of SEN pupils have 1 of 5 ‘primary needs’ (the primary, but not only, reason they require support), as shown in Table 3.11-1:

Table 3.10.1-1 Pupils with at least 1 of 5 primary needs\(^96\)

<table>
<thead>
<tr>
<th>Primary Need</th>
<th>Number of pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Learning Difficulty</td>
<td>1,503</td>
</tr>
<tr>
<td>Speech Language and Communication Needs</td>
<td>1,431</td>
</tr>
<tr>
<td>Social Emotional and Mental Health</td>
<td>1,090</td>
</tr>
<tr>
<td>Specific Learning Difficulty</td>
<td>755</td>
</tr>
<tr>
<td>Autism</td>
<td>676</td>
</tr>
</tbody>
</table>

Looking at demographics of SEND pupils:

- 25% of pupils with SEND are female and 75% male
- 36% of pupils with SEN Support are female and 64% male
- 73% of pupils with SEND are White British.
- 59% are primary school age.
- 36% are secondary school age.
- 5% are in a post-16 educational setting.

23% of children in care have an EHC plan, and 12% of children and young people ‘open to the Youth Justice Service’ (in other words, those with an open case with the Youth Justice Service) have an EHC plan.

Pupils in Newcastle with SEND make better progress at KS2 with reading, writing and mathematics than pupils nationally, but Newcastle pupils have made less progress at KS4 in 2019\(^97\).

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\(^96\) Ibid.

\(^97\) Ibid.
3.10.2 Children and young people with an Education, Health and Care Plan

In 2019, there were 1,490 children and young people aged between 0-25 years with Education, Health and Care plans (EHCs). This is a 63% increase since 2015, where there were 916 children and young people with an EHC plan. This is greater than the 47% increase nationally and 46% increase in the North East. Table 3.10.2-1 shows the learning setting where children and young people with EHCs receive education.

Table 3.10.2-1 Learning settings\(^\text{98}\)

<table>
<thead>
<tr>
<th>Learning</th>
<th>Percentage of pupils with EHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special schools</td>
<td>56.5%</td>
</tr>
<tr>
<td>Mainstream schools</td>
<td>20.4%</td>
</tr>
<tr>
<td>SEN units</td>
<td>4.0%</td>
</tr>
<tr>
<td>Resourced provision (ARC / ARP)*</td>
<td>2.7%</td>
</tr>
<tr>
<td>Other settings, including further education</td>
<td>16.4%</td>
</tr>
</tbody>
</table>

\(^*\) ARC = Additionally Resourced Centre; ARP = Additionally Resourced Provision.

In Newcastle there has been a recent rise in the number and proportion of pupils with SEND, resulting in Newcastle catching-up with the national average from a lower position over the last 5 years.

The increase in the number of children and young people with an EHC plan is due to a combination of the introduction of Government SEND reforms in 2014 resulting in a change to the SEND Code of Practice, and local policy changes in Newcastle affecting the number of children and young people with an EHC plan\(^\text{99}\).


\[^{99}\] Ibid.
4. Living well

This section of the City Profile looks at factors affecting adults’ lives in Newcastle, including air quality, climate change, immunisation, alcohol-related harm, long-term conditions such as diabetes and COPD, caring, cold-related ill-health, crime and community safety, the economy, learning disabilities and autistic spectrum disorders, physical and sensory disabilities, mental health, safeguarding adults, substance misuse and tobacco control, physical activity and obesity levels, and sexual health.

4.1 Air quality and climate change, including flooding

Having clean air to breathe protects our wellbeing and keeps us healthy. Pollutants in the air come mainly from human activities such as industry, burning fuel, road traffic and building heating. Some also come from natural sources such as the sea, wind-blown dust and decomposing organic matter.

Air pollution has an impact on everyone living and working in our city. However, it is the most vulnerable people such as children, older people and those with heart and respiratory conditions who will experience the effects most. People living near busy roads are exposed to higher levels of road traffic pollution. The effects of air pollution on health are described on the DEFRA website100.

It is estimated that air pollution shortens the life of many people in the UK. Long-term exposure to air pollution reduces life expectancy by increasing deaths from cardiovascular and respiratory conditions, and from lung cancer. It is estimated that long-term exposure to air pollution in the UK has an annual effect equivalent to 28,000 to 36,000 deaths101.

4.1.1 Air Quality

The Environment Act 1995 requires the Council to review and assess the air quality in Newcastle each year, looking specifically at the nine air pollutants in the Government’s National Air Quality Strategy:

1. Particles (PM10 and PM2.5)
2. Nitrogen Dioxide (NO₂)
3. Ozone (O₃)
4. Sulphur Dioxide (SO₂)
5. Polycyclic Aromatic Hydrocarbons (PAH)
6. Benzene (C₆H₆)
7. 1,3 Butadiene
8. Carbon Monoxide (CO)
9. Lead

We monitor air quality across the Newcastle so that we know and understand where problems with air quality are happening. The pollutant of most concern to us in Newcastle is nitrogen dioxide (NO₂), primarily caused by road traffic. We have four automatic

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monitoring stations, measuring a variety of pollutants. The monitors are in the following locations, where we think air pollution may be at risk of going above national air quality objectives:

1. St. Mary’s Place (Automatic Urban Network monitors for PM2.5, PM10, NO₂, benzene, and polyaromatic hydrocarbons such as fluorene and pyrene)
2. Percy Street (monitors NO₂)
3. Jesmond Road (monitors NO₂ and PM10)
4. Pilgrim Street, off Swan House roundabout (monitors NO₂)

The monitoring data results can be viewed in our Air Quality Annual Status Report (see below). Our most recent monitoring data for Jesmond Road can also be viewed online at Defra’s UK AIR website. We also have 75 non-automatic monitoring stations at locations across the city to monitor roadside levels of nitrogen dioxide.

Annual Air Quality Progress Reports and Air Quality Management Areas (AQMAs) for Newcastle are available on Newcastle City Council’s website.

Newcastle City Council (NCC) have declared two air quality management areas due to monitored exceedances of the annual mean NO₂ objective, which are:

1. City centre
2. Gosforth

Annual mean NO₂ concentrations measured in 2019 continue to exceed the annual mean objective at many sites in the centre and on key routes.

4.1.2 Climate Change

We know that: “Climate change will have significant impacts on the environment, public health and the economy. Climate change will cause deaths during heat waves, increase health problems as a result of additional particle emissions during droughts, exacerbate ozone and air quality related health problems, and intensify the distribution and spread of infectious diseases. It will also affect the basic elements of life, and hence our economy.”

More work is needed to understand the particular impact of projected climate change on Newcastle’s people, particularly those who are most vulnerable. However, some potential risks and opportunities could be:

- Risks from overheating or flooding caused by extreme weather.
- Disruption to everyday activity through cracking or melting of roads.
- Reduced productivity of workers.
- Development of new economic sectors, for example, if changes in the climate increase the viability of certain agriculture sectors.
- Changes in risks from infectious disease.

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Newcastle Future Needs Assessment City Profile – Updated April 2021

UK climate change projections from 2009 were updated with the publication of UKCP18, which included updated projections and climate outcomes. They include: projected temperature increases, average rainfall, sea-level rise, future storm surge for a range of emissions scenarios. Local headline outputs for 2100 in a high-emissions scenario include a projected 0.9m sea level rise in the North Sea, summer temperature rises of 6°C, and winter rises of 1.6°C, summers that are 27% wetter, and winters that are 14% wetter\(^{105}\).

4.1.3 Flooding

Newcastle is currently at risk from fluvial (river) flooding from the Tyne and Ouseburn, groundwater and mine water emissions from rising levels, although the main risk is presented by surface water flooding. The Environment Agency provided updated Flood Mapping for Surface Water (uFMfSW) in 2016. Figure 4.1.3-1 on the next page shows the uFMfSW for the city centre.

\(^{105}\) UK Climate Projections (UKCP18), online at (accessed 19 April 2021): http://ow.ly/4wvZ50EuhTv
Figure 4.1.3-1 Updated Flood Map for Surface Water (Newcastle City Centre)\textsuperscript{106}

\textsuperscript{106} Environment Agency, 2016
The Council has commissioned and approved these three major flood risk studies in recent years which inform our baseline predictions of flooding in the city and projects the impacts of climate change:

1. Newcastle Groundwater Flood Risk Assessment (Newcastle University, 2015)
2. Ouseburn Surface Water Plan (MWH, 2015)
3. Newcastle City Strategic Surface Water Management Plan (Amec Foster Wheeler, 2016)

Figure 4.1.3-2 Newcastle City Strategic Surface Water Management Plan (excerpt – City Centre North)
Newcastle Future Needs Assessment City Profile – Updated April 2021

Baseline (2015) and future (2030) flood risk modelling was undertaken for both ‘do nothing’ and ‘maintenance only’ scenarios. Option modelling then provided the mitigation impacts of various interventions that would improve flood resilience in the city.

Work has already taken place to implement some of the findings from the study. Two further major studies are ongoing in partnership with the Environment Agency and Arup, to develop opportunities identified in the Newcastle City Strategic Surface Water Management Plan into business cases that will provide a surface water flooding investment plan for the city.

From April 2021, the council, as the Lead Local Flood Authority and in partnership with the Environment Agency, will start its second 6-year programme to deliver flood alleviation projects in areas within the local authority area that are at significant risk of surface water flooding.

### 4.2 Immunisation and screening

#### 4.2.1 Cervical cancer screening

The NHS Cervical screening programme, or ‘smear test’, is offered to women aged 25 to 64 to check the health of cells in the cervix. It is offered every 3 years for those aged 26 to 49, and every 5 years from the ages of 50 to 64. The programme has made a significant impact on cervical cancer mortality since it was established in 1988, saving an estimated 5,000 lives a year. However, in recent years there has been a decline nationally and locally in the number of women receiving their ‘smear’ test.

In Newcastle, 68.1% of eligible women aged 25-64 were screened for cervical cancer in 2019/20. This is lower than the North East percentage (75.0%) and that for England (72.2%). Newcastle has seen a 0.2% increase in cancer screening coverage in 2019/20, compared to 2018/2019. There was also a small increase between 2017/18 and 2018/19.

There is a lower coverage rate for those aged 25 to 49 years (65.0%) compared to those aged 50 to 64 years (75.7%). In the second quarter of 2020/21, Newcastle has seen a decrease in screening coverage for the 25-49 population to 61.9%, and to 71.2% for those aged 50-65 years. This decrease has also been seen nationally.\(^\text{107}\)

#### 4.2.2 Bowel cancer screening

The bowel cancer screening programme aims to check for bowel cancer or abnormalities that could lead to bowel cancer. In England, people between the ages of 60 and 74 years are invited for screening through a test called the faecal immunochemical test (FIT). Bowel cancer is one of the most common types of cancer in the UK and was the second most common cause of cancer deaths in 2014-16, hence the need for this screening programme.

The number of people aged 60-74 screened for bowel cancer within six months of an invitation to be screened has increased across the Newcastle and Gateshead Clinical

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Newcastle Future Needs Assessment City Profile – Updated April 2021

Commissioning Group (CCG) area in recent years. In 2018/2019, 66.9% of those invited attended a screening, compared to 65.8% in England overall\textsuperscript{108}.

### 4.2.3 Breast cancer screening

The breast cancer screening programme aims to find breast cancer early, when it has the best chance of being cured. Overall, the breast screening programme finds cancer in about 9 out of every 1,000 women having screening\textsuperscript{109}. The current NHS Breast Screening Programme invites all women aged between 50 and 70 for screening every 3 years; women need to be registered with a GP to receive the invitation. 15,844 women in the Newcastle and Gateshead CCG area had their breast cancer screening within 6 months of receiving an invitation in 2019/20, which is a 70.1% uptake. This percentage uptake is similar to recent years\textsuperscript{110}.

### 4.2.4 Seasonal Immunisations – Influenza

Seasonal influenza (flu) vaccine uptake is monitored in key groups such as people aged over 65, populations with health complications that put them at risk, pregnant people, and healthcare workers. Data shows that in Newcastle, on average, three quarters of people aged over 65 receive an influenza vaccine each year. The latest data, for September 2020 to February 2021, shows an increase in uptake, with 83.3% of over-65s receiving an influenza vaccine. Influenza vaccine coverage for at-risk individuals has remained steady at around 50% for the last few years, and this has continued into 2020/21. 53.8% of under-65 year olds identified as at-risk individuals in Newcastle received an influenza vaccine in the period from September 2020 to February 2021\textsuperscript{111}.

### 4.3 Alcohol-related harm

Key indicators of alcohol-related harm within a population include admission rates for alcohol-related conditions and alcohol-related mortality. Wider affects include crime, litter and antisocial behaviour.

#### 4.3.1 Hospital admissions due to alcohol

Hospital admissions due to alcohol can be split into two categories: alcohol-related admissions and alcohol-specific admissions. Alcohol-related admissions can be further split into broad or narrow definitions as follows:

“A broad definition: A measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition. This represents a Broad measure of alcohol-related admissions, but is sensitive to changes in coding practice over time.

\textsuperscript{108} PHE, ‘Local Authority Profiles – Cancer Services’, online at (accessed 14 April 2021): http://ow.ly/75yL50Euiqw


\textsuperscript{110} PHE, ‘Local Authority Profiles – Cancer Services’, online at (accessed 14 April 2021): http://ow.ly/8PST50EuiqY

\textsuperscript{111} PHE, ‘Vaccine uptake guidance and the latest coverage data: Seasonal flu vaccine uptake - figures’ online at (accessed 14 April 2021): http://ow.ly/7Izo50Euis8
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Narrow definition: A measure of hospital admissions where the primary diagnosis (main reason for admission) is an alcohol-related condition. This represents a Narrower measure. Since every hospital admission must have a primary diagnosis it is less sensitive to coding practices, but may also understate the part alcohol plays in the admission.

In general, the Broad measure gives an indication of the full impact of alcohol on hospital admissions and the burden placed on the NHS. The Narrow measure estimates the number of hospital admissions which are primarily due to alcohol consumption, and provides the best indication of trends in alcohol-related hospital admissions.¹¹²

For this analysis the narrow definition has been used.

The rate of alcohol-related admissions in Newcastle has seen no significant change in recent years remaining statistically worse than the England rate and statistically similar to the regional rate. The latest directly standardised rate for Newcastle in 2018/19 was 914 per 100,000 (2,379 admissions). The rate of admissions is higher in males (1,138 per 100,000) than females (700 per 100,000).

The rate of alcohol-specific admissions in Newcastle is increasing and is statistically significantly worse than both the regional and England rate. This trend in Newcastle is not mirrored in the national or regional rate, suggesting it is a Newcastle pattern only. The latest directly standardised rate for admissions for alcohol-specific conditions was 1,177 per 100,000 in 2019/20 (no=2,920 admissions). This is in comparison to 936 per 100,000 in the North East, and 644 per 100,000 in England. Whilst the rate is higher in males in Newcastle, a steeper increase in rate since 2017/18 has been seen in females¹¹³.

4.3.2 Alcohol-related conditions

Alcohol has a significant impact on several health conditions, and is seen as a causal factor in more than 60 medical conditions. Public Health England’s Local Alcohol Profile (LAPE) provides data on some of the key alcohol-related health conditions in the form of hospital admissions, which include cardiovascular disease (CVD) and liver disease, as well as admissions from mental and behavioural disorders, unintentional injuries, and intentional self-poisoning.

Newcastle has seen a rise in the rate of hospital admissions for alcohol-related unintentional injuries between 2017/18 to 2018/19, with the highest rise in the male population.

Newcastle has the highest directly standardised rate in the North East for alcohol-related hospital admissions for liver disease, 277.6 per 100,000, with Gateshead the next highest at 271.3 per 100,000. After a period of decline in the rate of hospital admissions for alcohol-related CVD between 2013/14 to 2016/17, the rate has begun to increase. It is currently at 1,404 per 100,000 and is statistically worse than the national and regional rates.

There is also strong evidence linking alcohol consumption and cancer, including cancers of the oral cavity and pharynx, oesophagus, female breast, colorectum, larynx, liver, stomach, pancreas, lung, and gallbladder. The incident rate of alcohol-related cancer has seen an increase over recent years in Newcastle, from its lowest point of 38.24 per 100,000 in 2009-2011 to a peak of 44.61 in 2012-2014, and is currently 41.93 per 100,000.

¹¹³ Ibid.
in 2015-2017 statistically similar to the regional and national rates. Males in Newcastle have a higher rate of alcohol-related cancer than females, and this is also seen in the national rates.

4.3.3 Wider effects of alcohol upon society

Alcohol consumption and availability risks harm not only to personal health but also to the wider environment and economy. In 2015/2016 Balance North East (the alcohol awareness charity) estimated the cost of alcohol-related harm in Newcastle at £120.3 million or £411 per head of population. The largest cost was seen in crime and disorder (estimated to be £47.9m)\textsuperscript{114}.

4.3.4 Treatment for Alcohol Use

It is estimated that there are 4,383 adults in Newcastle who are alcohol dependant. Alcohol treatment services are available in Newcastle. Successful completion of alcohol treatment is defined as alcohol users who leave treatment alcohol-free and do not represent to treatment within six months of discharge. In 2019 Newcastle had the second lowest proportion of successful alcohol completions out of the North East local authorities. The proportion of successful alcohol completions of treatment in 2019 in Newcastle was 26.3% (113 cases). This is the lowest count and proportion for Newcastle since 2010. For comparison, the proportion of successful completions in England in 2019 was 37.8\%\textsuperscript{115}.

4.3.5 Alcohol-Related Mortality

There are two measures of mortality linked to alcohol: alcohol-specific mortality, which is defined as deaths to which alcohol can be wholly attributable, and alcohol-related mortality which is based on deaths from alcohol-related conditions (based on underlying cause of death). Alcohol-specific mortality is calculated as directly standardised rates over two-year periods, whereas alcohol-related mortality is over one year.

Alcohol-specific mortality has been increasing in Newcastle from 2011. The most recently available data (2017 to 2019) shows a small decline in the mortality rate at 16.9 per 100,000 (120 deaths). This is statistically worse than the England rate, but similar to the regional rate. It is too soon to say if this decrease is a trend or just a fluctuation. The rate of alcohol-specific mortality is higher in males than in females.

Alcohol-related mortality has remained static over the last few years in England whereas in Newcastle it has shown more fluctuation. The latest available data shows an increase in the directly standardised rate at 65.3 per 100,000 for 2018, which is the highest the rate has been in Newcastle since 2008. The rate has increased in males in Newcastle, but in females it has remained static since 2017\textsuperscript{116}.

\textsuperscript{115} Ibid.
\textsuperscript{116} Ibid.
4.4 Long-Term Non-Communicable Diseases: Cancer, Diabetes, COPD, CVD, etc.

Non-communicable diseases (NCDs), also known as chronic diseases, are not passed from person to person. They are of long duration and generally slow progression. The four main types of non-communicable diseases are:

- cardiovascular diseases (like heart attacks and stroke)
- cancers
- chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma)
- diabetes.

NCDs are often associated with older age groups, but evidence shows that conditions such as heart disease, stroke, cancer, diabetes and chronic lung disease, are collectively responsible for almost 70% of all deaths worldwide. Children, adults and the elderly are all vulnerable to the risk factors that contribute to non-communicable diseases, whether from unhealthy diets, physical inactivity, exposure to tobacco smoke or the effects of the harmful use of alcohol.

Long-term conditions or chronic diseases are conditions for which there is currently no cure, and which are managed with drugs and other treatment, for example: diabetes, chronic obstructive pulmonary disease, arthritis and hypertension.

The current population of Newcastle is 300,196 (as of 2018) and expected to rise to 308,888 by 2028\textsuperscript{17}. NCDs are expected to increase over the next decade alongside the increase in Newcastle’s population. Currently there are 62 GP surgeries in the Newcastle and Gateshead CCG area\textsuperscript{18} and 6 hospitals\textsuperscript{19}.

4.4.1 Cancer

To be updated: We are in the process of reviewing the most recent cancer datasets at the moment. This section will be updated shortly, once the data have been updated and analysed. This section will include:

- 4.4.1 Cancer prevalence
- 4.4.2 Factors affecting the prevalence of cancer – smoking and obesity
- 4.4.3 Breast cancer
- 4.4.4 Bowel cancer
- 4.4.5 Lung cancer


4.4.6 Diabetes

Diabetes is a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. Insulin is a hormone that regulates blood sugar. Hyperglycaemia, or raised blood sugar, is a common effect of uncontrolled diabetes and over time leads to serious damage to many of the body’s systems, especially the nerves and blood vessels.

4.8 million people were diagnosed with diabetes in the UK as of 2020. Many of these individuals are type 2 diabetics (require insulin), and one of the leading risks associated with type 2 diabetes is obesity. There has been an increasing trend in childhood obesity from 24.9% to 26% of the Newcastle population in the last 5 years between 2015 and 2020. However, adult obesity has decreased from 63.2% to 60.3% between 2015 and 2019.

In 2018/19 there were 17,196 people in Newcastle recorded on GP practice registers as having diabetes, this is a 26% increase from 2013/14. It is estimated that around 7.4% of the population have diabetes (18,187 people aged 16 and over) and that is projected to increase to 8% by 2035 (21,275 people aged 16 and over). However, these projections were published in 2016 and based on data from 2012-14 so only provide an estimate of prevalence, but they do indicate a potentially under-diagnosed population.

Cases of Type 1 diabetes have increased in Newcastle over the past 5 years for people aged under 40 from 45.7% to 47.7% of cases between 2015 and 2019. There has also been an increase in Type 2 diabetes from 3.7% to 4.5% of cases between 2015 and 2019. These are both above the average for England’s population at 44.7% for type 1 diabetes and 4% for type 2 diabetes.

4.4.7 Chronic obstructive pulmonary disease (COPD)

Chronic obstructive pulmonary disease (COPD) encompasses a group of lung conditions. These conditions will usually cause breathing difficulties and are more frequently observed among the smoking population. COPD has been found to worsen over an individual’s lifetime reducing life expectancy. In people who have never smoked, COPD has been found to coincide with a low reduction in life expectancy. However, in the smoking population COPD onset will continue to develop in severity over time, leading to a significant reduction in life expectancy in the 65 and older population, up to 5.8 years in the most chronic COPD cases. In former smokers, COPD has still been found to reduce life expectancy by around 1.3 years in chronic cases. However, there has been a real reduction in the amount of the population smoking in Newcastle from around 25% of adults reporting to smoke in 2013 to 13% in 2019.

In 2019/20 there were 12,979 people across the Newcastle and Gateshead CCG diagnosed with COPD and recorded on GP practice registers, which is 2.4% of the population. It is estimated that around 2.7% of the Newcastle population may have COPD.

121 PHE, ‘Local Obesity Profile’, online at (accessed 14 April 2021): https://fingertips.phe.org.uk/search/obesity
Newcastle Future Needs Assessment City Profile – Updated April 2021

It is important to ensure cases of COPD are diagnosed and receive the appropriate treatment, research suggests that high rates of undiagnosed COPD are associated with high hospital admission rates, therefore understanding more about who is being admitted, finding the undiagnosed and treating them should reduce hospital admissions in the future.

The adult smoking population is continuing to decrease in Newcastle. The number of people quitting smoking in Newcastle has increased over the past 5 years between 2015 and 2020. This has seen a rise from 1,743 cases (people stopping smoking) per 100,000 in the 2015-2016 period to 2,647 cases between 2019-2020. This is now above the national average in England of 1,808 per 100,000 head of population124.

However, Newcastle is still above the national average for smoking-related mortality of 339.6 cases per 100,000 head of population, compared to the England average of 250.2 per 100,000 for the period 2016-2018. This has decreased over the past 5 years from a peak of 400.3 cases per 100,000 in Newcastle in the period of 2014-2016125.

Newcastle’s COPD-related emergency hospital admissions have been gradually increasing, from 675 cases in 2015 to 761 in 2020. A peak of 845 cases per 100,000 head of population was seen during the 2018-2019 time period. By comparison, in England cases per 100,000 have remained stable with little change over the same period; between 411-415 cases per 100,000.

Though there has been a clear reduction in smoking, which can exacerbate COPD, and equally a reduction in smoking-related mortality, COPD-related hospital cases have continued to rise. This may be due to an increasing population of both smokers and former smokers now suffering increasingly worse symptoms of COPD. Many people are also noted by the NHS to not know they have COPD, meaning that increasing hospital cases may correspond to many previously undiagnosed cases being identified.

4.4.8 Cardiovascular disease (CVD)

Cardiovascular diseases (CVDs) are a group of disorders of the heart and blood vessels. They encompass many different heart-related conditions such as coronary artery diseases (CAD, such as a heart attack), stroke, abnormal heart rhythms, heart failure, and so forth. CVD has been found to be caused by many other health conditions such as diabetes, high cholesterol, smoking, and obesity. CVD also increases the risk of heart attack, stroke and developing some forms of dementia and is commonly observed with hypertension (high blood pressure) which frequently shows no symptoms. This makes it difficult to detect without regular health checks.

Because of the complexity of CVD and the different conditions it includes, it is difficult to determine a single root cause. Many cases are caused by a combination of factors, such as obesity and diabetes being interlinked with promoting CVD. This makes it far more difficult to monitor in populations due to many metrics being applicable126.

Cardiovascular disease also disproportionately affects the most deprived communities and CVD is the largest contributor to the gap in life expectancy between the most and least

125 Ibid.
deprived, accounting for up to 25% of the difference nationally. Premature CVD mortality is also four times higher in the most deprived communities\textsuperscript{127}.

### 4.4.8.1 Coronary Heart Disease (CHD)

In Newcastle it is estimated that 7.6% of the population aged between 55 to 79 years will have CHD (based on the 2015 data), compared to 7.9% nationally. In 2019/2020, there were 9,275 people diagnosed with Coronary Heart Disease (CHD) in Newcastle and recorded on GP practice registers which is 2.8% of the whole of Newcastle’s population (all ages). Newcastle has seen a decline in the number of people on the GP practise registers diagnosed with CHD. Newcastle is also below the England (3.1%) and the North East (4.1%) in the percentage of the population with a CHD diagnosis. It is important that people with CHD are identified and registered to ensure they receive the appropriate treatment for their condition\textsuperscript{128}.

### 4.4.8.2 Hypertension

In 2019/20 there were 39,681 people diagnosed with Hypertension in Newcastle and recorded on GP practice registers (12% of the population). However, modelling prevalence estimates from 2015 suggest that around 16.5% of the population will have a hypertension diagnosis in Newcastle and that a further 10.6% of the population, which equates to around 26,521 people, will have the condition but be undiagnosed.

The number of new patients aged between 30-74 who are identified as having hypertension has been decreasing in Newcastle over the past 5 years, from 73.6% in 2015-2016 to 60.9% in 2019-2020. This is now below the national average for England, which has remained relatively stable from 66.5% in 2015-2016 to 65.4% 2019-2020\textsuperscript{129}.

The reduction in hypertension cases in Newcastle has also been observed in parallel with a reduction in the retired population. Between the periods 2015-2016 and 2018-2019, the retired population without hypertension in Newcastle has decreased from 81.5% to 81.1%. However, this is still significantly better than the England average of 79.7%\textsuperscript{130}.

### 4.4.8.3 Stroke and Transient Ischaemic Attack

In 2019/20 there were 5,781 people in Newcastle diagnosed with Stroke or Transient Ischaemic Attack (also known as TIA; a ‘mini-stroke’ caused by a temporary disruption in the blood supply to part of the brain) and recorded on GP practice registers, which is 1.7% of the population. The estimated prevalence of strokes in the Newcastle population aged between 55-79 years is 3.76%, which is around 2,342 people in Newcastle.

### 4.4.8.4 Atrial fibrillation (AF)

AF is a heart condition associated with increased risk of stroke as well as reduced cardiac performance and early mortality. Stroke patients with uncontrolled AF are more likely to be diagnosed with severe stroke which can lead to poorer outcomes. The National Cardiovascular Intelligence Network estimated the prevalence of AF across the Newcastle and Gateshead CCG is 2.3% of the population which is around 12,000 cases across the CCG\textsuperscript{131}.

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\textsuperscript{128} PHE, ‘Local Authority Profiles - CVD’, online at (accessed 14 April 2021): \url{http://ow.ly/mCLY5OEwaGa}

\textsuperscript{129} Ibid.

\textsuperscript{130} Ibid.

\textsuperscript{131} National Cardiovascular Intelligence Network, ‘Estimations for Newcastle’, 2021.
4.4.9 Musculo-skeletal (MSK) conditions

Musculoskeletal conditions (MSK) are a major burden on individuals and health and social care systems, with predominant indirect costs. They are the most common cause of severe long-term pain and disability and affect millions of people around the world. Four major musculoskeletal conditions are osteoarthritis, rheumatoid arthritis, osteoporosis, and lower back pain.

MSK conditions have a significant impact on the economy as they are the leading cause of work limitations and working days lost. In 2016, musculoskeletal problems accounted for 30.8 million working days lost in the UK. People with MSK conditions are less likely to be employed than people in good health and are more likely to retire early, 59.4% of the working age population (16-64) with a MSK condition are in work, compared to 73.5% of the overall working age population in the UK\textsuperscript{132}. Nationally, 34.6% of people receiving a Personal Independent Payment (PIP) had MSK disease as their primary disease condition\textsuperscript{133}.

4.4.9.1 Total MSK in Newcastle

Arthritis Research UK in partnership with Imperial College London have developed the Musculoskeletal (MSK) calculator, a prevalence modelling tool for MSK conditions. It provides prevalence estimates at a Local Authority level on Knee and Hip osteoarthritis, back pain and rheumatoid arthritis. It suggests there are potentially 76,063 cases of MSK conditions across Newcastle, bearing in mind that one individual could have multiple MSK conditions. Table 4.4.9.1-1 shows the full range of estimated MSK conditions for Newcastle.

<table>
<thead>
<tr>
<th>Versus Arthritis UK Estimates</th>
<th>Newcastle</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Est no.</td>
<td>Est %</td>
</tr>
<tr>
<td>Hip osteoarthritis (total): aged 45 and over</td>
<td>10,900</td>
<td>10.6%</td>
</tr>
<tr>
<td>Knee osteoarthritis (total): aged 45 and over</td>
<td>18,015</td>
<td>17.5%</td>
</tr>
<tr>
<td>Back pain: all ages</td>
<td>45,497</td>
<td>16.1%</td>
</tr>
<tr>
<td>Total pain Conditions</td>
<td>76,063</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe pain</th>
<th>Est no.</th>
<th>Est %</th>
<th>Est. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back (severe)</td>
<td>28,959</td>
<td>10.3%</td>
<td></td>
</tr>
<tr>
<td>Hip osteoarthritis (severe): aged 45 and over</td>
<td>3,038</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Knee osteoarthritis (severe): aged 45 and over</td>
<td>6,097</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>

Note: This figure could include duplications; for example, one person could have multiple MSK issues. Note also that this estimation also does not include neck conditions.


\textsuperscript{133} Ibid.

4.4.9.2 Knee and hip osteoarthritis

There are an estimated 29,000 cases of knee and hip osteoarthritis in Newcastle, with the highest numbers occurring in those aged between 45-64. Table 4.4.9.2-1 shows the age breakdown.

Table 4.4.9.2-1: Versus Arthritis UK: MSK estimations for Newcastle

<table>
<thead>
<tr>
<th>Condition</th>
<th>45-64</th>
<th>65-74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip osteoarthritis: total</td>
<td>6,648</td>
<td>2,282</td>
<td>1,970</td>
<td>10,900</td>
</tr>
<tr>
<td>Hip osteoarthritis: severe</td>
<td>1,328</td>
<td>844</td>
<td>866</td>
<td>3,038</td>
</tr>
<tr>
<td>Knee osteoarthritis: total</td>
<td>11,265</td>
<td>3,779</td>
<td>2,971</td>
<td>18,015</td>
</tr>
</tbody>
</table>

Note: ‘Severe’ osteoarthritis is defined as the individual: suffering severe (as opposed to ‘mild’ or ‘moderate’) pain most of the time; being unable to walk one-quarter of a mile unaided, or; having undergone hip or knee replacement due to arthritis.

4.4.9.3 Osteoporosis

Information from the Quality Outcome Framework (QOF) looks at the percentage of patients with osteoporosis who are aged 50 and over, as recorded on the practice disease register for the Newcastle and Gateshead CCG area. In 2015/2016, it shows a rate of 303.3 cases per 100,000 head of population (502 individuals), which is an increase from the 2014/2015 rates of 208.8 per 100,000 (342 individuals). However, in 2015/2016 Newcastle had a lower rate of osteoporosis in those aged 50 and over than the overall CCG, at 278.4 cases per 100,000 head of population (244 individuals). Note that these numbers are considerably lower than those estimated in the Versus Arthritis UK MSK calculator.

Table 4.4.9.3-1 and table 4.4.9.3-2 on the next pages show the estimated prevalence of hip and knee osteoarthritis in Newcastle in relation to various risk indicators: sex, weight, age, smoking status, level of physical activity, and socio-economic status. Prevalence is notably higher among:

- females
- people who are overweight or obese
- people who smoke or who used to smoke
- people who have a low level of physical activity.
- older people: a greater percentage of those aged 65-74 years have hip or knee osteoarthritis, compared to those aged 45-64.

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Table 4.4.9.3-1: Prevalence of hip and knee osteoarthritis in Newcastle in relation to various risk indicators (sex, weight, age, smoking status, and level of physical activity)\textsuperscript{137}

<table>
<thead>
<tr>
<th>Type of osteoarthritis</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>13.2%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Knee</td>
<td>19.0%</td>
<td>15.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthy weight</th>
<th>Overweight</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>8.2%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Knee</td>
<td>12.2%</td>
<td>17.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 45-64</td>
<td>10.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Age 65-74</td>
<td>17.9%</td>
<td>18.4%</td>
</tr>
<tr>
<td>Age 75+</td>
<td>10.6%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smoking Status</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never-smoker</td>
<td>9.3%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Smoker</td>
<td>16.7%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Ex-Smoker</td>
<td>11.6%</td>
<td>19.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Activity</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedentary activity</td>
<td>14.9%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Low Physical Activity</td>
<td>14.9%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Moderate activity</td>
<td>14.9%</td>
<td>8.2%</td>
</tr>
<tr>
<td>High physical activity</td>
<td>14.9%</td>
<td>15.6%</td>
</tr>
</tbody>
</table>

Table 4.4.9.3-2: Prevalence of hip and knee osteoarthritis (total and severe pain) in Newcastle in relation to socio-economic indicators\textsuperscript{138}

<table>
<thead>
<tr>
<th>Socio-economic Indicators</th>
<th>Hip (Total)</th>
<th>Knee (Total)</th>
<th>Knee (Severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate occupations</td>
<td>8.7%</td>
<td>15.6%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Semi-routine occupation</td>
<td>10.7%</td>
<td>19.4%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Routine occupation</td>
<td>10.7%</td>
<td>19.3%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Higher managerial</td>
<td>10.7%</td>
<td>15.6%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Small employers</td>
<td>12.8%</td>
<td>15.6%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Lower supervisory</td>
<td>10.7%</td>
<td>20.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Lower managerial</td>
<td>10.7%</td>
<td>17.7%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Never worked, long-term unemployed</td>
<td>10.7%</td>
<td>15.6%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

\textsuperscript{137} Ibid.
\textsuperscript{138} Ibid.
4.4.9.4 Back pain
Back pain is one of the largest MSK condition groups. There are an estimated 45,497 cases of back pain in Newcastle – 16.1% of the population – with around 28,959 having severe back pain. It is estimated that women have a higher rate of back pain, as do people aged 35 to 64 years of age, shown in figure 4.4.9.4-1.

Figure 4.4.9.4-1: Estimated Newcastle Back Pain Gender and Age Profile\(^{139}\)

![Back Pain Gender and Age Profile](image)

Information from the GP Patient Survey carried out by NHS England suggests that of the adult population (aged 18 and over) residing in the Newcastle and Gateshead CCG area, 9.7% report having a long-term back problem. If applied to the CCG adult population, this would equate to 38,546 people with long-term back problems, which is lower than the Versus Arthritis estimate.

4.4.9.5 Neck pain
Neck pain is a significant MSK condition group. It is a common problem that around two out of three people will experience at some point. In conditions like osteoarthritis, the neck is one of the most commonly-affected joints, along with the knee, hips and back. The impact of neck pain can be seen in the Global Burden of Disease analysis. ‘Lower back and neck pain’ was the leading cause of disability adjusted life-years (DALYS) in the UK in 2013\(^{140}\). There are currently no accurate estimations on how many people in Newcastle are potentially affected by neck pain, as it is often combined with back pain when calculating estimations.

\(^{139}\) Ibid, and also Versus Research & PHE, ‘Newcastle Local Authority Bulletin’.

4.4.9.6 Rheumatoid Arthritis

The Quality Outcomes Framework provides information for rheumatoid arthritis, as recorded on the practice disease register (for people aged 16 and over). The number is much higher than osteoporosis; in 2015/2016, there were 3,621 residents in the Newcastle and Gateshead CCG on the disease register for rheumatoid arthritis (a rate of 887.4 per 100,000), which is an increase from 2014/2015 when this figure was 3,567 people registered. There are lower numbers registered at Newcastle GPs, with 1,518 on the rheumatoid arthritis disease register in 2015/2016 (a rate of 608.9 cases per 100,000 head of population)\(^1\).

Information from the GP Patient Survey carried out by NHS England suggests that of the adult population (aged 18 and over) residing in the Newcastle and Gateshead CCG area, 14.8% report arthritis or long-term joint problems. If applied to the CCG adult population, this would equate to 58,813 people with arthritis or long-term joint problems. Note that these numbers are significantly higher than the populations on the osteoporosis and rheumatoid arthritis disease registers for the CCG.

4.5 Carers

A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who could not manage to live independently, or whose health or wellbeing would deteriorate without this help. The 2011 Census showed that over 25,644 people in Newcastle of all ages were providing unpaid care, as shown in figure 4.5-1 below\textsuperscript{142}.

**Figure 4.5-1 Provision of unpaid care in Newcastle by age and hours provided, number of people\textsuperscript{143}\textsuperscript{144}**

During 2018-2019, Newcastle City Council adult social care services supported 2,298 carers. This has been decreasing year-on-year. In 2017-2018 this was 2,422 carers; in 2016-2017 this was 2,611 carers, and this is expected to continue decreasing\textsuperscript{144}.


\textsuperscript{143} Ibid.

\textsuperscript{144} SALT 2018/2019 (Short and Long Term Services), reported to NHS Digital in July each year.
4.6 Cold-related ill-health and excess winter deaths

The number of excess winter deaths depends on the temperature and the level of disease in the population, alongside other factors such as how well equipped people are to mitigate the effects of cold on their health (for example, having adequate housing, suitable clothing, and being able to pay for heating). Most excess winter deaths are due to circulatory and respiratory diseases, and the majority occur in later life. Research shows that mortality increases more in England and Wales compared to other European countries with colder climates, suggesting that more deaths could be preventable.

Public Health England uses the Excess Winter Deaths Index to monitor cold-related mortality within the population. The Excess Winter Deaths Index measures, as a ratio, ‘all-cause deaths that occur in the winter months, compared with the expected number of deaths (which is based on the average of the non-winter months)’.

The Excess Winter Deaths Index (over three years, for all ages) shows that in the latest figures for 2014-2016, there was a count of 423 excess winter deaths in Newcastle, a ratio of 17.6% in comparison to 21.1% nationally (which is statistically similar). Since 2006-2009, Newcastle has broadly followed the national ratio in terms of statistical similarity145.

Within the population aged 85 years and over (figures calculated annually) there were 31 excess winter deaths in Newcastle during 2018-2019. This equates to a ratio of 11.6%, which is the lowest this ratio has been since 2002146.

4.7 Crime and community safety

This section looks at crime, the fear of crime, and community safety. Four potential pathways connect fear of crime to people’s health and wellbeing:

- Anxieties induced by or expressed through fear of crime may have an impact on health.
- Poorer health may exacerbate fear of crime
- Fear of crime may lead to avoidance behaviours such as limiting one’s movements outside the home, which may have a negative impact on (a) social interaction and (b) physical activity
- Fear of crime may lead to decreased trust and cohesion within communities and to individual withdrawal – with associated impact on social wellbeing147

4.7.1 Feelings of safety

The Northumbria Police Safer Communities Survey is a continuous telephone survey carried out by Northumbria Police in partnership with the six local councils with the public in the Northumbria area (Newcastle upon Tyne, Gateshead, North Tyneside, South Tyneside, Sunderland, and Northumberland) speaking to over 15,000 residents each year148. Figure 4.7-1 shows that the vast majority of respondents living in the Newcastle

146 Ibid.
area feel safe in their local area; 95% said this in the most recent survey for 2019-2020. This is consistent across the years 2013-2020, and is also in line with the regional figures.

Figure 4.7.1-1 Feelings of safety in local neighbourhoods

![Percentage of respondents who feel very or fairly safe living in their neighbourhood](chart)

However, we know from past research (such as the Newcastle Residents Surveys in 2015 and 2017) that feelings of safety can vary across different geographical areas, among different groups of people, and also across different times of day. We do not currently have data available to analyse these differences, but will look to include this in future versions of this profile when this is feasible.

### 4.7.2 Total crime in Newcastle

We know that “crime may influence health in a range of ways. A distinction can be made between direct and indirect impacts. Direct impacts include both physical injuries and psychological trauma as a result of being victimised ….indirect impacts include a wide range of negative effects, [which are] likely to operate at a neighbourhood level.

“Evidence shows that crime and the fear of crime can cause residents to experience ‘time-space inequality’. [‘Time-space inequality’ means that people vary in their ability to use spaces both within their immediate environment and their wider environment at different times during the day or night.] This variation has been shown to result in poor mental health, including feelings of social isolation, negative mood and low self-esteem.”

This section presents the figures for total crime in Newcastle, then looks at the rates of different types of crime in the city, including violent and sexual offences, burglary, vehicle crime, criminal damage and arson, theft from the person, and anti-social behaviour. It is

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noticeable that crime rates have dropped in 2020-2021, which is to be expected given the impact of the coronavirus-related lockdown restrictions. We will monitor the changes in these rates as society opens up again from 2021 onwards. Please note that we do not currently have contemporary data for deliberate fires being started, but we will add this to the City Profile when we are able to obtain it.

In 2020/2021, total crime in Newcastle was 102 crimes per 1,000 population. Figure 4.7.2-1 shows how this has varied over time, and 4.7.2-2 shows how this varies by ward, with Elswick, Byker and Monument wards having the highest rates (note that Monument ward includes the city centre)\textsuperscript{151}.

**Figure 4.7.2-1 Total crime in Newcastle upon Tyne, 2015/16 to 2020/21\textsuperscript{152}**

![Newcastle upon Tyne Total crime rate 2015-2021](image)

Note: Figures calculated using population data from the 2016 ONS mid-year population estimates.

**Figure 4.7.2-1 Total crime in Newcastle upon Tyne in 2020/21 by ward\textsuperscript{153}**

![Total Crime Rate by Ward in Newcastle 2020/21](image)

Note: Figures calculated using population data from the 2018 ONS mid-year population estimates.

\textsuperscript{151} Police Data, online at (accessed 13 April 2021): \url{http://ow.ly/OxRL50Eujhv}

\textsuperscript{152} Ibid.

\textsuperscript{153} Ibid.
4.7.3 Violent and sexual offences in Newcastle

In 2020/2021, the rate of violent and sexual offences in Newcastle was 28.1 crimes per 1,000 head of population. Violent crime includes violence against the person, sexual offences and robbery. Figure 4.7.3-1 shows how this has varied over time, and figure 4.7.3-2 shows the rates for crime classified as ‘violence against the person’ by ward, with Byker, Monument, and Elswick having the highest rates. Please note that ‘violence against the person’ is a different definition, and does not include sexual offences.

Figure 4.7.3-1 Violent and sexual offences in Newcastle upon Tyne, 2015/16 to 2020/21\(^{154}\)

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Rate per 1,000 head of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>17.6</td>
</tr>
<tr>
<td>2016-17</td>
<td>31.3</td>
</tr>
<tr>
<td>2017-18</td>
<td>42.0</td>
</tr>
<tr>
<td>2018-19</td>
<td>47.7</td>
</tr>
<tr>
<td>2019-20</td>
<td>42.0</td>
</tr>
<tr>
<td>2020-2021</td>
<td>28.1</td>
</tr>
</tbody>
</table>

Note: Figures calculated using population data from the 2016 ONS mid-year population estimates. Violent and sexual offences are reported together in this Northumbria Police crime dataset.

Figure 4.7.3-2 Violence against the person in Newcastle in 2020/21 by ward\(^{155}\)

<table>
<thead>
<tr>
<th>Wards</th>
<th>Rate per 1,000 head of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Byker</td>
<td>75</td>
</tr>
<tr>
<td>Monument</td>
<td>51</td>
</tr>
<tr>
<td>Elswick</td>
<td>43</td>
</tr>
<tr>
<td>Walker</td>
<td>39</td>
</tr>
<tr>
<td>Benwell &amp; Gosforth</td>
<td>33</td>
</tr>
<tr>
<td>Walkergate</td>
<td>29</td>
</tr>
<tr>
<td>Denton &amp; Gosforth</td>
<td>28</td>
</tr>
<tr>
<td>Cullercoats</td>
<td>28</td>
</tr>
<tr>
<td>Gosforth</td>
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<tr>
<td>West Friernham</td>
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<tr>
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<tr>
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</tr>
<tr>
<td>Marsden Park</td>
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<tr>
<td>Dane &amp; Gosforth</td>
<td>10</td>
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<td>North Jesmond</td>
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</tr>
<tr>
<td>South Jesmond</td>
<td>8</td>
</tr>
</tbody>
</table>

Note: Figures calculated using population data from the 2018 ONS mid-year population estimates.

\(^{154}\) Ibid.

\(^{155}\) Ibid.
4.7.4 Burglary in Newcastle

In 2020/2021, the rate of burglary in Newcastle was 3.8 crimes per 1,000 head of population. Figure 4.7.4-1 shows how this has varied over time, and figure 4.7.4-2 shows the rates for burglary by ward, with Elswick, Monument and West Fenham having the highest rates.

Figure 4.7.4-1 Burglary in Newcastle upon Tyne, 2015/16 to 2020/21\(^{156}\)

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Rate per 1,000 head of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
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<td>2016-17</td>
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</tr>
<tr>
<td>2020-21</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Note: Figures calculated using population data from the 2016 ONS mid-year population estimates.

Figure 4.7.4-2 Burglary in Newcastle in 2020/21 by ward\(^{157}\)

Note: Figures calculated using population data from the 2018 ONS mid-year population estimates.

\(^{156}\) Ibid.
\(^{157}\) Ibid.
Newcastle Future Needs Assessment City Profile – Updated April 2021

4.7.5 Vehicle crime in Newcastle

In 2020/2021, the rate of vehicle crime in Newcastle was 3.4 crimes per 1,000 head of population. Figure 4.7.5-1 shows how this has varied over time, and figure 4.7.5-2 shows the rates for burglary by ward, with Byker, Heaton and Monument having the highest rates.

Figure 4.7.5-1 Vehicle crime in Newcastle upon Tyne, 2015/16 to 2020/21\textsuperscript{158}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure4751.png}
\caption{Rate of vehicle crime in Newcastle upon Tyne, 2015/16 to 2020-21}
\end{figure}

Note: Figures calculated using population data from the 2016 ONS mid-year population estimates.

Figure 4.7.5-2 Vehicle crime in Newcastle upon Tyne in 2020/21 by ward\textsuperscript{159}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure4752.png}
\caption{Vehicle crime rate in Newcastle upon Tyne by ward in 2020/2021}
\end{figure}

Note: Figures calculated using population data from the 2018 ONS mid-year population estimates.

\textsuperscript{158} Ibid.
\textsuperscript{159} Ibid.
4.7.6 Criminal damage and arson in Newcastle

In 2020/2021, the rate of criminal damage and arson in Newcastle was 13.2 crimes per 1,000 head of population. Figure 4.7.6-1 shows how this has varied over time, and figure 4.7.6-2 shows the rates for criminal damage and arson by ward, with South Jesmond, Ouseburn and Byker having the highest rates.

Figure 4.7.6-1 Criminal damage and arson in Newcastle upon Tyne, 2015/16 to 2020/21\(^{160}\)

<table>
<thead>
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</table>

Note: Figures calculated using population data from the 2016 ONS mid-year population estimates.

Figure 4.7.6-2 Criminal damage and arson in Newcastle upon Tyne in 2020/21 by ward\(^{161}\)

Note: Figures calculated using population data from the 2018 ONS mid-year population estimates.

\(^{160}\) Ibid.

\(^{161}\) Ibid.
4.7.7 Theft from the person in Newcastle

In 2020/2021, the rate of theft from the person in Newcastle was 13.2 crimes per 1,000 head of population. Figure 4.7.7-1 shows how this has varied over time, and table 4.7.7-2 shows the rates for theft from the person by ward, with Monument, Byker and Elswick having the highest rates.

Figure 4.7.7-1 Theft from the person in Newcastle upon Tyne, 2015/16 to 2020/21

![Theft from the person in Newcastle upon Tyne 2015/16 to 2020-21](image)

Note: Figures calculated using population data from the 2016 ONS mid-year population estimates.

Figure 4.7.7-2 Theft from the person in Newcastle upon Tyne in 2020/21 by ward

![Theft from the person in Newcastle upon Tyne by ward in 2020/2021](image)

Note. Figures calculated using population data from the 2016 ONS mid-year population estimates. Note that Monument ward includes the city centre.

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162 Ibid.
163 Ibid.
4.7.8 Anti-social behaviour in Newcastle

In 2020/2021, the rate of anti-social behaviour (ASB) in Newcastle was 13.2 reports to the police per 1,000 head of population (note that ASB is not classed as a crime). Figure 4.7.8-1 shows how this has varied over time, and table 4.7.7-2 shows the rates for anti-social behaviour reports by ward, with Monument, North Jesmond and Byker having the highest rates.

**Figure 4.7.8-1 Anti-social behaviour in Newcastle upon Tyne, 2015/16 to 2020/21**

![Graph showing anti-social behaviour rates from 2015-16 to 2020-21](image)

Rate per 1000 head of population

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
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<tr>
<td>2020-21</td>
<td>24.7</td>
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Note: Figures calculated using population data from the 2016 ONS mid-year population estimates.

**Figure 4.7.8-2 Anti-social behaviour in Newcastle upon Tyne in 2020/21 by ward**

![Graph showing anti-social behaviour rates by ward in 2020/21](image)

Rate per 1,000 head of population

<table>
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<td>Cullercoats</td>
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<td>Walker</td>
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<td>Benwell &amp; St Cuthbert</td>
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<td>Manor Park</td>
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</tr>
<tr>
<td>Parklands</td>
<td>22</td>
</tr>
</tbody>
</table>

Note: Figures calculated using population data from the 2018 ONS mid-year population estimates.

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164 Ibid.
165 Ibid.
4.8 Economy

This section of the Newcastle Future Needs Assessment City Profile was written immediately prior to the Covid-19 pandemic which began in March 2020. We are in the process of revising it to reflect the changed economic situation we now face, as more up-to-date data become available.

Newcastle is a major driver of growth and jobs, not just for the city, but also for the wider North East region. The city is home to a number of exceptional economic and educational assets. We have two world-class universities which are ‘anchor institutions’ for our economy that have strong links to our sectoral strengths, for which they provide innovation facilities, research collaborations and a skills base. We also have a responsive education sector.

The city is the strategic gateway for the wider region, home to the future HS2 Hub at Newcastle Central Station, which is used by over 8 million passengers each year, and Newcastle International Airport, the second largest airport in the North of England and of strategic importance to the UK as a whole.

In 2019 there were 8,190 businesses in the city. The overall annual business birth figure for 2018 was 1,260. However, there were 1,135 business deaths in the same year. Newcastle has a 85.5% one year survival rate for newly born businesses, below the UK average of 89%. The number of high-growth businesses in the city is the highest in the North East region\textsuperscript{166}.

NOMIS Official Labour Market Statistics show that the employment rate in Newcastle stands at 69.5% of the working-age population, significantly higher than 64.7% in 2014, but nevertheless still remains lower than the national employment rate of 75.7%\textsuperscript{167}. The rate and number of people in employment in Newcastle is at a historically high level, but recent falls indicate that the trend of a strengthening labour market may have levelled off.

The Public Health Outcomes Framework provides a useful graphical display of the city’s employment rate compared with regional data, although it is not updated as frequently\textsuperscript{168}. The occupational split of the city reflects its role as a regional capital, with a relatively high concentration of managerial, professional and technical roles. The proportion of employment in the city that is managerial, professional and technical has increased from just over 40% three years ago to just over 50%. The latest data from NOMIS shows a rise in the proportion of elementary roles, but there is insufficient data to determine if this is an ongoing trend or a short-term statistical effect\textsuperscript{169}.

The diversity of the city’s sector and employer base has served it well during recent downturns, ensuring resilience to economic shocks with the area not overly reliant on just a single sector or a small number of particularly large employers. Newcastle has significant strengths in business and professional services, health and life sciences, low carbon energy sector, one of the fastest growing digital sectors in the country, a strong visitor offer and great manufacturing businesses.

The unemployment rate in Newcastle is 5.4%. This compares to 5.7% for the North East and 3.9% nationally. While unemployment has been falling in Newcastle, it has been rising in the rest of the region, demonstrating the importance of the City in providing jobs. However, recent trends suggest that continued falls in unemployment in the City has come to an end at least for now. Since December 2014, the unemployment rate has reduced from almost 10%, by over 5,000 residents, but there appears to be a risk of a rise in the coming months.

Newcastle has a strong job density figure (this is the number of jobs in an area divided by its resident working-age population) of 1.01, which is above the wider North East average of 0.73 and the Great Britain average of 0.86. This means that there is one job for every resident aged between 16-64 in Newcastle. This is a reflection of the city’s sector strengths in financial, business and professional services, life sciences, digital, energy, retail, culture and creative industries, as well as our major new employment sites, notably in the city centre: the Newcastle Helix site, East Pilgrim Street, and the Stephenson Quarter.

Self-employment has added to the increase in employment in the city which has seen the number of self-employed people double over the last decade. In 2004 there were approximately 10,000 people self-employed in Newcastle, this now stands at around 20,000 (9.6%) which is higher than the regional level 8.5 but lower than the national average of 10.8%.

The split of full- and part- time employees in Newcastle is 67% to 33%, and this is broadly the same as regional and national averages. Precarious employment is a growing issue in Newcastle, just as it is nationally, with the rise in casual agency work, zero hours and short-hour contracts affecting many.

In 2018 there were 330 young people (those aged between 16 and 17) in Newcastle who were not in employment, education or training (NEET). This equates to 6.2% of that age group and is lower than the North East average (6.5%), but higher than the England average of 5.5%. This data is available and updated in the Public Health Outcomes Framework.

Average gross weekly pay for full-time workers in Newcastle in 2019 was £563, compared to £531 in the North East and £587 for Great Britain. The gap between Newcastle and the national average has narrowed from almost £75 per week in 2010, to just £24 per week in 2019. Compared to the regional average, Newcastle wages have increased from £16 per week lower in 2010, to £32 per week higher in 2019.

Of working-age Newcastle residents who are economically inactive, 45% are students, which represents the city’s large student population from two major universities: Newcastle University and Northumbria University. This proportion of students is significantly higher than the regional and national averages (24% and 27% respectively). This also contributes towards Newcastle’s high proportion of residents with NVQ4 or above qualifications, which is above the national average.

170 Ibid.
171 Ibid.
Source: http://ow.ly/B31P50Eukv8
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Of working-age Newcastle residents who are economically inactive, the second largest group (20%) are long-term sick\textsuperscript{175}.

The number of people claiming Job Seeker’s Allowance or Universal Credit due to unemployment was 9,105 (4%) in January 2020. This is above the national average of 3%. In Newcastle, this equates to just over 400 more people claiming benefits than one year earlier\textsuperscript{176}.

### 4.9 Learning disabilities and Autistic Spectrum Disorders

#### 4.9.1 Adults with a learning disability

The number of people in Newcastle aged 18-64 predicted to have a learning disability in 2019 was 4,869, and this is predicted to decrease slightly to 4,822 by 2025 but then increase to 4,930 by 2035. This is shown in figure 4.9.1-1 below.

**Figure 4.9.1-1: People in Newcastle aged 18-64 with a learning disability\textsuperscript{177}**


\textsuperscript{176} Ibid.

The number of people in Newcastle aged 65 and over predicted to have a learning disability in 2019 was 910, and this is predicted to rise to 1,011 by 2025 and 1,192 by 2035. This increase is in line with predicted growth in older population sizes, which is shown in figure 4.9.1-2 below.

**Figure 4.9.1-2: People in Newcastle aged 65+ with a learning disability**

![Graph showing predicted number of people aged 65+ with a learning disability in Newcastle from 2019 to 2035.](image)

**4.9.2 Adults with autistic spectrum disorders**

The number of people in Newcastle aged 18-64 predicted to have autistic spectrum disorders in 2019 was 2,011 and this is predicted to decrease slightly to 1,995 by 2025 but then increase to 2,047 by 2035. This is shown in figure 4.9.2-1 below.

**Figure 4.9.2-1: People in Newcastle aged 18-64 with autistic spectrum disorders**

![Graph showing predicted number of people aged 18-64 with autistic spectrum disorders in Newcastle from 2019 to 2035.](image)

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178 Ibid.
179 Ibid.
The number of people in Newcastle aged 65 and over predicted to have autistic spectrum disorders in 2019 was 409, and this is predicted to rise to 460 by 2025 and 539 by 2035. This is shown in figure 4.9.2-2 below.

Figure 4.9.2-2: People in Newcastle aged 65 and over with autistic spectrum disorders\textsuperscript{180}

4.10 Physical disabilities including mobility and personal care

4.10.1 People with a disability
The Census 2011 data suggests 18.7\% of people in Newcastle have a long-term health problem or disability that limits their day-to-day activity to some degree, which is a reduction from 21.6\% in 2001 (the previous Census date). We will analyse the Census 2021 data for a more up-to-date picture as soon as it is available.

In 2018-2019 Newcastle City Council adult social care received 9,968 new requests for social care support and it provided long-term services to 5019 adults aged 18 and over\textsuperscript{181}.

4.10.2 People with impaired mobility
'Mobility activities’ include: going outdoors and walking down the road, getting up and down stairs; getting around the house on the level (not going up stairs), getting to the toilet, and getting in and out of bed. The number of people in Newcastle aged 18-64 predicted to have impaired mobility in 2019 was 8,694 and this is predicted to rise to 8,725 by 2025 but then reduce slightly to 8,371 by 2035\textsuperscript{182}. This is shown in figure 4.10.2-1 on the next page.

\textsuperscript{180} POPPI, September 2020. Online at (accessed 19 April 2021): \url{https://www.poppi.org.uk/}
\textsuperscript{181} SALT 2018/2019 (Short and Long Term Services), reported to NHS Digital in July each year.
The number of people in Newcastle aged 65 and over predicted to be unable to manage at least one activity on their own in 2019 was 8,047, and this is predicted to rise to 8,814 by 2025 and 10,893 by 2035. This is shown in figure 4.10.2-2 below.

**Figure 4.10.2-1: People in Newcastle aged 65+ with impaired mobility**

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183 Ibid.

4.10.3 Personal care and self-care

The number of people in Newcastle aged 18-64 predicted to have a moderate or serious disability requiring support with personal care in 2019 was 7,816 and this is predicted to rise to 7,754 by 2025, but then reduce slightly to 7,539 by 2035. This is due to a predicted reduction in the 45-54 age group, whilst other age groups are expected to continue to increase. This is shown in figure 4.10.3-1 below.

Figure 4.10.3-1: People in Newcastle aged 18-64 predicted to have a moderate or serious personal care disability

During 2018-2019 there were 294 people aged 18-64 who received long-term social care support services from Newcastle City Council adult social care for the reason ‘physical support: personal care’.  

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186 SALT 2018/2019 (Short and Long Term Services), reported to NHS Digital in July each year.
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The number of people in Newcastle aged 65 and over predicted to need help with at least one self-care activity in 2019 was 12,447, and is predicted to rise to 13,693 by 2025 and 16,485 by 2035. The largest rise is expected to be within the age group of people aged 80 and over. This is shown in figure 4.10.3-2 below.

**Figure 4.10.3-2: People in Newcastle aged 65 and over predicted to need help with at least one self-care activity**

![Graph showing predicted number of people needing self-care help by age group from 2019 to 2035.](image)

During 2018-19 there were 1669 people aged 65 and over who received long-term social care support services from Newcastle City Council adult social care for the reason: 'physical support: personal care'.

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188 SALT 2018/2019 (Short and Long Term Services), reported to NHS Digital in July each year.
4.11 Sensory disabilities

4.11.1 People aged 18-64 with a visual impairment

The number of people in Newcastle aged 18-64 predicted to have a severe visual impairment in 2019 was 127. The numbers are predicted to remain static over the next 15 years. This is shown in figure 4.11.1-1 below.

Figure 4.11.1-1: People in Newcastle aged 18-64 predicted to have a visual impairment

During 2018-2019, there were 18 people aged 18-64 who received long-term social care support services from Newcastle City Council adult social care for the reason: ‘sensory support: visual impairment’.  

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190 Ibid.
4.11.2 People aged 65 and over with a visual impairment

The number of people in Newcastle aged 65 and over predicted to have a moderate or severe visual impairment in 2019 was 3827. The numbers are predicted to increase to over 4,000 by 2025 and 5,000 by 2035. Figure 4.11.2-1 presents further detail, and presents the predicted trend for those aged 75 and over who have registrable eye conditions.

Further details about how these figures are calculated are available on the POPPI website. Similar figures for under 18-year olds are not available. During 2018-19, there were 46 people aged 65 and over who received long term social care support services from Newcastle City Council adult social care for the reason: ‘sensory support: visual impairment’. 

192 SALT 2018/2019 (Short and Long Term Services), reported to NHS Digital in July each year.
4.11.3 Adults with a hearing impairment

In 2019, there were a total of 4,846 people in Newcastle aged over 18 years predicted to have a severe hearing impairment. This figure is expected to increase to 5,300 by 2025 and to 6,539 by 2035. Figure 4.11.3-1 below shows further detail, including predicted trends by age groups.

Figure 4.11.3-1: Adults in Newcastle predicted to have severe hearing loss\(^{193}\)

![Graph showing predicted severe hearing loss in Newcastle by age group](image)

During 2018-19 there were 23 people of all ages who received long term social care support services from Newcastle City Council adult social care for the reason: 'sensory support: hearing impairment'\(^{194}\).

4.12 Loneliness and social isolation

There is an identified link between loneliness and both poor mental and physical health. Loneliness and social isolation can display in feeling disconnected from family, friends and local communities, and withdrawing from usual activities.

4.12.1 Adult social care users

In Newcastle, just under half (49.3%) of adult social care users (aged 18 and over) have as much social contact as they would like. This is higher than the figure for England overall and in line with the North East figure. The latest data from the Newcastle Adult Social Care Survey (ASCS) 2019/2020 estimates that 5.4% of Newcastle adult social care users have little social contact with people and feel socially isolated, which is slightly lower than the


\(^{194}\) Ibid.
national average of 6.3%. Considering groups which are more likely to feel socially isolated, analysis shows that adults with a primary support reason of ‘mental health’ are most likely to feel socially isolated due to lack of social contact (9.2% nationally). Additionally, service users aged 18-64 (excluding those with learning disability support) are more likely than their older counterparts to report having little social contact and feeling socially isolated.

A large proportion of adult social care users are aged 65 and over, with more support with basic care needed due to the increased prevalence of health conditions and decline in general health and mobility experienced as people age. An estimated 48% of adult social care users aged 65 and over in Newcastle have as much social contact as they would like, which is higher than the England figure and in line with the figure for the North East195.

4.12.2 Adult carers

As well as people receiving adult social care, those who provide unpaid care to another person or persons are at risk of experiencing social isolation. In Newcastle, 44.1% of adult carers (those aged 18 and over) have as much social contact as they would like, which is higher than both the North East (39.6%) and England (32.5%) figures. Newcastle has consistently performed better in this context than England since 2012/2013. Around one in ten adult carers in Newcastle state they have little social contact with people and feel socially isolated (11.2%)196.

Analysis of data from the Survey of Adult Carers in England (SACE) 2018/2019 also shows some variation in the degree of social contact between different demographic characteristics at the national level. Adult carers aged between 18-24 are most likely to have as much social contact as they would like (41.7%), whilst those aged between 25 and 54 are least likely (26.8%-29.3%) to say this. Around one-quarter of adult carers aged between 25-34 (24.5%) and 35-44 (24.4%) report feeling socially isolated197.

4.13 Mental health and wellbeing

Many people will experience poor mental health at some point in their lives, with many factors known to influence mental health. The severity of poor mental health varies significantly from person to person and what works for one may not work for another. Multiple factors have been linked to improving and supporting mental wellbeing, including meaningful social interaction, being outdoors, and looking after your physical health through regular exercise and a balanced diet. However, for some people poor mental health can last for many years or across their entire life, in which additional provisions needs to be in place for support.

4.13.1 Children and young people

The latest data (for 2018) indicates an estimated 2.4% of primary school pupils have social, emotional and mental health needs in Newcastle, slightly lower than the national figure at 2.2%. In contrast to the national data, the proportion of secondary school children

197 Ibid.
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with social, emotional and mental health needs is lower than primary age children in Newcastle (1.9%) and lower than the national figure.

Hospital admission as a result of self-harm in 10-14 year olds in Newcastle has fluctuated over the last five years but has generally been higher than national figures, the latest data (2017/18) at 292.5 per 100,000 compared to 210.4 nationally. Looking at the slightly older age group of 15-24 year olds, hospital admissions as a result of self-harm in Newcastle have been generally lower than nationally, at 635 per 100,000 compared to 649.6 at a national level\(^{198}\).

4.13.2 Common mental health disorders

The most recent data (for 2017) indicates that an estimated 18.9% of the Newcastle population aged 16 and over have a common mental disorder (CMD), defined as any type of anxiety or depression. This is similar to the North East level (18.2%), but slightly higher than the national figure (16.9%). Looking at older age groups, the estimated prevalence of CMD in the Newcastle population aged 65 and above is at 11.5%, again in line with the regional figure of 11.3% in this population, and slightly higher than the national figure (10.2%).

The recorded prevalence of depression is measured through the estimated number of people with depression recorded on their practice register, as a proportion of the practice list size in the local authority area. This figure is lower in Newcastle than all other local authorities in the North East, with a prevalence of 8.4%. This is also lower than the estimated prevalence in England of 9.9%.

The trend from the last five years indicates an increase in prevalence of depression at a national, regional and local authority level. This is partially due to the reduction in negative stigma traditionally associated with mental health in recent years (though this stigma has not been eradicated), meaning that more people feel comfortable asking for support with their mental health\(^{199}\).

4.13.3 Severe mental illness

Quarterly data on the rate of people subject to the Mental Health Act is measured at Clinical Commissioning Group (CCG) level. The Newcastle and Gateshead CCG area has a higher rate than the national figure, and this has been the trend since data was first recorded in 2013/2014. In quarter 2 of 2019/2020, the rate was at 56.8 in Newcastle and Gateshead, compared to 45.6 nationally.

The rate of mental health admissions to hospital per 100,000 of the population has been consistently lower in NHS Newcastle and Gateshead CCG than in England. The latest data for Quarter 2 in 2019-2020 indicated a rate of 167.9 in Newcastle and Gateshead compared to 276.7 at a national level\(^{200}\).

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\(^{199}\) Ibid.

\(^{200}\) Ibid.
### 4.14 Substance misuse

Substance use may have negative short-term and long-term effects, both on the user and the wider population. For the user it can lead to addiction, poor health and social outcomes, homelessness, job loss, family breakdowns and in some cases death. To overcome substance use may require professional treatment, which can take years even once in recovery. Substance use not only affects the user but those closest to them, such as partners, children, other family and friends. For the wider population, substance use can affect neighbourhoods through drug litter, antisocial behaviour, and petty or organised crime.

#### 4.14.1 Drug Treatment - Introduction

Treatment for substance use is available in Newcastle for both young people and adults. The treatment of adults with substance misuse is not directly comparable to the treatment of young people (aged under 18), as there are different factors to consider and strategies may differ. In terms of outcomes and indicators the National Drug Treatment Monitoring System (NDTMS) provides publicly accessible reports on treatment service performance in England and for Local Authorities.\(^\text{201}\)

#### 4.14.2 Young People – Substance Use Treatment

Nationally the number of young people in treatment has been declining since the start of the decade; from 24,165 in 2009/2010 to 14,291 in 2019/2020.\(^\text{202}\) Locally, the number of young people in treatment has also declined over this time period. Young peoples’ treatment services are usually a separate service in order to cater to the unique response required for this population, that takes into account both age and maturity as well as the substance problem. Low counts of young people in substance-use treatment is not uncommon.

#### 4.14.3 Adults – Substance Use Treatment

NDTMS monitor numbers in adult treatment under the categories: opiate users, non-opiate only users, alcohol only users and alcohol and non-opiate users. It is important to note, however, that substances among the population in treatment are rarely used in isolation, with many using more than one substance. The number of opiate users in treatment in Newcastle declined between from 2009/2010 to 2014/2015. Since then, the numbers of those in treatment have remained similar each year.

Opiate users make up the largest number of those in substance-use treatment in Newcastle. The next highest number of those in treatment are those seeking treatment for alcohol-only issues. During the period 2016/2017 to 2019/2020, this count has been decreasing. Non-opiate and alcohol users are the third highest count in treatment; the count of those in treatment in Newcastle has remained relatively stable over the decade. The smallest count of those in treatment in Newcastle come under the non-opiate only category.

NDTMS and Public Health England monitor successful completions of drug treatment in three main categories: opiate users, non-opiate users, and alcohol-only users. In many complex cases, whilst users may be in recovery it may be necessary to remain under

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\(^{201}\) National Drug Treatment Monitoring System (NDTMS), online at (accessed 31 March 2021): [http://ow.ly/Sd3Y50Eum0D](http://ow.ly/Sd3Y50Eum0D)

\(^{202}\) Ibid.
treatment for some years, for example if receiving medically-assisted recovery (such as methadone). Therefore, the rate of successful treatment completions is not always the best indicator of how a service is performing.

Successful completion of drug treatment in opiate users is defined as the proportion of opiate users who complete treatment and do not re-present within 6 months of discharge, out of all opiate users in treatment. The proportion of successful opiate completions in Newcastle has been decreasing recently, and this trend has also been seen regionally. In 2019 1.6% of opiate users successfully completed treatment in Newcastle (22 cases), compared to 3.9% regionally and 5.6% nationally.

Successful completion for treatment in non-opiate users is defined as 'the proportion of non-opiate users who complete treatment and do not re-present within 6 months'. After a period of decline from 2013 to 2017, this indicator has seen a small improvement in Newcastle in recent years. However, Newcastle's most recent score is still significantly worse than the regional and England figures. In 2019, 21% of non-opiate users in Newcastle successfully completed treatment (93 people). This proportion was 27.3% regionally, and 34.2% for England203.

Successful completion of alcohol treatment figures can be found in the alcohol-related harm section (section 4.3).

### 4.14.4 Hospital admissions with a primary diagnosis of a drug-related mental or behavioural disorder

This indicator measures admissions for a drug-related mental or behavioural disorder. In 2019/20 there were 45 finished admission episodes for drug-related mental or behavioural disorder in Newcastle: 30 for males and 15 for females. As a rate per 100,000 this equates to 13 overall: 18 for males and 8 for females.

Newcastle has a similar rate to the England rate for all three. In comparison to the regional rate, the Newcastle overall rate and rate for males is lower. The rate for females both locally and regionally is similar. Looking at change over time, for Newcastle, after a period of increase up to 2018/2019, the latest data is now showing a decline in the rate, and this is also seen regionally. Nationally, the rate has plateaued since 2016/2017.

### 4.14.5 Hospital admissions with a primary or secondary diagnosis of drug-related mental or behavioural disorder

This indicator measures hospital admissions where drug-related mental and behavioural disorders were a factor in admission. There were 660 admissions for this indicator in Newcastle in 2019/2020: 425 males and 230 females (numbers have been rounded). In terms of rate per 100,000 this equates to 230 compared to 283 regionally and 181 in England. Newcastle has a higher female rate compared to the rate for the North East or England.

The longer-term trend of the rate per 100,000 in Newcastle, North East and England from 2013/2014 to 2019/2020 demonstrates an increase across all three over the time period. The increase in rate is more pronounced in the North East, compared to Newcastle or England204.

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203 Ibid.
204 Ibid.
4.14.6 Finished admission episodes for poisoning by drug misuse

This indicator is defined as ‘hospital admissions with a primary diagnosis of poisoning by drugs, that are also listed as controlled under the Misuse of Drugs Act 1971’ and includes both intentional and unintentional poisoning. In 2019/2020 there were 150 admissions for poisoning by drug misuse in Newcastle: 60 male and 90 female. This equates to 49 per 100,000. Newcastle’s rates of admissions both overall and in males is lower than the regional rate, but higher than the England rate. In females, the Newcastle rate is higher compared to both the regional rate and the rate for England.

Looking at the longer-term trend of the total rate for Newcastle, the North East and England for this indicator from 2013/2014 to 2019/2020 demonstrates that the rate for Newcastle had been increasing since 2016/2017, but in 2019/2020 it remained the same as the previous year. Both the North East and England saw a decline in rate from 2018/2019, although they too been showing an increase in rate prior to this time period.

4.14.7 Drug-related deaths

Deaths from drug use can be broadly grouped into two categories: deaths from drug poisoning, and deaths from drug misuse. This includes accidental and intentional self-poisoning. The distinction is that deaths from drugs misuse are defined as: “deaths which are coded with an underlying cause of death that relates to mental and behavioural disorders due to psychoactive substance use (but excluding alcohol, tobacco and volatile solvents) AND that have a drug controlled under the Misuse of Drugs Act 1971 listed on the death record”.

The Office for National Statistics (ONS) publishes age-standardised mortality rates for both drug poisoning and drug misuse. These rates are calculated by combining figures over two-year periods, for example: 2016 to 2018, 2017 to 2019, and so on. It is important to note that ONS calculated the rates using the date when the death was registered, rather than the date when it occurred. With drug-related deaths there is usually a gap between these two dates, as a coroner is involved in most cases. Therefore, some deaths that are included in one year’s data may have in fact occurred in a previous year. This is unlikely to affect the rates, but is worth noting for methodology.

The age-standardised mortality rate for deaths related to drug poisoning has been increasing in Newcastle. The latest rate for 2017/2019 is 13.9 (114 deaths) compared to 13.1 in the North East and 7.1 in England. The rate in Newcastle is higher in males (19.8) than females (8.0).

There has also been an increase in recent years in the age-standardised mortality rate for drugs misuse in Newcastle, with the most recent rate for 2017-2019 at 10.3 (85 deaths). For comparison, the rate is 9.1 in the North East, and 4.7 in England for the same time period. As with drug poisonings, the rate is higher in males in Newcastle (14.6) than females (6.0).

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206 Ibid.
4.15 Tobacco control

Smoking can be a major risk factor to many diseases including cancer, heart disease and respiratory diseases, yet it is a modifiable behavioural risk which can be reduced through public health control measures and interventions.

4.15.1 Smoking prevalence

Approximately 13% of the adult population in Newcastle were smokers in 2019 (based on weighted estimates of self-reported smokers in the Annual Population Survey) compared to 15.3% in the North East and 13.9% in England. Newcastle had the second lowest estimated percentage of smokers in the North East208.

Smoking in pregnancy can be detrimental to both the expectant mother’s and the foetus’ health with complications during birth also being a risk, as is the exposure of infants to second-hand smoke. Health services are therefore encouraged to document smoking status in pregnant women and make interventions available to help them quit smoking. In 2019/2020, 12.8% of new mothers in Newcastle were recorded as smokers at the time of delivery. From 2010 to 2016 this indicator decreased, but in recent years there has been no significant change. The percentage of mothers recorded as smoking at time of delivery for Newcastle is significantly worse than the England figure (10.4%) in 2019-2020209.

4.15.2 Smoking-related ill-health

The recent trend of smoking-attributable hospital admissions has been decreasing. However, the rate of admissions is still significantly worse than the England rate. Newcastle has the fifth highest rate in the region for smoking attributable hospital admissions (out of 12 local authority areas).

There is a known link between tobacco use and cancer, in particular lung cancer which is one of the more difficult cancers to treat. The directly standardised rate (DSR) of lung cancer registrations in Newcastle in 2016-2018 was 123.4 per 100,000. This equates to approximately 811 lung cancer registrations among the population. By comparison, the North East DSR was 106.7, and the England DSR 77.9. In 2016-2018 Newcastle had the second highest rate of lung cancer registrations in the North East (second to Middlesbrough)210.

4.15.3 Wider smoking-related impacts on society

Smoking not only has an impact on the smoker, but wider implications and costs for society. There is a myth that the revenue collected by the Treasury on taxes on tobacco products is profitable, but the costs to society at large from smoking outweigh any revenue. Smoking costs Newcastle communities approximately one and a half times as much as the revenue raised from tobacco duties. This is shown using Action on Smoking and Health’s Ready Reckoner tool that calculates and estimates costs to society from the smoking population.

For Newcastle, the tool estimates that each year the social costs of smoking total £67.7 million. This includes costs to healthcare across the NHS from smoking in Newcastle (£12.6m), potential wealth lost due to lost productivity (£49.6m), formal health and social

209 Ibid.
210 Ibid.
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care provision to adults with health conditions from smoking (£4.1m), and house fires (£1.4m). Another cost to society is the 15 tonnes of smoking-related waste produced annually, of which it is estimated that six tonnes is discarded as street litter. It is estimated that each smoker in Newcastle spends roughly £2000 a year on smoking products²¹¹.

4.15.4 Quitting smoking

Stopping smoking has been shown to be one of the most effective health interventions for decreasing risk of poor health. The Newcastle City Council Public Health team commission a free-of-charge Stop Smoking service available to people in Newcastle who wish to quit smoking. The crude rate of smokers setting a quit date in Newcastle has increased in recent years and is currently 5,632 per 100,000 in 2019/2020²¹². This is significantly better than the England rate. However, it should be noted that stop smoking services are not universal across England, with different service models and inclusion criteria making it difficult to compare services' performance to each other.

4.16 Obesity

Obesity is a significant ongoing issue in England, with around two-thirds of the population carrying excess weight and half of this group being defined as obese²¹³. Being overweight is linked to various and multiple health issues and conditions, worsened by continuing to carry excess weight for many years. Tackling obesity is key to improving the life expectancy and health of the nation, as well as reducing the strain on our healthcare services.

The prevalence of obesity is highest in the most deprived areas of the country. Across the North East region there are areas with high levels of deprivation, some among the most deprived in England, with the prevalence of obesity reflecting this. The latest data indicates Newcastle has a lower proportion of adults carrying excess weight than both the North East region and England overall. Three in every five adults in Newcastle are estimated as being overweight or obese (60.3%), compared to 64.9% regionally and 62.3% nationally.

Newcastle has the lowest percentage of adults classified as overweight or obese in the North East. However, it is likely that prevalence of carrying excess weight varies across the city due to health and social inequalities as well as inequality in life expectancy between wards.

National figures indicate that having specific characteristics links to a higher prevalence of adults being overweight or obese. Men are more likely than women to carry excess weight: 68.5% adult men carry excess weight, with the national rate for all adults being 56.1%. The prevalence of carrying excess weight in Year 6 (children aged 10-11) does not dramatically change until age 25, from which point age correlates positively with the proportion of overweight or obese adults.

²¹³ More information about Newcastle’s Stop Smoking Service can be found here: http://ow.ly/4Zch50EulYG

²¹³ From WHO – these may be defined as follows: “[Being] overweight and obesity are defined as ‘abnormal or excessive fat accumulation that presents a risk to health’. A body mass index (BMI) over 25 is considered overweight, and over 30 is obese.” Online at (accessed 6 April 2021): http://ow.ly/1c5p50EulZy
Moreover, 70.7% of adults who have a disability were overweight or obese in 2018/2019, compared to 60.6% of non-disabled adults. Many disabilities can cause mobility issues, leading to reduced physical activity or a lack of it, and subsequent carrying of excess weight\textsuperscript{214}. Recent data covering 2019/2020 on the national prevalence of excess weight in people aged 18 and older with learning disabilities indicates a higher prevalence of obesity in people with a learning disability compared to those without: 37.0% and 30.1% respectively\textsuperscript{215}.

\section*{4.17 Physical activity}

Regular physical activity has been linked to improving general health as well as supporting mental health and wellbeing. The current national recommendation is that adults undertake a minimum of 150 minutes of moderate physical activity per week, 75 minutes of vigorous activity per week, or a combination of the two. Physical inactivity is defined as doing less than 30 minutes of moderate physical activity per week.

\subsection*{4.17.1 Physical activity and inactivity among adults}

The latest figures from 2018/2019 indicate that 67.2% adults (aged 19 and over) in England are physically active. Physical activity is somewhat lower in the North East than other regions, at 64.9%. Newcastle has a higher level of physical activity than England, and the second highest in the North East region, with an estimated 69.2% of the adult population in Newcastle physically active in 2018/2019.

Just over one in five adults (21.4%) in England are physically inactive, the North East having a higher proportion of physical inactive adults. The proportion of adults physically inactive in Newcastle is again very similar to the national figure (21.9%) and slightly better than the North East region (23.8%). Both physical activity and physical inactivity in Newcastle have stayed relatively stable over the last four years, following similar trends to England.

Various factors affect people’s likelihood of being physically active or inactive, such as physical barriers to activity, or a difference in attitude towards the perceived importance of physical activity among other reasons. On a demographic level, as people age, they are increasingly more likely to be physically inactive, and this is most notable among those aged 75 and over. This is linked to multiple factors including physical capability, the existence of health conditions that are exacerbated by exercise or difficult to manage, and people having the confidence to go outside for physical activity. However, it is as important for older people’s physical and mental health to have some level of physical activity every week as it is for younger people.

Health conditions can also act as barriers to physical activity. At a national level, people who describe themselves as having a disability are twice as likely to be physically inactive than those without disabilities: 35.0% compared to 17.6% respectively. There is also a link between physical activity and ethnicity; people who are from Black and Asian ethnic groups are more likely to be physically inactive than other ethnic groups.

\textsuperscript{214} PHE, ‘Local Authority Profile - Obesity’. Online at (accessed 6 April 2021): http://ow.ly/5KGC50Eum4k
People who are in work are more likely to be physically active than those not actively working. Fewer than one in five employed adults are physically inactive compared to 30.4% unemployed adults and 29.1% adults with a working status as inactive. Only half of people who have either never worked or are long-term unemployed are physically active (49.9%), compared to 59.9% routine and manual workers, 67.4% in intermediate occupations, and 75.9% in managerial and professional occupations.

The higher a person’s socioeconomic status, and in turn their level of pay, the more likely they are to maintain a physically active lifestyle. Educational attainment has also been linked to level of physical activity, less than half of adults with no qualifications are physically active compared to three-quarters of adults with Level 4 qualifications and above\(^\text{216}\).

### 4.17.2 Physical activity and inactivity among children and young people

Physical activity in children is an essential part of development, maintaining health, promoting mental wellbeing and forming social bonds with others through physical activities and sport. However, less than half of children and young people (ages 5 to 16) in England are physically active. The proportion of children physically active in Newcastle is similar to both the national and regional figures at 45.7%.

There are variations between different demographic characteristics. At a national level, a greater proportion of boys are physically active than girls, and there is also variation in activity levels between ethnic groups in which White and Mixed ethnic groups are more physically active than Asian ethnic groups. The gap in physical activity prevalence is less pronounced between White and Black ethnic groups in childhood than adulthood.

While physical activity is a core part of the school curriculum, the data suggests that as children get older, they are less likely to engage in physical activity beyond school requirements. A higher percentage of children in Year 1 and 2, aged 5 to 7 years, are physically active (52.0%), than young people in Years 7 to 11, aged 11 to 16 (45.3%)\(^\text{217}\).

### 4.17.3 Active travel

Active travel involves walking or cycling as a mode of transport to a destination, this may be to work, school or to leisure facilities. An evidence review conducted by Public Health Evidence has found great benefits to walking and cycling as a mode of travel, including reducing the risk of long-term conditions such as cardiovascular and respiratory diseases, and Type 2 diabetes, as well as providing neurological benefits and improving mental wellbeing\(^\text{218}\). Active travel has benefits for the wider environment, reducing road congestion, particularly in inner city areas, and improving air quality, which in turn supports the health of the general population.

A higher percentage of adults in Newcastle walk as a mode of transport at least three days per week than at a regional and national level, 29% compared to 22.7% nationally and 18.4% at a North East region level. The prevalence of cycling is much lower, although Newcastle again has a higher level of prevalence than in England as a whole: 4.8% of Newcastle adults cycle for travel at least three days per week, compared to 3.1% in the

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\(^{217}\) Ibid.

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population of England overall. The infrastructure of the city, with cycle lanes, bike-friendly community transport networks and pedestrian-friendly zones, promotes active travel\(^\text{219}\).

### 4.18 Sexual and reproductive health in adults

Sexual and reproductive health affects the entire population. Key indicators of good sexual and reproductive health and education in a population include rate of sexually transmitted infections (known commonly as STIs or STDs), rate of teenage pregnancy and equitable access to sexual health services, contraception and terminations. In addition, socio-economic deprivation, education, availability of alcohol and sexual offenses should be considered as wider influences in the sexual health of a population. This section focusses on sexual and reproductive health in the adult (18 and over) population. Sexual and reproductive health in younger people can be found in section 3.10, which the exception of Chlamydia screening among people aged 15 to 24, which is discussed below in section 4.19.2.

#### 4.18.1 Prevalence of Sexually Transmitted Infections (STIs)

STIs are a common public health concern among the population. Left untreated, some STIs can affect long-term health with a range of complications including cardiovascular and neurological damage, Pelvic Inflammatory Disease (PID), and adverse pregnancy outcomes. Some STIs can be asymptomatic, and so regular testing is recommended among the population to reduce risk of long-term health issues and transmission.

The crude rate of all new STI diagnoses (excluding Chlamydia in under-25s) in Newcastle was 941 per 100,000 in 2019. The trend over the last decade for this indicator has remained mostly static, similar to the regional trend.

The crude rate of syphilis diagnosis has been reducing in recent years, with the latest data showing a crude rate of 9.2 per 100,000. This is the opposite to the trend at the national level, which has been seeing an increase in syphilis diagnoses over the decade.

The crude rate of gonorrhoea has increased over the decade, following the England trend, but is statistically significantly higher than England. Current crude rate in Newcastle is 145 per 100,000 in comparison to 63 per 100,000 in 2012\(^\text{220}\).

#### 4.18.2 Chlamydia

Chlamydia is an STI where the burden of the infection mostly falls on the younger population. As such, Public Health England runs a National Chlamydia Screening Programme with a focus on those aged 15 to 24 years old. In 2019, 23.7% of Newcastle population aged 15 to 24 were screened for Chlamydia, which is statistically better than the England percentage. When looking at the long-term trend, the percentage of Newcastle’s young population screened has been declining over the decade.

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The detection rate of Chlamydia was 2,058 per 100,000 population in 2019. This is similar to the detection rate for England as a whole\textsuperscript{221}.

4.18.3 HIV

Knowing their HIV status can increase a person’s survival rate and quality of life, and reduce transmission risk. Please note that data about HIV testing coverage show the number of eligible attendees at sexual health services who accept a HIV test, not how many had positive test results.

70.9% of eligible attendees in Newcastle in 2019 accepted an HIV test. This is significantly better than the regional (65.6%) and national (64.8%) proportion in the same time period. Testing coverage among men was 80.7% and among women 63.8%. Testing coverage specifically among Men who have Sex with Men (MSM) was 93.2\textsuperscript{222}.

4.18.4 Contraception

Access to contraception and choice of methods should be available across a population. NICE guidance recommends the use of Long-Acting Reversible Contraception methods (LARC) for their effectiveness (they do not rely on the user remembering to comply with them, for example remembering to take a pill each day) and cost effectiveness (some can last as long as 5 to 10 years). The crude rate per 1,000 of use of LARC in Newcastle (excluding injections) in 2019 was 58.8 (4,062 people). This is higher than the national (49.5) and regional (38.7) rate\textsuperscript{223}.

4.18.5 Termination of pregnancy (abortions)

The crude rate of termination of pregnancy (abortions) per 1,000 in women aged 15 to 44 years old in Newcastle has remained similar across recent years. In 2019 the rate in Newcastle was 15 per 1,000 (1,051 people). This is lower than the England rate.

Over a quarter of abortions in under-25s in England are repeat abortions. This can indicate poor access to contraception and reproductive advice. The percentage of abortions in under-25s where the person has already had a previous abortion in Newcastle was 20.5% in 2019 (98 people). This is statistically better than both the national and regional proportions.

Rates of abortions in those aged over 25 are increasing in England, although in Newcastle the rate has remained mostly static. The crude rate of abortions in over-25s in Newcastle in 2019 was 14.3 per 1,000 (574 people). This is lower than the England rate\textsuperscript{224}.

\textsuperscript{221} Ibid.
\textsuperscript{222} Ibid.
\textsuperscript{223} Ibid.
\textsuperscript{224} More details about Newcastle’s local Sexual Health services can be found on the council’s website, online here (accessed 6 April 2021): http://ow.ly/gdL250EumhU
5. Aging well

This section of the City Profile looks at factors affecting people’s wellbeing in later life, including life expectancy and disability-free life expectancy, dementia, frailty, injuries and falls, vulnerability in older people, premature and preventable mortality, residential and nursing care, and end-of-life care.

5.1 Life expectancy

5.1.1 Male Life Expectancy

Life expectancy at birth for an area is the average length of time someone born today could survive based on current death rates in that area. There is an increasing trend in life expectancy at birth for men in Newcastle. The most recent data (for 2017-2019) shows that average male life expectancy at birth in Newcastle is 77.9 years. This is less than the England average (79.8 years) by 1.9 years. Figure 5.1.1-1 shows how life expectancy in Newcastle has changed over time, and how this compares to life expectancy for males in England as a whole.

Figure 5.1.1-1 Male life expectancy at birth in Newcastle

Note that data for Newcastle is plotted in red on the chart.

5.1.2 Female Life Expectancy

There is also an increasing trend in life expectancy at birth for women in Newcastle. The most recent data (for 2017-2019) shows that female life expectancy in Newcastle is 81.9 years. This is less than the England average (83.4 years) by 1.5 years. Figure 5.1.2-1 shows how life expectancy in Newcastle has changed over time, and how this compares to life expectancy for females in England as a whole.

Figure 5.1.2-1 Female life expectancy at birth in Newcastle

Note that data for Newcastle is plotted in red on the chart.

We do not currently have contemporary life expectancy data for males and females at ward level available, but as soon as we can obtain this it will be included in the city profile, alongside a comparison of life expectancy for males and females in Core Cities in England.

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226 Ibid.
5.2 Disability-free life expectancy

As people get older, there is an increased likelihood of having a long-term illness, health problem or disability which limits their daily activities and the work they can do. This is a result of the accumulation of positive and negative effects on health and wellbeing throughout people’s lives. There is a great variation among this growing proportion of the population, and it is most useful to think about different stages, such as: preparing for later life, active later life, vulnerable later life, and dependent later life.

Variations between individuals mean that these ‘stages’ are not necessarily sequential and cannot be associated with specific age bands. It is also important to be aware that someone’s wellbeing and health affect more than the individual involved, as their family members, partners and/or close friends may have to change their own lives, perhaps changing working patterns, to accommodate caring responsibilities.

Disability-free life expectancy (DFLE) is a measure based on people’s self-reporting of whether they have an activity-limiting illness (or illnesses). It is an important measure, as it attempts to capture the quality of years lived. It is also a measure of people’s functional health status, which is relevance for fitness for work and independent living.

DFLE is an estimate of the average number of years a person could expect to live without an illness or health problem that limits their daily activities. Sometimes, the measure is calculated from birth using Census data (and therefore equates to age), whereas in other instances it is calculated at age 16 using Annual Population Survey data. The latter is carried out more frequently and is therefore more up to date, but is not available below local authority level.
5.2.1 Male Disability-free life expectancy

As shown in figure 5.2.1-1, male disability-free life expectancy in Newcastle dipped slightly in 2015-2017 (57.5) compared to 2014-2016 (58.8), but it has now increased slightly to 58.1 years, although this is still slightly lower than in 2014-2016, and also lower than the figures for the North East Region (58.3) and England as a whole (62.9).

Figure 5.2.1-1 Male disability-free life expectancy in Newcastle

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227 Ibid.
5.2.2 Female Disability-free life expectancy

As shown in figure 5.2.2-1, female disability-free life expectancy in Newcastle has decreased from 58.1 in 2014-2016, to 56.3 in 2015/2017, to 55.7 in 2016-2018. This is lower than the figures for the North East region for 2016-2018 (58.0) and England as a whole (61.9).

Figure 5.2.2-1 Female disability-free life expectancy in Newcastle

![Graph showing female disability-free life expectancy in Newcastle over years]

5.3 Dementia

“Dementia” is a general term for a group of symptoms, usually loss of thinking abilities including speech, memory and problem-solving skills. These symptoms begin to impact daily life and the person’s symptoms progressively deteriorate. Types of dementia include Alzheimer’s Syndrome, Vascular, Parkinson’s Disease, Huntington’s Syndrome, and Lewy-Body dementia, with Alzheimer’s being the most common. Some people may suffer from mixed dementia; that is dementia caused by more than one cause. Risk of dementia and reducing and mitigating impacts of dementia can be influenced by a range of factors, some unchangeable such as age, gender and ethnicity.

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228 Ibid.
There are some modifiable risk factors that can potentially reduce the risk of dementia that are mainly behavioural risk factors. These include:

- **Smoking**: Quitting smoking is one of the most beneficial changes a person can make for their health overall, not just reducing their risk of dementia. In the Newcastle and Gateshead CCG footprint an estimated 17.5% of registered patients smoke, within Newcastle alone it is estimated that 13% of adults smoke (see the ‘4.15 Tobacco control’ section for more information about this).

- **Obesity**: Excess weight can cause and exacerbate a number of health complaints and increase risk of dementia. In the Newcastle and Gateshead CCG footprint an estimated 12.1% of registered patients are documented as obese (see the ‘4.16 Obesity’ section for more information about this).

- **Other factors**: Other factors that may increase risk of dementia include low physical activity, diabetes, low educational attainment and overall poor physical health. Please see relevant sections of this City Profile for more information on each risk factor.

In the Newcastle and Gateshead Clinical Commissioning Group (CCG) area, the proportion of the GP-registered population aged 65 and over with a recorded dementia diagnosis was 4.43% in 2020. This is similar to previous years’ proportions. The crude rate of dementia diagnoses in the under-65 population is 3.39 per 10,000 (this indicator is not available as a proportion of the population).\(^{230}\)

Depending on the severity of dementia and the rate of deterioration in a person’s symptoms, some patients with milder dementia can continue to live at home and function with minimum support. 75.8% of those within the CCG area living with dementia had had their care plan reviewed within the previous 12 months, similar to the national proportion.

There were 812 deaths in persons with dementia on the Newcastle and Gateshead CCG footprint in 2019. This equates to a directly standardised rate of 927 per 100,000 which is statistically worse than the England rate (849 per 100,000). Of those deaths from dementia 73% in 2019 died in their usual place of residence (household or nursing/care home as opposed to hospital).\(^{231}\)

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\(^{231}\) Ibid.
5.4 Frailty

Frailty is a reduction in state of health which can leave people more susceptible to falls and injuries, infections and reduction in quality of life. Frailty can be interconnected with long term conditions and disability; a person with multi-morbidities may also have frailty or a person with a physical disability may have frailty, but not all people with long term conditions or physical disabilities are necessarily going to have frailty. It is therefore important to separate frailty as its own condition. It is also important to note that frailty is not an inevitable part of ageing and should be treated as a long term condition that is preventable and can be made better or worse through holistic treatment. Frailty can mean situations such as minor illness to a change in home environment can have a much more adverse effect than average.\(^{232}\)

5.4.1 Falls and hip fractures

One aspect of frailty is a reduction in muscle mass and coordination than can lead to increased risk of falls in older people. Falls are one of the largest causes of admissions to hospital in over 65s. The directly standardised rate (DSR) of emergency hospital admissions for falls in over-65s in Newcastle in 2019/20 was 2897 per 100,000 which is statistically significantly worse than the national DSR (2,222 per 100,000).

The directly standardised rate (DSR) of hip fractures in over-65s in Newcastle in 2019/20 was 683 per 100,000 compared to 572 per 100,000 in the national population showing Newcastle as statistically significantly worse than the national rate.\(^{233}\)

5.4.2 Reablement

Reablement is a joint effort between social care and health teams to provide support to a patient to recover so that they are able to return to their own home or place in an adult care setting and continue to live as independently as possible. The indicator used by public health measures the proportion of those offered reablement who are still in their own homes 91 days after discharge from hospital out of the total number of 65 and over discharged from hospital in the same period. In Newcastle in 2019/20 the proportion offered reablement from discharge was 2.5%, similar to the national proportion of 2.6%.\(^{234}\)


\(^{233}\) PHE, ‘Local Health Profile - Productive Healthy Ageing’. Online at (accessed 16 April 2021): http://ow.ly/a3bv50EumQe

\(^{234}\) Ibid.
5.5 Injuries and falls

5.5.1 Falls – People predicted to have a fall

The number of people in Newcastle aged 65 and over predicted to have a fall in 2019 was 11,670 and this is predicted to rise to 12,824 by 2025 and then to 15,472 by 2035, as shown in figure 5.5.1-1 below.

Figure 5.5.1-1 People in Newcastle aged 65 and over predicted to have a fall

The number of people in Newcastle aged 65 and over predicted to be admitted to hospital due to falls in 2019 was 1,416. This is predicted to rise to 1,539 by 2025 and then to 1,952 by 2035, with a greater increase in hospital admissions due to falls in those aged 80 and over, as shown in figure 5.5.1-1.

Figure 5.5.1-1 Predicted numbers of hospital admissions due to falls among people aged 65 and over in Newcastle


236 Ibid.
5.6 Premature and preventable mortality

5.6.1 Defining premature and preventable mortality

Premature mortality is defined as ‘deaths in the population of people aged under 75 (for all causes, combined and leading causes of death)’. Some premature deaths are further defined as preventable. Preventable mortality is defined as ‘deaths that could have potentially been avoided through broad public health measures (such as accident prevention)’.

The Global Burden of Disease study estimates Years of Life Lost (YLLs) due to premature mortality. The leading causes of YLL for both sexes in the UK in 2016 were: Ischemic Heart Disease, lung cancer, cerebrovascular disease, Chronic Obstructive Pulmonary Disease (COPD), and Alzheimer’s Disease or other dementias. The leading risk factors of YLL in England in 2016 (both sexes) were:

1. Tobacco
2. Dietary risks
3. High blood pressure
4. High body mass index
5. Alcohol and drug use
6. High total cholesterol
7. Occupational risks
8. High fasting plasma glucose
9. Air pollution
10. Low physical activity

It should be appreciated that premature mortality covers a large proportion of the population and the cause of premature death varies normally by age group with congenital defects, complications from birth, accidents and injuries and childhood diseases more common in the younger population. Self-harm, substance use and the complications of substance use and accidental injuries are more common causes in the young adult and working age population.

Older age groups (aged from 50 years to under 75) are likely to die prematurely from diseases or complications of long-term conditions such as ischemic heart disease, cancer and chronic obstructive pulmonary disease (COPD).

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237 High fasting plasma glucose is an indicator of potential prediabetes or diabetes. For more information about this see: Diabetes UK, ‘Diagnostic criteria for diabetes’. Online at (accessed 7 April 2021): http://ow.ly/YsWj50EumXS

5.6.2 Deaths in Newcastle, including Directly Standardised Rate (DSR)

Looking at the Global Burden of Disease study for deaths in the Newcastle population, we can see that:

- for deaths in those aged under 5 in 2019, neonatal disorders accounted for 41.7% and congenital birth defects accounted for 25.5% of the total deaths in this population.
- in the young adult and adult population (aged 15 to 49 years old) self-harm (12.6%), drugs (9.5%), cirrhosis and other forms of liver disease (7.3%) were more common causes of death.
- in the older population (aged 50 to 69 years old) ischemic heart disease and various forms of cancer are responsible for the highest percentages of total deaths.

The directly standardised rate (DSR) of all-cause mortality in under-75s has been slowly declining since 2014-2016 in Newcastle. The current DSR for Newcastle is 408 per 100,000 for the time period 2017-2019, compared to 392 per 100,000 for the North East region, and 326 per 100,000 for England.

In terms of inequalities, nationally the all-cause mortality DSR is greater in those living in more deprived areas (based on the Indices of Multiple Deprivation 2015, and mortality data 2015-2017) and greater in males than females. Locally, the DSR for males is also greater than the DSR for females.

5.6.3 Premature mortality rate in Newcastle

Public Health England’s mortality profile calculates the rate of premature mortality from several diseases, including cardiovascular diseases, cancer, liver disease, respiratory disease, and injuries. It then looks on a regional geographical footprint at deaths from those cases that could have been preventable. The under-75s mortality rate from all cardiovascular diseases (persons) in Newcastle has decreased since the start of the century but begun to level off in recent years. This mirrors the national rate over the same time period. The current DSR for this indicator for 2017-2019 in Newcastle is 87.9 per 100,000, compared to 82.1 in the North East region, and 70.4 in England. The local rate is higher in males (121.5) than females (54.4).

The under-75s mortality rate from all cancers in Newcastle is statistically worse than the England figure. The rate has shown a decrease since the early 2000s, but shows some fluctuations. Since 2014-2016, the rate in Newcastle has been decreasing and is currently at 157.9 per 100,000, compared to 149 in the North East region and 129.2 in England. The rate in males has seen a small increase from 2016-2018 to 2017-2019, whereas the female rate has shown a decrease over the same time period. Note that males have a higher overall DSR than females.

The number of premature deaths from liver disease (persons) has increased in recent years. Expressed as a DSR the latest rate for 2017-2019 equates to 28.3 per 100,000 (181 deaths). This is a higher rate than in both the North East region (26.1), and England (18.5). The rate is higher in males than females both locally and nationally.

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239 The full Global Burden of Disease model can be explored in more detail online here (accessed 7 April 2021): http://ow.ly/xicL50EumZZ
5.6.4 Mortality caused by respiratory disease in Newcastle

As a region with a recent past of heavy industry including steel works and mining, occupational risk factors alongside high levels of smoking in previous years translate into a risk of respiratory disease among the population. Newcastle has the sixth lowest rate of mortality from respiratory disease (persons) out of the 12 North East Authorities. The current DSR (2017-2019) is 46.3, compared to a regional rate of 44.5 and a national rate of 34.2. Newcastle’s overall rate is worse than that for England as a whole. However, when comparing the rates between males and females, the male rate has shown a recent decrease and is currently similar to the England rate for male mortality from respiratory disease241.

5.6.4 Premature mortality caused by injuries in Newcastle

Mortality from injuries can cover a large amount of deaths. For example, it includes but is not limited to: accidental poisonings and exposures, deaths involving road traffic collisions, exposure to mechanical forces or forces of nature (such as fire, heat, and so on), and accidental drownings242. The rate of premature deaths by injuries in persons in Newcastle has been increasing since 2011. The current DSR is 21.1 per 100,000 compared to 20.7 in the North East and 13.5 in England. Despite the majority of the count of deaths generally being in the male population, the recent rate for males has remained similar to the previous datapoint whereas the female rate, whilst lower, has been increasing243.

5.6.5 Preventable mortality in Newcastle

Considering which of these mortalities may have been preventable, Public Health England currently only looks at this at the regional level. As of the 2017-2019 period, the North East has the highest rates among the nine regions for mortality rate considered preventable244.

241 Ibid.
242 For a full list of included death types see the ICD-10 code list within the definitions section of the PHE Mortality Profile, online at (accessed 6 April 2021): https://fingertips.phe.org.uk/profile/mortality-profile
244 Ibid.
5.7 End-of-life care

Providing care at the end of life often involves the interaction of many different care agencies. By looking at indicators such as underlying cause of death, age of death and place of death, commissioners and providers of end-of-life care get a clearer picture of the end-of-life care needs of their local populations. This helps with planning and delivery of services, and supports drives locally towards improving end of life care.

5.7.1 Place of death

Table 5.7.1-1 shows the place of death for all ages in Newcastle in 2019, compared to those for England. Most deaths in Newcastle in 2019 took place in a hospital setting, with home the next most common setting, which is in line with national proportions.

Table 5.7.1-1 Place of death for all ages in Newcastle in 2019

<table>
<thead>
<tr>
<th>Place of death</th>
<th>Newcastle (%)</th>
<th>England (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>44.8</td>
<td>44.9</td>
</tr>
<tr>
<td>Home</td>
<td>24.8</td>
<td>24.4</td>
</tr>
<tr>
<td>Residential or nursing care facility</td>
<td>21.4</td>
<td>22.5</td>
</tr>
<tr>
<td>Hospice</td>
<td>6.9</td>
<td>5.8</td>
</tr>
<tr>
<td>Other</td>
<td>2.1</td>
<td>2.5</td>
</tr>
</tbody>
</table>

5.7.2 Causes of death

Diseases and conditions that may require end of life care include cancers, respiratory diseases and circulatory diseases among others. (Please see section 4.4 ‘Long-term conditions’ for more information on the population living with these conditions.) Table 5.7-2 shows proportions of deaths in Newcastle in 2019 by underlying cause of death and age group, with the equivalent national proportion is shown in brackets.

Table 5.7-2 Proportions of deaths in Newcastle in 2019 by underlying cause of death and age group

<table>
<thead>
<tr>
<th>Age group</th>
<th>Cancer</th>
<th>Respiratory Disease</th>
<th>Circulatory Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>29.9% (27.9%)</td>
<td>13.7% (13.6%)</td>
<td>21.9% (24.4%)</td>
</tr>
<tr>
<td>85+</td>
<td>17.9% (16%)</td>
<td>15.1% (15.1%)</td>
<td>21.5% (26.3%)</td>
</tr>
<tr>
<td>75-84</td>
<td>31.3% (31.5%)</td>
<td>16.5% (14.9%)</td>
<td>23.5% (24.8%)</td>
</tr>
<tr>
<td>65-74</td>
<td>47.2% (43.1%)</td>
<td>11.8% (13.3%)</td>
<td>21.4% (23%)</td>
</tr>
<tr>
<td>&lt;65 years</td>
<td>34.1% (35.8%)</td>
<td>7.9% (7.6%)</td>
<td>20.3% (20.1%)</td>
</tr>
</tbody>
</table>

Note: The equivalent national proportion is shown in brackets.

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245 Ibid.
246 Ibid.