

## 2.8 Healthy lifestyles

### Why does this matter?

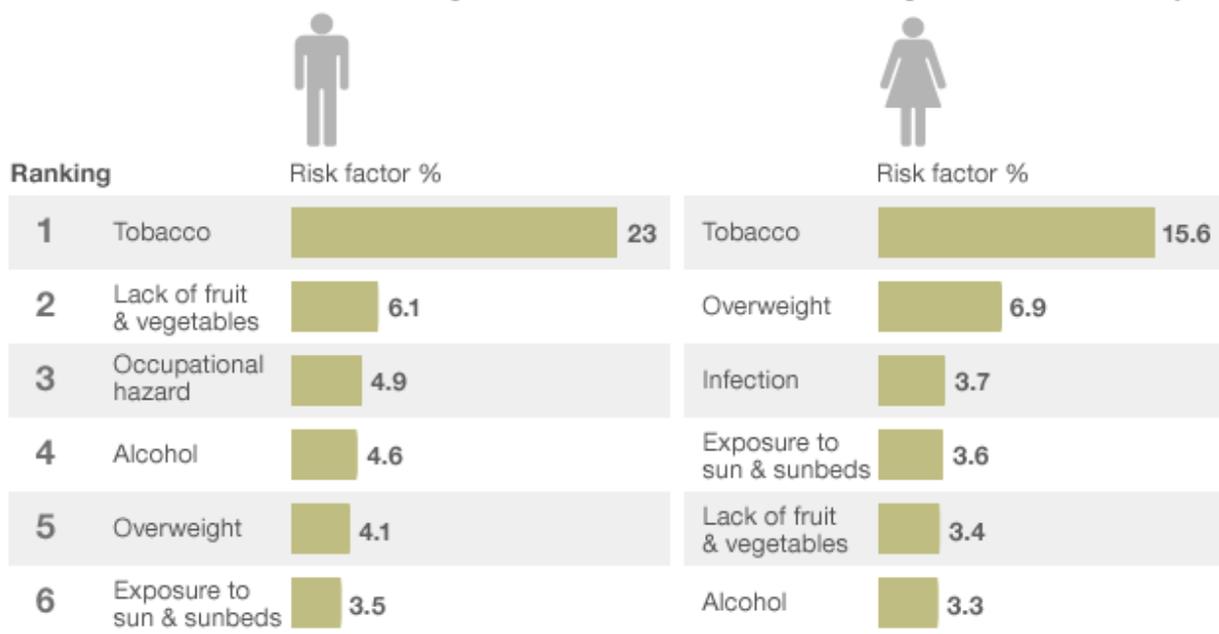
Individual lifestyle choices are shaped by a range of factors, including individual awareness (health literacy) and the physical and social environment in which people live.

“Individuals turn to alcohol, drugs and tobacco and suffer from their use, but use is influenced by the wider social setting.”<sup>1</sup>

As an example of the impact of lifestyles on health, research published by Cancer Research UK in December 2011 estimated that 40% of cancers in women and 45% of cancers in men could be prevented by a healthier lifestyle: drinking less alcohol, smoking less tobacco, and losing weight.<sup>2</sup> Of these, the largest risk factor by far is smoking, which causes 23% of cancers in men and 15.6% of cancers in women.

### Top six causes of all cancers in men and women

Risk factors of the 158,700 cancers diagnosed in men and 155,600 cancers diagnosed in women each year



Source: Cancer Research UK

## 2.8.1 Smoking

### Why does this matter?

“Social deprivation – whether measured by poor housing, low income, lone parenthood, unemployment or homelessness – is associated with high rates of smoking and very low rates of quitting. Smoking is a major drain on poor people’s incomes and a huge cause of ill health and premature death. But nicotine offers no real relief from stress or improvement in mood.”<sup>3</sup>

In 2014, overall smoking prevalence in Newcastle was estimated at **19.6%**<sup>4</sup> of the adult population, which remains higher than the England average (18.0%). Figure 2.8-1 demonstrates that this is a notable decrease compared to previous years.

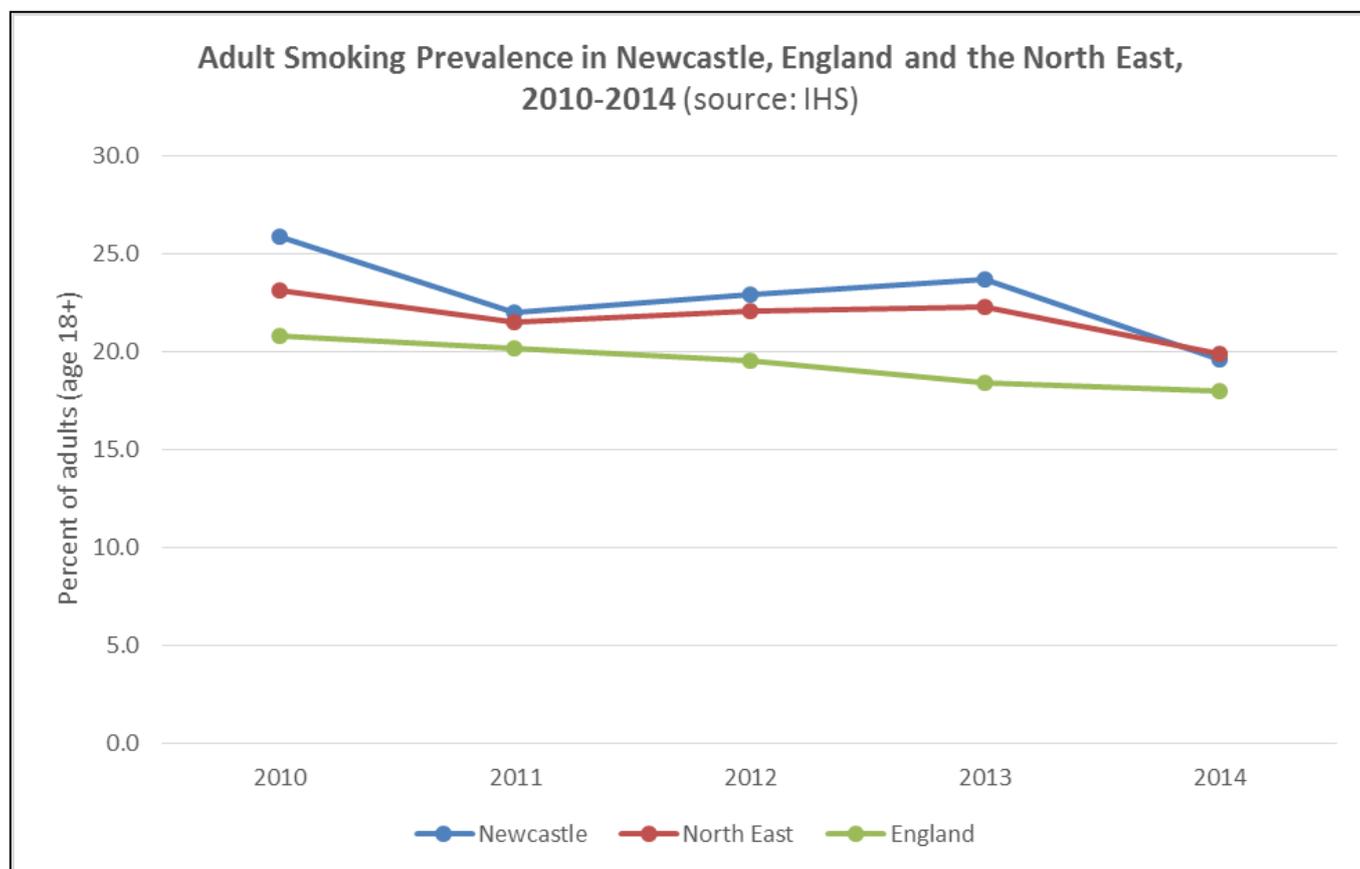


Figure 2.8-1: Smoking prevalence among adults in Newcastle, England, and the North East between 2010 and 2014.

Figure 2.8-2 also indicates that Newcastle’s smoking prevalence is now the fourth lowest in the Core Cities cluster (right after Sheffield, Birmingham, and Bristol).

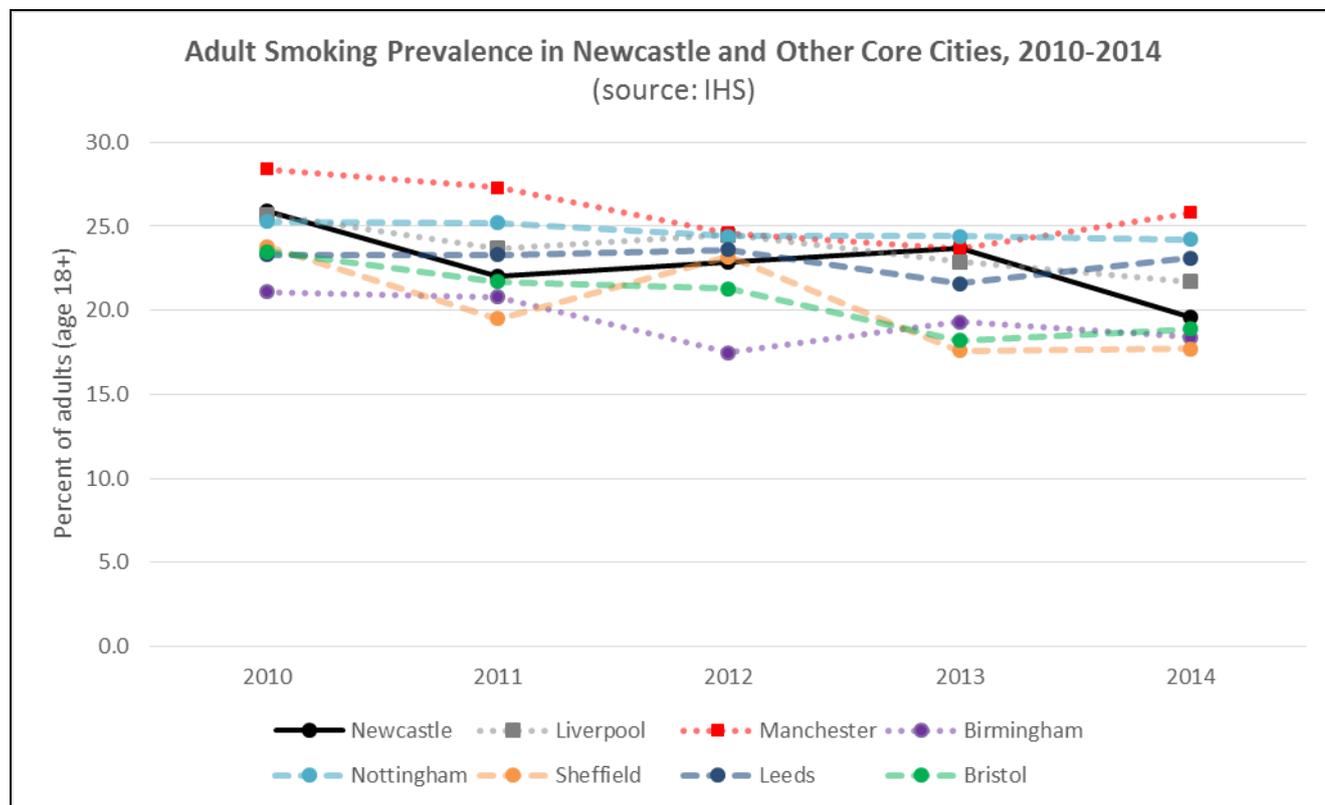


Figure 2.8-2: Smoking prevalence among adults in Newcastle and other English core cities between 2010 and 2014.

### 2.8.1.1 Smoking among routine and manual workers

People in routine and manual occupations account for a greater volume of smokers compared to other socio-economic groups. Research also suggests that, though smokers in routine and manual occupations tend to experience more difficulties in quitting smoking, they are not ‘hard to reach’ in terms of wanting to quit. Improved quit rates amongst this group, then, can ultimately denormalise smoking in communities with the highest smoking prevalence.<sup>5</sup>

In 2014, compared to the England average of 28.0%, Newcastle’s rate of smoking in this group is higher at **31.4%**. However, this represents a reduction since 2012 and 2013 (see Figure 2.8-3). It is the third highest among all core cities, right after Liverpool and Birmingham (see Figure 2.8-4).

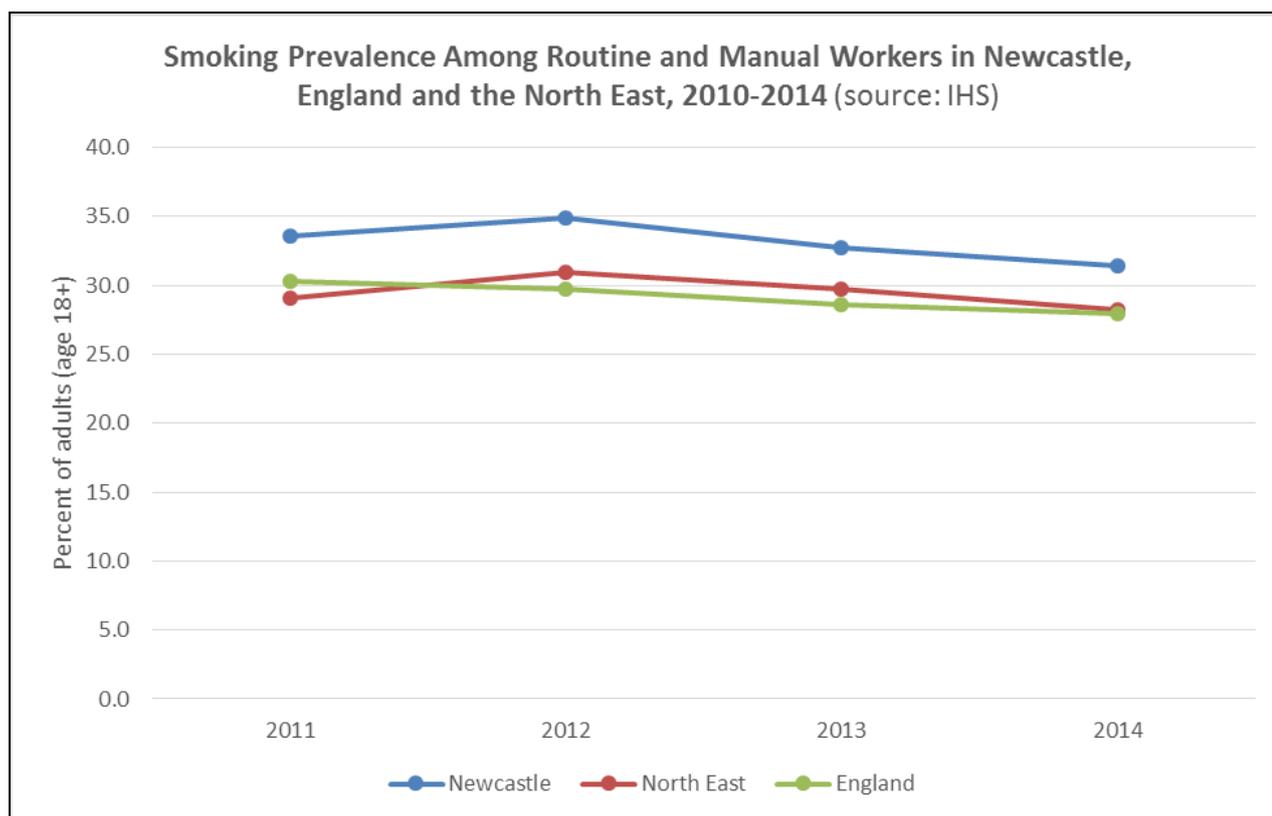


Figure 2.8-3: Smoking prevalence among routine and manual workers in Newcastle, England and the North East, between 2011 and 2014.

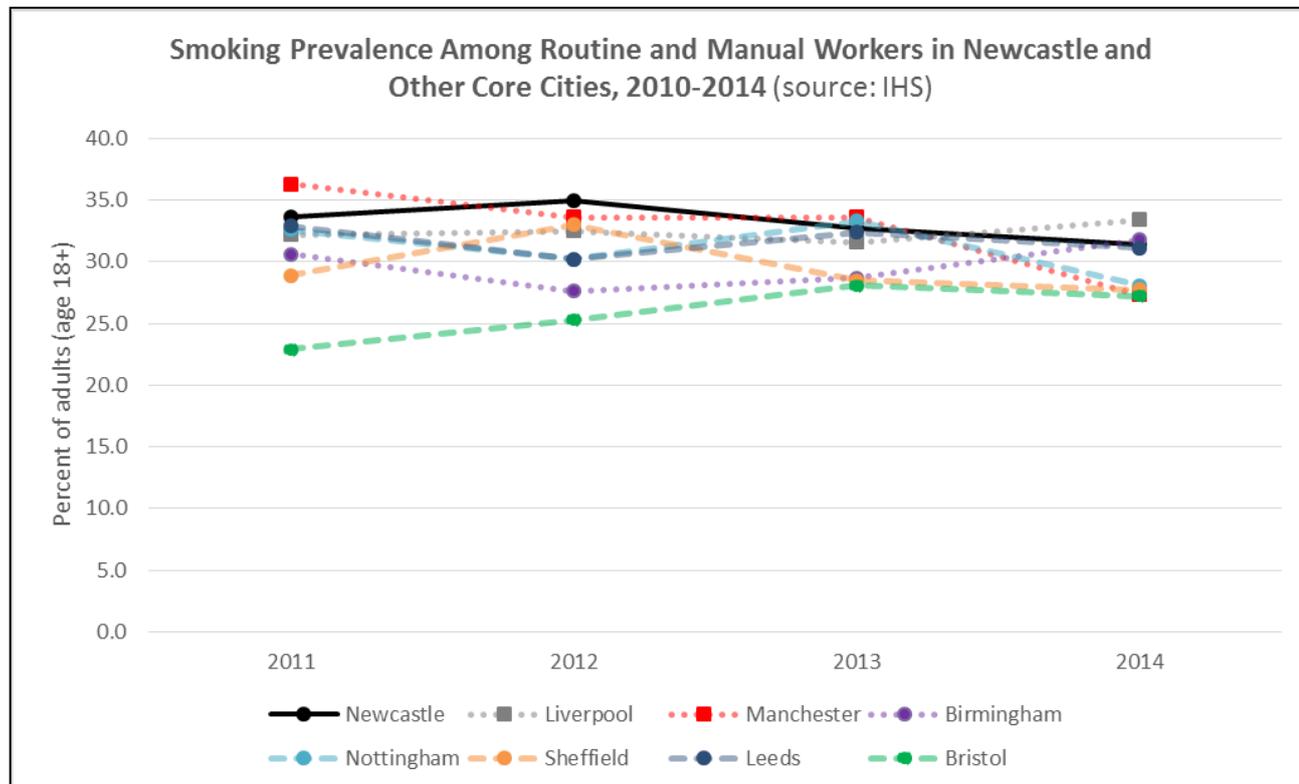


Figure 2.8-4: Smoking prevalence among routine and manual workers in Newcastle and other core cities, between 2011 and 2014.

### 2.8.1.2 Smoking among pregnant women

Smoking during pregnancy increases the risk of complications during pregnancy and labour, such as miscarriage, and can also result in low birth weight, genetic abnormalities such as cleft lip, and sudden infant death syndrome ('cot death').

Figure 2.8-5 shows trends in smoking at time of delivery over time in Newcastle, the North East and England, and Figure 2.8-6 shows this trend for the core cities. In 2014/15, Newcastle's rate of smoking among pregnant women (measured as smoking status at time of delivery) was 14.3%, which is approximately three percentage points higher than the England average of 11.4%. Within the core cities cluster, rates of smoking at time of delivery in Newcastle ranks 4<sup>th</sup>, just behind Nottingham, Liverpool and Sheffield. Newcastle has seen a downward trend from 2010/11, so performance is improving.

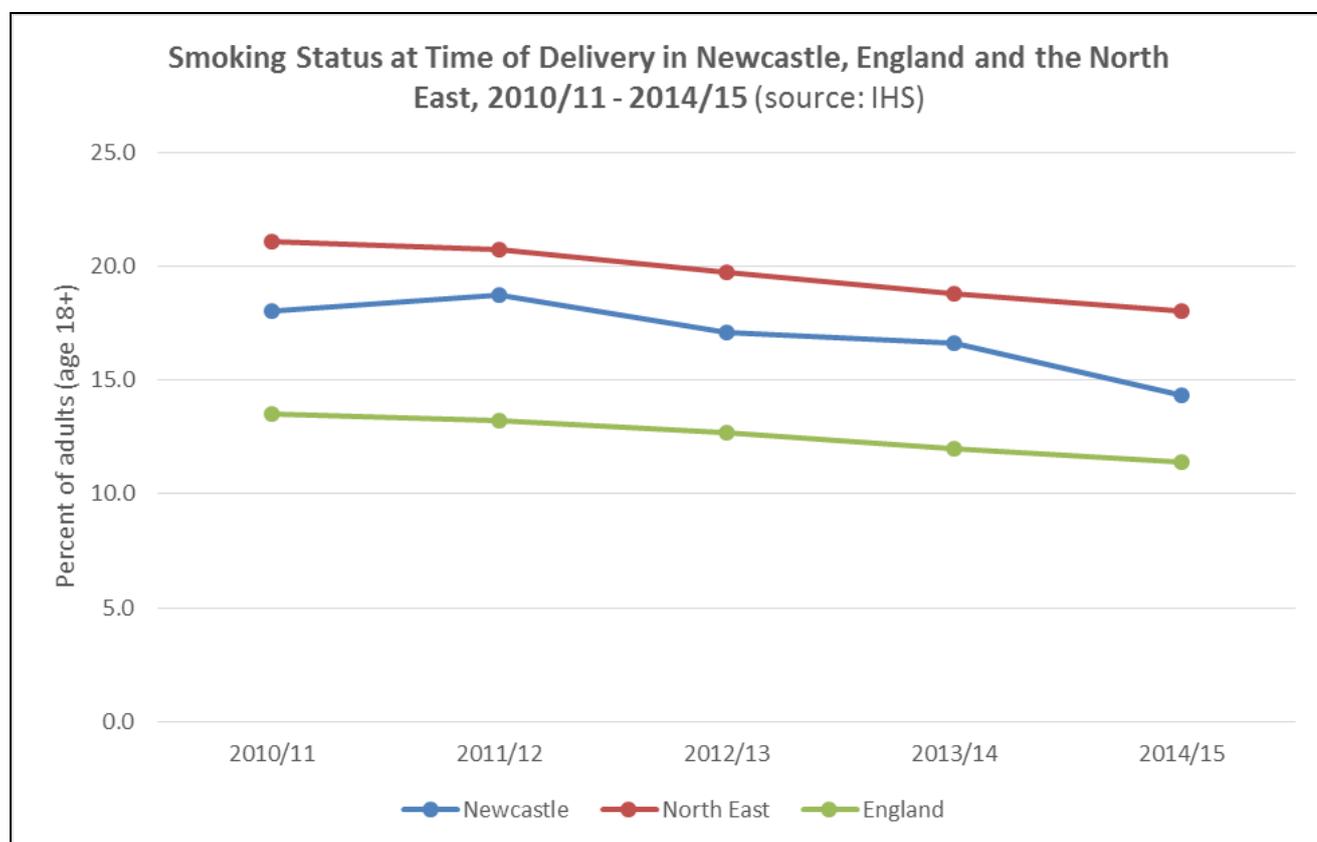


Figure 2.8-5: Percentage of pregnant women who were current smokers at the time of delivery in Newcastle, England, and the North East, 2010/11 to 2014/15.

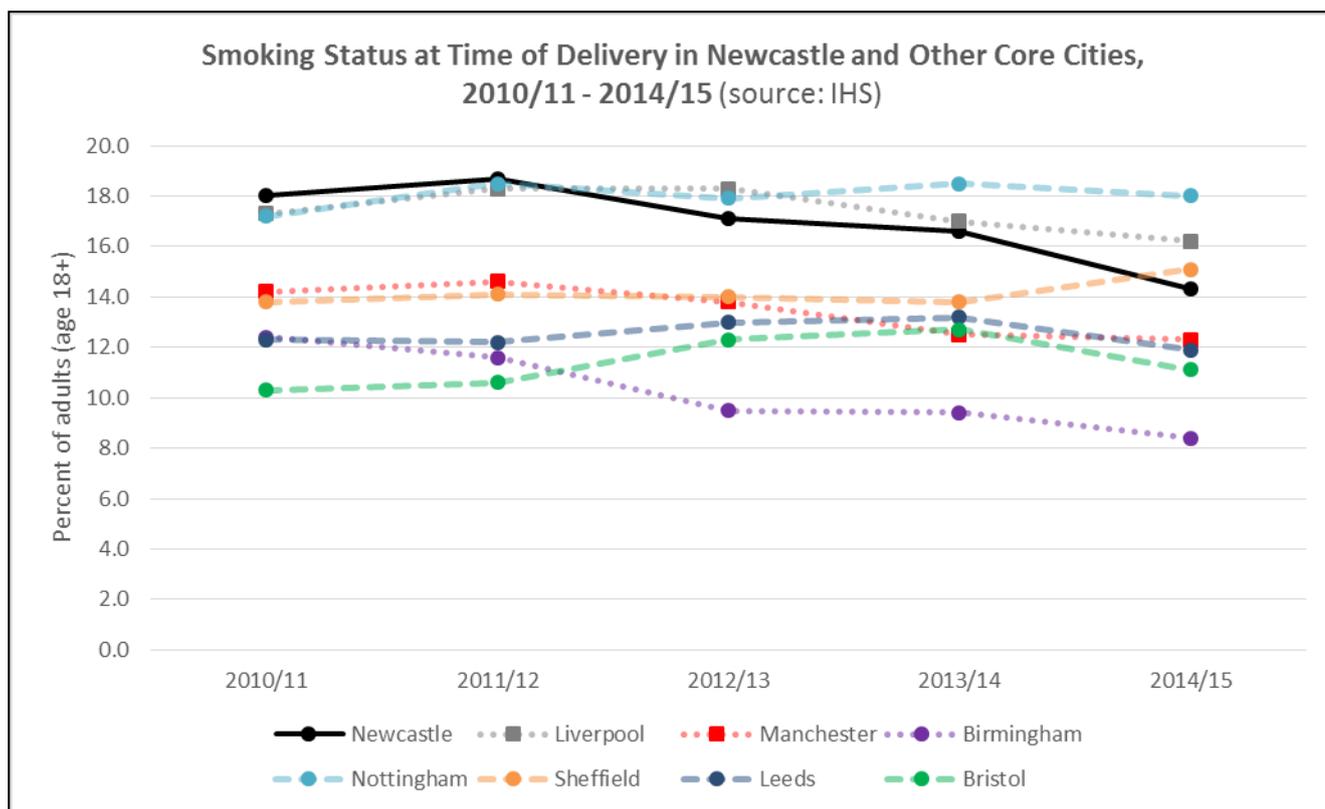


Figure 2.8-6: Percentage of pregnant women who were current smokers at the time of delivery in Newcastle and other core cities, 2010/11-2014/15.

### 2.8.1.3 Smoking among people with long term conditions

Smoking contributes to the onset and progression of a range of long term conditions. Although smoking cessation is advocated as part of the management of many of these conditions, a significant proportion of those suffering with a long-term condition continue to smoke.

30,008 people recorded by GPs in Newcastle North & East Clinical Commissioning Group (CCG) as having a long-term condition were also recorded to be smoking in 2013/14. The figure for Newcastle West CCG was 30,788.<sup>6</sup> This represents a total of 60,796 people in Newcastle, and a smoking prevalence of less than 23.7% (the overall smoking prevalence in Newcastle).



**Note: The ‘long-term conditions’ referred to above include coronary heart disease, peripheral artery disease (PAD), stroke or Transient Ischaemic Attack (TIA), hypertension, diabetes, chronic obstructive pulmonary disease (COPD), chronic kidney disease, asthma, bipolar affective disorder, schizophrenia, and other psychoses.**

### 2.8.1.4 Smoking within different communities

Whilst prevalence data are not available at the ward level, the most recently modelled estimates (2006-2008) suggest that there is an almost a four-fold difference in smoking prevalence between parts of the city with the highest prevalence and parts with the lowest.<sup>7</sup>

Some insights into variation within the city can be gained from the results of the Residents Survey. In 2015, 36.6% of respondents stated that they currently smoke which is a higher prevalence than previous years and is inconsistent with the other statistics reported above so needs to be considered with a note of caution. Figure 2.8-7 to Figure 2.8-10 illustrate how that varies by ward, age, respondent type and household type.

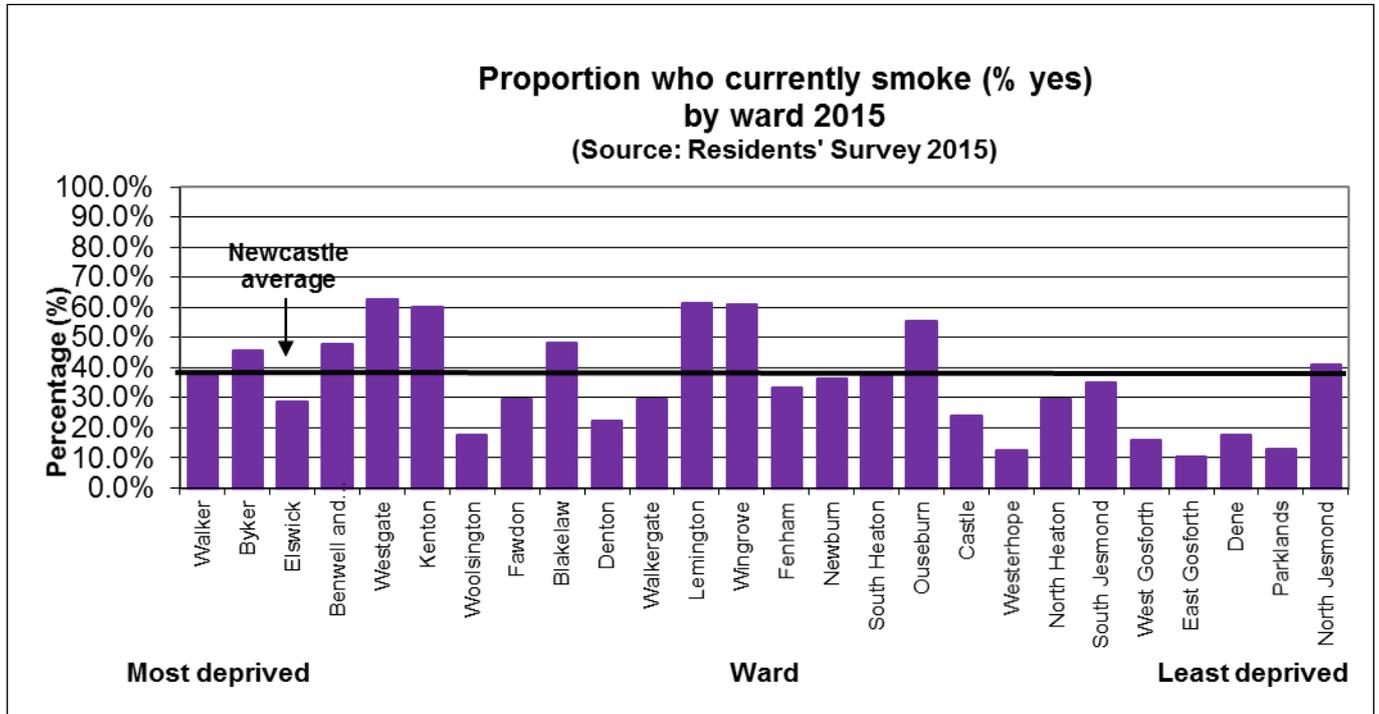


Figure 2.8-7: Proportion who currently smoke by ward 2015.

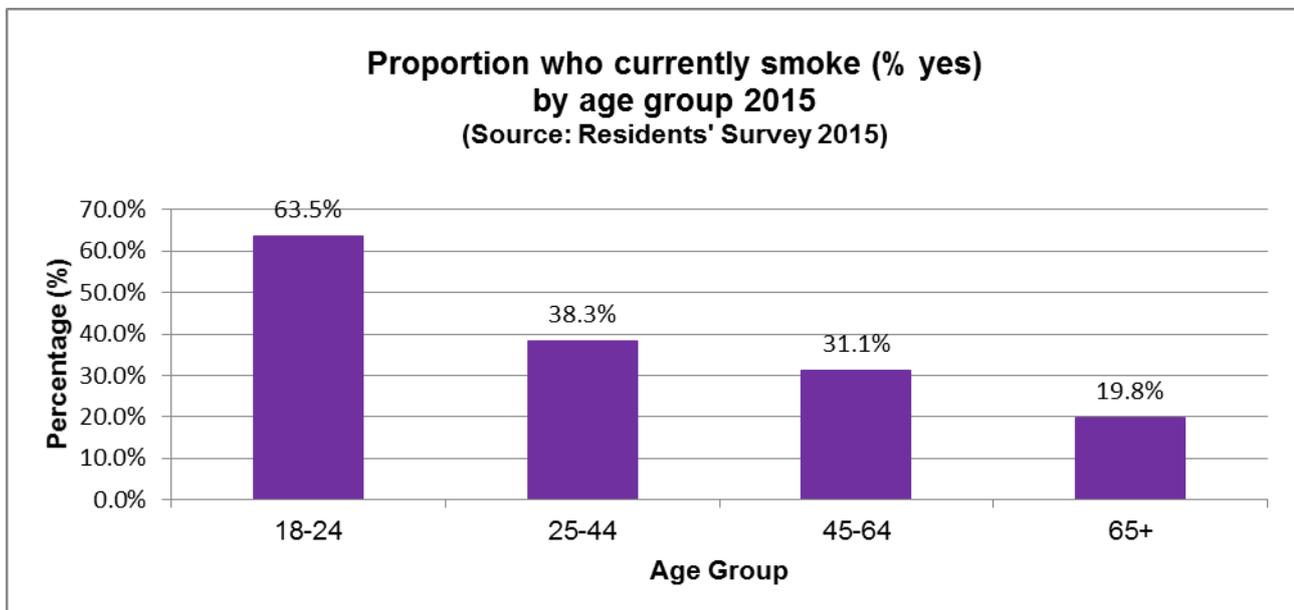


Figure 2.8-8: Proportion who currently smoke by age group 2015

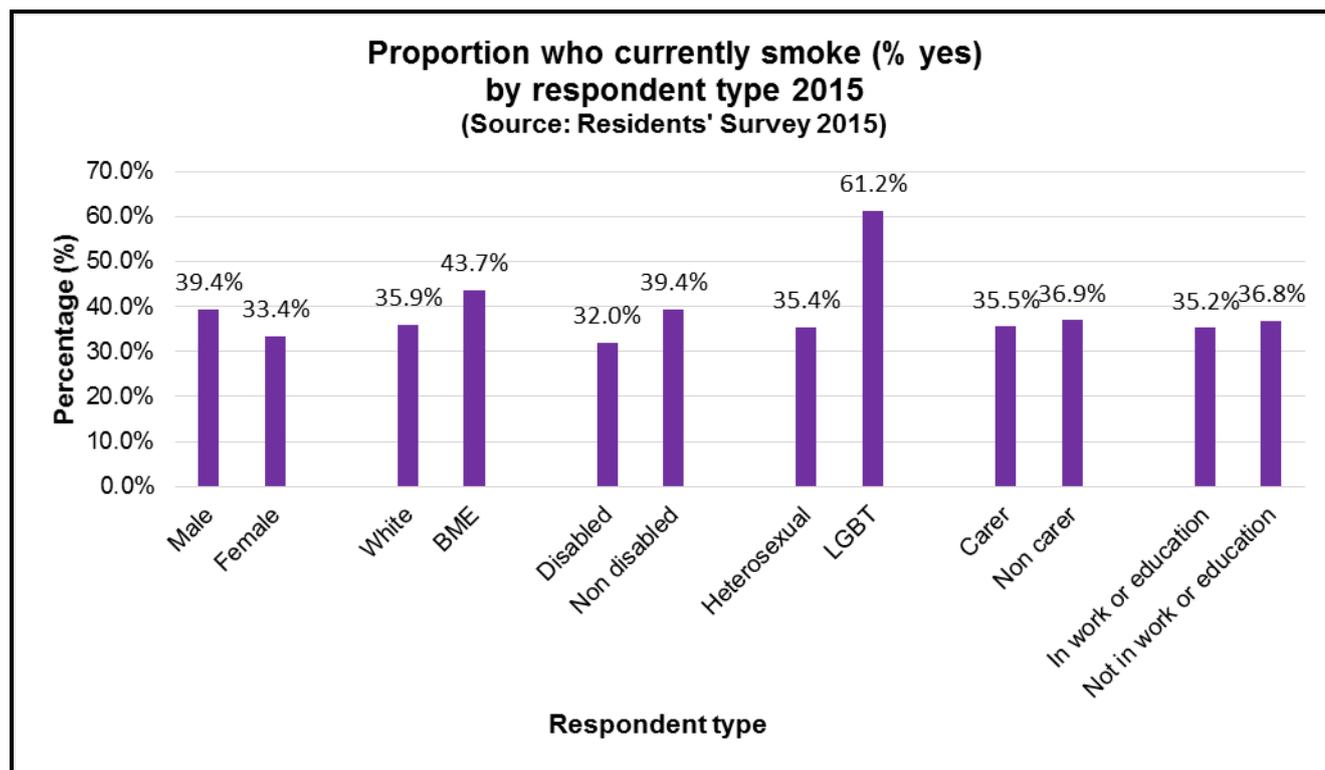


Figure 2.8-9: Proportion who currently smoke by respondent type 2015

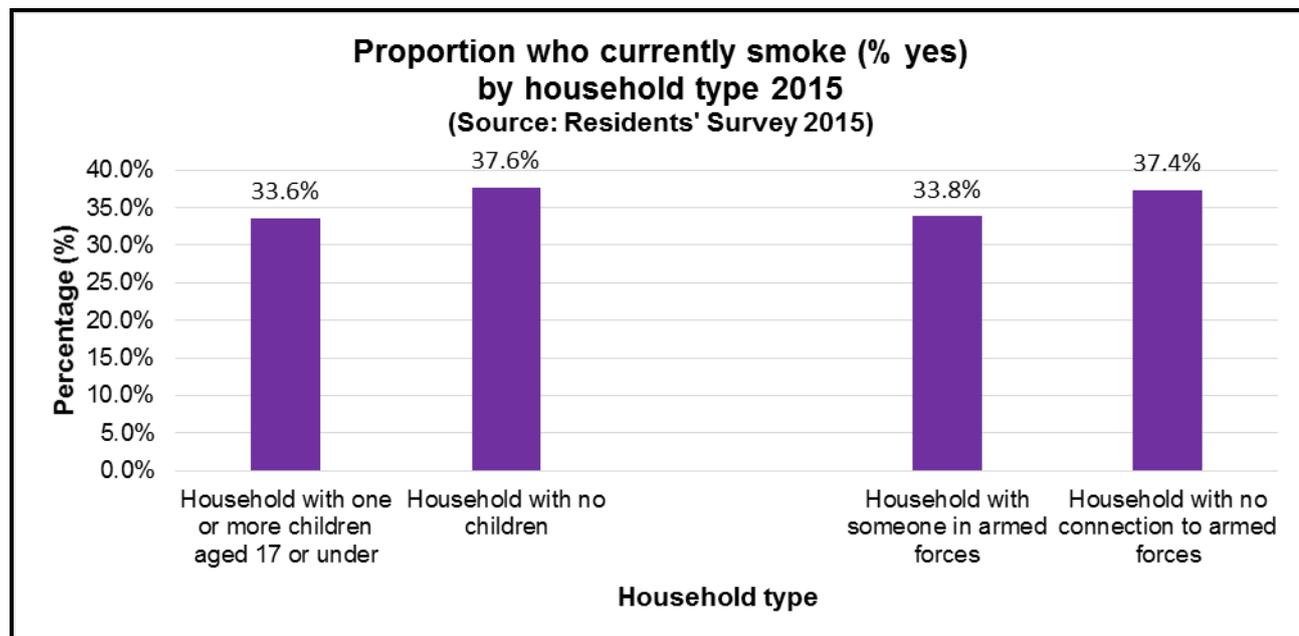


Figure 2.8-10: Proportion who currently smoke by household type 2015

### 2.8.1.5 Children: smoking and exposure to passive smoke

The Health-Related Behaviour Survey<sup>8</sup> was carried out in 2011, 2013 and 2015 in primary and secondary schools throughout the city. In the most recent survey (2015), over 3,500 primary school pupils in years 4 and 6 and over 2,400 secondary schools pupils in years 8 and 10 (and a small number of pupils in year 12) were surveyed.

In relation to smoking among children, the findings revealed that:

- 2.9% of primary school pupils had tried smoking, which represents a slight decrease since 2011 and 2013 (see Figure 2.8-11).
- 27.5% of secondary school pupils (13.4% in year 8, 34.1% in year 10) had tried smoking, which represents a decrease since 2011 but an increase since 2013 (see Figure 2.8-12).
- Out of secondary school pupils that had tried smoking, 31.1% had smoked a cigarette in the week preceding the survey and the average age at which they started smoking was 12.5 years. In most cases, tobacco was obtained from family or friends.
- 13.1% of primary school pupils answered 'yes' or 'maybe' when asked whether they thought they would smoke in future, while 12.5% of secondary school pupils stated that they would probably' or 'definitely' smoke a cigarette in the next year.
- For secondary school pupils, experimentation with smoking was more common among female students (31.7% versus 23.6% of males), who were also more likely to think that more people in their school smoke.

In relation to passive smoke exposure, the findings revealed that:

- 35.8% of the primary school pupils surveyed had at least one parent who smokes, 11.8% had a parent who smokes in the home, and 9.8% (of those whose parent has a car) had a parent who smokes in the car while travelling with them. These numbers reflect a decrease in all respects since 2011 and 2013 (see Figure 2.8-11).
- 38.2% of the secondary school pupils surveyed had at least one parent who smokes, 16.8% had a parent who smokes in the home, and 11.5% (of those whose parent has a car) had a parent who smokes in the car while travelling with them. These numbers reflect a decrease in all respects since 2011 and 2013 (see Figure 2.8-12).
- For both primary and secondary school pupils, having a parent who smokes was associated with a higher likelihood of having intentions to smoke in future (compared with not having a parent who smokes). In primary schools, 21.3% v 8.4% of pupils answered 'yes' or 'maybe' when asked if they thought they would smoke in future; 17.4% v 7.6% of secondary school pupils answered 'probably' or 'definitely' when asked about the likelihood of them smoking a cigarette in the next year.

In relation to e-cigarette/vaporiser use (in secondary schools), the findings revealed that:

- 34.5% of secondary school pupils had tried e-cigarettes/vaporisers (22.0% in year 8, 40.3% in year 10), most of whom had tried them only once. The most commonly cited reason for trying them was ‘curiosity’.
- Rates of using e-cigarettes/vaporisers were similar between male and female pupils.
- 11.4% of secondary school pupils had bought e-cigarettes/vaporisers.
- Use of e-cigarettes/vaporisers (compared to having never used them) was associated with far higher rates of: cigarette smoking (63.4% v 8.6%), drinking alcohol (77.0% v 30.5%), and use of cannabis, other illegal drugs, legal highs or anabolic steroids (28.4% v 2.0%).

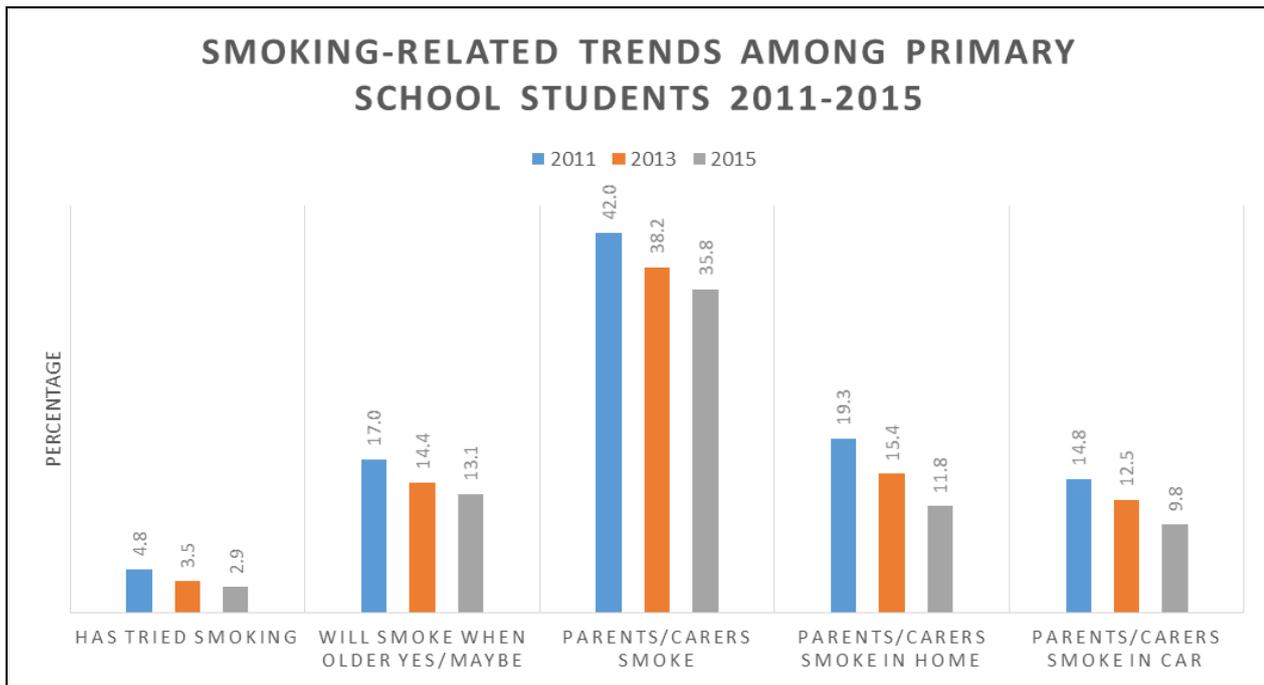


Figure 2.8-11: Smoking-related trends among primary school students in Newcastle, based on data from the Health-Related Behaviour Surveys in 2011, 2013, and 2015.

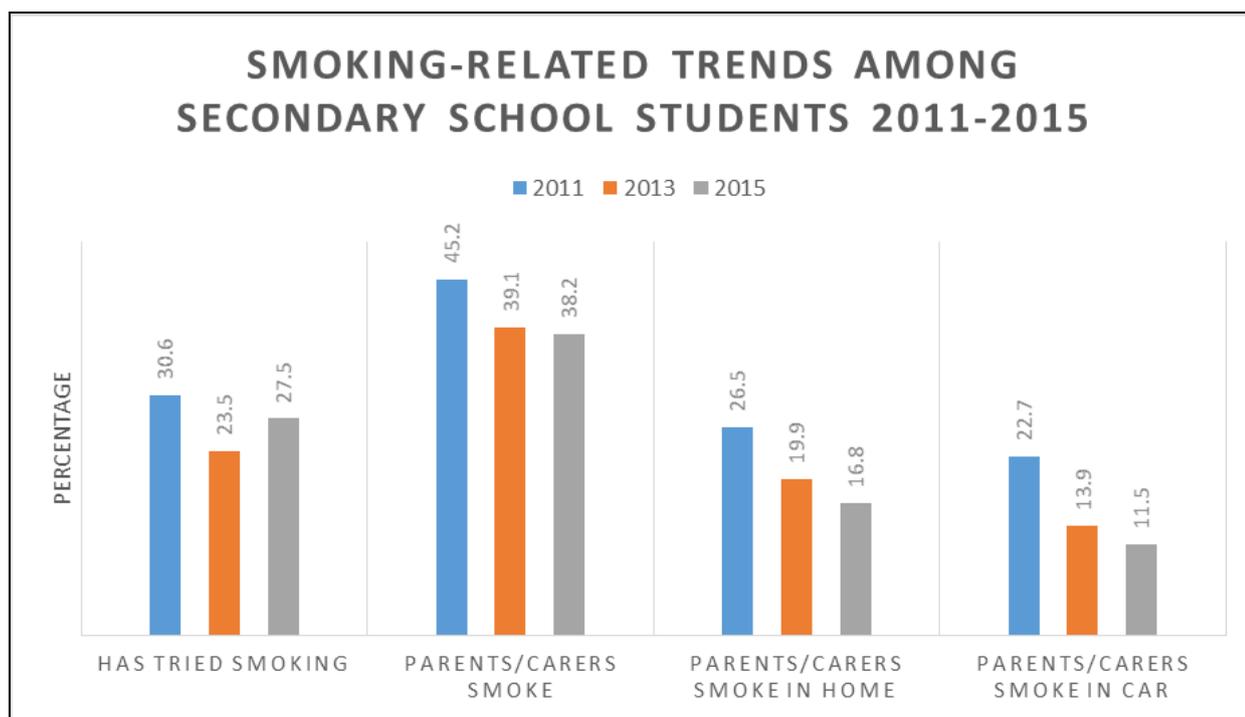


Figure 2.8-12: Smoking-related trends among secondary school students in Newcastle, based on data from the Health-Related Behaviour Surveys in 2011, 2013, and 2015.

According to statistics from the 2014/15 WAY survey, smoking prevalence at age 15 in Newcastle (recorded as ‘current smokers’) was 10.7%, which is notably lower than the experimentation rates recorded among secondary school pupils in the 2015 Health-Related Behaviour Survey (27.5%), though higher than the proportion of secondary school pupils recorded as having smoked recently (in the week preceding survey – 8.6%).

## 2.8.2 Alcohol consumption

### Why does this matter?

“People turn to alcohol to numb the pain of harsh economic and social conditions, and alcohol dependence leads to downward social mobility. The irony is that, apart from a temporary release from reality, alcohol intensifies the factors that led to its use in the first place.”<sup>9</sup>

Alcohol use not only harms the health of the individual; it is also associated with community safety concerns such as domestic violence, assaults and anti-social behaviour.

### 2.8.2.1 Alcohol drinking among adults

The Local Alcohol Profile for England (LAPE) provides a synthetic estimation of the drinking population aged 16 and over in Newcastle. Table 2.8-1 shows the LAPE estimates of the drinking population in Newcastle based on reports of drinking behaviour, including the frequency of drinking and amounts of alcohol consumed.

Table 2.8-1: Synthetic estimates of the alcohol drinking population aged 16 and over in Newcastle. Source: Local Alcohol Profile for England (2014).

Indicator:	Newcastle	North East	England
Abstainers (synthetic estimate)	<b>16.8%</b>	14.6%	16.5%
Lower Risk drinking (synthetic estimate)	<b>72.5%</b>	73.7%	73.3%
Increasing Risk drinking (synthetic estimate)	<b>19.9%</b>	19.6%	20.0%
Higher Risk drinking (synthetic estimate)	<b>7.6%</b>	6.7%	6.8%
Binge drinking (synthetic estimate)	<b>33.7%</b>	30.1%	20.1%

Based on the ONS 2014 mid-year population estimate (the population aged 16 years or over) of 239,822 people, these figures correspond to an estimated 18,226 people who engage in higher risk drinking, 47,725 people who engage in increasing risk drinking, and 80,820 who engage in binge drinking.

A 2013 survey conducted by Balance provides local authority findings from the North East Alcohol Behaviour and Perceptions Survey. This highlights that, in Newcastle:

- 75% of respondents drink, with 25% considered low risk drinkers and 50% high or increasing risk drinkers
- 94% of respondents are not concerned with how much alcohol they drink, with 6% either fairly or very concerned. 22% of respondents have thought about reducing the amount of alcohol they consume.
- 23% of respondents believe it is completely or fairly acceptable to drink for the purpose of getting drunk.
- There are good levels of awareness of the links between alcohol consumption and a range of health conditions, though lower levels of understanding of the strength of relationship between alcohol and various cancers.

Further insights into variation within the city can be gained from the results of the Residents Survey which uses a range of questions that group people into those who don't drink alcohol; those who drink but are not an increasing/higher risk drinker; and those who are increasing/higher risk drinkers. On average 45% of respondents are increasing/higher risk drinkers. Figure 2.8-13 to Figure 2.8-16 illustrate how that varies by ward, age, respondent type and household type.

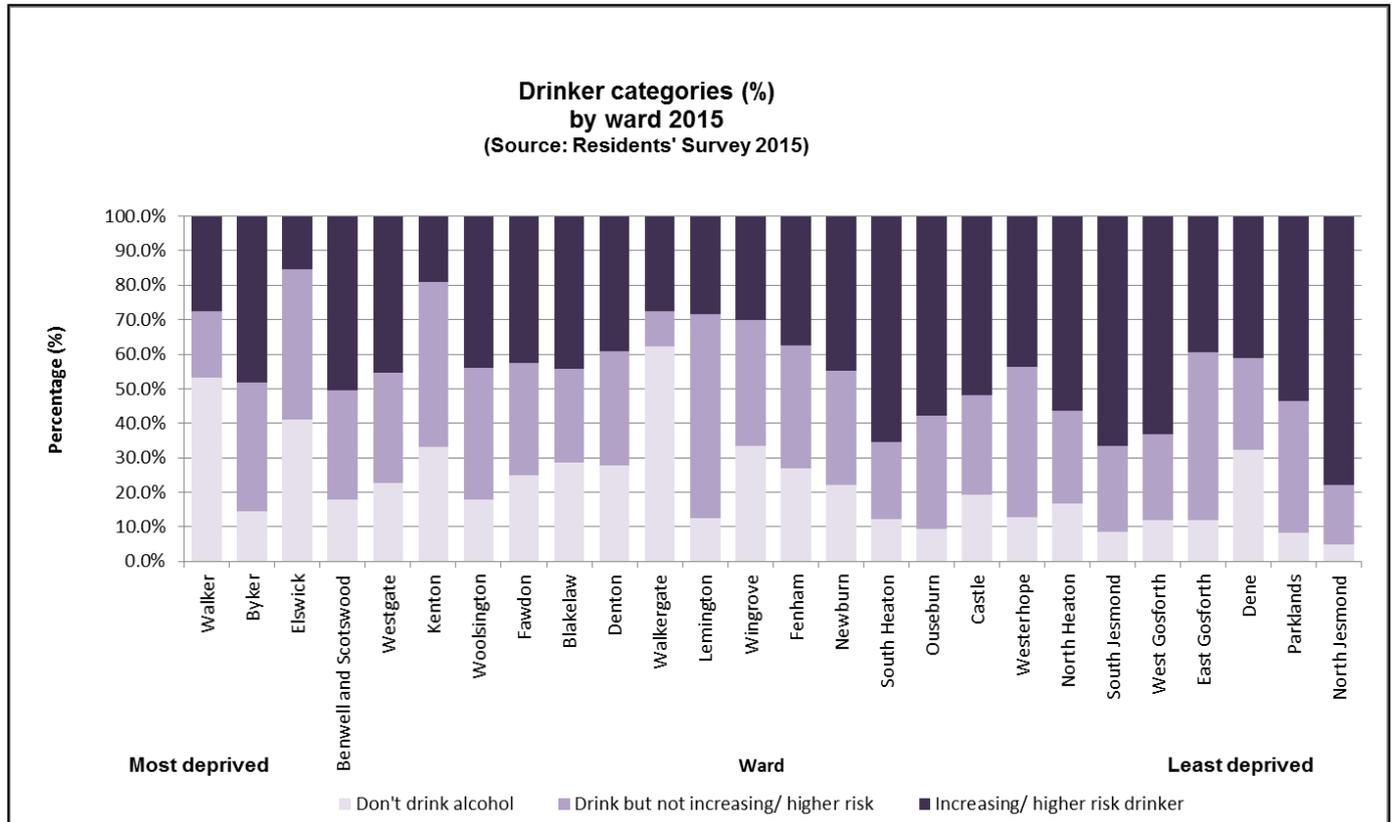


Figure 2.8-13: Drinker categories by ward 2015

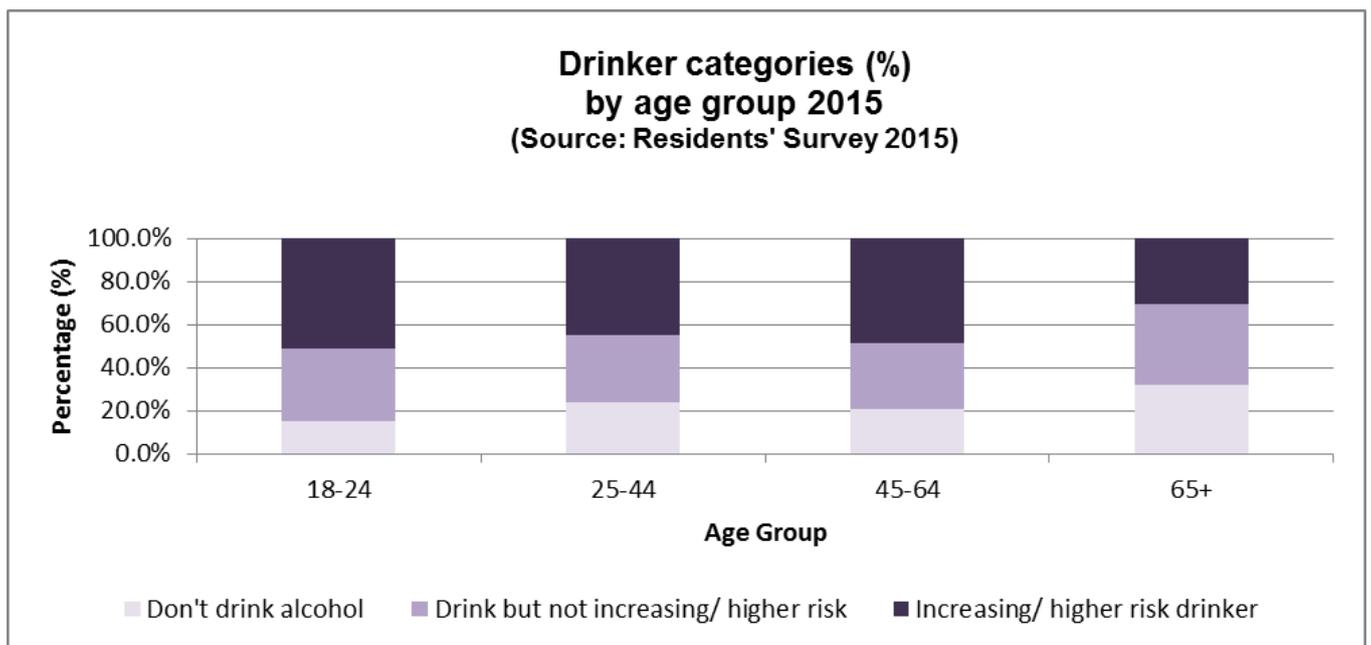


Figure 2.8-14: Drinker categories by age group 2015.

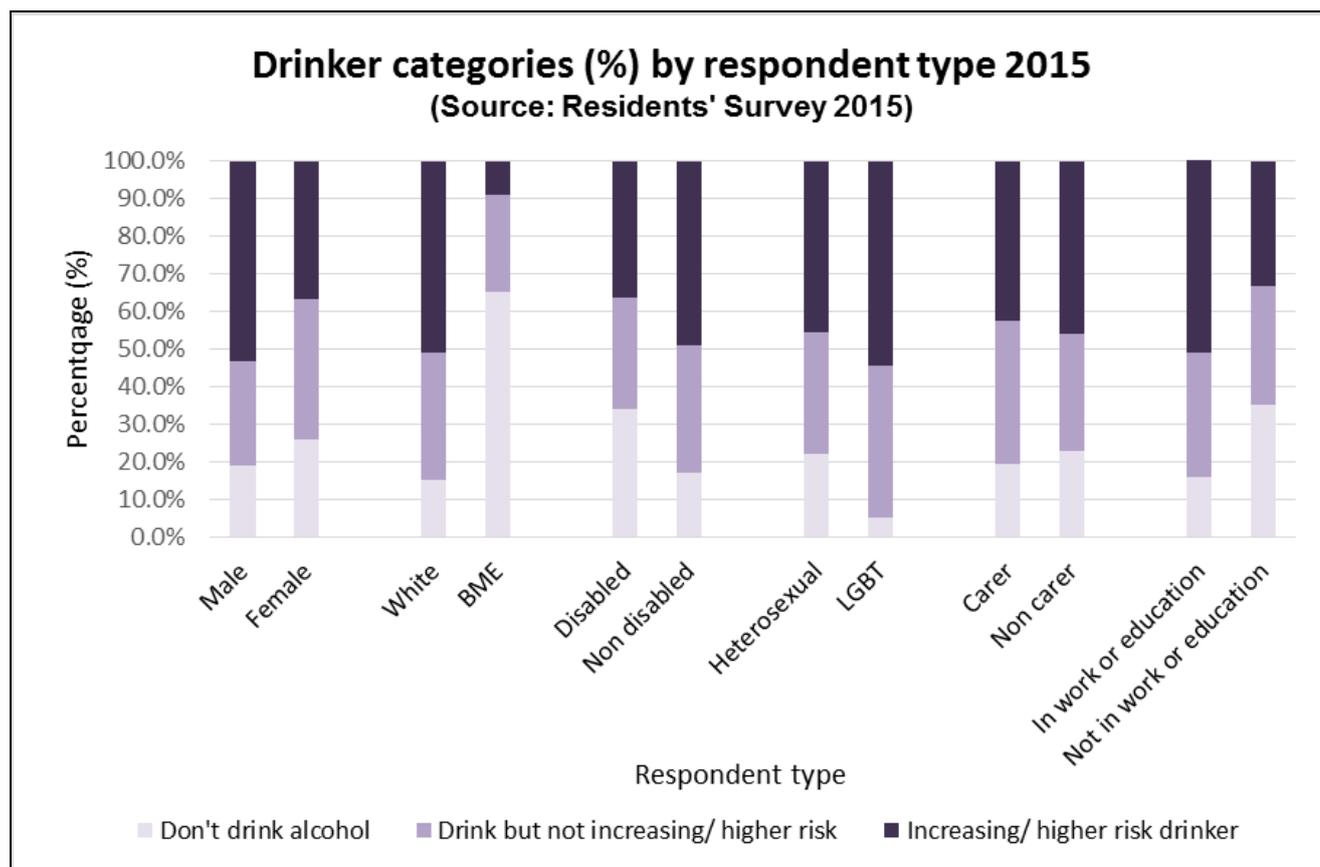


Figure 2.8-15: Drinker categories by respondent type 2015

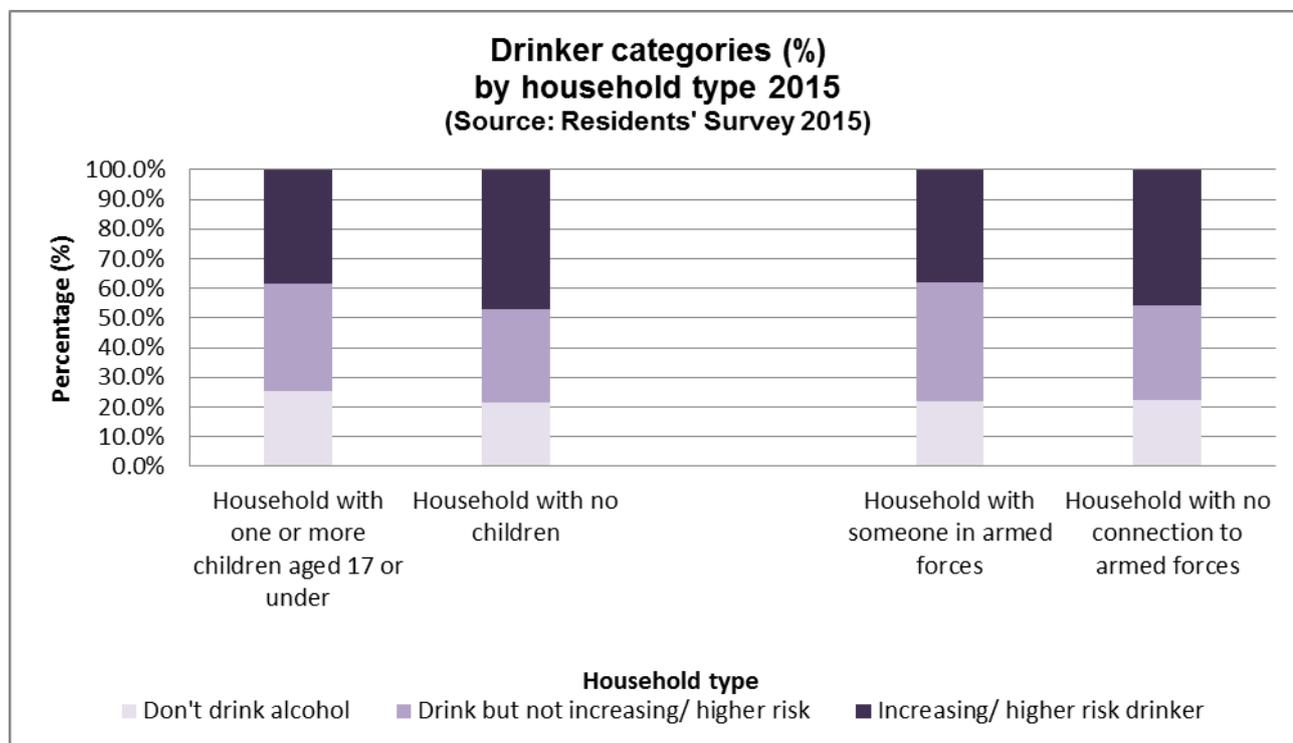


Figure 2.8-16: Drinker categories by household type 2015

### 2.8.2.2 Alcohol drinking among children and young people

The Health-Related Behaviour Survey,<sup>10</sup> carried out in 2011, 2013 and 2015 in primary and secondary schools throughout the city, surveyed over 3,500 primary school pupils in years 4 and 6 and over 2,400 secondary schools pupils in years 8 and 10 (and a small number of pupils in year 12) in 2015. The 2015 findings revealed that:

Among primary school pupils:

- 17.5% of the pupils surveyed had tried alcohol, which represents a decrease since 2013 (22.4%). Most of those who had tried alcohol had drunk alcohol just a few times (11.4% of all pupils) or only on special occasions (4.9% of all pupils).
- 3.1% of the pupils surveyed had an alcoholic drink in the week preceding the survey, which in most cases took the form of shandy, wine, beer or lager.
- Alcohol drinking was slightly more prevalent among males than females.

Among secondary school pupils:

- 59.0% of the pupils surveyed had tried alcohol (47.9% in year 8 and 66.9% in year 10), which does not represent a notable change since 2013 (60.1%). 12.9% were occasional or regular alcohol drinkers, or former alcohol drinkers who had quit.
- Over a quarter (27.8%) of pupils surveyed had been drunk in the last year. This figure does not represent a notable change since 2013 (26.8%).
- Of those that had tried alcohol, 13.6% had an alcoholic drink in the week preceding the survey. In most cases, alcohol took the form of spirits, cans of beer/lager or wine and was obtained from adult friends or family, including parents/carers.
- Alcohol drinking was slightly more prevalent among female than male pupils.
- The most commonly cited reasons for drinking alcohol were 'to socialise and have fun' and 'to get drunk'.
- Out of the students that had tried alcohol, 8.6% had their personal safety put at risk at least once and 12.2% had done something regrettable as a result of drinking alcohol.
- 17.5% of pupils who had tried alcohol had experienced hangover, nausea or other illness; 15.4% had embarrassed themselves; 13.6% experienced memory loss; and 10.2% had been punished by their parents as a result of drinking alcohol.

### 2.8.2.3 Alcohol related hospital admissions

Alcohol related hospital admissions are used as a way of understanding the impact of alcohol on the health of the local population. Admissions **do not** include attendance at Accident and Emergency departments. Admissions can be considered as wholly related to a particular outcome, such as alcoholic liver disease which is solely caused by alcohol use. They can also be partially attributable to alcohol, e.g. assault, which may be caused by a number of factors, in which case alcohol may be considered as the primary cause or as a secondary factor that contributed to the admission. As a broad measure, primary and secondary factors are taken into account. As a narrow measure, only those admissions primarily associated with alcohol use are taken into account. Table 2.8-2 shows the alcohol related hospital admissions during 2013/14.<sup>11</sup>

Table 2.8-2: Alcohol related hospital admissions 2013/2014. Source: Local Alcohol Profiles for England, Public Health England.

<b>Admissions per 100,000:</b>	Newcastle	North East	England
Broad definition hospital episodes	<b>1,684</b>	1,531	1,253
Narrow definition hospital episodes	<b>561</b>	535	444
<b>2011/12 – 2013/14</b>			
Under 18 hospital episodes	<b>41.5</b>	65.8	40.1

Trend data in Figure 2.8-17 shows a 2.8% increase in broad definition alcohol-related hospital admissions between 2008/09 – 2013/14, and an 8.4% decrease in narrow definition alcohol-related hospital admissions between 2008/09 – 2013/14. Figure 2.8-18 also shows that there has been a 46.7% decrease in admissions among under 18s between 2006/07-08/09 and 2011/12-13/14.

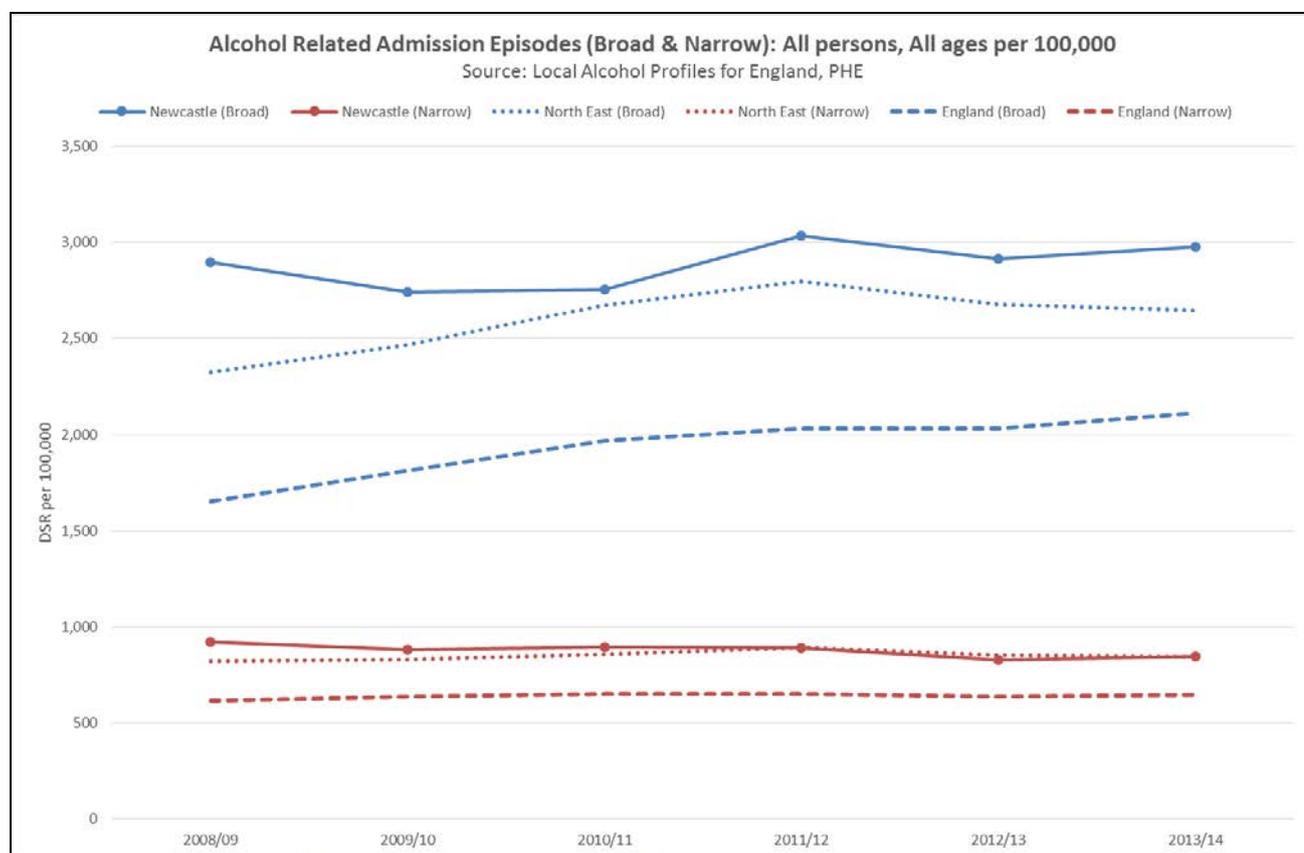


Figure 2.8-17: Alcohol related hospital admission episodes, 2008/09 – 2013/14. Source: Local Alcohol Profiles for England, Public Health England.

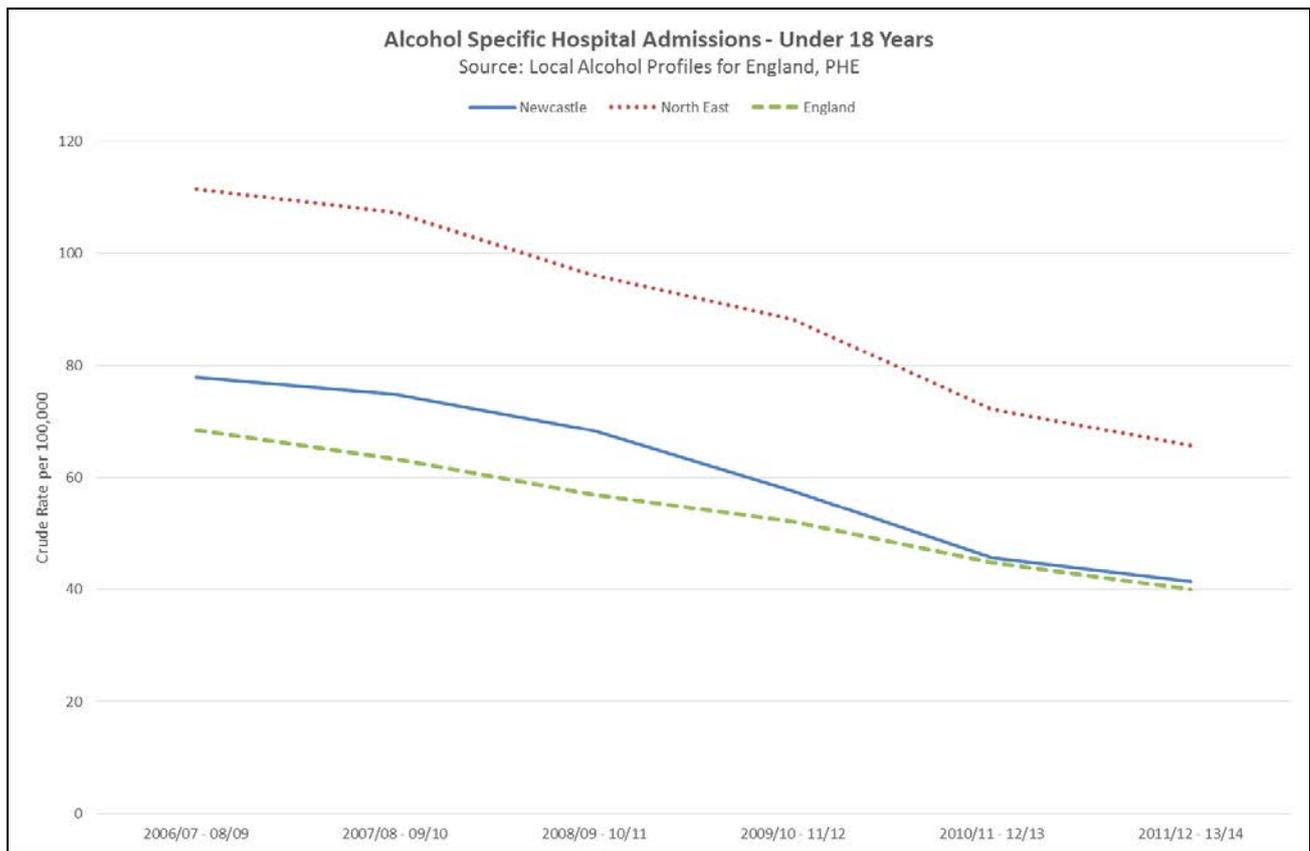


Figure 2.8-18: Alcohol related hospital admissions among people aged under 18, 2006/07 – 2013/14. Source: Local Alcohol Profiles for England, Public Health England.

### 2.8.3 Drug use

#### **Why does this matter?**

“Drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health. It offers users a mirage of escape from adversity and stress, but only makes their problems worse.”<sup>12</sup>

Drug use harms the health of the individual, has impacts on community and family life and is often associated with criminal activity. There are significant costs associated via health and social care and the criminal justice system. It is estimated that 2.7 million adults used illegal drugs in the last year and that 1.2 million people are affected by drug addiction in their families.

It can have serious impacts on children of users too. Drug use does not necessarily lead to bad parenting, but may in some circumstances reduce the parent’s capacity to put the needs of the child first and may lead to the child taking on inappropriate caring roles.

Drug misuse also damages health, such as overdoses, drug poisoning, liver damage from undiagnosed or untreated hepatitis C, poor vein health amongst injecting drug users, lung damage, cardiovascular disease, blood borne viruses and drug-related deaths.

#### **National Prevalence Data**

Nationally, findings from the 2014/15 Crime Survey for England<sup>13</sup> show that around 1 in 12 (8.6%) adults aged 16-59 years had taken an illicit drug in the previous year, which is similar to the 2013/14 survey (8.8%). This proportion is more than double among young adults aged 16-24 (19.4%); also similar to 2013/14 (when it was 19.0%). If these figures were applied to the Newcastle population, this would equate to 15,909 16-59 year olds, and 11,260 16-24 year olds.

Estimates from the survey show that 2.2% of adults were defined as frequent users (illicit use more than once a month on average in the previous year), with the proportion of young adults more than twice as high at 5.1%. This equates to around 36% of those who had taken drugs in the last year for both age groups classed as frequent users. Levels of frequent use were found to be more common among men (than women), people living in urban or deprived areas, and among people who frequently visited nightclubs or pubs.

The most commonly used drugs amongst all adults (aged 16-59) included cannabis (6.7%), powder cocaine (2.3%) and ecstasy (1.7%). For the 2014/15 survey the use of Novel Psychoactive Substances (NPS) or “legal highs” was measured for the first time. This showed that the use of NPS appeared to be concentrated amongst young adults aged 16-24 years (2.8%), particularly young men (4%). The majority of these had also used another illicit drug within the last year, and young adults who had previously taken an illicit substance were significantly more likely to have used NPS than those who had not. Herbal smoking mixtures were most commonly used amongst all NPS users (16-59 years - 61%), followed by powders, crystals, tablets and other substances.

## Local Drug supply

Drug supply has noticeably changed in the city over the past five years, with a range of substances available at 'street' level.

- Cocaine has increased in use, as has crack use recently
- Heroin availability and purity fluctuates, but the demand is still there. Strong batches have been linked to overdose and drug related death.
- Other opiates have become available and popular – such as diverted medication, where there is now a market and street value for the drugs pregabalin, gabapentin, Methadone and buprenorphine (Subutex).
- Benzodiazepines are also widely available on the street and very popular – these are usually sourced from the internet.
- Increase in steroid or performance and enhancing drug use, along with other substances such as alcohol and cocaine, particularly for young adults.
- There has been an increase in availability of Novel Psychoactive Substances (NPS) – so called 'legal highs' and different patterns of use and harm. This has been linked to the sales of NPS products through general stores – such as 'head shops' (shops specialising in smoking paraphernalia), and other general stores such as garages and takeaways. January 2016 has seen a high rise in adverse reactions and serious issues resulting from NPS use, including a significant number of call outs to North East Ambulance Service NHS Foundation Trust requiring emergency response. These have been linked to a number of synthetic cannabinoids, which are more potent and long lasting than cannabis.

### 2.8.3.1 Opiate and 'crack' cocaine user prevalence

Heroin, other opiates and crack cocaine are the drugs associated with the highest levels of harm and dependence alongside issues such as diseases resulting from intravenous injection with contaminated needles.

According to the most recent data (from 2011/12), there are an estimated **2221** Opiate and Crack users (OCU) residing in Newcastle, which equates to an estimated rate of 11.38 per 1000 of the 15-64 year old population. This includes an estimated 2021 opiate users, 597 crack users and 659 injecting drug users. Estimates of the OCU population in Newcastle are highest among people aged 25-34 years, at 22.1 per 1000.<sup>14</sup>

Figure 2.8-19 shows the estimated rate of opiate and crack users and injecting drug users for Newcastle, the North East and England. Newcastle is above the North East and England rate for estimated Opiate and Crack Users (OCU), and there is a significant difference between Newcastle and the England estimated rate of Opiate users.

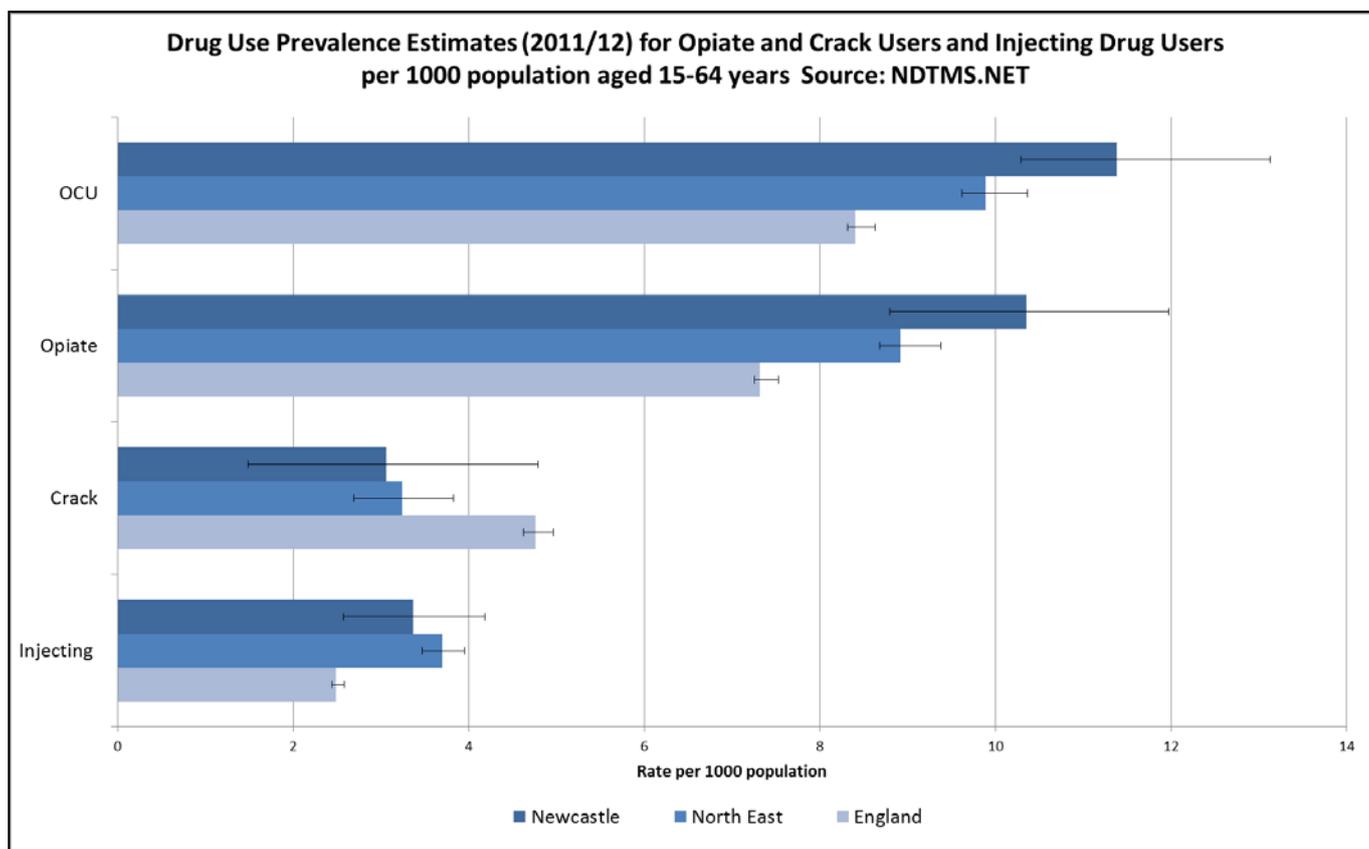


Figure 2.8-19: Drug use prevalence estimates (2011/12) for opiate and crack users and injecting drug users per 1000 population. Source: NDTMS.NET.

Data from our treatment system shows that around 57% of Newcastle’s estimated opiate and crack users have engaged in effective treatment in 2014/15. Cocaine, cannabis and benzodiazepine use are also seen in higher numbers (excluding OCU) either as a primary drug, or alongside others. Treatment engagement not only provides significant improvement to the life of the individual and their family, but significant harm and financial burdens on communities are also reduced. We know from our treatment population that a range of other factors in their life are affected by their drug misuse including:

- Parents with children – a third of the treatment population in Newcastle are parents and live with their children, with a further third who are parents but do not live with their children. Those who are parents are less likely to successfully complete treatment
- Blood-borne viruses – only 38% of the treatment population who were eligible accepted a hepatitis B vaccination (with only 9% going on to complete the course), and 76% of those eligible due to current or previous injecting received a hepatitis C test
- 60% of clients are unemployed or economically inactive, with a further 23% who are long term sick or disabled. Nearly two thirds of those in treatment are reliant on state benefits as their main source of income
- Nearly 20% of those new to treatment are of no fixed abode or have an urgent or current housing issue due to temporary accommodation
- Nearly a third of the treatment population are in contact with the criminal justice system

### 2.8.3.2 Drug Related Hospital Admissions

Drug related hospital admissions are used as a way of understanding the impact of drug misuse on the health of the local population. Admissions **do not** include attendance at Accident and Emergency departments. Hospital Episode Statistics (Table 2.8-3) show that Newcastle has a lower rate of admissions per 100,000 compared to the North East but higher than England for poisoning by illicit drugs (classified under the Misuse of Drugs Act 1971). Newcastle had a lower rate of admissions per 100,000 compared to the North East and England for primary or secondary drug related mental or behavioural disorders. Nationally all three indicators have shown increases compared to the previous year. Whilst Newcastle admissions are lower than the average, it should be noted that drug related deaths (poisoning) are significantly higher than the national and regional averages.

Table 2.8-3: Drug related hospital admissions 2013/2014. Source: HSCIC 2014

<b>Admissions per 100,000:</b>	Newcastle	North East	England
Poisoning by illicit drugs	<b>37</b>	40	26
Drug related mental & behavioural disorders (primary diagnosis)	<b>4</b>	11	13
Drug related mental & behavioural disorders (primary or secondary diagnosis)	<b>114</b>	137	127

### 2.8.3.3 Drug use among children and young people

The Health-Related Behaviour Survey,<sup>15</sup> carried out in 2011, 2013 and 2015 in primary and secondary schools throughout the city, surveyed over 3,500 primary school pupils in years 4 and 6 and over 2,400 secondary schools pupils in years 8 and 10 (and a smaller number of pupils in year 12) in 2015. The 2015 survey looked at the use of various drugs ('drug' here defined as cannabis, other illegal drugs such as heroin, cocaine and amphetamines, so called 'legal highs' and anabolic steroids). The 2015 survey revealed that:

Among primary school pupils:

- 6.9% of the pupils surveyed were certain or fairly sure they know someone who uses drugs, while 2.3% had been offered drugs. Rates were very similar between pupils in years 4 and 6.
- Compared to 2011/13 surveys, there are no notable changes in the likelihood of pupils stating that they know someone who uses drugs or have been offered drugs.
- Male pupils were more likely than female pupils to be fairly sure or certain they knew someone who uses drugs (8.0%, compared to 5.9% among females) and to state they had been offered drugs (3.1%, compared to 1.6% among females).

Among secondary school pupils:

- 21.6% of the pupils surveyed had been offered cannabis; 9.0% other illegal drugs; 9.6% legal highs; and 4.3% anabolic steroids.
- 11% of the pupils surveyed (3.1% in year 8, 15.5% in year 10) had taken at least one of the following: cannabis, other illegal drugs, legal highs, or anabolic steroids. This is an increase compared to 2011 (9.5%) and 2013 (8.1%).

- 4.5% of all pupils stated they had taken one of these drugs in the last month.
- Rates of experimentation with drugs were very similar between male and female pupils.
- Out of pupils who had tried a drug, the average age for first taking a drug was 13.5 years.
- Out of pupils who had tried a drug, 17.8% had taken more than one of these drugs at the same time and approximately half (49.8%) had taken a drug together with alcohol.

Perception of drug safety among secondary students:

- 34.9% of students considered cannabis as safe to use when used properly, or were not sure of its safety.
- 14.0% of students considered illegal drugs other than cannabis (e.g. heroin, cocaine) as safe to use when used properly, or were not sure of their safety.
- 27.0% of students considered legal highs as safe to use when used properly, or were not sure of their safety.
- 40.8% of students considered anabolic steroids as safe to use when used properly, or were not sure of their safety.
- Compared to the 2013 survey, a higher proportion of pupils perceive cannabis as 'safe if used properly' or are unsure (34.9%, v 31.4% in 2013).
- Compared to 2013, a smaller proportion of pupils perceive other illegal drugs and legal highs as being 'safe is used properly' or are unsure (14.0% v 23.3% in 2013 for other illegal drugs; 26.9% v 33.7% in 2013 for legal highs).
- Perceptions on the safety of anabolic steroids have not notably changed since 2013.

In terms of structured treatment for children and young people,

- 34% of young people cite NPS use, as compared with 5% nationally.

## 2.8.4 Physical activity

### Why does this matter?

“Regular exercise protects against heart disease and, by limiting obesity, reduces the onset of diabetes. It promotes a sense of wellbeing and protects older people from depression.”<sup>16</sup>

“Physical inactivity is the fourth leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £1.6 billion per year. The Chief Medical Officer currently recommends that adults undertake 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more. The overall amount of activity is more important than the type, intensity or frequency.”<sup>17</sup>

### 2.8.4.1 Physical activity among adults



**Note:** Insights into the proportions of active and inactive adults in Newcastle can be gained from the Active Peoples Survey (APS). The APS is commissioned by Sports England and measures the proportion of adults (over 16 years) participating in sports and/or undertaking some physical activity at moderate intensity or higher. However, it is not possible to provide trend information, due to a change in the way data was collected in 2013.

**Engaging in at least 150 minutes of moderate or equivalent physical activity per week indicates that one is ‘physically active’; engaging in less than 30 minutes of moderate or equivalent physical activity per week indicates that one is ‘physically inactive’.**

In Newcastle in 2014, **59.0%** of adults (aged over 16 years) reported doing the **recommended 150 minutes** of moderate or equivalent physical activity per week. This is above the North East average of 53.6% and above the England average of 57.0%, but less than in three other core cities (Leeds, Bristol, and Sheffield – see Figure 2.8-20).

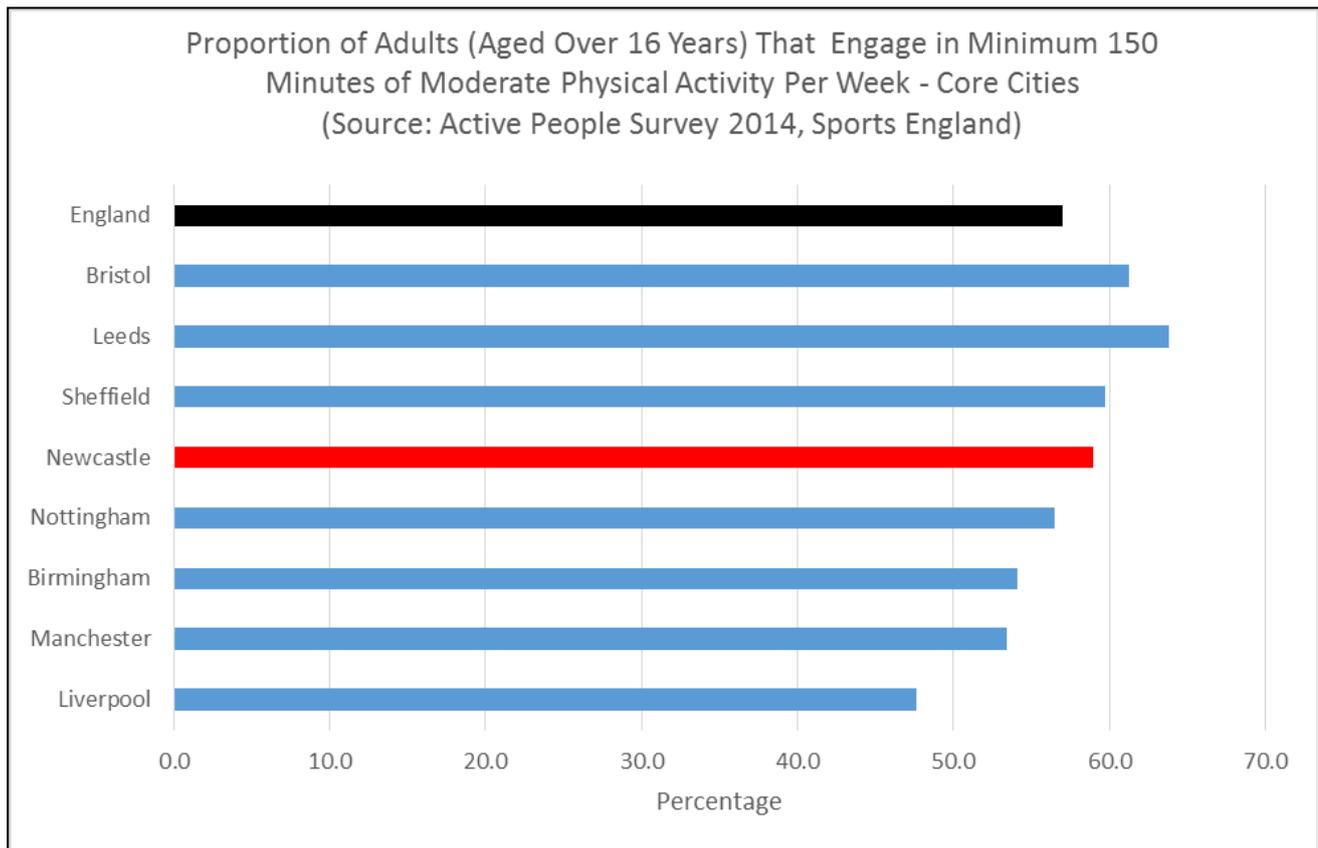


Figure 2.8-20: Adults that engage in at least 150 minutes of moderate or equivalent physical activity per week: Newcastle and the Core Cities. Source: Active People Survey 2014.

Further insights into variation within the city can be gained from the results of the Residents Survey, on average 30.3% of people are physically active. Figure 2.8-21 to Figure 2.8-24 illustrate how that varies by ward, age, respondent type and household type.

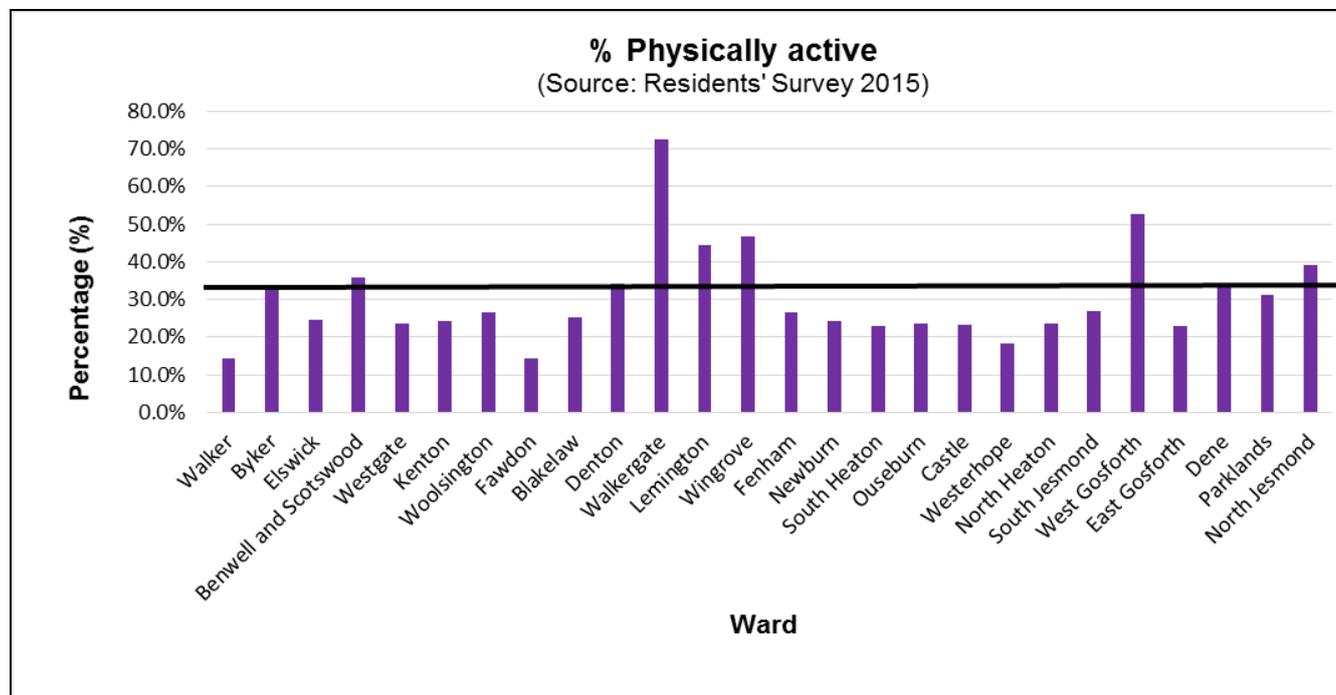


Figure 2.8-21: Physically active by ward 2015

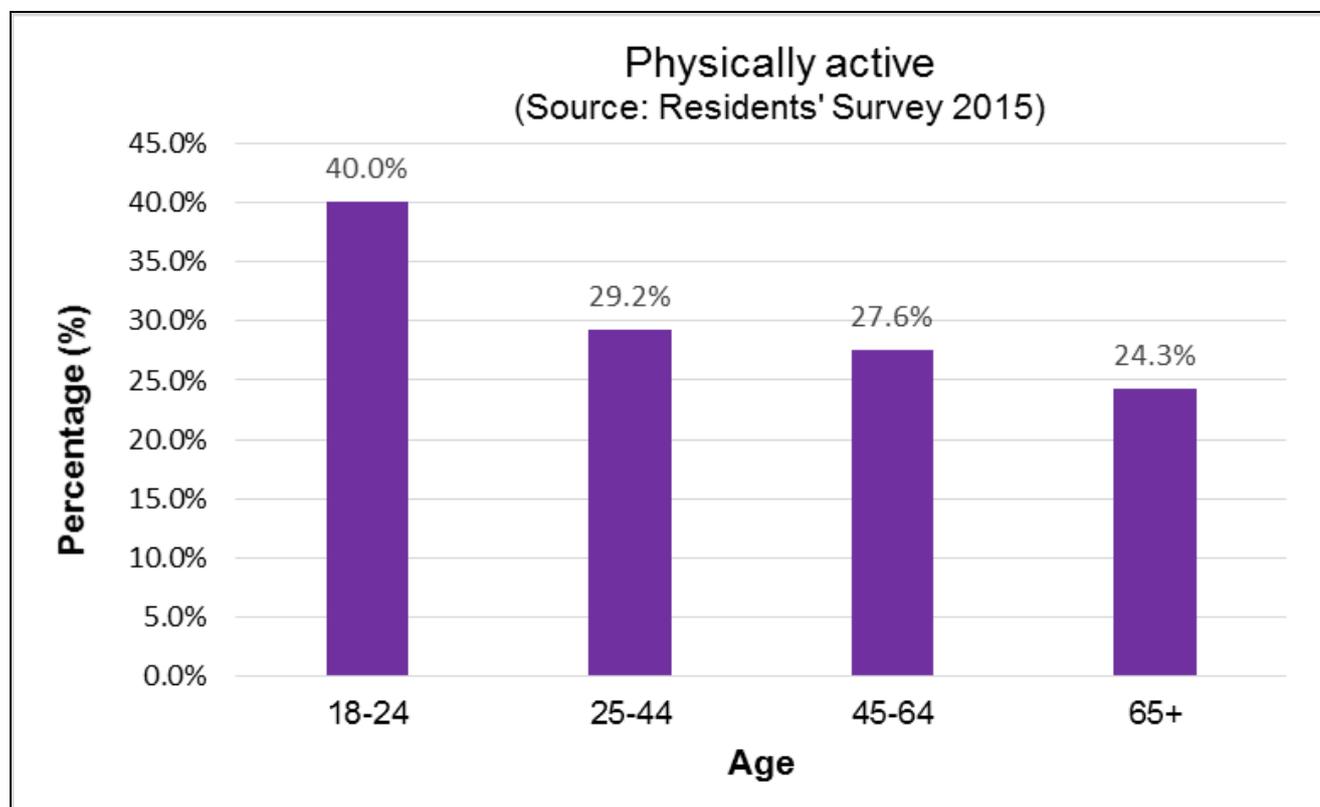


Figure 2.8-22: Physically active by age group 2015

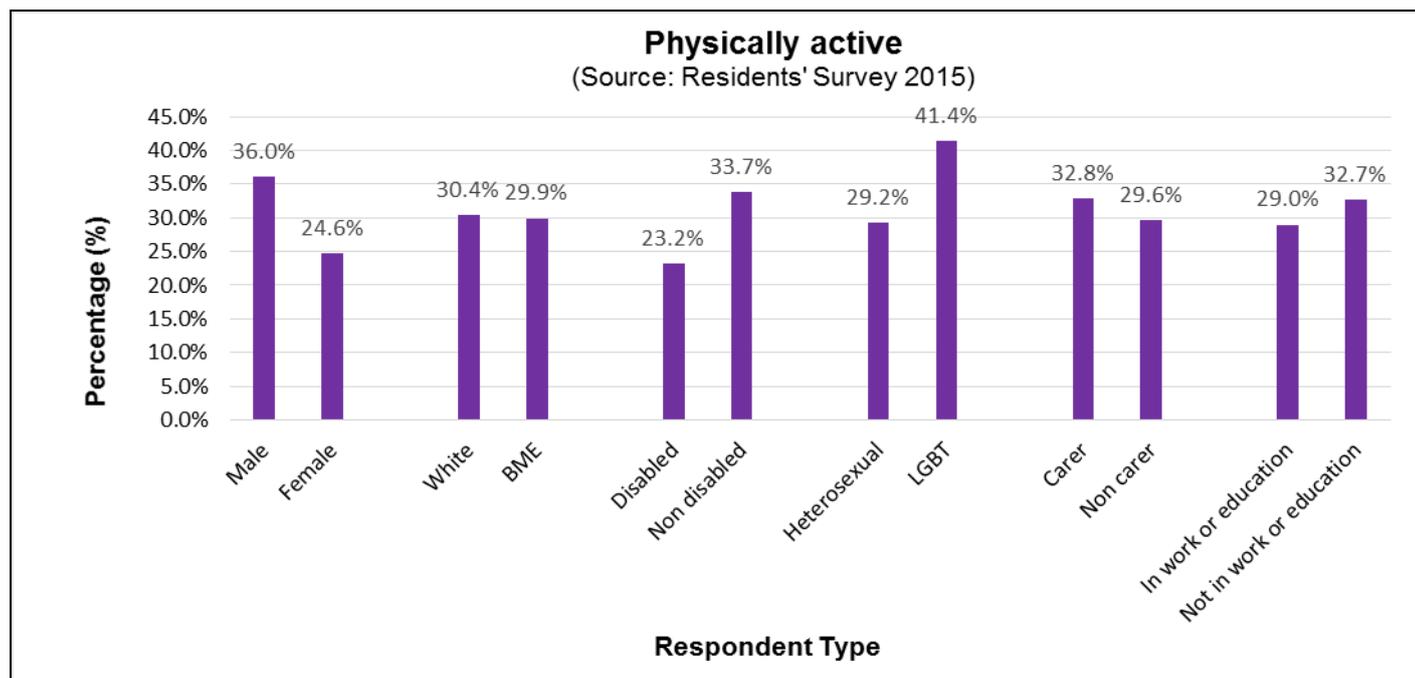


Figure 2.8-23: Physically active by respondent type 2015

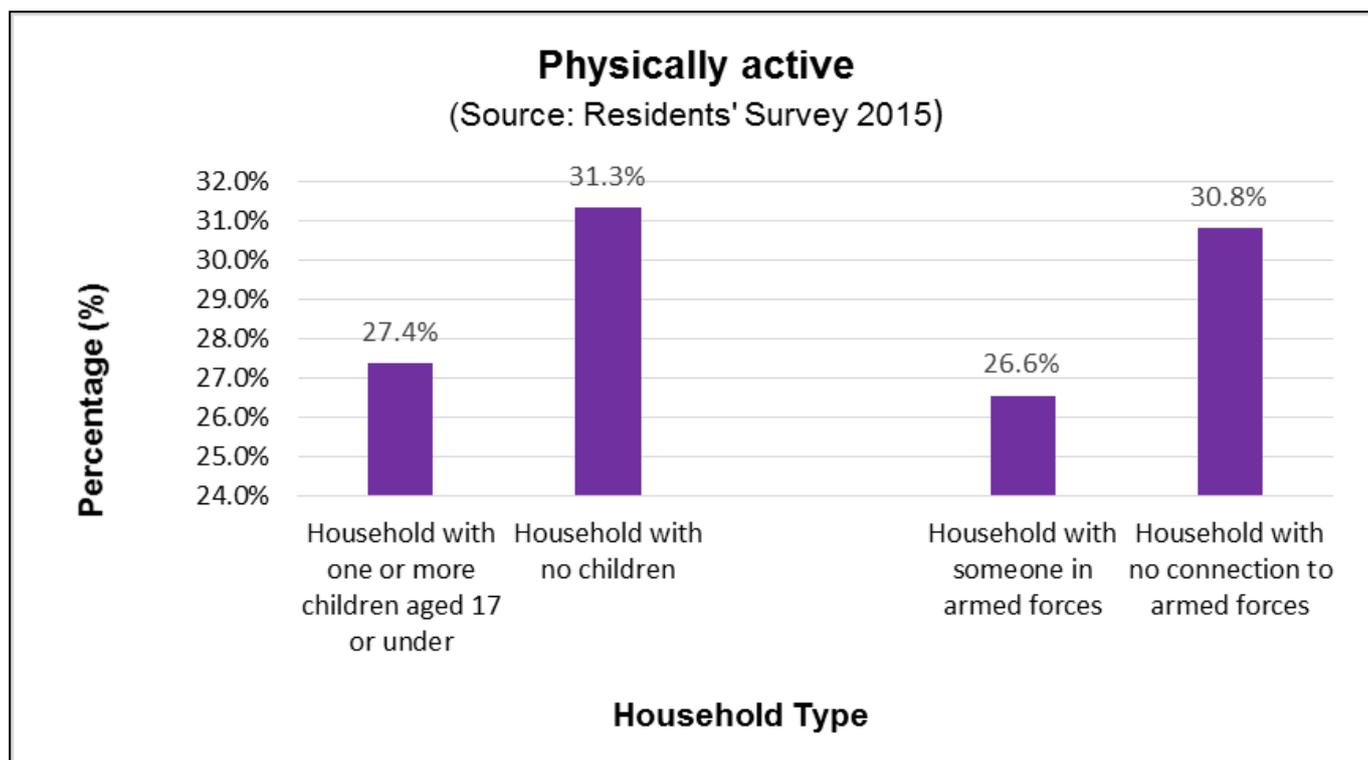


Figure 2.8-24: Physically active by household type 2015

In Newcastle in 2014, **27.8%** of adults over 16 years reported doing **less than 30 minutes** of moderate or equivalent physical activity per week. This is very similar to the England average (27.7%) and below the North East average of 32.2% (Figure 2.8-25).

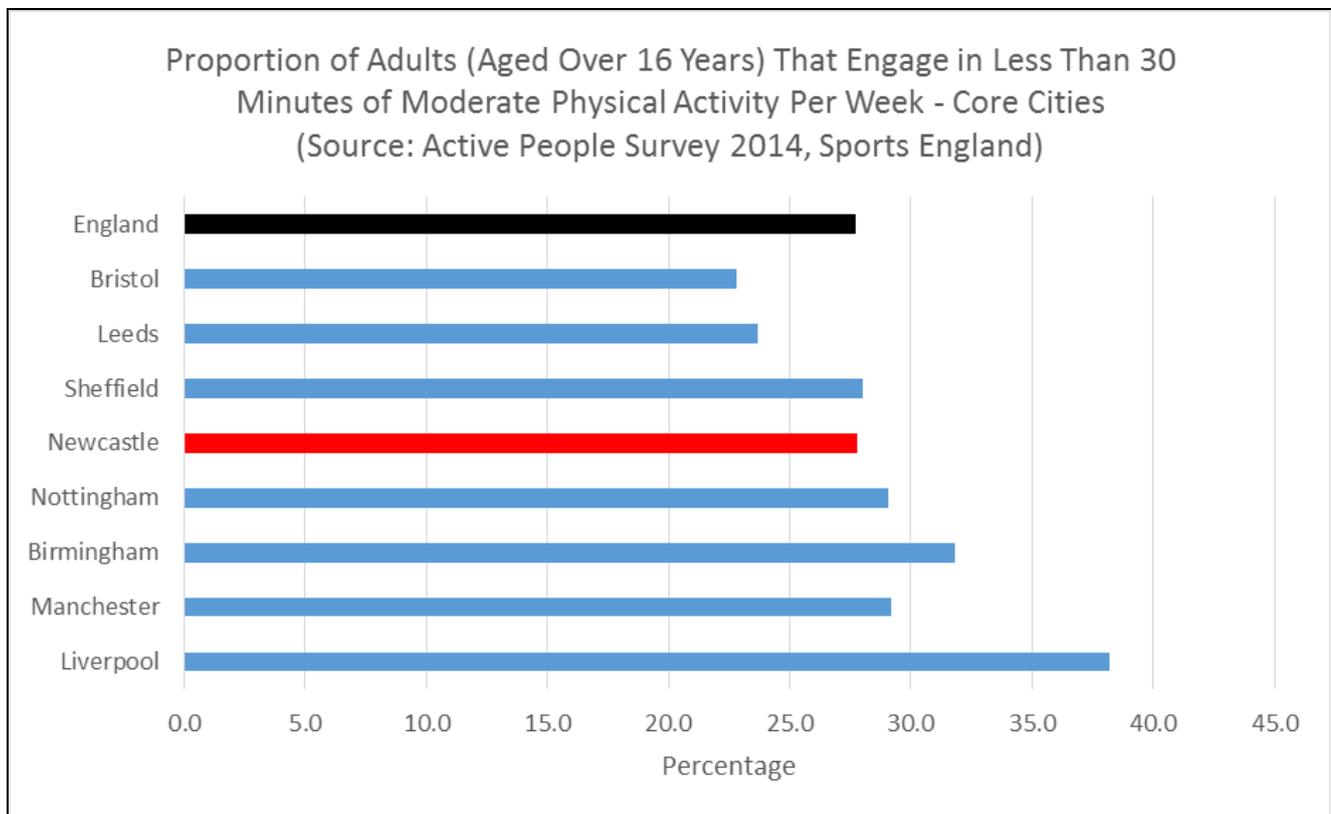


Figure 2.8-25: Adults that do less than 30 minutes of moderate equivalent physical activity per week: Newcastle and the Core Cities. Source: Active People Survey 2014.

Further insights into variation within the city can be gained from the results of the Residents Survey, on average 39.5% of people are physically inactive. Figure 2.8-26 to Figure 2.8-29 illustrate how that varies by ward, age, respondent type and household type.

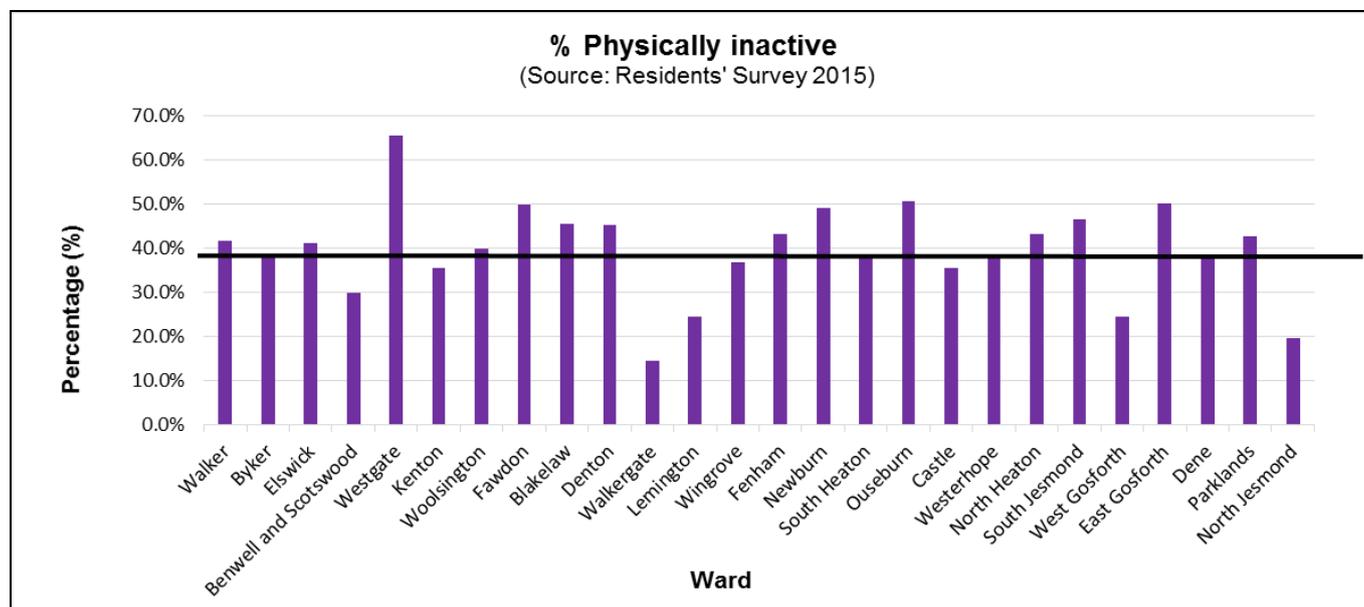


Figure 2.8-26: Physically inactive by ward 2015

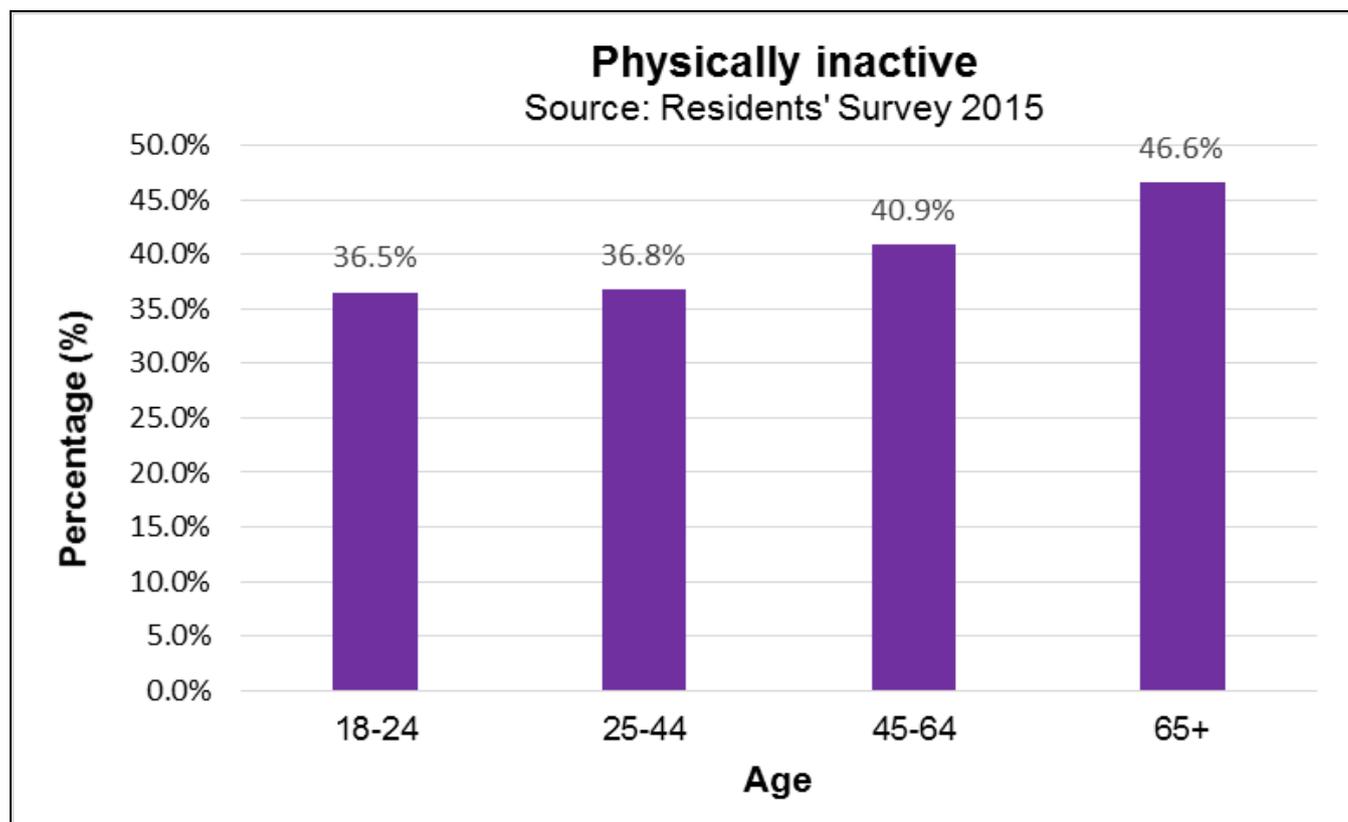


Figure 2.8-27: Physically inactive by age group 2015

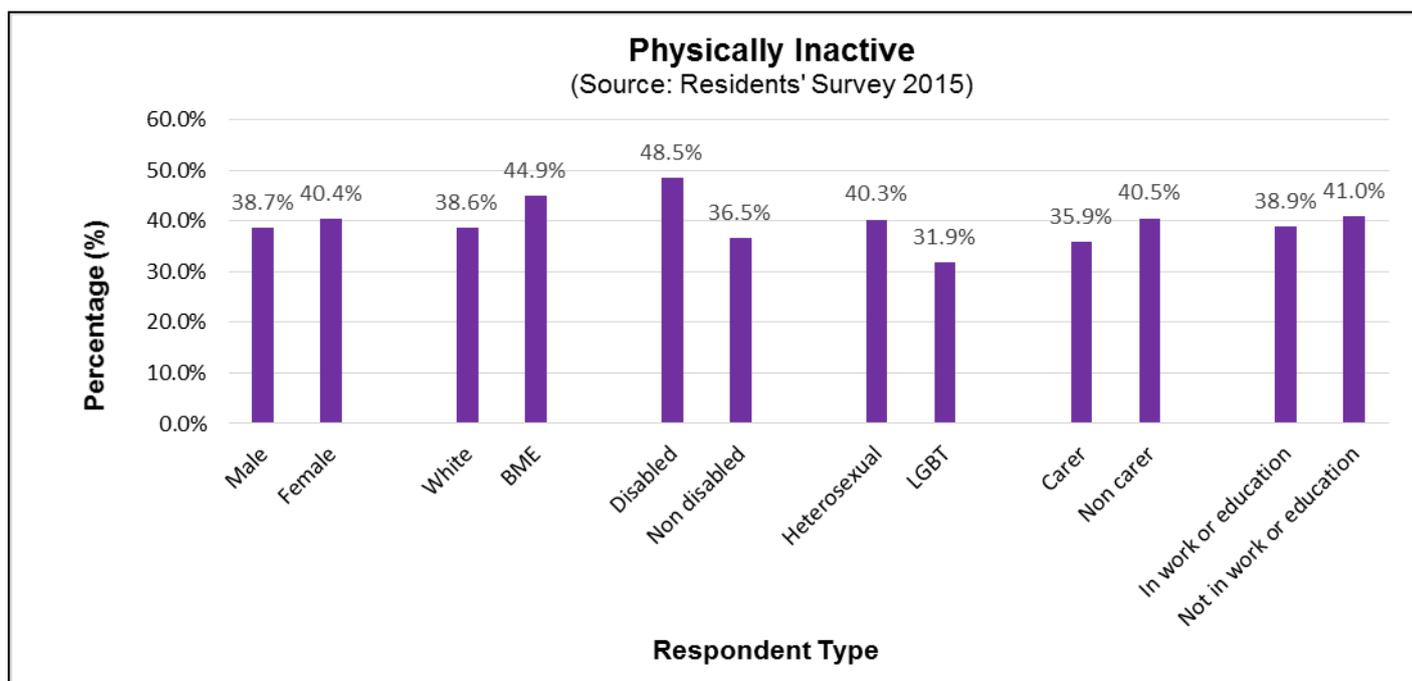


Figure 2.8-28: Physically inactive by respondent type 2015

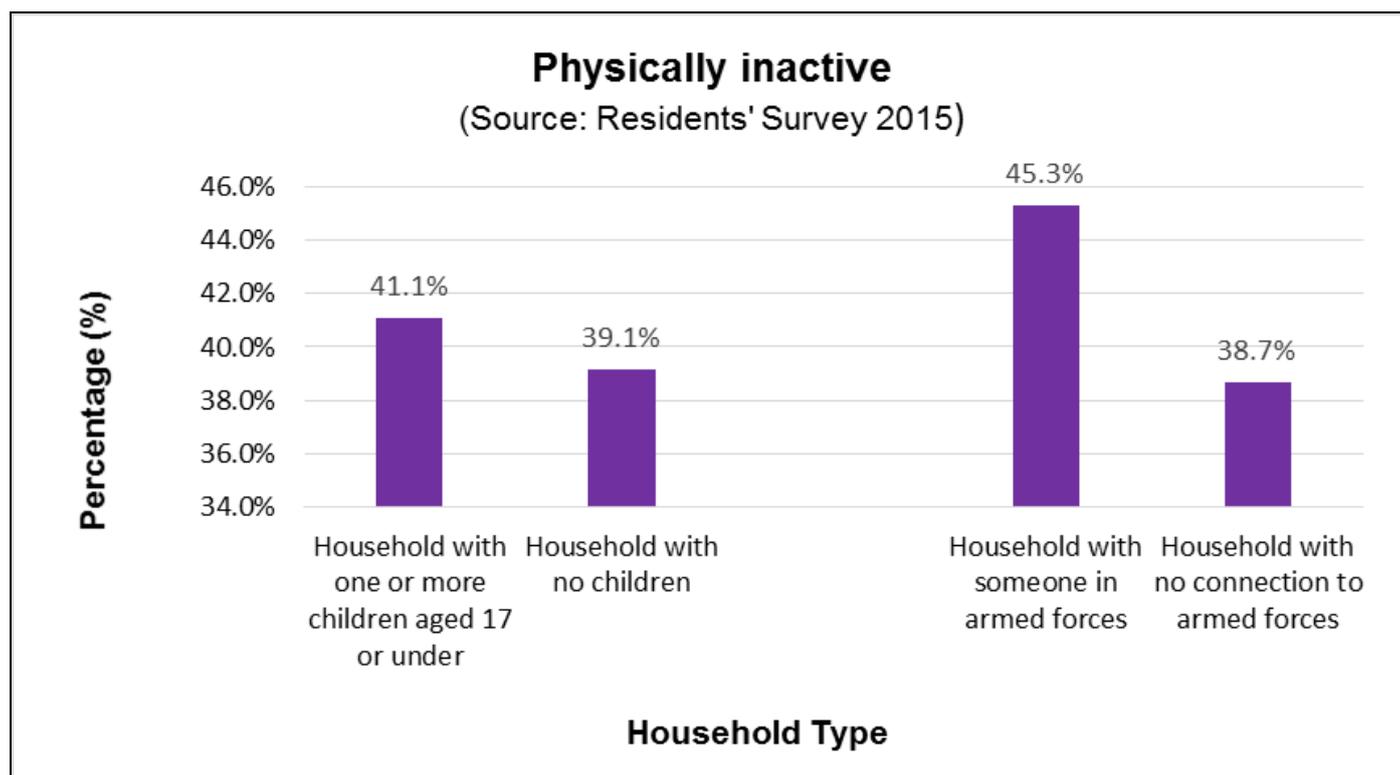


Figure 2.8-29: Physically inactive by household type 2015

### 2.8.4.2 Physical activity among children and young people

The Health-Related Behaviour Survey,<sup>18</sup> carried out in 2011, 2013 and 2015 in primary and secondary schools throughout the city, surveyed over 3,500 primary school pupils in years 4 and 6 and over 2,400 secondary schools pupils in years 8 and 10 (and a smaller number of pupils in year 12) in 2015. The 2015 survey looked at various indicators of physical activity, and revealed that:

Among primary school pupils:

- Most (41.7%) pupils walked all the way to school, with a smaller proportion (2.9%) going by bicycle. A large proportion (38.3%) of pupils went to school by car/van.
- 80.2% of pupils participated in physical activities at least once a week; in most cases walking, running, football, or team sports.
- Most (59.4%) pupils would prefer to walk or cycle to school.
- Most (82.9%) pupils enjoyed physical activities 'a lot' or 'quite a lot', and most (69.2%) considered themselves 'fit' or 'very fit'.

Among secondary school pupils:

- Over a third (35.7%) of pupils travelled to school by bus; another 22.5% by car/van. Almost a third walked all the way to school.
- Most pupils (29.4%) would prefer to walk all the way to school; a slightly smaller proportion (28.8%) prefer to travel to school by car/van, and 16.1% by bus.
- Most (64.9%) pupils engage in at least 3 hours of moderate/intensive physical activity per week.
- Most pupils (66.4%) enjoy physical activities 'a lot' or 'quite a lot'. Less than half (41.8%) perceive themselves to be 'fit' or 'very fit'; 41.7% as 'moderately fit'; and 16.6% consider themselves to be 'unfit' or 'very unfit'.

## 2.8.5 Diet and nutrition

### Why does this matter?

“A good diet and adequate food supply are central for promoting health and wellbeing. A shortage of food and lack of variety cause malnutrition and deficiency diseases. Excess intake (also a form of malnutrition) contributes to cardiovascular diseases, diabetes, cancer, degenerative eye diseases, obesity and dental caries. Food poverty exists side by side with food plenty. The important public health issue is the availability and cost of healthy, nutritious food. Access to good affordable food makes more difference to what people eat than health education”<sup>19</sup>

### 2.8.5.1 Early nutrition: breast milk

#### Why does this matter?

“Breast milk provides the ideal nutrition for infants in the first stages of life. There is evidence that babies who are breast fed experience lower levels of gastro-intestinal and respiratory infection, and studies have shown that breastfeeding is associated with lower levels of childhood obesity. Benefits to the mother include a faster return to pre-pregnancy weight and possibly lower risk of breast and ovarian cancer.” (Source: BMA Board of Science, 2009)

Figure 2.8-30 shows the rate of women initiating breastfeeding within the first 48 hours after delivery, as shown through information collected by the NHS. Newcastle’s initiation rate is at 68.4% in 2014/15, compared to the North East at 60.1% and England at 74.3%. Rates of breastfeeding initiation in Newcastle have improved year on year, increasing from 52.4% in 2006/07 to the current rate of 68.4%.

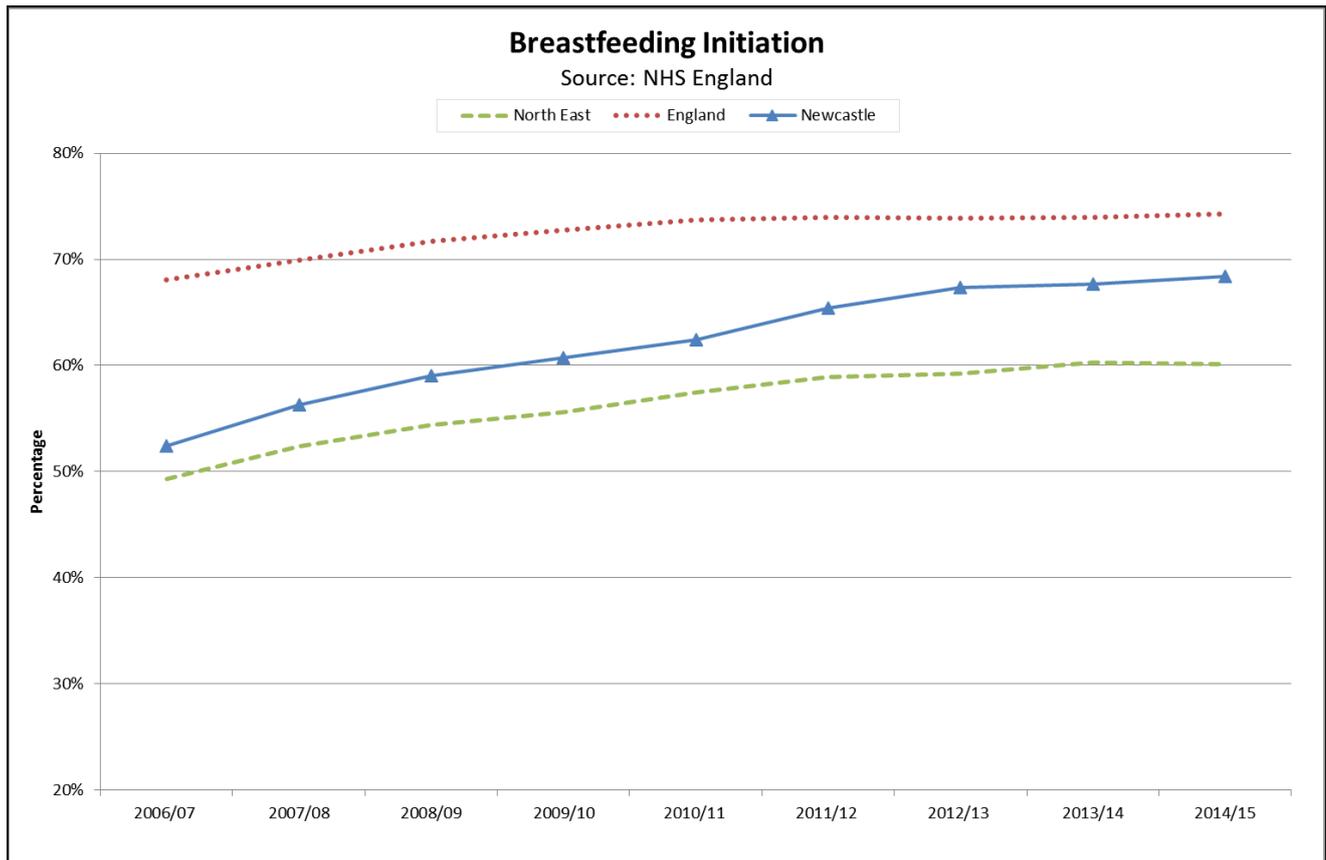


Figure 2.8-30: Initiation of breastfeeding within 48 hours of birth in Newcastle, North East and England. Source: NHS England 2014/15

Figure 2.8-31 shows the rate of women breastfeeding at 6 to 8 weeks after delivery. The 2014/15 figures show that Newcastle has a rate of 46.2% this is the highest rate over the 5 year period and an increase on the 2009/10 figure of 40.9%,.

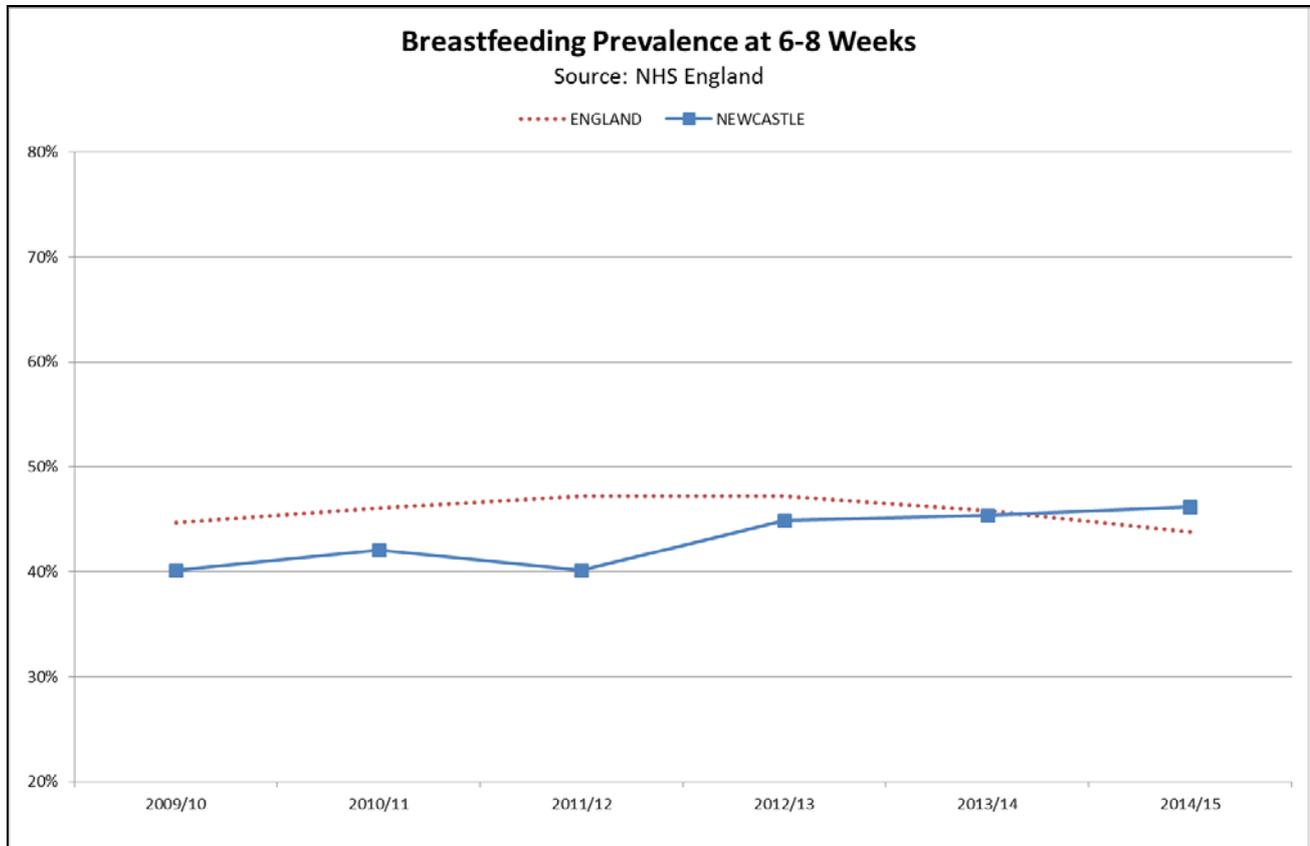


Figure 2.8-31: Breastfeeding at 6-8 weeks after delivery in Newcastle and England. Source: NHS England 2014/15.

The rate of breastfeeding at 6-8 weeks is shown at ward level for 2009/10 and 2013/14 in Figure 2.8-32. In 2013/2014, breastfeeding at 6-8 weeks ranged from 17% in Walker ward to 90% in North Jesmond ward.

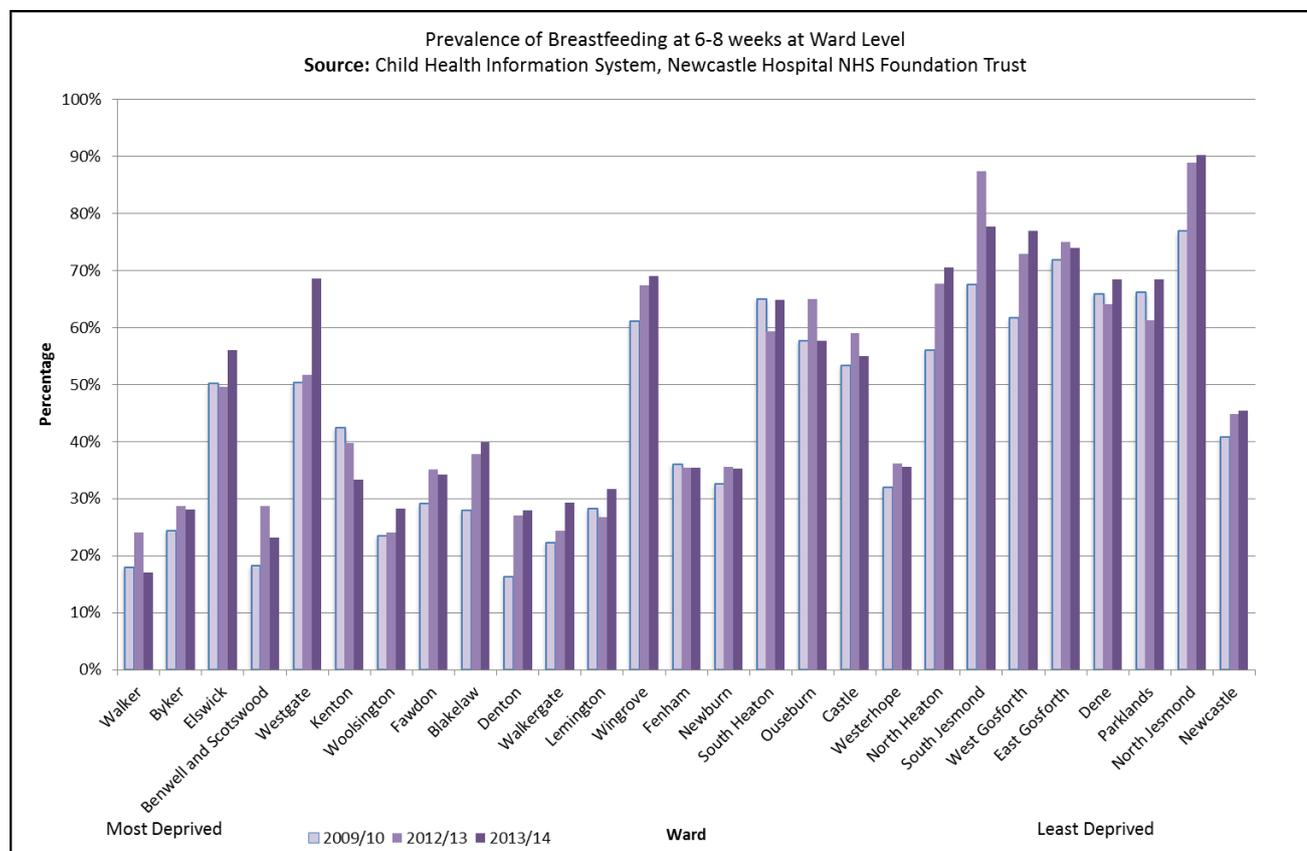


Figure 2.8-32: Breastfeeding at 6-8 weeks after delivery by ward between 2009/10 and 2013/14. Source: Child Health Information System, Newcastle Hospitals NHS Foundation Trust.

### 2.8.5.2 Nutrition among children and young people

The Health-Related Behaviour Survey,<sup>20</sup> carried out in 2011, 2013 and 2015 in primary and secondary schools throughout the city, surveyed over 3,500 primary school pupils in years 4 and 6 and over 2,400 secondary schools pupils in years 8 and 10 (and a smaller number of pupils in year 12) in 2015. The 2015 survey asked several questions related to nutrition, and revealed that:

Among primary school pupils:

- 33.7% of pupils had eaten at least five portions of fruit on the day preceding the survey.
- On the day of the survey, most (76.7%) pupils had cereal or toast/bread for breakfast, and most (77.1%) had water, milk, or fruit juice to drink. 7.6% of the pupils had eaten nothing, a further 7.4% had eaten crisps, chocolates, sweets, or biscuits, and 5.9% had a fizzy drink for breakfast.
- 56.5% of the pupils surveyed stated they ate fruit/vegetables on ‘most days’, while 7.1% stated the never ate fruit/vegetables.

- On 'most days', 24.6% pupils said they ate crisps, 14.1% chips or roast potatoes, 12.0% low-calorie fizzy drinks, 15.2% other fizzy drinks, 11.0% takeaway or fast food, and 23.1% had sweets or chocolates.

Among secondary school pupils:

- Most (71.5%) of the pupils surveyed had eaten lunch in the school cafeteria or a packed lunch on the day preceding the survey.
- Most (54.6%) pupils had cereal or toast/bread for breakfast on the morning of the survey, 12.8% had crisps, chocolate, sweets, pop tarts, cakes, or biscuits, and a further 25.5% had nothing to eat for breakfast. Most (37.0%) pupils drank water for breakfast, 43.3% had a hot drink, milk, or fruit juice, and 17.7% had a fizzy drink or high-caffeine drink (e.g. Red Bull).
- Less than half (39.0%) of the pupils surveyed considered their health 'often' or 'always' when choosing what to eat.
- On 'most days', most (52.4%) pupils ate fruit or vegetables, 14.4% had low-calorie fizzy drinks, 22.7% had other fizzy drinks, 25.4% ate crisps, and 26.6% had sweets or chocolate. 15.9% of the pupils surveyed had at least five portions of fruit or vegetables on the day before the survey.

### 2.8.5.3 Nutrition among adults

It is difficult to measure the **actual** prevalence of healthy eating as information is limited. Modelled estimates are drawn from the Health Survey for England and show the percentage of the population we would **expect** to eat healthily, given the characteristics of the local population. These modelled estimates therefore closely reflect socio-economic characteristics of people in different parts of the city.

It is estimated that 23.2% of the population in Newcastle eat healthily, compared to the England average of 28.7%. At ward level, the estimates closely reflect levels of deprivation, ranging from 13.7% - 33.7% across the city.

## 2.8.6 Maintaining a healthy weight

### Why does this matter?

A combination of lack of physical activity and poor diet leads to unhealthy weight.

“Developing a healthy lifestyle is important for young children, with increased risks to their wellbeing associated with obesity, junk food, and sedentary lifestyles. Learning to keep safe is an important element in the face of limitations imposed by a risk-averse society. Enabling parents to have the confidence, skills and motivation to get active with their families and to enjoy a healthy diet and avoid becoming ‘fussy eaters’ will be central to developing healthy lifestyles”<sup>21</sup>.

“Other problems due to obesity include:

- Musculoskeletal problems
- Reproductive and urological problems, including infertility
- Psychological and social problems by altered body image and stigma
- Respiratory problems (e.g. sleep apnea – interruptions to breathing while asleep)”<sup>22</sup>

“Obesity reduces life expectancy by an average of three years, or eight to ten years in the case of severe obesity (BMI over 40). This 8-10 year loss of life is equivalent to the effects of lifelong smoking”.<sup>23</sup>

### 2.8.6.1 Weight of children and young people

The UK’s Faculty of Public Health has produced a tool that provides an estimate of the number of children aged 2-15 years that are overweight or obese.<sup>24</sup> For Newcastle these numbers are **6542**, of which 3697 are boys and 2846 are girls, based on the 2012 Mid-year population estimates. Since this tool uses national data and does not take into account local factors such as ethnicity or deprivation that might affect overweight and obesity prevalence, it is very likely that it underestimates the true extent of the problem in Newcastle’s child population. Nevertheless, it gives some indication of numbers to enable us to assess the needs of the community and calculate the level of services needed to tackle overweight and obesity.

The most robust data are provided by The National Child Measurement Programme (NCMP) which is an annual programme that measures the height and weight of children aged 4-5 years (Reception) and 10-11 years (Year 6) in England. (Note that this is not the same cohort of children each year). Figure 2.8-33 shows trends in excess weight since 2006/07, with both year groups consistently higher than North East and England average since 2007/08. In 2011/12 there was a peak in the overall levels of excess weight, and in the proportion of pupils classified as obese amongst both year groups.

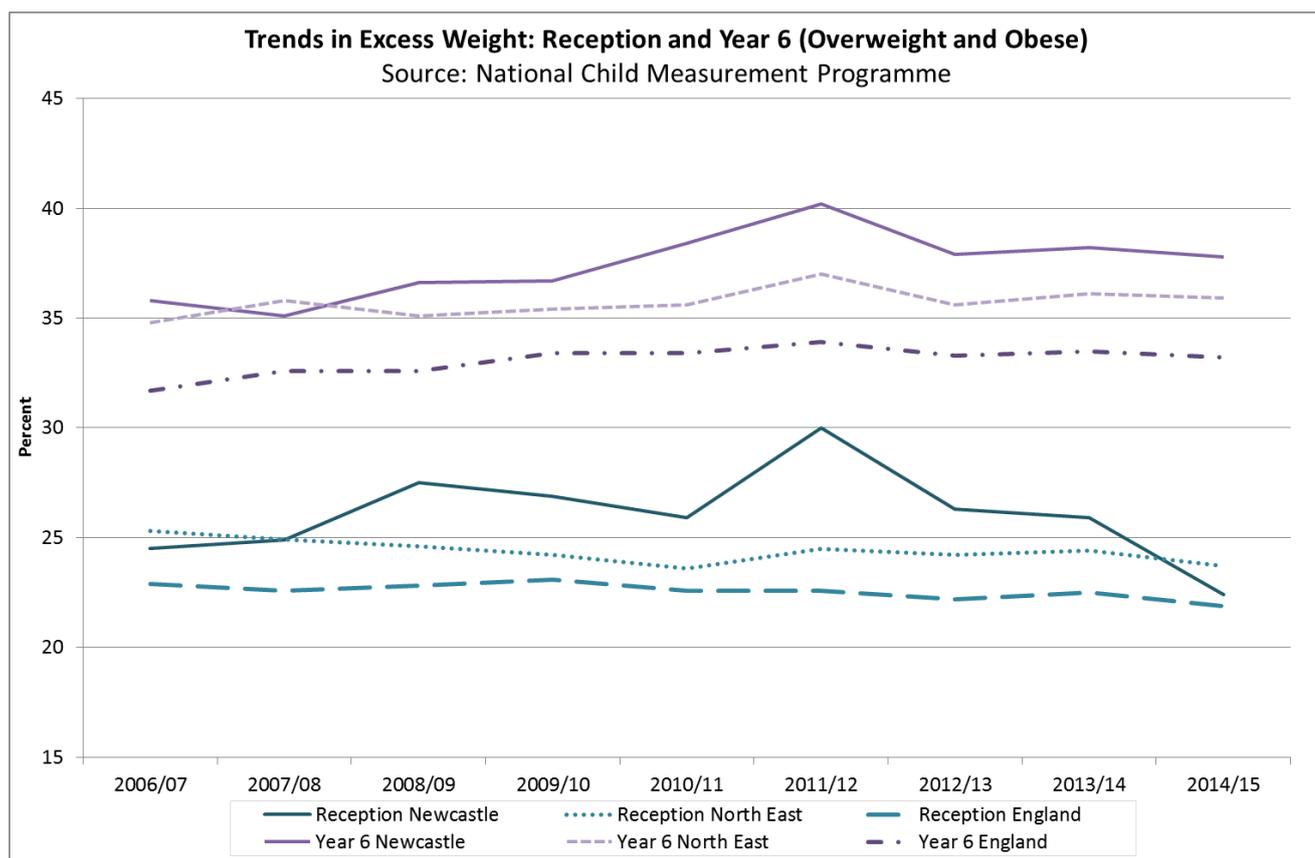


Figure 2.8-33: Trends in excess weight amongst Reception year and Year 6 pupils 2006/07–2014/15 for Newcastle, North East and England. Source: National Child Measurement Programme

### Reception (4-5 years old)

Overall 22.7% of Newcastle Reception year children were either overweight or obese in 2014/15, which is similar to the national average of 21.9% and the regional average of 23.7%. Compared to the group of core cities, Newcastle has gone from having the highest proportion of overweight or obese Reception pupils in 2013/14 to ranking 6<sup>th</sup> (of 8) highest (ranging from 20.6% in Sheffield to 27.6% in Nottingham).

10.1% of Reception year children were classified as obese, which is statistically similar to the England average of 9.1% and also the North East average of 10%. The proportion of children classified as overweight was 12.6%, similar to the national average of 12.8%.

There has been a stable trend in excess weight (overweight and obese) amongst Reception year, with the proportion increasing from 24.5% in 2006/07 to 30% in 2011/12 which has since declined to 22.7% in 2014/15. There was a peak in the proportion of pupils classified as obese in 2011/12 of 14.5%; however this has since declined to 10.1% in 2014/15 (Figure 2.8-34).

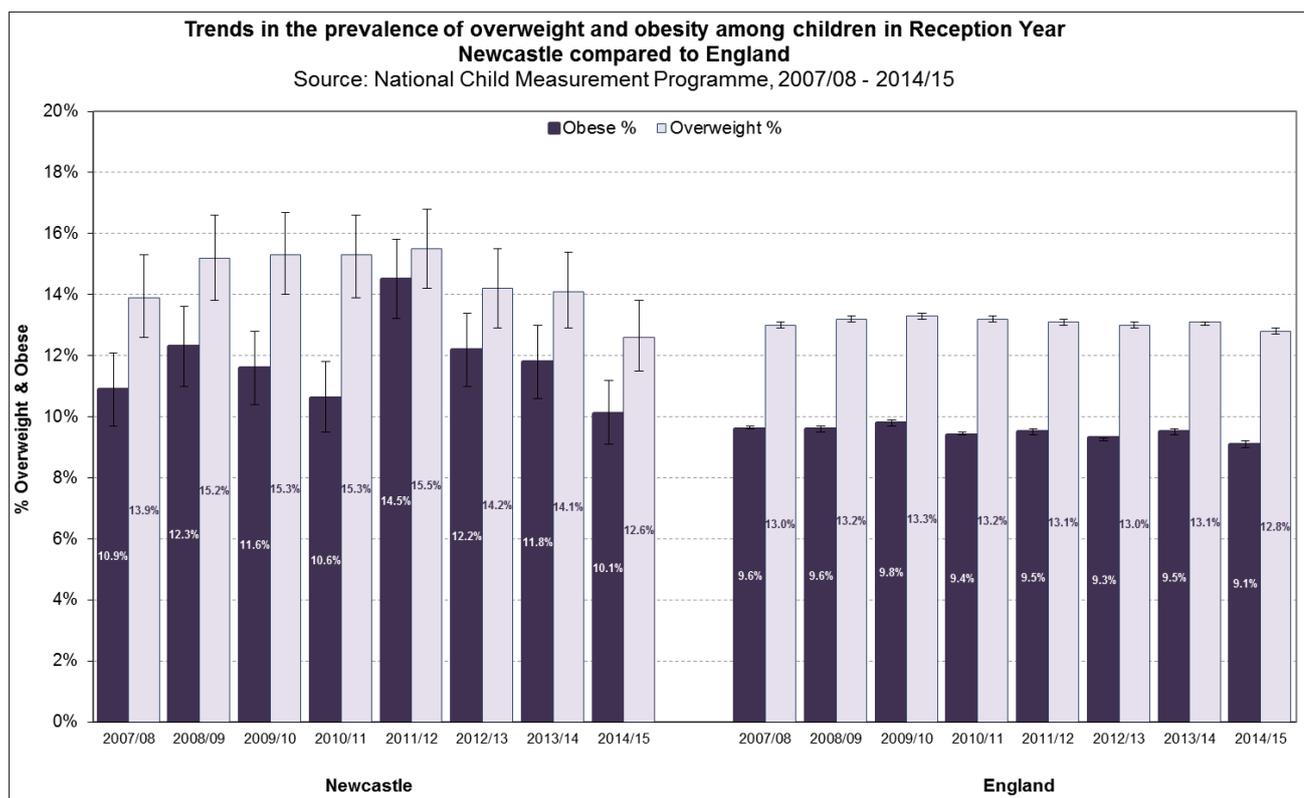


Figure 2.8-34: Trends in the prevalence of overweight and obesity among children in reception year (ages 4-5) for Newcastle and England. Source: NCMP, 2007/08 – 2013/14

The geographical distribution of obesity amongst Reception year children is shown in Figure 2.8-35. In the 2008/09 to 2010/11 data there was only one ward - West Gosforth - with an obesity rate which was statistically significantly lower than the Newcastle average, in the 2011/12 to 2013/14 data this has increased to four wards; North Heaton, East Gosforth, West Gosforth and Parklands, with no wards statistically significantly higher than the average. Note that data for North and South Jesmond are not presented due to small numbers and possible risk of disclosure of individual identities.

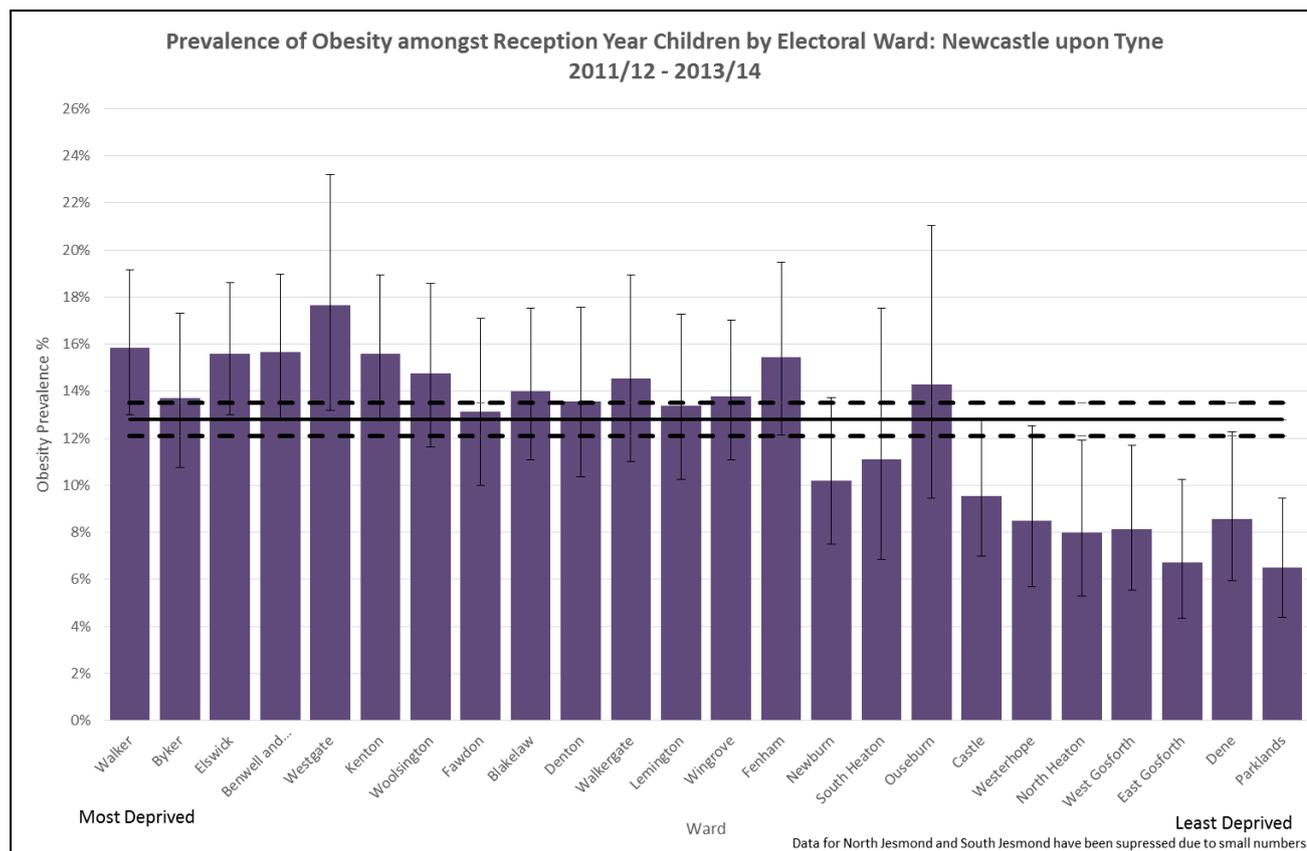


Figure 2.8-35: Prevalence of obesity among children in reception year by ward. Source: NCMP 2011/12-2013/14.

### Year 6 (10-11 years old)

In Year 6, the proportion of children overweight or obese rises to 37.6% in 2014/15; this figure is statistically significantly worse than both the North East (35.9%) and England (33.2%) average. Compared to the group of core cities, Newcastle has the fifth (of 8) highest proportion of overweight or obese Year 6 pupils, after Birmingham, Liverpool, Manchester and Nottingham (ranging from 33.0% in Leeds to 39.4% in Birmingham).

24% of year 6 children were classified as obese, more than double that of Reception, and statistically significantly higher than the North East (21.5%) and England (19.1%) average. 13.6% were classed as overweight, which is below the North East (14.5%) and England average (14.2%)

There is an overall increasing trend in excess weight (overweight and obese) within year 6, with the proportion increasing from 35.8% in 2006/07 to 37.6% in 2014/15, with a peak of 40.2% in 2011/12. The levels of pupils classified as obese peaked in 2011/12 at 25%; however this has declined to 24% in 2014/15 (Figure 2.8-36).

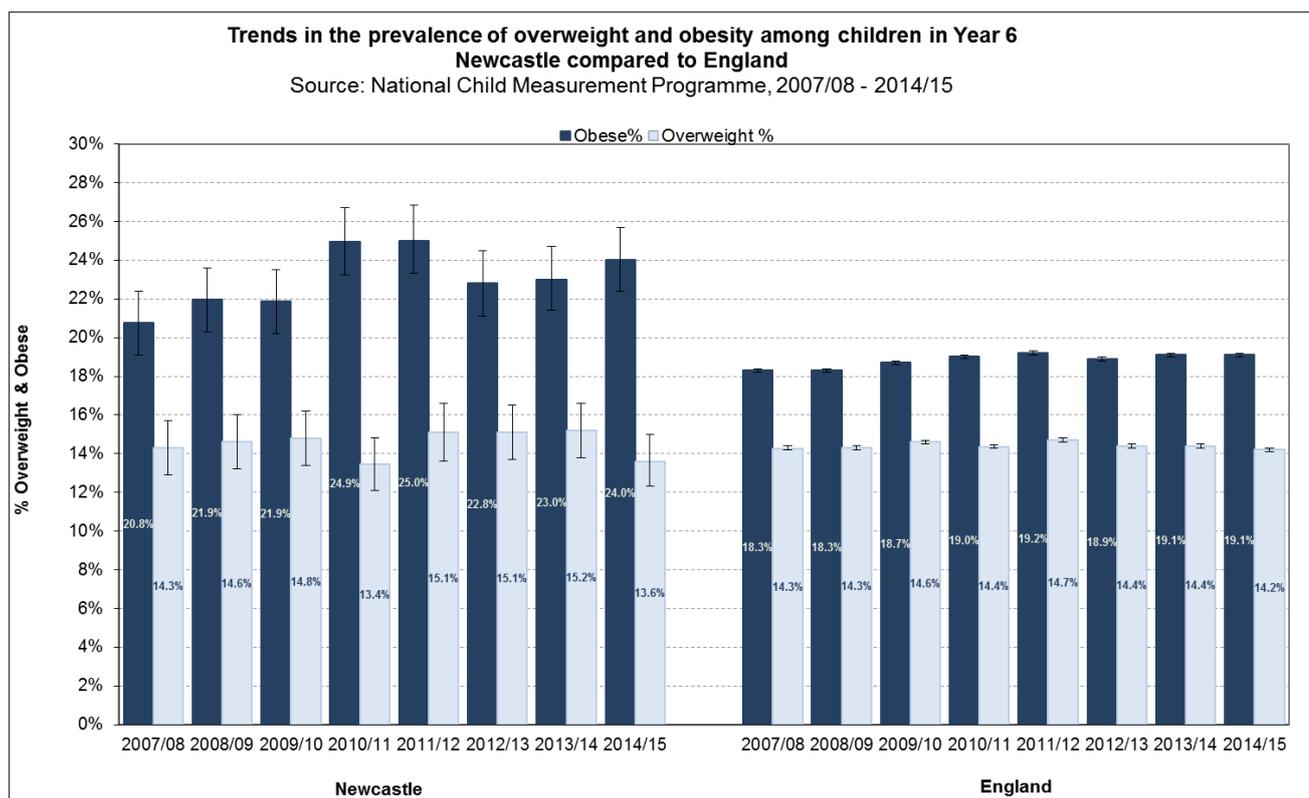


Figure 2.8-36: Trends in the prevalence of overweight and obesity among children in year 6 (ages 10-11) for Newcastle and England. Source: NCMP, 2007/08 – 2014/15.

The geographical distribution of obesity among Year 6 children is shown in Figure 2.8-37. In the 2008/09 to 2010/11 data there were three wards - West Gosforth, East Gosforth and Dene – that had obesity rates which were statistically significantly lower than the Newcastle average. In 2011/12 to 2013/14 this had increased to four wards – Castle, East Gosforth, Dene and Parklands which are amongst the least deprived wards in the city. There were also two wards which were statistically significantly higher than the average; Elswick and Benwell and Scotswood. The data for North and South Jesmond are not presented due to small numbers and possible risk of disclosure of individual identities.

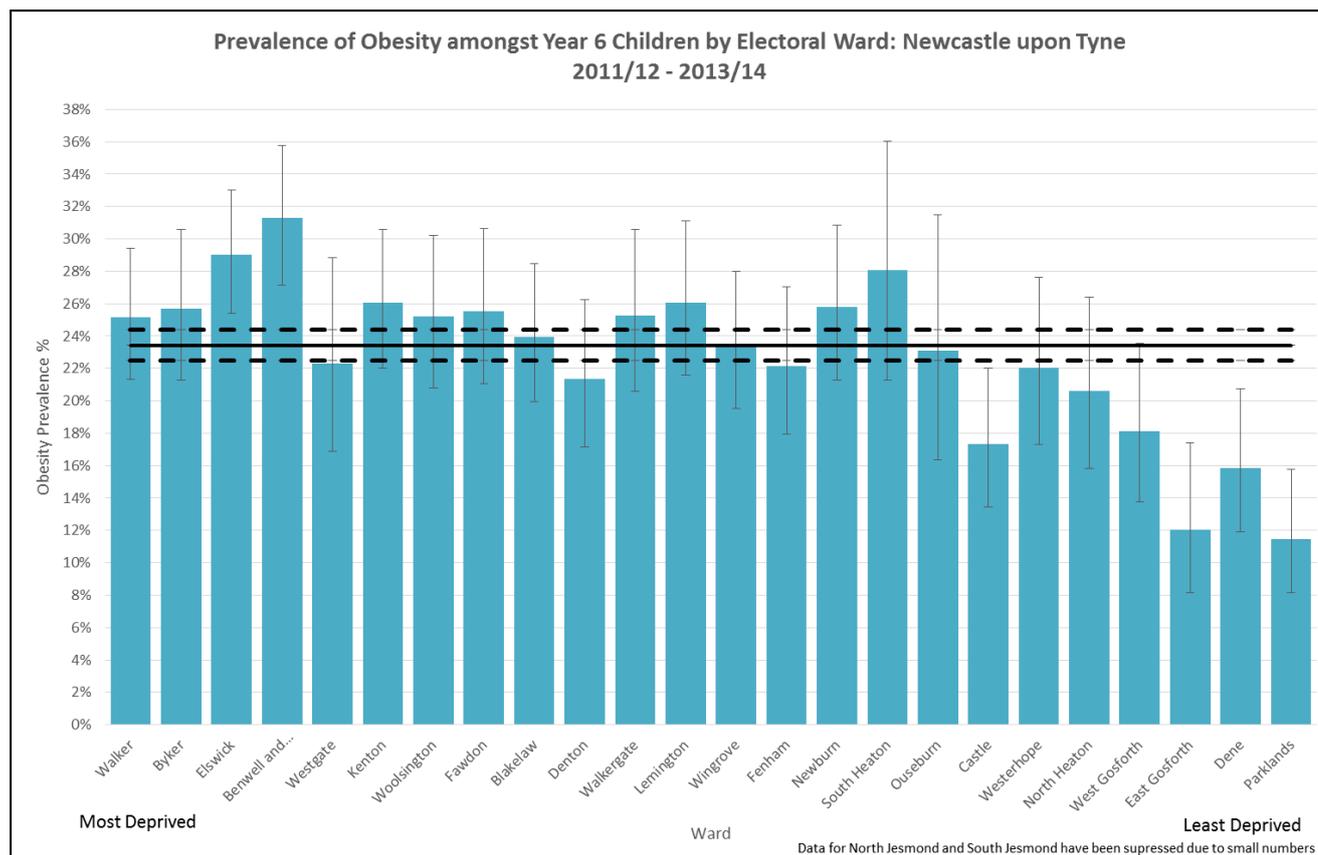


Figure 2.8-37: Prevalence of obesity among children in year 6 by ward. Source: NCMP 2011/12 – 2013/14.

### Socioeconomic status

Figure 2.8-38 highlights the relationship between deprivation and the levels of obesity amongst year 6 pupils using smaller geographical areas (Middle Layer Super Output Areas). There are typically lower levels of obesity seen in the least deprived geographical areas compared to the most deprived geographical areas.

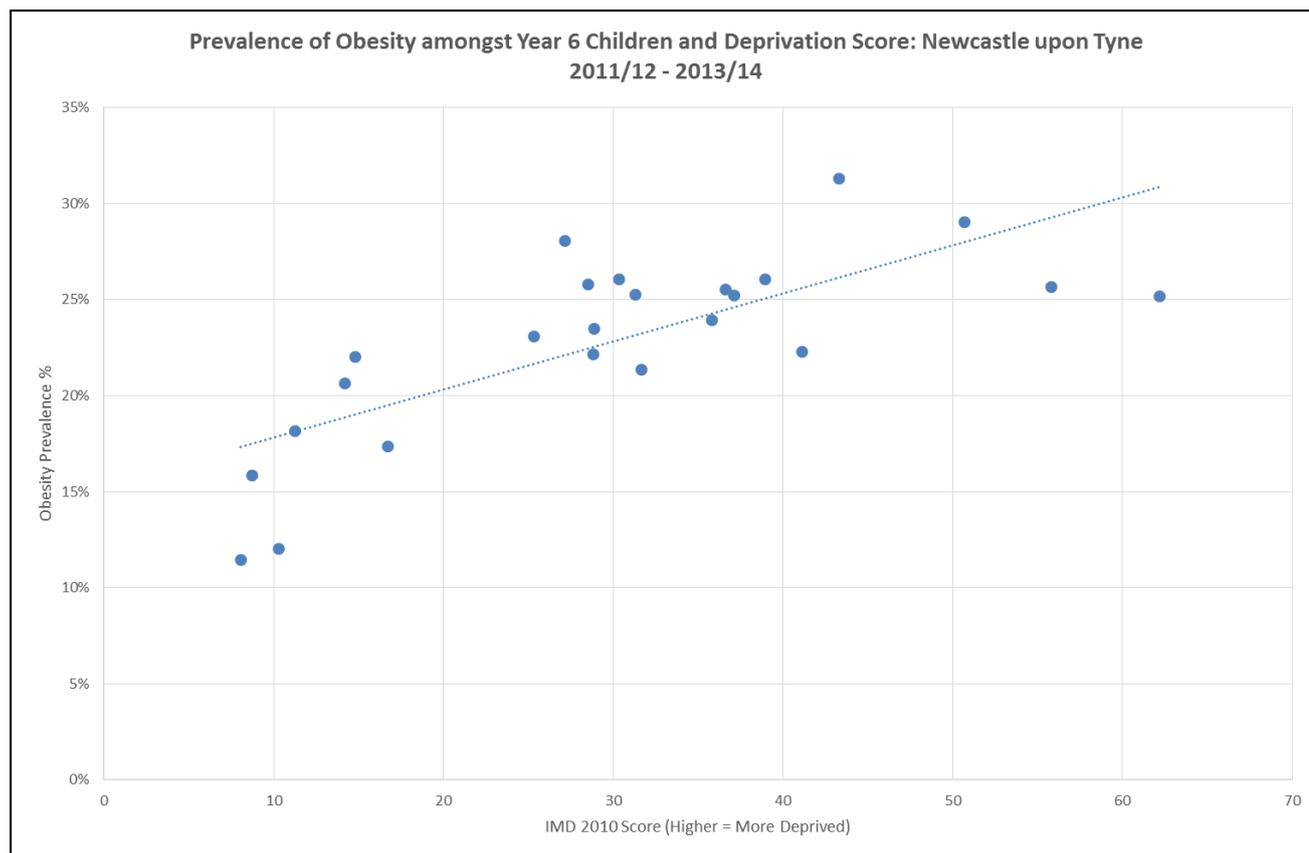


Figure 2.8-38: Relationship between Middle layer Super Output Areas (MSOAs) and percentage of year 6 children who are obese. Source: NCMP 2011/12 – 2013/14 and IMD 2010

### Ethnicity

The NCMP data also highlights differences in obesity prevalence between ethnic groups at the national level (Table 2.8-4).

Table 2.8-4: National differences in obesity prevalence for ethnic groups. Source: NCMP, 2014/15, Health and Social Care Information Centre (HSCIC).

Ethnic category	Reception		Year 6	
	Prevalence	95% confidence interval ±	Prevalence	95% confidence interval ±
England	9.1%	0.1%	19.1%	0.1%
White	8.5%	0.1%	17.7%	0.1%
Mixed	9.9%	0.4%	21.2%	0.6%
Asian or Asian British	10.0%	0.3%	24.1%	0.4%
Black or Black British	14.7%	0.4%	27.9%	0.6%
Chinese	7.6%	1.2%	18.1%	2.0%
Any Other Ethnic Group	11.0%	0.6%	24.4%	0.8%
Unknown	8.8%	0.2%	18.1%	0.2%

### **2.8.6.2 Weight of adults**

The Faculty of Public Health's tool referred to above also enables estimates of adult obesity prevalence to be calculated. For Newcastle, the number of adults aged 16 and over estimated to be obese is 51,932 based on the 2012 mid-year population estimates. The tool estimates 25,358 men and 26,574 women in Newcastle are obese.

The tool also estimate the number of adults aged 16 and over with central obesity as measured by a raised waist circumference. A raised waist circumference can be used to identify people at risk of the metabolic syndrome, a disorder characterised by increased risk of developing diabetes and cardiovascular disease. For Newcastle this figure is approximately 78,251. As mentioned previously, this tool uses national data and does not take into account local factors such as ethnicity or deprivation. Therefore, it is likely that it provides an underestimate of the true extent of overweight and obesity in Newcastle's adult population.

The 2014 Active People's Survey also included questions relating to height and weight to provide monitoring of excess weight at local authority level. This takes into account potential under-estimation from self-reporting among different populations. Estimates have therefore been adjusted to take this into account. BMI calculations from the adjusted data classified excess weight as a BMI greater than or equal to 25.

In Newcastle, the proportion of adults considered overweight or obese was 60.3%, which is less than the North East average of 68.0% and slightly less than the England average of 63.8%.

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- <sup>2</sup> Source Cancer Research UK. Extracted from 'Over 40% of cancers due to lifestyle, says review' BBC News On-line 7 December 2011. at <http://www.bbc.co.uk/news/health-16031149> [accessed 22 March 2011].
- <sup>3</sup> Wilkinson, R. and Marmot, M (editors) (2003) "Social determinants of health: the solid facts". 2nd edition, World Health Organisation.
- <sup>4</sup> Data on adult (ages 18 and above) smoking prevalence from the Integrated Household Survey (IHS) covering the period from April 2011 to March 2012. <http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/par/E12000001/ati/102/page/3>
- <sup>5</sup> DH/National Support Team – Tobacco Control, Tackling Health Inequalities – Targeting Routine and Manual Smokers in Support of the Public Service Agreement Smoking Prevalence and Health Inequality Targets, June 2009.  
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- <sup>6</sup> Monitoring data collected to support the Quality and Outcomes Framework, 2012/13.
- <sup>7</sup> Association of Public Health Observatories - Estimates of Adults' Health and Lifestyles
- <sup>8</sup> Young people in Newcastle: A focus on Smoking: A report from the Health Related Behaviour Survey 2013
- <sup>9</sup> Wilkinson, R. and Marmot, M (editors) (2003) "Social determinants of health: the solid facts". 2nd edition, World Health Organisation.
- <sup>10</sup> Young people in Newcastle: A focus on Smoking: A report from the Health Related Behaviour Survey 2013 and 2011
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- <sup>12</sup> Wilkinson, R. and Marmot, M (editors) (2003) "Social determinants of health: the solid facts". 2nd edition, World Health Organisation.
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- <sup>14</sup> Hay *et al* (2013), "Estimates of the prevalence of opiate use and / or crack cocaine use 2011/12: sweep 8 report
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- <sup>17</sup> Public Health Outcome Framework (PHOF), <http://www.phoutcomes.info/>
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- <sup>19</sup> Wilkinson, R. and Marmot, M (editors) (2003) "Social determinants of health: the solid facts". 2nd edition, World Health Organisation.
- <sup>20</sup> Young people in Newcastle: A focus on Smoking: A report from the Health Related Behaviour Survey 2013 and 2011
- <sup>21</sup> Spotlight on childhood obesity, January 2012.
- <sup>22</sup> [http://www.noo.org.uk/NOO\\_about\\_obesity/obesity\\_and\\_health/health\\_risk\\_adult](http://www.noo.org.uk/NOO_about_obesity/obesity_and_health/health_risk_adult)
- <sup>23</sup> [http://www.noo.org.uk/NOO\\_about\\_obesity/obesity\\_and\\_health](http://www.noo.org.uk/NOO_about_obesity/obesity_and_health)
- <sup>24</sup> Available at: [http://www.fph.org.uk/Obesity\\_Ready\\_Reckoner](http://www.fph.org.uk/Obesity_Ready_Reckoner)